NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 8th November 2021

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

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

130/21 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 (12/07/21) so they had the opportunity to attend and observe the meeting. A notice was also placed MFT's public website explaining how the meeting would be conducted and inviting people to request a link to the meeting should they wish to attend. The agenda and supporting documents had also been posted on the MFT Public Website (https://mft.nhs.uk/board-meetings/board-of-directors-meeting) beforehand and members of the public invited to submit any questions and/or observations on the content of the reports presented/discussed to the following e-mail address: Trust.Secretary@mft.nhs.uk.

131/21 Apologies for Absence

Apologies were received from Toli Onon, Barry Clare and John Amaechi.

132/21 Declarations of Interest

There were no declarations of interest received for this meeting.

133/21 Minutes of the 'virtual' Board of Directors' Meeting held on 13th September 2021

The minutes of the Board of Directors' meeting of 13th September 2021 were approved.

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

134/21 Matters Arising

There were no matters arising.

135/21 Group Chairman report

KC provided an overview of recent events of note.

On 16/9/21, the Year of the Nurse and Midwife Closing Event,took place at Manchester Cathedral. This was a special event, and all staff were invited to attend either virtually or in person. To symbolise the closure of the Year of the Nurse and Midwife, the MFT Lamp was passed to its final recipient during the event.

Citylabs 2.0 – which is situated opposite Royal Manchester Children's Hospital – is now complete and life sciences and diagnostics company, QIAGEN, will use the whole of the building for its Global Centre of Excellence for Precision Medicine. An opening ceremony took place on 22nd October 2021.

MFT colleagues have recently won a total of five awards. MFT won the prestigious Maternity Team of the Year at the Royal College of Midwives Awards and picked up four recognitions at the Nursing Times Awards which covered:

- Cancer Nursing across MFT with the safe introduction of an advanced nurse practitioner led telephone breast pain clinic.
- Promoting Patient Self-Management for patients with learning disabilities by Manchester LCO.
- The Public Health Healthy weight team, part of Manchester LCO.

- Respiratory Nursing across MFT and the importance of treating rhinitis in patients with refractory breathlessness.

KC offered her congratulations to all the winning teams.

Ground-breaking research by MFT staff, including Wythenshawe Hospital's Lung Health Check and RMCH's CAR-T therapy, features in a new national exhibition on cancer breakthroughs at Manchester's Science and Industry Museum. The exhibit, 'Cancer Revolution: Science, innovation, and hope', opened on Friday 22nd October 2021.

Black History Month, which was celebrated across the NHS by honouring the achievements, culture, and history of black people, finished at the end of October. KC referenced her pride in attending the launch event at Manchester Cathedral on behalf of MFT and highlighted how, throughout October, the Trust has shared and celebrated the achievements of black colleagues and communities in MFT and across Manchester. KC thanked all the staff and volunteers who have played their part in making it a month to remember.

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

136/21 Group Chief Executive's report

MD provided an overview of current issues and began by recognising how the best asset MFT has is its workforce and noting how good it was to see them being honoured through national awards.

It remains an incredibly challenging period with a range of pressures coming together at the same time: the ongoing presence of Covid in General and Acute wards and Critical Care; demand and pressure in Emergency departments; the requirement to address the long waiting lists which have built up over the last year; and a high staff absence rate due to illness and health issues. MFT continues its absolute focus on patent safety, alongside providing support to the whole of the workforce, and MD noted that that performance standards where not being met because of the challenging circumstances. This is in common with Trusts up and down the country.

With 10 months to go until the go-live date for the HIVE programme, there is still lots to do but the changes made to MFTs' leadership arrangements to support the programme are providing the required focus.

Additional money was identified for the NHS in the recent budget, but the detail is not yet clear.

MD thanked KC and the Non-Executive Directors (NEDs) for their continued scrutiny of the work of the Executive team.

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

137/21 Board Assurance Report

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

JE presented the 'Safety' section and echoed MD's earlier comments about MFT retaining an absolute focus on patient safety during these challenging times. 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 most patient outcomes that are as, or exceed, expectations);
- the use of SPC analysis to understand our data about harm, this has enabled us to identify, explore and understand the risk associated with any special cause variation;
- the consideration of multi sources of intelligence in relation to patient safety (qualitative and quantitative);
- a daily Trust-wide patient safety huddle; and
- a weekly Trust-wide Patient Safety Oversight Panel.

JE highlighted that there had been 9 Never Events since 1/4/21 including 4 since September and these were being closely monitored. A full analysis will come to Quality and Performance Scrutiny Committee in December.

AL presented the Patient Experience section. In September 2021, the percentage of formal complaints that were resolved in the agreed timeframe was 77.7% - a decrease of 10.2% from the previous month. The number of new complaints received across the Trust during September 2021 was 163, which is an increase of 30 when compared to 133 in August 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Friends and Family Test (FFT) was paused nationally between March and December 2020 to release capacity to support the response to the Covid pandemic. The Trust overall satisfaction rate for FFT (including data from the NMGH acquisition on 1st April 2021) is 91.7% in September 2021 which is a decrease compared to 92.4% in August 2021. There is a continued focus for all areas of the Trust to use both the positive and negative FFT feedback to improve the experience of MFT's patients.

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

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

DF explained that he would cover Operational Excellence matters in the next item on the agenda.

JEh confirmed that she would cover financial matters during her item later on the agenda.

PB spoke to the Workforce and Leadership section.

As MFT continues to prepare for Hive Go-Live, the Workforce Directorate is leading several key workstreams. Work has commenced to maximise staff availability and workforce supply in the pre and post Hive Go-Live period. Hospitals/ MCSs/ LCOs are currently developing staffing and workforce plans to drive a nuanced local response to identified workforce issues, whilst, at Group level, various cross cutting policy initiatives, and specialist support programmes, are being developed. Work to address digital literacy has also commenced and preparations for HIVE end user training continue.

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

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

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

138/21 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

DF presented the report which provided an update on MFT's response to, and recovery from, the COVID-19 (Covid) pandemic.

There is currently a greater level of Covid across the Trust than was described in the report – 9% of General and Acute beds and 17% of Critical Care beds are being used by Covid + patients.

The Greater Manchester (GM) and MFT systems are experiencing unprecedented Urgent and Emergency Care (UEC) pressures. Across GM, the demand for ambulances with higher acuity calls has grown. Whilst overall MFT activity is at pre-pandemic levels this is misleading as there are days of extreme pressure at peak levels across both adult and paediatric Emergency Departments (ED). In October, MFT's performance was 62%, GM was 63%.

A Risk Summit has been held with ED colleagues from across the Group to identify opportunities for improvement whilst maintaining an absolute focus on safety.

There are currently high numbers of medically fit patients in acute beds impeding flow through MFT hospitals, resulting in longer wait times in ED, impact on ambulance turnaround and constrained capacity to undertake elective activity. This is being addressed through a doubling of 'Discharge to Assess' beds in the community and an expansion of the Crumpsall Vale bed base.

Compared to 2019/20 activity levels, MFT is at 88% for first appointments and 93% for Follow-up appointments. MFT has an Outpatient programme as part of the overall recovery programme. This continues to focus on:

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

The overall waiting list size at the end of September 2021 was 150,730 of which the volume of >52-week waiters at the end was 14,184, an improvement of -3,249 (18.6%) on the position at the end of March 2021 (17,433).

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

Key programmes of work that will support the delivery, and maximisation of elective activity, and a reduction in the longest waits including:

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

Cancer referrals are at 115% of pre-Covid levels on average, with some specialties at 140%. So far this year there have been c.3500 more referrals than pre-Covid levels.

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

There has been an external peer review of Elective and Cancer pathways, carried out by the Northern Care Alliance and the GM Cancer Alliance.

Trusts are now required to review the impact of National Outpatient Transformation initiatives and whether they have limited access, outcomes, or the experience, for particular groups and to begin to report that through to Board level. This is part of the work to address health inequalities and will be reported alongside other performance information moving forward.

MFT has both an Outpatients Recovery Programme and an Inequalities group, both chaired by the Joint Group Medical Director, which are reviewing inequalities. The initial analysis of the National Outpatient Transformation Initiatives has highlighted several themes.

- Patients from most deprived neighbourhoods are less likely to access virtual outpatient appointments than those from the least deprived neighbourhoods.
- Capture of ethnicity for virtual outpatients is poorer (24% unknown vs 16% for all outpatient attends).
- There is little difference in virtual outpatient participation by age group, although evidence suggests 70+ year old patients find the experience of using video platforms more difficult.
- A larger proportion of patients from the least deprived neighbourhoods are put onto PIFU pathways, compared to those from more deprived neighbourhoods.
- Some ethnicities are less likely to be on PIFU pathways (Pakistani, African) than others (British).
- Broadly, the age profile of patients on PIFU pathways reflects Outpatient attendances.
- Advice and Guidance is difficult to assess due to minimal data capture from e-RS in A&G type requests from GPs, with IMD data distorted and ethnicity missing – no notable differences according to age groups.

MD pointed out that, despite the figures showing some challenges in meeting established performance measures, MFT's staff are focussing on patient safety and working exceptionally hard amidst unprecedented times. The Executive and Non-Executive Directors recognise the great work they are doing and will continue to ensure that the Scrutiny Committees are concentrating in-depth on the most salient issues.

IB explained that this was his last Board meeting as a NED and he has seen significant progress over his time at MFT with management and clinicians developing a clear focus on outcomes, patient safety and patient experience.

Board decision	Action	Responsible officer	Completion date
The Board noted the contents of the report; the updated national planning assumptions for H2, and the Trust's associated planning activities; and the position and associated actions being undertaken to support safe and timely urgent /emergency care and elective access for patients.	None	n/a	n/a

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

AL presented the report which provided an update on MFT's COVID-19 and Influenza Vaccination programme.

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

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

The MFT COVID-19 booster vaccine roll-out commenced on 22nd September 2021 and Flu vaccines were made available in clinics from 27th September 2021. Early data shows an average rate of 89.5% of staff who have attended having both vaccines at the same time, with a 95% dual vaccine uptake rate in some clinics. Flu-only clinics will be provided so that flu vaccines are not delayed due to ineligibility for the COVID-19 booster. The MLCO/TLCO school aged immunisation service (SAIS) teams are leading on the delivery of the COVID vaccine to healthy 12 to 15-year-olds in schools in Manchester and Trafford; the programme commenced on 22nd September 2021.

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. Systems are in place to ensure MFT procedures are amended in line with changes to national guidance and the governance team provide a weekly summary of all incidents related to the vaccination clinics. No level 3 or 4 incidents have been recorded to date. A Quality Assurance Framework (QAF) has been developed and includes a series of audits and governance reporting to ensure that quality, safety, and continuous improvement are embedded in the service. Vaccination programme meetings are held weekly, focusing on the strategic planning of the vaccine programme.

Board decision	Action	Responsible officer	Completion date
The Board noted the information provided in the report in relation to Coivd-19 Vaccination Programme; the Seasonal influenza vaccination programme; and the health 12–15-year-olds' vaccination programme.	None	n/a	n/a

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

AL presented the report which provided an update on the Infection, Prevention and Control (IPC) Board Assurance Framework (BAF); Nosocomial Transmissions of COVID-19; progress on the Infection Prevention and Control Development Pathway; and Structured Judgement Reviews.

Several changes have been made to the IPC BAF and these are listed in section 2.5 of the report.

- The Trust has assessed the systems and processes in place against indicators in the IPC BAF.
- The Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls[1].
- Patients and visitors are fully aware of the measures staff are required to take to prevent COVID-19 infections, and the measures they are themselves required to take to prevent COVID-19 infections.
- National IPC UKHSA guidance is regularly checked for updates and any changes are communicated to staff in a timely way.
- A COVID-19 dashboard has been developed to provide oversight of Nosocomial infections at Trust-wide level, and by hospital and clinical area.

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

- The key measures of hand hygiene, appropriate PPE and social distancing are embedded within all staff groups; regular audits are undertaken.
- The UKHSA campaign 'Hands, Face, Space' is visible across the Trust, clear signage is in place at all egress points as well as in clinical areas.
- Measures are in place to ensure staff can comply with social distancing and PPE in non-clinical areas.
- Measures are in place to routinely test staff using both Lateral Flow Testing and PCR testing; including PCR testing if an outbreak occurs.
- Regular audits of patient testing guidelines take place, with actions in place to improve compliance where required.
- The Trust has developed a database to monitor mask fit testing.
- Decontamination policies and procedures are in place.
- Monitoring of cleaning standards and frequencies in clinical and non-clinical areas are being addressed.
- The newly formed Anti-Microbial Stewardship Committee (AMC) will reconvene in November 2021 following a refresh of the current arrangements.
- The Board receive regular reports relating to the IPC BAF, which is also incorporated into the main Board of Directors BAF.

AL highlighted section 5.5 which provides an update on the number of Covid outbreaks across MFT and Section 8 which details the nosocomial transmission of other Healthcare Associated Infections.

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

There were 129 patients across MFT who died from an acquired HOCI (Hospital Onset COVID-19 Infection), defined as the first positive COVID-19 swab confirmed greater than 15 days after admission and who subsequently died within 30 days of their diagnosis. This represents 10.2% patients from all identified HOCI.

TR asked if there were any patients making claims against MFT for COVID-19 infections picked up in MFT's hospitals. AL confirmed there hadn't been any.

Board decision	Action	Responsible officer	Completion date
The Board noted the actions and progress to reduce the risk of transmission of Covif-19 and other Healthcare Associated Infections.	None	N/A	N/A

139/21 Chief Finance Officer's report

JEh presented the report which presented MFT's financial performance for Month 6 (September 2021).

Year to date to Month 6, September 2021, the Trust has delivered a surplus of £13.2m against the break-even plan for the year. Against the H1 targetted surplus of £23.1m there is a shortfall of £9.9m due to non-receipt of the £5m system monies and ongoing financial pressures across the Trust due to the wider impact of the Covid-19 pandemic. The surplus of £13.2m was achieved through a technical adjustment, releasing £10.95m of the Trust's provision against the cost of untaken annual leave, after review of the total held at the year-end for 20/21.

There is a requirement to submit a new plan to GM and to NHSE/I for H2 and this is currently being worked up for submission deadlines in mid to late November.

After adjusting for the impact of the pay award, including arrears payments, reflected in pay in month 6, and additional ERF accrued costs, September expenditure remains consistent with the run rate over the last few months - just 0.17% lower than month 5 and 0.2% higher than month 4.

The controls over additional investment linked to activity recovery have been established, in the short term these have been supported by additional income from the Elective Recovery Fund (ERF) however the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime.

Planning guidance for H2 was released in late September and the finance team is working with colleagues to develop the Trust's plan for submission to GM and NHSE/I in November. The value of system monies from GM for H2 is currently subject to negotiation so there remains risk around this in the context of working up plans for income and expenditure in H2 that deliver a breakeven position and the Trust's Waste Reduction Programme target of £50m for the full year. The updated plan will be brought to Finance & Digital Scrutiny Committee in December.

As of 30th September 2021, the Trust had a cash balance of £265.9m, which now includes £6m transferred in from the North Manchester balance sheet disaggregation. The cash balance was lower than forecast by £11m, due to PDC funds which have not yet been drawn down relating to the New Hospitals Programme (NHP, formerly HIP2) awards.

The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned spend into line with the system capital envelope. The total "envelope" plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £181.1m. The forecast outturn has seen a further decrease in month 6 of £9.4m, compared with the forecast reported in month 5, due to a further £8.8m reduction in the NHP project spend, caused by delays in approval, and £0.6m slippage on the NHP project IM&T Digital Business Case. The potential capital expenditure outturn may be £9m higher due to backlog maintenance pressures and thus slippage across the programme during the year will bring the actual spend back in line with the agreed envelope.

Additional national funding has recently been announced for capital bids in the Elective Recovery and Technology areas. The Trust is making its bids through GM and, should they be secured, there will be a requirement for this capital spend to be completed by 31 March 2022.

In the period up to 30th September 2021, £49.2m capital expenditure has been incurred against a plan of £68.9m – an underspend of £19.7m. £13.1m of the slippage relates to the NHP project and is due to delays in the approval of the Park House scheme and associated enabling works. As noted above, the estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £6.6m underspend, £5.7m relates to the NMGH emergency works which are funded through Emergency PDC. The Emergency PDC application has been submitted and is in discussion with NHSEI, but the plan assumed earlier approval of this. Continued underspend against this scheme is expected until the approval has been granted, the longer any approval takes the less likely the opportunity to spend within this financial year.

The transfer by absorption of the NMGH transaction was incorporated into the balance sheet in month 3 and is reflected in the I & E as a below the line Transfer by Absorption gain of £65.5m. This gain is reflected through the Trust reserves on the balance sheet.

LG asked why the 'system money' planned for H1 had not been provided to MFT.

JEh explained that this related to the deficit funding for NMGH, and it had not been clear in the H1 negotiations that this value had already been included in the wider GM system monies. Therefore the expectation had been that additional funding would be provided to GM. This has now been clarified for H2, and therefore the deficit funding is provided directly to MFT and NCA for H2.

JEh went on to explain that in relation to the Emergency PDC that has not yet been received, in general this funding was for organisations who had no cash available, where MFT clearly has a significant cash balance. However, the transfer of NMGH has brought with it a continuing need for significant capital works and, as part of the transaction discussions, it was agreed that MFT's overall financial position should not be disadvantaged by taking on responsibility for NMGH. Discussions are therefore ongoing with NHSE/I to resolve the issue.

TR confirmed that the matter would continue to be overseen at the Finance and Digital Scrutiny Committee, the next meeting of which is on the 21 December.

Board decision	Action	Responsible officer	Completion date
The Board noted the out-turn position against the H1 plan and the updates on cash and capital positions for the Trust.	None	n/a	n/a

CM temporarily left the meeting at this point.

140/21 Update on Strategic Developments

DB presented the paper which updated the Board in relation to strategic issues of relevance to MFT.

Designate chairs have been appointed to 38 of the 42 NHS integrated care boards of the new Integrated Care Systems, due to come into force on 1 April 2022. This includes the appointment of Sir Richard Leese as Chair designate of the Greater Manchester Integrated Care Board.

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

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

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

In terms of locality / place-based working, further guidance has been issued on the potential models for this and each of the ten localities in Greater Manchester is considering which option they would want to adopt.

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

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

NG asked what the most likely locality Governance arrangements for GM localities.

DB explained that most places were favouring Joint Committee arrangements.

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

141/21 Annual Planning

DB presented the report which updated the Board on the process to revise MFT's vision, and the draft timetable for the annual planning process for 2022/23.

There have been several major changes both within MFT and externally that should be considered when reviewing the vision.

- Single Hospital Service – MFT now incorporates NMGH.
- Integrated Care Systems – we will be required to work more collaboratively with other providers and as part of our local systems and to play our part in integrating care and addressing the wider determinants of health.
- Health inequalities – there is an increasing focus nationally on addressing the avoidable differences in health across the population.
- COVID-19 – the pandemic has had a deep and lasting impact on the organisation on the numbers waiting for treatment and the direct and indirect impact on our workforce.

The review to date has concluded that the vision statement remains valid, but that changes are required to the underpinning strategic aims. Board members were presented with some initial ideas and invited to comment upon them. A revised set of Strategic Aims will be presented to the Board of Directors' meeting in January 2022.

No guidance or timeline has yet been received for the national planning process. However, as the resources that will be available to MFT, and the targets that the Trust will be expected to achieve, are predominantly known, a provisional timetable for the internal MFT annual planning process has been developed.

LG commented that he was pleased to see that addressing health inequalities was included as a potential change to the strategic aims. He also pointed out that, while innovation features in the overall vision statement, there is not a strategic aim which covers it.

Board decision	Action	Responsible officer	Completion date
The Board supported the proposal to revise MFT's strategic aims and noted the provisional annual planning timetable.	Revised strategic aims to be presented to Board of Directors on 11 January 2022	Group Director of Strategy	11th January 2022

142/21 Manchester Locality Plan

DB spoke to the report which presented Manchester's Locality Plan.

All the Clinical Commissioning Groups (CCG) within GM, including Manchester, have recently refreshed their locality plans. These plans were first developed as part of 'Taking Charge', the original plan to improve the health and well-being of people living in Greater Manchester and since then have formed the bedrock of the GM Health and Care Strategy.

MFT members of staff have been involved in the refresh exercise and are content that there is alignment across this and MFT aims and strategic direction. As key partners, MFT are asked to confirm sign up to the aims and commitment to playing a part in delivering on the aims and objectives set out in the document.

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

143/21 Q2 Complaints report (2021/22)

AL presented the report which provides an overview of MFT's PALS/Complaints activity for Quarter 2 of 2021/22.

1,938 PALS concerns were received in comparison to 1,834 received in the previous quarter and 442 new complaints were received in comparison to 412 received in the previous quarter.

100% of complaints were acknowledged within 3 working days; this position was maintained throughout all the previous quarters of 2020/21 and 2021/22. 431 complaints were closed in comparison to 345 closed in the previous quarter. 87.7% of complaints were closed within the agreed timescale compared to 93.3% in the previous quarter. This is the first quarter in which the Trust has not achieved or exceeded the 90% target. 46 (10.7%) complaints investigated were upheld, 86 (20.0%) were not upheld and 278 (64.5%) were partially upheld. 7 cases were being investigated by the Parliamentary Health Service Ombudsman (PHSO) who didn't close any of our cases this quarter.

A decrease in complaints relating to outpatient and inpatient services was noted across the Trust and a slight increase in re-opened complaints. 12 virtual or face to face complaint local resolution meetings were held.

7 in-house Complaints Letter Writing Training Educational Sessions were held, with 56 number of staff attending. The Complaints Review and Scrutiny Group (CRSG), chaired by IB, met twice during Q2. The senior management teams from Manchester Royal Infirmary (MRI), Local Care Organisation (LCO), Saint Mary's Hospital and the Royal Manchester Children's Hospital each presented a case. In each case, learning was identified to improve patient care in the future, and this was described in the report.

IB stated that the report is very encouraging but could capture more of the improvements in practice which have occurred because of learning from complaints. He stated that he has seen a positive change in the culture of the organisation and how teams present at the Complaints Review and Scrutiny Group.

Board decision	Action	Responsible officer	Completion date
The Board noted the content of this Q2 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that MFT is responsive to concerns raised and learns from patient feedback to continuously improve the patient's experience.	None	n/a	n/a

Chris McLoughlin re-joined the meeting at this point.

144/21 Maternity Services update including Ockenden response

AL presented the report which provides assurance on matters relating to maternity services.

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 , was published on 11th December 2020.

The Ockenden Report was shortly followed by the publication of an assessment and assurance tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of effective implementation through the national maternity self-assessment tool.

St Mary's Managed Clinical Service (SM MCS) completed the assessment and assurance tool for services provided at MFT, which was reported to the Board of Directors in January 2021, and to NHS England through the Greater Manchester and East Cheshire Local Maternity System (GMEC LMS) on 15th February 2021.

The Board of Directors have received updates in March and May 2021. Further extensive submission of evidence related to areas of compliance was submitted to the GMEC LMS on 30th June 2021.

In Q1 and Q2 2021-2002, 3337 incidents have been reported across maternity services at Wythenshawe Hospital, Oxford Road Campus and North Manchester General Hospital). Of these: 94% were no harm incidents, 5% were slight harm incidents, 0.02% were major incidents, and 0.08% were reported as catastrophic incidents. In total, 13 cases were reported in the moderate, major, or catastrophic harm category. All incidents have been subject to a high impact learning assessment; with 4 cases reported via the Strategic Executive Information System (StEIS) and 3 cases reported to HSIB.

The high impact learning assessments have led to the following actions:

- a review of MDT staffing in maternity triage;
- ensuring educational updates and staff training in triage assessment processes;
- revised consultant-led MDT ward rounds; and
- an amended referral pathway for complex women into the pre-term birth clinic.

In addition, a duty of candour has been undertaken for each case and families given the opportunity to discuss events and raise concerns. All 13 families have had the opportunity to discuss the incident with the appropriate teams, with no additional concerns raised.

The Practice Review Forum (PRF) is well established across all three MCS sites and is valued as a process by which risk is identified, and mitigated by implementing immediate actions following incident review, or where local concerns about care provision are identified.

Reviews are undertaken by multidisciplinary clinical teams who are independent of the initial care providers, who confirm appropriateness of the care provided and actions required to mitigate risks to improve care and outcomes. Any clinical incident with an initial severity of 3 or above is reviewed within 72 hours of occurrence, thus supporting early feedback to women and their families, and supporting psychological wellbeing of staff.

During Q1 and Q2 2021-2022, a total of 180 reviews took place which include all at severity 3 and above. 78% of incidents with an initial severity of 3 and above have been completed within the timeframe of 72 hours against a target of 100%.

The practice reviews have identified four main themes for focussed improvement work and several examples of action taken because of learning from the reviews are highlighted in the report.

The Trust has two executive (Group Chief Nurse and Joint Medical Director) and one non-executive Maternity Board Safety Champions. The role of the safety champions is to strengthen Board oversight and assurance of effective perinatal clinical quality.

An Assurance Oversight Framework (AOF) is in place. It was developed locally and includes 13 metrics selected by the Obstetric Division as important indicators of safety with an associated scoring range of between 1 and 6. (1 being lowest and therefore safest position and 6 being the highest). The AOF is part of the governance framework and reports through to SM Quality and Safety Committee.

Patient experience is monitored using information derived from compliments, concerns through incidents, complaints, patient engagement and the national maternity survey.

To address workforce challenges, SM MCS made guaranteed offers of employment to 56 3rd year student midwives from local Higher Education Institutes (HEIs) in September 2021. These students, once qualified will transition to the NMC register. A modified recruitment campaign has taken place aimed at attracting newly qualified midwives from outside GM, along with experienced Band 6 midwives to SM MCS. In total, SM MCS made 82.4 WTE overall offers of employment of which 76 were accepted, over 40 new starters commenced in post during September and October, other start dates are in place up to January 2022.

Working closely with the Corporate Director of Nursing, Workforce and Education, the Director of Nursing and Midwifery has also overseen the recruitment of 8 international midwives, who will be welcome to SM MCS in June 2022.

Retention of qualified midwives is nationally recognised as an issue, currently 8.5 WTE midwives leave MFT each month. In October 2021, to support maternity providers in their retention of midwives, a one-year non-recurrent funding of £150,000 has been received by SM MCS from NHSE/I.

The SM MCS Ockenden responsive plan includes 83 actions against the 7 Immediate and Essential Actions (IEAS) of which 18 currently remain open. Of the 7 IEAs, good progress has been made against all or the associated actions, with one IEA fully completed. The last action is due to close on 31st December 2021.

The maternity safety self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. SM MCS submitted evidence for review by the Clinical Support Unit, Regional Maternity Transformation Programme. A draft report has now been returned for further review and additional evidence submission, prior to meeting with the regional teams.

CM stated that the approach taken had been very thorough, honest, and open. Meetings held with the Maternity Voices Partnership have proved very helpful. She is close to the action plan and kept up to date with progress.

Board decision	Action	Responsible officer	Completion date
The Board noted the information provided within the report and the assurance provided in respect of Saint Mary's Managed Clinical Service's Maternity Services, including the action plan for compliance against the Ockenden Report	None	n/a	n/a

145/21 Bi-Annual Nursing and Midwifery 'Safer Staffing' report

AL presented the report which provides the bi-annual comprehensive report to the Board of Directors on Nursing and Midwifery staffing.

The Covid pandemic has resulted in the nursing, midwifery and AHP workforce working in new ways and in unfamiliar settings. These changes have often happened rapidly to meet increased demand whilst ensuring the care provided continues to be of high quality. NHSE/I principles and the NMC regulatory guidance have been utilised by the Trust to support a response and maintain safe staffing measures. Co-ordinated approaches to training, staffing huddles and collaboration between the hospital sites has supported flexibility within the workforce.

Nursing and midwifery workforce supply continues to be a challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations. According to NHS workforce statistics, the current shortage of staff across the NHS in England is nearly 94,000, with 39,000 within the registered nursing workforce (NHSE/I). In September 2021 the National University and Colleges Admission Services (UCAS) received unprecedent interest in

healthcare programmes commencing in September 2021. This has translated into an increase in students commencing on Nursing, Midwifery and AHP programme during the summer.

At the end of September 2021 there was a total of 520wte (5.7%) qualified nursing and midwifery vacancies across the Group, compared to 655wte (7.2%) in April 2021, a reduction of 1.5%. Most vacancies are within the nursing and midwifery (Band 5) workforce. At the end of September 2021 there were 305wte (6.3%) compared to 344wte (7.1%) in April 2021. The vacancy position is expected to continue to improve during Q3 due to the international and domestic recruitment pipelines. The 12-month rolling turnover rate for the registered nursing and midwifery staff group was 11.6% and 13.9% within the Band 5 workforce.

There are currently 437 domestic nurses and midwives in the Band 5 recruitment pipeline, 153 of these are working through their recruitment checks and 284 are due to start in post over the next 9-12 months following graduation.

The Trust's International Recruitment Programme (IR) continues to provide an additional supply of Band 5 nurses to the workforce. A total of 405 Band 5 international nurses were recruited between September 2020 and March 2021 following the government's decision to lift travel restrictions. To date, 203 Band 5 international nurses have commenced at the Trust in 2021/22. International recruitment campaigns continue to support the hard to fill areas such as theatres, critical care, neonatal care, alongside a targeted recruitment campaign to support children's services.

There are currently 197 Nursing Associates (NARs) employed by the Trust working across general wards, community services and theatre areas with an additional 246 Trainee Nursing Associates (TNAs) in training across the Trust.

The sickness absence rate for nursing and midwifery was 5.0% at the start of the pandemic in March 2020. In September 2021 the unplanned absence rate for registered nursing and midwifery was 8.2% and 13.0% for unregistered staff. Due to the nature of absences, it is anticipated that this absence level will continue to remain significantly above 'normal' levels through 2021/22. The main reasons for this increase being Covid-related sickness and an increase in general sickness.

Staffing levels continue to be assessed daily across each shift to ensure they are adequate to meet patient acuity and dependency needs on each ward and department. Any changes to skill mix are risk assessed daily by a senior nurse, who reviews the actions being taken to mitigate risk to patient safety.

TR asked whether there is a 'tipping point' where services would need to be reduced because of staff shortages, and whether we are close to that point.

AL confirmed that there are clear processes to identify unsafe services because of staff shortages but that MFT is not at that point yet and still can move staff around to safely address any shortfalls.

MD also confirmed that, in addition to within MFT, mutual aid arrangements exist across Greater Manchester, building on the critical care arrangements led by JE.

Board decision	Action	Responsible officer	Completion date
The Board noted the progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.	None	n/a	n/a

146/21 'Freedom to Speak Up' Annual report (2020/21)

Karen Hawley, Freedom to Speak Up (FTSU) Guardian for MFT presented the 20/21 Freedom to Speak Up Annual Report which had already been presented at the HR Scrutiny Committee. Karen joined MFT as a full time FTSU Guardian on 4th May 2021.

The FTSU Team is supported by the Group Deputy Chief Executive along with Dr Ivan Benett as Non-Executive Lead. The Group Executive Director of Workforce & Corporate Business provides formal leadership to the Freedom to Speak-up Guardian.

The FTSU Team is also supported by a network of FTSU champions. The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. During 2020-21, targeted recruitment was undertaken to increase the diversity of the FTSU champion network and to extend the reach of FTSU at WTWA sites. By the end of March 2021, the FTSU work was supported by a network of 35 champions from a variety of clinical roles and backgrounds, including representation from night staff and champions who identify as being from Black, Asian, and Minority Ethnic (BAME) backgrounds.

During 2020-21, 77 cases were reported to the FTSU Team. 34% (26 cases) raised had an element of bullying and harassment. This is reduced from the number of cases raised to FTSU during the same period in 2019/20 (previously 58%). The figure is slightly higher than the national figure of 30%. 19% (15 cases) included an element of patient safety. This is similar to the national figure where 18% of cases reported to the National Guardian's Office had an element of patient safety. The number of cases raised anonymously via FTSU at MFT was 1% (1 case). This is significantly lower than the national average of 12%. The number of cases where staff have reported experiencing detriment because of raising concerns is 13% (10 cases). This is much higher than the national average of 3%.

NHSE/I and the National Guardian's Office have brought together 4 questions from the NHS staff survey into a FTSU index. These questions ask whether staff feel knowledgeable, secure, and encouraged to speak up and whether they would be treated fairly after an incident. MFT FTSU Index Score based on 2020 staff survey is 78.3, slightly below the national average of 79.2. The MFT FTSU Index Score has increased by 0.2% from the previous year.

Key FTSU objectives for 21/22 have been set.

- Continue to expand and develop the diverse FTSU network of champions across MFT.
- Review FTSU processes and systems to ensure consistency of approach across the team.
- Ensure FTSU processes and approaches are aligned with the MFT People Plan.

- Develop and embed best practice processes to ensure FTSU concerns are triangulated against patient safety issues and promote organisational learning.
- Update FTSU communications by a range of means so that all staff are aware of the role of FTSU and how to contact the team.
- Continue to develop staff skills and knowledge around speaking up, listening up and following up.
- Continue to work with the National Guardians Office and Regional FTSU Network to ensure that MFT learns from national best practice.

IB paid tribute to the work which MFT have put into this area of work and recognised the significant changes which have been put in place over the last 3 – 4 years. He thanked Karen and her predecessor, David Cain, for all the work they have done.

Board decision	Action	Responsible officer	Completion date
The Board noted the 2020/21 Freedom to Speak Up Annual Report and approved it for publication.	None	n/a	n/a

147/21 Board Assurance Framework (October 2021)

PB spoke to the report which presented MFT's Board Assurance Framework (BAF).

The format has been slightly altered following a workshop with the NEDs in October. Relevant Scrutiny Committee are now listed for each risk and scoring is now likelihood x impact to bring it in line with the way risk is scored across the organisation). A Standard Operating Procedure has been developed and was sent to risk owners this time to improve consistency of reporting. The format will be revised further in line with a review of the Group Risk Management Strategy. The BAF was reviewed by the Audit Committee at the beginning of November.

NG recognised the amount of work the risk owners must do and confirmed that the Audit Committee find the BAF very useful.

Board decision	Action	Responsible officer	Completion date
The Board accepted the latest BAF (October 2021) which is aligned to the MFT Strategic Aims.	None	n/a	n/a

148/21 Board of Directors Declarations of Interest

PB presented the report which detailed the directorships and other relevant, and material, interests which have been declared by the Executive and Non-Executive members of the Board of Directors.

Board decision	Action	Responsible officer	Completion date
The Board noted the MFT Board of Directors' Register of Interests (November 2021)	None	n/a	n/a

149/21 MFT Annual EPRR Core Standards Self-Assessment (2021/22)

DF spoke to the report which presented MFT's self-assessment against the NHSE E/I Core Standards for Emergency Preparedness, Resilience, and Response for 2021/22.

Based on MFT's self-assessment; 41 out of 46 Core Standards are declared as 'fully compliant', resulting in MFT receiving an overall EPRR assurance rating of 'Substantial' for 2021/2022. MFT receiving a rating of 'Substantial' should not be perceived as a negative assurance rating as MFT are delivering against each NHS Core Standards for EPRR. However, it indicates there are opportunities for the Trust to further improve over a period, through the implementation and monitoring of effective action plans. MFT also declared a compliance level of 'Substantial' for the previous year.

NG stated he would be interested in knowing how the self-assessment is tested.

KC explained that the best approach would be to have a conversation with DF outside of the meeting.

Board decision	Action	Responsible officer	Completion date
The Board noted and approved the MFT EPRR statement of compliance for 2021-22, with assurance of delivery of actions and future improved compliance monitored through the MFT EPRR governance structure.	None	n/a	n/a

150/21 Board of Directors' Sub-Committees' Terms of Reference (2021)

PB presented the report which sought ratification of the revised Terms of Reference for the Board of Directors' Sub-Committees.

The Terms of Reference are reviewed on an annual basis, in line with the requirements of MFT's Constitution. By the time of this meeting, all Terms of Reference presented had been approved by the relevant Committee apart from those of the Remuneration Committee. Should that Committee suggest any changes to those being presented, a further paper will come to the Board in January for ratification.

The report also proposed the standing down of the NMGH Scrutiny Committee and the LCO Scrutiny Committee.

Board decision	Action	Responsible officer	Completion date
The Board (i) approved the Terms of Reference of the Finance and Digital Scrutiny Committee, Quality & Performance Scrutiny Committee, HR Scrutiny Committee, Charitable Funds Committee, EPR Committee, and Group Risk Oversight Committee; (ii) approved the Terms of Reference of the Audit Committee and the Remuneration Committee with any changes proposed as a result of review at the relevant Committee will come to a future meeting of the Board of Directors for ratification; and (iii) approved the standing down of the NMGH Scrutiny Committee and the LCO Scrutiny Committee.	None	n/a	n/a

151/21 Committee Meetings

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

- Extraordinary Audit Committee held on 14th June 2021 and Audit Committee held on 8th September 2021
- Group Risk Oversight Committee held on 20th September 2021
- Charitable Funds Committee held on 28th September 2021
- Quality Performance & Scrutiny Committee held on 5th October 2021
- Human Resources Scrutiny Committee held on 12th October 2021

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

152/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 11th January 2022** at **2pm**.

153/21 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 8th November 2021			
Action	Responsibility	Timescale	Comments
Revised strategic aims to be presented to Board of Directors on 11 January 2022	Group Director of Strategy	January 2022	Completed

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alfie Nelmes, Head of Information Services
Date of paper:	January 2022
Subject:	Board Assurance Report – November 2021
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board Assurance Report is produced on a bi-monthly basis to inform the Board of compliance against key local and national indicators as well as commenting on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Alfie Nelmes, Head of Information Services Tel: 0161 276 4878

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(November 2021)

1. Introduction

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

2. Overview

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

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

3. Key Priority Areas

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

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

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

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

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

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)

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

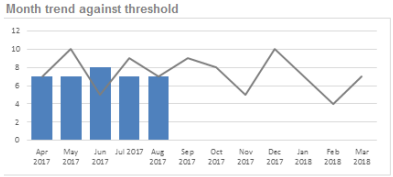
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

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.

> Board Assurance

November 2021

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	3	0	3	0

Headline Narrative

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

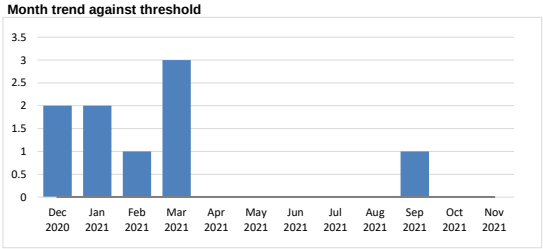
The Trust has reported 9 Never Events (YTD April 21 to November 21). The recently reported never events are currently under investigation. As a result the Trust-Wide never event risk has been reviewed and reframed in light of the recent never events and the need to focus on human/system interaction in the way we approach improvement. An externalreview has now been commissioned on the lessons learned and future approach.

Safety - Core Priorities

Mortality Reviews - Grade 3+ (Review Date) ✕

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

Month trend against threshold



Hospital level compliance

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

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

Key Issues

Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care. This has been revisited to provide further assurance in Q3. The data has still not been provided and all sites have been asked ot reprot on local learning via the Group Learning from Deaths Committee. it is clear that the ongoing pressures caused by the pandemic and retrospective reviews undertaken have had an impact on the routine reviews undertaken.

The data has not yet been available for review for Q1-3 21/22 - the narrative will be further updated when it is.

Triangulated data on crude mortality, HSMR and SHMI remain well within acceptable limits.

Actions

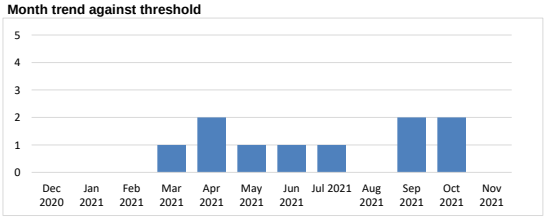
The focus is now on dissemination of the resulting changes and developments in practice across the organisation.

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

Never Events ✕

Actual	9	YTD (Apr 21 to Nov 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✓	✕	✕	✓	✓	✕	✓	✓
5	0	1	1	0	0	2	0	0

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

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally.
YTD (Apr 2021- Nov 2021) there have been 9 Never Events reported. There are key themes within the Never Events (and associated near-miss incidents) in relation to culture, psychological safety, communication, the use of checklists, the availability of guidance and the ergonomics of clinical environment design.

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

Actions

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

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

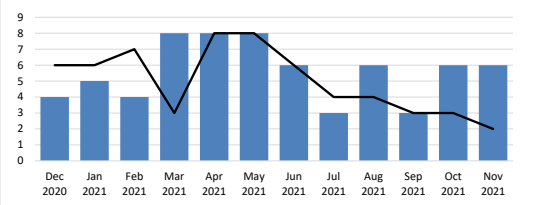
> Board Assurance

November 2021

Hospital Incidents level 4-5

Actual	46	YTD (Apr 21 to Nov 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	44	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✓	✗	✓	✓	✓	✗	✓
2	25	2	5	1	0	9	2	0

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

Key Issues

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

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

Actions

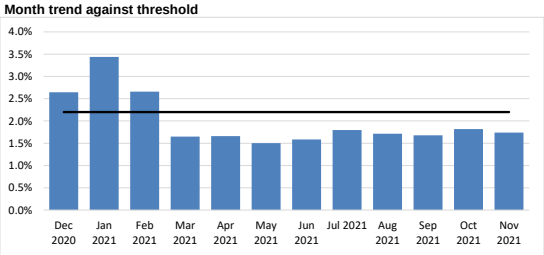
Routine examination of themes and trends through the safety oversight system which has led to additional high impact learning/assurance work in relation to a number of areas including:
- Nutrition and hydration
- Discharge
- Intra and inter hospital transfer
- Restraint

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

Crude Mortality

Actual	1.69%	YTD (Apr 21 to Nov 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✓	✓	✓	✓	◇	✗	NA
15.2%	1.9%	0.2%	0.2%	0.0%	0.0%	2.6%	3.0%	NA

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

Key Issues

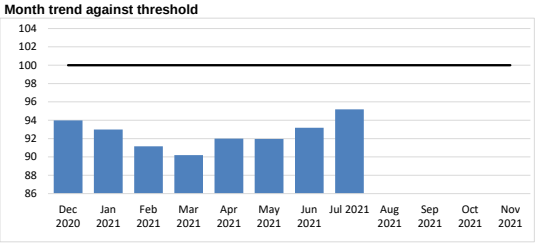
Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment.

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

SHMI (Rolling 12m)

Actual	93.2	R12m (Aug 20 to Jul 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	NA	NA
NA	91.5	NA	NA	NA	NA	90.2	NA	NA

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

Progress

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

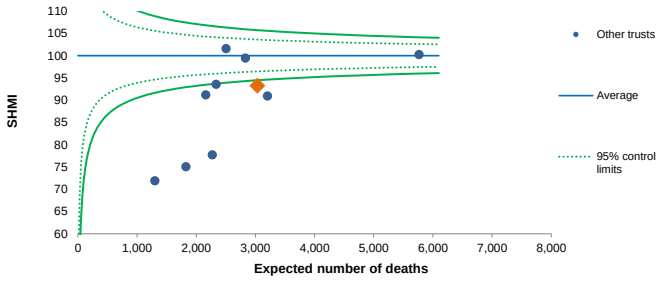
Risk adjusted mortality indices are not applicable to specialist children's hospitals.

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

Performance is well within the expected range.

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

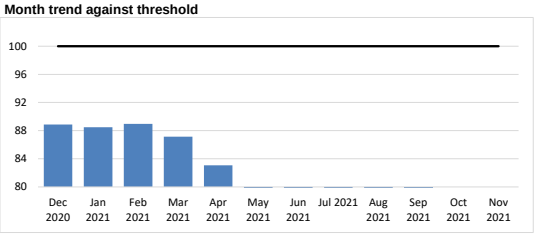
Summary Hospital-level Mortality Indicator for the Shelford Group, Aug 2020 - Jul 2021



HSMR (Rolling 12m)

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	NA	NA
NA	75.0	NA	NA	NA	NA	88.7	NA	NA

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

HSMR is a metric designed for adult practice.

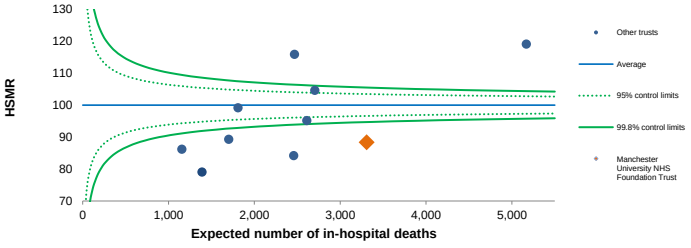
HSMR is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

Hospital Standardised Mortality Ratio for the Shelford Group, Apr 2020- Mar 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 November 2021 was 129, when compared with the 140 complaints received in October 2021 and 163 in September 2021. In November 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 88.6% this is a slight increase of 2.6% from the previous month. The number of new complaints received across the Trust during November 2021 was 129, which is a decrease of 11 when compared to 140 in October 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Friends and Family Test (FFT) was paused nationally between March and December 2020 in order to release capacity to support the response to the COVID-19 pandemic. The Trust overall satisfaction rate for FFT (including data from the NMGH acquisition on 1st April 2021) is 92% in November 2021 which is a decrease compared to 95.1% in October 2021. There is a continued focus for all areas of the Trust to use both the positive and negative FFT feedback to improve the experience of our patients.

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

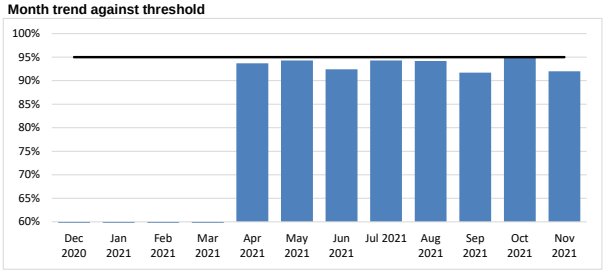
There have been 118 trust-attributable CDI reported so far this year. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 10 trust-attributable CDI cases reported for November 2021, all of which are pending review. There is a zero tolerance approach to MRSA bacteraemias,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

FFT: All Areas: % Very Good or Good

◇

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

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	◇	✓	✓	✓	✓	✕	✕
96.40%	96.40%	91.06%	95.66%	97.97%	98.91%	97.19%	87.10%	90.19%

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

Progress

In response to the Covid - 19 pandemic and in line with NHSE/I Guidance that was issued in March 2020, the submission of FFT data to NHSE/I was suspended. Further guidance that was received in May 2020 advised that where a provider was confident that any feedback collection method, including those received on electronic devices and on FFT cards, could be implemented safely, it may recommence and use those methods of patient feedback collection. Following consultation with the Infection Prevention and Control Team the Trust recommenced the collection of FFT data in May 2020 via these routes. The Health and Care Leaders update issued on 4th September 2020 advised that Acute and Community Providers should restart submitting the data to NHS Digital from December 2020 . The Trust overall satistaction rate for FFT (including data from the NMGH site following acqisition) for November is 92% compared to 95.1% in October 2021.There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

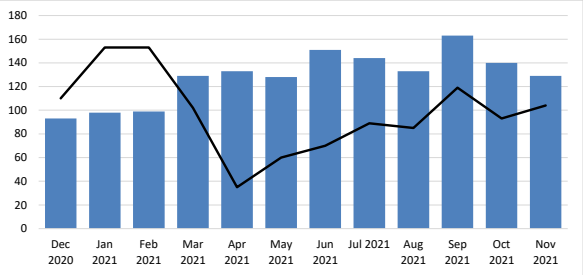
Actions

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

Complaint Volumes

Actual	1121	YTD (Apr 21 to Nov 21)	**Accountability**	C.Lenney
Threshold	1070	(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
✓	✓	✓	✗	✓	✗	✓	✗	✗
58	260	112	169	33	29	263	128	42

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 November 2021 was 129, when compared with the 140 complaints received in October 2021 and 163 in September 2021.

MRI received 37 complaints in November 2021 which is the highest number of complaints in the Trust (29.0% of the Trust total), when compared with the 38 received in October 2021 and 31 in September 2021.

Of the 37 MRI complaints received the top specific theme was 'Attitude of Staff'. Accident & Emergency was identified as a specific area in complaints relating to 'Attitude of Staff'.

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

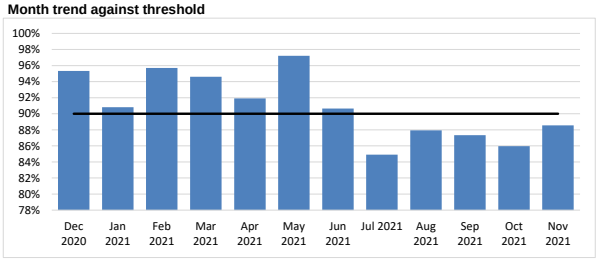
Actions
All Hospitals/MCS/LCO to continue to prioritise the closure of complaints that are older than 41 days. The Chief Executives are held to account for the management of complaints cases that exceed 41 days through the Accountability Oversight Framework (AOF).

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

Percentage of complaints resolved within the agreed timeframe

Actual	88.8%	YTD (Apr 21 to Nov 21)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✗	✓	✓	✓	✓	✗
95.7%	98.0%	100.0%	68.6%	100.0%	96.6%	95.5%	94.8%	55.1%

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

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

The November 2021 data identifies that 88.6% of complaints were resolved within the agreed timescales compared to 86.0% in October 2021 and 87.3% in September 2021: this is a slight increase of 2.6%.

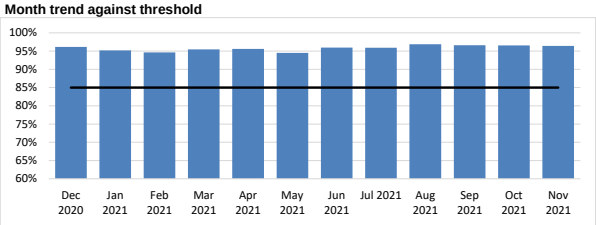
The Hospital/ MCS/LCO level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. It should be noted that where the Hospital/MCS/LCO receive lower numbers of complaints, this can result in high percentages.

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

Food and Nutrition ✓

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	NA	✓	✓	NA
94.3%	96.3%	93.1%	94.8%	99.5%	NA	97.5%	95.9%	NA

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

Progress

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

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

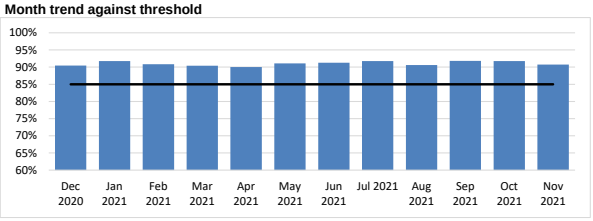
Utilising the Improving Quality programme (IQP) methodology, the MDT workstream engaged with patients and staff on Ward 12, at TGH to identify key areas to focus on improvement. Work commenced on the introduction of a hot breakfast and a 'snack round' from February 2020 with initial feedback reporting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

Whilst the Model Ward Programme was suspended due to the Covid - 19 pandemic from March to August 2020, the group continued to meet to provide support to the staff on Ward 12 to support the provision of a personalised dining experience during a period of change which resulted in a disruption to normal services. Work on the Model Ward Programme has now resumed with the re-introduction of a cooked breakfast, and a workplan to progress the other key areas that were identified at the onset of the programme.

Pain Management ✓

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	NA
93.6%	86.7%	89.9%	91.7%	98.1%	98.4%	93.6%	91.7%	NA

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

Progress

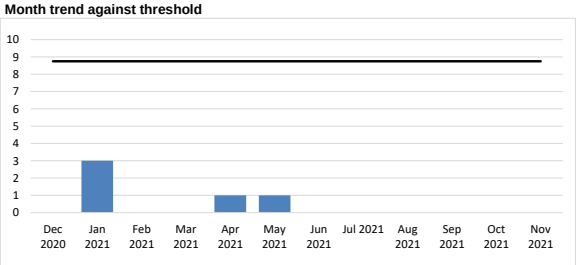
Work continues across the Trust to drive improvements in pain assessment and management.

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

Clostridium Difficile – Lapse of Care ✓

Actual	2	YTD (Apr 21 to Nov 21)	**Accountability**	C.Lenney
Threshold	70	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

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

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

Progress

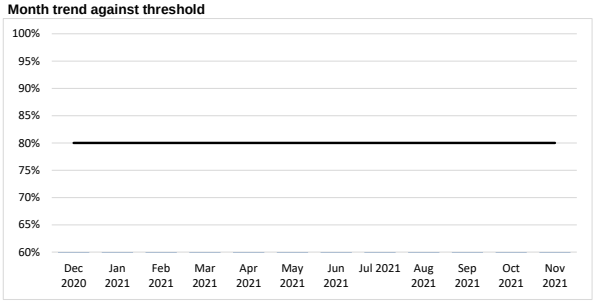
A total of 215 CDI cases were reported during 2020/2021: 179 (83%) of which were trust-attributable against a trajectory of 132. There have been 118 trust-attributable CDI reported so far this year. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 10 trust-attributable CDI cases reported for November 2021, all of which are pending review.

Nursing Workforce – Plan v Actual Compliance for RN

●

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

Month trend against threshold



Hospital level compliance

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

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

Progress

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

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

PALS – Concerns

-

Actual 5087 YTD (Apr 21 to Nov 21) | **Accountability** C.Lenney
Threshold None (Lower value represents better performance) | **Committee** Quality Committee

Month trend against threshold (includes corporate complaints)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
370	1217	447	676	228	141	1274	527	79

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

Key Issues

A total of 690 PALS concerns were received by MFT during November 2021 compared to 607 PALS concerns in October 2021 and 663 in september 2021.

MRI received the highest number of PALS concerns in November 2021; receiving 174 (25.2% of the total). This is an increase for MRI when compared to the 161 in October 2021. The specific themes for MRI related to 'Communication', 'Appointment/Delay/Cancellation (OP)' and Treatment and Procedure.

Of the 174 MRI PALS concerns received the top specific themes were 'Communication' and 'Treatment/Procedure'. Gastroentrology Department was identified as a specific area in complaints relating to 'Communication'.

Actions

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

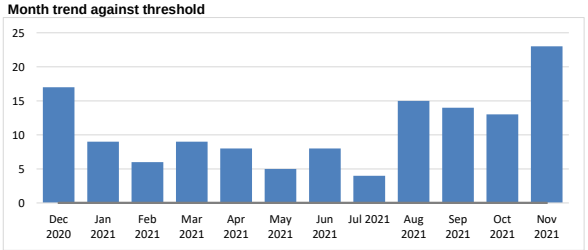
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 5 days.

All Attributable Bacteraemia

-

Actual 90 YTD (Apr 21 to Nov 21) | **Accountability** C.Lenney
Threshold None (Lower value represents better performance) | **Committee** Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	NA
7	32	13	5	0	0	21	12	NA

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

Progress

There were 595 incidents of E.coli bacteraemia reported to PHE during 2020/2021. Of these, 136 cases (23%) were determined to be hospital-onset. There have been a total of 88 trust-attributable E. coli bacteraemia reported so far in 2021/2022, of which 23 were reported during November 2021.

There were 15 trust-attributable MRSA bacteraemia cases reported to PHE during 2020/2021, and 9 community-attributable cases reported. There have been 7 trust-attributable MRSA bacteraemia reported for the current year, none reported throughout November.

Operational Excellence

D.Furnival

Core Priorities	✓	◇	×	No Threshold
	1	0	10	0

Headline Narrative

Reduced elective activity for significant periods over the past 22 months has had a profound detrimental impact on MFT performance against constitutional standards, particularly those related to elective access. Each peak of Covid inpatient and Critical Care demand requires the redeployment of nursing, medical and other operational staff for extended periods of time in order to support critical care demand.

The emergence of the Omicron variant of the Covid virus has required immediate management reviews of bed capacity to support expected increases in admissions which sites are now seeing. All plans to support the emergence of the new variant has not to date curtailed the planned recovery of the elective programme. MFT and GM continue to experience unprecedented peaks in emergency demand across both adult and paediatrics, which has required ad-hoc reduction in elective bed capacity in order to manage the non-elective demand.

Not with standing these operational challenges, MFT continues to progress actions aimed at improving performance against national operational standards. In addition, MFT has completed H2 planning requirements in line with the national planning guidance for the period Oct - March 2022, and developed associated trajectories and refreshed action plans in conjunction with CCGs.

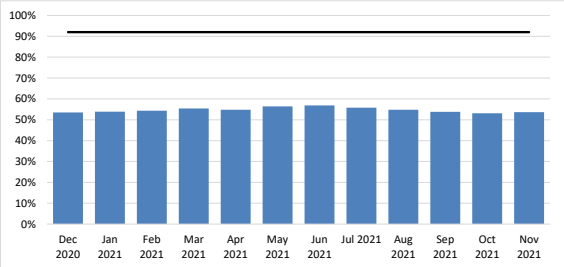
December summary:
• Whilst the elective waiting list has increased, at the end of November there has been an improvement of ~24.5% in the number of patients waiting over 52 weeks compared to April. (-4,133)
• The number of patients waiting longer than 104 weeks in November was 1.13 (%) of the overall waiting list, the position has increased due to the continued prioritisation of clinically urgent and cancer activity in line with national requirements.
• National performance against the 4 hour wait standards for Emergency Departments has steadily reduced since April, with the performance across GM and MFT following the same trend. Whilst performance in recent weeks has improved slightly it has generally reflected high levels of attendances across MFT Emergency Departments and ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of significant operational pressures and capacity constraints, there has been 212 breaches of the 12 hour DTA quality standard from September to date (16/12/21), Whilst no patient harm has occurred. corporate Governance has reviewed a selection of the breaches.
• Cancer performance has improved in 4 of the 6 cancer standards (31 days first treatment, 62 days screening, 31 days sub surgical treatment 31 days sub chemo treatment). Reducing the backlog of patients has been further challenged due to peak levels of cancer referral demand. A cancer recovery programme is in place to improve timely access for patients.

Operational Excellence - Core Priorities

RTT - 18 Weeks (Incomplete Pathways) ×

Actual	53.6%	(November 2021)	**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
×	×	×	×	×	×	×	×	×
63.9%	50.1%	58.8%	48.7%	63.4%	61.9%	56.3%	42.2%	50.2%

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

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

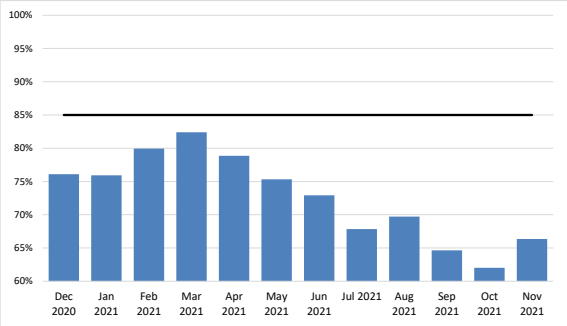
Actions
• Group Manchester Elective Surgical Hub has been mobilised to ensure patients with urgent clinical needs are treated, and maintain oversight and effective use of resources across MFT sites. This includes Independent Sector capacity already agreed for use by MFT.
• Maximising TGH hospital as a green site
• 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. Weekly RTT oversight and performance meetings holding hospitals / MCS to account on delivery.
• Group COO teams (Transformation and RTT) continue in place to support hospitals/ MCS, including consistent, safe approach to development of Attend Anywhere, Virtual triage and Patient initiated follow up programmes.
• Additional timely validation of PAS/waiting lists by Hospital sites and Group resource continues.

Progress
• In line with the national and regional picture the impact of Covid and the suspension of the elective programme has had a detrimental impact on the waiting list and RTT position since April 2020.
• The end of November wait list stands at 154,125 an increase of 2893 (1.88%) on October. Capacity for routine elective operations remains constrained due to the need to prioritise clinically urgent activity in line with national guidance
• The number of patients waiting longer than 52 weeks in November was 12749 (8.27%) of the overall waiting list. This is a 24.5% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in November was 1735 (1.13%) 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 November was 29% of all appointments inline with national requirements.

A&E - 4 Hours Arrival to Departure

Actual	64.1%	Q3 21/22 (Oct to Nov 21)	**Accountability**	D.Furnival
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	✓	✓	NA	✗	✗	NA
NA	62.9%	71.9%	96.6%	99.8%	NA	64.3%	60.3%	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.
- Increasing acuity is contributing to delayed handovers of patients and the numbers of ambulance holds
- Bed capacity constrains 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 are experiencing unprecedented UEC pressures, whilst overall activity is at pre-pandemic levels this is misleading as there are days of extreme pressure at peak levels not seen previously, both in adults and paediatrics.
- Staff absence is contributing to 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 of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).

MFT has also developed and implemented ED safety standards. Each site is undertaking a safety and point prevalence review. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.

- A MFT risk summit is being held in November, followed by a round table discussion between MFT, locality partners and NHSE.
- Locality winter plan in place, MFT winter preparedness exercises undertaken in October.

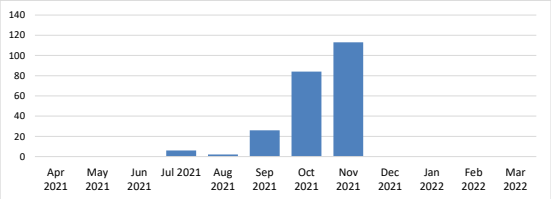
Progress

- November 2021 saw 4,559 (12.4%) additional attendances compared to April 2021. Volume, higher acuity of patients, IPC measures and short term staff sickness both medical and nursing have impacted performance.
- in line with the national and regional picture, MFT performance of 77.70% in Q1 has reduced to 67.4% for Q2 2021/22.Quarter 3 to date (16/12) is 64.4%
- The number of patients with 7+ and 21+ days Length of Stay in MFT beds at 30th November was 846 and 344 respectively. Hospital teams are focussed on long length of stay reviews.

A&E - 12 Hour Trolley Waits

Actual	231	YTD (Apr 21 to Nov 21)	**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	0	2	0	0	NA	1	228	NA

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

Key Issues

Contributing factors resulting in the increase in long waiters specifically at NMGH are:

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

Actions

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

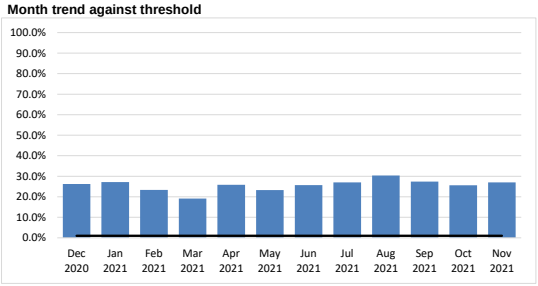
Progress

As a result of significant operational pressures, North Manchester site has reported 113 breaches of the 12 hour DTA quality standard during November, the majority of which were related to bed capacity constraints. Harm reviews are undertaken for all patients, with no harm identified.
learning from the root cause analysis undertaken for any breach of the standard has been implemented

Diagnostic Performance

Actual	27.0%	(November 2021)	**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
13.3%	35.9%	85.2%	41.2%	NA	NA	37.3%	44.9%	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
- North Manchester General Hospital from the 1st April 2021, is now reported by MFT.

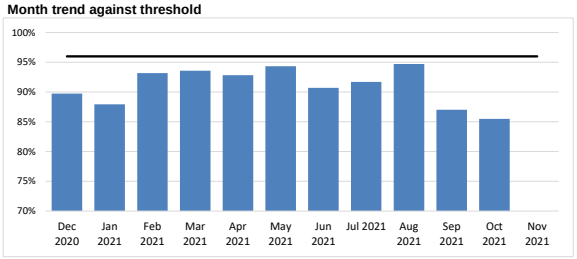
Actions
- Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved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

Progress
- Prior to merger with NMGH the waiting list size for diagnostic tests was improving month on month.
- Post integration and inclusion of NMGH diagnostic numbers, the waiting list as reported in November 2021 stands at 29,178. NMGH equates to circa 19.5% (5,680) of this.
- Group Performance, whilst remaining challenged at 27.0% in November 2021, shows marginal improvement when compared to performance in November 2020 (27.8%), taking into account the NMGH factor performance would be 22.7%.

Cancer 31 Days First Treatment

Actual	85.5%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✓	✗	NA	NA	✗	✗	NA
NA	77.4%	100.0%	81.3%	NA	NA	84.5%	93.0%	NA

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

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

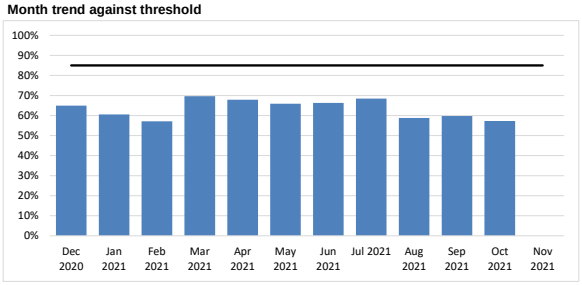
Actions
- Cancer treatments are being prioritised during the Covid pandemic, in line with national guidance on priority patients.
- Undated patients over 14 days are discussed at the group level Manchester Elective Surgical Hub (MESH) meetings with hospital / MCS leads.
- Capacity is assessed weekly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

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

Cancer 62 Days Referral to Treatment

Actual	57.3%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✗	NA	NA	✗	✗	NA
NA	41.6%	NA	42.1%	NA	NA	61.7%	63.6%	NA

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

Key Issues

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

Actions

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

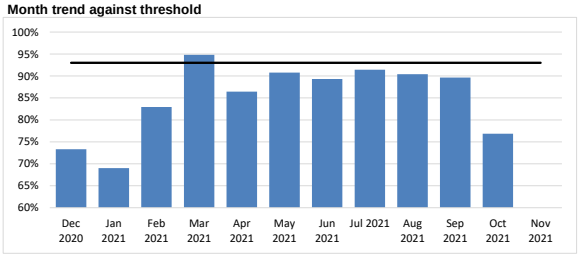
Progress

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

Cancer Urgent 2 Week Wait Referrals

Actual	76.8%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	✓	✓	NA	NA	✗	✗	NA
NA	95.7%	100.0%	95.2%	NA	NA	75.1%	65.0%	NA

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

Key Issues

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

Actions

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

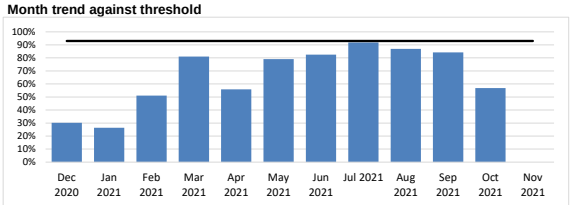
Progress

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

Cancer 2 Week Wait - Breast

Actual	56.8%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	NA	NA	NA	✗	✗	NA
NA	NA	NA	NA	NA	NA	74.4%	14.7%	NA

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

Key Issues

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

Actions

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

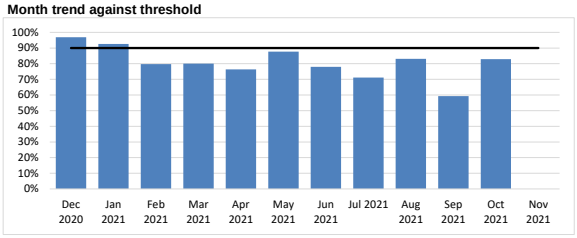
Progress

Performance is improved from Q1

Cancer 62 Days Screening

Actual	82.9%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✓	NA	NA	✗	✓	NA
NA	50.0%	NA	-	NA	NA	84.4%	100.0%	NA

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

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

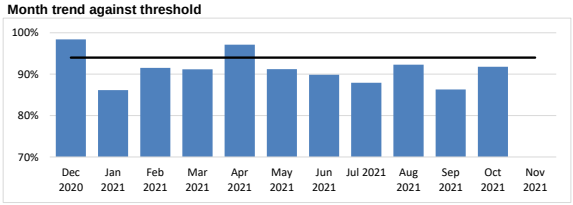
Actions
- The Actions listed under Cancer 62 Days are applicable to this standard.

Progress
- Approval has been given by the MFT strategic group to restart the Bowel screening programme, along with high risk breast patients, and the lung health checks has recommenced.
- As noted above performance is likely to reduce as activity increases and the backlog is reduced.
- The screening backlog over 62 days is reducing.

Cancer 31 Days Sub Surgical Treatment

Actual	91.8%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	✓	NA	NA	✗	✓	NA
NA	100.0%	NA	100.0%	NA	NA	86.8%	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

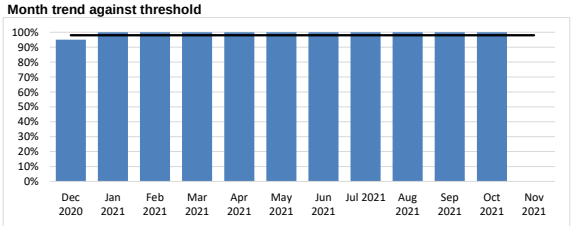
Actions
Actions noted under the above cancer standards.

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%	Q3 21/22 (Oct 21)	**Accountability**	D.Furnival
Threshold	98.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

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

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

Key Issues
- No current issues with chemotherapy provision.

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

Progress
•Standard achieved in month.

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	0	0	0	0

Headline Narrative

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

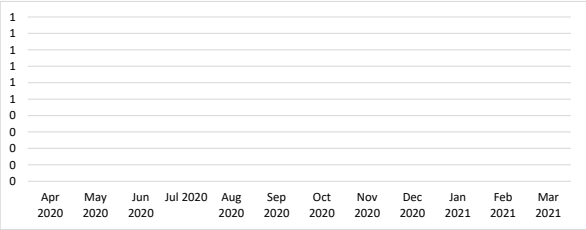
Finance - Core Priorities

Operational Financial Performance

Actual | **Accountability** A.Roberts

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

Month trend against threshold



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

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

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

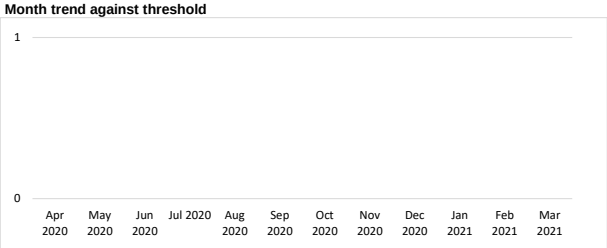
Actual

Threshold (Lower value represents better performance)

Accountability A.Roberts

Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



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

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

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	5	0	6	3

Headline Narrative

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

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

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

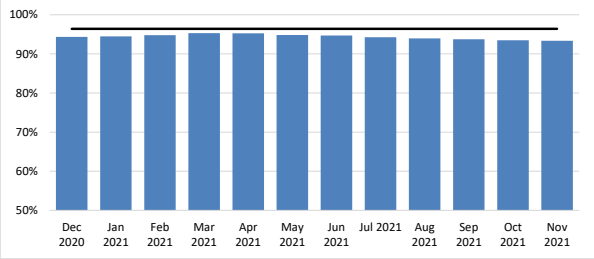
Workforce and Leadership - Core Priorities

Attendance ✕

Actual 93.4% (November 2021) **Accountability** P. Blythin

Threshold 96.4% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✕	✕	✕	✕	✕	✕	✕	✕
94.3%	92.3%	93.4%	94.1%	91.7%	94.3%	92.8%	92.7%	92.9%

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

Key Issues

The Group attendance rate for November was 93.4% which is lower than the previous month's figure (93.5%). This is also lower than the attendance rate at the same point last year (November 2020) of 94.6%. The latest figures released by NHS Digital show that for July 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.1% or 93.9% 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 July 2021 at 4.3% or 95.7% attendance rate.

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

Actions

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

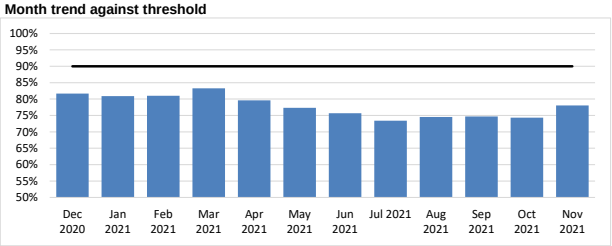
The Absence Manager system is in place across all MFT sites. The system was introduced at North Manchester at the beginning of August 2021 to enable real-time absence reporting. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers make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

Appraisal- non-medical ✕

Actual 78.1% (November 2021) **Accountability** P. Blythin

Threshold 90.0% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✕	✕	◇	◇	◇	◇	✕	✕
71.8%	83.2%	75.7%	85.6%	88.8%	87.0%	86.7%	68.2%	77.3%

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

Key Issues

Compliance increased by 3.8% across the Group in November 2021. Only the MRI, Corporate Services and the Eye Hospital have seen a reduction in their compliance score from October 2021, all other Hospitals and MCS's have a higher compliance rate compared to the previous month. North Manchester Hospital had the biggest increase from October at 5.7% and Corporate Services had the biggest drop in compliance at 1.5% with a score of 69.9% compared to 71.4% in October.

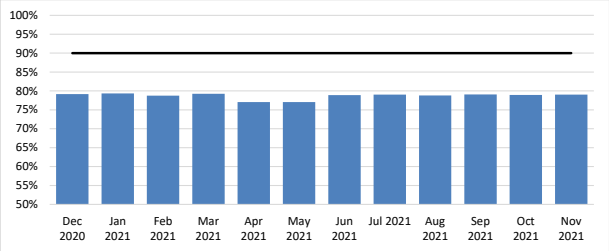
Actions

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

Level 2 & 3 CSTF Mandatory Training

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
76.9%	77.7%	79.5%	81.8%	81.6%	77.4%	81.6%	69.9%	81.1%

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

Key Issues

Compliance increased by 0.1% across the Group in November 2021. North Manchester Hospital had the largest increase in compliance at 1.5% with a score of 69.9% compared to 68.4% in October. The LCO had the largest decrease in compliance at 2.3% to 81.1% compared to 83.4% in October.

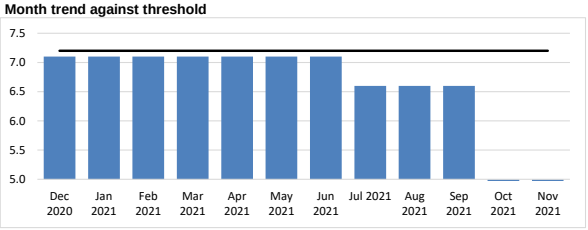
Actions

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.

Engagement Score (quarterly)

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

Month trend against threshold



Hospital level compliance

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

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

Key Issues

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

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

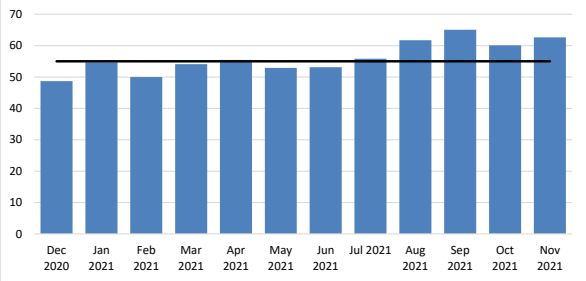
Actions

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

Time to Fill Vacancy

Actual	62.65	(November 2021)	**Accountability**	P. Blythin
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✓	✗	✗
59.3	72.6	69.2	69.4	62.8	94.7	48.5	66.7	62.5

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 October to 62.7 in November. Currently only WTWA is under the target in November.

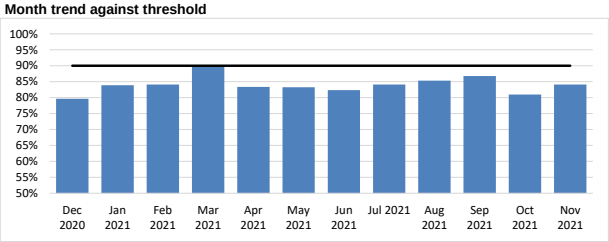
Actions

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

Appraisal- medical

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✗	◇	✗	◇	◇	◇	✗	✓
85.9%	82.9%	89.4%	83.2%	87.3%	88.9%	85.4%	60.1%	90.0%

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

Key Issues

Compliance increased by 3.1% across the Group in November 2021. North Manchester Hospital had the largest increase in compliance at 6.8% with a compliance score of 60.1% compared to 53.4% in November. SMH had the largest decrease in month of 8.7% to 83.2%.

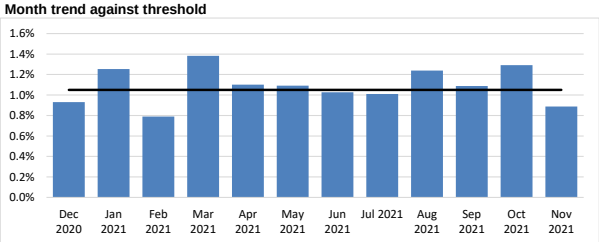
Actions

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.

B5 Nursing and Midwifery Turnover (in month)

Actual	0.9%	(November 2021)	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✗	✓	✗	NA	✓	✗	✗
0.54%	0.40%	1.26%	0.99%	1.06%	NA	0.98%	1.20%	1.38%

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 November 2021 is 0.9% against a monthly target of 1.05%. This is lower than the previous month at 1.3% (October 2021). The rolling 12 month average for B5 Nursing and Midwifery turnover was 13.6% in November 2021 which is 0.1% lower than last year (13.7%, November 2020).

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. The Trust is currently reviewing its preceptorship programme for both domestically and internationally recruited nurses. In 2021 a new series of leadership programmes were launched to support NMAHP staff to develop leadership skills, these programmes have been evaluated very positively by staff and recommissioned for next year.

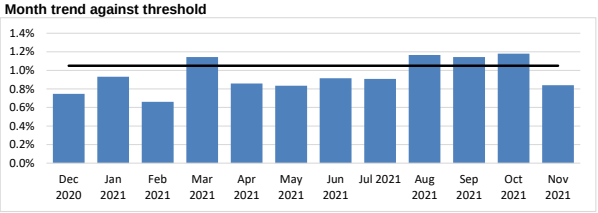
> Board Assurance

November 2021

Turnover (in month)

Actual	0.84%	(November 2021)	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✗	✓	✓	✓	✓	✗	✗
0.75%	0.72%	1.07%	0.66%	0.21%	0.00%	0.75%	1.13%	1.29%

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

Key Issues

The November 2021 single month turnover position for the Group is lower at 0.8% when compared to the previous month (October 2021, 1.2%).

The turnover rate was lower at the same point last year (November 2020) at 0.78%.

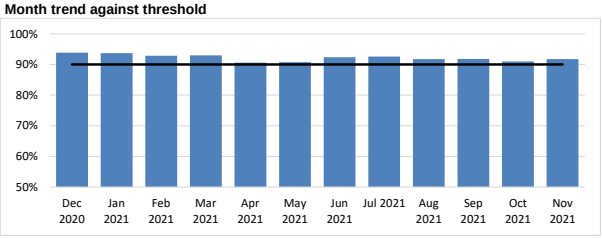
Actions

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.

Level 1 CSTF Mandatory Training

Actual	91.7%	(November 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✓	✓	✓	✓	✓	✗	✓
89.9%	92.4%	90.8%	92.6%	93.5%	93.8%	92.9%	88.2%	93.3%

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 November the aggregate compliance remained at 91.7%. Only NMGH and CSS has a compliance score below the 90% Trust target.

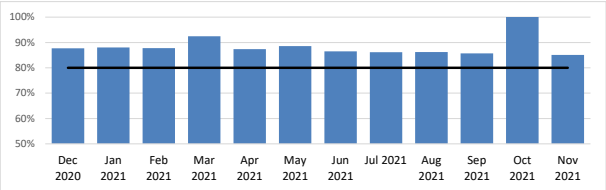
Actions

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

Nurse Retention ✓

Actual	85.1%	(November 2021)	**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✗	✓
85.6%	84.3%	87.5%	85.1%	86.3%	89.6%	84.8%	75.0%	83.8%

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 November 2021, Nursing and Midwifery retention stands at 85.1% which continues to be above the threshold of 80%.

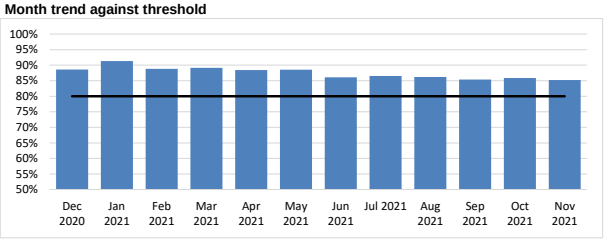
Actions

The retention threshold target for Nursing and Midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The Trust has implemented a guaranteed job offer for Student Nurses and Midwives whom have completed their studies within the Trust as part of the retention of home grown Nurses and Midwives, this curretnly being evaluated following its implement in Septemebr 2021.

BME Staff Retention ✓

Actual	85.2%	(November 2021)	**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	NA	✓
86.8%	85.1%	87.6%	85.8%	88.0%	94.4%	89.2%	NA	87.3%

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 November was 85.2%.

Action

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

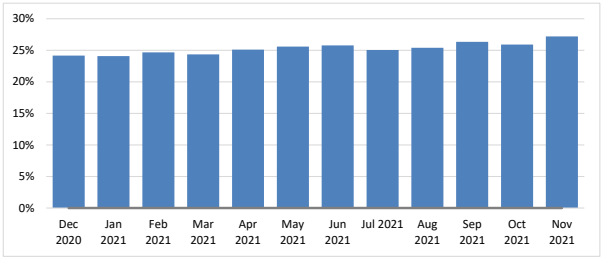
> Board Assurance

November 2021

% BME Appointments of Total Appointments

Actual	27.2%	(November 2021)	**Accountability**	P. Blythin
Threshold	None	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
31.9%	28.5%	25.1%	21.1%	38.6%	40.0%	30.6%	22.1%	18.6%

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 (27.2%); which is consistent month on month.

The Trust has increased its % BME appointments of Total Appointments by 3.0% when compared to the same point last year (November 2020, 24.2%).

Actions

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

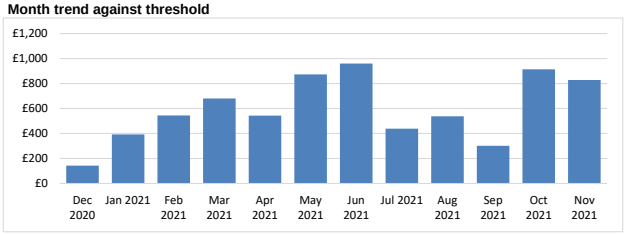
The Trust has launched the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

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

Medical Agency Spend

Actual	£828	(November 2021)	**Accountability**	P. Blythin
Threshold	None	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
£195.6	£313.2	£58.2	£53.1	£60.4	£0.0	£148.9	£0.0	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 November total value of Medical and Dental agency staffing was £828k compared to £913k in October.

Actions

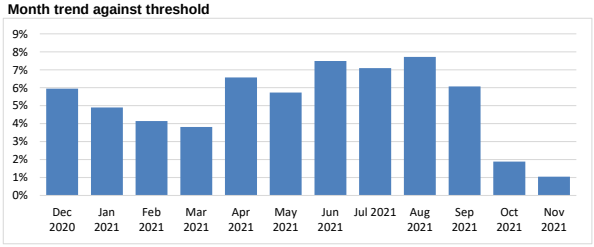
Spend continues to be reviewed for both bank and agency medics across all Hospitals/ MCSs and grades. This is including an in-depth monthly review of all of the cost centres using medical agency workers and opportunities identified where possible to reduce this. A more concentrated focus has been put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

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

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	1.0%	(November 2021)	**Accountability**	P. Blythin
Threshold	None	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	NA	-	-	NA
-14.4%	-2.4%	-5.6%	4.3%	4.3%	NA	4.8%	10.5%	NA

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

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

Key Issues

The majority of vacancies within Nursing and Midwifery are within the Staff Nurse (band 5) role.

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

Actions

During October 3 face to face band 5 recruitment events have been conducted, these were ttending well, with the majority of attendees being students who graduate in 2022. MFT have continued to succesfully recruit internationally, improving the Trust vacanicy position significantly.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	Group Director of Operations – Director Team
Date of paper:	January 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 are asked to note the contents of the report, the updated national planning assumptions for H2 and the Trust associated planning activities. In addition, the position and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.
Contact:	Name: Michelle Irvine, Group Director of Performance Tel: 0161 7015641

Manchester University
NHS Foundation Trust

UPDATE ON COVID RESPONSE AND RECOVERY

1. PURPOSE

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

2. COVID POSITION

The North West has experienced a greater Covid impact than other regions over a sustained period, which has significantly drained both staffing resource and the bed base for elective recovery. Sustained at 26% in critical care and 7% in general and acute beds. Furthermore, organisations are seeing the impact of the pandemic in staff sickness levels particularly related to mental health.

Whilst the current MFT Covid position is stable at c. 5% of Covid cases in critical care beds, and 15% in general and acute beds, the position across the region is forecast to rise rapidly due to the Omicron variant. Therefore, MFT are planning on this basis to proportionally respond to any rise in Covid, escalating plans as and when required, whilst balancing other Trust priorities including maintaining safe urgent care pathways and continuation of the elective programme:

- The existing MFT Covid Response and Recovery governance structure frequency has been stepped up overseen by the Group Director of Operations.
- In addition, Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) have refreshed their capacity escalation plans.
- Learning and the planning undertaken in previous waves has been collated into a framework document to support a further wave and will be instigated as required.
- Tactical arrangements run by the Group have been put in place from 20th December to provide additional support to hospital/MCS/LCO, and to provide a point of escalation.
- Oversight and impact of Covid and management of mutual aid continues across Greater Manchester, and MFT is a key contributor to these arrangements.
- A specific focus on increasing bed capacity prior to the Christmas period is being undertaken to pre-empt the increase in Covid cases. In particular, the Trust is working collaboratively with partners to increase safe, timely discharge, and reduce the number of patients with ‘no reason to reside’ in hospital.

3. PLANNING UPDATE AND ASSUMPTIONS

Following the receipt of planning guidance in late September, MFT submitted a plan for H2 (October – March ‘22) in November. MFT engaged with a check and challenge process led by GM, which led to some changes in the planning targets. The planning guidance asked Trusts to assume no increase in Covid-19 inpatients and non-elective levels at 19-20 levels. In addition, GM required Trusts to assume a ‘normal’ winter with no increase in staff absence from September 21 levels.

In addition to forecast activity rates and trajectories for outpatient transformation, the plan set trajectories for RTT and Cancer performance targets. MFT are expecting 52 week waiting patients to decrease throughout H2, but for the overall waiting list size to grow and for 104 week waiting patients to reduce marginally over H2. By contrast the trajectory saw a reduction in 2ww referral patients waiting more than 62 days for treatment or step-down. Cancer referral levels were forecast to remain around 115% of 19-20 levels.

4. URGENT CARE AND FLOW

Current Position:

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

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

Since April 21 there has been a steady decline in the national performance, with a similar trend across GM and MFT.

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

This is further compounded by high numbers of medically fit patients in acute beds impeding flow through MFT hospitals, resulting in longer wait times in ED, impact on ambulance turnaround and constrained capacity to undertake elective activity. Many of the patients who are medically fit and ready to leave the hospitals are waiting for social care provision where workforce shortages are impacting on availability of provision. A significant improvement programme is being led by the MLCO leadership and operational teams to drive down the number of delayed discharges over the coming weeks in preparation for the anticipated rise in Covid admissions by the end of December.

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

Oversight of MFT performance and delivery of recovery actions is taking place daily through routine reporting, and weekly through the MFT Covid Response and Recovery Group.

Ongoing Actions:

Detailed recovery plans are in place, prioritising the following interventions: -

- Focus on Ambulance Handover pathways in the hospital sites to ensure rapid and effective processes are embedded to release ambulance crews from the hospital in a timely way. The MFT Transformation team and NWAS are jointly supporting the hospital ED teams in implementing new ways of working including the implementation of the 'fit to sit' checklist.
- Improved flow through ED departments maximising the use of appointments within the UTC services – both appointments for patients accessing services via the 111 and Local Clinical Assessment Services, but also for self presenting patients who attend our ED departments.
- Maximising the SDEC services via direct access by NWAS and streaming patients directly from ED.
- Discharge and long length of stay patients – focus on discharge pathways and processes to deliver improvements on the number of medically optimised patients within the hospital sites, including work on 'take home' medications for patients, patient transport and the review of the Therapy pathway into the Discharge to Assess capacity to support more Therapy assessment being undertaken in the community and outside of the hospital setting.
- Continued focus on a system wide approach to 111 first with joint communication plan to local population - in line with the national comms campaign.

Expected Impact:

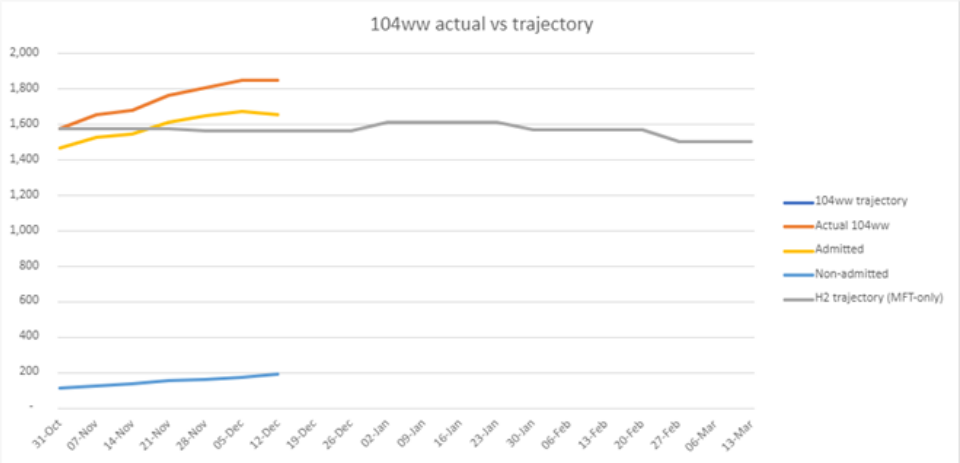
The aim of the actions being taken is to maintain patient safety across the UEC pathways. This will be achieved through alleviating pressure on the front door emergency departments by reducing avoidable attendance at ED and reducing waiting times for both patients and ambulance crews. In addition, the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

5. ELECTIVE ACCESS

Current Position:

The continued prevalence of Covid, UEC pressures, and the need to stand down elective activity for significant periods since March 2020 has had a profound impact on the shape and size of the waiting list at MFT.

MFT continues to follow national guidance to ensure it treats its most clinically urgent patients first. The impact of this is that whilst the overall number of 52+ week waiters is decreasing currently, the number of non-urgent patients waiting longer than 104+ weeks for treatment is increasing, although this is a very small proportion of the waiting list at 1.0%.



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

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

Ongoing Actions:

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

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

- Use of Trafford as a green site and reallocation of theatres based on 104ww demand
- Insourcing support
- Maximising the use of the Independent Sector capacity
- Maximising use of GM green site hubs

Trafford 'Green Site'

Trafford Hospital is a designated elective green site. Funding has been provided to support additional evening and weekend work primarily in Trauma and Orthopaedic and Paediatric dentistry specialties. As of the 8th November the theatre capacity was re-allocated to those services who have projected the

longest waits. Trafford is currently using 7 of the available 9 theatres, the expectation is that the number of theatres used at Trafford will increase during 2022 when additional manpower becomes available. It is also recognised that Trafford theatre utilisation could be optimised further, and a rapid improvement programme was launched on Monday 18th October. This programme is driving an increase in the scheduling of lists in Trafford and there has been a steady increase in overall theatre utilisation.

Insourcing

MFT is currently working with 4 insourcing organisations to bring staff into MFT to support the elective recovery. These are supporting Outpatients in ENT, Urology and Oral Surgery, Endoscopy diagnostics, and elective lists in ENT, General Surgery, OMFS, Urology and Vascular. This is a key area of support for MFT and enabling the organisation to maximise its fixed assets.

Independent Sector Capacity & Usage

MFT has worked with 13 other organisations offering capacity in independent sector settings. Currently, 11 of these are live or being worked up. In some of the more established local providers uptake has been strong and sustained despite the complexity of accessing the capacity, with utilisation over 90%.

GM Hubs / mutual aid

MFT is working within GM and the region (for paediatrics) to identify capacity that could treat MFT patients. Vascular surgery patients are currently being sent to Rochdale for treatment and discussions are underway with other large paediatric centres around specific specialties where MFT does not have sufficient capacity to treat long waiting patients.

Expected Impact:

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

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

P2 patients

As a result of the challenging operational environment caused by Covid, effective management of elective waiting lists at hospital / MCS level continues to be required to ensure MFT treats its most clinically urgent patients, including cancer, first given infection prevention and control and staffing constraints. This is playing a critical role in delivering elective activity as part of the recovery phase.

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

Discussions at site and Group MESH remain focussed on addressing and dating the priority 2 patients, including cancer patients, who have waited over 28 days for surgery.

Considerable progress has been made in Q1 and Q2 of 21-22 to reduce the numbers of undated P2 patients across MFT sites and specialties. Where appropriate, mutual aid across MFT sites and or use of GM hub capacity has been progressed.

In addition to the above performance improvement interventions, MFT has an established an overarching plan that covers the whole elective pathway from referral to discharge. There are three main improvement programmes that contribute to this: Outpatients, Booking and Scheduling, and Elective programme. An update on the program priorities are detailed in the sections below.

Outpatients Programme

The Outpatient programme continues to focus on:

- **Patient Initiated Follow Up (PIFU):** implementing in line with national target to get to 2% by end of March 22. The challenge around MFT systems (four dated PAS) will be reduced with Hive/Epic meaning full potential may not be realised until next year
- **Virtual Triage**: introduction of Referral Assessment Services in e-RS to triage referrals, which is driving an increase in “advice to referrer” and therefore a core part of A&G strategy and managing referrals at front door. Hive/Epic will allow this to be expanded to non-GP referrals
- **Care Gateway initiatives**: improving the Manchester referral Gateway, including strengthening links between Care Gateway triagers and secondary care triagers
- **Power BI reporting**: supporting hospitals through provision of data in Power BI
- **Waiting List Validation**: re-confirming patients waiting for appointments and validating in line with national programme
- **Primary Care Communications**: sharing outpatient developments within primary care e.g., Patient Groups, GP meetings

Initial evaluation of Virtual Triage has shown areas for improvement and learning, particularly around GP education. The initial pilot evaluation focused on Paediatric ENT and this is being expanded to Gynaecology and Gastroenterology as part of the second phase. Evaluation of the impact of PIFU will follow in 2022 given the longer timescales for this project to have an impact (patients typically use PIFU 3-12 months after first being discharged to PIFU).

Booking & Scheduling Programme

A booking and scheduling programme was stood up earlier in 21 to support the admin and clerical changes required to support Hive/Epic and improve booking efficiency. This programme’s scope covers outpatient booking, diagnostics, AHP and elective booking and scheduling. The exact form of the booking and scheduling structure is in development, but principles have been agreed. The programme comprises four main workstreams:

- **Job Descriptions**: standardise A&C job descriptions across MFT
- **AWESOME framework**: competency framework for A&C staff to standardise role and job competencies

- **Waiting Well / Unification**: introduction of a single point of contact to provide information for patients who are waiting, and unifying booking processes to improve patient experience and booking efficiency
- **Standard Operating Procedures**: standardising and implementing SOPs across all MFT hospitals

This programme supports longer term ambitions about how MFT schedule patients.

Elective Recovery Programme

To progress restoration of elective care a GM Task and Finish Group has been established, and continues to meet, reporting into the GM Elective Recovery and Reform Programme Board. The Recovery Task and Finish Group is chaired by MFT's Professor Jane Eddleston. The MFT elective recovery programme is aligned to agreed GM principles and national planning requirements, incorporating the following workstreams:

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

Cancer

Current Position:

MFT is a specialist cancer hub for a number of tumour groups, some of which are the largest volume cancer pathways. Whilst initially, cancer demand recovered more slowly than the national picture, this has recently changed and cancer referral activity is now at peak levels with circa 110% of pre-pandemic levels, with some tumour groups 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 has been strong throughout 20-21 and above the national position. However, a spike in breast referrals from the beginning of October has resulted in a slight dip in performance. The additional c.3500 cancer referrals seen so far in 21 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.

MFT continues to prioritise cancer treatments, with activity levels back to the level seen prior to the pandemic. This patient cohort is managed via the MFT Manchester Elective Surgical Hub process, as well as having access to mutual aid and the GM hub.

Ongoing Actions:

- The actions listed throughout the elective access section of this report will support delivery of increased and timely cancer pathways.
- MFT has a refreshed Cancer Action Plan following the H2 planning which is forming the basis of discussions with hospital sites for action required by March 22.
- The main actions focus on: -
    - improving timeliness of first appointment
    - maximising diagnostics and pathology capacity
    - implement actions from the LGI improvement week
    - increasing capacity to reduce backlogs to a sustainable level.
- In recognition of the need for timely treatment, MFT is both receiving and giving mutual aid for cancer, including: -
    - utilising Christie theatre capacity,
    - GM has provided a mobile CT unit on weekends,
    - working with the cancer alliance on the LGI pathway improvements,
- Safety remains paramount, with harm reviews undertaken for any long wait
- Group wide cancer peer review process was undertaken in September to identify best practice, to provide Group support where required, and ensure actions are in place to support pathway improvements, with actions tracked through local hospital / Managed Clinical Service Cancer Boards and the MFT Cancer Committee.

Expected Impact:

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

6. RECOMMENDATIONS

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

Agenda Item 7.2.1
Addendum

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:	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.

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

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

3.4. Mitigation includes:

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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Alison Lynch, Deputy Chief Nurse
Date of paper:	January 2022
Subject:	MFT COVID-19 and Influenza Vaccination Programme Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• Improve patient safety, quality and outcomes • Improve the experience of patients, carers and their families • People Plan: we look after each other
Recommendations:	The Board of Directors is asked to note the information provided in the report in relation to: • COVID-19 vaccination programme • Seasonal influenza vaccination programme • Healthy 12- to 15-year-olds vaccination programme
Contact:	Name: Alison Lynch, Deputy Chief Nurse Tel: 0161 276 5655

1. Purpose

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

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

2. Updates to National Guidance

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

2.2. On the 3rd December 2021 the Joint Committee on Vaccinations and Immunisations (JCVI) published advice in response to the emergence of the B.1.529 (omicron) variant, setting out the next steps for deployment[2].

2.3. The next steps advice includes:

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

2.4. The JCVI also advise that children and young people aged 12 to 15 years should be offered a second dose of the Pfizer-BioNTech COVID-19 vaccine at a minimum of 12 weeks from the first dose[3]

2.5. The proposed end date for the booster vaccine programme is 31st December 2021, however it is possible that this may be extended.

3. National and Regional Vaccination

3.1. Across the United Kingdom over 47 million people (89.5%) aged 12 and over, have had two COVID-19 vaccine doses; over 28 million people (46.8%) aged 12 and over have had their booster dose[4].

3.2. As of the 19th December 2021, 126,533,737 vaccinations have been given since the vaccination programme commenced in early December 2020.

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

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

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

[3] [3] C1485 Second Phase for children and young people aged 12-15: next steps for COVID-19 vaccine deployment NHSE/I

[4] Data accurate as of 4pm 19th December 2021. https://coronavirus.data.gov.uk/details/vaccinations

3.4. In the North West, 5.4 million people (73%) have received both doses; over 3 million people (44.4%) have had their booster vaccine[5]. By comparison, in London 5.6 million people (61.7%) have received both doses, and 2.8 million people (31.2%) have had their booster dose.

3.5. In Greater Manchester 77% of over 12 years of age have received their first vaccine; 70.2% have received their second dose.

3.6. On the 3rd December all ICS and STP leaders received a letter[6] including advice from the JCVI in respect of how systems should response to the emergence of the B.1.1.529 (omicron) variant. Section 7 of this paper describes the actions taken by the Trust in support of Greater Manchester's ambition to significantly improve the vaccination coverage by the end of December 2021.

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

4.1. The MFT COVID-19 vaccination programme commenced on 15th December 2020, delivering both AstraZeneca and Pfizer vaccines across the four clinics at Manchester Royal Infirmary, Wythenshawe, and Trafford General Hospital. The booster programme commenced on 22nd September 2021. As of August 2021, the Trust only offers Pfizer vaccine (now called Comirnaty[7]).

4.2. Through the MFT staff COVID-19 vaccination programme[8]:

- 90% have received their 1st vaccine
- 88% have received their 2nd dose
- 63% of staff have had their booster vaccination
- 100% of MFT staff have been offered the vaccination

4.3. Eligibility for COVID boosters varies dependent upon when the 2nd dose was administered; all appointments are offered in line with national guidance[9] to reduce to a 3-month interval between 2nd dose to booster dose

4.4. Through the MFT staff seasonal influenza programme[10]

- 56% of staff have received their flu vaccine

4.5. Flu-only clinics have been provided so that flu vaccines are not delayed due to ineligibility for the COVID-19 booster.

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

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

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

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[5] Data accurate as of 4pm 19th December 2021. https://coronavirus.data.gov.uk/details/vaccinations

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

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

[8] All data below accurate as of 17th December 2021. Some staff have had their vaccine elsewhere and are not yet recorded on Trust systems. Staff includes only those employed directly by MFT.

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

[10] All data below accurate as of 17th December 2021. Some staff have had their vaccine elsewhere and are not yet recorded on Trust systems. Staff includes only those employed directly by MFT.

4.8. 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%.

4.9. 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 complex programme is being developed, led by the Executive Director for Workforce and Corporate Business.

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

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

5.2. Specific patient cohorts are included in the provision offered by the MFT vaccine service as part of the programmes.

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

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

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

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

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

6.2. The primary offer for children to have their vaccine in school settings was achieved, with supplementary offers through the Mass Vaccination Centre and hospital hub sites augmenting delivery.

6.3. The programme aimed that 100% of the cohort would receive a vaccine offer by 30th November 2021. This aim was achieved by mid-November, with an all-school offer, resulting in over 11,000 children receiving their vaccine (around 27% across Manchester and Trafford).

6.4. On 13th December 2021, the JCVI stated that all children and young people aged 12 to 15 years should be offered a 2nd dose vaccine at a minimum of 12 weeks from the first dose[11].

6.5. An out of school offer through National Booking Systems for sites that already offer vaccinations to this age group, will be in place from 20th December 2021.

6.6. The Spring Term offer is expected to be deployed primarily by school aged immunisation services (SAIS). MFT is currently reviewing the impact of this and working with local partners to understand capacity alongside other school health services.

7. Greater Manchester

7.1. The letter received by the Trust on 3rd December[12] made it clear that hospital hubs continue to play a critical role in the vaccination of health and care staff. Hospital Hubs were asked to work with their system partners to review their capacity and extend their booster offer, specifically in Greater Manchester to significantly improve the vaccination coverage by the end of December 2021.

7.2. The priority remains to offer vaccinations to staff, and opportunistically extended to in-patients and outpatients.

7.3. As MFT has 'hospital hub+' status, we were once again asked to open vaccine appointments to members of the public through the National Booking System (NBS). From 16th December, around 17,000 appointments have been made available in the timeframe above without affecting the staff programme.

8. Communication & Engagement

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

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

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

8.4. An information pack is being prepared to support managers in holding wellbeing discussions with staff who have not accepted or declined the offer of vaccination, this links with Phase 1 of the vaccination as a condition of deployment programme.

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

[11] C1485 Second phase for children and young people aged 12 to 15: next steps for COVID-19 vaccine deployment
[12] C1468 JCVI Advice in response to the emergence of the B.1.1.529 (omicron) variant: next steps for deployment

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

9. Governance

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

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

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

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

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

10. Summary

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

10.2. Nationally, the focus remains on:

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

10.3. The MFT vaccine service objectives align with the objectives outlined in the Autumn and Winter Plan[13].

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

11. Recommendations

11.1. The Board of Directors is asked to note the information provided in the report in relation to:

- COVID-19 vaccination programme
- Seasonal influenza vaccination programme
- Healthy 12- to 15-year-olds vaccination programme

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

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 HR
Date of paper:	January 2022
Subject:	Update on mandating COVID vaccination for health workers
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 note the update on the mandating of the COVID vaccination for health workers
Contact:	Name: Peter Blythin, Group Director of Workforce and Corporate Business Tel: 0161 701 0190

1. Introduction

1.1. This paper explains the key messages set out in the national guidance – *Vaccination as a condition of Deployment (VCOD) for Health Workers* – released on Monday 6th December 2021 (Appendix A).

1.2. It also offers an explanation of the work underway to implement the guidance at MFT.

2. National Guidance

2.1. The national guidance has been issued as phase one with no firm date for release of phase two. Indications are that the second publication will be made early January 2022. This potentially poses a challenge for employers to plan redeployment and any dismissals from service within the current published timeframe of the 1st April 2022.

2.2. They key points in the national guidance are as follows:

- The scope is set as, "Workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity". Flowcharts and example scenarios are provided. The in scope staff are essentially those who deliver services in any CQC regulated activity.

- The guidance requires proof that students and trainees are fully vaccinated, as well as all independent contractors, agency or bank staff who fall under the scope.

- The last date for unvaccinated staff to receive their first vaccination is 3rd of February 2022.

- Exemptions to vaccination are described in the guidance but the list is relatively limited.

- Local Equality Impact Assessments must be completed.

- Employers are advised to undertake Data Protection Impact Assessments.

- Redeployment options are suggested to be considered at an ICS level. It also provides a temporary redeployment option when the second vaccination is scheduled after the 1st of April but requires staff not to return to frontline duty until they have had their second jab.

- Compliance will be monitored by CQC.

3. MFT Task and Finish Group

3.1. An internal task and finish group has been established. The Group is accountable to the Group Executive Director of Workforce & Corporate Business reporting to the Covid Recovery Group.

3.2. Membership of the task and finish group comprises Group HR, Corporate Nursing, Informatics, Hospital/MCS and LCO HRDs, Staff Side, Communications, and Group Joint Medical Directors' office. Frequency of the meetings has initially been set as weekly, with the provision to increase frequency should demand present.

3.3. Lessons from the Local Care Organisation experience with mandating vaccinations with care home settings have been discussed and is being considered as part of the programme development.

4. Key Priorities

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

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

4.2. Timescales for completion of the Programme are tight not just because of the need for all in scope staff to be vaccinated by early February, but also because of the need to plan for the anticipated employment / contractual challenges associated with any vaccine refusal.

4.3. Vaccination clinic capacity has been reviewed and clinic slots increased in anticipation of the increased requirement in January 2022. These plans will be kept under constant surveillance to ensure they match demand and meet any changes in national vaccination imperatives.

5. Staff Related Data / Reporting

5.1. A data sub-group has been established, reporting into the task and finish group. The primary task is to develop a staff vaccination reporting and monitoring framework. The framework will specify all reporting measures and methodology to deliver both national and local requirements relating to staff Covid vaccinations.

5.2. The data set will focus on staff who are unvaccinated, do not have evidence of vaccination status or their reason for exemption. As part of this work, a process is also being followed to gain assurance from staff groups not in the direct employment of MFT, but which provide services to MFT. For example, Sodexo, contractors, and trainees.

6. Collaboration with GM Trusts to agree a plan for agreement by PFB.

6.1. A response to the request for additional data / information to inform the PFB was made by MFT. Further collaboration with GM Trusts on policy and process will be undertaken to ensure consistency of implementation.

7. Conclusion

8. Internal planning to deliver the terms of the national guidance for mandatory Covid vaccination of Health Workers is well underway. The timeframe for delivery is challenging but all key stakeholders are engaged and committed to prioritise this work programme.

9. Recommendations

The Board of Directors is asked to note the update on the mandating of the COVID vaccination for health workers

APPENDIX A

Classification: Official
Publication approval reference: C1471

To:

- ICS leads
- All trust (acute, community, ambulance, mental health):
  - Chief Executives
  - Chief Operating Officers
  - Chief AHPs
  - Chief Nursing Officers
  - Medical Directors
  - Chief People Officers/HR Directors
  - Chief Dental Officers
  - Chief Pharmaceutical Officers
- CCG accountable officers
- CCG HR Directors
- PCN Clinical Directors and GP providers
- All NHS Primary Care Dental Contract Holders

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

6 December 2021

CC:

- Regional Directors
- Regional Directors of Commissioning
- Regional Directors of Primary Care and Public Health Commissioning
- Regional Directors of Performance and Improvement
- Regional Chief AHPs
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief People Officers
- ICS chairs
- Chairs of NHS trusts and foundation trusts
- CCG Chairs

Dear colleague

Update: Vaccination as a condition of deployment (VCOD) for all healthcare workers

On 10 November 2021, NHS England and NHS Improvement issued a letter to the service acknowledging the announcement made by the Department of Health and Social Care (DHSC) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care. The regulations will apply equally across the public (NHS) and independent health sector.

Guidance for HRDs and organisations

NHS England and NHS Improvement has worked with DHSC, NHS Employers, Social Partnership Forum and wider stakeholders to develop the guidance.

The purpose of this guidance is to support providers in preparing and planning for when the regulations (which are subject to parliamentary passage) are introduced. This document includes supporting material to provide further clarity and confirmation of which individuals are in scope of the regulations and those which are exempt, and guidance on increasing vaccination uptake; including among groups where uptake is lower. The guidance reiterates the importance of continuing to have supportive 1:1 conversations with colleagues and supports employers in ensuring the best protection for vulnerable patients and staff in healthcare settings.

Also attached is a supporting document curating useful tools to help increase vaccination uptake. These tools have been used to address concerns and hesitancy among specific groups such as women of childbearing age and ethnic minority communities and to aid 1:1 conversations that are already taking place effectively between line managers and individuals across the NHS. We know that holding 1:1 conversations in phase 1 of the staff vaccination programme was associated with an increased uptake by 10%. It is vital that we continue to drive up vaccination by engaging in meaningful conversations with unvaccinated staff to minimise the potential impact of VCOD across the healthcare service.

We will review and update the guidance in accordance with government advice, and we will continue to work with you to minimise service disruption while ensuring that patient care and safety continue to be our core priority.

Next steps from NHS England and NHS Improvement

Please note this is iterative guidance which will be reviewed regularly to ensure any legislative changes are reflected, and feedback and queries from colleagues across the healthcare system are considered.

Following completion of parliamentary passage, the second part of the guidance will be issued, focusing on the implementation of the new regulations inclusive of a redeployment framework and advice regarding formal steps for staff who remain unvaccinated on 1 April 2022.

Thank you for your continued support throughout the vaccination programme and for everything you are doing to care for patients and support your colleagues at this time.

Yours sincerely




Prerana Isaar	**Professor Stephen Powis**	**Ruth May**	**Dr Nikki Kanani MBE**	**Suzanne Rastrick OBE**
NHS Chief People Officer	National Medical Director	Chief Nursing Officer for England	Deputy SRO, COVID-19 Vaccination Deployment Programme, Medical Director for Primary Care	Chief Allied Health Professions Officer

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Head of Nursing for Infection Prevention & Control/Tissue Viability
Date of paper:	January 2022
Subject:	To provide assurance to the Board of Directors on IPC Management of COVID-19 and Nosocomial Infections
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Safety Patient Experience
Recommendations:	The Board of Directors is asked to note the actions and progress, to reduce the risk of transmission of COVID-19 and other HCAI across all our services.
Contact:	Name: Michelle Worsley, Head of Nursing for Infection Prevention & Control / Tissue Viability Tel: 0161 276 4042

1.0 Introduction

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

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

1.3 This paper provides an update on the IPC BAF, Variant of Concern-Omicron, updated UK Health Security Agency guidelines (24th November 2021) and an update of the current Trust position of nosocomial infections, including COVID-19.

2. IPC BAF

2.1 As previously reported the Trust has regularly undertaken assessments against the standards in the Board Assurance Framework (BAF) developed by NHS England/Improvement (NHSE/I). The main purpose of the Framework is to support healthcare providers to identify, address risk and self-assess compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance[2]

It also serves as an improvement tool to optimise actions and interventions. The IPC BAF was last updated by NHSE/I in June 2021[1] to include additional indicators. It is anticipated that a further iteration of the IPC BAF following new guidance[2] jointly issued by the Department of Health and Social Care (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.

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

- 13th July 2020. Board of Directors Meeting
- 14th September 2020. Board of Directors Meeting
- 14th October 2020. Group Infection Prevention and Control Committee (GICC)
- 9th November 2020. Board of Directors (amalgamated into the Board Assurance Framework).
- 11th December 2020. Board of Directors Meeting
- 11th January 2021. Board of Directors Meeting
- 8th March 2021. Board of Directors Meeting
- 20th April 2021. Group Infection Control Committee
- 10th May 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).
- 12th July 2021. Board of Directors Meeting

[1] NHSE Infection Prevention and Control Board Assurance Framework V1.6 30th June 2021
[2] Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS – CoV-2) for winter 2021 to 2022 24th November 2021 NHS England

- 21st July 2021. Group Infection Control Committee
- 19th October 2021. Group Infection Control Committee
- 7th November 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).

3.1 **For ease of reference updates to the 10 standards within the IPC BAF have been highlighted in yellow and can be found at Appendix 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 (updates included on pages 10-14, 16-19, 24 and 25)
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections (updates included on pages 33,34 and 36)
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance (update included on page 42)
- 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 (update included on page 43 and 44)
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people (updates included on pages 47, and 49-51)
- 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 (updates included on pages 58-60)
- Provide or secure adequate isolation facilities (update included on pages 63-65)
- Secure adequate access to laboratory support as appropriate (no change)
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections (no change)
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection (updated on pages 74-77)

3.2 **Assurance can be provided that:**

- The Trust has assessed the systems and processes in place against indicators in the IPC BAF
- The Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls[2]
- Patients and visitors are fully aware of the measures staff are required to take to prevent COVID infections, and the measures they are themselves required to take to prevent COVID infections
- National IPC UK HSA guidance is regularly checked for updates and any changes are communicated to staff in a timely way

4. Revised UK Health Security Agency (UKHSA) IPC guidance for healthcare

4.1 To support the safe and efficient management of patients with suspected or proven COVID-19 or other respiratory diseases through the winter, the UKHSApublished updated guidance called, Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 in November 2021.

4.2 This guidance supports efficient delivery of NHS services to meet wider patient needs, via the return to pre-COVID-19 social distancing and standard IPC measures for patients who do not have infectious respiratory diseases.

4.3 The main changes include,

4.3.1 Removal of the three COVID-19 specific care pathways (high, medium and low) and implementation of locally defined care pathways.

4.3.2 Further information for organisations/employers to support maximum workplace risk mitigation based on the 'hierarchy of controls'.

4.3.3 Universal use of face masks for staff and face masks/ coverings for all patients/visitors to remain as a key IPC measure within health and care settings over the winter period.

4.3.4 Recommendation that physical distancing should be at least 1 metre (increasing whenever feasible to 2 metres) across all health and care settings and **remain at 2 metres where infectious respiratory patients** are being cared for/managed.

4.3.5 Screening, triaging, and testing for SARS-CoV-2 should continue over the winter period. Testing for other respiratory pathogens will depend on the health and care setting according to local and country specific testing strategies, frameworks, and data.

4.3.6 The Senior Management Teams across all Trust hospitals/MCs' have considered the guidance and provided plans to the Trust Clinical Sub-Group following review of their existing pathways with assurance that appropriate pathways are in place.

5.0 Nosocomial Transmission of COVID-19 - Current Position

5.1 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 3rd December 2021 indicate the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West is 0.8 to 1.1, which remains the same as the previous report.

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

5.3 The number of newly confirmed cases and COVID-19 in-patient burden for MFT can be found in Charts 1 and 2 below, , this does not include NMGH patient information as samples are processed at Northern Care Alliance laboratory and the specimen information is not available within the MFT data warehouse, work is underway to address this. All other data within this report includes NMGH information.

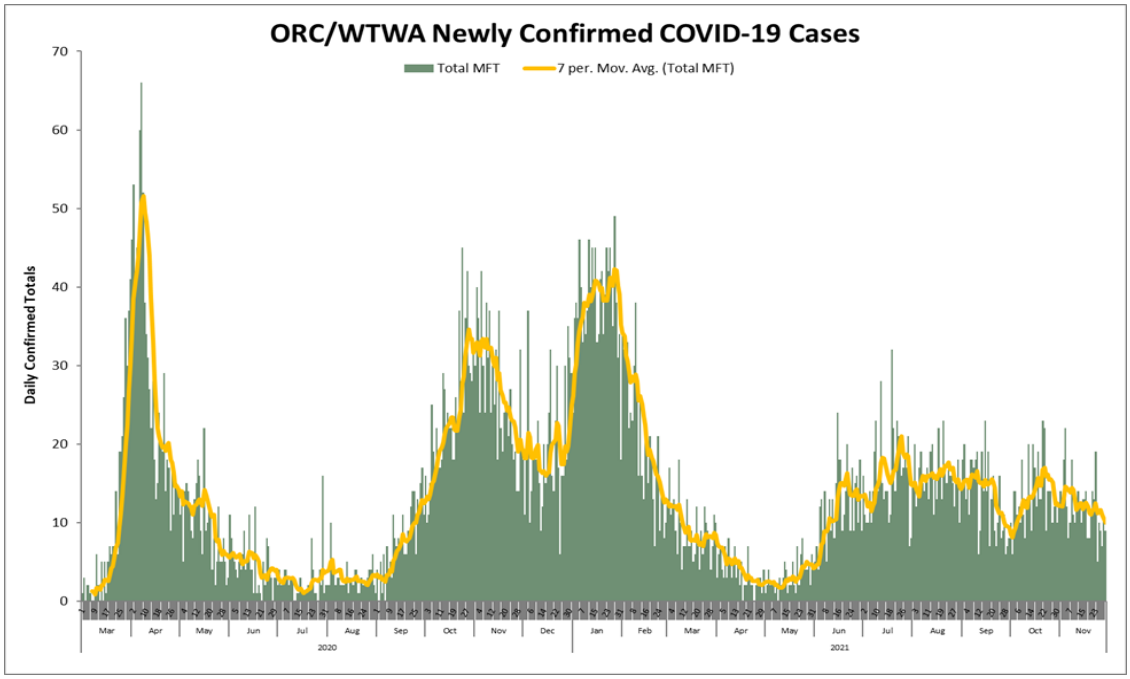


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – November 2021

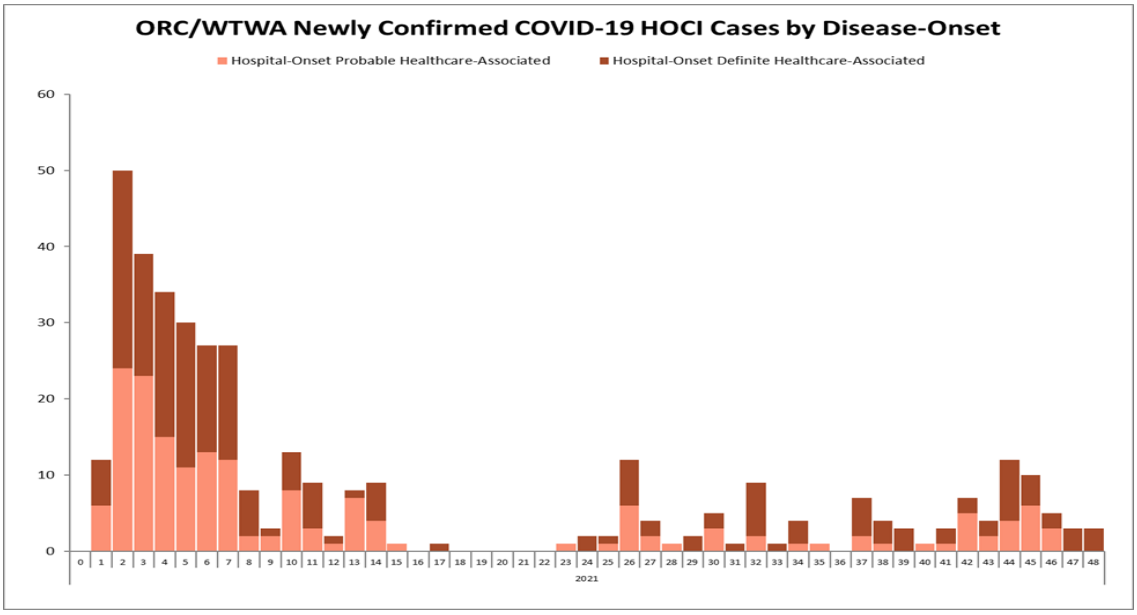


Chart 2- MFT newly confirmed COVID-19 HOCI cases presented by reporting week and disease-onset category, ORC and WTWA only

5.4 An outbreak is two or more cases of COVID-19 infection in patients occurring on or after day 8 of admission within the same ward/department with a 14-day period. If an outbreak is declared control measures are implemented. Daily updates on outbreaks

are circulated across the Trust. Each outbreak is reported to NHSE&I and monitored daily for 28 days in line with the Trust Outbreak Policy.

5.5 Table 1 below shows the number of COVID-19 outbreaks across MRI, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from September 2020 to November 2021

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

Table 1: MFT COVID-19 Outbreaks

6.0 Implementation of Actions from COVID Outbreak Reviews

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

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

7.0 COVID-19 Omicron Variant of concern

7.1 A new COVID-19 variant of concern (VOC) designated as Omicron (lineage B.1.1.529), has recently been identified. The variant was first identified in South Africa but has now been detected in several other countries. The new variant possesses several mutations that may affect transmissibility and vaccine response although at this point the exact nature of the new strain is still under investigation.

7.2 In response to the emergence of Omicron, the UK government has added several southern African countries to the red travel list with associated requirements for testing and quarantine upon arrival in the UK

7.3 Clinical guidelines were issued across MFT detailing isolation and management of patients who had recently returned from a red list country and therefore at increased risk of having the Omicron variant.

7.4 Currently all COVID-19 positive swab results are sent for whole genomic sequencing which will identify if any of the specimens are likely to be the Omicron variant.

8. 0 Nosocomial Transmission of other Healthcare Associated Infection (HCAI)

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

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

8.3 There have been **7** trust-attributable MRSA bacteraemia cases to date[3]. Key findings from investigations include:

- compliance with MRSA screening policy
- compliance with decolonisation therapy

8.4 There were **215** *Clostridium difficile* Infection (CDI) cases reported during 2020/2021. Of these, **179** were trust-attributable, against a threshold of **132**. There have been **117** Trust attributable cases to date[3]. Key findings from investigations include:

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

8.5 There were **299** (hospital onset) Gram Negative Bloodstream Infections (GNBSI) in 2020/21.Ongoing workstreams to further reduce the GNBSI include a set threshold for each hospital based upon a 15% reduction target to maintain the national trajectory of a 50% reduction overall. An action plan to achieve the reduction targets have been completed by each of the hospitals and is monitored as part of the AOF for GNBSI. There have been **194** hospital onset GNBSI to date across MFT.

9.0 Sustaining and Improving the Current Position

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

9.2 It is vital to maintain ongoing focus on the importance of IPC practices and processes in all aspects of patient care in view of emerging variants and the winter season.

9.3 In response to a rise in MFT HOCI cases and a potential rise in other respiratory viruses a reminder was issued to all staff via the communications team (12/11/21) reiterating the importance of following national guidance including the importance of wearing FRSM masks in both clinical and non-clinical areas.

10.0 Summary

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

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

11.0 Recommendation

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

Appendix 1

Infection Prevention and Control Board Assurance Framework V12 December 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as	• Clinical Sub-Groups / Clinical Advisory Groups are in place to oversee adjusted or adapted systems and processes approved within hospital settings. • Patient streaming at access points. Emergency Department is zoned to provide designated areas • Screening of non-elective admissions recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place. • Development of EMIS template to record patients who are COVID-19 positive or self isolating and associated SOP • Alerting system in place for other	• Some COVID-19 positive individuals present at hospitals as asymptomatic patients • Audit of community required to ensure SOPs being utilised – fully resolved	• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily • All women admitted to Delivery Unit are screened for COVID-19. This is repeated at day 3 and day 7. • All women who attend for an elective maternity admission (Induction of labour or elective Caesarean section) have COVID-19

possible/practical following admission across all the pathways; • when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; • infection risk is assessed at the front door and this is documented in patient notes	healthcare associated infections: (MRSA; CDT; GRE; CPE;MDROs) • Guidance for ambulance trusts in place to support safe pre-alert to hospital trusts https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • Monthly point prevalence audit of screening swabs) • MFT Guidelines and SOPs available at: https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus including: • Joint Pathways and Protocols (01.04.20) • Managing patients who meet criteria for COVID testing (12.3.20) • https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection updated 31 July 20 • Risk assessments in place for OPD appointments (Wythenshawe) • Risk Assessments for Interventional Radiology		screening 72-48 hours prior to admission • On arrival for all maternity appointments women and partners are screened using symptom checker • All neonates transferred from other units swabbed on arrival, and weekly screening is in place in neonatal units. • PHE/NHSE/I guidance in place • Revised guidance on ’10 point plan’ assessed with mitigating actions described • All clinical areas undertake a risk assessment using Hierarchy of controls where there is an increased risk of transmission https://intranet.mft.nhs.uk/content/important-information-about-covid-19-

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

	Executive and the DIPC. • New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020). • COVID-19: Guidance for maintaining services within health and case settings *Infection prevention and control recommendations* updated in June 2021 have been reviewed by the IPC team – principles remain unchanged • Assessment of "social distance" of beds in all in-patient areas completed. Risk assessment in place for reduction of social distance and bed numbers monitored in 3 times daily capacity meeting • Guidance for reducing isolation facilities produced in April 2021 by the IPC team to support recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and patients safe. • An assessment has been made against UK Health and Safety		ensuring right patient in right place. • Recommendation 2 of UKHSA has been supported partly, the Trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing PCR to include elective patients in further roll out. • The Trust has implemented the extension of the 'hot lab' to Wythenshawe, with the omicron variant it will be necessary that the ORC24/7 is maintained. • The POD system at ORC is being approved and with introduction of 24/7 service the Trust will be able to achieve fast turnaround without the need for a hot lab on each of the sites

	Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendations 1 & 2 are specifically related to Standard 1, 5 & 8 of the IPC BAF) Recommendation 1 to reduce physical distancing in low risk areas for elective procedures or planned care is accepted. • Recommendation 2 is partly accepted (see mitigation) • The Trust has received and is working toward assessing 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		•

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

	workplaces / workspaces / rest areas reviewed to remove all unnecessary items to optimise space. • Staff reminded of recommended social distancing when travelling to and from work, to avoid car sharing and follow public health guidance when outside of work. • Within community in-patient facilities visiting is also facilitated within garden areas/outside as appropriate • Hand hygiene posters advising when to clean hands and how to clean hands located in appropriate areas are visible in clinical areas • Posters, hand hygiene stations and Face covering stations are located at every entrance to the hospital. Posters, clinical waste bins and alcohol gel are located at the exits of the hospitals • Interim Visiting Policy in place. Adults, women's, and children have different robust processes in place. Ward visiting booking process in place within areas (for example siblings booking within RMCH) with additional visiting provided through virtual platforms in line with Trust Visiting Policy.		

	• There is a maternity specific visiting policy in place to support partner presence • For critical care areas there is an appointment system and virtual visiting is in place too • All ward areas have clear signage in relation to visiting guidance based on individual risk for that area. ED is currently reintroducing the family liaison role in order to take a proactive approach to family liaison and updates. • Risk assessments in place to manage physical distancing, which are reviewed regularly when capacity exceeds demand to ensure further mitigation is in place to manage any risk. • Further communication has been disseminated by the IPC team relating to clinical assessment of patients who may have travelled to a red list country prior to admission in response to new variant of concern.		

• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	• Screening protocols in place for patients discharged or transferred to another health care or residential setting in place based on PHE Guidance and incorporated in to Staff and Inpatient Testing Guidelines • An assessment is underway of guidance updated on 1st December 2021 'Stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients. • Monthly point prevalence audit		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance patients and staff are protected with PPE, as per the PHE national guidance	• Appropriate PPE defined by procedures in accordance with national guidance, including: • Face Masks and Covering Guidance • Communication with procurement/materials management • Education/training sessions for use of PPE to staff • Staff encouraged to raise concerns with line manager and complete incident forms if they consider a shortage of PPE • Escalation plans in place as per trust gold command and GM Gold command	• Issue with supplies of PPE • Occasional conflict between national guidance from NHSE/PHE and guidance from Royal Colleges	• Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution • Estates/environment review has progressed with permanent barriers and other structures now on site.

	• Signage is in place in clinical/non clinical areas. Access to signs that can be adapted for individual areas, and those that must not be adapted are available to print on the Trust intranet • Sanitization Stations are in place at Trust entrances and exits • Audit of PPE and hand hygiene are regularly undertaken – actions in place to improve where required • IPC Safety Officer Audit in place • See above for additional details		
• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Guidance cascaded through Strategic Oversight group • Daily communications email sent to all staff • IPC Team daily visit to clinical areas/departments, they also hold a caseload. • Weekend IPC team provision inplace • IPC team have developed reference posters for staff, with all guidance available on the staff intranet https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus • The following groups review new guidance/updates and recommend implementation:		• The Trust intranet provides a full range of information that is regularly updated and cascaded to all staff via daily communication. Links to the MFT Staff COVID-19 Resource Area are provided https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus • Regular and up to date information is published in this Resource Area,

	❖ High level IPC meeting chaired alternate weeks by DIPC ❖ Clinical subgroup chaired by joint medical director bi-weekly ❖ Clinical Advisory Group weekly chaired by Hospital Medical Director ❖ IPC Operational Group bi-weekly chaired by Hospital Deputy Director of Nursing		including the following key topics: ❖ Emergency Planning, Resilience and Response ❖ Employee Health & Well Being ❖ Research and Innovation for COVID-19 ❖ Infection Prevention & Control ❖ Hospital/MCS COVID-19 Resources
• changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Response to COVID outbreak managed by Exec leads for EPPR and DIPC through Strategic Gold Command and escalated through this route to the Board of Directors, sub board committees including: ○ Risk oversight committee ○ Group Infection Control Committee ○ Group Infection control committee • Risk register updated • Risk assessments in place, risk assessment documentation available via the Trust Intranet	• New risks to be identified as guidance changes • New risks may be identified through review of guidance published 20 August 2020 (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations).	• Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. • The Trust Board Assurance Framework is continuously updated and submitted to Board of Directors July 2021 • Weekly meetings with NEDs to keep informed of issues arising through EPRR led by COO • Twice weekly meetings with

			executive directors provides opportunity to raise issues
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• There is an over-arching Group IPC risk for COVID-19. Hospitals/MCS/LCO have identified local risks and added them to local risk registers. • Risks managed through Strategic COVID-19 group • Links made to the main Trust BAF, were reviewed at the Board of Directors meeting in July 2021	• Disruption to assurance framework by Suspension of Sub-board Committees due to COVID-19	• Sub committees re-instated • Risks reviewed formally at substantive groups and weekly through EPRR response due to the need to be responsive and adjust in real time • Subgroups have been re-instated in accordance with Trust governance and recovery programme
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Daily alert notifications continued and actioned • Monitoring of incidents of infection • Investigation of MRSA bacteraemia and CDIRCA completion • Accountability meetings with clinical leads re-instated • Hospital/MCS/LCO Infection control committees in place • Extraordinary meetings of COVID expert Group in place • Risk assessments in place address	• Three week period of non-toxin testing for CDI due to Aerosol generating procedures (resolved)	• All CDI patients clinically reviewed & PCR tested. • Alternative method for toxin testing implemented • Risk assessment and reports escalated • Investment in environmental mitigation: ❖ A number of Clinell Ready Rooms have

	wider HCAI issues for: ❖ 2m social distancing (please note above in respect of low risk areas for elective procedures) ❖ Contact tracing ❖ Outbreak management ❖ Isolation ❖ Testing ❖ Enhanced cleaning • Visibility of Executives and Directors. Frequent observation and review by DIPC, AMD and IPC team to address environmental issues as well as clinical practice		been purchased and will be put in place in designated/agreed areas ❖ Enhanced cleaning ❖ Partitions & physical barriers
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice. • staff adherence to hand hygiene • Staff social distancing across the workplace • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in : • a) Clinical setting • b) non-clinical setting	• Resources that support staff to comply with IPC practices are in place: ❖ Effective systems in place to support control of HCAI's ❖ Policies are in place for the prevention and management of HCAI's ❖ Systems are in place to ensure that resources are allocated to effectively protect people, including staff ❖ PPE is readily available ❖ Education & Training is in place ❖ Facilities are in place to support good hand hygiene:	• Policies are in place to support managers in addressing specific concerns that relate to adherence to IPC measures	• Escalation process in place to local senior management team

	these include hand sanitization stations, sufficient hand wash facilities, sufficient supplies ❖ Signage is clear ❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including ❖ Hand hygiene ❖ PPE audit ❖ Increase in frequency of audits on outbreak wards ❖ Hands, Face, Space Audits • Data is collected monthly and Feedback to Directors of Nursing to address areas of concern • See earlier section for further information		
• Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • that the role of PPE guardians/safety champions	• IPC nursing champions are in place in all hospitals /MCS/MLCO; specifically, their work includes: ❖ role modelling best practice ❖ monitoring compliance ❖ sharing good practice, and		

to embed and encourage best practice has been considered	❖ challenging non-compliance.		
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• Staff testing and isolation strategies are in place as part of the Trust Staff and Inpatient Testing Guidelines. • Staff PCR testing is routinely undertaken in identified high risk areas (where highly vulnerable patients receive treatment) and in areas where an outbreak occurs • Lateral Flow Testing is in place across the Trust, with clear guidance in place to ensure isolation and PCR testing follows a positive LFT test. • Staff with positive results advised to follow national guidance, including recent publication 3rd December 2021 'COVID-19 Management of Staff & Exposed Patients or Residents in health and social care settings', updated on 15th December 2021. This guidance is being incorporated into Trust Policy • App in place to support ease of reporting LFT results • SOP for Staff Test and Trace updated in July 2021 • SOP for Staff Returning to Work Early following contact from NHS Test and Trace developed and agreed in July 2021, and further	• Access to external test results • Compliance with staff reporting LFT results, specific gap noted in recording of results on a national system that is not fully visible to the Trust and separate from the Trust's own reporting system	• Staff asked to report external test results to absence manager • Communication strategy in place to remind staff to report LFT results • Improvements planned to the way in which compliance with routine PCR testing in high risk areas is monitored • COVID Testing Strategy Group will monitor compliance through refreshed Terms of Reference • Database being further developed to monitor compliance with testing • Task & Finish group supporting increased take up with the voluntary bi-weekly staff LFT testing programme • MFT app now able to retain staff testing history and scan QR

	updated in line with PHE Guidance following government changes to self-isolation on 16th August 2021 and again on 15th December. The 'return to work' terminology is replaced with the COVID-19 Management of Staff & Exposed Patients or Residents in health and social care settings. • The two Trust policies (Test & Trace and the Guidance to return to work from self-isolation) are currently being reviewed in line with guidance • Processes include involvement of the Director of Infection Prevention and Control oversight of decision making		codes, making it easier for staff to record their results
• Training in IPC Standard Infection Control and transmission-based precautions are provided to all staff.	• A series of IPC training packages are included in staff training profiles. • Practical training packages for donning and doffing (both for aerosol generating procedures (AGP's) and non AGP's) are in place via E learning. • An Infection Prevention & Control Development Pathway is newly developed and in place to assist staff development from fundamental awareness of IPC to specialist understanding. The IPCDP is available to registered and non-registered clinical staff.		• Compliance with training is monitored

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

	areas on Hand Hygiene/other IPC practices		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • IPC national guidance is regularly checked for updates and any changes are	• Staff attend the Trust mandatory training programme at the commencement of employment. • Practical competency training is in place which includes Hand Hygiene, use of PPE, donning and doffing • PPE Stocks are regularly monitored across all areas and there is an escalation procedure for areas where there has been increased demand • The Trust procurement team work closely with the IPC teams to ensure stock levels are maintained • The PHE campaign 'Hands Face Space' is visible across the Trust • National guidance is received by the Trust via EPRR email address and directly to Chief Nurse and Medical Directors. Timely distribution of updates are then cascaded, reviewed and implemented through: ❖ Clinical Sub-Group ❖ High Level Infection Prevention & Control Group		

effectively communicated to staff in a timely way • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Risks related to related to Infection Prevention & Control are assessed using robust risk assessment processes. They are reviewed and reflected in the Board of Directors Board Assurance Framework		
• The Trust Chief Executive, the Medical Director or the Chief Nurse approve and personally signs off, all daily data submissions via the daily nosocomial sitrep.	• The Chief Nurse/DIPC is responsible for all data submissions	• Easily accessible information in one place to support sign off requires development.	• A COVID-19 infection dashboard is under development. Once implemented this will provide Trust, hospital and ward overview of nosocomial infections. The purpose is to provide further clarity of a range of information in order to support nosocomial infection prevention and management.

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

	❖ Monthly Quality Care Rounds in place		

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

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

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

national guidance	high flow areas such as ED • Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative • Cleaning twice daily and providing additional enhanced cleaning in high risk/outbreak areas • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendation 3 is specifically related to Standard 2 of the IPC BAF) • Recommendation 3L standard cleaning procedures to be reintroduced in low risk areas is **NOT ACCEPTED:** enhanced cleaning to remain in all areas to end Q4, for review during Q4		all clinical and non-clinical areas.
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• additional frequency of cleaning schedules in place • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary		• Domestic cleaning in ED and assessment areas 12 hours a day after every patient use of facilities

	and high touch areas.		
• Cleaning and decontamination is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine,as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution. • Decontamination of patient shared equipment in outbreak/high risk areas is undertaken using a combined solution of detergent and 1,000ppm available chlorine (Chlor-clean tablets) • Electronic equipment is cleaned with a detergent wipe followed by 70% isopropyl alcohol wipe **u**sed in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy in process of update, final draft in place. • There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented. • The Estates and Facilities team are undertaking a full review of both clinical and non-clinical cleaning responsibilities as part of preparations for the implementation of National Standards of Cleanliness • 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.
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• See above		
• a minimum of twice daily cleaning of: - areas that have higher environmental contamination rates as set out in the PHE and other national guidance; - 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; - electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; - rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; -	• Enhanced cleaning specifications in place for clinical and non-clinical areas • Trust Policy for working safely based on PHE guidance is in place • Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have ben put in place across all sites to meet PHE guidance. • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas	• There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• Currently working with PFI partners/in-house teams to review enhanced cleaning and align with new national cleaning standards • Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented. • The Estates and Facilities team are undertaking a full review of both clinical and non-clinical cleaning responsibilities as part of preparations for the

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

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

- before inspection, servicing or repair equipment; • single use items are used where possible and according to Single Use Policy	cleaned) • UVc and HPV used to decontaminate equipment in high risk/outbreak areas • Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment. • Individual use blood pressure cuffs and stethoscopes are utilised in outbreak and high risk areas. • Individual use pens are provided in areas of high risk or outbreak.		
• reusable equipment is appropriately decontaminated in line with local and PHE national policy	• Re-useable equipment decontaminated in line with national guidance • Decontamination group is sub-group of Group ICC		• Decontamination group meeting re-instated from May 2020

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

• There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants.	• The Estates and Facilities team continue to clean all surfaces (excluding flooring) using Chlor Clean disinfectant as per IPC advice. • In the event that the IPC team review the low risk pathway Estates & Facilities team work with the cleaning management team to re-introduce GP detergents in appropriate location		• Continued the use of Chlor-clean across all areas of the adult Trust due to high community prevalence and risk of outbreaks
• Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• Non-clinical areas are regularly inspected, and any issues are responded to in liaison with the cleaning management teams. • E&F team respond to any reporting incidents or concerns raised to resolve issues effectively.	• Site inspections are undertaken using checklists in clinical areas • There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• Trust wide incident reporting effectively used to escalate concerns. • National Standards of Healthcare Cleanliness published April 2021. https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf • Project group in place will review the Commitment to Cleanliness Charter provided within the Standards to align with agreed Cleaning Responsibilities Matrix. To be in place by October

			2021 in acute settings. • Audit processes set out within the National Standards to be implemented and be signed off with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as scoring less than a Star Rating of 3 have a rectification action plan implemented.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Appropriate policies reviewed and approved by the AMC • Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. • Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) – see below • Monthly antimicrobial stewardship (AMS) audits on all ward areas • Microbiology support available 24 hours a day. • Antimicrobial prescribing advice available from pharmacy 24 hours a day • ICU ward rounds • Increased AMS support to COVID-19 cohort areas • Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing.	• Monthly AMS audits are being redeveloped to better inform prescribing practices. New audit proforma was introduced in June 2020 and is subject to ongoing review. • Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones. Previously these audits would be done by AMS pharmacists who now must not cross over zones.	• Plans in place to introduce virtual AMS ward rounds to COVID-19 cohort areas. This needs Trust wide support which is being reviewed in terms of: ○ Clinical engagement ○ IT infrastructure ○ Staffing and resources

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC • From November the Group AMC have convened with quarterly meetings and will have 3 working subgroups: ➢ Guideline Development Group ➢ Education Training and interventions ➢ Research, Quality Improvement and Audit • These subgroups will be chaired by infection specialists and will have clinical representation from across the Trust. • The newly formed committee will develop a risk register to gain an understanding of how it can provide assurance to the Medicines Optimisation Board, Group Infection Control Committee and how it connects with the individual hospitals and MCS's. The 1st meeting was held in November.		

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

Systems and processes are in place to ensure: • national guidance on visiting patients in a care setting is implemented;	• Policies/guidance in Acute sector updated to reflect pandemic • End of Life Policy adapted for current need • Controlled entrance & exits to Trust to minimise risk of cross infection • Policy reviewed following further guidance and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission • NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed • Interim Visiting Policy available via Trust Intranet and information published on the Website • New guidance has been reviewed, and although visiting can be relaxed this approach has not been taken. The Trust Interim Visiting Policy has been updated to increase restrictions in some areas to levels in place during the 2nd wave of the pandemic. National guidance suggesting relaxation is withing Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022		• Guidance regularly updated in line with NHSE/I • Risk assessments in place for Maternity and neonatal services • Specific work plan addressing access for maternity partners – key areas are early pregnancy and 12 weeks scans • Guidance in place for visitors • Significant flexibility in guidance to allow for compassionate visiting • Additional technology (tablets and phones) issued to all in-patient areas to facilitate communication with loved ones / advocates.

• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	• Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas – this will be reviewed in December in line with new guidance Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022 • Signage on entrances, signs are available to download and print via Trust Intranet • Screens in place at reception areas • Available guidance: ○ Coronavirus Restricted Access Measures Guidance May 2020	• Plans need to be flexible as situation changes	• Hospitals to re-assess as situation evolves. • Learning from outbreaks includes: ❖ Quick isolation and lock down of identified areas ❖ Testing and tracing of staff – Lateral Flow Testing in place for a time limited period
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Dedicated website for all COVID related information/policies	• Risk that information may be out of date	• Website regularly updated by Comms/EPPR Team
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Preadmission Screening processes in place for elective patients • Screening processes in place for NEL (see previous) • Compliant with PHE guidance on screening patients being transferred to residential care	• Insufficient single rooms and isolation facilities	• Risk assessments in place • Environments investment (see previous pods/curtains/2m space)

	• Where possible patients transferred in from referring hospitals are isolated until negative screen. When single rooms not available alternative models are used, such as cohorting • NMGH: Transfer documentation updated to include COVID status and individualized swabbing schedule (including for contact patients)		• SOP in place for maternity to use single and cohorting bays when required. Space in bays has been assessed by IPC to maximise distance between women. • Clinell readirooms utilised to isolate inter hospital transfer whilst covid status is confirmed.
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned stations to guide and challenge visitors /staff if appropriate	• Lack of concordance amongst some patients/visitors	• Local escalation process in place

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

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

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

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

• patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	• OPD services and community clinic services are using technology to undertake consultations where possible • Signage on entrances advising pathway for symptomatic patients. • Message on MFT phone services • Trust policy on managing patients who present with symptoms in place • All patients screened for symptoms on arrival (NMGH)		• New guidance has been reviewed and pathways (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	• Guidelines are in place to ensure that all patients are screened in accordance with national guidance i.e. prior to admission for elective treatment and on admission for non-elective patients. All patients screened on day 3, 5-7, and every 7 days thereafter • An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients. (Recommendations 1 & 2 are specifically related to Standard 1, 5 & 8 of the IPC BAF) Recommendation 1 to reduce physical distancing in low risk areas	• The dashboard has been implemented and screening compliance date is available for use by selective users. • Each hospital/MCS is in the process of providing an updated risk assessment against the new guidance	• Automated monitoring process being developed for Dashboard • Recommendation 2 of UKHSA has been supported partly, the Trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing PCR to include elective patients in further roll out.

	for elective procedures or planned care is accepted. • Recommendation 2 is partly accepted (see mitigation) • New guidance that relates to respiratory pathways published on 24th November is being reviewed: Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022		
• Staff are aware of agreed template for triage questions to ask.	• Staff are aware of and are use agreed triage questions, all patients screened for COVID-19 symptoms on admission • All patients streamed through a respiratory/non-respiratory pathway in ED's.		
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Staff are trained in the use of triage questions		• Triage audits are undertaken
• Face coverings are used by all outpatients and visitors	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages.	• Not all patients/visitors are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place

	• Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate • Identified pathway for patients where reasonable adjustments need to be made as they are unable to wear face mask		
• Face masks are available for patients and they are always advised to wear them	• FRSM available for all patients and visitors • Posters displaying FRSM masks and requirements to wear developed	• Not all patients are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; - patients, visitors and staff	• 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.	• As above	• Non-compliance is addressed locally in with local processes for escalation when there is an identified risk.

are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. - isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; • 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	• Staff request patients to wear a face covering when moving between departments. • Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement to comply with amber / green pathways. External transfers occur only if clinically justified • Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups and prioritisation of side room		

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

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

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

safe	• Bespoke training for Clinical leaders to become PPE expert trainers • Mandatory training in place • (See previous re PPE and fit testing)		• Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Microbiologist and AMD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing • New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).

• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe; • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put put it on and remove it	• Local information and guidance in place for COVID areas and non-COVID areas • PPE Infection Control Policy in place • PHE guidance in place • Donning and doffing videos available on the Trust intranet based on national guidance • Designated donning and doffing areas have relevant guidance and instruction displayed • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required • See previous on fit testing		
• a record of staff training is maintained	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment • Standard Operating Procedures developed for decontamination of visors • Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline	• Escalation in shortages of PPE	• Staff asked to complete an incident form and escalate to their manager

• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Staff advised to complete an incident form and report to their manager • Daily review of incidents submitted by risk management team		
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Audit of compliance undertaken regularly, actions taken to improve compliance and reduce risk where required		
• The use of hand dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand dryers are not used in accordance with trust policy • Guidance in public areas		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• posters and guidance in place https://intranet.mft.nhs.uk/content/hospitals-mcs/clinical-scientific-services/infection-control/hand-hygiene		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Monthly audits of hand hygiene compliance • Increase of audits on increased activity areas		

	• Mandatory ANTT assessments annually • Hand Hygiene Policy in place • ANTT Policy in place • Audit of PPE and hand hygiene regularly undertaken – actions in place to improve where required		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Temporary staff changing facilities identified on COVID-19 wards • Staff on COVID-19 areas wearing scrubs laundered through hospital laundry		
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• HR policies in place for staff to report on absence manager system if they are symptomatic • Trust complies with national guidance • EHWB service provides staff support • Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8 • SOP's in place to support staff to return to work following guidance published in July and August 2021	• Staff shortages due to COVID -19	• Escalation to Strategic oversight group of low staffing numbers. • Activity to be titrated by staffing levels • Escalation processes in place and monitored through EPRR including reducing elective programme as required

	'COVID-19 Management of Staff & Exposed Patients or Residents in health and social care settings', updated on 15th December 2021. This guidance is being incorporated into Trust Policy		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• Regional COVID-19 prevalence reviewed by Clinical Sub-Group and used to inform PPE practice. • Daily HOCI report generated by IPC surveillance and reviewed by IPC team to provide early identification of outbreaks. • Daily reporting of other HAIs to identify outbreaks. • Review of regional HPT alerts to provide early warning of community outbreaks. • Review of HAI rates and comparison to Shelford group as indicator of performance/ compliance with best practice.		
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	• There is separation of patient pathways at Emergency access points. • Use of one-way flow systems and restricted access /egress points in place in all diagnostic centers • Staff communal areas have clear signage and there are staggered breaks to facilitate reduced contact • Footfall reduced where possible	• Not always possible to maintain 2m distance in all areas because of building design constraints • Risk assessments are	• Local Risk assessment undertaken, and partitions used where appropriate.

	• New guidance that relates to respiratory pathways published on 24th November is being reviewed: Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS CoV2) for Winter 2021-2022	being completed for all sites following new guidance published 24th November 2021.	

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

• Frequent decontamination of equipment and environment in both clinical and non-clinical	• Enhanced cleaning in place for high risk vicinities such as amber areas (COVID-19 Indeterminate areas)		

areas.	where there is rapid turnover of patients with an unknown COVID-19 diagnosis. • Enhanced cleaning in place for wards where there is an outbreak • Disposable wipes available in communal toilet facilities		
• Clear visually displayed advice on use of face coverings and facemasks by patients /individuals, visitors and by staff in non-patient facing areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, **including PHE campaign 'hands fa**ce space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• The Trust is able to access PHE support directly through its on-site PHE laboratory • Local population, regional and national surveillance intelligence is presented by Trust expert virology team (linking with the on-site PHE lab as above) • A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at:	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

	❖ High Level Infection Control Meeting ❖ Clinical Sub-Group /Advisory Groups ❖ Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner • Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC and clinical teams		
• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation	• Investigations completed and IIMARCH forms submitted for 2 or more cases of HOCI. • All incidents of HOCI are reported on Ulysses/Datix for review and completion • Outbreaks are reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing		
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection	• Outbreak Policy is in place • Outbreaks reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing	• Closure of beds due to outbreaks	• Senior IPC cover available out with working hours available to undertake a risk

	• The Procedure for Managing an outbreak is provided to the relevant ward/department manager for completion at onset of outbreak.	impacts on patient flow	assessment with senior on-site team • Updated guidance for closure of wards based on risk assessment
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• patients are cohorted according to clinical presentation • Community inpatient facilities have single rooms • risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission • Isolation of Infectious Patients Policy in place • See previous on environment and assessment of pathways following guidance published 24th November 2021	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients)	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical location • Review of footprint of services across all hospitals to reduce risk of cross infection • Risk assessment undertaken based on symptoms (e.g. isolation of patients with diarrhoea)
• areas used to cohort patients with or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• programme of review of air flow and ventilation undertaken throughout the pandemic	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and

		• location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) • some areas of estate particularly old and in poor condition	geographical location • Review of footprint of services across all hospitals to reduce risk patient occupancy, flow and activity adjusted to align to the environment • Good IPC practice implemented in all areas of cross infection
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Daily alerts/surveillance for all relevant organisms (such as CPE, MRSA and C-diff) is currently reviewed by the IPC team • Daily report of new resistant HAIs generated by IPC surveillance and reviewed by IPC team to ensure appropriate management in line with national and local policies. • Guidance has been distributed to clinical teams receiving patient that may have travelled to areas on the 'Red List' (https://www.gov.uk/guidance/red-list-of-countries-and-territories) to support a series of actions including ensuring that a patient who has returned from a red list country is placed in a side-	• Potential delay between testing and identification of new resistant HAIs	• Rapid screening for some HAIs (e.g. CPE) • Pre-emptive risk assessment to manage high risk patients before results are known.

	room for 10 days from arrival regardless of PCR result.		
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff.	• In COVID-Wards and Outbreak wards, measures have been put in place to restrict footfall • An Interim Visiting Policy is in place which restricts access	• Staff need to leave the ward for rest/refreshment	• Food for staff delivered to high risk areas. • Breaks in Communal restrooms are staggered • Volunteers to support way finding
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas.	• Clear sign posting in place • Restricted access using keypad where appropriate	• Regular re-configuration of wards due to changing demand for Blue/green areas	• Estates and facilities have regular meetings with hospitals to review signage

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individual	• UKAS accredited PHE laboratory conducting testing for NW of England • Posters to support training for staff on how to take a swab		• Frequency of testing ensures staff competence
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Screening of non-elective patients in place • Hospitals/MCS putting in place pre 48 hour testing for elective admissions • Policy for staff screening developed • MFT site of PHE host laboratory and has capacity for extensive screening • A further Roche analyser has been procured and will be on site in Autumn 2021 • See previous on testing	• Lab capacity was initially affected by availability of reagents – this has significantly improved – therefore the risk to the lab due to analysers is reduced (improved).	• Sufficient reagent supply
• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		
• that all emergency patients are tested for COVID-19 on admission • Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening		
• Regular monitoring and reporting of the testing turnaround times with focus	• Turnaround times measured -planned programme of monitoring.	• Travel time for specimens from site to laboratory	• Additional transport runs put in place

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

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

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• Programme of training for redeployed staff including use of PPE, maintaining a safe environment in accordance with PHE guidance. • Bespoke training for Clinical leaders to become PPE expert trainers • Mandatory training in place • Plans for staff testing in high risk situations. • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Mircrobiolgist and AMD	• Staff anxiety about risks of exposure to COVID -19	• Increase of IPC support to COVID -19 Wards • Prompt response to clusters/outbreaks of COVID-19

	support • Expert Virology support • 7 day working from IPC/Health and Wellbeing		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Any changes are received and discussed at key strategic meetings: ❖ High Level IPC meeting ❖ Clinical Sub-Group • This review can be weekly and at times daily • Guidance updated on intranet and communicated daily via email • Cascade system in place across the Group		
• all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All waste associated with suspected or positive COVID-19 cases is treated as normal infectious waste (orange waste stream sent for alternative treatment to render safe before incineration or landfill) • Staff follow Trust waste management policy • Healthcare waste e-learning module is mandatory for all clinical staff, based on waste management policy.	• Since the outbreak of COVID-19 there have been changes to advice from government regards waste (in particular initial categorisation of COVID-19 waste as Category A (similar to Ebola), a national Standard Operating Procedure and numerous Regulatory Position Statements from the	• New refreshed waste guidance and communication document currently in production (for healthcare staff, porters and cleaners)and will be circulated Trust-wide • Guidance will be regularly assessed as the situation evolves and national guidance is updated. • Temporary approach to waste audits being

	• All bins are labelled to indicate which streams they have been designated for.	Environment Agency) – the changing guidance has been challenging to communicate clearly with staff. • Queries around disposal routes for visitor PPE – options for disposal which are both legal and practical are not currently clear. • COVID-19 precautions have meant Waste Team are no longer able to visit all wards to carry out waste pre-acceptance audits and establish that staff are following waste management policy. • There have been some waste related incidents whereby clinical waste (potentially infectious waste,	developed • Fortnightly meeting of all relevant staff involved in waste management at each site to share emerging risks and issues associated with waste. • Weekly conference call between Trust and its main clinical waste collection provider (SRCL) • Trust also has access to “national cell” (Environment Agency, Cabinet office, etc) who are managing waste nationally at a strategic level through COVID, as well as national NPAG group. • Regards community waste, draft options paper prepared to inform future policy and process – further scoping details still

		associated with COVID-19 cases) has been disposed of by staff as general domestic waste. • Gaps have been identified in relation to clear policy and process in relation to waste generated by COVID-19 cases and non-COVID-19 cases in the community	required and options will then be taken forward through the appropriate channels
• PPE stock is appropriately stored and accessible to staff who require it	• Materials management team asses local stock levels and replenish every 2- 3 days • Update on stock levels circulated to DIPC/IPCT	• Shortages in supply	• Escalation process in place • Re-useable respirators provided for staff working in high risk areas place
10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is	• EHWB Policy in place • Employee Health and Well Being Service COVID-19 Guidance and		

supported	Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8 • All staff complete a COVID-19 self-risk assessment, electronically stored • Staff have access to a wide range of physical and psychological support services provided by the Employee Health and Wellbeing Service. • Staff who are working remotely can also access support. • Details of all EHWB Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely. • EHW/OH advice and support is availabe to managers and staff 7 days a week.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Training records held		

• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staff not moved from COVID areas • Strict adherence to PPE guidance and practice • Staff testing policy in place • Daily staffing process are in place to manage safe and effective staff deployment	• Limited by access to reagents	• Prioritisation based on clinical and staff need
• all staff adhere to national guidance and are able to maintain 2 metre social distancing in all patient care areas if not wearing a facemask and in non-clinical areas	• Trust policy in place		• Instructions in place not to travel to and from work in uniform
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Workplace guidance in place		• Adaptation of space to increase opportunity of break staggering
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• HR policies in place for symptomatic staff to report on absence manager system. Positive results are fedback via the EHW Clinical Team - ensuring advice and support • HR policies in place for staff to report on sickness absence via the Absence Manager system. • All Trust protocols comply with National guidance and are kept		• Absence monitoring • Follow up and contact by line manager

	under constant review. HR advice and support is provided to managers. • Regular comms and briefings ensure that staff are aware of policies and procedures as well as the support available to them. • Trust policy 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.		
• staff who test positive have adequate information and support to aid their recovery and return to work	• EHWB service provides staff support • Staff receiving positive results are supported by an EHW Clinician to obtain advice and receive information regarding next steps, recovery and return to work.	• Some staff may choose to access alternative community test centres which means the results will not be known by the line manager and may be received via text message.	• Staff can contact Silver Command, Workforce Bronze, their line manager or the HR Team to seek advice on next steps having received their result via text. • Coronavirus (Covid-19) – Line Manager FAQ (fact sheet)
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including	• Risk assessments are in place and monitored through HR		

Black, Asian and Minority Ethnic (BAME) and pregnant staff.			
• Staff who carry out fit test training are trained and competent to do so.	• Staff are locally trained by staff who are trained and assessed as competent to do so.		
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• Staff are fit tested for FFP3 respirators	• Change in availability of make and model of FF3 respirators can cause anxiety and disruption	• The trust has procured additional fit testing machines to facilitate easy access to testing for FFP3 • Procurement alert the trust in advance of changes to make and model of FFP3 available
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly		
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• As above • Staff are fit tested for alternate FFP3 masks	• Centralised system to be developed to allow regular review by the Board through the Group Infection Control Committee	
• members of staff who fail to be adequately fit tested a discussion should be had regarding re deployment	• There are Trust Policies in place based on national guidance agreed with HR and EHWB to ensure that		

opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • A documented record of this discussion should be available for the staff member and held centrally within the organization.as part of employment record including Occupational health.	those who have failed fit testing are redeployed • The Trust has extended fit testing to include at least 2 alternative FFP3 respirators. Reasons for fail to fit test are recorded and escalated where appropriate		
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		
• Boards need to have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO • From 1st October 2021, the ambition is that all Fit Mask Testing is captured and reported via our Learning Management System, the Learning Hub to enable robust reporting via Group Infection Control Committee	• Centralised system to be developed to allow regular review by the Board through the Group Infection Control Committee	

• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• Risk assessments are undertaken locally and mitigating actions undertaken		
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have hygiene stations ensuring adequate provision of appropriate face masks, and hand gel for staff and visitors to use.		

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 Rachel McIlwraith, Operational Finance Director
Date of paper:	January 2022
Subject:	Financial Performance for Month 8 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 is recommended to note the position against the YTD plan and updates on Cash and Capital positions for the Trust
Contact:	Name: Jenny Erhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2021/22 has been split into 2 halves (H1 and H2) with the first half of 2021/22 representing a period of recovery and potentially stabilisation as the intensity of the activity directly related to Covid reduces but the implications of reduced activity over the previous period manifest themselves across almost all areas of clinical activity. This is also in the context of a range of workforce implications and ongoing health and wellbeing concerns. For GM MFT was tasked with delivering a surplus of £23.1m for H1 and developed the H1 plan to reflect this requirement, with a break-even position for H2. The surplus was reliant on the Trust delivering the planned WRP for H1 and on receipt of £5m system monies related to the NMGH transaction. YTD to Month 8, November 2021, the Trust has delivered a surplus of £7.7m; which is an improvement of £1.3m from the £6.4m surplus reported in month 7 and is in line with the H2 plan submitted to NHSE/I in late November. The NHSE/I H2 plan requires the Trust to breakeven in the six month period and overall to deliver a £13.1m surplus for the 12 months to March 2022 based on the performance achieved in month 1-6 against the H1 plan.
1.2	**Run Rate**	November expenditure at £191m has increased by circa £2.3m against month 7 but is more consistent with levels expended in the second quarter of H1. After removing the pay accrual in month 7 the total expenditure in month 8 is some £700k lower than month 7. The ongoing controls over additional investment linked to activity recovery have been established, in the short term these have been supported by additional income from the Elective Recovery Fund (ERF) and in Month 8 the Trust was notified of further Elective Recovery and discharge monies. As a high proportion of the funding is non-recurrent the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime for 22/23.
1.3	**Remedial action to manage risk**	The “expenditure led” financial regime that was in place in the last financial year presented a significant risk to the Trust, through the changed behaviours which it created. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key, even during the pandemic. The value of system monies from GM for H2 has been agreed and revised plans for income and expenditure in H2 that deliver a breakeven position have been factored into the H2 plan. The Trust’s WRP target remains at £50m for the full year, but the breakeven position for H2 only assumes that £30m of that will be achieved for the year to March 22. If we are to deliver £23m surplus for the year, then we will need to generate a further £10m of financial flexibilities or seek additional efficiencies in our operating performance.

1.4	**Cash & Liquidity**	As at 30th November 2021, the Trust had a cash balance of £282m. The cash balance was higher than forecast by £17m, this was primarily due to a higher than forecast HEE receipt for £29m, of which £16.8m was received in advance of the forecast date of January 2022.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned spend into line with the system capital envelope. The total capital plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £190m. The potential capital expenditure outturn may be £9m higher due to backlog maintenance pressures and thus slippage across the programme during the year will bring the actual spend back in line with the agreed envelope of £199m. In the period up to 30th November 2021, £67m of capital expenditure has been incurred against a plan of £108.1m, an underspend of £41.4m. £25.7m of the slippage relates to the New Hospitals Programme North Manchester project and is due to delays in the approval of the Park House scheme and associated enabling works, alongside the slower than anticipated programme for the new hospital. The estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £15.4m underspend, the most material elements are £6.8m relating to the NMGH emergency works which are due to be funded through Emergency PDC (the Emergency PDC application has been submitted and is in discussion with NHSEI, but the plan assumed earlier approval of this) and £4.1m relates to Hive and is a result of the changed profile of spend on the EPIC production platform which will be incurred later in the year.
1.6	**NMGH Transfer**	The transfer by absorption of the NMGH transaction was incorporated into the balance sheet in month 3 and is reflected in the I & E as a below the line Transfer by Absorption gain of £65.5m. This gain is reflected through the Trust reserves on the balance sheet.

Financial Performance

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

I&E Category	NHSI Plan M8	Year to date Actual - M8	Year to date Variance
	£'000	£'000	£'000
INCOME			
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	1,183,929	1,190,161	6,232
NHSE - Cost passthrough drugs (increase above threshold)	54,218	50,569	(3,649)
Trust (Rapid Diagnostic Centres)	119	436	317
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	114,710	114,710	0
GM System Funding 1-6 £5m	5,000	0	(5,000)
Elective Recovery Funding	8,266	13,512	5,246
Additional Funding outside financial envelope	2,328	4,474	2,146
Local authorities	25,784	26,087	303
Sub -total Income from Patient Care Activities	**1,399,915**	**1,407,091**	**7,176**
Private Patients/RTA/Overseas(NCP)	7,158	6,641	(517)
Total Income from Patient Care Activities	**1,407,073**	**1,413,731**	**6,659**
Training & Education	48,699	48,998	299
Training & Ed Non HEE	2,189	2,633	444
Training & Ed Notional	1,780	1,974	194
Research & Development	45,139	45,569	430
Misc. Other Operating Income	62,235	64,131	1,896
Other Income	**160,043**	**163,305**	**3,263**
TOTAL INCOME	**1,567,115**	**1,577,036**	**9,921**
EXPENDITURE			
Pay	(930,560)	(926,187)	4,373
Non pay	(588,691)	(591,646)	(2,955)
Training & Ed Notional Spend	(1,780)	(1,974)	(194)
TOTAL EXPENDITURE	**(1,521,031)**	**(1,519,807)**	**1,224**
EBITDA Margin	**46,084**	**57,229**	**11,146**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(24,045)	(22,258)	1,787
Interest Receivable	0	0	0
Interest Payable	(27,334)	(27,286)	48
Loss on Investment	0	0	0
Dividend	0	0	0
Surplus/(Deficit)	**(5,295)**	**7,685**	**12,982**
Technical Adjustments	5,295	0	(5,295)
Surplus/(Deficit) Adjusted Performance - Outturn	**0**	**7,685**	**7,686**
Surplus/(Deficit) as % of turnover	**-0.3%**	**0.5%**	
PSF / MRET Income		**0**	**0**
National top up funding		**0**	**0**
Transfers by Absorption		**65,489**	**65,489**
Impairment	**(66,037)**	**(49,403)**	**16,634**
Non operating Income	**720.460**	**1,598**	**878**
Depreciation - donated / granted assets	**(784)**	**(646)**	**138**
	(71,396)	**24,723**	**96,120**

The technical adjustment arises from combining H1 and H2 plans after Month 7 was finalised and reported.

Year to date (YTD) the Trust is reporting a surplus of £7.685m (£6.634m YTD at month 7) against the breakeven plan for Greater Manchester ICS in H2. This is as a result of an in-month surplus of £1.322m which is in line with the H2 plan and if finance performance continues in line with the H2 plan will mean a delivery of £13.1m surplus for the 12 months to March 22. If we are to achieve the £23m surplus we will need to deliver further WRP or performance efficiencies of £10m.

The YTD income variance has reduced substantially to £9.9m since the last reported variance of c£40m as H1 and H2 income and expenditure plans are combined now into an annual plan for reporting purposes and hence now show an eight-month YTD position, having corrected the YTD for month 1-6 actuals, this is a recurrent theme through this month's commentary and explains why most YTD variances are low compared to previously reported values.

That said as per the income and expenditure table above and the preceding paragraph the most significant YTD variance is in total income, the £9.9m favourable variance is made up of a number of items which include; a net improvement in the NHSE drugs baseline of £1.5m, £1.6m profiling adjustments relating to bowel screening, neonatal genomics and Hep C monitoring, additional Cepheid funds of £2.2m, a release of £1.5m relating to Genomics, Breast screening and Long Covid. There are also small favourable variances in training and education, research and development and sundry other items. Also included in the £9.9m movement is an increase to reflect full recognition of the ERF monies of £5.2m, the rationale being on a YTD basis the costs associated with the one-off Elective Recovery Fund are already included within the plan. The main adverse variance to plan in YTD income remains the £5m system monies relating to the NMGH transaction not received in H1, the H2 plan however includes funding for the NMGH transaction for the final 6 months of the year, this has been agreed as part of the GM systems envelope allocation.

The YTD variance for Pay expenditure was favourable to plan by £4.3m, which was offset partly by a £2.9m adverse variance in Non-pay also YTD, the overall YTD variances compare favourably to the in-month movements between month 8 and 7.

There was an adverse movement of some £4.2m in Pay expenditure when comparing Month 8 with Month 7, however £3m of the movement related to a technical adjustment; the pay award adjustment will be made in month 9 and reflected in the positions of the Hospitals, MCS and LCO. The remainder of the variance reflected movements in NMGH relating to substantive pay costs correcting a few YTD items, as well as recoding items between Non pay and Pay as the underlying reason for the costs have been worked through by the NMGH team.

Non-pay expenditure in month 8 YTD was adverse by £2.9m primarily due to the increased purchase of healthcare services from other NHS and non-NHS providers as the Trust focuses on reducing the level of 104 week waiters and as with Pay expenditure, the Month 8 position when compared with Month 7 showed a favourable variance caused in the main by a reduction in drug costs between the two months.

Depreciation YTD continues to be favourable at £1.8m but this variance reflects the year-to-date underspend in our Capital programme, discussed later in the paper.

Overall, the increase in the surplus from Month 7 has been driven by the recognition of increased income in month 8 as described above, the increased income has been offset by less material movements month on month in Pay expenditure and Non-pay. The agreement of the H2 plan has allowed the Trust to review the WRP position which has been adjusted to reflect revised expectations in the H2 plan, there remains a focus on delivering as much recurrent WRP as is possible as that places the Trust in a better position entering 22/23. The key and most immediate financial areas of focus by Hospitals/MCS/LCO and Corporate functions are the need to continue with tight cost control and the delivery of the remaining WRP in line with the plan.

Statement of Financial Position

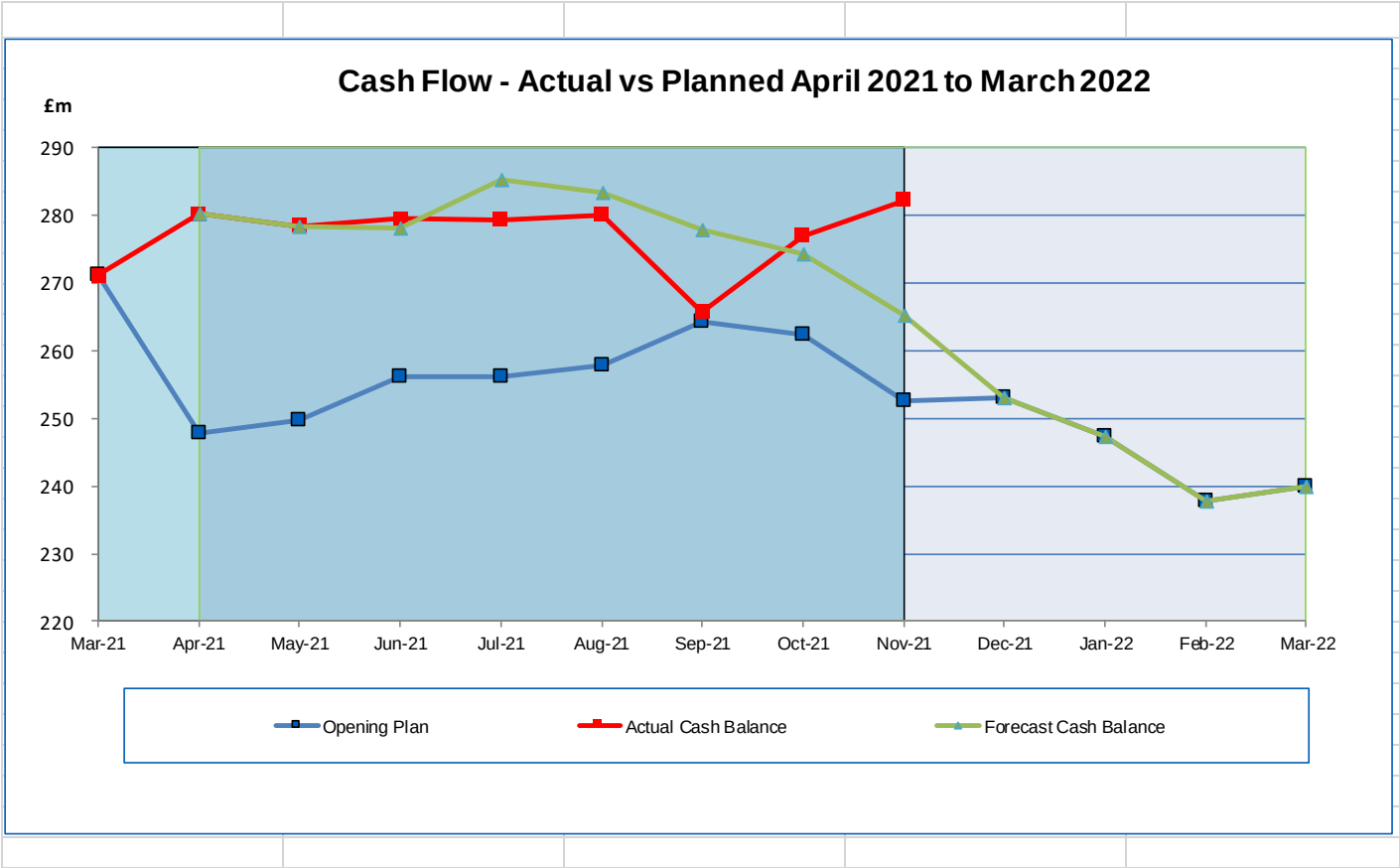
	Audited MFT Accounts 31/03/2021 £000	NMGH Opening SoFP 01/04/2021 £000	Enlarged MFT 01/04/2021 £000	Enlarged MFT 30/11/2021 £000	Enlarged MFT Movement in Year to Date £000
Non-Current Assets					
Intangible Assets	4,665	-	4,665	4,169	(496)
Property, Plant and Equipment	642,394	81,715	724,109	717,505	(6,604)
Investments	1,498	-	1,498	1,498	0
Trade and Other Receivables	5,645	1,896	7,541	7,533	(8)
Total Non-Current Assets	**654,202**	**83,611**	**737,813**	**730,705**	**(7,108)**
Current Assets					
Inventories	21,892	936	22,828	23,309	481
NHS Trade and Other Receivables	61,707	-	61,707	64,576	2,869
Non-NHS Trade and Other Receivables	46,854	3,391	50,245	50,760	515
Non-Current Assets Held for Sale	210	-	210	210	0
Cash and Cash Equivalents	271,199	6,311	277,510	282,321	4,811
Total Current Assets	**401,862**	**10,638**	**412,500**	**421,176**	**8,676**
Current Liabilities					
Trade and Other Payables: Capital	(33,594)	0	(33,594)	(17,623)	15,971
Trade and Other Payables: Non-capital	(287,755)	(2,981)	(290,736)	(325,380)	(34,644)
Borrowings	(20,290)	(1,448)	(21,738)	(21,922)	(184)
Provisions	(24,875)	(5,852)	(30,727)	(31,650)	(923)
Other liabilities: Deferred Income	(35,084)	(320)	(35,404)	(65,824)	(30,420)
Total Current Liabilities	**(401,598)**	**(10,601)**	**(412,199)**	**(462,399)**	**(50,200)**
Net Current Assets	**264**	**37**	**301**	**(41,223)**	**(41,524)**
Total Assets Less Current Liabilities	**654,466**	**83,648**	**738,114**	**689,482**	**(48,632)**
Non-Current Liabilities					
Trade and Other Payables	(2,598)	-	(2,598)	(2,599)	(1)
Borrowings	(374,948)	(17,664)	(392,612)	(378,530)	14,082
Provisions	(16,622)	-	(16,622)	(16,983)	(361)
Other Liabilities: Deferred Income	(3,817)	(495)	(4,312)	(998)	3,314
Total Non-Current Liabilities	**(397,985)**	**(18,159)**	**(416,144)**	**(399,110)**	**17,034**
Total Assets Employed	**256,481**	**65,489**	**321,970**	**290,372**	**(31,598)**
Taxpayers' Equity					
Public Dividend Capital	258,929	65,489	324,418	335,427	11,009
Revaluation Reserve	63,492	5,352	68,844	68,844	0
Income and Expenditure Reserve	(65,940)	(5,352)	(71,292)	(113,899)	(42,607)
Total Taxpayers' Equity	**256,481**	**65,489**	**321,970**	**290,372**	**(31,598)**
Total Funds Employed	**256,481**	**65,489**	**321,970**	**290,372**	**(31,598)**

As noted in the month 7 report, there has been an amendment in the values shown for the transfer from NMGH for the final values of assets to reflect an £11m reduction in Non-Current assets and PDC for IT assets.

The Month 8 position to 30th November has seen a material decrease in receivables of some £30m with the payment by HEE of a £29m invoice, also reflected in the cash position. Trade and other Payables has seen a further £11m decrease due to the increased Trust focus on the BPPC as detailed later in the paper.

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

Cash Flow

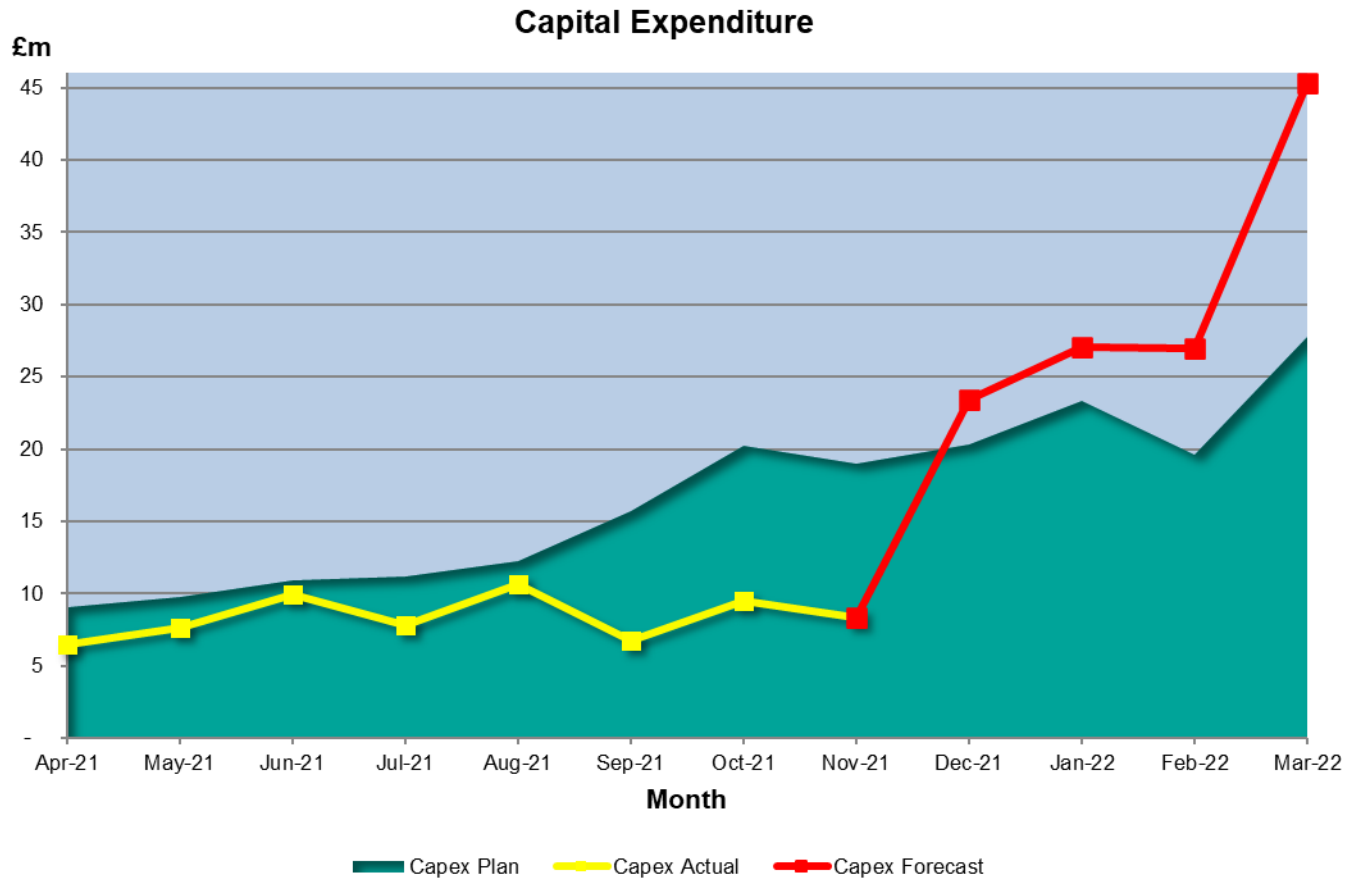


A reasonable measure of the level of liquidity required for the Trust could be that the amount of operational working capital consumed in 10 days which is £59.3m. Clearly the current and forecast cash balances sit well above this level throughout the financial year, although five year plans indicate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

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

As at 30th November 2021, the Trust had a cash balance of £282m. The cash balance was higher than forecast by £17m, this was primarily due to a higher than forecast HEE receipt for £29m, some £16.8m of which was received in advance of the forecast date of January 2022. The year end cash forecast is subject to review due to anticipated changes in timing of some significant capital payments.

Capital Expenditure



In the period to 30th November 2021, £67m of capital expenditure has been recognised against a plan of £108.1m, an underspend of £41.4m, some £25.7m of the slippage relates to the NHP project and is due to delays in the approval of the Park House scheme and associated enabling works. The estimated outturn has been updated to reflect the impact of this delay on the full year outturn. Of the remaining £15.4m underspend, the most material elements are £6.8m relating to the NMGH emergency works which are due to be funded through Emergency PDC (the Emergency PDC application has been submitted and is in discussion with NHSEI, but the plan assumed much earlier approval and utilisation of this) and £4.1m relates to Hive and is a result of spend on the EPIC production platform now expected to be incurred later in the year.

The capital plan reflects the result of negotiations across Greater Manchester (GM) to bring the total planned spend into line with the GM system capital envelope. The total MFT plan value for 2021/22 is £199.2m with a revised forecast outturn estimated to be £190m. The potential capital expenditure outturn may be £9m higher due to backlog maintenance pressures, however slippage across the programme during the year will bring the actual spend back in line with the agreed envelope of £199m.

Better Payment Practice Code

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

NHSE/I have written to MFT regarding BPPC performance and the Trust has shared our action plans.

NHSE/I require BPPC numbers to be provided in the monthly returns for the remainder of 2021/22. An extract of MFT's submission for month 8 is shown below:

Better Payment Practice Code (BPPC)	YTD to 31/10/2021 By Number	YTD to 31/10/2021 By £'000	YTD to 30/11/2021 By Number	YTD to 30/11/2021 By £'000
Non NHS				
Total bills paid in the year	139,949	721,424	164,192	828,874
Total bills paid within target	129,710	650,151	152,385	755,342
Percentage of bills paid within target	**92.7%**	**90.1%**	**92.8%**	**91.1%**
NHS				
Total bills paid in the year	4,588	175,349	5,384	201,852
Total bills paid within target	3,263	151,878	3,803	177,214
Percentage of bills paid within target	**71.1%**	**86.6%**	**70.6%**	**87.8%**
Total				
Total bills paid in the year	144,537	896,773	169,576	1,030,726
Total bills paid within target	132,973	802,029	156,188	932,556
Percentage of bills paid within target	**92.0%**	**89.4%**	**92.1%**	**90.5%**
Target	95.0%	95.0%	95.0%	95.0%
Distance from target	***(3.0%)***	***(5.6%)***	***(2.9%)***	***(4.5%)***

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Operating Officer
Paper prepared by:	Veronica Devlin, Programme Director
Date of paper:	January 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 ongoing work on the Hive programme.
Contact:	Name: Julia Bridgewater, Group Chief Operating Officer 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. This has since been extended to cover North Manchester General Hospital following the formal acquisition of NMGH on 1st April 2021.

1.3 MFT's future EPR solution is called Hive reflecting the importance of clinical transformation and wide-spread change and improvement in every part and process of the organisation to benefit patients and staff.

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

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

2. Why now?

2.1 The implementation of Hive is key to delivering MFT's strategic vision and its Digital Strategy as well as how it continues to respond to the current challenges faced by the COVID-19 pandemic.

2.2 The pandemic has shown how important it is to have integrated clinical and operational systems with the flexibility to support changing inpatient, outpatient and community services, whilst also supporting MFT's broad research and innovation portfolio.

2.3 The Board of Directors recognise that Hive will enable the organisation to transform how everyone works and realise benefits in improved clinical quality, patient experience, staff experience, operational efficiency and importantly drive research and innovation.

2.4 Hive will therefore:

2.4.1 Enable Hospitals / Managed Clinical Services and the Local Care Organisation to change and improve how they deliver services and support better clinical decision making.

2.4.2 Enable staff to work more efficiently by accessing the information they need to care for patients wherever and whenever they need and promoting the introduction of more digitally enabled interaction with patients and users of services.

2.4.3 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.

2.4.4 Increase patient safety by holding one record for each patient and providing alerts for potential medication errors, allergies and infection risks.

2.4.5 Hive will enable a single hospital-wide clinical record which will ensure that the correct information is available for every patient in the same place, first time, every time.

2.4.6 The Hive system is being built by MFT staff, trained and supported by Epic, the Trust's software partner.

3. Governance

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

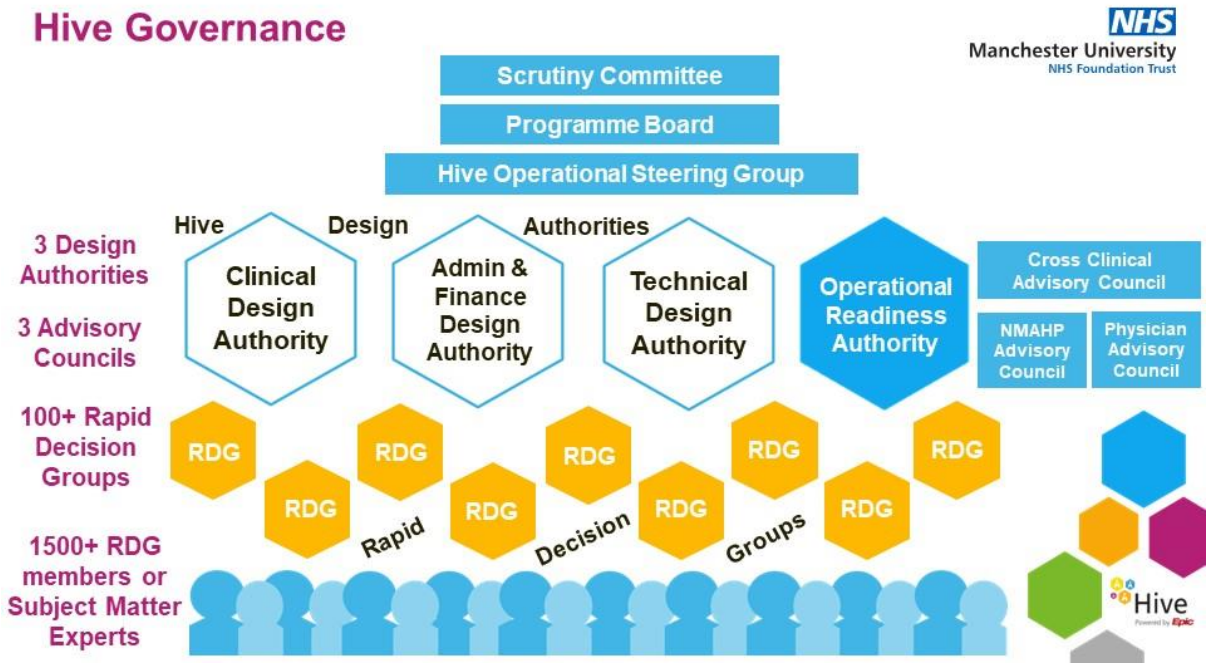
3.2 Three Design Authorities have been set up and report into the Hive Operational Steering Group. These Design Authorities make the important decisions about how Hive's EPR system will work for MFT. They monitor progress and decisions which come out of the Rapid Decision Groups (RGDs).

3.3 RDGs have been established with membership made up of clinicians and operational staff from across MFT to make fast-paced decisions to shape workflows in the Epic system.

3.4 To support Hospitals / Managed Clinical Services and the LCO to be ready for Hive, an Operational Readiness Authority has been set up with individual Hospital / MCS / LCO Operational Readiness Boards.

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

3.6 This Governance structure is illustrated in the following diagram:



4. High Level Risks

4.1 As part of the Programme Management approach, there is a programme-wide risk log which is monitored through the Hive Operational Steering Group and Programme Board. Mitigation plans are in place for all identified risks.

4.2 The Hive Team is actively managing these risks by working closely with operational colleagues to ensure appropriate management of the pandemic response as well as delivery of the Hive Programme.

5. Communications and Engagement

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

5.2 A key element in the delivery plan is to build momentum and excitement ready for Go Live and to mobilise advocates across the Trust to reach MFT's diverse staff groups.

5.3 Since September, a wide-ranging engagement campaign has been carried out which has delivered 196 touchpoints for staff across MFT to learn more about Hive. This has engaged approximately 15% of MFT staff through the following activities:

5.3.1 A ‘one year to go’ Countdown Campaign was launched on 6th September which saw a countdown clock on the Intranet and a range of visual material including lift vinyls and wall art.

5.3.2 During September and October, a series of Hive staff engagement sessions were delivered and Hive team members also presented at Hospital/ MCS local meetings.

5.3.3 Hardware Roadshows and walkabouts were held during October-December which included Hive Analysts visiting around 120 staff areas across Hospital/ MCS sites showing the Epic system and the equipment staff will use.

5.3.4 A series of Hive spotlight sessions have been run showcasing an integrated patient journey in the Epic system.

5.4 In the coming months, the engagement approach will continue to focus on reaching frontline staff as well as promoting the patient portal, called My MFT.

6. Next steps

6.1 The Hive programme is on track to ensure a successful Go Live on 8th September 2022.

6.2 This will be a key milestone underpinning the delivery and focus of the MFT Digital Strategy.

6.3 In preparation for Go Live, MFT is now part of a wider UK community of NHS Foundation Trusts using the Epic platform and is working collaboratively with those Trusts to provide mutual aid for each other’s go live dates.

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

7. Recommendation

7.1 The Board of Directors is asked to note the ongoing work on the Hive programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	Mike Beevers, Acting Group Director of Estates & Facilities
Date of paper:	January 2022
Subject:	MFT Green 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:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures whilst meeting the NHS commitment to be net zero carbon by 2040
Recommendations:	The Board of Directors is requested to approve MFT'S Green Plan covering the period 2022-2025
Contact:	Name: David Furnival, Group Director of Operations Tel: 0161 701 5067

1. Introduction

1.1. Every NHS Trust must finalise and submit a Board-approved 3-year Green Plan to their ICS by 14th January 2022.

1.2. The MFT Green Plan 2022-2025 builds on the Sustainable Development Management Plan (SDMP) that has been in place since 2017.

1.3. A significant step change in carbon reduction activity is required over this next three years if MFT is to meet the NHS commitment to be net zero carbon by 2040.

1.4. The MFT Green Plan 2022-2025 is the next step is supporting the NHS commitment and will support and focus the MFT response.

1.5. The draft MFT Green Plan has been developed with significant stakeholder engagement and all of the feedback received has been incorporated into the final version for approval.

2. Key elements of the Green Plan

2.1. The Green Plan sets out more than 50 objectives and supporting projects spanning ten areas of focus as shown below

- sustainable models of care
- digital transformation
- supply chain & procurement
- medicines, food & nutrition
- estates & facilities
- travel & transport
- climate change adaptation
- green spaces & biodiversity
- workforce, networks & system leadership

2.2. Each of the objectives and supporting projects requires a senior leader within MFT, and there will be further refinement of the objectives and supporting projects over the next twelve months once each objective has been assigned. This will ensure that the objectives are both deliverable & affordable.

2.3. Key to the success of the Green Plan will be the formation of a Climate Strategy Board (CSB), chaired by the Group Director of Operations.

2.4. The CSB will comprise members of the senior leadership team from each Hospital/MCS and the LCO and will span the full range of staff groups. Each of the CSB members will be assigned a number of the objectives and supporting projects to own and report against.

3. Recommendation

3.1. The Board of Directors is asked to approve the MFT Green Plan 2022-2025

NHS
Manchester University
NHS Foundation Trust

Code Green

Delivering Net Zero Carbon at MFT 2022–2025

HEALTHIER PLANET HEALTHIER PEOPLE

Contents

A Bit About Us

Manchester University NHS Foundation Trust (MFT) is the main provider of hospital care to approximately 750,000 people in Manchester and Trafford and the single biggest provider of specialised services in North West England.

We are an Acute Trust encompassing a family of 10 hospitals, which was formed in 2017 to create a 'Single Hospital Service' for the residents of Greater Manchester.

Around 3,000 members of our 28,000-strong workforce are deployed to Manchester and Trafford Local Care Organisations to provide community health services. By integrating services across the city region, we can provide consistent, high-quality care to residents, addressing historical local health inequalities.

MFT is also one of the major academic research centres and education providers in England. Research and innovation are at the heart of everything we do, enabling our patients to have access to the latest high-quality care and clinical trials.

Our Organisation Includes:

- Altrincham Hospital
- Manchester Royal Eye Hospital
- Manchester Royal Infirmary
- North Manchester General Hospital
- Royal Manchester Children's Hospital
- Saint Mary's Hospital
- Trafford General Hospital
- University Dental Hospital of Manchester
- Withington Community Hospital
- Wythenshawe Hospital

Manchester Local Care Organisation
Leading local care, improving lives in Manchester, with you

Trafford Local Care Organisation
Leading local care, improving lives in Trafford with you

Supported by MFT Clinical and Scientific Services (CSS) providing a broad range of services to patients treated in hospital and in the community.

Chairman's Foreword

I, and the rest of the senior leadership team at MFT, wholly endorse this new Green Plan which sets out how our organisation will continue to play its part in making healthcare more sustainable and tackling climate change.

Climate change is the single biggest threat facing humanity and is already impacting health in a number of ways. As a large multi-site organisation, we have a significant environmental impact. Over the last few years, we have made good progress in reducing the negative effects of our activities, but there is much more to be done.

The clear timelines for achieving net zero carbon and this pathway for the next three years, align with national NHS strategy and that of the city-region in which our hospitals and services are located.

This strategy not only sets out how we will tackle our own environmental impacts, for example by reducing carbon emissions and waste, but also considers how we will leverage and maximise positive opportunities, such as our ability to influence the sustainability behaviours of those who supply us and work for us, as well as sharing our learning more widely across the system.

As an anchor institution, we are fully committed to working with partners to bring about environmental improvements which will benefit the health and wellbeing of our region. Through this strategy, we aim to build the capacity and understanding, required across our organisation, to meet our collective objectives and improve sustainability outcomes for the benefit of all.

As one of the first Trusts to declare a climate emergency, this plan represents a vital next step in the way that we tackle this challenge, head on, and use our position as a system leader to inspire others.

Kathy Cowell OBE DL

Group Chairman

Board Net Zero Lead

Message from the Mayor

Our ambition is that Greater Manchester achieves carbon neutrality by 2038, more than a decade earlier than the national target.

This plan will only be realised if major healthcare providers work hard, individually and collectively, to limit their environmental impacts. So far, I am greatly encouraged by their progress and planning for further carbon reductions. This sector's continued commitment to our green agenda and active collaboration is delivering important health benefits for all in Greater Manchester. Thank you for this vital work.

Andy Burnham

Mayor of Greater Manchester

Introduction

This Green Plan marks the start of a new chapter for MFT. Building upon the progress made through our previous Sustainable Development Management Plan (SDMP), this strategy sets out our long-term vision for sustainable healthcare, and the progress we will need to make during the next three years.

The urgency of this plan stems from the knowledge that the now critical levels of carbon dioxide in the atmosphere require significant, accelerated change to business as usual across all sectors, as we face a future with average global warming of up to 2.4°C.

The NHS has already acknowledged that the climate emergency is a health emergency. We must both prepare our services for increased future demand, as our communities face the impacts and inequalities of climate change and, also, limit our own carbon contributions to reduce any further damage.

The breadth of this plan goes well beyond the traditional estates-based opportunities to reimagine how we deliver care in a net zero carbon NHS. Decision making will become more holistic, acknowledging sustainability impacts whilst continuing to protect patient safety as our priority. MFT's 'Single Hospital Service' provides a unique opportunity to address this challenge at scale, using local knowledge and working collaboratively across teams, hospitals and specialist services, to innovate and lead in the field of sustainable healthcare.

Headline objectives, set out in this plan, prioritise activities for the greatest cumulative impact for the three-year lifespan of this plan. These objectives will be underpinned by more detailed annual workplans and programmes developed and delivered by local teams.

Why Do We Need This Strategy?

International, national and regional policy considerations

Organisations in the Global North have a particular responsibility to plan how they will reduce carbon, and contribute to the wider social ambitions of the UN Sustainable Development Goals.

In England, the NHS has set out plans to reach net zero carbon by 2040 for the emissions it controls directly and, by 2045, for those it can influence, such as those created by the supply chain.

To reach that ambition, each NHS Trust and Integrated Care System (ICS) must have its own plan detailing its organisational approach to reaching net zero carbon in sustainable healthcare. This strategy, 'Code Green: Delivering Net Zero Carbon at MFT', is our third published sustainability strategy. It supersedes the previous Sustainable Development Management Plan (SDMP) and further refines the activities and targets needed to accelerate the widespread change required across the Trust.

This 3-year strategy represents a step change for MFT, preparing the organisation for the breadth and pace of sustainable innovations and changes needed to reach our net zero carbon targets.

It also aligns our net zero carbon target (MFT Carbon Footprint emissions) and the parameters (carbon budgets) for reaching this goal with those set out by the Greater Manchester Combined Authority (GMCA).

Addressing the health of Greater Manchester

Our strategy defines what actions we will take as an individual organisation and, in partnership with others, to not only reduce our own impacts, but significantly improve the lives of residents in Greater Manchester.

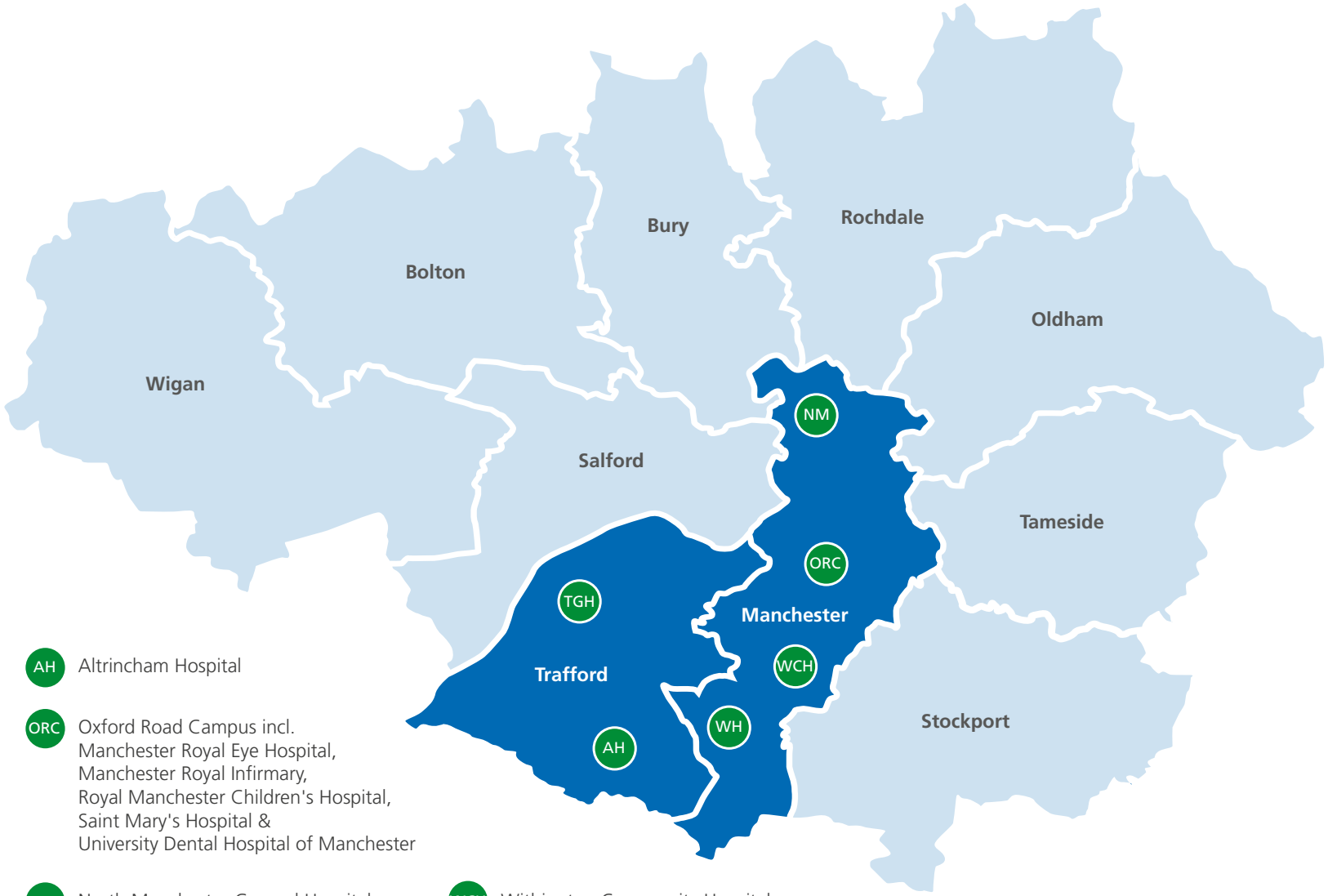
Over 1 million people in Greater Manchester are living in the most deprived areas of England. These residents can expect to die 9.8 years earlier than those living in the least deprived areas. Poor air quality contributes to 1,200 deaths every year in Greater Manchester, and the region has one of the highest rates in the country for emergency admissions in children with lower respiratory tract infections.

Our position, as the largest NHS Trust in England, means we are well placed to take action on climate change to reduce existing health and social inequalities, and to promote health equity.

Additionally, we will continue to work with our partners in the Greater Manchester ICS to tackle those environmental issues which are unique to healthcare delivery (e.g. medicines, models of care and clinical waste management) and capitalise on positive, cross-organisational opportunities (e.g. preventative care and social prescribing). This plan focuses us on these priorities.

A fuller list of the legislative and wider strategic drivers for change at a national and local level can be found in Appendix C.

MFT Hospital Sites within the Greater Manchester Health and Social Care Partnership



Our Impact

MFT undertakes a wide range of activities to deliver high quality health services to the local community. All these activities have a carbon impact.

These impacts can be split into three distinct categories which are:

- Our MFT Carbon Footprint (areas where we have most control over carbon reduction)
- Supply chain emissions
- Community emissions

These categories when combined together make up our 'MFT Carbon Footprint Plus' (see diagram).

To reach our net zero carbon goal, significant change and innovation will be required by our staff, patients and suppliers to contribute to the required carbon reduction. Whilst the MFT Carbon Footprint represents only 20% of our total carbon footprint, this is where we have the greatest influence and ability to make change.

The carbon data shown demonstrates our impact during 2019/20 and will become our new baseline year. This represents the most complete and accurate data set, not distorted by the impact of COVID-19 and updated to encompass North Manchester General Hospital and the newest supply chain carbon factors. This approach is in line with Greener NHS guidance and mirrors the baseline year used for the GMCA's 5-year Environment Plan.

MFT Carbon Footprint Plus: 424,978 tCO_2e

MFT Carbon Footprint

Where we have the most control: Gas, Electricity, Medical Gases, Fleet Vehicles, Waste Management, Water

84,915 tCO_2e

20% of the MFT Carbon Footprint Plus

Community Emissions

We can influence: Patient Travel, Staff Commuting

25,790 tCO_2e

6% of the MFT Carbon Footprint Plus

Supply Chain Emissions

We can work collaboratively to hold suppliers to account: Goods and services bought by MFT

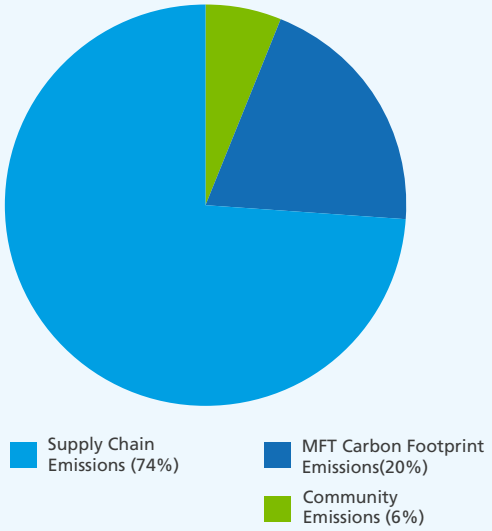
314,274 tCO2e

74% of the MFT Carbon Footprint Plus

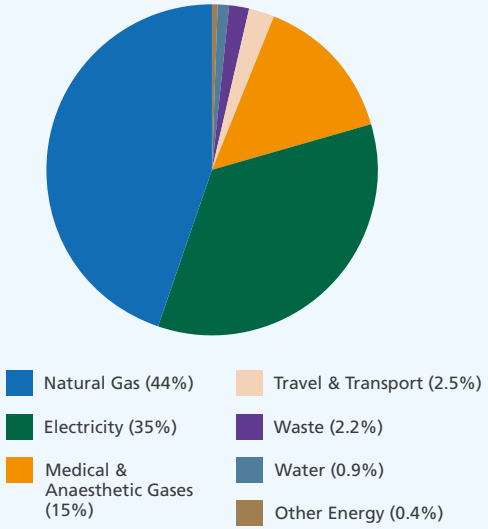
The carbon impact per inpatient, per bed day is 125kg CO_2e

The carbon impact of an outpatient hospital appointment is 76kg CO_2e

MFT Carbon Footprint Plus baseline 2019/20



A closer look at the MFT Carbon Footprint emissions



Our Impact

The breakdown of the MFT Carbon Footprint Plus largely mirrors that of the entire NHS and is typical of an acute Trust. The largest component of the Carbon Footprint Plus is the supply chain, calculated from Trust expenditure data, encompassing healthcare-related spend through to buildings and infrastructure. Within the MFT Carbon Footprint, are the emissions from energy (for heat and electricity), and these have steadily decreased since the Trust was formed in 2017/18.

To date, many carbon reduction measures have focused on estates-based opportunities and, since 2017/18, major energy efficiency and infrastructure projects have been implemented to reduce wastage and prepare for future low carbon technologies. These actions contributed to a 5% reduction in energy consumption over this period, however the equivalent carbon reductions have been significantly enhanced (22%), through greater use of renewables nationally, which has reduced the carbon intensity of electricity from the National Grid.

Whilst North Manchester General Hospital did not formally join the Trust until April 2021, the carbon impact of this site has been incorporated into our historical analysis from 2019/20 to establish an accurate pre COVID-19 baseline. When normalising this data to account for the fluctuating size of the estate, both the MFT Carbon Footprint and community emissions have shown a reduction trend. However, supply chain emissions have continued to rise, representative of increased spending on Trust activities and developments, and reflective of weaknesses in the supply chain carbon footprinting methodology.

A detailed look at our historical carbon footprint performance can be found in Appendix B.

Our Highlights So Far

PEOPLE

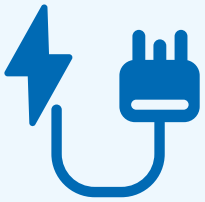
2
staff-focused sustainable healthcare E-learning modules launched

50
teams participate in MFT sustainability accreditation scheme **'Green Impact'**

120,000
staff sustainability actions recorded on **'Green Rewards'** pledge platform

PLACES

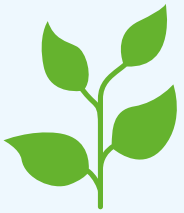
£18 million
investment secured to decarbonise our hospital buildings



45%
of MFT fleet now electric: reduces local air pollution

1,405 tonnes
tonnes of waste recycled annually

CARE



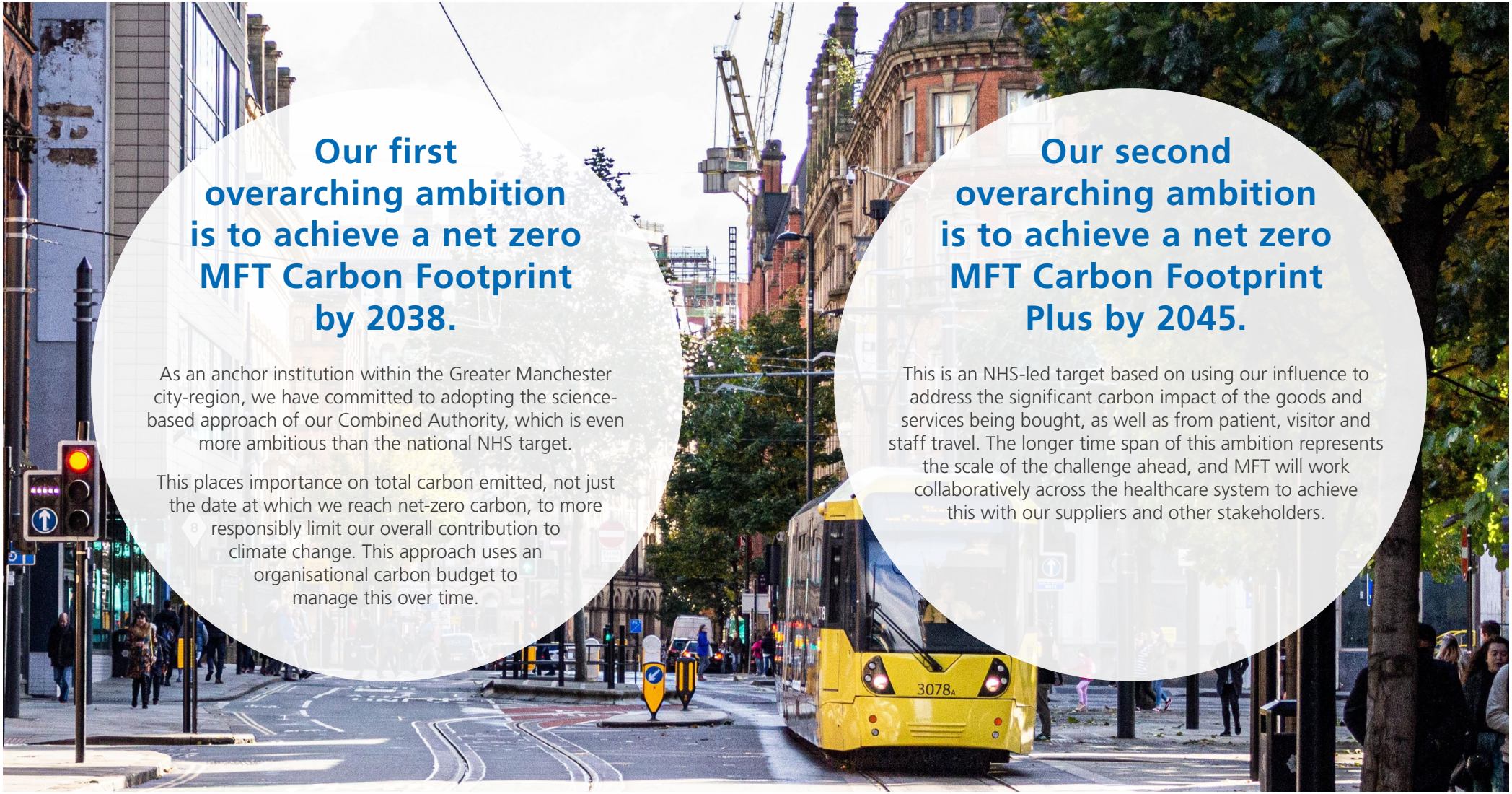
296
submissions to the innovative **Greener Operations** research project led by MFT clinicians

50
clinical services delivering virtual outpatient appointments, reducing patient travel footprint

Desflurane use reduced to just
3%
of all volatile anaesthetic gases

What We Want to Achieve

Our vision for sustainable healthcare is a future where carbon considerations are fully integrated into patient decision making and care pathways. Where all staff, contractors and suppliers are fully aligned with our net zero ambition, and we take a more holistic, collaborative and preventative approach. To achieve this vision and deliver net zero carbon, we have identified two overarching ambitions.



Our first overarching ambition is to achieve a net zero MFT Carbon Footprint by 2038.

As an anchor institution within the Greater Manchester city-region, we have committed to adopting the science-based approach of our Combined Authority, which is even more ambitious than the national NHS target.

This places importance on total carbon emitted, not just the date at which we reach net-zero carbon, to more responsibly limit our overall contribution to climate change. This approach uses an organisational carbon budget to manage this over time.

Our second overarching ambition is to achieve a net zero MFT Carbon Footprint Plus by 2045.

This is an NHS-led target based on using our influence to address the significant carbon impact of the goods and services being bought, as well as from patient, visitor and staff travel. The longer time span of this ambition represents the scale of the challenge ahead, and MFT will work collaboratively across the healthcare system to achieve this with our suppliers and other stakeholders.

What We Want to Achieve

Our carbon budget relates specifically to the emissions we directly control, the MFT Carbon Footprint, and is calculated based upon GMCA recommended carbon reductions of at least 10% per year, in order to avoid catastrophic climate change. Our carbon budget from our 2019 baseline until the end of this Green Plan is 397,870 tCO_2e.

By staying within this budget for the duration of this strategy, we will be on track to stay on our pathway to net zero carbon. If we emit more than the budget allows, subsequent plans will be more challenging to deliver and will require a reduced carbon budget to compensate. Carbon offsetting, which involves making financial contributions to local or international carbon reduction projects, will not be utilised over the timeline of this 3-year plan. Priority must be given to reducing our own emissions to demonstrate credible leadership on climate action. As the quality and assurance of carbon offsetting products develop, we will follow sector guidance to review the suitability for MFT as we move closer to the 2038 deadline.

Anticipated carbon savings have been calculated for existing estates, travel and medicine decarbonisation projects already in development and to be fully implemented over the duration of this Green Plan.

These measures alone will not meet our 3-year carbon budget, and further action is needed to prioritise additional carbon saving activities. It is imperative that decision making across the whole organisation is informed by this net zero priority, ensuring new or altered services are not negating carbon reductions being made elsewhere.

Progress towards our second key ambition will largely be determined by the rate of change within the supply chain across the sector. The International Leadership Group for a Net Zero NHS, which includes major global suppliers, have shown public commitment to the 2045 pledge, indicating a willingness and enthusiasm to innovate. The scale and breadth of healthcare activities we deliver within MFT means that our voice will be particularly significant in driving change regionally and nationally, and we will be vocal advocates for low carbon supplier partnerships and broader collaboration to achieve this commitment.

Whilst carbon is the focus of our overarching targets, the wider health and social impact of our sustainability activities remains a priority. Each of the ten areas of focus outlined in this plan have been assessed against both carbon and social impact through a materiality assessment which can be found on page 33. A balanced approach will be taken to ensure we prioritise our activities to achieve the greatest positive impact.

MFT Carbon Footprint Plus baseline 2019/20

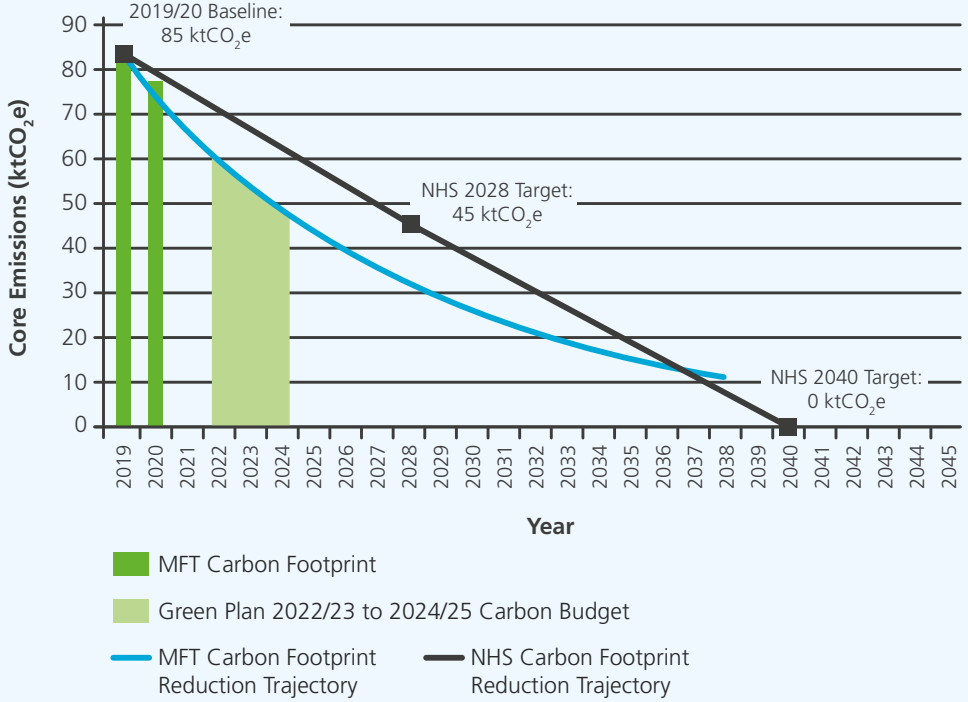
Total budget to 2038/39
745,900 tCO_2e

Interim budget to 2024/25
397,870 tCO_2e

By the end of this Green Plan we aim to use no more than 53% of our MFT Carbon Footprint budget

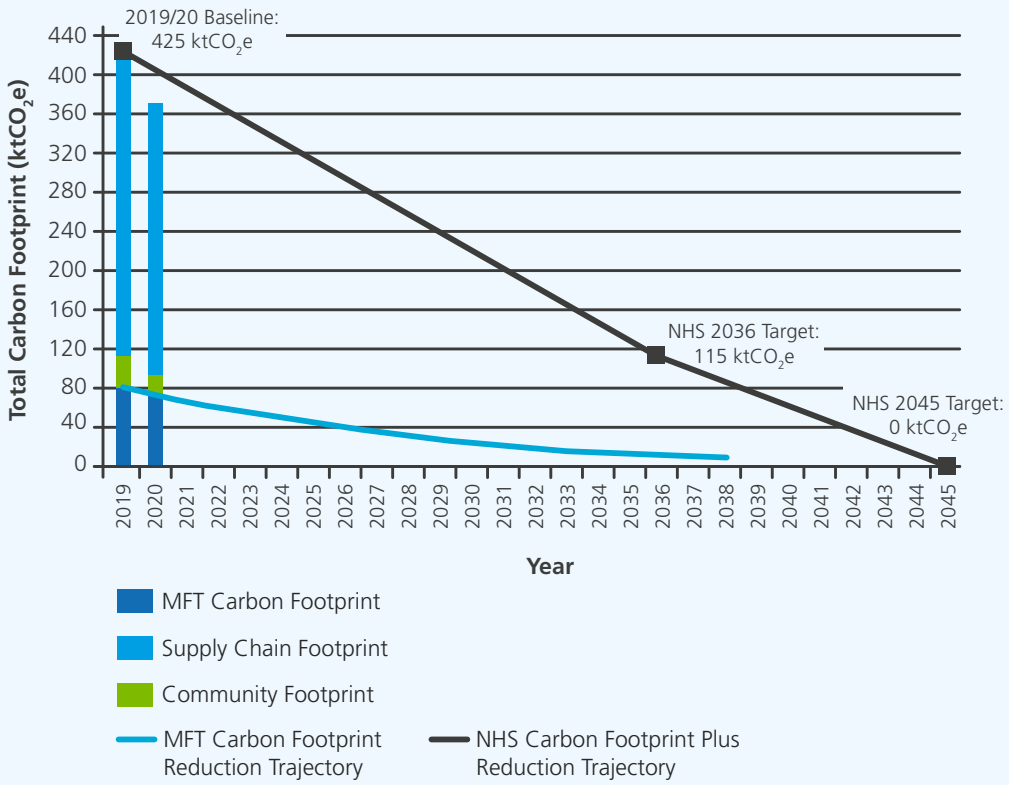
What We Want to Achieve

MFT Carbon Footprint Trajectories to Net Zero



- 2028 indicates the NHS interim 80% reduction target for the MFT Carbon Footprint.

MFT Carbon Footprint Plus Trajectories to Net Zero



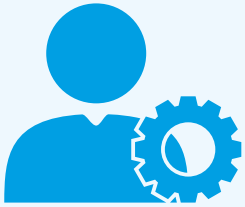
- 2036 indicates the NHS interim 80% reduction target for the MFT Carbon Footprint Plus.

Our Vision

Throughout the lifetime of this Green Plan, and beyond we will:

What You Can Do

STAFF

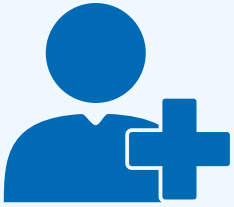


Educate
yourself to understand how your role relates to net zero carbon.

Connect
with similar departments and functions across the Trust to explore and share sustainability good practice.

Consider
what you buy. Is there a more sustainable option, can you use less or is it required at all?

PATIENTS



Talk
with your clinician. Are there more sustainable or lower carbon approaches to your care?

Fully understand
your treatment plan, to maximise the benefits, avoid wasted medicines and resources.

Preventative care
Keep active and healthy to reduce the need for more intensive healthcare.

SUPPLIERS

Measure & report
your impact to quantify where your carbon emissions are taking place.

Collaborate
with your NHS customers to identify practical opportunities to improve the sustainability of your goods and services.

Innovate
your goods and services to improve the full life cycle impacts of your products throughout the supply chain.

Risks and Opportunities

There are both risks and opportunities associated with the delivery of this Green Plan.

Risks

1. Access to Finance

With significant investment required to deliver the commitments in this plan, it will be key that external funding opportunities are maximised, and decarbonisation embedded into backlog maintenance and major redevelopment programmes, as well as upgrading of retained estate.

2. Staff Resources

With a growing demand for environmental professionals in the healthcare sector and beyond, we need to improve career development paths and succession planning in the sustainability team. Clinical programmed activities (PA) time must be allocated if commitments are to be effectively delivered locally.

3. Patient Demand

It will take several years for the NHS to catch up on missed elective surgery and the backlog of care generated during the COVID-19 pandemic. This will impact on resource usage and carbon footprint which may not reduce in absolute terms as fast as we need it to. As new diagnostic technology is adopted this will place pressure on energy supply. The need for remote healthcare services will become more pressing as healthcare demand grows.

4. Insufficient Electrical Capacity

To decarbonise the estate a significant increase in electrical capacity will be required. It will be key that needs are identified at an early stage, and we will need to liaise closely with the Power Network Operator, Electricity North West.

5. Reporting Requirements

Reporting requirements are becoming more frequent and demanding, and we need better data to monitor progress on a real-time basis. Investing in smarter systems for collating and reporting data will be key.

6. Reputation

With an increasing focus on net zero carbon, there is a risk of harm to our reputation if we do not deliver against our stated targets and other commitments. Environmental credentials are becoming increasingly important to the younger generation, and we risk not attracting and retaining staff if this agenda is not fully embedded.

Opportunities

1. Increased Costs of Waste and Utilities

Whilst the increasing cost of waste and utilities will place substantial pressure on organisational finances, it will make a stronger business case for investing in improvement and efficiency measures.

2. Integrated Care System and Collaboration

As the ICS (Integrated Care System) transitions to a legal entity, there will be greater opportunity to collaborate with our system partners on shared priorities, as well as embed net zero carbon more formally within the commissioning process as a requirement to deliver healthcare services.

3. Greener NHS

With an expanded national team and regional support, this programme will provide the tools and other supporting information required to deliver against this strategy.

4. Innovation

It will be essential that we stay close to national and international innovations and work with our Academic Health Science Network to identify where low carbon solutions are needed.

5. Enhanced equality

Actions for net zero carbon can address existing inequalities within the organisation. Equality Impact Assessments should be conducted for new activities which underpin this strategy.

6. Early action

The sooner we act to decarbonise the healthcare system, the lower the cost will be. It is widely recognised that the costs of inaction will far outweigh the cost of early action, and we can contribute to additional social value through the associated contracts.

7. Co-benefits

There will be significant co-benefits from decarbonising including cleaner air, which will drive economic benefits and reduce respiratory hospital admissions.

Areas of Focus

This section looks at the ten most important areas where we will direct our efforts to reduce carbon emissions and improve wider sustainability and health outcomes. Due to their interconnectivity, positive results in one area will also benefit others. The areas mirror national NHS priorities.

Sustainable Models of Care

Why it matters

We need to reimagine current care pathways to improve patient outcomes whilst making care less carbon and resource intensive and, where possible, reducing the need for care.

Examples include minor process changes, which save staff time and use less resources, or more system-wide approaches such as 'Patient Initiated Follow Ups (PIFU)', 'Same Day Emergency Care (SDEC)', 'Getting It Right First Time (GIRFT)', quality improvement projects or moving care closer to home to reduce pressure on hospitals and patient transport.

Some of these approaches will enable specific treatments to be less carbon intensive. Although carbon reductions may not be measurable by individual cases, this will support a better functioning health service with reduced waiting times, removal of unnecessary appointments/ referrals and provide better health outcomes.

To drive down the carbon footprint of care, a more holistic view of healthcare is needed together with greater collaboration between primary, secondary and community healthcare providers, enabling patients to be treated in the most appropriate way.

What we're doing

Creative and innovative transformational programmes are a long-standing feature of the Trust's work and have been accelerated during the pandemic. Several flagship projects demonstrate this:

- Redesign of care pathways to provide community-based specialist eye treatment reduce carbon from patient travel by 50% (30 tonnes CO_2e per annum)
- Virtual physiotherapy clinics, aided by kinetic sensors, allow patients to perform exercises using games, reducing the number of in-person physiotherapy appointments
- Specialist consultants provide advice and guidance via video calls to GPs on specific patient cases to avoid unnecessary hospital referrals or testing
- 'Patient Initiated Follow Ups (PIFU)' rolled out to eliminate unnecessary outpatient appointments
- 'No Delay May/Home by Noon in June' efficient patient discharge campaigns.

What we want to do

Ten hospitals and community services in the city of Manchester and Trafford are managed by our Trust as a Single Hospital Service. We will maximise this opportunity to embed the principles of sustainable innovation and quality improvement across all healthcare sites.

Major clinical transformation projects will conduct sustainability impact assessments to identify and quantify where carbon or resource savings will be made, and each clinical service unit (CSU) will have a designated sustainability lead to drive relevant innovations within their specialty.

The impacts from testing new models of care will be fully evaluated and shared within and between hospital sites and beyond. They will be encouraged to adopt proven methods of reducing the carbon intensity of care pathways.

Objectives

Headline objectives

- Pilot the redesign of at least 3 care pathways to reduce carbon
- 2% of patients discharged to a PIFU pathway

Supporting projects

- Establish at least 3 'green working groups' for clinical services with a high environmental impact
- Provide resources and training on Sustainable Quality Improvement (SusQI), to empower clinical leads to review and redesign care pathways to reduce carbon (in collaboration with system and regional partners)
- Continue to embrace the Getting It Right First Time (GIRFT) programme to avoid unnecessary procedures, admissions and bed days
- Measure and promote the specific carbon benefits of key, out-of-care hospital models such as Community Macular Treatment Centres
- Pilot innovative technologies that reduce the environmental impact of care and prevent ill-health

Digital Transformation

Why it matters

The use of digital technologies and tools to deliver and manage healthcare can help realise sustainability benefits and drive down the carbon intensity of care.

Direct carbon reduction can be delivered by reduced staff, patient and visitor travel, and reduced resource use as digital patient data systems become more integrated. Greater efficiency can be achieved as more preventative and proactive care measures are put in place.

Some digital health developments require more widespread adoption (e.g. virtual appointments and electronic patient communications), while others need further research and innovation (e.g. smartphone diagnostics) before they can be fully mainstreamed.

However, the digital approach is not always a low carbon or sustainable approach. Large data centres are a major contributor to greenhouse gas emissions, and there are significant ethical concerns over aspects of the digital supply chain, such as modern slavery and child labour, conflict minerals and rare earth elements and the environmental impact of mining. E-waste is the world's fastest growing waste stream, as technology becomes obsolete at an ever more rapid pace. Widespread uptake of digital technology can contribute to the exacerbation of health inequalities unless steps are taken to prevent digital exclusion.

What we're doing

The COVID-19 pandemic was the catalyst to accelerate many aspects of our existing digital programmes. In 2020/21 this included:

- Investment in and rollout of virtual outpatient services which facilitated 31% (380,000) of all outpatient contacts
- Virtual advice and guidance from MFT specialists to support GPs to avoid unnecessary tests or hospital visits. Over 4,000 GP contacts were made over the year, around 80% of which resulted in an avoided first appointment.

'HIVE' is an ongoing, major initiative for our Trust which involves digitising and streamlining 750 different patient records programmes into a single system. Once completed, it will enable staff to access crucial patient information quickly and efficiently and provide the foundation for future digital services at MFT.

What we want to do

Digital technologies can streamline healthcare delivery, whilst achieving tangible reductions in carbon. We will ensure our digital approach is a responsible one; ensuring we don't exclude any patient groups, improving awareness of sustainability and social impacts and working with partners to enhance understanding of our digital supply chain. We will be mindful of the carbon impact of unnecessarily storing large volumes of data.

Digital care will mean the most carbon intensive care option for patients (an on-site hospital visit) will only be used when necessary. Digital therapeutics will give clinicians more informed case information and patients greater control over their own health.

Objectives

Headline objectives

- Deliver 25% of all first outpatient appointments and 60% of all follow up appointments virtually
- Embed circular economy considerations within the procurement and disposal of IT equipment, including the development of reporting metrics

Supporting projects

- Collaborate with key partners to embrace digital innovations that have significant carbon benefits associated with them
- Work with key suppliers to embed circular economy considerations within procurement of IT and other digital infrastructure, including purchasing durable devices that can be repaired and upgraded, and embracing technology as a service rather than a product
- Identify and measure the sustainability benefits of 'HIVE' which digitalises and streamlines patient records into a single system

Supply Chain and Procurement

Why it matters

We require a huge network of suppliers to produce and deliver the goods and services needed to deliver healthcare.

The purchase of medical instruments and equipment, pharmaceuticals, IT, construction materials, business services and commissioned healthcare are, of course, essential for healthcare provision, but have associated environmental and social costs.

Greenhouse gases are emitted during the production and delivery of goods and services and these emissions account for the largest proportion of the overall NHS Carbon Footprint Plus (62%).

Whilst we don't have direct control over these emissions, we have significant influence and purchasing power. By working collaboratively with partners from across the system, we can maximise this leverage, putting more pressure on suppliers to adhere to the ambitious net zero carbon targets.

MFT's purchasing power also allows us to push for social good, especially in our local area. By making smart decisions at the point of purchasing, we can increase local employment and benefit our community.

What we're doing

MFT's supply chain is the largest contributor to our carbon footprint, responsible for 74% of all emissions in our baseline year (2019/20). Projects to address this are:

- Proactively investigating procurement data to target interventions with a focus on:
  - » Highest carbon intensity products
  - » Biggest suppliers by spend and carbon emissions
- Engaging with suppliers to build in circular economy principles
- Removing single use plastic items from on-site food outlets
- Piloting reusable PPE in the Critical Care Unit
- Increasing the proportion of recycled paper
- Reusing furniture and other equipment
- Rationalising clinical packs to remove unnecessary items.

What we want to do

All our suppliers will share our vision of a sustainable healthcare system. We will only work with those who align with the commitment to deliver net zero carbon by 2045. In practical terms:

- Carbon emissions will be minimised, while social and environmental benefit will be maximised
- More products will be sourced locally and social value properly considered
- Continued low carbon product innovation will be championed
- Suppliers will be expected to provide take-back or repair schemes where appropriate

Objectives

Headline objective

- Apply a social value weighting of at least 10% to all new purchasing contracts and work collaboratively with partners and suppliers to drive down our Carbon Footprint Plus

Supporting projects

- Develop a Sustainable Procurement Policy to support the transition to net zero carbon and more sustainable procurement models. This will embed circular economy principles, with suppliers expected to consider and take responsibility for all stages of the product lifecycle
- Work collaboratively across the system to develop interventions for the top 10 most carbon intensive products and suppliers
- Implement a programme of carbon literacy for procurement staff, achieving at least 50% of staff trained by 2024/25
- Pilot new methods for reporting on supply chain carbon emissions to improve the accuracy of the MFT Carbon Footprint Plus
- Increase the proportion of recycled paper purchased from 64% to 95% by 2024/25

Medicines

Why it matters

A quarter of the NHS Carbon Footprint Plus is from medicines. The majority is associated with supply chain manufacturing and transportation and some medicines such as anaesthetic gases, medical gases and certain types of metered-dose inhalers release high carbon emissions at the point of use. Collectively, these medicines account for 5% of all emissions nationally and, as such, are of particular focus in this 3-year period.

Preventing patients from requiring hospital treatment, including medicines, is key to reducing the impact of this area. Interventions such as social prescribing and other community-based resources, which support patients to adopt improved healthy behaviours, will become increasingly vital in the pathway to a decarbonised NHS. Where medicines are prescribed, they must be clinically necessary, but many treatments do not address the underlying causes of ill-health.

When medicines aren't being used correctly by patients or expire without being used at all, a further burden on the carbon footprint of the NHS is generated, without any benefit to patient health. We can minimise this impact through efficient prescribing combined with patient education.

Prescribing is relevant to the whole of the healthcare system, requiring collaboration between commissioning, primary, secondary and tertiary care providers to successfully incorporate sustainability into the decision-making process.

What we're doing

Several initiatives are already underway to minimise the environmental impact of medicines. Many of these activities have been prioritised towards those medicines with direct impacts on climate change at the point of use – anaesthetic gases, medical gases and metered-dose inhalers.

They include:

- Making clinical leads accountable for the sustainable use of anaesthesia
- Implementing a campaign for anaesthetists to substitute the most potent anaesthetic gas for a less carbon intensive alternative which reduced consumption by 96%
- Piloting nitrous oxide capture technology at Wythenshawe and St Mary's hospitals and removing backup nitrous oxide cylinders from Wythenshawe
- Auditing inhaler prescriptions across the Trust
- Implementing patient engagement measures to increase successful application of medicine at the Kellgren Centre for Rheumatology.

What we want to do

Our vision is that environmental impact is considered as a priority alongside clinical efficacy in the prescribing of medicines across all MFT hospitals. Our clinicians will take an informed approach to adopting low carbon prescribing, with best practice being proactively shared between professionals within our family of hospitals and the wider system. We will engage with and educate patients to help them make more informed choices around the use and disposal of medicines.

Objectives

Headline objective

- Reduce the carbon footprint of medicines that have a high GWP at the point of use (metered dose inhalers, medical gases, and volatile anaesthesia)

Supporting projects

- Appoint sustainable anaesthesia leads for MFT hospitals with allocated PA time for this agenda and ensure a collaborative working group operates across the whole Trust
- Implement a programme to minimise wasted Nitrous Oxide and Entonox
- Develop and implement a Trust-wide hierarchy for sustainable anaesthesia, maintaining desflurane usage at less than 5% of volatile halogenated agents (only used when clinically essential)
- Baseline carbon emissions from MFT prescribed inhalers and develop a programme of interventions to reduce the impact on our carbon footprint, including improving disposal of used inhalers
- Develop a campaign to further reduce over or unnecessary prescribing and wastage of medicines
- Require all anaesthetists to undertake mandatory training and regular CPD on the environmental impacts of anaesthesia

Food and Nutrition

Why it matters

The nutritional quality of food served to patients has a direct impact on their health and recovery. A well-balanced plate is also a low carbon plate, consisting of minimally processed foods and seasonal, ideally locally sourced, fruit and vegetables. Improving the quality of the food served within hospitals has the potential to significantly benefit the patient experience and recovery rates, as well as improve staff health and wellbeing.

The efficiency of meal delivery and wastage of food is another key consideration. The UK healthcare sector creates 121,000 tonnes of food waste annually, equating to a financial loss of £230 million a year. Wastage can be found throughout the food production system from food growing, storage and meal preparation, through to unserved food and plate waste. This creates a substantial financial and environmental burden through over-ordering and waste disposal costs, and a huge opportunity in tackling this.

What we're doing

Menu designs account for our patients' demographics and reflect their religious and cultural needs, including kosher, halal, vegan and Afro-Caribbean options. These are nutritionally assessed by our dietitians and meet government guidelines on nutrition and hydration.

The MFT Food and Nutrition Strategy encompasses our commitment to sustainability, to reduce the carbon impact of our food supply chain and adhere to the government buying standard for the sustainable procurement of food.

Single use cutlery and crockery for meals is only provided when strictly necessary. A food waste initiative has been piloted to weigh and accurately quantify food waste. We already segregate food waste and send it off-site for treatment via anaerobic digestion.

What we want to do

We buy 2.2 million patient meals a year and will use our purchasing power to invest in a positive food system. This requires working closely with our supply chain to integrate as much local, seasonal, low carbon (including plant-based) and responsibly sourced food as possible into meal design. Our meals will be nourishing and culturally appropriate, appetising to patients, and minimise avoidable plate wastage.

Our food ordering processes will be efficient and convenient; using technology to make it simple and quick for staff to manage and reduce avoidable wastage. Services will be consistent across all hospitals and will be an exemplary component of the MFT patient experience.

Objectives

Headline objective

- Reduce the carbon impact of food, minimise food waste and eliminate unnecessary single use plastics from catering

Supporting projects

- Increase the number of low carbon, sustainable and healthy patient meal options on offer as part of the Better Hospital Food Programme, and require catering providers to report progress at least once annually
- Work with ICS and PFI partners to take a more collaborative and robust approach to procurement of catering services with increased weighting on healthier, lower carbon and locally sourced options
- Undertake an in-depth food waste study across at least one MFT hospital, to identify and deliver priority interventions
- Eliminate all unnecessary single use plastics from staff catering facilities and ensure this is a contractual requirement for any new or renewed outsourced provision

Estates and Facilities

Why it matters

The environmental impact of our hospital buildings, through energy consumption for power and heating, water consumption and waste treatment, accounts for 82% of our MFT Carbon Footprint and 16% of our MFT Carbon Footprint Plus. One pound in every £187 is spent on energy used in buildings across the NHS. Delivering a net zero carbon hospital estate will be challenging but is one of the key areas we can directly control.

The management of this can be considered from two perspectives:

- **Supply side:** looking at what energy sources are available (non-renewable, off-site renewable, on-site renewable) and what waste contracts are in place (low carbon intensity/circular economy)
- **Demand side:** using less energy and water and generating less waste.

In the **short to medium term,** staff engagement, innovations in care pathways and engagement with suppliers can help identify immediate efficiencies in energy, water and waste to reduce resource use, whilst supporting high quality patient care.

In the **medium to long term** innovations in the supply side, locally, regionally and nationally, will be essential to reach the net zero carbon ambition of the NHS. From the demand side, we need to embed net zero carbon into the design of new buildings and major refurbishment schemes, as well as planned backlog maintenance and plant replacement.

What we're doing

We have already reduced CO_2e by 18% since MFT's inception in 2017/18.

- Projects delivered include on-site energy infrastructure upgrades, energy efficiency programmes such as building fabric improvements and LED lighting roll outs, as well as a decarbonisation of the grid.
- All imported grid electricity is backed by a Renewable Energy Guarantees of Origin (REGO) certificate.
- Installation of combined heat and power plants (CHP), high efficiency boilers, upgraded building management systems and over 10,000 LED lights at two hospitals have reduced total electricity consumption by 10%, saving 1,840 tCO_2e and £1m every year.

What we want to do

Become a **zero-waste organisation by 2030**, by:

- Preventing waste generation by applying circular economy principles to services and contracts
- Reusing resources on site or locally as much as practically possible
- Recycling resources which can't be reused and sending zero avoidable waste to landfill.

Achieve **net zero carbon emissions from our estate by 2038**, by:

- Transitioning heating away from fossil fuel sources
- Operating optimised energy efficient buildings, which provide greater patient comfort
- Increasing the proportion of on-site renewables
- Utilising renewable energy tariffs and power purchase agreements
- Ensuring that major new developments and refurbishments are designed and operated to a net zero carbon standard.

Objectives

Headline objectives

- Reduce carbon emissions from the building estate by at least 30% by 2024/2025 and ensure major schemes are energy efficient and low or zero carbon
- Implement innovative treatment technologies for waste and increase the recycling and reuse rate from 19% to 25%

Supporting projects

- Develop an Estates Decarbonisation Strategy, delivering ambitious energy and water reduction and efficiency schemes, desteaming hospital sites and seeking funding opportunities
- Develop decarbonisation plans for all existing fossil-fuelled CHP schemes and not commit to any new schemes unless they have a decarbonisation plan that aligns with our carbon budget
- Ensure that major hospital redevelopments, refurbishments and life-cycled infrastructure is designed to be low and zero carbon in-use
- Increase capacity of on-site renewable energy generation and only use certified renewable tariffs. Explore opportunities to work with partners to develop PPAs for off-site renewables
- Develop a plan for innovative treatment and prevention of waste, including working with key suppliers and social enterprises to develop a circular economy approach

Travel and Transport

Why it matters

Travel is fundamental to delivering health and care. 9.5 billion miles (3.5%) of all road travel in England is associated with patients, visitors, staff, and suppliers to the NHS. This travel has an impact on our climate, air quality, local environment, and health. Just a small reduction in transport-related nitrous oxide (16%) could prevent almost 160 deaths and save more than 350 days spent in Greater Manchester's hospitals due to respiratory conditions each year.

Our Trust both contributes to, and is affected by, the environmental impacts of travel and transport. As one of the largest employers in Greater Manchester, we have over 28,000 employees travelling to work. We also treat over 2 million patients and travel over 6 million miles for business every year. Travel and transport contribute 8% of our organisation's overall carbon footprint plus (2019/20).

1. https://cleanairgm.com/air-pollution/#your-health

What we're doing

We have been working on sustainable travel improvements for several years developing cycling infrastructure and providing incentives to cycle such as bike loans, free bike maintenance, subsidised bike locks and competitions. We have upgraded 45% of our transport fleet to electric vehicles and provide some free shuttle bus services to support low carbon business travel.

These results led to recognition including:

- Platinum Travel Choice Award from Transport for Greater Manchester (2020)
- Case study featured in the launch of 'For a Greener NHS Campaign' (2019)
- Highly commended at NHS Sustainability Day (2018)

What we want to do

We want to make sustainable travel the natural choice for patients and individuals and organisations working with and for MFT. The following aims will help us transition to net zero carbon and deliver improvements in air quality.

- **Reduce journeys:** e.g. through flexible working for staff, more digital patient appointments
- **Switch the mode:** provide incentives for employees to move away from cars, especially single occupancy vehicles, to walking, cycling and public transport
- **Reduce the impact** by:
  - » Electrification of fleet and specialist support vehicles
  - » Policies supporting sustainable business travel options and disincentivising higher carbon choices
  - » Ultra-low and zero emission vehicles (ULEV and ZEV)
  - » Optimising movements of goods and services vehicles

Objectives

Headline objectives

- Reduce the carbon emissions of travel and transport activities (business travel, fleet mileage, staff commuting and patient and visitor travel) by 25%
- Achieve a "Good" rating for the Clean Air Hospital Framework

Supporting projects

- Deliver the MFT Healthy Travel Strategy and implement campus-specific travel plans
- Reduce journeys through virtual outpatients' visits and the provision of care closer to home
- Review business travel and implement an action plan to reduce its environmental impact
- Actively seek funding to improve active travel infrastructure, whilst continuing to incentivise take-up through hire schemes and on-site cycle maintenance
- Fully electrify the in-house transport fleet, and only offer ultra-low and zero emitting vehicles through staff salary sacrifice schemes, improving charging infrastructure subject to funding and electrical capacity constraints
- Work with key suppliers and partners to consolidate orders and deliveries to sites
- Ensure that up-to-date information on active and sustainable travel is widely available to staff, patients and visitors

Climate Change Adaptation

Why it matters

More frequent extreme weather events and rising temperatures increase the risk of vector-borne diseases and pose threats to lung health, while the localised impacts of flooding, storms and heatwaves place growing pressure on staff, hospital buildings, critical infrastructure and the supply chain.

Climate change adaptation seeks to manage this risk to services, adapting or designing buildings and processes to ensure continuity of care, in a rapidly changing global climate.

An almost threefold increase in the frequency of extreme weather events (since pre 1994 levels) has been recorded in Greater Manchester. While we cannot change this, we can prepare for these occurrences. By adapting our estate and creating more resilience through the supply chain, we can minimise these potential risks.

Past occurrence of extreme weather and climate change hazard events across Greater Manchester

Event	1945-1969	1970-1993	1994-2017
Flood (all forms)	36 (44%)	24 (36%)	109 (52%)
Storm	18 (22%)	24 (36%)	44 (21%)
Cold	17 (21%)	11 (16%)	27 (13%)
Fog	8 (10%)	2 (3%)	15 (7%)
Heat	2 (2%)	4 (6%)	10 (5%)
Drought (water shortages)	1 (1%)	2 (3%)	5 (2%)
TOTAL EVENTS	**82**	**67**	**210**

(Source: Manchester Climate Change Agency: Manchester Climate Change Framework 2020-25, 2020)

What we're doing

- Our Climate Change Adaptation Plan (CCAP), which encompasses a detailed action plan to tackle this agenda, was updated in 2021. Adaptation requires a cohesive approach to future planning and is embedded within multiple Trust policies and procedures including: Emergency Preparedness, Resilience and Response Policy, including the threat to human health. Threat of severe weather is included on the Risk Register.
- Major Incident Plan and Business Continuity Plan to anticipate and coordinate the response for potential, major disruption which could be the consequence of an extreme weather event.
- Severe Weather Plan, Heatwave Plan and Fuel Shortage Plans are in place.

What we want to do

MFT will take all precautions possible to maintain a consistent high level of care, recognising the increasing frequency and likelihood of extreme weather events.

This will ensure that the health of those Manchester communities which are most vulnerable to the impacts of climate change, such as the homeless, elderly and economically deprived, are not disproportionately affected in the quality of care they receive.

Our investments in targeted interventions, such as nature-based solutions (e.g. trees, green spaces and sustainable urban drainage) to absorb flooding runoff and excessive heat, will help shield our hospitals from reaching critical operational limits. Additionally, our rigorous business continuity planning will ensure we are prepared for the consequences of more frequent, local extreme weather events.

Objectives

Headline objective

- Ensure our organisation is preparing to deal with the impacts of climate change by delivering and embedding the Climate Change Adaptation Plan (CCAP) and associated action plan

Supporting projects

- Deliver, maintain and report progress against the Climate Change Adaptation Plan (CCAP) and associated action plan
- Maintain and review climate change risks on the corporate risk register
- Work with city-wide partners to deliver shared priorities on climate change adaption and help ensure system-wide resilience
- Ensure that major new buildings and hospital campus redevelopments are planned and designed to be resilient to climate change impacts including hotter drier summers, and an increasing frequency of extreme weather events

Green Spaces and Biodiversity

Why it matters

High quality green spaces are an essential resource for human health. They function as attractive habitats which absorb and filter carbon dioxide, air pollution, rainwater and heat. Health, nature and wellbeing are inextricably linked, and hospital patients that have a view of nature from their window recover faster and need less medication.

In an urban environment, high quality external areas are an important asset to supporting physical and mental health, and help raise awareness of the benefits of the natural environment. Whilst the carbon benefit from hospital green spaces is minimal, our focus is on maximising staff wellbeing, patient recovery and supporting local biodiversity. Designed effectively, these outdoor spaces can also help to protect the Trust's infrastructure from extreme weather events. New developments are subject to the 'biodiversity net gain' principle, which leaves biodiversity in a better state than before.

What we're doing

The MFT Estate, across seven separate sites plus numerous community locations, spans both urban and suburban areas of Greater Manchester. Approximately 19% of this footprint is green spaces.

The spaces include a mixture of publicly accessible gardens, managed courtyards, balconies, grassed and planted landscaping. Rooftop beehives are situated on the roof of the Trust headquarters.

Our proactive and resourceful staff members are:

- Leading local gardening activities with patients to complement care on the ward
- More effectively using existing green spaces by developing formal gardens for staff contributing to the post pandemic workforce recovery efforts
- Undertaking micro initiatives such as planting a mini orchard and wildflower planting and showcasing departmental planters in an 'MFT in bloom' campaign.

What we want to do

By playing an active role in the development and management of on-site natural assets, staff, patients and community groups will feel better connected to the natural environment, benefitting their personal health and wellbeing.

We will adopt innovative approaches to enhance our green spaces and promote biodiversity, such as using vertical spaces, rooftops and courtyards. The site redevelopment of Wythenshawe and North Manchester General Hospitals provides a significant opportunity to integrate more innovative green infrastructure into building design.

Objectives

Headline objective

- Maximise the quality of on-site green spaces, identifying and delivering schemes that address one or more of the following priorities: improves local biodiversity, supports staff wellbeing and/or patient recovery, combats climate change or provides opportunities for social prescribing

Supporting projects

- Develop a Greenspace and Biodiversity Plan, establishing associated metrics
- Collaborate across estates, clinical teams and with local social enterprises to develop and seek funding for schemes
- Build green measures into major hospital redevelopment programmes
- Facilitate our staff beekeeping programme and assess the feasibility of expansion across other sites
- Require service providers to undertake annual tree condition surveys to establish a programme of recommended works
- Implement opportunities for wildflower planting, designated 'no-mow' zones to encourage wildlife, and expand hedgerow and tree cover

Workforce, Networks and System Leadership

Why it matters

This focus area looks at our ability to influence the thinking and behaviours of those who work with us and for us, enabling many of the other activities outlined throughout the Green Plan.

The NHS employs 1.3 million staff members. Engaging the workforce with the sustainability agenda is essential if we are to achieve the commitment to net zero carbon.

As a large teaching and research hospital Trust, we have a key role to play in making healthcare more sustainable now and in the future. Currently, around 8% of our staff have engaged in the MFT sustainability programme, and further work is needed to truly embed sustainability among the workforce. By educating and mobilising staff and creating new networks for change, we are expanding our capacity for low carbon innovation, and providing leadership across Greater Manchester and the North West.

We recognise that our influence can also bring about positive change in our employees' lives and wellbeing, for example how they heat and power their homes through to their transport, dietary and other consumer choices. These changes, stemming from the workplace, can encourage staff to explore ways to save money and improve their health whilst reducing their overall carbon footprint.

Climate focused groups within local government and the healthcare community are vital to accelerate place-based coordinated action. By actively engaging in these forums we're able to use our experiences to shape conversations, as well as inspire new projects and innovations within the Trust.

What we're doing

We are educating and incentivising our staff to adopt more sustainable ways of working and living. Currently, we run two main sustainability behaviour change programmes.

- **Green Impact:** teams work together to deliver sustainable change projects in their ward, team or department. This programme is one of the most mature in the NHS with over 50 teams engaged since launch.
- **Green Rewards:** individual employees can earn points for sustainable behaviours and convert those points into rewards. To date 1,400 staff have participated recording more than 100,000 actions.

Our staff can also take a Sustainable Healthcare eLearning Module, developed by the Centre for Sustainable Healthcare.

What we want to do

Our vision is that all employees are aware of the net zero carbon ambition for the NHS and understand what that means for their work and day-to-day activities. Visible sustainability leaders and networks will make this a more prominent aspect of the MFT culture.

Beginning from their time as a trainee, clinical staff will receive core training and continuous professional development related to their specialty, meaning an environmental focus becomes embedded within our healthcare delivery.

This is supported by the extension of the 'first do no harm' principle to cover the environment, as well as human health.

Objectives

Headline objectives

- Continue to educate and engage the workforce to understand the net zero ambition of the NHS
- At least 50% of staff with major influence or responsibility for carbon intensive areas to undertake training and/or CPD

Supporting projects

- Provide role-appropriate staff and student sustainability training. Work with partners at all levels to develop a tailored programme of learning
- Include a net zero carbon clause in all job descriptions and set appraisal objectives for those in key positions of leadership and influence
- Appoint undergraduate and postgraduate sustainable education leads to embed sustainability within MFT clinical trainee development
- Run focused campaigns and behavioural change programmes to increase awareness and action on specific sustainability themes
- Develop and maintain a net zero communications plan with key deliverables
- Widely promote our work through events, social media and case studies
- Enhance the package of 'green' staff benefits

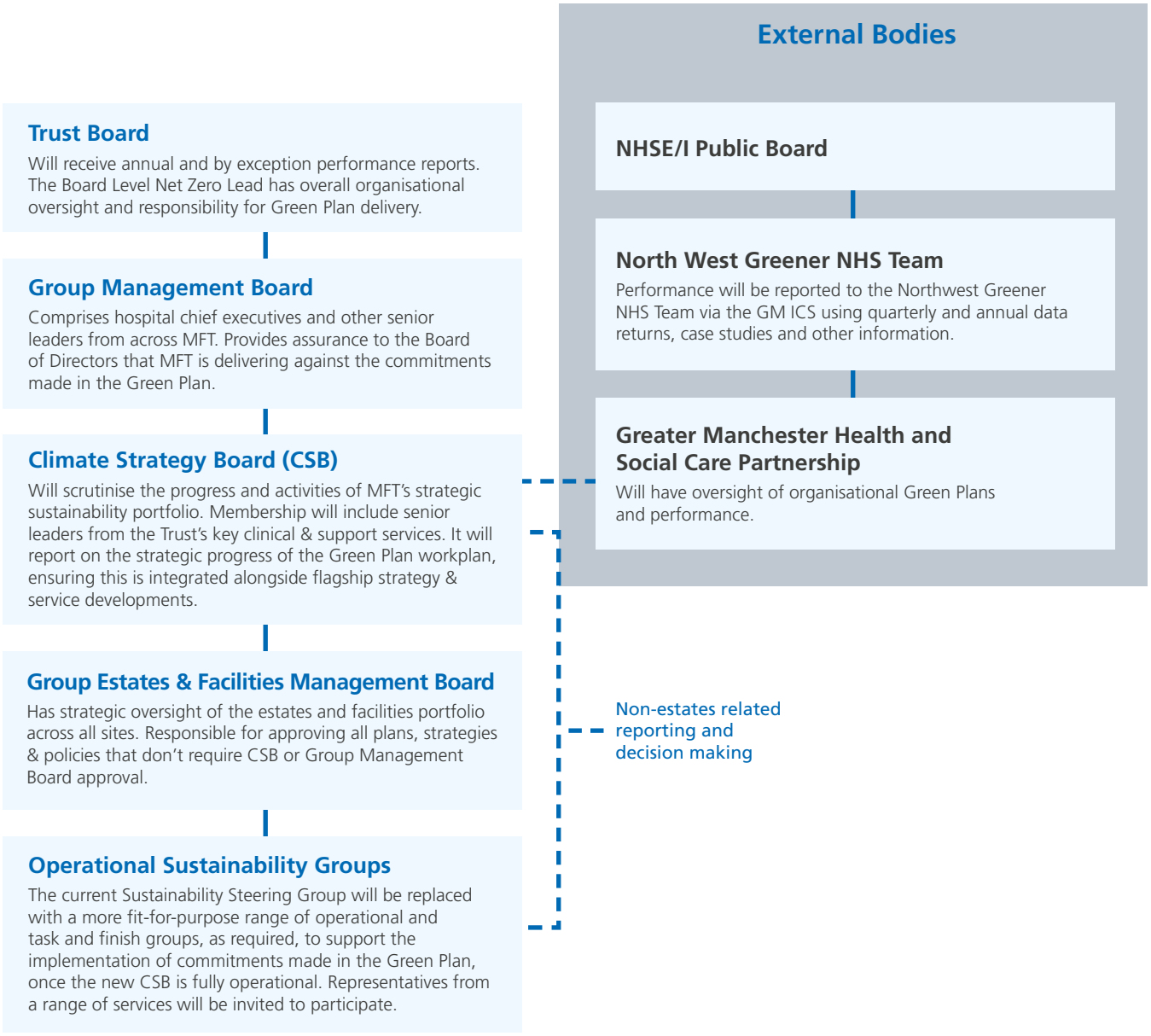
Cross-Cutting Themes

These cross-cutting themes underpin the delivery of our Green Plan commitments. With functional teams tasked with developing and implementing relevant sustainability targets, the themes explain how we maintain oversight, communicate requirements, drive and finance action, and track progress against our stated objectives.

Governance

Clear leadership and accountability are needed to ensure progress against this strategy is delivered consistently, efficiently and at pace across our large and complex Trust.

The development of a new Climate Strategy Board will provide greater opportunity to embed our targeted strategy to meet the net zero carbon agenda in all our work. Expanding this scope into more clinical and management fields, beyond estates and facilities, will enable a much greater cultural shift to meet our ambitious aims.



Tracking Progress

Data is at the heart of tracking the progress of our Green Plan objectives.

We use many data sets, both quantitative and qualitative, to assess performance across our individual hospitals as well as at Trust level. These data sets are collected and analysed with differing frequencies, depending on the availability of the data, complexity of processing and priority of issues. Reports and data submissions are made throughout the year, both internally and externally, and are summarised in a publicly accessible Annual Sustainability Report released each summer. See below for an indicative list of progress tracking mechanisms. Additional requirements may be added or removed over the course of this Green Plan as required locally, regionally, or nationally.

Monthly

Internal Reporting

- Utility data normalised by patient contacts, floor area and degree days
- Waste tonnages compared to historic averages
- Proportion of paper purchased which is recycled paper

External Reporting

- Recycled paper purchased as a proportion of all paper purchased, as reported to Greater Manchester procurement group

Quarterly

Internal Reporting

- Progress report on Green Plan objectives and corresponding workplan to Climate Strategy Board
- Report to Group Estates & Facilities Management Board

External Reporting

- Quarterly data collection, reported to Greener NHS including comparison with ICS and NW peers

Annually

Internal Reporting

- Carbon footprint and carbon footprint plus, including comparison against budget, in the MFT Sustainability Report
- Annual progress of Green Plan Objectives in the Annual Sustainability Report
- Annual Sustainability Report will be made publicly available via MFT's website

External Reporting

- Carbon footprint and Environmental Management Plan review, reported to Investors in the Environment
- Estates & Facilities ERIC and PAM reporting
- Carbon footprint, leadership and resilience reporting against United Nations Race to Zero campaign
- Fleet make-up and mileage reporting to Greener NHS
- Qualitative sustainability reporting through the Greener NHS Green Plan Support Tool

Communications

Engaging and accessible communications are an essential component of our approach to sustainability. The far-reaching measures required to meet our net zero carbon ambitions simply can't be done *to* our staff, they must be done *with* our staff.

To enable this, clear and concise information will continue to be shared through our monthly newsletter, social media presence (@MFTgreen) and Trust intranet pages. There will be specific campaigns and flagship projects. Content will then be disseminated through local channels via the MFT sustainability community who are proactive advocates for sustainable healthcare.

We are a large organisation with a complex structure, and whilst this poses some challenges to communication, it also generates a wealth of opportunities to share lessons between our 28,000 staff members. The experiences and voices of staff members and healthcare partners will be prioritised within our internal and external communications, providing a platform for local sustainability leaders, no matter what their role or responsibility.

Collaboration with colleagues across the Trust will help us to innovate in this area. We will refine our communication methods to ensure they are accessible and tailored to key audiences, making sure no one is left behind in understanding why we need to act, and what they can do. A communications plan will be developed and maintained as a 'live' document to ensure that we maximise the opportunities created through this strategy, and align with key national messaging and campaigns.

Finances

Delivering this strategy will require both staffing and budgetary resources.

It is essential that we remain closely sighted on national, regional and system level financing and grants, as we will not be able to solely rely on leveraging funding from internal budgets.

Whilst the major campus redevelopment schemes provide a huge opportunity to deliver a net zero carbon hospital, we know that the budget will be under pressure and a compelling case will need to be presented for measures with longer term paybacks or no cashable savings.

We also need to invest in our people and ensure that they have the required expertise to understand what net zero carbon means in relation to their area of responsibility. All major business cases need to consider whether they have a positive or negative impact on carbon, and how this can be tackled to enhance the benefits or minimise the disbenefits from the outset. We know that retrofitting costs significantly more than getting measures implemented as part of life cycling and new build.

Our commitments are to:

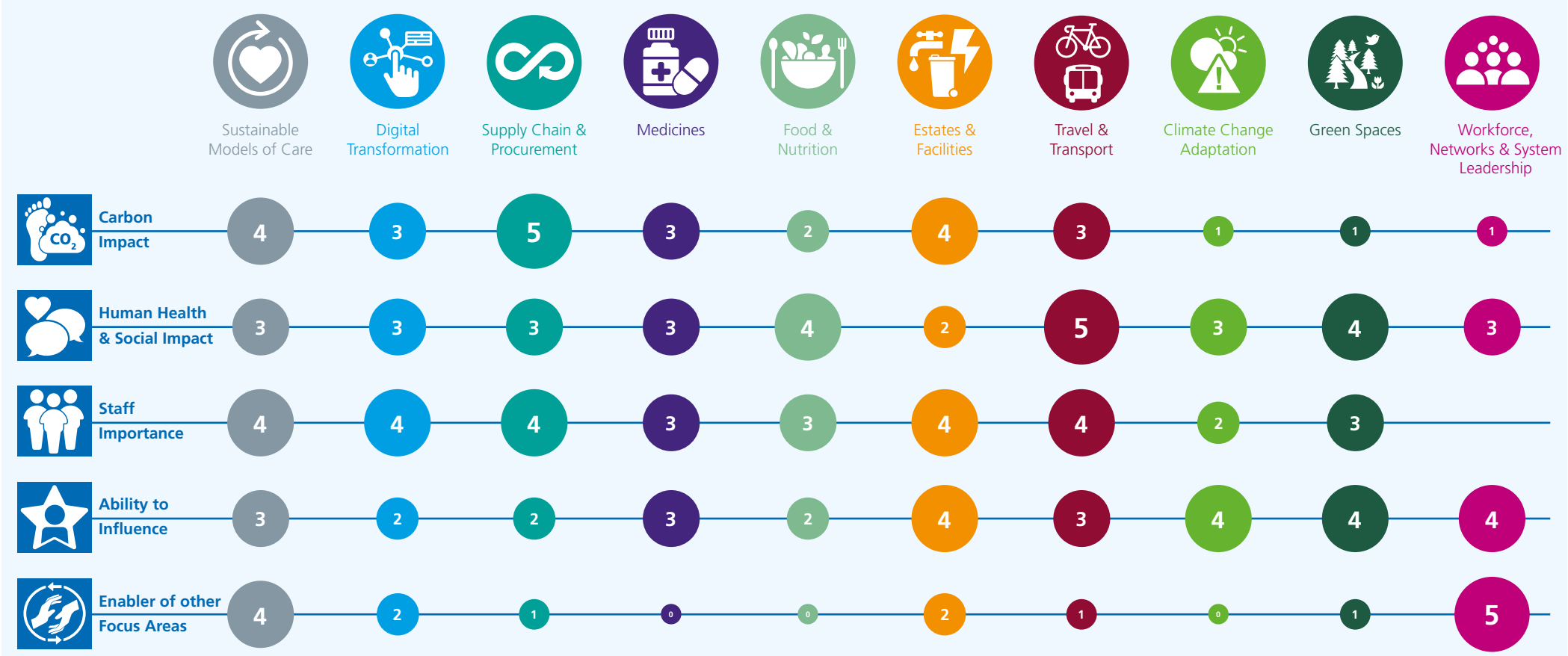
- Have a fully resourced sustainability team to coordinate the sustainability work programme and monitor and report performance, alongside dedicated time from clinicians to lead programmes of work
- Invest in training staff in key positions of leadership and influence
- Purchase utilities, services and products at a competitive rate, whilst using our position as an anchor organisation to influence suppliers, generate wider social value and apply net zero thinking to buying decisions
- Have an annual non-pay sustainability budget that reflects the requirements of delivering the Green Plan annual work programme, whilst retaining some ‘in-year’ flexibility
- Pursue national, regional and system opportunities for funding and grants
- Work closely with our PFI funders and shareholders to maximise benefits and address the challenge of decarbonising the PFI estate
- Ensure that both embodied and in-use zero carbon measures are fully considered and costed into life cycling, refurbishment and new build projects.

Further work will be undertaken on individual programmes to refine costs on a scheme-by-scheme basis.

Materiality

A materiality assessment, which allows us to prioritise the most important areas of focus, was conducted during the development of the Green Plan with the input of wider staff groups. Each area of focus has been assessed against the five criteria outlined below.

Whilst carbon reduction is the principle high level target, this assessment demonstrates how other sustainability issues are also very significant, particularly those which provide wider co-benefits to our health and society. Additionally, our 'ability to influence' identifies the importance of working collaboratively across the healthcare system. This materiality exercise helps us to concentrate our resources in the most appropriate place for each of the areas of focus.



Appendix A: Reporting Measures at a Glance

Area of Focus	Headline Objective	Reporting Measures
Sustainable Models of Care	Pilot the redesign of at least 3 care pathways to reduce carbon.	• CO_2e of avoided travel • PIFU data • Number of staff undertaking training
Digital Transformation	Deliver 35% of all outpatient appointments virtually. Embed circular economy considerations within the procurement and disposal of IT equipment, including the development of reporting metrics.	• % of virtual outpatient appointments • Tonnes of WEEE waste
Supply Chain & Procurement	Apply a social value weighting of at least 10% to all new purchasing contracts and work collaboratively with partners and suppliers to drive down our carbon footprint plus.	• CO_2e from supply chain • Number of staff undertaking training • Recycled paper purchasing data
Medicines	Reduce the carbon footprint of medicines that have a high GWP at point of use (inhalers, medical gases, and anaesthesia).	• CO_2e from medicines • Number of clinical sustainability leads • Sustainability programmed activity (PA) time
Food & Nutrition	Reduce the carbon impact of food, minimise food waste and eliminate unnecessary single use plastics from catering.	• % of plant-based meals/number of meals served • Tonnes of food waste • £ spent on plastic catering consumables/number of items
Estates & Facilities	Reduce carbon emissions from the building estate by at least 30% by 2024/2025 and ensure major schemes are energy efficient and low or zero carbon. Implement innovative treatment technologies for waste and increase the recycling and reuse rate from 17% to 25%.	• Projected CO_2e savings from designed projects • In use CO_2e from buildings • kWh on site renewables generation • Waste tonnage
Travel & Transport	Reduce the carbon emissions of travel and transport activities (business travel, fleet mileage, staff commuting and patient and visitor travel) by 25%. Achieve a "Good" rating for the Clean Air Hospital Framework.	• CO_2e from travel • Cycle parking capacity • Staff commuting modal split

Appendix A: Reporting Measures at a Glance

Area of Focus	Headline Objective	Reporting Measures
Climate Change Adaptation	Ensure our organisation is preparing to deal with the impacts of climate change by delivering and embedding the Climate Change Adaptation Plan (CCAP) and associated action plan.	• £ invested in climate change resilience infrastructure • Over-heating incidents
Green Spaces & Biodiversity	Maximise the quality of on-site green spaces, identifying and delivering schemes that address one or more of the following priorities; improve local biodiversity, support staff wellbeing and/or patient recovery, combat climate change or provide opportunities for social prescribing.	• Number of green space and biodiversity initiatives • Biodiversity value • Number of trees
Workforce, Networks and System Leadership	Continue to educate and engage the workforce to understand the net zero ambition of the NHS. At least 50% of staff with major influence or responsibility for carbon intensive areas to undertake training and/or CPD.	• Number of staff engaged through communications/campaigns • Number of staff and trainees undertaking sustainability training

Appendix B: Historical Data

Historic Data Performance

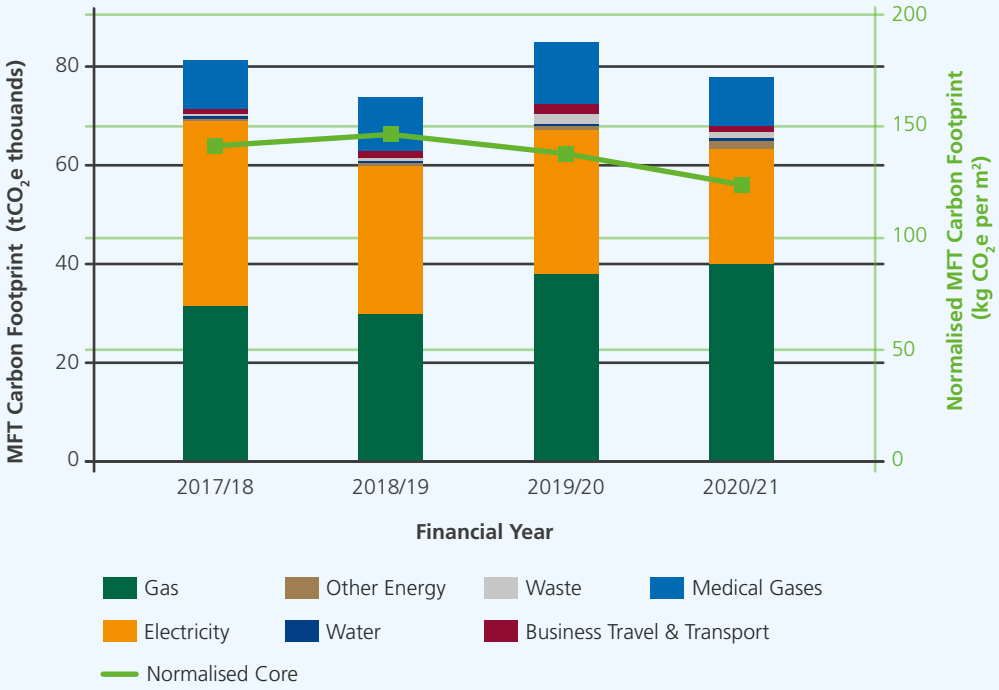
The MFT Carbon Footprint has been measured since its inception in 2017. For this Green Plan, North Manchester General Hospital has also been included in the footprints for 2019/20 and 2020/21 for the purposes of comparison. However, this site was not officially part of MFT until April 2021.

The footprints have been normalised by gross internal floor area to account for the changes in size of the trust over the time period. The normalised MFT Carbon Footprint has been decreasing since 2018/19, while the normalised MFT Carbon Footprint Plus, dominated by supply chain emissions, has increased from 2017/18 to 2019/20, before decreasing in 2020/21. During the pandemic, both footprints decreased in line with changes to normal activity. It is important now to harness positive opportunities that may have come about through pandemic responses.

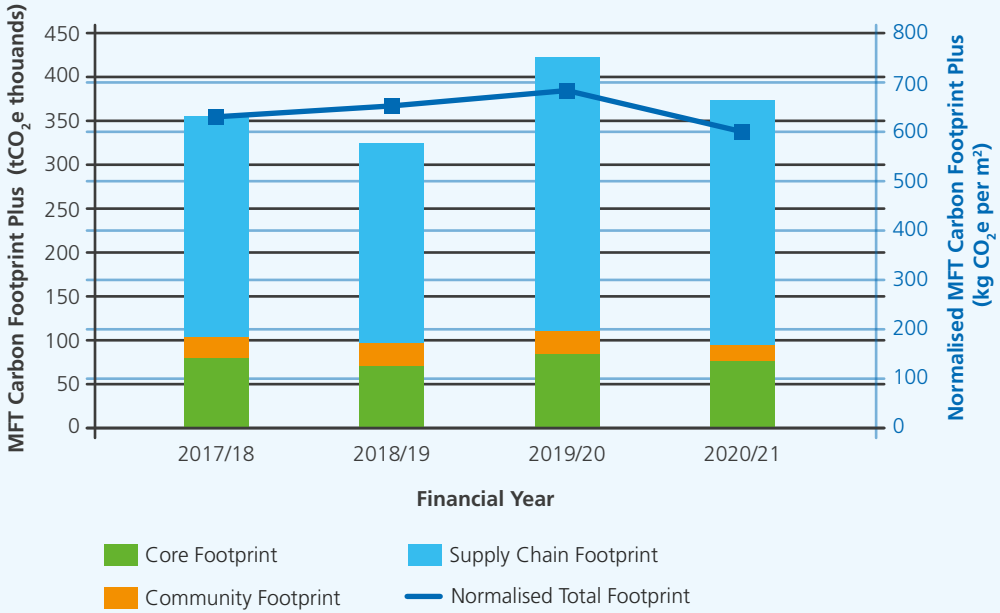
Theme	KPI	Unit	2017/18	2018/19	2019/20	2020/21
Carbon	MFT Carbon Footprint	tCO_2e	81,146	73,444	84,915	77,867
	Community Carbon Footprint	tCO_2e	23,769	23,735	25,790	18,309
	Supply Chain Carbon Footprint	tCO_2e	252,495	228,594	314,274	280,231
	MFT Carbon Footprint Plus	tCO_2e	357,410	325,773	424,978	376,407
	Normalised MFT Carbon Footprint	Kg CO_2e/m^2	142	147	138	123
	Normalised MFT Carbon Footprint Plus	Kg CO_2e/m^2	630	658	689	595
Utilities	Natural Gas Consumption	kWh	147,313,215	142,232,066	180,188,024	189,847,881
	Electricity Consumption	kWh	84,092,708	85,018,408	95,032,414	83,077,135
	On-site Renewable Generation	kWh	70,905	80,477	99,799	86,559
	Water Consumption	m^3	620,335	627,097	800,124	695,866
Waste	Total Waste	Tonnes	6,840	6,953	7,932	7,531
	Healthcare Waste	Tonnes	3,077	3,106	3,670	3,613
	Non-Healthcare Waste	Tonnes	3,763	3,847	4,262	3,918
	Recycling & Reuse	Tonnes	1,176	1,328	1,290	1,429
Travel	Total Fleet Mileage	km	153,182		697,042	579,013
	Total Business Travel Mileage	km	4,186,692	5,112,687	9,405,211	4,192,618
	Modelled Staff Commuting Mileage	km	110,862,889	118,335,755	146,295,961	139,496,383
	Modelled Patient & Visitor Travel Mileage	km	85,636,443	85,636,443	99,625,822	65,645,680

Appendix B: Historical Data

Historic MFT Carbon Footprint



Historic MFT Carbon Footprint Plus



Appendix C: Legislative and Policy Drivers

Drivers provide the legal and policy context for improving sustainability and can be divided into five key groups, as outlined below. This list is not intended to be exhaustive and key documents will be updated and released during the duration of this Green Plan.

1. Legislative

Building Regulations (2010)

Minimum standards for design, construction and alterations to buildings.

Civil Contingencies Act (2004)

Legislative framework for those responsible for preparing and responding to emergencies.

Climate Change Act (2008)

Established powers for the government to ensure that organisations in key sectors are aware of and prepared for the impact of a changing climate.

Environment Act (2021)

Includes provisions to establish a post-Brexit set of statutory environmental principles, a new environmental watchdog and provisions relating to waste, air, water and biodiversity.

Environmental Protection Act (1990)

Defines fundamental structure and authority for waste management and control of emissions into the environment.

Health and Care Bill (2021)

Puts Integrated Care Systems on a statutory legal footing. Integrated Care Boards take on NHS planning functions previously held by clinical commissioning groups (CCGs).

Public Services (Social Value) Act (2012)

Requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Requires minimum 10% weighting for social value on contracts.

The Waste Regulations (2011)

Built on the concept of the waste hierarchy – requires anyone managing waste to prevent, reuse and recycle.

2. Healthcare specific guidance, strategies and policies

Delivering a 'Net Zero' National Health Service

Sets out how the NHS will respond to the climate and health emergency and provides a robust analytical process regarding how the health system can reach net zero carbon.

Fair Society, Healthy Lives (The Marmot Review)

Report concludes that reducing health inequalities requires action on six policy objectives including health and sustainable places and communities.

Greener NHS Programme delivery reports and regional Memorandum of Understanding (MOU)

National programme working to deliver the NHS Net Zero Plan, engage the workforce and share learning to reach net zero across the healthcare system.

Health Technical Memoranda and Health Building Notes

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

NHS Constitution

The principles and values of the NHS in England. Expected to be updated in 2022 to embed climate change considerations.

NHS Long-Term Plan

A 10-year plan to ensure that the NHS is fit for the future.

NHS Operational Planning and Contracting Guidance – current version

Sets out priorities for the year including system planning, operational plan requirements, workforce transformation requirements, financial settlements and process and timescale for submission of plans.

NHS Standard Contract – Current Service Conditions for Sustainable Development

Mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

NHS X – What Good Looks Like

Builds on established good practice to digitise, connect and transform services safely and securely.

Appendix C: Legislative and Policy Drivers

Public Health Outcomes Framework

Sets out a vision for public health to improve and protect the nation's health and improve the health of the poorest fastest.

Report of the Independent Review of NHS Hospital Food

Highlights the main challenges for NHS catering and makes recommendations including sustainability.

Third Health and Care Adaptation Report

Summarises the current and future effects of climate change on the sector and outlines practical next steps to build resilience and adaptation.

3. International guidance and agreements

Glasgow Climate Pact

An agreement reached at COP26, the 2021 United Nations Climate Change Conference.

Intergovernmental Panel on Climate Change Global Warming of 1.5°C Report

A special report on the impacts of global warming of 1.5 degrees.

Paris Climate Change Agreement

A legally binding international treaty on climate change, adopted in 2015.

The Global Climate and Health Alliance

An alliance of health NGOs, health professional organisations, and health and environment alliances from around the world. Includes Healthcare without Harm, UK Health Alliance on Climate Change and Centre for Sustainable Healthcare.

UNFCCC Race to Zero campaign

A global campaign to rally leadership and support from businesses, cities, regions, investors for a healthy, resilient, zero carbon recovery.

United Nations Sustainable Development Goals

A call for action for all countries to promote prosperity while protecting the planet. Includes 17 goals to transform the world.

World Health Organisation: European Policy for Health and Wellbeing

Supports health and wellbeing of populations and ensure people-centred health systems are universal, equitable, sustainable and of high quality.

4. UK strategy and guidance

A Green Future: 25 Year Plan to Improve the Environment

Sets out government action to help the natural world regain and retain good health.

Clean Air Strategy 2019

Sets out plans for dealing with all sources of air pollution.

Greening Government: ICT and digital services strategy 2020-2025

Strategy setting out how government can provide responsible and resilient ICT and digital services to all its end users and customers.

Government Buying Standards

Sets out minimum, mandatory Government Buying Standards (GBS) for buying goods and services.

HM Treasury's Sustainability Reporting Guidance

Assists those in the public sector to report on sustainability within annual reports and accounts.

National Adaptation Programme 2018-2023

Sets out the actions that government and others will take to adapt to the challenges of climate change in England.

National Policy and Planning Framework

Sets out the government's planning policies for England.

Net Zero Strategy: Build Back Greener

Sets out policies and proposals for decarbonising all sectors of the UK economy.

Procurement Policy Notes (PPN)

Provides best practice for public sector procurement, including social value and carbon reduction plans.

Resources and Waste Strategy

Sets out how we will preserve material resources by minimising waste, promoting resource efficiency and moving towards a circular economy in England.

The Stern Review 2006: The Economics of Climate Change

Established principle that the benefits of strong and early action on climate change far outweigh the economic costs of not acting.

UK Climate Change Risk Assessment (CCRA) 2017

Sets out risk and opportunities facing the UK from climate change.

Appendix C: Legislative and Policy Drivers

5. Greater Manchester; local strategies and plans

GMCA 5-Year Environment Plan for Greater Manchester 2019-2024

Sets out the aim and priorities for Greater Manchester to be a carbon neutral city region by 2038.

Greater Manchester Local Industrial Strategy

Designed to deliver an economy fit for the future.

Greater Manchester Transport Strategy 2040

Sets out Greater Manchester's long-term ambition for transport.

Green and Blue Infrastructure Strategy for Manchester

Sets out the city's strategy for high quality green and blue infrastructure as an essential part of successful, liveable cities.

Manchester Climate Change Framework 2020-2025

Manchester's high-level strategy for tackling climate change.

Manchester Population Health Plan 2018-2027

The city's overarching plan for reducing health inequalities and improving health outcomes for residents.

Our Manchester – The MCR strategy 2016-2025

Sets out a long-term vision for Manchester's future and describes how we will achieve it.

Places for Everyone

A joint development plan for 9 of the 10 GM districts for jobs, new homes and sustainable growth. Replaced the Greater Manchester Spatial Framework.

Natural Capital Investment Plan

GM has developed a series of natural capital tools and resources and a series of programmes, projects and policies.

Trafford Council Carbon Neutral Action Plan

Sets out Trafford's priorities for carbon reduction.

Appendix D: Glossary

Climate change is a long-term shift in global temperatures and weather patterns. Human activity causes higher volumes of greenhouse gases (GHGs) to be released into the atmosphere. Different GHGs have a stronger or weaker effect on global temperature changes, so GHG emissions are measured in tonnes of carbon dioxide equivalent (tCO_2e) – the equivalent amount of carbon dioxide (CO_2) in tonnes that would have to be released to cause the same warming effect as the emitted GHGs.

To measure the impact that MFT has on climate change, we count the GHGs emitted as a result of our activity – this is called our carbon footprint.

1. Air Quality: the extent to which air is pollution-free. Poor air quality is damaging to human health, particularly children, the elderly and those with existing medical conditions. Major pollutants are emitted as a result of human activity, especially from fossil-fuelled transport and industry.
2. Anchor Institution: a large organisation with a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, buildings and land use.
3. Backlog Maintenance: the process of restoring buildings and estates up to a minimum physical condition, therefore optimising safety, and efficiency.
4. Biodiversity/Biodiversity Net Gain: the variety of life found in a particular space, including plants, animals, bacteria, and fungi. Generally, a high level of biodiversity denotes a healthy ecosystem. Biodiversity net gain is an approach to development which seeks to enhance the biodiversity of an area.
5. Carbon Budget: the maximum amount of carbon dioxide (CO_2) or carbon dioxide equivalent (CO_2e) that can be emitted over a defined period of time to limit the impacts of climate change to a specific global average temperature. Carbon footprint: A measure in tonnes of carbon dioxide equivalent (tCO_2e) of the greenhouse gases (GHGs) emitted by an individual, organisation, service or product. For definitions of NHS Carbon Footprint & NHS Carbon Footprint Plus, see Delivering A Net Zero National Health Service.
6. Carbon Neutrality: the balance between emitting carbon and absorbing carbon emissions from carbon sinks.
7. Carbon Dioxide (CO_2): a gas present in the atmosphere that is produced when carbon or organic matter, such as fossil fuels, are burned. Carbon dioxide is a prominent greenhouse gas (GHG), and increased levels of carbon dioxide in the atmosphere lead to climate change.
8. Clean Air Hospital Framework: a self-assessment tool to set ambitions on tackling air pollution in seven key areas. https://www.actionforcleanair.org.uk/clean-air-hospital-framework
9. Circular Economy: a model of production and consumption which maximises the useful life of resources through reuse, repair, refurbishment, sharing, leasing, and recycling.
10. Climate Change Adaptation: action to prepare for the current or expected impacts of climate change, in the short, medium, and long term.
11. Climate Emergency: political declaration to acknowledge the severe acceleration of human caused climate change and the dangers this causes.
12. Care Pathway: a tool used by the NHS to map out a patient journey from diagnosis and through treatment. They are used to set out best practice and enable the delivery of consistently high quality care to patients. To read more visit https://digital.nhs.uk/services/nhs-pathways
13. Co-benefit: the positive effects that a policy or measure aimed at one objective might have on other objectives, e.g. Active travel reduces air pollution and benefits health and wellbeing.
14. Desflurane: volatile anaesthetic drug used for general anaesthesia, with a global warming potential over 2,500 times higher than CO_2.
15. Digital Exclusion: individuals being unable to benefit from digital services due to one or more barriers, including: access, skills, confidence, motivation, ease of use, and awareness. To read more visit Digital NHS https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is
16. Electrical Capacity: the maximum threshold of electricity a site can use at any one time.
17. ERIC: the Estates Return Information Collection collates information on the running costs of providing, maintaining and servicing the NHS Estate https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2019-20
18. Getting it Right First Time: helps to improve the quality of care within the NHS by bringing efficiencies and improvements. https://www.gettingitrightfirsttime.co.uk

Appendix D: Glossary

19. Greenhouse Gases (GHGs): gases found in the atmosphere which trap heat. Many of these gases are emitted as a result of human activity, and when accumulated in the atmosphere, they cause global climate change. Carbon dioxide (CO_2), water vapour and methane are the most prevalent greenhouse gases. In the healthcare sector, volatile anaesthetics and medical gases are also significant.
20. Green Infrastructure: planned natural or semi-natural areas which enhance the environment by improving water quality, air quality, climate change mitigation and adaptation, biodiversity, as well as providing space for recreation/leisure.
21. Greener NHS: a campaign to tackle the climate 'health emergency' including a national team to support the programmes of work which is part of NHSE/I https://www.england.nhs.uk/greenernhs
22. Health Equity: the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).
23. Health Inequalities: unfair and avoidable differences in health between different groups in society, defined socially, economically, demographically, and geographically.
24. HIVE: a new 'operating system' for MFT, replacing current IT systems including a new electronic patient record (EPR) solution. https://mft.nhs.uk/hive-epr/
25. Integrated Care System: partnerships between health organisations within a geographical area to collectively plan health and care services to meet the needs of their population and tackle health inequalities.
26. Life-cycling: considering the environmental, social, and economic impacts of a product or service through the entirety of its life, from extraction to disposal. Term also used in a PFI context in relation to asset management and maintenance.
27. Natural Capital: stocks of natural assets which include geology, soil, water, air and all living things. It is from natural capital than humans derive a wider range of services, often called ecosystem services, which make life possible.
28. Net Zero Carbon: greenhouse gas (GHG) emissions produced are balanced with emissions removed from the atmosphere. Emissions produced are reduced as close to zero as possible, and anything remaining is offset.
29. Patient Initiated Follow Up: gives patients and their carers flexibility to arrange follow-up appointments as and when they need them, avoiding unnecessary trips to hospitals and clinics. https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/
30. Power Purchase Agreement: long term contract between a power producer and a consumer of electricity.
31. Premises Assurance Model (PAM): a management tool that provides NHS organisations with a way of measuring how well they run their estates and facilities services.
32. Private Finance Initiative (PFI): a method of funding major capital investments, where private firms are contracted to complete and manage public projects.
33. Same Day Emergency Care: sometimes called ambulatory care, emergency care is clinical care which is not provided within the traditional hospital bed base. https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/
34. Science Based Approach/Targets: approaches or targets which align with latest climate science, usually the Paris Agreement to limit global average temperature rise to well below 2°C.
35. Single Hospital Service: aimed outcome from the MFT merger, allowing standardised care across Manchester and Trafford, maximising the opportunity to increase research and education, reduce duplication, integrate patient record systems, and recruit and retain the best staff. More information can be found here https://mft.nhs.uk/2017/09/28/single-hospital-service/
36. Transport Mode: the type of transport used to travel, including: walking/running, cycling, bus, Metrolink, train, single occupancy car, car share etc. The most sustainable travel modes are active travel (walking/running and cycling) and the use of public transport.
37. Social Prescribing: method of local referral to holistic care focusing on a patient's health and wellbeing., usually instigated in a community setting.
38. Social Value: socio-economic and environmental benefits delivered through the procurement of goods or services.
39. Sustainable Quality Improvement: an approach to improving healthcare in a holistic way by assessing quality and value through the lens of a 'triple bottom line'. https://sustainablehealthcare.org.uk/susqi
40. Sustainability Impact Assessment: a formal evaluation of economic, social and environmental impacts of any project or proposal.
41. Trajectory: the projected path of future emissions, often designed to stay within a certain carbon budget.
42. Ultra Low Emissions Vehicles (ULEV)/Zero emissions vehicles (ZEV): motorised vehicles which emit zero or close to zero carbon dioxide (CO_2) during use.

Contact Us

If you have any questions, or would like to find out more about the work that we are doing please contact us via email: ECOteam@mft.nhs.uk or follow us on Twitter: @MFTgreen

This document was produced by the Energy & Sustainability Team at Manchester University NHS Foundation Trust:

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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:	January 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

NHS England Appointments

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

Integrated Care Systems

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

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

- housing and home adaptations
- technology and digitisation
- workforce training and wellbeing support
- support for unpaid carers, and improved information and advice
- innovation and improvement.

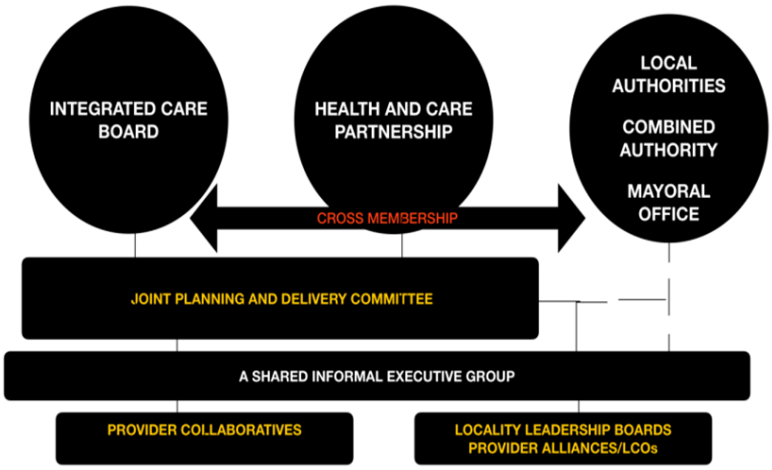
A further White Paper on integrating health and social care is expected in the new year.

At the time of writing there is a strong suggestion that the implementation of ICSs may be delayed by at least 3 months.

3. Regional Issues

Greater Manchester ICS

The shadow governance arrangements for the Greater Manchester ICS are as set out below.



A draft constitution for the GM Integrated Care Board has been submitted to NHS England for approval. It proposes the following membership:
Chair
Chief Executive
Director of Finance
Medical Director
Director of Nursing
Two independent non-executive members.
Partner members (one) representing each of:

- NHS Providers
- Local Authorities
- Primary Medical Services

GM proposals to appoint additional members are under consideration but will depend on what is allowed in the legislation.

The process to appoint to the executive director posts is in train. The process to appoint the NHS provider partners members is via nomination through the Greater Manchester Provider Federation Board and finalised by the Chair.

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

The ten localities in Greater Manchester are continuing to develop their own local proposals for how they will work together from April 2022. In order to ensure some level of consistency, some core features have been defined at GM level. These include a Locality Board, a place-based lead, an accountability agreement with the ICS, a mechanism for deciding priorities and determining funding flows, clinical and professional advisory input and a defined relationship with the local Health and Wellbeing Board.

4. MFT issues

<u>MFT Clinical Service Strategy</u>

Cancer Strategy

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

5. Actions / Recommendations

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	January 2022
Subject:	Annual Planning 2022/23 – MFT Vision and Strategic Aims
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to – Note the process undertaken to update the strategic aims – Approve the proposed revised strategic aims – Support the provisional annual planning timetable, recognising that this may shift due to Omicron.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

Following approval by the Board in November to undertake a review of the existing strategic aims, we have sought views from across the organisation and, based on the feedback, developed a proposed updated set of strategic aims.

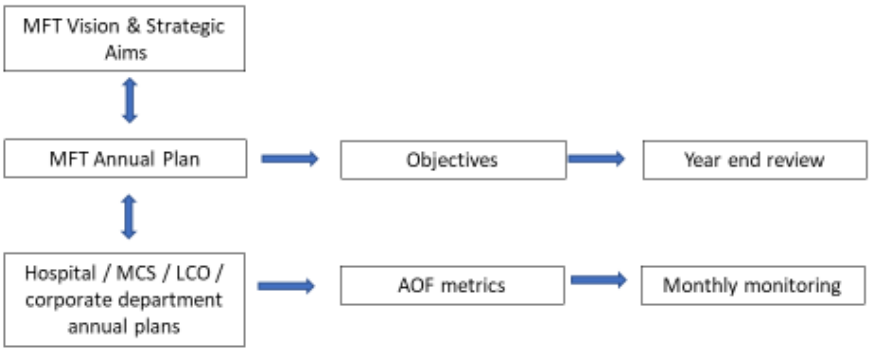
The purpose of this paper is to describe how the strategic aims fit with the annual planning cycle, seek approval for the updated aims and set out the draft timetable for the annual planning process for 2022/23.

2. MFT Strategic Aims

The MFT vision describes where the organisation is going and what it will look like when it gets there. The vision is made up of two elements; the vision statement and a series of strategic aims. The strategic aims flesh out the vision statement but are still set at a high level and describe a general direction of travel.

The main purpose of the strategic aims is to provide the framework for the development of our annual plans each year; they are the golden thread that helps to ensure that the whole of the organisation is working towards the same goals.

The strategic aims are designed to be in place over multiple years. Through the annual planning process, the Hospitals, Managed Clinical Services (MCSs), Local Care Organisations (LCOs) and corporate departments identify specific objectives and milestones to be delivered in-year that will contribute towards the achievement of the aims. The delivery of these more specific objectives is tracked and measured both during and at the end of the year as shown below.



3. Updating MFT Strategic Aims

Following agreement by the Board to update the current version of the strategic aims (see attachment A), a process of engagement with Directors, staff and governors was undertaken.

There was general support for the following suggested changes:

- To highlight access to care as a key part of quality and to refer to the recovery programme – both have become more important following the pandemic
- To reflect that improvement to patient safety and patient experience is a continuous process, not a one-off
- To reflect the importance of workforce – being a great place to work and developing skills
- To drop the aim on achieving the SHS because this has been delivered but to still reflect the need to deliver the benefits associated with the scale, size and complexity of the Group

- To add the need to maintain, as well as achieve, financial sustainability
- To add innovation as part of the research aim
- To add an additional aim around working in partnership and addressing health inequalities.

The following additional suggestions were made by members of the Board of Directors and the Group Management Board:

- Strengthen the aim on patient safety
- The need to translate delivery of the People Plan into action
- Refer to compassionate leadership and the importance of staff health and wellbeing
- Reflect the ambition to be a leader in our field
- Reflect the fact that MFT provides both community and acute services
- Add a reference to using technological advancement to support staff with improving patient care
- Refer to wider social value as well as health inequalities
- Refer to a more collaborative relationship with our patients and other healthcare providers to address poor outcomes due to health inequalities
- Refer to the Green strategy, EPR implementation and estates strategy
- Include more specificity on where we want to get to e.g., R&I

Given the breadth of MFT, the list of potential aims is long and there is therefore a need to prioritise. We also need to balance trying to give a simple message that resonates with staff and the public, with comprehensively reflecting all that we aim to do.

The proposed updated strategic aims are set out below.

- 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

Generally, we have tried to focus on what we are aiming to achieve, rather than how. How the aims will be achieved will be reflected in the annual objectives as described in section 2. For example implementation of the EPR will be a major undertaking for MFT next year. We would therefore expect objectives related to the implementation of the EPR to feature heavily in the annual plan for 2022/23, under the aim of improving patient safety.

The other main changes have been to:
- Strengthen the patient safety aim to reflect its importance
- Include two aims related to the workforce to reflect the fact that without our workforce none of this is possible.
- Expand the new aim around health inequalities to cover wider social value type issues
- Distribute the aim to achieve of the benefits of the SHS across the aims on social value, service development and workforce.

The table appended at attachment B describes the original aims, the proposed new aims and some comments on the proposed changes and their rationale.

Achievement of the aims is tracked through the updating process. Any aim that has been fully achieved would be removed, as was the case this year when the aim to create the Single Hospital Service was removed. Achievement of most of the aims will be incremental with progress being made each year. Due to their nature some will never be fully achieved as there will always be more that we can do.

4. Annual Planning Process 2022/23

The draft timeline for the annual planning process through which the strategic aims will be translated into specific objectives and actions for delivery in 2022/23 is set out below. However, we strongly suspect that the impact of Omicron and the need to focus our efforts towards supporting frontline staff and stand down non-essential activities will mean that the national timetable will be moved back. Although this would make sense operationally, it would mean that we would need to review our own timetable and adjust the key dates accordingly, including the timing of the annual planning session with the Council of Governors.

National planning guidance issued	24 December 21
Board approval of revised strategic aims	10 January 22
Hospital / MCS / LCO draft priorities for 22/23 completed based on revised strategic aims	28 January 22
CoG annual planning session	9 February 22
Draft Annual Plan circulated for comment	March 22
Annual Plan approved by Board of Directors	April 22

5. Actions/recommendations

The Board of Directors is asked to:

- Note the process undertaken to update the strategic aims
- Approve the proposed revised strategic aims
- Support the provisional annual planning timetable, recognising that this may shift due to Omicron.

Attachment A

Current MFT Vision

Our vision is to improve the health and quality of life of our diverse population *by building an organisation that:*
Excels in quality, safety, patient experience, research, innovation and teaching,
Attracts, develops and retains great people, and;
Is recognised internationally as a leading healthcare provider.

This is underpinned by our strategic aims, which are:

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

Attachment B

Original aims	Proposed new aim	Comments
To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner		This has been removed as the SHS has now been achieved. The delivery of the SHS benefits is distributed across the aims on service development, social value and workforce.
To improve patient safety, clinical quality and outcomes	To focus relentlessly on improving access, safety, clinical quality and outcomes	Patient safety is the first aim reflecting its importance and reinforcing the message that this is our priority above all. Access is included as it is viewed as a key part of quality. Pre-COVID access was taken for granted but post-COVID, we must strive to give patients access. Operational standards were always intended to enable safety and quality; but post-COVID this is even more important from a safety perspective.
To improve the experience of patients, carers and their families	To improve continuously the experience of patients, carers and their families	Refers to continuously to reflect that improvement is not one-off
To develop our workforce enabling each member of staff to reach their full potential	To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	Addresses the challenge of attracting and retaining staff
	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	Addresses the well-being and development of the workforce including the widened opportunities for staff following the creation of the SHS
To develop single services that build on the best from across all our hospitals	Use our scale and scope to develop excellent integrated services and leading specialist services	Refers to scale and scope. Scale to reflect our expanded size following the creation of the SHS and scope to reflect the fact that we provide community, acute, specialised and adult and children's services. Integrated covers all types of integrations children and adults, community and acute. Addresses the ambition in the vision statement to be a leader in our field.
To develop our research portfolio and deliver cutting edge care to patients	To develop our research and innovation activities to deliver cutting edge care that reflects the needs of our patients	Reflects our ambition around research and innovation linked to the needs of our diverse population

To achieve financial sustainability	To achieve and maintain financial sustainability	Covers not only achieving but also maintaining financial sustainability
	To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	Addressing health inequalities covers the work on neighbourhoods undertaken in the LCO and the work to address inequalities in acute services through the Health Inequalities Group. This aim also incorporates our contribution to the wider social value and green agendas as an anchor institution.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Group Director of Patient Safety / Patient Safety Specialist
Date of paper:	January 2022
Subject:	Patient and Public Involvement in Patient Safety
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	To improve Patient Safety, Clinical Quality and Outcomes
Recommendations:	The Board of Directors is asked to note the approach being taken to the implementation of the Patient and Public Involvement in Patient Safety Framework at the Trust, and the early progress being made. The Board of Directors is asked to approve the statement of commitment. The Board of Directors is asked to note the strategic approach supported by the Communications team planned in relation to the publication of the statement of Commitment.
Contact:	Name: Tanya Claridge, Group Director of Patient Safety / Patient Safety Specialist Tel: 0161 276 8764

1. Introduction

This paper and the proposed approach is recommended to the Board of Directors following approval at the Group Quality and Safety Committee in October 2021.

The NHS Patient Safety Strategy[1] (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety. Published in June 2021, the National Patient and Public Involvement in Patient Safety Framework[2] sets out how NHS organisations should involve patients in patient safety.

The framework is divided into two parts. Part A reinforces the need to involve patients in their own safety, through considering inequalities in health care safety, communication and empowering (and enabling) patients to take more responsibility for the safety of their healthcare. Part B describes the requirement for Patient Safety Partner (PSP) involvement in patient safety. PSP involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. Suggested roles for PSPs can therefore include, for instance:

- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- Involvement in patient safety improvement projects
- Working with organisation boards to consider how to improve safety
- Involvement in staff patient safety training
- Participation in investigation oversight groups

The Trust has established a sub-group of the Group Patient Safety Committee to lead the implementation of the framework across the Trust, the sub-group has representation from across the sites/MCS/LCO and corporate teams, including the equality and diversity team. The sub-group has developed an action plan to ensure the principles of the framework are implemented by June 2021. The Sub-group provides monthly updates in relation to progress being made to the Patient Safety Committee and by exception to the Group Quality and Safety Committee.

2. Early requirements to support the implementation of the Patient and Public Involvement Framework at Manchester University NHS Foundation Trust

There are two key required elements to the early work required to support the implementation of the framework, one is to understand the culture of the organisation, and its readiness to meaningfully involve patients in their care and the readiness to involve patient safety partners in organisational patient safety. The Trust has developed and validated a patient safety culture assessment tool (using a previously developed tool as a basis). One of the key dimensions of the tool is patient and public involvement, and this is now being used across the Trust to support the identification of where there are opportunities for change and improvement in our

[1] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

[2] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-summary-framework-for-involving-patients-in-patient-safety.pdf

readiness. This is an important element of 'socialising' the requirements of the framework with staff.

The second element is the publication of an expressed Board Commitment to patient and public involvement. Consultation with the members of the Patient Safety Committee and with support from the Communications team has resulted in the development of the following statement, presented here for approval.

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

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

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

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

Board of Directors, Manchester University NHS Foundation Trust

It is anticipated that a specific page of the intranet will be dedicated to commitment, with examples of how patient and public involvement has been used to improve and transform patient safety across the Trust, together with contact details and information about the Trust's Patient Safety Partner Programme as it is developed. This publication will be supported by a specific communications strategy.

3. Recommendations

The Board of Directors is asked to note the approach being taken to the implementation of the Patient and Public Involvement in Patient Safety Framework at the Trust, and the early progress being made.

The Board of Directors is asked to approve the statement of commitment.

The Board of Directors is asked to note the strategic approach supported by the Communications team planned in relation to the publication of the statement of Commitment.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing David Wright, Macmillan Lead Cancer Nurse, Cancer Services Philip Bryce, Macmillan Matron, Cancer Services
Date of paper:	January 2022
Subject:	Report of the results of the National Cancer Patient Experience Survey (2020).
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	This report reflects and supports the work of cancer teams to deliver the MFT Vision and Values with regards to: - Everyone Matters - Dignity and Care - Open and Honest
Recommendations:	The Board of Directors is asked to note the feedback and the opportunity for improvements in patient experience.
Contact:	Name: David Wright, Macmillan Lead Cancer Nurse Tel: 07971030036

1 Executive summary

1.1. The National Cancer Patient Experience Survey (NCPES) is designed to monitor national progress on cancer care and is scheduled on an annual basis as outlined in the 'National Cancer Strategy: Achieving World Class Cancer Outcomes', (2015). The NCPES (2020) is the 10th iteration of the survey since 2010.

1.2. Due to the pressure COVID-19 placed on the NHS, the 2020 NCPES was offered to all NHS Trusts on a voluntary basis; 55 Trusts (of 139) took up the offer, including MFT. For this reason, it is not possible to produce a national level report or reports at cancer alliance or CCG level, or for national comparisons to be made against previous years.

1.3. Participating Trusts received their results from the 2020 survey with comparisons to their previous NCPES results on 11th November 2021[1]. Actions taken as a result of this survey will not directly impact on the 2021 survey outcomes as fieldwork had already commenced at the time the 2020 survey was published. Eligible participants, i.e., all adult patients (aged 16 and over), with a confirmed diagnosis of cancer, who have been admitted to hospital as inpatients for cancer related treatment, or who were day case patients for cancer related treatment and have been discharged between 1st April 2021 and 30th June 2021 are currently responding to the survey between November 2021 and January 2022, with results available in Spring 2022. All NHS Trusts are participating in the 2021 survey.

1.4. The 2020 NCPES survey was carried out from 29 April to 8 July 2021. The survey results are a snapshot in time and give a specific insight into the impact of the pandemic on the experience of patients with cancer. It should be noted that during the sampling period there was variation in the effects of the pandemic in different parts of the country that also impact comparisons at a Trust level.

1.5. The survey was overseen by the national Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. The survey was commissioned and managed by NHS England.

1.6. The results of the NCPES (2019) were published on 11th November 2020 by the external provider (Picker), who are commissioned by NHS England and are responsible for designing, running, and analyzing the survey.

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[1] : https://www.ncpes.co.uk/wp-content/uploads/2021/11/CPES-2020-Trust-Manchester-University-NHS-Foundation-Trust-R0A.pdf

1.7. Nationally, out of 33,266 people, 19,610 people responded to the survey, yielding an overall response rate of 59%. MFT's response rate was 55%.

2 Purpose of the paper

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

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

2.1 The survey is open to adult NHS patients (aged 16 years and above) with a confirmed primary diagnosis of cancer, that have been discharged from the Trust after either an inpatient or day case episode for cancer related treatment during the months of the survey.

2.2 The voluntary participation resulted in reduced data for all the Trusts across Greater Manchester, or across all the Shelford Trusts, therefore no direct comparison can be made with the available results. Four of ten Shelford Group Trusts took part; five GM Trusts took part.

2.3 Tumour group specific information is only available where eleven or more responses have been received.

2.4 It must be noted that North Manchester General Hospital (NMGH) had not joined MFT at the time the survey was undertaken. The Cancer team will ensure that actions taken as a result of the MFT survey reflect internal recommendations at NMGH based on other intelligence. NMGH results cannot be disaggregated from Pennine Acute Hospitals NHS FT results.

3 Methodology and Sample

3.1 The NCPES methodology usually reflects the CQC standard for reporting comparative performance, based on the calculation of 'expected ranges'. This methodology flags Trusts as outliers only if there is statistical evidence that their scores deviate from the range of scores that would be expected for Trusts of the same size. The results of the 2020 survey do not provide expected ranges. However, the results are meaningful and

will be used to inform the development of the MFT Cancer Strategy, currently under development and due to be launched in late Spring 2022.

3.2 The sample size for the NCPES (2020) MFT, was 880 patients, with a response rate of 55% (484 patients), 4% below the national response. This was no change from the 2019 survey response rate of 55%.

3.3 Table 1 shows the Trust's sample size and survey response rate. The gender distribution is shown at Table 2.

	2019		2020	
	MFT	**National**	**MFT**	**National**
Sample size	1,260	111,366	880	33,266
Completed	697	67,858	484	19,610
Response rate	55%	61%	55%	59%

Table 1. Sample size & response rate

	2019	2020
Gender	**Respondents**	**Respondents**
Male	329 (47%)	216 (45%)
Female	368 (53%)	254 (55%)
Total	**697**	**484**

Table 2 gender distribution

3.4 The 2020 survey contains information relating to ethnicity for the first time. 92% of responders identified as white British, 2% declined to answer, and 6% identified across the other ethnicity groups. The City of Manchester has the highest proportion of non-white people of any district in Greater Manchester and therefore the results are not reflective of the population served in Manchester and Trafford. A key theme under development as part of the MFT Cancer Strategy, is inequalities and access, where the survey results will be considered, and work commenced to address. Table 3 below, shows a breakdown of ethnicity:

Ethnicity	**Number of responders**
White British	
English/Welsh/Scottish/Northern Irish/British	423
Irish	10
Gypsy or Irish Traveller	0
Any other white background	10
Mixed/ Multiple Ethnic Groups	
White and Black Caribbean	2
White and Black African	0

White and Asian	0
Any other Mixed/multiple ethnic background	0
Asian or Asian British	
Indian	6
Pakistani	8
Bangladeshi	2
Chinese	3
Any other Asian background	3
Black/African/Caribbean/Black British	
African	3
Caribbean	2
Any other Black/African/Caribbean background	0
Other Ethnic group	
Arab	2
Any other Ethnic background	1
Not given	
Not given	9

Table 3. Respondents by ethnicity

3.5 Table 4 shows the age profile of the Trust's survey sample with the single highest age range of respondents identified as 65-74 years, with a total of 83% of respondents aged between 55-84 years. This is comparable to the age profile of the survey sample in 2019, when 81% of respondents were aged between 55-84 years.

AGE	2019			2020		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
16-24	0	2	2	2	0	2
25-34	3	6	9	2	3	5
35-44	4	13	17	5	14	19
45-54	24	42	64	14	29	44
55-64	70	75	145	27	65	94
65-74	135	144	279	87	93	185
75-84	93	86	179	79	50	135
Total	**329**	**368**	**697**	**216**	**254**	**484**

Table 4. Age groups

3.6 The largest number of responses were from patients in the Lung, Breast and Haematology tumour groups, constituting 55% of the Trust overall response rate. This is consistent with the 2019 survey results when the same three tumour groups also accounted for the largest cohort of responses, constituting 56% of the total number. These cancer services are three of the largest by diagnosis at MFT.

Table 5 provides the number of responses by Tumour Group.

Tumour group	2019 Number of responses	2020 Number of responses	% change from 2019 - 2020
Brain & CNS[2]	0	0	N/A
Breast	116	78	-33%
Haematology	130	111	-15%
Upper GI[3]	27	25	-7%
Gynaecology	34	25	-26%
Urology	51	46	-10%
Prostate	35	15	-57%
Colorectal	63	20	-68%
Head& Neck	25	10	-60%
Sarcoma	5	5	No change
Lung	147	79	-46%
Skin	16	12	-25%
Other	48	56	+17%

Table 5. Results by Tumour Group

4. Trust Results

4.1 The 52 questions in the 2020 NCPES survey, were largely those asked as part of the 2019 survey, with some minor amendments to reflect current practices which were planned before the COVID-19 Pandemic.

4.2 The NCPES is structured into twelve thematic sections, as follows:

- Seeing your GP
- Diagnostic Tests
- Finding out what was wrong you
- Deciding the best treatment for you
- Clinical Nurse Specialist (CNS)
- Support for people with cancer
- Operations
- Hospital care as an inpatient
- Hospital care as a day patient / outpatient
- Home care and support
- Care from your general practice
- Your overall NHS care

4.3 Where tumour groups have eleven or less responses, no tumour-specific analysis has been provided. Responses for questions with one to eleven respondents are

[2] MFT does not treat brain and CNS cancers

[3] Upper GI includes patients diagnosed with liver, pancreatic or gall bladder cancer (HB).

suppressed, both to protect patient confidentiality and because uncertainty around the result is too great. Responses below eleven in number are seen for both Sarcoma and Head and Neck cancer services.

4.4 The national reduction in cancer diagnoses during the early months of the COVID- 19 pandemic is reflected in the MFT data. The average drop in responses was 27.5%, with Colorectal seeing the largest drop of 68%.

4.5 In line with previous surveys, patients were asked to rate their overall quality of care on a scale of 0 (very poor) to 10 (very good). The following tables show the MFT score for overall quality of care and those of participating GM Trusts shown in Table 6, and those of participating Shelford Trusts are shown in Table 7.

MFT	SRFT	Pennine Acute	Stockport	The Christie
8.8	8.6	9.0	8.6	9.0

Table 6. Overall Quality of Care scores for MFT and other participating GM Trusts

MFT	GSTT	Northumbria	UCL	Sheffield	Cambridge
8.8	8.8	8.9	8.7	8.9	9.0

Table 7 Overall Quality of Care scores for MFT and other participating Shelford Trusts

4.6 It is pleasing to note that high scores (>90%), were received for eight out of the fifty-two questions as detailed below in Table 8.

Question No.	**Question asked**	**2019**	**2020**
Question 5	Received all the information needed about the test	**93%**	**94%**
Question 19	Patient given the name of a CNS who would be able to support them through their treatment	**94%**	**93%**
Question 27	Beforehand, patient had all the information needed about the operation	**95%**	**93%**
Question 36	Patient always given enough privacy when discussing condition or treatment	**87%**	**92%**
Question 39	Patient always felt they were treated with respect and dignity while in hospital	**89%**	**92%**
Question 41	Hospital staff told patient who to contact if worried about condition or treatment after leaving the hospital	**95%**	**93%**
Question 44	Cancer doctor had the right documents at patient's last outpatient appointment	**96%**	**99%**
Question 54	GP given enough information about patient's condition and treatment	**92%**	**93%**

Table 8: scores above 90%

4.7 A further three questions demonstrated a significant improvement since the 2019 survey, as shown in Table 9.

Question No.	Question asked	2019	2020
Question 34	Patient thought there were always or nearly always enough nurses on duty to care for them	**69%**	**77%**
Question 44	Cancer doctor had the right documents at patient's last outpatient appointment	**96%**	**99%**
Question 59	Patient felt length of time for attending clinics and appointments for cancer was about right	**67%**	**75%**

Table 9: Questions showing a significant improvement in comparison of those in 2019

4.8 Four of the fifty-two questions asked, demonstrated a significant deterioration since the 2019 survey as shown below in Table 10.

Question No	Question asked	2019	2020
Question 2	Patient thought they were seen as soon as necessary	**82%**	**80%**
Question 16	Patient definitely given practical advice and support in dealing with side effects of treatment	**73%**	**63%**
Question 22	Hospital staff gave information about support or self-help groups for people with cancer	**90%**	**81%**
Question 60	Someone discussed with patient whether they would like to take part in cancer research	**44%**	**25%**

Table 10: Questions that have deteriorated in comparison to those in 2019

4.9 Actions will be taken to improve results that have deteriorated and include practical application of communication in respect of information provided, increased participation in cancer research (in part impacted by the pandemic), and support during treatment.

4.10 The Cancer Dashboard[4], co-produced by NHS England and Public Health England, is designed as a tool to help clinical leaders, commissioners, and providers to identify priority areas quickly and easily for improvement in their cancer services. There are six questions included in the survey which derive from the Cancer Dashboard, with questions reflecting areas considered four key patient experience domains:

- Provision of information
- Involvement in decisions

[4] National Cancer Dashboard. https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

- Care transition
- Interpersonal relations, respect, and dignity

4.11 Five of the six questions asked questions scored lower than 2019, whilst by comparison there was an improvement of 2% in one question, as shown in Table 11 below.

Question	2019	2020
	MFT Result	MFT Result
% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment	**83%**	**77%**
% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment	**94%**	**93%**
% of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist	**88%**	**87%**
% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital	**89%**	**91%**
% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital	**95%**	**93%**
% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.	**60%**	**50%**

Table 11: Performance on Cancer Dashboard Questions

4.12 As previously mentioned, unlike in previous years, no comparison can be made as to whether results were comparable to either GM or Shelford Trusts. However, it is possible to suggest that the reduced score in the % of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment may be in part due to reduced service accessibility during the pandemic.

4.13 In relation to the reduction in score in the question of whether respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment, the cancer team will ensure

that this is explored through the refresh of the Cancer Strategy and discussed through the Trust Cancer Committee.

5. Tumour Specific Analysis

5.1 Results for tumour-specific groups are provided where eleven or more patients have responded. The Trust received tumour specific scores for the tumour groups below:

- Breast
- Colorectal
- Gynaecology
- Haematology
- Head and Neck
- Lung
- Prostate
- Upper Gastro
- Urology
- Other

5.2 However, no tumour specific results were received for the Sarcoma cancer group, as only seven responses were received from this group. Table 12 below shows further breakdown of responses by tumour group

Tumour group	2019 Number of responses	2020 Number of responses	% change from 2019 - 2020
[5]Brain & CNS	0	0	N/A
Breast	116	78	-33%
Haematology	130	111	-15%
[6]Upper GI	27	25	-7%
Gynaecology	34	25	-26%
Urology	51	46	-10%
Prostate	35	15	-57%
Colorectal	63	20	-68%
Head& Neck	25	10	-60%
Sarcoma	5	5	No change
Lung	147	79	-46%
Skin	16	12	-25%
Other	48	56	+17%

Table 12. Survey responses by tumour group

5.3 The only tumour specific scores to contain a full library of results, were those for Lung cancer, as this was the only tumour group that received eleven or more responses in each set of questions. Every other tumour group contained at least one question where

[5] MFT does not treat Brain and CNS cancers
[6] Upper GI includes patients diagnosed with liver, pancreatic or gall bladder cancer (HPB).

less than eleven respondents had answered the questions, therefore results were not received for that section.

5.4 The survey does not provide national results for each of the tumour groups, therefore comparison within the same tumour groups is not possible.

5.5 Internal comparison amongst the tumour groups can be carried out, however the responses received, demonstrate the wide variations in scores across each of the different tumour groups. The responses to many of the survey questions demonstrate variations in scores between the different tumour groups. Further detailed analysis of the tumour-specific group data is being undertaken by the clinical teams and action plans developed for improvement.

5.6 Tumour-specific teams will take steps to ensure take action across the survey, particularly the six 'cancer dashboard' questions. The timing of this survey coincided with rapid reconfigurations of each service due to the COVID-19 pandemic. Therefore, variations in experience may be attributed to the changes during the pandemic and further analysis from each of the tumour services will be required to review and align the results.

5.7 Ongoing implementation of the Living with and Beyond Cancer agenda within the Trust will afford the opportunity for all teams to continue to improve the number of cancer patients receiving a Care Plan.

5.8 Two questions highlighted the issue of patients not being able to discuss worries or fears with a member of hospital staff during an inpatient or outpatient visit. It is possible that changes in the way Macmillan Cancer Information and Support Centre's were operating during the months of April – June 2020 due to the COVID-19 restrictions, may have impacted on patient experience.

5.9 During this time, these areas were not seeing patients face to face and in some cases were closed. During this time services began to reconfigure how they worked and staff from the Centre's in addition to staff from Living with and Beyond Cancer team commenced wellbeing calls to patients to ensure issues, concerns, worries and fears were still being addressed in the absence of face-to-face appointments.

5.10 Tumour groups that received a higher number of responses appear to have an overall positive consistency of experience across the age groups opposed to those with lower responses which were variable.

6. Specific response – Age and ethnicity

6.1 The results demonstrate a small number of responses for those in the younger age ranges, with most questions having none or limited responses from those under the age of 45.

6.2 The survey results do not show the Ethnic diversity of patients that received the survey. However, with 92% of responders identified as white British, 2% declining to answer and only 6% identified across the other ethnicity options, points to this not being reflective the diversity of recipients of care and treatment relating to cancer at MFT.

6.3 The only two groups to show data are White and Asian. Overall, where there is data from both groups the experience of patients identing as Asian is reportedly of poorer quality than those identifying as White as shown in Table 13 below.

Question No.	Question asked	White	Asian
Question 2	Patient thought they were seen as soon as necessary.	**81%**	**53%**
Question 3	Saw healthcare professional once or twice before being told they needed to go to hospital.	**78%**	**33%**
Question 55	General practice staff definitely did everything they could to support patient during treatment	**49%**	**29%**
Question 61	Patients average rating of care scored from very poor to very good	**8.8**	**8.5**

Table 13: Questions about experience by ethnic groups

7. Free Text responses

7.1 At the time of writing this report the free text responses from participants had not been released by Picker, however once received they will be incorporated into the action plan and aligned to the new Cancer Strategy to be launched in late Spring 2022.

8. Summary

8.1 The NPCES 2020 survey has not allowed for national or local comparison, however, has yielded rich information for teams to work on and to reflect in the MFT Cancer Strategy.

8.2 Results require further analysis by tumour-specific teams working closely together across the Trust to both identify areas to celebrate success and to identify areas for improvement.

8.3 Where common priorities exist across multiple teams, action plans will be agreed in the appropriate Trust forums to ensure parity of provision. The challenge remains for those tumour groups where eleven or fewer responses were received to consider how they can encourage patients to respond to the future surveys.

8.4 Actions are required to reach into groups who have not participated in the survey and reduce inequalities as a key theme of the MFT Cancer Strategy.

8.5 Overall, the NCPES (2020) results are comparable with the previous year for MFT, which is reflective of the hard work of all staff to provide cancer services during particularly uncertain months during the COVID-19 pandemic.

8.6 The report and the findings will be shared and discussed at the Group Cancer Committee.

9. Recommendations

9.1 The Board of Directors is asked to note the feedback and the opportunity for improvements in patient experience.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Mrs Alison Haughton, Acting CEO, Saint Mary's Managed Clinical Service (SM MCS) Dr Sarah Vause Medical Director SM MCS Mrs Kathryn Murphy, Director of Nursing and Midwifery, SM MCS
Date of paper:	January 2022
Subject:	Maternity Services Assurance Report (incorporating the Ockenden Report assurance framework, CNST MIS Safety Action update and Maternity Continuity of Carer)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation, and teaching To improve patient safety, clinical quality, and outcomes To improve the experience of patients, carers, and their families
Recommendations:	The Board of Directors is asked to note the information and assurance provided in the report, and current SM MCS position, noting the challenges to implementing MCoC as a default model of care without the additional workforce requirements.
Contact:	Name: Alison Haughton, Acting CEO, SM MCS Tel: 0161 276 6124

1. Purpose of paper

1.1. This paper provides:

- Assurance to the Board of Directors on matters relating to patient safety and workforce within maternity services
- An update provided in respect of the Ockenden Report[1], and the NHS England and Improvement (NHSE/I) maternity self-assessment tool submission
- information regarding to key Safety Actions linked to the Clinical Negligence Scheme for Trusts Year 4 Maternity Incentive Scheme (MIS)

2. Ockenden Report Update

2.1. The Board of Directors have received updates relating to Donna Ockenden's first report (the Ockenden Report): Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust[1], in January March, May and October 2021.

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

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

2.4. A summary of the action plan is attached to this paper at Appendix 1; the further detailed action plan is also attached at Appendix 2.

2.5. One action in IEA1 relating to compliance with information standard notice for the maternity services (appendix 2) sits within the Information Technology remit and has been escalated to Director of Information and Patient Services to ensure that this is completed by 31st December 2021.

2.6. As reported in October 2021, SM MCS submitted evidence of compliance with Ockenden recommendations via the Future NHS Collaborative Platform for review by the Clinical Support Unit (CSU), Regional Maternity Transformation Programme.

2.7. Feedback from CSU has been received via the Regional Maternity Team on the 9th December 2021. The review has noted that further information is required in the following areas:

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

2.8. The next step has been confirmed as taking the form of an Assurance Visit by the Regional team to review progress against the Ockenden recommendations.

2.9. In response to national review findings, a maternity safety self-assessment tool has been designed for NHS maternity services to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

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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

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

2.11. There are 7 overarching areas, with 41 actions and a total of 180 different pieces of evidence to be collated.

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

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

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

3. Patient Safety

3.1. As previously reported, governance processes are in place within SM MCS through which assurance in respect of Patient Safety is obtained. These include:

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

3.2. Each of these is further described below.

Incident Management

3.3 Table 1 illustrates incidents reported to date in October and November 2021, and those reported in Quarter 1 & 2 2021/2022..

	Oct		Nov		Qtr1		Qtr 2	
	Number	%	Number	%	Number	%	Number	%
No harm incidents	558	95.01	409	96.46	1483	93.13	1642	94.91
Slight harm incidents	25	4.26	14	3.30	102	6.41	82	4.74
Moderate incidents	3	0.51	1	0.23	6	0.38	4	0.23
Catastrophic Incidents	2	0.34	0	0	1	0.06	2	0.12
Total Incidents	587		424		1592		1730	

3.4 In October 2021, 5 cases were reported in the moderate, major, or catastrophic harm category, including one Never Event in Maternity Theatres. One of these cases was reported to Healthcare Safety Investigation Branch (HSIB).

3.5 There have been no moderate, major, or catastrophic harm incidents reported in November.

3.6 All incidents that are moderate and above have been reported to Greater Manchester and East Cheshire (GMEC) Patient Safety Special Interest Group.

3.7 All incidents moderate and above have been subject to a practice review and a high impact learning assessment has been undertaken.

3.8 High impact learning assessments have led to the following actions:

- Obstetric involvement in SM MCS and Group wide review of theatre processes, including a multi-professional Theatre Summit to identify human factors and cultural barriers.
- Maternity Theatre Group implemented to review pathways and processes for maternity theatres across SM MCS.
- Review of the controls and mitigations in place to prevent retained swabs occurring, in all settings across SM MCS.
- Educational update for staff regarding the escalation processes and accessing senior support.
- Lessons learnt incorporated into mandatory training to ensure they are shared with the wider team.
- Educational update for the management of breast lumps in pregnancy to be provided.

Board level Maternity Safety Champions

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

3.10 The role of the safety champions is to strengthen Board oversight and assurance of effective perinatal clinical quality. Recent activities of the maternity safety champions are highlighted below.

3.11 In line with the SM MCS endorsed Perinatal Clinical Quality Surveillance Model (approved by MFT Board in July 21), the MFT Board Safety Champion (Group Chief Nurse) attended the SM Quality & Safety Committee in September and October 2021. The Deputy Chief Nurse attended in December 2021.

3.12 The Medical Board Safety Champion meets with Obstetrics, Neonatal and SM MCS Medical Safety Champion every two months.

3.13 The Non-Executive Board Safety Champion has undertaken a walkaround at Oxford Road Campus in September 2021 and North Manchester in November 2021 and a walkaround is planned for Wythenshawe Hospital in January 2022.

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

Assurance Oversight Framework (AOF)

3.15 An Assurance Oversight Framework (AOF) is in place. The AOF was developed locally and includes 13 metrics selected by the Obstetric Division as important indicators of safety with an associated scoring range of between 1 and 6. (1 being lowest and therefore safest position and 6 being the highest). The AOF is part of the governance framework and reports through to SM Quality and Safety Committee.

3.16 The current (October 2021) overall score for all metrics is Level 6, an increase from the September score of 3 and from the previously consistent monthly score of 2. The score is predicted to be level 4 in November 2021.

3.17 The deterioration in score relates to the number of level 4 and 5 incidents (5 reported across SM MCS in October) and delays in the induction of labour pathway preventing the transfer of women to the delivery unit.

3.18 Four main risks have been identified for which workstreams, and action plans are in place include:

- Completion of the integration and alignment of the maternity service at North Manchester to SM MCS maternity governance structure
- Maternity Theatres on the Wythenshawe site
- Suspension of maternity services at East Cheshire Trust
- Induction of labour capacity

4 Midwifery Workforce within Maternity Services

4.3 The Birthrate Plus®[2] (BR+) workforce planning methodology is a safe staffing toolkit that supports the majority of the components in the NICE guideline on safe midwifery staffing for maternity settings[3].

4.4 SM MCS undertook the midwifery workforce review using the BR+ tool. The report was received SM MCS in January 2021 and identified a midwifery staffing gap of 17 WTE across the MCS.

4.5 As previously reported to Board SM MCS has been supported to increase the midwifery staffing establishment in line with the recommendations of the BR+ report through direct investment from NHSE/I to reduce variation in experience and outcomes for women and their families across England following the Ockenden Report.

4.6 The midwifery establishment, inclusive of the revised baseline following the BR+ findings and following a skill mix review at SM North Manchester, is 718.72 WTE across the 3 maternity units

Recruitment activity

4.7 In total, SM MCS made 82.4 WTE overall offers of employment of which 76 were accepted, over 40 new starters commenced in post during September and October, other start dates are in place up to January 2022.

4.8 To address the remaining vacancy factor of 23 WTE, active recruitment processes have re-commenced supported by the corporate workforce and resourcing team.

4.9 SM MCS has experienced challenges in recruiting to community midwifery teams. It has been suggested that this is in part due to lack of confidence in newly qualified midwives in respect of managing a community caseload and the knowledge many newly qualified

[2] https://birthrateplus.co.uk/
[3] NICE guideline NG4 Safe midwifery staffing for maternity settings. 17 February 2015

midwives do not hold a driving licence (this has been impacted by COVID-19 and the restrictions on driving lessons and tests during the height of the pandemic).

4.10 To address this work has commenced to support confidence in caseload management for midwives during preceptorship, led by Matrons for Community services across the 3 maternity sites.

Temporary staffing

4.11 To mitigate the impact of absence due to sickness, and maternity leave, temporary staff from NHS Professionals are utilised to support staffing levels.

4.12 During Q3, the registered midwifery workforce is being further supported using agency staff.

4.13 There has been limited benefit to date due to low uptake in agency shifts across SM MCS.

Retention

4.14 Retention of qualified midwives is nationally recognised as an issue, currently 8.5 WTE midwives leave MFT each month.

4.15 In October 2021, to support maternity providers in their retention of midwives, one-year non-recurrent funding of £150,000 has been received by SM MCS from NHSE/I.

4.16 The funding provides an opportunity to develop specific posts to support, complement and enhance retention plans. It is anticipated the post-holders will provide individualised support in clinical environments for students and newly qualified midwives in the early stages of their career, both in acute and community settings.

5 Maternity Incentive Scheme year 4

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

5.2 The year 4 MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

5.3 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 3 - Avoiding Term Admissions into Neonatal units (ATAIN)
- Safety Action 4 – Obstetric Workforce Standards
- Safety Action 9 section C - Board level safety champions have reviewed Continuity of Carer action plan

Safety Action 3

5.4 There is overwhelming evidence that separation of mother and baby soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, and long-term morbidity for mother and child. This makes preventing separation, except for a compelling medical reason, an essential practice in maternity services and an ethical responsibility for all healthcare professionals.

5.5 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.

5.6 Saint Mary's MCS has TC services, which are based on the British Association of Perinatal Medicine (BAPM) principles and that 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:

- Saint Mary's Oxford Road - Guideline for the Neonatal In-reach Service on ORC Post-Natal Wards (March 2021)
- Saint Mary's Wythenshawe –Standard Operating Procedure for Neonatal Nurse support on the Wythenshawe Postnatal Wards (April 2020)
- Saint Mary's North Manchester General Hospital – Admission Neonatal Unit Guideline (March 2021)

5.7 ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[4] to reduce admission of full-term babies to neonatal care. To achieve its aim of reducing harm and avoiding unnecessary separation of mother and baby there is a specific focus on:

- Respiratory care
- Jaundice
- Hypoglycaemia
- Hypoxic Ischaemic Encephalopathy.

5.8 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.

5.9 Regular reports to Board of Directors are integral to that action point. Furthermore, the Ockenden Report (December 2020) has also emphasised the need for Trust Boards to have sight of maternity safety.

Audits of Transitional Care (TC) provision for the period 1st April 2021 to 30th September 2021

5.10 A monthly audit relating to babies requiring TC is reported to the Obstetric and Neonatal Quality and Safety Committees, and a quarterly review is submitted to the Saint Mary's Quality and Safety Committee the maternity, neonatal and Board level safety champions and Local Maternity and Neonatal System (LMNS).

5.11 The reviews, as required by year 4 MIS, 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.

5.12 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.

5.13 There has been no change to the provision of TC across the Saint Mary's MCS during the period 1st April to 30th September 2021.

[4] 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

5.14 During Quarter 1 & 2 2021/22, one term baby that met the current Transitional Care admissions criteria was admitted to the Neonatal Unit due to staffing issues (Table 2).

Table 2

Site	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
ORC	0	0	0	0	0	0
Wythenshawe	1	0	0	0	0	0
North Manchester	0	0	0	0	0	0

5.15 During Quarter 1 & 2 2021/22, no term babies were admitted to or remained on NNU, because of their need for nasogastric tube feeding.

Review of term admissions to the Neonatal Unit using the Avoiding Term Admissions Into Neonatal units (ATAIN) framework

5.16 The ATAIN review process aims to reduce admissions to the Neonatal Unit by identifying and acting upon practice issues promptly to demonstrate improvements in care.

5.17 Respiratory distress remains the main reason for admission into the neonatal units across SM MCS. The team have commenced a Maternity Neonatal Safety Improvement Programme focusing on an early warning system that will alert staff to infants who have an increased risk of requiring admission the neonatal unit. This will include those infants at risk of requiring respiratory support. The aim of this programme is to ensure early intervention to avoid admission to the Neonatal Unit.

5.18 Care provision is reviewed to identify any avoidable term admissions. In the period 1st April to 30th September 2021 there were eight avoidable term admissions across Saint Mary's MCS. 4 babies on the ORC site, 1 on the Wythenshawe site and 3 on the North Manchester site.

Learning from the audit and reviews with an ongoing action plan (See Appendix 4)

5.19 An ATAIN action plan to address the local findings from the audit and reviews has been developed and agreed with the maternity and neonatal safety champions and Board level champions.

5.20 The Saint Mary's MCS ATAIN action plan focuses on the same four conditions, prioritised in the ATAIN programme and described above at point 5.7.

5.21 Progress with the ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions and LMNS.

5.22 To be compliant with Year 4 MIS Safety Action 3 Trusts should have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the ATAIN programme.

5.23 Saint Mary's MCS has maintained full compliance during Quarter 1 of 2021/2022. Appendix 5 includes further information in respect of Safety Action 3.

Safety Action 4

5.22 Safety Action 4 of Year 4 MIS sets workforce standards in relation to obstetric; anaesthetic; neonatal medical and neonatal nursing workforces, with the aim of supporting the delivery of safe maternity care

5.23 Safety Action 4 of Year 4 MIS requires that compliance with the two components of the Obstetric staffing standard, is reported to Board of Directors by the end of January 2022.

5.24 The two components of the Obstetric staffing standard are that:

- The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'[5] into their service. This document mandates the involvement and presence of Consultant Obstetricians in defined "high-risk" scenarios.

- Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

5.25 All three sites have a list of conditions where consultant attendance is mandated. Following the publication of the updated RCOG workforce document[4] in June 2021, this list was reviewed and updated in December 2021 to ensure consistency across all three sites, and to ensure that the 14 clinical situations described in the RCOG workforce document were included. These are shown below.

Table 4 Clinical situations with mandated consultant attendance in Obstetrics as defined by RCOG[4]

In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28 weeks
Twin birth <30 weeks
Eclampsia
4th Degree tear
Unexpected intrapartum stillbirth
Maternal collapse e.g septic shock, massive abruption
Caesarean birth 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated

5.26 This policy also requires an incident report to be submitted if one of the 14 clinical situations occurs and a consultant is not in attendance. This incident report is then reviewed through the usual incident review process.

[5] RCOG Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology Barber JS, Cunningham S Mountfield J, Yoong W, Morris E June 2021 - https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/.

5.27 Five clinical situations that occurred between 1st April 2021 and 3rd December 2021 from each site were selected and retrospectively reviewed, in accordance with policy monitoring. These situations were selected as reliable data on consultant presence for them is currently captured by the maternity data systems in use across the MCS.

5.28 Consultants were present for 38 of the 43 events reviewed (88%) (Table 5). The five events where consultants were not in attendance have been reviewed individually to determine the reasons and whether any further actions need to be taken. Competing clinical priorities and the urgency of the situation were the commonest reasons for non-attendance.

Table 5 Consultant attendance since the three-site merger on April 1st, 2021 – 3rd December 2021.

	Number of cases with consultant recorded as present		
	ORC	***Wythenshawe***	***NMGH***
Eclamptic Fit	1/1	1/1	0/0
4th degree tear	4/5	5/5	1/2
Caesarean-Placenta Accreta	2/2	0/0	1/1
Intrapartum Stillbirths	1/1	1/1	0/0
Caesarean -BMI>50	10/12	4/5	7/7

5.29 Compliance will continue to be monitored monthly.

5.30 Compliance monitoring data will be reported to the LMNS in addition to the Board of Directors and Board Safety Champions.

5.31 In summary, compliance with Safety Action 4 of year 4 MIS has been achieved.

Safety Action 9 section c

5.32 In line with year 4 MIS Safety Action 9 requirements, Saint Mary's MCS is required to provide assurance to the Board of Directors on progress and plans relating to the national ambition for Midwifery Continuity of Carer (MCoC) to be the default model of midwifery care by March 2023 (NHSE/1 2021)[6].

5.33 In response to the latest guidance from NHS England and NHS Improvement (NHSE/I, 2021), an action plan of how the transition from traditional models of care to MCoC will be achieved has been created with a focus on provision to those women most likely to

[6] NHS England and NHS Improvement, (2021). Delivering Midwifery Continuity of Carer at Full Scale: Guidance on planning, implementation and monitoring 2021/22

experience poorer outcomes, particularly those from Black, Asian and minority ethnics groups[7] and those living in the 1st centile of deprivation[8].

5.34 Compliance with the ambition of MCoC as a default model of care is predicated by safe midwifery staffing establishments.

5.35 The planning guidance (NHSE/I, 2021) sets out the building blocks in a self-assessment framework which are needed to be in place prior to and during rollout of MCoC.

5.36 SM MCS has assessed its readiness to implement and sustain MCoC by allocating a RAG status to the building blocks of the assessment framework (Appendix 6) should funding to support safe staffing be achieved by March 2023.

5.37 As a first step, SM MCS is taking actions to ensure sustainable models of MCoC aligned to the current funded midwifery establishments which will be in place by March 2022 as part of the wave 1 rollout.

5.38 SM MCS book approximately 18,500 women per year to receive their care across all three provider sites (Saint Mary's Oxford Road, Saint Mary's Wythenshawe and Saint Mary's North Manchester). Analysis of SM MCS booking data suggests approximately 38% of all women that Saint Mary's MCS provide care for are from a Black, Asian or Minority Ethnic backgrounds and approximately 37% of all women who Saint Mary's MCS provide care for live in the bottom decile of deprivation.

5.39 SM MCS wave 1 plan sees the establishment of 7 MCoC teams providing antenatal, intrapartum, and postnatal care to 1600 women. These are all in areas of high social deprivation and/or areas with a high proportion of women from Black, Asian and Minority Ethnic backgrounds.

5.40 To provide context of the size of the national ambition of offering MCoC as the default model, SM MCS would need to increase from 7 to 31 MCoC teams and see an additional 77 WTE midwifery post funded.

5.41 The action plan at Appendix 7 demonstrates a phased approach to scale-up of MCoC. SM MCS will continue to support the current MCoC teams which are in place with additional teams being added in waves, if the midwifery staffing establishment is increased. Additional teams will provide care to women living in geographical areas that could benefit the most from MCoC.

5.42 SM MCS will monitor actions within the action plan each month and these will be reviewed at SM MCS Obstetric Division Safety and Quality Meeting, and then submitted as an assurance paper to SM MCS Hospital Quality and Safety Committee (SM QSC), chaired by Dr Sarah Vause, Medical Director for SM MCS and co-chaired by Mrs Kathryn Murphy, Director of Nursing and Midwifery, SM MCS.

5.43 SM MCS will provide the Board of Directors with an update on progress against this MCoC action plan each quarter**.**

[7] Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (eds) on behalf of MBRRACE-UK (2020) Saving lives, improving mothers' care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. Oxford: National Perinatal Epidemiology Unit, University of Oxford.

[8] Hadebe R., Seed P., Essien D., Headen K., Mahmud S., Owasil S., Fernandez Turienzo C., Stanke C., Sandall J., Bruna M., Khazaesadeh N., Oteng-Ntim E. (2021). Can birth outcome inequality be reduced using targeted caseload midwifery? A retrospective cohort study. BMJ Open, 11(1)

6 Summary

6.1 This paper provides assurance on a range of topics related to maternity safety, including:

- Update to the Ockenden Report and the Maternity self-assessment tool
- Patient safety, incorporating clinical incident management processes and Board level maternity champions activity
- Midwifery Workforce challenges and actions taken
- NHS Resolution Maternity Investment Scheme – safety action 3,4 and 9c

6.2 The paper describes the focussed work to reduce and mitigate safety concerns against the context of increased activity, acuity, and staffing challenges.

6.3 This report provides assurance in respect of Saint Mary's Managed Clinical Services action plan for compliance against the Ockenden Report.

6.4 This report provides assurance that the care of babies requiring transitional care is reviewed monthly and the Saint Mary's MCS ATAIN action plan is updated based on these audits, in line with year 4 Maternity Incentive Scheme (MIS) Safety Action 3.

7. Recommendations

The Board of Directors is asked to note the information and assurance provided in the report, and current SM MCS position, noting the challenges to implementing MCoC as a default model of care without the additional workforce requirements.

Appendices

Appendix 1: Ockenden Action Plan Summary

Essential Action	Status	Monthly update	Timescale for completion
IEA1: Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity Neonatal System (LMNS) oversight.	In progress	1 action open Compliant with CNST MSDS V2 submissions and awaiting confirmation from IT that there is full compliance with the Information Standard Notice MSDS v2.0 DCB1513 Amd 10/218	31/10/2021
IEA2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.	Completed	Awaiting information from national team re the Senior Independent Advocate Role. NED undertaking safety walk arounds	Closed
IEA3: Staff training and working together: Staff who work together must train together.	Completed	Awaiting implementation of the LMNS process to ensure compliance with training. Draft proposal developed and circulated by the LMNS	Closed
IEA4: Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Completed	Saint Mary's handheld records have been developed to enable a consistent approach to the accurate documentation of the named consultant for women with complex pregnancies across the MCS. Education to be provided to staff across the MCS	Closed
IEA5: Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	Completed		Closed
IEA6: Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.		Education programme in place with lessons learnt shared Bid for Ockenden funding was unsuccessful and alternative sources of funding are to be explored.	Closed

Essential Action	Status	Monthly update	Timescale for completion
IEA7: Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	Completed	Updated Saint Mary's website implemented with support from the Maternity Voices Partnership. Developing proformas to support shared- decision making process and consistent information to women in specified clinical situations e.g., maternal choice Caesarean Section and Induction of Labour	Closed
Maternity Workforce Requirements	Completed	Commissioner meetings ongoing re: funding to support long term services related to SBL V2	Closed
NICE Guidelines	Completed	Process aligned across the MCS	Closed

Appendix 2: Detailed Ockenden Action Plan

Recommendation	Action	Lead	Due date	Update
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity Neonatal System (LMNS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g., through maternity dashboards. This must be a formal item on LMNS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMNS for scrutiny, oversight, and	Improve compliance with the SMH Maternity Services Data Set submissions relating to outcomes of care	MFT Informatics Data Quality Manager	**Closed**	**Completed**
	Review the internal review processes once the external HSIB review processes are embedded and decide on whether to continue with the dual review process of babies with poor outcomes	Governance Leads	**Closed**	**Completed**
	Develop a process for sharing learning identified through the LMNS Safety SIG and developing actions to improve care	Governance Leads	**Closed**	**Completed**
	Strengthen the reporting process to ensure details re maternity SI's are reported to the Group Board and included in Group Board minutes	Group Associate Director for Clinical Governance and Governance Leads	**Closed**	**Completed**
	Implement a process whereby the small group of cases of term babies with neonatal brain injury (declined by HSIB) are referred to the LMNS for external opinion.	Governance Leads and LMNS Safety Lead	**Closed**	**Completed**
	Develop a process with the LMNS to ensure an external review of eligible Perinatal Mortality Review Tool (PMRT) cases	PMRT Leads	**Closed**	**Completed**
	Review the MBRRACE-UK (Dec 2020) Saving Lives, Improving Mothers' Care Report and develop an action plan to ensure compliance	Clinical Head of Division	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
transparency. This must be done at least every 3 months	Ensure full compliance with Information Standard Notice MSDS v2.0 ECB1513 and 10/218	MFT Head of Data Services	**31/10/2021**	In progress Awaiting the development of the IT solution to ensure full compliance with the ISN including the explicit requirement about diagnostics. Compliant with MSDS V2 submissions (including North Manchester) for CNST Maternity Incentive Scheme.
	NMGH Action: Create Perinatal Mortality Review report to be submitted and discussed at LMNS Safety Special interest Group and at directorate update.	Governance Leads and LMNS Safety Lead	**Closed**	**Completed**
	NMGH Action: Define process following transaction regarding how data is submitted and reviewed within Saint Mary's MCS	HOM/ Digital Midwife	**Closed**	**Completed**
	NMGH Action: Put process in place to ensure learning from any review is shared with whole maternity team	Governance Lead	**Closed**	**Completed**
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their	Appoint an Independent Senior Advocate and agree the pathway once the role expectations have been confirmed by NHSE/I	TBC	TBC	

Recommendation	Action	Lead	Due date	Update
voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMNS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Strengthen the relationship with the Non-Executive Director and agree reporting processes	SMH MCS Safety Champions	**Closed**	**Co*mplete*d**
	Encourage greater involvement, integration, and oversight of safety activities by the NED	SMH MCS Safety Champions	**Closed**	**Completed**
	Explore further social media opportunities for wider engagement	Consultant Midwife	**Closed**	**Completed**
	Meet with MVPs to support role development and expectations including objectives and actions in partnership with the CCG as hosts	Heads of Midwifery	**Closed**	**Completed**
	Ensure that there is MVP involvement in transformation workstreams and service development.	Heads of Midwifery	**Closed**	**Completed** and ongoing
	Support the MVP to work closely with the Senior Independent Advocate to improve services and safety	Safety Champions	TBC	
	Continue to work with the local communities e.g., Caribbean and African Health Network (CAHN), Jewish community.	Consultant Midwife	**Closed**	**Completed** ongoing

Recommendation	Action	Lead	Due date	Update
	Expand the community engagement with other minority groups.	Refugee and Asylum seeker Midwife/MVP	**Closed**	**Completed**
	Consider the role of the independent advocate in the complaints process to support families.	MFT Head of Nursing Patient Experience	TBC	
	Consider increasing meetings of the scrutiny panel for maternity complaints	MFT Head of Nursing Patient Experience	**Closed**	**Completed**
	Develop a more robust process for the dissemination of learning from debriefs with women and families	Consultant Midwife/SMH Patient Experience Lead	**Closed**	**Completed**
	Consider sharing improvements made with MVP at regular events	SMH Patient Experience Lead	**Closed**	**Completed**
	NMGH Action: To support the implementation of the MFT Ward Accreditation process as part of the PTIP	Matrons	**Closed**	**Completed**
Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be	Work in partnership with the GMEC LMNS to support their process for validation of education and training 3 times per year and implement a local process to ensure compliance	Education Leads/ LMNS	**Closed**	**Completed**
	Undertake a spot check audit of the consultant led ward rounds	Matrons	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
externally validated through the LMNS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only.	Share the findings of the spot check audits of the consultant led ward rounds via site Obstetric Quality and Safety meetings (SOQS).	Governance Lead and Audit Lead	**Closed**	**Completed**
	Include the audit of consultant led ward rounds within the obstetric audit plan and share the audit reports via the Site Obstetric Quality and Safety Committee meetings.	Audit Lead	**Closed**	**Completed**
	Work with GMEC SCN to develop an agreed system definition for consultant led wards ward round and minimum standards to use across all maternity units	Site Lead Consultant Obstetrician	**Closed**	**Completed**
	Embed the ward round process for SMH at Wythenshawe team following the change in consultant presence in 2021.	Site Obstetric Lead	**Closed**	**Completed**
	NMGH Action: To review the Training Needs analysis following the Transaction as part of the Post Transaction Implementation Plan	Education Leads	**Closed**	**Completed**
	NMGH Action: align to SMH MCS development and evaluation of education programme.	Education Leads	**Closed**	**Completed**
	INMGH Action: Implement regular audit programme of Consultant Ward Rounds and include the audit of consultant led ward rounds within the QPCEC/ SMH QSC report.	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**
	NMGH Action: Share the findings of the spot check audits of the consultant led ward rounds via monthly divisional governance meeting	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Align existing Education and Training processes with SMH MCS	Quality and Safety Lead/ Governance Lead	**Closed**	**Completed**
Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Undertake a baseline spot-check audit of documentation of the named consultant	Matrons	**Closed**	**Completed**
	Share the findings of the spot-check audit of documentation of the named consultant via SOQS	Governance Lead	**Closed**	**Completed**
	Include the audit of documentation of the named consultant within the obstetric audit plan and share the audit reports via the Site Obstetric Quality and Safety Committee meetings.	Audit lead	**Closed**	**Completed**
	Develop a consistent approach to the accurate documentation of the named consultant on hospital case notes and handheld notes, for women with complex pregnancies across the MCS. Baseline audit completed December 2020, quarterly audits to be completed, awaiting standardised audit template from LMNS	Matrons	**Closed**	**Completed**
	NMGH Action: Improve documentation of the named lead consultant on all maternity records, including when this changes during pregnancy	Lead Midwives/ Administration Manager	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Improve communication with women regarding who their Consultant is by documenting this consistently on the handheld notes.	Lead Midwives	**Closed**	**Completed**
	NMGH Action: Establish ongoing audit programme which aligns with SMH MCS	Governance Lead for audit	**Closed**	**Completed**
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Undertake a spot check audit of the documentation of ongoing risk assessments completed in December 2020.	Matrons	**Closed**	**Completed**
	Undertake a full review of the current Antenatal Handheld notes to ensure that this supports the process for undertaking and documenting a risk assessment at every contact and consider developing a local handheld record	Matrons	**Closed**	**Completed**
	develop a process for recording the outcome of antenatal pathway changes following completion of antenatal risk assessment on the maternity data system	Directorate Manager/Digital Midwife	**Closed**	**Completed**
	Await standardised risk assessment to be released and make a commitment to implement this for each antenatal appointment within handheld records	Heads of Midwifery	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	Audit the use of Personalised Care and Support Plan for documenting preferences and choices throughout pregnancy	Matrons	**Closed**	**Completed**
	Incorporate documentation of the intended place of birth and preferred mode of birth into the AN booking proforma.	Matrons	**Closed**	**Completed**
	Provide information to women in a suitable format, including digital and in a range of languages other than English	Matrons	**Closed**	**Completed**
	Develop handwritten and electronic localised information to provide the risks and benefits of all available birthing locations and methods of birth to support informed choice.	Consultant Midwife	**Closed**	**Completed**
	Identify substantive resources and secure funding to support the provision of SBL training and midwifery ultrasound scans across the MCS	SMH Director of Finance/Divisional Director	**Closed**	**Completed**
	Restart carbon monoxide screening when appropriate following the pause during the COVID pandemic for SBL V2 Element 1; Reducing Smoking in Pregnancy -	antenatal services Matron	**Closed**	**Completed**
	Identify substantive funding to sustain the long-term services related to SBL V2 Element 1, Reducing Smoking in Pregnancy -	SMH Director of Finance/Divisional Director	**Closed**	**Completed**
Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated	Continue to support the process for learning from clinical incidents	Fetal monitoring Champions	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Develop standardised teaching package and competency-based assessment tool for intermittent auscultation across the SCN	Consultant Midwife	**Closed**	**Completed**
	Share Avoiding Term Admission to Neonatal Unit (ATAIN) audit findings monthly via Site Obstetric Safety and Quality Committee	CTG Champions	**Closed**	**Completed**
	Share ATAIN audit findings with clinical leadership on the delivery units	CTG Champions	**Closed**	**Completed**
	Develop a statement of case to secure a substantive expert team to support the ongoing and expanding requirements for CTG training and audit.	Directorate Manager/Deputy Head of Midwifery	**Closed**	**Completed**
	Develop a statement of case to secure a substantive expert team to support the ongoing and timely practice review	Directorate Manager/Clinical Head of Division	**Closed**	**Completed**
	NMGH Action: Ensure appropriate time within job plan for Named consultant lead for fetal monitoring	CHOD	**Closed**	**Completed**
	NMGH Action: Implement CTG ‘touch points’ during 12 months between annual CTG training and competency assessment	Midwife and Consultant Leads	**Closed**	**Completed**
	NMGH Action: Increased visibility in clinical areas from CTG champion	Midwife and Consultant Leads	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	NMGH Action: Strengthen process of cascading learning from ATAIN reviews ensuring it is shared with those working clinically.	ATAIN Lead and Lead Midwife	**Closed**	**Completed**
	NMGH Action: Audit to monitor progress of ATAIN actions	ATAIN Lead and Lead Midwife	**Closed**	**Completed**
	NMGH Action: Ensure midwives, Consultant Obstetricians, Anaesthetists and Neonatologists can undertake all practice review sessions within the 72-hour timeframe	Governance Midwife/Governance Lead	**Closed**	**Completed**
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum, and postnatal periods of care Women must be enabled to participate	Review the information leaflets shared with women	Directorate Manager	**Closed**	**Completed**
	Redesign the website to ensure accurate and appropriate information is easily accessible and, in a format, to meet the needs of our diverse population and in partnership with MVP	Obstetric Transformation Team, Divisional Director. Maternity Voices Partnership	**Closed**	**Completed**
	Develop information in languages other than English, which may be delivered as videos or audio	MFT Coms/SMH Patient Experience Lead/Matrons	**Closed**	**Completed**
	Develop a formal process for supporting choice by providing information and discussion with a senior midwife and Consultant Obstetrician through Birth Choice Clinic	Clinical Lead Consultants and Matrons	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Develop proformas to support shared-decision making process and consistent information to women in specified clinical situations e.g. maternal choice LSCS, IOL and care during IOL following 3 doses of Prostin	Clinical Leads	**Closed**	**Completed**
	Develop risk assessment tool to be used for all admissions for IOL	Clinical Leads	**Closed**	**Completed**
	Develop further information and consent checklists for other conditions such as induction, prelabour SROM, place of birth	Clinical Leads	**Closed**	**Completed**
	NMGH Action: Develop a process in place to support maternal requests for Caesarean section	Consultant Midwife	**Closed**	**Completed**
Maternity Workforce Standards	Submit the BR Plus report to the SMH Board	Heads of Midwifery	**Closed**	**Completed**
	Continue to review the risk related to staffing and capacity each month	Clinical Head of Division, Divisional Director and Heads of Midwifery	**Closed**	**Completed**
	Identify substantive funding to sustain the long-term services related to SBL V2	SMH Director of Finance/Divisional Director	**Closed**	**Completed**
	Review staffing requirements once the Birth Rate Plus assessment re Continuity of Carer has been received within the Division	Heads of Midwifery	**Closed**	**Completed**

Recommendation	Action	Lead	Due date	Update
	Continue to work with LMNS and HEI's to attract midwives to SMH.	Heads of Midwifery/Lead Midwife for Education/HR Business Partner	**Closed**	**Completed**
	NMGH Action: Recruit to substantive obstetrician posts.	Clinical Head of Division	**Closed**	**Completed**
	NMGH Action: Recruit to substantive Midwifery posts	Head of Midwifery	**Closed**	**Completed**
NICE Guidance related to Maternity	Include the risk assessments and review of the risk register for risks related to guidelines within the monthly guideline report	Consultant Guideline Lead	**Closed**	**Completed**
	Establish pathway from April 21 and alignment of guidelines with MFT.	Clinical Head of Division	**Closed**	**Completed**

Appendix 3: SM MCS Inhouse Scorecard for Perinatal Clinical Quality

CQC Maternity Ratings March 2019	Overall	Safe	Effective	Caring	Responsive	Well Led
	Good	Good	Good	Outstanding	Good	Good

Staff survey	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	79.1
Proportion of specialty trainees in O&G with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (reported annually)	83.7

Summary

- The data is validated each month and shared via the Q&SC process; this report contains the data for September
- Maternity incidents are reported separately via the governance reports presented at Q&SC
- All HSIB referrals are reviewed by MDT to identify lessons learnt and mitigate any risks

Major PPH > 2.5litres	Term admissions to NNU	Stillbirths
•Incidents monitored monthly •Major PPH being reviewed where there are increased numbers and quality improvement work being undertaken •Lessons learnt shared across the MCS	•All term admissions reviewed to identify if the admission was avoidable •MatNeo quality improvement work incorporating reducing term admissions •ATAIN audits completed monthly to identify areas for improvement and share lessons learnt	•Perinatal Mortality Review Tool and MDT review undertaken for all stillbirths •All stillbirths are incident reported and reviewed by the MDT •Figures submitted include Fetal Medicine Unit care and management

			GMEC current monthly average	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Perinatal	1:1 care in labour	Percent	97.98	99.3	99.2	96.5	99	98.2	98.6						
	3rd/4th degree tears	Percent	2.95	2.6	2.4	1.8	3.3	1.97	2.95						
	Obstetric haemorrhage > 2.5L	Rate per 1000	2.95	2.3	6.2	4.4	2.8	4.2	2.95						
	Term admissions to NNU	Rate per 1000	32.9	68.2	56.2	67.5	50.5	47.8	32.9						
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	8.75	5.8	15.1	10.3	6.1	11.8	8.75						
	Stillbirth number	Rate per 1000	2,21	2.3	5.4	4.3	8.4	6.2	2.21						
	Neonatal Deaths	Rate per 1000	1.27	2.26	1.55	1.43	0	1.39	1.27						

Patient Experience	Number of formal compliments	Number	1	3	2	2	3	4	0					
	Number of formal complaints	Number	5	12	11	7	7	7	8					
	Complaint response on time	Percent	100	83	100	86	-	-	-					
	Maternity Unit diverts	Number	0	0	1	0	3	2	1					

Training	Emergency skills and drills	Percent of staff trained	87.6	94.3	95.4	89.8	83	88.1	90.9					
	CTG training	Percent of staff trained	79.7	83.5	93.6	90.7	83.8	85.8	81.9					
	CTG competency assessment	Percent of staff assessed	88.1	92.2	91.8	93.4	91.9	87.8	88.3					

Coroner Reg 28 made directly to the Trust	No	No	No	No	No	No	No					
HSIB/ CQC concern or request for action	No	No	No	No	No	No	No					
StEIS reported incidents	1	0	2	1	9	2	4					
Incidents with moderate harm or above	0	0	3	0	2	0	0					
HSIB referrals	3	0	1	0	5	1						

Appendix 4: Saint Mary's Managed Clinical Service Action Plan for Avoiding Term Admissions into Neonatal Units – Updated September 2021

ATAIN Theme	Standard	Progress on action plan	Ongoing Action	Lead	Review date
Respiratory	All term neonates are cared for in the immediate postpartum period in line with the Dry Assess Skin to skin & Hat (DASH) campaign to ensure thermoregulation is achieved within the first hour of life. All term neonates maintain a temperature of 36.5 °C – 37.5 °C	ATAIN Training compliance: **ORC:** 89% (deteriorated from 91.69%) **Wythenshawe**: 76.5% (increase from 63.8%) **NMGH:** 93% (Compliance not robustly reported prior to December 2020) September 2021 Audits n=10 each site Proportion of babies with DASH documented **ORC** 90% (deteriorated from 95%) **Wythenshawe**: 100% (increased from 55%) **NMGH:** 40% DASH in early stages of implementation. Proportion of babies with temperature recorded prior to transfer from Intrapartum area. **ORC:** 100% (increased from 95%) **Wythenshawe:** 100% (increased from 80%)	• Ensure all midwives are compliant with the Hypoglycaemia prevention and Thermoregulation following Birth policy (2018) and the importance of care of the neonate in the first hour of life ➢ All staff to complete the ATAIN training package ➢ Education included on induction programme for all staff • Ensure all midwives document when DASH has been initiated and neonatal temperature is recorded prior to transfer ➢ Results of the audit to be shared with the intrapartum team on a monthly basis ➢ To be included as an agenda item within the monthly intrapartum forum and Quarterly Site Quality & Safety Committee ➢ Education to improve documentation and implementation of DASH at the North Manchester site.	Matrons for Education, Intrapartum and Inpatient areas	Quarterly audit of compliance to be reported through Site Quality & Safety Committee.

		NMGH: 100% (Compliance not robustly reported prior to December 2020)			
Respiratory	Elective caesarean section of term neonates is performed at 39 weeks gestation unless clinically indicated	September 2021 Audits n=20 each site Appropriate counselling re respiratory effects of early delivery to baby **ORC:** 100% (increased from 95%) **Wythenshawe:** 100% (increased from 27%) **NMGH:** 87% (Compliance not robustly reported prior to December 2020)	Theatre group working on capacity for elective LSCS across the MCS. Communication to medical staff regarding delivery <39 weeks and ensure appropriate counselling is provided.	Consultant leads Matrons for Intrapartum & Inpatient areas	Quarterly audit of compliance to be reported through Site Quality & Safety Committee.
Hypoglycaemia	All term neonates maintain a blood glucose level of >1mmol and hypoglycaemia is managed in accordance with the hypoglycaemia policy	Audit of antenatal medical records for women with Diabetes to ensure provided with education about the benefits of expressing breast milk from 36 weeks gestation to support hypoglycaemic control in the neonate. September 2021 N= 20 **ORC:** 100% maintained from 2020 **Wythenshawe**: 90% (increase from 30%) **NMGH:** 47% in early stages of implementation. Attendance at annual infant feeding updates **ORC**: 33.9% (deterioration from 72%)	➢ Ensure all midwives are compliant with the Hypoglycaemia prevention and Thermoregulation following Birth policy (2018) ➢ All eligible staff to complete the ATAIN training package ➢ Education included on induction programme ➢ All midwives and support staff to attend annual infant feeding update as part of their mandatory training, trajectory required to improve compliance as aspects of Mandatory training suspended during Covid-19. ➢ Feedback audit results and education of staff caring for DM women to improve advice about expressing breast milk, and to improve documentation.	Matron for Education Matron for Antenatal Services	Quarterly audit of compliance to be reported through Site Quality & Safety Committee.

		Wythenshawe: 71.6% **NMGH**: 93%	➢ To ensure that the weekly review of unexpected term admissions to the neonatal unit demonstrates early escalation to neonatal/in-reach team to support neonates highlighted as at risk of hypothermia at birth.	Matrons for Intrapartum and Inpatient areas	
Asphyxia	Reduce the number of admissions to the neonatal unit where misinterpretation of the CTG was identified in the practice review process	September 2021 Audit of case notes n=20 each site: Review by coordinator within 30 minutes of arrival on delivery unit: **ORC:** 80% maintained from 2020. **Wythenshawe:** 80% (increased from 35%) **NMGH**: 35% (Compliance not robustly reported prior to December 2020) Hourly CTG reviews in labour: **ORC:** 83% (Deteriorated from 100%) **Wythenshawe**: 93% (increased from 75%) **NMGH**: 78% (Compliance not robustly reported prior to December 2020) Proportion of CTGs buddied: **ORC:** 83% (increased from 71%) **Wythenshawe:** 93% (increased from 74%)	➢ The CTG champion to continue to support analysis of CTGs in practice on Delivery Unit & Triage ➢ Implementation of GM electronic Fetal heart monitoring teaching package ➢ CTG clubs to continue ➢ Ongoing audit of CTG assessment and buddying on both sites ➢ Results of the audit to be shared with the midwifery and obstetric teams ➢ Educate to ensure documentation of coordinator reviews within 30 minutes and buddying occurs. Introduction of “beat the clock” at NMGH to support improvement. Snapshot audit in October 2021 showed compliance of 95% ➢ Presentation of findings to Band 7 Coordinators to roll out throughout DU. ➢ Introduction of IA competency package across SM MCS	CTG Champion and Matron for Education Matron for Intrapartum areas	Quarterly audit of compliance to be reported through Site Quality & Safety Committee.

		NMGH: 40% (Compliance not robustly reported prior to December 2020)			
Jaundice	Reduce numbers of babies admitted to neonatal unit with jaundice	Audit of case notes n=20 each site: Proportion with daily jaundice checks **ORC:** 91% (increased from 80%) **Wythenshawe:** 100% (increased from 95% **NMGH:** 40% (Compliance not robustly reported prior to December 2020)	• Feedback audit results to governance meetings and to staff, to ensure education provided around importance of documentation of daily neonatal checks on the postnatal wards. • Ensure that neonatal notes are used on the NMGH site to document jaundice during daily checks.	Matrons for Intrapartum and Inpatient areas	Quarterly audit of compliance to be reported through Site Quality & Safety Committee.

Appendix 5

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 6: Readiness to Implement and Sustain MCoC Assessment Framework

Item	Detail/Notes	RAG
Planning spreadsheet	Demonstrates safety from a staffing perspective: • How many women can receive MCoC -reviewing in area and out of area, cross boundary movement. • Where women are cared for at any given time, now and in MCoC models (see NHSE/I toolkit for example of this. • Midwifery deployment plan for MCoC including timescales and recruitment plan for a phased scale up to default position.	
Safe Staffing	• Following workforce modelling SM MCs require 77 WTE midwives funding over the next 5 years to achieve MCoC as a default model.	
Communication and engagement	• Working with HR and RCM, along with showcasing current MCoC outcomes, it is hoped that more midwives will wish to join MCoC teams	
Skill mix	There will be a limited number of band 5 midwives placed in MCoC team. Band 5 (usually 1 per team) report being very well supported whilst undertaking preceptor programmes within MCoC teams.	
Training	Each midwife has planning on working in the team has a personal Training Needs Analysis (TNA) examples planned for the tool kit or existing ones can be used.	**Self-Assessment log**
Linked Obstetrician	Further work is required to understand how this will be implemented without requiring additional resources and duplication.	
Standard Operating Policy (SOP)	SM MCS needs to develop a SOP that outlines roles and responsibilities to support delivery of care in this way, it should pass through the maternity service governance processes as with other guidance documents.	
Pay	RCM requests that no midwife should be financially disadvantaged for working in this way. It is not expected that this would occur. If additional financial support is required, a further paper will be submitted seeking support.	
Estate and equipment	Community hubs will need to be reviewed. This may require considerable resource, project planning and investment. Should this be the case, a further Board paper will be submitted for consideration. There may need investment in IT infrastructure and equipment (such as mobile phones; fetal heart dopplers; stethoscopes and computers/laptops). Should this be the case, a further Board paper will be submitted for consideration.	
Evaluation	There will be local, regional, and national evaluation and reporting in place. Support will be sought from the LMNS as to ensure smooth process for regional and national reporting.	
Review Process	Date for initial plan to be review by Trust Board. Quarterly review dates set. Dates for LMNS reporting will be sought for both regional and national review.	

Appendix 7: Action plan MCoC

		Complete	In progress	Not due	Overdue

Action Number	Action	Narrative	Action taken by	Due by	Status as at 29.11.21
1	Review SM MCS against the 10 Building Blocks as identified by NHS E/I planning guidance	Apply RAG rating to each element within Building Blocks framework to ensure SM MCS able to scale up MCoC by March 2023	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
2	Undertake Safe staffing MCoC workforce modelling using recommended Workforce tool	SM MCS have completed as staffing review which has identified a staffing gap of 77 WTE required to implement MCoC as default model.	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
3	Recruiting to baseline BR+ establishment in line with newly funded establishment following Ockenden investment	SM MCS has established 7 MCoC teams, providing the default model of care safely to 1600 women.	HoM's across SM MCS	31.1.22	ongoing
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	ongoing
5	Submit Board Paper to GMEC LMNS	Subject to approval, submit Trust Board paper on current SM MCS position to GMEC LMNS.	K Murphy, Director of Nursing and Midwifery, SM MCS	11.1.22	ongoing
6	Request additional workforce funding	Following board review of SM MCS current position, link with GMEC LMNS to support a funding request to ICS for additional workforce required for SM MCS to achieve MCoC as default model.	Divisional Director, SM MCS DoF, SM MCS DoNM, MS MCS	March 2022	
7	Staff Engagement	Subject to funding approval, work with HR to create a workforce engagement strategy. Utilising the skills and experience of current MCoC teams to showcase the benefits of working in a MCoC model	HoM's across SM MCS	April – May 2022	

8	Develop MCoC Communications	Share outcomes of MCoC teams regularly across SM MCS to improve awareness of MCoC models	Team Leaders of MCoC teams	January 2022	ongoing
9	Develop SOP for MCoC	Create and submit SOP through divisional and hospital governance processes for approval, inclusive of linked obstetrician for each MCoC team	Team Leaders of MCoC teams Clinical Head of Division	February 2022	ongoing
10	Review Obstetric referral pathway	Review current obstetric referral pathways to support a link for MCoC. Resolve issues relating to increased workload, potential duplication for those requiring specialist care	HoM's and Clinical Head of Division	February 2022	ongoing
11	Review Staff training needs	Following EOI from staff wishing redeployment into Wave 2 MCoC teams, review individual needs using Self-Assessment Skills Log and support supernumary shifts to achieve any additional requirements.	Community and Intrapartum Matrons across SM MCS Education Team	April-June 2022	
12	Review community hub provision	Review current community hub capacity to support Wave 2 roll out	Divisional Director for Obstetrics, SM MCS	April – June 2022	
13	Review equipment required for MCoC teams	Review the equipment required for Wave 2 teams and order additional equipment where required	Community Matrons across SM MCS Finance Managers	April – June 2022	
14	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:	Joint Group Medical Director
Paper prepared by:	Mrs S Corcoran, Director of Clinical Governance
Date of paper:	January 2022
Subject:	CQC Statement of Purpose Amendment
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient Safety and Clinical Quality
Recommendations:	The Board of Directors is asked to note the change to the Statement of Purpose
Contact:	Name: Dr Tanya Claridge, Group Associate Director of Clinical Governance Tel: 01612768764

1. Introduction

The organisation is required by the CQC to have a Statement of Purpose. This document must be published on the CQC website and is defined by the CQC thus:

(1) The registered person must give the Commission a statement of purpose containing the information listed in Schedule 3.

(2) The registered person must keep under review and, where appropriate, revise the statement of purpose.

(3) The registered person must provide written details of any revision to the statement of purpose to the Commission within 28 days of any such revision.

SCHEDULE 3 - INFORMATION TO BE INCLUDED IN THE STATEMENT OF PURPOSE

1. The aims and objectives of the service provider in carrying on the regulated activity.

2. The kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet.

3. The full name of the service provider and of any registered manager, together with their business address, telephone number and, where available, electronic mail addresses.

4. The legal status of the service provider.

5. Details of the locations at which the services provided for the purposes of the regulated activity are carried on.

Regulation 12 and Schedule 3 of the Care Quality Commission (Registration) Regulations 2009

2. Amendment

The amendment required relates to Schedule 3, section 5: details of locations.

One location has been added to the Statement of Purpose: Manchester Academic Centre – MRI Escalation Capacity

The amendment has taken place and an emergency application submitted on 23rd December 2021. The full statement is attached at Appendix A.

3. Recommendation

The Board of Directors is asked to note this change to the Statement of Purpose.

Appendix A

Statement of purpose

Health and Social Care Act 2008

Part 2

Aims and objectives

Please read the guidance document *Statement of purpose: Guidance for providers*.

Aims and objectives
What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

The vision for Manchester University NHS Foundation Trust (MFT) is to improve the health and quality of life for our diverse population by building an organisation that:

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

The agreed strategic objectives are defined as follows:

- To improve patient safety, clinical quality and outcomes.
- To improve the experience of patients, carers and their families.
- To achieve financial sustainability.
- To develop single services that build on the best from across all our hospitals.
- To develop our research portfolio and deliver cutting edge care to patients.
- To develop our workforce enabling each member of staff to reach their full potential.

Manchester University NHS Foundation Trust was formed on October 1st 2017. It has a turnover of circa £2.4 billion and employs over 27,000 people. It operates clinical services in nine hospitals across nine discrete locations and provides a comprehensive range of functions ranging from local district general hospital services through to highly specialised regional and national specialities. It is the principal provider of hospital care to a local population of approximately 750,000 in Manchester and Trafford and is available to a much larger population providing regional and supra regional tertiary care.

The organisational form is based around ten Hospitals and a number of community sites.

The following Hospitals:

- Manchester Royal Infirmary
- Wythenshawe Hospital
- Royal Manchester Children's Hospital
- Saint Mary's Hospital
- Manchester Royal Eye Hospital
- Trafford General Hospital
- Withington Community Hospital
- Altrincham Hospital
- University Dental Hospital of Manchester
- North Manchester General Hospital

Other regulated activities are provided at the following sites:

- Buccleuch Lodge
- Dermot Murphy Centre
- Tameside Hospital MFT Renal Satellite
- North Manchester General Hospital MFT Renal Satellite
- Hexagon House MFT Renal Satellite
- Octagon House MFT Renal Satellite
- Harpurhey Health Centre
- Longsight Health Centre
- Moss Side Health Centre
- Newton Heath Health Centre
- Plant Hill Clinic
- Withington Community Clinic
- 144 Wythenshawe Road Short Break Service
- Gorton Parks
- Brownley Green Health Centre
- Wythenshawe Forum
- Cornerstone Centre
- Crumpsall Vale Intermediate Care Facility
- The Spire Hospital Manchester
- Transform Hospital Group Pines Hospital
- BMI The Alexandra Hospital, Manchester
- HCA Wilmslow Hospital
- Royal Oldham Hospital
- Fairfield General Hospital
- Rochdale Infirmary
- Delamere House Intermediate Care Unit
- Manchester Academic Centre – MRI Escalation Capacity

A number of other bases and sites are registered under the Trust Headquarters at Cobbett House, Oxford Road as they do not meet the criteria for standalone registration with the CQC. These are:

- Burnage Health Centre
- Northenden Health Centre
- Higher Openshaw Primary care Centre
- Vallance Health Centre
- Chorlton Health Centre
- Maddison Place
- Stratus House
- The Power House
- Pendleton Gateway
- Abbey Hey Clinic
- Starlac Centre
- Alexandra Park Health Centre
- Charleston Road Health Centre
- Cheetham Hill Primary Care Centre

- Clayton Health Centre
- The Longmire Centre
- Gorton Health Centre
- Levenshulme Health Centre
- Platt Lane Surgery
- Specialised Ability Centre
- Newton House
- Carys Bannister Building, University of Manchester

Full details of services provided and their location can be found on the Trust web pages at www.mft.nhs.uk

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business / Trust Board Secretary
Date of paper:	January 2022
Subject:	Remuneration Committee's Terms of Reference
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 robust and comprehensive Governance Framework, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is requested to approve the changes to the Terms of Reference for the Remuneration Committee highlighted in this report.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Board Secretary Tel: 0161 276 4841

Introduction

At its meeting in November 2021, the Board of Directors approved the Remuneration Committee's Terms of Reference with the caveat that, should there be changes proposed at the Committee's meeting on the 22nd November, they would come back to the Board of Directors for final approval.

The Remuneration Committee proposed some small changes to the version presented to the Board in November. The final version is presented in Appendix A.

The change, highlighted by being crossed out in the text in Appendix A, are:

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

Recommendations

The Board of Directors is requested to approve the changes to the Terms of Reference for the Remuneration Committee highlighted in this report.

Appendix A:

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

2. MEMBERSHIP

2.1 The Committee shall comprise:

- Group Chairman of the Group Board of Directors
- All Group Non-Executive Directors

2.2 No business should be transacted at a meeting unless the Chair and three Group Non-Executive Directors are present.

2.3 The Group Chairman of the Group Board of Directors shall be Chairman of the Committee and if unavailable for a meeting, the Group Deputy Chairman of the Group Board of Directors shall chair the meeting.

3. ATTENDANCE AT MEETINGS

3.1 The Group Chief Executive Officer and the Group Executive Director of Workforce and Corporate Business will join the Committee when discussing other Group Executive Directors, or, other designated individuals and/or staff groups.

3.1.1 The following participants are required to attend meetings of the Remuneration Committee.

- Trust Board Secretary.
- The Committee shall require the attendance of any Director or member of staff as required.

3.3 The Trust Board Secretary (or Nominated Deputy) shall be the secretary to the Committee and shall attend to take minutes of meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet at least once per annum.

5. OVERVIEW

5.1 The Remuneration Committee has been established by the Group Board of Directors to receive annual performance summaries for the Group Chief Executive and Group Executive Directors, and, ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales.

5.2 In line with the Department of Health & Social Care Guidance and best practice the Remuneration Committee will seek to ensure that all compensation decisions taken are fair and equality of opportunity, diversity and inclusion impacts are considered.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- To receive the annual performance summaries for the Group Chief Executive and the Group Executive Directors

- To determine the framework or broad policy for the remuneration of the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc.) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.

- To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.

- To advise on,and oversee contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.

- To understand the equality impacts of the decisions the Committee makes by having in each paper:

    - A breakdown on the impact of remuneration and changes to remuneration by protected characteristics in each pay paper.
    - Standard cover sheet including a section about how the author has consider equality and any actions taken to mitigate.

- To ~~pay due regard to the diversity of Committee members and~~ consider the impact of any gaps in representation on decision making.

7. AUTHORITY

7.1 The Remuneration Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

7.2 The Committee will make satisfactory arrangements to ensure it receives ~~adequate, independent~~ advice on remuneration levels elsewhere in the NHS, with due reference to national policy and guidance, as well as trends and developments in areas of benefits and terms and conditions of employment.

8. REPORTING

8.1 The Remuneration Committee shall ensure that the Group Board of Directors' emoluments are accurately reported in the required format in the Group's Annual Report.

9. REVIEW

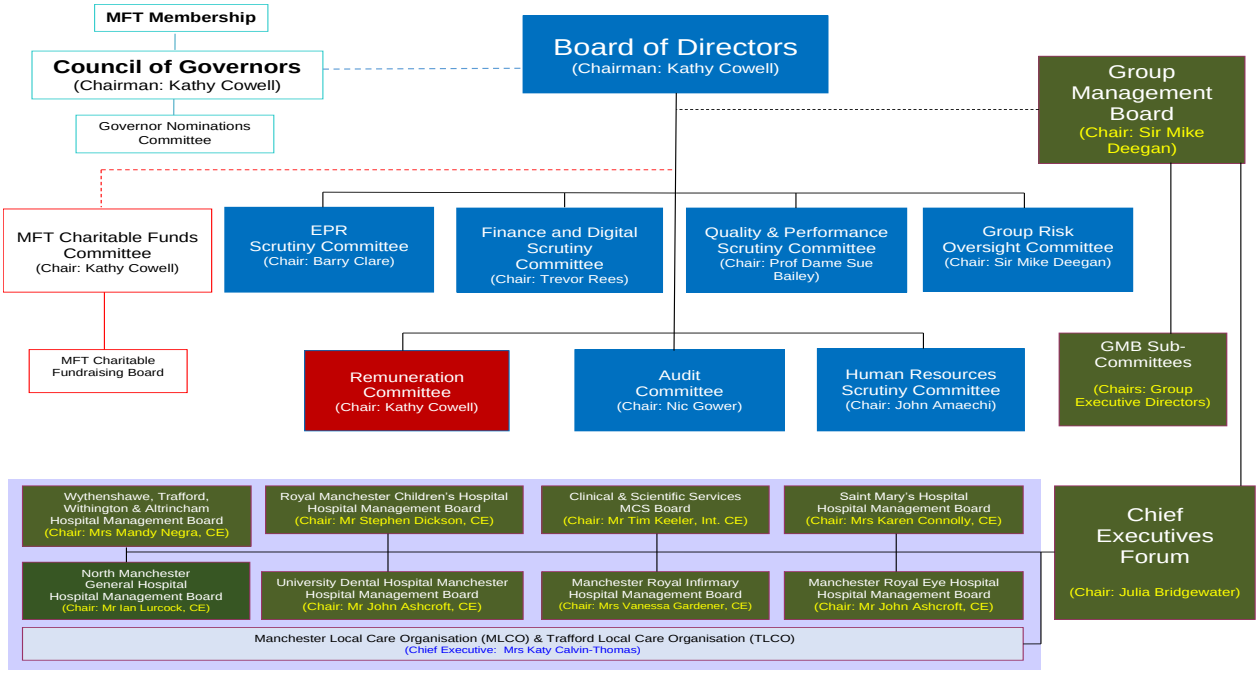
9.1 The Terms of Reference of the Committee will be reviewed at least annually.

10. KEY PERFORMANCE INDICATOR

10.1 These Terms of Reference will be measured against the following key performance indicator:

- 75% attendance of all listed members.

11. REPORTING STRUCTURE CHART



Approved: August 2017
Reviewed & Updated: March 2018
Reviewed & Updated: August 2018
Reviewed & Updated: August 2019
Reviewed & Updated: December 2020
Current review: November 2021
Date of Next Review: November 2022