NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 14th March 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 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
	Mr Barry Clare (BC)	Group Non-Executive Director
	Sir M Deegan (MD)	Group Chief Executive
	Professor Jane Eddleston (JEd)	Joint Group Medical Director
	Mrs J Ehrhardt (JEh)	Group Chief Finance Officer
	Mr David Furnival (DF)	Group Director of Operations
	Professor Luke Georghiou (LG)	Group Non-Executive Director
	Mr N Gower (NG)	Group Non-Executive Director
	Mrs G Heaton (GH)	Group Non-Executive Director
	Professor Cheryl Lenney (CL)	Group Chief Nurse
	Mrs C McLoughlin (CM)	Group Non-Executive Director
	Mr T Rees (TR)	Group Non-Executive Director
	Miss Toli Onon (TO)	Joint Group Medical Director
In attendance:	Mr N Gomm (NGo)	Director of Corporate Business / Trust Board Secretary
	Mrs Caroline Davidson (CD)	Director of Strategy

185/22 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.

186/22 Apologies for Absence

Apologies were received from Darren Banks

187/22 Declarations of Interest

There were no declarations of interest received for this meeting.

188/22 Minutes of the Board of Directors' Meeting held on 10th January 2022

The minutes of the Board of Directors' meeting of 10th January 2022 were approved with the addendum noted.

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

189/22 Matters Arising

There were no matters arising.

190/22 Group Chairman's Report

KC provided an overview of recent events of note, beginning by noting the current situation in the Ukraine and explaining the support available to affected staff at MFT, and the support MFT was giving to the national response. This includes the Procurement team providing medical equipment and supplies to the Department of Health and Social Care who are co-ordinating a central process for donations.

KC described other recent events of note including:

- The visit by HRH The Princess Royal to officially unveil the helipad at Oxford Road Campus and to visit the award-winning maternity services at Saint Mary's Hospital.
- Preparations to build the new multi-storey car park and cycle hub at North Manchester General Hospital as part of the hospital's ambitious redevelopment programme.
- The re-opening of Manchester Surgical Skills and Simulation Centre following the hiatus triggered by the pandemic.
- The achievement of Dr Anisa Jafar, an ST6 Junior Doctor in Emergency Medicine at MRI, in being named as Young Researcher of the Year by the NIHR Clinical Research Network.

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

191/22 Group Chief Executive's Report

MD began by noting that, despite the relaxation of national measures, the COVID-19 pandemic has not yet gone away and there are still over 200 in-patients with Covid in the Trust's hospitals.

The Trust's focus is now on addressing the significant waiting lists which have developed during the pandemic. All specialties, in all hospitals, are dedicated to this, supported by the Local Care Organisations ensuring prompt discharge, and responsive community services, for those who do not need to be in one of MFT's beds.

To address the challenges ahead, MFT aims to be an employer of first choice for those beginning their career or seeking out new opportunities in the NHS, whilst making sure that the Trust retains its current staff by listening to their views and delivering the People Plan.

The Hive programme is progressing well and is on target to meet the 8th September go-live date. It will underpin all of our recovery work, providing huge benefits for patient care, while supporting the Trust to work more efficiently and effectively.

MD concluded by stating how he was looking forward to working with Mike Fisher CBE who has been appointed Chief Executive of NHS Greater Manchester Integrated Care.

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

192/22 Update on Hive Programme

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

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/interfaces alongside the transformation required to support safe and effective care across the Trust. 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.

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.

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. Other key activities in this phase include planning and implementing the staff training, communicating any alterations to workflows, and assessing and supporting staff digital confidence in tandem with transformation projects required. Go-live Readiness Assessments are planned for 120, 90, 60, and 30 days from Go-live.

Transformation Roadshows commenced in February, these bring elements of the system out to staff across the Hospitals/MCSs/LCOs 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.

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

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.

BC noted that Hive was a significant organisational change programme and it would allow the Trust to become a true Single Hospital Service with consistent pathways across all sites.

JB explained that, in order to ensure staff were ready for Go-live, the programme had brought in an experience training manager who is having a positive impact. Additionally, some training roles were becoming permanent appointments to mitigate the risk of key training staff leaving.

In response to a question from TR regarding the next Deloitte report, JB confirmed that it would highlight some risks, but they were not risks that the programme team was unaware of. Alongside Go-live preparations, consideration is being given to the structure and scope of the programme from September 2022 to March 2023. She also highlighted that the interoperability between systems across GM was crucial and Hive will improve the current situation.

In response to a question from LG regarding future workforce capabilities, PB explained that staff would require a competent level of digital literacy and £500K had been invested in training programmes to address this. CL pointed out that sessions with undergraduates at the University of Manchester had already been established.

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

193/22 Board Assurance Report

JE began by presenting the Safety section of the Board Assurance report.

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 provided to patients. This approach ensures a smart approach to identifying opportunities for high impact and transferable learning, accelerated improvement and smart assurance through:

- the capture of 'Safety II' data (ensuring learning from the majority of patient outcomes that are as, or exceed expectations).

- the use of SPC analysis to understand data about harm, enabling the Trust 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.

SB commended the shift in emphasis to consideration of human factors in the learning from Never Events.

CL explained that she would talk to the main points within the Patient Experience section during her reports later on the agenda.

DF stated he would also pick up the main points from the Operational Excellence section within his report later on the agenda. He pointed out the increase in 12 hour trolley waits and explained that it had particularly affected North Manchester General Hospital (NMGH) but the situation had improved now the impact of the Omicron variant has lessened.

JEh stated that she would cover the main finance points within her item later on the agenda.

PB introduced the Workforce section, explaining that 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 periods.

Hospital/MCSs/LCOs continue to refine their staffing and workforce plans to drive a nuanced local response to identified workforce issues, supported at Group level with cross-cutting policy initiatives and specialist support.

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. He noted the 94% attendance rate and thanked staff and managers for this improvement.

Compliance with Level2/3 mandatory training and staff appraisals needs attention but progress continues to be made in implementing the MFT People Plan deliverables.

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

194/22 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

DF presented the report and explained that MFT implemented plans in late December that continued throughout January to proportionally respond to the rise in COVID-19 due to the Omicron variant. This included:

- 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.

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.

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/MCSs/LCOs.

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.

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 the number of patients in this category.

There are a number of actions being progressed across MFT Urgent and Emergency Care Departments with the aim of standardising processes across all three sites.

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 theatres.

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.

A number of actions are underway to address the challenges:

- A Theatre Efficiency Rapid Improvement (TERI) programme.
- Increased use of the Independent Sector.
- A focus on the highest clinical priority (P2) patients).

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

- Patient Initiated Follow Up (PIFU
- Virtual Triage
- Waiting List Validation
- Care Gateway initiatives
- Primary Care Communications

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 impact 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 Patient Tracking List 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.

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.

KC thanked DF for his update and advised that the issues raised would continue to be overseen at the Quality and Performance Scrutiny Committee.

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

Update on the COVID-19 Vaccination Programme

CL presented the report which provided an update on the COVID-19 and Influenza vaccination programme.

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 Comirnaty8).

Through the MFT staff COVID-19 vaccination programme:

- 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

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

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.

In response to a question from BC, CL explained that the Trust was continuing to offer COVID-19 vaccination, at every opportunity, to those who had not yet been vaccinated, including pregnant women, some of whom remain resistant as a result of media stories earlier on in the pandemic.

PB concurred, explaining that it was possible to carry out more targeted engagement due to the small numbers involved. This will continue to be monitored through the Human Resources Scrutiny Committee.

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.

Through the MFT staff seasonal influenza programme 53.6% of staff have received their flu vaccine. The national target for frontline healthcare workers is to offer 100% of staff access to the flu vaccine, with a target of 85% uptake.

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

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.

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; and Royal Manchester Children's Hospital offering vaccines to in-scope children and young people.

The MLCO/TLCO school aged immunisation service (SAIS) teams continues to lead 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.

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. 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.

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

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

CL began presenting the report by noting that the numbers of people with COVID-19 across Greater Manchester were increasing.

In response to a question from BC, CL explained that community testing ends at the end of March but every inpatient within MFT will continue to be tested.

MFT's visiting policy changed on the 14th February 2022 to allow one visitor per patient. This will be increased to two patients in line with national guidance. The national IPC manual is to be updated imminently.

The changes to the IPC BAF were noted and CL explained that the aim is to incorporate this within the organisational Board Assurance Framework in the future. A report will come to the next Group Risk Oversight Committee proposing downgrading of the IPC risk.

The Trust continues to comply with mandatory data submission on incidents of Healthcare Associated Infections (HCAI) through UK Health Security Agency (UKHSA) mandatory surveillance system. The data is reviewed by the Group Infection Control Committee along with common reasons/themes for HCAI. These are being addressed by each Hospital/MCS /LCO and include:

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

Board decision	Action	Responsible officer	Completion date
The Board noted the information provided in the report and the updated IPC BAF	None	n/a	n/a

195/22 Chief Finance Officer's report

JEh presented the report which provided an update on MFT's current financial position.

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.

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. The ERF for 2022/23 is however expected to be at a similar level to that of 2021/22, although still non-recurrent in nature.

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. However this under-delivery results in a higher pressure in the coming 22-23 financial year.

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.

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 for the year is delivered as planned.

JEh went on to mention the early results for February, Month 11. The plan has been achieved and the cash position has increased in February. A transaction has been agreed with the national team which will see £18.7m cash come to MFT, as a result of late changes to the distribution of capital resource. This will result in a net underspend on the capital programme, but this will solely be as a result of this transaction.

TR reiterated the capital challenge and the importance in meeting the original capital plan to maintain credibility for GM and MFT. NG asked what the plans were to make sure the capital position was managed more evenly across the next financial year.

JEh explained that planning was already underway with programme leads to make sure they are ready to commit funding as soon as the GM plan has been confirmed. She also pointed out that the scale of the challenge will be different next year as the capital envelope will be smaller. Further, in 21/22, a number of late allocations and decisions have been made nationally which have resulted in late expenditure approvals. It is anticipated that this will be on a smaller scale in 22/23 as the national team have committed to including as much as possible in the GM envelope at the start of the year.

In response to question about supply issues from LG, JEh noted that the Trust hadn't been significantly affected this year but it may be worse in 2022/23. It was a matter which would be managed closely with suppliers and with the national team.

Board decision	Action	Responsible officer	Completion date
The Board noted note the position against the YTD plan and updates on Cash and Capital positions for the Trust.	None	n/a	n/a

196/22 Update on the Financial Plan for 2022/23 and delegate approval of the financial plan to Finance and Digital Scrutiny Committee

The Financial Plan for 2022/23 is in development, requiring 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 (FDSC) 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. Decisions will be taken amongst Executive Directors on the balance of risks associated with cost pressures.

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 FDSC has been arranged on 29th March 2022 to scrutinise the budgets and financial plan.

Board decision	Action	Responsible officer	Completion date
The Board noted the work being undertaken through the FDSC on the annual financial plan for 2022/23 and delegated authority to the FDSC to approve the Financial Plan	None	n/a	n/a

197/22 Update on Strategic Developments

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

A further White Paper has been published on integration. This is a joint paper from DHSC and Michael Gove's communities department. It is part of a wider set reforms which includes the Health and Care Bill and the adult social care reform white paper 'People at the Heart of Care' which was published just before Christmas. This paper builds on both and sets out proposals for how we work together across health and social care at place level. It covers the development of shared outcomes frameworks, strengthening leadership in places and the enablers of integration: workforce, digital and pooled budgets.

As a White paper it is a set of proposals and the next step will be to consult with stakeholders. Implementation is scheduled for spring 2023.

At GM level an appointment has been made to the role of Chief Executive for the ICB. Mark Fisher, who is currently director general and secretary to the Grenfell Tower public inquiry takes up the post in April. The process to appoint to the other ICB executive director posts (finance, medical and nursing) is in train.

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 is important as it is one of the ways in which we will deliver the benefits of the SHS.

We are also working on our annual plan for 2022/23. This should be completed in April and will be brought back to the Board to sign off.

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

198/22 Q3 Complaints report 2021/2022

CL presented the report which provided:

- 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.

NG has taken over as Chair of the Complaints Scrutiny Group and a meeting will be helped with him to consider any changes required.

CL noted the value of the qualitative feedback received through Care Opinion and the NHS website. KC agreed pointing out how it allowed a fuller understanding of patient experience.

In response to BC's question regarding the spike in Outpatient complaints, CL stated that it was due to the length of current waiting lists as discussed earlier in the meeting. The situation would be monitored going forward.

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

199/22 Update report on the Ockenden review of Maternity Services

CL presented the report which:

- 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;

- provides an update in respect of the Ockenden Report, and the NHS England and Improvement (NHSE/I) maternity self-assessment tool (MSAT) submission; and
- reports 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

In January there were no catastrophic harm incidents and one incident in the moderate harm category. An investigation is underway with regard to the latter case – an avoidable delay in delivering the baby.

The Maternity Self-Assessment tool has 168 sections and 42 actions within it and is being used as a benchmark for Saint Mary's MCS (SM MCS) to measure itself against. As at the time of the Board meeting:

- 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

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

All targets within the NHS Resolution Maternity Incentive scheme have been met. This not only ensures safer services but will also lead to a reduction in CNST costs.

MD commended CL and the SM MCS for the work they are doing which was praised recently in a meeting he had with the national Chief Midwife. The fact that the Board and relevant Committees were kept informed on progress with delivery of various requirements was particularly recognised.

CM concurred, identifying the SM MCS's willingness to learn as key. In addition, the local Maternity Voices Partnerships have proven invaluable to enable the voice of parents to be heard.

Board decision	Action	Responsible officer	Completion date
The Board noted the report 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 The Board also noted the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety	None	n/a	n/a

200 /22 MFT 'Safer Staffing' bi-annual report

CL presented the bi-annual report to the Board of Directors on Nursing and Midwifery staffing. The report includes 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.

There are 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.

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.

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.

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.

The Safer Nursing Care Tool 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.

In common with other staff groups within MFT, there was a relatively high sickness rate during January as a result of the impact of the Omicron variant of COVID-19. The Nursing leadership teams are working closely with the Employee Health and Wellbeing Service to link staff with the support available.

In response to a question from GB regarding the potential in providing opportunities to Ukrainian nurses, CL confirmed that she and PB were looking into this.

Board decision	Action	Responsible officer	Completion date
The Board of Directors noted the report and the progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.	None	n/a	n/a

201/22 Board Assurance Framework 2021/2022

PB presented the Board Assurance Framework (BAF) which describes the risks which have the most potential to impede MFT's delivery of its Strategic Aims. In preparation for the 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.

TR noted that the Inherent risk rating is very similar to the Current risk rating in a number of areas and reflected that this was likely due to the impact of the pandemic over the last two years.

PB agreed and explained that the Group Risk Oversight Committee oversee the Trust's Risk Register.

Board decision	Action	Responsible officer	Completion date
The Board accepted the latest BAF (February 2022).	None	n/a	n/a

202/22 Committee Meetings

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

- Audit Committee held on 9th February 2022
- Group Risk Oversight Committee held on 17th January 2022
- Quality Performance & Scrutiny Committee held on 2nd February 2022
- Human Resources Scrutiny Committee held on 15th February 2022
- Finance Scrutiny Committee held on 16th February 2022
- EPR Scrutiny Committee held on 26th January 2022

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

203/22 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 9th May 2022** at **2pm**.

204/22 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 14th March 2022		
Action	Responsibility	Completion date
There were no actions raised at the Public Board of Directors Meeting.	n/a	n/a

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:

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

- 20 pre-qualification registered nurses appointed at Band 4 entering the workforce earlier
- 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 Executive Directors
Paper prepared by:	Alfie Nelmes, Head of Information Services
Date of paper:	May 2022
Subject:	Board Assurance Report – March 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

(March 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

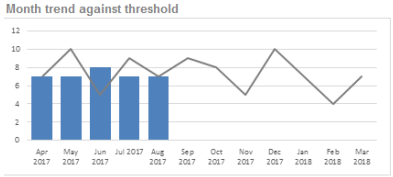
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities

Hospital Incidents level 4-5
MFT

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

Month trend against threshold



12 month trend (Sep 2016 to Aug 2017)

Hospital level compliance

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

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

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

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

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

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

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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

March 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 help 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) through a Trust wide daily huddle
- a weekly Trust-wide Patient Safety Oversight Panel.

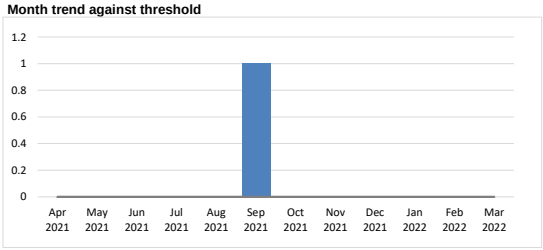
The Trust reported 11 Never Events during 2021/22, the most recent in March 2022. in relation to benchmarking, the Trust overall demonstrates performance the 'same' as other Trusts when Never Events are analysed as total events with statistical comparison to bed days (NHSI OBIEE NRLS StEIS (26 Mar 2022)). 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 proportion of reported patient safety incidents resulting in harm (20.3%) remains consistent with that of other Trusts. 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 Mar 22) **Accountability** J.Eddleston\T.Onon
Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

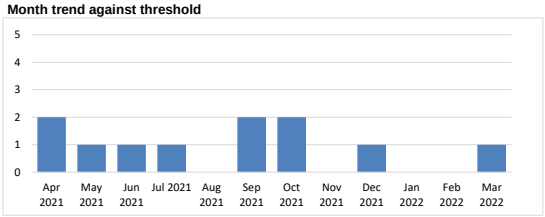
Key Issues
The programme of mortality reviews continues to be refined across the Trust, including the use of the mortality portal to support learning. All deaths where the outcome is judged as probably or definitely avoidable are subject to further evaluation aligned to the Trust's Patient safety Insight, Learning and Response Policy. The Structured Judgement review process is used proactively where potential learning is identified through complaints, incident management or medical examiner processes. Learning is routinely considered and contextualised through the Trust's safety oversight system. Key issues identified for further evaluation have included the timeliness of referrals into tertiary services and also the effective transfer between MFT sites for treatment and the implementation of the ReSPECT process. It should be noted that data is currently only provided by WTWA for this indicator, therefore the compliance data for other sites is misleading. This position will be reviewed by the Learning From Deaths Committee at its meeting in May.

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. The Annual Learning From Deaths report for 2021/22 is currently being produced.

Never Events ✕

Actual 11 YTD (Apr 21 to Mar 22) **Accountability** J.Eddleston\T.Onon
Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✓	✕	✕	✓	✓	✕	✓	✓
5	0	1	2	0	0	3	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.
During 2021/22 there have been 11 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. Invasive and surgical procedures remain the area where Never Events are occurring and are rightly the focus of further analysis and evaluation. A Trust-wide consensus building programme in relation to Local Safety Standards for Interventional Procedures (LocSSIPS) has been completed to support the integration of key controls into the EPR.

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. An external review is underway in relation to the effectiveness of how the Trust is learning from Never Events.

> Board Assurance

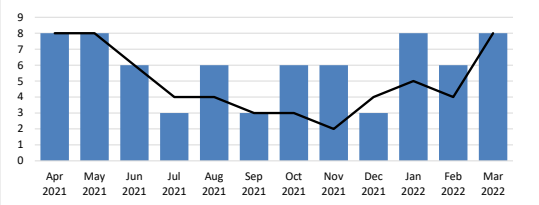
March 2022

Hospital Incidents level 4-5

✗

Actual	70	YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	66	(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
✓	✗	✗	✗	✓	✓	✓	✗	✓
3	32	4	6	1	0	16	8	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. The variation identified in March across all notifiable incidents is directly attributable to the reporting of potential Hospital Acquired COVID infections.

Actions

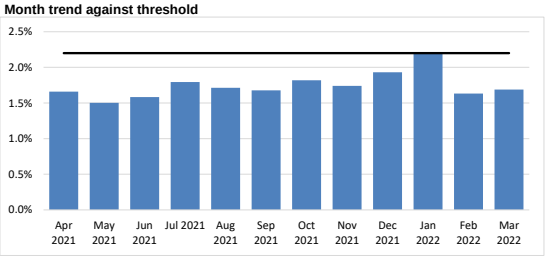
Routine examination of themes and trends through the safety oversight system which has led to additional high impact learning/assurance work in relation to a number of areas including:
- effective application of available controls to support patients with mental health problems waiting in emergency departments
- procedural based safety standards
- medication related incidents
- tracheostomy management
- falls prevention
- recognition and management of a deteriorating patient

Crude Mortality

✓

Actual	1.75%	YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✓	✓	✓	✓	✗	✗	NA
15.0%	2.0%	0.2%	0.2%	0.0%	0.0%	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.

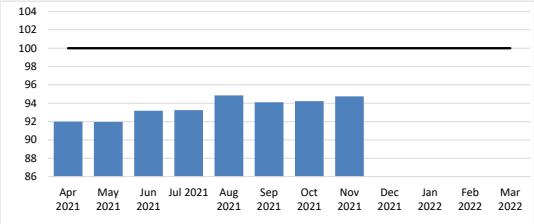
> Board Assurance

March 2022

SHMI (Rolling 12m)

Actual	94.8	R12m (Dec 20 to Nov 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

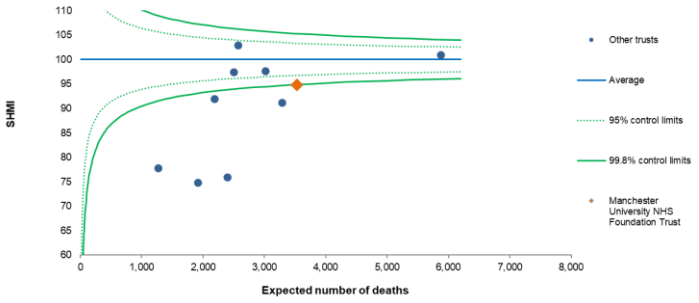
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	✗	NA
NA	91.8	NA	NA	NA	NA	88.7	112	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

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 range of mortality indicators.

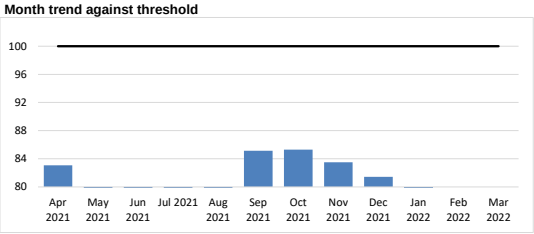
Summary Hospital-level Mortality Indicator for the Shelford Group, Dec 2020 - Nov 2021



HSMR (Rolling 12m)

Actual	81.4	R12m (Jan 21 to Dec 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	70.6	NA	NA	NA	NA	86.1	95	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.

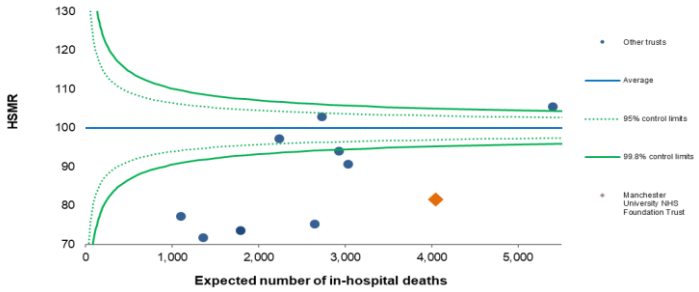
HSMR is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

Hospital Standardised Mortality Ratio for the Shelford Group, Jan 2021- Dec 2021



Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	3	2	1	3

Headline Narrative

The number of new complaints received across the Trust in March 2022 was 164, which is an increase of 24 when compared with the 140 complaints received in February 2022. In March 2022 the percentage of formal complaints that were resolved in the agreed timeframe was 86.0%, this is a notable decrease of 7.3% from the previous month. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Trust overall satisfaction rate for FFT (including data from the NMGH site following acquisition) for March 2022 was 96.5% compared to 96.1% in February 2022.There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

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.

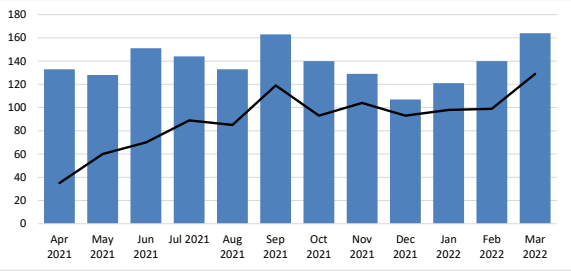
Trust performance is above trajectory for both MRSA and CDI:

There were 196 trust-attributable CDI reported for 2021/2022, against a threshold of 166. There is a zero tolerance approach to MRSA bacteraemia's, and a 15% reduction objective applied to E.coli bacteraemia's. There were 10 trust-attributable MRSA bacteraemia and 150 E. coli bacteraemia reported for this financial year.

Complaint Volumes ✕

Actual	1653	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	1588	(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
✓	✓	✓	✕	✕	✕	✓	✕	✕
98	354	167	244	61	42	407	186	58

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 March 2022 was 164, which is an increase of 24 and 43 respectively when compared with the 140 complaints received in February 2022 and 121 in January 2022.

Of the 164 complaints received by the Trust in March 2022, the high volume was attributed to WTWA, with 42 (25.6%) being received, which is a decrease when compared with the 44 received in February 2022 and an increase against the 27 in January 2022.

Of the 42 complaints received by WTWA there were no specific areas identified, however, the top specific three themes were 'Communication', 'Clinical Assessment' 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).

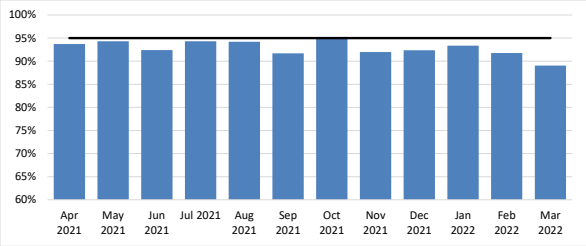
Progress

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	93.0%	YTD (Apr 21 to Mar 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%	96.12%	90.63%	95.75%	98.38%	98.45%	96.44%	86.94%	91.40%

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 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 increasing COVID-19 pressures facing Community Services, the Community Services Prioritisation Framework provided by NSHE outlined FFT collection to be paused for Community Services for January and February 2022. Although NSHE provided guidance for January and February 2022, activity remained paused for March 2022 and recommenced in April 2022.
The Trust overall satisfaction rate for FFT (including data from the NMGH site following acquisition) for March 2022 was 96.5%, which is an increase from the 96.1% received in February 2022 and 93.4% in January 2022. There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience

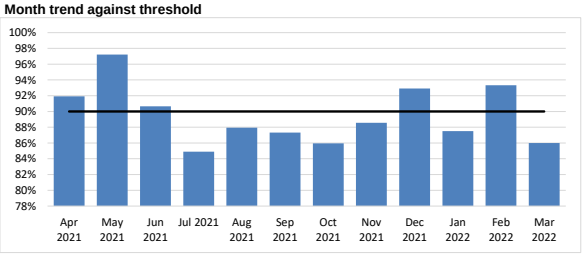
Actions

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	89.2%	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	✓	◇	✓	✓	✓	✓	✗
88.7%	97.4%	99.4%	73.9%	100.0%	97.6%	96.0%	92.3%	55.2%

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 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 March 2022 data identifies that 86.0% of complaints were resolved within the agreed timescales compared to 93.3% in February 2022 and 87.5% in January 2022: this is a notable decrease of 7.3%. The largest contributory factor for delays, is awaiting external contribution to the response.

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.

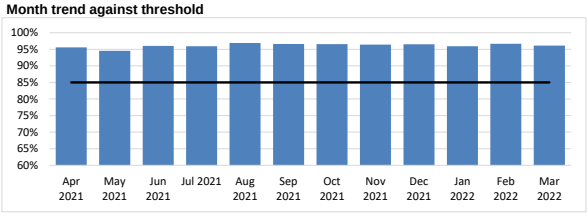
Actions

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

Food and Nutrition ✓

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	NA	✓	✓	NA
94.0%	96.5%	92.4%	95.7%	99.3%	NA	97.4%	96.4%	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.

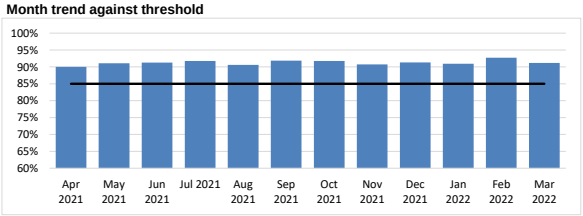
Whilst the Model Ward Programme was suspended due to the Covid - 19 pandemic from March to August 2020, the group continued to meet to provide support to the staff on Ward 12 to support the provision of a personalised dining experience during a period of change which resulted in a disruption to normal 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. Evaluation of the introduction of a cooked breakfast is in progress with an update expected in the near future.

Early discussions have been initiated on how the Model Ward concept can be replicated in other clinical areas.

Pain Management ✓

Actual	91.3%	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	NA
94.9%	86.8%	89.7%	91.3%	98.3%	99.0%	93.4%	92.7%	NA

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

Progress

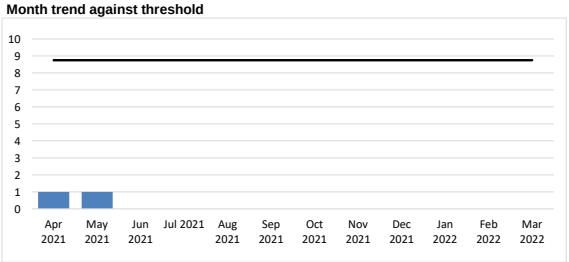
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm Free Care structure.

The Pain Steering Group meetings have been reconvened Bi-monthly lead by the Pain Specialist Nurse. QCR data continues to be reviewed/analysed bi-monthly to ensure Trust standards are being achieved and sustained, and areas are identified where improvements are required. Work continues across the Trust to drive improvements in pain assessment and management.

Clostridium Difficile – Lapse of Care ✓

Actual	2	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	105	(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 246 CDI cases were reported during 2021/2022: 196 (80%) of which were trust-attributable against a trajectory of 166. Cases from October 2021 onwards are currently being peer-reviewed to determine lapse in care status. There were 17 trust-attributable CDI cases reported for March 2022, all of which are pending review.

> Board Assurance

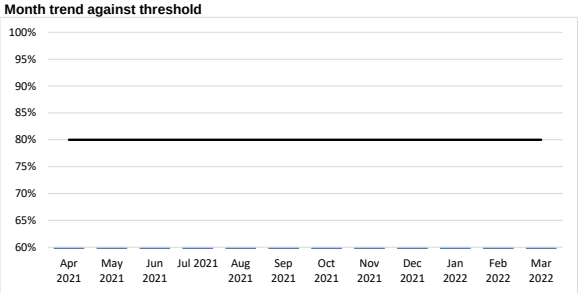
March 2022

Nursing Workforce – Plan v Actual Compliance for RN

●

Actual | **Threshold** 80.0% (Higher value represents better performance) | **Accountability** C.Lenney | **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 7697 YTD (Apr 21 to Mar 22) | **Threshold** None (Lower value represents better performance) | **Accountability** C.Lenney | **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
-	-	-	-	-	-	-	-	-
544	1800	674	1132	353	214	1962	760	110

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

Key Issues

A total of 767 PALS concerns were received by MFT during March 2022, which is an increase of 125 and 113 respectively in comparison to the 642 PALS received in February 2022 and 654 in January 2022.

Of the 767 PALS concerns received in March 2022, the highest volume were attributed to WTWA, with 193 (25.1% of the total) being received. This is a continued increase for WTWA when compared to the 181 in February 2022 and 177 in January 2022. The specific themes for WTWA related to 'Communication', 'Appointment/Delay/Cancellation (OP)' and 'Treatment and Procedure'.

Of the 193 WTWA PALS concerns received, Burns and Plastics and Head and Neck Directorate were identified in the complaints relating to 'Appointment/Delay/Cancellation (OP)', 'Communication' and 'Treatment and Procedure'. Cardiology and Respiratory Directorates were also specific areas identified in complaints relating to 'Appointment/Delay/Cancellation (OP), and General Surgery, Urology and Breast Directorate identified in complaints relating to 'Treatment and Procedure'.

Actions

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

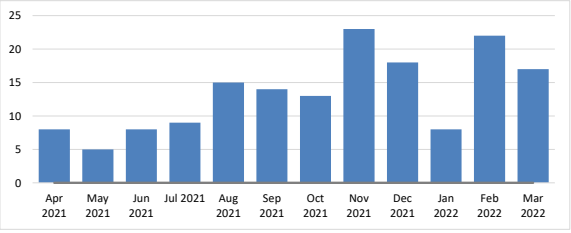
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 5 days.

All Attributable Bacteraemia

-

Actual 160 YTD (Apr 21 to Mar 22) | **Threshold** None (Lower value represents better performance) | **Accountability** C.Lenney | **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
16	63	14	10	0	0	33	24	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 623 incidents of E.coli bacteraemia reported to UKHSA during 2021/2022. Of these, 150 cases (24%) were determined to be hospital-onset. There were 17 hospital-onset cases reported in March 2022.

There were 10 trust-attributable MRSA bacteraemia cases reported to UKHSA during 2021/2022, and 11 community-attributable cases reported. There were no trust-attributable MRSA bacteraemia Reported for March 2022.

Operational Excellence

D.Furnival

Core Priorities	✓	◇	×	No Threshold
	1	0	10	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.

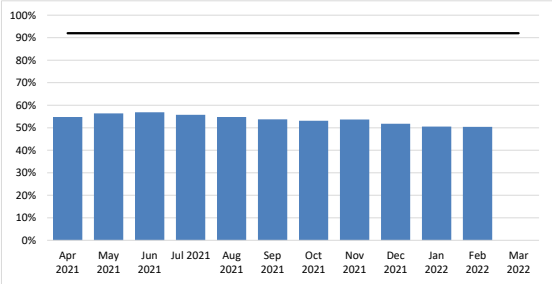
February summary:
• The overall RTT elective waiting list stood at 157,589 which is growth of 17.2% (22,041) on the position reported in April 2021. The number of patients waiting longer than 52 weeks was 13,795 which represents an overall reduction of 18.3% on that reported in April and accounts for 8.8% of the current waiting list.
• The number of patients waiting longer than 104 weeks in February was 1.4 (%) of the overall waiting list (2,142), the position had increased due to the continued prioritisation of clinically urgent and cancer activity in line with national requirements although focussed actions over the next quarter will reduce this number significantly down to 0 by the end of June.
• National performance against the 4 hour wait standards for Emergency Departments has steadily reduced since April 21, with the performance across GM and MFT closely following the same trend. Whilst performance in recent months had showed marginal improvement month on month since September, the slight downturn in February has continued 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 54 breaches of the 12 hour DTA quality standard in February with 605 in the year to date with none resulting in patient harm following route cause analysis (RCA). Corporate Governance retain oversight.
• Cancer performance has improved in 4 of the 6 cancer standards in February compared to January, these are the Two week wait performance measure, the 31 day and 62 day performance measures and sub surgery although the national standards were not achieved. 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	50.4%	(February 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
×	×	×	×	×	×	×	×	×
58.9%	46.0%	57.0%	45.9%	10.4%	54.0%	51.9%	43.2%	60.4%

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.

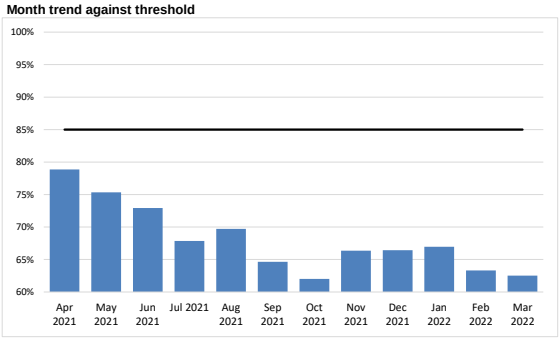
Actions
• Group Manchester Elective Surgical Hub continues to ensure patients with urgent clinical needs are treated, and maintain oversight and effective use of resources across MFT sites. This includes Independent Sector capacity already agreed for use by MFT.
• Maximising TGH hospital as a green site
• 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 February wait list stands at 157,589 an increase of 20,041 (17.2%) on April 21. Capacity for routine elective operations remains constrained due to the need to prioritise clinically urgent and long waiters activity in line with national guidance.
• The number of patients waiting longer than 52 weeks in February was 13,795 (8.8%) of the overall waiting list. This is a 18.3% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in February was 2,142 (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 February was 29% of all appointments inline with national requirements.

A&E - 4 Hours Arrival to Departure

Actual	64.2%	Q4 21/22 (Jan to Mar 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	54.2%	68.6%	95.3%	100.0%	NA	62.2%	59.2%	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.

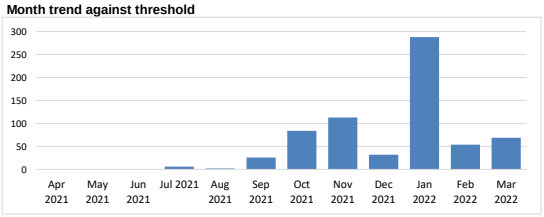
Progress

- February 2022 saw 1,300 attendances per day compared to 1,225 in April, an additional 75 attendances per day, higher acuity of patients, IPC measures and short term staff sickness both medical and nursing have impacted performance.
- In line with the national and regional picture, MFT performance of 81.0% in Q1 has reduced to 62.7% for Q4 2021/22.
- The number of patients with 7+ and 21+ days Length of Stay in MFT beds at 28th February was 687 and 286 respectively. Hospital teams are focussed on long length of stay reviews.

A&E - 12 Hour Trolley Waits

Actual	551	YTD (Apr 21 to Mar 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

Whilst pressures are evident across the trust footprint they are specifically exacerbated at NMGH where:

- 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 due to IPC restrictions and physical estate.
- Higher than optimal reason to reside patients, 31 of whom 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.

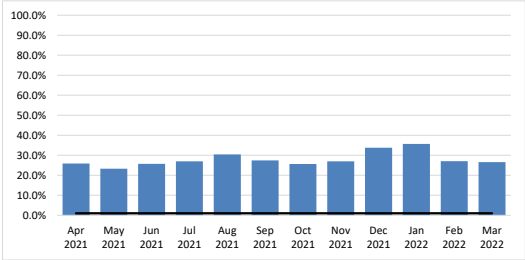
Progress

As a result of significant operational pressures the Trust has reported 605 breaches of the standard to date, North Manchester site accounts for 583 with 47 of these DTA breaches occuring during February, the majority of which were related to bed capacity constraints. Harm reviews are undertaken for all patients, with no harm identified in any of these breaches following RCA.
learning from the root cause analysis undertaken for any breach of the standard has been implemented

Diagnostic Performance

Actual	26.6%	(March 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
16.5%	21.0%	78.0%	52.4%	NA	NA	38.2%	42.1%	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

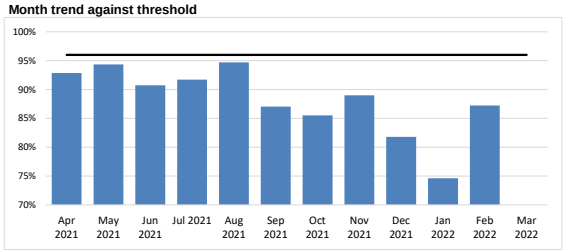
Actions
Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved 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
- The overall diagnostic waiting list stood at 29,172 in February which is an increase of 2,290 from that reported in April.
- The number of patients waiting longer than 6 weeks was 7,895 equating to group performance of 27.1%, this is an improvment on January reported position of 35.7%.
- The number of patients waiting over 13 weeks stood at 3,577 which amounts to 12.6% of the overall list with some extended waits within this cohort. Focus on these is ongoing to ensure all long waits are dated and DQ issues are resolved in preparation for migration.

Cancer 31 Days First Treatment

Actual	81.0%	Q4 21/22 (Jan to Feb 22)	**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	85.3%	100.0%	100.0%	NA	NA	82.9%	97.8%	NA

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

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

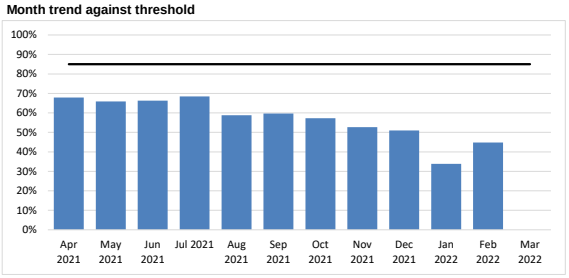
Actions
- Cancer treatments are being prioritised during the Covid pandemic, in line with national guidance on priority patients.
- Undated patients over 14 days are discussed at the group level Manchester Elective Surgical Hub (MESH) meetings with hospital / MCS leads.
- Capacity is assessed weekly by Cancer Managers, Hospital and Clinical Leads.
- Mutual aid for capacity is being coordinated via MESH internally and the GM surgical hub is still available for use.
- Cancer Recovery Workstream in place, details under the 62 day standard.
- Skin capacity moved back from the Independent sector in October. Plans are in place to accommodate internally.

Progress
- 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.
- Internal single PTL for capacity across sites in place.

Cancer 62 Days Referral to Treatment

Actual	38.9%	Q4 21/22 (Jan to Feb 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	✗	✗	NA
NA	59.3%	NA	12.5%	NA	NA	39.0%	46.0%	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.
- Capacity being utilised in the independent sector and the Christie to support timely treatment

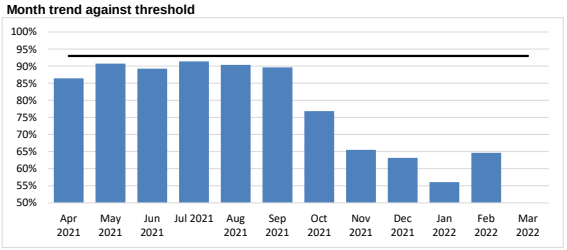
Progress

- 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	60.6%	Q4 21/22 (Jan to Feb 22)	**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	97.9%	100.0%	95.0%	NA	NA	59.3%	37.5%	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. Breast performance is the main driver.

Actions

- Two specific tumour group 2ww workstreams in action - breast and skin.
- February performance has improved
- MRI continue to provide mutual aid to WTWA for head and neck referrals.

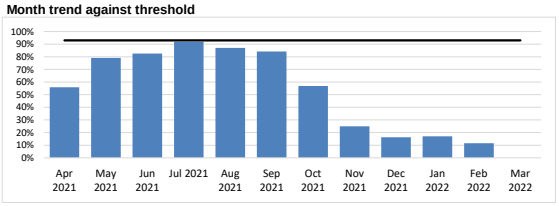
Progress

- Cancer 2ww referrals have returned to >100% pre Covid averages. Feb 2022 is 102% of Feb 2019 although March has risen again to 120%.

Cancer 2 Week Wait - Breast

Actual	14.3%	Q4 21/22 (Jan to Feb 22)	**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	13.1%	6.8%	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.

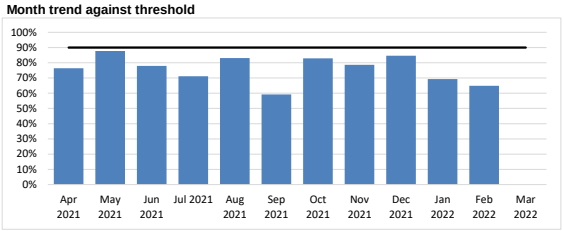
Progress

Performance is improved from Q1

Cancer 62 Days Screening

Actual	66.9%	Q4 21/22 (Jan to Feb 22)	**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	68.4%	-	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.

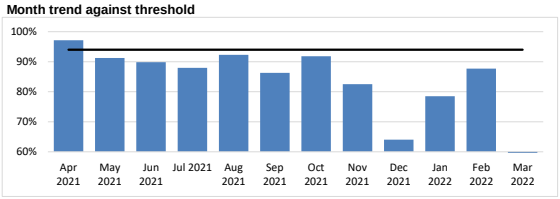
Actions
- The Actions listed under Cancer 62 Days are applicable to this standard.

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	82.9%	Q4 21/22 (Jan to Feb 22)	**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	87.5%	NA	100.0%	NA	NA	79.5%	100.0%	NA

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

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

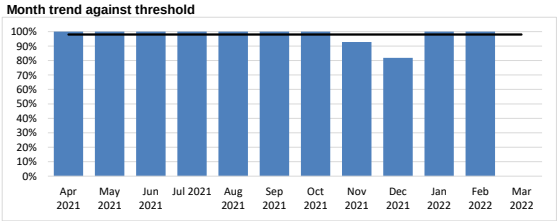
Actions
Actions noted under the above cancer standards.

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

Cancer 31 Days Sub Chemo Treatment

Actual	100.0%	Q4 21/22 (Jan to Feb 22)	**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	100.0%	-	NA

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

Key Issues
- No current issues with chemotherapy provision.

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

Progress
•Standard achieved in month.

Finance

J.Ehrhardt

Core Priorities	✓	◇	×	No Threshold
	0	0	0	0

Headline Narrative

Key financial issues are presented to each meeting of the Board in the form of the Group Chief Finance Officer's Report. In addition, updates are provided through regular papers to the Finance and Digital Scrutiny Committee.

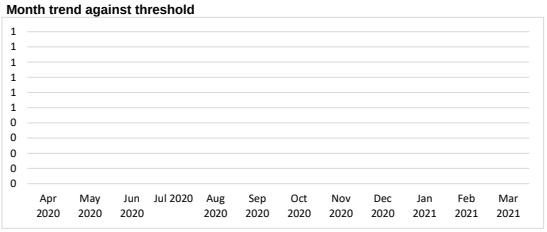
Finance - Core Priorities

Operational Financial Performance

Actual | **Accountability** J.Ehrhardt

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

Month trend against threshold



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

Hospital level compliance

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

Regulatory Finance Rating

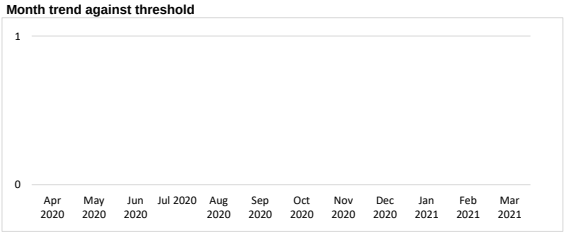
Actual

Threshold (Lower value represents better performance)

Accountability J.Ehrhardt

Committee GMB 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

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

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	3	1	7	3

Headline Narrative

As Hive Go-Live approaches, the Workforce Directorate is overseeing a variety of workforce workstreams to underpin the Hive programme and its transition to business as usual. These include the delivery of Hive programme training and future state training requirements, workforce transformation, organisational development, and resourcing to name a few key examples. The Group HR team is working closely with Hospitals/MCS/LCO to develop robust plans throughout this period of change to ensure the effective management of workforce resources and workforce engagement.

Work to continues to deliver and embed our People Plan commitments and support the COVID-19 workforce recovery agenda. .

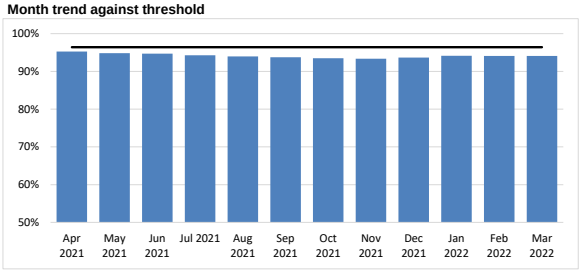
Workforce and Leadership - Core Priorities

Attendance

Actual 94.1% (March 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
✕	✕	✕	✕	✕	✕	✕	✕	✕
95.0%	92.9%	94.2%	94.3%	94.2%	94.2%	93.9%	93.4%	93.6%

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

Key Issues

The Group attendance rate for March was 94.1% which is the same as the previous month's figure (94.1%). This is lower than the attendance rate at the same point last year (March 2021) of 95.3%. The latest figures released by NHS Digital show that for December 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.0% or 94.0% 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 December 2021 at 4.9% or 95.1% 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.

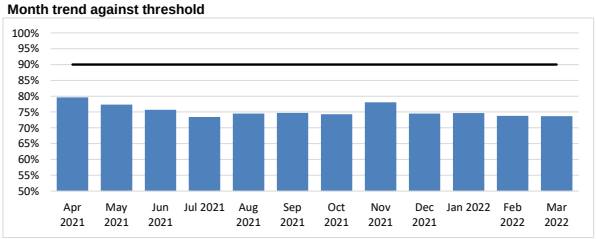
The Absence Manager system is in place across all MFT sites. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers make best use of the Absence Manager system in the effective management of absence and to support the health and wellbeing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

Appraisal- non-medical

Actual 73.7% (March 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
✕	✕	✕	✕	✕	✕	✕	✕	✕
71.2%	83.0%	71.6%	83.2%	80.9%	78.8%	80.1%	59.5%	69.2%

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 decreased by 0.1% across the Group in March 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.

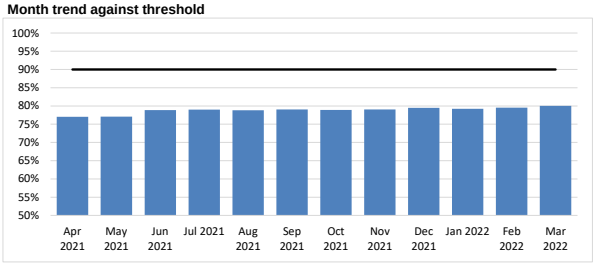
Actions

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	80.0%	(March 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
✗	✗	✗	✗	✗	✗	✗	✗	✗
79.7%	79.2%	79.0%	83.4%	81.2%	77.9%	81.9%	71.1%	82.0%

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 increased by 0.4% across the Group in March 2022. 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.

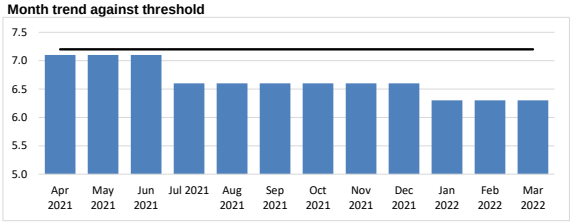
Actions

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	6.30	Q4 21/22 (Jan to Mar 22)	**Accountability**	P. Blythin
Threshold	7.20	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
6.4	6.1	6.3	6.3	5.9	5.9	6.4	6.2	6.4

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 6.3. No Hospital or MCS has met the target threshold of 7.2.

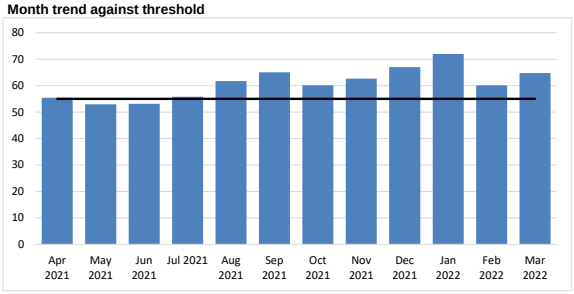
Actions

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.

Time to Fill Vacancy

Actual	64.7	(March 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	56.4	60.5	71.2	68.5	94.7	48.5	66.7	71.8

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 60.1 in February to 64.7 in March. Currently only WTWA is under the target in March.

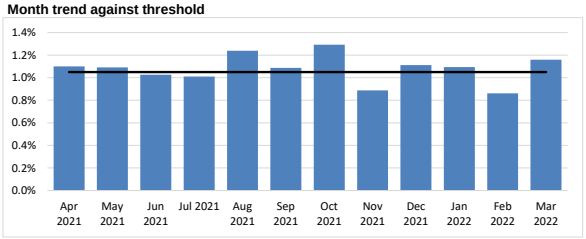
Actions

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	1.2%	(March 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	✗	✓	✓
0.70%	1.17%	1.00%	1.53%	0.64%	NA	1.78%	0.54%	0.54%

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 March 2022 is 1.2% against a monthly target of 1.05%. This has increased from 0.9% in February.

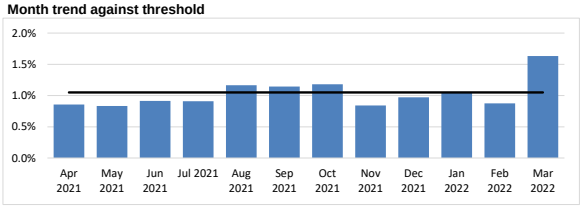
Actions

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 preceptorship programme for both domestic and internationally educated nurses, Midwives and AHPs has been approved by Professional Board and will commence delivery in May 2022. The programme acknowledges the challenges to both graduate UK nurses and those from overseas joining the trust and focuses on supporting them to adapt into their role as and an NMC registrant. Further expansion of the CPD offer continues with the inclusion of access to the NHS leadership academy 360 appraisal and access to the Florence Nightingale Academy supporting both nurses on the frontline.

Turnover (in month)

Actual	1.63%	(March 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
✗	✗	✗	✗	✓	✓	✗	✗	✗
1.27%	2.25%	1.32%	1.84%	0.97%	0.53%	1.55%	1.51%	1.87%

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 March 2022 single month turnover position for the Group is higher at 1.6% when compared to the previous month (February 2022, 0.9%).

The turnover rate was lower at the same point last year (March 2021) at 1.1%.

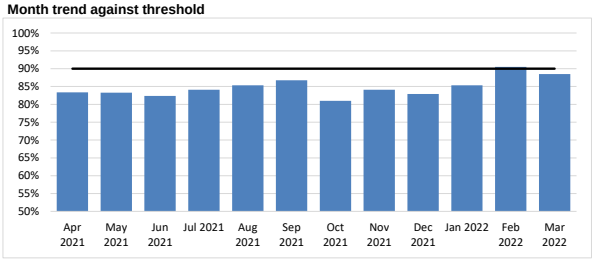
Actions

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	88.5%	(March 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
✓	✗	◇	◇	✓	✗	◇	✓	◇
92.4%	82.8%	85.9%	89.2%	92.0%	83.8%	87.7%	98.1%	88.9%

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

Key Issues

Compliance decreased by 2.0% across the Group in March 2022. NMGH, REH and CSS are all meeting the 90% target.

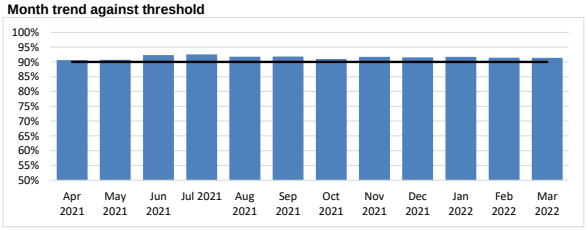
Actions

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	91.4%	(March 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
✗	✓	✗	✓	✓	✓	✓	✗	✓
89.6%	92.0%	89.3%	93.0%	92.2%	92.5%	92.0%	89.6%	92.6%

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 March 2022 the aggregate compliance decreased by 0.1% to 91.4%. Only NMGH, RMCH and CSS has a compliance score below the 90% Trust target.

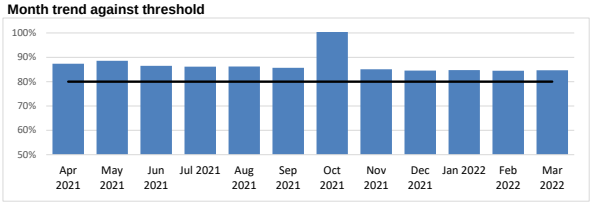
Actions

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%	(March 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
✓	✓	✓	✓	✓	✓	✓	✓	✓
85.4%	83.8%	86.3%	85.2%	85.2%	89.0%	84.1%	83.4%	84.4%

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

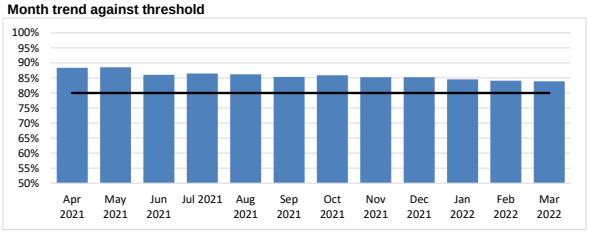
Actions

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. A new preceptorship programme is being launched in May 2022, this programme is designed to support and help retain newly qualified and new internationally recruited nurses.

BME Staff Retention ✓

Actual	83.9%	(March 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%	81.4%	85.6%	84.9%	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 March was 83.9%.

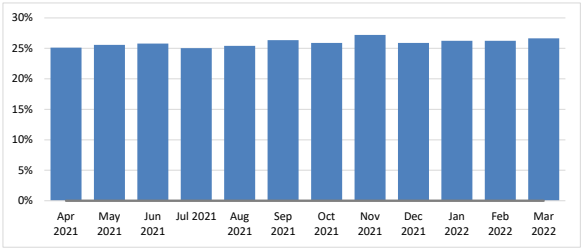
Action

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 26.6% (March 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
-	-	-	-	-	-	-	-	-
31.8%	32.8%	26.7%	18.7%	45.9%	32.4%	30.2%	27.3%	18.3%

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 (26.6%); 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 (March 2021, 25.6%).

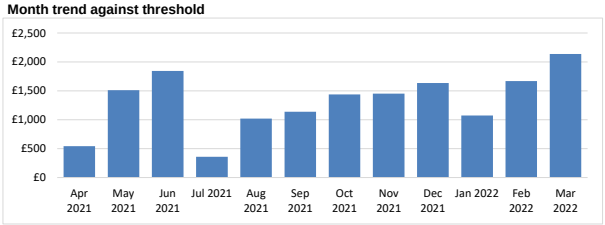
Actions
The Group figure is higher than the Greater Manchester BME population of almost 17% but lower than the Manchester BME population of over 30%.

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 £2,138 (March 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
-	-	-	-	-	-	-	-	-
£298.4	£353.5	£59.6	£45.4	£66.2	£0.0	£137.8	£1,195.8	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.

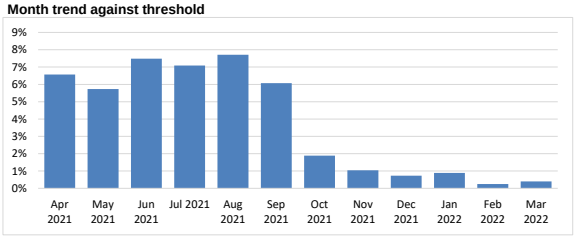
Key Issues
The March total value of Medical and Dental agency staffing was £2,138k compared to £1,667 in February.

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 0.4% (March 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
-15.5%	-2.1%	-5.1%	4.7%	-0.5%	NA	5.8%	-1.3%	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. This is expected to be resolved following 2022/23 budget setting and validation.

Actions
The trusts guaranteed job offer campaign continues for our Greater Manchester MFT students graduating in September 2022. The Trust band 5 vacancy rate is significantly impacted by the success of our international recruitment, circa 48 nurses per month join the organisation.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	David Furnival, Group Director of Operations – Director Team
Date of paper:	May 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 safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors are asked to note the contents of the report and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.
Contact:	Name: Lorraine Cliff, Director of Performance Tel: 0161 276 6121

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

Following the peak in admissions during January due to the Omicron variant there has been a growing trend across Greater Manchester (GM) which spiked again in early April. The impact has in the main been on general and acute beds (G&A) with 17% covid patients in G&A beds across GM. Critical care has remained stable across both GM and MFT. MFT has mirrored the GM position with 16% in general and acute beds and 6% in critical care beds. Existing COVID Response and Recovery governance structure has continued throughout overseen by the Group Director of Operations.

3. 22/23 PLANNING UPDATE

MFT have now submitted an annual plan to GM as part of the 22/23 annual planning round. For MFT, this sets out a plan to reduce long-waiters, with 104 week waits reduced to zero by the end of June, and a reduction in 78 week waits by March 2023. It includes a plan to significantly reduce long-waiting cancer patients and sets out plans to increase the rate of Outpatient Patient Initiated Follow Ups (PIFU) and specialist advice. This plan needs to be seen as part of a multi-year recovery, one that will be supported by HIVE EPR, and which improves patient experience.

4. URGENT CARE AND FLOW

Urgent Care Current Position – end March 2022 compared to prior months

Performance against the A&E 4-hour standard has deteriorated over February and March compounded by the Omicron wave on flow and Infection Prevention Control (IPC) restrictions. The has been coupled with an increase in attendances throughout March and admissions from ED were up by 8%.

Ambulance wait times at MFT continued to be challenged throughout March. As a proportion, MFT had 6.9% of ambulances wait more than 60 minutes at the front door since December through to March, with surge attends correlating to the rise in the Omicron demand.

Significant focus on reducing patient numbers with no reason to reside has continued and has gradually reduced since January although this continues to be a pressure across MFT and the wider GM system.

Ongoing Actions:

There continues to be a programme of improvement activities across the Emergency Departments as follows:-

- All sites have now gone fully live with Streaming at the Point of Entry and booked appointments for Urgent Treatment Centres (UTC). Patients arriving between 21:30 – 07:00 hrs who are

amenable to UTC care are offered an appointment for the next day. This supports long waits overnight and reduces footfall in the departments. The next steps are to maximise the number of bookable slots each department offers per day and standardise across all three sites the mix of patients to include both minor injury and minor ailments.

- An Ambulance Handover Summit has taken place to increase the focus on improving handover times, turnaround times, eliminating 60-minute breaches and delayed admission. Visits to other Trusts who perform well at handover have taken place and the collective actions from each site have been presented back to MFT sites with the aim of taking up similar processes at pace. The Transformation Team have worked with the Local Care Organisation (LCO) and commissioners to identify what actions their organisations are taking to support improved ambulance handover, acknowledging that this is a system wide problem and requires a system wide response.
- The Discharge Processes Project is nearly complete on the Wythenshawe site with the last of the focused team sessions concluding by mid-April. A range of improvements have been identified with the teams contributing to how discharge rates can be improved throughout the day and overall.
- The Virtual Ward (VW) programme continues with a recent launch event taking place and a Programme Management approach has been established to take the work forward.
- The Transformation Team are supporting the newly formed Urgent Care Operational Delivery Cell at Wythenshawe Hospital. This group will focus on the urgent care priorities including establishing a fully integrated Same Day Emergency Care (SDEC) service co-located to ED, improved UTC service and ambulance handover performance. All projects in the work of the cell will make a significant impact on quality, safety and performance across urgent care at Wythenshawe.

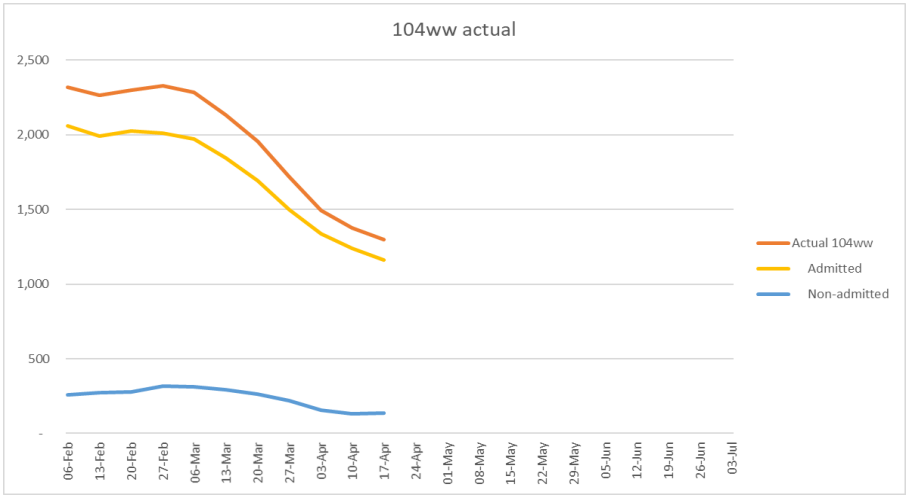
Expected Outcomes

- Admission and attendance avoidance to reduce the footfall into ED's and lower the volume of attendances per day
- Reducing occupancy levels across non-elective pathways by supporting earlier discharge and avoiding admission in the first instance and maximising the Virtual Ward option
- Improvement in ambulance handover to within acceptable levels
- Improve flow out of Emergency Departments across the 24-hour period

5. ELECTIVE ACCESS

ELECTIVE CARE

Following January's step down in elective activity due to the Omicron variant, and the impact this had on 104 week waits, MFT ramped up activity in February and March. Coupled with an intensive focus from management teams this has led to a significant reduction in patients over 104 week waits. MFT came in c370 below the March-end target agreed with NHSEI and is continuing to reduce 104ww with a target of zero by the end of June, shown in the chart overleaf.



Focus continues on ensuring clinically urgent patients are being seen in a timely manner and this continues to be tracked through the weekly MESH (elective surgical hub). Sites are regularly challenged through the MESH process to ensure the delivery of both the P2 demand and the 104ww targets, ensuring clinical safety is maintained.

There has been an increase in the number of P2 patients waiting during March and this has impacted on the number of patients waiting beyond 28 days. There are a number of specialties that are particularly challenged and require closer monitoring and subgroups remain in place with clear delivery plans.

Ongoing Actions:

The scope of on-going work to recover the elective programme continues focusing on the delivery and management of both clinically urgent and long wait patients, ensuring that the elective pathways are as robust and efficient as possible.

The MFT programme has strong links to the GM recovery programme, ensuring that MFT utilise system capacity, as well as providing green-site capacity at Trafford for other GM trusts.

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

The Theatre, Efficiency and Rapid Improvement (TERI) project is moving into phase 2, capitalising on the improvement programmes delivered in phase 1. The primary objective of the TERI programme is to ensure Trafford as a Green site works as an exemplar with excellent practices and processes throughout the elective pathway. An update on the key programmes is below:

- Theatre Scheduling – 90%+ of lists are now scheduled to above 85% and pathways have been developed to improve planned throughput across the Trafford lists. Phase 2 is focusing on improving the utilisation of available sessions. Utilising the theatre system (ORMIS) and Four Eyes data to identify opportunities to improve in-session utilisation.
- Pre-operative assessment – agreement at the Peri Operative workshop to implement early pre op pathways at Trafford for all specialities. Integrated programme of work underway with Hive colleagues to ensure pathways are fit for purpose in HIVE.
- Peri-operative pathways – initial focus on peri-operative anaemia pathways to improve patient outcomes and reduce both LOS and post op transfusions. Currently this service is only available at Oxford Road Campus and the programme is focused on implementing this pathway across MFT, in line with early pre op booking and to ensure future readiness for Hive

- Start and Finish times – process established at Trafford site to record, manage and escalate late starts using improved performance data. Phase 2 will continue to build on this improvement work, linking in scheduling and review of early finish data.
- Theatre Data Improvement – focused across MFT sites, improving ORMIS data input and agreeing standardised data processes to improve both internal and national reporting i.e. Model Health System
- 23 hour stay model – test of change is being planned in General Surgery to operate a 23hr model at Trafford that will allow an increase in the types of cases that can be undertaken for this specialty

Use of the Independent Sector

The Transformation team have been asked to establish a centralised IS admin team. This team will:

- Reduce admin demand at Site level for IPT transfers
- Standardise IS pathways and improve efficiency
- Increase use of IS capacity across MFT

Expected outcomes:

- Improved and timely theatre scheduling that results in maximising capacity and reducing short notice cancellations
- Addressing data quality errors that impact reporting both at local and national level, to ensure that going forward decisions are based on sound accurate data and intelligence.
- Development of internal reporting for theatres through Power BI to support Hive Go Live and beyond

OUTPATIENTS

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 commenced in March 2022.

CANCER

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 2020-21 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.3500 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 March, MFT was above trajectory reduce the backlog of 104 and 62+ days. Actions are being planned with hospitals / MCS to address the above areas for development. A new trajectory is in development to take MFT below pre pandemic backlog levels by March 2023

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 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
- Breast services improvement workshop held on 22nd February and improvement plan in place. Rapid assessment and triage being implemented. Patient pathway Navigator due to commence in post in May. Clinic templates reviewed and changes implemented from April to ensure capacity is maximised.
- Urology- all surgical activity now being undertaken at Wythenshawe with approval to use an in-sourcing company at weekends to increase capacity. Some complex surgery is still being carried out at The Christie using the MFT@Christie model.
- Head and Neck – MRI supporting Wythenshawe with capacity for patients breaching 14 days and surgical capacity for NMGH patients.
- Continued use and focus to utilise IS capacity for endoscopy demand.
- Additional clinical capacity in place weekdays and weekends for example breast 'Super-Saturdays.
- Additional consultant recruited at NMG for Lung Cancer Team
- Site based weekly reviews of all patients > 62 days with clear action plans in place reviewed.

Expected Impact:

The focused actions aim to increase the number of patients being seen within 7 days, reduce the diagnostic phase with more patients being given a diagnosis within 28 days and reduce the overall treatment times.

6. RECOMMENDATIONS

The Board of Directors are asked to note the contents of the report 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:	Julie Cawthorne MBE, Assistant Chief Nurse (ACN) and Clinical Director of Infection Prevention and Control (CDIPC) Alison Lynch, Deputy Chief Nurse
Date of paper:	May 2022
Subject:	Update on the Infection Prevention and Control response to COVID-19, including: • Nosocomial Infections • Infection Prevention & Control Board Assurance Framework (IPC BAF) • COVID-19 and Seasonal Influenza vaccination programmes
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 • The updated IPC Board Assurance Framework (Appendix 1)
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse and Clinical Director of Infection Prevention and Control Tel: 0161 276 4042

1. 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) response to COVID-19, including:

- Update on national and regional guidance
- Healthcare associated infections (nosocomial transmission) of COVID-19 and other organisms.
- The Infection Prevention and Control (IPC) Board Assurance Framework (BAF)
- The COVID-19 and seasonal influenza vaccination programmes

2. Update on National and Regional Guidance

2.1. From 1st April 2022 substantial changes have been made to existing COVID-19 guidance (included in the references below), with several key documents withdrawn in line with the governments 'Living with COVID-19' white paper, published on 23rd February 2022[1].

2.2. The overall theme of the new guidance is to move to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as influenza and respiratory syncytial virus (RSV).

2.3. On 1st April 2022, the national case definition for COVID-19 was replaced by a broader definition for 'people with symptoms of a respiratory infection including COVID-19'.

2.4. North West principles to support the delivery of 'Living with COID-19 using current IPC guidance and hierarchy of controls were distributed on 11th April 2022[2].

2.5. The principles, which were already in place at MFT, are based on current guidance and hierarchies of control [3] [4] [5] [6] with an emphasis on local decision making around patient pathways and dynamic management of risk. The principles are designed to support consistency of approaches in both NHS trusts and system-wide arrangements.

2.6. As described above, the principles align closely with those already in place and are reflected in MFT policies and procedural documents that have been developed by the IPC team.

2.7. The MFT chief nurse and senior IPC team have continually contributed to national and regional discussions on infection prevention and control matters throughout the pandemic.

[1] HM Government COVID-19 Response: Living with COVID-19. 23rd February 2022
[2] NHSE/I Final draft: North West principles to support the delivery of 'Living with COVID' using current IPC guidance and Hierarchy of Controls'. 11th April 2022
[3] Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022. Updated 14th April 2022.
[4] Infection prevention and control: resource for adult social care. 4th April 2022 (published 31st March 2022)
[5] C1623 Testing for elective care pre-admission patient pathways V1 4th April 2022
[6] C1624 Testing for inpatients V1 4th April 2022

3. Healthcare Associated Infections - Nosocomial Transmission

3.1. COVID – 19

3.1.1 Chart 1 below demonstrates newly confirmed COVID- 19 cases across MFT between 1st March 2020 and 31st March 2022.

3.1.2 There has been a gradual reduction in outbreaks of Hospital Onset COVID-19 Infection (HOCI) since a peak in January 2022.

- 12 outbreaks in March 2022
- 16 outbreaks in February 2022
- 29 outbreaks in January 2022.

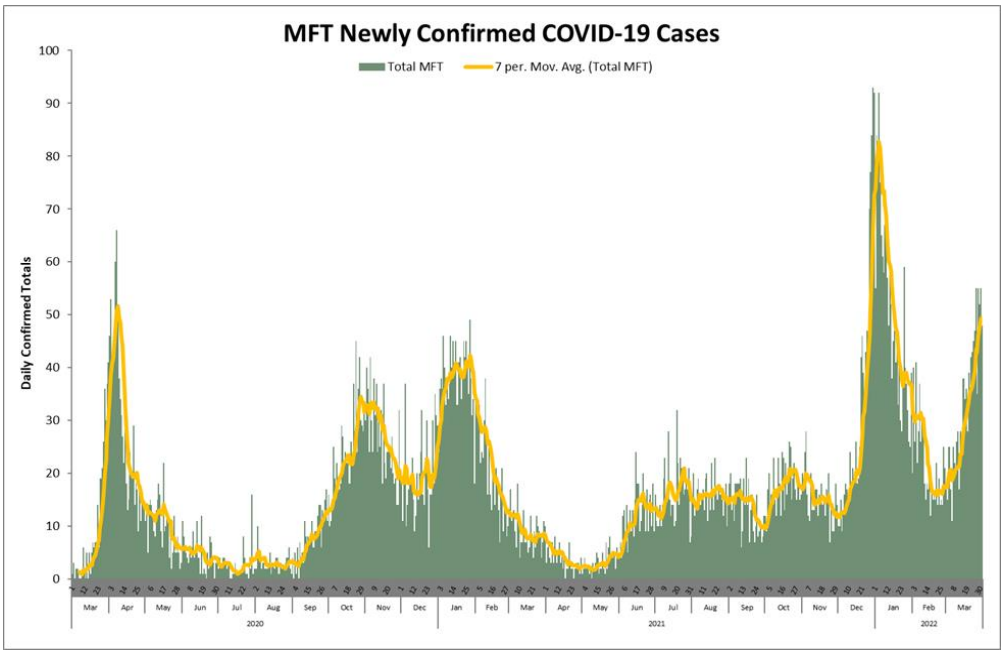


Chart 1. MFT newly confirmed COVID- 19 cases from 1st March 2020 – 31st March 2022

3.1.3 Whilst COVID-19 is still circulating, the current variant is less virulent; most in-patients who are found to have COVID-19 are asymptomatic and those who are symptomatic have significantly reduced severity of illness.

3.2. Other HCAI

3.2.1. The Trust is committed to reducing incidents of avoidable HCAI. Table 1 below shows the number of incidents of reportable HCAI from year ending March 2021 compared to year ending March 2022

HCAI	Year ending March 2021	Year ending March 2022	Annual threshold
Meticilin Resistant *Staphylococcus aureus* Bacteraemia	12	10	0

Clostridium difficile Infection	215	194	117
Gram Negative Bacteraemia	299	301	162
Vancomycin Resistant Bacteraemia	34	30	Not applicable

Table 1 Reportable HCAI's March 2021 – March 2022

3.3. Identified themes

3.3.1. A review of HCAI cases takes place at the end of year through a process led by the Chief Nurse with the directors of nursing and IPC leads for each hospital/MCS/ LCO during March 2022.

3.3.2. Themes identified included:

- Compliance with Trust screening/isolation policies particularly in clinical areas where isolation facilities are less available.
- Compliance with fundamental IPC principles
- Environmental factors concerning the age of some areas of the estate

3.3.3. The directors of nursing and IPC leads are adapting and updating local IPC action plans to address the themes, with outcomes to be reported to the Group Infection Control Committee. An example of an action to be taken, led by the assistant chief nurse for IPC is the development of a Trust-wide 'Gloves off' Campaign, to reduce the use of single use disposable gloves and re-focus on the importance of good hand hygiene.

4. The IPC Board Assurance Framework

4.1. The IPC Board Assurance Framework has been reviewed regularly since its introduction in June 2020. The Trust IPC BAF has been further reviewed during May and April 2022 following release of updated guidance described in section 2 of this paper, changes are highlighted in Appendix 1.

5.2. Mitigating actions are in place to address any gaps in assurance; these are highlighted in the ten key areas listed below.

- Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

  Gaps in assurance / mitigation in place

  - COVID-19 positive patients present with no symptoms, COVID status is an incidental finding; *mitigating actions* include routine screening on Day 1, 3 & 5-7, fundamental IPC measures, and risk assessments.
  - Rapid pace of change may cause confusion; *mitigating actions* include communication cascade in place, where there may be over-reliance on electronic methods face to face communication is led by senior leaders.

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

Gaps in assurance / mitigation in place

- Some Trust estate is old and does not comply with NHS Estates Building Notes (HBN) affecting cohorting / ventilation; *mitigating actions* include that Trust ventilation engineers are consulted, changes in functions are assessed and agreed through an MDT approach supported by IPC, Estates and Facilities Teams.

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

  Gaps in assurance / mitigation in place

  - Surveillance data is supported by ad hoc; *mitigating actions* include surveillance officer support sought, consumption data and accuracy has been discussed with Regional AMS lead with acknowledgement that HIVE/Epic will improve information sharing / communication.

- 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

  Gaps in assurance / mitigation in place

  - Lack of concordance amongst some patients/visitors; *mitigating actions* include the interim Visiting Policy available via Trust intranet, and at ward level and are discussed when arranging visiting.

- 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 / mitigation in place

  - Some Trust estate is old and does not comply with NHS Estates Building Notes (HBN) affecting cohorting / patient placement ventilation; *mitigating actions* include 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 using the hierarchies of control.

- 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 / mitigation in place

  - 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; *mitigating actions* include ability to use FFP3 masks where risk cannot be entirely eliminated through ‘routine’ pandemic PPE usage, local risk assessment and pre-emptive assessment before results are known, and re-fresh of the Dress Code Policy in April 2022.

- Provide or secure adequate isolation facilities
  Gaps in assurance / mitigation in place
  - Lack of side rooms for isolation, potential delay between testing and identification of infection status; *mitigating actions* include risk assessments undertaken based on symptoms where status is unknown.

- Secure adequate access to laboratory support as appropriate
  Gaps in assurance / mitigation in place
  - Travel time for specimens from site to laboratory dependent on transport; *mitigating actions* include additional transport in place to mitigate risk.

- 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 / mitigation
  - Staff changing facilities are not available in all areas; *mitigating actions* in place include staff advised on how to decontaminate uniforms and Dress Code policy in place (undergoing re-fresh in April 2022.

- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
  Gaps in assurance / mitigation in place
  - Vaccination rates in staff. *Mitigating actions* include the 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.
  - Staff absences. *Mitigating actions* in place include the process of monitoring supported through EHWB support policies and procedures, particularly since the change in practice to remove the requirement for staff to have a confirmatory PCR post a positive LFD test.

5.3. The IPC BAF is fully incorporated into the main Board of Directors Board Assurance Framework, where there is oversight of all associated risks and mitigation.

- 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.
- The Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls[7]
- Patients and visitors are aware of the measures staff are required to take to prevent COVID-19 infections, and the measures they are themselves required to take to prevent infections and help prevent spread.
- UKHSA guidance is regularly checked for updates and any changes are communicated to staff in a timely way

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

- An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control

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

5.1. Through the MFT staff vaccination programme[8]:

- 92.7% have received their 1st vaccine
- 81.6% of clinically vulnerable staff have had a booster/3rd dose
- 90.1% 2nd dose vaccines have been administered
- 74.5% of staff have had a COVID-19 Booster Vaccine
- 61.7% of staff have had their Flu Jab
- 48.4% of BME staff have had a Flu Jab
- 61.5% of BME staff have accessed a COVID Booster vaccine
- 100% of MFT staff have been offered the vaccinations

6. Recommendations

7.1. The Board of Directors are asked to note:

- The information provided in the report
- The updated IPC Board Assurance Framework (Appendix 1)

[8] Taken from the MFT Power BI dashboard. Data as at 4th April 2022.

Appendix 1

Infection Prevention and Control Board Assurance Framework V15 April 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
	• 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 updated March 2022. Trust guidance updated.
	• https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-
		• Some COVID-19 positive individuals present at hospitals as asymptomatic patients
		• Unpredictability of COVID-19 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

increasing case numbers where they occur. • 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	control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations • COVID-19 SOP Testing for inpatients V1 4th April 2022 (NHS England) • COVID-19 SOP Testing for elective care pre-admission patient pathways V1 4th April 2022 (NHS England) • UKHSA Guidance Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 test result 1st April 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 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		recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes • 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

infection/new variants of concern in thelocal area. • 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,	Nurse), daily assessment and situational guidance is in place using an MDT approach that considers the Hierarchy 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 are in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. These principles align to the Final Draft North West Regional IPC Principles to support the delivery of 'Living with COVID' using current IPC guidance and Hierarchy of Controls' published 11th April 2022.		CoV2) for Winter 2021-2022, that Trusts may review their pathways in line 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

knowledge, and experience to be able to recognise the hazardsassociated with respiratory infectious agents. • 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.	• 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. • 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		recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and 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.

• 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).
• 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.
	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)
	• 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 and this plan is monitored at boardlevel.	• The Estates and Facilities team have undertaken a full review of both clinical and non-clinical cleaning responsibilities as part of preparations for the implementation of National Standards of Cleanliness • Multi-disciplinary project implementation team in place	• Old estate unable to provide good ventilation in some areas • Local weather conditions may make it	• Enhanced cleaning specifications in place for clinical and non-clinical areas • Trust Policy for working safely based on PHE guidance is in place • Increased cleaning in public

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. 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	• Variation process in place if a department require a risk category revision. Efficacy audits assess if risk category/specification is appropriate – these commence 1st April 22 • Technical audits of cleaning taking place to assure standards. A rectification process is included should the standards not be achieved. This will be in line with NSOC from 1st April 22. • Enhanced cleaning implemented in liaison with IPC upon declaration of outbreak. This is detailed in cleaning policy and outbreak meetings initiated by IPC. • All surface cleaning (with exception of floors) currently utilises chlorine based product. • Any supply issues would be escalated to Trust Procurement and IPC. Alternative products would be IPC instructed and approved • Cleaning Policy submitted to the	difficult to maintain internal temperature if door and windows are open • Challenges around recruitment of monitoring officers and domestic supervisors who will be conducting the audits.	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 • FR1 & FR2 audits will be prioritised along with areas of known concerns/outbreak areas • Trust ventilation engineers consulted prior to purchasing any technologies.

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. Donning & doffing areas 'Frequently touched' surfaces eg, door/toilet handles, patient callbells, over bed	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 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.		

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 room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air	• 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 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.		

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 minimum air changes refer to country specific guidance.
In patient Care Health Building Note 04-01: Adult
	• 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 where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative		

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. • when considering screens/partitions in	• 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 rates required following AGP and systems in place locally to manage the dilution time within vacated rooms. • Ventilation system monitoring and management		

reception/ waiting areas, consultwith estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	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 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 with correct antibiotic.
• mandatory reporting requirements are adhered
	• 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 Committee.
	• The AMC has senior representatives from each hospital/MCS including medical, nursing and pharmacy. Each
		• 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 consumption.

to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	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. • 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 considered appropriate during outbreaks withininpatient areas This is an organisational decision following a risk assessment.	• 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 visiting restrictions across the Trust from 4th April 2022, based on principles of community prevalence, local COVID-19 burden (related to	• Lack of concordance amongst some patients/visitors	• Interim Visiting Policy available via Trust Intranet and information published on the Website

• 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. • Implementation of the Supporting excellence in infection prevention and	outbreaks) and including other HCAI's. Visitors are reminded to adhere to NHS requirements to wear a FRSM unless exempt, they no longer need to undertake an LFT test, to practice good hand hygiene and to wear PPE where indicated. • End of Life Policy adapted to support visiting during the pandemic. • Hand sanitisation stations at 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 • 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		

control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	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 undertaken prior to attendance wherever possibleto enable early	• 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 and elective admissions as per Trust guidance, including routine at	• 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 • Individuals who are clinically extremely vulnerable from

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	1,3 and 7 days and screening for those who develop symptoms. Patients are no longer routinely swabbed on a weekly basis on Day 8, except unless they are severely immunocompromised. • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place. • 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 encouraging patients to wear face		COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk. • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for

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	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		vulnerable groups and prioritisation of side room

worn by staff and patients in 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.	specific plan of care to mitigate 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 are in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. These principles align to the Final Draft North West Regional IPC Principles to support the delivery of 'Living with COVID' using current IPC guidance and Hierarchy of Controls' published 11th April 2022.		

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;	• 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	• 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

• adherence to national guidance on the use of PPE is regularly audited withactions in place to mitigate any identified risk. • 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	instruction displayed • Register of staff training and fit testing for FFP3 masks are 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		• Increased Microbiologist and AMD support • 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

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 • 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.	breaks to facilitate reduced contact to ensure that footfall reduced where possible • Local population, regional and national surveillance intelligence is presented by Trust expert virology team (linking with the on-site PHE lab as above) • A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at: • High Level Infection Control Meeting • Clinical Sub-Group /Advisory Groups • Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner		masks in all clinical and non-clinical areas • Additional Hand 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

	• Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC and clinical teams • Outbreak Policy in place		• Pre-emptive risk assessment to manage high risk patients before results are known.

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	• 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	• 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

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 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	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 risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately.		• Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients)

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	• A set of IPC principles are in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. These principles align to the Final Draft North West Regional IPC Principles to support the delivery of 'Living with COVID' using current IPC guidance and Hierarchy of Controls' published 11th April 2022. • 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	• 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	• Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site

• 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. • 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.	• 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 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		

• 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 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	following IPC / microbiology and virology support.		

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.	• 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.	• 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

• 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	• 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 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		• Uniform Policy in place

	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	• 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	• Vaccination rates in staff	• Prioritisation based on clinical and staff need • 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

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. • 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	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 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.		

– 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, 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;	• 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 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 LFT results are fedback to line managers with the EHW Clinical Team ensuring advice and support is provided in accordance with policy.		

that advice is available to all health and social care staff, including specific 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 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	• 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 documents published 1st April 2022 - COVID-19: managing healthcare stff with symptoms of a respiratory infection; & Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 test result, which replaced the previous UKHSA guidance. Trust guidelines amended. • Manager well-being sessions are in place to support staff in respect of vaccination.		

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 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.	• 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 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		

• 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 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.			

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).

Appendix 2

Infection Prevention and Control Board Assurance Framework V13 January 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
	• 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
		• 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

increasing case numbers where they occur. • 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	activity (including COVID-19, RSV and other seasonal pressures). POCT testing is in place in 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		recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes • 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

infection/new variants of concern in thelocal area. • 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,	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. • 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.		CoV2) for Winter 2021-2022, that Trusts may review their pathways in line 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

knowledge, and experience to be able to recognise the hazardsassociated with respiratory infectious agents. • 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.	• 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		recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and 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.

• 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).
• 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.
	place (education, training, estates and facilities, supported by a clear governance structure)
	• 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 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	• 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	• 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 • Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have ben put in place across all sites to meet 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.

environmental decontamination schedules for patient isolation rooms andcohort areas. • 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 effectiveagainst enveloped viruses. • manufacturers' guidance and recommended product 'contact time' isfollowed for all cleaning/disinfectant solutions/products.	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 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)		

• a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ 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	• Electronic equipment is cleaned with a detergent wipe followed by 70% isopropyl alcohol wipe **u**sed in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities. 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		

discharge or transfer (this includes removaland disposal/or laundering of all curtains and bed screens); • following an AGP **if 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	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 where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative		

of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for 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	• 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 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		

• 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. • 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.	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 screens within North West Ventilation Unit. Sodexo partners informed of requirement for inclusion into cleaning schedule as required.		

4. 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 with correct antibiotic.
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
• risk assessments and
	• 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 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.
		• 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 consumption.

mitigations are in place to avoid unintended consequences from other pathogens.	• 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. • 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 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	• 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 increase restrictions in some areas to levels in place following risk assessment, however visiting has not been stopped, named visitors are allowed in some agreed areas, with compassionate visiting in place across the Trust. Maternity,	• Lack of concordance amongst some patients/visitors	• Interim Visiting Policy available via Trust Intranet and information published on the Website

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. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-	neonatal and paediatric visiting continues with a series of restrictions in place. • 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 • 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		

behaviours-imp-toolkit.pdf (england.nhs.uk)	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 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	• 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 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	• 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 • Non-compliance is addressed locally in with local processes for escalation when there is an identified risk. • 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 • Individuals who are clinically extremely vulnerable from

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 linewith 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 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	• 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 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.		COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk. • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups

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 all health and carefacilities. • where infectious respiratory patients are cared for physical distancingremains at 2 metres distance.	• 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 risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately.		and prioritisation of side room

• 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.	• 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. • gloves are worn when exposure to blood and/or other	• 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 maintained by hospitals/MCS,	• Staff anxiety about risks of exposure to COVID -19 • Staff and patient fatigue • Not all patients are willing to comply • 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,	• 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 • Increased Microbiologist and AMD support • Expert Virology support • 7 day working from

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 greaterwherever 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 • to monitor compliance and	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 national surveillance intelligence is	it is not possible to monitor compliance	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 hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas.

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.	presented by Trust expert virology team (linking with the on-site PHE lab as above) • A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at: • High Level Infection Control Meeting • Clinical Sub-Group /Advisory Groups • Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner • Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC		• 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.

	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.	• 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	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) • Potential delay between testing and identification	• Risk assessments undertaken on a daily basis to support patient placement • Risk assessment undertaken based on symptoms when status is unknown

• patients who are known or 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 carefor 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	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 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	of HAIs	

deceased	safety. • 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).	• 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.	• Lab capacity was initially affected by availability of reagents – this has significantly improved – therefore the risk to the lab due to analysers is reduced (improved). • Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site

• screening for other potential infections takes place. • 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	• COVID-19 Testing, Streaming and Stepdown Guidelines are in place that 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.		

organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation 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	• 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	• 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

accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it	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. • 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	• 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.	• 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; rapid PCR tests have been made available through agreed Trust papers. • 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 • Escalation process in place • Absence monitoring and follow up and contact by line manager

may need to wear respiratory protection. • 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, absenceand vaccination against seasonal influenza and COVID-19 – encourage staff vaccine uptake. • staff who have had and recovered from or have	• All MFT staff complete a COVID-19 self-risk assessment, electronically 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.		

received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, 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. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; o that advice is available to all health and social care staff, includingspecific advice to those at risk from complications. o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. o A risk assessment is required for health and social care staff at high risk	• MFT are the GM lead for the nMAB (anti-viral programme), any member of staff who would be eligible would 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		

of complications, including pregnant staff. • vaccination and testing policies are in place as 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,	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: 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		

there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative 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.	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 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		

• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • 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:	May 2022
Subject:	Financial Performance for Month 12 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 Month 12 and pre final audit position against the 21/22 plan and final 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 reduces but the implications of reduced activity over the previous period manifest themselves across almost all areas of clinical activity. This is also in the context of a range of workforce implications and ongoing health and wellbeing concerns. At the financial year end, to March 2022, the Trust has delivered a surplus of £13.1m, which is an improvement of £1.5m from the £11.6m year to date surplus reported in month 11 and is in line with the H2 plan submitted to NHSE/I in late November 21
1.2	**Run Rate**	March 22 total expenditure at £253m has increased by £59m against that of February 22. However, most of this movement relates to a movement between income and pay for the Trust's pension contributions, in the sum of £53.6m, which is a normal part of the year end process.
1.3	**Cash & Liquidity**	As at 31st March 2022, the Trust had a cash balance of £319.1m. The cash balance was higher than forecast by £16m, this was primarily due to additional income received from NHSEI.
1.4	**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 and a forecast outturn of £192.3m. In the period up to 31st March 2022, £192.6m of capital expenditure has been incurred against the plan of £199.2m, an underspend of £6.6m, these results are in line with NHSI agreements. The underspend consists of £37.1m slippage relating to the NHP project and is due to 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 underspend on the NHP project has been partially offset by a number of overspends where additional funding has been made available during 2021/22 and as such neither the funding nor the associated spend are included in the 2021/22 capital plan, the most material being: £16.4m of equipment PDC funded schemes (including £8.8m for Digital Pathology and £3.9m for the Community Diagnostics Hub); £6.4m of Informatics PDC funded schemes and £2.9m GMCA decarbonisation scheme grant funding.

Financial Performance

Income & Expenditure Account for the period ending 31st March 2022

I&E Category	NHSI Plan M12 £'000	Year to date Actual - M12 £'000	Year to date Variance £'000
INCOME			
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	1,791,463	1,821,277	29,814
NHSE - Cost passthrough drugs/devices (increase above thresho	82,792	78,222	(4,571)
Trust (Rapid Diagnostic Centres)	1,130	2,216	1,086
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	172,438	172,438	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)	9,000	2	(8,997)
Additional Funding outside financial envelope	4,420	7,403	2,983
Local authorities	38,818	39,700	882
Sub -total Income from Patient Care Activities	**2,113,327**	**2,134,693**	**21,366**
Private Patients/RTA/Overseas(NCP)	10,294	9,638	(656)
Total Income from Patient Care Activities	**2,123,621**	**2,144,331**	**20,710**
Training & Education	74,854	78,983	4,129
Training & Ed Non HEE	3,662	4,384	722
Training & Ed Notional	2,664	3,041	377
Research & Development	69,536	75,219	5,683
Misc. Other Operating Income	96,508	160,230	63,722
Other Income	**247,225**	**321,857**	**74,632**
TOTAL INCOME	**2,370,845**	**2,466,188**	**95,342**
EXPENDITURE			
Pay	(1,399,782)	(1,461,952)	(62,170)
Non pay	(890,723)	(912,016)	(21,293)
Training & Ed Notional Spend	(2,664)	(3,041)	(377)
TOTAL EXPENDITURE	**(2,293,170)**	**(2,377,009)**	**(83,839)**
EBITDA Margin	**77,676**	**89,179**	**11,503**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(36,727)	(34,721)	2,006
Interest Receivable	0	154	154
Interest Payable	(40,949)	(40,718)	231
Loss on Investment	0	(628)	(628)
Dividend	0	(325)	(325)
Surplus/(Deficit)	**0**	**12,941**	**12,941**
Technical Adjustments	0	163	163
Surplus/(Deficit) Adjusted Performance - Outturn	**0**	**13,104**	**13,104**
Surplus/(Deficit) as % of turnover	**0.0%**	**0.5%**	
Transfers by Absorption		**61,680**	**61,680**
Impairment	**(127,134)**	**(134,243)**	**(7,109)**
Non operating Income	**900**	**6,677**	**5,777**
Depreciation - donated / granted assets	**(1,200)**	**(1,185)**	**15**
	(127,434)	**(53,967)**	**73,466**

For the financial year-end, to 31st March 2022, the Trust has reported a surplus of £13.1m against the breakeven plan for Greater Manchester ICS.

The favourable year end income variance of £95.3m has increased from the previous month's position of £15.3m and is favourable to plan in month by £80.0m and is greater than the previous month by £80.4m. The main reasons for these large movements were:

- Transfer of pension contribution costs from income to pay as part of the year end process for £53.6m
- Additional HEE and Research monies received in month 12 totalling £9.2m
- Additional monies from Commissioners at year end totalling £14.7m for various projects

The year-end variance for pay expenditure was adverse to plan by £62.2m. The main reason for this was the corresponding £53.6m pension contribution movement from income already described above. The other big movement was a £7.5m increase in the Trust's annual leave provision against untaken leave in the year that remains due to staff not taking as many holidays as anticipated as a result of increased levels of sickness.

Both movements described above are also relevant when comparing run rates to month 11. In addition to the variances to plan above the other main movement compared to the previous month has been an increase in accruals at the year-end across the hospitals to ensure that all costs for agency and bank staff are captured in the final figures (an increase of £2.2m) and for provisions against known expenditure that will need to be paid in 2022/23.

Non-pay expenditure in month 12 was adverse plan by £15.6m. The difference to plan is broadly reflected as an overspend against cost pass through drugs, circa £4.5m, which has a corresponding favourable variance to plan in income, the increases in Research & Development costs to match the income increase of £5.3m, year end stock movements after stock takes and, as with pay, ensuring relevant provisions are made for known expenditure to be incurred in 2022/23.

Comparing non-pay run rates to month 11, there has been an adverse movement of £15.3m. The majority of this was due to items described above, as variances to plan. Additionally, there were movements due to the purchase cycles of certain clinical supplies, as there is every month, with month 11 showing favourable variances against items that now reflect an adverse variance in month 12.

Depreciation at year-end shows a favourable variance of £2.0m reflecting that there was a large year-to-date underspend against the Capital programme at month 11. A large proportion of the annual spend against the Capital programme occurred subsequently in month 12 and depreciation related to this expenditure will start in the 1st quarter of 2022/23 instead of the planned 4th quarter of 2021/22.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £50m, this target is increased slightly for areas that have experienced additional pressures deemed to fall within their control. The tables below outline the 21/22 outturn against the planned savings. On a consolidated basis all areas together have achieved £34.2m against schemes that have progressed to L3 or higher on WAVE. This reflects an adverse variance of £2.5m compared to the plan against L3 or higher schemes, with 93% achievement against them. This achievement reflects the value required to deliver the Trust's overall financial plan for 21/22 after revision for H2.

MFT Summary

Workstream	Savings to Date				Forecast 21/22 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Plan (21/22) £'000	Act/F'cast (21/22) £'000	Variance (21/22) £'000	Financial BRAG
Hospital Initiative	6,624	6,693	69	101%	6,624	6,693	69	101%
Contracting & income	6,031	4,126	(1,904)	68%	6,031	4,126	(1,904)	68%
Procurement	4,712	4,010	(702)	85%	4,712	4,010	(702)	85%
Pharmacy and medicines management	1,740	1,657	(83)	95%	1,740	1,657	(83)	95%
Length of stay	202	182	(20)	90%	202	182	(20)	90%
Outpatients	79	79	0	100%	79	79	0	100%
Theatres	451	258	(192)	57%	451	258	(192)	57%
Workforce - medical	3,185	2,936	(248)	92%	3,185	2,936	(248)	92%
Workforce - nursing	3,826	3,701	(125)	97%	3,826	3,701	(125)	97%
Admin and clerical	810	817	6	101%	810	817	6	101%
Workforce - other	3,580	4,285	705	120%	3,580	4,285	705	120%
Blood Management	2,583	2,583	0	100%	2,583	2,583	0	100%
Budget Review	1,283	1,283	0	100%	1,283	1,283	0	100%
Integration	196	186	(10)	95%	196	186	(10)	95%
Non Pay Efficiencies	1,438	1,410	(27)	98%	1,438	1,410	(27)	98%
Total (L3 or above)	**36,738**	**34,206**	**(2,532)**	**93%**	**36,738**	**34,206**	**(2,532)**	**93%**

Summary against Target M1-12	YTD
Target	50,000
Actuals (L3 or above)	34,206
Variance to Target	- 15,794
Lost opportunity (value of schemes below L3)	792
Variance to target if all schemes delivered as plan	- 15,003

Summary against Target 21/22	Act/F'cast (21/22)
Target	50,000
Actuals/Forecast (L3 or above)	34,206
Variance to Target	- 15,794
Value of schemes below L3 (M13-12)	792
Variance to target	- 15,003

Financial BRAG

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

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

Hospital/MCS	21/22 Target	21/22 Actual/Forecast	21/22 Variance	% Variance
MRI	7,630	8,757	1,128	15%
RMCH	5,424	2,168	(3,255)	-60%
ST. Mary's	4,855	3,489	(1,366)	-28%
CSS	9,522	5,675	(3,847)	-40%
Corporate	2,857	2,933	76	3%
WTWA	10,223	5,565	(4,658)	-46%
Eye&Dental	1,707	1,119	(588)	-34%
LCO	3,947	218	(3,729)	-94%
NMGH	3,836	4,282	446	12%
Grand Total	**50,000**	**34,206**	**(15,794)**	**-32%**

Statement of Financial Position

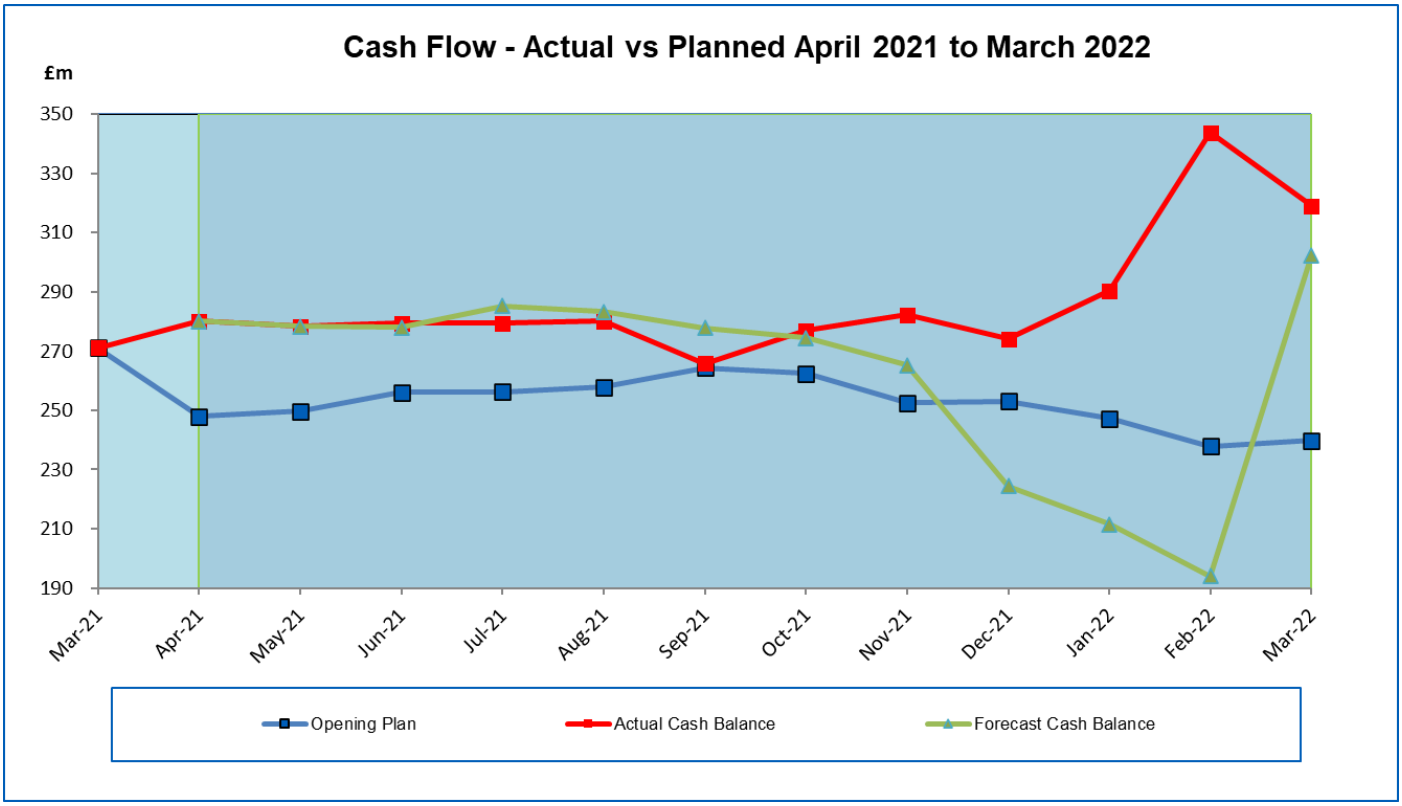
	Audited MFT Accounts 31/03/2021 £000	NMGH Opening SoFP 01/04/2021 £000	Enlarged MFT 01/04/2021 £000	Enlarged MFT 31-Mar-22 £000	Enlarged MFT Movement in Year to Date £000
Non-Current Assets					
Intangible Assets	4,665	-	4,665	30,501	25,836
Property, Plant and Equipment	642,394	81,715	724,109	784,206	60,097
Investments	1,498	-	1,498	870	(628)
Trade and Other Receivables	5,645	1,896	7,541	15,657	8,116
Total Non-Current Assets	**654,202**	**83,611**	**737,813**	**831,234**	**93,421**
Current Assets					
Inventories	21,892	936	22,828	21,809	(1,019)
NHS Trade and Other Receivables	61,707	-	61,707	22,429	(39,278)
Non-NHS Trade and Other Receivables	46,854	3,391	50,245	65,950	15,705
Non-Current Assets Held for Sale	210	-	210	2,510	2,300
Cash and Cash Equivalents	271,199	6,311	277,510	319,112	41,602
Total Current Assets	**401,862**	**10,638**	**412,500**	**431,810**	**19,310**
Current Liabilities					
Trade and Other Payables: Capital	(33,594)	0	(33,594)	(42,810)	(9,216)
Trade and Other Payables: Non-capital	(287,755)	(2,981)	(290,736)	(360,393)	(69,657)
Borrowings	(20,290)	(1,448)	(21,738)	(24,001)	(2,263)
Provisions	(24,875)	(5,852)	(30,727)	(32,246)	(1,519)
Other liabilities: Deferred Income	(35,084)	(320)	(35,404)	(59,360)	(23,956)
Total Current Liabilities	**(401,598)**	**(10,601)**	**(412,199)**	**(518,810)**	**(106,611)**
Net Current Assets	**264**	**37**	**301**	**(87,000)**	**(87,301)**
Total Assets Less Current Liabilities	**654,466**	**83,648**	**738,114**	**744,234**	**6,120**
Non-Current Liabilities					
Trade and Other Payables	(2,598)	-	(2,598)	-	2,598
Borrowings	(374,948)	(17,664)	(392,612)	(371,694)	20,918
Provisions	(16,622)	-	(16,622)	(13,903)	2,719
Other Liabilities: Deferred Income	(3,817)	(495)	(4,312)	(2,386)	1,926
Total Non-Current Liabilities	**(397,985)**	**(18,159)**	**(416,144)**	**(387,983)**	**28,161**
Total Assets Employed	**256,481**	**65,489**	**321,970**	**356,251**	**34,281**
Taxpayers' Equity					
Public Dividend Capital	258,929	65,489	324,418	408,780	84,362
Revaluation Reserve	63,492	5,352	68,844	97,412	28,568
Income and Expenditure Reserve	(65,940)	(5,352)	(71,292)	(149,941)	(78,649)
Total Taxpayers' Equity	**256,481**	**65,489**	**321,970**	**356,251**	**34,281**
Total Funds Employed	**256,481**	**65,489**	**321,970**	**356,251**	**34,281**

The capital programme expenditure and the results of the revaluation review are reflected in the increase in Property, Plant and Equipment. The movement in NHS Trade and other receivables relate to further reductions in NHS debt.

The increase in non-capital trade creditors is largely due to increased accruals as part of hospitals closing their year-end financial positions.

The deferred income movement includes £5m of LDA funding received in advance.

Cash Flow



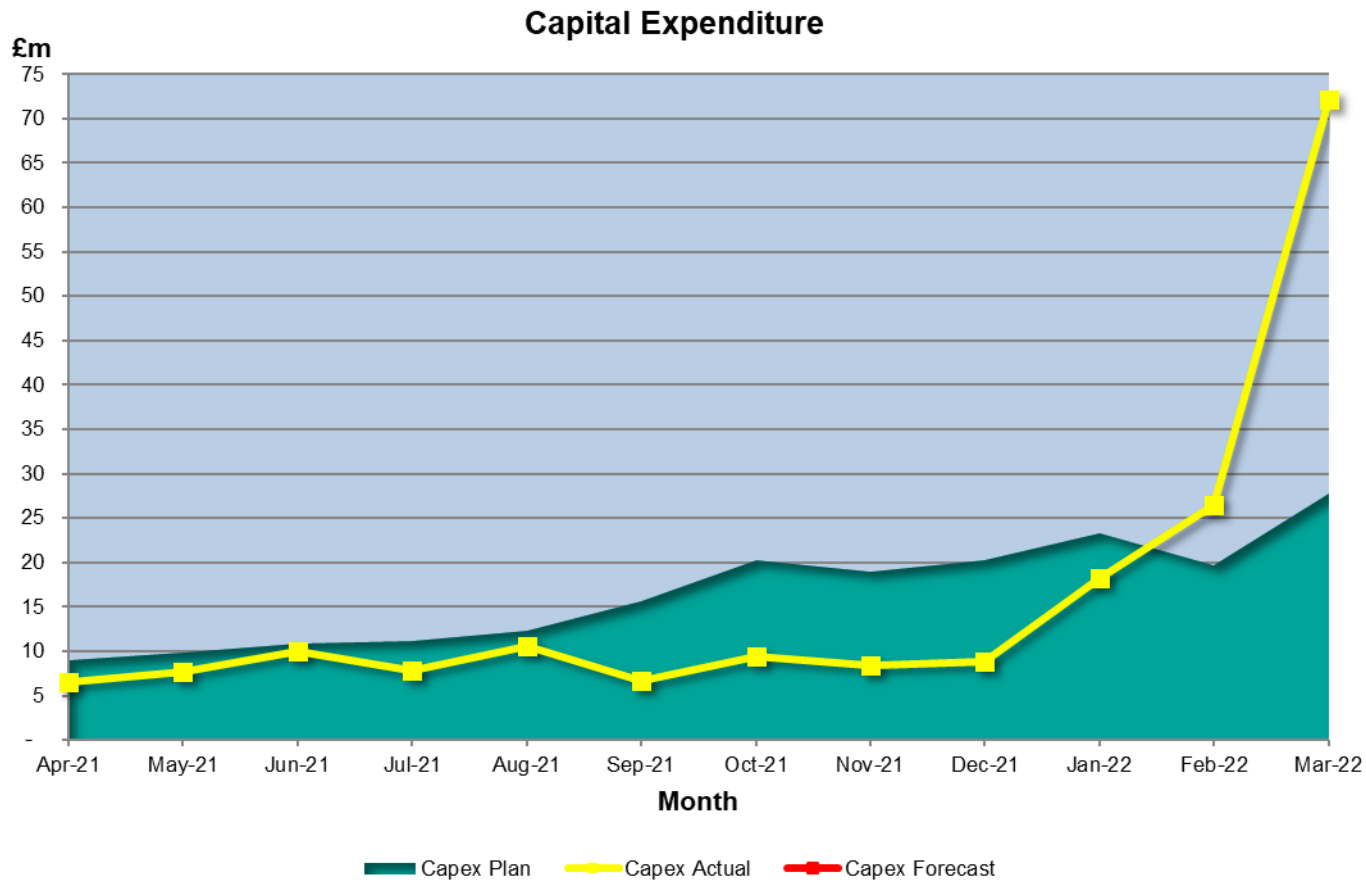
A reasonable measure of the level of liquidity required for the Trust could be that the amount of operational working capital consumed in 10 days which is £59.3m. Clearly the current and forecast cash balances have been well above this level throughout the financial year, although five-year plans indicate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

As previously noted, the cash balances include £6m for the NMGH transaction opening balances.

As at 31st March 2022, the Trust had a cash balance of £319.1m. The cash balance was higher than forecast by £16.6m, this was primarily due to additional funding being received from NHSE/I.

Capital expenditure is in line with forecast and any remaining cash impact will unwind during the first quarter of 2022/23.

Capital Expenditure



In the period to 31st March 2022, £192.6m of capital expenditure has been incurred against the plan of £199.2m, an underspend of £6.6m. £37.1m of the slippage relates to the NHP project and is due to delays in the approval of the Park House scheme and associated enabling works, alongside the slower than anticipated implementation of the programme of build for the new hospital. The underspend on the NHP project has been partially offset by a number of overspends where additional funding has been made available during 2021/22 and as such neither the funding nor the associated spend are included in the 2021/22 capital plan, the most material being: £16.4m of equipment PDC funded schemes (including £8.8m for Digital Pathology and £3.9m for the Community Diagnostics Hub); £6.4m of Informatics PDC funded schemes and £2.9m GMCA decarbonisation scheme grant funding.

The MFT capital plan for 2021/22 of £199.2m reflects the result of negotiations across Greater Manchester (GM) to bring the total planned expenditure into line with the GM system capital envelope. The GM envelope element of the MFT plan was set at £113.4m and an outturn of £94m was forecasted due to: the inclusion of £18.7m of PDC funding and £0.7m of savings requested by GM in order to facilitate the release of "Plan B" funding into the GM capital envelope. For the period up to 31st March 2022, £94m of GM envelope expenditure was incurred against the plan of £113.4m plan therefore delivering the required outturn.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Operating Officer/Hive SRO
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	May 2022
Subject:	Update on the 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 on 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 and also now includes the Manchester Local Care Organisation.

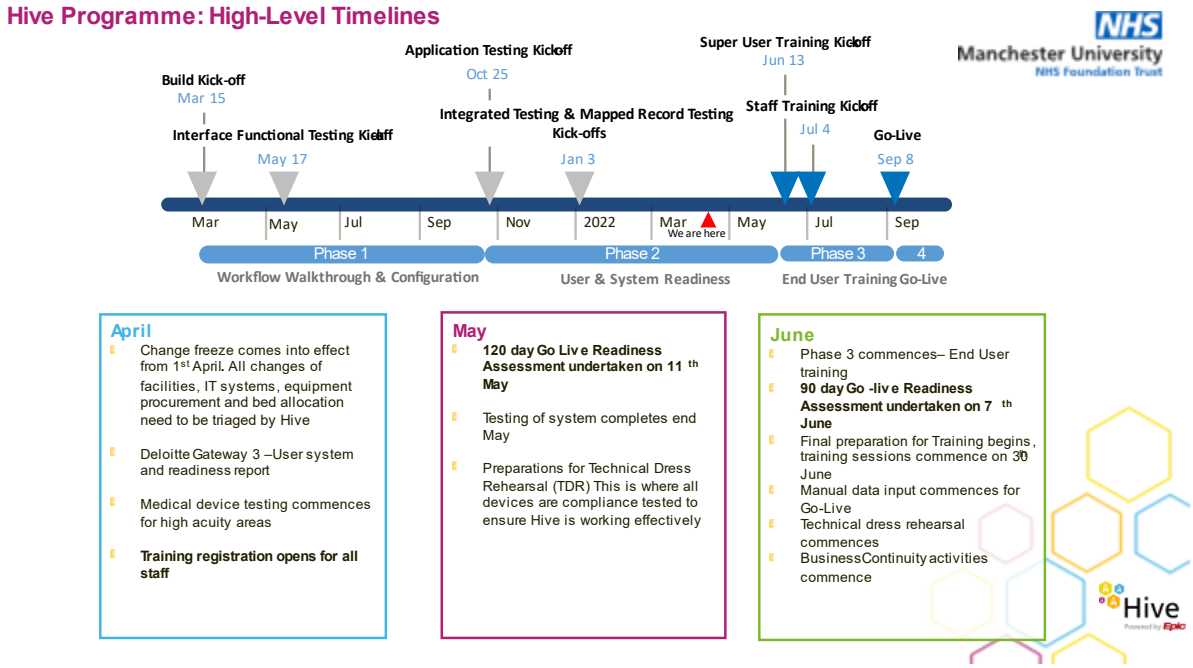
1.3 MFT's future EPR solution is called Hive reflecting the importance of clinical transformation and wide-spread change and improvement in every part and process of the organisation to benefit patients and staff. It complements the work underway to deliver the Trust Digital Strategy and supports the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

2.1 The high-level timelines as the programme moves towards system readiness is shown below which also shows key tasks for the coming quarter



2.2 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) and Local Care Organisation.

2.3 The Hive governance and programme management functions are well developed and embedded. These have been recently refined as the design, building, testing, data migration and training preparations enter their final stages.

2.4 The Hive governance assurance process includes formal risk summits which are attended by all key stakeholders. These are chaired by Julia Bridgewater and the panel includes senior leaders so that decision making is dynamic and so mitigation plans are supported and led at the highest level. This approach will then be followed with the Go Live Readiness Assessments which begin in April 2022.

2.5 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 May 2022 and will review testing, training, risk management and readiness for *Go Live.*

2.6 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.

2.7 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. Phase 3 will begin in June as face-to-face training commences for all staff

2.8 In preparation for the commencement of training for all staff a new Learning Management System (LMS) has been procured. This was launched on 12th April 2022 and allows staff to complete their bespoke eLearning modules and book onto their face-to-face training sessions which commence in June.

2.9 Each Hospital/MCS will complete a series of Go Live Readiness Assessments at 120, 90, 60 and 30 days prior to Go Live. These will be chaired by their respective Chief Executives and review key activities such as training, testing of equipment and patient appointment conversion to Hive.

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. There will be no reduction in clinical activity for the training of staff in the lead up to Go Live as this will take place in non-clinical time in their rotas

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.

4.3 Key communications activities that have been completed this quarter include:

- Organisation of Super User induction sessions and the development of a Super User boarding pass and guidance booklet
- Presentation to GP Citywide event with over 400 GPs in March which will be followed by monthly updates through CCG GP newsletters
- Launch of comprehensive training registration communications plan including lead-in comms, a pre-launch day message to all staff, a training focussed issue of The Buzz including a vlog from Julia Bridgewater, social media content and a message pack for operational and clinical leads.

5. Go-live readiness

5.1 Formal planning for the Go-Live event is now well established, with a Go-Live planning Committee in place. A detailed project plan including roles for deployment was completed in March with clear roles and responsibilities defined for the team for all tasks.

5.2 Go-Live Readiness Assessments (GLRAs) are planned for 120, 90, 60, and 30 days from Go-Live. These will take place in each Hospital where they will be chaired by their respective Chief Executives. These will then be followed by MFT wide GRLAs which will be chaired by Julia Bridgewater, Group Executive Responsible Officer for Hive.

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 and these provide a high-level look at aspects of the Hive system, the benefits the system will bring and how this will impact and change the way that staff work.

6.3 The Booking and Scheduling programme has focussed on standardisation and development of access to MFT services so that there is consistency on quality and efficiency across all services.

7. Technical Deployment

7.1 The Technical Programme has continued to build its team to enable projects to be delivered to achieve delivery on the critical path.

7.2 Preparations are taking place as part of the deployment phase for the Technical Dress Rehearsals (TDRs) which will commence in June. This will involve the end user testing of all medical equipment and devices such as bar code scanners to ensure they are ready for *Go Live*. This work will be overseen and monitored via the Go Live Readiness Assessments

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 has been reviewed. This planning and development process is following 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.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Claire Macconnell, Group Director of Human Resources
Date of paper:	May 2022
Subject:	To receive an update report on the MFT People Plan
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of sufficient operational and strategic effort on workforce matters the sustainability of MFT would be compromised.
Recommendations:	The Board of Directors is asked to receive and note the breadth of work underway to: • Support, engage, and develop our workforce. • Deliver the MFT People Plan.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce & Corporate Business Tel: 0161 276 5850

1. Purpose

1.1. This paper provides an overview of progress made in relation to delivery of the MFT People Plan. The paper provides assurance that work to deliver the People Plan and to support, engage and develop our workforce is being progressed as intended.

2. Introduction

2.1. The MFT People Plan (*All Here For You: Together we can*) was launched in May 2021 as a two-year delivery plan which captures the Trust's aspiration to be an employer of choice that recruits and develops staff fairly which in turn attracts talented people who choose to join, remain, and grow with the Trust.

2.2. The MFT People Plan has been developed in the context of the National People Plan, MFT's COVID-19 response and recovery, national strategies and wider MFT strategies such as the Clinical Services Strategy and Single Hospital Service goals.

2.3. The Plan takes into consideration other workforce strategies such as Leadership and Culture, Equality Diversity and Inclusion, and the Trust values and behaviours to share the expectation that all of these are integral to anything aimed to be achieved within the plan.

2.4. To help increase the relevance and acceptability of the plan across the entire workforce there has been a conscious move away from the use of corporate language. This stretches from the overarching themes of the plan through to the products for communication and the language used for updates or briefings. This is key to delivery of the People Plan which is illustrated in the copy at appendix A.

3. Themes of the MFT People Plan

3.1. As seen in the MFT People Plan icon, there are five themes within *All Here for You: Together we can*. These themes were discussed widely with staff, managers and senior leaders. They are based on the different elements of the employee lifecycle from seeing an advertisement for a job right through to being part of MFT and all that goes in between.

3.2. The five themes are:

- We want to work here; *MFT will be a great place to work.*
- We look after each other; *we care for you, as you care for others.*
- We are supported to be our best; *we care that you can develop your skills.*
- We feel valued and heard; *we show you how important you are and hear what you have to say.*
- We can shape the future; *our staff are at the forefront of shaping the future of care for our patient.*

4. Delivering The MFT People Plan

4.1. There are 128 deliverables that make up the MFT People Plan. These deliverables have been allocated appropriately to Deliverable Owners across the Workforce Directorate and across relevant Group Departments / Directorates to ensure full expertise and sufficient resources are allocated to maximise on what each deliverable is aiming to achieve.

4.2. **People Plan Delivery Group**

The People Plan Delivery Group (PPDG), which consists of Deliverable Owners, was founded to oversee the delivery and completion of the MFT People Plan. The PPDG (supported by a Programme Management Office) provides governance, targeted effort and specialist oversight to achieve delivery.

Each Deliverable Owner has the responsibility to manage how their respective team will effectively deliver the required work within the expected timeframe, with monthly robust reporting to the Group HR Director to share progress made, including points for consideration, areas for escalation and lessons identified. Further opportunities to share progress or issues are welcomed either through management meetings or ad-hoc drop in sessions.

4.3. **Ensuring Quality Delivery**

The PPDG provides control and coordination for the delivery of the MFT People Plan to ensure that the Trust takes all reasonable steps to ensure delivery. The group provides regular review of the delivery of MFT's People Plan and appropriate scrutiny of the timelines and deliverables by group members. The PPDG records, manages, and seeks mitigation of associated risks for the delivery of the People Plan.

Closure reports are produced to gain approval of any completed deliverables, documenting how the benefits will be measured, lessons identified, how staff have been engaged with and agreed next steps including any further work expected. This will support a Trust wide communications campaign to share the outcomes of delivering the People Plan.

The PPDG connectivity to communications contributes to the increased visibility of the MFT People Plan. The PPDG also helps in supporting decision making around branding, marketing, and communications through exploring a variety of approaches to reach across the MFT Group.

4.4. **Dedicated Programme Management Office**

The Workforce Programme Management Office supports Deliverable Owners through close monitoring of expected delivery, which is managed through robust tracking documentation. Regular reporting and engagement and a series of detailed Dashboards provide transparency on progress made.

4.5. **Assurance of Delivery**

Progress of the People Plan will be demonstrated to the HR Scrutiny Committee for assurance purposes. The Committee will seek assurance that appropriate mitigation is in place to manage risks and that appropriate links are made to the Board Assurance Framework.

To understand whether the actions taken to date are having a positive impact on our workforce work is underway to align key sources of intelligence to the People Plan pillars. A new People Plan Workforce Dashboard has been developed, with the key metrics as follows.

The key metrics include:

We want to work here - *MFT will be a great place to work*	Relative Likelihood of White Staff Being Appointed % BME Appointments against Total Appointments Time to Fill
We look after each other - *We care for you, as you care for others*	Absence Manager Call-backs/Return to Works Attendance Sickness (Rolling 12m) COVID Risk Assessments COVID Vaccinations Flu Vaccination
We are supported to be our best - *We care that you can develop your skills*	Appraisal – Medical and Non-Medical Level 1 CSTF Training Level 2 & 3 CSTF Training Postgraduate Medical Indicator Undergraduate Medical Indicator
We feel valued and heard - *We show how important you are to us and hear what you have to say*	Staff Motivation Score Staff Involvement Score Staff Advocacy Score
We can shape the future - *Our staff are at the forefront of shaping the future of care for patients*	Retention Data Vacancies

5. Local Delivery Plans

5.1. In response to the implementation of the MFT People Plan, local People Plans have been developed by Hospitals / Managed Clinical Services / LCOs / Corporate. These Local plans will use the groundwork laid out by the National People Plan and the MFT People Plan to help to build a comprehensive plan nuanced to local requirements. To support this, the PPDG provide local HR teams with regular updates on delivery of the overall MFT People Plan so that developments can be incorporated within local plans.

5.2 Hospital/Managed Clinical Services/ Local Care Organisation HR Directors will continue to be invited to PPDG meetings to share their experiences and progress, ensuring there is two-way engagement with both the PPDG and local People Plans, by exception based on agenda items.

6. MFT People Plan Progress

6.1 Significant progress on delivering the MFT People Plan has supported the completion of over 40 key deliverables, which represents 31.3% of plan. Figure 1 displays delivery progression against the five themes of the plan as of 21st March 2022.

Figure 1:Progression for delivering the MFT People Plan, 21st March 2022.

6.2. Examples of some of the newly completely deliverables are referenced below:

6.2.1. **Delivering the Removing the Barrier Programme** - A sustainable programme has been created that can continue to grow and support the outcomes of increasing ethnic diversity at Bands 8a and above. The *Removing the Barriers Programme* has introduced a designated intranet page, interactive guidance documents, welcome meetings for new members and regular catchups with existing members to update and gain feedback, and regular communications to all Black and Ethnic Minority staff currently working a Band 7 or above in relation to opportunities with the Trust. The programme communication plan includes case studies and regular MFT Time promotions, engagement of Equality, Diversity & Inclusion Networks, Staff Engagement Groups, Hospital / Managed Clinical Services/ Local Care Organisation Equality, Diversity & Inclusion Groups, HR Director and HR Business Partner meetings to continually promote the programme and ensure ongoing engagement.

6.2.2. **The Expansion of Networks and Forums -** Three Staff Networks and three Staff Engagement Groups are now in operation with the Disability Staff Network membership now over 160. Effective engagement with staff continues to be achieved with the aim to create positive staff experience. Amongst other benefits, this engagement has provided

MFT with the opportunity to make sure that staff feel valued and respected for their contribution and the opportunity to connect with each other to share their experience.

6.2.3. **Delivering stereotyping, prejudice and discrimination training** – The Trust, with support from the PPDG, took the opportunity to review the Mandatory Training currently available and overhauled the mandatory Equality, Diversity and Inclusion eLearning to align with the NHS competency framework and NHS Employers Guide for Equality, Diversity and Inclusion eLearning. The new mandatory Equality, Diversity and Inclusion eLearning was communicated through MFT Time articles and networks, including Equality, Diversity and Inclusion Coordinators' Network, Staff Engagement Groups, and Hospital / Managed Clinical Services/ Local Care Organisation specific groups.

6.2.4. **Developing an MFT-wide Workforce Equality Action Plan** - Action was taken to develop an MFT-wide Workforce Equality Action Plan that addresses the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and other workforce equality profile data. Work to complete this deliverable achieved statutory and contractual compliance and improved equal opportunities for staff in recruitment and progression and treatment. Completion of this MFT People Plan deliverable has benefitted the *Removing the Barriers Programme* and was engaged through MFT Time articles and numerous networks, including Equality, Diversity and Inclusion Coordinators' Network, Staff Engagement Groups, and Hospital / Managed Clinical Services / Local Care Organisation specific groups.

6.2.5. **Expanding MFT's NHS Ambassadors** – Marketing and growing the MFT NHS Ambassador Programme to further connect young people to NHS careers has recently increased the number of MFT Ambassadors. Materials were redeveloped and programmes were relaunched through HR Business Partners, Equality, Diversity and Inclusion networks, internal communications and social media which has had a direct positive effect. This has now been embedded as routine activity.

6.2.6. **Expand access to a range of psychological and mental health services for all staff including investment in the sustainability of Employee Assistance Programme Services** This programme has resulted in 217 Mental Health First Aiders across MFT with course and numbers growing each month. Employee Health & Wellbeing (EHW) also commissioned their own in-house instructor training course to train 12 locally agreed trainers to support wider expansion of the programme. The course is planned for March and nominated representatives from the Local Care Organisation, North Manchester General Hospital, St Mary's Hospital, Royal Manchester Children's Hospital, Clinical and Scientific Services, Manchester Royal Eye Hospital, Wythenshawe Hospital, Trafford General Hospital, Withington Community Hospital and Altrincham Hospital are currently signed up. Employee Assistant Programme (EAP) awareness sessions have been delivered across the last 6 months with over 450 members of staff attending the 30-minute sessions. Communications explaining the EAP offer to staff were ramped up ahead of the Christmas period, where an additional 6 EHW Awareness sessions were delivered. An EAP awareness E pack continues to be circulated monthly to colleagues. Targeted interventions have been held for Critical Care and Emergency Department teams facilitated in conjunction with the resilience hub. On-going partnership working has been established to support critical need.

7. Communicating The MFT People Plan

7.1. Communicating to staff and engaging with them about what the MFT People Plan means for them has been a core task throughout plan delivery. The objectives of the MFT People Plan communications is to deliver clear, targeted, effective communications and engagement activity to show what has already done to deliver the MFT People Plan and generate excitement about what is coming up. This will include using creative, innovative approaches to encourage people to share what working at MFT is like for them and what would make a positive difference to the way they work.

7.2. The key messaging is based on the following principles:

- Showing real examples of offers for staff already available and linking to the five themes which are all about supporting and developing staff.

- '*All here for you – Together we can'*: Evidence of progress to support MFT ambition to be an employer of choice that recruits and develops staff fairly, so talented people choose to join, remain, and grow within the Trust.

- Showing staff voices are being heard so that their diverse experiences inform and shape decision making.

- How a culture that embodies MFT values and behaviours is being developed.

7.3. Using MFT Time and Bitesize articles, MFT Intranet, Staff App, and more recently social media accounts, the Communications Team is using every opportunity to inform staff of what progression means for them and are continuously linked programmes, initiatives, and new opportunities back to the MFT People Plan.

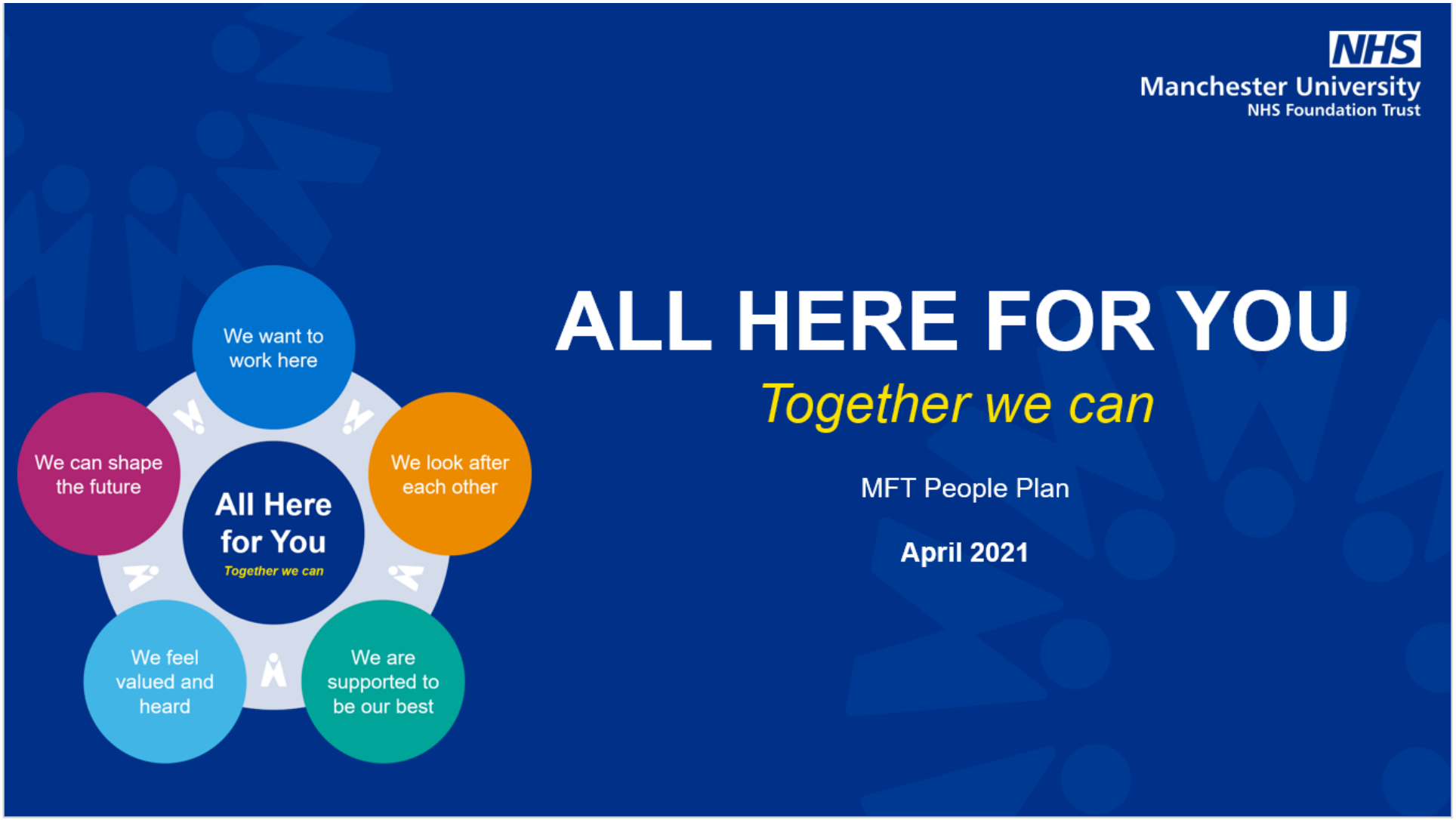
7.4. Over the coming months, the Communications Team with support from the PPDG, are planning to introduce a number of new communications resources to really embed and accelerate engagement. These include a printed magazine for distribution across hospitals/ MCSs/ LCOs, staff photography – with People Plan selfie frames, mobile video booth, e-book focusing on case studies and showcasing digital content and a further staff recognition film.

8. Recommendations

8.1. The Board of Directors are asked to receive and note the breadth of work underway to:

- Support, engage, and develop our workforce.
- Deliver the MFT People Plan.

Appendix 1 – MFT People Plan



Foreword

There is so much to be proud of at MFT but most of all our committed and dedicated workforce. Staff 'make the place' and everyone, whatever job they do, contributes in some way to the positive reputation of MFT. Thank you for the part you have, and continue to play, in making MFT a great Trust.

This last year has been more challenging than usual because of the Pandemic. Undeterred Team MFT 'stepped up to the plate' to care for patients and to look out for each other. All told a brilliant effort which I wish to acknowledge on behalf for the Board of Directors.

The Pandemic has certainly provided a new focus on the workforce which I am keen to promote further through a dedicated MFT People Plan. MFT wants to be an employer of choice that recruits and develops staff fairly, so that talented people choose to join, remain, and grow within the Trust. We want to hear the voices of staff so that their diverse experiences inform and shape decision making. Most of all we want to have a culture that embodies our values and behaviours.

To help achieve this I am sharing the new MFT People Plan. This is our roadmap to creating a working environment that we all truly value and are proud of.

The MFT People Plan - ***All Here for You: Together we can*** - describes the actions we will take together over the next 12 – 18 months, highlighting what we can expect to see, hear and feel as MFT employees. The plan initially offers an insight into the organisation and how we have developed the actions set out in the plan but if you wish to jump ahead to view the detail, you will find this starting on page 10.

I recognise the plan is ambitious and, as with any undertaking of this size and scale, there will be a few 'bumps in the road' and challenges to overcome. We will not get it right every time but with a collective commitment to make improvements I firmly believe we can achieve so much and make a real difference to what it feels like to work at MFT.

Thank you again for all you do to care for patients, support colleagues and make MFT a successful Trust.

Peter Blythin
Group Executive Director of Workforce & Corporate Business

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ALL HERE FOR YOU

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Workforce at the forefront

We understand that the workforce determines our culture and with the experience of the Pandemic still being acutely felt there is no greater time to reflect on what we need to do together to deliver a People Plan which is relevant and achievable. Above all a plan which we can work on jointly to make a difference to the working lives of all our staff.

Focusing on the lived experience of staff and their rich and diverse backgrounds we want to understand what it means to work at MFT and hear first-hand what would make a positive difference to the working lives of all staff. This will include a refreshed approach to how we ensure staff wellbeing, workforce supply, deployment, training and education.

Bottom-line, we want to make MFT an even greater place to work than it already is. Employee voice and involvement is critical to making this a reality.

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Together we can

Change will not occur in isolation through the efforts of a few. To make MFT a special place to work we need to apply a collective effort to drive change and embed the right cultures - ***Together we can***.

Building on the established work of staff and the challenges posed by the Pandemic there is a demonstrable willingness to work collaboratively, across professional boundaries and services to ensure the best possible care for patients. Staff have reached out to colleagues in times of need, considered the health and wellbeing of each other and thought about the communities and families affected by COVID-19. In doing all of this you have shown remarkable compassion and empathy as well as an aptitude for flexible and agile ways of working to maintain services. The MFT People Plan reflects on and captures this learning and offers a plan which takes account of the National People Plan, the Trust's overarching Strategic Direction as well as key policy frameworks which MFT must account for.

Our MFT People Plan

The MFT People Plan is a roadmap for all staff, regardless of role, service or future ambition, and supports a collective vision that together we can make MFT a great place to work. We are building on our recognised brand of *All Here for You* to really demonstrate that we truly are here for one another and describe how the organisation will transform its approach to workforce and truly hear the voices of our staff, taking positive action to bring about change.

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Staff Engagement

To ensure that "***All Here for You: Together we can"*** is a plan that staff can relate to and identify with, a period of staff engagement has taken place, spanning over twelve months in total.

Prior to COVID-19, the foundations for a MFT People Plan were laid and staff were asked to identify what mattered to them in the workplace. A survey was undertaken as well as World Café events, focus groups and engagement sessions in the atriums of the Hospitals. This rich data played a pivotal role in informing thinking and direction of the workforce agenda.

Given the impact of COVID-19, efforts were paused but in September 2020, staff were re-engaged in the planning and development of the Plan. Over 100 staff contributed to Microsoft Teams engagement events and were asked what mattered to them under the five themes of MFT People Plan. The voices of our BAME Staff Network, LGBT+ colleagues, disabled staff, colleagues from across the Hospitals, Managed Clinical Services, Local Care Organisations, Corporate Services and North Manchester General Hospital were captured via these engagement events and actively contributed to the approaches taken, the deliverables and the ambitions of this Plan.

To demonstrate to staff how valuable their views, experiences and opinions are, and have been, in shaping this Plan, they are included throughout as quotes of ***employee voice***.

Thank you to all the hundreds of staff that have supported the development of this plan over the last twelve months. Your contributions are valued and appreciated.

"Collectively, we can assure staff that their voice is the golden thread throughout this plan making it something we can all own and feel empowered to deliver. Look out for your quotes, statements, voices and images throughout."

Claire Macconnell, Group HR Director

ALL HERE FOR YOU

Together we can

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#TeamMFT

Manchester University NHS Foundation Trust (MFT) has become the largest NHS Foundation Trust in England, employing over 28,000 staff and an annual turnover of £2billion.

We are the main provider of NHS care to approximately 750,000 people in Manchester and Trafford who are among the most diverse communities in the country. Over one in three of Manchester residents are from Black, Asian and Minority Ethnic backgrounds, over 190 languages are spoken in the city, one in five residents have a disability or long-term condition and we serve one of the largest LGBT+ communities in the country. Aside from the population diversity, Manchester and Trafford are also economically diverse with varying social deprivation profiles.

Most recently, MFT has led the completion of the Single Hospital Service for Manchester and Trafford. This brings North Manchester General Hospital into the MFT Group to continue to build on the great work that they have been doing for the North of the City.

MFT is the single largest provider of specialised services in the Northwest of England and the lead provider for a significant number of complex specialised services within Greater Manchester. Collectively our group of ten hospitals and community services is a leading internationally competitive health and research organisation.

Aside from our direct provision of healthcare, we are proud to be woven into the fabric of the region, providing job opportunities and skill development alongside supporting communities through our responses, volunteers and partnerships with Local Care Organisations.

As we have come together, our focus has remained on keeping services running safely and smoothly across our hospitals for our patients and the communities we serve. One of the benefits of this is the close-knit collaboration we're seeing between some of healthcare's brightest talents. Many teams have been sharing their strengths and looking at how we can transform services for the benefit of patients and staff, with several improvements and leading initiatives already in place.

We are proud to be working towards the harmonisation of health services, with the goal of creating one health service for Manchester, Trafford and beyond, and we are excited about the opportunities this gives to our people.

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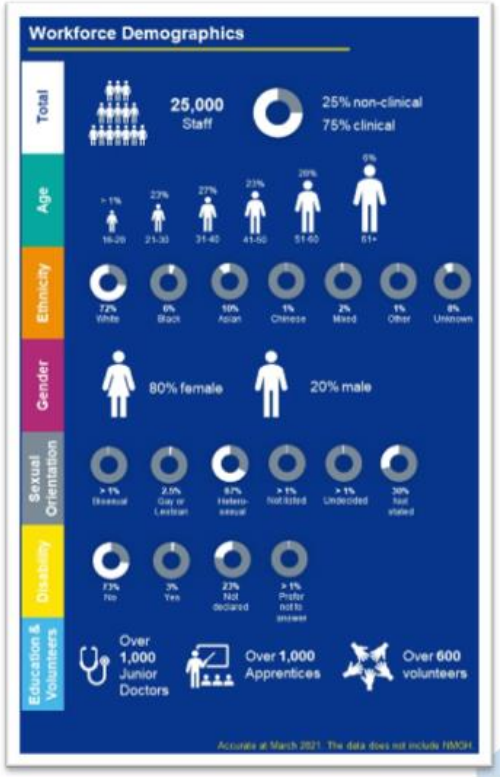
Our People

We have a workforce of c28,000 with the recent addition of North Manchester General Hospital. Each play a critical role in making MFT a great place to receive care and work. Our people are the driving influence behind the delivery of ambitions and vital to our continued success as an organisation.

The size and diversity of our workforce and organisation makes MFT a unique and exciting place to work. As a leading provider of cutting-edge healthcare and research, MFT can grow and develop you whatever your ambition.

As North Manchester General Hospital integrates into our services and structures, our workforce demographics will be updated to reflect the diversity and experiences staff bring to MFT.



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Setting the Scene

"All Here for You: Together we can" is MFT's People Plan. It sets out the actions we will take across the Trust, to deliver and support workforce transformation, change and sustainable growth over the next two years as the basis for further strategic development into 2023 -2025.

The focus will be upon how we can work together to create and foster a culture of inclusion and belonging, provide equal opportunities for career development and progression that are fair, open and transparent, protect the health and wellbeing of staff and shape the future of MFT together.

We want to build the foundations for how the organisation will collectively shape the workforce offer to ensure that MFT is a great place to work and learn thereby helping to inspire talent from across the region and beyond to make MFT their employer of choice.

We have included the annual National Staff Survey results, outcomes from the cultural diagnostic initiative and pulse surveys both pre and post COVID-19 to take a holistic approach and accommodate as much feedback as possible.

The NHS People Plan, *We are the NHS: People Plan for 2020/21 – action for us all* has provided an important framework for us to build a proactive and responsive plan that takes into account that national direction of workforce matters. The principles of the national plan have guided thinking and planning to ensure that MFT can work with other NHS bodies enabling more people, working differently to join our compassionate and inclusive cultures.

Within MFT, there are also several strategies that provide important context for the MFT People Plan. This includes Leadership and Culture, Communications, Informatics, Equality, Diversity and Inclusion, Clinical Service Strategies and the implementation of our Electronic Patient Record digital solution, HIVE Electronic Patient Record (EPR). These strategies and teams have supported the actions that will need to be taken and demonstrated the importance of collaboration and inter-team working.

The MFT People Plan complements and builds on these strategies and in turn, these key themes are strengthened via our People Plan deliverables.

Themes of the Plan

As seen in the MFT People Plan icon, there are five themes within ***All Here for You: Together we can***. These themes have been discussed widely with staff, managers and senior leaders. They are based on the different parts of an employee's time with us from seeing an advertisement for a job right through to being part of MFT and all that goes in between.

Our five themes are:

- **We want to work here**; MFT will be a great place to work
- **We look after each other**; we care for you, as you care for others
- **We are supported to be our best**; we care that you can develop your skills
- **We feel valued and heard**; we show you how important you are and hear what you have to say
- **We can shape the future**; our staff are at the forefront of shaping the future of care for our patients

This document sets out what we can all expect from the plan, our leaders and each other under these five themes and most importantly, what we can expect to *experi*ence as members of staff. The following pages describe how the actions taken will impact our experience at work and how accountability for progress will be measured and monitored.

A detailed delivery plan underpins this plan.

ALL HERE FOR YOU

Together we can

NHS Manchester University NHS Foundation Trust

We want to work here | We look after each other | We are supported to be our best | We feel valued and heard | We can shape the future

We want to work here

MFT will be a great place to work

We want MFT to be the employer of choice for local, regional, national and global talent.

"MFT is the biggest NHS Trust – it's diverse and there are opportunities to progress for life."

Employee Voice

We want it to be a great place to work and to do this we will focus on three key areas;

- Attraction
- Accessibility
- Recruitment

Attraction	Accessibility	Recruitment
Be known locally and globally as a great place to work. Offer flexibility and opportunity. Promote our success and achievements.	Ensure our opportunities reach the communities we serve. Work with our communities to develop the skills they need, and we need. Offer experiences to explore what it is like to work with us. Adapt our ways of working to ensure we see people's full potential.	Ensure our recruitment processes are fair. Recruit people for their values as well as their skills. Provide a great candidate experience. Ensure our service will be safe, up to date, and easy to navigate.

"The organisation is somewhere that demonstrates it values its people by being welcoming and having opportunities to progress."

Employee Voice

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We want to work here

MFT will be a great place to work

Most importantly, we will measure the success of these high-level ambitions through your experience of the workplace.

If these ambitions are achieved, it will mean you will:

- Work in a team where you feel able to work at your best.
- Work with diverse and great people.
- Experience an equal likelihood of being recruited across protected characteristics*.
- Be able to inspire our future workforce.
- Contribute to the growth of our community and city.
- Be assured our recruitment processes are safe.
- Be able to build a lifetime career at MFT.
- Feel proud to work for MFT.

* Image taken pre-COVID-19 Pandemic

"Being part of an exciting organisation."

Employee Voice

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ALL HERE FOR YOU

Together we can

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We want to work here | We look after each other | We are supported to be our best | We feel valued and heard | We can shape the future

We look after each other

We care for you, as you care for others

The health and wellbeing of each other has never been more important than during these challenging times. The impact of the Pandemic has meant many of us have struggled with our mental and physical health, and the disproportionate impact on protected characteristics has increased the impact further for many.

It is important that we focus on keeping each other safe and well through our approach to work and the support services provided.

We also need to focus on the experience we have in the workplace. It should be free from bullying, harassment and discrimination. We should all role model the behaviours we expect and want to see, valuing and respecting the great diversity of our workforce.

We will look after each other in three key areas;

- People Safety
- Health and Wellbeing
- Fair Treatment.

People Safety	Health and Wellbeing	Fair Treatment
Ensure safety in the workplace is a priority. Embrace agile and flexible ways of working, improving staff and team experiences. Follow national working safely guidance to create effective working environments both on-site and remotely. Work in high performing teams that are collaborative. Provide reasonable adjustments to enable all staff to be safe and supported in the workplace.	Ensure all staff take quality rest periods to recharge and look after themselves. Provide access to a range of health & wellbeing support, easily accessible tailored to your individual needs. Create 'common interest' networks. Maintain fitness to work which positively impacts on your health and mental health. Recognise that we have different personal responsibilities out of work. Create opportunities to help you to increase your physical activity levels.	Ensure you are treated and treat others with respect. Make sure people's voices are heard and appropriate action taken. Support leaders and managers to role model positive behaviours. Ensure we communicate the processes to challenge behaviour that you do not think is fair. Ensure zero tolerance to workplace bullying and harassment is a priority.

"Treating each other with dignity and respect in the workplace."

Employee Voice

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ALL HERE FOR YOU

Together we can

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We want to work here | **We look after each other** | We are supported to be our best | We feel valued and heard | We can shape the future

We look after each other

We care for you, as you care for others

If we are achieving these high-level ambitions, it means you will:

- Have confidence that this is a safe place to work, where your personal needs are important.
- Have reasonable adjustments made where you need them.
- Have access to the right health and wellbeing support when you need it.
- Be treated fairly by colleagues, managers, patients and carers.
- Feel safe at work free of bullying and harassment.
- Feel that your life outside of work is respected and supported.

"Support me at work so I can have a happy life at home."

Employee Voice

* Image taken pre-COVID-19 Pandemic

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We are supported to be our best

We care that you can develop your skills

From speaking to colleagues, we heard two messages clearly; we need good line managers that have the necessary tools, skills and knowledge to be effective and we need to offer equal opportunities at all levels for all ambitions.

By supporting each other to be our best we are recognising talent, building opportunities for growth and development, personally and professionally, and looking to develop innovative ways of enhancing learning and development.

We want to have great line managers who can get support for their queries quickly and easily and have accessible tools and resources. We know there are a lot of expectations on managers and collectively, we need to be supportive.

We will do this by focusing on three key areas;

- Learning and Education
- Talent
- People Management

Learning & Education	Talent	People Management
Develop your competence and confidence as leaders and managers.	Provide access to a coaching and mentoring service.	Provide the basic HR systems and processes that make it easy for you to do your day job.
Give you access to professional education and CPD development.	Help you have quality conversations with your line manager about potential career pathways.	Ensure day to day people management queries can be answered 24/7 via self-service.
Make apprenticeship opportunities available to you at all levels.	Develop innovative graduate programmes to support our next generation leaders.	Ensure you are able to access specialist people management support.
Ensure its easy for you to access learning in different ways.	Develop inclusive, fair and equal access to new role opportunities.	Create a single place to go to for all things related to HR and people management.
Develop a learning culture where you can grow and learn 'on the job'.	Give equal access to opportunities.	
	Increase diversity at Board and senior management levels.	

"Realistic portfolios of work and support to achieve potential in your role."

Employee Voice

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ALL HERE FOR YOU

Together we can

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We want to work here | We look after each other | **We are supported to be our best** | We feel valued and heard | We can shape the future

We are supported to be our best

We care that you can develop your skills

We will know we are achieving these ambitions, as you will:

- Have access to relevant quality learning opportunities at all levels.
- Have equal opportunities to reach your full potential in new and different roles.
- Have accessible and easy systems to help you navigate your time at work.
- Be empowered to have quality conversations with your line manager.
- Know how to live our values in your daily job

"Celebrating achievements within our team, no matter how small."

Employee Voice

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ALL HERE FOR YOU

Together we can

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We want to work here | We look after each other | We are supported to be our best | **We feel valued and heard** | We can shape the future

We feel valued and heard

We show how important you are to us and hear what you have to say

We want to hear the voices of our staff. The diversity of lived experiences amongst colleagues provides a valuable insight into how to enrich and improve the working environment for all. We want to be more creative in how we hear that voice mobilising Staff Networks and ensuring staff engagement informs approaches and decision making.

"Being the first to be asked instead of the last."

Employee Voice

We also want to think about the rewards, benefits and recognition you receive. We know how valuable our staff awards are and how much we enjoy celebrating the great achievements of our peers.

To value and hear our staff we will focus on three key areas;

- Engagement
- Rewards and Recognition
- Staff Networks

Engagement	Reward & Recognition	Staff Networks
Use data to improve your experiences. Hear your feedback. Ensure our approaches will be based on evidence and best practice. Work together to shape MFT's culture. Make it easy for you to give us feedback via surveys. Regularly review our plans for leadership and culture.	Involve you in how we recognise you for the work that you do. Launch an improved offer to staff. Take opportunities to celebrate our staff. Offer an engaging rewards and recognition scheme.	Support staff networks to grow and develop. Ensure staff networks will contribute to decision making.

"Seeing real changes from staff ideas."

Employee Voice

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Together we can

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We want to work here | We look after each other | We are supported to be our best | **We feel valued and heard** | We can shape the future

We feel valued and heard

We show how important you are to us and hear what you have to say

Most importantly, we want you to be our measures of success. If we are achieving these high-level ambitions, you will:

- Feel empowered to have a voice and know what routes you can use to be heard.
- Know how your feedback has been used to make changes or improvements.
- Feel valued and appreciated for the work that you do.
- Have access to a range of rewards and benefits.
- Feel able to discuss how to improve work-life balance.
- Have access to staff networks.
- Feel able to use your voice to contribute to decision making

"Opportunities to shape the values of our Trust."

Employee Voice

"Having a thank you goes a long way whether they are from friends, patients or colleagues. A thank you can make a tough day worthwhile."

Employee Voice

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ALL HERE FOR YOU

Together we can

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We want to work here | We look after each other | We are supported to be our best | We feel valued and heard | **We can shape the future**

We can shape the future

Our staff are at the forefront of shaping the future of care for patients

We have achieved so many advancements during the Pandemic. We have demonstrated our abilities to adapt quickly and effectively to new technologies and we have shown how flexible we are as a workforce learning new skills, being redeployed and supporting new and different teams. We have all been encouraged to think differently and keep responding to unprecedented levels of change. This requires gratitude but also acknowledgement of the exciting future that lays ahead.

"Vision for workforce is created with involvement."

Employee Voice

To ensure that we are shaping the future of MFT together, at all levels, we will focus on three key areas;

- Technology
- People Retention
- Future Readiness

Technology	People Retention	Future Readiness
Make technology and training available to increase your digital skills and confidence. Maintain a focus on technology system developments and implementation. Build technology into daily operational delivery to improve patient and staff experience.	Create a climate where staff feel they belong and are committed to MFT. Support our leavers. Ensure decisions about change and transformation are made for the long term rather than reactionary. Staff at all stages of their career are equally valued.	Use our size and scale to create opportunities of new, innovative career choices across our family of hospitals, managed clinical services and community services. Plan the future workforce that is right for patient care. Help you to develop the skills you'll need for the future. Ensure our workforce is resilient and agile for change when needed. Offer you opportunities to be part of cutting-edge research.

"An organisation that works collaboratively with patients and stakeholders to achieve the best services we can."

Employee Voice

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We want to work here | We look after each other | We are supported to be our best | We feel valued and heard | **We can shape the future**

We can shape the future

Our staff are at the forefront of shaping the future of care for patients

If we are achieving our high-level ambitions for the future, you will:

- Have opportunities across MFT to progress and work towards your personal career goals.
- Work in an environment which has the right shape, size and structures to meet patient needs.
- Be at the forefront of excellence in care.
- Work in a Trust and Teams that reflect the diversity of the people we serve.

"Involved in the future vision."

Employee Voice

"A multi-skilled diverse workforce where everyone has a voice, and everyone is valued."

Employee Voice

* Images taken pre-COVID-19 Pandemic

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Summary

Thank you to all those that contributed to the development of ***All Here for You: Together we can***. Your voices, experiences and willingness to be open and honest has enabled the development of a plan that is inclusive, relevant and gives clear actions for us all. We need to work collectively and collaboratively to bring about the change we want to see to make MFT truly, a great place to work.

Sat beneath this plan will be a deliverable plan to hold teams accountable for delivery. This plan will also provide a framework for local People Plans that will show you how your Hospital or Managed Clinical Service will implement these ambitions in your areas.

For a summary of this plan, you can watch our video here.

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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:	May 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

Health & Social Care Bill

The Health and Social Care Bill is expected to be passed in the coming weeks enabling Integrated Care Boards (ICB) to be formally established.

It will also mean that NHSI will be abolished and most of its powers pass to NHSE. The incoming chair of NHSE is Richard Meddings, a former banker. Sir Andrew Morris, former Frimley Health Foundation Trust chief, and Wol Kolade, who are both NHSI non-executive directors, will transfer to NHS E and will be appointed as joint deputy chairs.

Other non-executive directors (NEDs) of NHSE will include:

- Sir Munir Pirmohamed, a top pharmacologist and geneticist, who is on the NHSI board, but previously sat on the NHSE board;
- Jeremy Townsend, chair of NHSE's audit and risk assurance committee.
- Michael Coupe, former Sainsbury CEO
- Susan Kilsby, a senior businesswoman in retail and banking
- Laura Wade-Gery, a former retail chief who is NHS Digital chair

Lord Ara Darzi will stand down as an NHSE NED after the Health and Care Bill is passed, and NHSI NEDs Lord Patrick Carter and Rakesh Kapoor will also stand down.

3. Regional Issues

Greater Manchester Integrated Care System (ICS)

The development of the Greater Manchester ICS and the appointments to the Integrated Care Board is continuing. The following appointments have been confirmed:
Chair – Richard Leese
Non-executive directors - Richard Paver and Shazad Sarwar
Chief Executive – Mark Fisher
Appointments to the other Board-level posts (Medical Director, Director of Finance and Director of Nursing) are progressing.

A GM Integrated Care Operating Model is being developed that sets out the GM vision and objectives, architecture, characteristics and enablers that will underpin how GM will operate post-transition.

At place level, the GM model describes the core features of a locality as being:

- An Integrating Care Neighbourhood Model and Local Provider Collaborative
- A Locality Board
- A Place-Based Lead (PBL) for Integrated Care
- A Population Health System
- Clinical and Care professional leadership.

There is flexibility in how the core model is implemented and the ten localities in GM are developing their proposals for how they will work in the future. We are involved in the work to look at how these arrangements should be implemented in Manchester and Trafford.

4. MFT issues

MFT Single Services

The development of the operating models for those services that are provided across MRI, WTWA and NMGH is progressing. Work on the operating models for cardiac services, vascular services, orthopaedics and GI services has commenced. This work is dovetailing with the HIVE programme so that the planned arrangements can, as far as possible, be reflected in how services are set up in the EPR system.

Annual Plan

The 2022/23 annual planning round is now complete. The overarching MFT Annual Plan 2022/23 is being presented today to the Board for approval. Delivery of the objectives set out in the plan will be assessed through the year-end review. Hospitals/MCSs/LCOs plans are also now complete and delivery will be monitored through the Accountability Oversight Framework.

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:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	May 2022
Subject:	MFT Annual 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:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to approve the MFT Annual Plan 2022/23 recognising that there remain ongoing GM discussions to finalise the organisation level finance control totals.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The purpose of this paper is to seek approval from the Board of Directors for the MFT 2022/23 Annual Plan.

2. Background and Context

The Annual Plan sets out what we intend to do in the coming year in order to respond to the immediate challenges facing us and to make progress towards achieving our longer-term vision and strategic aims.

Our vison and strategic aims, our values and our group and clinical service strategies form the framework within which the Annual Plan is developed. The plan is also shaped by national plans and strategies, in particular the priorities set for the year by NHS England / Improvement.

Our plans for 2022/23 are dominated by the need to recover from the COVID-19 pandemic and the implementation of our Electronic Patient Record (EPR).

In the coming year we will need to focus on the challenge of restoring services, meeting new demands and reducing the backlogs that have built up a result of the pandemic. Equally important will be maintaining our focus on workforce and prioritising staff health and wellbeing.

At the same time we are facing one of the biggest transformation programmes that we have ever undertaken; the implementation of an electronic patient record (EPR). This is not just about the introduction of a new information system, it is a major transformation programme affecting every part of the organisation which is known as Hive.

The implementation of Hive is key to delivering our vision as well as responding to current challenges and recovering from the impact of COVID-19. Ultimately it will transform how everyone works and enable us to realise the benefits of improved clinical quality, patient experience and staff experience, increased operational efficiency and will help drive research and innovation.

The MFT Annual Plan (attachment A) brings together, at a summary level, the key actions that the Hospital, MCS, LCO and corporate teams intend to take in 2022/23, formatted to show the contribution made by each Hospital, MCS, LCO and corporate team to each of the Trust's strategic aims.

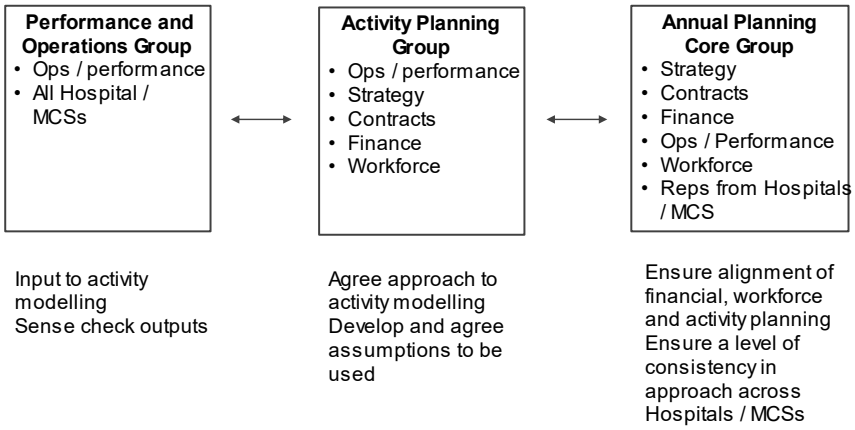
3. MFT Annual Planning Process 2022/23

A single annual planning process was established to:

- Develop the MFT level Annual Plan for 22/23 that brings together the Hospital / MCS plans with the plans of the corporate teams under each of the Trust strategic aims.
- Develop Hospitals / MCS /LCO annual plans, including activity plans, for 22/23 that set out what each Hospital /MCS plans to deliver and how they plan to do it, within their allocated resources.
- Complete the MFT element of the GM / national Operational Plan submission which includes financial, activity and workforce information

The three groups below were set up to facilitate the process have been established to and to:

- Reduce the burden on operational teams who were dealing with the pandemic at the time the plans were being developed, as well as enabling them to contribute where necessary
- Ensure that we make as realistic assumptions as possible
- Ensure alignment of activity, financial and workforce planning



4. Financial Planning

The Trust is working within a new financial regime as the NHS exits the last two years of Covid finance regime, and is not returning to the pre-Covid Payment by Results regime. In parallel, the development of the ICS structure nationally is part of the new finance regime, whilst within GM the ICS is not yet operational and appointments to key posts have been behind other areas. Thus the discussions on the financial plan for 22/23 have been extended and are ongoing at the time of writing. This has a material impact on the Trust's financial plan due to the value of money which is now distributed at an ICS level, and therefore needs agreement across the ICS as to the method of distribution to individual organisations.

The indication for the Trust is that income is the same in 22/23 as it was in 21/22. Given increased costs due to inflation, costs of Hive and the national expectation of increased activity this results in a significant challenge to achieve the financial performance the Trust has delivered in recent years. The requirement for delivery of Waste Reduction across all areas of the Trust, at a level approximately double that delivered in 21/22, after financial flexibilities have been exhausted represents a significant risk to delivery of the financial plan. At the time of writing the level of WRP identified is about half the required value and so the financial risk is very high as we move into the second month of the financial year. There is already tension between delivery of operational targets and financial stability, which will require innovative approaches to operational performance and a change from the last two years' approach. The finance regime in 22/23 requires a return to more standard NHS finance practice of cost control, which is naturally more of a challenge to operational delivery.

Internally, the Trust has undertaken a robust budget setting exercise, although this has been later than a "normal" year due to the external factors. The risk of variation from the GM discussions is in the main being held at Group level. Control totals will have been issued to

Hospitals/MCS/LCO and Corporate areas by the time of the Board meeting, which will include confirmed Waste Reduction targets.

It is anticipated that nationally a further financial plan submission will be required in the coming weeks given the level of deficit across the GM system. Internally, every area of the Trust is working on delivering its Waste Reduction target, which is the key risk within the plan as it currently stands.

5. Monitoring Delivery

Risks to delivering the plan are monitored and managed through the established Trust risk management processes.

Delivery of the plans will be monitored throughout the year through the Accountability Oversight Framework (AOF), Board Assurance Report, Hospital / MCS / LCO Review process and the year-end review of the Annual Plan which will be undertaken in December.

6. Recommendations

The Board of Directors is asked to approve the MFT Annual Plan 2022/23 recognising that there remain ongoing GM discussions to finalise the organisation level finance control totals.

Manchester University NHS Foundation Trust

2022/23 Annual Plan

CONTENTS

Glossary of Abbreviations

A&G	Advice and Guidance
AOF	Accountability Oversight Framework
AHP	Allied Health Professions
ASC	Adult Social Care
ATMP	Advanced Therapy Medicinal Products
BMTU	Bone Marrow Transplant Unit
BOBL	Better Outcomes, Better Lives programme
CAMHS	Children and young people's mental health services
CDMU	Covid Medicines Delivery Unit
CQC	Care Quality Commission
CSS	Clinical Scientific Services
CUETIP	Covid-19 Understanding and Elimination-Trials Implementation Panel
ED	Emergency Department
EPR	Electronic Patient Record
GIRFT	Getting It Right First Time
GMCA	Greater Manchester Combined Authority
GMHSC	Greater Manchester Health and Social Care Partnership
HSCT	Haematopoietic Stem Cell Transplantation
HSE	Health and Safety Executive
HVLC	High Volume Low Complexity
ICB	Integrated Care Boards
ICS	Integrated Care System
iMRI	Intraoperative magnetic resonance imaging
IOSH	Institution of Occupational Safety and Health
IPC	Infection Prevention and Control
JIC	Joint investment committee
LCO	Local Care Organisations
LD	Learning Difficulties
MCS	Managed Clinical Service

ME	Medical Examiner
MFT	Manchester University NHS Foundation Trust
MIC	Medtech and In vitro diagnostics Co-operative
MLCO	Manchester Local Care Organisation
MREH	Manchester Royal Eye Hospital
MRI	Manchester Royal Infirmary
MSSSC	Manchester Surgical Skills and Simulation Centre
NHP	New Hospitals Programme
NICE	National Institute for Health and Care Excellence
NIHCR	National Institute for Health and Care Research
NMAHP	Nursing, Midwifery and Allied Health Professionals
NMGH	North Manchester General Hospital
OD	Organisational Development
PALS	Patient Advice and Liaison Service
PAs	Programmed Activities
PCN	Primary Care Network
PIFU	Patient-initiated follow-up
PSIRF	Patient Safety Incident Response Framework
R&I	Research & Innovation
RAG	Red, Amber, Green
RMCH	Royal Manchester Children's Hospital
RTT	Referral to treatment
SARC	Sexual Assault Referral Centre
SBA	Strengths-based approach
SDEC	Same Day Emergency Care
SJR	Structured Judgement Review
SLA	Service Level Agreements
SLT	Senior Leadership Team
SME	Small & Medium Sized Enterprise
SMH	Saint Mary's Hospital
SOP	Standard Operating Procedure
SV	Social Value

TERI	Theatre efficiency rapid improvement
TGH	Trafford General Hospital
TOM	Target Operating Model
UDH	University Dental Hospital of Manchester
UEC	Urgent and emergency care
UTC	Urgent Treatment Centre
WMTM	What Matters To Me
WNB	Was Not Bought
WRES	Workforce Race Equality Standard
WTWA	Wythenshawe, Trafford, Withington & Altrincham

1. Introduction

The purpose of the annual planning process is to develop a set of coordinated plans for the year that describe how, over the coming 12 months, we are going to respond to the immediate challenges facing us and make progress towards achieving our longer-term vision.

Our vision describes our aspirations for the next 5 years and is the framework for the development of our annual plans; it is the golden thread that ensures that the whole of the organisation is working towards the same long term goals. Given the recent external events (such as the COVID pandemic and the move to Integrated Care Systems) and internal changes, in particular the achievement of the Single Hospital Service for Manchester, we have reviewed our vision to ensure that it is still fit for purpose.

The new vision is set out below. The key changes have been to strengthen the strategic aims around patient safety and workforce – the pandemic has emphasised the importance of both, and to add a new aim around working in partnership and addressing health inequalities wider social issues.

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

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

This is underpinned by our strategic aims, which are:

- *To 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*

Our plans for this year will be dominated by the need to recover from the COVID-19 pandemic and the implementation of our Electronic Patient Record (EPR).

The pandemic has had a profound impact on all that we do. For 2022/23 we will need to focus on the challenge of restoring services, meeting new demands and reducing the backlogs that have built up a result of the pandemic. Equally important will be maintaining our focus on workforce and prioritising staff health and wellbeing.

In line with the NHS E guidance we will need to:

- grow the workforce and work differently and keep our focus on the health, wellbeing and safety of our staff.
- use what we have learnt through the pandemic to adopt new models of care.
- work with our partners from across Greater Manchester to make the most effective use of the resources.
- develop plans for any new monies to increase our capacity and invest in our buildings and equipment.

At the same time we are facing one of the biggest transformation programmes that we have ever undertaken – the implementation of our electronic patient record system (EPR). This is not just about the introduction of a new information system, it involves wide-spread change and improvement in every part of the organisation. This major transformation programme is known as Hive. The EPR will go live in September 2022 but this is just the beginning. The Hive programme will continue as we tweak and refine the system, roll out new features, and continue to improve how we work.

The implementation of Hive is key to delivering our long-term vision and responding to current challenges. It will transform how everyone works and enable us to realise the benefits of improved clinical quality, patient experience and staff experience, increased operational efficiency and help drive research and innovation. More specifically it will:

- Enable us to change and improve how we deliver services and support better clinical decision making.
- Enable staff to work more efficiently by accessing the information they need to care for patients wherever and whenever they need it
- Improve the patient experience by giving patients more control over their own care through a patient portal and phone app, reducing the need for people to give the same information to different members of staff.
- Increase patient safety by holding one record for each patient and providing alerts for potential medication errors, allergies and infection risks.
- Ensure that the correct information is available for every patient first time, every time.

This plan describes the actions that we intend to take in 2022/23 to respond to the immediate challenges facing us and make progress towards achieving our longer-term vision and strategic aims.

2. Manchester University NHS Foundation Trust - who we are

Manchester University NHS Foundation Trust (MFT) is one of the largest NHS Trusts in England providing community, general hospital and specialist services to the populations of Greater Manchester and beyond. We have a workforce of over 28,000 staff. We are the main provider of local hospital care to approximately 750,000 people in Manchester and Trafford and provide more specialised services to patients from across the North West of England and beyond. We are a university teaching hospital with a strong focus on research and innovation.

Our services are delivered through the following management units:

- ***Royal Manchester Children's Hospital (RMCH)*** - RMCH is a specialist childrens hospital and provides general, specialised and highly specialist services for children and young people across the whole of MFT.

- ***Saint Mary's Hospital (SMH)*** - Saint Mary's Hospital is a specialist women's hospital as well as being a comprehensive Genomics Centre and provides general and specialist medical services for women, babies and children across MFT.

- ***Manchester Royal Eye Hospital (MREH)*** – MREH is a specialist eye hospital and provides inpatient and outpatient ophthalmic services across MFT.

- ***University Dental Hospital of Manchester (UDH)*** – UDH is a specialist dental hospital and provides dental services across MFT

- ***Manchester Royal Infirmary (MRI)*** – MRI is an acute teaching hospital and provides general and specialist services including kidney and pancreas transplants, haematology, cardiac services and sickle cell disease.

- ***Wythenshawe, Trafford, Withington and Altrincham (WTWA)*** – WTWA is an acute teaching hospital and provides specialist services including cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, cancer and breast care services and general services across Wythenshawe, Trafford, Withington and Altrincham hospitals

- ***North Manchester General Hospital (NMGH)*** - NMGH provides a full range of general hospital services to its local population and is the base for the region's specialist infection disease unit.

- ***Clinical and Scientific Support Services (CSS) –*** CSS provides laboratory medicine, imaging, allied health professional services, critical care, anaesthesia & perioperative medicine and pharmacy across MFT.

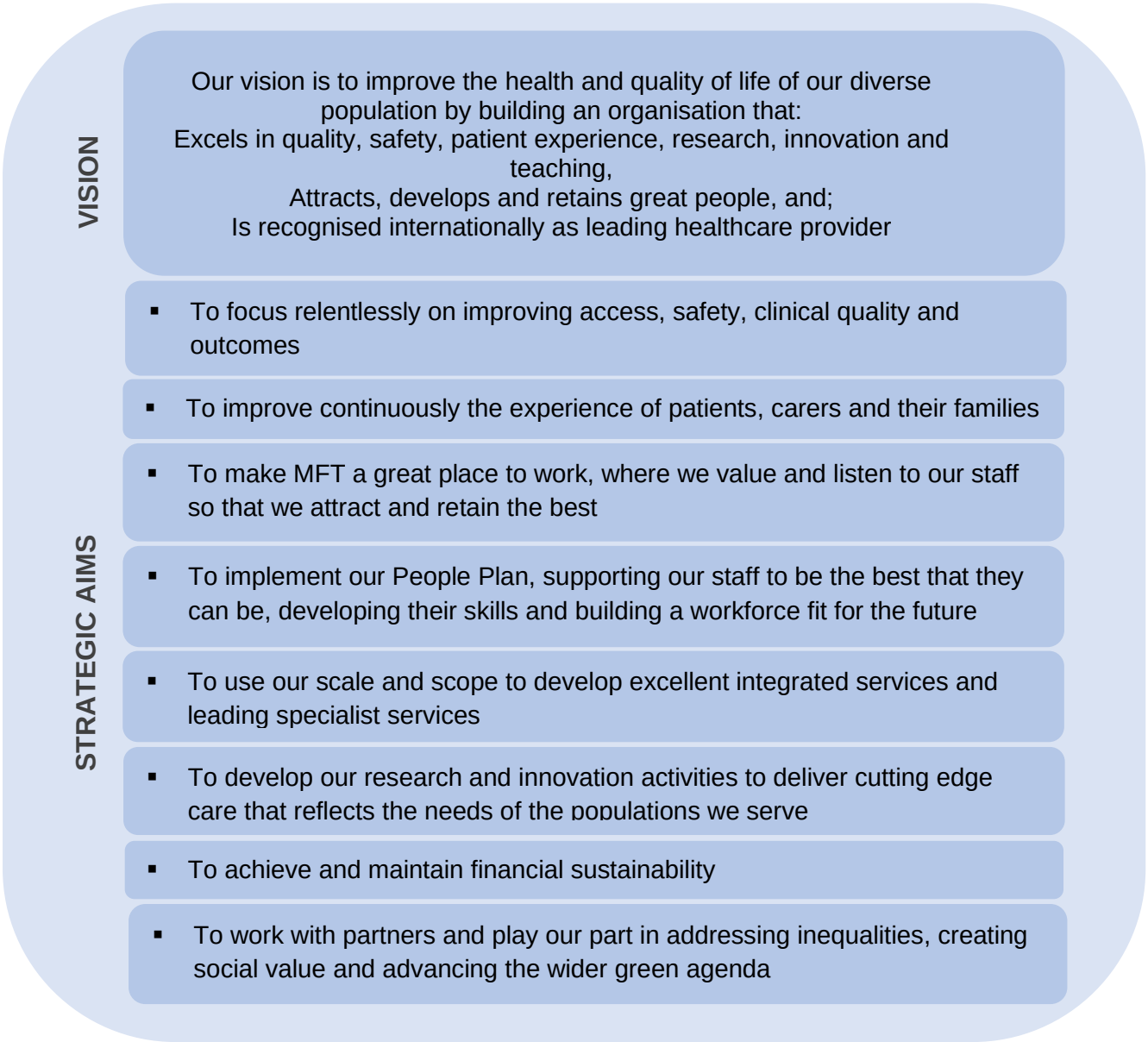
- ***Local care Organisation (LCO) –*** the LCO provides community and out-of-hospital care across Trafford and Manchester

3. MFT Planning Framework

Our Annual Plan sets out what we intend to do in the coming 12 months. It is developed in the light of our existing longer-term plans and strategies; key amongst these are our vison and strategic aims, our values and our group and clinical service strategies. It is also shaped by national plans and strategies, in particular the priorities set for the year by NHS England / Improvement.

Our Vision

Our vision sets out what sort of organisation we want to become over the next 5 to 10 years. It is underpinned by seven strategic aims that describe in more detail what we want to achieve over that timeframe.



Our Values

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

Our Vision

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

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

Our Values

Together Care Matters

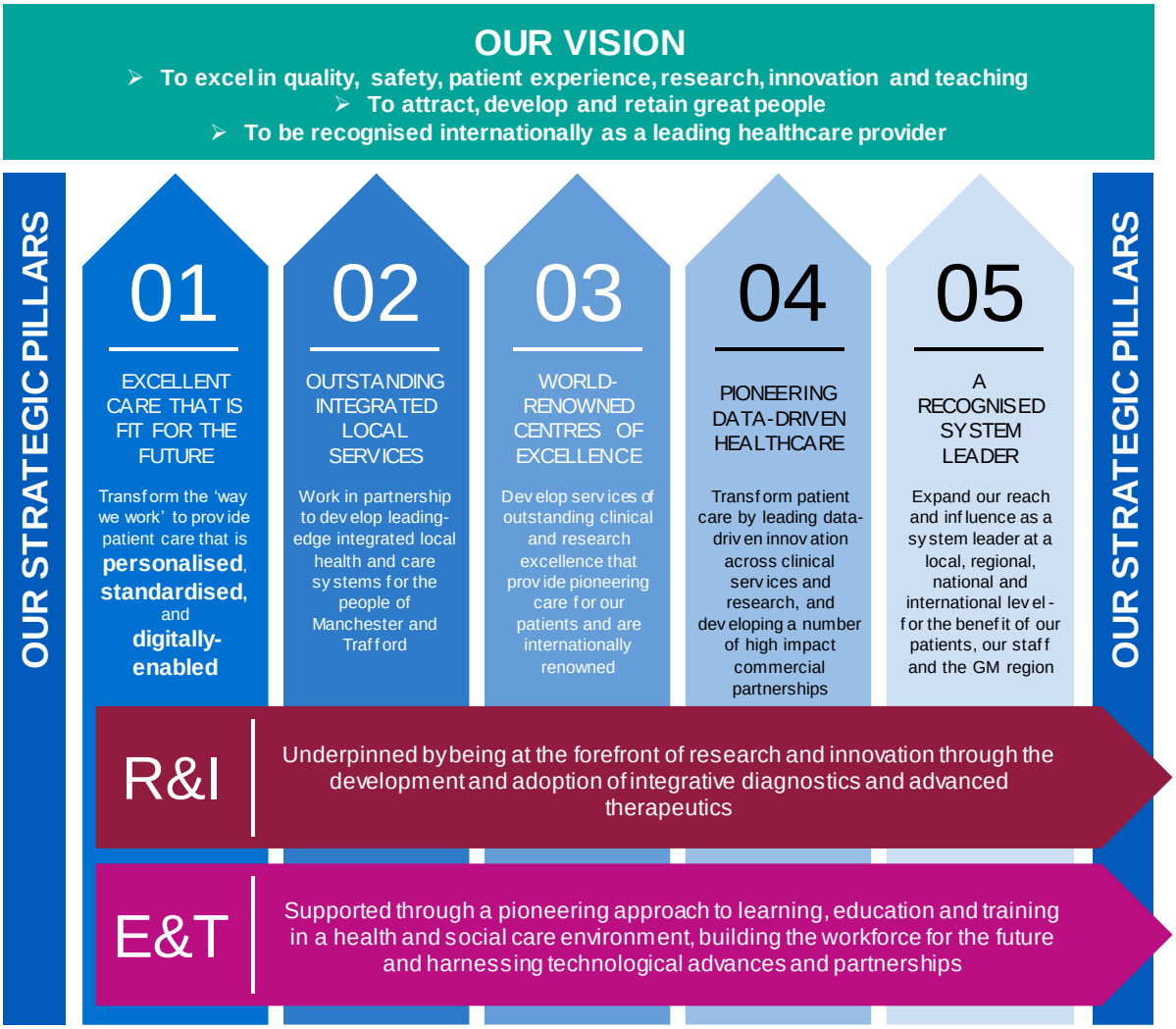
Everyone Matters
Working Together
Dignity and Care
Open and Honest

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

Our Group and Clinical Service Strategies

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

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



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

This Annual Plan describes the actions that we need to take in 2022/23 in order to deliver the group and individual clinical service strategies.

NHS England & NHS Improvement - Priorities for 2022/23

The national planning guidance issued by NHS England & NHS Improvement sets out ten priorities for 2022/23 as shown in the table below.

A	**Invest in our workforce** – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
B	**Respond to COVID-19 ever more effectively** – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
C	**Deliver significantly more elective care** to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
D	**Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity** – keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
E	**Improve timely access to primary care** – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
F	**Improve mental health services and services for people with a learning disability and/or autistic people** – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
G	**Continue to develop our approach to population health management, prevent ill health and address health inequalities** – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
H	**Exploit the potential of digital technologies** to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
I	**Make the most effective use of our resources** – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
J	**Establish ICBs and collaborative system working** – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

4. Priorities and Plans for 2022/23

Taking into account all of the internal and external context and drivers, the Hospitals, Managed Clinical Services (MCSs), LCOs and corporate teams have developed their own priorities and plans that will enable them to deliver on those priorities for the coming year. The following tables set out what we plan to do to take forward each of our strategic aims.

To focus relentlessly on improving access, safety, clinical quality and outcomes

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Corporate Nursing	Deliver an effective infection prevention and Control (IPC) Strategy to support recovery from COVID-19 and continued focus on prevention and control of other healthcare acquired infections	The MFT IPC Strategy will be launched, capturing best practice to deliver, monitor and drive improvements
		Build on positive experiences of delivering infection prevention and control principles during a pandemic to improve IPC practice and engage staff in the delivery of IPC programmes
		Staff flu and COVID-19 vaccination programme achieved
Group Medical Director /Chief Nurse	Develop and implement a Trust-wide quality and safety strategy	Human factors, system thinking and quality improvement methodologies fully integrated
		NHS Model for improvement implemented and recognised as a Trust-wide methodology and supporting small scale rapid tests of change and scale-up and improvement spread
Joint Group Medical Director Office	Implement the National Patient Safety Strategy in full to optimise patient safety learning through the delivery of the Trust's Patient Safety Profile and Plan aligned to the Trust-Wide Quality and Safety Strategy	Patient Safety Incident Response Framework across the Trust implemented with each site/MCS/LCO having a published Patient Safety Incident Response Plan
		Specific focused action plans in place to address opportunities for change and improvement in relating to equality and patient safety
		Patient safety management system implemented within each site/MCS/LCO
		National patient safety training requirements implemented, and additional training requirements identified through a learning needs analysis addressed
		Effective governance and assurance processes in place aligned to the Patient Safety Incident Response Framework (PSIRF), assured through review and internal audit
		The National framework for patient and public involvement in patient safety implemented
		Safety oversight system optimised with an electronic solution
		Human Factors Academy effectively resourced
		Human Factors Academy formally launched through effective comms strategy
		Human Factors Academy formally launched through effective comms strategy

	To understand and reduce unwanted variation in outcome across the organisation for similar services	Full understanding of the impact of inequality on outcomes through measurement and monitoring
		Focused action plans and interventions designed to eliminate inequality in patient experience, safety and outcomes
		Recommendations arising from national confidential enquiries, where relevant to the Trust implemented in full
		All relevant national clinical audits participated with good data acquisition and quality
		All published national audit reports have a management summary and action plan/risk assessment, where relevant
		Annual programme of local clinical audit approved and implemented
		National Institute for Health and Care Excellence (NICE) guidance implemented where relevant and embedded into every day clinical practice with an exception/ risk report for all partially and non-compliant guidance.
		Recommendations from the Getting it Right First Time Programme (GIRFT), where possible, and relevant implemented
		Priority clinical standards for seven-day hospital services implemented and assured
		Improving clinical outcomes strategy developed to support a progressive reduction in preventable deaths and to support the achievement of the highest level of care reliability aligned to the implementation of HIVE, based on a rigorous analysis of outcome data relevant to the Trust's services
	Develop new clinical services that are required for our patients as a result of the Covid-19 pandemic	Strengthen the newly launched MFT Covid Medicines Delivery Unit (CDMU) to establish it as Managed Clinical Service.
		Transition the CMDU to a recurrent service in one of the Group Hospital/MCS
	Launch of Hive EPR Results acknowledgment	Use the learning from the MFT Results acknowledgment to inform the solution for Hive
	To continue achieving high standards of health and safety through the provision of healthy working environments, safe working practices and safe people working therein.	Strategic governance approach to leading and managing our response to the COVID pandemic in operation and assured
		Health and Safety Strategy for 22/23 in place and monitored
		Safety II approach effectively applied to health and safety
		Effective integration of ergonomics into service redesign, human factors academy and incident investigation
	To continue achieving high standards of health and safety through the provision of healthy working environments,	Effective stakeholder relationship management with all stakeholder groups, including e.g. HSE, CQC, NHS Employers, IOSH, CIPD etc., informing policy / practice in year

	safe working practices and safe people working therein.	
	Ensure and assure compliance with CQC fundamental standards of Quality and Safety	Assurance map and framework developed for all regulatory standards and escalation process for gaps in assurance used effectively
		Appropriate governance arrangements in place across the Trust to support assurance and escalation
	Implement a strategic approach to becoming outstanding (CQC) across all domains	Individualised 'becoming (or being) outstanding plans' in place across all site/MCS/LCOs
		Appropriate governance arrangements in place across the Trust to support identification of outstanding practice and relevant assurance
Informatics	Support implementation of the Epic Electronic Patient Record, transforming services to provide better quality care to patients	Prepare legacy systems for smooth migration of data to new systems
		Upgrading/replacing end user computing devices across the estate to ensure compatibility with Hive requirements
	Continued development of North Manchester Digital Hospital	Define Target Operating Model across clinical and non-clinical services
		Produce single redevelopment/digital full business case
	Support implementation of the Epic Electronic Patient Record, transforming services to provide better quality care to patients	Commence and complete testing
		Commence and complete staff training for HIVE
		System optimisation commenced
	Improve the definition, understanding and prioritisation of Informatics workload and new demand, to ensure that resources are aligned accordingly	Establish and implement an Informatics demand management function
R&I	Engage in HIVE implementation, equality initiatives and highest ethical standards	HIVE implementation for R&I/clinical trials activity and data use by Clinical Data Science Unit
		Create new Quality and Safety Matron post
		Review and develop Sponsorship team
Estates & Facilities	Development of Bone Marrow Transplant Unit (BMTU)	BMTU Phase 2 completed – delivery of additional patient bedrooms & isolation suites.
Transformation Team	Transform urgent and emergency care	Participated fully in GM led same day emergency care (SDEC) Review to maximise Same Day Emergency Care services across MFT Urgent Care
		Streaming pathways (criteria) to SDEC services standardised across MFT Urgent Care Portals
		Calendar based system implemented in SDECs including GP referrals, GMCAS/111/999 to support flow, aligned to UEC 10 Point plan and Hive implementation of SDEC.

		Hospital sites supported to achieve SDEC provision 12hrs, 7 days as a minimum as per UEC 10 Point Plan
		Acute Frailty Services available to MFT Type 1 Emergency Departments reviewed
		UTC by Appointment, Streaming at Point of Entry and Navigate to Deflect in all Type 1 EDs embedded across MFT
		Robust pathways developed for safe deflection of patients to community services as soon as possible after arrival in Emergency Portals
		Improvements made to ward level processes for discharging patients
	Transform elective care	Four Eyes Dashboard developed to support elective scheduling and improvement works implemented in areas of greatest opportunity across MFT
		Completion of the Booking and Scheduling TERI project at Trafford
		Booking and Scheduling best practice from TERI project scaled up MFT-wide
		Hive-ready pre-operative assessment process implemented at Trafford General Hospital (TGH) supporting theatre utilisation by ensuring there are always patients ready to undergo surgery
		Full pre-op transformation implemented at TGH which includes full patient support comms package and individual peri-operative pathway redesign (pre-anaemia, smoking cessation and diabetes)
		MFT Theatre Dashboard developed and implemented to be ready by Hive Go Live, including associated reporting
		Work on the improvement of data quality continued
		Theatre training programme rolled out to improve ORMIS data reporting and prevent data quality errors at source
		Cancellation reasons agreed for elective pathway
		Centralised Independent Sector booking team implemented with clear processes and agreed key performance indicators
		Trafford developed as an orthopaedic Green Site Hub for orthopaedics across GM
		23 hour stay model developed at TGH to support greater number of General Surgery patients through this site
		72 hour stay model developed at TGH to support greater number of General Surgery patients through this site
	Transform booking and scheduling	MFT level individual process standard operating procedures (SOPs) rolled out for all Booking and Scheduling processes (outpatients and Inpatient electives) these will focus on Access Policy, Data Quality requirements and best practice and will be rolled out to electives, AHP and diagnostics
		Standardisation of outpatient partial booking progressed and Pre-OP Assessment Process and Theatre scheduling supported to enable a smoother transition to HIVE
		Develop a Readiness Assessment Tool to support the AWSOME Framework for staff competency in booking and scheduling skills

		Standard admin job descriptions developed across the 10 legacy hospital prior to HIVE go live
		Delivery of While you Wait and My Planned Care initiatives supported
		Development and delivery of a single MFT Access service across the Trust supported
	Develop Virtual Wards	Development of comprehensive plans to deliver virtual ward capacity equivalent to: 40-50 virtual ward 'beds' per 100k population by December 2023 (560 for MFT) supported
		Current capacity identified and a trajectory developed to meet the NHS annual planning targets for 22/23
		Hospitals within MFT supported to develop business cases for GM funding to further expand virtual wards across MFT
		Current Health Wearable technology piloted across all sites
		Pathways suitable for virtual wards identified and standardized across MFT aligning with GM
	Transform outpatients	Uptake of Patient-initiated follow-up (PIFU) expanded to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
		Referral optimisation achieved, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including advice and guidance (A&G), per 100 outpatient first attendances by March 2023
		Outpatient follow-ups reduced by a minimum of 25% against 2019/20 activity levels by March 2023

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Successfully deliver, embed and optimise Hive across CSS
	Deliver CSS operational and workforce resilience across all MFT sites
	Manage increasing demand through capacity maximisation thereby accelerating recovery of elective and cancer diagnostic care
	In response to the elective recovery challenge ensure CSS services at Trafford are resourced and prepared to support the 2022/23 activity challenges

LCO	Deliver 2-hour crisis response standard
	Learning Disability services; review all commissioned services and packages of care
	Deliver HIVE programme for the LCOs (inc rationalise EMIS, plan to improve data quality across services and improve staff digital access and literacy)

MREH	Ensure that the hospital has completed all programmes of work associated with data quality readiness critical to HIVE implementation and business as usual
	Ensure that all staff attend the necessary HIVE training and implementation events to ensure they are able to fulfil their roles following 'go-live'
	Ensure that the necessary governance processes are in place to ensure that HIVE is implemented safely and issues affecting 'Go Live' are escalated and managed in a timely manner
	Extend the scope of the internal 'Mesh' process to include those patients waiting 52-104 week waits for a surgery date.
	Implement new pathways for patients with urgent/emergency eye conditions
	Work with all specialties to maximise opportunities for virtual reviews.
	Improve theatre and outpatient utilisation information to drive improvements in throughput and utilisation
	Ensure compliance with the GIRFT High Volume Low Complexity (HVLC) metrics for routine cataract lists at Withington Cataract Centre
	Maintain a robust process to reduce the risk of harm due to delays in follow up review.

NMGH	HIVE Implementation – develop robust audit plan ready for the launch of HIVE to enable oversight of patient outcome data. Harness the benefits of HIVE to drive improvements in performance, quality and safety.
	Urgent Care and Patient Flow – recovery and improvement including focus on 12 hour total waits, 4 hour performance, SDEC, patient flow and discharge
	Referral to treatment (RTT) – recovery and improvement including reducing 104 week waits and ensuring clinical prioritisation
	Cancer Performance –improvement in attainment of key standards and maintaining access for patients through cancer services disaggregation process
	MFT Integration – embed operational and clinical benefits of integration to MFT group model
	Optimise standards of IPC within the current estates infrastructure
	Patient Safety – delivery of safety initiatives aligned to the MFT objectives of decreasing harm by 50% by 23/24. Delivery of enhanced staffing establishments to meet national recommended ratios of activity and acuity assessment
	Mortality Improvements – targeted reduction in Hospital Standardised Mortality Ratios & Summary Hospital-level Mortality Indicator through embedding Mortality Review Process and appointing SJR reviewers. Focus on sustaining a culture that

	avoids never events and avoidable death through the Hospital Quality and Safety programme

RMCH	Reduce waiting times for treatment and support children to be in the right place and discharged in a timely manner
	Implement the national Paediatric Early Warning System including triggers on parental concerns
	Utilise the HIVE electronic patient record to standardise clinical policies across the MCS which improve the efficiency and effectiveness of care
	Standardise medication safety for children through the development of a Medicines Safety Strategy
	Continue to learn from past harm, embed the mortality review process and year on year reduction in level 4 and 5 harms

SMH	Engaging the entire MCS in preparing for and delivering the benefits of Hive.
	Elective Care Recovery, building the capacity and capability required to address waiting lists in Gynaecology.

UDH	Ensure that the hospital has completed all programmes of work associated with data quality readiness critical to HIVE implementation and business as usual
	Ensure that all staff attend the necessary HIVE training and implementation events to ensure they are able to fulfil their roles following 'go-live'
	Ensure that the necessary governance processes are in place to ensure that HIVE is implemented safely and issues affecting 'Go Live' are escalated and managed in a timely manner
	Extend the scope of the internal 'Mesh' process to include patients waiting 52-104 weeks for a surgery date.
	Improve theatre and outpatient utilisation information to drive improvements in throughput and utilisation
	Ensure compliance with the GIRFT and HVLC metrics for routine paediatric dental extraction lists
	Work with the University of Manchester to increase undergraduate teaching capacity
	Ensure that where appropriate the recommendations from the 'GIRFT Report' in Hospital Dentistry have been implemented

WTWA	We will utilise the benefits of the enhanced Electronic Patient Record (HIVE) to improve safety and outcomes for patients and support our recovery programme
	We will have a focus on ensuring best practice for infection prevention and control and also ensure the appropriate use of antibiotics
	Treat all patients waiting 104 weeks for elective care
	Cancer Performance- Right size cancer capacity, apply relentless focus on managing pathways, apply transformation methodology
	Patient flow & Urgent care –UTC model at Wythenshawe embedded, fully implement SDEC model
	We will implement a theatre safety improvement programme across WTWA

MRI	Ensure robust infection prevention and control

	Deliver personalised holistic patient care to provide them with an excellent experience with a particular focus on nutrition and hydration

To improve continuously the experience of patients, carers and their families

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Corporate Nursing	Deliver excellence in Patient Experience through the MFT quality and patient experience programme underpinned by integration of quality and safety governance and data, and digital transformation	We will develop the Patient Experience agenda, making demonstrable improvements in fundamentals of care.
		All services continue to improve on quality measures (Quality Care Round, What Matters To Me survey and Friends & Family Test, Clinical Accreditation Programme)
		Optimise patient experience in service improvement through use of Quality Impact Assessments
		Engaging patients, service users and client feedback from complaints, Patient Advice and Liaison Service (PALS), and concerns raised to support service transformation
	Establish a programme of excellence in Learning Difficulties (LD) / autism care	LD/autism strategy for MFT in place
Joint Group Medical Director Office	Launch the Medical Examiner (ME) Service in the community	Complete ME pilots in the community
		Use learning to from pilots to launch full community ME service
Informatics	Support implementation of the Epic EPR, transforming services to provide better quality care to patients	Go-live and stabilisation of Hive EPR
	Implement improved ways of working for staff utilising specialist systems and solutions	Implementation of the approved Informatics Capital Programme
R&I	Protect and develop dedicated clinical research space	Acquire and develop existing space for dedicated clinical research delivery.

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Embedding HIVE processes to support service development and improved patient experience
	Support the development and implementation of service changes across MFT Infection Prevention and Control: leadership and governance

LCO	Deliver the MLCO (Adult Social Care) Commissioning Plan and integrate deployed health commissioning functions into the MLCO Operating model
	Super Patient Treatment: Establish integrated admission avoidance and discharge pathways across MLCO and MFT Hospitals
	Deliver the nationally mandated vaccination requirements (staff) and support vaccination programmes
	Building on the Better Outcomes, Better Lives programme (BOBL) - embed strengths-based approach across our services
	Continue to support Care market resilience through a care market strategy

MREH	Review and refresh the hospitals intranet and internet pages to ensure they are relevant and user friendly
	All clinical areas consistently deliver high quality care

NMGH	MFT ward accreditation – expand to all areas and further develop ward-based learning processes
	HIVE benefits realisation – Capitalise on EPR to improve patient experience
	What Matters to Me (WMTM) framework – fully embedded at NMGH.
	Patient experience focus – evaluate high impact roles introduced to support improving patient experience with full alignment to workplans and key indicators

RMCH	Work together with families and Sodexo to improve nutrition
	Implement a bespoke volunteering programme across RMCH MCS and involve children and family voices in hospital committees

SMH	Continued delivery of the Maternity safety and transformation agenda.
	Deliver against 7 Patient Safety Incident Response Plan priorities agreed by MCS

UDH	All clinical areas consistently deliver high quality care
	Review and refresh the hospitals intranet and internet pages to ensure they are relevant and user friendly

WTWA	Utilise the benefits from the implementation of the HIVE MyMFT app, sharing information directly with patients
	Establish a Patient Experience and Involvement Delivery Group to strengthen the service user voice in shaping our services
	Respond to complaints & PALs in a timely manner to optimise patient feedback which will inform quality improvement initiatives.
	Fully utilise ‘What Matters to Me’ framework to act upon feedback to improve the experience of service users and support recovery from covid.

MRI	Deliver reduced waiting times and ensure patients are discharged from hospital in a timely manner

To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Corporate Nursing	Develop a programme to support a highly skilled workforce through development opportunities and research to support service transformation and COVID recovery	We will work with Higher Education Institutions, increasing the number of NMAHP graduates through increasing placement capacity
		We will further develop and embed the Professional Nurse Advocate role
		Recruitment pipeline will further improve, and vacancies reduce in hard to fill areas
		Minimum 450 International Recruitment nurses recruited to support service transformation programmes attracting staff with specialist skills
		Continuously review roles to consider how best we can deliver services across professions
		Review access to programmes to ensure equity of access, and support a workforce that reflects the population served
		Deliver a series of conferences including themes of research, workforce, patient safety and quality.
Workforce	Further Develop our Attraction & Reward strategy	Relaunch of work experience and pre-employment programmes
		Expansion of T Level placements
		Targeted attraction campaigns to increase staff availability
		Research and scope reward initiatives
		Develop and engage stakeholders on new reward strategy and delivery plan
	Create a positive health and wellbeing culture	An established Rapid Access Physio Treatment Service
		An Employee Health and Wellbeing Leadership course for managers
		Embedded Phycological Wellbeing and Mental Health Services
		High take-up levels for flu and COVID-19 vaccination
		Expansion of Mental Health First Aider and Wellbeing Champion roles to support preventative activity
		Robust infrastructure to share best practice and provide assurance on impact of local health & wellbeing plans.
	Embed MFT Leadership and Culture plan	Delivery of MFT Organisational Development Plan
		Delivery of OpenDoor staff engagement and recognition platform
		An established Culture Ambassador Recognition Scheme
		An embedded Freedom to Speak Up programme
		An embedded ‘Leadership Way’ national competency framework
		Robust talent pipelines through the delivery of Talent and Development centres
		Launch of the ‘Developing Our Digital Workforce’ programme to increase our digital capabilities and drive digital enablement

		Launch of Learning & Education Strategy
Workforce, Corporate Nursing and Medical Directors	Develop MFT Putting People First Framework	Approval of disciplinary and MHPS policy to reflect Putting People first
		Roll out of training programme
		Communications and engagement campaign
Informatics	Implement fit for purpose and effective systems for staff	Support corporate services development/deployment of systems.
R&I	Consistent processes across all R&I	Standardise processes and train non-clinical research delivery staff
	Revise processes for invention capture	New processes for better management of inventions created by MFT staff
	Capacity building	Promote research as everyone's business in the Trust
		Map and revise guidance for Consultant research Programmed Activities (PAs)
		Fellowships – Pump-prime internally and otherwise support external applications
		R&I representation in recruitment of Trust staff

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Implement refreshed CSS Recognition Plan
	Support ongoing development of divisional wellbeing groups
	Promote and develop the CSS brand to ensure sense of belonging for all staff and affiliates

LCO	A review of the impact of / learning from year one of people plan
	Deliver a staff engagement event – Freedom 2 Lead

MREH	Evaluate the flexible working opportunities that have been implemented in 2021/22 for admin and clerical staff, make further enhancements where appropriate and share outcomes with staff.
	Promote the culture and positive conditions for equality, diversity and human rights to flourish within MREH
	Promote an open culture where staff feel empowered to speak up safety.
	Reduce levels of sickness absence by identifying themes and develop actions accordingly
	Develop a Hospital Recognition Report which acknowledges contribution of staff covering achievements, developments, research and innovation.

NMGH	Staff wellbeing and positive culture – Systematise Schwartz Rounds. Deliver key initiatives including lived experience for all staff through Big Conversations. Push towards zero-tolerance culture for bullying and harassment. Embed the Just Culture Charter.
	Vibrant & inclusive development offer – Introduce activities to address barriers that exist for BAME staff. Continue to identify development opportunities to improve the diversity of senior management posts.
	Positive Staff engagement - build on the identity of NMGH whilst harnessing the benefits of the MFT group model. Continue to recruit to our vacancies and to reduce our turnover through positive staff engagement activities.

RMCH	Ensure recruitment campaigns demonstrate strong commitment to workforce diversity
	Expand health and wellbeing initiatives at MCS and team level as we recovery from covid

SMH	Continue to implement the MCS People Plan with an emphasis on staff wellbeing, engagement and involvement and the development of our workforce for the future
	Development of our approach to Civility Saves Lives and cultural behaviours

UDH	Promote the culture and positive conditions for equality, diversity and human rights to flourish with UDHM.
	Reduce levels of sickness absence by identifying themes and develop actions accordingly
	Develop and share a Hospital Recognition Report which details and acknowledges the contribution of staff covering achievements, developments, research and innovation
	All clinical areas consistently deliver high quality care

	Review and refresh the hospitals intranet and internet pages to ensure they are relevant and user friendly

WTWA	Valuing our diversity, implementing Workforce Race Equality Standard (WRES) action plan
	Focussing on wellbeing of staff as we recover from covid
	Develop 2021 WTWA staff survey action plan and implement
	Continue to support the Civility Saves Lives campaign and kindness culture

MRI	Embed the 4 levels of leadership and continue our talent development

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

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Joint Group Medical Director Office	Improve Training Opportunities of Medical and other staff and support lost training time as a result of Covid-19	Launch the Manchester Surgical Skills and Simulation Centre (MSSSC) for 12-month pilot
		Following pilot, develop business case for recurrent MSSSC
	Ensure we use the time of our consultants efficiency and effectively so that Covid recovery plans are delivered	Use the fully completed job plans from all Hospitals/MCS to inform Covid recovery plans
		Complete all job plans by December 22 to inform planning for 22/23
	Reduce our medical vacancies via improving our recruitment programmes	Develop international recruitment strategy for medical staff and supporting business case
		Implement new international recruitment strategy
Workforce	Deliver and embed the MFT People Plan	Completion of plan deliverables in line with target dates
		High levels of staff engagement so that our people understand the improvements being made and what they mean for them
		Assurance from HR Scrutiny Committee that the plan is delivering the Trust's ambitions
	Deliver our Workforce Digital Strategy	A clear Workforce Digital Strategy aligned with our Trust Informatics Strategy
		Conclusion of medical rostering, managing interdependencies with and pre-requisites for HIVE
		Progression of nursing/ midwifery projects and clinical professionals rostering in line with strategy
		Implementation of non-clinical rostering to expand benefits and consolidate for payroll
		Procurement of a HR advice portal
		Introduction of automation within HR services
	Continue our policy review process	Delivery of policy ratification aligned to policy review schedule
		Fit for purpose policies, consistent with MFT values
	Enhance our Learning & Development offer	An embedded, accessible, relevant MFT Mandatory Training programme that achieves over 90% compliance
		A fully embedded learner experience platform, offering an extensive range of digital learning opportunities
		A dynamic and forward-thinking Apprenticeship Offer that is responsive to the needs of the Trust
	Further development of Workforce	Embedded predictive workforce modelling techniques
		Clear, multi-level workforce planning approach

	Information, Analysis, Modelling and Planning	A community of practice for workforce analytics, modelling and planning
		Power BI dashboard in place
		Enhanced support for workforce transformation, new roles, career pathways
	Disaggregation and alignment of services to North Manchester	Transfer of outstanding North Manchester services
		Continued alignment of workforce services post integration of North Manchester
Workforce Corporate Nursing	Review of Nursing Assistant roles in clinical settings	In partnership with front line staff and trade unions review skill mix and progress management of change process
Workforce, HIVE	Deliver the people elements of our HIVE programme	Delivery of a HIVE training programme plan
		Progression of workforce transformation to realise HIVE benefits
		Retention of HIVE skills, knowledge and experience to support transition to business as usual
Informatics	Develop an Informatics people plan	Implement a Management and Leadership programme for staff within Informatics
R&I	Consistent processes across all Trust	Standardise processes and train non-clinical research delivery staff
	Revise processes for invention capture	New processes for better management of inventions created by MFT staff
	Capacity building	Promote research as everyone's business in the Trust
		Map and revise guidance for Consultant research PAs
		Fellowships – Pump-prime internally and otherwise support external applications
		R&I representation in recruitment of Trust staff

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Innovative and agile recruitment strategies across the CSS Divisions (Widening participation, international recruitment)
	Supporting and developing new educational routes into our CSS professions

LCO	Deliver mandatory training and appraisal requirements, supporting team managers to have wellbeing conversations with their staff and teams
	Embed strengths-based approach (SBA) across our services and empower frontline teams to deliver service improvement and transformation.

MREH	Develop an Admin and Clerical Development Group to identify development, progression and satisfaction opportunities resulting from HIVE.
	Ensure that all staff are equipped and supported to adapt to HIVE and that there is a robust communication strategy in place to aid safe effective implementation
	Ensure that all Job plan reviews and appraisals are carried out to a high standard
	Implement Multi-Disciplinary Team Clinical Practice Committee to oversee new roles/practice and identify opportunities to develop non-medical extended roles.
	Develop an ophthalmic programme of education for nursing
	Introduce a staff forum that allows open exchange of ideas and concerns

NMGH	HIVE Implementation – embed new ways of working and improve digital literacy
	Review and strengthen our development offer for staff . Pilot a Staff Advice and Liaison Service and enhanced staff network development
	MFT Management Standards – commence pilot in NMGH
	Mandatory COVID-19 Vaccinations – ensure compliance with national legislation

RMCH	Enable HIVE EPR implementation through digital skills assessment, training and support and provide a foundation for further digital transformation of services.
	Retain focus on mandatory training and appraisals
	Deliver our MFT and RMCH people plan - ‘All here for you’ – embedding Division, SLT and CAMHS leadership development
	Deliver training programme in CAMHS and End of Life care to support growing need for skills across RMCH hospitals

SMH	Development of Newborn Clinical Education Academy.
	Continuing the development of an Independent Sexual Violence Adviser Training Package Training Package in Sexual Assault Referral Centre (SARC).

UDH	Develop an admin and clerical Development Group to identify development, progression and satisfaction opportunities resulting from HIVE
	Ensure that all staff are equipped and supported to adapt to HIVE and that there is a robust communication strategy in place to aid safe effective implementation.
	Introduce a staff forum that allows open exchange of ideas and concerns
	Ensure all Job plan reviews and appraisals are carried out and to a high standard
	Work with Health Education England and the School for Dental Care Professionals to increase education opportunities for Dental Nurses

WTWA	Building on WTWA OD plan, support new operating model and develop talent
MRI	Create the feeling of belonging at team level to embrace difference and ensure well being

To use our scale and scope to develop excellent integrated services and leading specialist services

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Informatics	Develop the sharing of information across specialist services	Implementation of the approved Informatics Capital Programme
	Coordinate and manage ongoing disaggregation of NMGH services and support progressive integration into MFT.	Disaggregate NMGH from Northern Care Alliance systems.
		Unify the ordering of diagnostic testing from NMGH
		Roll out MFT technology across NMGH
		Implement digital solutions for shared services where the pathways are clinically redesigned
R&I	Develop strategic initiatives	Diagnostics and Technology Accelerator
		Clinical Data Science Unit in partnership with Informatics
		Trust Rare Conditions Centre
Strategy	Review MFT Service Strategy post COVID	Revised MFT Service Strategy
	Develop MFT strategy for specialised services	MFT Specialised Services strategy produced
	Develop MFT single service models	Service configuration and operating models agreed for those service that are delivered across MRI, WTW and NMGH
	Seek approval for service changes related to COVID and the clinical service strategy	Commissioner approval received for service changes
	Develop cancer services strategy for MFT	MFT Cancer Service Strategy completed and approved by Board of Directors
	Develop surgical techniques / robotics strategy for MFT	MFT Surgical Techniques strategy produced
	Develop plans for advanced therapies	Costed long-term plan for the development of advanced therapies produced

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Lead MFT implementation of Advanced Therapy Medicinal Products (ATMPs)

LCO	(With MRI / RMCH) develop a service strategy for the Manchester Sickle Cell and Thalassemia Centre
	Develop a service strategy for community services inc. full service stocktake.
	Work with PCNs to deliver Anticipatory Care, reduce inequalities and roll out Virtual wards
	Develop the Manchester Provider Collaborative; building the delivery and impact plan for the Locality Plan

MREH	Work with primary care and community services to reduce burden on hospital services.
	Take the lead across GM in developing sustainable services for specialist ophthalmology services (Retinopathy of Prematurity, paediatrics)
	Maintain a national profile through joint working and collaboration with UK Ophthalmology Alliance, Royal College of Ophthalmologists and National Council of Educational Research and Training

NMGH	Implementation of HIVE – operational readiness for HIVE alongside wider IT disaggregation.
	Clinical Service Strategies – Implementation of single service models for identified priority areas. Delivery of Community Diagnostic Centre plan for NMGH.
	Delivery of disaggregation plans for NMGH Delivery of SLAs and associated disaggregation/integration plans within MFT in collaboration with Hive implementation programme. Develop a roadmap for complex service disaggregation including clearly defined commissioner decision-making and assurance process
	Redevelopment of NMGH – complete and submit the updated outline business case and commence full business case development

RMCH	Continue to lead the equitable recovery of children waiting for treatment across Greater Manchester through standardised protocols, increased access (hubs) and more efficient High Volume / Low Complexity pathways
	Deliver RMCH MCS Transformation plan standardising MCS wide working and introducing innovative new models of care including the RMCH Virtual Ward
	Secure and implement new highly specialist services including Cystinosis, Battens Disease and Inherited White Matter Disorders and HSCTs
	Deliver iMRI full business case to enable mobilisation of cutting-edge care and the feasibility of a robotics surgery model for children

SMH	Support the development of a Northwest Maternal Medicine Network
	Work with RMCH to support the development of advanced therapies.
	Work with commissioners to make assisted conception services fit for the future.
	Support the mobilisation of the Rare Conditions Centre.

UDH	Maintain a national profile through joint working and collaboration with the Association of Dental Hospitals
	Work with the University of Manchester to respond to changes in Dental Education Training.
	Consider opportunities to take a lead role in delivering dental apprenticeship training

WTWA	Building on the foundations of our clinical service strategies and addressing health inequalities - Cardiac, Trauma and orthopaedic, Stroke & Urology and integration of NMGH, GM Lung Screening programme

MRI	Utilise the HIVE electronic patient record to improve the efficiency and effectiveness of care
	Implement our transformation plan to ensure HIVE benefits and waste reduction are delivered and our specialised services pathways continue to deliver cutting edge care

To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Corporate Nursing	Continue to build on NMAHP research activity	Launch the Manchester Clinical Academic Centre for NMAHP's and Pharmacy that will deliver our vision to improve the health and quality of our diverse population through research
Informatics	Develop our capacity and capability to undertake analysis on large scale patient data for research through our Clinical Data Science Unit (CDSU)	Exemplar projects identified
	Develop the Electronic Patient Record to support research	Improved accessibility and quality of patient clinical and research data for R&I purposes
		Increased integration between systems to support research
	Improve the collaboration across organisational boundaries	Implement a solution that links Genomics and laboratory data systems
R&I	Engage in HIVE implementation, equality initiatives and highest ethical standards	Address health inequity, including initiatives within:
	Support NIHR infrastructure applications and implementations	NIHR infrastructure renewal applications and new initiatives - Applied Research Collaborative (ARC)
		NIHR infrastructure renewal applications and new initiatives - Biomedical Research Centre (BRC)
		NIHR infrastructure renewal applications and new initiatives - Clinical Research Facility (CRF)
		NIHR infrastructure renewal applications and new initiatives - Clinical Research Network (CRN)
		NIHR infrastructure renewal applications and new initiatives - Medtech and In vitro diagnostics Co-operative (MIC) – new for 2022
	Research delivery performance	Research income and open studies at/above 90% of 2019-20 level
		Top 10 recruiting Trust for CUETIP (previously UPH) research projects (COVID-19)

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Digital and wearable technology
	Develop a CSS network of transformation and innovation
	Diagnostic Training Academy and Clinical Trials Facility

LCO	Develop the Manchester Provider Collaborative; building the delivery and impact plan for the Locality Plan and a key partner in the development and mobilisation of the Trafford provider collaborative

MREH	Develop MREH Education and Research Steering Group to ensure that our staff have the appropriate clinical competencies for specialist care and to develop evidence based practice.
	Promote and develop R&I opportunities for the nursing and non-medical workforce

NMGH	Improve Clinical Trial Access - demonstrating year on year growth of patients recruited to NIHR funded studies
	Research Involvement – consolidate our academic programmes in Infection, Diabetes and Paediatric Emergency Medicine, but also to develop a NMGH Research, Discovery and Innovation plan for 2022-25 to widen participation and engagement across all staff groups.
	Innovative Academic Posts – develop and appoint new academic posts across different professions at NMGH

RMCH	Deliver Children's Research 2025 plans for the Children's Research Institute and MFT Advanced Therapies programme including stage 1 of the HSCT / Gene Therapy expansion and stage 2 Outline Business Case

SMH	Improve communication and awareness of the MCS research activity.
	Develop research strategies in each element of the MCS.

UDH	Develop UDHM Education and Research Steering Group to ensure our staff have the appropriate clinical competencies for specialist care and develop evidence-based practice.
	Utilise estate such as The Manchester Dental Education Centre for Post-graduate courses to build MFT reputation and provide revenue source
	Promote and develop R&I opportunities for the nursing and non-medical workforce

WTWA	Renew, refresh and expand the NIHR Manchester Biomedical Research Centre and Clinical Research Facility
	Embed robust systems to enable Research and Innovation activity growth and support our covid recovery

MRI	Ensure our research and innovation portfolio is core to providing excellent clinical services

To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda

MFT wide plans

Who is going to do it	What we are going to do	What will be achieved in 2022/23
Workforce	Delivery of Equality, diversity and inclusion Strategy	Fully embedded Removing the Barriers Programme
		Clear action plan to address harassment, bullying & abuse
		Diverse representation in our governance structures
		Expansion of forums and networks to encourage and enable individuals to voice opinions and lead improvements and change
		Enhanced training offer to create a culture based on positive attitudes towards welcoming diversity and meeting diverse needs
		Development of NICE Guidelines for support to Homeless Patients
Informatics	Continued development of North Manchester Digital Hospital business cases.	NHP/JIC approval of revised Digital and Redevelopment Outline Business Case
		Development of the MFT redevelopment full business case
Procurement	Train 25 members of the Procurement Team on Social Value (SV)	Greater awareness of SV in Procurement
	Add min 5% award criteria for SV building upon 21/22 progress	
	Continue to with local authority and public sector partners in GM through Mayoral Group and Public Procurement Forum to share ideas and approaches	
	Continue to monitor Small & Medium Sized Enterprise (SME) supplier spend and GM/City of Manchester supplier spend from current baseline	Increase SME spend by 10%
	Continue to monitor SME supplier spend and GM/City of Manchester supplier spend from current baseline	Increase GM spend by 10%
	Identify opportunities for SV in the Furniture and Equipping Programme	Identify value of available spend to take to market after
	Identify opportunities for SV in the Furniture and Equipping Programme	Identify specific opportunities for GM based suppliers esp. SMEs
R&I	Commercial partnerships	Support our strategic partners;
		One new partnership per year;
		Attract optimum partners to co-locate on site

	Non-commercial partnerships	Regular communication with University of Manchester, Health Innovation Manchester, Integrated Care System for GM
		Consistent approval processes across Manchester;
		Link with other EPIC Trusts
		Supply paid R&I services to other Trusts
Estates & Facilities	Establish a new Climate Strategy Board to provide senior strategic leadership in relation to the delivery of and embedding of the new Green Plan	Board to be established and first meeting to take place
		Deliver the agreed 2022/23 Green Plan workplan
	Continue to lead the NW Greener NHS programme, and provide resources and support to the NW ICB's and other partners to facilitate delivery of shared regional objectives outlined in a Memorandum of Understanding.	Host a small regional Greener NHS team
		Deliver against 2022/23 priorities
	Improve communication of the new Green Plan and raise Trust reputation for this area of work	Hold Green Plan launch event
		Develop communications plan
		Deliver communications plan including an ongoing programme of staff stories, case studies, and press releases
	Play a lead role in finalising and delivering the GMHSC Green Plan	Support the socialising, resourcing and approval process for the plan
		Facilitate ICS Operational Leads network and participate in and contribute to other GM leadership forums
		Support relevant aspects of the GMCA 5-Year Environment Plan work programme

Hospital / MCS / LCO plans

Who is going to do it	What we are going to do
CSS	Continue to lead the implementation of Community. Diagnostic Centres on behalf of MFT.
	Continue to develop our offer for entry level positions.
LCO	Develop the Neighbourhood model and use the Neighbourhood model and use to implement national Ageing well model and develop plans with wider partners to address population health/health inequalities
	Design of Target Operating Model (TOM) for the NMGH Wellbeing hub (with NMGH) as part of wider site TOM
	Deliver comms and engagement of communities to support key neighbourhood, locality and system-wide priorities (i.e. vaccination)
MREH	Maintain robust processes to ensure that there is continual grip on the financial performance (Vacancy control, procurement meetings, Business Case Tracker, pharmacy/drug usage reviews).
	Maximise use of off site facilities, improving access to speciality ophthalmic services closer to home.
	Collaborate with key stakeholders e.g RNIB, Henshaws to ensure that we meet the needs of patients with a visual impairment.
NMGH	Reducing health inequalities – reducing health inequalities and improving access as part of our core mission for NMGH. Improve access to training on health inequalities
	NMGH Knowledge Quad – Launch in 2022 in collaboration with partners
	Joint Ambitions with MLCO – to address health inequalities and advance priority areas of integration
RMCH	Deliver NW-wide network of excellence services which improve children's health and wellbeing including cardiology, healthy weight, surgery, Long Term Ventilation, Major Trauma, Covid and Gender Identity
	Collaborate with the Children's Hospital Alliance to lead a review on variation in children who are not brought to hospital to understand inequalities and changes to pathways which reduce WNB
SMH	Continue to implement MCS People Plan and our support to Removing the Barriers.
	Relocate SARC to Peter Mount Building.
	Delivery of various IT developments that will cutdown the use of paper.
UDH	Work closely with the Greater Manchester Dental Managed Clinical networks to improve patient care, access and which address health inequalities.
WTWA	Make Trafford a 'green site' to support the elective recovery activity
	Expand the services offered at the Community Diagnostic Centre at Withington Community Hospital
MRI	Lead the creation of centres of excellence in vascular and major trauma through single services across MFT
	Progress the Project RED redevelopment of our Emergency Department and expansion of our Theatre suite
	Focus on creating conditions for high performance in our priority areas

5. Finance

6. Risk and Monitoring Arrangements

Risks to Delivery

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

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

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

Monitoring Delivery

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

Accountability Oversight Framework (AOF)

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

Board Assurance Report

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

Hospital / MCS / LCO Review

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

Annual Review

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	May 2022
Subject:	Risk Management Framework and Strategy 2022-25
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval • Ratify ✓
Consideration against the Trust's Visions & Values and Key Strategic Aims:	The Trust's Risk Management Framework and Strategy underpins the delivery of, and assurance processes related to the Trust's Vision, Values and Strategic Aims
Recommendations:	The Board of Directors is asked to note the approval of the Risk Management Framework and Strategy 2022-25 at the Group Risk Oversight Committee The Board of Directors is asked to note the minor amendment made in relation to the role and responsibility of the Audit Committee in terms of 'Clinical Audit' (P25) (made subsequent to approval at the Group Risk Oversight Committee in March 2022) The Board of Directors is asked to ratify the Trust's Risk Management Framework and Strategy 2022-25
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RISK MANAGEMENT FRAMEWORK AND STRATEGY 2022-2025

Contents

1. Introduction

1.1. Manchester University NHS Foundation Trust ('the Trust') has a clearly articulated vision, *'to improve the health and quality of life of our diverse population by building an organisation that excels in quality, safety, patient experience, research, innovation and teaching; attracts, develops and retains great people and is recognised internationally as a leading healthcare provider'*

1.2. The Trust recognises that in working to achieve that vision, providing a wide range of clinical services, across multiple hospital sites, managed clinical services (MCS) and a Local Care Organisation (LCO), the activities associated with employing staff, providing premises, and managing finances are an inherently risky undertaking, but that risk, properly managed can bring with it advantages, benefits and opportunities. This is because understanding risks and managing them appropriately will result in better decisions, support the effective delivery of Strategic Objectives, and enable improvements in clinical quality and performance.

1.3. Risk influences every aspect of the Trust's day-to-day clinical operations and non-clinical business, and the continued delivery of high-quality care requires the identification, management and minimising of events or activities which could result in unnecessary risks to patients, staff, and visitors/members of the public.

1.4. The continued changes in the healthcare environment, increasing competition and the increased regulatory and statutory requirements create considerable challenge, uncertainty, and opportunity.

1.5. Authorisation as a Foundation Trust requires strategic business risk management, in addition to the management of the risks associated with the delivery of clinical services. Maintaining Foundation Trust status is dependent on regular 'self-certification' by the Trust Board that clinical service, governance, and financial standards are met. In turn, self-certification requires access to high quality risk and assurance reports that are the product of an effective risk management strategy.

1.6. Risk management activities undertaken within the Trust operate at a number of levels: for example, a health or social care professional creating a risk management plan for a patient; corporate planning around the organisational response to a major incident; risk assessment and mitigation for business expansion and development.

1.7. Therefore, the management of risk is a key organisational responsibility and is the responsibility of all staff employed by the Trust. Risk management is an integral part of good clinical and corporate governance, and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical or non-clinical. Risk management is therefore embedded within the Trust's overall performance management framework and links with business planning and investment decisions.

1.8. This document describes how the Trust's strategy and its related procedures and protocols (detailed in the Trust's Risk Management Handbook) serve to set these various risk management activities within a broad corporate framework ensuring a consistent approach to risk management across the Trust.

2. Statement of Intent

2.1. Manchester University NHS Foundation Trust ('the Trust') is committed to ensuring that risk management is aligned to Strategic Objectives, clinical strategy, business plans and day-to-day operational management systems.

2.2. The Trust recognises that the specific function of risk management is to identify and manage risks that threaten our ability to achieve our Strategic Objectives. It is clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital to making the Trust a safe, effective, and reliable organisation.

2.3. The Trust acknowledges that in delivering health improvements and in embracing positive advantages risks may need to be taken. The Trust recognises that it cannot create a risk-free environment, but rather one in which risk is considered as an integral part of everything it does and is appropriately identified and controlled.

2.4. The Trust therefore identifies risk as either an opportunity or a threat, or a combination of both, and will assess the significance of risk as a combination of probability and consequences of the occurrence.

2.5. All staff have a responsibility for identifying and minimising risk. This will be achieved within a progressive, honest, and open culture where risks, system variability and incidents are identified quickly and acted upon in a positive way.

2.6. This document describes the Trust's Risk Management Framework and Strategy for 2022-2025.

3. Scope and Objectives

3.1. This document provides the overarching strategic approach to risk management and the framework within which risk is managed by the Organisation. It is fully endorsed by the Trust Board. The Board consider it a contemporary strategy and is assured through the work of the Group Risk Oversight Committee that it reflects currently available information, guidance and legislation governing the NHS.

3.2. This Risk Management Framework and Strategy has been developed aligned to the Trust's Vision and Values, in particular the values and behaviours framework.

3.3. This Risk Management Framework and Strategy is designed to strengthen the Trust's ability to achieve its Strategic Objectives and business targets, and therefore ensuring the continuation of the safe, effective, and responsive delivery of services.

3.4. It will do this by detailing the risk management processes and associated infrastructure to enable the Trust to:

- actively pursue the identification of uncertainties in order that threat can be mitigated, and opportunity utilised
- continue to develop a mature risk aware and safety culture

- ensure that a consistent and integrated approach to risk management is embedded in the day-to-day working practices of the Organisation at all levels, embracing clinical, non-clinical and corporate risks
- ensure that the risk management process covers the full range of the Trust activities
- continue developing the systems and structures in place for identifying, assessing, escalating, and recording risk
- optimise its approach to assurance throughout the Trust
- make effective use of information from risk assessments, and multi-source intelligence, for instance in relation to system variability, incidents, complaints, audit, claims, effective implementation of external recommendations and other external sources (including HM Coroner and regulators) to improve quality and support organisational learning
- ensure that Governors, Board, and senior management are provided with adequate assurance that risks are being appropriately identified, assessed, and mitigated
- demonstrate compliance with legal and regulatory compliance; the Trust operates within a complex regulatory framework and all regulators require a consistent and comprehensive approach to ensuring adherence risk management standards (for instance NHS England/NHS Improvement [NHSE/I], the Care Quality Commission [CQC], the Health and Safety Executive [HSE])
- use Internal Audit effectively to provide independent assurance in relation to the effectiveness of controls in place to manage risk

4. Types of risk exposure

4.1. The Trust is exposed to a wide range of risks which can be categorised within a taxonomy. As part of demonstrating compliance with its Provider Licence, the Board must self-certify that risks identified in these areas are being successfully mitigated, or else declare non-compliance and develop an action plan where this is not the case.

4.2. The risk categories are as follows (and can be mapped to the Board Assurance risks described in Section 7.4):

4.2.1. **Quality, Governance and Performance Risk**: This covers risks to compliance with the Trust's licence and includes third party investigations that could suggest material issues with governance e.g. CQC concerns, fraud, CQC reviews, planned or unannounced, and its outcomes / findings and other patient safety issues which may impact compliance with the Provider Licence (e.g. serious incidents, complaints)

4.2.2. **Continuity of Services Risk**: This encompasses risks to the Trust being able to provide ongoing availability of key services. For example, future transactions potentially affecting the continuity of services risk rating or the risk of a failure to maintain registration with the CQC for Commissioner Requested Services (CRS)

4.2.3. **Information Security Risk**: This is the potential for unauthorised use, disruption, modification, or destruction of information assets. Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Without effect cyber security, incidents can threaten

health, breach privacy, disrupt business continuity, damage assets, and facilitate other crimes such as fraud. The Trust has a legal obligation to ensure that appropriate security management arrangements are in place for the protection of data

4.2.4. **Operational Risks**: These are risks concerns directly with the operational activity of the Trust. This category of risk would, therefore, include sub-divisions such as performance, workforce, health and safety, security, and fire

4.2.5. **Financial Risk**: This encompasses risks arising from financial planning and management and includes credit risk, market risk, liquidity risk, budget risk, accounting risk, fraud risk etc. It would also include requirements for additional working capital facilities, failure to comply with the statutory reporting guidance and an adverse report from internal or external auditors or any independent review

4.2.6. **Business Risk**: The Trust is also exposed to commercial risks as a result of operating in a dynamic and competitive health and social care market. Within this environment the Trust faces risk from loss of referrals or contracts, changes in commissioner strategy or procurement actions, threats arising from major transactions such as mergers and acquisitions, and loss of business through patient choice

4.2.7. **Reputational Risk**: This encompasses current or prospective risk arising from the adverse perception of the image of the Trust by commissioners, partners, individuals, the local community, or regulators. Consideration of how clinical and non-clinical risks may adversely affect the Trust's reputation should be made as part of the overall assessment of a risk at its initial assessment and following mitigation when considering residual risk

5. Risk appetite

5.1. The Trust understands risk appetite as a mechanism to translate risk metrics and methods into decisions, reporting and the day-to-day business of the Trust and that it provides a framework linking corporate strategy, target setting and risk management. Risk appetite is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time, and every risk needs to be assessed for the acceptable level of risk appetite.

5.2. On an annual basis the Trust's Board of Directors, through the work of the Group Risk Oversight Committee, will confirm its risk appetite statement. The risk appetite statement will be generated from a formal discussion and will focus on the key categories of risk as described in Section 4 and supported by the application of a Risk Appetite Matrix for NHS Organisations (see Appendix 1). The Board's risk appetite, as detailed in the statement, will be aligned to the Trust's Strategic Objectives to support integration into the Board Assurance Framework (see Section 6).

5.3. In addition to the Risk Appetite Statement, the Trust will also express its risk appetite through:

5.3.1. **A standardised approach to identifying a potentially unacceptable level of risk**: As described in Section 6, the Trust will use a 5 x 5 matrix (likelihood and consequence) to identify risk

ratings. The Trust has set a boundary on the risk matrix, the 'risk appetite line' which is set out at 15. Any risks rated at or above this level are escalated for consideration at the Group Risk Oversight Committee (see Section 7), and directly influence the assurances contained within the Board Assurance Framework (see Section 6). A risk score of 15 or above is therefore treated as a trigger for a discussion as to whether the Trust is willing to accept this level of risk

5.3.2. **Target risk ratings**: Target risk ratings should be set for all risks. This risk rating is a means of expressing a target for the highest acceptable (tolerated) level for that risk. When setting target risk ratings, risk leads should consider what level of tolerated risk they are willing to retain. For some risks, the target risk rating could be high, especially where the consequences are potentially severe, or some elements of the risk lie outside the direct control of the Trust

5.3.3. **Risk Appetite rating**: All risks will have a risk appetite rating which will be derived from the Risk Appetite Matrix for NHS Organisations (see Appendix 1)

6. Implementing Risk Management Trust-wide

6.1. Integrated risk management is a process through which organisations comprehensively identify, assess, analyse, and manage all risks and incidents.

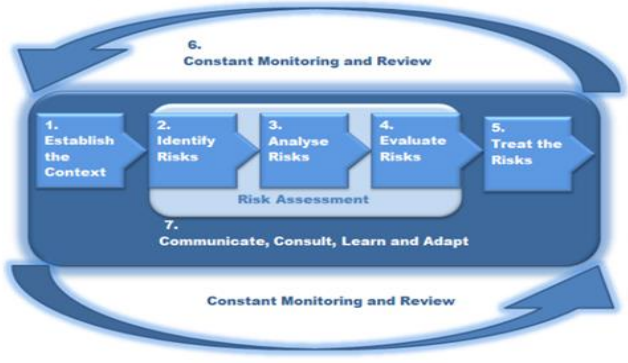
6.2. Risk management across the Trust is supported by a range of organisational policies and procedures, and the Trust's Risk Management Handbook provides operationally focused detail and advice particularly in relation to risk assessment, action planning, monitoring, review and identifying assurance.

6.3. Risk management is used to:

- identify potential risks with the intention of initiating and monitoring action to prevent or reduce the adverse effects of risks
- manage the treatment of risk in a systematic way so that the organisation can determine acceptability of residual risks
- provide a comprehensive approach to improving patient and staff safety
- improve decisions about resources and priorities
- provide information to the Board through the committee governance infrastructure structure so that it can make informed decisions

6.4. The risk management process is illustrated in Figure 1.

Figure 1: The Risk Management Process



Establish the Context

6.5. This Risk Management Framework and Strategy serves to establish the external, internal and risk management context in which the rest of the process will take place. The Trust's Risk Management Handbook provides details of the established criteria against which risk will be evaluated and the structure of the analysis is defined within the Trust's Electronic Risk Management System and explained in the Trust's Risk Management Handbook.

Risk assessment

6.6. The formal method of identifying and understanding risks within the Trust is using risk assessments.

6.7. A risk assessment is the systematic identification, assessment, and evaluation of anything that can interfere with the delivery of the highest standard of service and working environment within the Trust. The Trust's Risk Management Handbook provides a practical guide to risk assessment.

Risk identification

6.8. The Trust takes both proactive and reactive approaches to identifying and understanding risk.

6.9. The Trust will take steps to proactively identify risk by using a range of information sources, including but not limited to audit outcomes, patient and staff survey, external enquiries, CQC intelligence, and horizon scanning, identifying, evaluating, and managing changes in the risk environment locally (e.g. socio-economic trends), nationally (e.g. legislation) and internally (e.g. public health intelligence). More information about sources used for proactive identification of risk are detailed in the Trust's Risk Management Handbook.

6.10. The Trust has a range of sources of intelligence about names of actual and emergent risk within the Organisation. These include a patient safety management system, an Accountability Oversight Framework and benchmarked Trust-wide performance indicators (for instance within the Model Hospital).

Risk Analysis

6.11. Determining the relative importance of individual risks is a key element of the risk management process, enabling risk control priorities to be identified and appropriate action to be taken in response. All risks identified are graded using a common grading matrix (see Figure 2), which measures the risk in terms of both consequence and likelihood. This is achieved by:

A. assigning a score to the 'likelihood' of a risk event occurring
B. assigning a score to the 'severity' or 'impact' of the consequences of the risk event
C. identifying the risk rating via a risk matrix (5x5); the risk rating is calculated as the likelihood (probability or frequency) x severity of consequence

6.12. The Trust's Risk Management Handbook describes in detail the approach to grading in the Trust and describes the approach to the validation of risk assessment outcomes.

Figure 2: Risk Matrix					
Consequence (B)	**Likelihood (A)**				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score 5	Score 10	Score 15	Score 20	Score 25
4 Major	Score 4	Score 8	Score 12	Score 16	Score 20
3 Moderate	Score 3	Score 6	Score 9	Score 12	Score 15
2 Minor	Score 2	Score 4	Score 6	Score 8	Score 10
1 Negligible	Score 1	Score 2	Score 3	Score 4	Score 5

Risk evaluation and escalation

6.13. Risk evaluation involves the comparison of estimated levels of risk against the pre-established criteria (see Figure 3). This enables risks to be ranked to support the identification of management priorities. Risk evaluation should always be undertake directly considering the risk appetite for that area of risk.

Figure 3. Risk Evaluation: Risk level, tolerance, action, and escalation			
Risk level	Score	Actions	Required escalation
Low	1-3	Managed through normal local control measures	Managed at local level
Moderate (Acceptable risk threshold)	4-6	Review control measures through formal risk assessment Entered on Risk Register	Managed at service level
High	8-12	Review control measures through formal risk assessment Treatment plans to be developed, implemented, and monitored Entered onto Risk Register	Managed at Hospital Site/Managed Clinical Service/LCO or Corporate level through local risk escalation framework
Extreme	15-25	Review control measures through formal risk assessment Treatment plans to be developed, implemented, and monitored Immediate actions required to reduce risk Entered onto Risk Register	Escalated to Group Risk Oversight Committee for Executive and Non-Executive Director scrutiny and oversight

6.14. **Risk tolerance** is the acceptable level of variation relative to the achievement of an individual objective. It is the amount of risk to which a programme or an activity is prepared to be exposed to or that its resources allow it to be exposed to before actions become necessary.

6.15. The Trust has set its tolerance threshold for acceptable risk as moderate. This threshold is set in expectation of what risks are likely to be actually realised and the resources needed to realistically control them. The Trust has an established framework (see Figure 3) to support the escalation of risks that exceed the threshold of acceptable risk.

6.16. If the levels of risk established are low (1-3), then risks may fall into an acceptable category and treatment may not be required however, action should always be taken to reduce risks unless this involves measures that are clearly disproportionate in relation to the risk.

6.17. At or below the tolerance threshold all risks are monitored and evaluated within hospital site, Managed Clinical Services, the Local Care Organisation, within a Single Hospital Service or Corporate departments on an ongoing basis to

confirm and reassess their rating. All risks at, or above this threshold (throughout the Organisation) are actively managed and mitigating actions taken to bring the risk back into tolerance.

6.18. All risks graded at 12 or above, meaning that a major outcome is possible, and a moderate outcome is likely are escalated for consideration and oversight at Hospital Site, Managed Clinical Service or Local Care Organisation Risk Committees and Hospital Management Boards and within the senior management infrastructure corporately, including at Trust-wide Boards with a specific focus (for instance, the Urgent and Emergency Care Board, or the HIVE Project Board). These risks are used to contextualise the assurances within the Board Assurance Framework (see Section 7). These risks can, at the discretion of the senior management infrastructure described above, be escalated or consideration by the Group Risk Oversight Committee, if it is assessed that the impact of the risk on achievement of a Strategic Objective is potentially significant, for instance in relation to its interdependency with another risk.

6.19. All risks graded at 15 or above where a catastrophic outcome is possible, a major outcome is likely, or a moderate outcome is certain are escalated for consideration and oversight in relation to the achievement of the Trust's Strategic Objectives at the Group Risk Oversight Committee. The effectiveness of the mitigation in place in relation to these risks directly influences the assurances within the Board Assurance Framework (see Section 7).

Treat the risk

6.20. In planning the response to or 'treatment' of an identified risk, the following principles should be considered:

- balancing relative risks; where the management of one risk adversely effects the management of another risk or increases the rating of that risk, a decision will be required about proceeding with planned controls based on the significance of each risk
- avoiding creating a risk from controlling a risk; establishing controls and mitigations for one risk may in itself create a different or new risk and measures should therefore be assessed for their unanticipated consequences
- ensuring mitigation/control is proportionate to risk; proportionality will include time, effort and resources balanced with the overall rating and significance of the risk being managed
- paying attention to changes in risk ratings, and ensuring regular reviews of ratings and controls, while the level of risk will determine its priority the focus should not solely be on high and extreme risks
- aligning risk management with the development and implementation of policies and procedures; policies and procedures should anticipate and address risks and should form part of the controls and assurance for mitigating and removing risks; similarly, development or review of policies should identify the risks they are in place to mitigate or remove
- the consequences of a risk occurring will generally stay the same, any treatment of the risk is designed to reduce the likelihood of the risk materialising

6.21. The Trust recognises that it may be necessary to accept a risk, for example, if no further mitigation is possible or if there is an appetite for taking a risk because of

the perceived benefits of doing so. The decision as to whether a risk can be accepted should be made based on the appetite for acceptance and agreed according to the risk escalation framework (see Figure 3). All risks of ≥15 that are accepted must be reviewed and reported to the Group Risk Oversight Committee at least every 12 months or additionally in the event of any changes to the risk score or controls.

6.22. The Trust's Risk Management Handbook provides information about risk treatment and approaches to assuring the effectiveness of actions taken to mitigate the risk.

Risk monitoring

6.23. Risks must be systematically and dynamically monitored and reviewed. Risks are constantly changing and therefore effective control of risk can only be achieved with contemporaneous information on the risks, the controls in place and the provision of evidence that the controls are managing the risk as anticipated.

6.24. All risks that require active and monitored mitigation should be recorded on the Trust's risk register (see the Trust's Risk Management Handbook for details relating to this process).

6.25. The risk register provides the means of describing, scoring and ranking risks. It identifies ownership, controls in place, the need for further reduction and the recording of additional controls that are to be put in place. The overall aim of the risk register is not to document all the risks faced by the Trust, but the more significant ones and to record the action plans to mitigate those risks to acceptable levels.

6.26. All records of risk assessments on the Trust's risk register should include specific components (see Figure 4) which support the documentation of the severity of the risk and the likelihood of it occurring in order, taking account of the '**existing controls**' to identify the '**inherent**' risk score and also the '**residual**' risk score, which is what the score will decrease to following implementation of '**planned actions**'. In addition, the risk assessment should include a '**target**' score (see 5.3.2.).

Figure 4: Specific Components of a risk assessment	
Component	**Assessment information sourced from**
Inherent Risk	Risk and Control Self-Assessment Key Risk Indicators
Existing Controls	Risk and Control Self-Assessment Key Control Indicators Controls assurance
Planned actions	Designed to add new control and mitigation measures
Residual Risk	Risk and Control Self-Assessment Residual risk Key Risk Indicators Risk Incidents
Target Risk	Based on risk appetite, the level of risk of the Trust wants to take, and what level of risk is acceptable

6.27. The Trust's risk register therefore provides a Trust-wide database of all risks faced by the Organisation, categorised by their risk score, their combined consequence and likelihood. This is an invaluable source of information for the Trust and supports the effective escalation of significant risks aligned to the Trust's risk tolerance (see 6.14).

6.28. The Trust's Risk Management Handbook provides standard operating procedures for the management of the Trust's risk register at service, Organisation, and corporate levels, providing explicit guidance in relation to the management and escalation of risks with a potential Trust-wide impact, or those relating to a Single Hospital Service.

Communicate and consult, adapt and learn

6.29. The Trust is committed to communicating and consulting about risk widely, including with external stakeholders as appropriate, at each stage of the risk management process.

6.30. The Trust established an Integrated Governance and Risk Committee to support the optimising and integration of transferable learning from the management of risk across the Trust.

7. Strategic Risk and Assurance

7.1. Boards of all provider organisations are required to ensure there is an effective and comprehensive process in place to identify, understand, monitor, and address current and future risks to the achievement of their Strategic Objectives. The purpose of the Board Assurance Framework (BAF) is to bring together all the risks the Organisation faces that threaten its ability to achieve its Strategic Objectives together with objective evidence and assurance of how those risks are being mitigated.

7.2. The BAF document identifies the Strategic Objectives, the risks in achieving those objectives, the level of risk, source and quality of assurance, and a high-level position statement. The document is structured to satisfy the requirements of Trust regulators and supports the Annual Governance Statement.

7.3. The Trust's risk register is structured to allow risks to be linked (for instance risks being managed within a Hospital Site, Managed Clinical Service, Local Care Organisation or corporately that are related to risks that have been escalated for strategic oversight) and contextualised within a principal risk infrastructure.

7.4. All risks are analysed and themed into a suite of principal risks, aligned to the Trust's Strategic Objectives these principal risks are categorised as follows: There is a risk that the Trust fails to:

- maintain the quality of patient services
- sustain an effective and engaged workforce
- maintain operational performance
- maintain financial sustainability
- deliver the required transformation of services
- achieve sustainable contracts with commissioners
- deliver the benefits of strategic partnerships
- maintain a safe environment for staff, patients, and visitors

- meet regulatory expectations, and comply with laws, regulations, and standards
- continually learn and improve the quality of care for patients

7.5. The Board Assurance Framework is an interactive tool and used throughout the governance of the Organisation to support risk and assurance processes. It is considered by the Board of Directors bi-annually.

8. Accountability and Responsibility: Board and Committee Governance

8.1. The Trust has an established Board and Committee governance framework that supports the implementation of this strategy. A summary of the key elements of the Governance Framework is provided in Appendix 2.

8.2. In brief, the Group Board of Directors is accountable for the delivery of this risk management strategy and has a collective responsibility to ensure that the risk management processes provide adequate and appropriate information, and assurances relating to risks which threaten the achievement of the Trust's Strategic Objectives. The Board is required to approve an annual self-certification confirming that risk management systems are effective and fit for purpose. This self-certification includes an assessment of risks which could adversely affect the terms of the Trust authorisation.

8.3. This accountability is underpinned by a committee and governance infrastructure that is designed to provide both effective and proportionate risk escalation and enable scrutiny of assurance.

9. Accountability and Responsibility: Individual Officers

9.1. The **Chair** is a Non-Executive Director who chairs the Board of Directors and the Council of Governors, ensuring the appropriate and proportionate scrutiny of the risk management arrangements within the Trust.

9.2. **Non-Executive Directors (NEDs)** are responsible for providing an additional layer of scrutiny to seek assurance of the effectiveness of the Trust risk management and risk reporting systems. It is the responsibility of the NEDs through the Board level committee structure to assure that risks are appropriately reflected in the delivery of Trust strategic priorities and business objectives.

9.3. **Trust Governors** provide an additional layer of assurance that strategic decisions taken by the Board are informed by the views and opinions of local people, patients, and staff.

9.4. The **Group Chief Executive** has overall accountability for risk management across the Trust and exercises this responsibility through membership of the Trust Board and attendance at the Audit Committee. The Group Chief Executive delegates general risk management responsibilities to all Group Executive Directors. It is the Group Chief Executive who signs off the annual governance statement on behalf of the Board as the Accountable Officer with overall responsibility for risk management. They chair the Group Risk Oversight Committee.

9.5. **Group Executive Directors** are responsible for the identification, assessment, and management of risk within their own area of responsibility as delegated by the Group Chief Executive. All Executive Directors oversee progress and provide position statements within the Board Assurance Framework for their areas of responsibility.

9.6. The **Group Director of Clinical Governance** is responsible for overseeing all elements of the implementation of the Risk Management Strategy across the Trust. They chair the Group Integrated Governance and Risk Committee.

9.7. The **Group Director of Corporate Business/Trust Board Secretary** is responsible for facilitating the population and update of the Board Assurance Framework.

9.8. The **Group Head of Health and Safety** oversee the implementation of the Trust's Health and Safety Strategy and provide specialist health and safety management, advice, and training in order to achieve high standards of health and safety management throughout the Trust in line with the Trust's Health and Safety policies.

9.9. The **Hospital Site, Managed Clinical Service and Local Care Organisation Chief Executives** are responsible for the implementation of this Strategy in their Organisation. They are expected to participate in the strategic development of risk management in the Trust through representation on the Group Risk Oversight Committee. This ensures that the Trust's Strategy, policies, procedures, structure, and decision making on risk management take into account the services provided by each Hospital Site, Managed Clinical Service and Local Care Organisation. They are responsible for ensuring that their Organisation has established, approved, and assured risk management governance framework directly aligned to the Trust Risk Management Framework and Strategy to ensure a consistent approach to risk management throughout the Organisation.

10. Accountability and Responsibility: Managers and staff

10.1. **Clinical, non-clinical and corporate service managers** are responsible for ensuring that risks in their area are identified, monitored, and controlled according to the principles in this Strategy. They must allow time for risk issues to be included in governance meetings to support the effective identification, management, and escalation of risk. Each service manager should identify a designated lead for risk management for their service.

10.2. The **Designated Lead** for risk management should ensure that staff are up to date with all risk management policies, documentation and understand their responsibility for conducting risk assessments, agreeing any action plans to reduce/mitigate risk and for incorporating such plans into the business planning process for their area. The designated lead should ensure that the training needs of the service have been assessed, adequate resource is available for the leadership role and the responsibilities of the leadership role are fulfilled and included within performance reviews.

10.3. **Department and ward managers** are responsible for ensuring that staff in the workplace understand risk management issues, adhere to risk management

policies and procedures, receive, and provide feedback regarding incidents and risks, and adopt changes to practice accordingly.

10.4. **All managers** have a direct responsibility for the health, safety, and welfare of staff and for ensuring a safe environment for the delivery of care. Managers must apply the Trust's Health and Safety policies and ensure that risks of this type are included within risk assessment, risk registers and action planning.

10.5. **All staff**, including those on temporary or fixed term contracts, placements or secondments, and contractors, must keep themselves and others safe. They have a responsibility for managing incidents and risks within their area of responsibility. They must commit to being made aware of their responsibilities and of the risk management process through:

- induction into the Trust or into a new role
- discipline or department specific training
- management and supervisory training
- mandatory update training
- awareness raising or ad-hoc events
- inclusion in personal development plans and appraisal discussion

All staff should contribute to the identification of risk either as part of risk assessment or in reporting any risks, hazards, adverse events, or complaints. All staff should then comply with any action requiring them to reduce risks which have been identified.

11. Training

11.1. Contributing to risk management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all clinical and non-clinical staff.

11.2. A formal risk management training needs analysis will be undertaken every three years to ensure that training provided meets the needs of specific groups of staff. The strategic risk management training needs analysis describes the key training requirements of all staff, including Board members. Progress against the Strategic Risk Management Training Needs Analysis is monitored through the Integrated Governance and Risk Committee, providing assurance to the Group Risk Oversight Committee. Risk management training is part of the mandatory training for all staff. The training needs analysis is included in the Risk Management Handbook.

11.3. The following training and education will be provided to support the implementation of effective governance and the risk management strategy itself.

11.4. The commitment and engagement of the **Board of Directors** within the Organisation is paramount in creating the foundation for the implementation of this strategy and embedding the key principles throughout the Trust. To support this priority, relevant updates and awareness training programmes will be provided by both internal and external experts. For Executive and Non-Executive Directors, this will form part of an ongoing Board development programme.

11.5. Risk management awareness and the identification and management of incidents is a structured part of the induction programme for **new staff**, including medical staff.

11.6. Risk management updates for **all staff** linked to specific clinical risk or health and safety training programmes, including raising awareness of key policies (for instance Health and Safety) will be provided through the Trust-wide and site level governance infrastructure.

11.7. Training for **line managers** in risk assessment and grading, high impact learning assessment processes following an incident, and the use of data and intelligence to support the identification of latent risk (for instance in variability in performance) will be provided, developed from the outcome of the training needs analysis.

12. Monitoring and assurance

12.1. Compliance with the Risk Management Strategy will be monitored through an annual report presented to the Group Risk Management Committee in May each year. The Annual Report will confirm, as a minimum:

- the key individuals for risk management that are discharging their responsibilities in line with the Strategy through attendance at key committees and there is evidence of activity through the minutes of those meetings
- the Board level Committees have discharged their responsibilities in line with their terms of reference in areas relating to risk management and escalation, including reporting arrangements into and between committees aligned to committee workplans and the Trust risk escalation framework
- the Board of Directors (through the work of the Group Risk Oversight Committee) and other Scrutiny and Operational Committees review the Organisation wide risk register aligned to the Risk Escalation Framework as identified in the minutes of appropriate meetings
- risks are assessed using a standard template and a Trust-wide grading matrix in line with the Risk Management Handbook
- risk is managed locally through review of incident reporting, compliance with the Trust wide clinical and non-clinical risk assessment process and evidence of maintenance of risk registers across the Trust, as evidenced through the work of the Integrated Governance and Risk Committee

12.2. Where deficiencies are identified in the annual report, an action plan to address recommendations made will be assured through the Group Risk Oversight Committee.

13. Equality, Diversity and Human Rights Impact Assessment

13.1. The Trust Risk Management Framework and Strategy 2022-25 has been assessed by the author using the Trust's Equality, Diversity and Human Rights Impact Assessment.

13.2. The Equality, Diversity and Human Rights Impact Assessment score is in the low priority category[1].

[1] Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015.en.pdf

14. Consultation, approval, and ratification process

14.1. The main local stakeholders are all represented in the Foundation Trust Governors, part of whose role is to ensure that the Trust operates in a way that is consistent with its statement of purpose. To ensure that all interested parties can keep themselves fully informed, this Risk Management Framework and Strategy is available on the Trust's website.

14.2. The key corporate stakeholders for this Framework and Strategy are:

- Hospital Sites/Managed Clinical Services/Local Care Organisation
- Manchester Health and Care Commissioners
- Greater Manchester Health and Social Care
- Care Quality Commission
- NHS England/Improvement
- Health Education North West

14.3. The updates made to the Framework and Strategy do not impact the stakeholders apart from the Hospital Sites/MCS/LCO. A six-month programme of engagement was undertaken with Governance leads from each of the Organisation to support the redevelopment of this Framework and Strategy.

14.4. The Framework and Strategy was circulated for consultation to the members of the Integrated Governance and Risk Committee, Corporate Directors, and the Executive Directors for review prior to submission to the Group Risk Oversight Committee for approval. When all comments were received, these were retained for governance purposes and amendments are made as deemed appropriate by the author.

14.5. The Trust Risk Management Framework and Strategy will be ratified by the Board following approval at the Group Risk Oversight Committee. The ratification of the Risk Management Framework and Strategy 2022-25 must be documented in the Board minutes.

15. Dissemination and implementation

15.1. To effectively deliver this Risk Management Framework and Strategy there will be an action plan implemented which is designed to deliver:

- an articulated and demonstrated Board commitment to risk management
- a clearly articulated organisational risk appetite described and ratified on at least an annual basis by the Group Risk Oversight Committee on behalf of the Board of Directors
- incorporation and integration of all risks from all sources into risk register development and oversight, aligned to the principal risk structure
- integration of processes and decisions about risk into future business and strategic plans
- an effective Trust Governance and Quality Framework to support the effective application of this Strategy
- integration of all sources of information, both reactive i.e. as a result of something that has happened (e.g. incidents) and proactive i.e. anticipating what could or might happen (e.g. risk assessments)

- comprehensive systems of risk assessment to improve clarity and communication of risk, articulated in a risk management handbook
- implementation of a consistent approach to risk management training
- staff participation, consultation, and accountability in risk management processes
- effective systems to ensure that risks identified from organisational and service transformation are incorporate into operational risk assessments and mitigation strategies
- effective mechanisms for incidents to be immediately reported and categorised by their potential impact, consequences and investigated to determine and learn from system failure or variability in an open and fair manner
- formal and effective mechanisms to measure the effectiveness of risk management strategies, plans and processes, mapped against national and regulatory standards: an assurance framework and map
- preventative risk management principles and processes applied to the management of facilities amenities and equipment
- risk management principles and processes applied to contract management especially when acquiring, expanding, or outsourcing services
- safe systems of work and practice in place for the protection and safety of patients, visitors, and staff
- plans for emergency preparedness, emergency response, business continuity and contingency
- application of this Strategy across the Organisation, including hospital sites, managed clinical services, the Local Care Organisation and corporately

15.2. The ratified Strategy will be available on the Trust Intranet under the Policies section, and this will be communicated through various channels.

15.3. The Strategy will be sent electronically to all key stakeholders.

15.4. Progress on implementation of this Strategy will be reported to the Group Risk Oversight Committee.

16. Appendices

Appendix 1: Risk Appetite Matrix
Appendix 2: Risk Management Governance Infrastructure

Appendix 1: Risk Appetite Matrix to support sensitive decision making[2]						
	0 Avoid	**1 Minimal**	**2 Cautious**	**3 Open**	**4 Seek**	**5 Mature**
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	ALARP (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low-cost option as Value for M is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. Value for Money (VfM) is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic, but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovative/ Quality/ outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/ technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

[2] Risk Appetite for NHS Organisations A matrix to support better risk sensitivity in decision taking www.goodgovernance.org.uk

Appendix 2: Governance Framework supporting risk management		
Level	**Structure**	**Function in relation to the Risk Management Strategy**
Holds to account	Council of Governors	The Council of Governors is responsible for holding the Non-Executive Directors to account for the performance of the Board of Directors on behalf of the Foundation Trust membership. In relation to risk management, they are presented with the Trust's annual accounts (including the Annual Governance Statement), any report of the auditor on them and the annual report at a general meeting of the council. The presentation of the annual report and accounts means that the Council can provide feedback to the board of directors based on its view of the overall performance of the board.
Accountable	Board of Directors	The Board of Directors has a clear focus on ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to observe the principles set out in the NHS Improvement NHS Foundation Trust Code of Governance. The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy through the Council of Governors. The Board of Directors receives exception reports against performance and quality standards, and these assist the Board in scrutinising areas of high risk. The Board Assurance Framework is used to understand the impact of those areas of high risk on the achievement of the Trust's strategic objectives. The Board of Directors is responsible for • Monitoring progress against the Trust's Strategic Objectives • Identifying the significant risks that may threaten the delivery of the strategic objectives • Maintaining dynamic risk management arrangements including a well-founded risk register and Board Assurance Framework It is essential that the Board knows what key risks are and is satisfied that they are being properly managed.
Assuring (Trust-wide)	Audit Committee (Board Sub-Committee)	The Audit Committee reviews the establishment and maintenance of an effective system of audit, risk management and internal control across the whole of the organisation's activities that supports the achievement of the organisation's objectives. Of particular relevance the Committee reviews the adequacy of • The processes supporting all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission standards), together with any accompanying Head of Internal Audit statement, external audit opinion or any other appropriate independent assurance • The underlying assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks related to the appropriateness of the above disclosure statements • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the counter fraud and security management service.
Assuring (Trust-wide)	Group Risk Oversight Committee (GROC) (Board Sub-Committee)	The GROC, chaired by the Group Chief Executive, attended by all Executive Directors and with senior representation from all sites/MCS/LCO, has oversight of all risks scoring 15 or more across the organisation on a bi-monthly basis, together with exception reports relating to new, escalating, or updated risks scoring 15 or more. A detailed review of all risks scoring 15 or more is scheduled based on the immediacy of the risk or the complexity of the mitigation. In addition, other risks are considered by the Committee, escalated through the governance infrastructure, where because of interdependencies with other risks they are deemed to have a potential significant impact on the delivery of the Trust's Strategic Objectives. The GROC also considers risks escalated for review/support by Hospitals/MCS/LCO where further mitigation is outside of the control of the Hospital/MCS/MLCO (for example a national tariff issue). The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues The GROC considers risks in the principal risk infrastructure, supporting the management of the Board Assurance Framework, particularly in identifying gaps in assurance in relation to risk mitigation effectiveness. The work of the Committee also supports the compilation of the Annual Governance Statement.
Assuring (Trust-wide)	Board Sub-Committees	The Board Sub-Committees, chaired by Non-Executive Directors, provide the Board of Directors with assurance that effective risk management and governance arrangements are in place in relation to their areas of work, Quality and

		Performance, Finance, Human Resources and Group Management. The Committees receive reports describing routine assurance in relation to the effectiveness of controls, and reports by exception where risks, gaps in assurance or negative assurance have been identified. The Board-Sub Committee monitor progress with the delivery of the Trust's strategic objectives and approve the related commentary and content within the Board Assurance Framework.
Responsible	Executive Director Chaired Committees	The Board Sub-Committees are supported by the work of Executive Director chaired Committees. These Committees, based on an established workplan, provide the Board Sub-Committees with assurance that effective governance associated with risk management is in place, including the effectiveness of risk escalation and assurance processes relating to areas of risk. A number of these Committees are part of a specific statutory framework, for instance Infection Prevention and Control, Information Governance and Health and Safety. These Committees receive assurance and escalation from a range of Committees and Groups
Responsible	Integrated Governance and Risk Committee	The Group Integrated Governance and Risk Committee is responsible for ensuring the delivery of the Risk Management Framework and Strategy and its integration with the Group Assurance Strategy. The Committee profiles risk across the organisation, ensuring risk interdependencies, learning and Trust-wide risks are being managed appropriately. The Committee also identifies areas of regulation and legislation where risks. These Committees receive assurance and escalation from a range of Committees and Groups to compliance have been identified and uses the Trust's Assurance Framework, Map and Strategy to ensure actions taken in mitigation are effective and that there is appropriate escalation of risk. The IGRC reports into the GROC.
Accountable	Hospital/MCS/LCO Management Boards	The Hospital/MCS/LCO Management Boards are responsible for the management of the Hospital/MCS/LCO and for ensuring proper standards of corporate governance are maintained throughout the organisation. The Management Boards account for the performance of each individual organisation and receives exception reports against performance and quality standards and these assist in scrutinising areas of high risk**.** The work of the Management Boards is supported by a committee and governance infrastructure as defined in each Hospital/MCS/LCO's Governance Framework. The Management Boards are responsible for the escalation of risks scored at 15 or over to the GROC for scrutiny

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Tim Barlow, Deputy Group Chief Finance Officer Edd Berry, Programme Finance Director
Date of paper:	May 2022
Subject:	Proposed Amendments to Standing Financial Instructions (SFIs) and Scheme of Delegation (SORD)
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:	Requirement of the MFT Constitution (and supporting annexes) relating to core governance documents
Recommendations:	To approve the updated Standing Financial Instructions (SFIs), and Scheme of Reserved Decisions and Scheme of Delegation (SORD) as reviewed by the Audit Committee in April 2022
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Amendments to Standing Financial Instructions (SFIs), and Scheme of Delegation (SORD)

1. Introduction

1.1 The purpose of this paper is to present the updated Standing Financial Instructions (SFIs) and Scheme of Reserved Decision and Scheme of Delegation (SORD) for approval. These documents have been reviewed by the Audit Committee in April 2022.

1.2 Both documents should be reviewed again during the course of 22/23 in light of any changes in connection with governance or structure of reporting and levels of delegation that result from the introduction of the Integrated Care System and Integrated Care Board in Greater Manchester.

2. Review and Amendments

2.1 The SFIs and SORD are generally reviewed annually to ensure they remain up to date and are fit for purpose and in so doing support robust governance throughout the organisation. Proposed changes have been identified through a process of engagement and internal review, with comments incorporated from Non-Executive Directors, Executive Directors and Corporate Directors and for further rigor, via a review of recent updates to SFIs and SORD published by NHS peer organisations (for example the Shelford Group of Trusts). All updates have then been combined for final review by the Audit Committee.

2.2 The latest review of these documents has incorporated changes to the following section (paragraph references in brackets) along with minor updates to reflect changing job titles and external organisational changes:

- Inclusion of additional guidance surrounding the use of payment cards (5.5)
- NHS Contracts – minor change to improve clarity (6)
- Clarity on scope of remuneration committee (7.1.1)
- New section detailing Information Technology security within the context of financial data (20)
- Additional section detailing guidance related to Research and Innovation funding (21)

2.4 Changes to the Scheme of Reserved Decisions and Scheme of Delegation include:

- Clarification on the sign off of lease contracts, with those above £1m requiring Board approval
- Change in approval levels for Research and Innovation to match NHSE/I guidance
- Clarification surrounding the sign off for group corporate business cases
- Regrouping of asset related rules into the Asset Management section

3. Recommendation

3.1 The Board is asked to approve the updated Standing Financials Instructions and Scheme of Delegation as reviewed by the Audit Committee.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

DOCUMENT CONTROL PAGE

Title	**Title: Scheme of Reserved Decisions and Scheme of Delegation** **Version: 4** **Reference Number:**
Supersedes	**Supersedes: Scheme of Reserved Decisions and Scheme of Delegation Version 3 – April 2020** **Significant Changes: Changes to lease sign off limits and R&I approval limits** **Additions: n/a**
Originator	**Originated By: Jenny Ehrhardt** **Designation: Group Chief Finance Officer** **Modified by: Jenny Ehrhardt, Tim Barlow** **Designation: Group Chief Finance Officer, Deputy Group Chief Finance Officer**
Ratification	**Referred for approval by: Audit Committee** **Date of Referral: 9th May 2022** **Board of Directors Approved:**
Application	**All Staff**
Circulation	**Issue Date: May 2022** **Circulated by: Deputy Group Chief Finance Officer** **Dissemination and Implementation:**
Review	**Review Date: June 2023** **Responsibility of: Group Chief Finance Officer**
Date placed on the Intranet: (tbc)	**EqIA Registration Number : 20/16**

SCHEME OF RESERVED DECISIONS AND SCHEME OF DELEGATION

Contents

SCHEME OF RESERVED DECISIONS AND SCHEME OF DELEGATION

1. INTRODUCTION

1.1 This Schedule of Reserved Decisions and Scheme of Delegation sets out all the roles and decision levels by which the Board of Directors operates. Many of the areas shown can be linked to specific paragraphs in the Standing Orders, Standing Financial Instructions or Procurement Regulations and these should also be consulted as required. (The Schedules are set out in the following tables).

1.2 The general description of the roles of the Board of Directors, the Chairman, the Group Chief Executive Officer and Group Executive Directors, are shown below followed by descriptions of the role/decision level in more specific areas which are part of the Trust's regular business.

2. GENERAL CONDITIONS

2.1 All powers are vested in the Board of Directors and remain to be exercised by the Board unless specifically delegated within a scheme of delegation authorised by the Board.

- The ultimate responsibility for all decisions taken under delegated powers remains with the Board of Directors
- Decisions made under delegated powers must comply with statutory and legal provisions, with Trust policy and regulations and must not incur expenditure that is not provided for, in the Trust's Business Plan (revenue or capital budget).
- No Committee may exercise powers greater than those available to the Board of Directors or greater than those specifically delegated by the Board.
- It is the responsibility of each Chairman (or acting Chairman) of each Committee, operating within delegated powers, to ensure that:
    - Business is conducted in accordance with formal agenda reports.
    - Minutes are compiled in respect of all business considered at meetings and that those minutes are comprehensive and clear and adequately reflect the considerations and decisions made.
    - Minutes of meetings including reference to decisions taken, should be submitted to the Board of Directors at the earliest practical opportunity, but in any case on a regular and timely basis.

3. ROLE OF THE BOARD OF DIRECTORS

3.1 The Trust sets the strategic direction of the organization having regard to NHS I Single Oversight Framework and overall NHS policy, sets objectives and the plans to meet them and oversees their delivery. It aims to ensure high standards of corporate governance and personal behaviour in the conduct of business with high standards of financial stewardship and value for money and achieves this through officers led by the Group Chief Executive Officer and a team of Group Executive

Directors who will advise and appraise – it is important to note that the Board of Directors function as a unified Board as opposed to individuals' accountabilities.

4. ROLE OF THE CHAIRMAN

4.1 The Chairman acts as the main link in communication between the Group Chief Executive Officer and the Board of Directors; to provide a focus for Directors' views; to act on behalf of the Board between meetings where necessary and to report on such actions where appropriate; to advise and guide the Group Chief Executive Officer; and to maintain close contact with Governors and other NHS Chairmen; to act as the main spokesperson for the Board. The Chairman also has a responsibility for authorising, on behalf of the Trust, urgent actions in respect of appropriate matters. In the event of the absence of the Chairman, the Deputy Chairman will deputise over the whole range of the Chairman's responsibilities.

5. ROLE OF THE GROUP CHIEF EXECUTIVE OFFICER

5.1 The Group Chief Executive Officer is directly accountable to the Board of Directors in relation to the performance of all of the Trust's functions. Whilst Group Executive Directors have a crucial role in the development of policy, The Group Chief Executive Officer is ultimately responsible for advice to the Board and for ensuring that the Board's policies and decisions are implemented. The only exception to this is when advice is given by other officers in their professional capacity.

6. ROLE OF THE GROUP EXECUTIVE DIRECTORS

6.1 Responsible to the Group Chief Executive Officer for the scope of work delegated to them and for assisting him in the formulation of policy and advice to the Board. It is an intrinsic part of the organisation that Group Executive Directors work closely together.

7. ROLE OF EMERGENCY ACCOUNTABLE OFFICER

7.1 Responsible to the Group Chief Executive Officer in the event of a designated national or local emergency the Emergency Accountable Officer (normally the Group Chief Operating Officer) shall have additional delegated authority over resources including workforce, finances and estates and facilities for the duration of the emergency - see Appendix B.

8. EQUALITY IMPACT ASSESSMENT

8.1 This document has been Impact assessed by the author using the Trust's Equality Impact assessment (EqIA)

8.2 The Equality Impact Assessment has been completed and submitted to the Equality and Diversity Team for equality sign off.

9. CONSULTATION APPROVAL AND RATIFICATION PROCESS

9.1 The main Internal Stakeholders for the purpose of this document are the Trust Directors and Senior Leaders and those tasked in supporting due and appropriate governance.

10. DISSEMINATION AND IMPLEMENTATION

10.1 To be placed on the Intranet for leaders and staff to reference as required.

11. STANDARDS AND KEY PERFORMANCE INDICATORS

11.1 This document should be reviewed every three years or when there are significant changes to the document.

12. REFERENCES AND BIBLIOGRAPHY

12.1 Trust Standing Orders (Trust intranet)
Standing Financial Instructions

13. SCHEME OF DECISION AND SCHEME OF DELEGATION

Governance
Finance
Procurement
Human Resources
Asset Management
PFI Approvals
Corporate Investments
Contracts for Provision of Services.

14. APPENDICES

Appendix A - PFI Scheme of Delegation
Appendix B – Process in the event of a national or local emergency

Scheme of Reservation and Delegation – Detailed Schedules

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
1.	Governance					
1.1	Standing Orders/ Standing Financial Instructions (Sos / SFIs)	Approves	Chairman in conjunction with the Group Chief Executive Officer and Board Secretaryis the final authority in interpretation of Sos and the Audit Committee for SFIs	Responsible for creation/submission of Standing Orders or through delegation to GDWCB.	GCFO responsible for creation/ amendment of SFI's and submission for approval	SFI 1.2.1 (c) SFI 1.2.1 (d) SFI 1.2.2
1.2	Audit Arrangements	Approval through Audit Committee. Action on points raised by External Auditors			GCFO manages the arrangements for the provision of external and internal audit. Advises Chairman/GCEO on points raised by auditors	SFIs 2
1.3	Emergency Powers / Urgent Decisions		In conjunction with the Group Chief Executive Officer takes action as appropriate and reports to the next Board meeting			SFI 1.2.3 SO 7
1.4	Health and Safety Arrangements	Approves policy on Health & Safety and arranges for the undertaking of specific reviews on the advice of the Risk Oversight Committee		Overall responsibility for operational arrangements with delegation to GDWCB	GDWCB to ensure effective implementation of Trust policy to monitor on a day-to-day basis and to advise GCEO of requirements. GDs / Senior Managers responsible for arrangements within their scope of operation	
1.5	Code of Conduct, Hospitality etc.	Approves overall policy.	Approval of attendance at conferences or similar visits by Non-Executive Directors and GCEO	Overall responsibility for the arrangements for Director/Officer hospitality in line with Trust policy and national guidance.	GDWCB to ensure that the Trust's Code of Conduct for Directors and Employees is brought to the attention of staff including new starters.	SFI 15

KEY:						
	GCEO	Group Chief Executive Officer	GMD	Group Medical Directors	AMD	Associate Medical Director
	GDCEO	Group Deputy Chief Executive Officer	GCN	Group Chief Nurse / Director of Patient Services	GDWCB	Group Director of Workforce and Corporate Business
	GCFO	Group Chief Finance Officer	GDs	Group Directors	DRI	Director of Research and Innovation

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
1. Governance					
1.6 Risk Management	Approves Policy. Receives regular reports on quantified Risks from the Risk Oversight Committee. Through the Audit Committee approves Statement on Internal Control.		Overall responsibility for Risk Management. Delegatedto JGMD. Signed Statement on Internal Control.	GMD to ensure that the Risk Management Policy is implemented. Advises Board and GCEO of significant risk. GED's/Senior Manager responsibility to put in place Risk Management for arrangements within the scope of operations and for taking appropriate action based upon risk assessments.	
1.7a Sealing of Documents	Receives Annual Reports on the documents on which the Common Seal has been fixed in the presence of Chairman (or a Group Non Executive Director) and Group Chief Executive Officer (or a Group Director)	Chairman to be present or a Group Non-Executive Director and to be attested by him/her	Group Chief Executive Officer to be present or a Group Director, and to be attested by him/her		SO 13.3
1.7b Signing of Documents	Contracts above £1m approved by Board			Limits for signing contracts for goods and services received or provided excluding the NHS Contracts & SLAs (SFIs 6):- Hospital / Divisional / Corporate Director £250,000 Deputy Group CFO £500,000 Group CFO £1m Lease documents for Clinical, Business and Residential Accommodation shall be signed by the Group Director of Estates and Facilities upto a total lifetime cost of £1m. Lease documents for all accommodation with a lifetime cost of greater than £1m require approval by the Board of Directors before signature by the Group Director of Estates and Facilities.	
1.8 Complaints against the Health Service	Assesses and actions reports submitted on complaints or allegations of ill treatment/inappropriate treatment.		Advises Chairman/Board on specific issues.	GCN advises GCEO on specific issues.	

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
1. Governance					
1.9 Research & Innovation	Approves policy and strategy having regard to the advice of the Research Governance Committee.		Reports Research and Innovation performance and governance to Board of Directors	JGMD to put in place an effective Research Governance System and reporting. Divisional Director of Research and Innovation approves and signs research contracts. DRI issues Honorary Research contracts.	
1.10 Data Protection	To ensure policy on data protection is effective.			GCFO in line with statute and Trust policy to nominate a Data Protection Manager. Reports to Board annually and as required.	
1.11 Research Grants				Submission of the bids and approval of contracts for research grant funding. Limits for signing bid and contractsfor research grant funding:- Managing Director of Research and Innovation approves all — Up to upper NHS E/I grant limit (currently £0.5m) Group Chief Executive Officer approves all above — Above upper NHS E/I grant limit (currently £0.5m)	SFI21

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
2.	Finance					
2.1	Business Plan, Budget, Annual Report and Accounts	Accepts and approves reports submitted by the GCEO/GCFO		Approves Business Plans of the Trust and of Hospital units. Annual Report and Accounts for submission to the Board of Directors.	GCFO overseas the development of financial plans for the Trust and for constituent Hospital units and presents summary plan and financial reports to the Board.	SFI 3
2.2	Delegation of Budgets and Approval to spend.	Accepts and approves delegated budgets		· Regulatory positioning & overall financial strategy · Assessment of risk / escalation status appropriate for each Hospital · Decisions on recovery time boundaries & whether Turnaround programme required · Decision on trigger point for and specific nature of 'Financial Special Measures' based on Accountability Oversight Framework (AOF)	· Financial strategy and Operational Plan - Hospital/MCS/LCO/Corporate Budget Setting and Operational Delivery of Financial Plan · Hospital/MCS/LCO/Corporate level Scheme of Delegation (Items outside of local levels of delegate schemes refer to Scheme of Delegation) · Financial authorisation controls	SFI 8.1.1
2.3	Service Development & Business Cases (including responding to Health Tenders/ Contracts)	Approves Trust's Annual Plan and any in-year developments exceeding delegated limits of Hospitals / Divisions		As Trust's accountable officer is responsible for the legality of service developments & approves in-year developments up to delegated limits.	Approval of business cases at Hospital Chief Executive level if the 5 year gross costs are < 2% of annual Hospital budget. (This is subject to AOF review process) Provided that overall integrity of Hospital forward plan is delivering the required bottom line control total position and this is maintained throughout the period covered. Approval of Group Corporate business cases up to £1m Executive Group Director. Up to £5m to be approved by GCFO. Business cases above £5m approved by Board.	SFI 10.1.1
2.4	Operation of all Detailed Finance Matters including Bank Accounts and Banking Procedures.				GCFO to be responsible for the implementation of the Board's financial policies, in accordance with SFIs.	SFIs

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
2. Finance					
2.5 Banking	All banking arrangements must be approved by the Board of Directors.			GCFO to advise the Board on: Banking needs The provision of banking services The need for re-tendering. GCFO to stipulate operational and day-to-day controls.	SFI 4
2.6 Insurance Arrangements	Approves insurance portfolio.		Reports to Board on potential insurable risks.	GCFO draws up insurance portfolio recommendations. JGMD responsible for R&I clinical indemnity arrangements.	SFI 17
2.7 Management and Control of stocks				GCFO defines what is to be classed as stock and the controls and records required. Hospital Chief Executives are responsible for stocks under their control but may delegate day-to-day control to Divisional Directors/Heads of Department.	SFI 11
2.8 Recording and Monitoring of Payments under the Losses and Compensation Regulations				Directors and Senior Managers will notify GCFO in writing of losses and special payments who will arrange for the appropriate authorisation, notify the GCFO and provide quarterly reports to the Audit Committee. GCFO will notify the GCEO/Chairman/Board of Directors of specific items of a managerial nature without delay.	SFI 12

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
2. Finance					
2.9 Management of Charitable Funds (Endowment Funds)	Approve the composition of Charitable Funds Committee. Charitable Funds Committee approves Charity/ Endowment Scheme of Delegation and sets overall policy on investments and accepts annual progress reports.			GCFO acts as Treasurer to the Charitable Fund Committee GCFO to be responsible for ensuring management and accounting arrangements are in place which must comply with legislation. Fund Advisor Up to £4,999 Directorate Mgr. £5k - £24,999 Divisional Director or Clinical Head of Division £25k-£49,999 Appropriate Group Director / Hospital Chief Executive £50k-£99,999 Charitable Funds Committee Above £100k	SFI 14
2.10 External/Internal Audit	Through the Audit Committee takes necessary action on external audit reports and internal audit provision.		Considers submission to Board of Directors.	GCFO monitors audit issues.	SFI 2

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
3. Procurement					
3.1 General	Agrees Standing Orders regarding tendering.		Ensures compliance with Standing Orders.	GCFO advises GCEO on Standing Order requirements.	SFI 8 & 18
3.2 Receipt and Opening of Tenders				GCFO nominates and authorises Senior Officers and decides on admissibility and acceptance of tenders. Two nominated Senior Officers to open and receive tenders. Neither should have been involved in the commissioning of the work.	Procurement of Goods and Services Policy
3.3 Post Tender Negotiations				GCFO agrees to post tender negotiations taking place. Directors Advise GCFO in writing that post tender negotiations are to take place or are being considered.	Procurement of Goods and Services Policy
3.4 Approvals and Limits	Agrees tendering limits as part of Standing Orders/ Standing Financial Instructions. Approves acceptance of tenders over £5m Waiving of competitive tendering in excess of £500,000			Details of all tenders accepted to be reported to the GCFO. Limits for approving acceptance of tenders:- Hospital Chief Executives/ Group Directors £1,000,000 GCFO £5,000,000 The GCFO authorises waiving of competitive tendering within a limit of £500,000 including VAT	Procurement of Goods and Services Policy

DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
		CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
3. Procurement					
3.5 Ordering Goods and Services			Authorises named individuals to raise and sign orders within prescribed monetary levels.	At all times within approved budgets / business cases (and subject to AoF): Budget Holder/Dept. Head — Up to £5,000 Directorate / CSU Manager — Up to £25,000 Hospital / MCS /LCO/SLT Corporate Directors — Up to £250,000 Group Corporate Directors — Up to £500,000 Group Exec Directors / Hospital / MCS / LCO Chief Executive — Up to £1,000,000 GCFO — Up to £5,000,000 Director of Pharmacy: Pharmaceutical products & medical gases under nationally or locally agreed contract. — Up to £500,000 For orders outwith agreed contracts — Up to £50,000	

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
3.	Procurement					
3.6	Appointment of Management Consultants	Approval of appointments with value in excess of £50,000. Accepts outcome and performance reports and considers value for money of appointments.		Agrees appointments up to £50,000 and all cases where competition is considered to be inappropriate. Considers outcome and performance reports on consultancy appointments for potential submission to Board.	GCFO to follow quotation/tendering procedure where budgetary provision has been made and cost does not exceed £30,000. Approval of GCEO is required when competition is not considered appropriate Relevant GDs to report quarterly on outcomes and performance to GCEO on all appointments with a value in excess of £50,000.	SFI 19

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
4.	Human Resources					
4.1	Remuneration and Terms of Services for GDs	To be determined following recommendations from Remuneration Sub Committee			GDWCB advises Remuneration Sub Committee	SFI 7.1 SFI 7.2
4.2	Personnel Policy Disputes/Arbitration/ Disciplinary Matters	Approves policies for Trust		Determines submission to Board. Approves all recommendations to Remuneration Committee re retire and return arrangements.	GDWCB to prepare options and draft policy in liaison with GDs. GDWCB reports to GDs or Board as required.	
4.3	Education and Training	Approves overall policy and monitors implementation			GDWCB drafts policy in liaison with GDs	
4.4	Workforce Plan	Approves as part of Annual Plan			Hospital / MCS / LCO Finance Director and Hospital / MCS / LCO HR Director for variations to Hospital Operational Plan	SFI 7.6

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
5.	Asset Management					
5.1	Management and Control of Computer Systems and Facilities	Approves overall corporate IT policy on procurement and control of systems and facilities based on reports submitted by GDs.			GCFO co-ordinates IT policy on behalf of Trust and is responsible for ensuring satisfactory arrangements exist for the control and security of hardware, software and data.	SFI 14 SFI 20
5.2	Management of Land and Buildings	Approves the general policy in respect of acquisitions, sale exchange or reservation of land and buildings and also the apportionment of proceeds as required			Group Director of Estates & Facilities to be responsible for the day-to-day management of land and Buildings and surveys of land / buildings for acquisition and disposal. GD E&F responsible for land and building disposal proposals. Sign off in accordance with SFI 10.2.4	SO Appendix A
5.3	Management of medical equipment	Approves overall corporate policy on procurement and control of equipment based on reports submitted by GDs.			GCFO co-ordinates policy on behalf of Trust and is responsible for ensuring satisfactory arrangements exist for the control and security equipment.	SFI 14
5.4	Management of Other Significant Assets			Authorise purchase or determines submission to Board of Directors on the purchase or sale of capital assets	Individual Hospital CE's responsible for assets within their delegated control. Report to GCEO on items with a value of £1,000,000. GMD responsible for Intellectual Property	SF10
6	Capital & PFI Approvals	See Appendix A	See AppendixA	See Appendix A	See Appendix A	

	DESCRIPTION	DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
7.	Corporate Investments					
7.1	Commercialisation of Trust's Intellectual Property	Approves overall corporate policy on any investments in third party corporate vehicles and/or any internal financial support required to protect the Trust's Intellectual Property, based on reports submitted by GDs.			GCFO co-ordinates policy on behalf of Trust and is responsible for ensuring satisfactory arrangements exist for the control on any investments in third party corporate vehicles and/or any internal financial support required to protect the Trust's Intellectual Property.	
7.2	Strategic Alliances, Partnerships and Joint Ventures		Approves the general policy in respect of joint ventures and strategic alliances, based on reports submitted by GD's.		GCFO to be responsible for the structuring of any joint ventures and strategic alliances and the accounting treatment of such transactions.	
7.3	Major Projects	Approves the general policy in respect of acquisitions, sale exchange or reservation of land and buildings and also the apportionment of proceeds as required.			Group Director of Estates & Facilities to be responsible for the design and management of capital schemes, surveys, land and building acquisition and disposal, GDE&F to be responsible for the day-to-day management of land and buildings.	

DESCRIPTION		DECISION BY BOARD	DECISION BY ROLE OF:			SO/SFI REF
			CHAIRMAN	GROUP CHIEF EXECUTIVE OFFICER	DIRECTOR /SENIOR MANAGER	
8.	Contracts for Provision of Services					
8.1	Contracts for Provision of Services	Receives Annual overview of Contract agreements/ baseline and consistency with Annual Budget plan. Receives updates on contractual negotiations and exception reporting on material contractual matters.			Limits for signing formal Contracts/SLA's:- Contracts Director Up to £10,000,000 GCFO signs all contracts with value In excess of £10,000,000 Contracts Director responsible for agreeing baseline values within overall Contracts, and ensuring consistency or variation reporting, comparing to Trust plans contained within the Annual Budget plan.	SFI 6

Appendix A – Capital & PFI Scheme of Delegation

1. Estates Capital & PFI

Value of Variation	Quote/Tender	Adjudicated By	Accepted By
Up to £500,000	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Senior Capital Programme Manager	Director of Estates & Facilities – Development
£500,001 - £1m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Director of Estates & Facilities – Development	Group Director Estates & Facilities
£1,000,001 - £5m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Group Director Estates & Facilities	GCFO and GCOO
Over £5m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Group Director Estates & Facilities	Board of Directors

2. Variations which Affect Services and Result in Changes to Tariff/Unitary Payments

Value of Variation	Quotation	Adjudicated By	Accepted By
Up to £25,000	Variation Confirmation	Service Adviser	Deputy Directors Estates & Facilities ORC, WTWA, NMGH
£25,001 – £250,000	Variation Confirmation	Director of Estates & Facilities ORC, WTWA, NMGH	Group Director Estates & Facilities
£250,001 - £1m	Variation Confirmation	Group Director Estates & Facilities	GCFO and GCOO
Over £1m	Variation Confirmation	Group Director Estates & Facilities	Board of Directors

3. Review, Approval and Certification of Unitary Payment Invoices (within Contract Terms)

By:	Group Director of Estates & Facilities

4. IM&T

Value of Order	Accepted By	Quote/Tender
Up to £500,000	Group Chief Informatics Officer	£10,000 to £49,999.99 incl. VAT the following is required: Minimum of 3 Formal Quotations – these being issued by and returned to the Procurement Team (or nominated officers in Informatics or Estates as appropriate) utilising the Trust Quotation Form and appropriate NHS Terms and Conditions
£250,001 - £5m	GCFO	
Over £5m	Board of Directors	Above £50,000 - Minimum of 3 Formal Tenders issued and received in accordance with Trust Policy

5. Equipment

Value of Order	Accepted By	Quote/Tender
Up to £250,000	Chief Of Staff	£10,000 to £49,999.99 incl. VAT the following is required: Minimum of 3 Formal Quotations – these being issued by and returned to the Procurement Team (or nominated officers in Informatics or Estates as appropriate) utilising the Trust Quotation Form and appropriate NHS Terms and Conditions
£250,001 - £5m	GCFO	
Over £5m	Board of Directors	Above £50,000 - Minimum of 3 Formal Tenders issued and received in accordance with Trust Policy

Appendix B – Process in the event of a national or local emergency

Scheme of Decision making in Event of National / Local Emergency - Oversight by EAO			
Value of Variation	**Quote/Tender**	**Adjudicated By**	**Accepted By**
Up to £500,000	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Senior Capital Programme Manager	Director of Estates & Facilities – Development
£500,001 - £1m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Director of Estates & Facilities – Development	Group Director Estates & Facilities
£1,000,001 - £5m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Group Director Estates & Facilities	GCFO and GCOO
Over £5m	PFI: Project Co Valuation & Q/S advice Non PFI: Valuation & Q/S advice	Group Director Estates & Facilities	Board of Directors

2. Variations which Affect Services and Result in Changes to Tariff/Unitary Payments			
Value of Variation	**Quotation**	**Adjudicated By**	**Accepted By**
Up to £25,000	Variation Confirmation	Service Adviser	Deputy Directors Estates & Facilities ORC, WTWA, NMGH
£25,001 – £250,000	Variation Confirmation	Director of Estates & Facilities ORC, WTWA, NMGH	Group Director Estates & Facilities
£250,001 - £1m	Variation Confirmation	Group Director Estates & Facilities	GCFO and GCOO
Over £1m	Variation Confirmation	Group Director Estates & Facilities	Board of Directors

3. Review, Approval and Certification of Unitary Payment Invoices (within Contract Terms)	
By:	Group Director of Estates & Facilities

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

DOCUMENT CONTROL PAGE

Title	**Title: SFIs - Standing Financial Instructions** **Version: 4** **Reference Number:**
Supersedes	**Supersedes: SFIs Version 3 – April 2020** **Significant Changes: Additional specific SFI guidance for Information Technology and Research & Innovation** **Additions: Information Technology 20, Research & Innovation 21, Purchasing Cards 5.5**
Originator or modifier	**Originated By: Jenny Ehrhardt** **Designation: Group Chief Finance Officer** **Modified by: Jenny Ehrhardt, Tim Barlow** **Designation: Group Chief Finance Officer, Deputy Group Chief Finance Officer**
Ratification	**Referred for approval by: Audit Committee** **Date of Referral: 9th May 2022** **Board of Directors Approved:**
Application	**All Staff**
Circulation	**Issue Date: May 2022** **Circulated by: Deputy Group Chief Finance Officer** **Dissemination and Implementation:**
Review	**Review Date: June 2023** **Responsibility of: Group Chief Finance Officer**

Date placed on the Intranet: (tbc)	**EqIA Registration Number : 20/16**

STANDING FINANCIAL INSTRUCTIONS

Contents

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Standing Financial Instructions (SFIs)

1. KEY OBJECTIVES

1.1 Introduction

1.1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and the Independent Regulator's relevant guidance. They should be used in conjunction with the Scheme of Reserved Decisions and Scheme of Delegation and the standing orders adopted by the Trust.

1.1.2 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including any trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Group Chief Finance Officer. These SFIs do not set out in full the requirements of the Independent Regulator's guidance and all relevant guidance of the Independent Regulator should be consulted. Such guidance will also change over time and these SFIs do not record or reference all such applicable guidance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Group Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

1.1.4 Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal and/or criminal prosecution.

1.1.5 If for any reason these SFIs are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Group Chief Finance Officer as soon as possible.

1.1.6 Officers of the Trust should note that the SFIs, SOs and 'Scheme of Reserved Decisions and Scheme of Delegation' do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation and any applicable judgment of a relevant court of law which is a binding precedent in England) and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to the SOs, SFIs and Scheme of Reserved Decisions and Scheme of Delegation. All such legislation and binding guidance and directions shall take precedence over these SFIs, SOs and the Scheme of Reserved Decisions and Scheme of Delegation. The SFIs, SOs and Scheme of Reserved Decisions and Scheme of Delegation shall be interpreted accordingly.

1.1.7 All policies and procedures of the Trust, to the extent that they are consistent with this SFI, must be followed by all Governors, Directors and Officers of the Trust in addition to the provisions of this SFIs (whether specifically referenced in this schedule or not).

1.2 Responsibilities and delegation

1.2.1 The Board of Directors

1.2.1.1 The Board exercises financial supervision and control at Group level through:

(a) formulating the financial strategy

(b) requiring the submission and approval of the Annual Operational and Financial Plan and budgets including income and both revenue and capital expenditure

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the 'Scheme of Reserved Decisions and Scheme of Delegation'.

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Scheme of Reserved Decisions and Scheme of Delegation' to the Board' document. All other powers have been delegated to such other Committees as the Trust has established.

1.2.3 If ambiguity arises in the interpretation of reserve matters, 'Scheme of Reserved Decisions and Scheme of Delegation' or any specific proposed transaction which does not fit into the above, then the Group Chief Finance Officer will have responsibility for providing clarification and ensuring matters are referred to the Board of Directors as deemed necessary.

1.2.4 The Group Chief Executive Officer and Group Chief Finance Officer

1.2.4.1 The Group Chief Executive Officer and Group Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.2.4.2 Within the Standing Financial Instructions, it is acknowledged that the Group Chief Executive Officer is ultimately accountable to the Board of Directors, and as Accountable Officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Group Chief Executive Officer has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4.3 It is a duty of the Group Chief Executive Officer to ensure that Members of the Board of Directors, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 The Group Chief Finance Officer

1.2.5.1 The Group Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Group Chief Finance Officer include:

i. the provision of financial advice to other members of the Board and employees,

ii. the design, implementation and supervision of systems of internal financial control, and

iii. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 All Employees

1.2.6.1 All staff of the Trust are severally and collectively responsible for:

(a) the security of the property, assets and resources of the Trust

(b) avoiding loss

(c) exercising economy and efficiency in the use of resources

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the 'Scheme of Reserved Decisions and Scheme of Delegation'.

1.2.7 Contractors and Their Employees

1.2.7.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Group Chief Executive Officer to ensure that such persons are made aware of this.

1.2.7.2 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Group Chief Finance Officer.

2. AUDIT

2.1 Audit Committee ("The Committee")

2.1.1 The Committee has been formally constituted as a standing Committee of the Group Board of Directors in accordance with its Standing Orders.

2.1.2 The Committee is authorised by the Group Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any requests made by the Committee.

2.1.3 The Committee is authorised by the Group Board of Directors to obtain outside legal or other independent professional advice. The Committee is authorised by the Group Board of Directors to request the attendance of individuals from outside the Group with relevant experience and expertise if it considers it necessary or expedient to the carrying out of its functions.

2.2 Scope and Duties

2.2.1 Financial Statements and the Annual Report

2.2.1.1 Monitor the integrity of the financial statements of the Group, any other formal announcements relating to the Group's financial performance, reviewing the significant financial reporting judgements contained in them.

2.2.1.2 Review the annual statutory accounts, before they are presented to the Group Board of Directors, in order to consider their compliance, objectivity, integrity and accuracy. This review will cover but is not limited to: the meaning and significance of the figures, notes and significant changes; areas where judgement has been exercised; adherence to accounting policies and practices; explanation of estimates or provisions having material effect; any unadjusted statements; and any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

2.2.1.3 Review the annual report and annual governance statement before they are submitted to the Group Board of Directors to determine compliance, objectivity, integrity and accuracy.

2.2.1.4 Review each year the accounting policies of the Group and make appropriate recommendations to the Group Board of Directors.

2.2.1.5 Review all systems of control including accounting and reporting systems that support the production of the annual report before review by the Group Board of Directors

2.2.2 Internal Control and Risk Management

2.2.2.1 Review the Group's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

2.2.2.2 Review and maintain an oversight of the Group's general internal controls and risk management systems, liaising with separate sub-committees as required.

2.2.2.3 Review processes to ensure appropriate information flows to the Audit Committee from executive management and other Group committees in relation to the Group's overall internal control and risk management position.

2.2.2.4 Review the adequacy of the policies and procedures in respect of all counter-fraud work.

2.2.2.5 Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

2.2.2.6 Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

2.2.3 Whistleblowing

2.2.3.1 Review arrangements, including Freedom to Speak-up provisions that allow staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

2.2.3.2 Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

2.2.4 Corporate Governance

2.2.4.1 Monitor corporate governance compliance (e.g. compliance with terms of the license, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

2.2.5 Internal Audit

2.2.5.1 Conduct an annual review of the provision of internal audit services taking into consideration relevant UK professional and regulatory requirements.

2.2.5.2 Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

2.2.5.3 Oversee on an ongoing basis the effective operation of internal audit in respect of: adequate resourcing; its coordination with external audit; meeting relevant internal audit standards; providing adequate independent assurances; it having appropriate standing within the foundation trust.

2.2.5.4 Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

2.2.6 External Audit

2.2.6.1 Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

2.2.6.2 In line with NFT's constitution, the Council of Governors is responsible for appointing, re-appointing and removing external auditors and will work with the Audit Committee in agreeing the criteria for this. To support them in this task, the Audit Committee should:

- provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees.

- make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

2.2.6.3 Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with internal audit and any other external regulatory body who may contribute to the formation of the audit opinion.

2.2.6.4 Assess the external auditor's work and fees each year and based on this assessment, to make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor.

2.2.6.5 Oversee the conduct of a market testing / evaluation exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

2.2.6.6 Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

2.2.6.7 Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant professional rules and ethical guidance.

2.2.7 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

2.2.7.1 Review on behalf of the Group Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution and standards of business conduct; including maintenance of registers.

2.2.7.2 Examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

2.2.7.3 Review the operation of, and proposed changes to, the Group 'Scheme of Reserved Decisions and Scheme of Delegation'.

2.2.8 Other

2.2.8.1 Review performance indicators relevant to the remit of the Audit Committee. Examine any other matter referred to the Audit Committee by the Group Board of Directors and initiate investigation as determined by the Audit Committee.

2.2.8.2 Develop and use an effective Assurance Framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes, so as to fulfil its functions in connection with the Audit Committee's Terms of Reference and these SFIs.

2.2.8.3 Review the work of all other Group committees in connection with the Audit Committee's assurance function.

2.2.8.4 Consider the outcomes of significant reviews carried out by other bodies including, but not limited to, regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

2.3 Group Chief Finance Officer

2.3.1 The Group Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; ensuring that the internal audit is adequate and meets the NHS internal audit standards, the Audit Code for NHS Foundation Trusts and the Guide for Governors: Audit Code for NHS Foundation Trusts;

(b) ensuring that the Trust maintains adequate counter fraud and corruption arrangements and deciding at what stage to involve the Local Counter Fraud Specialist (LCFS) and/or the police in cases of fraud, misappropriation and other regularities in conjunction with NHS Counter Fraud Authority; and

(c) ensuring there are appropriate terms of reference for the internal audit function, and that these are reflected in the SFIs.

2.3.2 The Group Chief Finance Officer or designated Auditors/LCFS are entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

(b) access at all reasonable times to any land, premises, and members of the Board or Officers of the Trust

(c) the production of any cash, stores or other property of the Trust under a member of the Board and/or Officer's control; and

(d) explanations concerning any matter under investigation

2.4 Role of Internal Audit

2.4.1 In accordance with Public Sector Internal Audit Standards there are two key roles of internal audit:

- The Provision of an independent and objective opinion to the Accountable Officer, the Board, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives.

- The provision of an independent and objective consultancy service, specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.4.2 The Head of Internal Audit will provide an annual opinion statement, in accordance with Public Sector Internal Audit Standards, which will be based on a systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

(a) establish, and monitor the achievement of, the Trust's objectives

(b) identify, assess and manage the risks to achieving the Trust's objectives

(c) ensure the economical, effective and efficient use of resources

(d) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations

(e) safeguard the Trust's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption; and

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes

2.4.3 Where key systems are being operated on behalf of the Trust by anybody external to the Trust, the Head of Internal Audit must ensure arrangements are in place to form an opinion on their effectiveness.

2.4.4 Where the Trust operates systems on behalf of other bodies, the Head of Internal Audit must be consulted on the audit arrangements proposed or in place.

2.4.5 Whenever a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Group Chief Finance Officer must be notified immediately.

2.4.6 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Group Chief Executive Officer of the Trust.

2.4.7 The Group Chief Finance Officer shall produce written procedures for the issue and clearance of audit reports. These shall include the appropriate following action and the steps to be taken when managers fail to take remedial action within the appropriate time period.

2.4.8 Where in exceptional circumstances the use of normal reporting channels could be seen as possibly limiting the objectivity of the audit, the Head of Internal Audit shall have access to report directly to the Chair or Vice Chair of the Board, Chair of the Audit Committee or Group Chief Executive Officer.

2.4.9 The Head of Internal Audit shall be accountable to the Group Chief Finance Officer. The reporting system for internal audit shall be agreed between the Group Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.5. External Audit

2.5.1 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

2.5.2 The Audit Code for NHS Foundation Trusts ("The Audit Code") contains directions of the Independent Regulator under Schedule 7, paragraph 24 of the National Health Service Act 2006, with respect to the standards, procedures and techniques to be adopted by the Auditor.

2.5.3 The Trust shall apply and comply with the Audit Code.

2.5.4 The Auditor shall be required by the Trust to comply with the Audit Code.

2.5.5 SFI 2.5.2 relates equally to internal and external audit.

2.5.6 In the event of the Auditor issuing a public interest report the Trust shall forward a report to the Independent Regulator within 30 days (or such shorter period as the Independent Regulator may

specify) of the report being issued. The report shall include details of the Trust's response to the issues raised within the public interest report.

2.6. Fraud and Corruption & Security Management

2.6.1 The Trust shall take all necessary steps to counter fraud, bribery and corruption and deal effectively with security management issues affecting NHS funded services in accordance with:

(a) the NHS Anti-Fraud Manual published by NHS Counter Fraud Authority (previously known as the Counter Fraud and Security Management Service (CFSMS) and then NHS Protect until 2017)

(b) The requirements of the NHS Standard Contract clauses that relate to anti-crime measures

(c) the policy statement "Applying appropriate sanctions consistently" published by NHS Counter Fraud Authority.

(d) any other reasonable guidance or advice issued by NHS Counter Fraud Authority that affects efficiency, systemic and/or procedural matters; and

(e) the security management manual

2.6.2 The Group Chief Executive Officer and Group Chief Finance Officer shall monitor and ensure compliance with the above.

2.6.3 The Trust shall nominate a suitable person to carry out the duties of the local counter fraud specialist (LCFS) and local security management specialist (LSMS) in accordance with relevant NHS Counter Fraud Authority guidance and NHS Standard Contract clauses.

2.6.4 The Group Chief Finance Officer shall instruct the Internal Auditor to investigate any breaches of the Standing Orders and Standing Financial Instructions as he/she may deem appropriate and necessary. Where there is evidence to suggest misappropriation has taken place, the Group Chief Finance Officer shall instruct the LCFS to investigate as he/she deems appropriate and necessary.

2.6.5 The LCFS and LSMS shall report to the Group Director of Finance and shall work with staff in NHS Counter Fraud Authority in accordance with the Department of Health anti-fraud manual and NHS Standard Contract clauses.

2.6.6 The LCFS will provide periodic updates, including a written annual report, on anti-fraud, bribery and corruption activities undertaken across the Trust.

3. ANNUAL ACCOUNTS AND REPORTS

3.1 Annual Accounts

3.1.1 NHSE/I may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts. The accounts are to be audited by the Trust's external Auditor. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

(a) the accounts

(b) any records relating to them; and

(c) any report of the external Auditor on them.

3.1.2 The Trust is to prepare in respect of each financial year annual accounts in such form as NHSE/I may direct with the approval of the Secretary of State. NHSE/I may with the approval of the Secretary of State direct a Trust:

(a) to prepare accounts in respect of such period or periods as may be specified in the direction

(b) that any accounts prepared by it by virtue of paragraph (a) are to be audited in accordance with such requirements as may be specified in the direction.

3.1.3 In preparing its annual accounts or in preparing any accounts by virtue of 4.1.3 (a) the Accounting Officer shall cause the Foundation Trust to keep proper accounts and proper records in relation to the accounts that comply with any directions given by NHS E/I with the approval of the Secretary of State as to:

(a) the methods and principles according to which the accounts are to be prepared

(b) the content and form of the accounts.

3.1.4 The annual accounts, any report of the external Auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

3.1.5 The Trust shall:

(a) lay a copy of the annual accounts, and any report of the external Auditor on them, before Parliament; and

(b) send copies of those documents to NHS E/I within such a period as NHS E/I may direct:

i. a copy of any accounts prepared by virtue of 4.1.3 (a); and

ii. a copy of any report of an auditor on them prepared by virtue of 4.1.3 (a).

3.1.6 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Group Chief Executive Officer.

3.2 Annual Report

3.2.1 The Trust is to prepare annual reports and send them to NHSE/I, the Independent Regulator. The reports are to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies and the classes of the staff constituency is representative of those eligible for such membership;

(b) information on the Trust's policy on pay and on the work of the committee established and such other procedures as the Trust has on pay; and

(c) information on the remuneration of the directors and on the expenses of the governors and directors; and

(d) any other information NHSE/I, the Independent Regulator requires.

3.2.2 The Trust is required to comply each year with the requirements of any guidance issued by NHS E/I (currently NHSE/I's NHS Foundation Trust Annual Reporting Manual (FT ARM)) with regard to:

(a) the form of the reports

(b) when the reports are to be sent

(c) the periods to which the reports are to relate.

3.3 Annual Plan

3.3.1 The Trust is to give information as to its forward planning in respect of each financial year to NHS E/I. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

4. BANKING

4.1 General

4.1.1 The Group Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will consider guidance/ directions issued from time to time by NHSE/I or HM Treasury. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using the Government Banking Service (GBS) accounts for all banking services.

4.1.2 The Board shall approve the banking arrangements.

4.2 Bank and GBS Accounts

4.2.1 The Group Chief Finance Officer is responsible for:

(a) bank accounts and the Government Banking Service (GBS) accounts

(b) establishing separate bank accounts for the Trust's non-exchequer (Charitable) funds

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn

(e) monitoring compliance with the Independent Regulator's guidance on the level of cleared funds

4.3 Banking Procedures

4.3.1 The Group Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

4.3.2 The Group Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

4.4 Tendering and Review

4.4.1 The Group Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

4.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

5. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

5.1 Income Systems

5.1.1 The Group Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

5.1.2 The Group Chief Finance Officer is also responsible for the prompt banking of all monies received.

5.2 Fees and Charges

5.2.1 The Trust shall follow the Department of Health advice in the Payment by Result (PbR) guidelines and any other applicable guidance in setting prices for contracts with NHS Commissioners for all services falling within PbR or other nationally agreed methodology from time to time.

5.2.2 The Group Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is being considered the guidance in the Department of Health's Commercial Sponsorship – Ethical Standards in the NHS shall be followed.

5.2.3 All employees must inform the Group Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.4 As per the 2012 Health and Social Care Act the Trust shall ensure the following:

(a) the income received from providing goods and services for the NHS is greater than their income from other sources.

(b) publish information within the forward plan on all their non-NHS work and to explain its impact on the delivery of goods and services for the NHS.

5.2.5 Should the Trust wish to increase the share of its income from non-NHS sources (including private work) by more than five percentage points in any one year, prior approval from the Council of Governors must be sought.

5.3 Debt Recovery

5.3.1 The Group Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

5.3.2 Income not received should be dealt with in accordance with losses procedures.

5.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated in accordance with the Trust's Overpayment Policy.

5.3.4 Debt write off will be managed in line with the debt write off procedures with overall authorisation by the Group Chief Finance Officer.

5.4 Security of Cash, Cheques and other Negotiable Instruments

5.4.1 The Group Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

(b) ordering and securely controlling any such stationery

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

5.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

5.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Group Chief Finance Officer.

5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

5.5 Purchasing Cards

5.5.1 The use of purchasing cards is to be minimised and a more appropriate procurement route should be followed wherever possible. Notwithstanding this, the Group Director of Procurement is responsible for:

a) approving and determining the purchasing capabilities of procurement cards and expenditure limits

b) prescribing and maintaining procedures on behalf of the Trust which ensures expenditure complies with the conditions of the card

c) ensuring segregation of duties exist for reviewing all transactions and purchases comply with these SFIs.

6. NHS CONTRACTS AND SERVICE LEVEL AGREEMENTS FOR THE PROVISION OF SERVICES

6.1 Contracts and Service Level Agreements

6.1.1 The Group Chief Executive Officer, as the Accountable Officer, is responsible, where directed, for ensuring the Trust enters into appropriate service contracts with the appointed bodies for commissioning the provision of NHS services. This responsibility is delegated to the Group Chief Finance Officer with the Contracts Director overseeing this on a day-to-day basis. Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that, in line with the limits set out in the Scheme of Delegation~~,~~ an appropriate contract is present and signed by both parties.

6.1.2 The Trust will look to adhere to the terms and conditions of the NHS standard contract in so far as these are mutually acceptable and balance risk in a reasonable way. In discharging this responsibility, the Group Chief Finance Officer with the Contracts Director shall pay particular attention to:

- the contract term and conditions precedent
- the standards relating to the service quality requirements inclusive of the service specifications
- the costing and pricing of services, referencing to national and local tariffs
- provision of information and activity
- the payment terms and conditions
- governance requirements to include:
    - provider roles and responsibilities
    - performance and contract management

6.1.3 Contract Variations that arise during the course of the contract period e.g. regarding new Commissioner policies, changes to contract funding levels etc. will be reviewed appropriately by the Contracts Director and relevant colleagues consulted and notified as appropriate.

6.2 Stakeholder Partnership and Risk Management

6.2.1 A robust contract management framework is based on effective stakeholder relationships, working together across the health and social care system, to provide high quality, sustainable and value for money services. This will require the Group Chief Executive Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of services. Where appropriate, risk will be managed across the care system and responsibilities shared to influence outcomes and delivery of integrated services.

6.3 Reports to Board

6.3.1 The Group Chief Finance Officer with the Contracts Director will ensure that the Board and other management forums have appropriate oversight of contract agreements and contract performance. This will typically be via the monitoring of performance KPIs, quality standards and information on Hospital activity performance through high level point of delivery information.

6.4 Provider to Provider SLAs

6.4.1 The Hospital / MCS/ LCO Chief Executives and their respective Finance Directors are responsible for ensuring that appropriate SLAs are in place and regularly maintained regarding the provision and receipt of services to/from other NHS providers, including annual price reviews and confirmation that service specifications reflect the current service needs.

6.4.2 Officers detailed in 6.4.1 should seek advice from the Contracts Director and their team to support any significant changes to these agreements, in particular in relation to pricing discussions.

7. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

7.1 Remuneration

7.1.1 The Remuneration Committee has been established by the Group Board of Directors to ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive Officer, the Group Executive Directors and other staff paid on Very Senior Manager (VSM) Pay or non-standard pay scales.

7.2 Scope and Duties

7.2.1 To determine the framework or broad policy for the remuneration of the Group Chief Executive Officer, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.

7.2.2 To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.

7.2.3 To advise on and oversee contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.

7.2.4 The Council of Governors will decide the remuneration and allowances, and the other terms and conditions of the non-executive Directors.

7.2.5 The Group Board of Directors' emoluments will be accurately reported in the required format in the Group's annual report.

7.3 Staff Appointments

7.3.1 No officer or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so within the 'Scheme of Reserved Decisions and Scheme of Delegation'; and

(b) they are within the approved limit of the annual plan i.e. the approved financial budget

7.3.2 The Board will approve procedures presented by the Executive Director of Workforce and Corporate Business and the Group Chief Finance Officer and in line with the 'Scheme of Reserved Decisions and Scheme of Delegation' for the determination of commencing pay rates, condition of service, etc, for employees.

7.4 Processing Payroll

7.4.1 The Group Executive Director of Workforce and Corporate Business is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications

(b) the final determination of pay and allowances

(c) making payment on agreed dates

(d) agreeing method of payment.

7.4.2 The Group Executive Director of Workforce and Corporate Business will issue instructions regarding:

(a) verification and documentation of data

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay

(d) security and confidentiality of payroll information

(e) checks to be applied to completed payroll before and after payment

(f) authority to release payroll data under the provisions of the Data Protection Act

(g) methods of payment available to various categories of employee and Officers

(h) pay advances and their recovery; up to the point finance is notified of payment/recovery to be made

(i) separation of duties of preparing records

(j) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

7.4.3 The Group Chief Finance Officer will issue instructions regarding:

(a) procedures for payment by cheque, bank credit, or cash to employees and Officers

(b) procedures for the recall of cheques and bank credits

(c) pay advances and their recovery; from the point finance are notified of payment / recovery to be made

(d) maintenance of regular and independent reconciliation of pay control accounts.

7.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables

(b) completing time records and other notifications in accordance with the Group Executive Director of Workforce and Corporate Business' instructions and in the form prescribed by the Group Executive Director of Workforce and Corporate Business

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or Officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Group Executive Director of Workforce and Corporate Business must be informed immediately.

7.4.5 Regardless of the arrangements for providing the payroll service, the Group Executive Director of Workforce and Corporate Business shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.5 Contracts of Employment

7.5.1 The Board shall delegate responsibility to the Group Executive Director of Workforce and Corporate Business for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

7.6 Funded Establishment

7.6.1 The workforce plans incorporated within the annual budget will form the funded establishment.

7.6.2 The funded establishment of any department may not be varied without the approval of an authorised officer in line with the Scheme of Reserved Decisions and Scheme of Delegation.

7.6.3 No appointment can be made without a funded / established post on the ledger and ESR systems.

8. NON-PAY EXPENDITURE

8.1 Delegation of Authority

8.1.1 The Scheme of Reserved Decisions and Scheme of Delegation sets out the delegated powers.

8.2 Requisitioning

8.2.1 The Trust provides End User Requisitioning (EUR) facility to order goods and services via catalogues supported by Trust/NHS contracts, frameworks and pricing agreements.

8.2.2 Where a service or good is not available on catalogue then the requisitioner should consult with the Procurement department. In choosing the item to be supplied (or the service to be performed) best value for money for the Trust should always be sought. Where the advice of the Procurement department is not acceptable to the requisitioner, the Group Chief Finance Officer (and/or the Group Chief Executive Officer) shall be consulted.

8.3 System of Payment and Payment Verification

8.3.1 The Group Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

8.3.2 The Group Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed

(b) prepare procedural instructions or guidance within the Scheme of Reserved Decisions and Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds

(c) be responsible for the prompt payment of all properly authorised accounts and claims

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of Trust employees authorised to certify invoices.

ii. Proper Certification

8.4 Prepayments

8.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments

(c) The Group Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Group Chief Executive Officer if problems are encountered.

8.4.2 The sole exception being with regard to maintenance contracts where the industry standard terms are for prepayment. In these circumstances the contract details will be tracked and the prepayment adjustment will be enacted to reflect the correct expenditure for the year to date position.

8.5 Official orders

8.5.1 The Group Chief Finance Officer will issue instructions to ensure:

(a) that written assurance has been obtained from each provider that they themselves are compliant with the requirements of the anti-bribery legislation

(b) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

i. isolated gifts of a trivial nature or inexpensive seasonal gifts, such as calendars
ii. conventional hospitality, such as lunches in the course of working visits

This provision needs to be read in conjunction with and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" and the 'adequate procedures' requirements of the Bribery Act 2010 as outlined in the Trust's Anti-Fraud, Bribery and Corruption Policy.

(c) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Group Chief Finance Officer on behalf of the Group Chief Executive Officer

(d) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash; in exceptional circumstances a confirmation order can be raised prior to payment of associated invoices.

(e) verbal orders must only be issued very exceptionally - by an employee designated by the Group Chief Executive Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(f) orders are not split or otherwise placed in a manner devised to avoid the financial thresholds

(g) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase

(h) changes to the list of employees and Officers authorised to certify invoices are notified to the Group Chief Finance Officer

(i) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Group Chief Finance Officer

(j) petty cash records are maintained in a form as determined by the Group Chief Finance Officer.

8.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

8.6.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Group Chief Finance Officer which shall be in accordance with these Acts.

9. EXTERNAL BORROWING AND INVESTMENTS

9.1 Borrowing

9.1.1 The Trust must ensure compliance with guidance from the Independent Regulator. The degree to which the organisation's income covers its financing obligations is a key determinant of the Trust's financial stability and will therefore be clearly referenced in determining appropriate levels of borrowing over time.

9.2 Public dividend capital

9.2.1 On authorisation as a Foundation Trust the public dividend capital held immediately prior to authorisation continues to be held on the same conditions.

9.2.2 Additional public dividend capital may be made available on such terms the Secretary of State (with the consent of the treasury) decides.

9.2.3 Draw down of public dividend capital should be authorised in accordance with the mandate held by the Department of Health cash funding team and is subject to approval by the Secretary of State.

9.2.4 The Trust shall be required to pay annually to the Department of Health a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

9.3 Commercial borrowing

9.3.1 The Trust may borrow money from any commercial source for the purposes of or in connection with its functions, subject to NHSE/I guidance. Any exercise of this freedom will take full account of the considerations referenced in 9.1.1.

9.4 Investments

9.4.1 The Trust may invest money (other than money held by it as charitable Trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

9.5 Investment of Temporary Cash Surpluses

9.5.1 Temporary cash surpluses must be held only in such public and private sector investments as approved in the Trust's treasury management policy which should be drawn up by the Group Chief Finance Officer and pursuant to all applicable guidance including Managing Operating Cash in NHS Foundation Trusts published by the Independent Regulator.

9.5.2 The Group Chief Finance Officer shall report periodically to the Board of Directors concerning the performance of investments held.

9.5.3 The Group Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Trust's treasury management policy will incorporate guidance from the Independent Regulator as appropriate.

9.5.4 The Trust shall comply with all relevant guidance published on investments from time to time in force.

10. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Group Chief Executive Officer:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges

(d) shall ensure that the Trust complies with prevailing regulatory requirements and best practice.

10.1.2 For every capital expenditure proposal (other than replacement equipment or rolling programmes) the relevant Hospital Chief Executive, or for Trust level proposals the responsible Executive Director shall ensure:

(a) that a business case is produced setting out:

i. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

ii. a robust assessment of risks together with appropriate mitigation plans for these risks,

iii. a benefits realisation programme with clear accountable officers and timeline set out for delivery and monitoring

iv. the involvement of appropriate Trust personnel and external agencies

v. appropriate project management and control arrangements

(b) that the appropriate Director of Finance has certified professionally as to the costs and revenue consequences detailed in the business case.

10.1.3 The requirements of 10.1.2 shall also apply to the procurement of assets through lease arrangements or Managed Equipment Services contracts and such transactions will be reported appropriately adhering to IFRS requirements applicable at the time of procurement.

10.1.4 The Group Director of Estates & Facilities shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.1.5 For capital schemes where the contracts stipulate stage payments, the responsible Executive Director will issue procedures for their management, incorporating the recommendations of ESTATECODE.

10.1.6 The Group Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.7 The Group Director of Estates & Facilities, in consultation with the Group Chief Finance Officer shall issue to the Director responsible for any scheme:

(a) specific authority to commit expenditure

(b) authority to proceed to tender

(c) approval to accept a successful tender (see overlap with Scheme of Reserved Decisions and Scheme of Delegation)

10.1.8 The Group Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

10.2 Asset Registers

10.2.1 The Group Chief Executive Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Group Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted as appropriate.

10.2.2 The Trust shall maintain an asset register recording Property, Plant & Equipment (fixed assets). The minimum data set to be held within these registers shall be as specified in accordance with the International Financial Reporting Standards (IFRS) or any other guidance applicable for the periods concerned.

10.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads

(c) lease agreements in respect of assets held under a finance lease and capitalised.

10.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Prior approval will be required from the Group Chief Finance Officer for assets with a value in excess of £75,000, including in circumstances where assets are replaced / superseded by new items e.g. medical equipment. (See 12.1.2)

10.2.5 The Group Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

10.2.6 The value of each asset shall be depreciated using methods as allowed in the IFRSs.

10.3 Procedure for the Security of Assets

10.3.1 The overall control of fixed assets is the responsibility of the Group Chief Executive Officer.

10.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and including donated assets) must be approved by the Group Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset

(b) identification of additions and disposals

(c) identification of all repairs and maintenance expenses

(d) physical security of assets

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

10.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Group Chief Finance Officer.

10.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to Trust property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

10.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses.

10.3.6 Where practical, assets should be marked as Trust property.

11. STORES AND RECEIPT OF GOODS

11.1 General Position

11.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum

(b) subjected to annual / rolling stock take

(c) valued at the lower of cost and net realisable value.

11.2 Control of Stores, Stocktaking, condemnations and disposal

11.2.1 Subject to the responsibility of the Group Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Group Chief Executive Officer. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Group Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel, oil and coal of a designated estates manager.

11.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

11.2.3 The Group Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.2.4 Stocktaking arrangements shall be agreed with the Group Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

11.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Group Chief Finance Officer.

11.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Group Chief Finance Officer for a review of slow moving and obsolete items and for

condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Group Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI on Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.3 Goods supplied by NHS Supply Chain

11.3.1 For goods supplied via NHS Supply Chain central warehouses, the Group Chief Executive Officer shall identify those authorised to requisition and accept those goods. Generally, goods will be ordered through the Materials Management system and will be ordered to regularly agreed stock levels. Any discrepancies to order should be reviewed and resolved with NHS Supply Chain.

12. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

12.1.1 Procedures

12.1.1.1 The Group Chief Finance Officer is responsible for preparing detailed procedures for the disposal of assets including condemnations and transfers, and to ensure that these are notified to all Trust Departments.

12.1.1.2 The authorisation of a disposal has been delegated by the Group Chief Finance Officer to the Head of Financial Services.

12.1.1.3 When it is decided to dispose of a Trust asset, a Trust official with the appropriate delegated authority will notify the Head of Financial services. The Head of Financial services will establish the carrying amount of the asset and determine the financial impact of the disposal, taking professional advice where necessary. (see 10.2.4)

12.1.1.4 All unserviceable articles shall be disposed of in line with the Transfer and Disposals of Assets Policy.

12.1.1.5 A Trust official with delegated authority for disposal of the asset shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Head of Financial Services who will take the appropriate action.

12.1.1.6 In the case of obsolete, or otherwise unusable, assets the Trust may approve the gift of the item to a registered charity including those working overseas e.g. obsolete medical equipment. This is subject to confirmation that appropriate decontamination procedures can be carried out at negligible costs or where these costs will be refunded by the charity. Packaging and transport would be the responsibility of the charity.

12.2 Losses and Special Payments

12.2.1 **Procedures**

12.2.1.1 The Group Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

12.2.1.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Group Chief Executive Officer and the Group Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Group Chief Finance Officer and/or Group Chief Executive Officer.

12.2.1.3 Where a criminal offence is suspected, the Group Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption, or of anomalies which may indicate fraud or corruption, the Group Chief Finance Officer must inform the Trust's LCFS in accordance with the NHS Standard Contract clauses.

12.2.1.4 The Group Chief Finance Officer must notify NHS Counter Fraud Authority, via the LCFS. The Group Chief Finance Officer should also notify the Board, Audit Committee and External Audit as/when appropriate to do so.

12.2.1.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if below £100k, the Group Chief Finance Officer must promptly notify:

(a) the Board,

(b) the External Auditor.

12.2.1.6 Within limits delegated to it by the Department of Health and in accordance with the Scheme of Delegation, the Board shall approve the writing-off of losses.

12.2.1.7 The Group Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

12.2.1.8 For any loss, the Group Chief Finance Officer should consider whether any insurance claim can be made.

12.2.1.9 The Group Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

12.2.1.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health, NHS I and H.M. Treasury.

12.2.1.11 All losses and special payments arising in the previous period must be reported to the Audit Committee at every meeting.

13. PATIENTS' PROPERTY

13.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead, on arrival.

13.2 The Group Chief Executive Officer is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)

- hospital admission documentation and property records
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

13.3 The Group Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

13.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Group Chief Finance Officer.

13.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

13.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

13.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

14. FUNDS HELD ON TRUST

14.1 Corporate Trustee

14.1.1 The Trust is responsible, as a corporate Trustee, for the management of funds it holds on Trust and shall comply with Charities Commission latest guidance and best practice.

14.1.2 The discharge of the Trust's corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

14.1.3 The Group Chief Finance Officer shall ensure that each Trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

14.2 Accountability to Charity Commission and Secretary of State for Health

14.2.1 The Trustee responsibilities must be discharged separately, and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Secretary of State for all exchequer funds held on Trust.

14.2.2 The Scheme of Reserved Decisions and Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board of Directors members and Trust Officers must take account of that guidance before taking action.

14.3 Applicability of Standing Financial Instructions to funds held on Trust

14.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on Trust.

14.3.2 The over-riding principle is that the integrity of each of the Trust and the Charity must be severally maintained and statutory and regulatory obligations met. Materiality relating to the Charity must be assessed separately from Exchequer activities and funds.

15. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

15.1 The Group Chief Executive Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff (The Trust's 'Standards of Business Conduct and Hospitality Policy'). This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Financial Instructions and the MFT Standing Orders (Annex 7, MFT Constitution - October 2017).

15.2 Staff are also reminded that the offering, promising, giving, requesting, receiving or agreeing to receive gifts, hospitality and other benefits in kind, under certain circumstances, may also constitute offences under the Bribery Act 2010. (Further advice and guidance can be sought from the LCFS).

15.3 Staff and Officers are also required to comply with the Trust's instructions regarding the declaration of interests' processes.

16. RETENTION OF RECORDS

16.1 The Group Chief Executive Officer shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

16.2 The records held in archives shall be capable of retrieval by authorised persons.

16.3 Records held in accordance with the latest NHS Code of Practice shall only be destroyed at the express instigation of the Group Chief Executive Officer. Detail shall be maintained of records so destroyed.

17. INSURANCE

17.1 Insurance: Risk Pooling Schemes administered by NHS Resolution (formerly NHSLA)

17.1.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution (formerly the NHS Litigation Authority) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

17.2 Insurance arrangements with commercial insurers

17.2.1 The Group Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

17.3 Arrangements to be followed by the Board in agreeing Insurance cover

17.3.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Group Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Group Chief Finance Officer shall ensure that documented procedures cover these arrangements.

17.3.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Group Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Group Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

17.3.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Group Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

18. TENDERING AND CONTRACTING PROCEDURE

18.1 The Scheme of Reserved Decisions and Scheme of Delegation and the Trust's Procurement of Goods and Services policy, specify the procurement arrangements that should be applied along with provisions for instances where the invitation of competitive offers or the prescribed number of competitive offers is not appropriate.

19. CONSULTANCY

19.1 The Trust shall comply with any guidance from NHS E/I regarding the utilisation of consultancy support including any approvals processes and reporting requirements applicable.

19.2 Any planned use of consultancy requires the approval of the Board for appointments in excess of £50,000 (thresholds include irrecoverable VAT and other costs e.g. expenses). The approval of the Group Chief Executive Officer is required for expenditure above £30,000 and approval of the Group Chief Finance Officer for expenditure up to £30,000. These values also apply where the threshold is reached due to a contract extension or variation.

20. INFORMATION TECHNOLOGY

20.1 The Group Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection and Computer Misuse Acts

b) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment

d) ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks

e) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as are considered necessary are being carried out.

20.2 The Group Chief Financial Officer shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.

20.3 The Group Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

20.4 Where another health organisation or any other agency provides a computer service for financial applications, the Senior Information Risk Owner shall periodically seek assurances that adequate controls are in operation.

20.5 Where computer systems have an impact on corporate financial systems the Senior Information Risk Owner shall satisfy him/herself that:

a) systems acquisition, development and maintenance are in line with Trust policies

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists

c) Trust’s Finance Officers have access to such data; and

d) such computer audit reviews carried out as necessary.

21. RESEARCH & INNOVATION

21.1 Principles

21.1.1 The principles surrounding Research and Innovation (R & I) contained in these Standing Financial Instructions are of direct relevance to all those who host, conduct, fund or participate in research within the Trust.

21.1.2 These SFIs should be read in conjunction with the R&I Standard Operating Procedures (SOPs) and Policies which are available on the R&I Trust intranet web pages.

21.1.3 Financial probity and compliance with the law and rules laid down by H M Treasury for the use of public funds are applicable to R & I activities being undertaken within the Trust.

21.1.4 There are two types of R & I activity as follows:

i. "Commercial R & I" – where R & I is primarily conducted for commercial purposes and funded by an external company, for example a drug trial prior to licensing.

ii. "Non-Commercial R & I" – where R & I is funded by a charitable organisation, a Research Council, the Department of Health or other government agencies.

21.2 Use of funding gained through Research and Innovation

21.2.1 Any funding which is received through R & I activity is covered by the Trust's SFIs as is the case for all other funding sources within the Trust. This includes all rules associated with issues such as hospitality.

21.2.2 It is not possible to carry forward surplus funds following the completion of a research project into the next financial year under NHS accounting rules.

21.2.3 Researchers do not have the authority to use the funding for purposes other than that specifically authorised. The use of any surpluses which occur must comply with the contractual terms of the research grant / contract.

21.2.4 In some cases, if the research activity is not fully delivered, under the contractual obligations an element of the funding will need to be returned to the external funding body and will not be retained by the Trust.

21.2.5 Where it is appropriate that the Trust retains any surpluses, the use of these must be approved through the normal budget holder structure within the area concerned.

21.2.6 Most R & I funding streams are non-recurrent. Permanent commitments such as the appointment of staff to research positions on permanent contracts should only be made if there is an agreed income stream to cover the on-going commitment once the funding source has ceased.

21.2.7 Payments to staff for research activities must be in line with Trust payroll procedures and no arrangements to avoid taxation liabilities should be entered into.

21.2.8 Any income which is gained from NHS activities must be paid into and managed as part of normal Trust exchequer accounts. Funds must not be held within special accounts, (external bank accounts), Charitable funds or within any other charitable trust funds.

21.2.9 Before approval, any potential applications for research need to be fully assessed from a financial perspective and approved in line with normal Trust budgetary management arrangements. In particular any deficits identified in the study need to be agreed by the management team in that area and accounted for accordingly.

21.2.10 A nominated member of the research team undertaking the research activity, supported by finance managers is responsible for ensuring that there is on-going monitoring of the recovery of income awarded under any approved grant / contract and should any income not be forthcoming, appropriation action taken.

21.2.11 A nominated member of the research team is responsible for controlling and monitoring spend, ensuring that it is contained within the approved funding allocation and that the spend represents value for money, liaising with the management team for their area and with the appropriate finance manager.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business / Trust Secretary
Date of paper:	May 2022
Subject:	NHSI FT Self-Certification Requirements (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:	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (previously Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence. The greatest damage is most likely to be to reputation, and the impact that has on patient choice and stakeholders' confidence in MFT as a provider of NHS services.
Recommendations	The Board of Directors is asked to approve NHSI FT Self-Certifications for Condition G6(3), G6(4) & CoS7(3) and note progress with Self-Certificate FT4(8)
Contact	Name: Nick Gomm, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

NHSI FT Self-Certification Requirements (2022)

1. Background

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

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

The Manchester University NHS Foundation Trust has an NHS Provider Licence (**No. 130164**). This year (2022), in keeping with NHSI guidance (updated in March 2019), the Trust is required to self-certify the following three Licence Conditions after the financial year-end:

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

2. NHSI Foundation Trusts Self-Certification

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

Not later than two months from the end of the Financial Year, the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

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

Recommendation: In keeping with the requirements of Condition G6(4), the Trust will publish its self-certification - Condition G6(3**)** - by 30th June 2022

2.2 Self-Certification - Condition FT4(8)

The Board of Directors is required to self-certificate "Confirmed" or "Not confirmed" to a number of governance-related statements (see Appendix B for summary of statement requirements) and set-out any risks and mitigating actions planned for each one within the NHSI self-declaration template. The Board has already received an electronic copy

of the draft summary set of evidence to support this 'Condition FT4' Self-Certification with the aim of identifying any risks with compliance and any action taken or being taken to maintain future compliance.

Recommendation: The Board is recommended to review and comment (via the Board Secretary) on the draft governance statements by the 10th June 2022.

Recommendation: The Board is recommended to delegate authority for 'sign-off' of the Self-Certification for 'Condition FT4(8)' to the Group Chairman & Group Chief Executive in order to meet the self-certification deadline of 30th June 2022; which is prior to the next Board of Directors meeting on 12th July 2022.

2.3 Self-Certification - Condition CoS7(3)

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

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

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

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

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

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

APPENDIX A

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

- Throughout the 2020/22 COVID-19 National Emergency, the Trust has been meticulous in maintaining the integrity of Board and related governance arrangements and processes. This involved an assessment of existing arrangements to judge what should continue, what could be modified and what could be stood down to ensure compliance with infection prevention rules and government guidance on meetings. Attention was paid to the advice proffered by NHS E/I about Board governance and associated reporting;

- Board meetings and Scrutiny Committees were maintained, albeit 'virtually'. All decisions about the construct of meetings and business agenda were taken with the full endorsement of the Group Chairman. Moreover, Group NED briefings were introduced at the outset of the Pandemic and have continued, reducing in frequency from weekly to monthly as the impact of the pandemic has reduced. Written briefings are provided to NEDs during those weeks where there is not a NEDs' meeting. These measures have been complemented by frequent and regular briefings to the MFT Council of Governors;

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

- Frequent and regular staff communications complemented regular staff side meetings and special events. Additional staff-based groups were established including new staff networks and a safe working practices committee. The results of the COVID-19 staff survey have been used to inform the response to staff need at the hight of the Pandemic. This was coupled by a significant extension of the Employee Health and Wellbeing Service across 7 days.

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

- The MFT Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance and Digital Scrutiny Committee, EPR Scrutiny Committee, and the Group Risk Oversight Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance, and finance.

  Examples include: Board Assurance Reports; Internal & External Audit Reports; Clinical Audit Reports; Patient Surveys; Staff Surveys; CQC Inspection Reports; Board Assurance Framework (BAF); Royal College Accreditation; H&S Executive Inspection Reports; Internal Quality Review Reports (and FU); Senior Leaderships Walk-rounds; Ward / Department Accreditation; Clinical Pathology Accreditation; and Equality, Diversity & Inclusion Reports.

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

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

  - New risks at level ≥15 – single report detailing management and oversight arrangements
  - Group wide risks at ≥15 – single report detailing management and oversight arrangements

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

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

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

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

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

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

- A focused governance and accountability framework was maintained throughout the Group during 2021/22 in response to any rapidly escalating phases of the COVID-19 pandemic with a robust command and control (EPRR) framework in place to provide the effective leadership and fast decision-making required. Throughout, the Trust maintained performance management oversight through its committee structure. Performance and quality reports continued to be produced and presented to the Board of Directors, Group Management Board, selected Board Sub-Committees, and Council of Governors.

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

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

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

- The Trust has a well-established Improving Quality Programme (IQP) and Accreditation process in place which examines performance across four domains; leadership and culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver, or gold. Areas that consistently achieve a Gold rating become eligible for an Excellence in Care Award providing a Gold rating is achieved in all domains. Patient experience survey data and quality of care data is used along with Accreditation outcomes to drive continuous improvement. The Board of Directors receives regular reports on accreditation outcomes and receive an Annual Accreditation Report.

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

- Governors hold Group Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that MFT does not breach the terms of authorisation. Governors receive details of meetings, agendas, and approved minutes of each Board of Directors' Meeting. During the COVID-19 National Emergency, the Group Chairman (supported by the Group NEDs) has held 'virtual' Chairman / Governor Surgeries a short time following the Board meetings (as an alternative to face-to-face meetings). This has also included *'Getting to know your NEDs'* sessions. Governors monitor the performance of MFT via the main Council of Governors meetings (which have all been held 'virtually' and have continued uninterrupted and on schedule throughout 2021/22 despite the ongoing COVID-19 National Emergency and UK Governments Social Distancing requirements), quarterly Performance Review Meetings (during non-COVID periods) to ensure high standards are maintained.

- A further, comprehensive suite of evidence from MFT's Hospitals/ MCSs/ LCOs in support of this Self-Certification has been gathered through the Annual 'Well Led' Self-Assessment process, currently being undertaken.

APPENDIX B

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

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

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time

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

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

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

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

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

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

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

Training of Governors

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

APPENDIX C

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

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

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

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

- In March 2016, the Manchester CCGs decided to extend that position through until at least October 2017. Since then, Manchester CCG has extended this in light of the MFT merger, ongoing SHS and LCO developments. Given this, it would not be meaningful for MFT in isolation to undertake self-certification work across all services

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

- In 2020/21 and 2021/22 there was no formal requirement to sign off full contract documentation between providers and commissioners, due to the impact of COVID-19. With addressing COVID-19, and subsequent elective recovery, any potential to review the list of CRS services has been severely constrained and, with the imminent change from CCGs to ICBs, to ensure consistency across GM, it is now more likely this will be picked up for 2023/24 contract at the earliest.

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group 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:	May 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 position in respect of Ockenden IEAs and the work ongoing to ensure the safety of women and babies in SM MCS.
Contact:	Name: Alison Haughton, Acting CEO, SM MCS Tel: 0161 276 6124

1. Executive Summary

1.1. The report provides an update in respect of the initial Ockenden Report[1], and the recent Final Report[2] published on 30th March 2022. The report provides assurance to the Board of Directors on matters relating to patient safety within maternity services, themes identified from clinical incidents, shared learning and monitoring of actions.

1.2. As reported to Board of Directors in January 2022, and March 2022, SM MCS have completed all provider level Ockenden actions required from the initial report published in December 2020. There are 3 outstanding actions with currently no estimated date of completion which sit with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMS) relating to a process on how the system is to receive maternity training data.

1.3. The second and final report from Ockenden was published on 30th March 2022 and has identified a further 15 Immediate and Essential Actions (IEAs) which all providers must implement and report compliance against. Currently a date has not been set regarding when compliance must be achieved.

1.4. The Ockenden report focuses on maternity services however the 4 overarching themes identified provide wider learning for the Trust. These are:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

1.5. SM MCS is undertaking a detailed review of the 15 IEAs which will set out compliance and areas of focus. Actions will be put in place to ensure compliance and will be reported in full to the meeting of the Board of Directors in July 2022. Actions will be identified and monitored through SMH Q&S and also through the Q&PSC.

1.6. SM MCS reported 1666 incidents between 1st January 2022 to 31st March 2022 (Q4 2021/2022). All incidents were reviewed through robust governance processes, > 95% (1584) were validated as no harm, 4.5% (76) were validated as slight harm and <0.5% (6) were validated as moderate harm or above.

1.7. Of the 6 moderate harm or above, 5 cases did not highlight any trend and there were no similar incidents within the preceding 6 months. One incident occurred on maternity triage and SM MCS identified a theme emerging in this area. The learning from this incident has been shared and actions have been implemented and monitoring continues within the maternity division.

1.8. SM MCS continue to work through the 10 standards for Maternity Incentive Scheme (MIS) year 4 and are currently compliant with 8 of the 10 standards. One area of non-compliance relates to Standard 6, Saving Babies Lives Care Bundle, specifically CO (Carbon Monoxide) screening. Actions plans are in place across each site in the MCS to address this with improvements in compliance now been seen.

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

[2] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

1.9. Training within both Standard 6 and Standard 8 are non-compliant and trajectories are in place to achieve compliance by the end of June 2022.

1.10. Whilst there has been no confirmation of a new submission date for MIS year 4, SM MCS expect to achieve full compliance and will continue to report progress to the Board of Directors against all 10 standards.

1.11. In conclusion the maternity division within Saint Mary's MCS is in a good position having completed and embedded the initial Ockenden actions. An initial review of the final 15 IEAs from the second report published in March 22, demonstrates over half of all elements are compliant and there are robust plans to address the remaining elements. A perinatal surveillance model has been developed which remains an iterative process and when fully implemented will provide ward to board visibility in respect of incident reporting and learning. Work to ensure compliance with Year 4 MIS continues to progress and SM MCS are confident that this will be achieved.

1.12. The Board of Directors are asked to note the position in respect of Ockenden IEAs and the work ongoing to ensure the safety of women and babies in SM MCS.

1. Ockenden Reports Update

1.1. Trust 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 updates in January and March 2022.

1.2. The March 2022 update confirmed compliance against all Immediate and Essential Actions which sat with SM MCS and informed Trust Board of Directors that continued compliance is monitored Maternity Services Divisional Quality and Safety Committee. The outstanding actions are being reviewed by GMEC LMS.

1.3. As described previously to MFT Board of Directors, the next step in respect of monitoring has been confirmed and will be taking the form of an Assurance Visit by the Regional Maternity Team to review progress against the Ockenden recommendations. Provisional dates have been provided for the end of June 2022.

1.4. On 30th March 2022, the final Ockenden report[3] was published and contains 15 Immediate and Essential Actions (IEAs) which are in addition to the previous 7 IEAs from the first report.

1.5. On initial review, SM MCS are fully compliant with 3 of the 15 IEAs and partially compliant for 12. Areas of focus for SM MCS include:

- Recruitment and Retention – working to address current vacancies
- Training - ensuring that all staff receive maternity specific training and remain in date
- Learning from incidents – sharing and learning regarding triage pathways
- Listening – Both to workforce by undertaking a new culture survey, and to women through commencing '15 steps walkarounds' across all 3 sites with families, commissioners, Non-Executive Director and Maternity Safety Champions

1.6. Table below provides all 15 IEAs (incorporating 26 sections) and SM MCS current compliance.

Action	Section	Comment
Safety Action 1 - workforce planning and sustainability	Financing a safe maternity workforce	Work ongoing
	Training	Work ongoing
Safety Action 2 - Safe staffing	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals	Work ongoing
Safety Action 3 - Escalation and Accountability	Staff must be able to escalate concerns if necessary	Work ongoing
	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend	Work ongoing

[3] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

Action	Section	Comment
Safety Action 4 - Clinical Governance Leadership	Trust boards must have oversight of the quality and performance of their maternity services.	Compliant
	In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Compliant
Safety Action 5 - Clinical Governance Incident Investigation and complaints	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner	Work ongoing
Safety Action 6 - Learning from Maternal Deaths	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.	Work required by external bodies (RCOG)
	In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings	Work required by external (RCOG)
Safety Action 7 - MDT Training	Staff who work together must train together	Compliant
	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	Work ongoing
	Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	Work ongoing
Safety Action 8 - Complex Antenatal Care	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.	Compliant
	Trusts must provide services for women with multiple pregnancy in line with national guidance	Compliant
	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Compliant
Safety Action 9 - Preterm Birth	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.	Work ongoing
Safety Action 10 - Labour and Birth	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	Work ongoing
	Centralised CTG monitoring systems should be mandatory in obstetric units	Compliant
Safety Action 11 - Obstetric anaesthesia	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.	Work ongoing
	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets	Work required by external bodies

Action	Section	Comment
	that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.	
	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	Work ongoing
Safety Action 12 - Postnatal Care	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.	Work ongoing
	Postnatal wards must be adequately staffed at all times	Compliant
Safety Action 13 - Bereavement Care	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services	Compliant
Safety Action 14 - Neonatal Care	There must be clear pathways of care for provision of neonatal care.	Work ongoing
Safety Action 15 - Supporting Families	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.	Work ongoing

1.7. SM MCS have undertaken an initial review to identify areas of compliance, areas which require additional action to be compliant, and areas where external bodies (such as NHS England & Improvement, Royal Colleges, Health Education England, Local Maternity and Neonatal Systems) are required to address.

1.8. On initial review of the 15 IEAs, there are 27 sections comprising of 94 separate elements which Trusts must achieve to be compliant.

1.9. This initial review of the 94 elements has demonstrated that within SM MCS:

- 56 elements are compliant
- 26 elements require ongoing work to achieve compliance
- 4 elements require work to be undertaken by both SM MCS and external bodies to achieve compliance
- 8 elements require work to be undertaken by external bodies to achieve compliance

1.10. SM MCS are already fully compliant with Safety Actions 4, 8 and 13.

1.11. SM MCS ask Trust Board of Directors to note that one of the elements within Safety Action 1 is the implementation of all recommendations made by Health and Social Care Committee Report[4].

1.12. Within this report[5] there are 31 recommendations of which:

- 23 require work to be undertaken by external bodies to achieve compliance
- 6 are compliant for SM MCS
- 2, linked to maternity training, require ongoing work by SM MCS to achieve compliance

[4] https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm
[5] https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

1.13. A detailed review of all IEAs and action plan to address areas of non-compliance will be provided in the next report to Trust Board of Directors.

2. Maternity Self-Assessment Tool (MSAT)

2.1. As reported previously to MFT Board of Directors in March 2022, SM MCS have undertaken a full review of the maternity safety self-assessment tool (MSAT) which has been used as a benchmark for SM MCS against the core principles of good safety standards within Maternity services.

2.2. SM MCS ask Trust Board of Directors to note that undertaking this review is also an IEA within the final Ockenden Report[6], and is required to be shared with Trust Board of Directors.

2.3. SM MCS has now completed this review with full details attached in Appendix 2 which demonstrates where evidence has been collated.

2.4. SM MCS ask Trust Board of Directors to note that of the 168 elements for SM MCS there 2 elements considered non-compliant, one is linked to having standalone maternity risk strategy and the other is the requirement of Trust Board of Directors to open each meeting with a patient story.

2.5. The review was presented at SM MCS Quality and Safety Committee in March 2022, with actions to address areas requiring further work and the process for ongoing monitoring where required.

3. Patient Safety

3.1. As previously reported to the Trust 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.

3.2. In line with SM MCS embedded Assurance Oversight Framework (AOF) the following sections relate to incident management, with particular focus on those where harm has been caused and includes details relating to maternal deaths and neonatal brain injuries. A full review of stillbirths and neonatal deaths is provided within the quarterly Perinatal Mortality Review Report, and includes identified themes, areas for learning and monitoring of actions. Q3 2021/2022 was reported to Trust Board of Directors in March 2022. Q4 data will be submitted to Trust Board of Directors in July 2022.

3.3. Table 1 illustrates incidents reported in Quarter 4 2021/2022 and provides a full account of all incidents report throughout 2021/2022.

Table 1

Incidents	Quarter 1		Quarter 2		Quarter 3		Quarter 4		2021/22 totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
No harm	1483	93.13	1642	94.91	1457	95.41	1584	95.07	6166	94.64
Slight harm	102	6.41	82	4.74	58	3.8	76	4.56	318	4.89
Moderate	6	0.38	4	0.23	9	0.59	4	0.24	23	0.35
Major	0	0	0	0	0	0	1	0.06	1	0.02

[6] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

Catastrophic	1	0.06	2	0.12	3	0.2	1	0.06	7	0.11
Total Incidents	**1592**		**1730**		**1527**		**1666**		**6515**	

3.4. In February and March there were a total of 6 cases reported in the moderate, major or catastrophic harm category:

- Of which one was a staff fall which in line with process, was RIDDOR reported.

- For four of the five clinical incidents, one was related to a wound infection; one related to antenatal screening pathway; one related to missed referral for ultrasound and one related to urethral trauma. All 4 incidents were referred within appropriate 72-hour time frame. Incident data shows that none of these relate to a specific trend and no similar incidents have occurred in the last 6 months. Learning identified included improving communication and increased awareness around referral pathways.

- The fifth clinical incident related to care provided in Maternity Triage, where inaccurate advice was provided verbally. There is a noted theme of clinical incidents occurring in Triage such as delays in clinical assessment, escalation and transfer to birthing rooms. The SM team are working with the patient safety lead to address the themes which includes: increased midwifery staffing, amendments to Triage pathway and specifically following the above incident a Triage telephone competency assessment has been developed for midwives that incorporates real life clinical scenarios. All midwives working on triage will undertake the competency assessment prior to making clinical assessments over the phone. This learning has been shared and implemented across SM MCS.

3.5. Through February and March 6 cases were referred to the Healthcare Safety Investigation Branch (HSIB) in line with national reporting due to suspected hypoxic ischaemic encephalopathy. All 6 have been validated by the division as no harm and care was considered appropriate. HSIB reviews are ongoing:

- One case related to an abnormal antenatal CTG on the induction of labour (IOL) pathway. Incident data demonstrated a theme of delays in IOL pathway and work remains ongoing to address this. The care provided in this case however was timely and appropriate with no identified learning.

- Three cases related to pathological CTGs during labour on delivery unit and one case related to a birth which occurred on the birth centre

- One case related to transfer from maternity triage to delivery unit (See 2.4); in this incident there was miscommunication within the team, which is not an issue that has been previously identified as a trend and there are no similar incidents within the last 6 months.

3.6. There have been no maternal deaths occurring within SM MCS in Quarter 4 2021/2022. There was one maternal death reported in February 2022 which occurred at a neighbouring trust. The death has been reported to MBBRACE-UK in line with the Confidential Enquiry into Maternal Death process and SM MCS was informed as the trust provided care to this woman during her pregnancy in 2021.

3.7. In line with perinatal surveillance model, SM MCS maternity division monitor maternity data monthly via the maternity Score Card (appendix 1).

4. Maternity Incentive Scheme (MIS) Year 4

4.1. As previously reported to MFT Board of Directors, there remains a pause on MIS data collection and a new submission date is yet to be released.

4.2. SM MCS can confirm that since the March 2022 Board of Directors report, compliance has now been achieved for Safety Action 2 Maternity Data submission to NHS Digital

4.3. Table 2 provides an overview of the SM MCS current Year 4 MIS compliance.

Table 2

Safety Action	**Indicator/ standard**	Current position Mar 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?	Compliant	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

4.4. SM MCS currently meet all required standards for 8 of the 10 Safety Actions and as such request MFT Board of Directors to note and approve the detail shared in the appendices as part of ongoing external reporting.

4.5. 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 6 – Compliance with the 5 elements of Saving Babies' Lives Care Bundle version 2
- Safety Action 8 – Training
- Safety Action 9 – Safety Champions and Midwifery Continuity of Carer

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

5.1. 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)[7].

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

5.3. Element 1 - Smoking Cessation and CO measurement

5.3.1. There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth[8], fetal growth restriction, intrapartum complications and pre term birth[9].

5.3.2. To meet year 4 MIS Safety Action 6 element 1, it is required for at least 80% of women to have a Carbon Monoxide (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.

5.3.3. 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%
Quarter 4	91%	93%	98%	94%

5.3.4. SM MCS continue to meet the required standard for CO measurement at booking and continues to monitor compliance monthly via Maternity Services Divisional Quality and Safety Committee.

[7] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
[8] 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
[9] National Institute for Health and Care Excellence (2018). Smoking: stopping in pregnancy and after childbirth (Public Health Guideline 26).

5.3.5. 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%
Quarter 4	70%	82%	90%	76%

5.3.6. Significant improvement has been seen in Quarter 4 however it is acknowledged that SM MCS is yet to meet the required standard for CO measurement at 36 weeks.

5.3.7. Actions put in place are improving compliance and further support from administration and maternity support workers is expected to increase this further.

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

5.4. **Element 2 – Fetal Growth Restriction (FGR)**

5.4.1. 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.

5.4.2. Work remains ongoing to support data extraction across SM MCS, however local audit data demonstrates SM MCS meet the expected standard with over 90% across maternity sites.

5.5. **Element 3 – Reduced Fetal Movements**

5.5.1. As previously reported to Trust Board of Directors, SM MCS are compliant with both requirements for this element.

5.6. **Element 4 – Fetal Monitoring**

5.6.1. 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 are compliant with this element

5.6.2. 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.

5.6.3. SM MCS currently have approximately 83% 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 (section 7)

5.6.4. It is expected that by June 2022 SM MCS will be compliant with element 4 and training compliance is monitored monthly.

5.7. **Element 5 – Preterm Birth**

5.7.1. 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.

5.7.2. 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.

5.7.3. SM MCS continue to be compliant with this element.

5.7.4. 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.

6. Safety Action 8 – Training

6.1. 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.

Table 5 Multidisciplinary Emergency Training (%)

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	85%	87%	77%
Obstetricians	86%	76%	73%
Anaesthetists	70%	38%	58%
Theatre Staff	70%	46%	72%
Maternity Support Workers	78%	87%	45%

Table 6 Fetal Monitoring Compliance (%)

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	93%	84%	87%
Obstetricians	80%	64%	80%

Table 7 Neonatal Resuscitation (%)

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	85%	87%	78%
Neonatologists	100%	30%	100%
Neonatal Nurses and ANNP's	95%	100%	95%

6.2. SM MCS acknowledge that current training compliance is below the expected standard.

6.3. It was previously reported that both those non-compliant and those due to expire on or before 31st March 2022 had been allocated to attend training sessions between February and April 2022.

6.4. Unfortunately, due to increased number of staffing absences experienced across the 3 sites during March 2022, the expected progress in training compliance has not been made.

6.5. A further review has been undertaken and staff who are not compliant have been allocated sessions in April and May 2022.

6.6. 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.

6.7. It is expected that by June 2022 SM MCS will be compliant with Safety Action 8.

7. Safety Action 9

7.1. Safety Champions

7.1.1. To achieve compliance with Year 4 MIS safety action 9, SM MCS are required to have robust processes which provide assurance to Trust Board of Directors on maternity and neonatal quality and safety issues.

7.1.2. As reported to Trust Board of Directors previously, SM MCS met the required standard and have site based frontline maternity, neonatal and obstetric safety champions who undertake monthly 'feedback/staff walkaround sessions' with executive and non-executive safety champions.

7.1.3. Staff feedback regarding safety concerns are addressed promptly and progress is communicated to the teams bi-monthly using safety huddles and safety notice boards. (Appendix 3).

7.1.4. As previously reported to Trust Board of Directors, the Non-Executive Board Safety Champion has undertaken walkarounds at Oxford Road Campus and North Manchester and was scheduled to undertake a walkaround for Wythenshawe Hospital in February/March 2022. Unfortunately, this did not take place due to increased pressures caused by COVID-19 and will be rescheduled for April 2022.

7.1.5. As required by MIS Year 4 safety action 9, this assurance paper is presented to Trust Board by MFT Board Safety Champion and highlights incidents reported as serious harm (Section 2); staff feedback (8.3); maternity staffing (section 9); and staff training compliance (section 7).

7.2. Midwifery Continuity of Carer

7.2.1. In line with year 4 MIS Safety Action 9 requirements, Saint Mary's MCS previously provided assurance to the Trust Board of Directors on the progress and plans relating to the national ambition for Midwifery Continuity of Carer (MCoC)[10].

7.2.2. Following the release of the final Ockenden Report[11] on 30th March 2022, one of the IEAs is for the suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present.

[10] NHS England and NHS Improvement, (2021). Delivering Midwifery Continuity of Carer at Full Scale: Guidance on planning, implementation and monitoring 2021/22

[11] https://www.donnaockenden.com/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

7.2.3. On 1st April 2022, the NHS Chief Nursing Officer for England (CNO) released a letter to all Chief Executives and Chief Nurses requiring all providers to review current MCoC teams against current staffing levels.

7.2.4. In line with NHS CNO requirement, SM MCS is currently undertaking a risk assessment to review staffing and ability to continue with existing MCoC teams.

7.2.5. Following completion of the risk assessment and approval from SM MCS Board, SM MCS Maternity Division will communicate to staff members the outcome of the risk assessment, speak directly to those who may be impacted and what the next steps would be. This may involve safe and sensitive redeployment into community and hospital-based roles.

7.2.6. Should any suspension be required, SM MCS will ensure women on current MCoC pathways are safety transferred to traditional community models of care.

7.2.7. SM MCS will pause progress on the current MCoC action plan (Appendix 5) until further direction from NHS England is received, or until safe staffing is achieved to support further roll out.

7.2.8. It is possible that current year 4 MIS Safety Action 9 requirements may change regarding MCoC. Should this occur, an update will be provided to Trust Board of Directors within the next assurance report.

8. Workforce

8.1. A review of the midwifery workforce is submitted to Trust Board of Directors 6 monthly as an embedded process to provide assurance on midwifery staffing.

8.2. As previously reported to Trust Board of Directors SM MCS workforce establishment was increased in Q3 2021/22. This increase of 17 WTE was as a result of funding received from NHSE/I to address the staffing gap identified following receipt of Birthrate Plus®[12] (BR+) safe staffing toolkit report in January 2021.

8.3. The midwifery establishment, inclusive of the revised baseline following the BR+ findings and following a skill mix review at SM North Manchester, is 722.07 WTE across the 3 maternity units.

8.4. SM MCS is committed to maintaining the above establishment which, based on BR+ workforce planning methodology, supports a large number of components in the NICE guideline on safe midwifery staffing for maternity settings[13].

8.5. At the time of reporting, SM MCS midwifery vacancy is 32 WTE across 3 sites, which are mainly band 6 posts and above. This is an unusual position at Q4 for SM MCS as in recent years Q4 is either at establishment or slightly over established due to successful recruitment to turnover.

Recruitment

8.6. Recruitment continues, supported by Talent Attraction and Senior Acquisition service and further interviews are in place during April 2022.

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[12] https://birthrateplus.co.uk/

[13] NICE guideline NG4 Safe midwifery staffing for maternity settings. 17 February 2015

8.7. In line with the previous 2 years, SM MCS have made substantive employment offers to 57 3rd year students due to qualify in September 2022 subject to course completion and NMC registration.

8.8. In addition, there has been a noted increase in the number of 3rd year students outside of SM MCS who have made contact wishing to be informed when SM MCS recruit newly qualified midwives in Q1 2022/23.

8.9. A new recruitment drive, along with SM MCS open days planned on each site throughout April 2022 with the aim to increase the number of suitable midwifery applications in line with the ambition to recruit to turnover against the midwifery workforce establishment. If successful, this approach would see SM MCS in a position of over establishment by Q4 22/23.

8.10. SM MCS usually expect a small number of student midwives completing their 18-month training and commencing employment during Q4 each year.

8.11. The impact of COVID-19 has delayed the 18-month course start date in 2021, which subsequently will delay 5 student midwives from qualifying and commencing employment until Q3 22/23

8.12. Recruiting during this time has seen a limited number of qualified midwifery applications due to a reduced number of midwives wishing to stay closer to home or stay in a maternity unit they are familiar with. There has also been an increase in candidates not suitable for shortlisting as they are applying from overseas without work permits or active NMC registration.

8.13. GMEC LMS submitted a bid towards the allocation of internationally recruited midwives for the Northwest region, funded through the NHSE/I investment into maternity improvements. SM MCS have been allocated 8 international midwives from the submission. SM MCS are currently supporting GMEC LMS with recruitment and aim to have the international midwives in post by July 2022.

Temporary staffing

8.14. To mitigate the impact of absence due to sickness, which currently is 9% across SM MCS at the time of reporting, temporary staff from NHS Professionals are utilised to support staffing levels.

8.15. Since the onset of COVID-19 pandemic, SM MCS supported an enhanced NHSP rate along with overtime payments as part of the commitment to valuing staff contribution

8.16. During Q3 2021/2022, the registered midwifery workforce was further supported on the Oxford Road and Wythenshawe sites using agency staff (North Manchester had continued to use agency staff following the transaction into Saint Mary's MCS in April 2021).

8.17. There remains limited benefit to date due to low uptake in agency shifts which accounted for 4% of fill rate at Oxford Road and Wythenshawe. North Manchester agency fill rate at 12%, has remained unchanged for over a year

Retention

8.18. Retention of qualified midwives is nationally recognised as an issue, currently 8.5 WTE midwives leave MFT each month, which is an increase from 12 months ago when retention was 7.3 WTE each month.

8.19. As reported to Board in January 2022, SM MCS have received £150,000 from NHSE/I to develop specific posts to support, complement and enhance retention plans.

8.20. These positions have been recruited to and commenced in post in March 2022. It is expected that these posts 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.

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 requirements; the plans to meet new Ockenden requirements; 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: Maternity Data 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 February
- 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 – no themes identified

			GMEC monthly average (Feb 22)	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	97.57	99.3	99.2	96.5	99	98.2	98.6	98.62	99.7	99.38	99.22	98.75	
	3rd/4th degree tears	Percent	2.93	2.6	2.4	1.8	3.3	1.97	2.95	1.43	3.08	1.97	1.91	1.44	
	Obstetric haemorrhage > 2.5L	Rate per 1000	4.55	2.3	6.2	4.4	2.8	4.2	2.95	4.00	2.21	6.56	0.38	5.6	
	Term admissions to NNU	Rate per 1000	31.01	68.2	56.2	67.5	50.5	47.8	32.9	60.21	53.4	58.4	63.38	57.79	
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	5,74	5.8	15.1	10.3	6.1	11.8	8.75	5.02	12.14	16.8	8.61	11.38	
	Stillbirth number	Rate per 1000	2.38	2.3	5.4	4.3	8.4	6.2	2.21	5.91	5.82	7.91	4.96	3.15	
	Neonatal Deaths	Rate per 1000	0.00	2.26	1.55	1.43	0	1.39	1.27	1.31	4.37	2.88	2.13	3.15	

Patient Experience	Number of formal compliments	Number	1	3	2	2	3	4	0	7	1	3	2	
	Number of formal complaints	Number	5	12	11	7	7	7	8	11	3	11	6	
	Complaint response on time	Percent	100	83	100	86	57	86	100	91	100	100	-	
	Maternity Unit diverts	Number	0	0	1	0	3	2	1	0	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	79.4	
	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	85.8	
	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	67.2	

Coroner Reg 28 made directly to the Trust	No	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	No	
StEIS reported incidents	1	0	2	1	9	2	6	2	1	1	5	
Incidents with moderate harm or above	0	0	3	0	2	0	5	1	2	1	3	
HSIB referrals	3	0	1	0	5	1	4	2	2	1	4	

Appendix 2

SAINT MARY'S MANAGED CLINICAL SERVICE – Maternity Division - Maternity Self-Assessment Tool

BACKGROUND

2.1. As reported to SM MCS Quality and Safety Committee every 2 months, SM MCS responded to the 7 Immediate and Essential Actions (IEAS) identified in 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[14] and completed all identified actions prior to 31st December 2021.

2.2. In addition, an extensive submission of evidence related to areas of compliance was submitted to NHS England (NHSE) via the Future NHS Collaborative Platform for review by the Clinical Support Unit (CSU), Regional Maternity Transformation Programme on 30th June 2021. A review of the evidence was completed, and feedback was provided in November 2021.

2.3. As reported in February 2022 to SM MCS Quality and Safety Committee, there remains 4 elements where evidence is required from GMEC LMNS regarding external reporting processes and one element which required evidence of Non-Executive Director safety walkarounds. All of which continue to be monitored monthly at Maternity Services Division Quality and Safety Committee

2.4. In response to national review findings, inclusive of Ockenden recommendations, a maternity safety self-assessment tool (MSAT) was created by NHS E.

2.5. This tool, originally released in February 2021 then later updated in July 2021, was designed for NHS maternity services to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

2.6. The MSAT has been used as a benchmark for SM MCS against the core principles of good safety standards within Maternity services.

2.7. In January 2022, an update of the current SM MCS position against the tool was provided to MFT Group Board of Directors.

2.8. This paper provides a full review of SM MCS position and action plans to address areas of non-compliance.

MATERNITY SELF-ASSESSMENT TOOL (MSAT)

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

3.1. Similar to the evidence uploaded for the Ockenden report, the MSAT requires a large amount of evidence to be collated. The evidence demonstrates where SM MCS are compliant, where work is ongoing and where there are areas for improvement.

3.2. There are 7 overarching areas, with 42 actions and a total of 168 sections where evidence required to show compliance.

3.3. A table demonstrating overall compliance is provided in Appendix 1.

3.4. On review of the 42 actions for SM MCS:

- 32 actions have all evidence collated
- 3 actions require 1 identified piece of evidence to be compliant
- 3 actions require evidence from GMEC LMNS
- 3 actions are awaiting receipt of 2 or more pieces of evidence
- 1 action is considered non-compliant

3.5. Within these actions, of the 168 sections for SM MCS:

- 150 sections are compliant with all evidence collated
- 13 sections are in progress and awaiting evidence
- 3 sections require evidence from GMEC LMNS
- 2 sections are non-compliant

SECTIONS AWAITING EVIDENCE

4.1. There are currently 13 sections awaiting evidence. Progress on actions can be found within Table 1 action plan.

4.2. These issues have been allocated to named leads and further updates will be provided in due course.

4.3. Table 1

Section Number	Detail	Current Status	Lead	Expected completion date
7.3	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	Maternity strategy currently in place no co-produced. It is expected that this will be captured in the next revision of the strategy	HoM DD CHoD	End of February 2023
7.5	Maternity strategy aligned with trust board LMNS and MVP's strategies	Maternity strategy currently in place no co-produced. It is expected that this will be captured in the next revision of the strategy	HoM DD, CHoD	End of February 2023

7.6	Strategy shared with wider community, LMNS and all key stakeholders	Maternity strategy currently in place not co-produced. It is expected that this will be captured in the next revision of the strategy	SM Management Board	End of February 2023
8.3	All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	Awaiting update from SM MCS HoM's	HoMs	End of April 2022
8.4	Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	Awaiting update from SM MCS Maternity Safety Champion following NED meeting	Director of Nursing and Midwifery	End of April 2022
25.4	All clinical guidance and quality standards reviewed and updated in compliance with NICE	During guideline harmonisation all guidelines will be compared against NICE.	Governance Leads, SM MCS	End of September 2022
28.3	Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	Awaiting completed Job Plans	Clinical Head of Division	End of April 2022
41.4	Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	Staffing is not within current business plan. This will be amended when next reviewed	Divisional Director	End of December 2022
41.5	Consultant job plans in place and meet service needs in relation to capacity and demand	Staffing is not within current business plan. This will be amended when next reviewed	Divisional Director	End of December 2022
41.6	All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	Staffing is not within current business plan. This will be amended when next reviewed	Divisional Director	End of December 2022
41.7	Business plans ensures all developments and improvements meet national standards and guidance	This is partially within current business plan. This will be amended when next reviewed	Divisional Director	End of December 2022
41.8	Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	This is partially within current business plan.	Divisional Director	End of December 2022

		This will be amended when next reviewed		
41.9	Business plans include dedicated time for clinicians leading on innovation, QI and Research	Not within current plan. This will be amended when next reviewed	Divisional Director	End of December 2022

SECTIONS REQUIRING EVIDENCE FROM GMEC LMNS

5.1. There are currently 3 sections which require evidence from GMEC LMNS. Progress on actions can be found within Table 2 action plan.

5.2. These issues have been escalated to GMEC LMNS and further updates will be provided in due course.

5.3. Table 2

Section Number	Detail	Current Status	Lead	Expected completion date
16.2	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Currently postponed due to COVID. Awaiting new date	GMEC LMNS	TBC
23.3	In date and reflective of local maternity system plan	Maternity Specification was produced in 2017. Requires updating	GMEC LMNS	TBC
24.3	Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of CNST compliance	Awaiting confirmation from GMEC LMNS regarding reporting structure	GMEC LMNS	TBC

SECTIONS WHERE SM MCS ARE NON-COMPLIANT

6.1. There are currently 2 sections which SM MCS do not meet the requirement and would therefore be considered non-compliant.

6.2. It is a requirement of the MSAT that maternity services have an in-date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF. Currently there is an in-date risk management strategy within the MFT corporate strategy, which incorporates maternity.

6.3. There is also a requirement for Trust Board to open with a patient story, which currently does not occur. SM MCS do have a patient story to open Divisional and Hospital Quality and Safety Committee meetings each month.

6.4. Progress on actions can be found within Table 3 action plan.

6.5. Table 3

Section Number	Detail	Current Status	Lead	Expected Completion date
20	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	For review with SM MCS Management Board to decide if wish to propose a change to current Trust policy.	Medical Director, SM MCS	End of May 2022
40.4	Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	For review with SM MCS Management Board to decide if wish to propose a change to current Trust Board process.	Director of Nursing and Midwifery. SM MCS	End of May 2022

NEXT STEPS

7.1. SM MCS Maternity Division will monitor the progress on all 3 action plans via Divisional Quality and Safety Committee.

7.2. In line with SM MCS perinatal surveillance model, an update on progress will be provided within the Maternity Assurance Paper, presented to SM MCS Quality and Safety Committee and Trust Board of Directors bi-monthly.

Appendix 1 of MSAT

Key for Actions

Complete – All Evidence obtained
Outstanding LMNS Evidence for 1 Element
Outstanding MFT Evidence for 1 Element
Outstanding MFT Evidence for 2 or more Elements
Non-Compliant

Key for RAG rating

Complaint
Work ongoing MFT
Awaiting Evidence LMNS
Non-Compliant

Area for Improvement	Maternity Self-Assessment Actions	Element Number	Element Evidence Requirement	Self-assessed compliance (RAG)
Directorate/care group infrastructure and leadership	Clinically-led triumvirate	1.1	Trust and service organograms showing clinically led directorates/care groups	
		1.2	Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	
	Director of Midwifery (DoM) in post	2.1	DoM job description and person specification clearly defined	
		2.2	Agenda for change banded at 8D or 9	
		2.3	In post	
	Direct line of sight to the trust board	3.1	Lines of professional accountability and line management to executive board member for each member of the triumvirate	
		3.2	Clinical director to executive medical director	
		3.3	DoM to executive director of nursing	
		3.4	General manager to executive chief operating officer	

		3.5	Maternity services standing item on trust board agenda as a minimum three-monthly. Key items to report should always include: SI Key themes report, Staffing for maternity services for all relevant professional groups · Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. Job essential training compliance. · Ockenden learning actions	
		3.6	Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	
		3.7	There should be a minimum of three PAs allocated to clinical director to execute their role	
	Collaborative leadership at all levels in the directorate/ care group	**4.1**	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	
		4.2	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate, Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	
		4.3	Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	
		4.4	Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	
		4.5	Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	
		4.6	From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	
		4.7	Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly	
		4.8	Leadership culture reflects the principles of the '7 Features of Safety'.	
	Leadership development opportunities	**5.1**	Trust-wide leadership and development team in place	

		5.2	Inhouse or externally supported clinical leadership development programme in place	
		5.3	Leadership and development programme for potential future talent (talent pipeline programme)	
		5.4	Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	
	Accountability framework	**6.1**	Organisational organogram clearly defines lines of accountability, not hierarchy	
		6.2	Organisational vision and values in place and known by all staff	
		6.3	Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	
	Maternity strategy, vision and values	**7.1**	Maternity strategy in place for a minimum of 3–5 years	
		7.2	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	
		7.3	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	
		7.4	Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	
		7.5	Maternity strategy aligned with trust board LMNS and MVP's strategies	
		7.6	Strategy shared with wider community, LMNS and all key stakeholders	
	Non-executive maternity safety champion	**8.1**	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	
		8.2	Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	
		8.3	All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	
		8.4	Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	

		8.5	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	**9.1**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	
		9.2	Record of attendance by professional group and individual	
	Multiprofessional training programme	**10.1**	Recorded in every staff member's electronic learning and development record	
		10.2	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	
		10.3	A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	
		10.4	All staff given time to undertake mandatory and job essential training as part of working hours	
		10.5	Full record of staff attendance for last three years	
		10.6	Record of planned staff attendance in current year	
		10.7	Clear policy for training needs analysis in place and in date for all staff groups	
		10.8	Compliance monitored against training needs policy and recorded on roster system or equivalent	
		10.9	Education and training compliance a standing agenda item of divisional governance and management meetings	
		10.10	Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	
	Clearly defined appraisal and professional revalidation plan for staff	**11.1**	Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	
		11.2	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	
		11.3	Compliance with annual appraisal for every individual	
		11.4	Professional validation of all relevant staff supported by internal system and email alerts	

		11.5	Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	
	Multiprofessional clinical forums	**12**	Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	
	Multiprofessional inclusion for recruitment and HR processes	**13.1**	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	
		13.2	Organisational values-based recruitment in place	
		13.3	Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	
		13.4	Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	
		13.5	Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	
		13.6	Schedule of attendance from multiprofessional group members available	
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	**14.1**	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	
		14.2	Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	
	Collaborative multiprofessional input to service development and improvement	**15.1**	Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	
		15.2	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	
		15.3	Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	
		15.4	Identification of the source of evidence to enable provision of assurance to all key stakeholders	
		15.5	The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	

		15.6	Clear communication and engagement strategy for sharing with key staff groups	
		15.7	QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	
	Multiprofessional approach to positive safety culture	**16.1**	Weekly/monthly scheduled multiprofessional safety incident review meetings	
		16.2	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	LMS
		16.3	Positive and constructive feedback communication in varying forms	
		16.4	Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	
		16.5	Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	
	Clearly defined behavioural standards	**17.1**	Schedule of focus for behavioural standards framework across the organisation	
		17.2	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	
		17.3	Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	**18.1**	All policies and procedures align with the trust's board assurance framework (BAF)	
		18.2	Governance framework in place that supports and promotes proactive risk management and good governance	
		18.3	Staff across services can articulate the key principles (golden thread) of learning and safety	
		18.4	Staff describe a positive, supportive, safe learning culture	
	Maternity governance structure within the directorate (to include as minimum)	**19.1**	Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	
		19.2	Maternity governance lead (Current RM with the NMC)	
		19.3	Consultant Obstetrician governance lead (Min 2PA's)	

		19.4	Maternity risk manager (Current RM with the NMC or relevant transferable skills)	
		19.5	Maternity clinical incident leads	
		19.6	Audit midwife	
		19.7	Practice development midwife	
		19.8	Clinical educators to include leading preceptorship programme	
		19.9	Appropriate Governance facilitator and admin support	
		19.10	Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	
		19.11	Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales	
	Maternity-specific risk management strategy	**20**	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	
	Clear ward-to-board framework aligned to BAF	**21.1**	Clearly defined in date trust wide BAF	
		21.2	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	
	Proactive shared learning across directorate	**22.1**	Mechanism in place for trust-wide learning to improve communications	
		22.2	Mechanism in place for specific maternity and neonatal learning to improve communication	
		22.3	Governance communication boards	
		22.4	Publicly visible quality and safety board's outside each clinical area	
		22.5	Learning shared across local maternity system and regional networks	
		22.6	Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	
		22.7	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	

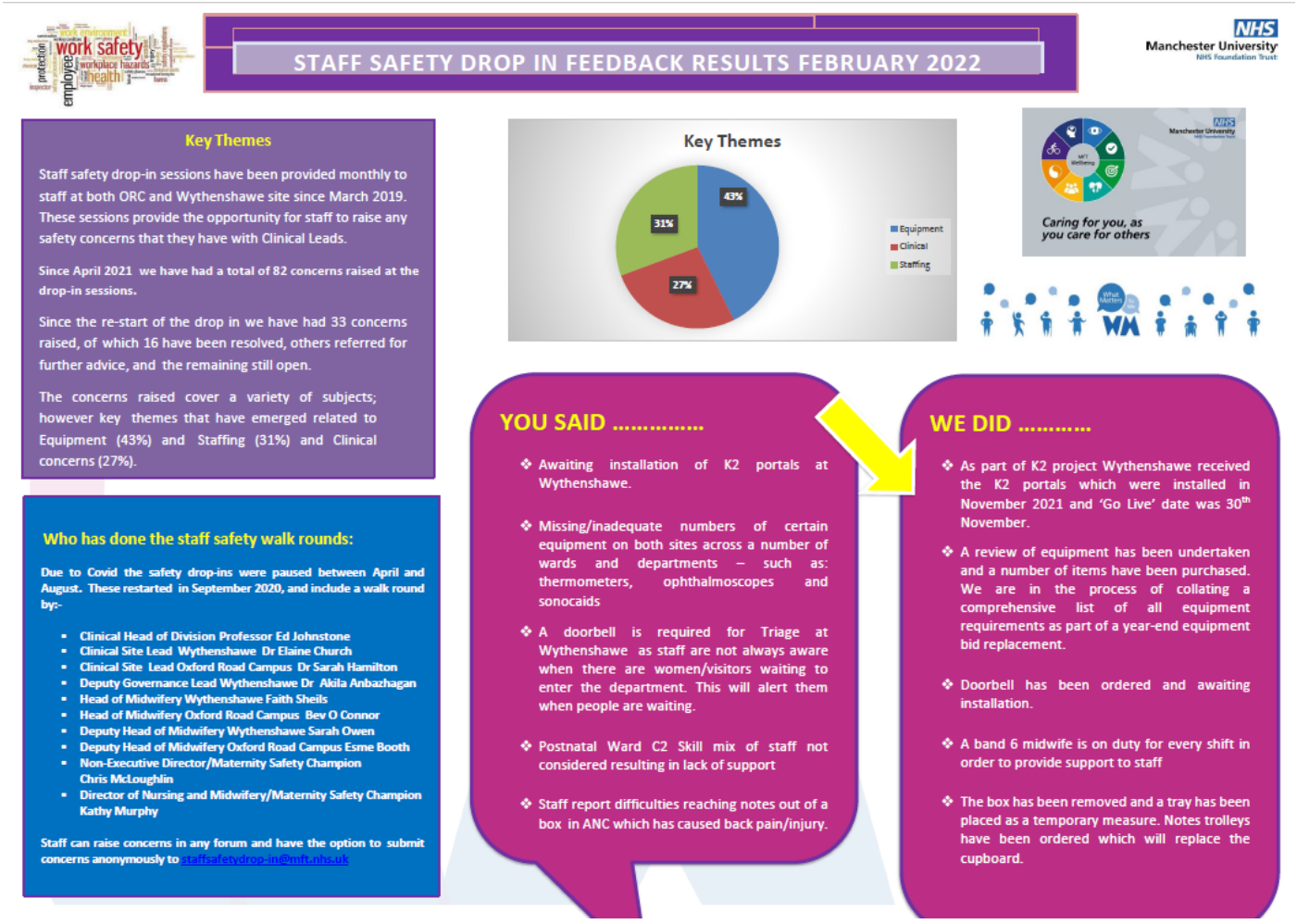
Application of national standards and guidance	**Maternity specification in place for commissioned services**	**23.1**	Multi-agency input evident in the development of the maternity specification	
		23.2	Approved through relevant governance process	
		23.3	In date and reflective of local maternity system plan	LMS
	Application of CNST 10 safety actions	**24.1**	Full compliance with all current 10 standards submitted	
		24.2	A SMART action plan in place if not fully compliant that is appropriately financially resourced.	
		24.3	Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	LMS
	Clinical guidance in date and aligned to the national standards	**25.1**	Clear process for multiprofessional, development, review and ratification of all clinical guidelines	
		25.2	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	
		25.3	All guidance NICE complaint where appropriate for commissioned services	
		25.4	All clinical guidance and quality standards reviewed and updated in compliance with NICE	
	Saving Babies Lives care bundle implemented	**26.1**	All five elements implemented in line with most updated version	
		26.2	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	
		26.3	Trajectory for improvement to meet national ambition identified as part of maternity safety plan	
	Application of the four key action points to reduce inequality for BAME women and families	**27.1**	All four key actions in place and consistently embedded	
		27.2	Application of equity strategy recommendations and identified within local equity strategy	
	Implementation of 7 essential learning actions from the Ockendon first report	**28.1**	All actions implemented, embedded and sustainable	
		28.2	Fetal Surveillance midwife appointed as a minimum 0.4 WTE	
		28.3	Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	

	A-EQUIP implemented	**29.1**	Plan in place for implementation and roll out of A-EQUIP	
		29.2	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	
		29.3	Training plan for transition courses and succession plan for new professional midwifery advocate (PMA)	
		29.4	A-EQUIP model in place and being delivered	
	Maternity bereavement services and support available	**30.1**	Service provision and guidance aligned to national bereavement pathway and standards	
		30.2	Bereavement midwife in post	
		30.3	Information and support available 24/7	
		30.4	Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	
	Quality improvement structure applied	**31.1**	Quality improvement leads in place	
		31.2	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	
		31.3	Recognised and approved quality improvement tools and frameworks widely used to support services	
		31.4	Established quality improvement hub, virtual or otherwise	
		31.5	Listening into action or similar concept implemented across the trust	
	MatNeoSip embedded in service delivery	**32**	Continue to build on the work of the MatNeoSip culture survey outputs/findings.	
	Maternity transformation programme (MTP) in place	**33**	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	**34.1**	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	
		34.2	Standing agenda item on key directorate meetings and trust committees	
	Freedom to Speak Up (FTSU) guardians in post	**35**	FTSU guardian in post, with time dedicated to the role	
	Human factors training available	**36.1**	Human factors training lead in post	

		36.2	Human factors training part of trust essential training requirements	
		36.3	Human factors training a key component of clinical skills drills	
		36.4	Human factors a key area of focus in clinical investigations and formal complaint responses	
	Robust and embedded clinical handovers in all key clinical area at every change if staff shift	**37.1**	Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: Consultant obstetrician, ST7 or equivalent; ST2/3 or equivalent; Senior clinical lead midwife; Anaesthetist. And consider appropriate attendance of the following:· Senior clinical neonatal nurse; Paediatrician/neonatologist?; Relevant leads from other clinical areas eg, antenatal/postnatal ward/triage.	
		37.2	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern. Audit required.	
	Safety huddles	**38.1**	A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process'	
		38.2	Guideline or standard operating procedure describing process and frequency in place and in date	
		38.3	Audit of compliance against above	
	Trust wide Swartz rounds	**39.1**	Annual schedule for Swartz rounds in place	
		39.2	Multiprofessional attendance recorded and supported as part of working time	
		39.3	Broad range of specialties leading sessions	
	Trust-wide safety and learning events	**40.1**	Trust-wide weekly patient safety summit led by medical director or executive chief nurse	
		40.2	Robust process for reporting back to divisions from safety summit	
		40.3	Annual or biannual trust-wide learning to improve events or patient safety conference forum	
		40.4	Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	
Comprehension of business/ contingency plans impact on quality.(ie	**Business plan in place for 12 months prospectively**	**41.1**	In date business plan in place	
		41.2	Meets annual planning guidance	
		41.3	Business plan supports and drives quality improvement and safety as key priority	

Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)		**41.4**	Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	
		41.5	Consultant job plans in place and meet service needs in relation to capacity and demand	
		41.6	All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	
		41.7	Business plans ensures all developments and improvements meet national standards and guidance	
		41.8	Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	
		41.9	Business plans include dedicated time for clinicians leading on innovation, QI and Research	
		41.10	That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance.	**That Employment Policies and Clinical Guidance meet the publication requirements of Equity and Diversity Legislation.**	**42.1**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	
		42.2	Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	

Appendix 3 – Safety Posters



Appendix 4

ATAIN Report

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Saint Mary's Quality and Safety Committee

Report of:	Professor Edward Johnstone, Clinical Head of Division, Obstetrics, Saint Mary's Managed Clinical Service Beverley O'Connor, Faith Sheils and Esme Booth, Heads of Midwifery, Saint Mary's Managed Clinical Service
Paper prepared by:	Jen Sager, Associate Head of Midwifery, Saint Mary's Managed Clinical Service
Date of paper:	4th April 2022
Subject:	Quarterly Report of Transitional Care pathway January 1st to March 31st 2022 (Q4 21/22) as required in Safety Action 3, Year 4 Maternity Incentive Scheme (sections b, e, f, and g)
Purpose of Report:	Indicate which by **(tick as applicable-please do not remove text)** • Information to note • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality, and outcome • Improve the experience of patients, carers, and families
Recommendations:	The Committee is requested to accept and note the details in the report.
Contact:	Name: Jen Sager, Associate Head of Midwifery Email: jen.sager@mft.nhs.uk

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[15] 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 4 2021/22, one term baby met the current Transitional Care admissions criteria was admitted to the neonatal unit due to the requirement of nasogastric tube feeding. (Table 1)

3.3. Work is ongoing to support nasogastric tube feeding as part of a wider workstream to harmonise transitional care pathways across SM MCS. (Appendix 1)

3.4. **Table 1**

Site	January 2022	February 2022	March 2022
ORC	0	1	0
Wythenshawe	0	0	0
North Manchester	0	0	0

3.5. 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 Q4 2021/22.

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

[15] 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

- 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 January 2022 and 31 March 2022 there were 10 avoidable term admissions across Saint Mary's MCS. 4 babies on the ORC site, 3 on the Wythenshawe site and 3 on the North Manchester site.

4.5. Themes identified include:
- Inappropriate method of fetal monitoring used
- Delay in commencing CTG
- Delay in recognising abnormal antenatal CTG
- Infant feeding pathway not followed

4.6. Following integration of North Manchester, a new report to capture themes and share learning across SM MCS has now been developed and will be a quarterly agenda item on the Maternity Services Divisional Quality and Safety meeting.

4.7. The new report will be captured within Q1 22/23 Quarterly ATAIN review as an appendix.

5. Action Plan

5.1. An overall ATAIN action plan (Appendix 1), as required by MIS year 4 (section f), has been amended to capture any learning, actions and progress on harmonisation of TC model and guidelines.

6. Conclusion

6.1. Saint Mary's MCS has maintained full compliance during Quarter 4 of 2021/2022. Appendix 2 provides clear overview of compliance of MIS Year 4 Safety Action 3.

Appendix 1 of ATAIN

Action plan for MIS Safety Action 3 – Reviewed April 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	Complete
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 2 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 5: MCoC Action Plan

		Complete	In progress	Paused	Not due	Overdue

Action Number	Action	Narrative	Action taken by	Due by	Status as at 29.3.22
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	ongoing	Ongoing recruitment to address vacancies across workforce. Staffing of MCoC under review in light of Ockenden Final report and IEA
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	Recruit 3.2 WTE Band 3 MSWs to continuity teams (ORC and Wythenshawe) using LMS funds	Develop job descriptions, advertise and recruit	Cons midwife, ORC comm matron	April 2022	1.8 WTE soon to start. Additional recruitment paused for CoC whilst under review
7	Recruit 1 WTE Band 7 post (NMGH) to support further continuity team using LMS funds.	Advertise and recruit 12 month secondment	Comm Matron	April 2022	Recruitment paused whilst CoC under review
8	Request additional midwifery 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	May 2022	Submission completed
9	Staff Engagement	Subject to funding approval, work with HR to create a workforce engagement strategy. Utilising the skills and experience of	HoM's across SM MCS	April – May 2022	Ongoing. Talent attraction and senior acquisition service team working with maternity team to undertake focused advertising

		current MCoC teams to showcase the benefits of working in a MCoC model			and recruitment drive for community/continuity. Survey currently ongoing.
10	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. Newsletter in development. Plan to be circulated quarterly.
11	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. Meeting with Matrons and TL regarding SOP draft. Expected to be circulated for Divisional approval April 2022
12	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
13	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	
14	Review community hub provision	Review current community hub capacity to support Wave 2 roll out	Divisional Director for Obstetrics, SM MCS	June 2022	
15	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	
16	Wave 2	Commence Wave 2 Roll Out	Community Matrons across SM MCS	Sept-Dec 2022	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	May 2022
Subject:	Complaints & PALS Report: Quarter 4, 2021/22
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board of Directors are asked to note the content of this Q4 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.
Recommendations:	Members of the Board of Directors are asked to note the content of the Report
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality & Patient Experience. Tel: 0161 276 8862

1. Introduction

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaint activity across Manchester University NHS Foundation Trust (MFT) during Q4 (January – March) 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
- Supporting information referred to throughout the report is included at **Appendix 1**.

1.4 The report refers to all Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) across the MFT Group.

2. An overview of PALS and Complaints activity Q4 2021/22

- 2,066 PALS concerns were received in comparison to 1,865 received in the previous quarter, an increase of 27.6% (570) for the same period in Q4, 2020/21[1].
- 426 new complaints were received in comparison to 384 received in the previous quarter. This shows an increase of 23.2% (99) for the same period in Q4, 2020/21[2].
- Of the 426 new complaints received 135 related to in-patient services. This shows an increase of 21.4% (29) in comparison to 106 received in the previous quarter.
- WTWA received the greatest number of complaints (45); an increase of 49% (22) in comparison to the 23 WTWA received in the previous quarter. Of the 45 complaints received at WTWA there were no single themes or trends. (See 3.1)
- 100% of complaints were acknowledged across the Group within 3 working days; this position was maintained throughout all quarters in 2020/21 and 2021/22.
- The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 89.5% of complaints were closed within this agreed timescale compared to 89.8% in the previous quarter[3].
- 31 (9.56%) complaints investigated were upheld, 215 (66.3%) were partially upheld and 61 (19.0%) were not upheld (please refer to section 5:3).
- The PHSO partially upheld and closed 1 case during this quarter. In the one case, the Trust was required to pay £300 redress in recognition of the missed aspects of discharge planning and inaccurate documentation.

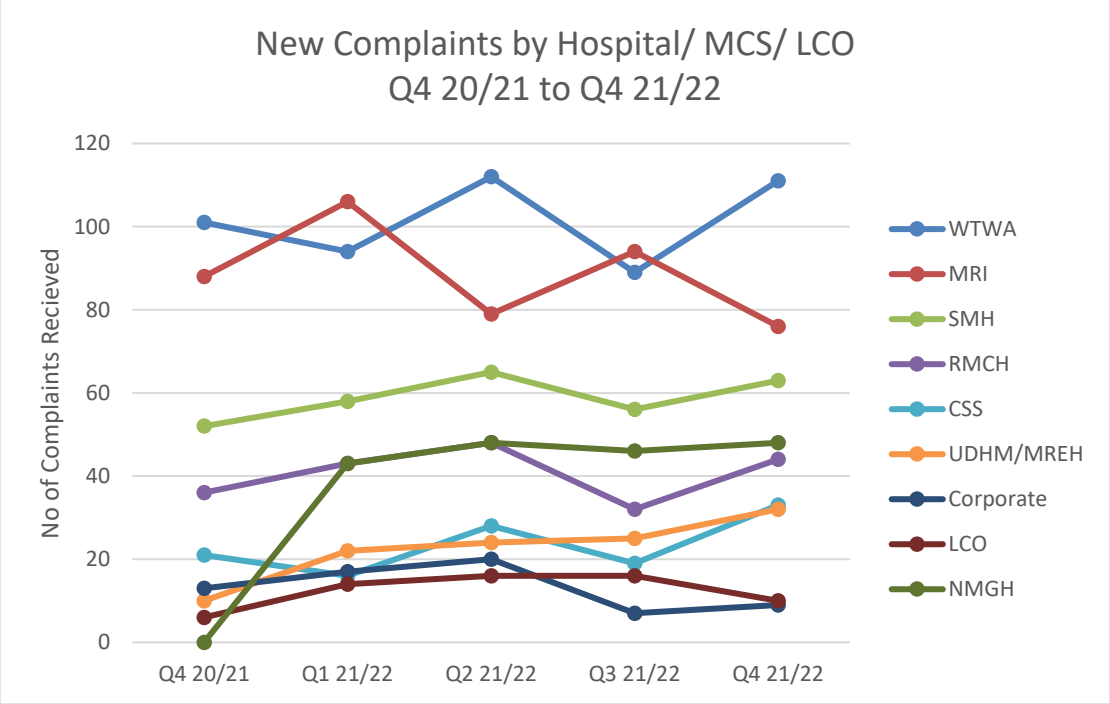
[1] Contributed to by NMGH joining from 1st April 2021

- During this quarter the PHSO opened 6 cases. Details of the 'open' PHSO cases are set out in **Appendix 1, Table 1**.
- There was a total of 74 re-opened complaints received. This compares to 79, a 6.75% decrease compared to the previous quarter.
- 31 virtual or face to face complaint local resolution meetings were held. This compares to 13, a 58% increase compared to the previous quarter.
- 5 in-house Complaints Letter Writing Training Educational Sessions were held, with 41 members of staff attending.
- The Complaints Review and Scrutiny Group (CRSG), chaired by a Non-Executive Director, met once during Q4. The senior management teams from WTWA presented 2 cases. The learning identified from these cases is detailed in Section 5 of this report.

3.0 An overview and brief thematic analysis of PALS and complaints contacts

3.1 The increase in PALS concerns from the previous quarter, and Q4 2020/21 comparatively specifically relating to WTWA 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 and the increase in PALS specifically relating to SMH coincides with patients not being able to access the Gynaecology department via telephone due to the reduced staffing levels within services.

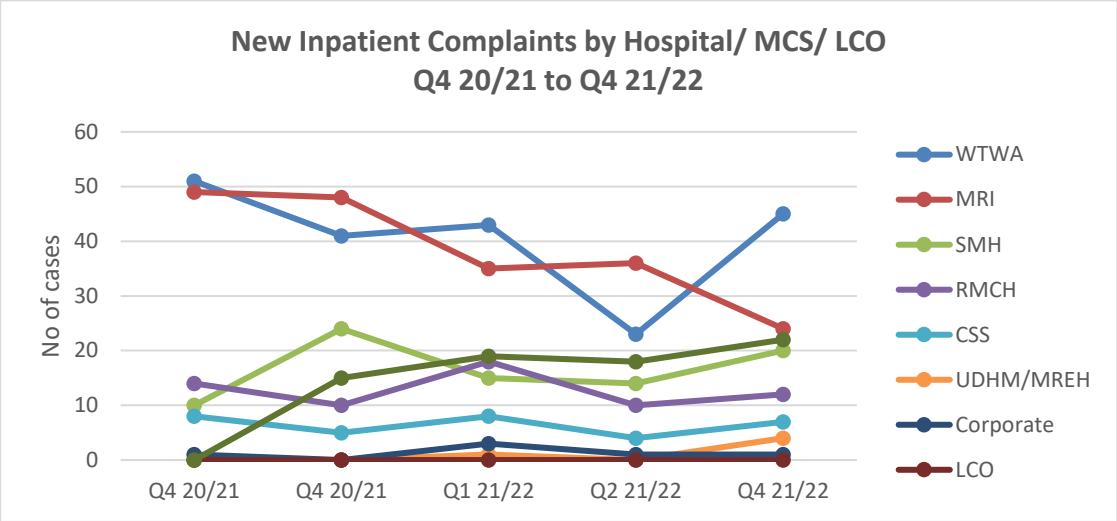
3.2 In Q4 the Trust saw an increase in complaints with 426 new complaints being received. Graph 1 below shows the number of complaints received by each Hospital / MCS / LCO each quarter. WTWA received the greatest number of complaints. Further detail is provided in **Table 2**, **Appendix 1**.



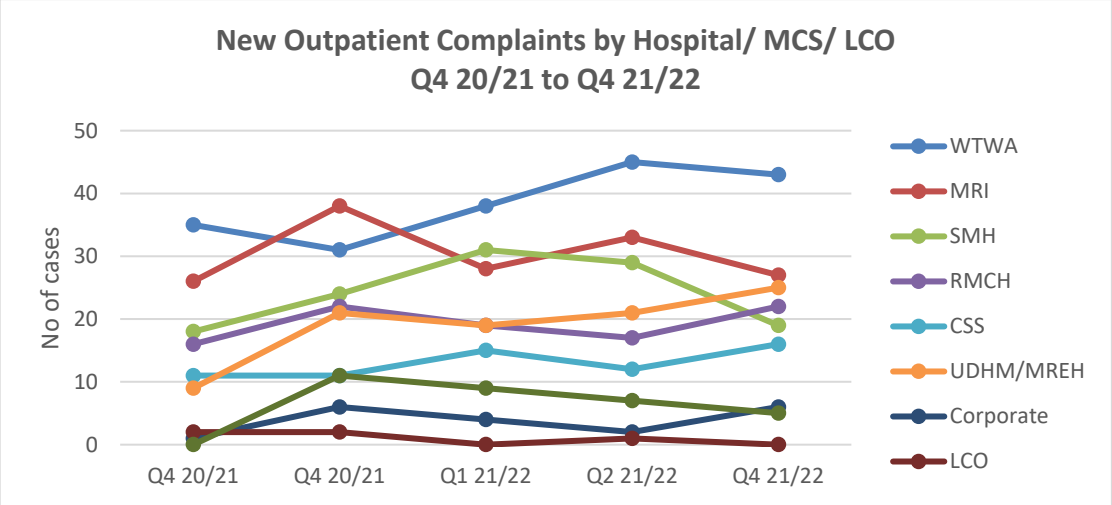
[2] Contributed to by NMGH joining from 1st April 2021

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

3.3 **Graphs 2 and 3** illustrate the number of new complaints relating to inpatient and outpatient services during Q4 2020/21 – Q4 2021/22. Overall, the greatest increase in complaints relates to in-patient services with a slight reduction in complaints relating to outpatient services being noted.



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

3.4 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 89.5% of complaints were closed within the agreed timescale representing a slight decrease 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 Q4 was registered within SMH on 9th August 2021 and was 149 days old when it closed on 10th March 2022. The third-party investigations at Greater Manchester West Mental Health Trust and Northern Care Alliance, and the arranging of a local resolution meeting impacted the overall response time. The complainant was kept updated and was fully supported throughout this process.

4.3 The oldest complaint case open at the end of Q4 was within NMG H; it was 86 days old at the end of Q4, 21/22. The complaint involves a local resolution meeting impacting in the Trust's overall response time. The complainant continues to be kept updated and fully supported 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 Q4, 31 (9.56%) of the complaints investigated and responded to were fully upheld, 215 (66.30%) were partially upheld and 61 (19.0%) were not upheld. **Appendix 1, Table 5** demonstrates the outcome status of all complaints between Q4 2020/21 and Q4 2021/22.

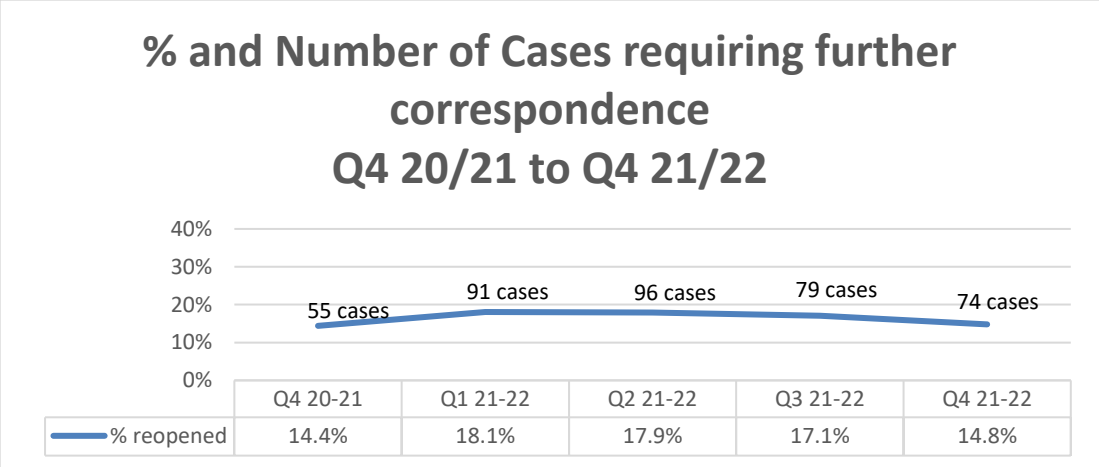
6.0 Re-opened complaints

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 Q4, 14.8% of complaints were reopened (74 cases in total) against the Trust tolerance threshold of 20%. In the previous quarter, 17.1% of complaints were reopened (79 cases in total).

6.3 **Graph 4** demonstrates the number of complaints re-opened from Q4 2020/21 – Q4 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.



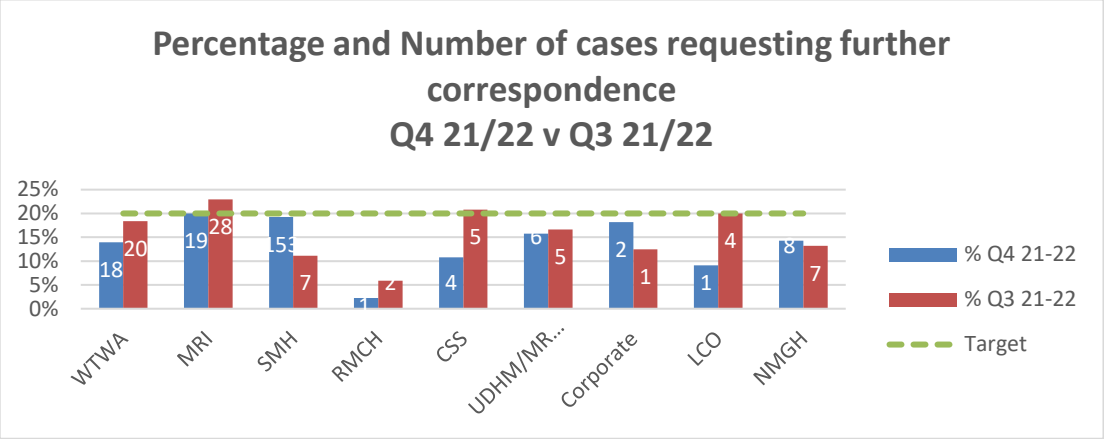
Graph 4: Total Re-opened complaints Quarter 4, 2020/21 to Quarter 4, 2021/22

6.4 In 38 of the 74 complaints requiring re-opening, the primary reason was due to the complainant being 'dissatisfied with the response', with MRI and WTWA receiving the greatest number, 19 and 18 respectively.

6.5 The 20% threshold was not exceeded by the Hospitals/MCSs/LCO **(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.

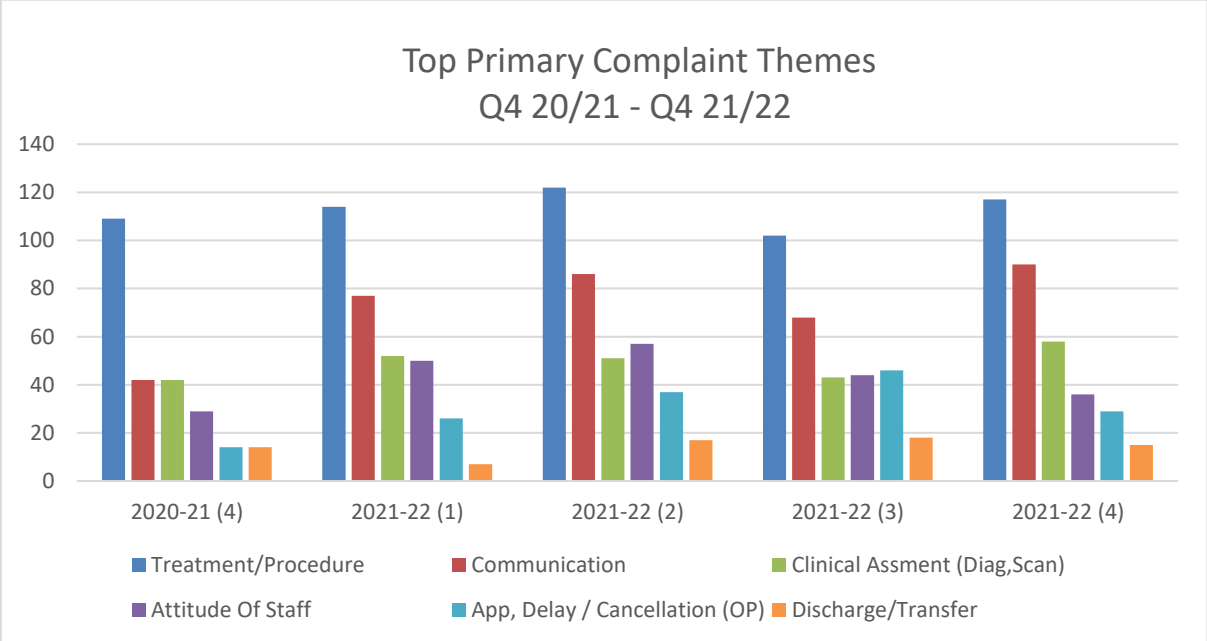


Graph 5: Percentage and number of re-opened complaints, Quarter 4, 2021/22

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 Q4, the top 5 primary categories remained unchanged with Treatment / Procedure' remaining the top category **(Graph 6)**.



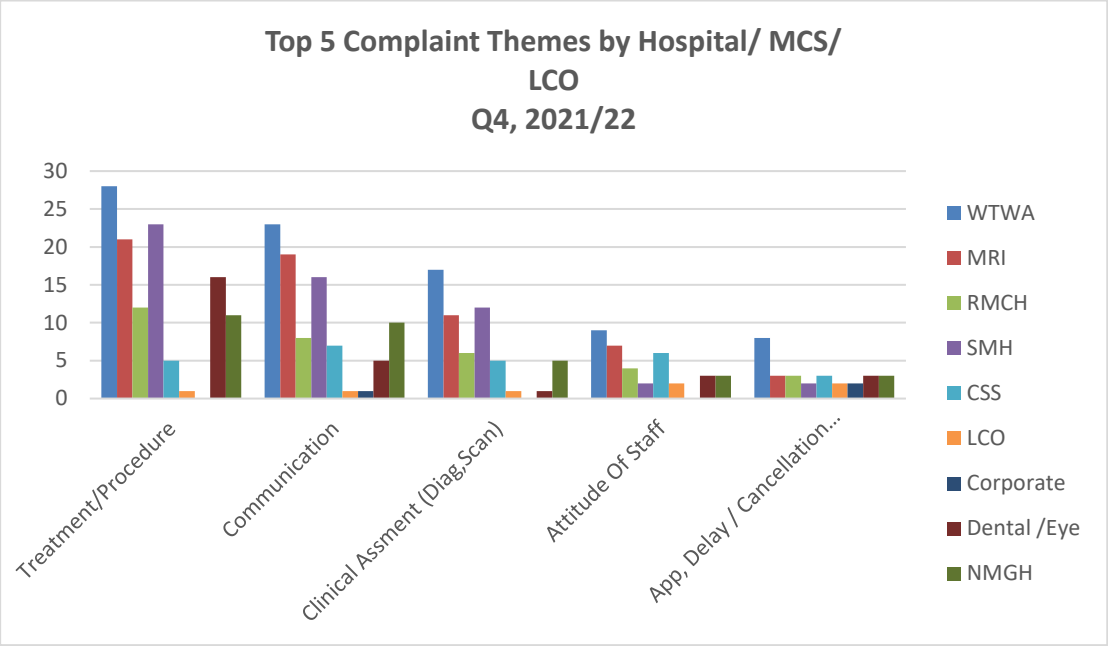
Graph 6: Top Primary Complaint Themes Q4, 2020/21 to Q4, 2021/22

7.3 As in all top primary themes, WTWA received the most complaints relating to 'Treatment/Procedure', some examples include:

- a patient experiencing delays in the arranging of investigations and plan of treatment and care

- a patient experiencing intra and post operative problems following cardiac surgery

7.4 **Graph 7** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q4 2021/22.



Graph 7 Top 5 themes by Hospital/MCS/LCO in Q4 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 Q4.

Quarter 4, 2021/22
Saint Mary's Hospital
"Excellent experience, caring staff" I was incredibly nervous prior to the treatment that I had to have but the staff at Saint Mary's really put me at ease. They talked me through each step of the procedure so that I knew what was going to happen next. They distracted me but also acknowledged my anxieties and didn't once make me feel silly for feeling that way. They were patient, and nothing was rushed even though I am sure they are very busy. I was offered a brew and biscuits after my procedure which was very much appreciated. Really recommend this team.
Response

Thank you for your positive comments posted on the NHS Website regarding your care within the Gynaecology Outpatient Department. 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 so it was reassuring to read that you found all the staff caring and that your experience has been a positive one. I can assure you that we have passed on your feedback to the Clinical Head of Division for Gynaecology, Interim Divisional Director for Gynaecology and the Head of Nursing who will be delighted to share your feedback with the staff.

North Manchester General Hospital

"Informing families" 07/01/2022
Why does this hospital not inform family and friends on the progress of the patient once admitted? During this stage of the pandemic visits are prevented and our family is fraught not knowing about the progress of my mum, who is in a serious condition and has cancer which was about to be treated elsewhere. That's not a professional or sensitive way to treat her loved ones who care and love her. Almost 2 years into the pandemic and procedures should be in place to communicate with relatives and friends!

Response

Thank you for sharing your recent experience and we are very sorry that you have experienced distress with the lack of communication on your Mum's progress at North Manchester General Hospital. Guidance is available for staff to support patients and families to ensure communication remains effective especially during these difficult and challenging times. As you indicate, it has been necessary to adapt some practices to ensure the safety of our patients, staff, and visitors and this is reviewed regularly. We apologise that communications have not met our high standards in this case and would like to rectify this. It is difficult to respond to all posts in a full way often because of a lack of detailed information. If you would find it helpful to discuss your experience with us in more detail, please do not hesitate to contact, the Head of Nursing for Quality and Patient Experience at NMGH directly on 0161 720 2498.

University Dental Hospital Manchester

"A credit to the NHS"
I went in with two extremely decayed teeth that was causing me a tonne of pain. I only wanted the pain gone so I wasn't expecting much. However, I was called it almost as soon as I sat down. I was told I need an extraction and root canal; the dentist could only remove the root so opted for a temporary filling and to go private to have the root canal. The extraction was easy peasy. The dental surgeon was amazing. I cannot thank you all enough for being so gentle and kind. Without you all we would still be in absolute agony. Thank you, thank you.

Response

Thank you for your recent feedback about the care you received at Manchester University Dental Hospital. It is wonderful to hear that you were seen quickly, the tooth extraction was pain-free and that the dental surgeon was amazing. We feel that comments like these reflect the hard work and dedication of our staff and are grateful to receive them. We have passed on your comments to the Head of Nursing who will share with the team involved. In the meantime, we wish you the best of luck with your root canal treatment.

North Manchester General Hospital

"Excellent treatment" 20/03/22
Thank you for the excellent treatment my husband received in casualty (9.3.22) but the 7-hour wait was traumatic for his 86 years. The quality of the surgery was excellent.

Response

Thank you for your wonderful comments regarding the treatment your husband received in casualty at North Manchester General Hospital. We are delighted to hear you felt the quality of the surgery was excellent and we have shared with the Head of Department who will share with all the staff involved. We apologise for the 7-hour wait and fully understand why this was of a concern to you. The demand on the Emergency Department has been very high in recent weeks which has resulted in the need for a high number of attendees to be admitted to the hospital for ongoing care, as was the case for your husband. I am sorry that your husband experienced this. When delays are experienced in the Emergency Department, the Nursing Team increase the frequency of the quality and communication rounds that they complete routinely and this enables any queries to be addressed in real time, patient's comfort maintained and when necessary, concerns escalated to seek additional support. Thank you again for your lovely comments and I hope that your husband's ongoing recovery following surgery continues.

Saint Mary's Hospital

"No answer on the phone"

I received an unexpected call 10 days ago to say an operation I've been waiting over 2 years for was going ahead on 29th March and to expect a letter with further details. I have not received a letter and simply cannot get through on the phone. I have questions about my operation as the scheduler couldn't answer any. The receptionist at the hospital advised answering calls was a known issue. This is a contact on a scheduled operation so not a general query, both frustrating and stressful 😑

Response

Thank you for your feedback. We are sorry to learn that your experience in contacting the Women's Outpatient Department at Saint Mary's Hospital has been a disappointing and frustrating experience for you. I have discussed these events with the Matron for Gynaecology and the Deputy Directorate manager who were both very sorry to hear of your experience. A voicemail has been left confirming your admission details and one of the admin team will attempt to contact you again. An investigation is being undertaken to identify why this error in communication has occurred.
The Division of Gynaecology currently has significant administrative staffing pressures across the Gynaecology administrative service which has resulted in a reduction of staff available to answer the phones. A new telephone system has recently been implemented which is designed to allow patients to choose the exact area in which they need to make contact, however with the current staffing gaps in the service we are not able to answer all calls that we receive as efficiently as we would normally aim for. When the new telephone system was implemented, it was agreed the opening hours would be identified however, no voicemail would be available as often all messages could not be responded to in a timely manner due to high volume of calls that we receive. Saint Mary's MCS appreciate that this is an issue within the service currently and are working hard to rectify this situation and improve the way in which patients can communicate with the Trust.
It is challenging to respond to all posts in a full way often because of a lack of detailed information, therefore if you would like to discuss your experience with us in more detail,

please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686.
Withington Community Hospital
"Rapid, personal and professional service" The NHS at its best! Contacted GP on Monday, referred to rapid access Dermatology clinic, receptionist phoned Tuesday with a cancellation, seen Wednesday morning. Reassured. Summary letter received 8 days later. Thank you!
Response
Thank you for your positive comments posted on the NHS Website regarding the care you received at the Dermatology Clinic in Withington Hospital. It was very kind of you to take the time to write and compliment the staff as it is always good to receive positive feedback which reflects their hard work and dedication. It is reassuring to read that you feel it is a rapid, personal and professional service that allowed you to be seen within the same week. It is also wonderful for us to know that this support has helped you to feel reassured. We are sincerely grateful for your kind words, and we have passed on your appreciation and gratitude to the Head of Nursing, who will share with all the staff involved.

Table 7: Examples of Care Opinion/ NHS Website Postings and Reponses Q4 2021/22

8.3 This quarter a total of 37 comments were received via the websites, of which 21 (57.0%) were positive, 13 were negative (35.0%) and 3 were mixed (08.0%). 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 Q4 2021/22 MFT's Non-Executive Director (NED) and newly appointed lead for Complaints joined the Complaints Review Scrutiny Group (CRSG) panel, chairing the one meeting which took place during this quarter. The management team from WTWA presented two cases in March 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.

9.4 In response to discussions with the newly appointed NED and to improve the existing CRSG standards and enhance the monitoring compliance and effectiveness of the CRSG, an Action Plan has been developed and implemented. The action plan will be undertaken during the next 3 months and will involve the Head of Customer Services taking steps to implement a clear operating framework which will frame future reviews.

Hospital / MCS / LCO	Learning	Actions
WTWA (Surgery)	We learnt that: • A patient's Research Study diagnostic examination findings suggestive of cancer had not been upgraded or added to the Cancer Pathway • A delay in the patient's pathway had not been incident reported • Work undertaken by new and temporary administration staff had not been checked for accuracy	 • Incidental Findings Research Project Standard Operating Procedure being developed • Research Leads to be reminded of importance of reporting incidental findings to clinicians whose patients are involved in research • Incident logged on Ulysses • Incident and learning shared with all staff groups • Implementation of a process for onward referrals and communications to be completed at the time of discharge • Review of induction and training procedures for temporary administration staff to be undertaken
WTWA (Trauma & Orthopaedic)	We learnt that: • A patient and their family received poor communication • Escalation Policy was not applied by staff due to their lack of awareness of the Policy	 • All staff reminded of the importance of clear and compassionate communication • All staff reminded of the expected standards of documentation and audit undertaken • Monitoring of fluid balance training and education undertaken by staff • Complaint shared and discussed with the nursing staff and the

	• An incident was not logged correctly or in a timely manner on the system	Complex Health and Orthogeriatric team • Increase focus to raise staff awareness around the Escalation Policy • All staff reminded of the importance of the 'Daily Huddles' being utilised to raise and escalate concerns • Incident logged on to Ulysses

Table 9: Actions identified at the Trust Complaints Scrutiny Group during Q4 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	Difficulties contacting Maternity Triage when the patient had concerns regarding her pregnancy and poor communication and support experienced by the patient relating to a receptionist in the Antenatal Clinic (ANC).	Additional midwife provision per shift. Implementation of a dedicated Telephone Triage Midwife to support and ensure appropriate advice and assistance is available to women and to provide clear communication channels. The importance of the ANC Matron ensuring a qualified member of staff communicates personally with the pregnant women when they telephone for advice discussed with the administration staff in the ANC.
MREH	Concerns regarding the decision to remove a patient from the waiting list without prior notice.	Patient reassured they had not been removed from the waiting list and that the delay in treatment being provided was due to the suspension of 'routine

		appointments as a result of the COVID-19 pandemic. As a direct result of the complaint the Assistant Directorate Manager has reviewed all actions undertaken by staff during a managing of waiting times process Staff reminded of the importance of ensuring all patients who enquire about waiting times are provided with clear and effective communication.
UDHM	Concerns regarding the treatment received and the clinician's manner whilst questioning activities affecting the success of the patient's treatment.	To provide assurance the Supervising Consultant has reviewed the patient's medical records. Concerns shared and clinician supported in reflecting on the events leading to the complaint. Clinician reminded of the importance of communicating professionally and sensitively with their patients.
LCO	Difficulties in arranging appointments for daily dressing changes with the Trafford District Nursing service.	All staff at the Treatment Room service reminded of the importance of: - Clearly documenting all conversations with patients. - Offering patient appointments with Manchester Treatment Rooms should there be no appointments available within the Trafford service. - Reviewing clinic capacity to sufficiently meet the needs of service demands.
WTWA	Concerns regarding treatment received, poor communication failure, and nursing staff's attitude and lack of support afforded to the family upon notifying	Complaint shared anonymously with the nursing and medical teams within Cardiac Surgery and Transplantation. Staff on the ward supported in reflecting on the events leading up

	the family of the patient death.	to the complaint and provided with appropriate training where identified. Ward staff reminded of the importance of the Trust's Vision and Values. Ward Sister participation at 'Supporting Patients and their Families Through Distressing Situations including, Death, Dying and Bereavement' Training. All staff have undertaken or are booked on to Sage and Thyme Training. Review of "visiting" processes on the ward and new MFT Visiting Policy fully embedded.
CSS (Critical Care)	Poor communication experienced by the family resulting in them not be able to be with the patient during end of life	Enhanced Communication training around supporting families/relatives of patients with deteriorating conditions/end of life to be undertaken by nursing staff
RMCH	Concerns expressed relating to the lack of communication in relation to the outcome of a 'no harm' incident review.	Review of Standard Operating Procedure to enhance roles and responsibilities of staff when managing incidents.
NMGH	Concerns regarding the lack of communication regarding the length of time waiting to be seen in the Emergency Department.	All staff reminded of the importance of clear communication with patients regarding delays in being seen, assessed and treated.
MRI (Emergency Assessment and Access)	Lack of reasonable adjustments being made for a patient attending the department with learning difficulties resulting in a poor patient experience	All staff reminded of the importance of applying and providing holistic care. All staff reminded of the importance of clear communication with patients and relatives.

Table 10: Examples of the application of learning from complaints to improve services, Q4 2021/22

11.0 Quality Improvements during Q4 2021/22 included

11.1 PHSO'S NHS Complaint Standards Framework 2021-22

11.1.1 In response to the NHS Complaints Standards Framework the Head of Customer Services has undertaken an exhaustive gap analysis to look at the current state of MFT's complaint handling procedures to assess evaluation against the draft NHS Complaint Standards and Expectations. In doing so this has highlighted the need for improving the way complaints are handled at the Trust, and how it is using complaints as opportunities to learn and improve.

11.1.2 Ahead of the NHS Complaint Standards Framework being implemented and to ensure MFT is responsive to the Expectations within it, an 'Immediate Results Improvement Plan' has been developed. The planned improvements specific to the Standards are detailed in **Appendix 1**, Table 16 of this report. In addition to this, a 'Long Term Improvement Plan' has been developed and will be presented at Professional Board.

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 Q1 completing the PALS and Complaints Customer Service Advanced e-learning package. Following quality checks and approval it is anticipated the launch of Module 2 will be in Q2, 22/23.

11.3 Ask, Listen, Do commitment

11.3.1 Following the Trust's commitment to improving the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service work continued during this quarter putting the Trust's commitment into action. Work will continue throughout Q1 and Q2, 22/23 exploring how the services can make a difference.

11.3.2 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 approximately 222 people have accessed the training session.

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

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

13.1 Complaints are seen as an opportunity to learn and improve. They are a valuable tool which helps the Trust to identify what changes are required in practice.

13.1.1 To define targeted actions/practices that work, during Q1 and throughout 22/23, the Head of Customer Services will work with the Hospitals/MCSs/LCO to evaluate the current complaint learning environments in place across the Trust and define and communicate a vision for learning and transformation. By developing and applying guidance on tangible practices and behaviours, the Trust can ensure appropriate channels are in place to allow individual and team learning and reflection to feed into MFT's decision making. Work will continue throughout Q1 reviewing the structures and systems in place to support learning from complaints.

14.0 Complainant's Satisfaction Survey

14.1 Understanding the experience of the complainant during and after a complaint investigation is considered good practice. By asking the complainant about their experiences about the quality of the services they have received, the Trust can use this feedback to make changes and improve our processes and procedures.

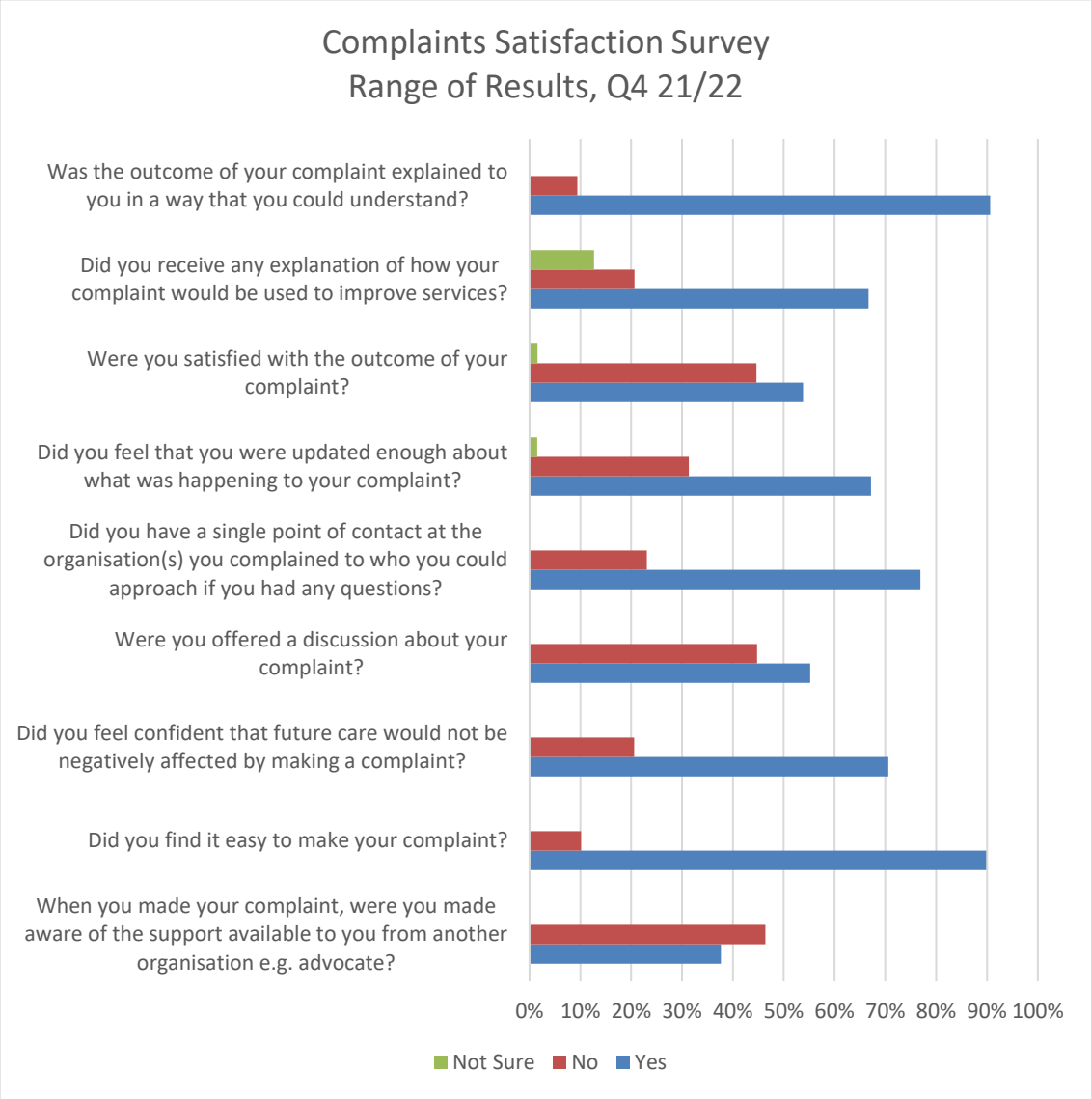
14.2 In order to ensure MFT is responsive to this feedback work commenced during this quarter and will continue throughout Q1, 22/23 looking at opportunities of actively sharing and promoting this important feedback across the Trust. The plans for improvement will be reported in this report upon finalisation.

14.3 In Q4, 731 surveys, based on the 'My Expectations'[4] paper, was distributed to complainants across all MFT Hospital's/MCS's/LCO at the closure of complaint, with 69 questionnaires returned; the results are shown in **Graph 8** below.

14.4 As in previous quarters, collection of these surveys remains inconsistent. During this quarter work also continued in the Corporate PALS and Complaints team 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. A combination of approaches continues to be explored through online platforms.

14.5 There is a continued increase in the number of complainants reporting that the outcome of their complaint was explained to them in a way that they could understand, which correlates to the noted continued 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 Q4 2021/22

14.6 The following are examples of feedback from complainants. Comments received during Q4 2021/22 include the following:

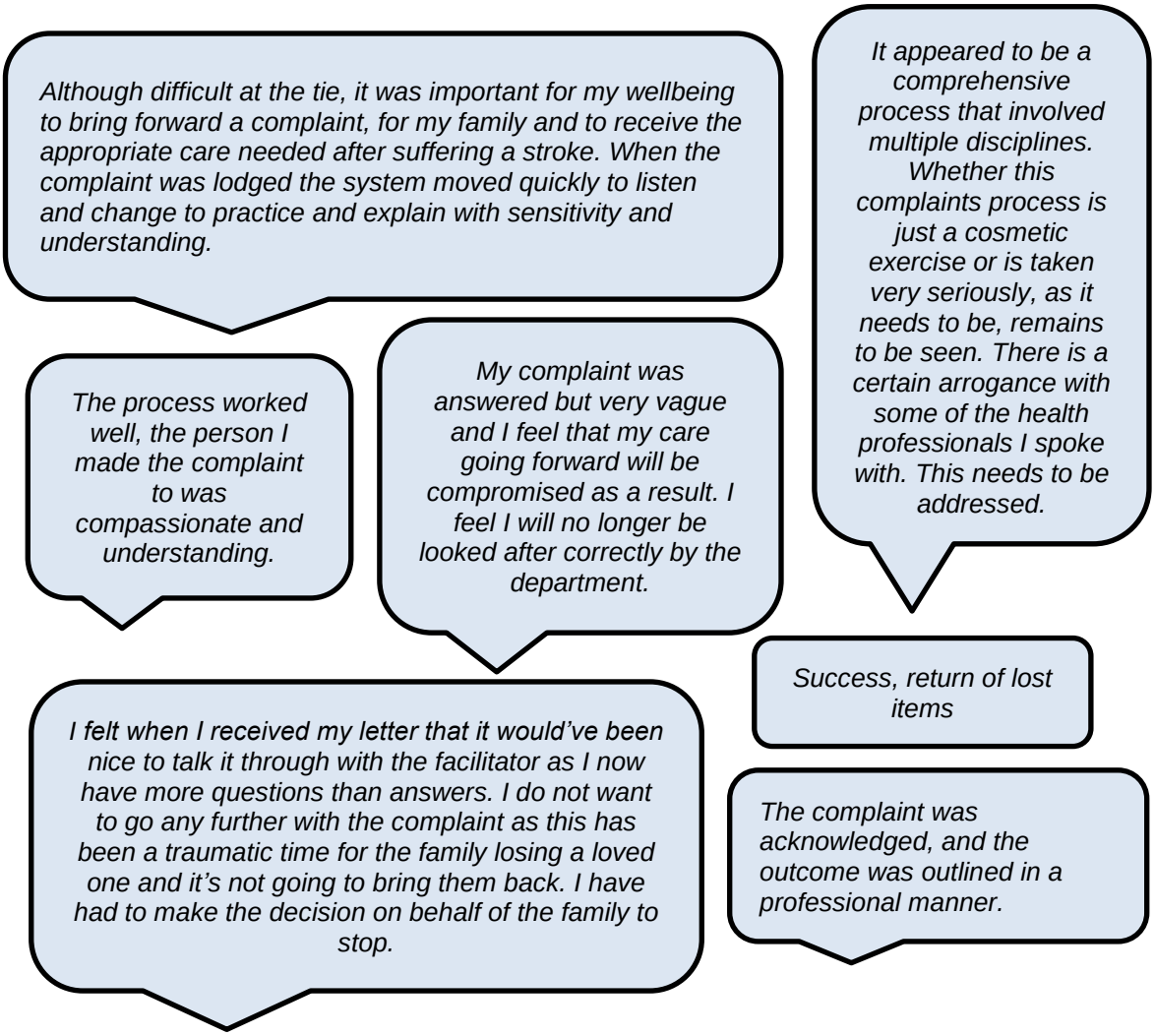
The investigation and the write up was carried out by the party responsible, leading to bias. I had to keep making contact to get an update.

The way the team approached/ handled my complaint was dealt with in a professional manner I was pleased with the way my questions were answered and the detailed actions that the team made towards resolving it

I did not know the procedure to make a complaint as I do not speak English. I had to approach my neighbour who does not speak the same language to make the complaint for me. If she had said no, I would have been unable to complain

A lot of the points I raised seemed to have been ignored.

Although it didn't change the way I was treated after surgery, it may help somebody in the future due to the health care staff reflecting on their actions and making an active change to insure future post-surgery treatment is to the best standards



15.0 Planned Improvements

15.1 Many areas for improvement and development have been identified for Q1, 22/23 and throughout 2022/2023, including the following activities:

- PHSO'S NHS Complaint Standards Framework – Implementation of 'Immediate Results Improvement Plan'
- Completion and launch of the PALS and Complaints Customer Service Advanced e-learning package
- Ask, Listen, Do commitment - Improving the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service
- Heightening of PALS and Complaints training across Hospitals/MCSs/LCO
- Optimising learning from Complaints via Quality and Patient Experience Forum
- Optimising learning from Complaints via Education
- Optimising submission methods of Complainant Satisfaction Survey feedback
- Actively sharing learning and communicating Complainant Satisfaction Survey feedback
- Exploration of the introduction of a PHSO/complaints 'upheld' Learning Sub-Group'

- Review of Complaints and Incidents pathways
- Development of dedicated PALS Volunteer role
- Enhancement of collection of Equality and Diversity data
- Relocation of the PALS office and Reception to a new, more visible location within NMGH
- PALS and Complaints team working and objective setting through the Affina Team Journey

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 (22%), however continued evidence of the ongoing need to improve reporting on 'disability', 'religion' and 'ethnicity' was identified; only 11.7%, 27.4% and 51.1% being received respectively.

16.3 The PALS and Complaints Managers continue to look at ways of improving the collection of this data with approaches being explored through configuration auditing, triangulation of data in qualitative research and the introduction of a mandatory Equality and Diversity field in the Customer Services module on Ulysses. The outcome of which will be presented in Q1's report.

17.0 Conclusion and recommendations

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

17.2 The Board of Directors are asked to note the content of this Q4 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams, to ensure that 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 cases open at the PHSO as at 31st March 2022

Hospital/ MCS/ LCO	Cases/s	PHSO Investigation Progress
MRI (5)		
Cardiovascular Specialty	1	Awaiting Final Report
GI Medicine & Surgical Specialty	1	Awaiting Provisional Report
Rheumatology Specialist Medicine	1	Awaiting Final Report
In-Patient Medical Specialties	1	Scoping
Emergency Assessment & Access	1	Scoping
WTWA (5)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Meeting with PHSO and MFT 23/12/21 PHSO re-reviewing evidence – awaiting outcome
Surgery (ENT)	1	Awaiting Provisional Report
Medicine (Urgent Care)	1	Awaiting Provisional Report
Surgery (Burns, Breast & Plastics)	1	Scoping
RMCH (2)		
CAMHS	1	Comments awaited from RMCH on PHSO Provisional Report – deadline 21/04/22
CAMHS	1	Awaiting Provisional Report
SMH (1)		
Obstetrics	1	Scoping
TOTAL	**13**	

Table 2: Number of Complaints received by Hospital/ MCS / LCO Q4 2020/21 – Q4 2021/22

	Q4,20/21	Q1,20/21	Q2, 21/22	Q3, 21/22	Q4, 21/22
WTWA	101	94	112	89	111
MRI	88	106	79	94	76
SMH	52	58	65	56	63
RMCH	36	43	48	32	44
CSS	21	16	28	19	33
UDHM/MREH	10	22	24	25	32
Corporate	13	17	20	7	9
LCO	6	14	16	16	10
NMGH	0	43	48	46	48
Grand Total	**327**	**413**	**440**	**384**	**426**

Table 3: Complaints Acknowledgement Performance

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

Table 4: Comparison of complaints resolved by timeframe: Q4 2020/21 – Q4 2021/22

	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22	Q4,21/22
Resolved in 0-25 days	240	285	294	332	286
Resolved in 26-40 days	15	24	55	50	37
Resolved in 41+ days	35	39	75	106	58
Total resolved	**290**	**348**	**424**	**488**	**381**
Total resolved in timescale	**272**	**324**	**370**	438	341
% Resolved in agreed timescale	**93.8%**	**93.1%**	**87.3%**	**89.8%**	**89.5%**

Table 5: Outcome of Complaints, Q4 2020/21 – Q4 2021/22

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
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
Q4,21/22	426	31	215	61	9	5	2	1

Table 6: Re-opened Complaints by Hospital/MCS/LCO Q4 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	2	6	1	9	18
MRI	3	3	4	9	19
SMH	2	3	4	6	15
CSS	0	3	0	1	4
RMCH	0	0	0	1	1
UDHM/MREH	0	1	2	3	6
Corporate	0	0	1	1	2
LCO	0	1	0	0	1
NMGH	0	0	0	8	8
Grand Total	**7**	**17**	**12**	**38**	**74**

Table 8: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q4 2021/22

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q4 21/22			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	**3**	**2**	**1**
WTWA	**10**	**0**	**1**
CSS	**1**	**1**	**0**
Corporate	**0**	**0**	**0**
UHDM/MREH	**2**	**2**	**0**
LCO	**0**	**0**	**0**
RMCH	**0**	**0**	**0**
SMH	**2**	**4**	**0**
NMGH	**3**	**4**	**1**
Grand Total	**21 (57.0%)**	**13 (35.0%**	**3 (08.0%)**

Table 11: Number of PALS concerns received by Hospital/ MCS/ LCO Q4 2020/21 – Q4, 2021/22

	Q4,20/21	**Q1,21/22**	**Q2,21/22**	**Q3,21/22**	**Q4,21/22**
WTWA	390	459	491	458	527
MRI	448	406	479	469	451
RMCH	140	172	149	176	178
UDHM/MREH	128	130	156	122	159
SMH	232	253	254	262	364
CSS	82	124	153	138	133
Corporate	57	62	46	39	31
LCO	14	25	35	20	28
R&I	1	0	1	6	5
Nightingale NW (NNW)	4	0	0	0	0
NMGH	0	203	193	175	190
Grand Total	**1496**	**1834**	**1957**	**1865**	**2066**

Table 12: Closure of PALS concerns within timeframe Q4 2020/21 – Q4, 2021/22

	Q4,20/21	**Q1,20/21**	**Q2,20/21**	**Q3,21/22**	**Q4,21/22**
Resolved in 0-10 days	1303	1598	1717	1717	1833
Resolved in 11+ days	152	181	246	212	180
% Resolved in 10 working days	**89.6%**	**89.8%**	**87.5%**	**89.0%**	**91.1%**

Table 13: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Q4 2020/21 – Q4, 2021/22

	Q4,20/21	Q1,20/21	Q2,21/22	Q3,21/22	Q4,21/22
WTWA	27	32	53	40	34
MRI	45	36	71	78	48
RMCH	16	20	17	31	27
UDHM/MREH	5	15	12	2	0
SMH	38	30	39	23	38
CSS	9	10	14	11	14
Corporate	6	21	10	10	8
LCO	5	2	6	3	6
R&I	0	0	0	0	0
NNW	1	0	0	0	0
NMGH	0	15	24	14	5
Grand Total	**152**	**181**	**246**	**212**	**180**

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

	Q4,20/21	Q1,20/21	Q2,21/22	Q3,21/22	Q4,21/22
No of cases escalated	17	20	24	22	12

Table 15: Equality and Diversity Monitoring Information

	Q4,20/21	Q1,21/22	Q2,21/22	Q3,21/22	Q4,21/22
Yes	13	26	28	24	34
No	9	8	12	15	16
Not Disclosed	305	379	400	344	376
Total	**327**	**413**	**440**	**384**	**426**
Disability Type					
Learning Difficulty/Disability	1	0	1	0	2
Long-Standing Illness or Health Condition	18	16	19	10	28
Mental Health Condition	3	6	5	6	9
No Disability	0	0	0	0	0
Other Disability	3	5	4	4	2
Physical Disability	2	1	5	1	8
Sensory Impairment	1	2	2	1	2
Not Disclosed	299	383	404	362	375
Total	**327**	**413**	**440**	**384**	**426**
Gender					
Man (Inc Trans Man)	133	147	169	151	175
Woman (Inc Trans Woman)	190	256	268	229	245

Non-Binary	0	0	0	0	0
Other Gender	0	0	1	0	0
Not Specified	4	9	2	4	6
Not Disclosed	0	1	0	0	0
Total	**327**	**413**	**440**	**384**	**426**
Sexual Orientation					
Heterosexual	92	75	96	63	92
Lesbian / Gay/Bi-sexual	4	4	4	1	3
Other	0	0	0	0	0
Do not wish to answer	5	3	3	4	9
Not disclosed	226	331	337	316	322
Total	**327**	**413**	**440**	**384**	**426**
Religion/Belief					
Buddhist	3	0	0	0	0
Christianity (All Denominations)	61	48	51	44	64
Do Not Wish to Answer	0	0	4	4	12
Muslim	11	5	8	10	8
No Religion	21	25	38	20	40
Other	0	0	1	0	4
Sikh	0	1	0	0	0
Jewish	0	3	1	3	0
Hindu	3	0	0	1	0
Not disclosed	227	331	336	301	297
Humanism	1	0	0	1	1
Paganism	0	0	1	0	0
Total	**327**	**413**	**440**	**384**	**426**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	1	3	1
Asian Or Asian British - Indian	6	6	2	3	1
Asian Or Asian British - Other Asian	0	3	7	3	3
Asian Or Asian British - Pakistani	17	3	10	7	6
Black or Black British – Black African	5	6	3	7	4
Black or Black British – Black Caribbean	3	0	2	6	6
Black or Black British – other Black	1	1	0	3	3
Chinese Or Other Ethnic Group - Chinese	1	0	1	1	1
Mixed - Other Mixed	3	0	2	2	4
Mixed - White & Asian	1	2	0	0	2
Mixed - White and Black African	1	0	1	1	3
Mixed - White and Black Caribbean	3	1	1	1	0
Not Stated	58	79	92	98	93
Other Ethnic Category - Other Ethnic	4	5	2	0	10
White - British	147	160	145	104	148

White - Irish	3	5	9	4	9
White - Other White	4	2	4	12	7
Not disclosed	69	139	158	129	125
Total	**327**	**413**	**440**	**384**	**426**

Table 16: Overview of 'Immediate' requirements and subsequent responses to bridge the gaps to improve MFT's performance in complaints handling

PHSO Complaint Standards Framework – Immediate Results Improvement Plan			
Leads	Corporate Director of Nursing, Quality and Patient Experience Head of Nursing, Quality and Patient Experience Head of Customer Services Complaints Manager PALS Manager	Completion Date	June 2022

No.	Expectation	Our measure of success to bridge the gaps identified
Governance		
1	Every organisation has appropriate governance structures in place to ensure that senior staff regularly review information arising from complaints and are held accountable for ensuring the learning taken from feedback is acted upon to improve services	Standard Operating Procedure (SOP) in place ensuring all patient stories from complaints featuring improvements are captured and feature at Group BoDs meetings
		SOP in place for 'Incident & Complaints Running Alongside Each Other'
		SOP in place for 'Reasonable Adjustments/Accessibility'
		Timely updates/reasonable adjustments functions/fields built into Customer Services module on Ulysses
Learning		
	Organisations have clear processes in place to show how they capture learning from complaints, report on it, and use it to improve services. Organisations report on the feedback they have received and how they used that feedback to improve their services. This information is easy to compare with that of other organisations	Assurances sought and provided from Hospitals/MCSs/LCO re how they monitor & share their learning – SOP in place for 'Capturing and Sharing of Learning from Complaints'
	Organisations ensure staff have the confidence to be open and honest when things have gone wrong or where improvements can be made. Staff ensure the right balance between taking accountability and identifying what learning can be taken from a complaint and how the learning will be acted on to improve services and support staff	
	Organisations provide meaningful opportunities for those who use their service (and national and local groups who represent those users) to discuss how the organisation has used learning from complaints to improve local services	Standard Operating Procedure (SOP) in place ensuring all patient stories from complaints featuring improvements are captured and feature at Group BoDs meetings

Seeking Feedback		
	Organisation also publish the results of their success in meeting the expectations given in the Framework by seeking feedback from those who raise complaints (as well as staff involved) on their experience. This shows how the organisation has performed towards meeting what users expect to see as described in 'My Expectations'	Newsletter in place reporting results and analysis of patient/complainant feedback
		SOP in place for Complaints Satisfaction Survey feedback
	Organisations regularly promote their wish to receive feedback from their users and promote how they use this learning to improve services.	Enhanced promotion to the public of MFT's desire to receive and learn from comments and complaints
Training		
	All staff have the freedom to actively seek feedback to improve services and resolve issues quickly and effectively. Staff receive training in how to do this and how to ensure people know they are being listened to and treated with empathy, courtesy and respect	Quarterly/Annual Master PALS and Complaints Training schedule in place across all sites
Providing support to patients/relatives/carers and staff		
	Organisations make sure people know how to access advice and support to raise a concern or make a complaint, including giving details of appropriate independent complaints advocacy and advise providers and other support networks.	Actively promote 'how to raise a concern/complaint' via Hospedia and television channels across the Hospitals/MCSs/LCO
		Implementation of dedicated PALS Volunteers / Way finder at each PALS Reception
		Patient Experience Matter Leaflets and posters on all sites, departments and wards
	Organisations actively reassure people who use their services that their care will not be compromised if they raise a concern or make a complaint	All staff and communications clearly explain/detail complainants can raise concerns and complaints 'in a way that suits them'
	Organisations clearly advertise how people can raise concerns and complaints in a way that suits them. Organisations offer a range of ways people can give feedback, including online	A wide range of options are available to people wishing to give feedback, including online
	Organisations make it easy for anyone to raise a concern or make a complaint when they want to. It is easy for everybody to understand how the process works, including who can raise a concern or make a complaint and what will happen next	Demonstration/assurance that all complainants have received an initial call to discuss the process
	Each stage in the concerns and complaints procedure is responsive to the needs of each individual. Every stage meets the needs of minority	SOP in place for 'Reasonable Adjustments/Accessibility' SOP

	and vulnerable groups and makes reasonable adjustments where required	implement mandatory reasonable adjustments functions/fields in Customer Services module and SOP
	Organisations ensure staff who are subject to a concern or complaint are made aware and know how to get access to advice and support throughout the process	SOP in place for capturing and supporting 'People Involved in Complaints' on Customer Services Module, Ulysses
Complaint Investigations		
	Staff make sure they respond to concerns and complaints at the earliest opportunity. Staff consistently meet expected timescales for acknowledging a concern or complaint and give clear timeframes for how long it will take to look into the issues, taking into account the complexity of the matter	Audits Demonstration/assurance that all complainants have: - received an initial phone call to discuss their concern, points for investigation and timescales and preference of contact - been updated accordingly should a delay be experienced in the complaint investigation
		Speak with Ulysses to implement additional functions and make amends to SOP
	For complaints that involve multiple organisations, the lead organisation provides a single response to the complaint that includes what the other organisations have done to look into the issues and the conclusions they reached. Where needed, the response clearly explains how each organisation will remedy any mistakes it made	Robust process in place for sharing partial responses

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Corporate Director of Nursing Karen Sutcliffe, Acting Head of Nursing, Professional Education & Development
Date of paper:	May 2022
Subject:	Nursing and Midwifery Revalidation Annual Report 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:	1. Patient Safety 2. Patient Experience 3. Productivity and efficiency
Recommendations:	The Board of Directors are asked to note the content of this report and the identified actions for 2022/23 to support revalidation of nurses, midwives and nursing associates.
Contact:	Name: Anne-Marie Varney, Corporate Director of Nursing Tel: 0161 276 8862

1. Introduction

1.1 This paper provides an annual overview of Nursing and Midwifery Professional Revalidation at MFT, describing the current practice and assurance systems in place to support nurses, midwives and nursing associates to meet the Nursing and Midwifery Council's (NMC) revalidation requirements.

1.2 This paper reports the Trust's revalidation activity from 1st April 2021 to 31st March 2022.

2. Background

2.1 Since April 2016, Nurses and Midwives have been required to undergo a three-yearly process of revalidation to demonstrate that their practice is in line with the Nursing and Midwifery Council (NMC) professional standards of practice.[1] Following the regulation of the Nursing Associate role, this profession is also required to undertake revalidation every 3 years.

2.2 Revalidation is the process that nurses, midwives, and nursing associates need to follow to maintain their registration with the NMC. The process requires the registrant to reflect on their current practice and to demonstrate that they are meeting the standards set out in The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associates (NMC, 2018).

2.3 All registrants receive formal notification from the NMC 60 days before their revalidation submission deadline. This enables the registrant to collate their portfolio of evidence which demonstrates they have met the requirements for revalidation. The portfolio of evidence must contain:

- 450 practice hours or 900 if renewing two registrations (for example as a nurse and midwife)
- 35 hours of Continuing Professional Development, including 20 hours of participatory feedback
- Five pieces of practice related feedback
- Five written reflective accounts
- Reflective discussion
- Health and character declaration
- Professional indemnity arrangement

2.4 Confirmation that a registrant has met the required standard occurs through a standardised confirmation process set by the NMC by another NMC registrant.

[1] Nursing and Midwifery Council (NMC), 2018, The Code: professional standards of practice for nurses, midwives and nursing associates

2.5 It is the individual nurse, midwife and nursing associate's professional responsibility to ensure that they meet the revalidation standards. However, the Trust has a responsibility to support registrants in meeting revalidation requirements, thereby assuring that their practice is safe and effective.

3. Current Situation

3.1 Revalidation is now well embedded within the nursing and midwifery profession having been a requirement since 2016. Nurses and midwives are encouraged to maintain a portfolio of evidence and feedback in preparation for revalidation.

3.2 The first cohort of nursing associates graduated and registered with the NMC from January 2019. This cohort completed their revalidation in January 2022 and for subsequent cohorts, this will be their first revalidation cycle. Additional support, information sharing, and revalidation workshops are being provided to support the nursing associates with the revalidation process.

3.3 Revalidation compliance is monitored by the Corporate Director of Nursing responsible for workforce and education. A monthly workforce report generated from the NMC register is utilised to inform the Trust's revalidation assurance process. Revalidation champions are established in each Hospital/MCS/LCO and are responsible for monitoring staff revalidation and supporting staff through the revalidation process.

3.4 If member of staff fails to meet the revalidation requirement, their registration remains active for one month, prior to their registration expiring. In this situation the Trusts Professional Registration Policy would come into effect.

3.5 Revalidation requirements have been integrated into the Nursing and Midwifery CPD dashboard and recording process on the Trust Learning Management System. This provides a mechanism for staff to upload and monitor their continuing professional development and to log their reflective learning as part of their revalidation portfolio.

4. Covid-19 Pandemic and Revalidation

4.1 Throughout the Covid-19 pandemic the NMC has not altered the revalidation requirements or reinstated the emergency standards that were active during the beginning of the pandemic.

4.2 Any staff who are unable to meet the NMC requirements are required to apply on an individual basis to the NMC for a personal extension.

5. Staff Revalidation - 2021/2022

5.1 The total number of nurses, midwives and nursing associates who have revalidated with the NMC in 2021/2022 is **2504** out of a total of 2519. 15 staff did not revalidate as they either retired, resigned or allowed their registration to lapse.

6. Revalidation Work Programme

6.1 To support the revalidation process for 2022/23, the following priorities have been identified:

- Continue the provision of revalidation workshops to support the nursing associate workforce in preparation for their first revalidation.
- Integration of NMC revalidation requirements and monitoring into the new learning management system

7. Conclusion

7.1 The Board of Directors are asked to note the content of this report and the identified actions for 2022/23 to support revalidation for nurses, midwives and nursing associates.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Director of Corporate Business/ Trust Board Secretary
Date of paper:	May 2022
Subject:	MFT Board of Directors' Register of Interests (April 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:	The MFT *'Constitution'* and *'Standing Orders for the Practice & Procedure of the Board of Directors'* requires the Board of Directors to provide a Register of Interests.
Recommendations	The Board is asked to note the MFT Board of Directors' Register of Interests (April 2022)
Contact	Name: Nick Gomm, Director of Corporate Business/ Trust Board Secretary Tel: 0161 276 4841

1. Introduction

In line with the MFT constitution and standing orders, the Board of Directors is required to make a declaration of its register of interests.

The register must include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive members.

The Register is available to the public on the MFT Public Website:

https://mft.nhs.uk/the-trust/the-board/register-of-directors-interests/

2. Recommendation

The Board is asked to note the MFT Board of Directors' Register of Interests (April 2022).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(May 2022)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2022

NAME	POSITION	INTERESTS DECLARED
Kathy Cowell OBE DL	Group Chairman	• Member of the General Assembly, The University of Manchester • Member Manchester Academic Health Science Centre • Vice Chair Cheshire Young Carers • Mentor on the Aspirant Chairs Programme (NHSI) • Member of the QVA's mentoring panel (Cheshire) • Chairman of Totally Local Company • Deputy Lieutenant for Cheshire • Chairman of the Hammond School (Chester) • People Ambassador for Active Cheshire • Vice President, St Ann's Hospice
Barry Clare	Group Deputy Chairman	• Partner (Clarat Partners LLP) • Partner (Clarat Healthcare LLP) • Non-Executive Director (Ingenion Medical Ltd) • Chairman (Crescent OPS Ltd) • Chairman (FLOBACK Ltd) • Chairman Evgen Pharma PLC • Non-Executive Chairman of Porton Biopharma Ltd • Non-Executive Chairman (Ori Biotech) • Non-Executive Director (Arterius Ltd)

NAME	POSITION	INTERESTS DECLARED
Professor Dame Susan Bailey OBE DBE	Group Non-Executive Director	• Independent Chair of Health Education England (HEE) Mental Health New Ways of Working Group • Chair Autistica UK user carer subcommittee • Chair of Trustees, Centre for Mental Health • Bevan Commissioner • Council Member of Salford University • Independent NED KOOTH plc – Mental Health Online Platform – remunerated • Vice President BACP • Member Advisory Board Education Policy Institute
Professor Luke Georghiou	Group Non-Executive Director	• Deputy President and Deputy Vice-Chancellor, University of Manchester • Non-Executive Director of Manchester Science Partnerships Ltd • Non-Executive Director, Manchester Innovation Factory • Member of Manchester Graphene Company, Shadow Board • Member of NWBLT (North West Business Leadership Team) • Member GESL (Graphene Enabled Systems Board) • Chair of Steering Group, EUA (European Universities Association / CDE (Council for Doctoral Education) • Non-Executive Director, Northern Gritstone Investment Company
Nic Gower	Group Non-Executive Director	• Director Furness Building Society [NED]

NAME	POSITION	INTERESTS DECLARED
Chris McLoughlin OBE	Group Non-Executive Director & Senior Independent Director (SID)	• Corporate Director of People and Integration • Director of Children's Services, Stockport Metropolitan Borough council • Member of Association of Director of Children's Services Ltd • Chair of Greater Manchester Social Work Academy Board • Member of Greater Manchester Mental Health Partnership • Chair of Greater Manchester Start Well & School Readiness Board • Chair of Greater Manchester Children and Young People Health and Wellbeing Executive • Daughter – Employed by MFT
Trevor Rees	Group Non-Executive Director	• Treasurer/Trustee (Manchester Literary and Philosophical Society) • Independent Co-opted member (Audit Committee at University of Manchester (not a Board Member) • Non-Executive Director of Totally Local Company, Stockport (3-year Term) • Chair of the Audit Committee of GB Taekwondo
Gaurav Batra	Group Non-Executive Director	• Chairman, Bolesworth Estate (Salaried, comprising directorships of the following entities): Bolesworth Holding Company 1 Bolesworth Holding Company 2 Bolesworth Investment Company Bolesworth Estate Company • Chairman, Stockport Sports Trust • Director IE8 Limited (Strategic Consultancy)
Angela Adimora	Group Non-Executive Director	• Governor, Salford University • Senior Director of HR Operations, UK & Europe

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2022

NAME	POSITION	INTERESTS DECLARED
Sir Mike Deegan CBE	Group Chief Executive Officer	• Board Member, The Corridor, Manchester • Board Member, Health Innovation Manchester
Gill Heaton OBE	Group Deputy Chief Executive	• Chair of the Manchester LCO Accountability Board
Darren Banks	Group Executive Director of Strategy	• Nominated Director for Manchester LCO Partnership Board • Spouse - Finance Director of Rochdale Infirmary, PAT • Board Member, The Corridor, Manchester
Peter Blythin	Group Executive Director of Workforce & Corporate Business	• No interests to declare
Julia Bridgewater	Group Chief Operating Officer	• Foundation Director of Multi Academy, All Saints Catholic Collegiate
Professor Jane Eddleston	Joint Group Medical Director	• Chair of Adult Critical Care CRG [NHSE] • Clinical lead for Healthier Together Programme • GM Partnership Joint Medical Executive lead for Acute Care
Jenny Ehrhardt	Group Chief Finance Officer	• Trustee and Treasurer – Faculty of Medical Leadership & Management • Personal Financial Advice sought and paid personally from Mazars (External Auditors for the Trust) • Chair of Sub-Committee of the National Finance Leadership Council

NAME	POSITION	INTERESTS DECLARED
Professor Cheryl Lenney OBE	Group Chief Nurse	• Spouse – Director of Workforce & Organisational Development, Manchester Local Care Organisation
Miss Toli Onon	Joint Group Medical Director	• No interests to declare
David Furnival	Group Director of Operations	• Spouse - Chief of Regulatory Compliance and Improvement, NWAS