NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 10th January 2022

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

Present:	Ms Angela Adimora (AA)	Group Non-Executive Director
	Professor Dame S Bailey (SB)	Group Non-Executive Director
	Mr D Banks (DB)	Group Director of Strategy
	Mr Gaurav Batra (GB)	Group Non-Executive Director
	Mr P Blythin (PB)	Group Director of Workforce & Corporate Business
	Mrs J Bridgewater (JB)	Group Chief Operating Officer
	Mrs K Cowell (Chair) (KC)	Group Chairman
	Sir M Deegan (MD)	Group Chief Executive
	Mrs J Ehrhardt (JEh)	Group Chief Finance Officer
	Mr David Furnival (DF)	Group Director of Operations
	Professor L Georghiou (LG)	Group Non-Executive Director
	Mr N Gower (NG)	Group Non-Executive Director
	Mrs G Heaton (GH)	Group Deputy CEO
	Alison Lynch (AL)	Deputy Chief Nurse
	Mrs C McLoughlin (CM)	Group Non-Executive Director
	Mr T Rees (TR)	Group Non-Executive Director
In attendance:	Mr N Gomm (NGo)	- Director of Corporate Business / Trust Board Secretary

154/22 Board of Directors' (Public) Meetings

At the outset, the Group Chairman reported that in response to the ongoing COVID-19 (Covid) 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 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.

155/22 Apologies for Absence

Apologies were received from Professor Jane Eddleston

156/22 Declarations of Interest

There were no declarations of interest received for this meeting.

157/22 Minutes of the 'virtual' Board of Directors' Meeting held on 8th November 2021

The minutes of the Board of Directors' meeting of 8th November 2021 were approved.

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

158/22 Matters Arising

There were no matters arising.

159/22 Group Chairman report

KC provided an overview of recent events of note.

She began by welcoming two new Non-Executive Directors to their first Board of Directors meeting. Angela Adimora and Gaurav Batra joined the Trust on the 20th December and replaced Dr Ivan Benett and John Amaechi.

KC then noted that, in the recent New Year's honours' list, Dr Marie Marshall, MFT's Nurse Consultant for Transition, was awarded an MBE for services to Children and Young People's Health. Marie has worked collaboratively to develop transition services that meet the needs of children and young people and has also played a leading role within RMCH to embed research within clinical practice. KC asked for the Board's congratulations to Marie to be recorded.

KC recognised the way in which the ongoing pandemic has meant everyone has had to adapt to the way people organise and attend events. She talked about the 'Carols in the City' concert, the Galaxy House RMCH live music event, and Disability History month; and explained how, despite the required adaptations, all the events were successful and hugely inspiring.

KC highlighted the launch of MFT's Research Van, describing how the purpose-built vehicle includes a pharmacy and clinical area containing all equipment necessary to run vaccine programmes, clinical trials, and bespoke clinical projects out in the community.

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

160/22 Group Chief Executive's report

MD began by reflecting that the impact of Covid on MFT services had become more acute over the last few weeks and was due to remain so in the near future, as a result of the Omicron variant. He stressed that the overriding priority is to ensure that the services we deliver are and, in addition to that, MFT's focus is on:

- Maintaining operational grip;
- Supporting our staff, focussing on their health and wellbeing, and addressing the significant staff absence figures; and
- Seeking out opportunities to transform services

MFT is fortunate to have strong and effective working relationships across the city region as part of Greater Manchester Health and Social Care Partnership. This enables GM health and care organisations to support each other through mutual aid arrangements, deliver pan-GM solutions to the current issues, and make decisions as a unified group of health and social care organisations. In the first week of January, the difficult decision to suspend some aspects of elective care had been made to ensure that services which prevent death or severe disability can continue, safely. This decision is to be reviewed on 17th January based on what the data and evidence is indicating at the time.

MD finished by thanking Board members for all that they are doing to support MFT in these difficult times and recognised the dedication and professionalism of Trust's workforce who continue to work, day and night, to provide safe, high-quality care to patients.

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

161/22 Board Assurance Report

The Executive Directors 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 began by talking about patient safety issues.

In February 2021, the Trust implemented a group-wide safety management system which enables the timely contextualisation of multi-source information regarding the safety of the care provided to patients. This approach ensures a smart approach to identifying opportunities for high impact and transferable learning, accelerated improvement and smart assurance through:

- the capture of 'safety II' data (ensuring learning from the majority of patient outcomes that meet, or exceed, expectations);
- the use of SPC analysis to understand data about harm that has enabled MFT to identify, explore, and understand the risk associated with any special cause variation;

- the consideration of multiple sources of intelligence in relation to patient safety (qualitative and quantitative);
- a daily Trust-wide patient safety huddle; and
- a weekly Trust-wide Patient Safety Oversight Panel.

There is a focus on preventing Never Events, of which there have been 10 since April 2021. Human factors play a considerable role in those hence work is underway to address this. Learning from Never Events is studied and adopted within the relevant site, and shared across the whole of MFT. An external review has been commissioned to further look into this and provide an independent view on actions the Trust should be taking with regard to Never Events. In addition, analysis is undertaken of the times when everything is performed to the highest level to see what can be learned from that, through a system of Excellence Reporting.

MD underlined the importance of the Board Assurance Report which complements the scrutiny of these areas undertaken within the Trust's Scrutiny Committees.

TR, the Chair of the Patient Safety Committee, confirmed that they had received presentations on Never Events and he had been impressed by the frankness of the staff and their willingness to learn lessons.

SB concurred with MD's comments and described the 'deep dive' into this area carried out at the last Quality and Performance Scrutiny Committee. She welcomed the commissioning of the external review.

CL then presented the Patient Experience section of the report.

The number of new complaints received across the Trust in November 2021 was 129, when compared with the 140 complaints received in October 2021 and 163 in September 2021. In November 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 88.6% this is a slight increase of 2.6% from the previous month. The number of new complaints received across the Trust during November 2021 was 129, which is a decrease of 11 when compared to 140 in October 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

Saint Mary's complaints numbers are higher than most and the senior team are looking into this. There remain data quality issues regarding complaints at North Manchester General Hospital (NMGH); and Manchester Royal Eye Hospital (MREH), Manchester/Trafford Local Care Organisations (LCOs), and Clinical and Scientific Services (CSS), are showing low numbers of complaints at the moment.

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 92% in November 2021 which is a decrease compared to 95.1% in October 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 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 118 trust-attributable CDI reported so far this year. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 10 trust-attributable CDI cases reported for November 2021, all of which are pending review. There is a zero tolerance approach to MRSA bacteraemias, and a 15% reduction objective applied to E.coli bacteraemia's to meet the national 50% reduction objective by 2024. There have been 7 trust-attributable MRSA bacteraemia reported for the current year, none reported throughout November.

GB asked if MFT looks at the numbers of complaints upheld rather than just total number of complaints.

CL explained that the Q3 Complaints report will come to the next Board meeting and that will include the numbers of upheld complaints.

DF explained that he would cover the salient issues from the Operational Excellence section of the report in item 7.2.1.

MD asked how learning, and positive changes to work practices, to work practices are embedded across sites.

DF explained that change is tested in one part of the Trust and then embedded across the whole Trust if successful. He gave the example of the 'Fit to Sit' programme in NMGH which is being overseen by the Urgent Care Forum.

JE explained that the highlights from the Finance section of the Board Assurance Report would be covered in item 7.3.

PB talked to the Workforce and Leadership section of the report.

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. Hospitals/ MCSs/ LCOs have developed 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 has also commenced and preparations for Hive end user training continue.

Work continues with regards to COVID-19 workforce recovery. The key areas of focus include the mitigation of staff unavailability and an enhanced focus on Employee Health and Wellbeing Services.

Progress continues to be made to progress the MFT People Plan deliverables.

KC asked about the investment which had been made in workforce support initiatives.

PB explained that the Board had agreed funding of approximately £1m during this financial year in addition to circa £350K of funding from the MFT Charity.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	n/a	n/a	n/a

162/22 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

DF presented the report which provided an update on the Trust's ongoing response to the Covid pandemic.
He began by explaining that the report had been written prior to the impact of the Covid Omicron variant being fully felt. He therefore provided up to date figures during his update.

As at 9th January 2022, there are 421 Covid-positive patients in General and Acute (G & A) beds, up from 120 a month previously. This represents 85% of the number at the peak of the first wave of Covid. 28 patients in Critical Care are Covid-positive which is only four more than a month previously. This represents 23% of the number at the peak of the first wave.

Covid-response governance has been reinstated at hospital, Trust and GM levels underpinned by seven-day response.

Staff absence rates have peaked at an average of 15% during this wave and currently sit at 13%. The PCR testing venue for staff has been re-established at the Alexandra Health Centre.

In the first week of January 2022, a decision was taken at GM Gold to cancel routine surgery, with a review to take place on the 17th January 2022.

CM asked DF to say more about how the LCOs were supporting MFT's response.

DF explained that the LCOs had been key throughout the pandemic in supporting discharge and preventing admissions and readmissions.

LG commended the presentation and noted the reinstatement of multi-level governance. He asked whether there were any particular pressure points in the system at present.

DF described the strength-in-depth of leadership across the Trust which has aided resilience throughout the last two years. MFT has also had the experience of the previous Covid waves which has enabled a swift and pro-active response to this variant.

LG noted the frequent written briefings that NEDs had been receiving and valued the updates they provided.

MD asked CL to explain the work in progress to support staff at present.

CL introduced the addendum to this report which had been circulated to Board members prior to the meeting (appended to these minutes).

Despite the lower severity of illness caused by the Omicron variant, it has meant that many staff members are absent due to illness or isolation requirements. A 'Safer Staffing' is in place but it may be necessary to escalate up the levels described within the policy over the next few weeks. There will be over 100 new starters in January 2022 and a training programme has been implemented to enable non-clinical staff to provide clinical roles, if required, under appropriate supervision. The situation is being reviewed on a daily basis and the progress will be discussed at the Quality and Performance and Human Resources Scrutiny Committees.

BC asked about balancing priorities and sought assurance that patient nutrition and hydration levels were still an area of focus.

CL confirmed that nutrition and hydration levels were still a priority and that this was an example of work that non-clinical staff could assist with.

KC agreed and highlighted the importance of staff health from a nutrition and hydration prespective.

MD explained that discussions had been had with Ann Ford from the CQC about how clinical risk could be managed within and between organisations.

DF explained that the Covid Response meeting closely monitors key metrics to identify where further capacity or skills are required. Clinicians are fully involved in these discussions.

AA noted the work and underlined the importance of retaining key staff and identifying ex-employees who could come back and support the Trust during these challenging times.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	n/a	n/a	n/a

Update on the COVID-19 Vaccination Programme

CL presented the report which provided an update on the Covid vaccination programme.

On the 3 December 2021, the Joint Committee on Vaccinations and Immunisations (JCVI) published advice in response to the emergence of the B.1.529 (omicron) variant, setting out the next steps for vaccine deployment. The next steps advice includes:

- an acceleration of COVID-19 booster vaccinations to all those over the age of 18, and;
- to offer the booster at a 12-week (3 months) interval from the 2nd dose, in line with advice offered on optimal timing. Previously the interval had been 6 months.

The proposed end date for the booster vaccine programme is 31st December 2021, however it is possible that this may be extended. The JCVI also advise that children and young people aged 12 to 15 years should be offered a second dose of the Pfizer-BioNTech COVID-19 vaccine at a minimum of 12 weeks from the first dose.

Th MFT vaccination figures had risen since the report was written. 92% of MFT staff had received their first vaccine and 89% had had their second vaccine.

Flu vaccination rates are not as high as those for Covid but, in previous years, the end of February has seen an increase.in flu uptake.

MFT's vaccination hub sites are available to the public as well as staff from other health and care organisations, working closely with the LCOs and system partners. There are 30000 additional slots across GM. There is a focus on working with BAME staff whose vaccination rates are lower at the moment.

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. 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+). 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.

NG asked whether it had been possible to keep up with the ever-changing national guidance.

CL confirmed it was with the changes communicated from national, to regional, to GM, and then to Trusts. MFT can respond swiftly to any developments with a clinical sub-group 'sense-checking' any changes to ensure they are safe.

KC explained that the QPSC and HRSC get regular update regarding vaccination activity.

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

Update on the COVID vaccination for NHS staff

PB presented the report which provided an update on implementation of the national guidance – Vaccination as a condition of Deployment (VCOD) for Health Workers – released on Monday 6th December 2021.

They key points in the national guidance are as follows:

- The scope is set as, "Workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity". Flowcharts and example scenarios are provided. The in-scope staff are essentially those who deliver services in any CQC-regulated activity.
- The guidance requires proof that students and trainees are fully vaccinated, as well as all independent contractors, agency or bank staff who fall under the scope.
- The last date for unvaccinated staff to receive their first vaccination is 3rd of February 2022.
- Exemptions to vaccination are described in the guidance but the list is relatively limited.
- Local Equality Impact Assessments must be completed.
- Employers are advised to undertake Data Protection Impact Assessments.
- Redeployment options are suggested to be considered at an ICS level. It also provides a temporary redeployment option when the second vaccination is scheduled after the 1st of April but requires staff not to return to frontline duty until they have had their second jab.
- Compliance will be monitored by CQC.

An internal task and finish group has been established. The Group is accountable to the Group Executive Director of Workforce & Corporate Business reporting to the Covid Recovery Group. Membership of the task and finish group comprises Group HR, Corporate Nursing, Informatics, Hospital/MCS and LCO HRDs, Staff Side, Communications, and Group Joint Medical Directors' office. Frequency of the meetings has initially been set as weekly, with the provision to increase frequency should demand present. Lessons from the Local Care Organisation experience with mandating vaccinations with care home settings have been discussed and is being considered as part of the programme development.

The local delivery plan has been assessed against the national guidance to ensure all aspects are covered. Key areas contained within the delivery plan include:

- Confirming which staff are in scope for mandatory vaccination.
- Deciding how clinical exemptions will be applied using national criteria.
- Changing pre-recruitment processes to mandate vaccination as a condition of employment.
- Promoting vaccination with unvaccinated staff.
- Data governance and reporting.
- Employment issues inclusive of plans for potential staff redeployment.
- Equality Impact Assessment.
- Communication and Engagement

PB explained that staff would be required to receive their first vaccination by 3rd February 2022 in order to be fully vaccinated by the deadline. National guidance was expected and this would be discussed at the HRSC.

KC explained that mandatory vaccination had been added to the Trust's risk register.

TR asked what the grounds for dismissal would be for those staff who didn't comply and whether there was any requirement to make financial provision for redundancy.

PB explained that it was expected that the national guidance would cover this issue.

TR asked for an update at the Finance and Digital Scrutiny Committee (FDSC) if there were any financial implications.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	Report to come to FDSC should there be any financial implications due to the mandatory vaccination programme.	PB	Complete. Mandatory vaccination requirements withdrawn by Government therefore no FDSC update required.

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

CL presented the report which included updates to the Infection Prevention and Control Board Assurance Framework (IPCBAF)

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

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
- 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
- 19th October 2021. Group Infection Control Committee
- 7th November 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).

CL explained that the IPCBAF had recently been redesigned and the Board would see the new version at their March meeting.

Nosocomial transmission of Covid had risen considerably over the last 10 days due to asymptomatic patients attending the hospital. There had been 12 outbreaks so far in 2022. Other HCAIs were being monitored as usual.

BC asked about the impact of the rise in Covid + patients on bed capacity.

CL confirmed that there had been a considerable impact and patients were being 'cohorted' and cleaning schedules were being increased to address this.

NG commented that the IOPCBAF had become so large that it was ceasing to be useful as a control document.

CL explained that consideration was being given as to how the new IPCBAF would be presented.

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

163/22 Chief Finance Officer's report

JEh presented the report which presented MFT's financial performance for Month 8. The financial regime for 2021/22 has been split into 2 halves (H1 and H2).

At month 8, November 2021, the Trust has delivered a surplus of £7.7m; which is an improvement of £1.3m from the £6.4m surplus reported in month 7 and is in line with the H2 plan submitted to NHSE/I in late November.

The NHSE/I H2 plan requires the Trust to breakeven in the six-month period and overall to deliver a £13.1m surplus for the 12 months to March 2022 based on the performance achieved in month 1-6 against the H1 plan.

November expenditure at £191m has increased by circa £2.3m against month 7 but is more consistent with levels expended in the second quarter of H1. After removing the pay accrual in month 7 the total expenditure in month 8 is some £700k lower than month 7.

The ongoing 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) and in Month 8 the Trust was notified of further elective recovery and discharge monies. As a high proportion of the funding is non-recurrent the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime for 22/23.

The value of system monies from GM for H2 has been agreed and revised plans for income and expenditure in H2 that deliver a breakeven position have been factored into the H2 plan. The Trust's WRP target remains at £50m for the full year, but the breakeven position for H2 only assumes that £30m of that will be achieved for the year to March 22. If we are to deliver £23m surplus for the year, then we will need to generate a further £10m of financial flexibilities or seek additional efficiencies in our operating performance.

As at 30th November 2021, the Trust had a cash balance of £282m. The cash balance was higher than forecast by £17m, primarily due to a higher than forecast HEE receipt for £29m, of which £16.8m was received in advance of the forecast date of January 2022.

In the period up to 30th November 2021, £67m of capital expenditure has been incurred against a plan of £108.1m, an underspend of £41.4m. £25.7m of the slippage relates to the New Hospitals Programme North Manchester project and is due to delays in the approval of the Park House scheme and associated enabling works, alongside the slower than anticipated programme for the new hospital. The estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £15.4m underspend, the most material elements are £6.8m relating to the NMGH emergency works which are due to be 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) and £4.1m relates to Hive and is a result of the changed profile of spend on the EPIC production platform which will be incurred later in the year.

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.

TR stated that the current focus needs to be on capital expenditure and the FDSC are closely looking at this. He recognised the good work of the Finance team in light of the late H2 national guidance and the number of one-off funds which have been made available.

KC asked whether there were any issues with the Trust complying with the Better Payment Code.

JEh explained that, while MFT performance was not where she wanted it to be, other Trusts were finding compliance with the code more difficult. Some Trust departments, for example Pharmacy, were finding it difficult to get invoices approved. The Trust's compliance rates were improving and it is an area of focus for the Finance team.

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

164/22 Update on the Hive programme

JB presented the report which provided an update on the progress of the Hive programme.

Hive will go live on 8th September 2022 and there is a robust programme management approach in place to oversee the implementation. The roll out will continue after this date once the initial phase is live.

A robust Governance process has been set up with the Hive Programme Board responsible for overseeing the implementation and providing assurance to the EPR Scrutiny Committee.

Three 'Design Authorities' have been set up and report into the Hive Operational Steering Group. These Design Authorities make the important decisions about how Hive's EPR system will work for MFT. They monitor progress and decisions which come out of the Rapid Decision Groups (RDGs) which have been established, with membership made up of clinicians and operational staff from across MFT, to make fast-paced decisions to shape workflows in the Epic system.

To support Hospitals/MCSs/LCOsto be ready for Hive, an Operational Readiness Authority has been set up with individual Hospital / MCS / LCO Operational Readiness Boards.

Given the nature of the programme, external assurance is also in place with a number of Gateway Reviews in the run up to the go-live date.

As part of the Programme Management approach, there is a programme-wide risk log which is monitored through the Hive Operational Steering Group and Programme Board. Mitigation plans are in place for all identified risks. The Hive Team is actively managing these risks by working closely with operational colleagues to ensure appropriate management of the pandemic response as well as delivery of the Hive Programme.

A comprehensive Communications and Engagement Strategy is in place, supported by a clear brand identity, with a focus on ensuring a multi-layered approach for raising staff awareness and communicating with key external audiences.

JB summed up by stating that the Hive programme is on track to ensure a successful Go-Live on 8th September 2022. This will be a key milestone underpinning the delivery and focus of the MFT Digital Strategy. In preparation for Go Live, MFT is now part of a wider UK community of NHS Foundation Trusts using the Epic platform and is working collaboratively with those Trusts to provide mutual aid for each other's go live dates. Assurance will continue to be provided to the EPR Scrutiny Committee supported by further updates to each Board of Directors' meeting.

MD stated that this is the major programme for MFT and the whole organisation needed to put its weight behind it. He noted that MFT clinicians are very supportive due to the potential it has to improve patient care.

NG pointed out that the programme had external assurance embedded through Deloitte.

BC concurred, explaining that Deloitte have been very helpful due to their involvement in Hive implementations in other Trusts. He reminded the Board that Hive is not an IT programme, it is an organisational change one, and he noted that JB was getting lots of support from clinical colleagues.

CL stated that Hive would provide additional opportunities for patients to engage with their healthcare.

JEh noted that initially there was a small financial benefits realisation initially but that this would grow over time.

KC asked if staff were being released in sufficient numbers for training.

PB explained that he was working with JB and Hospital/MCS/LCO /Corporate staff to identify and confirm plans as to how staff would be made available for training.

JB concluded by noting that staff are very engaged at present and excited by the potential which Hive offers.

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

165/22 Update on the MFT Green Plan

DF presented MFT's Green plan, seeking approval from the Board of Directors for its adoption across the Trust.

The Green Plan sets out more than 50 objectives and supporting projects spanning ten areas of focus. Each of the objectives and supporting projects requires a senior leader within MFT, and there will be further refinement of the objectives and supporting projects over the next twelve months once each objective has been assigned. This will ensure that the objectives are both deliverable & affordable.

Key to the success of the Green Plan will be the formation of a Climate Strategy Board (CSB), chaired by the Group Director of Operations. The CSB will comprise members of the senior leadership team from each Hospital/MCS/LCO and will span the full range of staff groups. Each of the CSB members will be assigned a number of the objectives and supporting projects to own and report against.

MD stated he was fully behind the work and asked how MFT can ensure that the CSB has the impact it needs to have across the Trust.

DF explained the CSB will draw a cross section of leaders from across the Trust, supported by technical and knowledge experts, and will report into GMB. Challenging discussions will be required to meet the ambition set out in the Plan.

PB noted that MFT's Green credentials were one of the most asked about issues by new staff.

AA echoed what PB had said, pointing out that a high-profile green agenda was a significant aspect of being an employer of choice.

BC stated that it was important to engage with an external perspective on our plans and to avoid 'green washing'.

DF stated that he fully agreed and noted that some change will need to be implemented over a long period of time.

Board decision	Action	Responsible officer	Completion date
The Board approved MFT's Green Plan.	None	n/a	n/a

166/22 Update on Strategic Developments

DB presented the report which updated the Board on current strategic issues.

NHS England appointed Sir David Sloman as Chief Operating Officer on 14 December 2021. He was previously London Regional Director, and Group Chief Executive of the Royal Free London NHS Foundation Trust. Mark Cubbon, who was previously the interim Chief Operating officer has been appointed as NHS England Chief Delivery Officer.

On 1 December 2021, a White Paper on the reform of adult social care was published. It sets out a 10-year vision for adult social care. It describes how some of the money announced in the autumn spending review will be spent over the next 3 years to begin to transform the adult social care system in England, such as new investments in:

- housing and home adaptations
- technology and digitisation

- workforce training and wellbeing support
- support for unpaid carers, and improved information and advice
- innovation and improvement.

A further White Paper on integrating health and social care is expected in the new year.

DB noted that the implementation of ICSs is to be delayed by at least 3 months.

A draft constitution for the GM Integrated Care Board has been submitted to NHS England for approval. It proposes the following membership:

- Chair
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Two independent non-executive members.
- Partner members (one) representing each of:
    - NHS Providers
    - Local Authorities
    - Primary Medical Services

GM proposals to appoint additional members are under consideration but will depend on what is permitted in the legislation. The process to appoint to the executive director posts is in train. The process to appoint the NHS provider partners members is via nomination through the Greater Manchester Provider Federation Board and finalised by the Chair.

The shadow governance arrangements are being put in place. The Joint Planning and Delivery Committee has started to meet and a core executive leadership group, which brings together leaders form all levels in the new system has been established.

DB confirmed that Work to develop a cross-cutting cancer strategy for MFT is progressing. Engagement with the Council of Governors has taken place and the strategy document is now being drafted and will be taken through the MFT approval process.

CM stated that the 3 month delay to the implementation of the ICS was to be welcomed and asked if the development of locality arrangements was progressing.

DB confirmed that it is and that the GM Operating model has proved useful. There needs to be an appropriate level of consistence across the ten GM localities.

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

167/22 Annual Planning 2022/23 – MFT Strategic Aims

DM talked to the report which presented MFT's revised Strategic Aims following a period of engagement with key stakeholders, including MFT's Governors, which led to several amendments.

The proposed updated strategic aims are:

- To focus relentlessly on improving access, safety, clinical quality and outcomes
- To improve continuously the experience of patients, carers and their families
- To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best

- To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future
- To use our scale and scope to develop excellent integrated services and leading specialist services
- To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve
- To achieve and maintain financial sustainability
- To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda

The draft timeline for the annual planning process through which the strategic aims will be translated into specific objectives and actions for delivery in 2022/23 is as follows:

- Hospital / MCS / LCO draft priorities for 22/23 completed (28 January 2022)
- CoG annual planning session (9 February 2022)
- Draft Annual Plan circulated for comment (March 2022)
- Annual Plan approved by Board of Directors (April 2022)

DB noted that the national annual planning timetable may be delayed this year due to the impact of Covid.

BC asked how the 'Green agenda' was being reflected within the work.

DB explained that the Strategic Aims would be translated into plans and actions which would include consideration of MFT's Green Plan. Any slippage in progress would be highlighted to the Board.

KC asked that a clear process for reporting MFT's action of 'green issues' to the Board was identified.

Board decision	Action	Responsible officer	Completion date
The Board noted the report	Develop a clear process for reporting progress on 'green issues' to the Board.	DF	May 2020

168/22 Approve the draft statement for publication on Patient and Public Involvement in Patient Safety

TO presented the report which sought Board approval for a statement of commitment to patient and public involvement.

The NHS Patient Safety Strategy[1] (July 2019) recognises the importance of involving patients, their families and carers, and other lay people, in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own care.

The Trust has established a sub-group of the Group Patient Safety Committee to lead the implementation of the framework across the Trust The sub-group has representation from across the sites/MCS/LCO and corporate teams, including the equality and diversity team. The sub-group has developed an action plan to ensure the principles of the framework are implemented by June 2022. The sub-group provides monthly updates in relation to progress being made to the Patient Safety Committee and by exception to the Group Quality and Safety Committee.

The Trust has developed and validated a patient safety culture assessment tool (using a previously developed tool as a basis). One of the key dimensions of the tool is patient and public involvement with a requirement for publication of an expressed Board Commitment to patient and public involvement. The following was presented for approval by the Board:

Involvement of our patients and our local communities is essential to the way we understand and make improvements in the safety of the services we provide across our organisation.

We are committed to making sure that this involvement is meaningful.

Our patients are actively and directly involved in the safety of their care.

Patients, patient groups, and our local communities are valued partners in the way we organise, deliver and understand the safety of care we provide'

KC confirmed that the statement had already been considered at the QPSC.

SB stated that the approach will need to ensure involvement of all patient voices, especially people with protected characteristics.

Board decision	Action	Responsible officer	Completion date
The Board noted the approach being taken to the implementation of the Patient and Public Involvement in Patient Safety Framework at the Trust, and the early progress being made; approved the statement of commitment; and noted the strategic approach supported by the Communications team planned in relation to the publication of the statement of Commitment.	None	n/a	n/a

169/22 Update report on the results of the Cancer Patient Experience Survey (2020/21)

CL presented the report which provided an overview of MFT's results from the National Cancer Patient Experience Survey (NCPES) 2020.

Due to the pressure COVID-19 placed on the NHS, the 2020 NCPES was offered to all NHS Trusts on a voluntary basis; 55 Trusts (of 139) took up the offer, including MFT. For this reason, it is not possible to produce a national level report or reports at cancer alliance or CCG level, or for national comparisons to be made against previous years. Nationally, out of 33,266 people, 19,610 people responded to the survey, yielding an overall response rate of 59%. MFT's response rate was 55%.

The report provided an overview of MFT's results following the NCPES 2020. The paper includes an overview of:

- Respondents' demographics
- Areas requiring further analysis,
- Opportunities for improvement, and
- Areas of improvement from the previous survey
- Links to the Cancer Strategy, which is under development

The results require further analysis by tumour-specific teams working closely together across the Trust to both identify areas to celebrate success and areas for improvement. Where common priorities exist across multiple teams, action plans will be agreed in the appropriate Trust forums to ensure parity of provision. The challenge remains for those tumour groups where eleven or fewer responses were received to consider how they can encourage patients to respond to the future surveys. Actions are required to reach into groups who have not participated in the survey and reduce inequalities - a key theme of the MFT Cancer Strategy.

Overall, the NCPES (2020) results are comparable with the previous year for MFT, which is reflective of the hard work of all staff to provide cancer services during particularly uncertain months during the COVID-19 pandemic. The report and the findings will be shared and discussed at the Group Cancer Committee.

TR commended the decision to take part in the survey and asked about how the results were to be shared with primary care.

CL confirmed that the results would be shared with primary care with the learning overseen by the Group Cancer Committee.

PC concurred explaining that primary care colleagues sit on the Cancer Improvement Board.

KC noted that the results were comparable with recent years despite the impact of Covid on service provision.

Board decision	Action	Responsible officer	Completion date
The Board noted the feedback and the opportunity for improvements in patient experience	None	n/a	n/a

170/22 Maternity Assurance Report (including an update on Ockenden Report, and NHSR Safety Actions)

CL presented the paper which provided assurance to the Board of Directors on matters relating to patient safety and workforce within maternity services; an update in respect of the Ockenden Report and the NHS England and Improvement (NHSE/I) maternity self-assessment tool submission; and information regarding to key Safety Actions linked to the Clinical Negligence Scheme for Trusts Year 4 Maternity Incentive Scheme (MIS).

The Board of Directors has received updates relating to 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[1], in January March, May and October 2021.

A further extensive submission of evidence related to areas of compliance was submitted to the Greater Manchester and Eastern Cheshire Local Maternity Neonatal System (GMEC LMNS) on 30th June 2021.

The Saint Mary's Managed Clinical Service (SM MCS) Ockenden response plan includes 83 actions against the 7 Immediate and Essential Actions (IEAS) all of which were all planned to close by the 31 December 2021.

As reported in October 2021, SM MCS submitted evidence of compliance with Ockenden recommendations via the Future NHS Collaborative Platform for review by the Clinical Support Unit (CSU) of the Regional Maternity Transformation Programme. Feedback from CSU has been received via the Regional Maternity Team on the 9th December 2021. The review has noted that further information is required in the following areas:

- 4 areas required evidence from GMEC LMNS regarding external processes
- 2 areas which were not compliant at the point of submission in February 2021 have been addressed. These were a review of the website by the chairs of SM MCS site specific Maternity Voices Partnership (MVP) and evidence of Non-Executive Director safety walkarounds.

An Assurance Visit by the Regional team will be undertaken to review progress against the Ockenden recommendations.

In response to national review findings, a maternity safety self-assessment tool has been designed for NHS maternity services to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. SM MCS is currently undertaking a review and collating the evidence against these actions. At present:

- 2 actions have all evidence collated
- 10 actions are in receipt of most of the identified evidence
- 21 actions are awaiting receipt of identified evidence
- 8 actions are in review to identify evidence required.

Although the second Ockenden Report was expected to be published in December 2021 or January 2022, an announcement on 25th November 2021 confirmed that the publication will be delayed until March 2022.

Governance processes are in place within SM MCS through which assurance in respect of Patient Safety is obtained. These include:

- Incident management systems and processes,
- Board Maternity Safety Champions
- Locally embedded assurance oversight framework (AOF)

In October 2021, 5 cases were reported in the moderate, major, or catastrophic harm category, including one Never Event in Maternity Theatres. One of these cases was reported to Healthcare Safety Investigation Branch (HSIB). There have been no moderate, major, or catastrophic harm incidents reported in November. There have been 4 in December which will be reported on in future Board reports.

All incidents that are moderate and above have been reported to Greater Manchester and East Cheshire (GMEC) Patient Safety Special Interest Group. And have been subject to a practice review and a high impact learning assessment has been undertaken.

High impact learning assessments have led to the following actions:

- Obstetric involvement in SM MCS and Group wide review of theatre processes, including a multi-professional Theatre Summit to identify human factors and cultural barriers.
- Maternity Theatre Group implemented to review pathways and processes for maternity theatres across SM MCS.
- Review of the controls and mitigations in place to prevent retained swabs occurring, in all settings across SM MCS.

- Educational update for staff regarding the escalation processes and accessing senior support.
- Lessons learnt incorporated into mandatory training to ensure they are shared with the wider team.
- Educational update for the management of breast lumps in pregnancy to be provided.

The Trust has two executive (Group Chief Nurse and Joint Group Medical Director) and one non-executive Maternity Board Safety Champions (CM).

The MFT Board Safety Champion (Group Chief Nurse) attended the SM Quality & Safety Committee in September and October 2021. The Deputy Chief Nurse attended in December 2021. The Medical Board Safety Champion meets with Obstetrics, Neonatal and SM MCS Medical Safety Champion every two months. The Non-Executive Board Safety Champion has undertaken a walkaround at Oxford Road Campus in September 2021 and North Manchester in November 2021 and a walkaround is planned for Wythenshawe Hospital in January 2022.

The Board Maternity Safety Champions will have visibility of the maternity oversight dashboard, which is under development as part of the Hive programme, it is due to be fully implemented in September 2022.

As previously reported to Board SM MCS has been supported to increase the midwifery staffing establishment in line with the recommendations of the Birthrate + (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.

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. To address the remaining vacancy factor of 23 WTE, active recruitment processes have re-commenced supported by the corporate workforce and resourcing team. SM MCS has experienced challenges in recruiting to community midwifery teams. To address this work has commenced to support confidence in caseload management for midwives during preceptorship, led by Matrons for Community services across the 3 maternity sites.

To mitigate the impact of absence due to sickness, and maternity leave, temporary staff from NHS Professionals are utilised to support staffing levels. During Q3, the registered midwifery workforce is being further supported by agency staff.

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. The funding provides 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, both in acute and community settings.

NHS Resolution is operating year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. On 23 December 2021, it was announced that CNST reporting would be paused for national reporting. Local reporting will continue.

CL described the Transitional Care services within SMCS and the NHSE/I ATAIN programme and other ‘Safety actions’ within the MIS.

CM recognised that it has been a busy time to define and address the safety actions within the MIS but noted the commitment to improve at all levels. She has spent time in all maternity units and has met up with the Chairs of the Maternity Services Partnership.

SB thanks everyone for their hard work and identified three themes from this and other items on the agenda: the potential of Hive, the pressure on staff, and the link between patient and public involvement and patient safety.

Board decision	Action	Responsible officer	Completion date
The Board noted the information and assurance provided in the report, and current SM MCS position, noting the challenges to implementing MCoC as a default model of care without the additional workforce requirements.	None	n/a	n/a

180/22 CQC Statement of Purpose Amendment

TO presented the report which proposed a change to MFT's Statement of Purpose. The amendment was to add 'Manchester Academic Centre – MRIU Escalation Capacity' as a new location.

Board decision	Action	Responsible officer	Completion date
The Board noted this change to the Statement of purpose	None	n/a	n/a

181/22 Ratify amendments to the Remuneration Committee's Terms of Reference

PB presented the report which sought approval for changes to the Remuneration Committee's Terms of Reference following discussion at the Committee.

The changes were:

- To remove the words 'pay due regard to the diversity of Committee members and' from the last bullet point in 6.1 as the membership of the Remuneration Committee is determined solely by who the Non-Executive Directors are.
- To remove the words 'adequate, independent' in reference to advice in 7.2 to prevent any potential issues with interpretation of their meaning.

Board decision	Action	Responsible officer	Completion date
The Board approved the changes to the Terms of Reference for the Remuneration Committee	None	n/a	n/a

182/22 Committee Meetings

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

- Audit Committee held on 3rd November 2021
- Group Risk Oversight Committee held on 20th September 2021 22nd November 2021
- Charitable Funds Committee held on 30th November 2021
- Quality Performance & Scrutiny Committee held on 6th December 2021
- Human Resources Scrutiny Committee held on 15th December 2021
- Finance Scrutiny Committee held on 26th October 2021

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

183/22 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 14th March 2022** at **2pm**.

184/22 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 10th January 2022		
Action	Responsibility	Completion date
Report to come to FDSC should there be any financial implications due to the mandatory vaccination programme.	PB	Complete. Mandatory vaccination requirements withdrawn by Government therefore no FDSC update required.
Develop a clear process for reporting progress on 'green issues' to the Board.	DF	May 2020

Addendum to 162/22

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Alison Lynch, Deputy Chief Nurse
Date of paper:	6th January 2022
Subject:	Addendum to Update on MFT COVID Response & Recovery
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 addendum report in relation to COVID-19 Super Surge Capacity • Clinical Model • Safer Staffing
Contact:	Name: Alison Lynch, Deputy Chief Nurse Tel: 0161 276 5655

1. Introduction

1.1. This addendum covers Agenda Item 7.2.1. and covers the policy in place for providing nursing staff to support the bed expansion required for hospital super surge capacity, due to increasing numbers of patients admitted with Covid-19.

1.2. It is anticipated that the current wave of COVID-19 infection caused by the Omicron variant risks large surges in admissions during January 2022. The impact of the surge will mean that demand for hospital beds may exceed current capacity.

1.3. Nurse staffing escalation policies already exist and form part of the Trust EPRR response for business continuity. The policy mirrors the trust escalation levels which trigger the need for additional capacity.

1.4. The difference between previous surges and the one resulting from the Omicrom variant is the increasing number of staff affected and absent due to Covid, which means that the escalation levels in the policy are likely to be triggered sooner.

1.5. This addendum is provided due to the speed in which the variant has evolved and impacted on the system over the recent weeks and is to remind the Board of Directors of the systems in place, to support the care of patients using a risk- based approach.

1.6. Previous surges significantly impacted on Critical Care and nurses and therapists were deployed following some training to support ICU. This surge has had a significant impact on General and Acute beds and there are less staff to deploy to the wards who are clinically skilled.

1.7. Similar nursing pressures also exist within our community teams.

2. Staffing model

2.1. The medical staffing model for additional capacity areas includes oversight of a medical consultant, supported by junior medical staff. The nursing and therapy model includes oversight from a lead nurse, matron, ward manager and therapy lead.

2.2. The increasing ratio of patients to Registered Nurses is not risk free but may be required in extreme circumstances which have arisen due to the pandemic. These decisions will be made on a shift-by-shift basis by senior nurses using the guidance within the policy.

2.3. Nurse staffing will be monitored across all hospitals using this guidance which describes minimum staffing levels and mitigation when appropriate ratios may not be achieved. The current MFT guidance (MFT Pandemic Safer Nursing & Midwifery Staffing Guidance)[1], is supported by national guidance but requires professional judgement at the point of care.

3. Governance & Mitigation

3.1. Reported on the compound Covid-19 pandemic risk reported at Group Risk Oversight Committee.

3.2. Nurse ratios will be reported through the existing reporting structure through EPRR and via Directors of Nursing to the Chief Nurse.

3.3. Internal monitoring will include Quality and Performance Scrutiny Committee and HR Scrutiny Committee to support the delivery of safe care and staff satisfaction.

3.4. Mitigation includes:

- 20 pre-qualification registered nurses appointed at Band 4 entering the workforce earlier

[1] MFT Pandemic Safer Nursing & Midwifery Staffing Guidance V4 December 2021

- 41 newly qualified RN.
- 54 International nurses on the temporary NMC register (a further 150 by end of March).
- >100 health care support workers commence in the next 8 weeks.
- Nonclinical staff trained in basic care to support ward-based staff.
- Move to task orientated/team nursing.
- Non-essential, nonclinical work ceased to focus solely on patient needs.
- Nonclinical support includes for example support for meals and hydration.
- Work to support wellbeing of staff will continue as previously set out by the Executive Director of Workforce.

4. Recommendation

The Board of Directors are asked to note the implementation of the nurse staffing escalation plans, associated risks and mitigation.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Operating Officer / Hive SRO
Paper prepared by:	Veronica Devlin, Programme Director
Date of paper:	March 2022
Subject:	Update on Hive Programme
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The implementation of Hive supports the delivery of MFT's vision and all of its Strategic Aims.
Recommendations:	The Board of Directors is asked to note the progress made by the Hive programme.
Contact:	Name: Julia Bridgewater, Group Chief Operating Officer / Hive SRO Tel: 0161 701 5641

Update on the HIVE Programme

1. Background

1.1 As one of the largest NHS Foundation Trusts in the UK, MFT requires a future Electronic Patient Record (EPR) solution which supports its vision to be a world-class academic and teaching organisation.

1.2 Following an extensive procurement exercise, MFT signed a contract with Epic following approval of the EPR Full Business Case by the Board of Directors in May 2020. This has since been extended to cover North Manchester General Hospital following the formal acquisition of NMGH on 1st April 2021.

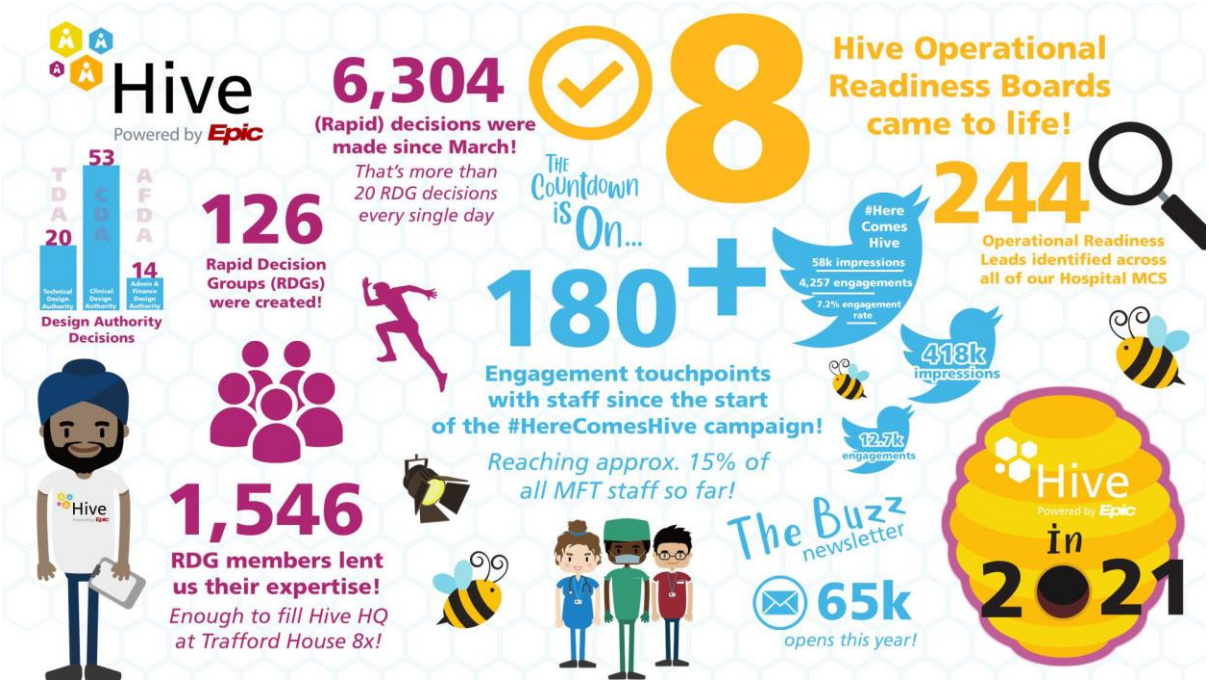
1.3 MFT's future EPR solution is called Hive reflecting the importance of clinical transformation and wide-spread change and improvement in every part and process of the organisation to benefit patients and staff. It complements the work underway to deliver the Trust Digital Strategy and supports the Trust research portfolio.

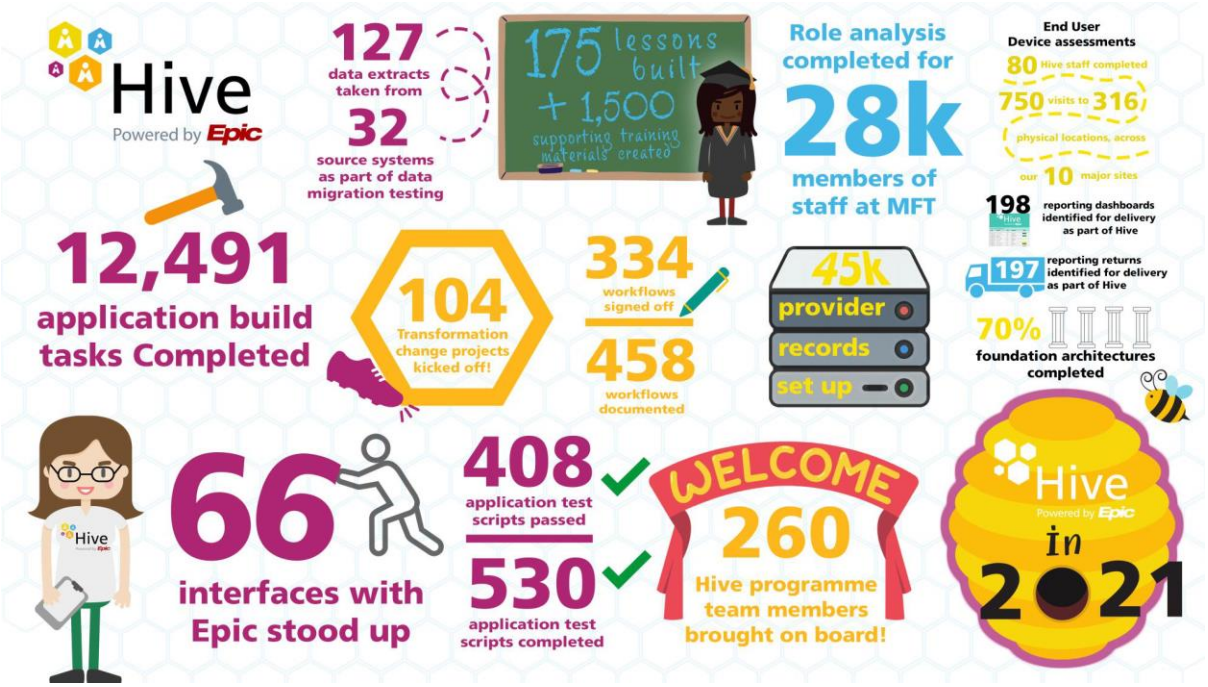
1.4 Hive will Go-Live on 8th September 2022 supported by a robust programme management approach to oversee the implementation. The roll out will continue post 8th September once the initial phase is live.

1.5 From September 2021, Julia Bridgewater, Group Chief Operating Officer is providing dedicated Executive level oversight and leadership for the Hive Programme.

2. Progress to date

The Programme in numbers as at the start of 2022 is outlined in the graphic below:





2.1 The Programme is on track for the Go-Live date of 8th September 2022. Over 200 staff are working to deliver the technical infrastructure and digital solutions and interfaces alongside the transformation required to support safe and effective care across our ten hospitals and Managed Clinical Services (MCS).

2.2 The Hive governance and programme management functions are well developed and embedded. This includes the completion of equality impact assessments for the programme and specific work streams.

2.3 Robust external assurance arrangements are in place with Deloitte providing regular gateway reviews. The next scheduled review is due to report at the end of March 2022.

2.4 Given the size and complexity of the programme a standalone EPR Scrutiny Committee meets on a bi-monthly basis chaired by Barry Claire, Non-Executive Director.

2.5 Several Local Care Organisation (LCO) services have now been scoped into the Hive Programme, and communications on this have been developed and shared with staff. Work is ongoing to design detailed training tracks for staff for the various areas of the Hive system which will be essential to their day-to-day work.

2.6 The Hive Programme entered **Phase 2: User and System Readiness** in November 2021. This marks a shift from a focus on the build of the EPR itself, to readying the infrastructure, linkages to other existing systems and medical devices as well as preparing staff for delivery of the system.

2.7 Other key activities in this phase include planning and implementing the staff training, communicating any alterations to workflows, assessing and supporting staff digital confidence in tandem with transformation projects required.

2.8 Operational readiness is supported at Group and Hospital, MCS and LCO level by a number of structures within the Programme governance. Comprehensive supporting resources are available in the form of Operational Readiness 'Playbooks' which explain the detailed activities required at Hospital/MCS level to ensure readiness for the Go-Live.

3. Activity Planning 2022/23

3.1 Given the operational pressures it is vital that through operational readiness preparations all actions are taken to mitigate reduction in elective patient activity during Go-Live.

4. Communications and Engagement

4.1 Implementation of our robust and successful multichannel Communications and Engagement Plan continues. Activities include: staff awareness surveys, dedicated staff engagement sessions for various groups and disciplines, system demonstrations, staff digital confidence assessments, engagement initiatives to identify peer trainers, regular online newsletters, social media campaigns and so forth.

4.2 Communication with other trusts, Greater Manchester and national bodies is a key component given the significance of the changes.

5. Go-live readiness

5.1 Formal planning for the Go-Live event has commenced, with a Go-Live planning Committee in place. A detailed project plan including roles for deployment will be completed in March 2022.

5.2 Go-Live Readiness Assessments are planned for 120, 90, 60, and 30 days from Go-Live.

6. Transformation

6.1 100 discrete change projects have been identified linked to the Hive Programme, and work has commenced on these across the Trust.

6.2 Transformation Roadshows commenced in February, these bring elements of the system out to staff across our hospitals, MCS and LCO and provide an opportunity for staff to see the system and understand the change which will result in their day-to-day work, as well as giving the opportunity for questions and discussion.

7. Technical Deployment

7.1 A comprehensive programme of work to ensure the Wi-Fi infrastructure, end user devices and technical requirements are in place is well under way.

7.2 Testing of integrated workflows is also underway and a technical dress rehearsal for the system including end user devices will take place in this quarter.

8. Benefits Realisation

8.1 Given the significant impact of Covid on the operating environment and changes to the financial regime the Hive benefits case is being reviewed. This planning and development process will follow the same rigorous governance process undertaken in each hospital/MCS in respect of the normal year-on-year safety, efficiency and productivity programmes.

9. Next Steps

9.1 The Hive Programme is on track to ensure a successful Go-Live on 8Th September 2022.

9.2 This will be a key milestone underpinning the delivery of the MFT Digital Strategy.

9.3 September 8th represents the beginning of a process of continuous improvement in patient experience and of our digital capability.

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

10. Recommendation

10.1 The Board of Directors is asked to note the progress made by the Hive Programme.

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:	March 2022
Subject:	Board Assurance Report – January 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:	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

(January 2022)

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)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

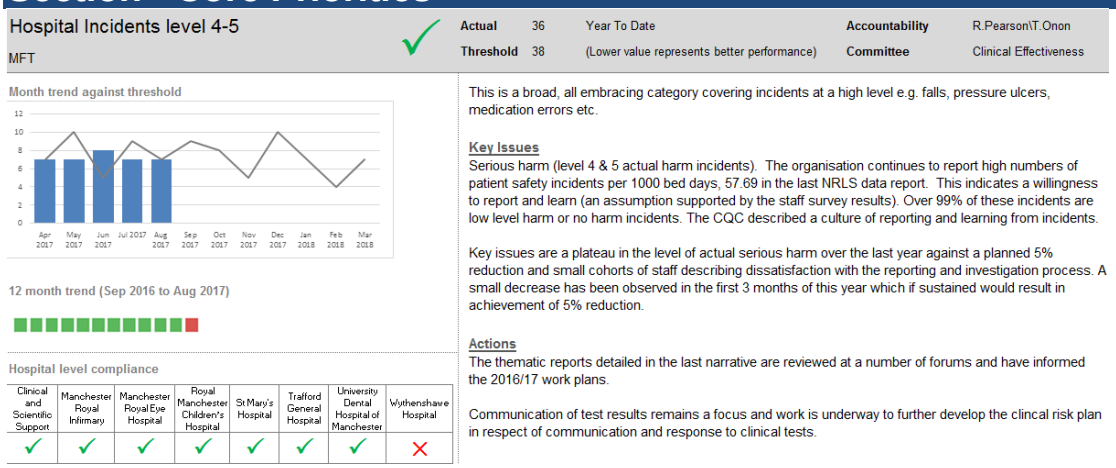
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

January 2022

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.

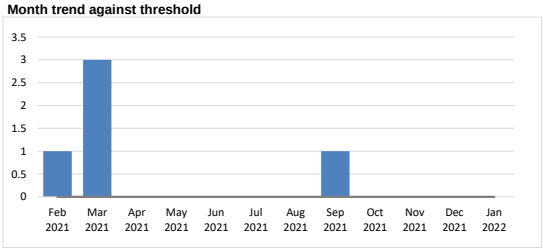
The Trust has reported 10 Never Events (YTD April 21 to February 2022). A Trust-Wide risk is being managed strategically which focuses on the optimisation of human/system interaction in the way understand, respond to and improve patient safety. The learning to support the mitigation for this risk was considered at a Trust-wide Patient Safety Summit in December 2021.The Trust continues with its programme of work to implement the National Patient Safety Strategy.

Safety - Core Priorities

Mortality Reviews - Grade 3+ (Review Date) ✕

Actual	1	YTD (Apr 21 to Jan 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

The programme of mortality reviews continues to be refined across the Trust, including the use of the mortality portal to support learning. In addition to quantitative analysis of avoidability, a qualitative review of learning from 154 deaths in the mortality portal from August 2020 to August 2021,has been undertaken. This has shown that even if a death is scored as a 6, 'definitely not avoidable', the learning from the narratives have been valuable with themes and trends reflecting data arising from other elements of the patient oversight system. These include the implementation of the ReSPECT process, especially with input from Learning Disability teams if required; responsive end of life care and discharge, and patient transfers. There is close collaboration with the Medical Examiners Officers, to ensure an optimised approach to deaths where a Structured Judgement Review will likely yield high impact learning. Mortality data (HSMR and SHMI) remains under continuous monitoring.

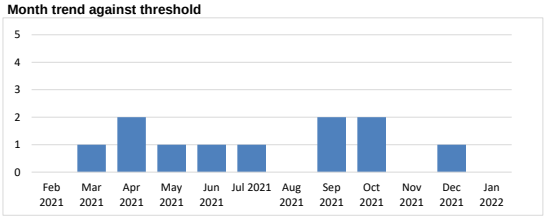
Actions

Optimising transferable high impact learning across MFT is a key priority for 2022/23. the Safety Oversight System allows for continual triangulation of intelligence. Safety II, learning from when things have gone well, and translating that into the mortality review process is also a key focus.

Never Events ✕

Actual	10	YTD (Apr 21 to Jan 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✓	✕	✕	✓	✓	✕	✓	✓
5	0	1	2	0	0	2	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- Jan 2022) there have been 10 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 availability of guidance and the ergonomics of clinical environment design.

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

Actions

The Trust-Wide risk, which is being managed strategically, focuses on the optimisation of human/system interaction in the way understand, respond to and improve patient safety aligned to the Trust's approach to integrating safety I and safety II data to enhance our learning and improvement

Significant rapid learning and improvement is underway in relation to safe and effective placement and management of Naso Gastric (NG) tubes (including simulation of a new trust wide policy), the use of local safety protocols for invasive procedures (developing a consensus of the principles based on national and trust learning and including integration into HIVE), the implementation of a Trust-wide safety culture assessment tool and a clear focus on enabling safety through psychological safety and ergonomic design of clinical areas. All incidents relating to prevented never events are subject to a high impact learning review to increase opportunities for learning.

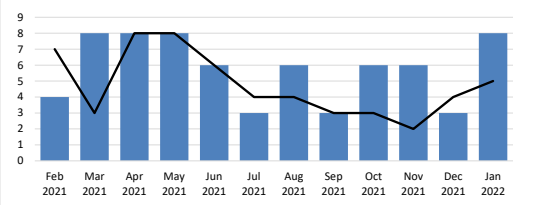
> Board Assurance

January 2022

Hospital Incidents level 4-5

Actual	57	YTD (Apr 21 to Jan 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	56	(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
✓	✗	✓	✓	✓	✓	✓	✗	✓
2	28	3	5	1	0	13	5	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

Patient safety incidents are analysed using Statistical process control, rather than counts, in line with the implementation of the Patient Safety Incident Response Framework, all notifiable (under Duty of Candour) incidents are analysed in this way.

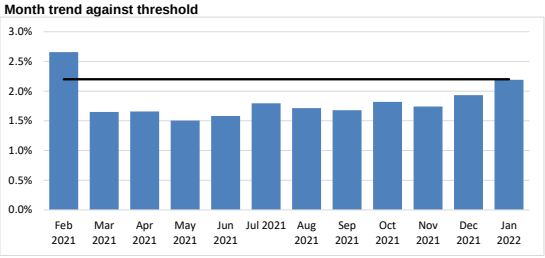
Actions

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
- Procedural based safety standards
- Discharge
- Safety culture
-central venous access
- use of ReSPeCT process

Crude Mortality

Actual	1.76%	YTD (Apr 21 to Jan 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✓	✓	✓	◇	✗	✗	NA
15.6%	2.0%	0.2%	0.2%	0.0%	2.1%	2.7%	3.3%	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 effective benchmarking of this data is currently under review, and sites where the threshold is exceeded actively interrogate the data to explore meaningful trends. There is a Trust-wide focus on understanding mortality data in a more sophisticated way through the use of the HED system, enabling scrutiny of a wider rang of mortality indicators.

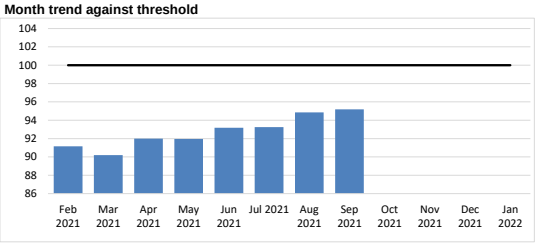
> Board Assurance

January 2022

SHMI (Rolling 12m)

Actual	94.1	R12m (Oct 20 to Sep 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



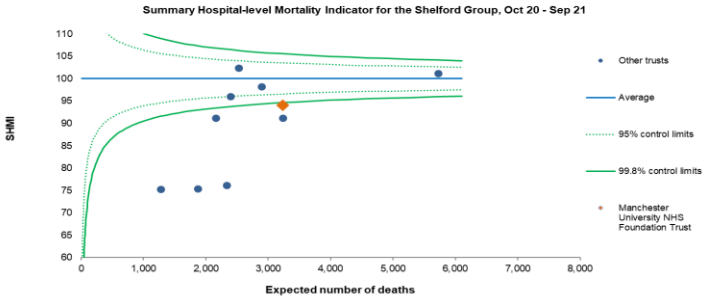
Hospital level compliance

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	92.7	NA	NA	NA	NA	88.5	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

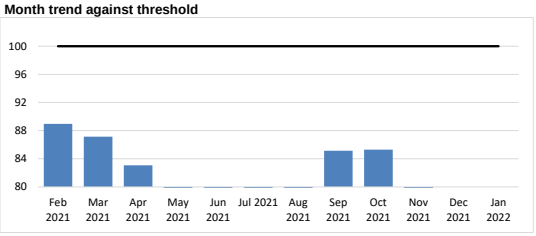
Performance across the Trust is well within the expected range.
The SHMI at NMGH is currently under review along with the crude mortality rate.



HSMR (Rolling 12m)

Actual	85.3	R12m (Nov 20 to Oct 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	76.6	NA	NA	NA	NA	89.8	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.

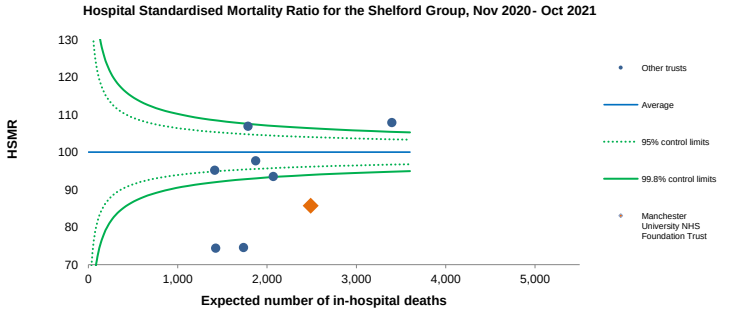
HSMR is a metric designed for adult services.

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	2	1	3

Headline Narrative

The number of new complaints received across the Trust in January 2022 was 121, which is an increase of 14 when compared with the 107 complaints received in December 2021. In January 2022 the percentage of formal complaints that were resolved in the agreed timeframe was 87.5% this is a notable decrease of 5.4% from the previous month. 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) was 93.4% in January 2022 which is an increase compared to 92.4% in December 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. A recent review of all attributable HCAI was performed and presented to the Group Infection Control Committee in January: key themes were recorded and actions for reduction were determined. End of year HCAI reviews are currently being undertaken by all sites/CSU and overseen by IPC.

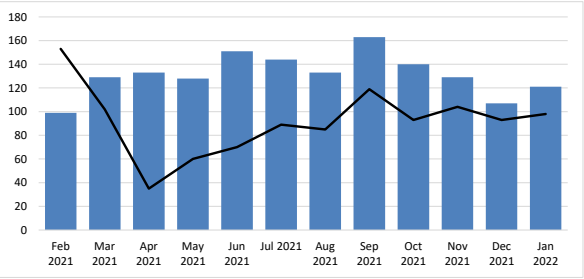
Trust performance is above trajectory for both MRSA and CDI:

There have been 154 trust-attributable CDI reported so far this year, against a threshold of 130. There is a zero tolerance approach to MRSA bacteraemias, and a 15% reduction objective applied to E.coli bacteraemias. There have been 8 trust-attributable MRSA bacteraemia and 113 E. coli bacteraemia so far this financial year.

Complaint Volumes ✕

Actual	1349	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	1333	(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
✓	✓	✓	✕	✕	✕	✓	✕	✕
72	299	138	200	51	33	321	152	49

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 January 2022 was 121, when compared with the 107 complaints received in December 2021 and 129 in November 2021.

WTWA received 27 complaints in January 2022 which is the highest number of complaints in the Trust (22.3% of the Trust total), when compared with the 31 received in December 2021 and 27 in November 2021.

Of the 27 WTWA complaints received the top specific two themes were 'Communication' and 'Treatment and Procedure. There were no specific areas identified in the complaints relating to 'Communication' and 'Treatment and Procedure'.

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).

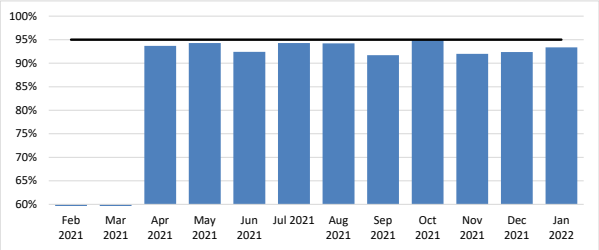
Progress

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.

FFT: All Areas: % Very Good or Good

Actual	93.5%	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	◇	✓	✓	✓	✓	✗	◇
96.59%	96.53%	91.45%	95.59%	98.27%	98.62%	97.14%	87.19%	91.38%

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 experience 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 satisfaction rate for FFT (including data from the NMGH site following acquisition) for January 2022 was 93.4% compared to 92.4% in December 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.

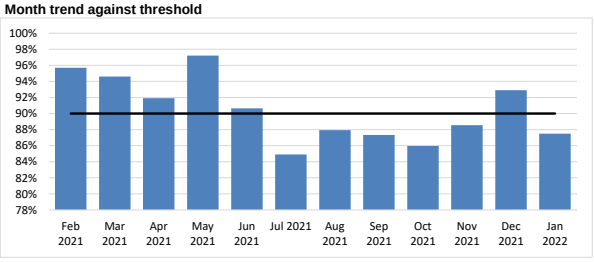
Actions

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.

Percentage of complaints resolved within the agreed timeframe

Actual	89.1%	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	◇	✓	✓	✓	✓	✗
96.2%	97.6%	100.0%	71.6%	100.0%	97.1%	96.1%	92.1%	53.3%

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 January 2022 data identifies that 87.5% of complaints were resolved within the agreed timescales compared to 92.9% in December 2021 and 88.6% in November 2021: this is a notable decrease of 5.4%.

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

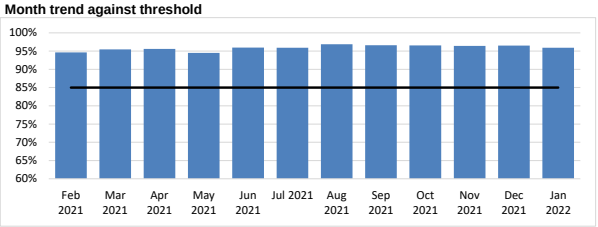
Actions

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

Food and Nutrition ✓

Actual	96.1%	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	NA	✓	✓	NA
94.2%	96.4%	92.5%	95.3%	99.6%	NA	97.5%	96.2%	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. The Trust's Nutrition & Hydration Oversight Committee launched October 2021 will be establishing a Task & Finish Group to review the MFT Nutrition & Hydration (food & drink) Strategy 2019-2022.

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.

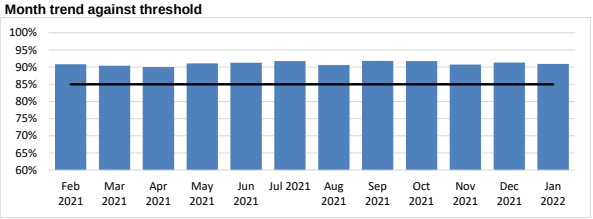
Utilising the Improving Quality programme (IQP) methodology, the MDT workstream engaged with patients and staff on Ward 12, at TGH to identify key areas to focus on improvement. Work commenced on the introduction of a hot breakfast and a 'snack round' from February 2020 with initial feedback reporting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

Pain Management ✓

Actual	91.1%	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	NA
94.2%	86.9%	89.9%	91.2%	98.2%	98.8%	93.0%	92.2%	NA

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

Progress

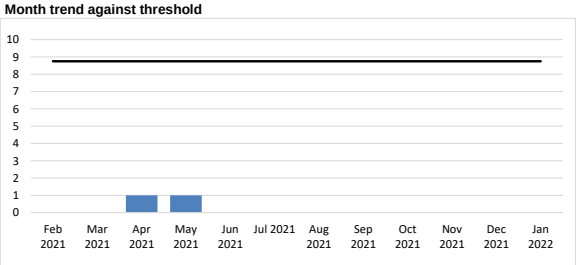
Work continues across the Trust to drive improvements in pain assessment and management.

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. No further update

Clostridium Difficile – Lapse of Care ✓

Actual	2	YTD (Apr 21 to Jan 22)	**Accountability**	C.Lenney
Threshold	88	(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 154 trust-attributable CDI reported so far this year, against a current threshold of 130. Of these cases, 2 have been confirmed as demonstrating a lapse in care with a number of cases currently under review. There were 17 trust-attributable CDI cases reported for Jan 2022, all of which are pending review.

> Board Assurance

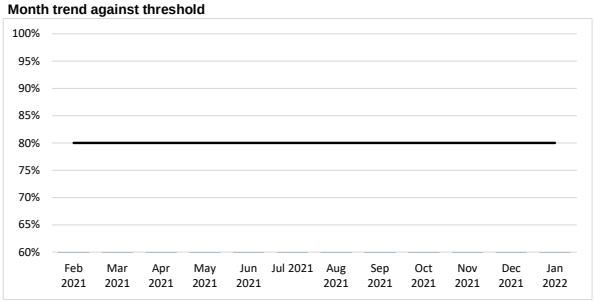
January 2022

Nursing Workforce – Plan v Actual Compliance for RN

●

Actual | **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 Hospitals/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. 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 Safer Nursing Care Tool (SNCT) data collection census was undertaken during November which has provided a baseline for inpatient ward establishments. Two further census periods will be undertaken before completing establishment reviews in Q2.

PALS – Concerns

-

Actual 6288 YTD (Apr 21 to Jan 22) | **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
-	-	-	-	-	-	-	-	-
456	1483	559	883	285	174	1588	623	89

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

Key Issues
A total of 654 PALS concerns were received by MFT during January 2022 compared to 547 PALS concerns in December 2021 and 690 in November 2021.

WTWA received the highest number of PALS concerns in January 2022; receiving 177 (27.0% of the total). This is an increase for WTWA when compared to the 137 in December 2021. The specific themes for WTWA related to 'Communication', 'Appointment/Delay/Cancellation (OP)' and 'Treatment and Procedure'.

Of the 177 WTWA PALS concerns received there was no specific area identified in the complaints relating to 'Communication', 'Appointment/Delay/Cancellation (OP)' and 'Treatment and Procedure'.

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

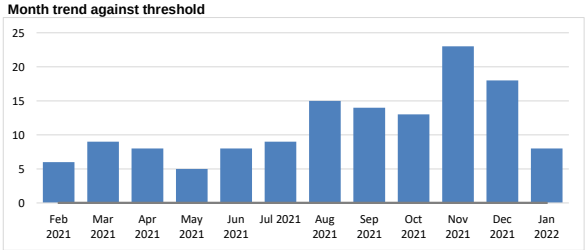
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 5 days.

All Attributable Bacteraemia

-

Actual 121 YTD (Apr 21 to Jan 22) | **Accountability** C.Lenney
Threshold None (Lower value represents better performance) | **Committee** Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	NA
10	46	14	8	0	0	25	18	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 113 trust-attributable E. coli bacteraemia reported so far in 2021/2022, of which 8 were reported during Jan 2022.

There were 15 trust-attributable MRSA bacteraemia cases reported to PHE during 2020/2021, and 9 community-attributable cases reported. There have been 8 trust-attributable MRSA bacteraemia reported for the current financial year, with the last case reported in Dec 2021.

Operational Excellence

D.Furnival

Core Priorities	✓	◇	✕	No Threshold
	0	0	11	0

Headline Narrative

MFT's elective recovery plan continues utilising available opportunities as Covid numbers continue to decrease. Infection Prevention Control (IPC) measures remain in place as at 21/02/22, this impacts significant bed numbers right across MFT. MFT and GM continue to experience peaks in emergency demand across both adult and paediatrics, which has required ad-hoc reduction in elective bed capacity to manage the non-elective demand.

Not with standing these operational challenges, MFT continues to progress actions aimed at improving performance against national operational standards. MFT has completed 2022/23 planning requirements in line with the national planning guidance developing associated trajectories and refreshed action plans in conjunction with CCGs.

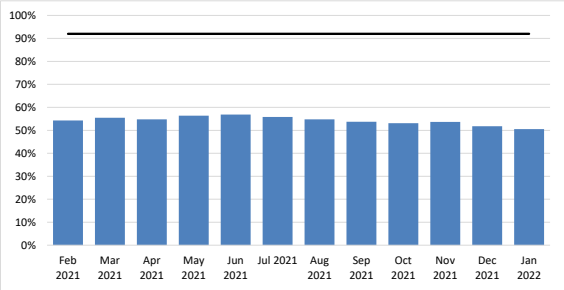
January summary:
• Whilst the elective waiting list has increased, at the end of January there has been an improvement of ~24.5% in the number of patients waiting over 52 weeks.
• The number of patients waiting longer than 104 weeks in January was 1.13 (%) of the overall waiting list, the position has 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. Whilst performance in recent months has improved month on month since September, February has seen a slight decline and generally reflects MFT Emergency Departments ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of operational pressures and capacity constraints, there has been 343 breaches of the 12 hour DTA quality standard from January to date (21/02/22), Whilst no patient harm has occurred. Corporate Governance retain oversight.
• Cancer performance has improved in 1 of the 6 cancer standards from Q2 to Q3, which is the screening performance. 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	50.5%	(January 2022)	**Accountability**	D.Furnival
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
✕	✕	✕	✕	✕	✕	✕	✕	✕
59.4%	46.3%	58.1%	45.8%	60.2%	54.6%	52.1%	42.0%	57.8%

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 Q4 of 2021/22 using a clinically prioritised basis through regular Group Manchester Elective Surgical Hub (MESH) meetings.
• The periodic redeployment of staff to support critical care requirements associated with Covid, and subsequent need for cautious release given ongoing underlying Covid incidence was of significant challenge at times.

Actions
• Group Manchester Elective Surgical Hub continues 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
• Private sector capacity, GM and regional pathways are under constant review in order to maximise utilisation of the opportunity to ensure we optimise 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.
• 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 January wait list stands at 156,475 an increase of 1034 (0.7%) on December. 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 January was 13,580 (8.7%) of the overall waiting list. This is a 16.6% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in January was 2165 (1.4%) 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 following agreed policy.
• The number of virtual outpatient appointments undertaken in January was 32% of all appointments inline with national requirements.

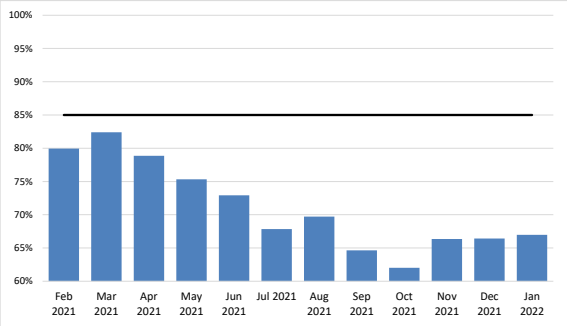
> Board Assurance

January 2022

A&E - 4 Hours Arrival to Departure

Actual	64.8%	Q4 21/22 (Jan 22)	**Accountability**	D.Furnival
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	61.1%	82.6%	93.1%	100.0%	NA	64.0%	61.2%	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.
- Reductions to delayed handovers of patients alongside the numbers of ambulance holds continues.
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
- Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions

- Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
- These plans are underpinned by 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 and stronger promotion 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 ED safety standards are a key focus for sites. Each site is undertaking a safety and point prevalence review.
MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.

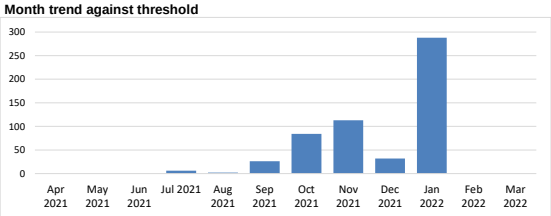
Progress

- January saw a modest increase (317) (0.86%) additional attendances compared to April 2021. Less than expected omicron variant attendances and stays in hospital have supported this reduction from previous months. IPC measures and short term staff sickness both medical and nursing continue to impact performance.
- In line with the national and regional picture, MFT performance of 75.70% in Q1 reduced to 67.4% for Q2 2021/22.Quarter 3 reduced further to 64.78%, with Quarter 4 indicating a slight increase in performance of 65.20% as at 24/02/2022
- The number of patients with 7+ and 21+ days Length of Stay in MFT beds at 23rd February was 285 and 126 respectively. Hospital teams remain focussed on long length of stay reviews.

A&E - 12 Hour Trolley Waits

Actual	551	YTD (Apr 21 to Jan 22)	**Accountability**	D.Furnival
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	5	2	0	0	NA	7	537	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 has remained stubbornly high (NMGH)

Actions

- Flexible use of space between paeds and adult ED to address demands.
- Refreshed and relaunched site escalation flow charts, 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.

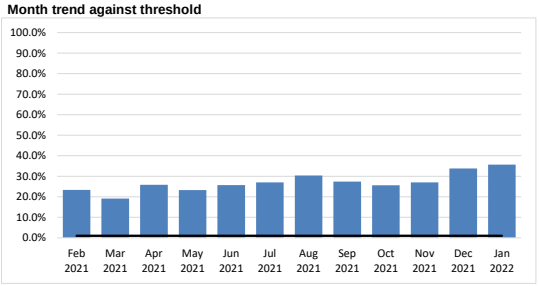
Progress

Continued operational pressures at North Manchester site during February reported 57 breaches of the 12 hour DTA quality standard an improvement on previous month. The majority of breaches 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	35.7%	(January 2022)	**Accountability**	D.Furnival
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
19.9%	31.3%	83.9%	72.2%	NA	NA	48.0%	56.1%	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.
- Increased volumes of unplanned tests linked to increased Non Elective attendance / admissions
- Increased short notice staff sickness

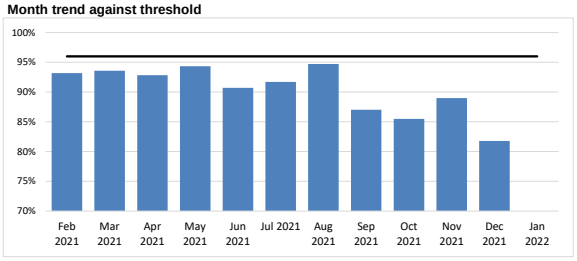
Actions
Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.
- Diagnostic clinical prioritisation undertaken.
- Additional CT scanning lists secured on a weekend
- Focus on reducing long waits given the tail of the waiting list is increasing, 13.8% of the list size currently over 13 weeks (4,010).

Progress
- Group Performance, remains challenged at 35.67% in January 2022.

Cancer 31 Days First Treatment

Actual	85.5%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	79.3%	100.0%	78.3%	NA	NA	76.3%	98.8%	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.

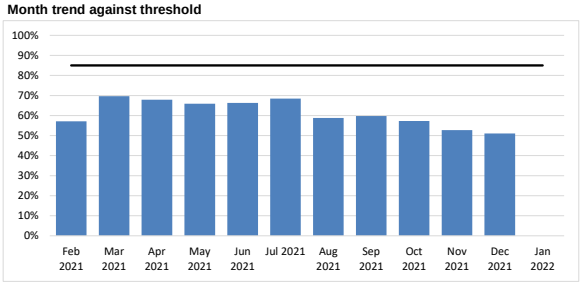
Actions
- Cancer treatments are being prioritised during the Covid pandemic, in line with national guidance on priority patients.
- Undated patients over 14 days are discussed at the group level Manchester Elective Surgical Hub (MESH) meetings with hospital / MCS leads.
- Capacity is assessed weekly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

Progress
- The most challenged tumour sites are Skin, Gynaecology and 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	53.4%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	47.1%	NA	12.5%	NA	NA	57.3%	51.2%	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% of pre-pandemic levels 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

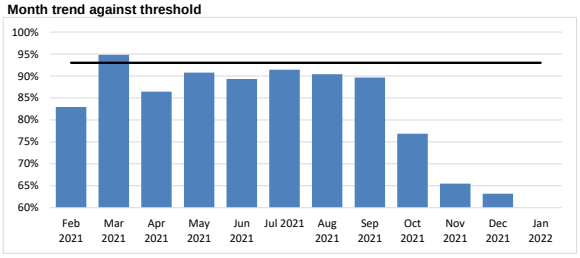
Progress

- 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 have been 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	68.7%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	95.4%	100.0%	94.2%	NA	NA	56.5%	44.5%	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.

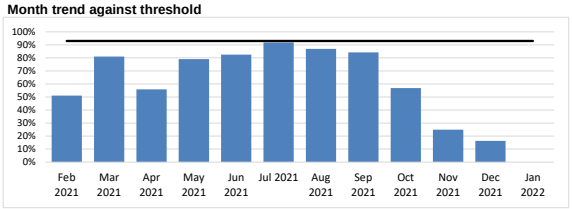
Progress

- 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	32.6%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	16.3%	16.4%	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.

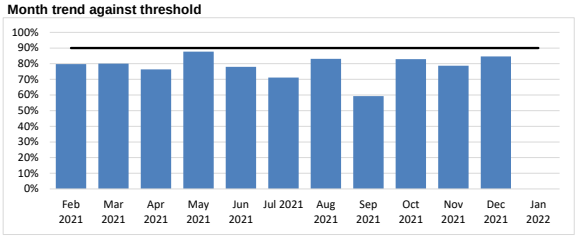
Progress

Performance is improved from Q1

Cancer 62 Days Screening

Actual	82.0%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	-	NA	100.0%	NA	NA	81.8%	-	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.

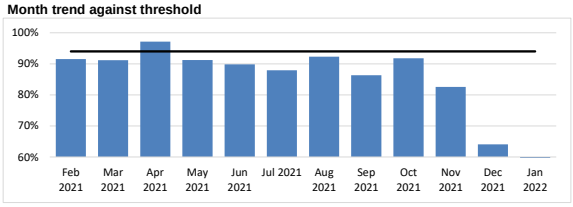
Actions
- The Actions listed under Cancer 62 Days are applicable to this standard.

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	79.3%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	54.3%	80.0%	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

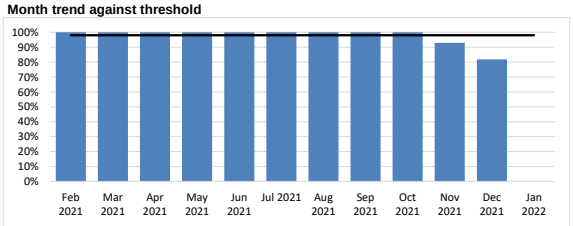
Actions
Actions noted under the above cancer standards.

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	93.0%	Q3 21/22 (Oct 21 - Dec 21)	**Accountability**	D.Furnival
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	81.8%	-	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

J.Ehrhardt

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.

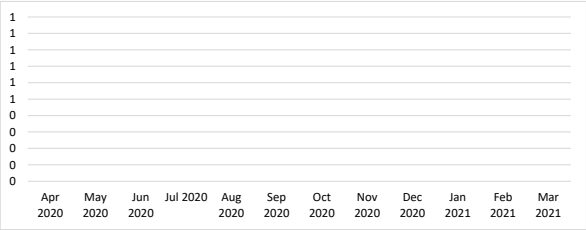
Finance - Core Priorities

Operational Financial Performance

Actual | **Accountability** J.Ehrhardt

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 & Altrincham	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

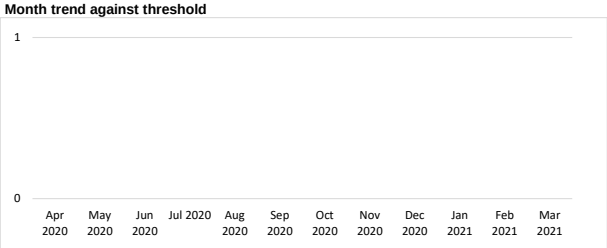
Actual

Threshold (Lower value represents better performance)

Accountability J.Ehrhardt

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

MFT continues to prepare for Hive Go-Live, with work ongoing to maximise staff availability and workforce supply in the pre and post Hive Go-Live period. Hospital/ MCSs/ LCO continue to refine their staffing and workforce plans to drive a nuanced local response to identified workforce issues, whilst Group have are supporting with cross cutting policy initiatives and specialist support. The 'Developing Our Digital Workforce' programme is building digital confidence across the organisation in readiness for the launch of HIVE end user training.

The COVID-19 workforce recovery agenda continues to gather pace. The Employee Health & Wellbeing Team launched the enhanced Physiotherapy Advice and Treatment Service on the 13th of December 2021. Uptake, engagement and feedback has been overwhelmingly positive and the Trust has already seen a fall in musculoskeletal absence.

Progress continues to be made to progress the MFT People Plan deliverables.

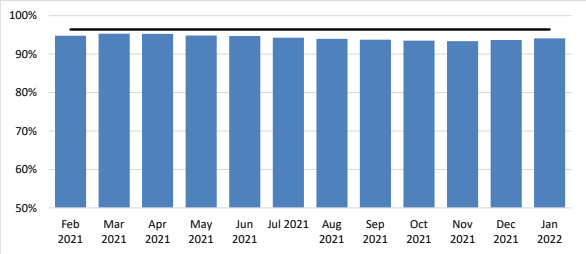
Workforce and Leadership - Core Priorities

Attendance ✕

Actual 94.1% (January 2022) **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
✕	✕	✕	✕	✕	✕	✕	✕	✕
94.9%	93.2%	94.5%	94.7%	92.9%	93.1%	93.9%	91.7%	93.9%

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 January was 94.1% which is higher than the previous month's figure (93.7%). This is lower than the attendance rate at the same point last year (January 2021) of 94.5%. The latest figures released by NHS Digital show that for September 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.4% or 93.6% 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 September 2021 at 4.7% or 95.3% 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.

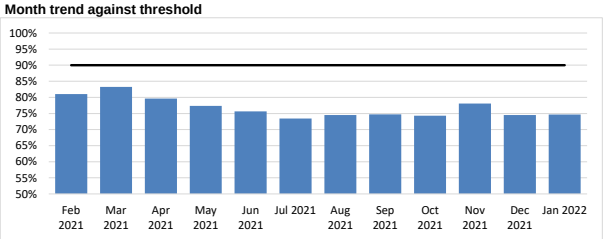
The Absence Manager system is in place across all MFT sites. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers make best use of the Absence Manager system in the effective management of absence and to support the health and wellbeing of our staff.

Appraisal- non-medical ✕

Actual 74.7% (January 2022) **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
✕	✕	✕	✕	✕	✕	✕	✕	✕
70.6%	83.2%	71.1%	82.4%	80.9%	80.3%	82.0%	66.6%	71.2%

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 January 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI. This was last achieved by the Dental Hospital in September 2021 at 92.2%. The only other Hospital to reach this target in the last year is the Eye Hospital.

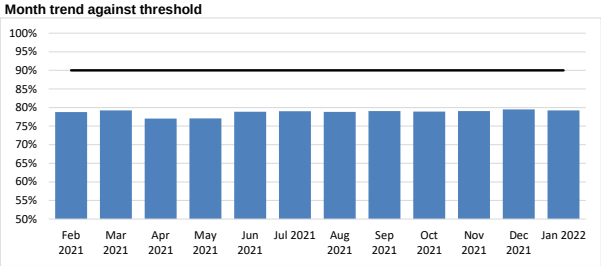
Actions

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

Level 2 & 3 CSTF Mandatory Training

Actual	79.2%	(January 2022)	**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
✗	✗	✗	✗	✗	✗	✗	✗	✗
77.9%	78.4%	79.5%	81.5%	80.2%	78.7%	81.7%	69.9%	81.2%

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 for Level 2 & 3 CSTF Mandatory Training has decreased by 0.3% across the Group in January 2022. Clinical Scientific Services had the largest increase in compliance at 0.6% with a score of 77.9% compared to 77.3% in December. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI or has met this target in the last year.

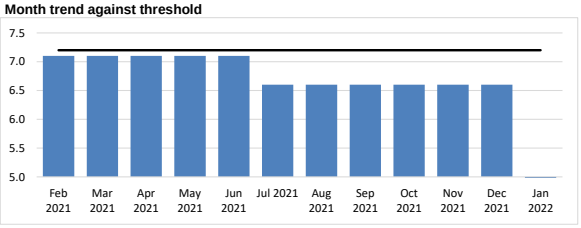
Actions

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. Hospitals/MCS/LCO are planning mandatory training for staff aligned to the HIVE workforce plans to ensure completion. The system for mandatory training is available earlier than the anniversary due date to increase flexibility of completion.

Engagement Score (quarterly)

Actual	6.60	Q3 21/22 (Oct to Dec 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
✗	✗	✗	✗	✗	✗	✗	✗	✗
6.6	6.5	6.6	6.4	6.2	6.3	6.4	6.6	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.

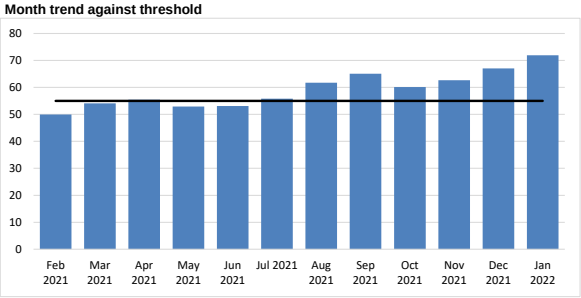
Actions

The 2021 Staff Survey launched 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. MFT currently awaits the outcome of the survey.

Time to Fill Vacancy

Actual	71.94	(January 2022)	**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	73.8	66.5	65.1	59.1	94.7	48.5	66.7	78.4

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, excluding Band 5 Nursing, has increased from 67.1 in December to 71.9 in January. Currently only WTWA is under the target in January.

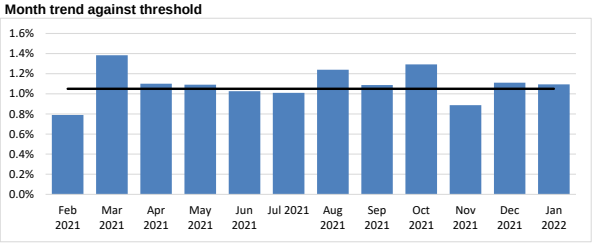
Actions

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.

B5 Nursing and Midwifery Turnover (in month)

Actual	1.1%	(January 2022)	**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	✓	✗	✗
1.16%	0.67%	1.20%	1.09%	0.55%	NA	0.56%	2.98%	1.58%

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 January 2022 is 1.1% against a monthly target of 1.05%. This is static figure from the previous month.

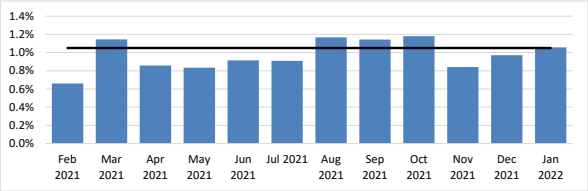
Actions

Retention of Nurses and Midwives remains a key focus for the Trust. The trust continues to offer CPD programmes, both internally and externally delivered. A new approach to preceptorship for both domestic and internationally educated nurses, Midwives and AHPs has been developed and will be launched in Q1, to support the retention of newly qualified practitioners. The programme acknowledges the challenges to both graduate UK nurses and those from overseas joining the trust during the pandemic to revisit the opportunities of coaching and mentorship during their early career.

Turnover (in month)

Actual	1.06%	(January 2022)	**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
✓	✓	✗	✗	✓	✗	✗	✗	✗
0.97%	0.87%	1.10%	1.05%	0.53%	1.77%	1.08%	1.46%	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 January 2022 single month turnover position for the Group is higher at 1.1% when compared to the previous month (December 2021, 1.0%).

The turnover rate was lower at the same point last year (January 2021) at 0.9%.

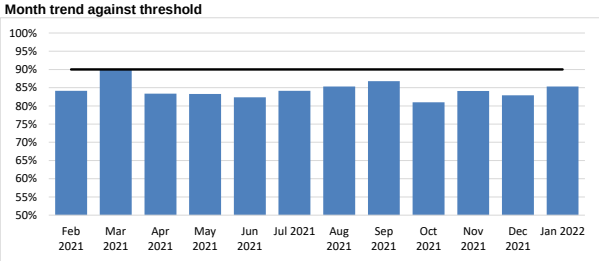
Actions

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.

Appraisal- medical

Actual	85.3%	(January 2022)	**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
◇	✗	◇	◇	◇	◇	◇	✗	✗
87.4%	81.8%	87.2%	88.1%	85.3%	89.2%	86.5%	73.2%	82.8%

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

Key Issues

Compliance increased by 2.4% across the Group in January 2022. North Manchester Hospital had the largest increase in compliance at 7.2% with a compliance score of 66.0% compared to 73.2% in January. The LCO had the largest decrease in month of 7.2% to 82.8%. Only Corporate Services is currently meeting the threshold target of 90% although a number of the Hospitals and Managed Clinical Services have met this target in the last year.

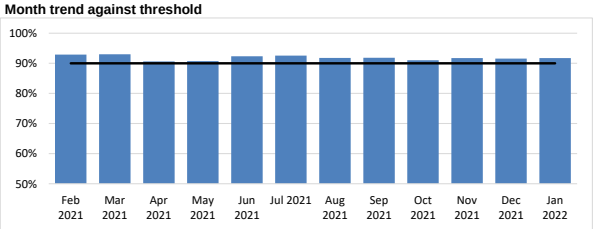
Actions

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. The Management Brilliance - OD Resource Portal provides line managers with 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	91.7%	(January 2022)	**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
✗	✓	✓	✓	✓	✓	✓	✗	✓
89.7%	92.6%	90.5%	92.4%	92.4%	92.2%	92.5%	89.2%	93.2%

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 January 2022 the aggregate compliance increased by 0.1% to 91.7%. Only NMGH and CSS has a compliance score below the 90% Trust target.

Actions

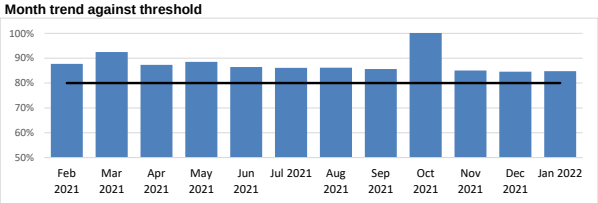
The 5 key Mandatory Training work streams, overseen at CEO / Director level, have progressed in line with the KPMG audit where we received significant reassurance. Work to integrate this programme into business as usual processes is now underway. NMGH have now been successfully integrated into the Learning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

Nurse Retention ✓

Actual 84.7% (January 2022) **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
✓	✓	✓	✓	✓	✓	✓	✗	✓
85.6%	84.0%	86.5%	85.1%	84.6%	86.9%	84.8%	45.5%	83.7%

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 January 2022, Nursing and Midwifery retention stands at 84.7% which continues to be above the threshold of 80%.

Actions

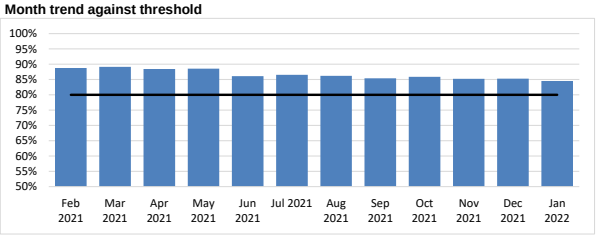
The retention threshold target for Nursing and Midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. Targeted programmes of work are being lead to developed both CPD programmes to improve NMAHP retention and programmes focusing on staff well being.

BME Staff Retention ✓

Actual 84.5% (January 2022) **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%	83.3%	86.3%	84.6%	88.0%	94.4%	89.2%	NA	87.8%

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 January was 84.5%.

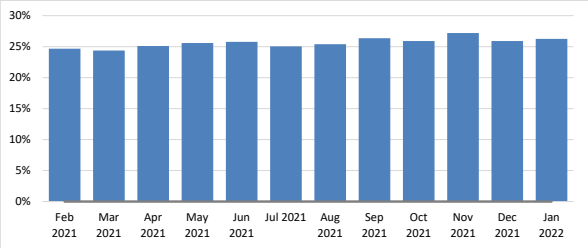
Action

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

% BME Appointments of Total Appointments

Actual	26.2%	(January 2022)	**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
-	-	-	-	-	-	-	-	-
30.9%	31.0%	25.0%	17.8%	42.3%	38.9%	30.3%	27.3%	17.7%

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 (26.2%); which is consistent month on month.

The Trust has increased its % BME appointments of Total Appointments by 1.0% when compared to the same point last year (January 2021, 25.2%).

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%.

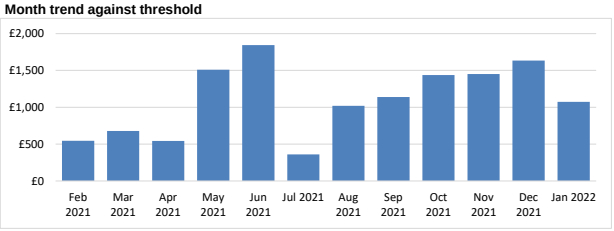
The Trust has launched the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

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

Medical Agency Spend

Actual	£1,073	(January 2022)	**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
-	-	-	-	-	-	-	-	-
£151.3	£59.5	£16.6	£18.1	£57.2	£0.0	£153.5	£536.7	NA

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 January total value of Medical and Dental agency staffing was £1,073k compared to £1,634 in December.

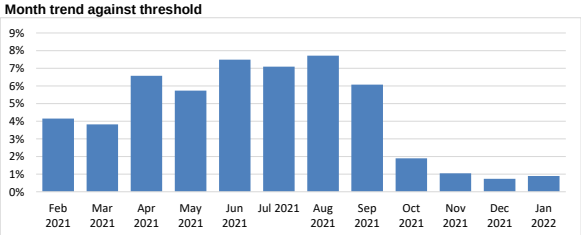
Actions

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.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	0.9%	(January 2022)	**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	-	-	NA
-16.2%	-1.1%	-6.0%	4.0%	-0.1%	NA	5.7%	5.7%	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.

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, business cases and the budget setting process.

Actions

The Trust has restarted face to face recruitment events, with 3 events held in October/November 2021. Attendances at these events has been positive and candidates directed to Live Trac applications. Over 400 attendees attended over the 3 events, many of whom were students graduating in September 2022. Further recruitment events are planned for 2022, alongside the Trusts Guaranteed Job Offer campaign. International recruitment continues and is impacting on the Band 5 vacancy rate.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	Group Director of Operations – Director Team
Date of paper:	March 2022
Subject:	Update on MFT Covid Response & Recovery
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 care safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors is asked to note the contents of the report, the updated national planning assumptions for FY22/23 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.
Contact:	Name: James Allison, Director of Performance and EPRR Tel: 0161 701 0521

Manchester University
NHS Foundation Trust

UPDATE ON COVID RESPONSE AND RECOVERY

1. PURPOSE

The purpose of this briefing is to provide an overview of the Manchester Foundation Trust (MFT) ongoing response to the Covid 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, which has significantly drained both staffing resource and the bed base for elective recovery. During December, the MFT Covid position had stabilised to c. 5% of Covid cases in critical care beds, and 15% in general and acute beds. However, the rapid emergence of the Omicron variant in January meant that again the North-West and Greater Manchester urgently needed to respond to a further Covid wave.

Throughout the Covid pandemic MFT has needed several periods of escalation and de-escalation measures to meet the demands of our services with unprecedented agility. This coupled with the need to recover elective services and maintain a safe environment for our patients in the face of high levels of staff absence has been an ongoing challenge.

MFT implemented plans in late December that continued throughout January to proportionally respond to the rise in Covid due to the Omicron variant, escalating plans as and when required, whilst balancing other Trust priorities including maintaining safe urgent care pathways and continuation of the elective programme through:

- Step up of the existing MFT Covid Response and Recovery governance structure to daily frequency overseen by the Group Director of Operations, with implementation of learning from previous waves;
- Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) refreshing and maintaining their capacity escalation plans;
- Plans were put in place, although ultimately not required, for 'super surge' capacity.
- The Trust worked collaboratively with partners to increase safe, timely discharge, and reduce the number of patients with 'no reason to reside' in hospital;
- Escalation processes established to oversee nursing and medical staffing levels.
- Oversight and impact of Covid and management of mutual aid, which continued across Greater Manchester, and MFT is a key contributor to these arrangements; and

- Step up of Tactical arrangements run by the Group to provide additional support to hospital/MCS/LCO, and to provide a point of escalation, which ran from 20th December to the end of January 2022.

3. PLANNING UPDATE AND ASSUMPTIONS

2022/23 annual planning guidance was released at the end of 2021. This guidance outlines ten priority areas for systems and sets out ambitious targets for activity recovery and levels of performance for providers, this includes:

- Elective activity levels (clock stops) exceed 110% of the 2019-20 baseline levels
- Diagnostic activity levels exceed 120% of 2019-20 baseline levels
- 104 week waiters are eliminated by July 2022, and 78 / 52 week waits to be reduced
- Cancer backlogs return to pre-pandemic levels
- Provision of specialist advice to support patient management in primary care (16 for every 100 Outpatient first appointments)
- Patient initiated follow up (5 for every 100 Outpatient attendances)
- >25% reduction in outpatient follow ups by March 2023.

In line with national requirements the Trust remains focused on its key priorities of ensuring the most clinically urgent patients are treated first and foremost, followed by the longest waiting patients. The most pressing priority area is the elimination of 104 week waits by July, which for MFT is unlikely to be achieved in full given: current non-elective demands on the bed base, remaining IPC restrictions, the volume of specialist / cancer work undertaken. Although services are looking at all options to continue to reduce these to minimal levels.

Additional funding has been made available for elective recovery, with both capital and revenue funding available to systems. MFT are due to submit a draft plan to NHSE via GM on 4th March and a final plan on 14th April 2022. Planning is being led corporately with input from hospitals/MCS.

4. URGENT CARE AND FLOW

Urgent care and other performance measures

MFT maintained a stable A&E 4-hour performance in January despite the impact of the Omicron wave and very limited reduction in emergency attendances. However, the impact on flow and IPC restrictions hit MFT hard particularly in the peak two weeks of January and during this time the longest waits in A&E increased, alongside increased delays in ambulance handover.

Ambulance wait times at MFT continued to be challenged in January. As a proportion MFT had 6.0% of ambulances wait more than 60 minutes at the front door in both December and January, with peaks correlating to the rise in the Omicron demand.

Significant focus on reducing patient numbers with no reason to reside took place in December in line modelling for the Omicron wave, and to provide additional capacity over the Christmas and into January. No reason to reside continues to be a pressure across MFT and the wider GM system, and further activities are being undertaken throughout February to reduce these further.

Ongoing Actions:

There are a number of actions being progressed across MFT Type 1 Emergency Departments with the aim of standardising processes across all three.

- All sites are implementing a standard approach to navigation and streaming of patients at the point of entry, and a booked appointment service for Urgent Treatment Centres. The Standard Operating Policy (SOP) has been ratified at the Urgent Care Workflow Committee after extensive consultation with site representatives. Full implementation will be completed by the end of March 2022.

- All sites have now implemented the NWAS Escalation Process and Fit to Sit. Both processes have required joint working with NWAS colleagues to embed successfully. Aims are to improve ambulance turnaround times and releasing crews as early as possible. Further work is ongoing to develop processes that will remove the need to enact the NWAS Escalation process. Work will commence initially at NMGH in March and any new practice shared across the other sites.
- A project has commenced on medical wards at Wythenshawe Hospital with Group Transformation Team supporting the improvement of discharge processes. The aim is to achieve a smoother release of beds both across and earlier in the day to match the demand from Emergency Departments, as well as supporting optimum length of stay. Process improvements will be clinically led. Learnings will be shared across all hospital sites.
- Work has continued on improving the daily management of discharges and patients with no reason to reside (R2R). An interim process has been agreed until end of March and following consultation with all sites a draft SOP and report will be presented to the MFT Recovery and Resilience meeting and the Manchester and Trafford Cell w/c 7th March to approve the new process.
- The Group Transformation Team are supporting Emergency Departments to realise some immediate improvements to flow and performance by identifying and removing process waste with the aim of increasing productivity. The non-admitted pathway provides an opportunity to gain immediate improvement in performance against the 4-hour care standard. This pathway has been fully mapped and there is a clear understanding of where changes will improve performance.

Expected Impact

Individual workstreams are aimed at improving patient safety, patient experience and performance against Urgent Care key performance indicators. All projects are explicitly linked to HIVE through joint working so that any process changes now support benefits realisation in September. The work described above is intended to impact on the following:

- Ensuring only the patients that need Emergency Department services are streamed there;
- Decongesting Emergency Departments of patients with a decision to admit earlier in the day by providing available beds in receiving areas reducing the numbers of patients exceeding a 12-hour length of stay in Emergency Departments;
- Reducing crowding, long waiting and queuing at point of entry though booked appointments for low acuity patients;
- Releasing ambulance crews quickly, improving handover turnaround times; and
- Improving non-admitted performance in Emergency Departments.

5. ELECTIVE ACCESS

Clinically urgent and long waiting patients

The continued prevalence of Covid, UEC 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.

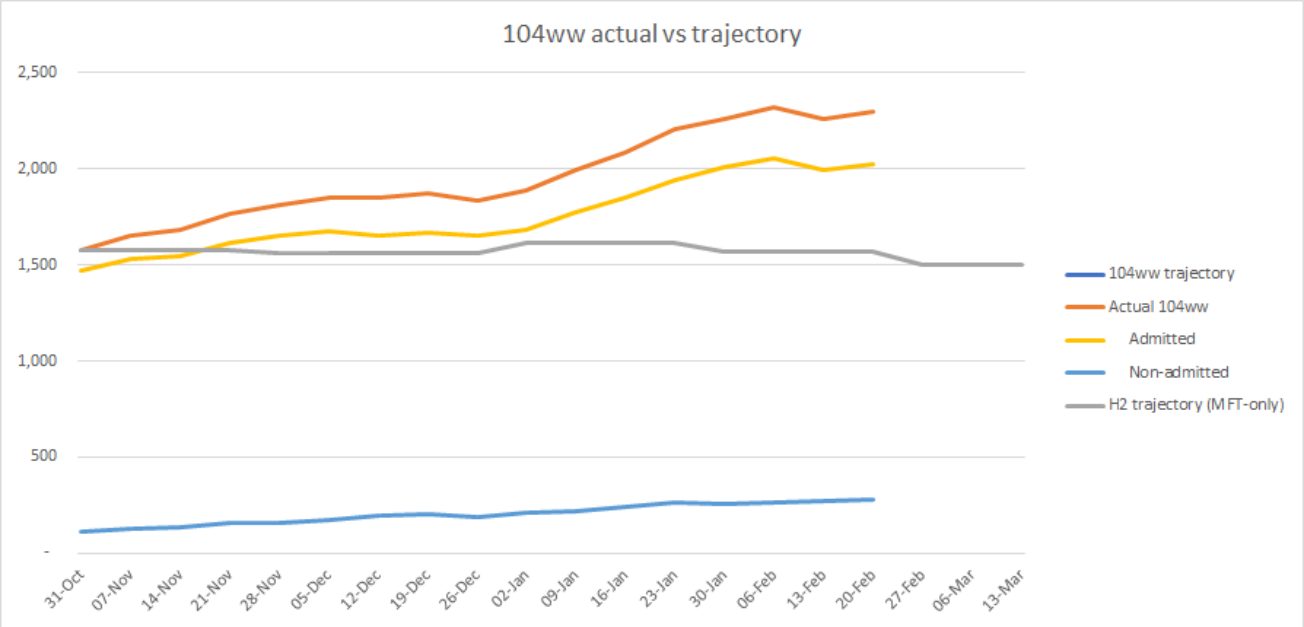
In agreement, across Greater Manchester, non-urgent elective activity was stood down for three weeks in January to support the response to Omicron, and as a result this meant that MFT specialties could not deliver the planned reduction in the number of long-waiting patients as shown in the table above.

The most challenged specialties for long waits remain 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 Trauma & Orthopaedic 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.

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 total waiting list at 1.5%. review of long waiting patients has continued by clinical teams and potential harm assessments are also undertaken for the longest waiting patients to ensure patient safety.

The chart below is a graphical representation of the impact of the Omicron wave on the ability of MFT to treat the number of patients planned to be seen during January 2022.



Ongoing Actions:

Theatre Efficiency, Data Quality, & Theatre Efficiency Rapid Improvement (TERI)

The Theatre Efficiency Rapid Improvement (TERI) project continues to focus on the Trafford Site, with an aim of scaling up all project outcomes across MFT. The primary objective of TERI is to maximise available theatre lists and to schedule to each list to a minimum of 85%. The four key work streams that support this are:

- Theatre Scheduling – improved 6-4-2 and scheduling process, utilisation of lists to initially >85%;
- Pre-operative assessment – improving the pre op pathway to ensure that patients are clinically optimised for surgery and that there is a pool of patients who have been pre-operatively assessed ensuring there are always patients ready to be scheduled;
- Pre-operative assessment - A pilot project will focus on Trauma & Orthopaedics at WTWA looking at the concepts of virtual pre op and how patients can 'wait well' between pre-op and the day of surgery. A second pilot will focus on anaemia;
- Improving the trauma pathway - to reduce the impact of trauma on elective scheduling at Trafford; and
- Start and Finish times - Ensuring lists start on time and clear escalation process of lists where this does not occur.

Key improvement plans are focused on:

- Supporting improved theatre scheduling through data driven reviews of theatre efficiency.
- Development of an insourcing model at Trafford to support Group-wide reduction of 104 week wait backlogs.
- Development of a 23 hour stay model for General Surgery at Trafford. This will increase throughput and allow for further reduction of 104 week waits. The model is essentially nurse led and focuses on nurse led discharge. Test of change will happen across a small number of general surgery lists during March 2022.

Use of the Independent Sector

To reduce the numbers of patients waiting 104 weeks and above, the Trust continues to work with independent sector providers (IS). Through the MESH process and supported by Group Transformation Team a number of actions continue with the aim of maximising all available capacity to treat patients based on clinical priority and waiting time:

P2 patients (highest clinical priority)

The P2 patient backlog at MFT remains a priority for MESH and continues to be closely monitored for all sites and specialties across MFT. Management of the P2 backlog is superseded by all of the actions in this paper:

- Cardiac surgery – which is particularly challenged in respect of specialist anaesthetic capacity, additional capacity has been sourced in the IS for 10 cases per month, additional theatre capacity for 2 days per week commenced in February 2022.
- Urology – across all sites urology is now being considered on a MFT wide footprint in order to maximise the urology resource and capacity. This includes consultants cross site working and moving patients across the system to ensure they receive their care in a timely manner. To support this a SOP has been developed with a detailed checklist in place to ensure activity can be moved around the system safely. A significant piece of work is underway to validate the urology waiting list at North Manchester General Hospital.

Expected Impact

The scope of on-going work to recover the elective programme at MFT is extensive. The most important programme of work aims to reduce the number of patients waiting for surgery where this has been disrupted due to Covid. The issue of long waits has been exacerbated in December and January as a result of the Omicron variant.

A second important programme of work is the development of robust governance for the recovery programme. This has a focus on improving data quality and it's uses, maximising capacity through improved scheduling and addressing the causes of lost/wasted capacity. The programme also plans improvement in the way MFT works with the IS so that the Elective Recovery programme can address the backlog of work and introduce new ways of working together for long term sustainability.

Outpatients Programme

The Outpatient programme continues to focus on key areas of national planning requirements and internal development areas:

- **Patient Initiated Follow Up (PIFU):** implementing national target to get to 2% by end of March 2022 and 5% by March 2023. MFT is currently at c.1% performance, meaning c1,500 patients are being discharged to PIFU monthly.
- **Virtual Triage**: rollout of virtual triage to suitable services is 85% complete. Hive will expand this to non-GP referrals in these services. c1,500 referrals are being re-directed or provided with specialist advice through this route each month.
- **Waiting List Validation**: re-confirming patients waiting for appointments and validating. A national outpatient validation and clinical prioritisation programme is due to commence in March 2022.
- **Care Gateway initiatives**: improving the Manchester referral Gateway, including strengthening links between Care Gateway triagers and secondary care triagers.
- **Primary Care Communications**: sharing outpatient developments within primary care e.g., Patient Groups, GP meetings

Evaluation of virtual triage is underway with CCG and primary care colleagues, with a view to designing a programme of work around GP education, building on the Care Gateway initiatives.

Cancer

Total referrals for suspected cancer have returned to at least to pre-Covid levels at aggregate across MFT sites, although there is variability both month on month and between tumour groups and sites.

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 changed and cancer referral activity is now at peak levels with circa 110% of pre-pandemic levels, with some tumour groups more than 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 has been managed and MFT cancer performance against the 2 week wait standard remained strong throughout 2020-2021 and above the national position. However, a spike in breast referrals from the beginning of October 2021 resulted in a slight dip in performance. The additional c.3,500 cancer referrals seen in 2021 places a significant drain on diagnostic resources, which

is the key challenge for MFT to achieve timely pathways. The most pressured pathways remain Gynaecology, Lower/upper Gastrointestinal, Urology, Head and Neck, which is in line with the rest of GM.

Prioritisation reviews are undertaken through Trust MESH process and general PTL management to support the reduction of cancer waits above 104 and 62 days. At the end of January, MFT was above trajectory to reduce the backlog of 104 and 62+ days to pre-covid baseline. Actions are being planned with hospitals / MCS to address the above areas for development.

Ongoing Actions:

The actions listed throughout the elective access section of this report will support delivery of increased and timely cancer pathways, and MFT has a refreshed Cancer Action Plan following the H2 planning which is forming the basis of discussions with hospital sites for action.

Other Trust wide actions to reduce waits and increase activity in cancer pathways include:

- Increased surgical capacity for Breast and Skin;
- Flexible use of MFT capacity to treat patients in as timely manner as possible;
- Continued use and focus to utilise IS capacity for endoscopy demand;
- Additional clinical capacity in place weekdays and weekends;
- Enhanced process in place for PTL management for Lung Cancer, and;
- Additional consultant recruited at NMG for Lung Cancer Team.

Expected Impact:

The focussed actions aim to increase the number of cancer pathway patients being seen within 7 days, reduce the diagnostic phase with more patients being given a yes no diagnosis within 28 days and reduce the overall treatment times.

6. RECOMMENDATIONS

The Board are asked to note the contents of the report, the updated national planning assumptions for FY22/23 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, Deputy Chief Nurse
Date of paper:	March 2022
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 • At risk 5- to 11-year-olds vaccination
Contact:	Name: Alison Lynch, Deputy Chief Nurse Tel: 0161 701 0331

1. Purpose

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

- National guidance
- National and regional vaccination programmes
- MFT COVID-19 and seasonal influenza vaccination programmes

2. Updates to National Guidance

2.1. The COVID-19 and seasonal influenza programmes are recognised as essential activities within the updated Department of Health & Social Care Autumn and Winter Plan[1].

2.2. On 22nd December 2021 the JCVI advised that:

- Primary COVID-19 vaccination of 5–11-year-olds should commence
- COVID-19 Boosters should be given to 12–17-year-olds[2]

On 7th January 2022 the JCVI reviewed the COVID-19 booster programme, stating that the main aim of the vaccination programme remains prevention of severe disease. JCVI advise that although they will continue to review the requirement for further boosters, protection against mild or asymptomatic infection with existing vaccine products would require regular (perhaps as frequent as 3 monthly) booster vaccinations which is not considered a sustainable long-term strategy. Describing that the booster programme has provided high levels of protection against severe disease from COVID-19 (both Delta and Omicron variants) across the population, JCVI advise that the priority for the programme remains increasing coverage of the first booster dose across the adult population. JCVI also state that they will continue to review new vaccines, in order to provide planning for long-term protection for those most at risk of serious disease.[3]

2.3. The 'Get Boosted Now' Campaign launched on 10th January, encouraging pregnant women to be vaccinated. This is a joint initiative between the Royal College of Gynaecologists, the Royal College of Midwives and the Department of Health and Social Care.[4]

2.4. On 31st January the Secretary of State for Health made a statement that there would be further consultation around Vaccination as a Condition of Deployment legislation for healthcare workers and that all activity relating to this should be paused for further consultation. The consultation closed on 16th February 2022.

3. National and Regional Vaccination

3.1. Across the United Kingdom over 48 million people (85%) aged 12 and over, have had two COVID-19 vaccine doses; almost 38 million people (66.1%) aged 12 and over have had their booster dose[5].

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[1] COVID-19 Response: Autumn and Winter Plan 2021. 9th November 2021

[2] JCVI statement on COVID-19 vaccination of children and young people: 22 December 2021

[3] JCVI statement on the adult COVID-19 booster vaccination programme and the Omicron variant: 7 January 2022

[4] Press Release: New campaign launched urging pregnant women to Get Boosted Now. 10th January 2022

[5] Data accurate as of 4pm 20th February 2022. https://coronavirus.data.gov.uk/details/vaccinations

3.2. As of the 20th of February 2022, 139,427,540 vaccinations have been given since the vaccination programme commenced in early December 2020.

3.3. Whilst uptake of 1st and 2nd doses has reduced, there has been a steep rise in people having boosters.

3.4. In the Northwest, 5.2 million people (75.7%) have received both doses; over 3.9 million people (57.3%) have had their booster vaccine[6]. By comparison, in London almost 5.9 million people (64%) have received both doses, and over 4.1 million people (45%) have had their booster dose.

3.5. In Greater Manchester 78.3% of over 12 years of age have received their primary vaccination course, 52.5% have received their booster dose[7].

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

4.1. The MFT COVID-19 vaccination programme commenced on 15th December 2020. The booster programme commenced on 22nd September 2021. The Trust only offers Pfizer vaccine (now licensed as Comirnaty[8]).

4.2. Through the MFT staff COVID-19 vaccination programme[9]:

- 93.9% have received their 1st vaccine
- 91.09% have received their 2nd dose
- 72.8% of staff have had their booster vaccination
- 100% of MFT staff have been offered the vaccination

4.3. Eligibility for COVID boosters varies dependent upon when the 2nd dose was administered; all appointments are offered in line with national guidance[10] to reduce to a 3-month interval between 2nd dose to booster dose

4.4. Through the MFT staff seasonal influenza programme[11]

- 53.6% of staff have received their flu vaccine

4.5. 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.

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

4.7. 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%.

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[6] Data accurate as of 10am 20th February 2022. https://coronavirus.data.gov.uk/details/vaccinations

[7] Data accurate as of 08.30am 21st February 2022. Data Sources Vaccinations Feed (from Arden and GEM CSU)

[8] https://www.pfizer.co.uk/products/prescription-medicines/comirnaty

[9] All data below accurate as of 18th February 2022. Some staff have had their vaccine elsewhere and are not yet recorded on Trust systems. Staff includes only those employed directly by MFT.

[10] C1468 JCVI Advice in response to the emergence of the B.1.1.529 (omicron) variant: next steps for deployment

[11] All data below accurate as of 14th February 2022. Some staff have had their vaccine elsewhere and are not yet recorded on Trust systems. Staff includes only those employed directly by MFT.

4.8. Lower uptake has been seen both regionally and nationally this year for the seasonal Flu Vaccine; the national average in January 2022 is recorded at 58.5% for frontline healthcare workers[12].

4.9. Through MFT Flu Engagement Groups, reasons for low flu vaccine uptake include perceptions of flu as being less of risk due to reduced prevalence, and prioritisation of COVID-19 booster (despite offer for co-administration). Manager well-being conversations, improved communication, and direct offers of local flu vaccinators in clinical areas are in place to support staff to take up the offer of flu vaccination,

4.10. On 6th December 2021, guidance was published relating to Phase 1 (planning and preparation) of vaccination as a condition of deployment for healthcare workers. This was paused on 31st January, with a consultation currently in progress to rescind this legislation.

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

5.1. Specific patient cohorts are included in the provision offered by the MFT vaccine service as part of the programmes in place until 1st April 2022.

5.2. 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
  - 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
  - Paediatric inpatients and outpatients aged 5-11 in an at-risk group

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

6.1. The MLCO/TLCO school aged immunisation service (SAIS) teams have led the delivery of the COVID vaccine to healthy 12 to 15-year-olds in schools in Manchester and Trafford; with the second phase of the programme commencing on 14th January 2022.

6.2 The second phase requires SAIS teams to offer second and first doses to 12 to $17^{3}/_{4}$-year-olds in school settings before half term (11th February 2022 for Trafford and 18th February 2022 for Manchester) and completed by 31st March 2022. All schools have been offered a first visit.

6.3 As with the first phase, there are supplementary offers through the Mass Vaccination Centre, Community Pharmacies, Primary Care Networks and Hospital Hubs.

[12] Data accessed 10am 14th February 2022. https://www.gov.uk/government/statistics/seasonal-flu-and-covid-19-vaccine-uptake-in-frontline-healthcare-workers-monthly-data-2021-to-2022

6.4 From 24th January 2022 delivery of the programme has been via two sub-contracted community pharmacies. Subcontracting arrangements negate the need to augment the SAIS with wider School Health Service and M&TLCO staff and enables the SAIS to deliver other programmes as part of the School Aged Immunisation Programmes (SAIP).

6.5 Where there has been low take up of the offer, schools have been offered a follow up visit. These are being planned into the timetable and agreed with the Community Pharmacies.

6.6 Working with system partners across Manchester and Trafford a number of priority schools have been identified where there has been a low take up and/or areas of deprivation. Additional support is being provided to work with these schools, parents and community groups to maximise take up of the in-and-out of school offer in those areas.

7. Greater Manchester

7.1. The letter received by the Trust on 3rd December[13] made it clear that hospital hubs continue to play a critical role in the vaccination of health and care staff. The priority remains to offer vaccinations to staff, and opportunistically extended to in-patients and outpatients.

7.2. As MFT has 'hospital hub+' status, we were once again asked to open vaccine appointments to members of the public through the National Booking System (NBS). From 1st December 2021 to 14th February 2022, MFT have provided 8,296 COVID-19 vaccines to the public via NBS. A total of 30,000 slots were made available through the NBS booking system from 1st December 2021 to 31st March 2022.

8. Communication & Engagement

8.1. 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.

8.2. 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+).

8.3. 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.

8.4. An information pack has been prepared to support managers in holding wellbeing discussions with staff who have not accepted or declined the offer of vaccination and training sessions for managers will run until the end of February to support them with this.

8.5. A vaccination email address is well established, handling enquiries from staff, patients, and the public.

[13] C1468 JCVI Advice in response to the emergence of the B.1.1.529 (omicron) variant: next steps for deployment

8.6. A series of interactive Q&A sessions involving a range of experts have been held, all have been well attended and each has resulted in an increase in vaccination figures.

9. Governance

9.1. 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.

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

9.3. Vaccination programme meetings are held bi-weekly, focusing on the strategic planning of the vaccine programme

9.4. 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.

9.5. 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.

9.6. Plans are in place to review the current service provision to align with any future requirements for COVID-19 vaccination deployment from 1st April 2022

10. Summary

10.1. There has been good uptake of the COVID-19 vaccination across MFT staff, however the flu vaccination rates are less positive. Work continues to improve coverage in both vaccinations.

10.2. Nationally, the focus remains on:

- Maximising uptake of the vaccine among those that are eligible for a booster dose but have not yet taken up the offer, with a focus on MFT staff and affiliate frontline healthcare workers

10.3. The MFT vaccine service objectives align with the objectives outlined in the Autumn and Winter Plan[14]. Plans are in place to consider the future of the vaccination programme across MFT to align with any changes to national vaccine deployment.

11. Recommendations

11.1. 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
- At risk 5- to 11-year-olds vaccination

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse and Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse (ACN) and Clinical Director of Infection Prevention and Control (CDIPC) Alison Lynch, Deputy Chief Nurse
Date of paper:	March 2022
Subject:	Update on COVID-19 IPC response (inc updated IPC BAF) and Nosocomial Infections
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Safety Patient Experience
Recommendations:	The Board of Directors are asked to note: • The information provided in the report, and • The updated IPC Board Assurance Framework (Appendix 2)
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse (ACN) and Clinical Director of Infection Prevention and Control (CDIPC) Tel: 0161 276 4042

Section 1: INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK:

1.0 Purpose

1.1 The purpose of this paper is to provide an update to the Board of Directors on the Infection Prevention and Control (IPC) Board Assurance Framework (BAF), including identification of supporting evidence, potential gaps in assurance and mitigating actions against 10 IPC standards as set out in the Code of Practice (2008).

2. Background

2.1 NHSE/I have further developed the existing Board Assurance Framework1 to support all healthcare providers to effectively self-assess their compliance with UK Health Security Agency (UKHSA) Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections.

2.2 The legislative framework is in place to protect patients, service users and staff from avoidable harm in a healthcare setting. The framework is structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.3 Throughout the pandemic, the Infection Prevention and Control Team have rapidly adapted the ways of working to ensure effective actions are in place and continue to be fundamental to all decisions made to keeping patients, staff, and visitors safe.

3.0 The IPC Board Assurance Framework

3.1 The IPC Board Assurance Framework has been reviewed regularly since its introduction in June 2020. Appendix 1 provides detail of where the BAF has been presented. The Trust IPC BAF has been further updated during January and February 2022. There is mitigating action in place to address any gaps in assurance; these are highlighted in the ten key areas listed below.

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

Gaps in assurance / mitigation action

- In cases where COVID-19 positive patients present with no symptoms or COVID status is an incidental finding; mitigating actions include routine screening, fundamental IPC measures, and risk assessments.
- Rapid pace of change may cause confusion there is a communication cascade in place. Where there may be over-reliance on electronic methods, face to face communication is led by senior leaders.

1 NHSE Infection Prevention and Control Board Assurance Framework V1.8 24th December 2021

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

Gaps in assurance / mitigating actions

- Some Trust estate is old and does not comply with NHS Estates Building Notes (HBN) affecting cohorting / ventilation. Trust ventilation engineers are consulted, changes in functions are assessed and agreed through an MDT approach supported by IPC, Estates and Facilities Teams and implemented once the risk is known and mitigation is put in place.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Gaps in assurance / mitigating actions

- Insufficient data to monitor antimicrobial use consistently. A revised Antimicrobial Stewardship Committee is in place. Ad hoc surveillance officer support is in place until the full implementation of HIVE (Electronic prescribing) and consumption data and accuracy has been discussed with Regional AMS lead.

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

Gaps in assurance / mitigating actions

- Conformance with Trust Visiting policy/adhering to IPC controls. The Trust Interim Visiting Policy has been updated to support lifting visiting restrictions across the Trust from 14th February 2022, based on principles of community prevalence, local COVID-19 burden (related to outbreaks) and including other HCAI's. Visitors are reminded to adhere to NHS requirements to wear a FRSM unless exempt, undertake an LFT test, to practice good hand hygiene and to wear PPE where indicated.

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

Gaps in assurance / mitigating action

- Some Trust estate is old and does not comply with NHS Estates Building Notes (HBN) affecting cohorting / patient placement ventilation. Patient screening and pathways are in place, non-compliance is addressed locally and agreed through an MDT approach supported by IPC, microbiology, virology, and clinical teams with a balanced risk-based approach taken.

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

Gaps in assurance / mitigating action

- Not always possible to maintain social / physical distancing due to site constraints, staff fatigue, and ability to monitor policy when staff are travelling to work; ability to use FFP3 masks where risk cannot be eliminated through 'routine' pandemic PPE usage, local risk assessment and pre-emptive assessment before results are known.

7. Provide or secure adequate isolation facilities

Gaps in assurance / mitigating action

- Lack of side rooms for isolation, potential delay between testing and identification of infection status. Risk assessments undertaken based on symptoms where status is unknown.

8. Secure adequate access to laboratory support as appropriate

Gaps in assurance / mitigating action

- Travel time for specimens from site to laboratory dependent on transport; additional transport in place to mitigate risk.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Gaps in assurance / mitigating action

- Staff changing facilities are not available in all areas; staff advised on how to decontaminate uniforms and uniform policy in place

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Gaps in assurance / mitigating action

- Staff who require a PCR test to support return to work may not have access to a test for timely turnaround to return to work. Rapid PCR tests have been made available.

3.2 Assurance can be provided that:

- The Trust has assessed the systems and processes in place against the new indicators in the IPC BAF that have flexibly responded to emerging variants of concern. More recently responding to the omicron variant which was more transmissible than previous variants in the context of post pandemic recovery, increased non-elective demand, and activity in non-elective as is usually seen in a winter period, and in the context of seasonal influenza and RSV infections.
- 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

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

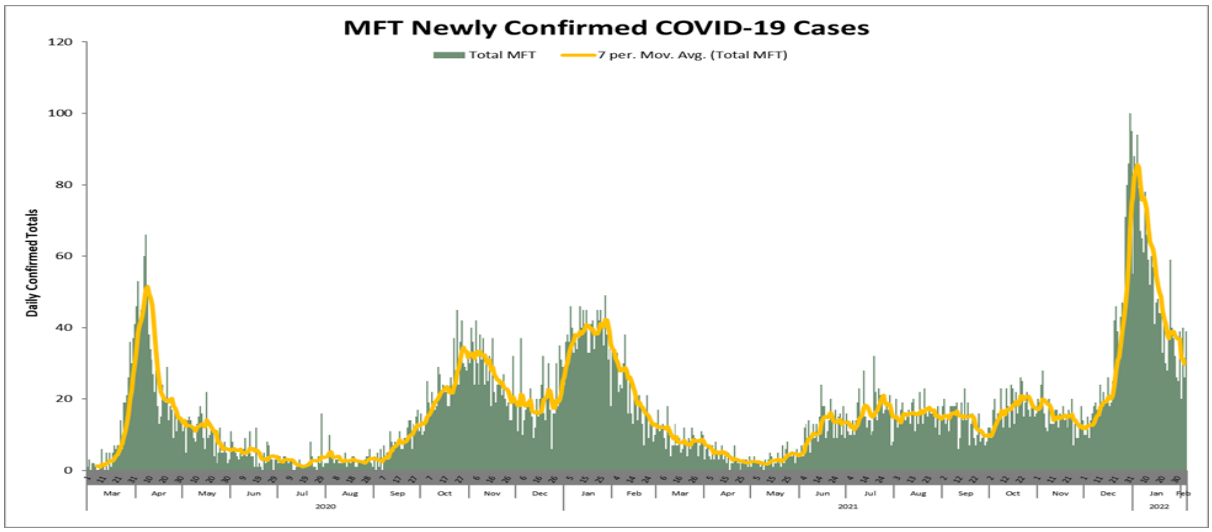
- UKHSA guidance is regularly checked for updates and any changes are communicated to staff in a timely way
- An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients3.
- The Board receive regular reports relating to the IPC BAF, which is also incorporated into the main Board of Directors BAF

Section 2: NOSOCOMIALTRANSMISSION OF COVID-19 and OTHER HEALTHCARE ASSOCIATED INFECTIONS

4.0 Nosocomial Transmission of COVID-19 - Current Position

4.1 There was a spike in the number of in-patient cases with the Omicron variant in January 2022 (see Chart 1 below), that caused a severe impact on capacity and patient flow. There were 13 outbreaks of Hospital Onset Covid Infection (HOCI) across the Trust in December 2021 and 29 outbreaks of HOCI in January 2022 compared to two in November 2021 and seven for this month to date (16/02/22).

4.2 Following a risk assessment triggered by the sudden surge in cases temporary new IPC guidance was introduced to balance the risks of patient safety.



5.0 National Overview of Omicron Variant

5.1 Recent studies have confirmed the overall risk of hospitalisation for Omicron compared to Delta. Findings indicate that there is a substantial reduction in risk of hospitalisation for Omicron cases after 3 doses of vaccine compared to those who are unvaccinated, with overlapping estimate ranges.

5.2 Despite the estimated reduction in hospitalisation risk and preserved vaccine effectiveness against hospitalisation, the very high number of Omicron cases means that there may still be

3 https://www.gov.uk/government/publications/ukhsa-review-into-ipc-guidance

large numbers of admissions to hospital. (UKHSA Technical briefing: Update on hospitalisation and vaccine effectiveness for Omicron, published 31st December 2021).

6.0 Local Overview of Omicron Variant.

6.1 The findings of these studies are reflected locally. Figures 1 and 2 below demonstrate the overall declining numbers of COVID-19 positive cases within the community and the proportions of the COVID-19 variants (Delta and Omicron) at the Oxford Road Campus and Wythenshawe Hospital from 9th December 2021 – 31st January 2022.

6.2 The impact of the rise in numbers of the Omicron variant in patients who required mechanical ventilation can be seen in Figure 3. This shows that despite an increased number of admissions to hospitals across Greater Manchester between the 15th December 2021 and 10th January 2022 there was no increase in the number of patients being mechanically ventilated. This suggests the Omicron variant is less virulent than the Delta variant.

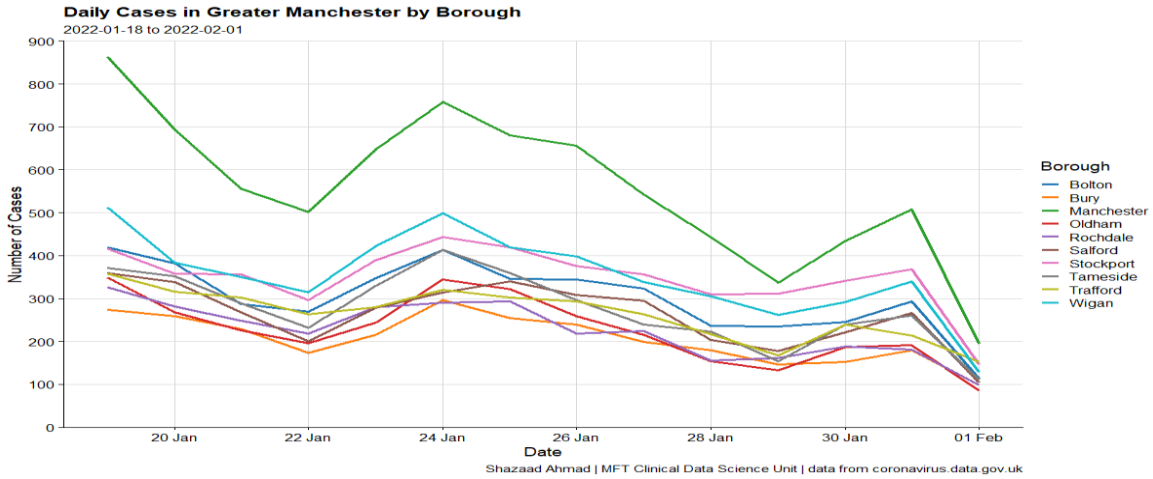


Fig.1 Daily cases in Manchester by borough. (coronovirus.data.gov.uk)

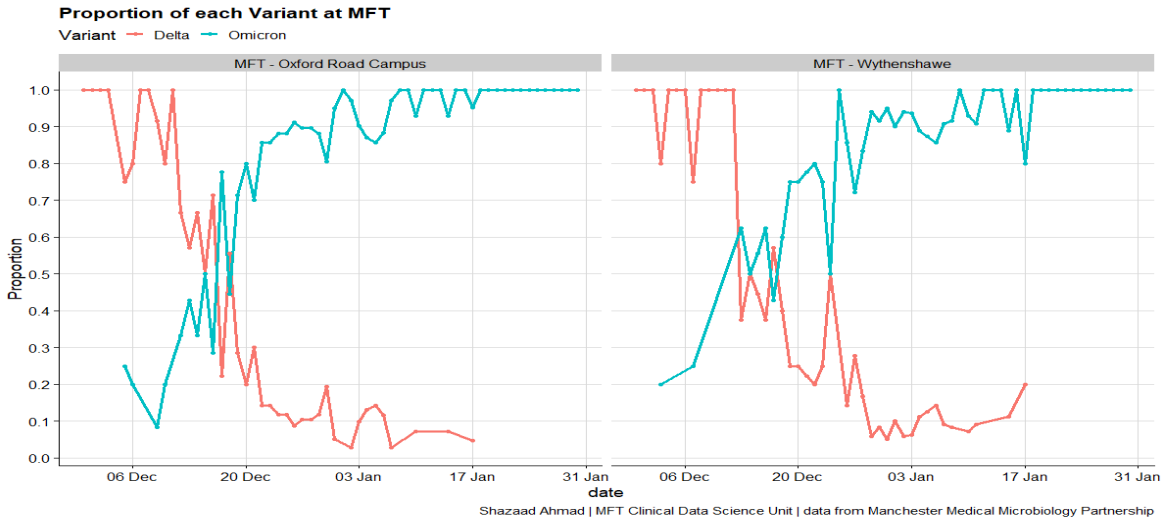


Fig.2 Proportion of each variant, Delta and Omicron in MFT patients (Manchester medical microbiology partnership)

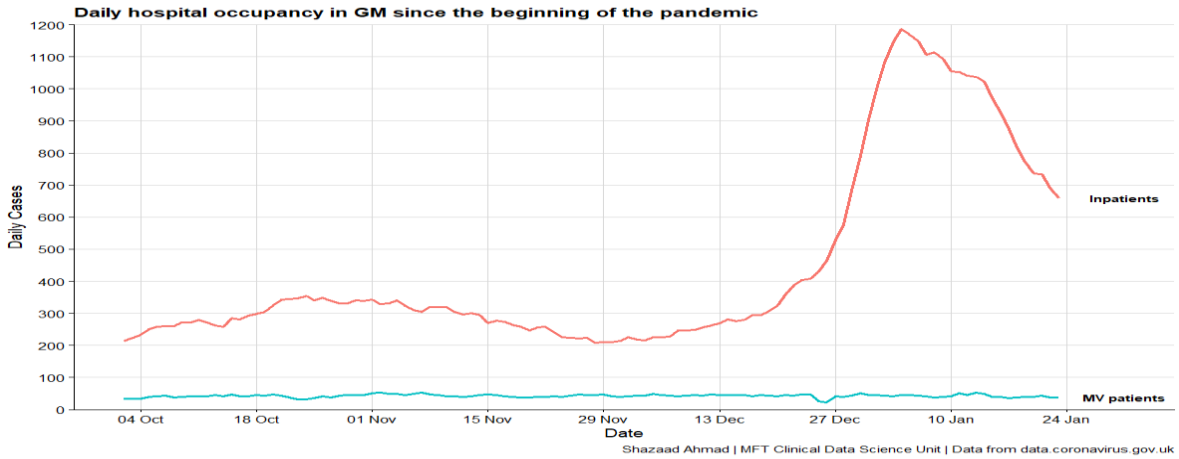


Fig.3 Daily hospital occupancy in Greater Manchester since the beginning of the pandemic. (coronovirus.data.gov.uk)

7.0 IPC for Seasonal Respiratory Infections in Healthcare Settings (Including SARS CoV-2) for Winter 2021-22 (UK Health Security Agency 17th January 2022).

7.1 Changes to the national guidance for the principles of IPC are regularly reviewed by the IPC Team and discussed at the Clinical Sub-Group before approval at the COVID-19 Response and Recovery Group.

7.2 The most recent UKHSA guidance, reflects the changes in the background carriage rate and the virulence of the Omicron variant and have been used to update local guidance.

8.0 Nosocomial Transmission of other Healthcare Associated Infection (HCAI)

8.1 The Trust complies with mandatory data submission on incidents of HCAI through UK Health Security Agency (UKHSA) mandatory surveillance system. The table below compares the data for year ending 31st March 2021 with the first three quarters of this year.

HCAI	Year ending March 2021	April – December 2021(Q1 -Q3)	Annual Target
Meticilin Resistant *Staphylococcus aureus* Bacteraemia	12	8	0
Clostridium difficile Infection	215	178	117
Gram Negative Bacteraemia	299	228	162

Vancomycin Resistant Bacteraemia	34	24	Not applicable

The data above was presented to the Group Infection Control Committee in January 2022. Following investigation, the overarching common themes identified included.

- Lack of appropriate documentation
- Inability to Isolate patients with infection
- Compliance with screening programmes
- Intravenous line care
- Reduced Antimicrobial Stewardship

The findings of the investigation are currently being addressed by each Hospital/MCS and will be appraised during their end of year IPC review led by the Chief Nurse/DIPC.

9.0 Summary

9.1 National studies have demonstrated that there is a reduced risk of hospitalisation for Omicron cases after 3 doses of vaccine compared to those who are unvaccinated.

9.2 Local evidence suggests that Omicron is the predominant variant of concern in circulation and that despite an increased number of admissions to hospitals across Greater Manchester between the 15th December 2021 and 10th January 2022 there was no increase in the number of patients being admitted to critical care.

9.3 The number of in-patients with COVID-19 rose sharply during the two weeks pre and post the Christmas period across Greater Manchester but is now in decline.

9.4 The consistent message continues to be to always maintain the basic principles of IPC. In addition, the Trust must continue to take a flexible risk assessment approach to managing the wider risk to capacity and patient flow, depending on the number of cases and virulence of the variant.

10. Recommendations

The Board of Directors are asked to note:

- The information provided in the report, and
- The updated IPC Board Assurance Framework (Appendix 2)

Appendix 1

The IPC BAF has been presented at the following Board of Directors meetings or sub-committees since its publication in June 2020.

- 13th July 2020. Board of Directors Meeting
- 14th September 2020. Board of Directors Meeting
- 14th October 2020. Group Infection Prevention and Control Group, a Sub-Committee of the Board of Directors
- 9th November 2020. Board of Directors Meeting (amalgamated into the Trust Board Assurance Framework).
- 11th December 2020. Extraordinary Board of Directors Meeting
- 11th January 2021. Group Infection Prevention and Control Group.
- 8th March 2021. Board of Directors Meeting (as part of a report relating to Nosocomial Infections)
- 20th April 2021. Group Infection Prevention and Control Committee.
- 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 2021. Board of Directors Meeting
- 19th October 2021. Group Infection Control Committee
- 7th November 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).
- 10th January 2022. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).
- 19th January 2022. Group Infection Control Committee[4]

[4] The IPC BAF presented to GICC on 19th January 2022 has been amended to reflect updates to the Interim Visiting Policy on 14th February 2022

Appendix 2

Infection Prevention and Control Board Assurance Framework V14 February 2022

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 that:
• A respiratory season/winter plan is in place:
  • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services
  • to enable appropriate segregation of cases depending on the pathogen.
  • plan for and manage increasing case numbers where they occur.
	• Agreed pathways for non-elective patients in line with guidance issued jointly by the DHSC, Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, NHS National Services Scotland, UK Health Security Agency (UKHSA) and NHS England as official guidance; Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022
	• A Winter Surge plan is in place that describes, escalation and management based on modelled activity (including COVID-19, RSV and other seasonal pressures). POCT testing is in place in
		• Some COVID-19 positive individuals present at hospitals as asymptomatic patients
		• Unpredictability of omicron and other variants of concern; transmissibility or potential conversion to critical care / increased burden in general and acute beds
		• Rapid pace of change may cause confusion
			• Patient placement guidance in place
			• All patients admitted via ED are screened for COVID-19, data is reviewed daily
			• All clinical areas undertake a risk assessment using Hierarchy of controls where there is an increased risk of transmission
			• Screening of non-elective admissions recorded on ED systems and communicated to bed

• a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan. • health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in thelocal area.	appropriate settings: ED / assessment areas that support triage / placement of patients depending on pathogen • Risk assessments in place, supported by the IPC Senior Team (Associate Medical Director, and Clinical DiPC/Assistant Chief Nurse), daily assessment and situational guidance is in place using an MDT approach that considers the Hierarch of Controls. • Plans include increasing capacity to support COVID-19 restrictions that assess staff safety, patient placement and patient flow through anticipated surge in admissions, with specific regard to COVID-19 • Clinical Sub-Groups / Clinical Advisory Groups are in place to oversee adjusted or adapted systems and processes approved within hospital settings. • A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific		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 • Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE;MDROs) • National recognition through guidance Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022, that Trusts may review their pathways in line

• applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.** • communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazardsassociated with respiratory infectious agents.	circumstances to support whole site safety. • GM Gold Command has an overview of escalation through situational reporting. • IPC teams / microbiology and virology teams support risk assessments, and have the skills, competence and required expertise.		with infection burden and balance of risk • Hospital Outbreak Control Procedure in place • Policy for Isolation of Infectious Patients • 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

• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE)for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless there is a change in their infectious status, clinical need, or availability of services. • the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas. • resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency	• An update of the number of outbreaks and infections is received by the Board of Directors • Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement to comply with agreed pathways. Transfers occur only if clinically justified. • Daily data collection/submission reported externally is validated and checked for accuracy by the Chief Nurse/DIPC. • 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 • Resources that support staff to comply with IPC practices are in place (education, training, estates and facilities, supported by a clear governance structure)		patients safe. • Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution • Non-compliance is addressed locally in with local processes for escalation when there is an identified risk.

and external contractors).
• the application of IPC practices within this guidance is monitored, eg:
  • hand hygiene.
  • PPE donning and doffing training.
  • cleaning and decontamination.
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.
• the Trust Board has oversight of ongoing outbreaks and action plans.
• the Trust is not reliant on a particular mask type and ensure that a range ofpredominantly UK Make FFP3 masks are available to users as required.
	• Monitoring systems are in place for hand hygiene, donning and doffing training, and cleaning and decontamination.
	• The IPC BAF is presented at every Board of Directors Meeting, Group Infection Control Committee and will undergo scrutiny at the Quality and Performance Scrutiny Committee as part of the main Trust Board Assurance Framework.
	• The Board of Directors receive a report on the impact of COVID-19, including information on outbreaks and action planning.
	• There are 2 types of fit masks available across the Trust. Any additional requirements are made on an individual basis (eg respirator hoods).		

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: The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness (NSOC) and this plan is monitored at boardlevel. the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment. increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms andcohort areas.	• The Estates and Facilities team have undertaking a full review of both clinical and non-clinical cleaning responsibilities as part of preparations for the implementation of National Standards of Cleanliness • Cleaning Policy to be submitted to the Estates and Facilities Board in January 2022 for ratification prior to submission to the Group Infection Control Committee for noting • Changes to room function are assessed and agreed through an MDT approach supported by IPC, Estates and Facilities teams and implemented once appropriate risk assessment completed. • Cleaning twice daily and providing additional enhanced cleaning in high risk/outbreak areas. Cleaning standards are routinely monitored, local action plans in place to resolve issues, including where more frequent cleaning schedules are in place (for example, side rooms, cohort areas, COVID-19 wards and	• Old estate unable to provide good ventilation in some areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Enhanced cleaning specifications in place for clinical and non-clinical areas • Trust Policy for working safely based on PHE guidance is in place • NSOC Policy to be ratified at Group estates and Facilities Management Board 3rd March 2022 • Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have been put in place across all sites to meet UKHSA (ex PHE) guidance. • Staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas • Trust ventilation engineers consulted prior to purchasing any technologies.

Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solutionat 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) are consulted on this to ensure that this is effective against enveloped viruses. manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. a minimum of twice daily cleaning of: patient isolation rooms. cohort areas.	outbreak wards) in accordance with UKHSA guidance (ex PHE). • 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 • 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		

Donning & doffing areas 'Frequently touched' surfaces eg, door/toilet handles, patient callbells, over bed tables and bed rails**.** where there may be higher environmental contamination rates,including: - toilets/commodes particularly if patients have diarrhoea • A terminal/deep clean of inpatient rooms is carried out: • following resolutions of symptoms and removal of precautions. • when vacated following discharge or transfer (this includes removaland disposal/or laundering of all curtains and bed screens); • following an AGP **if**	per COSHH data sheet held by facilities. staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch 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 • Group Estates and Facilities Decontamination Policy is in place. • UKHSA (ex PHE) guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to UKHSA (ex PHE) guidance is deployed in high flow areas such as ED • Increased cleaning in wards		

room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
• 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.
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for
	where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative
	• MFT authorised engineers undertaken assessment of ventilation systems in all areas of the trust where AGP are carried out and departmental managers are aware of the air exchange		

minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken tosupport location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows anddoors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	rates required following AGP and systems in place locally to manage the dilution time within vacated rooms. • Ventilation system monitoring and management is undertaken in conjunction with Estates and facilities and Sodexo. Regular window opening undertaken in areas of the trust have where no mechanical ventilation system is in place. • Regular window opening in areas where there are no mechanical ventilation systems in place. Window fans installed in some areas to facilitate air dilution. • Alternative technologies utilised to increase air exchange rates in various areas across the Trust i.e. window fans and air scrubbing systems to facilitate patient safety and flow in areas undertaking AGP's. • Ventilation engineers input in all areas where there is a potential to affect air flow i.e. Prior to installing Redirooms, plans to segregate ED, installation of Perspex		

• when considering screens/partitions in reception/ waiting areas, consultwith estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	screens within North West Ventilation Unit. Sodexo partners informed of requirement for inclusion into cleaning schedule as required.		
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 for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing. ○ to ensure patients with infections are treated promptly	• The new Group wide MFT AMS Committee (AMC), has developed an AMS vision and strategy. The AMC meets on a quarterly basis and is supported by, 3 new subgroups which provide assurance in areas of guideline development, education and training and quality improvement, audit and research. • The AMC provides assurance to the Medicines Optimisation Board and the Group Infection Prevention and Control	• Access to all data as surveillance officer support is ad hoc • Clarification on risk assessment for unintended consequences of other pathogens being sought	• HIVE/EPIC implementation will improve information sharing/ communication. • Surveillance officer support sought. • Consumption data and accuracy has been discussed with the Regional AMS lead and it is acknowledged that HIVE/EPIC will enhance Trust reporting of antimicrobial

with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Committee. • The AMC has senior representatives from each hospital/MCS including medical, nursing and pharmacy. Each hospital/MCS has a reporting and dissemination structure for AMS in place. • The AMC oversees the development and review of the MicroGuide app which ensures that the right antimicrobial is selected and used. Usage data for Microguide is monitored by the AMC. • Monthly point prevalence audits on each sites reported via the AMC to all hospitals/MCS's. • AMS ward rounds by an infection specialist. • Acute care team monitor sepsis data including access to prompt antimicrobial treatment if sepsis is suspected. • Microbiology support available 24 hours a day.		consumption.

	• Antimicrobial prescribing advice available from pharmacy 24 hours a day • Consumption data of antimicrobial usage. • Monthly ACTION (prescribing standards) audits on all ward areas. • AMS audit forward plan which is monitored by the Quality Improvement and Research Group.		

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: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be	• NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed • The Trust Interim Visiting Policy has been updated to support lifting in	• Lack of concordance amongst some patients/visitors	• Interim Visiting Policy available via Trust Intranet and information published on the Website

considered appropriate during outbreaks withininpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients'visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should bemade aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. area. However, if the visit is considered essential for compassionate (endof life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they areconsidered essential following a risk assessment eg, carer/parent/guardian.	visiting restrictions across the Trust from 14th February 2022, based on principles of community prevalence, local COVID-19 burden (related to outbreaks) and including other HCAI's. Visitors are reminded to adhere to NHS requirements to wear a FRSM unless exempt, undertake an LFT test, to practice good hand hygiene and to wear PPE where indicated. • Visitors are asked to inform staff of their negative lateral flow status at the point of visiting. • End of Life Policy adapted to support visiting during the pandemic. • Controlled entrance & exits to Trust to minimise risk of cross infection • Policy reviewed following further guidance using the toolkit and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission		

• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• All ward areas have clear signage in relation to visiting guidance based on individual risk for that area. ED is currently reintroducing the family liaison role in order to take a proactive approach to family liaison and updates.		
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 that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving receptionstaff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is	• Agreed triage questions, undertaken by trained staff, ensures that patients are screened for COVID-19 symptoms / respiratory symptoms on admission • All patients streamed through a respiratory/non-respiratory pathway in ED's, with infection status communicated. • 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 • All non- elective admissions tested	• Environmental issues and age of estate • Not all patients are willing/able to comply	• Patient placement guidance in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily • Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement to comply with amber / green pathways. External transfers occur only if clinically justified

undertaken prior to attendance wherever possibleto enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection asper national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soonas possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • patients with suspected or confirmed respiratory infection are provided with asurgical facemask (Type II or Type IIR) to be worn in multi-bedded bays	and elective admissions as per Trust guidance, including routine at 1,3 and 7 days and screening for those who develop symptoms. • Trust has an internal test and trace policy • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place/being developed • FRSM available for all patients and visitors, 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		• 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

and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised forplacement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protectiveIPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in	encouraging patients to wear face coverings. • Staff actively encourage patients to wear face coverings when outside of their bed space and offer a replacement on regular intervals. • Staff request patients to wear a face covering when moving between departments. • Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement unless where clinically justified (for individual patient and wider patient safety based on Hierarchy of Controls). • 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		for protective isolation for vulnerable groups and prioritisation of side room

all health and care facilities. • where infectious respiratory patients are cared for physical distancingremains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physicaldistancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • 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. • isolation, testing and instigation of contact tracing is achieved for all patientswith new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms ofCOVID-19 are managed appropriately.	risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • Principles that support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups and prioritisation of side room • A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety.		
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: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct useof PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environmentare trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited withactions in place to mitigate any identified risk.	• Programme of training for all staff and those who are redeployed including use of PPE, maintaining a safe environment in accordance with PHE guidance. • Local information and guidance in place within COVID-19 and non-COVID areas • PPE Infection Control Policy in place • Donning and doffing videos available on the Trust intranet based on national guidance • Designated donning and doffing areas have relevant guidance and instruction displayed • Register of staff training and fit testing for FFP3 masks are	• Staff and patient fatigue factors • Not always possible to maintain 2m distance in all areas because of building design constraints • Whilst staff are reminded to maintain social distancing when travelling to work, it is not possible to monitor compliance	• Increased IPC support to daily Recovery and Response Meetings (7 days per week where required) • Prompt response to clusters/outbreaks of COVID-19 • Multiple communication channels – daily briefing/dedicated website • Ability to use FFP3 masks where risk elimination is reduced • Increased Microbiologist and AMD support

• gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's andTBP's. • the use of hand air 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. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	maintained by hospitals/MCS, Trustwide database in place • Hand dryers are not used in accordance with guidance • Hand Hygiene Policy and ANTT Policy in place • Audit of PPE and hand hygiene regularly undertaken – actions in place to improve where required • Guidance displayed in public areas • Regional COVID-19 prevalence reviewed by Clinical Sub-Group and used to inform PPE practice. • Daily reporting of other HAIs to identify outbreaks. • Staff communal areas have clear signage and there are staggered breaks to facilitate reduced contact to ensure that footfall reduced where possible • Local population, regional and		• Expert Virology support • 7 day working from IPC/Health and Wellbeing • Increase of audits on increased activity areas • Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Staff on COVID-19 areas wearing scrubs laundered through hospital laundry • Local Risk assessment undertaken, and partitions used where appropriate in addition to FRSM masks in all clinical and non-clinical areas • Additional Hand

• to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates ofinfection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • 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 and are reported.	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		hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas. • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Social media campaigns remind staff and public to follow public health guidance outside the workplace • Pre-emptive risk assessment to manage high risk patients before results are known.

	daily basis and acted upon by IPC and clinical teams • Outbreak Policy in place		
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: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around theward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic schedulingto reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or	• 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.	• Lack of side rooms for isolation • Potential delay between testing and identification of HAIs	• Risk assessments undertaken on a daily basis to support patient placement • Risk assessment undertaken based on symptoms when status is unknown • Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for

suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred,their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipmentneeds (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring forthe deceased	• Patient pathways are compliant with Infection Prevention and Control guidance and limit internal patient movement unless where clinically justified (for individual patient and wider patient safety based on Hierarchy of Controls). • 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. • A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety.		Cardiac patients)

	• IPC principles continue to be applied when caring for the deceased		

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 • patient testing for all respiratory viruses testing is undertaken promptly and inline with national guidance; • staff testing protocols are in place • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is 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.	• UKAS accredited PHE laboratory conducting testing for NW of England based on Oxford Road Campus. Testing undertaken through the laboratory is in accordance with UKHSA guidance • Posters to support training for staff on how to take a swab • Staff testing protocols are in place. Trust Testing Strategy Group to receive regular reports to monitor compliance – • Turnaround times measured -planned programme of monitoring in place. • COVID-19 Testing, Streaming and Stepdown Guidelines are in place that	• Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site

• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retestedfor COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous90 days), and result is communicated to receiving organisation prior to discharge. • those patients being	supports staff in decision making / patient placement. • Screening for other potential infections has continued throughout the pandemic • 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. • Consideration of whether to consider daily COVID-19 testing would be made following IPC / microbiology and virology support.		

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 as per national guidance • there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients whoare fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance			

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			

• the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it	• Resources that support staff to comply with IPC practices are in place (education, training, estates and facilities, supported by a clear governance structure) • Monitoring systems are in place for IPC practices, local action plans are held to improve where required. • Changing facilities are not in place in all areas of the Trust, break areas are identified. • Outbreak policy in line with UKHSA (ex PHE) guidance • Outbreaks contained and reported to NHSE/I using IIMARCH (Information, Intent, Method, Administration, Risk Assessment, Communication, Humanitarian issues) documentation and daily sitrep reports • 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 changing facilities are not available in all areas	• Increase of IPC support to COVID -19 Wards • Prompt response to clusters/outbreaks of COVID-19 • Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Uniform Policy in place

	• 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. • Materials management team asses local stock levels and replenish every 2- 3 days • Update on stock levels circulated to DIPC/IPCT and reviewed through the Recovery and Response Group.		
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 seek advice when required from their IPCT/occupational healthdepartment/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of acase of COVID-19 are enabled to return to work without the need to self- isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection.	• 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 • Bank and agency staff are supported to follow IPC advice through local induction and on-boarding • Staff guidance (include temporary staff and students) is in place to support staff who are identified as contacts through Test and Trace or as household contacts. The guidance is regularly updated as national guidance emerges / changes. • COVID-19 specific e-learning is in place, including donning and doffing of PPE, and RPE where required. • All MFT staff complete a COVID-19 self-risk assessment, electronically	• Staff who require a PCR test to support return to work may not have access to a test in a short order to support return to work • Vaccination rates in staff – vaccination as a condition of deployment status	• Prioritisation based on clinical and staff need • Staff access to rapid PCR swabs when asymptomatic through agreed processes • Absence monitoring and follow up and contact by line manager • A task and finish group led by the Executive Director of Workforce is in place

• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  • lead on the implementation of systems to monitor for illness andabsence
  • facilitate access of staff to antiviral treatment where necessary andimplement a vaccination programme for the healthcare workforce
  • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19
  • encourage staff vaccine uptake.
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions,
	stored
	• 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.
	• Absence manager process in place to support COVID related absences, with high level monitoring at Recovery and Response Meetings on a daily basis.
	• Staff vaccination programme is in place – 4 hospital hub clinics provide a 7 day per week service to provide vaccination to new starters or those who have yet to be vaccinated.
	• MFT are the GM lead for the nMAB (anti-viral programme), any member of staff who would be eligible would		

including PPE, as outlined in national guidance. • a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; that advice is available to all health and social care staff, includingspecific advice to those at risk from complications. Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as	receive this although not as routine nor related to work activity. • Daily staffing process are in place to manage safe and effective staff deployment • 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 is provided in accordance with policy. • HR policies in place for staff to report on sickness absence via the Absence Manager system. • All Trust protocols comply with National guidance and are kept under constant review. HR advice and support is provided to managers. • Regular comms and briefings ensure that staff are aware of policies and procedures as well as the support available to them. • Trust policy aligns with national guidance • An assessment has been made of UKHSA guidance 'COVID-19:		

advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used. • all staff required to wear an FFP3 respirator should be fit tested to use atleast two different masks • a record of the fit test and result is given to and kept by the trainee andcentrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative	management of staff and exposed patients or residents in health and social care settings' in relation to staff who are contacts of people with Omicron variant of COVID-19, to ensure that they remain isolated for the designated period and do not return to work even if their PCR test is negative. • Manager well-being sessions are in place to support staff in respect of vaccination. • Experts panel sessions held regularly with contribution from HR, pharmacy, obstetrics, and staff side to support staff with decision making. • Staff are locally trained by staff who are trained and assessed as competent to do so. • There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly • There are Trust Policies in place based on national guidance agreed with HR and EHWB to ensure that		

respiratorsand hoods. • that where fit testing fails, suitable alternative equipment is provided. • Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate withthe 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 organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care	those who have failed fit testing are redeployed • The Trust has extended fit testing to include 2 alternative FFP3 respirators. Reasons for fail to fit test are recorded and escalated where appropriate		

across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. • 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. • staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.			

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:	March 2022
Subject:	Financial Performance for Month 10 2021/22
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	The Board of Directors is recommended to note the position against the YTD plan and updates on Cash and Capital positions for the Trust.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	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 reduced but the implications of reduced activity over the previous period manifested 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. To month 10, January 2022, the Trust has delivered a year-to-date surplus of £10.3m; which is an improvement of £1.3m from the £9.0m year to date surplus reported in month 9 and is in line with the H2 plan submitted to NHSE/I in late November. The revised NHSE/I H2 plan requires the Trust to breakeven in the six-month period and overall to deliver a £13.1m surplus for the 12 months to March 2022 based on the performance achieved in month 1-6 against the H1 plan.
1.2	**Run Rate**	January 22 total expenditure at £201m has increased by circa £14.1m against that of December 22. Much of this adverse movement relates to technical adjustments through the non-pay category with circa £4.8m related to matching increases in income (pass-through drugs and Research & Innovation expenditure). Excluding such corrections and adjusting early months for the AfC pay award back pay, expenditure run rates have been relatively consistent across the year. The ongoing 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) and in Month 8 the Trust was notified of further Elective Recovery and discharge monies, including amounts designated for winter. As a high proportion of the funding is non-recurrent the Trust must maintain a strong grip of the recurrent level of expenditure as elements may prove unaffordable in a revised financial regime for 22/23.
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. However, through the governance structures, there has been a consistent message that maintaining control of expenditure is key, even during the pandemic. The value of system monies from GM for H2 has been agreed and revised plans for income and expenditure in H2 that deliver a breakeven position have been factored into the H2 plan. The Trust’s WRP target remains at £50m for the full year, but the breakeven position for H2 only assumes that £30m of that will be achieved for the year to March 22.

1.4	**Cash & Liquidity**	As at 31st January 2022, the Trust had a cash balance of £290m. The cash balance was higher than forecast by £79m, this was primarily due to £55m of capital expenditure delays and £18m of funds received from NHSE/I to fund the annual leave provision made at the end of 2020/21 against the backlog of untaken leave due to the Covid-19 pandemic.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned expenditure in line with the system capital envelope. The total plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £198.4m. In the period up to 31st January 2022, £94.0m of capital expenditure has been incurred against a plan of £151.8m, an underspend of £57.7m. £36.9m of the slippage relates to the NHP project and is due to known delays in the approval of the Park House scheme and associated enabling works, alongside the slower than anticipated implementation of the programme of build for the new hospital. The estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £20.8m underspend, the most material elements are: £8.3m relating to the NMGH emergency works which were due to be funded through Emergency PDC which are now proceeding, albeit later than had been planned; £5.0m relating to Hive and is a result of the phasing of expenditure on the EPIC production platform being changed from earlier in the year to February and March; and £4.5m on the SARC relocation and the Wythenshawe and Trafford theatres which due to delays means expenditure will be incurred later than planned. Capital Programme leads are working very hard to ensure that the capital programme is delivered as planned.
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 31st January 2022

I&E Category	NHSI Plan M10 £'000	Year to date Actual - M10 £'000	Year to date Variance £'000
INCOME			
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	1,487,232	1,495,978	8,746
NHSE - Cost passthrough drugs (increase above threshold)	68,505	65,343	(3,162)
Trust (Rapid Diagnostic Centres)	257	1,220	963
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	143,574	143,574	0
GM System Funding 1-6 £5m	5,000	0	(5,000)
Elective Recovery Funding	8,266	13,434	5,168
Other (Other devolved / IOM / NORs & Wales)	7,281	8,901	1,620
Additional Funding outside financial envelope	3,374	5,724	2,350
Local authorities	32,300	33,024	724
Sub -total Income from Patient Care Activities	**1,755,789**	**1,767,198**	**11,409**
Private Patients/RTA/Overseas(NCP)	8,728	7,939	(789)
Total Income from Patient Care Activities	**1,764,517**	**1,775,137**	**10,620**
Training & Education	61,776	62,075	299
Training & Ed Non HEE	2,926	3,399	474
Training & Ed Notional	2,222	2,305	83
Research & Development	57,339	59,950	2,611
Misc. Other Operating Income	79,371	79,283	(88)
Other Income	**203,634**	**207,013**	**3,379**
TOTAL INCOME	**1,968,151**	**1,982,150**	**13,999**
EXPENDITURE			
Pay	(1,165,170)	(1,163,314)	1,856
Non pay	(738,913)	(743,629)	(4,716)
Training & Ed Notional Spend	(2,222)	(2,305)	(83)
TOTAL EXPENDITURE	**(1,906,306)**	**(1,909,248)**	**(2,943)**
EBITDA Margin	**61,845**	**72,902**	**11,056**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(30,351)	(27,974)	2,377
Interest Receivable	0	19	19
Interest Payable	(34,142)	(34,053)	89
Loss on Investment	0	(576)	(576)
Dividend	0	0	0
Surplus/(Deficit)	**(2,648)**	**10,318**	**12,965**
Technical Adjustments	2,648	0	(2,648)
Surplus/(Deficit) Adjusted Performance - Outturn	**0**	**10,318**	**10,318**
Surplus/(Deficit) as % of turnover	**-0.1%**	**0.5%**	
Transfers by Absorption		**65,478**	**65,478**
Impairment	**(92,404)**	**(58,924)**	**33,480**
Non operating Income	**810**	**3,014**	**2,204**
Depreciation - donated / granted assets	**(992)**	**(814)**	**178**
	(95,233)	**19,072**	**114,306**

** The technical adjustment arises from combining H1 and H2 plans after month 7 was finalised and reported*

Year to date (YTD) at month 10 the Trust is reporting a surplus of £10.318m (£9.019m YTD at month 9) against the breakeven plan for Greater Manchester ICS in H2. This is because of an in-month surplus of £1.299m which is in line with the H2 plan and if finance performance continues in line with the H2 plan will mean a delivery of £13.1m surplus for the 12 months to March 22.

The favourable YTD income variance of £14.0m has increased significantly from the previous month's position of £5.2m which is mainly due to a £3.4m increase in cost pass through income for drugs and gene therapies and inclusion of £4.1m of monies relating to bowel screening, neonatal genomics and Hep C in month 10. Within other operating income, monies for R&I increased by £1.9m, offset by a corresponding increase in the expenditure value, since R&D deferrals of income are matched to expenditure on a monthly basis.

The YTD variance for pay expenditure was favourable to plan by £1.9m, a reduction of £0.8m from the month 9 favourable variance of £2.7m. As was the case last month the in-month adverse variance is primarily down to higher than planned premium pay cost for both backfill of sickness rates due to the Omicron variant of Covid-19 and also due to increased rates agreed for medical staff to undertake additional work to continue clearing the elective backlog. It must be noted though that pay costs remain below planned expenditure year to date.

Comparing run rates to month 9, there has been a reduction in costs of £0.9m against pay expenditure, with spend on Consultants falling by £1.3m. Although YTD expenditure against agency and bank staff is above planned levels spend has fallen in month 10 by £0.6m with over £0.5m of this drop against agency Consultants.

Non-pay expenditure in month 10 YTD was adverse to plan by £4.8m. The difference to plan is broadly reflected as an overspend against cost pass through drugs which has a corresponding favourable variance to plan in income. Comparing non-pay run rates to month 9, there has been an adverse movement of £15.0m, however, the majority of this was down to technical adjustments in month 10 and movements between last month's technical adjustments – these movements account for £8.5m of the variance. The remaining movements were against pass-through drugs (adverse £3.0m - offset by income increase), Research & Innovation non-pay (adverse £1.8m – offset by income increase) and a year-to-date recalculation of costs against the Trust's PFI charges (adverse £1.7m) to correct the split between loan interest and principal payments.

Depreciation YTD continues to be favourable at £2.4m reflecting the year-to-date underspend against the Capital programme. This has also led to a favourable variance against Impairments of £33.5m with less building work done than planned leading to a lower impairment value – this charge is excluded from the Trust's surplus/deficit calculation and therefore does not count against the YTD favourable position to plan of £10.3m.

The agreement of the H2 plan has allowed the Trust to review the WRP position which has been adjusted to reflect revised expectations in the H2 plan, there remains a focus on delivering as much recurrent WRP as is possible as that places the Trust in a better position entering 22/23. The key and most immediate financial areas of focus by Hospitals/MCS/LCO and Corporate functions are the need to continue with tight cost control and the delivery of the remaining WRP in line with the plan.

Statement of Financial Position

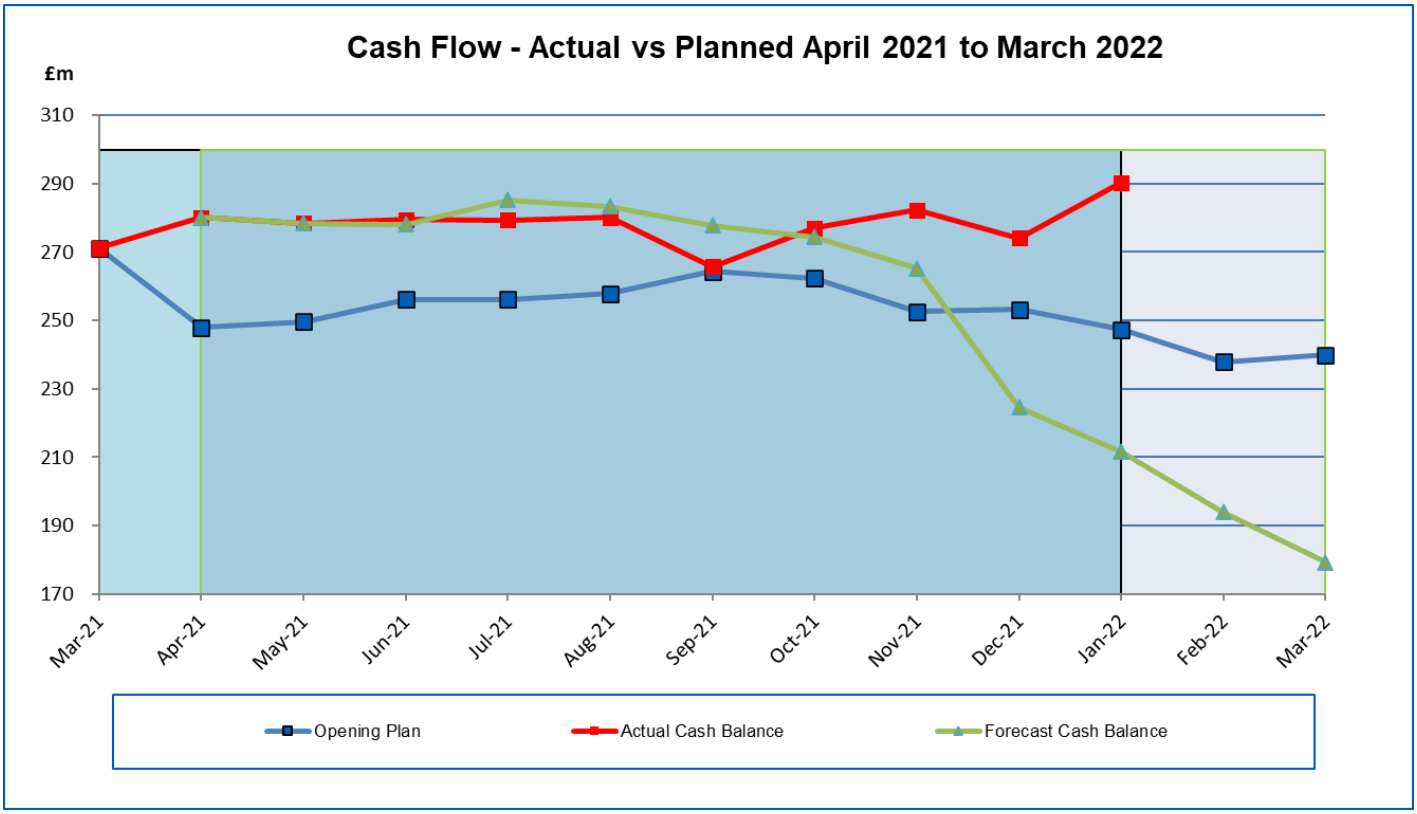
	Audited MFT Accounts 31/03/2021 £000	NMGH Opening SoFP 01/04/2021 £000	Enlarged MFT 01/04/2021 £000	Enlarged MFT 31/01/2022 £000	Enlarged MFT Movement in Year to Date £000
Non-Current Assets					
Intangible Assets	4,665	-	4,665	4,045	(620)
Property, Plant and Equipment	642,394	81,715	724,109	729,198	5,089
Investments	1,498	-	1,498	922	(576)
Trade and Other Receivables	5,645	1,896	7,541	7,534	(7)
Total Non-Current Assets	**654,202**	**83,611**	**737,813**	**741,699**	**3,886**
Current Assets					
Inventories	21,892	936	22,828	22,446	(382)
NHS Trade and Other Receivables	61,707	-	61,707	50,881	(10,826)
Non-NHS Trade and Other Receivables	46,854	3,391	50,245	50,893	648
Non-Current Assets Held for Sale	210	-	210	210	0
Cash and Cash Equivalents	271,199	6,311	277,510	290,337	12,827
Total Current Assets	**401,862**	**10,638**	**412,500**	**414,767**	**2,267**
Current Liabilities					
Trade and Other Payables: Capital	(33,594)	0	(33,594)	(21,943)	11,651
Trade and Other Payables: Non-capital	(287,755)	(2,981)	(290,736)	(324,296)	(33,560)
Borrowings	(20,290)	(1,448)	(21,738)	(22,051)	(313)
Provisions	(24,875)	(5,852)	(30,727)	(33,786)	(3,059)
Other liabilities: Deferred Income	(35,084)	(320)	(35,404)	(70,616)	(35,212)
Total Current Liabilities	**(401,598)**	**(10,601)**	**(412,199)**	**(472,692)**	**(60,493)**
Net Current Assets	**264**	**37**	**301**	**(57,925)**	**(58,226)**
Total Assets Less Current Liabilities	**654,466**	**83,648**	**738,114**	**683,774**	**(54,340)**
Non-Current Liabilities					
Trade and Other Payables	(2,598)	-	(2,598)	1	2,599
Borrowings	(374,948)	(17,664)	(392,612)	(376,981)	15,631
Provisions	(16,622)	-	(16,622)	(17,076)	(454)
Other Liabilities: Deferred Income	(3,817)	(495)	(4,312)	(1,097)	3,215
Total Non-Current Liabilities	**(397,985)**	**(18,159)**	**(416,144)**	**(395,153)**	**20,991**
Total Assets Employed	**256,481**	**65,489**	**321,970**	**288,621**	**(33,349)**
Taxpayers' Equity					
Public Dividend Capital	258,929	65,489	324,418	339,327	14,909
Revaluation Reserve	63,492	5,352	68,844	68,844	0
Income and Expenditure Reserve	(65,940)	(5,352)	(71,292)	(119,550)	(48,258)
Total Taxpayers' Equity	**256,481**	**65,489**	**321,970**	**288,621**	**(33,349)**
Total Funds Employed	**256,481**	**65,489**	**321,970**	**288,621**	**(33,349)**

The main movements in NHS Trade and other receivables since Month 9 (when they stood at £110m) are a reduction of £11.5m due to central income received during January, and an increase of £5.3m in the prepayment for CNST negligence premiums in M10.

The slower than anticipated capital expenditure is temporarily improving the cash balance.

The working capital position reflects the normal pattern of movement for this period of the financial year and is consistent with the trend noted in the prior year.

Cash Flow



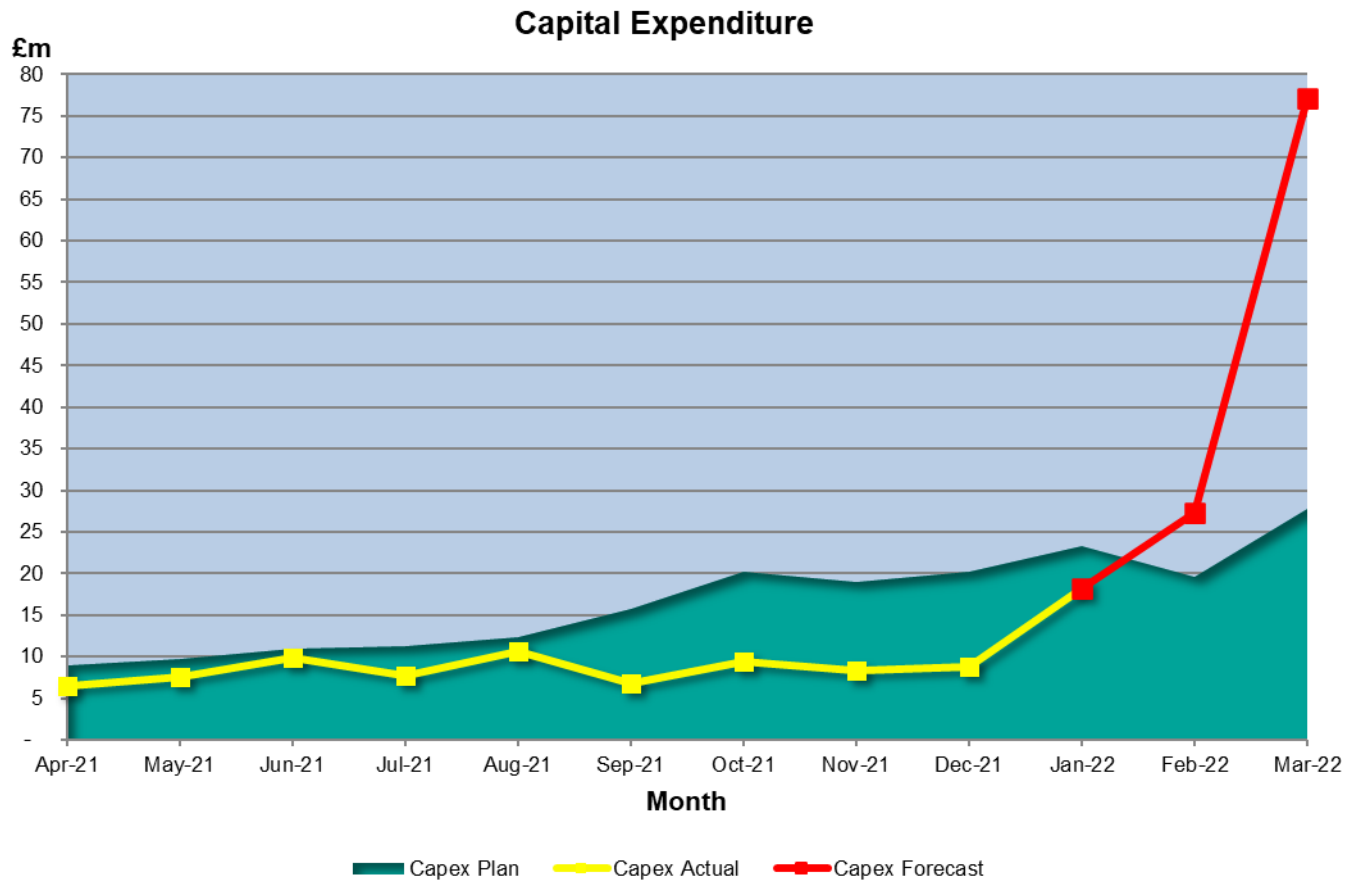
A reasonable measure of the level of liquidity required for the Trust could be that the amount of operational working capital consumed in 10 days which is £59.3m. Clearly the current and forecast cash balances sit well above this level throughout the financial year, although five-year plans indicate substantial reductions in this balance, mainly through expenditure required on Capital projects.

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

As at 31st January 2022, the Trust had a cash balance of £290.3m. The cash balance was higher than forecast by £78.72m, this was primarily due to lower than forecast capital expenditure of £55m and cash received from NHSEI which was to fund the annual leave provision made at the end of 2020/21 against the backlog of untaken leave due to the Covid-19 pandemic.

The forecast cash for the remainder of the year has been amended to reflect that the Trust no longer expects the inflows of PDC of £25m and loans of £34m related to capital projects in the current year. The cash position and forecast remain the subject of close attention by the finance team and any further changes in the forecast will be communicated as they arise.

Capital Expenditure



In the period to 31st January 2022, £94.0m of capital expenditure has been recognised against a plan of £151.8m, an underspend of £57.7m, some £36.9m 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. The estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £20.8m underspend, the most material elements are: £8.3m relating to the NMGH emergency works which were due to be funded through Emergency PDC; £5.0m relating to Hive and is a result of expenditure on the EPIC production platform now being incurred in February and March; and £4.5m on the SARC relocation and the Wythenshawe and Trafford theatres which, due to delays, means expenditure will be incurred later than planned.

The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned expenditure into line with the GM system capital envelope. The total MFT plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £198.4m. This has increased from £179.3m in December predominantly due to the Trust receiving additional PDC funding for several schemes including £10.75m Digital Pathology and £4.2m Frontline Digitisation.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Jenny Ehrhardt, Group Chief Finance Officer
Date of paper:	March 2022
Subject:	Financial Plan 2022/23
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 of Directors is asked to note the work being undertaken through the Finance and Digital Scrutiny Committee on the annual financial plan for 2022/23 and to delegate authority to approve the Financial Plan to F&DSC.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Background

The Financial Plan for 2022/23 is in development and reaching a final position requires significant work with partners across Greater Manchester to determine the level of revenue system funding and the allocation of the system capital envelope between organisations. An initial draft plan of the MFT 22/23 position was presented to the Finance & Digital Scrutiny Committee on 17th February 2022, but the GM-wide discussions remain ongoing and so a final plan cannot be shared with the Board as yet.

All parts of MFT are developing their budgets which will form part of the overall financial plan, alongside the development of the waste reduction programme. Check and challenge meetings are continuing with Hospitals/MCSs/LCO and Corporate departments to verify the budgets and to understand any emerging cost pressures. Ultimately decisions will be taken amongst Executive Directors on the balance of risks associated with cost pressures.

Good governance would require that the Trust's overall plan is approved before the start of the financial year. A draft plan is required by NHSE/I by the 17th March and a final GM and Trust plan by the 28th April. To meet these reporting timelines an extraordinary F&DSC has been arranged on 29th March 2022 to scrutinise the budgets and financial plan.

Recommendation

The Board of Directors is asked to note the work being undertaken through the Finance and Digital Scrutiny Committee on the annual financial plan for 2022/23 and to delegate authority to approve the Financial Plan to F&DSC.

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:	March 2022
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

Integration White Paper

The white paper 'Health and social care integration: joining up care for people, places and populations' was published jointly by the health and communities departments on 9 February 2022. The paper sets out how the NHS and local government will work together to deliver for local communities.

Although strategic, at-scale planning will be carried out at the integrated care system (ICS) level, 'places' are seen as being the engine for delivery and reform. 'Places' will normally be top-tier local council areas and will operate under the ICS.

There is an expectation that all places within an ICS will adopt a place board model, or equivalent, by April next year. This will include a 'single accountable person' who will be accountable for the delivery of the shared plan and outcomes for the place. This will not however change the current accountability arrangements.

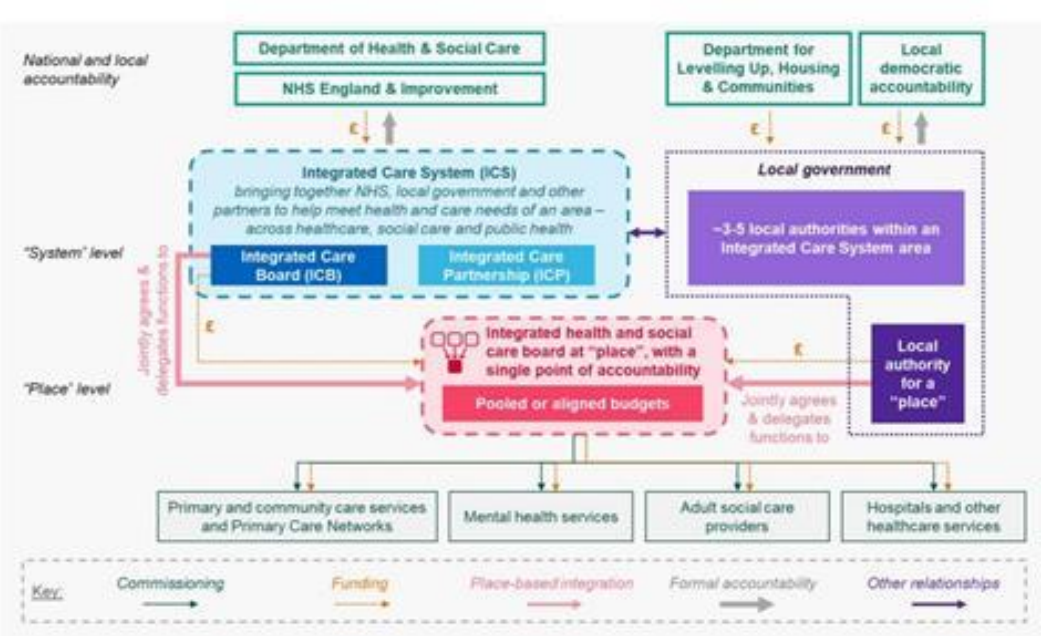
Places will develop and agree a 'shared outcomes framework', to try to avoid incentives pulling organisations in different directions. Implementation of shared outcomes will begin from April 2023, and there will be mandatory reporting against them.

The proposed model also envisages resources for health and care activity being held and overseen by the place-based board with increasing numbers of pooled or aligned budgets to support more integrated models of service delivery.

The paper proposes an 'ICS first' approach to digital integration and transformation. This includes encouraging organisations within an ICS to use the same digital systems to improve interoperability and provide care teams with an individual's information across a whole pathway

.

The diagram below sets out the potential governance arrangements but it should be noted that this is a simplified version and not a full representation of the richness, complexity and range of partnership working across the organisations within systems



3. Regional Issues

Greater Manchester ICS

The development of the Greater Manchester ICS and the appointment to the Integrated Care Board is continuing.

Two non-executive directors have been appointed. Richard Paver formerly City Treasurer at Manchester City Council and Treasurer has been appointed Chair of the Audit Committee. Shazad Sarwar, Managing Director at a specialist consultancy that provides strategic support and advice to the public, private and third sector has been appointed Chair of the Remuneration Committee.

We anticipate that an announcement will be made shortly confirming the appointment of the GM ICB Chief Executive.

The process to appoint to the other executive director posts (finance, medical and nursing) is in train.

The ten localities in Greater Manchester are continuing to develop their own proposals for how the local authority and health services will work together at place level.

4. MFT issues

MFT Single Services

The development of the operating models for those services that are provided across MRI, WTWA and NMGH had been paused due to COVID. The process has now recommenced and a group has been established to agree the arrangements that will best support the delivery of the benefits of the Single Hospital Service and the implementation of the clinical

services strategies. This work is being informed by the experience of the Managed Clinical Services in setting up and running MFT-wide services.

Annual Plan

The MFT Annual Plan for 2022/23 is being developed. Draft priorities for 2022/23 have been shared and discussed with the Council of Governors t the Annual Planning session and the draft Annual Plan document has been circulated for comment. The final plan will be presented to the Board in April for approval.

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 Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Emma Orton, Head of Nursing, Quality, Patient Experience and Professional Practice Claire Horsefield, Head of Customer Services
Date of paper:	March 2022
Subject:	Complaints & PALS Report: Quarter 3, 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:	To improve the experience of patients, carers, and their families.
Recommendations:	The Board of Directors are asked to note the content of this Q3 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality And Patient Experience Tel: 0161 701 0909

1. Executive Summary

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaints activity across Manchester University NHS Foundation Trust (MFT) during Q3 (October – December) 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. Learning from complaints provides a rich source of information to support sustainable change.

1.3 This report provides:

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

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

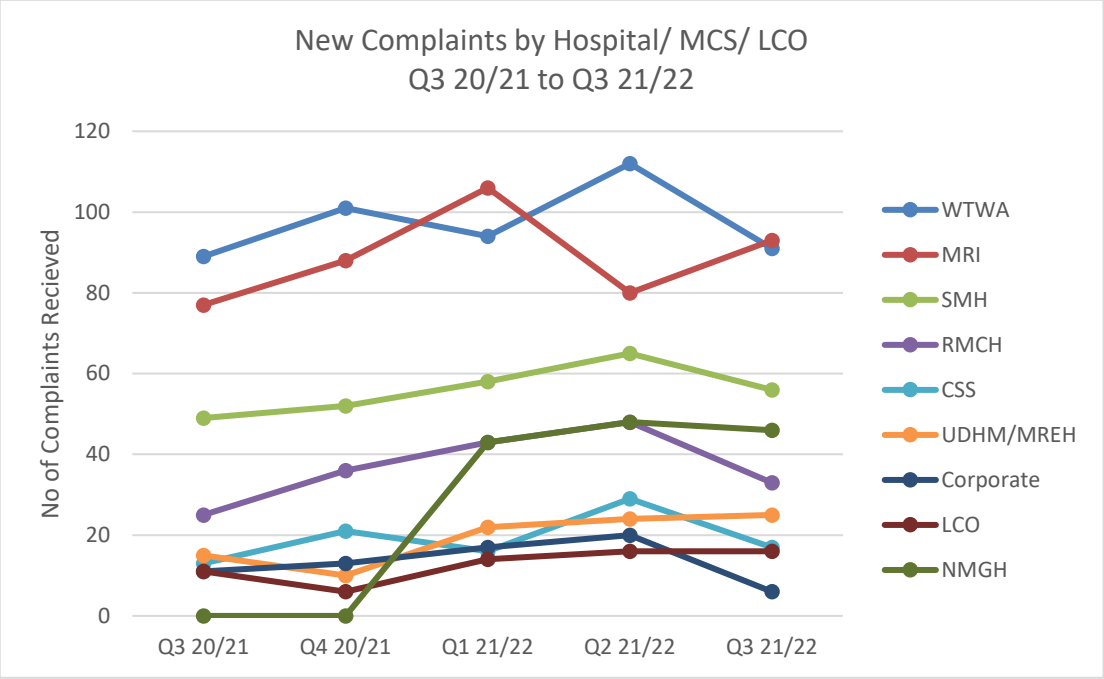
2. Q3 2021/22, summary of activity for PALS and Complaints Activity

- 1,866 PALS concerns were received in comparison to 1,958 received in the previous quarter. This shows an increase of 24.9% (465) for the same period in Q3, 2020/21[1].
- 383 new complaints were received in comparison to 442 received in the previous quarter. This shows an increase of 28.1% (108) for the same period in Q3, 2020/21[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
- 89.2% of complaints were closed within the agreed timescale compared to 87.1% in the previous quarter[3]. The Trust has a target of 90% of complaints to be responded to within an agreed timescale.
- 55 (11.0%) complaints investigated were upheld, 345 (69.0%) were partially upheld and 77 (15.4%) were not upheld (please refer to section 3:10)
- The PHSO closed 0 cases during this quarter. Details of the 'live' PHSO investigations are set out in **Appendix 1, Table 1**.
- A continued decrease in complaints relating to inpatient services was noted across the Trust.
- There was a total of 79 re-opened complaints received. This compares to 96, a 21.5% decrease compared to the previous quarter.
- 13 virtual or face to face complaint local resolution meetings were held.
- 3 in-house Complaints Letter Writing Training Educational Sessions were held, with 8 members of staff attending.

- The Complaints Review and Scrutiny Group (CRSG), chaired by a Non-Executive Director, met once during Q3. The senior management teams from Clinical Sciences Services (CSS) and the Local Care Organisation (LCO) each presented a case. The learning identified from these cases is detailed in Section 5 of this report.

3.0 An overview and brief thematic analysis of complaints contacts

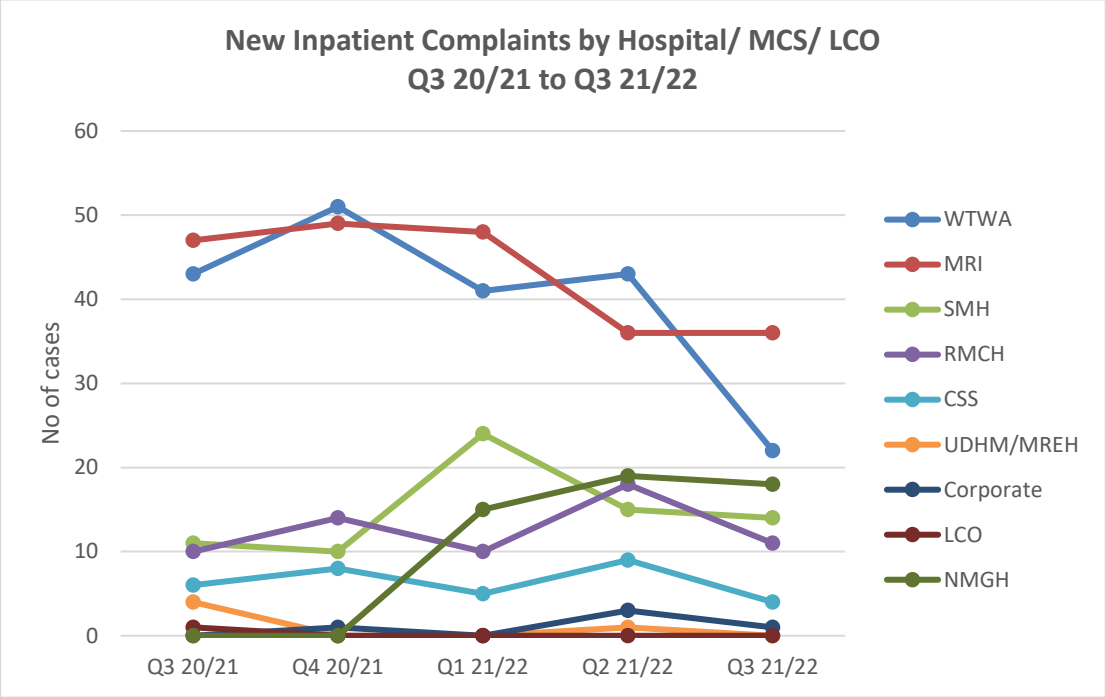
3.1 In Q3 the Trust saw a decrease in complaints with 383 new complaints being received. Graph 1 below shows the number of complaints received by each Hospital / MCS / LCO each quarter. Manchester Royal Infirmary (MRI) received the greatest number of complaints. Further detail is provided in Table 2, Appendix 1.



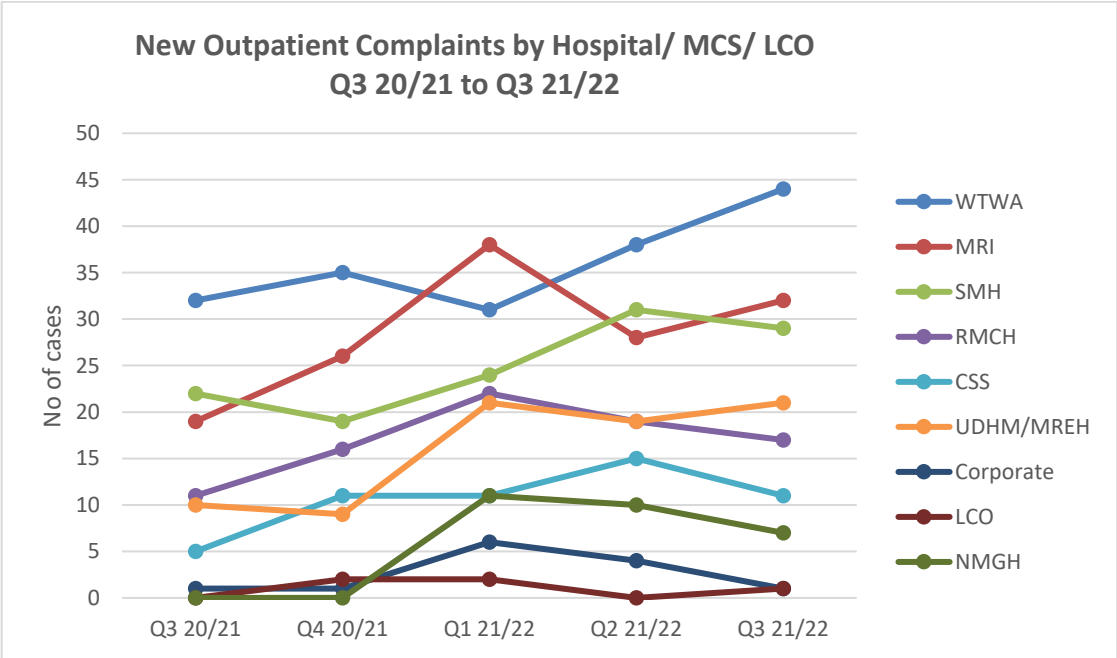
Graph 1: New Complaints Received by Hospital/MCS/LCO

3.2 **Graphs 2 and 3** illustrate the number of new complaints relating to inpatient and outpatient services during Q3 2020/21 – Q3 2021/22. Overall, the greatest increase in complaints relates to outpatients with a reduction in complaints relating to in-patient services being noted. The increase in complaints specifically relating to outpatient services coincides with the rise in waiting times for care and treatment, as a result of the impact of the COVID-19 pandemic on service provision.

[1] Contributed to by NMGH joining from 1st April 2021
[2] 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. The Trust met this indicator., **Appendix 1, Table 3** demonstrates the complaints acknowledgment performance.

4.0 Complaints resolved within agreed timescales

4.1 89.2% of complaints were closed within the agreed timescale representing a slight increase in comparison to the previous quarter, **Appendix 1**, **Table 4** provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

4.2 The oldest complaint case closed during Q3 was registered within Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) on 6th October 2020, and was 113 days old when it closed on 14th October 2021. The complaint involved the provision of third-party investigations at the Christie and Stockport NHS Foundation Trust, which resulted in WTWA not being able to provide a timely response. The complainant was kept updated and was fully supported throughout this process.

4.3 The oldest complaint cases open at the end of Q3 were two re-opened cases within Corporate Information Governance on 27th July 2021; both were 110 days old at the end of Q3, 21/22. Both complaints involved an essential in-depth detailed review of all documentation across multiple notes and IT systems which required specialist IT support. Regrettably due to delays were experienced during these processes impacting in the Trust's response times. The complainants were kept updated throughout the process.

5.0 Outcomes from Complaint Investigations

5.1 All NHS organisations and those delivering NHS services are required to submit quarterly returns to NHS Digital. The Hospital and Community Health Services Complaints Collection (KO41a) has been accepted by the Standardisation Committee for Care Information (SCCI) and is 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 to ensure both equity and excellence are key drivers to improve the patient experience and provide opportunity to listen to the public voice.

5.2 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating teams, the Corporate Complaints team review each of the issues raised to determine what happened. If failings are found in all the issues raised, and substantive evidence (evidence based on which a fact is proven) is identified to support the complaint, then the complaint is recorded as fully upheld. If failings are found in one or more of the issues, but not all, the complaint is recorded as partially upheld. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as not upheld.

5.3 During Q3, 55 (11.0%) of the complaints investigated and responded to were fully upheld, 345 (69.0%) were partially upheld and 77 (15.4%) were not upheld. **Appendix 1, Table 5** demonstrates the outcome status of all complaints between Q3 2020/21 and Q3 2021/22.

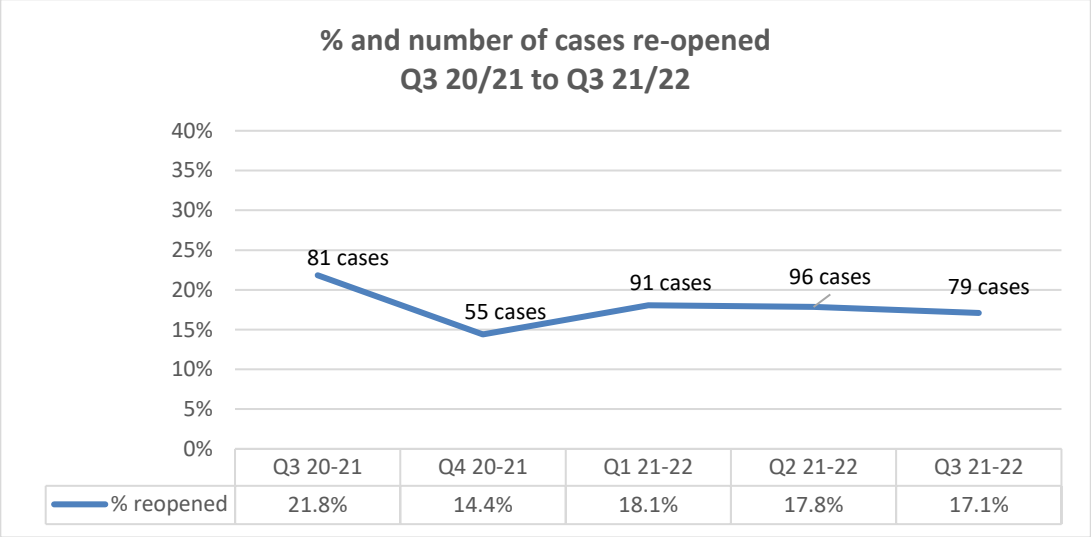
6.0 Re-opened complaints

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

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

6.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q3, 17.1% of complaints were reopened (79 cases in total) against the Trust tolerance threshold of 20%. In the previous quarter, 17.8% of complaints were reopened (96 cases in total).

6.3 **Graph 4** demonstrates the number of complaints re-opened from Q3 2020/21 – Q3 2021/22. **Appendix 1, Table 6** provides an overview of the primary reasons for the complaint being re-opened by Hospital/MCS/LCO during Q3.



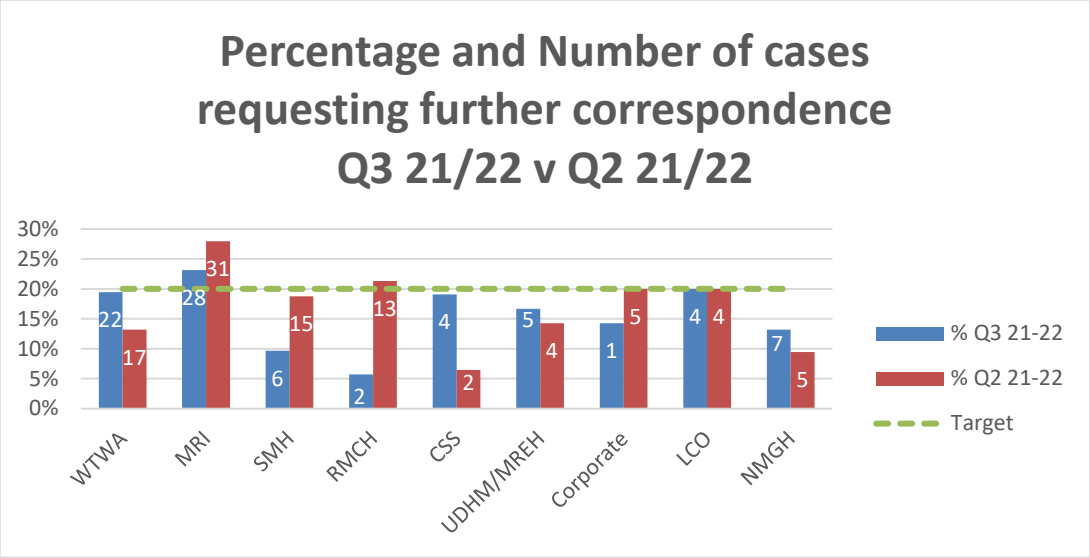
Graph 4: Total Re-opened complaints Quarter 3, 2020/21 to Quarter 3, 2021/22

6.4 In 46 of the 79 complaints requiring re-opening, the primary reason was due to the complainant being 'dissatisfied with the response', with WTWA and MRI receiving the greatest number, 22 and 28 respectively.

6.5 The 20% threshold was exceeded by MRI at 23.1% **(Graph 5)**

6.6 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 are low, which is the case for CSS, UDHM/MREH, Corporate Services and the LCO.

6.7 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.

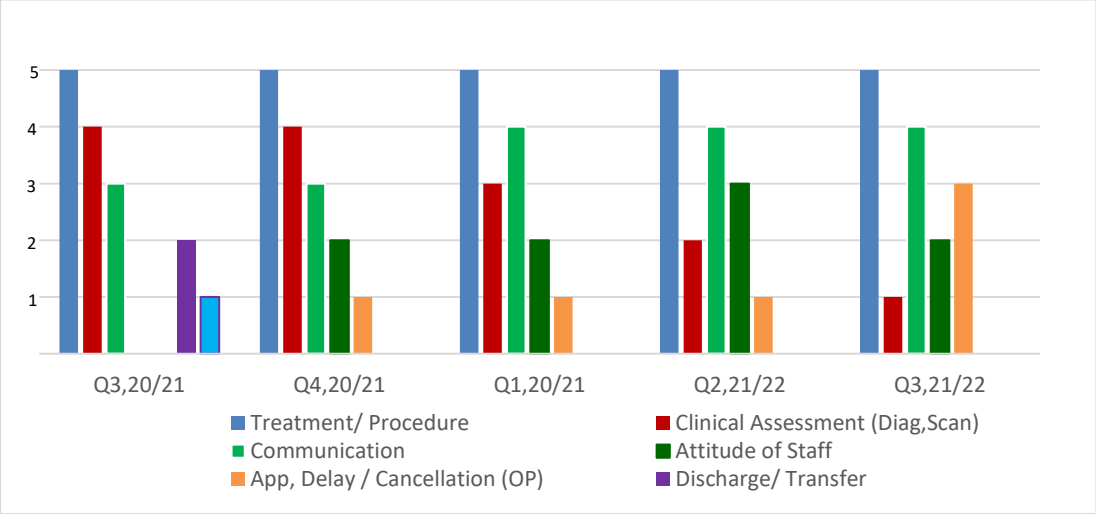


Graph 5: Percentage and number of re-opened complaints, Quarter 3, 2021/22

7.0 Brief thematic overview of complaints

7.1 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.

7.2 During Q3, the top 5 primary categories remained unchanged with Treatment / Procedure' remaining the top category **(Graph 6)**.

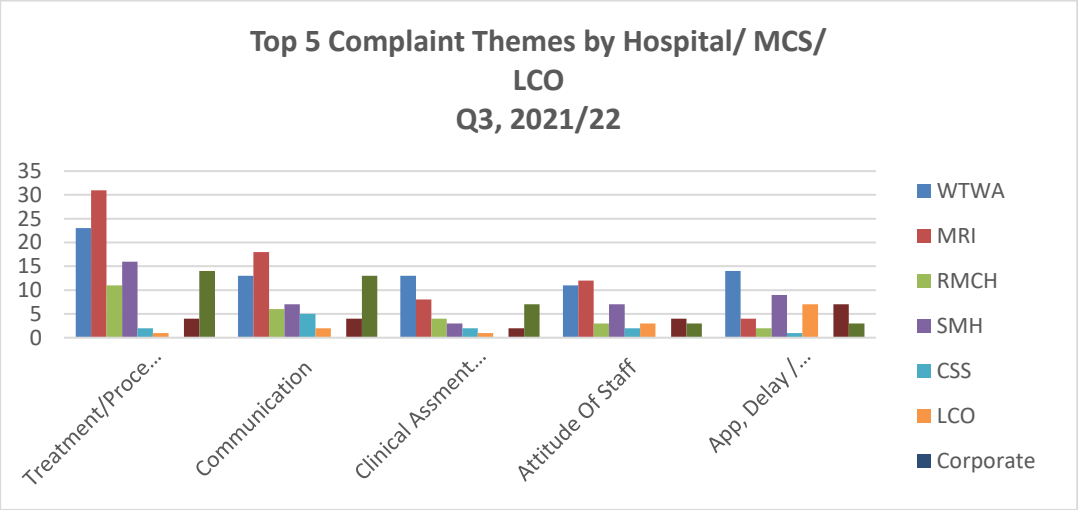


Graph 6: Top Primary Complaint Themes Q3, 2020/21 to Q3, 2021/22

7.3 MRI received the most complaints relating to 'Treatment/Procedure', some examples include:

- a patient experiencing delays in appointments, scan results and plan of care
- a patient experiencing an unexpected outcome following surgery resulting in readmission to hospital and emergency surgery

7.4 **Graph 7** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q3 2021/22.



Graph 7 Top 5 themes by Hospital/MCS/LCO in Q3 2021/22

8.0 Care Opinion and NHS Website feedback

8.1 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.

8.2 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 7** below provides examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q3.

Quarter 3, 2021/22
Wythenshawe, Trafford, Withington and Trafford Hospitals
"*New clinic at Withington Community Hospital*" I took my wife to a new clinic for long term ventilation, an outreach location from the usual site at Wythenshawe Hospital. We found the whole experience very satisfactory, from parking to the usual professional treatment from welcoming doctors and nurses. Hopefully, this site will have a successful trial, and continue to be fully utilised.
Response

Thank you for posting your positive comments on NHS website about the new clinic at Withington Hospital. It is great to hear that you and your wife found the experience from the parking facilities to the professional treatment from doctors and nurses very satisfactory. We feel that comments like these reflect the hard work and dedication of our staff and are grateful to receive them as well as your feedback about the clinic continuing as a service after the trial. I can assure you that we have passed on your comments to the Head of Nursing who will share with the staff involved.

Manchester Royal Eye Hospital

"Very disappointed"
Attended A&E Ophthalmology with a relative after they were referred by their optician. We arrived at 11 am and left at 4.30 pm and we did not mind the long wait as we were grateful to be seen. When we left the hospital, we were told that a two week follow up would be arranged and given appropriate medication to cover that period. One month later no appointment has been received and the medication has run out on more than one occasion. This has been quite costly and as the condition has not really improved and no review received, is the prescribed medication still relevant? We are so disappointed at the level of communication and aftercare. Eyesight is precious, the person concerned has paid into the NHS for many years and never misused it. We are so disappointed, and we did expect far better from this hospital.

Response

The Matron for the Eye Emergency Department would like to thank you for your feedback of the service and is sorry for your concerns caused by the lack of communicating regarding the follow up appointment. The Matron is sorry that you and your relative had a longer wait in the Eye Emergency Department but acknowledges your positive comments about the care and treatment your received whilst you were here. It is difficult to respond to all posts in a full way often because of a lack of detailed information, in order for the hospital to pursue your concerns regarding the follow up appointment and ongoing medication we would need the details of your relative who attended the department. If you would like to discuss your experience with us in more detail, please do not hesitate to contact the Matron directly on 0161 276 5234.

Saint Mary's Hospital

"Can't thank you all enough"
I was booked in for a next day induction by my consultant, who had given me brilliant advice and assistance throughout my difficult pregnancy. I was induced due to how ill I was with an Ulcerative Colitis flare. The induction ward was so busy that we couldn't start in a private room. The staff were amazing, so helpful and friendly though and my experience was made so much easier by their help. The student midwife and midwife that were looking after me were both amazing and attentive. The student midwife will make a brilliant midwife, I couldn't have asked for anyone better to be looking after me. In the delivery suite I was assisted by many people. All of you were amazing and the birth of my daughter went really well. I was so well looked after! Everyone's attitude was so supportive and positive. Unfortunately having my waters broken was unusually extremely painful (people I know said this wasn't painful for them, but it was for me) and my contractions weren't monitored correctly due to a cracked monitoring unit, but these weren't big issues as the birth went so well. The midwife and student midwife knew that I was at the pushing stage even though there was this problem. Once on the ward I was also taken care of so well. A midwife on the night shift helped me with breastfeeding and checked on my daughter regularly in the night. The midwife looking after me during the day also sorted out and took me for my COVID vaccination and was so lovely and attentive. All the staff on the ward were great and so helpful. Everyone was so busy but made me feel supported and at ease and couldn't do enough for me. From my booking appointment to my discharge, everyone that I saw was so lovely, I can't thank you all enough.

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 the Clinical Head of Division for Obstetrics and Head of Midwifery 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.
North Manchester General Hospital
"Great hard working caring staff" Excellent caring professional staff on Ward C4. I was here for 6 days with no visitors allowed. I was so scared after my long 9-hour operation. The staff treated me like they were my family. Thank you so much each and every one of you.
Response
Thank you for taking the time to share your positive feedback on the NHS Website regarding your care at North Manchester General Hospital on Ward C4. We are pleased to read that the staff were warm, reassuring and treated you like family during what was a difficult and scary time for you. It was kind of you to compliment the staff as it is good to receive positive feedback which reflects their hard work and dedication. We have shared this with the Head of Nursing, who will share with the staff involved. In the meantime, we wish you a speedy recovery.

Table 7: Examples of Care Opinion/ NHS Website Postings and Reponses Q3 2021/22

8.3 This quarter a total of 30 comments were received via the websites, of which 21 (70.0%) were positive, 7 were negative (23.0%) and 2 were mixed (07.0%). The number of Care Opinion and NHS Website comments by category; positive, negative, and mixed, are detailed in**, Appendix 1**. **Table 8**

9.0 Learning from Complaints

9.1 This section of the report provides examples of improvements made in response to feedback from complaints. Further detail is provided in Section 6, which outlines the opportunities being explored to support learning and transformation through shared vision, and positive change through open dialogue and reflection.

9.2 Patient complaints offer intelligence that can be used to change practice and improve patient experience and outcomes. Whilst the focus on the performance of managing and responding to complaints is key it is also important that there is a clear intent to ensure that learning from the outcomes of complaints is shared, and improvements are acted upon and disseminated widely to improve patient experience.

9.3 During Q3 2021/22 the Complaints Review Scrutiny Group, chaired by a Non-Executive Director, met once. The management teams from CSS and NMGH each presented a case in November 2021. Learning and associate actions identified from the two cases were discussed and provided assurance that complaints are investigated, and appropriate action taken when needed. Outcomes from the 2 cases discussed are provided in **Table 9** below.

Hospital / MCS / LCO	Learning	Actions
CSS	We learnt that: • A patient's surgery was cancelled due to a lack of anaesthetist availability • Inaccurate information was available to staff regarding patient's results being accessible across all sites	• Explore the integration of the Anaesthetic Rota in to Hive • Raise awareness by: – Improving staff communications - Liaising with the Trust's Medical Directors across all sites
NMGH	We learnt that: • Visiting guidelines were not applied for patients with a recognised mental health condition during restricted visiting • No communication system was in place on the AMU to provide families with regular updates during restricted visiting • Patient' using their own means of communication was poorly facilitated	• Development of a 'What to Expect During Restricted Visiting' patient information leaflet/poster • Systems put in place to provide next of kin/nominated family member with appropriate updates and discharge planning arrangements • Complaint shared with staff • Key themes from the complaint shared at 'Themes of the Week' • Explore the reintroduction of Hospital Volunteers in the area • Expedite resolution of NMGH website signposting patient's/carers to NCA rather than MFT

Table 9: Actions identified at the Trust Complaints Scrutiny Group during Q3 2021/22

10.0 Hospital /MCS/ LCO Learning from complaints

10.1 Each Hospital/ MCS/ LCO holds regular forums where themes, trends relating to complaints are discussed with focused actions agreed for improvement.

10.2 Detailed below, in **Table 10**, 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
SMH	Poor communication, and outpatient/treatment appointment delays and cancellations experienced within Gynaecology Services. (14 formal complaints received in total, (6 – poor communication, 8 appointment delays/cancellations))	In view of the difficulties patients have experienced with appointment cancellations and delays, the Senior Leadership team within Gynaecology have reviewed all cases and undertaken a triage process as agreed by the Royal College of Obstetrics and Gynaecology enabling each patient to be assigned one of four levels prioritising patients with or suspected cancers. Each patient is advised of their triaged level to better manage their expectations in timescale for treatment and reassured that their cases will be reviewed in the event of a change of condition. The challenge of administrative and communication delays experienced by the patients has been severely compromised by workforce issues which the Senior Management Team within the Division are currently working hard to rectify through staff recruitment and improved telecommunication links.
MREH	Concerns regarding the waiting time in clinic and staff's lack of concern and nonchalant manner whilst questioning the delay in being seen in clinic. the shortage of seating in the waiting area.	Departmental process (Intentional/Patient Focused Rounding) developed and implemented to provide patients with timely updates throughout the clinic session in relation to waiting times and/or delays. In line with current IPC Guidance seating capacity in the clinic waiting areas to be regularly reviewed. As part of the improvement work streams the Outpatients Department capacity and utilisation to be reviewed.
UDHM	Concerns regarding the treatment received, the clinician's attitude, and the lack of lighting, cleanliness, and music in the treatment room.	Concerns shared and clinician supported in reflecting on the events leading to the complaint. Clinician reminded of the importance of communicating effectively with their patients.
CSS	Lack of privacy and dignity – Confidential discussion had with patient on a public corridor.	Concern shared and radiographer supported in reflecting on the events leading to the complaint.

		Radiographer reminded of the importance of ensuring private and sensitive communications are undertaken in a private setting.
RMCH	Concerns regarding a mother recently having given birth via caesarean section and provided with a camp bed to facilitate another child's admission.	Arrangements made to purchase high back chairs for breast feeding mothers. Nursing team reminded of the importance of liaising with the Bed Management Team to establish bed status in other areas of the hospital. Nursing team reminded of the importance of the need for children's specific beds to be returned to the Children's Ward.
NMGH	Concerns regarding a delay in treatment being received in the Emergency Department, poor communication and staff not displaying empathy.	Complaint shared at the PED team meeting regarding communication and explanation of treatment. Cleaning schedules reviewed. Review in progress of senior paediatric decision makers/ competencies within the department. Patient's poor experience shared at the senior team meeting. Staff reminded of the importance of medication review prior to discharge. Staff reminded of the importance of providing clear instructions to patients on the use of EpiPen. Staff reminded of the importance of ensuring all patients who are assessed to be in pain are provided with adequate pain relief.
WTWA	Concerns raised relating to patient's consultation and lack of empathy received from consultant.	Concerns shared and reflection undertaken. Learning to be shared in the departmental meeting. Standards of communication reiterated to all staff.
LCO	Impact of a staff member's abrupt manner and lack of empathy towards the patient.	All relevant staff members to undertake advanced communication skills training.

		All staff to be reminded of the importance of clear communications the purpose and procedure of an initial assessment visit, the reason for gaining a range of information and how this information will be made available to other team members.

Table 10: Examples of the application of learning from complaints to improve services, Q3 2021/22

11.0 Quality Improvements during Q3 2021/22 included

11.1 PHSO'S NHS Complaint Standards 2021-22 Pilots – Evaluation Framework – Early Adopter Group

11.1.1 The PHSO's NHS Complaint Standards, model complaint handling procedure and guidance sets out how organisations providing NHS services should approach complaint handling. The Standards aim to support organisations in providing a quicker, simpler, and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on how learning should be used to improve services.

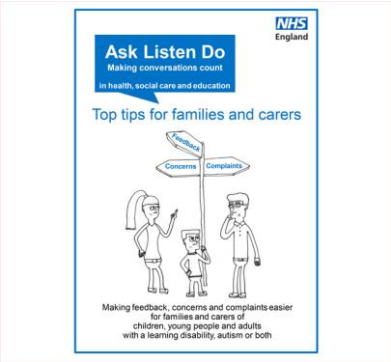
11.1.2 The Complaint Standards are based on 'My Expectations', which set out what patients expect to see when they make a complaint about health or social care services. The Standards and the guidance modules developed by the PHSO describe how staff can meet those expectations. The Standards and the supporting materials are currently being tested and to make sure the PHSO receive as much feedback as possible they are asking organisations to participate in their 'Early Adopters' Group of the Complaint Standards.

11.1.3 The Trust has accepted the request by the PHSO to participate in the 'Early Adopters' Group and participation commenced in Q3. The PHSO plan to use all feedback from the group to look at the short-term impact of the Standards, alongside looking at what it tells them about the longer-term benefits the Standards could bring and what needs to be done to improve them. The PHSO plan to refine and introduce the Standards across the NHS in 2022/23.

11.2 In house E-Learning Customer Service – Module 2, PALS, and Complaint's package

11.2.1 Work continued in this quarter and will continue during Q4 designing the PALS and Complaints Customer Service Advanced e-learning package. Completion of the newly developed advanced e-learning package will be completed in Q1, 22/23.

11.3 **Ask, Listen, Do commitment**



11.3.1 Ask, Listen, Do is an NHS England initiative which 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.

11.3.2 The Trust is committed to making a difference and ensuring young people, and adults have equal access to the PALS and Complaints service at the Trust. This is an important piece of work and during Q3 the PALS and Corporate Complaints team put the Trust's commitment into action. Work will continue throughout Q4 exploring what the services can do to improve the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service.

11.3.3 Further details on Ask Listen Do are available on the NHS England website (www.england.nhs.uk)[3]

12.0 Education

12.1 Following the launch in Q3, 2020/21, the In-house Complaints Letter Writing Training Package has been available to all staff across the Trust via the Learning Hub's Big Blue Button. Since the launch 181 people have accessed the training session.

13.0 Learning from Complaints - Enhancing how MFT demonstrates learning in practice across the Hospitals/MCS/LCO

13.1 A combination of approaches continues to be explored through the Quality and Patient Experience Forum and staff education and training, which will provide a prime opportunity to expand knowledge and share good practice. This includes Bee Brilliant as wells as:

13.1.1 **A Faculty of Learning**

To support the Trust to learn from complaints the aim of the internal initiative would be to showcase educational learning material and resources developed by the Corporate PALS and Complaints team.

13.1.2 **Development of a PHSO/Complaints 'upheld' Learning Sub-Group**

With the intention of the introduction of a Learning Sub-Group the Head of Customer Service is currently exploring how best practice can be shared across all complaint work streams. The sub-group would ensure oversight of all PHSO action plans and seek assurances and review the impact of learning from the PHSO reviews and 'upheld' complaints across Hospital/MCS/LCO.

13.1.3 **Development of an In-house Module 3 E-learning Customer Services – PALS and Complaints package**

[3] https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/

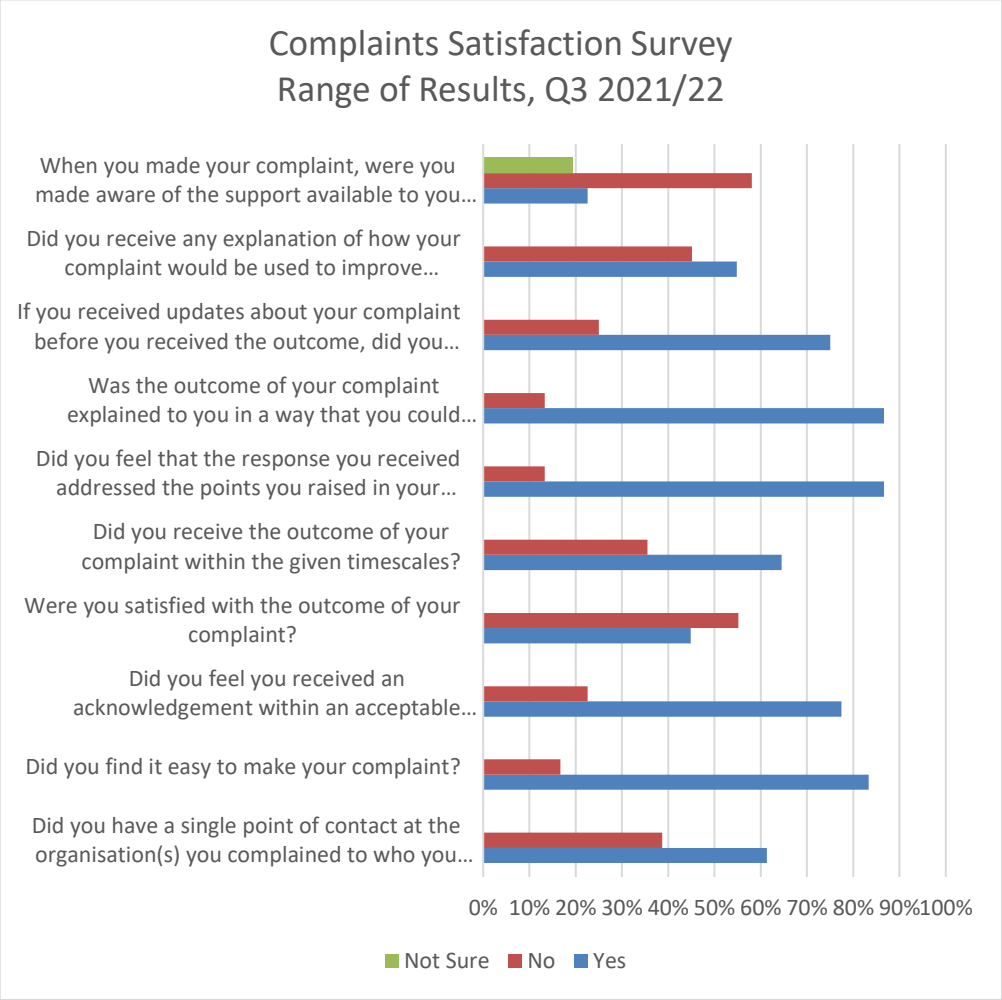
Discussions are planned throughout 22/23 for the Head of Customer Services and Assistant Chief Nurse - Professional Education, Development and Workforce to combine and demonstrate learning from complaints within Continuing Professional Development (CPD). The outcome of which will be presented in Q4's report.

14.0 Complainant's Satisfaction Survey

14.1 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 Q3, 497 surveys were distributed, with 30 questionnaires returned; the results are shown in **Graph 8** below. As in previous quarters, collection of these surveys remains inconsistent. The Corporate PALS and Complaints team are currently reviewing how this process can be enhanced further to ensure complainants are offered alternative methods of submitting their response thus ensuring accessible information standards are met.

14.2 There is a continued increase in the number of complainants reporting that the response they received addressed the points they raised in their complaint, which correlates to the noted decrease in re-opened complaints.

[4] https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf



Graph 8: Complaints Satisfaction Survey results for Q3 2021/22

14.3 The following are examples of feedback from complainants. Listening to complainant feedback provides staff with opportunities to improve the standard of care and service provided. Comments received during Q3 2021/22 include the following:

"Reply was factually inaccurate. Didn't address my complaint and when I rang the number given on the letter and left two messages – no reply to these calls."

"When I was admitted for my surgery 4/52 later, I was treated differently in a better way."

"I got explanations I felt more listened to."

"I feel it was investigated appropriately and thoroughly, I feel the staff member in question will learn from this and hopefully improve their behavior. I received a telephone call to explain that there had been delays in the response but to assure me that it was being dealt with, so I was pleased with this. I am over the moon with the outcome and the fact that other parents will not have to experience similar difficulties in a very stressful and worrying time in their lives.

15.0 Planned Improvements

15.1 Several areas for improvement and development have been identified for Q4, 21/22 and throughout 2022/2023, including the following activities:

- Relocation of the PALS office and Reception to a new, more visible location within NMGH
- Optimising learning from Complaints via Quality and Patient Experience forums.
- Development of a PHSO Learning Sub-Group
- PALS and Complaints team working and objective setting through the Affina Team Journey
- Initiation of PALS and Complaints Safeguarding Supervision and Training Sessions
- Development of dedicated PALS Volunteer role

- Enhancement of learning and actively communicating Complainant Satisfaction Survey feedback
- Equality and Diversity Audit: PALS and Complaints Handling
- Heightening of PALS and Complaints training across Hospitals/MCSs/LCO
- Review of Complaints and Incidents pathways
- Using the Complaint Quality Audit and Analysis tool quality standards spot checks and reviews to be undertaken every 3 months of Hospital/MCS/LCO complaint response letters.

16.0 Equality and Diversity Monitoring Information

16.1 The collection of equality and diversity data is shown in Appendix 1, Table 15. As in previous quarters, collection of this information remains inconsistent.

16.2 Improved collection was found in relation to 'gender' data (99.0%), however continued evidence of the ongoing need to improve reporting on 'disability', 'religion' and 'ethnicity' was identified; only 10.1%, 21.6% and 40.7% being received respectively.

16.3 The PALS and Complaints Manager is currently looking at ways of improving the collection of this data with consideration to be given to triangulation of data in qualitative research. The triangulation data collection method facilitates validation of data through cross verification from several sources, for instance the Inpatient Survey, Incidents. It will test the consistency of findings obtained through different tools and increase control and assess, some of the causes influencing our results.

17.0 Conclusion and recommendations

17.1 This report provides a concise review of matters relating to Complaints and PALS during Q3. 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.

17.2 The Board of Directors are asked to note the content of this Q3 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of PHSO Cases open as at 31st December 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 Final Report
WTWA (3)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Meeting with PHSO & MFT 23.12.21 PHSO re-reviewing evidence – await outcome
Surgery	1	Awaiting Provisional Report
RMCH (1)		
CAMHS	1	Awaiting Provisional Report
TOTAL	**7**	

Table 2: Number of Complaints received by Hospital/ MCS / LCO Q3 2020/21 – Q3 2021/22

	Q3,20/21	Q4,20/21	Q1,20/21	Q2, 21/22	Q3, 21/22
WTWA	89	101	94	112	91
MRI	77	88	106	80	93
SMH	49	52	58	65	56
RMCH	25	36	43	48	33
CSS	13	21	16	29	17
UDHM/MREH	15	10	22	24	25
Corporate	11	13	17	20	6
LCO	11	6	14	16	16
NMGH	0	0	43	48	46
Grand Total	**290**	**327**	**413**	**442**	**383**

Table 3: Complaints Acknowledgement Performance

3 Day Target	Q3, 20/21	Q4, 20/21	Q1, 21/22	Q2, 21/22	Q3, 21/22
100% acknowledgement	100%	100%	100%	100%	100%

Table 4: Comparison of complaints resolved by timeframe: Q3 2020/21 – Q3 2021/22

	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22
Resolved in 0-25 days	272	241	286	296	332
Resolved in 26-40 days	21	15	24	55	53
Resolved in 41+ days	47	35	39	77	115
Total resolved	**340**	**291**	**349**	**428**	**500**
Total resolved in timescale	**325**	**273**	**325**	**373**	446
% Resolved in agreed timescale	**95.6%**	**93.8%**	**93.1%**	**87.1%**	**89.2%**

Table 5: Outcome of Complaints, Q3 2020/21 – Q3 2021/22

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q3,20/21	340	57	189	79	7	7	0	1
Q4,20/21	291	25	184	70	3	8	1	0
Q1,21/22	349	34	242	62	3	6	1	1
Q2,21/22	428	47	277	84	8	9	2	1
Q3,21/22	501	55	345	77	10	12	1	1

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	4	1	4	13	22
MRI	6	5	4	13	28
SMH	0	0	0	6	6
CSS	2	1	0	1	4
RMCH	0	0	0	2	2
UDHM/MREH	0	1	1	3	5
Corporate	0	0	0	1	1
LCO	0	0	0	4	4
NMGH	0	1	3	3	7
Grand Total	**12**	**9**	**12**	**46**	**79**

Table 8: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q3 2021/22

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q3 21/22			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	**3**	**1**	**1**
WTWA	**8**	**1**	**0**
CSS	**2**	**0**	**0**
Corporate	**0**	**0**	**0**
UHDM/MREH	**1**	**3**	**0**
LCO	**0**	**0**	**0**
RMCH	**2**	**0**	**0**
SMH	**2**	**0**	**1**
NMGH	**3**	**2**	**0**
Grand Total	**21 (70.0%)**	**7 (23.0%**	**2 (07.0%)**

Table 11: Number of PALS concerns received by Hospital/ MCS/ LCO Q3 2020/21 – Q3, 2021/22

	Q3,20/21	**Q4,20/21**	**Q1,21/22**	**Q2,21/22**	**Q3,21/22**
WTWA	382	390	459	490	461
MRI	439	448	406	480	468
RMCH	128	140	172	149	175
UDHM/MREH	84	128	130	156	122
SMH	203	233	253	255	262
CSS	101	82	124	153	137
Corporate	58	57	62	46	40
LCO	24	14	25	35	20
R&I	3	1	0	1	6
Nightingale NW (NNW)	2	4	0	0	0
NMGH	0	0	203	193	175
Grand Total	**1424**	**1497**	**1834**	**1958**	**1866**

Table 12: Closure of PALS concerns within timeframe Q3 2020/21 – Q3, 2021/22

	Q3,20/21	**Q4,20/21**	**Q1,20/21**	**Q2,21/22**	**Q3,21/22**
Resolved in 0-10 days	1337	1306	1599	1725	1761
Resolved in 11+ days	112	152	181	246	220
% Resolved in 10 working days	**92.3%**	**89.6%**	**89.7%**	**87.5%**	**88.9%**

Table 13: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Q3 2020/21 – Q3, 2021/22

	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22
WTWA	17	27	32	53	41
MRI	42	45	36	71	78
RMCH	7	16	20	17	32
UDHM/MREH	7	5	15	12	3
SMH	22	38	30	39	25
CSS	9	9	10	14	13
Corporate	7	6	21	10	11
LCO	1	5	2	6	3
R&I	0	0	0	0	0
NNW	0	1	0	0	0
NMGH	0	0	15	24	14
Grand Total	**112**	**152**	**181**	**246**	**220**

Table 14: Number of PALS concerns escalated to formal investigation Q3 2020/21 – Q3 2021/22

	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22
No of cases escalated	10	17	20	25	22

Table 15: Equality and Diversity Monitoring Information

	Q3,20/21	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22
Disability					
Yes	12	13	26	28	24
No	8	9	8	12	15
Not Disclosed	270	305	379	402	344
Total	**290**	**327**	**413**	**442**	**383**
Disability Type					
Learning Difficulty/Disability	0	1	0	1	0
Long-Standing Illness or Health Condition	15	18	16	19	10
Mental Health Condition	5	3	6	5	6
No Disability	0	0	0	0	0
Other Disability	0	3	5	4	4
Physical Disability	3	2	1	5	1
Sensory Impairment	2	1	2	2	1
Not Disclosed	265	299	383	406	361
Total	**290**	**327**	**413**	**442**	**383**
Gender					

Man (Inc Trans Man)	115	133	147	169	151
Woman (Inc Trans Woman)	167	190	256	270	228
Non-Binary	0	0	0	0	0
Other Gender	1	0	0	1	0
Not Specified	7	4	9	2	4
Not Disclosed	0	0	1	0	0
Total	**290**	**327**	**413**	**442**	**383**
Sexual Orientation					
Heterosexual	64	92	75	96	63
Lesbian / Gay/Bi-sexual	2	4	4	4	1
Other	0	0	0	0	0
Do not wish to answer	0	5	3	3	4
Not disclosed	224	226	331	339	315
Total	**290**	**327**	**413**	**442**	**383**
Religion/Belief					
Buddhist	0	3	0	0	0
Christianity (All Denominations)	36	61	48	51	44
Do Not Wish to Answer	3	0	0	4	4
Muslim	3	11	5	8	10
No Religion	18	21	25	38	20
Other	2	0	0	1	0
Sikh	0	0	1	0	0
Jewish	2	0	3	1	3
Hindu	1	3	0	0	1
Not disclosed	224	227	331	338	300
Humanism	1	1	0	0	1
Paganism	0	0	0	1	0
Total	**290**	**327**	**413**	**442**	**383**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	1	1	3
Asian Or Asian British - Indian	4	6	6	2	3
Asian Or Asian British - Other Asian	2	0	3	7	3
Asian Or Asian British - Pakistani	6	17	3	10	7
Black or Black British – Black African	4	5	6	3	7
Black or Black British – Black Caribbean	2	3	0	2	6
Black or Black British – other Black	1	1	1	0	3
Chinese Or Other Ethnic Group - Chinese	1	1	0	1	1
Mixed - Other Mixed	5	3	0	2	2
Mixed - White & Asian	2	1	2	0	0
Mixed - White and Black African	0	1	0	1	1
Mixed - White and Black Caribbean	1	3	1	1	1
Not Stated	54	58	79	92	98

Other Ethnic Category - Other Ethnic	2	4	5	2	0
White - British	116	147	160	145	103
White - Irish	7	3	5	9	4
White - Other White	5	4	2	4	12
Not disclosed	77	69	139	160	129
Total	**290**	**327**	**413**	**442**	**383**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Dr Sarah Vause Medical Director SM MCS Mrs Kathryn Murphy, Director of Nursing and Midwifery, SM MCS
Date of paper:	March 2022
Subject:	Maternity Services Assurance Report (incorporating the Ockenden Report assurance framework, CNST MIS Safety Action 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:	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 are asked to: • Note the overall content of the paper and the assurance provided in relation to the Governance infrastructure in place across SM MCS to support the implementation of the Ockenden recommendations the Maternity self-assessment tool and NHS Resolution Maternity Incentive Scheme • Note the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety
Contact:	Name: Alison Haughton, Acting CEO, SM MCS Tel: 0161 276 4738

1. Purpose of paper

1.1. This paper provides:

- Assurance to the Board of Directors on matters relating to patient safety within maternity services, inclusive of themes identified from clinical incidents, shared learning and monitoring of actions.
- An update provided in respect of the Ockenden Report[1], and the NHS England and Improvement (NHSE/I) maternity self-assessment tool (MSAT) submission
- Progress regarding all key Safety Actions linked to the Clinical Negligence Scheme for Trusts Year 4 Maternity Incentive Scheme (MIS), inclusive of Perinatal Mortality Reviews; maternity data reporting; Avoiding Term Admissions In Neonatal units (ATAIN); staffing for all relevant professional groups; Service user feedback; training for all relevant professional groups; maternity safety champions; and referrals to Healthcare Safety and Investigation Branch (HSIB) reports

2. Patient Safety

2.1. As previously reported to the Group Board of Directors, governance processes are in place within Saint Mary's Managed Clinical Service (SM MCS) through which assurance in respect of patient safety is obtained. This is inclusive of external reviews of all incidents classified as moderate and above reported to Greater Manchester and East Cheshire (GMEC) Local Maternity System (LMS) Patient Safety Special Interest Group.

2.2. Incident data inclusive of numbers detail and learning for Quarters 1, 2 and 3 2021/2022 was reported to the Board in the January 2022 paper, except for one incident from Q3. This was a COVID-19 related maternal death in December 2021which occurred at 53 days postpartum (late maternal death) and in line with national guidance has been reported to MBRRACE-UK. A joint mortality review is planned between ICU and Obstetrics. The woman had been offered but declined COVID19 vaccination during her pregnancy.

2.3. At the time of writing Only January data is available and as such Quarter 4 data will be fully reported to the May 2022 Board and February data will be reported verbally.

2.4. Table 1 illustrates incidents reported in January 2022.

Table 1

	January 2022	
	Number	%
No avoidable harm incidents	496	92
Slight avoidable harm incidents	42	7.79
Moderate incidents	1	0.18
Catastrophic Incidents	0	0
Total Incidents	539	

2.5. In January 2022 there was one case reported in the moderate avoidable harm category due to an avoidable delay in delivering the baby. Following review by the Consultant Obstetrician an emergency caesarean section was performed and the baby was admitted to the Neonatal Unit. HSIB investigation is in progress.

[1] Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES at the Shrewsbury and Telford Hospital NHS Trust. December 2020

2.6. There were no catastrophic harm incidents reported in January 2022.

2.7. In line with the Ockenden Report recommendations[2], the next quarterly assurance paper will contain a review of Stillbirths, Neonatal Deaths, Maternal Deaths, and neonatal brain injuries in line with the National Maternity Safety strategy[3].assurance and will be reported to SM MCS Hospital Board and the Board of Directors.

3. Ockenden Report Update

3.1. The Board of Directors have received updates relating to 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, on four occasions during 2021 along with an update in January 2022.

3.2. There are a range of measures in place to ensure that the actions are embedded including audit, monitoring outcomes and compliance with NHS Resolution Maternity Incentive Scheme. These are monitored quarterly within Maternity Services Divisional Quality and Safety Committee.

3.3. The next step in respect of monitoring has been confirmed and there will be an Assurance Visit by the Regional Maternity Team to review progress against the Ockenden recommendations during March 22.

3.4. Publication of the second Ockenden Report is delayed until March 2022.

3.5. An update on the Ockenden Report, phase 1 and 2, will be provided in the next report to the May Board of Directors as set out in the SM MCS Perinatal Surveillance Model.

4. Maternity Self-Assessment Tool (MSAT)

4.1. In response to national review findings, inclusive of Ockenden recommendations, a maternity safety self-assessment tool (MSAT) has been designed for NHS maternity services to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

4.2. The MSAT has been used as a benchmark for SM MCS against the core principles of good safety standards within Maternity services. Similarly, to the evidence upload for the Ockenden report, the self-assessment tool requires a large amount of evidence to be collated. The evidence will demonstrate where SM MCS are compliant, where work is ongoing and will highlight further areas for improvement.

4.3. There are 7 overarching areas within the MSAT, with 42 actions and a total of 168 sections where evidence is required to show compliance.

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[2] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

[3] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

4.4. SM MCS is currently undertaking a review and collating the evidence against these actions. At present:

- 28 actions have all evidence collated
- 6 actions require 1 identified piece of evidence to be compliant
- 3 actions require evidence from GMEC LMNS
- 4 actions are awaiting receipt of 2 or more pieces of evidence

4.5. It is expected that the review will be completed by the end of February 2022 and a full report, highlighting any areas of non-compliance will be presented to SM MCS Quality and Safety Committee in March 2022, with actions to address these and the process for ongoing monitoring where required.

4.6. SM MCS Maternity Services Division will provide a bi-monthly position to SM MCS Quality and Safety Committee, SM MCS Management Board and MFT Board of Directors as set out in the SM MCS Perinatal Surveillance Model.

5. Maternity Incentive Scheme (MIS) Year 4

5.1 NHS Resolution is operating year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

5.2 On 23rd December 2021, NHSR announced that in recognition of the current pressure on the NHS and maternity services, most reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) 10 safety actions would be paused from 23rd December 2021 for a minimum of 3 months. SM MCS have continued to report as it was not considered onerous.

5.3 The original submission date to NHS Resolution was 30th June 2022. It is requested the BOD note the final external reporting date for Year 4 MIS submission is unlikely to be required until at least 30th September 2022.

5.4 To provide consistency in reporting and reduce separate maternity papers relating to individual safety actions, this paper will provide an update on all Year 4 MIS safety actions and provide assurance of SM MCS current position and expected compliance ahead of Year 4 MIS submission date when confirmed.

5.5 Table 2 provides an overview of the SM MCS current Year 4 MIS compliance. Further details of each safety action are provided below.

Table 2

Safety Action	**Indicator/ standard**	Current position Feb 2022	Expected at submission
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Compliant	Compliant
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Working towards	Compliant
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Compliant	Compliant

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant	Compliant
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant	Compliant
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Working towards	Compliant
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliant	Compliant
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Working towards	Compliant
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant	Compliant
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Compliant	Compliant

5.6 SM MCS currently meet all required standards within Safety Action 1,3,4,5,7,9 and 10 and as such request the Board of Directors **to note and approve the detail shared in the appendices as part of ongoing external reporting.**

5.7 The focus of the current paper will be the 3 Safety actions for which ongoing action is required at this point in the reporting cycle set out in year 4 MIS, SM MCS are required to submit actions and updates to the Board of Directors for the following Safety Actions:

- Safety Action 2 – Submitting data to the Maternity Services Data Set (MSDS)
- Safety Action 6 – Compliance with the 5 elements of Saving Babies' Lives Care Bundle version 2
- Safety Action 8 – Training

6. MIS Safety Action 2 – MSDS

6.1. SM MCS continue to provide maternity data within Maternity Services Data Set (MSDS) v2.0 as required by NHS Digital.

6.2. Feedback has been provided from NHS Digital to highlight several data submissions which do not meet their data quality standards. An informatics team task and finish group has been set up to ensure that all MSDS metrics meet defined data quality standards.

6.3. The task and finish group identified approximately 38 MSDS metrics which require further work. Currently 9 MSDS metrics have been completed, with a further 18 currently being worked on, and progress is reviewed as a minimum 3 times per week.

6.4. Weekly meetings have been established with NHS Digital and SM MCS IS ON target to complete all metrics required by End of March 2022.

6.5. It is expected that once the task and finish group have completed all required actions, SM MCS will achieve compliance at the time of MIS Year 4 submission

6.6. SM MCS continue to provide a quarterly update to all safety champions via SM MCS Quality and Safety Committee and Trust Board of Directors on progress and compliance.

7. Safety Action 6 – Saving Babies Lives Care Bundle version 2

7.1. SM MCS, as part of 20/21 standard contract, and in line with best available evidence to reduce perinatal mortality, has fully implemented each of the 5 elements within version 2 of the Saving Babies Lives Care Bundle (SBLCB)[4].

7.2. Element 1 - Smoking Cessation and CO measurement

7.2.1. There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth[5], fetal growth restriction, intrapartum complications and preterm birth[6].

7.2.2. Identification of women who smoke at booking (or inhale passive smoke) will enable prompt referral to smoking cessation services and ensure appropriate risk assessments and care planning are in place. Practically this is done by asking women and taking a Carbon Monoxide (CO) measurement.

7.2.3. To meet year 4 MIS Safety Action 6 element 1, it is required for at least 80% of women to have a CO measurement recorded at their booking appointment and again when they attend their appointment at 36 weeks gestation. Compliance has been monitored monthly at site specific quality and safety meetings.

7.2.4. As previously reported to Board, CO measurement was paused for 12 months from March 2020 to March 2021 due to the potential risk of increasing COVID19 transmission.

7.2.5. Table 3 provides quarterly progress of CO measurement at the woman's booking appointment.

Table 3

2021/2022	Oxford Road	Wythenshawe	North Manchester	Overall
Quarter 1	67.4%	92.2%	59.6%	72%
Quarter 2	81.1%	93.7%	88.4%	85.8%
Quarter 3	88%	92.4%	95.1%	90.7%

7.2.6. Due to a delay in receipt of consumables to support CO monitoring, there was a delay in the commencement of CO measurements at Oxford Road and North Manchester sites. Whilst this was addressed the delay impacted on compliance in Quarter 1.

7.2.7. SM MCS met the required standard for CO measurement at booking in Quarters 2 and 3 2021/22

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[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

[5] Marufu TC., Ahankari A., Coleman T. and Lewis S. (2015). Maternal smoking and the risk of still birth: systematic review and meta-analysis. BMC Public Health: 15:239. doi:10.1186/s12889-015-1552-5. A

[6] National Institute for Health and Care Excellence (2018). Smoking: stopping in pregnancy and after childbirth (Public Health Guideline 26).

7.2.8. There is a monthly audit of the element which is reported via Maternity Services Divisional Quality and Safety Committee to ensure continued compliance.

7.2.9. Overall, there has been improvement each quarter across SM MCS and it is expected that this standard will continue to be achieved on submission of MIS later this year.

7.2.10. Table 4 provides quarterly compliance of CO measurement at 36 weeks.

Table 4

2021/2022	Oxford Road	Wythenshawe	North Manchester	Overall
Quarter 1	11.9%	20.9%	44.8%	20.8%
Quarter 2	22.9%	39.5%	65.1%	36.5%
Quarter 3	49.6%	60.3%	83.6%	59.4%

7.2.11. Despite progress it is acknowledged that SM MCS currently do not meet the required standard for CO measurement at 36 weeks.

7.2.12. An action plan is in place to achieve compliance, which includes giving ownership to the community team leaders to address individual non-compliance, ensure appropriate consumables and equipment are in place, training is up to date and clear documentation that CO monitoring has been completed.

7.2.13. Further scrutiny of monthly progress is now applied at the Maternity Services Divisional Quality and Safety Committee.

7.2.14. It is expected that SM MCS will achieve compliance at time of submission and will continue to provide a quarterly update to SM MCS Quality and Safety Committee and Trust Board of Directors.

7.3. Element 2 – Fetal Growth Restriction (FGR)

7.3.1. To reduce the risk of stillbirth and meet year 4 MIS Safety Action 6 element 2, SM MCS are required to identify and record each woman's risk status for having a growth restricted fetus at booking.

7.3.2. For Oxford Road and Wythenshawe sites, this data can be extracted from site specific maternity information systems (MIS).

7.3.3. Since the transaction of maternity services from North Manchester site into SM MCS in April 2021, there have been significant challenges to extract certain data metrics specific maternity information systems, which included FGR risk status data.

7.3.4. This is a high priority for SM MCS informatics team and is in the current scope of work within the task and finish group, which is expected to complete by the end of March 2022.

7.3.5. Local data and audits indicate that current compliance at Saint Mary's North Manchester for FGR risk assessment at booking is 92% for Quarter 3 2021/2022.

7.3.6. Compliance for Quarter 3, 2021/2022 for Saint Mary's Oxford Road is 96% and 100% for Saint Mary's Wythenshawe.

7.3.7. Whilst work remains ongoing to support data extraction across SM MCS, it is expected that SM MCS will achieve compliance at time of submission and will continue to provide a quarterly update to SM MCS Quality and Safety Committee and Trust Board of Directors.

7.4. Element 3 – Reduced Fetal Movements

7.4.1. To reduce the risk of stillbirth and meet year 4 MIS Safety Action 6 element 3, SM MCS are required to ensure all women booked for antenatal care have received a reduced fetal movements (RFM) leaflet by 28 weeks of pregnancy.

7.4.2. In additional, all women who attend with RFM should have a computerised cardiotocograph (CTG).

7.4.3. SM MCS have incorporated the national reduced fetal movements leaflet into the bespoke SM MCS handheld maternity record. As such, all women who book for care within SM MCS from 20th December 2021 will receive this information.

7.4.4. Currently 96% of women across SM MCS have a computerised CTG when attending with a history of RFM.

7.4.5. It is expected that SM MCS will continue to be compliant at time of submission and will continue to provide a quarterly update to SM MCS Quality and Safety Committee and MFT Group Board of Directors.

7.5. Element 4 – Fetal Monitoring

7.5.1. To improve fetal outcomes by providing training in fetal monitoring and to meet year 4 MIS Safety Action 6 element 4, SM MCS are required to have a dedicated lead Midwife for Fetal Monitoring and lead Obstetrician for Fetal Monitoring per maternity site. SM MCS 3 maternity sites and are compliant with this element

7.5.2. In addition, in line with Safety Action 8, SM MCS are required to have 90% of eligible staff attend multi-professional fetal monitoring training annually.

7.5.3. Due to staff absence and pressures of the COVID-19 pandemic SM MCS currently have 85% of eligible staff who have completed their fetal monitoring training within the last 12 months. Actions regarding how this is being addressed are described in greater detail below (7.7)

7.5.4. It is expected that by May 2022 SM MCS will be compliant with element 4 and training compliance is monitored monthly.

7.6. Element 5 – Preterm Birth

7.6.1. To improve neonatal outcomes and meet year 4 MIS Safety Action 6 element 5, SM MCS must ensure that women who birth before 34 weeks gestation receive a full course of antenatal corticosteroids within 7 days of birth.

7.6.2. In addition, magnesium sulphate which improves neonatal neurological outcome must be given within 24 hours prior to birth for women who birth before 30 weeks gestation.

7.6.3. Compliance of 80% is required for both elements. Trusts will not fail this element if compliance is below 80% but must have an action plan in place for achieving 80%.

7.6.4. In Quarter 3 2021/2022, SM MCS provided 79% of women with a full course of antenatal corticosteroids within 7 days of preterm birth.

7.6.5. During the same period, 83% of women received magnesium sulphate within 24 hours prior to birthing before 30 weeks gestation.

7.6.6. Given the nature of preterm birth, there are occasions where the provision of magnesium sulphate or antenatal corticosteroids is not possible.

7.6.7. Where improvements can be made, a localised action plan is created and monitored via site-based monthly Quality and Safety Committee, and further scrutinised at Maternity Services Divisional Quality and Safety committee.

7.6.8. It is expected that SM MCS will be compliant at time of submission and will continue to provide a quarterly update to SM MCS Quality and Safety Committee and Trust Board of Directors.

7.6.9. It is acknowledged that SM MCS, along with other GM providers, could not have made such progress with SBLCBv2 without the support of GMEC LMS. Specifically, the funding of several elements within the care bundle and additional funding of SBL champions.

7.6.10. GMEC LMS have provided this non-recurrent funding for 4 years.

7.6.11. SM MCS are currently working with GMEC LMS to bid for funding from GM commissioners to ensure SBLCBv2 is appropriately funded and enable work currently in place to continue as part of a commissioned maternity service and not be dependent on non-recurrent funding.

8. Safety Action 8 – Training

8.1. SM MCS have an embedded process to review the local training plan annually and ensure that all 6 core modules of the Core Competency Framework[7] are included in SM MCS maternity unit training programme.

8.2. The COVID19 pandemic caused a significant impact on the training of all relevant staff groups due to social distancing, which reduced the number of attendees per session, and staff absences which required redeployment from training to support direct clinical care.

8.3. This has had a significant impact on providing maternity specific training required to meet Safety Action 8, which includes MDT emergency training, neonatal resuscitation and fetal monitoring and surveillance training.

8.4. Tables 5-7 provides training compliance on 31.1.2022 across all three maternity sites.

Table 5 Multidisciplinary Emergency Training (n and %)

Staff Group	Oxford Road	North Manchester	Wythenshawe	Total
Midwives	278/362 = 77%	144/171 = 84%	161/209 = 77%	78.5%
Obstetricians	54/74 = 73%	32/47 = 68%	39/47 = 83%	74.4%

[7] https://www.england.nhs.uk/publication/core-competency-framework/#:~:text=A%20framework%20to%20address%20known,every%20maternity%20and%20neonatal%20service.

Anaesthetists	TBC	16/26 = 62%	11/28 = 39%	
Theatre Staff	TBC	15/17 = 88%	11/15 = 73%	
Maternity Support Workers	53/65 = 81.5%	41/46 = 89%	34/58 = 58.5%	75.7%

Table 6 Fetal Monitoring Compliance (n and %)

Staff Group	Oxford Road	North Manchester	Wythenshawe	Total
Midwives	316/362 = 87%	149/171 = 87%	173/209 = 83%	85.9%
Obstetricians	66/74 = 89%	37/47 = 79%	41/47 = 87%	85.7%

Table 7 Neonatal Resuscitation (%)

Staff Group	Oxford Road	North Manchester	Wythenshawe	Total
Midwives	77%	84%	77%	80%
Neonatologists	100%	50%	100%	83%
Neonatal Nurses and ANNP's	95%	95%	95%	95%

8.5. Safety Action 8 expects that 90% of all relevant staff groups (identified in Table 5-7) must have received maternity specific training prior to submission of Year 4 MIS.

8.6. SM MCS acknowledge that current training compliance is below the expected standard and has allocated an increased number of training sessions, both virtual and face to face, throughout February and March 2022 to address this.

8.7. A review of all relevant staff groups has been undertaken and identified both those non-compliant and those due to expire on or before 31st March 2022 and have been allocated to attend training sessions between February and April 2022.

8.8. Following support from MFT Infection Prevention and Control, by ensuring all attendees can adhere to current Personal Protective Equipment (PPE) and regular lateral flow testing guidance, social distancing is no longer required in face to face teaching sessions. This will further support an increased number of attendees per session and improve training compliance.

8.9. The current training compliance is monitored monthly at SM MCS Maternity Services Divisional Quality and Safety Committee with appropriate scrutiny to ensure that training remains a focus for all relevant staff groups.

8.10. It is also reported quarterly via this assurance paper to SM MCS Quality and Safety Committee and MFT Board of Directors.

8.11. It is expected that by May 2022 SM MCS will be compliant with Safety Action 8.

9. Recommendations

9.1. It is recommended that the MFT Group Board of Directors:

- Note the overall content of the paper and the assurance provided in relation to the Governance infrastructure in place across SM MCS to support the implementation of the Ockenden recommendations the Maternity self-assessment tool and NHS Resolution Maternity Incentive Scheme
- Note the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety

Appendix 1: PMRT Report

1. Purpose

1.1 This paper provides the Board of Directors with a summary of the perinatal mortality reviews carried out by Saint Mary's Managed Clinical Service during Quarter 3 2021/2022 as required by the NHSR Maternity Incentive Scheme.

2. Background

2.1. The NHS Long Term Plan[8] reaffirmed the Department of Health and Social Care's commitment to halve stillbirth and neonatal mortality by 2025. Whilst giving birth in the UK is largely safe, reports over the past decade have highlighted significant discrepancies in the quality of care provided.

2.2. The recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)[9] reported that between 60-80% of term deaths might have been prevented.

2.3. It is critical for services to undertake robust reviews and learn lessons to reduce the number of parents who experience such a tragic loss, and it is on this foundation that Perinatal Mortality Reviews are included as Safety Action One of the Maternity Incentive Scheme (CNST).

2.4. Regular reports to Boards of Directors are integral to that action point. Furthermore, the Ockenden Report[10] has also emphasised the need for Trust Boards to have sight of maternity safety.

3. Definitions

3.1. *Perinatal mortality* refers to **stillbirths and deaths that occur in the first week of life** (early neonatal mortality).

3.2. *Stillbirth*: A stillbirth is when a baby is born without signs of life after 24 completed weeks of pregnancy.

3.3. *Neonatal Death (early and late)*: Is a baby born at any time during pregnancy who lives, even briefly, but dies within 4 weeks of being born.

4. Perinatal Mortality Review Tool

4.1. A collaboration led by MBRRACE-UK developed and established a national standardised Perinatal Mortality Review Tool (PMRT). The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'. The PMRT is utilised by maternity units in England, Wales and Scotland.

4.2. The PMRT aims to support a systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surround each stillbirth and neonatal death.

4.3. The process includes active communication with parents to ensure that they are informed that a review of their care, and that of their baby, will be carried out and how they can contribute to

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[8] NHS Long Term Plan. January 2019 https://www.longtermplan.nhs.uk/

[9] Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, Boby T, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2019. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2021.

[10] HC l081 Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust Ref: ISBN 978-1-5286-2304-9 Dec 2020

the process. A report is generated which can be shared with parents. Where possible the report includes an explanation of why their baby died and includes a grading of care provided.

4.4. To ensure that lessons are learnt, and that parents are provided with information in a timely way, it is recommended that reviews are multidisciplinary, commenced within 2 months of the stillbirth or death. A draft report should be available at 4 months and completed by 6 months.

4.5 The PMRT has been used within Saint Mary's Managed Clinical Service (MCS) since its introduction in 2018, with summarised data being reported to the Maternity Services Divisional Quality and Safety Committee and then to the Saint Mary's Quality and Safety Committee. Learning is disseminated across the Saint Mary's MCS.

4.6 The NHSR Maternity Incentive Scheme (Safety Action 1) requires quarterly reports to be submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. Although reviews have been ongoing in Saint Mary's MCS for over three years, this report will therefore focus on this specified time period, with further quarterly reports being submitted to Board.

5. Update of Perinatal Mortality Reviews from 1st July 2021 to 30th September 2021

5.1 As previously reported to MFT Group Board of Directors in January 2022, there were 31 stillbirths and late fetal losses reported to MBRRACE-UK reported by SM MCS between 1st July 2021 and 30th September 2021. Of these 28 required a PMRT review.

5.2 All 28 have been reviewed using the PMRT tool, with 14 having a report published. 6 of the reports were shared with MFT Group Board of Directors in November 2021.

5.3 An action plan related to learning identified from the 6 reports has been updated below to provide evidence of progress. All actions have been completed.

5.4 **Table 1**

Recommendation	Action	Lead	Due date	Update
Ensure appropriate pathways of care are provided to support choice	Implement the personalised care and support plans.	Heads of Midwifery	**Closed**	
	Audit use of the personalised care and support plan and share the findings of the audit	Deputy Heads of Midwifery	**Closed**	Compliance at 80%. Now captured within documentation audit.
Ensure all women are provided with information re reduced fetal movements	Audit the documented discussion re reduced fetal movements	Saving Babies Lives Champions	**Closed**	
Improve the care provided to women at risk of drug misuse on the North Manchester site	Implement Substance Misuse and Mental Health Midwife role at North Manchester	Head of Midwifery	**Closed**	
	Substance Misuse and Mental Health Midwife to develop the service to support women and families on the North Manchester site, including appropriate risk assessment and referral	Drug and Alcohol Midwife	**Closed**	Commenced in post 4th January 2022

5.5 Historically, the learning and subsequent actions from each review have been kept locally on-site specific databases and not all have been completed in full on the MBRRACE-UK reporting system. It is acknowledged that this does not support the capture of themes across SM MCS and as such each completed review will now be entered as a complete report on MBRRACE-UK. There will be a change in the format of SM MCS PMRT quarterly report to reflect this.

5.6 The next quarterly SM MCS quarterly PMRT report, which will be submitted as part of SM MCS Maternity Assurance Paper to MFT Group Board of Directors in July 2022, will capture:

- the number of completed reviews to date, inclusive of reviews commenced in Q1, Q2 and Q3 2021/2022, and any identified learning
- the number of stillbirths and late fetal losses in Q4 2021/2022
- the number of PMRT reviews required for Q4 2021/2022
- the number of PMRT reviews already completed for Q4 2021/2022
- the grading of each case following PMRT review
- the learning from each completed PMRT review where care could have been improved
- Overarching themes across SM MCS

6. Perinatal Mortality Reviews from 1st October 2021 to 31st December 2021

6.1 Cases

6.1.1 During the period 1st October 2021 to 31st December 2021, Saint Mary's Managed Clinical Service (SM MCS) reported 28 stillbirths and late fetal losses to MBRRACE-UK. Of these 19 required a PMRT review. In this period 16 neonatal deaths were reported of which 11 PMRT reviews were required. Stillbirths and neonatal deaths of babies weighing less than 500g or resulting from termination of pregnancy are reported to MBRRACE-UK but are out with the criteria for PMRT review, hence the difference in the numbers.

6.2 Timeliness of reviews

6.2.1 As described above it is recommended that reviews of care commence within 2 months with a draft report being completed by 4 months of the death.

6.2.2 Of the 19 stillbirths requiring PMRT review, 16 reviews have been commenced within the recommended 2-month period. The remaining 3 yet to commence are within the 2-month period, having occurred at the end of November or during December 2021: no reviews are overdue commencement. Of the 19, 7 reviews have been completed, 9 are in progress and 3 are due to start but all are within the recommended timeframe of 4 months.

6.2.3 In the 11 neonatal death cases, 1 review has been completed and the remaining 10 reviews are within recommended timescales for completion.

6.3 Multidisciplinary involvement

6.3.1 During the period 1st October 2021 to the 31st December 2021, six meetings took place to review the cases. All six meetings had the required appropriate multidisciplinary involvement, with participants including obstetricians, midwifery staff, neonatologists and neonatal nursing staff.

6.4 Of the 7 stillbirths where reviews have been completed, one baby was between 24- and 27-weeks' gestation, two babies between 28- and 31-weeks' gestation, two babies between 32 and 36 weeks and two babies were born at 37+weeks.

6.5 One neonatal death review has been completed for a baby who was born between 32- and 36-weeks' gestation.

6.6 The one neonatal cause of death was Trisomy 18.

6.7 Five stillbirths occurred during the antenatal period and the timing of two stillbirths were unknown (as the women presented in labour and it was not possible to determine whether the stillbirth had occurred prior to or during labour).The causes of death were as follows:

- In one case, due to suspected anoxia (lack of oxygen) as a result of an abruption (bleeding behind the placenta causing it to separate from the wall of the womb)
- In one case, due to antenatally diagnosed abnormalities of baby: spinal myelomeningocele, lemon shaped cranium, abnormal cerebellum, bilateral talipes - club foot, likely placenta insufficiency was contributory to death
- In one case, due to extreme prematurity potential anoxia due to suspected placental abruption
- In one case, due to fetal growth restriction
- Undetermined in three cases.

6.8 Post-mortems were offered to all parents (2 declined) and placental histology was undertaken in all cases.

6.9 All parents were provided with an opportunity to discuss their views and concerns which were included in the review.

7. Grading of Care

7.1 The multi-professional review group assessed that in one of the cases that issues with care identified in the review **may** have made a difference to the outcome of the baby.

7.2 There were no cases where the review group identified care issues which they considered **were likely to** have made a difference to the outcome for the baby. Table 2 below provides further information in relation to all cases following multi-professional review.

7.3 Following confirmation of the stillbirth the subsequent care of all mothers was assessed to have been appropriate

Stillbirths and late fetal losses	Number
A – The review group concluded that there were **no issues** with care identified up to the point that the baby was confirmed as having died	3
B – The review group identified care issues which they considered would have made **no** difference to the outcome for the baby	3
C – The review group identified care issues which they considered **may** have made a difference to the outcome for the baby	1
D – The review group identified care issues which they considered **were likely to** have made a difference to the outcome for the baby	0

Table 2 Grading of care following multi-professional review of six cases

8. Learning from the Reviews

8.1 The reviews provide valuable learning, with areas of learning and improvement highlighted through the reviews.

8.2 In one case, fundal height measurements were not correctly plotted; referrals for scans and/or further investigations were not undertaken when required; the baby was small for gestational age at birth, scans were indicated but had not been performed. Learning has been shared with

the clinical teams as these areas of learning relate to workstreams within Saving Babies Lives Care Bundle 2[11].

8.3 **Table 3** below highlights the recommendations and associated actions.

Recommendation	Action	Lead	Due date	Update
Ensure all midwives are aware of appropriate referrals and Fundal Height monitoring	SBL Champions to undertake walkarounds to support learning in practice. Continue to audit via SBL champions. Training compliance reviewed monthly	Saving Babies Lives Champions	**March 2022**	**Training compliance ongoing, above 90%**
	Individual reflection for staff member	Community Matron,	**closed**	
Ensure all midwives are aware of appropriate referrals for ultrasound scan	SBL champions to undertake walkaround to share learning and provide updates regarding criteria for scan referral	Saving Babies Lives Champions	**closed**	

Table 3 Recommendations and actions following reviews

8.4 In one case, a referral to fetal medicine unit was not made in accordance with current guidance and care pathway. Information was shared via governance newsletter to all midwifery and obstetric workforce regarding the current referral pathway. It was not considered that the absence of the referral contributed to the outcome for the baby.

8.5 In one case, North West Ambulance Service did not assess the volume of PV blood loss and attended maternity triage instead of labour ward. This delayed appropriate care by approx. 3 minutes. Due to the significant placental abruption, which had occurred at home, it was not considered that this 3 minute delay would have altered the outcome for the baby. Learning shared with NWAS.

8.6 In one case, symphysis fundal height (SFH) was not plotted at the correct time/interval; previous group B strep (GBS) infection was not accurately recorded in handheld notes. Additional training was provided for the individual midwife regarding timings of when to plot SFH and where to record GBS in handheld notes.

9. Maternity Incentive Scheme Safety Action 1

9.1 Year four of NHS Resolution Maternity Incentive Scheme specifies in safety action one that Trusts should utilise the national Perinatal Mortality Review Tool. The Trust has maintained full compliance during quarter 3 of 2021/2022 as outlined in Table 4 below

Indicator/ Standard	Compliant Y/N
All perinatal deaths eligible to be notified to MBRRACE-UK from 1st September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	Yes
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8th August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by Trust staff and the baby died.	Yes

11 NHS England Saving Babies' Lives Care Bundle Version 2 March 2019 https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

Indicator/ Standard	Compliant Y/N
At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	Yes
For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	Yes
Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	Yes

Table 4 CNST summary

10. Summary and recommendations

10.1 The report summarises the use of the Perinatal Mortality Review Tool which aims to reduce the number of babies who sadly die from preventable factors. It is important that for each parent that has lost a baby that maternity services actively learn and improve to reduce the chance of another parent experiencing that tragic loss. This report summarises the learning identified, and action taken. It is acknowledged that further improvement work is required, and this is ongoing.

10.2 The MFT Group Board of Directors are asked to note the information provided within this report.

Appendix 2: ATAIN Report

1. Background and Purpose

1.1. This paper provides a quarterly update, as required by Maternity Incentive Scheme (MIS) year 4 to comply with Safety Action 3 (sections b, e, f and g), and is submitted to Saint Mary's Quality and Safety Committee as part of Saint Mary's MCS perinatal surveillance model, which ensures Maternity, Neonatal and Board level safety champion oversight.

2. Introduction

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[12] to reduce admission of full-term babies to neonatal care.

2.2. Transitional Care (TC) services support care of vulnerable babies within the maternity setting to reduce avoidable admissions to neonatal services and minimise separation of mothers and their babies.

2.3. It is critical for services to undertake robust reviews and learn lessons to reduce the number of mothers and babies that are separated after birth, and it is on this foundation that audits of TC are included as Safety Action 3 of year 4 MIS.

2.4. Saint Mary's MCS has TC services, which are based on the British Association of Perinatal Medicine (BAPM) principles and meet the standard set by NHS Resolution Maternity Incentive Scheme. Saint Mary's MCS has guidelines in place for their TC services jointly developed and approved by maternity and neonatal teams. Guidelines on all sites are available on the local intranet and are currently under review to harmonise following the transaction of North Manchester maternity unit into Saint Mary's MCS in April 2021.

3. Audits of Transitional Care (TC) provision for October 2021 to December 2021 (Q3 21/22)

3.1. As required by Year 4 MIS Safety Action 3, this quarterly review details the number of admissions to the neonatal unit which met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding.

3.2. During Quarter 3 2021/22, no term babies that met the current Transitional Care admissions criteria were admitted to the neonatal unit due to capacity or staffing issues or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding. (Table 1)

3.3. **Table 1**

Site	October 2021	November 2021	December 2021
ORC	0	0	0
Wythenshawe	0	0	0
North Manchester	0	0	0

3.4. Despite the impact of COVID19 on Maternity and Neonatal services, there has been no change to the provision of TC across the Saint Mary's MCS during Q3 2021/22.

[12] https://www.england.nhs.uk/wp-content/uploads/2021/03/reducing-harm-leading-to-avoidable-admission-of-full-term-babies-into-neonatal-units-summary.pdf

4. Review of term admissions to the Neonatal Unit using the Avoiding Term Admissions Into Neonatal units (ATAIN) framework

4.1. The ATAIN programme aims to reduce admissions to the Neonatal Unit by identifying and acting upon practice issues promptly to demonstrate improvements in care. Focusing on:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia)
- Hypothermia

4.2. Documentation audits occur monthly by ATAIN champions and compliance is monitored on a quarterly basis at Maternity Services Divisional Quality and Safety meeting.

4.3. A weekly multidisciplinary review of unexpected admissions to the neonatal unit occurs on each maternity site, highlighting themes, actions, learning and whether the admission could have been avoided.

4.4. In the period 1st October to 31st December 2021 there were 9 avoidable term admissions across Saint Mary's MCS. 3 babies on the ORC site, 5 on the Wythenshawe site and 1 on the North Manchester site, with each site creating local actions to address any identified issues.

4.5. Following integration of North Manchester, a new report to capture themes and share learning across SM MCS is being developed and will be a quarterly agenda item on the Maternity Services Divisional Quality and Safety meeting.

5. Action Plan

5.1. An overall ATAIN action plan (Appendix a), as required by MIS year 4 (section f), has been amended to capture the ATAIN audit compliance, actions and learning from care reviews and progress on harmonisation of TC model and guidelines.

6. Conclusion

6.1. Saint Mary's MCS has maintained full compliance during Quarter 3 of 2021/2022. Appendix b provides clear overview of compliance of MIS Year 4 Safety Action 3.

Appendix 2a of ATAIN

Action plan for MIS Safety Action 3 – Reviewed January 2022

	Action	Lead	By When	Status
1	Develop action plan to address ATAIN audit compliance	ATAIN Champions, supported by Deputy Heads of Midwifery	December 2021	Complete
2	Develop ATAIN audit compliance report for ongoing review at quarterly Maternity Services Divisional Quality and Safety meeting	ATAIN Champions	December 2021	Complete
3	Develop a harmonised MCS report to capture themes and learning from unexpected admissions to neonatal unit	DHoM's Maternity Services Division	April 2022	In progress
4	Harmonise Transitional Care model across Saint Mary's MCS	Neonatal Matron and Inpatient Matron at North Manchester to work with Lead Nurse for Newborn Service to fully implement TC model	June 2022	In progress
5	Harmonise Transitional Care Guidance across Saint Mary's MCS	Lead Nurse for Neonatal Service and DHoM's to lead in harmonisation of TC guideline on all sites	June 2022	In progress

Appendix 2b of ATAIN

Indicator/ standard	Compliant Yes/No
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Yes
c) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	Yes
d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies	Yes
e) Reviews of term admissions to the neonatal unit continue a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. The reviews should report on the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were admitted to or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	Yes
f) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.	Yes
g) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.	Yes

Appendix 3 – Posters for feedback following Safety Walkaround

Appendix 4 – Posters for feedback following Safety Walkaround

STAFF SAFETY DROP IN FEEDBACK RESULTS AUGUST 2021

NHS Manchester University NHS Foundation Trust

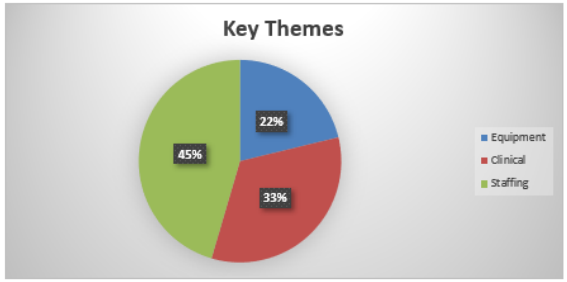
Key Themes

Staff safety drop-in sessions have been provided monthly to staff at both ORC and Wythenshawe site since March 2019. These sessions provide the opportunity for staff to raise any safety concerns that they have with Clinical Leads.

Since the start of the drop-in sessions we have had a total of 145 concerns raised.

Since the re-start of the drop in we have had 33 concerns raised, of which 16 have been resolved, others referred for further advice, and the remaining still open.

The concerns raised cover a variety of subjects; however key themes that have emerged related to Equipment (22%) and Staffing (45%) and Clinical concerns (33%).



Who has done the staff safety walk rounds:

Due to Covid the safety drop-ins were paused between April and August. These restarted in September 2020, and include a walk round by:-

- **Clinical Head of Division Dr Clare Tower**
- **Interim Clinical Head of Division Professor Ed Johnstone**
- **Clinical Site Lead Wythenshawe Dr Elaine Church**
- **Clinical Site Lead Oxford Road Campus Dr Sarah Hamilton**
- **Deputy Governance Lead Wythenshawe Dr Akila Anbazhagan**
- **Head of Midwifery Wythenshawe Faith Sheils**
- **Head of Midwifery Oxford Road Campus Bev O Connor**
- **Deputy Head of Midwifery Wythenshawe Sarah Owen**
- **Deputy Head of Midwifery Oxford Road Campus Esme Booth**
- **Non-Executive Director/Maternity Safety Champion Chris McLoughlin**
- **Director of Nursing and Midwifery/Maternity Safety Champion Kathy Murphy**

Staff can raise concerns in any forum and have the option to submit concerns anonymously to staffsafetydrop-in@mft.nhs.uk

YOU SAID .....

- K2 portals escalate for repair.
- Missing/inadequate numbers of certain equipment (e.g., thermometers).
- Stocks of supplies are sometimes not replenished on time resulting in not having enough items.
- There is a backlog of filing which is a concern as clinical may not be available to support clinical decision making resulting in a poor outcome.
- Staffing remains a concern in all areas, currently some wards/departments are unable to facilitate breaks/lunch.

WE DID .....

- As part of K2 project, Oxford Road Campus has received 15 portals with an additional 21 portals secured. Awaiting installation.
- Capital bid requests for those items more than £5k have been submitted. A review of other equipment has been undertaken with some items being purchased.
- Stocks increased from weekly to twice weekly stock delivery. Housekeeper to monitor stock to ensure adequate supply.
- NHSP staff have been employed over the summer months to ensure that the backlog is reduced. Additional staff are being recruited to prevent the backlog building up in future.
- Senior midwifery team ensured that breaks are facilitated and re-iterated the importance to staff of being proactive and escalating these problems early to the 2099.

Appendix 5: MCoC Action Plan

	Complete	In progress	Not due	Overdue

Action Number	Action	Narrative	Action taken by	Due by	Status as at 7.2.22
1	Review SM MCS against the 10 Building Blocks as identified by NHS E/I planning guidance	Apply RAG rating to each element within Building Blocks framework to ensure SM MCS able to scale up MCoC by March 2023	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
2	Undertake Safe staffing MCoC workforce modelling using recommended Workforce tool	SM MCS have completed as staffing review which has identified a staffing gap of 77 WTE required to implement MCoC as default model.	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
3	Recruiting to baseline BR+ establishment in line with newly funded establishment following Ockenden investment	SM MCS has established 7 MCoC teams, providing the default model of care safely to 1600 women.	HoM's across SM MCS	31.1.22	Ongoing. Challenges exist in recruiting to financed baseline (BR+) establishment. Ongoing rolling recruitment on all sites. C of C teams almost at full establishment.
4	NHS E/I requirement for MFT Board of Directors to be cited on staffing gap identified and long-term trajectory to move towards default model of MCoC safely	SM MCS position, staffing gap and action plan for MCoC approval ahead of Trust Board 10.1.22.	K Murphy, Director of Nursing and Midwifery, SM MCS	20.12.21	Completed
5	Submit Board Paper to GMEC LMNS	Subject Board approved continuity action plan to GMEC LMS	K Murphy, Director of Nursing and Midwifery, SM MCS	11.1.22	Completed
6	Request additional workforce funding	Following board review of SM MCS current position, link with GMEC LMNS to support a funding request to ICS for additional workforce required for SM MCS to achieve MCoC as default model.	Divisional Director, SM MCS DoF, SM MCS DoNM, MS MCS	March 2022	Ongoing. Ongoing discussions with LMS
7	Staff Engagement	Subject to funding approval, work with HR to create a workforce engagement strategy.	HoM's across SM MCS	April – May 2022	Ongoing. *Talent attraction and senior acquisition service* team

		Utilising the skills and experience of current MCoC teams to showcase the benefits of working in a MCoC model			working with maternity team to undertake focused advertising and recruitment drive for community/continuity. Survey developed by KW/BO and to be sent out week commencing 7/2/22
8	Develop MCoC Communications	Share outcomes of MCoC teams regularly across SM MCS to improve awareness of MCoC models	Team Leaders of MCoC teams	April 2022	Ongoing. Need to agree template to be used across all teams in MCS. Newsletter to be developed and circulated quarterly.
9	Develop SOP for MCoC	Create and submit SOP through divisional and hospital governance processes for approval, inclusive of linked obstetrician for each MCoC team	Team Leaders of MCoC teams Clinical Head of Division	May 2022	Ongoing. Due to increased maternity pressures related to Covid-19 the requirements for reporting/planning have been delayed by the national team for 3 months. Timelines adjusted accordingly
10	Review Obstetric referral pathway	Review current obstetric referral pathways to support a link for MCoC. Resolve issues relating to increased workload, potential duplication for those requiring specialist care	HoM's and Clinical Head of Division	May 2022	ongoing
11	Review Staff training needs	Following EOI from staff wishing redeployment into Wave 2 MCoC teams, review individual needs using Self-Assessment Skills Log and support supernumerary shifts to achieve any additional requirements.	Community and Intrapartum Matrons across SM MCS Education Team	June 2022	
12	Review community hub provision	Review current community hub capacity to support Wave 2 roll out	Divisional Director for Obstetrics, SM MCS	June 2022	
13	Review equipment required for MCoC teams	Review the equipment required for Wave 2 teams and order additional equipment where required	Community Matrons across SM MCS Finance Managers	June 2022	
14	Wave 2	Commence Wave 2 Roll Out	Community Matrons across SM MCS	Sept-Dec 2022	

Appendix 6 Scorecard

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 January
- Maternity incidents are reported separately via the governance reports presented at Q&SC
- Exception report details are below
- 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 reviewed due to increased numbers and quality improvement work being undertaken (Saint Mary's at Wythenshawe) • Lessons learnt shared across the MCS	• All term admissions reviewed to identify if the admission was avoidable • MatNeo quality improvement programme in progress to reduce term admissions • ATAIN audits completed monthly to identify areas for improvement and share lessons learnt	• Perinatal Mortality Review Tool used to complete MDT review for all stillbirths • All stillbirths are incident reported and reviewed by the MDT • Increased stillbirth rate noted on GMEC dashboard – being reviewed (Saint Mary's at Wythenshawe)

			GMEC monthly average (Dec21)	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	96.62	99.3	99.2	96.5	99	98.2	98.6	98.62	99.7	99.38	99.22		
	3rd/4th degree tears	Percent	3.79	2.6	2.4	1.8	3.3	1.97	2.95	1.43	3.08	1.97	1.91		
	Obstetric haemorrhage > 2.5L	Rate per 1000	3.43	2.3	6.2	4.4	2.8	4.2	2.95	4.00	2.21	6.56	0.38		
	Term admissions to NNU	Rate per 1000	38.92	68.2	56.2	67.5	50.5	47.8	32.9	60.21	53.4	58.4	63.38		
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	13.74	5.8	15.1	10.3	6.1	11.8	8.75	5.02	12.14	16.8	8.61		
	Stillbirth number	Rate per 1000	6.11	2.3	5.4	4.3	8.4	6.2	2.21	5.91	5.82	7.91	4.96		
	Neonatal Deaths	Rate per 1000	1.82	2.26	1.55	1.43	0	1.39	1.27	1.31	4.37	2.88	2.13		

Patient Experience	Number of formal compliments	Number	1	3	2	2	3	4	0	7	1	3		
	Number of formal complaints	Number	5	12	11	7	7	7	8	11	3	11		
	Complaint response on time	Percent	100	83	100	86	57	86	100	-	100	-		
	Maternity Unit diverts	Number	0	0	1	0	3	2	1	0	0	0		

Training	Emergency skills and drills	Percent of staff trained	87.6	94.3	95.4	89.8	83	88.1	90.9	75.6	77.5	73.5		
	CTG training	Percent of staff trained	79.7	83.5	93.6	90.7	83.8	85.8	81.9	80	80.8	90.7		
	CTG competency assessment	Percent of staff assessed	88.1	92.2	91.8	93.4	91.9	87.8	88.3	87.9	89.2	87.4		

Coroner Reg 28 made directly to the Trust	No	No	No	No	No	No	No	No	No	No		
HSIB/ CQC concern or request for action	No	No	No	No	No	No	No	No	No	No		
StEIS reported incidents	1	0	2	1	9	2	6	2	1	1		
Incidents with moderate harm or above	0	0	3	0	2	0	5	1	2	1		
HSIB referrals	3	0	1	0	5	1	4	2	2	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:	March 2022
Subject:	Safer Staffing – To provide the Board of Directors with the bi-annual Nursing, Midwifery and AHP 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 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.
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].

1.2 In the absence of a national safer staffing standard for Allied Health Professionals (AHPs), the report provides an overview of the AHP workforce to ensure the Board of Directors have oversight.

1.3 The guidance[1] recommends that the Board of Directors receive a biannual report on staffing to comply with the CQC fundamental standards on staffing and requirements outlined in the well-led framework.[3]

1.4 The Board of Directors received a report in November 2021 outlining the Trusts position against the NQB standards. This paper will provide analysis of the Trusts nursing and midwifery workforce position at the end of **December 2021** and the actions being taken to mitigate risk and reduce the vacancy position, specifically within the band 5 staff nurse and midwifery bands 5 and 6 workforce.

1.5 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 the most recently published NHS workforce statistics (September 2021), the current shortage of staff across the NHS in England is circa 99,500 (7.6%), with 39,813 within the registered nursing workforce (10.5%)[4].

1.6 In England there has been a marked increase in pre-registration applications to study Nursing, Midwifery and AHP programmes. University and Colleges Admission Services (UCAS)[5] reported record numbers of nursing and midwifery students accepting places on programmes commencing this academic year 30,185 accepted places to study commencing in September 2021, a 1.5% on the previous year. This has been a year-on-year increase since 2018, there have been a 34% increase in students enrolling to enter these professions.

1.7 Across Greater Manchester, GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Figures for Academic Year 2021/22 indicate a stable position on Adult Nursing learner numbers, an increase in Children's Nursing (7%), Mental Health (1%) and Midwifery (15%).

[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
[5] GOV.UK 2021, Record numbers accept a place to study nursing and midwifery

1.8 At the end of December 2021, the Trust reported an improved vacancy position across Nursing Midwifery and Allied Health Professions compared to April 2021. There are a total of **291.2wte (3.18%)** registered nursing and midwifery vacancies across the Trust compared to **655wte (7.20%)** in April 2021, a reduction of **4.02%.** At the end of December 2021, the AHP vacancy position was **56.17wte (3.5%),** this is an improved position of **1.5%** compared with a vacancy position of **77.6 wte** in April 2021.

1.9 There are currently **46** domestic nurses and midwives in the Band 5 recruitment pipeline with confirmed start dates and a further **157** who are working through their recruitment checks and due to commence by the end of Quarter 1.

1.10 The sickness absence rate for nursing and midwifery was **5.0%** at the start of the pandemic in March 2020. In December 2021 the unplanned absence rate for registered nursing and midwifery was **10.2%** and **14.2%** for unregistered staff, this is due to the surge in Covid related sickness due to the Omicron variant. During December 2021 and January 2022 high levels of Nursing and Midwifery Sickness and absence were reported with the majority staff unavailability due to COVID-19 sickness or staff isolating. In the first week in January registered nurse sickness was **14.9% (1,318wte)** and unregistered **20.3% (626.5wte)**.

1.11 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. Staff have been relocated, temporary staff utilised, and staff redeployed as required to ensuring safe staffing levels are maintained during periods of increased absence levels. Assurance of safe staffing levels are provided through the daily situational report into the Hospital/ MCS/LOC governance structures.

1.12 The SNCT census undertaken in November 2021 has provided the assurance that 75% of ward establishments are safe and match the SNCT recommended establishment. A further 20 wards require further census data to validate the recommended establishment for these areas. This work will be undertaken following the March and June census collections. The November census identified 72 in-patient wards funded establishment is equal to the SNCT recommended establishments.

1.13 The Trust has an established approached to annually reviewing Nursing and Midwifery establishments, which is adopted from NHSE/I's guidance[1&2]. The Trusts guidance adopts a triangulated approach utilising, a valid acuity and dependency assessment tool (SNCT)[6] and (Birth Rate Plus)[7] , patient and staff outcome measures, professional judgement and benchmarking with comparable organisations. There is no national AHP safer staffing tool available. Current national available resources to ensure AHP safe staffing are only available in specific acute clinical areas namely GPICS[8] guidelines for critical care and BSRM/SSNP[9] for rehabilitation. The Trusts Chief AHP is leading a pilot to develop a MFT safe staffing standard for the AHP workforce.

[6] NHSE 2019, Safer Nursing Care Tool
[7] Birth Rate Plus 2020,
[8] FICM 2019, Guidelines for the Provision of Intensive Care Services
[9] BSRM 2009, Standards for Rehabilitation Services

1.14 A summary of the biannual Hospital/MCS/LCO safer staffing reports are provided to the Board of Directors in Appendix 1.

1.15 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[1], and the NHS England (NHSE) 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.

2.2 This report provides analysis of the Trust nursing and midwifery workforce position at the end of **December 2021.** The report describes the hospital/MCS workforce plans to support the pandemic response and workforce recovery plans.

2.3 In the absence of a national safer staffing standard for Allied Health Professionals (AHPs), the report provides an overview of the AHP workforce to ensure the Board of Directors have oversight.

2.4 Covid-19 continues to significantly impact and influence service delivery and staffing levels across the Trust since the November report to the Board of Director. Namely covid related sickness continues to impact significantly on staff absence. There is robust professional leadership in place, supported by existing safe staffing governance frameworks and pandemic specific escalation criteria to ensure safe staffing levels and the effective deployment of staff as required. This report references the on-going work and oversight in relation to safe staffing during the pandemic and any changes to normal process, which have been required. The sustained clinical pressures alongside staffing shortages from increased sickness absence rates and maternity leave continue to be a challenge across the Trust.

3. National Context

3.1 The Covid-19 Pandemic continues to place a severe strain on the Health System within the UK and worldwide. During the winter months the UK has and continues to experience a surge in the percentage of the population who have been infected with the Covid-19, specifically the Omicron variant. In the England in the week ending the 31st of December 2021, it is estimated that 3,270,800 people in England had Covid-19, this equated to 1 in 15 people[10].

3.2 During this time, the NHS has seen both an increase in the number of patients admitted to hospital with Covid-19 and an increase in staff sickness and absence. An average of circa 36,000 staff within the NHS were off sick during the last week of December 2021[11] placing a significant pressure on the NHS.

[10] Office for National Statistics 2022, Coronavirus (COVID-19) Latest Data
[11] NHSE 2022, NHS Weekly Winter Operational Update

3.3 The NHS workforce is the key enabler in supporting the national recovery from the pandemic. According to NHS workforce statistics, the current shortage of staff across the NHS in England is circa 99,500 (7.6%), with 39,813 within the registered nursing workforce (10.5%)[12].

3.4 During the pandemic the rates of staff leaving the NHS had fallen, these numbers are now on the rise, but remain relatively low[13]. Strategies to retain the workforce are integral to the NHS people plan[14], programmes of work to embed the key principles of the people plan are being prioritised through workforce covid recovery planning.

4. MFT NMAHP Workforce Position

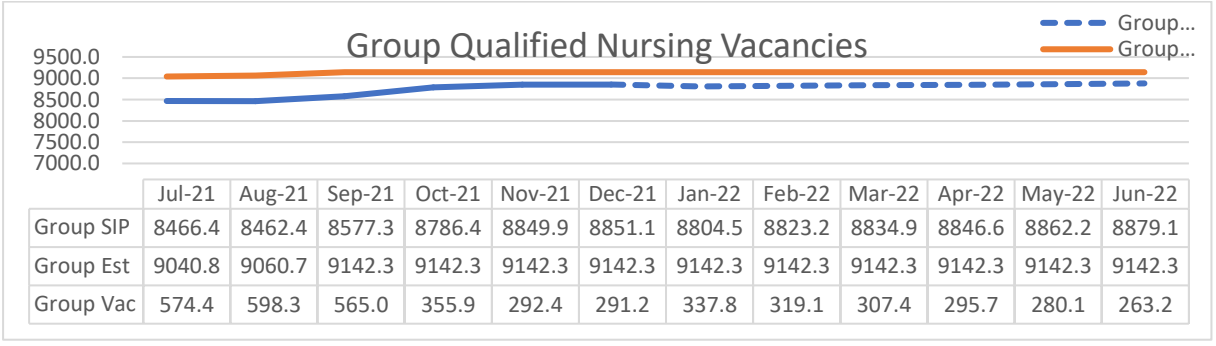
4.1 The Trust workforce position has improved over the last 12 months despite the pandemic. Both domestic and international recruitment programmes have resulted in **1494wte** registered nurses and midwifes joining the organisation, this is an increase of **432wte (41%)** compared to the previous 12-month period.

4.2 This improved vacancy position, is due to the significant increase in the number of internationally recruited nurses. During the current financial year **575** internationally recruited nurses will commence in post, this is an increase of **157 (27%)** from the last financial year.

4.3 At the end of December 2021 there were a total of **291wte (3.2%)** registered nursing and midwifery vacancies across the Trust compared to **655wte (7.2%)** in April 2021, a reduction of 4%. This equates to an overall reduction in vacancies of **364wte (55%)** during this period demonstrating a strong position, this position is expected to continue to improve in 2022 due to the numbers in the domestic and international recruitment pipeline.

4.4 **Graph 1** provides the overall nursing and midwifery vacancy trajectory until the end of Q1. Recent workforce modelling predicts an improved trajectory throughout 2022/23 when the nursing and midwifery vacancies are predicted to be **263wte (2.88%)** at the end of June 2022.

Graph 1



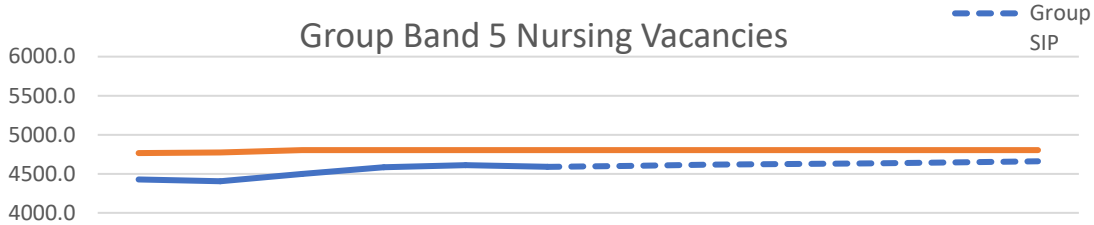
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Group SIP	8466.4	8462.4	8577.3	8786.4	8849.9	8851.1	8804.5	8823.2	8834.9	8846.6	8862.2	8879.1
Group Est	9040.8	9060.7	9142.3	9142.3	9142.3	9142.3	9142.3	9142.3	9142.3	9142.3	9142.3	9142.3
Group Vac	574.4	598.3	565.0	355.9	292.4	291.2	337.8	319.1	307.4	295.7	280.1	263.2

[12] NHS Digital 2021, NHS Workforce Statistics
[13] Nuffield Trust 2022, The long goodbye? Exploring rates of staff leaving the NHS and social care
[14] NHS England 2020, NHS People Plan

4.5 The majority of vacancies are within the nursing and midwifery (Band 5) workforce. At the end of December 2021 there were **213.6wte (4.45%)** compared to **344wte (7.1%)** in April 2021 and overall reduction of **130.4wte (2.65%).**

4.6 **Graph 2** provides the registered nursing and midwifery band 5 vacancy trajectory until the end of Q1, 2022. Recent workforce modelling predicts an improved trajectory throughout the next financial year when the nursing and midwifery vacancies are predicted to be **143.3wte (2.98%)** at the end of June 2022.

Graph 2



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Group SIP	4427.4	4404.6	4498.3	4583.8	4610.5	4589.8	4602.6	4617.0	4626.0	4635.0	4647.0	4660.0
Group Est	4765.1	4774.3	4803.3	4803.3	4803.3	4803.3	4803.3	4803.3	4803.3	4803.3	4803.3	4803.3
Group Vac	337.7	369.7	305.0	219.5	192.8	213.6	200.7	186.3	177.3	168.3	156.3	143.3

4.7 At the end of December 2021, the AHP vacancy position was **56.17wte (3.5%),** this is an improved position of **1.5%** compared with a vacancy position of **77.6 wte** in April 2021.

Nursing and Midwifery Turnover

4.8 At the end of December 2021, the 12-month rolling turnover rate for the registered nursing and midwifery staff group was **11.7%** and **13.7%** within the Band 5 workforce. This is a slight increase from April 2021 when the turnover for nurse and midwives was **11.3%** and Band 5 turnover was **13.4%.** The current national turnover rate for nursing and midwifery is **10.8%**[15].

4.9 **Sickness Absence**

In December 2021, the unplanned absence rate for registered nursing and midwifery was **10.2%**, **14.2%** for unregistered staff and **7.2%** for AHP. Compared to April 2021, rates have increased by **4.1%** for registered staff and **4.4%** unregistered staff and **3.3%** for AHP for. During December 2021 and January 2022 due to Covid the Trust has seen high levels of Nursing and Midwifery Sickness and absence with the majority staff unavailability due to COVID-19 sickness or staff isolating. In the first week in January registered nursing and midwifery sickness was **1,318wte (14.9%)**, unregistered nursing and midwifery sickness was **626.5wte (20.3%)** and AHP was **190.8wte (12.4%)**.

[15] NHS Digital 2021, NHS Workforce Statistics

4.10 Between the beginning April 2021 and December 2021 the average absence rate for registered nurses and midwives is **8.6%(738wte)**, AHPs **6.5%(100wte)** and unregistered staff **12.6% (400wte).** The impact of this absence has been monitored through the Pandemic daily staffing reporting. Additional temporary staffing usage both registered and non-registered staff, rostering of non-rostered leadership roles, and the redeployment of personnel has ensured safe staffing levels have been maintained.

5. Nursing and Midwifery Recruitment

Domestic Recruitment

5.1 There are currently **46** domestic nurses and midwives in the Band 5 recruitment pipeline with confirmed start dates and a further **157** band 5 nurse and midwives who are working through their recruitment checks and due to commence by the end of Q1.

5.2 The Trust has restarted face to face recruitment events, with 3 events held in October/November 2021. Attendances at these events has been positive and candidates directed to Live Trac applications. Over 400 attendees attended over the 3 events, many of whom were students graduating in September 2022. Further recruitment events are planned for 2022, alongside the Trusts Guaranteed Job Offer campaign. The Trust is hosting a Nursing Assistant recruitment Open day in May 2022, to show case this vital supportive role and developmental opportunities available to Nursing Assistants within the organisation.

5.3 In January 2022 a guaranteed job offer has been sent to GM Nursing, Midwifery and Nursing Associate students who have undertaken placements within the Trust during their final year on programme and due to graduate in Q3, **72% (402)** have accepted the offer pending confirmation of clinical area allocation.

International Recruitment

5.4 The international recruitment (IR) programme has continued to provide the Trust with a strong supply of Band 5 nurses. A total of **505** Band 5 overseas nurses have commenced in the Trust since April 2021. The Trust plans to recruit an additional **65** IR nurses by the end of March 2022 to support an improving vacancy trajectory, HIVE preparatory work and Trust recovery plans. The Trust is planning to recruit Circa 450 internationally educated nurses during the next financial, this will be flexed in accordance with the Trust vacancy factor and recovery plans.

5.5 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 rigour is applied in screening midwives applying to the NMC register. MFT is recruiting **8** internationally educated Midwives through this pilot programme.

5.6 Projected workforce modelling, based on staff turnover, has identified the Trusts need to recruit the same number or more band 5 nurses and midwives in Q3 2022 to maintain a **5-6%** band 5 vacancy factor. Additional targeted recruitment will be undertaken to support service expansion as required.

6. Nursing Associates

6.1 The Trust continues to focus on growing the Nursing Associate workforce, there are **249** Trainee Nursing Associates across the trust undertaking an apprenticeship pathway or through a self-funded route. A further cohort of **38** new Trainee Nursing Associate apprentices start on programme in April 2022.

6.2 There are **188** registered Nursing Associates working across the hospitals, community settings and theatre areas.

6.3 Further expansion of the Nursing Associate workforce will be led by the establishment reviews following further Safer Nursing Care data collection censuses. A focussed programme of work is being undertaken to identify areas for role expansion and continued professional development for Nursing Associate to support service need.

7. Undergraduate Nursing, Midwifery and AHP Pre Registration Education

7.1 In England University and Colleges Admission Services (UCAS)[16] reported record numbers of nursing and midwifery students accepting places on programmes commencing this academic year. The publicity about the professions response to the global pandemic have seen unprecedent number of applicants to nursing and midwifery programmes for the second year in a row. 30,185 accepted places to study commencing in September 2021, a 1.5% on the previous year. Since 2018 there have been a 34% increase in students enrolling to enter these professions.

7.2 Across GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Academic Year 2021/22 has seen a stable position in adult nursing learner numbers, an increase in Children's Nursing (7%), Mental Health (1%) and Midwifery (15%).

7.3 Across Greater Manchester, HEIs and practice partners are working together to increase NMAHP learning environment (placement) capacity. The MFT target set by GM is to increase learning environment capacity by **280** for nursing and midwifery and **111** for AHP by Q2. Across the Trust the internal target is to expand pre-registration nursing capacity by **500** before the start of the 2022 academic year.

7.4 Learning environment capacity for AHP programmes is currently under review both across GM and within the Trust. Physiotherapy is the current priority profession with an estimated projected shortfall of physiotherapy learning environment capacity across GM of **circa 382** placements for the 21/22 academic year. A targeted project within the Trust led by the Chief AHP has commenced to identify a new process to both identify

[16] GOV.UK 2021, Record numbers accept a place to study nursing and midwifery

and centrally manage learning environment capacity and allocations, this has resulted in the Trust offering an additional **49** placement to our partner HEIs in Q4.

8. Workforce Retention

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[17]. This is a 3-year programmes of development based on the HEE funding received. Since the launch of MFT CPD, 43% of the nursing, midwifery and AHP workforce have accessed education that has received MFT CPD points. This is a significant achievement as it has been developed during the pandemic.

8.2 Essential programmes have been prioritised since the launch, such as leadership and infection prevention control. New leadership programmes for clinical educators, team leaders, matrons and lead nurses, midwives and AHPs have been designed, developed, and delivered. Feedback from the first cohorts have demonstrated a positive impact on the workforce, with all programmes being recommissioned for continued delivery.

8.3 Development of our extensive MFT Continual professional development portfolio for the NMAHP workforce continues. Programmes are being developed in response to service need and staff feedback, to support staff development and retention. The Trust are working in partnership with the University of Bolton to validate two Perioperative CPD modules, to support the establishment of a theatre career pathway for nurses and nursing associates as part of theatre recovery.

8.4 A new approach to preceptorship for both domestic and internationally educated nurses, Midwives and AHPs has been developed and will be launched in Q1, to support the retention of newly qualified practitioners. The programme acknowledges the challenges to both graduate UK nurses and those from overseas joining the trust during the pandemic to revisit the opportunities of coaching and mentorship during their early career.

8.5 The Trust's Nursing, Midwifery and Allied Health Professional conference was held in October 2021. This year's conference recognised the challenges that professional have confronted over the past 18 months. The conference considered the learning that will inform our future, with marketplaces focussing on staff well-being. Over 300 colleagues registered for the conference, which took place across three MFT sites and was also live -streamed.

[17] HEE 2019, Health Education England welcomes funding boost for 2020/21

Health and Well-being of NMAHP Workforce

8.6 The Trust continues to focus on initiatives to support the health and mental well-being of staff as the workforce recovers from the pandemic. MFT have launched a new staff experience platform, MFT Open Door, this new platform enables staff to receive messages of recognition and appreciation.

8.7 Further expansion to the national Professional Nurse Advocate role continues across the Trust. The PNA role 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 has 31 Nurses who have undertaken the PNA programme and have commenced in role and a further 36 in training. Restorative supervision initiatives have been launched within the pilot areas of Adult Critical Care, the Local Care Organisations and the Royal Manchester Children's Hospital.

9. Safe Staffing

9.1 Covid-19 continues to significantly impact and influence NMAHP workforce supply. As a result of the pandemic the hospitals/MCSs/LCO have had to work very differently in how they have managed skill mix and staffing levels and deploy staff. There is robust professional leadership in place, supported by existing safe staffing governance frameworks and pandemic specific escalation criteria to ensure the most safe and effective deployment of staff. The sustained clinical pressures alongside staffing shortages from increased sickness absence rates has required daily 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 The Trust Pandemic 'Safe Nursing and Midwifery Staffing Guidance'[18] was developed at the beginning of the pandemic providing a governance framework and escalation risk assess. The guidance has been revised throughout the pandemic in response to the escalation level of the emergency and workforce availability. This has required Directors of Nursing to work differently at each wave of the pandemic and as the workforce challenges have increased. 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 this recent pandemic surge, 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.

[18] Pandemic Safer Nursing & Midwifery Staffing Guidance – Inpatient Ward Areas and Maternity services v5, internal document

9.3 Following reconfiguration of wards and clinical environments during the most recent Covid surge, a programme of work has commenced to re-establish alignment between ward establishments, health roster templates and service delivery models, providing the assurance of safe staffing.

9.4 Temporary staffing has been utilised to support staffing levels throughout the pandemic. Weekly NHS Professionals (NHSP) temporary staffing huddles have continued to ensure maximisation of engagement between our corporate team, Hospital/MCS/LCOs and NHSP. Opportunities to maximise our temporary staffing fill remain the priority with NHSP, new models of incentives and allocation on arrive have been utilised during the recent surge. In December 202, NHSP have provided registered nursing for **141,192** hours of cover and **158,094** for unregistered nursing. With a reduction being seen in absence and an improved vacancy factor work is underway to review and reduce the reliance on temporary staffing.

Safer Nursing Care Tool (SNCT)

9.5 The SNCT[19] 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 4-week period. The tool was introduced across MFT in 2018 to support annual establishment reviews within inpatient areas. A comprehensive and thorough staffing review was completed for 2019/20 in line with national guidance however due to the reconfiguration of wards throughout the pandemic further census collections had been delayed.

9.6 A SNCT baseline census collection period was undertaken in November 2021. Further census collections will be undertaken in March and June 2022 to inform establishment reviews, scheduled to be completed by the end of Q2.

9.7 The SNCT census undertaken in November 2021 has provided the assurance that 75% of ward establishments are safe and match the SNCT recommended establishment. The November census identified 72 in-patient wards funded establishment is equal to the SNCT recommended establishments. A further 20 wards require further census data to validate the recommended establishment for these areas. This work will be undertaken following the March and June census collections.

9.8 A national Emergency Department (ED) Safer Nursing Care Tool has been developed by NHSE. Following training on the use of the tool, an ED census will be undertaken in both adult and paediatric ED departments in Q1. Establishment reviews will be undertaken across each ED applying evidence-based methodology using the new SNCT tool for ED

[19] The Shelford Group, Safer Nursing Care Tool 2021

Safe Staffing in Maternity Services – Birth Rate Plus

9.9 In 2018 the NQB[1] published an evidence-based improvement resource to support safe staffing of maternity services. This guidance endorses the Birth-Rate Plus[7] (BR+) Midwifery Workforce Planning Tool. The tool 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.

9.10 In April 2021, SMH MCS submitted requests to NHSE/I via the GMEC LMS, to ensure the SMH workforce aligned with the recommendations of both the NQB and the Ockenden report[20]. The submissions were approved, and funding has been received to support Midwifery establishments. Saint Mary's Oxford Road have seen an increase in baseline establishment of an additional **9.4wte** posts and Wythenshawe **7.6wte** from Ockenden NHSE funding allocation.

9.11 Following the transaction of North Manchester into Saint Mary's MCS the skill mix of the midwifery workforce has been reviewed. This has enabled an increase in midwifery establishment from **165.36 to 173.09 wte** whilst remaining within the allocated staffing budget. This increase has supported the recruitment of additional roles such as Antenatal Services Matron, night bleep holders, Triage manager, Drugs and Alcohol midwife, Bereavement midwife.

9.12 The Trust is unable to fully implement CoC which has been partially suspended by NHSE during the pandemic. The implementation of Better Births[21] in relation to the Continuity of Carer (CoC) work stream continues to have implications on the SM MCS midwifery workforce. This is due to decreasing of midwifery caseloads in line with the Continuity of Carer Agenda (6-8 Midwives in a team with a case load of 1:36 per Midwife).

9.13 Both a Birth Rate Plus workforce CoC calculation and a calculation using National Workforce Tool for Continuity recommends that, an additional **77wte** midwives are required to implement Maternity Continuity of Carer (CoC) as a default model of care across SM MCS. Further discussions will take place with the LMS as there are similar shortfalls across GM.

AHP Safe Staffing

9.14. At the end of 2020 NHSE/I, stood down the development of the AHP safe staffing tool 'AHPOST'. In place of this the development of a new workforce tool, directly linked to patient pathways, is under way, to date no national tool has been published.

9.15. Current national available resources to ensure AHP safe staffing are only available in specific acute clinical areas namely GPICS[8] guidelines for critical care and BSRM/SSNP[9] for rehabilitation. Individual AHP groups tend to have their own tools for calculating safe caseloads, but these are not widely implemented across services.

[20] OGL 2020, Maternity Services Review

[21] NHSE 2017, Implementing Better Births

9.16 The Chief AHP is leading a pilot to approach an MFT safe staffing standard for the AHP workforce. This will facilitate benchmarking to assess requirements for additional resourcing/new ways of working. The CSS AHP division has commenced a review of AHP staffing levels across medicine and this work will feed into the group approach.

10. Allied Health Professions Workforce Transformation

10.1 In October 2021, the Trust appointed their first Chief Allied Health Professional, key responsibilities of the role are to lead the AHP workforce to deliver safe, coordinated, kind and excellent care.

10.2 As a result of HEE funding an AHP Workforce Project team commenced in post during early December 2021. The overall aim of the project team is to support the newly appointed Chief AHP to produce an organisational AHP strategic workforce plan, based on data intelligence and project outputs/learnings. The AHP workforce team are working closely with the Trust's Workforce Planning & Information team to develop an AHP workforce demand dashboard for the Trust. This will ensure oversight of AHP staffing levels across the hospitals, managed clinical services and local care organisations and establish a process to report recurrent AHP workforce data more accurately.

10.3 A Non-Medical Job Planning programme commenced in January 2021 with the overarching aim to deploy electronic job planning to non-medical clinical staff by March 2022 following recommendations outlined in the NHS Long Term Plan. The programme has followed a staggered approach with all AHP teams included in one of ten cohorts, the first of which commenced in April 2021 and the last of which has recently commenced in January 2022, with a view to them being completed and fully signed off by March 2022.

11. Summary

11.1 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 November 2021 the Trust has been in a further period of escalation to support the emergency pandemic response which has had a significant impact and influenced some of the detailed actions and outcomes contained within this report. There continues to be ever-changing workforce demands that the Trust has and continues to respond to.

11.2 The Trust has seen an improved workforce position over the last 6 months, with a reduction of 4% in the Trusts nursing and midwifery vacancy position. At the end of December 2021 there was a total of **291.2wte (3.18%)** qualified nursing and midwifery vacancies across the Trust compared to **655wte (7.20%)** in April 2021. Both domestic and international recruitment programmes have supported this position.

11.3 Between the beginning April 2021 and December 2021, the average absence rate for registered nurses and midwives is **8.6%(738wte)**, AHPs **6.5%(100wte)** and unregistered staff **12.6% (400wte).** Service impact has been mitigated through the

monitoring of staffing levels, rostering of non-rostered roles, redeployment of personnel and the utilisation of temporary bank and agency staff.

11.4 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. Assurance of safe staffing levels are provided through the daily situational report into the Hospital/ MCS/LOC governance structures.

11.5 The SNCT census undertaken in November 2021 has provided the assurance that 75% of ward establishments are safe and match the SNCT recommended establishment. The November census identified 72 in-patient wards funded establishment is equal to the SNCT recommended establishments. A further 20 wards require further census data to validate the recommended establishment for these areas.

11.6 Appendix 1provide a summary of the workforce positions and safer staff assurance for the Hospitals/MCS/LCOs.

12. Conclusion

12.1 The Board of Directors are 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.

Appendix 1	Hospitals/ Managed Clinical Services/ Local Care Organisation NMAHP Workforce Report Summary

The Hospitals/MCS/LCO 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 is provided in the Appendix1.

1. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

Nursing Workforce Position

1.1 At the end of December 2021, there were a total of **107.4wte (5.46%)** registered nursing vacancies across WTWA compared to **120.4wte (6.27%)** in April 2021. This is a reduction of **13wte (0.81%)** nursing vacancies**.**

1.2 The number of Band 5 nursing vacancies has also reduced. At the end of December 2021 there were **47.4wte (4.67%)** vacant Band 5 nursing posts compared to **70.7wte (6.97%)** in April 2021. This is a reduction of **23.2wte** (**2.30%).** Theatres, urgent and emergency care and the acute medical units are the areas with significant recruitment challenges, with most of the Band 5 vacancies being in these areas across WTWA.

1.3 There are **27** Band 5 nurses in the domestic recruitment pipeline for WTWA, **6** with confirmed start dates by March 2022. There are an additional **55** internationally recruited nurses planned to arrive before the end of March 2022.

1.4 The rolling 12-month turnover for nursing has improved since April 2021 reducing to **9.8%** from **11.3%.** The turnover for Band 5 staff nurses is currently **12.6%** which has improved over in the same period from **13.0%**.

1.5 Sickness absence within the registered nursing and staff group at WTWA was **180.4wte (9.7%)** for registered nurses and **140.1wte (16.5%)** for unregistered staff in December 2021. AHP sickness reduced from April 2021 **12.5%** to **8.1%** in December 2021.

AHP Workforce Position

1.6 At the end of December 2021 there are current no AHP vacancies within WTWA.

1.7 The rolling 12-month turnover for AHPs at WTWA is **13.2%** which is under the national AHP benchmark. Sickness absence within the registered AHP group at WTWA is **7.2wte (8.1%)** in September 2021.

1.8 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.

WTWA Safe Staffing

1.7 Following the movement into the new WTWA operational structures, a data cleansing exercise is being undertaken on the WTWA Nursing and AHP workforce position, to ensure that ESR data and the financial ledger are aligned.

1.8 Theatre and the emergency department are the areas with higher vacancies. 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. Dedicated Nursing Associate roles are being introduced into the UTC workforce model. Additional places are being supported to train emergency nurse practitioners for both the ED and the UTC.

2. Manchester Royal Infirmary (MRI)

Nursing Workforce Position

2.1 At the end of December 2021, there were a total of **5.7wte (0.37%)** registered nursing vacancies across MRI compared to **110.8wte (7.29%)** in April 2021. This is a reduction of **105.1wte (6.91%)** nursing vacancies**.** The hospital's low vacancy position is expected to be maintained through Q4 and Q1.

2.2 Due to the number of band 5 domestic and international starters deployed to MRI since April 2021, there are currently no band 5 registered nursing vacancies in the hospital. The Band 5 vacancy position is expected to remain positive throughout Q4 and Q1.

2.3 There are **35** Band 5 nurses in the domestic recruitment pipeline for MRI, **9** with confirmed start dates by March 2022. There are an additional **50** internationally recruited nurses planned to arrive before the end of March 2022. These nurses will fill vacancies due to turnover, service expansion and the implementation of HIVE.

2.4 The rolling 12-month turnover for nursing is **12.1%** (184wte) within MRI which is an increase from April 2021 when it was **11.6%.** The turnover within the Band 5 nurse workforce is **14.4%** (124.66wte) which is a **1%** decrease from April 2021 where it was **15.4%**.

2.5 Sickness absence within the registered nursing and staff group at MRI was **146.2wte (9.6%)** for registered nurses and **120.9wte (16.3%)** for unregistered staff in December 2021.

2.6 Workstreams have been implemented across the hospital to focus on staff health and wellbeing in response to the Covid pandemic. Increasing visibility of senior nursing team to ensure staff are taking measures to maintain current Covid19 guidance. Increasing availability of Mental Health First Aiders and MRIs Health and Wellbeing

Champions, to ensure staff feel safe to speak to a colleague when work stresses cause staff to feel pressured, threatened, or anxious.

MRI Safe Staffing

2.7 The MRI Director of Nursing is currently overseeing a programme of work with Deputy Director of Finance to ensure that MRI ward establishments reflect agreed established requirements following the significant reconfiguration of the MRI ward areas over the last 12 months.

2.8 Areas with higher-than-average vacancies continue to have robust recruitment improvement plans, specialist area such as Theatres, Haemodialysis and Emergency Department (ED) provide the greatest challenge. The Head of Nursing for Workforce and Education has been working with the workforce information team to review trends by ward area to develop with each of the CSU Lead Nurses, specific improvement plans to improve vacancies and reduce turnover in these areas.

2.9 Analysis of band 5 leavers from the hospital in 2021, highlights that the critical time where the hospital sees a high level of attrition of band 5 nursing staff is between 2 and 5 years of starting in post. Nurse retention initiatives to enhance support with improved induction, preceptorship, mentorship and flexible options to reduce avoidable leavers are incorporated in the workplan of the Wellbeing and Workforce Matron.

3 North Manchester General Hospital (NMGH)

Nursing Workforce Position

3.1 At the end of December 2021, the registered nursing vacancies have reduced by **16.3wte (10.9%)** registered nursing vacancies across NMGH from **61.6wte (8.95%)** in April 2021 to **45.3wte (6.32%).**

3.2 In April 2021, the vacancy rate was **69.4wte (8.35%)** band 5 registered nursing, through focused deployment of domestic and IR band 5 starters, this has now been reduced by **42.5wte** in 9 months to **30wte (7.16%)**

3.3 There are currently **30** qualified staff in the NMGH domestic pipeline, undergoing pre-employment checks and **5** are expected to commence in post before the end of March 2022. In addition, **37** international nurses are due to arrive before the end of March 2022.

3.4 Sickness absence within the registered nursing staff group at NMGH was **58.4wte (8.7%)** and **34.1wte (9.3%)** for unregistered staff in December 2021.

NMGH Safe Staffing

3.5 A nurse staffing establishment review was commissioned by the NMGH Director of Nursing in October 2021, in response to the significant changes to ward configurations during the COVID-19 pandemic. Due to the lack of SNCT data for NMGH an

establishment review has been undertaken based on a review of existing rosters, clinical professional judgement, and benchmarking against comparable clinical areas.

3.6 The new establishments were compared to pre-covid establishments to demonstrate any variance, a deficit of circa 40 Registered Nurses has been identified. A business case requesting this investment was approved in November 2021. A base line SNCT establishment review has been undertaken in Nov 2021, with 2 furthers census planned for 2022 prior to further establishment reviews in Q 3.

3.7 Targeted work is underway to implement initiatives to enhance employee engagement. These include the introduction of health and wellbeing huddles, the employment of wellbeing practitioners and the development of bespoken development programmes for bands 5 and 6 nurses. Targeted rotational programmes for newly qualified nurses between ED and the Acute Medical units are being introduced to support and improved vacancy factor and turnover.

4. Royal Manchester Children's Hospital (RMCH)

Nursing Workforce Position

4.1 At the end of December 2021, there are currently no registered nursing vacancies at RMCH.

4.2 There are **32** staff nurses currently in the domestic recruitment pipeline, with **11** due to start by March 2022. A further **6** international nurses are expected to arrive before the end of March 2022.

4.3 The rolling 12-month turnover for nursing is **9.8%** (100.5wte) within RMCH which is an increase from April 2021 when it was **7.3%.** The turnover within the Band 5 staff nurse workforce is **11.1%** (65.2) which has also increase from April 2021 when it was **8.1%**.

4.4 Sickness absence within the registered nursing and staff group at RMCH is **121.1wte (11.8%)** for registered nurses and **44.7wte (15.5%)** for unregistered staff in December 2021.

RMCH Safe Staffing

4.5 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. Public Health England provided predictions of a prolonged season of respiratory illness for young children in 2021/2022, the peak season is usually November – December, predictions for 2021 were that it would begin in August 2021 and continue to March 2022, with hospitals nationally being required to plan for a potential 20-50% increase of patients with respiratory illness, impacting on paediatric critical care and the inpatient areas in RMCH and MCS. Initial predictions were correct with respiratory illness impacting on paediatric critical care and inpatient areas from August 2021, but then with cases plateauing prior to a second increase in December

2021. GM paediatric meetings have been held up to daily to review the impact and ensure flow across the system continues.

4.6 Admissions to RMCH/MCS of young people in the care of Child and Adolescent Mental Health, (CAMHS), or Social Care without an appropriate placement, has continued to cause significant challenge to the workforce during the winter period. These patients require a higher level of supervision and display behaviours, along with the interventions required which impact on staff well-being, this in turn impacting upon acuity in the clinical areas, requiring additional staffing support and close working with Security and Employee Health Being.

4.7 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.

4.8 The first stage of Paediatric Emergency Department (PED) expansion was completed at the end of November 2021 with a handover of a new space to PED to enable the re-opening of the Children's Clinical Decision Unit at the beginning of December 2021. A business case is being submitted to increase the establishment by **35wte** registered nurses, a sustained workforce will maintain the use of the new area. A phased recruitment plan will be developed if the business case is approved.

4.9 Haematology activity has increased as new therapies are introduced with RMCH providing specialist service provision in and out of region. The existing units, (Bone Marrow Transplant Unit and Stem Cell and Gene Therapy Unit) no longer have sufficient capacity to manage the activity demand a business case has been developed to increase capacity which has resulted in an increase in **17wte** registered nurses being required and **6wte** non-registered nurses. Recruitment to these posts is ongoing.

5. St Mary's Hospital MCS

SMH Nursing Workforce Position

5.1 At the end of December 2021 there was an overall nursing vacancy position of **66.1wte (4.94%)** of which **27.8wte** were within the Band 5 nursing group.

5.2 There are **13** Band 5 nurses currently in the domestic pipeline, **4** of these nurses are confirmed to start by March 2022, **1** appointed to work within Newborn Services and **3** appointed for gynaecology. Targeted international recruitment to attract experienced nurses for Newborn Services has been undertaken, **19** IR nurses are predicted to commence before March 2022.

5.3 The rolling 12-month turnover in SMH MCS registered nursing workforce has increased from **11.5%** in April 2021 to **12.9%** at December 2021. In the same period, the Band 5 registered nursing 12-month turnover has decreased slightly from **16.8%** to **16.7%**. Work has commenced to enhance the retention of Newly qualified Midwives through the development of an early careers' pathway, supported by NHSE funding.

5.4 Sickness absence within the registered nursing and midwifery staff group at SMH was **148.6wte (11.7%)** for registered nurses and midwives and **31.9wte (12.3%)** for unregistered staff in December 2021.

New-born Services – Safe Staffing

5.5 The NHS Long Term Plan has committed to new investment in neonatal services until March 2024 to support delivery of the Neonatal Critical Care Transformation Review (NCCR)[22]. In support of this New-born Services are applying for funding from NHSE to support an increase of establishment of **24.71wte** cot side staff further to be fully compliant with the British Association of Perinatal Medicine (BAPM) standards to calculate staffing requirements based upon activity and acuity.

5.6 New-born Services are working with the Northwest Neonatal Operational Delivery Network (NWODN) to look at ways to fast-track staff with paediatric and oversees neonatal experience though the neonatal induction programme (NIP). This course is a pre-requisite for undertaking the Qualified in Speciality (QIS) course, which is a nationally driven directive where 70% of the registered workforce must hold a QIS.

5.7 New-born Services Division continues implement strategies to support nurses new to the service. All new band 5 starters to New-born Services are supported to rotate between the level 3 and level 2 sites during the induction period as part of a career progression pathways to support nurses new to the speciality.

SMH Gynaecology

5.8 Gynaecology have recently undertaken a successful recruitment campaign to fill vacancy gaps across all areas within gynaecology nursing, which has led to the improved vacancy position.

5.9 Robust career pathways have been developed to equip staff with speciality specific skills, as part of a programme to retain newly recruited nurses. Working is commencing to create new roles within Gynaecology to deliver advanced clinical skills to provide another layer of advanced clinical skills and expertise to our client group and to ensure we maintain and develop our provision of nationally accredited specialist services.

[22] NHSE 2020, Implementing the Recommendations of the Neonatal Critical Care Transformation Review

SMH Midwifery Workforce Position

5.10 In December 2021 there was **26.1wte (6.83%)** registered midwife vacancies across SMH MCS. There are 10 newly qualified Midwives in the band 5 pipeline to commence before the end of Q1.

5.11 The rolling 12-month turnover within the midwifery workforce is **12.6%.** This is an increase of **1.5%** from April 2021 when turnover was **11.1%.**

6. Clinical Support Services MCS (CSS)

Nursing Workforce Position

6.1 At the end of December 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 beds across adult critical care.

6.2 Within CSS the rolling 12-month turnover for all qualified nurses in December 2021 was **10.5%** which is a reduction of **1.3%** from April 2021 when turnover was **11.8%** The 12-month rolling turnover for band 5 nurses for the same period is **11.2%** which is also a decrease from **13.0%** in April 2021.

6.3 Sickness absence within the registered nursing and staff group in CSS was **85.9wte (8.7%)** for registered nurses and **13.1wte (12.2%)** for unregistered staff in December 2021.

AHP Workforce Position

6.7 At the end of December 2021 there were a total of **68.66wte (7.1%)** registered AHP staff vacancies within CSS. Specialist team within Dietetics, Speech and Language Therapy, Occupational Therapy and Physiotherapy have high numbers of vacancies.

6.8 The sickness absence rate in December 2021 within the AHP workforce was **61.5wte (6.8%)**.

6.9 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%**.

6.10 Across the MCS there are ongoing difficulties in recruiting to band 5 occupational therapy posts. The Division is working collaboratively with the Local Care Organisations to support 2 OT assistant commence on the occupational therapy apprenticeship in March 2022.

CSS Workforce Transformation

6.11 Adult Critical Care Services have worked to ensure emergency, transplant and elective services have been maintained alongside critical care delivery for patient with Covid 19. This has been achieved by expanding critical care capacity and reconfiguring units, to be able to continue to deliver non-COVID-19 services, as well as having enough capacity to meet future projected COVID-19 demand. CSS have seen an establishment increase from **715wte** in April 2020 to the current establishment of **935wte** post the integration of NMGH. Accelerated national and international recruitment of nursing staff has been pivotal in achieving the current vacancy position.

6.12 An additional business case is currently being developed for the further expansion of CTCCU at Wythenshawe Hospital with a planned increase in capacity from the current 31 beds to 43. This will support the Trust Cardiac Services Strategy to address health inequalities and inequity of Cardiothoracic services across Greater Manchester (GM). Additionally, a redesign process is underway at NMGH which includes the provision of a new Critical Care Unit

CSS Safe Staffing

6.13 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[23] 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, transferring staff between units during periods of staffing escalation has maintained these standards.

6.14 Within the Radiology intervention unit staffing levels are compliant with national guidance on 24-hour Interventional Radiology Services on the Oxford Road campus[24]. A review of services on the Wythenshawe Hospital site has been undertaken to move to a 24- hour staffing model, the outcome of the review and final approval is pending.

CSS Staff Wellbeing

6.15 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 to-date 14 staff have completed the training programme, a PNA lead has been appointed to support the implementation of this initiative across CSS.

6.16 Targeted work is ongoing to address staff satisfaction and well-being. Initiatives such as ‘Thoughtful Thursday’ (staff served coffee and cake in a socially distanced environment), ‘Reflective Rounds’/’Wellbeing Sessions’ (weekly meetings led by both nursing and medical staff to provide an opportunity to share how they feel, to reflect on challenging situations, focus on the emotional impact) and staff exercise and walking events, are well established.

[23] FICM 2019, Guidelines for the Provision of Intensive Care Services

[24] RCR 2017, Standards for providing a 24-hour interventional radiology service

6.17 During the recent covid wave the focus was intensified towards staff wellbeing which led to the development of Wellbeing Link Nurses and 'Quiet Rooms' for staff. In conjunction with HR colleagues and Employee Health and Wellbeing, psychologists visited the units and met and spoke with staff and now support the Reflective Rounds/Wellbeing Sessions.

7. Manchester Royal Eye Hospital (MREH)

Nursing Workforce Position

7.1 At the end of December 2021, there were a total of **6.2wte (3.85%)** 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 **12.3%** for qualified staff (from **15.7%**).

7.2 Sickness absence within the registered nursing and staff group across MREH is **20.1wte (13.0%)** for registered nurses and **8.9wte (15.2%)** for unregistered staff in December 2021.

7.3 Transformation of the nursing workforce is critical to the successful delivery of the COVID-19 recovery plans and longer-term strategic direction of MREH and UDHM. A review of all the nurse staffing establishments has been untaken during 2021, across MREH and an Emergency Eye Department (EED) specific and general MREH nursing workforce Business Cases have been prepared. The Business cases seek support to substantiate current unfunded posts, which equates to **12.97wte**.

7.4 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.

AHP Workforce

7.5 The Orthoptic Department is fully established with no vacancies and does not experience any issues recruiting high calibre orthoptists at all bands.

7.6 During the recent Omicron surge of activity from MREH are redeployed as vaccinators (part-time) to NMGH to support delivery of the vaccination programme.

MREH Safe staffing

7.7 Safe Staffing levels have been maintained throughout the pandemic. Staffing across all MREH during the pandemic has been monitored through a staffing and service escalation meeting chaired by the director of nursing. A 7-day forward look for planned versus actual staffing was introduced in November 2021 and is updated at the daily staffing meeting.

8. University Dental Hospital (UDHM)

UDHM Workforce Position (Dental Nurses)

8.1 At the end of December 2021, the Dental Hospital has **0.6wte** vacancies**.** The UDHM does not experience any issues in recruiting dental nurses at all bands, therefore the Hospital will continue to recruit to turnover.

8.2 Sickness absence has decreased over the last 6 months across UDHM. Sickness absence in UDHM was **0.6wte (9.3%)** in December 2021, compared to **0.9wte (14.4%)** in April 2021.

9. Manchester Local Care Organisation/Trafford Local Care Organisation (M&TLCO)

Nursing Workforce Position

9.1 At the end of December 2021 there was a total of **103.2wte (9.48%)** registered nurse vacancies across the M&TLCO compared to **101.3wte (9.3%)** at the start of the financial year.

9.2 There are **27** Band 5 nurses currently in the domestic pipeline to start in the M&TLCO, **7** of these are booked to start by March 2022. There are **20** international nurses expected to arrive before the end of March 2022.

9.3 The rolling 12-month turnover for nursing is **15.9%** which is an increase of **3%** since April 2021 when it was **12.9%**.

9.4 Sickness absence within the registered nursing staff group at M&TLCO is **97.5wte (9.9%)** in December 2021.

AHP Workforce Position

9.5 There are **29.8wte (6.1%)** AHP vacancies in the M&TLCO in December 2021, recruitment of Dietitians and Children's Speech and Language Therapists continues to be a challenge. The AHP 12 month rolling turnover position is **14.4%**.

9.6 The sickness absence rate within the M&LCO AHP workforce was **34.1wte (7.5%)** in December 2021.

M&TLCO Safe Staffing

9.7 The M&TLCO Recovery, Reform and Portfolio Board which was initially established to oversee the recovery of services following the first wave of the COVID-19 pandemic, oversees changes to service provision and service development. Reviews are currently being undertaken: to standardise urgent care provision across both LCOs, increase intermediate care beds and the provision of School Health Immunisation programmes, to deliver Covid 19 vaccinations

9.8 The current workforce challenge remains within the District Nursing Services across both Manchester and Trafford. The staffing challenge is twofold, capacity outweighing demand due to increased referrals and this is compounded by vacancies and staff absence. District Nursing staffing during the evening and overnight is a particular pressure. The M&TLCO have established a task and finish group to benchmark current establishments within the District Nursing teams across Manchester and Trafford. 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.

9.9 A daily situation report has been introduced to manage caseloads and share resources where required, ensuring staffing safety is maintained. 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.

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:	March 2022
Subject:	Board Assurance Framework (February 2022)
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 (February 2022) 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 (June 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 Board Assurance Framework (BAF) presents the risks which have the most potential to impede MFT's delivery of its Strategic Aims. In preparation for this report, the Trust's Scrutiny Committees have reviewed the BAF risks which are allocated to them.

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.

At January's Board meeting, MFT's Strategic Aims for April 2022 onwards were agreed. As they are different from the existing Aims, the BAF which is presented at July's Board meeting will be significantly different in content. The format of the BAF will be reviewed at the same time to ensure that it is presenting Board members with the clearest information possible to receive assurance. It will also respond to MFT's new Risk management Framework, currently being developed, and reflect suggestions and recommendations over the last year with Non-Executive Directors and internal auditors.

The BAF is received and noted 3 times a year by the full Board of Directors. The updated BAF for June 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 (February 2022) 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

(February 2022)

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

Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): There is a risk that we will not optimise the safety and the effectiveness of the care we provide if we do not identify, respond to and/or manage effectively opportunities for learning change and improvement in the safety and effectiveness of the care we provide

Enabling Strategy:
QUALITY AND SAFETY STRATEGY

Group Executive Lead:
JOINT GROUP MEDICAL DIRECTOR

RISK CONSEQUENCES (What might happen if the risk materialises?):

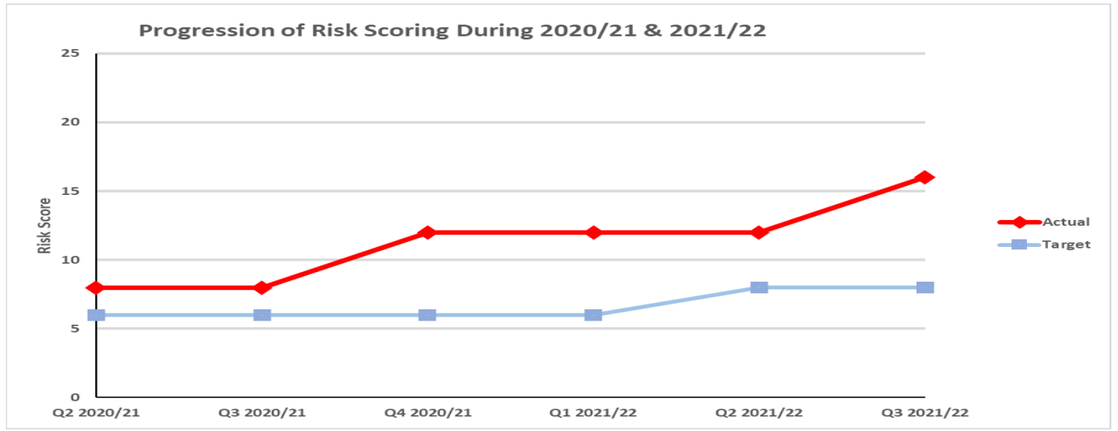
1. Increased likelihood of harm to patients
2. Failure to design and/or transform services effectively and safely
3. Failure to ensure the maturation of our patient safety culture
4. Failure to eradicate 'Never Events'
5. Reputational damage because of safety concerns
6. Disengagement of and psychological distress of staff
7. Regulatory implications
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 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 Patient Safety Profile and Plan (including Site PSIRPs) A.4 Risk management strategy A.5 Patient experience strategy A.6 Safety Management system including PSIRF A.7 Safety Oversight System A.8 Infection Prevention and Control Standards A.9 LocSSIPS programme A.10 Quality and safety improvement collaboratives A.11 Incident reporting benchmarking A.12 Human Factors Academy A.13 Patient Safety alert management process A.14 Patient Safety Specialist Network A.15 Health and safety benchmarking A.16 Structured Judgement Review Programme/Mortality review A.17 Friends and Family test A.18 National Inpatient survey A.19 Other National Patient Surveys A.20 Complaint benchmarking A.21 CQC compliance action plan A.22 Performance (RTT/ECS/Cancer) benchmarking A.23 PLACE assessments A.24 Clinical Accreditation Scheme A.25 Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students) A.26 Data Security Protection Toolkit A.27 Mandatory Training Programme A.28 Medical Examiner System	B.2 F2SU not fully embedded B.4 National Patient Safety Training offer not formalised B.5 General Patient Safety training not in place B.6 Lack of patient and public involvement in patient safety B.7 Lack of embedded 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 B19 Lack of consistent approach to assurance B20 Policy control sub-optimal	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 C.10 Internal audit reports C.11 Development of an assurance framework and map aligned to the regulatory framework C.12 Embedded patient safety and integrated risk governance structure C.13 Medical Examiners System	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 D.8 lack of understanding of the impact of inequality on patient safety and patient outcomes	**16 (4x4)**	C.12 Refine policy oversight and Governance process B.2 Evaluate F2SU process and oversight C.12 Undertake 6 monthly assurance reviews of revised governance infrastructure B.4 Implement the strategic deliverables of the Human Factors Academy B.4 Review 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 Test the suite of interventions to support the development and maturation of patient safety culture 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 and delivery of masterclasses on assurance processes B.20 Revise approach to accelerated improvement to policy management	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. Sub-optimal progress, approach to be reviewed Jan 2022 and ensure integration with HIVE 2. Revised safety, risk and effectiveness governance infrastructure under assurance review/Internal Audit of effectiveness of controls 3. Group Safety Management System in operation since February 2021-report provided to QPSC February 2022 4. Human Factors Academy Strategic Deliverables Units have leadership and operational support to deliver requirements 5. Sub-group of Patient Safety Committee established to ensure delivery of national patient and public involvement in patient safety framework 6. Sub-group of patient safety committee established to ensure that we make patient safety data count 7. SPC now used as standard for safety data 8. Safety II data being captured through Ulysses (Proxy through excellence reporting currently) 9. Membership of safety and governance team in a number of HIVE RDGs confirmed 10. Project 2v has delivered a draft hot debrief tool and is developing a training package 11. Strengthened approach to the management of assurance processes associated with implementation of NICE guidance 12. Strengthened approach to the management of assurance processes associated with national audit 13. HED system now procured to support mortality and effectiveness data requirements 14. Safety focused summits held in relation to urgent and emergency services and never events 15. Risk in relation to Never Events reviewed and escalated to GROC with a risk score of 20 16. Concerning profile of Never Events across the Trust, accelerated learning in place in relation to LocSSIPS, NG Tube placement and patient safety culture in theatre environments 17. Review of Quality Impact Assessment Tool underway to support assurance when services transition 18. Proposal in relation to a consitent approach to psychological safety across the Trust developed and being presented to the Group Q&S Committee in February	**8 (4x2)**

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?):

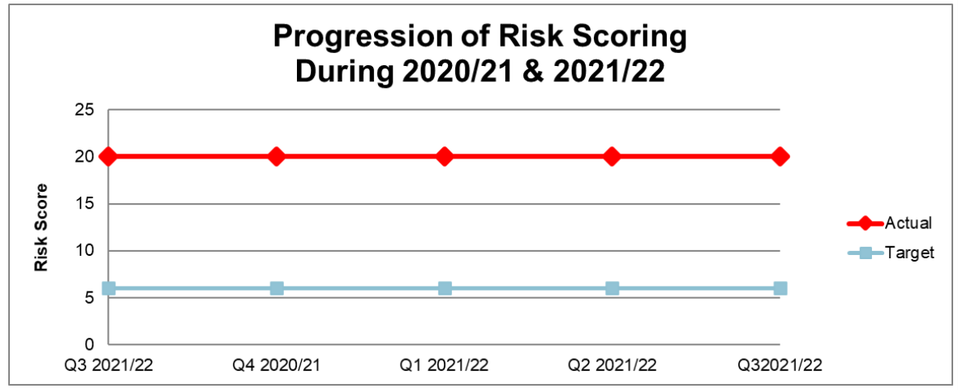
1. **Increase in serious harm to patients**
2. **Increase in nosocomial infections**
3. **Increase in staff outbreaks**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

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	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 to be ratified in January 2022. B3. Monthly AMS audits inform prescribing practices. 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. 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.	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	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 24th December 2021. Significant changes have been incorporated for inclusion in Q4 BAF report. A standalone IPC BAF, that includes changes within the newly issued BAF will be presented to Group Infection Control Committee in January 2022. Through December 2021, assurance and controls have been assessed. against each indicator with mitigating actions in place. A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. 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. All patients admitted via ED are screened for COVID-19, data is reviewed daily Covid 19 Outbreak in place 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	**6 (3X2)**

	○ Fit testing databases are in place in hospitals/MCS, Trust level database under development ○ Variety of makes of FFP3 disposable respirators increased - The training hub includes a series of COVID-19 training resources, local induction includes IPC measures. - A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety.		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			IPC/Health and Wellbeing			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	

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		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 developed, and reporting to the Medicines Optimisation Board and Group Infection Control Committee 3 sub-groups of AMC formed including - Guidelines and development group - Education and training interventions - Research quality improvement and audit	**6 (3X2)**

			for current need C4. Controlled entrance & exits to Trust to minimise risk of cross infection							

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 1,3, 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		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 C8. Test 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	Guidance is in place, aligned to UKHSA directions that support staff returning to work following identification as a contact or following COVID-19 infection.	**6 (3X2)**

	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.										

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

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	Sep-21	Oct-21	Nov-21
A&E 4-hour Access	95%	64.65%	62.01%	66.36%
RTT <18 weeks %	92%	53.80%	53.10%	53.60%
52-week breaches	-	14,184	13,534	12,749
Incomplete waiting list	-	150,730	152,617	154,125
12-hour Trolley Waits	0	26	84	113
DM01 Diagnostics %>6wks	<1%	27.40%	25.60%	27.00%
Cancer 2ww	93%	89.64%	76.84%	65.50%
Cancer 31 days	96%	87.02%	85.50%	88.99%
Cancer 62 days	85%	59.72%	57.29%	52.68%

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)	MFT Covid Governance Framework established including: 1.1. Response & Recovery Group - chaired by GDO 1.2. Operational Response - Hospital Management 1.3. Regional Covid Governance Structure, which MFT is represented at including: 1.4. GM Gold 1.5. Hospital / Community Cells 1.6. NW EPRR Single Point of Contact 1.7. 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. 1.8. In line with national planning guidance for 21/22, H2 activity planning was submitted. This includes performance trajectories for managing urgent (inc. Cancer) and longest waiting patients. 1.9. Reporting in place to track activity levels against the revised planning expectations and associated performance trajectories. 1.10. 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. This group has been superseded by Response &	2.1 Currently assessing the requirements of 2022/23 planning guidance to ensure Performance Management Frameworks are aligned to new guidance.	3.1 Reporting to the Executive Board and Committees in relation to the Covid Pandemic, Recovery programme and performance. 3.2 Daily Response & Recovery Group meetings who regularly scrutinise performance of UEC, elective and Cancer 3.3 Minutes and papers relating to Trust Committees. 3.4 Hospital Activity, capacity, and annual plans 3.5 Internal/external audits of data quality 3.6 Annual Review and NHSI sign off Trust Access Policy	4.1 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 Improved flow through ED departments maximising the use of appointments within the UTC services, and streaming patients to SDEC services 6.2 Additional discharge to assess capacity has been commissioned to improved flow and minimise the number of patients in beds who do not meet the criteria to reside 6.3 Use of Trafford as a green site and reallocation of theatres based on 104ww demand: ensuring that specialties with the largest elective backlogs and long-waiters can access theatre capacity 6.4 Maximising the use of the Independent Sector to reduce long waiting routine patients 6.5 Patient Initiated Follow Up: implemented PIFU in>50 specialties in order to support patient choice and ensure patients are only followed up in outpatients where this is needed. 6.6 Virtual Triage: implementing consultant-led electronic triage of all GP referrals to ensure patients are seen right place, first time, reducing levels of inappropriate first appointments and maximising the efficiency of non-admitted pathways.	15 (3X5)

	Recovery Meetings 10/21 to support MFTs revised Senior Operational Corporate Structure 1.11. Governance and reporting structure in place to support the Recovery Programme, with a Response & Recovery Group established, and routine reporting into the MFT Executive Team. 1.12. MFT Board and Committee activity and performance reporting in place 1.13. MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.14. Patient Access Policy 1.15. MFT EPRR Policies and Plans to support organisational response to Major Incident and Business Continuity incidents 1.16. 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. 1.17. 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. 1.18. Covid contact tracing 1.19. Vaccination programme 1.20. Transformation plans on Urgent Care and Flow and elective workstreams have been implemented and continue to be developed 1.21. H2 planning submission 11/21 to continue to support recovery of activity and therefore delivery of performance									

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

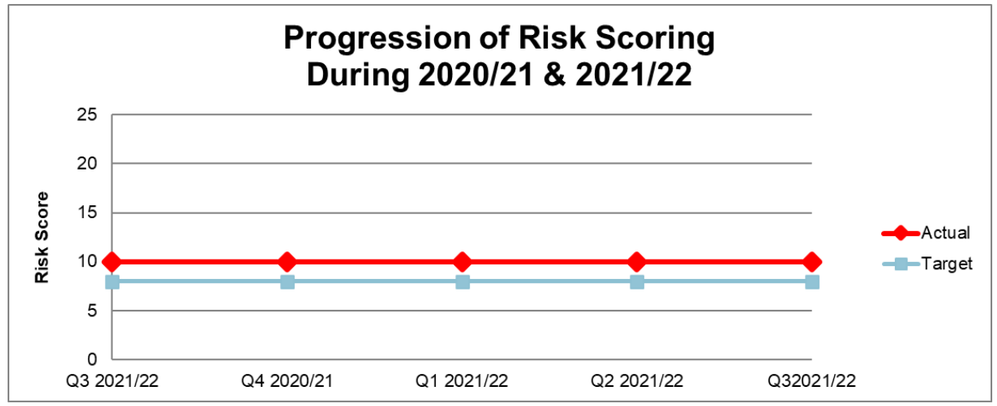
RISK CONSEQUENCES (What might happen if the risk materialises?):

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 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"*
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.	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	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	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	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. At St Mary's ORC, when a pregnant woman who is not booked for care at St Mary's ORC presents to maternity triage, a notification is sent to the Named Midwife for Safeguarding and the Senior Specialist Midwife Safeguarding who then access the relevant part of the NHS Spine Portal Summary care record. CP-IS is now being accessed on the next working day following the presentation *in addition* to the other safeguards which were previously in place. At St Mary's @ Wythenshawe there are two areas where CP-IS is required, maternity triage and the Early Pregnancy Unit. For un-booked women presenting at maternity triage the Named Midwife safeguarding can view CP-IS on the next working day following the presentation. Within the Early pregnancy unit, the Named Midwife for Safeguarding has initiated a workstream to fully implement use of CP-IS by relevant staff so that it is accessed for all presentations. The EPIC / HIVE team have advised that CP-IS will be integrated into HIVE. 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. Staff can access face to face and online MCA/DoLs seminars, available at WTWA, ORC and NMGH monthly. These can be booked through the Trust Learning Hub. 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 completed and appropriately sent to the LA has improved by nearly 50% (figures taken from audit completed December 2021). A process has been agreed with Manchester LA to trial an urgent notification system to escalate DoLS referral for specific cases by end of Q4. This will be highlighted by the Trust Safeguarding mental health team where there is evidence of increased levels of restriction, with continuous level of supervision for the patient. The trial will determine if the Manchester LA DoLS manager is able to escalate the BIA assessment to confirm or rescind the DoLS in response to the specific request. A report will be compiled by end of Q4 with LA partner to show whether the effectiveness of this system has produced positive results to maintain statutory requirements/ protect patient rights and support making safeguarding personal. Consideration will also be given to sharing trial outcomes with other DoLS management hubs in Q1/22. 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%** with **90%** expected by March 2022. The safeguarding and learning and development teams have commissioned a revised safeguarding training	**8 (2x4)**

	A12 AOF monitoring (LCO)	B6. LD and/or Autism Strategy not yet finalised	safeguarding audit programme C11. Safeguarding supervision data			assurance documents and evidence and scrutinise any areas of concern.			package with an online content that includes virtual/participatory learning - an implementation plan to deliver this training package has been developed. Level 3 safeguarding children compliance has decreased to 67.73% at the end of Q3 (73% at the end of Q2) Level 3 Safeguarding Adults compliance has increased to 66.48% at the end of Q3 (63% at the end of Q2) although trajectories are in place it is unlikely that 90% compliance by the end of Q4 can be achieved with the numbers of staff currently absent from work. 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. Progress continues to be made with the development of the new training packages. 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. The LD Safeguarding team is currently fully recruited. Specialist LD nurses are making connections across MFT and with partner agencies. The Team complete intentional rounding's for LD patients that also form part of the safeguarding audit plan. Outcomes are shared with site safeguarding committees, LD champions and LD delivery groups. 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. The Safeguarding Mental Health/LD & Autism Team Matron attends these meetings and is an active part of the service improvements. The Team have also accepted responsibilities for LeDeR service improvements and reporting from Q4/22. 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. This is supported by the intentional rounding tool which is completed by the team. This tool gives evidence about quality of care and encourages immediate action to effect positive adjustments to improve care for the patient. 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. The CQC Regulation 13 Self Assessments for 2021 have been completed for all areas except for St Mary's and the LCO although work to progress this continues.	

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

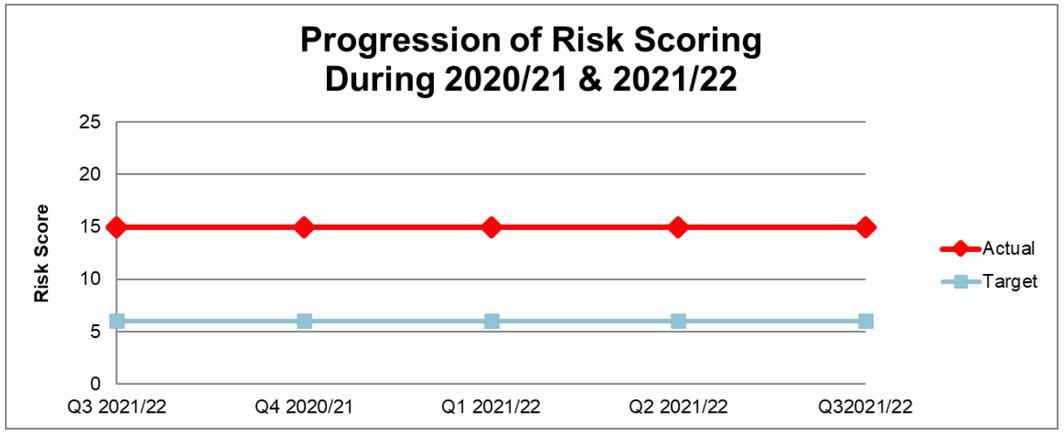
Group Executive Lead:
CHIEF OPERATING OFFICER

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 D.3. Undertake compliance audits across MFT estate	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 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 Compliance audit underway at ORC and being arranged at Wythenshawe	**6 (3x2)**

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

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**

Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

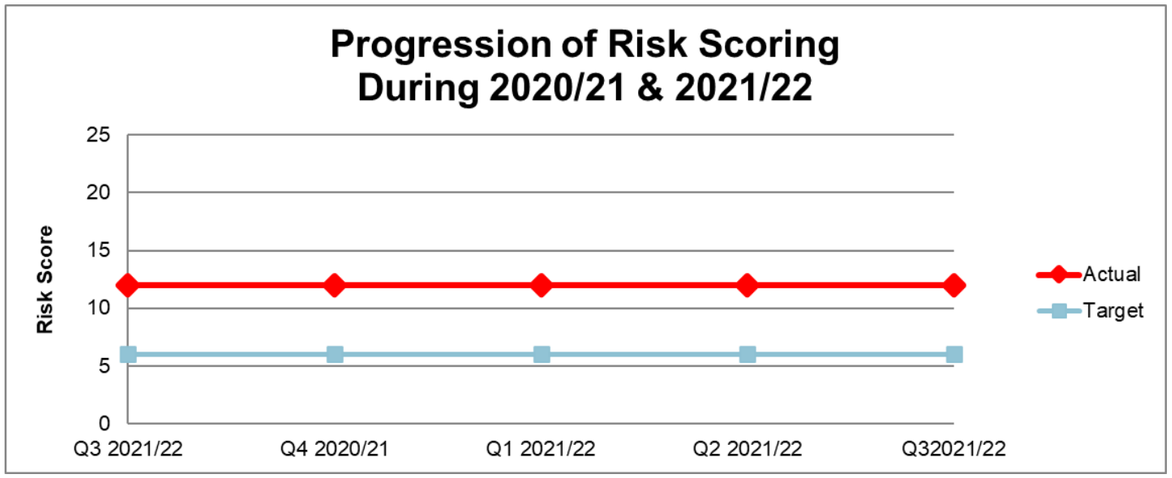
Group Executive Lead:
CHIEF NURSE

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 on target to recruit 575 international nurses by the end of March 2022 to support pandemic recovery plans and in readiness for HIVE (367 arrived). 3 The registered nurse and midwifery vacancy rate continues to improve - reduced to 3.8% in December 2021 (7.1% April 2021) 4 A Guaranteed Job Offer has been offered to all 3rd year student nurses and midwives who undertake their final year placements at the Trust. 5. 12 month rolling turnover rate for nursing and midwifery remains static - 11-12% 6. Directors of Nursing undertaking baseline establishment reviews to support reconfiguration of ward/department area. 7. Review of midwifery services across SM MCS. through both Birthrate plus and the Maternity Continuity of Care Workforce Tool to determine future maternity workforce model 8. Safe staffing census data was collected in November, with further census planned for March and June 2022 to inform in patient ward establishment reviews following 3 census periods. 9. Nursing and midwifery managers are working closely with NHS Professionals to ensure adequate bank and agency supply to cover increased sickness absence rates. 10. Twice daily staffing escalation meetings in place across the trust to undertake twice daily staffing risk assessment and completion of hospital staffing sitrep. 11 Weekly DONs staffing escalation meeting – chaired by DepCN 12. Hospitals/MCS continue to focus on programmes to support staff health and well-being	**6** **3x2**

Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): Failure to deliver medical workforce workstreams (consolidated risk)

Enabling Strategy: **WORKFORCE STRATEGY**

Group Executive Lead: **JOINT GROUP MEDICAL DIRECTORS**

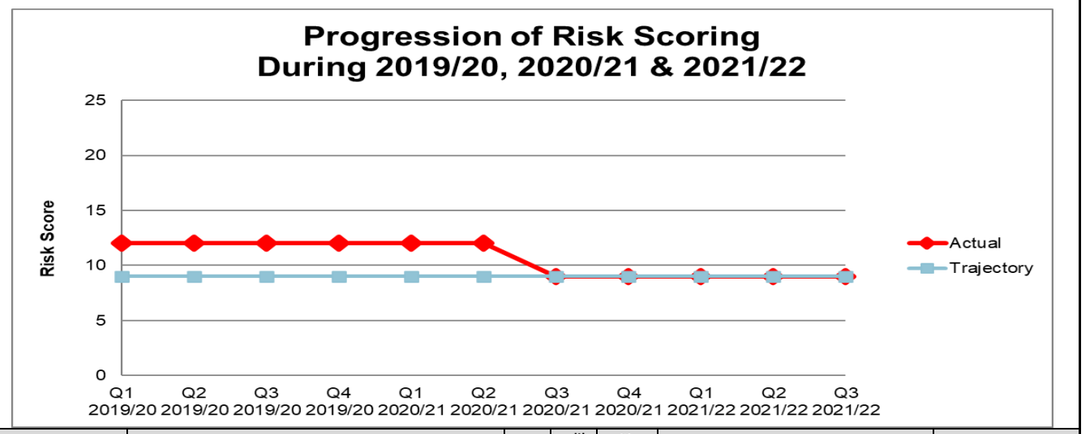
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Patient safety & quality of care risk if unable to fill medical shifts/vacancies**
2. **Inequity of care delivered at weekends v weekday**
3. **Loss of control on medical agency & internal bank spend**

Associated Committee: **WORKFORCE & EDUCATION COMMITTEE**

Operational Lead: **CHIEF OF STAFF / GROUP ASSOCIATE DIRERCTOR OF WORKFORCE**

Material Additional Supporting Commentary (as required):



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12 (3X4)	A1. Group Executive Sponsors of Medical Workforce Workstreams A2. Hospital/MCS Executive teams A3. HR Scrutiny Committee oversight A4. Finance scrutiny committee oversight A5. Hospital Review meetings A6. Accountability Oversight Framework (AOF) A7. Medical Directors' Workforce Board A8. Workforce Systems Programme board A9. LNC Liaison A10.Job Planning & Medical Leave Policy A11.Medical Workforce Electronic systems (job planning, rotas etc) A12.Internal Turnaround governance programme including WAVE A13.Management of Direct Engagement supplier A14. 7DS Joint Assurance Group A15. 7DS action plan A16. Locum and agency dashboards A17. Guardian of Safe working (GOSW)	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Key medical workforce processes (job planning, leave etc) require alignment across Group) B3. Medical Workforce systems not fully rolled out across Group B4. Medical workforce dashboards not fully in place and information not shared between systems B5. No electronic means of recording the 7DS standards.	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**9 (3X3)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Roll out new MFT job plan policy and leave policy B2. Develop job plan training guide for clinical leaders B2. Provide regular reports on job plan status to Hospitals/MCS B3. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. (and D1) Develop and roll out new dashboards for Medical temporary staffing B5. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment D2. Develop GOSW reports to include non training grade vacancies	Group Medical Directors Team & Group HR Directors Team	March 2022	Human Resources Scrutiny Committee	B1. New bank supplier *Go Live* went smoothly in Nov 2020 & will be rolled out to NMGH by Sept 22. MFT Tier 5 GMC sponsorship continues with **increased** international recruitment. New single contract for locally employed junior doctors **agreed & launched** for new starters B2. MFT Job Planning Policy approved in Jan 2020. Roll out delayed by Covid. Job planning restarted with target date for all to be completed by end of Mar 22 B2. Job plan training guide to support roll out **developed** & refined for Covid recovery Monthly reports sent to hospitals/MCS on job plan status and bi-weekly 'heat maps' **now sent** B3. Project team in place for roll out of Allocate Medical Workforce systems. Completion by March 22 delayed by Covid however will be completed before Hive *Go Live* in Sept 22. B5. 7DS standard now i**ncluded** in Patientrack and reporting will be available in Q1 22/23 D1. Complete - Updated dashboards rolled out & be further improved with Power-Bi functionality D2. New GOSW **recruited** & in post reports updated and full link to vacancies will be available when Allocate rotas fully rolled out	**9 (3X3)**

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.**

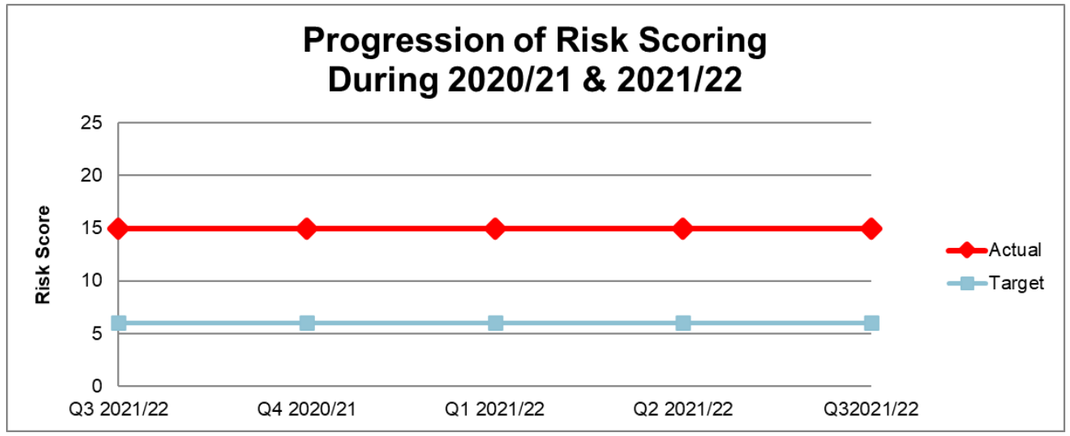
Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Scrutiny Committee:
Group Risk Oversight Committee/ Finance and Digital Scrutiny 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.



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15 (3x5)	• Internal technical Informatics governance inplace including Cyber focussed Group • Group Information Governance in place to monitor compliance • 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 inaddressing cyber threat and other IT security vulnerabilities	• Effective and integrated Executive governance and oversight	• Implementation and monitoringof the Group Informatics Cyber Security Action Plan through trust committees • National tools used for monitoring, and detection of threats • Regular reporting against national4 key metrics	• Papers and minutes from Cyber group • Further developed detailed monthly reporting • Stakeholder engagement planon cyber threats • Dedicated expertise in place • Clear Cyber Security Strategyand roadmap	15 (3x5)	• Robust implementation and monitoring of the Group Informatics Cyber Security Action Plan • Recruitment to appropriate senior resource • Development of strategy • Agree the contents of Monthly Report.	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. • IT Security and Compliance Manager now in post to support reporting • Active market engagement to procure external provider to develop Cyber strategy and roadmap engaging with Gartner service to ensure MFT are aligning to industry best practise standard.	**6 (2x3)**

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

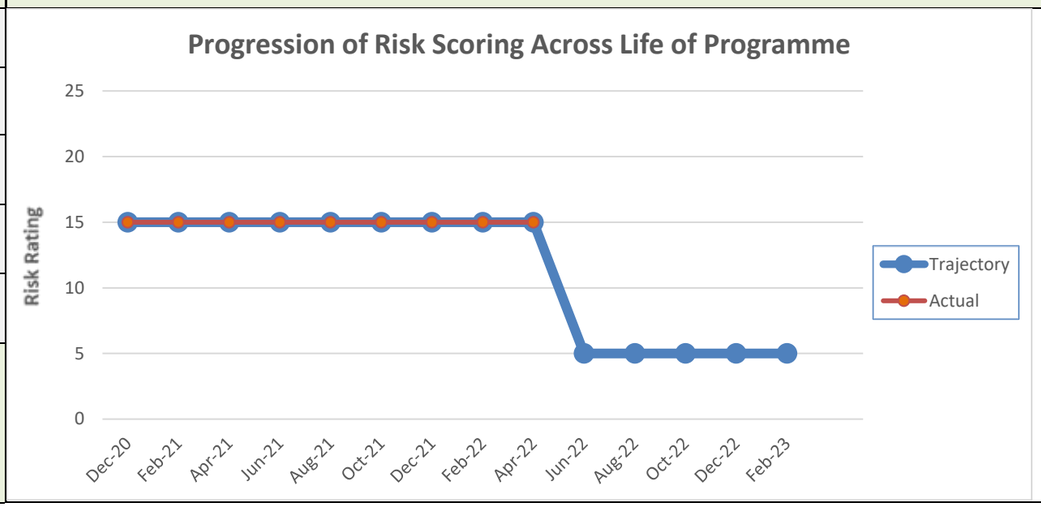
RISK CONSEQUENCES (What might happen if the risk materialises?):

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



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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 in development • Transformation plan in place	• Deployment team not currently in place to manage Go-live • Finalisation of training room bookings as part of end user training strategy	• 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.	• Successful completion of testing plan • Completion of interfaces to enable go-live	15 (3x5)	• Transformation change 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 • Completion of training room booking • Completion of staff training track loading on LMS • Successful completion of testing strategy and actions • Successful completion of data migration strategy and actions • Completion of staff training registrations • Plan for making existing systems ready for data migration, including addressing relevant data quality issues, and engagement with system users	Group Chief Operations Officer/SRO	Ongoing	• Actions against recommendations of Gateway 1 and 2 External Assurance report completed • Gateway 3 report expected late March 2022 • 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 • Transformation Roadshows in progress • Benefits Review Phase 1 complete • Role analysis complete and training tracks and curriculum in development • Risk review complete and new programme management approach implemented •	5 (1x5)

	• Testing plan in place and testing has commenced • Extensive review of Programme risks and refreshed programme management approach including robust highlight reporting and series of Risk Summits in place										

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:

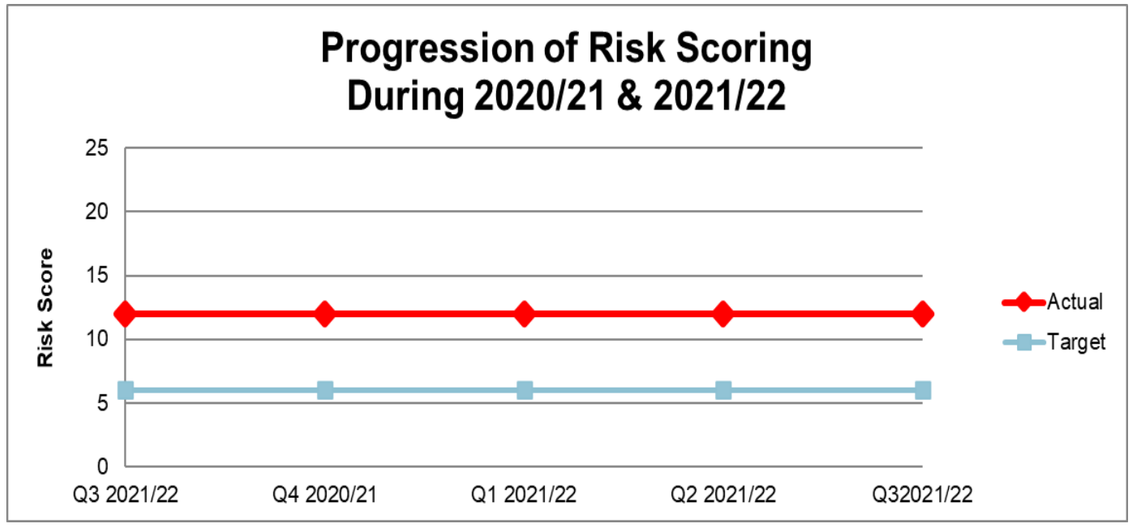
QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

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	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 WMTM has now been rolled out to all areas, including community. Patient Experience team are prioritising the implementation of the CIVICA digital platform in Q4 21/22 as the contract with the incumbent provider ends at the end of March 22. This will provide an improved Trust wide solution to the collection of WMTM, FFT and QCR data, and support a more robust data analysis. 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^{R} 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. Work will commence in Q4 21/22 to identify an Always Event site at NMGH. 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.	**6 (2X3)**

		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							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 level 1 training package was completed and approved in Q2. Additional comments from the EHO to further enhance the e-learning package have been forwarded to the PWO in January 2022 for approval. Awareness of the food safety training was highlighted in the Bee Brilliant Campaign, Professional Practice in December 2021, with a "Call to Action "for all staff to complete the training. Development of Level 2 Food Safety training will commence in January 2022. 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. In response to increased transmissibility of omicron variant and increase in COVID-19 burden, senior leadership walks and the accreditation programme were stepped down in the month of January 2022. At the end of Q3 21/22 - 81% of the areas on the accreditation programme had been reviewed. A remedial action plan has been devised with the aim that remaining areas are accredited by 28 March 2022. C2 AOF reporting re-established in May 2021. C5 Data collection restarted in May 2021 C8: FFT collection recommenced following the revised NHSE/I guidance issued in May 2020. The 'Community services prioritisation framework' issued publication reference PAR1257 on the 11 January 2022 setting out national advice in relation to prioritisation of community health services advising the pause of FFT collection from 11 January 2022 to 28 February 2022.	

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 Safety level 1 e-learning training has been developed by Dynamic. and has received final sign-off. Further awareness of the food safety training was highlighted in the Bee Brilliant Campaign, Professional Practice in December 2021, with a "Call to Action for all staff to complete the training. Level 2 training for staff such as AHPs that are involved in patient food preparation will commence development January 2022. 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. Whilst Patient Experience continue to support the use of this technology is now part of every day practice performed the ward staff. B6. MFT and St John Ambulance volunteers were recruited to provide assisted patient dining services from Q2 2020/21: this service continues. We have signed an MOU with SJA to launch the SJA cadet program. 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. In response to increased transmissibility of omicron variant and resultant increase in the COVID-19 burden, senior leadership walks were stepped down in January 2022 and areas postponed rescheduled within the 2022/23 programme. 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 March 2022	**6** **3x2**

										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.	

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 is Non-Recurrent, with additional short term funding, there are existing cost pressures, WRP of £50m and operational pressures, which as a result of recovery from COVID-19, may prevent the Trust from delivering its financial target and thus impact on long-term sustainability.

RISK CONSEQUENCES (What might happen if the risk materialises?):

Failure to deliver the required surplus identified in the internal 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 for future years.

Enabling Strategy:
MFT CONSTITUTION & LICENCE REQUIREMENTS

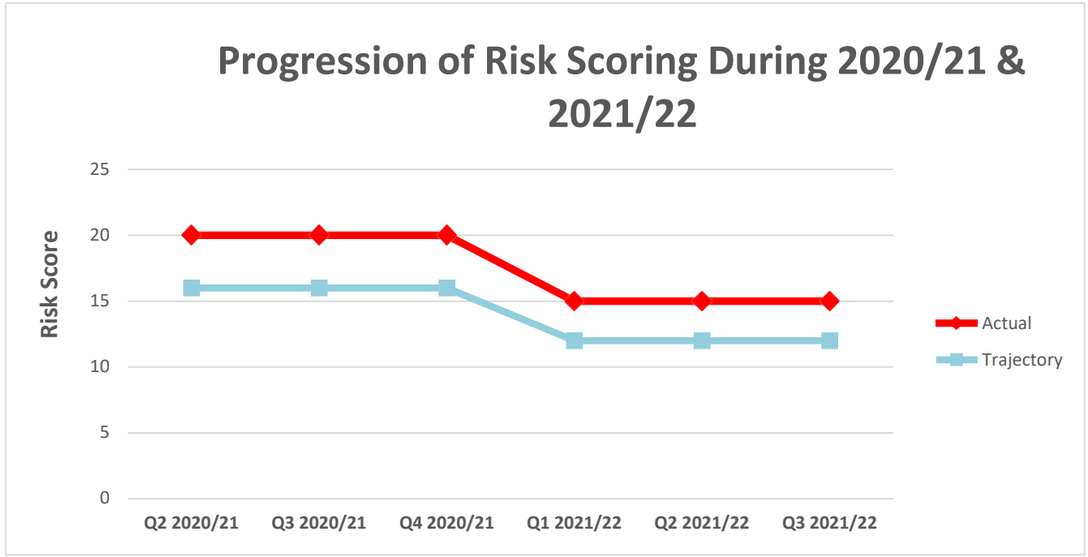
Group Executive Lead:
CHIEF FINANCE OFFICER

Associated Committee:

Scrutiny Committee:
FINANCE AND DIGITAL SCRUTINY COMMITTEE

Operational Leads:
GROUP FINANCE AND 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.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"*
20 (5x4)	A.1. The budget framework has been maintained linked to BAU processes to retain hospital level financial targets and requirements for improvement A.2. Ongoing financial assessment and oversight into all elements of COVID 19 recovery programme including response to ERF and other recovery programmes through the Covid Recovery and Response meetings. A.3.Monthly review of financial performance against Control Totals that reflect the revised financial regime A.4. Forecasting regime for Hospitals/ MCS/LCO to ensure WRP and recovery plans are developed with financial sustainability as a key part of the planning A.5. Hospital/MCS/LCO control totals (including Waste Reduction Targets) set in for the full year and therefore in advance of H2 funding regime, the funding expectation for H2 within the plan was set at a "prudent" level A.6. Progressing implementation of EPR system to support and drive changes and appropriate standardisation of clinical care and operational support processes A.7. Funding for 22/23 has been identified and under discussion at a GM level, MFT need to secure an appropriate share to deliver its programme of work.		C.1.An extensive framework of review, challenge and escalation is fully embedded and understood within the organisation C.2.Hospitals/MCS/LCO are assigned an AOF rating against the finance domain based on their forecast performance and the proportion of non-recurrent WRP relative to recurrent, which determines the level of progress recognised, intervention and support required, with regular reviews consisting of Hospital/MCS/ LCO CEO/FDs and Group COO and CFO, the timing of which is dependent on the Finance Accountability Framework rating for the relevant area. C.3.Trust-wide monthly finance reported to GMB, FDSC and Board in line with timing of meetings	None	15 (5x3)	MFT will need to continue to work on delivery of its WRP, review the level and requirement for provisions on its Balance Sheet and secure funding which needs to be at least broadly in line with H2 as part of the share of system funding in the emerging GM ICS in 22/23.	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	As at end of January 2022, MFT is on course to deliver the surplus committed to in the ICS plan and in line with its NHSI plan. Good progress has been made on delivery of WRP which is expected to reach some £37m for 21/22.	**12 (4x3)**

Strategic Aim: To Achieve Financial Sustainability

PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity than its ambition.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF INFORMATICS OFFICER (GCIO)

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.**

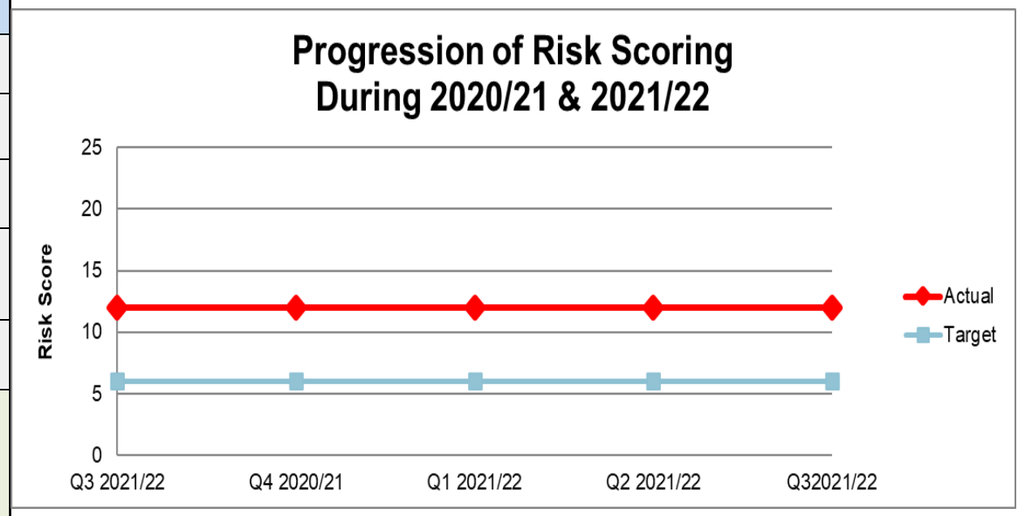
Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Scrutiny Committee:
Group Risk Oversight Committee/EPR Scrutiny Committee/Finance and Digital 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 especially on Information Services
- Increased demand on Information services to support modelling work and changes to information reporting requirements at a GM and National level



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16 (4x4)	• Informatics governance framework completed and revised governance structure and associated processes implemented including revised terms of reference for new Portfolio Board • Integrated governance with workforce for related strategies • Integration Steering Group monitoring of Informatics PTIP Plan. • Capital Management and Monitoring Group monitoring and Capital Strategic Group supporting planning and delivery of the capital programme • 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 • Finance and Digital Scrutiny Committee • GM Digital Transformation Board and GM CIO Providers		• 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 • An extensive framework of review, challenge and escalation is in place for the EPR programme including external assurance • Finance and Digital Scrutiny committee review of papers/progress and validation of BAF.	• 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 • Develop and implement target operating model for future state post Hive to embed further digital improvements • Implement and monitor a robust demand management process and structure to ensure a continued focus on trust strategies. • Refresh the Informatics Digital strategy to ensure it reflects latest requirements including ICS compliance • Initiate benefits management tracking through Group Informatics Portfolio Board to ensure digital maturity is continually monitored and validated • Ensure every investment request references the impact on digital maturity	Group Chief Informatics Officer	Ongoing	• Hive programme progressing to plan. Number of key resources leaving or left the programme. All fixed term start offered permanent roles to support retention. • Robust Monthly monitoring against plans • Future state plans in progress to complete by end of March in line with new financial year • Interim Head of Demand Management in place to support recruitment of permanent resources. • Draft strategy produced and engagement approach in development to initiate stakeholder engagement through February and March • Digital workforce strategy approved through Informatics governance	**6 (3x2)**

Risk Rating
Apr-2021

Strategic Aim: **To develop single services that build on the best from across all our hospitals**

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES, GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

RISK CONSEQUENCES (What might happen if the risk materialises?):

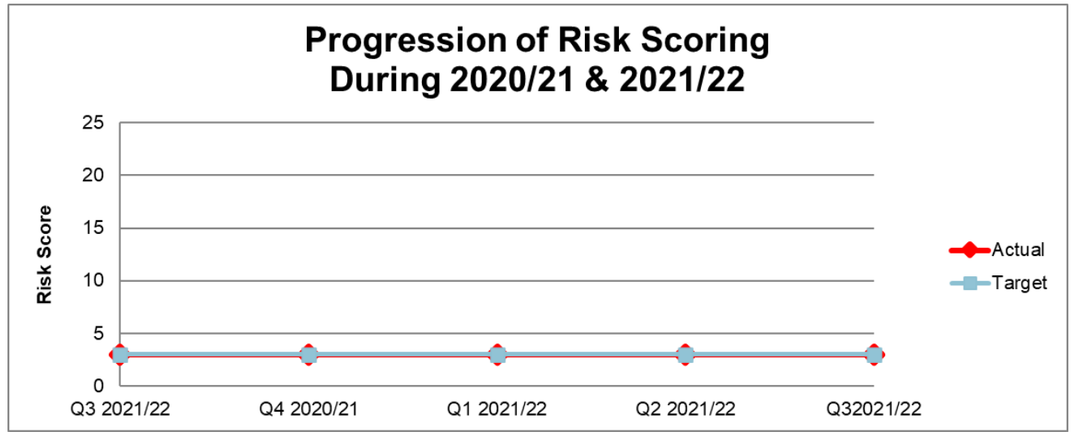
1. **Loss of Service**
2. **Reduction in a range of services (offered within GM and across NHS)**
3. **Damage to reputation**
4. **Loss of staff**
5. **Reduction in research opportunities**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Scrutiny Committee:

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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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	

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

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of united voice for GM**

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)

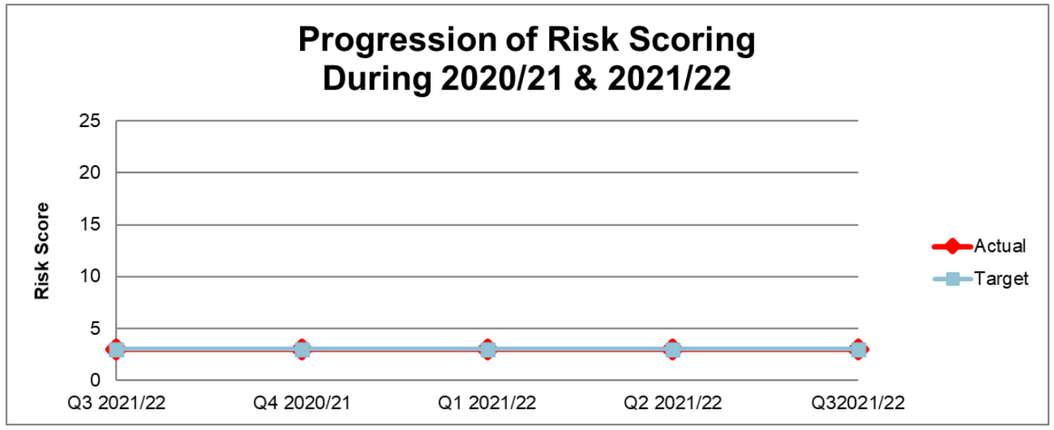
Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

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"*
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.		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 strategies from key GM stakeholders C.6 The Joint Commissioning Board has agreed, subject to	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.	

	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.		consultation, GM Models of care for breast, vascular and respiratory services.			D.2 Complete service strategies for CSS, engaging with GM stakeholders in development.	MFT Strategy team	Q1 22/23	Work completed but not yet approved by the Board.	

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

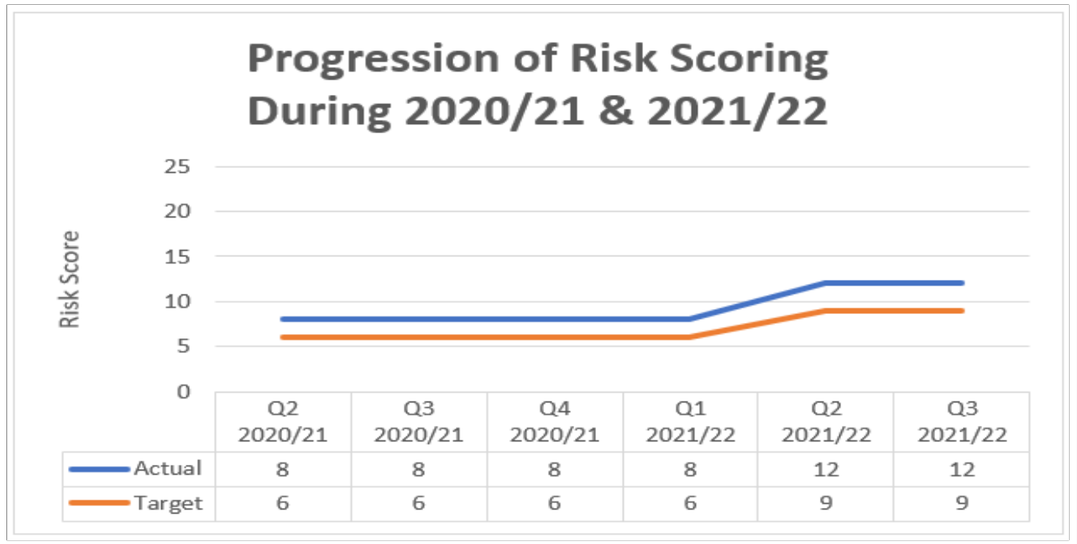
1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**

Associated Committee:
WORKFORCE & EDUCATION COMMITTEE
HR SCRUTINY COMMITTEE

Scrutiny Committee:
HR SCRUTINY COMMITTEE

Operational Leads:
GROUP DIRECTOR OF HR
CORPORATE WORKFORCE DIRECTOR

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 embedded 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 strategy (informatics strategy) 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	B.1 Policy development programme has not concluded B.2 Key workforce system are not in place for all staff groups and all sites. B.3 Apprenticeship delivery programme to be embedded B.4 Workforce plans are still in development, linking to activity/ demand & recovery planning. B.5 SOPs are under-development for a number of workforce processes. B.6 Real time, establishment control not in place B.7 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 /LCO 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 C.13 Calendar of activities developed to support staff to make an informed decision in relation to COVID-19 vaccinations. C.14 Workforce Education Committee monitoring report. C.15 People plan performance dashboard. C.16 Predictive workforce modelling is currently monitored against actuals	D1. Workforce metrics are limited due to ongoing finalising digitalisation of processes D2. Workforce metrics are not fully triangulated with other data sets e.g. finance, clinical D3. Collaborative Staff side negotiations on policy development. D4. Medium / long-term impact of the Pandemic on the workforce	**12 (4x3)**	B.1 Complete policy review programme B.2 Continued oversight of Mandatory Training Steering Group to provide ongoing oversight. 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 policy implementation plan.	Workforce Team	March 2022	***B.1 Policy programme continues – strategy currently being developed to agree progression of key policies.*** ***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 being piloted. 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 The Apprenticeship Steering Group and Operational Delivery Group has been embedded and 98% of the Ofsted actions completed, with associated evidence.*** ***D.1 In conjunction with Informatics, data warehousing has been developed to support sickness absence reporting.*** ***D2. The MFT People Plan has now been launched. A governance structure has been established and a performance dashboard is in place.*** ***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.*** ***A.15 Mandatory vaccination programme developing and is being monitored closely to oversee impact on staff and services.***	**9 (3x3)**

	A.14 Employee Health & Wellbeing Service Delivery model. A.15 Mandatory Vaccination Programme delivery plan developed and being implemented.		C.17 Staff networks established - BAME, LGBT and Disability providing effective engagement and involvement in workforce topics. C.18 Employee Relations Group. C.19 Mandatory Vaccination Task and Finish Group and PMO. C.20 Addition of a senior post i.e., Corporate Director of workforce to lead on EHW/ED&I, Rewards etc.							