NHS
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MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 13th September 2021

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

Present:	Mr J Amaechi (JA) Professor Dame S Bailey (SB) Mr D Banks (DB) Dr I Benett (IB) Mr P Blythin (PB) Mrs J Bridgewater (JB) Mrs K Cowell (Chair) (KC) Mr B Clare (BC) Sir M Deegan (MD) Professor J Eddleston (JE) Mrs J Ehrhardt (JEh) Professor L Georghiou (LG) Mr N Gower (NG) Mrs G Heaton (GH) Professor C Lenney (CL) Mrs C McLoughlin (CM) Miss T Onon (TO) Mr T Rees (TR)	- 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 (joined meeting at 14.33) - Group Non-Executive Director - Group Deputy CEO - Group Chief Nurse - Group Non-Executive Director - Joint Group Medical Director - Group Non-Executive Director
In attendance:	Mr N Gomm	- Director of Corporate Business / Trust Board Secretary

108/21 Board of Directors' (Public) Meetings

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

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

109/21 Apologies for Absence

No apologies were received.

110/21 Declarations of Interest

There were no declarations of interest received for this meeting.

111/21 Minutes of the 'virtual' Board of Directors' Meeting held on 12th July 2021

The minutes of the Board of Directors' meeting of 12th July 2021 were approved.

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

112/21 Matters Arising

There were no matters arising.

113/21 Group Chairman Report

KC presented a summary of recent events of note.

Following the success of the film, 'Our MFT Story' which was shared at the end of July, an ebook is now available to view showcasing several individuals and teams from across Hospitals/ Managed Clinical Services, the Local Care Organisations and Corporate Services at MFT. Each story reflects how that team or individual responded to the pandemic. Part two of 'Our MFT Story' film was premiered on Friday 10th September. This work is part of a wider recognition campaign, as part of the MFT People Plan.

MFT is part of a vanguard of ten NHS Trusts who will work in partnership with NHS England and LGBT Foundation, to pilot a new NHS Rainbow Badge model. The NHS Rainbow Badge Pilot will develop the existing Rainbow Badge Scheme into an NHS Trust Accreditation model, enabling Trusts like ours to demonstrate their commitment to LGBTQ+ inclusion, to improve patient care, and be the best place to work.

More than 430 colleagues have now signed up to be a part of the #TeamMFT blue wave at the Great Manchester Run on Sunday 26th September. This event is a brilliant opportunity to improve team morale and support health and wellbeing.

On 14th September, MFT will celebrate Armed Forces Day, following the postponement of the planned event in June due to COVID-19 (Covid) restrictions. The event is a chance to show support for the men and women who make up the Armed Forces community: from currently serving troops to service families, veterans, and cadets. Amongst the guests are the Lord Lieutenant, the Lord Mayor of Manchester, the Mayor of Greater Manchester, and several representatives of the armed forces,

This year's Annual Members' Meeting (AMM) is taking place on Tuesday 21st September virtually. The AMM pre-recorded presentations will be available to view on the MFT website on 21st. We are using the virtual format again this year to protect our members, and the wider public, while the coronavirus pandemic continues.

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

114/21 Group Chief Executive's Report

MD highlighted three key issues.

There are unprecedented levels of pressure across MFT's sites at present. There is an ongoing, significant, Covid workload; demand on urgent care services is high; and the elective recovery work continues to be delivered. This is against a backdrop of less capacity available across sites due to the need to maintain the measures introduced to protect patients and staff against Covid infection. MFT is focussing on the safety of services and ensuring the best care is provided to each patient. Delivery of national targets is important but patient safety must continue to be paramount. These pressures will continue, and likely intensify, through the winter months and it will be crucial to look after our workforce in these challenging times.

The work required to deliver HIVE EPR is significant and there is less than 12 months to the 'go live' date. As a result, Julia Bridgewater, Group Chief Operating Officer, will concentrate full time on the Programme for the next 12 months or so. David Furnival, in his capacity as Deputy Group Chief Operating Officer, will assume responsibility for the operational portfolio as Group Director of Operations.

Further guidance regarding the implementation of the Health and Care Bill was published by NHSE/I two weeks ago. The guidance provides more information regarding the duties and responsibilities of the new Integrated Care Systems which will come into force from April 2022. Interviews have been held for the Chair of Greater Manchester's ICS and an announcement of the successful candidate is awaited. The appointment of the Chief Executive will follow in the coming weeks.

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

115/21 Board Assurance Report

The Executive Directors, responsible for the different areas covered, presented the report which informs the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.

TO presented the Safety section and explained that, in February 2021, the Trust implemented a Group-wide safety management system which enables the timely contextualisation of multi-source information about the safety of the care we provide to patients. This approach ensures a smart approach to identifying opportunities for high impact and transferable learning, accelerated improvement and smart assurance through a range of initiatives including a weekly Trust-wide Patient Safety Oversight Panel.

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

CL presented the Patient Experience section and highlighted the percentage of formal complaints that were resolved in the agreed timeframe was 86.1% - a decrease of 11.1% from the previous two months. The number of new complaints received across the Trust during July 2021 was 140, which is a decrease of 9 when compared to 149 in June 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF). The Trust overall satisfaction rate for the Friends and Family Test (FFT) is 94.3% in July 2021 which is an increase compared to 92.4% in June 2021.

MFT's performance is above trajectory for both Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile infection (CDI): when comparing MFT's Q1 position to that of Q2, CDI rates have increased from 24.8 to 33 cases per 100,000 overnight beds and MRSA bacteraemia rates have increased from 1.6 to 2.3 cases per 100,000 overnight beds. E. coli rates have increased from 31.8 to 35.1 cases per 100,000 overnight beds. There have been 60 trust-attributable CDI reported so far this year, against a threshold of 52. There have been 3 trust-attributable MRSA bacteraemia and 27 E. coli bacteraemia so far this financial year.

JB explained that she would provide detail on the Operational Excellence section under item 7.2 on the agenda.

PB presented the Workforce and Leadership section and described the challenges currently being faced, with high staff absence rates. Work continues to progress the MFT People Plan with associated communications focussing on a monthly theme, with the first month's theme being 'Recognition - We feel valued and heard'. The People Plan Delivery Group (PPDG) has now been established and receives progress updates and escalations from Deliverable Owners.

Accelerated recruitment initiatives are taking place in key areas and a variety of recovery-focused team development packages have been created. Work to further enhance the psychological support for staff is underway and partnership arrangements with Greater Manchester Mental Health (GMMH) are currently being explored. The procurement of a new Learning Management System is near completion and preparations for HIVE end user training have commenced.

The Finance section is covered later on the Board agenda.

TR asked about the current position about international recruitment.

CL replied that there was a healthy pipeline for international nurses and conversations were ongoing with Health Education England to establish similar arrangements for midwives.

PB explained that they had delivered a successful project recruiting radiographers from the Caribbean.

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

116/21 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

JB presented the report which provided an update on MFT's ongoing response to the COVID-19 pandemic (Covid).

Since the start of June 2021 there has been an increasing incidence of Covid in the community, and this resulted in a sharp and sustained increase in Covid inpatient and Critical Care numbers at MFT. At 25th August MFT had 156 Covid inpatients and 23 Covid patients in Critical Care.

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

The continued prevalence of Covid, and the need to stand down elective activity for significant periods since March 2020 has had a profound impact on the shape and size of the waiting list at MFT. The overall waiting list size at the end of July 2021 was 141,545 of which the volume of >52-week waiters at the end was 14,442, a decrease of 2,991 (17.2%) on the position at the end of March 2021(17,433).

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

The MFT elective recovery programme is aligned to the GM principles and has four main workstreams:

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

Bids have been submitted for funding through the Elective Recovery Fund to use Trafford hospital as a standalone elective hub facility.

Planning for 2021/22 has been split into two sections: H1 planning, which covered April to September, and H2 planning, which will cover October to March. There has been limited information released about the H2 requirements, however it is apparent that there will be further national focus on reduction of long waiters over 104+ weeks. It is also understood that targets will be set for Outpatient transformation, with a 2% target for follow-up patients added to Patient Initiated Follow Up ("PIFU") and a 15% target for advice and guidance ("A&G") to be given to new referrals.

Since mid-February, MFT Emergency Departments (EDs) have encountered significant pressures with high attendances and an increase in acuity of patients. As a result of high demand, and a continued need to split estate and flow to manage IPC requirements, MFT continues to have a significant number of breaches across Eds. Given current attendance and performance levels, monitoring of delivery is taking place daily through routine reporting, and weekly through Strategic Group.

At the mid-point of Quarter 2 of 2021/22, the overall levels of outpatient activity have fallen to 82% with all hospitals experiencing a fall in activity compared to 19/20. This is in part due to site pressures as Covid inpatients have increased on the acute sites and staff redirected from outpatients. However, it is also driven by the greater than usual staff sickness absence and annual leave. Virtual activity levels have remained at close to 30% across Q2.

Recognising the unequal impact of Covid across society, MFT has recently established a data-led Health Inequalities Group. The Group is chaired by the Joint Group Medical Director and attended by representatives from the hospitals/MCS, corporate teams and the Clinical Commissioning Group.

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

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

MFT's performance across Urgent Care, Planned Care, Diagnostics, and Cancer were noted by the Board.

MD emphasised that MFT's focus was on the safety of patients whilst recognising the importance of national targets and explained that the winter period was going to be challenging.

KC pointed out that the Board seminar in October would be used to look at these performance issues within a Greater Manchester context. Despite the challenges over the last 18 months, MFT's performance has been impressive. For example, the Trust has delivered two babies every hour of every day. KC also stated that the Senior Leadership Walk Rounds had proved useful to see the hard work of staff and the way in which they were focussing on patient safety.

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

Update on the COVID-19 Vaccination Programme

CL presented the report which provided an update on MFT's Covid Vaccination programme. LG joined the meeting at this point.

Over 140,000 vaccinations have been provided and MFT continues to work in partnership with Manchester Health and Care Commissioning in delivery of the Manchester vaccine programme by:

- Walk-in clinics to specifically targeted groups.
- Offer of vaccination to pregnant women of all ages, including staff who are booked for care at St Mary's.
- Opportunistic in-patient vaccination, including paediatric in-patients and particularly vulnerable groups, for example patients who have undergone stem cell transplant since initial vaccination course completed

Significant work continues to persuade pregnant women to be vaccinated. Dr Teresa Kelly has been at the forefront of promoting the benefits and the importance of it.

For the next phase of the programme, MFT planning aligns with the national approach by supporting co-administration of flu and COVID-19 vaccines for MFT staff in the same appointment to allow more efficient use of resources, as well as supporting improved uptake of both vaccines. A national announcement is expected soon regarding the vaccination of 12-15 year-olds.

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

Update on the COVID-19 Infection Prevention Control Response and Nosocomial Infections

CL presented the paper which provided an update on the Infection Prevention Control (IPC) Board Assurance Framework, Nosocomial Transmissions of COVID-19 and progress on the Infection Prevention and Control Development Pathway.

Assurance was provided that:

- the Trust has assessed the systems and processes in place against the new indicators in the IPC BAF.
- the Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls2.
- patients and visitors are fully aware of the measures staff are required to take to prevent COVID infections, and the measures they are themselves required to take to prevent COVID infections.
- national IPC Public Health England (PHE) guidance is regularly checked for updates and any changes are communicated to staff in a timely way.
- a COVID-19 dashboard has been developed to provide oversight of nosocomial infections at Trust-wide level, and by hospital and clinical area.
- the key measures of hand hygiene, appropriate PPE and social distancing are embedded within all staff groups; regular audits are undertaken.
- the PHE campaign 'Hands, Face, Space' is visible across the Trust, clear signage is in place at all egress points as well as in clinical areas.
- measures are in place to ensure staff can comply with social distancing and PPE in non-clinical areas.
- measures are in place to routinely test staff using both Lateral Flow Testing and PCR testing; including PCR testing if an outbreak occurs.
- regular audits of patient testing guidelines take place, with actions in place to improve compliance where required.
- the trust has developed a database to monitor mask fit testing.
- decontamination policies and procedures are in place.
- identified gaps relating to monitoring of cleaning standards and frequencies in clinical and non-clinical areas are being addressed.
- the Board receive regular reports relating to the IPC BAF, which is also incorporated into the main Board of Directors BAF.

There were four Covid outbreaks across MFT in July, and three in August up to 23rd August. Each outbreak is reviewed to learn lessons.

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

The Joint Group Medical Directors have supported the development of guidance[5] which has been developed by the North West Structured Judgement Review (SJR) Task and Finish Group. This is a framework for reviewing deaths from COVID-19 nosocomial infection and captures all the information required.

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

117/21 Chief Finance Officer's Report

JEh presented the report and highlighted the fact that the national finance guidance for H2 (1 October 2021 to 31 March 2022) was not yet available.

MFT is required to deliver a surplus of £23.1m for H1 and has developed the H1 plan to reflect this requirement, with a break-even position for H2. There is a significant assumption, and therefore risk, included in the H2 plan of system funding being available at a level of half that in H1.

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

Year to date to Month 4, July 2021, the Trust has delivered a surplus of £2.4m against the break-even plan. This represents steady performance but significant improvement in the financial position is required to meet the H1 target.

During July, the expenditure run rate has continued to increase with expenditure increasing across the hospitals. Subsequently some of the Hospitals/MCS/LCO forecasts are significantly above the levels of agreed control totals. Work is ongoing with each Hospital/MCS/LCO to understand the reasons for the variance and to bring the variance down. It is recognised that we are in a particularly challenging operational environment, however the need to maintain strong financial governance and control remains essential, particularly in view of the revised financial framework for 2021/22.

The Trust undertakes a top-down forecast monthly based on the YTD run rate and key known changes and this is compared to the more detailed hospital and department forecasts. The controls over additional investment linked to activity recovery have been established, in the short term these have been supported by additional income from the Elective Recovery Fund (ERF) however the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime.

The "expenditure led" financial regime that was in place in the last financial year presented a significant risk to the Trust, through the changed behaviours which it created. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic.

Formal notification has been received that the current financial regime will largely remain in place for H2 of 2021/22, although the scale of funding has not yet been released. The Finance Accountability Framework has been updated and clarified, and is now being implemented, as part of the overall Accountability Oversight Framework.

As at 31st July 2021, the Trust had a cash balance of £279.4m, which includes £4.1m transferred in from the North Manchester balance sheet disaggregation. Overall, this position represents a decrease of £3.0m from the underlying MFT position at the end of May, with the reduction primarily due to final VAT submission for 20/21. The overall high cash balance reflects ongoing levels of accruals and provisions such as the annual leave and HCSW pay review provisions at the end of 20/21 and ongoing slippage against the Capital programme.

The capital plan reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the system capital envelope. The "envelope" plan value for 2021/22 is £199.2m with the potential outturn estimated to be £208.5m, reflecting backlog maintenance pressures. Slippage across the programme during the year will bring the actual spend back in line with the agreed envelope.

The position across GM is that additional funding streams identified through the year will also be applied to assist in closing the gap, where appropriate, as opposed to being entirely new spend.

Up to July 2021 £31.9m capital expenditure has been incurred against a plan of £40.9m – an underspend of £9.0m. The majority of the slippage, £6.2m, relates to the HIP2 project and is due to delays in the approval of the Park House scheme and associated enabling works.

The transfer by absorption of the NMGH transaction was incorporated into the balance sheet in month 3 and is reflected in the I & E as a below the line Transfer by Absorption gain of £76.4m. This gain is reflected through the Trust reserves on the balance sheet.

TR commented that the lack of certainty about the H2 was unhelpful for financial planning but that it was encouraging to see the progress made through the Waste Reduction Programme.

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

118/21 Update on Strategic Developments

DB presented the report which gave an overview of current strategic developments.

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

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

Nationally chairs have been appointed for 25 of the 42 NHS integrated care boards. Where this is not the case, as in Greater Manchester (GM), the appointment process has begun and it is expected that it will be completed by the end of September. Recruitment of Chief Officers will follow shortly after.

In order to facilitate the transition to a statutory ICS, shadow governance arrangements are being put in place in GM. This includes the establishment of an ICB and a new Health & Care Partnership that replaces the existing GM Health & Care Partnership Board. It is expected that implementation of the shadow arrangements will start from October.

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

One of the features of ICSs is 'Provider Collaboratives'. In GM, there is already the Provider Federation Board which brings together all the acute, mental health, ambulance and community service provider organisations and the Primary Care Board, which brings together providers of primary care, in place. Proposals are being developed for the role that PFB will play in the new arrangements and specifically where it will take greater leadership of the GM priority programmes.

MFT has been designated as a Haemaglobinopathy Coordinating Centre (HCC). As an HCC MFT is responsible for coordinating, supporting and promoting a system-wide networked approach to the delivery of haemoglobinopathy services and supporting hospitals in the area who have less expertise in these conditions.

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

KC explained that part the Board seminar in October would be used to gain a better understanding of ICSs

Board decision	Action	Responsible officer	Completion date
The Board noted the contents of the report	Discussion on ICSs to be part of the agenda for October's Board seminar	DB	October 2021

119/21 Trafford Locality Plan

DB introduced the report which presented the refreshed Trafford Locality Plan.

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

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

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

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

In response to a question from BC, DB confirmed that the Trafford plan was convergent with the Manchester plan. IB highlighted the importance of this to ensure that those residents living on the border of Manchester and Trafford had access to a consistent set of services.

Board decision	Action	Responsible officer	Completion date
The Board confirmed MFT support and commitment to delivering the refreshed Trafford Locality Plan.	None	n/a	n/a

120/21 Report on the North Manchester General Hospital transaction and integration processes

PB presented an update report on the North Manchester General Hospital (NMGH) transaction process and integration work.

A third and final version of the NMGH Post-Transaction Integration Plan (PTIP) has been produced and approved by North Manchester Programme Board. The document provides an update on the integration work that has been completed in the first 100 days since the NMGH acquisition and offers assurance that all relevant milestones and integration plans have been completed.

There is a total of 87 SLAs between MFT and Pennine Acute Hospitals NHS Trust (PAHT). The SLAs under which MFT buys a service off PAHT have a total value of £31.4m, and the services which PAHT buys from MFT have a value of £5.5m. There is an on-going process to review these SLAs and determine how, and when, the parties might withdraw from them.

There are several clinical service areas where, because of the complexity of existing service delivery and/or a range of strategic issues, the precise nature of disaggregation has not yet been agreed. These clinical areas include General Surgery, Urology, ENT, Trauma and Orthopaedics and Cardiology. PAHT asked MFT and SRFT to develop a 'statement of intent' for each of these services to aid transparency and to foster a collaborative approach to planning.

The intention is for SRFT to acquire the Bury, Oldham and Rochdale sites and services on 1st October 2021. The Provider Oversight Committee of NHS Improvement/NHS England (NHS E/I) considered the proposal at its meeting on 14th September 2021 and gave a transaction risk rating of Amber. Given this transaction risk rating, the SRFT Board has confirmed its intention to complete the acquisition. The PAHT Board has also formally asked the Secretary of State (SoS) to dissolve the Trust and a decision on this is expected by the 30th September 2021.

Within the terms of the MFT Constitution, the Council of Governors (CoG) does not need to give formal support for the legal changes that are intended to occur at 1st October. However, CoG has been fully briefed of the transaction processes throughout, and a further comprehensive update was given at the Governors' Summer Development session on 31st August 2021. CoG continues to be supportive of both the transaction processes and the arrangements to integrate NMGH into MFT.

PB advised that the approvals process had been altered, and the final sign off of the contractual documentation (Transfer Order and Schedules, Legacy Management Agreement) would now happen on 23 September, after the final meeting of the PAHT Board (22 September). Following this, it is expected that the Transfer and Dissolution Orders will be made on 27 September.

The final versions of the contractual documentation have only very limited variations from the draft versions as agreed in March 2021 (i.e. in preparation for the Prior Commercial Transaction). Independent specialist legal advice has been taken on this documentation throughout the process. Assurance on the content of the schedules comes from the workstreams in the shared governance arrangements that have underpinned the transaction process, which MFT representatives have participated in actively.

KC asked when NHSE/I's grading of the remaining transaction would be known and congratulated the team on their work on completing this important programme of work.

PB explained that it would have to be done by 15th September to meet the necessary deadline.

The Board confirmed that it was satisfied with the delegated authority arrangements for the execution of the legal documents.

Board decision	Action	Responsible officer	Completion date
The Board: Noted the ongoing work on the SLA/disaggregation and integration processes. Noted the ongoing work to deliver the SRFT statutory transaction and the dissolution of PAHT.	None	n/a	n/a

121/21 Q1 Complaints Report (2021/22)

CL presented the report which related to Patient Advice & Liaison Service (PALS) and Complaints activity across Manchester University NHS Foundation Trust (MFT) during Q1 2021/22. For the first time, data and information are included from services at North Manchester General Hospital (NMGH), who joined MFT from 1st April 2021. This has contributed to a proportionate increase in complaints and PALS activity.

The report provided:

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

IB confirmed that he felt that CL's team had a grip on this work and were looking into everything they needed to.

SB explained that the Quality and Performance Scrutiny Committee had looked at the report in great details.

KC expressed her disappointment and surprise at the increase in number of re-opened complaints and stated how much she enjoyed reading the patient feedback towards the end of the report.

CL explained that the increase in re-opened complaints may be because the initial response raised further questions for the complainant or that the initial response was insufficient.

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

122/21 Annual Patient Experience Report

CL presented the report and explained that this annual report would usually provide a summary of the MFT results of the mandatory national surveys that have been published throughout 2020. However, the mandatory national surveys have been affected by the Coronavirus pandemic, which has resulted in national decisions to delay or stand down implementation of the survey schedule. No mandatory survey results are therefore included in the report.

The 2020 Maternity Survey was stood down by the Care Quality Commission and Trusts were offered the opportunity to participate in the optional National New Mothers' Experience of Care Survey 2020 instead. MFT elected to participate in this survey, which is therefore the only national survey that is included in this annual report. As this is the first time this survey has been used and as only 12 Trusts nationally agreed to participate, no national comparison data is available, however the analysis includes a comparison of local data between MFT's maternity sites.

For some periods during the Coronavirus pandemic, all non-essential activity was stood down to enable clinical staff to focus on direct care delivery, and to release members of the corporate workforce to support the Trust's response to the pandemic. This included the suspension of data collection from electronic devices and paper surveys in line with the NHS England (NHSE) guidance between March and May 2020. This temporary pause in quality and patient experience data collection is reflected in this report.

An update on the positive progress undertaken during 2020/21 in relation to the MFT What Matters to Me (WMTM) Patient Experience Programme is within the report. This includes an overview of the Trust's NHSE Always Events pilot and an update on the delivery of the MFT Experience and Involvement Strategy: Our Commitment to patients, families, and Carers 2021-2023.

A summary of some of the improvement work that has been undertaken across the Hospitals/MCS/LCOs as a result of patients' and relatives' feedback during the pandemic response is also included.

CM stated that the identification and support of at-risk pregnant women was encouraging to see and explained that she had spent time at St Mary's Hospital listening to women and their families.

KC commented how she missed the patient story at Board meetings and recognised the role of volunteers within MFT and the value of a celebration event to say 'thank you' to them. CL agreed that such events should continue.

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

123/21 Annual Accreditation Assurance Report (2020/21)

CL presented the report and explained that the Clinical Accreditation Programme is a process that assesses the quality of care and aims to raise the overall standard of care provided to patients. The accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high-quality care and the best patient experience. The process is underpinned by the Improving Quality Programme and supported by, the Trust Values, the 'What Matters to Me' (WMTM) patient experience programme and the Nursing, Midwifery and AHP Strategy.

210 areas in MFT had been accredited over the last year and nobody's accreditation had deteriorated since last year and all would be put forward for revalidation.

CL particularly thanked Sue Ward for all her work in this area, recognising that Sue would be retiring in 2021.

KC stated that Sue Ward would be hugely missed by MFT, and SB concurred, recognising Sue's contribution to the Trust.

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

124/21 Update on 'Learning from Deaths (COVID)'

JE presented the report which provided an overview of mortality for the full year 20/21 and Q1 21/22 and a specific focus on mortality associated with COVID-19, Hospital Onset Covid Infection (HOCI).

The Summary Hospital-level Mortality Indicator (SHMI) data for MFT was presented along with regional and national data.

There have been 129 deaths because of HOCI between 1 March 2020 and 26 June 2021.

Analysis of the individual cases has led to significant learning points for the organisation and the depth of knowledge gained has enabled MFT to address the Duty of Candour owed to each family. Learning included the following:

- Advanced age, frailty, significant comorbidity, alcohol related liver disease, obesity, diabetes, smoking, renal failure and raised CRP all impact on mortality.
- Delayed discharge and the patients most susceptible to that (those often termed as 'complex discharges') are at increased risk of nosocomial infection.

- National evidence suggests patients with a recognised learning disability have poorer outcomes.
- Patient moves, patient outliers, patient placement and tertiary referral processes contribute to nosocomial infection rates.
- Environment and bed space are contributory factors.
- Some patients are admitted with COVID-19 symptoms but have a negative swab, they have a positive swab later, this may cause some wrongly attributed nosocomial infections.
- Consistent compliance with PPE requirements has been identified, particularly for staff in clinical areas not providing direct patient care.
- Sustained rise in community transmission was accompanied by an increase in HOCI.
- Asymptomatic cases remain a significant challenge.
- Availability of PCR testing for staff in early phases of the pandemic challenged the diagnosis of asymptomatic carriage.

SB stated how helpful it was that JE had described the complexity and changing definition of Covid deaths over the last 18 months.

IB pointed out that the mortality statistics were good in the main and explained that he had been assured that work was ongoing to find the reason for the higher SHMI in North Manchester General Hospital.

KC thanked JE for her work on this.

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

125/21 Annual Revalidation and Statement of Compliance

TO presented the report which described the progress of the Trust over the last financial year in the management of medical appraisal and revalidation. It also sought to provide assurance to the Board that the Trust is compliant as a designated body for medical revalidation, continues its pursuit of quality improvement, and that the Responsible Officer (RO) is discharging their statutory responsibilities.

At the end of the last appraisal year (31 March 2021), MFT had 1,920 doctors with a prescribed connection plus an additional 86 dentist. 93.4% of connected doctors had an appraisal within the year

The Quality Assurance of the process is subject to ongoing review and appraisers are being trained or refreshed to ensure they all meet the required standards. The appraisers were rated as Very Good or Good by 98% of appraisees who submitted feedback.

Medical appraisal and revalidation were amended to streamline the system due to theCOVID-19 pandemic. Due to the pause of revalidation, a greater number of doctors are due to be revalidated this year (01 April 2021 – 31 March 2022) with 628 due in total.

Work is continuing to ensure that the processes for all doctors in MFT are aligned and consistently applied, following the acquisition of NMGH, and to support the doctors who have transferred.

The Trust has been requested to submit a signed Statement of Compliance to NHS England for 2020/21.

Board decision	Action	Responsible officer	Completion date
The Board of Directors noted the contents of the paper, progress made to date and the challenges to be faced in the coming year. The Board of Directors approved submission of the Annual Statement of Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013), signed on behalf of the designated body by the Group Chief Executive Officer.	None	n/a	n/a

126/21 Update on the Manchester Arena Inquiry

JE presented the report which described the expected input of MFT staff into the Manchester Arena Inquiry, and the support which would be provided to those staff. The Manchester Arena Inquiry is looking into the tragic circumstances on 22 May 2017 which led to the death of 22 victims and injuries to 800 more.

All 14 potential witnesses have been contacted and advised that they may be called to give evidence at the Inquiry. Contact was made via a senior member of staff in the MRI and RMCH divisions and their educational supervisors advised. Staff were also signposted to employee health and wellbeing, psychological wellbeing support and the Greater Manchester resilience hub for additional support if required.

Staff will also be supported through the Inquiry process by the ORC Legal Services Department, our Trust Solicitors and QC.

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

127/21 Committee Meetings

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

- Extraordinary Audit Committee held on 5th July 2021
- Group Risk Oversight Committee held on 19th July 2021
- Charitable Funds Committee held on 28th July 2021
- Human Resources Scrutiny Committee held on 10th August 2021
- Quality Performance & Scrutiny Committee held on 11th August 2021
- Finance Scrutiny Committee held on 25th August 2021

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

128/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 8th November 2021** at **2pm**.

129/21 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 12th July 2021			
Action	Responsibility	Timescale	Comments
Delete NMGH principal risks from BAF and incorporate residual risk issues within other schedules as appropriate	Trust Board Secretary	November 2021	Completed

Board Meeting Date: 13th September 2021			
Action	Responsibility	Timescale	Comments
The Board noted the contents of the report	Discussion on ICSs to be part of the agenda for October's Board seminar	DB	Completed

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(September 2021)

1. Introduction

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

2. Overview

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

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

3. Key Priority Areas

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

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

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

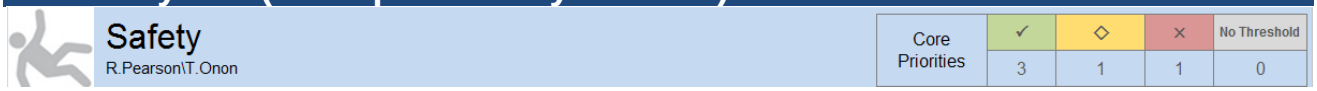
The narrative is provided by the person(s) accountable for the individual priority areas.

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

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)



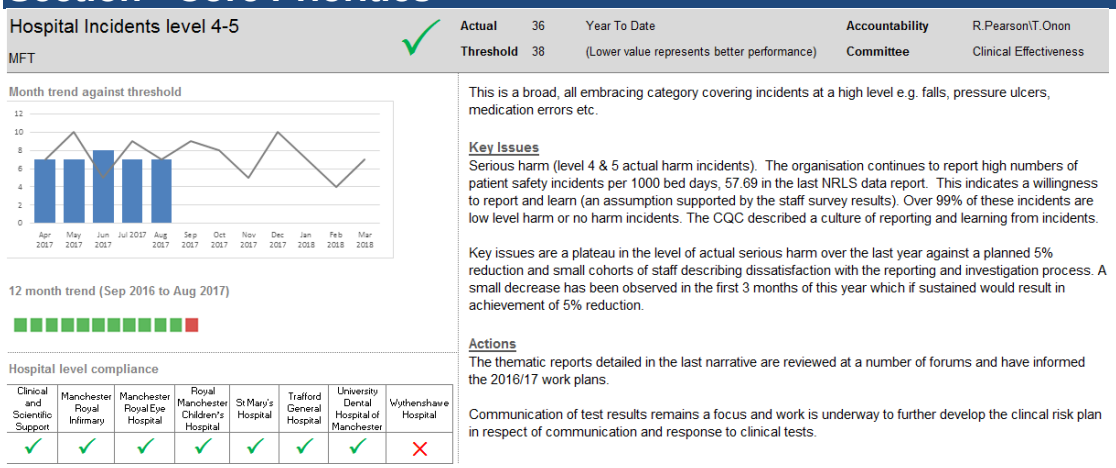
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

September 2021

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	3	0	3	0

Headline Narrative

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

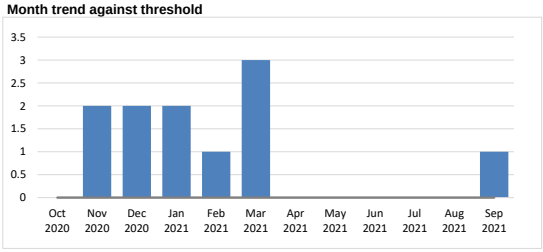
The Trust has reported 7 Never Events (YTD April 21 to September 21). The recently reported never events are currently under investigation. As a result the Trust-Wide never event risk has been reviewed and reframed in light of the recent never events and the need to focus on human/system interaction in the way we approach improvement.

Safety - Core Priorities

Mortality Reviews - Grade 3+ (Review Date) ✕

Actual 1 YTD (Apr 21 to Sep 21) **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	LCO
✓	✓	✓	✓	✓	✓	✕	✓	NA
0	0	0	0	0	0	1	0	NA

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

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

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

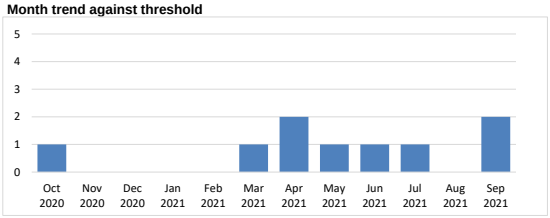
Actions
The focus is now on dissemination of the resulting changes and developments in practice across the organisation.

A key focus in 21/22 has been understanding the impact of COVID-19 on mortality, understanding the improvements required and early implementation of lessons learned and completion of duty of candour. This work is now neairng completion with reprots made to Board and DoC for definite HOCI in the process of completion.

Never Events ✕

Actual 7 YTD (Apr 21 to Sep 21) **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	LCO
✕	✓	✕	✓	✓	✓	✕	✓	✓
5	0	1	0	0	0	1	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 (Apr 2021- Sep 2021) there have been 7 Never Events reported. There are key themes within the Never Events (and associated near-miss incidents) in relation to culture, psychological safety, communication, the use of checklists, the availabilty of guidance and the ergonomics of clinical enviroment design.

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

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

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

> Board Assurance

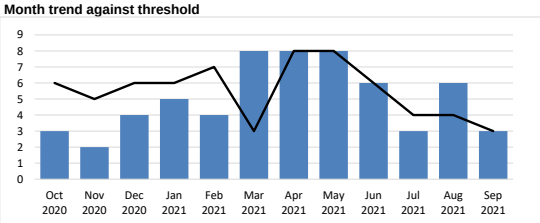
September 2021

Hospital Incidents level 4-5

✗

Actual	34	YTD (Apr 21 to Sep 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	33	(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	LCO
✓	✗	✗	✓	✓	✓	✓	✗	✓
1	20	2	3	0	0	7	1	0

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

Key Issues

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

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

Actions

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

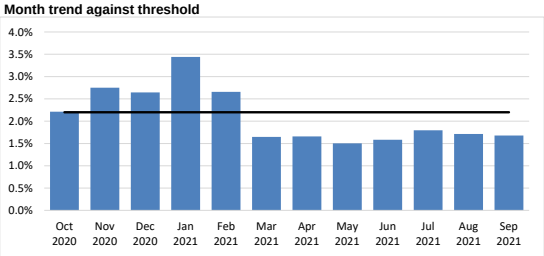
The Hospital Onset COVID infection reporting process was agreed during this period. The reports relate to incidents over the past 12 months and are not reported within this data set, once validated they will be included.

Crude Mortality

✓

Actual	1.66%	YTD (Apr 21 to Sep 21)	**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	LCO
✗	✓	✓	✓	✓	✓	◇	✗	**NA**
15.3%	1.9%	0.2%	0.2%	0.0%	0.0%	2.5%	2.8%	NA

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

Key Issues

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

The 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.

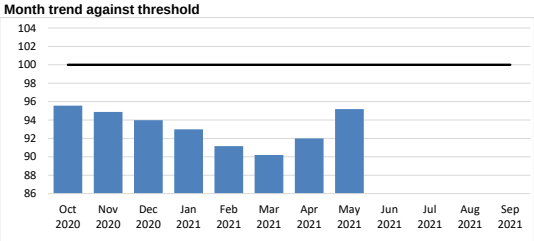
> Board Assurance

September 2021

SHMI (Rolling 12m)

Actual	92.0	R12m (Jun 20 to May 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	NA	**NA**
NA	93.2	NA	NA	NA	NA	89.2	NA	NA

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

Progress

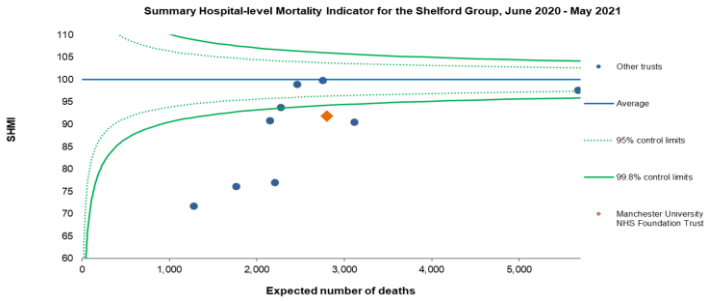
SHMI is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded).

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

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

Performance is well within the expected range.

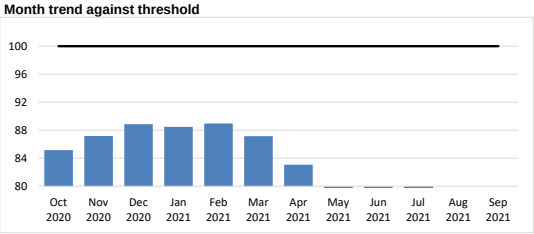
NMGH Data, not yet available. Legacy data reviewed suggesting SHMI of 115 which is under review.



HSMR (Rolling 12m)

Actual	83.1	R12m (May 20 to Apr 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	NA	**NA**
NA	75.0	NA	NA	NA	NA	89.5	NA	NA

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

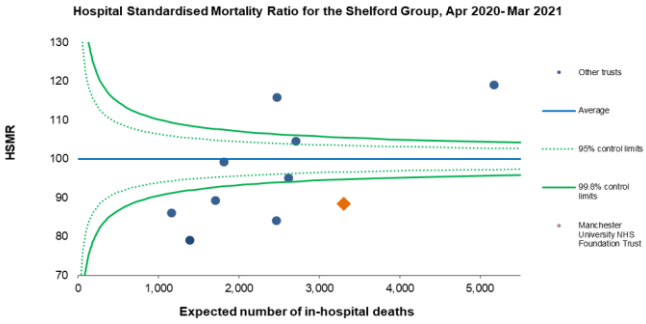
HSMR is a metric designed for adult practice.

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

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.



Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	3	1	2	2

Headline Narrative

In September 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 77.7% this is a decrease of 10.2% from the previous month. The number of new complaints received across the Trust during September 2021 was 163, which is an increase of 30 when compared to 133 in August 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 91.7% in September 2021 which is a decrease compared to 92.4% in August 2021. There is a continued focus for all areas of the Trust to use both the positive and negative FFT feedback to improve the experience of our patients.

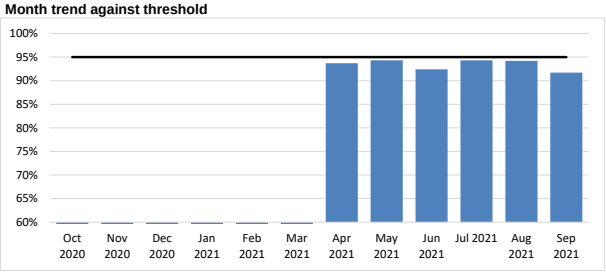
Infection prevention and control remains a priority for the Trust. Trust performance is above trajectory for both MRSA and CDI: When comparing MFT's MRSA bacteraemia rates from Q2 to Q3, there has been a decrease from 2.1 to 1.4 attributable cases per 100,000 overnight, there has been an increase in CDI rates from 27.1 to 32.2 per 100,000 overnight beds. E. coli rates have increased from 12.5 to 24.7 cases per 100,000 overnight beds.

There have been 85 trust-attributable CDI reported so far this year, against a threshold of 78. There is a zero tolerance approach to MRSA bacteraemias, and a 15% reduction objective applied to E.coli bacteraemias to meet the national 50% reduction objective by 2024. There have been 5 trust-attributable MRSA bacteraemia and 54 E. coli bacteraemia so far this financial year.

FFT: All Areas: % Very Good or Good ✕

Actual	93.6%	YTD (Apr 21 to Sep 21)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	◇	✓	✓	✓	✓	✕	✕
96.18%	96.38%	91.05%	95.25%	97.77%	98.78%	96.82%	86.83%	90.19%

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 September is 91.7 % compared to 94.2% in August 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.

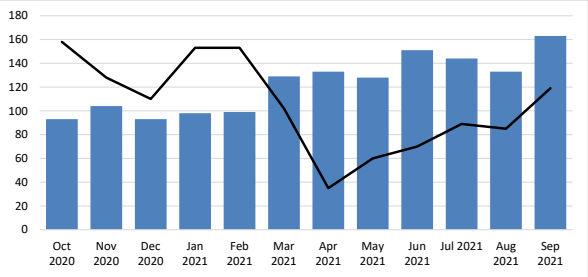
Actions

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	852	YTD (Apr 21 to Sep 21)	**Accountability**	C.Lenney
Threshold	784	(Lower value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✗	✓	✗	✓	✗	✗
46	185	90	124	24	22	202	91	31

NOTE: MFT total includes Corporate data not represented in Hospital Compliance chart and table
The KPI shows total number of complaints received. Complaint volumes allow the Trust to monitor the number of complaints and consider any trends.

Key Issues
The number of new complaints received across the Trust in September 2021 was 163, when compared with the 133 complaints received in August 2021 and 144 in July 2021.

WTWA received 41 complaints in September 2021 which is the highest number of complaints in the Trust (25.1% of the Trust total), when compared with the 38 received in August 2021 and 41 in July 2021.

Of the 41 WTWA complaints received the top specific themes were 'Treatment/Procedure' and 'Clinical Assessment (Diagnostic/Scan)'. Accident & Emergency was identified as a specific area in complaints relating to 'Clinical Assessment (Diagnostic/Scan).

At the end of September 2021 there was a total of 42 complaints that were over '41 days old', 5 of which had not been resolved within the agreed timeframe (11.9% of the total). This represents an increase when compared to 33 complaints over '41 days old' at the end of July and August 2021 respectively.

The service area with the highest number of cases over 41 days which have not been resolved within agreed timeframe at the end of September 2021 was Corporate & NMGH with 2 cases each (4.76% of the total).

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

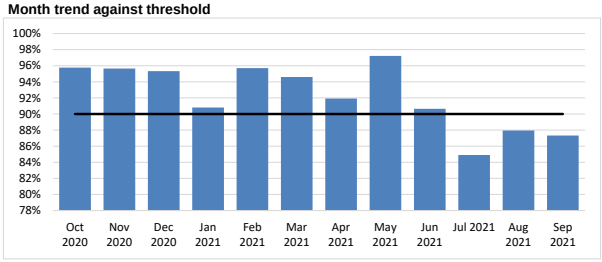
Actions
All Hospitals/MCS/LCO to continue to prioritise the closure of complaints that are older than 41 days. The Chief Executives are held to account for the management of complaints cases that exceed 41 days through the Accountability Oversight Framework (AOF).

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	89.5%	YTD (Apr 21 to Sep 21)	**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	LCO
✓	✓	✓	◇	✓	✓	✓	✓	✗
95.7%	98.4%	100.0%	76.4%	100.0%	95.0%	96.4%	98.3%	46.9%

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

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 September 2021 data identifies that 77.7% of complaints were resolved within the agreed timescales compared to 87.9% in August 2021 and 84.9% in July 2021: this is a decrease of 10.2%.

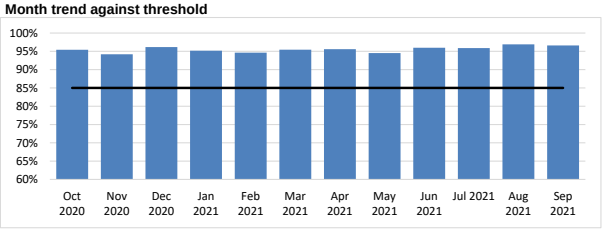
The Hospital/ MCS/LCO level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. It should be noted that where the Hospital/MCS/LCO receive lower numbers of complaints, this can result in high percentages.

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

Food and Nutrition ✓

Actual	95.9%	YTD (Apr 21 to Sep 21)	**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	LCO
✓	✓	✓	✓	✓	**NA**	✓	✓	**NA**
94.8%	96.1%	92.7%	94.8%	99.3%	NA	97.4%	95.6%	NA

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.

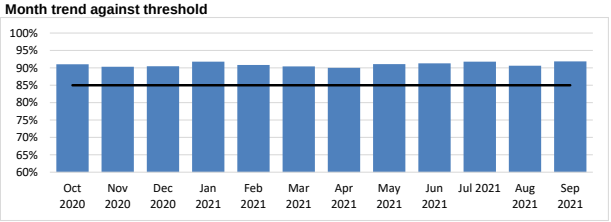
Utilising the Improving Quality programme (IQP) methodology, the MDT workstream engaged with patients and staff on Ward 12, at TGH to identify key areas to focus on improvement. Work commenced on the introduction of a hot breakfast and a 'snack round' from February 2020 with initial feedback reporting 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	91.1%	YTD (Apr 21 to Sep 21)	**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	LCO
✓	✓	✓	✓	✓	✓	✓	✓	**NA**
94.1%	86.5%	90.0%	91.8%	97.6%	97.9%	93.4%	91.7%	NA

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

Progress

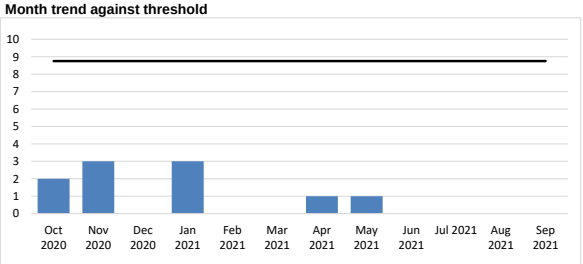
Work continues across the Trust to drive improvements in pain assessment and management.

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

Clostridium Difficile – Lapse of Care ✓

Actual	2	YTD (Apr 21 to Sep 21)	**Accountability**	C.Lenney
Threshold	53	(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	LCO
✓	✓	✓	✓	✓	✓	✓	✓	**NA**
0	2	0	0	0	0	0	0	NA

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

Progress

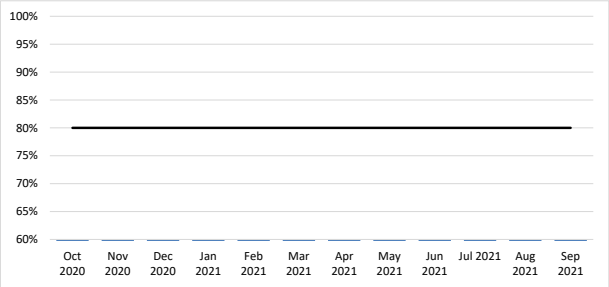
A total of 215 CDI cases were reported during 2020/2021: 179 (83%) of which were trust-attributable against a trajectory of 132. There have been 85 trust-attributable CDI reported so far this year, against a current threshold of 78. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 11 trust-attributable CDI cases reported for September 2021, all of which are pending review.

Nursing Workforce – Plan v Actual Compliance for RN

●

Actual		(September 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	LCO
•	•	•	•	•	•	•	•	•

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

Progress

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

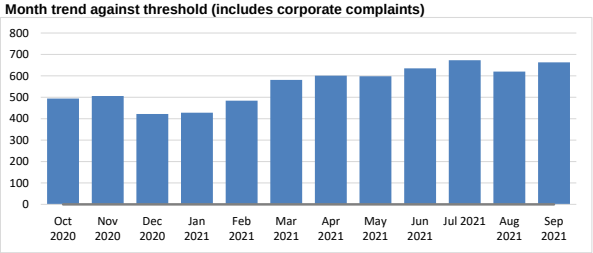
A safe staffing daily risk assessment is undertaken by the Director of Nursing for each hospital/MCS and the escalation level reported to the Trust Tactical Commander. Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels that meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals. A SNCT data collection census will commence on the 1st of November.

PALS – Concerns

-

Actual	3790	YTD (Apr 21 to Sep 21)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
275	882	320	508	172	114	953	396	62

NOTE: MFT total includes Corporate data not represented in Hospital Compliance chart and table

Key Issues

A total of 663 PALS concerns were received by MFT during September 2021 compared to 620 PALS concerns in August 2021 and 673 in July 2021.

MRI received the highest number of PALS concerns in September 2021; receiving 174 (26.2% of the total). This is an increase for MRI when compared to the 146 in August 2021 and 156 in July 2021. The specific themes for MRI related to 'Communication', 'Appointment/Delay/Cancellation (OP)' and Treatment and Procedure.

There were no particular areas identified relating to the specific themes.

Actions

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

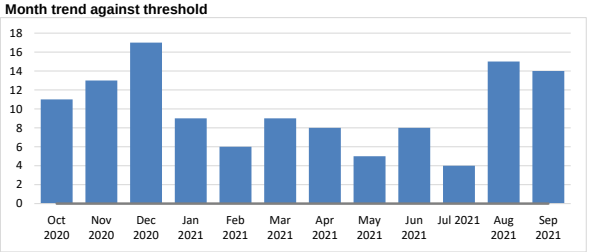
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 5 days.

All Attributable Bacteraemia

-

Actual	54	YTD (Apr 21 to Sep 21)	**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	LCO
-	-	-	-	-	-	-	-	**NA**
3	18	9	3	0	0	16	5	NA

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 54 trust-attributable E. coli bacteraemia reported so far in 2021/2022 against a trajectory of 48, of which 13 were reported during September 2021.

There were 15 trust-attributable MRSA bacteraemia cases reported to PHE during 2020/2021, and 9 community-attributable cases reported. There have been 5 trust-attributable MRSA bacteraemia reported for the current year, 1 of which was reported in September.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	1	0	10	0

Headline Narrative

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

Whilst stable the prevalence of Covid continues to consume MFT bed capacity, and anaesthetic resources impacting on the elective programme. In addition, MFT and GM are experiencing unprecedented peaks in emergency demand across both adult and paediatrics, which has required ad-hoc reduction in elective bed capacity in order to manage the non-elective demand.

Not with standing these continuing operational challenges, MFT continues to progress actions aimed at improving performance against national operational standards. In addition, MFT is currently undertaking planning requirements in line with the national planning guidance for the period Oct - March 2022, developing associated trajectories and refresh of action plans.

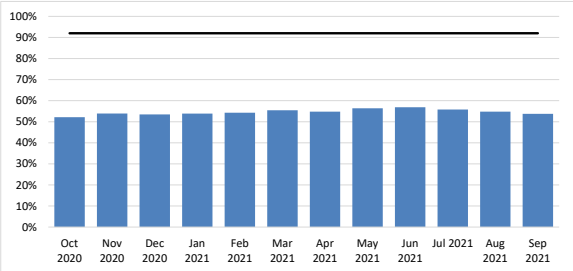
September summary:
• Whilst the elective waiting list has increased, at the end of September there has been an improvement of 16% in the number of patients waiting over 52 weeks compared to April.
• The number of patients waiting longer than 104 weeks in September was 1265 (0.8%) of the overall waiting list, the position has increased due to the continued prioritisation of clinically urgent and cancer activity in line with national requirements.
• National performance against the 4 hour wait standards for Emergency Departments has steadily reduced since April, with the performance across GM and MFT following the same trend. Performance reflects peak levels of attendances across MFT Emergency Departments and ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of significant operational pressures and capacity constraints, North Manchester site has reported 26 breaches of the 12 hour DTA quality standard during September, with no patient harm occurring.
• Cancer performance has improved in 4 of the 6 cancer standards (31 days first treatment, 62 days screening, 31 days sub surgical treatment 31 days sub chemo treatment). Reducing the backlog of patients has been further challenged due to peak levels of cancer referral demand. A cancer recovery programme is in place to improve timely access for patients.

Operational Excellence - Core Priorities

RTT - 18 Weeks (Incomplete Pathways) ✕

Actual	53.8%	(September 2021)	**Accountability**	J.Bridgewater
Threshold	92.0%	(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	LCO
✕	✕	✕	✕	✕	✕	✕	✕	✕
61.4%	48.1%	57.3%	50.4%	63.1%	57.8%	56.3%	49.0%	57.0%

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

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

Actions
• Group Manchester Elective Surgical Hub 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.
• Maximising TGH hospital as a green site
• The potential to utilise private sector capacity, GM and regional pathways are 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.
• Additional timely validation of PAS/waiting lists by Hospital sites and Group resource continues.

Progress
• In line with the national and regional picture the impact of Covid and the suspension of the elective programme has had a detrimental impact on the waiting list and RTT position since April 2020.
• The end of September wait list stands at 150,730 an increase of 3,203 (2.2%) on August. Capacity for routine elective operations remains constrained due to the need to prioritise clinically urgent activity in line with national guidance
• The number of patients waiting longer than 52 weeks in September was 14,184 (9.4%) of the overall waiting list. This is a 16.0% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in September was 1,265 (0.80%) of the overall waiting list, relating to the lowest clinical risk cohort on the waiting list.
• 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 September was 30% of all appointments inline with national requirements.

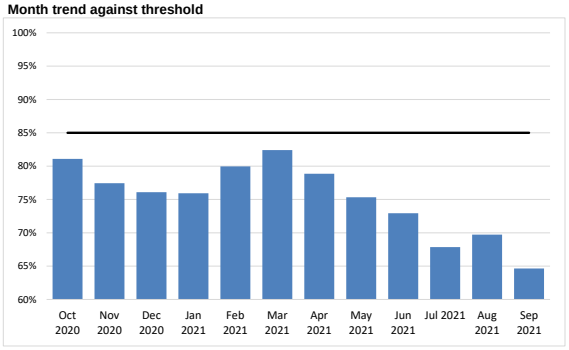
> Board Assurance

September 2021

A&E - 4 Hours Arrival to Departure

Actual	67.4%	Q2 21/22 (Jul to Sep 21)	**Accountability**	J.Bridgewater
Threshold	95.0%	(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	LCO
NA	✗	✗	✓	✓	NA	✗	✗	NA
NA	56.5%	72.7%	98.1%	99.8%	NA	64.4%	60.7%	NA

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

Key Issues

• Covid restrictions impacting on flow within the ED.
• Bed capacity constrains due to: Covid patients consuming the bed base, higher levels of patients who are medically fit and have no reason to reside in Hospital and are awaiting discharge.
• GM and MFT system are experiencing unprecedented UEC pressures, whilst overall activity is at pre-pandemic levels this is misleading as there are days of extreme pressure at peak levels not seen previously, both in adults and paediatrics.

Actions

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

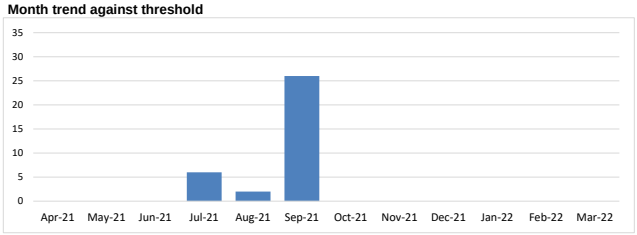
Progress

• September 2021 saw 4,972 (13.5%) additional attendances compared to April 2021. Volume, higher acuity of patients, IPC measures and short term staff sickness both medical and nursing have impacted performance.
• in line with the national and regional picture, MFT performance of 77.70% in Q1 has reduced to 67.4% for Q2 2021/22
• The number of patients with 7+ and 21+ days Length of Stay in MFT beds at 30th September was 747 and 299 respectively. nb. The Trust will always have a element of LLoS due to clinical complexity.

A&E - 12 Hour Trolley Waits

Actual	34	YTD (Apr 21 to Sep 21)	**Accountability**	J.Bridgewater
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	✓	✓	✓	NA	✗	✗	NA
NA	0	0	0	0	NA	1	33	NA

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

Key Issues

Contributing factors resulting in the increase in long waiters specifically at NMGH are:
• Bed capacity, currently -37 beds compared to 2019, this is exclusive of the increase in activity demand from April which would contribute a further 16 beds.
• Department capacity is constrained
• Higher than optimal reason to reside patients half of which are out of area, which restricts bed capacity and flow out of the emergency department.

Actions

• Flexible use of space between paeds and adult ED to address demands.
• Refreshed and relaunched escalation policy, including the ED and workforce triggers.
• New site patient flow team 24/7 - This team adds an additional layer of focus on patient flow.
• Working with the MFT Transformation team to review decision to admit processes.
• Refreshed over-arching Urgent Care Improvement Plan and governance & assurance process to support the improvements.
• Organisational escalation SOP in place for the reporting of long waits both in and out of hours.

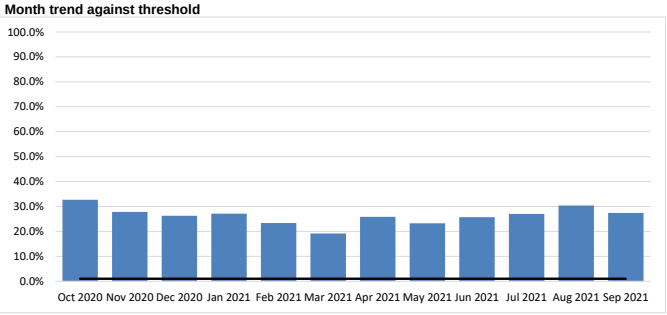
Progress

As a result of significant operational pressures, North Manchester sites has reported 26 breaches of the 12 hour DTA quality standard during September, the majority of which were related to bed capacity constraints. Harm reviews are undertaken for all patients, with no harm identified.
learning from the root cause analysis undertaken for any breach of the standard has been implemented

Diagnostic Performance

Actual	27.4%	(September 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	LCO
✗	✗	✗	✗	NA	NA	✗	✗	NA
12.8%	42.2%	82.3%	32.1%	NA	NA	39.7%	41.8%	NA

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

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

Key Issues
- Impact of the Covid waves and reduction in capacity and activity as a result.
- North Manchester General Hospital from the 1st April 2021, is now reported by MFT.

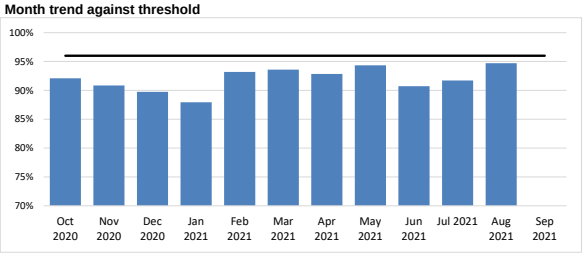
Actions
- Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.
- Diagnostic clinical prioritisation undertaken.
- Endoscopy improvement week undertaken with learning and actions being undertaken at a GM and Trust level.
- Additional CT scanning lists secured on a weekend

Progress
- Prior to merger with NMGH the waiting list size for diagnostic tests was improving month on month.
- Post integration and inclusion of NMGH diagnostic numbers, the waiting list as reported in September 2021 stands at 27,415 NMGH equates to circa 18.4% (5,054) of this.
- Group Performance, whilst remaining challenged at 27.4% in September 2021, has improved when compared to performance in September 2020 (38.7%), taking into account the NMGH factor performance would be 24.1%.

Cancer 31 Days First Treatment

Actual	93.1%	Q2 21/22 (Jul to Aug 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	LCO
NA	✗	✓	✗	NA	NA	✗	✓	NA
NA	94.7%	100.0%	89.5%	NA	NA	93.8%	97.8%	NA

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

Key Issues
- Cancer Demand, Theatre and HDU capacity, exacerbated by Covid impact.

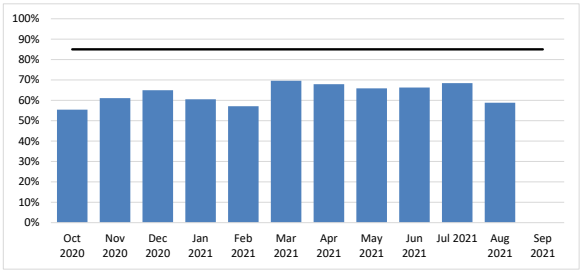
Actions
- Cancer treatments are being prioritised during the Covid pandemic, in line with national guidance on priority patients.
- Undated patients over 14 days are discussed at the group level Manchester Elective Surgical Hub (MESH) meetings with hospital / MCS leads.
- Capacity is assessed weekly 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.
- Skin capacity is moving back from the Independent sector in October. Plans are in place to accommodate internally.

Progress
- The most challenged tumour sites are Skin, Gynaecology, Head and Neck
- Urology capacity is being utilised at the Christie under an MFT@Christie provision. The same is being sought for other tumour groups.
- Cancer Recovery Workstream in place, details under the 62 day standard.
- NMGH and RMCH are performing against the target.

Cancer 62 Days Referral to Treatment

Actual	64.0%	Q2 21/22 (Jul to Aug 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	LCO
NA	✗	NA	✗	NA	NA	✗	✗	NA
NA	53.5%	NA	30.4%	NA	NA	60.2%	65.1%	NA

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

Key Issues

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

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 above pre-Covid levels whilst the Trust is still reducing its backlogs due to diagnostics delays and patient choice.
- The wider GM system has put a number of actions in place to coordinate system capacity, including mutual aid for capacity coordinated via a GM Cancer Surgical Hub. In addition, GM wide work is taking place on the introduction of a single PTL for 4 specialist diagnostic tests.
- MFT participated in the GM led LGI improvement week in August with actions and learning now being implemented at a Trust and GM level. LGI patients are the highest volumes of long waiters across the whole of GM.
- Capacity being utilised in the independent sector and the Christie to support timely treatment

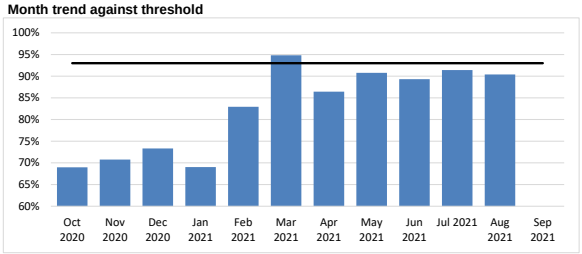
Progress

- Demand has increased to pre-pandemic levels with peaks across tumour groups.
- Performance - 62 day performance has dropped from Q1 so far but this is expected as the backlog clears
- New 62 day trajectories are being modelled.
- Safety remains a key priority and harm reviews continue to be undertaken for the longest wait patients.

Cancer Urgent 2 Week Wait Referrals

Actual	90.9%	Q2 21/22 (Jul to Aug 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	LCO
NA	✓	✓	✓	NA	NA	✗	✗	NA
NA	94.0%	95.2%	97.2%	NA	NA	87.3%	91.1%	NA

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

Key Issues

- Demand has increased to >100% of pre Covid position, with some tumour groups at peak levels.

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.

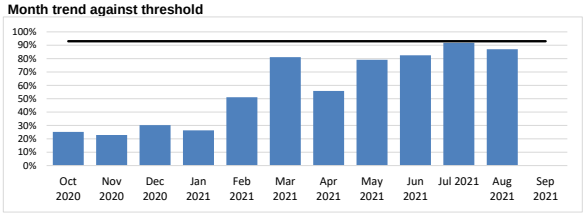
Progress

- Cancer 2ww referrals have returned to >100% pre Covid averages (currently 110% compared to Jan - Sept 2019 - not including NMGH due to historical data) . There is fluctuation between tumour groups with head and neck receiving 125% and LGI 120%. LGI received the highest number of referrals in September since Jan 2019
- Head and Neck is challenged with pathway mapping being undertaken in this service.
- Skin remains a pressure which is replicated across GM

Cancer 2 Week Wait - Breast

Actual	89.5%	Q2 21/22 (Jul to Aug 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	LCO
NA	NA	NA	NA	NA	NA	✗	✗	NA
NA	NA	NA	NA	NA	NA	87.7%	85.5%	NA

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

Key Issues

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

Actions

- All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
- 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.

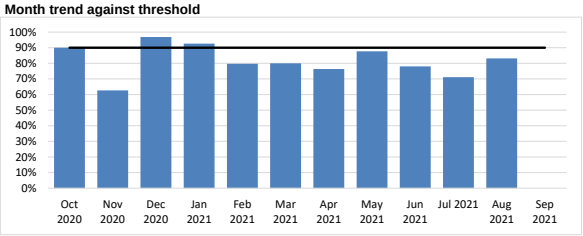
Progress

Performance is improved from Q1

Cancer 62 Days Screening

Actual	76.7%	Q2 21/22 (Jul to Aug 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	LCO
NA	✗	NA	•	NA	NA	◇	✓	NA
NA	33.3%	NA		NA	NA	86.8%	100.0%	NA

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.

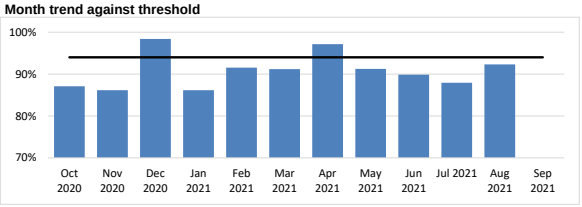
Actions
- The Actions listed under Cancer 62 Days are applicable to this standard.

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.
- The screening backlog over 62 days is reducing.

Cancer 31 Days Sub Surgical Treatment

Actual	90.0%	Q2 21/22 (Jul to Aug 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	LCO
NA	✓	NA	✓	NA	NA	✗	✓	NA
NA	100.0%	NA	100.0%	NA	NA	87.9%	100.0%	NA

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

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

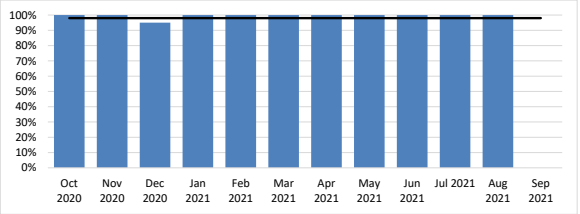
Actions
Actions noted under the above cancer standards.

Progress
- Progress noted above under the 31 day first standard.
- Urology performance was challenged to address this mutual aid has been provided and patients are now being treated at WTWA or MFT@Christie.
- Some of the underperformance is related to patient choice factors.

Cancer 31 Days Sub Chemo Treatment

Actual	100.0%	Q2 21/22 (Jul to Aug 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	LCO
NA	•	NA	NA	NA	NA	NA	✓	NA
NA		NA	NA	NA	NA	NA	100.0%	NA

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
- No current issues with chemotherapy provision.

Actions
- Actions are outlined under the cancer 62 day standard.

Progress
•Standard achieved in month.

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.

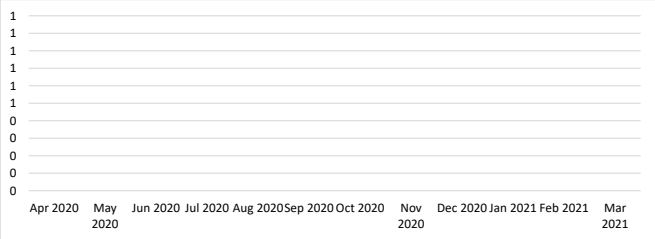
Finance - Core Priorities

Operational Financial Performance

Actual | **Accountability** A.Roberts

Threshold | **Committee** TMB and Board Finance Scrutiny Committee

Month trend against threshold



Hospital level compliance

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

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

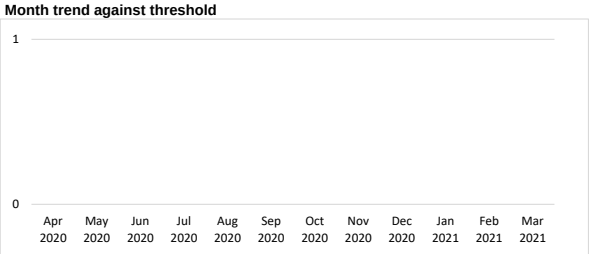
Please see the Chief Finance Officer's report for more detail.

Regulatory Finance Rating

Actual | **Accountability** A.Roberts

Threshold (Lower value represents better performance) | **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

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	3	1	7	3

Headline Narrative

As MFT continues to prepare for Hive Go-Live, the Workforce Directorate is leading a number of key workstreams. Work has commenced focused on maximising staff availability and workforce supply in the pre and post Hive Go-Live period. Hospital/ MCSs/ LCO are currently developing staffing and workforce plans to drive a nuanced local response to identified workforce issues, whilst Group is developing various cross cutting policy initiatives and specialist support. A programme of work to address Digital Literacy is has also commenced and preparations for HIVE end user training continue.

Work continues with regards to COVID-19 workforce recovery. A GM Workforce Collaborative Funding application has been submitted regarding the development of Physician's Associate (Anaesthesia) role to support elective recovery in the medium to longer term by increasing anaesthetic capacity. A recovery grant application has been submitted to NHS Charities Together under a project to enhance support for staff with long term chronic conditions, including those with long COVID and fatigue symptoms. With a successful application, a multi-disciplinary clinical team based within the structure of our Employee Health and Wellbeing Service would focus on appropriate and rapid on-site access to rehabilitation and support.

Progress continues to be made to progress the MFT People Plan deliverables. As at September 2021, 16.2% of the 136 deliverables have been achieved and delivered across MFT spread across a range of themes. The completed deliverables have had a wide-ranging impact across the Trust from delivery of the COVID-19 vaccination programme implemented by Employee Health & Wellbeing to implementing diverse recruitment panels for senior bandings delivered by the Equality, Diversity, and Inclusion Team. Deliverable Owners are working closely with the Communications Team to highlight these success stories and share with staff the impact the People Plan is having on the workplace and their experiences within it.

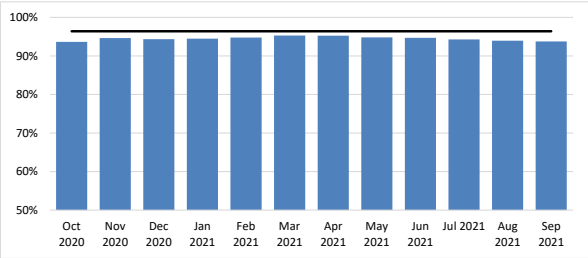
Workforce and Leadership - Core Priorities

Attendance ✕

Actual 93.8% (September 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	LCO
✕	✕	✕	✕	✕	✕	✕	✕	✕
94.6%	92.4%	94.2%	93.9%	92.0%	94.8%	93.3%	91.7%	94.1%

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 September was 93.8% which is lower than the previous month's figure (94.0%). This is also lower than the attendance rate at the same point last year (September 2020) of 95.0%. The latest figures released by NHS Digital show that for May 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.3% or 94.7% attendance rate (these figures include all provider organisations and commissioners) and were the highest in England. The London region reported the lowest sickness absence rate in May 2021 at 3.7% or 96.3% attendance rate.

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

Actions

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

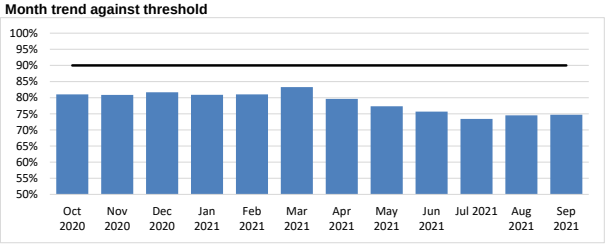
The Absence Manager system is in place across all MFT sites. The system was introduced at North Manchester at the beginning of August 2021 to enable real-time absence reporting. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers make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

Appraisal- non-medical ✕

Actual 74.7% (September 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	LCO
✕	✕	✕	✕	◇	✓	✕	✕	✕
66.3%	79.1%	74.7%	84.9%	86.3%	92.2%	79.4%	58.1%	76.1%

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 increased by 0.2% across the Group in September 2021. Only WTWA, MRI and St Mary's increased their compliance score from August 2021, all other Hospitals and MCS's have a lower compliance rate compared to the previous month. MRI had the biggest increase from August at 5.6% and Research had the biggest drop in compliance at 8.3% with a score of 76.4% compared to 84.7% in August.

Actions

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

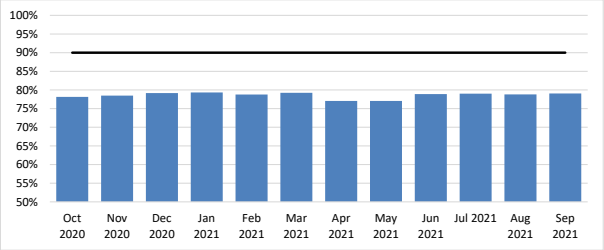
> Board Assurance

September 2021

Level 2 & 3 CSTF Mandatory Training

Actual	79.1%	(September 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	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
77.5%	76.8%	79.7%	82.1%	80.1%	78.8%	80.8%	69.0%	83.2%

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 0.3% across the Group in September 2021. Dental Hospital had the largest increase in compliance at 1.2% with a score of 78.8% compared to 77.6% in August. MRI had the largest decrease in compliance at 2.2% to 76.8% compared to 80.0% in August.

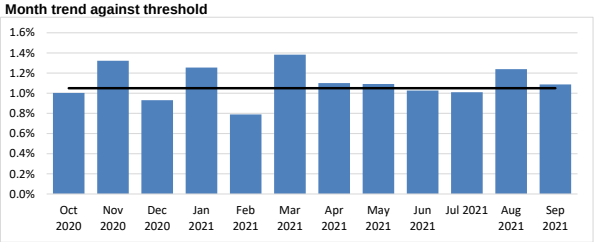
Actions

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

B5 Nursing and Midwifery Turnover (in month)

Actual	1.1%	(September 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	LCO
✓	✓	✗	✗	✓	NA	◇	✗	✗
0.83%	0.45%	1.93%	1.26%	0.00%	NA	1.00%	1.20%	1.72%

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 September 2021 is 1.1% against a monthly target of 1.05%. This is lower than the previous month at 1.2% (August 2021). The rolling 12 month average for B5 Nursing and Midwifery turnover was 13.9% in September 2021 which is 0.5% higher than last year (13.4%, September 2020).

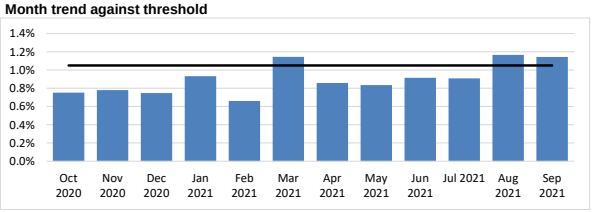
Actions

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

Turnover (in month)

Actual	1.14%	(September 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	LCO
✗	✗	✗	✗	✓	✓	✗	✓	✗
1.29%	1.11%	1.07%	1.07%	0.62%	0.00%	1.15%	0.83%	1.22%

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 September 2021 single month turnover position for the Group is lower at 1.1% when compared to the previous month (August 2021, 1.2%).

The turnover rate was lower at the same point last year (September 2020) at 0.9%.

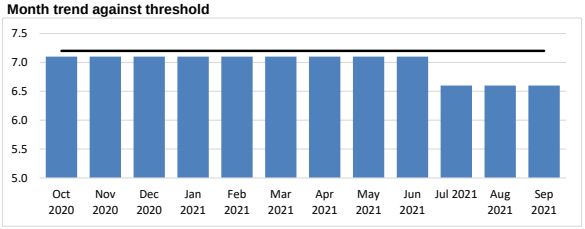
Actions

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

Engagement Score (quarterly)

Actual	6.60	Q2 21/22 (Jul to Sep 21)	**Accountability**	P. Blythin
Threshold	7.20	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	NA	✗
6.6	6.5	6.6	6.4	6.2	6.3	7.1	NA	6.7

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

Key Issues

The staff engagement score for the MFT Group is 6.6. No Hospital or MCS has met the target threshold of 7.2.

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

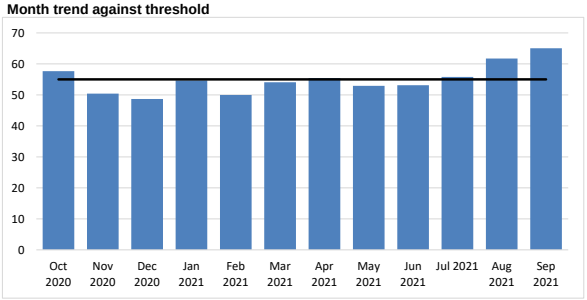
Actions

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

Time to Fill Vacancy

Actual	65.05	(September 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	LCO
✗	✗	✗	✗	✗	✗	✓	✗	✓
59.3	63.7	73.1	67.3	69.8	94.7	48.5	66.7	50.9

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

Key Issues

The Time to Fill (TTF) figure, exluding Band 5 Nursing, has increased from 61.7 in August to 65.0 in September. Currently only WTWA and the LCO were under the target in September.

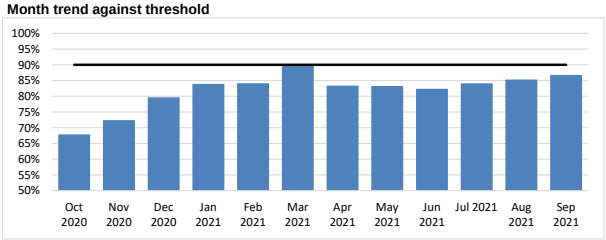
Actions

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

Appraisal- medical

Actual	86.8%	(September 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	LCO
✓	◇	◇	✓	✓	◇	◇	✗	✓
90.1%	87.3%	89.2%	91.8%	95.5%	85.3%	87.7%	53.3%	93.3%

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

Key Issues

Compliance increased by 1.5% across the Group in September 2021. The LCO had the largest increase in compliance at 3.3% with a score of 93.3% compared to 90.% in August. WTWA had the largest decrease in month of 3.3% to 87.7%.

Actions

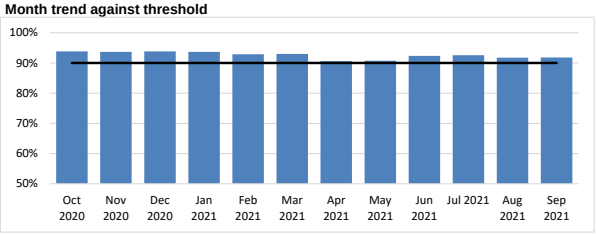
Appraisal reporting and compliance remains a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals have continued twice a month to support line managers, with over 100 managers attending sessions in first 3 months of launch in November 2020. NMGH was supported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

Level 1 CSTF Mandatory Training ✓

Actual 91.8% (September 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	LCO
✓	✓	✓	✓	✓	✓	✓	✗	✓
90.8%	92.5%	92.0%	93.5%	93.8%	94.4%	92.5%	87.2%	93.5%

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

Key Issues

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In September the aggregate compliance remained at 91.8%. Only NMGH has a compliance score below the 90% Trust target.

Actions

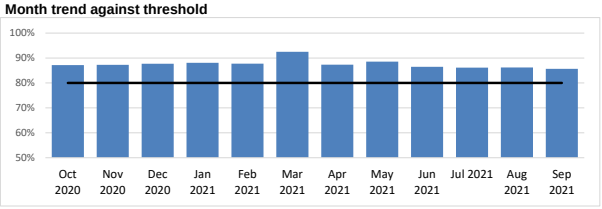
The 5 key Mandatory Training work streams, overseen at CEO / Director level, have progressed in line with the KPMG audit where we received significant reassurance. Work to integrate this programme into business as usual processes is now underway. NMGH have now been successfully integrated into the Learning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

Nurse Retention ✓

Actual 85.7% (September 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	LCO
✓	✓	✓	✓	✓	✓	✓	•	✓
86.2%	85.7%	88.6%	85.1%	87.2%	92.3%	82.9%		87.0%

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

Key Issues

In September 2021, Nursing and Midwifery retention stands at 85.7% which continues to be above the threshold of 80%.

Actions

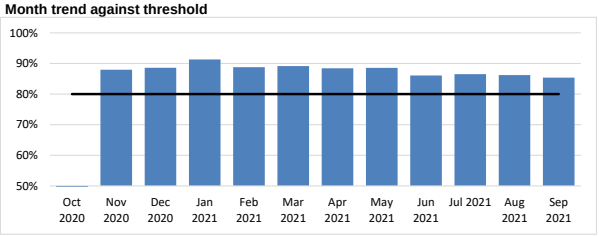
The retention threshold target for Nursing and Midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The Trust has implemented a guaranteed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

BME Staff Retention ✓

Actual 85.4% (September 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	LCO
✓	✓	✓	✓	✓	✓	✓	NA	✓
86.8%	85.7%	88.6%	85.1%	88.0%	94.4%	82.9%	NA	89.5%

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 September was 85.4%.

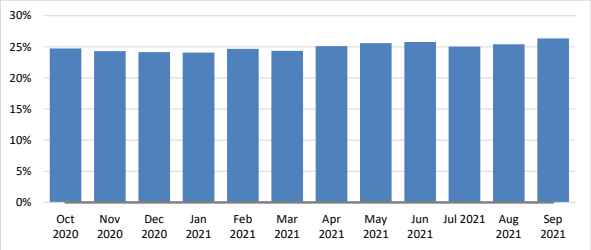
Action

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	26.3%	(September 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	LCO
-	-	-	-	-	-	-	-	-
30.0%	26.1%	25.4%	20.4%	36.9%	41.7%	29.5%	21.7%	18.9%

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

Key Issues

One in four appointments is of black and minority ethnic origin (26.3%); which is consistent month on month.

The Trust has increased its % BME appointments of Total Appointments by 3.0% when compared to the same point last year (September 2020, 23.3%). The Workforce Directorate has completed the Workforce Race Equality Standard Report for 2020/21 and reported to HR Scrutiny Committee. Hospital / MCS / LCO / Corporate action plans near completion.

Actions

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

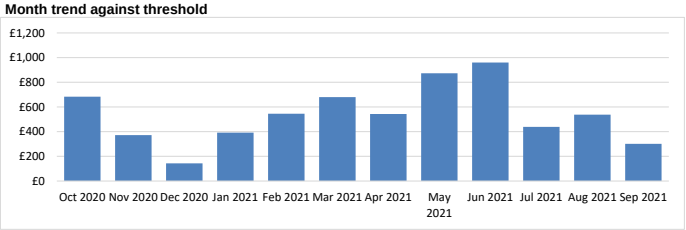
The Trust has launched the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

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

Medical Agency Spend

Actual	£301	(September 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	LCO
-	-	-	-	-	-	-	-	-
£0.0	£181.1	£0.0	£49.0	£71.1	£0.0	£0.0	£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 September total value of Medical and Dental agency staffing was £301k compared to £537k in August. This is a considerable drop from August which was due to the increase in doctor change over and holidays.

Actions

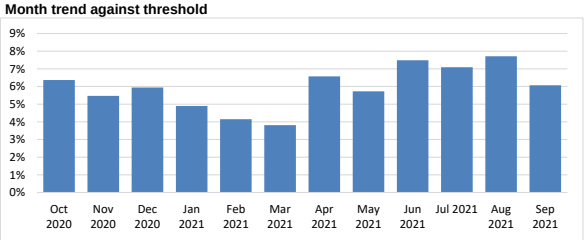
Spend continues to be reviewed for both bank and agency medics across all Hospitals/ MCSs and grades. This is including an in-depth monthly review of all of the cost centres using medical agency workers and opportunities identified where possible to reduce this. A more concentrated focus has been put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

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

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	6.1%	(September 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	LCO
-	-	-	-	-	-	-	-	**NA**
-10.4%	5.7%	-1.1%	8.2%	5.6%	NA	7.7%	20.6%	NA

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 September 2021 there were 305.0 (6.1%) Staff Nurse / Midwife / ODP (band 5) vacancies across the Trust Group.

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

Actions

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	Rachel Bayley, Deputy Group Director of Operations
Date of paper:	November 2021
Subject:	Update on Performance and Transformation
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board is asked to note: • the contents of the report; • the updated national planning assumptions for H2 and the Trust associated planning activities; and • the position and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.
Contact:	Name: Rachel Bayley, Deputy Group Director of Operations Tel: 0161 701 5641

Manchester University
NHS Foundation Trust

UPDATE ON PERFORMANCE AND TRANSFORMATION

1. PURPOSE

The purpose of this briefing is to provide the Board of Directors with an overview of the Manchester Foundation Trust (MFT) ongoing response to the Covid 19 pandemic, including ongoing operational planning, performance and improvement / transformation activities to ensure safety and enable timely access to services for patients.

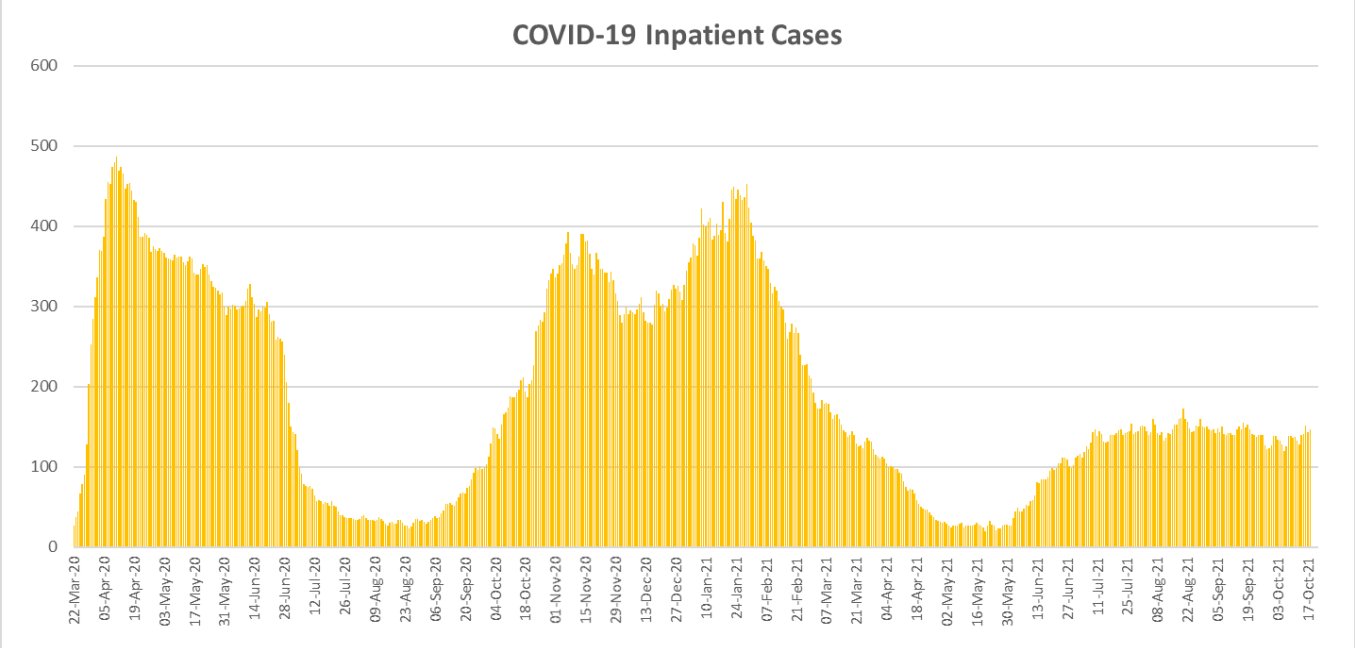
2. COVID POSITION

The North West has experienced a greater Covid impact than other regions over a sustained period of time, which has significantly drained both staffing resource and the bed base for elective recovery.

The below chart demonstrates that MFT continues to manage a challenging, but stable Covid position across the Trust over the last three months:

- The range of Covid patients in general and acute beds has been between c.120-150 patients, representing c. 6% of bed occupancy.
- Covid occupancy of critical care beds is broadly stable at 11% (20 beds).

Due to social distancing requirements MFT has been operating on a reduced bed base with 169 less beds in use than in 2019. Despite the challenges, MFT has and continues to offer mutual aid across Greater Manchester (GM) and the region to support patient safety.



1. PLANNING UPDATE AND ASSUMPTIONS

In late September the Trust received the H2 (October 21-March 22) planning guidance:

- An initial (draft) plan was submitted to GM on the 11th October
- The supporting narrative was submitted on the 15th October
- A final plan is due to be submitted to GM on the 5th November.

The planning guidance contains several key elements including an Activity and Performance template, a Workforce template and a Finance template for submission to NHSE/I.

The key messages and requirements set out in the planning guidance include:

- Reduction of the longest waiting times for elective and cancer patients and stabilisation of waiting lists.
- Maximising new models of care and innovative ways of working for outpatient and cancer diagnostic pathways.
- Increase of activity levels linked to the Elective Recovery Fund.
- Focus on urgent and emergency care with a reduction in ambulance handovers times and the longest waits in EDs, in addition maximising safe and time discharge.

The draft submission shows that GM will be challenged in meeting a number of the requirements set out in the planning guidance, in part due to the disproportionate impact that Covid has had on GM compared to other regions.

In preparation for the Final submission on the 5th November, GM Trusts are engaged in "confirm and challenge" sessions with partner organisations which will ensure plans are robust and ambitious, but also realistic. Provider plans will be submitted to Provider Federation Board before final submission via GM.

2. URGENT CARE AND FLOW

Current Position:

Compounding the ongoing Covid load across organisations in GM, providers are experiencing high emergency demand/acuity and a large proportion of the bed base is consumed with emergency admissions, impacting on available capacity for elective recovery as well as negatively affecting front door waiting times.

The GM and MFT systems are experiencing unprecedented Urgent and Emergency Care (UEC) pressures to levels that have not been previously seen. Across GM the demand for ambulances with higher acuity calls has grown. Whilst overall MFT activity is at pre-pandemic levels this is misleading as there are days of extreme pressure at peak levels across both adult and paediatric Emergency Departments (ED).

Since April 2021 there has been a steady decline in the national performance, with a similar trend across GM and MFT. The range of performance in GM for Quarter 3 is between 61% - 72%, with only one provider above 70%. The table below shows September performance:

National	GM	MFT
75.2%	67.42%	64.65%

The UEC pressures are contributing to MFT experiencing increased Non-Elective admissions, resulting in high non-elective bed occupancy across the Trust. This has had a direct impact on elective beds, with elective wards having to be converted to support emergency admissions and maintain safety across the urgent care pathway.

This is further compounded by high numbers of medically fit patients in acute beds impeding flow through MFT hospitals, resulting in longer wait times in ED, impact on ambulance turnaround and constrained capacity to undertake elective activity. Many of the patients who are medically fit and awaiting to leave the hospitals are waiting Pathway 1 (home) and Pathway 2 (non-acute bed) capacity which is limited due to care sector workforce capacity.

During this time of heightened pressure, the focus on safety remains paramount. This focus is maintained by a number of factors including: delivery of the safety standards in place with the EDs, undertaking safety audits alongside Root Cause Analysis for long wait patients, and thematic reviews to drive improvement actions. Crucially the ED teams are responding to the challenges, but with a fatigued and depleted workforce and higher sickness levels as a result of the pandemic. Therefore, MFT continues its focus on staff health and wellbeing with multiple offers in place to support teams and individuals.

Oversight of MFT performance and delivery of recovery actions is taking place on a daily basis through routine reporting, and weekly through the MFT Strategic Group.

Ongoing Actions:

In response to the sustained pressures MFT is holding a 'risk summit' in the first week of November 2021. This will review current and/or emerging risks in the Hospitals/MCS and establish whether the actions in place can deliver the required risk mitigation or whether further actions are required. In addition, a round table discussion will be held by the locality, including MFT representatives to provide assurance of the actions being taken and plans for winter. Furthermore, MFT hospital sites have undertaken winter preparedness activities with scenario planning exercises undertaken in October.

The MFT urgent care recovery plan is focused on the delivery of the national priorities for urgent care and is in line with the H2 planning focus with the aim to deliver:

- Development and implementation of the ED safety standards including review of 12 hour waits (from arrival).
- Embedding of the pre ED streaming pathways that have been developed across all hospitals
- A system wide approach to 111 first with joint communication plan to local population - in line with the national comms campaign.
- Appointments for Urgent Emergency Care in ED and Urgent Treatment Centre (UTC) for NHS 111 and Local Clinical Advice Service and walk in patients, in place to reduce crowding in waiting rooms across ED and UTC departments.
- Ambulance handovers - Transformation working with hospital sites and North West Ambulance Service (NWAS) colleagues to review alternative ways of working to support rapid release of ambulance crews- taking learning from other NWAS and GM sites. These include the utilisation of the ambulance handover checklist.
- Same Day Emergency Care maximisation – direct conveyance pathways have been agreed with NWAS and primary care to enable bypass to ED.

- Expedited discharge - The Local Care Organisation (LCO) is working in partnership with staff at Trafford General Hospital, focusing on education and training of the community offer and different options for home therapy support and discharge, to expedite discharge with a view to rollout widely across MFT following evaluation.
- Hospital level focus on long length of stay in-patients and working with LCO and Clinical Commissioning Group colleagues for medically fit patients– utilising the Reason to Reside data for objective review and action.

Expected Impact:

The aim of the actions being taken is to maintain patient safety across the UEC pathways. This is achieved through alleviating pressure on the front door emergency departments by reducing avoidable attendance at ED and reducing waiting times for both patients and ambulance crews. In addition, the aim is to reduce avoidable admission to hospital, whilst also focusing on discharge pathway improvements to improve the flow through the hospital overall ensuring sufficient bed capacity to sustain the emergency and elective programmes.

3. ELECTIVE ACCESS:

3.1 Outpatients

Current Position:

Compared to 2019/20 activity levels, overall recovery of Outpatient activity in September is:

- 88% for First Appointments
- 93% for Follow-up Appointments

In areas of the Trust, Infection Prevention and Control guidance still requires intensive cleaning between patients, meaning full recovery of outpatient throughput cannot be achieved, and it is likely this guidance will remain in place through to March 2022.

The H2 planning guidance identifies three transformation priorities for the next 6 months, with associated initiatives supporting the medium-term recovery:

Planning Priority	MFT Performance
25% outpatient activity to be virtual	MFT is currently at c.30% although this has decreased throughout H1 as recovery focuses on face to face activity
2% of all Outpatient appointments discharged to Patient Initiated Follow Up (PIFU) by March 2022	MFT is currently at 0.75% but has rapidly expanded PIFU to >50 specialties compared to the 5 required in H2 guidance and PIFU levels continue to increase.
Advice and Guidance to constitute an equivalent of 12% of First Appointments	MFT's overall level of Advice and Guidance is 4.4% of First Appointments. However, for activity linked to GP-referrals MFT's A&G is 11% and this remains the focus area

Ongoing Actions:

MFT has an Outpatient programme as part of the overall recovery programme. This continues to focus on:

- The key transformational priorities for Outpatients,
- Supporting delivery of community phlebotomy clinics (now live in 8 sites across Manchester and Trafford),
- Expansion of outsourced letter provision and standardisation of patient correspondence
- Re-introduction of text reminder services and waiting list validation work, working alongside the CCGs and GP members,
- Supporting closer working between secondary care and primary care through initiatives such as GP education.

Expected Impact:

MFT introduced PIFU and Virtual Triage in the summer of 2021. From November an evaluation of the Virtual Triage project is being undertaking to ascertain impact on patient pathways, referrals and the need for first appointments. A later evaluation of PIFU will follow given the longer timescales for this project to have an impact (patients typically use PIFU 3-12 months after first being discharged to PIFU).

3.2 Cancer

Current Position:

MFT is a specialist cancer hub for a number of tumour groups, some of which are the largest volume cancer pathways. Whilst initially cancer demand recovered more slowly than the national picture this has recently changed and cancer referral activity is now at peak levels with circa 110% of pre-pandemic levels, with some tumour groups in excess of this level. In addition, long waits at other providers impacts on MFT as patients are transferred on for treatment at the specialist hub.

Despite increased demand this is being managed and MFT cancer performance against the 2 week wait standard is strong and above the national position. The additional c.3500 cancer referrals seen so far in 2021 places a significant drain on diagnostic resources, which is the key challenge for MFT to achieve timely pathways. The most pressured pathways are Gynaecology, Lower/upper Gastrointestinal, Urology, Head and Neck, which is in line with the rest of GM whereby the single largest pathway affecting long waits for cancer is Lower Gastrointestinal (LGI).

MFT is effective at treating cancer, with activity levels back to the level seen prior to the pandemic, and this patient cohort as a clinical priority is subject to the MFT Manchester Elective Surgical Hub process outlined below, as well as access to the GM hub and mutual aid across GM. The key issue to overcome is to undertake additional activity for a period of time in order to remove the backlog and reach a sustainable position, which has a risk of impacting on routine elective activity.

Ongoing Actions:

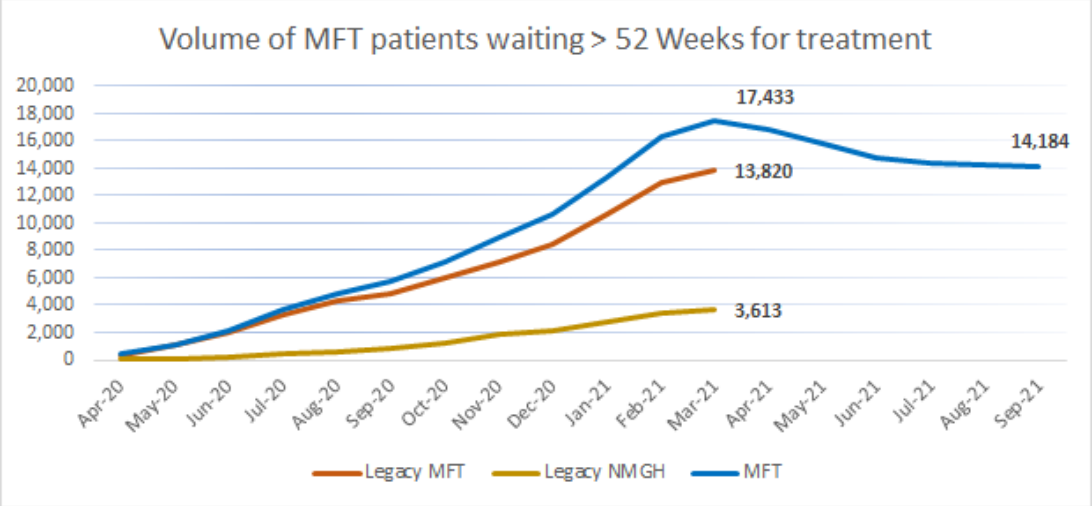
- The actions listed in sections 3.4 – 3.7 will support delivery of increased and timely cancer pathways
- MFT has a Cancer programme in place as part of the overarching recovery programme.
- H2 planning and modelling is currently being undertaken for cancer pathways with a focus of critical actions on:
    - improving timeliness of first appointment,
    - maximising diagnostics and pathology capacity,

  - implement actions from the LGI perfect week and
  - increasing capacity to reduce backlogs to a sustainable level.
- In recognition of the need for timely treatment, MFT is both receiving and giving mutual aid for cancer, including
  - utilising Christie theatre capacity,
  - GM has provided a mobile CT unit on weekends,
  - working with the cancer alliance on the LGI pathway improvements,
  - MFT is giving aid to NCA on the H&N pathway.
- Safety remains paramount, with harm reviews undertaken for any long wait
- Group wide cancer peer review process was undertaken in September to identify best practice, to provide Group support where required, and ensure actions are in place to support pathway improvements, with actions tracked through local hospital / Managed Clinical Service Cancer Boards and the MFT Cancer Committee.

3.3 Long Waiting Patients

Current Position:

The continued prevalence of Covid, urgent and emergency care pressures, 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 September 2021 was 150,730 of which the volume of >52-week waiters at the end was 14,184, an improvement of -3,249 (18.6%) on the position at the end of March 2021 (17,433).



MFT continues to follow national guidance to ensure it treats its most clinically urgent patients first. The impact of this is that whilst the overall number of 52+ week waiters is decreasing currently, the number of non-urgent patients waiting longer than 104+ weeks for treatment is increasing, although this is a very small proportion of the waiting list at 0.76%. Limited elective capacity as outpatients convert onto the admitted pathway is a significant cause of the >104 week wait pressure, with 92% of the current MFT long waits awaiting surgery.

Continued review by clinical teams of the waiting list is undertaken, in addition potential harm assessments are undertaken for the longest waiting patients to ensure patient safety.

The most challenged specialties are those specialties that experience high volumes of routine elective procedures: Oral Surgery, ENT, Paediatric Dentistry, General Surgery, Urology, which correlates to GM pressures and limits options for mutual aid. In addition, routine elective patients that have more complex needs are competing with the highest clinical priority patients: clinically complex T&O patients requiring organ support and need to be treated on an acute site, and Paediatric Gastroenterology patients who need to be seen in a paediatric theatre.

Ongoing Actions:

A number of actions are being taken to support recovery with the Group Director of Operations team continuing to oversee hospital / MCS delivery, clinical validation of patients, and support the modelling of capacity at hospital / MCS and specialty level through several forums. The priority of this work is to ensure the number of long waiters is minimised where possible, using GM hub and Independent Sector provision where appropriate.

In addition, the below sections outline other key programmes of work that will support the delivery, and maximisation of elective activity, and a reduction in the longest waits including:

- the GM Elective Task and Finish Group and MFTs associated Elective Recovery Programme
- the MFT Manchester Elective Surgical Hub
- The development of Trafford Hospital as a 'green site'
- Maximising use of the Independent Sector

3.4 GM Task and Finish Group/MFT Elective Recovery Programme:

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

The MFT elective recovery programme is aligned to the GM principles listed above and national planning requirements, incorporating the four workstreams:

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

3.5 Manchester Elective Surgical Hub (MESH)

As a result of the challenging operational environment caused by Covid, effective management of elective waiting lists at hospital / MCS level continues to be required to ensure MFT treats its most clinically urgent patients, including cancer, 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 Manchester Emergency & Elective Surgical Hub (MESH) groups have continued to meet regularly since the start of the year. Given current pressures on availability of critical care beds, MESH processes have been strengthened and each hospital / MCS is now required to rank patients in order of clinical priority and need for post-operative critical care bed.

Current Position:

Discussions at site and Group MESH remain focussed on addressing and dating the priority 2 patients, including cancer patients, who have waited over 28 days for surgery. The below table shows the 5 specialties with the highest number of patients in this category. As additional theatre resource becomes operational, it is then directed towards the treatment of patients in the specialties with the highest wait times.

Ongoing Actions:

Considerable progress has been made in Q1 and Q2 of 2021/22 to reduce the numbers of undated P2 patients across MFT sites and specialties. Where appropriate, mutual aid across MFT sites and or use of GM hub capacity has been progressed. To address speciality pressures as noted above the following actions are being taken.

- The urology pressures are predominately experienced at North Manchester Hospital. To reduce the backlog and equalise waiting times across the trust a task and finish group has been established to undertake a demand and capacity exercise. To create additional capacity one additional all-day operating list is now being provided in the Christie.
- To reduce cardiac surgery waits additional operating lists are being provided at the MRI on a Saturday. In addition, additional capacity has been sourced in the independent sector commencing at the end of October. Regional assistance was requested however no other NHS Trusts in the region can provide additional capacity.
- Additional operating lists for oral surgery begin at Trafford to reduce the backlog.

3.6 Trafford 'Green Site'

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.

Trafford Hospital has been designated as MFTs elective green site, and bids have been submitted for funding from GM through the Elective Recovery Fund mechanism. The funding supports additional evening and weekend work primarily in Trauma and Orthopaedic and Paediatric dentistry specialties. Funding has also been secured to increase the total number of theatre sessions run during the week. From the 8th November the theatre capacity has been re-allocated to those services who have projected the longest waits.

3.7 Independent Sector Capacity & Usage

In order to support elective recovery, MFT has sought additional capacity through Independent Sector (IS) organisations and is working with 7 IS provider sites, across 13 sub specialities. Uptake has been strong and sustained despite the complexity of accessing the capacity, with utilisation over 90% for the period Jul – Sept (excluding Trauma & Orthopaedics). T&O IS usage has been more challenged in part due to the geography of IS sites, although plans are in place to continue to maximise this capacity.

The biggest challenge currently is the mismatch between available specialities across independent sector providers and those specialties with the longest waiting times. ENT and Gynaecology are two challenged specialities however, there is no GM-wide ISP capacity available to MFT for these services.

MFT is now seeking further contracts with IS providers to mitigate the gaps and seek further opportunities at a regional / national level.

Expected Impact:

The actions are being taken to minimise the number of patients facing an extended wait to elective treatment at MFT. The focus is on maximising the use of current MFT resources and capacity, as well as implementing best practice and national planning requirements. In addition, the actions seek additional capacity through other routes to reduce the longest waiting times for patients.

A key risk to recovery of the elective programme and reduction of waiting times is the ongoing impact of the urgent and emergency care pathway, increased winter pressures including Covid, and or, infection outbreaks. The use of Trafford and Independent Sector capacity is key in protecting elective activity from these pressures.

4. INEQUALITIES

Covid-19 has entrenched health inequalities across society. The Elective Recovery Fund requires Trusts to take regard of pre-pandemic and pandemic related health inequalities across all waiting lists. As part of the H1 requirement it asked Trusts to review the impact of National Outpatient Transformation initiatives and whether they have limited access, outcomes or the experience of particular groups, and to begin to report that through to Board level.

MFT has both an Outpatients recovery programme and an Inequalities group, both chaired by the Joint Group Medical Director, and through these programmes inequalities are being reviewed. The initial analysis of the National Outpatient Transformation Initiatives has highlighted the following:

- Patients from most deprived neighbourhoods are less likely to access virtual outpatient appointments than those from the least deprived neighbourhoods – range of 37% to 46% (IMD 1 vs IMD 10)
- Capture of ethnicity for virtual outpatients is poorer (24% unknown vs 16% for all outpatient attends), possibly due to patients not attending in person where the first appointment is virtual, and so it is difficult to extract any meaningful insight as this distorts the percentages within ethnic groups

- Little difference in virtual outpatient participation by age group, although evidence suggests 70+ year old patients find the experience of using video platforms more difficult
- A larger proportion of patients from the least deprived neighbourhoods are put onto PIFU pathways, compared to those from more deprived neighbourhoods
- Some ethnicities are less likely to be on PIFU pathways (Pakistani, African) than others (British)
- Broadly, the age profile of patients on PIFU pathways reflects Outpatient attendances
- Advice and Guidance is difficult to assess due to minimal data capture from e-RS in A&G type requests from GPs, with IMD data distorted and ethnicity missing – no notable differences according to age groups

The PIFU and A&G analysis is influenced by the specialties and their patient cohorts, that have gone live with these initiatives. Therefore, further work is needed to analyse this at a more granular level and further analysis is ongoing relating to how inequalities manifest across pathways, with some deep-dive areas selected and actions being agreed in the Outpatients and Inequalities groups. Reporting on inequalities will be routinely embedded with work is ongoing to establish the most informative measures.

5. RECOMMENDATIONS

The Board are asked to note the contents of the report, the updated national planning assumptions for H2 and the Trust associated planning activities. In addition, the position and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Alison Lynch, Corporate Director of Nursing
Date of paper:	November 2021
Subject:	MFT COVID-19 and Influenza Vaccination Programme 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:	• Improve patient safety, quality and outcomes • Improve the experience of patients, carers and their families • People Plan: we look after each other
Recommendations:	The Board of Directors are asked to note the information provided in the report in relation to: • COVID-19 vaccination programme • Seasonal influenza vaccination programme • Healthy 12- to 15-year-olds vaccination programme
Contact:	Name: Alison Lynch, Corporate Director of Nursing Tel: 0161 276 5655

1. Purpose

1.1. This paper provides an update and information related to:

- National guidance
- National and regional vaccination programmes
- COVID-19 staff & affiliate vaccination programme
- COVID-19 patient vaccination programme
- Seasonal influenza vaccination programme
- Healthy 12- to 15-year-olds vaccination programme
- Communication and engagement
- Programme governance

2. Updates to National Guidance

2.1. On the 14th September 2021 the Joint Committee on Vaccinations and Immunisations (JCVI) advised that for the 2021 COVID-19 booster vaccine programme, individuals who received vaccination in Phase 1 (cohorts 1 to 9) should be offered a third dose COVID-19 booster vaccine[1].

2.2. This advice also stated that the booster vaccine dose should be offered no earlier than 6 months after completion of the primary vaccine course, with further clarification that the optimal "window" for booster vaccination is 182 days to 238 days after the last dose.

2.3. The proposed end date for the booster vaccine programme is 17th December 2021, however it is possible that this may be extended.

2.4. Data from the ComFluCOV trial indicates that coadministration of influenza and COVID-19 vaccines is generally well tolerated with no diminution of vaccine-induced immune responses to either vaccine[2].

2.5. The COVID-19 Response: Autumn and Winter Plan sent to NHS trusts in the same week advised that this would be deployed via the school immunization teams.

2.6. The COVID-19 and seasonal influenza programmes are recognised as an essential activity within the Autumn and Winter Plan.

2.7. On 1st September 2021 the JCVI recommended that individuals aged 12 and over with severe immunosuppression in proximity of their 1st or 2nd COVID-19 vaccine doses in the primary schedule, should be offered a 3rd primary dose vaccine.

2.8. On 13th September 2021 the Department of Health and Social Care (DHSC) announced advice from the chief medical officers confirming that young people aged 12- to15 should be offered a COVID vaccine[3].

2.9. This was followed with a letter to all NHS trusts dated 30th September 2021. This letter outlined that all patients should have been identified and written to and 3rd primary dose vaccines offered. If this is not possible at the NHS trust, then this should be supported by the GP.

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[1] https://www.gov.uk/government/publications/jcvi-statement-september-2021-covid-19-booster-vaccine-programme-for-winter-2021-to-2022/jcvi-statement-regarding-a-covid-19-booster-vaccine-programme-for-winter-2021-to-2022#fnref:9:1

[2] Results from the ComFluCOV study looking at giving a COVID-19 vaccine and flu vaccine at the same time. 30 September 2021. https://www.sciencemediacentre.org/results-from-the-comflucov-study-looking-at-giving-a-covid-19-vaccine-and-flu-vaccine-at-the-same-time/

[3] https://www.gov.uk/government/publications/universal-vaccination-of-children-and-young-people-aged-12-to-15-years-against-covid-19/universal-vaccination-of-children-and-young-people-aged-12-to-15-years-against-covid-19

2.10. On 1st October guidelines[4] were received on the exemption from COVID-19 vaccination, the process for providing exemptions and the clinical criteria to be applied.

2.11. The guidance has also been included in the MFT COVID-19 Vaccination Policy for Care Home Entry which applies to staff who enter care homes as a part of their role[5].

3. National and Regional Vaccination

3.1. Across the United Kingdom more than 49 million people have had a first COVID-19 vaccine dose: 89.8% of adults over 16 years of age[6]; and over 45 million, or about 82.5%, have had their second dose. As of 11th October, 94,376,101 vaccinations have been given since the vaccination programme commenced in early December 2020.

3.2. COVID-19 Vaccination rates have now levelled off in every age group in England, apart from 12 to 17-year-olds, where uptake continues to rise.

3.3. The highest rates of COVID-19 vaccination can be seen in the oldest age groups who were among the first to be vaccinated.

3.4. In the North West almost 5 million people have received their first COVID vaccine, with over 89% also having received their second dose[7].

3.5. In Greater Manchester 66.4% of adults over 16 years of age have received their first vaccine; 60.1% have received their second dose.

3.6. On 12th September 2021, the UK's 4 chief medical officers announced that on balance, it is likely that vaccination will help reduce transmission of COVID-19 in schools which are attended by children and young people aged 12 to 15 years.

3.7. The programme is commissioned by NHS England to be delivered by School Aged Immunisation Services (SAIS) alongside other immunisation programmes.

3.8. The programme commenced across GM on 22nd September 2021.

3.9. Offers will be made to all pupils before October half term, with the vaccination programme completed by 30th November 2021.

4. MFT COVID-19 and Seasonal Influenza Staff & Affiliate Vaccination Programme

4.1. The MFT COVID-19 vaccination programme commenced on 15th December 2020, delivering both AstraZeneca and Pfizer vaccines across the four clinics at Manchester Royal Infirmary, Wythenshawe, and Trafford General Hospital.

4.2. Through the MFT staff vaccination programme:

- 90.6% have received their 1st vaccine
- 90.5% of clinically vulnerable staff have been vaccinated
- 88.2% 2nd dose vaccines have either been administered or booked
- 100% of MFT staff have been offered the vaccination

[4] Department of Health and Social Care: Clinical Guidance on Exemption from COVID-19 Vaccination or Vaccination and Testing (NWICC 10554)

[5] COVID-19 Vaccination Policy for care Home Entry V1 (HR50/2021)

[6] The government announced via https://coronavirus.data.gov.uk/details/vaccinations that the vaccination uptake percentages for the UK will not be updated while a solution to include 12-15 year olds is developed.

[7] Data accurate at 9th September 2021

4.3. The MFT COVID-19 booster vaccine rollout commenced on 22nd September 2021.

4.4. Co-administering influenza and COVID-19 vaccines in the same appointment will allow more efficient use of resources and a better service for patients, as well as potentially helping to improve uptake of both vaccines.

4.5. Eligibility for COVID boosters and flu vaccination will vary dependent upon when the 2nd dose was administered.

4.6. Flu vaccines were made available in clinics from 27th September 20218.

4.7. Early data shows an average rate of 89.5% of staff who have attended having both vaccines at the same time9, with a 95% dual vaccine uptake rate in some clinics.

4.8. Flu-only clinics will be provided so that flu vaccines are not delayed due to ineligibility for the COVID-19 booster.

5. MFT COVID-19 and Seasonal Influenza Patient Vaccination Programme

5.1. The aim of both the COVID-19 and seasonal influenza vaccination programmes is to protect our employees against debilitating illness, reduce operational impact due to increased sickness absence and the associated costs, and reduce the infection risks to our patients.

5.2. The Vaccination Strategic Group has approved criteria for inpatient and outpatient inclusion in the provision of COVID-19 and flu vaccines.

5.3. The MFT Vaccine Service 'Case of Need' provided for 1000 patient vaccines to be administered.

5.4. Patient cohorts will be included in the provision offered by the MFT vaccine service for a 4-week period from Monday 25th October 2021 as part of the agreed programmes.

5.5. An exception to this will be pregnant inpatients and outpatients for 1st and 2nd COVID-19 and flu vaccines, and patients who have undergone stem cell transplantation for re-commencement of their primary course after treatment. These cohorts will be included for vaccine appointments throughout the programme.

5.6. The MFT vaccine service supports training, governance, and systems for:

- Local maternity services offering flu-only vaccination in Saint Mary's Hospital and Managed Clinical Services ante-natal clinics.
- RMCH vaccine services offering vaccines to:
- Paediatric inpatients with LOS > 21 days that meet the criteria for seasonal flu vaccination
- Paediatric outpatients that meet the criteria for seasonal flu vaccination and have been referred in due to complex vaccination needs and accepted by the Royal Manchester Children's Hospital operational group
- Paediatric inpatients aged 12-17 in an at-risk group

[8] Flu Vaccination will commence at NMGH 05/10/2021

[9] Based on Sit Rep daily reporting

- Paediatric outpatients aged 12-17 in an at-risk group and have been referred in due to complex vaccination needs and accepted for vaccination by the RMCH vaccine operational group

5.7. The national target for frontline healthcare workers is to offer:

- 100% of staff access to the flu vaccine, with a target of 85% uptake, and
- 100% offer of COVID-19 boosters to all staff.

5.8. The seasonal influenza vaccination season commenced on 1st October and runs until end February 2022.

5.9. In 2020-2021, MFT delivered a successful seasonal influenza programme, vaccinating 81.01% of frontline healthcare workers (12,867 staff). 76.14% of the whole workforce (16,987 staff) received a vaccine. The 2020-21 uptake exceeded the previous year uptake which was 79.4%.

6. MFT COVID-19 Healthy 12–15-year-old Vaccination Programme

6.1. The MLCO/TLCO school aged immunisation service (SAIS) teams are leading on the delivery of the COVID vaccine to healthy 12 to 15-year-olds in schools in Manchester and Trafford; the programme commenced on 22nd September 2021.

6.2. The primary offer for children will be to have their vaccine in school settings. Supplementary offers are being developed to provide vaccination capacity in MFT hospital hubs, and through PCN's.

6.3. In line with national guidance, parental consent is sought for vaccination 48 hours prior to administration.

6.4. Pharmacy processes are in place that provide supply oversight, transport planning, and accountability in line with MFT Standard Operating Procedures, national PGD and protocols and national guidance and recommendations.

7. Communication & Engagement

7.1. 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.

7.2. The Vaccination Engagement Group continues to meet monthly, involving hospital/MCS/LCO and corporate vaccination leads, employee health and well-being (EHW), pharmacy, communication teams, staff-side representation, and network representatives (BAME, EDI, LGBT+).

7.3. The Group focus on ensuring that the vaccine programme is inclusive, easily accessible to all staff and that barriers or concerns are identified and addressed in an informative and supportive way.

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

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

7.6. A series of interactive Q&A sessions have been scheduled, with the first being well received.

7.7. Network collaboration has led to improvements in data recording for ethnicity and sex/gender within the service. This will aid with reporting and uptake in 'hard to reach' groups and will support reductions in health inequalities.

8. Governance

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

8.2. Systems are in place to ensure MFT procedures are amended in line with changes to national guidance.

8.3. Vaccination programme meetings are held weekly, focusing on the strategic planning of the vaccine programme

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

8.5. A Quality Assurance Framework (QAF) has been developed and includes a series of audits and governance reporting to ensure that quality, safety and continuous improvement are embedded in the service. An overview of the monthly QAF report will be shared at the vaccine strategic group.

9. Summary

9.1. The MFT vaccine service leadership team are running an effective vaccine programme in a rapidly changing environment.

9.2. There has been good uptake of the COVID-19 vaccination across MFT staff and a good early response to taking COVID and flu vaccines at the same time.

9.3. Nationally, the focus remains on:

- Maximising uptake of the vaccine among those that are eligible but have not yet taken up the offer.
- Offering booster doses to individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1-9). With a trust focus on our MFT staff and affiliate frontline healthcare workers
- Offering a first dose of vaccine to 12–15-year-olds.

9.4. The MFT vaccine service objectives align with the objectives outlined in the Autumn and Winter Plan[10].

9.5. This provision will continue to offer high levels of protection against influenza and COVID-19 for our staff and eligible patients, whilst ensuring a person-centred, high quality standard of service.

10. Recommendations

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

[10] HM Government; COVID-19 Response: Autumn & Winter Plan (September 2021)

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Head of Nursing for Infection Prevention & Control/Tissue Viability
Date of paper:	November 2021
Subject:	Infection Prevention and Control Report on Nosocomial Infections (incorporating the IPC BAF in respect of COVID-19 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 is asked to note the actions and progress to reduce the risk of transmission of COVID-19 and other HCAI across all our services.
Contact:	Name: Michelle Worsley, Head of Nursing for Infection Prevention & Control / Tissue viability Tel: 0161 276 4042

1. Introduction

1.1 The Trust is committed to the prevention and management of Nosocomial Infections as demonstrated in the continuing actions and improvement programmes set out in the IPC Board Assurance framework (BAF) updated October 2021 (Appendix 1).

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

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

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

2. IPC BAF

2.1 As previously reported the Trust has regularly undertaken assessments against the standards in the Board Assurance Framework (BAF) developed by NHS England/Improvement (NHSE/I).

2.2 The main purpose of the Framework is to support healthcare providers to identify, address risk and self-assess compliance with Public Health England (PHE) now known as the UK Health Security Agency (UKHSA) and other COVID-19 related infection prevention and control guidance.

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

2.4. The IPC Board Assurance Framework has been reviewed at the following meetings of the Board of Directors and sub-committees since its publication in June 2020.

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

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

- 20th April 2021. Group Infection Control Committee
- 10th May 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and nosocomial infections).
- 12th July 2021. Board of Directors Meeting
- 21st July 2021. Group Infection Control Committee
- 13th September. Board of Directors (as part of a report relating to the COVID-19 response and nosocomial infections)
- 19th October 2021. Group Infection Control Committee

2.5. For ease of reference updates of the BAF are highlighted in green and summarised below.

- 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 7, 8, 9 and 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 to 28, 30 and 31)
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance (update included on page 32 and 33)
- 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 (no change)
- 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 (updates included on pages 39, 40 and 43)
- 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 55 and 56)
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections (no change)
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection (updated on pages 64 and 65)

3. Highlights from the recent review of the IPC BAF

3.1. Review of recently released guidance from the newly formed The United Kingdom Health Security Agency (UKHSA) published recommendations[2] for changes to COVID-19 infection prevention and control advice to help ease pressure on the NHS.

[2] UKHSA review into IPC guidance: Recommendations for changes to COVID-19 IPC advice to help ease pressure on the NHS. 27th September 2021.

3.2 Recommendation 1 describes the reduction of physical distancing from 2m to 1m+ in low-risk wards and departments where elective procedures or planned care is undertaken in line with a risk assessment incorporating the Hierarchy of Controls. The Trust response is that:

- Increasing the bed capacity utilising the risk assessment will further support the recovery of elective programmes whilst maintaining the safety of patients and staff.
- Hospitals are currently reviewing elective ward capacity in conjunction with Infection Prevention Team with a view to increasing capacity where it is safe to do so.

3.3 Recommendation 2, to change the pre-procedure testing advice prior to elective procedures or planned care has been partly accepted. Staff will continue with current policy of testing using laboratory-bases PCR testing and will continue to develop Point of Care PCR testing to include elective patients in further rollout.

3.4 Recommendation 3, to reintroduce standard cleaning procedures in low-risk areas, has not been accepted. Enhanced environmental cleaning will remain in low-risk areas and will be reviewed during Q4.

- The Estates and Facilities team are undertaking a review of both clinical and non-clinical environmental cleaning as part of the implementation of National Standards of Cleanliness.

3.5. The newly formed Anti-Microbial Stewardship Committee (AMC) will reconvene in November 2021 following a refresh of the current arrangements. The committee will oversee three working groups including guideline development group, education, training and interventions group and Research, Quality Improvement and Audit group.

3.6. The AMC will develop a risk register to gain insight on how it will provide assurance to both the Medicines Optimisation Board and the Group Infection Control Committee and how it will connect with hospitals and Managed Clinical Services (MCS)

3.7. The Covid-19 dashboard is now live and provides real time data relating to Covid-19 patients on site and compliance with patient screening. The developers continue to make changes to the database to improve performance for the end users.

3.8. From 1st October 2021 all staff fit mask testing is recorded on the Learning Management System enabling robust reporting compliance to the Group Infection Control Committee. All staff must now be fit tested for at least 2 FFP3 masks from UK based manufacturers.

4. Assurance can be provided that:

- The Trust has assessed the systems and processes in place against indicators in the IPC BAF
- The Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls[3]
- 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 UKHSA 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 UKHSA 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 can 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
- Monitoring of cleaning standards and frequencies in clinical and non-clinical areas are being addressed
- The Board receive regular reports relating to the IPC BAF, which is also incorporated into the main Board of Directors BAF

5. Nosocomial Transmission of COVID-19 - Current Position

5.1 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 21st October 2021 indicate the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West is 0.9 to 1.1, which is an increase from the previous report.

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

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

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

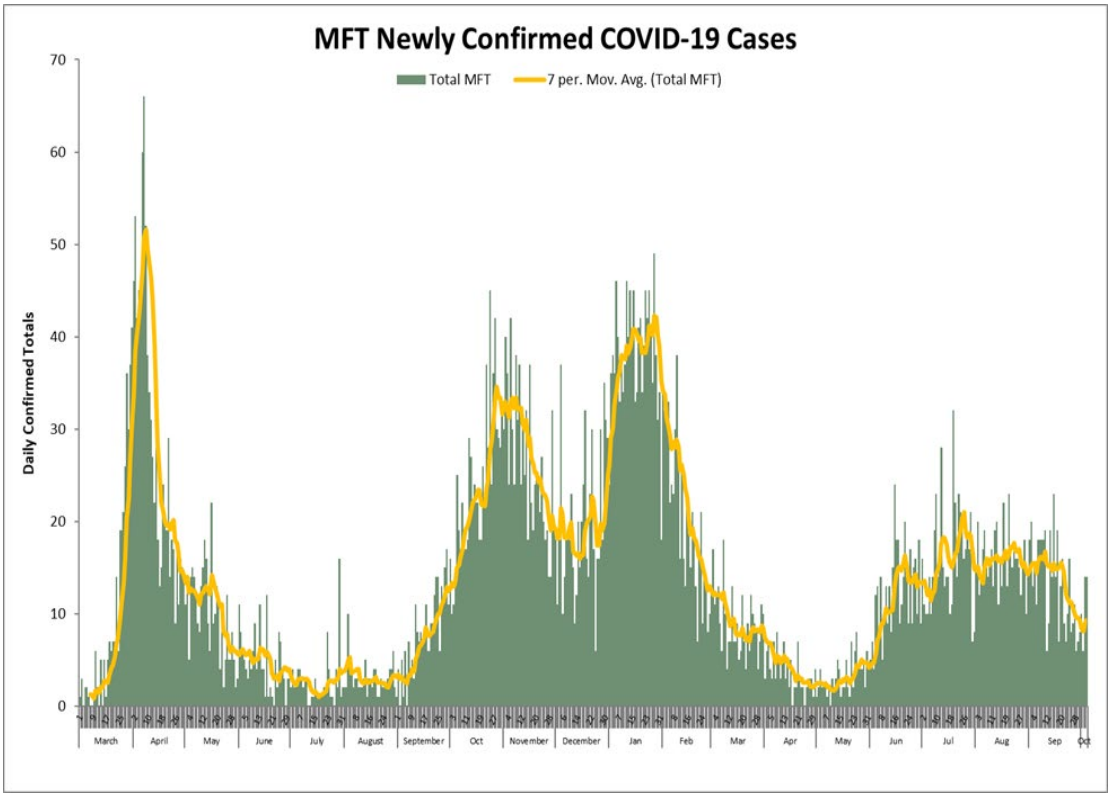


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – October 2021

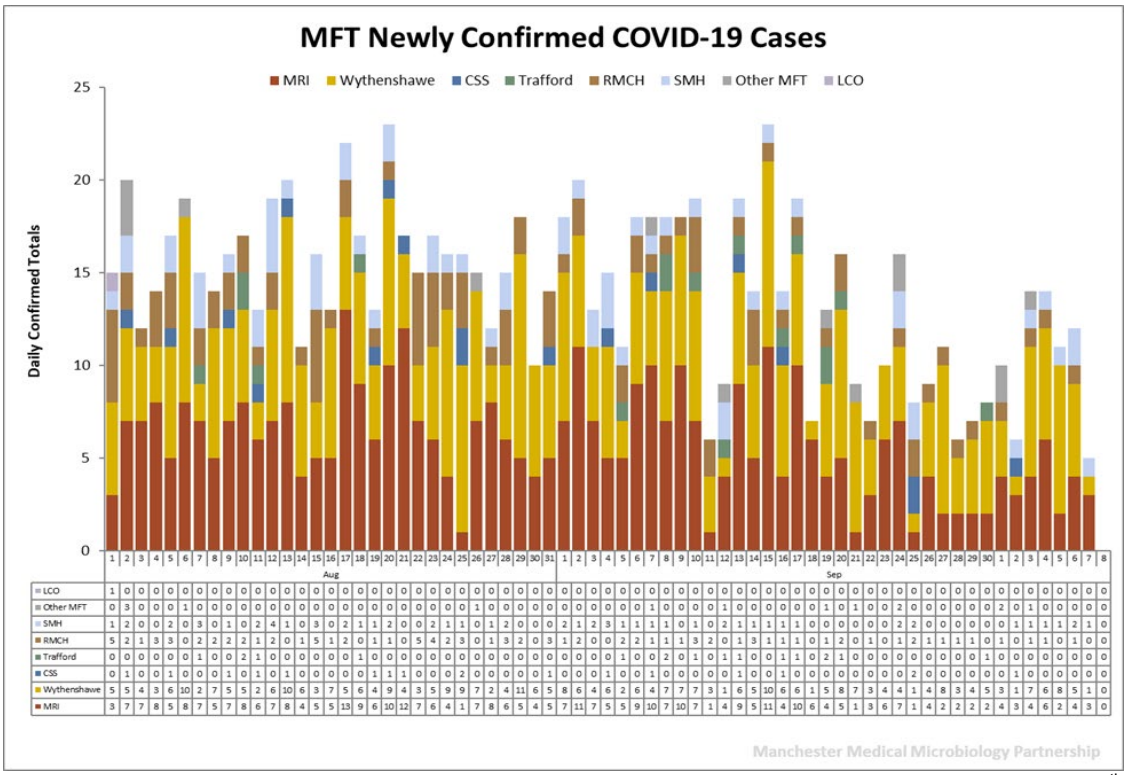


Chart 2 – Daily MFT inpatient burden of COVID-19 cases (laboratory-confirmed cases), June 2021 – 7th October 2021.

5.4 An outbreak is two or more cases of Covid-19 infection in patients occurring on or after day 8 of admission within the same ward/department with a 14-day period. If an outbreak is declared control measures are implemented. Daily updates on outbreaks are circulated across the Trust. Each outbreak is reported to NHSE&I and monitored daily for 28 days in line with the Trust Outbreak Policy.

5.5. Table 1 below shows the number of COVID-19 outbreaks across MRI, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from September 2020 to date (20th October 2021).

MFT COVID-19 Outbreaks	
September 2020	7
October 2020	21
November 2020	19
December 2020	17
January 2021	22
February 2021	12
March 2021	6
April 2021	1
May 2021	0
June 2021	6
July 2021	4
August 2021	3
September 2021	4
October 2021 (up to 20th Oct)	2

Table 1: MFT COVID-19 Outbreaks

6. Implementation of Actions from COVID Outbreak Reviews

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

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

7. The Infection Prevention and Control Development Pathway

7.1 An educational pathway, intended to increase awareness, skills and knowledge for all healthcare staff, has been launched as part of the wider system response to nosocomial infections. The Infection Prevention and Control Development Pathway (IPCDP) was developed across GM by a working group of infection prevention and control specialists and led by MFT Group Chief Nurse. The pathway is designed to assist development from a fundamental awareness of IPC skills and knowledge, through intermediate understanding to a more specialist level of understanding across all areas of Infection Prevention and Control. The IPCDP consists of three pathways:

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

7.2 Staff from both MFT and across GM hospitals continue to enrol onto the foundation pathway.

7.3 The Intermediate pathway commences in November 2021.

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

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

8.2 As reported in the Infection Prevention and Control Annual report in 2020/21, there were **15** trust attributable Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases compared to **8** trust attributable cases in 2019/20.

8.3 There have been **5** trust-attributable MRSA bacteraemia cases to date[4]. Key findings where improvements can be made include:

- compliance with MRSA screening policy
- compliance with decolonisation therapy

8.4 There were **215** *Clostridium difficile* Infection (CDI) cases reported during 2020/2021. Of these, **179** were trust-attributable, against a threshold of **132**. There have been **85** Trust attributable cases to date[5]. Key findings from investigations include:

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

8.5 There were **299** (hospital onset) Gram Negative Bloodstream Infections (GNBSI) in 2020/21. Ongoing workstreams to further reduce the GNBSI include a set threshold for each hospital based upon a 15% reduction target to maintain the national trajectory of a 50% reduction overall. An action plan to achieve the reduction targets have been completed by each of the hospitals and will be monitored as part of the AOF for GNBSI. There have been **130** hospital onset GNBSI to date across MFT[6].

[4] Data correct as of 21st October 2021
[5] Data correct as of 21st October 2021
[6] Data correct as of 21st October 2021

9. Reviewing Deaths from Nosocomial Infection

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

9.2 There were **129** patients across MFT who died from an acquired HOCI (Hospital Onset COVID-19 Infection), defined as the first positive COVID-19 swab confirmed greater than 15 days after admission and who subsequently died within 30 days of their diagnosis. This represents 10.2% patients from all identified HOCI. A decision on the mortality review process and duty of candour for the patients who died with a 'probable' HOCI (defined as first positive COVID-19 swab confirmed greater than 8 days after admission) is yet to be determined. Table 1 shows the definite HOCI deaths by site across MFT between 01/03/20-26/06/21.

Site	Definite HOCI deaths by site	Probable HOCI deaths by site
Oxford Rd Campus	53	34
Trafford/Wythenshawe	59	52
NMGH	17*	38*
Total	**129**	**124**

* To 31st May 2021

9.3 Significant learning from the reviews was included in a report provided to the Board of Directors in September 2021.

10. Sustaining and Improving the Current Position

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

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

11. Summary

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

11.2 Good IPC practice is paramount to maintaining patient safety in view of the upcoming winter months and the potential impact upon patient pathways and patient safety.

12. Recommendation

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

Appendix 1

Appendix 1

Infection Prevention and Control Board Assurance Framework V11 October 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all	• 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 or elective

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

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

	and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020). • COVID-19: Guidance for maintaining services within health and case settings *Infection prevention and control recommendations* updated in June 2021 have been reviewed by the IPC team – principles remain unchanged • Assessment of "social distance" of beds in all in-patient areas completed. Risk assessment in place for reduction of social distance and bed numbers monitored in 3 times daily capacity meeting • Guidance for reducing isolation facilities produced in April 2021 by the IPC team to support recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and patients safe. • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection		• Recommendation 2 of UKHSA has been supported partly, the Trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing PCR to include elective patients in further roll out.

	prevention and control in the management of elective procedure patients. (Recommendations 1 & 2 are specifically related to Standard 1, 5 & 8 of the IPC BAF) Recommendation 1 to reduce physical distancing in low risk areas for elective procedures or planned care is accepted. • Recommendation 2 is partly accepted (see mitigation)		
• resources are in place to enable compliance and monitoring of IPC practice including: - staff adherence to hand hygiene; - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE	• HH/PPE audits completed weekly and updated to the Trust Dashboard monthly. • Non compliance issues addressed at time of the audit – escalation process in place for any continued issues • Compliance reviewed in appropriate IPC meetings, with action plans reviewed regularly. • Risk assessments in place across RMCH/MCS wards and departments supporting social/physical distancing for both patients, parents/carers and staff • HH & PPE audit leads identified for all clinical areas. • Support offered if required re HH & PPE audits, i.e. audit adapted to meet specific needs of an area. • Workplaces / workspaces / rest areas reviewed against 2m social		

	distancing requirements and adjusted as needed to comply. • Alternative workspaces / rest areas identified and utilised to optimise compliance. • Senior staff monitor use of workplaces / workspace / rest areas to ensure compliance. • Trust notices re safe working displayed. • Furniture and equipment in workplaces / workspaces / rest areas reviewed to remove all unnecessary items to optimise space. • Staff reminded of recommended social distancing when travelling to and from work, to avoid car sharing and follow public health guidance when outside of work. • Within community in-patient facilities visiting is also facilitated within garden areas/outside as appropriate • Hand hygiene posters advising when to clean hands and how to clean hands located in appropriate areas are visible in clinical areas • Posters, hand hygiene stations and Face covering stations are located at every entrance to the hospital.		

	Posters, clinical waste bins and alcohol gel are located at the exits of the hospitals • Ward visiting booking process in place within all areas with additional visiting provided through virtual platforms in line with Trust Visiting Policy. Risk assessments in place to manage physical distancing, which are reviewed regularly when capacity exceeds demand to ensure further mitigation is in place to manage any risk.		
• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	• Screening protocols in place for patients discharged or transferred to another health care or residential setting in place based on PHE Guidance and incorporated in to Staff and Inpatient Testing Guidelines • Monthly point prevalence audit		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context;	• Appropriate PPE defined by procedures in accordance with national guidance, including: • Face Masks and Covering Guidance • Communication with	• Issue with supplies of PPE • Occasional conflict between national guidance from NHSE/PHE and	• Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution

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	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 • Audit of PPE and hand hygiene are regularly undertaken – actions in place to improve where required • IPC Safety Officer Audit in place • See above for additional details	guidance from Royal Colleges	• Estates/environment review has progressed with permanent barriers and other structures now on site.
• 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		• 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

	• 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		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	• 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	• Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. • The Trust Board Assurance Framework is

	○ Group Infection control committee • Risk register updated • Risk assessments in place, risk assessment documentation available via the Trust Intranet	remobilisation of services within health and care settings – Infection Prevention and control recommendations).	continuously updated and submitted to Board of Directors July 2021 • Weekly meetings with NEDs to keep informed of issues arising through EPRR led by COO • Twice weekly meetings with executive directors provides opportunity to raise issues
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• There is an over-arching Group IPC risk for COVID-19. Hospitals/MCS/LCO have identified local risks and added them to local risk registers. • Risks managed through Strategic COVID-19 group • Links made to the main Trust BAF, were reviewed at the Board of Directors meeting in July 2021	• Disruption to assurance framework by Suspension of Sub-board Committees due to COVID-19	• Sub committees re-instated • Risks reviewed formally at substantive groups and weekly through EPRR response due to the need to be responsive and adjust in real time • Subgroups have been re-instated in accordance with Trust governance and recovery programme

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

• 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	❖ Policies are in place for the prevention and management of HCAI's ❖ Systems are in place to ensure that resources are allocated to effectively protect people, including staff ❖ PPE is readily available ❖ Education & Training is in place ❖ Facilities are in place to support good hand hygiene: these include hand sanitization stations, sufficient hand wash facilities, sufficient supplies ❖ Signage is clear ❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including ❖ Hand hygiene ❖ PPE audit ❖ Increase in frequency of audits on outbreak wards		

	❖ Hands, Face, Space Audits • Data is collected monthly and Feedback to Directors of Nursing to address areas of concern • See earlier section for further information		
• Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered	• IPC nursing champions are in place in all hospitals /MCS/MLCO; specifically, their work includes: ❖ role modelling best practice ❖ monitoring compliance ❖ sharing good practice, and ❖ challenging non-compliance.		
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	• 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	• Access to external test results • Compliance with staff reporting LFT results, specific gap noted in recording of results on a national system that is not fully visible to the Trust and separate from the Trust's own reporting system	• Staff asked to report external test results to absence manager • Communication strategy in place to remind staff to report LFT results • Improvements planned to the way in which compliance with routine PCR testing in high risk areas is monitored • COVID Testing Strategy Group will monitor compliance

• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• App in place to support ease of reporting LFT results • SOP for Staff Test and Trace updated in July 2021 • SOP for Staff Returning to Work Early following contact from NHS Test and Trace developed and agreed in July 2021, and further updated in line with PHE Guidance following government changes to self-isolation on 16th August 2021. • Processes include involvement of the Director of Infection Prevention and Control oversight of decision making		through refreshed Terms of Reference • Database being further developed to monitor compliance with testing • Task & Finish group supporting increased take up with the voluntary bi-weekly staff LFT testing programme • MFT app now able to retain staff testing history and scan QR codes, making it easier for staff to record their results
• Training in IPC Standard Infection Control and transmission-based precautions are provided to all staff.	• A series of IPC training packages are included in staff training profiles. • Practical training packages for donning and doffing (both for aerosol generating procedures (AGP's) and non AGP's) are in place via E learning. • An Infection Prevention & Control Development Pathway is newly developed and in place to assist staff development from fundamental awareness of IPC to specialist understanding. The IPCDP is available to registered and non-registered clinical staff.		• Compliance with training is monitored

• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training.	• The Trust learning hub includes a series of COVID-19 Training Resources. Examples include a series of 'essential skills' training. • Trust wide local induction include COVID-19 IPC measures • Specific COVID-19 training is in place in identified areas, for example the Emergency Department, Respiratory, • Mandatory training compliance is in place, with action plans to address areas for improvement • COVID-19 training adapted to meet requirements of specific areas when required, for example MREH Emergency Eye Department.	New and temporary staff are updated on the local and most up to date practice when being introduced to the clinical area	
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work.	• The PHE campaign 'Hands Face Space' is visible across the Trust • There is clear signage at all access egress points as well as in all clinical areas • Regular reminders are distributed via trust-wide daily communications, including at safety huddles • Monthly audits of HH, PPE, Hands Face space audit results are fed back to teams for information regarding compliance. Areas for improvement are addressed at the time and through local action plans. • IPC team provide additional support and training in high risk/outbreak		

	areas on Hand Hygiene/other IPC practices		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • IPC national guidance is regularly checked for updates and any changes are	• 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		

effectively communicated to staff in a timely way • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Risks related to related to Infection Prevention & Control are assessed using robust risk assessment processes. They are reviewed and reflected in the Board of Directors Board Assurance Framework		
• The Trust Chief Executive, the Medical Director or the Chief Nurse approve and personally signs off, all daily data submissions via the daily nosocomial sitrep.	• The Chief Nurse/DIPC is responsible for all data submissions	• 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.

• The Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• The Trust Board receive regular information from the Chief Nurse/DIPC on nosocomial transmission of COVID-19 • Nosocomial infection reports are presented and discussed at the following meetings: ❖ COVID-19 Strategy Group ❖ High Level Infection Prevention & Control Group ❖ Group Infection Control Committee (a sub-committee of the Trust Board) ❖ Council of Governors meetings ❖ Hospital/MCS Infection Control Committees • There are opportunities for senior leaders to provide check and challenge in both clinical and non-clinical areas with IPC principles agreed in advance, through: ❖ Senior Leadership Walkrounds with executive / senior leaders from clinical and non-clinical backgrounds ❖ Accreditation Visits ❖ Informal visits to clinical and non-clinical areas	• See above	• See above

	❖ Monthly Quality Care Rounds in place		

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

	practice (NMGH)		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance • Group Estates and Facilities Decontamination Policy is in place and available via the Trust intranet • E and F/PFI partners and IPC Team have reviewed cleaning frequencies in line with updated guidance • Terminal clean sign-off processes are in place • Action plans are held locally when required to mitigate any risk following terminal sign off	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams. • Local area walk rounds by Matrons and senior nursing team to ensure cleanliness compliance is maintained. • Senior Leadership / Director Team undertake Senior Leadership Walkrounds on a monthly basis with opportunities taken to observe IPC activity
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance is deployed in		• Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased demand and that the service provision includes

national guidance	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 • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendation 3 is specifically related to Standard 2 of the IPC BAF) • Recommendation 3L standard cleaning procedures to be reintroduced in low risk areas is **NOT ACCEPTED:** enhanced cleaning to remain in all areas to end Q4, for review during Q4		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		• Domestic cleaning in ED and assessment areas 12 hours a day after every patient use of facilities

	and high touch areas.		
• Cleaning and decontamination is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine,as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution. • Decontamination of patient shared equipment in outbreak/high risk areas is undertaken using a combined solution of detergent and 1,000ppm available chlorine (Chlor-clean tablets) • Electronic equipment is cleaned with a detergent wipe followed by 70% isopropyl alcohol wipe **u**sed in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy in process of update, due to be ratified in October 2021 • There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented. • The Estates and Facilities team are undertaking a full review of both clinical and non-clinical cleaning responsibilities as part of preparations for the implementation of National Standards of Cleanliness
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per	• See above		

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

bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment;			

• linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	• Linen managed according to national guidance for foul/infected linen, Trust Policy in place – updated July 2020 • Staff in COVID-19 areas are wearing 'scrubs' – laundered through Trust laundry • Guidance on how to care for uniform published on Trust intranet		
• reusable non-invasive care equipment is decontaminated: - between each use or after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment;	• Single use items used according to local policy based on national guidance. • Dynamic mattress contract includes re-processing (off site), between each patient use • Patient shared equipment decontaminated in the clinical area is marked with a green tape to indicate that it has been cleaned) • UVc and HPV used to decontaminate equipment in	• Policy to be incorporated into Cleaning Policy, to be ratified in October 2021	• Policy will be updated by IPC Team

• single use items are used where possible and according to Single Use Policy	high risk/outbreak areas • Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment. • Individual use blood pressure cuffs and stethoscopes are utilised in outbreak and high risk areas. • Individual use pens are provided in areas of high risk or outbreak.		
• reusable equipment is appropriately decontaminated in line with local and PHE national policy	• Re-useable equipment decontaminated in line with national guidance • Decontamination group is sub-group of Group ICC		• Decontamination group meeting re-instated from May 2020
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air. • Review and ensure good ventilation in admission and	• 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	• Considering use of window and other air filtration systems of ventilation in older estate

waiting areas to minimise opportunistic airborne transmission		internal temperature if door and windows are open	
• 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 dentistry 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 work with the cleaning management team to re-introduce GP detergents in appropriate location		• Continued the use of Chlor-clean across all areas of the adult Trust due to high community prevalence and risk of outbreaks

• Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• Non-clinical areas are regularly inspected, and any issues are responded to in liaison with the cleaning management teams. • E&F team respond to any reporting incidents or concerns raised to resolve issues effectively.	• Site inspections are undertaken using checklists in clinical areas • There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• 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 the Commitment to Cleanliness Charter provided within the Standards to align with agreed Cleaning Responsibilities Matrix. To be in place by October 2021 in acute settings. • Audit processes set out within the National Standards to be implemented and be signed off with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as scoring less than a Star Rating of 3 have a

			rectification action plan implemented.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Appropriate policies reviewed and approved by the AMC • Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. • Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) – see below • 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 • From November the Group AMC will reconvene with quarterly meetings and will have 3 working subgroups: ➢ Guideline Development Group ➢ Education Training and interventions ➢ Research, Quality Improvement and Audit • These subgroups will be chaired by infection specialists and will have clinical representation from across the Trust. • The newly formed committee will develop a risk register to gain an understanding of how it can provide assurance to the Medicines Optimisation Board, Group Infection Control Committee and how it connects with the individual hospitals and MCS's. The 1st meeting will be held in November.		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

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

• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	• Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas • Signage on entrances, signs are available to download and print via Trust Intranet • Screens in place at reception areas • Available guidance: ○ Coronavirus Restricted Access Measures Guidance May 2020	• Plans need to be flexible as situation changes	• Hospitals to re-assess as situation evolves. • Learning from outbreaks includes: ❖ Quick isolation and lock down of identified areas ❖ Testing and tracing of staff – Lateral Flow Testing in place for a time limited period
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Dedicated website for all COVID related information/policies	• Risk that information may be out of date	• Website regularly updated by Comms/EPPR Team
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Preadmission Screening processes in place for elective patients • Screening processes in place for NEL (see previous) • Compliant with PHE guidance on screening patients being transferred to residential care • 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	• 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

	• NMGH: Transfer documentation updated to include COVID status and individualized swabbing schedule (including for contact patients)		IPC to maximise distance between women. • Clinell readirooms utilised to isolate inter hospital transfer whilst covid status is confirmed.
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned stations to guide and challenge visitors /staff if appropriate	• Lack of concordance amongst some patients/visitors	• Local escalation process in place
• Implementation of the Supporting excellence in infection prevention and control behaviours implementation Toolkit has been considered C1116- supporting-excellence-in-ipcbehaviours-imp-toolkit.pdf (england.nhs.uk)	• Principles have been implemented across MFT examples below: - in messaging patients/visitors and staff - role modelling -senior leadership walk rounds - support resources provided by EHWB • identified 'wobble rooms' for staff		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	• Patient streaming at access points in place at all ED access areas • See previous on streaming • Clear signage in place to support effective streaming of patients presenting at ED • Identified respiratory pathway in ED with dedicated triage, waiting and resuscitation space. • Respiratory Receiving unit to support assessment and ambulatory pathways • Virtual ward pathway in place to support management of covid positive patients at home and avoid admission.	• See environmental issues and age of estate	• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus/safe-working-environment https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus

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

	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 • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendations 1 & 2 are specifically related to Standard 1, 5 & 8 of the IPC BAF) Recommendation 1 to reduce physical distancing in low risk areas	• Manual monitoring in place at present, dashboard development continues	• Automated monitoring process being developed for Dashboard • Recommendation 2 of UKHSA has been supported partly, the Trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing PCR to include elective patients in further roll out.

	for elective procedures or planned care is accepted. • Recommendation 2 is partly accepted (see mitigation)		
• Staff are aware of agreed template for triage questions to ask.	• Staff are aware of and are use agreed triage questions, all patients screened for COVID-19 symptoms on admission • All patients streamed through a respiratory/non-respiratory pathway in ED's.		
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Staff are trained in the use of triage questions		• Triage audits are undertaken
• Face coverings are used by all outpatients and visitors	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate • Identified pathway for patients where reasonable adjustments	• Not all patients/visitors are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place

	need to be made as they are unable to wear face mask		
• Face masks are available for patients and they are always advised to wear them	• FRSM available for all patients and visitors • Posters displaying FRSM masks and requirements to wear developed	• Not all patients are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but	• All patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise • Patient information posters are in place • Advice information is provided to patients/parents/carers and families around mask wearing in ward department areas (includes moving around the ward) • Posters in clinical areas encouraging patients to wear face coverings. • Staff actively encourage patients to wear face coverings when outside of their bed space and offer a replacement on regular intervals. • Staff request patients to wear a face covering when moving between departments. • Patient pathways are compliant with Infection Prevention and	• As above	• Non-compliance is addressed locally in with local processes for escalation when there is an identified risk.

there is potential to use screens, e.g. to protect reception staff. - isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	Control guidance, and limit internal patient movement to comply with amber / green pathways. External transfers occur only if clinically justified • Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups and prioritisation of side room		
• For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative.	• All patients with new onset symptoms are tested and isolated. Risk assessment undertaken of all potential contacts		

• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• All patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • Regular audits of patient testing guidance takes place, with actions in place to improve where required • COVID MDT in place to review COVID-19 positive patients and facilitate discussion in relation to covid symptomatic patients. • Terms of Reference for COVID-19 MDT refreshed and agreed through COVID-19 Strategic Group October 2021		• Regular reports to be received by the Trusts COVID Testing Strategy Group to ensure robust monitoring of compliance

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Programme of training for all staff and those who are redeployed including use of PPE, maintaining a safe environment in accordance with PHE guidance. • Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS • Bespoke training for Clinical leaders to become PPE expert trainers • Mandatory training in place • (See previous re PPE and fit testing)	• Staff anxiety about risks of exposure to COVID -19	• Increase of IPC support to COVID -19 Wards • Prompt response to clusters/outbreaks of COVID-19 • Plans for staff testing in high risk situations. • Use of posters/videos FAQ's • Multiple communication

			channels – daily briefing/dedicated website • Increased Microbiologist and AMD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing • New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working	• Local information and guidance in place for COVID areas and non-COVID areas • PPE Infection Control Policy in place • PHE guidance in place		

environment is safe; • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put put it on and remove it	• 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	• Audit of compliance undertaken regularly, actions taken to improve		

place to mitigate any identified risk	compliance and reduce risk where required		
• The use of hand dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand dryers are not used in accordance with trust policy • Guidance in public areas		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• posters and guidance in place https://intranet.mft.nhs.uk/content/hospitals-mcs/clinical-scientific-services/infection-control/hand-hygiene		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Monthly audits of hand hygiene compliance • Increase of audits on increased activity areas • Mandatory ANTT assessments annually • Hand Hygiene Policy in place • ANTT Policy in place • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required		

• staff understand the requirements for uniform laundering where this is not provided for on site	• Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Temporary staff changing facilities identified on COVID-19 wards • Staff on COVID-19 areas wearing scrubs laundered through hospital laundry		
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• HR policies in place for staff to report on absence manager system if they are symptomatic • Trust complies with national guidance • EHWB service provides staff support • Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8 • SOP's in place to support staff to return to work following guidance published in July and August 2021	• Staff shortages due to COVID -19	• Escalation to Strategic oversight group of low staffing numbers. • Activity to be titrated by staffing levels • Escalation processes in place and monitored through EPRR including reducing elective programme as required
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• Regional COVID-19 prevalence reviewed by Clinical Sub-Group and used to inform PPE practice. • Daily HOCI report generated by IPC surveillance and reviewed by IPC team to provide early identification of outbreaks.		

	• Daily reporting of other HAIs to identify outbreaks. • Review of regional HPT alerts to provide early warning of community outbreaks. • Review of HAI rates and comparison to Shelford group as indicator of performance/ compliance with best practice.		
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	• There is separation of patient pathways at Emergency access points. • Use of one-way flow systems and restricted access /egress points in place in all diagnostic centers • Staff communal areas have clear signage and there are staggered breaks to facilitate reduced contact • Footfall reduced where possible	• Not always possible to maintain 2m distance in all areas because of building design constraints	• Local Risk assessment undertaken, and partitions used where appropriate.
• Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • staff maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct	• Additional Hand hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas. • All seating facilities in communal areas are marked to encourage 2m distancing • Corridor floors signed to say keep left • There is signage across all areas of the hospitals, including PHE campaign ‘hands face space’ messages.	• Whilst staff are reminded to maintain social distancing when travelling to work, it is not possible to monitor compliance	

care. • Staff are maintaining social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	• Social media campaigns remind staff and public to follow public health guidance outside the workplace		
• Frequent decontamination of equipment and environment in both clinical and non-clinical areas.	• Enhanced cleaning in place for high risk vicinities such as amber areas (COVID-19 Indeterminate areas) where there is rapid turnover of patients with an unknown COVID-19 diagnosis. • Enhanced cleaning in place for wards where there is an outbreak • Disposable wipes available in communal toilet facilities		
• Clear visually displayed advice on use of face coverings and facemasks by patients /individuals, visitors and by staff in non-patient facing areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, **including PHE campaign 'hands fa**ce space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		

• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• The Trust is able to access PHE support directly through its on-site PHE laboratory • Local population, regional and national surveillance intelligence is presented by Trust expert virology team (linking with the on-site PHE lab as above) • A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at: ❖ High Level Infection Control Meeting ❖ Clinical Sub-Group /Advisory Groups ❖ Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner • Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC and clinical teams	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

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

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• patients are cohorted according to clinical presentation • Community inpatient facilities have single rooms • risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission • Isolation of Infectious Patients Policy	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of support services	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical location

	in place • See previous on environment	(e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients)	• Review of footprint of services across all hospitals to reduce risk of cross infection • Risk assessment undertaken based on symptoms (e.g. isolation of patients with diarrhoea)
• areas used to cohort patients with or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• programme of review of air flow and ventilation undertaken throughout the pandemic	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) • some areas of estate particularly old and in poor condition	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical location • Review of footprint of services across all hospitals to reduce risk patient occupancy, flow and activity adjusted to align to the environment • Good IPC practice implemented in all areas of cross infection
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Daily alerts/surveillance for all relevant organisms (such as CPE, MRSA and C-diff) is currently reviewed by the IPC team	• Potential delay between testing and identification	• Rapid screening for some HAIs (e.g. CPE)

	• Daily report of new resistant HAIs generated by IPC surveillance and reviewed by IPC team to ensure appropriate management in line with national and local policies.	of new resistant HAIs	• Pre-emptive risk assessment to manage high risk patients before results are known.
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff.	• In COVID-Wards and Outbreak wards, measures have been put in place to restrict footfall • An Interim Visiting Policy is in place which restricts access	• Staff need to leave the ward for rest/refreshment	• Food for staff delivered to high risk areas. • Breaks in Communal restrooms are staggered • Volunteers to support way finding
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff 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 • A further Roche analyser has been procured and will be on site in Autumn 2021 • See previous on testing	• Lab capacity was initially affected by availability of reagents – this has significantly improved – therefore the risk to the lab due to analysers is reduced (improved).	• Sufficient reagent supply
• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		
• that all emergency patients are tested for COVID-19 on admission • Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening		
• Regular monitoring and reporting of the testing turnaround times with focus	• Turnaround times measured -planned programme of monitoring.	• Travel time for specimens from site to laboratory	• Additional transport runs put in place

on the time taken from the patient to time result is available.		dependent on Transport	where the laboratory is not on site
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID negative patients daily. • that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the	• The Staff and In-Patient COVID-19 Testing Guidelines reflect national guidance in routine and responsive testing – the SOP has been updated and is now called COVID-19 Testing, Streaming and Stepdown Guidelines. Information that • Patients discharged to a nursing home must complete their remaining isolation • Elective patients should self-isolate for at least 3 days prior to admission, depending on their own clinical condition • Screening for other potential infections has continued throughout the pandemic • Testing is undertaken through PHE laboratory in accordance with PHE guidance • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendations 1 & 2 are specifically related to Standard 1, 5 & 8 of the IPC BAF) Recommendation 1 to reduce physical distancing in low risk areas for elective	• Trust Testing Strategy Group to receive regular reports to monitor compliance – under development.	• Recommendation 2 of UKHSA has been supported partly, the Trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing PCR to include elective patients in further roll out.

previous 90 days) and result is communicated to receiving organisation prior to discharge • that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	procedures or planned care is accepted. • Recommendation 2 is partly accepted (see mitigation)		

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	• 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

	support • Expert Virology support • 7 day working from IPC/Health and Wellbeing		
• 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.	• 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	• 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

	• All bins are labelled to indicate which streams they have been designated for.	Environment Agency) – the changing guidance has been challenging to communicate clearly with staff. • Queries around disposal routes for visitor PPE – options for disposal which are both legal and practical are not currently clear. • 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,	developed • Fortnightly meeting of all relevant staff involved in waste management at each site to share emerging risks and issues associated with waste. • Weekly conference call between Trust and its main clinical waste collection provider (SRCL) • 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

		associated with COVID-19 cases) has been disposed of by staff as general domestic waste. • Gaps have been identified in relation to clear policy and process in relation to waste generated by COVID-19 cases and non-COVID-19 cases in the community	required and options will then be taken forward through the appropriate channels
• 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	• EHWB Policy in place • Employee Health and Well Being Service COVID-19 Guidance and		

supported	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 EHWB Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely. • EHW/OH advice and support is availabe to managers and staff 7 days a week.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Training records held		

• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staff not moved from COVID areas • Strict adherence to PPE guidance and practice • Staff testing policy in place • Daily staffing process are in place to manage safe and effective staff deployment	• Limited by access to reagents	• Prioritisation based on clinical and staff need
• all staff adhere to national guidance and are able to maintain 2 metre social distancing in all patient care areas if not wearing a facemask and in non-clinical areas	• Trust policy in place		• Instructions in place not to travel to and from work in uniform
• consideration is given to staggering 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		• Absence monitoring • Follow up and contact by line manager

	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		
• staff who test positive have adequate information and support to aid their recovery and return to work	• EHWB service provides staff support • Staff receiving positive results are supported by an EHW Clinician to obtain advice and receive information regarding next steps, recovery and return to work.	• Some staff may choose to access alternative community test centres which means the results will not be known by the line manager and may be received via text message.	• Staff can contact Silver Command, Workforce Bronze, their line manager or the HR Team to seek advice on next steps having received their result via text. • Coronavirus (Covid-19) – Line Manager FAQ (fact sheet)
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff.	• Risk assessments are in place and monitored through HR		
• Staff who carry out fit test training are trained and competent to do so.	• Staff are locally trained by staff who are trained and assessed as competent to do so.		
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• Staff are fit tested for FFP3 respirators	• Change in availability of make and model of FF3 respirators can cause anxiety and	• The trust has procured additional fit testing machines to facilitate easy access to testing for FFP3

		disruption	• Procurement alert the trust in advance of changes to make and model of FFP3 available
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly		
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• As above • Staff are fit tested for alternate FFP3 masks	• Centralised system to be developed to allow regular review by the Board	
• members of staff who fail to be adequately fit tested a discussion should be had regarding re deployment 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 to ensure that those who have failed fit testing are redeployed • The trust has extended fit testing to include at least 2 alternative FFP3 respirators. Reasons for fail to fit test are recorded and escalated where appropriate		

• Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		
• Boards need to have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO • From 1st October 2021, the ambition is that all Fit Mask Testing is captured and reported via our Learning Management System, the Learning Hub to enable robust reporting via Group Infection Control Committee	• Centralised system to be developed to allow regular review by the Board	
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• Risk assessments are undertaken locally and mitigating actions undertaken		
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages.		

	• Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Head of Group Reporting & Financial Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	November 2021
Subject:	Financial Performance for Month 6 2021/2022
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	The Board is recommended to note the outturn position against the H1 plan and updates on Cash and Capital positions for the Trust.
Contact:	Name: Jenny Erhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2021/22 has been split into 2 halves (H1 and H2) with the first half of 2021/22 representing a period of recovery and potentially stabilisation as the intensity of the activity directly related to Covid reduces but the implications of reduced activity over the previous period manifest themselves across almost all areas of clinical activity. This is also in the context of a range of workforce implications and ongoing health and wellbeing concerns. For GM MFT was tasked with delivering a surplus of £23.1m for H1 and developed the H1 plan to reflect this requirement, with a break-even position for H2. The surplus was reliant on the Trust delivering the planned WRP for H1 and on receipt of £5m system monies related to the NMGH transaction. Year to date to Month 6, September 2021, the Trust has delivered a surplus of £13.2m against the break-even plan for the year. Against the H1 target there is a shortfall of £9.9m due to non-receipt of the £5m system monies and ongoing financial pressures across the Trust due to the wider impact of the Covid-19 pandemic. The surplus was achieved through a technical adjustment, releasing £10.95m of the Trust's provision against the cost of untaken annual leave, after review of the total held at the year end for 20/21. There is a requirement to submit a new plan to GM and to NHSE/I for H2 and this is currently being worked up for submission deadlines in mid to late November.
1.2	**Run Rate**	After adjusting for the impact of the pay award, including arrears payments, reflected in pay in month 6 and additional ERF accrued costs, September expenditure remains consistent with the run rate over the last few months, just 0.17% lower than month 5 and 0.2% higher than month 4. The controls over additional investment linked to activity recovery have been established, in the short term these have been supported by additional income from the Elective Recovery Fund (ERF) however the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime.
1.3	**Remedial action to manage risk**	The "expenditure led" financial regime that was in place in the last financial year presented a significant risk to the Trust, through the changed behaviours which it created. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic. Planning guidance for H2 was released in late September and the finance team is working with colleagues to develop the Trust's plan for submission to GM and NHSE/I in November. The value of system monies from GM for H2 is currently subject to negotiation so there remains risk around this in the context of working up plans for income and expenditure in H2 that delivers a breakeven position and the Trust's WRP target of £50m for the full year.

1.4	**Cash & Liquidity**	As at 30th September 2021, the Trust had a cash balance of £265.9m, which now includes £6m transferred in from the North Manchester balance sheet disaggregation. The cash balance was lower than forecast by £11m, due to PDC funds which have not yet been drawn down relating to the New Hospitals Programme (NHP, formerly HIP2) awards.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned spend into line with the system capital envelope. The total "envelope" plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £181.1m. The forecast outturn has seen a further decrease in month 6 of £9.4m, compared with the forecast reported in month 5, due to a further £8.8m reduction in the NHP (formerly HIP2) project spend, caused by delays in approval, and £0.6m slippage on the NHP project IM&T Digital Business Case. The potential capital expenditure outturn may be £9m higher due to backlog maintenance pressures and thus slippage across the programme during the year will bring the actual spend back in line with the agreed envelope. Additional national funding has recently been announced for capital bids in the Elective Recovery and Technology areas. The Trust is making its bids through GM and should they be secured there will be a requirement for this capital spend to be completed by 31 March 2022. In the period up to 30th September 2021, £49.2m capital expenditure has been incurred against a plan of £68.9m – an underspend of £19.7m. £13.1m of the slippage relates to the NHP project and is due to delays in the approval of the Park House scheme and associated enabling works. As noted above, the estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £6.6m underspend, £5.7m relates to the NMGH emergency works which are funded through Emergency PDC. The Emergency PDC application has been submitted and is in discussion with NHSEI, but the plan assumed earlier approval of this. Continued underspend against this scheme is expected until the approval has been granted, the longer any approval takes the less likely the opportunity to spend within this financial year.
1.6	**NMGH Transfer**	The transfer by absorption of the NMGH transaction was incorporated into the balance sheet in month 3 and is reflected in the I & E as a below the line Transfer by Absorption gain of £65.5m. This gain is reflected through the Trust reserves on the balance sheet.

Financial Performance

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

I&E Category	NHSI Plan M6 £'000	Year to date Actual - M6 £'000	Year to date Variance £'000
INCOME			
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	872,149	896,663	24,515
NHSE - Cost passthrough drugs (increase above threshold)	39,930	40,137	207
Trust (Rapid Diagnostic Centres)	0	306	306
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	85,846	85,846	0
GM System Funding 1-6 £5m	5,000	0	(5,000)
Elective Recovery Funding	8,266	13,512	5,246
Other (Other devolved / IOM / NORs & Wales)	3,798	5,222	1,425
Additional Funding outside financial envelope	1,282	3,341	2,059
Local authorities	19,266	19,565	299
Sub -total Income from Patient Care Activities	**1,035,537**	**1,064,593**	**29,056**
Private Patients/RTA/Overseas(NCP)	5,010	4,392	(618)
Total Income from Patient Care Activities	**1,040,547**	**1,068,985**	**28,438**
Training & Education	35,621	35,921	300
Training & Ed Non HEE	1,453	1,870	417
Training & Ed Notional	1,341	1,429	88
Research & Development	32,939	34,141	1,202
Misc. Other Operating Income	45,089	47,160	2,071
Other Income	**116,442**	**120,521**	**4,079**
TOTAL INCOME	**1,156,988**	**1,189,506**	**32,517**
EXPENDITURE			
Pay	(680,504)	(693,429)	(12,925)
Non pay	(436,857)	(444,662)	(7,805)
Training & Ed Notional Spend	(1,341)	(1,429)	(88)
TOTAL EXPENDITURE	**(1,118,702)**	**(1,139,520)**	**(20,818)**
EBITDA Margin	**38,286**	**49,986**	**11,699**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(17,809)	(16,336)	1,473
Interest Receivable	0	0	0
Interest Payable	(20,477)	(20,473)	4
Loss on Investment	0	0	0
Dividend	0	0	0
Surplus/(Deficit)	**0**	**13,177**	**13,177**
Surplus/(Deficit) as % of turnover	**0.0%**	**1.1%**	
Transfers by Absorption		**65,489**	**65,489**
Impairment	**(49,596)**	**(38,204)**	**11,392**
Non operating Income	**630**	**270**	**(360)**
Depreciation - donated / granted assets	**(576)**	**(484)**	**92**
	(49,541)	**40,248**	**89,790**

In line with national planning requirements the Trust submitted a H1 plan for the first half of the year, this plan reflected the breakeven position identified as the GM requirement and excludes the anticipated technical adjustments referred to in the Month 1 report of £20m which would support delivery of the £23.1m surplus required to support the planned capital investment programme. The NHSI Plan was resubmitted in June to include £8.266m of anticipated Elective Recovery Funding income matched by increased pay (medical and nursing) and clinical supplies additional expenditure budget.

Year to date (YTD) the Trust is reporting a surplus of £13.177m against the breakeven plan. Within the income numbers for month 6 are additional ERF monies of £5.246m, these have been confirmed as due to MFT by GM, offset by an equal value of expenditure. The total ERF monies earned by MFT in H1 stands at £13.512m and of this £11.308m has been approved at Strategic Group to be expended for schemes across the hospitals that deliver improved patient flow and reduce waiting lists, all funds are non-recurrent and must be utilised over the remaining 6 months of 2021/22.

The year to date income variance of £32.5m reflects an increase of £26m which includes an £18.5m accrual for pay award funding and additional ERF monies in month 6 of £5.2m. These are both reflected in expenditure. The remainder of the favourable variance mainly relates to Genomics deferred income of £1.2m and other movements in corporate income. The main adverse variance to plan against income for September is the £5m system monies related to the NMGH transaction not received. The Trust position for H1 fully reflects this non-receipt of planned income so there is nothing further to carry into H2.

Research and Development and Education and Training income is ahead of the planned position YTD by £1.2m however, this is matched by an associated increased expenditure.

Pay expenditure in month 6 includes £18.5m for the 3% pay award for AfC and Medical staff (excluding Junior Medical staff) with arrears payments back to 1st April 2021 and includes uplifts for bank staff. As directed by national guidance, this has been offset by an income accrual for the same amount, since funding has not yet been given to Trusts. This funding will be delivered through an uplift to the Trust's Block contract payments rather than as a separate payment – currently it is unknown whether the income received via this method will fully cover the additional costs to the organisation. This should become clearer once revised Block values have been agreed as part of the H2 planning process.

Pay costs in month 6 also include a further £3.5m to deliver elective recovery – which is not in the budget, with a further £1.75m of cost included in non pay; there is an equal amount accrued in income. Excluding the impact of the pay award, the pay variance across the Hospitals/MCS/LCO and Corporate pay was higher than month 5 by £3.5m with a 248 WTE increase in Substantive staff, due to recruitment against approved business cases, including within IM&T for HIVE, and higher use of agency Consultants at NMGH, MRI and WTWA.

The resulting cost related to resolution of the Flowers case, where it was ruled that overtime payments were to be taken account of in holiday payments, was £1.4m in month 6, however, this was offset by a provision held so the impact to the Trust's bottom line is zero.

The overspend against non-pay is due to additional CNST payments of £1.1m for North Manchester (not within the plan) and for new CPT drugs (£4.5m YTD), such as Zolgensma, which has a cost of £1.6m per patient – the Trust has issued this drug four times up to month 6. Both unplanned costs are covered by additional income. Additionally, £1.75m of ERF costs are included at month 6.

Statement of Financial Position

	Audited MFT Accounts 31/03/2021 £000	NMGH Opening SoFP 01/04/2021 £000	Enlarged MFT 01/04/2021 £000	Enlarged MFT 30/09/2021 £000	Enlarged MFT Movement in Year to Date £000
Non-Current Assets					
Intangible Assets	4,665	-	4,665	4,293	(372)
Property, Plant and Equipment	642,394	81,715	724,109	716,842	(7,267)
Investments	1,498	-	1,498	1,498	0
Trade and Other Receivables	5,645	1,896	7,541	7,536	(5)
Total Non-Current Assets	**654,202**	**83,611**	**737,813**	**730,169**	**(7,644)**
Current Assets					
Inventories	21,892	936	22,828	24,235	1,407
NHS Trade and Other Receivables	61,707	-	61,707	98,412	36,705
Non-NHS Trade and Other Receivables	46,854	3,391	50,245	35,927	(14,318)
Non-Current Assets Held for Sale	210	-	210	210	0
Cash and Cash Equivalents	271,199	6,311	277,510	265,891	(11,619)
Total Current Assets	**401,862**	**10,638**	**412,500**	**424,675**	**12,175**
Current Liabilities					
Trade and Other Payables: Capital	(33,594)	0	(33,594)	(24,485)	9,109
Trade and Other Payables: Non-capital	(287,755)	(2,981)	(290,736)	(335,640)	(44,904)
Borrowings	(20,290)	(1,448)	(21,738)	(21,630)	108
Provisions	(24,875)	(5,852)	(30,727)	(31,756)	(1,029)
Other liabilities: Deferred Income	(35,084)	(320)	(35,404)	(39,671)	(4,267)
Total Current Liabilities	**(401,598)**	**(10,601)**	**(412,199)**	**(453,182)**	**(40,983)**
Net Current Assets	**264**	**37**	**301**	**(28,507)**	**(28,808)**
Total Assets Less Current Liabilities	**654,466**	**83,648**	**738,114**	**701,662**	**(36,452)**
Non-Current Liabilities					
Trade and Other Payables	(2,598)	-	(2,598)	(2,599)	(1)
Borrowings	(374,948)	(17,664)	(392,612)	(383,840)	8,772
Provisions	(16,622)	-	(16,622)	(16,398)	224
Other Liabilities: Deferred Income	(3,817)	(495)	(4,312)	(4,038)	274
Total Non-Current Liabilities	**(397,985)**	**(18,159)**	**(416,144)**	**(406,875)**	**9,269**
Total Assets Employed	**256,481**	**65,489**	**321,970**	**294,787**	**(27,183)**
Taxpayers' Equity					
Public Dividend Capital	258,929	65,489	324,418	324,318	(100)
Revaluation Reserve	63,492	5,352	68,844	68,844	0
Income and Expenditure Reserve	(65,940)	(5,352)	(71,292)	(98,375)	(27,083)
Total Taxpayers' Equity	**256,481**	**65,489**	**321,970**	**294,787**	**(27,183)**
Total Funds Employed	**256,481**	**65,489**	**321,970**	**294,787**	**(27,183)**

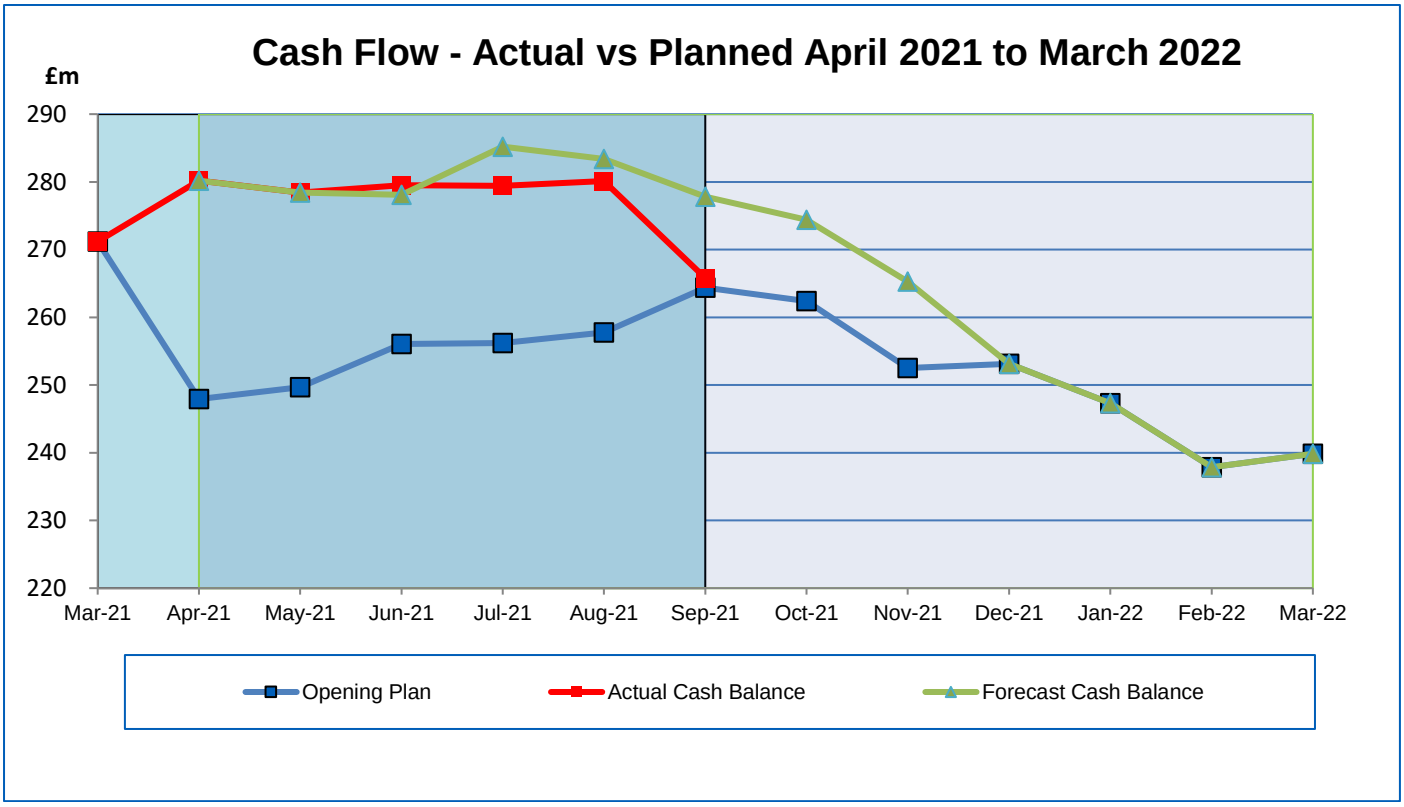
As noted in the month 5 report, there has been an amendment in the values shown for the transfer from NMGH for the final values of assets to reflect an £11m reduction in Non-Current assets and PDC for IT assets.

While there has been a reanalysis of amounts between NHS and Non-NHS receivables, there is also an overall increase of around £21m which relates to invoices and accruals for income from commissioners during the year, offset in M6 by pay award and elective recovery adjustments. This reflects the normal pattern of income for this period of the financial year and is consistent with the trend noted in the prior year.

The Flowers overtime pay and the AfC increases in M6 have affected pension and social security liabilities by £10m which is offset against the release of holiday pay accruals of £10.95m.

There is an increased focus on BPPC which is aiming to drive down trade creditor balances.

Cash Flow

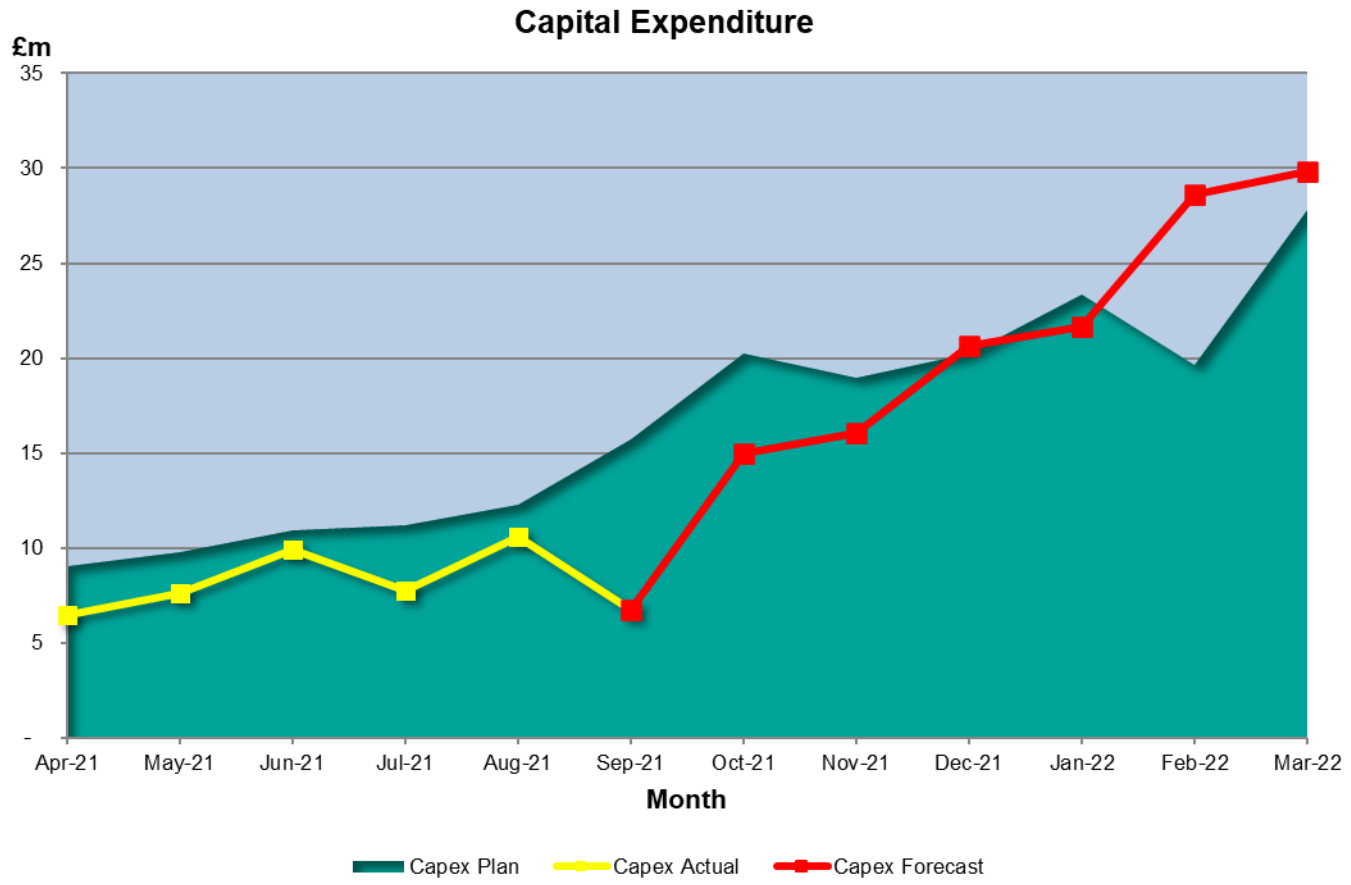


A reasonable measure of the level of liquidity required for the Trust could be that the amount of operational working capital consumed in 10 days is £59.3m. Clearly the current and forecast cash balances sit well above this level throughout the financial year.

As above, the cash balances now include £6m for the NMGH transaction opening balances.

The cash balance held by the Trust at the end of September 2021 was £265.9m which was lower than forecast by £11m. At this stage, the forecast does not include adjustments for changes to the trust pay bill relating to the Clinical Excellence Awards and holiday pay accruals. The 3% pay award and the Flowers overtime claim were transacted in M6. A drawdown request has been submitted to reflect the spend on the New Hospital Programme year to date.

Capital Expenditure



The chart above reflects a forecast of £181.1m which has reduced from the £190.5m forecast in month 5. The lower forecast is due to:

- The New Hospitals Programme (formerly HIP2) is £13.1m behind plan at month 6 as the Trust continues to await confirmation on the next stage from Government. There remains expectation that some expenditure will be accelerated once approval to proceed has been granted with the shortfall forecast to reduce to circa £7m by month 12;
- £0.6m on the IM&T Digital Business Case which is a requirement of the NHP project and also subject to the delays noted above.

The potential outturn is £190.1m although it is expected that the actual spend and the agreed plan will become aligned during the course of the year, due to a combination of slippage and additional funding approvals.

Better Payment Practice Code

NHSE/I have placed a focus on organisation's performance against the Better Payment Practice Code (BPPC) numbers this financial year, with scrutiny initially falling on the worst performers. The target for all NHS organisations is to pay 95% of invoices within payment terms.

NHSE/I have written to MFT regarding BPPC performance and the Trust has shared the action plans. No further communication on this issue has been forthcoming as of month 6.

NHSE/I require BPPC numbers to be provided in the monthly returns for the remainder of 2021/22. An extract of MFT's submission for month 6 is shown below:

Better Payment Practice Code (BPPC)	YTD to 31/08/2021		YTD to 30/09/2021	
	By Number	By £'000	By Number	By £'000
Non NHS				
Total bills paid in the year	92,488	494,286	114,631	605,253
Total bills paid within target	85,848	431,589	106,252	537,624
Percentage of bills paid within target	**92.8%**	**87.3%**	**92.7%**	**88.8%**
NHS				
Total bills paid in the year	3,009	117,569	3,885	146,652
Total bills paid within target	2,141	101,723	2,748	125,800
Percentage of bills paid within target	**71.2%**	**86.5%**	**70.7%**	**85.8%**
Total				
Total bills paid in the year	95,497	611,855	118,516	751,905
Total bills paid within target	87,989	533,312	109,000	663,424
Percentage of bills paid within target	**92.1%**	**87.2%**	**92.0%**	**88.2%**
Target	95.0%	95.0%	95.0%	95.0%
Distance from target	***(2.9%)***	***(7.8%)***	***(3.0%)***	***(6.8%)***

The Accounts Payable team continues to work on the compliance sessions put in place with the Divisions and Hospitals to help address issues around invoices on hold. These training sessions are ongoing and continue to be well received and attended.

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:	November 2021
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

Integrated Care Systems

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

At the time of writing, nationally designate chairs have been appointed to 38 of the 42 NHS integrated care boards including the appointment of Sir Richard Leese as Chair designate of the Greater Manchester Integrated Care Board.

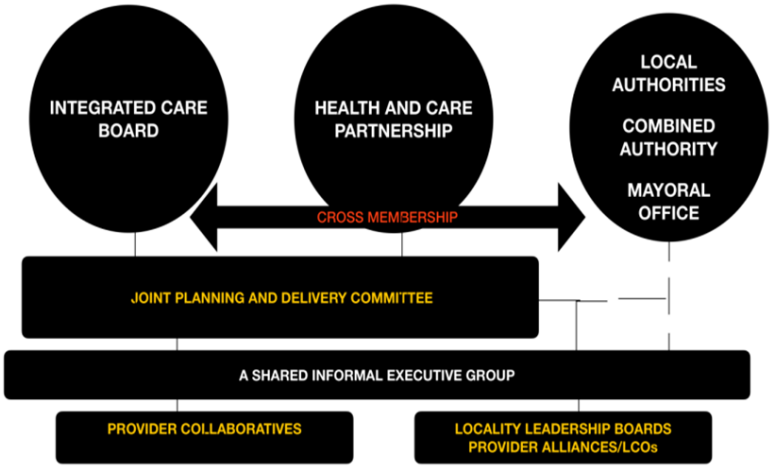
As part of the funding settlement announced in September, the government also announced that it will publish a white paper later this year with further ambitions on integration and social care reform. This will be focused on adult social care reform and will cover supporting and enabling integration between health and social care and creating incentives for integration and prevention. It will include proposals for:

- Yearly reporting on spending on prevention, as well as outcomes, and trajectories.
- A single set of health and care outcomes that local systems (including ICSs and Local Authorities) will be asked to deliver with increased transparency over the delivery of these outcomes.
- A new national prevention service.

3. Regional Issues

Greater Manchester ICS

The shadow governance arrangements for the Greater Manchester ICS have been agreed and are as set out below.



The Integrated Care Board and Integrated Care Partnership (described in GM as the Health & Care Partnership) are the two groups required by the legislation that collectively make up the GM ICS. In addition, a Joint Planning and Delivery Committee and a shared executive group have been created within the proposed GM governance to coordinate delivery, support the work of the GM ICS and link to the Combined Authority / Mayoral Office / Local Authorities.

In terms of locality / place-based working, further guidance has been issued on the potential models for this. There are five models described in the guidance for the potential form of governance that may exist within a locality / place. The guidance does not describe or prescribe the functions of the locality governance arrangements.

- *Consultative forum - a collaborative forum that advises the ICB*
- *Individual executives or staff – a committee that has been convened by a member of the ICB staff who has been delegated specific responsibilities from the Board*
- *Committee of a statutory body - a committee of a statutory body with delegated authority to make decisions about the use of resources.*
- *Joint Committee - a committee established between partner organisations such as the ICB, local authorities, statutory NHS providers or NHSE /I. The relevant statutory bodies agree to delegate defined decision-making functions to the joint committee*
- *Lead Provider - a lead provider manages resources and delivery at place-level as part of a provider partnership, under a contract with the ICB and/or local government*

Each of the ten localities in Greater Manchester is considering which option they would want to adopt.

4. MFT issues

MFT Clinical Service Strategy

Cancer Strategy

Work to develop a cross-cutting cancer strategy for MFT is progressing. The approach has been to undertake a series of 1-1 and group meetings to gather views on how our cancer services need to develop. These are now being tested in two multidisciplinary workshops. There has been wide engagement with tumour group leads, Hospital cancer leads, Hospital and MCS leadership teams and external partners such as Manchester Health and Care Commissioning, GM Cancer, and Manchester Cancer Research Centre.

The next steps are to engage with the Council of Governors and following this the strategy document will be drafted and taken through the MFT approval process.

5. Actions / Recommendations

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

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:	November 2021
Subject:	Annual Planning 2022/23 – MFT Vision and Strategic Aims
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 – Support the proposal to revise our strategic aims – Comment on the suggested changes – Note the provisional annual planning timetable.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The starting point for the planning cycle each year is to review the Trust vision and strategic aims; they form the basis of all of our planning activities.

Our strategic aims currently include achieving the Single Hospital Service which has now been delivered and so it is considered timely to undertake a more in-depth review than in previous years to assess if, and if so how, our vision needs to change.

The purpose of this paper is to update the Board on the process to revise our vision and leading on from this, the draft timetable for the annual planning process for 2022/23.

2. Background

A vision describes where an organisation is going and what it will look like when it gets there. It describes the organisation's purpose, what it's striving for, and what it wants to achieve. Given the nature of a vision, change should be kept to a minimum. However as the external environment changes and the organisation evolves it is good practice to test out periodically that it remains fit for purpose.

The MFT vision is made up of two elements; the vision statement and a series of strategic aims that set out what we want to achieve across the key areas of our business. The current MFT vision is set out below:

> ***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 a 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*

3. Review of the Vision

There have been a number of major changes both within MFT and externally that should be considered when reviewing the vision, including:

- Single Hospital Service – MFT now incorporates NMGH
- Integrated Care Systems – we will be required to work more collaboratively with other providers and as part of our local systems and to play our part in integrating care and addressing the wider determinants of health
- Health inequalities – there is an increasing focus nationally on addressing the avoidable differences in health across the population

- COVID-19 – the pandemic has had a deep and lasting impact on the organisation on the numbers waiting for treatment and the direct and indirect impact on our workforce. Recovering from this is not going to be a quick-fix.

The review to date has concluded that the vision statement remains valid, but that changes are required to the underpinning strategic aims. The following are suggested changes:

- To highlight access to care as a key part of quality post pandemic
- To reflect that improvement to patient safety and patient experience is continuous, not a one-off
- To reflect the key strands of the MFT People Plan
  - We want to work here; MFT will be a great place to work
  - We look after each other; we care for you, as you care for others
  - We are supported to be our best; we care that you can develop your skills
  - We feel valued and heard; we show you how important you are and hear what you have to say
  - We can shape the future; our staff are at the forefront of shaping the future of care for our patients
- To reflect the need to deliver the benefits for patients and staff associated with the scale, size and complexity of the Group
- To add the need to maintain, as well as achieve, financial sustainability.

4. Annual Planning Timetable

No guidance or timeline has yet been received for the national planning process. However as the national guidance includes important planning information about the resources that will be available to us and the targets that we will be expected to achieve, it dictates the timetable for our internal MFT annual planning process. Based on previous years the table below sets out **provisional deadlines** for signing off the revised vison aligned to the expected planning timetable.

Engage with CoG on revised vision	November 21
National planning guidance issued	December 21
Board approval of revised strategic aims and proposed annual planning process	December 21
Review of 2021/22 – CoG session	December 21 / January 22
Looking forward 22/23 – CoG session	January 21 / February 22
Draft Annual Plan circulated for comment	March 22
Plan approved by Board of Directors	April 22

5. Action / Recommendations

The Board of Directors is asked to

- Support the proposal to revise our strategic aims
- Comment on the suggested changes
- Note the provisional annual planning timetable.

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:	November 2021
Subject:	Manchester Locality Plan
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to confirm MFT support and commitment to delivering the refreshed Manchester Locality Plan.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

All of the Clinical Commissioning Groups (CCG) within Greater Manchester, including Manchester and Trafford, have recently refreshed their locality plans. The MFT Board approved the refreshed Trafford Plan in September. The purpose of this paper is to seek confirmation of our support for the aims and our commitment to playing our part in the delivery of the updated Manchester Plan.

2. Background

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

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

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

3. Manchester Locality Plan

Attachments A is the refreshed locality plan for Manchester. This is an initial refresh to reflect the impact of COVID and in preparation for working as part of an Integrated Care System. A further refresh, which has greater levels of engagement, will be undertaken in due course.

MFT members of staff have been involved in the refresh exercise and are content that there is alignment across this and MFT aims and strategic direction. As key partners we now need to confirm that we are signed up to the aims and to committed to playing our part in delivering on the aims and objectives set out in the document.

It should be noted that the plan is still subject to sign off at Manchester Health & Well-Being Board in November.

4. Action / Recommendations

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

MANCHESTER LOCALITY PLAN

"Our Healthier Manchester"

2021 REFRESH

MASTER COPY
V10 MPB

CONTENTS

STRATEGIC CONTEXT

OUR HEALTHIER MANCHESTER

The original Locality Plan: Our Healthier Manchester, produced in 2016, set out the ambition to improve health and care outcomes for the people of Manchester within a financially sustainable health and social care system. The initial focus led to a rationalisation of the Manchester system, through the creation of a single commissioning function (SCF), a single hospital service (SHS), and a local care organisation (LCO). The first update to the Locality Plan (April 2018) was set within the context of the city's Our Manchester strategy, shifting the emphasis away from structural change to a focus on Our People, Our Services and Our Outcomes.

A Locality Plan Refresh (November 2019) was produced within the context of a maturing health and social care system, and in response to both the Greater Manchester Health and Social Care Partnership's (GMHSCP) Prospectus (March 2019) and the requirements of the NHS Long Term Plan. It was reflective of key Greater Manchester strategies, including the Greater Manchester Unified Model of Public Services and the Local Industrial Strategy – underpinned by the Greater Manchester Independent Prosperity Review. Turning the 3rd Locality Plan into delivery was, however, interrupted by the advent of the COVID-19 pandemic.

The pandemic has had a major impact on the health and wellbeing of the people of Manchester, as it has impacted people all across the world. We are incredibly grateful for the herculean efforts made by NHS & Council staff, carers and the voluntary, community and social enterprise (VCSE) sector to maintain essential services and support people through such challenging times. What we have learned, however, is that the long-standing inequalities in our City have significantly disadvantaged people further in respect of COVID-19 morbidity and mortality, widening the gap in health outcomes still further. We need to recognise, therefore, that our vision, strategic aims and intended outcomes may still remain true to that original Locality Plan in 2016, but the targets we set for improved health outcomes have become more challenging.

We also need to recognise that the context in which we operate is going to change. The recent Health & Care Bill introduced new measures to promote and enable collaboration and integration in health and care. It also seeks to formalise Integrated Care Systems (ICS) by turning them into statutory bodies, whilst disestablishing Clinical Commissioning Groups (CCGs). In Greater Manchester this will mean a shift from the Greater Manchester Health & Social Care Partnership (GMHSCP) arrangements to a new Greater Manchester ICS. Work is underway to prepare for this shift, determining the future role and governance of the GM ICS and the 10 localities in the new structure. The Manchester health and care system continues to work collaboratively in pursuit of the Locality Plan vision, whilst the new health infrastructure and governance develops (see page 14).

Manchester was ranked as the 6th most deprived Local Authority in England in the 2019 Index of Multiple Deprivation [1], which takes into account factors such as income, housing, education and employment, all of which contribute to people's health and wellbeing. Furthermore, we are operating in the context of a growing and changing population in Manchester. The population is forecast to grow by more than 14% over the next decade, which is the equivalent of 84,900 people. This presents opportunities for the city, but also some challenges in how we plan for the health and care needs of this expanding population.

This latest refresh of Manchester's Locality Plan has been produced at a time of unprecedented change and we don't yet know or understand the full impact that this has had on the health and wellbeing of our people. Nevertheless, this Plan seeks to reaffirm our City's ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that our plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

1. To allow comparison between the 317 English local authorities, the deprivation scores of each small area (LSOA) in a district are averaged and then the districts are ranked based on these averages. Manchester ranks as the 6th most deprived local authority on the index of multiple deprivation.

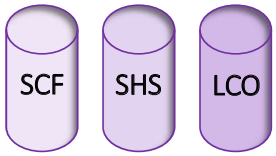
HOW MANCHESTER'S STRATEGY HAS EVOLVED

OUR HEALTHIER MANCHESTER

Manchester's approach to achieving the strategic aims of the Locality Plan has evolved since the first Locality Plan was written in 2016. The graphic below charts this evolution.

2016

Three Pillars

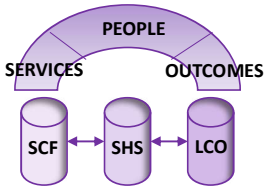


Laying the foundations

Manchester's first Locality Plan in 2016 emphasised the need to focus efforts on establishing the building blocks for system integration by prioritising structural change. This involved the creation of three new integrated organisations (three pillars): a single commissioning function (SCF); a single hospital service (SHS); and a local care organisation (LCO), plus confirmation of Greater Manchester Mental Health Trust (GMMH) as the provider of integrated mental health and care for the City.

2018

The Rainbow

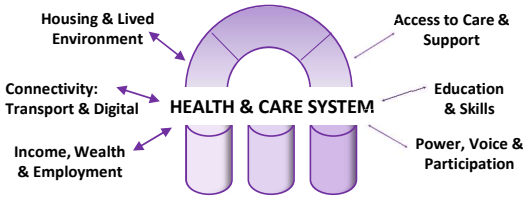


Focusing on outcomes for people

The second iteration of the Locality Plan in 2018 emphasised the need to switch the focus from structural transformation – the three pillars – to achieving better outcomes for people. A 'Rainbow' graphic was introduced to illustrate the new focus. A number of key milestones were identified up to 2026/27 under the headings: *'Our Services'; 'Our People'; and 'Our Outcomes'.*

2021

System Integration & Collaboration



Build Back Better – Build Back Fairer

Health care is only one of the many factors that impacts on health outcomes and we know that the COVID-19 pandemic has further exacerbated deep-seated inequalities experienced by many in our population. Building on the 2020 Refresh, this plan acknowledges the many challenges that we face, whilst reaffirming our resolve to work collaboratively, as an integrated system, to improve outcomes.
We also recognise that the Locality Plan doesn't exist in isolation. It sits alongside the Manchester Population Health Plan (2018-2027) as a primary strategy driving improved health and care outcomes, and together they form the health & care element of the overall city strategy: **Our Manchester**

STRATEGIC AIMS & PRIORITIES

OUR HEALTHIER MANCHESTER

Manchester's Locality Plan has five Strategic Aims, outlined in the graphic below. Progress is tracked against a range of indicators in the Locality Plan Outcomes Framework, with the key intended outcomes included below. The Manchester Partnership Board (the City's newly formed senior leadership forum for integrated health and care) has identified eight key priorities that will contribute to the achievement of these strategic aims. The priorities and associated work programmes are explained in more depth in Annex 1.

STRATEGIC AIMS	KEY INTENDED OUTCOMES	NOTABLE PROGRESS/ CHANGES
 **Improve the health and wellbeing of people in Manchester**	➢ Narrow the life expectancy gap between the city's residents ➢ Improved health & well-being – social care quality of life ➢ Reduction in preventable deaths (all causes).	Under 75 Mortality Rate from causes of death considered preventable *
 **Strengthen the social determinants of health and promote healthy lifestyles**	➢ Reduction in smoking prevalence to 15% or lower by 2021 ➢ Increase in the number of children who are school ready ➢ Reduction in residents who are out of work due to an underlying health condition/disability.	A sustained decease in smoking prevalence **
 **Ensure services are safe, equitable and of a high standard with less variation**	➢ All providers have a CQC rating of good or above ➢ All national and local quality standards are met.	Percentage of GP practices, Nursing and Care Homes CQC rated good or above **
 **Enable people and communities to be active partners in their health and wellbeing**	➢ Increase the level of knowledge and confidence that people have in managing their own health.	People feeling in control of their daily life, and feeling safe and secure (pre-COVID-19) **
 **Achieve a sustainable system**	➢ Achievement of financial balance across the system ➢ Achievement of constitutional and statutory targets ➢ Developing a sustainable workforce.	Number of people and the length of time waiting for elective care, diagnostic tests and cancer treatment. **

MANCHESTER PARTNERSHIP BOARD PRIORITIES

1. Health infrastructure developments as a driver of economic regeneration
2. Covid response and recovery
3. Reduce inequalities
4. Supercharging the MLCO
5. Major transformation programmes
6. Development of Greater Manchester ICS and Manchester Local System arrangements
7. Refresh of key City strategies
8. Development of a short and long term approach to resource allocation

***Indicators relating to data available for period 2017/19 **Indicators relating to data available over the period 2019/21**

SYSTEM CHALLENGES – CURRENT & EMERGING

OUR HEALTHIER MANCHESTER

The Manchester Partnership Board priorities outlined on the previous page also take account of the need to address the challenges Manchester's health and care system is currently facing, many of which have been exacerbated by COVID-19. A selection of pressing system challenges related to standards, access and quality of care have been grouped into 'operational', 'financial' and 'workforce', and are detailed below. In addition to these challenges, the next few pages identify the challenges, and emerging approaches, associated with population health, health equity and the wider determinants of health.

Key system OPERATIONAL challenges

Acute and Mental Health system pressures

- The acute health care system continues to experience operational pressures as a result of the national pandemic that is impacting on delivery of NHS constitutional targets for Manchester patients. Safety is being prioritised across emergency, urgent and elective pathways and system-wide improvement programmes are in place to support recovery (MPB priority 2). It is envisaged that progress will be made in reducing elective backlogs over the coming months, however this will be incremental and in the context of wider pressures. Specific operational challenges include:
- **Impact of COVID-19 on long waits:** COVID-19 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 June 2021 was 141,545 with 14,706 patients waiting over 52 weeks.
- **Urgent Care:** As a result of high demand and the continued need to split estate and flow to meet infection prevention and control requirements the number of breaches to the 4 hour A&E standard has been significantly high across all sites.
- **Cancer:** Delivery against the 62-day referral to treatment standard has been challenged throughout the pandemic. Reducing the number of patients waiting for cancer treatment is a key priority with good progress being made across all hospital sites in Manchester.
- **Mental Health:** Mental Health Services in Manchester have experienced extreme pressure with increased demand being seen in a number of service areas; Manchester Community Mental Health Teams have experienced sustained, higher levels of demand that are above pre-COVID-19 rates, delayed transfers of care remain challenging, and there has been a rise in demand for inpatient beds resulting in an increase in patients being placed out of area.

Primary care

- The COVID-19 pandemic has led to unprecedented change in the way General Practice works. The continued provision of services throughout the pandemic combined with the rapid implementation of digital and triage first models of care and the increasing demands for the delivery of the largest vaccination programme in history is seeing General Practice endure one of the most challenging periods in its history.
- A combination of reduced staffing levels in primary care due to sickness and self-isolation, coupled with increasingly complex patients presenting who did not access care throughout the pandemic is presenting significant operational challenges.
- The primary care quality, recovery and resilience scheme (PCQRRS) is focusing on restoring service provision, preparing for future waves of the pandemic, and supporting reform and recovery. It will support the recovery, boost the resilience of our primary care workforce and fund time to ensure quality is embedded in recovery across Manchester General Practice to meet the needs of our diverse communities.

Social Care

- There are real challenges being experienced in the care home and home care markets particularly in relation to staffing capacity which will potentially be exacerbated by the mandated vaccinations for care home workers – a risk which is being managed closely. In home care in particular workforce capacity is a national issue which continues to create challenges locally in both the community and in supporting hospital flow.

Community

- High levels of COVID-19 related sickness/vacancies are leading to challenges in the delivery of community services, where both activity levels and complexity are greater now than pre-pandemic, at a time when community staff are also supporting the COVID-19 vaccination programme.

SYSTEM CHALLENGES – CURRENT & EMERGING

OUR HEALTHIER MANCHESTER

Key system FINANCIAL challenges

The current financial landscape is very different to those which previous locality plans have been based upon. In response to the global pandemic the health and care financial regimes have been changed to allow greater focus on the response to the crisis, targeted resources to critical areas and now as we emerge – focus on recovery. Arrangements for the coming years in respect of the level of financial autonomy and national requirements post pandemic are still awaiting clarification, including the outcome and scope of the spending review for Local Authorities. What will be of particular focus for Manchester is the transition to the ICS arrangements and how this will impact the funding flows between a Greater Manchester and a locality level.

We are aware of significant national pressures on resources and likely efficiency targets. Greater Manchester and Manchester health and care systems are currently spending significantly more than previously notified allocations. The Manchester system will need to identify issues arising from non recurrent funding and prioritise future funding in line with the delivery of the locality plan.

Finance system leaders are working in partnership to ensure that Manchester is able to respond in a coordinated and agile manner to address the challenges outlined above.

CASE STUDY – DIGITAL PRIMARY CARE

The COVID-19 pandemic has accelerated previous plans to build a different relationship between patients and primary care. Alongside the face to face appointments that remain important to many people and for many conditions, an increasing number of patients are now able to use digital technology to access and interact with primary care. We have found that for some patients, digital access has revolutionised their experience of GP care, whereas others preferred the traditional system. Knowing that digital is not better for everyone means that digital inclusion is now a key priority going forward. We now have the challenge of embedding the benefits that digital working provides, whilst ensuring that patient experience and digital inclusion are improved for all.

Key system WORKFORCE challenges

Previous iterations of the Locality Plan have recognised the need for our health and care system to work collaboratively ***'to make Health and Care in Manchester the best place to work',*** with priorities set around: Recruitment, Retention and progression; Equality, Inclusion and Social Value; Health and Wellbeing; Workforce Development; Workforce Planning; and the development of a Workforce Operating Model.

Our strategic intent is unchanged, however, we need to recognise the impact that the pandemic has had on our workforce. The demands placed upon our people in the last 18 months were unprecedented and we know that they are exhausted and need to recover. We recognise, therefore, that supporting staff health and wellbeing will be crucially important if we are to continue to support the health and care needs of our population effectively.

We also know that the pandemic has disproportionately affected people in our population who experience racial inequality which includes our staff. We have, therefore, renewed our commitment to creating a culture where people can develop and thrive in a compassionate and inclusive environment that addresses systemic and structural inequalities. We want our health and care system to be representative of the people we serve, celebrating diversity.

CASE STUDY – SHARED CARE RECORD

The rollout of the Greater Manchester Care Record (GMCR) was rapidly accelerated due to the COVID-19 pandemic, as technological and information governance barriers were addressed, allowing patient information sharing across GM regardless of organisation or geography. This meant, for the first time, those providing care had access to a wider range of health and care data from organisations across the whole of Greater Manchester.
When the vaccination programme began in December 2020 Manchester developed an innovative solution to utilise data from the GMCR, including a suite of resources to understand vaccination coverage by multiple population groups. These resources were used to identify and reduce vaccination inequalities in BAME groups through targeted interventions.
Vaccination data, coupled with the development of a re-identification tool, has supported vaccination sites to identify and target patients that may have been otherwise missed.

SYSTEM CHALLENGES – LONG-STANDING

OUR HEALTHIER MANCHESTER

Health Equity & Wider Determinants

Manchester has entrenched health inequalities dating back for generations. The City has amongst the worst health inequalities in the country and also experiences wide variation between different communities within the City itself. The wider determinants of health such as employment and education also have worse outcomes than the country as a whole. The Manchester Population Health Plan (2018–2027) details these inequalities.

COVID-19 has had a profound impact upon the population's health. It has impacted disproportionately on different communities within our City, largely exacerbated by existing inequalities experienced across different ethnic groups and areas of deprivation. For example, life expectancy has reduced and instances of life limiting illnesses have increased. This comes on top of the recent Marmot report 'Build Back Fairer', which identified that mortality was already double in areas of highest deprivation, nationally, compared with the least. Our response to the pandemic has mitigated some of this differential but we expect to see greater variation in health outcomes across the City and compared to the rest of the country. Some of this variation is evident now; some we know will emerge in the future and some impacts may, as yet, remain unknown.

Reducing Health Inequalities

We recognise the need for continuous improvement in addressing inequalities and promoting inclusion and, in support of This, Manchester has identified seven priority actions: -

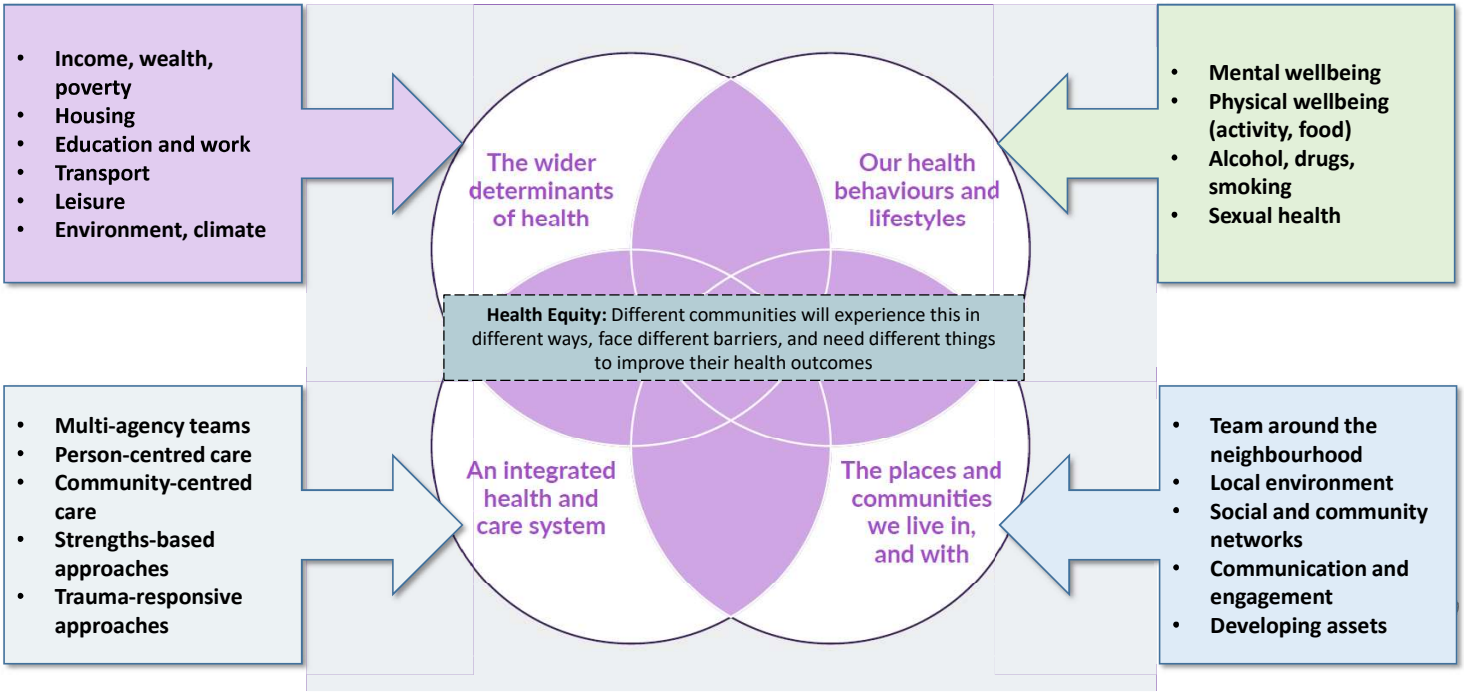
- Improved demographic data collection;
- Community research to inform service delivery;
- Improved access, experience and outcomes;
- Culturally competent workforce risk assessment;
- Culturally competent education and prevention;
- Targeted culturally competent health promotion and disease prevention;
- Ensure recovery plans reduce inequalities caused by wider determinants.

Manchester has put these priority actions into practice throughout the pandemic. COVID-19 Health Equity Manchester (CHEM) was set up to address the disproportionate effects that COVID-19 has had on specific population groups in Manchester including: communities that experience racial inequality; disabled people and Inclusion Health groups. A number of Sounding Boards (see panel) were developed to build insight and inform action planning. These included, for example, changes to how our vaccine delivery occurred e.g. pop up sites in different locations and community leaders engaging directly with their communities to encourage uptake.

As part of the Population Health Recovery framework, the CHEM approach and infrastructure will be built on to address a broader health and wellbeing remit and support the implementation of the Locality Plan.

A POPULATION HEALTH APPROACH TO ADDRESSING OUR CHALLENGES *OUR HEALTHIER MANCHESTER*

The Manchester Population Health Plan (2018–2027) is at the heart of our long-term plan to tackle Manchester's entrenched health inequalities, outlined on the previous pages. The plan for the city will requires a whole system, all-age approach as depicted in the framework below; with a strengthened approach to health equity in response to the systemic inequalities for certain communities highlighted by the COVID-19 pandemic. Collaborative delivery of this framework will involve all system partners. Each of the four components of this framework is described in more detail on the following slides, including relevant case studies.



THE WIDER DETERMINANTS OF HEALTH

In order to have maximum impact, the partners in the City will need to work as a collective system on the activities that address the social determinants of health for people at an individual and community level, ensuring every resident has the opportunity for better health and support.

The City Council as part of its civic leadership role is ideally placed to harness the collective strengths of organisations and sectors across the city to address the wider determinants of health. It is proposed that, under the Health and Wellbeing Board, the Director of Public Health will establish and lead a focused Task Group to respond to the recent Marmot Report with a clear action plan relating to the wider determinants. This work will feed into the refresh of the Manchester Population Health Plan from April 2022.

Manchester has a number of complimentary strategies that are interdependent, all of which will positively impact upon the wider determinants of health, as illustrated below.

Wider determinants of health	Strategies to address
Housing and lived environment	Manchester Housing and Residential Growth Strategy
Education and skills	Manchester Children and Young People's Plan; Work and Skills Strategy
Power, voice and participation	The Our Manchester approach
Income, wealth and employment	Powering Recovery; Our Manchester Industrial Strategy for inclusive growth
Connectivity: (transport and digital	Greater Manchester Transport Strategy 2040; Manchester Digital Strategy
Access to Care and Support	MLCO Operating Plan; Better Outcomes Better Lives (Adult Social Care transformation); Bringing Services Together for People in Places

CASE STUDY – INCLUSIVE GROWTH

North Manchester is embarking on a transformation period of major investment, with a total value of £4.5bn over the next 15-20 years.

Victoria North - £4bn residential led redevelopment of 7 districts from the edge of the city centre and up through the Irk Valley. This will create green space and some 15,000 new homes for around 35,000 people

The Manchester College - £140m transformation programme, including a new £93m campus on the southern edge of North Manchester. This industry Excellence Academy will be designed and delivered with leading employers.

Park House Mental Health Unit - £72m, 150-bed adult mental health inpatient facility. This will greatly improve the quality of care for patients in the best therapeutic environment possible

BENEFITS

- Boosting life expectancy of North Manchester residents by 1.3 years
- Creation of 15,000 good quality, affordable, low-carbon homes
- Diversification of housing choice and tenure
- GDV of £4.5bn with investment in the local economy
- Good-quality skills, training and employment opportunities
- Better connected and more liveable neighbourhoods
- Improved digital connectivity and infrastructure

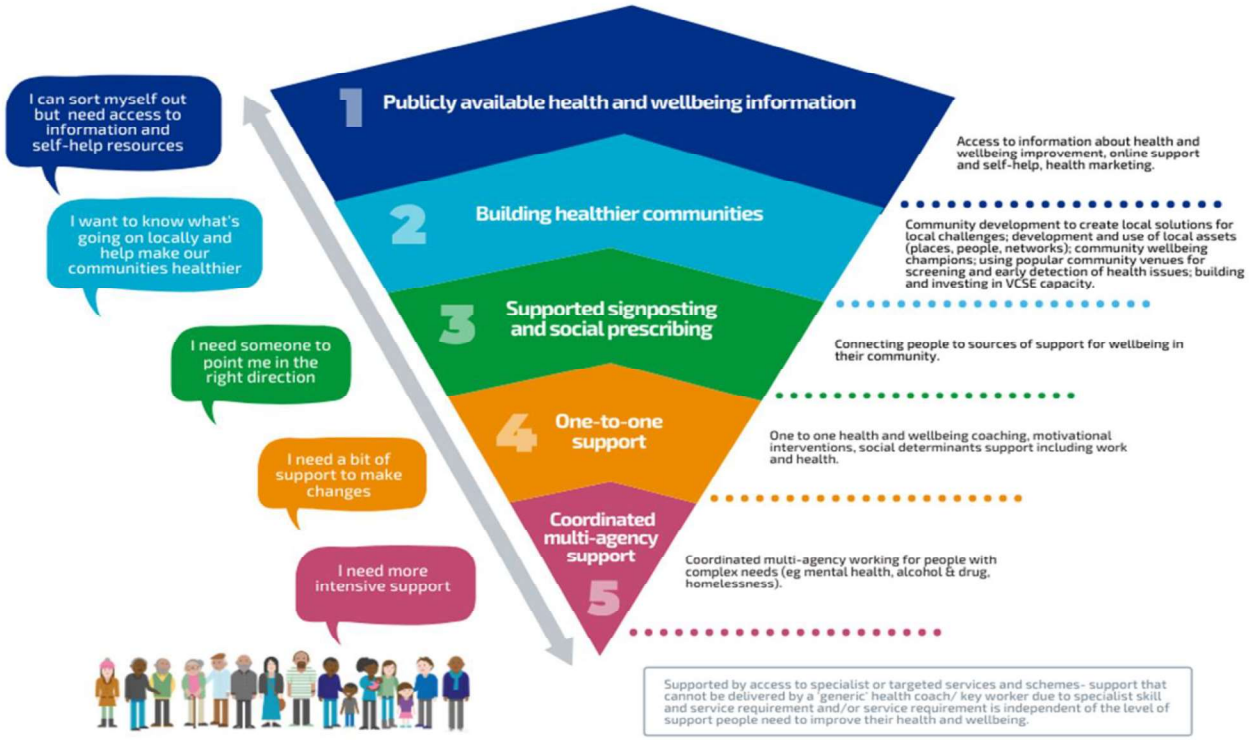
Manchester City Council is bringing ALMO Northwards Housing back in-house, facilitating the retrofit of approximately 13,000 homes in North Manchester

North Manchester General Hospital - £350m redevelopment. This will include a sustainable health campus with integrated health and social care facilities, new homes, access to better education and training, and a new centre for healthy ageing.

HEALTH BEHAVIOURS & LIFESTYLES – WELLBEING MODEL

OUR HEALTHIER MANCHESTER

Manchester's Wellbeing Model outlined in the graphic below provides the delivery framework for services and approaches to improving outcomes for Manchester's residents based on the level of support people need to look after their own health and wellbeing.



AN INTEGRATED HEALTH AND CARE SYSTEM

OUR HEALTHIER MANCHESTER

Bringing Services Together - Team Around the Neighbourhood

We recognise that the health and wellbeing of residents and the demand for health and social care services are significantly dependent on the contribution of other public services. INTs are one part of the neighbourhood approach across the City, supporting residents to be independent and well. Local authority, Police and Housing services also work on neighbourhood footprints, linking in with INTs. We call this joint working across the public sector "Team Around the Neighbourhood", which is part of the Bringing Services Together. initiative set up to coordinate and co-produce solutions.

CASE STUDY – HEALTH EQUITY

The Manchester COVID-19 Vaccination Programme followed a 'whole-system', three stage approach to addressing barriers to vaccination uptake amongst communities experiencing entrenched health inequalities:

Access: increasing capacity and opportunities to be vaccinated, improving the ways in which people can access these opportunities, and removing barriers that make it difficult for people to get their vaccine;

Information: provision of tailored, targeted and culturally competent information about COVID and vaccination with bespoke use of the "3Ms" as appropriate for the target audience (Message, Messenger, Media);

Motivation: activities that create conditions for people to want the vaccine, and build trust and confidence in the vaccine.

Bespoke offers and pop up clinics were offered at a range of venues targeted at people experiencing barriers to vaccination.

- Deaf institute;
- Homeless offer including hostels;
- Care homes/wider care homes and housebound offer;
- Supermarkets/local community venues;
- Schools/colleges and university offers.

THE PLACES AND COMMUNITIES WE LIVE IN AND WITH

OUR HEALTHIER MANCHESTER

Community health & care services in Manchester are delivered through the Manchester Local Care Organisation's 12 Integrated Neighbourhood Teams (INTs) operating on neighbourhood footprints, alongside Manchester's 14 Primary Care Networks (PCNS).

About INTs

- The Core Neighbourhood Team is consistent across all 12 neighbourhoods;
- They are a multi-agency, multi-disciplinary team (MDT) working closely together whilst maintaining links to relevant employers/professions;
- The Voluntary, Community & Social Enterprise (VCSE) sector plays an important role in multi-agency working including MDT involvement in neighbourhoods and co-opted leadership roles in some areas;
- Each team is co-located in their neighbourhood, to support multi-disciplinary meetings and co-working;
- The teams adopt a strengths/asset-based approach underpinned by Manchester's Wellbeing model, focusing on prevention and cognisant of the impact of the wider determinants of health.

The Core Neighbourhood Team

- **INT Lead**
- **Adult Community Nursing lead**
- **Adult Social Care Lead**
- **Adult Mental Health Lead**
- **GP Lead,** linking to GP practices in the neighbourhood and Primary Care Networks
- **Health Development Coordinator**
- **Care Navigator**
- **VCSE representation** from the neighbourhood

CASE STUDY – POPULATION HEALTH MANAGEMENT (DIABETES)

Working in partnership with Primary Care Networks (PCNs), Manchester Local Care organisation (MLCO) is piloting a data enabled approach to improve health and care outcomes in neighbourhoods.

Alongside local knowledge and insight, there is now a real focus on using data to agree local priorities and action plans for improving health and wellbeing in local communities. This approach has identified a need to radically improve outcomes for people living with type 2 diabetes in the Chorlton, Whalley Range and Fallowfield neighbourhood.

It is expected that this approach will create an early opportunity to demonstrate how using the local health and care system's shared capacity differently can lead to improved outcomes for disadvantaged parts of the population, as well as reducing costs.

Below is a summary of the pilot's objectives -

- Provide a proof of concept of a data enabled health improvement project in a neighbourhood.
- Develop a clear understanding of the data analysis skills, competencies and activities required to support this type of project, including the data requirements and data gaps that may currently exist.
- Demonstrate to the Manchester Partnership Board (MPB) that a sustainable reduction in hospital activity is achievable through local actions by services, people and communities working together in a neighbourhood.
- Demonstrate that by using data analysis alongside neighbourhood partnership working that entrenched health inequalities can be effectively tackled and reduced.
- Creating a data enabled approach and methodology which is replicable as part of the health improvement and reform function of MLCO.

HOW WE ARE ORGANISED - SYSTEM ARCHITECTURE

OUR HEALTHIER MANCHESTER

Manchester's Health & Care system governance is evolving, in response to the establishment of the GM ICS. Emerging responsibilities are detailed below, and supporting infrastructure (resources and assets) are being identified.

Manchester Partnership Board (MPB)

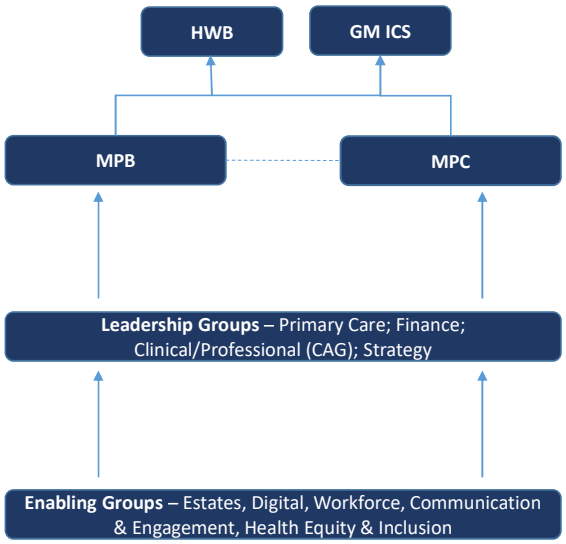
- MPB is the senior leadership forum for health and care within the City. Its role will include: setting strategy; agreeing system transformation priorities; high level resource allocation; strategic engagement with partners; and a potential assurance role for the GM ICS. It will comprise political, clinical and managerial leadership.
- It will receive delegated responsibilities, powers and budgets for specific responsibilities (to be determined but expected to have an emphasis on care delivered out of hospital). The Partnership Board will have 'sight' and influence over the full locality budget for health, care and public health;
- The MPB will be the strategic interface between the NHS and wider public sector strategy in the City, optimising the wider determinants of health and the NHS' contribution to the City strategy.
- The Partnership Board will have the primary line of reporting for Manchester's responsibilities to both the NHS ICS Board and the Manchester Health and Wellbeing Board (HWB), bringing together key partners to plan health & social care services for Manchester.

Manchester Provider Collaboration (MPC)

- The MPC approach is still in development, but it is being built from a strong base of provider collaboration that already takes place between/across statutory and non-statutory organisations, providing health & care services at neighbourhood, locality and city-wide levels every day;
- Manchester providers will work individually and collectively to deliver integrated, safe and effective services; shifting care upstream, reducing demand on acute and long term care. Care will be organised at a neighbourhood level so that it is well connected to local people, communities and assets and health and care teams will work at an operational level with other public sector front line teams to ensure a holistic offer to residents.

Underpinning governance

- The MPB and MPC will be supported by wider governance arrangements working at a system level;
- The Primary Care Forum will act as a conduit to primary care within the locality and GM ICS primary care functions;
- The finance, clinical/professional (Clinical Advisory Group) and strategy leadership groups will work individually and collectively to support direction setting and the transformation agenda;
- Enabling groups including workforce, estates, digital, communications & engagement and health equity and inclusion will wrap support around system priorities.



ANNEX 1 - KEY PRIORITIES AND WORK PROGRAMMES

OUR HEALTHIER MANCHESTER

Priorities	Work Programmes	Description
1.**Health infrastructure developments as a driver of economic regeneration**	New NMGH	Secure the investment for the redevelopment of the North Manchester General Hospital (NMGH) site, through the New NMGH Transformation Programme.
	New Park House	Developing the full business case and plans to redevelop the New Park House mental health facility on the NMGH site .
	Wythenshawe Master Plan	Developing the case for investment for the redevelopment of the Wythenshawe Hospital site by building on the Strategic Regeneration Framework (SRF) .
2.Covid response and recovery	Recovery Framework - M&T Community Cell	The framework sets out how health, as a major sector within the city, and a significant presence within communities, will contribute to the wider city recovery. This will support MPB to gain a full picture of progress & tailor strategic direction to determine its transformation priorities.
	MLCO Recovery and Reform	Re-establishing and reforming community services to meet the increased and changing needs of our residents and the new context in which we find ourselves as a result of the COVID-19 pandemic. Covers 1) urgent care, 2) alignment of management responsibilities, 3) adult nursing, 4) therapy services, and 5) end of life and palliative care
	MFT Recovery programme	Initially largely focused on returning activity levels to the new normal, these four programmes are also rethinking how activity is best delivered in the future and the COVID-19 pandemic has acted as a natural catalyst for rapid change. Covers 1) elective care, 2) outpatients, 3) urgent and emergency care, and 4) community diagnostic hubs.
3.Reduce inequalities	Reducing inequalities	Focused on addressing health inequalities and a commitment to put into practice the Marmot 2020 report's recommendations by working across all public services in our city region to ensure that policies, approaches and resources are geared towards creating a fairer, more equal society.
4.Supercharging MLCO	MLCO Transitions Board	MLCO led programme with all partners represented to deliver plans to 'supercharge' MLCO by April 2022. Includes 1) embedding a Population Health Management (PHM) approach, 2) development of neighbourhood model ((work with Primary Care Networks (PCNs) and Greater Manchester Mental Health NHS Foundation Trust)), 3) development of deployed commissioning and contracting functions, 4) bolstering of corporate functions, and 5) development of people and culture (HR) and organisational development (OD).
5.Major transformation programmes	Bringing Services Together for People in Places (BST)	A multi-partner programme of work that will help to provide a space and mechanism for collaboration between services and partners to develop new ways of working, join up individual service offers and reduce duplication.
	Neighbourhood Development	Continue the work to integrate services at the INT level and the extent to which they are joined up around residents/patients. Creating opportunities to support residents to prevent ill health, be independent, in control, and connected to their communities.

KEY PRIORITIES AND WORK PROGRAMMES

OUR HEALTHIER MANCHESTER

Priorities	Work programmes	Description
	MH Transformation programme	A refocusing of mental health priorities following publication of the Mental Health Long Term Plan and a shift in priorities as a result of the impacts of COVID-19.
	Better Outcomes Better Lives	MLCO's transformation programme for Adult Social Care. The programme is structured around six key workstreams – 1) maximising independence, 2) providing early help, 3) short term offers to support independence, 4) transforming community and specialist teams, 5) responsive commissioning, and 6) performance framework.
	North Manchester Strategy	Implementation of the NM Strategy with a focus on placemaking and partnerships; regeneration, economic and social impact, service transformation, and progression of the wider site / campus redevelopment under the Strategic Regeneration Framework
	Adults LTC	System wide review and service model design for the management and provision of Long Term Condition (LTC) services across the whole health and care pathway. Covering 1) respiratory, 2) vascular, 3) long COVID, and 4) community diagnostic hubs.
	Children and Young People	Delivering services that meet the health needs of children and young people, and support them and their parents and carers in managing those health needs. Includes 1) virtual ward and LTC, 2) Special Education Needs and Disabilities (SEND), 3) Transitions, 4) think family (community hubs), and 5) year of the child 2022.
6.Development of Greater Manchester ICS and Manchester local system arrangements	MPB engine room	Development of the system infrastructure required to support the activities to integrate care and improve population health driven by commissioners and providers collaborating at a locality level.
	Influencing the GM ICS	Influencing the blueprint for developing the GM ICS. Reviewing spatial levels to determine what future work is undertaken at what level (e.g. GM vs locality level).
7.**Refresh of key city strategies**	Our Manchester Strategy	Refreshed strategy (taking into account the impacts of COVID-19) that provides aspiration and resets priorities to ensure Manchester can achieve its aim of being a top-flight world class city by 2025, with equality, inclusion and sustainability at its centre.
	Population Health Plan	Taking into account the impacts of COVID-19, the development of the refresh of the population health plan for 2022 moving towards a new individual, communities and heath equity approach
	Locality Plan	Refresh and reset of the Manchester Locality plan to describe how the health and social care system in Manchester will be transformed with improved health and wellbeing, high quality services, a balanced budget and making the most of the many strengths we already have. This will be in the context of a post pandemic world & new NHS ICS legislative changes.
8.**Development of a short and long term approach to resource allocation**	H2 Planning	Setting a financial plan for Q3 & Q4. Given that national guidance is expected to predominantly outline a rollover of H1 arrangements with a further savings requirement, the greater work might be planning for 2022/23.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Alison Lynch, Group Deputy Chief Nurse Barbara Mitchell, Assistant Chief Nurse Safeguarding, Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	November 2021
Subject:	Complaints & PALS Report: Quarter 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:	The Board of Directors is asked to note this Complaints and PALS report, including information relating to Q2 2021/2022, on the following topics: • Complaints & PALS activity • Brief analysis of identified themes • Summary of achievements, and improvements planned • Overview of complainants' satisfaction survey
Recommendations:	The Board of Directors are asked to note the content of this Q2 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that MFT is responsive to concerns raised and learns from patient feedback to continuously improve the patient's experience.
Contact:	Name: Barbara Mitchell, Assistant Chief Nurse Safeguarding, Quality & Patient Experience Tel: 0161 701 0909

1. Executive Summary

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaint's activity across Manchester University NHS Foundation Trust (MFT) during Q2 2021/22.

1.2 Our aim is to provide timely resolutions when people raise concerns or complaints about their experiences of the care they have received. We aim to remedy the situation as quickly as possible, ensuring the individual is satisfied with the response they receive. Findings and learning from complaints are used to improve services systemically and locally for the people who use them, as well as for staff working in within them.

1.3 This report provides:

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

1.4 Supporting information referred to throughout the report is included at Appendix 1.

2. Q2 2021/22, summary of activity for PALS and Complaints Activity

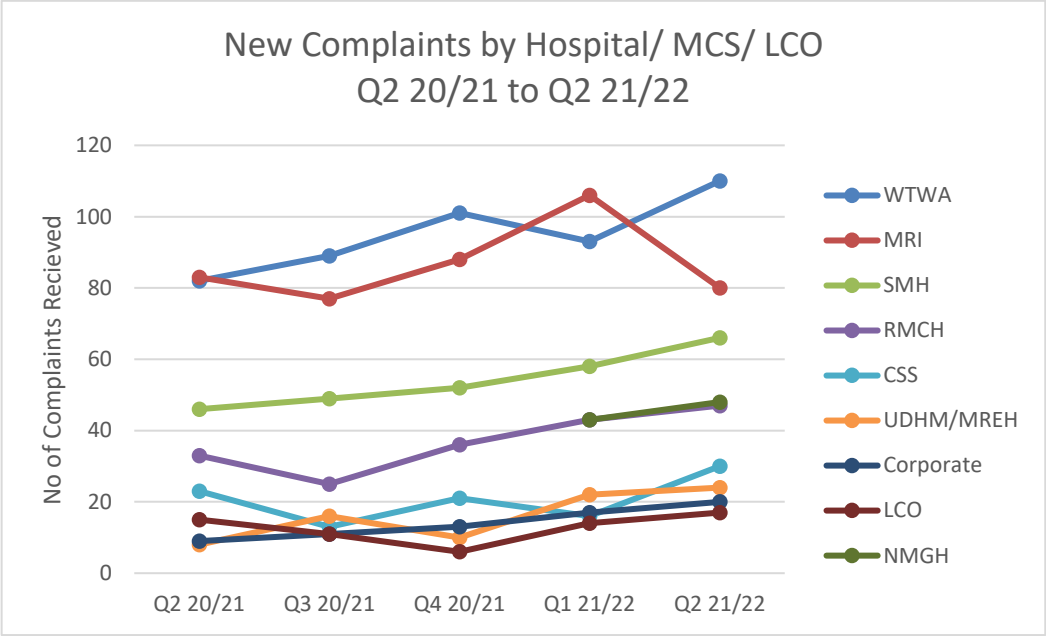
- 1,938 PALS concerns were received in comparison to 1,834 received in the previous quarter[1]
- 442 new complaints were received in comparison to 412 received in the previous quarter[2]
- 100% of complaints were acknowledged within 3 working days; this position was maintained throughout all the previous quarters of 2020/21 and 2021/22
- 431 complaints were closed in comparison to 345 closed in the previous quarter[3]
- 87.7% of complaints were closed within the agreed timescale compared to 93.3% in the previous quarter. This is the first quarter in which the Trust has not achieved or exceeded the 90% target
- 46 (10.7%) complaints investigated were upheld, 86 (20.0%) were not upheld and 278 (64.5%) were partially upheld
- 7 cases were being investigated by the Parliamentary Health Service Ombudsman (PHSO)
- A decrease in complaints relating to outpatient and inpatient services was noted across the Trust and a slight increase in re-opened complaints.
- The PHSO closed 0 cases during this quarter. Details of the 'live' PHSO investigations are set out in **Table 1, Appendix 1**.
- 12 virtual or face to face complaint local resolution meetings were held.
- 7 in-house Complaints Letter Writing Training Educational Sessions were held, with 56 number of staff attending.

[1] Contributed to by NMGH joining from 1st April 2021

- The Complaints Review and Scrutiny Group (CRSG), chaired by a Non-Executive Director, met twice during Q2. The senior management teams from Manchester Royal Infirmary (MRI), Local Care Organisation (LCO), Saint Mary's Hospital and the Royal Manchester Children's Hospital each presented a case. The learning identified from these cases is detailed in Section 6 of this report.

3.0 An overview and brief thematic analysis of complaints contacts

3.1 In Q2 the Trust continued to see an increase in complaints with 442 new complaints being received. **Graph 1** below shows the number of complaints received by each Hospital/MCS/LCO each quarter. WTWA received the greatest number of complaints and this is not unexpected as they are one of the larger hospital sites than others. Further detail is provided in **Table 2**, **Appendix 1**.



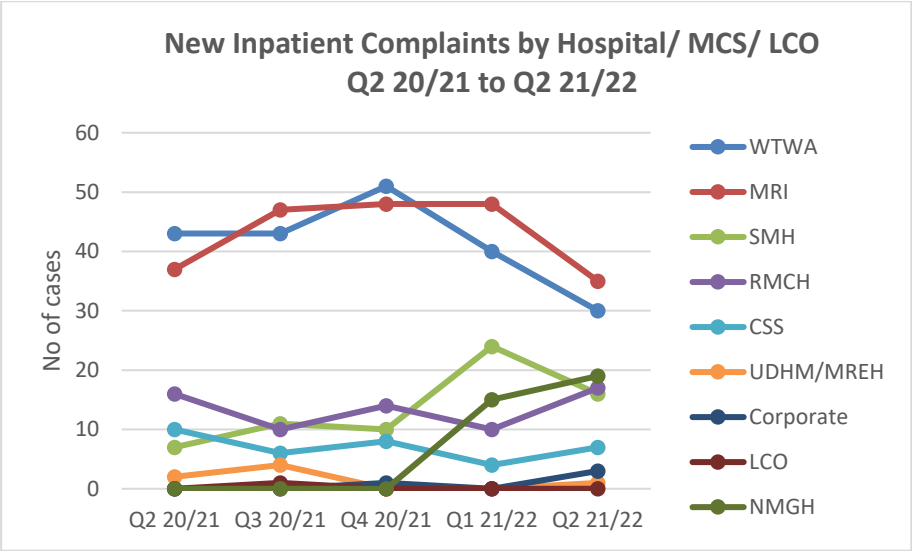
Graph 1: New Complaints Received by Hospital/MCS/LCO

3.2 **Graphs 2 and 3** below illustrate the number of new complaints relating to inpatient and outpatient services during Q2 2020/21 – Q2 2021/22.

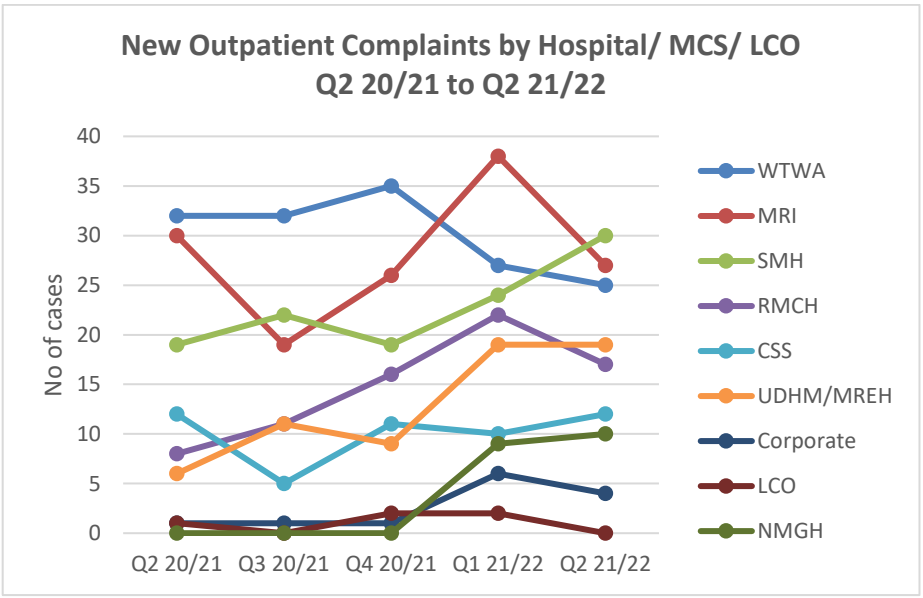
3.3 Overall Q2 saw a decrease in complaints relating to both outpatients and in-patient services.

3.4 It is considered that the decrease noted should be viewed in the context of continued, activity increasing in Outpatient Departments and an increase in waiting times for elective work as the NHS continues to work towards recovering from the pandemic.

[2] Contributed to by NMGH joining from 1st April 2021
[3] Contributed to by NMGH joining from 1st April 2021



Graph 2: Number of new complaints relating to inpatient services by Hospital/MCS/LCO



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

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

3.4 Complaints resolved within agreed timescales

3.5 87.7% of complaints were closed within the agreed timescale. Given that the Trust has achieved above the agreed 90% target for the last 4 quarters, this is the 1st quarter this target has not been achieved. **Table 4, Appendix 1**, provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

3.6 The oldest complaint case closed during Q2 was reopened within WTWA on 4th November 2020 and was 174 days old when it closed on 13th July 2021. The arranging of the local resolution meeting impacted the overall response time. The complainant was kept updated and was fully supported throughout this process.

3.7 Outcomes from Complaint Investigations

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

3.8 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating team, the Corporate Complaints team review each of the issues raised to determine what happened. If failings are found in all the issues complained about, and substantive evidence is identified to support the complaint, then the complaint is recorded as fully upheld. If failings are found in one or more of the issues, but not all, the complaint is recorded as partially upheld. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as not upheld. Where are complaint is withdrawn, or consent to investigate not received, no outcome can be recorded.

3.9 During Q2, 46 (10.7%) of the complaints investigated and resolved were fully upheld, a continued increase from the previous 2 quarters, whilst 278 (64.5%) were partially upheld. **Table 5**, **Appendix 1** demonstrates the outcome status of all complaints between Q2 2020/21 and Q2 2021/22.

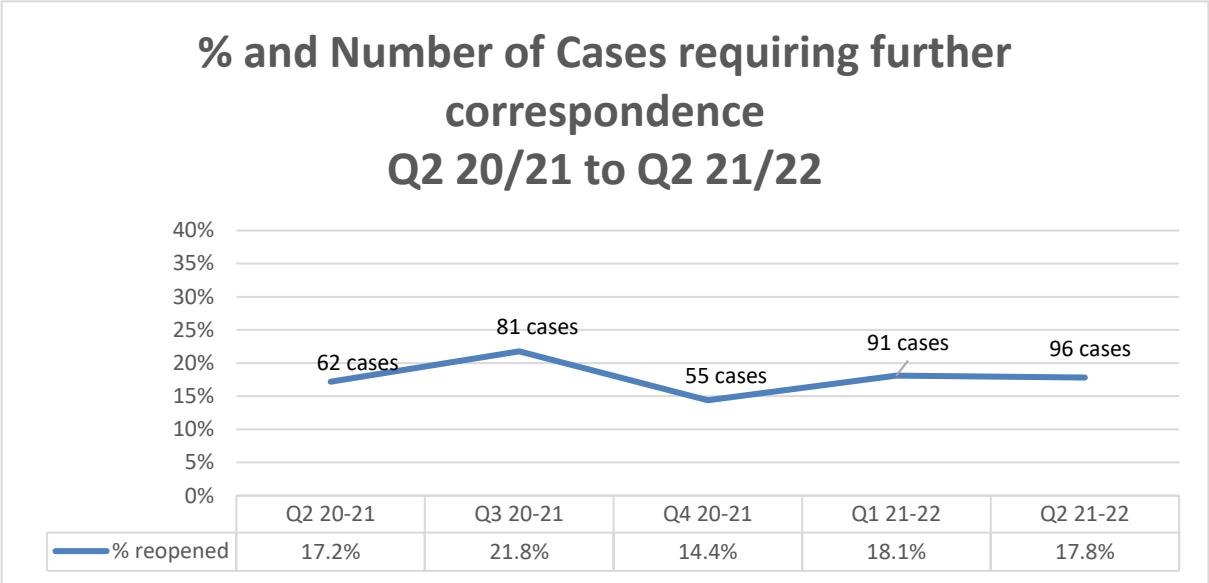
3.10 Re-opened complaints

3.11 A complaint is considered ‘re-opened’ if any of the following categories can be applied:

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

3.12 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed. During Q2, 17.8% of complaints were reopened (96 cases in total). In the previous quarter, 18.1% of complaints were reopened (91 cases in total).

3.13 **Graph 4** demonstrates the number of complaints re-opened from Q2 2020/21 – Q2 2021/22. **Table 6, Appendix 1** provides an overview of the predominant reasons for the complaint being re-opened by Hospital/MCS/LCO during Q2.



Graph 4: Total Re-opened complaints Quarter 2, 2020/21 to Quarter 2, 2021/22

3.14 In 54 of the 96 complaints requiring re-opening, the predominant reason for was due to the complainant being 'dissatisfied with the response', with WTWA and MRI receiving the greatest number.

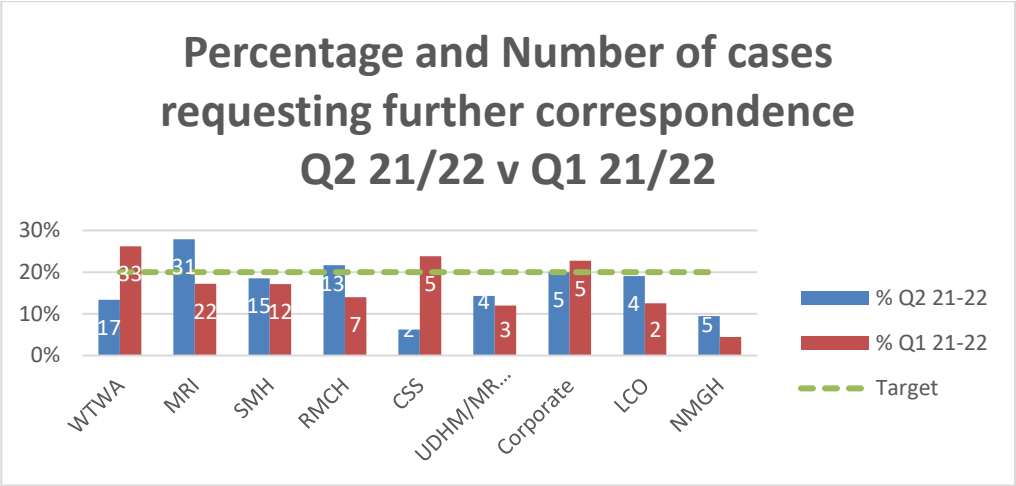
3.15 The 20% threshold was exceeded is as follows:

- MRI: 27.9%
- RMCH: 21.7%

3.16 **Graph 5** below shows re-opened complaints demonstrating WTWA, SMH, CSS, UDHM/MREH, Corporate, LCO and NMGH meeting or falling below the 20% threshold.

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

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



Graph 5: Percentage and number of re-opened complaints, Quarter 2, 2021/22

3.19 Brief thematic overview of complaints

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

3.21 During Q2, 3 of the 5 top primary categories remained unchanged with 'Treatment/Procedure' remaining the top category; however, in Q2 'Attitude of Staff' was the third category replacing 'Clinical Assessment' and 'Clinical Assessment' was the fourth category replacing 'Attitude of Staff'.

3.22 The top primary themes in Q2 from complaints are shown in Table 7 below. Themes from previous quarters are included to enable comparison.

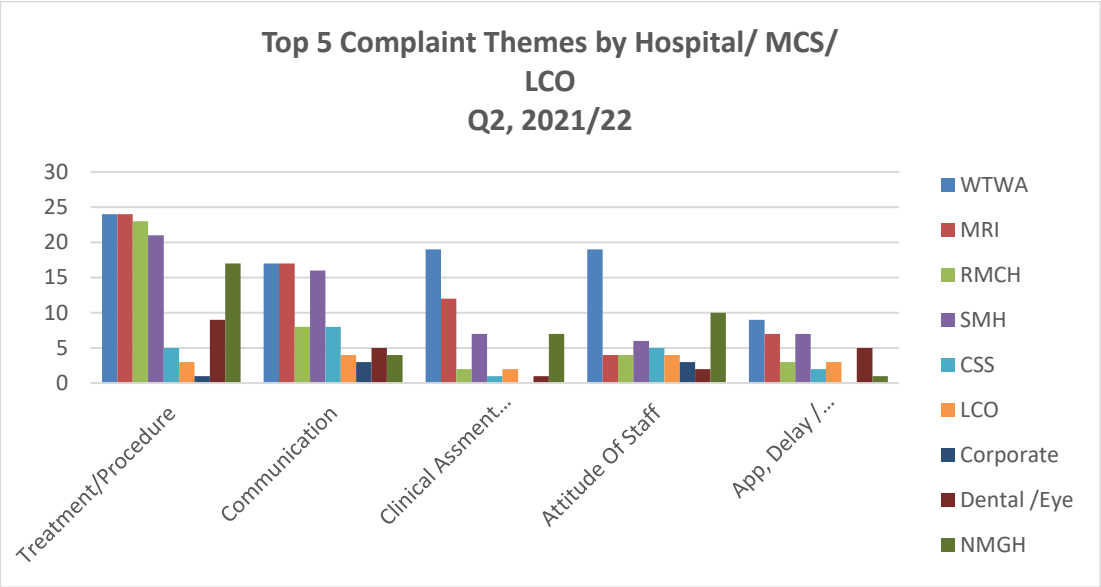
	Q2,20/21	Q3,20/21	Q4,20/21	Q1,20/21	Q2,21/22
1	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure
2	Communication	Clinical Assessment (Diag,Scan)	Communication	Communication	Communication
3	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Clinical Assessment (Diag,Scan)	Attitude of Staff
4	Attitude of Staff	Discharge/ Transfer	Attitude of Staff	Attitude of Staff	Clinical Assessment (Diag,Scan)
5	Access	Access	App, Delay / Cancellation (OP)	App, Delay / Cancellation (OP)	App, Delay / Cancellation (OP)

Table 7: Top Primary Complaint Themes Q2, 2020/21 to Q2, 2021/22

3.23 The MRI and WTWA received the most complaints relating to 'Treatment/Procedure'. Most of the new complaints relate to inpatient and outpatient services and some examples include:

- a patient experiencing a sudden decline in health resulting in an unexpected clinical outcome
- a patient experiencing a delay in receiving treatment

3.24 **Graph 6** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q2 2021/22.



Graph 6 Top 5 themes by Hospital/MCS/LCO in Q2 2021/22

3.25 Work continued during this quarter to align identified themes from complaints to the MFT What Matters to Me (WMTM) categories.

3.26 The themes identified from Q2 2020/21 to Q2, 2021/22 are shown in Table 8 below. In this report, as in the previous reports, Positive Communication and Professional Excellence are noted as the top 2 WMTM themes. Some examples of complaints received relating to Positive Communication and Professional Excellence include:

- a patient receiving poor communication in relation to receiving a date for surgery
- a patient not receiving timely treatment

3.27 Table 8 below shows themes of complaints mapped to MFT WMTM categories, Q2 2020/21 – Q2, 2021/22

WMTM themes	Q2,20/21	Q3,20/21	Q4,20/21	Q1,20/21	Q2,21/22
Positive Communication	78	47	97	196	149
Environment	17	6	8	20	11
Organisational Culture	59	24	44	92	87
Professional Excellence	65	48	78	164	149
Leadership	22	11	10	10	9
Employee Wellbeing	3	0	1	1	0
Grand Total	**244**	**136**	**238**	**483**	**405**

Table 8: Themes of complaints mapped to MFT WMTM cateogories, Q2 2020/21 – Q2, 2021/22

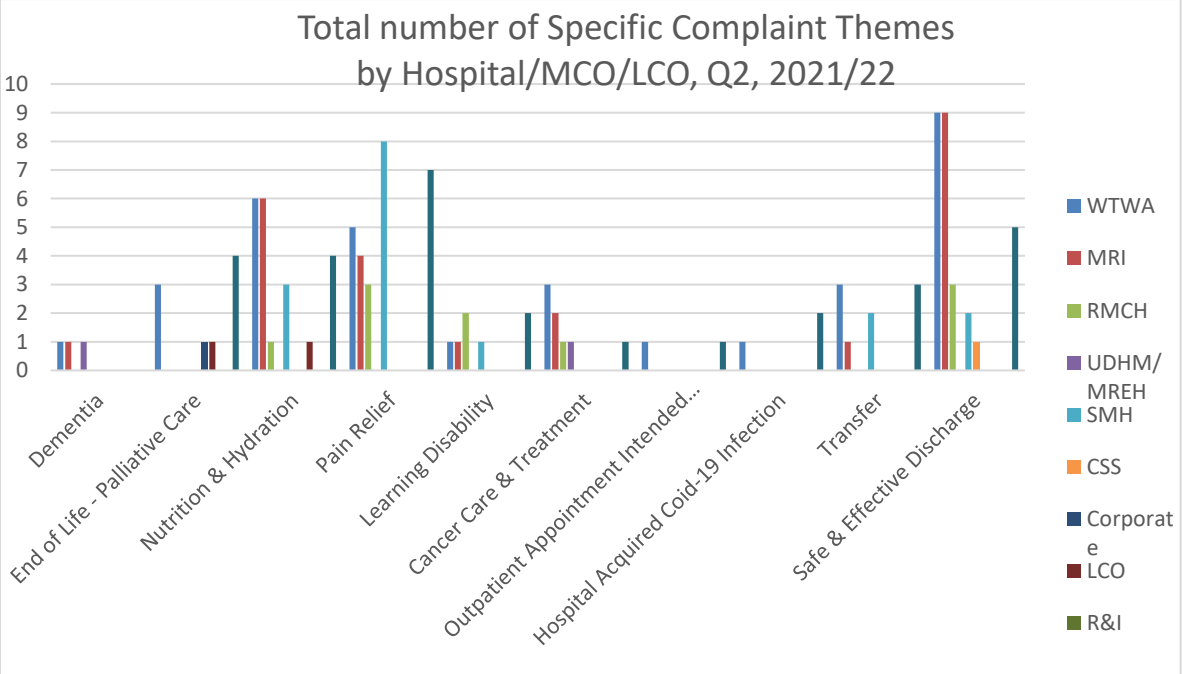
3.28 The themes identified from Q2 2020/21 – Q2, 2021/22 are shown in Table 9 below. This quarter 'Safe and Effective Discharge' was the top category replacing 'Pain Relief'. Further detail is provided in **Table 10**, **Appendix 1** of this report.

Specific themes	Q2,20/21	Q3,20/21	Q4,20/21	Q1,20/21	Q2,21/22
Dementia	1	1	1	2	3
End of Life – Palliative Care	4	4	11	7	10
Nutrition & Hydration	5	5	11	15	21
Pain Relief	7	8	14	32	27
Learning Disability	0	1	2	2	7
Cancer Care & treatment	0	4	5	16	8
Outpatient Appointment intended but not booked after in-patient stay	0	0	0	2	2
Hospital Acquired Covid-19 Infection	0	0	2	2	3
Transfer	0	0	1	1	9
Safe & Effective Discharge	0	0	3	13	29
Grand Total	**17**	**23**	**50**	**92**	**119**

Table 9: Total number of New Complaints by specific themes, Q2 2020/21 – Q2, 2021/22

3.29 **Graph 7** below shows the themes identified from complaints received in Q2 2021/22. WTWA and MRI received the most complaints relating to 'Safe and Effective Discharge'. Some examples of complaints received relating to 'Safe and Effective Discharge' include:

- a patient not being provided with pain relief or wound care within the community.
- a patient not being provided with the appropriate equipment prior to discharge



Graph 7: Total number of Specific Complaint Themes by Hospital/MCO/LCO, Q2 2021/22

3.30 Understanding the secondary complaint themes in deeper detail continued during Q2. Table 11 below illustrates these themes which tie into the primary themes for Q1 – Q2 2021/22. This quarter 'Unsafe and Ineffective Discharge – Readmission to hospital, Safeguarding concern' was the top secondary specific complaint theme. 'Nutrition and Hydration' is noted as the second top secondary theme.

Complaint themes	Q1,20/21	Q2,20/21
Missed Cancer/Delayed Cancer Diagnosis	2	4
Hospital Acquired Infections	1	6
Unsafe and Ineffective Discharge – readmission to hospital, Safeguarding concern	1	24
Pain Relief	0	6
Nutrition and Hydration	0	10
Lost to Follow up	0	4
Dementia – Safeguarding concern	0	2
Falls	0	3
Lack of Communication	0	2
Loss of Personal Property	0	1
Surgical Error – return to theatre/corrective surgery	0	2
Lack of patient hygiene/Dignity	0	4
Ward Transfers	0	1
Delayed Diagnosis/treatment	0	7
Not Listening to parents / patients / carers	0	5
Undiagnosed fractures	0	3
Waiting Times / Staffing levels	0	1
Injuries sustained whilst an in-patient – pressure sores, leg contracture	0	1
Delay in patient being reviewed/monitored	0	5
Grand Total	**4**	**91**

Table 11: Total number of specific complaint themes, Q1, 2021/22 – Q2, 2021/22

3.31 The Daily and Group Safety Huddles provides the Trust's Risk Management's team and the Hospitals/MCS/LCO with an overview of themes possibly impacting the safety of service users and in turn identifies the specific areas across the Trust where there are hot spots and trends. The Head of Customer Services and/or PALS and Complaints Manager attendance at the Trust's Risk Management's Daily and Group Safety Huddles continues to support this work.

Examples of areas where there is specific action in place include:

- nutrition and hydration collaborative
- re-focus on the dementia care strategy
- development of the Trusts End of Life Care Strategy
- development of the Trusts Cancer Strategy
- safe & effective discharge collaborative
- pain management collaborative

4.0 Care Opinion and NHS Website feedback

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

4.2 All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO. Responses are required for publication within 5 working days. Designated senior staff within each Hospital/MCS/LCO review the comments and provide a response for publication. Table 12 below provides examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q2.

Quarter 2, 2021/22
Royal Manchester Children's Hospital
"Wonderful hospital" We attended the Starlight Day Unit at Wythenshawe Hospital yesterday with our 3-year-old for complex surgery. Absolutely everyone involved in her care were wonderful, everyone went above and beyond to ensure she was happy and comfortable. The Plastics team are just amazing, and I can't thank them enough for what they've done for her. The anaesthetist and play specialist were both angels, so grateful for the care they provided before her surgery and in the anaesthetic room and all the nurses on the ward were out of this world. Thank you so much for providing such good care.
Response
Thank you for your positive comments posted on the NHS Website regarding your daughter's care on Starlight Day Unit at Wythenshawe 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 their hard work and dedication. It is wonderful to read that you felt all the staff involved went above and beyond to ensure she was happy and comfortable. We are glad to hear that she has been treated with such care and compassion, and your comments has reflected the care our teams are delivering. We are sincerely grateful for your feedback and have passed on your thanks and appreciation to the Head of Nursing who will share with all the staff involved.
Clinical Scientific Services – Trafford General Hospital
"1 out of 10 for everything" *I attended a kidney scan and my appointment was 30 minutes late. Thank goodness another patient was sat nearby and asked a passing nurse what was going on as everyone else in the waiting area was seen except for me. When I did finally have my appointment, the nurse did not first apologise for the delay although I arrived on time. I never had a scan before, and she was meant to explain the process but she cared more about getting it out the way and rushed through it. I did ask a question quickly, but she gave a short flippant reply, which made me feel uncomfortable. She made me unwelcome and uncomfortable, if she had honoured my actual appointment time there wouldn't be any issues.*
Response
Please accept our apologies for your unsatisfactory experience while attending Trafford General and for the distress and upset this has caused you. In order for us to investigate your concerns, we will need further details from you so that this can be resolved. We take all issues surrounding patient care very seriously and so please contact our Patient Liaison and Advise Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk
Manchester Royal Infirmary
"Fantastic care" *The staff in Acute Coronary Care were fantastic, great care and attention, Ward 3 was the same, great care. The Pacing team fantastic and my surgery staff in theatre were caring and informative. Only downside is the food it was terrible, apart from that great hospital, better than the North East.*
Response
Thank you for taking the time to share your feedback on the NHS Website regarding your care at Manchester Royal Infirmary in Cardiothoracic Surgery and Ward 3. We are pleased to read that you received great care and your treatment from the Pacing team and surgery staff was fantastic. We are grateful for your feedback and acknowledge your comment regarding the food which has been passed onto our Estates and Facilities Department. We are grateful for your kind words and they will be shared with the Lead Nurse, to pass onto all the staff involved. We wish you all the best in your recovery.
Saint Mary's Hospital
"Fantastic Experience"

Throughout my pregnancy I had a fantastic experience at St. Mary's, especially as a first-time mum it can be a daunting experience, more so given during COVID but I couldn't thank the whole operation at the hospital enough. *All initial appointments were thorough with friendly staff, scans were completed as necessary then further excellent care when I was admitted for induction of labour and whilst giving birth. I stayed for a total of 5 nights between Ward 64, Ward 65 and post-natal ward. My whole birthing experience was amazing, and I was given the utmost care throughout my stay. The team introduced themselves, made me feel comfortable and kept us informed along our journey. From my husband and I thank you to the whole operation at St. Mary's - we really had a great experience and couldn't speak highly enough about it!*
Response
Thank you for your positive comments posted on the NHS website regarding the care you received throughout your pregnancy and during the delivery of your baby in the Maternity 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 midwifery and medical teams practice so it was reassuring to read that you found the midwifery staff caring, and supportive and that your experience throughout the delivery of your baby has been a positive one. I can assure you that we have passed on your feedback to senior members of staff who will be delighted to share your feedback with the staff involved.* *I would like to take this opportunity to wish your family well for the future.*

Table 12: Examples of Care Opinion/ NHS Website Postings and Reponses Q2 2021/22

4.3 This quarter a total of 37 comments were received via the websites, of which 23 (62.0%) were positive. 11 negative comments were received (30.0%). The number of Care Opinion and NHS Website comments by category; positive, negative and mixed, are detailed in **Table 17, Appendix 1**.

5.0 Learning from Complaints

5.1 This section of the report provides examples of improvements made in response to feedback via complaints.

5.2 The Complaints Review Scrutiny Group, chaired by a Non-Executive Director, met twice during Q2 2021/22. The management teams from MRI and LCO each presented a case in July 2021, and SMH and RMCH each presented a case in September 2021. Learning and associate actions identified from the 4 cases were discussed and assurance provided that complaints are investigated, and appropriate action taken when needed. Outcomes from the 4 cases discussed are provided in **Table 18** below.

Hospital/MCS/LCO	Learning	Actions
MRI	We learnt that patient's investigations and outcomes were not communicated effectively which resulted in the patient's lack of understanding of diagnostic and prognostic information	• Routinely copy patients into correspondence • Enhance strategies to confirm patient understanding • Raise awareness/Increase sharing of patient visual communication resources: simple medical diagrams, drawings, pictures
LCO	We learnt that a patient nearing the end of life and their family carers had experienced poor communication	• Process implemented ensuring face to face visits take place in addition to telephone contact with patients and relatives • Introduction of electronic scheduling appointment system ensuring appointments are not missed • Process implemented ensuring face to face appointments/re-assessment needs are under-taken when a family carer

		raises concerns regarding the patient's condition • Participation in of End of Life audits
SMH	We learnt of the risk of TransWarmers being used on extreme preterm infants to maintain their core body temperature	• TransWarmer use and associated risks added to Newborn Services Risk Register • Review of guidelines for assessing fragility of infants backs and consideration to be given regarding the implementation of hourly reviews • Implementation of Nurse Education and Training updates • To ensure wider learning incident shared with other Neonatal services
	We learnt there had been a failure to communicate the infant's injury in a timely manner to the parents	• Discuss with the team the importance of strengthening timely communications with parents • Enhance the handover process
RMCH	We learnt of the impact of the lack of basic nursing interventions undertaken	• Undertake reviews regularly to ensure competence and accurate completion of fluid balance charts • Quality Improvement Project to be initiated in the future
	We learnt that Intussusception had not been considered as a diagnosis in a patient presenting with a normal Early Warning Score (EWS) and rectal bleeding	• With the support of the Medical and Surgical teams develop guidelines on PR bleeding
	We learnt of the failure to listen to parental concerns	• Undertake a study to highlight the importance of recognising parental concerns and the importance of listening to, responding to, and escalating concerns raised by parents • With the support of MRI explore and develop clear processes for joint working and dissemination of shared learning across the whole of MFT • Share widely across all Hospitals/MCS/LCO the learning from the study

Table 18: Actions identified at the Trust Complaints Scrutiny Group during Q2 2021/22

5.3 Detailed below, in **Table 19**, are some examples of how learning from complaints has led to changes that have been applied in practice.

Hospital/ MCS/LCO	Reason for complaint	Action Taken
LCO Trafford Locality	Concerns regarding the length of time waiting to be seen by the Community Neuro Rehabilitation Team (CNRT)	Referral and Waiting List review being undertaken by LCO and Trafford Clinical Commissioning Group. Waiting List initiative agreed to manage the long waits' patients are experiencing.

		CNRT service model review being undertaken.
MRI (GI Medicine & Surgical Specialties)	Delay in a patient's procedure taking place.	Standard Operating Procedure developed guiding staff through the correct process of handling patient's urgent scan results when a consultant has taken unexpected absence.
MRI (Outpatient Clinical Services)	Difficulties booking and obtaining Family Planning Clinic outpatient appointments whilst planning around the patient's work commitments.	In view of the difficulties GP's are experiencing with access and availability of family planning provision issue raised with the Commissioners. Training packages developed by the Sexual Health Service at MFT for GP's resulting in the number of trained specialists in the area.
MREH	Patient spoken to rudely by a staff nurse whilst questioning the delay in administration of her medication.	Concern shared and staff nurse supported in reflecting on the events leading to the complaint. Delayed Discharges Improvement Project to be undertaken by the staff nurse.
UDHM	Concerns raised relating to treatment received, lack of communication, delays and treatment going forwards.	All staff reminded of the importance of providing patients with an explanation relating to the immediate denture process. All undergraduate students to be reminded of the Trust's Visions and Values.
CSS (Imaging)	Concerns regarding COVID and mask exemptions.	Concerns shared and radiographer supported in reflecting on the events leading to the complaint. Departmental process developed for patients who are unable to wear face coverings. All staff reminded of the importance of patient confidentiality. All staff reminded of the importance of keeping patients informed of any delays. Patient's experience to be shared anonymously with the team.
CSS (Imaging)	Poor communication experienced by the patient relating to a student doctor being present at the examination, and lack of information regarding a last-minute decision to change the type of biopsy being taken during the consultation.	Template developed and introduced on the Clinical Record Interactive system (CRIS) to enhance clinician and patient conversation and enable recording of patient's consent. Enhancement of current 'Biopsy Procedures' leaflet to be undertaken with the creation of 2 new patient information leaflets: one for 'Core Cut Biopsies' and one for 'Fine Needle Aspiration Biopsies'.
SMH	Poor dignity and care experienced within the Antenatal Clinic. Body Mass Index (BMI) discrimination and breech of patient confidentiality. Insensitive use of language and focus on weight rather than pregnancy.	Complaint to be shared anonymously with the Midwifery Education Team and included within the multidisciplinary mandatory training. Complaint to be shared and discussed anonymously at the Maternity Voices Partnership (MVP). Consideration to be given to the suggestion of changing the name of the clinic. Increase focus in obtaining patient and visitor feedback in the BMI clinic using "What matters to me"

		A change of Consultant and Matron ensures future antenatal clinic appointments take place in alternative consultant antenatal clinics.
WTWA	Several concerns and complaints received in relation to patient's lost property.	Development and implementation of Ward Matrons Focus Group. Disclaimer Forms Usage Audit undertaken, and repeat audits planned in the future. Review of property categorisation - 'What is Property?'. Review of patient's journey undertaken, and discussions held to enhance documentation process. Poster developed and introduced on the wards.
RMCH	Impact of a safeguarding referral and poor communication with the patient's family.	Consultant supported in reflecting on the events leading to the complaint. 'Safeguarding' Patient Information leaflet to be developed providing information about aspects of the safeguarding procedures. Complaint to be shared and discussed at the Hospital Peer review for wider learning. 'Skeletal Survey Examination' Patient Information leaflet to be developed explaining the outpatient appointment process, and benefits and risks of the radiological examination. Investment in additional radiographer skeletal survey examination training to support the delays and reduce the additional stress to both parents and child caused by the lengthy wait for this examination.

Table 19: Examples of the application of learning from complaints to improve services, Q2 2021/22

6.0 Quality Improvements during Q2 202/21 included

6.1 MFT Concerns and Complaints Policy (2021)

- The MFT Concerns and Complaints Policy (2021) provides a framework for MFT to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) and provides staff with support and assistance in dealing with concerns and complaints. During Q2 the Policy was reviewed, updated, and ratified accordingly.

6.2 On-going implementation of the formal restructure of the Trust's Corporate and Complaints Service

- Setting of SMART Objectives

To provide focus, direction and setting of clear expectations during Q2 with the involvement of the PALS and Complaints Team Leaders clear objectives were drafted and agreed. By properly utilising SMART, clear objectives this will allow the PALS and Complaints Team Leader's to be fully equipped to deliver the best results for our service users. Plans are place to develop, implement and roll out SMART objectives across the wider team throughout 2021/22.

- Dedicated Complaints Triage System

  Through the continued development of a triangulated approach with the Trust's Risk Management's team and the Hospitals/MCSs/LCO with effect from Q2 all complaints received in the Trust are solely triaged by the Head of Customer Services and/or the PALS and Complaints Manager. The dedicated triage system provides a clear overview of all complaints, enhances detection of specific themes possibly impacting on patient safety, as well as identifying specific hot spots, and trends across MFT.

6.3 Internal Complaints Audit Action Plan

- Following the internal audit recommendations during this quarter evidence to support the completion of the action plan was submitted and the Audit Action Plan recorded as completed.

6.4 Internal Audit 2021/22: NMGH Complaints Handling

- In the context of NMGH joining the Trust and following the undertaking of the Internal Complaints Handling Audit in Q3, 2020/21 an internal audit to provide assurance that the Trust's policies and processes for responding to patient complaints at NMGH commenced during Q2. The findings will be reported to the Quality and Safety Committee upon completion of the audit.

6.5 Introduction of Capturing, Learning and Sharing from Complaints Task and Finish Group

- At the Quality and Patient Experience Forum during Q2 the Patient Services Manager and Head of Customer Services commenced their review of existing assurance mechanisms which will directly support work in the enhancement of capturing, learning and sharing from complaints across MFT. In support of this work, members of the Quality and Patient Experience Forum accepted the Patient Services Manager and Head of Customer Services request to participate in their research. A core group of members has been agreed and the newly developed Task and Finish Group are due to meet during Q3. The Task and Finish Group will be accountable to the Quality and Patient Experience Forum.

6.6 In-house E-Learning Customer Service – Module 1, Customer Service - PALS and Complaints package:

- Following its launch in Q1, Module 1 of the Customer Service package has been available to all staff across the Trust via the Learning Hub. Since the launch 427 people have accessed the course, of which 316 have completed the module.

- Work continued in this quarter and will continue during Q3 designing the PALS and Complaints Customer Service Advanced e-learning package. It is anticipated that Module 2 will go live in Q4.

6.6 Equality and Diversity Audit: PALS and Complaints Handling

- Following the implementation of the Equality and Diversity Checklist in Q4, 2020/21 a further audit during this quarter was undertaken to further evaluate the collection of this data.

- The audit involved a review of a sample of 40 PALS and 40 complaint cases and for each case in the sample it was assessed whether equality and diversity data for 'ethnicity', 'religion' 'disability' and 'gender' had been collect or not. The results detailed below are a summary of the 80 cases included.

  Of the 40 PALS cases included:
  - 15 cases identified the complainant's ethnicity
  - 2 cases identified the complainant's religion
  - 1 case identified the complainant's disability status
  - 40 cases identified the complainant's gender

  Of the 40 complaint cases included:
  - 14 cases identified the complainant's ethnicity
  - 10 cases identified the complainant's religion
  - 10 cases identified the complainant's disability status
  - 10 cases identified the complainant's gender

  Whilst good compliance was found in PALS with regards to 'gender' data (100%), the audit found that 'gender' data was collected in only 25.0% of Complaint cases; the audit found that 'ethnicity' data was collected in only 36.25% of the PALS and Complaint cases and overall compared to the previous audit demonstrated a reduction in the data collection for 'ethnicity' (-53.75%), 'religion (-6.25%) and 'disability' (-2.5%).

  All complainants have a right to be informed of their right to support with their 'religion' and/or 'disability' status; however, the audit findings, as identified in the first audit, have acknowledged poor compliance and continued lack of consistency in the collection of this data, despite the introduction of a departmental Equality and Diversity Checklist.

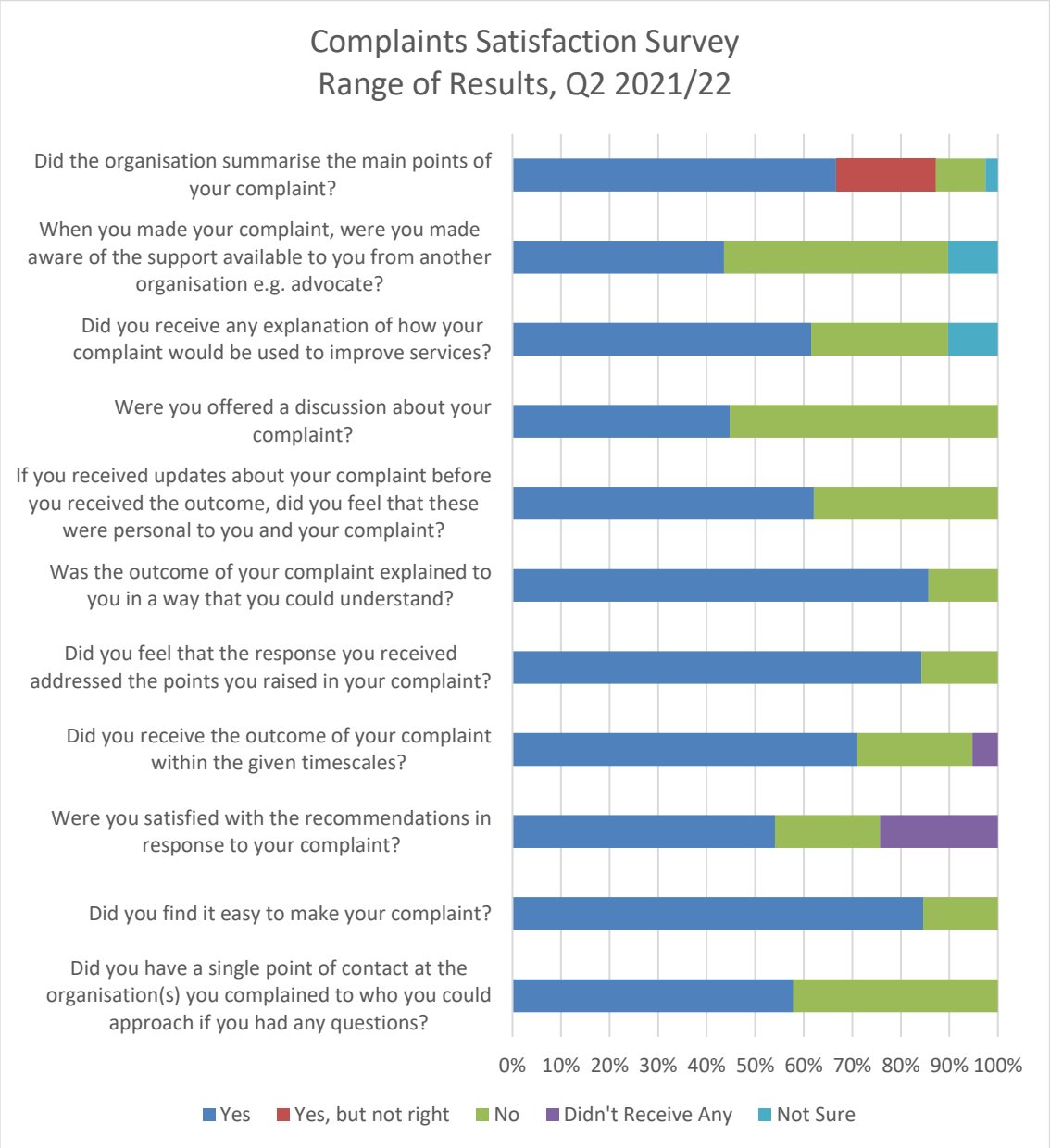
  Opportunities for further improvement will continue during Q3 with the Equality and Monitoring Information being tailored within the SMART objectives. In addition to this, implementation of Ask, Listen, Do is planned for Q3.

  Led by NHS England, Ask, Listen, Do aims to improve the experiences of people with a learning disability, autism or both (and their families and carers) when giving feedback, raising a concern or making a complaint about healthcare, social care or education provision/providers.

A further audit will be also be undertaken during Q4.

7.0 Complainant's Satisfaction Survey

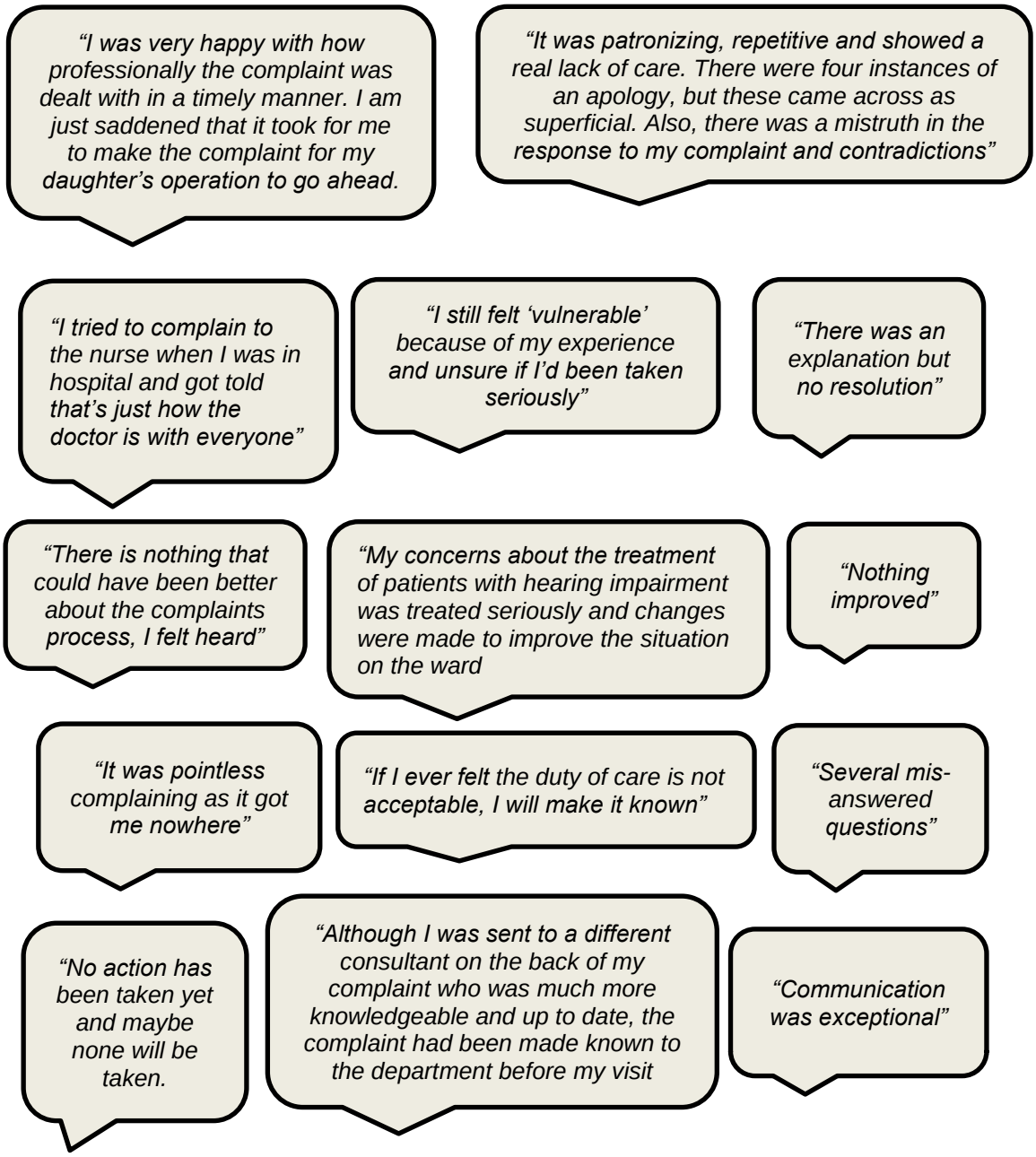
7.1 A satisfaction survey, based on the 'My Expectations'[4] paper, is sent to complainants across all MFT Hospital's/MCS's/LCO's once the complaint is closed. In Q2, 531 surveys were distributed, with 39 questionnaires returned; the results are shown in **Graph 8** below. There is a continued decrease in satisfaction in respect of complainants receiving the outcome of their complaint within the given timescales, which correlates to the noted decrease in achieving the 90% target.



Graph 8: Complaints Satisfaction Survey results for Q2 2021/22

7.2 The following are examples of feedback from provides staff with opportunities to improve the standard of care and service provided. Comments received during Q2 2021/22 include the following:

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



8.0 Planned Improvements

8.1 Several areas for improvement and development have been identified for Q3, including the following activities:

- Implementation of Ask, Listen, Do
- Implementation and embedding of the Affina Team Journey
- Piloting the PHSO's NHS Complaint Standards – Early Adopter Group
- Development of dedicated PALS Volunteer role
- Explore and identify ways to improve customer service through PALS and Complaints telephone system
- Complaint Acknowledgement Quality Assurance
- Actively communicating Complainant Satisfaction Survey feedback

9.0 Equality and Diversity Monitoring Information

9.1 The collection of equality and diversity data is shown in **Table 20,** Appendix 1. As in previous quarters, collection of this information remains inconsistent.

9.2 This quarter, as in previous quarters, good compliance was found with regard to 'gender' data (99.3%). However, the need to improve 'disability', 'religion' and 'ethnicity' has been identified; only 9.4%, 22.6% and 36.1% being received respectively.

9.3 Supported by departmental Equality and Diversity Checklist the Corporate PALS and Complaints team continue to ensure complainants are informed of their right to support with their 'religion' and/or 'disability' status. Findings and actions to undertake from the additional audit measuring the outcome of the checklist will be published in Q4's report.

10.0 Conclusion and recommendations

10.1 This report provides a concise review of matters relating to Complaints and PALS during Q2. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place.

10.2 Members of the Board of Directors are asked to note the content of this Q2 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that MFT is responsive to concerns raised and learns from patient feedback to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of PHSO Cases open as at 30th September 2021

Hospital/ MCS/ LCO	Cases/s	PHSO Investigation Progress
MRI (3)		
Cardiovascular Specialty	1	Awaiting Final Report
GI Medicine & Surgical Specialty	1	Awaiting Provisional Report
Rheumatology Specialist Medicine	1	Awaiting Provision Report
WTWA (3)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Awaiting Provisional Report
Surgery	1	Awaiting Provisional Report
RMCH (1)		
CAMHS	1	Awaiting Provision Report
TOTAL	**7**	

Table 2: Number of Complaints received by Hospital/ MCS / LCO Q1 2020/21 - Q1 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,20/21	Q2, 21/22
WTWA	82	89	101	93	110
MRI	83	77	88	106	80
SMH	46	49	52	58	66
RMCH	33	25	36	43	47
CSS	23	13	21	16	30
UDHM/MREH	8	16	10	22	24
Corporate	9	11	13	17	20
LCO	15	11	6	14	17
NMGH	0	0	0	43	48
Grand Total	**299**	**291**	**327**	**412**	**442**

Table 3: Complaints Acknowledgement Performance

3 Day Target	Q2, 20/21	Q3, 20/21	Q4, 20/21	Q1, 21/22	Q2, 21/22
100% acknowledgement	100%	100%	100%	100%	100%

Table 4: Comparison of complaints resolved by timeframe: Q2 2020/21 – Q2 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22
Resolved in 0-25 days	176	272	240	282	293
Resolved in 26-40 days	20	21	15	24	56
Resolved in 41+ days	49	48	36	39	82

Total resolved	**245**	**341**	**291**	**345**	**431**
Total resolved in timescale	227	325	274	322	378
% Resolved in agreed timescale	**92.7%**	**95.3%**	**94.2%**	**93.3%**	**87.7%**

Table 5: Outcome of Complaints, Q2 2020/21 - Q2 2021/22

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q2,21/22	431	46	278	86	9	9	2	1
Q1,21/22	345	34	238	62	3	6	1	1
Q4,20/21	291	25	185	69	3	8	1	0
Q3,20/21	341	57	189	79	7	7	1	1
Q2,20/21	245	37	144	55	6	2	1	0

Table 6: Re-opened Complaints by Hospital/MCS/LCO Q2 2021/22

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Dissatisfied with response	TOTAL
WTWA	1	3	3	10	17
MRI	1	11	4	15	31
SMH	4	3	0	8	15
CSS	0	0	1	1	2
RMCH	0	1	5	7	13
UDHM/MREH	0	1	0	3	4
Corporate	0	0	0	5	5
LCO	3	0	0	1	4
NMGH	0	0	1	4	5
Grand Total	**9**	**19**	**14**	**54**	**96**

Table 10: Specific themes by Hospital/MCS/LCO, Q2 2020/21 – Q2 2021/22

	WTWA	MRI	SMH	RMCH	CSS	UDHM /MREH	Corp-orate	LCO	NMGH	Total
Dementia	1	1	0	0	0	1	0		0	3
End of Life – Palliative Care	3	0	0	0	0	0	1	1	4	9
Nutrition & Hydration	6	6	3	1	0	0	0	1	4	21
Pain Relief	5	4	8	3	0	0	0	0	7	27
Learning Disability	1	1	1	2	0	0	0	0	2	7
Cancer Care & Treatment	3	2	0	1	0	1	0	0	1	8
Outpatient Apt intended & not booked after in-patient stay	1	0	0	0	0	0	0	0	1	2

Hospital Acquired Covid-19 Infection	1	0	0	0	0	0	0	0	2	3
Transfer	3	1	2	0	0	0	0	0	3	9
Safe & Effective Discharge	9	9	2	3	1	0	0	0	5	29
Grand Total	**33**	**24**	**16**	**10**	**1**	**2**	**1**	**2**	**29**	**118**

Table 13: Number of PALS concerns received by Hospital/ MCS/ LCO Q2 2020/21 – Q2, 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22
WTWA	344	382	390	459	489
MRI	374	439	448	406	469
RMCH	115	128	140	172	145
UDHM/MREH	104	84	128	130	156
SMH	148	203	233	254	254
CSS	100	101	82	123	152
Corporate	50	58	57	62	45
LCO	34	24	14	25	34
R&I	2	3	1	0	2
Nightingale NW (NNW)	0	2	4	0	0
NMGH	0	0	0	203	192
Grand Total	**1271**	**1424**	**1497**	**1834**	**1938**

Table 14: Closure of PALS concerns within timeframe Q2 2020/21 – Q2, 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,20/21	Q2,21/22
Resolved in 0-10 days	1094	1338	1309	1602	1767
Resolved in 11+ days	97	112	152	184	257
% Resolved in 10 working days	**91.9%**	**92.3%**	**89.6%**	**89.7%**	**87.3%**

Table 15: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Q2 2020/21 – Q2, 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22
WTWA	25	17	27	33	56
MRI	32	42	45	37	73
RMCH	5	7	16	20	18
UDHM/MREH	5	7	5	15	14
SMH	16	22	38	31	41
CSS	3	9	9	10	14
Corporate	5	7	6	21	10
LCO	6	1	5	2	6

R&I	0	0	0	0	0
NNW	0	0	1	0	0
NMGH	0	0	0	15	25
Grand Total	**97**	**112**	**152**	**184**	**257**

Table 16: Number of PALS concerns escalated to formal investigation Q2 2020/21 – Q2 2021/22

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22
No of cases escalated	8	10	17	20	24

Table 17: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q2 2021/22

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q2 21/22			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	**6**	**4**	**2**
WTWA	**10**	**0**	**0**
CSS	**0**	**1**	**0**
Corporate	**0**	**1**	**1**
UHDM/MREH	**0**	**0**	**0**
LCO	**0**	**0**	**0**
RMCH	**1**	**0**	**0**
SMH	**4**	**4**	**0**
NMGH	**2**	**1**	**0**
Grand Total	**23 (62.0%)**	**11 (30.0%)**	**3 (08.0%)**

Table 20: Equality and Diversity Monitoring Information

	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22
Disability					
Yes	21	12	13	26	28
No	6	8	9	8	12
Not Disclosed	272	271	305	373	402
Total	**299**	**291**	**327**	**412**	**442**
Disability Type					
Learning Difficulty/Disability	1	0	1	0	1
Long-Standing Illness or Health Condition	10	15	18	16	19
Mental Health Condition	0	5	3	6	5
No Disability	0	0	0	0	0
Other Disability	2	0	3	5	4
Physical Disability	4	3	2	1	5
Sensory Impairment	1	2	1	2	2

Not Disclosed	281	265	299	382	406
Total	**299**	**291**	**327**	**412**	**442**
Gender					
Man (Inc Trans Man)	123	115	133	147	169
Woman (Inc Trans Woman)	172	168	190	255	270
Non-Binary	0	0	0	0	0
Other Gender	0	1	0	0	1
Not Specified	4	7	4	9	2
Not Disclosed	0	0	0	1	0
Total	**299**	**291**	**327**	**412**	**442**
Sexual Orientation					
Heterosexual	65	64	92	75	96
Lesbian / Gay/Bi-sexual	2	2	4	4	4
Other	0	0	0	0	0
Do not wish to answer	2	0	5	3	3
Not disclosed	230	225	226	330	339
Total	**299**	**291**	**327**	**412**	**442**
Religion/Belief					
Buddhist	0	0	1	0	0
Christianity (All Denominations)	39	36	40	48	51
Do Not Wish to Answer	3	3	1	0	4
Muslim	1	3	6	5	8
No Religion	24	18	13	25	38
Other	1	2	0	0	1
Sikh	1	0	0	1	0
Jewish	0	2	0	3	1
Hindu	0	1	1	0	0
Not disclosed	228	234	240	330	338
Humanism	1	1	1	0	0
Paganism	1	0	0	0	1
Total	**299**	**291**	**327**	**412**	**442**
Ethnic Group					
Asian Or Asian British - Bangladeshi	0	1	1	1	1
Asian Or Asian British - Indian	4	4	6	6	2
Asian Or Asian British - Other Asian	2	2	0	3	7
Asian Or Asian British - Pakistani	9	6	17	3	10
Black or Black British – Black African	2	4	5	6	3
Black or Black British – Black Caribbean	5	2	3	0	2
Black or Black British – other Black	0	1	1	1	0
Chinese Or Other Ethnic Group - Chinese	1	1	1	0	1
Mixed - Other Mixed	0	5	3	0	2

Mixed - White & Asian	1	2	1	2	0
Mixed - White and Black African	1	0	1	0	1
Mixed - White and Black Caribbean	2	1	3	1	1
Not Stated	48	54	58	79	92
Other Ethnic Category - Other Ethnic	2	2	4	5	2
White - British	121	117	147	160	145
White - Irish	3	7	3	5	9
White - Other White	11	5	4	2	4
Not disclosed	87	77	69	138	160
Total	**299**	**291**	**327**	**412**	**442**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Mrs Alison Haughton, Acting CEO, Saint Mary's Managed Clinical Service (SM MCS) Dr Sarah Vause Medical Director SM MCS Mrs Kathryn Murphy, Director of Nursing and Midwifery, SM MCS
Date of paper:	November 2021
Subject:	Maternity Services Assurance Report (incorporating the Ockenden Report assurance framework)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support✓ • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation and teaching To improve patient safety, clinical quality and outcomes To improve the experience of patients, carers and their families
Recommendations:	The Board of Directors is asked to note the information provided within the report and the assurance provided in respect of Saint Mary's Managed Clinical Services Maternity Services, including the action plan for compliance against the Ockenden Report
Contact:	Name: Alison Haughton, Acting CEO, SM MCS Tel: 0161 701 0909

1. Purpose of paper

1.1. To provide assurance to the Board of Directors on matters relating to maternity services. The paper includes information on patient safety, patient experience and engagement, and workforce within maternity services. An update is also provided in respect of the Ockenden Report[1], and the NHS England and Improvement (NHSE&I) maternity self-assessment tool submission.

2. Background

2.1. During Q1 and Q2,8348 babies have been born at Saint Mary's Managed Clinical Services (SM MCS), an increase on the same time last year. To ensure safety within maternity services, SM MCS have well established governance processes underpinned by the core principles good safety standards.

2.2. These core principles also underpin the implementation of the NHS Patient Safety Strategy (2019) of a just culture, openness and transparency and continuous improvement form the golden thread that underpins the national vision for maternity and neonatal safety through the Maternity Transformation Programme[2].

2.3. The core principles aim to:

- improve outcomes for women, their babies and families as set out in Better Births; Improving outcomes of maternity services in England (2016)[3],
- to reduce the rate of stillbirths, maternal and neonatal deaths by 50% by 2025 and neonatal brain injuries occurring during or soon after birth by 2030.

2.4. Each of the workstreams of the national Maternity Transformation Programme underpin the key safety improvement drivers of the NHS Patient Safety Strategy[4];

- **Insight:** Review of routinely collected data along with standards and development of high-quality reviews and investigations to drive improvements in care
- **Involvement:** development of the safety culture within the workforce
- **Improvement:** delivery of harm reduction programmes to improve the safety of maternity services

2.5. Donna Ockenden's first report (the Ockenden Report): Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust[5], was published on 11th December 2020.

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[1] Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES at the Shrewsbury and Telford Hospital NHS Trust. December 2020
[2] https://www.england.nhs.uk/mat-transformation/
[3] https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/
[4] NHS Patient Safety Strategy. Safer culture, safer systems, safe patients. July 2019
[5] Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES at the Shrewsbury and Telford Hospital NHS Trust. December 2020

2.6. The Ockenden Report was shortly followed by the publication of an assessment and assurance tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of effective implementation to their boards, Local Maternity System (LNS) and NHS England and NHS Improvement (NHSE&I) regional teams through the national maternity self-assessment tool[6].

2.7. Saint Marys Managed Clinical Service (SM MCS) completed the assessment and assurance tool for services provided at MFT, which was reported to the Board of Directors in January 2021, and to NHS England through the Greater Manchester and East Cheshire Local Maternity System (GMEC LMS) on 15th February 2021.

2.8. The Board of Directors have received updates in March and May 2021. Further extensive submission of evidence related to areas of compliance was submitted to the GMEC LMS on 30th June 2021.

2.9. In response to the Ockenden report, 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 clinical concerns at each level from the Obstetric Division across the MCS to the Board of Directors.

2.10. This is intended to create a maternity safety infrastructure which links the Maternity Services 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

2.11. A summary of the action plan is attached to this paper at Appendix 1; the further detailed action plan is also attached at Appendix 2.

3. Patient Safety

3.1. Saint Mary's Managed Clinical Service has four main governance processes by which assurance in respect of Patient Safety is obtained. These are:

- incident management systems and processes,
- an embedded incident practice review forum (PRF) process
- Board Maternity Safety Champions
- locally embedded assurance oversight framework (AOF).

[6] NHSE&I Maternity Services system learning. Maternity self-assessment tool. V6 July 2021

3.2. Each of these is further described below.

Incident Management

- SM MCS adhere to the Trust Incident Reporting and Investigation Policy. A monthly summary of all clinical incidents is reported through the governance processes in place at SM MCS, the Obstetric Quality & Safety Committee, and the Saint Mary's Quality & Safety Committee.
- These committees receive information on incident severity, particularly where moderate harm or above has occurred, when emerging themes can be identified. Any maternity cases that require reporting to the Healthcare Safety Investigation Branch (HSIB) are also reviewed through the governance processes described.
- In Q1 and Q2 2021-2002, 3337 incidents have been reported across maternity services at Wythenshawe Hospital, Oxford Road Campus and North Manchester General Hospital). Of these:

  - 94% were **no harm** incidents,
  - 5% were **slight harm** incidents,
  - 0.02% were **major** incidents, and
  - 0.08% were reported as **catastrophic** incidents.

- In total, 13 cases were reported in the moderate, major, or catastrophic harm category.
- All incidents have been subject to a high impact learning assessment; with 4 cases reported via the Strategic Executive Information System (StEIS) and 3 cases reported to HSIB.
- The high impact learning assessments have led to the following actions:

  - A review of MDT staffing in maternity triage
  - Ensuring educational updates and staff training in triage assessment processes
  - Revised consultant led MDT ward round
  - An amended referral pathway for complex women into the pre-term birth clinic

- In addition, a duty of candour has been undertaken for each case and families given the opportunity to discuss events and raise concerns. All 13 families have had the opportunity to discuss the incident with the appropriate teams, with no additional concerns raised.

Embedded Practice Review Forum Process

- The Practice Review Forum (PRF) is well established across all three MCS sites and is valued as a process by which risk is identified, and mitigated by implementing immediate actions following incident review, or where local concerns about care provision are identified.
- Reviews are undertaken by multidisciplinary clinical teams who are independent of the initial care providers, who confirm appropriateness of the care provided and actions required to mitigate risks to improve care and outcomes.
- Any clinical incident with an initial severity of 3 or above is reviewed within 72 hours of occurrence, thus supporting early feedback to women and their families, and supporting psychological wellbeing of staff.

- During Q1 and Q2 2021-2022, a total of 180 reviews have taken place which includes all at severity 3 and above.
- 78% of incidents with an initial severity of 3 and above have been completed within the timeframe of 72 hours against a target of 100%.
- To support an increase in compliance to the agreed target, SM MCS have implemented a cross site PRF model, between ORC and Wythenshawe to support improvement, with the expectation to be fully compliant and inclusive of NMGH by April 2022.
- The MCS' at Oxford Road Campus and Wythenshawe Hospital share the same governance structure. Accordingly, assurance is monitored via the obstetric Assurance Oversight Framework (AOF) which is reported through the Obstetric Quality & Safety Committee to the SM Quality & Safety Committee as previously described.
- The practice reviews have identified four main themes for focussed improvement work:

  - Transfer of women from the antenatal ward to delivery unit for the second stage of the induction of labour pathway
  - Initial assessment of women when attending maternity triage
  - Escalation and review when maternal and/or fetal observations are abnormal
  - Accurate completion of fluid balance chart and monitoring

- Examples of learning and examples of actions taken are described below:

  - Patient flow and waiting times for transfer for ongoing induction of labour, which are intrinsically linked, are monitored throughout every day by the maternity bleep holder. Monitoring by the bleep holder provides a holistic oversight of the status of the maternity unit and supports escalation as required.
  - Maternity Unit Status (SITREP) reports, including the number of women delayed more than 48 hours for induction of labour, are received electronically three times daily by the senior midwifery and obstetric team, the SM MCS senior leadership team and the Group Chief Nurse. This SITREP provides oversight of the status of the maternity unit during each shift to senior leadership for information and escalation.
  - Daily consultant review of the list of women awaiting transfer to the delivery unit is in place. This review is to clinically assess and prioritise risk status for all women on the list.
  - A daily capacity meeting has been implemented to support activity across SM MCS.
  - Wherever possible, an offer of transfer to an alternative maternity unit is given to women waiting more than 48 hours for transfer to the delivery unit. This is dependent on capacity within other maternity units across GMEC to provide support to SM MCS. This is an informally agreed process currently but work is ongoing with the GM SCN and Safety Group to Group to generate an SOP to support more formal arrangements between providers .
  - A quality improvement project has commenced led by the Acute Care Midwife to improve knowledge, understanding and management of fluid balance
  - Education programme to improve recognition and management and escalation of abnormal maternal observations.
  - Ongoing education by cardiotachograph (CTG) champions to share lessons learned and improve knowledge and understanding of fetal physiology when reviewing CTG.

- Staffing levels; the workforce section of this paper describes the current position in relation to midwifery staffing including shortages and recruitment activity.
- It is expected that SM MCS will be able to report an improved position against induction of labour delays once there is resolution of workforce challenges currently faced.

3.3. Saint Mary's MCS existing risk (MFT/00219, Staffing & Capacity) remains at a score of level 15. This is currently driven by the midwifery staffing pressures which continue to impact on patient flow

3.4. The risk and its actions are monitored monthly at SM MCS Quality & Safety committee & SM MCS Risk committee and at the MFT Risk Oversight committee.

3.5. To provide further assurance, SM MCS implemented an agreed audit plan, that includes:

- Audit of use of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) which was developed to better see and treat women who attend hospital with concerns.
- The BSOTS audit was completed in July and showed an improvement from 59% to 74% (combined performance between ORC and Wythenshawe) in the number of women being reviewed within 15 minutes of arrival at Maternity Triage. There is a plan to reaudit in January 2022.
- Sepsis audits – these are undertaken each month and have shown improvements with fluid balance management and timely review of abnormal observations.

3.6. All practice review documentation is uploaded to the Trust electronic incident reporting system and used to ensure that the outcome of reviews can be shared with the appropriate teams.

3.7. Lessons learned are shared across SM MCS and, where appropriate with other clinical services across the Trust.

3.8. In addition, all Practice Review documents are reviewed and discussed at the weekly Divisional Governance Team Safety Huddle, providing an opportunity to ensure appropriate actions are agreed and lessons learnt have been shared.

3.9. A maternity oversight dashboard is being developed to help identify areas of good practice and areas of improvement in real time. In the interim period, the SM in-house scorecard has been developed to provide an overview of perinatal clinical quality and high-level incidents. The in-house scorecard is included at Appendix 3.

Board level Maternity Safety Champions

3.10. The Trust has two executive (Group Chief Nurse and Joint Medical Director) and one non-executive Maternity Board Safety Champions.

3.11. The role of the safety champions is to strengthen Board oversight and assurance of effective perinatal clinical quality. Recent activities of the maternity safety champions are highlighted below:

- In line with the SM MCS endorsed Perinatal Clinical Quality Surveillance Model (approved by MFT Board in July 21), the MFT Board Safety Champion (Group Chief Nurse) attended the SM Quality & Safety Committee in September and October 2021.
- The Medical Board Safety Champion meets with Obstetrics, Neonatal and SM MCS Safety Champions every two months.
- The Non-Executive Board Safety Champion has undertaken a walkaround at Oxford Road Campus in September 2021 and walkarounds are planned for Wythenshawe Hospital and North Manchester General Hospital.

3.12. The Board Safety Maternity Champions will have visibility of the maternity oversight dashboard, which as described is under development as part of the introduction of Epic and the Hive programme, it is due to be fully implemented in September 2022.

Assurance Oversight Framework (AOF)

3.13. An Assurance Oversight Framework (AOF) is in place. It was developed locally and includes 13 metrics selected by the Obstetric Division as important indicators of safety with an associated scoring range of between 1 and 6. (1 being lowest and therefore safest position and 6 being the highest). The AOF is part of the governance framework and reports through to SM Quality and Safety Committee.

3.14. The current (September 2021) overall score for all metrics is Level 3, a decrease from the previously consistent monthly score of 2. The slight deterioration in score relates to:

- Inclusion of a newly agreed metric relating to induction of labour
- One Level 4 harm incident
- Timeliness of validation of incidents

3.15. Work has been undertaken throughout September and October to achieve required improvements. Examples include improved recruitment and retention rates in respect of midwifery staff and the consequential positive impact on patient flow.

3.16. The maternity service at North Manchester General Hospital is in the process of developing governance processes to fully align with monitoring via the AOF through to SM MCS Quality and Safety Committee. The timeline for implementation across all 3 areas is April 2022.

4. Patient Experience

4.1. Patient experience is monitored using information derived from compliments, concerns through incidents, complaints, patient engagement and the national maternity survey.

Compliments

4.2. Saint Mary's Managed Clinical Service maternity services have received 14 formal compliments during Q1 and Q2 20210-2022, in addition to the many informal compliments received through cards delivered at ward and department level.

4.3. The key messages received through the compliments relate to kindness and support that patients and relatives reported they experienced. Description of how small acts of kindness make a huge difference was highlighted, as was satisfaction in respect of continuity of midwives and being listened to by staff.

4.4. Compliments are shared with any named individual members and all other staff members at core huddles and through divisional meetings.

4.5. Compliments are also used to inform patient stories which feature at the start of several SMMCS governance meetings.

Complaints

4.6. During Q1 and Q2 2021-22 51 formal complaints have been received.

4.7. The top key themes identified include communication and staff attitude. Actions taken to improve include:

- Sharing patient stories through core huddles to highlight the importance of good communication and the impact on individual patient experience.
- Where an individual member of staff has been identified, a reflective discussion with line managers or educational supervisors takes place and in some cases personal written reflections are undertaken to support medical staff and midwives as part of their revalidation process.

Patient Engagement

4.8. Patient and public engagement and involvement includes patients, family members, carers and the public in the various aspects of work to help develop and improve the services offered in a meaningful and informed manner. The importance of patient and public engagement in has been emphasised in the findings of many key reports, including the Ockenden Report, 2020.

4.9. Saint Mary's MCS maternity services have embraced the notion that patient involvement in the development of services, as well as their own individual care, is key to making sustained improvements in safety.

4.10. The maternity teams have worked with Manchester Health & Care Commission (MHCC) in the development of a dedicated Maternity Voices Partnership (MVP) for each site.

4.11. MVP is an NHS working group; a team of women and their families, commissioners, and providers (midwives and doctors) who work together to review and contribute to the development of local maternity care.

4.12. Both nationally and locally, MVP's support co-production of maternity and neonatal services with service users.

4.13. The Chairs of each partnership work collaboratively between SMMCS sites, and with MVPs from the wider GMEC LMS.

4.14. Patient and family feedback is provided at site specific monthly meetings. In addition, there is a quarterly combined MVP meeting across SMMCS, attended by Heads of Midwifery, where themes from women's feedback is presented and discussed.

4.15. A survey of women in relation to their experience of induction of labour has recently been undertaken, once the report is finalised it will be shared with the SMMCS and reported to the Board of Directors at a future meeting.

4.16. The Trust 'What Matters to Me' approach is undertaken at ward level in all three maternity units. Patient feedback is also gathered through Quality Care Round processes, where patients directly report their experience in real time.

National Maternity Survey

4.17. The national maternity survey is undertaken annually by Picker Institute for MFT and considers all aspects of maternity care for women who have given birth in February of the year under review.

4.18. The 2021 Maternity Survey initial results have been received during the week commencing 18th October 2021, with high level findings demonstrating that women reported feeling that they were treated with respect and dignity during their labour and birth, and that they had confidence and trust in the staff caring for them.

4.19. Results of all the surveys (once all are received) will be reviewed and triangulated with other methods of receiving patient experience information, trends spotted in practice, and themes from incidents and outcomes.

4.20. It is this triangulation, pivotal to improving safety, that will inform an overarching action plan for SM MCS. The action plan will be reported via the Obstetric Quality and Safety Committee and to SM Quality and Safety Committee, and findings reported to the Board of Directors in January 2021.

5. Workforce within Maternity Services

5.1. The Birthrate Plus®[7] (BR+) workforce planning methodology is a safe staffing toolkit that supports the majority of the components in the NICE guideline on safe midwifery staffing for maternity settings[8]. SM MCS undertook the midwifery workforce review using the BR+ tool. The report was received SM MCS in January 2021.

[7] https://birthrateplus.co.uk/
[8] NICE guideline NG4 Safe midwifery staffing for maternity settings. 17 February 2015

5.2. The report identified a registered midwifery staffing gap of **17 WTE** across SM MCS. SM MCS has been supported to increase the midwifery staffing establishment in line with the recommendations of the BR+ report through direct investment from NHSE&I to reduce variation in experience and outcomes for women and their families across England following the Ockenden Report.

5.3. On 8th April 2021, the Trust received notification from the Chief Nursing Officer, Chief Midwifery Officer and National Clinical Director for Maternity and Women's Health that submissions could be made to support meeting BR+ recommendations for midwifery workforce, and training and development requirements.

5.4. SM MCS submitted a successful financial submission bid on 26th April 2021 via the GMEC LMS (as per point 5.2 of this report above). The submissions were expected to cover gaps against midwifery workforce establishments, medical workforce establishment and multi-disciplinary team (MDT) training

5.5. The midwifery establishment, inclusive of the revised baseline following the BR+ findings is **711WTE** across the 3 maternity units

Recruitment activity

5.6. SM MCS made guaranteed offers of employment to 56 3rd year student midwives from local Higher Education Institutes (HEIs) in September 2021. These students, once qualified will transition to the NMC register.

5.7. A modified recruitment campaign has taken place aimed at attracting newly qualified midwives from outside GM, along with experienced Band 6 midwives to SM MCS.

5.8. In total, SM MCS made 82.4 WTE overall offers of employment of which 76 were accepted, over 40 new starters commenced in post during September and October, other start dates are in place up to January 2022.

5.9. Working closely with the Corporate Director of Nursing, Workforce and Education, the Director of Nursing and Midwifery has overseen the recruitment of 8 international midwives, who will be welcome to SM MCS in June 2022.

5.10. In order to address the remaining vacancy factor of 23 WTE, active recruitment processes have re-commenced.

Temporary staffing

5.11. To mitigate the impact of absence due to sickness, and maternity leave, temporary staff from NHS Professionals are utilised to support staffing levels.

5.12. During October 2021, the registered midwifery workforce is being further augmented using agency staff.

Retention

5.13. Retention of qualified midwives is nationally recognised as an issue, currently **8.5 WTE** midwives leave MFT each month.

5.14. In October 2021, to support maternity providers in their retention of midwives, one year non-recurrent funding of £150,000 has been received by SM MCS from NHSE&I (see point 5.2 above).

5.15. The funding has provided an opportunity to develop specific posts to support, complement and enhance retention plans. It is anticipated the post-holders will provide individualised support in clinical environments for students and newly qualified midwives in the early stages of their career. Recruitment is planned to commence in November 2021.

5.16. Medical staffing in maternity services also face pressures at both consultant and junior grades. At consultant level, 3 locum consultants are employed on a temporary basis in established posts, with 2 substantive appointments planned in February 2022.

6. The Ockenden Report: an update

6.1. The SM MCS Ockenden responsive plan includes 83 actions against the 7 Immediate and Essential Actions (IEAS) of which 18 currently remain open.

6.2. Of the 7 IEAs, good progress has been made against all or the associated actions, with one IEA fully completed.

6.3. The last action is due to close on 31st December 2021.

6.4. Progress and continuous review of the actions is monitored through the SM Quality and Safety Committee. The SM Quality Committee have recently extended 8 actions to allow inclusion of:

- education for staff prior to implementing the revised Saint Mary's hand-held records,
- identification of alternative sources of funding, and
- to enable richer analysis of quarterly audits

7. Maternity Self-Assessment Tool

7.1. The maternity safety self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

7.2. The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

7.3. SM MCS submitted evidence via the Future NHS Collaborative Platform for review by the Clinical Support Unit, Regional Maternity Transformation Programme. A draft report has now been returned for further review and additional evidence submission, prior to meeting with the regional teams toward the end of October 2021. This report and evidence submission forms part of Phase 2 of the Ockenden Report, with final reports presented at:

- Provider level
- LMS level
- Regional level

8. Recommendations

8.1. This paper provides assurance on a range of topics related to maternity safety, including:

- Patient safety, incorporating clinical incident management processes
- Board level maternity champions activity
- Patient engagement
- Workforce challenges and actions taken
- Update to the Ockenden Report and the Maternity self-assessment tool

8.2. The report describes the focussed work to reduce and mitigate safety concerns in the context of increased activity, acuity, and staffing challenges.

8.3. The Board of Directors is asked to note the information provided within this report and the assurance provided in respect of Saint Mary's Managed Clinical Services Maternity Services, including the action plan for compliance against the Ockenden Report

Appendices

Appendix 1: Ockenden action plan summary

Essential Action	Status	Monthly update	Timescale for completion
IEA1: Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	In progress	1 action open Compliant with CNST MSDS V2 submissions and awaiting confirmation from IT that there is full compliance with the Information Standard Notice MSDS v2.0 ECB1513 and 10/218	31/10/2021
IEA2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.	In progress	Awaiting information from national team re the Senior Independent Advocate Role. NED undertaking safety walk arounds	31/12/2021
IEA3: Staff training and working together: Staff who work together must train together.	In progress	Awaiting implementation of the LMS process to ensure compliance with training. Draft proposal developed and circulated by the LMS	30/11/2021 Date extended as awaiting LMS process to be agreed and implemented.
IEA4: Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	In progress	Saint Mary's handheld records have been developed to enable a consistent approach to the accurate documentation of the named consultant for women with complex pregnancies across the MCS. Education to be provided to staff across the MCS	30/11/2021 Date extended to support the implementation of the redesigned handheld records across three sites with education for staff re the changes in documentation
IEA5: Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	Completed		Closed
IEA6: Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	In progress	Education programme in place with lessons learnt shared Bid for Ockenden funding was unsuccessful and alternative sources of funding are to be explored.	31/12/2021

Essential Action	Status	Monthly update	Timescale for completion
IEA7: Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	In progress	Updated Saint Mary's website implemented with support from the Maternity Voices Partnership. Developing proformas to support shared- decision making process and consistent information to women in specified clinical situations e.g. maternal choice Caesarean Section and Induction of Labour	31/12/2021
Maternity Workforce Requirements	In progress	Commissioner meetings ongoing re; funding to support long term services related to SBL V2	31/12/2021
NICE Guidelines	Completed	Process aligned across the MCS	Closed

Appendix 2: Detailed Ockenden action plan

Recommendation	Action	Lead	Due date	Update
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Improve compliance with the SMH Maternity Services Data Set submissions relating to outcomes of care	MFT Informatics Data Quality Manager	**Closed**	**Completed**
	Review the internal review processes once the external HSIB review processes are embedded and decide on whether to continue with the dual review process of babies with poor outcomes	Governance Leads	**Closed**	**Completed**
	Develop a process for sharing learning identified through the LMS Safety SIG and developing actions to improve care	Governance Leads	**Closed**	**Completed**
	Strengthen the reporting process to ensure details re maternity SI's are reported to the Group Board and included in Group Board minutes	Group Associate Director for Clinical Governance and Governance Leads	**Closed**	**Completed**
	Implement a process whereby the small group of cases of term babies with neonatal brain injury (declined by HSIB) are referred to the LMS for external opinion.	Governance Leads and LMS Safety Lead	**Closed**	**Completed**
	Develop a process with the LMS to ensure an external review of eligible Perinatal Mortality Review Tool (PMRT) cases	PMRT Leads	**Closed**	**Completed**
	Review the MBRRACE-UK (Dec 2020) Saving Lives, Improving Mothers' Care Report and develop an action plan to ensure compliance	Clinical Head of Division	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	Ensure full compliance with Information Standard Notice MSDS v2.0 ECB1513 and 10/218	MFT Head of Data Services	31/10/2021	In progress Awaiting the development of the IT solution to ensure full compliance with the ISN including the explicit requirement about diagnostics. Compliant with MSDS V2 submissions (including North Manchester) for CNST Maternity Incentive Scheme.
	NMGH Action: Create Perinatal Mortality Review report to be submitted and discussed at LMS Safety Special interest Group and also at directorate update.	Governance Leads and LMS Safety Lead	**Closed**	**Completed**
	NMGH Action: Define process following transaction regarding how data is submitted and reviewed within Saint Mary's MCS	HOM/ Digital Midwife	**Closed**	**Completed**
	NMGH Action: Put process in place to ensure learning from any review is shared with whole maternity team	Governance Lead	**Closed**	**Completed**
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their	Appoint an Independent Senior Advocate and agree the pathway once the role expectations have been confirmed by NHSE	TBC	TBC	

Recommendation	Action	Lead	Due date	Update
voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Strengthen the relationship with the Non-Executive Director and agree reporting processes	SMH MCS Safety Champions	**Closed**	**Completed**
	Encourage greater involvement, integration and oversight of safety activities by the NED	SMH MCS Safety Champions	31/12/2021	In progress
	Explore further social media opportunities for wider engagement	Consultant Midwife	**Closed**	**Completed**
	Meet with MVP's to support role development and expectations including objectives and actions in partnership with the CCG as hosts	Heads of Midwifery	**Closed**	**Completed**
	Ensure that there is MVP involvement in transformation workstreams and service development.	Heads of Midwifery	**Closed**	**Completed** and ongoing
	Support the MVP to work closely with the Senior Independent Advocate to improve services and safety	Safety Champions	TBC	
	Continue to work with the local communities e.g. Caribbean and African Health Network (CAHN), Jewish community.	Consultant Midwife	**Closed**	**Completed** ongoing

Recommendation	Action	Lead	Due date	Update
	Expand the community engagement with other minority groups.	Refugee and Asylum seeker Midwife/MVP	31/12/2021	In progress
	Consider the role of the independent advocate in the complaints process to support families.	MFT Head of Nursing Patient Experience	TBC	
	Consider increasing meetings of the scrutiny panel for maternity complaints	MFT Head of Nursing Patient Experience	**Closed**	**Completed**
	Develop a more robust process for the dissemination of learning from debriefs with women and families	Consultant Midwife/SMH Patient Experience Lead	**Closed**	**Completed**
	Consider sharing improvements made with MVP at regular events	SMH Patient Experience Lead	**Closed**	**Completed**
	NMGH Action: To support the implementation of the MFT Ward Accreditation process as part of the PTIP	Matrons	**Closed**	**Completed**
Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times	Work in partnership with the GMEC LMS to support their process for validation of education and training 3 times per year and implement a local process to ensure compliance	Education Leads/ LMS	30/11/2021 Date extended as awaiting the process for providing assurance to the LMS 3 times per year to be ratified.	In progress Draft process developed by LMS
	Undertake a spot check audit of the consultant led ward rounds	Matrons	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Share the findings of the spot check audits of the consultant led ward rounds via site Obstetric Quality and Safety meetings (SOQS).	Governance Lead and Audit Lead	**Closed**	**Completed**
	Include the audit of consultant led ward rounds within the obstetric audit plan and share the audit reports via the Site Obstetric Quality and Safety Committee meetings.	Audit Lead	**Closed**	**Completed**
	Work with GMEC SCN to develop an agreed system definition for consultant led wards ward round and minimum standards to use across all maternity units	Site Lead Consultant Obstetrician	**Closed**	**Completed**
	Embed the ward round process for SMH at Wythenshawe team following the change in consultant presence in 2021.	Site Obstetric Lead	**Closed**	**Completed**
	NMGH Action: To review the Training Needs analysis following the Transaction as part of the Post Transaction Implementation Plan	Education Leads	**Closed**	**Completed**
	NMGH Action: align to SMH MCS development and evaluation of education programme.	Education Leads	**Closed**	**Completed**
	INMGH Action: Implement regular audit programme of Consultant Ward Rounds and include the audit of consultant led ward rounds within the QPCEC/ SMH QSC report.	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**
	NMGH Action: Share the findings of the spot check audits of the consultant led ward rounds via monthly divisional governance meeting	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Align existing Education and Training processes with SMH MCS	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**
Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Undertake a baseline spot-check audit of documentation of the named consultant	Matrons	**Closed**	**Completed**
	Share the findings of the spot-check audit of documentation of the named consultant via SOQS	Governance Lead	**Closed**	**Completed**
	Include the audit of documentation of the named consultant within the obstetric audit plan and share the audit reports via the Site Obstetric Quality and Safety Committee meetings.	Audit lead	**Closed**	**Completed**
	Develop a consistent approach to the accurate documentation of the named consultant on hospital case notes and handheld notes, for women with complex pregnancies across the MCS. Baseline audit completed December 2020, quarterly audits to be completed, awaiting standardised audit template from LMS	Matrons	30/11/2021 Date extended to support education of staff across the MCS with the newly developed Saint Mary's handheld records	In progress
	NMGH Action: Improve documentation of the named lead consultant on all maternity records, including when this changes during pregnancy	Lead Midwives/ Administration Manager	30/11/2021 Date extended to support the education of staff across the MCS with the newly developed Saint Mary's handheld records	In progress

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Improve communication with women regarding who their Consultant is by documenting this consistently on the handheld notes.	Lead Midwives	30/11/2021 Date extended to support the education of staff across the MCS with the newly developed Saint Mary's handheld records	In progress
	NMGH Action: Establish ongoing audit programme which aligns with SMH MCS	Governance Lead for audit	**Closed**	**Completed**
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Undertake a spot check audit of the documentation of ongoing risk assessments completed in December 2020.	Matrons	**Closed**	**Completed**
	Undertake a full review of the current Antenatal Handheld notes to ensure that this supports the process for undertaking and documenting a risk assessment at every contact and consider developing a local hand held record	Matrons	**Closed**	**Completed**
	develop a process for recording the outcome of antenatal pathway changes following completion of antenatal risk assessment on the maternity data system	Directorate Manager/Digital Midwife	**Closed**	**Completed**
	Await standardised risk assessment to be released and make a commitment to implement this for each antenatal appointment within handheld records	Heads of Midwifery	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	Audit the use of Personalised Care and Support Plan for documenting preferences and choices throughout pregnancy	Matrons	**Closed**	**Completed**
	Incorporate documentation of the intended place of birth and preferred mode of birth into the AN booking proforma.	Matrons	**Closed**	**Completed**
	Provide information to women in a suitable format, including digital and in a range of languages other than English	Matrons	**Closed**	**Completed**
	Develop handwritten and electronic localised information to provide the risks and benefits of all available birthing locations and methods of birth to support informed choice.	Consultant Midwife	**Closed**	**Completed**
	Identify substantive resources and secure funding to support the provision of SBL training and midwifery ultrasound scans across the MCS	SMH Director of Finance/Divisional Director	**Closed**	**Completed**
	Restart carbon monoxide screening when appropriate following the pause during the COVID pandemic for SBL V2 Element 1; Reducing Smoking in Pregnancy -	antenatal services Matron	**Closed**	**Completed**
	Identify substantive funding to sustain the long-term services related to SBL V2 Element 1; Reducing Smoking in Pregnancy -	SMH Director of Finance/Divisional Director	**Closed**	**Completed**
Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated	Continue to support the process for learning from clinical incidents	Fetal monitoring Champions	31/12/2021	In progress

Recommendation	Action	Lead	Due date	Update
expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Develop standardised teaching package and competency-based assessment tool for intermittent auscultation across the SCN	Consultant Midwife	31/12/2021	In progress
	Share Avoiding Term Admission to Neonatal Unit (ATAIN) audit findings monthly via Site Obstetric Safety and Quality Committee	CTG Champions	**Closed**	**Completed**
	Share ATAIN audit findings with clinical leadership on the delivery units	CTG Champions	**Closed**	**Completed**
	Develop a statement of case to secure a substantive expert team to support the ongoing and expanding requirements for CTG training and audit.	Directorate Manager/Deputy Head of Midwifery	31/12/2021 Date extended as Ockenden bid was unsuccessful and further opportunity to fund is in development	In progress Bid submitted for Ockenden funding was unsuccessful and alternative resources need to be identified
	Develop a statement of case to secure a substantive expert team to support the ongoing and timely practice review	Directorate Manager/Clinical Head of Division	**Closed**	**Completed**
	NMGH Action: Ensure appropriate time within job plan for Named consultant lead for fetal monitoring	CHOD	31/12/2021 Date extended as Ockenden bid was unsuccessful and further opportunity to fund is in development	In progress Bid submitted for Ockenden funding was unsuccessful and alternative resources need to be identified
	NMGH Action: Implement CTG ‘touch points’ during 12 months between annual CTG training and competency assessment	Midwife and Consultant Leads	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Increased visibility in clinical areas from CTG champion	Midwife and Consultant Leads	**Closed**	**Completed**
	NMGH Action: Strengthen process of cascading learning from ATAIN reviews ensuring it is shared with those working clinically.	ATAIN Lead and Lead Midwife	**Closed**	**Completed**
	NMGH Action: Audit to monitor progress of ATAIN actions	ATAIN Lead and Lead Midwife	**Closed**	**Completed**
	NMGH Action: Ensure midwives, Consultant Obstetricians, Anaesthetists and Neonatologists are able to undertake all practice review sessions within the 72-hour timeframe	Governance Midwife/Governance Lead	**Closed**	**Completed**
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate	Review the information leaflets shared with women	Directorate Manager	**Closed**	**Completed**
	Redesign the website to ensure accurate and appropriate information is easily accessible and, in a format, to meet the needs of our diverse population and in partnership with MVP	Obstetric Transformation Team, Divisional Director. Maternity Voices Partnership	**Closed**	**Completed**
	Develop information in languages other than English, which may be delivered as videos or audio	MFT Coms/SMH Patient Experience Lead/Matrons	31/12/2021	In progress
	Develop a formal process for supporting choice by providing information and discussion with a senior midwife and Consultant Obstetrician through Birth Choice Clinic	Clinical Lead Consultants and Matrons	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Develop proformas to support shared-decision making process and consistent information to women in specified clinical situations e.g. maternal choice LSCS, IOL and care during IOL following 3 doses of Prostin	Clinical Leads	31/12/2021 Date extended to support development and education across the MCS	In progress
	Develop risk assessment tool to be used for all admissions for IOL	Clinical Leads	31/12/2021	In progress
	Develop further information and consent checklists for other conditions such as induction, prelabour SROM, place of birth	Clinical Leads	31/12/2021	In progress
	NMGH Action: Develop a process in place to support maternal requests for Caesarean section	Consultant Midwife	31/12/2021	In progress
Maternity Workforce Standards	Submit the BR Plus report to the SMH Board	Heads of Midwifery	**Closed**	**Completed**
	Continue to review the risk related to staffing and capacity each month	Clinical Head of Division, Divisional Director and Heads of Midwifery	31/12/2021	In progress
	Identify substantive funding to sustain the long-term services related to SBL V2	SMH Director of Finance/Divisional Director	31/12/2021 Date extended as awaiting information re funding	In progress Meetings with the Commissioners are in progress – no decision re funding has been made.
	Review staffing requirements once the Birth Rate Plus assessment re Continuity of Carer has been received within the Division	Heads of Midwifery	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	Continue to work with LMS and HEI's to attract midwives to SMH.	Heads of Midwifery/Lead Midwife for Education/HR Business Partner	**Closed**	**Completed**
	NMGH Action: Recruit to substantive obstetrician posts.	Clinical Head of Division	**Closed**	**Completed**
	NMGH Action: Recruit to substantive Midwifery posts	Head of Midwifery	**Closed**	**Completed**
NICE Guidance related to Maternity	Include the risk assessments and review of the risk register for risks related to guidelines within the monthly guideline report	Consultant Guideline Lead	**Closed**	**Completed**
	Establish pathway from April 21 and alignment of guidelines with MFT.	Clinical Head of Division	**Closed**	**Completed**

Appendix 3: SM MCS inhouse scorecard for perinatal clinical quality

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

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

Summary

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

Major PPH > 2.5litres	Term admissions to NNU	Stillbirths
• Incidents monitored monthly • Major PPH being reviewed where there are increased numbers and quality improvement work being undertaken • Lessons learnt shared across the MCS	• All term admissions reviewed to identify if the admission was avoidable • MatNeo quality improvement work incorporating reducing term admissions • ATAIN audits completed monthly to identify areas for improvement and share lessons learnt	• Perinatal Mortality Review Tool and MDT review undertaken for all stillbirths • All stillbirths are incident reported and reviewed by the MDT • Figures submitted include Fetal Medicine Unit care and management

			GMEC current monthly average	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Perinatal	1:1 care in labour	Percent	94.4	99.3	99.2	96.5	99	98.2							
	3rd/4th degree tears	Percent	2.79	2.6	2.4	1.8	3.3	1.97							
	Obstetric haemorrhage > 2.5L	Rate per 1000	3.99	2.3	6.2	4.4	2.8	4.2							
	Term admissions to NNU	Rate per 1000	44.02	68.2	56.2	67.5	50.5	47.8							
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	11.08	5.8	15.1	10.3	6.1	11.8							
	Stillbirth number	Rate per 1000	4.42	2.3	5.4	4.3	8.4	6.2							
	Neonatal Deaths	Rate per 1000	1.27	2.26	1.55	1.43	0	1.39							

Patient Experience	Number of formal compliments	Number	1	3	2	2	3	1						
	Number of formal complaints	Number	5	12	11	7	7	7						
	Complaint response on time	Percent	100	83	100	-	-	-						
	Maternity Unit diverts	Number	0	0	1	0	3	1						

Training	Emergency skills and drills	Percent of staff trained	87.6	94.3	95.4	89.8	83	88.1						
	CTG training	Percent of staff trained	79.7	83.5	93.6	90.7	83.8	85.8						
	CTG competency assessment	Percent of staff assessed	88.1	92.2	91.8	93.4	91.9	87.8						

Coroner Reg 28 made directly to the Trust			No	No	No	No	No	No						
HSIB/ CQC concern or request for action			No	No	No	No	No	No						
StEIS reported incidents			1	0	2	1	9	2						
Incidents with moderate harm or above			0	0	3	0	2	0						
HSIB referrals			3	0	1	0	5	1						

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Corporate Director of Nursing Jenny Halse, Assistant Chief Nurse, Workforce and Education
Date of paper:	November 2021
Subject:	Safer Staffing – To provide the Board of Directors with the bi-annual Nursing and Midwifery Safer Staffing Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Impact of report on key priorities and risks to give assurance to the Board that's its decisions are effectively delivering the Trust's strategy in a risk aware manner. 1. Patient Safety 2. Patient Experience 3. Productivity
Recommendations:	The Board of Directors is asked to receive this paper and note progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.
Contact:	Name: Anne-Marie Varney, Corporate Director of Nursing Tel: 0161 276 8862

1. Executive Summary

1.1 This paper provides the bi-annual comprehensive report to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[2]. The Guidance recommends that the Board of Directors receive a biannual report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.[3]

1.2 The Board of Directors received a report in February 2021 outlining the Trusts position against the NQB standards. This paper will provide analysis of the Trust nursing and midwifery workforce position at the end of **September 2021** and the actions being taken to mitigate and reduce the vacancy position, specifically within the band 5 staff nurse and midwifery band 5 and 6 workforce. The report also includes a summary of the Allied Health Professions (AHP) workforce as per the NHSI guidance.

1.3 The COVID pandemic has resulted in the nursing, midwifery and AHP workforce working in new ways and in unfamiliar settings. These changes have often happened rapidly to meet increased demand whilst ensuring the care provided continues to be of high quality. NHSE/I principles and the NMC regulatory guidance have been utilised by the Trust to support a response and maintain safe staffing measures. Co-ordinated approaches to training, staffing huddles and collaboration between the hospital sites has supported flexibility within the workforce.

1.4 Nursing and midwifery workforce supply continues to be a challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations. According to NHS workforce statistics, the current shortage of staff across the NHS in England is nearly 94,000, with 39,000 within the registered nursing workforce (NHSE[4]). In September 2021 the National University and Colleges Admission Services (UCAS) received unprecedent interest in healthcare programmes commencing in September 2021. This has translated into an increase in students commencing on Nursing, Midwifery and AHP programme during the summer.

1.5 At the end of September 2021 there was a total of **520wte (5.7%)** qualified nursing and midwifery vacancies across the Group, compared to **655wte (7.2%)** in April 2021, a reduction of 1.5%. The majority of vacancies are within the nursing and midwifery (Band 5) workforce. At the end of September 2021 there were **305wte (6.3%)** compared to **344wte (7.1%)** in April 2021. The vacancy position is expected to continue to improve during Q3 due to the international and domestic recruitment

[1] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[2] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[3] CQC 2020, Inspection framework: NHS trusts and foundation trusts, trust-wide well-led
[4] NHS Digital 2021, NHS Workforce Statistics

pipelines. The 12-month rolling turnover rate for the registered nursing and midwifery staff group was **11.6%** and **13.9%** within the Band 5 workforce.

1.6 There are currently **437** domestic nurses and midwives in the Band 5 recruitment pipeline, **153** of these are working through their recruitment checks and **284** are due to start in post over the next 9-12 months following graduation.

1.7 The Trusts International Recruitment Programme (IR) continues to provide an additional supply of Band 5 nurses to the workforce. A total of **405** Band 5 international nurses were recruited between September 2020 and March 2021 following the government's decision to lift travel restrictions. To date **203** Band 5 international nurses have commenced at the Trust in 2021/22. International recruitment campaigns continue to support the hard to fill areas such as theatres, critical care, neonatal care, alongside a targeted recruitment campaign to support children's services.

1.8 There are currently **197** Nursing Associates (NARs) employed by the Trust working across general wards, community services and theatre areas with an additional **246** Trainee Nursing Associates (TNAs) in training across the Trust.

1.9 The sickness absence rate for nursing and midwifery was **5.0%** at the start of the pandemic in March 2020. In September 2021 the unplanned absence rate for registered nursing and midwifery was **8.2%** and **13.0%** for unregistered staff. Due to the nature of absences, it is anticipated that this absence level will continue to remain significantly above 'normal' levels through 2021/22. The main reasons for this increase being COVID related sickness and an increase in general sickness.

1.10 Staffing levels continue to be assessed daily across each shift to ensure they are adequate to meet patient acuity and dependency needs on each ward and department. Any changes to skill mix are risk assessed daily by a senior nurse, who reviews the actions being taken to mitigate risk to patient safety.

1.11 The Board of Directors are asked to receive this paper and note progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.

2. Introduction

2.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery and Allied Health Professionals staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[5], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[6]. The Guidance recommends that the Board of Directors receive a biannual report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.

2.2 This report provides analysis of the Trust nursing and midwifery workforce position at the end of **September 2021.** The report describes the hospital/MCS workforce plans to support the pandemic response and workforce recovery plans. The report also provides a summary of the Allied Health Professions (AHP) workforce as per the guidance.

3. National Context

3.1 Currently, more than 5.3 million people are waiting for elective care for more than 18 weeks and over 330,000 are waiting more than 52 weeks (NHS England)[7]. The Office for National Statistics (ONS) predicts that by 2040 there will be over 17 million UK residents aged 65 years and over, meaning that the demand for elderly care services will make up 24% of the total population. These are challenges that must be prepared for now by increasing the number of people training as healthcare professionals. The NHS workforce needs to adapt and expand to accommodate new ways of working to support the increase in demand.

3.2 Within the paediatric population respiratory infections have begun to rise significantly, the surge witnessed in the summer saw children presenting with these symptoms out with the normal seasonal patterns[8]. Nationally paediatric services are preparing for a further rise in children needing treatment during this autumn and winter. Surge planning is underway to increase both inpatient and paediatric critical care capacity and workforce plans are being developed to respond to the potential emergency.

3.3 According to NHS workforce statistics, the current shortage of staff across the NHS in England is nearly 94,000 (7.2%), with 39,000 within the registered nursing workforce (10.3%)[9]. The workforce challenges are highlighted within the recently launched NHS People Plan[10].

[5] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[6] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[7] NHSE 2021, Consultant-led Referral to Treatment Waiting Times Data 2021-22
[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1027644/Weekly_Flu_and_COVID-19_report_w42_v2.pdf
[9] NHS Digital 2021, NHS Workforce Statistics
[10] NHSE 2021, We are the NHS: People Plan for 2020/21 – action for us all

3.4 The People Plan acknowledges the need to make the most of the current high profile of the NHS to recruit at pace and scale. The government has pledged to train, recruit and retain an additional 50,000 nurses by 2024, focusing on domestic recruitment, international recruitment and encouraging staff to return to practice. A key priority of the plan is looking after the NHS workforce, creating a culture of respect, and belonging, whilst growing the NHS workforce to deliver care through new models that make effective use of the full range of the workforce's skills.

3.5 University and Colleges Admission Services (UCAS) reported unprecedent interest in healthcare programmes commencing in September 2021. Applications to nursing programmes have increased by a third; 48,830 applications have been received to commence study nursing in England in September 2021, an increase of 12,870 on this time last year. This increase in interest has converted to a 11% increase in acceptance onto nursing and midwifery programmes and a 27% growth on AHP programmes, the largest we have seen in over a decade[11].

4. Greater Manchester (GM) Context

4.1 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the number of students enrolling on pre–registration nursing and midwifery education programmes. Figures for September 2021 indicate a stable position on adult nursing learner numbers and a slight increase in midwifery and mental health nursing. The Greater Manchester Workforce Programme Management Office (GM PMO) is working closely with the GM HEI's to increase recruitment to adult nursing programmes that are available within the academic year 2022.

4.2 The GM PMO, HEIs and GM Trusts continue to work in partnership to ensure the impact of the pandemic on learner practice experience is minimised and any concerns or changes to government advice and guidance is addressed timely.

4.3 GM Chief Nurses and HEIs have met and developed a set of principles which support the nursing, midwifery and AHP workforce challenges. This includes a programme of work with GM HEI's to increase the number of students on programmes over the next 3 years and to increase student placement capacity across all GM NHS Trusts.

4.4 The GM PMO have developed a BAME Student Learning Experience Ambassador model. These roles will offer support to BAME learners in the practice setting to raise concerns and enable these to be address timely. During Black History Month communications and virtual events are being held to raise the profile of the Ambassador role.

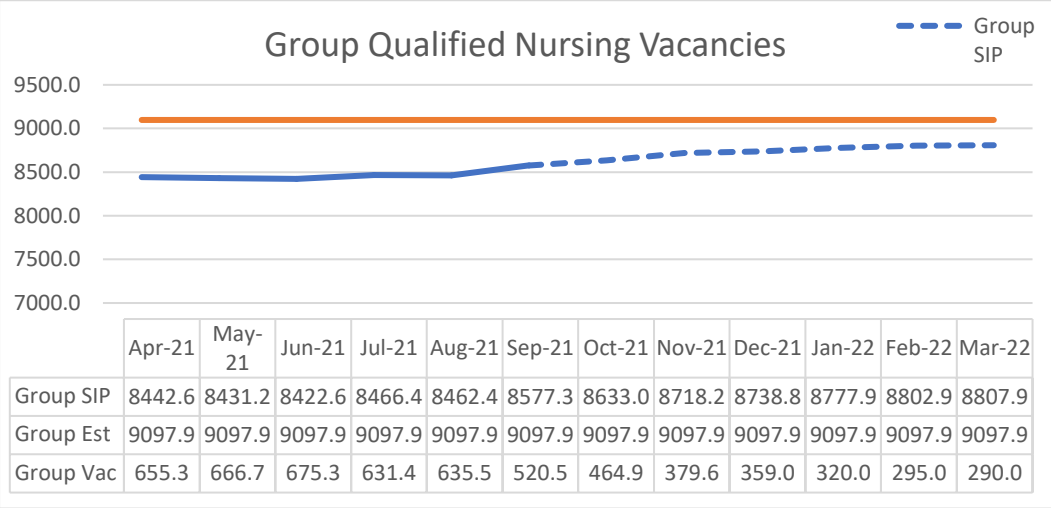
[11] Gov.uk 2021, Nursing applications in England up by over a third to 48,830

5. MFT Workforce Position

5.1 At the end of September 2021 there were a total of **520wte (5.7%)** registered nursing and midwifery vacancies across the Trust compared to **655wte (7.2%)** in April 2021, a reduction of 1.5%. The vacancy position for nursing and midwifery is expected to continue to improve in Q3 and Q4 due to the number of domestic recruitment appointments and ongoing international recruitment programme.

5.2 Graph 1 provides the overall nursing and midwifery vacancy trajectory until the end of Q4. Recent workforce modelling predicts an improved trajectory throughout 2021/22 when the nursing and midwifery vacancies are predicted to be **290wte (4%)** at the end of March 2022.

Graph 1



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Group SIP	8442.6	8431.2	8422.6	8466.4	8462.4	8577.3	8633.0	8718.2	8738.8	8777.9	8802.9	8807.9
Group Est	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9	9097.9
Group Vac	655.3	666.7	675.3	631.4	635.5	520.5	464.9	379.6	359.0	320.0	295.0	290.0

5.3 The majority of vacancies are within the nursing and midwifery (Band 5) workforce. At the end of September 2021 there were **305wte (6.3%)** compared to **344wte (7.1%)** in April 2021. Prior to the NMGH transaction the Trust had seen a continuing improvement in Band 5 vacancies with an overall reduction of 4%. Following the transaction in April 2021 and an increase to the workforce requirements in CSS there was an increase of **163wte** vacancies between March and April 2021. It is anticipated by March 2022 we will have decreased our vacancy position due to the international and domestic recruitment programmes.

Nursing and Midwifery Turnover

5.4 At the end of September 2021, the 12-month rolling turnover rate for the registered nursing and midwifery staff group was **11.6%** and **13.9%** within the Band 5 workforce. This is a slight increase from the same period in September 2020 when the turnover for nurse and midwives was **11.1%** and Band 5 turnover was **13.4%.** The current national turnover rate for nursing and midwifery is **15.4%.**

Sickness Absence

5.5 The sickness absence rate for nursing and midwifery was **5.0%** at the start of the pandemic in March 2020. In September 2021 the unplanned absence rate for registered nursing and midwifery was **8.2%** and **13.0%** for unregistered staff. Due to the nature of absences, it is anticipated that this absence level will continue to remain significantly above 'normal' levels through 2021/22 and persist over the autumn and winter periods. The main reasons for this increase being COVID related absence and an increase in general sickness.

5.6 The Hospitals/MCS/LCO continue to focus on staff wellbeing as part of the COVID recovery plans continuing to promote wellbeing initiatives and resources encouraging staff to utilise what's available to them.

5.7 In Spring 2021 the Chief Nursing Officer for England (CNO) launched the introduction of the Professional Nurse Advocate role (PNA). The PNA model focuses on supporting the wellbeing of nurses through restorative supervision and psychological support to improve their capacity to cope, especially in managing difficult and stressful situations. The Trust are supporting 45 staff to undertake the national PNA training programme, with additional cohorts now being planned. The first pilot areas with the organisation for this role have been identified as CSS, RMCH and the LCO.

6. Recruitment

6.1 The Trust workforce position has improved over the last 12 months despite the pandemic. Both domestic and international recruitment programmes have resulted in an additional 20% of new starters compared to the previous 12-month period.

Domestic Recruitment

6.2 There are currently **437** domestic nurses and midwives in the Band 5 recruitment pipeline, **153** of these are working through their recruitment checks and **284** are due to start in post over the next 9-12 months following graduation.

6.3 Alternative recruitment strategies have been in place over the last 18 months to support ongoing nursing and midwifery recruitment. Face to face recruitment open days are now planned from October 2021 with events being held on each of the Hospital sites and representation at regional events.

6.4 A guaranteed job offer (GJO) has been implemented across the Trust for all 3rd year student nurses and midwives who have undertaken a placement at within the last 6 months of their training. Students have been invited to state three areas they wish to work upon completion of their training and where possible matched into a vacancy within their preferred area.

International Recruitment

6.5 The international recruitment (IR) programme has continued to provide the Trust with an additional supply of Band 5 nurses. A total of **405** Band 5 international nurses were recruited between September 2020 and March 2021 following the government's decision to lift travel restrictions. To date 203 Band 5 international nurses have commenced at the Trust in 2021/22. The workforce predictions and improving vacancy position is dependent on recruiting **450** international nurses in 2021/2022 with circa 40 nurses expected to arrive each month for the remainder of the year.

6.6 The international recruitment pipeline has remained a challenge throughout the pandemic due to travel restrictions and quarantine arrangements. The Trust is working closely with NHSE and UK Immigration following ethical recruitment guidance from approved countries and ensuring all travel requirements are met.

6.7 The Trust is working in partnership with NHSE and the GM Maternity Network to develop a pilot programme recruiting a cohort of international midwives. A GM training and assessment programme is being developed to ensure the same level of rigor is applied in screening midwives applying to the NMC register. It is expected the first cohort of international midwives will be recruited to start in the Trust before the end of March 2022.

7. Nursing Associates

7.1 The Trust continues to focus on growing the Nursing Associate workforce with **197** registered Nursing Associates working across the hospitals and community settings and theatre areas.

7.2 There are **246** Trainee Nursing Associates across the trust undertaking an apprenticeship pathway or through a self-funded route. The Trust have introduced a guaranteed job offer for Trainee Nursing Associates in their second year of training to secure a position following registration.

8. Continuing Professional Development (CPD)

8.1 In September 2020, the Trust launched a programme of work to support nursing, midwifery and AHP continuing professional development (CPD) utilising the new national funding model available for every nurse, midwife, nursing associate and AHP. The funding is used to develop internal education resources and training programmes and to support staff to undertake external programmes.

8.2 Programme development had been prioritised following completion of a hospital/MCS/LCO learning needs analysis and staff engagement sessions. Consideration has also been given to learning from incidents, patient feedback. Over the last 12 months new programmes have been launched in, clinical skills, communication, leadership, coaching, end of life care and infection prevention and

control. Further programmes are currently being developed in emergency and acute care, theatre care, wound and end of life care.

9. Safe Staffing

9.1 The pandemic response has seen the hospitals/MCSs/LCO work very differently in how they have managed and deployed staffing levels and skill mix. This has been, based on assessing the acuity and dependency of patients and service needs with senior professional oversight by the Directors of Nursing to ensure nursing and midwifery staffing levels remain safe and staff are deployed effectively when required.

9.2 In line with Trust policy, staffing levels continue to be assessed across each shift to ensure they are adequate to meet patient acuity and nursing needs on each ward and department across the Trust. A dynamic response has been used by senior nurses during the pandemic with planned staffing levels changing on a day-by-day basis as the complexity and need changes. Hospital/MCS senior nurses/midwives complete the daily pandemic staffing risk assessment to calculate the daily staffing escalation level and to mitigate the impact when planned staffing levels are not achieved deploying staff the areas of need.

9.3 Ward staffing establishment levels are being reviewed as wards are being reconfigured following phase 2 escalation. The Directors of Nursing are applying professional judgement when undertaking these reviews to determine the appropriate skill mix and to mitigate any risks.

Safer Nursing Care Tool (SNCT)

9.3 The SNCT is an evidence-based tool used to calculate the recommended staffing establishments across inpatient wards by collecting patient acuity and dependency data on each ward over a 3-week period. The tool was introduced across MFT in 2018 to support annual establishment reviews within inpatient areas. An SNCT baseline census collection period was undertaken in May 2021. Further census collections will be undertaken in November 2021 and March 2022 to complete establishment reviews in April 2022.

10. Safe Staffing in Maternity Services – Birth Rate Plus

10.1 In 2018 the NQB published an evidence-based improvement resource to support safe staffing of maternity services. The guidance endorses Birth-Rate Plus (BR+) Midwifery Workforce Planning Tool which is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women with a higher clinical need.

10.2 During 2020, as part of Greater Manchester and East Cheshire Local Maternity system (GMEC LMS), SM MCS undertook a Birth Rate Plus midwifery workforce review and the report was received in January 2021. This demonstrated that there was a registered midwifery staffing gap of **17wte** and a staffing gap of **24.5wte** Maternity Support Workers across SM MCS.

10.3 In line with the national announcement of investment into Maternity Services to support the implementation of the recommendations of the Ockenden report[12], SMH MCS submitted its financial submission bid to NHSE/I in April 2021 via the GMEC LMS. The submissions were to cover gaps against Midwifery workforce establishments as determined by Birth Rate Plus (BR+). SM MCS has been supported to increase the midwifery establishment to the recommended Birth Rate Plus gap.

11. Hospitals and Managed Clinical Services Workforce

11.1 The Hospitals/MCS Directors of Nursing are required to present a quarterly NMAHP workforce report to their hospital Boards. A summary from these reports follows, together with an updated workforce position.

12. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

Workforce Position

12.1 At the end of September 2021, there were a total of **136.0wte (6.9%)** registered nursing vacancies across WTWA compared to **182.8wte (9.7%)** at the same period in the previous year. This is a reduction of **46.8wte (2.8%)** nursing vacancies**.**

12.2 The number of Band 5 nursing vacancies has also reduced. At the end of September 2021 there were **79.0wte (7.7%)** vacant Band 5 nursing posts compared to **143.5wte (14.2%)** in September 2020. This is a reduction of **64.5wte** (**6.5%).** Theatres, urgent and emergency care and the acute medical units are the areas with significant recruitment challenges. The Band 5 vacancy situation will continue to improve during Q3 following the graduation of newly qualified nurses. There is however an expectation that workforce requirements will increase due to the ongoing discussions regarding surgical recovery plans and increased activity through the WTWA sites.

12.3 There are **60** Band 5 nurses in the domestic recruitment pipeline for WTWA, **28** with confirmed start dates by December 2021. There are an additional **61** internationally recruited nurses planned to arrive before the end of March 2022.

12.4 The rolling 12-month turnover for nursing has improved over the previous 12 months reducing to **9.9%** from **12.2%.** The turnover for Band 5 staff nurses is currently **12.3%** which has improved over the last 12-month period from **14.2**%.

12.5 Sickness absence within the registered nursing and staff group at WTWA was **7.7**% for registered nurses and **15.6%** for unregistered staff in September 2021.

[12] OGL 2020, Maternity Services Review

WTWA Safe Staffing

12.6 There has been significant reconfiguration of ward areas to support the response to the pandemic and the recovery programmes. Business cases and workforce modelling are currently underway to support the staffing in the newly configured Acute Medical Unit (AMU) and Acute Surgical Unit (ASU). Business cases will support the additional 12 beds opened in AMU and the new service profile and requirement across the ASU.

12.7 Within theatres across WTWA, there continues to be considerable challenges in recruitment as reflected in the national picture. International recruitment has been a focus for theatre areas with a long-term workforce plan in development to look at developing career pathways in theatre areas and support international nurses and domestic nurses to gain dual qualifications and career opportunities across the different theatre specialities. Additionally, the role of the Nursing Associate has been introduced in theatres at both the Wythenshawe and Trafford sites. A theatre education group has been established to specifically review and develop the education and support processes in place for non-theatre background registrants to widen the attraction for staff into these areas. Additional places have been secured for nurses to undertake a post-registered anaesthetic module during this academic year.

13. Manchester Royal Infirmary (MRI)

MRI Workforce Position

13.1 At the end of September 2021, there were a total of **75.6wte (4.9%)** registered nursing vacancies across MRI compared to **81.7wte (5.4%)** in September 2020. This is a reduction of **6.1wte (0.5%)** nursing vacancies**.** The hospital vacancy position is expected to continue to improve through Q3 and Q4.

13.2 The number of Band 5 nurse vacancies has also reduced. At the end of September 2021 there were **48.5wte (5.70%)** vacant Band 5 nurse posts compared to **64.1wte (7.91%)** in September 2020, a reduction of **15.6wte (2.21%).** The Band 5 vacancy position is expected to continue to reduce during Q3 and Q4.

13.3 There are **77** Band 5 nurses in the domestic recruitment pipeline for MRI, **21** with confirmed start dates by December 2021. There are an additional **59** internationally recruited nurses planned to arrive before the end of March 2022.

13.4 The rolling 12-month turnover for nursing is **12.7%** within MRI which is an increase from Sept 2020 when it was **10.7%.** The turnover within the Band 5 nurse workforce is **16.0%** which is an increase from Sept 2020 where it was **13.9%**. Staff engagement sessions have been held in hot spot areas, shift patterns and fair share approach to staff redeployment is being developed based on staff feedback.

13.5 Sickness absence within the registered nursing and staff group at MRI was **8.4%** for registered nurses and **15.4%** for unregistered staff in September 2021.

13.6 The hospital has recently appointed a Matron who will lead on workforce, well-being and the freedom to speak up agenda. Within the MRI a specific focus has been placed on staff well-being along with the promotion of 'its okay not to be okay' and well-being Wednesdays, sponsored by the MRI Director Team.

MRI Safe Staffing

13.7 Daily staffing levels continue to be assessed across each shift to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. A dynamic response has been used by senior nurses during the pandemic with planned staffing levels changing on a day by day basis as the complexity and need changes.

13.8 Ward/Department establishments have been reviewed with the DON and Clinical Service Unit (CSU) Lead Nurses as part of the recovery plans to align the establishments to the new ward configurations, 'MRI Back to Better Plan'. The review has been undertaken in line with the MFT principles for reviewing establishments, considering that previous SNCT data could not be used due to the significant change in ward configurations and therefore professional judgement has been utilised.

13.9 Areas with higher that average vacancies continue to have robust recruitment improvement plans which are monitored by the MRI Head of Nursing for Workforce. Specialist area such as Theatres, Haemodialysis and Emergency Department (ED) provide the greatest challenge. Twice daily MRI wide staffing processes ensures that appropriate nurse staffing resource is in place aligned to patient acuity. The use of bank and agency staff to backfill vacancies is utilised to ensure the delivery of safe and effective care to our patients.

13.10 Workforce recovery plans have been established to meet increasing demand on both Haemodialysis and ED. Refinement of ED workforce recovery plans have been required to meet the significant and ongoing challenge of meeting the current demands created by unscheduled care. ED service expansion connected to project RED (Redevelopment of Emergency Department) acknowledge increase workforce needs associate with the growth in capacity Project RED will deliver.

14 North Manchester General Hospital (NMGH)

NMGH Workforce Position

14.1 At the end of September 2021, there were a total of **76.2wte (10.9%)** registered nursing vacancies across NMGH.

14.2. There are currently **32** qualified staff in the NMGH domestic pipeline, undergoing pre-employment checks and **11** are expected to commence in post before the end of December 2021. In addition, **55** international nurses are due to arrive before the end of March 2022.

14.3 Sickness absence within the registered nursing staff group at NMGH was **8.6%** and **10.1%** for unregistered staff in September 2021.

NMGH Safe Staffing

14.4 Prior to the COVID pandemic establishments and staffing at NMGH have been determined using clinical professional judgement, with general wards aiming for Registered Nurse to patent ratio of 1:8, with a supervisory coordinator at a minimum on the early shift. Specialist services have a different nurse to patient ratio dependent on acuity/ clinical requirements. NMGH has not previously used the SNCT to inform establishment reviews. In order to assure safe nurse staffing levels are maintained and appropriately risk assessed, the Director of Nursing has implemented a formal process monitor and address staffing levels on a daily basis, which is aligned to the "Pandemic Safer Staffing Guidance – Inpatient Ward Areas".

NMGH Workforce Transformation

14.5 The flexibility of NMGH staff has supported service delivery from the start of the pandemic. Skill mixes introduced on wards and departments now encompass a wider range of specialist skills for each area. Professional judgement has been applied to determine appropriate staffing levels.

14.6 Allied Health Professionals (AHPs) have supported services by working differently and undertaking responsibilities that would traditionally have not been a routine part of their job, including supporting the proning team in critical care.

14.7 Steps are being taken to retain improved ways of working and lessons learnt during the first waves of the pandemic. Work is underway on NMGH's redevelopment and service transformation. There are separate project groups in place to ensure staff are involved and engaged in the hospital's future workforce plans. A Clinical Lead will be appointed to support this work.

15. Royal Manchester Children's Hospital (RMCH)

RMCH Workforce Position

15.1 At the end of September 2021 there was **19.0wte (1.86%)** registered nursing vacancies across RMCH. The hospital vacancy position is expected to remain static between 1-2% during Q3 and Q4.

15.2 There are **32** staff nurses currently in the domestic recruitment pipeline due to start by December 2021. A further **18** international nurses are expected to arrive before the end of March 2022.

15.3 The rolling 12-month turnover for nursing is **7.9%** within RMCH which is an improved position from Sept 2020 when it was **8.6%.** The turnover within the Band 5 staff nurse workforce is **9.2%** which has also improved from Sept 2020 when it was **10.1%**.

15.4 Sickness absence within the registered nursing and staff group at RMCH is **7.5%** for registered nurses and **14.6%** for unregistered staff in September 2021.

RMCH Safe Staffing

15.5 Respiratory syncytial virus (RSV) is the most common cause of bronchiolitis in children under 2 years old. Around 1 in 3 children in the UK will develop bronchiolitis during their first year of life. It most commonly affects babies between 3 and 6 months of age. Usually, by the age of 2, almost all infants will have been infected with RSV and up to half will have had bronchiolitis. The non-pharmacological interventions that have been in place to manage the pandemic (social distancing, wearing face masks, school closures etc.) have resulted in children missing out on the normal exposure to respiratory viruses which has increased the spread in 2021 as lockdowns have lifted.

15.6 Following the COVID pandemic and the trends observed in the Southern Hemisphere, Public Health England (PHE)[13] modelling suggested an earlier start to the RSV season with a peak in November 2021 which will last throughout the winter period. The increased demand on paediatric services has resulted in increased activity demand in RMCH and the Managed Clinical Services.

15.7 A significant challenge within the region is to ensure capacity for the activity surge whilst also prioritising elective activity. Planning for the increased activity requires an increase in Paediatric Critical Care beds which requires additional nursing and medical workforce. Whilst the hospital has achieved fully established nursing teams, the benefits of this are not being felt due to increased sickness absence rates and increased activity demand, with paediatric critical care seeking support through mutual aid to maintain safe staffing ratios.

15.8 A daily staffing huddle is completed to assess the staffing levels for each clinical area, identifying areas of shortfall and appropriate re-deployment of staff to support. Clinical areas are RAG rated according to their staffing levels and appropriate escalation / steps are taken to resolve staffing issues either at individual department level, at CSU level or as an overall hospital response. Mutual aid is currently being offered to support RMCH during this period of increased acuity and activity.

Child and Adolescent Mental Health Service

15.9 Admissions to RMCH/MCS of young people in the care of Child and Adolescent Mental Health, (CAMHS), has increased during COVID with an average of 15 young people across the wards over the summer, a proportion of these display challenging behaviours impacting upon acuity in the clinical areas, requiring additional staffing support including close working with the security team and Employee Health Being to support staff. In response to this increase in demand, additional staffing establishment of **12.2wte** Band 6 roles have been established and staff recruited.

[13]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1027644/Weekly_Flu_and_COVID-19_report_w42_v2.pdf

15.10 A Focused Support Team, incorporating qualified Mental Health and Learning Disability Practitioners who work alongside the paediatric nurses in inpatient areas providing support, training, and connection to the CAMHS network is being developed.

16. St Mary's Hospital MCS

SMH Nursing Workforce Position

16.1 At the end of September 2021 there was an overall nursing vacancy position of **44.2wte (7.2%)** of which **32.2wte** were within the Band 5 nursing group. Most nursing vacancies are within Newborn Services with the remaining in gynaecology.

16.2 There are **10** Band 5 nurses currently in the domestic pipeline, 7 appointed to work within Newborn Services and 3 appointed for gynaecology before the end of December 2021. SMH have undertaken an international recruitment campaign to attract experienced international nurses for Newborn Services. It is predicted that they will receive **12** IR nurses before March 2022.

16.3 The rolling 12-month turnover in SMH MCS registered nursing workforce has increased from **11.3%** in September 2020 to **13.2%** at September 2021. The Band 5 registered nursing 12-month turnover has remained at a similar position to previous year at **17.2%**. Work has commenced to enhance an early careers pathway for newly qualified nurses.

16.4 Sickness absence within the registered nursing and midwifery staff group at SMH was **8.5%** for registered nurses and midwives and **8.8%** for unregistered staff in September 2021.

Newborn Services – Safe Staffing

16.5 Within Newborn Services staffing is reported via the Badger Net System which utilises British Association of Perinatal Medicine (BAPM) standards to calculate staffing requirements based upon activity and acuity.

16.6 In March 2021, Newborn Services across SMH MCS have participated in the National Neonatal Critical Care Review (NCCR[14]) which focuses on ensuring nursing establishments are compliant with national standards. For SMH MCS Newborn Services this would mean an increase in baseline establishment by **29.91wte**. Newborn Services will work in collaboration with the North West Neonatal Operational Delivery Network (NWODN) to submit further bids to NHSE for funding to realise this gap.

[14] NHSE 2019, Implementing the Recommendations of the Neonatal Critical Care Transformation Review

SMH Gynaecology

16.7 In November 2020 the Emergency Gynaecology Service was relocated to Wythenshawe Hospital site in response to the COVID pandemic to ensure the health and wellbeing of patient accessing services across the MCS. This relocation created a workforce challenge in regard to skill mix within the department, change in culture and processes. An emergency gynaecology training programme was developed and continues to be delivers across the Emergency Gynaecology Unit.

16.8 Gynaecology have recently undertaken a recruitment campaign to fill vacancy gaps across all areas within gynaecology nursing. It is anticipated that these new members of staff will join the Trust October/November 2021

SMH Midwifery Workforce Position

16.9 In September 2021 there are 47.7wte (6.83%) registered midwife vacancies across SMH MCS. We anticipate these vacancies to be reduced throughout Q3 and Q4.

16.10 The rolling 12-month turnover within the midwifery workforce is **12.3%.** This is an increase from the same time in the previous year September 2020 when turnover was **11.4%.**

16.11 Due to the changes in midwifery curriculums under the Pandemic NMC Emergency Standards, (NMC[15]). There has been delays in completion of midwifery studies for students, which has led to some third-year students having to delay completion of their training and graduation. There are **33** newly qualified midwives due to start in October 2021, **47** have been delayed. Educational plans are in place to support learners who are expected to join the workforce during Q3.

16.12 The Professional Midwifery Advocate (PMA) are embedded across SMH MCS, supporting restorative clinical supervision. “What Matters to Me” sessions have been held monthly, alongside the “Caring for You” campaign support by a Royal College of Midwives representatives.

16.13 SMC MCS have recently secured funding from NHSE to employ a team to provide pastoral support to new starters and work with the teams to support, advance and embed retention plans moving forwards.

17. Clinical Support Services MCS (CSS)

CSS MCS Workforce Position

17.1 At the end of September 2021 there were no funded nursing vacancies in CSS however both domestic and international recruitment has continued to maintain safe staffing levels to support increased activity and escalation across adult critical care areas (including NMGH) and ward 14 (ORC).

[15] https://www.nmc.org.uk/standards-for-education-and-training/emergency-education-standards/

17.2 Within CSS the rolling 12-month turnover for all qualified nurses in September 2021 was **11.8%** which is the same as this time last year. The 12-month rolling turnover for band 5 nurses for the same period is **12.7%** which is a decrease from **14.4%** in September 2020

17.3 Sickness absence within the registered nursing and staff group in CSS was **7.8%** for registered nurses and **10.2%** for unregistered staff in September 2021.

17.4 Work is ongoing to continue to address staff satisfaction and wellbeing and expand the support to staff. The units received excellent verbal feedback on initiatives in place from the national team visiting units across the country to look at support for staff in Critical Care Units. The units are engaged in working with the Greater Manchester Resilience Hub and utilising the funding that has been made available nationally to critical care teams to work with psychologists to support staff well being

17.5 CSS has actively engaged in the national Professional Nurse Advocate training programme to support staff to develop the skills to facilitate restorative supervision (to enhance health and wellbeing) to colleagues and teams within our critical care services as well as supporting them to lead and deliver quality improvement initiatives in response to service demands and changing patient requirements. To date 12 staff have completed the training programme and another 6 will be commencing the training in September 2021.

CSS Workforce Transformation

17.6 April 2021 saw the integration of NMGH critical care services. The NMGH nursing team in the 12-bed unit has been fully incorporated into the wider Adult Critical Care Service. Additional nurse staffing has and is still being recruited to in order to address the legacy staffing issues and associated risk to ensure additional registered nursing support on each shift and sufficient weekend Critical Care Outreach capability.

17.7 Since April 2021, work has resumed on the CSS recovery programme and the redevelopment of services as part of the Trust reconfiguration of estate, processes and pathways to support new ways of working with COVID all of which has significant implications for the CSS nursing workforce.

CSS Safe Staffing

17.8 Professional standards have and continue to be the main reference in terms of CSS nursing workforce are Guidelines for the Provision of Intensive Care Services[16] and include the ratios of nurses to patients per shift, coordinators and support nurses per shift, numbers of clinical education nurses and use of agency staff. The units are compliant with all GPICS nurse staffing standards.

[16] https://www.ficm.ac.uk/standards-research-revalidation/guidelines-provision-intensive-care-services-v2

17.9 Within the Radiology intervention unit staffing levels are compliant with national guidance on 24-hour Interventional Radiology Services[17]. Services will move to a 24-hour staffing model on the Wythenshawe Hospital site once the additional staff have been recruited and have completed the appropriate competency training (aiming for Sept 2021).

18. Manchester Royal Eye Hospital (MREH)

MREH Workforce Position

18.1 At the end of September 2021, there were a total of **6.6wte (4.%)** registered nursing vacancies across MREH. Due to the low number of vacancies the hospital continues to recruit to turnover to maintain a static workforce position. The 12-month rolling turnover rate has improved to **11.9%** for qualified staff (from **16.4%**).

18.2 Sickness absence within the registered nursing and staff group across MREH is **10.3%** for registered nurses and **10.4%** for unregistered staff in September 2021.

18.3 Transformation of the nursing workforce is critical to the successful delivery of the COVID recovery plans and longer-term strategic direction of MREH. A review of nurse staffing establishments has been untaken and a business case to reflect the workforce gaps has been written and is due to be presented to SLT in November 2021. The business case includes the substantiation of currently unfunded posts in the establishment, funding of newly developed and extended services to include extension of clinic hours and 7-day Cataract Programme and development of the ACP role.

18.4 A in-house ophthalmology course and theatre programme is being developed to support training of specialist skills within the newly recruited workforce, as part of the MFT CPD portfolio.

MREH Safe staffing

18.5 Safe Staffing levels have been maintained throughout the pandemic, even with high numbers of staff deployed to other areas within MFT and NW Nightingale. Staffing across all MREH open areas have been reviewed daily by the Matrons and staff have been deployed internally across MREH sites where required to maintain safe staffing levels.

19. University Dental Hospital (UDHM)

UDHM Workforce Position (Dental Nurses)

19.1 At the end of September 2021, the Dental Hospital has **0.7wte** vacancies**.** The UDHM does not experience any issues in recruiting dental nurses at all bands, therefore the Hospital will continue to recruit to turnover.

[17] RCR 2017, Standards for providing a 24-hour interventional radiology service

19.2 Sickness absence has decreased over the last 6 months across UDHM. Sickness absence in UDHM was **3.3%** in September 2021, compared to **14.4**% in April 2021.

UDHM Safe Staffing

19.3 The UDHM is looking at new ways of working post COVID to fully utilize the skills of the workforce, including those staff that cannot be patient facing. Although the clinical activity within the hospital is significantly reduced in comparison to the pre-COVID activity plans, the pressures faced by the nursing workforce are significant. This is due to the way in which dentistry is supported by 1:1 nursing per clinical session in all specialties.

19.4 Nursing assistants are providing support to the dental nursing teams, assisting the donning and doffing process for Aerosol Generating Procedures (AGPs) and acting as runners during clinics to enable the smooth running and flow of the clinics.

19.5 The hospital has recently recruited 8 student dental nurse apprentices who will undertake an 18-month apprenticeship rotational training course delivered by the School of Dental Care Professionals (DCP's) based within the UDHM. This will provide additional support to the nursing team within the UDHM.

20. Manchester Local Care Organisation/Trafford Local Care Organisation (M&TLCO)

M&TLCO Workforce Position

20.1 At the end of September 2021 there was a total of **96.7wte (8.8%)** registered nurse vacancies across the M&TLCO compared to **101.3wte (9.3%)** at the start of the financial year.

20.2 There are **40** Band 5 nurses currently in the domestic pipeline to start in the M&TLCO before December 2021. There are **14** international nurses expected to arrive before the end of March 2022.

20.3 The rolling 12-month turnover for nursing is **15.2%** which is an increase of **2.3%** since April 2021 when it was **12.9%**.

20.4 Sickness absence within the registered nursing staff group at M&TLCO is **8.9%** in September 2021.

M&TLCO Safe Staffing

20.5 The response to the pandemic has required an unprecedented increase in the number of M&TLCO front-line staff working differently to support essential services. A M&TLCO Recovery Programme Board established to oversee the reintroduction of stopped or partially stopped services based on localities and specialist teams. Due to high levels of staff absence in some teams' service recovery has been dependant on safe staffing levels.

20.6 The M&TLCO Recovery, Reform and Portfolio Programme Board oversees the recovery of services and changes to service provision with services completing Quality Impact Assessments for informed decision-making and assurance that changes are monitored in relation to quality and safety. The Board also reviews the impact of COVID on increased waiting lists for both Adult and Children's Services.

20.7 The M&TLCO have established a task and finish group to benchmark current establishments within the District Nursing teams across Manchester and Trafford. The District Nursing Service continues to receive an increased number of referrals due to a reduction in hospital length of stay, increased frailty of patients and patients requiring end of life care, patients who are shielding or self-isolating requiring home visits and reduced capacity within clinics due to the requirements of social distancing. The group will consider total nursing establishments, skill mix, roles, responsibilities and competencies at each band as well as consider the appropriateness of the provision of city-wide rather than locality-based services to improve efficiency and patient safety.

20.8 In order to ensure safe staffing levels there are several mechanisms in place across services to monitor and manage caseloads. A daily situation report has been introduced to manage caseloads and share resources where required. The situation report is based upon the scheduling element of the EMIS IT system and has proved useful when making decisions regarding temporarily relocating staff from either neighbourhoods or localities. The system has been further expanded during the pandemic to introduce action cards to support safe clinical decision making.

21. Allied Health Professions Workforce

21.1 There is currently a **6.8%** vacancy rate within generalist AHPs across GM. Within services there are shortfalls within the speciality posts such as adult acute Occupational Therapists (OT); Podiatrists; and paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT) due to reduced numbers attending training and the subsequent reduction in the number of universities delivering these programmes.

CSS MCS AHP Workforce Position

21.2 At the end of September 2021 there were a total of **91.9wte (9.6%)** registered AHP staff vacancies within CSS. The AHP vacancy rate is currently higher than the national vacancy comparison, however the Trust provides Paediatrics and other specialist tertiary care which prove the most challenging to recruit.

21.3 The sickness absence rate in September 2021 within the AHP workforce was **3.7%**.

21.4 The rolling 12-month turnover rate for registered AHPs within CSS is **12.5%** and slightly less than the national AHP benchmark of **14.8%.** Within Physiotherapy and Occupational Therapy there has been an increase in turnover within CSS. This is due to the new opportunities for these professionals across the Trust and GM, such as the expansion the first contact practitioner role, new neonatal network posts and HIVE.

21.5 Across the MCS there are ongoing difficulties in recruiting to band 5 occupational therapy posts. The Division is working collaboratively with MRI to develop the occupational therapy apprenticeship, to support OT assistant to undertake an apprenticeship and progress into registered posts.

WTWA AHP Workforce Position

21.6 At the end of September 2021 there were **5.94wte (7.6%)** AHP vacancies within WTWA, this is a reduction from the 9% vacancy rate in the same period last year.

21.7 The rolling 12-month turnover for AHPs at WTWA is **11.3%** which is under the national AHP benchmark. Sickness absence within the registered AHP group at WTWA is **6.5%** in September 2021.

21.8 The AHPs at WTWA have continued to offer support to AHP services in CSS during the COVID pandemic by redeploying staff to acute respiratory areas. There has also been support offered between services within WTWA and the M&TLCO to manage the backlog of referrals from the first wave of the pandemic.

Manchester (MLCO) and Trafford TLCO AHP Workforce Position

21.9 There are **29.6wte (6.1%)** AHP vacancies in the M&TLCO in September 2021 with the majority of vacancies in podiatry and occupational therapy. The AHP 12 month rolling turnover position is **12.4%**.

21.10 The sickness absence rate within the M&LCO AHP workforce was **2.6%** in September 2021.

MREH AHP Workforce

21.11 The Orthoptic Department is fully established with no vacancies and does not experience any issues recruiting high calibre orthoptists at all bands. AHPs are required to implement job planning by 2021 and this is a current work stream of high quality and safe staffing for Orthoptists with the intention to implement early at MREH. Nationally Orthoptics is recognised as one of the four vulnerable AHP professions.

22. AHP Safe Staffing

22.1 The Trust continues to work in collaboration with NHSE/I and the Shelford AHP Group who have commissioned the AHP Pro project. The aim of the project is to develop an evidence-based workforce acuity measurement tool (AHPOST) to determine optimal AHP staffing requirements. The initial 'proof of concept' phase has now completed, and the results are due to be presented at the National AHPs into Action Programme Board in October 2021.

22.2 During the pandemic the AHP workforce have responded by changing the way they work. Virtual consultations, the use of digital platforms and Apps were introduced, these new approaches continue to be utilised and have been embedded into service delivery.

22.3 Workforce availability continues to be monitored through local reporting and governance structures. With risk assessments being undertaken across all services to identify areas of concern and where mitigation actions have been agreed in response.

AHP Service Transformation

22.4 The newly appointed Chief Allied Health Professional is working alongside Health Education England on a AHP workforce supply project. The project aims to give an understanding on AHP workforce priorities to meet the needs of service users and populations now and in the future. Specifically, the project will provide robust workforce intelligence and planning, with the aim to facilitate short term targeted growth via return to practice and international recruitment and support practice placement expansion. Strategies to grow local apprenticeships and improve recruitment and retention of students and newly qualified AHPs will also be considered, together with growth and development of the AHP support workforce.

22.5 Utilising HEE continual professional development funding, bespoke programmes of education have been commissioned for the AHP workforce, which had been identified as priorities through the 2020/21 learning needs analysis. These have included specific clinical skills training to enhanced service delivery alongside, leadership programmes.

23. Summary

23.1 This paper outlines the continuing challenges in relation to nursing and midwifery and AHP staffing. Since presenting the previous bi-annual safe staffing report to the Board of Directors in February 2021 the Trust has been in escalation to support the continued national emergency pandemic response, alongside developing COVID recovery plans. There continues to be ever-changing workforce demands that the Trust has and continues to respond to. During this time and in summary, teams have been required to consider:

- Development of sustainable models of care delivery that accommodate both COVID and non-COVID patient pathways
- Expansion of services in response to increase waiting lists of no emergency care, namely increased diagnostic, and theatre capacity
- Supporting increased numbers of international nurses and newly qualified nurses and midwives
- Upskilling staff to support critical care areas or return to clinical front line
- Higher proportion of staff absence due to sickness, shielding and isolating
- Safe working practices for clinical and non-clinical staff and consideration for those most at risk
- Development and implementation of COVID vaccinations centres across the Group
- The deployment of staff to support the Royal Manchester Children's across all sites and services

23.2 Improved Workforce Position

The Trust has seen an improved workforce position over the last 6 months. At the end of September 2021 there was a total of **520wte (5.7%)** qualified nursing and midwifery vacancies across the Trust compared to **655wte (7.2%)** in April 2021. Both domestic and international recruitment programmes have supported this position. The vacancy position for nursing and midwifery is expected to continue to improve in Q3 and Q4 due to the number of domestic recruitment appointments and ongoing international recruitment programme.

23.3 There has been a small increase **(0.5%)** in the overall turnover of nursing and midwifery staff compared to the previous 12-month period. Due to a reduction in trust leavers during the pandemic, it was expected to see an increase in turnover through 2021 and this is now the current national trend. The trust nursing and midwifery turnover rate is **3.8%** below the current national turnover rate of 15.4%.

23.4 The emergency response and transferability of skills during the pandemic has provided opportunities to consider how we retain staff and create new opportunities for existing staff to develop, to ensure that MFT has a flexible and responsive workforce. Continual professional development programmes have been and continue to be developed from this learning, to support this.

23.5 Across the Trust each Hospital/MCS has established a workforce recovery plan outlining plans to support remerging services and NMGH transformation plans whilst ensuring the safety of patients and staff. Progress on these work streams is reported to the Hospitals/MCS Management Boards by the Directors of Nursing, Midwifery and AHPs. The following work streams have been identified as the current key priorities to support nursing, midwifery and AHP workforce plans:

23.6 **Support the health and well-being of staff**

- Continue to focus on initiatives to support the health and mental well-being of staff as the workforce recovers from the pandemic.

- Develop and implement the PNA role across clinical areas following the success of the pilot areas.

23.7 **Strategy to support safe staffing**

- Complete SNCT census (November, January and March) across all in patient areas and Emergency Departments (ED) and undertake establishment reviews.
- To undertake local risk assessment of AHP services in the absence of a national evidence-based tool.

23.8 **Recruitment**

- To reinstate face to face recruitment events with 6 Group level band 5 events to be held each year.
- Develop and update a responsive recruitment strategy to include both domestic and international recruitment to support growth of the nursing and midwifery workforce and inform targeted campaigns for areas of need.

23.9 **Retention**

- Develop educational programmes to support newly qualified and new international nurses working in Emergency care and Acute Medical Units.
- Review the current trusts preceptorship programme for newly qualified nurses, midwives and AHP's.
- Develop CPD programme to support the retention of Nursing Associates.

23.10 **Developing the Unregistered Workforce**

- Undertake a skill mix review of the unregistered workforce to align service needs with band 2 and 3 nursing assistant job roles skill requirements.
- Develop knowledge and skills frameworks to support vocational (apprenticeship) training and access to career opportunities.

23.11 Progress on these work streams will be monitored through the NMAHP Professional Board.

24. Conclusion

The Board of Directors is asked to receive this paper and note progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Freedom to Speak Up Guardian
Paper prepared by:	Karen Hawley, Freedom to Speak Up Guardian
Date of paper:	November 2021
Subject:	Freedom to Speak Up Annual Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• This report is aligned with the Trust's Vision to:Excel in quality, safety & patient experience. Attract, develop & retain great people. The report is also aligned to the Trust's Values: • Everyone matters • Working together • Dignity & Care • Open & Honest
Recommendations:	The Board is asked to note the 2020/21 Annual Freedom to Speak Up Report.
Contact:	Name: Karen Hawley, Freedom to Speak Up Guardian Tel: 07964900492

NHS
Manchester University
NHS Foundation Trust

Freedom to Speak Up Annual Report

April 1st 2021 to 31st March 2021

1. Purpose of Report

1.1 The purpose of this report is to provide the Board of Directors with an overview of the work of the Manchester University NHS Foundation Trust (MFT) Freedom to Speak Up (FTSU) Team over the period 1st April 2020 to 31st March 2021. The Report also provides an update from the annual report of the National Guardian's Office (NGO) to allow national comparisons and context.

1.2 The Report also details the input FTSU had during the establishment of the NHS Nightingale Hospital North West.

1.3 On 1st April 2021, North Manchester General Hospital (NMGH) formally joined the MFT Group. The report, therefore, outlines the preparations that were made to safely transfer FTSU processes and responsibilities into MFT.

2. Background

2.1 The roles of Freedom to Speak Up (FTSU) Guardians and the National Guardian's Office (NGO) were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC.

2.2 Freedom to Speak Up Guardians help protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. They do this by ensuring that workers are supported in speaking up and that issues raised are used as opportunities for learning and improvement. They work within their organisations to help ensure that barriers to speaking up are addressed and a positive culture of speaking up is fostered.

3. Outline of Roles / Responsibilities for FTSU

3.1 During the period of this report, the FTSU Team was led by the FTSU Guardian, David Cain.

3.2 The FTSU Team is supported by the Group Deputy Chief Executive, Gill Heaton, along with Ivan Benett as Non-Executive Lead. The Group Executive Director of Workforce &Corporate Business provides formal leadership to the Freedom to Speak-up Guardian.

3.3 The FTSU Team is also supported by a network of FTSU champions. The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. During 2020-21, targeted recruitment was undertaken to increase the diversity of the FTSU champion network and to extend the reach of FTSU at WTWA sites. By the end of March 2021, the FTSU work was supported by a network of 35 champions from a variety of clinical roles and backgrounds, including representation from night staff and also champions who identify as being from Black, Asian and Minority Ethnic (BAME) backgrounds.

3.4 An indication of the work of the FTSU Champions is demonstrated in video format at https://vimeo.com/nicecatmedia/download/617904337/03e0fd7354

4. Assessment of Cases raised via FTSU.

4.1 During 2020-21, 77 cases were reported to the FTSU Team. Comparison numbers from previous years is provided in table 1 below:

Table 1:

Year	Number of Cases reported by FTSU
2020-21 (12 months)	77
2019-20 (12 months)	69
2017-2019 (18 months)	84

4.2 Table 2 and the graph below illustrate the data for the nationally reportable elements of the cases raised to FTSU at MFT during 2020/2021:

Table 2:	Q1	Q2	Q3	Q4	Total
Total Number of Cases	23	21	14	19	77
Number of cases raised anonymously	1	0	0	0	1
Number of cases including an element of patient safety	2	4	4	5	15
Number of cases including an element of bullying / harassment	5	9	7	5	26
Number of cases where people have indicated they are suffering a detriment because of raising a concern	2	3	4	1	10

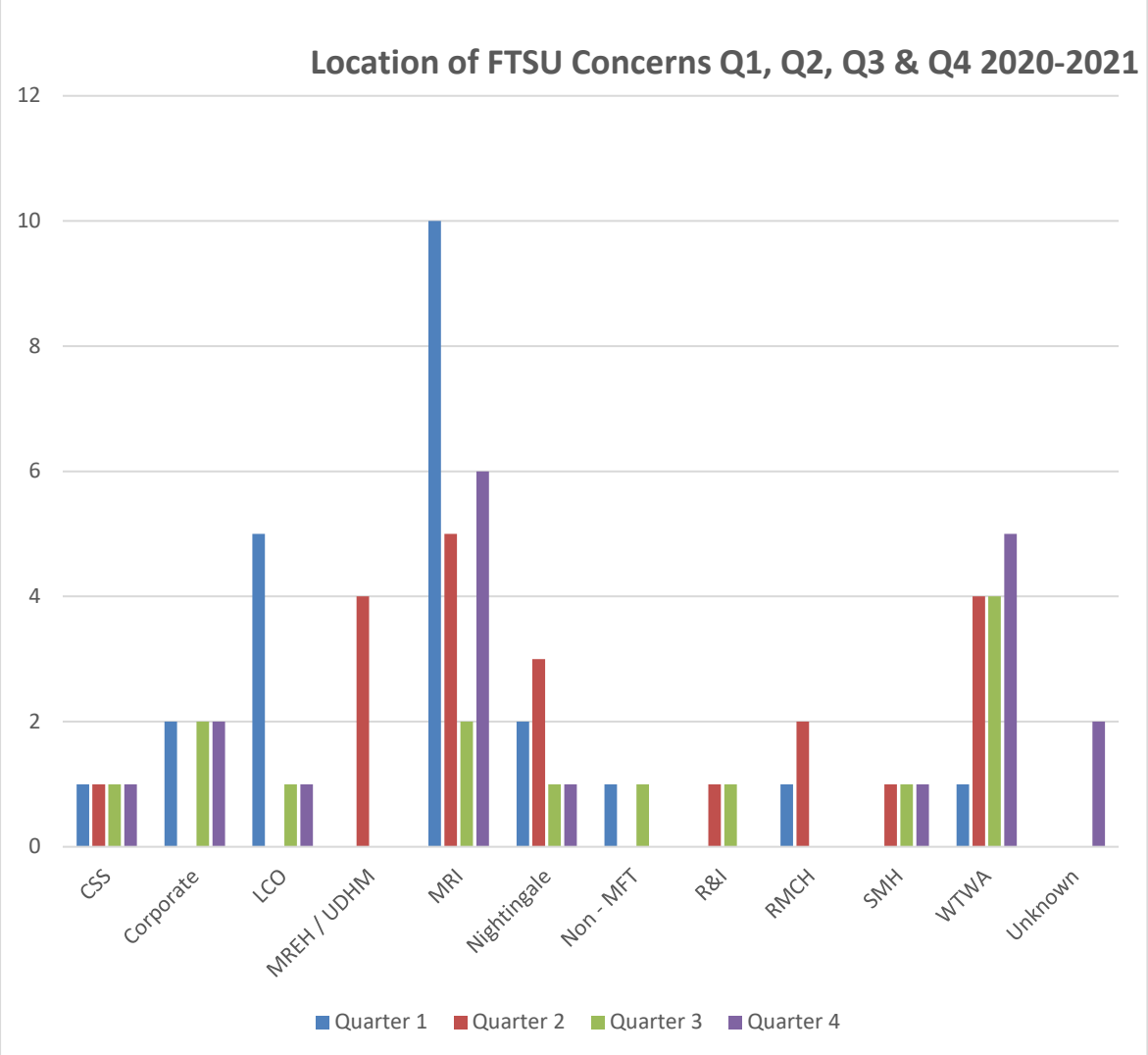
4.3 34% (26 cases) of the cases raised had an element of bullying and harassment. This is reduced from the number of cases raised to FTSU during the same period in 2019/20 (previously 58%). The figure is slightly higher than the national figure of 30%.

4.4 19% (15 cases) of the cases included an element of patient safety. This is similar to the national figure where 18% of cases reported to the National Guardian's Office had an element of patient safety.

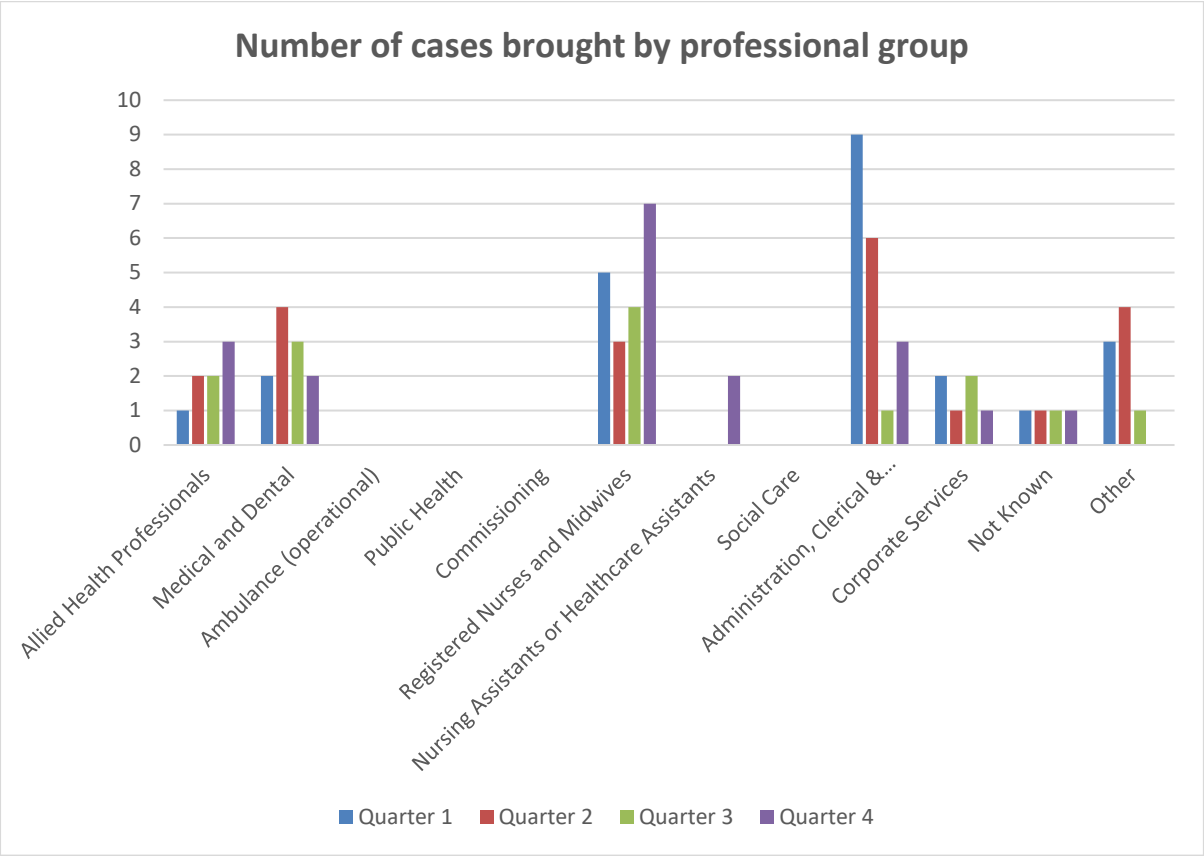
4.5 The number of cases raised anonymously via FTSU at MFT was 1% (1 case). This is significantly lower than the national average of 12%.

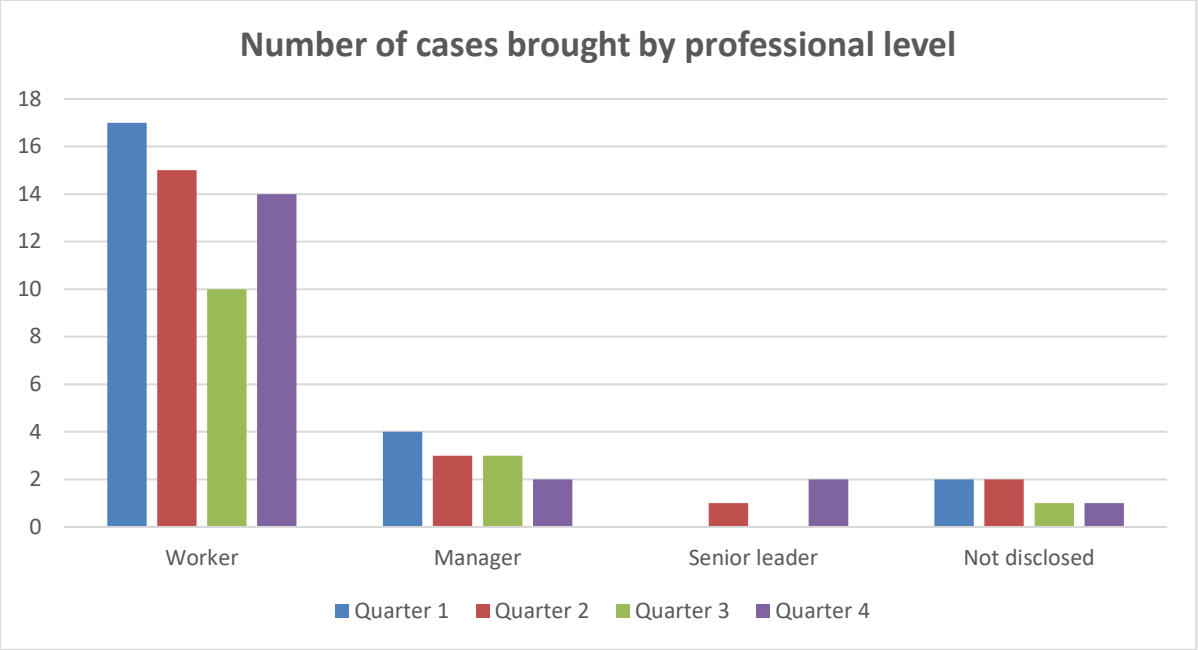
4.6 The number of cases where staff have reported experiencing detriment as a result of raising concerns is 13% (10 cases). This is much higher than the national average of 3%.

4.7 The following graph illustrates the location of concerns at MFT:



4.8 The following graphs illustrate the professional groups raising concerns to FTSU at MFT, and the staff level. The top two staff groups who have raised concerns to FTSU are Registered Nurses and Midwives along with Administrative, Clerical, Maintenance and Ancillary staff. These groups are similarly the highest groups reporting concerns nationally and this has been the case for the past two years.





5. The NHS Nightingale Hospital North West and FTSU

5.1 The NHS Nightingale Hospital North West was established in Manchester as a key facility to help the region's response to COVID-19. FTSU was included

in the induction for all staff working on the site and a dedicated FTSU champion was available to support staff, including third party providers. Meetings were held frequently to monitor concerns. In addition, robust links were built with the HR Business partners to support the escalation processes and cases raised through embedded FTSU routes.

5.2 In the year this report covers, while The NHS Nightingale North West remained open, 7 concerns were raised to FTSU. Most cases were from third party suppliers in relation to HR issues and grievances. The individuals were signposted by the FTSU champion to the right source of support. One contact to FTSU was to discuss mediation support and the staff concerned were signposted by the FTSU champion on site to the correct supportive route.

6. Freedom to Speak Up Index

6.1 NHS England and the National Guardian's Office have brought together 4 questions from the NHS staff survey into a FTSU index. These questions ask whether staff feel knowledgeable, secure, and encouraged to speak up and whether they would be treated fairly after an incident.

6.2 The FTSU index allows trusts to see how an aspect of their speaking up culture compares with other organisations so learning can be shared, and improvements made.

6.3 The questions from the survey which are included in the Freedom to Speak Up Index are:

- **16a** - % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss o incident fairly.
- **16b** - % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents.
- **17a** - % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it.
- **17b** - % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice.

6.4 There was an additional question (18f) included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally. This was not included in the 2020 FTSU Index calculation– to allow for comparability to previous years – but has been analysed alongside the index score for this report

- **18f** - % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation.

6.5 MFT FTSU Index Score based on 2020 staff survey = 78.3. This is slightly below the national average of 79.2. The MFT FTSU Index Score has increased by 0.2% from the previous year. A breakdown of performance against the individual questions for each of the MFT Hospital/MCS/LCO/ Corporate areas is shown below in Table 3.

NMGH is included within this table for comparison, however, the scores were not included in the overall MFT position in 20/21 as they were not formally part of the MFT Group at that time.

A RAG rating has been applied to the scores; whereby green indicates as score above the national average, amber indicates a score within 1% of the national average and Red indicates a score which is more than 1% below the national average.

Table 3: breakdown of FTSU index scores by hospital/MCS/LCO/Corporate areas

	16a	16b	17a	17b	18f
National Average	60.9%	88.3%	94.9%	72.5%	65.6%
MFT	63%	87%	93%	71%	63.6%
Corporate	61%	81%	88%	61%	65%
Dental Hospital	61%	90%	93%	63%	57%
LCO	64%	89%	96%	75%	66%
MRI	60%	84%	93%	72%	59%
MREH	60%	84%	92%	71%	60%
SMH	68%	93%	95%	74%	61%
WTWA	61%	84%	94%	71%	64%
Children's	64%	89%	94%	78%	67%
CSS	67%	90%	93%	73%	65%
NMGH			98%	75%	
E&F	61%	87%	88%	60%	69%
Charitable	38%	67%	90%	26%	43%
R&I	64%	89%	94%	71%	70%

6.6 Whilst there are many factors within the organisation that would influence the FTSU Index score, the FTSU Programme should help to support an improvement in this score. Discussions are ongoing with Corporate Governance and HR Directors in relation to factors which will impact this score and work stream programmes to support improvements.

7. Preparation for transition of NMGH FTSU teams into MFT

7.1 On 1st April 2021 NMGH formally joined the MFT Group. Prior to this, FTSU processes and reporting was managed via the Northern Care Alliance (NCA) During 2020/21 work was undertaken to ensure a smooth transition of the FTSU Programme. This was facilitated by regular meetings between the NCA and NMGH FTSU Lead Guardians and operational support.

7.2 Training for the NMGH FTSU Team regarding MFT systems and processes was completed and the NMGH team was invited to the MFT FTSU network meetings prior to transition. Continuity for staff raising concerns was maintained throughout the process and the NMGH FTSU Team is now successfully embedded into MFT.

7.3 The NMGH FTSU Team transition to MFT has led to the inclusion of an additional Freedom to Speak Up Guardian. Joanne Williamson provides 4 hours of FTSU time per week alongside her substantive clinical role in Theatres at NMGH. This role will provide increased support across the MFT FTSU network.

8. FTSU Guardian

8.1 In April 2021 David Cain retired from the role of MFT FTSU Guardian. A new, full time FTSU Guardian, Karen Hawley, was successfully appointed and commenced in post on 4th May 2021.

8.2 The creation of a full time Guardian role will allow the previous work to embed FTSU within the organisation to be consolidated and further embedded / extended. In turn this will support work to promote a culture of speak up, listen up and follow up. The additional FTSU guardian resource within the organisation will also allow effective relationships to be built with relevant stakeholders and will support delivery of the MFT people plan and MFT Group Trust values.

9. Key Actions for 2021-2022

9.1 The National Guardian's Office mission is to 'make speaking up business as usual'. Raising concerns should be a normal part of an effective and safe work environment. To support this at MFT, the high-level deliverables for FTSU, over the next 12 months, are as follows:

9.2

Proposed FTSU Objectives, 2021-2022
Continue to expand and develop the diverse FTSU network of champions across MFT.
Review FTSU processes and systems to ensure consistency of approach across the team.
Ensure FTSU processes and approaches are aligned with the MFT People Plan.
Develop and embed best practice processes to ensure FTSU concerns are triangulated against patient safety issues and promote organisational learning.
Update FTSU communications by a range of means so that all staff are aware of the role of FTSU and how to contact the team.
Continue to develop staff skills and knowledge around speaking up, listening up and following up.
Continue to work with the National Guardians Office and Regional FTSU Network to ensure that MFT learns from national best practice.

9.3 More detailed plans, regarding these milestones, will be developed by the FTSU Guardian, with input from relevant stakeholders. Progress against these objectives will be reported via the HR Scrutiny Committee, and a summary of achievements will be set out in the 2021/22 annual report.

10. Conclusion

10.1 The MFT Freedom to Speak Up Programme has continued to make good progress during 2020/21 and this report outlines the achievements and impact FTSU has had during this year. The impact of the Covid-19 Pandemic on the NHS has meant that it has never been more important for staff to feel able to raise concerns about patient safety or their own experiences.

10.2 The appointment of a full time FTSU Guardian in May 2021, will provide huge opportunities to further embed FTSU across the hospitals, MCS, LCO and corporate services to help support an effective ‘Speak Up, Listen Up, Follow Up’ culture.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Director of Corporate Business / Trust Secretary
Date of paper:	November 2021
Subject:	Board Assurance Framework (October 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 (October 2021) which is aligned to the MFT Strategic Aims.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (October 2021)

1. Introduction

Significant risks to achieving the Trust's key strategic aims are 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.

In October 2021, a workshop was held with Non-Executive Directors to identify any required improvements to the format and content of the BAF. This has led to an additional cell on each risk template to identify the relevant Scrutiny Committee where relevant. The scoring has also been changed from 'impact x likelihood' to 'likelihood x impact' to reflect the way risk is recorded across MFT.

Following recommendations from a recent internal audit, a Standard Operating Procure has been produced for risk owners. Further work to increase the consistency with which risks are described and scored by the different contributors will take place over the coming months.

The BAF is received and noted at least twice a year by the full Board of Directors. The updated BAF for October 2021 is attached (**APPENDIX A**.)

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):

1. *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*
2. *To improve patient safety, clinical quality and outcomes*
3. *To improve the experience of patients, carers and their families*
4. *To achieve financial sustainability*
5. *To develop single services that build on the best from across all our hospitals*
6. *To develop our research portfolio and deliver cutting edge care to patients*
7. *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 (October 2021) which is aligned to the MFT Strategic Aims (2021/22) and also highlights the continued impact of the ongoing COVID-19 National Emergency.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(October 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

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

Enabling Strategy:
QUALITY AND SAFETY STRATEGY

Group Executive Lead:
JOINT GROUP MEDICAL DIRECTOR

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**

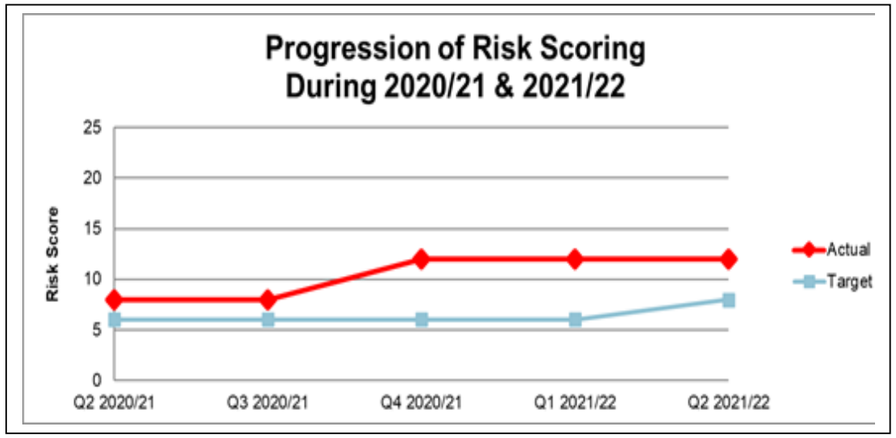
Scrutiny Committee:
QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Monitoring Committee:
QUALITY AND SAFETY SCRUTINY 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 Likelihood/Impact *"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 Likelihood/Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood/Impact *"Based on successful impact of Controls to mitigate the risk"*
16 **4x4**	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.2 F2SU not fully embedded 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 B.18 Lack of standardised approach to evidence presentation to regulatory bodies	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** **(3x4)**	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 B10 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 Develop a revised assurance process in relation to NICE guidance implementation B.10 Develop a revised assurance process in relation to the management of national and local clinical audit B.14 Develop an analytic strategy to ensure effective integration of NMGH data B.15 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 B18. Preparation of a guidance document on evidence preparation and presentation. Development ad delivery of masterclasses on assurance processes	Medical Directors/ Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business	December 2023	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 feeding into Safety Oversight System 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 now procured to support mortality and effectiveness data requirements	**8** **(2x4)**

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?):

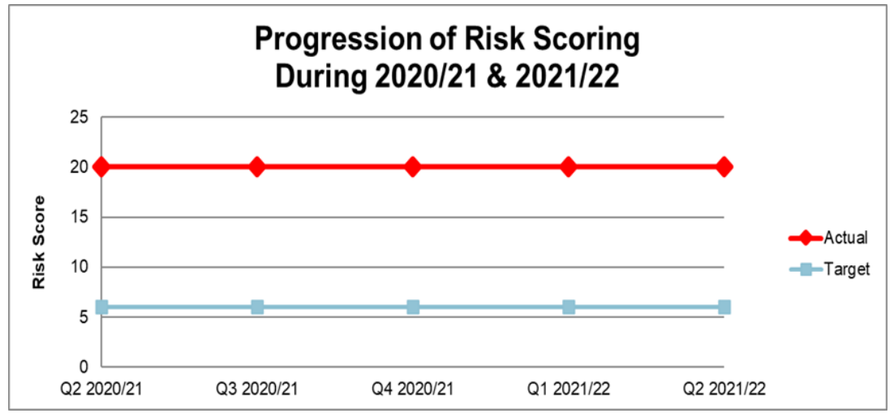
1. **Increase in serious harm to patients**
2. **Increase in nosocomial infections**
3. **Increase in staff outbreaks**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee:
INFECTION CONTROL COMMITTEE

Scrutiny Committee
QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Lead:
ASSISTANT CHIEF NURSE IPC/TV
CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"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 Likelihood/Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"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 - Terms of reference for COVID-19 MDT refreshed and agreed through COVID-19 Strategic Group October 2021 – 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 o Variety of makes of FFP3 disposable respirators increased - 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.Plans in place to adopt recommendation 1, to reduce physical distancing in low risk areas for elective patients in accordance with of UKHSA Guidance 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 to support the flow throughout the patient journey. E1. Patient placement guidance in place E1. Keeping Safe - Protecting You – Protecting Others Document approved and in place – This is currently under review 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	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 – This is currently under review 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 Fit testing databases are in place in hospitals/MCS, from 1st October 2021 all fit testing for FFP3 respirator will be captured and reported on the learning hub to enable robust reporting via Group Infection Control Committee	**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	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. – Enhanced cleaning to remain in place in all areas until end of Q4 – 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. – – Quarterly 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. From November the Group AMC will re-convene with quarterly meetings. 3 sub-groups to be established 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. 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. Stage 1 – all scores displayed to be completed by October 2021 in all clinical areas Stage 2 – electronic monitoring to be full implemented by April 2022 Project group in place to review the commitment to the cleanliness Charter provided within the National Standards to align with agreed cleaning responsibilities matrix	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	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 Estates and Facilities team are undertaking a review of both clinical and non clinical cleaning responsibilities as part of preparation for implementation of Cleaning Strategy. 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 3 sub-groups of AMC formed including - Guidelnes and development group - Education and training interventions - Research quality improvement and audit	**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**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	**A4. The Trust provides 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** – Message on MFT phone services – Visiting Policy in place – Patient Information Leaflets in place – Notification of any hospital outbreaks to NHSE – Staff outbreak informed by the test and trace national policy – Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical face mask when moving around the hospital – PHE Hands, Face, Space Campaign is visible throughout the Trust **A5. The Trust ensures 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 too other people** - Test and trace implemented nationally - Staff outbreak informed by the test and trace national policy - 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. - Trust has an internal test and trace policy - Outbreak policy in line with NHSE guidance - Outbreaks contained and reported to NHSE/I - Executive and DiPC oversight of externally reported data - Screening and triage of patients by staff trained as per IPC guidelines is in place **A6. Systems are in place 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** – Widespread implementation of PHE Personal Protective Equipment (PPE) guidance in all areas of the organisation including both Aerosol Generating Procedures (AGP) and non AGP procedures – There is separation of patient pathways with one way flow systems and restricted access / egress points as appropriate. Restricted access is in place, with clear signage in support of IPC measures. – Additional hand hygiene facilities are available at all entrances/exits to the hospital buildings and at entrance and exits to clinical areas – Seating facilities in communal areas are marked to encourage 2m distancing – Corridor floor signed to encourage 'keep left' principles – Frequent decontamination of equipment and environment in both clinical and non-clinical area, – Communication with procurement/materials management – Implementation of appropriate face masks for staff, patients and visitors to the organisation as per recent PHE guidance – Provision of PPE education to senior members of staff to support local implementation of PPE policy – Working with Employee Health & Wellbeing and Equality and Diversity to ensure staff who have issues relating to the use of face masks have risk assessments and alternate provision to PPE as required – 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 – they are symptomatic – Trust complies with national guidance – EHWB service provides staff support.		C4. Policy reviewed following further guidance and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission C4. NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed Visiting Policy available via Trust Intranet and information published on the Website C4. Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas C4. Screens in place at reception areas C4. Available guidance: Coronavirus Restricted Access Measures Guidance May 2020 C5. Patient streaming at access points in place at all ED access C5. Policy of testing by conventional PCR will continue whilst the trust continues to develop point of care testing PCR to include elective patients in further rollout C7. Keeping Safe Policy in place focusing on the 'Four pillars of working safely' C8. Track and Trace Protocol is being refreshed to include updated PHE guidance		20 (4X5)		ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020		**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?"*
25 (5x5)	**A7. The Trusts has provision for / can secure adequate isolation facilities** – patients are cohorted according to clinical presentation – risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission – Isolation of Infectious Patients Policy in place – programme of review of air flow and ventilation undertaken throughout the pandemic – There is separation of patient pathways with one way flow systems and restricted access / egress points as appropriate. Restricted access is in place, with clear signage in support of IPC measures. – Additional hand hygiene facilities are available at all entrances/exits to the hospital buildings and at entrance and exits to clinical areas – Seating facilities in communal areas are marked to encourage 2m distancing – Corridor floor signed to encourage 'keep left' principle – Guidance for reducing isolation facilities produced in April 2021 by the IPC team to support recovery whilst still maintaining IPC measures and keeping staff and patients safe. **A8. There is secure adequate access to laboratory support as appropriate** – UKAS accredited PHE laboratory conducting testing for NW of England – Screening of non-elective patients in place – Hospitals/MCS putting in place pre 48 hour testing for elective admissions – Policy for staff screening is in place – MFT site of PHE host laboratory and has capacity for extensive screening, however capacity is constrained until further platforms are in place. – Screening for alert organisms continued in line with trust policy – Tracking systems are in place to support priority screening and results availability – Turnaround times are measured (additional transport is in place to improve travel time for specimens from site to laboratory – Recommendation 2 of UKHSA has been partly supported. The trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing using PR to include elective patients in further rollout **A9. The Trust has and adheres to policies designed for the individual's care and provider organisations that will help to prevent and control infections** – 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 – Microbiologist support – Virology support – 7 day working from IPC/Health and Wellbeing – Guidance updated on intranet and communicated daily via email – 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. **A10. The Trust has a system in place to manage the occupational health needs and obligations of staff in relation to infection** – Widespread implementation of PHE Personal Protective Equipment (PPE) guidance in all areas of the organisation including both Aerosol Generating Procedures (AGP) and non AGP procedure – Working with Employee Health & Wellbeing and Equality and Diversity to ensure staff who have issues relating to the use of face masks have risk assessments and alternate provision to PPE as required – EHWB Policy in place – Employee Health and Well Being Service COVID-19 Guidance and Support available via Trust intranet – 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 available to managers and staff 7 days a week. – Policies are in place to support staff who fail to be adequately fit tested. – A centralised system will be develop to allow regular review of maintenance of safety in relation to fit testing. **A11. Test and trace implemented nationally** - Staff outbreak informed by the test and trace national policy **A12. COVID-19 Staff Vaccination Programme in place** - NHSE/I Directions and guidance cascaded through Strategic oversight group. This includes PHE publication of updates to Chapter 14a of The Green Book. - Links established with GM Oversight group - Chief Nurse has executive oversight of MFT vaccination programme - All staff have been offered the vaccine - A dashboard is under development to monitor staff compliance with vaccination **A12. Escalation plans in place as per trust gold command and GM Gold command** - **Communication:** -Guidance cascaded through Strategic Oversight group -Daily communications email sent to all staff -IPC Team daily visit to clinical areas -Attendance in wards/departments -Weekend IPC team provision -IPC team have developed reference posters for staff

	-Guidance on staff intranet - message on MFT phone services - **Oversight:** 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 Quality & Performance Scrutiny Committee Group Infection Control Committee COVID-19 Expert Group established - Microbiology and Virology support in place

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 issues of demand pressures, capacity, workforce and estate constraints, and ongoing incidence of Covid across our hospitals / MCS.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284).

Following the merger of North Manchester General Hospital and MFT in April 2021, work continues to disaggregate residual service elements and should be taken into account when considering delivery risks.

Enabling Strategy:
- Quality & Safety Strategy
- Transforming Care for The Future Strategy

Group Executive Lead:

Group Director of Operations

RISK CONSEQUENCES

1. Increased 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

Scrutiny Committee:
Quality and Performance Scrutiny Committee

Operational Leads:
Hospital / MCS Chief Executives

Key performance Indicator	Standard	Performance			
		June-21	July-21	August-21	September-21
A&E 4-hour Access	95%	72.92%	67.85%	69.19%	64.65%
RTT <18 weeks %	92%	56.97%	55.73%	54.84%	Not available
52-week breaches	-	14,706	14,442	14,222	Not available
Incomplete waiting list	-	141,545	145,823	147,527	Not available
12-hour Trolley Waits	0	-	6	2	26
DM01 Diagnostics %>6wks	<1%	27.51%	27.00%	30.40%	Not available
Cancer 2ww	93%	89.30%	90.99%	90.39%	Not available
Cancer 31 days	96%	90.72%	91.71%	94.71%	Not available
Cancer 62 days	85%	66.27%	68.44%	58.81%	Not available

Inherent Risk Rating Likelihood/ Impact *"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 Likelihood/ Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"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 GDO • 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. On call Structures have been revised and adapted to support the hospital/MCS response to the pandemic and ongoing covid incidence, in addition to business-as-usual operational running. Further supported by the strategic management arrangements. 1.4. In line with national planning guidance for 21/22, H2 activity planning is underway. This includes performance trajectories for managing urgent (inc. Cancer) and longest waiting patients. 1.5. Reporting in place to track activity levels against the revised planning expectations and associated performance trajectories. 1.6. 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.	2.1 Regular audits to confirm that hospitals / MCS are using all available capacity including GM hub and Independent Sector capacity.	3.1 Reporting to the Executive Board and Committees in relation to the Covid Pandemic, Recovery programme and performance. 3.2 MFT Covid 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.	4 Appropriate review and action plans for performance improvement of elective slot utilisation	15 (3x5)	5.1. Key actions are outlined in the Risk Report to the Group Risk Committee. 5.2. 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. 5.3. 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. 5.4. Effective management of elective waiting lists to ensure that MFT treats its most clinically urgent patients first. 5.5. 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. 5.6. 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. 5.7. Diagnostics: is incorporated within a number of recovery workstreams, in addition, the Trust is linking into GM structures for Diagnostics. 5.8. Workforce is a key element to all recovery workstreams, with HR representatives on these groups to ensure the workforce implications are considered and addressed.	David Furnival	Ongoing throughout 2021/22	6.1. Workstream progress is being reported into the Strategic Group, The Board of Directors, and Group Risk Management Committee. 6.2. The performance position against national standards is reported via the Covid Recovery and Performance report to the Board of Directors.	12 (3X4)

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 issues of demand pressures, capacity, workforce and estate constraints, and ongoing incidence of Covid across our hospitals / MCS.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284).

Following the merger of North Manchester General Hospital and MFT in April 2021, work continues to disaggregate residual service elements and should be taken into account when considering delivery risks.

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 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. 1.7. MFT Board and Committee activity and performance reporting in place 1.8. MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.9. Patient Access Policy 1.10. MFT EPRR Policies and Plans to support organisational response to Major Incident and Business Continuity incidents 1.11. 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. 1.12. 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. 1.13. Covid contact tracing 1.14. Vaccination programme 1.15. Reason to reside moved into business-as-usual processes 1.16. Planned transformation Urgent Care and Flow workstreams have been implemented and continue to be developed 1.17. H2 planning submission 11/21 will support recovery of activity and therefore delivery of performance

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

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**

Enabling Strategy:
QUALITY & SAFETY STRATEGY
ESTATES STRATEGY

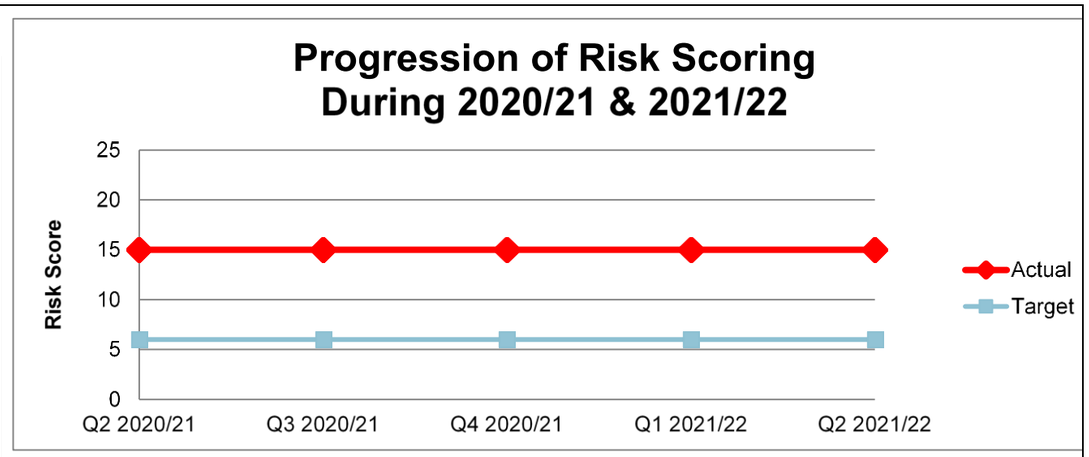
Group Executive Lead:
CHIEF OPERATING OFFICER

Associated Committee:
CEO FORUM

Scrutiny Committee:

Operational Lead:
GROUP DIRECTOR OF ESTATES AND FACILITIES

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"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 Likelihood /Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood/Impact *"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.5 Some controls are reactionary, based on minimising impact should an issue occur	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 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	15 (3x5)	D.1 Complete surveys and agree programme of remedial works by site and infrastructure system D.2 Infrastructure schematics updated in line with the survey and remedial work	Chief Operating Officer	Assurance task complete Remedial actions will run for a prolonged period (circa 24 months)	Survey and remediation work ongoing Schematics being updated on an as needed basis 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. Significant work ongoing with ProjectCo; Sodexo and Engie to enhance record keeping and Trust access to records as required. Workstream in place with Sodexo & Project Co at Wythenshawe to improve Trust access to maintenance records	**6 (3x2)**

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

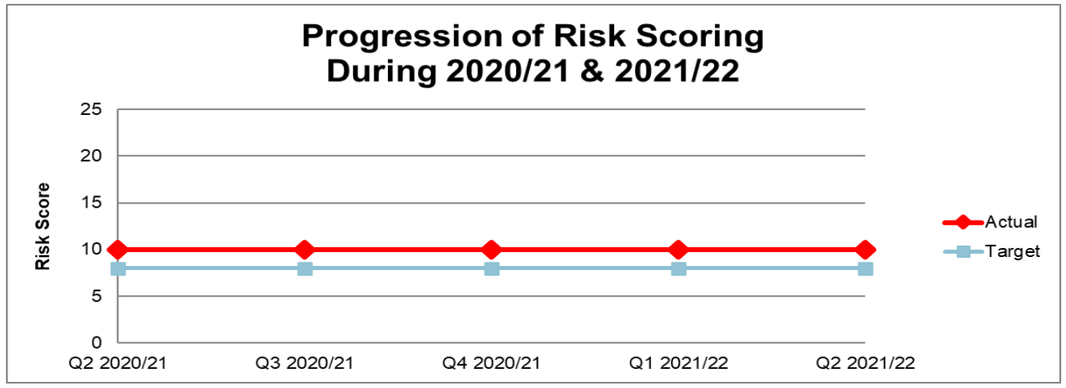
RISK CONSEQUENCES (What might happen if the risk materialises?):

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

Scrutiny Committee:
QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Lead:
DEPUTY CHIEF NURSE /ASSISTANT CHIEF NURSE (SAFEGUARDING, QUALITY AND PATIENT EXPEREINCE)



Inherent Risk Rating Likelihood x IImpact *"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 Likelihood x impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x impact *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	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 (2x5)**	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	A11.The installation of CP-IS within SMH maternity services has been delayed due to pressures within the IT department, system incompatibilities particularly during the COVID 19 pandemic response. The implementation for St Mary's at Oxford Road is currently being reviewed. The CPiS system is implemented within the NMGH Emergency Department but it is not being consistently applied - an implementation plan is in place to address this. 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 all staff on the safeguarding intranet site. At the end of Q2 **63.3%** of staff who are mapped to level 3 Adult Safeguarding training had achieved compliance. The plan is to achieve 90% compliance by March 2022. The Mental Capacity Act policy and Deprivation of Liberty Safeguards policy were reviewed in Q2 and were ratified at the Group Safeguarding Committee in August 2021. The Safeguarding Audit Calendar includes review of the application of the DoLS process across the hospitals/MCS/LCO. Audits completed in Q1 and Q2 identified that further development work is required to ensure consistent application of the DoLS processes across the Trust. 2 Mental Capacity/Mental Health Officers are now in post – a part of their role is to monitor the quality of the DoLS applications submitted to the Local Authority and to 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 the **1015** DoLS applications made by MFT in Q1 2021/22, only **10** were authorised, **447** applications were awaiting assessment at the end of Q1 and **395** were no longer required as the subject individuals were no longer inpatients. DoLS audits demonstrate some inconsistency in application of DoLS processes. The Safeguarding Mental Health Matron is leading work with both Manchester and Trafford LA DoLS leads to continue to improve compliance. B3. Role requirements/competencies have been matched in accordance with the revised Intercollegiate Guidance. Improvement plans have been developed and implemented by the Directors of Nursing to improve compliance. Overall safeguarding training compliance at the end of Q2 was **87.88%** compared to a Trust target of 90% and a CQC target of 85%. Level 3 safeguarding training is available online with a participatory workbook to evidence learning. Level 3 safeguarding children's training increased to **81%** at the end of Q1 however reviewed mapping across the hospitals/MCS/LCOs has resulted in Level 3 Safeguarding Children's compliance at the end of Q2 reducing to **73%.** Level 3 safeguarding adult training has increased to **63%** wit**h 90%** expected by March 2022. The safeguarding and learning and development teams have commissioned a revised safeguarding training package with an online content that includes virtual/participatory learning - an implementation plan to deliver this training package has been developed. B4. The online safeguarding training programme with completion of a 'workbook' to evidence learning continues to receive positive feedback and evaluation. The Trust target of 76% in respect of Level 3 safeguarding adults training by end of Q2 is 13% below the expected trajectory – this is being addressed at the site safeguarding committees. B5.Following a successful business case to expand LD Specialist Nurse capacity and recruitment to North Manchester General Hospital, 3xband 7 and 3xband 6 posts have been recruited to. B6 The LCO Director of Nursing is 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 the Programme Director with PMO support. System leadership includes MHCC, MFT, Primary Care, GMMH and MLCO. The Directors of Nursing continue to lead the local improvements within hospitals/MCS's/LCO's. B6. The updated LD work programme informed by self-assessment against the NHSE/ I learning disability improvement standards for NHS trusts continues and regular updates are provided to the Group Safeguarding Committee. C3. The Hospital/MCS/LCOs are required to provide evidence/assurance of compliance with CQC Regulation 13 through the completion of an annual assurance template/document. The Assistant Chief Nurse- Safeguarding, Quality and Patient Experience meets with the Directors of Nursing to seek/provide assurance of compliance. Any gaps/lack of assurance are escalated to the Group Deputy Chief Nurse for further scrutiny/challenge.	**8 (2x4)**

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

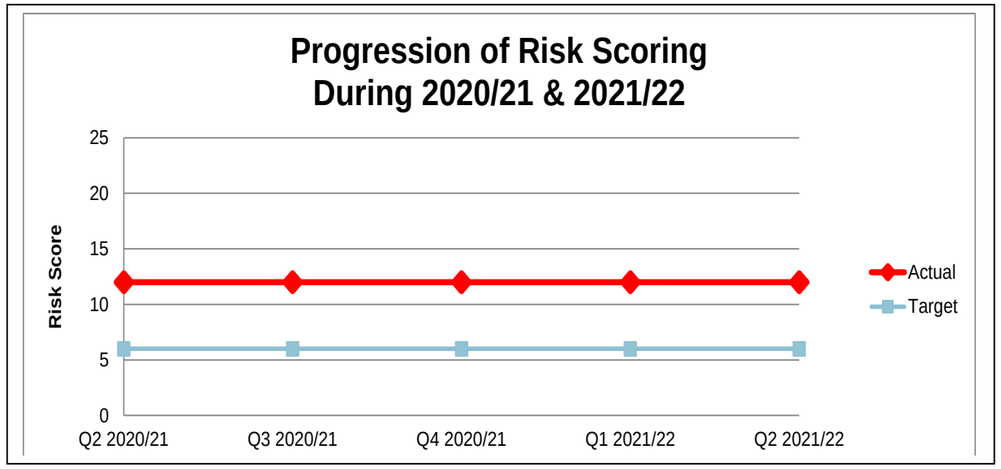
RISK CONSEQUENCES (What might happen if the risk materialises?):
1. **Compromised patient care**
2. **Adverse patient experience**
3. **Increased complaints**
4. **Failure to comply with NHSI regulatory standards**
5. **Inability to recruit well trained nursing and midwifery staff further compounding the staffing issue**
6. **Inability to offer a quality training experience to students**

Associated Committee:
NMAHP PROFESSIONAL BOARD

Scrutiny Committee:
HR SCRUTINY COMMITTEE

Operational Lead:
CORPORATE DIRECTOR OF NURSING (WORKFORCE & EDUCATION)

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"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 Likelihood /Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"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 supply to support staffing demands and patient/service needs aligned with financial controls 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	B1 Nationally recognised shortage of domestic nurses B2 Uncertainty due to the long-term impact of CV19 on clinical workforce and long term absence	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) census data to support annual inpatient workforce establishment reviews. C10 Safe staffing guidance and staffing escalation process to support risk assessment and escalation	D1 Variation in staffing levels and workforce supply within the hospitals MCS/ MLCO. D2 realign establishment data with reconfigured clinical areas and services post pandemic	**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, reduce vacancies and support capacity demand post pandemic. E4 Reduce turnover and improve retention rate in band 5 roles. E5 Review all in-patient ward areas' staffing establishments following reconfiguration of hospital/MCS service models E6 Reduce staff absence, focus on staff health and wellbeing E7 Finance programme to realign establishment data with reconfigured clinical areas and services post pandemic	Chief Nurse' s Team	November 2020	1 Programme of local and overseas recruitment events planned for the next 12 months. 2 The Trust is to recruit 450 international nurses before the end of March 2022 to support pandemic recovery plans (220 arrived). 3 The registered nurse and midwifery vacancy rate has reduced to 5.2% in September 2021. It was 7.2% in April 2021. 3 A Guaranteed job offer has been introduced for all 3rd year student nurses and midwives who undertake their final year placements at the Trust. 4 Annual rolling turnover rate for nursing and midwifery remains between 11-12% (13.5% pre-pandemic) 5 Directors of Nursing undertaking baseline establishment reviews to support reconfiguration of ward/department area. 6 Safe staffing census data will be collected in November and January with a baseline establishment review to be undertaken following 3 census periods to support a baseline staffing establishment review. 7 Nursing and midwifery managers are working closely with NHS Professionals to ensure adequate bank and agency supply to cover sickness absence. 8 Daily staffing escalations meetings in place across the trust. 9 Daily staffing risk assessment completed by each hospital following the escalation matrix 10. Weekly DONs staffing escalation meeting – chaired by DepCN 11 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.**

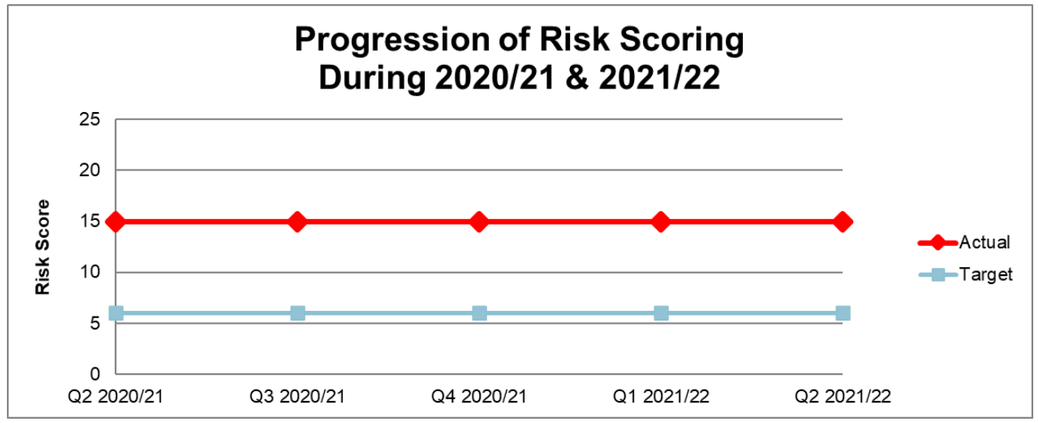
Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Scrutiny Committee:
GROUP RISK OVERSIGHT COMMITTEE

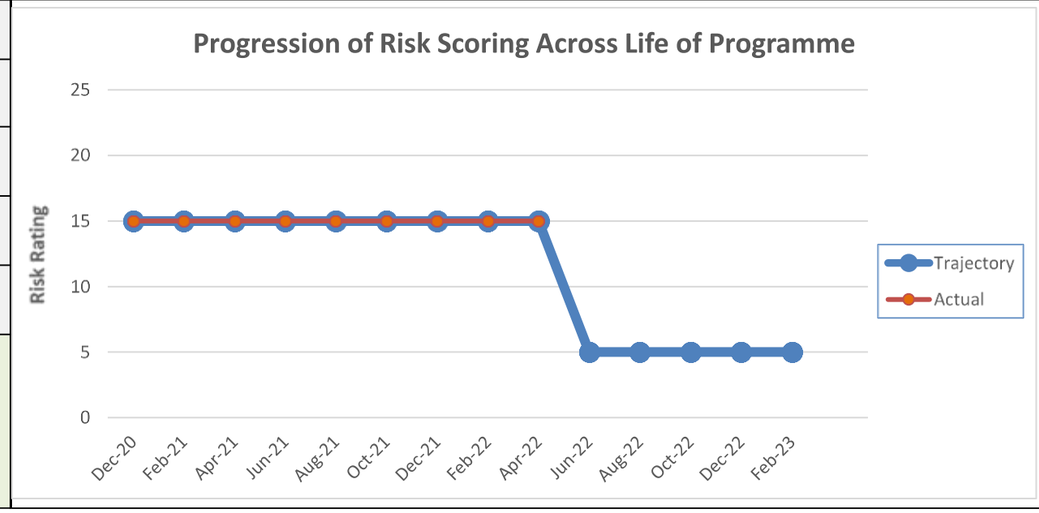
Operational Lead:
GROUP CHIEF INFORMATICS OFFICER

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 Likelihood x Impact *"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 Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	• Internal technical Informatics governance in place including Cyber Board • Group Information Governance in place • Technical tools in place to monitor and preventing threats • Active member of National and Advisory groups (Care Cert) • Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	• Effective and integrated Executive governance and oversight	• Papers and minutes from existing governance groups • Implementation of the Group Informatics Cyber Security Action Plan • National tools monitoring direct detection	• Detailed monthly reporting • Stakeholder engagement plan on cyber threats • Dedicated expertise in place • Clear Cyber Security Strategy and roadmap	15 (3x5)	• Implementation and monitoring of the Group Informatics Cyber Security Action Plan • Recruitment to appropriate resources • Development of strategy	Group Chief Informatics Officer	Ongoing	• Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. • Active market engagement to procure external provider to develop Cyber strategy and roadmap. • IT Security and Compliance Manager to start in January	**6 (2x3)**

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. Poor patient experience, patient safety, quality of care and outcomes 2. Reduction in staff morale. 3. High unwarranted variation in clinical and administrative management and operational processes. 4. Failure to meet the Trust objective of achieving financial stability by failure to realise the benefits case. 5. The Trust would remain at a low and worsening level of digital maturity. 6. Organisational reputational damage experienced	Associated Committee: **EPR PROGRAMME BOARD** Scrutiny Committee: **EPR SCRUTINY COMMITTEE** Operational Lead: **HIVE EPR PROGRAMME DIRECTOR**	

Inherent Risk Rating Likelihood x Impact *"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 Likelihood x impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x impact *"Based on successful impact of Controls to mitigate the risk"*
16 (4x5)	• EPR Task and Finish Committee approved the Full Business Case on the 18th May 2020. • Robust contractual and commercial arrangements in place with the contract signed on the 19th May 2020. • EPR Governance Framework defined and approved by Trust Board EPR Task and Finish Committee. Board of Directors involvement in scrutiny committee • Terms of Reference defined and approved for EPR Implementation and Benefits Realisation Board. • Internal Audit commissioned to carry out Hive Programme Risk Assurance • Introduction of an IT Literacy framework to support rapid adoption of the solution. • Implementation of a data quality and migration strategy. • Implementation of end-user training strategy. • External Assurance Review reports commissioned to conduct 5 reviews across Programme lifetime. • Clinical Hazard assessments in place in line with clinical safety standards DCB 129 and 160 • Operational Readiness Authority established to oversee all readiness activities supported by revised Hospital operational boards • Staff Availability Task and Finish group established led by Group Executive Director of Workforce and Corporate Business to ensure staff are released appropriately for training/testing	• Go-live strategy to be developed • Transformation strategy in place	• Attendance at engagement activities with key stakeholders and subject matter experts representing all areas of the Trust and patient community • Detailed Financial reports on capital and revenue spend against the planned business case Technical Scheme. • EPR Implementation and Benefits Realisation Board minutes and papers and attendance report demonstrating representation • EPR Scrutiny Committee papers and minutes • Internal audit reports to Audit Committee • External Assurance Review reports commissioned to conduct 5 reviews across Programme lifetime.	• Single source of truth across programme and MCS for all risks	15 (3x5)	Review Internal Audit terms of reference for EPR Programme Risk Assurance and update to ensure they are complimentary to external assurance service. • Transformation change strategy defined and activities implemented to schedule • Communication and Engagement Strategy activities delivered to plan • Detailed tracking of financial spend against business case • Delivery of staff Availability task and finish group action plan • Plan for making existing systems ready for data migration, including addressing relevant data quality issues, and engagement with system users • Review programme plan in context to develop options based on modelling with winter pressures/recovery and changes in COVID levels	Group Chief Operations Officer/SRO	Ongoing	• Actions against recommendations of Gateway 1 External Assurance report completed • Gateway 2 External Assurance Report expected 21/10/21 • Operational Readiness activities commenced, via Operational Readiness Authority and Hospital Operational Readiness Boards, Operational Readiness Leads identified and inducted • Communications and engagement Strategy formulated and in operation to support operational readiness • Face to face engagement events, equipment and system demos in progress • Benefits Review Phase 1 complete • Role analysis complete and training tracks and curriculum in development • Risk review underway	5 (1x5)

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:

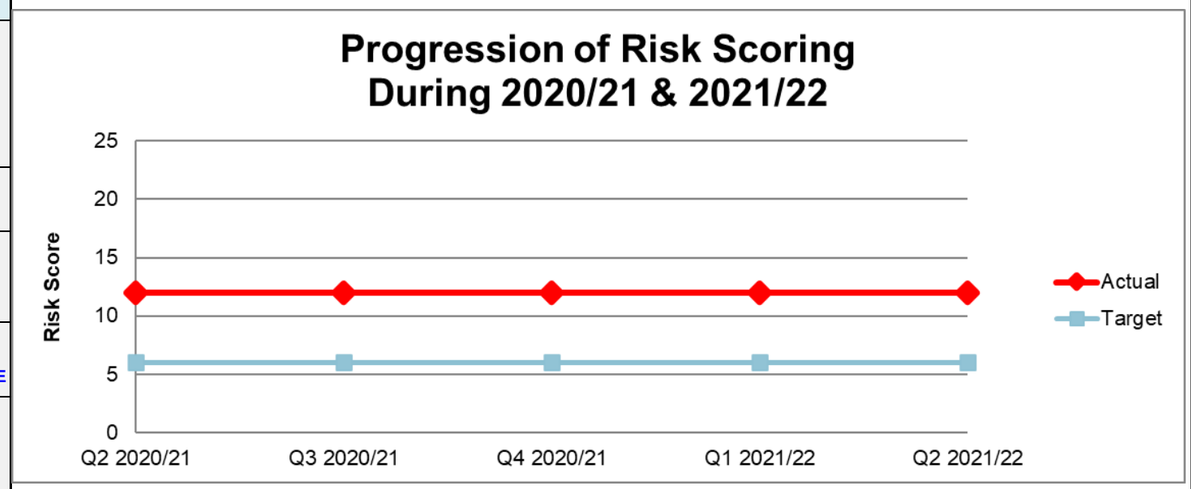
QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Scrutiny committee:

QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Leads:

DEPUTY CHIEF NURSE, ASSISTANT CHIEF NURSE (SAFEGUARDING, QUALITY & PATIENT EXPERIENCE), HEAD OF NURSING (QUALITY & PATIENT EXPERIENCE)



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12 (3X4)	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. The strategy is due for review which is underway in Q4. B4. Patient Experience & Involvement Strategy not fully embedded. B5 Food handling training not fully rolled out to comply with the EHO. E-Learning module will be available at Level 1 for all clinical staff involved in Patient Dining. recommendations B6 Visiting restricted since March 2020 to reduce Covid-19 transmission. Visiting Policy reviewed 16th April 2021 and visiting restrictions lifted in April 2021 B7. Patient Environment of Care (PEOC) stood down during Q3, 2020/21 due to Covid-19. POEC meetings restarted 22 February 2021	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. Data collection restarted in May 2021 C8. FFT stood down nationally during Covid-19 pandemic response – now recommenced.	**12 (3X4)**	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-Completed in Q2 and will be rolled out in November C1. Roster Matrons onto clinical shifts to support quality standards	Chief Nurse's Team	March 2021	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/LCO 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. WMTM has been introduced into the LCOs. B1. Following successful completion of the Always Events® Programme, Always Events will become part of the WMTM Framework. New areas commencing the programme will be monitored and shared through the Quality and Patient Experience Forum. B3. A nutrition & hydration responsive review was undertaken in Q1 of 2021/22 and presented to the Quality and Safety Committee in Q2. As an outcome, a multidisciplinary Nutrition and Hydration Oversight Committee has been established in Q2 as a sub-group of the Quality & Safety Committee with a focus on patient safety. Hospital/MCS/LCO/E&F nutrition and hydration activity is also monitored at the Patient Environment of Care and Quality and Patient Experience Forums. Group Lead Nurse for Quality and Professional Practice and Matron for Professional Practice in post and will support improvement activity. B.4 The Patient Experience & Involvement Strategy 2020-2023 was launched in Q2, 2020/21 and work is ongoing in hospitals/MCS/LCOs to implement the strategy. B5 A food safety training package was completed and approved in Q2. The 'Food Safety in the Clinical Environment' Policy was launched in August 2021. C1. Matrons continue to be rostered to work alongside clinical staff to support quality standards. The accreditation programme and Senior leadership walk rounds recommenced in May 2021. 53% of accreditations were completed by mid-October 2021. C2 AOF reporting re-established in May 2021. C5 Data collection restarted in May 2021 C8: FFT collection recommenced.	**6 (2X3)**

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. MFT Visiting Policy revised in April 2021	(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. Full accreditation programme recommenced. 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. New Patient Experience Platform Provider CIVICA contract agreed in Q3 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 the quality of food was reported in the national patient survey 2019. All other scores are within the average range. The Terms of Reference for the Patient Environment of Care (PEOC)Bi-monthly meeting have been reviewed and agreed. D2 The Hospital's/MCS's/LCO's action plans exception reports are monitored on an ongoing basis. D3 The 'Food Safety in the Clinical Environment Policy' was ratified at the ICP Committee on 13/01/21. A 'Policy on a Page' document was developed and distributed to provide a summary of the key aspects of the policy. The Policy was launched during Nutrition & Hydration week which was 14th -20th June 2021. Mandatory food handling e-learning training has been developed by Dynamic and has received final sign-off – the training will be available for all clinical staff involved in Patient Dining in November 2021. This will coincide with the Q2 Bee Brilliant Professional Practice-Nutrition and Hydration and will be 'a call to action' which includes all staff completing the Level 1 training. Level 2 training for staff such as AHPs that are involved in patient food preparation is currently under development with Dynamic. Clinical areas have commenced 'patient brought in food' fridge temperature monitoring. B5 A Food task and finish group has been established with E&F and nursing membership and focuses on compliance with the regulatory requirements. A 'Food Safety in the Clinical Environment' Policy has been developed. A Patient food fridge monitoring booklet has been completed and distributed, with 500 copies being printed and circulated during Nutrition & Hydration week, 14th -20th June 2021 A Food safety training sub-group has been established to enable compliance with the EHO recommendations. A patient visitor food safety sub-group has been established. B6 Virtual visiting services were established in August 2020. This continues in Q2 2020/21. B6. MFT and St John Ambulance volunteers were recruited to provide assisted patient dining services from Q2 2020/21: this service continues. C1. Alternate temporary assurance processes were implemented whilst full accreditation programmes were not possible (due to the pandemic), which includes observation of clinical areas, assessment of all quality and safety data and assurance meetings between the Directors of Nursing and the Group Chief Nurse/Deputy Chief Nurse. Clinical observation visits are on-going and assurance meetings conducted for MREH/UDHM and RMCH in Q3. The full/revised accreditation programme recommenced in May 2021. C1. The Senior Leadership Walkrounds recommenced in May 2021 C2 The AOF patient experience metrics have been revised and monitoring continues. C4,5&8 QCR data collection was re-established in May 2020. The WMTM survey was re-established from July 2020 and the National FFT reporting recommenced in December 2020. The New Patient Experience Platform with CIVICA is due to be launched 1st December 2021 C6 The National Inpatient, Urgent & Emergency Care and Children & Young People's Surveys field work has commenced. The 2020 Maternity Survey was stood down and NHS Trusts were allowed the option to participate in the National New Mothers' Experience of Care Survey 2020 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

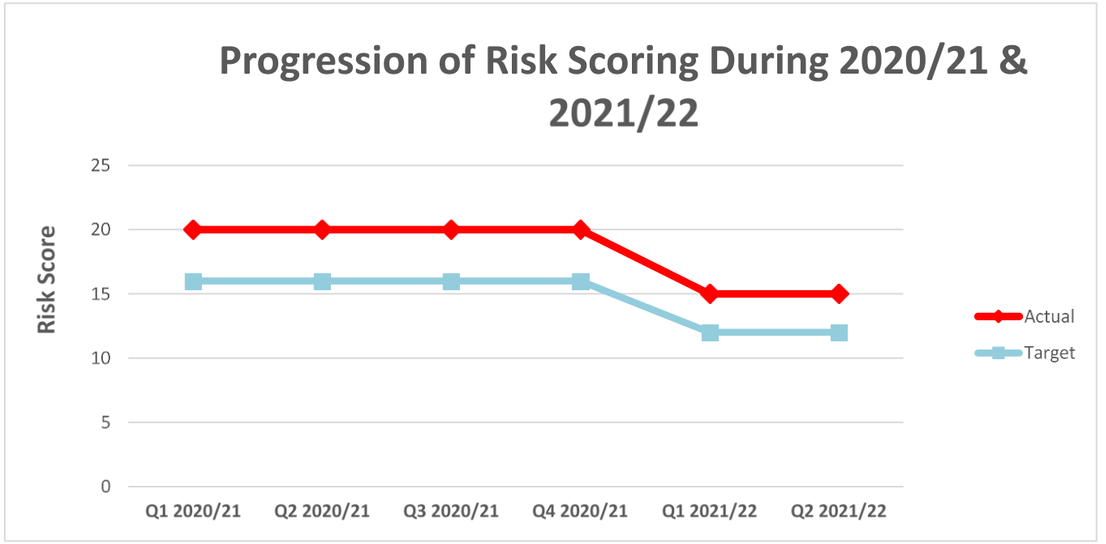
Group Executive Lead:
CHIEF FINANCE OFFICER

Associated Committee:

Scrutiny Committee:
FINANCE SCRUTINY COMMITTEE

Operational Leads:
HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood x Impact *"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 Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
20 (4x5)	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 (3x5)	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 ongoing discussions, funding needs to be at least 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	As at 20 October 2021, MFT has delivered a month 6 position of £13m against the internal plan of £23m, on a straight-line basis we continue to be behind on delivery of WRP requirements. GM CFO's are working through the implications of H2 funding, but we have not been allocated a final figure. It is already apparent that a continued focus on delivery of recurrent WRPs is key to achieving the target financial sustainability, along with early planning for 22/23.	**12 (3x4)**

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 FINANCE 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.**

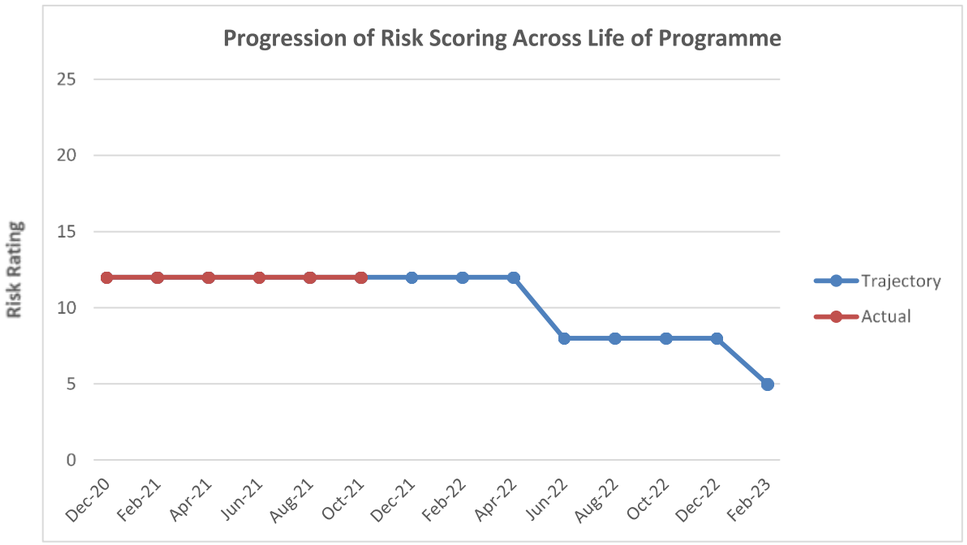
Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Scrutiny Committee:
Group Risk Oversight Committee/EPR Scrutiny Committee

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
- 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



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16 (4x4)	• GM Digital Transformation Board and GM CIO Providers • Capital Management & Monitoring Committee oversight • Informatics governance framework completed and revised structure and associated processes implemented including revised terms of reference for new Portfolio Board • Integrated governance with workforce for related strategies • Corporate Integration Steering Group monitoring of Informatics PTIP Plan for North Manchester. • EPR Governance Framework defined and approved by Trust Board EPR Task & Finish Committee. • EPR Implementation & Benefits Realisation Programme Board Terms of Reference defined. • EPR Task Full Business Case approved		• HIMSS digital maturity Index and publication of results and GM developed digital maturity assessment and plan • Capital Planning financial spotlights, delivery, and review/summary capital plans • Programme plan and close down documentation of COVID recovery stream to deliver digital solutions • Formal internal Informatics assurance risk documentation • Informatics PTIP Reporting for NMGH • Regular board updates to Hospitals and Group Corporate services including operational readiness work programme in place to support cultural change • EPR programme ongoing governance review and external assurance • Detailed phasing sign off for EPR Hive delivery	• Refreshed Informatics Strategy (post EPR delivery) and future state organisational structures • Demand Management - process in place with clear responsibilities • Benefits Realisation - Qualitative and Quantitative across Informatics programmes .	**12 (4x3)**	• Successfully deliver Hive EPR including all related activities • Refresh the Trust Digital strategy • Develop and implement target operating model for future state post Hive • Implement and monitor a robust demand management process and structure. • Initiate benefits management tracking through Group Informatics Portfolio Board	Group Chief Informatics Officer	Ongoing	• Hive programme progressing to plan • Resource assigned to develop first draft refreshed Digital Strategy on track by end of December • Robust Monthly monitoring against plans • Active developments of plans for future state in place and on track for completion by end of December	**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.

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**

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES, GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

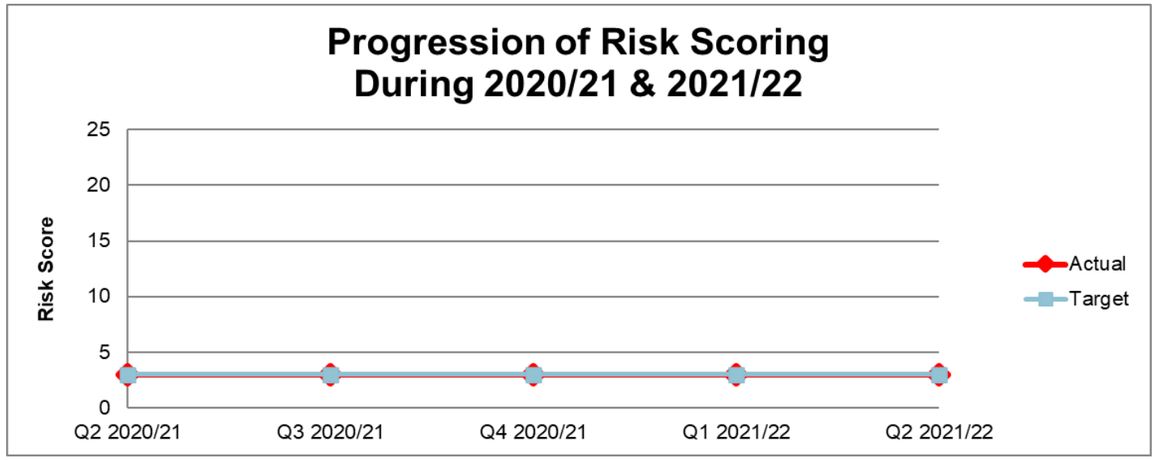
Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Scrutiny Committee:

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood x Impact *"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 Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
6 (3x2)	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 C.5 Process for the identification of strategic development risks developed for GSSC	D.1 No Gaps in assurance.	**3 (1x3)**	B.2 Annual surveillance reviews are unlikely to go ahead this year. The annual Trust wide review will recommence 22/23.	Group Governance Team	October 2021	Ongoing	**3 (1x3)**
						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 any residual issues will be included in 21/22 plans.	Hospitals / MCS	Ongoing	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	As necessary	As necessary	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews.	Group Strategy Team	Ongoing	Ongoing	
						A.1 Continued review of single service progress across MFT e.g. single governance, single clinical teams through COVID reviews.	Hospitals / MCS/Group	Ongoing	Underway	
						B3 Specialised services dashboards to be reviewed by GSSC.	Hospitals / MCS	Q4 21/22	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?):

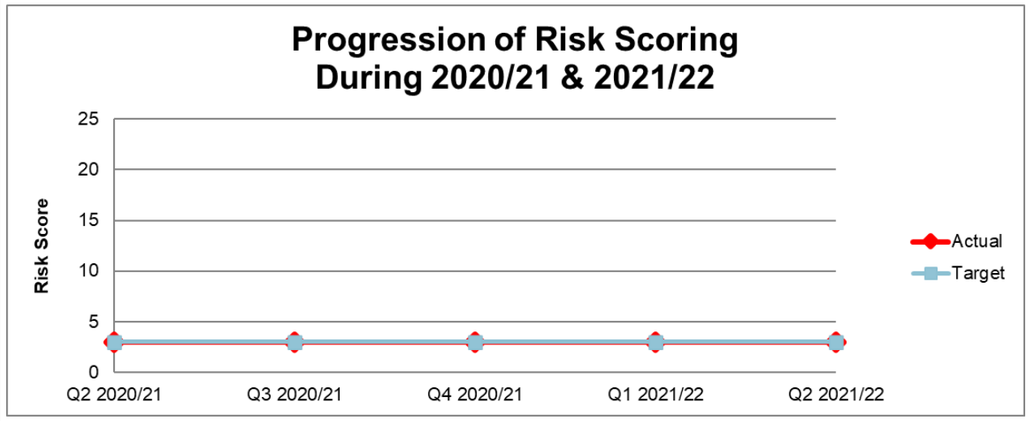
1. Loss of united voice for GM

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Scrutiny Committee:

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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8 (2X4)	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 (ISC programme remains stood down) 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 (completed) A.7 New governance for COVID. MFT representation on key GM groups incl GM Gold, GM Recovery groups.		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 strategiesfrom 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 (1x3)	A.1 Maintenance of control - Ensure regular MFT representation at all GM meetings	MFT Strategy team	On-going	Mapping of all meetings and MFT coverage underway	3 (1x3)
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1 19/20	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	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	Q4 21/22	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

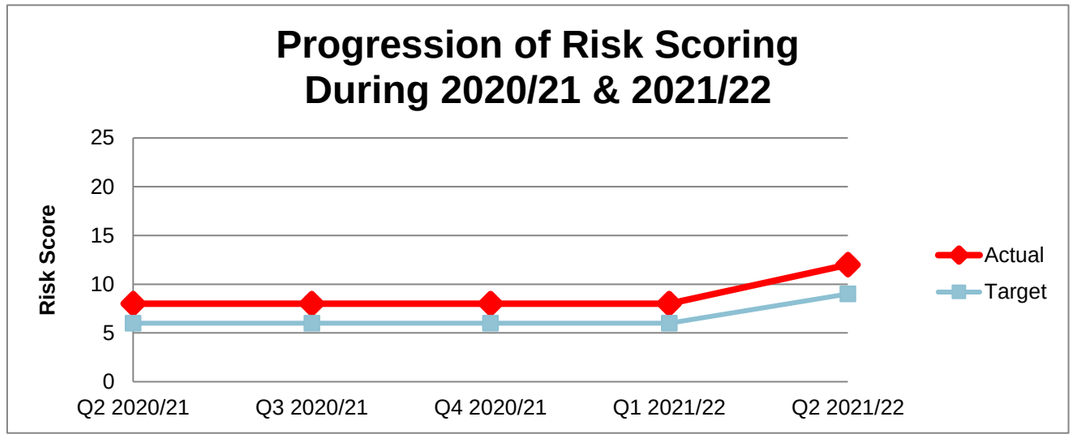
1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**

Associated Committee:
WORKFORCE & EDUCATION COMMITTEE
HR SCRUTINY COMMITTEE

Scrutiny Committee:
HR SCRUTINY COMMITTEE

Operational Leads:
GROUP DIRECTOR OF HR

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood x Impact *"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 Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	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.	**12 (4x3)**	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	***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.***	**9 (3x3)**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Director of Corporate Business/ Trust Board Secretary
Date of paper:	November 2021
Subject:	MFT Board of Directors' Register of Interests (October 2021)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The MFT *'Constitution'* and *'Standing Orders for the Practice & Procedure of the Board of Directors'* requires the Board of Directors to provide a Register of Interests.
Recommendations	The Board is asked to note the MFT Board of Directors' Register of Interests (November 2021)
Contact	Name: Nick Gomm, Director of Corporate Business/Trust Board Secretary Tel: 0161 276 4841

1. Introduction

In line with the MFT constitution and standing orders, the Board of Directors is required to make a declaration of its register of interests.

The register must include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive members.

The Register is available to the public on the MFT Public Website:

https://mft.nhs.uk/the-trust/the-board/register-of-directors-interests/

2. Recommendation

The Board is asked to note the MFT Board of Directors' Register of Interests (October 2021).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(November 2021)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – October 2021

NAME	POSITION	INTERESTS DECLARED
Kathy Cowell OBE DL	Group Chairman	• Chair of the Manchester Health Academy Trust Board • Member Manchester Academic Health Science Centre • Vice Chair Cheshire Young Carers • Mentor on the Aspirant Chairs Programme (NHSI) • Member of the QVA's mentoring panel (Cheshire) • Chairman of Totally Local Company • Deputy Lieutenant for Cheshire • Chairman of the Hammond School (Chester) • People Ambassador for Active Cheshire • Vice President, St Ann's Hospice
Barry Clare	Group Deputy Chairman	• Partner (Clarat Partners LLP) • Partner (Clarat Healthcare LLP) • Non-Executive Director (Ingenion Medical Ltd) • Chairman (Crescent OPS Ltd) • Chairman (FLOBACK Ltd) • Chairman Evgen Pharma PLC • Non-Executive Chairman of Porton Biopharma Ltd • Non-Executive Chairman (Ori Biotech) • Non-Executive Director (Arterius Ltd)

NAME	POSITION	INTERESTS DECLARED
Dr Ivan Benett	Group Non-Executive Director	• Standing member of a NICE Quality Standards Committee and Topic Specific Guideline Update Committee • Director of the Primary Care Cardiology Society • Salaried GP with Heart Network (Manchester) • Trustee to the Hideaway Youth Project
John Amaechi OBE	Group Non-Executive Director	• Founder, APS Intelligence (APS Intelligence Ltd, London) • Non-Executive Director, KPMG UK LLP Inclusive Leadership Board (ILB) • Non-Executive Director, Greencore Group PLC • Senior Fellow, Applied Centre for Emotional Literacy, Learning and Research (ACELLR), USA • Professional Member, European Mentoring & Coaching Council • Member, BPS Division of Occupational Psychology • Member, BPS Psychological Testing Centre (PTS) • Research Fellow, University of East London • Fellow, Royal Society for Public Health
Professor Dame Susan Bailey OBE DBE	Group Non-Executive Director	• Independent Chair of Health Education England (HEE) Mental Health New Ways of Working Group • Chair Autistica UK user carer subcommittee • NED – Department of Health & Social Care (ends 31st October 2020) • Chair of Trustees, Centre for Mental Health • Bevan Commissioner • Council Member of Salford University • Independent NED KOOTH plc – Mental Health Online Platform – remunerated • Vice President BACP

NAME	POSITION	INTERESTS DECLARED
Professor Luke Georghiou	Group Non-Executive Director	• Deputy President and Deputy Vice-Chancellor, University of Manchester • Non-Executive Director of Manchester Science Partnerships Ltd • Non-Executive Director, Manchester Innovation Factory • Member of Manchester Graphene Company, Shadow Board • Member of NWBLT (North West Business Leadership Team) • Member GESL (Graphene Enabled Systems Board) • Chair of Steering Group, EUA (European Universities Association / CDE (Council for Doctoral Education) • Non-Executive Director, Northern Gritstone Investment Company
Nic Gower	Group Non-Executive Director	• Director Furness Building Society [NED]
Chris McLoughlin	Group Non-Executive Director & Senior Independent Director (SID)	• Director of Children's Services, Stockport Metropolitan Borough council • Member of Association of Director of Children's Services Ltd • Chair of Greater Manchester Social Work Academy Board • Member of Greater Manchester Mental Health Partnership • Chair of Greater Manchester Start Well & School Readiness Board • Chair of Greater Manchester Children and Young People Health and Wellbeing Executive • Daughter – Employed by MFT

NAME	POSITION	INTERESTS DECLARED
Trevor Rees	Group Non-Executive Director	• Treasurer/Trustee (Manchester Literary and Philosophical Society) • Independent Co-opted member (Audit Committee at University of Manchester (not a Board Member) • Non-Executive Director of Totally Local Company, Stockport (3-year Term) • Chair of the Audit Committee of GB Taekwondo

BOARD OF DIRECTORS

REGISTER OF INTERESTS – October 2021

NAME	POSITION	INTERESTS DECLARED
Sir Mike Deegan CBE	Group Chief Executive Officer	• Board Member, The Corridor, Manchester • Board Member, Health Innovation Manchester
Darren Banks	Group Executive Director of Strategy	• Nominated Director for Manchester LCO Partnership Board • Spouse - Finance Director of Rochdale Infirmary, PAT • Board Member, The Corridor, Manchester
Peter Blythin	Group Executive Director of Workforce & Corporate Business	• No interests to declare
Julia Bridgewater	Group Chief Operating Officer	• Foundation Director of Multi Academy, All Saints Catholic Collegiate • Director – North Staffs Shadow Board for the merger of Newman Catholic Collegiate and All Saints Catholic Collegiate
Professor Jane Eddleston	Joint Group Medical Director	• Chair of Adult Critical Care CRG [NHSE] • Clinical lead for Healthier Together Programme • GM Partnership Joint Medical Executive lead for Acute Care
Jenny Ehrhardt	Group Chief Finance Officer	• Trustee and Treasurer – Faculty of Medical Leadership & Management • Personal Financial Advice sought and paid personally from Mazars (External Auditors for the Trust) • Chair of Sub-Committee of the National Finance Leadership Council
Gill Heaton OBE	Group Deputy Chief Executive	• Chair of the Manchester LCO Accountability Board

NAME	POSITION	INTERESTS DECLARED
Professor Cheryl Lenney OBE	Group Chief Nurse	• Spouse – Director of Workforce & Organisational Development, Manchester Local Care Organisation
Miss Toli Onon	Joint Group Medical Director	• No interests to declare
David Furnival	Group Director of Operations	• No interests to declare

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations / Accountable Emergency Officer
Paper prepared by:	Beth Warburton, Emergency Preparedness Resilience and Response Manager James Lomas, Emergency Preparedness Resilience and Response Manager
Date of paper:	November 2021
Subject:	2021-22 MFT Emergency Preparedness Resilience and Response Core Standards Self-Assessment
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 quality care, safety for patients and clinical quality across the Trust, validated through EPRR compliance.
Recommendations:	The Board of Directors are asked to note and approve the MFT EPRR statement of compliance for 2021-22, with assurance of delivery of actions and future improved compliance through the MFT EPRR governance structure.
Contact:	Name: James Lomas, Emergency Preparedness Resilience and Response Manager Tel: 0161 701 5752

Manchester University
NHS Foundation Trust

2021-22 MFT EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE CORE STANDARDS SELF-ASSESSMENT

1. INTRODUCTION

The purpose of this report is to provide the Board of Directors with the MFT self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2021-22.

2. CONTEXT

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

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

The minimum requirements Acute Providers must meet are set out in the NHSE Core Standards for EPRR, which are in accordance with the CCA 2004 and the Health and Social Care Act 2012. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, with a 2021-22 submission deadline of 29/10/2021 comprising key documents of:

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

There are a total of 46 standards and additionally each year a ‘deep dive’ is conducted to gain additional assurance into a specific area. In 2021 the ‘deep dive’ topic is oxygen supply, and a deep dive was undertaken against the 7 core standards although these do not contribute towards the overall Trust compliance level. There are 4 levels of compliance:

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

3. COMPLIANCE

Based on MFT's self-assessment; 41 out of 46 Core Standards were declared as 'fully compliant', resulting in MFT receiving an overall EPRR assurance rating of **'Substantial'** for 2021/2022. MFT receiving a rating of **'Substantial'** should not be perceived as a poor assurance rating as a Trust MFT are delivering against each NHS Core Standards for EPRR. However, it indicates there are opportunities for the Trust to further improve over a period, through the implementation and monitoring of effective action plans. Please note MFT declared a compliance level of **'Substantial'** for the previous year.

Prior to 2020 NHSE have requested a self-assessment against 64 core standards, the number of core standards this year is lower due to the national impacts of COVID-19. The MFT EPRR team played a significant role in both the immediate response and recovery during the last 18 months, which has reduced the capacity of the team to implement the actions and fully resolve those standards partially compliant in 2020-21 to the level of full compliance in 2021-22.

The full statement of compliance has been provided in Appendix A.

Actions to address the partially compliant standards are in place as outlined in Appendix B. The action plan will be overseen by the MFT EPRR Committee to ensure delivery, with assurance to the Group Management Board via Committee minutes. Cascade of actions will be undertaken through the MFT EPRR governance structure to local hospital EPRR Forums. In addition, external oversight, and peer review of provider EPRR self-assessments and associated action plans, is provided through the Local Health Resilience Partnership and Health Economy Resilience Groups.

4. RECOMENDATIONS

The Board of Directors are asked to note and approve the MFT EPRR statement of compliance for 2021-22, with assurance of delivery of actions and future improved compliance through the MFT EPRR governance structure.

Manchester University
NHS Foundation Trust

Appendix A

Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

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

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

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

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

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

Signed by the organisation's Accountable Emergency Officer

25/10/2021

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report
	08.11.2021	

Appendix B – Partial Compliant Standards Action Plan

Domain	Standard	Standard Detail	Partial Compliance Rationale	MFT Actions	Responsible Officer	Timescale for Full Compliance
Duty to Maintain Plans	Critical Incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	The current MFT Business Continuity Plan (2018 version) does not include or document specific arrangements to respond to a critical incident.	MFT Business Continuity Plan to be rewritten to include critical incident response arrangements.	EPRR Managers.	31st January 2022.
	Shelter and Evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff, and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	MFT does not have a completed Shelter and Evacuation Plan that has been signed off or validated. In previous years all GM Acute Trusts were advised by the Local Health Resilience Partnership to declare partial compliance on this standard.	Produce an MFT Shelter and Evacuation Plan. Exercise and validate the MFT Shelter and Evacuation Plan.	EPRR Managers / Directors of Operations.	Plan written by 31st July 2022. Plan exercised by 1st October 2022.
Business Continuity	Business Continuity Management System (BCMS) Scope and Objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	The scope and objectives of the MFT BCMS are not currently documented in any MFT plans or policies.	To develop an MFT Business Continuity Strategy which includes the scope and objectives of the BCMS, to sit alongside the existing MFT Business Continuity Plan.	EPRR Managers.	31st March 2022.

	Business Continuity Management System Continuous Improvement Process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	The process to assess the effectiveness of the MFT BCMS are not currently documented in any MFT plans or policies.	To develop an MFT Business Continuity Strategy which includes the process to assess the effectiveness of the MFT BCMS, to sit alongside the existing MFT Business Continuity Plan.	EPRR Managers.	31st March 2022.
	Assurance of Commissioned Providers / Suppliers Business Continuity Plans	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	MFT utilises a wide range of NHS and Public Sector Procurement Framework suppliers.	Ensure Business Continuity is part of the MFT pre-qualification and tendering process. Ensure the system for random audit of commissioned providers / suppliers Business Continuity Plans is documented in the MFT Business Continuity Strategy.	EPRR Managers / Group Director of Procurement.	31st March 2022.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business/ Trust Board Secretary
Date of paper:	November 2021
Subject:	Update on the Review of the Board of Directors Sub-Committees Terms of Reference
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 Governance Framework, 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: • Approve the Terms of Reference of the following sub-committees of the Board of Directors following their review and agreement at the relevant Committees: - Finance and Digital Scrutiny Committee - Quality & Performance Scrutiny Committee - HR Scrutiny Committee - Charitable Funds Committee - EPR Committee - Group Risk Oversight Committee • Approve the Terms of Reference of the Audit Committee and the Remuneration Committee. Any changes proposed as a result of review at the relevant Committee will come to a future meeting of the Board of Directors for ratification. • Approve the standing down of the NMGH Scrutiny Committee and the LCO Scrutiny Committee
Contact:	Name: Nick Gomm, Director of Corporate Business/ Trust Board Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Annual Review of the Board of Directors Sub-Committees Terms of Reference

1. Purpose

The Board of Directors is invited to approve a selected number of Board of Directors Sub-Committees' Terms of Reference (ToR) following their annual review during October 2020.

2. Annual Review Update

In keeping with Annex 7 of MFT's Constitution (Standing Orders for the Practice & Procedures of the Board of Directors - Section 6 - Committees), and MFT's Standard Operating Guidelines for the Conduct & Governance of Meetings (November 2018), all Board Sub-Committees should undertake at least an annual review and refresh (where required) of their ToR.

Following review and approval at the Committee to which the ToRs equate, the following six ToRs are now recommended by the relevant Board Sub-Committees for Board approval:

Appendix	Board Sub-Committee	Original date of ratification	Last reviewed & updated	Reviewed & updated (2021)
A	**Finance and Digital Scrutiny Committee**	August 2017	October 2020	October 2021
B	**Quality & Performance Scrutiny Committee**	August 2017	August 2020	October 2021
C	**HR Scrutiny Committee**	August 2017	August 2020	October 2021
D	**Charitable Funds Committee**	August 2017	November 2020	September 2021
E	**EPR Committee**	January 2020	January 2021	September 2021
F	**Group Risk Oversight Committee**	August 2017	May 2020	May 2021

The following ToR have been reviewed and approved by the Chair and the lead Executive Director(s) for the Committee they equate to but, at the time of writing, have not yet been reviewed and agreed at the Committee they equate to. The date of the Committee where this will happen is included in the table.

Appendix	Board Sub-Committee	Original date of ratification	Last reviewed & updated	Reviewed & updated by Chair and Lead Executive Director	Date of Committee for review and agreement
G	**Audit Committee**	August 2017	October 2020	October 2021	3 November 2021
H	**Remuneration Committee**	August 2017	August 2019	October 2021	22 November 2021

The business of two existing Scrutiny Committees - the North Manchester General Hospital (NMGH) Scrutiny Committee and the Local Care Organisation (LCO) Scrutiny Committee – has now been subsumed into the business of the existing Committees. Both NMGH and the LCOs are now fully embedded within MFT's operations and governance processes and therefore no longer require their own Scrutiny Committees. It is therefore recommended that both these Scrutiny Committees are formally stood down.

3. Recommendation

The Board of Directors is asked to:

- Approve the Terms of Reference of the following sub-committees of the Board of Directors following their review and agreement at the relevant Committees:
    - Finance and Digital Scrutiny Committee
    - Quality & Performance Scrutiny Committee
    - HR Scrutiny Committee
    - Charitable Funds Committee
    - EPR Committee
    - Group Risk Oversight Committee

- Approve the Terms of Reference of the Audit Committee and the Remuneration Committee. Any changes proposed as a result of review at the relevant Committee will come to a future meeting of the Board of Directors for ratification.

- Approve the standing down of the NMGH Scrutiny Committee and the LCO Scrutiny Committee.

Appendix A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

FINANCE & DIGITAL SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

2. MEMBERSHIP

2.1 The Finance and Digital Scrutiny Committee shall comprise:

- Group Non-Executive Director – Chairman
- Group Non-Executive Directors
- Group Executive Directors

2.2 Quorum: No business shall be conducted unless the Chairman (or nominated deputy), two Group Non-Executive Directors and two Group Executive Directors are present.

2.3 All other Group Executive Directors and Non-Executive Directors will be entitled to attend meetings of the Committee.

3. ATTENDANCE AT MEETINGS

3.1 The following participants may be required to attend meetings of the Finance and Digital Scrutiny Committee:

- Corporate Directors and members of their leadership teams, as required
- Hospital/MCS/LCO Chief Executives and their leadership teams, as required
- Other Trust employees or, agents of the Trust as required.

3.2 The Trust Board Secretary (or Nominated Deputy) shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. The Group Chief Finance Officer & Group Chief Operating Officer will also be available to advise the Chair and Committee members. The Group Chief Information Officer will be available to advise the Committee.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet as required but no fewer than four times in every 12 month period.

5. OVERVIEW

5.1 The Finance and Digital Scrutiny Committee will examine the incidence, nature, and potential impact of emerging or identified significant financial and digital risks to the Group's on-going position and performance, either in-year or forward-looking.

5.2 The Finance and Digital Scrutiny Committee will seek assurance on the Trust's ongoing response to National Emergencies, Policies and Directives in relation to all Trust Finance and Digital matters.

5.3 The Committee will have oversight of all matters regarding informatics, data, analytics, and information technology in the Trust.

5.4 The Finance and Digital Scrutiny Committee will seek and receive additional levels of assurance not routinely available within the confines of regular on-going Group Board of Directors papers and discussion, together with scrutinising the specific turnaround or mitigation plans as developed, presented to and approved by the Group Board of Directors, in relation to managing the scale and impact of the identified risks.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- Provide for appropriate scrutiny of the Trust's response to National Emergencies, Policies and Directive(s) in relation to finance and digital matters and associated Implementation Plans and/or Recovery Programme(s).

- To provide the Group Board of Directors with a means of gaining additional assurance on the Group's plans for managing significant identified financial and digital risks.

- To provide opportunity for in-depth exploration of the incidence, nature, and potential impact of emerging or identified significant financial and digital risks, to the Group's on-going position and performance.

- To review the specific turnaround and/or mitigation plans presented to and approved by the Group Board, for management of these risks, focusing particularly on:

    - The scale, impact and timing of the turnaround or mitigation actions proposed, in relation to the scale and impact of the identified risks.

    - The development of additional or complementary actions arising from in-depth exploration of the risks and action plans so far identified.

    - Monitoring, reporting and examination of progress in relation to the approved actions in place.

- To monitor, and seek assurance on, the development and delivery of Trust strategies and work programmes concerning informatics, data, analytics, and information technology, including cyber security.

- To receive additional levels of assurance on the implementation of approved plans.

- To report to the Group Board of Directors, the level of additional assurance received in relation to the risks under review.

- To review the Trust's annual financial plan and longer term financial and digital strategy.

7. AUTHORITY

The Finance and Digital Scrutiny Committee is empowered to examine and investigate any activity within the Group pursuant to the above scope and duties.

8. REPORTING

The minutes of the Finance and Digital Scrutiny Committee will be received at the next Group Board of Directors and Group Audit Committee meetings.

9. REVIEW

These Terms of Reference shall be reviewed at least annually

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

- That the agenda of the Committee reflects identified escalations of all financial and digital risk scores above '15' in the Group's risk register, or adverse in-year financial performance against plan in excess of 1% of annual total income and this is reported to the Board.

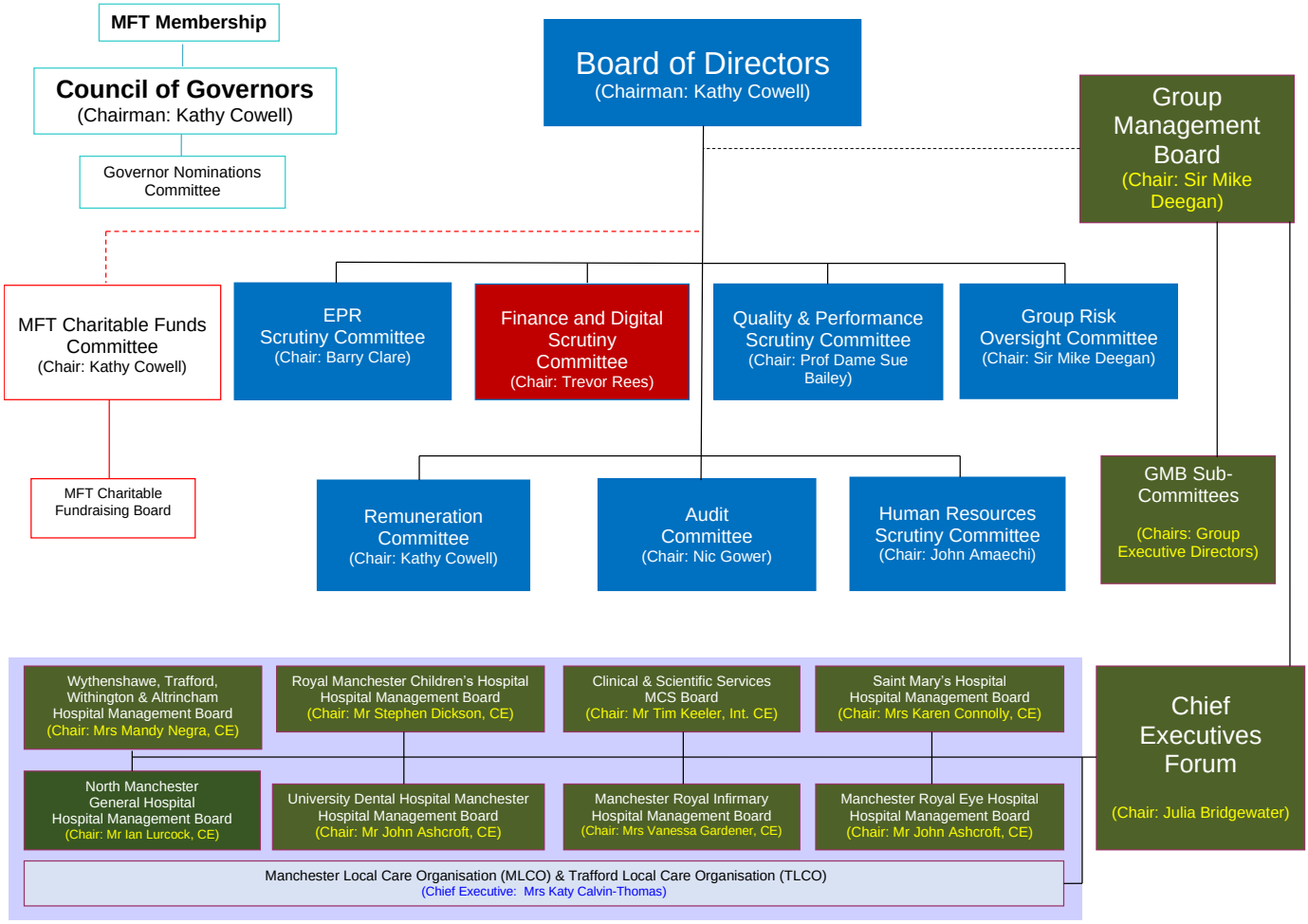
- The level of information provided to, and review undertaken by the Committee enables the Group Board of Directors to gain additional assurance, regarding the implementation of appropriate plans to mitigate risks and/or turn around deviations from planned performance, to maintain or restore acceptable overall financial and digital delivery as determined by the Group Board.

- The level of information provided to, and review undertaken by the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of appropriate mitigation plans to address identified forward financial and digital risks.

- Additional information needs of the Committee and the Group Board of Directors as arising, will be identified and relevant information provided.

- Listed members are required to attend at least 75% of meetings.

11. REPORTING STRUCTURE CHART



Originally Approved: August 2017
Reviewed & Updated: November 2017
Reviewed & Updated: August 2018
Reviewed & Updated: October 2020
Review: October 2021
Date of next review: October 2022

Appendix B

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

QUALITY & PERFORMANCE SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Board of Directors in accordance with its Standing Orders and will report to the Trust Board of Directors.

2. MEMBERSHIP

2.1 The Quality and Performance Scrutiny Committee shall comprise:

- Group Non-Executive Director – Chairman
- Group Non-Executive Directors
- Joint Group Medical Directors
- Group Chief Nurse
- Group Chief Operating Officer

2.2 Quorum: No business shall be conducted unless the Chairman (or nominated deputy), two Group Non-Executive Directors and two Group Executive Directors are present.

2.3 All other Group Executive and Non-Executive Directors will be entitled to attend meetings of the Committee.

3. ATTENDANCE AT MEETINGS

3.1 The following participants may be required to attend meetings of the Quality & Performance Scrutiny Committee:

- Corporate Directors and their leadership teams, as required
- Hospital/MCS/LCO Chief Executives and their leadership teams, as required
- Other Trust employees, or, agents of the Trust, as required.

3.2 The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members. The Joint Group Medical Director/s, Group Chief Nurse, and Group Chief Operating Officer will also be available to advise the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The committee shall meet bi-monthly.

5. OVERVIEW

5.1 The Accountability Oversight Framework (AOF) ratings will be reported to the Group Executive Director Team and an overview report will be presented to the Quality & Performance Scrutiny Committee. The AOF performance is summarised to the Group Management Board via the Chief Operating Officer's (COO) Report.

5.2 The Group Audit Committee will review the adequacy of underlying 'Quality & Performance' controls and assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. However, internal or external audits of clinical process or outcomes will be reviewed at the Quality & Performance Scrutiny Committee.

5.3 The Quality & Performance Scrutiny Committee will seek assurance on an exception, or, as required basis on the Group's work on Quality (Patient Safety, Clinical Effectiveness & Patient Experience) and Performance (all key performance measures excluding Workforce & Finance) and associated Implementation Plans and Recovery Programme(s).

5.4 The Committee will be chaired by a Group Non-Executive Director and it will identify areas that require more detailed scrutiny arising from: a suite of internal metrics, the AOF, the Group Board Assurance Report, the Board Assurance Framework (BAF), the Trust's ongoing response to National Emergencies, National Policies, National Directives, National Reports, NHS Regulators, internal and external audits with a clinical focus, patient /service user feedback and public interest issues. The chair will also be advised of any emergent issues such as an unannounced regulatory review which may lead to a requirement for urgent assurance.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- Provide for appropriate scrutiny of the Trust's ongoing response to National Emergencies, Policies and Directive(s), paying particular attention to issues relating to Quality & Performance.
- To review information on the Group Board Assurance Report & AOF where exceptions and/or emerging issues have been identified, paying particular attention to the Patient Safety, Patient Experience & Performance Strategic Aims and Key Priorities.
- To make recommendations to other fora on action required in response to the Group Assurance Report, the ongoing COVID-19 National Emergency and /or the Group Risk Register.
- To receive summary reports on the key findings and recommendations of level 5 actual harm incidents and Never Events, and seek assurance on Hospital and Managed Clinical Services (MCS) action plans.
- To consider any relevant risks within the Group Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee, or, the Group Board of Directors, as appropriate.
- To undertake a regular (annual as a minimum) review of Group Board Safety and Quality metrics to ensure the right areas of concern are presented.

- To receive progress reports on key safety and quality work programmes.

- To receive summary information on themes arising from complaints and concerns and consider the responses by Hospital / MCS / LCO and corporately as determined by the committee.

- To review the Group's Operational Performance against its Annual Plan and to monitor any necessary corrective planning and action.

- To consider regulatory reports on an exception basis where the Trust has services that require improvement or are subject to regulatory action

7. AUTHORITY

7.1 The Committee is empowered to examine and investigate any activity within the Group pursuant to the above scope and duties.

8. REPORTING

8.1 The minutes of the Quality & Performance Scrutiny Committee will be received and considered at the next Group Board of Directors and Group Audit Committee meetings.

8.2 The Committee will use the following reference sources to decide on areas of scrutiny: Group Risk Management Committee: Group Quality & Safety Committee; Group Safeguarding Committee; Hospital/MCS CEO Forum; Group Infection Control Committee; Group Cancer Committee; the Accountability & Oversight (AOF) Dashboard; the Group Board Assurance Framework (BAF) and Board Assurance Report, and also CQC Regulatory Reports; internal and external clinical audits; national reports; public interest reports; reports from voluntary organisations serving health and social care such as Patients Association and Health Watch.

8.3 Meetings of the Committee shall be set at the start of the financial year. The agenda and supporting papers shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

9. REVIEW

9.1 The Terms of Reference of the Committee will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators.

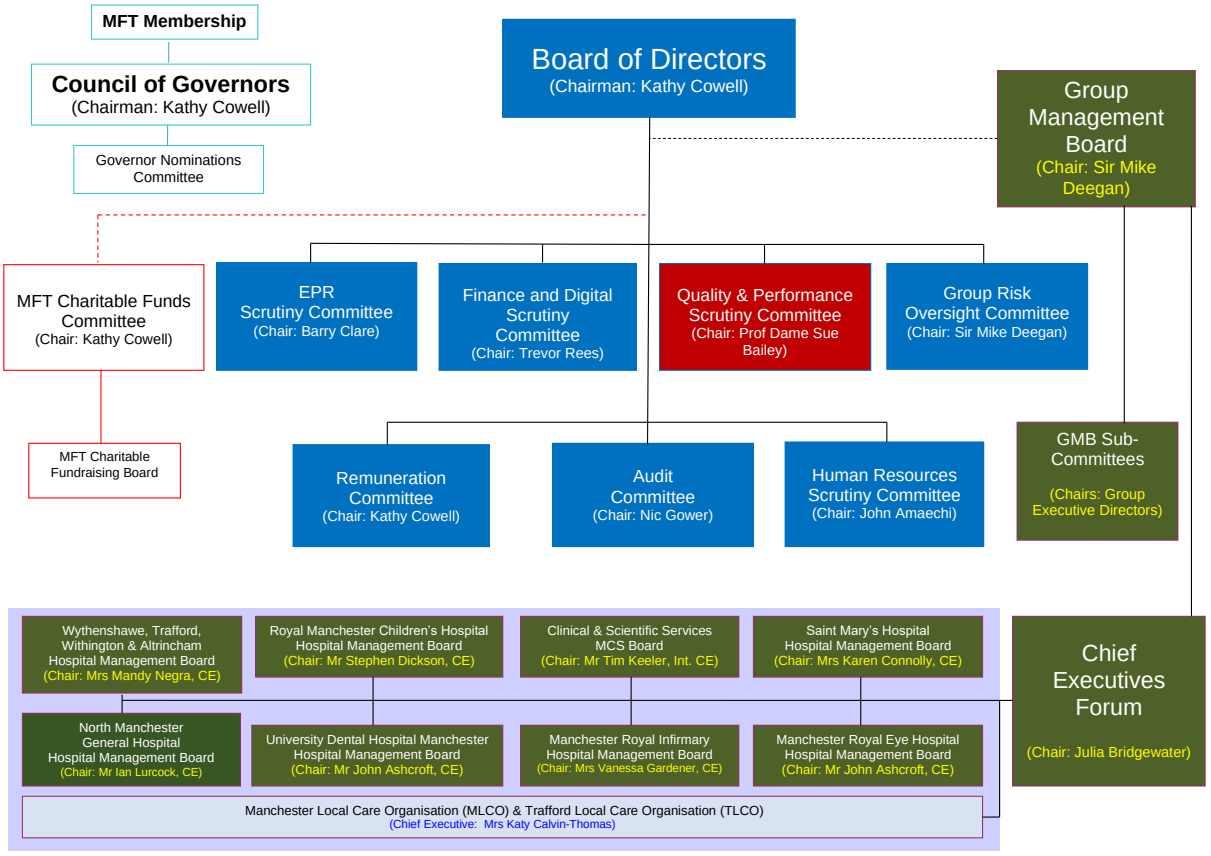
- The level of information provided to the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of turnaround and mitigation plans to address identified Quality & Performance risks

- 75% attendance of all listed members.

- Feedback on the Committee's activities to be presented at the Group Board of Directors meetings as required.

- 100% submission of Quality & Performance Scrutiny Committee minutes to the next Group Audit Committee and Group Board of Directors meetings.

11. REPORTING STRUCTURE CHART



Originally Approved: August 2017
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Reviewed & Updated: August 2018
Reviewed & Updated: August 2019
Reviewed & Updated: October 2020
Date of Review: September 2021
Date of next Review: October 2022

Appendix C

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

HUMAN RESOURCES SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

2. MEMBERSHIP

2.1 The HR Scrutiny Committee shall comprise:

- Group Non-Executive Director – Chairman
- Group Non-Executive Directors
- Group Executive Director of Workforce and Corporate Business
- Group Chief Nurse
- Joint Group Medical Director

2.2 Quorum: No business shall be conducted unless the Chairman (or nominated deputy), two Group Non-Executive Directors and two Group Executive Directors are present.

2.4 All other Group Executive Directors and Non-Executive Directors will be entitled to attend meetings of the Committee.

3. ATTENDANCE AT MEETINGS

3.1 The following participants may be required to attend meetings of the Human Resources Scrutiny Committee:

- Group Director of HR (or nominated deputy)
- Corporate Directors and their leadership teams, as required
- Hospital/MCS/LCO Chief Executives and their leadership teams, as required
- Other Trust employees or, agents of the Trust as required.

3.2 The Trust Board Secretary (or Nominated Deputy) shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. The Group Executive Director of Workforce and Corporate Business, and, Group Director of HR will also be available to advise the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet not less than bi-monthly.

5. OVERVIEW

5.1 The Committee will review the Group's People Plan and scrutinise risks associated with delivery. The Committee will seek assurance that appropriate mitigation is in place to manage those risks and that appropriate links are made to the Board Assurance Framework. Specifically, the Committee will scrutinise delivery of:

- MFT People Plan
- All principal Workforce and Organisational Development Strategies and delivery plans including Health and Wellbeing
- The Trust's response to National Emergencies, Policies and Directives; paying particular attention to issues relating to the Workforce.
- Equality, Diversity and Inclusion Strategy.
- Statutory or regulatory requirements relating to workforce.

5.2 Areas which require more detailed scrutiny arising from Group Board Reports or emerging or identified significant risks will be addressed by the Committee as required.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- To monitor implementation of the Group People Plan ensuring appropriate scrutiny of risks as identified in the Board Assurance Framework. This to include examination of mitigating actions.
- To scrutinise Workforce Key Performance Indicators to understand performance and gain assurance that plans are being implemented.
- To explore the potential impact of identified or emergent workforce risks.
- Provide for appropriate scrutiny of the Trust's response to National Emergencies, Policies and Directive(s); paying particular attention to issues relating to the Workforce and associated Implementation Plans and/or Recovery Programme(s).
- To review annual reports relating to workforce to gain assurance that workforce initiatives are well executed and relevant to the overarching strategic direction of MFT.

6.2 Six meetings each year will focus on one key deliverable; the remaining two meetings will be available to undertake more detailed scrutiny of specific risks, should this be required.

7. AUTHORITY

7.1 The Human Resources Scrutiny Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

8.1 The minutes of the Human Resources Scrutiny Committee will be submitted to the next available Group Board of Directors and Group Audit Committee meetings.

9. REVIEW

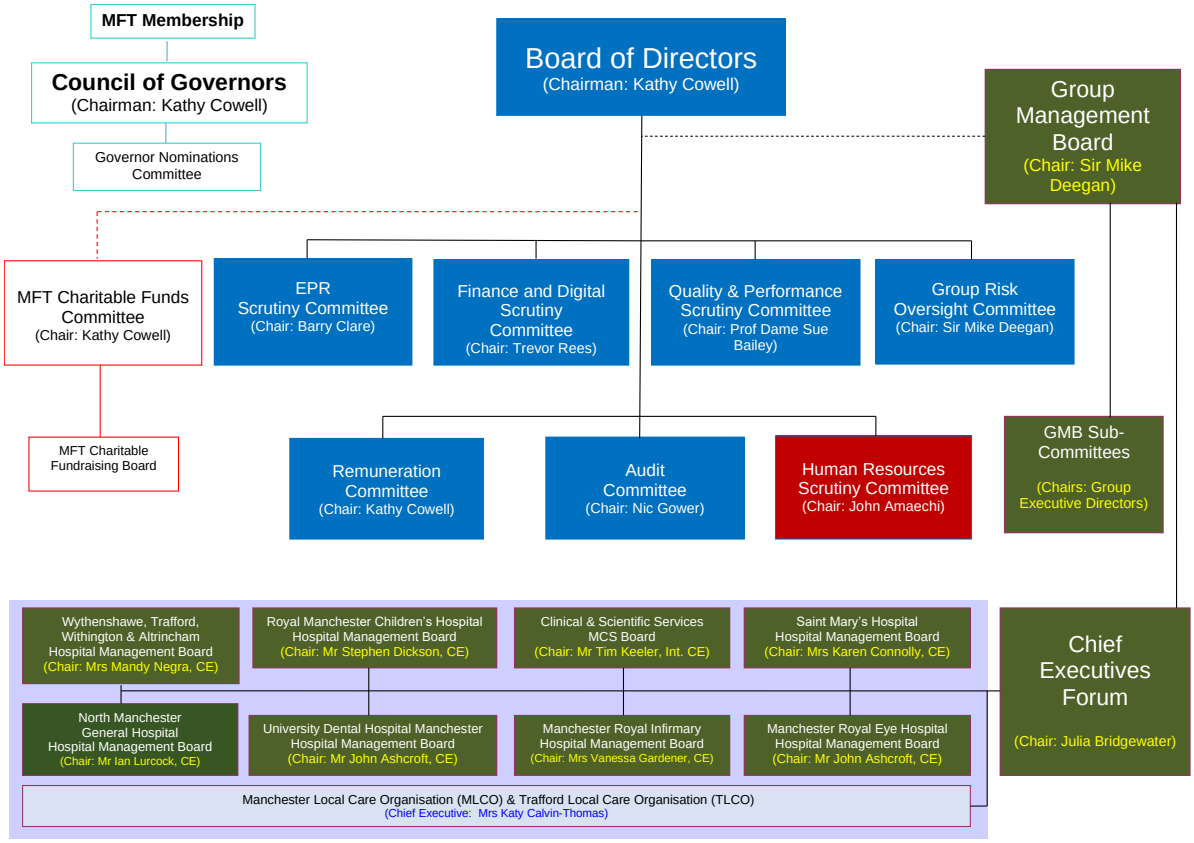
9.1 These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

10.1 The Terms of Reference will be measured against the following key performance indicators:

- The level of information provided to the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of turnaround and mitigation plans to address identified workforce risks.
- Annual review of performance against the Group People Plan and related material.
- 75% attendance of all listed members.
- 100% submission of Human Resource Scrutiny Committee minutes to the next Group Management Board and Group Board of Directors meetings.

11. REPORTING STRUCTURE CHART



Approved: August 2017
Reviewed & Updated: April 2018
Reviewed & Updated: August 2018
Reviewed & Updated: August 2019
Reviewed & Updated: October 2020
Review: September 2021
Date of next review: September 2022

Appendix D

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted as a standing Committee of the Group Board of Directors in accordance with its Standing Orders, and in accordance with its power to delegate as Trustee of the Foundation Trust's charitable funds. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Group Board of Directors' meetings.

1.2 References to the Group or Group Board shall have the same meaning, respectively, as the Trustee, or the Board representing the sole corporate Trustee.

2. MEMBERSHIP

2.1 The Committee shall comprise:

- The Group Chairman
- All Group Non-Executive Directors & Group Executive Directors (or nominated deputies)

2.2 No business shall be transacted at a meeting unless the Chairman, three Group Non-Executive Directors, and two Group Executive Directors (or nominated deputies) are present.

3. ATTENDANCE AT MEETINGS

3.1 Only members of the Charitable Funds Committee have the right to attend meetings but the Committee may require the attendance for advice, support and information routinely meetings from:-

- Chairman of Fundraising Board
- Deputy Chairman of the Fundraising Board
- Group Board Secretary
- Any other officer/advisor as appropriate

3.2 The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet not less than four times per year.

5. OVERVIEW

5.1 The Charitable Funds Committee has been established by the Group Board of Directors, being the Trustee of the charitable funds to make and monitor arrangements for the control and management of charitable funds. The Trustee has ultimate responsibility for all decisions made but also has delegated the scope and duties to the Committee.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- To apply all charitable funds in accordance with charity law, including but not limited to the Charities Act 2011, the NHS Charities Acts 1960 and 1993 (or any statutory re-enactment or modification of them) to ensure that decisions on the use and/ or investment of such funds is restricted by the objectives and powers defined in the Declaration of the Trust governing the funds or in any special trust included within them.

- To ensure that the Group policies and procedures for charitable funds investments are followed.

- To make decisions involving the sound investment of charitable funds consistent with prudent investment and ensuring compliance with:

    - The Trustee Act 2000
    - The Charities Act 2011
    - The Charities (Protection and Social Investment) Act 2016
    - Terms of the Funds' Governing documents

- To receive at each meeting reports for ratification from the Group Chief Finance Officer on investment decisions and actions taken through delegated powers.

- To oversee and monitor the functions performed by the Group Chief Finance Officer as defined in Standing Financial Instructions.

- To monitor the progress of the Group's Charity.

- To receive the minutes of the Fundraising Board (see separate Terms of Reference).

- To approve all charitable fund expenditure in excess of £100,000. Expenditure above £50,000 is reviewed annually (Policy in situ for the administration of grant applications below this value)

- To ensure the MFT Charity adheres to the Charity Commission / Fundraising Regulator Code of Conduct

7. DELEGATED POWERS AND DUTIES OF THE GROUP CHIEF FINANCE OFFICER

7.1 The Group Chief Finance Officer has prime responsibility for the Group's Charitable Funds as defined in the Group's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Group Chief Finance Officer are to:

- Administer all existing charitable funds
- Arrange for the creation of any new charitable funds including the preparation of governing documents
- Be responsible for the Corporate Services portfolio including Charitable Appeals, provide guidelines in respect of donations, legacies and bequests, fundraising and trading income
- Be responsible for the management of investment of funds
- Ensure appropriate banking services are available to the Charity
- Prepare reports including the Annual Accounts

8. AUTHORITY

8.1 All decisions relating to the Charity's investment lie entirely with its Trustees. They may not lawfully delegate this responsibility to anyone.

8.2 The Charitable Funds Committee retains control of the investment policy. Where it does delegate discretionary power in respect of an investment, it must ensure:

- the scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it
- that there are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently
- that they review regularly the performance of the person or persons exercising the delegated power
- that where an investment manager is appointed, that the person is regulated under the Financial Services and Markets Act 2000.
- that acquisitions or disposals of a material nature must always have written authority of the Charitable Funds Committee or the Chairman of the Charitable Funds Committee in conjunction with the Group Chief Finance Officer or nominated deputy.

8.3 The banking arrangements for the charitable funds will be kept entirely distinct from Manchester University NHS Foundation Trust's other funds.

8.4 Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations.

8.5 The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

8.6 The Charitable Funds Committee will establish and maintain an approved list of counterparties for investment activities.

8.7 Except where a specific fund's governing document does not allow for pooling, all funds should be pooled for investment purposes. The Charitable Funds Committee shall decide on the basis for applying accrued income to individual funds in line with Charity Commissioner Guidance.

8.8 The Charitable Funds Committee should obtain professional advice to support its investment activities as appropriate.

8.9 The Charitable Funds Committee shall regularly review investments to see if other opportunities or investment managers offer a better return.

9. REPORTING

9.1 Formal minutes shall be taken at all Committee meetings.

9.2 Minutes of the Charitable Funds Committee will be presented to the next available Group Board of Directors' meeting.

9.3 The Committee will receive the Charitable Funds Finance Report containing the Statement of Financial Activity (SOFA), Balance Sheet, Investment Fund Report and Cash flow Forecast.

9.4 The Committee will receive the Charity Fundraising Report.

10. REVIEW

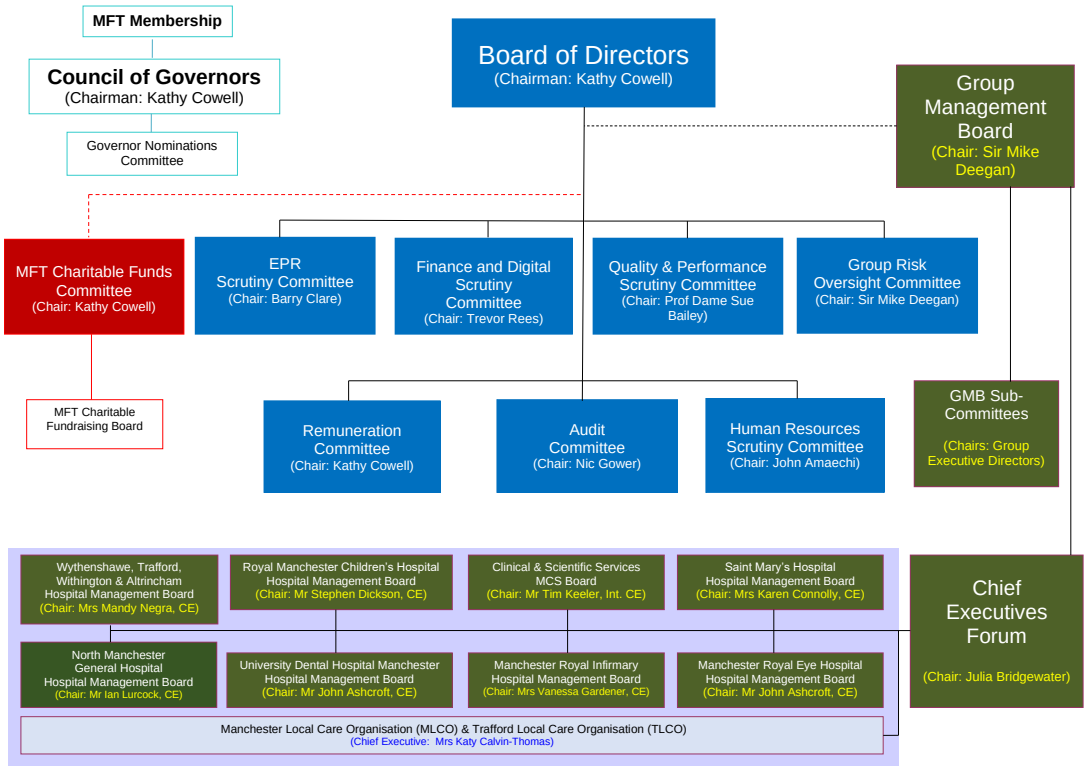
10.1 The Terms of Reference shall be reviewed by the Group Board when required, but at least annually.

11. KEY PERFORMANCE INDICATORS

11.1 These Terms of Reference will be measured against the following key performance indicators:

- 75% attendance of each listed member or nominated deputy
- The Charitable Funds Annual Report and Accounts will be published in a timely manner.
- The Annual Report will detail the achievements of the previous year.

12. REPORTING STRUCTURE CHART



Approved: August 2017
Reviewed & Updated: November 2017
Reviewed & Updated: August 2018
Reviewed & Updated: August 2019
Reviewed & Updated: November 2020
Date of Review: September 2021
Date of next review September 2022

APPENDIX E

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

ELECTRONIC PATIENT RECORD (EPR) SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

1.2 The Committee has delegated authority for oversight and scrutiny of the Electronic Patient Record (EPR) Programme to ensure successful delivery in accordance with the Full Business Case

2. MEMBERSHIP

2.1 The Committee will comprise:

- Chairman (Non-Executive Director)
- Group Non-Executive Directors
- Group Executive Directors

2.2 Quorum: No business shall be conducted unless the Chairman (or nominated Deputy) and two Group Non-Executive Directors and two Group Executive Directors are present.

3 ATTENDANCE AT MEETINGS

3.1 The following participants are required to attend meetings of the EPR Scrutiny Committee:

- The Chief Informatics Officer shall be required to attend meetings of the Committee, together with such other EPR and IM&T Directors as may be reasonably required; and

- Other Trust employees or agents of the Trust, as required.

3.2 The Trust Board Secretary (or Nominated Deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

3.3 The Committee may require the attendance of other Group employees or agents of the Group as required.

4 FREQUENCY OF MEETINGS

4.1 The Committee shall meet every two months.

5 OVERVIEW

5.1 The Committee will review the delivery of the EPR Programme through the EPR Implementation and Benefits Realisation Programme Board including:

- Oversight of the implementation of the Epic EPR through the EPR Programme Plan to agreed milestones in accordance with the Board-approved Business Case;
- Oversight of the delivery of the Benefits Plans within the agreed Full Business Case;
- Oversight of clinical and operational adoption including management of change for Phase 1 to Go-Live and Phase 2 post Go-Live to ensure continuous quality improvement for benefits realisation.
- Oversight of the EPR Epic Contract;
- Monitoring of EPR Programme risk register;
- Monitor delivery of the EPR Communications & Engagement Programme;
- Gain assurance about the overall governance arrangements of the EPR Programme and undertake regular and appropriate review of the effectiveness of these arrangements;
- Explore the potential impact of emerging or identified significant risks in relation to EPR Programme delivery, implementation and realisation of associated benefits and report to other relevant scrutiny committees or the Board Directors as appropriate.

6 SCOPE AND DUTIES

The scope and duties of the Committee are:

6.1 To monitor the delivery of the EPR Programme; scrutinise performance against the key implementation milestone deliverables (see section 5) and review actions and mitigation plans including timescales.

6.2 Meetings will focus on key deliverables against EPR Programme milestones and detailed scrutiny of specific risks (should this be required) to achieve a successful Go-Live of the EPR in September 2022.

6.3 To monitor the development of the Go-Live Plan and scrutinise and assure clinical and operational adoption plans to ensure a successful Go-Live of the EPR (date to be agreed).

6.4 To monitor the benefits realisation plans and the readiness of the organisation to deliver benefits to plan and timescale pre and post Go-Live of the EPR.

6.5 To receive and consider assurance reports from external bodies.

6.6 To recommend to the Board of Directors that the programme is ready to ‘Go Live’.

7 AUTHORITY

7.1 The Committee is empowered to examine and investigate any activity within the Group pursuant to the above scope and duties.

8 REPORTING

8.1 The minutes of the EPR Scrutiny Committee will be received at the next Group Board of Directors and Group Audit Committee meetings.

8.2 Meetings of the Committee shall be set at the start of the financial year. The agenda and supporting papers shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

9 REVIEW

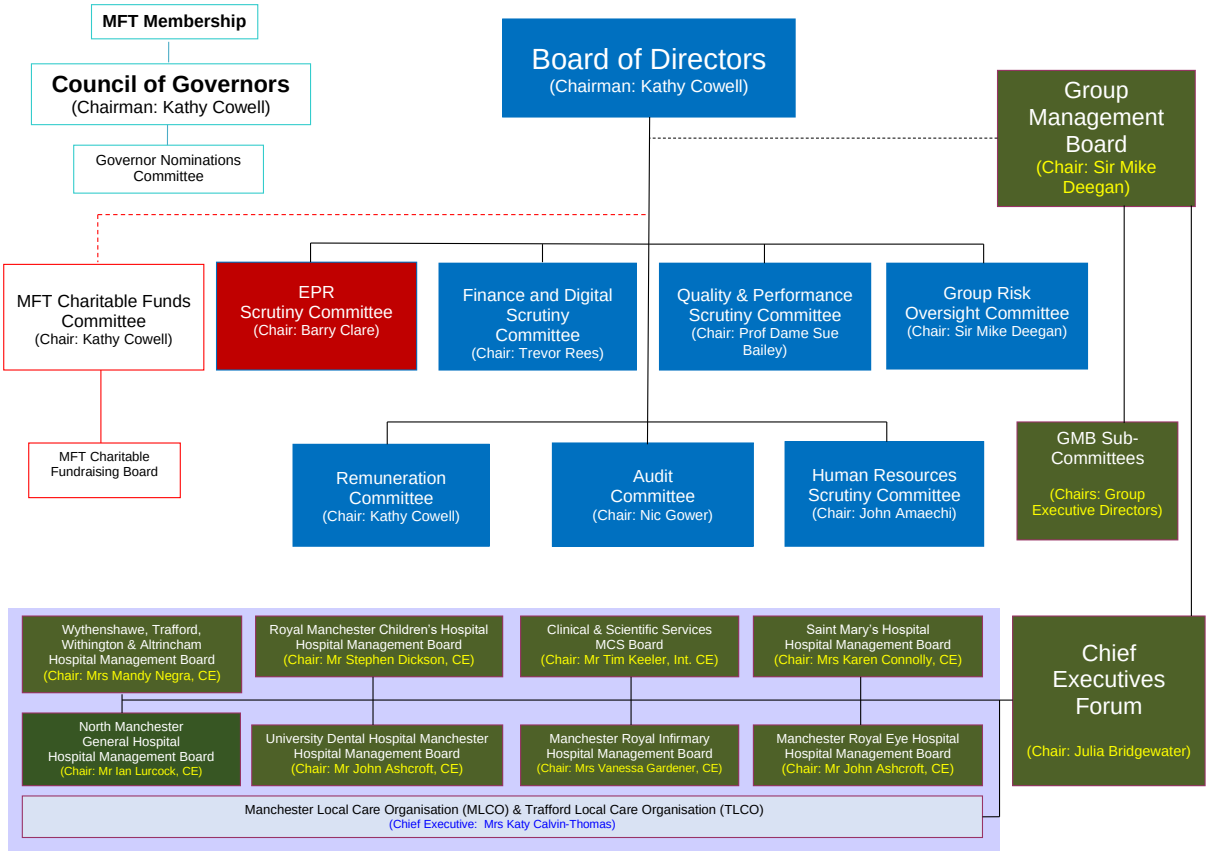
9.1 These Terms of Reference will be reviewed at least annually. The Terms of Reference may require material amendments if the contractual structure for, and/or the approach to the delivery of the proposed EPR Programme is amended.

10 KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators.

- The level of information provided to the Committee enables the Group Board of Directors to gain additional assurance on the delivery of the EPR Programme;
- 66% attendance of all listed members; and
- 100% submission of EPR Scrutiny Committee minutes to the next MFT Board of Directors and Group Audit Committee meetings.

11 REPORTING STRUCTURE CHART



Approved: January 2020
Reviewed and updated: January 2021
Date of Review: September 2021
Date of Next Review: November 2022

APPENDIX F

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

GROUP RISK OVERSIGHT COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors has established a Committee of the Board to be known as the Group Risk Oversight Committee (the Committee)

2. MEMBERSHIP

Chief Executive Officer (Chair)
Group Medical Directors
Group Chief Nurse
Group Chief Finance Officer
Group Director of Workforce and OD
Group Chief Operating Officer
Group Director of Strategy
Hospital/MCS Directors
Group Director of Corporate Services/Trust Secretary
Group Director of Clinical Governance
Associate Directors of Clinical Governance
Corporate Directors as required

In attendance Internal Audit Representative

3. ATTENDANCE AT MEETINGS

3.1. Non-Executives of the Trust may attend this Committee and will be provided with copy papers in advance of each meeting

3.2. The Committee may require the attendance of any Trust employee or agent of the Trust

3.3. A quorum shall consist of eight members including a minimum of one Executive Director and one Hospital/MCS Director

4. FREQUENCY OF MEETINGS

4.1. Every two months and at other times as may be necessary

5. OVERVIEW

5.1. The Committee will review and report on the overall risk profile of the organisation and ensure that effective assurance mechanisms are in place

5.2. The Committee will approve the process for the management of risk, communicated through the Group Risk Management Strategy, and set the tone and appetite for risk across the Group

6. SCOPE AND DUTIES

6.1. To provide an assurance to the Board of Directors that risks of all types are identified, and controlled to an acceptable level, and to advise the Board on significant risks (those with a residual score of 15 or above)

6.2. To receive the Trust Risk Register from the Risk Management Department and any significant risks identified through other reports and ensure the Board Assurance Framework is updated with reference to these risks, any gaps in control and gaps in assurance

6.3. The GROC will review reports on the following:

- New risks at level ≥15 – single report detailing management and oversight arrangements
- Scheduled risk reports for Hospital/MCS/MLCO/Corporate risks
- Risks escalated for review/support by Hospitals/MCS where further mitigation is outside of the control of the Hospital/MCS (for example a national tariff issue)
- Level ≥15 risks in Hospital/MCS with an AOF score of 6
- The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues

6.4. To provide a forum for consultation between all professions on methods for assessing risks of all types in a consistent fashion and to propose levels of acceptability for Board of Directors' approval

6.5. To provide the Board of Directors with the Group Risk Management Strategy for its approval

6.6. To raise awareness and understanding of risk management at all levels and among all professions in the Trust

6.7. Based upon the reporting and assurance framework, advise the Board of Directors on risk considerations relevant to the agreement of strategic objectives and investment priorities

6.8. To agree and oversee the methodology for treating risks for use by operational management and to propose the relationship between this and the business planning process

6.9. To ensure that there is an effective mechanism for reporting significant risks to the Board or senior management in a timely fashion (outside the usual reporting mechanism)

6.10. To ensure that there are effective mechanisms for reporting risks to the appropriate bodies both internally, for example –

- pharmacy
- occupational health
- medical equipment

Externally for example –

- Care Quality Commission
- NHS E/I
- NHS North West
- Medicines Healthcare products Regulatory Agency
- Health and Safety Executive

6.11. To investigate and propose longer term risk indicators and report on progress against them to the Board of Directors

6.12. To ensure an effective mechanism for escalating issues from Trust groups to the appropriate Committee of the Board of Directors and the Board Assurance Framework

6.13. To provide the Board of Directors with an assurance that the risk is well managed. This should be through quarterly reporting which demonstrates:

- The risk management reporting route includes all aspects of risk arising out of Trust activities
- Risk management training reflects the needs of all professions and that content and delivery is effective
- Risk assessments, risk registers and risk planning include clinical issues

6.14. To ensure that systems are in place which improve all practice appropriately as a consequence of risk assessment, incidents, complaints, or claims

6.15. To provide an assurance to the Audit Committee that the risk management structure contributes to a system of internal control, by reporting on:

- The methods for ensuring the full range of risks is encompassed
- Accountability for aspects of risk management and internal control
- Any high-level risk associated with progress on completing baseline self-assessments of local and national standards and generating subsequent action plans

6.16. To ensure an effective mechanism for reporting risk issues to all levels of management and staff

6.17. To receive a report of the Operational Integrated Governance and Risk Committee

6.18. To receive the minutes of the Trust Strategic Health and Safety Committee

7. DOCUMENT REVIEW

7.1. The Committee will be responsible for the review and submission of the following documents:

7.1.1. The Group Risk Management Strategy

8. RELATIONSHIPS AND REPORTING

8.1. The Committee report shall be considered at the next Board of Directors' meeting

8.2. The Committee report shall be considered at the next Trust Audit Committee

8.3. The Committee may request formal reports from any other Trust Committees when relevant

8.4. The Committee will work closely with both the Audit Committee and other Board sub-committees to provide assurance to the Board of Directors that there are effective systems of internal control

9. AUTHORITY

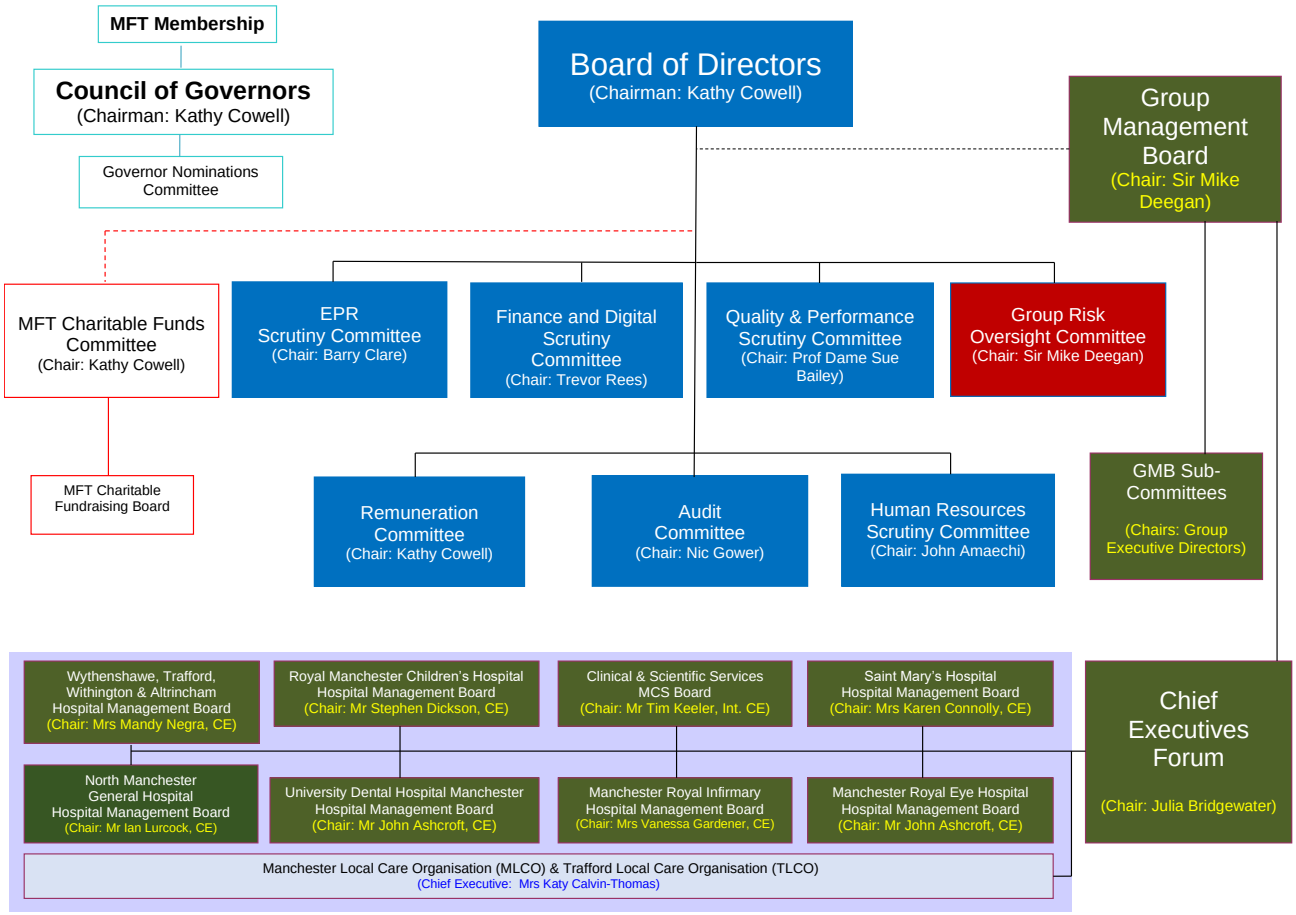
9.1. The Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties

10. KEY PERFORMANCE INDICATORS

10.1. These Terms of Reference will be measured against the following key performance indicators:

10.1.1. 75% attendance of all listed members or nominated deputy
10.1.2. Presentation of the Group Risk Management Strategy
10.1.3. Presentation of risk management in detail in the Annual Report
10.1.4. Contribution to the Annual Governance Statement
10.1.5. Documented discussion at each meeting of risk referral
10.1.6. Annual Report for the Health and Safety Committee

11. REPORTING STRCTURE



These Terms of Reference will be reviewed in May 2022

APPENDIX G

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted as a standing Committee of the Group Board of Directors in accordance with its Standing Orders. Its constitution and Terms of Reference shall be as set out below, subject to amendment at a future Group Board of Directors' meeting.

2. MEMBERSHIP

2.1 The Committee will comprise:

- Group Non-Executive Directors

2.2 The Committee shall have sufficient skills to discharge its responsibilities. At least one Committee member should have recent and relevant financial experience. The Group Chairman shall not chair, or, be a member of the Committee.

2.3 No business should be transacted at the meeting unless the Chair (or Nominated Deputy) and three members are present.

3. ATTENDANCE AT MEETINGS

3.1 Only members of the Audit Committee have the right to attend meetings, but the Group Chief Finance Officer, Trust Board Secretary, the Head of Internal Audit of the Group, a representative of the external auditors, and a representative of the local Counter Fraud service shall generally be invited to attend meetings of the Audit Committee.

3.2 Group Executive Directors and/or staff shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

3.3 The Group Chairman may be invited to attend meetings of the Audit Committee as required.

3.4 The Trust Board Secretary (or Nominated Deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

3.5 The external and internal auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Group Executive Directors present.

4. FREQUENCY OF MEETINGS

4.1 Meetings shall be held at least four times per year, with additional meetings where necessary.

5. OVERVIEW

5.1 The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Group Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions (examples of key reference/source documents include Board Minutes & Reports, Board Sub-Committee Minutes, BAF, AOF Dashboard, Board Assurance Report, Internal & External Audit Reports)

5.2 The Audit Committee shall provide the Group Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes, and risk management across the whole of the Group activities ~~(clinical and non-clinical~~) both generally and in support of the annual governance statement.

The Group Board of Directors is responsible for ensuring effective financial decision-making, management and internal control including:

- Management of the Group's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

6. SCOPE AND DUTIES

6.1 Financial Statements and the Annual Report

6.1.1 Monitor the integrity of the financial statements of the Group, any other formal announcements relating to the Group's financial performance, reviewing the significant financial reporting judgements contained in them.

6.1.2 Review the annual statutory accounts, before they are presented to the Group Board of Directors, in order to consider their compliance, objectivity, integrity and accuracy. This review will cover but is not limited to: the meaning and significance of the figures, notes and significant changes; areas where judgement has been exercised; adherence to accounting policies and practices; explanation of estimates or provisions having material effect; any unadjusted statements; and any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

6.1.3 Review the annual report and annual governance statement before they are submitted to the Group Board of Directors to consider compliance, objectivity, integrity and accuracy.

6.1.4 Review each year the accounting policies of the Group and make appropriate recommendations to the Group Board of Directors.

6.1.5 Review all systems of control including accounting and reporting systems that support the production of the annual report before review by the Group Board of Directors,

6.2 Internal Control and Risk Management

6.2.1 Review the Group's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

6.2.2 Review and maintain an oversight of the Group's general internal controls and risk management systems, liaising with separate sub-committees as required.

6.2.3 Review processes to ensure appropriate information flows to the Audit Committee from executive management and other Group committees in relation to the Group's overall internal control and risk management position;

6.2.4 Review the adequacy of the policies and procedures in respect of all counter-fraud work.

6.2.5 Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

6.2.6 Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.3 Whistleblowing

6.3.1 Review arrangements that allow staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

6.3.2 Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

6.4 Corporate Governance

6.4.1 Monitor corporate governance compliance (e.g. compliance with terms of the license constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

6.5 Internal Audit

6.5.1 Conduct an annual review of the provision of internal audit services taking into consideration relevant UK professional and regulatory requirements.

6.5.2 Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.5.3 Oversee on an ongoing basis the effective operation of internal audit in respect of: adequate resourcing; its coordination with external audit; meeting relevant internal audit standards; providing adequate independent assurances; it having appropriate standing within the foundation trust.

6.5.4 Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.6 External Audit

6.6.1 Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

6.6.2 In line with MFT's Constitution, the Council of Governors is responsible for appointing or removing the external auditor and will work with the Audit Committee in agreeing the criteria for this. To support them in this task, the Audit Committee should:

- provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees.
- make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.6.3 Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with internal audit and any other external regulatory body who may contribute to the formation of the audit opinion.

6.6.4 Assess the external auditor's work and fees each year and based on this assessment, to make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor.

6.6.5 Oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

6.6.6 Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.6.7 Develop and implement a policy on the engagement of the external auditor in regard to the supply non-audit services, taking into account relevant professional rules and ethical guidance.

6.7 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

6.7.1 Review on behalf of the Group Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution and standards of business conduct; including maintenance of registers.

6.7.2 Examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.7.3 Review the operation of, and proposed changes to, the Group Scheme of Delegation.

6.8 Other

6.8.1 Review performance indicators relevant to the remit of the Audit Committee. Examine any other matter referred to the Audit Committee by the Group Board of Directors and initiate investigation as determined by the Audit Committee.

6.8.2 Develop and use an effective Assurance Framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these Terms of Reference.

6.8.3 Review the work of all other Group committees in connection with the Audit Committee's assurance function.

6.8.4 Consider the outcomes of significant reviews carried out by other bodies including, but not limited to, regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7. AUTHORITY

7.1 The Audit Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

7.2 The Audit Committee is authorised by the Group Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Audit Committee.

7.3 The Audit Committee is authorised by the Group Board of Directors to obtain outside legal or other independent professional advice. The Committee is authorised by the Group Board of Directors to request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

8. REPORTING

8.1 The minutes of all meetings of the Audit Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Group Board of Directors. The submission to Group Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

8.2 The Group's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

8.3 As part of the Group's annual performance review process, the Committee shall review its collective performance and that of its individual members.

9. REVIEW

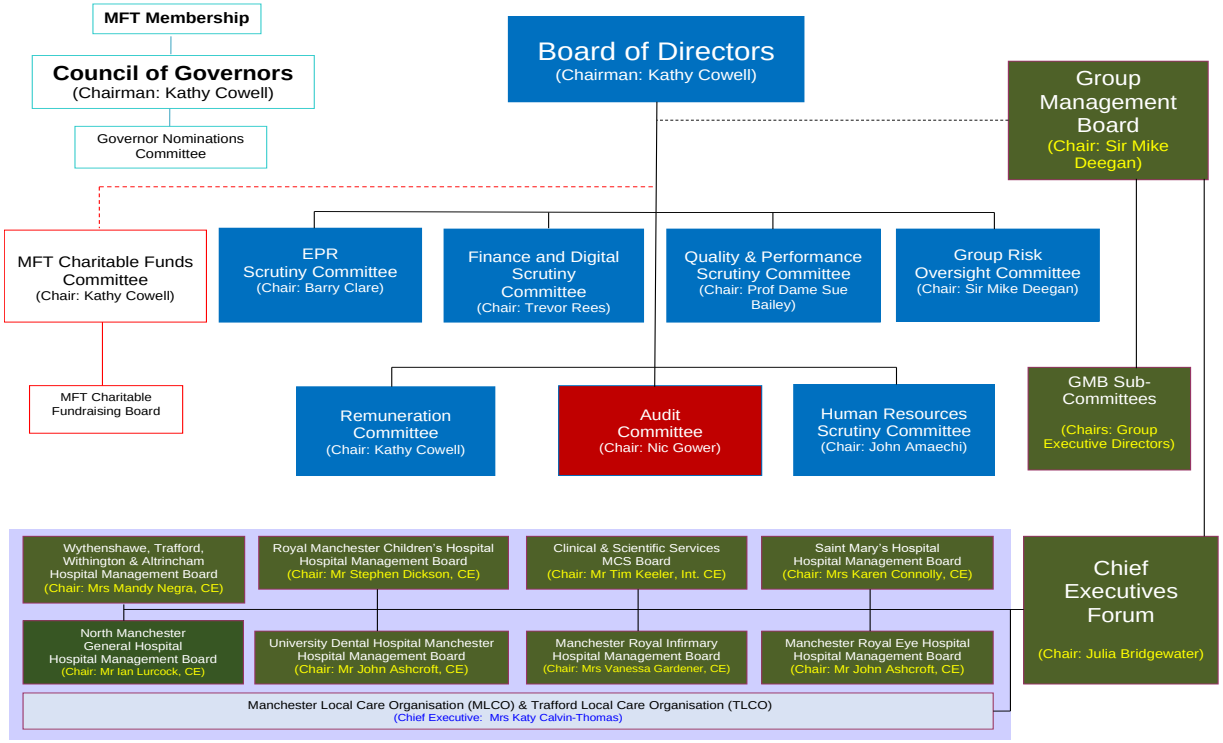
9.1 The Terms of Reference of the Audit Committee shall be reviewed by the Group Board of Directors at least annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

- Listed members or nominated deputies will attend at least 75% of the meetings each year.
- An Audit Committee work programme will be developed on an annual basis with measurable outputs.
- Training needs of the committee will be identified and relevant training provided
- An Audit Committee Annual Report will be incorporated within the Trust's Annual Report & Accounts

11. REPORTING STRUCTURE CHART



Approved: August 2017
Reviewed & Updated: August 2018
Reviewed & Updated: August 2019
Reviewed & Updated: October 2020
Date of Review: November 2021
Date of next review: November 2022

APPENDIX H

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

2. MEMBERSHIP

2.1 The Committee shall comprise:

- Group Chairman of the Group Board of Directors
- All Group Non-Executive Directors

2.2 No business should be transacted at a meeting unless the Chair and three Group Non-Executive Directors are present.

2.3 The Group Chairman of the Group Board of Directors shall be Chairman of the Committee and if unavailable for a meeting, the Group Deputy Chairman of the Group Board of Directors shall chair the meeting.

3. ATTENDANCE AT MEETINGS

3.1 The Group Chief Executive Officer and the Group Executive Director of Workforce and Corporate Business will join the Committee when discussing other Group Executive Directors, or, other designated individuals and/or staff groups.

3.2 The following participants are required to attend meetings of the Remuneration Committee.

- Trust Board Secretary.
- The Committee shall require the attendance of any Director or member of staff as required.

3.3 The Trust Board Secretary (or Nominated Deputy) shall be the secretary to the Committee and shall attend to take minutes of meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet at least once per annum.

5. OVERVIEW

5.1 The Remuneration Committee has been established by the Group Board of Directors to receive annual performance summaries for the Group Chief Executive and Group Executive Directors, and, ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales.

5.2 In line with the Department of Health & Social Care Guidance and best practice the Remuneration Committee will seek to ensure that all compensation decisions taken are fair and equality of opportunity, diversity and inclusion impacts are considered.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- To receive the annual performance summaries for the Group Chief Executive and the Group Executive Directors

- To determine the framework or broad policy for the remuneration of the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc.) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.

- To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.

- To advise on, and oversee contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.

- To understand the equality impacts of the decisions the Committee makes by having in each paper:

    - A breakdown on the impact of remuneration and changes to remuneration by protected characteristics in each pay paper.
    - Standard cover sheet including a section about how the author has consider equality and any actions taken to mitigate.

- To pay due regard to the diversity of Committee members and consider the impact of any gaps in representation on decision making.

7. AUTHORITY

7.1 The Remuneration Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

7.2 The Committee will make satisfactory arrangements to ensure it receives adequate independent advice on remuneration levels elsewhere in the NHS, with due reference to national policy and guidance, as well as trends and developments in areas of benefits and terms and conditions of employment.

8. **REPORTING**

8.1 The Remuneration Committee shall ensure that the Group Board of Directors' emoluments are accurately reported in the required format in the Group's Annual Report.

9. **REVIEW**

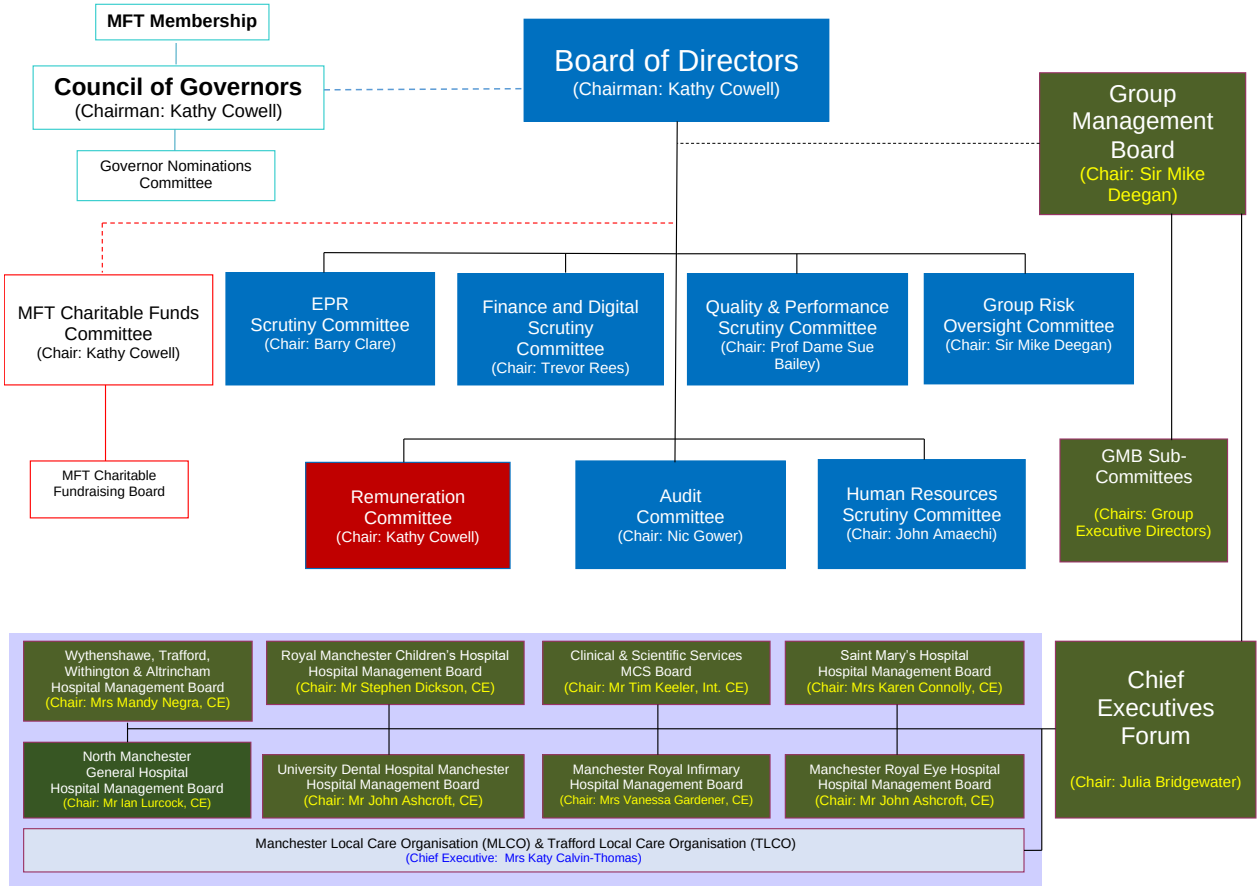
9.1 The Terms of Reference of the Committee will be reviewed at least annually.

10. **KEY PERFORMANCE INDICATOR**

10.1 These Terms of Reference will be measured against the following key performance indicator:

- 75% attendance of all listed members.

11. **REPORTING STRUCTURE CHART**



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