NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 9th May 2022

Conference Rooms
Citylabs 1.0

Present:	Professor Dame S Bailey (SB)	Group Non-Executive Director
	Mr Darren Banks (DB)	Group Director of Strategy
	Mr Gaurav Batra (GB)	Group Non-Executive Director
	Mr P Blythin (PB)	Group Director of Workforce & Corporate Business
	Mrs J Bridgewater (JB)	Group Chief Operating Officer
	Mrs K Cowell (Chair) (KC)	Group Chairman
	Mr Barry Clare (BC)	Group Non-Executive Director
	Sir M Deegan (MD)	Group Chief Executive
	Mrs J Ehrhardt (JEh)	Group Chief Finance Officer
	Mr David Furnival (DF)	Group Director of Operations
	Professor Luke Georghiou (LG)	Group Non-Executive Director
	Mr N Gower (NG)	Group Non-Executive Director
	Professor Cheryl Lenney (CL)	Group Chief Nurse
	Mrs C McLoughlin (CM)	Group Non-Executive Director
	Mr T Rees (TR)	Group Non-Executive Director
	Miss Toli Onon (TO)	Joint Group Medical Director
In attendance:	Mr N Gomm (NGo)	Director of Corporate Business / Trust Board Secretary

206/22 Apologies for Absence

Apologies were received from Ms Angela Adimora, Mrs Gill Heaton and Professor Jane Eddleston.

207/22 Declarations of Interest

There were no declarations of interest received for this meeting.

208/22 Minutes of the Board of Directors' Meeting held on 14th March 2022

The minutes of the Board of Directors' meeting of 14th March 2022 were approved.

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

209/22 Matters Arising

There were no matters arising.

210/22 Group Chairman's Report

KC began by welcoming everyone to the first face-to-face Board of Directors' meeting for over two years. She thanked the Governors present, and all of their colleagues, who have continued to represent the voices of local people and our staff during the challenging circumstances of the last two years. After the Board meeting finishes, Governors would have the opportunity to stay behind and ask questions they may have regarding the issues discussed.

KC went on to recognise the terrible, ongoing situation in Ukraine which continues to produce horrific events of brutality alongside amazing stories of courage from the Ukrainian people. MFT continues to offer a broad range of support to staff who may be affected by these events, alongside providing care and treatment to Ukrainian children, and supporting the national effort through provision of medical equipment and supplies.

April saw the launch of the Manchester Clinical Academic Centre (MCAC) for Nurses, Midwives and AHPs - a new initiative between MFT and the School of Health Sciences in the Faculty of Biology, Medicine and Health at the University of Manchester (UoM). The work of the MCAC will build on the work already undertaken between the two organisations to embed research as a core activity for all nurses, midwives and AHPs.

Also in April, Admin Professionals' Day was celebrated - an opportunity to express respect and gratitude for the vital work of administrative and clerical staff across MFT. KC noted that clinical colleagues are rightly celebrated for their work and dedication, but administrative staff are often overlooked. MFT services would not function without clinical and non-clinical colleagues working together as part of one close team.

53 young people have recently gained employment with MFT via the Government's Kickstart scheme which has been set up to counter the impact of the pandemic on young people's employment prospects. As the largest employer in the city, MFT has a considerable role to play in providing opportunities to local people to help Manchester and Greater Manchester thrive as we recover from the last two years

KC highlighted some forthcoming events including Equality, Diversity and Human Rights week, Armed Forces Day on the 23rd June, and the launch of MFT's Rare Conditions' Centre on the 29th June.

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

211/22 Group Chief Executive's Report

MD began by echoing KC's comments about returning to face-to-face meetings, recognising that it was a sign that the impact of COVID-19 is reducing, but noting that there are still large numbers of COVID-19-positive patients in MFT's hospitals, and the events of the last two years have produced a significant backlog of care.

The last two months have seen MFT make significant in-roads in treating the longest waiting patients, but it will take a long time to get back to the sort of waiting times we expect to be able to offer to local people. This is covered in detail in item 7.2.1 on the agenda.

Amongst other things, the implementation of MFT's Electronic Patient Record programme, Hive, will help address the problem, improving the efficiency and effectiveness of our services, supporting patients to understand and engage with their own treatment and care. Progress with the Hive programme is detailed in agenda item 7.4.

MD recognised the amazing efforts of our workforce over the last two years. Every member of staff has gone above and beyond to ensure MFT provides the best possible care despite the challenges the NHS has faced, and the impact COVID-19 has had on friends and family members.

MD concluded by saying 'thank you' to all staff on behalf of the Board.

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

212/22 Board Assurance Report

KC introduced this item by informing the Board that the format and content of the Board Assurance Report is currently being revised and the new version would come to July's meeting of the Board. It is expected that further iteration of the report would follow with the introduction of HIVE

TO began by introducing the 'Safety' section and highlighting that there had been 11 Never Events over the last financial year. Whilst MFT was not an outlier when compared proportionally to other Trusts, reducing the number of Never events is being treated as a key priority. All Never Events are reported externally, the Duty of Candour is met, and lessons are learned and disseminated across the Trust. An external review has been commissioned to identify any additional issues which need consideration to improve the situation.

SB explained that each Never Event was scrutinised at the Quality and Performance Scrutiny Committee, and she was satisfied that the right actions were in place for improvement.

CL agreed with the chair to talk to the patients experience metrics in the agenda items (Complaints quarterly report and infection prevention and control update).

DF explained that he would address the information in the Operational Excellence section as part of agenda item 7.2.1. He explained that the revised Board Assurance Report presented at July's meeting will incorporate the performance measures MFT will be monitored against during 2022/23.

PB introduced the Workforce and Leadership section and explained that all the metrics were scrutinised and discussed in detail at the Human Resources Scrutiny Committee. Absence rates are heading in the right direction but there are still some challenges in some specialties. Action to improve non-medical appraisal rates is underway.

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

213/22 Update on the Trust's ongoing response to the COVID-19-19 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-19-19 (COVID-19) pandemic.

The impact of the recent Omicron variant peaked in mid-April when occupancy levels of patients with COVID-19 were at 87% of the first peak and has rapidly declined since.

MFT's Urgent Care performance has been affected more significantly, relative to other hospitals in GM, due to greater demand. The ongoing programme of improvement activities includes:

- Streaming at the point of entry across all sites;
- Learning lessons from other Trusts to continue to improve ambulance handover times;
- A Discharge Processes Project on the Wythenshawe site
- The Virtual Ward programme

At the time of the Board meeting, there were c.300 in-patients with 'no reason to reside' in MFT's hospitals – equivalent to 10 wards' worth of patients. MFT teams are focussed on reducing this number with the LCOs running 'tests for change' on all types of care to accelerate discharge processes.

From an elective care perspective, MFT was 370 patients ahead of its 104 week trajectory at the end of March with the aim for zero 104 week waiters by the end of June in line with national targets. The situation is monitored three times a week alongside a continued focus on treating P2 patients. The work to address the elective care backlog is underpinned by a 'Theatre Efficiency and Rapid Improvement' project which is implementing a number of actions to improve productivity and efficiency.

MFT's Outpatient programme continues to focus on key areas of national planning requirements and internal development areas including Patient Initiated Follow Up (PIFU), virtual triage, and waiting list validation.

From a cancer perspective, the focus is on reducing the number of 62 day waiters amidst a context of increased demand across the Trust with referral levels at 117% of pre-pandemic levels. The most pressured pathways remain Gynaecology, Lower/upper Gastrointestinal, Urology and Head and Neck.

MFT has a refreshed Cancer action plan which is forming the basis of discussions with hospital sites about actions required. Other Trust-wide actions include:

- Increased surgical capacity for Breast and Skin.
- Breast services improvement workshop held on 22nd February and improvement plan in place. Rapid assessment and triage being implemented. Patient pathway Navigator due to commence in post in May. Clinic templates reviewed and changes implemented from April to ensure capacity is maximised.

- Urology- all surgical activity now being undertaken at Wythenshawe with approval to use an in-sourcing company at weekends to increase capacity. Some complex surgery is still being carried out at The Christie using the MFT@Christie model.
- Head and Neck – MRI supporting Wythenshawe with capacity for patients breaching 14 days and surgical capacity for NMGH patients.
- Continued use and focus to utilise IS capacity for endoscopy demand.
- Additional clinical capacity in place weekdays and weekends for example breast 'Super- Saturdays.
- Additional consultant recruited at NMGH for Lung Cancer Team.
- Site based weekly reviews of all patients > 62 days with clear action plans in place reviewed.

TR asked what was being done to proactively contact patients who were on waiting lists to update them on the situation.

DF explained that patients on waiting lists were contacted at least every 90 days. The MESH programme enables clinical reviews of patients which can accelerate their care should their condition require it.

TO confirmed this explaining that each patient is given a clinical priority and reviewed every 3 months. This happens consistently across MFT and capacity is used in other hospitals when it is available.

KC noted that there are 580 patients with 'no reason to reside' across GM and DF confirmed this was the equivalent of approximately 19 wards' worth.

In response to a question from BC regarding the ongoing impact of COVID-19, DF confirmed that activity levels were at 92% of pre-pandemic levels and this was a result of the need to provide safe care to all patients within the context of continuing high number of COVID-19-positive patients.

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

Update on COVID-19 Infection Prevention Control Response and Nosocomial Infections Including COVID-19 Vaccine Programme

CL presented the report which provided an update on:

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

From 1st April 2022 substantial changes have been made to existing COVID-19 guidance with several key documents withdrawn in line with the governments 'Living with COVID-19' white paper, published on 23rd February 2022. The overall theme of the new guidance is to move to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as influenza and respiratory syncytial virus (RSV). On 1st April 2022, the national case definition for COVID-19 was replaced by a broader definition for 'people with symptoms of a respiratory infection including COVID-19'.

The Northwest principles for living with COVID-19 are already in place at MFT and are based on current guidance and hierarchies of control with an emphasis on local decision making around patient pathways and dynamic management of risk. The principles are designed to support consistency of approaches in both NHS trusts and system-wide arrangements.

There has been a gradual reduction in outbreaks of Hospital Onset COVID-19 Infection (HOCI) over this year with 12 outbreaks in March 2022, 16 outbreaks in February 2022, and 29 outbreaks in January 2022.

The Trust is committed to reducing incidents of avoidable Healthcare Associated Infections (HCAI) and review of HCAI cases takes place at the end of year through a process led by the Chief Nurse with the directors of nursing and IPC leads for each hospital/MCS/ LCO. Themes identified included compliance with Trust screening/isolation policies (particularly in clinical areas where isolation facilities are less available); compliance with fundamental IPC principles; and environmental factors concerning the age of some areas of the estate.

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

CL highlighted the changes to the IPC Board Assurance Framework since the last Board meeting along with actions being taken to mitigate any gaps in assurance. New guidance suggests that a standalone IPC BAF is now optional, and it is proposed to incorporate it into the main Board Assurance Framework.

CL noted that flu vaccination rates are down this year, in common with Trusts across the country but over the national average at 64%, due to the combined flu/Covid vaccine offer.

LG asked if there has been a positive impact on other infections due to the precautionary methods adopted to counter the pandemic.

CL stated that there hasn't been the impact that might have been predicted within hospitals due to the increased cross-infection risks caused by changes to ward configurations and associated movement of patients and inherent risks associated with variable PPE usage. CL noted an initiative known as The 'Gloves off' campaign, as part of the response to this in conjunction with the RCN.

CL explained that the Trust is finalising visiting policies anticipate a full return to the pre-pandemic guidance. Visitors wouldn't be tested but would be asked to continue to wear masks.

In response to a question from TR regarding any changes of staff attitudes as a result of COVID-19, PB explained that there had been more advice sought from the Employee Health and Wellbeing Service.

NG commented that the detail within the IPC BAF had proven a useful assurance tool and asked if it would continue to be used.

CL said that a revised version would still be overseen at Group level and at the IPC Committee.

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

214/22 Chief Finance Officer's report

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

At the financial year end, to March 2022, the Trust has delivered a surplus of £13.1m, which is an improvement of £1.5m from the £11.6m year to date surplus reported in month 11 and is in line with the H2 plan submitted to NHSE/I in late November 21.

March 22 total expenditure at £253m has increased by £59m against that of February 22. However, most of this relates to a movement in both income and pay for the Trust's pension contributions, in the sum of £53.6m, which is a normal part of the year-end process.

As at 31st March 2022, the Trust had a cash balance of £319.1m. The cash balance was higher than forecast by £16m, this was primarily due to additional income received from NHSEI.

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

JEh confirmed that the draft accounts for 2021/22 had been submitted a day ahead of the deadline.

TR commented that the report represented a great outcome for 2021/22, in particular the attainment of the capital plan. He congratulated all those involved.

In response to a question from LG regarding the impact of inflation on future capital plans, JEh explained that some capital contracts had already been signed off, e.g., Hive, but others would have to be managed on a case by case basis. DF added that, in some cases, the risk was covered by contracts including a guaranteed maximum price but noted that it may be more challenging in 2023/24.

BC asked if there had been any issues with supply chains and cited the shortage of HRT medicines as an example.

JEh explained that the Procurement and Pharmacy teams manage these collaboratively with regional and national colleagues and have successfully mitigated potential shortages over recent months and there is nothing to highlight at this stage.

KC concluded the item by congratulating the Finance team on their work in achieving a successful year-end position, particularly within the context of the national funding regime during the pandemic.

Board decision	Action	Responsible officer	Completion date
The Board noted the Month 12 and pre-final audit position against the 21/22 plan, and final cash and capital positions for the Trust.	None	n/a	n/a

215/22 Update on the Hive Programme

JB presented the report which gave an update on progress in delivering the Hive programme which is the largest ever implementation of an electronic patient record system in the UK involving the transfer of over 500,000 medical records.

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

The Hive governance and programme management functions are well developed and embedded. These have been recently refined as the design, building, testing, data migration and training preparations enter their final stages. Go-Live readiness assessments began in April 2022. Each Hospital/MCS will complete a series of Go-Live Readiness Assessments at 120, 90, 60 and 30 days prior to Go-Live. These will be chaired by their respective Chief Executives and review key activities such as training, testing of equipment, and patient appointment conversion to Hive.

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

42% of superusers, and 27% of end users, are now booked in for the relevant training.

Robust external assurance arrangements are in place with Deloitte providing regular Gateway Reviews. The next scheduled review is due to report at the end of May 2022 and will review testing, training, risk management and readiness for Go Live.

BC, Chair of the EPR Scrutiny Committee overseeing the Hive programme, commented that the transfer of responsibility from Group level to Hospitals/MCSs/LCOs was a crucial part of the programme. Staff training remained a risk and it was important to ensure that staff had sufficient time and opportunity to receive the training. Deloitte's input has been invaluable as external assurance for the EPR Scrutiny Committee.

TR asked if there could be a high level Board briefing at some stage which focussed on the benefits for patients and staff, as well as the wider potential offered by a single electronic patient record across the whole of MFT.

KC thanks JB for the progress made and noted that in depth scrutiny of progress takes place through the EPR Scrutiny Committee.

Board decision	Action	Responsible officer	Completion date
The Board noted the progress made on the Hive programme.	Board briefing to be prepared.	JB	July 2022

216/22 Update on MFT People Plan

PB introduced the report which provided an overview of progress in delivering MFT's People Plan.

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

There are 128 deliverables that make up the MFT People Plan. These deliverables have been allocated appropriately to Deliverable Owners across the Workforce Directorate and across relevant Group Departments / Directorates to ensure full expertise and sufficient resources are allocated to maximise on what each deliverable is aiming to achieve. Significant progress on delivering the MFT People Plan has supported the completion of over 40 key deliverables, which represents 31.3% of plan.

Progress in delivering the People Plan is monitored in depth at the HR Scrutiny Committee for assurance purposes. This includes consideration of quantitative and qualitative evidence.

KC commented that it was useful to hear feedback from staff at HR Scrutiny Committees and proposed the re-introduction of patient stories before Board meetings.

In response to a question from TR regarding data against all of the key metrics, PB confirmed that there was in place, and it would be reported through the HR Scrutiny Committee.

CM noted the level of detail covered in the HR Scrutiny Committee and that the dedication of MFT staff was clear.

In response to KC's noting of the significant investment in the Employee Health and Wellbeing service, PB highlighted the increasing use by staff of the Lime Arts service and reminded Board members of the Lime Arts Symposium on 20th May.

Board decision	Action	Responsible officer	Completion date
The Board noted the breadth of work to support, engage, and develop MFT's workforce, and deliver the MFT People Plan.	Patient stories to be presented at the beginning of every Board of Directors' meeting	CL	July 2022 onwards

217/22 Update on Strategic developments

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

Nationally, the Health and Care Act 2022 has received royal assent, enabling Integrated Care Boards (ICB) to be formally established and meaning that NHSI will be abolished and most of its powers pass to NHSE.

The development of the Greater Manchester Integrated Care System (GMICS) and the appointments to the Integrated Care Board is continuing with Dr Manisha Kumar appointed as Medical Director and Sam Simpson as Director of Finance. The recruitment process for the Director of Nursing is underway. The structure of the Executive team has also been determined. A GM Integrated Care Operating Model is being developed that sets out the GM vision and objectives, architecture, characteristics, and enablers that will underpin how GM will operate post-transition.

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

MD noted that Hive would be a key enabler for the successful delivery of single services across MFT and it was important to accelerate their development now the impact of the pandemic was lessening.

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

218/22 MFT Annual Plan 2022/2023

DB presented the item which sought approval for the MFT 2022/23 Annual Plan which was appended to the report.

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

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

The implementation of Hive is key to delivering MFT's vision. It will transform how everyone works and realise the benefits of improved clinical quality, patient experience and staff experience, increased operational efficiency, and will help drive research and innovation.

The Trust is working within a new financial regime (as the NHS exits the last two years of COVID-19 finance regime) and is not returning to the pre-COVID-19 Payment by Results regime. In parallel, the development of the ICS structure nationally is part of the new finance regime and, within GM, the ICS is not yet operational. The discussions on the financial plan for 22/23 have, therefore, been extended and are ongoing at the time the report was written.

The indication is that Trust income is the same in 22/23 as it was in 21/22. Given increased costs due to inflation, costs of Hive, and the national expectation of increased activity, this results in a significant challenge to achieve the financial performance the Trust has delivered in recent years. At the time of writing the report, the level of Waste Reduction Programme savings identified is about half the required value and so the financial risk is very high as MFT moves into the second month of the financial year.

Internally, the Trust has undertaken a robust budget setting exercise, although this has been later than a "normal" year due to the external factors. The risk of variation from the GM discussions is in the main being held at Group level. Control totals, including Waster Reduction targets, have been issued to Hospitals/MCS/LCO and Corporate areas.

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

Board decision	Action	Responsible officer	Completion date
The Board approved the MFT Annual Plan 2022/23 recognising that there remain ongoing GM discussions to finalise the organisation level finance control totals.	None	n/a	n/a

219 /22 MFT's Risk Management Framework and Strategy

TO presented the report which sought ratification of the Risk Management Framework and Strategy 2022-25 which had been approved at the Group Risk Oversight Committee (GROC) and had been developed through collaboration with the Hospitals/MCSs/LCOs. She highlighted a small amendment which had been made since approval at GROC.

NG confirmed he was very happy with the detailed approach.

220/22 Delegated authority to the Audit Committee for sign-off of the MFT Annual Report and Accounts for 2021/2022

JEh asked the Board of Directors to delegate authority for the approval of the Annual Report and Annual Accounts to the Audit Committee. The request was due to the fact that approval was required prior to the next Board of Directors' meeting.

Board decision	Action	Responsible officer	Completion date
The Board delegated authority to the Audit Committee for the approval of the Annual Report and Accounts for 2021/22.	None	n/a	n/a

221/22 Update on Standard Financial Instructions and Scheme of Delegation

JEh presented the report which sought approval of the updated Standing Financial Instructions (SFIs), and Scheme of Reserved Decisions and Scheme of Delegation (SORD)

The updated versions of these key documents had been reviewed and agreed by the Audit Committee in April 2022.

As Chair of the Audit Committee, NG explained that this was an annual process but there had been a more thorough approach this year and he was very satisfied with the resulting documents. He also noted that there would be a need to monitor the progress of the ICS over the coming year to identify any developments which may impact upon these documents.

Board decision	Action	Responsible officer	Completion date
The Board approved the updated Standing Financial Instructions (SFIs), and Scheme of Reserved Decisions and Scheme of Delegation (SORD) as reviewed by the Audit Committee in April 2022	None	n/a	n/a

222/22 Approve the NHSI FT Self-Certification Requirements (2022)

PB presented the report which sought approval for MFT's NHS E/I's Foundation Trust Self-certifications.

All NHS Foundation Trusts are required to self-certify whether or not they had complied with the conditions of the NHS provider licence, had the required resources available if providing commissioner requested services, and had complied with governance requirements. The guidance issued by NHSI in April 2017 required NHS Providers to self-certify only three Licence Conditions after each financial year-end, namely, Condition G6(3); Condition G6(4); Condition FT4(8); and Condition CoS7(3).

PB described the evidence presented for each condition and following a short discussion it was agreed that based on the evidence highlighted in the supporting documentation, Condition G6(3) & Condition G6(4) Self-Certification would be formally signed-off as 'Confirmed'. Similarly, and based on the evidence highlighted, the Board agreed that declaration 'B' within the Condition CoS7(3) Self-Certification would be formally signed-off as 'Confirmed'.

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

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

Board decision	Action	Responsible officer	Completion date
The Board approved Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) as 'Confirmed' and agreed that the Group Chairman & Chief Executive would be given delegated authority to 'sign-off' the Self-Certification ('Condition FT4(8)') in order to meet the self-certification deadline of 30th June 2021.	None	n/a	n/a

223/22 Maternity services assurance report (including Ockenden update)

CL presented the report which provides an update in respect of the initial Ockenden Report, and the recently published Final Report. It provides assurance to the Board of Directors on matters relating to patient safety within maternity services, themes identified from clinical incidents, shared learning, and monitoring of actions.

As reported to Board of Directors in January 2022, and March 2022, Saint Mary's Managed Clinical Service (SMMCS) have completed all provider-level Ockenden actions required from the initial report published in December 2020. There are 3 outstanding actions with currently no estimated date of completion which sit with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMS) relating to a process on how the system is to receive maternity training data.

The second and final report from Ockenden was published on 30th March 2022 and has identified a further 15 Immediate and Essential Actions (IEAs) which all providers must implement and report compliance against. A date has not yet been set regarding when compliance must be achieved.

SM MCS is undertaking a detailed review of the 15 IEAs which will set out compliance and areas of focus. Actions will be put in place to ensure compliance and will be reported in full to the meeting of the Board of Directors in July 2022. Actions will be identified and monitored through SMH Quality and Safety Committee and also through the QPSC.

SM MCS reported 1666 incidents between 1st January 2022 to 31st March 2022 (Q4 2021/2022). All incidents were reviewed through robust governance processes and > 95% (1584) were validated as no harm, 4.5% (76) were validated as slight harm and <0.5% (6) were validated as moderate harm or above.

Of the 6 moderate harm or above, 5 cases did not highlight any trend and there were no similar incidents within the preceding 6 months. One incident occurred on maternity triage and SM MCS identified a theme emerging in this area. The learning from this incident has been shared and actions have been implemented and monitoring continues within the maternity division.

SM MCS continue to work through the 10 standards for Maternity Incentive Scheme (MIS) year 4 and are currently compliant with 8 of the 10 standards. One area of non-compliance relates to Standard 6, Saving Babies Lives Care Bundle, specifically CO (Carbon Monoxide) screening. Actions plans are in place across each site in the MCS to address this with improvements in compliance now been seen.

Training within both Standard 6 and Standard 8 are non-compliant and trajectories are in place to achieve compliance by the end of June 2022.

Whilst there has been no confirmation of a new submission date for MIS year 4, SM MCS expect to achieve full compliance and will continue to report progress to the Board of Directors against all 10 standards.

Overall, the maternity division within Saint Mary's MCS is in a good position having completed and embedded the initial Ockenden actions. An initial review of the final 15 IEAs from the second report published in March 22, demonstrates over half of all elements are compliant and there are robust plans to address the remaining elements. A perinatal surveillance model has been developed which remains an iterative process and when fully implemented will provide ward to board visibility in respect of incident reporting and learning. As Maternity Board Safety Champion, CM noted the importance of the extended governance arrangements which are well-established across SMMCS, and at Trust level. These monitor progress, identify any issues, and are complemented by Senior Leadership Walk Rounds.

CL noted that the Hive system will help produce a detailed and timely patient dashboard to further boost oversight of maternity services.

TR stated that a patient story regarding maternity care had been presented at a recent Patient Safety Learning Committee and this had indicated how learning is being shared across sites and services.

Board decision	Action	Responsible officer	Completion date
The Board noted the position in respect of Ockenden IEAs and the work ongoing to ensure the safety of women and babies in SMMCS.	None	n/a	n/a

224/22 Q4 Complaints Report

CL presented the report which gave an overview of Complaints and PALS activity from January to March 2022.

2,066 PALS concerns were received in comparison to 1,865 received in the previous quarter, an increase of 27.6% (570) for the same period in Q4, 2020/211.

426 new complaints were received in comparison to 384 received in the previous quarter. This shows an increase of 23.2% (99) for the same period in Q4, 2020/212. Of the new complaints received, 135 related to in-patient services. This shows an increase of 21.4% (29) in comparison to 106 received in the previous quarter. 25% were concerning appointments and management of appointment processes.

Wythenshawe, Trafford, Withington, and Altrincham hospitals (WTWA) received the greatest number of complaints (45); an increase of 49% (22) in comparison to the 23 WTWA received in the previous quarter. Of the 45 complaints received at WTWA there were no single themes or trends.

100% of complaints were acknowledged across the Group within 3 working days; this position was maintained throughout all quarters in 2020/21 and 2021/22. The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 89.5% of complaints were closed within this agreed timescale compared to 89.8% in the previous quarter.

31 (9.56%) complaints investigated were upheld, 215 (66.3%) were partially upheld and 61 (19.0%) were not upheld.

The Parliamentary Health Service Ombudsman (PHSO) partially upheld and closed 1 case during this quarter. In the one case, the Trust was required to pay £300 redress in recognition of the missed aspects of discharge planning and inaccurate documentation. It is predicted that the numbers of PHSO cases reported will increase over the coming months due to the PHSO working through the backlog which grew during the pandemic.

CL explained following a review of the process with NG the chair of the CSG (Complaints Scrutiny Group) will now be the Corporate Director of Nursing for Patient Experience with NG in attendance as a panel member. In addition, attendees to the meeting would be invited back to give progress reports on how lessons learned that had been presented to panel were implemented.

NG welcomed these changes and stated that he was confident that MFT treats every complainant well and with respect.

BC asked if the increase in complaints over this period was due to the increased impact of COVID-19 due to the Omicron variant. In order to understand whether that was the case, CL committed to including comparisons with pre-pandemic data within the Complaints Annual report.

In response to a question from BC, TO explained that patients were regularly reviewed whilst on waiting lists and optimised for surgery so they could be seen as soon as there is an opportunity to do so. She added that data regarding the protected characteristics of patients will be improved when Hive is in place so that the work to address health inequalities can be further enhanced.

Board decision	Action	Responsible officer	Completion date
The Board noted the contents of the report.	Comparison with pre-pandemic complaint numbers to be included in the Complaints Annual report	CL	July 2022

225/22 Annual Nursing and Midwifery Revalidation Report (2021/2022)

CL presented the report which provides an annual overview of Nursing and Midwifery Professional Revalidation at MFT, describing the current practice and assurance systems in place to support nurses, midwives, and nursing associates to meet the Nursing and Midwifery Council's (NMC) revalidation requirements. It covers the period from April 1st 2021 to 31st March 2022.

Revalidation is now well embedded within the nursing and midwifery profession having been a requirement since 2016. Nurses and midwives are encouraged to maintain a portfolio of evidence and feedback in preparation for revalidation. The first cohort of nursing associates graduated and registered with the NMC from January 2019. This cohort completed their revalidation in January 2022 and for subsequent cohorts, this will be their first revalidation cycle. Additional support, information sharing, and revalidation workshops are being provided to support the nursing associates with the revalidation process.

Revalidation compliance is monitored by the Corporate Director of Nursing responsible for workforce and education. A monthly workforce report generated from the NMC register is utilised to inform the Trust's revalidation assurance process. Revalidation champions are established in each Hospital/MCS/LCO and are responsible for monitoring staff revalidation and supporting staff through the revalidation process.

The total number of nurses, midwives and nursing associates who have revalidated with the NMC in 2021/2022 is 2504 out of a total of 2519. 15 staff did not revalidate as they either retired, resigned, or allowed their registration to lapse.

To support the revalidation process for 2022/23, the following priorities have been identified:

- Continue the provision of revalidation workshops to support the nursing associate workforce in preparation for their first revalidation.
- Integration of NMC revalidation requirements and monitoring into the new learning management system

Board decision	Action	Responsible officer	Completion date
The Board noted the content of this report and the identified actions for 2022/23 to support revalidation for nurses, midwives, and nursing associates.	None	n/a	n/a

226/22 Board of Directors Declarations of Interest

PB presented the report which detailed the declarations of interest for all Board members as at April 2022. It was noted that Angela Adimora's declaration required amendment to name the company which she works for.

Board decision	Action	Responsible officer	Completion date
The Board noted the MFT Board of Directors' Register of Interests (April 2022)	Angela Adimora's declaration to be amended	Trust Board Secretary	May 2022

227/22 Committee Meetings

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

- Group Risk Oversight Committee held on 21st March 2022
- Charitable Funds Committee held on 23rd March 2022
- Audit Committee held on 6th April 2022
- Quality and Performance Scrutiny Committee held on 6th April 2022
- Human Resources Scrutiny Committee held on 12th April 2022
- Extraordinary Finance & Digital Scrutiny Committee held on 29th March 2022

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

228/22 Date and Time of Next Meeting

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

229/22 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 9th May 2022		
Action	Responsibility	Completion date
Board briefing to be prepared identifying how Hive will benefit patients and staff and the wider potential offered by a single electronic patient record across the whole of MFT.	JB	To be included in the report presented at the Public Board Meeting on 11th July 2022
Patient stories to be presented at the beginning of every Board of Directors' meeting	CL	July 2022 onwards
A comparison with pre-pandemic complaint numbers to be included in the Complaints Annual report	CL	To be presented at the Public Board Meeting on 11th July 2022
Angela Adimora's declaration of interests to be amended to include her employer's name.	Trust Board Secretary	Complete

NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' SEMINAR

Meeting Date: 13th June 2022

MS Teams

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

The deadline for submission of the final financial plan for 2022/23 was notified in late May and fell between Board of Directors' meetings. As a result, the Financial Plan for 2022/23 was discussed and considered for approval at the Board of Directors' seminar on the 13th June 2022.

Apologies for Absence

Apologies were received from Toli Onon

Financial plan 2022/23

JEh presented the report which sought approval for MFT's financial plan for 2022/23 which detailed a breakeven plan at a control total level and for agreement of onwards submission to NHSE/I and the GM ICS by the 20th June.

Additional income has been allocated to GM to cover inflationary pressures of £78.8m, on the basis that GM will submit a breakeven plan, of which £28.6m is assumed to flow to MFT. The overall GM ICS submission will reflect a breakeven position at final plan stage (£187m deficit for April submission) within which the MFT position will also be at breakeven (£52.2m deficit in April submission). As at 8th June 2022 the GM deficit stands at £52.1m and work continues to resolve the GM gap. Plans include a 5% 'CIP' for Providers and 5% 'QIPP' for Commissioners.

GM Capital plans are now within the allowable margin of difference within which MFT's share is now £68.5m.

As the Board are aware the Hospital/MCS/LCO control totals have been issued and agreed. Corporate budgets have yet to be agreed across the Group Directorates, and discussions are ongoing to conclude these before the end of June 2022.

There are a number of significant risks to delivery of the breakeven plan:

- To achieve breakeven assumes delivery of a Waste Reduction Plan (WRP) requirement of £117.2m. This would be delivered through £66.5m by Hospitals/MCS/ LCO/ Corporate and Estates with flexibilities held at Group level used to bridge the gap non-recurrently to the total requirement. The £66.5m remains in excess of figures delivered in previous years and is therefore a significant risk.

- Inflation - £78.6m of inflation pressure including pay awards has been assumed but movement to breakeven would require £8m reduction in underlying assumptions, making MFT susceptible to ongoing inflationary cost pressures. The share of the additional national monies, discussed earlier, of £28.6m, badged as offsetting inflationary pressures, is required to support MFT's move to breakeven.

- The Plan includes an assumed Agenda for Change pay award of 2% and no subsequent action from Unions.

- Due to its size and complexity, Hive presents further potential for risk, including a financial risk against its approved budgets.

- No further funding is available for Hospitals in the breakeven position, therefore productivity improvements must be delivered to increase activity and achieve the 104% of 2019/20 activity by value, rather than assuming additional funding will be available.

- Discussions are ongoing at GM level about the number of critical care beds required, and the funding supporting them

Workforce and operational assumptions include:

- Absence Rates of circa 7.5% during Q1 falling to 6% by the end of the financial year.

- Annual Leave carried over from 21/22 will be utilised during 22/23.

- Staff Turnover will add an additional 0.5% pressure to vacancy profiles.

- International recruitment will add c. 650 new nurses during 22/23 and up to 80 doctors.

- An estimated 80% of healthcare support workers will be re-banded at band 3.

- Locum rates will be standardised across MFT during the year.

- COVID-19 G&A bed occupancy will be less than 5% by the end of the financial year.

- Theatre productivity will significantly increase compared to pandemic period.

- Outpatient slot utilisation will increase from quarter 2 onwards.

- Outpatient attendances will increase by more than 5%, as a result of reduced IPC measures.

- There are technical changes in clinical coding through Hive that will impact on reporting and comparative data.

JEh talked through the capital plan, which had reduced overall since the previous submission due to a number of changes agreed at a GM level. These are: an assumption that MFT will part-fund the Hive programme by £15m through additional PDC funding via the "Levelling up – Digital Maturity" national programme; a further reduction of £9m is required to remain within the GM envelope; changes to New Hospitals Programme phasing and minor changes on other lines.

Key risks for the capital plan include:
- the assumed HIVE funding from "Levelling Up – Digital Maturity" PDC – a £15m risk if not received, although MFT have sought and been provided the assurance that this is deemed a system risk and therefore not solely an MFT risk.
- The IFRS 16 mechanisms are still to be confirmed and there is an up to £140m risk regarding the number of leases that will need to be capitalised in 2022/23

Next steps following a successful GM submission on 20th June 2022 include:
- Agreement of the content of internal budgets for 22/23 control totals for Corporate Directorates
- Continued identification and development of WRP schemes seeking greater focus on productivity
- Finalised internal budget movements ready for month 3 reporting
- Work with GM colleagues to seek further system savings

Board members recognised the challenging financial position MFT faces during 2022/23, in particular noting the challenge in delivering the unprecedented WRP target. Progress in delivering the plan will be monitored through the Finance and Digital Scrutiny Committee and the Board of Directors, a further updated paper will be presented to the next Board Meeting.

Board decision	**Action**	**Responsible officer**	**Completion date**
The Board approved the financial plan for 2022/23 and agreed its onward submission by 20th June.	None	n/a	n/a

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(May 2022)

1. Introduction

The Board Assurance Report is produced every two months 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 (BAR) 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 Accountability Oversight Framework (AOF) process reviews the performance for all MFT Hospitals / MCS and LCOs and is reported into MFT's Quality and Performance Scrutiny Committee.

It was agreed at the start of this year that the metrics within both the BAR and AOF, and the scoring logic for the AOF, would benefit from a full-scale review due to:

- the endemic nature of COVID-19 prevalence and the impact on performance; and
- the need to ensure that domain metrics are aligned to national planning and performance guidance, and NHS Oversight Framework.

In light of this, there have been some changes to the metrics reported in this BAR compared to that which was presented to the Board of Directors in May. In addition to the range of metrics presented here, the BAR which come to September's Board will include data on:

- Transfer of patients outside Saint Mary's MCS due to capacity/delays
- Avoidable admissions to the neonatal unit
- Reportable organism infections.

3. Key Priority Areas

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

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

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.

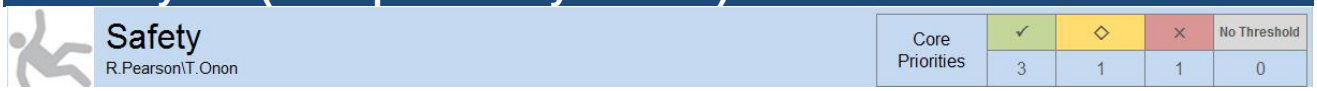
The narrative is provided by the lead Director accountable for the individual priority areas.

‘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. Each domain is structured as follows:

Summary Bar (Example –Safety Domain)



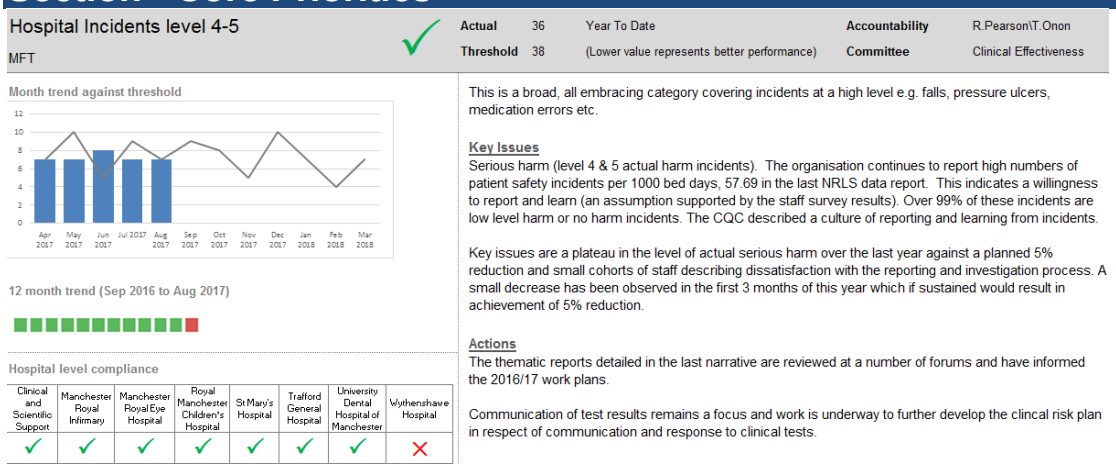
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	6	0	2	0

Headline Narrative

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

The Trust continues to identify Never Events within its incident profile, however, in relation to benchmarking, the Trust overall demonstrates performance the 'same' as other Trusts when Never Events are analysed as total events with statistical comparison to bed days (NHSI OBIEE NRLS StEIS (26 Mar 2022)). A Trust-Wide risk is being managed strategically which focuses on the optimisation of human/system interaction in the way understand, respond to and improve patient safety, the proportion of reported patient safety incidents resulting in harm remains consistent with that of other Trusts. The Trust continues with its programme of work to implement the National Patient Safety Strategy.

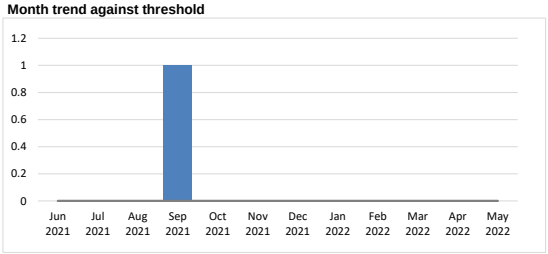
Safety - Core Priorities

Mortality Reviews - Grade 3 (Review Date) ✓

Actual 0 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Key Issues

The programme of mortality reviews continues to be refined across the Trust, including the use of the mortality portal to support learning. All deaths where the outcome is judged as probably or definitely avoidable are subject to further evaluation aligned to the Trust's Patient safety Insight, Learning and Response Policy. The Structured Judgement review process is used proactively where potential learning is identified through complaints, incident management or medical examiner processes. Learning is routinely considered and contextualised through the Trust's safety oversight system. Key issues identified for further evaluation have included the timeliness of referrals into tertiary services and also the effective transfer between MFT sites for treatment and the implementation of the ReSPECT process. It should be noted that data is currently only provided by WTWA for this indicator, therefore the compliance data for other sites is not available. This position has been reviewed and actions being developed to ensure a consistent approach to repoting avoidability.

Actions

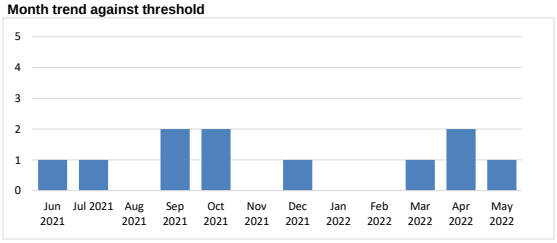
Optimising transferable high impact learning across MFT is a key priority for 2022/23. The Safety Oversight System allows for continual triangulation of intelligence. Safety II, learning from when things have gone well, and translating that into the mortality review process is also a key focus. The Annual Learning From Deaths report will be presented to the Group Quality and Safety Committee in August 2022.

Never Events ✕

Actual 3 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

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. There continue to be 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. A Trust-wide consensus building programme in relation to Local Safety Standards for Interventional Procedures (LocSSIPS) has been completed to support the integration of key controls into the EPR.

Detailed reports have been presented Group Risk Oversight Committee and Quality and Performance Scrutiny Committee. The Trust commissioned an external review in relation to its approach to learning from Never Events, this has now been received and will be used alongside an Internal Audit of the effectiveness of controls in place to ensure learning related to patient safety to develop the Group and Site/MCS/LCO level Patient Safety Incident Response Plans.

Actions

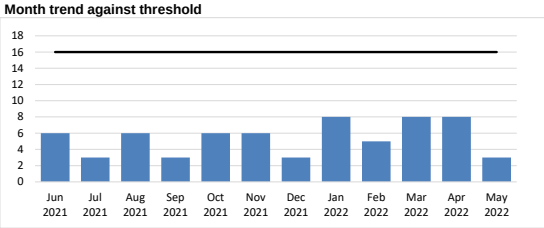
The Trust-Wide risk, which is being managed strategically, focuses on the optimisation of human/system interaction in the way to understand, respond to and improve patient safety aligned to the Trust's approach to integrating safety I and safety II data to enhance our learning and improvement.

Significant rapid learning and improvement is underway in relation to the role of the independent check for medication and invasive procedures, this requires a Trust-wide focus. All incidents relating to prevented never events are subject to a high impact learning review to increase opportunities for learning. An external review is underway in relation to the effectiveness of how the Trust is learning from Never Events.

Hospital Incident level 4-5 ✓

Actual	11	YTD (Apr 22 to May 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	16	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	✓
1	2	0	2	0	0	3	3	0

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

Key Issues

Patient safety incidents are analysed using Statistical process control, rather than counts, in line with the implementation of the Patient Safety Incident Response Framework, all notifiable (under Duty of Candour) incidents are analysed in this way. The variation identified in March across all notifiable incidents is directly attributable to the reporting of potential Hospital Acquired COVID infections. All sites/MCS/LCOs receive routine detailed profiles of types of patient safety incidents and clinical area based incidents to identify potential risk or opportunities for change and improvement. The profiles are currently being used to develop the site/MCS/LCOs draft Patient Safety Incident Response plans. The themes identified within the serious and notifiable incident profiles across the Trust are aligned to those identified in following investigation into never events.

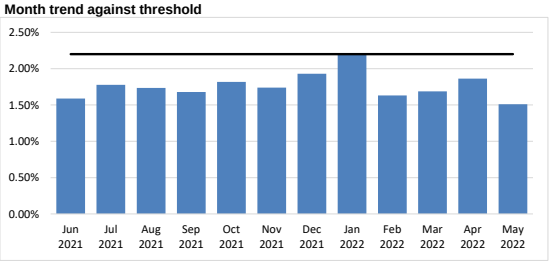
Actions

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:
- implementation of the Mental Health Act
- safe and effective discharge
- falls prevention
- recognition and management of a deteriorating patient
- safe and effective management of venous access
- the effective application of the Duty of Candour
- the conistent approach to MDT meetings
- opportunities for change and improvement in relation to Consent

Crude Mortality ✓

Actual	1.69%	YTD (Apr 22 to May 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(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
10.67%	2.13%	0.28%	0.24%	0.32%	0.00%	2.68%	3.20%	NA

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

Key Issues

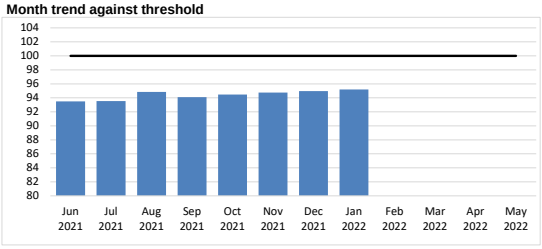
Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment. The effective benchmarking of this data is currently under review, and sites where the threshold is exceeded actively interrogate the data to explore meaningful trends. There is a Trust-wide focus on understanding mortality data in a more sophisticated way through the use of the HED system, enabling scrutiny of a wider range of mortality indicators.

The areas of non-compliance will be a focus for discussion and assurance at the Group Learning from Deaths Committee.

Summary Hospital-level Mortality Indicator (SHMI)

Actual	95.2	R12m (Feb 21 to Jan 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

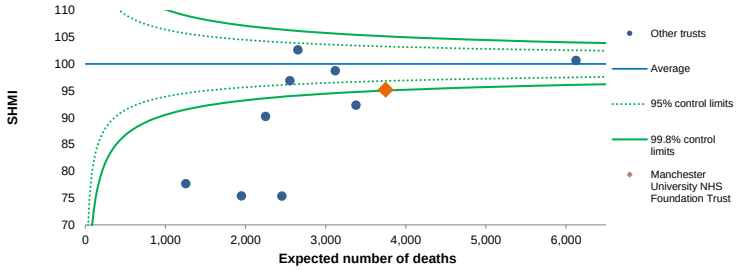
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	✗	NA
NA	92.4	NA	NA	NA	NA	89.0	111	NA

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

Progress

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

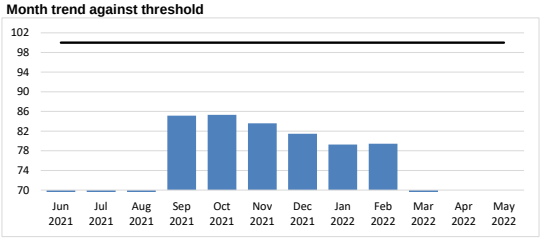
Summary Hospital-level Mortality Indicator for the Shelford Group, Feb 21 - Jan 22



Hospital Standardised Mortality Ratio (HSMR)

Actual	79.4	R12m (Mar 21 to Feb 22)	**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	69.0	NA	NA	NA	NA	80.4	96.9	NA

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

HSMR is a metric designed for adult services.

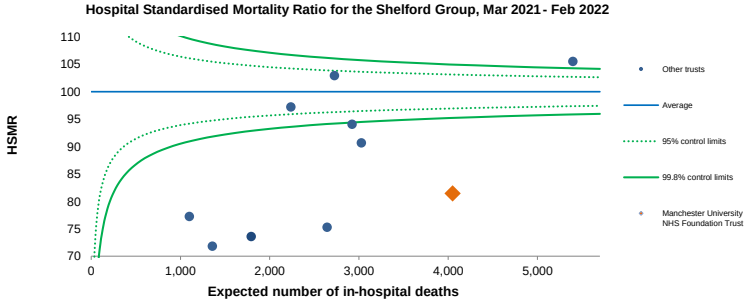
HSMR is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

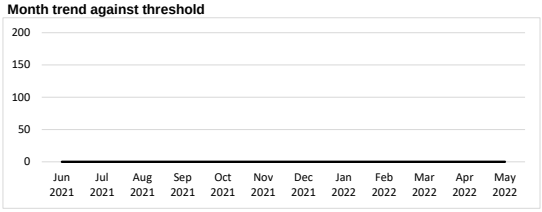
Hospital Standardised Mortality Ratio for the Shelford Group, Mar 2021 - Feb 2022



HM Coroner Prevention of Future Deaths Report ✓

Actual	0	R12m (Jun 21 to May 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

Report provided by the coroner following an inquest, where the coroner believes action should be taken to prevent future deaths.

Progress

The information provided for July 2021 to May 2022 return is zero.

Reportable organism infections - attributable (MSSA) bacteraemia

Actual 12 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold (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
-	-	-	-	-	-	-	-	-
0	6	1	0	0	0	4	1	0

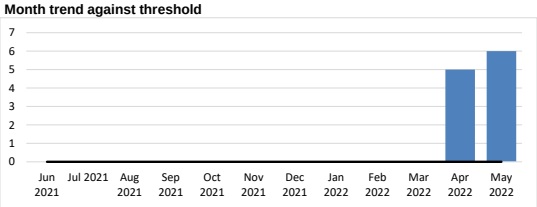
Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Reportable organism infections - attributable (VRE) bacteraemia

Actual 11 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold (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
-	-	-	-	-	-	-	-	-
0	9	0	0	0	0	1	1	0

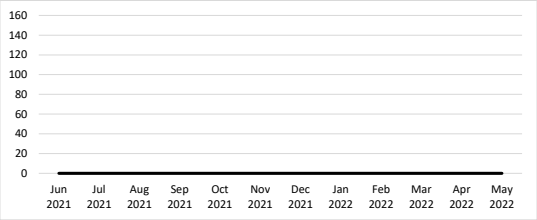
Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Reportable organism infections -attributable (CPE) bacteraemia

Actual 0 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold (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
-	-	-	-	-	-	-	-	-
0	0	0	0	0	0	0	0	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Progress

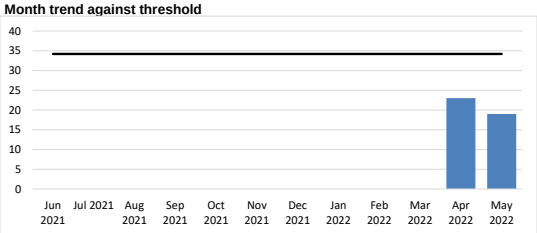
The information provided for April 2022 and May 2022 return is zero.

Reportable organism infections - attributable (Gram -ve bacteraemia)

Actual 42 YTD (Apr 22 to May 22) **Accountability** J.Eddleston\T.Onon

Threshold 34.2 (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
✓	✓	✓	✓	✓	✓	✓	✓	✓
0	21	7	1	0	0	8	5	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Patient Experience

C.Lenney

Core Priorities	✓	◇	×	No Threshold
	2	1	1	3

Headline Narrative

The number of new complaints received across the Trust in May 2022 was 147, which was equal to the volume received in April 2022. In May 2022 the percentage of formal complaints that were resolved in the agreed timeframe was 93.7%, this is a notable increase from 88.2% from the previous month. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Trust overall satisfaction rate for FFT May 2022 was 91.2% compared to 90.3% in April 2022. There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

Infection prevention and control remains a priority for the Trust. A recent review of all attributable HCAI was performed and presented to the Group Infection Control Committee in January: key themes were recorded and actions for reduction were determined. End of year HCAI reviews are currently being undertaken by all sites/CSU and overseen by IPC.

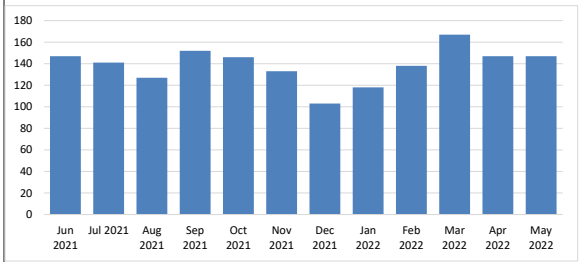
Trust performance is above trajectory for both MRSA and CDI:

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

Complaints: Volumes -

Actual	1620	YTD (Apr 22 to May 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
98	354	167	244	61	42	407	186	58

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

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.

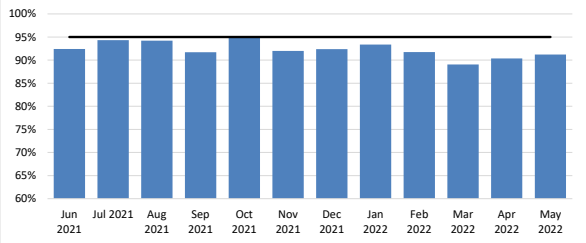
> Board Assurance

May 2022

FFT: All Areas: % Extremely Likely and Likely

Actual	93.0%	YTD (Apr 22 to May 22)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	◇	✓	✓	✓	✓	✗	◇
96.59%	96.52%	90.63%	95.75%	98.38%	98.45%	96.44%	86.94%	91.40%

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

Progress

The Community Services Prioritisation Framework provided by NSHE, outlined FFT collection to be paused for Community Services for January and February 2022 in response to the increasing COVID-19 pressures facing Community Services. Although NSHE provided guidance for January and February 2022, activity remained paused for March 2022 and recommenced in April 2022.
The Trust overall satisfaction rate for FFT for May 2022 was 91.2%, which is an increase from the 90.3% received in April 2022 and 89% March 2022.
There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

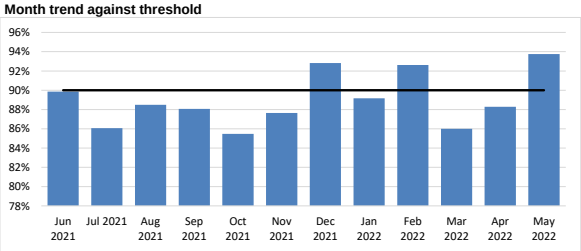
Actions

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

Complaints: Resolved Within Agreed Timeframe

Actual	91.0%	YTD (Apr 22 to May 22)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	✓	◇	◇	◇	✓	✓	✓
72.2%	98.1%	100.0%	82.5%	85.7%	70.0%	98.8%	92.3%	100.0%

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

Progress

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

The May 2022 data identifies that 93.7% of complaints were resolved within the agreed timescales compared to 88.2% inApril 2022 and 86% in January 2022: this is a notable increase of 5.5%. The largest contributory factor for delays, is awaiting external contribution to the response.

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

Actions

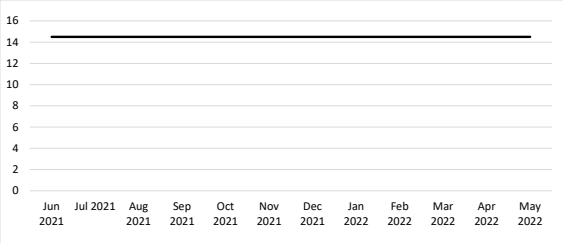
Performance is monitored and managed through the Accountability Oversight Framework (AOF).

Cdiff: Lapse of Care ✓

Actual 0 YTD (Apr 22 to May 22) **Accountability** C.Lenney

Threshold 15 (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	0	0	0	0	0	0	0	NA

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

Progress

A total of 246 CDI cases were reported during 2021/2022: 196 (80%) of which were trust-attributable against a trajectory of 166. Cases from October 2021 onwards are currently being peer-reviewed to determine lapse in care status. There were 17 trust-attributable CDI cases reported for March 2022, all of which are pending review.

PALS – Concerns -

Actual 7716 YTD (Apr 22 to May 22) **Accountability** C.Lenney

Threshold None (Lower value represents better performance) **Committee** Quality Committee

Month trend against threshold (includes corporate complaints)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	#REF!	LCO
-	-	-	-	-	-	-	-	-
545	1800	675	1134	354	213	1938	759	108

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

Key Issues

A total of 726 PALS concerns were received by MFT during May 2022, which is an increase from the 646 received in April 2022.

Of the 726 PALS concerns received in May 2022, the highest volume were attributed to WTWA, with 205 (28% of the total) being received. This is a continued increase for WTWA when compared to the 186 in April 2022 and 188 in March 2022. The top specific themes for WTWA related to 'Appointment Cancellation/Delay' (64), Communication (60) and 'Treatment and Procedure' (49).

Of the 205 WTWA PALS concerns received, the Directorates with the highest number of concerns raised were the Burns & Plastics/Head and Neck Directorate which were identified in concerns relating to 'Appointment/Delay/Cancellation (OP)', 'Communication' and 'Treatment and Procedure'. General Surgery & Urology Directorates had specific areas identified relating to 'Appointment/Delay/Cancellation (OP). Medical Specialties had specific areas identified relating mainly to 'Appointment Delay/Cancellation' (OP).

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.

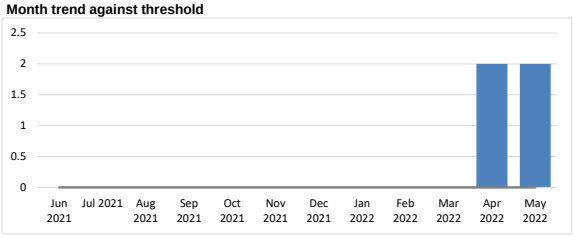
> Board Assurance

May 2022

PHSO Enquiries

Actual	4	YTD (Apr 22 to May 22)	**Accountability**	C.Lenney
Threshold	0	(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
✗	✗	✓	✗	✓	✓	✓	✓	✓
1	2	0	1	0	0	0	0	0

The number of new PHSO enquires received in May 2022 was 2, this is the same volume recived in April 2022.

Progress

10 PHSO cases received prior to the 1st April 2022 remain open:

- 9 of which are awaiting a provisional report, final report or actions to be completed
- 1 in which WTWA have disputed the PHSO decision, an external review was undertaken and the report provided to the Trust on 18th April 22 and Sent to PHSO on 4/5/22. Currently the case remains open pending further communication from the PHSO.

A further 7 cases received prior to the 1st April are currently under review and awaiting medical notes, complaint files and other information.

MFT have received two early resolution requests:

- UDH: PHSO have requested early resolution by way of compensation, (level 3 on their severity of injustice scale) in the sum of £500-900.
- Wythenshawe: PHSO have requested a meeting between complainant, the Trust and the PHSO as a means of mediation.

Operational Excellence

D.Furnival

Core Priorities	✓	◇	×	No Threshold
	1	0	13	1

Headline Narrative

MFT's elective recovery plan continues to utilise all available opportunities as Covid numbers continue to decrease. MFT and GM continue to experience peaks in emergency demand across both adult and paediatrics, which has required ad-hoc reduction in elective bed capacity to manage the non-elective demand.

Notwithstanding these operational challenges, MFT continues to progress actions aimed at improving performance against national operational standards. MFT completed 2022/23 planning requirements in line with the national planning guidance developing associated trajectories and refreshed action plans in conjunction with CCGs.

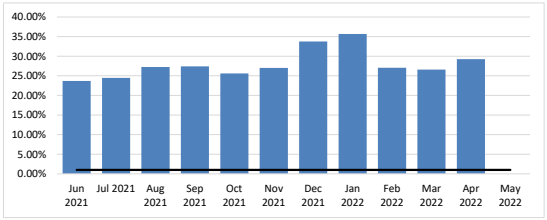
May summary:
• The overall RTT elective waiting list stood at 164,237 which is growth of 4.2% (6,648) on the position reported in April 2022. The number of patients waiting longer than 52 weeks was 15,608 which represents an overall growth of 13.1% on that reported in April and accounts for 9.5% of the current waiting list.
• The number of patients waiting longer than 104 weeks at the end of May submitted snapshot was 507 (0.3%) of the overall waiting list and continues to fall in line with plans to reduce long waits to zero by the end of June.
• National performance against the 4 hour wait standards for Emergency Departments has steadily reduced since April 21, with the performance across GM and MFT closely following the same trend. This downward trend appears to have plateaued over the last quarter at around 63.5% and generally reflects MFT Emergency Departments ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of operational pressures and capacity constraints, there has been 21 breaches of the 12 hour DTA quality standard in May with 148 in the year to date, following following route cause analysis (RCA), none of these have been found to have contributed to patient harm. Corporate Governance retain oversight.
• A cancer recovery programme is in place to improve timely access for patients. Only 1 standard for cancer was reached in April which was the provision of Chemotherapy as a subsequent treatment.

Operational Excellence - Core Priorities

Diagnostic Performance ×

Actual	29.24%	(April 22)	**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
20.9%	22.42%	78.88%	47.62%	No Data	No Data	48.81%	42.10%	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.
Due to NMGH outage incident, data for May 2022 is not available at time of publishing.

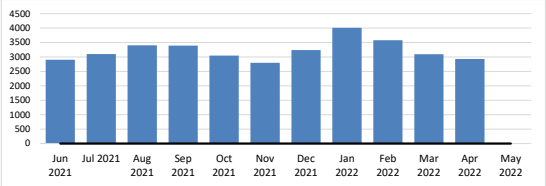
Key Issues
• Impact of the Covid waves and reduction in capacity and activity as a result.
• Increased volumes of unplanned tests linked to increased Non Elective attendance / admissions
• Increased short notice staff sickness

Actions
Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
• Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.
• Diagnostic clinical prioritisation undertaken.
• Additional CT scanning lists secured on a weekend
• Focus on reducing long waits given the tail of the waiting list is increasing
• Strategic overview of operating principles, processes and practices underway W/C 20th June to improve performance and deliver a singular process across MFT.

Diagnostic wait > 13 weeks

Actual	2931	(April 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	-	-	✗	✗	NA
571	93	358	8	No Data	No Data	1140	761	NA

The number of patients waiting over 13 weeks for ony one of 15 key diagnostic tests.
Due to NMGH outage incident, data for May 2022 is not available at time of publishing.

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 internal demand
- Increased short notice staff sickness

Actions

Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.

- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.
- Diagnostic clinical prioritisation undertaken.
- Additional CT scanning lists secured on a weekend
- Focus on waiting list validation and Access policy application
- Focus on reducing long waits given the tail of the waiting list is increasing
- Strategic overview of operating principles, processes and practices underway W/C 20th June to improve performance and deliver a singular process across MFT.
- Develop a singular PTL for diagnostics in line with elective care.

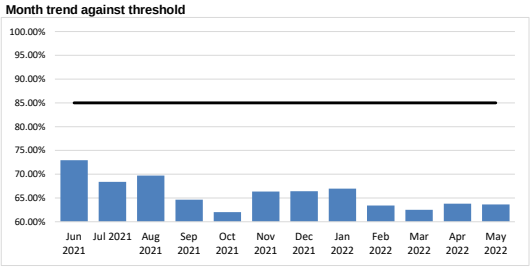
Progress

- Director of Performance is leading strategic focus on diagnostic processes and practices in line with Access policy W/C 20th June.
- Development of singular PTL underway with inclusion of NMGH data to give a Trust wide position on a daily basis for the first time to enable operational oversight.

A&E - 4 Hours Arrival to Departure

Actual	63.7%	Q1 (Apr to May 22)	**Accountability**	D.Furnival
Threshold	85%	(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	52.21%	74.47%	95.55%	99.93%	NA	63.81%	61.10%	NA

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

Key Issues

- Covid restrictions impacting on flow within the ED.
- Reductions to delayed handovers of patients alongside the numbers of ambulance holds continues.
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
- Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions

- Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
- These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:

I. Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).

MFT ED safety standards are a key focus for sites. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.

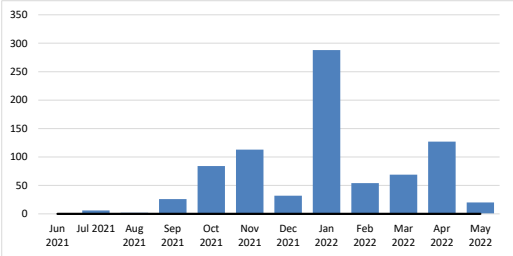
Progress

- May 2022 saw 1,273 attendances per day compared to 1,331 in April, this is reflective of the impact of the NCA systems outage impacting NMGH along with increasing acuity of patients across the footprint, IPC measures and short term staff sickness, both medical and nursing.
- MFT performance had plateaued with ~64.0% in Q4 compared to 62.6% in GM and 71.2% nationally.
- The number of patients with 7+ and 21+ days length of stay in MFT beds at 31st May was 502 and 196 respectively. Hospital teams are focused on long length of stay reviews.

12 hour trolley waits

Actual	147	YTD (Apr 22 to May 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✓	✓	NA	✓	✗	✗	NA
NA	5	0	0	NA	0	1	141	NA

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

Key Issues

Whilst pressures are evident across the trust footprint they are specifically exacerbated at NMGH where:
- Bed capacity, currently -37 beds compared to 2019, this is exclusive of the increase in activity demand from April 21 which would contribute a further 16 beds.
- Department capacity is constrained due to IPC restrictions and physical estate.
- Higher than optimal reason to reside patients which restricts bed capacity and flow out of the emergency department has remained stubbornly high with OOH area patients a particualr concern at NMGH.

Actions

- Flexible use of space between paeds and adult ED to address demands.
- Refreshed and relaunched site escalation flow charts, including the ED and workforce triggers.
- New site patient flow team 24/7 - This team adds an additional layer of focus on patient flow.
- Continued focus supported by 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.
- Discharge Resilience programme led by the MLCO with Hospitals to improved on delayed discharges and flow out of the hospital

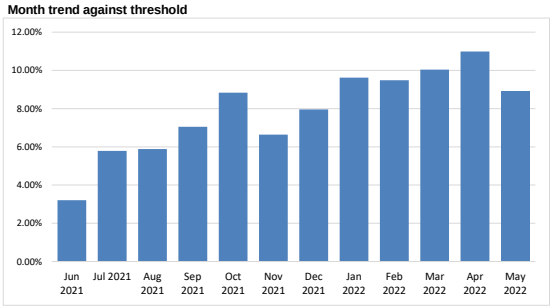
Progress

As a result of significant operational pressures the Trust has reported 147 breaches of the standard to date. North Manchester site accounts for 141 of these DTA breaches, the majority of which were related to bed capacity constraints. Harm reviews are undertaken for all patients, with no harm identified in any of these breaches following RCA. Learning from the root cause analysis undertaken for any breach of the standard has been implemented.

Over 12 hour waits in ED

Actual	8.91%	(May 22)	**Accountability**	D.Furnival
Threshold		(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	13.83%	1.07%	0%	No Data	NA	8.64%	9.34%	NA

Number of Patients spending more than 12 hours in A&E before a decision to admit is made, if required, or when treament is completed (whichever is later).

Key Issues

- Covid restrictions impacting on flow within the ED.
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
- Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions

- Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
- These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:

I. Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).
MFT ED safety standards are a key focus for sites. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.
- Finalise the performancethresholds with Hospitals / MCS

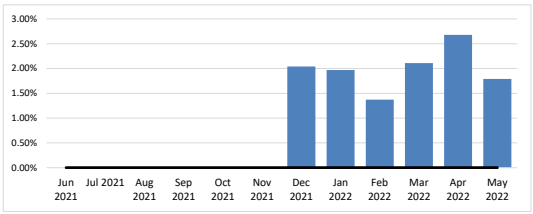
Progress

- Transformational teams continue to develop plans with site teams which includes reviewing existing protocols for admission and flow through the departments into the wider site
- Focused work with NWAS to increase avoidance strategies (See and treat)

MFT - Ambulance hold % Attend

Actual	1.79%	(May 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	-	-	NA	NA	✓	✗	NA
NA	0.60%	No Data	No Data	NA	NA	0%	5.46%	NA

The ratio of NWAS conveyances to the Trust compared to those that have been "held" . Holds are determined where NWAS have not been able to transfer their patients to the department >15 minutes after arrival.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
• Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.
• 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 Increase avoidance / redirection at streaming stage, eg See and Treat in relation to NWAS.
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;

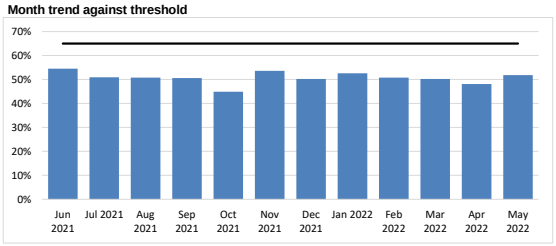
Progress

• Increasing volumes of UTC attends, MFT accounts for 99% of all UTC bookings reported within GM in the last three months with around 3,000 each month equating to ~28% of the North regions bookings (131 sites) with MRI being the highest contributor axcross each of the last three months.

Handover between Ambulance and A&E - within 15 minutes

Actual	51.8%	(May 22)	**Accountability**	D.Furnival
Threshold	65.0%	(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
NA	50.8%	No Data	No Data	NA	NA	49.0%	56.8%	NA

% of patients transferred from ambulance to A&E within 15 mins.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites with improving ambulance handover turnaround times. A follow up summit is planned for the 21st of June, with representatives from all MFT Emergency Departments, system partners and the Northwest Ambulance Service

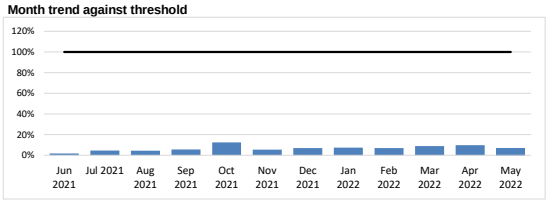
Progress

• Progress is already being made at all sites around process improvement which is expected to demonstrate an impact in June's performance.
• Accuracy of reporting has been identified as an issue and a rapid improvement process is underway to simplify handover with a turnaround standard operating procedure at all sites being developed jointly with NWAS
• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.

Handover between Ambulance and A&E - > 60 minutes

Actual	7.0%	(May 22)	**Accountability**	D.Furnival
Threshold	100%	(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
NA	7.8%	No Data	No Data	NA	NA	5.4%	8.0%	NA

% of patients transferred from ambulance to A&E within 60 mins.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites with improving ambulance handover turnaround times. A follow up summit is planned for the 21st of June, with representatives from all MFT Emergency Departments, system partners and the Northwest Ambulance Service
• Implementation of virtual ward
• A detailed assessment of the current utilisation of medical SDEC service has taken place and clear actions have been

Progress

• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit

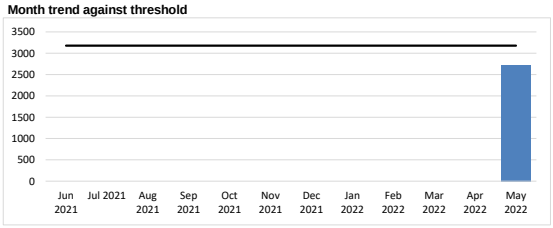
> Board Assurance

May 2022

RTT - 78 Weeks (Incomplete Pathways)

Actual	2728	(May 22)	**Accountability**	D.Furnival
Threshold	3178	(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
✗	✗	✗	✗	✗	✗	✗	✓	✓
8	1033	232	757	105	86	540	417	0

The number of patients waiting over 78 weeks on an incomplete pathway.

Key Issues

- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- Impact of the Covid waves and reduction in capacity and activity as a result.
- Patient choice linked to Covid.

Actions

- Develop a trajectory to reduce long waits in line with national priority expectations and review in line with hospitals / MCS.
- Develop reporting framework using similar method for current long waits and circulate to operational teams weekly.

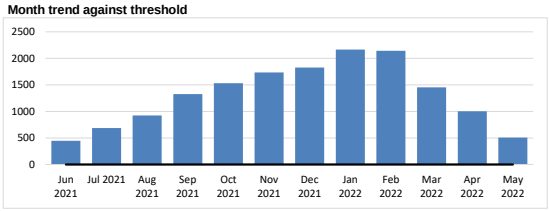
Progress

- In line with planning guidance and focus on reducing long waits, a trajectory on reducing long waits in year has been produced and shared with Hospitals / MCS to review and operationalise. This will be managed weekly in line with current long waits reductions
- Next steps to produce weekly monitoring report by site and include metrics within EDT reporting outputs.

RTT - 104 Weeks (Incomplete Pathways)

Actual	507	(May 22)	**Accountability**	D.Furnival
Threshold	423	(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
✗	✗	✓	✗	✓	✓	✗	✓	✓
1	260	27	97	5	15	77	25	0

The number of patients waiting over 104 weeks on an incomplete pathway.

Key Issues

- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures with consequential impact on elective capacity

Actions

- Planning work was undertaken with hospitals / MCS to ensure reduction in long waits in line with national priorities to reach 0 by the of June.
- Daily circulation of performance vs trajectory with particual focus on dating patients, DQ, transacting outcomes and reviewing "pop ons"

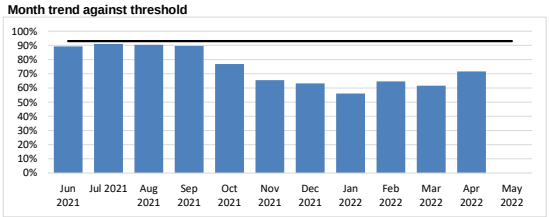
Progress

- Long waits have reduced significantly given the joint working between hospitals and group teams. Currently stands at 296 at 21st June, this includes P6 and clinically complex patients. A reduction of over 3,869 long waiters since 1st January 22.

Cancer Urgent 2 Week Wait Referrals

Actual	71.7%	Apr-22	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	✓	✓	NA	NA	✗	✗	NA
NA	96.9%	100.0%	93.1%	NA	NA	57.0%	80.0%	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. Breast performance is the main driver, however head and neck at WTWA has decreased in performance to only 5% in April.

Actions

- Two specific tumour group 2ww workstreams in action - breast and skin. MRI and WTWA are working to standardise pathways across head and Neck across both sites and therefore extend capacity.
- Full NMGH data is not included here but updated performance estimates 21.8% performance

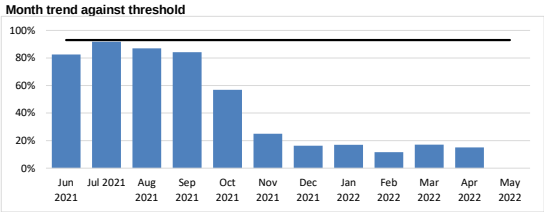
Progress

- Cancer 2ww referrals have returned to >100% pre Covid averages. February and March saw an increase following a drop in December and January. May has seen an increase to the extremely high levels seen Sep - November last year - including a rise in colorectal referrals to almost double previous months.

Cancer 2 Week Wait breast Symptom

Actual	15.0%	Apr-22	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	NA	NA	NA	✗	-	NA
NA	NA	NA	NA	NA	NA	15.0%	No Data	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.

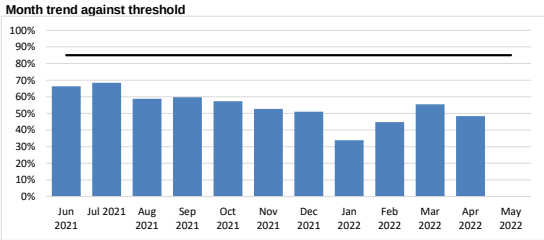
Actions
•All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
• Work continues across sites for breast to understand capacity shortfall and look for solutions internally and externally.
•NMGH performance for April is estimated to be around 7%

Progress
May performance estimate is 27.9%.

Cancer 62 Days RTT

Actual	48.4%	Apr-22	**Accountability**	D.Furnival
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✗	NA	NA	✗	✗	NA
NA	51.7%	NA	37.5%	NA	NA	50.8%	11.1%	NA

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

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

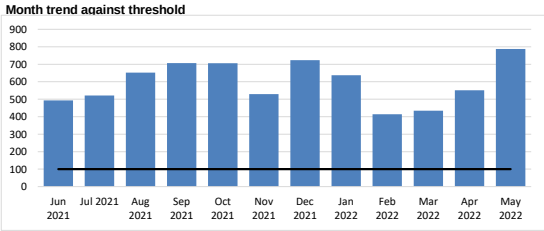
Actions
• All sites have action plans in place to improve performance.
• Referral rates have increased to above pre-Covid levels whilst the Trust is still reducing its backlogs due to diagnostics delays and patient choice.
• The wider GM system has put a number of actions in place to coordinate system capacity, including mutual aid for capacity coordinated via a GM Cancer Surgical Hub. In addition, GM wide work is taking place on the introduction of a single PTL for 4 specialist diagnostic tests.
• Capacity being utilised in the independent sector and the Christie to support timely treatment. In June patients have been sent for mutual aid for treatment in LGI and Gynaecology alongside the MFT@Christie urology lists.
• Reviews of the most challenged pathways in place alongside a general CSS diagnostic review, which includes the intoduction of a cancer specific radiology PTL meeting.
• Updated NMGH data sits at 42.9%

Progress
• Demand has increased to pre-pandemic levels with peaks across tumour groups.
• Performance - 62 day performance remains low and is not expected to improve whilst 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 62 Days Backlog

Actual	788	(May 22)	**Accountability**	D.Furnival
Threshold	100	(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	✗	✗	NA
NA	108	NA	51	NA	NA	382	247	NA

Reduction in number of patients waiting to be seen over 62+ days and back to 19/20 baseline.

Key Issues
• The continued increased referral rate and pathway delays in the diagnostic section have led to the backlog increases.

Actions
• All sites to increase focus on clearing the backlog and stopping tip ins. Actions as above in 62 day section.
• The trajectory for the end of May position was 357.

Progress
• The IT outage at NMGH led to some of the increase as pathways could not be closed and reported. However there was an increase in backlog at all sites from the end of April position. Backlog has started to decrease in mid June.

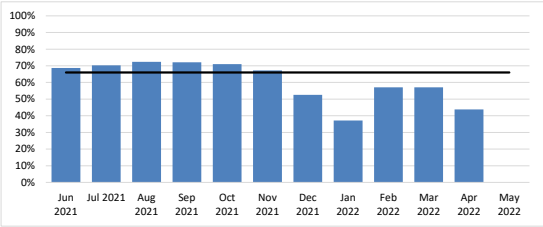
> Board Assurance

May 2022

Cancer Faster Diagnosis

Actual	43.8%	(April 22)	**Accountability**	D.Furnival
Threshold	66.0%	(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	55.3%	NA	50.0%	NA	NA	56.0%	No Data	NA

Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer

Key Issues

- Issues in some specialties with time to first seen (WTWA Head and Neck and Breast across sites)
- Diagnostic delays are reducing performance both CSS and non CSS. Pathology turnaround is a specific issue in some areas such as skin and gynaecology and CSS are working on shorter term improvements.

Actions

- Review of provision of BPTP (Best Practice Timed Pathways)
- Other improvements mentioned in 2ww and 62 day sections also apply to the FDS standard.

Progress

- NMGH April data estimated at 24.13%

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	1	4	6	0

Headline Narrative

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

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

Workforce and Leadership - Core Priorities

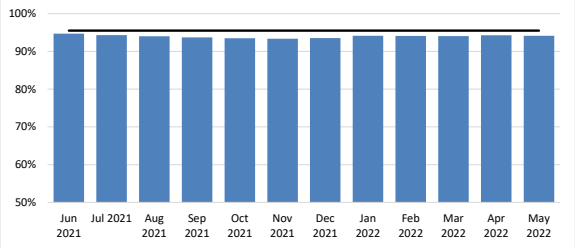
Attendance

✕

Actual 94.1% (May 22) **Accountability** P. Blythin

Threshold 95.5% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✕	✕	✕	✕	✕	✕	✕	✕
95.3%	93.1%	94.6%	94.6%	93.2%	93.8%	94.0%	94.6%	94.2%

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

Key Issues

The Group attendance rate for May was 94.1% which is lower than the previous month's figure (94.3%). This is lower than the attendance rate at the same point last year (May 2021) of 94.8%. The latest figures released by NHS Digital show that for January 2022 the monthly NHS staff sickness absence for the whole of the North West HEE region was 7.9% or 92.1% attendance rate (these figures include all provider organisations and commissioners) and were the highest in England. The South East region reported the lowest sickness absence rate in January 2022 at 5.9% or 94.1% attendance rate.

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

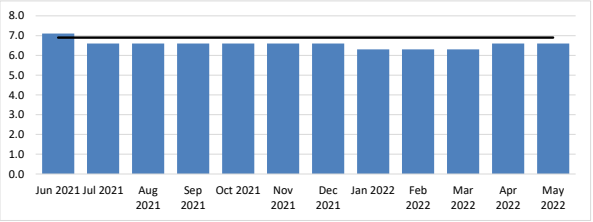
Engagement Score (quarterly)

✕

Actual 6.6 Q1 (Apr to May 22) **Accountability** P. Blythin

Threshold 6.9 (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
✕	✕	✕	✕	✕	✕	✕	✕	✓
6.5	6.4	6.6	6.5	6.4	5.8	6.3	6.7	7.0

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. The only Hospital or MCS that has met the target threshold of 6.9 was the Local Care Organisation.

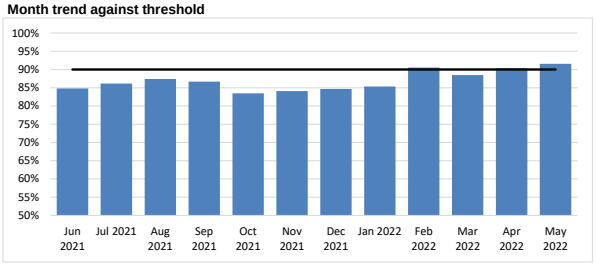
Actions

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

Appraisal - Medical

Actual	91.6%	(May 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	◇	✓	✓	✗	✓	✓	✓
92.5%	91.7%	89.4%	94.4%	93.2%	77.5%	91.5%	95.0%	92.3%

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

Key Issues

Compliance increased by 1.3% across the Group in May 2022. Only RMCH and the Dental Hospital are not meeting the 90% target.

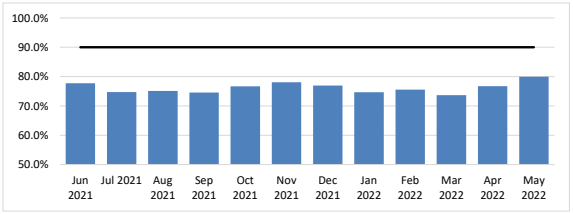
Actions

Appraisal reporting and compliance remains a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals have continued twice a month to support line managers. The Management Brilliance - OD Resource Portal provides line managers with access to guidance and toolkits. Work continues now in four areas: completion of an internal audit by KPMG to provide even greater assurance; accelerated support for NMGH; support for line managers detailed in our People Plan; and initiation of research and work to deliver a digital appraisal.

Appraisal - Non-Medical

Actual	80.0%	(May 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	◇	✗	◇	✗	◇	✗
77.0%	80.2%	78.4%	86.9%	83.6%	88.2%	83.5%	88.8%	79.2%

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

Key Issues

Compliance increased by 2.3% across the Group in May 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI. This was last achieved by the Dental Hospital in September 2021 at 92.2%. The only other Hospital to reach this target in the last year is the Eye Hospital.

Actions

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

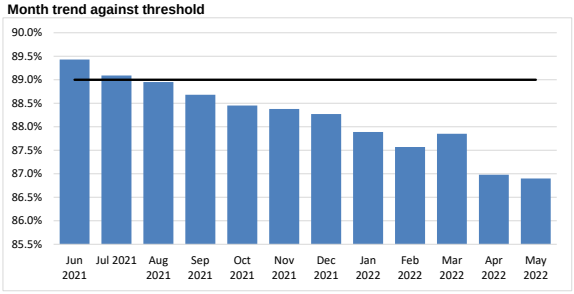
> Board Assurance

May 2022

Retention - rolling 12 months

Actual	86.9%	R12m (Jun 21 to May 22)	**Accountability**	P. Blythin
Threshold	89.0%	(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
◇	✗	◇	✗	◇	◇	✗	✗	✗
85.1%	82.5%	85.0%	84.2%	85.7%	88.9%	83.8%	83.0%	82.2%

The Retention figure shows employees as a percentage that have been at the Trust for 12 months or more.

Key Issues

The Group retention rate for May was 86.9% which is lower than the previous month's figure (87.0%). No Hospital or Managed Clinical Service is currently meeting the 89.0% threshold target for this KPI.

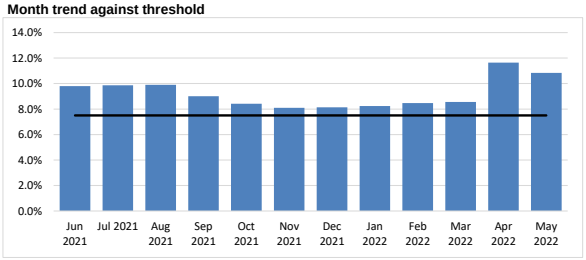
Actions

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.

All Vacancies

Actual	10.8%	(May 22)	**Accountability**	P. Blythin
Threshold	7.50%	(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
✗	✗	✗	✗	✗	✗	✗	✗	◇
11.24%	11.43%	12.80%	11.44%	11.35%	21.95%	13.52%	13.56%	8.58%

This metric shows the number of vacancies at the Trust by taking the establishment figure and minusing the staff in post to show the number of vacancies. This is then divided by the establishment to get the percentage.

Key Issues

The Group vacancy rate for May was 10.8% which is lower than the previous month's figure (11.6%). No Hospital or Managed Clinical Service is currently meeting the 7.5% threshold target for this KPI.

Work is ongoing to understand the differences between what establishment is held in the ledger and staff that are not on ESR which is causing an inflated vacancy percentage. There could be Junior Doctors for example which are included in the establishment but not on ESR which is causing some of the discrepencies.

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.

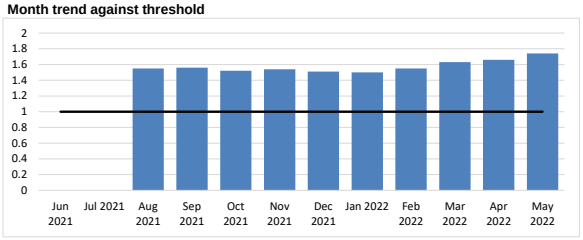
> Board Assurance

May 2022

Relative Likelihood of White Staff vs BME Staff being Appointed

Actual	1.74	(May 22)	**Accountability**	P. Blythin
Threshold	1.00	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	◇	✗	✗	✓	✗	◇	◇	✗
1.83	1.5	1.95	2.51	0.85	2.74	1.5	1.49	2.37

Relative likelihood of White staff being appointed from Shortlisting across all posts compared to BME staff being appointed from Shortlisting across all posts.

Key Issues

The Group relative likelihood of white staff being appointed compared to BME staff for May was 1.74 which is higher than the previous month's figure (1.66). Only the Eye Hospital is currently meeting the 1.00 threshold target for this KPI.

Actions

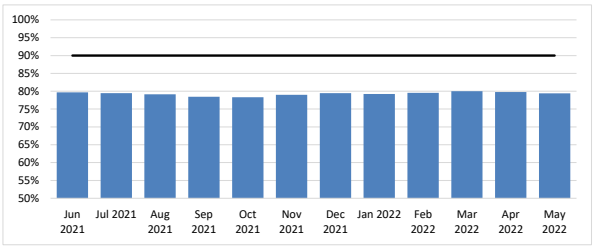
The Trust has launched the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

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

Level 2 & 3 Mandatory Training

Actual	79.4%	(May 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
79.7%	77.9%	77.7%	84.4%	80.7%	80.6%	81.4%	70.0%	81.5%

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

Key Issues

Compliance for Level 2 & 3 CSTF Mandatory Training has decreased by 0.3% across the Group in May 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI or has met this target in the last year.

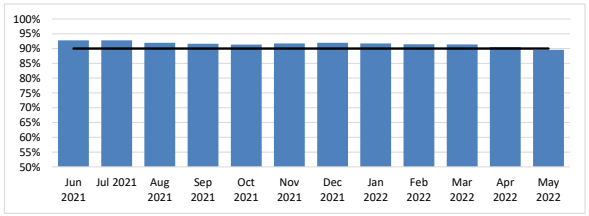
Actions

The 5 key Mandatory Training work streams, overseen at CEO / Director level, have progressed in line with the KPMG audit where we received significant reassurance. Work to integrate this programme into business as usual processes is now underway. All courses are now assigned within individual's dashboards on the Learning Hub helping to drive understanding and compliance. Work continues to drive compliance through the weekly reporting and regular communications. Hospitals/MCS/LCO are planning mandatory training for staff aligned to the HIVE workforce plans to ensure completion. The system for mandatory training is available earlier than the anniversary due date to increase flexibility of completion.

Level 1 CSTF Mandatory Training

Actual	89.6%	(May 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	◇	◇	✓	✓	✓	✓	◇	✓
87.4%	89.6%	88.1%	91.7%	91.7%	93.7%	90.4%	87.5%	90.8%

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

Key Issues

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In May 2022 the aggregate compliance decreased by 0.9% to 91.4%. NMGH, RMCH, MRI and CSS has a compliance score below the 90% Trust target.

Actions

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	David Furnival, Group Director of Operations / Director Team
Date of paper:	July 2022
Subject:	Update report on the Trust's ongoing response to Covid-19 National Emergency, Performance Standards & Recovery 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:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors are asked to note the contents of the report and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.
Contact:	Name: Lorraine Cliff, Director of Performance Tel: 0161 276 6121

UPDATE ON COVID RESPONSE AND RECOVERY

1. PURPOSE

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

2. COVID POSITION

The national team have recognised that the threat level from COVID has reduced, and the incident level was downgraded on the 19th May from a level 4 to a level 3 incident. For MFT the number of COVID positive patients reduced significantly during May, however, there has been an increase of 17% during the first half of June with the equivalent of 5.5 wards being occupied by COVID positive patients. The number of COVID positive patients in critical care beds has also risen, currently 4% consumed with COVID albeit the demand on critical care has not been as great as in previous waves.

Existing COVID Response and Recovery governance structure has continued throughout overseen by the Group Director of Operations.

3. URGENT CARE AND FLOW

Performance against the A&E 4hr standard has remained stable during Q1. The COVID burden on general and acute beds continues to challenge flow across Hospitals and overall MFT occupancy is at 90%, albeit medical ward capacity is much higher at c.98-99%. Hospitals continue to focus efforts on improving flow out of the department and ensuring patient safety is maintained.

Ambulance handover delays have shown an improving picture albeit it remains challenged and in May stood at 8.5% of conveyances having a delay of between 30 and 60 minutes, which is consistent with the figures across Greater Manchester. Longer waits have also shown a steady improvement with work ongoing with the transformation team to improve process and increase accuracy of reporting.

Significant focus on reducing patient numbers with no reason to reside continues at pace and has shown a reduction since January where there was an average of 340 patients at any one time waiting onward care. Whilst showing a reducing trend it remains stubbornly high across MFT and the Discharge Resilience programme led by the MLCO with Hospitals is striving to improve on this.

Ongoing Actions:

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

Ambulance Handover Times

The Transformation Team continues to support the sites with improving ambulance handover turnaround times. A follow up summit is planned for the 21st of June, with representatives from all MFT Emergency Departments, system partners and the Northwest Ambulance Service. Progress is already being made at all sites around process improvement which is expected to demonstrate an impact in June's performance. Accuracy of reporting has been identified as an issue and a rapid improvement process is

underway to simplify handover with a turnaround standard operating procedure at all sites being developed jointly with NWAS.

Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day.

WTWA Urgent Care Operational Delivery Cell

The Transformation Team have been working with the Wythenshawe Urgent Care Operational Delivery 'cell'. Led by the Deputy Chief Executive, the cell is coordinating a number of clearly defined pieces of work across the urgent care pathway including: -

- Improving Same Day Emergency Care (SDEC) utilisation for medical, surgical and respiratory SDEC services
- Transfer of Urgent Treatment Centre (UTC) activity out of the main ED footprint
- Improving Ambulance Handover Turnaround Times
- Establishing a sub-48-hour length of stay on Acute Medical Unit
- Bed modelling and reconfiguration

Virtual Ward

- This project is in response to the national requirement to expand Virtual Ward under the 'Hospital at Home Programme' It is a 2-year transformation programme building on learning from implementation during the COVID-19 pandemic and a requirement to expand new capacity by a target of 40-50 virtual ward 'beds' per 100k population by December 2023. Health Innovation Manchester are leading the programme on behalf of Greater Manchester Combined Authority (GM).
- Of note, so far NMGH, MRI and Wythenshawe are taking part in the GM funded wearable technology pilots until December 2022.
- Learning from the pilots is being used to inform the model and approach with the aspiration to have around 560 virtual ward beds across Manchester and Trafford.

Expected Outcomes

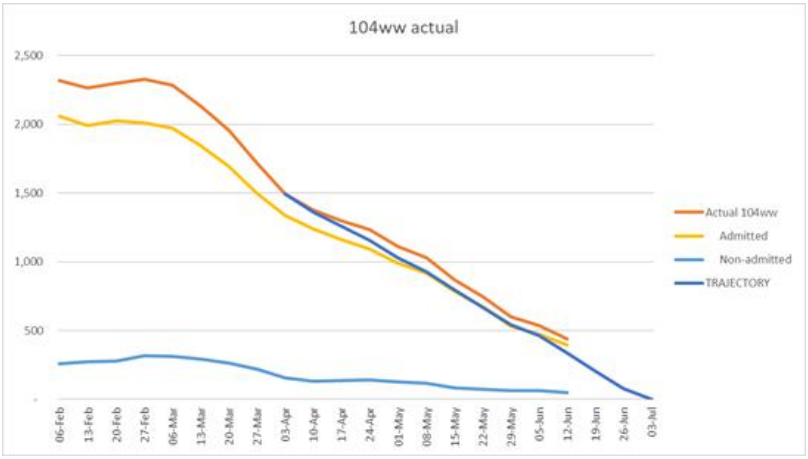
- Admission and attendance avoidance to reduce the footfall into ED's and lower the volume of attendances per day
- Reducing occupancy levels across non-elective pathways by supporting earlier discharge and avoiding admission in the first instance and maximising the Virtual Ward option
- Improvement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

4. ELECTIVE ACCESS

ELECTIVE CARE

The Elective Care programme continues to focus on the management of clinically urgent (P2) patients, cancers and long waits. Hospitals have been proactively managing their long wait patients to reduce the number of patients waiting 104+ weeks to zero by the end of June. Significant progress has been made and the Trust is on track to deliver this target, excluding patients who have chosen to defer beyond June or who are clinically complex. Hospitals are continuing to focus on reducing long-wait backlogs even further with clearance required for 78-week-wait patients by March 2023. It is recognised that delivering

the 78-week-wait target will be challenging and the Trust continues to work with Independent Sector Providers (ISPs) to support.



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

Ongoing Actions:

The elective programme continues to focus on supporting sites to treat both long waiting and clinically urgent patients across MFT. Transformation resource is being utilised to improve in-session efficiency in theatres, booking and scheduling performance, use of system-wide capacity such as Independent Sector and GM hub capacity at Rochdale and the Christies, as well as undertaking dedicated support at Trafford through the Theatre Efficiency Programme.

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

The Theatre Efficiency and Rapid Improvement (TERI) programme continues to focus on dedicated programmes of improvement work at the Trafford Hospital site. An update on the key programmes is as below:

- Scheduling % remains consistently above 85% for most specialities. Review and challenge is on-going for specialities where scheduling performance is below trajectory and a deep-dive review into the Trafford timetable is scheduled to ensure capacity is allocated to sites with the greatest need (long waits/Trafford suitable P2s) and where efficiency is consistently good.
- The preoperative assessment transformation programme has been aligned fully with Hive Transformation to deliver pre-operative pathway changes across MFT. All sites are developing plans to deliver the pre-op pool model to support Hive-readiness
- The late starts project for Trafford has moved into BAU (Business as Usual) and Trafford is currently in the top decile nationally for start time performance. Initial discussions through the TERI team have begun with Manchester Royal Infirmary to roll out this project further.
- The 23 hours stay pilot for General Surgery is progressing well with a pilot start date for July. A model has been agreed including nurse-led discharge protocols and medical cover.
- Work to improve data quality in ORMIS and Theatre Man continues. Improvement has been seen across MFT for time stamp reporting errors (reported into NHSEI) and expansion of DQ review metrics has begun to improve other reporting metrics. A dedicated North Manchester General

Hospital working group has been established to support NMGH with some specific DQ theatre data challenges

Expected outcomes:

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

OUTPATIENTS

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

- MFT is achieving 1.5% of patient initiated follow ups (PIFU) against a target of 4% by March 2023, meaning on average 2000 patients are being placed on a PIFU pathway monthly. We currently have approximately 14,000 active PIFU patients.
- Rollout of virtual triage to suitable services is 85% complete. HIVE will expand this to non-GP referrals in these services. c1,500 referrals are being re-directed or provided with specialist advice through this route each month.
- Between April 2021 and April 2022, the Trust delivered 23% of clinic activity virtually against a target of 25%.

CANCER

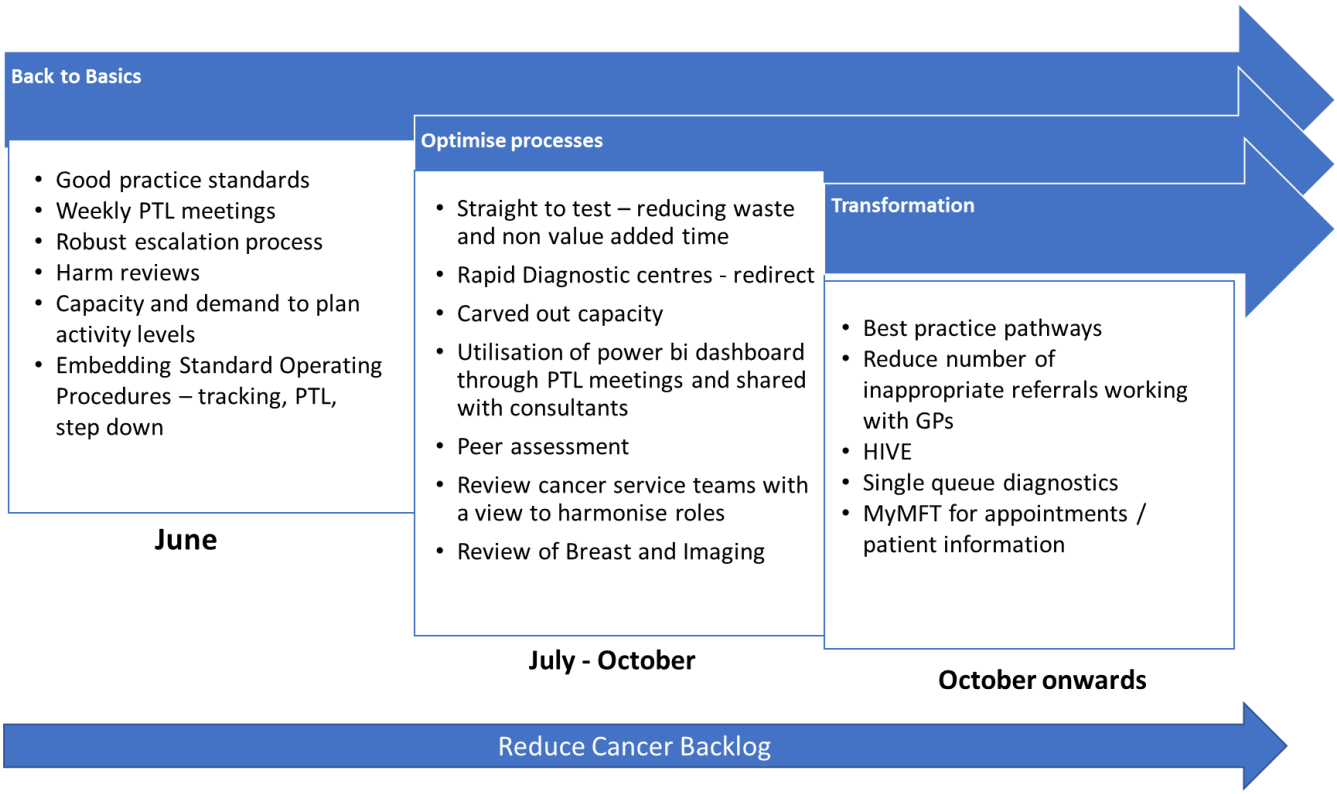
Total referrals for suspected cancer have returned to at least pre-COVID levels at aggregate across MFT sites, although there is variability both month on month and between tumour groups and sites.

A spike in breast referrals from the beginning of September 2021 resulted in a dip in performance, whilst these returned to pre-pandemic levels at the start of the year referrals spiked again in February and May. Head and neck referrals have also risen and remain elevated to pre-COVID position (c140%) leading to a failure of the 2ww standard. May has seen an increase in colorectal referrals thought to be due to media coverage and increased awareness campaigns. The increase in cancer referrals continues to place a significant drain on diagnostic resources, which is the key challenge for MFT to achieve timely pathways.

Prioritisation reviews are undertaken through Trust MESH process and general PTL management to support the reduction of cancer waits above 104 and 62 days. Recovery plans and trajectories are in place across Hospitals/MCSs to address the above areas.

Ongoing Actions:

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



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

- Review of Imaging planned for June with the aim to develop an improvement plan that will see a sustainable change across the Service to support improved patient experience and quality of care and improve on the 6 week diagnostic turnaround pathway
- Capacity and demand modelling by tumour site to determine capacity deficits with growing demand seen across a number of pathways and to understand requirements to increase the number of patients seen within 7 days
- Surgical mutual aid provided by the Christie to be increased with capacity for Lower GI, Gynaecology and Urology patients alongside the MFT@Christie model in place.
- A review of cancers resources is planned across sites with a view to harmonising practices and roles
- Patient pathway Navigator for Breast has commenced in post in May. Clinic templates reviewed and changes implemented from April to ensure capacity is maximised.
- Continued use and focus to utilise IS capacity for endoscopy demand.
- Additional clinical capacity in place weekdays and weekends for example breast 'Super-Saturdays.
- Site based weekly reviews of all patients > 62 days with clear action plans in place reviewed.
- Diagnostic patient tracking meeting to commence in June

Expected Impact:

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

6. RECOMMENDATIONS

The Board are asked to note the contents of the report and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse (ACN) Infection Prevention and Control/Tissue Viability Alison Lynch, Group Deputy Chief Nurse
Date of paper:	July 2022
Subject:	Update on the Infection Prevention and Control response to COVID-19, including: • Nosocomial Infections • Infection Prevention & Control Board Assurance Framework (IPC BAF) • COVID-19 and Seasonal Influenza vaccination programmes
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Safety Patient Experience
Recommendations:	The Board of Directors are asked to note the content of this report
Contact:	Name: Michelle Worsley, Assistant Chief Nurse (ACN) Infection Prevention and Control / Tissue Viability Tel: 0161 276 4042

1. Purpose

1.1. The purpose of this paper is to provide an update to the Board of Directors on the Infection Prevention and Control (IPC) response to COVID-19, including:

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

1.2. The paper also provides a brief update on monkeypox infection and associated vaccination programme at MFT.

2. Update on National and Regional Guidance

2.1. From 14th April 2022 existing national COVID-19 guidance was withdrawn and replaced with the National infection prevention and control manual (NIPCM) for England[1]

2.2. The document has been implemented within England to support compliance with the ten criteria within the Health and Social Care Act 2008[2]

2.3. The NIPCM is non pathogen specific and is based upon the standard infection control principles which are basic IPC measures necessary to reduce the risk of transmitting infections and transmission-based precautions which are additional precautions required when caring for patients with known or suspected pathogens.

2.4. Pathogen specific guidance is produced separately by UK Health Security Agency (UKHSA)

2.5. The NIPCM reflects that while COVID-19 is still circulating across the UK, and will continue to do so, infections in communities are far lower than at peaks during the pandemic. Furthermore, the level of vaccinations and the less virulent strains mean that while we remain under pressure, there are significantly fewer admissions related to COVID-19 being admitted to critical care.

2.6. The principles in place at MFT are based upon current guidance and the Hierarchy of Controls with an emphasis on local decision making using a risk-based approach. The principles align closely with those already in place and are reflected in MFT policies and procedural documents that have been developed by the IPC team.

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

[1] National Infection Prevention and Control Manual for England (2022)
[2] Health and Social Care Act (2008)

3. Healthcare Associated Infections - Nosocomial Transmission

3.1. COVID – 19

3.1.1 Chart 1 below demonstrates newly confirmed COVID- 19 cases across MFT between 1st March 2020 and 7th June 2022.

3.1.2 There has been a continued reduction in outbreaks of Hospital Onset COVID-19 Infection (HOCI) since the last report.

- 16 outbreaks April 2022
- 5 outbreaks May 2022
- 2 outbreaks (to 20th June)) June 2022

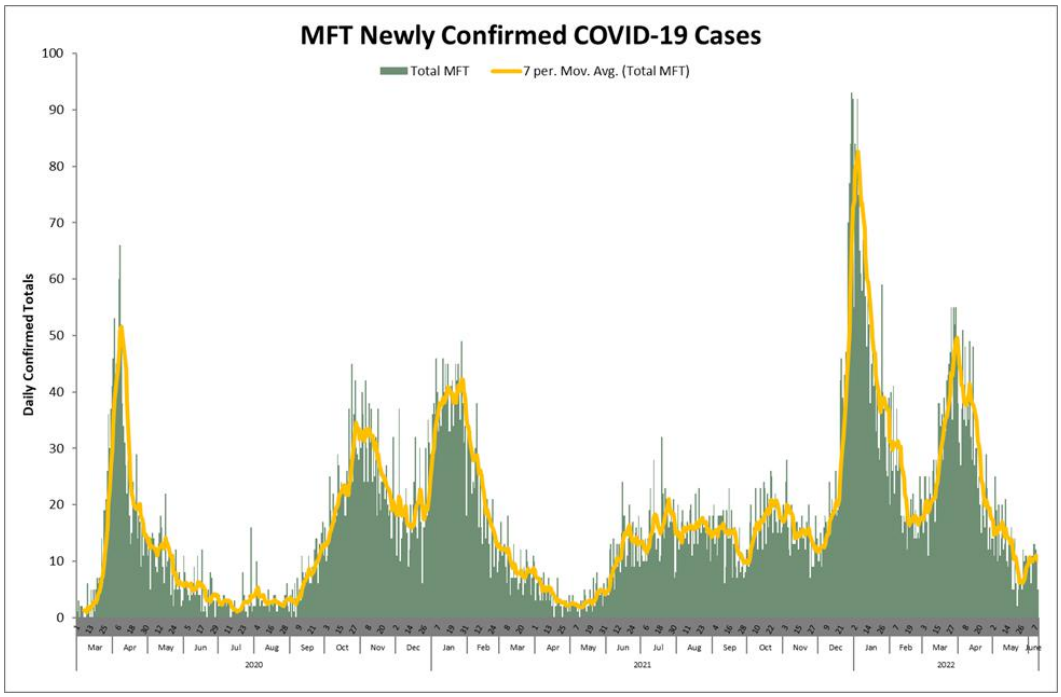


Chart 1. MFT newly confirmed COVID- 19 cases from 1st March 2020 – 7th June 2022

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

3.2. Other HCAI

3.2.1. The Trust is committed to reducing incidents of avoidable HCAI. Table 1 below shows the number of incidents of reportable HCAI from the two previous financial years data alongside the current data and annual threshold.

HCAI	Financial Year 2020/2021	Financial Year 2021/2022	Current Year to Date (2022/2023)	Annual Threshold	Year to Date Threshold
Meticilin Resistant *Staphylococcus*	12	10	1	0	0

aureus Bacteraemia					
Clostridium difficile Infection	215	196	29	174	29
Gram Negative Bacteraemia	299	304	42	410	68
Vancomycin Resistant Bacteraemia	34	31	10	N/A	N/A

Table 1 Reportable HCAI's since April 2022

3.3. Root Cause Analysis and Identified themes

3.3.1. All cases of MRSA and VRE bacteremia undergo a root cause analysis with a report presented at hospital level accountability meetings chaired by the hospital Director of Nursing.

3.3.2. Themes identified from recent RCA include:

- Compliance with Trust screening/isolation policies particularly in clinical areas where isolation facilities are less available.
- Compliance with fundamental IPC principles
- Some evidence of patient accessing intravenous lines themselves.

4. Monkeypox

4.1. Monkeypox is a rare disease that is caused by infection with monkeypox virus. It belongs to the genus Orthopoxvirus in the family Poxviridae. Monkeypox was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research.

4.2. The first human case was recorded in 1970 in the Democratic Republic of the Congo (DRC), and since then the infection has been reported in a number of central and western African countries. Most cases are reported from the DRC and Nigeria. In 2003. Monkeypox was recorded in the United States (US)[3] when an outbreak occurred following the importation of rodents from Africa. Cases were reported in both humans and pet prairie dogs. All the human infections followed contact with an infected pet and all patients recovered.

4.3. Between 2018 and 2021, there had been 7 cases of monkeypox in the UK. Of these, 4 were imported, 2 were cases in household contacts, and 1 was a case in a health care worker involved in the care of an imported case.

4.4. Spread of monkeypox may occur when a person comes into close contact with an animal (rodents are believed to be the primary animal reservoir for transmission to humans), human, or materials contaminated with the virus.

[3] Past U.S. Cases and Outbreaks | Monkeypox | Poxvirus | CDC

4.5. The symptoms of monkeypox begin 5-21 days (average 6-16 days) after exposure. The illness is usually mild and most of those infected will recover within a few weeks without treatment although some individuals can develop severe disease.

4.6. As of 20th June 2022, the UK Health Security Agency (UKHSA) has detected 793 laboratory confirmed cases of monkeypox since 7th May 2022. There have been 766 cases in England, 3 cases in Northern Ireland, 18 cases in Scotland, and 6 cases in Wales.

4.7. The risk to the public from monkeypox is still low, however it is important that the response mounted limits the virus from being passed on and reduces the severity of illness.

4.8. North Manchester General Hospital (NMGH) High Consequence Infectious Diseases (HCID) unit has been identified as one of two sites, the other being Liverpool University Hospitals NHS FT(LUFT), to act as surge units if required, for admission of severely ill patients (Group A patients).

4.9. MFT pharmacy have been asked by the Regional Chief Pharmacist to hold Imvanex[4] vaccine for use in the region, along with LUFT. A vaccination programme for staff who are likely to be exposed or have been exposed to potential monkeypox cases has been established through the Vaccination Service based within Employee Health and Wellbeing (EHWB).

5. **The IPC Board Assurance Framework**

5.1. The IPC Board Assurance Framework[5] has been reviewed regularly since its introduction in June 2020. As reported previously, the Trust IPC BAF has been fully incorporated into the Trust Board Assurance Framework and will no longer be included as part of this IPC report.

5.2. It is anticipated that NHS England will amend the IPC BAF to align with the NIPCM described at section 2.1 of this report.

5.3. The Board of Directors can be assured through the Trust Board Assurance Framework that until such time that the IPC BAF is aligned to the NIPCM or withdrawn as COVID-19 alert levels reduce, the IPC team regularly review all principal risks to patients and staff as they relate to COVID-19, and other infections.

6. MFT Vaccination Programmes:

6.1. MFT COVID-19 and Seasonal Influenza Staff & Affiliate Vaccination Programme Through the MFT staff vaccination programme[6]:

- 90.1% have received their 1st vaccine
- 81.5% of clinically vulnerable staff have had a booster/3rd dose
- 87.6% have received their 2nd vaccine
- 72.6% of staff have had a COVID-19 Booster Vaccine
- 62.3% of staff have had their Flu Jab

[4] Imvanex is a vaccine used to protect against smallpox in adults. It contains a live modified form of the vaccinia virus called 'vaccinia Ankara', which is related to the smallpox virus

[5] NHS England Board Assurance Framework V1.8 published December 2021

[6] MFT Power BI dashboard. Data as at 14th June 2022

- 2913 BME staff have had a Flu Jab
- 3679 BME staff have accessed a COVID Booster vaccine
- 100% of MFT staff have been offered the vaccinations

It should be noted that changes in the vaccination rates are attributed to staff changes, and the nationally imposed suspension of the digital link between booking services and national vaccination databases.

6.2. Monkeypox Vaccine Programme for Staff

Through the MFT staff vaccination programme[7]

- 123 MFT Staff have been referred for pre-exposure prophylaxis
- 37.3% have been vaccinated, or have booked appointments
- 4% have declined or not attended their booked appointment

6.3. Monkeypox Vaccine Programme Post Exposure[8]

- 18 Referrals have been made to the service to date
- 33% have been internal staff referrals
- 66% have been UKHSA referrals from the community
- 28% have been eligible for post-exposure vaccination at the time of referral
- 100% of those eligible have been vaccinated within the recommended timeframe

7. Recommendations

7.1. The Board of Directors are asked to note the information provided in the report.

[7] MFT Power BI dashboard. Data as at 14th June 2022

[8] MFT Power BI dashboard. Data as at 14th June 2022

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Head of Group Reporting & Financial Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	July 2022
Subject:	Financial Performance for Month 2 2022/23
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	The Board of Directors is recommended to note the Financial Performance for Month 2 2022/2023
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2022/23 is focussed on recovery of elective activity, reduction of waiting lists that have reached historic highs and the continued drive to prevent hospital admissions. The move away from PbR is further reflected in the way funding flows will work in 22/23 as is the move away from the COVID funding regime that was still in place in H2 last year. For MFT this means that income related to COVID now forms a very small part of our allocation in 22/23 and the majority is targeted towards Elective recovery. Overall, there is little change in the income envelope between years with the tariff uplift and ERF increase being offset by the efficiency requirement in the tariff and the cessation of COVID funding. The implication of this 'flat cash' environment is, with rising inflation and an increasing workforce, historic high levels of cost reduction through the waste reduction programme (WRP) are required to achieve the financial plan balance for 22/23.This is also in the context of a continued range of workforce implications and ongoing health and wellbeing concerns that, due to the persistence of COVID variants, could not be fully addressed in 21/22. A plan was submitted to NHSEI in April that would deliver a deficit of £52.2m for 22/23, as part of the GM ICS overall submission. The GM submission was 'non-compliant' against the requirement for the ICS to breakeven. Subsequently NHSEI have improved the income offer to GM, increasing it by £78.8m to offset inflationary pressures, with £28.6m of this expected to flow to MFT. These additional monies have been offered on the basis that the ICS overall submits a breakeven plan for 22/23. MFT is required to submit an updated plan that reflects this on 20th June 2022, proposed to achieve breakeven, as approved at Board on 13th June 2022. MFT will need to restate the YTD financial position against this updated plan once approved and submitted. For clarity the "Plan" columns in this report reflect the April submission. The internal plan was to achieve breakeven in 22/23 and this will not change with the revised external plan submission. In May 2022, the Trust has delivered a YTD deficit of £11.2m against the current external planned deficit of £17.8m for month 2 (with actuals updated to include 2/12ths of the additional £28.6m annual funding described above) – favourable by £6.6m. Against the breakeven plan this reflects a YTD adverse variance of £11.2m. In order to recover the YTD position it is essential that work on delivery of WRP schemes is given the highest priority and focus across the entire organisation.
1.2	**Run Rate**	In May 2022 total expenditure was £202.9m. This is an increase of £7.3m compared to the April 2022 figure of £195.6m. An increase in bank costs, particularly around nursing, has driven up pay expenditure by £0.5m, and within non pay, CPT drugs of £2.4m, adjustments to the SLA values for 22/23 of £1.9m and increased expenditure on clinical supplies of £1.2m have driven the increase.
1.3	**Cash & Liquidity**	As at 31st May 2022, the Trust had a cash balance of £245.2m. The cash balance continues to reduce from the year-end position due to payments for capital expenditure in the old year. The cash balance was lower than forecast by £17m, this was primarily due to timing issues around annual contract payments, PDC income and VAT repayments.

1.4	**Capital Expenditure**	The Trust will operate within the agreed GM final capital allocations. The plan to be submitted on 20th June assumes that £15m of the HIVE programme will be funded by PDC capital funding rather than internal funds and also requires a further £9m reduction in spend against the GM capital envelope – the exact allocation and profile of this reduction is being worked through and hence the in-month and year to date spend is being compared to the original plan. The Trust's element of the final GM capital submission is a total plan value for 2022/23 of £136.4m, with the GM envelope component being £68.6m. In the period up to 31st May 2022, £11.2m of capital expenditure has been incurred against the plan of £17.4m, an underspend of £6.2m (£0.2m of the underspend relates to schemes within the GM capital envelope). The underspend against the total plan value is materially made up of £5.1m of slippage relating to the NHP project and is due to a reduction in the approved funding in 2022/23. The overall funding for NHP has now been agreed with the national team, the plan will be updated in the June submission, which will require a re-statement of year to date variances at that time.

Financial Performance

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

I&E Category	NHSI Plan M2	Year to date Actual - M2	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	148,015	150,528	2,514
Clinical commissioning groups	201,651	206,417	4,766
NHS Trust and Foundation Trusts	638	637	(1)
Local authorities	5,940	5,939	(1)
Non-NHS: private patients, overseas patients & RTA	1,676	1,564	(112)
Non NHS: other	1,484	1,505	21
Sub -total Income from Patient Care Activities	**359,404**	**366,591**	**7,188**
Research & Development	10,884	10,761	(123)
Education & Training	13,634	13,858	224
Misc. Other Operating Income	13,652	13,316	(336)
Other Income	**38,170**	**37,935**	**(235)**
TOTAL INCOME	**397,574**	**404,526**	**6,952**
EXPENDITURE			
Pay	(245,821)	(245,838)	(17)
Non pay	(148,711)	(152,563)	(3,852)
TOTAL EXPENDITURE	**(394,532)**	**(398,401)**	**(3,869)**
EBITDA Margin	**3,042**	**6,125**	**3,083**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(12,557)	(9,475)	3,082
Interest Receivable	100	340	240
Interest Payable	(8,151)	(7,946)	205
Loss on Investment	0	0	0
Dividend	(258)	(258)	0
Surplus/(Deficit) against external plan	**(17,824)**	**(11,214)**	**6,610**
Internal Plan Adjustments	17,824	0	(17,824)
Surplus/(Deficit) against internal breakeven plan	**0**	**(11,214)**	**(11,214)**
Surplus/(Deficit) as % of turnover	**-4.5%**	**-2.8%**	
Impairment	**(13,104)**	**(6,512)**	**6,592**
Non operating Income	**772**	**260**	**(512)**
Depreciation - donated / granted assets	**(166)**	**(204)**	**(38)**
Surplus/(Deficit) after non-operating adj. (external plan)	**(5,326)**	**(4,758)**	**568**
Surplus/(Deficit) after non-operating adj. (internal Plan)	**(12,498)**	**(17,670)**	**(5,172)**

For month 2, May 2022, the Trust has reported a YTD deficit of £11.2m against the external planned deficit of £17.8m, with actuals adjusted for 2/12ths of the additional £28.6m income, up to month 2 and against the internal breakeven plan.

There is a favourable variance against income YTD to month 2 of £2.0m which is primarily due to CPT drugs being higher than plan and is reflected in non-pay within expenditure. Additionally, the income for Education & Training is already above plan by £0.2m YTD – a trend seen in previous years. Offsetting these favourable variances are lower than planned RTA income, with the Trust's plan being increased from 21/22 based on more traffic on the road post the main impact of COVID, this is not being seen to increase income yet and a £0.5m adverse variance against car parking income which will largely be rectified in the updated iteration of the plan, since the original plan assumed staff charging would recommence from April 2022 but has since been postponed to recommence in October 2022.

Pay expenditure was broadly on plan YTD to month 2, although this reflects the profile of the external plan, as it stands, and will change once the updated plan has been submitted. This will lead to a YTD adverse position since the Trust will be moving from a planned deficit of £52.2m to breakeven and this will impact on both pay and non-pay reported variances once restated.

Compared to month 1 2022/23 temporary pay expenditure increased by £0.7m with increases in bank spend mainly in NMGH (adverse £0.23m), WTWA (adverse £0.22m), MRI (adverse £0.14m) and SMH (adverse £0.13m). The highest adverse variance against agency pay was in WTWA (adverse £0.24m). There was a reduction in expenditure against Substantive pay of £0.2m between month 1 and month 2 to offset some of the impact of increased temporary staff costs.

Non-pay expenditure, excluding Depreciation, YTD to month 2 22/23 was adverse to plan by £3.9m. The difference was due to higher CPT Drugs costs of £2.4m, offset by a corresponding favourable variance against income and higher than planned expenditure against clinical supplies of £1.2m across some of the hospitals. Depreciation charges are £3.0m favourable to plan YTD and this was driven by lower charges against the estimated impact of IFRS 16 in months 1 and 2. There were also small favourable variances against interest charges and income YTD of £0.2m for each.

Comparing non-pay run rates to month 1 2022/23, there has been an adverse movement of £5.4m, with the CPT Drugs and clinical supplies costs described above being a high proportion. The remaining movement can be explained by a catch up on SLA charges for 22/23 of £1.9m due to budgets not being finalised at the reporting date.

Overall, the run rate implied by a deficit of £5.4m in month 2, following a deficit of £5.8m in month 1, would lead to an outturn deficit of more than £67m. With the revised breakeven plan still to be submitted to NHSEI, and the internal target to achieve breakeven, there will need to be a high degree of focus on delivering the WRP savings in 22/23 if the Trust is to achieve these plans.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £65.8m, made up of £15.8m undelivered savings from 21/22 and the 22/23 target of £50m.

The tables below outline the 22/23 progress against the planned savings. On a consolidated basis all areas together have achieved £11.7m against schemes that have progressed to L3 or higher on WAVE. This reflects a small adverse variance of £0.2m compared to the plan against L3 or higher schemes. However this falls a long way short of the overall YTD target of £19.1m, by £7.4m, meaning that the Trust continues to 'play catch up'.

The schemes delivering savings in month 2, plus others at L3 or above that have not yet begun, are forecast to deliver £70m of savings by the end of the financial year.

MFT Summary

Workstream	Savings to Date				Forecast 22/23 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Plan (22/23) £'000	Act/F'cast (22/23) £'000	Variance (22/23) £'000	Financial BRAG
Admin and clerical	86	80	(6)	93%	444	438	(6)	99%
Budget Review	338	338	0	100%	2,030	2,030	0	100%
Contracting & income	320	321	1	100%	896	897	1	100%
Hospital Initiative	938	939	0	100%	5,584	5,584	0	100%
Length of stay	129	132	3	102%	831	834	3	100%
Non Pay Efficiencies	47	47	0	100%	664	664	0	100%
Outpatients	3	3	0	100%	20	20	0	100%
Pharmacy and medicines management	414	353	(61)	85%	2,435	2,374	(61)	97%
Procurement	344	323	(22)	94%	3,203	2,757	(446)	86%
Theatres	1	1	0	100%	4	4	0	100%
Workforce - medical	225	187	(38)	83%	1,098	1,091	(7)	99%
Workforce - nursing	318	286	(33)	90%	1,706	1,667	(39)	98%
Workforce - other	92	90	(3)	97%	574	559	(15)	97%
Total (L3 or above)	**3,256**	**3,099**	**(157)**	**95%**	**19,490**	**18,919**	**(571)**	**97%**
Trust Initiative	8,576	8,576	0	100%	51,456	51,456	0	100%
MFT Total	**11,832**	**11,675**	**(157)**	**99%**	**70,946**	**70,375**	**(571)**	**99%**

Summary against Target M1-2	YTD
Target	19,087
Actuals (L3 or above)	11,675
Variance to Target	- 7,412
Lost opportunity (value of schemes below L3)	1,280
Variance to target if all schemes delivered as plan	- 6,132

Summary against Target 22/23	Act/F'cast (22/23)
Target	117,246
Actuals/Forecast (L3 or above)	70,375
Variance to Target	- 46,871
Value of schemes below L3 (M3-12)	16,737
Variance to target	- 30,133

Financial BRAG

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

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

Hospital/MCS	22/23 Target	22/23 Actual/Forecast	22/23 Variance	% Variance
Corporate	5.8	0.5	(5)	-91%
CSS	13.3	5.9	(7)	-56%
Eye&Dental	2.1	0.5	(2)	-77%
LCO	7.9	0.4	(7)	-96%
MRI	6.8	3.6	(3)	-48%
NMGH	4.4	0.1	(4)	-97%
RMCH	8.5	3.8	(5)	-55%
St. Mary's	3.9	0.6	(3)	-84%
WTWA	13.1	3.5	(10)	-73%
Hospital/MCS/LCO Subtotal	**65.8**	**18.9**	**(47)**	**-71%**
Trust	51.5	51.5	0	0%
MFT Total	**117.2**	**70.4**	**(47)**	**-40%**

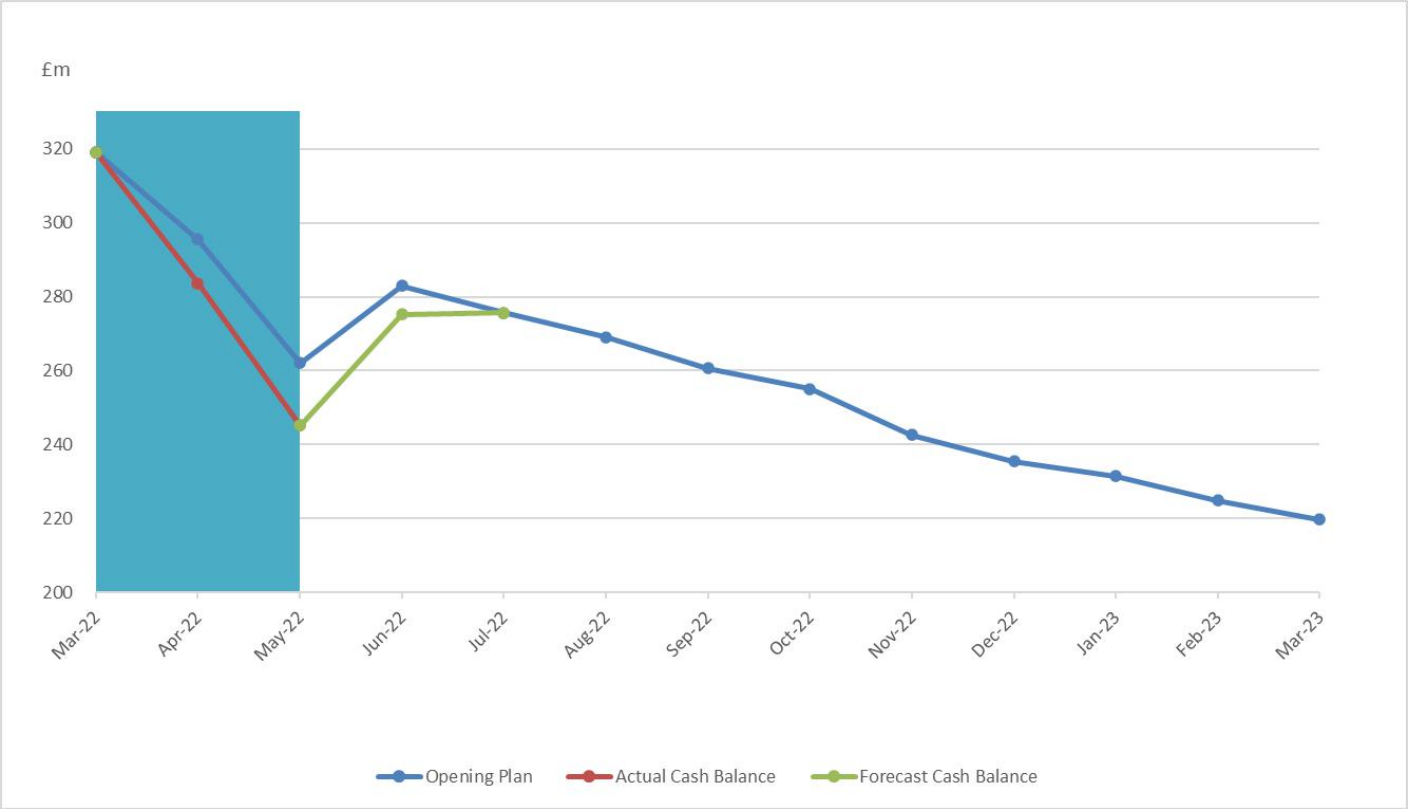
Statement of Financial Position

	31-Mar-22 £000	31-May-22 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	30,501	30,333	(168)
Property, Plant and Equipment	784,242	1,007,310	223,068
Investments	870	870	0
Trade and Other Receivables	15,657	14,683	(974)
Total Non-Current Assets	**831,270**	**1,053,196**	**221,926**
Current Assets			
Inventories	21,809	22,066	257
NHS Trade and Other Receivables	27,117	65,319	38,202
Non-NHS Trade and Other Receivables	61,262	48,209	(13,053)
Non-Current Assets Held for Sale	2,510	2,510	0
Cash and Cash Equivalents	319,112	245,257	(73,855)
Total Current Assets	**431,810**	**383,361**	**(48,449)**
Current Liabilities			
Trade and Other Payables: Capital	(42,471)	(28,934)	13,537
Trade and Other Payables: Non-capital	(360,767)	(341,315)	19,452
Borrowings	(24,001)	(44,306)	(20,305)
Provisions	(32,246)	(32,246)	0
Other liabilities: Deferred Income	(59,360)	(56,997)	2,363
Total Current Liabilities	**(518,845)**	**(503,798)**	**15,047**
Net Current Assets	**(87,035)**	**(120,437)**	**(33,402)**
Total Assets Less Current Liabilities	**744,235**	**932,759**	**188,524**
Non-Current Liabilities			
Trade and Other Payables	1	(1)	(2)
Borrowings	(371,695)	(573,943)	(202,248)
Provisions	(13,904)	(13,903)	1
Other Liabilities: Deferred Income	(2,386)	(6,332)	(3,946)
Total Non-Current Liabilities	**(387,984)**	**(594,179)**	**(206,195)**
Total Assets Employed	**356,251**	**338,580**	**(17,671)**
Taxpayers' Equity			
Public Dividend Capital	408,780	408,780	0
Revaluation Reserve	97,411	97,412	1
Income and Expenditure Reserve	(149,940)	(167,612)	(17,672)
Total Taxpayers' Equity	**356,251**	**338,580**	**(17,671)**
Total Funds Employed	**356,251**	**338,580**	**(17,671)**

The capital programme expenditure and accruals movements continue to affect the Property, Plant and Equipment value in the accounts, resulting in an increase in Property, Plant and Equipment and a reduction in cash and capital payables. In addition, there is also a continued unwinding of accruals made in M12 as part of hospitals closing their year-end financial positions.

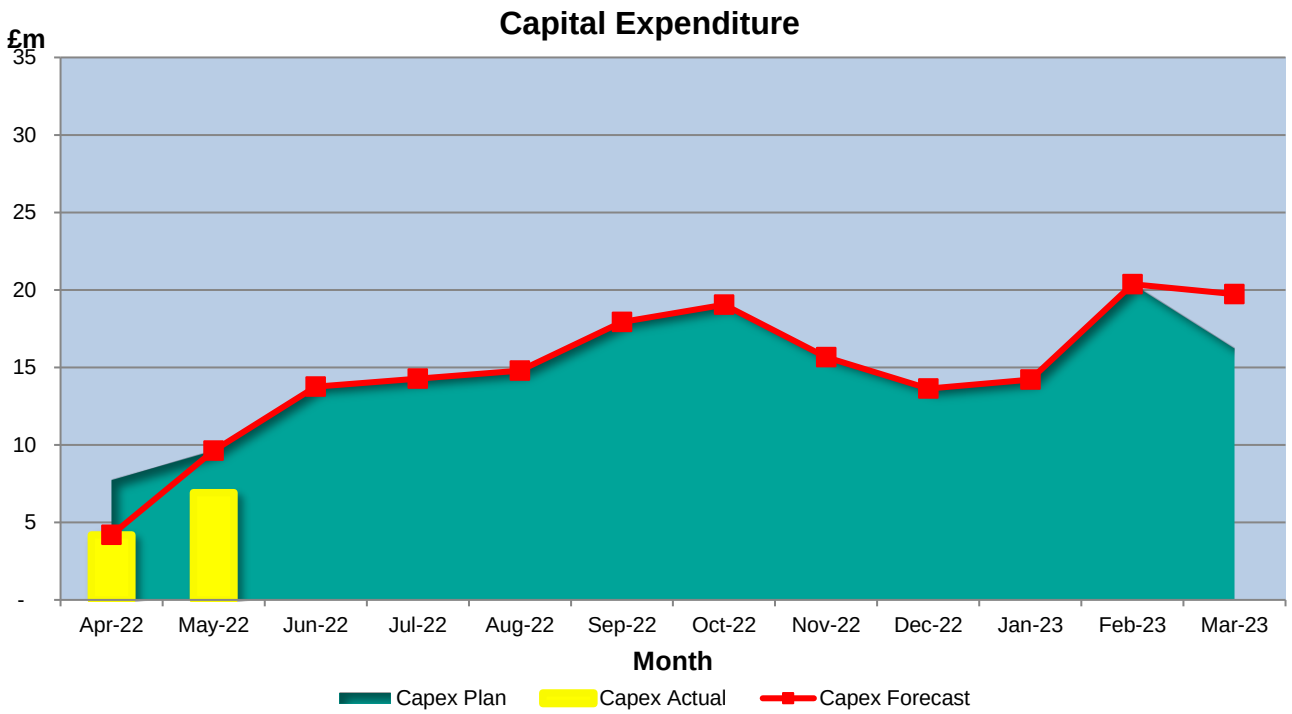
The changes to IFRS16 lease accounting are reflected in the £225m movement in borrowings as leases are brought onto the balance sheet on 1st April 2022 on first adoption of the standard. This is also reflected in the increase in Property, Plant and Equipment shown.

Cash Flow



The cash balance at 31st May is lower than the £262m forecast due to a number of timing differences, including PDC funding not received (£6m), VAT receivables received after the month end (£10m) and SoftwareONE annual contract fees (£7m).

Capital Expenditure



In the period to 31st May 2022, £11.2m of capital expenditure has been incurred against the plan of £17.4m, an underspend of £6.2m. £5.1m of the slippage relates to the NHP project and is due to a reduction in the approved funding in 2022/23 with spend reprofiled into 2023/34. The overall funding for NHP has now been agreed with the national team, the plan will be updated in the June (M3) submission, which will require a re-statement of year to date variances at that time.

The Trust will operate within the agreed GM final capital allocations. These assume that £15m of the HIVE programme will be funded by PDC capital funding. As reported to the Board on 13th June 2022, F&DSC need to be aware that whilst MFT have agreed to adopt this reporting position, if the £15m is not obtained by means of PDC all other provider Trusts have agreed to limit their expenditure to ensure there is sufficient funding to finalise the HIVE programme, and the final allocation also requires a further £9m reduction in spend against the GM capital envelope – the exact allocation and profile of this reduction is being worked through and hence in the in-month and year to date spend for Month 2 this is being compared to the original plan. The Trust's element of the final GM capital submission is a total plan value for 2022/23 of £136.4m, with the GM envelope component being £68.6m. For the period up to 31st May 2022, £9.1m of GM envelope expenditure was incurred against the original plan of £9.4m, an underspend of £0.3m. The underspend is due to timing and is expected to be spent during 2022/23.

Approval of land transaction with GMMH

The redevelopment of the North Manchester General Hospital site is now well underway with the completion of the new North Manchester House and the demolition of Limbert House and Trust HQ progressing at pace, as we begin to deliver the approved masterplan which will include the new North Manchester General Hospital and Greater Manchester Mental Health Trust's new development to be known as North View, replacing the current Park House facility.

The Trust entered into a Memorandum of Understanding with Greater Manchester Mental Health (GMMH) Trust in July 2021 to prepare for the handover of the former Trust HQ site to GMMH for the construction of North View. The formal handover of the site is planned to take place on 15 August 2022 and the Trust now need to finalise the required legal documentation to facilitate the handover of the Trust HQ site. The basis of

the handover is an equitable ‘land swap’ between the Trusts with GMMH taking a new lease on the former Trust HQ site and MFT taking freehold ownership of the current Park House land.
The Trust seeks approval from the Board to progress to completion and exchange of agreements between the Trusts on condition that all necessary documentation is in place.

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
Date of paper:	July 2022
Subject:	Annual Plan 2022-23
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	After consideration of risks contained within the paper, the Board is recommended to: • Note the required level of currently required WRP to enable delivery of a breakeven plan • Note the capital programme planning position that is subject to a further £9m internal reduction. • Note the Cashflow for the period to March 2023 • Note the assessment of significant risks and mitigations and in particular the level of GM system risk • Note the national position on financial plans which impose conditions on receipts of "additional national funding" • Confirm the Financial Plan for 2022-23 as set out in this paper and submitted to GM and NHSE/I as a breakeven position at a control total level
Contact:	Name: Tim Barlow, Deputy Group Chief Finance Officer Tel: 0161 276 6692

MFT Finance Plan 2022-23

1. Purpose of paper

The Board is recommended to confirm the Financial Plan as contained within this paper, which summarises the income and expenditure plan, capital programme and cash flow plans for 2022-23 which were presented recently to the Board Seminar. Board members will be aware that the outline of the Financial Plan for 2022-23 was approved for submission at the Board Seminar that took place on the 13th June 2022, and thus subsequently delivered to the ICS and NHSE/I on the 20th June 2022, in accordance with their agreed timetable. This paper documents the presentation upon which that approval was based.

Board members will note the process to agree the financial plan for 2022-23 has been complicated and thus both extremely time and resource intensive with the move to working as an Integrated Care System and with the overall pressure faced by all systems resulting from the introduction of a new funding regime for 2022-23.

The financial regime for 2022-23 is focused on recovery of elective activity, reduction of waiting lists that have reached historic highs and the continued drive to prevent hospital admissions. The move away from the previous Payment by Results (PbR) regime is further reflected in the way funding flows will work in 2022-23, as is the move away from the COVID funding regime that was still in place in H2 last financial year. For MFT this means that income related to COVID now forms a very small part of our overall allocation in 2022-23 and the majority of "new" funding is targeted towards Elective recovery. Overall, however there is little change in the income envelope between this year and last with the tariff uplift and ERF increase being offset by the efficiency requirement in the tariff and the cessation of COVID funding.

The implication of this 'flat cash' environment is, with rising inflation and an increasing workforce, that historic high levels of cost reduction through the waste reduction programme (WRP) are required to achieve the financial plan balance for 2022-23. The figure for WRP for 2022-23 is some £117m compared to the required figure in 2021-22 of £50m.This is also in the context of a continued range of workforce implications and ongoing health and wellbeing concerns that, due to the persistence of COVID variants, have not been fully addressed in 2021-22.

On the 20th June the ICS submitted a breakeven plan for 2022-23 to NHSE/I. MFT within that ICS plan also submitted a breakeven plan, as approved at the Board on 13th June 2022 and the constituent parts of that plan are detailed below.

2. 2022-23 Income and Expenditure Plan

The Trust has sought to develop a realistic plan for the entirety of 2022-23 to enable financial governance and control moving into this new financial year.

As the Board is aware there has been a period of significant uncertainty regarding the level and allocation of funding available to the Northwest Region, Greater Manchester ICS and then to the Trust. This has been to an extent further complicated by the key element of performance recovery and the costs associated with the expected activity levels as the Trust moves onto activity recovery.

The fundamental shift away from PbR as a basis for Commissioner payment is further consolidated within the latest guidance but raises several issues in terms of previous planning assumptions and planned developments that may no longer prove affordable. It is also reasonable to anticipate that there will be a shift in priorities over the forthcoming months as the Trust and region move to recovery of elective backlogs caused by COVID.

The breakeven plan position has been derived from bottom-up work throughout the Group, helped this year by the introduction of a budgeting tool "Anaplan". The 2021-22 outturn position has been adjusted for the following items;

- Non-recurrent COVID-19 costs removed
- Non-recurrent other costs (including Single Hospital Services (SHS)) removed

- Adjustments to the control total for other large one off or exceptional items (where outturn doesn't reflect a typical run rate) an example would be Drugs that are Cost Pass Through.
- Re-instatement of non-pay costs to support the recovery of operational activity
- An allowance within the envelope available for priority investments and service developments

This approach was considered to provide a reasonable financial baseline position for 2022-23 control totals. Hospitals, LCO and MCSs and Corporate were requested to confirm the full year effect of approved service developments and previously approved business cases, in addition to the planned increased investment in the EPR programme due to go live on 8th September 2022. These developments are in addition to the expected increase in Pass-Through (CPT) Drug expenditure which is matched by assumed income. These developments have been reviewed through an approvals process and prioritised into Control Totals at a Hospital level.

The level of inflation applied to expenditure is highlighted below as this is a material change this year in the context of the plan and the consequent WRP requirement. Some further allowance of additional funding (for MFT £28.6m) has been received from the centre during May 2022, the acceptance of which places greater central controls over Bank and Agency and Consultancy commitments.

	Assumptions included %	Assumptions included £m	Comments
Pay			
Pay - Pay Award	2%	27.5	National planning guidance assumption used of 2% for Pay Award
Pay - Incremental drift	0.60%	8.6	Trust pay modelling used to calculate the incremental drift impact for 22/23
Pay - NI change	1.25%	10.6	Inclusion of additional NI costs of 1.25% for the Health and Social Care Levy
Non-pay			
Drugs	0	0.0	National planning guidance assumptions included 0.9% drugs inflation; drug budgets however have not been uplifted as we have set the expectation that these costs are to be managed.
Premises	20%-26%	4.0	Local premises inflation assumptions of 20% increase for electricity and 26% for Gas included
CNST	-0.80%	-0.5	National planning guidance assumptions included a reduction of 0.1%. For MFT we have included our notified CNST costs for 22/23, which was a reduction of 0.8% compared to 21/22.
Non-pay	0	0.0	National planning guidance included a 2.7% non-pay inflation assumption. Rather than applying this across budgets, as part of the budget setting process, pressures were identified and funded where appropriate and Procurement continue to work with suppliers to reduce the impact of inflation as much as possible.
Other			
PFI costs		12.3	Increase in PFI costs includes assumptions of 2% Pay Award and RPI as of February of 8.2%
Capital charges		15.7	Increase in capital charges includes the impact on depreciation of IM&T services transferring from NCA.
PDC Dividend		2.0	PDC Dividend costs calculated based on planned net relevant assets for 22/23

2.1 Waste Reduction Plan Requirement

The value of required Waste Reduction generated through the above assumptions is in the order of £117m, which represents c5% of the Trust's relevant costs. This increase is due to several factors including the £15m under delivery of WRP in 2021/22 and delivery on a non-recurrent basis of £8m during last year, this was the same for most Trusts due to Covid 19, as with the change to the contracting/payment regime which removes the ability to forecast previous PbR income associated with activity increases arising from service developments, and the constraints of the current capital envelope.

Hospitals / MCS/ LCO and Corporate have been set a WRP of some £65.7m. The residual gap of £51.4m to the total WRP required will need to be addressed through further system funding of which the £28.6m mentioned earlier is a material contribution, the remainder will need to come from GM system collective efficiencies and flexibilities afforded to MFT through a formal review of its balance sheet. Delivery of this level of WRP is unprecedented and is therefore a material risk in achieving the 2022-23 financial plan

2.2 2022-23 Summary Income and Expenditure plan

The assumptions set out above result in the Income & Expenditure financial plan for 2022-23, as summarised below.

£'000m	21/22 Actual	22/23 Plan
Income from Patient Care	2,191	2,190
Other Income	282	236
Total Income	**2,473**	**2,426**
Pay	-1,462	-1,426
Non-pay	-1,042	-1,053
Total Operating Expenditure	**-2,504**	**-2,479**
Total Non-operating Income and Expenditure	**20**	**-50**
Total Net Income and Expenditure	**-11**	**-103**
Control Total adjusting items	24	103
Position on a Control Total basis	**13**	**0**

3. Capital Planning 2022-23

The total capital programme for MFT for 2022-23 is £136.4m in the final submission, within which there is an assumption that £15m of the HIVE programme requirement will be funded by PDC capital funding rather than internal funds, this change was agreed through the GM ICS process. Additional to comply with envelope requirement MFT have taken a further £9m reduction in spend against the GM capital envelope, the exact allocation and profile of this reduction is being worked through with Capital Programme leads. Overall, this has reduced from the plan in April of £173.9m. The Trust's element of the final GM capital submission is for the submission a total plan value for 2022-23 of £136.4m, with the GM envelope component being £68.6m. The overall funding for NHP has now been agreed with the national team, which has resulted in a reduction in the Trust's capital plan due to a change in the phasing of this funding.

	Core GM CDEL envelope £'000	ERF £'000	Targeted Allocations £'000	PDC Funded schemes £'000	PFI £'000	Charity and grant funded schemes £'000	Full capital plan £'000
Previous plan submission	92,528	8,880	6,845	50,109	10,342	5,288	**173,992**
Updated plan submission	**68,567**	**4,536**	**6,845**	**43,044**	**8,114**	**5,288**	**136,394**

4. Cash and Balance Sheet

4.1 2022-23 Cash Flow - main assumptions

The Trust's planned cash flow for 2022-23 recognises repayment commitments against existing DH loans and PFI liabilities, and investment in the capital programme. There is an overall cash deterioration of £99m to a closing cash position as of the 31st March 2023 of £219m. In arriving at this position, we have assumed a breakeven position and that WRP will be achieved; the cash position allows for capital creditors of £55m at 2021-22 year end reducing to around £15m monthly. Reduction takes effect across months 1 and 2 and is included in the asset purchases figure.

The capital programme requires that PDC cash draw down takes place throughout 2022-23, in relation to the New Hospitals Programme enabling works and Lease repayments include the effects of IFRS 16 changes, and subsequent reduction in rental costs through I&E.

Extract of Cash Flow statement from revised plan – submitted 20th June.

Movements	Revised Plan 2022/23 £m
Opening Cash and Bank	**319.1**
Operating Deficit	(80.6)
Depreciation	87.8
Impairments	107.0
Interest Payments	(48.8)
Operating Cash	**65.4**
Asset Purchases	**(152.4)**
PDC Received	**54.4**
Interest received	0.6
Loans received	2.6
Loan repayments	(9.0)
Lease repayments	(44.2)
PFI repayments	(14.5)
Other finance costs	(2.3)
Finance Costs	**(66.8)**
Net Cash Movement	**(99.4)**
Closing Cash and Bank	**219.7**

4.2 2022-23 Balance Sheet - main assumptions

The material movements in the Trust balance sheet include those for a large increase in borrowings and non-current assets due to implementation of IFRS 16: some £230m has been added at 1/4/22, additionally some £135m asset additions and borrowings in year as result of IFRS 16 have been added for 2022-23. The Capital creditors which are high at 1/4/22 following significant expenditure in M12, will reduce over M1 and M2 of 2022-23. As detailed above there are several significant Cash outflows in year to support the operating position, capital investment plans in 2022-23, paying down 2021-22 capital creditors (noted above) and the recurrent PFI loan and Lease repayments.

Extract of Balance Sheet from revised plan – submitted 20th June.

		Revised Plan
Category	**Opening 01/04/22 £m**	**M12 2022/23 £m**
Tangible and intangible assets	1,042.7	1,124.1
Investments	0.9	0.9
Non-current receivables	15.7	15.7
Non-Current assets	**1,059.2**	**1,140.6**
Assets held for sale	2.5	2.5
Inventories	21.8	21.8
Receivables	88.4	88.4
Cash and Bank	319.1	219.7
Current assets	**431.8**	**332.4**
Payables	(403.2)	(367.3)
Borrowings	(68.2)	(56.2)
Provisions and other liabilities	(91.6)	(83.6)
Current liabilities	**(563.0)**	**(507.1)**
Borrowings	(555.5)	(642.1)
Provisions and other liabilities	(16.3)	(16.3)
Non-current liabilities	**(571.8)**	**(658.4)**
Total net assets employed	**356.3**	**307.6**
PDC	408.8	463.2
Revaluation Reserve	97.4	97.4
I&E reserve	(149.9)	(253.1)
Total Taxpayers Equity	**356.3**	**307.6**

5. Key Risks associated with the 2022-23 financial plan

5.1 Key risks to achievement of 2022-23 Plan and mitigations

The plan as set out in this paper carries a significant level of risk, there is also a level of system risk at a GM level which is recognised as a collective responsibility by the entire system. There are several mitigations already identified, however there are also risks which are not yet mitigated. The risks and mitigations are summarised in the table below.

Risk	Detail	Mitigation
Waste Reduction delivery	Delivery of the required waste reduction programme on a recurrent basis. The scale will require at least containment of staffing costs and expectation of system income during the year	The WRP programme has identified some £37.5m to date, work continues to identify further schemes. Further pressures will only be agreed when there is funding certainty. Some contributions will inevitably be non-recurrent.
Inflation	Whilst we have recognised in the submitted plan c£80m of inflation pressure including pay awards, we have not included all inflationary pressures and we are susceptible to further escalating inflationary cost pressures.	We have taken a balanced position on this risk which given the uncertainty means that funding has been allocated to elective recovery and to meet cost pressures. The share of the additional national monies of £28.6m, for offsetting inflationary pressures, are required to support MFT's move to breakeven
Patient Safety & Experience	Patient safety and experience maintained in context of significant change management / waste reduction programme	Quality Impact Assessments will be carried out for all WRP plans as in previous years.
HIVE	The most significant transformation programme in the history of MFT, impacts nearly every process and person in the organisation, the requirement to have a successful implementation may see additional cost pressures.	Whilst every effort has been made to mitigate risks a programme of such size will have further potential for risk, strong financial and operational control, and regular meetings to monitor budgets will provide early warnings of any further pressures.
Performance against 104% activity target and aactivity trajectories and elective recovery funding	Whilst ERF income is included for 104% elective recovery, at a Trust level this has offset the reduction in Covid funding. No further funding is available for Hospitals in the breakeven position, the risk is a requirement for further funding to support elective and other activity recovery	Productivity and efficiency measures must be delivered to increase activity rather than additional funding.

System risk – GM ICS

Following a robust and challenging planning process, GM has reached a position where the system submitted an overall balanced financial plan, but this results in some Trusts in the system submitting deficit plans, and most Trusts holding a level of system risk within their plans.

The achievement of a balanced plan will require the delivery of a system efficiency of c£100m in addition to the challenging efficiency plans already built into organisational plans. This system efficiency sits across most of the NHS organisations in GM.

There is a collective responsibility of all organisations in the system to manage this risk, reviewing the opportunities for mitigation including:

- Emerging system wide efficiency programmes
- Identification of further system wide flexibilities and application of additional allocations to the system throughout the year to offset expenditure plans.
- Review of capacity i.e., Critical Care beds, discharge cost.

There is a further risk to GM in that the full value of ERF has been assumed as income, which requires delivery of cost-weighted activity levels at 104% of 2019/20 levels. If this level of activity is not delivered, the potential loss of ERF will add to the system efficiency requirement.

These risks and mitigations will be managed through the system Financial Recovery Board, with the governance for this group currently being finalised.

6. Summary

This paper sets out the financial plan for 2022-23 along with its component parts and material risks and mitigations. The plan submitted is at a breakeven position for 2022-23 (£13m - 2021/22) on a control total basis. To achieve this breakeven position, the overall 2022-23 financial delivery challenge faced by the Trust is currently to achieve some £117m of Waste Reduction items. The Board will recognise that is a significant challenge, especially, unlike in the previous two years, there is a requirement to meet stretching levels of patient activity to help reduce part of the backlog of activity.

Also, within this plan is the proposed capital programme for 2022-23 in total some £136.4m but with a substantially reduced GM envelope and a requirement to supplement this with PDC backed capital. The Trust's liquidity position remains strong but will reduce by just under £100m in year to support delivery of the capital plan.

7. Recommendations

After consideration of the risks contained within the paper, the Board is recommended to:

- Note the capital programme planning position that is subject to local change.
- Note the Cashflow for the period to March 2023
- Note the assessment of significant risks and mitigations and in particular the level of GM system risk
- Note the required level of currently required WRP to enable delivery of a breakeven plan
- Note the national position on financial plans which impose conditions on receipts of "additional national funding"
- Confirm the Financial Plan for 2022-23 as set out in this paper and submitted to GM and NHSE/I as a breakeven position at a control total level

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

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

Update on the HIVE Programme

1. Background and recap

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

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

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

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

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

2. Benefits Hive will bring

2.1 Hive will transform how everyone works across MFT. It will bring benefits to both the staff and patient experience.

2.2 From Go Live, there will be immediate benefits to staff such as reduced administration time, duplication of processes and reduced transcription. For patients, there will be immediate benefits including reduced duplication of tests, improved prescribing and safety.

2.3 However, benefits will build over time and lead to improvements to scheduling, throughput, efficiency, patient communication, patient self-management, staff communication and safety.

2.4 Overall, the benefits Hive will bring are:

- Improving clinical quality, patient and staff experience, operational effectiveness and driving research and innovation.

- Improving how Hospitals and Managed Clinical Services deliver services and support better clinical decision making, helping MFT deliver its strategic vision.

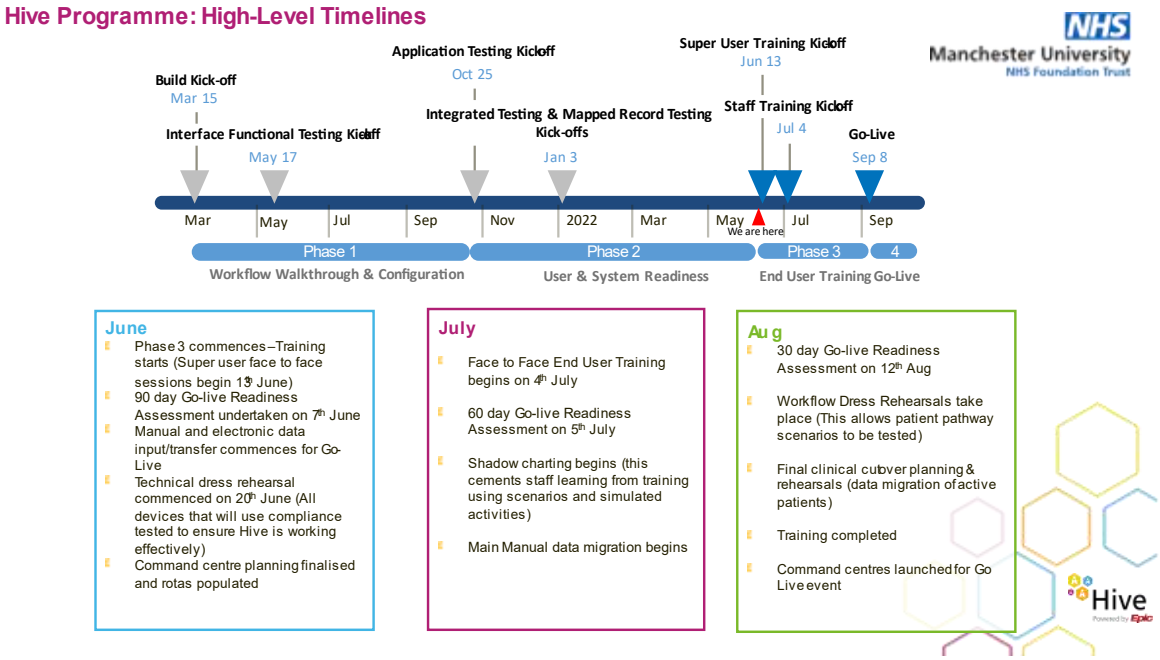
- Enabling staff to work more efficiently by accessing the information they need to care for patients wherever and whenever they need and promoting the introduction of more digitally enabled interaction with patients and users of services.

- Improving the patient experience by giving patients more control over their own care through a patient portal and phone app, MyMFT. This will reduce the need for people to give the same information to different members of staff.

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

3. Progress to Go Live

3.1 The Programme is on track for the Go-Live date of 8th September 2022. The key tasks and high-level timeline required between and Go Live are illustrated below.



3.2 As part of the Go Live readiness work, ~200 Hive staff are working with all Hospitals, Managed Clinical Services and the Local Care Organisation on system and user readiness activities.

3.3 The system and user readiness activities include manual data migration, patient scenario simulations and pathway rehearsals. These are important activities to ensure the Hive processes are tested but are also valuable training exercises.

3.4 The Hive governance and programme management functions are well developed and embedded. These have been refined further in June to ensure that the critical path for final design, building, testing, data migration and training are delivered with *Board to Ward* oversight.

3.5 The Hive governance assurance process includes Go Live Readiness Assessments (GLRAs) at 120, 90, 60 and 30 days prior to Go Live. There are two types of GLRA:

- Local GLRAs:
  These take place in each Hospital/ Managed Clinical Service/ Local Care Organisation and are chaired by their respective Chief Executives. They focus on their local readiness activities and outputs feed into the central GLRA.

- Central GLRA:
  Chaired by Julia Bridgewater, the panel includes Group Executives, Hive Programme Team, Hospital/ Managed Clinical Service/ Local Care Organisation Executives and Deloitte representatives *(Deloitte provides external assurance).*

3.6 Robust external assurance arrangements remain in place with Deloitte providing regular gateway reviews. The next scheduled review is due to report at the start of July 2022 and will review testing, training, programme governance risk management and readiness for *Go Live.*

3.7 Given the size and complexity of the programme, a standalone EPR Scrutiny Committee meets on a bi-monthly basis chaired by Barry Claire, Group Deputy Chairman.

3.8 The Hive Programme entered **Phase 3: User Training & Go Live** in June 2022. This marks a key juncture in the programme as all staff across the entire organisation begin training, all the medical devices are tested to ensure they are Hive compliant, and testing and build are finalised.

4. Training

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

4.2 Over 140 full time staff are delivering face to face training in over 80 dedicated Hive training rooms. All rooms have been kitted out with Hive equipment to ensure users are trained on the actual systems that will be used.

4.3 Super User training commenced on 13th June and all other staff training will start on 4th July.

4.4 Doctors, dentists, nurses, midwives and other allied health professions have been trained to be Peer Trainers. The MFT Peer trainers support the training sessions ensuring that they are clinically led.

5. Communications and Engagement

5.1 As we approach Go Live, the Communications and Engagement Strategy has entered a new phase with activities focussed on supporting readiness work and building a network of Hive champions in order to reach all staff across MFT.

5.2 It also includes a clear focus on patient, GP and external stakeholder communications including other Trusts, Greater Manchester and national bodies in the run up to Go Live.

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

- Dedicated staff communications to support the training registration process, supported by face to face atrium stands to promote awareness.

- Completion of the Go Live communications plan for internal and external stakeholders with key priorities including a monthly GP update, a pack of information for all service areas about Go Live and patient facing messages.

- Refocussed staff facing communication channels to a weekly newsletter in order to agile and responsive to readiness information.

- Introduction of a fortnightly 7 key messages briefing document to help Super Users reach staff right across MFT. Further 'keep in touch sessions' are being planned for Super Users.

- Development of a marketing plan to support sign up of patients to MyMFT, the patient portal and to build staff and patient awareness about the benefits MyMFT will bring.

- Supporting Super Users, Readiness Facilitator and Digital Matrons to share information as widely as possible,

- Developing a bespoke clinical narrative to support engagement with medical colleagues.

6. Transformation

6.1 90 discrete change projects have been identified linked to the Hive Programme. The majority of these have moved beyond the discover/ design phase and are now in the delivery phase.

6.2 In addition to project level engagement:

- 1,800 staff attended Transformation Roadshows between February and May
- 4,000 staff attended ACE day

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

6.3 Workflow dress rehearsals will take place during August. These will provide the application teams with a chance to check that the workflows have been configured correctly, that users can successfully complete the workflows in Epic, and that operational users are communicating and understand the downstream effects of their workflows.

6.4 The Booking and Scheduling programme has focussed on standardisation and development of access to MFT services so that there is consistency on quality and efficiency across all services. This will be delivered MFT Standard Operating Procedures, via mandatory training for our admin and clerical staff.

6.5 The programme is also working with services to develop the operational management structures which will support Single Hospital Services using the opportunities made available with implementation of Hive

7. Technical Deployment

7.1 The Technical Programme now has its full team in place to enable projects to be delivered to achieve delivery on the critical path.

7.2 Pilot Technical Dress Rehearsals (TDRs) took place in early June with the learning used to inform the launch of the full-scale TDR.

7.3 Following the deployment of the new Hive equipment (such as workstations, medical equipment and bar code scanners), the TDR process involves testing every single piece of equipment in situ to ensure Hive works correctly and all equipment is ready for Go Live.

7.4 Full scale TDR commenced on 20th June and will take place until August. This work will be overseen and monitored via the Go Live Readiness Assessments.

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

8. Risk Management

8.1 The management of the Hive Programme has a robust risk management and strategy in place that aligns to and reports directly into the Trust Group Risk Oversight Committee (GROC). This ensures that there is clear executive ownership on Hive risks and also that the risks are assessed and mitigated in line with interdependences on all the other Trust workstreams.

8.2 Given the size and complexity of the overall Hive Programme the programme there are two overall risks that have been reported into and managed via GROC. These relate to potential impacts on safety if the programme is not delivered effectively and the risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live.

8.3 There are three other specific Hive Risks that are reported into GROC. These are the management of complex pathways at North Manchester General Hospital, the inclusion of the Local Care Organisation into the Hive Programme (which was agreed later than the acute hospitals) and training. Each of these risks has dedicated mitigations in place which are reported into GROC and managed through the Hive Programme Governance process.

9. Benefits Realisation

9.1 Given the significant impact of COVID on the operating environment and changes to the financial regime, the Hive benefits case has been reviewed. In terms of cash releasing benefits, the review work has focused on re-baselining and planning of benefits with either expected early delivery or material financial value, or both.

9.2 Work has also been undertaken on developing a benefit register for all types of benefit, including the identification of appropriate key performance indicators to measure delivery of the benefit post Hive implementation.

9.3 This planning and development process is following the same rigorous governance process undertaken in each Hospital/ MCS in respect of the normal year-on-year safety, efficiency and productivity programmes.

10. Next Steps

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

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

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

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

11. Recommendation

11.1 The Board of Directors is asked to note the progress made.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	July 2022
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

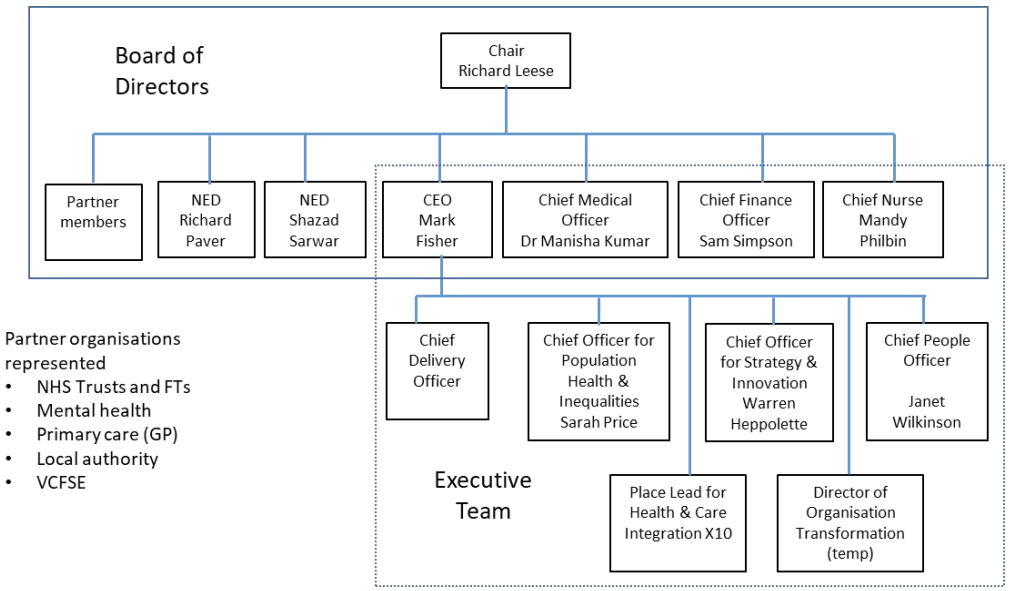
Health & Social Care Bill

The Health and Social Care Bill was passed enabling Integrated Care Boards (ICB) to be formally established on 1 July 2022. NHS England and NHS Improvement will formally become one body on 1 July.

3. Regional Issues

Greater Manchester Integrated Care System (ICS)

The development of the Greater Manchester ICS is progressing. Recruitment to senior posts in the new structures continues. The graphic below shows the Integrated Care Board and supporting Executive Team.



The development of the arrangements to facilitate joint working at place level are also progressing. Place leads for integration have been appointed across Greater Manchester. These roles will be responsible for driving the local integration of health and social care, connecting it to wider public services to address the social determinants of health. Working closely with local partners, place leads will play a central role in improving health outcomes and the quality of care, reducing health inequalities, and maximising the value of public resources within communities.

In Manchester Joanne Roney Chief Executive of Manchester City Council has taken on the role of Place-Based Lead for Integration. Manchester Partnership Board will bring together the senior leader of health and care across the locality and will be called Manchester Integrated Care Partnership Board.

In Trafford Sarah Todd, Chief Executive of Trafford Local Authority has taken on the role of Place-Based Lead for Integration. The Trafford 1-system Board will bring together the senior leader of health and care across the locality and will be called Trafford Integrated Care Partnership Board.

4. MFT issues

MFT Single Services

The development of the operating models for those services that are provided across MRI, WTWA and NMGH is progressing. Changes to the management and leadership arrangements that will better facilitate the achievement the benefits of the Single Hospital Service are being implemented in services including Head & neck, GI medicine, orthopaedics, breast, cardiac and infectious diseases.

Lung Health Checks

In conjunction with partners across GM (GM Cancer Alliance, Northern Care Alliance, The Christie), MFT is leading work to support the roll out of lung health checks in Greater Manchester. Lung Health Checks will be delivered close to peoples' homes through the use of both fixed and mobile diagnostics capacity. This programme is part of the wider NHS commitment to diagnose patients with lung cancer at an early stage when the disease is more treatable.

Community Diagnostics Centres

Having been successful in its bid for funding as part of the national Community Diagnostics Centre Programme in 21/22 and 22/23, MFT is now working with local and GM partners to develop a business case for both capital and revenue funding for a further 2 years. The business case is due to be submitted to NHS England in July. If successful it would see the expansion of CDC services across Manchester and Trafford, including mobile diagnostic services across North Manchester and a capital development at the Withington Community Hospital site.

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:	July 2022
Subject:	NHS Oversight Framework 2022/23
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updated NHS Oversight Framework.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The updated NHS Oversight Framework was published on 27 June 2022. It describes NHS England's approach to NHS oversight for 2022/23. It will take effect from 1 July 2022.

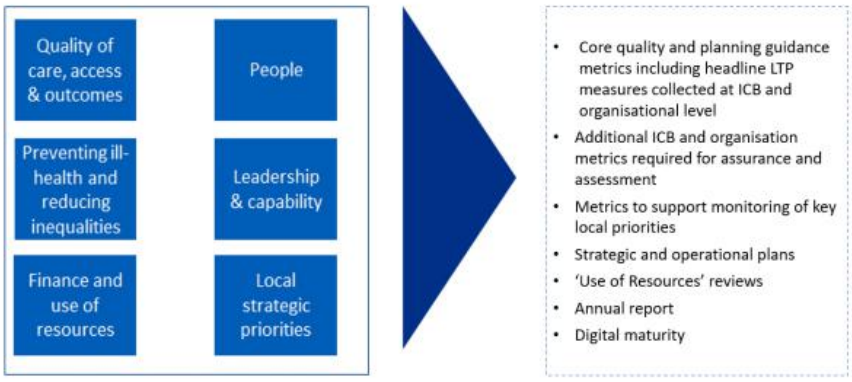
2. Background

The purpose of the NHS Oversight Framework is to:
- ensure the alignment of priorities across the NHS and with wider system partners
- identify where Integrated Care Boards (ICB) and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS E will intervene.

NHS England has statutory accountability for oversight of both ICBs and NHS providers. Its approach to oversight is characterised by the following key principles:
- working with and through ICBs, wherever possible, to tackle problems
- a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching accountability for results with improvement support
- autonomy for ICBs and NHS providers as a default position
- compassionate leadership behaviours that underpin all oversight interactions.

3. Approach

The NHS Oversight Framework is based on:
- Five national themes that apply across trusts and ICBs with an aligned set of high-level oversight metrics (metrics are set out in attachment A):
  - quality of care, access and outcomes
  - preventing ill-health and reducing inequalities
  - people
  - finance and use of resources, and
  - leadership and capability
- A sixth theme, local strategic priorities. This reflects the ICB's contribution to the ambitions and priorities of its ICS.



NHS England regional teams will lead the oversight of ICBs on delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. Where necessary regional teams will lead and co-ordinate support requirements identified for the ICB.

ICBs will lead the oversight of NHS providers, assessing delivery against the domains, working through provider collaboratives where appropriate. ICBs will consult with their NHS

England regional team on areas of concern, specific support requirements and any issues requiring formal intervention by NHS England.

4. Oversight Cycle

The oversight process follows a three-step cycle in which NHS E teams and ICBs work together to identify and deploy the right support and intervention to drive improvement and address the most complex and challenging problems (see attachment B).

1. Monitoring ICB and NHS organisation performance and capability

- NHS England will monitor and gather insights about performance under the six themes using the published Oversight Framework metrics and other information from conversations with ICBs, formal reporting documents and other routine information.

2. Identifying the scale and nature of support needs

- Regional teams have allocated all ICBs and trusts to one of four 'segments' which indicate the scale and nature of support needs from no specific needs (segment 1) to a requirement for mandated intensive support (segment 4) (see attachment C).
- Primary care providers and primary care networks will not be allocated to segments, but overall quality of primary care will inform ICB segmentation decisions
- For individual trusts, NHS E and the ICB will discuss segmentation and support requirements. NHS E will be responsible for making the final segmentation decision and taking any necessary formal enforcement action
- ICBs and trusts placed in segment 3 or 4 will be subject to enhanced direct oversight by NHS E (for individual trusts this will happen in partnership with the ICB) and additional reporting requirements and financial controls.
- For ICBs and trusts placed in segment 3, NHS E will develop and deliver a bespoke mandatory support package through the relevant regional improvement hub, drawing on the national intensive support team as required
- For ICBs and trusts allocated to segment 4, the national Recovery Support Programme (RSP) will provide focused and integrated support, working with the ICB, regional and national NHS England teams.

3. Co-ordinating support activity and formal intervention

- NHS E will work flexibly with ICBs to deploy the right support through this cycle, drawing on the expertise and advice of national colleagues. During 2022/23 NHS E will explore with ICBs the role of peer review in the oversight model.
- Where the operation of the ICB itself is deemed to be a causal part of the identified issue, this could result in a change to the oversight approach normally associated with the system's previously assessed maturity level.

5. ICB Assessment

NHS E has a legal duty to annually assess the performance of each ICB in each financial year. The NHS E regional team will conduct the annual assessment. This will include consulting the relevant health and wellbeing boards as to their views on the ICB's implementation of any joint local health and wellbeing strategy and considering how successfully the ICB has:

- contributed to the wider local strategic priorities of the ICS
- performed its statutory functions
- delivered on any guidance set out by NHS England or the Secretary of State regarding the functions of the ICB.

6. Actions/recommendations

The Board of Directors is asked to note the updated NHS Oversight Framework.

Attachment A
NHS oversight metrics for 2022/23

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
Quality of care, access and outcomes	Elective care	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	✓	✓
	Elective care	Total elective activity undertaken compared with 2019/20 baseline	✓	✓
	Elective care	Total diagnostic activity undertaken compared with 2019/20 baseline	✓	✓
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	✓	✓
	Cancer	Proportion of patients meeting the faster cancer diagnosis standard	✓	✓
	Cancer	Total patients treated for cancer compared with the same point in 2019/20	✓	✓
	Outpatient transformation	Outpatient follow-up activity levels compared with 2019/20 baseline	✓	✓
	Urgent and emergency care	Proportion of ambulance arrivals delayed over 30 minutes	✓	✓
	Urgent and emergency care	Ambulance average response times by category		✓
	Urgent and emergency care	Proportion of patients spending more than 12 hours in an emergency department	✓	✓
	Maternity and children's health	Neonatal deaths per 1,000 total live births	✓	
	Maternity and children's health	Stillbirths per 1,000 total births	✓	
	Primary care and community services	Proportion of Urgent Community Response referrals reached within two hours	✓	
	Primary care and community services	Proportion of patients discharged from hospital to their usual place of residence	✓	✓

	Primary care and community services	Available virtual ward capacity per 100k head of population	✓	✓
	Primary care and community services	Number of general practice appointments per 10,000 weighted patients	✓	
	Primary care and community services	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a. general practice and b. NHS111 per 100,000 population	✓	
	Primary care and community services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	✓	
	Mental health services	Number of children and young people accessing mental health services as a % of population	✓	
	Mental health services	Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	✓	
	Mental health services	Access rate for IAPT services	✓	
	Mental health services	Access rates to community mental health services for adult and older adults with severe mental illness	✓	
	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days		✓
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	✓	
	Learning disabilities and autism	Inpatients with a learning disability and/or autism per million head of population	✓	
	Personalised care	Rate of personalised care interventions	✓	
	Safe, high quality care	Summary Hospital-level Mortality Indicator		✓
	Safe, high quality care	National Patient Safety Alerts not completed by deadline		✓

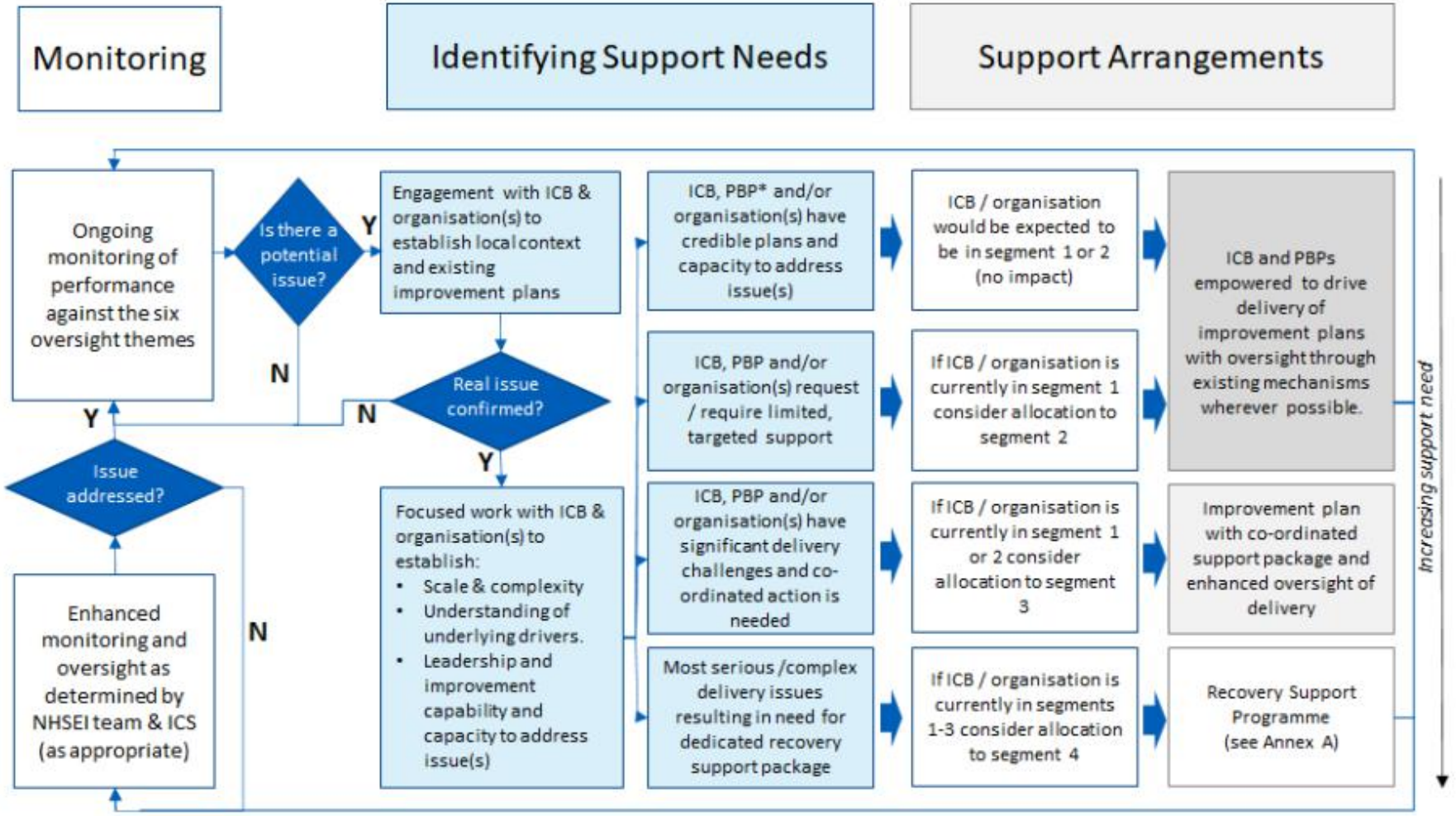
	Safe, high quality care	Potential under-reporting of patient safety incidents		✓
	Safe, high quality care	Overall CQC rating		✓
	Safe, high quality care	Percentage of patients describing their overall experience of making a GP appointment as good	✓	
	Safe, high quality care	Acting to improve safety - safety culture theme in the NHS staff survey		✓
	Safe, high quality care	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		✓
	Safe, high quality care	Clostridium difficile infection rate		✓
	Safe, high quality care	E. coli bloodstream infection rate	✓	✓
	Safe, high quality care	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓	
Preventing ill health and reducing inequalities	Reducing inequalities	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities[1]	✓	✓
	Prevention and long term conditions	Number of people receiving mechanical thrombectomy as a % of all stoke patients	✓	
	Prevention and long term conditions	Proportion of people with CVD treated for cardiac high-risk conditions	✓	
	Prevention and long term conditions	Proportion of diabetes patients that have received all eight diabetes care processes	✓	
	Prevention and long term conditions	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	✓	

[1] NHS England has developed a national approach to support the reduction of health inequalities across the NHS, Core20PLUS5. For all relevant metrics NHS England, ICBs and providers must consider how inequalities of access and outcome are being reduced. A Healthcare Inequalities Improvement Dashboard is available via NHS Foundry to further support these considerations.

	Prevention and long term conditions	Number of referrals to NHS digital weight management services per 100k head of population	✓	
	Prevention and long term conditions	Proportion of acute or maternity inpatient settings offering smoking cessation services	✓	✓
	Prevention and long term conditions	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	✓	✓
	Screening, vaccination and immunisation	Bowel screening coverage - % patients aged 60 - 74 screened in the last 30 months	✓	
	Screening, vaccination and immunisation	Breast screening coverage - % females aged 53 - 70 screened in the last 36 months	✓	
	Screening, vaccination and immunisation	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	✓	
	Screening, vaccination and immunisation	Proportion of people over 65 receiving a seasonal flu vaccination	✓	✓
	Screening, vaccination and immunisation	Population vaccination coverage – MMR for two doses (5 year olds)	✓	
Leadership and capability	Leadership	Aggregate score for NHS staff survey questions that measure perception of leadership culture	✓	✓
	Leadership	CQC well-led rating		✓
Finance and Use of Resources	Finance	Financial efficiency - variance from efficiency plan	✓	✓
	Finance	Financial stability - variance from break-even	✓	✓
	Finance	Achievement of Mental Health Investment Standard	✓	
	Finance	Agency spending		✓
People	Looking after our people	Staff survey engagement theme score	✓	✓
	Looking after our people	Staff survey bullying and harassment score	✓	✓
	Looking after our people	Leaver rate	✓	✓

	Looking after our people	Sickness absence rate	✓	✓
	Belonging in the NHS	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women	✓	✓
	Belonging in the NHS	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓
	Growing for the future	FTE doctors in General Practice per 10,000 weighted patients	✓	
	Growing for the future	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	✓	

Attachment B
Oversight, diagnosis and support and intervention process



Attachment C
Support segments: description and nature of support needs

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Support segments: segmentation approach

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics and • Balanced plan, actual/forecast breakeven or better and • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	**For ICBs:** • Success in tackling variation across the system and reducing health inequalities • Whether the ICB consistently demonstrates that it has built the capability and capacity required to deliver on its statutory and wider responsibilities **For trusts:** • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICB priorities
2	This is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics or • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas or • Plan not balanced and/or a material actual/forecast deficit or • A CQC rating of 'Requires Improvement' overall and for well-led (trusts)	**For all:** • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (e.g. delivery against the national and local transformation agenda) • A material concern with regard to the quality or safety of services being provided or a failure to escalate such risks • Evidence of capability and capacity to address the issues without additional support, e.g. where there is clarity on key issues with

	Eligibility criteria	Additional considerations
		an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances **For ICBs:** • Evidence of collaborative and inclusive system leadership across the ICB, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope • Clarity and coherence of system ways of working and governance arrangements **For trusts:** • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts or • A catastrophic safety failure or • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS or • A significant underlying deficit and/or significant actual or forecast gap to the financial plan or • CQC recommendation (trust)	

Annex A: Intervention and mandated support

Introduction

1. Mandated support applies when integrated care boards (ICBs), NHS trusts and foundation trusts ('trusts'), have serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support.

2. Mandated support consists of a set of interventions designed to remedy the problems within a reasonable timeframe. There are two levels depending on the severity and complexity of the issues:

- Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3 of the NHS Oversight Framework.
- Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme (RSP). This level of support means automatic entry to segment 4 of the NHS Oversight Framework.

3. While the eligibility criteria for mandated support will be assessed at ICB and trust level, mandated support packages will always be designed and delivered within the relevant system context (e.g. place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

4. Mandated support may involve the use of NHS England's statutory enforcement powers. A decision by NHS England to take such action must comply with the relevant statutory threshold and conditions. A trust considered to be in need of mandated support may be subject to enforcement action that requires it to carry out specific actions as part of the intervention.

5. This annex explains:

- how NHS England determines the requirement for mandated support and the level of support
- what happens to an ICB or organisation when mandated support applies
- the roles and responsibilities of other key organisations involved, specifically the Care Quality Commission (CQC)
- how an ICB or trust exits from mandated support
- what Recovery Support Programme (RSP) review meetings are.

6. This annex supersedes the previously published policy described as 'special measures' and should be read in conjunction with the 2022/23 NHS Oversight Framework.

7. While regulatory action arising from this framework at NHS foundation trusts will utilise the NHS provider licence, NHS England will, from July 1, use the legacy NHS Trust Development Authority powers it will inherit on that date to underpin any enforcement/mandated actions at NHS trusts until they receive a licence as per section 49 of the Health and Care Act 2022.

How NHS England determines the need for mandated support

8. NHS England determines which ICBs and trusts require mandated support with reference to a set of objective criteria, but also by considering other appropriate considerations. Any ICB or trust meeting the objective criteria set out below is eligible to be considered for the relevant level of mandated support but may also be excluded from this in light of other relevant considerations.

Mandated support (segment 3)

9. An ICB or trust is eligible to be considered for mandated support and entry to segment 3 if:

- performance against multiple oversight themes is in the bottom quartile nationally based on the relevant oversight metrics

or

- there has been a dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas

or

- it has an underlying deficit that is in the bottom quartile nationally and/or is reporting a negative variance against the delivery of the agreed financial plan and/or it is not forecasting to meet plan at year end

or

- for trusts, there is a CQC rating of 'Requires Improvement' overall and for well-led.

10. Where there are material concerns about an ICB's and/or trust's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (eg delivery against the national and local transformation agenda), this may also trigger consideration of mandated support. In these circumstances regional teams will also consider the extent to which the above objective eligibility criteria are met.

11. Meeting one of the objective eligibility criteria does not automatically lead to entry to segment 3. In considering whether an ICB or trust that has met the eligibility criteria would benefit from mandated support, regional teams will consider whether:

For all:

- there is the capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions
- there are other exceptional mitigating circumstances.

For ICBs:

- there is evidence of collaborative and inclusive system leadership across the ICS, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope
- there is clarity and coherence in ways of working and governance arrangements across the system.

For trusts:

- whether the trust is working effectively with other system partners to address

the problems.

12. NHS foundation trusts will only be placed in segment 3 where there is evidence that they are in actual/suspected breach of their NHS provider licence conditions (or equivalent for NHS trusts).

Mandated intensive support (segment 4)

13. An ICB or trust is eligible to be considered for mandated intensive support and entry to segment 4 if, in addition to the considerations for mandated support above, any of the following criteria are met:

- longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts

or

- a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan

or

- a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS

or for trusts only:

- a recommendation is made by the CQC.

14. The CQC, through the Chief Inspector of Hospitals, will normally recommend to NHS England that a trust is mandated to receive intensive support when it is rated 'Inadequate' at the single trust rating level.

15. The evidence provided by the CQC will include the reasons why it is recommending the trust is mandated to receive intensive support, the specific areas of improvement where actions need to be taken and what improvements in quality need to be achieved.

16. Based on the full range of information and judgement, NHS England will decide, following national moderation, whether the trust will be placed in segment 4 and receive intensive support through the RSP.

What happens when NHS England mandates support for an ICB or trust

Mandated support (segment 3)

17. NHS England will communicate its decision to the ICB or trust, and work with it to develop and deliver a bespoke mandatory support package through the relevant regional improvement hub, drawing on system and national expertise as required.

18. The relevant NHS England regional leadership will sign off the criteria that the ICB or trust must meet to exit mandated support (exit criteria) and the ICB or trust will develop an improvement plan with a target timeline for meeting the exit criteria.

19. Typically, the following additional interventions will be put in place:

- enhanced monitoring and oversight of the ICB or trust by the NHS England regional team

• NHS England advisory role for senior appointments, including shortlisting and as external assessor on interview panels.

20. The interventions listed above may be supported or implemented using formal statutory enforcement action

21. Depending on the nature of the problem(s) identified and the support need, further interventions may include enhanced:

- scrutiny/assurance of plans
- reporting requirements
- financial controls including lower capital approval limits.

Mandated intensive support (segment 4)

22. NHS England will communicate its decision to the ICB or trust and then make a formal public announcement.

23. Mandated intensive support will be agreed with the region and delivered through the nationally co-ordinated RSP. The RSP has been developed to provide intensive support either at organisation level (with system support) or across a whole health and social care system.

24. A diagnostic stocktake involving all relevant system partners will:

- identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
- recommend the criteria that must be met for the ICB or trust to exit mandated intensive support (exit criteria) and an indicative exit timeline. These must be agreed by NHS England.

25. NHS England will review the capability of the ICB's or trust's leadership. This may lead, if necessary, to changes to the management of the ICB/trust to make sure the board and executive team can make the required improvements. Where changes are required, this will happen as soon as is practical and the necessary support will be provided to facilitate this.

26. At the same time as helping to address the specific issues that triggered mandated intensive support, NHS England will consider whether long-term solutions are needed to address any structural issues affecting the ICB's or trust's ability to ensure high quality, sustainable services for the public.

27. NHS England will appoint a system improvement director (SID) or an improvement director (ID) who will act on its behalf to provide assurance of the ICB's or trust's approach to improving performance. The SID or ID will support the ICB or trust to develop an improvement plan with an indicative timescale for meeting the exit criteria (typically within 12 months).

28. The ID will work with the trust and/or ICB to co-ordinate the necessary support from the system, NHS England teams, the broader NHS or, where appropriate, an external third party. This could include:

- intensive support for emergency and elective care

- intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
- intensive support for workforce and people practices
- financial turnaround/recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review
- governance review
- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as ‘well led’, ‘better tomorrow’ and ‘making data count’.

29. Typically, the following additional interventions will be put in place:
    - regular formal progress and challenge meetings with national-level NHS England oversight
    - board vacancies filled on the direction of NHS England (trusts).

30. Depending on the nature of the problem(s) identified and the support need, further interventions may include:
    - NHS England-appointed board adviser
    - enhanced reporting requirements
    - enhanced financial controls including:
        – NHS England control of applications for Department of Health and Social Care financing (trusts)
        – peer review of expenditure controls
        – reduced capital approval limits (trusts)
        – rapid roll out of extra controls and other measures to immediately strengthen financial control, including those set out in NHS England guidance (including the ‘Grip and Control’ checklist).

31. The interventions listed above may be supported or implemented using formal statutory enforcement action

32. Where a trust is deemed to require mandated intensive support on the recommendation of the CQC, there will be close dialogue between the CQC, NHS England, the trust and ICB, which will include what improvements in quality would give assurance of progress being made. These improvements form the basis of joint reviews of progress during the mandated intensive support period, as well as the existing regular information exchange between the CQC and NHS England regional leads.

33. This process of information exchange and review will enable extra support or intervention to be considered as needed. These decisions need not wait until the next re-inspection.

34. NHS England will ensure that the trust addresses any urgent patient safety and quality issues identified as a priority. The CQC will continue to monitor quality at the trust. If at any time patients are at immediate serious risk of harm, the CQC can use its urgent powers to safeguard them.

35. The expectation is that the CQC will re-inspect the trust within 12 months of the start of mandated intensive support. It will judge if the quality of patient care and the trust's leadership have improved.

How ICBs and trusts exit from mandated support

36. Exit from mandated support will ordinarily occur when it can be demonstrated that exit criteria have been met in a way that is sustainable. Over time it may be necessary to review or revise these exit criteria. Any change to exit criteria must be approved by NHS England. Mandated support (segment 3)

37. To be considered for removal from mandated support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When deciding on a recommendation to exit, the NHS England regional team will also consider whether a targeted and time-limited post-exit support package is needed to ensure the improvement is sustained.

Mandated intensive support (segment 4)

38. To be considered for removal from mandated intensive support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When making a decision on a recommendation to approve exit, NHS England will also consider the proposed transitional support package that will be needed when an ICB or trust enters segment 3 to ensure the improvement is sustained.

39. Where a trust is in segment 4 and so in receipt of mandated intensive support as a result of a recommendation of the CQC, NHS England will take account of any recommendation by the Chief Inspector of Hospitals before deciding the trust should exit that segment. The Chief Inspector will usually recommend this where there is no reason on grounds of quality why a trust should remain in receipt of mandated intensive support – that is, if the quality of care is showing sufficient signs of improvement, even if it is not yet 'good', and if the trust leadership is robust enough to ensure that the trust will sustain current improvements and make further improvements. NHS England must also be confident that improvements will be sustained.

40. Where NHS England is not satisfied that the exit criteria have been met, mandated intensive support will be extended for a short period to allow the ICB or trust to make the improvements needed. This might occur, for example, where there have been changes to the leadership team and more time is needed for the new team to bring about change. In the case of an extension, the ICB or trust will prepare a revised improvement plan that lists actions to address any outstanding or new concerns.

41. NHS England will inform the ICB or trust in question of its exit decision once it has completed its formal decision-making processes. NHS England will then make a formal public announcement.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce & Corporate Business
Date of paper:	July 2022
Subject:	To receive a report on the MFT Staff Survey (2021/2022)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The national NHS Staff Survey results are the primary method by which we measure how well we support the well-being of our workforce and enable each member of our staff to reach their full potential. This is essential to maintaining improved organisational performance.
Recommendations:	The Board of Directors is asked to: • Consider the strengths, improvements and areas for development following the 2021 Staff Survey results. • Note the actions being taken in response to the survey results.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce & Corporate Business Tel: 0161 276 4795

National Staff Survey Results 2021

1. Background and Context

1.1. The 2021 NHS Staff Survey results are based on staff in post and organisational structures as of 1st September 2021.

1.2 MFT receives two reports: a national one issued by the Survey Co-ordination Centre (SCC) published for public scrutiny, which includes national benchmark data and a report issued by Quality Health to the Trust.

1.3 National reporting for 2021 includes results at Trust / Hospital / Managed Clinical Service (MCS) / Local Care Organisation (LCO) and Corporate / Research & Innovation (R&I) levels. The results are also broken down to a national People Promise element and a theme level for *staff engagement and morale* with question-level reporting provided on a Trust basis. The national report also includes benchmarked data for individual questions at Trust level.

1.4 Survey questions for 2021 are categorised into seven national People Promise elements and two themes of *staff engagement* and *morale*. These elements and themes include 102 questions, with 72 comparable to the 2020 staff survey. The remaining questions are reported separately.

1.5 Survey results are measured against the seven national *People Promise* elements and two previous 'themes' *staff engagement* and *morale*. The ability to report and analyse most of the existing questions has been maintained to preserve longitudinal data at a question level. Most questions and some key themes and indicators - *staff engagement*, *morale*, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) have been maintained complete with historical comparability. However, as the new questions are aligned to the national *People Promise* element all other themes will have no historical data to apply retrospectively.

1.6 Although *morale* as a theme score has been maintained, it has been recalculated this year to include additional questions in the measure. Previously the score was calculated as the average of two sub-scores: *Stress* and *Intention to leave*. For 2021, the theme is calculated from the average of three sub-scores:

- Stressors (similar to the previous Stress sub-score but incorporating an additional question).
- Thinking about leaving (identical to the previous Intention to leave sub-score).
- Work pressure (new).

1.7 In the 2021 reporting the *morale* theme score is recalculated for previous years based on the new calculation so that trend data can be shown. It should be noted however, that the results for this theme are not comparable to those previously published.

1.8 New demographic questions have also been included for 2021, providing richer reporting and insight into the lived experience of our people. New sub-scores, robustly calculated, that enable as accurate and representative a measure of employee

experience as it possibly can be. The results are available at national People Promise element/theme level, a sub-score level and a question level.

1.9 Questions linked to appraisals have been re-introduced in 2021. These were removed in 2019 to accommodate new questions related to COVID-19.

1.10 Five years of trend data is provided by the SCC at Group-level from 2018 to 2022.

1.11 The national benchmark group for MFT in 2021 is "acute and combined acute and community trusts', the previously used benchmark group of 'combined acute and community trusts' having been withdrawn in 2019.

1.12 The 2021 Staff Survey results were published nationally by the SCC on 30th March 2022.

2. Key Highlights

- The Trust staff engagement score is 6.7 compared to 7.0 in 2020.
- MFT is within 0.1 of the average sector score for 6 of the 7 national People Promise elements and 2 of the themes and 0.2 for the element *'We Work Flexibly*". Details are shown in the table in section 4 below.
- For the first time the survey includes a valid and robust measure of '*burnout*' as part of the *'We are Safe and Healthy'* reporting element.
- As part of the '*We Have a Voice Element'* there has been a significant improvement since 2020 with a +2.79% difference in staff feeling secure about raising concerns about unsafe clinical practices.
- *Staff engagement* and *morale* themes have both shown a statistically significant decline with *Morale* at 5.6 in 2021 compared to 6.0 in 2020.
- Analysis suggests that for those staff working remotely during the pandemic, including from home, scores were higher across all the national *People Promise* elements. Scores were generally lower for those staff who were working on a COVID-19 ward and/or redeployed, particularly for 4 of the 7 *People Promise* themes "*We are Rewarded and Recognised*", *'We are Safe and Healthy',* "*We are Always Learning*", "*We Work Flexibly*", along with "*Morale*."

3. Response Rate

3.1 MFT ran a census survey mode in 2021. There were 7,951 completed surveys, giving a response rate of 30% (33% in 2020). The median response rate for the benchmark group was 46%.

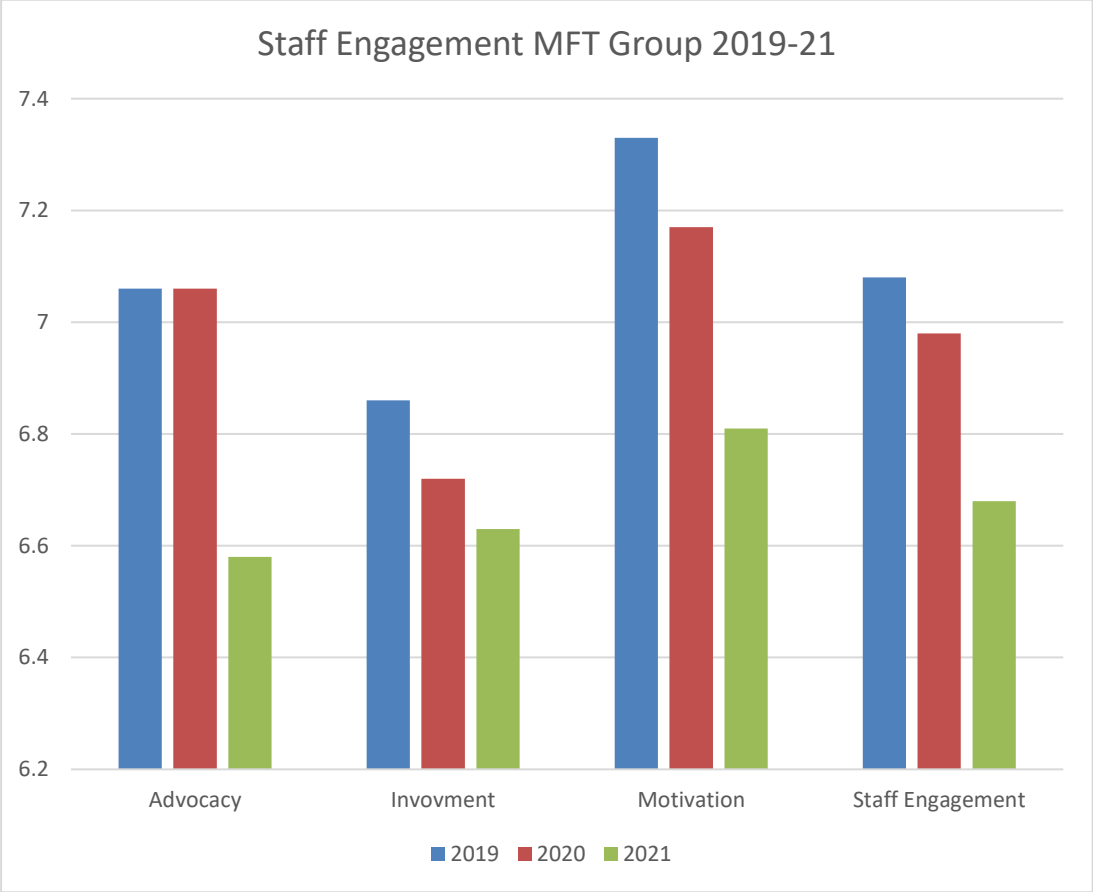
4. Trust Results: Summary – Overall Staff Engagement

4.1 The staff engagement score is a composite of nine questions in the survey, with questions clustered into three sub-categories: 'advocacy', 'involvement' and 'motivation'.

4.2 The overall staff engagement score for MFT was 6.7 compared to 7.0 in 2020, against a benchmark sector average of 6.8 (7.0 in 2020).

4.3 At MFT, there was a statistically significant decline in scores for those questions linked to motivation, involvement, and advocacy.

4.4 The chart below compares staff engagement scores across the factors of advocacy, motivation, and involvement at MFT over the past three years.



5. Trust Results Summary – Key Themes

5.1 Survey questions in 2021 are measured against the seven national *People Promise* elements and two previous 'themes' staff engagement and morale. Questions not covered by these themes are reported individually. The table overleaf shows the key themes results for 2021.

5.2 This year only *staff engagement* and *morale* can be compared to 2020, due to the introduction of the national People Promise elements. Because of this there can be no direct comparison at an element level, however the majority of questions have been maintained to preserve longitudinal data.

People Promise Element	Sub Themes	MFT score	Average Score
Promise Element 1: **We are compassionate and inclusive** Overall score = 7.1 (Average 7.2)	Compassionate Culture	**6.9**	7.1
	Compassionate Leadership	**6.6**	6.8
	Diversity and Equality	**8.0**	8.1
	Inclusion	**6.7**	6.8
Promise Element 2: **We are recognised and rewarded** Overall score = 5.7 (Average 5.8)	Features no sub-scores		
Promise Element 3: **We each have a voice than counts** Overall score = 6.6 (Average 6.7)	Autonomy and Control	**6.8**	6.9
	Raising Concerns	**6.4**	6.4
Promise Element 4: **We are safe and healthy** Overall score = 5.8 (Average 5.9)	Health and Safety Climate	**5.0**	5.2
	Burnout	**4.8**	4.8
	Negative experiences	**7.7**	7.7
Promise Element 5: **We are always learning** Overall score = 5.1 (Average 5.2)	Development	**6.1**	6.3
	Appraisals	**4.1**	4.2
Promise Element 6: **We work flexibly** Overall score = 5.7 (Average 5.9)	Support for work-life balance	**5.7**	6.0
	Flexible Working	**5.8**	5.9
Promise Element 7: **We are a team**. Overall score = 6.5 (Average 6.6)	Team working	**6.5**	6.5
	Line Management	**6.5**	6.6
Staff Engagement		**6.7**	6.8
Morale		**5.6**	5.7

5.3 The SCC does not report on the statistical significance of differences between Trust and sector key theme scores. MFT is however, within 0.1 of the sector average score for all 7 People Promise elements and 2 themes, apart from *We work flexibly* which is within 0.2. At a sub level all scores are either equal or below the sector average with '*Support for Work Life Balance'* 0.3 below the sector average.

5.4 Appendix 1 outlines the MFT key theme scores, compared to sector averages and best and worse scores.

6. National Summary and Trends – Key Themes

- For 2021 new summary indicators have been introduced to provide an overview of staff experience in relation to the 7 elements of the national *People Promise*. Trend analysis from 2020 at element level is therefore, not possible.

- *Staff Engagement* is lower than in previous years at 6.8 (down from 7.0 in 2017-20).

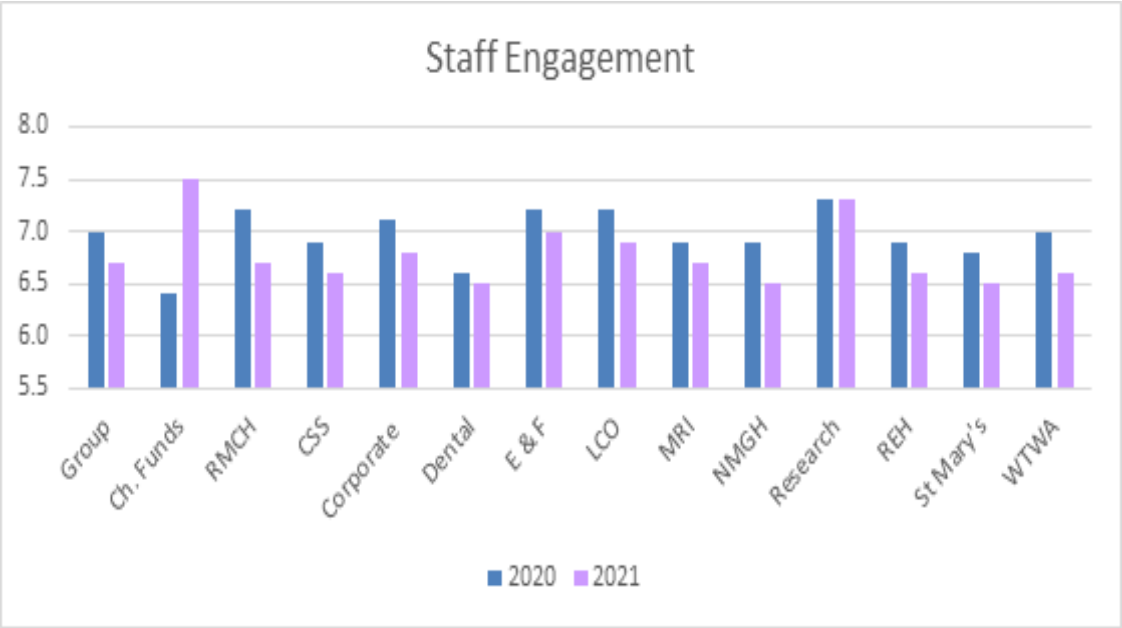
- *Morale* theme score at 5.8 has declined to below the 2017 level, having been improving steadily between 2017 (5.9) and 2020 (6.1).

- The COVID-19 pandemic national responses report that 37.7% of staff had worked on a COVID-19 specific ward or area, slightly more than 2020 (34.2%). Within the Acute/Acute and Community Trust this proportion was highest (42.7%) with redeployment most likely amongst staff in this sector.

- 39.4% of staff had been required to work remotely from home, slightly more than in 2020 (36.0%).

7. Hospital/MCS/LCO/Corporate Summary – Staff Engagement & Key Themes

7.1 Reports at Hospital / MCS / LCO / Corporate level are provided by the SCC for key themes only. The chart below shows the overall staff engagement scores by Hospital / MCS / LCO / Corporate:



8. COVID-19 Related Questions

8.1 In 2021 three classification questions relating to staff experience during the COVID-19 pandemic were included in the survey:

- **Have you worked on a Covid-19 specific ward or area at any time?**
  34% of respondents had worked on a covid-specific ward or area (sector = 44%).

- **Have you been redeployed due to the Covid-19 pandemic at any time?**
  19% had experienced redeployment (sector = 20%).

- **Have you been required to work remotely/from home due to the Covid-19 pandemic?**
  35% had worked remotely / at home (sector = 31%).

8.2 The table overleaf shows the breakdown of national *People Promise* element scores for staff answering “yes” compared with the results for all staff at MFT.

	All staff		Worked on Covid-19 specific ward/area		Redeployed		Required to work remotely/home	
	MFT	Avg.	MFT	Avg.	MFT	Avg.	MFT	Avg.
Promise Element 1: We are compassionate and inclusive	**7.1**	7.2	**6.9**	7.0	**6.8**	7.0	**7.3**	7.4
Promise Element 2: We are recognised and rewarded	**5.7**	5.8	**5.5**	5.5	**5.4**	5.6	**6.2**	6.2
Promise Element 3: We each have a voice than counts	**6.6**	6.7	**6.4**	6.5	**6.3**	6.5	**6.8**	6.9
Promise Element 4: We are safe and healthy	**5.8**	5.9	**5.4**	5.5	**5.4**	5.6	**5.9**	6.1
Promise Element 5: We are always learning	**5.1**	5.2	**5.1**	5.2	**5.1**	5.2	**5.4**	5.4
Promise Element 6: We work flexibly.	**5.7**	5.9	**5.4**	5.6	**5.4**	5.7	**6.2**	6.5
Promise Element 7: We are a team	**6.5**	6.6	**6.3**	6.4	**6.3**	6.5	**6.8**	6.8
Staff Engagement	**6.7**	6.8	**6.5**	6.8	**6.5**	6.7	**6.9**	7.0
Morale	**5.6**	5.7	**5.3**	5.5	**5.2**	5.5	**5.7**	5.9

9. National Summary and Trends

9.1 Below is a summary of the key findings from national data on responses to individual questions, as supplied by NHS Providers.

9.2 The percentage of staff who would recommend their organisation as a place to work has declined by more than 7% from 66.8% (2020) to 59.4% (2021). **MFT score for 2021 is 54.0% (-10.6% compared to the 2020).**

9.3 The percentage of staff who are happy with the standard of care provided by their organisation has declined by more than 6% from 74.2% (2020) to 67.8% (2021). **MFT score for 2021 is 65.8% (-10.4% compared to the 2020).**

9.4 The number of staff who felt their organisation acts fairly in relation to career progression or promotion slightly declined from 56.1% (2020) to 55.5% (2021), and is

now 3% lower than in 2017 (58.5%). **MFT score for 2021 is 53.3% (-1.5% compared to 2020).**

9.5 The percentage of staff reporting that their immediate line manager asks for their opinions before making decisions that affect their work has increased by around 1% to 57.00%, compared to 2020. **MFT score for 2021 is 55.0% (+0.5% compared to the 2020).**

9.6 Respect for individual difference, such as different cultures, working styles and backgrounds and ideas was 68.5% (**MFT 64.4%)** with 70.5% of staff reporting that the people they work with are understanding and kind to each other (**MFT 68.1%**) and 71.9% are polite and treat each other with respect **(MFT 69.5%).**

9.7 70.2% of staff felt able to make suggestions to improve the work of their team/department **(MFT 69.1%).**

9.8 The percentage of staff reporting that they would feel secure about raising concerns about unsafe clinical practice has increased by 2% from 72.5% (2020) to 74.9% (2021). of staff reported, which is almost 5% higher than in 2017. **MFT reported a significant improvement in this question at 73.9% in 2021 (+2.7% compared to 2020).**

9.9 The percentage of staff reporting that they have felt unwell due to work-related stress in the past year, increased by 2.8% since 2020 to 46.8% (2021). This figure has increased for 4 consecutive years and is now more than 8% higher than in 2017. **MFT score for 2021 is 48.2% (+4.6% compared to 2020).**

9.10 The percentage of staff reporting that they were satisfied with the opportunities they have for flexible working patterns declined by 3% from 56.9% (2020) to 53.9% (2021). **MFT score for 2021 is 50.6% (-4.8% compared to 2020).**

9.11 The sub theme score of *Burnout* in the '*We are Safe and Healthy'* element was 4.9, **(MFT 4.8)** with 38% finding their work emotionally exhausting (**MFT 38.2%)** and 34.3% feeling they feel burnt out because of their work **(MFT 36.5%).** Nationally, Ambulance (operational) staff (51.0%) and Registered Nurses and Midwives (40.5%) were particularly likely to describe feeling burnt out**.**

9.12 Within the staff engagement sub theme of *Motivation* 52.5 % of staff reported that they looked forward to going to work **(MFT 48.7%)**. This has declined nationally by more than 6% since 2020 and is now 7% lower than 2019.

9.13 Those thinking about leaving the organisation has increased this year to 31.1% (**MFT 34.8%).** Those looking for another job and leaving the organisation is higher than at any point over the last 4 years at 16.6% **(MFT 19.9%).**

10. Summary of Performance Against the Key Priority Areas Agreed Following the 2020 Staff Survey

10.1 Following the analysis of the 2020 staff survey results, the following priority areas were agreed for 2020, these being the key themes that were below the sector average and / or had declined since the 2019 survey:

- Equality, Diversity and Inclusion.
- Immediate Managers.
- Morale.

- Staff Engagement.
- Teamworking.

10.2 Due to the changes in reporting, apart from staff engagement and morale, these themes are no longer directly comparable, however some questions that relate to these areas and were asked in the 2021 survey can be compared.

11. Action Plans and Next Steps

11.1 A stocktake of the survey results is being completed by the Group Executive Director of Workforce & Corporate Business in the context of existing workforce policies and initiatives including the MFT People Plan, "*All here for you, Together we can*". The work will involve Group Executives, senior leaders across MFT and Staff Side colleagues.

11.2 The 2021 results are being considered as part of the current round of Hospital/ Managed Clinical Services/Local Care Organisation Reviews led by the Group Chief Executive. They also form part of the Accountability Oversight Framework discussions being led by the Group Director of Operations with the support of Group Executive Directors.

11.3 In addition, the results have been disseminated to Hospitals / Managed Clinical Services / Local Care Organisations and Corporate Leadership Teams to consider, reflect and develop action plans. Action plans are now aligned to localised versions of the MFT People Plan.

11.4 To support a consistent approach to action planning and goal setting, a *'Staff Survey Action Plan Playbook'* has been created which supports leaders and managers to work through a four-stage process in developing their plans. The *Playbook* includes how to lead staff engagement, the four enablers of engagement, how to develop staff survey action plans, example actions and resources and planning templates. This collection of resources enables Hospitals / Managed Clinical Services / Local Care Organisation / Corporate Services to take ownership of their data and produce evidence-based plans that can be directly measured through staff engagement indicators.

11.5 A key delivery of the MFT People Plan has been the introduction of the new staff engagement and recognition system *OpenDoor*. This digital engagement and recognition platform will allow for a clear focus on the areas that need to be improved from the staff survey results, through the MFT Big Conversations. This will enable more focus on local activity and allow for responsive instant action at a local level and having the opportunity to share those actions to staff immediately, at both local and organisational levels, through appropriate feedback and communication channels.

11.6 Work is also underway to extract local Equality, Diversity, and Inclusion data for each Hospital / Managed Clinical Service / Local Care Organisation / Corporate Services to understand the lived experience of staff with protected characteristics. Discussions are ongoing at HR Director meetings chaired by the Group Executive Director of Workforce & Corporate Business. This is in addition to regular meetings of the various staff networks to further understand the perspective of those staff groups, focusing on using WRES and WDES data.

11.7 Staff experience of working the COVID-19 Pandemic and the related pressures have had a significant impact on their responses to the 2020 and 2021 Staff Survey. Trust results indicate that the experience of those staff who were redeployed during the

Pandemic or working on a dedicated COVID-19 wards, generally led to lower survey scores. Work to support the health and wellbeing of these staff has been and will continue to be, a priority.

11.8 Since the 2020 staff survey results several work streams have been introduced to complement the NHS and MFT People Plans. The focus is on the lived experience of staff, supporting policy, practice and leadership to be more compassionate and inclusive. The next MFT Big Conversation will have a clear focus on bullying, harassment and abuse through the *Choosing Kindness Programme.* This will support wider workstreams including *Putting People First, MFT Civility, and a Just Culture*. The Staff Survey results from both 2020 and 2021, benchmarked against Regional and National contexts, have provided clear areas of strength and development to feed into these programmes of work.

11.9 The MFT leadership and culture programme of work that underpins the MFT People Plan has been updated in-line with national changes and based on MFT Staff Survey insights to ensure a targeted measurable approach is taken to embedding a culture of compassion, inclusion, and staff engagement. Also, in recognition of the data in relation to the percentage of employees thinking about leaving the organisation, a detailed review of staff turnover across each Hospital/Managed Clinical Services /Local Care Organisation /Corporate Services has commenced in help gain a better understanding of the current position, so that the Trust can respond constructively.

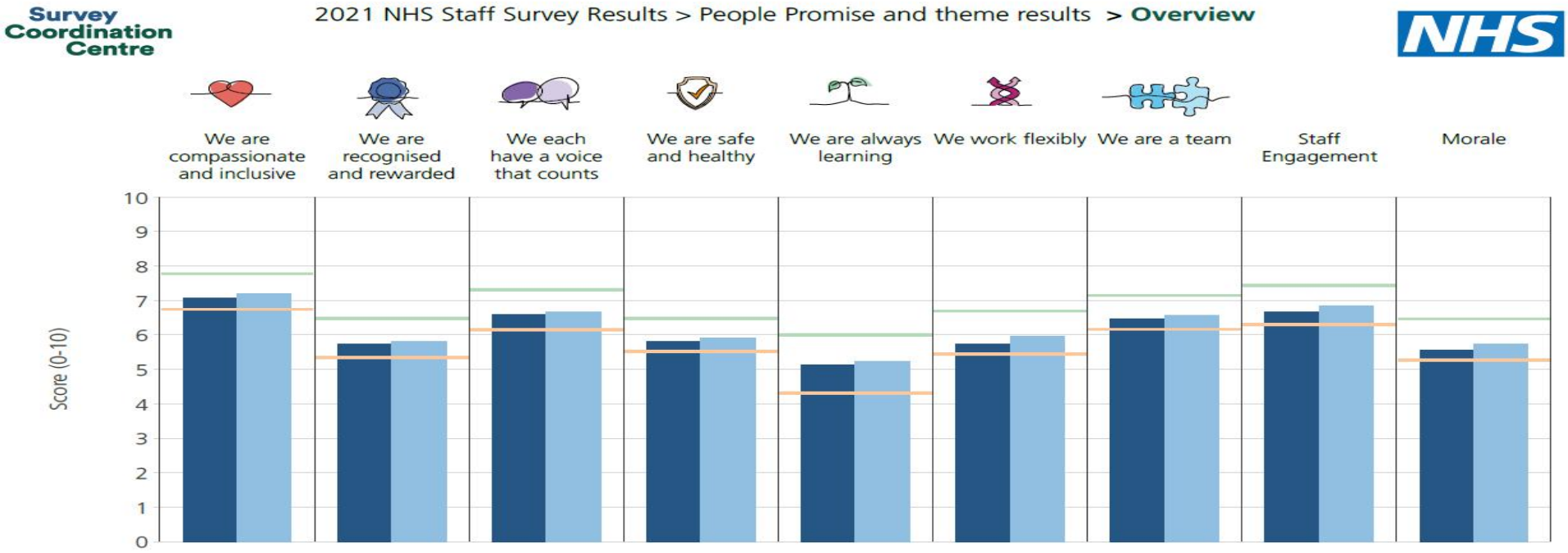
11.10 Finally a new MFT line manager framework, Managing@MFT, has been introduced which will help and support line managers at all levels to understand the expected standards as well as access to the learning, resources and support capacity and capability. This will support the *We are always learning* People Promise element in supporting all staff in their development through the appraisal system.

12. Recommendations

12.1 The Board of Directors is asked to:

- Consider the strengths, improvements and areas for development following the 2021 Staff Survey results.
- Note the actions being taken in response to the survey results.

Appendix 1: MFT Key Theme score, compared to sector average and best and worst scores



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.7	6.6	5.8	5.1	5.7	6.5	6.7	5.6
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	7,921	7,824	7,853	7,899	7,562	7,792	7,905	7,937	7,935

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce & Corporate Business Nick Bailey, Director of Corporate Workforce
Date of paper:	July 2022
Subject:	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Standards 2021/22
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The report aligns with the principal risk of failure to deliver high quality, safe care due to the inability to recruit, retain and engage the current and future diverse workforce of MFT. The WRES and WDES are part of the NHS Standard Contract and a requirement of healthcare providers.
Recommendations:	The Board of Directors is asked to receive the WRES and WDES data and note the work underway to make improvements against both equality standards.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce & Corporate Business Tel: 0161 276 5850

1. Background and Context

1.1 The purpose of the Workforce Equality Standards is to ensure NHS organisations review their data against the prescribed indicators/metrics to produce an action plan to close the gaps in the workplace for ethnic minority staff and disabled staff.

1.2 Both equality standards are included in the NHS Standard Contract. The WRES has been a requirement of NHS commissioners and NHS healthcare providers including independent organisations since July 2015 and the WDES since April 2019. All NHS Trusts are required to produce and publish their WRES and WDES annually.

1.3 The scope of the reports is set by NHS England and indicators/metrics are different for each standard.

2. Key Highlights

2.1 Workforce Race Equality Standard (WRES)

2.1.1 **Indicator 1 – Workforce Profile** - The overall representation of staff who identify as being from a Black, Asian, or Minority Ethnic (BAME) background is 22%.

2.1.2 The term BAME is used in this report as a data label. Wherever possible the report will refer to specific ethnic groups in line with best practice guidance.

2.1.3 **Indicator 2 – Recruitment** - White candidates are 1.65 times more likely to be appointed from shortlisting than candidates from ethnic minority backgrounds. Last year's data showed White candidates to be 1.42 times more likely than candidates from ethnic minority backgrounds to be appointed from shortlisting.

2.1.4 **Indicator 3 – Disciplinary Process** – Staff from Black, Asian, or Minority Ethnic background are 2.58 times more likely than White colleagues to enter formal disciplinary process. This has increased by 0.72 when compared to last year's data.

2.1.5 **Indicator 4 – Training** - The data shows that staff from Black, Asian, or Minority Ethnic background, are equally likely to access Non-Mandatory Training as colleagues from White backgrounds.

2.1.6 **Indicator 5 – 8 (staff experience)**

- Slightly higher percentage of colleagues from Black, Asian or Minority Ethnic backgrounds experiencing bullying, harassment and abuse (BHA) from the patients, compared to White colleagues. (27.1% compared to 26.4%).

- Significantly more colleagues from Black, Asian, or Minority Ethnic backgrounds experienced BHA from other staff, compared to White colleagues. (32.8% compared to 25%).

- Significant increase in BHA against Black, Asian, or Minority Ethnic and White colleagues. (20.6% in 2020 to 27.1% in 2021).

- Significant difference between colleagues from Black Asian or Minority Ethnic backgrounds who think the organisation does provide equal opportunities when compared to White colleagues. (39.9% compared to 57.1%).

- Significantly higher percentage of colleagues from Black Asian or Minority Ethnic backgrounds experiencing discrimination from manager/team leader when compared to White colleagues. (21.7% compared to 7.5%).

2.1.7 **Indicator 9 – Board Representation** - 6% of the Trust Board identify as being from ethnic minority backgrounds. Representation has decreased compared to last year, from 16%.

2.2 **Workforce Disability Equality Standard (WDES)**

2.2.1 **Metric 1 – Staff Bandings** - The data shows that the overall percentage of colleagues with a disability or long-term condition/illness has increased from 3% to 4% in the last year. (The Trust's percentage of colleagues with a disability or long-term condition/illness is likely higher than this, as indicated by the NHS National Staff Survey declaration rate, where 19% of the Trust's staff who completed the survey declare that they identify as disabled).

2.2.2 **Metric 2 – Recruitment** - The data shows that the relative likelihood of non-disabled candidates compared to disabled candidates being appointed from shortlisting has improved from 1.65 last year, to 1.28 this year. A likelihood of 1 would be an equal likelihood.

2.2.3 **Metric 3 – Disciplinary Process** - The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process is 0.61, compared to last year's likelihood of 0.

2.2.4 **Metrics 4-8: (staff experience)**

- Significant increase of colleagues with a disability or long-term condition/illness (LTC) who have experienced BHA from patients (25.7% in 2020 compared to 32.8% in 2021).

- Increase of colleagues with a disability or long-term condition (LTC) who have experienced BHA from staff (20.8% in 2020 compared to 22.3% in 2021).

- Significantly more colleagues with a disability or LTC who have experienced BHA, than colleagues without a disability or LTC (32.8% compared to 24.5%).

- Significantly higher percentage of colleagues with a disability or LTC experiencing discrimination from manager/team leader when compared to colleagues without a disability or LTC (22.3% compared to 11.4%).

- Significant difference of colleagues with a disability or LTC who think the organisation does provide equal opportunities when compared to colleagues without a disability or LTC (48.2% compared to 55.3%).

- Slight reduction in the percentage of colleagues with a disability or LTC, who feel pressured by their manager to come in to work (34.9% in 2020 to 32.8% in 2021).

- Significantly higher percentage of colleagues with a disability or LTC who feel they have been pressured to come in to work by their manager when compared to colleagues without a disability or LTC (32.8% compared to 21.7%).

- Significant reduction in the percentage of colleagues with a disability or LTC, who

believe the Trust has made reasonable adjustments for it to carry out their work (70.7% in 2020 compared to 64.4% in 2021).

2.2.5 **Metric 9** – **Engagement Score –** The data shows that the engagement score for disabled staff is below that of non-disabled staff and has reduced in the past year. (6.2 compared to 6.8).

2.2.6 **Metric 10 - Board Representation** - 6% of the Trust Board have declared that they are disabled. This is the same percentage representation as last year.

3. Analysis of the Workforce Race Equality Standard (WRES) data

3.1 The WRES data included in this report has been obtained from the following sources:

- Indicators 1, 2 and 9 - Electronic Staff Records (ESR).
- Indicator 3 - Human Resource Records.
- Indicator 4 – Electronic Staff Record and Organisational Development records.
- Indicators 5, 6, 7 and 8 - NHS National Staff Survey.

3.2 The definition of ethnicity used for the purpose of this report is provided in the WRES Technical Guidance as outlined below:

3.3 *"White" staff includes White British, Irish and Eastern European and any "White Other".*

3.4 The term BAME for the purpose of this report refers to staff that are from a Black or Minority Ethnic background that is not White.

3.5 **Indicator 1 – Workforce Profile** - The overall representation of staff who identify as being from a Black, Asian, or Minority Ethnic background is 22%. It is noted that 9% of staff have not declared their ethnicity on the ESR system. The Trust has seen an increase of 1% in the representation of staff from ethnically diverse backgrounds in the last year.

3.6 **Indicator 2 – Recruitment** - All relative likelihood indicators can be understood by the following:

- A result of one means equal likelihood.
- A result of more than one means a less favourable variation for ethnic minority staff.
- A result of less than one means a more favourable likelihood for ethnic minority staff.

3.7 The data shows that White candidates are 1.65 times more likely to be appointed from shortlisting than candidates from ethnic minority backgrounds. Last year's data showed White candidates to be 1.42 times more likely than candidates from ethnic minority backgrounds to be appointed from shortlisting.

3.8 **Indicator 3 – Disciplinary Process** - The data for indicator 3 shows that staff from ethnic minority backgrounds are 2.58 times more likely than White colleagues to enter formal disciplinary process. This has increased by 0.72 when compared to last year's data which was 1.86. The Trust will continue to review disciplinary cases involving members of staff from ethnic minority backgrounds annually, to identifying and address any variation in experience or outcome.

National data shows that NHS staff from Black, Asian, and Minority Ethnic backgrounds are 1.16 times more likely to enter the formal disciplinary process.

3.9 **Indicator 4 – Training** - The data shows that staff from White backgrounds are 0.99 times more likely than to access Non-Mandatory Training or CPD than staff from ethnic minority backgrounds. This is an improvement compared to last year's data which was 1.04. This means that staff from ethnic minority backgrounds at the Trust are equally likely to access Non-Mandatory Training as colleagues from White backgrounds.

3.10 **Indicators 5 – 8 - Staff Experience**

- Indicators 5 to 8 are drawn from the NHS National Staff Survey. The results show the experience of staff from ethnic minority backgrounds compared to staff from White backgrounds. 30% of the Trust's staff completed the NHS Staff Survey in 2021, 18% of which identified as being from an ethnic minority background. The results for indicators 5-8 are reflective of these responses.

- The data for indicator 5 shows that the percentage of staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in last 12 months has increased. It has increased by 7% for staff from ethnic minority backgrounds (from 20% to 27%). It has increased by 5% for staff from White backgrounds (from 21% to 26%). Staff from Black, Asian, and Minority Ethnic backgrounds are more likely to experience harassment, bullying, or abuse from patients, relatives, or the public.

- The data for indicator 6 shows that the percentage of staff experiencing harassment, bullying, or abuse from staff in the last 12 months has also increased for staff from ethnic minority backgrounds. It has increased by 3% for staff from ethnic minority backgrounds (from 30% to 33%). It has increased by 2% for staff from White backgrounds (from 23% to 25%). Black, Asian, and Minority ethnic staff remain significantly more likely to experience harassment, bullying, or abuse from other staff.

- The data for indicator 7 shows that the percentage of staff who believe that the Trust provides equal opportunities for career progression or promotion has decreased significantly. The data shows that this belief has decreased by 27% for staff from ethnic minority backgrounds, from 67% last year to 40% this year. The data also shows a decrease for staff from White backgrounds of 29%, from 86% last year, to 57% this year. This shows that it remains the case that Black, Asian, and Minority Ethnic staff are significantly less likely to believe that the Trust provides equal opportunities for progression or promotion.

- The data for indicator 8 shows that the percentage of staff who have reported to have personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months has increased. The instance of this experience has increased by 4% for staff from ethnic minority backgrounds, from 18% last year, to 22% this year. This has increased for staff from White backgrounds by 1%, from 7% to 8%. This shows that staff from Black, Asian, and Minority Ethnic backgrounds remain significantly more likely to experience instances of discrimination at work from colleagues.

3.11 **Indicator 9 – Board Representation** - 6% of the Trust Board identify as being from ethnic minority backgrounds. Representation has decreased compared to last year. It is noted that the Board would be considered a very small data set. This means that the addition or removal of one or two individuals will have a significant impact on the

percentage representation. It is also important to note that 28% of the Board membership has not declared their ethnicity. The data indicates that the Board is 16% less representative than the wider workforce based on the available data.

4. Actions Taken or underway within the Trust in response to the WRES data

4.1 As part of the WRES process MFT is obliged to publish the action it is taking to address the analysis of the WRES. These actions include delivery of the Trust equality, diversity and inclusion strategy – *Diversity Matters*. This will involve continued action centred on three principal aims.

- Improved patient access, safety and experience.
- A representative and supported workforce.
- Inclusive Leadership.

4.2 Strategic oversight and governance of WRES delivery will continue through the Group Equality Diversity and Human Rights Group, co-chaired by the Group Joint Medical Director and a Hospital Chief Executive. The Health Inequalities Group and Strategic Workforce Equalities Group which progress a range of relevant work streams report into the Group Equality Diversity and Human Rights Group.

4.3 In support of the drive to make improvements the Trust supports a BAME Staff Network, which facilitates feedback and communication with Black, Asian, and Multi-Ethnic colleagues. The work of this group is supported through a BAME Engagement Group, chaired by a Hospital HR Director.

4.4 As part of the overall governance on WRES the Trust will continue to prioritise delivery of its People Plan objective which is to create an inclusive workplace by continuing to engage with the voice of ethnic minority staff. It will achieve this by ensuring strong relationships with its well established BAME Staff Engagement Group which includes representation from the BAME staff networks. The group reports into the Workforce Strategic Equality Group which is chaired by the Group Executive Director Workforce & Corporate Business enabling further senior support for the voice of ethnically diverse staff.

4.5 The Trust will also continue to build on the success achieved in the past year or so through the investment in its *Removing the Barriers Programme*, which has seen an increase in senior representation above Agenda for Change band 8a. Mandated diverse recruitment panels, development opportunities for Black, Asian, and Minority Ethnic staff and a successful reciprocal mentoring scheme between senior leaders and colleagues from a Black, Asian, and Minority Ethnic background feature as part of this programme.

4.6 In keeping with the objectives set out in *Diversity Matters,* creating an understanding of, and ownership for, race equality at a local level is a priority for the Trust. To enable this local understanding and ownership, the Trust will continue to provide all Hospitals, Managed Clinical Services, Community, and Corporate facilities with their local WRES data annually. This data is being used to inform local action planning to advance race equality.

4.7 The Trust is also working to ensure all employment relation cases are recorded using the Empactis-Case Manager System. This will enable the review of disciplinary cases to be assessed, so that any variation in experience or outcome can be identified and addressed.

4.8 Recognising the concerns regarding BHA, the Trust Freedom to Speak Up Scheme is increasing the number of Champions across the Trust and has a 24% representation of Black, Asian and Multi-Ethnic Champions.

4.9 To help address BHA across the Trust, a number of programmes have been developed and introduced which include:

- **Choose Kindness Campaign** - *Choose Kindness* will outline a clear zero-tolerance approach to bullying through the delivery of actions plans, guidance and a Trust wide 'Big Conversation'. At a local level, Hospitals/Managed Clinical Services/ Local Care Organisation and Corporate Services will be encouraged to continue to host listening to events to actively engage staff.

- **Putting People First Programme** - The approach to bullying, harassment and abuse is part of the Trust's broader *Putting People First Programme* aimed at strengthening culture around employment issues. It builds on what is already in place such as Freedom to Speak Up and on national NHS initiatives such as the NHS violence reduction, and the hate crime reporting provision at MFT.

- **Learning and Development** - Development offers in the form of structured learning and personal reflection, including *Behaviours in the Workplace***,** *Reducing Bullying Harassment and Abuse awareness sessions* and the *Black Cultural Anti-Racist Programme* in collaboration with the Manchester Caribbean and African Health Network.

- **Be Inclusive Campaign** - This campaign was launched in May 2022 and is targeted at all staff across the Trust to be inclusive with their colleagues through a host of events, small acts of kindness and understanding. Currently there are 1244 colleagues who have signed up to actively support the campaign. The goal is to significantly increase this number over the coming months.

4.10 To complement the various initiatives the Equality Diversity and Inclusion Team has developed a training programme, with accredited trainers/facilitators called '*Let's talk about race and racism'*. This programme is designed to provide managers with the tools to identify and with confidence, address the issues of racism in the workplace.

5. Analysis of the Workforce Disability Equality Standard (WDES)

5.1 The WDES is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information informs the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for disabled staff. The WDES was mandated for all Trust's from April 2019. It is included in the NHS Standard Contract.

5.2 The data in this report has been obtained from the following sources:

- Metrics 1, 2 and 10 - Electronic Staff Records (ESR).
- Metric 3 - Human Resource Team Records.
- Metrics 4, 5, 6, 7, 8 and 9 - NHS National Staff Survey.

5.3 **Metric 1** - This Metric shows the percentage of staff in Agenda for Change pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data

analysis is separate for non-clinical and for clinical staff. The WDES standard requires organisations to 'group' staff into 'clusters.'

5.4 The data shows that the overall percentage of disabled staff has increased from 3% to 4% in the last year. The Trust's disabled workforce is likely higher than this, as indicated by the NHS National Staff Survey declaration rate, where 19% of the Trust's staff who completed the survey declare that they identify as disabled. The declaration percentage from the national Staff Survey is closer to the 18% of Manchester's population who identify as disabled.

5.5 The representation of disabled staff in the clinical workforce has remained the same. Disabled staff continue to be more represented in non-clinical roles.

5.6 Disabled staff are underrepresented in senior roles at MFT, especially in clinical roles. National data shows that 59% of trusts have five or fewer disabled staff in senior positions (bands 8a and above, including medical consultants and Board members).

5.7 **Metric 2** - The data shows that the relative likelihood of non-disabled candidates compared to disabled candidates being appointed from shortlisting has improved from 1.65 last year, to 1.28 this year. A likelihood of 1 would be an equal likelihood.

5.8 **Metric 3** - This year's data shows that the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process is 0.61, compared to last year's likelihood of 0. This means that disabled staff are equally likely to enter this process as non-disabled staff. The data quality for this metric is impacted by factors including, it being calculated from a small data set and the low rate of declaration by disabled staff at the Trust.

5.9 **Metric 4 – 8 Staff Experience**

- Metric 4 - The data shows that the percentage of staff experiencing harassment, bullying, and abuse from patients and the public has increased when compared to last year. This has increased by 7% for disabled staff and by 5% for non-disabled staff. Disabled staff remain significantly more likely to experience harassment, bullying, and abuse from patients and the public.

- The data shows that the percentage of staff experiencing harassment, bullying, or abuse from managers has increased compared to last year. This has increased by 1% for both disabled and non-disabled staff. Disabled staff remain significantly more likely to experience harassment, bullying, or abuse from a manager.

- The data shows that the percentage of staff experiencing harassment, bullying, and abuse from other colleagues has increased compared to last year. This has increased by 3% for disabled staff and 2% for non-disabled staff. Disabled staff remain significantly more likely to experience harassment, bullying, and abuse from other colleagues.

- The percentage of disabled compared to non-disabled staff who, last time they experienced harassment, bullying or abuse at work, they or a colleague reported it has increased by 1% in the last year. The Trust will continue to promote reporting of all instances of harassment, bullying or abuse.

- **Metric 5** - The data shows that the percentage of disabled staff compared to non-Disabled staff who believe that the Trust provides equal opportunities for career progression or promotion has decreased significantly over the last year. For Disabled staff this has decreased by 30%, from 77% last year, to 48% this year. This has also decreased for non-disabled staff from 84% last year, to 55% this year. Disabled staff remain significantly less likely to believe that the Trust provides equal opportunities for career progression or promotion.

- **Metric 6** - The data shows that the percentage of disabled staff compared to non-Disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has improved. This has improved by 2% for disabled and non-disabled staff. Disabled staff remain significantly more likely to feel they experience pressure from their manager to come to work, despite not feeling well enough to perform their duties.

- **Metric 7** - The data shows that the percentage of disabled staff compared to non-disabled staff who said that they are satisfied with the extent to which their organisation values their work has decreased by 9% for disabled staff, from 40% last year to 31% this year. This has also decreased for non-disabled staff from 49% to 43%. Disabled staff remain significantly less likely to feel satisfied with the extent to which their organisation values their work.

- **Metric 8** - The data shows that the percentage who felt the Trust has made adequate adjustment(s) to enable them to carry out their work has decreased from 70% last year, to 64% this year.

5.10 **Metric 9** - The data shows that the engagement score for the Trust has decreased from 7.1 last year to 6.7 this year. This has decreased from 6.5 to 6.2 for disabled staff, and from 7.1 to 6.8 for non-disabled staff. The engagement score for disabled staff consistently remains lower than the score for non-disabled staff.

5.11 **Metric 10** - 6% of the Trust Board have declared that they are disabled. This is the same percentage representation as last year. The Trust Board is representative of the workforce based on the data; however, it is noted that the declaration rate being significantly low impacts this comparison.

6. Actions taken or underway within the Trust in response to the WDES Data

6.1 The Trust will continue to support the development of the Diverse Ability Staff Network, which is the least mature of the staff networks, but is the fastest growing network. Through the network issues are identified for action through the Disabled Staff Engagement Group, chaired by one of the Trust's HR Directors.

6.2 Alongside the Diverse Ability Staff Network, a Disabled People's User Forum has been formed to concentrate on patient care and safety, as well as assess the impact of MFT procedures on those with disabilities.

6.3 The Trust will develop and deliver the Disabled Staff Equality Plan, working with the Network, Engagement Group and User Forum, to direct the MFT response to improving access across MFT.

6.4 Through the Employee Health and Wellbeing Team, the Equality and Diversity and Inclusion Team the Trust is working with the Network, Engagement Group and User

6.5 Forum to improve the provision of reasonable adjustments across the Trust, create effective recording of staff adjustments and mandate regular reviews by managers.

6.6 The introduction of the ACAS Reasonable Adjustment Webinar to guide managers in the development of reasonable adjustments and an understanding of what a reasonable adjustment would be.

6.7 The development of E-Learning Disability Modules, designed for managers and colleagues of staff with disabilities and LTCs, particularly Disability Awareness and Vision and Hearing Impairment Awareness.

6.8 To address the real inequalities faced by colleagues with disabilities, as with the programme of work to address racial inequalities, there are a series of campaigns and programmes which support and address colleagues in the addressing equality, diversity, and inclusion in the workplace and BHA.

6.9 The Trust is working to ensure that all HR cases are recorded using the Empactis-Case Manager System. This will enable the annual review of disciplinary cases to be assessed, so that any variation in experience or outcome can be identified and addressed.

6.10 The Trust has the Guaranteed Interview Scheme in place to ensure all disabled candidates who meet the essential criteria for a role can select to be guaranteed an interview for the post. The Trust will provide reasonable adjustment(s) to all candidates who require them as part of the recruitment process.

7. The Trust will work toward 'Disability Lead Employer' status over the coming year, through the national Disability Confident Scheme.

7.1

Conclusion

7.2 The Trust recognises that analysis of the WRES and WDES identifies that considerable work is required to gain the confidence of our diverse workforce and secure a sustainable model of equality in the workplace.

8. The Board of Directors and senior leaders across the Trusts are committed to making the effort to improve the position for colleagues from all diverse backgrounds.

8.1

Recommendation

The Board of Directors is asked to receive the WRES and WDES data and note the work underway to make improvements against both equality standards.

Appendix A: WRES Results for Manchester University NHS Foundation Trust (MFT) 2021-2022

WRES Indicator	MFT 2020-2021	MFT 2021-2022		MFT 2021-2022 Clinical		MFT 2021-2022 Non-clinical	
Indicator 1: Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.	Band 1: 46.70% Band 2: 21.13% Band 3: 16.65% Band 4: 13.43% Band 5: 24.28% Band 6: 15.47% Band 7: 11.98% Band 8a: 9.94% Band 8b: 6.91% Band 8c: 3.59% Band 8d: 2.53%	Band 1 Band 2 Band 3 Band 4 Band 5 Band 6 Band 7 Band 8a Band 8b Band 8c Band 8d Band 9 VSM Medical & Dental Other Locally Agreed	40.78% 25.81% 17.67% 14.58% 26.97% 18.68% 13.91% 12.37% 6.34% 4.98% 5.71% 0.00% 5.06% 44.48% 58.33%	Band 1 Band 2 Band 3 Band 4 Band 5 Band 6 Band 7 Band 8a Band 8b Band 8c Band 8d Band 9 VSM Medical & Dental Other Locally Agreed	0.00% 27.64% 20.65% 15.56% 28.22% 19.22% 13.62% 12.05% 6.37% 2.04% 2.27% 0.00% 0.00% 44.48% 62.50%	Band 1 40.78% 84 Band 2 23.76% 527 Band 3 15.48% 240 Band 4 13.76% 175 Band 5 16.38% 103 Band 6 13.75% 66 Band 7 15.34% 77 Band 8a 13.31% 43 Band 8b 6.29% 11 Band 8c 7.32% 9 Band 8d 8.20% 5	

	Band 9: 0.00% VSM: 6.67% Medical and Dental: 38.14% Other Locally Agreed: 18.89% Trust Total: 20.00%	**TOTAL 22.42%**	**TOTAL 24.19%**	Band 9 0.00% 0 VSM 5.88% 4 Other Locally Agreed 50.00% 2 **TOTAL 17.60%** **1,346**

WRES Indicator	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
Indicator 2: Relative likelihood of white candidates being appointed from shortlisting compared to black candidates across all posts.	1.67 times more likely	1.42 times more likely	1.65 times more likely
Indicator 3. Relative likelihood of black staff entering formal disciplinary process compared with white staff, as measured by entry into formal disciplinary investigation. This indicator will be based on data from a two-year rolling average of the current year and the previous year.	1.13 times more likely	1.86 times more likely	2.58 times more likely

WRES Indicator	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
Indicator 4: Relative likelihood of white staff accessing non-mandatory training and CPD compared with Black staff.	1.14 times more likely	1.04 times more likely	0.99 times more likely
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.	BAME 23% White 23%	BAME 20% White 21%	BAME 27% White 26%
Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	BAME 21% White 16%	BAME 30% White 23%	BAME 33% White 25%
Indicator 7: Percentage believing that trust provides equal opportunities for career progression or promotion.	BAME 70% White 86%	BAME 67% White 86%	BAME 40% White 57%
Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following Manager/team leader or other colleagues?	BAME 13%	BAME 18%	BAME 22%

WRES Indicator	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
	White 6%	White 7%	White 8%
Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.	BAME 16.67% The percentage difference between the organisation's Board executive membership and its overall workforce will be: -3.3%	BAME 16.67% The percentage difference between the organisation's Board executive membership and its overall workforce will be: -4.35%	BAME 5.56% The percentage difference between the organisation's Board executive membership and its overall workforce will be: -11.31%

Appendix B: WDES Data for Manchester University NHS Foundation Trust (MFT) 2021-2022

WDES Metric	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
Metric 1. **Percentage of staff in Agenda for Change (AfC) pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce:** **Cluster 1: AfC Band 1, 2, 3 and 4** **Cluster 2: AfC Band 5, 6 and 7** **Cluster 3: AfC Band 8a and 8b** **Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)** **Cluster 5: Medical and Dental staff, Consultants** **Cluster 6: Medical and Dental staff, Non-consultant career grade** **Cluster 7: Medical and Dental staff, Medical and dental trainee grades**	**Overall: 2.97%** Cluster 1: 2.96% Cluster 2: 3.47% Cluster 3: 2.52% Cluster 4: 2.26% Cluster 5: 0.58% Cluster 6: 0.78% Cluster 7: 1.16% Other Locally Agreed: 1.11% **Clinical** **Overall: 2.83%** Cluster 1: 2.70% Cluster 2: 3.37% Cluster 3: 2.34% Cluster 4: 2.19% Cluster 5: 0.58% Cluster 6: 0.78% Cluster 7: 1.16% Other Locally Agreed: 0.00% **Non-Clinical** **Overall: 3.37%** Cluster 1: 3.20% Cluster 2: 4.38% Cluster 3: 3.01%	**Overall 3.17%** Cluster 1 3.35% Cluster 2 3.53% Cluster 3 2.83% Cluster 4 1.73% Cluster 5 0.72% Cluster 6 1.09% Cluster 7 1.24% **Clinical** **Overall 2.98%** Cluster 1 3.05% Cluster 2 3.47% Cluster 3 2.14% Cluster 4 1.40% Cluster 5 0.72%	**Overall 3.62% 1031** Cluster 1 3.98% 396 Cluster 2 3.92% 543 Cluster 3 3.41% 58 Cluster 4 2.20% 10 Cluster 5 0.77% 11 Cluster 6 1.70% 4 Cluster 7 1.04% 9 **Clinical** **Overall 3.37% 70** Cluster 1 3.53% 16 Cluster 2 3.89% 47 Cluster 3 2.74% 33 Cluster 4 1.21% 2 Cluster 5 0.77% 11

WDES Metric	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
Note: Definitions for these categories are based on ESR occupation codes except for medical and dental staff, which are based upon grade codes.	Cluster 4: 2.30% Other Locally Agreed: 2.17%	Cluster 6 1.09% Cluster 7 1.24% **Non-Clinical Overall 3.70%** Cluster 1 3.63% Cluster 2 4.02% Cluster 3 4.48% Cluster 4 1.92%	Cluster 6 1.70% 4 Cluster 7 1.04% 9 **Non-clinical Overall 4.31% 33** Cluster 1 4.38% 23 Cluster 2 4.16% 67 Cluster 3 5.02% 25 Cluster 4 2.77% 8
Metric 2: Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	1.53 times more likely	1.65 times more likely	1.28 times more likely
Metric 3: Relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	7.68 times more likely	0 times more likely	0.61 times more likely
Metric 4. Staff Survey **a) Percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse from:**	(a) i. Disabled 28% Non-Disabled 23% ii. Disabled 18% Non-Disabled 9%	(a) i. Disabled 26% Non-Disabled 20% ii. Disabled 21% Non-Disabled 11%	(a) i. Disabled 33% Non-Disabled 25% ii. Disabled 22% Non-Disabled 11%

WDES Metric	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
i. Patients/service users, their relatives or other members of the public **ii. Managers** **iii. Other colleagues** **b) Percentage of Disabled staff compared to Non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**	iii. Disabled 25% Non-Disabled 15% (b) Disabled 49% Non-Disabled 46%	iii. Disabled 27% Non-Disabled 16% (b) Disabled 47% Non-Disabled 44%	iii. Disabled 30% Non-Disabled 18% (b) Disabled 48% Non-Disabled 45%
Metric 5. Staff Survey Percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled 75% Non-Disabled 85%	Disabled 77% Non-Disabled 84%	Disabled 48% Non-Disabled 55%
Metric 6. Staff Survey Percentage of Disabled staff compared to Non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled 32% Non-disabled 21%	Disabled 35% Non-Disabled 24%	Disabled 33% Non-Disabled 22%
Metric 7. Staff Survey Percentage of Disabled staff compared to Non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled 41% Non-Disabled 52%	Disabled 40% Non-Disabled 49%	Disabled 31% Non-Disabled 43%

WDES Metric	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
Metric 8. Staff Survey Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	70% - yes	70% - yes	64%-yes
Metric 9. **a. The staff engagement score for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.** **b. Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)**	(a) Disabled 6.6 Non-disabled 7.2 Trust 7.1 (b) Yes	(a) Disabled 6.5 Non-disabled 7.1 Trust 7.1 (b) Yes	(a) Disabled 6.2 Non-disabled 6.8 Trust 6.7 (b) Yes
Metric 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:	Overall representation: 5.56% Difference: • By voting membership of the Board. 2.59%	Overall representation: 5.56% Difference: • By voting membership of the Board. 2.83%	Overall representation: 5.56% Difference: • By voting membership of the Board. 1.94%

WDES Metric	MFT 2019-2020	MFT 2020-2021	MFT 2021-2022
• **By voting membership of the Board.** • **By Executive membership of the Board.**	• By Executive membership of the Board. -2.97%	• By Executive membership of the Board. -3.17%	• By Executive membership of the Board. 7.49%

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	July 2022
Subject:	Annual Complaints Report 2021/22 for MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations:	The Board of Directors is asked to note the content of this report, the work undertaken during 2021/22 and, in line with statutory requirements, provide the approval for the report to be published on the Trust website.
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

1. Executive Summary

1.1 The Trust adheres to the Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under the NHS Complaint Regulations (2009)[1]. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the current and legacy Trusts, received between 1st April 2021 and 31st March 2022.

1.2 This report describes achievements, whilst acknowledging continuous improvement is fundamental to improve processes and services across the Trust. The impact of North Manchester General Hospital joining Manchester University NHS Foundation Trust (MFT), and the increase in activity as the Trust worked towards recovering from the COVID-19 pandemic on complaints and PALS activity is highlighted throughout the report.

1.3 Throughout the report the term **Complaints** is used to describe complaints requiring a response from the Chief Executive's and Group Chief Executive and the term **Concerns** is used to describe contacts with the Patient Advice and Liaison Service (PALS), which require a speedier resolution to issues that may be resolved in real time.

1.4 The report refers to all Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) across the Manchester Foundation Trust (MFT) Group.

1.5 The Trust noted a significant decrease in complaints and concerns during 2020/21 due to the reduced activity undertaken during the pandemic. This report therefore provides comparator information where appropriate from 2019/20. Please note that the data from 2019/20 does not include NMGH.

2. Summary of Activity

2.1 As in 2020/21, the quality of complaint data reporting continued to improve as did the overall year performance for the timeliness of closing complaints.

2.2 The impact of NMGH joining MFT, activity increasing in Outpatient Departments and an increase in waiting times for elective work as the NHS worked towards recovering from the COVID-19 pandemic, contributed to an increase in the number of Complaints and PALS concerns compared to 2020/21.

2.3 The total number of PALS concerns received in 2021/22 was **7,722**. This is an increase of **2,822** (57.59**%**) when compared with the **4,900** received in 2020/21 during the period of the pandemic. In 2019/20 **5,897** PALS concerns were received.

2.4 The total number of complaints received in 2021/22 at MFT was **1,665**. This is an increase of **606 (57.22%%**) when compared to the **1,059** complaints received, in 2020/21. In 2019/20 **1,628** complaints were received.

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[1] The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). Available from: http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

2.5 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 1** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2021/22 compared to previous years.

Table 1: Complaints received in context of activity

		2018/19	2019/20	2020/21	2021/22
Inpatient	Finished Consultant Episodes (FCE)	438,411	431,667	337,049	455,841
	Formal Complaints Received (FC)	574	523	419	531
	Rate of FCs per 1000 FCEs	1.31	1.21	1.24	1.16
Outpatient	Number of Appointments	2,482,635	2,541,377	1,293,384	1,470,442
	Formal Complaints Received (FC)	714	711	380	665
	Rate of FCs per 1000 Appointments	0.29	0.28	0.29	0.45
AE	Number of Attendances	410,916	413,741	267,867	482,908
	Formal Complaints Received (FC)	138	191	105	270
	Rate of FCs per 1000 attendances	0.34	0.46	0.39	0.55

2.6 The Trust has an internal target of no more than 20% of unresolved cases being over 41 days old at any one time. This allows the Trust to investigate complex complaints, which may involve multiple organisations as well as allowing sufficient time to undertake a High Impact Learning Assessment (HILA) where appropriate.

2.7 At the end of March 2022, **39** (**16.6%)** cases were over 41 days, compared to **19.3%** at the end of March 2021. This represents a **2.7%** decrease in unresolved cases over 41 days old. All cases over 41 working days old continue to be escalated within the relevant Hospital/MCS/LCO and assurance is provided via the monthly Accountability Oversight Framework (AOF).

2.10 The average response rate for patients and carers raising a concern through PALS was **3.9** days during 2021/22, compared with **4.3** days during 2020/21.

2.11 The national statutory requirement for the acknowledgement of complaints, according to the NHS Complaints Regulations (2009) is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. As in 2020/21, throughout 2021/22, **100%** was achieved.

2.12 The Parliamentary and Health Service Ombudsman (PHSO) represents the final stage of the NHS complaints process, and the Trust works together with the PHSO to ensure that all feedback and lessons learnt from complaints contribute to service improvement throughout the year.

2.13 The PHSO closed **5** cases pertaining to the Trust between 1st April 2021 and 31st March 2022; of these; **3** complaints were partly upheld and **2** were upheld. The details of the **5** PHSO cases are set out in this report (Section 12). This position compares to **3** cases closed in 2020/21 when **2** cases were partly upheld, and **1** case was not upheld. It should be noted that in February 2022, the PHSO advised they had a backlog of over 2,500 complaints waiting to be looked at and because of this would only look further into the more serious cases. MFT had **10** cases under review by the PHSO at the end of March 2022, compared to **9** at the end of March 2021.

2.14 WTWA is the Hospital/MCS with the highest level of activity within the MFT Group and received the highest number of complaints in 2021/22, with **406** (**24.4%**) out of a total of **1,665**. This represents a decrease of **24** complaints received when compared to **430** in 2020/21.

2.15 WTWA received the highest number of PALS concerns with **1,931** (**25.0%**) out of a total of **7,722**. This compares to **1,351** (**27.5%**) PALS concerns received in 2020/21, which is an increase of **580** cases. This significant increase should be viewed in the context of the increase in activity as WTWA worked towards recovering from the pandemic.

2.16 The oldest complaint case recorded as closed during 2021/22 was received by WTWA. The case was opened on 7th October 2020 and the case was **186** days old when it was closed on 9th August 2021. The complaint involved 3 other NHS organisations; delays in receiving outcomes of the external investigations and the arranging of the local resolution meeting impacted the overall response time. The complainant was kept updated and fully supported throughout the process.

2.17 A significant focus and work to deliver improvements in 2021/22, has specifically demonstrated:

- The average response rate of complaints responded to within the agreed timescale has **improved** from **88.1%** in March 2021 compared to **90.8%** in March 2022.

- The number of re-opened complaints during 2021/22 was **339** (**16.9%**), representing an increase when compared to **248** (**19.0%**) re-opened in 2020/21.

3. Complaints Review Scrutiny Group

3.1 The Complaints Review Scrutiny Group demonstrates Board level engagement and assurance regarding complaints handling through the Non-Executive Director Chair. This role is complimented by other core group members, which include a Trust Governor, an Associate Medical Director, the Head of Nursing (Quality, Patient Experience and Professional Practice), the Trust's Head of Customer Services and the Corporate Complaint Case Handler. The group met five times in total during 2021/22 and reviewed **10** cases involving **9** Hospitals/MCS/LCOs across MFT. For each participating Hospital/MCS/LCO and presented case, an evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion was undertaken.

4. Complaints Improvement Programme

4.1 The Trust is committed to the delivery of continuous improvement in all aspects of the

complaints process and to this end an annual improvement plan is developed and implemented. The Corporate Director of Nursing (Quality and Patient Experience), Head of Nursing (Quality, Patient Experience and Professional Practice) has continued to work with the Head of Customer Services, the PALS and Complaints Managers, the PALS and Complaints teams and the Hospital/MCS/LCO teams to continue to identify and deliver improvements to the management of PALS and Complaints handling within the Trust.

4.2 Significant improvements delivered in 2020/21 include:

- Reopening of NMGH PALS office and Reception
- Implementation of the formal restructure of the Trust's Corporate PALS and Complaints Service
- Launch of an in-house Customer Service PALS and Complaints Module 1 e-learning package
- Review, updating and ratification of MFT's Concerns and Complaints Policy
- Implementation of a dedicated Complaints Triage System
- Introduction of Equality and Diversity Audits
- Development of an in-house PALS and Complaints Customer Service Advanced e-learning package
- Putting the Ask, Listen, Do commitment into action
- Enhancement in demonstrating learning in practice

5. Learning

5.2 This report details examples of learning and change as a direct result of feedback received from complaints and concerns. Examples of learning from complaints have been published in each Quarter during 2021/22 as part of the Board of Directors Quarterly Complaints and PALS Report.

6. People

6.1 The Trust is grateful to those patients, families and carers who have taken the time to raise concerns and complaints and acknowledges their contribution to improving services, patient experience and patient safety.

6.2 The Trust would like to apologise to all those people who have had cause to raise concerns and complaints. MFT is committed to continually improving our services and acknowledge that whilst it does not always get it right, MFT believes that this report demonstrates the learning and changes it has made as a direct result.

6.3 The Trust is committed to being open and honest and thanks all its staff for their openness and candour when undertaking investigations.

7. Recommendation

7.1 The Board of Directors is asked to note the content of this report and in line with statutory requirements provide approval for it to be published on the Trust website.

Contents

1. Statement

1.1 The Trust adheres to the Statutory Instruments No. 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public under the NHS Complaints Regulations (2009)[1]. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the Trust, received between 1st April 2021 and 31st March 2022.

2. Introduction

2.1 This report sets out achievements and improvements, whilst acknowledging that there are further improvements required in the context of continuous improvement.

2.2 Throughout this report the term **Complaints** is used to describe formal complaints requiring a response from the Chief Executives/Group Chief Executive and the term **Concerns** is used to describe informal contact with PALS requiring a speedier resolution to concerns that may be resolved in real time.

2.3 The quality of complaints data reporting has continued to improve throughout 2021/22 and comparative data is provided within the report.

2.4 Due to the nature of the complaints' handling processes and management, the data fluctuates on a daily basis as complaints progress through the procedure; this can influence the accuracy of the numbers reported within anyone reporting period. For example, once a complaint has been received and registered, it may be withdrawn, de-escalated to PALS, identified as being out of time, or consent may not be received. Small variances within monthly, quarterly, and annual reporting are therefore expected and accepted.

2.5 It should be noted that for the first time, data and information are included from services at North Manchester General Hospital (NMGH), who joined Manchester University NHS Foundation Trust (MFT) from 1st April 2021. This has contributed to a proportionate increase in complaints and PALS activity.

3. Overview of Activity

3.1 The number of PALS concerns received for 2021/22 was **7,722**, which is **2822** more than the number received in 2020 (**4,900**) and **1825** more than the number received in 2019 (**5,897**). This demonstrates a **57.59%** increase in the number of PALS concerns received during the last year. It is important to note however, that this significant increase should be viewed in the context of NMGH joining the Trust, and the increase in activity as the Trust worked towards recovering from the pandemic.

3.2 **Graph 1** provides the number of PALS concerns received by month for the financial year 2021/22.

Graph 1: Number of PALS contacts (by month) for 2021/22, MFT

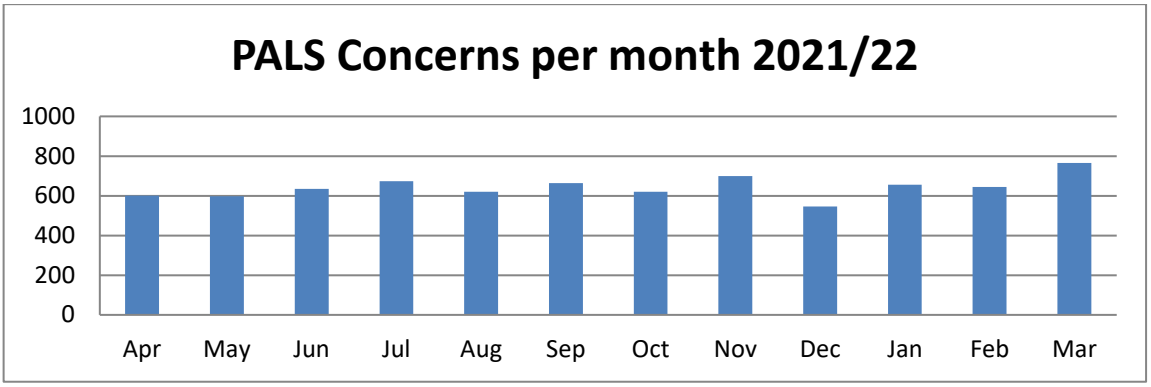


Table 2: Number of PALS contacts by Hospital/ MCS/ LCO

Hospital / MCS / LCO	2018/19	2019/20	2020/21	2021/22
Clinical Scientific Services (CSS)	277	335	303	548
Corporate Services	214	298	211	180
Manchester & Trafford Local Care Organisation (LCO)	25	52	82	108
Manchester Royal Infirmary (MRI)	1,671	1,531	1,458	1,806
Research & Innovation (R&I)	18	15	6	12
Royal Manchester Children's Hospital (RMCH)	561	621	432	673
Saint Mary's Hospital (SMH)	467	526	673	1,134
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	528	447	384	568
Wythenshawe, Trafford, Withington, and Altrincham (WTWA)	1,901	1,920	1,351	1,931
North Manchester General Hospital (NMGH)	-	-	-	761
Not Stated / General Enquiry / Non-MFT	243	19	0	1
MFT Total	**5,905**	**5,897**	**4,900**	**7,722**

3.4 **Table 2** above demonstrates that WTWA received the highest number of PALS concerns, **1,931** out of a total of **7,722** (25.0%). This is an increase of **580** cases from the same reporting period in 2020/21 data when **1,351** (27.5%) were received by WTWA.

3.5 MRI received the second largest number of PALS concerns with **1,806** out of a total of **7,722** (23.4**%**). This is an increase of **348** cases from the same reporting period in 2020/21 when **1,458** (29.7**%**) were received. As with WTWA, this increase should be viewed in the context of the increase in activity as the Trust worked towards recovering from the pandemic.

3.6 As WTWA and MRI are the largest services in the Trust, it is expected that these two areas would receive the greatest proportion of PALS concerns.

3.7 All PALS concerns are RAG rated upon receipt based on the severity of the initial details of the concerns raised. **Table 3** below indicates the number of MFT contacts by risk rating grade. Analysis shows that 2021/22 has seen a significant increase in the number of PALS concerns rated in all 3 categories. Of the **2** PALS concerns rated as red:

1 = treatment/procedure – delay/failure

1 = communication failure with patient/relative

This position compares to **0** PALS concerns rated as red in 2020/21.

Table 3: 2021/22 PALS contacts by risk grading, MFT

Category	2018/20	2019/20	2020/21	2021/22
Green	4,808	4,420	4,202	5,858
Yellow	819	933	532	1,277
Amber	29	68	5	205
Red	1	2	0	2
Not graded, escalated or enquiry	248	474	161	380
MFT Total	**5,905**	**5,897**	**4,900**	**7,722**

3.8 In this report year, the total number of PALS concerns includes those cases that were escalated for formal investigation (these are reported in Section 4 of this report), were withdrawn by the complainant, or were considered to be out of time according to the NHS Complaints Regulation (2009)[1] timescales.

3.9 **Tables 4 to 7** are presented in **Appendix 1**. These tables indicate how people access the PALS and provide information about their demographics.

3.10 **Table 4** shows that the number of concerns raised face to face has increased from **97** in 2020/21 to **316** in 2021/22: this is an increase of **225.8%**. This significant increase should be viewed in the context of the increase in activity as the Trust worked towards recovering from the pandemic. The number of concerns raised by email and telephone continues to be the most favoured route of contact.

3.11 **Table 5** in **Appendix 1** details the number of contacts by age: the age range relates to the people who were the focus of the PALS concern as opposed to the person raising the concern.

3.12 **Table 6** in **Appendix 1** details the number of contacts by gender; again, the gender relates to the people who were the focus of the PALS concern. **Table 7** in **Appendix 1** describes the ethnicity of the patients who were the focus of the PALS enquiry.

3.13 The demographic data for PALS concerns presented within **Appendix 1** supports the findings[2] that younger people (or their parents) are more likely to express dissatisfaction with services than older people and that women more likely to express dissatisfaction with services than other sexes.

3.14 The percentage of people who did not state their ethnicity for PALS concerns has continued to increase from 53.1% in 2020/21 to 63.8% in 2021/22. Work has continued throughout this annual report year to improve the quality of this data to enable continued development of a responsive service: further information is detailed in Section 15 of this report.

3.15 **Graph 2** and **Table 8** provide a more detailed analysis of the main PALS themes and indicates that the greatest proportion of PALS concerns relate to communication, appointment delays/cancellations (outpatients) and treatment and procedure.

[2] DeCourcy, West and Barron (2012) The National Adult Inpatient Survey conducted in the English National Health Service from 2002 to 2009: how have the data been used and what do we know as a result? BMC Health Services Research series: Open, Inclusive and Trusted 2012 12:71

Graph 2: Top 5 PALS Themes 2021/22, MFT

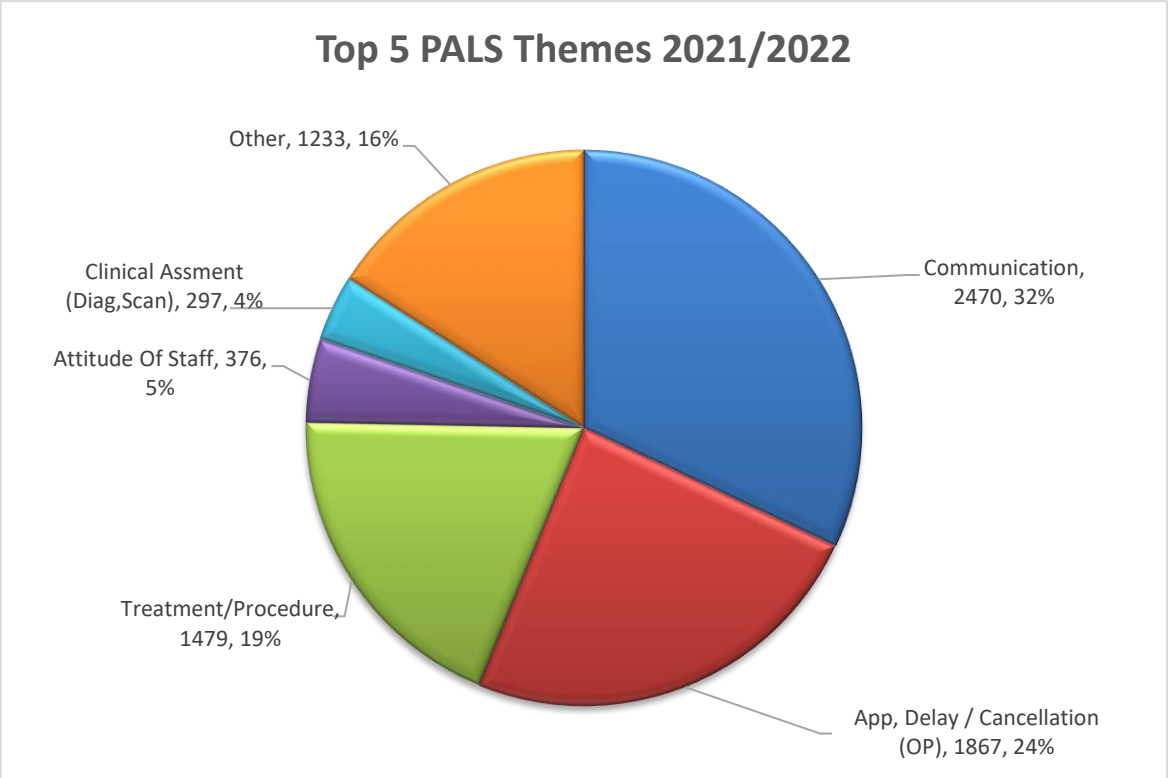


Table 8: Comparison of Top 5 PALS Themes**,** MFT

	2018/19	2019/20	2020/21	2021/22
1	App, Delay / Cancellation (OP)	Communication	Communication	Communication
2	Communication	Appointment Delay / Cancellation	App, Delay / Cancellation (OP)	App, Delay / Cancellation (OP)
3	Treatment / Procedure	Treatment / Procedure	Treatment/ Procedure	Treatment/ Procedure
4	Clinical Assessment (Diagnosis, Scan)	Clinical Assessment (Diagnosis, Scan)	Security	Attitude of Staff
5	Attitude Of Staff	Attitude of Staff	Clinical Assessment (Diagnosis, Scan)	Clinical Assessment (Diagnosis, Scan)

3.16 The average response rate for patients and carers raising a concern through PALS at MFT was **4.9** days during 2021/22 (5.1 days for Oxford Road Campus and 4.8 days for Wythenshawe Campus). This compares to **4.3** days during 2020/21.

4. Complaints Activity

4.1 The number of complaints has increased in 2021/22 compared to the 2020/21 data. This year there were a total of **1,665** complaints received, compared to **1,059** in 2020/21, this is an increase of 57.22%. However, there is little change between 2021/22 and the most recent similar year (in respect of being pre-pandemic), where there were **1,628** complaints: a count of 40 more complaints.

Table 9: Number of Complaints, MFT

Year	2018/19	2019/20		2020/21		2021/22	
Complaints Received	1,573	1,628	↑ 3.4%	1,059	↓ 34.9%	1,665	↑ 57.2%

4.2 WTWA received the most complaints **406:** this represents an increase of **28.1%** compared to the **317** received in 2020/21. The themes identified for WTWA were 'Treatment and Procedure, 'Communication' and 'Clinical Assessment'.

4.3 UDHM/MREH received **103** complaints this annual report year. This represents an increase of **164.1%** compared to the **39** received in 2020/21. Worthy of note, however, is that where services are dealing with a smaller number of complaints this can appear to have a larger impact when these figures are presented as percentages.

4.4 **Table 10** below details the 3-year trend for complaints at Hospital/MCS and LCO level.

Table 10: Number of complaints by Hospital/ MCS and LCO

Hospital / MCS / LCO	2018/19	2019/20		2020/21		2021/22	
Clinical Scientific Services (CSS)	82	103	↑ 25.6%	67	↓ 34.9%	96	↑ 43.2%
Corporate Services	91	68	25.2%	44	35.2%	54	22.7%
Manchester & Trafford Local Care Organisation (LCO)	27	44	62.9%	38	13.6%	56	47.3%
Manchester Royal Infirmary (MRI)	452	419	7.30%	283	32.4%	356	25.7%
Research & Innovation (R&I)	2	0	-	0	-	0	-
Royal Manchester Children's Hospital (RMCH)	167	189	13.1%	111	41.2%	167	50.4%
Saint Mary's Hospital (SMH)	190	194	2.10%	160	17.5%	243	51.8%
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	115	96	16.5%	39	59.3%	103	164.1%
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	442	515	16.5%	317	38.4%	406	28.1%
North Manchester General Hospital (NMGH)	-	-	-	-	-	184	-
Not Stated / General Enquiry / Non-MFT	5	0	-	0	-	0	-
MFT Total	**1,573**	**1,628**	**3.49%**	**1,059**	**34.9%**	**1,665**	**57.2%**

4.5 Complaints are risk rated using a matrix aligned to that used to assess the severity of incidents within the Trust. This matrix assigns a level of Red, Amber, Yellow or Green dependent upon the risk score.

4.6 When compared to 2020/21, the numbers of red, yellow and green complaint cases received in 2021/22 have increased. Green cases increased by **317.9%** from 28 in 2020/21 to **117** in 2021/22. Yellow cases increased by **72.8%** from **650** in 2020/21 to **1123** in 2021/22. Red cases increased by **550%** from 4 in 2020/21 to **26** in 2021/22. It is considered that the increase noted in red cases should be viewed in the context of the implementation of the dedicated complaints triage system. Further information is provided in Section 15 of this report. Of the **26** rated as Red in 2020/21:

- **12** related to treatment/procedure
- **6** related to clinical assessment (diagnostic/scan)
- **3** related to communication
- **2** related to personal accident/incident
- 1 relates to discharge/transfer
- 1 relates to infection control incident
- 1 relates to safeguarding patients

4.7 **Table 11**, presented in **Appendix 2**, provides the breakdown of the risk rating of complaints for 2021/22 compared to 2020/21.

4.8 Equality monitoring data is collected in relationship to complainants' protected characteristics. Complainants are requested to provide information regarding their protected characteristics when they receive a written acknowledgement in response to a complaint; this information is presented within **Tables 12** to **14** in **Appendix 2**.

4.9 The age and gender of the patients involved in complaints for the past 4 fiscal years are highlighted in **Tables 12** and **13** in **Appendix 2**. **Table 14** describes the ethnicity of the patients represented in complaints for the past 4 fiscal years.
As described above, work continued throughout 2020/21 to improve the quality of this data and further information is detailed in Section 15 of this report.

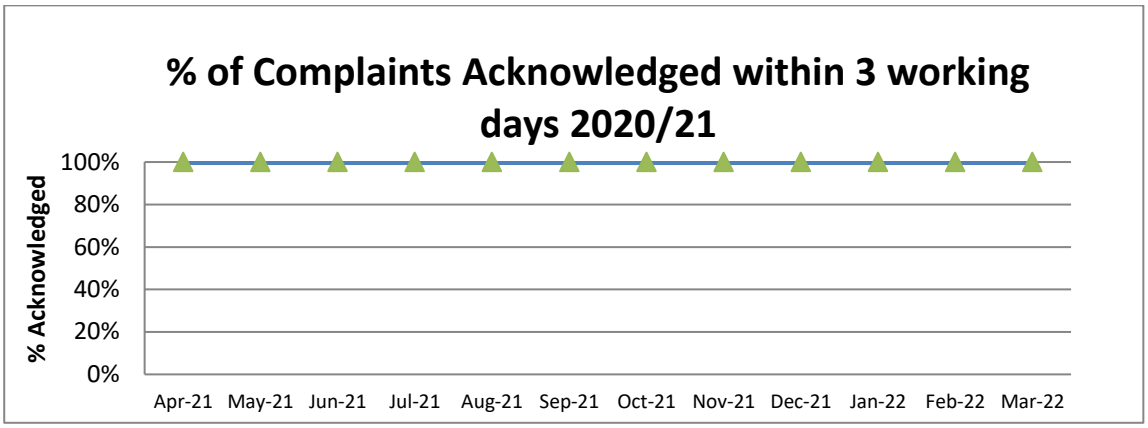
4.10 In respect of complaints, the percentage of people who did not declare their ethnicity has risen, increasing from **18.4%** in 2020/21 to **51.2%** in 2021/22.

5. Acknowledging Complaints

5.1 The NHS Complaints Regulations (2009)[1] place a statutory duty upon the Trust to acknowledge 100% of complaints within 3 working days (**Graph 3**).

5.2 Complaints requiring acknowledgement include those which are withdrawn, those where consent or required information is not received, and those that are de-escalated or are deemed 'out of time' under the 2009 NHS Complaints Regulations.[1] As in 2020/2021 and 2019/2020, throughout 2021/22, **100%** performance was achieved in all 12 months of the fiscal year.

Graph 3: Percentage of complaints acknowledged ≤ 3 working days during 2021/22, MFT



6. Response Times

6.1 The Trust target of resolving **80%** of complaints within 25 working days continues to be monitored closely. Based on the complexity of complaints and the Trust's Complaints Triage Process, all 'High' category complaints are allocated 60 working day timeframes. **Table 15** and **Graph 4** provide a breakdown of performance in 2021/22.

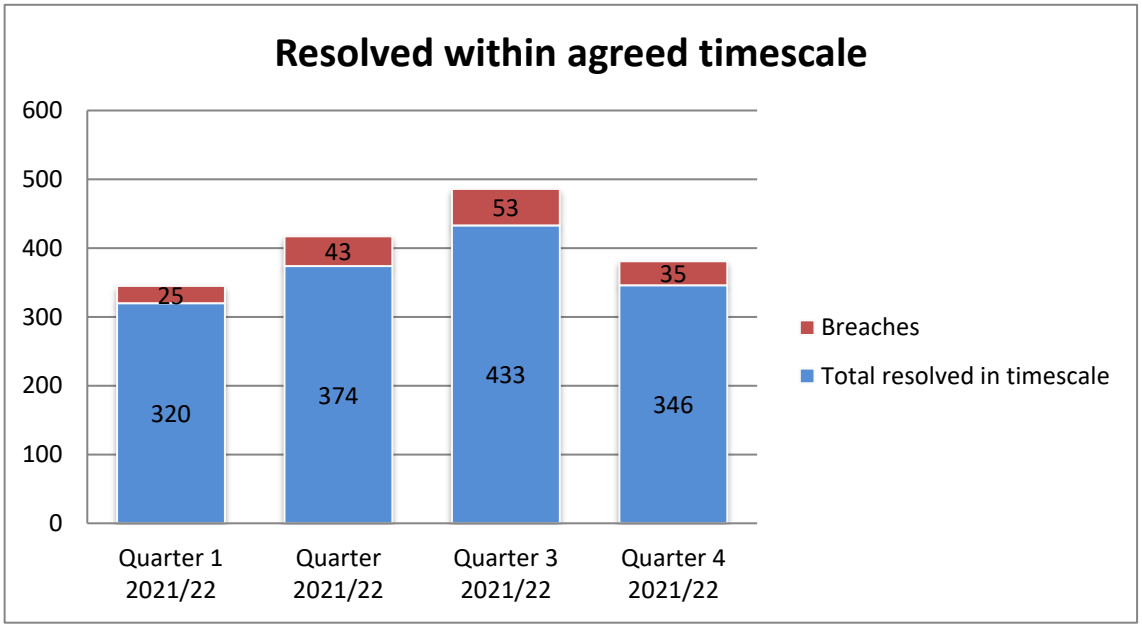
6.2 The Trust's performance in response times (**Table 15**) has been variable throughout the year with **1160** (**71.20%**) complaints responded to in 0-25 working days, **162** (**9.94%**) being resolved in 26-40 days and **307** (**18.84%)** responded to in 41+ days. **18** complaints exceeded 100 days due to their complexity.

6.3 As in 2020/21, focus throughout 2021/22 has been to continuously deliver improvements in response times. In March 2022, **346** (**90.8%**) of complaints were responded to within the agreed timescale, compared to **320** (**92.5%)** in April 2021 (**Graph 4**). The continued focus and work on improvements has resulted in a continuously improving trend, therefore the current strategy for improvement will continue into 2022/23.

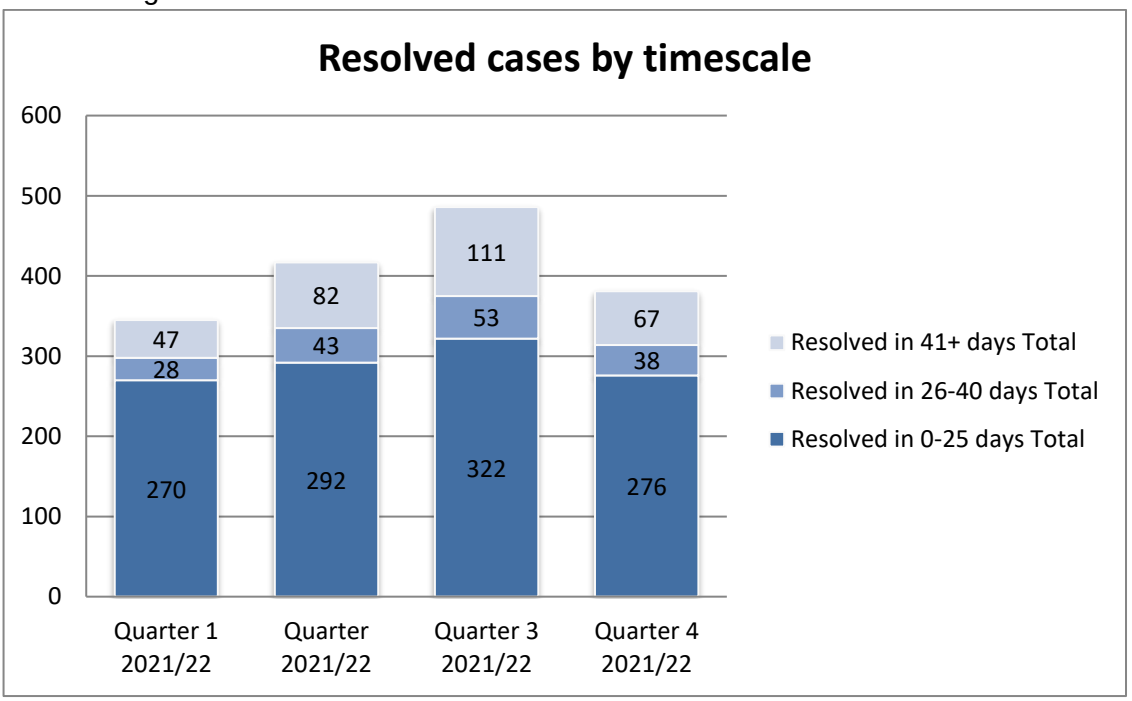
Table 15: Comparison of complaints resolved by timeframes, 2021/22, MFT

		2021/22
Complaints resolved	New Reopened **Total**	1361 268 **1629**
Resolved in 0-25 days	New Reopened **Total**	999 161 **1160**
Resolved in 26-40 days	New Reopened **Total**	162 0 **162**
Resolved in 41+ days	New Reopened **Total**	200 107 **307**
Total resolved in timescale		**1473**
Breaches		**156**
Total resolved		**1629**

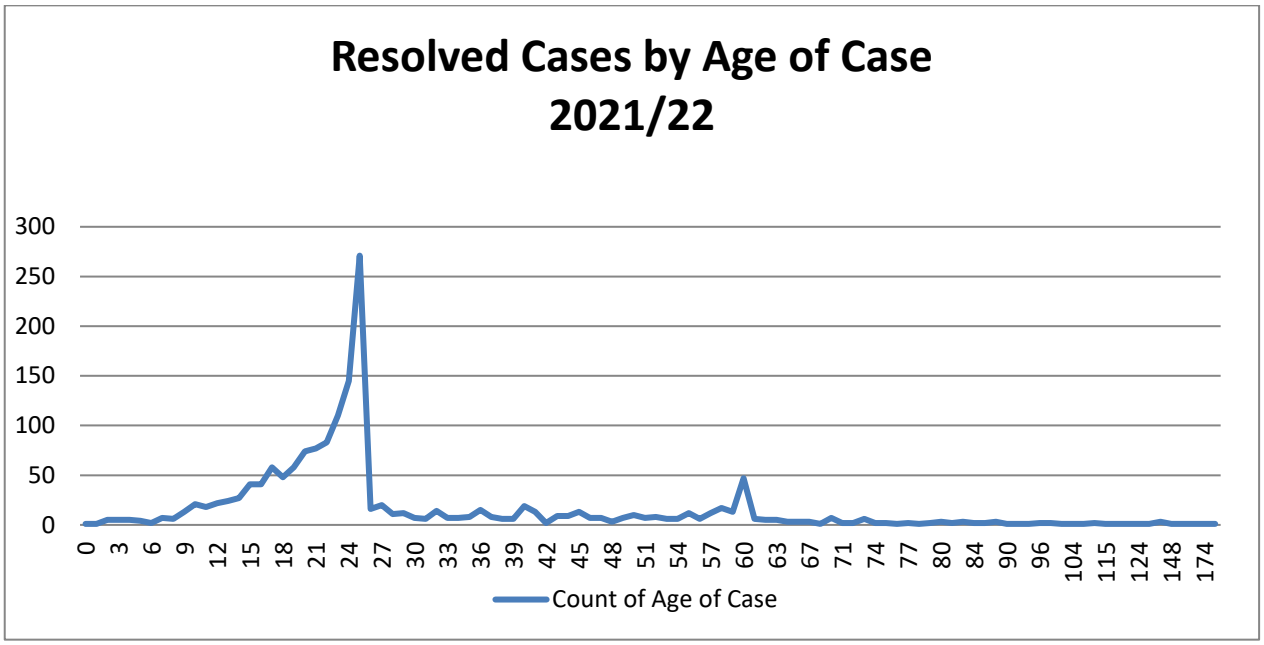
Graph 4: Breakdown of complaints closed within agreed timescales 2021/22, MFT



6.4 **Graph 5** shows the overall performance in relation to response times for complaints closed during 2021/22.



6.5 **Graph 6** then presents a granular level breakdown of the data shown in Graph 5.

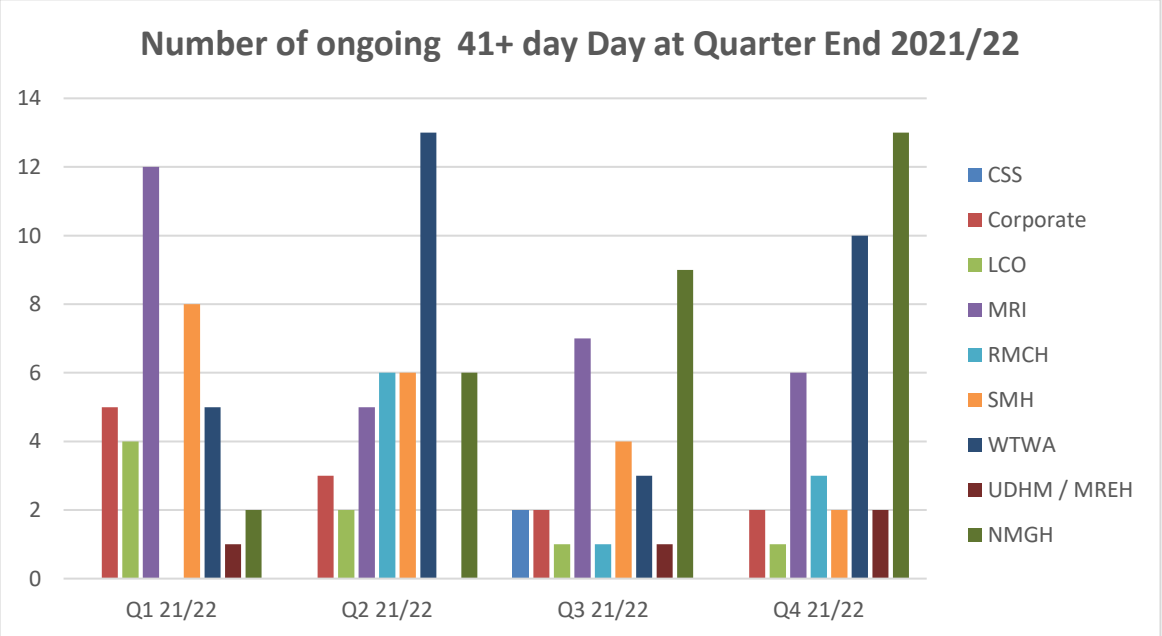


On-going Complaints

6.6 As in 2020/21 there has been a continued focus throughout 2021/22 on managing the number of open complaints that were over 41 working days old. At the beginning of April 2021, **33** (**19.3%**) of the total number of open cases (**171**) Trust-wide that were unresolved over 41 days. However, this figure did fluctuate throughout the year, ranging from **37** open cases at the end of June 2021, **42** at the end of September 2020, and **39** (**16.1%**) of open cases (**234**) at the end of March 2022.

6.7 **Graph 7** shows the number of open complaints, by Hospital/MCS/LCO unresolved after 41 days at the end of each quarter of 2021/22 and demonstrates variable number of cases throughout the fiscal year.

Graph 7: Open complaints by Hospital/MCS and LCO unresolved after 41 days at the end of each quarter 2021/22.



Number of ongoing 41+ day cases at Quarter end 2021/22			
Q1 21/22	**Q2 21/22**	**Q3 21/22**	**Q4 21/22**

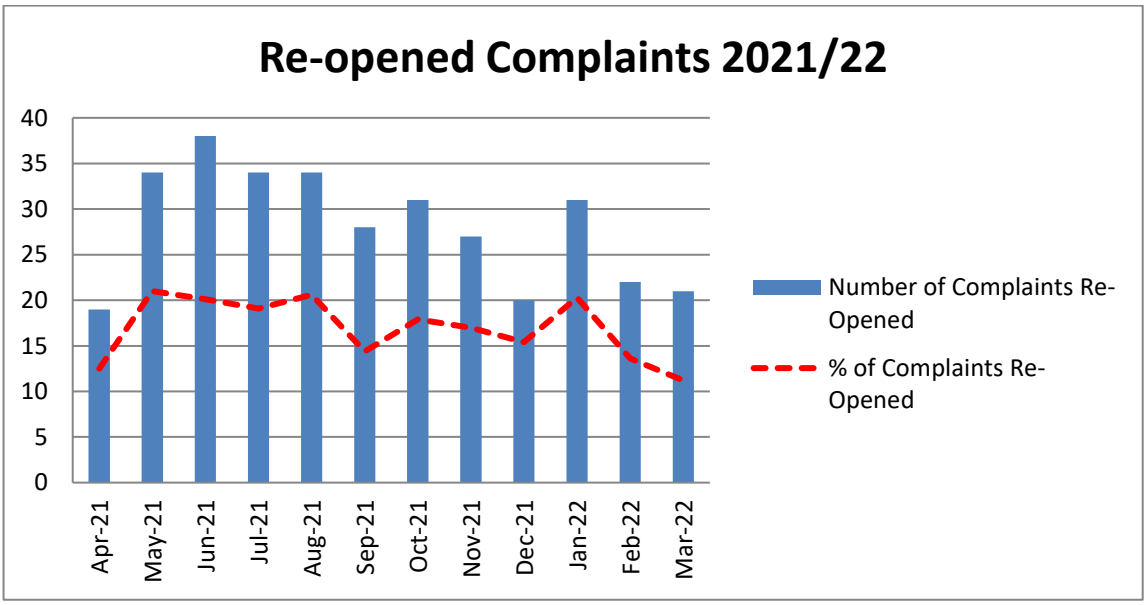
Corporate	5	3	2	2
CSS	0	0	2	0
UDHM / MREH	1	0	1	2
MRI	12	5	7	6
RMCH	0	6	1	3
SMH	8	6	4	2
WTWA	5	13	3	10
LCO	4	2	1	1
NMGH	2	6	9	13
MFT Total	**37**	**41**	**30**	**39**

6.8 All cases over 41 working days are monitored at Group level via the AOF, which informs the decision-making rights of Hospital/MCS and LCO Chief Executives and their teams.

6.9 The oldest complaint case closed during 2021/22 was received by WTWA. The case was opened on 7th October 2020 and the case was 186 days old when it was closed on 9th August 2021. The complaint involved 3 other NHS organisations; delays in receiving outcomes of the external investigations and the arranging of the local resolution meeting impacted the overall response time. The complainant was kept updated and fully supported throughout the process.

6.10 Further contact from complainants after receipt of the Trust's written response is recorded as being re-opened and provides an indication of the quality and completeness of the response. A total of **339** (**16.9%**) cases were re-opened during 2021/22. This compares to **248** (**19%**) re-opened in 2020/21.

6.11 **Graph 8** details the number of re-opened complaints by month during 2021/22, MFT

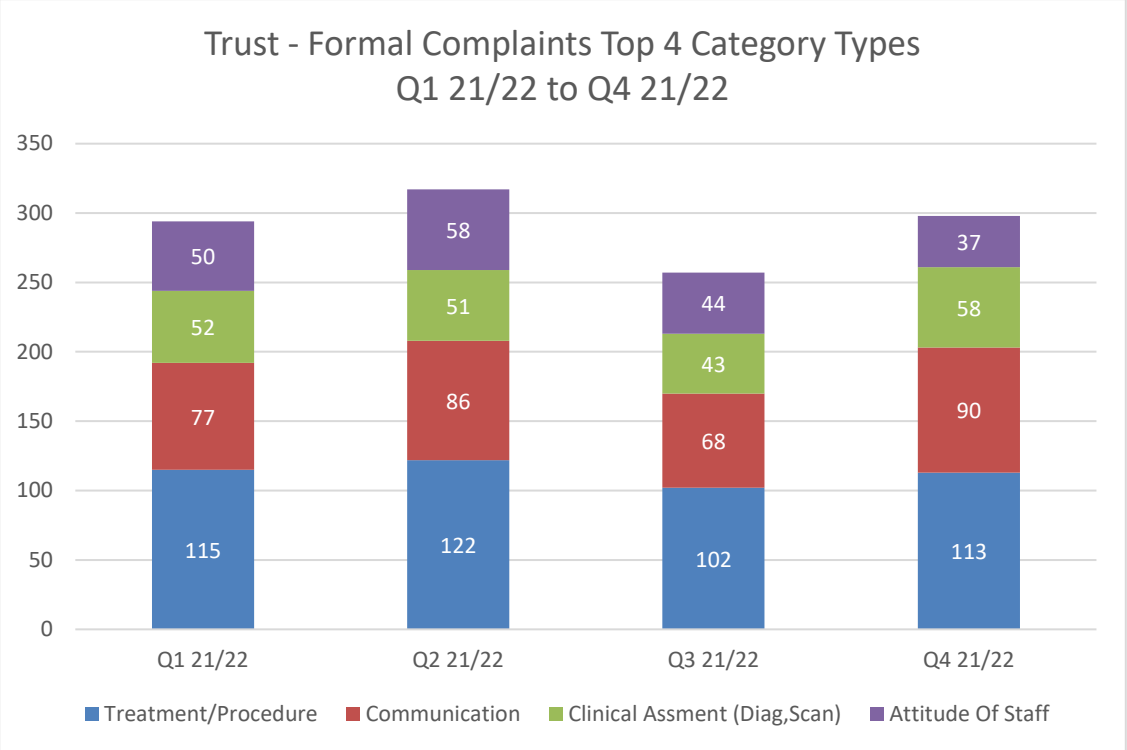


7. Themes

7.1 The themes and trends from complaints are reviewed at several levels across MFT. Each Hospital/MCS and LCO consider local complaints on a regular basis as part of their weekly complaints review meetings and the monthly Quality and Clinical Effectiveness Forums. Further analysis of complaint themes and trends is provided in the quarterly complaints reports to the Board of Directors.

7.2 **Graph 9** below demonstrates the 4 most prevalent categories of issues raised in 2021/22.

Graph 9: Top 4 Complaint Themes, MFT



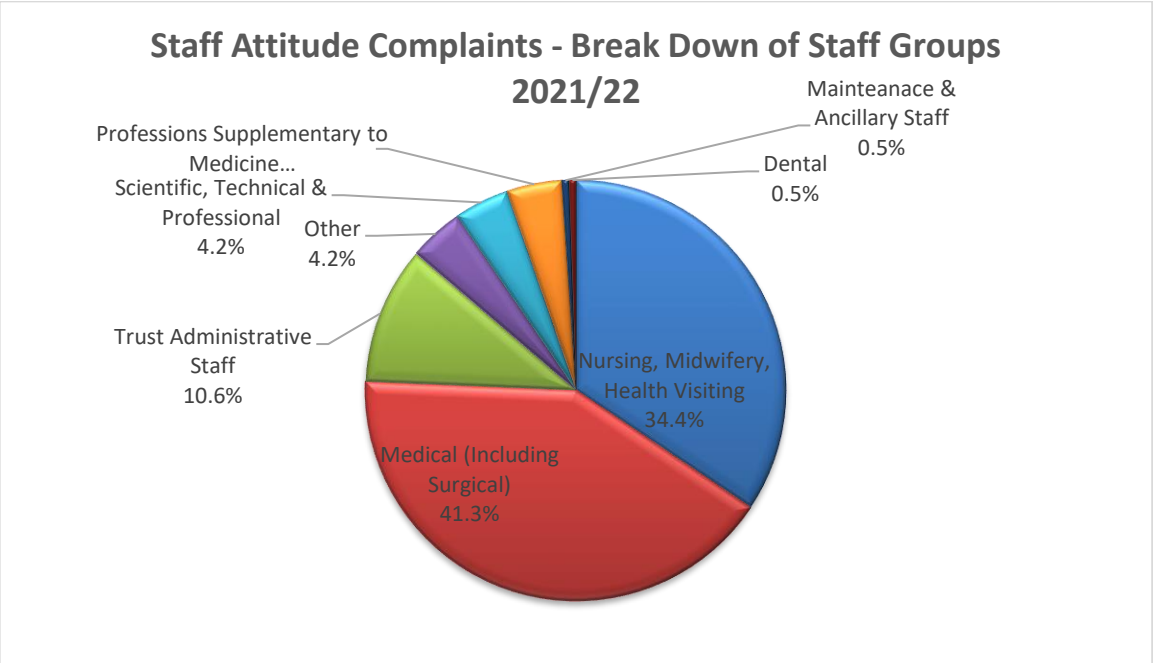
8. Our People

8.1 **Table 16** below provides the number of complaints and PALS concerns that refer to 'staff attitude' whilst **Graph 12**, also below, breaks these down into the staff groups involved.

Table 16: Number of complaints and concerns that refer to staff attitude

Attitude of Staff	2018/19	2019/20	2020/21	2021/22
PALS Concerns	304	247	186	376
Complaints	350	121	81	189
Total	**654**	**368**	**267**	**565**

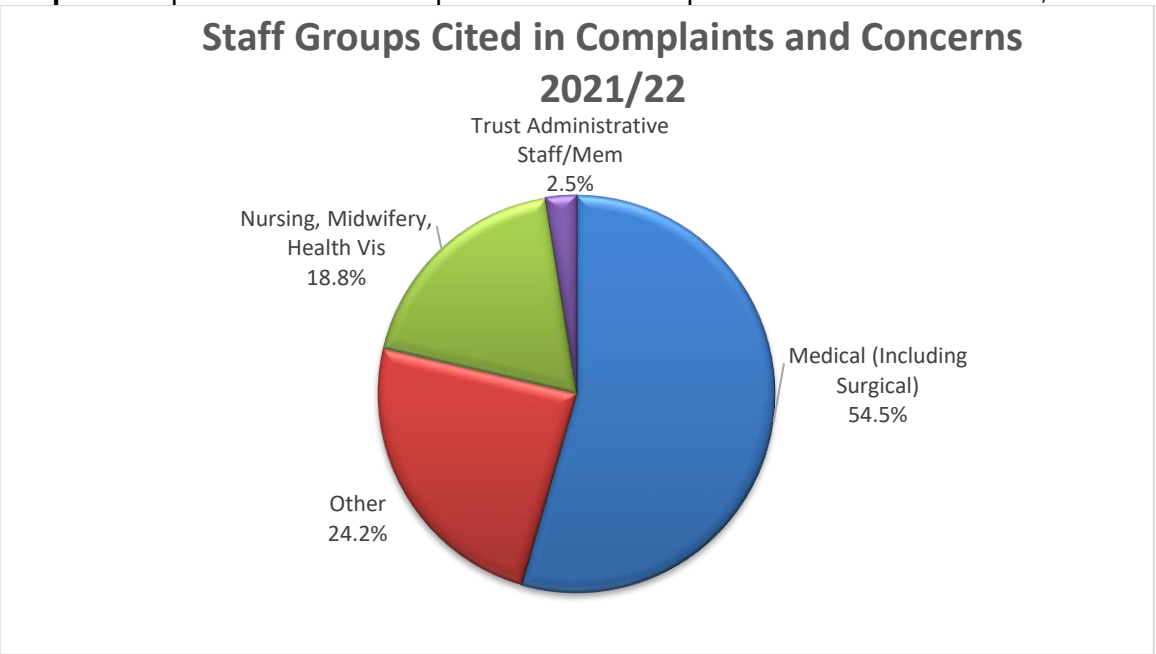
Graph 12: Percentage of complaints and PALS concerns relating to staff attitude by staff group, MFT



8.2 During 2021/22, the number of complaints and PALS concerns received (**9,387**) which cited staff attitude increased in number to **565** (**6.0%**) compared to **267** (**4.5%)** during 2020/21. It is, however, important to note that this increase coincides with the COVID-19 pandemic and the increased level of clinical activity Trust wide. The Trust's Values and Behaviours, "What Matters to Me" Patient Experience framework and Improving Quality Programme (IQP) play a vital role in continuing to reduce concerns relating to attitude, and work will continue throughout 22/23 triangulating this data. The attitude of the medical staff group was cited in more complaints (**41.3%**) than any other staffing group; notably this is the Trust's second largest staff group. This is a significant increase when compared to **21.7%** in 2020/21. In 2021/22 there was also a **2.9%** increase noted in the number of complaints received citing the attitude of the nursing, midwifery, health visiting staff groups medical staffing group (**34.4%**). This is a very slight increase when compared to **31.5%** in 2020/21. Of note in 2021/22 there was a **4.4%** reduction in the number of complaints received citing the attitude of the Trust's administration staff (**10.6%**). This a slight reduction when compared to **15.0%** in 2020/21.

8.3 **Graph 13** below highlights the top 3 professions referenced in complaints and PALS concerns for any reason. As in 2020/21 Medical Staff are the highest group referenced with a total of **4,072** concerns/complaints, followed by nursing, midwifery, health visiting staff who are referenced in **1,407** concerns/complaints. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff or certain nursing, midwifery or health visiting staff, it is recognised that medical staff are usually the lead practitioner for episodes of care, and nursing, midwifery and health visiting staff are often the first point of contact for patients. It is not, therefore unusual, or unexpected for these staff groups to be cited by patients who wish to raise a concern or make a complaint.

Graph 13 Top 3 most referred to professions in Complaints and PALS concerns, MFT



9. Overview and Scrutiny

9.1 The Trust's Complaints Review Scrutiny Committee is chaired by a Non-Executive Director and is a sub-group of the Group Quality and Safety Committee. Meetings are held every two months.

9.2 The main purpose of the Committee is to review the Trust's complaints processes in a systematic and detailed way through the analysis of actual cases, to ascertain learning that can be applied to continuously improve the overall quality of complaints handling management; with the ultimate aim of improving patient experience.

9.3 During 2021/22 the committee met five times in total reviewing ten presented cases involving ten Hospitals/MCSs/LCO across MFT.

9.4 The actions agreed at each of the Complaints Review Scrutiny Committee meetings, are recorded and provided to the respective Hospital/MCS/LCO following the meeting in the form of an Action Log, with progress being monitored at subsequent meetings.

9.5 Examples of the learning identified from the cases presented and actions discussed and agreed at the meetings in 2021/22 are outlined in **Table 17** below. All Hospitals/MCSs/LCO teams are asked to identify and share transferable learning from the scrutiny process within and across their services and Trust wide.

Table 17: Actions identified at the Complaints Review Scrutiny Committee during 2021/22

	Hospital/ MCS/LCO	Learning	Actions
Quarter 1	**MREH**	Unacceptable behaviour displayed by patients can have a negative impact on staff.	Creative engagement/dialogue with staff establishing contributing key factors surrounding unacceptable patient behaviour. Staff to be provided with support and the tools they need to determine an appropriate course of action to deal with patients

			demonstrating unacceptable behaviour. Raise staff awareness to support staff in recognising patients who demonstrate unacceptable behaviour. All staff encouraged to incident report any instances of unacceptable behaviour.
Quarter 1	**UDHM**	Poor communication experienced regarding the taking of long-term antibiotic cover and their severe associated side effects.	Development of a protocol for the management of post radiotherapy patients and the use of long-term antibiotics.
		Patient's outpatient appointments cancelled on several occasions. - patient not informed of cancellation. - failure to cancel outpatient appointments in a timely manner. Clinics overbooked and reduced in capacity.	Development of a 'management of multiple outpatient appointment cancellations' process. Audit of 'monitoring cancelled appointments' to be undertake. Await outcome of submitted Business Case for supporting additional clinic provision.
Quarter 2	**MRI**	Poor communication afforded to a patient when delivering investigation results and outcomes resulting in the patient's lack of understanding.	Patients to be routinely copied into correspondence. Strategies to be enhanced to confirm patient understanding. Increase sharing/raise awareness of patient visual communication resources: simple medical diagrams, drawings, pictures.
Quarter 2	**LCO**	Poor communication experienced by the family of a patient at the end of life.	Process implemented ensuring face to face visits take place in addition to telephone contact with patients and relatives. Introduction of electronic scheduling appointment system ensuring appointments are not missed. Process implemented ensuring face to face appointments/re-assessment needs are under-taken when a family carer raises

			concerns regarding the patient's condition. Participation in End-of-Life audits.
Quarter 2	**SMH**	TransWarmers are a risk when being used to maintain the core body temperature of an extreme preterm infant.	TransWarmer use and associated risks added to New-born Services Risk Register. Guidelines for assessing fragility of infant's backs reviewed and consideration given regarding the implementation of hourly reviews. Implementation of Nurse Education and Training updates. Learning from incident shared with other Neonatal services.
		Failure to communicate an infant's injury to the parents in a timely manner.	Importance of strengthening timely communications with parents discussed with the team. Enhancement of the handover process.
Quarter 2	**RMCH**	Lack of basic nursing interventions undertaken.	Reviews undertaken regularly to ensure competence and accurate completion of fluid balance charts. Initiation of Quality Improvement Project.
		Intussusception (inversion of one portion of the intestine within another) had not been considered as a diagnosis in a patient presenting with a normal Early Warning Score (EWS) and rectal bleeding.	Guidelines on PR bleeding to be developed by the Medical and Surgical teams.
		Failure to listen to parental concerns.	Study to be undertaken to highlight the importance of recognising parental concerns and the importance of listening to, responding to, and escalating concerns raised by parents. Share the learning from the study widely across all Hospitals/MCSs/LCO.

			With the support of MRI explore and develop clear processes for joint working and dissemination of shared learning across the whole of MFT.
Quarter 3	**CSS**	A patient's surgery was cancelled due to lack of anaesthetist availability.	Explore integration of the Anaesthetic Rota in to Hive (Integrated Electronic Patient Record)
		Inaccurate information accessible to staff across all sites regarding a patient's results.	Raise awareness by: - Improving staff communications - Liaising with the Trust's Medical Directors across all sites
Quarter 3	**NMGH**	Visiting guidelines for patients with a recognised mental health condition were not applied during restricted visiting.	Development of a 'What to Expect During Restricted Visiting' patient information leaflet/poster. Systems put in place to provide next of kin/nominated family member with appropriate updates and discharge planning arrangements. Complaint shared with all staff. Key themes from the complaint shared at 'Themes of the Week'. Explore reintroducing Hospital Volunteers into the area. Expedite the resolution of NMGH website incorrectly signposting patient's/carers to Northern Care Alliance rather than MFT.
		Families were not provided with regular updates during restricted visiting due to the communications system not being in place on AMU.	
		Poor facilitation of patient's using their own means of communication.	
Quarter 4	**WTWA (Surgery)**	A patient's Research Study diagnostic examination findings suggestive of cancer had not been upgraded or added to the Cancer Pathway.	Development and Implementation of an 'Incidental Findings Research Project' Standard Operating Procedure. Research Leads reminded of the importance of reporting incidental findings to the clinicians whose patients are involved in research.
		There was a delay in the patient's pathway being incident reported.	Incident logged on Ulysses.

			Incident and learning shared with all staff groups. Process implemented for onward referrals and communications to be completed at the time of discharge.
		Work undertaken by new and temporary administration staff had not been checked for accuracy.	Review to be undertaken of the induction and training procedures for temporary administration staff.
Quarter 4	**WTWA (Trauma & Orthopaedic)**	Poor communication afforded to a patient and their family.	All staff reminded of the importance of clear and compassionate communication. All staff reminded of the expected standards of documentation. Audit undertaken. Monitoring of fluid balance training and education undertaken by staff. Complaint shared and discussed with the nursing staff and the Complex Health and Orthogeriatric team.
		Due to staff's lack of awareness of the Escalation Policy, the policy was not applied.	Increase focus on raising staff awareness around the Escalation Policy. All staff reminded of the importance of utilising the 'Daily Huddles' to raise and escalate concerns.
		The incident was not logged correctly or in a timely manner on the Trust's incident reporting system (Ulysses).	Incident logged on to Ulysses.

9.6 In addition to the scrutiny described above, complaints are also reviewed within the Accreditation process to assess if teams are aware of complaints specific to their area and to examine what actions have been taken and what changes have been embedded

to improve services.

9.7 Complaints are also triangulated with feedback received through a number of different processes including the Friends and Family Test (FFT), National Survey data, the Care Opinion and NHS Websites and the Trust's real time "**What Matters to Me"** Patient Experience surveys in order to identify and act upon any trends.

10. Patient Experience Feedback

10.1 Care Opinion and NHS Website Feedback

Care Opinion is an independent healthcare feedback platform service whose objective is to promote honest conversations about patient experience between patients and health services. The NHS Website (formally NHS Choices) was launched in 2007 and is the official website of the NHS in England. It has over 43 million visits per month and visitors can leave their feedback relating to the NHS services that they have received. The Care Quality Commission[3] (CQC) utilises information from both websites to help monitor the quality of services provided by the Trust.

10.2 There has been an increase from **98** postings in 2020/21 to **146** postings in 2021/22 **(49.0%).** The number of posts on these websites by category; positive, negative, and mixed negative comments, are detailed in **Table 18** below**.** This data demonstrates that most comments received in 2021/22 were again, as in 2020/21 (73.5%) positive **(60.3%)**. **33.6%** of the comments related to a negative experience in respect of Trust services in 2021/22.

Table 18 Number of Care Opinion postings by Hospital/MCS and LCO 2021/22

Number of Patient Opinion Postings received by Hospital/MCS/LCO 2021/22			
Hospital/MCS/LCO	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	5	2	0
Corporate Services	0	2	1
Manchester & Trafford Local Care Organisation (LCO)	0	0	0
Manchester Royal Infirmary (MRI)	17	17	4
Research & Innovation (R&I)	0	0	0
Royal Manchester Children's Hospital (RMCH)	4	0	0
Saint Mary's Hospital (SMH)	13	11	1
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	5	6	0
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	28	2	2
North Manchester General Hospital (NMGH)	16	9	1
Total	**88 (60.3%)**	**49 (33.6%)**	**9 (6.1%)**

10.3 **Table 19** provides seven examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website that were published in 2021/22

[3] https://www.cqc.org.uk/what-we-do/how-we-use-information/how-we-use-information

Manchester Royal Infirmary

"Amazing staff - thank you!"

My mum had to attend the Manchester Royal Infirmary A&E Department on Tuesday night. We would like to thank each and every member of staff we had contact with from the security lady and gentleman who were professional and supportive in their very difficult role on the door; the 2 triage staff who were so welcoming, efficient and made it feel as though they had all the time to listen and care then the 2 staff at reception after triage again so caring and reassuring and then the wonderfully patient, caring, calm nurses, particularly the lead nurse who dealt with a particularly loud and disgruntled patient with dignity and such professionalism, and eventually the caring and efficient doctor who saw my mum. I cannot imagine the immense pressure that they were all under, but the way they all treated every single person who came through their care with the same level of support and help was truly wonderful. We want to thank them for making such a huge difference to what was, a very traumatic experience. Please pass on our deep appreciation and thanks.

Response

Thank you for your positive comments posted on the NHS Website regarding your experience at Manchester Royal Infirmary in Accident and Emergency. It was very kind of you to take the time to write and compliment the staff as it is always good to receive excellent feedback which reflects their hard work and dedication. It was reassuring to read that from the moment you arrived, all staff were professional and that the care your mum received was efficient. It is wonderful for us to know that you felt everyone was so welcoming and overall, you had a positive experience throughout. We are sincerely grateful for your kind words, and we have passed on your appreciation and gratitude to the Head of Nursing, who will share with all the staff involved.

Saint Mary's Hospital

"No answer on the phone"

I received an unexpected call 10 days ago to say an operation I've been waiting over 2 years for was going ahead and to expect a letter with further details. I have not received a letter and simply cannot get through on the phone. I have questions about my operation as the scheduler couldn't answer any. The receptionist at the hospital advised answering calls was a known issue. This is a contact on a scheduled operation so not a general query, both frustrating and stressful 😑

Response

Thank you for your feedback. We are sorry to learn that your experience in contacting the Women's Outpatient Department at Saint Mary's Hospital has been a disappointing and frustrating experience for you. I have discussed these events with the Matron for Gynaecology and the Deputy Directorate Manager who were both very sorry to hear of your experience. A voicemail has been left confirming your admission details and one of the administration team will attempt to contact you again. An investigation is being undertaken to identify why this error in communication has occurred.

The Division of Gynaecology currently has significant administrative staffing pressures across the Gynaecology administrative service which has resulted in a reduction of staff available to answer the phones. A new telephone system has recently been implemented which is designed to allow patients to choose the exact area in which they need to make contact, however with the current staffing gaps in the service we are not able to answer all calls that we receive as efficiently as we would normally aim for. When the new telephone system was implemented, it was agreed the opening hours would be identified

however, no voicemail would be available as often all messages could not be responded to in a timely manner due to high volume of calls that we receive. Saint Mary's MCS appreciate that this is an issue within the service currently and are working hard to rectify this situation and improve the way in which patients can communicate with the Trust.
It is challenging to respond to all posts in a full way often because of a lack of detailed information, therefore if you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686.

Clinical Scientific Services – Trafford General Hospital

"1 out of 10 for everything"
I attended a kidney scan, and my appointment was 30 minutes late. Thank goodness another patient was sat nearby and asked a passing nurse what was going on as everyone else in the waiting area was seen except for me. When I did finally have my appointment, the nurse did not first apologise for the delay although I arrived on time. I never had a scan before, and she was meant to explain the process, but she cared more about getting it out the way and rushed through it. I did ask a question quickly, but she gave a short flippant reply, which made me feel uncomfortable. She made me unwelcome and uncomfortable, if she had honoured my actual appointment time there wouldn't be any issues.

Response

Please accept our apologies for your unsatisfactory experience while attending Trafford General and for the distress and upset this has caused you. In order for us to investigate your concerns, we will need further details from you so that this can be resolved. We take all issues surrounding patient care very seriously and so please contact our Patient Liaison and Advise Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

University Dental Hospital Manchester

"A credit to the NHS"
I went in with two extremely decayed teeth that was causing me a tonne of pain. I only wanted the pain gone so I wasn't expecting much. However, I was called in almost as soon as I sat down. I was told I need an extraction and root canal; the dentist could only remove the root so opted for a temporary filling and to go private to have the root canal. The extraction was easy peasy. The dental surgeon was amazing. I cannot thank you all enough for being so gentle and kind. Without you all we would still be in absolute agony. Thank you, thank you.

Response

Thank you for your recent feedback about the care you received at Manchester University Dental Hospital. It is wonderful to hear that you were seen quickly, the tooth extraction was pain-free and that the dental surgeon was amazing. We feel that comments like these reflect the hard work and dedication of our staff and are grateful to receive them. We have passed on your comments to the Head of Nursing who will share with the team involved. In the meantime, we wish you the best of luck with your root canal treatment.

North Manchester General Hospital

"Informing families"
Why does this hospital not inform family and friends on the progress of the patient once admitted? During this stage of the pandemic visits are prevented and our family is fraught not knowing about the progress of my mum, who is in a serious condition and has cancer which was about to be treated elsewhere. That's not a professional or sensitive way to

treat her loved ones who care and love her. Almost 2 years into the pandemic and procedures should be in place to communicate with relatives and friends!

Response

Thank you for sharing your recent experience and we are very sorry that you have experienced distress with the lack of communication on your Mum's progress at North Manchester General Hospital. Guidance is available for staff to support patients and families to ensure communication remains effective especially during these difficult and challenging times. As you indicate, it has been necessary to adapt some practices to ensure the safety of our patients, staff, and visitors and this is reviewed regularly. We apologise those communications have not met our high standards in this case and would like to rectify this.

It is difficult to respond to all posts in a full way often because of a lack of detailed information. If you would find it helpful to discuss your experience with us in more detail, please do not hesitate to contact, the Head of Nursing for Quality and Patient Experience at NMGH directly on 0161 720 2498.

Withington Community Hospital

"Rapid, personal and professional service"

The NHS at its best! Contacted GP on Monday, referred to rapid access Dermatology clinic, receptionist phoned Tuesday with a cancellation, seen Wednesday morning. Reassured. Summary letter received 8 days later. Thank you!

Response

Thank you for your positive comments posted on the NHS Website regarding the care you received at the Dermatology Clinic in Withington Hospital. It was very kind of you to take the time to write and compliment the staff as it is always good to receive positive feedback which reflects their hard work and dedication. It is reassuring to read that you feel it is a rapid, personal and professional service that allowed you to be seen within the same week. It is also wonderful for us to know that this support has helped you to feel reassured. We are sincerely grateful for your kind words, and we have passed on your appreciation and gratitude to the Head of Nursing, who will share with all the staff involved.

Corporate Services (Estates and Facilities)

"Heavy handed tactics"

Having made an appointment to visit my father in ICU, along with mum and my sister, all authorised, I was disgusted by the attitude of the security guard today. I've been visiting without issues until today where I was made to feel like I was lying to enter the hospital. The security man was very rude, asking if I had an appointment and what time and where! He then told me he would have to check to make sure I had! I'd just told him. This was in front of other visitors and was highly embarrassing as upsetting. There are ways of speaking to people and making them feel like liars is not one of them. I'm going to enter through a different entrance tomorrow as I HAVE made another appointment to visit my father. He almost lost his life last week and luckily every other member of staff has been wonderful.

Response

Thank you for your feedback regarding the experience you had whilst visiting Wythenshawe Hospital, Intensive Care Unit. The Security Officers are positioned at the doors to manage the flow of patients and visitors across site, in order to manage the risks relating to COVID-19 transmission. The Trust would like to apologise that you felt that

your interaction with the Security Officer was embarrassing and upsetting. Whilst the Security team are tasked with ensuring traffic on site is managed, it is essential that this is carried out in a professional and courteous manner. Your feedback has been shared with the Security Management Team and the importance of customer care will be reiterated to the team. It is difficult to respond to all posts in a full way often because of a lack of detailed information, therefore if you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

11. Meetings with Complainants

11.1 A total of **137** Local Resolution Meetings (LRMs) are recorded as taking place during 2021/22 of which **37** related to MRI, **27** related to WTWA, **24** related to SMH, **20** related to NMGH with the remainder being spread evenly across CSS, Corporate, UDHM/ MREH, LCO and RMCH. This compares to **46** LRMs held in 2020/21 and represents an increase of **198%.** The increase can be attributed to the Trust's response working towards recovering from the COVID-19 pandemic.

11.2 Meetings are arranged by the Corporate Complaints team and a high-level summary post meeting letter provided to the complainant with an audio recording of the discussion on CD. This enables the complainant to listen to the recording outside the meeting should they wish to review specific responses or consider any further questions they may wish to raise.

12. Parliamentary and Health Service Ombudsman (PHSO)

12.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO is not part of government, NHSE, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

12.2 The PHSO make final decisions on complaints that have not been resolved by NHSE and UK government departments and other public organisations. The PHSO do this fairly and without taking sides. Their service is free. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

12.3 During 2021/22 the PHSO informed the Trust of **5** complaint investigation outcomes. **Table 20** below shows the financial year in which the Trust initially received the complaints, which have since been closed in 2021/22 following PHSO investigation.

Table 20: Financial year in which the Trust, including legacy organisations, initially received the complaints closed in 2021/22 following PHSO investigation.

Year	Number Received
2018/19	2
2019/20	3

12.4 **Table 21** shows the outcome of the PHSO investigation for complaints resolved in 2020/21 and 2021/22.

Table 21: Outcome of PHSO investigations 2020/21 and 2021/22, MFT

	2020/21	2021/2022
Fully upheld	0	2 (40.0%)
Partially upheld	2 (66.6%)	3 (60.0%)
Not upheld or withdrawn	1 (33.3%)	0

12.6 In summary, **2** cases were fully upheld, **3** cases were partially upheld, and **0** cases were not upheld. In two of the partially upheld cases the Trust was required to pay **£500** to complainants in 2021/22. This compares to the Trust not being required to pay any financial redress in 2020/21. The Trust had **10** cases under review by the PHSO at the end of Quarter 4 in 2021/22.

12.7 **Table 22**, presented in **Appendix 3** provides details of the PHSO cases that were resolved in 2021/22 and shows the distribution of PHSO cases across the Hospitals/MCS/LCOs.

13. Complaint Data Analysis and Implementing Learning to Improve Services

13.1 All Hospitals/MCS/LCOs receive their complaint data via automated reports produced by the Ulysses Customer Services Module. Hospitals/MCS/LCOs also review the outcomes of complaint investigations at their Quality or Clinical Effectiveness Committees. The following tables show the complaint data for each of the Hospitals/MCS/LCOs mapped against several key performance indicators. A selection of complaints is provided to demonstrate how learning from complaints has been applied in practice to contribute to continuous service improvement during 2021/22. All of these examples have been published in the quarterly Board of Directors Complaints Reports during 2021/22.

13.2 Manchester Royal Infirmary

Manchester Royal Infirmary (MRI)	2019/20	2020/21	2021/22
Number of Complaints	419	283	356
Number of PALS Concerns	1531	1458	1805
Number of Re-Opened	99	78	100
Number Closed in 25 days	261	216	311
Number Closed Over 41 Days	103	68	52
Number of Meetings Held	33	15	37
Top 3 Themes			
Treatment/Procedure			
Communications			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
Theatres & Elective In-Reach **Q1**	Patient Experience: A patient raised concerns as they were unable to communicate with staff during their in-patient stay due to their hearing aids not being in-situ; This resulted in staff advising the patient's family that the patient was confused. As a result of the complaint the following action was taken: ▪ 'Patient Focus Rounding' process enhanced incorporating and facilitating aid requirement checks.

MRI (Emergency Assessment and Access) **Q4**	Patient Experience: A complaint was received in relation to the lack of reasonable adjustments made for a patient attending the department with learning difficulties. As a result of the complaint the following actions were taken: ▪ All staff reminded of the importance of applying and providing holistic care. ▪ All staff reminded of the importance of clear communication with patients and relatives.

13.3 Royal Manchester Children's Hospital

Royal Manchester Children's Hospital (RMCH)	2019/20	2020/21	2021/22
Number of Complaints	189	111	167
Number of PALS Concerns	621	432	671
Number of Re-Opened	22	25	21
Number Closed in 25 days	81	94	137
Number Closed Over 41 Days	56	37	30
Number of Meetings Held	7	2	6
Top 3 Themes			
Treatment/Procedure			
Communication			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
RMCH Q2	Communication: A complaint was received from the parents of a patient raising concerns that the safeguarding referral and poor communication had negatively impacted on their family. As a result of the complaint the following actions were taken/agreed: ▪ Consultant supported in reflecting on the events leading up to the complaint. ▪ 'Safeguarding' Patient Information leaflet to be developed providing information about aspects of the safeguarding procedures. ▪ Complaint to be shared and discussed at the Hospital Peer review for wider learning. ▪ 'Skeletal Survey Examination' Patient Information leaflet to be developed explaining the outpatient appointment process, and the benefits and risks of the radiological examination. ▪ Investment in additional radiographer skeletal survey examination training to support the delays and reduce the additional stress to both parents and child caused by the lengthy wait for this examination.

RMCH Q3	Facilities: A complaint was received in relation to a patient's mother's needs not being considered when the patient was admitted to hospital. As a result of the complaint the following actions were taken: ▪ Arrangements made to purchase high back chairs for breast feeding mothers. ▪ Nursing team reminded of the importance of liaising with the Bed Management Team to establish bed status in other areas of the hospital. ▪ Nursing team reminded of the importance of the need for children's specific beds to be returned to the Children's Ward.

13.4 Wythenshawe, Trafford, Withington and Altrincham (WTWA)

Wythenshawe, Trafford, Withington and Altrincham (WTWA)	**2019/20**	**2020/21**	**2021/22**
Number of Complaints	515	317	406
Number of PALS Concerns	1920	1351	1940
Number of Re-Opened	104	72	87
Number Closed in 25 days	377	256	301
Number Closed Over 41 Days	94	92	88
Number of Meetings Held	33	15	27
Top 3 Themes			
Treatment/Procedure			
Communication			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	**Complaint and Lessons Learnt**
WTWA Q2	A rise in concerns and complaints were received in relation to patient's lost property. As a result of the complaints the following actions were taken: ▪ Development and implementation of a Ward Matrons Focus Group. ▪ A 'Disclaimer Forms Usage Audit' undertaken, and repeat audits scheduled for the future. ▪ A review of property categorisation - 'What is Property?' ▪ A review of a patient's journey undertaken, and discussions held to enhance documentation process. ▪ Development and introduction of Patient Property Poster on all the wards.

WTWA Q4	Communication: A patient's family complained regarding poor communication, and of the nursing staff's attitude and lack of support afforded to the family upon being informed of the patient's death. As a result of the complaint the following actions were taken/agreed: ▪ The complaint was shared anonymously with the nursing and medical teams. ▪ All ward staff were supported in reflecting on the events leading up to the complaint and provided with appropriate training where identified. ▪ All ward staff were reminded of the importance of the Trust's Vision and Values. ▪ Ward Sister undertook 'Supporting Patients and their Families Through Distressing Situations including, Death, Dying and Bereavement' Training. ▪ All nursing staff to undertake Sage and Thyme Communication Skills Training. ▪ Review to be undertaken of the "visiting" processes on the ward and the new MFT Visiting Policy to be fully embedded.

13.5 Saint Mary's Hospital (SMH)

Saint Mary's Hospital (SMH)	2019/20	2020/21	2021/22
Number of Complaints	194	160	243
Number of PALS Concerns	526	673	1134
Number of Re-Opened	49	19	49
Number Closed in 25 days	149	114	190
Number Closed Over 41 Days	35	48	33
Number of Meetings Held	23	6	24
Top 3 Themes			
Treatment/Procedure			
Communication			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
SMH Q1	Patient Experience, Communication: A complaint was received regarding the provision of misleading/inaccurate information on a completed social care document. As a result of the complaint the following actions were taken/agreed: ▪ Recruitment of a Specialist Nurse in New-born Services to support communication and other identified competencies, such as accurate record keeping of individual family composition and needs. ▪ Addition to be placed on the infant's paper medical records. ▪ Complaint shared anonymously and discussed with staff at core huddles. ▪ Via the Safeguarding Newsletter all staff to be reminded of the process of handling concerns relating to parental attendance and the

	importance of documenting discussions. ▪ Matron to provide support to the nursing staff in the checking of correct patient/family information and to ensure records are kept accurate.
SMH Q4	Communication: A complaint was received in relation to difficulties being experienced in contacting Maternity Triage when the patient had concerns regarding her pregnancy. The patient also raised further concern regarding the poor communication and support experienced from a receptionist in the Antenatal Clinic (ANC). As a result of the complaint the following actions were taken/agreed: ▪ Provision of an additional midwife per shift. ▪ Implementation of a dedicated Telephone Triage Midwife. ▪ A qualified member of staff will communicate with a pregnant woman personally when they telephone ANC seeking advice.

13.6 Clinical & Scientific Services (CSS)

Clinical & Scientific Services (CSS)	2019/20	2020/21	2021/22
Number of Complaints	103	67	96
Number of PALS Concerns	335	303	535
Number of Re-Opened	22	21	18
Number Closed in 25 days	79	59	69
Number Closed Over 41 Days	18	12	16
Number of Meetings Held	6	0	7
Top 3 Themes			
Communication			
Attitude of Staff			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
CSS Q2	Patient Experience, Communication: A complaint was received from a patient raising concerns regarding COVID-19 and his mask exemption requirements not being met. As a result of the complaint the following actions were taken: ▪ Concerns shared and radiographer supported in reflecting on the events leading up to the complaint. ▪ Departmental process developed for patients who are unable to wear face coverings. ▪ All staff reminded of the importance of patient confidentiality. ▪ All staff reminded of the importance of keeping patients informed of any delays.

CSS (Critical Care) Q4	Communication: A complaint was received from a patient's family regarding the poor communication they had experienced resulting in them not being able to be with the patient at the end of life. As a result of the complaint the following action was agreed: ▪ Enhanced Communication training to be undertaken by nursing staff around supporting families/relatives of patients with deteriorating conditions/end of life.

13.7 University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)

University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)	2019/20	2020/21	2021/22
Number of Complaints	96	39	103
Number of PALS Concerns	581	384	569
Number of Re-Opened	13	10	18
Number Closed in 25 days	78	36	81
Number Closed Over 41 Days	6	7	14
Number of Meetings Held	5	2	6
Top 3 Themes			
Treatment/Procedure			
Appointment/Delay/Cancellation (outpatient)			
Communication			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
MREH Q1	A complaint was received from a patient raising concerns that a clinician had not followed correct measures when wearing Personal Protection Equipment (PPE). As a result of the complaint the following action was taken: ▪ Clinician retrained in the correct use of PPE and additional Infection Prevention and Control training undertaken.

MREH Q3	Patient Experience, Communication: A complaint was received from a patient raising concerns regarding the waiting time in clinic, a staff's nonchalant manner and the shortage of seating in the waiting area. As a result of the complaint the following actions were taken/agreed: ▪ Departmental process (Intentional/Patient Focused Rounding) developed and implemented to provide patients with timely updates throughout the clinic session in relation to waiting times and/or delays. ▪ Seating capacity in the clinic waiting areas to be regularly reviewed in line with current Infection Prevention and Control (IPC) guidance. ▪ As part of the improvement work streams the Outpatients Department capacity and utilisation to be reviewed.
UDHM Q1	Patient Experience: A complaint was received from a patient raising concerns regarding the impact a clinician's assumptions had had on her in relation to her family unit. As a result of the complaint the following actions were taken: • Concern shared and clinician supported in reflecting on the events leading up to the complaint. • LGBTQ+ awareness session delivered at MREH/UDHM ACE day in June 2021. • Concern shared and discussed with the Paediatric team at the departmental specific training session held in June 2021.
UDHM Q3	Treatment, Patient Experience, Facilities: A patient raised concern regarding the treatment received, the clinician's attitude, and the lack of lighting, cleanliness, and music in the treatment room. As a result of the complaint the following actions were taken: • Concerns shared and clinician supported in reflecting on the events leading up to the complaint. Clinician reminded of the importance of communicating effectively with their patients.

13.8 North Manchester General Hospital

North Manchester General Hospital	**2019/20**	**2020/21**	**2021/22**
Number of Complaints	-	-	184
Number of PALS Concerns	-	-	765
Number of Re-Opened	-	-	22
Number Closed in 25 days	-	-	121
Number Closed Over 41 Days	-	-	21
Number of Meetings Held	-	-	20
Top 3 Themes			
Treatment/Procedure			
Communication			
Clinical Assessment (Diag.Scan)			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
NMGH Q3	Treatment: A complaint was received in relation to a delay in receiving treatment, poor communication and the staff's lack of empathy. As a result of the complaint the following actions were taken: ▪ Complaint shared at the Paediatric Emergency Department team meeting. ▪ Cleaning schedules reviewed. ▪ Review of senior paediatric decision makers/ competencies within the department. ▪ Patient's poor experience shared at the senior team meeting. ▪ Staff reminded of the importance of medication review prior to the patient's discharge. ▪ Staff reminded of the importance of providing clear instructions to patients on the use of an EpiPen. ▪ Staff reminded of the importance of providing all patients who are assessed to be in pain with adequate pain relief.
Q4	Communication: A patient raised concern regarding the lack of communication in relation to the waiting time in the Emergency Department. As a result of the complaint the following action was taken: ▪ All staff reminded of the importance of clear communication.

13.9 Research & Innovation (R&I)

Research & Innovation (R&I)	2019/20	2020/21	2021/22
Number of Complaints	0	0	0
Number of PALS Concerns	15	6	13
Number of Re-Opened	0	0	0
Number Closed in 25 days	0	0	0
Number Closed Over 41 Days	0	0	0
Number of Meetings Held	0	0	0
Top 3 Themes			
Communication			
Appointment/Delay/Cancellation (outpatient)			
Clinical Assessment (Diag.Scan)			

13.10 Corporate Services

Corporate Services	2019/20	2020/21	2021/22
Number of Complaints	68	44	54
Number of PALS Concerns	298	211	181
Number of Re-Opened	13	11	13
Number Closed in 25 days	25	23	45

Number Closed Over 41 Days	23	29	10
Number of Meetings Held	1	1	4
Top 3 Themes			
Infrastructure (Staffing, Environment)			
Attitude of Staff			
Communication			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
Corporate	Communication: A range of complaints received during these quarters demonstrated the difficulty patients were experiencing when contacting PALS. As a result of the complaint the following actions were taken: ▪ Submission of application for funding to purchase an enhanced, quality, telephone call centre software. ▪ Installation plan implemented to meet the requirements of the Trust.

13.11 Manchester and Trafford Local Care Organisation (LCO)

LCO	2019/20	2020/21	2021/22
Number of Complaints	44	38	56
Number of PALS Concerns	52	82	109
Number of Re-Opened	9	12	11
Number Closed in 25 days	15	13	17
Number Closed Over 41 Days	14	31	41
Number of Meetings Held	6	5	6
Top 3 Themes			
Appointment/Delay/Cancellation (outpatient)			
Attitude of staff			
Communication			

Hospital/ MCS/LCO	Complaint and Lessons Learnt
LCO Q2	Treatment: A complaint was received from a patient raising concerns in relation to the waiting time to be seen by the Community Neuro Rehabilitation Team (CNRT) As a result of the complaint the following actions were agreed/taken: ▪ In conjunction with Trafford Clinical Commissioning Group a review to be undertaken of the CNRT Referral and Waiting List. ▪ Waiting List initiative agreed to manage the long waits' patients are experiencing. ▪ CNRT service model review to be undertaken.
Q3	Patient Experience: A complaint was received from a patient raising concerns as to a staff member's abrupt attitude and lack of empathy shown towards the patient. As a result of the complaint the following actions were agreed/taken:

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

14. Complaint Satisfaction Survey

14.1 The Complaint Satisfaction Survey was developed by the Picker Institute and is based on the PHSO, the Local Government Ombudsman (LGO) and Healthwatch England's user-led 'vision' of the complaints system; **'My Expectations for Raising Concerns and Complaints'**[4]. The survey was sent to **2,020** MFT complainants following closure of their complaints during 2021/22, with a decreased response rate of **8.36%** compared to **31.6%** in 2020/21.

14.2 Whilst **69.8%** of the complainant survey respondents indicated that they received the outcome of their complaint within the given timescales, only **54.4%** of complainants felt that the response they received addressed all of the points they raised in their complaint, with a further **14.7%** reporting that the response did not address any of the points. **60.3%** of complainants felt they received an explanation of how their complaint would be used to improve services, with a further **17.1%** of complainants wanting an explanation, but reporting that they had not received one.

14.3 As in 2020/21 these results indicate the need for continuous improvements to the writing and communicating of the complaint responses. It is anticipated that in conjunction with the Complaints Letter Writing Training Educational Sessions, the draft guidance modules produced to help Trust's implement and deliver the expectations set out in the PHSO Complaints Standards (further details of which are in Section 15 of this report) will bring improvements to this process.

Comments received from complainants include the following:

[4] PHSO, the Local Government Ombudsman (LGO) and Healthwatch (2014) My Expectations for Raising Concerns and Complaints. Available from: https;//www.ombudsman.org.uk/publications/my-expectations-raising- concerns-and-complaints

15. Work Programme 2021/22 - Update

15.1 In 2021/22 the Corporate PALS and Complaints team committed to several work-streams; a progress update for each is detailed below:

- **Implementation of the formal restructure of the Trust's Corporate PALS and Complaints Service**

15.2 Following a formal restructure, changes to the PALS and Complaints service were implemented in Q1, 2021/22. Through the development of a team approach, the reorganisation offers a more responsive service to all of the Hospital's/MCS's/LCO's and their patients and families and provides greater service resilience, as well as supporting the development of a career pathway for the Corporate PALS and Complaints staff members.

- **Delivery of a North Manchester General Hospital Corporate PALS and Complaints Service**

15.3 The reopening of the PALS office at NMGH took place in Q1, 2021/22.

The reopened PALS facility will enable patients and members of the public to make face to face enquiries and book appointments to see a PALS Team Leader, Facilitator or Officer.

Given the expansion of the PALS team at NMGH and the absence of a meeting room for patients to meet confidentially with a PALS Case Worker, during 2021/22 work continued exploring the relocation of the PALS office to a larger location within NMGH. Building work commenced at the end of May 2022 and relocation of the PALS team and hand over of the Swan Suite is anticipated in July 2022.

- **MFT Concerns and Complaints Policy (2021)**

15.5 The MFT Concerns and Complaints Policy (2021) provides a framework for MFT to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) and provides staff with support and assistance in dealing with concerns and complaints. In Q2, 2021/22 the policy was reviewed, updated, and ratified accordingly. Following the piloting, refining and introduction of the PHSO's NHS Complaint Standards, further review, updating and ratification of the policy will commence with the implementation of the PHSO NHS Complaint Standards.

- **Dedicated Complaints Triage System**

15.6 Through the continued development of a triangulated approach with the Trust's Risk Management's team and the Hospitals/MCSs/LCO with effect from Q2, 2021/22 a dedicated complaints triage system was implemented. All complaints received in the Trust are solely triaged by the Head of Customer Services and/or the PALS and Complaints Manager/s. The dedicated triage system provides a clear overview of all complaints, enhancing detection of specific themes possibly impacting on patient safety, as well as identifying specific hot spots, and trends across MFT.

- **Internal Audit 2021/22: NMGH Complaints Handling**

15.7 In the context of NMGH joining the Trust and following the undertaking of MFT's Internal Complaints Handling Audit in 2020/21, an internal audit to provide assurance that the Trust's policies and processes for responding to patient complaints at NMGH commenced in Q2, 2021/22. This audit included assessment of the design of the local complaints process within NMGH, including how these align to the overall Trust Complaints' Policy.

15.8 The audit reviewed a sample of 5 patient complaints relating to NMGH in 2021/22. Overall the audit found:

- The Group has set deadlines for complainants to receive a written response by.

- There are improvements to be made in relation to timeliness of complaint responses.
- All cases identified a Complaints Case Manager in writing to the complainant and all were assigned a risk rating and logged in Ulysses (Trust's Customer Services database) and not in the legacy system used by NMGH.
- 3 out of the 5 complaints were responded to outside of the Group's timeframe and extensions were not requested for these responses. Of the 3 late responses, the audit found that:
    - 1 was a low risk complaint that was responded to 1 working day late.
    - 1 was a low risk complaint that was responded to 9 working days late.
    - 1 was a complex complaint that was responded to 11 working days late.
    - All 5 complainants were informed in writing when they should expect a response by.
    - The Complaints Review Scrutiny Group meetings focus on learning from a complaint at a different site each time. In November 2021 NMGH attended the meeting and presented learning from a complaint it handled for the first time since it joined the Group.
    - Each divisional lead emails a 'theme of the week' to their staff, which includes key messages from learning arising from external and internal complaints.
- **1** low priority recommendations in relation to timeliness of complaint responses
- Overall raiting of "**Partial assurance with improvements required**" was provided to the Trust

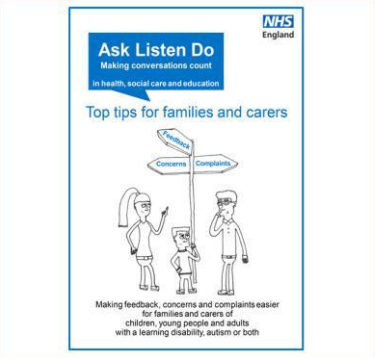
A Complaints Audit Action Plan was developed and implemented to address the recommendations in Q4, 2021/22.

- **Equality and Diversity Monitoring Information**

15.9 Following the introduction of the departmental Equality and Diversity Checklist during the latter part of 2020/21 and in light of the continued challenges in the collection of the equality and diversity data in Q2, 2021/22 a further audit to evaluate the collection of this data was undertaken. Whilst good compliance was found in PALS with regards to 'gender' data (100%), the audit found that 'gender' data was collected in only 25.0% of Complaint cases; the audit found that 'ethnicity' data was collected in only 36.25% of the PALS and Complaint cases and overall compared to the previous audit demonstrated a reduction in the data collection for 'ethnicity' (-53.75%), 'religion (-6.25%) and 'disability' (-2.5%).

15.10 All complainants have a right to be informed of their right to support with their 'religion' and/or 'disability' status; however, the audit findings, as identified in the first audit, have acknowledged poor compliance and continued lack of consistency in the collection of this data, despite the introduction of a departmental Equality and Diversity Checklist. Opportunities for further improvement continued in Q3, 2021/22 with the Equality and Monitoring Information being tailored within staff 'SMART' objectives.

- **Ask, Listen, Do commitment**



15.11 Ask, Listen, Do is an NHS England initiative which aims to improve the experiences of people with a learning disability, autism or both (and their families and carers) when giving feedback, raising a concern, or making a complaint about healthcare, social care or education provision/providers.

15.12 The Trust is committed to making a difference and ensuring young people, and adults have equal access to the PALS and Complaints service at the Trust. This is an important piece of work and in Q3, 2021/22 the PALS and Corporate Complaints team put the Trust's commitment into action. Work continued throughout Q4, 2021/22 exploring what the services can do to improve the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service. It is anticipated that this review and call to action will be completed by the middle of 2022/23.

15.13 Further details on Ask Listen Do are available on the NHS England website (www.england.nhs.uk)

- **Education**

15.4 **In-house Customer Service e-learning package**
Module 1 of the Trust's e-learning Customer Service & PALS and Complaints package was launched in Q1, 2021/22 for staff wishing to access training created to help them understand why good customer service is so important.

15.5 Launch of the second module of the e-learning education package on the Trust's Learning Hub will be completed in Q2, 2022/23. Through this e-learning package Trust staff will be given the opportunity to understand what good complaints handling looks like in line with The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

15.14 **In-house Complaints Letter Writing training package**
Q3, 2020/21 saw the launch of the In-house Complaints Letter Writing Training Package to all staff across the Trust via the Learning Hub's Big Blue Button.

15.15 **PALS and Complaints Training**

Throughout 2021/22 the Corporate PALS and Complaints teams facilitated educational sessions as part of the Band 7 Team Leader Senior Cliniciain Leadership and Management Programme.

MFT CPD
CPD at Manchester University NHS Foundation Trust

During 2021/22 the Oxford Road Campus PALS Team Leader also facilitated educational sessions as part of the RMCH Nursing Study Day.

- **PHSO NHS Complaint Standards Framework**

15.16 The Standards continue to be tested in pilot sites and the PHSO plan to refine and introduce the Standards across the NHS in 2022/23. The Standards set out how organisations providing NHS services should approach complaint handling. They apply to all NHS organisations in England who deliver NHS funded care.

The Standards aim to support organisation in providing a quicker, simpler, and more streamlined complaint handling service, with a strong emphasis on early resolution by empowered and well-trained staff. Combined with training and further guidance from the PHSO the Framework will see organisations following similar processes across the country and will lead to a better, clearer, and consistent approach to complaint handling across Trusts delivering NHS services.

Further details of the Standards are available on the PHSO's website (https://www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards/nhs-complaint-standards-summary-expectations)

15.17 Ahead of the NHS Complaint Standards Framework being implemented and to ensure MFT is responsive to the Expectations within it, an 'Immediate Results Improvement Plan' has been developed. The PALS and Complaints team will ensure oversight and completion of the 'Immediate Results Improvement Plan' throughout Q1 and Q2, 2022/23.

16. Work Programme 2022/23

16.1 The PALS and Complaints key priorities for 2022/23 include:

- **Putting the PHSO NHS Complaint Standards Framework into practice:**

  Continue to support this commitment making sure this tailored model is reflective in MFT's approach to dealing with concerns and complaints. Following the introduction of the Standards in 2022/23, a full review, updating and ratification of MFT's Concerns and Complaints Policy will commence.

- **PALS and Complaints Processes and Training**

  Continue to offer training to staff in the Hospitals/MCSs/LCO teams and implement an enhanced PALS and Complaints training programme and bespoke supervisory sessions on complaints management. This will include timely responsiveness to complaints, complaint investigations and the processes by which they are managed, in line with national recommendations.

- **Feedback and learning in practice:**
  Continue to improve the utilisation of complaints feedback to inform improvement activity and demonstrate learning in practice. Work is also planned to commence exploring triangulation across all feedback sources, namely Friends and Family Test,

Quality Care Rounds, Inpatient Surveys, PALS and WMTM focusing on negative feedback to support the identification of areas for improvement.

- **PALS Volunteers:**
  Continue to explore, develop, and recruit to dedicated PALS volunteer roles that support the current needs of MFT and provide opportunities for people to develop key transferable skills.

- **Telephone Call Centre:**
  It is our aim to always achieve a high level of customer satisfaction and communication and call handling is one of our primary objectives. In response to feedback from service users in which they reported difficulties in contacting the PALS and Complaints teams, and to increase service user experience work is planned to implement an enhanced/upgraded PALS and Complaints Call Centre in July 2022.

- **Complaints and Incidents Pathways**
  Continue to work with the Hospitals/MCS/LCO teams to improve the process by which complaints and incidents concurrently run in parallel, making the necessary changes, in line with due processes and national recommendations.

- **Supporting Staff**
  Continue to support PALS and Complaints Team Leaders through the development and implementation of bespoke supervisory sessions.

- **Ask, Listen, Do commitment**
  In response to Ask, Listen, Do and the Trust's commitment being put into action, work will continue to identify and improve the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service.

17. Conclusion and Recommendation

17.1 During this annual report year a significant amount of work has continued to take place to improve the timeliness of complaint responses, to reduce the number of re-opened complaints and to manage the number of open complaints over 41 working days old. As a result, there has been an improvement, in the average response rate of complaints responded to within the agreed timescale, however, there remains opportunity for further improvement in the reduction of the number of re-opened complaints. Close monitoring and always seeking positive performance and improvement, will continue with, performance being monitored at a Group level via the Accountability Oversight Framework (AOF).

17.2 The three primary themes of dissatisfaction remain the same as 2020/21, with the top themes being Treatment/Procedure, Communication, and Clinical Assessment. The actions outlined in this report demonstrate that complaints received by the Trust are acted upon and are used to inform work aimed at improving the patient's experience. Analysis of the complaint themes and trends will continue to be closely monitored at Group level and via local governance forums.

17.3 In order to ensure that the Trust delivers an enhanced, responsive, and compliant Corporate Complaints and PALS service across MFT, the Trust's Complaints Policy and procedures will be reviewed and updated following the implementation of the PHSO NHS Complaint Standards in 2022/23. Additionally, Complaints and PALS processes will continue to be reviewed and developed throughout the year. The

development of an enhanced PALS and Complaints training programme and bespoke supervisory sessions in complaints management will be utilised to continue to support the delivery of education and to support continual improvement in the Trust's customer service offer, as well as the quality of complaint investigations and responses during 2022/23.

17.4 The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns and complaints and acknowledges their contribution to improving services, patient experience and patient safety.

17.5 The Board of Directors is asked to note the content of this report, the work undertaken by the Corporate and Hospitals /MCSs and LCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provide approval for the report to be published on the Trust's website.

Appendix 1

Tables 4 to 7 provide information regarding how people access the PALS service and provides their demographical breakdown.

Table 4: Source of PALS Concerns by enquirer

Source	2018/19	2019/20	2020/21	2021/22
Email	2089	2454	2276	3723
Face to Face	584	473	97	316
Complaints	2	0	2	0
Family Support	1	0	0	0
PALS	4	1	0	1
Letter	67	55	43	29
MP	4	0	5	0
Other	40	21	21	9
Telephone	3110	2892	2424	3644
Family Member / Friend	4	1	32	0
Totals	**5905**	**5897**	**4900**	**7722**

Table 5 details the number of contacts by age; the age range relates to the people who were the focus of the PALS concern as opposed to the person raising the concern

Age Range	2018/19	2019/20	2020/21	2021/22
0 – 18	1137	1092	650	972
19 – 29	594	574	506	854
30 - 39	749	767	745	1115
40 - 49	668	640	544	889
50 – 59	856	828	576	1033
60 – 69	688	754	598	902
70 – 79	725	739	661	940
80 – 89	395	412	472	606
90 – 99	90	87	144	158
100+	3	4	4	3
Totals	**5905**	**5897**	**4900**	**7722**

Table 6 details the number of contacts by sex; the sex relates to the people who were the focus of the PALS concern.

	2018/19		2019/20		2020/21		2021/22	
Sex	Number of concerns	% of concerns	Number of concerns	% of concerns	Number of concerns	% of concerns	Number of concerns	% of concerns
Female	3257	55.2%	3306	56.1%	2878	58.7%	4608	94.0%
Male	2564	43.4%	2549	43.2%	1998	40.8%	3045	62.1%
Not Specified	83	1.4%	39	0.7%	23	0.5%	68	1.4%
Other	1	0.0%	3	0.1%	1	0.0%	1	0.0%
Total	**5905**		**5897**		**4900**		**7722**	

Table 7 describes the ethnicity of the patients who were the focus of the PALS enquiry.

Category	2018/19	2019/20	2020/21	2021/22
Any Other Ethnic Group	46	58	64	63
Asian or Asian British - Bangladeshi	7	9	6	13
Asian or Asian British - Indian	33	44	47	43
Asian or Asian British - Other Asian	29	34	23	38
Asian or Asian British - Pakistani	62	106	112	130
Black or Black British - African	30	60	47	52
Black or Black British - Caribbean	28	46	41	36
Black or Black British - Other Black	14	22	14	29
Chinese Or Other Ethnic Group - Chinese	8	12	8	22
Mixed - Other Mixed	15	15	22	25
Mixed - White & Asian	5	15	10	18
Mixed - White & Black African	5	10	4	3
Mixed - White & Black Caribbean	52	56	22	18
White - British	1791	2041	1751	2152
White - Irish	53	64	51	54
White - Other White	54	87	72	89
Do Not Wish to Answer	0	380	4	14
Not Stated	3673	2838	2602	4923
Totals	**5905**	**5897**	**4900**	**7722**

Appendix 2

Tables 11 to 14 provide information regarding the risk rating of complaints and the demographic details of the person affected because of the complaint

Table 11: Complaint Risk Rating

Category	2018/19	2019/20	2020/21	2021/22
Not Stated / Other	1	0	0	4
White	0	0	0	0
Green	60	49	28	117
Yellow	807	903	650	1123
Amber	691	670	377	395
Red	14	6	4	26
Totals	**1573**	**1628**	**1059**	**1665**

Table 12: Age range of person who was the subject of the complaint

Age Range	2018/19	2019/20	2020/21	2021/22
0 - 18	471	384	218	290
19 - 29	138	159	88	175
30 - 39	187	222	143	262
40 - 49	165	172	99	165
50 - 59	159	186	142	200
60 - 69	154	184	122	179
70 - 79	176	178	135	177
80 - 89	96	109	85	116
90 - 99	26	34	27	40
100+	1	0	0	1
Totals	**1573**	**1628**	**1059**	**1665**

Table 13: Sex of person who was the subject of the complaint

	2018/19		2019/20		2020/21		2021/22	
Sex	Number of concerns	% of concerns	Number of concerns	% of concerns	Number of concerns	% of concerns	Number of concerns	% of concerns
Female	880	55.9%	907	55.7%	605	57.1%	999	60.0%
Male	642	40.8%	706	43.4%	436	41.2%	645	38.7%
Not Specified	50	3.2%	13	0.8%	17	1.6%	18	1.1%
Other	1	0.1%	2	0.1%	1	0.1%	3	0.2%
Total	**1573**		**1628**		**1059**		**1665**	

Table 14: Ethnicity of the person who was the subject of the complaint

Category	2018/19	2019/20	2020/21	2021/22
Any Other Ethnic Group	12	13	9	16
Asian or Asian British - Bangladeshi	1	8	2	6
Asian or Asian British - Indian	7	16	14	11
Asian or Asian British - Other Asian	6	15	5	17
Asian or Asian British - Pakistani	29	38	33	30
Black or Black British - African	8	31	18	21
Black or Black British - Caribbean	10	14	12	14
Black or Black British - Other Black	7	8	3	9
Chinese Or Other Ethnic Group - Chinese	0	4	2	3
Mixed - Other Mixed	3	1	7	9
Mixed - White & Asian	6	9	5	5
Mixed - White & Black African	2	5	2	1
Mixed - White & Black Caribbean	11	14	7	5
White - British	445	712	434	595
White - Irish	10	25	17	33
White - Other White	9	42	24	29
Do Not Wish to Answer	0	327	270	9
Not Stated	1007	346	195	852
Totals	**1573**	**1628**	**1059**	**1665**

Appendix 3

Table 22: Complaints closed between 1st April 2021 and 31st March 2022 following PHSO investigation

Hospitals/MCS/LCO	Outcome	Date complaint initially received by the Trust	PHSO Rationale/Decision	Recommendations
Quarter 1				
CSS (Critical Care)	Upheld	March 2019	Failure to provide appropriate care needs. Failure in communication in respect of - a medical event - tissue donation Failure to provide support to family members.	Provide a full acknowledgement of failings and apology for impact, distress and suffering caused. Explain what actions have been taken to address failings and identify specific reasons for failings and outline learning taken from specific issues.
MRI (Vascular Surgery)	Upheld	April 2019	Failure to provide appropriate standard of care.	Provide a full acknowledgement of failings and apology for impact, anxiety and suffering caused. Explain what actions have been taken to address failings and identify specific reasons for failings and outline learning taken from specific issues.
WTWA (Trafford Orthopaedics)	Partially Upheld	December 2019	Injuries caused to skin during surgery.	Provide a full apology for the damage caused. Pay £200 in recognition of minor injuries caused.
WTWA (Lung Cancer and Thoracic Surgery)	Partially Upheld	December 2019	Failure in fully recording and providing adequate nutrition and hydration.	Provide a full acknowledgement of failings and apology for distress and worry caused.

			Failure in identifying and addressing all failings in respect of the complaint response.	Explain what action have been taken to address failings and identify specific reasons for failings and outline learning taken from specific issues.
Quarter 4				
MRI (Gastroenterology /Hepatology)	Partially Upheld	December 2018	Failure to arrange appropriate nursing care and support in the community. Poor nursing documentation.	Pay £300 financial redress in recognition of failings identified.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Director of Nursing for Quality and Patient Experience. Michelle Ashworth, Lead Nurse for Professional Practice
Date of paper:	July 2022
Subject:	To provide an overview and analysis of the 2021-2022 Accreditation Programme and a summary of the changes implemented in response to feedback from key stakeholders.
Purpose of report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Recommendations:	The Board of Directors is asked to note the content of this report, the work undertaken during 2021/22
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

1. Introduction

1.1. The accreditation process is part of Manchester University NHS Foundation Trust's (MFT), assurance mechanism for ensuring high-quality care and the best possible patient experience. The process is underpinned by the Improving Quality Programme (IQP) and supported by MFT's Values and Behaviours Framework, the 'What Matters to Me' (WMTM) Patient Experience Programme and the Nursing Midwifery and Allied Health Professional (AHP) Strategy.

1.2. The purpose of this paper is to provide the Board of Directors with an overview and analysis of the 2021-2022 accreditation programme, and a summary of the changes implemented in response to feedback from key stakeholders, with the aim of strengthening the accreditation process, providing firm assurance to the Board on the effectiveness of the accreditation Programme as a quality assurance mechanism.

2. Background

Accreditation Programme (2020-2021)

2.1. In May 2020, it was agreed that the 2020/21 accreditation programme, would be replaced by an assurance process due to the impact of COVID-19.

2.2. Assurance meetings were supported by the Quality Improvement Team (QI Team) and led by the Chief Nurse or Deputy Chief Nurse. Prior to each meeting, an assurance template was populated with agreed key metrics to provide assurance around patient safety and the patient experience. In addition, a one hour walk-round undertaken by a senior Nurse/ Midwife or member of the QI Team, supported triangulation of the data providing further assurance.

Accreditation Programme (2021-2022)

2.3. In 2021, it was agreed that the accreditation process would be re-introduced with consideration given to the ongoing COVID-19 pandemic.

2.4. Following the NMGH Transaction on 1st April 2021, the number of accreditations to be completed rose from 154 to 174.

2.5. The number of staff required to complete an accreditation was reduced to minimise footfall in clinical areas as well as releasing pressures on the nursing/midwifery workforce.

2.6. Adoption of digital technology and the digital platform, Microsoft Teams, to support the accreditation process was introduced to support new ways of working, creating greater flexibility within the accreditation team.

2.7. An integrated dashboard was introduced providing a range of data to view in a single place, including Quality Care Round (QCR) data, WMTM, Family & Friends Test (FFT), Harm free care (HFC), Infection Prevention & Control (IPC) indicators, Pharmacy audits, Workforce and Retention, Complaints & Concerns and Student Feedback.

2.8. The accreditation documentation was reviewed with further alignment to the Care Quality Commission's (CQC) Key Line of Enquiry Standards (Safe, Effective, Responsive, Caring and Well Led).

2.9. In addition, a standardised approached to questioning and observation was presented with the introduction of mandatory core questions for each KLOE.

3. Accreditation Outcomes for 2021-2022

3.1. The accreditations completed represented areas from all Hospitals, Managed Clinical Services (MCS) and Local Care Organisations (LCO) including, adult and children's In-patient areas, Out-patient areas, Emergency Departments, Theatres and Community Locations.

3.2. The distribution of awards demonstrated 24 areas (13.8%) achieved Bronze, 84 areas (48.3%) achieved Silver and 66 areas (37.9%) achieved Gold. There were no White areas identified (Table1; pie chart 1).

Gold	66	37.9%
Silver	84	48.3%
Bronze	24	13.8%
Total	174	100.0%

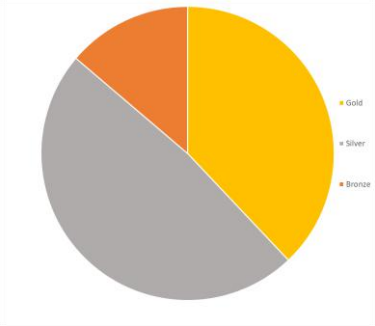


Table 1 and Pie chart 1, demonstrates the distribution of Bronze, Silver and Gold during the 2021-22 accreditation Programme.

3.3. In comparison to the previous year:

- 41 areas improve their award
- 74 areas maintain the same award
- 33 areas demonstrate a deterioration in their award
- 26 areas had not previously been accredited

	Total
Number of areas that improved	41
	Total
Number of areas that deteriorated	33
	Total
Number of areas that stayed the same	74
Number of areas accredited once	26

Table 2. demonstrates the number of areas that improved, deteriorated, or maintained their accreditation award in 2021-22 compared to 2020-21.

3.4. Of the 41 areas that improved their award:

- 4% (6 areas) improved their award from Bronze to Silver
- 20% (29 areas) improved their award to from Silver to Gold
- 4% (6 areas) improved their award from Bronze to Gold

	Bronze to Silver	Silver to Gold	Bronze to Gold	Total
Number of areas that improved	6	29	6	41

Table 3. Demonstrates the shift in areas that improved their accreditation award 2021-22.

3.5. Of the 33 areas that deteriorate in their award:

- 13% (19 areas) showed a deterioration from Gold to Silver
- 5% (7 areas) deteriorated from Silver to Bronze
- 5% (7 areas) deteriorated from Gold to Bronze

	Gold to Silver	Silver to Bronze	Gold to Bronze	Total
Number of areas that deteriorated	19	7	7	33

Table 4. Demonstrates the shift in areas that deteriorated their accreditation award 2021-22.

3.6. Of the 74 areas that maintained their award

- 1% (2 areas) retained a Bronze award
- 28% (42 areas) retained a Silver award
- 20% (30 areas) retained a Gold award

	Bronze to Bronze	Silver to Silver	Gold to Gold	Total
Number of areas that stayed the same	2	42	30	74

Table 5. Demonstrates the proportion of areas that maintained their accreditation award 2021-22.

4. Thematic Analysis of the findings of the 2021-22 Accreditation Programme

4.1. Integral to the accreditation process, is the provision of initial feedback to the area being accredited prior to the team leaving the area.

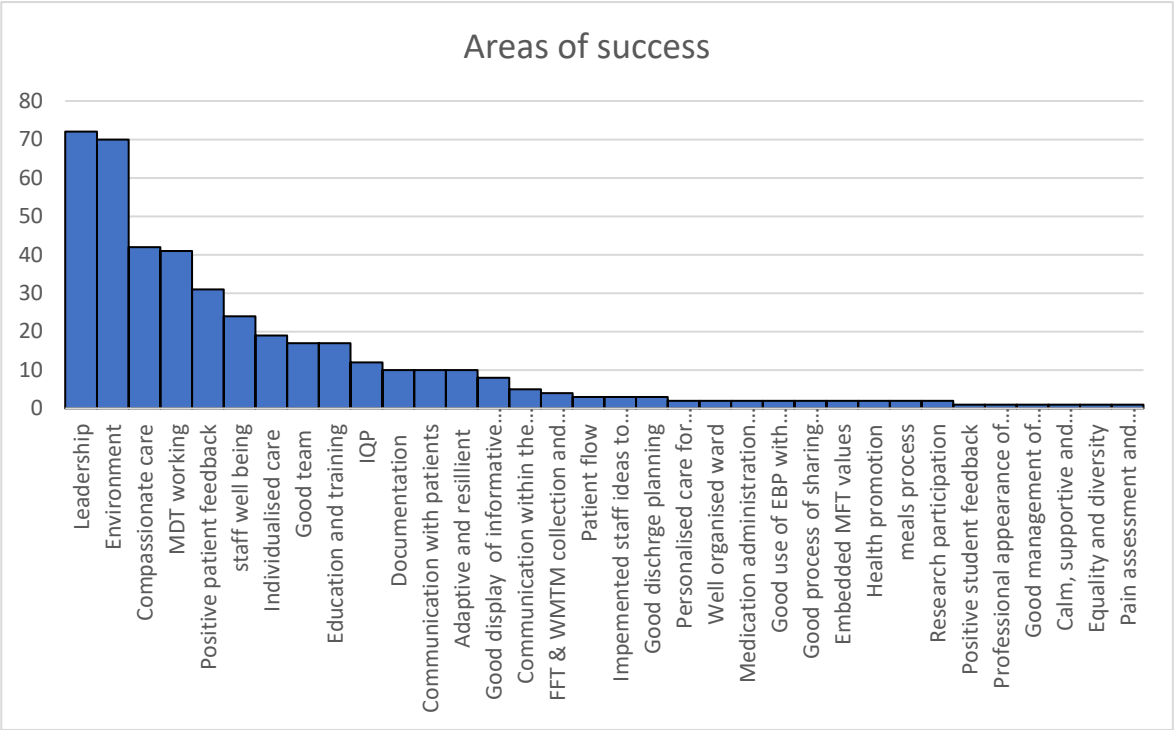
- Three areas of success are identified to celebrate what is going well
- Three areas for improvement are identified to provide focus for areas of improvement

4.2. Additionally, Immediate Actions may be identified during the visit in response to issues seen on the day that can be simply rectified or issues that relate to safety that require to be addressed immediately.

Themes of Areas of Success 2021-22

4.3. From the ‘areas of success’ documented, thirty-five themes were recognised, with leadership being identified as the main area of success and 65% of these areas were presented a Gold award.

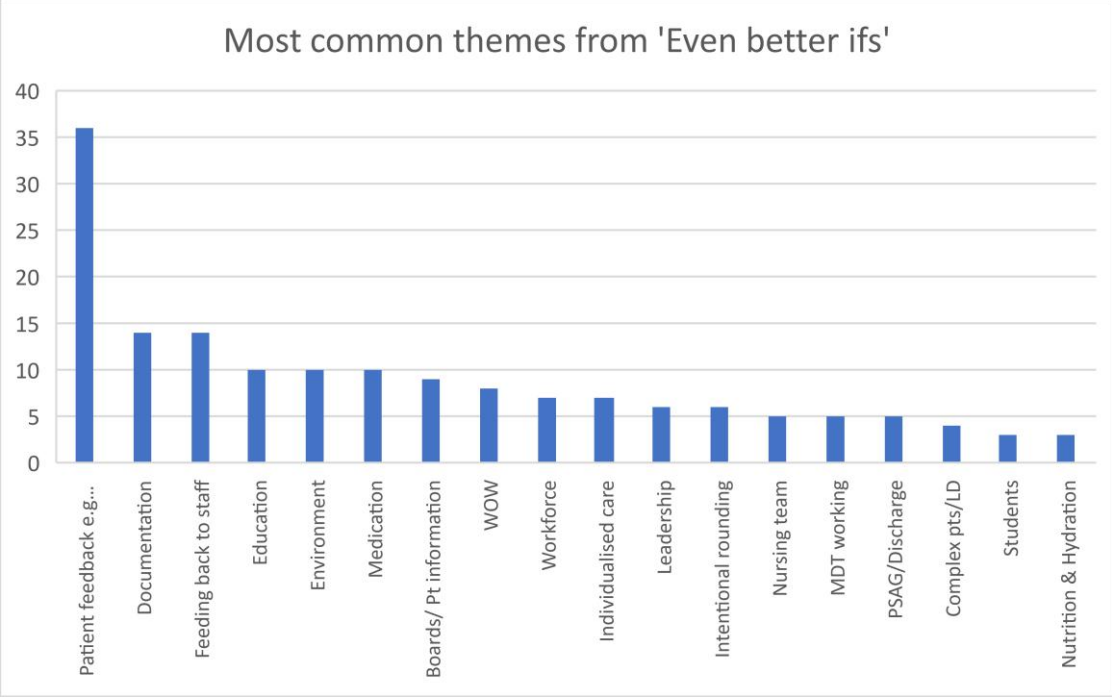
4.4. Additionally, 11 out the 12 areas that had IQP as an ‘area of success’, were presented a Gold accreditation.



Bar Chart 1. Demonstrates the themes identified from the areas of success fed back during the 2021-22 accreditation programme.

Themes of Areas for Improvement 2021-22

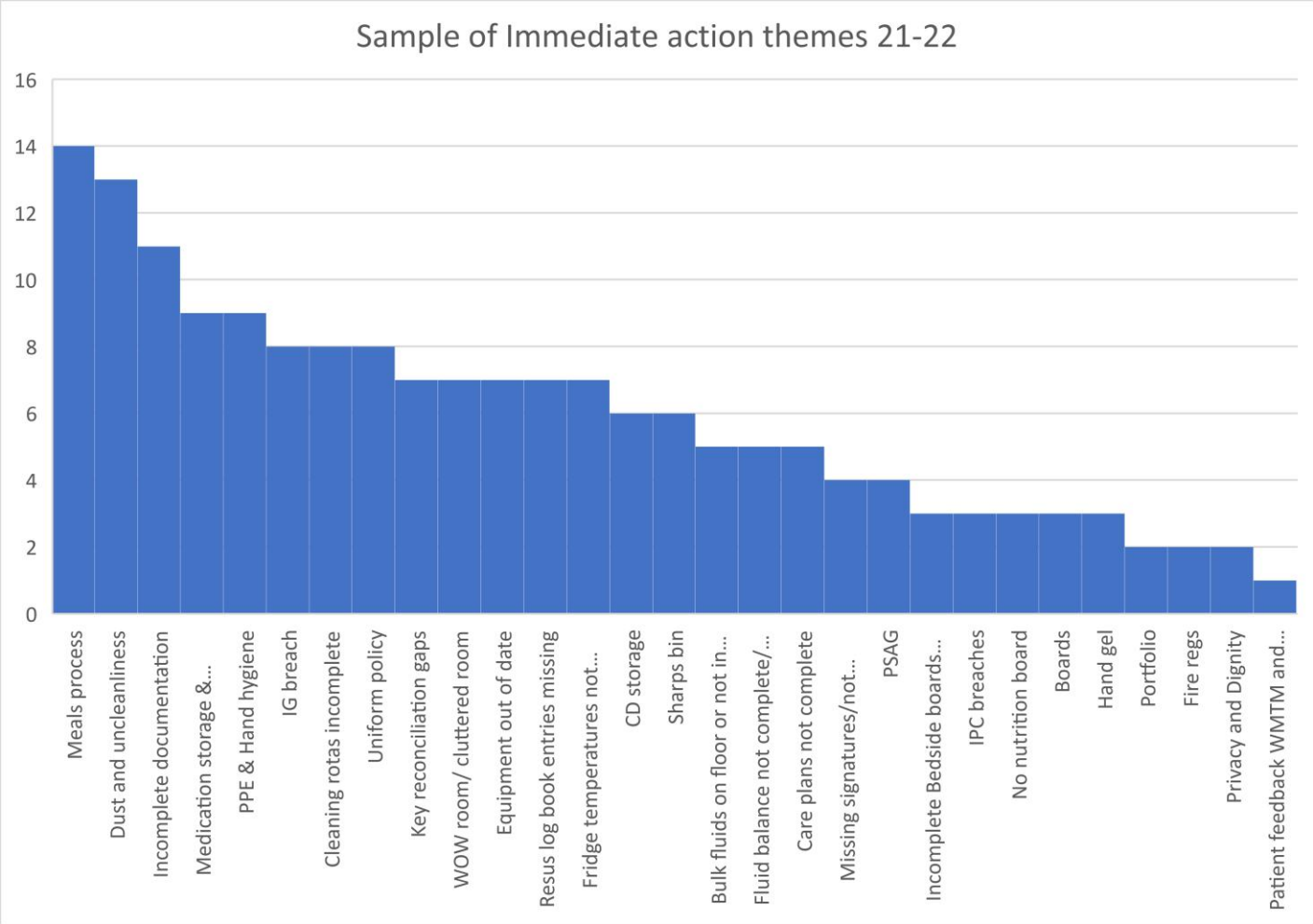
4.5. From the 'areas for improvement' documented, twenty-one themes were recognised, with lack of patient feedback being the main area identified as requiring improvement.



Bar Chart 2. Demonstrates the themes identified as areas for improvement in the accreditation programme 2021-22

Themes from Immediate Actions

4.6. From the Immediate Actions issued, thirty-one themes were identified with the mealtime process being highlighted as the main area for concern.



Bar Chart3. Demonstrating the themes identified as Immediate Actions in the accreditation programme 2021-22

5. Challenges of 2021-22 Accreditation Programme

Scheduling

5.1. The COVID-19 pandemic presented additional challenges to accreditation programme, requiring the corporate nursing and QI Team to be responsive to an evolving, everchanging situation.

5.2. To take account of any changes made to ward configurations in response to ongoing COVID-19 demands, all areas were provided with 4 weeks' notice of an accreditation visit. Whilst beneficial for the reason intended, provision of notice added to the complexities of managing the rota when unforeseen events occurred.

5.3. To be able to manage unforeseen events impacted by COVID-19, dates for accreditations were released on a month-by-month basis to maximise the availability and suitability of the accreditation team allocated to a particular clinical area. This action in turn presented additional challenges, as dates offered then became unavailable compounding the need to reschedule accreditations.

5.4. In total 48 (28%) accreditations had to be rescheduled.

Suspected or actual COVID-19 infection within the accreditation team
Areas moving or closing in response to COVID-19
Additional pressures due to COVID-19 on Clinical & Scientific Services (CSS)
Fire at Trafford General Hospital
Team member no longer available

Table 6. Summarises the main causes for accreditations to be rescheduled 2021-22

I-pads

5.5. To support the accreditation process digital technology and the digital platform, Microsoft Teams, was introduced to support new ways of working with the intention of creating greater flexibility within the accreditation team.

5.6. The introduction of I-pads to complete the accreditation documentation presented an opportunity to contribute to the Trust's commitment to becoming Carbon neutral.

5.7. Numerous issues impacted on the success of the implementation of I-pads. Variable Wi-Fi connectivity was the largest barrier to use, resulting in a lack of confidence in the system and staff then reverting to paper.

5.8. In addition to Wi-Fi connectivity, the interoperability of the accreditation documentation with apple I-pads was not ideal resulting in further obstacles in accessibility and a poor user experience.

5.9. The corporate team engaged with Information Technology (IT) to trouble shoot the problems of connectivity and interoperability.

5.10. An options review identified temporary solutions that might support connectivity issues including having native office apps downloaded to the I-pads removing the need for VDI to access to Microsoft Teams. However, the review concluded that a longer-term solution would be required to support the migration of accreditation documentation to a digital web form.

5.11. Work continues to resolve this issue with plans to link in with HIVE. In the interim, documentation during the visit remains in paper format however, the use of the digital platform, Microsoft Teams continues to be used for all other aspects of the accreditation process with excellent user feedback.

Validation

5.12. Validation is an integral part of the accreditation process in ensuring consistency of results awarded. The intention is to validate 2 areas per validation session.

5.13. In 2021-22, 60 sessions had to be rescheduled. Many of the challenges impacting on the accreditation process were mirrored in the validation process such as unexpected sickness due to COVID-19 or unavailability of the accreditation Lead.

5.14. Incomplete documentation resulted in 28 areas being deferred to a later date to enable staff to complete one or more sections of the accreditation documentation.

5.15. In addition to the impact of COVID-19 on validation, a combination of staff being unfamiliar with the newly revised documentation and the addition of new staff to the accreditation process, meant that validation meetings became protracted, resulting in only one area being validated per session.

5.16. Additionally, some validation sessions were adjourned as it was identified that insufficient evidence was documented to confidently provide assurance around one or more of the KLOE Standards. This required teams to review the evidence they had provided and then resubmit to the validation panel later.

6. Review of the 2021-22 Accreditation process

Engagement

6.1. Utilising IQP methodology, the corporate nursing and QI Team, reviewed the 2021-22 accreditation process based on observations and feedback from numerous stakeholders.

6.2. To gain a deeper understanding of the sense of the issues, an initial focus group was arranged. The session was held by Microsoft Teams and with the use of interactive technology, members of the group were able to provide instant feedback. The initial questions asked focused on areas of success, areas for improvement, immediate actions, preparation for accreditations, the accreditation visit and validation.
Wordles 1 demonstrates the key themes generated from Question 2 of the focus group. '***In planning for the accreditation process 2022/23, what do you think we could do better?'***

6.3. Based on the initial feedback from the focus group, the QI Team engaged further with the Directors of Nursing/ Midwifery (DoNs/DoM) and subject matter experts (SMEs) to drill down further into areas for improvement.

Changes to the Accreditation/Validation process.

6.4. Following analysis of the data obtained from all participating stakeholders, changes were made to the accreditation process in readiness for the 2022-23 accreditation programme.

6.5. The QI team tested all the changes made to the documentation on four pilot wards.

6.6. The accreditation SOP was amended to reflect the changes made and agreed at Quality & Performance Scrutiny Committee in April 2022.

6.7. The below Table (Table 7) summarises the changes implemented following review of the 2021-22 accreditation programme.

Process	Change
Rota	• Staff were able to submit their availabilities for the 2022-23 rota via a Microsoft Teams channel to provide visibility for teams to co-ordinate. • It was agreed that all dates required out of those provided would be release for the year opposed to month-on-month. • Staff were asked to provide their area of expertise to ensure that areas being accredited would have a team member with a deeper insight into the speciality of the clinical area being accredited.
Accreditation Team	• The core team number of each team will increase from 3 to 4 members, with additional experts in larger or more complex areas including theatres, emergency departments, out-Patient areas, and community settings. • Matrons have been returned to the accreditation team. • Allied Health Professionals (AHP) have joined the accreditation team. • Notification of the location of an accreditation and the team composition is provided 72hours before the visit.
Documentation	• KLOEs reviewed and clear guidance provided on questions to ask, processes to observe, documentation to review and the key stakeholders to capture feedback from identified. • A speciality tab has been introduced to ask specific questions to capture the nuances of individual specialities including maternity, children's, out-patients, community, theatres, eye and dental. • Subject matter expert questions have been included to capture greater understanding of the needs of specific patient groups, such as patients living with dementia or patients at their end of life. • The duration of accreditations has changed to a whole day to facilitate completion of the documentation in real time. • Access to data on a Microsoft Teams channel is available 72 hours prior to the planned accreditation to support timely review by the team member before the planned visit.

Education & Training	• All team members have had an opportunity to receive education and training on the accreditation process prior to the 2022-23 programme commenced with additional training planned for staff new in role. • New staff will be given the opportunity to shadow an accreditation before becoming a full member of the team.

Table 7. Summarises the changes implemented following review of the 2021-22 accreditation programme.

7. Education and Training

7.1. Due to the pandemic, in 2020, IQP education and training was paused.

7.2. In 2021, the QI Team delivered 154 training sessions (including the roll-out of IQP at NMGH, Making Matrons Matter and Bee Brilliant).

7.3. The analysis of the 2021-22 accreditation outcomes has provided an overview on where to focus support for teaching and training.

7.4. The data suggests that there is a clear correlation between the knowledge of IQP methodology, leadership, and the accreditation outcome.

7.5. To date in 2022, 170 training sessions have been delivered, including Introduction to IQP & Portfolio training for community areas, the RMCH DoN Fellowship and Well Organised Area (WOA) at NMGH.

7.6. The QI Team are currently working with OD to develop a CPD accredited e-learning IQP package which will enable a wider audience to access training at a time more convenient to the learner. This package once developed will be a pre-requisite to attendance at a 'Quality Clinic' where staff will be able to explore their QI project with a QI Manager.

7.7. In ensuring success across the group, investment in the QI Team has been a priority. The team have all attended the Advancing Quality Alliance (AQuA) Improver training, and utilised the skills learnt to engage and improve the current accreditation process.

7.8. Additionally, further QI training is currently being delivered to the QI team by an external company to refocus the team on the principles of IQP.

7.9. The QI Team have begun the process of welcoming learners to the team as a placement and there are plans for the Graduate Management Officers (GMO) to have a placement within the team thus beginning the process of embedding IQP at the start of the healthcare career journey.

7.10. The QI Team have identified a need to connect with the Quality leads across the hospitals/MCS and LCOs to be able to offer support and to work collaboratively to improve patient care and support staff and a Quality forum has been newly established, and each member of the QI Team has an identified hospital/ MCS/LCO to support.

7.11. In addition to identifying areas for improvement, the accreditation programme offers opportunities to celebrate and share success, therefore Glimmers of excellence have recently been relaunched by the QI Team with the accompanying hashtag #MFTGlimmers.

8. Conclusion

8.1. The accreditation programme for 2021-22 successfully reviewed 174 clinical areas amidst the challenges of the COVID-19 pandemic.

8.2. The accreditation programme for 2022-23 will see a further 56 clinical areas added to the accreditation rota, demonstrating the Trust's continued commitment for ensuring high-quality care and the best possible patient experience.

8.3. Despite the challenges presented, the 2021-22, the accreditation programme has built on the successes of previous years, with the introduction of digital platforms to support agile working and an updated accreditation document designed to improve standardisation across all areas being accredited.

8.4. In total, 78% of areas accredited retained or improved their award score from the previous assessment, demonstrating resilience in unprecedented times during the COVID-19 Pandemic and 26 areas were accredited for the first time providing a baseline for future success.

8.5. Extensive stakeholder engagement during the 2021-22 programme has strengthened the robustness of the accreditation programme going forward into 2022-23, and reaffirms the objective of providing the Trust Board with an effective quality assurance mechanism whilst also providing a vehicle for continued service improvement.

9. Recommendations

9.1. The Board of Directors is asked to note the content of this report, the work undertaken to improve the process.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse /Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthrone MBE, Assistant Chief Nurse (ACN) and Clinical Director of Infection Prevention and Control (CDIPC)
Date of paper:	July 2022
Subject:	Annual Infection Prevention and Control Report 2021/22
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Experience Staff and Patient Safety
Recommendations:	The Board of Directors are asked to receive the Infection Prevention and Control Report 2021 to 2022.
Contact:	Name: Julie Cawthorne MBE, Assistant Chief Nurse/ Clinical Director of Infection Prevention Control) Tel: 0161 276 4042

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control (IPC) Annual Report 2021/2022

1. Executive Summary

1.1 The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). Under this Act the Board of Directors are required to receive an annual report from the Director of Infection Prevention and Control (IPC). This report details Infection Prevention and Control activity from April 2021 to March 2022, outlining key achievements, and is presented in context of being the second year of the COVID-19 pandemic.

1.2 The prevalence of COVID-19 decreased during the summer months of 2021. The dominant variant (was Delta at that time) which was not associated with significant morbidity and mortality in part due to the widespread uptake of vaccination as part of the national programme. There was a surge in the number of in-patient cases in late December 2021 and January 2022 to the rapid spread of the highly transmissible Omicron variant.

1.3 Throughout 2021/2022 the Trust continued to respond to the continuous fluctuating levels of the background levels of the COVID-19 virus maintaining a balance of risk between patients who were admitted on COVID-19 and non-COVID-19 pathways. The Trust-wide response from all staff coming together to provide the best possible standards of safe care for all our patients is to be commended. Staff have supported visitors and each other to implement policies and procedures to reduce the risk of transmission of COVID-19.

2. Key Achievements

2.1 The Group Infection Control Committee (GICC) has corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. During 2021/22 the GICC met four times during the year, chaired by the Chief Nurse/Director of Infection Prevention Control.

2.2 The Chief Nurse/DIPC commissioned an end of year review for each hospital/MCS. The review meetings were held individually with the Directors of Nursing (lead directors for IPC in the hospitals/MCS/LCOs), supported by their Senior Team, local Infection Control Doctor and IPCN(s). The sessions represented an opportunity to reflect on the previous year, focus on activity and performance, celebrate achievement, and understand lessons learnt.

2.3 The Trust IPC/ Tissue Viability (TV) Team were asked to renew the provision IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and Little Hulton through a Service Level Agreement (SLA).

2.4 In September 2021 the Trust was the first in the country to appoint two trainee advanced clinical practitioners (TACP's) for Infection Prevention and Control (IPC). These exciting new roles will support the Team as it continues to develop.

2.5 The IPC/TV Team were awarded the CSS Chief Executive Award in July 2021 for their response and support across the Trust during the first year of the pandemic.

2.6 The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. There were two meetings a week to manage theCOVID-19 response and COVID-19 recovery. These two meetings were combined as the Response and Recovery Group from September 2021 and were held two to three times a week depending on the situation.

2.7 The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus (RSV), as well as SARS-CoV-2 in health and care settings for winter 2021 to 2022. The BAF was reviewed regularly in line with each new version and presented to the Board of Directors. Mitigating actions were implemented to address any gaps in assurance.

2.8 The Trust assessed the systems and processes in place against a series of identified COVID-19 risks. The initial score at the height of the pandemic was 20 (Likelihood 5 x Consequence 4) with a target of 8, (Likelihood 2 x Consequence 4). The risk was regularly reviewed and at the time of this report the current risk score is 12 (Likelihood 3 x Consequence 4). Gaps in assurance have been identified, with mitigating actions/controls in place to reduce the impact or likelihood of the risk occurring.

2.9 In July 2021 the Government announced a new phase in the response to the pandemic, moving away from stringent restrictions on everyone's day-to-day lives, towards advising people on how to protect themselves and others, alongside targeted interventions to reduce risk. Whilst COVID-19 restrictions ended in many settings, UK Health and Security Agency (UKHSA) Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services.

2.10 The focus of national guidance moved towards a risk-based approach in healthcare facilities. Clinical areas were asked to undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls. The risk assessment was undertaken locally, documented and reviewed at regular intervals.

2.11 Responding to the surge in cases of the omicron variant in the New Year required the Trust to move to another temporary phase regarding the principles of IPC guidance. There were several areas where a change in practice was introduced to support flow of patients and ensure patient safety.

2.12 The temporary guidance was withdrawn in February 2022 as although COVID-19 continued to circulate, the circulating variant was less virulent and most in-patients who were found to have COVID-19 were asymptomatic. Those who were symptomatic had significantly reduced severity of illness.

2.13 There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further actions required put in place.

2.14 If a case formed part of an outbreak, (defined as two or more cases of Hospital Onset COVID-19 Infection (HOCI) in a ward within a two- week period), an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

2.15 In March 2022, in line with national recommendations the Trust reviewed COVID-19 guidance on screening, testing and isolation of patients based on a risk assessment, that took into consideration the reduced virulence of the circulating variant and the need to admit patients on other pathways.

2.16 In addition, staff were no longer required to undertake PCR testing, (Pilar 2PCR testing is no longer available), Staff were expected to continue to test using LFD twice a week and record the outcome on the government portal, where tests can also be ordered. In areas of high risk such as haematology or renal, weekly PCR testing continues.

2.17 In April 2021, a guidance document by NHS England/Improvement North-west was published, describing the process for undertaking an enhanced structured judgement reviews (SJRs) for those patients who had died from hospital onset Covid-19 infections (HOCI). In total 129 definite and 124 probable HOCI deaths were reviewed. Lessons learnt were showed at the Trust Quality and Safety meeting and disseminated through the MFT governance meetings.

2.18 In March 2020, a strategic decision was made to restrict visiting across the Trust aligned to the national guidance produced by NHSE/I to protect patients and staff by reducing footfall to minimise the transmission of COVID-19. An interim visiting policy was developed and has been regularly updated.

2.19 All versions of the policy have supported a compassionate approach by facilitating visiting in specific circumstances, In March 2022 reflecting the changes in the level of circulating virus, the guidance was updated to allow a more flexible and welcoming approach to supporting visitors return into the healthcare setting to visit patients.

2.20 To support the effective management of patients at Wythenshawe hospital, rapid testing for COVID-19, Influenza and RSV using the Cepheid GeneXpert® was introduced to the site in December 2021 following a successful pilot in the adult Emergency Department which demonstrated a significant reduction in the turnaround time for results.

2.21 The Trust participated in the COG UK HOCI study in 2021. The results have now been published[1]. The study demonstrated that rapid sequencing of COVID-19 from hospital

[1] Stirrup et al, Effectiveness of rapid SARS-CoV-2 genome sequencing in supporting infection control for hospital-onset COVID-19 infection: multicentre, prospective study; medRx 2022.02.10.22270799;https://doi.org/10.1101/2022.02.10.22270799

outbreaks had a significant impact on the management of outbreaks, especially where results were obtained within 5 days of sampling.

2.22 The UK HSA COVID-19 whole genome sequencing laboratory at MFT is now full operational and has recently increased capacity to 3000 genomes per week to provide a service to the North of England. Data from COVID-19 sequencing at MFT has provided valuable information to assist with the management of the pandemic[2] as well as providing clinically useful information to guide the management of patients, especially during the early phase of the Omicron variant wave.

2.23 The prevention and control of infection is a high priority for the Trust and there is a strong commitment to prevention of all HCAI Infections. There were 10 incidents of Trust attributable Meticilin Resistant Staphylococcus aureus (MRSA) bacteraemia this year compared to 12 for the previous year.

2.24 When comparing MFT's attributable Clostridium difficile Infection (CDI) rates from 2020/2021 to 2021/2022, there has been a decrease from 30.6 to 26.8 cases per 100,000 overnight beds.

2.25 There was a total of 918 Gram-Negative Bloodstream Infections (GNBSI) reported during 2021/2022. Of these, 304 cases (33%) were determined to be hospital-onset, a slight increase on the previous year which saw 299 hospital onset cases of GNBSI. GNBSI figures are considered against a locally calculated trajectory informed by the national reduction objective (50% reduction from 2016 baseline to be achieved by 2023). The previous year's target was 216 cases.

2.26 A total of 31 Vancomycin-resistant Enterococci (VRE) bacteraemia were reported during 2021/2022. This compares to 34 reported during the previous year.

2.27 There was a total of 416 Carbapenemase-producing Enterobacterales (CPE) acquisitions recorded for 2021/2022, compared to 244 for the previous financial year. There were 4 attributable CPE bacteraemia's reported during 2020/2021, but only 1 trust-attributable CPE bacteraemia reported for 2021/2022.

2.28 All incidents of CDI and reportable bacteraemia attributable to the Trust were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings. Key themes to emerge were non-compliance with policy, antimicrobial stewardship, and delays to commencing isolation and decolonisation therapy. Each hospital MCS incorporated key findings into local action plans.

2.29 The national and local programme for surgical site infection surveillance was suspended from 1st April 2020 due to the pandemic, this has not recommenced yet.

2.30 In total, there were 6827 lost bed days for 2021/2022 due to outbreaks of infection. A total of 12 wards were closed or partially closed over 18 occasions due to outbreaks of CPE.

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[2] Ahmad S, Brown B, Charlett A, et al. Early signals of Omicron severity in sentinel UK hospitals. Research Square; 2021. DOI:10.21203/rs.3.rs-1203019/v1.

2.31 Extended Spectrum Beta-Lactamase (ESBL) bacteria, MRSA and Diarrhoea and Vomiting between April 2021 March 2022. Control measures were implemented and the outbreaks successfully managed.

2.32 This year the COVID-19 and seasonal influenza vaccine programmes were combined in accordance with national guidance and were recognised as an essential activity within the MFT Autumn and Winter Plan.

2.33 The MFT COVID-19 booster vaccine rollout commenced on 22nd September 2021, with co administration of influenza and COVID-19 vaccines. There was mixed response, with some staff opting for both vaccines and others selecting a single vaccine to date:

2.34 Through MFT Flu Engagement Groups stakeholder feedback has been collected to investigate the reasons for low flu vaccine uptake. These included perceptions of flu as being less of risk due to reduced prevalence, and prioritisation of COVID-19 booster (despite offer for co-administration).

2.35 The MLCO/TLCO School Aged Immunisation Service (SAIS) teams led the delivery of the COVID-19 vaccine to healthy 12 to 15 year-olds in schools in Manchester and Trafford, with the second phase of the programme completed on 31st March 2022.

2.36 This year the structure of the MFT Antimicrobial Stewardship (AMS) Committee G-AMC was revised, creating a group wide strategic committee with three working sub-groups. The new G-AMC was in place since November 2021, chaired by the Medical Director for MRI and membership includes medical directors/ equivalent from all the hospitals in the Group.

2.37 There have been developments in national and regional antimicrobial resistance (AMR) /AMS structures in NHS England, with a new National AMR lead and a new Northwest AMS lead pharmacist. This had led to further developments in the new Integrated care system (ICS) structure with the formation of a Greater Manchester AMR Board and an AMS committee. MFT has medical and pharmacist representatives on both groups.

2.38 The Trust cleaning services were provided by both internal and external contractors/teams. The services at North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.

2.39 In addition, the standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, the Ward Accreditation Process and the What Matters to Me (WMTM) Tracker, although during the continued pandemic restrictions some aspects of these additional quality measures were reduced or suspended. These results informed areas of best practice and areas where additional focus was required.

2.40 As required by the new National Standards of Healthcare Cleanliness (NSoC) Commitment to Cleanliness Charters were publicly displayed in all clinical areas, replacing cleaning schedules, and Star Ratings to demonstrate the standard of cleaning delivered on each Ward and Clinician Department have been displayed in accordance with the NSoC.

2.41 Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

The review of areas classified as Augmented Care for the purpose of sampling for Pseudomonas took place across the ORC and WTWA sites and was agreed by Water Safety Groups. Agreed schedules of sampling for Pseudomonas were produced and sampling continued in accordance with HTM04-01 Part C.

2.42 The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. The Group Ventilation Systems Management Safety Policy has been revised to take account of the changes in HTM 03-01: Specialised Ventilation for Healthcare Premises which was published in June 2021.

2.43 The decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the STERIS facility based in Wythenshawe in July 2021, for the DSD at ORC to undergo a life cycling refurbishment program which is being undertaken through the Trust's PFI Partner Equans. All decontamination service provision to the Trust has been maintained to an acceptable and satisfactory level during this period.

2.44 In accordance with the requirements of the IPC Board Assurance Framework (BAF) local Hospitals/MCS fit testing records were transferred to the Central learning hub from October 2021. All key areas across the Trust identified staff who could become fit testers. A range of train the trainer sessions for fit testers were organised throughout the year and were well attended. In addition, external support from Ashfield Healthcare, to fit test staff was extended for a further nine months.

2.45 Following a review by the Greater Manchester specialist workforce for IPC the 'Infection Prevention and Control Development Pathway' (IPCDP) was commissioned in October 2020. which has been overseen by the Chief Nurse/DIPC at MFT supported by the regional IPC team. The framework supports the development of knowledge, skills, and behaviours in IPC in all healthcare workers.

2.46 The Chief Nurse/DIPC undertook an end of year IPC review with the IPC Leads for each Hospital/MCS/ LCO during March 2022. The review meetings were held individually with the Directors of Nursing, supported by their Senior Team and local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC. The sessions were an opportunity to reflect and focus and feedback was very positive from all those involved

Recommendation

The Board of Directors are asked to receive the Infection Prevention and Control Annual Report for 2021/22 and approve for publication.

SECTION 3: INFECTION PREVENTION and CONTROL ARRANGEMENTS

3.1 The Director of Infection Prevention and Control (DIPC)

Professor Cheryl Lenney was appointed as the Chief Nurse and designated DIPC for the Trust from September 2017. Cheryl started working at Central Manchester Foundation Trust (CMFT) in 2002 and was appointed as Chief Nurse/DIPC for Manchester Foundation Trust (MFT) and its predecessor organisation from 2015.

3.2 The Infection Prevention and Control Team (IPCT)

Dr Rajesh Rajendran Associate Medical Director in Clinical and Scientific Services for IPC. Rajesh was appointed as Regional IPC Doctor and Medical Microbiologist from July 2021 and became Clinical Director of the Division of Laboratory Medicine in November 2021.

Mrs Julie Cawthorne provided senior nursing and strategic leadership as **Assistant** Chief Nurse IPC/Tissue Viability/Clinical DIPC**.** Julie has been a Specialist Nurse in IPC since 1994 and held several senior nursing roles within the IPC Team since joining CMFT in 2009 and previously at South Manchester University Foundation Trust.

Mrs Michelle Worsley was the of Head of Nursing for IPC. Michelle was appointed as an IPC Specialist Nurse in 2007 and moved to the Manchester Royal Infirmary (MRI) and later the Manchester Royal Eye Hospital (MREH) to develop her clinical leadership experience before returning to the IPC Team in 2020.

Dr Nicholas Machin Consultant Virologist, Clinical Lead for Virology maintained his role as an Infection Control Doctor (ICD). Nicholas was pivotal to the set up the UKHSA/Regional COVID-19 genome sequencing Laboratory.

Dr Shazaad Ahmad Consultant Virologist continued his role as an Infection Control Doctor. Shazaad helped to set up the Data Science Unit at MFT in the field of infection data that has been used to inform regional and national decision making regarding COVID-19.

3.3 Microbiology and Virology Laboratory Services

Microbiology and Virology Laboratory services were provided on-site at the Oxford Road Campus (ORC) by the Manchester Medical Microbiology Partnership (MMMP) Virology services were provided across the region as well to the Trust.

3.4 The Infection Prevention and Control (IPC)/Tissue Viability (TV) Team

All IPC services are managed within the Clinical and Scientific Services (CSS). The Medical members of the IPC Team are in the Division of Laboratory Medicine. The Nursing Team are in the Corporate Division of CSS. A business case is being progressed to create a Division of IPC services to strengthen the Team to meet the needs of the service.

Recruitment and succession plans are in place for both the medical and nursing team, to fulfil the need to ensure that the IPC team develops its workforce.

In September 2021 the Trust was the first in England to appoint two Trainee Advanced Clinical Practitioners (TACP's) for Infection Prevention and Control (IPC). These exciting new roles will support the delivery of IPC services as it continues to develop.

An organogram demonstrating an overview of the structure of the IPC/TV Nursing Team can be found in Appendix 1.

3.5 CSS Star Awards 2021

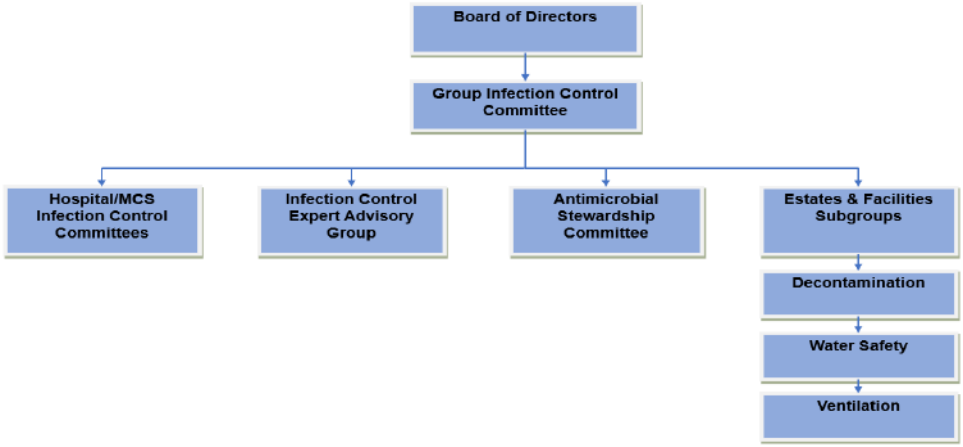
The IPC/TV Team were awarded the CSS Chief Executive Award in July 2021 for their response and support across the Trust during the first year of the pandemic.

3.6 The Group Infection Control Committee (GICC)

The Group Infection Control Committee has corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. The GICC met four times during the year chaired by the Chief Nurse/DIPC. The Group Infection Control Committee reported to the Group Management Board. The GICC, terms of reference (TOR) can be found in Appendix 2.

3.7 Framework for IPC

The IPC governance framework can be seen below.



3.8 Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)/Local Care Organisation (LCO)

Infection Control Committees are in place within each Hospital/MCS and LCO. The day to day management for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS/LCOs appointed a Clinical Lead to support IPC policy and practice across professional groups and represent their Hospitals/MCS/LCO at the GICC.

Each hospital/MCS/LCO presented their Infection Control minutes from the ICC and escalate any issues or concerns. Attendance at the hospital/MCS/LCO meetings includes designated IPC nurses and ICDs.

The Chief Nurse/DIPC commissioned an end of year review for each hospital/MCS The review meetings were held individually with the Directors of Nursing (lead directors for IPC in the hospitals/MCS/LCOs), supported by their Senior Team, local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by the Associate Medical Director for IPC and the Assistant Chief Nurse for IPC/Tissue Viability/Clinical DIPC.

The sessions were an opportunity to reflect on the previous year, focus on activity and performance, celebrate achievement, and understand what we had learnt, feedback was very positive from all those involved. A Summary of each review can be found in Appendix 3.

3.9 Service Level Agreement (SLA) with St Ann's Hospice

The Trust IPC/TV Team were asked to renew the provision IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and Little Hulton through a Service Level Agreement (SLA).

SECTION 4: MANAGEMENT OF THE COVID-19 PANDEMIC APRIL 2021 – MARCH 2022

4.1 Overview

The prevalence of COVID-19 decreased during the Summer of 2021. The dominant Delta variant (at that time) was not associated with significant morbidity and mortality partly due to the widespread uptake of the vaccine.
There was a surge in the number of in-patient cases in late December 2021 and early New Year due to the rapid spread of the Omicron variant.

4.2 Trust IPC Framework to Manage COVID-19

The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. There were two meetings a week to manage the COVID-19 response and COVID-19 recovery. These two meetings were combined as the Response and Recovery Group from September 2021 and were held two to three times a week depending on the situation.

The Clinical Sub-Group (CSG) continued to meet and was chaired by the Medical Director. It was a forum to discuss and advise the Response and Recovery Group on treatments for COVID-19, and Clinical pathways for patients with COVID-19. The frequency of the meetings convened varied according to need.

The Trust responded to changing national guidance as knowledge of the virus increased and the continuous fluctuating levels of the circulating variant of the virus. The Chief Nurse/DIPC chaired a high-level Expert IPC Group as part of the response to support the rapid interpretation and implementation of IPC guidance. This group reported into the Response and Recovery Group and the Group Infection Control Committee.

4.3 Board Assurance Framework

NHS England/Improvement (NHSE/I), continued to further develop the IPC Board Assurance Framework (BAF) to support all healthcare providers to effectively self-assess their compliance with UK Health Security Agency (UKHSA) Infection prevention and control policies and procedures.

The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus, as well as SARS-CoV-2 in health and care settings for winter 2021 to 2022.
The BAF was reviewed regularly in line with each new version and presented to the Board of Directors. Mitigating actions were implemented to address any gaps in assurance.

4.4 COVID-19 Risk Assessment

The Trust assessed the systems and processes in place against a series of identified risks (Risk MFT/004292). The initial score at the height of the pandemic was 20 (Likelihood 5 x Consequence 4) with a target of 8, (Likelihood 2 x Consequence 4).
Throughout the pandemic, oversight of the risks relating to COVID-19 infection was in place through several channels:

- High Level Infection & Prevention Group
- COVID-19 Clinical Sub-Group

- COVID-19 Response & Recovery Group (was COVID-19 Strategic Group)
- Group Infection Prevention and Control (through the IPC Board Assurance Framework)
- Group Risk Oversight Committee

At the time of writing this report the current risk score is 12 (Likelihood 3 x Consequence 4) Gaps in assurance have been identified, with mitigating actions/controls in place to reduce the impact or likelihood of the risk occurring.

There are no scores below 'adequate or satisfactory attributed to the effectiveness of the mitigation in place. Mitigation includes:

- A dynamic risk-based approach to patient pathways in place, including use of Hierarchy of Controls and regional/national IPC Guidance.
- Supporting range of policies and procedures in place
- Reduction in severity of illness (noted by reduced admissions to critical care)
- Increased vaccine coverage in public and staff
- System of receiving, assessing, and implementing change with communication channels to advise staff of changes to practice

4.5 Response to Changes in COVID-19 Guidance, July 2021

In July 2021 the Government announced a new phase in the response to the pandemic, moving away from stringent restrictions on everyone's day-to-day lives, towards advising people on how to protect themselves and others, alongside targeted interventions to reduce risk. Whilst COVID-19 restrictions ended in many settings, UKHSA Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services.

The focus of national guidance moved towards a risk-based approach in healthcare facilities. In line with Government guidance, everyone accessing or visiting healthcare settings across the Trust were still required to continue to wear a fluid resistant facemask (FRSM), unless exempt, to reduce the risk of infection with COVID-19 to themselves and others. The use of FRSM in non- clinical buildings across the Trust did not cease until February 2022.

All staff undertaking/assisting with an Aerosol Generating Procedure (AGP) were required to wear an FFP3 respirator, (for which they had been fit tested). This applied to all patient pathways that is, High risk (Blue), Medium risk (Amber) and Low risk (Green). The decision to increase the use of an FFP3 respirator for AGP's amongst low-risk patients was based on local risk assessment i.e. the risk of asymptomatic carriage of COVID-19 amongst patients and Healthcare workers. In addition, staff were encouraged to make a personal risk assessment when choosing whether to wear an FFP3 respirator.

Clinical areas were asked to undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls. The risk assessment was documented and reviewed at regular intervals and included:

- Increasing ventilation by opening windows, putting extractors into window, use of air filter machines
- Encouraging patients and visitors to wear a FRSM

- Reviewing the number of people in one room/area to allow for social distancing
- Encouraging staff to have the vaccination and perform twice weekly lateral flow testing to protect themselves and others

4.6 Changes to IPC COVID-19 Guidance, November 2021

In November 2021 IPC guidance for health and care settings during the COVID-19 pandemic was updated. The overall theme of the new guidance was to move to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as Influenza and Respiratory Syncitial Virus (RSV).

There was an emphasis on local decision making around patient pathways and management of risk. The guidance was used to update local policy. The key points included:

- Removal of the COVID-19 high, medium, and low risk care pathways so that everyone without symptoms of a respiratory illness would follow the same precautions, such as at least 1 metre physical distancing instead of 2 metres
- Physical distancing reduced to at least 1 metre, increasing whenever feasible to 2 metres, for non-respiratory patients across all health and care settings – this could expedite the faster treatment of people with non-respiratory conditions across health and care settings
- Screening, triaging, and testing for SARS-CoV-2 continued. All patients were screened on admission and on days 3, 5-7 and in accordance with MFT policy every 7 days thereafter
- The inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days, except for those patients who were immune-supressed

4.7 Response to the Omicron Surge December 2021 – January 2022

Responding to the surge in cases of the omicron variant in the New Year required the Trust to move to another temporary phase regarding the principles of IPC guidance. There were several areas where a change in practice was introduced to support flow of patients and ensure patient safety. The new MFT IPC Principles for Managing SARs Co-V2 Omicron Wave were based on updated national guidance. Changes/additions to IPC precautions included:

- Cohorting of patients who had been exposed to COVID-19 during their in-patient stay (contact cases)
- inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days
- Mixing cohorts of exposed patients on designated wards to increase bed capacity
- On declaration of an outbreak the ward was assessed by the outbreak management team (OMT) and depending upon the number of patients identified as COVID-19 positive ward may have remained open. Staff screening during outbreaks ceased

The temporary guidance was withdrawn in February 2022 as although COVID-19 continued to circulate, the current variant was less virulent and most in-patients who were found to have COVID-19 were asymptomatic. Those who were symptomatic had significantly reduced severity of illness.

4.8 MFT Newly Confirmed COVID-19 Cases

Chart 1 below demonstrates the number of newly confirmed COVID-19 in-patient cases from March 2020 (declaration of the pandemic) to March 2022

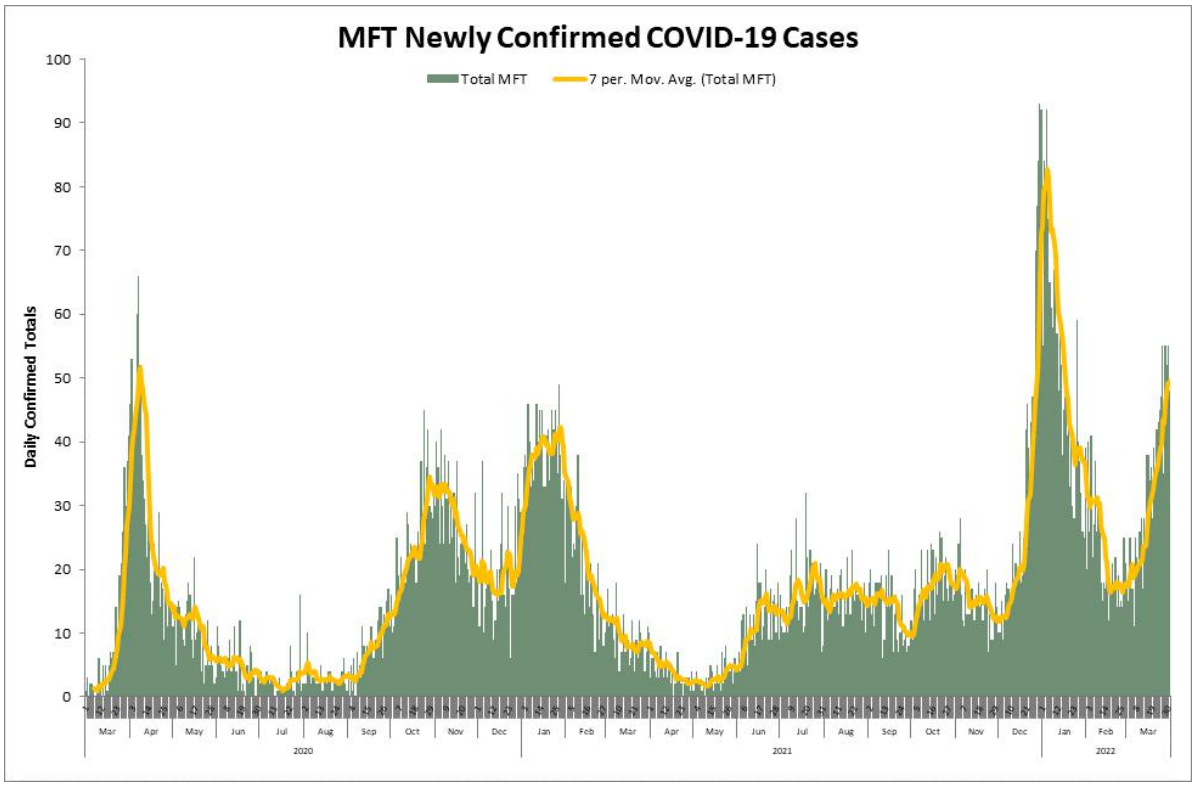


Chart 1 newly confirmed Covid-19 in-patient cases March 2020 to April 2021

4.9 MFT Hospital Onset COVID-19 Infections (HOCI)

The national definition of a HOCI, was an infection occurring on or after day eight of admission. All incidents of HOCI were investigated and reported to NHSE/I.

4.10 Outbreaks of Hospital Onset COVID-19 Infection (HOCI) Outbreaks

There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further actions required put in place.

If a case formed part of an outbreak, (defined as two or more cases of HOCI in a ward within a two week period), an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

Table 1 below shows the number of COVID-19 outbreaks across ORC, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from 1st April 2021– 31st March 202. The rise in numbers in January 2022 was due to the surge in the prevalence of the omicron variant.

The escalation in numbers between October 2020 and January 2021 can be attributed in part to the rising local community prevalence rate.

MFT COVID-19 Outbreaks	
April 2021	**0**
May 2021	**0**
June 2021	**6**
July 2021	**4**
August 2021	**3**
September 2021	**4**
October 2021	**7**
November 2021	**2**
December 2021	**13**
January 2022	**29**
February 2022	**12**
March 2022	**20**

Table 1 COVID-19 outbreaks across MFT April 2021 – March 2022

4.11 Overview of Changes to COVID-19 Patient Screening Testing and Isolation from March 2022

In line with national recommendations the Trust reviewed COVID-19 guidance on screening, testing and isolation of patients based on a risk assessment, that took into consideration the reduced virulence of the circulating variant and the need to admit patients on other pathways.

There has been a reduction in the requirement for Polymerase chain reaction (PCR) testing for staff and patients with an emphasis on the use of lateral flow devices (LFD) where testing is still required. The Trust has continued to use PCR testing in most cases, with exceptions being in low-risk elective cases, due in the main to challenges to maintaining accuracy of external reporting.

During the Summer of 2020 the Trust made the decision, in the interest of patient safety but outwith the national guideline, to screen all in-patients every seven consecutive days of their admission. Following the review, screening after day eight of admission was ceased (unless the patient was symptomatic), as there has been no benefit to reducing the risk of Hospital Onset COVID-19 Infection (HOCI).

Patients who are symptomatic and test positive for COVID-19 were moved to a dedicated COVID-19 ward. Patients who test positive and are asymptomatic are risk assessed and may be cared for in a single room. Routine contact screening was discontinued.

4.12 Overview of Changes to Staff Testing for COVID-19

In accordance with national guidance updated throughout 2021 – 2022, staff were no longer required to undertake PCR testing (Pilar 2 PCR testing is no longer available). Staff are expected to continue to test using LFD twice a week and record the outcome on the government portal. Testing kits were provided through Trust procurement.

Symptomatic staff were advised to undertake an LFD test if they develop COVID-19 symptoms. If positive they were asked to self-isolate for a minimum of five days and return to work after two consecutive daily LFD tests, starting no sooner than day five. Staff who were still LFD positive at day 10 would undertake a local risk assessment with their line manager.

Staff working in areas where patients are immunocompromised, such as renal transplant or oncology wards continued to access COVID-19 screening through PCR testing on a weekly basis.

4.13 Serious Judgement Review on Harm and Mortality associated with HOCI

In April 2021 a guidance document by NHS England/Improvement North-west was published, describing the process for undertaking an enhanced structured judgement reviews (SJRs) for those patients who had died from hospital onset COVID-19 infections (HOCI).The guidance identified that the standard SJR mortality review proforma did not interrogate the cause or potential impact of any type of nosocomial infection, and that the mortality review and the infection prevention and control (IPC) review processes were not always linked.

The Patient Safety team worked with both informatics and the IPC team to incorporate additional questions either into the SJR mortality review tool, or within the IPC questionnaire, as appropriate. In total 129 definite and 124 probable HOCI deaths were reviewed**.**

Lessons learnt were shared at the Trust Quality and Safety Committee and disseminated through the MFT governance meetings.

4.14 MFT COVID-19 Interim Visiting Policy

In March 2020, a decision was made to restrict visiting across the Trust aligned to the national guidance produced by NHSE/I to protect patients and staff by reducing footfall to minimise the transmission of COVID-19. An interim visiting policy was developed and has been regularly updated.

All versions of the policy have supported a compassionate approach by facilitating visiting in specific circumstances, such as at the end of life or for patients living with a learning disability. In March 2022 the guidance was updated to allow a more flexible and welcoming approach to supporting visitors return into the healthcare setting to visit patients.

All agreed visitors were asked to comply with safety measures, including face masks, PPE, social distancing, and handwashing.

4.15 Update on Diagnostic Services to Support the IPC COVID-19 Response

Introduction of Rapid testing to Wythenshawe Hospital

- To support the effective management of patients at Wythenshawe hospital, rapid testing for COVID-19, Influenza and RSV using the Cepheid GeneXpert® was introduced to the site in December 2021 following a successful pilot in the adult Emergency Department which demonstrated a significant reduction in the turnaround time for results (fig 1).

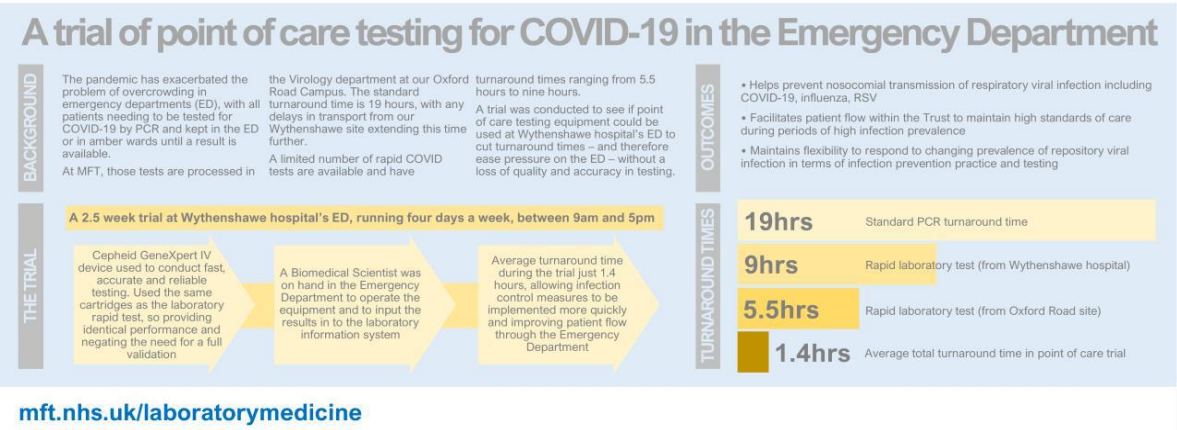


Figure 1. Results of the POC trial for COVID-19 testing in Wythenshawe Emergency Department

- Although the initial pilot was successful, certain IT limitations were unable to be resolved resulting in the requirement for the GeneXpert® instrument to be operated by a Biomedical scientist. For this reason, the instrument was relocated to the Haematology laboratory at Wythenshawe.
- Since go-live the Trust was successful in its bid to NHSE/I, supporting a larger instrument with full IT connectivity.
- The larger instrument and full IT connectivity will increase the capacity for testing at the Wythenshawe site. A broader range of staff will also be able to operate the instrument, enabling extended hours of staffing and potential for the instrument to be operated by health care assistants in the Emergency Department.

4.16 Update on Whole Genome Sequencing of COVID-19

- Results of the COG UK HOCI study have now been published[3]).The study demonstrated that rapid sequencing of COVID-19 from hospital outbreaks had a significant impact on the management of outbreaks, especially where results were obtained within 5 days of sampling.
- The UK HSA COVID-19 whole genome sequencing laboratory at MFT is now full operational and has recently increased capacity to 3000 genomes per week to provide a service to the North of England. Data from COVID-19 sequencing at MFT has provided valuable information to assist with the management of the pandemic[4] as well as providing clinically useful information to guide the management of patients, especially during the early phase of the Omicron variant wave.

SECTION 5: HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

5.0 HCAI Performance Targets

This section contains a summary of the data submitted through The UK Health Security Agency (UKHSA) mandatory surveillance system. The Healthcare Associated Infections Data Capture System (HCAI-DCS) and summaries of additional alert organisms/trends

[3] Stirrup et al, Effectiveness of rapid SARS-CoV-2 genome sequencing in supporting infection control for hospital-onset COVID-19 infection: multicenter, prospective study;
[4] Ahmad S, Brown B, Charlett A, et al. Early signals of Omicron severity in sentinel UK hospitals. Research Square; 2021.

under local surveillance. Data is presented as number of cases unless otherwise stated. Surveillance data for COVID-19 is included in section four.

Surveillance data for North Manchester General Hospital (NMGH) are included only from when they joined the MFT IPC Team (April 2021/2022): prior to that data was reported by the Pennine Acute Hospitals Trust.

During the last 12 months the Trust has seen a reduction in the number of incidents of Meticilin Resistant *Staphylococcus aureus* (MRSA) bacteraemia (Chart 2) and *Clostridioides difficile* infection, (Chart 3).

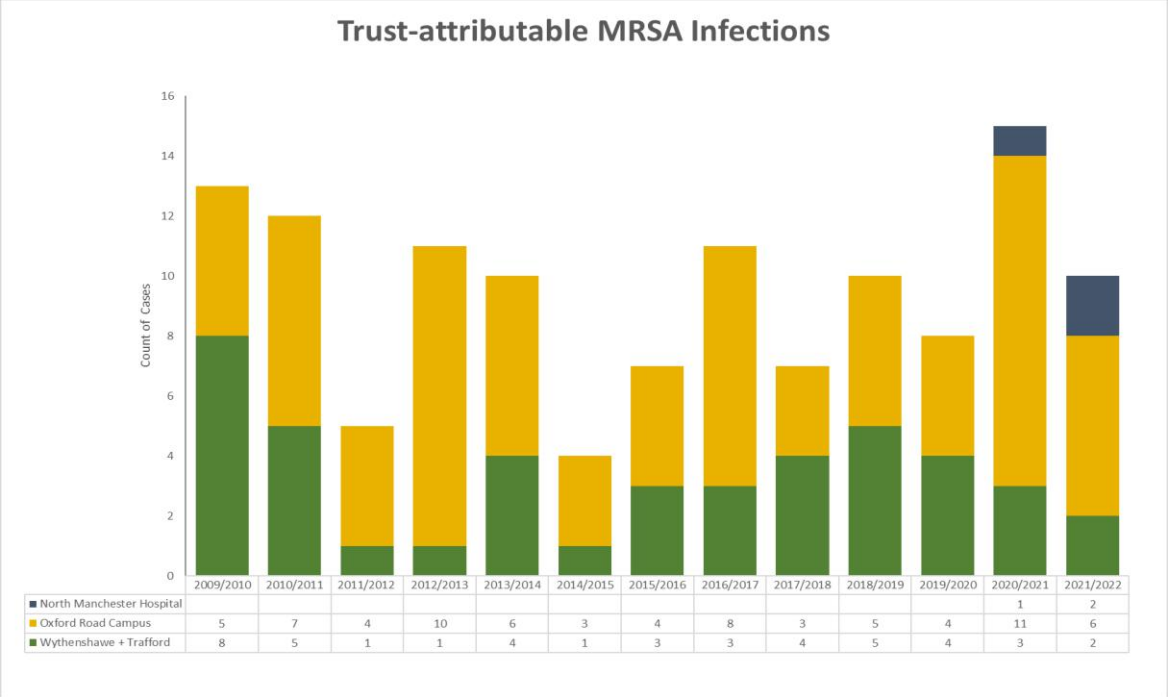


Chart 2: Trust – Attributable MRSA bacteraemia (2009/10 – 2021/22)

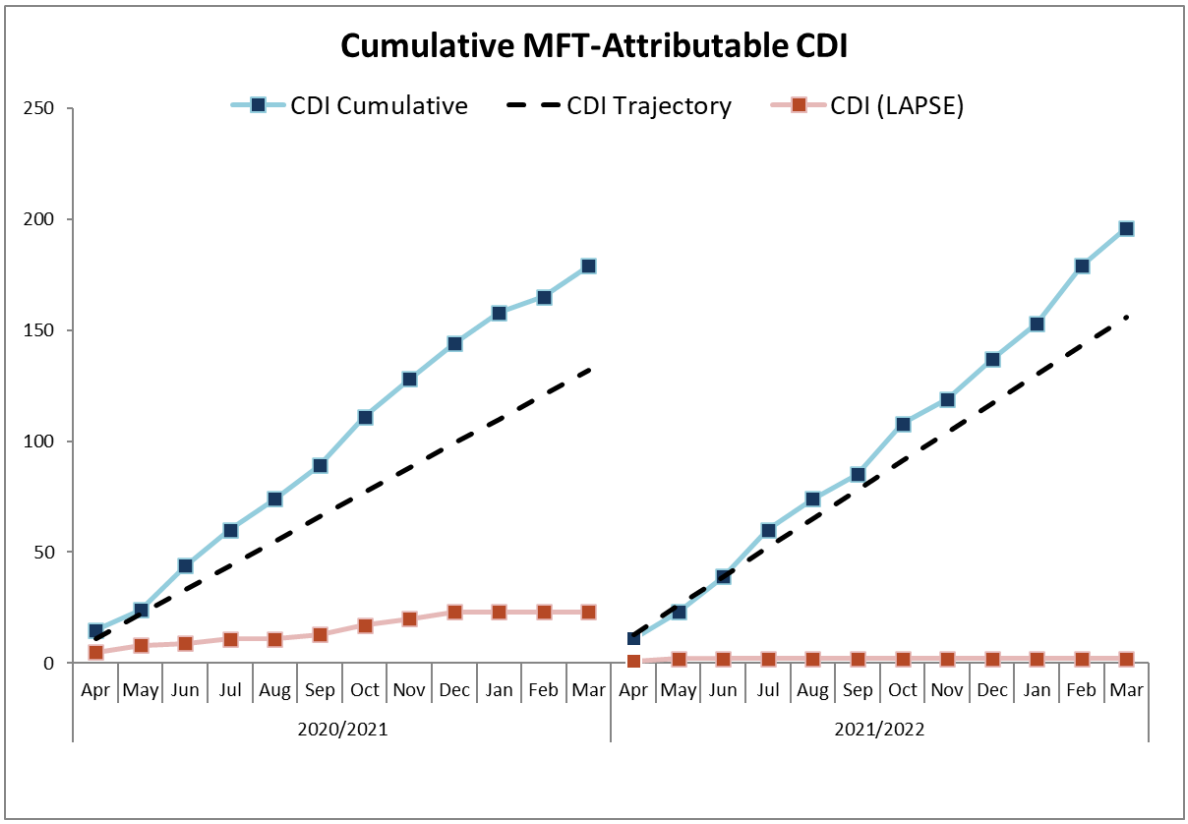


Chart 3: Cumulative Trust Attributable CDI with lapses of care against Trust trajectory

5.1 Key Themes Identified from Investigations into Incidents of MRSA bacteraemia and CDI 2021/2022

The following key themes have been identified from a review of MRSA bacteremia and CDI cases from 2021-2022.

MRSA Bacteraemia	**CDI**
• Non -compliance with MRSA admission screening policy • Manipulated sites not sampled during screening • Delays in commencing MRSA decolonisation therapy.	• Antimicrobial stewardship • Non-compliance with policy of isolating a patient with onset of diarrhoea • Delays in sample collection for laboratory testing.

5.2 Gram Negative Bloodstream Infections (GNBSI)

There was a total of 918 Gram-Negative Bloodstream Infections reported during 2021/2022. Of these, 304 cases (33%) were determined to be hospital-onset, a slight increase on the previous year which saw 299 hospital onset cases of GNBSI. GNBSI figures are considered against a locally calculated trajectory informed by the national reduction objective (50% reduction from 2016 baseline to be achieved by 2023). The previous year's target was 216 cases.

5.3 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Mandatory reporting of all MSSA bacteraemia began in January 2011. A total of 255 MSSA bacteraemia cases were reported during 2021/2022. Of these, 86 cases (34%)

were determined to be hospital-onset. There is currently no reduction objective associated with MSSA bacteraemia incidence.

5.4 Vancomycin-resistant Enterococci (VRE) bacteraemia cases

A total of 31 VRE bacteraemia were reported during 2021/2022 (see Table 2 below for distribution of cases of VRE bacteraemia across MFT). This compares to 34 reported during the previous year and therefore represents a decrease. Individual incidents of VRE bacteraemia were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings. Cases were seen across the organisation, with most cases occurring in Clinical and Scientific Services CSS)/Critical care areas and in Manchester Royal Infirmary (MRI).

Hospital /MCS	Number of Cases
CSS	14
MRI	10
NMGH	1
RMCH	5
WTWA	1

Table 2 Distribution of Cases of VRE Bacteraemia

5.5 Carbapenemase-producing Enterobacterales (CPE)

There were a total of 416 CPE acquisitions recorded for 2021/2022, compared to 244 for the previous financial year. There were 4 attributable CPE bacteraemias reported during 2020/2021, but only 1 trust-attributable CPE bacteraemia reported for 2021/2022. Monthly performance can be seen in Chart 4 which presents CPE acquistion data for all MFT sites.

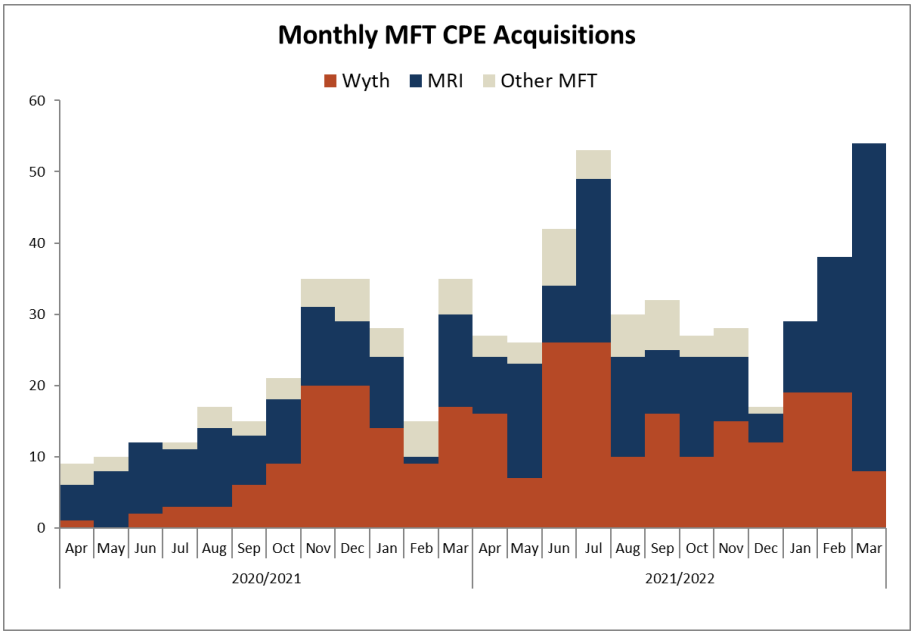


Chart 4: Monthly MFT CPE acquisitions

5.6 Summary of Outbreaks of Infection April 2021 – March 202

Outbreaks of Infection (non-COVID-19)

In total, there were 6827 lost bed days for 2021/2022 due to outbreaks. A total of 12 wards were closed or partially closed over 18 occasions due to outbreaks of CPE, ESBL, MRSA and Diarrhoea and Vomiting between April 2021 March 2022. Control measures were implemented and the outbreaks successfully managed.

Ward	Hospital/CSU	Date of closure	Number of patients affected	Number of staff affected	Total number of beds closed	Number of Days Closed	Number of Bed days lost
MVC/EVC	MRI	15/02/2022	24	0	25	7	175
A5	Wyth	03/04/2021	8	0	28	12	336
A5	Wyth	11/06/2021	34	0	28	20	560
A5	Wyth	15/07/2021	9	0	28	16	488
F12	Wyth	12/11/2021	6	0	28	13	364
F15	Wyth	04/01/2022	15	0	22	19	418
F15	Wyth	02/02/2022	5	0	22	16	352

Table 3: Ward Closures due to CPE (April 2021 - March 2022)

Table 4: Ward Closures due to ESBL (April 2021 - March 2022)

Ward	Hospital/CSU	Date of closure	Number of patients affected	Number of staff affected	Total number of beds closed	Number of Days Closed	Number of Bed days lost
Ward 68	St Marys	09/03/2022	30	0	54	46	2,484

Table 5: Ward Closures due to MRSA (April 2021 - March 2022)

Ward	Hospital/CSU	Date of closure	Number of patients affected	Number of staff affected	Total number of beds closed	Number of Days Closed	Number of Bed days lost
Ward 68	St Marys	15/04/2021	4	0	0	0	0

Table 6: Ward Closures due to Diarrhoea and Vomiting (April 2021 - March 2022)

Ward	Hospital/CSU	Date of closure	Number of patients affected	Number of staff affected	Total number of beds closed	Number of Days Closed	Number of Bed days lost
Ward 85	RMCH	07/02/2021	5	2	9	3	20
Ward 83	RMCH	14/08/2021	4	4	4	6	24
Ward 83	RMCH	20/08/2021	7	6	11	14	154
Ward 2	MRI	07/02/2022	2	1	28	10	280
Ward 1	MRI	11/02/2022	6	0	28	11	308
Ward 86	RMCH	07/03/2022	7	2	27	8	216
Ward 84	RMCH	10/03/2022	8	6	24	6	144
Ward 2	Trafford	31/12/2022	3	3	28	18	504

5.7 Ward 84 VRE outbreak

An outbreak of VRE was identified on Ward 84 in May 2021. There was a total of 26 cases identified. IPC measures were implemented including isolation, screening, environmental decontamination, and patient management. Most cases occurred between May and August 2021. At the end of August 2021 Ward 84 patients were relocated to Ward 86 increasing side room capacity by 60%. This reduced the acquisition rate however there was a further spike of cases in October 2021 of 5 cases. The environment was reviewed in collaboration with IPC and Sodexo and further improvements made. Monitoring of the ward is ongoing with a further 2 cases identified between December 2021 and March 2022. All VRE acquisitions are reviewed at the RMCH accountability meetings.

5.8 Peripheral Blood Culture Trends

There is no national UK standard for contamination rates, but rates should be below 3%, aiming for zero. The most recent contamination rates in adults (>16 yrs.) were 3.5% and 4% for children (<16 yrs).

5.9 Shelford Group Comparison

MFT's performance compared to other members of the Shelford Group can be found in Charts 5 to 8**.** The charts detail the 2021/2022 HCAI rates using KH03 occupied overnight beds data (per 100,000) considering Hospital Onset - Healthcare Associated (HOHA) cases only.

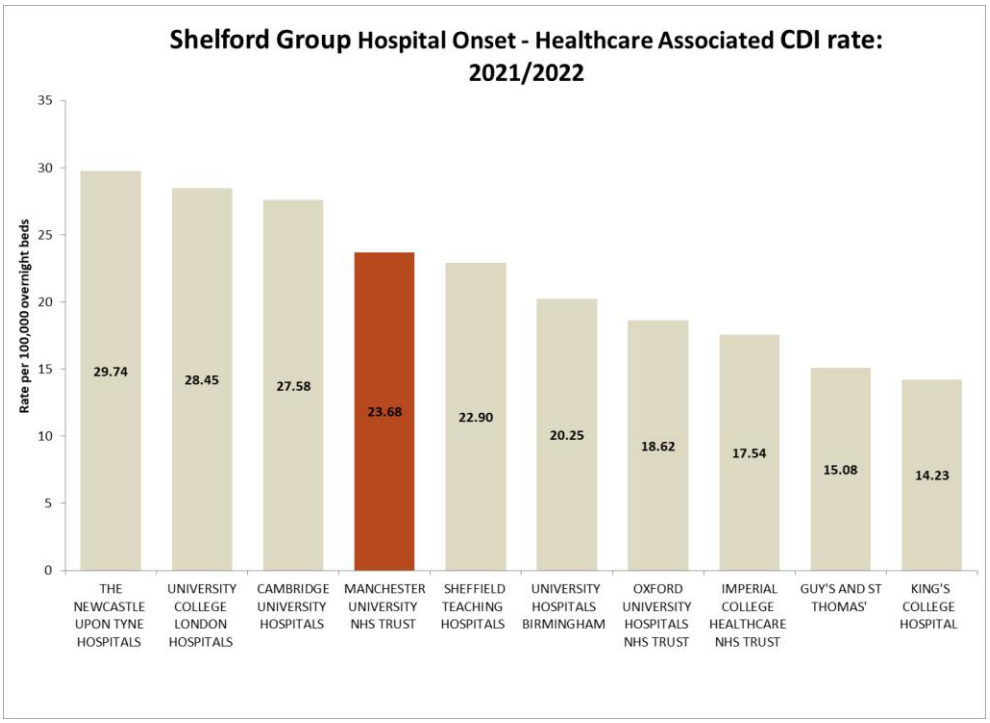


Chart 5 – Shelford Group HOHA CDI rates (per 100,000 overnight beds)

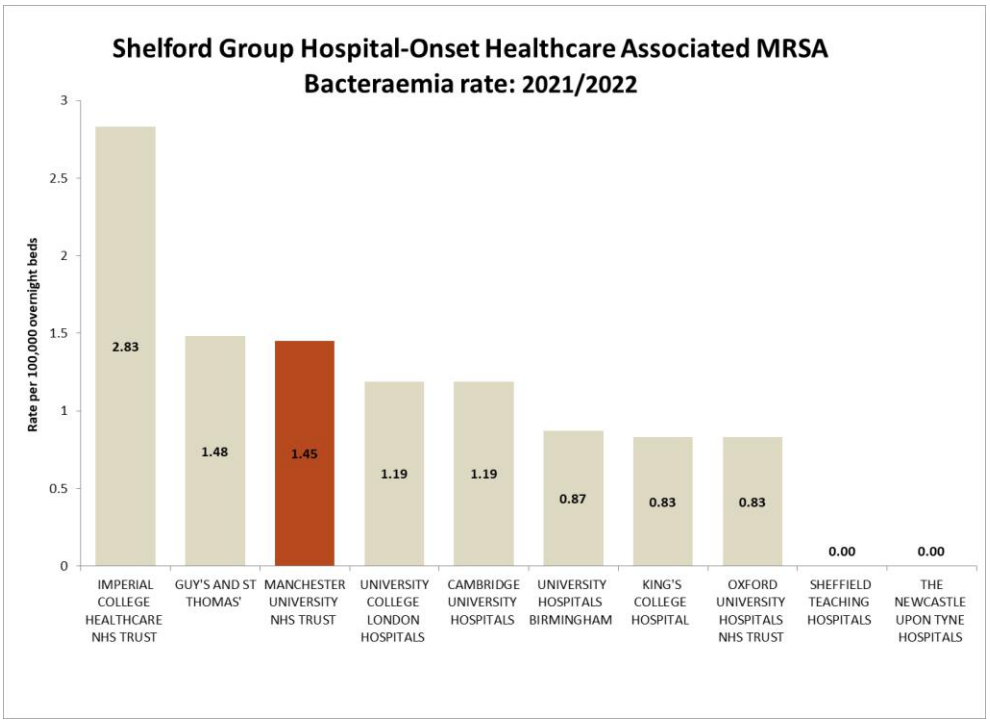


Chart 6 – Shelford Group HOHA MRSA bacteraemia rates (per 100,000 overnight beds)

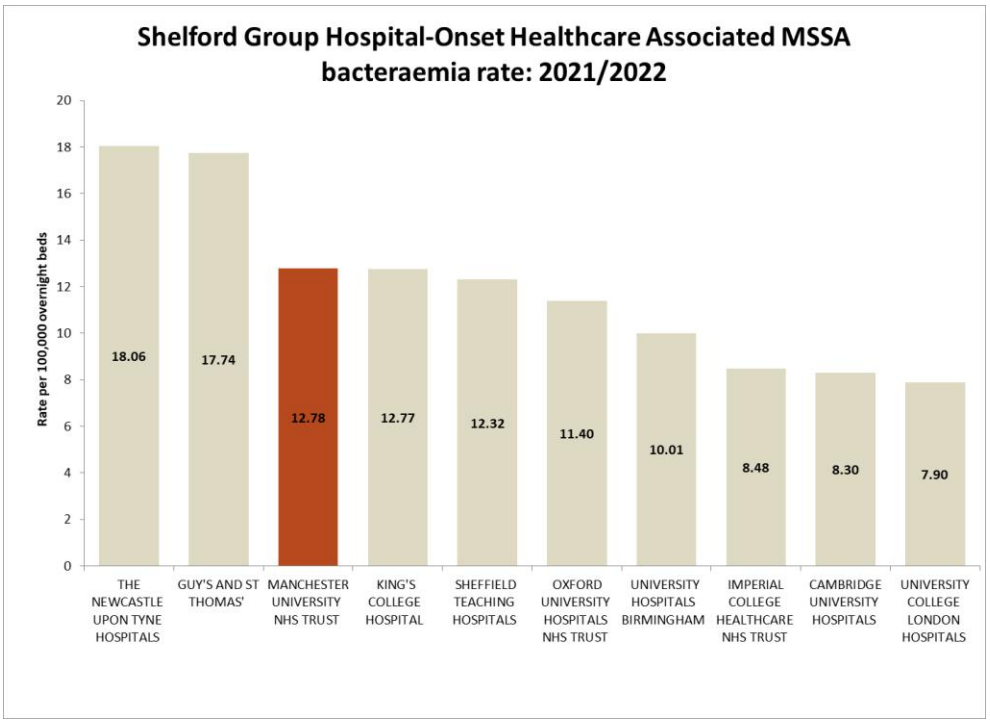


Chart 7 – Shelford Group HOHA MSSA bacteraemia rates (per 100,000 overnight beds)

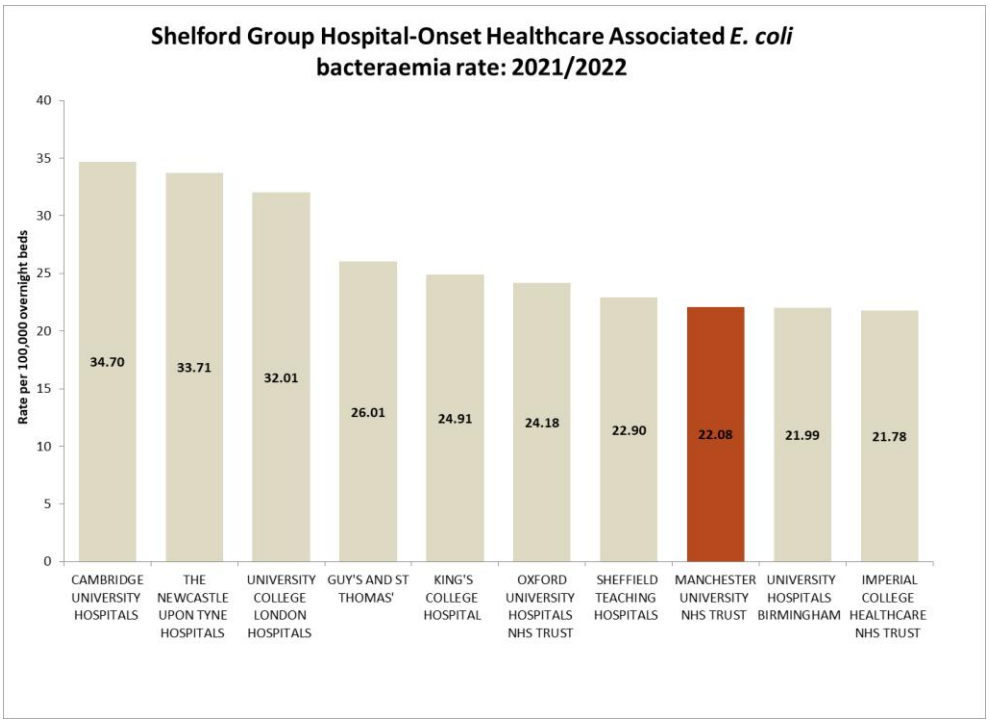


Chart 8 – Shelford Group HOHA *E.coli* bacteraemia rates (per 100,000 overnight beds)

SECTION 6: MFT COVID-19 AND INFLUENZA VACCINATION PROGRAMME

6.1 National Guidance

This year the COVID-19 and seasonal influenza vaccine programmes were combined in accordance with national guidance and were recognised as an essential activity within the MFT Autumn and Winter Plan.

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

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

All Trusts were expected to use the national protocol as the legal mechanism for administration of vaccine to enable greater use of the non-registered workforce to make best use of people's skills. Trusts were able to access both paid and unpaid workforce via their lead employer.

Where agreed locally, NHS Trusts also provided vaccinations to the following:

- Non-Trust frontline health and social care workers
- Local communities using the National Booking Service
- HCW clinics to validate MHRA approved vaccinations or provide additional doses
- Clinical trials participants

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

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

The MFT COVID-19 vaccine rollout commenced on 15th December 2020. The MFT COVID-19 booster vaccine rollout commenced on 22nd September 2021, with co-administration of influenza and COVID-19 vaccines. There was mixed response, with some staff opting for both vaccines and others selecting a single vaccine to date:

- 92.7% have received their 1st COVID-19 vaccine
- 81.6% of clinically vulnerable staff have had a booster/3rd dose
- 90.1% 2nd dose vaccines have been administered
- 74.5% of staff have had a COVID-19 Booster Vaccine
- 61.7% of staff have had their Flu Jab (the target was 85% uptake)
- 48.4% of black and minority ethnic (BME) staff have had a Flu Jab
- 61.5% of BME staff have accessed a COVID Booster vaccine
- 100% of MFT staff have been offered the vaccinations

The seasonal influenza vaccination season commenced on 1st October and ended on 1st March 2022. Flu uptake rates were significantly reduced compared to the same period last year (81.1%). Through MFT Flu Engagement Groups stakeholder feedback has been collected to investigate the reasons for low flu vaccine uptake. These include perceptions of flu as being less of risk due to reduced prevalence, and prioritisation of COVID-19 booster (despite offer for co-administration).

6.3 MFT COVID-19 and Seasonal Influenza Patient Vaccination Programme

The MFT vaccine service supported training, governance, and systems for:

- Local maternity services offering flu-only vaccination in Saint Mary's Hospital and Managed Clinical Services ante-natal clinics (during flu season)
- Designated Patient Flu areas (during the flu season)
- RMCH vaccine services offering COVID-19 vaccines to:
- Paediatric inpatients aged 12-17 in an at-risk group
- Paediatric outpatients aged 12-17 in an at-risk group and have been referred in due to complex vaccination needs and accepted for vaccination by the RMCH vaccine operational group
- Paediatric inpatients aged 5-11 in an at-risk group

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

The MLCO/TLCO School Aged Immunisation Service (SAIS) teams led the delivery of the COVID-19 vaccine to healthy 12- to 15-year-olds in schools in Manchester and Trafford, with the second phase of the programme completed on 31st March 2022.

The second phase required SAIS teams to offer second and first doses to 12 to 173/4-year-olds in school settings before half term (11th February 2022 for Trafford and 18th February 2022 for Manchester) and completed by 31st March 2022. All schools were offered a visit, with some schools offered additional support.

From 24th January 2022 delivery of the programme was via two sub-contracted community pharmacies. Subcontracting arrangements negated the need to augment the SAIS with wider School Health Service and M&TLCO staff and have enabled the SAIS to commence redelivery of other programmes as part of the School Aged Immunisation Programmes (SAIP).

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

There continued to be supplementary offers of COVID-19 vaccination through the Mass Vaccination Centre, Community Pharmacies, Primary Care Networks and Hospital Hubs. A plan to 'catch-up' on core vaccines, delayed by COVID-19 and the need to dedicate staff to the 12-15 programme has been produced which will be implemented throughout 2022.

SECTION 7: ANTIMICROBIAL STEWARDSHIP

7.1 Antimicrobial Stewardship Vision at MFT

In April 2021 the Trust developed a new patient centred antimicrobial stewardship vision and strategy for MFT.

7.2 Vison

- Ensure only patients who have an infection are treated with the right antimicrobial, at the right time, at the right dose for the right duration giving the best outcome and minimising harm.
- Working collaboratively with prescribers, pharmacists, lab services, infection specialists, AMC, hospital boards
- Making stewardship everybody's business with strategic buy in and leadership

7.3 Group Antimicrobial Stewardship Committee (G-AMC)

This year the structure of the Group Antimicrobial Stewardship Committee (G-AMC) was revised, creating a Group wide strategic committee with three working sub-groups, see Chart 9 below. The new G-AMC was in place since November 2021, chaired by the Medical Director for MRI.

7.4 Accountability Structure

The G-AMC report into Group infection Control Committee and Group Medicines Optimisation Board.

The Chair of the G-AMC (supported by the AMS pharmacy team) met with each of the medical directors for the hospitals in the Group to discuss the AMS vision and strategy and understand the accountability structures for AMS within each hospital. Each medical director has been tasked with formally outlining the accountability structure for AMS to the G-AMC at the June 2022 meeting.

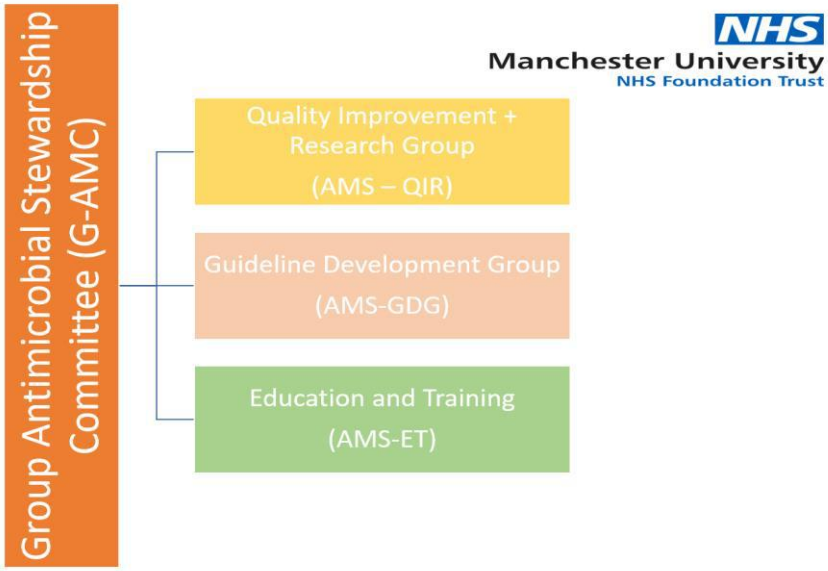


Chart 9 Group Antimicrobial Stewardship Working Sub Groups

7.5 Regional AMR structure

There have been developments in national and regional AMR/AMS structures in NHS England, with a new National AMR lead and a new Northwest AMS lead pharmacist. This had led to further developments in the new ICS structure with the formation of a Greater Manchester AMR Board and an AMS committee. MFT has medical and pharmacist representatives on both groups with the AMR Board being jointly chaired by Associate Medical Director for Research and Innovation, and Consultant Pharmacist as the deputy chair for the AMS committee. The regional AMR workplan will give MFT access to more usable surveillance and consumption data which can help drive forward the AMR plans.

7.6 Antimicrobial Stewardship Team

In October MFT develop and recruited a Consultant Antimicrobial Stewardship Pharmacist this post has been accredited with the Royal Pharmaceutical Society and the post holder is going through the consultant credentialling process. In January 2022 a new Lead AMS pharmacist joined the team.

The AMS pharmacy team developed the clinical roles and have reviewed job plans as a result of COVID-19. The clinical focus will be the admissions units, targeting AMS and diagnostic stewardship at the “front door”. The team have a flexible approach which enables them to act responsively to support clinical areas where there are identified areas of concern such as outbreaks, increased surveillance etc.

7.7 Impact of COVID on AMS pharmacy team capacity

The capacity of the AMS pharmacy team to undertake AMS work was affected by the COVID-19 pandemic. The team maintained responsibility for:

- The continual programme of MFT COVID-19 guideline review and maintenance, responding flexibly to frequent changes to the guidance from NHS England based on the most up to date evidence.
- Maintenance of the COVID-19 new drug supply chain and overseeing the Blueteq process.
- Supporting the daily COVID MDT. Supporting the ward-based pharmacy clinical services.

7.8 Monthly Antimicrobial ‘’ACTION’’ audit

Background

In Summer 2020 the Antimicrobial Stewardship Pharmacy Team revised the antimicrobial audit standards to include more of a focus on the compliance with Trust guidelines, whether diagnostics were taken, and whether documentation was complete. The standards remained in line with the DoH guidelines but aimed to provide more of a detailed picture of the quality of infection management compared with previous audits. The audit was temporarily suspended until August 2021 due to contingency pressures within the department due to Covid-19. The audit was then relaunched on the Pharmassist platform to enable automatic report generation to allow faster feedback of results.

SECTION 8: MAINTAINING A CLEAN ENVIRONMENT

8.1 The Role of the Infection Prevention and Control Team:

The Infection Prevention and Control Team worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo and internal providers to ensure cleaning standards were met across the Trust and any changes required such as increased touch point cleans were introduced throughout the pandemic.

8.2 Contracting Arrangements:

The Trust cleaning services were provided by both internal and external contractors/teams.

- Sodexo Healthcare were the main contractor for the provision of cleaning services across the Oxford Road Campus, including the Dental Hospital, and at Wythenshawe Hospital.
- North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had services provided by in-house teams.

8.3 Monitoring Arrangements:

As part of the contracts, Sodexo were required to self-monitor the performance of cleaning services against key performance indicators. These were reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Estates and Facilities Team.

The services at North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.

In addition, the standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, the Ward Accreditation Process, and the What Matters to Me (WMTM) Tracker, although during the continued pandemic restrictions some aspects of these additional quality measures were reduced or suspended. These results informed areas of best practice and areas where additional focus was required.

Processes were in place to report and escalate cleaning problems. These included: an agreed process which provided users with information on what services should be delivered and how to escalate non-compliance.

8.4 National Standards of Healthcare Cleanliness (NSoC)

A multi-disciplinary team developed the Trust processes to deliver the new National Standards of Healthcare Cleanliness (NSoC) which came into effect from 1 April 2022. The NSoC provides a consistent approach to cleaning across the NHS and aims to deliver improvements in cleanliness standards and reporting of these. In addition, a revised Cleaning Policy has been delivered to incorporate the new NSoC and detail of cleaning responsibilities and audit arrangements.

8.5 Commitment to Cleanliness Charters

As required by the new NSoC Commitment to Cleanliness Charters are publicly displayed in all clinical areas, replacing cleaning schedules, and Star Ratings to demonstrate the

standard of cleaning delivered on each Ward and Clinician Department have been displayed in accordance with the NSoC.

8.6 Infection Prevention and Control Training for Domestic Staff:

All new employees attended a generic induction which included the principles of Infection Prevention and Control.

8.7 Patient Led Assessment of the Care Environment (PLACE):

The PLACE assessments were suspended nationally in 2020/21 due to COVID-19. At the time of writing this report, the national PLACE Team are considering the structure and future development for PLACE.

8.8 WATER SAFETY

8.8.1 Management of Risk for Legionella:

Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

All building and engineering projects were required to provide additional testing if they included modification or connection to the existing water system, including the need to undertake Water Risk Assessments in line with the above guidance.

Site Water Safety Groups (WSGs) continued to meet quarterly to monitor any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works.

Wythenshawe, Trafford, Withington & Altrincham (WTWA) continued to ensure water safety in accordance with Trust policies and procedures, and continues to review, develop, and implement plans and protocols. Training has been developed to support the governance structure. WTWA Trust staff have undergone RP training, L8 & HSG 274 and Legionella risk assessment training in the last quarter.

Since joining the Trust on 1st April 2021, North Manchester General Hospital (NMGH) has undertaken a great deal of work to ensure water safety in accordance with Trust policies and procedures, and continues to review, develop, and implement plans and protocols.
MFT continued to obtain assurances that regulations and guidance are being complied with in community premises, by regular meetings with landlords, requesting copies of documents such as Legionella Risk Assessment and Water Safety Plans that are required under the regulations and general updates on water system compliance and maintenance. Any non-compliances were discussed and addressed at the meetings. Issues that required escalation were taken to the Group Water Safety Committee.

A separate working group was set up to identify "infrequently used outlets" across the Trust and establish protocols for their flushing in accordance with the HTM guidance.

8.8.2 Management of *Pseudomonas aeruginosa* from Water Outlets in Higher-Risk Clinical Areas:

The review of areas classified as Augmented Care for the purpose of sampling for *Pseudomonas* took place across the ORC and WTWA sites and was agreed by Water Safety Groups. Agreed schedules of sampling for *Pseudomonas* were produced and sampling continued in accordance with HTM04-01 Part C.

Oxford Road Campus (ORC) undertook a review of which outlets within Augmented Care Units need to be sampled. In agreement with IPC, it has been decided that from April 2022, samples from outlets within staff areas will no longer be taken. This decision has been ratified by the ORC Water Safety Group.

NMGH is reviewing its processes and systems for the management of *Pseudomonas aeruginosa*, with IPC, the Authorising Engineer (AE) and Responsible Person (RP). This includes risk Assessments to identify outlets for sampling within Augmented Care areas, and protocols for any suspected positive samples. Currently all outlets are sampled, and these are collected internally.

The jointly appointed AE on the ORC site is working well & all parties continue to work collaboratively. The AE carried out a series of audits in 2021 and work is ongoing to address their findings.

NMGH have appointed the same AE Water, as engaged by ORC & WTWA. The AE and RP met monthly to ensure that the actions identified from the audit were completed. A Written Scheme of Control has been implemented, and a draft Water Safety Plan (WSP) has been developed. A contract for the sampling of Legionella using a UKAS accredited laboratory has also been awarded.

WTWA appointed a RP for the sites, with the Wythenshawe site being supported by a Sodexo RP. The AE carried out a series of audits in 2021 and work is in place to address findings.

8.9 VENTILATION:

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. The Group Ventilation Systems Management Safety Policy has been revised to take account of the changes in HTM 03-01: Specialised Ventilation for Healthcare Premises which was published in June 2021.

All new and refurbishment schemes were required to provide verification reports, inclusive of commissioning information and any derogations where new systems were introduced or were being connecting to existing plant. Where new critical ventilation was installed, i.e. theatres, independent validations were carried out which were approved and accepted via AE (Ventilation) and Trust APs.

The quarterly site Ventilation Safety Groups (VSG) continued to monitor risks, issues, failed verifications, remedial works, reactive works, derogations, and lifecycle works. Issues that require escalation are taken to the Group Ventilation Committee.

ORC site appointed a new AE (the same AE as appointed at WTWA), was undertook an initial audit and found significant issues with the ventilation systems serving theatres 1-12.

These have been reported to Theatres Clinical Management & to EFGMB with Sodexo having made significant progress to correct the issues identified. Works are ongoing which will ensure the risks to health & safety of staff and patients within theatre environments are mitigated as much as is practicable. It is anticipated that there will be additional underlying issues therefore a program of further audit visits by the AE is being developed to ensure all other ventilation systems & equipment are reviewed throughout the rest of the year.

NMGH appointed an AE who completed an Assurance Audit. No significant issues were raised, and the Estates Team are progressing the actions that were identified. A Condition Audit was also undertaken across a selection of the theatre ventilation systems. The report is still awaited. Several Local Exhaust Ventilation (LEV) systems within the Dental Unit which were previously maintained by the service, are now being maintained by the Estates Team to improve compliance and management of the maintenance records.

WTWA Estates Teams has worked alongside the close with IPC to provide adequate ventilation conditions to identified COVID-19 wards. Damper surveys were completed across WTWA sites. The AE carried out a series of audits in 2021 and 2022 for WTWA sites and work is ongoing to address their findings. In 2022 the Estates team undertook CPs and HSG258 LEV - COSHH Regulations training.

Across the Community estate, there are three properties where Orthotics Workshops have fume cupboards in situ, with LEV systems. The revised HTM 03-01 defines any system classified as an LEV system under the COSHH Regulations as a critical ventilation system. These are currently managed by the service and not the property landlords or E&F and will be risk assessed.

8.9.1 Achievements:

At WTWA 4 APs were appointed for resilience. New competent persons were appointed to provide support across sites.

8.10 MFT DECONTAMINATION SERVICES:

Maintenance and servicing of all the decontamination equipment across the Trust has continued with the active support of our service contractors.

The decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the STERIS facility based in Wythenshawe in July 2021, for the DSD at ORC to undergo a life cycling refurbishment program which is being undertaken through the Trust's PFI Partner Equans.

All decontamination service provision to the Trust has been maintained to an acceptable and satisfactory level during this period. The refurbishment program is due for completion at the end of June 2022 when the services of the DSD will be transferred back into the facility at ORC.

The Endoscopy Services, across the Trust have continued to provide satisfactory, compliant, and accredited levels of service to all sites. All Endoscope Washer disinfectors and Endoscope Drying Cabinets are regularly tested and validated accordingly. Currently

there is a replacement program for all of the Wythenshawe Hospital Endoscope Drying Cabinets which is progressing well. It is planned that all cabinets will have been replaced with new by August 2022. The Wythenshawe Endoscope Decontamination Department has almost completed its full refurbishment and upgrade program of works during 2021 / 2022. Final handover of the department is expected by the end of April 2022.

The new electronic tracking and traceability system (TDOC) for all flexible endoscope decontamination process has also progressed. Full upgrade was satisfactorily completed at ORC in 2021 together with successful installation of the system into the refurbished department at Wythenshawe Hospital. It is planned via the Trusts Informatics department to upgrade the current systems being used at Withington Community Hospital and at NMGH to TDOC by the end of 2022.

Sterilisation of reusable surgical devices was undertaken centrally on-site at the ORC in the DSD (temporarily transferred to NMGH IN July 2021) and at the HSDU in NMGH. Both Departments are accredited to ISO 13485:2016 (medical devices quality management system requirements for regulatory purposes) and were also assessed and certified as meeting the requirements of the new UK Medical Devices Regulations during 2021.

Wythenshawe, Trafford, and Withington Hospitals continued in partnership with Christies and Warrington to receive their sterile services provision from Steris, the independent decontamination services provider, from their facility in Wythenshawe. This was monitored by the Wythenshawe, Trafford, Withington & Altrincham (WTWA) Estates & Facilities Decontamination Group and through Positional Reports provided by the Contract Manager.

In the community premises, decontamination is confined to the community dental practices where instruments are processed through benchtop sterilisers. The community dental practices are within the remit of NHS Property Services who maintain the sterilisers to HTM 01-05: Decontamination in Primary Care Dental Practices. Annual Audits to HTM 01-05 were undertaken by the dental service during 2021. The audits did not identify that any serious corrective actions were required. The service was curtailed during the Pandemic, but all decontamination equipment was regularly tested and remained in a satisfactory operational condition.

8.10.1 Achievements:

Both of the Trust's Sterile Services Departments have achieved certification against the new UK Medical Devices Regulations (MDR),

Successful retaining of the Joint Advisory Group (JAG) Accreditation requirements where the Endoscope Decontamination Departments are audited as part of the accreditation process.

Successful installation and replacement of the electronic endoscope tracking and traceability across the ORC and Wythenshawe Hospital.

Successful refurbishment and upgrade program for the Wythenshawe Hospital Endoscope Decontamination Department.

SECTION 9: COVID-19

9.1 Fit testing for FFP3 Respirators and Personal Protective Equipment (PPE) Training

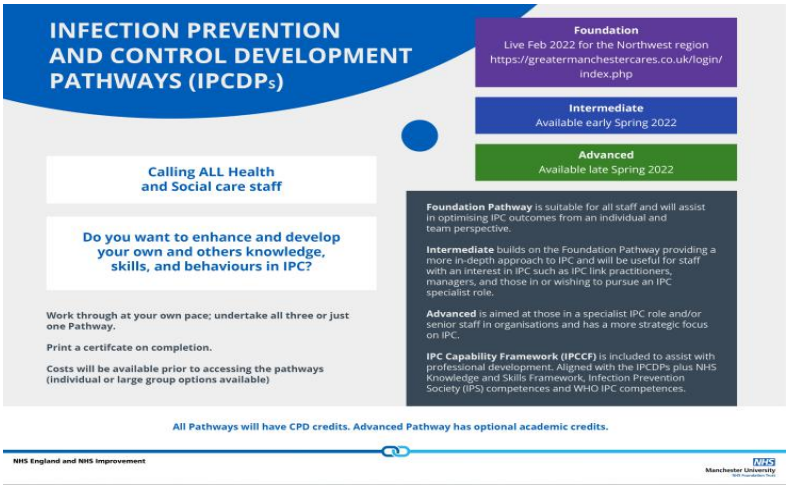
In accordance with the requirements of the IPC Board Assurance Framework (BAF) local Hospitals/MCS fit testing records were transferred to the Central learning hub from October 2021. All key areas across the Trust identified staff who could become fit testers. A range of train the trainer sessions for fit testers were arranged throughout the year and well attended.

An additional requirement of the IPC BAF was to implement and monitor staff trained in the use of PPE. Throughout this year this training has been provided locally by the Practice based Educators (or equivalent). The IPC Team have recently updated a video for donning and doffing PPE. Which will form part of a mandatory training module that will involve individuals watching the video and then undertaking a self-assessment. Results will be recorded on the learning hub.

9.2 The Infection Prevention and Control Development Pathway (IPCDP)

Following a review by the Greater Manchester specialist workforce for IPC the 'Infection Prevention and Control Development Pathway' (IPCDP) was commissioned in October 2020. A member of the MFT IPC/TV Nursing Team was seconded to help develop the programme which has been overseen by the Chief Nurse/DIPC at MFT supported by the regional IPC team. The framework supports the development of knowledge, skills, and behaviours in IPC in all healthcare workers and consists of three levels:

- Foundation – aimed at broadening participants understanding of IPC and application to everyday practice in all areas.
- Intermediate – aimed at further learning for staff in relation to application of IPC knowledge into practice
- Advanced aimed at development of specialist IPC knowledge with an optional final unit to gain 20 Level 7 Masters accreditation points with the University of Bolton



The Foundation and Intermediate levels were available to access nationally on the Greater Manchester Cares learning hub and the Advanced module will be uploaded in May 2022.

The Foundation level is available free of charge (until 1st April 2023). Participants from a wide range of roles have accessed this level, from varying healthcare settings including Acute, community and health and social care and feedback to date is excellent.

The Intermediate and Advanced Levels are available at a cost, and access may be purchased via an organisational or individual basis. No participants have accessed these levels to date as details of payment and enrolling are due to be confirmed by April 2022.

SECTION 10: END OF YEAR REPORTS

10.0 End of Year Reports

The Chief Nurse/DIPC undertook an end of year IPC review with the IPC Leads for each Hospital/MCS/ LCO during March 2022. The review meetings were held individually with the Directors of Nursing, supported by their Senior Team and local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by the Associate Medical Director for IPC and the Assistant Chief Nurse IPC/Tissue Viability/Clinical DIPC**.** The sessions were an opportunity to reflect and focus and feedback was very positive from all those involved. Common themes to emerge included:

- Low level compliance with Trust screening/isolation policies particularly in clinical areas where there are insufficient isolation facilities
- Low level compliance with IPC principles
- Lack of consistent engagement with some professional groups in the IPC agenda
- Environmental factors concerning the age of some areas of the estate.

The Hospital/MCS/LCO leads are reviewing and updating their local IPC action plans and will report to the Group Infection Control Committee on outcomes.

The Hospital/MCS/LCO teams were supported to prepare and attend the review by a named IPC Nurse and Infection Control Doctor. A summary of all the reviews can be found in Appendix 3.

SECTION 11: CONCLUSION and RECOMMENDATIONS

11. This report demonstrates the response to the second year of the pandemic of COVID-19. It evidences the commitment, dedication, and hard work of all staff at all levels of the organisation to work together to achieve safe standards of patient care in unprecedented circumstances.

As this report demonstrates, there is no room for complacency. To maintain patient safety and reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. It is imperative that practice and attitudes do not return to pre-pandemic practices.

The Trust would like to acknowledge the contribution of all staff across all disciplines, including volunteers and patients in supporting efforts to prevent, control and manage infections.

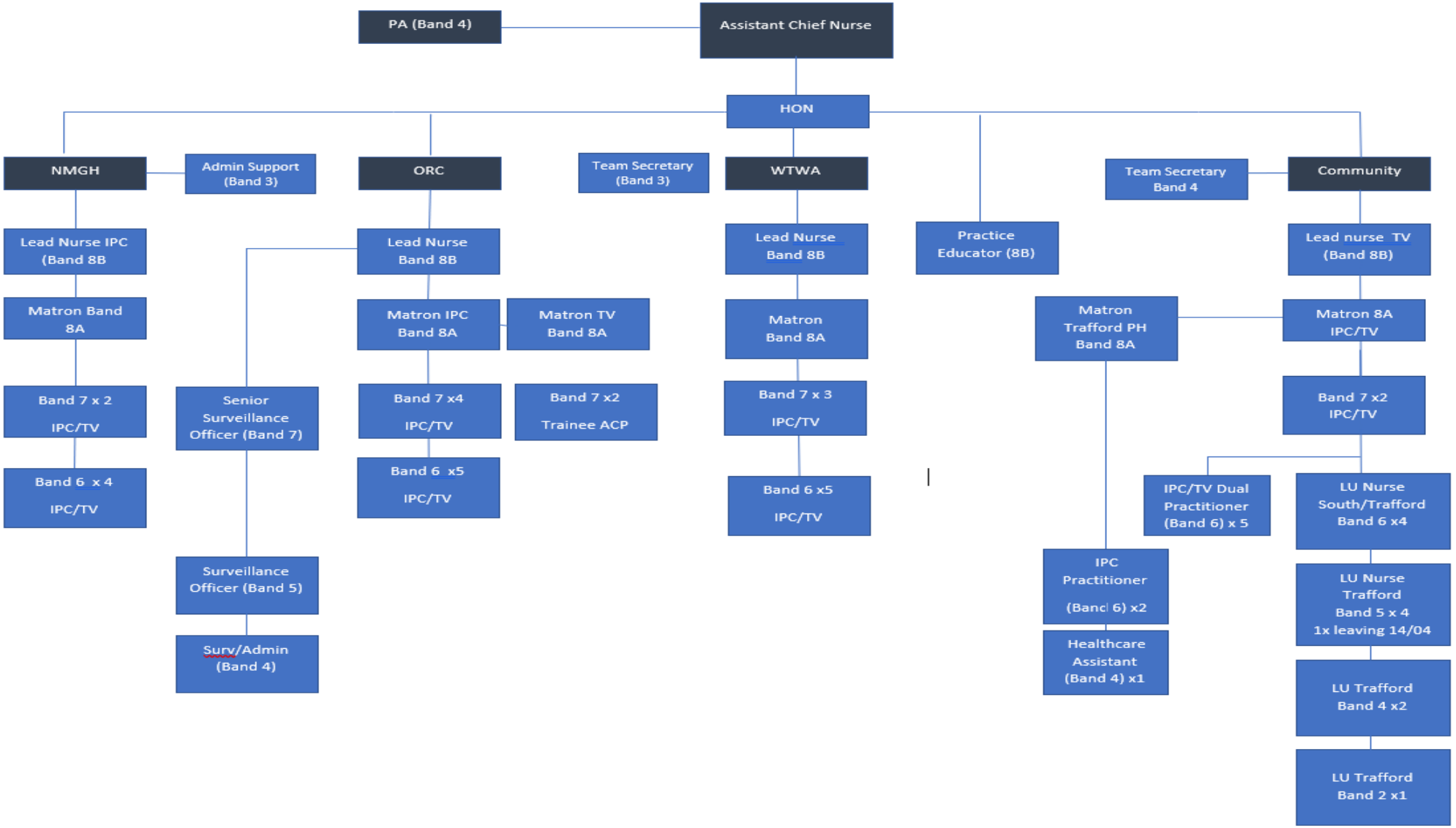
Staff are committed to the learning and continuous improvement highlighted in this report and will continue to strive to deliver the safest and best care in IPC.

11.1 RECOMMENDATIONS

The Board of Directors are asked to receive this report for April 2021 to March 2022 and approve for publication.

Appendix 1

MFT IPC/TV Nursing Team Structure 2021/22



Appendix 2

GROUP INFECTION CONTROL COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Group Management Board has established a Committee to be known as the Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Infection Control Committee is chaired by the Chief Nurse/ Director of Infection Prevention and Control.

2. MEMBERSHIP

2.1 Membership shall consist of:

Chief Nurse/DIPC (CHAIR)
Associate Medical Director (Infection Control)
Assistant Chief Nurse Clinical DIPC
Consultant Virologists
Directors of Nursing
Head of Nursing IPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
LCO to Hospitals/MCS
Consultant in Communicable Disease (Public Health England)
Lead Antimicrobial Pharmacist
Director of Estates and Facilities
Assistant Chief Nurse, Patient Safety & Clinical Governance
Assistant Director, Employee Health & Wellbeing
Chair of Antimicrobial Committee

All group executives have an open invitation to and may attend committee meetings

2.2 No business should be transacted at the meeting unless a minimum of ten members are present, which must include the Chair or Deputy Chair, four Hospital Clinical Leads, and either the Director of Nursing (Corporate) or the Assistant Chief Nurse/Clinical DIPC

3. ATTENDANCE AT MEETINGS

3.1 The Infection Control Committee may require the attendance of any Trust employee (or agent of the Trust)

4. FREQUENCY OF MEETING

4.1 The Committee will meet every three months (four times a year) but may be convened at other times as deemed necessary.

5. OVERVIEW

5.1 The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

5.2 The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence based practice and standards.

6. SCOPE AND DUTIES

6.1 Provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets.

6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites.

6.3 Approve the programme of work of the Trust Clinical Infection Control committee.

6.4 Receive Hospital/MCS ICC performance and exception reports

6.5 Receive, review, and ratify group policies, clinical pathways, and reports, including the Annual Infection Control Report.

6.6 Approve the annual audit calendar to provide assurance that standards are met and any required changes to practice, systems and processes are delivered.

6.7 To report to the Group Management Board on performance against infection control indicators and audits, including actions taken to address any areas for improvement.

6.8 To determine and commission programmes of work required to deliver the work programme of the Infection Control Committee

6.9 Oversee the Trust's involvement in and response to, internal and external assessments and inspections.

6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

6.11 Approve the Trust's Annual Infection Control Report.

6.12 To describe, review and monitor the principle and significant risks related to infection control on behalf of the Trust and present these with the plan of controls to the Group Management Board and Risk Management Committee.

6.13 The Infection Control Committee will receive exception reports from the Hospital/MCS Infection Control leads where performance is out with the standards set out in the IPC strategy

6.14 The Infection Control Committee will receive at each meeting a report from the Trust Infection Control Group to include:

1. Policy and pathway development
2. Infection Control Group activity
3. Changes to national or local strategy
4. Trust wide themes identified from adverse events

7. AUTHORITY

7.1 The Infection Control Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

8.1 The Committee will report to the Group Management Board.

8.2 The Committee will work closely with relevant Group Committees and the Clinical Advisory Committee and will provide assurance to the Board of Directors in relation to infection prevention and control

8.3 The minutes and exception report (as required) will be considered at the next Risk Management Committee and Quality and Performance Scrutiny Committee

9. REVIEW

9.1 These terms of reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

1. 75% attendance of all listed members or nominated deputy
2. Presentation of the Annual Infection Control Report.

Appendix 3

Royal Manchester Children's Hospital and Managed Clinical Services End of Year Infection Prevention and Control Update March 2022

Framework for IPC within Hospital/MCS

RMCH/MCS IPC

Director of Nursing – Julia Birchall-Searle

Clinical Lead – Graham Mason – Associate Medical Director / Consultant Paediatric Critical Care

Deputy Director of Nursing – Karen Vaughan

IPC Nurses – Lorraine Durham and Karen Mathieson

Lead IPC Doctor – Nicholas Machin

IPC Committee Meetings

Chair – Julia Birchall-Searle

Microbiology – Nicholas Machin

Frequency – Bi-Monthly

IPC KPI Meetings

Chair – Karen Vaughan

IPC – Karen Mathieson

Line Specialist – Holly Kay

Frequency – Weekly

IPC Accountability Meetings

Chair – Julia Birchall-Searle

Clinical Lead – Graham Mason

Microbiology – Nicholas Machin

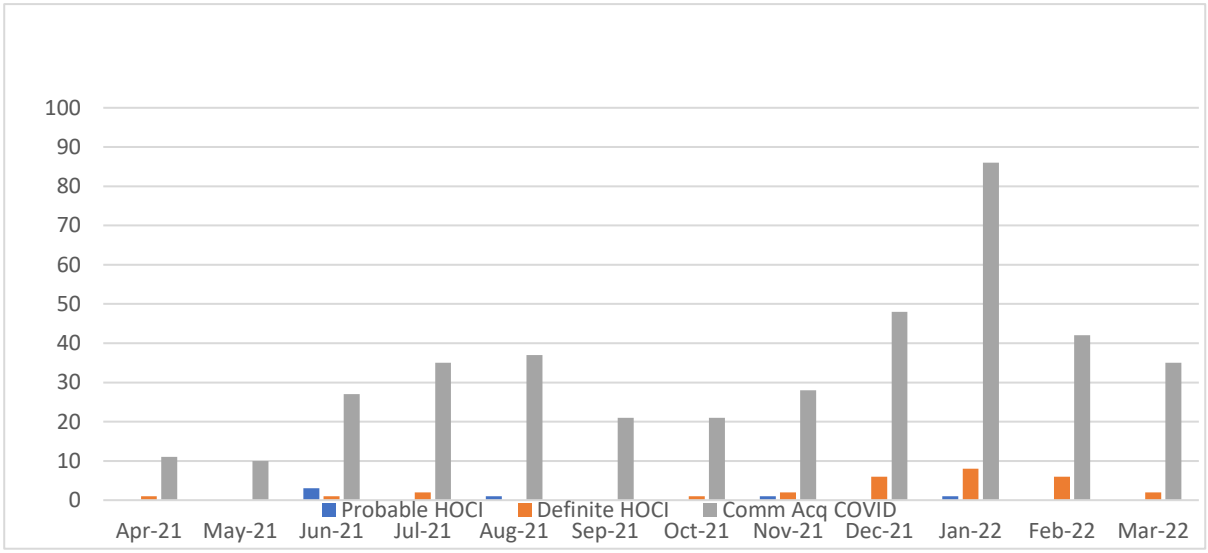
Frequency – As required

RMCH/MCS IPC Committee Meeting Representation

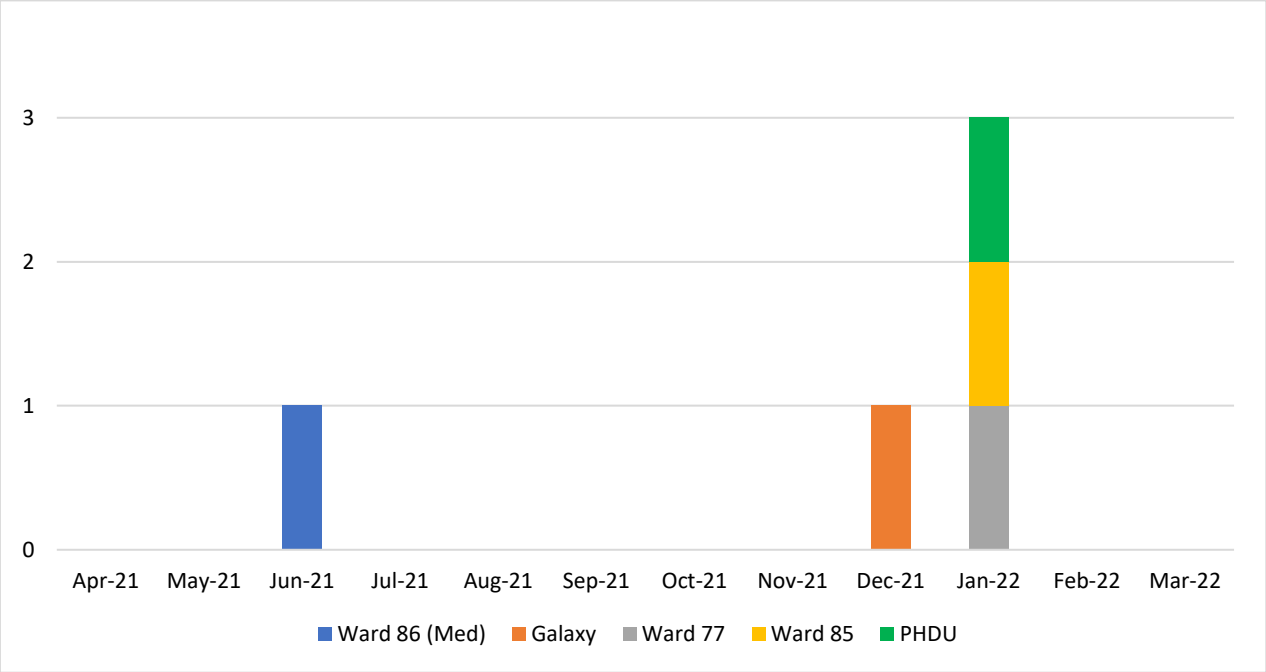
Director of Nursing, Clinical Lead, Deputy Director of Nursing, Microbiology, IPC Nursing, Divisional Head of Nursing, Lead Nurses and Matrons, RMCH Pharmacy, Lines Nurse Specialist, Sodexo and Estates representative.

COVID-19

Graph 1 - Total Number of COVID-19 patients (from April 2021 - March 2022)



Graph 2 - Covid-19 Outbreaks – April 2021 to March 2022



Key Issues

- Resident parents
- Mask compliance
- Share parent facilities
- Home leave
- Environment cleanliness
- Pre-admission screening
- Achieving Day 3 and Day 7 testing consistently.

Actions taken

- Parents information developed in line with the Visiting Policy, which includes guidance on mask wearing, movement around the clinical environment and use of shared parent facilities.
- Resident parents supported to complete Lateral Flow Testing.
- Collaborative working with Ronald Macdonald House.
- Testing prior to home leave and on return in place, patients return to cubicle or 'home leave' bay. Development of a home leave Algorithm
- Ward Manager / Matron and Sodexo walk rounds reinstated, with local information developed for all areas on supervisor contact and escalation process.
- SHINE audit documentation refreshed with relaunch through Quality Lead Nurse.
- IPC visibility supporting environmental walk rounds.
- Lateral flow testing being considered for on the day screens patients.
- Day 0, 3, 7 Testing audit with accountability reporting in IPC Committee.

Lessons learned

- Review of HOCI's – predominant finding of link to either positive parent or following home leave.
- Resident parent mask wearing – need for increased information to parents relating to need at all times even in cubicles, but not possible to achieve 24 hours per day.

Healthcare Associated Infections

Table 3 – HCAI – Bacteraemia and CDI

HCAI incidents	21/22	20/21	19/20	Threshold from AOF 21/22	Additional information on 21/22 alerts
MRSA Bacteraemia	1	2	0	0	No gaps identified, 2nd MRSA Bacteraemia for this patient – complex skin condition – difficult to manage line site, multiple team management requirement for line site.
CPE Bacteraemia	1	0	2	NA	Gaps identified in line documentation; gaps identified in clinical skills for port management.
VRE	5	2	0	NA	Haematology/Oncology Patients – Line documentation good, gaps in applying all aspects of CVC Guidelines due to specific care needs (skin wash / parafilm)
GNBSI	42	33	30	31	Predominantly Haematology/Oncology/Gastro Patients – Line documentation good, gaps in applying all aspects of CVC Guidelines due to specific care needs (skin wash / parafilm). Patients at high risk of translocation due to complex abdominal anatomy, mucositis and typhlitis. High incidence of immunocompromise in cases reviewed. GNBSI Action Plan Progress - On Track / Business as Usual (Appendix 1)
CDI	3	3	2	2	Attributable, unavoidable cases, complex patients, immunocompromised/complex abdominal anatomy, multiple antibiotic usage .

Table 4 – Bacteraemia Breakdown by Department

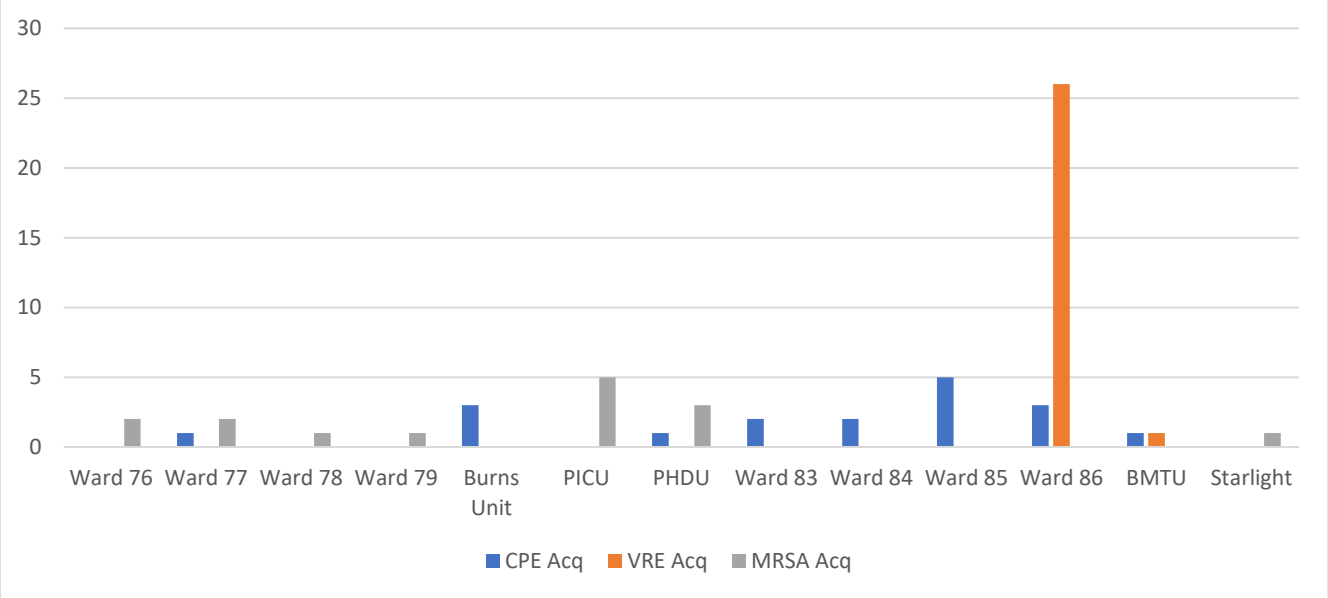
HCAI	Ward	Count
MRSA Bacteraemia	PHDU	1
CPE Bacteraemia	Ward 85	1
VRE Bacteraemia	Ward 86	3
	BMTU/SCU	2
GNBSI	BMTU/SCU	14
	Ward 86	10
	Ward 77	6
	PICU	4
	Ward 85	3
	Ward 84	2
	Ward 81	1
CDI	Ward 77	1
	Ward 86	1
	PICU	1

Table 5 – HCAI – CPE/VRE/MRSA Acquisitions

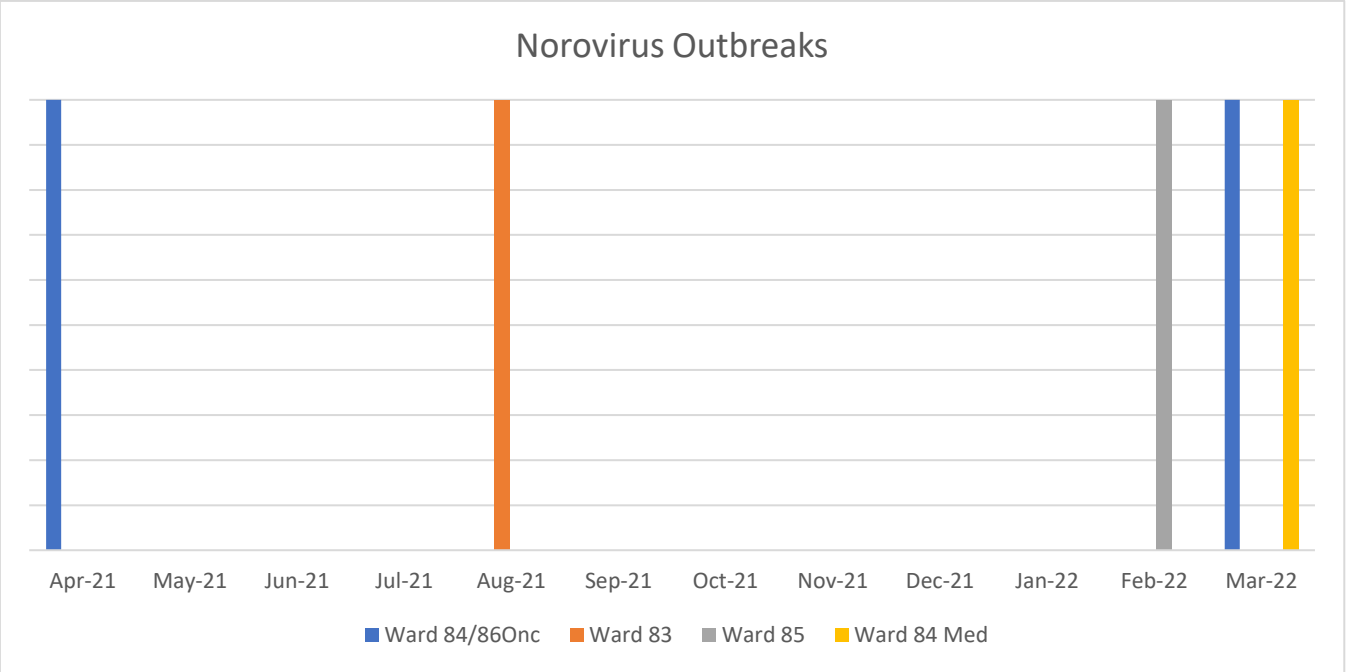
HCAI incidents	21/22	20/21	19/20	Themes / Actions
CPE	15	13	24	• 20/21 overall hospital activity reduced due to pandemic, improvement in position noted from 19/20. • Theme in cases in 21/22 of acquisitions in areas where no other known positives in the ward. • Overall screening compliance improved.

				• Increased need to risk assess CPE positive patients and nurse in bays by a sink following Paediatric IPC Principles to Support RSV/COVID Surge Response Plan, (2021). • All CPE Acquisitions heard at KPI.
VRE	27	9	7	• All cases in 21/22 in haematology/oncology patients with 26 of the cases being linked to one Ward. • Majority of cases occurred between May and Aug 2021. Haematology/Oncology ward relocated late Aug 21 to an area with 60% increase in cubicles which resulted in an immediate reduction in acquisitions occurring. • There was a further spike of 5 cases in Oct/Nov 21, partnership working with IPC and Sodexo occurred to review the environment and suggest further improvements. • 2 cases between Dec 21 and Mar 22. • Ongoing environmental monitoring in place. • All VRE Acquisitions heard at KPI from Jan 2022.
MRSA	22	12	18	• Overall screening compliance improved. • Good recognition and response to positive results with pathway being implemented at point of alert. • Increased need to risk assess MRSA positive patients and nurse in bays by a sink following Paediatric IPC Principles to Support RSV/COVID Surge Response Plan, (2021). • All MRSA Acquisitions heard at KPI.

Graph 6 – Acquisitions Breakdown by Department



Graph 7 – Outbreaks of Infection, (excluding COVID-19) - April 2021 to March 2022



Themes / Actions

- Increase in Norovirus outbreaks in the total 12 months
- 2 outbreaks in same area, (84/86) consistently at full bed capacity and over, with high proportion of resident parents. Same area also had increase in VRE Acquisitions through the year, with actions identified in Table 5.
- Feb/Mar 22 outbreaks during a period of increased community prevalence.
- All outbreaks involved patients, parents and staff.
- IPC / Sodexo walk rounds provided with regular sessions being co-ordinated for all areas to be led by Matron and Lead Nurse.
- SHINE Audit refreshed and re-launched.
- Consistent approach to Mattress Audit agreed for all areas.
- Frequency of local Hand Hygiene Audit increased to weekly.

Compliance with IPC Clinical Practice *(% per clinical unit)*

Key:		Hand Hygiene and PPE Audit Results					
95%-100% Compliance							
75%-94% Compliance		Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken?	Is PPE doffed in the correct order?
Below 75% Compliance							
Not Applicable							
		Nurses	Medical	AHPs	Other		
Hospital/MCS		SUM%	SUM%	SUM%	SUM%	SUM%	SUM%
RMCH/MCS		97%	88%	95%	91%	96%	96%

Actions taken in areas where there is less than 95% compliance

- Frequency of hand hygiene increased to weekly in areas where compliance below 95%.
- Professional challenge in clinical area, with escalation of any concerns to relevant professional lead.
- Review of medical staff induction to ensure to ensure hand hygiene included.
- Light Box campaigns.
- Review of 'other' group – identified concerns relating to domestic staff compliance – joint working with Sodexo supervisors, Hospital School and Play Therapists.

ANTT Compliance for Nursing

- 100% compliance maintained across clinical areas (excluding those on Maternity Leave, Long Term Sickness).
- Process of assessment reviewed in areas where complex medicine regimes are administered to ensure assessment process replicates the level of complexity.

Fit Testing Compliance

Number of staff (approx.) required to be fit tested	staff fit tested to 1 brand of FFP3 respirator only	staff fit tested to 2 brands of FFP3 respirator
1800	763	397

Recovery

Priorities 2022/2023

- Review of cubicle capacity in RMCH and options to increase due to increasing challenges in achieving required isolation in line with IPC guidance impacting in long waits in PED, delays in external admissions and delayed flow out of PCC.
- Confirm need for continued use of Surfacide UV Cleaning system. High rate of breakdown/repair requirements with increasing maintenance cost. Not being used consistently across wards and Deprox used in high risk / outbreak circumstances.
- Implement Antimicrobial Stewardship support – Graham Mason, Nicholas Machin and Paddy McMaster representing RMCH at the group antimicrobial stewardship committee. Planned site meeting April 2022 with RMCH colleagues and Jon Simpson and Fran Garraghan to discuss and agree RMCH strategy and action plan for antimicrobial stewardship.
- Introduce Divisional Accountability reports to IPC Committee to include, Clinical Practice Compliance, CVC Audit, HCAI, Outbreak Information, key themes, findings and action plans.
- Introduce LFT for low risk patient pathways.
- Review CVC Audit results in conjunction with GNBSI alerts to demonstrate effectiveness of achieving complete compliance with CVC guidance. (Anti-microbial skin wash, toralock, parafilm and kouros cap usage).

NMGH End of Year Infection Prevention and Control Update March 2022

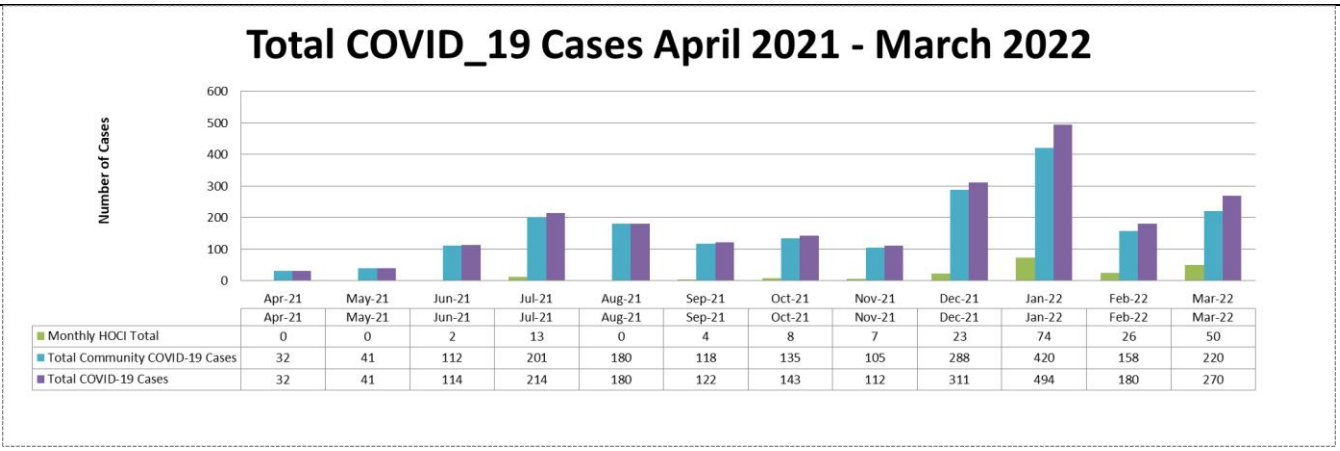
Framework for IPC within Hospital/MCS

- NMGH IPCC is chaired by Director of Nursing, core members are the Divisional and Corporate HONs, Lead Nurses, Deputy Medical Director, IPCC Matron and Lead Nurse, Directorate Manager for AHPs (AHP Clinician) Estates and Facilities Matron.

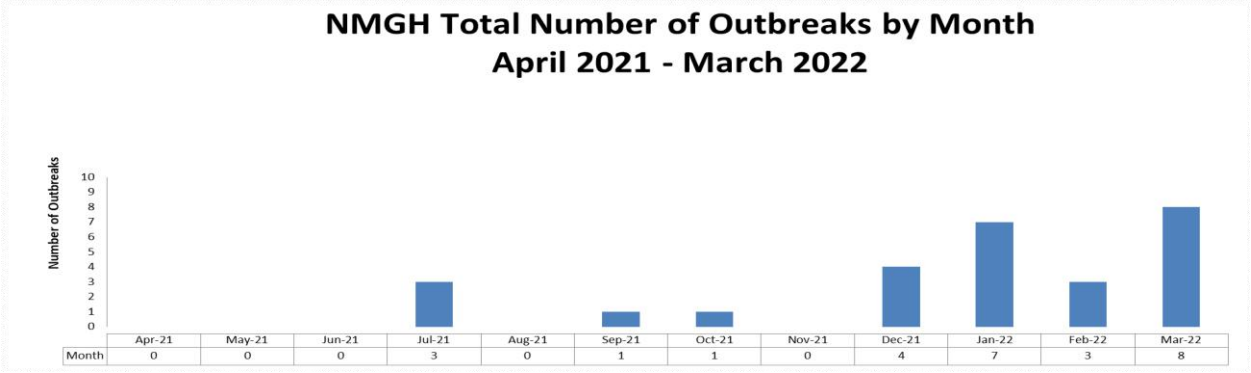
- IPCC meets monthly and has associated action log that Is reviewed at the monthly meetings. The committee reports into NMGH Quality and Safety forum, which receives minutes and items for escalation. Minutes of the hospital meeting are overseen at Group IPCC
- Support and advice from Group IPC transferred to MFT January 2022
- NMGH has a thrice weekly outbreak management meeting scheduled as a standing rolling forum which is linked with the operational management of the site. This is led by the DoN/DDoN to ensure that there is a clinical IPC oversight and support of issues and decisions to support patient flow.
- During the COVID 19 pandemic an operational IPC meeting was held biweekly, chaired by DDoN to support rapid decision making and supporting the clinical teams with changes IPC guidance.
- Subgroups that report into the IPCC are
  NMGH Cleaning Committee
  Catering Report
  Estates & Facilities Report
  Water Safety Group & Legionella
  Decontamination Committee
- Ventilation Theatres/Endoscopy
- Good engagement from antimicrobial pharmacist who is engaged and active across the site
- *Record of attendance at meetings*

COVID-19

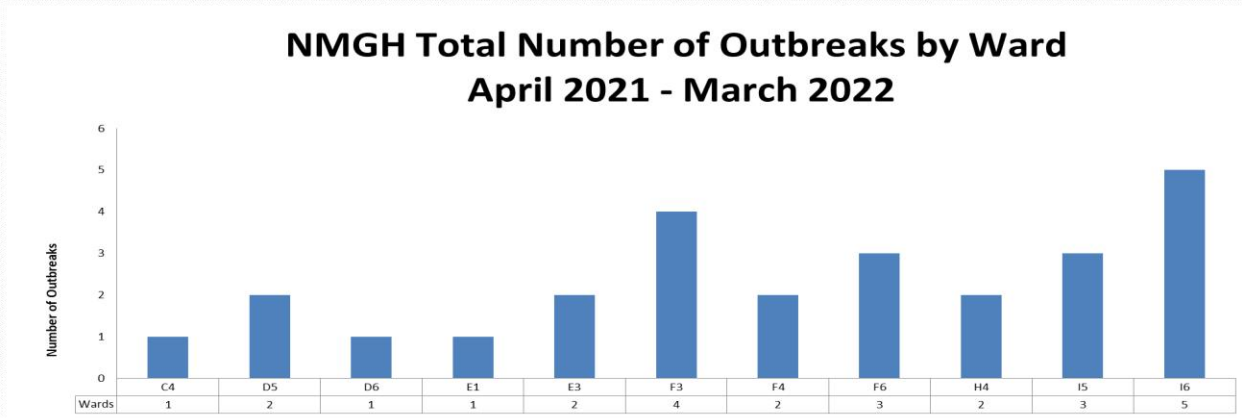
- During 2021/22 the hospital has reported 2224 COVID 19 cases, 193 (**8.7%**) of these cases were nosocomial acquisitions. The percentage of nosocomial COVID 19 cases reported for the site in the previous year was **12.8%**. The site clinical teams have focused on the maintaining high standards around the fundamental standards of IPC practice, along with ensuring and checking the vaccination status of patients accessing services.
- Key challenges for the Hospital is the ward and department environment and ongoing estate issues which pose a challenge to social distancing, due to the close proximity of bed spaces, lack of side room capacity and poor ventilation.
- Hierarchy of controls implemented with risk assessment for each ward and escalation process for use of FFP3 respirator masks
- NMGH has an excellent working relationship with the Estates and Facilities Teams who are responsive and reactive to the requirements of the clinical areas.
- All areas have implemented a fundamental standards checklist which is completed weekly by Matrons
- Outbreak meeting stood up to daily
- Implemented a local patient surveillance system
- Swabbing compliance measured through monthly point prevalence
- Results acknowledgement-Implemented senior nurse check out of hours to prevent delays in recognition of positive results.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Monthly HOCI Total	0	0	2	13	0	4	8	7	23	74	26	50
Total Community COVID-19 Cases	32	41	112	201	180	118	135	105	288	420	158	220
Total COVID-19 Cases	32	41	114	214	180	122	143	112	311	494	180	270



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Month	0	0	0	3	0	1	1	0	4	7	3	8



	C4	D5	D6	E1	E3	F3	F4	F6	H4	I5	I6
Wards	1	2	1	1	2	4	2	3	2	3	5

Actions taken

- There was an increased surveillance of fundamental standards
- Campaign was relaunched around hand hygiene and PPE compliance
- Monthly swabbing point of prevalence was introduced and monitored through IPCC
- Introduced Senior Nurse oversight of COVID 19 results Out of Hours
- Provided training program on swabbing regimes
- Developed risk assessment for hierarchy of control breaches, which was adopted across group
- Relaunched key messages through themes of the week and huddle forums
- Increased observational audit from Matrons/Lead Nurses
- Developed information for supporting inpatient visiting
- Increased scrutiny and overview of LFT Compliance
- Reviewed all hospital acquired cases through HOCI Panel
- Duty of Candour process implemented but linked and cross checked in HOCI panel
- Introduced swabbing at point of referral in ED rather than decision to admit, which reduced swab turnaround times

Healthcare Associated Infections

- *Incidents of MRSA/VRE/Gram neg bacteraemia/ CDI (from April 2021 - March 2022) – in a chart see example below:*

	Target 2021-2022	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD Performance/ Target
MRSA BSI	0	0	0	0	0	0	0	2	0	0	0	0	0	2/0
MRSA Acquistion	20	0	1	0	1	0	0	0	1	0	2	0	0	5/20
MSSA BSI	10	0	0	0	1	0	0	1	0	1	0	2	2	7/10
GNB Total	31	1	1	3	2	1	3	1	5	5	3	5	1	31/31
E.coli BSI		0	0	1	2	1	0	1	3	4	2	4	1	19
Klebsiella BSI		1	0	2	0	0	2	0	2	1	1	1	0	10
Pseudominas BSI		0	1	0	0	0	1	0	0	0	0	0	0	2
CDI	31	2	1	1	1	1	1	4	2	5	2	4	3	27/31
CPE Acquisition	5	0	0	0	1	1	0	1	0	0	0	2	0	5/5
VRE BSI	10	0	0	0	0	0	0	0	0	0	0	0	0	0/10
COVID-19 HOCI		0	0	2	12	0	4	7	4	20	71	23	50	193

NMGH has not reported any outbreaks other than COVID 19

NMGH has a process of accountability reviews and oversight in place however this is an area where we are currently focusing on strengthening as there are separate forums which report into IPCC and following review, we are looking to bring all the forums under a single process. Accountability meetings are chaired by DoN/DDoN with attendance from MD/DMD. During January/Feb we have seen a delay in the timely completion of RCA which is now being monitored with HoNs weekly.

Issues identified through RCA process

MRSA/MSSA Bacteraemia

- IV care, management, and escalation for difficult access
- ICP implementation
- Delay in decolonisation

GNBSI

- Delays in Sepsis screen pathway
- Blood Culture stickers not evidenced
- Nurse cleaning failure noted
- <90% level 2 IPC mandatory training
- Failed elements of ward VIP/Catheter audits
- Omissions in PICC daily charting
- Omissions in urinary sampling

CDI

- Missed stool sampling
- Failed HH/PPE audits
- Missed CDI risk assessments
- Inappropriate ABX prescribing by the GP
- Inappropriate NMGH clinicians prescribing
- Delayed isolation

Overview of actions taken

- Communication campaign around IPC fundamentals of care
- Implemented IPC fundamental of care checklists
- Increased ANTT education and assessment
- Implemented GMBSI improvement plan focusing on improvements in hydration, IV-line care, Hand Hygiene, developed nutrition and hydration forum which is driving through the campaigns
- IPC team have delivered targeted training for CDI awareness
- Delivered antibiotic stewardship campaign with strong medical leadership
- Linked into CCG to highlight antibiotic stewardship issues noted in community

Compliance with IPC Clinical Practice *(% per clinical unit)*

Key:		Hand Hygiene and PPE Audit Results													
95%-100% Compliance															
75%-94% Compliance															
Below 75% Compliance		Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken ?	Is PPE doffed in the correct order?	Are Visors worn as per guidance?	Are Masks worn as per guidance?	Are aprons / long sleeved gowns worn as per guidance?	Are the Gloves worn as per guidance?	Is there an appropriate level of PPE available for the ward/departmen	Is the area where PPE is stored for	Are there instructio nal posters displayed	
Not Applicable															
No submission this month *(view using filter on col. C)*															
		Nurses	Medical	AHPs	Other										
Hospital Site	Month	Sum%	SUM%	SUM%	SUM%	SUM%	SUM%	SUM%	SUM%	SUM%	SUM%	Yes/No	Yes/No/NA	Yes/No/NA	
NMGH	Sep-21	100%	92%	100%	100%	99%	97%	98%	100%	100%	100%	100%	90%	100%	98%
	Oct-22	100%	85%	100%	93%	94%	96%	97%	97%	96%	98%	100%	100%	100%	97%
	Nov-22	95%	82%	94%	90%	95%	100%	90%	97%	100%	98%	95%	100%	100%	95%
	Dec-22	100%	96%	100%	99%	100%	99%	88%	100%	97%	100%	95%	100%	100%	98%
	Jan-22	100%	99%	100%	100%	98%	100%	87%	100%	98%	99%	100%	100%	96%	98%
	Feb-22	98%	87%	93%	90%	95%	94%	86%	100%	100%	99%	100%	100%	100%	96%
	Mar-22	99%	94%	99%	94%	98%	98%	91%	99%	95%	97%	100%	100%	99%	97%
	Sep.21 to Mar.22 Av.Score	99%	91%	98%	95%	97%	98%	91%	99%	98%	99%	99%	99%	99%	97%

Average monthly audit results Sep-21 to Mar-22.

Prior to the introduction of Smart Survey 'Hand Hygiene and PPE audit', hand hygiene and PPE audits were undertaken in the clinical areas and the results kept locally within the division and reported in Divisional reports.
Smart Survey 'Hand Hygiene and PPE audit' was introduced at NMGH in September 2021. Clinical areas submit their audit results to Smart Survey on a monthly basis and a report produced the following month, which is distributed to the leads. Actions which arose for individual areas and professions are reported and monitored through the Divisional Assurance Report.

Embedded document shows details of individual areas and scored.

ANTT Compliance <u>Nursing Staff</u>

The requirements for ANTT compliance changed following the transition of staff from NCA to MFT, meaning that there will be an increase in the number of assessments required (NCA policy allows any 1 ANTT procedure to assure compliance, where MFT policy states 2 procedures with IV being mandatory). In addition to this there is some slight variations to the ANTT policies in MFT and NCA (differences in drying time being an example). The site IPCNs are supporting the process of reviewing both policies and plan alignment with MFT, this will require a training/awareness campaign which the NMGH team will support.

A number of staff within the areas of very low compliance are new starters and international recruits (E3

All areas within Medicine and Surgery have plans in place and we have released additional resource from (2 x Ward Managers who are not in clinical numbers at present) to support the Divisional trajectories to be 100% compliant by the end of March.

WARD	DIVISION	ANNT Score %
A + E	Urgent Care	90%
ACU	Urgent Care	100%
C3	Surgery	92%
C4	Surgery	88%
C5	Medicine	94%
C6	Medicine	94%
CCU	Medicine	100%
CCW	Augmented Care	90%
CRUMPSALL VALE 2	Acute Medicine	100%
D5	Surgery	30%
D6	Surgery	40%
DSU	Surgery	95%
E1	Medicine	81%
E2	Surgery	81%
E3	Medicine	30.77%
Endoscopy	Surgery	84%
F1	Medicine	83.33%
F2	Surgery	97%
F3	Surgery	82%
F4	Medicine	50%
F6	Surgery	100%
GUM	Medicine	50%
H3	Medicine	62%
H4	Medicine	79%
I5	Surgery	85%
I6	Medicine	30%
J3/J4	Medicine - ID	65%
J6	Urgent Care	62%
OPD	clinical/diagnostic services	76%
Pre Op	Surgery	100%
Theatres Main	Surgery	84%
Theatres Phase 1	Surgery	84%
Cardiac Services	Medicine	67%
Diabetes Centre	Medicine	75%
PIU	Medicine	100%
ID Specialist	Medicine	100%
TB Nurses	Medicine	100%
ARAS	Medicine	33%
Mamillian Murses	Medicine	75%
Lung Cancer team	Medicine	33%

ANTT <u>Medical Staff</u>

The has been migration of systems in relation to ANTT training for Medical Staff, historically training was uploaded onto PREP (2020-2021 saw compliance at 74%) migration of systems and processes to the learning hub now see training recorded at 29%, this is unsatisfactory and we are developing systems that offer a reliable training offer and a process to ensure it is represented as one of the three mandatory practical modules on the learning hub, and hence the central registry

Number of staff (approx.) required to be fit tested	***staff fit tested to 1 brand of FFP3 respirator only***	***staff fit tested to 2 brands of FFP3 respirator***
1940	1437 (74%)	650 (33.5%)

- Responsibility of the fit mask testing service has been moved into the Division of Surgery
- Divisions are reporting individual areas of compliance through their IPC reports and associated actions in place

NMGH has a structural gap for training and assessment, in that with the exception of ED and Theatres there are no practice-based educators on site, this is mainly due to the different model of education between MFT and NCA. This is currently noted on the hospital risk register and a business case is planned to be developed.

Recovery

- Review bed capacity to support activity and maintenance of social distancing to avoid outbreaks and bed closure
- Lab transition to support better access and surveillance of screening
- Theatre's refurbishment will increase access to surgery
- ED footprint- to substantively staff areas to support the activity and attendances and ensure IPC principles can be maintained
- Ward reconfigurations review underway to open additional elective care beds and avoid whole ward closures
- Implementing LFT revised policy for pre op
- Improvement work to continue on the Endoscopy Department ventilation to support increased activity.

Wythenshawe, Trafford, Withington, Altrincham (WTWA)

End of Year Infection Prevention and Control Update March 2022

Framework for IPC within Hospital/MCS

This paper provides an overview of the IPC governance and number of Hospital Associated Infections during the period between 1st April 2021- 31st March 31st 2022 within WTWA.

The quarterly WTWA Infection Control committee is one of five governance committees (the others being Workforce & Education Committee, Finance & Operational Excellence Committee, Quality and Safety Committee and Safeguarding Committee. All committees report to the WTWA Hospital Management Board

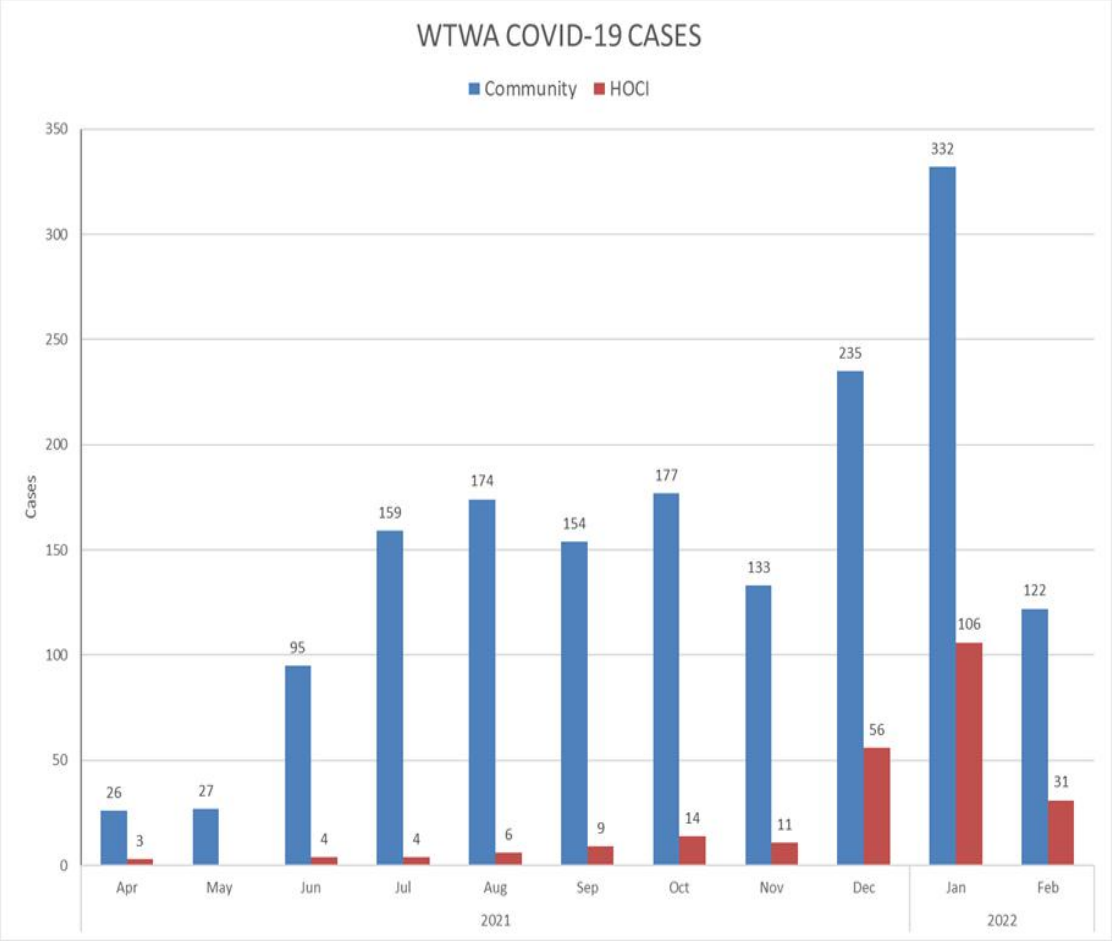
and the accountability oversight for each of these committees is held within each Hospital Division (Emergency Care Village, Cardiac, T&O/ Burns and plastics/ H&N/ Medicine and outpatients, Surgery and Theatres and Respiratory.

The following outlines the IPC governance processes across WTWA:

WTWA Infection Control Committee	Chaired by DoN Focus on risk and assurance Divisional exception/assurance reports Quarterly report to Hospital Management Board
HCAI Accountability Meetings	Chaired by Deputy Director of Nursing Lessons learnt Quarterly report to Hospital Management Board
Divisional IPC meetings	Chaired by Head of Nursing/ CHoD Divisional risks incidents and lessons learned, drive divisional IPC workstreams
IPC Outbreak meetings **(3 x week, reduced from 5 x weekly 21/2/22)**	Chaired by Director of Nursing/Deputy DoN Attended by clinical teams, IPC, E+F and Sodexho Focus on ensuring robust management of outbreaks
Weekly IPC Walk rounds	Head of Nursing, IPC, Sodexho, E+F, Facilities Matron
WTWA IPC Delivery Group	Chaired by DDoN Focus on key priorities and IPC action plans (IPC, GNBSI and CPE)
Other mechanisms	IPC screening audit (MRSA, CPE and Covid-19) Practice audits – HH & PPE SHINE Matron reviews QCR and Patient Experience Trackers HCAI surveillance reports – daily and weekly

COVID-19

During the period of 1st April 2021 to 31st March 2022, WTWA reported both community and HOCI Covid-19 positive results (from April 2021-March 2022).

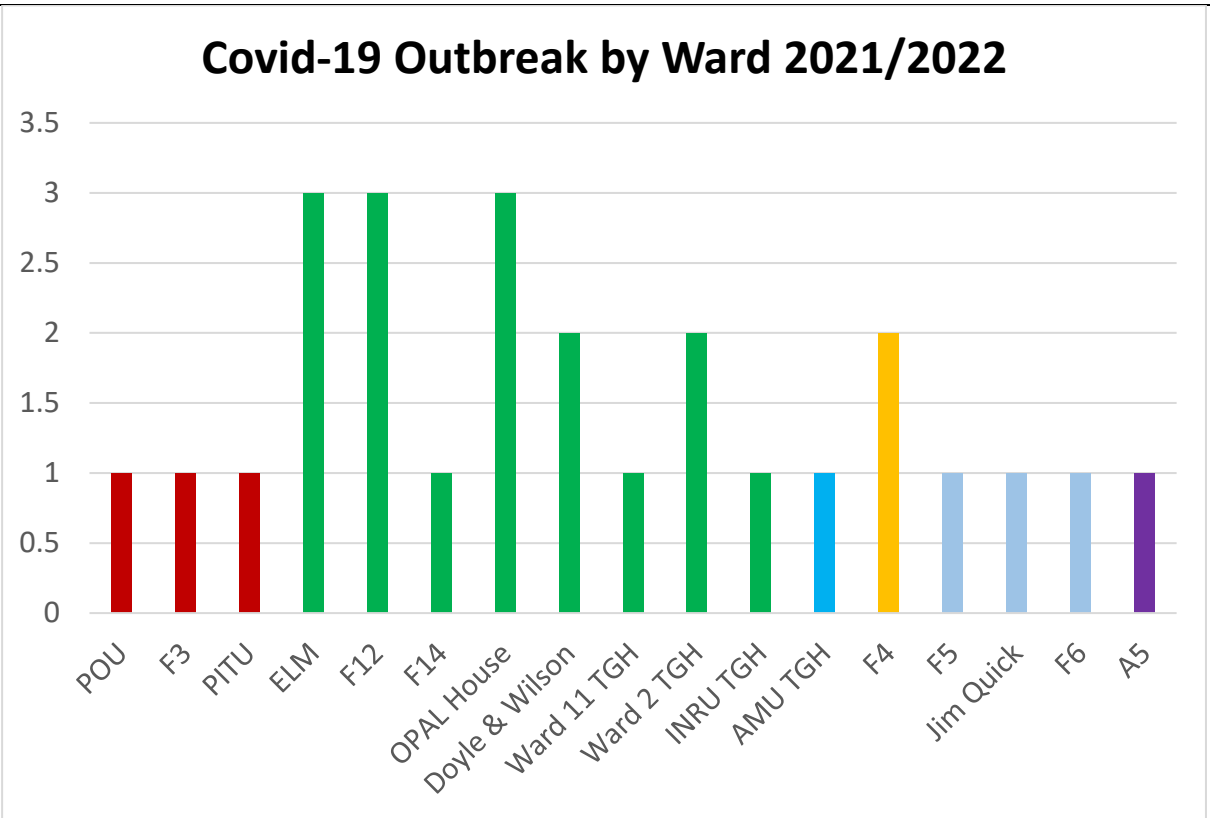


During April 2021-March 2022 there were 218 HOCI's of Covid 19. These were attributed to the following wards/ units across WTWA:

Ward/Dept	No of HOCIs
ELM unit	12
Ward 12	2
A5	5
F15	11
A3	2
F12	43
F14	9

POU	**7**
Doyle and Wilson	**20**
OPAL House	**22**
Jim Quick	**3**
TGH AMU	**2**
INRU	**15**
TGH Ward 11	**4**
A6	**1**
F3	**5**
F6	**4**
TGH Ward 2	**11**
A4	**2**
A2	**4**
A9	**2**
Pearce Ward	**2**
Ward 6 TGH	**1**
F9	**2**
F4	**19**
F5	**8**
TOTAL	**218**

With the definition of an outbreak being 2 HOCI's in 14 days, and being reported for a minimum of 28 days, WTWA reported the following outbreaks for the period of 1st April – 31st March 2022.



To ensure best practice of IPC, communication between the multidisciplinary teams and continuity of management of outbreaks, the three times weekly meetings chaired by the DoN/ DDoN, supported by Microbiology, a senior member of the IPC team and Sodexo preventative continue during this period. Any ward/unit with a HOCI attended the meeting and a management plan was discussed, agreed and implemented. Outbreak meetings were also used as an educational opportunity to share best practice and learning.

Key issues	Key control measures implemented
Screening of patients for Covid-19 at 3 and at 7 days – existing screening database compliance poor	Matrons checking patient screening in their areas daily New IPC screening oversight process

Multiple patient moves from ward to ward	Patient flow workstreams focused on earlier discharge and proactive management of patient IPC pathways and side room utilisation.
Inconsistent compliance with hand hygiene	Hand Hygiene roadshow November 21 All WTWA completed HH pledge Education and engagement Daily HH audits in high prevalence areas/areas of concern
Inconsistent compliance with PPE	Daily PPE audits in high prevalence areas/areas of concern Education and engagement
Poor fabric of ward	IPC, Senior nursing team and E+F agreed and completed schedule of urgent work on relevant wards
Inconsistent cleaning standards	Escalations to supervisors and managers attend outbreak meetings Walk wound with IPC, Sodexho and senior nurses twice weekly on areas of concern
High volume of visitors	MFT temporary visiting policy adhered to Ward processes in place to communicate and update loved ones
Trial to step exit screen and step down outbreaks at day 7 (rather than 10) – interim guidance provided by the IPC team, to support site challenges	This was trailed on F12 , OPAL house and Doyle and Wilson all wards had further cases and were re-closed to outbreak

The lessons learnt for the covid 19 HOCI's for April 2021-March 2022 have been as follows:

Environment

- Understanding cleaning responsibilities (nursing and Sodexho) and holding teams to account – this will further develop with embedding NSoC
- Enhanced cleaning and monitoring in areas of concern
- Focus on kitchen cleaning (CPE) supports improvement

Estates and Facilities

- Poor fabric wards had more outbreaks
- Development of strong relationships between clinical teams and E+F supports focus on required work
- Plan for Life cycling of F block highlighted as a mutual priority

- Supporting appropriate ventilation changes and adjuncts provided to support (window fans and air scrubbers)

Practice

- Weekly IPC screening audit tool developed (Covid, MRSA and CPE)
- FIT Testing – PBEs manage process and compliance Donning/Doffing Processes
- HH audits identified key to focus on fundamentals – 2 new light boxes ordered and out on wards
- All staff group engagement is essential and peer challenge encouraged
- PPE fundaments drive – glove usage a key focus
- Mask fatigue – education and compassionate leadership
- Uniform standards driven including when (usually not) to wear scrubs

Managing outbreaks vs patient flow

- Whole team approach – everyone needs to know escalation process and next steps
- Standard Operating Process in place however close working with IPC team to risk assess
- Daily outbreak meetings during waves of pandemic – MDT including IPC, ward teams, Medics, AHP, E+E and Sodexho and chaired by DoN/DDoN – supported decision making, education and assurance

Governance and support

- Increased OOH support from senior team: Tactical command/shadow GM rotas and late senior nurse rotas
- Risk assessments completed by all divisions – hierarchy of controls implemented and documented
- Leadership visibility/ SLT engagement events
- Focus on wellbeing, flexibility and psychological safety including civility

Social distancing

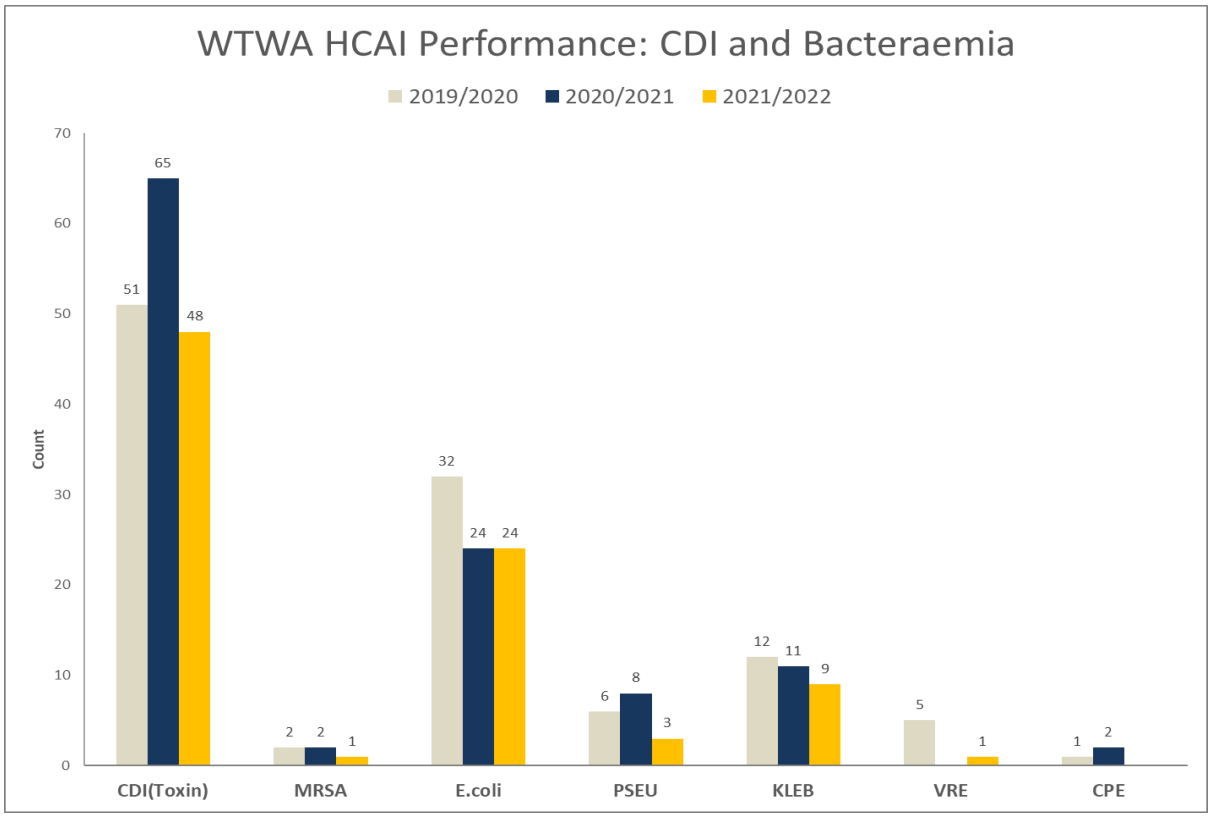
- ED, assessment areas and OP reviewed regularly and risk assessments in place
- Visiting policy implemented and reduced footfall – security support

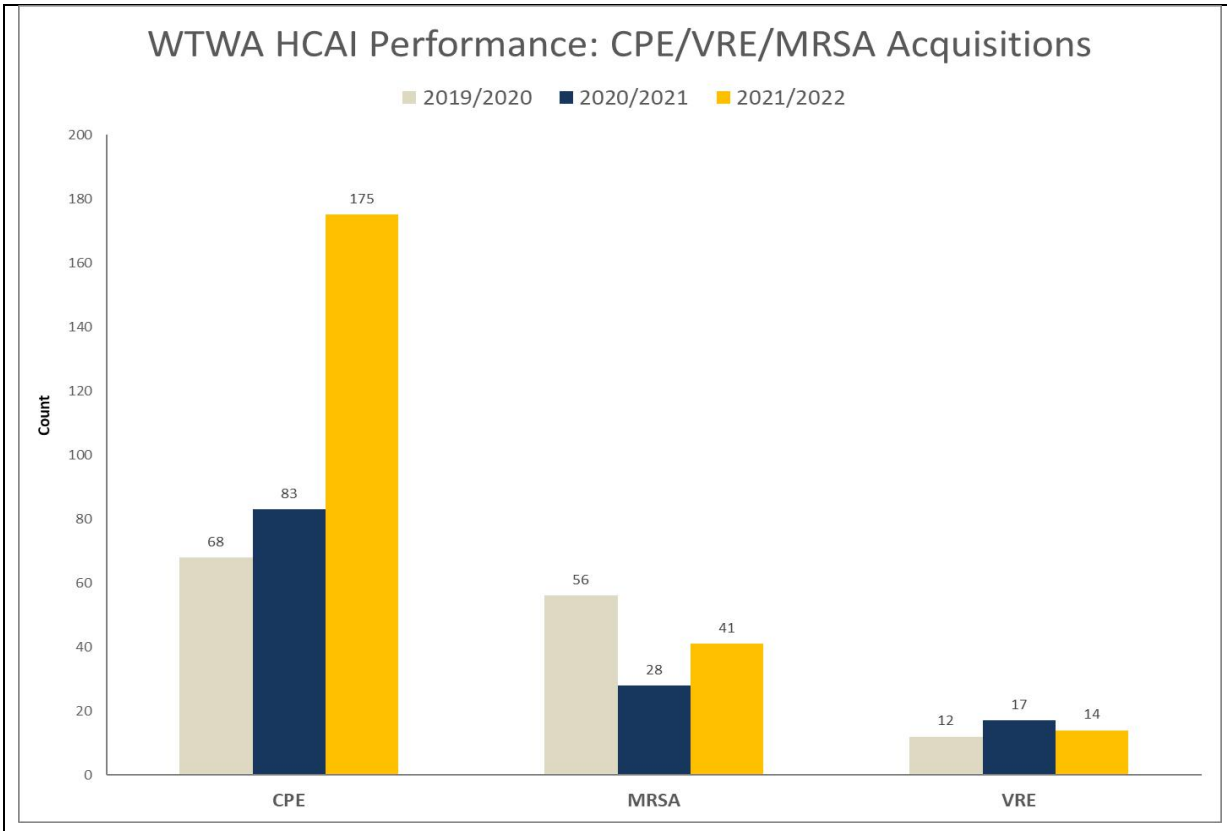
Vaccination and LFT

- Clear information to staff and myth busting
- Supporting wellbeing conversations
- LFT availability and sign-posting staff

Healthcare Associated Infections

The first chart below demonstrates the number of WTWA Hospital acquired infections for both CDI and Bacteaemia and the second demonstration the WTWA HCAI performance for CPE/ VRE and MRSA acquisitions. Both for the period of 1st April 2021- 31st March 2022.





A significant increase in CPE acquisition has been seen during the period 1st April 2021-31st March 2022. This is felt to be related to the Trafford General Hospital (TGH) pathways. The Fractured Neck of Femur (NOF) pathway from Ward A5 required all patients to be screened prior to transfer to TGH ELM unit. The majority of these patients do not meet the criteria to be screened on admission. They were considered acquisitions, however the admission status is unknown. Furthermore, the Pathway to TGH, Ward 2 and AMU changed: patients prior to pandemic would transfer to TGH medicine from admission portals and not require CPE screen, patients now transfer from base wards and require a screen to transfer to TGH. These patients again often did not meet the screening criteria on admission.

Consideration regarding lapses in care are concluded below followed by the themes, actions taken and also the lessons learned.

HCAI	No.	Threshold from AOF	Additional information	Lapses in care themes

MRSA Bacteraemia attributable	1	0	1 case with lapses in care	• Screening on admission • Completion of VIP charts
CDI	46	51	4 cases with lapses in care	• Antibiotic prescribing/documentation • Isolation not timely • ICP not commenced timely
GNBSI	40	41	Action plan in place	NA
VRE/CPE	14	NA	Action plan in place	NA

Themes	**Lessons learned**	**Implemented changes**
Prescribing/documentation of antimicrobials	• Need to document indication and duration • Early advice from microbiology • Senior review	• Re-start AMS audit • Medical representative at accountability meeting • DMD to chair AMS committee
Patients with diarrhoea not consistently isolated at onset of symptoms	• Side room usage not consistently prioritised as per IPC guidance • IPC advice not always sought	• Patient flow team daily review of side room utilisation and escalate issues to senior divisional nurse • IPC now contacted to support decision making by ward/pt. flow
Inconsistent completion on IPC pathway documentation	• Not consistently started prior to positive CDI result or when previously MRSA +ve	• ICP usage added to matron monthly SHINE audits • HIVE RDG involvement • IPC roadshow November 2021 – refresh of IPC usage completed

ANTT compliance scrutiny – focus on medical compliance ongoing	• Records held locally since OLM removed • Medical staff unclear process to ensure compliance	• Lead PBE devised SOP for upload to learning hub – being rolled out • DMD reviewing medical process – Pas to be medical ANTT trainers

Compliance with IPC Clinical Practice *(% per clinical unit)*

Hand Hygiene and PPE Audit Results

The data below is taken from the average of the submitted Hand Hygiene and PPE audit results from April 2021- March 2022 and demonstrates the IPC compliance across WTWA clinical areas.

95-100% compliance 75=-94% compliance Below 75% compliance Not Applicable			Hand Hygiene and PPE Audit Results compliance % per area			
Ward/Dep	Nurse	Medical	AHPs	Other	PPE appropriate for task?	PPE doffed in correct order
ED	100%	80%	100%	N/A	90%	100%
TGH UTC	100%	100%	N/A	100%	100%	100%
AMU	100%	90%	100%	70%	100%	100%
AMU TGH	100%	100%	100%	100%	80%	100%
A7	100%	80%	100%	60%	100%	100%
Doyle and Wilson	100%	80%	100%	80%	100%	100%
A9	100%	80%	100%	N/A	100%	100%
OPAL House	100%	100%	100%	N/A	100%	100%
OAU	100%	100%	100%	100%	100%	100%
F12	100%	80%	100%	N/A	100%	100%
F14	100%	67%	83%	N/A	100%	75%
F15	100%	90%	100%	100%	100%	100%
ELM	100%	N/A	100%	100%	100%	100%
Ward 2 TGH	100%	100%	100%	100%	100%	100%
Ward 11 TGH	100%	N/A	100%	100%	75%	75%
INRU	100%	N/A	100%	100%	40%	100%
A1	100%	100%	100%	80%	100%	100%
A2	100%	100%	100%	100%	100%	90%
Pearce ward	100%	100%	100%	100%	100%	100%
POU	100%	100%	100%	100%	100%	100%
F3	100%	100%	100%	100%	100%	100%
F11/PITU	100%	100%	100%	100%	100%	100%
NWVU	100%	N/A	100%	100%	90%	90%
A4	95%	90%	N/A	N/A	100%	100%
A6	100%	100%	100%	N/A	100%	100%
A Theatres	100%	100%	100%	100%	100%	100%
F Theatres	100%	100%	100%	N/A	100%	100%
TDC	100%	100%	N/A	100%	100%	100%
TGH Theatres	60%	40%	100%	60%	100%	100%
F4	100%	90%	N/A	N/A	100%	100%
F7	100%	100%	100%	N/A	100%	100%
A3	100%	100%	100%	80%	100%	100%
A5	80%	80%	90%	100%	100%	100%
Burns unit	100%	100%	100%	100%	100%	100%
F9	100%	88%	100%	100%	90%	100%
Ward 12 TGH	100%	100%	100%	100%	100%	100%
F2	100%	100%	100%	90%	100%	100%
F5	100%	100%	100%	90%	100%	100%
Jim Quick	100%	100%	100%	100%	100%	100%
F6	100%	91%	100%	100%	100%	100%
CT Theatres	100%	100%	100%	100%	100%	100%
CCU	100%	100%	100%	100%	100%	100%

The below actions are taken where compliance is less than 95%:

Medical Hand hygiene

- Medical IPC champions being identified in each division
- IPC agenda item on Clinical Director (CD) weekly meeting
- MFT IPC Lead Consultant attending CD meeting and held medical engagement sessions
- Escalation of concerns around IPC practice to CHoD and Medical Director
- Ward based HH training with light box including medical staff

TGH Theatres

- New Lead Nurse focusing on standards with increased audit, education and accountability processes

PPE compliance

- Focus on glove overuse across all areas
- Mask fatigue – ensuring staff remain updated on guidance and supported to take breaks

ANTT compliance

The data below is the ANTT compliance (Nursing only) per ward across WTWA from April 2021- March 2022.

95-100% compliance	
75=-94% compliance	
Below 75% compliance	
Not Applicable	
Ward/Dep	ANTT Compliance
ED	91%
TGH UTC	100%
AMU	95%
AMU TGH	100%
A7	100%
Doyle and Wilson	94%
A9	100%
OPAL House	100%
OAU	100%
F12	100%
F14	92%
F15	100%
ELM	100%
Ward 2 TGH	100%
Ward 11 TGH	100%
INRU	100%
A1	100%
A2	100%
Pearce ward	100%
POU	100%
F3	100%
F11/PITU	100%
NWVU	100%
A4	95%
A6	100%
A Theatres	100%
F Theatres	100%
TDC	100%
TGH Theatres	100%
F4	100%
F7	100%
A3	100%
A5	100%
Burns unit	100%
F9	100%
Ward 12 TGH	100%
F2	100%
F5	100%
Jim Quick	100%
F6	100%
CT Theatres	100%
CCU	100%

The below actions are taken where compliance is less than 95%:

- Amber areas having focused training from PBE team
- Oversight on monthly ward manager 1:1 process
- Monitored via monthly Divisional IPC meetings
- Compliance reported monthly into WTWA IPC committee

Furthermore, it is recognised a robust process is required to record Medical & AHP ANTT compliance.

Fit Testing

- 47% of WTWA staff meet criteria for fit testing
- 53% of WTWA staff are fit testing on 1 mask type (6% more than requirement)
- 11% of the staff fit tested are tested to 2 or more brands

The following processes were in place across WTWA to ensure staff were FIT tested:

- Lead Practice Based Educator maintains database
- Monthly education newsletter detailing fit testing requirement and testing sessions sent out to all clinical areas
- All areas have local Fit test Trainer
- 4 days a week (Mon-Thursday) fit testing available
- Weekly reminders to all fit tested staff and managers to encourage 2nd mask testing

Recovery

The following priorities are in place within the WTWA IPC action plan, and the deliverables will be measured through the WTWA delivery group:

- Recruit IPC clinical lead role
- Fully embed IPC Delivery Group to drive improvement against IPC/GNBSI action plans
- Reduce CPE acquisitions
- Continue to embed learning from Covid-19 outbreaks and reduce HOCI

- Drive compliance to fundamentals of IPC practice – 6 monthly Fundamentals of IPC Campaign (April and October launch)
- Improve and maintain IPC screening standards – Launch of new screening compliance audit tool 7th March 2022
- Wythenshawe F block life cycling process – priority areas F12 and F15 for 2022/2023
- Focus on practice and documentation of indwelling devices
- Governance of Antimicrobial stewardship including re-established AMS monthly audit and AMS oversight committee chaired by Deputy Medical Director

Conclusion

During 1st April- 31st March 2022, WTWA have continued to adapt their practice in line with current Covid-19 guidance, policies, and learning. WTWA are committed to provide the best patient care and have a robust governance and accountability oversight framework in place to ensure the delivery of such.

Manchester Local Care Organisation and Trafford Local Care Organisation
End of Year Infection Prevention and Control Update March 2022

Framework for IPC within Hospital/MCS

- Lorraine Ganley, Director of Nursing and Professional Lead, Manchester Local Care Organisation (MLCO) and Trafford Local Care Organisation (TLCO) (M&TLCO) is the lead for IPC and is the **Chair of the M&TLCO IPC Group**; Paula Flint, Deputy Director of Nursing and Professional Lead M&TLCO is the **deputy chair**.
- **Clinical Leads** - Alex Barker, Head of Nursing Adults M&TLCO; Karen Fishwick, Head of Nursing Children M&TLCO and Nicky Boag, Head of Allied Health Professionals (AHPs) M&TLCO
- **Infection Prevention and Control** - Julie Mullings, Lead Nurse Community Services Tissue Viability and Infection Control; Rachael Wardell, Matron Infection Prevention and Control and Tissue Viability Nurse.
- M&TLCO have access to Rajesh Rajendran, Associate Medical Director (Infection Control) and Julie Cawthorne, Assistant Chief Nurse IPC/Tissue Viability.
- **M&TLCO IPC meetings** are standalone meetings and with operational pressures due to Omicron the meeting changed to quarterly from bi-monthly from October 2021. This will be reviewed over the next few meetings. Over the last 12 months there have been five meetings.
- Meetings are **attended** by all Lead Nurses, Lead Nurse Community Services Tissue Viability and Infection Control and Matron Infection Prevention and Control and Tissue Viability Nurse. Lead AHPs will deputise for the Lead

Nurses as required to ensure there is representation from each of Manchester localities and Trafford. A record of attendance is documented and monitored by the Chair – this can be found in the minutes.

COVID-19

Key Issues Identified with implementing control measures:

- Challenges in implementing national Care Home guidance (mandatory vaccination and LFTs) which differed to MFT guidance.
- Introduction of the Care Home legislation in August 2021 presented difficulties in ensuring resilient service provision.
- The requirement to FIT Test staff on more than one mask for resilience purposes created pressure on the community FIT Testing service.
- Workforce requirements to undertake 12–15-year-old COVID Vaccination programme.

Actions taken:

- Introduction of cohort nursing and moving beds where necessary
- Reminders to staff regarding mask use when car sharing. Staff encouraged to supportively challenge colleagues if they are not complying with PPE requirements and escalate to line managers as appropriate.
- Refresher training in donning and doffing of PPE
- Increased cleaning frequencies and disinfection for multiple use areas/equipment, that is bathrooms, staff bases, telephones, equipment
- Supporting relatives/carers to follow the visiting policy and social distancing requirements in order to reduce the risk of transmission
- Outbreaks highlighted the need for all staff to be working to the same policies and procedures, which accelerated the need to have all inpatient facilities staffed by MFT health care workers
- Ensuring doors are kept closed in patients' rooms

Lessons learned:

- Revisit home working arrangements to ensure that all staff who are returning to work feel safe to do so in accordance with IPC guidance.
- Reassessment of environment as the number of staff returning to work increases, for example in offices and staff break areas.
- Importance of obtaining adequate ventilation in office spaces, particularly as COVID restrictions reduce.
- All office risk assessments to be formally reviewed and peer reviewed. Risk assessments to be shared with team members with opportunity to engage about measures and any mitigations around health and wellbeing.
- PPE, hand hygiene and environmental audits are undertaken monthly, however, daily if an outbreak is declared, with leadership team visits to check adherence to guidance.

Overall lessons learned:

- Constantly reinforcing social distancing and correct use of PPE and ventilation in both clinical and non-clinical areas for staff.
- Cleaning of high touch areas in clinical and non-clinical areas for staff.
- Reinforcing to staff the importance of keeping up to date with IPC information in the trust communications.

Healthcare Associated Infections

Incidents of MRSA/VRE/Gram neg bacteraemia/ CDI (from April 2021 - March 2022)

There have been three incidents of **Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia** investigated by M&TLCO from 1st April 2021 – 31st March 2022. None of these have been attributable to M&TLCO.

There have been no incidents of **Carbapenemase Producing Enterobacteriaceaae (CPE)**, **Vancomycin-resistant Enterococcus (VRE)** or **Gram-negative bacteraemia** from 1st April 2021 – 31st March 2022.

There was one **Clostridioides difficile (CDI)** attributable case in the reporting period which was identified in October 2021. Root cause analysis has been completed for the incident.

Lessons learned have been:

- Raising awareness of timely sampling and bowel monitoring.
- Timely clerking of patients transferred to the Intermediate Care facility over the weekend.
- Development of improved processes for timely actioning of sample results.

Good Practice was identified as:

- Timeliness of GP prescribing appropriate treatment (Vancomycin).
- Patient was nursed in isolation since admission.

Compliance with IPC Clinical Practice *(% per clinical unit)*

Key:		Hand Hygiene and PPE Audit Results		
95%-100% Compliance				
75%-94% Compliance		Has Hand Hygiene been undertaken?	Is PPE appropriate for the task undertaken?	Is PPE doffed in the correct order?
Below 75% Compliance				
Not Applicable				

		Nurses	Medical	AHPs	Other		
Hospital/MCS		SUM%	SUM%	SUM%	SUM%	SUM%	SUM%
M&TLCO					94%*		

*The figures for M&TLCO are reported as one overall median percentage, as staff work in integrated multidisciplinary teams. For individual areas where compliance for Hand Hygiene falls below the required 95%, action plans have been put in place which are monitored in the locality/Trafford Quality & Safety (Q&S) or Harm Free Care (HFC) meetings.

ANTT Compliance	
Locality	*% compliance*
MLCO North	95%
MLCO Central	62%
MLCO South	88%
M&TLCO Children's	95%
TLCO Adults	65%

LCO Compliance*	**81%**

Accurate information regarding ANTT compliance has been challenging to obtain. This is now on the learning hub and the data is currently being interrogated by clinical leads. ANTT champions are reminding staff to record compliance with practical skills on the Learning Hub as this requires improvement. 47 assessors for ANTT attended training provided by the IPC team as part of the improvement plan. ANTT compliance is shared at every locality monthly HFC/Q&S meetings with targeted action plans where compliance remains low.

Number of staff (approx.) required to be fit tested	***staff fit tested to 1 brand of FFP3 respirator***	***staff fit tested to 2 brand of FFP3 respirator***
325 tested April 21-March 22	*42*	*283*

High numbers of staff were required to be Fit Tested in 2020 due to the requirement for a FFP3 mask for resuscitation purposes.

Staff undertaking aerosol generating procedures are prioritise for testing with two masks.

1138 staff require re-testing in August/September 2022 – the large numbers are mainly due to resuscitation requirements.

Recovery

Priorities for 2022/23

- Member of IPC medical team attendance at LCO IPC meetings to strengthen IPC offer and reflect consistency across MFT.
- North Manchester community services to receive IPC advice and support from MFT community IPC/TV team.
- Standardise IPC policies, processes and guidelines across M&TLCO.
- Be responsive to IPC environmental audits and develop action plans to address issues raised.
- Improve mandatory training compliance to consistently achieve 95%.

CSS End of Year Infection Prevention and Control Update - March 2022

Framework for IPC within Hospital/MCS

- **Director of Nursing; Clinical Lead, IPC; Lead IPC Nurse(s); Lead Infection Control Doctor**
- **Framework for Hospital IPC meetings**
- **Record of attendance at meetings**

1. CSS Infection Prevention and Control Meeting

- Frequency - Bimonthly CSS IPC Meetings, meetings are chaired by Clinical Director for ACCP and the Director of Nursing with all Divisions represented with attendance from IPC, Microbiology and Virology. The meetings are well attended by all disciplines.
- Board Assurance Framework reviewed regularly at these meetings.
- Some challenges noted, which we are in the process of addressing such as antimicrobial speciality input, we have identified a Lead Antimicrobial Pharmacist to attend the meetings and wider sharing of Divisional IPC minutes.
- Number of meetings over the last 12 months X6, none have been stood down although at peak times the meetings were shortened to an hour due to competing clinical demands.

2. Divisional IPC Meetings

- The Critical Care Units hold local meetings these are either fortnightly or monthly, these are led by the Lead Nurse/Matron and Critical Care Consultant IPC Lead for the Units. The Units on both ORC and Wythenshawe hold a joint local meeting to ensure shared learning across the site. Learning from IPC concerns are shared across the ACCP division at the CSS BI monthly IPC and HFC meetings and an overview is shared at ACCP Divisional Board.
- Accountability meetings are arranged as required following the identification of a bacteraemia or CDT. Attendance at the accountability meeting includes HON (Chair) ACCP Clinical Director, IPC Senior Nurse, Virology/Microbiology, Antimicrobial Pharmacist, Senior Nursing Teams from relevant Units.
- There were 5 accountability meetings held in 2021/22, with 1 pending.

3. Division of Imaging

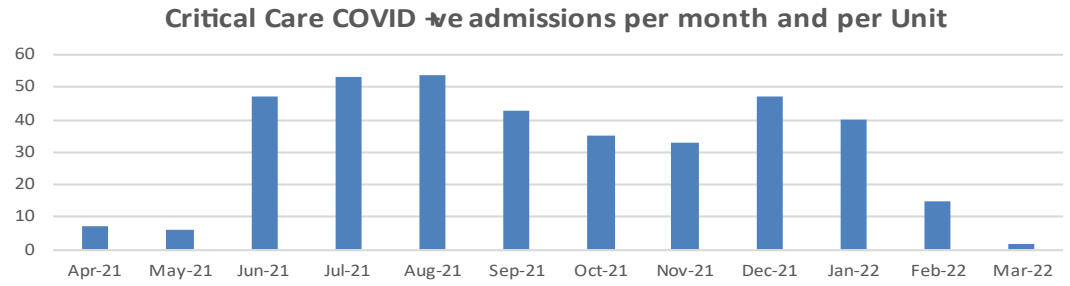
- Monthly divisional IPC meetings are resumed via teams to encourage all site champions to attend. Minutes and IPC actions are reported via Imaging Q&S meetings.
- Matron for Imaging leads on Imaging Divisional IPC
- HH & PPE audits of all imaging areas are now submitted in the link used by other areas of trust.
- PIC/CVC Line Expert Group led by Radiologist for MFT, Trust PIC line Policy has been completed.
- Some areas of imaging are also part of National cleanliness audits and other areas will join the audit programme this year.
- All modalities within imaging have identified IPC champions, fit testers and ANTT assessors to support maintaining IPC standards across the division
- Covid -Protocols for imaging areas are regularly reviewed and in place to ensure safe service is delivered through both inpatient and outpatient pathways for patient flow within the departments.
- North Manchester Imaging areas are now added to Imaging IPC Audits and focus is on to review and harmonize IPC standards in line with existing MFT areas of Imaging
- Environmental audits undertaken in all imaging areas will now be added to the digital survey link to support with regular audit reporting and action planning within imaging.

The remaining Divisions, Pharmacy, DLM, AHP's in CSS have IPC focus groups who undertake audit and share IPC information with their teams and via their local Quality and Safety agenda. Minutes of the meetings are shared via the CSS ICP Meeting for information

A record of attendance is taken at each of the meetings noted above.

COVID-19

4.Total Number of COVID-19 patients (from April 2021 - March 2022) in a bar chart with total number for each month. Each month total to be split by HOCI and Community acquired.



COVID +ve Admisisons per month													
Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
ACCU	4	3	19	23	23	23	17	18	25	28	12	1	196
AICU	1	1	12	26	16	11	14	11	12	10	1	1	116
CSITU					1	1							2
CTCCU	1	1	8	2	7	4	2	2	5	1	1		34
NMGH	1	1	8	2	7	4	2	2	5	1	1		34
Total	7	6	47	53	54	43	35	33	47	40	15	2	382

5.How many outbreaks of COVID-19 in a bar chart by ward/clinical area for the year

There have been no outbreaks of Covid -19 and no HOCI within Critical Care during this time frame which is an excellent achievement.

6.Key issues identified with implementing control measures in your area (e.g., compliance with IPC practices /environment cleanliness)

- Visor compliance issues
- Maintaining compliance with Fit testing requirements and regular FFP3 mask changes
- Isolation limitations particularly for those patients that we were unable to isolate with other infections such as VRE/CDT. We have seen an improvement in incident reporting when we are unable to isolate patients as required.
- Managing blue, yellow and green capacity to ensure we met the needs of all patients in our clinical areas.

- Utilising HDU at ORC as a level 3 facility, noted re the number of acquisitions in this area, environment not suited to this increased patient acuity in terms of space and layout.
- Impact on Burns ICU capacity due to close location of the Covid area on AICU.
- Staff absence due to Omicron was significant at 16% at its highest level and posed specific challenges for the wider MDT Team.

Actions taken

- Re visor compliance, sought to understand reasons for non-compliance, sought alternative eye protection, reiterated importance of eye protection to staff by Senior Nurses and Clinicians
- New process re fit testing implemented to ensure that each member of staff tested for x 2 masks
- Bioquell PODS installed at NMGH x 4, with plans to introduce at other sites.
- Worked closely with Burns Team to ensure safe care provision
- Critical Care ORC Team Supporting CSS at ORC with provision of swabs for staff to access rapid PCR Screening
- Staff sickness/absence due to Covid managed closely with clear process for risk assessment and early return to work

Lessons learned

- Flexibility within the agreed escalation plans to maximise critical care resources
- Dynamic approach with daily review to changing landscape and patient groups
- Maintained excellent practice and managed PPE well throughout the pandemic with good compliance despite a lot of staff changes/ new staff.

Healthcare Associated Infections

8.Incidents of MRSA/VRE/Gram neg bacteraemia/ CDI (from April 2021 - March 2022)

HCAI incidents	No	Threshold from AOF (N/A for VRE)	Additional information	No
MRSA Bacteraemia	0	0		
VRE	15	NA	No lapses in care following review	
GNBSI	37	71	Progress against Action Plan	
CDI	26	30	Lapse in care PII	0 3
CPE	0			0

Points to note.

- GNBSI Action Plan in place and progress closely monitored by CSS IPC Committee
- GNBSI cases reviewed locally by Matron and Consultant and shared at local IPC Accountability Meetings
- Learning from GNBSI at NM Critical Care re line care, IQP project underway to support improvements in practice

- Accountability Meeting Summary for VRE Bacteraemia's - shared learning as part of CSS IPC Meeting feedback.

- No lapses in care identified following RCA: issues identified - unable to isolate all patients with loose stools on ICU/HDU due to covid side rooms used for suspected/ unknown status.
- Observational HH audits, walk rounds with IPC, incidents reported when unable to isolate
- Actions implemented - long sleeve PPE gowns, bare below elbow, gowns changed between each patient following nursing care (easy accessible gowns for staff) before moving to next patient, focussed environmental cleaning, decluttering bed areas, education for staff -bite size teaching.
- Challenging visiting Medical Teams.

- CVC - Audits of line care are completed daily in Critical Care and are at 100%

9.Outbreaks of infection (excluding COVID-19) – list each outbreak and location

- CDI X 3 episodes PII – May 21 ICU/HDU, Feb 22 ICU and Mar 22 CTCCU
- No lapse in care identified to date during review of these cases, 2 most recent cases still under review but preliminary findings indicate no lapses in care
- IPC Team complimentary regarding the team's responsiveness to the CDI infections

Themes following review.

- Gaps in documentation of episodes of loose stool in the pathway – staff education (bite size teaching core huddles),
- Implemented isolation precautions to follow at the bedside when unable to isolate patients with the use of designated bedside trolley (gloves, gowns, etc).

Compliance with IPC Clinical Practice *(% per clinical unit)*

Key:		**Hand Hygiene and PPE Audit Results**					
95%-100% Compliance							
75%-94% Compliance							
Below 75% Compliance		Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken ?	Is PPE doffed in the correct order?
Not Applicable							
No submission this month *(view using filter on col. C)*		Nurses	Medical	AHPs	Other		
Critical Care	EHDU	100%	93%	100%	97%	93%	97%
	HDU	98%	100%	100%	97%	67%	97%
	ITU	97%	98%	100%	90%	82%	99%
	CICU	92%	91%	100%	97%	82%	97%
	AICU	100%	83%	93%	90%	91%	100%
	CTCCU	100%	88%	98%	82%	87%	97%

	NM Critical Care	88%	86%	89%	100%	100%	100%
Pain Team	Pain Clinic	100%	73%	73%	47%	100%	100%
Imaging	CT Scan (ORC)	N/A	40%	50%	100%	100%	100%
	RADU (ORC)	100%	78%	100%	73%	100%	100%
	MRI Adult Radiology	N/A	N/A	100%	100%	100%	100%
	Ultrasound (ORC)	98%	83%	95%	90%	97%	98%
	General X-Ray (ORC)	N/A	N/A	100%	100%	100%	N/A
	MR Scan (ORC)	100%	100%	100%	N/A	100%	100%
	Neurophysiology (ORC)	N/A	100%	100%	N/A	100%	100%
	Nuclear Medicine (ORC)	100%	100%	100%	100%	100%	100%
	Interventional Radiology (ORC)	93%	73%	93%	N/A	93%	87%
	VA4-GI (ORC)	N/A	100%	100%	N/A	100%	100%
	Breast Screening (Wythenshawe)	N/A	N/A	100%	N/A	100%	100%
	Interventional Radiology (Wythenshawe)	100%	83%	100%	50%	87%	87%
	Neurophysiology (Wythenshawe)	N/A	100%	N/A	100%	100%	100%
	Imaging - Withington	N/A	N/A	N/A	100%	100%	100%
	Imaging - Trafford	N/A	N/A	100%	100%	100%	100%
	Interventional Radiology (NMGH)	100%	100%	100%	100%	100%	100%
		98%	88%	95%	90%	95%	98%

10.Actions taken in areas where there is less than 95% compliance

- Visors - actions as noted in section above.
- Improving HH compliance in areas with low compliance such as IR via detailed Divisional Action Plan.
- Ensure that all imaging areas are submitting monthly HH & PPE audits, these are taking place more frequently in i.e. weekly areas of low compliance, observational walk rounds arranged in IR and supported by the IPC Team.

11.CSS Nursing ANTT Compliance Figures – March 2022

Area	IV Medication %	CVC Dressing %
Critical Care		
ICU/HDU/14/HCU	79%	76%
CICU	73%	74%
AICU	100%	100%
CTCCU	87%	87%
NMICU	91%	94%
Pain Team	**IV%**	
ORC	100%	
WTWA	100%	
Radiology	**IV %**	
IR (ORC)	100%	
IR (Wyth)	75%	By 4.4.22 will be at 100%
IR (North Manchester)	100%	
Paediatric Xray	80%	By 4.4.22 will be at 100%
Nuclear Medicine	100%	

12.Fit Testing

Number of staff (approx.) required to be fit tested	Staff fit tested to 1 brand of FFP3 respirator only	Staff fit tested to 2 brands of FFP3 respirator
ACCP - 1398	**100%**	**Approximately 50%**
AHP – 495	**57%**	**25%**
Imaging – 51	**90%**	**Approximately 60%**

We now have access to CSS wide information as part of a central database stored on the Learning Hub however at present this is difficult to use to interpret compliance figures. Divisional Leads are identified who are responsible for monitoring and maintaining fit testing compliance and local data approximates compliance as detailed above. Critical Care fit testers have supported AHP fit testing which has been prioritised for in patient therapy staff working in areas such as Critical Care and Respiratory Care.

Recovery

13.List your 5-6 priorities (bullet points) for 2022/23

- Continue to support staff wellbeing

- Vaccination programme continues to be fully supported in CSS,

  Flu vaccination 68.5% (Trust 62%),

  Covid 1st 95% (Trust 93%), 2nd 93% (Trust 90%)

  Booster 79.3% (Trust 74.6%),

- Covid RA utilised effectively to allow staff to RTW safely

- Antimicrobial Stewardship fully supported in CSS
- Reduce incidence of CDI and VRE acquisition in line with agreed IPC trajectories
- Continued GNBSI reduction and progress with current action plan

- PIC/ CVC Lines Expert Group to report into CSS IPC Committee, CSS to provide support to ensure all workstreams/processes are implemented and monitored fully.
- Standardising line care and LOCCSIP's documentation and process across Adult Critical Care at MFT
- NMGH Critical Care environmental refurbishments are completed
- Additional Bioquell Pods installed to provide isolation flexibility to ensure effective use of critical care resources
- Utilise HIVE to monitor improvements in documentation standards relating to IPC care and practice.

14.What went well

- No HOCI's.
- Nursing Staff Turnover low, latest figures Qualified 10.5% (TT 12.6%), Band 5 11.4% (TT 12.6%).
- Staff risk assessments and availability of clear protocols along with effective collaborative working to manage PPE across departments helped with staff assurance to provide a safe working environment.

What went well Imaging:

- Good communication from Imaging Senior Leadership Team and CSS Management Team helped to ensure the division was able to keep up with the changes proposed
- At divisional and team meetings staff had opportunities to address any IPC related queries enabling staff engagement.
- The Imaging team were able to work collaboratively with other CSS areas in utilizing PPE resources effectively

Key areas for improvement Imaging:

- Improving HH compliance in areas with low compliance via Divisional Action Plan.
- Ensure that all imaging areas are submitting monthly HH & PPE audits, these are taking place more frequently in areas of low compliance
- Improve fit testing compliance across the division. Plan to purchase a fit testing machine which will be available to support compliance for imaging departments.
- Improve attendance of IPC Champions to monthly IPC meeting which is very low due to clinical commitments.
- Improve ANTT assessment compliance and monitoring database for AHP's , Radiographer Assistants and Radiologists.

Manchester Royal Eye Hospital (MREH) and University of Manchester Dental Hospital (UDHM)

End of Year Infection Prevention and Control Update March 2022

Framework for IPC within Hospital/MCS

- ***Director of Nursing-*** Debra Armstrong
- ***Clinical Lead-*** Bill Newman
- ***IPC; Lead IPC Nurse(s)***-Karen Mathieson, IPC Team, Jonathan Trzos (MREH), Ellie Barclay (UDHM)
- ***Lead Infection Control Doctor-*** Aruna Dharmasena
- ***Framework for Hospital IPC meetings***- Joint MREH / UDHM monthly standalone meetings
- ***Record of attendance at meetings***-

Attendance of Core Representatives	
DoN / Lead Nurse (Chair)	100%
Matron / Senior Nurse	100%
UDHM Matron / Senior Nurse	100%
IP&C Matron / Senior Nurse	87%
MREH/UDHM Medical Director / Lead	100%
MREH / UDHM CE Lead	100%
MREH AHP representative	92%
Admin lead	58%

COVID-19

- ***Total Number of inpatients identified with COVID-19 <u>after</u> admission to ward (from April 2021- February 2022)*** MREH – **3**, UDHM - **0**
- ***NO*** *outbreaks of COVID-19 for the year*
- ***Key issues identified with implementing control measures in MREH***
  - ❖ All patient pathways and management processes updated to comply with national and Trust guidance.
  - ❖ SOPs updated to define and describe patient management.
  - ❖ Patient management in clinical areas reconsidered and zoned as per non respiratory and respiratory pathways
  - ❖ Continual review of patient and staff management and reconfiguration as required.
  - ❖ Swabbing day 1,3,5
- ***Key issues identified with implementing control measures in UDHM***
  - ❖ Patient pathways and management processes revised in line with changes to national and Trust guidance to ensure compliance.
  - ❖ SOPs updated to define and describe patient management.
  - ❖ Patient management in clinical areas reconsidered and zoned as respiratory and non-respiratory pathways.

- ❖ Due to the age and fabric of the Estate and ventilation systems it has resulted in the need to continually review and reconfigure some services to increase capacity.

Healthcare Associated Infections

MREH

- ***Incidents of MRSA/VRE/Gram neg bacteraemia/ CDI (from April 2021 - March 2022****)*

HCAI incidents	***No***	***Objective (N/A for VRE)***	***Additional information***	***No***
MRSA Bacteraemia	*0*			
VRE	*0*			
GNBSI	*0*			
CDI	*0*			
Endophthalmitis	*1*		*1 case identified following a Trabeculectomy in October 2021, the bacteria identified was a mouth commensal, which equates to 1 infective case of 3,923 (0.03%) surgical procedures performed between April 2021 and February 2022.* *No avoidable causative factor/s identified by the investigation.*	

Prevalence of endophthalmitis cases in MREH reported average of 0.02%. National average for endophthalmitis cases is 0.1%.

- ***Outbreaks of infection (excluding COVID-19) - none***
- *MREH monitor rates of endophthalmitis.*
- *Each associated case of infected endophthalmitis occurring within MREH is subject to a High Impact Learning Assessment.*

UDHM

- ***Incidents of MRSA/VRE/Gram neg bacteraemia/ CDI (from April 2021 - March 2022****)*

HCAI incidents	***No***	***Objective (N/A for VRE)***	***Additional information***	***No***
MRSA Bacteraemia	*0*			
VRE	*0*			

GNBSI	*0*			
CDI	*0*			
Acute Apical Abscess	*0*			

- ***Outbreaks of infection (excluding COVID-19)*** *-* ***none***
- *UDHM monitor rates for Acute Apical Abscess, requiring intravenous antibiotics.*
- *Each identified case of Acute Apical Abscess occurring within UDHM is subject to a High Impact Learning Assessment*

Compliance with IPC Clinical Practice *(% per clinical unit)*

MREH:

Key:		Hand Hygiene and PPE Audit Results					
95%-100% Compliance							
75%-94% Compliance		Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken?	Is PPE doffed in the correct order?
Below 75% Compliance							
Not Applicable							
		Nurses	Medical	AHPs	Other		
MREH		99.3%	97.1%	98.6%	98.6%	99.9%	99.8%

Overall percentage for each clinical unit April 2021– February 2022		
	Hand Hygiene	*Donning & Doffing*
Ward 55	*100%*	*100%*
Ward 54	*100%*	*98.90%*
MTC	*97.70%*	*100%*
Theatres	*96.40%*	*99.20%*
Day case	*100%*	*100%*
WCH	*100%*	*100%*
OPD	*98.10%*	*98.80%*
EED	*98.60%*	*100%*

Trafford	*100%*	*100%*
Altrincham	*100%*	*100%*
MTC North	*100%*	*100%*
MTC South	*100%*	*100%*
Clinic F	*100%*	*100%*
Clinic G	*100%*	*99.60%*
Clinic H	*100%*	*100%*
ACTIONS UNDERTAKEN		
Cross Departmental assurance audits ***Actions discussed at monthly IPC meeting.*** ***Matron led assurance audits undertaken.***		

Nursing team local ANTT compliance	
Ward / Unit	
Ward 55	78.30%
Ward 54	80.00%
Theatres	90.30%
MTC MREH	94.40%
MTC Trafford	100.00%
MTC North	100.00%
MTC South	100.00%
Eye J Day Case	93.30%
Outpatient Department	100.00%
Eye Emergency Department	83.30%
Altrincham Eye Clinic	83.30%
Withington Cataract Centre	86.90%

Professional Group	***No. of staff ANTT compliant***		***Total %***	
	LOCAL	***CENTRAL***	***LOCAL***	***CENTRAL***
Medical Staff	***52***	***42***	***76.5%***	***55.3%***
Nursing Staff	***187***	***170***	***90.8%***	***81.7%***
Optometrists Orthoptists	***83***	***31***	***83.8%***	***34.8%***

Comments	***Work underway to validate and update centrally held records on learning hub.*** ***Locally held records for assurance.*** ***Recognise requirement for medical compliance focus*** ***ANTT Roadshows scheduled at ACE days to target medical staff*** ***Associate medical directors discussing 1:1 with all medical colleagues***

Number of staff (approx.) required to be fit tested	***staff fit tested to 1 brand of FFP3 respirator***	***staff fit tested to 2 brand of FFP3 respirator***
367	*222*	*129*

UDHM:

Key:		**Hand Hygiene and PPE Audit Results**					
95%-100% Compliance							
75%-94% Compliance		Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken?	Is PPE doffed in the correct order?
Below 75% Compliance							
Not Applicable							
		Nurses	Medical	AHPs	Other		
UDHM		100%	100%	100%	100%	100%	100%

Overall percentage for each clinical unit April 2021 – February 2022		
	Hand Hygiene	Donning & Doffing
Restorative	100%	100%
Oral Surgery	100%	100%
Oral Medicine	100%	100%
E D C	100%	100%
Orthodontics	100%	100%
Childrens	100%	100%
Radiology	100%	100%
ACTIONS UNDERTAKEN		
Cross Departmental assurance audits Actions discussed at monthly IPC meeting. Matron led assurance audits undertaken.		

Nursing team local ANTT compliance	
Ward / Unit	
Dental Nursing	95.83%
Oral Surgery - TGH	100%

Professional Group	*No. of staff ANTT compliant*		*Total %*	
	LOCAL	*CENTRAL*	*LOCAL*	*CENTRAL*
Clinicians	*28*	*13*	*81.5%*	*46.4%*
Dental Nursing	*92*	*91*	*95.8%*	*93.8%*
Comments	*High number of Dental tutors work minimal sessions within the Dental Hospital. Therefore, there is a challenge in accessing training. A rolling training programme in place for these staff.* *ANTT Roadshows scheduled at ACE days to target medical staff* *Associate medical directors discussing 1:1 with all medical colleagues*			

Number of staff (approx.) required to be fit tested	*staff fit tested to 1 brand of FFP3 respirator*	*staff fit tested to 2 brands of FFP3 respirator*
296	223	73

Recovery

MREH

- Increase compliance for FFP3 fit testing
- Review of patient flow and social distancing in all clinical areas to optimise services safely as activity increases to Pre-pandemic levels
- Increase compliance of medical staff ANTT compliance
- Obtain further patient feedback regarding how safe patients feel with infection control measures when accessing our services.

UDHM

- To further expand the Housekeeper workforce throughout the Hospital
- More robust supervision of cleaning. Collaborative working implemented with Sodexo and MFT Monitoring teams and improvements seen initially.
- Further review of Ventilation expertise by returning to pre pandemic activity.
- Commence DSD process mapping to inform improvements and communications issues
- Increase compliance of Dental and Medical staff ANTT compliance
- Obtain further patient feedback regarding how safe patients feel with infection control measures when accessing our services.
- Review of patient flow and social distancing in all clinical areas to optimise services safely as activity increases to Pre-pandemic levels

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Barbara Mitchell, Assistant Chief Nurse, Safeguarding Ruth Speight, Head of Nursing, Safeguarding
Date of paper:	July 2022
Subject:	Annual Report: Safeguarding Children and Adults and Looked After Children 2021/2022
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Safety Patient Experience
Recommendations:	The Board of Directors are asked to note the report and the assurance it provides that statutory safeguarding responsibilities are in place across Manchester University NHS Foundation Trust services
Contact:	Name: Barbara Mitchell, Assistant Chief Nurse, Safeguarding Tel: 0161 274 4981

Safeguarding

Children and Adults

and

Looked After Children

Annual Report

2021/2022

Authors:

Ruth Speight, Head of Nursing (Safeguarding)

Barbara Mitchell, Assistant Chief Nurse (Safeguarding)

Alison Lynch, Group Deputy Chief Nurse

In collaboration with the MFT Safeguarding Teams

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SECTION A

Purpose of the Report

1. Purpose of the Report

1.1. The Safeguarding Annual Report for 2021-2022 provides assurance to the Board of Directors that Manchester University NHS Foundation Trust (MFT) is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004[1] and in the Care Act 2014[2]. This report provides assurance that systems are in place to support MFT staff to keep service users safe and protect them from neglect or harm whilst they are in the care of MFT Hospitals, Managed Clinical Services (MCS) or Manchester and Trafford Local Care Organisations (MLCO, TLCO). The report also identifies how patients, service users and their loved ones have a voice, by ensuring that they are actively involved in decision-making regarding their safety and protection and ensuring that they feel safe.

1.2. The report also informs the Board of Directors of the internal and external safeguarding activity undertaken in 2021-2022 and outlines the key priority areas for 2022-2023.

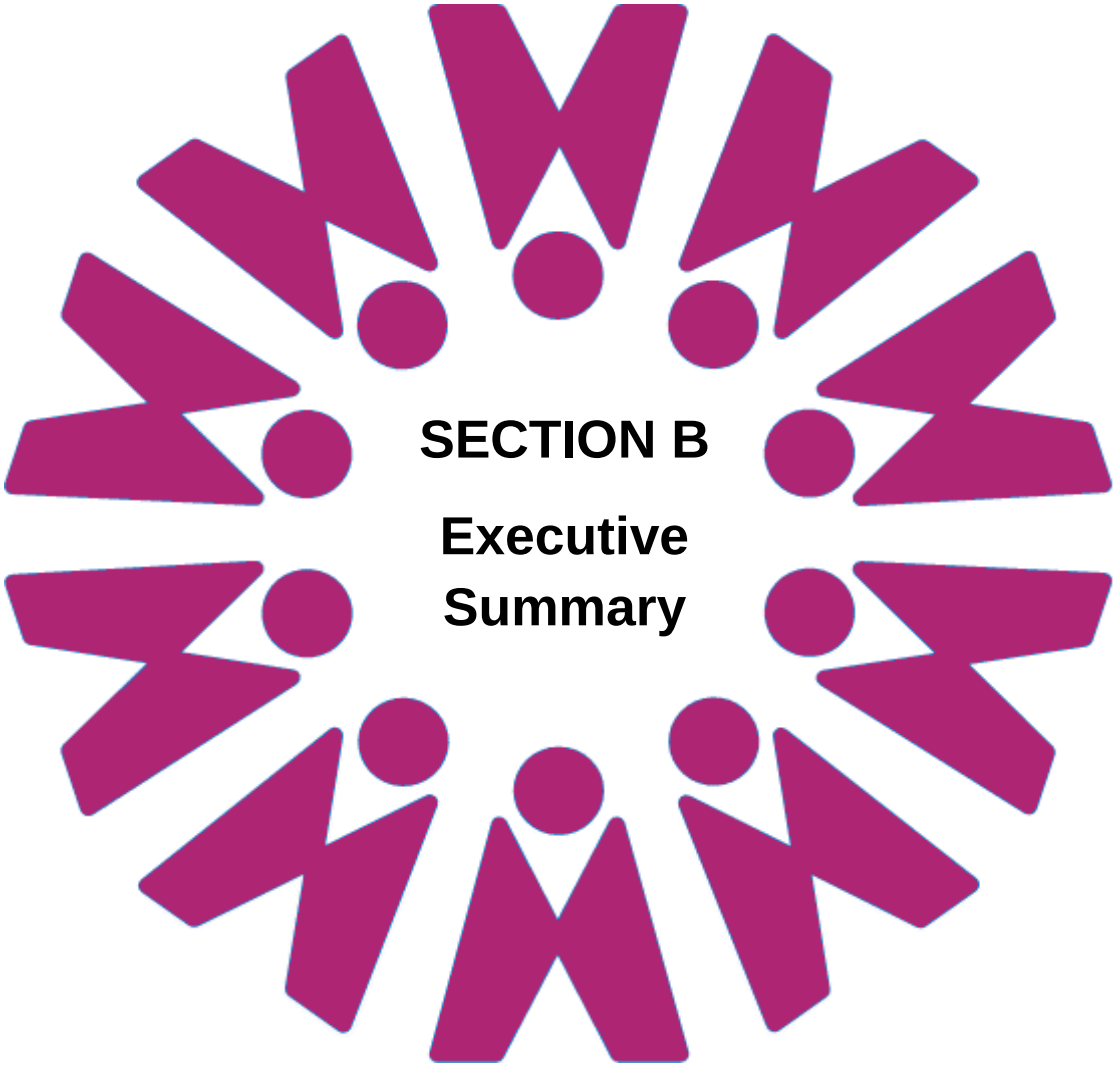
1.3. Safeguarding activity is underpinned by standard and statutory guidance outlined in **Figure 1**. This is not an exhaustive list but outlines the key legislation and statutory guidance that the Trust is required to follow to ensure statutory safeguarding compliance.

1.4. Key Documents

Figure 1: Standard and Statutory Guidance

- CQC registration standards, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13
- The Children Act (1989)
- The Children Act (2004)
- Domestic Abuse Act (2021)
- Coronavirus Act (2020)
- The Sexual Offences Act (2003)
- The Serious Crime Act (2015)
- The Care Act (2014)
- Mental Capacity Act (2005)
- Mental Capacity Amendment Act (2019)
- Mental Health Act (2007)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)

[1] The Children Act 2004
[2] The Care Act 2014



SECTION B

Executive Summary

2. Executive Summary

2.1 This 2021-2022 annual report reflects the huge amount of work undertaken and the progress made throughout the Trust in relation to Safeguarding and Looked after Children Health Services and outlines some of the key priorities across the city of Manchester and the borough of Trafford.

2.2 The MFT Safeguarding and Looked after Children Teams work with other health organisations and multi-agency partners to ensure a cohesive and consistent approach to safeguarding the unborn, children, young people and adults at risk across the MFT footprint.

2.3 In the context of the COVID-19 pandemic, 2021-2022 has been an extremely busy year for Safeguarding and Looked after Children Services with challenges, changes and opportunities within the Trust and across Manchester and Greater Manchester. Changes to legislation, national policy and guidance continue to influence the safeguarding and Looked after Children agendas

2.4 Safeguarding and Looked after Children Services continues to operate at a whole system level across the Trust and beyond. Throughout the year, the underpinning principle has remained unchanged: ***'We listen, we believe, we act'.***

2.5 Supporting staff to ensure that all patients and service users are protected is crucial to ensuring safe and effective safeguarding of all age groups regardless of ethnicity, religion, gender, or background. Central to this message is listening and hearing the voice of children, young people, adults at risk and their families and ensuring that safeguarding is always made personal. Hearing the voice of patients and service users is vitally important to the Trust.

2.6 The safeguarding and Looked after Children service is delivered as a single corporate, Trust-wide service, with teams based at two community and four hospital sites. The service provides a resilient, visible, and accessible offer across all our hospitals/managed clinical services (MCS) /local care organisations (LCO).

2.7 The Trust has invested in a new team of safeguarding practitioners to lead and support safeguarding in North Manchester General Hospital (NMGH). The team have worked closely with the Director of Nursing and NMGH colleagues to embed the MFT safeguarding governance structure, safeguarding policy and training on site at NMGH. This has resulted in an increase in safeguarding referrals from NMGH this annual report year confirming that frontline services are recognising and responding to safeguarding concerns.

2.8 Throughout this year, the safeguarding and Looked after Children service has continued to review models of working to further 'future-proof' safeguarding in MFT. The year has seen strengthened partnership working across the three Manchester localities and in Trafford.

2.9 The safeguarding leadership provided by our community safeguarding children named nurses at the Manchester Safeguarding Partnership (MSP) locality safeguarding fora has been commended in an external review of the Manchester Multi-agency Safeguarding Arrangements[3] which described the safeguarding fora "as a great success engaging a wide range of professionals on important discussions".

2.10 Key drivers have shaped the safeguarding and Looked after Children services during 2021-2022, some of which have challenged our teams to think and work differently.

Figure 2 provides an overview of some of the drivers that have informed the Trust's safeguarding priorities.

Figure 2: Key Drivers

Key Driver	Key Change
Mental Capacity Amendment Act (2019)	Preparation for implementation of the Liberty Protection Safeguards to replace the Deprivation of Liberty Safeguards
Domestic Abuse Act (2021)	Recognition that children and young people who see or hear domestic abuse are victims in their own right and the inclusion of the new offence of non-fatal strangulation has resulted in revised policy guidance and training for MFT
Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)	Three-year implementation plan to deliver mandatory Level 3 Safeguarding Adult Training has been completed this year
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)	Review of the mapping, content, and delivery of the Safeguarding Children Training.

2.11 The MFT Care Quality Commission (CQC) Inspection report, published in March 2019, recognised that effective systems were in place to safeguard patients in the organisation, citing several examples of good practice. However, the inspection report also highlighted that the Trust should review its systems to provide assurance that the required staff have completed their mandatory safeguarding training. This was a key priority for the safeguarding service working with the Hospitals, MCS and LCOs in 2021/2022. The year-end data identifies that substantial improvements in compliance have been achieved, however work is still required in relation to level 3 adult and child safeguarding training in order to achieve the Trust's target compliance level of 90%.

2.12 This year the Trust's mandatory safeguarding training mapping, compliance and programme was reviewed with a plan for a new training strategy and a revised virtual training programme to be implemented in quarter 2 (2022-2023).

2.13 The Trust has actively supported the work of the Manchester Safeguarding Partnership and Trafford Strategic Safeguarding Partnerships (MSP and TSSP). The safeguarding service has worked to ensure representation at all of the MSP boards, and all of the MSP and TSSP subgroups, and work streams. The partnership priorities have informed the Trust's safeguarding work plan.

[3] Review of Manchester Multi-agency Safeguarding Arrangements (Adult and Children) "Taking it to the next level" (2021) Carol Brookes Associates

2.14 In respect of adult safeguarding there has been continued development of a consistent and unified approach across the Trust with the implementation of a Trust wide response to adult safeguarding enquiries involving hospital/MCS/LCO working closely with risk and governance and the safeguarding teams. There has been an increase in the volume of adult safeguarding referrals to the safeguarding teams, which is consistent with local MSP reporting and national statistics.

2.15 Deprivation of Liberty Safeguards (DoLS) remains a challenge both nationally and within the Trust. In 2019 the Mental Capacity (Amendment) Act (MCA) set out proposed changes to legislation, which reforms the process for authorising arrangements for people who lack capacity to consent to their care or treatment. The new legislation recommends that DoLS are repealed and replaced by a new Liberty Protection Safeguards (LPS) process, which will streamline the process for the deprivation of an individual's liberty where appropriate. In 2019 the new legislation was given royal assent, however, there has been a delay in the national implementation plan with the MCA and LPS Code of Practice consultation being released in March 2022. The current challenges with the DoLS process are associated with limited capacity within the Local Authority (LA) DoLS teams to undertake timely assessments to enable the authorisation of the deprivation of liberty. Across MFT this issue has been acknowledged and processes are in place to recognise and escalate the risk this poses to the Trust for any patient who is deprived of their liberty.

2.16 There has been a notable increase in reporting of adult, unborn, children and young people safeguarding concerns this year. The increase in the Trust footprint has attributed to some but not all of the increased reporting, therefore acknowledging that frontline staff are increasingly recognising and responding to safeguarding concerns. Concerns related to neglect in the care of adults and children, domestic abuse and the impact of mental health concerns on safeguarding are the most frequent categories of concern reported to the safeguarding team, this is consistent with the national data. The safeguarding response to concerns around neglect and mental health will continue to be a priority for MSP and the Trust next year.

2.17 Following investment by the Trust in a new team of specialist mental health and learning disability nurses in 2020, this year the established team has provided specialist leadership and support to frontline services to promote high quality care and reasonable adjustments for our patients with a learning disability and or autism or mental health concerns.

2.18 In this annual report year the Trust has completed the MSP self-assessment 'Section 11' of the Children Act 2004 audit, the Adult Assurance self-assessment and the Greater Manchester (GM) Safeguarding Contractual Standards 2021-22 audit tool to measure compliance with the NHS Assurance and Accountability Framework for Safeguarding (Safeguarding Vulnerable People in the NHS 2015)[4]. The outcome of these audits has demonstrated that MFT is compliant with statutory requirements and has an action plan in place to improve safeguarding standards in the application of the mental capacity act and recognition and response to self-neglect.

[4] Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework

2.19 Throughout this year, safeguarding has remained a key priority for the Trust and the safeguarding service has continued to work with frontline staff to respond to changes in legislation, policy and practice in order to prioritise safeguarding vulnerable children, young people, adults at risk and their families.

2.20 In summary, during 2021-2022, the MFT safeguarding team has continued to lead and develop arrangements across the Trust to meet local and national challenges whilst remaining focussed on ensuring that patients/service users are afforded safety and protection whilst in the care of the Trust, and that staff are supported to listen, recognise, respond and act to ensure best outcomes for vulnerable people.

SECTION C

National Overview and Reflections on Manchester City-wide and Trafford Safeguarding

3. Manchester and Trafford Overview

3.1 The city of Manchester is a culturally diverse metropolitan borough of Greater Manchester. Manchester is the 6th most deprived borough in the country[5] and consists of 12 local neighbourhoods each with their own unique culture and demography. The Manchester 'State of Our City Report' and local intelligence statistics[6] identifies further comparative data regarding the demographics of Manchester. Trafford is classified as 191st out of 317 in the index of deprivation (1 is the most deprived); it is comprised of 21 local wards[7]. MFT provide acute and community health services across Manchester and Trafford. This requires the safeguarding provision to span the diversity and specific needs of all of these neighbourhoods and wards.

Keeping People Safe in Manchester and Trafford

3.2 The Manchester Safeguarding Partnership vision is[8]:

> "Working together to create a place where all children and adults in Manchester are safe, free from abuse and neglect and supported to live happy and healthy lives.

3.3 The Trafford Safeguarding partnership[9] aim is to:

> "Remains committed to an integrated all-age approach to safeguarding and will continue to focus on safeguarding adults and children, ensuring a joined-up approach that delivers continuous improvement and maximises the best use of available resources".

3.4 As a committed partner, MFT embraces these visions and has established robust systems to ensure that people at risk who access MFT services are protected from abuse and neglect.

[5] Manchester Indices of Deprivation
[6] Manchester State of Our City Report
Manchester City Council Manchester Statistics and Intelligence
Manchester Child Health Profile
[7] Trafford Joint Strategic Needs Assessment
[8] Manchester Safeguarding Partnership Annual Report 2020-2021
[9] Trafford Strategic Safeguarding Partnership

Safeguarding Adults at Risk

3.5 **Safeguarding Adults at Risk National and Local Context**

3.6 The Care Act (2014) outlines the following categories of abuse for adults:

Figure 3: Categories of Abuse

3.7 All MFT staff, regardless of their role, have a part to play in identifying and escalating safeguarding concerns, along with taking the necessary steps to prevent harm or abuse occurring. This includes the identification of professional practice, which may put a patient or service user at risk.

3.8 The latest national data for Safeguarding Adults in England 2020/21 identifies key themes (**Figure 4** below).[10]

Figure 4: Key themes identified by National Data for Safeguarding Adults in England (based on the most recent national data)

- There was a 5% increase in safeguarding concerns (to 498,260) on the previous year.
- There was a 6% decrease (to 152,270) in Section 42 adult safeguarding enquires.
- The most common type of risk in Section 42 adult safeguarding enquiries was Neglect and Acts of Omission, which accounted for 30% of risks.
- The most common location of the risk was the person's own home at 50%.
- In 89% of completed Section 42 enquiries the outcome was that the risk was reduced or removed.

[10] Safeguarding Adults, England 2020-21

3.9 The MSP commitment for safeguarding adults is:

> 'Ensuring every citizen in Manchester is able to live in safety, free from abuse and neglect'.
>
> 'Everyone who lives and works in the City has a role to play.'

3.10 TSSP[11] identifies adult safeguarding as:

> "Protecting an adults right to live in safety, free from abuse and neglect. It is about people and organisations working together to present and stop the risk and experience of abuse and neglect whilst ensuring the adult's wellbeing is promoted."

3.11 **Figure 5** below explores the number of safeguarding concerns and Section 42 adult safeguarding enquiries in England, Manchester and Trafford in the latest available national data set (2020/2021)[12] with a comparison to the previous year.

Figure 5: Safeguarding adult concerns and Section 42 adult safeguarding enquiries

Area	Number of safeguarding Adult Concerns		Section 42 Enquiries Adult Safeguarding Enquiries	
	2019/2020	2020/21	2019/2020	2020/2021
England	475,560	498,260	161,910	152,270
Manchester	11,075	13,180	945	1,475
Trafford	4,525	4,860	435	415

The number of reported safeguarding concerns has increased this year in England Manchester and Trafford. However, the number of concerns converted to adult safeguarding enquiries has reduced in England and Trafford but has increased in Manchester.

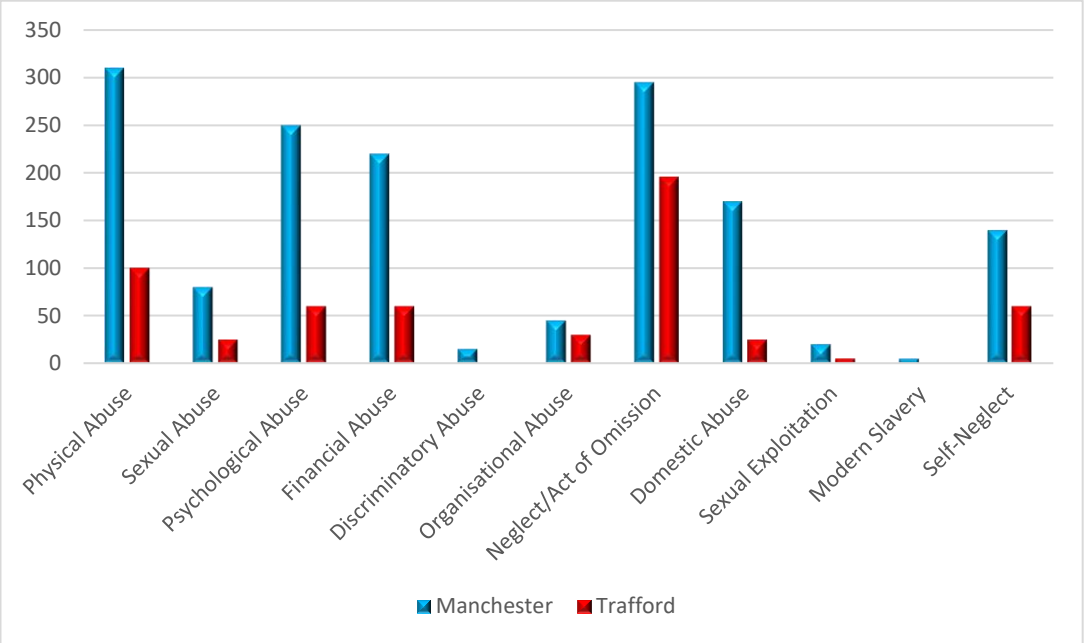
Figure 6: Safeguarding enquiries (no.) according to types of abuse in England, Manchester, and Trafford

Area	Physical Abuse	Sexual Abuse	Psychological Abuse	Finical Abuse	Discriminatory Abuse	Organisational Abuse	Neglect Act of Omission	Domestic Abuse	Sexual Exploitation	Modern Slavery	Self-Neglect
England	40,240	7,410	30,080	28,225	1,395	8,920	61,190	13,880	1,665	525	12,920
Manchester	310	80	250	220	15	45	295	170	20	5	140
Trafford	100	25	60	60		30	195	25	5		60

[11] Adult Safeguarding Annual Report 2020
[12] Safeguarding Adults, England 2020-21

3.12 **Figures 6,** above and **figure 7** below identify the safeguarding enquiries according to types of abuse completed in Manchester and Trafford. Neglect and omission in care/self-neglect were the most recognised forms of adult abuse in England, and Trafford. In Manchester the most frequently reported type of abuse was physical abuse followed by neglect/omission of care and psychological abuse. In Trafford, in line with the national trend, physical abuse was the second most frequently reported category.

Figure 7: Safeguarding enquiries according to types of abuse completed in Manchester and Trafford



Deprivation of Liberty Safeguards (DoLS)

3.13 **Figure 8**, below sets out the national data regarding DoLS in England in 2020/21.[13]

- The number of applications has decreased by 3% during 2020/21 following a 14% increase from 2014 until 2019/20.
- The number of authorised/granted applications has also increased each year, by an average of 19% since 2014-15.
- 57% of applications that were not granted were due to a change in the individuals' circumstances.
- The average length of time for completed applications was 148 days.

3.14 A key focus of adult safeguarding for the Trust is ensuring that all patients in MFT hospitals, who lack capacity to consent to care and treatment and who are not free to leave, have had a mental capacity assessment completed and a DoLS submitted to the LA to ensure that their best interests have been considered in relation to their care arrangements within the legislative framework.

[13] Mental Capacity Act 2005, Deprivation of Liberty Safeguards-2020-21

3.15 In 2020/21 Manchester LA received 3,265 DoLS applications, which included 1,585 from acute[14] hospitals. From the number of applications completed 1,410 applications were granted and 2,090 were not. The most common reason for an application not being granted was a change in the person's circumstance.

3.16 Trafford LA received 2,375 DoLS applications which included 1,000 from acute hospitals. From this number 550 applications were granted and 1,390 were not. The most common reason for an application not being granted was a change in the person's circumstance.

3.17 There are established processes in place across MFT to identify categories of abuse and neglect. Clear procedures are also embedded across the Trust to support staff when completing safeguarding referrals or enquiries and for making DoLS applications. Section F of this report provides detail of the Trust's local data on categories of abuse and neglect and DoLS applications.

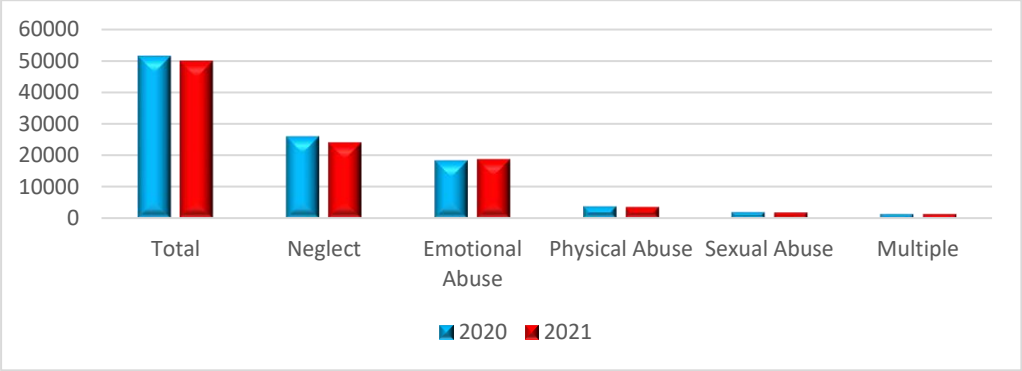
Keeping Children Safe - The National and Local Context in Manchester and Trafford

3.18 Comparison with the national position provides local context.

3.19 On 31st March 2021, 50,010 (compared to 51,510 2020 the previous year) children in England[15] were the subject of a child protection plan (CPP) due to experiencing or being at risk of abuse or neglect. This is a small decrease from the previous year (2.9%) and the lowest rate at 41 per 10,000 children since 2013.

3.20 **Figure 9** below shows the number of children subject to a CPP in each category of abuse and neglect in England in the last 2 years. Child neglect remains the most frequently reported category of abuse.

Figure 9: Number of children subject to CPP by initial category of abuse and neglect in England in the last 2 years



[14] The national data identies acute hospitals and does not state which Trust made the referral.
[15] Characteristics of children in need 2021

3.21 A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be impaired without the provision of services, or the child is disabled. On the 31st March 2021[16] there were 388,490 'Children in Need' (CIN) in England. This is a slight decrease of 0.2% from 2020 and is the lowest rate since 2013.

3.22 The MSP commitment vision for children and young people is for:

> "Every Child in Manchester is Safe, Happy, Healthy and Successful.
>
> To achieve this, we will: Be child-centred, listen to, and respond to children and young people, focus on strengths and resilience, and take early action."

3.23 The TSSP statement of purpose[17] to guide work with children, young people and families is:

> "The safeguarding partners and all relevant agencies that work with children and families are committed to ensuring that safeguarding arrangements are of the highest quality, that they consistently promote the welfare and effective safeguarding of children whatever their circumstances".

3.24 As a committed partner, MFT embraces these visions and priorities and we have systems in place to ensure that all children who receive care from the Trust are protected from abuse and neglect.

3.25 Manchester and Trafford have a number of children and young people who require services under the Children Act (1989) framework to keep them safe, as either a Child in Need (Section 17) or Child Protection (Section 47) of the Children Act (1989). A robust partnership approach is essential in identifying children and young people who are at risk of, or who are suffering harm, in order to ensure the best protection is afforded to them.

3.26 The most recent data[18] (**Figures 10a and 10b**) outlines how Manchester and Trafford compare statistically in relation to National, North West and statistical neighbours' data in respect of the numbers of children who are categorised as CIN or who are on a CPP.

[16] Characteristics of Children in Need 2020
[17] Trafford Strategic Safeguarding Partnership Annual Report 2020-21
[18] Characteristics of Child in Need

Figure 10a: CIN Statistical Comparison

Area	CIN on 31st March 2020	CIN on 31st March 2021
England	**389,260**	**388,490**
North West	**58,080**	**57,670**
Manchester	**5,330**	**5,312**
Liverpool (statistical neighbour)	**4,156**	**4,329**
Trafford	**1,420**	**1,467**
Bury (statistical neighbour)	**1,302**	**1,428**

3.27 The CIN statistics identify a decreasing number of children in need in Manchester, but the number remains higher than national rates. In Trafford there has been an increase in children in need, but the rate remains lower than English average rates.

Figure 10b: Children Subject to a CPP Statistical Comparison

Area	Children on a CPP on 31st March 2020	Children on a CPP on 31st March 2021	Rate of CPP 31st March 2020 per 10,000 children
England	**51,510**	**50,010**	**41.4**
North West	**7,880**	**7,390**	**47**
Manchester	**731**	**564**	**45.5**
Liverpool (Statistical Neighbour)	**544**	**622**	**64.3**
Trafford	**205**	**184**	**32.5**
Bury (statistical neighbour)	**146**	**201**	**46.5**

3.28 The number of children subject to a CPP has decreased in Manchester, however the rate is higher than the national average. In Trafford, the number of children subject to a CPP has also decreased and remains lower than the national average. It is important to note that early data for 2021/2022[19], not yet collated in the national annual statistics, identifies that in Manchester the number of children on CPP's continues to decrease whilst in Trafford there has been a small increase. This is explored further in section F of this report.

[19] MSP and TSSP quarterly data sets submitted to Safeguarding Effectiveness Committees

SECTION D

Safeguarding Governance and Accountability

4. Safeguarding Governance and Accountability

4.1 The Group Chief Nurse is the Board Executive lead for safeguarding and is accountable for safeguarding across MFT. The Chief Nurse is supported by a robust senior management and operational structure that ensures both acute and community safeguarding services are aligned in terms of governance and accountability. The Group Deputy Chief Nurse provides strategic leadership, and the Assistant Chief Nurse (Safeguarding) provides expert leadership across the Trust and supports the Group Deputy Chief Nurse strategically across the partnerships. Hospital/MCS/LCO Directors of Nursing/Midwifery are accountable for local safeguarding governance. The Head of Nursing (Safeguarding) provides operational leadership across the safeguarding service whilst also contributing to partnership activity to underpin the objectives of the local safeguarding partnerships.

4.2 Effective safeguarding communication and information sharing across MFT is essential to support the Hospitals, MCS and LCOs in the Trust's Group structure, whilst aligning to both Manchester, Trafford, and Greater Manchester safeguarding governance requirements.

4.3 To effectively address the breadth of safeguarding practice, a clear governance structure is in place. This ensures that there is a clear line of sight from multi-agency work-streams into the Hospitals/MCS/LCO.

4.4 The Group Safeguarding Committee is chaired by the Group Chief Nurse and its thematic sub-groups are chaired or supported by a senior member of the safeguarding team with a representative from all of the Hospitals, MCS and LCOs. Each Hospital/MCS/LCO has a safeguarding committee chaired by the Director of Nursing/Midwifery or agreed senior lead. The sub-groups and the Hospital/MCS/LCO safeguarding committees are accountable to the Group Safeguarding Committee, which reports through the Trust's governance structure, to the MFT Board of Directors.

4.5 The Trust's named nurses, midwives and doctors are statutory roles and are responsible for supporting all of the activities necessary to ensure that the Trust meets its statutory responsibilities. Named doctors for safeguarding children and Looked after hildren provide leadership, training, and advice to medical colleagues to support the clinical assessment and care of children and young people where there are safeguarding/child protection concerns. The safeguarding named nurses, midwives and doctors ensure that the Trust has robust safeguarding policies and procedures in place in line with legislation, national guidance, and the guidance of the MSP/TSSP.

4.6 The following section provides an overview of the MFT Group Safeguarding Committee subgroup activity and the work completed in these thematic work streams during 2021-22.

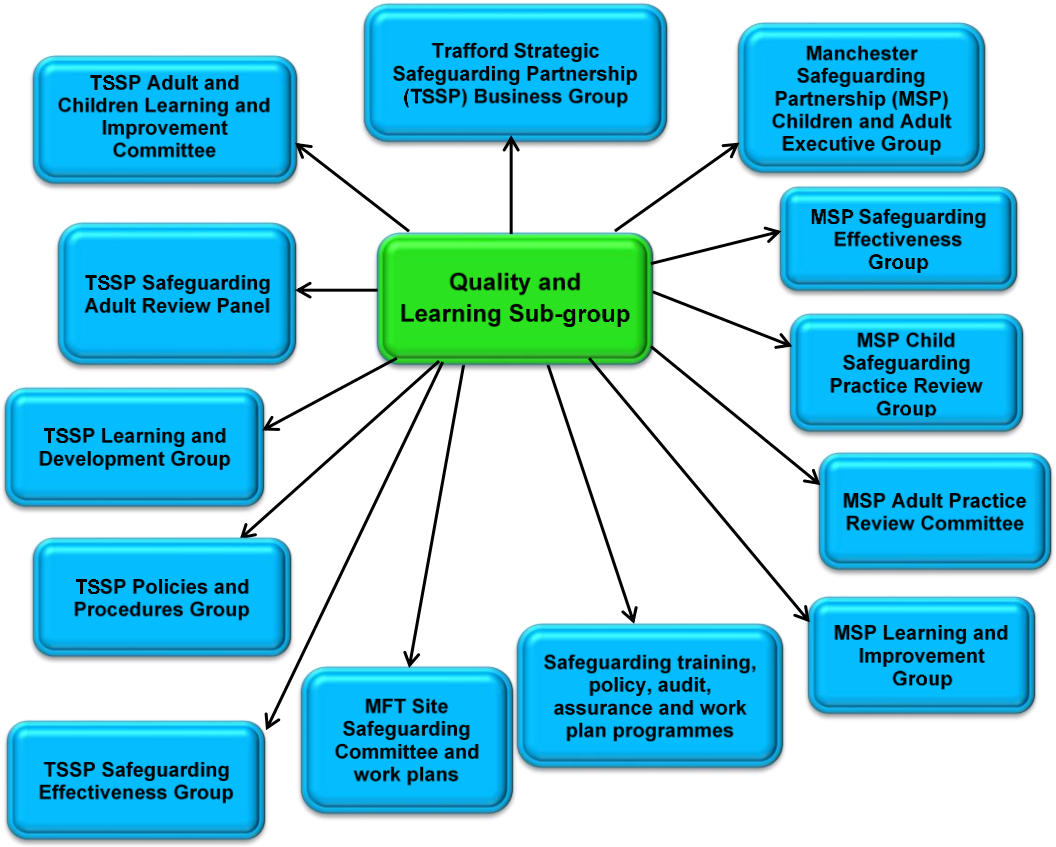
4.7 In 2021/22 following recommendations from an external safeguarding audit[20] all safeguarding subgroups have reviewed their terms of reference to ensure they align the with multi-agency safeguarding arrangements. In addition, all safeguarding subgroups have now standardised their meeting minutes, action trackers and exception reporting.

MFT Quality and Learning Sub-group

4.8 **Purpose of the Group**

The aim of the Safeguarding Quality and Learning Sub-group is to ensure that national and local safeguarding messages influence and inform policy development, training programmes and safeguarding practice across the Trust. The group provides oversight of both single and multi-agency safeguarding audits, inspections, and reviews, the group monitors the implementation and progress of safeguarding work plans and review/audit action plans.

4.9 **Group Work Streams and Relationships with Multi-Agency Groups**



4.10 **Key Achievements**

- ✓ The group has established membership and benefits and good attendance from all of the hospitals/MCS/LCO. NMGH representatives have joined the group and have shared the progress of their safeguarding workplan.

[20] Internal audit 2020/21 Safeguarding (KPMG)

- ✓ All safeguarding policies have been reviewed this year to align with practice at NMGH. There is an ongoing policy implementation plan at NMGH and audit in 2022/23 will review the policy implementation.
- ✓ Compliance with mandatory safeguarding training is now at the Trust's expected compliance levels for Levels 1 & 2 safeguarding training. Significant improvements have been made in the compliance with Level 3 Adult Safeguarding training.
- ✓ Learning from safeguarding reviews has been shared and recommendations that require actions for MFT are closely monitored and scrutinised. This year learning has been shared from Manchester Safeguarding Adult Reviews[21], 'Olia', 'Johnny' and the Self-Neglect and Carers Thematic reviews, Manchester Serious Case Reviews (SCR)[22] 'X1`, 'T1' and 'R1', Bury SCR 'Joshua[23]' and Salford Child Safeguarding Practice Review, 'Chloe[24]'.
- ✓ Learning from reviews has continued to highlight the vulnerability of non-mobile babies and a new Safeguarding Management of Injury guidance and guidance to support staff in response to the identification of bruising to immobile babies has been developed.
- ✓ The "Think Family, whole family approach" has continued to be promoted especially in the context of parental mental health, substance misuse and domestic abuse following learning from reviews.
- ✓ Key messages and priorities to and from the Safeguarding Partnerships have been shared and have influenced safeguarding practice in the Trust. The Learning from the Child Protection Strategy Meeting audit has informed wider partnership work on the expectations of frontline staff in attending strategy meetings through multi-agency audit and practice standards.[25]

4.11 **Areas for Development**

- Multi-agency safeguarding reviews and MFT safeguarding audits have identified a continued requirement to support frontline practitioners to improve in the consistent application of the Mental Capacity Act (MCA) and DoLS. To support with this updated guidance, training and podcasts have been developed and implemented by the safeguarding menatal health team. There is a plan to further audit MCA and DoLS compliance in 2022/23.
- Hospitals/MCS/LCO workplans consistently report on their local work to improve mandatory safeguarding training complinace, especially for level 3 safeguarding training. This year the MFT training strategy and mapping has been reviewed, and a new safeguarding training package is in development. It has been acknowledged that local mapping has increased the number of staff requiring level 3 training which has reduced theTrust wide compliance data. In 2022/23 the training strategy will be launched with the introduction of the new training package.
- The hospitals/MCS/LCO have exception reported in their safeguarding workplans that there has been an increase in the volume and acuity of patients admitted with mental health concerns or who are displaying distressed behaviours and are awaiting a mental health hospital admission or LA placement. This work has

[21] Manchester Safeguarding Partnership Safeguarding Adult Reviews
[22] Manchester Safeguarding Partnership Child Case Reviews
[23] Bury Integrated Safeguarding Partnership SAR Joshua
[24] Salford Safeguarding Children Partnership CSPR Chloe
[25] MSP Multi-agency audit into the efficacy of strategy meetings 2021
MSP Strategy Meeting Practice Standards (in development)

informed the partnership response to the Greater Manchester Children in Crisis framework and has led to the development of local MFT policy and guidance.[26]

MFT Early Help and Neglect Sub-group

4.12 **Purpose of the Group**

The remit of the subgroup is to ensure that the key areas of the Early Help and Neglect agenda are embedded across the children/young people and adult services/departments /wards/teams across hospitals/MCS/LCOs and to ensure quality assessments/information in line with multi-agency standards. This group's remit is to:

- Ensure local practice and procedures are reflective of the national messages, the Manchester and Trafford Safeguarding Partnerships strategic and operational groups and learning from safeguarding reviews.
- Develop and implement training and briefings for hospitals/MCS/LCO in line with Early Help and Neglect requirements.
- Ensure that health care professionals have the tools and support to work sensitively to undertake assessments and care plans in partnership with children, parents, adults, and other professionals.
- Ensure that Early Help support, is accessible to all service users.
- Seek assurance on the hospital/MCS/LCO compliance with safeguarding legislation and regulation in relation to early help and neglect.

4.13 **Group Work Streams and Relationships with Multi-Agency Groups Early Help and Neglect Sub-Group.**

[26] Guidance for Children and Young People who are medically fit for discharge but with no place to be discharged to Care for adult patients who experience behavioural disturbance due to mental health conditions

4.14 Key Achievements

- ✓ The relaunch of the Early Help and Neglect subgroup included reviewed Terms of Reference reflecting the whole family approach. This included the promotion of safeguarding adults in the context of neglect/self-neglect and hoarding.
- ✓ As part of the relaunch, work plans, contribution and support to the sub-group has been reviewed and enhanced. Bespoke support for hospitals/MCS/ LCO has been provided. This has resulted in improved attendance, contribution, and evidence of how the group is influencing practice.
- ✓ Following subgroup attendance, the hospitals and MCS's have invited Early Help partners to their site safeguarding meetings and other local fora to provide information and updates.
- ✓ Evidence from hospitals/MCS/LCOs meeting minutes illustrate how messages from the subgroup are updating the safeguarding committees, providing assurance that messages are being embedded.
- ✓ Learning from local and national safeguarding children, adult, and domestic homicide reviews has provided the framework to explore key early help trigger points and have been brought to the group to develop wider learning. This included the publication of learning from the Manchester Adult Self-Neglect Thematic Review[27].
- ✓ This wider learning has been further developed by representatives bringing examples of how learning is applied to local practice through a patient story at each meeting.
- ✓ Learning from the MSP Carer's Review[28] has highlighted the positive role of carers and has identified three key areas of learning: Empowerment - showing due regard

[27] MSP Safeguarding Adult Reviews
[28] MSP Safeguarding Adult Reviews

to the carer, Prevention – adopting a more robust and enquiring approach when talking to carers, Protection – adopting an improved awareness of safeguarding alerts.

- ✓ The subgroup work plan prioritises making safeguarding personnel and hearing the voice of the child/young person within early help and neglect practice.
- ✓ There has been contribution to and sharing of the TSSP Neglect Strategy 2021[29] and the MSP Manchester Child Neglect Strategy 2021-24[30].
- ✓ Completion of the MSP Children's Neglect and Adult Self-Neglect audit, with multi-agency outcomes of the audit expected in 2022/23.
- ✓ Completion of the TSSP Neglect audit which identified that children subject to a CIN plan for longer than 6 months should be reviewed by managers across all agencies.
- ✓ A TSSP Neglect Conference was held in Trafford with a speaker from the Trafford Child and Safeguarding Families Team.
- ✓ Strong links with the Manchester Early Help hubs have been developed. This provides valuable resources that contain links for support for both children and adults.
- ✓ Adult Safeguarding week took place In November 2021 with events across all sites to raise awareness of the impact of carer stress and homelessness. Podcasts were developed and shared widely and provided MFT staff with the opportunity to undertake learning and updates using varied mediasystems .
- ✓ Learning from the MFT Early Help and Neglect sub-group on adult self-neglect and hoarding was shared with the MSP Safeguarding Fora and Greater Manchester Police.

4.15 **Areas for Development**

- To ensure recommendations and lessons learned in relation to early help and neglect from local and national child safeguarding practice reviews, safeguarding adult reviews are implemented across hospitals/MCS/LCO.
- For the hospitals/MCS/LCOs to further develop their provision of evidence within their safeguarding work plan. The safeguarding team will support the hospitals/MCS/LCOs to further develop their provision of evidence within their safeguarding work plan, supporting education and development regarding early help and neglect.
- Manchester's Child Neglect Strategy 2021-24 was published at the end of 2021-22. An operational implementation plan is in place which will inform a whole family approach and response to early help and neglect. The Strategy can be further embedded linking with the published MSP Learning Review 'Jessie'.
- Scoping and development of a child neglect early assessment tool to support the use of the Graded Care Profile 2[31] tool which supports practitioners in the identification of neglect.
- Reviewing the process of Graded Care Profile 2 training to support and increase the completion of the tool with children and families.
- The continued development of working with children and young people who are experiencing childhood obesity in the context of neglect.

[29] TSSP Neglect Strategy 2021
[30] Manchester Child Neglect Strategy 2021-24
[31] Graded Care Profile Tool 2

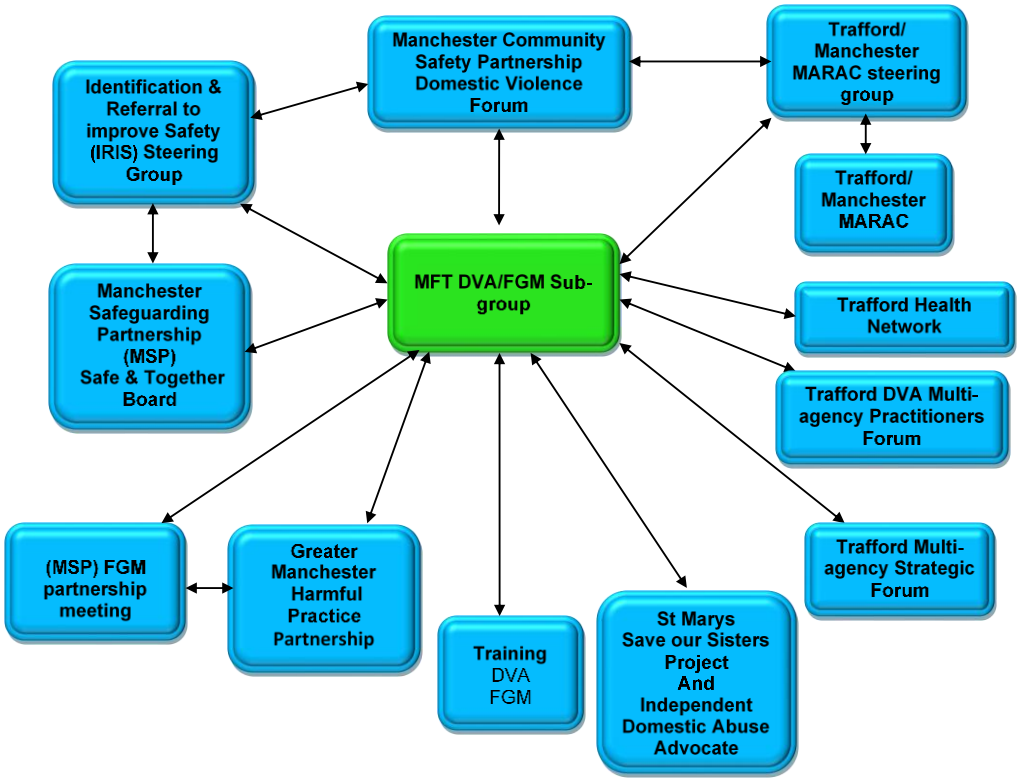
- Prioritise making safeguarding personnel and hearing the voice of the child/young person within early help and neglect practice. The Early Help and Neglect subgroup has a specific aim to capture the child/adult or family voice or view using relevant link worker/language line/ tools to obtain the disabled child's/non-verbal child/ baby voice. Patient stories will capture and evidence how the child/adult voice is sought and responded to.
- To strengthen the workplan in relation to adult Self-Neglect.

MFT Domestic Violence and Abuse (DVA) and Female Genital Mutilation (FGM) Sub-group

4.16 **Purpose of the Group**

The DVA and FGM sub-group develops policy, practice and training, and cascades key messages and learning from local and national reviews/messages to improve the response in the recognition, risk assessment and safeguarding of victims and survivors of DVA and FGM. The membership of the group ensures that messages from operational and strategic domestic violence and FGM groups in Manchester, Trafford and Greater Manchester inform and influence practice across the Trust.

4.17 **Group Work streams and relationships with multi-agency groups**



4.18 **Key Achievements**

✓ The DVA sub-group chair submitted a report to the Group Safeguarding Committee with information about two key Strategies driving the DVA work at local level - The Greater Manchester Gender-Based Violence Strategy[32] which was

[32] Greater Manchester Gender-Based Violence Strategy

published in September 2021 and the Manchester Domestic Abuse Strategy[33] which was completed by the Manchester Community Safety Partnership in collaboration with MSP which was the published on 31st October 2021. The report outlined the common goals of both strategies and how this would be included in the DVA work across the MFT footprint with its implementation being supported by the DVA subgroup.

- ✓ The group continues to have a consistent membership and receives regular reports from the clinical areas to provide assurance of the Trust's response to DVA and FGM.
- ✓ A DVA training module has been developed that incorporates national and local data and key messages identifying priority groups for training. The training has previously been delivered face to face and through a virtual offer. DVA training will now be a mandatory module as part of level 3 safeguarding training in the new training package which is due to be launched in quarter 2 (2022/23). Additional bespoke face to face training will continue to be delivered to support and develop frontline practitioner skills in recognising and responding to domestic abuse.
- ✓ Specialist training on the Manchester Children's Services 'Safe and Together[34]' Model for safeguarding children is being delivered. The MFT safeguarding team contribute to the MSP Safe & Together board and work closely with the MSP to assess training needs: this work is being independently evaluated by the University of Sterling.
- ✓ A 'Support for staff in relation to Domestic Abuse' policy has been implemented. This policy has been embeded in practice and has enabled line managers and the safeguarding team to support staff who may be victims of DVA.
- ✓ The MFT Domestic Abuse policy has been reviewed and updated to ensure that it reflects the changes in legislation outlined in the Domestic Abuse Act[35] that gained royal ascent at the end of April 2021. The policy is being used across the MFT footprint.
- ✓ Focus has been given in meetings to national DVA campaigns, for example in December 2021, '16 days of action for Violence Against women and girls'. Members of the sub-group supported the chairs in sharing information via the Trust safeguarding newsletter, MFT Twitter accounts, MFT intranet pages and the LCO staff updates. Information sharing regarding domestic abuse and the support services that are available has continued to be disseminated.
- ✓ TLCO have continued to contribute to the subgroup and the skills, knowledge, and experience of TLCO professionals has enhanced discussion and information sharing at the sub-group around the impact of DVA on the LGBTQ+ community.
- ✓ Messages from domestic homicide reviews/serious case reviews and adult safeguarding reviews where domestic abuse is a feature has been shared with the group for dissemination across the Hospitals/MCS/LCOs.
- ✓ Partnership working continues with both the MSP and TSSP and Greater Manchester DVA/FGM groups to ensure key messages and themes are shared. Attendance, feedback, and contribution to operational and strategic groups has been maintained by the safeguarding named nurses and midwife.

[33] Manchester Domestic Abuse Strategy
[34] Manchester Children's Services 'Safe and Together
[35] Domestic Abuse Act 2021

- ✓ The named nurse safeguarding has contributed to the development of 'Operation Encompass', the purpose of hich is to ensure information is shared about school age children experiencing DVA in their home.
- ✓ Partnership work by the named nurse safeguarding with the Manchester Advice and Guidance Service (AGS) social care "front door" has given the opportunity for improved contribution to and scrutiny from the Trust of the multi-agency DACC process (domestic abuse and child concern).
- ✓ The Trust continues to make an important contribution to the MARAC meetings
- ✓ MFT are contributing to the DRIVE project led by Greater Manchester Police (GMP) which focuses on work with DVA perpetrators.
- ✓ Strong partnership links remain between MFT and NESTAC[36] as a key partner agency who deliver training, support and expert advice based on academic research into FGM.
- ✓ Communication with key partners including Greater Manchester Police and the LA is ongoing and further analysis and scrutiny is being given to national and local data on FGM.
- ✓ The Greater Manchester FGM Task & Finish group membership has been reviewed and a new chair has been appointed to develop the Greater Manchester Harmful Practice Partnership.

4.19 **Areas for Development**

- The Greater Manchester FGM Task & Finish group membership has been reviewed and a new chair appointed to develop the Greater Manchester Harmful Practice Partnership. The work of the group going forward will include considering the broader local and national agenda for violence against women and girls (VWAG) including domestic servitude, breast ironing, forced marriage, assault and harassment. The MFT safeguarding team will contribute to this work.
- There will be MFT contribution to the MSP – Front Door Domestic Violence and Abuse Workstream. The purpose of this work is to review the effectiveness of the current DAC (Domestic Abuse and Child Concern) meetings.
- To ensure the group's workplan is informed by the Manchester Community Safety Partnership DVA Forum to deliver the 3 key priorities of the Manchester Domestic Abuse Strategy 2021 which are:
  1. Prevent abuse and promote healthy relationships.
  2. Identifying abuse and intervening.
  3. Support Victims and recovery.
- To strengthen links with the TSP and Trafford Community Safeguarding Partnership Strategic Groups.

Mental Health Safeguarding Group

4.20 **Purpose of Group**

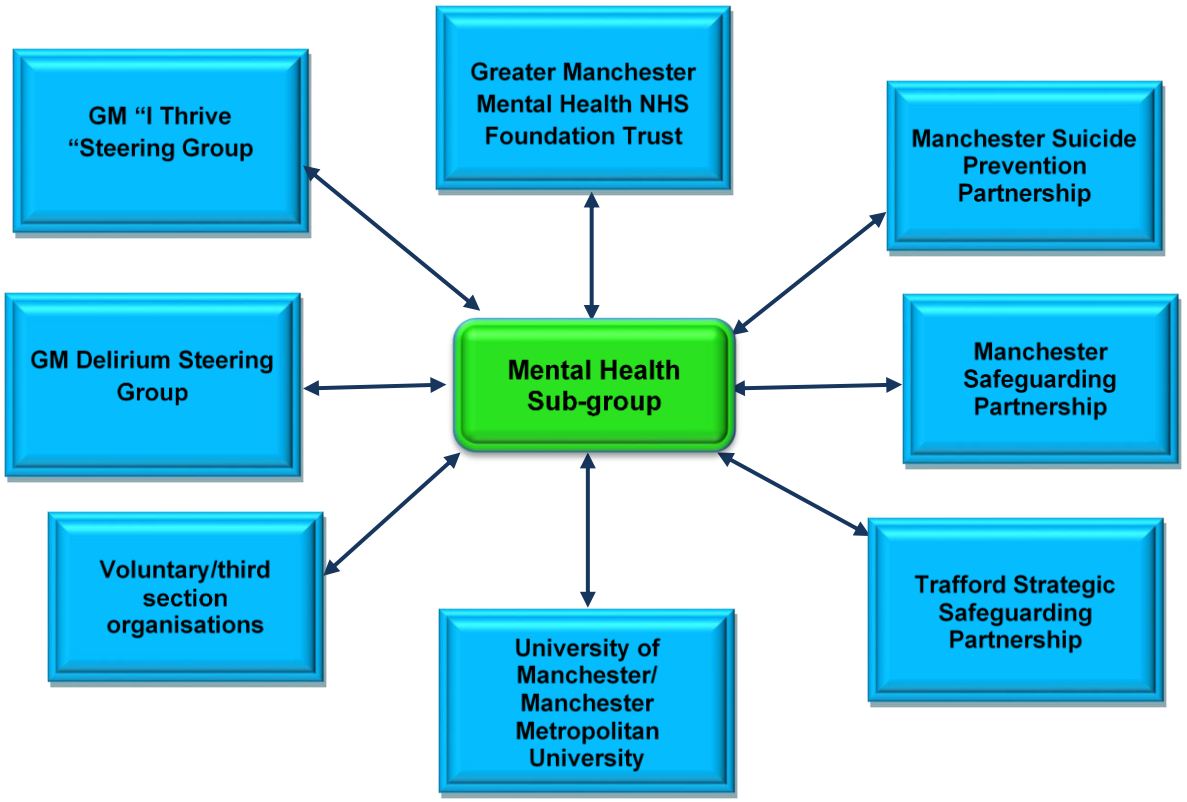
The purpose of the Mental Health Safeguarding Group is to provide corporate oversight across the Trust relating to the quality standards for mental health care. This includes:

- Lead on the development of an overarching mental health policy, in collaboration with commissioned liaison mental health service managers and clinicians.

[36] NESTAC www.nestac.org

- Work with workforce development to ensure that all staff receive targeted education and training to deliver best care including mental health care for all patients.
- Develop and monitor action plans for tracking progress to meet quality standards and to mitigate the mental health related risks, including risks recorded on the corporate/local risk register.
- Audit and monitoring of key performance targets, particularly in relation to risk management.

4.21 **Mental Health Safeguarding Group Work Streams and Relationships with Multi Agency Groups**



4.22 **Key Achievements**

- ✓ Improved Mental Health Act (MHA) compliance with Trust legal framework and protection of patient rights.
- ✓ Improved support with MHA appeal process to support patients and staff should an appeal be requested by the patient.
- ✓ Broset Violence Checklist (BVC) well used across the Trust to predict escalation in risk of violence and aggression.
- ✓ Restrictive Interventions – additional standard operating procedure (SOP) developed to simplify actions for staff, as well as further blended learning through podcasts and training film for delirium.
- ✓ Roll out of ligature risk management training across all hospitals in the Trust.
- ✓ Use of the Integrated Care Pathway (ICP SH-S) for Self Harm/ Suicide at MRI ED, with plan to include ICP SH-S within HIVE at go live in September 2022.

4.23 **Areas of Development and Priorities for 2022-2023**

- Establishment of Trust workstreams to support implementation of Liberty Protection Safeguards (LPS) to replace DoLS.
- Implement new training strategy for use of physical restraint by clinical staff in line with Reducing Restrictive Interventions Network (RRN) standards.
- Develop conflict resolution and de-escalation training, with supervision from safeguarding mental health team to respond to increasing risk of verbal abuse or threatening behaviour by patients or other visitors to the Trust.

- Develop additional workstreams for safeguarding vulnerable patients regarding:
  - Missing and absconding patients
  - Frequent attenders to ED
- Continue roll out of improved MCA / DoLS training – further face to face sessions will be added to the learning hub following HIVE go live.
- Support NMGH to switch to Ulysses for reporting DoLS instead of current EVOLVE system.
- Support MRI senior leads to develop plans to migrate to the new ED, with agreed contingencies in place to ensure environmental safety of Mental Health patients awaiting mental health assessment.
- Continue to support RMCH with children & young people mental health pathway escalation development.
- Adapt Mental Health Level 2, and Level 3 training to be available as eLearning option.
- Roll out new Trust Suicide Prevention Policy.

Learning Disability Steering Group

4.24 **Purpose of Group**

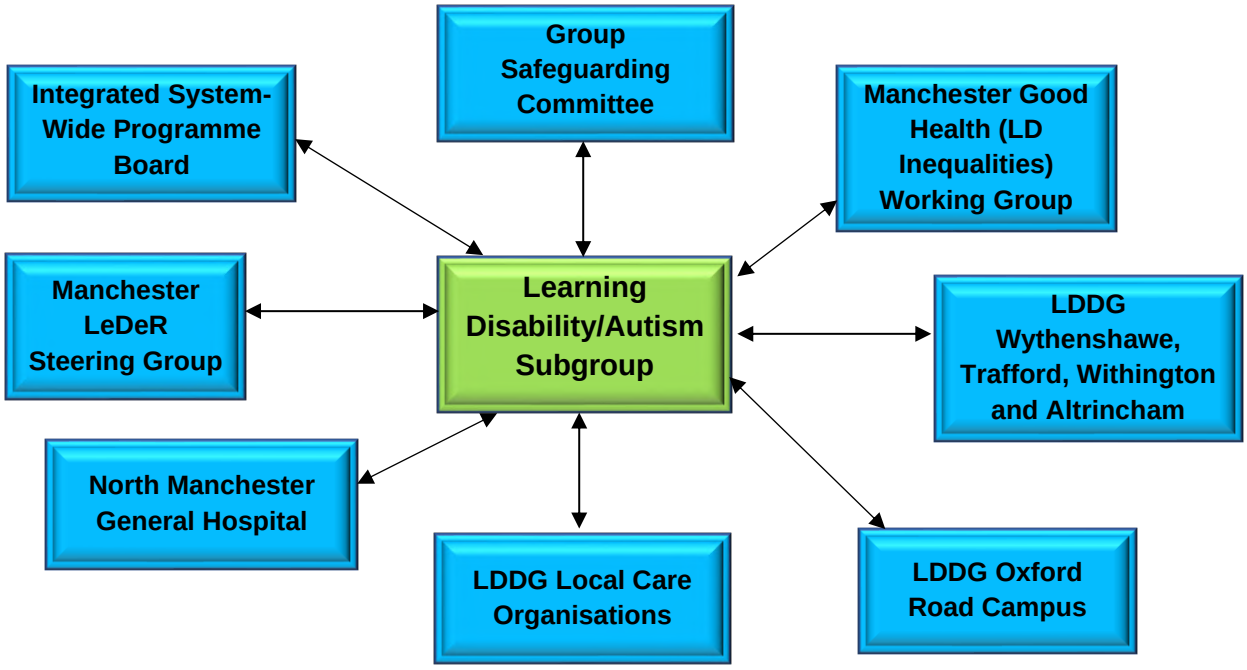
The purpose of the Learning Disability Steering Group (LDSG) is to oversee and drive both assurance and improvements for people with a learning disability (LD) and/or autism, their families and carers accessing healthcare services across MFT via the Hospitals, Managed Clinical Services (MCS) and Local Care Organisations (LCO's) LD Delivery Groups.

This includes:

- Setting the strategic direction within the Trust for the care received by people living with a LD and/or autism across all services.
- Responsible for reviewing standards for people with a LD and/or autism in line with national and local policy, guidance and standards.
- Ensure robust, effective arrangements are in place to meet the standards by NHS Improvement Guidance, National Institute for Health and Care Excellence (NICE) guidance and local standards.
- Provide oversight of LD and/or autism policy development, in collaboration with recognised patient experience/carer forums.
- Provide oversight for all Hospital/MCS/LCOs LD and/or autism workplans, to provide assurance that co-ordinated work takes place across all areas.

- Co-ordinate and share best practice across the Trust, including dissemination of learning and ensuring LD and/or autism delivery group action plans are progressed in line with agreed time scales.

4.25 **Group Work Streams and Relationships with Multi-agency Groups**



4.26 **Key Achievements**

- ✓ Further to changes implemented to the structure of the Oxford Road Campus (ORC) LD Delivery Groups there is representation from each Hospital/MCS/LCOs on the LD Steering Group and mechanisms are in place for feedback.
- ✓ The Manchester Royal Informary (MRI) Matron for Complex Needs has worked with the Patient Experience Team to ensure that there is a robust system in place to capture what matters to patients with LD and/or autism and their family/carers attending MRI. The learning from the experience of MRI will be shared across all Hospitals/MCS/LCOs.
- ✓ A LD guidance document has been developed for inclusion in all community services' staff induction packs. This provides key contact information for the Community Adult Learning Disability Team (CALDS) and the offer for new staff to spend some time with the specialist team as part of their induction.
- ✓ A standard reporting template into the LCOLDDG has been developed and implemented.
- ✓ There has been an increase in the number of Wythenshawe, Trafford, Whithington and Altrincham (WTWA) annual health checks in 2020/2021 which has been supported by the CALDS.
- ✓ A centralised Focus Support Team (FST) has been established within Royal Manchester Children's Hospital (RMCH) supporting clinical areas and patients with reasonable adjustments, social stories, 1:1 activities and leave support.

- ✓ Members of the FST have joined the National Paediatric LD/Autism Spectrum Disorder (ASD) Acute Liaison Network. This is a network to support best practice for those working with children and young people (CYP) with a LD and/or autism in the acute sector.
- ✓ The LD Safeguarding Team have undertaken audits relating to hospital passport and the use of Reasonable Adjustment Checklist.
- ✓ A MFT LD and Autism Strategy has been developed aligned to the Greater Manchester LD Strategy and Manchester system-wide LD workstreams.
- ✓ The Hidden Disabilities Sunflower Scheme has been implemented within MRI Outpatient Departments and Elective Day Case Admissions Units. In adopting the scheme, patients who may require additional support and adaptations are identified and staff are able to support them to have a positive experience.
- ✓ A first draft of a hospital passport for CYP has been developed with an autism and LD care plan under development. This is being undertaken by a multidisciplinary team comprising of mental health (MH) practitioners, LD Practitioners, paediatric staff and Advanced Clinical Practitioners.
- ✓ Within NMGH, a pilot has commenced with NHS Professionals (NHSP), using 'Allocate on Arrival'. Temporary staff with LD or MH experience are purposely sought and are then allocated to clinical areas based on need/risk to support clinical areas in providing high quality care to those most in need.
- ✓ A system is in place to identify patients with LD who have been admitted to RMCH and a daily huddle takes place highlighting patients across RMCH MCS, identifying actions required to provide support them.
- ✓ The LD Safeguarding team have introduced a follow up letter to patients GP's to ensure MRI patients are on the special register and invited for their annual physical assessment. This has come from lessons learnt following the Learning Disabilities Mortality Review (LeDeR) and includes an easy read version for patients to send themselves.

4.27 **Areas of Development**

- Plan implementation of the Sunflower scheme across MFT to recognise hidden disabilities and develop work to improve patient experience for these individuals.
- Launch the MFT LD and Autism Strategy during LD awareness week (20th – 26th June 2022).
- Review the template for the Safeguarding workplan to provide assurance that the strategy is being implemented across all Hospitals/MCS/LCOs and to share good practice.
- In liaison with the Patient Exeperience Team roll-out of the MRI pilot to collect what matters to me (WMTM) information from patients with LD and/or autism.
- Increase staff knowledge and understanding of the Mental Capacity Act (MCA) process, appropriate use of Independent Mental Capacity Advocates (IMCA) and completion of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms.
- Recruit additional mental health and LD Nursing Assistants in RMCH who will link with the FST, based on the general paediatric ward.
- Implement positive behaviour support (PBS) and Makaton Training across RMCH.
- Ensure that the care pathway for people living with LD and/or autism who are preparing for in-patient admissions/out-patient appointments leads to improved

patient experience, with a clear plan showing how reasonable adjustments are applied across the Trust, including the proactive use of hospital passports or equivalent tool.

- Support the development of a Trust policy for learning disability and/or autism care standards that inform staff how to meet the required standards effectively.
- Ensure clear leadership and oversight for specific cross-site workstreams.

MFT Complex Safeguarding Sub-Group

4.28 **Purpose of the Group**

The remit of the Complex Safeguarding Subgroup is to ensure that all practitioners understand their individual and corporate responsibility and accountability regarding safeguarding adults and children from all forms of exploitation. The subgroup members communicate information and share best practice in relation to the Complex Safeguarding agenda. This includes, but is not exhaustive:

- Exploitation (sexual/criminal/adult/child)
- Modern slavery
- Vulnerability and organised crime
- Serious Youth Violence
- Manchester Complex Safeguarding Hub and Trafford Complex Safeguarding Team SHINE
- Development
- Link to Prevent programme
- Missing from home

4.29 **Group Work Streams and Relationships with Multi-Agency Groups**

4.30 **Key Achievements**

- ✓ Good representation from across the Trust.
- ✓ Terms of reference were reviewed in June 2021 in consultation with the subgroup members.
- ✓ An adult/young person story is shared at the beginning of each meeting to highlight the vulnerabilities of adults/young people impacted by exploitation.
- ✓ The majority of the actions from the workplan 2021-2022 have been completed.
- ✓ A dip sample of the risk indicator check lists (RIC) completed in 2021-2022 has been completed.
- ✓ The Complex Safeguarding policy is available for staff on the intranet and there is a directory of services to support staff, where there are concerns about exploitation
- ✓ The exploitation risk indicator checklist and pathway and the acute hospital risk assessment for young people who attend following serious youth crime – knife, gun, serious assault continues to be promoted through the subgroup
- ✓ Prevent updates have been provided by the lead community specialist nurse safeguarding children and MFT Prevent Lead
- ✓ Guidance on information sharing and governance for all NHS organisations for Prevent and Chanel shared.
- ✓ In the Greater Manchester exploitation week of action members of the group used it as an opportunity to promote the child sexual exploitation (CSE) and child

criminal exploitation (CCE) 7minute briefings through displaying on ward/unit safeguarding noticeboards, team huddles/meetings.

- ✓ Regular updates from Trafford and Manchester Exploitation subgroups and Manchester Modern Slavery and Trafficking subgroup shared.
- ✓ Regular updates from the Navigator Project Lead provided.
- ✓ Feedback provided from Trafford and Manchester CSE audits.

4.31 **Areas for Development**

- Review the terms of reference in 2022 to ensure they remain in line with national and local messages around complex safeguarding.
- The agenda and workplan will reflect more of a safeguarding adult focus through support from the adult safeguarding team
- There is still a need to consider a Risk Indicator Checklist (RIC) for adults which will remain on the new workplan
- There is a need to continue to promote the child exploitation RIC through the subgroup and through the new level 3 safeguarding training complex safeguarding module planned to be launched in Quarter 2 2022/23
- Targeted work by the CSE Specialist Nurse to be completed in RMCH and MRI emergency departments (ED) with the support of the acute safeguarding team and ED managers.
- Re audit and evaluate the children's RIC in 12 months when the new safeguarding level 3 Complex Safeguarding training module is firmly embedded
- Continue to have regular updates from the Navigator Project in Manchester Royal Infirmary (MRI) and Royal Manchester Children's Hospital (RMCH) Emergency Departments.

- Ensure that key messages are fed across the reinstated MSP operational Complex Safeguarding sub-group in addition to messages being fed up and down into the strategic MSP Complex Safeguarding sub-group, Manchester Complex Safeguarding Executive and TSSP Exploitation sub-group.

Our Children (Looked after Children) Sub-group

4.32 **Purpose of the Group**

The remit of the subgroup is to ensure that the key areas of the Looked after Children agenda are embedded across adult and children services within all of the hospitals/MCS/LCOs; these include:

- Service delivery and practice development
- Quality of Statutory health assessments
- Voice and Influence of 'Looked after Children'
- Partnership work and key messages from Corporate Parent Panel, Looked after Children Strategic Board and multi-agency subgroups.

4.33 **Our Children (Looked after Children) Sub-Group Work Streams and Relationships with Multi Agency Groups**

4.34 **Key Achievements**

- ✓ The Looked after Children subgroup has seen consistent representation from the hospitals/MSC/LCOs.
- ✓ Achieved improved awareness of Looked after Children amongst the health teams across the MFT workforce.
- ✓ Inclusion of quarterly health reports within the sub-group to provide assurance of compliance with statutory requirements.
- ✓ Development and implementation of a comprehensive training package for professionals including community and acute providers to inform the health needs of Looked after Children, their journey throughout the looked after process and the professional's roles and responsibilities in achieving the best outcomes.
- ✓ Demonstration that the views of Looked after Children have been sought on what improvements need to be made to the services they use, through consultation in the development of the Care Leaver Summary.

4.35 **Areas for Development**

- Continue to raise awareness and ensure ongoing delivery of training packages for professionals including community and acute to inform of the health needs of Looked after Children, their journey throughout the looked after process and the professionals roles and responsibilities in achieving the best outcomes.
- Work in collaboration with key partners to improve the health outcomes for Looked after Children.
- Review and develop strategies to improve performance against KPI, including improved reporting on care leaver summaries
- To promote strategies to support children and young people who are looked after to achieve a healthy weight.

5. Partnership Working

5.1 MFT Contribution to Manchester Safeguarding Partnership (MSP) and Trafford Strategic Safeguarding Partnerships (TSSP)

MFT is fully committed to multi-agency working for both adult and child safeguarding, Our staff are committed to playing an active role in the safeguarding partnership activity at all levels, and to contributing to the wider work of the partnerships by ensuring that

feedback from multi-agency sub-groups and lessons from serious case reviews/child safeguarding practice reviews (SCR/CSPR) and safeguarding adult reviews (SAR) are embedded into practice.

5.2 MFT Progress against Manchester and Trafford Strategic Safeguarding Partnership Priorities and Strategic Objectives 2021-2022

In the 2020-2021 MFT Safeguarding Annual Report, the Trust committed to ensuring that the strategic objectives of the MSP and TSSP were clearly embedded in the safeguarding agenda across MFT. Evidence of how this was achieved can be found in **Figure 11**.

Figure 11: MFT Achievements against Manchester and Trafford Strategic Safeguarding Partnership Objectives

Safeguarding Priority	Partnership	Trust Response
Neglect Child Neglect, Wilful Neglect and Self-Neglect	**MSP TSSP**	**MFT has an Early Help and Neglect Safeguarding Subgroup with Trust-wide representation which oversees practice around neglect.** The Early Help and Neglect Subgroup terms of reference and work plan have been refreshed this year. MSP and TSSP have published Manchester's and Trafford's Child Neglect Strategy. The Early Help and Neglect Subgroup is progressing on implementation of the strategies. Underpinning the strategies is the use of the Graded Care Profile (GCP2) tool. A GCP2 awareness e-learning training package is available for all staff (adult, children's services acute and community) to raise awareness of the GCP2 assessment and enable staff to understand how they can provide information to support the completion of the assessments. It has been highlighted that over 200 Trust staff have been trained in using the tool but only a limited number of tools have been implemented in practice across the partnership. This has been discussed by the Trust safeguarding team with the MSP neglect strategic leads. To support the use of the GCP2 tool a draft tool is in development to assist in the identification of neglect in children. The Manchester and Trafford community safeguarding teams have completed the TSSP and MSP multi-agency child neglect audit and the MSP adult safeguarding self-neglect audit. The safeguarding team contributed to the presentation at the TSSP Neglect conference and multi-agency neglect and obesity training.
		The Managing High Risk Together pathway has been launched in the Trust to support staff in safeguarding patients where there are concerns around neglect/self-neglect. During Safeguarding Adult Week in November 2021 awareness was raised on recognition and response to self-neglect in adults including promotion of the Managing High Risk Together pathway.

Domestic Violence and Abuse	**TSSP**	**MFT has a domestic violence and abuse safeguarding subgroup with Trust wide representation which oversees and ensures domestic abuse training policy and practice.** There is a domestic abuse training programme which is being delivered virtually and staff complete participatory workbooks to evidence completion of this course. Additional bespoke domestic violence and abuse training has been provided to 264 staff. The Trust Domestic Violence and Abuse Policy has been updated in line with the Domestic Abuse Act 2021.[37] Safe and Together[38] single and multi-agency training workshops have been held with 213 staff attending. The workshops are now available to all health staff both in the community and acute settings and promoted in the safeguarding newsletter. Bespoke external training in the use of the Domestic Abuse, Stalking and Honour Based Violence Risk Indicator Checklist[39] with young people has been delivered by Safe Lives to 19 children in care, sexual health and safeguarding nurses to review our risk assessment process with young people. The Trafford safeguarding team has contributed to the TSSP domestic abuse round table events.
Exploitation/Complex Safeguarding	**TSSP**	**The Trust has a complex safeguarding subgroup with trust wide representation which has implemented training, policies, and risk assessments around complex safeguarding**. The group has promoted a 7-minute briefing on recognition and response to modern slavery and human trafficking, child sexual exploitation, child criminal exploitation launched in the Complex Safeguarding week of action. Information relating to Greater Manchester tackling exploitation week of action was shared to raise awareness of exploitation across the Trust. The Child Sexual Exploitation (CSE) Specialist Nurse took part in a multi-agency activity, organised by the Complex Safeguarding Hub, visiting hotels in the city centre to raise awareness of child sexual exploitation. The Navigator scheme to support young people affected by knife crime and serious violent assault was implemented at Manchester Royal Infirmary (MRI) and Royal Manchester Children's Hospital (RMCH) emergency departments and was subsequently extended across acute and community services. During Q4 (2021-22), 61 young people that live in Manchester were referred into the project. Greater Manchester multi-agency audits have been completed to review the Trust health response to young people impacted by child sexual exploitation in Trafford. MFT contribute to the

[37] Domestic Abuse Act 2021

[38] Manchester Safeguarding Partnership uses the Safe and Together approach to safeguarding children who are exposed to domestic violence and abuse

[39] The Safe Lives Risk Identification Checklist (RIC) for the identification of risk in cases of domestic abuse, stalking and 'honour'-based violence in young people's relationships helps practitioners to identify known risks in domestic abuse and includes specific considerations in relation to young people to inform professional judgment to identify suitable cases to be reviewed at a MARAC and inform referrals to children's social care

		Manchester Complex Safeguarding monthly joint governance reviews. Trafford and Manchester community safeguarding teams have a complex safeguarding/CSE specialist nurse post as part of the multi-agency complex safeguarding teams. There has been a strengthening of communication between the acute hospital safeguarding teams and the Complex Safeguarding Hub which has resulted in timely information being received relating to young people who have experienced serious youth violence. The use of the risk assessment checklist, for any patient presenting to hospital settings with injuries relating to knife or gun crime or serious assault is well embedded in the hospitals ensuring the safety of young people admitted with stab injuries.
Early Help and Prevention	**TSSP**	**MFT has an Early Help and Neglect Safeguarding Subgroup with trust wide representation which oversees practice around Early Help and Prevention.** Early Help information has been shared through the safeguarding newsletter and through the Trust's Early Help and Neglect subgroup. A review of school nursing and health visiting has been completed in Trafford. Named Nurse provides support to the Engage project in South Manchester. This a police led panel aiming to identify children on the periphery of criminal behaviour, to identify what early intervention offers are available. The Early Help and Neglect subgroup has reviewed an adult patient story to promote a think family adult and child safeguarding response.
Embedding Safeguarding Arrangements	**TSSP**	**MFT ensures representation at all the safeguarding MSP and TSSP groups and has clear reporting arrangements to align the work of the partnership with the Group Safeguarding Committee and thematic Safeguarding Subgroups.** The safeguarding team has reviewed membership and reporting arrangements to/from the Trust to TSSP to ensure that the safeguarding team is represented at all TSSP meeting with a clear reporting to frontline services for Trafford citizens. The MSP and TSSP Section 11 audit identified MFT met all expected safeguarding standards. MSP Adult Safeguarding Assurance has been completed identifying the need for an action plan regarding strengthening the frontline services response in application of mental capacity act and recognition and response to self-neglect. The safeguarding team ensure attendance at monthly multi-agency referral meetings chaired by the locality children's service lead to review referrals to children's social care. The community safeguarding named nurses have continued to co-chair the MSP children's safeguarding for a which have been highlighted in an external review of MSP[40] as "superb"

[40] Review of Manchester Multi-Agency Safeguarding Arrangements 'Taking it to the next level', conducted by Carole Brooks Associates

		and a “great success for MSP” demonstrating a great way to engage professionals on important topics with good discussion and professional curiosity.

MFT contribution to the Multi-agency Safeguarding Hub (MASH) and Manchester Advice and Guidance Service

Manchester Locality Advice and Guidance Service

5.3 Manchester has three multi-agency locality-based hubs called the Advice and Guidance Service (AGS), which are in the north, central and south areas of the city. A specialist health visitor (HV) supported by a safeguarding administrator is based in the AGS and supports the multi-agency function of the children’s services front door process by gathering and sharing health information, which contributes to assessing the level of risk to children. A named nurse from the MFT safeguarding service provides professional support and leadership to the HV in the AGS as well as supporting the development of policies, procedures, and guidance to ensure the role of health services is understood in the hubs. The named nurse also maintains a strategic link between the management teams in the AGS and the wider health economy, supporting the management of difficult cases or complex decision making, whilst ensuring that the escalation process is fully understood and utilised when required. The HV is based in the central hub with virtual support offered to the north and south hubs. There is still a need to understand how the AGS will be resourced in the long term and discussions have been held with Manchester Health Care Commissioning (MHCC) to explore the resource requirement.

5.4 There were **1,915** (2,016 in 2020/21) referrals into the AGS regarding a child/children, which required health information to support the identification of risks to these children. In total **3,070** (2,858) health checks were completed on the referrals, which included system checks and telephone calls with community health, primary care professionals, and health colleagues in the acute hospitals. The total enquiries for each area were:

- North **590 (**501)
- Central **698** (702)
- South **432** (541)

5.5 The AGS HV completes a quarterly review of MFT referrals into the AGS to assess if referrals are received using the correct process, to identify if effective multi-agency working is taking place, to ascertain if referrals are at an appropriate level of concern for a social care assessment and that feedback is provided to the referrer. The key messages are shared quarterly in the MFT Safeguarding Newsletter and through the Quality and Learning Subgroup with a plan of what needs to happen to improve practice where necessary.

Review of referrals this year has included an analysis of information when there are concerns around perplexing presentations and/or fabricated and induced illness which has informed the development of the new draft MSP pathway.[41]

[41] MSP Perplexing Presentations, Fabricated and Induced Illness pathway (in draft currently being piloted in MFT)

5.6 The AGS health lead coordinates health information to Channel[42] which is part of the Prevent strategy. A review of the information sharing with Channel identified that the AGS health practitioner supported an understanding of the nature of health vulnerabilities and personal circumstances of individuals to enable planning of support options most appropriate to the individual's needs; which contributed to planning effective ways of delivering appropriate interventions and understanding the GP/primary care relationship with the individual and how the GP information can be useful, to delivering Channel support.

Manchester Adult Multi-agency Safeguarding Hub (MASH)

5.7 The Adult MASH is located centrally in the city. The provision of services to Adult MASH is led by MHCC. The MFT safeguarding team has worked closely with the MASH throughout this annual report year to ensure appropriate information sharing processes and good working relationships are in place.

Manchester Complex Safeguarding Hub

5.8 A senior specialist nurse for child sexual exploitation (SSN CSE) is based within the Manchester multi-agency Complex Safeguarding Hub to provide specialist health advice and to act as the conduit for information sharing between health colleagues and the multi-agency teams to inform multi-agency risk assessments. This specialist nurse also offers an advice and consultation service to health professionals in respect of CSE as well as providing supervision, training and briefing sessions for MFT and multi-agency staff. The SSN CSE has a clinical caseload of young people who are 16-18 years old, hard to reach and do not have access to a school nurse for support.

5.9 A total of **217** (242**)** referrals were made to the Manchester Complex Safeguarding Hub. The breakdown included child sexual exploitation (CSE) **61** (71)**,** child criminal exploitation (CCE) **138** (160) and both CSE and CCE **18** (11).

5.10 The SSN CSE provided health information on **217** (225) children and young people in the daily briefing meetings which is where referrals are discussed. Updates have been provided to lead health professionals on **871** (685) cases, the GP has been informed of referrals and closures in **325** (273) cases that were open to the Complex Safeguarding Hub.

5.11 The SSN CSE contributes to the MFT audit plan and the monthly multi-agency review of cases, to quality assure input by each agency. The outcome of these reviews is shared with relevant service managers including school health to inform service development.

5.12 A podcast related to CSE has been developed to provide a short awareness briefing which has been shared with MFT staff through the Complex Safeguarding Subgroup. The SSN CSE delivers single and multi-agency training which includes contribution to two Greater Manchester Complex Safeguarding sessions with the National Autistic Society in relation to the vulnerabilities of this specific group of young people. There is

[42] Channel is an early intervention scheme which supports people who are at risk of radicalisation aiming to help people to make positive choices about their lives and providing practical support tailored to individual needs.

a complex safeguarding module in development, as part of the revised level 3 safeguarding children training offer; this is on track to be completed by July 2022.

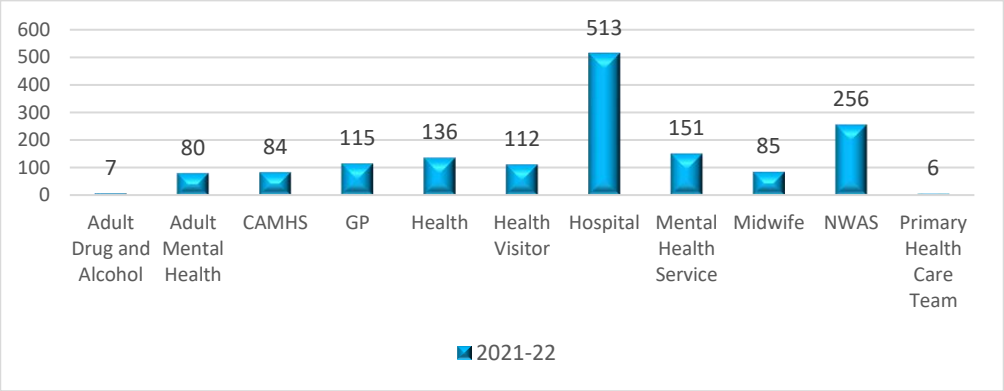
5.13 The SSN CSE provides safeguarding supervision to the Sexual Health Service. This has supported the links between the Complex Safeguarding Hub (CSH) and sexual health. The Sexual Health Service has developed a new 'Best Interest' form following learning from a serious case review, to ensure that the safeguarding needs of attendees under the age of 13 years are properly considered and responded to.

5.14 The role of the SSN CSE is commissioned to focus on CSE and requires review to reflect the changes in the Complex Safeguarding Hub which includes Child Criminal Expolitation (CCE) and serious youth violence. Discussions have been ongoing between the MFT safeguarding team and Director of Safegaurding at MHCC in respect of the service specification for the MFT health resource for the Complex Safeguarding Hub.

Trafford First Response

5.15 The Specialist Health Practitioner who works within Trafford Children's First Response Team (TCFRT) (the Front Door of Children's Social Care) supports the multi-agency team by gathering and sharing health information which contributes to assessing the level of risk to children. The health practitioner searches for, shares and collates health information from a wide range of NHS providers interpreting and sharing information that is necessary and proportionate to safeguard and/or promote the welfare of a child, whilst providing liaison between the first response team and community health, primary care and acute hospitals. During 2021/22 there was a total of **9181** referrals to the team with **1,539** identified as health referrals.

Figure 12: Heallth referrals to Trafford First Response Team.



The specialist health practitioner completed a monthly a dip sample of health referrals to TCFRT to review if the correct referral process was used, that referrals are being submitted at the appropriate level of need and that feedback is provided to the referrer. Multi-agency working and Information sharing continues to work well within TCFRT, with evidence of excellent inter-agency working. The health role is being continually developed with a plan for the specialist health practitioner to be more involved with screening the referrals received going forwards. The informative and prompt information that is shared enables the right support for the families to be given at the

right time. Areas for development include collecting the figures of the number of health practitioner contributions to safeguarding referrals that TCFRT receive.

Trafford Complex Safeguarding Team SHINE

5.16 This year has seen the successful recruitment to the health practitioner in the Trafford Complex Safeguarding Team SHINE.

5.17 The Senior Specialist Complex Safeguarding Nurse (SSCSN) holds a split role of 3 days per week with the Complex Safeguarding Team and 2 days per week as the Youth Justice Nurse. This role included undertaking healthcare assessments to specific groups of children/young people, including the review of previously un-met health needs and a review of any assessments or referrals that have been made in earlier years, particularly where there is an Education and Health Care Plan (EHCP) or identified special education needs and/or disability (SEND).

5.18 The role provides expert health advice and support to stakeholders working with children who are being exploited; and involves the attendance at complex safeguarding meetings to address any issues/concerns regarding CSE/CCE and missing from home (MFH).

5.19 The SSCSN provides health representation at safeguarding meetings and children in care reviews for a defined caseload (currently **52** young people), and delivers health interventions that improve the health and wellbeing of children who are being sexually and/or criminally exploited; to reduce gaps in service delivery by using knowledge of health systems/service and pathways

5.20 The SSCN has received feedback directly from a young people about the difference her intervention has made including the following message.

'she is so nice, and I actually spoke to her about everything, it felt so good to get it all of my chest. She opened my eyes to so much'. When I saw XXX yesterday, she said after speaking to the nurse, she thought about her body and health in ways she hadn't before, she told me she has already started to eat more instead of trying not to eat. You really made a big impression on her".

5.21 SSCSN provides training to MFT and multi-agency colleagues and supports the completion of complex safeguarding audits.

Serious Case Reviews (SCR)/Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Domestic Homicide Reviews (DHR)

5.22 CSPR, SARs and DHRs are commissioned through the multi-agency partnership arrangements in accordance with the statutory guidance following the death of or serious harm of a person through abuse, neglect or domestic homicide where there is concern that agencies have not worked together to protect the victim. The purpose of the review is to learn lessons to improve multi-agency practice to safeguard children, young people and adults at risk and their families.

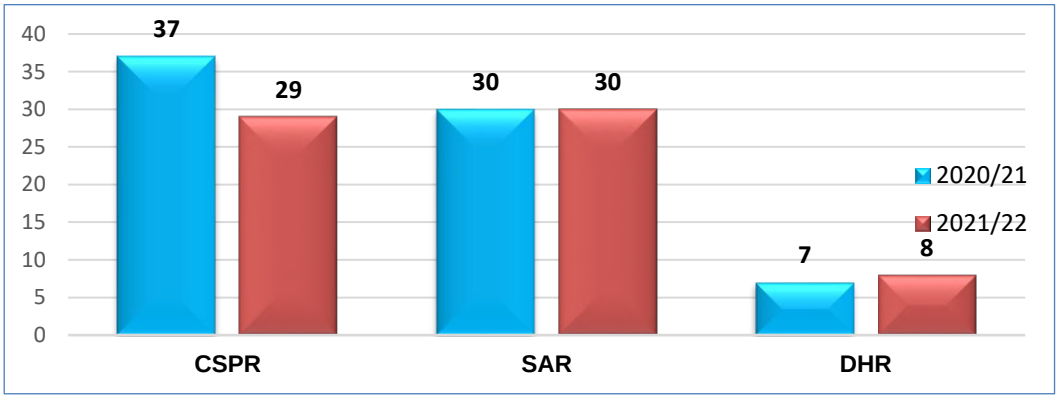
5.23 In June 2019, implementation of the 'new Working Together to Safeguard Children' (2018) statutory guidance determined that all new child reviews should be known as

child safeguarding practice reviews (CSPR). This year has, seen the continued completion of the legacy SCRs as well as new CSPRs that have been requested.

5.24 Prior to the decision to conduct a CSPR/SAR/DHR agencies are required to undertake a scoping exercise to provide initial information about the case.

Figure 13 below. Identifies the numbers of requests for scoping for CSPR/SAR/DHR this annual report year.

Figure 13: Scoping for CSPR/SAR/DHR, compared with 2020/2021



5.25 In 2020/21 there was a notable increase in activity for scopings, which was recognised locally and nationally, as being attributed to increased reporting by acute services of serious safeguarding incidents during the enforced COVID-19 pandemic lockdowns.

5.26 This year there has been a reduction in requests for child safeguarding serious incidents. The key safeguarding themes and concerns from this years incidents have been regarding the sudden unexpected death of children and young people with a history of complex health needs, safeguarding concerns associated with parental factors (including domestic abuse and substance misuse), the vulnerability of babies under the age on 1 year to physical harm, the knowledge and skills of frontline services in relation to the indicators of sexual abuse and neglect and the impact of physical harm in the context of complex safeguarding including death through knife crime.

5.27 Key themes in adult scoping reviews are frontline services knowledge and skills in the recognition and response to concerns around neglect and self-neglect and the response to safeguarding concerns in the context of mental illness, suicide and domestic abuse where there has been ongoing multi-agency working with people with vulnerabilities, and complex safeguarding concerns, including the importance of reasonable adjustments for people with learning disability.

5.28 Requests for scoping have predominantly been received from Manchester and Trafford Safeguarding Partnerships, however, there has been an increasing number of requests from Bury, Oldham and Rochdale reflecting the communities use of services at NMGH which is now part of MFT. Due to the tertiary footprint of MFT, referrals have also been received from other Greater Manchester safeguarding partnerships.

5.29 Currently the MFT Safeguarding Service are working with the Safeguarding Partnerships in Manchester, Trafford, Salford, Rochdale and Bury with ongoing reviews as well as new and emerging concerns.

5.30 Senior safeguarding nurses from across the safeguarding teams represent MFT on the review panels, including ensuring that contributions to the review are provided from the hospitals/MCS/LCO and ensuring that key messages and lessons learned from the reviews are shared across the Trust through safeguarding training, the safeguarding newsletter, briefings presented to the safeguarding governance groups and specific hospital/MCS/LCO action plans.

5.31 For each serious case review, a Trust action plan is developed to ensure the learning is embedded in the organisation. The themes from the reviews are collated through the Quality and Learning Subgroup to ensure learning is shared with frontline practitioners. In 2021/22 there were **13** action plans implemented in MFT following SARs with all actions for the Trust being completed in **8 of the** cases. From the **11** SCR/CSPR, the action plans from **6** of the cases were completed. All remaining actions plans will continue to be reviewed and completed in 2022/23.

5.32 Key messages from CSPR/SCRs this year include the vulnerability of non-mobile babies, the importance of training and policy guidance in recognition and response to domestic abuse, implementing the Manchester Safe and Together[43] programme, and the MSP neglect strategy including the ICON[44] programme (prevention of abusive head injuries) and support for professionals working with hostile families.

5.33 Learning from SARs includes the importance of supporting frontline services to consistently apply the Mental Capacity Act in assessments and safeguarding care planning to make safeguarding personal and the requirement for safeguarding assessment for frequent hospital attenders and people who miss appointments or self-discharge from our care.

5.34 Learning from reviews continues to emphasise the importance of multi-agency partnership working, documentation of concerns and consideration of a “think whole family approach to safeguarding unborn, children, young people and adults at risk”

[43] Safe and Together is the Manchester model for children’s safeguarding in the context of domestic abuse
[44] ICON Following a number of incidents in Manchester, and across the country, where young babies have been the victim of abusive head trauma, Manchester Safeguarding Partnership commissioned the roll-out of ICON programme across the city.

SECTION F

Safeguarding Activity and Performance

6. MFT Safeguarding Activity and Performance from 1st April 2021 to 31st March 2022

Introduction

6.1 This section of the report provides an overview of MFT safeguarding activity and performance from 1st April 2021 to 31st March 2022. It provides assurance that MFT has fulfilled its statutory and regulatory requirements for safeguarding children and adults as outlined in the Children Act 1989 and 2004, the Care Act 2014 and CQC Regulation 13.

6.2 MFT Safeguarding Services are comprised of the following teams:

- Acute Child Safeguarding
- Acute Adult Safeguarding
- Maternity Safeguarding
- Manchester and Trafford Community Safeguarding Children Teams
- Manchester and Trafford Looked after Children Teams
- Safeguarding Mental Health, Learning Disabilities & Vulnerabilites Teams

6.3 The safeguarding services are based on the Oxford Road Campus (ORC), Wythenshawe Hospital, NMGH, in the community at Rusholme Health Centre and Trafford Town Hall. Although they are centrally based, the teams work throughout the hospitals/MCS/LCOs aiming to be visible and accessible to all Trust services.

6.4 Following considerable investment by the Trust a new integrated safeguarding team has been established at NMGH which comprises of adult, child and maternity safeguarding nurses and learning disability/autism and mental health nurses.

6.5 There has been good progress this year in ensuring consistent ways of working across the safeguarding service and incorporating a whole family approach to safeguarding. The introduction of the new electronic patient record through HIVE across the Trust in 2022/23 will further strengthen consistency in the safeguarding response and documentation across the acute hospital sites.

Safeguarding Referrals for Adults and Children

6.6 Safeguarding referrals/notifications relate to cases that have been notified to the safeguarding teams and for which the teams have provided advice and case management support to MFT practitioners. A small proportion of these cases will be referred to the LA child or adult services. The role of the MFT safeguarding team is to support practitioners in their decision making to ensure that each referral to child or adult protection services is at the correct threshold for statutory intervention.

6.7 **Figure 14** (below) provides a breakdown of referrals across the safeguarding teams for this report period.

Figure 14: MFT safeguarding referrals to each safeguarding team, 2021/22

MFT Safeguarding Team	Oxford Road Campus	Wythenshawe, Trafford, Withington, and Altrincham	NMGH	TOTAL	Top Three Categories of Referral
Children's Acute Safeguarding	**3272**	**1688**	**1571**	**6531**	• Neglect • Child and Young Person mental health including self-harm • Domestic Abuse
Adult Safeguarding team	**1952**	**1769**	**627**	**4348**	• Neglect • Domestic Abuse • Sexual Abuse
Maternity Team	**6828**	**1301**	**2370**	**10499**	• Mental Health • Domestic Abuse • FGM
Manchester Children's Community Safeguarding	**5043**			**5043**	• Neglect • Mental Health • Domestic Abuse
Trafford Children's Community Safeguarding	**391**			**391**	• Domestic Abuse • Mental Health • Neglect
Safeguarding Mental Health & Learning Disability Team	**3878**			**3878**	• Mental Health • Learning Disability
Combined Total				**30690**	

6.8 Collectively during this annual reporting period MFT safeguarding teams have dealt with **30,690** referrals for children and adults with varying levels of need who were at risk of, or there were concerns that they were suffering abuse and/or neglect. This is higher than last year when there were **23,720** referrals received. The increase in referrals is related to the increased footprint of the Trust with the NMGH safeguarding team receiving **3,568** referrals. In addition, there were **3,878** contacts to the safeguarding mental health and learning disability teams following Trust investment in this service in 2020. The acute safeguarding adults, children and maternity safeguarding teams have also identified an increase in referrals this year. The increase equates to **84** safeguarding concerns alerted every day in the Trust.

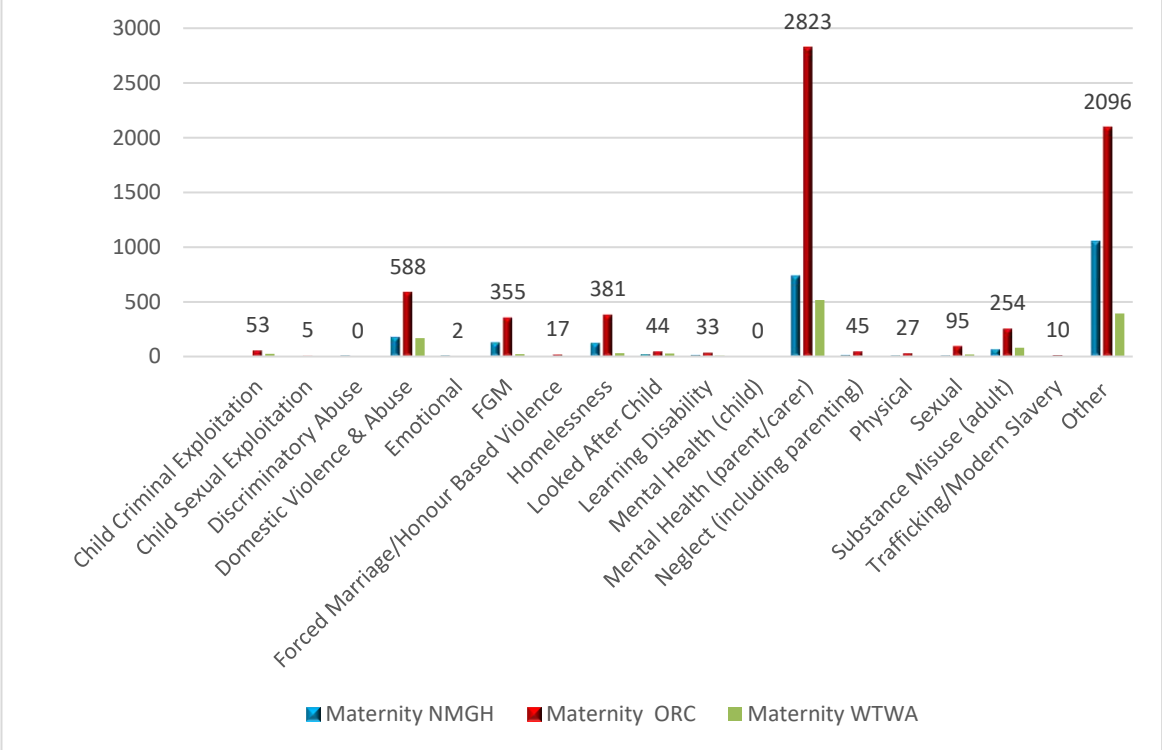
6.9 Safeguarding concerns relating to neglect in the care of adults and children, domestic abuse and the impact of mental health concerns on safeguarding are the most frequent categories of concern reported to the safeguarding team. This is consistent with the national data that identifies that neglect/omission of care and neglect in childhood is the most frequently reported safeguarding concern. Following the COVID-19 pandemic there has been an increase in safeguarding concerns relating to mental ill health.

Maternity Safeguarding Activity

6.10 Maternity safeguarding services are based at ORC, NMGH and Wythenshawe Hospital. The teams provide support to hospital and community-based services across MFT. The safeguarding maternity team continue to receive all referrals for vulnerable pregnant women, newly delivered women, new-born babies and their siblings.

6.11 **Figure 15** below shows the number of safeguarding referrals made to the Safeguarding Team at each site and the reason for the referral.

Figure 15: Maternity Safeguarding Referrals



6.12 Safeguarding midwives across all three sites continue to receive a high volume of referrals through the completion of the Maternity Information Sharing Form (MIRF). The total number of referrals has increased this year to **10,499** referrals (8,138 in 2020/21). This was mainly due to the increased footprint of the Trust with **2,370** referrals being received from NMGH. Consistent with previous annual reporting the most common category remains maternal mental health followed by domestic violence and abuse.

6.13 For all unborn babies who will be subject to a CPP at birth, any case where care proceedings are planned to be initiated at birth, or in any case where particular actions to safeguard the mother or baby are required by the midwives during the pregnancy or at the time of the baby's birth a maternity safeguarding careplan is completed. In 2021/22 **846** care plans were completed (NMGH 96,WTWA 171 and ORC 579).

6.14 There were **87** incidents of public law child care proceedings initiated immediately following the birth of the baby (NMGH 22. St Mary's WTWA 20 ORC 45).

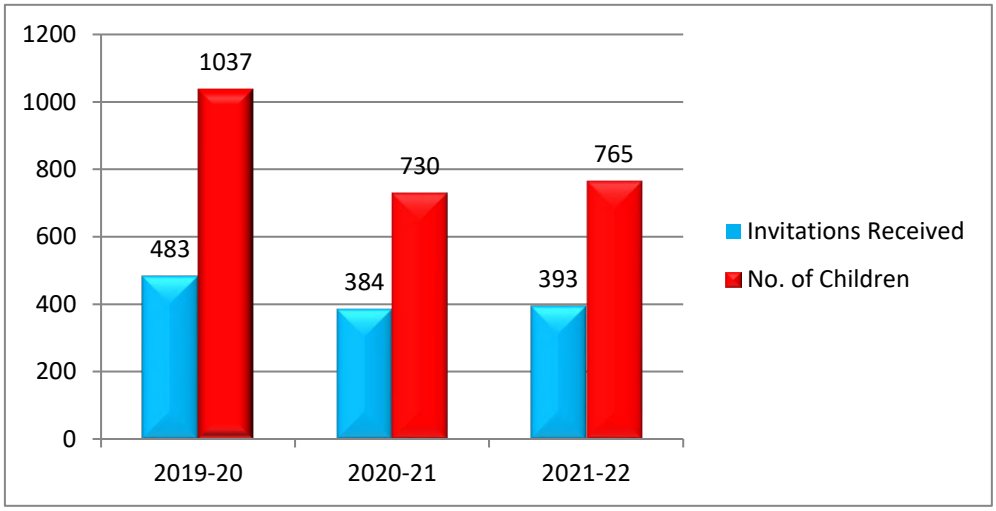
6.15 Across the MFT footprint all pregnant or postnatal women can be referred to an Independent Domestic Violence Advisor (IDVA) who works closely with the safeguarding team to risk assess victims/survivors of domestic abuse and formulate safety plans for victim/survivors, their unborn babies and families. At St Marys Hospital (ORC) this service is provided by an IDVA who is employed by Manchester City Council and at St Marys Hospital (WTWA) and NMGH, this service is provided by an IDVA employed by Women's Aid who covers both sites. The IDVA's have an honorary contract with MFT.

6.16 Maternity services at ORC identified **355** service users impacted by Female Genital Mutilation (FGM) with **(130)** identified at NMGH and (**23**) identified at Wythenshawe Hospital. The reporting demonstrates that routine enquiry about FGM at the maternity booking appointment remains well embedded. The number of women making FGM disclosures is reflective of the local population in Manchester and the increased vulnerabilities of women and girls living in FGM traditional practicing communities. Considerable work has been undertaken to raise awareness of the harmful impact of FGM to women and girls in Manchester. In recognition of this, St Mary's Hospital (SMH) hosts a 'New Steps' to African Communities psycho-social clinic to ensure service users are offered a holistic response to the identification of FGM.

MFT Contribution to Manchester Child Protection Plans (CPP)

6.17 When children are identified as being at risk of, or suffering harm, abuse and/or neglect health professionals contribute to the multi-agency child protection planning process. On 31st March 2022 Manchester LA identified that **503**[45] (**564** 2021) children were subject to CPP in Manchester. This is a continued decrease from the **798** reported in 2020. **Figure 16** below shows the numbers of families where MFT health professionals were invited to attend Manchester child protection case conferences to ascertain if the child/ren were subject to, or at risk of, harm and required child protection planning.

Figure 16: Initial Child Protection Conference Invitations Manchester 2018-2021



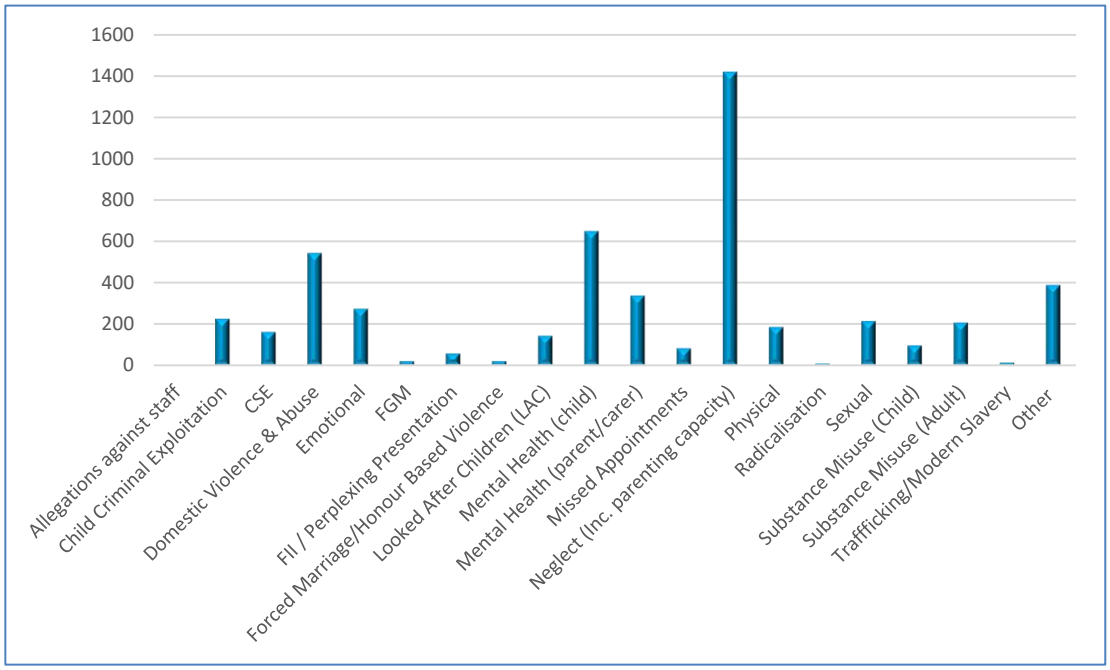
[45] Data reported in MSP Children Safeguarding Children Quarterly Dataset reported to Safeguarding Effectiveness Committee'

Manchester Community Children's Safeguarding Activity

6.18 The community safeguarding children team provide a citywide safeguarding service to all community staff working with children. Support for the community workforce is vitally important as health visitors and school nurses hold and manage high levels of complex child protection caseloads.

6.19 **Figure 17** below identifies the categories of concern notified to the community teams.

Figure 17: Community children's safeguarding notifications 2021-2022 by category



6.20 The Manchester picture aligns with the national messages that neglect is the most common cause of safeguarding concern for children and young people. Throughout this annual report year the community team have been working hard to implement the new Manchester Child Neglect Strategy.[46]

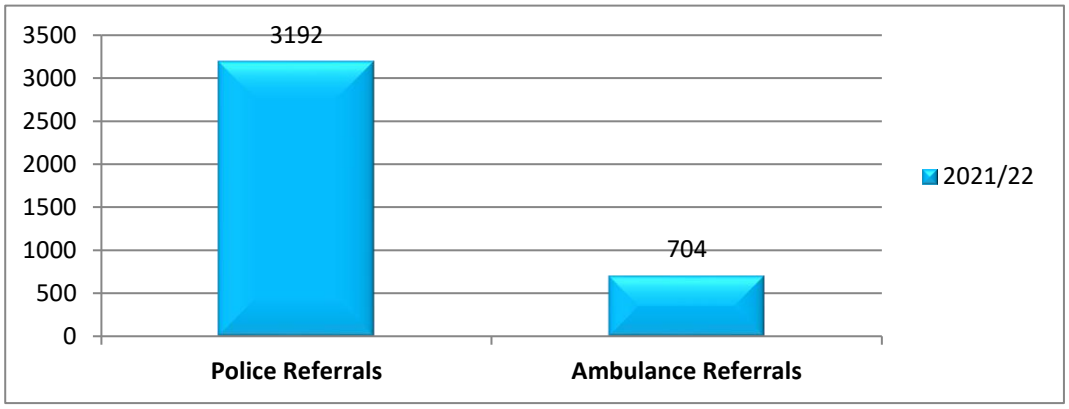
Police and Ambulance Safeguarding Referrals

6.21 The citywide community safeguarding children team process safeguarding referrals from the police and ambulance services, ensuring that this information is disseminated to frontline health visitors and school nurses as appropriate. The referrals from the police are cases where there has been a Domestic Abuse Child Concern (DACC) meeting held in the locality AGS and the information is shared to notify community health services to enable the child's community health caseload holder (health visitor or school nurse) to review the incident to ensure the child or young person's health needs are being met and to assess if there are any additional vulnerability or risk factors for the child and family.

[46] Manchester Child Neglect Strategy (2021-2024)

This also allows the health practitioner to build a chronology around a child's daily lived experience. In addition, for all preschool children there is an information sharing pathway between the police and health visitors facilitated by the child health department to inform of all domestic abuse incidents not reaching the DACC criteria to enable the delivery of 'Operation Encompass' in preschool children.[47]

Figure 18: Police and Ambulance Referrals to MFT Safeguarding Services



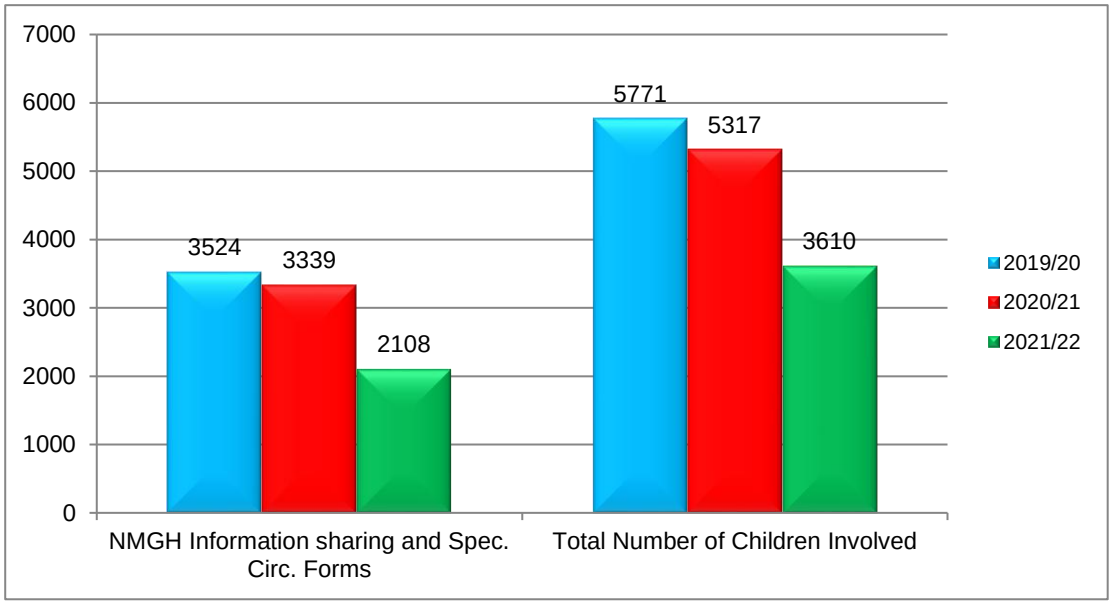
6.22 This year 3,192 police referrals were received identifying the information from the AGS and is being shared with MFT.

Referrals from North Manchester General Hospital

6.23 Lord Laming's recommendations following the Victoria Climbie inquiry in 2003[48] requires all emergency departments to notify the health visitor or school nurse when a child has attended. These notifications are well established across all Manchester hospitals and are shared by the MFT emergency departments directly with children's community services. The information from NMGH is processed via the MFT community safeguarding team. The community safeguarding team ensures that these notifications are disseminated to the health visiting and school nursing teams, which are provided by MFT, for information and case management. **Figure 19** below shows the number of notifications on the NMGH site over the past 3 years, year on year. In 2022/23 the information sharing from NMGH will be streamlined by being sent directly to the community teams.

[47] Operation Encompass
[48] The Victoria Climbie Inquiry

Figure 19: North Manchester General Hospital Information sharing and Special Circumstances Forms 3-year comparison

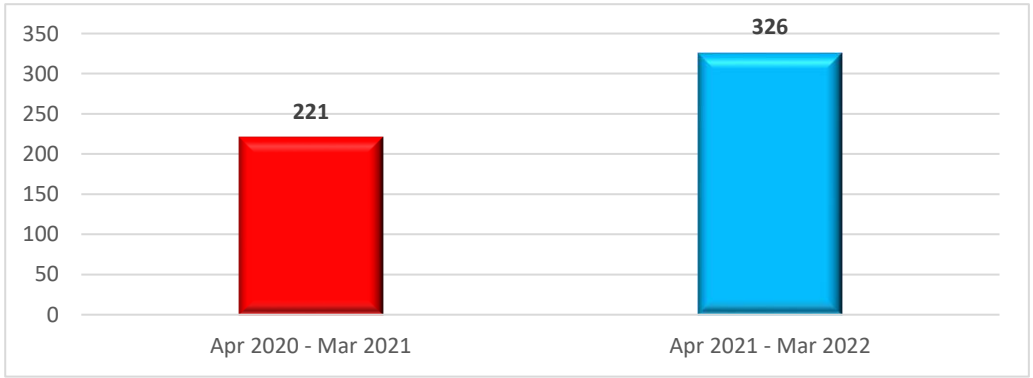


Manchester Community Section 47 Child Protection Medicals

6.24 The Coral Suite is the citywide community service provision for Manchester providing medical assessment and opinion on physical injuries in children undergoing child protection enquiries and supports the multiagency section 47 investigations. Onward dental referrals and photographic documentation of injuries is provided on site. The service is compliant with RCPCH 2020 standards for section 47 medicals[49] and there are links to the community paediatric services for follow up.

6.25 Referral criteria to the Coral Suite are that children should be over 18 months of age and they have a physical injury that does not require urgent medical treatment. The numbers of children seen for section 47 medicals has increased this year following a low referral rate in 2020/21 attributed to decreased visibility of children in the COVID-19 pandemic lockdowns.

Figure 20: Number of Section 47 child protection medicals carried out 2020/21 compared to 2021/22



[49] https://www.rcpch.ac.uk/news-events/news/rcpch-publishes-uk-wide-child-protection-standards

Trafford Community Safeguarding Team

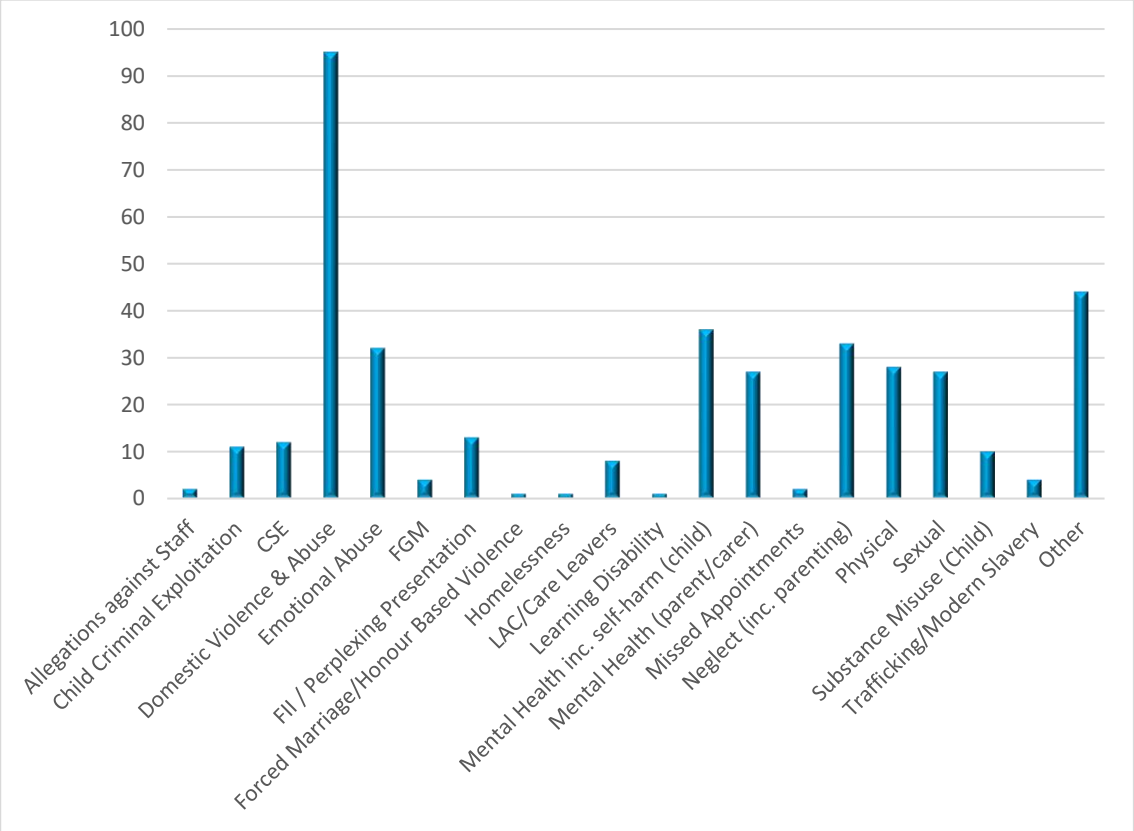
MFT Contribution to Trafford Child Protection Plans (CPP)

6.26 On 31st March 2022 Trafford LA identified that **191**[50] **(193)** children were subject to CPP in Trafford. The safeguarding team support the health professionals to safeguard these children and to effectively contribute to child protection planning. The number of children on CPPs is **32.5** per 10,000 children which is lower than statistical neighbours, North West and England.

Trafford Community Safeguarding Children Activity

6.27 The Trafford community safeguarding children team provide a borough wide safeguarding service to all children's community staff. **Figure 21** below reports the referrals to the Trafford team and identifies that this year domestic abuse and neglect are the most prevalent reasons for practitioners contacting the service for support and advice. Child mental health is another frequent concern for practitioners. The Trafford team have worked with the TSSP to deliver neglect training and a neglect conference as well as domestic abuse multi agency roundtable events. In addition, local domestic abuse training in the recognition and response to coercive control is being delivered to respond to the local priority safeguarding concerns.

Figure 21: Referrals to Trafford Community Safeguarding Team 2021/22

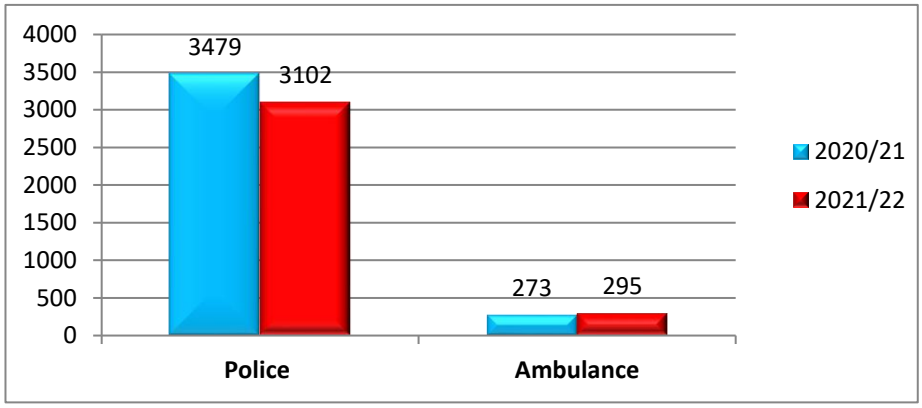


[50] Trafford Strategic Safeguarding Partnership Safeguarding Effectiveness Committee Children's Quarterly Dataset.

Police and Ambulance Safeguarding Referrals

6.28 The community safeguarding children team process safeguarding referrals from the police and ambulance service ensuring that this information is disseminated to frontline health visitors and school nurses. There were **3,102** police child protection notifications received compared to **3,479** in the previous year. The safeguarding team share information with the community health practitioners in order to inform their safeguarding risks assessments when referrals are shared from North West Ambulance Service. There were **295** referrals this year compared to **273** in the previous year, demonstrating a slight increase.

Figure 22: Police and Ambulance Referrals 2020/21 compared to 2021/2022



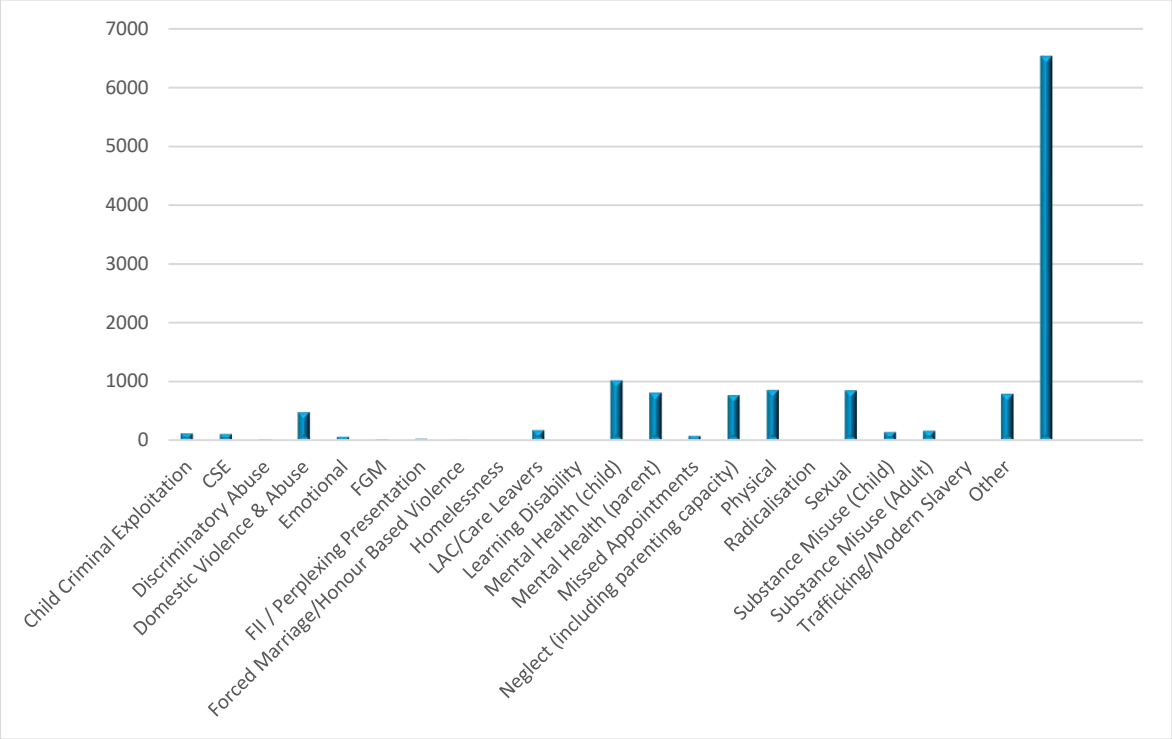
Children's Acute Safeguarding Activity

Children's Acute Referrals

6.29 The acute safeguarding children service is delivered from ORC, NMGH and Wythenshawe Hospital. The teams have continued to promote their availability and visibility across the service areas this annual report year.

6.30 **Figure 23** shows the number of referrals or alerts to the acute child safeguarding team in 2021/22 by category of abuse. The data shows an increase in the total number of referrals and alerts to the acute team this year from **3,789** in 2020-2021 to **6,531** in 2021-22. This reflects the data from NMGH data (**1,571** referrals). There has been a strengthening of safeguarding supervision this year throughout the children's acute footprint and it is hoped that this has also impacted on the frontline practitioner's recognition and response to safeguarding concerns.

Figure 23: Referrals to the Acute Safeguarding Children Teams



6.31 The reporting of safeguarding concerns this year continues to show high levels of child safeguarding concerns around adult and child mental health following the impact of the COVID-19 pandemic. In contrast to community/maternity services and the national data, the referrals with concerns around sexual abuse remain high, this is attributed to the service supporting Greater Manchester and Merseyside Sexual Assault Referral Centre (SARC). Referrals for physical abuse have increased this year and remain high reflecting the support the team provide to RMCH which is a tertiary hospital and a significant number of children and young people attend the hospital following serious safeguarding incidents following physical harm including knife crime. Referrals for child neglect have also increased following the national trends in reporting.

6.32 In acknowldgement of the increased reporting of children and young people presenting in distress the acute safeguarding team in collaboration with RMCH and the legal team have reviewed and supported the Trust response to children and young people presenting in crisis who are awaiting a mental health hospsital admission or a looked after placement to ensure this vulnerable group are safeguarded within legislative framework requirements. This work will be formalised into guidance in 2022/23

Section 47 Child Protection Medicals

6.33 Child protection medicals are provided by acute paediatricians to contribute to section 47 child protection enquiries in hospitals for children less than 18 months of age or where an acute or urgent out of hour's medical is required or when a child presents to hospital's with safeguarding injuries.

Oxford Road RMCH Section 47 Child Protection Medicals

6.34 The electronic database at RMCH has recorded **115** child protection assessments undertaken by the paediatric team. Most of these assessments have been a result of clinicians identifying potential safeguarding concerns relating to the child's presentation.

Wythenshawe/RMCH Child Protection Medicals

6.35 Wythenshawe Paediatric team continue to provide child protection/s47 medicals for South Manchester and Trafford Children's Social Care (CSC) for children aged under 18 months and for older children when medicals are not available in the community clinics, as well as for patients seen acutely at the hospital where safeguarding concerns have been raised. **35** medicals were completed over the last year, **12** of which were requested by CSC.

North Manchester/RMCH Child Protection Medicals

6.36 There were **51** child protection medicals completed at the NMGH sitethis annual report year.

Adult Acute Safeguarding Activity

6.37 The safeguarding adult teams are based at ORC, NMGH, Wythenshawe and Trafford community locations and support MFT hospital and community services. The safeguarding mental health and learning disability specialist nurses are based within these teams and provide a service across the whole of the MFT footprint.

Acute Adult Referrals

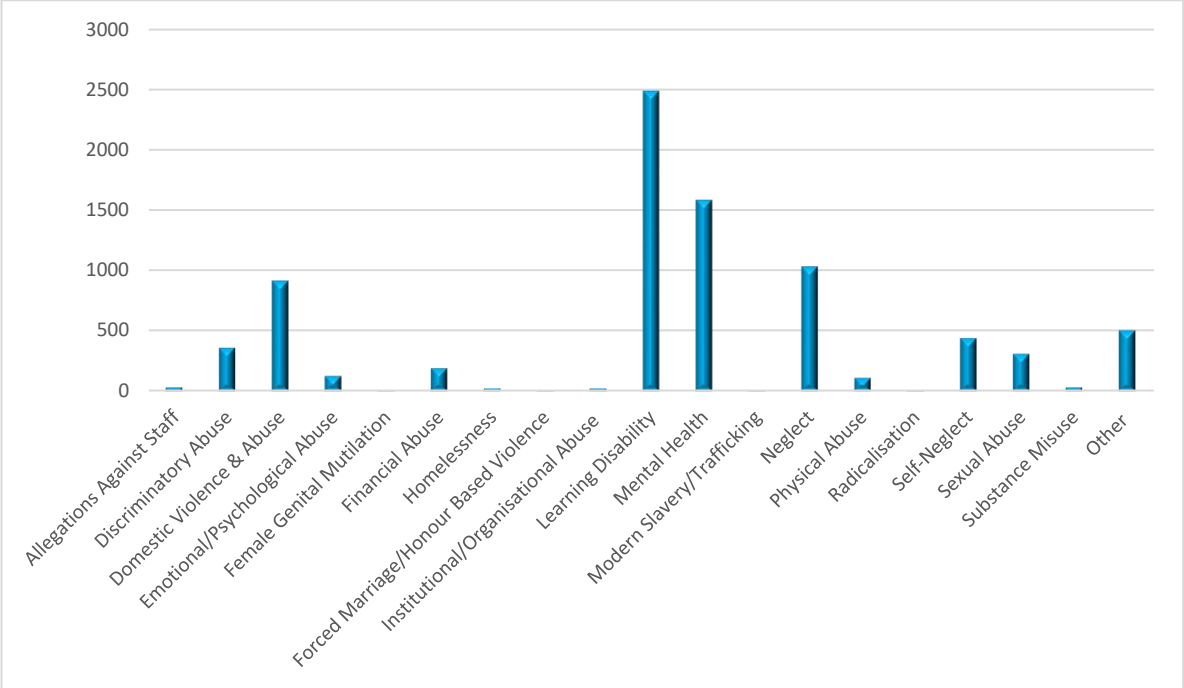
6.38 The total number of referrals to the adult acute safeguarding teams in 2021/22 was **8226** compared to **5,838** in 2020/2021. The referral data this year includes the referrals from NMGH (**627**). In 2019 a 3 year adult safeguarding training plan was introduced to implement the Royal College Intercollegiate training guidance.[51] By the end of March 2022 **8,160** clinical staff had completed this training and it is hoped that the increased awareness of adult safeguarding has increased reporting of concerns.

6.39 In addition, the Trust's safeguarding adult data now reflects the work of the safeguarding mental health service and the learning disability service, which received **3,878** contacts. The increased reporting of adult safeguarding concerns is in line with the Manchester and national data of increased reporting.

[51] Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)

Figure 24 shows the breakdown of referrals by site and category.

Figure 24: Referrals to the Adult Safeguarding Teams



6.40 The key categories of concern identified by MFT staff in safeguarding referrals reflect the local Manchester picture (identified in Section B of this report); namely neglect/omission in care and domestic violence and abuse is a safeguarding concern. The high referral/notification rate for sexual abuse at ORC relates to safeguarding support given to the SARC, which is a Greater Manchester and Merseyside service.

6.41 Figures for mental health and learning disability reflect the support from the safeguarding team to frontline practitioners in the care of our patients with a learning disability and/or autism or where there are mental health concerns. There has been an increase this year to **3,878** reports compared to **2,150** in 2020/21 reflecting increased capacity of the team and improved data collection of safeguarding concerns around mental health.

Deprivation of Liberty Safeguards (DoLS) activity

6.42 MFT is a managing authority under DoLS legislation and is required to apply to the relevant LA (supervisory body) if it is identified that a patient who is deemed to not have mental capacity to consent to care and treatment is being deprived of their liberty. If a potential deprivation of liberty is identified, hospital/care home staff are required to complete the relevant documentation self-authorising the deprivation for 7 calendar days. This completed form is forwarded via secure email to the relevant LA where the patient is a usual resident.

6.43 Once processed by the LA, the LA is required to commission a Best Interest Assessor and a Mental Health Assessor who will complete the six assessments required to authorise a standard application. This assessment process should occur prior to the expiry date of the urgent authorisation. This year, **4,303** DoLS applications were made by MFT staff. This is an increase from **1,965** reported last year.

6.44 There has been considerable activity through training, policy guidance and the use of the Ulysses informatics systems to promote, streamline and ensure DoLS are put into place appropriately.

6.45 The data provided in **Figure 25** identifies the Trust activity regarding DoLS.

Figure 25: 2021/22 Deprivation of Liberty Applications and Outcomes

	ORC				NMGH				WTWA				Total
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Number of DoLS applications	163	243	240	255	497	488	419	382	355	335	475	451	**4303**
Number granted/authorised	0	0	1	0	5	4	3	1	5	1	3	3	**26**
Number waiting assessment	11	49	85	88	48	30	75	90	322	316	452	431	**1997**
Number RIP/discharged prior to assessment	13	194	148	167	366	450	331	286	16	14	6	4	**1995**
Number withdrawn/regained capacity	3	0	6	0	28	4	3	5	2	4	8	13	**76**
Number declined by LA	0	0	0	0	0	0	0	0	0	0	1	0	**1**

6.46 **Figure 25** outlines the numbers of DoLS applications assessed and granted by the LA compared to those submitted. Of the **4,303** DoLS urgent authorisations/standard applications made only **26** were granted. Delays have continued in the processing and assessment of DoLS applications by Manchester and Trafford City Council. The number of DoLS authorised remains consistent with 2020/21 where **21** were authorised even though there was an increase in applications to **4,303** from **1,965** in 2020/21. The delays and the associated low numbers of DoLS authorised have been recognised as an organisational risk and are recorded on the Trust risk register. The increase in applications is partly related to NMGH completing **1,786** applications.

6.47 The safeguarding team has reviewed the internal application process for DoLS through audit and review as well as through external escalations pathway work with Manchester LA to piortise completion of DoLS for patient's requiring more restrictive interventions. The Trust audit plan in 2022/23 will continue to review the application of the mental capacity act in assessment and best interest care planning and the application of the DoLS process.

6.48 The challenges to the current DoLS process are recognised nationally and responded to in the Mental Capacity Amendment Act (MCA), which was granted Royal Assent in May 2019, and which introduces the new Liberty Protection Safeguards process (LPS). LPS aims to streamline the current process but will place increased duty on acute settings for the authorisation of the deprivation. There is currently a national consultation due to conclude on the 7th July 2022 on the Code of Practice for MCA and DoLS which will inform the Trust's LPS implementation plan. The current "Go Live" date for LPS is not known but the LPS working group for the Trust will report to the Mental Health subgroup from May 2022.

Domestic Violence and Abuse (DVA)

6.49 Domestic violence and abuse (DVA) training is in place across the Trust, with the aim of preparing staff to be able to recognise, respond and refer when DVA is a safeguarding concern. The training is delivered virtually with a participatory workbook, with additional bespoke training offered.

6.50 Manchester Safeguarding Partnership have implemented the 'Safe and Together[52]' model to work together to support families where there is domestic abuse. The model supports practitioners to partner with the victim and engage with perpetrators so that the safety and well-being of children and young people in the family is maximised. **213** staff have attended the monthly Safe and Together virtual training workshops.

Multi-agency Risk Assessment Conference (MARAC) Activity

6.51 The Safeguarding Service continue to support the Trust contribution to MARAC, which is the process where all agencies including health staff identify and risk assess victims of domestic abuse referring the highest risk victims for a multi-agency risk assessment conference to facilitate safety planning in order to reduce the risk of harm and domestic violence/homicide.

6.52 The Trust makes a significant contribution to the Manchester and Trafford MARAC with **3407** referrals to Manchester MARAC this year, which is a slight decrease from the **3,492** in 2020/2021.

6.53 In Trafford there were **813** MARAC referrals, which is an increase from **706** last year. From this number **699** children/young people were living in the households: this is an increase from **573** children/young people involved last year.

Female Genital Mutilation

6.54 Mandatory reporting and the FGM Data Collection Tool

There are three information systems/situations where information about women and girls affected by FGM must be shared[53] by health professionals.

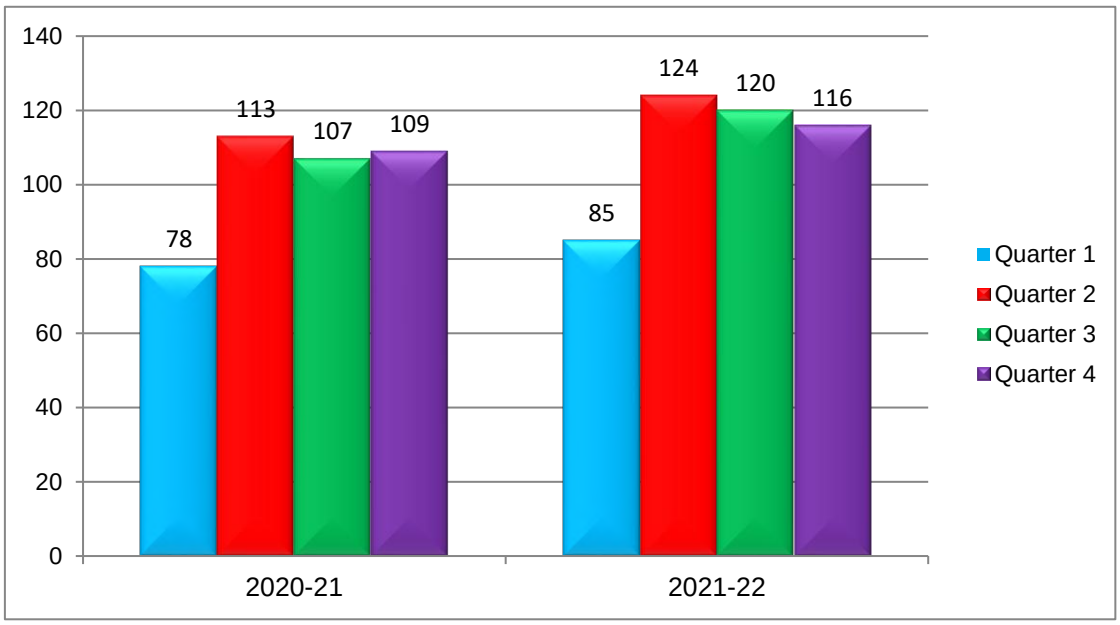
- FGM Information Sharing System (FGM IS). Information is uploaded at birth to a female child's health record if they are born to a mother who has had FGM. This information is used to support safeguarding throughout her childhood.
- FGM mandatory reporting to the police when a girl under 18 years old discloses or is observed to have had FGM. Safeguarding referrals to children's social care must also be completed.
- FGM enhanced data set is completed through the FGM reporting tool when a contact is made with a service user who has had FGM. This enables patient population statistics to be collected.

6.55 The mandatory reporting data identifies a slight increase in the number of observations and disclosures from service users who have had FGM, with **445** reports this year

[52] Manchester Safe and Together
[53] FGM Risk Indication System

compared to **407** in 2020/21. In comparison with the NHS national dataset[54] MFT continues to have one of the highest prevalence of FGM reporting in the country. The data reflects the local population demography of communities associated with a high risk of practising FGM as well as demonstrating an awareness of FGM across the Trust and a consistent and embedded approach to routine enquiry regarding FGM in health visiting and midwifery practice.

Figure 26: FGM Mandatory Reporting Data



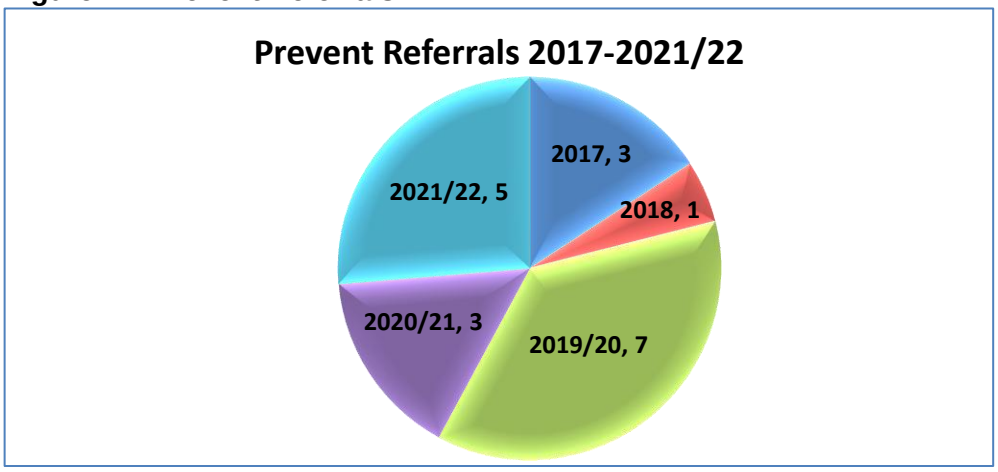
Prevent Activity

6.56 The safeguarding team provides advice and guidance where there are concerns around radicalisation. The team also manage referrals to the Channel programme, which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. In 2021/22 there were **35** information sharing requests completed for Channel and **5** Prevent referrals were made by MFT.

6.57 This data demonstrates that very few referrals are made to Channel by the Trust, despite mandatory training and raising of awareness at all levels. The data aligns with the GM Prevent data sets shared through local Prevent networks, which identifies the majority of Prevent referrals from health services are from mental health providers. Additional training on Prevent is being undertaken by the safeguarding team to raise awareness and improve the knowledge of staff. In 2022/23 the Trust will also strengthen links with the Manchester Channel Panel.

[54] Female Genital Mutilation national dataset

Figure 27: Prevent Referrals

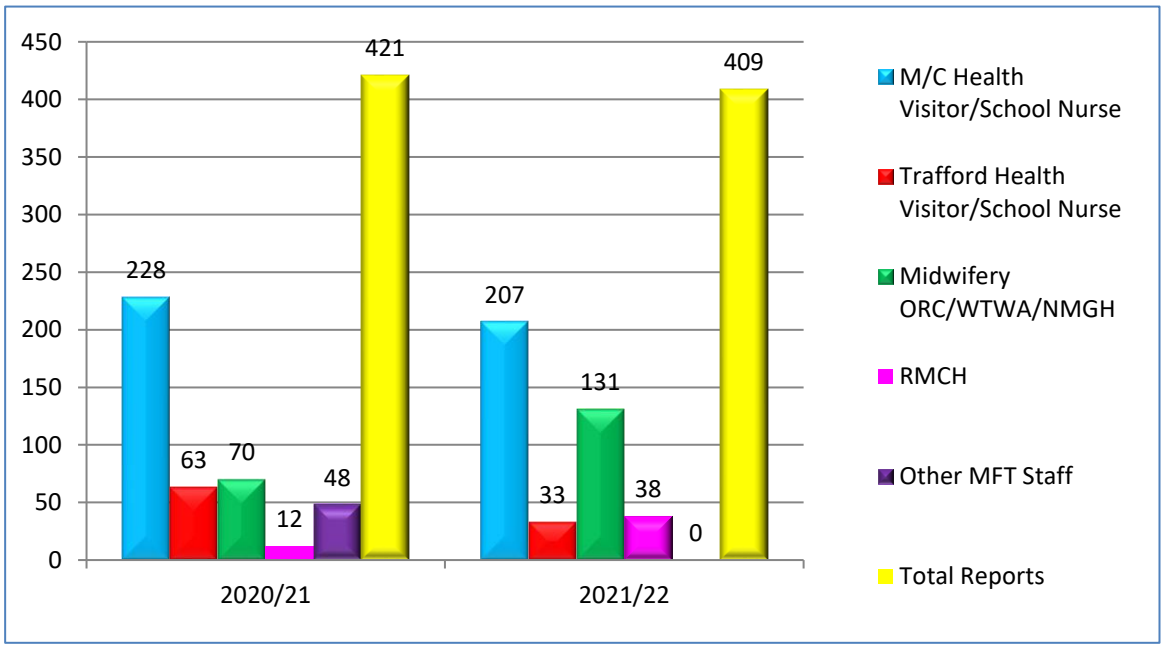


Court Report Activity for Child Care Proceedings

6.58 Court reports are requested by Manchester City Council (MCC) and Trafford Metropolitan Borough Council legal teams and have to be completed by health practitioners within defined timescales. Robust quality assurance by the MFT safeguarding team prior to submission of the reports ensures that very few frontline practitioners are called to give evidence in court.

6.59 **Figure 28** below outlines the numbers of court reports quality assured by the safeguarding team in 2021-22 compared to 2020-21. Childcare proceedings are commenced when the multi-agency safeguarding concerns have reached the threshold for legal intervention. Feedback from legal services demonstrates that the quality of court reports submitted by MFT community staff continues to be very high.

Figure 28: Court reports quality assured by the Safeguarding Team



Safeguarding Supervision Performance

6.60 Local and national learning highlights the importance of relevant staff receiving safeguarding supervision to support reflective and critical analysis in complex safeguarding cases. For this reason, safeguarding supervision is mandatory for all child services community staff who are caseload holders. This year safeguarding supervision has been delivered both virtually and face to face. All safeguarding nurses who are delivering safeguarding supervision have attended a recognised safeguarding supervision training course.

6.61 **Figure 29** below shows the high levels of compliance maintained this year for the delivery and attendance of safeguarding supervision within children's community services in Manchester. In Trafford the safeguarding team has worked with community services and the wider safeguarding team to strengthen the safeguarding supervision process. In 2022/23 the community safeguarding team in Trafford will continue to work with community health leads to promote improved and consistent compliance in safeguarding supervision.

Figure 29: Community Safeguarding Supervision Compliance 2021-22

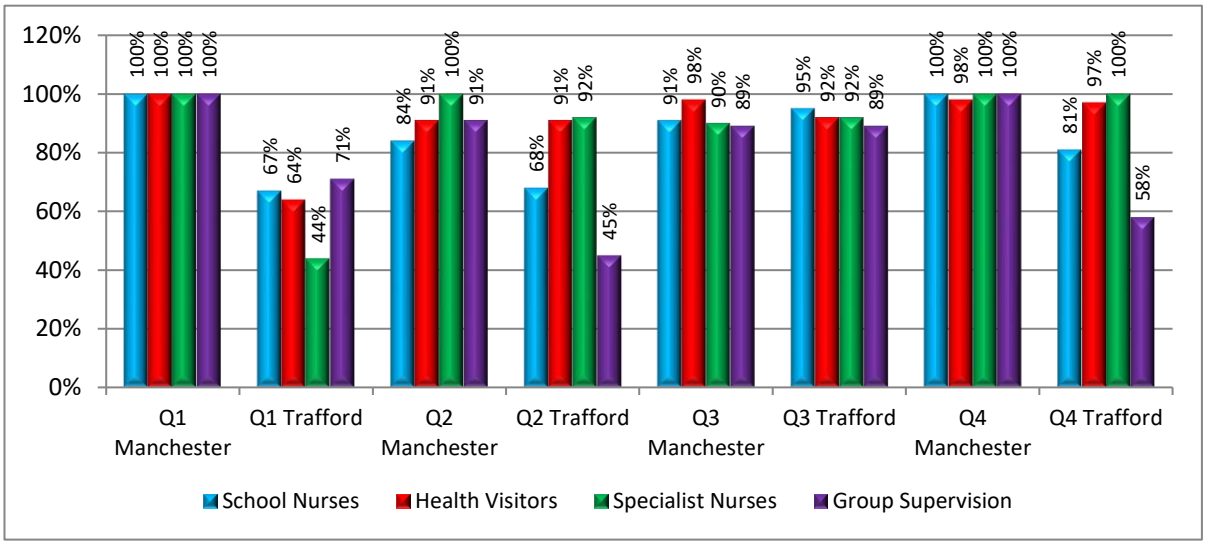


Figure 30: Total Number of Staff receiving Safeguarding Supervision across MFT 2021/22

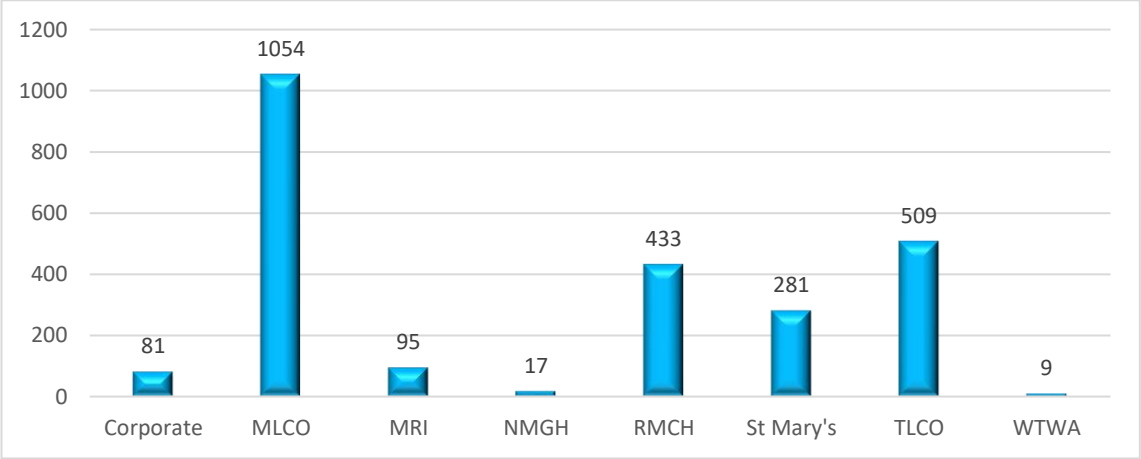


Figure 30 shows the numbers of staff receiving safeguarding children supervision across the Trust (**2,479)**. As well as to LCO practitioners, supervision is delivered to the midwives in St Marys, to paediatric and CAMHS services in RMCH, to sexual health staff in MRI and to the corporate safeguarding team as per the statutory requirements. This year has seen a strengthening in the supervision offer in RMCH, an introduction of adult and child "think family" safeguarding supervision and a new safeguarding supervision offer to the eye and dental teams with work ongoing to establish supervision in CSS. There is a requirement in 2022/23 to review data and recording of safeguarding supervision across the footprint.

Safeguarding Training

Mandatory Training

6.62 It is a mandatory requirement that all staff regardless of role/responsibility undertake safeguarding training on a 3-yearly basis, as per the Royal College Intercollegiate Documents for Adult and Child safeguarding training[55].

6.63 All staff in the Trust are mapped on the Trust 'Learning Hub' to the relevant, appropriate level of adult and child safeguarding training. It is the responsibility of the staff member and their service manager to ensure that they complete their safeguarding training. Levels 1 and 2 safeguarding training are delivered by e-learning whilst level 3 is currently being delivered through a virtual training package with a participatory workbook.

The Trust compliance target for safeguarding children training is 90%, the Clinical Commissioning Group (CCG) require 85% compliance and the CQC target is 80%.

Figure 31 below shows the training compliance data: the RAG rating aligns to the Trust requirements for 90% or above.

Figure 31: Mandatory Training Compliance (2021/22)

	Q1	Q2	Q3	Q4
Level 1 Safeguarding Adults e-Learning as part of corporate mandatory training	92%↓	91%↓	91% ↔	90%↓
Level 1 Safeguarding Children e-Learning as part of corporate mandatory training	93%↑	93%↔	93%↔	93%↔
Level 2 Safeguarding Adult e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	91%↑	91%↔	91%↔	91%↔
Level 2 Safeguarding Children e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	92%↔	91%↓	92%↑	92%↔
Level 3 Safeguarding Adults 3-year Cohort with full compliance expected March 2022/measured against expected trajectory to achieve 90% compliance	60/69%↑	64/76%↑	66/83% ↑	70/90%↑
Level 3 Safeguarding Children	81%↑	72%↓	68%↓	71%↑

[55] Adult Safeguarding: Roles and for Health Care Staff (2018) 1st edition
[55] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

6.64 There has been a sustained improvement in safeguarding training compliance across the Trust with levels 1 and 2 meeting all of the expected compliance levels. The level 3 adult safeguarding training has shown an increase in the number of staff completing the training but, the trajectory to achieve 90% compliance by March 2022 was not achieved with only 70% of mapped staff (**8,160** out of **11,660**) achieving the training. Level 3 child safeguarding training has shown a decrease in compliance with only **71%** of the mapped staff (**5,274** out of **7,410**) achieving the training. This year has seen an increase in staff completing the level 3 safeguarding child training but, due to a revised mapping exercise of roles and responsibilities there has been an increase in the number of staff requiring this training compared to 2020/21 when **3,919** staff from **4,962** mapped to the competency achieved the training. The Hospitals/MCS/LCOs are undertaking further work to ensure that all staff are trained within expected timescales, with safeguarding training being prioritised before the implementation of the HIVE electronic patient record system.

6.65 The safeguarding team has been working closely with the Learning and Development Service and Dynamic to revise the safeguarding training package to a new virtual offer which will streamline adult and child safeguarding training and avoid repetition. The new package is due to be finalised in quarter 2 (2022/23) with the level 1 safeguarding training package being ready to implement with the launch of the new learning system in quarter 1.

6.66 The mapping of safeguarding training to roles and responsibilities has been reviewed across the footprint and has informed the development of the Trust Safeguarding Training Strategy which will be launched with the implementation of the new training package in 2022/23.

6.67 In addition to mandatory safeguarding training, MFT staff are offered a range of 'bespoke' safeguarding courses, as shown in **Figure 32**. Bespoke training has focused on priority areas of safeguarding which we know requires improvement including domestic abuse and the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Figure 32: Numbers of staff attending additional training

Years	Child Sexual Exploitation (CSE)/RIC Training	Children' s Social Care Referral Workshops (NMGH)	DoLS/MCA Training	Domestic Violence and Abuse (DV&A) Abuse	Safe and Together Domestic Abuse training	Emergency Department Fundamentals	Forced Marriage and Honour Based Violence	International Nurses Training	Neglect in Children Graded Care Profile 2 Training:
2020/21	19	0		206	233	0	0	0	28
2021/22	19	38	366	264	213	11	51	18	36

The safeguarding team has continued to provide training packs and 7-minute briefings following the publication of safeguarding reviews which are shared at the safeguarding meetings across the Trust. This year has seen the introduction of safeguarding podcasts to supplement learning, the podcasts available include:

- 5 safeguarding adult.
- 9 podcasts to increase staffs understanding of the care of patients with mental health concerns.
- domestic abuse
- child sexual exploitation
- Mental Capacity Act
- 9 podcasts to support in the care of patients with an LD and/or autism.

Prevent Training

6.68 All health staff, according to their roles and responsibilities, are mapped to receive Prevent training at either Level 1-2 (Basic Prevent Awareness) or Level 3-5 (Workshop Raising Awareness of Prevent). All prevent training within MFT is delivered via e-learning. As of 31st March 2022, MFT were 90% compliant with level 1-2 training and 90% compliant with 3-5 prevent training.

6.69 Monthly compliance reports for all levels of mandatory training are now available online for managers, allowing them to monitor compliance and identify individual staff and groups who require training.

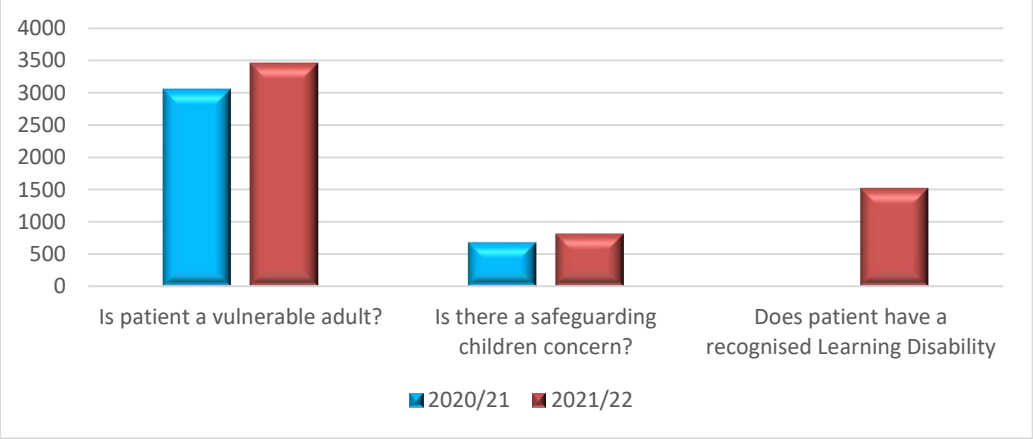
MFT Safeguarding Newsletter

6.70 The safeguarding newsletter continues to be published monthly.The newsletter supports learning and development and the disemination of best practice across the Trust. The newsletter receives very positive feedback from front line practitoners.

Incident Reporting

6.71 The Trust incident reporting system includes a facility for incidents to be categorised as safeguarding. Incident reports identify if the service user has a vulnerability, which is reflected in **Figure 33a**. All safeguarding incidents are reviewed by the safeguarding team to enable expert support and advice to be provided to the hospital/MCS/LCOs in respect of the investigation process and the safeguarding response if applicable.

Figure 33a: Incident Reports Identifying if the Service User has a vulnerability



6.72 In this report year **2,652** safeguarding incidents were reported compared to **2,154** in 2020-2021. This evidences increasing identification and reporting of adult safeguarding concerns.

6.73 A thematic review of safeguarding incidents is undertaken quarterly and reported to the Trust Group Safeguarding Committee. **Figure 33b** provides a summary of the annual incident themes reported by category and **Figure 33c** provides a breakdown of reporting by hospital/MCS/LCO.

Figure 33b: Incident Reporting by Category

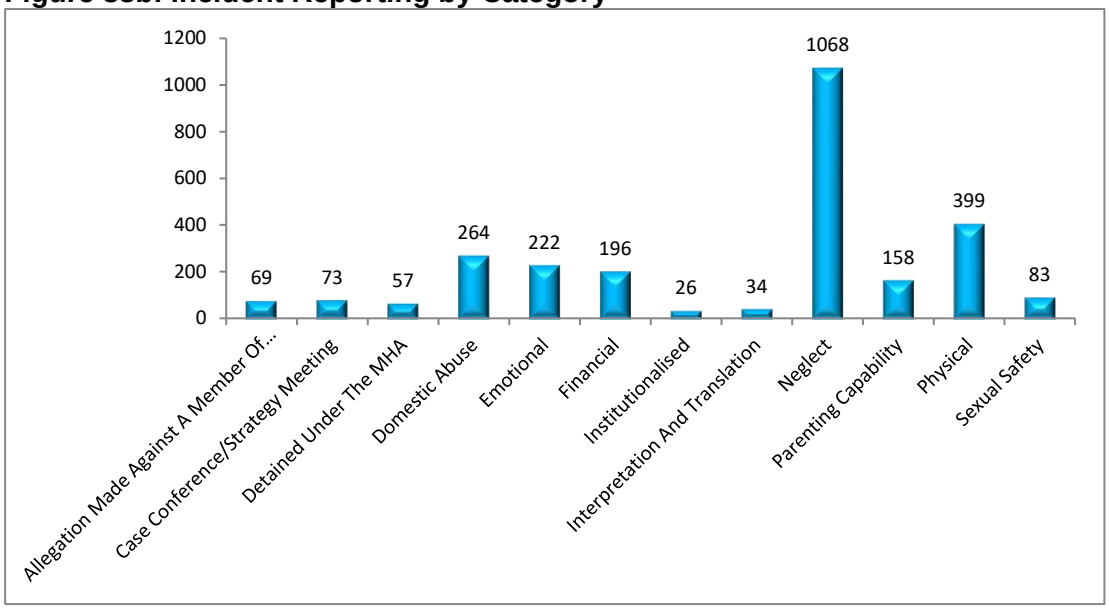
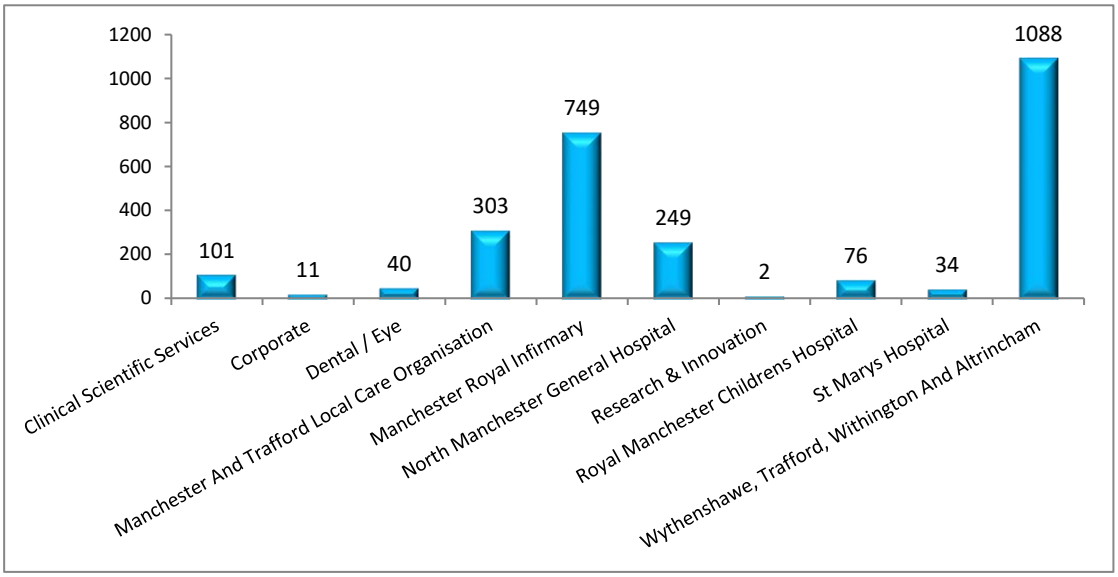


Figure 33c: Incident Reporting by Reporting Hospital/MCS/MLCO



Analysis of Incident Data

6.74 MFT has a culture of transparent incident reporting evidenced by the number of safeguarding incidents reported. The safeguarding adult reporting process is closely aligned to the incident reporting process, hence the higher number of safeguarding incidents in adult safeguarding. Child safeguarding incidents are reported where the safeguarding process has not worked according to expected practice. The Trust is in line with national reporting identifying that the most frequent safeguarding incident is neglect/omission in care.

This data provides assurance that the Trust recognises and responds to all allegations against staff to safeguard individuals. This is supported through the Trust-wide 'Managing Allegations against Staff Policy' which is currently being reviewed following the review of the MSP Policy for 'Managing Concerns around People in Positions of Trust with Adults who have Care and Support Needs.[56]

6.75 The Trust has a statutory obligation to contribute to child protection case conferences and strategy meetings. An incident report is completed when services are unable to meet this requirement. Non-attendance is related to the high numbers of children on CPPs and the demand that this places on services, mainly health visiting and school nurses, who are often expected to attend up to six case conferences daily. The incidents reported this year have reduced to **73** (**82** 2021/22) this may be due to improved accessibility through child protection meetings being held virtually. Improvements in attendance at child protection strategy meetings has been identified in a local audit at the Wythenshawe hospital site.

6.76 The highest number of safeguarding incidents reported is from WTWA, MRI and LCO. This would be expected as it is through the emergency departments, medical areas, and community services that most safeguarding concerns are recognised and actions are required/taken to appropriately safeguard.

Assurance Visits and Meetings

6.77 Unannounced safeguarding assurance visits to hospitals/MCS/LCOs have continued throughout this annual report year. These monthly unannounced visits review safeguarding at a ward/department level with feedback and actions being shared with the wards or department managers and the site safeguarding committees to support real time learning.

6.78 Compliance with CQC Regulation 13 (Safeguarding service users from abuse and improper treatment) assurance meetings have taken place by the Assistant Chief Nurse – Safegaurding with the Directors of Nursing for the hospitals/MCS/LCO, with the exception of St Mary's Hospital which due to unforeseen circumstances has had to be rescheduled a number of times. This is scheduled to take place in June 2022. These meetings include each hospitals/MCS/LCO providing high level assurance that they have a zero tolerance approach to abuse, unlawful discrimination and restraint and that they can demonstrate and evidence the governance systems that they have in place to support this.

Risk Register

6.79 The risk register is reviewed quarterly. At the end of this reporting period the following five risks relating to corporate safeguarding were recorded on the organisational risk register and mitigation is in place to reduce the risk:

[56] MSP Position of Trust Policy Refresh

✓ **Deprivation of Liberty Safeguards (DoLS)**

This is an accepted risk and relates to the pressures experienced by the LA in authorising DoLS applications.

✓ **Mental Capacity Act (MCA)**

This risk relates to implementation of the MCA across the organisation and ensuring compliance with the statutory requirements of the legislation to empower and protect adults who lack capacity to make their own decisions.

✓ **Looked After Children (LAC) Health Assessments**.

It is the responsibility of the local authority to provide consent and information to health providers to enable statutory health assessments within defined timescales. Performance from the local authority is below the expected standard in sharing information in a timely way, impacting the ability of MFT to achieve compliance. Considerable multi-agency work has been completed to address this and it is anticipated that performance will improve in 2022/23.

✓ **Use of ligatures as a means of self-harm.**

A Suicide Prevention policy and training has been implemented to mitigate this risk. However, local audit has identified partial compliance of hospitals/MCS/LCO with training standards of the policy indicating the requirement for further work in this area.

✓ **Mental Health Act**

If a patient is not detained appropriately under the Mental Health Act (MHA) 1983, patients may be placed at risk and the organisation exposed to legal challenge. The Trust's mental health act administrators track and monitor compliance with the MHA.

Safeguarding Audit

6.80 The audit plan aims to review how the Trust is meeting its statutory responsibilities, evidences safeguarding against the GM CCG Safeguarding Contractual Standards[57] and reviews the implementation of learning following SAR/SCR/CSPR/DHR recommendations.

6.81 This year **20** MFT safeguarding audits were commenced with **14** completed and **6** to be finalised in 2022/23. The completed audits reviewed safeguarding practice in the following areas:

✓ **Safeguarding children and the unborn.**

Audits were completed in safeguarding information sharing, documentation and the referrals process. Adherence to statutory guidance for child protection medicals and strategy meetings were audited as well as a review of practice for children impacted by child sexual exploitation.

[57] Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards 2021-22 A Collaborative Greater Manchester (GM) Document The trust is required to submit evidence against 67 safeguarding standards in APPENDIX 2: 2021-2022 - NHS PROVIDER SAFEGUARDING AND LOOKED AFTER CHILDREN AUDIT TOOL

- ✓ **Adult Safeguarding and vulnerable groups**
  Audits were completed into the application of Mental Capacity Act and the DoLS process. Care of vulnerable groups was reviewed through review of the reasonable adjustment tool for patients with a learning disability and or autism and the impact of quality care rounds for patients with a learning disability. Compliance with the integrated pathway for self-harm and suicide and the application of the suicide prevention policy was reviewed.

- ✓ The Trust completed the Annual MSP and TSSP Section 11 audit with a rag rating of green being achieved in all areas. The MSP Adult Assurance audit identified the Trust met expected standards in the majority of areas but that further work is required in 2022/23 to ensure consistent application of the Mental Capacity Act at the frontline and in the recognition and response to self-neglect.

- ✓ In addition, the Trust completed **8** contributions to the TSSP/MSP/GM multi-agency audits in mental capacity, self-neglect in adult safeguarding, child neglect, domestic abuse and child sexual exploitation.

Recommendations and learning from audits were overseen by the Trust Quality and Learning Subgroup and shared via the site Safeguarding Committees.

SECTION G

Safeguarding Team Achievements 2020/21

7. Safeguarding Team Achievements 2021/22

Delivery of Safeguarding Work Plan 2021-2022

7.1 MFT has continued to prioritise the delivery of its statutory safeguarding obligations. The safeguarding team has supported the Trust to maintain safeguarding service delivery through safeguarding meetings, training, policy development, support and supervision. Safeguarding newsletters, briefings and safety alerts have been cascaded across the Trust in responses to change in legislation, national learning and local learning themes across the safeguarding partnership. This year has seen closer working relationships with the Patient Safety team, with the safeguarding team now attending Group Safety Huddle on a daily basis. The safeguarding teams have developed close working relationships with site Risk and Governance teams with oversight from the Group Patient Safety team which has resulted in a consistent safeguarding consideration in the Trust response to section 42 adult safeguarding enquiries, CQC enquiries and complaints where there are safeguarding concerns.

7.2 The establishment of the integrated safeguarding team of safeguarding adult and children practitioners, midwives, learning disability and mental health nurses has supported the delivery of a highly visible and approachable safeguarding team at North Manchester General Hospital (NMGH). Safeguarding policies, training and practice has been reviewed at the NMGH site and are] now in line with the wider MFT processes.

7.3 **Figure 34** summarises the outcomes achieved through the delivery of the MFT safeguarding audit and work plan in 2021-22.

Key Priority	Key outcome	Achieved	
Making Safeguarding Personal	To ensure making safeguarding personal/voice of the child/young person/'what matters to me' is embedded in all safeguarding operational and strategic practice.	✓	Safeguarding audit and assurance visits has identified the voice of the child is captured in safeguarding and looked after health assessments Feedback from our service users is collected through what matters to me, friends and fasmily testing and the RMCH Youth Forum
	All hospitals/MCS/MLCO are aware of the need to include the child and vulnerable adult's wishes and views in all safeguarding decisions. The safeguarding work plans identify strengths and areas for development identified within hospitals/MCS/MLCO and there is evidence of plans to manage any gaps in practice areas.	✓	All safeguarding work plan's have been reviewed quarterly at the Quality and Learning Committee Group and site safeguarding committes included patient stories and review of safeguarding cases to champion our service user experience

	Safeguarding adult and children champions are in place across all frontline areas.		The safeguarding champions network is in place. The terms of reference and structure of safeguarding champions has been revised to incorporate adults and children's safeguarding
Adult and Children's Safeguarding **Keeping People Safe**	Safeguarding adults and children at risk remains a priority to the Trust		Annual Adult Safeguarding Assurance, Section 11 Audit and Completion of GM CCG Contractual Standards have been completed with action plans in place to evidence safeguarding standards in the Trust are met
	There are systems and processes in place to recognise and respond to risk in unborn, children, young people adults at risk and their families		A new safeguarding team has been established at North Manchester General Hospital.
	Policies and practice are reviewed and updated within timescales and all divisions receive timely updates.		The Safeguarding governance groups have all been held with oversight of attendance at Group Safeguarding Committee
	Hospitals/MCS/MLCO have provided assurance that these have been embedded across all relevant staff groups.		All safeguarding policies have been reviewed and aligned with practice in North Manchester Regulation 13 Annual Assurance visits have been completed Safeguarding unannounced assurance visits have been completed.
Adult and Children's Safeguarding Training	To work in partnership with hospitals/MCS/LCO to improve training compliance to expected 90% compliance levels		Safeguarding training has been delivered virtually and compliance is monitored through Group and Site Safeguarding Committees.
	To review the level 3 safeguarding training in line with the Trust's review of mandatory training		Level 1 and 2 training is at expected compliance levels. Level 3 training requires an improvement in compliance A new streamlined adult and children's safeguarding training package is in development with implementation planned for July 2022.

			A safeguarding training strategy has been developed and there has been revised mapping across the Trust of staff roles and responsibilities alignment to level 1 2 and 3 safeguarding training.
Supervision and support	All staff has access to supervision and support relevant to their area of work.		The safeguarding supervision policy has been reviewed to incorporate a whole family approach to safeguarding supervision
	Community safeguarding supervision compliance is above 90% for all relevant staff.		Safeguarding supervision has been delivered to 2,479 staff across the footprint Community safeguarding supervision in the majority of areas has been above 90% compliance in Manchester but further work is required to achieve consistent compliance in Trafford.
	Supervision developed in areas such as CAMHS, Royal Manchester Children's Hospital, St Marys, and sexual health services		Safeguarding supervision has been strengthened across the acute footprint including new "think Family "supervision sessions.
Looked after Children and Care Leavers	All services are enabled to effectively safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people and care leavers		The looked after children subgroup has representation from across the Trust. Awareness raising sessions regarding looked after children have been delivered in acute settings with LAC 7-minute briefings available on the Trust intranet A LAC Annual Report has been completed
Mental Capacity Act (MCA) **Deprivation of Liberty Safeguards (DoLS)** **Liberty Protection Safeguards (LPS)**	Staff have an increased understanding of MCA/DoLS across the Trust.		Trust policy has been reviewed. Mandatory and additional bespoke training and local guidance has been provided including the development of MCA and DoLS podcasts Internal audits incidents and external reviews have identified the need to raise awareness and support MFT staff in the application of the Mental Capacity Act.
	Staff understand their role and responsibility and are following guidelines		

	To work with hospitals/MCS/LCO on the implementation of LPS		National implementation of LPS has been delayed with with the code of practice currently out to consultation until 7th July 2022.The LPS implementation working group will commence in May 2022.
Raising Concern/Managing Allegations	There is a culture where staff can raise concerns		The Managing Allegations against MFT Staff who work with Children and Adults at Risk is being reviewed in line with updated MSP Policy for Managing Concerns for People in Positions of Trust who have Care and Support Needs.
Complex and wider safeguarding	Staff contribute to the wider safeguarding agenda and know how to escalate concerns to the needs of vulnerable groups		Trust thematic safeguarding sub groups have been held with representation from across the MFT footprint. Terms of reference and reporting have been reviewed.
Safeguarding in the Context of a Citizen with Mental Health Needs or Learning Disability	There are systems and processes in place to enabler staff to recognise and respond to the needs of people with a mental health condition and learning disability/autism		The Safeguarding Mental Health and Learning Disability/Autism team have now become established across MFT footprint to support the frontline services in making reasonable adjustments to provide high quality services to patients with a learning disability/mental health condition. The Trust strategy "Our plan for people with learning disabilities and/or autism, their families and carers 2022-2025 has been written Policy guidance is in place to support the care of patients presenting with behavioual disturbance due to mental health conditions.
Accountability/ Accessing Information/Documentation	Trust adheres to legal and professional safeguarding documentation standards		Safeguarding documentation and referral audits have been completed across the Trust

Partnership/Information Sharing	To ensure key messages from local and partnership groups are shared with the Trust through safeguarding governance groups.	✔	There is a clear reporting governance structure to share messages to and From MSP TSSP and MFT.
	To ensure there are robust processes in place and learning is disseminated to all areas from Serious Case Reviews/Child Safeguarding Practice Reviews/ Safeguarding Adult Reviews and Domestic Homicide Reviews	✔	The safeguarding newsletter was produced monthly and shares learning from local and national safeguarding reviews, legislaticve guidance policy and practice guidance MFT have contributed to all requests for partnership safeguarding reviews with learning and review of actions cordinated through the Quality and Learning group.

7.4 The key achievements of the MFT safeguarding teams by team

7.4.1 Midwifery Safeguarding, ORC, NMGH and WTWA

Name of Team	**Safeguarding Maternity - ORC, NMGH and WTWA**
Has the team delivered on actions within the safeguarding work plan 2020/21	The Safeguarding Workplan 2021/2022 for maternity has provided assurance that key objectives are being met with the following exceptions: • The CP-IS system is not implemented in Maternity Triage (NMGH Wythenshawe and ORC sites) and the Emergency Gynaecology Unit at WTWA. This will be achieved following the introduction of HIVE in September 2022. Assurance can be provided however that at all women who attend Triage department who are not booked at MFT, have robust checks with their local maternity hospital and social care prior to being discharged from hospital if they have delivered their babies.WTWA Emergency Gynaecology Unit IT systems are already configured to enable access to CP-IS. • Domestic Violence and Abuse training remains amber in the RAG rating in the workplan. The Head of Midwifery is supporting compliance by advising all matrons and band 7 midwives to complete the training, as mandatory local compliance. This training will be mandatory in future level 3 safeguarding training to be launched in 2022/23. • There is continued development required in safeguarding documentation. At NMGH an action plan is in place following a limited assurance audit for safeguarding documentation within medical records. Following learning from serious case reviews at ORC, there is a risk that written documentation is often not filed contemporaneously in the main hospital case note and would be missing should the Trust be required to share information in order to inform risk assessments, this remains on St Mary's risk register at ORC. • Managing Allegations of Abuse training continues to be rolled out to Matrons and Band 7 bleep holders and managers across the St Mary's footprint.

Key achievements	**NMGH site** From 1st April 2021, there has been a named midwife and safeguarding maternity team based on site at NMGH, to provide robust support and guidance to staff caring for maternity clients and their families, with identified safeguarding concerns, both in the acute and community settings. There have been changes in safeguarding process and practice introduced to staff, which continues to be developed: ➢ All referrals made to children's social care are now made appropriately and follow the correct pathway for each local authority. ➢ Safeguarding group supervision is now provided. ➢ All disclosures of Female Genital Mutilation are now formally risk assessed, according to MFT policy[58]. ➢ Safeguarding care plans and discharge planning meetings are in place for babies subject to child protection plan or childcare legal proceedings with reporting in place for safeguarding meetings. ➢ Safeguarding and domestic abuse training is now in place. **WTWA site** There is now a named midwife based within the safeguarding maternity team at WTWA site to support the existing safeguarding midwives in providing robust support and guidance to staff caring for maternity clients and their families with identified safeguarding concerns. There have been some changes made in safeguarding processes and practice introduced to staff, which has been well accepted, and practice continues to develop: - ➢ A scoping exercise regarding the safeguarding risk assessment which is undertaken at the booking appointment was carried out following a safeguarding incident. This was not found to be robust, therefore a new safeguarding risk assessment was developed and rolled out. The intention is to audit this in quarter 2 (2022-23). ➢ Safeguarding group supervision has been promoted and has been well received by midwives and compliance with all safeguarding supervision has increased. ➢ Safeguarding accountability and responsibilities were raised as a concern with the Head of Midwifery and midwifery matrons, this has resulted in increased report writing and attendance at child protection meetings by community midwives. ➢ At St Marys Hospital, WTWA, there has been a significant increase in complex mental health presentations resulting in intensive support being required from the Trust and external legal teams who have had to present at High Court to request court of protection directions. The safeguarding midwives have intensely supported the mental health specialist midwife with regards to the management of these particularly complex cases. ➢ Links have been made with the learning disability safeguarding team and in conjunction with the Disability Midwifery Advocate (DMA), learning disability passports are now being utilised for women who may have additional learning needs. ➢ Safeguarding midwives at St Mary's, WTWA have supported with the

[58] Prevention Recognition and Safeguarding Women and Girls from Female Genital Mutilation

	robust sharing of information and care planning of pregnant women who have been diverted to Wythenshawe Hospital to deliver their babies due to Macclesfield General Hospital in-patient services being suspended due to the COVID Pandemic and refurbishment. **ORC** Safeguarding Midwives have maintained a visible and robust presence within the main maternity hospital and are available to support safeguarding at Lanceburn Health Centre in Salford and Trafford Hospital antenatal clinic. ➢ Audit of FGM processes offered significant assurance. ➢ Audit work undertaken by postnatal ward managers offers significant assurance that ICON pathways are being followed. **Trust Wide** ➢ In order to reduce the incidence of Abusive Head Trauma in babies, the ICON pathway has been introduced across Manchester and Trafford, Salford and more recently Bury. Training for Midwives and Health Support Workers at NMGH has commenced. ➢ There has been an increase in safeguarding supervision provision, this has been well received by midwives and compliance with all safeguarding supervision has increased. The group supervision for specialist midwives now takes place virtually and invitation has been extended to equivalent midwives at NMGH and St Mary's at WTWA. This has promoted cross-site working and collaboration within maternity services.

Manchester Children's Community Safeguarding

7.4.2 Manchester Safeguarding Children Community Team

Name of Team	Manchester Community Safeguarding Team
Has the team delivered on actions within safeguarding work plan	• There has been ongoing work with Manchester Health Care Commissioning (MHCC) to explore the health resource for the Advice and Guidance Service and Complex Safeguarding Hub. • Improved integrated working relationships with the Looked after Children and the Community Safeguarding Teams were developed. • Following the safeguarding supervision audit in 2021, which gave limited assurance, the safeguarding supervision policy was revised and comments from practitioners were taken into consideration in the review. The revised policy encompasses the "Whole Family" approach to safeguarding, acknowledging that staff from adult services require supervision related to child concerns and vice versa. A repeat safeguarding supervision audit has been completed in Q1 (2022-23) and is currently being analysed. A decision was taken to concentrate the audit on Manchester and Trafford Community LCO and CAMHS services where supervision should be firmly embedded. • There has been continued development of "Safe and Together" training, workshops, and clinics with evaluation of the impact on practice when safeguarding families where there is a risk of domestic violence and abuse. • Domestic violence and abuse training offered to NMGH staff. • During the Covid-19 pandemic the team adapted to work in different ways utilising Microsoft Teams meetings, resulting in increased productivity of

	the team through less time travelling around the city. Following the staff feedback and the reduction of Covid restrictions, a blended model of working has been developed using both face-to face and online contacts, prioritising face to face supervision where possible. • Manchester Child Neglect Strategy 2021-24 was published, and an operational implementation group is to be established. Work has been ongoing to support the use of the Graded Care Profile 2 in recognition and response to neglect in children. • Work is ongoing to support the implementation and evaluation of Manchester Safeguarding Partnership (MSP) Practice Standards for multi-agency child protection meetings. • The health visitors are now using the revised guidance on bruising for non-mobile babies to support their decision making. • A multi-agency audit into the efficacy of strategy meetings was completed by an MSP task and finish group with contribution from a community senior specialist safeguarding nurse.
Key Achievements 2020/21	➢ CSE Audit of 10 cases was completed to look at the quality of practice involvement from school nurses, LAC nurses and Specialist Nurse CSE. ➢ A child protection record keeping audit was completed and a document was developed to support community practitioners with recording multi-agency meetings with a prompt to ensure Child Protection information Sharing (CPIS) is on the record and a child protection plan is uploaded in the ➢ The safeguarding leadership provided by the community safeguarding children's named nurses at the Manchester Safeguarding Partnership (MSP) locality safeguarding fora was commended in an external review of the Manchester Multi-agency Safeguarding Arrangements[59] which described the safeguarding fora as a great success engaging a wide range of professionals on important discussions. ➢ Supported the Integrated Sexual Health Services in developing a Best Interest Form following a serious case review. ➢ Lead contributors to the development of the draft Perplexing Presentations/Fabricated and Induced Illness pathway which is currently being piloted. ➢ Responsible for developing guidelines for improving the quality of the Safeguarding Newsletter. ➢ Worked with TLCO to align safeguarding supervision processes and support to improve supervision compliance ➢ Safeguarding Champions established network of children's community practitioners has been extended to include adult practitioners. ➢ Prevent package developed by a specialist nurse who has a lead role for Prevent within the safeguarding team and training provided to the wider safeguarding team.

Manchester and Trafford Community Service

[59] Review of Manchester Multi-agency Safeguarding Arrangements (Adult and Children) "Taking it to the next level" (2021) Carol Brookes Associates

7.4.3 Manchester and Trafford Children's Community Named Doctor

Name of Team	**Named Doctor Safeguarding Children Community including Child Protection (Community) Clinic** **Children's Community Paediatrics - Trafford Local Care Organisation**
Has the team delivered on actions within safeguarding work plan 2020/21	• The Named Doctor has continued to facilitate practice changes in line with RCPCH guidelines. • There has been community safeguarding contribution to the revised Fabricated and Induced Illness/Perplexing Presentation MSP pathway work.
Key achievements 2020/21	➢ The team has continued to provide dedicated Child Safeguarding Clinics Supporting and Chairing Fabricated and Induced Illness (FII0 cases and meetings as needed. ➢ Chairing and recording peer review meetings. ➢ Ensuring that the RCPCH Standards of Child protection medicals are abided by. ➢ Maintains an overview of effective communication with stakeholders like Children's Social Care and and School Health.

7.4.4 Trafford Safeguarding Children Community Team

Name of Team	Trafford Safeguarding Children Community Team
Has the team delivered on actions within safeguarding work plan 2020/21	• Delivery of coercive and controlling behaviour within domestic abuse relationships to frontline health staff completed with positive feedback • There has been continued promotion of good practice in relation to neglect and the Graded Care Profile, including the design and delivery of multiagency training for front line practitioners regarding Obesity and neglect, as part of the TSSP Neglect strategy, more dates are proposed next year.
Key achievements	➢ Supporting Trafford strategic safeguarding partnership with delivery of multiagency training such as Domestic abuse round table events in placed based area teams, completing multiagency audits regarding sexual exploitation and neglect. ➢ Safeguarding record keeping audit of community health records completed. ➢ Safeguarding supervision audit has been completed Q4 and the audit report will be completed, and learning shared in 2022/23. ➢ The team has offered a safe, high quality and effective service to Trafford frontline. ➢ Positive feedback has been received regarding good content and analysis of risk regarding the neglect and sexual exploitation audits from TSSP. ➢ Positive feedback received from practitioners following assistance from the team in escalating concerns with multi-agency partners. ➢ Positive feedback from the TSSP domestic abuse roundtable events, neglect conference and obesity and neglect training.

7.4.5 Safeguarding Children, ORC, NMGH and WTWA

Name of Team	**WTWA, ORC, NMGH Safeguarding Children Team**

Has the team delivered on actions within safeguarding work plan	• Safeguarding Children's acute team have successfully aligned all acute processes across ORC, WTWA and NMGH. • Safeguarding Children's acute team attend peer support/supervision and the Named Nurses liaise weekly with Senior RMCH Nursing Leads for safeguarding oversight and review. • All children's NMGH acute safeguarding policies and guidelines have been aligned with MFT policies and guidelines. • Safeguarding Supervision has been strengthened across the footprint via: - An increase in the offer of generic group sessions for staff - An increase in the offer of bespoke sessions for staff - An increase in the offer to targeted medical and nursing teams (Paediatric Intensive Care PICU, Paediatric Emergency Department PED) - An increase in the offer to targeted Child Mental Health and Learning Disability teams - A more personalised approach to sending out evidence-based resources to teams following supervision for example 7 minute briefings (7MB), themes from learning reviews and tools to support safeguarding practice such as in parental responsibility and consent, having difficult conversations, trauma informed practice, obesity and safeguarding. considerations. • A Fabricated illness//perplexing presentations pathway has been developed across Community and Acute children's services with input from Named Doctors for Safeguarding Children acute. • ICON, (prevention of abusive head injury) has been implemented opportunistically via teaching sessions in PED and leaflets being given to parents. A further PED ICON week is planned for September 2022. • RMCH have an embedded electronic referral pathway into the acute safeguarding team.
Key Achievements 2020/21	➢ Safeguarding contribution to CAMHS Pathway /referral criteria for admission of eating disorder patients at RMCH. ➢ Safeguarding contribution to the review and development of North West Trauma Guidelines ➢ Safeguarding contribution and development of MFT internal guidelines and response for children and young people presenting to the hospital in crisis. The team have supported implementation of the draft Greater Manchester multi-agency children in crisis framework which has included implementation of the Multi-Agency Leads Meeting (MALM) when children and young people are medical fit for discharge but are awaiting a mental health admission or local authority placement. ➢ Increased uptake of safeguarding supervision in the acute setting. ➢ Provided bespoke safeguarding training (in response to identified safeguarding need and risks) at NMGH, WTWA and RMCH. This has included bespoke training on safeguarding referrals and safeguarding induction delivered to all new starters in PED (Nursing and Medical). ➢ Leadership and contribution to the development of safeguarding training for ED Nurses and International Nurses.

7.4.6 **Named Doctor Acute, ORC, NMGH and WTWA**

Name of Team	**Named Doctor Safeguarding Acute ORC, NMGH and WTWA**

Key achievements 2020/21	➢ There has been a new guideline developed, 'The Safeguarding Management of Injuries in Infants', to highlight the importance in recognising injuries in infants and to support staff in the emergency department and the paediatric wards in initiating the correct safeguarding response when an infant is brought to hospital with an injury. The Named Doctors are providing regular teaching sessions to the Emergency Department staff and paediatric staff at Wythenshawe Hospital and the Oxford Road site. ➢ At Wythenshawe Hospital audits have been completed which demonstrate close working between the paediatric doctors and safeguarding nurses in complex patients and that there is very good professional attendance at strategy meetings. ➢ Safeguarding Peer Review is established at all three sites with good attendance of medical and nursing staff and meets the standards required by RCPCH.

7.4.7 **Acute Safeguarding Adults**

Name of Team	**Adult Safeguarding Team, Oxford Road Campus (ORC), Wythenshawe Trafford Withington and Altrincham (WTWA) Teams and North Manchester General Hospital (NMGH)**
Has the team delivered on actions within safeguarding work plan	The adult safeguarding team has met the objectives of the workplan due in part to the consistency and application of the whole team who have worked well to support each other but also the wider MFT clinical teams. • Team integration - the adult safeguarding team has continued to work with the acute children's safeguarding team jointly on cases and liaising on other cases under the Think Family agenda. Over the past year as the mental health and learning disability specialist safeguarding teams have become based at the three hospital safeguarding offices, the teams have continued to build rapport/relationships enabling greater integration which in turn has led to joint working on cases with greater complexity. The teams regularly use their specialist skills to support the patients and staff to keep the focus on making safeguarding personal using a think family approach. The NMGH adult safeguarding team has successfully integrated the use of reporting safeguarding concerns via the Ulysses system ensuring continuity across the MFT footprint to recognise and respond to concerns. • Streamlining Services -There has been continued work with hospital/MCS/LCO, and site risk and governance teams to review section 42 adult safeguarding enquiry guidance and process with a framework of monitoring of section 42's requested and completed. This gives the Trust and partners much better assurance around Section 42 enquiries and enables an oversight of learning themes and trends across the sites. • Supervision- The safeguarding team have provided 1-1 safeguarding supervision sessions to staff requesting support. The adult safeguarding team provide supervision to staff at WTWA and the Trafford Local Care Organisation (TLCO). Staff are invited to bring cases to supervision to discuss them in a supportive environment. This gives staff the confidence to consider safeguarding issues and escalate them when needed.

	• At the NMGH site the newly established safeguarding team have supported. ➢ The introduction of level 3 safeguarding training (face-to-face) thus ensuring the 'think family' approach is embedded. ➢ NMGH representation on thematic MFT safeguarding subgroups from the clinical divisions. ➢ All clinical areas at NMGH have been encouraged to display safeguarding boards in areas visible to, not only staff, but members of the public to encourage the raising of concerns and to 'make safeguarding personal' by encouraging involvement, this is also contributed to via the safeguarding champions initiative. ➢ Liaison across the site with divisional leads and heads of departments has continued to ensure safeguarding is high on the agenda across the North of the city.
Key Achievements 2020/21	**Training** ➢ Bespoke training sessions have been provided covering all aspects of adult safeguarding agenda to clinical areas across the Trust, including domestic abuse training in NMGH ➢ The bi-monthly MCA/DoLS training continues, providing a 'back to basics' overview of mental capacity incorporating DoLS, LPA, and executive functioning especially in relation to self- neglecting behaviour. ➢ There has been participation in FY1 training programme covering MCA, linking executive functioning to self- neglecting behaviour and providing guidance on domestic abuse and the referral process. ➢ In conjunction with the wider safeguarding team, safeguarding teams have facilitated the Emergency Departments Fundamentals of Care programme, ensuring that undertaking the course are up to date with their roles and responsibilities towards safeguarding, using a "think Family" approach with positive feedback received ➢ Support has been provided to site Safeguarding Committees and with Clinical Leads to review initiatives aiming to improve uptake of level 3 adult safeguarding training. ➢ During the winter months the adult safeguarding team undertook ward specific training when themes/issues were identified from incident reporting (Winter Pressures ward) covering MCA/DoLS, identification of safeguarding concerns and referral processes. ➢ The team has been facilitating internationally recruited (IR) Nurses training preceptorship programme which now will include two safeguarding supervision sessions delivered within this preceptorship programme. **Audit** ➢ DoLS Point Prevalence audits conducted across adult clinical wards identified that, at MRI the onward sharing of applications to the local authority was not consistent, therefore an action plan was developed with the Deputy Director of Nursing to improve the application process. The adult safeguarding team has introduced a more robust process for the management of DoLS incidents and this appears to show some improvement with the applications process. ➢ The team continue to monitor incidents and identify themes. Following specific incidents, the teams have provided specific support including. ➢ Over the winter period a number of incidents were raised concerning nutrition/hydration and general care on the winter

	pressures ward. Local escalation led to a targeted approach from the safeguarding team – attending board-rounds throughout the week offering 'in the moment' advice and support. As a result, the named nurse attended the Serious Incident (SI) panel presenting additional information, this resulted in a round table care review being undertaken and learning identified to influence/inform the planning/organisation of the next year winter pressures ward. ➢ In WTWA bespoke training was arranged following an incident and staff were asked to bring cases to the sessions every Wednesday for seven weeks. Staff did bring cases about patients they had cared for and they were able to discuss these cases with the team. **Making Safeguarding Personal ()** ➢ There has been an Increase in a more visible approach to addressing safeguarding concerns with frontline staff by ward walk rounds, this has resulted in more appropriate and timely referrals. ➢ The NHS England Safeguarding Adults week held in November 2021 highlighted the theme of 'safer culture', hospitals have embraced this with a series of events across the week to engage staff and the public including stalls and quizzes. ➢ The team has been attending Falls Accountability meetings. The main aim of the team attending is o keep the focus on the patient and ensure all actions are taken to keep the patients safe. **Keeping People Safe** ➢ Safeguarding podcasts, which include domestic abuse, self-neglect and neglect. have been developed for staff to access.

7.4.8 **Mental Health and Learning Disability Safeguarding Service**

Name of Team	**Safeguarding Mental Health and Learning Disability Team**
Has the team delivered on actions within safeguarding work plan 2020/21	• The Mental Health Team has been working on reducing the use of restrictive interventions. Guidance on this changed in April 2021 and the team has been working with the Learning and Development Team and Trust Security Services to develop a new policy and training package. The new policy includes a Royal College of Nursing Checklist which has been piloted by the team and also aims to reduce restrictive interventions. This will support some of our most vulnerable patients across MFT and will lead to a more trauma informed way of working. • The team has been working on the introduction of Liberty Protection Safeguards (LPS). However due to the implementation being delayed nationally the LPS steering group has not progressed as expected. However, the team has concentrated on improving the knowledge of staff around the Mental Capacity Act (MCA) by the facilitation of MCA training on a monthly basis (both face-to-face and virtually). The MCA training includes a section on executive capacity and how that directly affects the decision making of some of our most vulnerable patients.
Key achievements	**Making Safeguarding Personal Mental Health Team** ➢ An audit was undertaken around the Integrated Care Pathway for

	Self-harm and Suicide (ICP). The ICP is designed to offer the patient a bespoke pathway based on their needs whilst at MFT. The audit showed good compliance at WTWA, however results indicated there is improvement required at MRI and NMGH are not currently using this pathway but do have a similar document. Improvements will be seen once the new electronic patient record system; Hive is introduced as the ICP will be an integral part of an assessment. ➢ The Mental Health/Capacity Act (MHA) Officers and the lead for mental health have set up an escalation pathway with Manchester Local Authority to ensure that Deprivation of Liberty Safeguards, requiring an increased level of restrictions, are assessed by a Best Interest Assessor as soon as possible. This ensures that the rights and dignity of the patients involved are maintained. The MHA/MCA Officer has also been working with staff and patients regarding the MHA and a person's rights, under the MHA, to appeal against a mental health section. ➢ The conception of the Learning Disability (LD) champions across MFT is well underway. The aim of the LD champion is to monitor and ensure an area is fulfilling its responsibility for people with a Learning Disability. ➢ The LD team have been building on the quality rounds which provide assurance that the ward areas are doing everything possible to support patients with an LD by scrutinising care plans, Respect forms and risk assessments with the aim of a high quality personal care plan. ➢ The LD team is also available to meet with patients and family to offer extra support and specialist advice. Feedback from patients and family is received via the LD support inbox which is monitored by the Senior Specialist LD Safeguarding Nurses. The team also undertake bespoke training across the Trust. ➢ The LD team also play an important role in mortality reviews reviewing learning from reviews to influence future practice ➢ The mental health Team have produced a number of podcasts available on the intranet. The podcasts cover a wide range of patient safety subjects. ➢ The mental health team also continues to offer bespoke training around suicide prevention, self-harm and reducing restrictive interventions. The team also responds to incidents that are raised and offer advice and support around the incident. They will also communicate with the Mental Health Liaison Team and Community Mental Health Teams to ensure the safety of the patient.

SECTION H
Safeguarding Forward Plan for 2021/22

8. MFT Safeguarding Team Development Plans for 2021/2022

8.1 During 2021/22 the Trust will continue to develop safeguarding practice and structures to continuously improve support to staff, multi-agency colleagues and service users. The MFT 2022/23 safeguarding work plan, which will be implemented by all hospitals/MCS/LCOs, supported and monitored by the safeguarding teams, has the following objectives:

Figure 35: Trust Safeguarding Work Plan 2022/23 Objectives

1. **Making safeguarding personal (voice of the adult at risk), voice of the child.** A culture of listening and hearing the voice of children and adults at risk and their families, taking account of their wishes and feelings both in individual decisions and the development of services
2. **Adult Safeguarding, keeping people safe.** Ensuring there are systems and processes in place to enable staff to recognise and respond to the needs of adults at risk to safeguard them from abuse and neglect.
3. **Safeguarding Children, keeping children safe.** Ensuring there are processes in place to ensure the needs of the child are prioritised and that the Trust and Hospitals/MCS/LCOs are committed to prioritising the protection of children in all work streams.
4. **Staff have access to supervision and support to safeguard vulnerable people.** To ensure staff are supported when dealing with difficult and complex safeguarding cases.
5. **Mandatory Adult and Children's Safeguarding Training.** To ensure we meet our statutory requirements and policy guidance safeguarding training are met.
6. **All staff will be enabled to effectively safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people and care leavers as outlined statutory guidance**[60].
7. **Application of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards (LPS) is appropriate and proportionate across the Trust.**
8. **Raising Concerns/Managing Allegations for People in Positions of Trust working with unborn, children and families and adults at risk.** There is a culture whereby patients and relatives can raise concerns. Evidence of making safeguarding personal in all responses to concerns raised. If an allegation is made against a member of staff, all staff involved are aware of the processes to be followed.
9. **Complex and wider safeguarding**. Staff contribute to the wider safeguarding agenda and know how to escalate concerns in respect of responding to the needs of vulnerable groups.
10. **Safeguarding in the Context of a Citizen with Mental Health needs or Learning Disability.** There are systems and processes in place to enable staff to recognise and respond to the needs of people with; a mental health condition, a learning disability and/or autism
11. **Documentation. Accountability/Accessing information/Documentation**
12. **Partnership Working/Information sharing.** Staff work with other agencies to ensure the safety and protection of adults and children at risk.

[60] Statutory Guidance for Child Safeguarding Training is outlined in Section 11 of the Children Act 2004, and statutory guidance in Working Together 2018. Policy guidance for adult and children safeguarding training is identified in, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Adult Safeguarding: Roles and Competencies for Health Care Staff and Looked After Children: roles and responsibilities of healthcare staff (2020) and statutory guidance in Promoting the health and wellbeing of Looked After Children (2015)

8.2 This year the safeguarding team will continue to streamline safeguarding processes across the Trust footprint. The teams will review service provision in line with the changes introduced with the Integrated Care Systems expected to be implemented in 2022/23.

8.3 The Trust will continue to support the safeguarding partnerships in the delivery of their revised safeguarding objectives. There will be support to implement the multi agency learning from Manchester and Trafford Ofsted inspections[61], in Manchester actions to support children in need and requiring protection and Trafford actions delivered through the Traffords ambitions plan[62].

8.4 The key priority in our hospitals will be to implement the HIVE electronic patient record and utilise the system to support the delivery and documentation of safeguarding across the Trust.

8.5 The revised safeguarding training package and strategy will be launched this year and all hospital/MCS/LCO will be required to complete the new program.

8.6 All safeguarding and specialist mental health and learning disability teams will focus on being visible and available to frontline services to promote, develop, support, monitor and review the highest quality safeguarding and care to all patients with a priority to reviewing and supporting the care of patients with a mental health condition, learning disability and/or autism.

8.7 Each of the safeguarding teams has identified actions in support of the priorities set out in the Trust safeguarding workplan, which are summarised below:

8.8 **Midwifery Safeguarding NMGH, ORC and WTWA**

Name of Team	**Midwifery Safeguarding NMGH, ORC and WTWA**
• Named midwife/matron safeguarding will meet monthly with the Head of Midwifery and midwifery matrons to ensure that the safeguarding workplan is assured and that any safeguarding incidents are discussed. There will be continued promotion of each clinical and ward area having a safeguarding champion to promote the safeguarding agenda and update the safeguarding noticeboard including the newsletter. Bespoke training will be provided regarding the safeguarding champion role and the expectations. • Named midwife/matron safeguarding is supporting with the implementation of an initiative to support women whose babies are removed at birth at MFT in response to the Born into Care: agreeing best practice principles[63]. Parents and the baby are each given a box contain in various matching items. The purpose of the box is to aid connection between parents and baby once separated and to be used as a motivational tool to encourage parents to engage with professionals with the aim of possible reunification in the future. **NMGH** • To increase visibility, Safeguarding Midwives have secured an office for on-sight support, based within the antenatal clinic area at NMGH. This is initially for 2 days per week. Safeguarding Midwives will arrange to attend Community Midwife meetings in-order to increase visibility and support in this area.	

[61] Manchester and Trafford Ofsted inspections

[62] Trafford Ambitions plan

[63] Born into Care: agreeing best practice principles when the State intervenes at birth guideline (Feb 2022)https://www.nuffieldfjo.org.uk/resource/born-into-care-developing-best-practice-guidelines-for-when-the-state-intervenes-at-birth

- Recent audits relating to safeguarding documentation and FGM processes did not demonstrate required level of assurance, due to the low number of cases which fit the time scale criteria. Both audits will be repeated in Q3. The introduction of the ICON pathway will also be audited for compliance in Q4.
- ICON training will continue to be delivered across NMGH and Fairfield General Hospital.

WTWA

- In order to further raise awareness of the safeguarding team, it is the intention of the Safeguarding Midwives to generate a Safeguarding Newsletter in order to raise awareness of the role of the Safeguarding Midwives this will incorporate statistics regarding number of referrals received, details of children made subject to Child Protection Plans/Child In Need Plans, care proceedings that have been initiated and hot topics or themes from incidents.
- An audit regarding the Safeguarding Risk Assessment/documentation at booking is scheduled to take place in Q2 and an audit regarding ICON is scheduled to take place in Q3.

ORC

- A plan is to be developed for the introduction of Group Safeguarding Supervision with the following additional groups, SARC practitioners at both Manchester and Liverpool sites, Senior Midwives within Maternity Services who carry the unit bleep out of hours and Practitioners within Genomics.

8.9 Manchester Safeguarding Children Community Team

Name of Team	Manchester Safeguarding Children Community Team

- Review the way the community safeguarding team works with the wider safeguarding teams
- Review the complex safeguarding specialist nurse resource in the complex safeguarding hub
- Streamline MARAC process in Manchester and Trafford.
- Support and align processes for Complex Safeguarding and Trafford's First Response
- Enable ongoing development of the community specialist nurses with the wider safeguarding team and facilitate opportunities for professional development
- Review the quality of safeguarding supervision plans as a response to the safeguarding supervision audit.
- Review child in need and child protection plans in response to the record keeping audit.
- Contributing to the Healthy Weight subgroup and developing a workplan to take account of the Neglect Strategy.

8.10 Coral Suite Child Protection Team, Community Paediatrics and Trafford Community Named Doctor

Name of Team	Coral Suite Child Protection Team, Community Paediatrics

- Continue to provide the dedicated children safeguarding clinics and provide the highest standard of care.
- Ensurine that the RCPCH Standards of Child protection medicals are abided by.
- Maintain an overview of effective communication with stakeholders like Children's Social Care and and School Health.

8.11 Trafford Community Children Safeguarding Team

Name of Team	Trafford Community Children Safeguarding Team
• Following learning from a child safeguarding rapid review scoping where there were concerns about professionals identifying the indicators and risks of sexual. An action plan has been developed to raise professional awareness of sexual abuse prevalence, risk and indicators including signposting to resources in individual and group safeguarding supervision. • Trafford community safeguarding team will align with safeguarding processes across MFT. The priority this year is adopting the model used by Manchester community health services for completing court statements for childcare public law proceedings to ensure reports are more analytical and concise. This will include formalising and delivering a training package to front line practitioners. • Continue to support Trafford Strategic Safeguarding Partnership with training events, multiagency work and audits. Proposed training dates have been offered for obesity as part of the wider neglect strategy and neglect roundtable events to promote the continued use of the Graded Care Profile 2. • Identify and embed safeguarding champions within frontline services. Continue to offer safeguarding support and advice to frontline practitioners. The team plans to meet with service managers and area teams to increase awareness of support available. • Safeguarding supervision and record keeping audits completed in quarter 4 will be reported and learning shared.	

8.12 Safeguarding Children NMGH, ORC and WTWA Teams

Name of Team	Safeguarding Children NMGH, ORC and WTWA Teams
• Continue to increase the offer of safeguarding supervision targeting senior nursing staff, paediatric medical staff and adult acute areas. • Continue to recruit and stabilise staffing in the acute children's team. • Implement new HIVE/EPR systems and review team processes as appropriate. • Implementation of internal MFT guidelines for children and young people in Crisis. • Provide training to Medical Professionals (including adult) regarding capacity assessments and applications to court of protection for DoLS • Develop closer working relationships and partnerships with Greater Manchester Mental Health Liaison Team (MHLT).	

8.13 Named Doctor Acute

Name of Team	Named Doctor Acute
• Complete and implement the pathway for the management of FII across Central Manchester. • Continue to support NMGH in the implementation of trust wide CP processes including peer review, attendance at strategy meetings child protection documentation and audit. • Provide training to medical professionals involved in capacity assessments and applications to the Court of Protection for Deprivation of Liberty. • Audit of guidance on safeguarding management injuries in infants. • Integrating processes to safeguard children into the new HIVE system	

8.14 **Adult Safeguarding NMGH, ORC and WTWA Teams**

Name of Team	Adult Safeguarding NMGH, ORC and WTWA Teams
• The team will consider sensitive ways of receiving feedback from patients and their families. There is a plan to receive feedback from domestic abuse victims via leaflets in the emergency departments. This will help to ensure the trust is making safeguarding personal and the patients voice influences our safeguarding offer • Safeguarding supervision is to be strengthened including offering supervision to the safeguarding administration team as the team are acutely aware of the amount of distressing content dealt with daily. • There will be continued focus on regular meetings between safeguarding named nurses and Deputy Director of Nursing and the Medical Director with the aim of building communication across the teams and allowing for maximum efficacy. • Relationships will continue to be strengthened with Trafford Local Authority the CCGs and the TLCO which will benefit the team and ultimately our patients. • Poor completion of DASHs and the need to recognise and respond to domestic violence & abuse (DVA) has been highlighted as an area for improvement across NMGH by the safeguarding team. The north MARAC has highlighted that a large number of people heard at the conference have presented to NMGH but concerns around DVA were not addressed at the time by staff, therefore all clinical areas are to be offered bespoke training on DVA recognition and response including, DASH completion and continued encouragement in completing E-learning modules for DVA. • Currently NMGH complete DoLS applications via the Evolve system, this system will cease with the introduction of HIVE in September 2022, therefore the safeguarding team will be assisting with the transition from Evolve to Ulysses for DoLS applications. • With the new legislation surrounding deprivation of liberties and the introduction (of Liberty Protection Safeguards (LPS), the adult safeguarding team will be working towards ensuring the MCA is continued to be knowledgeably applied, whilst supporting in the implementation plans of LPS. • It has been recognised across the Trust footprint that our international nurses have required extra training on arrival for their role and responsibilities towards safeguarding and a program of training is being commenced across sites with input from all safeguarding teams and practice educators. • Maintain the adult safeguarding team influence on harm free care agenda.	

8.15 **Safeguarding Mental Health and Learning Disability Team**

Name of Team	Safeguarding Mental Health and Learning Disability Team
• The team will be building on the work for LPS. An LPS working group has been set up and will be led by the Matron Mental Health and Learning Disabilities • The reducing restrictive interventions work will continue and training around this will be rolled out across the Trust • Hive will allow the use of the Self-Harm/Suicide ICP across the Trust and will also allow this to be successfully audited • The team is developing ward packs for patients with a Learning Disability. • The team is to attend regular meetings with the Community LD teams.	

- The Oliver McGowan training will be rolled out this year and will be mandatory for all NHS staff.
- The team is working with IT to supply videos/photos of specific areas to help patients who have elective appointments or elective surgery.
- The team is working with gynaecology on writing a new pathway with the Community Central Team to aid people with an LD/Autism access appropriate health care.

Safeguarding Audit Plan 2022/23

8.16 The audit plan aims to review how the Trust is meeting its statutory responsibilities, evidence safeguarding against the Greater Manchester (GM) Clinical Commissioning Group (CCG) Safeguarding Contractual Standards[64] and reviews the implementation of learning following SAR/SCR/CSPR/DHR recommendations.
Figure 36: Trust Safeguarding Audit Plan summaries the 2022/23 safeguarding audit plan

Figure 36: Trust Safeguarding Audit Plan 2022/23

1. Safeguarding Children and the Unborn audits will review
   - Safeguarding Supervision
   - Safeguarding Documentation
   - Application of safeguarding policies including, child exploitation risk indicator checklist, safeguarding information sharing in prevention of female genital mutilation, safeguarding management of injuries in babies and children and young people medically fit for discharge but with no place to be discharged to guidance.
   - Implementation of ICON programme to prevent abusive head trauma in babies
   - Safe discharge for children subject to child protection plans.

2. Looked After Children (LAC) Audit will review
   - Unaccompanied asylum seekers views of service development and provision.
   - LAC documentation including the voice of the child and young person.
   - LAC placed out of area.

3. Safeguarding Adults and Vulnerable Groups audits will review
   - Application of the Mental Capacity Act and DoLS process including an audit of least restrictive interventions process.
   - Application of suicide prevention policy including the integrated care pathway for suicide and self-harm.
   - Implementation of learning from safeguarding reviews including care planning and delivery in maintaining patient's nutrition and hydration needs, use of learning disability/autism passports and recognition of self-neglect.

4. Multi-agency audit as advised by Manchester and Trafford Safeguarding Partnerships including the annual Section 11 and the Adult Assurance audits.

[64] Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards 2021-22 A Collaborative Greater Manchester (GM) Document The trust is required to submit evidence against 67 safeguarding standards in APPENDIX 2: 2021-2022 - NHS PROVIDER SAFEGUARDING AND LOOKED AFTER CHILDREN AUDIT TOOL

Conclusion and Recommendations

8.17 Manchester continues to have one of the country's highest rates of deprivation, bringing with it a range of challenges for safeguarding. Trafford borough is a diverse area with areas of affluence and deprivation and with localised safeguarding needs and vulnerabilities. This annual report demonstrates the complexity of the safeguarding work undertaken within the Trust to ensure that patients, services users, and staff are safe.

8.18 Safeguarding is a key priority for the Trust, and this report provides assurance that the safeguarding team continue to deliver high volume and high-quality support to staff, to enable them to fulfil their safeguarding obligation and to enable the Trust to meet its statutory requirements.

8.19 Safeguarding activity has been extensive across the Trust during this reporting period. A wide-reaching training programme has been delivered to support the development of knowledge and skills across the workforce and, although improvement is still required to increase compliance with level 3 training; the impact of this training is evidenced by the high numbers of referrals to the Trust safeguarding team, which averages **84** (65 in 2022/23) referrals every day.

8.20 The MFT safeguarding service continues to ensure that the Trust remains sighted on legislative and practice changes that affect safeguarding. The key Acts affecting safeguarding will be the implementation of the amendment to the Mental Capacity Act 2019 regarding introduction of Liberty Protection Safeguards, implementation of the Health and Care Act 2022[65] and review of the implications of the Independent Review of Children's Social Care[66].

8.21 There has been investment by the Trust to support the delivery of safeguarding in NMGH and the investment has resulted in a highly visible integrated whole family safeguarding team who have supported the hospital in the establishment of MFT safeguarding governance, policy, training and practice resulting in increased identification of safeguarding concerns and opportunities to reduce risks for our patients.

8.22 Challenges continue to emerge and require a robust response with the further embedding of the complex and contextual safeguarding agenda including this year, learning about serious youth violence from safeguarding reviews as well as the need to prepare for future challenges and opportunities within the evolving health and social care landscape as the Integrated Care System develops. The safeguarding team will continue to support the Trust to embrace best practice, actively participate as a key multi-agency partner, but most importantly ensure that all patients and service users are afforded the best possible protection form abuse and neglect.

[65] Health and Care Act 2022
[66] Independent Review of Children's Social Care

8.23 The safeguarding team will focus this year on assurance and impact to evidence that the Trust is achieving its safeguarding obligations and identifying the impact of the training programme and supervision through assurance visits, audit and delivery of the safeguarding workplan.

8.24 The Board of Directors is asked to note the extensive activity undertaken within the Trust and across the multi-agency partnership to support MFT staff and services to be responsive to the safeguarding needs of patients and service users. Members of the Board of Directors are asked to continue to support the Trust's on-going focus on safety, which ensures that safeguarding remains a key organisational priority.

SECTION I

Manchester Looked After Children and Trafford Children in Care Annual Reports 2021/22

Annual Report for the Looked after Children Health Service in Manchester 2021/2022

Contributors to the report:
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Naomi Sherwood – Named Doctor for Looked after Children

Section 1: Introduction

The Health and wellbeing of Looked after Children

1.1 It is recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and the blended effects of poverty, poor parenting, chaotic lifestyles, abuse, and neglect, Looked after Children are often at greater risk and have poorer health than their peers[67]. The Royal College of Paediatrics and Child Health (2020) states that Looked after Children have greater mental health problems, increased developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. They are more likely to be involved in risk taking behaviour, the youth justice system and have poorer educational attainment. Furthermore, the Department for Education and the Department of Health (2015)[68] report that almost half of Looked after Children have a diagnosable mental health disorder and two thirds have special educational needs. Delays in identifying or meeting emotional and mental health needs can have a detrimental effect on all aspects of a person's life and can lead to unhappy, unhealthy lives as adults.

The Definition of a Looked after Child

1.2 Under the Children Act 1989, a child is legally defined as 'looked after' by a Local Authority (LA) if he or she is:

- provided with accommodation by the LA for a continuous period of more than 24 hours
- subject to a care order.
  or
- subject to a placement order

A child that is being looked after by the LA might be living with:

- foster parents
- their parents at home under the supervision of children's social care
- in residential children's units
- other residential settings such as a school or a secure unit

They might have been placed in care voluntarily by parents struggling to cope or children's social care may have intervened because a child was at significant risk of harm.

[67] Reference: Promoting the health and well-being of looked after children (2015) Department for Education and Department of Health (DFE, DH, 2015)
[68] Reference: Promoting the health and well-being of looked after children (2015) Department for Education and Department of Health
Reference: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework (2020) Royal College of Paediatrics and Child Health

1.3 A child ceases to be looked after when they reach their 18th birthday. From this day their status changes from being looked after to being a young adult eligible for help and assistance from the LA, they are known as a Care Leaver. Such help and assistance is usually provided in accordance with the various aftercare provisions of 'The Children and Social Work Act' (2017)[69].

Section 2: Purpose of the Report

2.1 The purpose of this report is to provide an overview of the progress, challenges, opportunities and the future to support and improve the health and wellbeing of Looked after Children in Manchester. This includes all Looked after Children for whom Manchester LA is responsible, no matter where they are residing.

2.2 This report covers the period 1st April 2021 to 31st March 2022. It summarises key improvements and service performance, along with setting out the objectives and priorities for the next financial year (2022/2023).

2.2 In Manchester the children and young people cared for by the LA have been asked to be known as 'Our Children' in recognition of Manchester's corporate parenting responsibilities. However, within all national and local policies and guidance, the service is known as the Looked after Children service; this is the language that will be used throughout this report.

Section 3: National Policies and Legislation relevant to Looked after Children

3.1 The statutory guidance focused around Looked after Children is in plentiful. The key documents and legislation are outlined as follows:

The 'Children Act' (1989, 2004)
Under this 'Act' a child is defined as being 'looked after' by the LA under the following 4 main groups:

- **Section 20** - children who are accommodated under a voluntary agreement between their parents and the LA.
- **Section 31 and 38 -** children who are subject to either an interim care order or a full care order.
- **Section 44 and 46** - children who are subject to emergency orders.
- **Section 21** children who are compulsory accommodated including children remanded into the care of the LA or subject to criminal justice supervision with a residence requirement.

The 'Adoption and Children Act' (2002)
This 'Act' modernised the law regarding adoptive parenting in the UK and international adoption. It has enabled more people to be considered by the adoption agencies as prospective adoptive parents. This 'Act' also places the needs of the child being adopted above all else.

[69] Reference: www.legislation.gov.uk/ukpga/2017/16/contents/enacted

Care Matters: Time for Change (2007)
This document builds on responses to the government's document Care matters: transforming the lives of children and young people in care.

The 'Children and Young People's Act' (2008)
The purpose of this 'Act' is to extend the statutory framework for Looked after Children in England and Wales and to ensure that such young people receive high quality care services which are focused on and tailored to meet their needs.

The 'Children and Families Act' (2014)
This 'Act' strengthens the timeliness of the processes in place to ensure that children/young people are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs.

'Promoting the Health and Wellbeing of Looked after Children' (2015)
This is joint statutory guidance from the Department for Education and the Department of Health. It is for Local Authorities (Las), Clinical Commissioning Groups (CCGs) and NHS ENGLAND – it applies to England only.

The 'Children and Social Work Act' (2017)
This 'ACT' is intended to improve support for Looked after Children and care leavers, promote the welfare and safeguarding of children, and make provisions about the regulation of social workers.

'Looked after Children: Knowledge, skills, and competencies of health care staff, Intercollegiate Framework' (2020)
This document sets out the specific knowledge, skills and competencies for professionals who work in dedicated roles with Looked after Children.

'Looked after Children and Young People' NICE Guideline [NG205]
This guideline covers how organisations, practitioners and carers should work together to deliver high-quality care, stable placements, and nurturing relationships for Looked after Children. It aims to help Looked after Children to reach their full potential and have the same opportunities as their peers.

Section 4: National and Local Context

4.1 Nationally the number of Looked after Children has increased steadily over the past 10 years. There were 80,850 Looked after Children on 31st March 2021, an increase of 1% compared to 31st March 2020. This increase does appear to be lower compared to previous years data however the most up to date national figures for 2021/2022 are not yet available from the Department for Education.

4.2 **Figures 1 to 3**, below set out the national and local position.

4.3 **Figure 1: Number of Looked after Children in England on 31st March 2015 to 31st March 2021**

Year	Number	Rate per 10,000 child population
2015	69,470	60
2016	70,410	60
2017	72,610	62
2018	75,370	64
2019	78,150	65
2020	80,080	67
2021	80,850	67

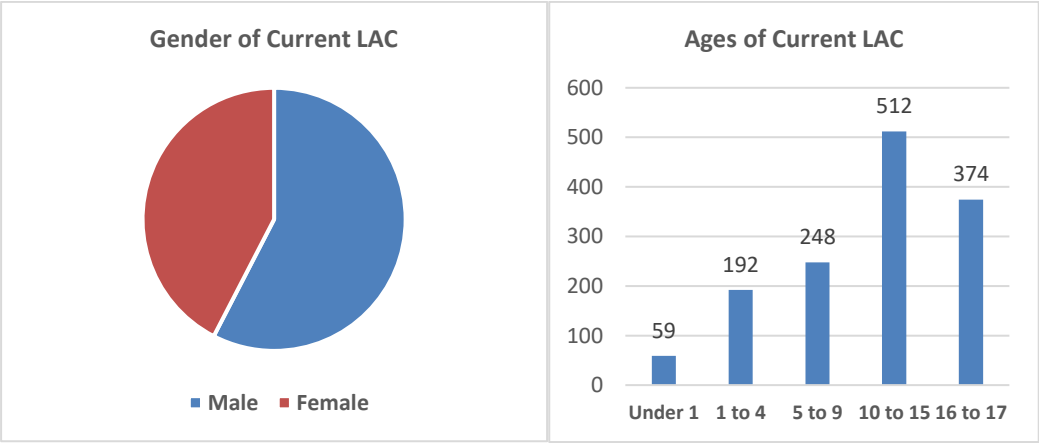
Ref: Data made available from Department for Education publications

4.4 **Figure 2: Number of Looked after Children in Northwest England and Manchester on 31st March 2015 to 31st March 2022**

Year	Northwest		Manchester	
	Number	Rate per 10,000 child population	Number	Rate per 10,000 child population
2015	12,490	82	1,310	114
2016	12,550	82	1,252	107
2017	13,220	86	1,169	97
2018	14,050	91	1,258	104
2019	14,660	94	1,290	106
2020	15,130	97	1,407	114
2021	15,260	97	1,371	111
2022			1,385	

Ref: Data made available from Department for Education publications and Manchester City Council.

4.5 **Figure 3: Profile of Looked after Children in Manchester**



4.6 The numbers of children in the care of Manchester Local Authority (LA) at the end of 2021/2022 has remained relatively stable, which differs to the national picture where there continues to be an increase. Manchester continues to have a significantly higher proportion of Looked after Children per 10,000 child population compared to the Northwest and England profiles.

Section 5: Commissioning Arrangements

5.1 Looked after Children's access to health services is underpinned by a complex set of commissioning arrangements within the responsible commissioner guidance (2013)[70]. The guidance advises that the child's registered GP at the point of placement determines the responsible Clinical Commissioning Group (CCG) for the cost of any health services in addition to universal services. This includes services provided through its commissioned services such as Child & Adolescent Mental Health (CAMHS) or community paediatrics as well as for routine health assessments. Currently there is an agreement within the Greater Manchester health economies that there is no cross charging for the completion of health assessments.

5.2 Manchester Health and Care Commissioning (MHCC) currently commission the Manchester University NHS Foundation Trust (MFT) Looked after Children Health Team to ensure the health needs of Manchester's Looked after Children, young people and care leavers are met in line with national guidance and the local service specification. The Manchester Local Care Organisation are commissioned to meet the health needs of Looked after Children within the health visiting and school health services, which includes undertaking review health assessments (RHA's) and liaising with all relevant agencies to support and promote their health and wellbeing. The completion of initial health assessments (IHA) is included within this commissioning arrangement.

Section 6: Key Performance Indicators

6.1 The work undertaken by the Looked after Children Health Team is underpinned by the statutory requirements against which performance is monitored by the Trust and reported to Manchester Health and Care Commissioning.

6.2 Statutory guidance set out in the 'Care Planning, Placement and Case Review (England)[71] Regulations' (2015) states that:

- LA's must arrange for all Looked after Children to have a health assessment.
- The IHA must be undertaken by a registered medical practitioner.
- The IHA should result in a health plan, which should be available in time for the first statutory review of the child's care plan by the Independent Reviewing Officer (IRO).
- The case review by the IRO must happen within 20 working days from when the child became looked after (Regulation 33 (1).

[70] Ref: Who pays? Determining responsibility for payments for providers: Rules and Guidance for CCG's: NHS Commissioning Board (2013)
[71] Reference: Children Act 1989 guidance and regulations volume 2: care planning, placement, and case review (2015) Department for Education

- A health review should be undertaken at least once in every period of 6 months before the child's 5th birthday and at least once in every period of 12 months after the child's 5th birthday.

6.3 The Key Performance Indicators (KPI) as set within the Service Specification for Specialist Looked after Children Health Services by Manchester Health and Care Commissioning are identified below:

Figure 4: Key Performance Indicators

Our Children	KPI
% of IHA's within Statutory Timescales	90%
% of RHA's within Statutory Timescales	95%
% Immunisation Status	90%
% Dental Attendance	95%
% SDQ's available to inform the RHA	85%
% of young people leaving care who are in receipt of a Care Leaver Health Summary	80%
% of up-to-date Health Surveillance Checks	95%
% Body Mass Index (BMI's) recorded	95%
% of Health Assessments containing the voice of the child	95%

Section 7: Manchester Looked after Children Health Team

7.1 The Looked after Children Health Team provide a citywide health service for Looked after Children placed in Manchester by Manchester LA and for Looked after Children from other LA areas placed in Manchester. They also retain overall responsibility for Manchester children and young people residing in other LA areas. This is achieved by close working relationships with the Looked after Children Health teams in the other LA areas and a robust oversight process within the health team.

7.2 As Manchester has higher numbers of Looked after Children compared with national and Northwest figures this places increased pressures on the health team, as well as on the paediatricians, health visitors and school nurses who are responsible for ensuring that the statutory health needs of these children are met. The increasing numbers of children/young people being received into the care of the LA is also having an impact on primary care services including General Practitioners (GP's) and dental services.

7.3 MFT is commissioned to provide the IHA's and the RHA's for Manchester children placed in Manchester and for children/young people from other LA areas placed in Manchester.

Unaccompanied Asylum-Seeking Children (UASC)

7.4 UASC are children and young people under the age of 18 years who have applied for asylum in the UK without their parents and are not being cared for by an adult who by law has responsibility to do so. Under section 20 of the Children Act 1989, LA's have a statutory obligation to provide accommodation for UASC who present in their area.

These children should be safeguarded and have their welfare promoted in the same way as any other Looked after Child/Young Person.
Many of these children will have lived through trauma and/or stressful circumstances and often present with a variety of complex physical and emotional health needs, which means that they are more likely to require specialist care.

7.5 The Manchester Looked after Children Health Team has a 0.8WTE dedicated UASC specialist nurse to support the health needs of the UASC population in Manchester ensuring the best possible health outcomes for this cohort of young people. The UASC specialist nursing capacity has reduced from the previous year due to promotion within the team. However, all the specialist nurses within the team now have UASC on their individual caseloads to ensure that they obtain the skills and experience in supporting this cohort of young people. The UASC specialist nurse continues to provide oversight and support to the specialist nurses.

7.6 The numbers of UASC in Manchester have increased compared to the previous reporting period. There are currently **135** UASC who are the responsibility of Manchester LA which equates to approximately 10% of the looked after population. It was anticipated that this figure would increase during 2021/2022 once the COVID-19 pandemic restrictions eased. Economic and political issues affecting countries across the world have also contributed to the increase.

7.7 At the time of writing this report, the majority of the UASC are male with only **7** being female. The ages range from 13 years to 18 years with a high proportion being in the 17 years age bracket (66%). The highest number of young people originate from the Sudan (21%) with representation from 20 other countries including Iran (9%), Afghanistan (8%) and Eritrea (7%). Most of the young people are residing in semi-independent living accommodation (60%) with the remainder either living independently (17%) or with foster carers (22%).

7.8 The UASC specialist nurse continues to have strong relationships with the New Arrivals Team within Manchester LA providing valuable health support to the social workers and to the young people.

Care Leavers

7.9 A Care Leaver is an adult who has spent time in care as a child, such as foster care, living with family or in a residential care setting. Their time in care could have lasted for a few months or from birth until their 18th birthday. All young people who leave care at 16, 17 or 18 years of age are statutorily provided with support from the LA in the area in which they live.

7.10 Statutory Guidance on Promoting the Health and Well-Being of Looked after Children (2015)[72] requires LA's, CCGs, and NHS England to ensure that there are effective plans in place to enable Looked after Children aged 16-17 years to make a smooth transition to adulthood.

[72] Promoting the health and well-being of looked-after children

This includes providing them with as much detail as possible on their health history including birth details. Care leavers should expect the same level of care and support that other young people get from their parent. Young people looked after by Manchester LA are provided with a summary of their health history prior to their 18th birthday.

7.11 The introduction of the Children and Social Work Act 2017[73] ensures that all LAs provide a local offer for care leavers including the provision of a personal advisor up to the age of 25 years. This has been reflected within the Looked after Children Health Team whereby they continue to support care leavers through advice and consultation during their transition into adulthood.

7.12 The Looked after Children Health Team has established strong relationships with the LA Leaving Care Team to ensure that the health needs of care leavers are being supported. A 'drop-in' service for care leavers and Personal Advisors has been established to further enhance this support.

The MFT Looked after Children Nursing Team

7.13 **Key Achievements**

- ✓ Partnership working with Manchester LA to identify and improve health outcomes for Looked after Children.
- ✓ Partnership working with the New Arrivals Team to improve health outcomes for UASC.
- ✓ Improved relationships with universal services within Manchester Local Care Organisation by providing support to health visitors and school nurses through attendance at team meetings and training.
- ✓ Joint development and implementation of the Combined Consent Form incorporating consent to placement, medical treatment, health assessments and information sharing with Manchester LA.
- ✓ Joint development and implementation of an alert on Manchester City Council's electronic record Liquid Logic system to notify social workers of upcoming RHAs.
- ✓ Maintained robust oversight of the health needs of Looked after Children residing out of the Manchester area.
- ✓ Delivery of a training programme for MFT staff in both acute and community settings.
- ✓ Development and implementation of 'Drop-In' sessions for Care Leavers, Residential Units including UASC to provide health promotion support.
- ✓ Development and implementation of 'Multi-Agency Guidance on the Strengths and Difficulties Questionnaire for Manchester' Looked after Children'.
- ✓ Attendance at the 'Children in Care Cooperative Sessions' to seek the voice of the child.

7.14 **Challenges**

- Capacity within the nursing team to deliver statutory requirements due to nurse and administrative sickness and vacancies.

[73] Children and Social Work Act 2017

- The reporting systems required to support the data collection from the electronic patient record have not been fully utilised by health practitioners to enable reporting of the work undertaken.
- Limited access to dental services for routine examinations for Looked after Children and young people.

Paediatric Looked After Children Service

7.15 **Key Achievements**

- ✓ Continued to offer IHAs within statutory time scales.
- ✓ Completed move the back to face-to-face appointments for all IHA's, following previous conversion to remote appointments in keeping with national guidance during the first COVID-19 lockdown in 2020; continued appropriate precautions, including screening with 'COVID questions' for all children, young people and carers attending appointments.
- ✓ Continued liaison with CAMHS-Looked after Children team and the Looked after Children nursing team to enable appropriate referral and support for those with emotional health difficulties.
- ✓ Piloting the implementation of a detailed template specific for IHA's for unaccompanied UASC young people.
- ✓ Completed audit of immunisations for children and young people in care, data to be used to inform plans for ensuring prompt administration of immunisations to Looked after Children and young people.

7.16 **Challenges**

- Delay in receiving notification from the LA of a child becoming looked after, impacting on the timeliness of the appointment offered for an IHA; new processes agreed to improve communication with the LA.
- Continued need for remote working by some professionals, including interpretation service – still coordinating appointments with face-to-face interpretation whenever possible, ingoing work with service to avoid delayed or cancelled appointments for UASC children and young people.

7.17 **Development Plan for 2022/2023**

- Update guidelines for bloodborne infection testing for Looked after Children
- Participate in multi-agency audit on children who are looked after and have educational health care plans
- Service development engagement initiative to establish young people's views on their health assessments and incorporate this feedback into future service plans.

Section 8: Performance

Figure 5: Performance against Key Indicators

Our Children	KPI	Q1	Q2	Q3	Q4
% of IHAs within Statutory Timescales	90%	70%	61%	57%	71%
% of RHAs within Statutory Timescales	95%	79%	78%	85%	82%
% Immunisation Status	90%	80%	79%	80%	85%
% Dental Attendance	95%	23%	29%	50%	41%
% SDQ's available to inform the RHA	85%	1%	2%	1%	61%
% of young people leaving care in receipt of a Care Leaver Health Summary	80%	25 shared	41 shared	27 shared	43 shared
% up to date Health Surveillance Check	95%	100%	100%	100%	100%
% Body Mass Index (BMI) recorded	95%	88%	90%	93%	94%
% of Health Assessments that contain the Voice of the Child	95%	98%	98%	99%	100%

8.1 **Initial Health Assessments (IHAs)**

There has been a fluctuation in the completion of IHAs within the statutory timescales of 20 working days from entering care and it has been difficult to establish specific reasoning for this. Despite the intensive joint working between the Looked after Children Health Team and Manchester LA, only 65% of children and young people entering care during 2021/2022 had their IHA completed within the statutory timescale.

8.2 Many of the breaches continue to be attributed to the delays in the receipt of a consent and request form from the LA. A review of the current consent form used was undertaken by the LA and the Named Nurse - Looked after Children with consultation with the Looked after Children Named Doctors and Designated Professionals and a combined consent was developed which integrates previous consents to placement, medical treatment, health assessments and information sharing. The combined consent is a paper consent which requires the signature of birth parents, the consent is then uploaded onto the Manchester LA Liquid Logic system to be shared with the Looked after Children Health Team. The new consent process was implemented in October 2021 and whilst compliance remains outside its performance indicator, there have been improvements during the latter end of the reporting period. Performance continues to be reviewed monthly by both partners to further develop an understanding of the delays.

8.3 Compliance Looked after Children residing out of the Manchester area remains particularly poor which is mainly attributed to the delays in obtaining the consent and request form timely but is also due to the appointment availability in the host area. This is currently being reviewed with the Designated team at Manchester Health and Care Commissioning and work will be ongoing in the next reporting period to address this issue. There is a national review being undertaken to evaluate the inequity of health services for Looked after Children who are not placed within their home LA.

Manchester Health and Care Commissioning are contributing to the review with the support of the Named Nurse – Looked after Children.

8.4 **Review Health Assessments (RHAs)**
Compliance of RHA's completed within the statutory timescales has also been varied during the year, again attributed to delays in consents and requests particularly for the children and young people residing out of the Manchester area. There have also been issues of staffing capacity within the Health Visiting and School Nursing Service as well as within the Looked after Children Nursing Team which has affected timeliness. Whilst it can be assured that the health assessments are being completed this may not always be within the statutory timescales.

8.5 There have been challenges in the accuracy of the data reporting throughout the year particularly in the under 5 age group which has required manual validation by the Looked after Children Health Team to confirm performance. The reasoning behind this continues to be explored with the MLCO data warehouse.

8.6 An alert system within Manchester LA's Liquid Logic system has been introduced to act as a reminder for the social worker that a RHA is due and to initiate the correct documentation. Requests and consents are now being received by the Looked after Children Health Team through the Liquid Logic system instead of via the secure email which has streamlined processes.

8.7 RHA's for children and young people residing out of area continues to be a concern, with continued delays in the receipt of requests and consents from the LA. The new combined consent form used at the IHA also includes an 'enduring consent' for the completion of health assessments for the duration that the child/young person is in care which has the potential to reduce the delays in the receipt from the LA. The impact of the enduring consent form will become evident during the next reporting period, however, for children and young people residing out of area, an update request form would still require completion.

8.8 **Immunisations**
Immunisation compliance has improved during 2021/2022 which is partly attributed to the Immunisation Team recommencing immunisation sessions within school following the previous restrictions due to the COVID- 19 Pandemic. There has also been a validation exercise undertaken each quarter of the GP immunisation records to identify children and young people who have received their immunisations but where it has not been updated within the reporting system. There continues to be challenges in the agreement of the Looked after Children Nurses administering the immunisation programme for this age group and discussions remain ongoing, however the Looked after Children Nurses are following up and encouraging carers and young people with outstanding immunisations to access their GP. It remains a concern that compliance in Manchester is below the Northwest and England profile. The Named Nurse – Looked after Children is working with Public Health and Manchester Health and Care Commissioning to identify and implement solutions to improve the compliance.

8.9 **Dental Attendance**

Dental attendance has been the most concerning area of health need, as many dental practices have provided limited services during and following the COVID-19 pandemic, which has caused difficulties in ensuring children and young people are being seen for their routine dental care. A Greater Manchester Escalation Pathway was developed during this report period by NHS England Northwest which enabled practitioners to refer children and young people to a central referral hub for review and allocation to a specified dental practice. This has resulted in a positive improvement in dental attendance although this is not reflected within the data. It is understood that the apparent reduction in compliance may be due to the ability to record the information onto the reporting system in a timely manner. A triangulation of the data will be undertaken between health and the LA to ensure that both reporting systems have the most up to date information. Dental data from both agencies will be cross referenced to achieve a combined report with each agency being responsible for ensuring they update their own electronic child/young person's record.

8.10 **Strengths and Difficulties Questionnaire (SDQ's)**

The SDQ is a tool that is used to screen for any problems related to a child/young person's emotional well-being. Receipt of SDQ's to inform the RHA has remained a challenge throughout the reporting period, however intensive collaborative working between the LA and the Looked after Children Health Team has resulted in an improvement in the compliance towards the end of the period. It is anticipated that this will continue to improve as the new processes are embedded within both agencies. The 'Multi-Agency Guidance on the Strengths and Difficulties Questionnaire' was revised and has been implemented within partner agencies to support the new processes.

8.11 **Care Leaver Health Summary**

A care leaver health summary has been shared with young people in Manchester since its recommendation in statutory guidance in 2015. Whilst it has remained difficult to obtain the percentage of Care Leavers who have received a health summary due to the challenges in the implementation of the reporting template, **136** health summaries have been shared with young people during this time. This is a 53% increase on the number of summaries shared last year. Revised processes and a more robust communication pathway have been established between the Looked after Children Health Team and the Leaving Care Team to ensure that all young people including those who reside out of the Manchester receive their health summary to ensure they are informed of their health needs as they transition into adulthood. A monthly drop in has been established at 'The Beehive' predominantly for the Leaving Care Personal Advisors/Workers but also for young people should they wish to attend. The drop-in sessions have assisted in strengthening relationships between the Looked after Children Health Team and the Leaving Care Team with dedicated space being provided to the Health Team for health promotion.

8.12 **Health Surveillance Check**

Health surveillance checks in line with the national Healthy Child Programme are being undertaken at the relevant ages and stage of development.

8.13 **Body Mass Index (BMIs)**

Nationally there are concerns in relation to childhood obesity and this concern is mirrored within Manchester. The number of children and young people identified as having a higher-than-normal BMI continues to increase for Looked after Children particularly for those residing in the Manchester area. The relaxing of the COVID- 19 pandemic restrictions has enabled practitioners to obtain weight measurements on children and young people which could account for the increase. This position may also reflect that many children and young people were unable to undertake the levels of physical activity they had previously due to COVID-19 restrictions. A review of the higher-than-normal BMI's is to be undertaken to explore the support that children, young people, and carers require to achieve a healthy weight.

8.14 **Voice of the Child**

The voice of the child is paramount throughout all work with children and young people and should be accurately reflected within any contact that is undertaken with them. Health assessments are key milestones within a Looked after Child's journey through the care system and it should provide the opportunity for them to confidently share/voice their wishes and feelings. The voice of the child has been positively captured throughout this reporting period through their health assessments. To continue to improve services and support for Looked after Children and young people, the Looked after Children Health Team are undertaking a consultation with young people to identify any gaps in service delivery and to take into consideration what young people feel that they need to improve their health.

Section 9: Governance

Looked After Children Subgroup of the Safeguarding Committee

9.1 **Purpose of the Sub-Group**

The remit of the subgroup is to ensure that the key areas of the Looked after Children agenda are embedded across adult and children services across the hospitals/MCS/LCOs; these include:

- Service delivery and practice development
- The quality of the statutory health assessments
- Voice and Influence of Looked after Children
- Partnership work and key messages from the Corporate Parent Panel, the Looked after Children Strategic Board and the multi-agency subgroups.

9.2 **Key Terms of Reference**

- Ensure the Looked after Children policy, strategy and guidance is disseminated across all the hospitals/MCS/LCOs
- Develop and implement training and briefings for hospitals/MCS/LCOs in line with Looked after Children requirements
- Seek assurance that Looked after Children priorities are known and understood, including statutory requirements across the hospitals/MCS/LCOs.

9.3 **Group Looked after Children Workstream**

Figure 7: Relationship with MFT and partnership workstreams

9.4 **Key Achievements**

- ✓ The Looked after Children subgroup has seen consistent representation from the hospitals/MSC/LCOs.
- ✓ Achieved improved awareness of Looked after Children across the MFT workforce.
- ✓ Inclusion of quarterly health reports within the sub-group to provide assurance and compliance with statutory requirements.
- ✓ Development and implementation of a comprehensive training package for professionals including community and acute providers to inform the health needs of Looked after Children, their journey throughout the looked after process and the professional's roles and responsibilities in achieving the best outcomes.

9.5 **Priorities for 2021-2022**

- Continue to raise awareness and ensure ongoing delivery of training packages for professionals including community and acute to inform their understanding of the health needs of Looked after Children, to achieve the best outcomes.
- Work in collaboration with key partners to improve the health outcomes for Looked after Children.
- Review and develop strategies to improve performance against KPI, including improved reporting on care leaver summaries
- To promote strategies to support children and young people who are looked after to achieve a healthy weight.

9.6 **Partnership Working**

A partnership approach is essential to ensuring best outcomes for children and young people, with the Looked after Children Health Team working closely with Manchester LA colleagues to ensure they have the correct information in a timely manner to provide a robust health offer. Escalation processes are also agreed and in place between MFT and Manchester LA to address issues as they arise to ensure a timely response and improve service provision.

9.7 **Engagement**

The Looked after Children Health Team attended and contributed to the 'Children in Care Cooperative Sessions' arranged by the Manchester LA Corporate Parenting Board. These sessions were an opportunity to meet children and young people and to obtain/hear their voice based on the key strategic priorities set out in the 'Manchester's Strategy for Our Children Young People and Corporate Parenting'. The Looked after Children Health Team are undertaking consultations with young people and the UASC population to review and improve service provision.

9.8 **Audit and review**

There has been limited audits undertaken throughout this reporting period due to staffing capacity within the Looked after Children Health Team and the priority to embed improved services for Looked after Children. However, following the positive embedment of refined processes between the Looked after Children Health Team, the MLCO and Manchester LA, there is a robust audit plan in place which will focus on health outcomes for Looked after Children.

Section 10: Objectives and Priorities for 2022/2023

10.1 **Objectives**

- Continue to raise awareness of the specialist Looked after Children Health Team across the Trust to develop pathways for coordinated care delivery.
- Undertake an in-depth analysis of health assessment data to develop an understanding of the difficulties and to identify a solution to the delays in timely compliance.
- Engage in consultations with children and young people to continue to improve services and outcomes.
- Revise the current training package (to include an online learning option) for professionals to inform them of the health needs of Looked after Children, their journey throughout the looked after system and the professionals' roles and responsibilities in supporting them to achieve the best outcomes.
- Establish robust reporting and collation of data from the electronic patient record to support service development
- Work in partnership with the LA to ensure continued positive transference of information between the two agencies
- Undertake a further review of immunisation coverage for Looked after Children with a view to increasing performance with Public Health and MHCC.
- Continued liaison with MHCC and the Greater Manchester Partnership to ensure that dental services are easily and readily accessible for Looked after Children.

- Undertake relevant and appropriate audits to ensure that Looked after Children receive positive health outcomes during their looked after journey.

Section 11: Conclusion

11.1 Whilst the COVID-19 pandemic restrictions haven't been as stringent as in the previous year, there has still been an impact on service delivery with health professionals, carers, children, and young people having periods of self-isolation which has affected the timeliness and the implementation of support. Reduced capacity within the Looked after Children Health Team has also affected the ability to enhance the service and improve health outcomes with the need to prioritise and meet statutory requirements. Despite this the team have continued to support practitioners both within health and social care in respect of the health needs of Looked after Children and they have been creative in establishing new ways to support children, young people, and professionals such as through the delivery of 'drop-in' sessions.

11.2 2021/2022 has seen some improvements to performance and ultimately health outcomes for Looked after Children, however, these have not been consistent in meeting national key performance indicator thresholds for our most vulnerable children and young people. Achieving positive health outcomes for all Looked after Children regardless of where they reside is a priority for the health team with a focus on gaining a deeper understanding of the barriers to overcome them.

Annual Report for the Looked after Children (Children in Care) Health Service in Trafford 2021/2022

Completed by:
Karen Holgate – Named Nurse Looked after Children, Manchester
Elizabeth Ross – Senior Specialist Nurse Cared For Children; MFT Trafford Looked after Children Health Team

Section 1: National and Local Context

1.1 Figure 1: Number and rate of children looked after in Trafford from 31st March 2015 to 31st March 2021

Year	Trafford	
	Number	Rate per 10,000 child population
2015	334	62
2016	331	61
2017	384	70
2018	383	69
2019	417	74
2020	378	67
2021	392	69

Ref: Data made available from Department for Education

1.2 Nationally, the number of Looked after Children has continued to rise. At 31st March 2021, the total number of Looked after Children by Local Authorities (LA's) in England increased by 1% to 80,850. Data provided by Trafford Local Authority (LA) has demonstrated that the numbers of Looked after Children showed a slight increase during the last twelve months. Local data shows a peak in the number of Looked after Children in April 2021 as 394 (69.7 per 10,000 children), demonstrating a slightly higher figure than the national increase.

1.3 Children can be placed in foster care (with the LA or independent agency foster carers), or in a connected person (family or friends) placements. These placements are all vetted. Some young people live in supported accommodation or move to independent living. Other arrangements are put in place for children with more complex needs. A small number of children live in secure settings.

Section 2: Trafford Looked after Children Health Service

2.1 The MFT Looked after Children Health Team ensures that the health needs of Trafford's Looked after Children and Care Leavers are met in line with national guidance and the local service specification. In Trafford, historically, Looked after Children have asked to be known as Children in Care. However, the LA have recently started to use the terminology 'Cared for and care experienced children and young people'. Terminology used for the service will be an area for review in the coming year. For the purposes of this report the term Looked after Children is used for consistency. The service specification for the Looked after Children Health Team incorporates responsibility for:

- Children and young people (aged 0-18) who are looked after by Trafford and are placed in borough.
- Children and young people (aged 0-18) who are looked after by another LA, but reside in borough.
- Trafford LA children (aged 0-18) placed out of borough.
- Open access to care leavers from 16 up to age 21 who are living within the borough.

Overview of the Service

2.2 The Trafford Looked after Children Health Team comprises of:

- Named Nurse - Safeguarding Children/Looked after Children
- Named Doctor - Looked after Children
- Senior Specialist Nurse - Looked after Children / Team Leader
- Specialist Looked after Children Nurses
- Administrative Assistants

2.3 The Team works closely with Trafford Local Care Organisation (TLCO) colleagues including the 0-19 Service, which is commissioned to provide the universal child health programme to Looked after Children. The TLCO Paediatric Team provide initial health assessments (IHA's) for all Looked after Children residing in Trafford when they enter care. Review health assessments (RHA's) for children who are under 5 years of age are undertaken by the Trafford health visitors. The Looked after Children Specialist Nursing Team complete the RHA's for school age children and those young people who are aged 16 years and over. Trafford has many Looked after Children that are resident in the borough from other LA's. Requests from other LA's for RHA's for school aged children placed in Trafford are completed by the child's school nurse (SN) with the Looked after Children Health Team available to provide specialist support to them where required. Many of these children are placed away from their LA due to being at risk of exploitation and/or because they have complex needs that require specialist provision.

2.4 The Looked after Children Health Team is part of the wider Looked after Children multi-agency service within Trafford. Health and social care colleagues are co-located, which strengthens multi-agency working and facilitates a more coordinated approach to meeting the health needs of the children and young people. The Named Nurse and Senior Specialist Nurse meet regularly with the social care service managers, the Virtual School, the Children's Advocacy service, and the principle psychologist for Traffords 'Child and Adolescent Mental Health Service' (CAMHS) for Children in Care service. The health team work closely with the Designated Nurse for Safeguarding and Looked after Children within Trafford Clinical Commissioning Group (CCG) who provides strategic oversight.

Unaccompanied Asylum Seekers (UASC)

2.5 UASC are children and young people under the age of 18 years who have applied for asylum in the UK without their parents and are not being cared for by an adult who by law has responsibility to do so. Under section 20 of the Children Act 1989, LA's have a statutory obligation to provide accommodation for UASC who present in their area. These children should be safeguarded and have their welfare promoted in the same way as any other Looked after Child/Young Person.
Many of these children will have lived through trauma and/or stressful circumstances and often present with a variety of complex physical and emotional health needs, which means that they are more likely to require specialist care. At the end of March 2021 there were thirty children/young people who entered care as UASC residing in Trafford.

Nine of these are Looked after by Trafford LA with the remainder placed by other LA's. The Looked after Children Health Team promote effective provision and oversight of health services and support for UASC in Trafford regardless of the placing borough.

Care Leavers

2.6 A Care Leaver is an adult who has spent time in care as a child. The statutory guidance 'Promoting the Health and Well-Being of Looked after Children' (2015) requires LA's, CCGs and NHS England to ensure that there are effective plans in place to enable Looked after Children aged 16-17 years to make a smooth transition to adulthood. This includes providing them with as much detail as possible of their health history including their birth details. The introduction of the Children and Social Work Act 2017 states that all LA's must provide a local offer for care leavers including the provision of a 'personal advisor' up to the age of 25 years. The Looked after Children Health Team currently provide support to care leavers, through consultation with their 'personal advisor' in respect of complex health issues.

Section 3: The Looked after Children Nursing Team

3.1 Key Achievements 2020/2021

- ✓ Review health assessment templates were updated, which reflect a deeper understanding of the voice and views of the child and provides nursing analysis of the child's health. This further harmonises the documentation between Manchester and Trafford Looked after Children Health Teams.
- ✓ Partnership working with Trafford social care colleagues to discuss at a monthly panel Looked after Children who are placed with their parents; providing additional scrutiny in cases where a lack of progress in the child's lived experience is evidenced.
- ✓ Delivery of UASC training to Trafford GP's in collaboration with the Designated Doctor for Looked after Children.
- ✓ Working in collaboration with the LA to ensure eligible care leavers have access to free prescriptions.
- ✓ The Specialist Nursing Team supported the School Nursing Service who were experiencing capacity issuesto ensure that RHA's for school aged children placed by other LA's had been completed and key health priorities for Looked after Children were being met.
- ✓ Attending and engaging in the Greater Manchester Combined Authority Dental Recovery Pathway for Looked after Children to ensure that their dental health needs are reviewed.
- ✓ After a two year break (due to the COVID-19 pandemic) the Level 3 training 'Promoting the health of care experienced children' was rolled out again, to Trafford School Nurses and Health Visitors and received positive feedback.

Challenges

3.2 The Specialist Nurses contribute to complex safeguarding and care planning for Looked after Children by attending child focused meetings, placement support meetings and strategy meetings. The Specialist Nurses have continued to work hard to reduce the backlog of RHA's, and the Key Performance Indicator (KPI) threshold. Unfortunately, extended periods of sickness within the nursing team has meant a backlog remains.The nurses continue to use a risk-based prioritisation tool to guide their work.

3.3 The model of service delivery used in Trafford is different to that provided in other areas such as Manchester, as the Looked after Children Nurses complete all of the RHA's for school age children/young people who are Looked after by Trafford LA. Complex cases are prioritised, and as positive work towards improving health outcomes takes place, time to complete statutory work can be pressurised.

3.4 Statutory guidance advises that Care Leavers should be equipped to manage their own health needs wherever possible and that they should be provided with a summary of their health records. The nursing team prioritised the completion for care leaver summaries in 2021/2022 and these are now up to date.

3.5 Partnership working continues between the Head of Nursing - Safeguarding and the School Nursing Service to explore how the needs of our school-age Looked after Children can be met. Due to COVID-19, and the prioritisation of the school's based immunisation programme for COVID-19 within the School Nursing Service, there has been some delay in generating the new school nursing model for Trafford.

Section 4: Paediatric Looked after Children Service

4.1 Key Achievements 2021/2022

- ✓ Monthly virtual Looked after Children meetings involving the Named Doctor – LAC, the Specialist Nursing Team, the Paediatric Administrator, and the Paediatric Service Manager. These meetings will continue to take place in the absence of the Named Doctor (this post is currently vacant) to support a close working relationship between services.
- ✓ Close working relationship with the newly appointed Designated Doctor for Looked after Children who sits within both Manchester and Trafford commissioning.
- ✓ An IHA 'missed appointments' audit was completed.
- ✓ Working towards embedding a UASC specific IHA template to capture the unique health needs of this vulnerable group of children/young people and further harmonising with the Manchester LAC service.

Challenges

4.2 The Paediatric Service complete IHA's for children placed in Trafford by other boroughs, some of which are UASC. These assessments can take longer due to differing and often more complex health needs and the requirement for an interpreter to be used. There have been instances of delay in completing the IHA's due to difficulties in accessing interpreting services for specific languages. Work is ongoing to address this across Greater Manchester.

Development Plans for 2022/2023

4.3 Development plans are to be agreed with the new Named Doctor – Looked after Children when appointed. Priority will be given to ensuring the IHA's are completed to meet statutory timescales.

Section 5: Performance

Figure 2: Performance measures for the MFT Children in Care (CIC) Health Service for 2021/2022.

Our CIC	KPI	Q1	Q2	Q3	Q4
% of Initial Health Assessments within Statutory Timescales	90%	74% 17 out of 23	66.7% 12 out of 18	50% 8 out of 16	58% 15 out of 26
% of Initial Health Assessments within 20 working days of receipt of information	90%	78% 18 out of 23	66.7% 12 out of 18	62.5% 10 out of 16	58% 15 out of 26
% of Review Health Assessments within Statutory Timescales under 5 years	90%	84% 31 out of 37	94% 31 out of 33	74% 28 out of 38	94% 32 out of 34
% of Review Health Assessments within Statutory Timescales over 5 years	90%	84% 222 out of 265	89% 236 out of 265	88% 236 out of 268	91% 237 out of 260
% Immunisation Status		85% 258 out of 304	81.6% 248 out of 304	85% 259 out of 306	91% 269 out of 294
% Dental Attendance		25% 75 out of 304	29% 89 out of 304	27% 83 out of 306	55% 162 out of 294

5.1 The work undertaken by the Trafford Looked after Children Health Team is underpinned by the statutory requirements for Looked after Children. Performance of compliance with the statutory requirements is monitored by the Trust and reported to Trafford Clinical Commisioning Team (CCG). The table above shows performance measures for the MFT Looked after Children Health Service for 2021/2022.

5.2 Initial Health Assessments

5.2.1 Statutory guidance requires a registered medical practitioner to carry out an IHA of a child's health and to provide a written report of the assessment. This report should then result in a health care plan being available for the child's first statutory review, which is within 20 working days of the child entering the care of the LA. The TLCO Paediatric Team is commissioned to complete IHA's for all Looked after Children placed in Trafford.

5.2.2 Compliance of completion of IHA's within statutory timeframes has declined over the year. Many IHA's that were not completed within timescale were for children placed out of borough, therefore the assessments are completed by the 'out of area' paediatric teams. In addition, the expectations of the information required prior to completion of assessments can vary across boroughs: this can also impact on timescales. Most often this relates to a request for a LA to obtain written consent for a health assessment. All delayed assessments for children residing out of borough are actively followed up by the Looked after Children Health Team. Work is ongoing with the LA to address how access to written consent can be obtained.

5.2.3 Whilst most appointments are clinic-based, the team has worked flexibly to accommodate the individual needs of our Looked after Children, including assessing children and young people out of clinic, where other settings are better equipped to meet their needs. The team liaises with social workers, parents, carers, and young people to facilitate appointments and support with transport arrangements where appropriate.

5.2.4 Work is ongoing with the LA to ensure that the timeliness of alerting the Looked after Children Health Team of a child entering care is prompt allowing for the statutory timescale for IHA's to be met. The Named Nurse for Safeguarding and Looked after Children, and the Head of Service for Cared for and Care Experienced Children acknowledge this as a priority.

5.3 Review Health Assessment

5.3.1 Statuatory guidance requires that a review of a child's health plan must take place at least once every six months before a child's 5th birthday and at least once every twelve months after the child's 5th birthday. The review is to be undertaken by a registered medical practitioner, a registered nurse, or a registered midwife.

5.3.2 Annual review health assessments (RHAs) for Looked after Children residing in Trafford that are under the age of 5 years are carried out by the Trafford Local Care Organisation (TLCO) health visitors. Trafford health visitors have been experiencing pressures during the past 12 months with a number of vacant posts and some challenges to recruitment. The Looked after Children Health Team are working closely with team leaders and service managers for the TLCO 0-19 Service to ensure RHA's are completed in a timely way, as well as actively following up those for children placed out of borough that need completing by the out of area teams.

5.3.3 The Looked after Children Health Team undertake yearly RHA's for all school-age children and 16 and 17-year olds residing in borough. The KPI for RHA's has met the national threshold in quarter 4 of this annual report year.

5.4 Dental Attendance

5.4.1 Data on dental attendance continues to be provided through joint working with Trafford Council. There are limitations to the reliability of this data due to it not usually being updated between health assessments, which for most children and young people is undertaken annually. Therefore, if a child or young person attends the dentist in the

interim period before the next assessment, this information is not added to the child/young person's record in a timely way, therefore impacting on the accuracy of data reporting. During quarter 4 of this annual report year the LA took a manual approach to contacting parents and carers for an update on dental reviews. This has led to an increase in reporting from 27% to 55% compliance with the key performance indicator.

5.4.2 During the COVID-19 pandemic a reduction in the availability of routine NHS dental appointments was noted nationally. This issue was raised with Trafford CCG, the Greater Manchester Health and Social Care Partnership, NHS England, and the Department for Education. The Greater Manchester Dental Recovery Pathway is now utilised by the Specialist Nursing Team.

5.4.3 The Looked after Children Health Team continues to promote accessing dental care at health assessments by signposting carers to NHS Choices and liaising with dental practices, raising awareness of the vulnerability of this group of children/young people and sharing the evidence base behind the requirement for timely dental care.

Section 6: Partnership Working

6.1 A partnership approach is key to ensuring best outcomes for Looked after children. The Looked after Children Health Team works closely with Trafford Council colleagues to ensure they have the correct information in a timely manner to provide a robust health offer. This includes following escalation processes to address issues as they arise.

6.2 The Looked after Children Health Team have participated as subject matter experts on the health of our children and young people in the following multiagency working groups:

- Case Progression Panel, monthly
- Self-Harm Practice Guidance Document and Workforce Development
- Youth Justice Disproportionality
- Care Leaver Prescription offer
- Missing From Home Demand Reduction meeting
- Education, Health and Care Plan working group, to align care planning across education, social care and health.

6.3 A significant number of Looked after children are affected by criminal and sexual exploitation. There is now a commissioned health worker based within the Trafford Complex Safeguarding Team (Shine) to lead on the health response to exploited young people. The Senior Specialist Nurse for Looked after Children works closely with the Senior Specialist Complex Safeguarding Practitioner (Shine) to ensure there is timely information sharing and support for the children involved.

6.4 The Looked after Children Health Team has continued to contribute to Trafford's Healthy Care Partnership, which acts as the health workstream of the Corporate Parenting Board to support a coherent and collaborative approach to meeting the health needs of Looked after Children across the health economy and with partner agencies.

6.5 The Named Nurse for Safeguarding Children and Looked after Children, or the Senior Specialist Nurse for Looked after Children attend and engage in the Corporate Parenting Board.

Engagement

6.6 The Looked after Children Health Team have regularly provided updates for the Foster Carer Bulletin, promoting ways to maintain good physical and mental health including signposting to local COVID-19 vaccination centres and providing information on a variety of topics on health.

6.7 The Looked after Children Health Team were welcomed in attending the Trafford AfterCare Forum in March 2022. Young people shared their views on health, how they feel 'labelled' by medical conditions and how professionals talk about their trauma, but do not support them in a way that the group would like. It is important to the Looked after Children Nursing Team that these observations are shared in the future training provided to health professionals.

6.8 The Looked after Children Health Team enjoyed an interactive session with the Children in Care Council in July 2021. The nurses covered the importance of hand hygiene, in the context of the COVID -19 pandemic using an Ultra-Violet Hand Hygiene light box. The group also learned about the health implications of drinking alcohol and everyone navigated themselves around the room using the 'beer goggles'.

Section 7: Objectives and Priorities 2022/2023

7.1 Looked after Children Health Team Objectives

- Continued prioritisation of the completion of statutory health assessments in a timely way using the risk-based prioritisation tool.
- Continue to raise awareness of the health needs of our Looked after Children and further develop pathways for coordinated care.
- Deliver a local comprehensive Looked after Children training package to run alongside the Trust-wide training offer to support staff to complete high quality health assessments in line with local processes.
- Complete an audit of the quality of Looked after Children health records.
- Meet with the After-Care Forum and the Children in Care Council to promote healthy lifestyles and listen to the views of young people in relation to their worries and priorities regarding their health. Involve the views of children and young people to improve and develop our service to meet the changing needs of the children we work with.

- Improve information sharing to better align action plans from health assessments and Education and Health Care Plans (EHCP) so that Looked after Children are supported in a holistic and coordinated way.
- Continue to liaise with social care, CAMHS and virtual school to explore whether a different approach could be taken to support best practice for completion of SDQs in line with statutory guidance.
- Ensure completion of Care Leaver Health Summaries are up to date and available in a timely way.
- Training for all new Health Visitor and School Nurse starters to arrange a short visit to the Looked after Children Health Team as part of their induction. The nursing team will provide training for completion of RHA's. Level 3 training will continue to be provided to practitioners in line with the Intecollegiate Document, 2020; Looked after Children: roles and competencies of healthcare staff.

Section 8: Conclusion

8.1 Looked after Children in Trafford continue to receive a service from a dedicated and passionate team of health professionals who work with them to ensure their health needs are met to a high standard. This includes delivering a creative, 'needs-led' service to all regardless of the placing LA.

8.2 2021/2022 has seen a continued commitment to the Looked after Children health agenda across the Trafford health system at both operational and strategic levels.

8.3 The MFT Trafford Looked after Children Health Team will continue to work with relevant providers and commissioners in borough and across Greater Manchester to strengthen existing systems and pathways and strive to develop a service which makes a positive difference to Looked after Children in Trafford.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Dr Sarah Vause, Medical Director Saint Marys MCS Mrs Kathryn Murphy, Director of Nursing and Midwifery, Saint Marys MCS
Date of paper:	July 2022
Subject:	Maternity Services Assurance Report, incorporating the Ockenden Report assurance framework and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Safety Action update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support✓ • Accept ✓ • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation and teaching. To improve patient safety, clinical quality and outcomes To improve the experience of patients, career and their families
Recommendations:	The Board of Directors are asked: **To note** • The immediate and essential actions from the independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust – the Ockenden Reports • The work in place to ensure the safter of women and babies in Saint Marys Managed Clinical Service (MCS) **To approve** • The recommendations within Saint Marys MCS Report in relation to Maternity Continuity of Carer • The proposal to delegate receipt of maternity patient story to the Saint Marys MCS Quality and Safety Committee
Contact:	Name: Alison Haughton, Acting CEO, Saint Marys MCS Tel: 0161 276 6124

1. Executive Summary

1.1. In line with current reporting framework this paper provides:

- An update on progress of actions identified to be compliant with the Final Report of the Ockenden Review[1] published on 30th March 2022, and
- Assurance to the Board of Directors on matters relating to patient safety within maternity services, compliance with the recently updated Year 4 Maternity Incentive Scheme[2], themes identified from clinical incidents, shared learning and monitoring of actions.

1.2. As reported to the Board of Directors in January, March and May 2022, Saint Mary's Managed Clinical Service (MCS) have completed all Ockenden actions required by provider organisations from the initial report published in December 2020. Three outstanding actions, which sat with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS), relating to a process on how the system is to receive maternity training data have now been completed.

1.3. As reported to the Board of Directors in May 2022, the second and final Ockenden Report identified a further 15 Immediate and Essential Actions (IEAs) which all providers must implement and report their compliance. A date by which compliance must be achieved is yet to be set.

1.4. Saint Mary's Managed Clinical Service (SM MCS) has completed a detailed review of the 15 IEAs in April 2022. This review demonstrates over 65% compliance with the IEAs and progress towards completion is monitored through an action plan to address the remaining areas of non-compliance, through Saint Mary's Quality and Safety Committee (SM QSC) and Group Quality and Safety Committee and completed by December 2022.

1.5. Saint Mary's MCS Maternity Division reported 1210 incidents between 1st April 2022 to 31st May 2022. All incidents were reviewed through robust governance processes

- >96% (1164) were validated as no harm
- 3.5% (39) were validated as slight harm
- <0.5% (7) were validated as moderate harm or above

1.6. Of the 7 moderate harm or above, 6 cases did not highlight any themes and there were no similar incidents within the preceding 6 months. One incident related to a lack of recognition of delayed progress in labour. The learning from this incident has been shared, actions have been implemented and monitoring continues within the Maternity Division.

1.7. Since the pause of Maternity Incentive Scheme (MIS) Year 4 reporting in December 2021, Saint Mary's MCS have continued to work through the 10 Safety Actions and are currently compliant with 8 and will be fully compliant by end of October 2022.

[1] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

[2] https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf

1.8. Evidence of compliance will be submitted for approval to the Board of Directors in November 2022 against all Year 4 MIS Safety Actions. A progress report will be provided to the Board of Directors against all 10 Safety Actions in September 2022.

1.9. As previously reported to the Board of Directors in May 2022, the perinatal surveillance model was developed to provide 'ward to board' visibility in respect of incident reporting and learning

1.10. A review of the governance and reporting arrangements has been commissioned by the SMH MCS leadership team in recognition of the volume of reporting required to assure the Board of Directors on maternity safety. Along with the introduction of HIVE it is anticipated that this will result in a more streamlined approach to reporting. This will be considered at the SMH MCS governance committees and group Quality and Safety Committee and the Quality and Performance Scrutiny committee later this year.

1.11. The Board of Directors are asked to note the work ongoing to ensure the safety of women and babies across Saint Mary's MCS and to approve the following recommendations:

1. The recommendations within Saint Mary's MCS Report in relation to Maternity Continuity of Carer (MCoC). These include approving the decision to suspend 5 MCoC teams based on the risk assessment provided; approving a delay in the roll of the next MCoC team until Q3 23/24; approving a phased approach over 6 years and acknowledging that this will not meet the current national ambition of offering MCoC as a default model of care by March 2024.
2. To delegate receipt of a maternity patient story to the Saint Mary's MCS Quality and Safety Committee

1. Ockenden Reports Update

1.1. The Board of Directors have received updates relating to Donna Ockenden's first report[3], on four occasions during 2021 along with updates in January, March, and May 2022.

1.2. In May 2022, the report confirmed compliance and continued monitoring against all Immediate and Essential Actions (IEAs) allocated to Saint Mary's MCS. The Board of Directors received information that three actions that were outstanding were being reviewed by GMEC LMNS. GMEC LMNS have confirmed that these actions are expected to be completed by the end of June 2022.

1.3. Assurance visits by the Regional Maternity Team to review progress against the first Ockenden report 7 IEAs have now been confirmed to take place on 24th August 2022 at Wythenshawe, 25th August 2022 at Oxford Road and 26th August 2022 at North Manchester.

1.4. In preparation for the assurance visits, Saint Mary's MCS must provide evidence on specified metrics within the 7 IEAs and upload these onto the NHS Futures online platform before 17th August 2022. On review it is expected that this will involve uploading approx. 60 separate documents. Each document will be quality assured through Saint Mary's MCS governance team prior to uploading.

1.5. The final Ockenden report[4] was published in March 2022 and an initial review was provided to the Board of Directors in May 2022 demonstrating Saint Mary's MCS position against the 15 IEAs which were in addition to the previous 7 IEAs from the first report.

1.6. Saint Mary's MCS have identified areas of compliance, areas which require additional action to be compliant, and areas where external bodies (such as NHS England & Improvement, Royal Colleges, Health Education England, Local Maternity and Neonatal Systems) are required to address.

1.7. Of the 15 IEAs there are 97 separate elements against which maternity providers must achieve compliance.

1.8. Of these 97 elements, as of 25th June 2022, 64 are compliant, which is an increase of 8 since the May 2022 report. There remain 12 elements which require external input and 1 related to neonatal medical staffing which remains non-compliant.

1.9. Saint Mary's MCS are fully compliant with IEAs 4, 8 and 13 and partially compliant for the other 12 IEA's. Areas of focus for include:

- Recruitment and Retention – working to address current vacancies within both maternity and neonatal workforce
- Training - ensuring that all relevant staff receive maternity specific training and remain in date.
- Learning from incidents – sharing and learning regarding triage pathways

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

[4] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

- Listening – Both to workforce by undertaking a new culture survey, and to women through commencing '15 steps walkarounds' across all 3 sites with families, commissioners, Non-Executive Director and Maternity Safety Champions

1.10. A detailed action plan to address areas of non-compliance has been created and is provided in Appendix 1.

1.11. In May 2022, Saint Mary's MCS were asked to provide the detailed action plan and response to Ockenden to Manchester City Council's Health Scrutiny Committee 22nd June 2022, providing assurance across the 15 IEAs.

1.12. On 1st June 2022, the Care Quality Commission (CQC) requested the Ockenden response and action plans from all Trusts who provide maternity services. This was provided on 7th June 2022. No feedback has yet been received from the submission.

1.13. As per Saint Mary's MCS extended governance framework, the progress of the detailed action plan will be monitored via Divisional Quality and Safety Committee, with onward reporting to both Saint Mary's MCS Quality and Safety Committee and the Board of Directors bi-monthly via the Maternity Assurance report. The action plan will also be shared with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS) as part of the wider perinatal quality surveillance framework.

2. Maternity Self-Assessment Tool (MSAT)

2.1. Saint Mary's MCS shared the completed maternity safety self-assessment tool (MSAT) review with the Board of Directors in May 2022, where it was noted that the MSAT is also part of an IEA within the final Ockenden Report[5]

2.2. As of 23rd June 2022, of the 168 elements for Saint Mary's MCS:

- 152 elements are compliant with all evidence collated: in May 2022 there were 150 elements compliant, demonstrating an increase of 2.
- 11 elements are in progress and awaiting evidence: an action plan is in place to monitor progress
- 3 elements require evidence from GMEC LMNS: it is expected 1 element will be completed at the end of June 2022.
- 2 elements are non-compliant

2.3. As reported in May 2022 to the Board of Directors there are 2 elements considered non-compliant. One element is linked to having standalone maternity risk strategy separate from MFT risk strategy and has been escalated to Group Quality and Safety Committee in June 2022 for consideration.

2.4. The remaining element considered non-compliant is the requirement of the Board of Directors to open each meeting with a patient story. Saint Mary's MCS propose that as each Saint Mary's MCS Divisional and Hospital Board meeting open with a patient story, this should be considered compliant and request approval of this proposal from the Board of Directors.

[5] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

2.5. An action plan has been created following presentation of the review at Saint Mary's MCS Quality and Safety Committee in March 2022. This is being monitored through the Saint Mary's MCS governance process as described in 1.13.

3. Patient Safety

3.1. This section of the report relates to incident management, aligned to the Saint Mary's MCS Assurance Oversight Framework (AOF), with particular focus on those where harm has been caused and includes details relating to maternal deaths and neonatal brain injuries.

3.2. As previously reported to the Board of Directors, governance processes are in place within Saint Mary's MCS where assurance in respect of patient safety is obtained. This includes external reviews of all incidents classified as moderate and above that are reported to GMEC LMNS Patient Safety Special Interest Group.

3.3. As already reported to the Board of Directors in May 2022, Saint Mary's MCS completes a quarterly Perinatal Mortality Review (PMR) Report which provides a full review of stillbirths and neonatal deaths and includes identified themes, areas for learning and monitoring of actions. The Q4 2021/2022 PMR report has been completed and did not identify any themes but did identify areas for learning with actions being monitored within Saint Mary's MCS Maternity Division. The report will be presented in July 2022 to the Board of Directors meeting held in private to maintain confidentiality where sensitive details may be identifiable.

3.4. Table 1 illustrates incidents reported in April and May 2022.

Incidents	April 2022		May 2022	
	Number	%	Number	%
No harm	566	95.9	598	96.5
Slight harm	21	3.6	22	3.6
Moderate	2	0.34	2	0.32
Major	1	0.17	1	0.16
Catastrophic	0	0	1	0.16
Total Incidents	**590**		**620**	

Table 1 Reported incidents April and May 2022

3.5. In April and May 2022, a total of 7 cases were reported in the moderate, major, or catastrophic harm category:

- 4 cases were referred to the Healthcare Safety Investigation Branch (HSIB). Please see 3.6 below for further details.

- Of the remaining 3 clinical incidents:
  - 1 case was related to missed antenatal prophylactic anti-D
  - 1 case related to an inappropriate transfer of a woman who had experienced an antepartum haemorrhage
  - 1 case was related to the management of hypertension.

3.6. All incidents were reviewed within the appropriate 72-hour time frame. Incident data shows that none relate to a specific theme, with no similar incidents occurring in the last 6 months. Learning identified includes improving communication and increased awareness of appropriate referral pathways.

3.7. During April and May 2022, 7 cases were referred to the Healthcare Safety Investigation Branch (HSIB) in line with national reporting, due to suspected hypoxic ischaemic encephalopathy, with all 7 reviews ongoing. 3 were considered no harm, care was provided appropriately with no identified learning. The remaining 4 were reported in the moderate, major, or catastrophic harm category:

- 1 case related to a woman who had contacted Maternity Triage and the appropriate clinical details to support care were not obtained. This case highlighted the need for a consistent approach to communicating care plans across the MCS and these will be added into the appropriate IT systems. The team have also implemented a competency assessment for midwives taking telephone calls (major harm)

- 1 case related to antenatal care and follow up of suspected ruptured membranes. In this incident it was identified that the guideline for management of suspected ruptured membranes was not followed. This is not an issue that has been previously identified in the antenatal ward; the lessons learnt in this case have been shared with the clinical teams (moderate harm)

- 1 case related to a lack of recognition of delayed progress in labour. This case has highlighted the need for an objective assessment on admission and an understanding of the impact of human factors on decision making process. This links to the quality improvement work being undertaken for intrapartum care (moderate harm)

- 1 case related to a delay in arranging induction of labour for a woman with deteriorating blood results. On admission the CTG (fetal heart rate monitoring) was pathological and there was a timely transfer to theatre for an emergency (category 1) caesarean section (major harm)

3.8. No maternal deaths occurred within Saint Mary's MCS in April or May 2022.

3.9. In line with the perinatal surveillance model, Saint Mary's MCS Maternity Division monitor maternity data monthly via the Maternity Score Card (Please see Appendix 2).

4. Maternity Incentive Scheme (MIS) Year 4

4.1. As previously reported to the Board of Directors, there was a pause on MIS data collection in December 2022.

4.2. On 6th May 2022, MIS Year 4 was relaunched with a new submission date of 5th January 2023. To ensure timely Board of Directors approval, Saint Mary's MCS will submit evidence of compliance in November 2022.

4.3. Table 2 provides an overview of the Saint Mary's MCS current Year 4 MIS compliance.

Safety Action	Indicator/ standard	Current position June 2022	Expected at submission
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Compliant	Compliant
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant	Compliant
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Compliant	Compliant
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant	Compliant
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant	Compliant
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Working towards	Compliant
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliant	Compliant
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Working towards	Compliant
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant	Compliant
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Compliant	Compliant

Table 2 Year 4 MIS compliance

4.4. Saint Mary's MCS currently meet all required standards for 8 of the 10 Safety Actions and as such request the Board of Directors to note and approve the detail shared in the appendices as part of ongoing external reporting.

4.5. At this point in the reporting cycle set out for Year 4 MIS, Saint Mary's MCS are required to submit actions and updates to the Board of Directors for the following Safety Actions:

- Safety Action 4 – Medical Workforce
- Safety Action 6 – Compliance with the 5 elements of Saving Babies' Lives Care Bundle version 2
- Safety Action 8 – Training

- Safety Action 9 – Safety Champions and Midwifery Continuity of Carer

5. Safety Action 4 – Medical Workforce

5.1. In January 2022, Saint Mary's MCS reported ongoing compliance with Safety Action 4 to the Board of Directors, demonstrating commitment to incorporating the principles outlined in the RCOG workforce document and ongoing monitoring of compliance in relation to the obstetric workforce.

5.2. On 6th May 2022 MIS Year 4 was relaunched and included a revised metric within Safety Action 4.

5.3. This revised metric requires Saint Mary's MCS to review current compliance with the two components of the obstetric staffing standard and report this to the Board of Directors.

5.4. The two components of the obstetric staffing standard are that:

5.4.1. 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'[6] into their service. This document mandates the involvement and presence of Consultant Obstetricians in defined "high-risk" scenarios.

5.4.2. Units should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG 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.

5.5. MIS Year 4 requires that the first component (described at 5.4.1) is formally acknowledged at the Board of Directors by 16th June 2022. Saint Mary's MCS are compliant with this action as this was submitted to the Board of Directors in January 2022.

5.6. MIS Year 4 amended requirement following relaunch is that by 29th July 2022 monthly compliance of the second component (described at 56.4.2) is being monitored and evidence of this is provided to the Board of Directors.

5.7. Table 3 describes the 14 clinical situations with mandated consultant attendance required as defined by RCOG.

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

[6] 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/.

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

Table 3 14 Situations with mandated consultant attendance

5.8. Within Saint Mary's MCS it is expected that an incident report is submitted if one of the 14 clinical situations occur and a consultant is not in attendance.

5.9. Due to certain data not being captured reliably on current maternity data systems, it is only possible to audit 8 of the 14 clinical situations described above. Eight clinical situations which occurred between 1st January 2022 to 31st March 2022 have been reviewed and data is provided in Table 4.

5.10. Of the remaining 6 clinical situations, there have been no incident reports between 1st January 2022 to 31st March 2022 for non-attendance of a consultant. It is expected that the launch of HIVE information system in September 2022 will provide the required data for these clinical situations and support Saint Mary's MCS to audit all 14 clinical situations going forwards.

5.11. On review, Obstetric Consultants were present for 83/85 events reviewed. Please see Table 4 for details.

	Number of cases with consultant recorded as present		
	ORC	***Wythenshawe***	***NMGH***
Eclamptic Fit	0/0	0/0	0/0
PPH ≥2000mls	42/42	6/6	7/7
4th degree tear	1/2	4/5	4/4
Twin Births < 30 weeks	2/2	2/2	0/0
Caesarean Sections<28 weeks	0/0	1/1	0/0
Caesarean -Placenta Accreta	4/4	0/0	0/0

Caesarean section: Major placenta praevia	9/9	9/9	1/1
Intrapartum Stillbirths	0	0/0	0/0

Table 4 Consultant attendance 1st January to 31st March 2022

5.12. There were two events when the consultant is not documented to be present in theatre for a fourth-degree tear. In one, the consultant was present on the unit managing competing priorities and a competent non-consultant grade doctor undertook the procedure with clear awareness to escalate if required. The procedure was completed with no concerns raised and the woman made a full recovery. The other was a repair done by a competent non-consultant grade doctor due the urgency of the situation with direct access to the consultant should escalation be required. The procedure was completed with no concerns raised and the woman made a full recovery.

5.13. Compliance will continue to be monitored monthly via Maternity Division Quality and Safety Committee and onwards to Saint Mary's MCS Quality and Safety Committee.

5.14. Compliance monitoring data will be reported to GMEC LMNS in addition to the Board of Directors and Board Safety Champions.

5.15. Compliance with the Obstetric Workforce element within Safety Action 4 of the Maternity Incentive Scheme Year 4 has been achieved.

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

6.1. Saint Mary's MCS, as part of 2020/2021 standard contract, and in line with best available evidence to reduce perinatal mortality, has fully implemented each of the 5 elements within version 2 of the Saving Babies Lives Care Bundle (SBLCB)[7].

6.2. It is expected that Saint Mary's MCS will achieve compliance at the time of submission and will continue to provide an update to Saint Mary's MCS Quality and Safety Committee and the Board of Directors

6.3. Element 1 - Smoking Cessation and CO measurement

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

6.3.2. Q1 2022/2023 compliance data will be submitted to the Board of Directors September 2022.

6.3.3. Whilst Q1 data is not available at time of reporting, there continues to be improvement seen locally with April and May 2022 data demonstrating over 80% compliance at both booking and 36 weeks gestation.

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

6.3.4. Further scrutiny of monthly progress continues to be applied at the Maternity Services Divisional Quality and Safety Committee.

6.4. Element 2 – Fetal Growth Restriction (FGR)

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

6.4.2. Saint Mary's MCS meet the expected standard with over 90% across all three maternity sites.

6.5. Element 3 – Reduced Fetal Movements

6.5.1. As previously reported to the Board of Directors, Saint Mary's MCS are compliant with both requirements for this element.

6.6. Element 4 – Fetal Monitoring

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

6.6.2. In addition, in line with Safety Action 8, Saint Mary's MCS are required to have 90% of eligible staff attend multi-professional fetal monitoring training annually.

6.6.3. Saint Mary's MCS currently do not meet the required standard for element 4. Further information on training compliance and actions are provided in section 8.

6.7. Element 5 – Preterm Birth

6.7.1. To improve neonatal outcomes and meet year 4 MIS Safety Action 6 element 5, Saint Mary's MCS must ensure that women who birth before 34 weeks gestation receive a full course of antenatal corticosteroids within 7 days of birth.

6.7.2. In addition, magnesium sulphate which improves neonatal neurological outcome must be given within 24 hours prior to birth for women who birth before 30 weeks gestation.

6.7.3. Saint Mary's MCS continue to be compliant with this element.

6.7.4. It is expected that Saint Mary's MCS will be compliant at time of submission and will continue to provide a quarterly update to Saint Mary's MCS Quality and Safety Committee and the Board of Directors.

7. Safety Action 8 – Training

7.1. Safety Action 8 expects that 90% of all relevant staff groups (identified in Table 5-7) must have received maternity specific training prior to submission of Year 4 MIS.

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	95%↑	90%↑	91%↑
Obstetricians	88%↑	83%↑	90%↑
Anaesthetists	83%↑	69%↑	91%↑
Theatre Staff	70%↔	14%↓	47%↓
Maternity Support Workers	83%↑	93%↑	82%↑

Table 5 Multidisciplinary Emergency Training (%) at end of May 2022.

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	97%↑	94%↑	96%↑
Obstetricians	92%↑	85%↑	90%↑

Table 6 Fetal Monitoring Compliance (%) (either face to face or virtual training)

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	94%↑	83%↑	95%↑
Neonatologists	100%↔	TBC%	100%↔
Neonatal Nurses and ANNP's	95%↔	100%↔	95%↔

Table 7 Neonatal Resuscitation (%)

7.2. Saint Mary's MCS acknowledges that current training compliance for some staff groups remains below the required standard. However. in May 2022 there have been marked improvements in compliance for most staff groups. Areas of lower compliance have been escalated to relevant divisional leads.

7.3. Work is now focussed on getting all staff members who are currently non-compliant with training, trained prior to the commencement of HIVE training.

7.4. To support the delivery of HIVE training, there is limited room capacity to provide face to face skills drills training on the North Manchester site between June and August 2022. Where is it not possible to provide face to face PROMPT training, virtual prompt sessions similar to those run during the height of COVID-19 pandemic are being provided and compliance is monitored at Divisional Quality and Safety Committee.

7.5. The relaunch of MIS Year 4 in May 2022 has acknowledged the pressures to achieve training compliance due to the impact of COVID-19 pandemic. As such, whilst the requirement to achieve 90% compliance remains, staff will be considered compliant if they have received maternity specific training within the last 18 months prior to MIS Year 4 submission.

7.6. Training data is now being reviewed and an updated training compliance position, reflecting the change in Safety Action 8, will be provided to the Board of Directors in September 2022.

7.7. Training compliance continues to be monitored monthly at Saint Mary's MCS Maternity Services Divisional Quality and Safety Committee with appropriate scrutiny to ensure that training remains a focus for all relevant staff groups.

8. Safety Action 9

8.1. Safety Champions

8.1.1. To achieve compliance with Year 4 MIS safety action 9, Saint Mary's MCS are required to have robust processes which provide assurance to the Board of Directors on maternity and neonatal quality and safety issues.

8.1.2. As reported to the Board of Directors previously, Saint Mary's MCS met the required standard and have site based frontline maternity, neonatal and obstetric safety champions who undertake monthly 'feedback/staff walkaround sessions' with executive and non-executive safety champions.

8.1.3. Staff feedback regarding safety concerns are addressed promptly and progress is communicated to the teams bi-monthly using safety huddles and safety notice boards. (Please see Appendix 3).

8.1.4. As previously reported to the Board of Directors, the Non-Executive Board Safety Champion has undertaken walkarounds at Oxford Road Campus and North Manchester. A scheduled walkaround at Wythenshawe Hospital in April 2022 did not take place due to unforeseen circumstances and a further date is being scheduled.

8.1.5. Following the relaunch of MIS Year 4 there has been an amendment to the requirements for Board Level Safety Champions. It is required that Board Level Safety champions undertake bi-monthly engagement sessions across each of the 3 maternity sites. Dates are being scheduled in July 2022 to ensure compliance with this new requirement.

8.1.6. As required by MIS Year 4 safety action 9, this assurance paper is presented to the Board of Directors by the Board Safety Champion and highlights incidents reported as serious harm (Section 3); staff feedback (8.1.3); maternity staffing (section 9); and staff training compliance (section 7).

8.2. Midwifery Continuity of Carer

8.2.1. In line with Year 4 MIS Safety Action 9 requirements, Saint Mary's MCS provided assurance to the Board of Directors on the progress and plans relating to the national ambition to achieve Midwifery Continuity of Carer (MCoC)[8] as the default maternity offer by March 2023.

8.2.2. In May 2022, Saint Mary's MCS reported to the Board of Directors that progress on the current MCoC action plan would be paused.

8.2.3. This was in response to receipt of a letter on 1st April 2022 from the NHS Chief Nursing Officer for England (CNO) requiring all providers to review current MCoC teams

[8] NHS England and NHS Improvement, (2021). Delivering Midwifery Continuity of Carer at Full Scale: Guidance on planning, implementation and monitoring 2021/22

against current staffing levels following the release of the final Ockenden Report[9] on 30th March 2022 which required suspension of the MCoC model until, and unless, safe staffing is shown to be present.

8.2.4. The Board of Directors were informed that Saint Mary's MCS would complete a risk assessment to review staffing and the ability to safely continue with existing MCoC teams.

8.2.5. On 6th May 2022, NHS England released further guidance regarding MCoC. This, along with amendments within Year 4 MIS, have confirmed that MCoC as a default maternity offer should be achieved by March 2024. In addition, the guidance also required that any decision to suspend existing MCoC teams along with an updated action plan and a supporting paper describing how providers aimed to achieve MCoC as a default model, would require approval from the Board of Directors.

8.2.6. An updated MCoC report, inclusive of a staffing risk assessment for MCoC teams, has been completed and provided in Appendix 4 for approval by the Board of Directors approval.

8.2.7. The MCoC staffing risk assessment (Appendix A within MCoC report) demonstrated an increased risk to Saint Mary's MCS maternity services should the plan to roll out additional MCoC teams continue without additional recruitment.

8.2.8. As previously reported to the Board of Directors in January 2022 and to GMEC LMNS, Saint Mary's MCS require an additional 77 WTE midwives above current budgeted establishment over the next 6 years to safely roll out additional MCoC teams.

8.2.9. Saint Mary's MCS request the Board of Directors approve the recommendation to delay roll out of additional MCoC teams until Q3 2023/2024, subject to additional funding and subsequent recruitment into new posts has been achieved.

8.2.10. The MCoC staffing risk assessment also indicated an increased risk to sustain 5 of the current 7 MCoC teams in place within Saint Mary's MCS as they currently do not provide 24/7 MCoC provision due to midwifery vacancies.

8.2.11. As described below in section 10, at the end of May 2022 there were **48.85 WTE** midwifery vacancies within Saint Mary's MCS.

8.2.12. Saint Mary's MCS request that the Board of Directors approve the recommendations within the report to suspend 5 MCoC teams until such a time that vacancies within Saint Mary's MCS current midwifery establishment have been recruited to.

8.2.13. The Saint Mary's MCS updated MCoC action plan is a phased approach over 6 years and is projected to be achieved by Q3 2027/2028. This approach aims to ensure safety and stability of the maternity service during a period of transformational change in delivering maternity care.

[9] https://www.donnaockenden.com/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

8.2.14. Saint Mary's MCS request the Board of Directors approve the recommendations within the MCoC report and acknowledge that Saint Mary's MCS will not meet the current NHS England ambition to offer MCoC as a default model of care by March 2024.

8.2.15. Once approved, the action plan and paper will be submitted to GMEC LMNS for ongoing review and monitoring as required by NHS England.

9. Workforce

9.1. A review of the midwifery workforce is submitted to the Board of Directors every six months as an embedded process to provide assurance on midwifery staffing. The last submission was in March 2022.

9.2. In June 2022, Saint Mary's MCS midwifery vacancy was **48.85 WTE** across 3 maternity sites. Work remains ongoing to increase recruitment and address vacancies, details of which will be provided in the bi-annual workforce report.

10. Recommendations

10.1. It is recommended that the Board of Directors:

- note the information provided in this report in relation to:
    - The Immediate and Essential Actions from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust – the Ockenden Reports
    - the work in place to ensure the safety of women and babies in Saint Mary's Managed Clinical Service (MCS)
- approve:
    - The recommendations within Saint Mary's MCS Report in relation to Maternity Continuity of Carer. These include approving the decision to suspend 5 MCoC teams based on the risk assessment provided; approving a delay in the roll of the next MCoC team until Q3 23/24; approving a phased approach over 6 years and acknowledging that this will not meet the current national ambition of offering MCoC as a default model of care by March 2024.
    - the proposal to delegate receipt of a maternity patient story to the Saint Mary's MCS Quality and Safety Committee
- Note the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety

Appendix 1: Detailed Final Ockenden Action Plan – Created May 2022, update June 2022

Key -

With regional or national team to address	Work ongoing	Completed

Recommendation	Action	Lead	Due date	Update
• **Immediate and Essential Action 1: WORKFORCE PLANNING AND SUSTAINABILITY** • The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented • The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**April 2022**	**Request made in April 2022; no update received as of 6.6.22**

Recommendation	Action	Lead	Due date	Update
are able to safely meet organisational CNST and CQC requirements. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH. • All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.				
Immediate and Essential Action 1: WORKFORCE PLANNING AND SUSTAINABILITY	Review current NQM workforce to understand how many staff are due to rotate to community within 12 months of qualification and amend accordingly.	Rotation Leads across MCS	**Completed**	**Closed**

Recommendation	Action	Lead	Due date	Update
Training • All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Amend preceptorship package to ensure that NQM do not receive a rotation into community	Education Team	**Completed**	**Closed**
	Gap Analysis of all leadership and management roles - Midwifery	DHoM ORC, supported by HoM	**August 2022**	**Ongoing**
	Gap Analysis of all leadership and management roles – Obstetrics	CHoD	**August 2022**	**Ongoing**
	Develop succession planning Strategy and SOP for midwifery	DHoM ORC, supported by HoM	**September 2022**	**Ongoing**
	Develop succession planning Strategy for Obstetrics	CHoD	**September 2022**	**Ongoing**

Recommendation	Action	Lead	Due date	Update
Immediate and essential action 2: Safe Staffing. • All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain. • The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction • The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change • Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles	Review and risk assess current MCoC teams	Consultant Midwife and Associate Head of Midwifery	**Completed**	**Closed**
	Update MCoC Action plan in line with amends from risk assessment	Consultant Midwife and Associate Head of Midwifery	**June 2022**	**Amendments required due to new guidance released 6th May 2022. Paper submitted to SM QSC for 9th June and onward reporting to Trust Board of Directors**
	Submit review and updated Action plan to SM QSC, Trust Board and GMEC LMS	Consultant Midwife and Associate Head of Midwifery	**June 2022**	
	Full review of obstetric training needs analysis which includes maternity specific training to be captured within job plan	CHoD	**July 2022**	**ongoing**
	SOP to be developed regarding use of matron, ward manager and LW Coordinator handbook	Deputy Heads of Midwifery	**July 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
Immediate and essential action 3: Escalation and Accountability • All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Amend bleep holder policy to clearly reflect role and ongoing escalation process	Inpatient/labour Ward site Matron	**Aug 2022**	**Bleep holder guideline in final stages before ratification.**
	Create SOP for Bleep holder regarding process of activating a deflect across SM MCS maternity sites	Head of Midwifery North Manchester	**June 2022**	**Ongoing**
Immediate and essential action 5: Clinical Governance Incident Investigation and complaints • Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. • All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	SOP to be created	Divisional Governance Lead Obstetrician and Lead Midwife for Governance	**Aug 2022**	**Ongoing**
	Discuss with SM MCS complaint Chair regarding how this can be incorporated in line with MFT complaints process	Associate Head of Midwifery	**June 2022**	**ongoing**
Immediate and essential action 6: Learning from Maternal Deaths • NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that a joint review panel is provided in any case of a maternal death. • This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff, and	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**April 2022**	**Request made in April 2022; no update received as of 6.6.22**

Recommendation	Action	Lead	Due date	Update
seek external clinical expert opinion where required.				
Immediate and essential action 7: MDT Training • All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS. • Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Review current human factor training and submit to LMS for approval	Lead Midwife for Education GMEC LMS	**July 2022**	**Training plan submitted to GMEC LMS. Awaiting LMS response regarding approval of human factors training**
	Review maternity workforce to identify current gap	Matrons	**Completed**	**Closed**
	Review Obstetric workforce to identify current gap	Lead Obs	**Completed**	**Closed**
	Allocate all outstanding on nearest available training	Education team/CTG champions	**Completed**	**Closed**
	Undertake gap analysis review on those requiring training over next 3 months ensuring all allocated to prevent any non-compliance	Education team/CTG champions	**June 2022**	**Ongoing. Staff identified and training sessions now booked to support continued training compliance.**
	Communicate with all staff the importance of remaining compliance with CTG and emergency skills training.	CHoD and HoM	**Completed**	**Closed**

Recommendation	Action	Lead	Due date	Update
Immediate and essential action 9: Preterm Birth • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered • Discussions must involve the local and tertiary neonatal teams, so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Capture compliance of discussion and documentation in maternity record within PreCEpT audit	Precept champions	**July 2022**	**ongoing**
Immediate and essential action 10: Labour and Birth It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Await risk assessment to be created by national team			**Request made for update of progress in April 2022, no update received as of 19.5.22**
	Review current information provided by Community Midwives	Consultant Midwife	**July 2022**	**ongoing**
	Link with NWAS to confirm current transfer times for birth outside of hospital	Consultant Midwife	**July 2022**	**ongoing**
Immediate and essential action 11: Obstetric anaesthesia	Request CSS response for compliance across all 3 maternity sites.	Associate Head of Midwifery	**completed**	**Report received 10.6.22**
• Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets	Await resources to be created and made available nationally	CSS	**TBC**	**Awaiting update from RCoA**

Recommendation	Action	Lead	Due date	Update
and what constitutes a satisfactory anaesthetic record to maximise national engagement and compliance				
• Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia	Ensure all pathways in place ahead of the introduction of HIVE to include a postnatal database detailing patients being followed up. This will significantly upgrade the ability to track patients and outcomes.	CSS	**September 2022**	**Most Pathways in place. Awaiting HIVE go live**
• Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Develop SOP to detail role and responsibilities across anaesthetic service. Once created this will support HIVE and he ability to track patients and outcomes.	CSS	**September 2022**	Will be fully compliant with HIVE in September and completion of action plan of HIVE - linked in with obstetric RDGs
• All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Integrate documentation into HIVE and provide harmonised approach across 3 sites.	CSS	**September 2022**	Will be fully compliant with HIVE in September and completion of action plan of HIVE - linked in with obstetric RDGs
• Obstetric anaesthesia staffing guidance to include: The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the	Whilst compliant across all 3 sites work ongoing to strengthen process including harmonisation of SOPs.	CSS	**TBC**	**In process of harmonisation including terms and conditions/ standard**

Recommendation	Action	Lead	Due date	Update
need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.				**operating procedures / CLW rota app- evidence**
• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Harmonisation of all anaesthetic policies	CSS	**TBC**	**Work ongoing with policy harmonisation**
• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Require competency assessment from RCoA	CSS	**TBC**	**Waiting update from RCoA**
• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report	Compliant		**Closed**	**Closed**
Safety Action 12 - Postnatal Care • All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. • Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Review consultant capacity to support postnatal activity on all 3 sites	Clinical Head of Division	**July 2022**	**ongoing**
	Amend postnatal guideline to support change in practice for readmissions	Lead Obstetrician for inpatients	**Sept 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
Safety Action 12 - Neonatal Care • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation. • Each network must report to commissioners annually what measures are in place to prevent units from working in isolation. • Implement recommendation from Neonatal Critical Care Review (2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce, and enhance the experience of families	**NW ODN confirmed compliance with this action**	Northwest ODN	**Completed**	**Closed.** **Update from NW ODN 8.6.22 has confirmed compliance with all metrics within this action.**
• Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care	Recruit to junior medical vacancy on Wythenshawe site Consider additional work required to increase in consultant workforce to be compliant	Newborn Services CHoD and DD	**Sept 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
24/7 in line with national service specifications.				
Safety Action 15 – Supporting families • There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences**.**	Work with Mental Health team to ensure robust monitoring and referral pathways	Consultant Midwife and Mental Health Team	**Dec 2022**	**ongoing**
	Review capacity of current specialist maternity counsellor and link with SLA	Head of Midwifery, North Manchester	**October 2022**	**ongoing**
	Review current counselling service across SM MCS and create business case for cross site service where required	HoM/DD/CHoD	**Dec 2022**	**ongoing**

Appendix 2: 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 March
- Maternity incidents are reported separately via the governance reports presented at Q&SC
- Exception report details are below
- All HSIB referrals are reviewed by MDT to identify lessons learnt and mitigate any risks

Major PPH > 2.5litres	Term admissions to NNU	Stillbirths
• Incidents monitored monthly • Major PPH quality improvement work undertaken • Lessons learnt shared across the MCS	• All term admissions reviewed to identify if the admission was avoidable • MatNeo quality improvement programme in progress to reduce term admissions • ATAIN audits undertaken to identify areas for improvement and share lessons learnt	• Perinatal Mortality Review Tool used to complete MDT review for all stillbirths • All stillbirths are incident reported and reviewed by the MDT

							GMEC monthly average (Apr 22)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Jan-22	Feb-22	Mar-22

Perinatal	1:1 care in labour	Percent	89.8	99.22	98.75	96.80	97.04							
	3rd/4th degree tears	Percent	2.80	1.91	1.44	1.54	1.87							
	Obstetric haemorrhage > 2.5L	Rate per 1000	2.42	0.38	5.6	5.16	0.74							
	Term admissions to NNU	Rate per 1000	42.88	63.38	57.79	53.23	54.52							
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	8.97	8.61	11.38	9.68	4.88							
	Stillbirth number	Rate per 1000	4.23	4.96	4.96	3.64	5.18							
	Neonatal Deaths	Rate per 1000	0.00	2.13	2.13	2.19	1.48							

Patient Experience	Number of formal compliments	Number		3	2	1	5							
	Number of formal complaints	Number		11	6	15	8							
	Complaint response on time	Percent		-	-	-	-	-						
	Maternity Unit diverts	Number		0	0	0	0							

Training	Emergency skills and drills	Percent of staff trained		73.5	79.4	74.18	79.52							
	CTG training	Percent of staff trained		90.7	85.8	81.6	85.4							
	CTG competency assessment	Percent of staff assessed		87.4	67.2	66.05	62.1							

Coroner Reg 28 made directly to the Trust				No	No	No	No							
HSIB/ CQC concern or request for action				No	No	No	No							
StEIS reported incidents				1	5	3	5							
Incidents with moderate harm or above				1	3	2	3							
HSIB referrals				1	4	2	4							

Feedback from Safety Walkarounds across Saint Mary's MCS
June 2022

NHS Manchester University NHS Foundation Trust

Key Themes

Staff safety drop-in sessions have been provided monthly since March 2019. These sessions provide the opportunity for staff to raise any safety concerns that they have with Clinical Leads.

These sessions are now provided across the MCS. Below are some of the responses to concerns raised on all three sites.

Since January 2022 we have had a total of 61 concerns raised at the drop-in sessions.

Of these, 29 have been resolved which is 47.5%.

The concerns raised cover a variety of subjects; however key themes that have emerged related to Equipment (39%), Staffing (46%) and Clinical concerns (15%).

Who are your safety champions?

- Clinical Head of Division Professor Ed Johnstone
- Head of Midwifery Wythenshawe Faith Sheils
- Head of Midwifery Oxford Road Bev O Connor
- Head of Midwifery North Manchester Esme Booth
- Director of Nursing and Midwifery Kathy Murphy
- Medical Director Sarah Vause
- Non-Executive Director/Maternity Safety Board Champion Chris McLoughlin
- Chief Nurse/Maternity Executive Board Safety Champion Cheryl Lenney

YOU SAID	WE DID
There is concern about the lack of availability of CTG leads on ward 65, Oxford Road campus.	New pulse oximeters have been sourced and ordered.
Ward clerk staffing on DS at Wythenshawe needs to be improved.	There is now a process in place to cover ward clerk duties on DS when the ward clerk is unavailable, from other areas, such as BC.
Pulse oximeters are not working on Dawes Redman CTGs in antenatal areas at North Manchester.	More pulse oximeters on order, however, the new CTG guideline has changed and pulse oximeters are no longer mandatory.

Safety walkarounds occur every month across each maternity site for anyone to raise concerns. Please note, should you wish to raise a concern you can email staffsafetydrop-in@mft.nhs.uk at any time. The safety champions look forward to seeing you on the next walkaround.

Appendix 4

SAINT MARY'S MANAGED CLINICAL SERVICE

Saint Mary's Quality and Safety Committee 9th June 2022

Report of:	SM MCS Maternity Division Professor Edward Johnstone, Clinical Head of Maternity Services Division Mrs Beverly O'Connor, Head of Midwifery Mrs Faith Shiels, Head of Midwifery Miss Esme Booth, Head of Midwifery Mr Medwyn Jones, Interim Division Director	
Paper prepared by:	Jen Sager Associate Head of Midwifery Kylie Watson Consultant Midwife	
Date of paper:	7th June 2022	
Subject:	Implementing Midwifery Continuity of Carer at scale	
Purpose of Report:		
	Information to note	✓
	Support	
	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 SM QSC are asked to: Support and approve the action plan for implementing Midwifery Continuity of Care at scale	
Contact:	Jen Sager Jen.sager@mft.nhs.uk	

1. Purpose of paper

1.1. To provide an update on Saint Mary's Managed Clinical Service (SM MCS) position and plans to SM MCS Quality and Safety Committee (SM QSC) on matters relating to midwifery continuity of carer (MCoC). The paper includes information on the background regarding MCoC and staffing levels required to provide MCoC as the default model of care. In response to the latest guidance from NHS England and NHS Improvement in October 2021[10], an action plan of how this will be achieved has been created. It is anticipated that it will take at least 6 years to fully implement this action plan.

1.2. In line with the requirements for Year 4 Maternity Incentive Scheme, the paper detailing SM MCS position has previously been seen by Trust Board of Directors in January 2022 and a further updated position, to reflect the change in national guidance in May 2022, will be shared at the next Trust Board of Directors meeting on 11th July 2022.

2. Background

2.1. The national view is that Midwifery Continuity of Carer (MCoC) has been proven to deliver more personalised maternity care. MCoC should be provided by midwives who are organised into teams of eight or fewer (headcount). Each midwife aims to provide antenatal, intrapartum, and postnatal midwifery care to approximately 36 women per year (pro rata), with support from the wider team for out-of-hours care.

2.2. Building on the recommendations of Better Births[11] in 2016 and the commitments of the NHS Long Term Plan[12] in 2019 the ambition for the NHS in England is for MCoC to be the default model of care for maternity services. Where safe staffing allows and building blocks are in place, this should be available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes.

2.3. In January 2022, as required, SM MCS provided the local maternity system (LMS) with an action plan that described how MCoC as the default model of care would be offered to all women using a building block approach. Feedback from the LMS on the action plan was expected by the end of January 2022.

2.4. This review by the LMS was paused as not all providers were able to submit action plans due to significant pressures on NHS services caused by COVID-19.

2.5. In May 2022, NHS England requested an update of MCoC plans to be sent to LMS by 15th June 2022.

2.6. In the latest guidance from NHS England and NHS Improvement, released on 6th May 2022, the expected date for achieving a default model has now changed from March 2023 to March 2024 and requires a review of the action plan to reflect these changes.

2.7. The revised plan must include:

- number of women expected to receive MCoC, when offered as the default model of care
- when this level of provision will be achieved by; and a redeployment plan into MCoC teams to staff it, phased alongside the fulfilment of recommended staffing levels

[10] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

[11] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[12] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

- how MCoC teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- how rollout will be prioritised for those most likely to experience poor outcomes, including with the development of enhanced models of MCoC
- how care will be monitored locally, and providers ensure accurate and complete reporting on provision of MCoC

3. SM MCS Current Midwifery Continuity of Carer Position

3.1. Currently, SM MCS provide care for approximately 20,320 women per year across all three provider sites (Saint Mary's Oxford Road, Saint Mary's Wythenshawe, and Saint Mary's North Manchester). This figure is based on 2021/2022 activity and known current bookings and includes an attrition rate (women who experience a miscarriage or undergo a termination of pregnancy) of approximately 10%. It is therefore expected that SM MCS would support the care of approximately 18,485 women.

3.2. Approximately, 2351 women access antenatal and postnatal community midwifery care aligned to SM MCS and choose to birth with an alternative provider. It is unlikely that this will change significantly in the near future.

3.3. Approximately 8180 women choose to birth at one of the 3 maternity sites within SM MCS but live outside of the designated community midwifery areas of those sites. One of the reasons for this is the need for tertiary level care which may not be provided closer to the woman's home. In addition, some women chose to access intrapartum care within SM MCS due to previously giving birth here.

3.4. There are approximately 7954 women who live in area and will be cared for by midwives from within the 3 maternity sites of SM MCS throughout their pregnancy episode and this is the number of women who are eligible for MCoC.

3.5. Approximately 38% of women that Saint Mary's MCS provide care for are from a Black, Asian, or Mixed Ethnic background which are distributed across several postcodes. These areas will be focussed on within future MCoC plans (see accompanying action plan).

3.6. Approximately 37% of women for whom Saint Mary's MCS provide care for live in the bottom decile of deprivation, with a higher proportion of women concentrated within North and Central Manchester localities.

3.7. Prior to May 2022, SM MCS had 7 MCoC teams providing antenatal, intrapartum, and postnatal care to women in areas with a high proportion of women from Black, Asian, and Mixed ethnicities and/or areas of high social deprivation.

3.8. Following a requirement from the Chief Nursing Officer for England on 1st April 2022 a review and risk assessment was undertaken (see **Appendix A**) which required the suspension of 5 MCoC teams as it was not possible to safely provide a sustainable 24/7 MCoC model.

3.9. Currently SM MCS have 2 MCoC teams which are geographically based in areas which have a high proportion of women from Black, Asian and Mixed Ethnicities and/or in the bottom decile of deprivation. These teams provide MCoC to approx. 600 women including both low and high-risk pregnancies.

3.10. As SM MCS provide a large proportion of care to women who do not live within defined community midwifery areas, to achieve the ambition of offering MCoC as the default

model to the 7954 women who receive antenatal, intrapartum, and postnatal care within the 3 maternity sites (approximately 49% of total births), SM MCS would require a total 30 teams of 8 midwives (headcount).

4. Building Blocks and Action Plan

4.1. SM MCS has reviewed the building blocks and allocated a RAG status to all the building blocks that need to be in place to achieve and monitor sustained transformation (see **Appendix B**). Each of the building blocks have been described in more detail below. The planning guidance[13] sets out that building blocks need to be in place prior to and during the rollout of MCoC. The building blocks indicate a readiness to implement and sustain MCoC and are the key elements needed to roll out MCoC from the current position to default MCoC for eligible women.

5. Safe Staffing

5.1. The new guidance for MCoC[14] makes it clear that safe staffing of current maternity services must be in place prior to scaling up the MCoC teams.

5.2. The Birthrate Plus®[15] (BR+) workforce planning methodology is a safe staffing toolkit that supports most of the components in the NICE guideline on safe midwifery staffing for maternity settings[16]. SM MCS undertook the midwifery workforce review using the BR+ tool. The report was received SM MCS in January 2021.

5.3. The report identified a registered midwifery staffing gap of **17 WTE** across SM MCS for traditional midwifery services.

5.4. Following the initial Ockenden report[17] in December 2020, BR+ also provided a workforce establishment modelling based on SM MCS offering 51% MCoC which indicated that SM MCS required approximately **94 WTE** additional midwives to provide 51% MCoC.

5.5. Through direct investment from NHSE&I to reduce variation in experience and outcomes for women and their families across England following the Ockenden Report[18], SM MCS was supported to increase the midwifery staffing establishment in line with the recommendations of the BR+ report for traditional midwifery services. The bid for investment in the remaining **77 WTE** (to support MCoC) was declined.

5.6. The midwifery establishment, inclusive of the revised baseline following the BR+ findings was **711 WTE** across the 3 maternity units however following an increased requirement for senior midwifery leadership and skill mix review, the revised midwifery establishment is **718 WTE**.

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[13] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

[14] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

[15] https://birthrateplus.co.uk/

[16] NICE guideline NG4 Safe midwifery staffing for maternity settings. 17 February 2015

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

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

5.7. The latest guidance advises providers to use NHS England and NHS Improvement workforce tool (available online https://continuityofcarer-tools.nhs.uk/tools).

5.8. SM MCS have used this tool, which indicates that a further **77 WTE** midwives above the current establishment of 718 WTE midwives are required to enable the maternity service to offer MCoC as the default model of care across the 3 maternity sites (see Appendix C, D and E). This echoes the additional requirement from BR+ in January 2021.

5.9. The default model would ultimately require **30 MCoC teams** with 8 midwives per team (headcount) totalling approximately **230 WTE** midwives across SM MCS working in MCoC teams (with some teams having 8 WTE and others having 7.5 WTE). A full breakdown of teams for each site can be found in Appendices 7, 8 and 9.

5.10. This would mean a total of **795 WTE** midwives are required to achieve MCoC as a default model for those eligible, whilst maintaining safe staffing levels for all areas.

5.11. The recent NHSE/I guidance[19] clearly states that having the correct number of midwives in post is one of the key building blocks for safety and must be in place prior to rolling out MCoC plans at scale.

5.12. There is currently a midwifery vacancy for the MCS of **50.0 WTE** (May 2022) due to a notable increase in midwives choosing to retire in Q4 21/22 and a reduction in external applications.

5.13. There is an active recruitment process ongoing at SM MCS to reduce the current vacancies and mitigate vacancies rising from turnover (currently 8.5 WTE per month across the MCS). It is expected recruitment to the budgeted establishment of 718 WTE midwives will be achieved by Q3 2022/23.

5.14. Without recruitment to establishment and additional funding to support the increase in midwifery establishment of 77 WTE midwives it is not possible for SM MCS to scale up and provide MCoC as the default model of care.

5.15. It is estimated that over the 6 years **£15,007,744** will be required to pay for the increase of 77 WTE in the midwifery establishment and a further **£4,662,931** in recurrent costs thereafter. A breakdown of these costs, based on 22-23 pay scales, has been provided by Saint Mary's Finance team in Appendix K.

5.16. Support will be sought from the Integrated Care System to fund an increase in midwifery establishment on a recurrent basis over the next 6 years. See Table 1 below.

[19] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

5.17. Table 1

Site	Recruitment 23/24	Recruitment 24/25	Recruitment 25/26	Recruitment 26/27	Recruitment 27/28	Allocation of additional Requirement WTE Midwives
Oxford Road	10	10	10	10	9	49
Wythenshawe	2	4	4	4	0	14
North Manchester	4	4	4	2	0	14
Total MCS	16	18	18	16	9	77

5.18. The action plan accompanying this paper shows a phased approach to scale-up of MCoC. SM MCS will continue to support the current MCoC teams that are in place with additional teams being added in waves, as the midwifery staffing establishment is increased. Additional teams will provide care to women living in geographical areas that could benefit the most from MCoC. (Appendix F).

5.19. Prior to any further Wave implementation, the impact that any existing MCoC teams are having on experience and outcomes will be explored. Each team will ensure robust data collection as well as collating feedback from women about care within a MCoC team. The experience of midwives working within the teams will also be explored to ensure that any lessons learnt from existing teams can be utilised with further roll out.

6. Planning Spreadsheets

6.1. SM MCS has developed the MCoC offer over 5-6 waves for each site (Appendix G, H, I). Based on the best evidence our MCoC teams will comprise of mostly mixed risk (women defined as either low or high risk for complications in the perinatal period) geographically based teams. Each team will consist of 6-8 midwives, with a minimum of 5 WTE.

6.2. SM MCS currently have 14.8 WTE midwives deployed in 2 teams. This represents wave 1. Five other teams are suspended but it is anticipated that three of these teams may be able to re-start during the last quarter of wave 1 (Sept 2022 – August 2023)

6.3. Before commencing wave 2 roll out of MCoC SM MCS will need to recruit to establishment and be in receipt of additional funding as per table 1. For 2023 this would require recruitment of an additional 16 midwives above current establishment. An evaluation will be undertaken prior to beginning a new wave to review current staff in post; additional workforce requirements and emerging patterns such as a reduction in triage admissions or length of stay.

6.4. MCoC teams will be prioritised for roll out areas with high numbers of Black, Asian and Mixed Ethnicity populations and the postcodes of the lowest deciles. This will ensure that women who are most likely to experience adverse outcomes are targeted first.

7. Communication and engagement plan

7.1. In November 2020 a staff survey across SM MCS was undertaken to explore staff awareness of MCoC and the appetite for working in MCoC teams. Of the 199 staff

who completed the survey, 39% did not have any interest in working in a MCoC team. Deeper analysis identified issues relating to childcare; increased travel; not wishing/able to work on call; not wishing/able to change from long day working; not wishing/able to work in the community setting. Many staff felt that antenatal and postnatal MCoC was the most important factor and that this is what should be aimed for. The results of the staff survey were not dissimilar to findings from a larger survey undertaken by the University of Birmingham in 2019[20] which demonstrated a reluctance of midwives to work in MCoC models.

7.2. To address these themes further and improve the number of midwives wishing to work in a MCoC team, SM MCS will need to undertake a comprehensive staff engagement project that demonstrates to midwives the benefits of working in a MCoC team, and how this can support work life balance, along with improving outcomes of care to women and babies. This programme of engagement will be undertaken with support from GMEC LMS, the Royal College of Midwives representatives and SM MCS Human Resources. Experiences of midwives working in successful MCoC models will be showcased to contribute to successful recruitment into teams. See Action plan (Appendix F).

7.3. SM MCS will develop a communication strategy which will provide an update on MCoC including feedback from women receiving care within the teams. SM MCS will also work with the local Maternity Voices Partnerships to ensure all voices are being heard.

8. Skill mix planning

8.1. Within the new continuity guidance[21], it states that consideration should be made to ensure that each team provides care for all women, regardless of clinical history, in a defined geographical area. These teams must have the appropriate skill mix of midwives, able to provide antenatal, intrapartum, and postnatal care.

8.2. Following publication of the final Ockenden report[22] in March 2022, Immediate and Essential Action 1 stipulates that newly qualified Band 5 midwives must remain withing the hospital setting for a minimum of one year post qualification.

8.3. Each team will have no more than one WTE Band 5 midwife (qualified for at least 12 months prior to working within the team) to ensure appropriate skill mix, whilst ensuring new midwives develop and gain confidence working in MCoC models.

9. Training

9.1. It is acknowledged that some midwives moving into continuity teams will need varying amounts of exposure to new areas and additional skills to confidently work across the childbirth continuum. This will be facilitated on an individual basis before any midwife moves into an MCoC team using a Self-Assessment Skills Log (Appendix J). SM MCS will ensure that all midwives receive appropriate support from education teams and receive tailored programmes to meet their individual needs.

[20] https://doi.org/10.1016/j.midw.2019.05.005

[21] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

9.2. Learning identified as an outcome of the self-assessment where possible will be planned within working hours and if not possible, financial approval will be sought to offer additional hours or bank shifts. It is acknowledged that the period of time for gaining any additional skills will vary, depending on individual midwives existing skills and knowledge.

10. Team Building

10.1. As each team is identified a meeting will be arranged to support team building. Time will be given for team building activities and there will be encouragement for midwives to utilise professional midwifery advocates and retention and recruitment midwives for additional support.

10.2. Once established, each team will be supported to have regular meetings to discuss caseloads, support reflective learning and progress on team deliverables.

11. Standard Operating Procedure (SOP)

11.1. In line with SM MCS governance processes, SM MCS will develop and approve a MCoC SOP for all teams to use. This will provide clarity around roles and responsibilities and contain operational policy on staffing within teams (inclusive of annual leave rotas, on-call availability and pay; referral processes; service delivery; and transfers of care). The SOP will also detail how each MCoC team is linked to an obstetrician irrespective of clinical circumstances.

12. Pay

12.1. It is not expected that pay will be negatively affected for any staff member working in a MCoC team. Time on call will be renumerated accordingly as described in the above SOP.

12.2. Further work may be required as more MCoC teams establish regarding whether an on-call payment or an uplift is preferable to both the service and to the workforce.

13. Estate and equipment

13.1. Currently, within Wave 1, the 2 ongoing MCoC teams are based within the hospital or community satellite clinics. Community services across all three maternity sites are currently being evaluated with a view to creating community hubs for midwifery teams. This may require considerable resource, project planning and investment. Should this be the case, a further Board paper will be submitted for consideration.

13.2. It is also acknowledged that providing MCoC at scale will require an investment in IT infrastructure and equipment (such as mobile phones; fetal heart dopplers; stethoscopes and computers/laptops).

13.3. Following a review of the equipment required, it has been calculated that over the 6 years £306,597 will be required for non-recurrent costs relating to equipment and a further £46,020 in recurrent costs thereafter. A breakdown of these costs, provided by SM Finance team, has been provided in Appendix L.

14. Evaluation and Review Process

14.1. It is a requirement of the Continuity guidance[23] for SM MCS to provide Manchester Foundation Trust (MFT) Board with an update on progress against the action plan each quarter**.**

14.2. 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 within the maternity assurance paper to SM MCS Hospital Quality and Safety Committee (SM QSC), chaired by Dr Sarah Vause, Medical Director for SM MCS.

14.3. Each Quarter it is expected that the action plan is on SM QSC agenda for review prior to onward submission to MFT Board.

15. Summary

15.1. SM MCS Maternity Division ask SM MCS QSC to acknowledge the information and current position alongside future plans.

15.2. Acknowledge the additional workforce requirements needed to implement MCoC as the default model of care across SM MCS.

15.3. SM MCS QSC are asked to accept an update of this action plan each quarter and onward submission to MFT Trust Board of Directors.

[23] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/

Appendix A Risk assessment for continuation of MCoC teams

SAINT MARY'S MANAGED CLINICAL SERVICE
Saint Mary's Quality and Safety Committee

Report of:	SM MCS Maternity Division Professor Edward Johnstone, Clinical Head of Maternity Services Division Mrs Beverly O'Connor, Head of Midwifery Mrs Faith Sheils, Head of Midwifery Miss Esme Booth, Head of Midwifery Mr Medwyn Jones, Interim Division Director	
Paper prepared by:	Jen Sager Associate Head of Midwifery Kylie Watson Consultant Midwife	
Date of paper:	18th May 2022	
Subject:	Review of safe staffing and Midwifery Continuity of Carer	
Purpose of Report:	Indicate which by x (tick as applicable-please do not remove text)	
	Information to note	
	Support	x
	Resolution	
	Approval	x
	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 SM QSC are asked to: Support and approve the risk assessment and recommendations regarding Midwifery continuity of carer teams	
Contact:	Jen Sager Jen.sager@mft.nhs.uk	

Background

1.1. Saint Mary's Managed Clinical Service (SM MCS) have worked with both regional and national directives to implement Midwifery Continuity of Carer (MCoC) since the recommendation was first made within Better Births in 2016[24]. These recommendations required Trusts to work towards achieving expectations to book 20% of all women on MCoC models by March 2020 and 50% by March 2022.

1.2. SM MCS have actively worked to engage the midwifery workforce and have implemented MCoC models of care across all 3 maternity sites. This has resulted in prioritising the most vulnerable cohorts as it was considered nationally that this is where the benefit of MCoC would be realised.

1.3. In November 2021, an updated report on MCoC was published by NHS England[25] which asked for MCoC to be offered as the default model of care by March 2023 for all women who receive antenatal, birth and postnatal care by the same maternity provider SM MCS completed a review and subsequent action plan to achieve this.

1.4. One of the actions (was to complete a staffing toolkit provided by NHS England

1.5. The toolkit identified that, to provide MCoC as the default model of care for all women who receive antenatal, birth and postnatal care by the same maternity provider, an additional 77 WTE midwives would be needed across SM MCS in addition to the current Birth Rate Plus agreed midwifery establishment.

1.6. A phased roll out of MCoC teams was proposed subject to additional funding of the required midwifery workforce. This phased roll out was submitted to Manchester Foundation Trust Board of Directors in January 2022 which, following approval, was submitted to Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS).

1.7. The action plan is updated monthly and submitted bi-monthly within the Maternity Assurance report to Trust Board of Directors, in accordance with Year 4 maternity incentive scheme reporting requirements.

1.8. On 1st April 2022, Ruth May, the Chief Nursing Officer for England, along with Amanda Pritchard, NHS Chief Executive, and Professor Stephen Powis Chief Nursing Officer National Medical Director asked all trusts to immediately review their staffing position in relation to Midwifery Continuity of Carer (MCoC). This was in response to the final Ockenden report[26] of the Shrewsbury and Telford Maternity Services published on 30th March 2022 which contained an Immediate and Essential Action (IEA) relating to MCoC. Specifically, this was that:

[24] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
[25] https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/
[26] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

'All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.'

1.9. The letter asked each Trust to review the staffing position against the following 3 options:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should:

A - cease further roll out and continue to support at the current level of provision
B - only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

MCOC teams and staffing prior to risk assessment

2.1. Throughout the COVID-19 pandemic SM MCS has continued to support MCoC teams despite challenges.

2.2. In late 2021, COVID-19 sickness absence increased to 12% and challenges with recruiting to MCoC midwifery vacancies impacted on some of the MCoC teams and their ability to offer 24/7 MCoC provision. This led to the suspension of 2 MCoC teams

In March 2022 SM MCS had 5 active MCoC teams. There were 2 teams which had been suspended due to ongoing absences within community midwifery and difficulty recruiting into MCoC vacancies.

2.3. Priority will be given to re-establishing the 2 suspended teams as both are in neighbourhoods in the bottom most deprived decile nationally as defined by IMD (referred to as deprived neighbourhood throughout this paper) and one has a high proportion of women from Black, Asian and Mixed Ethnicity groups.

2.4. Detail is provided below with overall data presented in Table 1 for each the current 7 MCoC teams.

<u>At Oxford Road</u>

2.5. Team 'Worth' is a mixed risk geographical based MCoC in a deprived neighbourhood. In November 2021, the team was temporarily suspended due to high staffing absences within the team and community services. The team is budgeted for 8 WTE. Currently there are 4.8 WTE in post and provide care in a traditional community model.

2.6. Team ‘Lowry’ provides mixed risk geographical based MCoC in a deprived neighbourhood with a high proportion (70%) of women from Black, Asian and Mixed Ethnicity backgrounds. This team is budgeted for 8 WTE and currently has 6 WTE in post and 0.6 WTE on maternity leave.

At North Manchester

2.7. Team ‘Bluebell’ was originally a low risk MCoC, however in March 2022 changed to become a mixed risk geographically based team in a deprived neighbourhood with a high proportion (50%) of women from Black, Asian and Mixed Ethnicity backgrounds. This team is budgeted for 7.4 WTE and currently has 6.48 WTE in post and 0.76 WTE on maternity leave.

2.8. Team ‘Rainbow/Blossom’ is a high risk MCoC team providing care for families who have suffered previous loss or preterm birth. This team is budgeted for 4 WTE and currently has 3 WTE in post and 1 WTE is on maternity leave.

2.9. Team M8 is a mixed risk geographical based MCoC in a deprived neighbourhood with a high proportion (80%) of women from Black, Asian and Mixed Ethnicity backgrounds. The team was temporarily suspended in February 2022 due to high staffing absences within the team and community services. The team is budgeted for 8 WTE. Currently there are 4 WTE in post providing care in a traditional community model.

At Wythenshawe

2.10. Team ‘Lotus’ is a high risk MCoC team providing care for families who have suffered previous loss or preterm birth. This model differs to the other MCoC models, using a shift based approached rather than an on-call model. There are currently 4.6 WTE, shortly to reduce to 3.8 WTE as a member of staff is leaving.

2.11. Team ‘Sapphire’ is a mixed risk geographical based MCoC team which is not based in a deprived area nor one which has a high proportion of women from Black, Asian, and Mixed ethnicity groups. The team is budgeted for 6.88 WTE and currently has 4.6 WTE in post.

Table 1

	Establishment	Vacancy	Maternity Leave or Long-Term sickness	Actual staff in post	Able to provide MCoC 24/7 provision currently
Team Worth	8	3	0	4.8	No
Team Lowry	8	0.4	0.6	7	Yes
Team Bluebell	7.4	0.16	0.76	6.48	Yes

Team M8	8	4	0	4	No
Team Rainbow	4	0	1	3	No
Team Sapphire	6.88	1	1.28	4.6	No
Team Lotus	4.6	0.8	0	3.8	No

Current Staffing across SM MCS

3.1. In line with safer staffing, SM MCS submit a bi-annual workforce report to Trust Board of Directors, which confirm the staffing position and recruitment plan. The last report was submitted in January 2022 which reported that SM MCS have a funded midwifery establishment in line with Birth Rate plus recommendations and a recruitment plan to address vacancies.

3.2. The next workforce report will be submitted to Trust Board of Directors in July 2022 and will be amended to include staffing required for SM MCS to provide MCoC as a default model of care.

3.3. In February 2022 there were 17 WTE vacancies within SM MCS. This has increased to a vacancy of 32 WTE in April 2022 (9.36 WTE are within MCoC teams). In May 2022 the vacancy rate is 50 WTE.

3.4. The vacancy rate in May 2022 is significantly higher than previous months, with a large proportion of staff choosing to retire this year than previous years.

3.5. On average there are approx. 8.5 WTE leavers each month across SM MCS. Whilst work is being undertaken to address this with the appointment of retention midwives, the ability to close this staffing gap remains a challenge.

3.6. Recruitment plans are in place with interviews planned in June 2022.

3.7. In line with Ockenden Final Report (2022)[27], providers have been required to ensure Newly Qualified Midwives (NQM) consolidate their training by completing 12 months in the hospital environment, which in turn prevents NQM from joining MCoC teams.

Risk assessment to suspend roll out of additional MCOC teams

4.1. A risk assessment has now been undertaken which has reviewed current staffing provision of MCoC teams, caseload, and ability to provide MCoC.

4.2. The chart below provides the risk assessment model used.

[27] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

		Consequence				
		Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Likelihood	5 Almost certain	Moderate 5	High 10	Extreme 15	Extreme 20	Extreme 25
	4 Likely	Moderate 4	High 8	High 12	Extreme 16	Extreme 20
	3 Possible	Low 3	Moderate 6	High 9	High 12	Extreme 15
	2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
	1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

4.3. Table 2 provides the risk assessment when considering option 1 (see 1.9 for further details).

Table 2

Risk	Detail	Mitigation	Risk Score Impact x Likelihood
Without additional staffing above current budgeted establishment, rolling out further MCoC teams would reduce staffing within the inpatient service which may impact on patient safety and increase pressure on current traditional community teams	Without significant staffing increases to current establishment, to create additional teams would require redeployment of 16 midwives across the MCS from maternity areas.	Action plan has been submitted to GMEC LMS outlining required additional midwives with a request to support funding bid with ICS. Should additional posts be funded the challenge would be to recruit to these additional vacancies.	To redeploy 16 midwives into CoC teams without additional workforce would have a risk of 4 x 5 = 20
Without rolling out further MCoC, not all women will be offered MCoC as default model of care	This may cause upset to women and families where MCoC is not being offered	This is current practice and models for women will not change	To pause roll out of MCoC teams would have a risk of 2 x 2 = 4

4.4. The risk assessment demonstrates it is not possible to safely continue with additional roll out of MCoC teams until additional funding is identified and recruitment to additional posts is achieved. As such, it is not possible to safely implement option 1.

Risk assessment to continue existing MCoC teams

5.1. Table 3 provides the risk assessment with considering option 2A and 2B.

Table 3

Risk	Detail	Mitigation	Risk Score Impact x Likelihood
There is a risk that if MCoC teams are not at full establishment this could: 1, Restrict ability to achieve the offer of full CoC pathway for all women booked for care 2, By aiming to meet all 3 elements of pathway, put unacceptable workload on existing CoC teams (leading to burnout) 3, Reduce the caseload numbers in MCoC which would disproportionately impact on caseloads of traditional community models	Due to ML, sickness, and vacancies several teams do not have recommended WTE to provide all 3 elements of care, with intrapartum care being impacted most. As Table 2 demonstrates, it is not possible to redeploy from current maternity services. As such, it is not possible to safely fill the current vacancies within existing teams without external recruitment. Current vacancies/absences within community services increase the caseloads for existing community midwives Recruitment adverts out for community and continuity over last 3 months have not demonstrated interest in CoC teams	3.64 WTE are on ML and will improve ratio on return. Impact of this will not be seen until December 2022 onwards.	To continue with MCoC teams not currently within acceptable WTE and 24/7 provision there is a risk of 3 x 4 = 12
To pause CoC teams and redeploy into the maternity unit, there is a risk that: 1, women at greatest need currently on the CoC pathway will be negatively affected	Some MCoC teams have been set up in areas in of high social deprivation or care for a high proportion for women from Black, Asian and Mixed Ethnicities. Pausing all teams will impact on these women. Pausing all teams will negatively impact on the engagement work being undertaken to encourage midwives to work in a MCoC model and restrict the ability to	Should any of the teams in areas in of high social deprivation or care for a high proportion of women from Black, Asian and Mixed Ethnicities not have ability to provide MCoC without increased risk, a phased approach, to ensure all women currently on the caseload remain cared for, will be taken.	To continue with MCoC teams currently within acceptable WTE and 24/7 provision there is a risk of 2 x 2 = 4 To phase out MCoC teams currently not with acceptable WTE and 24/7 provision there is a risk of 2 x 2 = 4

	continue with a phased action plan to achieve the national ambition of providing MCoC as the default model of care.	Further women will be allocated traditional antenatal care.	To pause all MCoC teams there is a risk of 3 x 3 = 9

5.2. The risk assessment demonstrates that there is minimal risk to continue with MCoC teams which are fully established and able to provide 24/7 MCoC provision.

5.3. There is greater risk to continue with MCoC teams which are not fully established and unable to provide 24/7 MCoC provision.

Next steps

Team Bluebell (North Manchester)

6.1. To continue to support at the current level of provision with current MCoC team, monitoring outcomes of both achievement of continuity pathway and of staff wellbeing. A review of both outcomes will be undertaken every 3 months. As per the national letter, this is option 2A.

Team Rainbow (North Manchester)

6.2. On review of the current establishment, it is not possible to provide 24/7 MCoC provision without increasing the risk of burnout for existing team members. As such, Team Rainbow will only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

6.3. As the caseload begins to reduce the team should be supported to provide midwifery care for women in a traditional community model or hospital-based setting dependent upon the requests of individual team members and the needs of the service. This will positively improve the clinical caseloads in the area of redeployment by 2 WTE.

6.4. Whilst unlikely, due to the phased approach taken, should any women be affected by the suspension they will receive a personal communication detailing next steps and ensure that they receive appropriate follow up within a traditional or bespoke community model of care.

6.5. The team would support traditional models of care until such a time that a MCoC team can be reinstated with appropriate establishment to support 24/7 provision. It is likely that the Rainbow Team will alter the MCoC model and expand to ensure a sustainable MCoC model. This is option 2B.

Team M8 (North Manchester)

6.6. The suspension of the M8 team will remain in place until such a time that additional external recruitment into MCoC teams has been achieved, which will enable the team to provide all aspects of MCoC 24/7 provision. This is option 3.

6.7. The members of Team M8 have already been redeployed within the community and have improved some of the clinical caseloads. The team will continue to provide care in a traditional community model until external recruitment has been achieved.

6.8. There is a priority to recommence the M8 team as soon as safely possible to do so.

Team Lotus (Wythenshawe)

6.9. Currently the caseload numbers for Team Lotus, the model of care provided and the challenge to recruit additional team members make the current MCoC team unable to provide 24/7 provision. As such, Team Lotus should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs. This will positively improve the clinical caseloads in the area of redeployment by 3 WTE.

6.10. Midwives in Team Lotus should be safely supported into other areas of maternity provision until such a time that additional external recruitment into MCoC teams has been achieved, which will enable the team to provide all aspects of MCoC 24/7 provision. As per the national letter, this is option 3.

6.11. All women affected by the suspension should receive personal communication detailing the reason why the team is being suspended and ensure that they receive appropriate follow up within a traditional or bespoke community model of care.

Team Sapphire (Wythenshawe)

6.12. Currently due to significant staffing absences within the team and overall community service, maintaining a 24/7 MCoC provision is not possible.

6.13. It is recommended that Team Sapphire only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision until such a time that additional external recruitment into MCoC teams has been achieved, which will enable the team to provide all aspects of MCoC 24/7.This is option 2B.

6.14. As the caseload begins to reduce. the team should be supported to provide midwifery care for women in a traditional community model or hospital-based setting dependent upon the requests of individual team members and the needs of the service. This is likely to be within community services and improve staffing by 1.8 WTE as 3 WTE would be required to care for the 300 women already within the geographical area of the MCoC team.

Team Worth (Oxford Road)

6.15. The suspension of Team Worth will remain in place until such a time that additional external recruitment into MCoC teams has been achieved, which will enable the team to provide all aspects of MCoC 24/7. This is option 3.

6.16. The members of Team Worth have already been redeployed within the community and have improved some of the clinical caseload numbers. The team will continue to provide care in a traditional community model until external recruitment has been achieved.

6.17. There is a priority to recommence Team Worth as soon as safely possible to do so.

Team Lowry (Oxford Road)

6.18. There is a current vacancy of 1.4 WTE within Team Lowry, which includes 1 WTE currently on secondment for 3 months.

6.19. This short-term vacancy will be covered from within the traditional community team and bring the team to an acceptable establishment of 7 WTE to continue providing 24/7 MCoC provision.

6.20. A review of both achievement of continuity pathway and of staff wellbeing will be undertaken every 3 months. As per the national letter, this is option 2A.

Summary

7.1. Due to the current challenge in recruiting to MCoC teams externally and the significant risk to redeploying midwives from within current maternity establishment to MCoC teams, it is not possible to safely continue with plans for additional roll out of MCoC teams.

7.2. Should funding be provided and recruitment to the new funded posts be successful, SM MCS would look to continue with the phased approach to roll out MCoC as a default model.

7.3. Based on the risk assessments above, only existing MCoC teams with appropriate staffing to sustain 24/7 MCoC provision should continue. This is due to current vacancies within the teams which increases the risk of staff burnout and reduces the likelihood of women being in full receipt of MCoC pathways.

7.4. The midwives who are redeployed during MCoC teams being suspended will support current staffing gaps both within community and inpatient services.

7.5. SM MCS will continue with 2 MCoC teams which are able to provide 24/7 MCoC provision as appropriately staffed to do so.

7.6. SM MCS will review this risk assessment every 3 months, or earlier should any significant changes occur in the interim.

7.7. Whilst MCoC roll out is suspended, SM MCS will work to improve antenatal and postnatal continuity within traditional community models of care.

7.8. An updated action plan for MCoC, which considers the proposed changes to the teams above, will be provided to SM MCS Quality and Safety Committee in June 2022.

7.9. An update on the action plan will be shared with Hospital Board Maternity Safety Champions and Executive Board Maternity Safety Champion monthly, and to Trust Board of Directors bi-monthly.

Recommendation

8.1. The SM MCS Quality and Safety Committee is asked to approve MCoC next steps and support 2 MCoC to continue whilst suspending others which will support community and inpatient areas until staffing vacancies have been addressed.

Appendix B 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	• How many midwives required • How many in post • Recruitment plan to optimal midwifery staffing with time frames	
Communication and engagement	• Provides evidence of staff engagement and logs responses/counter responses • Gives opportunity to share vision • Whether or not you plan to do a consultation	
Skill mix	• Review of skill mix, including number of band 5 midwives placed in MCoC team. B5 midwives those working in the core ensuring appropriate support throughout. Band 5 (usually 1 per team) report being very well supported whilst undertaking preceptor programme.	
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.	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working	
Linked Obstetrician	Has there been obstetric involvement and linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?	
Standard Operating Policy (SOP)	Each Trust needs 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. Each Trust	

	needs to review and manage but there is helpful information in the NHSE/I toolkit	
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Where problems are encountered this should be escalated at Trust Board quarterly review and to ICS.	
Evaluation	There will be local, regional, and national evaluation and reporting in place. Is there a system for this to occur smoothly?	
Review Process	Date for initial plan to be review by Trust Board. Quarterly review dates set. Dates set for LMS and regional and national review.	

Appendix C
Saint Mary's North Manchester Workforce Modelling

Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care	4600

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	800
Out of area referrals	1300
Attrition	345
Total women not eligible	2445

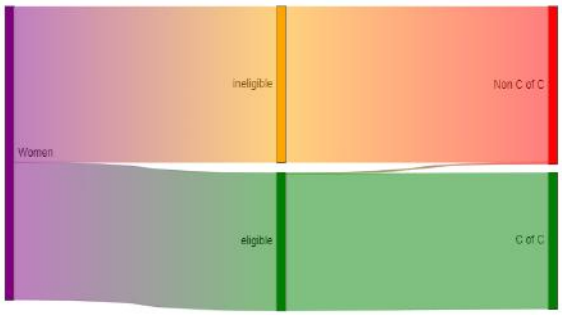
Total women eligible for full Continuity of Carer pathways	2155

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway	2,155 Women
Number of eligible women not on full C of C pathway	0 Women
Current budgeted establishment	173.09 WTE

Service Breakdown



Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	4,600 Women
- of which number not eligible for C of C pathway	2,445 Women
- of which number eligible for C of C pathway	2,155 Women
In this scenario 100 % of eligible women receive care on C of C pathway	2,155 Women
- Midwives required to provide C of C @ 1:36 ratio	59.86 Midwives
- No. of C of C teams required @ team size of 7.4	8 Teams
Total not cared for on Continuity of Carer pathway	2,445 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	127.10 Midwives
Workforce establishment required to provide care for all women	186.96 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 173.09 WTE	-13.87 Midwives

Midwives for 2,155 women on full Continuity of Carer pathway

Midwife to woman ratio

one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE
MWs per team (between 4 & 8)

7.4

You will need **59.86 Midwives** to look after **2,155 Women** on full Continuity of Carer pathway, working in **8 teams** of **7.4**

Midwives for 2,445 women not on full C of C pathway

These are the 2,445 women who are not eligible for C of C plus the 0% (0) not on full pathway

Midwife to woman ratio for 800 women requiring postnatal and antenatal care: one to 96

This will be **8.33 midwives** looking after **800 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 1300 out of area referrals (care for birth only): 17

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	62.49
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, FMU)	8.36
Specialist midwives (breast feeding, bereavement, etc)	16.32
Midwives in non clinical management (ward sisters, matrons)	14.6
Other	0
Total needed for minimum safe staffing	101.76999999999998

Appendix D Saint Mary's Oxford Road Workforce Modelling

Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care	10020

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	751
Out of area referrals	4600
Attrition	1000
Total women not eligible	6351

Total women eligible for full Continuity of Carer pathways	3669

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway	3,669 Women
Number of eligible women not on full C of C pathway	0 Women
Current budgeted establishment	351.83 WTE

Midwives for 3,669 women on full Continuity of Carer pathway

Midwife to woman ratio

one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE MWs per team (between 4 & 8)

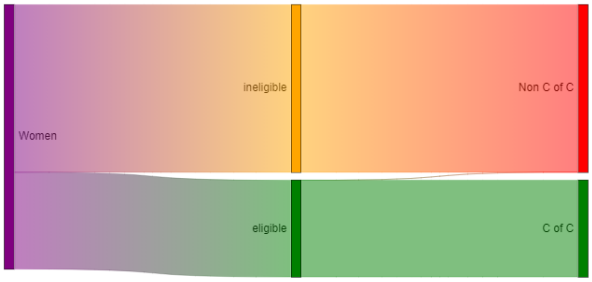
8

You will need **101.92 Midwives** to look after **3,669 Women** on full Continuity of Carer pathway, working in **13 teams** of **8**

Midwives for 6,351 women not on full C of C pathway

These are the 6,351 women who are not eligible for C of C plus the 0% (0) not on full pathway

Service Breakdown



Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	10,020 Women
- of which number not eligible for C of C pathway	6,351 Women
- of which number eligible for C of C pathway	3,669 Women
In this scenario 100 % of eligible women receive care on C of C pathway	3,669 Women
- Midwives required to provide C of C @ 1:36 ratio	101.92 Midwives
- No. of C of C teams required @ team size of 8	13 Teams
Total not cared for on Continuity of Carer pathway	6,351 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	299.12 Midwives
Workforce establishment required to provide care for all women	401.04 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 351.83 WTE	-49.21 Midwives

Midwife to woman ratio for 751 women requiring postnatal and antenatal care: one to 96

This will be **7.82 midwives** looking after **751 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 4600 out of area referrals (care for birth only): 56

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	127.4
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, FMU)	39.9
Specialist midwives (breast feeding, bereavement, etc)	23.4
Midwives in non clinical management (ward sisters, matrons)	27.6
Other	17
Total needed for minimum safe staffing	235.3

Appendix E – Saint Mary's Wythenshawe Workforce Modelling

Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care	5700

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	800
Out of area referrals	2280
Attrition	490
Total women not eligible	3570

Total women eligible for full Continuity of Carer pathways	2130

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway	2,130 Women
Number of eligible women not on full C of C pathway	0 Women
Current budgeted establishment	193 WTE

Midwives for 2,130 women on full Continuity of Carer pathway

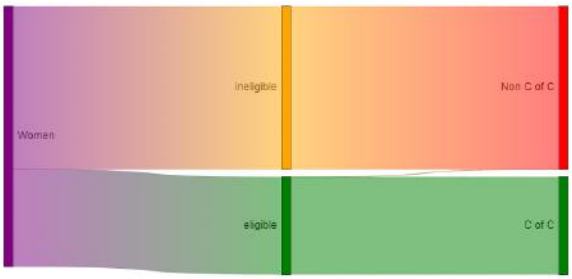
Midwife to woman ratio: one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE MWs per team (between 4 & 8): 7.4

You will need **59.17 Midwives** to look after **2,130 Women** on full Continuity of Carer pathway, working in **8 teams** of **7.4**

Service Breakdown



Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	5,700 Women
- of which number not eligible for C of C pathway	3,570 Women
- of which number eligible for C of C pathway	2,130 Women
In this scenario 100 % of eligible women receive care on C of C pathway	2,130 Women
- Midwives required to provide C of C @ 1:36 ratio	59.17 Midwives
- No. of C of C teams required @ team size of 7.4	8 Teams
Total not cared for on Continuity of Carer pathway	3,570 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	147.88 Midwives
Workforce establishment required to provide care for all women	207.05 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 193 WTE	-14.05 Midwives

Midwives for 3,570 women not on full C of C of C pathway

These are the 3,570 women who are not eligible for C of C plus the 0% (0) not on full pathway

Midwife to woman ratio for 800 women requiring postnatal and antenatal care: one to 96

This will be **8.33 midwives** looking after **800 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 2280 out of area referrals (care for birth only): 27.4

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	63.25
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, FMU)	19.23
Specialist midwives (breast feeding, bereavement, etc)	14.67
Midwives in non clinical management (ward sisters, matrons)	15
Other	0
Total needed for minimum safe staffing	112.15

Appendix F – MCoC Action plan

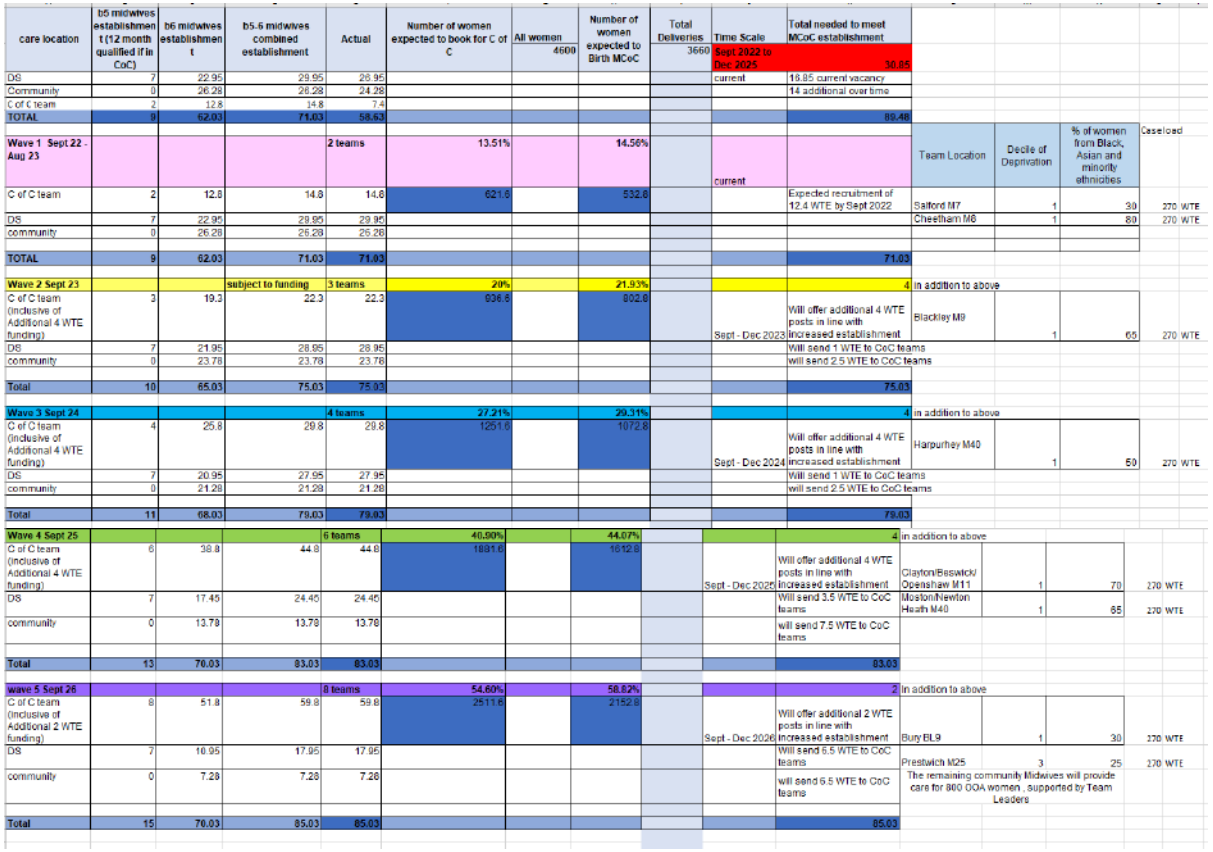
		Complete	In progress	Not due	Overdue

Action Number	Action	Narrative	Action taken by	Due by	Status as at 6.6.22
1	Review SM MCS against the 10 Building Blocks as identified by NHS E/I planning guidance	Apply RAG rating to each element within Building Blocks framework to ensure SM MCS able to scale up MCoC by March 2023	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
2	Undertake Safe staffing MCoC workforce modelling using recommended Workforce tool	SM MCS have completed as staffing review which has identified a staffing gap of 77 WTE required to implement MCoC as default model.	J Sager, DHoM K Watson, Consultant MW	29.11.21	Completed
3	Recruiting to baseline BR+ establishment in line with newly funded establishment following Ockenden investment	Ongoing recruitment plan in place	HoM's across SM MCS	ongoing	Ongoing. Challenges exist in recruiting to current vacancies. Ongoing rolling recruitment on all sites. Update May 2022 – 2 teams ongoing following risk assessment in relation to Ockenden. Will review in 3 months.
4	NHS E/I requirement for MFT Board of Directors to be cited on staffing gap identified and long-term trajectory to move towards default model of MCoC safely	SM MCS position, staffing gap and action plan for MCoC approval ahead of Trust Board 10.1.22.	K Murphy, Director of Nursing and Midwifery, SM MCS	20.12.21	Completed
5	Submit Board Paper to GMEC LMNS	Subject Board approved continuity action plan to GMEC LMS	K Murphy, Director of Nursing and Midwifery, SM MCS	11.1.22	Completed
6	Recruit 3.2 WTE Band 3 MSWs to continuity teams (ORC and Wythenshawe) using LMS funds	Develop job descriptions, advertise and recruit	Cons midwife, ORC comm matron	April 2022	2.6 WTE in post. Further recruitment paused due to suspension of MCoC teams. Will review in 3 months

7	Recruit 1 WTE Band 7 post (NMGH) to support further continuity team using LMS funds.	Advertise and recruit 12-month secondment	Comm Matron	August 2022	Recruitment paused due to suspension of MCoC team. Will review in 3 months
8	Request additional midwifery workforce funding	Following board review of SM MCS current position, link with GMEC LMNS to support a funding request to ICS for additional workforce required for SM MCS to achieve MCoC as default model.	Divisional Director, SM MCS DoF, SM MCS DoNM, MS MCS	May 2022	Ongoing. Financial bid submitted to LMS. Awaiting LMS update.
9	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	Ongoing. Talent attraction and senior acquisition service team working with maternity team to undertake focused advertising and recruitment drive for community/continuity.
10	Develop MCoC Communications	Share outcomes of MCoC teams regularly across SM MCS to improve awareness of MCoC models	Team Leaders of MCoC teams	April 2022	Ongoing. Newsletter in development. Reassessed following suspension of teams.
11	Develop SOP for MCoC	Create and submit SOP through divisional and hospital governance processes for approval, inclusive of linked obstetrician for each MCoC team	Team Leaders of MCoC teams Clinical Head of Division	May 2022	Ongoing. Meeting with Matrons and TL regarding SOP draft. Expected to be circulated for Divisional approval July 2022
12	Review Obstetric referral pathway	Review current obstetric referral pathways to support a link for MCoC. Resolve issues relating to increased workload, potential duplication for those requiring specialist care	HoM's and Clinical Head of Division	August 2022	Due to suspension of MCoC, this work has been paused. Further work to be completed to include referral pathway into SOP for MCoC
13	Undertake risk assessment following IEA from Ockenden 2	Review continuation of existing teams and undertake risk assessment	HOMs/Consultant Midwife	May 2022	Completed
14	Submit risk assessment to board		HOMs/Consultant Midwife	May 2022	Completed
15	Undertake LMS implementation assurance tool	Identify trajectory including details of all teams including those suspended	HOMs/Consultant Midwife	May 2022	Completed

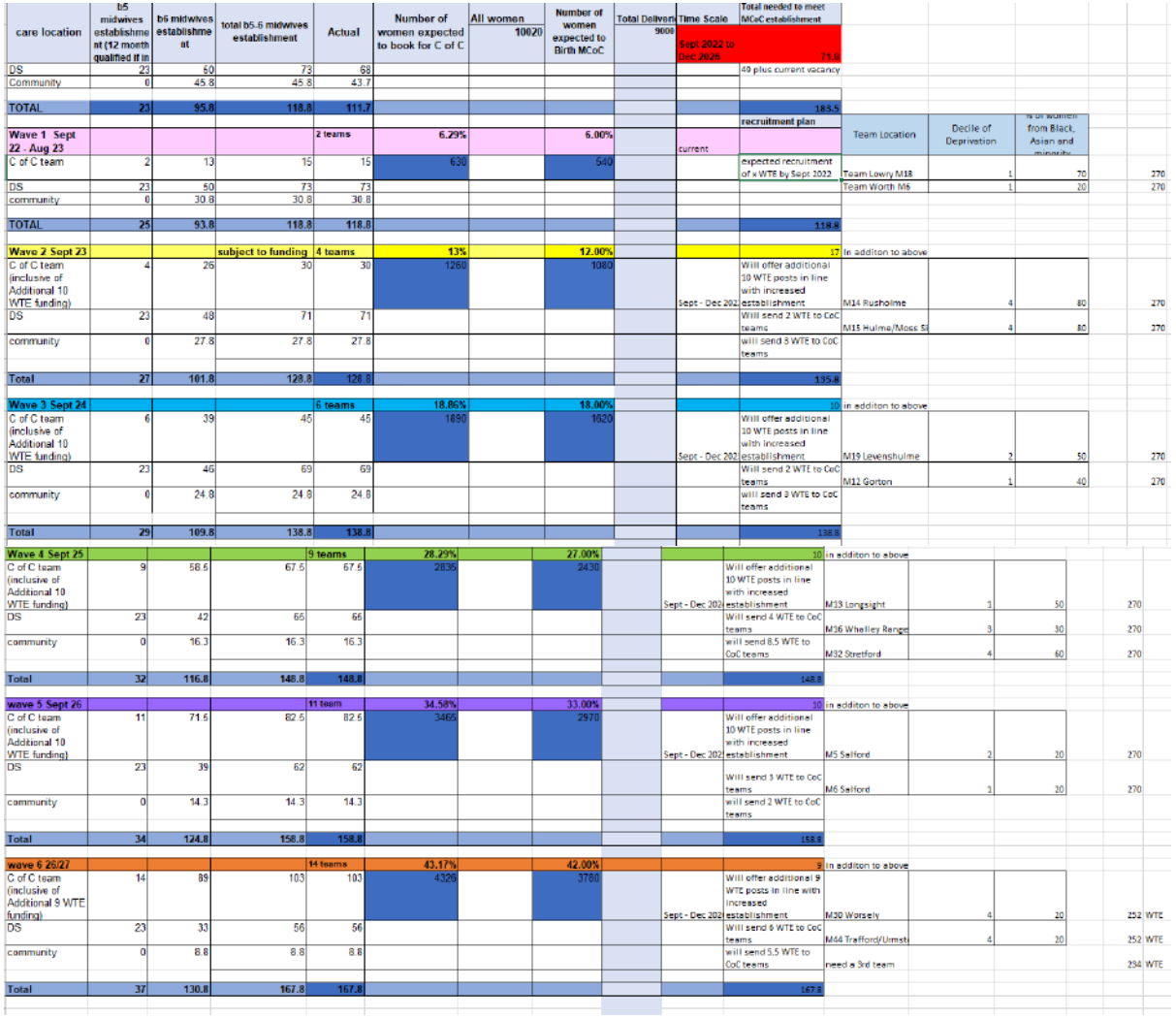
16	Re-submit amended board paper/implementation tool to LMS following approval by SLT		HOMs/Consultant Midwife	June 2022	
17	Review Staff training needs	Following EOI from staff wishing redeployment into Wave 2 MCoC teams, review individual needs using Self-Assessment Skills Log and support supernumerary shifts to achieve any additional requirements.	Community and Intrapartum Matrons across SM MCS Education Team	September 2022	Delayed due to suspension of MCoC teams
18	Review community hub provision	Review current community hub capacity to support Wave 2 roll out	Divisional Director for Obstetrics, SM MCS	September 2022	Delayed due to suspension of MCoC teams
19	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	Septmeber2022	Delayed due to suspension of MCoC teams
20	Wave 1	Review suspended MCoC teams with view to reinstate where possible	HOMs/community matrons	August 2022	
21	Review outcomes of current MCoC teams	Review clinical outcomes, patient and staff feedback, and implication on whole service	Community Matrons supported by HoM's	October 2022	
22	Wave 2	Commence Wave 2 Roll Out	Community Matrons across SM MCS	Sept 2023	

Appendix G – Saint Mary's North Manchester Planning Spreadsheet



care location	b5 midwives establishment (12 month qualified if in CoC)	b6 midwives establishment	b5.6 midwives combined establishment	Actual	Number of women expected to book for C of C	All women 4600	Number of women expected to Birth MCoC	Total Deliveries 3660	Time Scale Sept 2022 to Dec 2025	Total needed to meet MCoC establishment 30.85				
DS	7	22.95	29.95	26.95					current	18.85 current vacancy				
Community	0	26.28	26.28	24.28						14 additional over time				
C of C team	2	12.8	14.8	7.4										
TOTAL	9	62.03	71.03	58.63						69.48				
											Team Location	Decile of Deprivation	% of women from Black, Asian and minority ethnicities	Caseload
Wave 1 Sept 22 - Aug 23				2 teams	13.51%		14.56%		current					
C of C team	2	12.8	14.8	14.8	621.6		532.8			Expected recruitment of 12.4 WTE by Sept 2022	Salford M7	1	30	270 WTE
DS	7	22.95	29.95	29.95							Cheetham M8	1	80	270 WTE
community	0	26.28	26.28	26.28										
TOTAL	9	62.03	71.03	71.03						71.03				
Wave 2 Sept 23			subject to funding	3 teams	20%		21.93%			4	In addition to above			
C of C team (inclusive of Additional 4 WTE funding)	3	19.3	22.3	22.3	936.8		802.8		Sept - Dec 2023	Will offer additional 4 WTE posts in line with increased establishment	Blackley M9	1	65	270 WTE
DS	7	21.95	28.95	28.95						Will send 1 WTE to CoC teams				
community	0	23.78	23.78	23.78						will send 2.5 WTE to CoC teams				
Total	10	65.03	75.03	75.03						75.03				
Wave 3 Sept 24				4 teams	27.21%		29.31%			4	In addition to above			
C of C team (inclusive of Additional 4 WTE funding)	4	25.8	29.8	29.8	1251.6		1072.8		Sept - Dec 2024	Will offer additional 4 WTE posts in line with increased establishment	Harpurhey M40	1	50	270 WTE
DS	7	20.95	27.95	27.95						Will send 1 WTE to CoC teams				
community	0	21.28	21.28	21.28						will send 2.5 WTE to CoC teams				
Total	11	68.03	79.03	79.03						79.03				
Wave 4 Sept 25				6 teams	40.90%		44.07%			4	In addition to above			
C of C team (inclusive of Additional 4 WTE funding)	6	38.8	44.8	44.8	1891.6		1612.8		Sept - Dec 2025	Will offer additional 4 WTE posts in line with increased establishment	Clayton/Beswick/ Openshaw M11	1	70	270 WTE
DS	7	17.45	24.45	24.45						Will send 3.5 WTE to CoC teams	Moston/Newton Heath M40	1	65	270 WTE
community	0	13.78	13.78	13.78						will send 7.5 WTE to CoC teams				
Total	13	70.03	83.03	83.03						83.03				
wave 5 Sept 26				8 teams	54.60%		58.82%			2	In addition to above			
C of C team (inclusive of Additional 2 WTE funding)	8	51.8	59.8	59.8	2511.6		2152.8		Sept - Dec 2026	Will offer additional 2 WTE posts in line with increased establishment	Bury BL9	1	30	270 WTE
DS	7	10.95	17.95	17.95						Will send 6.5 WTE to CoC teams	Prestwich M25	3	25	270 WTE
community	0	7.28	7.28	7.28						will send 6.5 WTE to CoC teams	The remaining community Midwives will provide care for 800 OOA women , supported by Team Leaders			
Total	15	70.03	85.03	85.03						85.03				

Appendix H – Saint Mary's Oxford Road Planning Spreadsheet



care location	b5 midwives establishment (12 month qualified if in	b6 midwives establishment	total b5-6 midwives establishment	Actual	Number of women expected to book for C of C	All women 10020	Number of women expected to Birth MCoC	Total Deliveri 9000	Time Scale	Total needed to meet MCoC establishment Sept 2022 to Dec 2026 71.8				
DS	23	50	73	68						49 plus current vacancy				
Community	0	45.8	45.8	43.7										
TOTAL	23	95.8	118.8	111.7						183.5				
										recruitment plan	Team Location	Decile of Deprivation	% of women from Black, Asian and minority	
Wave 1 Sept 22 - Aug 23				2 teams	6.29%		6.00%		current					
C of C team	2	13	15	15	630		540			expected recruitment of x WTE by Sept 2022	Team Lowry M18	1	70	270
DS	23	50	73	73							Team Worth M6	1	20	270
community	0	30.8	30.8	36.8										
TOTAL	25	93.8	118.8	118.8						118.8				
Wave 2 Sept 23			subject to funding	4 teams	13%		12.00%			17	In additon to above			
C of C team (inclusive of Additional 10 WTE funding)	4	26	30	30	1260		1080			Will offer additional 10 WTE posts in line with increased				
DS	23	48	71	71					Sept - Dec 202	establishment Will send 2 WTE to CoC teams	M14 Rusholme	4	80	270
community	0	27.8	27.8	27.8						will send 8 WTE to CoC teams	M15 Hulme/Moss Si	4	80	270
Total	27	101.8	128.8	128.8						135.8				
Wave 3 Sept 24				6 teams	18.86%		18.00%			10	In additon to above			
C of C team (inclusive of Additional 10 WTE funding)	6	39	45	45	1890		1620			Will offer additional 10 WTE posts in line with increased				
DS	23	46	69	69					Sept - Dec 202	establishment Will send 2 WTE to CoC teams	M19 Levenshulme	2	50	270
community	0	24.8	24.8	24.8						will send 8 WTE to CoC teams	M12 Gorton	1	40	270
Total	29	109.8	138.8	138.8						138.8				
Wave 4 Sept 25				9 teams	28.29%		27.00%			10	In additon to above			
C of C team (inclusive of Additional 10 WTE funding)	9	58.6	67.6	67.6	2835		2430			Will offer additional 10 WTE posts in line with increased				
DS	23	42	65	65					Sept - Dec 202	establishment Will send 4 WTE to CoC teams	M13 Longsight	1	50	270
community	0	16.3	16.3	16.3						will send 8.5 WTE to CoC teams	M26 Whalley Range	3	30	270
Total	32	116.8	148.8	148.8						148.8	M32 Stretford	4	60	270
wave 5 Sept 26				11 team	34.58%		33.00%			10	In additon to above			
C of C team (inclusive of Additional 10 WTE funding)	11	71.5	82.5	82.5	3465		2970			Will offer additional 10 WTE posts in line with increased				
DS	23	39	62	62					Sept - Dec 202	establishment	M5 Salford	2	20	270
community	0	14.3	14.3	14.3						Will send 3 WTE to CoC teams will send 2 WTE to CoC teams	M6 Salford	1	20	270
Total	34	124.8	158.8	158.8						158.8				
wave 6 26/27				14 teams	43.17%		42.00%			9	In additon to above			
C of C team (inclusive of Additional 9 WTE funding)	14	89	103	103	4326		3780			Will offer additional 9 WTE posts in line with increased				
DS	23	33	56	56					Sept - Dec 202	establishment Will send 6 WTE to CoC teams	M30 Worsely	4	20	252 WTE
community	0	8.8	8.8	8.8						will send 5.5 WTE to CoC teams	M44 Trafford/Urmst	4	20	252 WTE
Total	37	130.8	167.8	167.8						167.8	need a 3rd team			294 WTE

Appendix I – Saint Mary's Wythenshawe Planning Spreadsheet

care location	b5 midwives establishment (12 month qualified if in CoC)	b6 midwives establishment	total b5-6 midwives establishment	Actual	Number of women expected to book for C of C	All women	Number of women expected to Birth MCoC	Total Deliveries	Time Scale	Total needed to meet MCoC establishment			
						5700		4900	Sept 2022 to Dec 2025	24.35			
DS (plus 1 per	14	27.65	41.65	40.95					current	14 additional over time			
Community	0	48.24	48.24	33.24						10.35 vacancy			
TOTAL	14	75.89	89.89	74.19						114.24			
Wave 1 Sept 22 - Aug 23				1 teams	6.43%		5.51%		current	0	Team Location	Decile of Deprivation	% of women from Black, Asian and minority ethnicities
C of C team	1	6.5	7.5	7.5	315		270			Expected recruitment of x W	M20	2	31
DS	14	27.65	41.65	41.65									
community	0	40.74	40.74	40.74									
TOTAL	15	74.89	89.89	89.89						89.89			
Wave 2 Sept 23			subject to funding	2 teams	13%		11.02%			18	in addition to above		
C of C team (inclusive of Additional 2 WTE funding)	2	13	15	15	630		540		Sept - Dec 202	Will offer additional 2 WTE posts in line with increased establishment			
DS	14	25.65	39.65	39.65						Will send 2 WTE to CoC tea	WA14 Warrington	2	14
community	0	37.24	37.24	37.24						will send 3.5 WTE to CoC teams			
Total	16	75.89	91.89	91.89						107.89			
Wave 3 Sept 24				3 teams	19.29%		16.53%			4			
C of C team (inclusive of Additional 4 WTE funding)	3	19.5	22.5	22.5	945		810		Sept - Dec 202	Will offer additional 4 WTE posts in line with increased establishment	Team Sapphire M23	3	19
DS	14	24.65	38.65	38.65						Will send 1 WTE to CoC teams			
community	0	34.74	34.74	34.74						will send 2.5 WTE to CoC teams			
Total	17	78.89	95.89	95.89						95.89			
Wave 4 Sept 25				5 teams	32.14%		27.55%			4			
C of C team (inclusive of Additional 4 WTE funding)	5	32.5	37.5	37.5	1575		1350		Sept - Dec 202	Will offer additional 4 WTE posts in line with increased establishment	M33 Barlow Moor/Sale	3	15
DS	14	20.65	34.65	34.65						Will send 4 WTE to CoC tea	M31 Partington	4	9
community	0	27.74	27.74	27.74						will send 7 WTE to CoC teams			
Total	19	80.89	99.89	99.89						99.89			
Wave 5 25/26				8 teams	51.43%		44.08%			4			
C of C team (inclusive of Additional 4 WTE funding)	8	52	60	60	2520		2160		Sept - Dec 202	Will offer additional 4 WTE posts in line with increased establishment	M22	4	20
DS	14	13.65	27.15	27.15						Will send 7 WTE to CoC tea	M23	4	20
community	0	16.24	16.24	16.24						will send 11.5 WTE to CoC te	M41	4	20
Total	22	81.89	103.39	103.39						103.89			

Appendix J – Self-Assessment Skills Log

CONTINUITY TEAM:

SELF-ASSESSMENT SKILLS LOG

This skills log has been developed as a self-assessment tool to guide individual midwives in identifying their professional development needs in preparation for work in a continuity team. It is NOT to be used as an assessment tool or as a tool to measure competency.

(Modified from 'The ACMI Midwifery Practice Development Self Assessment Inventory' by kind permission of Nicky Leap Director of Midwifery Practice, South Eastern Sydney and Illawarra Area Health Authority, Associate Professor of Midwifery, University of Technology, Sydney and visiting Senior Research Fellow Florence Nightingale School of Nursing and Midwifery, King's College London and Pat Brodie Professor of Midwifery Research and Practice Development University of Technology, Sydney.)

General skills, knowledge and experience

Midwifery skills/knowledge/experience	I am confident in this area	I will need to work on this	Comments
Understand the principles and challenges regarding women centred care and informed choice			
Confidently support women wishing to receive care during pregnancy and birth which may be outside of trust guidelines			
Understand indications for referral for obstetric care			
Able to access trust guidelines via intranet			
Familiar and confident to use current IT systems used in maternity i.e., Chameleon, K2, E3,CIMIS, (ICE)			
Facilitate and assess the educational needs of midwifery students			
Engage in reflective practice with peers and others. Knows how to access a PMA and/or RCS sessions			

Identify own needs for ongoing continuing professional development			
Document and record practice in contemporaneous, comprehensive, logical, legible, clear, concise and accurate notes			

Suggestions to help you achieve competency/confidence in the above areas:

Skills, knowledge and experience for antenatal care

Midwifery skills/knowledge/experience	**I am confident in this area**	**I will need to work on this**	**Comments**
Engage women in a comprehensive history taking			
Offer, explain and interpret all routine antenatal booking blood tests, investigations and ultrasound scans			
Undertake screening for domestic violence, including knowledge of advice/referral/ contact numbers			
Provide advice re early pregnancy bleeding, miscarriage			
Be able to discuss nutrition and lifestyle issues with women			

Undertake referral to and consultation with Specialist services within the trust i.e., Safeguarding, perinatal mental health, IDVA etc			
Knowledge of antenatal visit schedule (according to Trust guidelines)			
Assist the woman and her family in planning and preparing for birth and early parenting			
Can direct women to antenatal education resources			
Understand physical and emotional changes in pregnancy and the potential effect on women's lives and well-being			
Discuss place of birth options with women and family			
Discuss non-pharmacological and pharmacological options for pain relief in labour			
Discuss coping strategies for latent phase of labour			

Articulate the management of emergencies during pregnancy including APH, eclampsia, and cord prolapse			
Promote and facilitate homebirths			

Suggestions to help you achieve competency/confidence in the above areas

3. Skills, Knowledge and Experience for Midwifery during Labour and Birth

Midwifery skills/knowledge/experience	**I am confident in this area**	**I will need to work on this**	**Comments**
Support and management of women in latent phase of labour, and identification of transition into established labour			
Identify strategies for keeping birth normal			
Support women and their birth partners through labour			
Support women undertaking hypnobirthing			
Understand behavioural indicators of progress in labour			

Monitor and record labour progress and diagnose deviations from normal labour - refer to obstetric team/transfer to labour ward where appropriate			
Articulate strategies that prevent and address labour dystocia			
Understand the principles of fetal monitoring in labour and risk assessment for appropriate method			
Understand the indications for continuous fetal monitoring and interpretation of CTG			
Understand the advantages, the limitations and potential consequences of inhalation and opiate analgesia			
Understand the advantages, limitations and potential consequences of remifentanil analgesia, and manage labour with remifentanil analgesia			
Understand the advantages, limitations and potential consequences of epidural anaesthesia, and manage labour with epidural anaesthesia			

Understand the need for, limitations and consequences of oxytocin use (induction and augmentation)			
Perform vaginal examinations accurately including performing ARM and applying FSE			
Use IV equipment and administer drugs intravenously			
Perform venepuncture			
Perform cannulation			
Understand perineal management during birth including OASIS care bundle			
Understand evidence regarding episiotomy and perform when indicated			
Facilitate a normal birth			
Support women undergoing instrumental birth			
Facilitate a water birth, understanding advantages and limitations			
Perform immediate newborn assessment and resuscitation where needed			
Perform a shoulder dystocia drill			

Understand the advantages of and carry out a physiological third stage			
Understand the advantages of and carry out an active management of the third stage			
Perform a PPH drill			
Confidently undertake perineal repair including 1st & 2nd degree and labial tears			
Confidently identify severe perineal trauma requiring referral to obstetric team			
Understand principles of, promote and undertake optimal cord clamping			
Understand indications for the collection of cord blood			
Understand the importance of skin to skin contact and early feeding			
Support women undergoing procedure in theatre i.e., trial of instrumental birth, LSCS, MROP, perineal repair			
Understand adaptations for emergencies (shoulder dystocia, cord prolapse, PPH, neonatal resus) in the home environment			

Support and facilitate birth for women and families experiencing pregnancy loss			
Care for women who require ‘high dependency care’ on labour ward i.e., massive obstetric haemorrhage, pre-eclampsia, sepsis			

Suggestions to help you achieve competency/confidence in the above areas:

4. Skills, knowledge and Experience for Midwifery during the Postnatal Period

Midwifery skills/knowledge/experience	**I am confident in this area**	**I will need to work on this**	**Comments**
Discuss with the woman normal events and the signs and symptoms of common disorders of postnatal period			
Understand and be able to recognise postpartum infections and make appropriate referrals when necessary			
Understand emotional and psychological aspects of early parenting			
Identify signs of deteriorating mental health and referral to appropriate agency			
Understand the criteria for referral to for vulnerable babies			

Have knowledge of the principles of breast-feeding and management of common breast-feeding problems			
Facilitate breast-feeding using hands off techniques to promote successful attachment and foster women's self-reliance			
Demonstrate knowledge of nutritional needs of the newborn properties of breast milk and formula milk and methods of infant feeding			
Understand the pathways and referral process for weight management in the newborn			
Have knowledge of the stimulation and suppression of lactation			
Counsel and undertake newborn screening (NBS)			
Perform basic observations on newborn			
Appropriately trained to perform newborn and infant physical examination (NIPE)			
Have knowledge of the implications of hypothermia and hypoglycaemia and manage these according to Trust guidelines			

Understand and explain to women and the newborns caregivers the principles relating to prevention of SIDS			
Give advice to women and families relating to ‘shaking babies’			

Suggestions to help you achieve competency/confidence in the above areas

Please comment below re any other areas you feel have not been addressed:

Appendix K Additional Pay Requirements

Across Saint Mary's MCS

	Additionality per year cumulative	
	WTE Required	Cost required £000's
Recruitment 23/24	16.00	£991,035.80
Recruitment 24/25	18.00	£2,074,545.80
Recruitment 25/26	18.00	£3,158,055.80
Recruitment 26/27	16.00	£4,121,175.80
Recruitment 27/28	9.00	£4,662,931.32
	77	£15,007,744.52

Oxford Road (Additional costs each year)

Additionality per year		SM MCS Default Model	
WTE Required	Cost required £000's	Achieve MCoC Number	Achieve MCoC Percentage
10.00	£604,488.19	1152	31.40%
10.00	£601,950.57	1728	47.10%
10.00	£601,950.57	2592	70.65%
10.00	£601,950.57	3168	86.35%
9.00	£541,755.52	3669	100.00%
49	£2,952,095.42		

Wythenshawe (Additional costs each year)

Additionality per year		SM MCS Default Model	
WTE Required	Cost required £000's	Achieve MCoC Number	Achieve MCoC Percentage
2.00	£133,078.21	672	31.55%
4.00	£240,780.23	942	44.23%
4.00	£240,780.23	1482	69.58%
4.00	£240,780.23	2130	100.00%
14	£855,418.90		

North Manchester (Additional costs each year)

Additionality per year		SM MCS Default Model	
WTE Required	Cost required £000's	Achieve MCoC Number	Achieve MCoC Percentage
4.00	£253,468.33	893	41.44%
4.00	£240,780.23	1263	58.61%
4.00	£240,780.23	1757	81.53%
2.00	£120,390.11	2155	100.00%
14	£855,418.90		

Appendix L Additional non-pay requirements

Additional Non-Pay requirements

Add discription as per requirement	Additionality Non-recurrent £000's	Additionality Recurrent £000's
Fetal monitoring doppler FFY244 - £543.59	83386.706	
Blood pressure cuffFBF1643 - £7.80	1196.52	
Stethoscope FFE669 - £23.40 PCK 10	365.04	
SphygmomanometerFFE9947 - £34.80	5338.32	
ThermometerFWH225 - £1.06	162.604	
Pinard StethoscopeFFE682 - £15.60 PCK 10	243.36	
ScalesFDQ136 - £293.23 This includes bag	9148.776	
Community midwife bagWDC063 - £48.49	7438.366	
Maternal Scales	5803.2	
Opthalmoscope FER14211 £47.40	3775.2	
Sats Monitor	14664	
Vacu Aide portable suction	7816.9	
Oxylitre demand value unit	3458	
Smart Phone (£150 each)	23010	
Mobile phone contracts (£25)		£140,790.00
	165806.992	£140,790.00

	Additionality per year Non-recurrent £000's	Additionality per year Recurrent £000's
22/23	£28,728.00	£8,190.00
23/24	£29,800.16	£16,770.00
24/25	£43,705.75	£28,470.00
25/26	£48,431.54	£41,340.00
26/27	£15,141.54	£46,020.00
	£165,806.99	£140,790.00

Control Check (Should equal Zero)	£0.00	0

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	July 2022
Subject:	Trust Risk Appetite Statement 2022-23
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify ✓
Consideration against the Trust's Vision & Values and Key Strategic Aims:	This Risk Appetite Statement is relevant to all organisational priorities
Recommendations:	The Board of Directors is asked to ratify the Trust's Risk Appetite Statement, noting the process undertaken to develop it.
Contact:	Name: Miss Toli Onon, Joint Group Medical Director Tel: 10205

1. Introduction

The Risk Appetite Statement (RAS) sets out how the Trust balances threats and opportunities in pursuit of achieving its strategic objectives. Understanding and setting a clear risk appetite level is essential to achieving an effective risk management framework. Establishing and articulating the risk appetite level helps to ensure that the Trust responds to risk consistently, in line with a shared vision for managing risk. There are risks the Trust is exposed to, such as legal compliance, where its risk appetite is very low. Conversely there are risks related to transformation of services or research and innovation where some risk taking is expected.

The RAS forms a key element of the Trust's assurance and governance framework. The Board of Directors recognises that, in pursuit of its strategic objectives, it may choose to accept different degrees of risk in different areas. Where the Board of Directors chooses to accept an increased level of risk it will do so, subject always to ensuring that:

- benefits and threats are fully understood before actions are authorised
- it has sufficient risk capacity, with the effectiveness of existing controls fully understood
- proportionate measures to mitigate risk are established and monitored for effectiveness

Aligned to the Trust's Risk Management Framework and Strategy 2022-25, the Trust has agreed a boundary on the risk matrix, the 'risk appetite line' which is set at 15. Any risks rated at or above this level are escalated for consideration at the Group Risk Oversight Committee (GROC) and directly influence the assurances contained within the Board Assurance Framework. A risk score of 15+ is therefore treated as a trigger for a discussion as to whether the Trust is willing to accept this level of risk, given the risk controls and mitigations in place. Breaches of risk appetite escalated for discussion and resolution at GROC may indicate a need to review the RAS, since risk appetite is subject to change and needs to align with the organisation's strategic environment; and as such the RAS will be reviewed on a regular basis and at least annually.

2. Developing the Risk Appetite Statement

The RAS was developed through an iterative consultation with Board members, through a Board Development session, subsequent consensus focused deliberations by Executive Directors and further consultation with Non-Executive Directors. The RAS was developed using the strategic objectives of the Trust, consideration of the inherent and emergent risks associated with their delivery and used the Good Governance Institute's Risk Appetite for NHS Organisations; A matrix to support better risk sensitivity in decision making (2012) (see Annex 1) as a basis for the discussion and subsequent articulation of the RAS.

3. Risk Appetite Statement

'The Board of Directors recognises that the Trust's long-term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community and our strategic partners, is dependent upon the delivery of our strategic objectives.

A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective and given the challenging financial and operational environment that currently exists across the NHS, it is inevitable that a higher level of risk is inherent in these areas.

We are mindful that there must be consideration of the balance of risk across all domains, hence financial risk is considered alongside all others. Therefore:

- *We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk*
- *We believe that all regulatory standards, including clinical, professional, and financial standards, are the minimum that we need to achieve to be outstanding; we are strongly averse to any risk that could result in non-compliance with standards, or poor clinical or professional practice*
- *We are strongly averse to any risk where it involves potential exposure to significant harm for our people*
- *We will be cautious about any risk that could compromise data quality or data security in the context of performance and reputational risks; and we commit to continuous improvement in these areas*
- *We are open to taking opportunistic risk in improving the recruitment and retention of a diverse inclusive workforce, recognising the challenging recruitment environment*
- *We are open to taking opportunistic risk associated with the implementation of emerging technology. However, we seek to minimise exposure to cyber risk*
- *We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients'*

4. Recommendations

The Board of Directors is asked to ratify the Trust's Risk Appetite Statement, noting the process undertaken to develop it.

Annex 1

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Director of Corporate Business / Trust Secretary
Date of paper:	July 2022
Subject:	Board Assurance Framework (June 2022)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to accept the latest BAF (June 2022) which is aligned to the MFT Strategic Aims.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (June 2022)

1. Introduction

Significant risks to achieving the Trust's key strategic aims are reviewed and reported on at the Group Risk Oversight Committee (GROC) and through otherr established governance routes, dependent on the risk rating.

The Board Assurance Framework (BAF) presents the risks which have the most potential to impede MFT's delivery of its Strategic Aims. These risks are also overseen by the Board of Directors' Scrutiny Committees.

The Trust's Scrutiny Committees, on behalf of the Board of Directors, utilise the risks under their purview, alongside other sources of information, to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

At January's Board meeting, MFT's Strategic Aims for April 2022 onwards were agreed and these are incorporated into the BAF presented here.

Each year, MFT's Internal Auditor's, KPMG, review the BAF. At April's Audit Committee, they reported the results of this review and awarded a rating of 'Significant Assurance with minor improvements required'. Their recommendations were sent to the owners of each BAF risk for consideration whilst compiling their update for this Board meeting.

Following receipt of KPMG's assessment, discussions have begun with Executive Directors, Non-Executive Directors, KPMG and MFT's Group Director of Clinical Governance to consider how the BAF can be improved to ensure that it:

- focuses on providing assurance regarding progress toward achieving MFT's strategic aims;
- is directly linked to MFT's Strategic Risk Register and Risk Appetite statement; and
- is clearly formatted and user friendly

This work will be complete in time for a newly-formatted BAF to be presented to the Board of Directors at its November meeting – the next time is it scheduled to be discussed.

The BAF is received and noted 3 times a year by the full Board of Directors. The updated BAF for June 2021 is attached (**APPENDIX A**.)

2. MFT Strategic Aims (2022/23)

MFT's strategic aims are:

- *To focus relentlessly on improving access, safety, clinical quality and outcomes*
- *To improve continuously the experience of patients, carers and their families*
- *To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best*
- *To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future*
- *To use our scale and scope to develop excellent integrated services and leading specialist services*
- *To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve*
- *To achieve and maintain financial sustainability*
- *To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda*

3. Recommendation

The Board of Directors is asked to accept the latest BAF (June 2022) which is aligned to the MFT Strategic Aims (2022/23).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(July 2022)

Introduction

The Board Assurance Framework (BAF) is one of several tools the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the BAF each financial year, the potential risks to achieving the Strategic Aims are regularly assessed for inclusion on the framework. As such, all principal risks on the BAF are set out under each of the organisation's Strategic Aims.

The construct of the Trust's BAF is based on several key elements as follows:

- **Strategic Aims**
- **Principal Risk** & **Risk Consequence** – *'What is the cause of the risk?'*, and, *'What might happen if the risk materialises?'*
- **Inherent Risk Rating** – Likelihood & Impact (without Controls).
- **Existing Controls** – *'What controls/systems are currently in place to mitigate the risk'*
- **Gaps in Controls** – *'What Controls should be in place to manage the risk but are not?'*
- **Assurance** – *'What evidence can be used to show that controls are effectively in place to mitigate the risk?'*
- **Gaps in Assurance** – *'What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?'*
- **Current Risk Rating** – Likelihood and Impact (with Controls)
- **Actions Required** – *'Additional actions required to bridge gaps in Controls & Assurance'*
- **Progress**
- **Target Risk Rating** – Likelihood & Impact (*'Based on successful impact of Controls to mitigate the risk')*

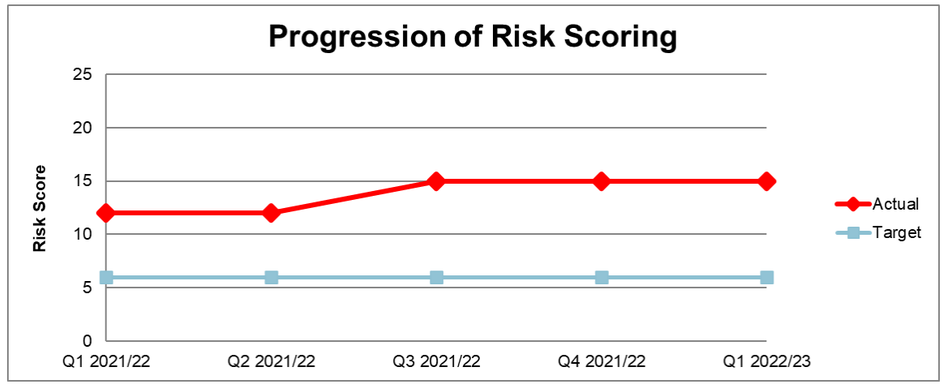
Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

	Likelihood				
Severity	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 Slight	2 Very Low	4 Very Low	6 Low	8 Low	10 Medium
3 Moderate	3 Very Low	6 Low	9 Low	12 Medium	15 High
4 Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5 Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

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

PRINCIPAL RISK (What is the cause of the risk?): There is a risk that we will not optimise the safety and the effectiveness of the care we provide if we do not identify, respond to and/or manage effectively opportunities for learning change and improvement in the safety and effectiveness of the care we provide	Enabling Strategy: **QUALITY AND SAFETY STRATEGY** Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Increased likelihood of harm to patients** 2. **Failure to design and/or transform services effectively and safely** 3. **Failure to ensure the maturation of our patient safety culture** 4. **Failure to eradicate 'Never Events'** 5. **Reputational damage because of safety concerns** 6. **Disengagement of and psychological distress of staff** 7. **Regulatory implications** 8. **Failure to provide evidence based and effective care** 9. **Sub-optimal/negative patient experience** 10. **Sub-Optimal patient outcomes**	Scrutiny Committee: **QUALITY AND PERFORMANCE SCRUTINY COMMITTEE** Monitoring Committee: **QUALITY AND SAFETY COMMITTEE** Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE** Material Additional Supporting Commentary (as required): The patient safety commentary detailed here covers all aspects of patient safety including but not limited to, clinical outcomes, infection control, clinical incidents (including never events), mortality review and harm free care.



Inherent Risk Rating Likelihood/ Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood /Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood/Impact *"Based on successful impact of Controls to mitigate the risk"*
16 **4x4**	A.1 Freedom to Speak Up (F2SU) programme and personnel A.2 Quality and Safety Strategy (22-25) A.3 Patient Safety Profile and Plan (including Site PSIRPs) A.4 Risk management strategy A.5 Patient experience strategy A.6 Safety Management system including PSIRF A.7 Safety Oversight System A.8 Infection Prevention and Control Standards A.9 LocSSIPS programme A.10 Quality and safety improvement collaboratives A.11 Incident reporting benchmarking A.12 Human Factors Academy A.13 Patient Safety alert management process A.14 Patient Safety Specialist Network A.15 Health and safety benchmarking A.16 Structured Judgement Review Programme/Mortality review A.17 Friends and Family test A.18 National Inpatient survey A.19 Other National Patient Surveys A.20 Complaint benchmarking A.21 CQC compliance action plan A.22Performance:RTT/ECS/Cancer benchmarking A.23 PLACE assessments A.24 Clinical Accreditation Scheme A.25 Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students) A.26 Data Security Protection Toolkit A.27 Mandatory Training Programme A.28 Medical Examiner System	B.2 F2SU not fully embedded B.4 National Patient Safety Training offer not formalised B.5 General Patient Safety training not in place B.6 Lack of patient and public involvement in patient safety B.7 Lack of embedded standard approach to quality and safety culture assessment and development B.8 Patient safety commitment not fully embedded into recruitment practice B. 9 Assurance processes in relation to NICE Guidance not fully effective B.10 Management processes in relation to the National Audit Programme not fully effective B.11 Lack of real time quality and safety data B.12 Lack of data quality kitemarking of patient safety data B.13 Lack of contemporaneous mortality and effectiveness data B.14 Integration of NMGH data post acquisition B.15 PSIRF implementation delayed B.16 Quality and Safety Strategy expires 2021 B.17 Approach to learning from death requires strengthening B.18 Lack of standardised approach to evidence presentation to regulatory bodies B19 Lack of consistent approach to assurance B20 Policy control sub-optimal	C.1 Trust safety oversight exception reporting detailing outputs of the safety management system ensuring learning and assurance) C.2 Monthly safety profiling of the Trust by exception C.3 Use of SPC to understand patient safety data C.4 Routine reports from patient experience/IPC/safeguarding C.5 Staff survey results C.4 Regulatory inspection processes C.6 Internal quality assurance processes (Internal Audit, Ward accreditation, Quality Review) C.7 AOF and patient safety metrics reporting (under review) C.8 CQC compliance reporting C.9 Assurance process in relation to effectiveness of actions following a significant patient safety event C.10 Internal audit reports C.11 Development of an assurance framework and map aligned to the regulatory framework C.12 Embedded patient safety and integrated risk governance structure C.13 Medical Examiners System	D.1 Patient safety event reporting does not routinely capture 'what went well' to enable safety II type learning D.2 All harm to patients may not be captured on the reporting system D.2 Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels D.3 Staff survey does not adequately capture full understanding of patient safety culture D.6 Patient safety metrics not yet fully reported on D.6 Lack of full understanding of finance and performance cost of harm D.7 Lack of understanding of the experience of staff in volved in patient safety events D.8 lack of understanding of the impact of inequality on patient safety and patient outcomes	**16** **(4x4)**	C.12 Refine policy oversight and Governance process B.2 Evaluate F2SU process and oversight C.12 Undertake 6 monthly assurance reviews of revised governance infrastructure B.4 Implement the strategic deliverables of the Human Factors Academy B.4 Review training needs analysis aligned to the Quality and Safety Strategy/PSIRF B.4 Develop local suite of patient safety training aligned to the TNA B.7 Develop a standard approach to the development, implementation and testing in relation to a MFT patient safety culture assessment tool B.7 Test the suite of interventions to support the development and maturation of patient safety culture B.6 Implement the National patient and public involvement in patient safety framework B.7 To develop and implement patient safety commitment standards to be included in job descriptions B.11/12 To make safety data count through the use of enhanced analytics, data quality kite marking and the development of a dashboard with benchmarked data B.11 To ensure safety and effectiveness governance is fully represented throughout the HIVE RDGs D.7 Deliver project 2v (second victim support) B.9 Develop a revised assurance process in relation to NICE guidance implementation B.10 Develop a revised assurance process in relation to the management of national and local clinical audit B.14 Develop an analytic strategy to ensure effective integration of NMGH data B.15 Continue to implement and embed the National Patient Safety Incident Response Framework (PSIRF) through a revised patient safety policy and a PSIRP B.16 Rewrite the Q&S strategy aligned to the CQC strategy, National patient safety strategy and all other relevant national strategy documents B.17 Strengthening of approach to learning from deaths including from SJR process, MEO, inquests, LeDeR external PFDs B18. Preparation of a guidance document on evidence preparation and presentation. Development and delivery of masterclasses on assurance processes B.20 Revise approach to accelerated improvement to policy management	Medical Directors/ Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business	December 2023	1. Sub-optimal progress continues in relation to safety critical policy review and testing. Additional resource secured and development aligned to HIVE integration. 2. Internal Audit of effectiveness of controls within risk management framework-Complete with significant assurance. 3. Internal Audit in relation to the learning from harm underway 4. External review of approach to learning from never events completed and shared vis Quality and Safety Committee 5. Group Safety Management System in operation since February 2021. Routine reports provided to Q&S and QPSC 6. Human Factors Academy Strategic Deliverables Units continue to have leadership and operational support to deliver requirements 7. Sub-group of Patient Safety Committee established to ensure delivery of national patient and public involvement in patient safety framework-progress with this initiative is positive and the Trust will meet the national deadline 8. Sub-group of patient safety committee established to ensure that we make patient safety data count 9. SPC used as standard for safety data 10. Safety II data being captured through Ulysses (Proxy through excellence reporting currently) 11. Membership of safety and governance team in a number of HIVE RDGs confirmed 12. Strengthened approach to the management of assurance processes associated with implementation of NICE guidance 13. Strengthened approach to the management of assurance processes associated with national audit 14. HED system now procured to support mortality and effectiveness data requirements 15. Risk in relation to Never Events reviewed and managed through GROC with a risk score of 20 16. Concerning profile of Never Events across the Trust, accelerated learning in place 17. Review of Quality Impact Assessment Tool underway to support assurance when services transition 18. Proposal in relation to a consistent approach to psychological safety across the Trust developed and subsequently approved by the Group Quality and Safety Committee	**8** **(4x2)**

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

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)

Enabling Strategy:
INFECTION PREVENTION AND CONTROL STRATEGY

Group Executive Lead:
GROUP CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):

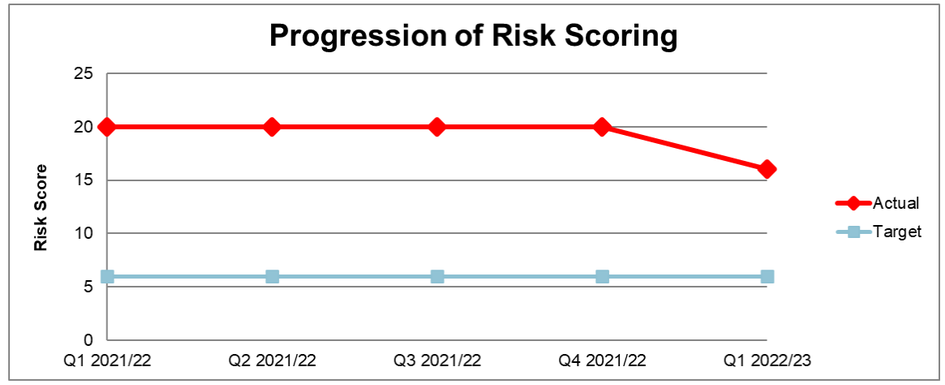
1. **Increase in serious harm to patients**
2. **Increase in nosocomial infections**
3. **Increase in staff outbreaks**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee:
INFECTION CONTROL COMMITTEE

Scrutiny Committee
QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Lead:
ASSISTANT CHIEF NURSE IPC/TV
CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood/Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	***A1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users*** – *All non-elective patients are screened upon admission* – *Preadmission screening implemented for elective admission* – *Screening protocols for patients discharged or transferred to another health care or residential setting in place – Joint Protocols are in place* – *Good infection prevention and control education and practice throughout the Group* – *Escalation plans in place as per trust gold command and GM Gold command* - *Response to COVID outbreak managed by Exec leads for EPPR and DIPC through Strategic Gold Command and escalated through this route to the Board of Directors, sub board committees including:* o *Risk oversight committee* o *Quality & Performance Scrutiny Committee* o *Group Infection Control Committee* o *COVID-19 Expert Group established - Microbiology and Virology support in place* - *Terms of reference for COVID-19 MDT refreshed and agreed through COVID-19 Strategic Group October 2021* – *Use of HPV/UVC in addition to PHE guidance* – *Covid and non-Covid clinical areas defined across the Trust. All Non-elective admissions tested and elective admissions as per guidance* – *Guidance for reducing isolation facilities produced in April 21 by the IPC team to support recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and patients safe.* – *Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced* – *Trust policy on managing patients who present with symptoms in place* – *Good infection prevention and control education and practice throughout the Group* – *PPE assessments in place* o *Use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment* o *Standard Operating Procedures developed for decontamination of visors* o *Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline*	*B1. Some COVID-19 positive individuals present at hospitals as asymptomatic patients* *B2.* *B3. Monthly AMS audits inform prescribing practices.* *B4. Plans need to be flexible as situation changes*	*C1. Patient streaming at access points. Emergency Department is zoned to provide designated areas.* *C1. LFD used in ED to inform patient pathway from ED, confirmatory PCR performed upon admission.* *C1. Screening of non-elective admissions recorded on ED systems* *C1. Screening of elective patients 48 hours prior to admission, SOP's developed.Screen results available via MFT systems* *C1. Weekly PCR screening of vulnerable patients* *C1. Joint Protocols are in place* *C1. Hospitals have identified green, yellow and blue patient areas.* *C1. Adoption of recommendation 1, to reduce physical distancing in low risk areas for elective patients in accordance with of UKHSA Guidance in place to facilitate patient flow.* *C1 HCAI Surveillance in place incorporating NHS guidance on probable/definite hospital acquisition*	*For All Existing Controls, plans need to be flexible as situation changes* *Hospitals to re-assess as situation evolve*	*16 (4X4)*	*E1. Hospitals have identified green, yellow and blue areas to support the flow throughout the patient journey.* *E1. Patient placement guidance in place* *E1.* *E1. All patients admitted via ED are screened for COVID-19, data is reviewed daily* *E1. Areas such as ICU, radiology and other areas which have a transient patient population are identifying flow throughout the departments to ensure risk level to patient minimized.* *E2. Increase of IPC support to COVID -19 Wards* *E2. Use of posters/videos FAQ's* *E2. Multiple communication channels – daily briefing/dedicated website* *E2. Microbiologist support* *E2. Virology support* *E2. 7 day working from IPC/Health and Wellbeing*	*ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL*	*September 2020*	*NHSE Infection Prevention and Control Board Assurance Framework re-issued on 24th December 2021. Significant changes have been incorporated for inclusion in Q4 BAF report. A standalone IPC BAF, that includes changes within the newly issued BAF will be presented to Group Infection Control Committee in January 2022.* *Through December 2021, assurance and controls have been assessed.* *against each indicator with mitigating actions in place. A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety.* *Plans in place to address gaps in assurance based on national guidance as available* *Patient placement guidance in place – further guidance for reducing isolation facilities produced in April 2021 by the IPC team to support elective recovery and non-elective patient flow by escalating and de-escalating areas.* *All patients admitted via ED are screened for COVID-19, using POCT and confirmatory PCR.* *Covid 19 Outbreak policy in place* *Developed guidance around the use of alternate PPE as required, monitoring of compliance with IPC practices is in place.* *Introduction of masks and face coverings*	***6 (3X2)***

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)
CONTINUED

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
	○ Fit testing databases are in place in hospitals/MCS, Trust level database under development ○ Fit testing databases are in place in hospitals/MCS, Trust level database under development ○ Variety of makes of FFP3 disposable respirators increased ○ Monthly PPE audit undertaken and monitored by Directors of Nursing - The training hub includes a series of COVID-19 training resources, local induction includes IPC measures. - A set of IPC principles in response to the Omicron variant have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. - National Cleaning standards implemented and MFT Cleaning policy ratified in April 2022. - Omicron variant less pathogenic therefore reduced patient admission to critical care services. - HCAI results communicated via the Trust daily alert database to all ward and department managers. **A2. The Trust provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** – Estates and Facilities /PFI partners and IPC Team meeting to review cleaning frequencies in line with updated guidance – Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative – Enhanced cleaning specifications in place for clinical and non-clinical areas. – Enhanced cleaning review undertaken and enhanced cleaning in place in areas where symptomatic patients are cared for in line with national guidance. – Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken – Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place – Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas – Signage on entrances – Screens in place at reception areas – Hygiene Programme of review of air flow and ventilation undertaken throughout the pandemic – All clinical waste related to confirmed or possible COVID-19 cases is handled managed in accordance with current national guidance	B5. patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital B5. Policy in place for wearing of facemasks in all areas B5. Point of care testing at implementation stage B7. Availability of some PPE B7. Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) B7. Some areas of estate particularly old and in poor condition	C1. Audit tool developed so individual wards and departments can audit compliance to the guidance. C1. Cleaning audits in place C1. Hand hygiene audits in place C1. PPE audits in place C1. Clinical Sub-Group in place to oversee adjusted or adapted systems and processes approved within hospital settings C1. Recording of staff concerns raised C1. Incident reporting system C2. Programme of training for redeployed staff including use of PPE, maintaining a safe environment C2. Bespoke training programme for Clinical leaders to become PPE expert trainers C2. IPCT undertake regular reviews/ and provide visible presence in cohort areas Staffing levels increased C.2 National Cleaning policy implemented C.2 Use of Hydrogen peroxide vapour (HPV) on a planned and responsive basis C3. Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC C3. From November the Group AMC will re-convene with quarterly meetings. 3 sub-groups to be established			E2. Domestic staff have access to EHWB services E2. Increase of IPC support to COVID -19 Wards E2. Use of posters/videos FAQ's Walk rounds led by IPC to review cleanliness of hospital facilities as required. E.2 Cleaning audit undertaken with monitoring teams in line with National Cleaning Standards. E.2 Regular monitoring of ward/departmental cleanliness undertaken by operational teams and reported via Quality care round tool E2. Use of window and other air filtration systems are being considered in older estate. E3. Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones.			week commenced 15th June 2020 Sitrep reporting for nosocomialoutbreaks in place Estates/environment review has progressed with permanent structures to entrances now in place Fit testing databases are in place in hospitals/MCS, all fit testing for FFP3 respirator captured and reported on the learning hub to enable robust reporting via Group Infection Control Committee Regular and up to date information is published in this Resource Area, including the following key topics: – Emergency Planning, Resilience and Response – Employee Health & Well Being – Research and Innovation for COVID-19 – Infection Prevention & Control Hospital/MCS COVID-19 Resources – Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. Increase in IPC team on call/availability out of hours rota Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased demand and that the service provision includes all clinical and non-clinical areas Estates and Facilities and IPC teams have undertaken a review of the clinical and non clinical cleaning responsibilities and this is included in the Cleaning policy.. Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital Point of Care Testing has been implemented in ED's	

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**									
PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111) CONTINUED										
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**EXISTING CONTROLS** *"What controls/systems are currently in place to mitigate the risk?"*	**GAPS IN CONTROLS** *"What Controls should be in place to manage the risk but are not?"*	**ASSURANCE** *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	**GAPS IN ASSURANCE** *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	**Current Risk Rating Impact / Likelihood** *"With Controls"*	**ACTION(S) REQUIRED** *"Additional actions required to bridge gaps in Controls & Assurance"*	**RESPONSIBILITY**	**COMPLETION TIMESCALE**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	**A3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** – Specific antimicrobial policies related to COVID-19 available on the Trust's Microguide platform. – Quarterly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) – Monthly antimicrobial stewardship (AMS) audits on all ward areas – Microbiology support available 24 hours a day. – Antimicrobial prescribing advice available from pharmacy 24 hours a day – IPC ICU ward rounds – Increased AMS support to COVID-19 cohort areas Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing		C3. Appropriate policies reviewed and approved by the AMC C3. Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. C3. Monthly antimicrobial stewardship (AMS) audits on all ward areas C3. Microbiology support available 24 hours a day. C3. Antimicrobial prescribing advice available from pharmacy 24 hours a day C3. ICU ward rounds C3. Increased AMS support to COVID-19 cohort areas C3. Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing. C4. Policies/guidance in Acute sector updated to reflect pandemic C4. End of Life Policy adapted for current need C4. Hand hygiene facilities and face coverings available at all Trust entrances to facilitate C4. Policy reviewed following further guidance and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission C4. NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed Visiting Policy available via Trust Intranet and information published on the Website C4.		16 (4X4)	E4. Website regularly to be updated by Comms/EPPR Team E5. Assessment underway against new National Cleaning Standards. All scores are displayed at ward dept entrances. Stage 2 – electronic monitoring to be full implemented by April 2022		September 2020	Continue to cohort patients as per policies Anti-Microbial strategy developed, and reporting to the Medicines Optimisation Board and Group Infection Control Committee 3 sub-groups of AMC formed including - Guidelines and development group - Education and training interventions Research quality improvement and audit	**6 (3X2)**
	A4. The Trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion – Visiting Policy in place and updated in line with national guidance – Patient Information leaflets in place – Ward/Department information displayed at entrances – Notification of any hospital outbreaks to NHSE via national reporting database – Staff outbreak informed by the test and trace national policy – Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical face mask when moving around the hospital – Patient/visitor information visible at entrances to wards and departments.								Guidance is in place, aligned to UKHSA directions that support staff returning to work following identification as a contact or following COVID-19 infection.	

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)
CONTINUED

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	**A5. The Trust ensures prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people** - Test and trace implemented nationally - Staff outbreak informed by the test and trace national policy - Patients who develop symptoms are tested again and the trust has UKHSA guidance in place on the testing of patients at 1,3, 5-7 days and every 7 days thereafter in vulnerable patients - Trust has an internal test and trace policy - Outbreak policy in line with NHSE guidance - Outbreaks contained and reported to NHSE/I - Executive and DIPC oversight of externally reported data - Screening and triage of patients by staff trained as per IPC guidelines is in place - Symptomatic patients isolated and screened using PCR **A6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection** – Widespread implementation of UKHSA Personal Protective Equipment (PPE) guidance in all areas of the organisation including both Aerosol Generating Procedures (AGP) and non AGP procedures – There is separation of patient pathways with symptomatic patients cared for in isolation/cohort wards. – Additional hand hygiene facilities are available at all entrances/exits to the hospital buildings and at entrance and exits to clinical areas – Seating in communal areas are placed to encourage physical distancing – Corridor floor signed to encourage 'keep left' principles – Frequent decontamination of equipment and environment in both clinical and non-clinical area, – Communication with procurement/materials management – Implementation of appropriate face masks for staff, patients and visitors to the organisation as per recent UKHSA guidance – Provision of PPE education to senior members of staff to support local implementation of PPE policy – Regular audit and reporting of hand hygiene and PPE usage in clinical areas – Working with Employee Health & Wellbeing and Equality and Diversity to ensure staff who have issues relating to the use of face masks have risk assessments and alternate provision to PPE as required – Staff advised on how to decontaminate uniforms in accordance with NHSE guidance – Temporary staff changing facilities identified on COVID-19 wards – Trust complies with national guidance – EHWB service provides staff support.		C4. Screens in place at reception areas C4. C5. Patient streaming at access points in place at all ED access C5. Policy of testing by conventional PCR will continue whilst the trust continues to develop point of care testing PCR to include elective patients in further rollout C8. Screening Triaging and Testing policy updated in line with national guidance		16 (4X4)		ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020		**6 (3X2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)
CONTINUED

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*
25 (5x5)	**A7. The Trusts has provision for / can secure adequate isolation facilities** – patients are cohorted according to clinical presentation – risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission – Isolation of Infectious Patients Policy in place – programme of review of air flow and ventilation undertaken throughout the pandemic – There is separation of patient pathways with one way flow systems and restricted access / egress points as appropriate. Restricted access is in place, with clear signage in support of IPC measures. – Additional hand hygiene facilities are available at all entrances/exits to the hospital buildings and at entrance and exits to clinical areas – Seating facilities in communal areas are marked to encourage 2m distancing – Corridor floor signed to encourage 'keep left' principle – Guidance for reducing isolation facilities produced in April 2021 by the IPC team to support recovery whilst still maintaining IPC measures and keeping staff and patients safe. **A8. There is secure adequate access to laboratory support as appropriate** – UKAS accredited PHE laboratory conducting testing for NW of England – Screening of non-elective patients in place – Hospitals/MCS putting in place pre 48 hour testing for elective admissions – Policy for staff screening is in place – MFT site of PHE host laboratory and has capacity for extensive screening, – Screening for alert organisms continued in line with trust policy – Tracking systems are in place to support priority screening and results availability – Turnaround times are measured (additional transport is in place to improve travel time for specimens from site to laboratory) – Recommendation 2 of UKHSA has been partly supported. The trust will continue with current policy of testing by conventional PCR and continue to develop point of care testing using LFD to include elective patients in further rollout **A9. The Trust has and adheres to policies designed for the individual's care and provider organisations that will help to prevent and control infections** – Programme of training for redeployed staff including use of PPE, maintaining a safe environment in accordance with UKHSA guidance. – Bespoke training for Clinical leaders to become PPE expert trainers – Mandatory training in place – Plans for staff testing in high risk situations. – Use of posters/videos FAQ's – Multiple communication channels – daily briefing/dedicated website – Microbiologist support – Virology support – 7 day working from IPC/Health and Wellbeing – Guidance updated on intranet and communicated daily via email – All waste associated with suspected or positive COVID-19 cases is treated as normal infectious waste (orange waste stream sent for alternative treatment to render safe before incineration or landfill) – Staff follow Trust waste management policy – Healthcare waste e-learning module is mandatory for all clinical staff, based on waste management policy. – All bins are labelled to indicate which streams they have been designated for. **A10. The Trust has a system in place to manage the occupational health needs and obligations of staff in relation to infection** – Widespread implementation of PHE Personal Protective Equipment (PPE) guidance in all areas of the organisation including both Aerosol Generating Procedures (AGP) and non AGP procedure – Working with Employee Health & Wellbeing and Equality and Diversity to ensure staff who have issues relating to the use of face masks have risk assessments and alternate provision to PPE as required – EHWB Policy in place – Employee Health and Well Being Service COVID-19 Guidance and Support available via Trust intranet – Staff complete a COVID-19 self-risk assessment, electronically stored – Staff have access to a wide range of physical and psychological support services provided by the Employee Health and Wellbeing Service. – Staff who are working remotely can also access support. – Details of all EHW Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely. – EHW/OH advice and support is available to managers and staff 7 days a week. – Policies are in place to support staff who fail to be adequately fit tested. – A centralised database developed to support the reporting of staff fit testing compliance. **A11. Test and trace implemented nationally** - Staff outbreak informed by the test and trace national policy **A12. COVID-19 Staff Vaccination Programme in place** - NHSE/I Directions and guidance cascaded through Strategic oversight group. This includes PHE publication of updates to Chapter 14a of The Green Book. - Links established with GM Oversight group - Chief Nurse has executive oversight of MFT vaccination programme - All staff have been offered the vaccine - A dashboard is in place to monitor staff take up of vaccination

2	Strategic Aim: To improve patient safety, clinical quality and outcomes
PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111) CONTINUED	
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*
	A12. Escalation plans in place as per trust gold command and GM Gold command - **Communication:** -Guidance cascaded through Strategic Oversight group -Regular communications email sent to all staff -IPC Team daily visit to clinical areas -Attendance in wards/departments -Weekend IPC team provision -IPC team have developed reference posters for staff -Guidance on staff intranet - - **Oversight:** Response to COVID outbreak managed by Exec leads for EPPR and DIPC through Strategic Gold Command and escalated through this route to the Board of Directors, sub board committees including: Risk oversight committee Quality & Performance Scrutiny Committee Group Infection Control Committee COVID-19 Expert Group established - Microbiology and Virology support in place

Strategic Aim: **To focus relentlessly on improving access, safety, clinical quality and outcomes**

PRINCIPAL RISK (MFT/004513):

Under delivery of activity / capacity which will impact on achievement of national operational standards for urgent and elective care, including cancer and diagnostics, due to issues of demand pressures, capacity, workforce and estate constraints, and ongoing incidence of Covid across our hospitals / MCS.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284).

Following the merger of North Manchester General Hospital and MFT in April 2021, work continues to disaggregate residual service elements and should be taken into account when considering delivery risks.

Enabling Strategy:
- Quality & Safety Strategy
- Transforming Care for The Future Strategy

Group Executive Lead:

Group Director of Operations

RISK CONSEQUENCES

1. Increased risk of serious harm to patients
2. Poor patient experience
3. Reputational damage to Trust
4. Low system confidence – increased scrutiny from regulators

Associated Committee:
Quality & Safety Committee

Scrutiny Committee:
Quality and Performance Scrutiny Committee

Operational Leads:
Hospital / MCS Chief Executives

-

Key performance Indicator	Standard	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A&E 4 Hour Access	95%	67.0%	63.4%	62.5%	63.8%	63.5%
RTT <18 weeks %	92%	50.6%	50.5%	49.5%	47.7%	50.1%
52 - Week breaches	-	13,580	13,795	13,734	14,613	15,608
Incomplete Waiting List	-	156,475	157,589	159,107	160,262	164,237
12-hour trolley waits	0	288	54	69	127	21
DM01 Diagnostics % >6 wks.	1%	35.7%	27.1%	26.6%	29.3%	TBC
Cancer 2ww	93%	56.1%	64.6%	61.6%	59.8%	65.6%
Cancer 31 days	96%	74.6%	87.2%	91.0%	87.2%	TBC
Cancer 62 days	85%	33.8%	44.8%	55.5%	48.4%	TBC

- Diagnostic performance data delayed due to NCA IT Outage affecting NMGH

Inherent Risk Rating Likelihood/ Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood/ Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"Based on successful impact of Controls to mitigate the risk"*
20 (4x5)	MFT Covid Governance Framework established including: 1.1. Response & Recovery Group - chaired by GDO 1.2. Operational Response - Hospital Management 1.3. Regional Covid Governance Structure, which MFT is represented at including: 1.4. GM Gold 1.5. Hospital / Community Cells 1.6. NW EPRR Single Point of Contact 1.7. On call Structures have been revised and adapted to support the hospital/MCS response to the pandemic and ongoing covid incidence, in addition to business-as-usual operational running. Further supported by the strategic management arrangements. 1.8. In line with national planning guidance for 21/22, H2 activity planning was submitted. This includes performance trajectories for managing urgent (inc. Cancer) and longest waiting patients. 1.9. Reporting in place to track activity levels against the revised planning expectations and associated performance trajectories. 1.10. MFT Recovery programme established following wave one of the pandemic, underpinned by several workstreams several which focus on recovery of activity levels and associated performance against national operational standards related to: Outpatients, Elective Access, Cancer, Urgent Care. This group	2.1 Currently assessing the requirements of 2022/23 planning guidance to ensure Performance Management Frameworks are aligned to new guidance.	3.1 Reporting to the Executive Board and Committees in relation to the Covid Pandemic, Recovery programme and performance. 3.2 Daily Response & Recovery Group meetings who regularly scrutinise performance of UEC, elective and Cancer 3.3 Minutes and papers relating to Trust Committees. 3.4 Hospital Activity, capacity, and annual plans 3.5 Internal/external audits of data quality 3.6 Annual Review and NHSI sign off Trust Access Policy	4.1 Appropriate review and action plans for performance improvement of elective slot utilisation	15 (3x5)	5.1. Key actions are outlined in the Risk Report to the Group Risk Committee. 5.2. Overarching MFT recovery programme in response to the Covid19 pandemic, of which the outpatient, elective, urgent care, and cancer workstreams align to national constitutional standards. 5.3. Urgent Care and Flow transformation workstreams continue to progress work aimed at a reduction in footfall in type 1 EDs across MFT. Supporting development of specific MFT and site-based programmes of work and actions to deliver performance improvements. 5.4. Effective management of elective waiting lists to ensure that MFT treats its most clinically urgent patients first. 5.5. Deliver programmes of activity to increase delivery of outpatient activity, reduce wait times, and optimise virtual technologies and other transformational aspects to improve patient access and experience. Other priorities include waiting list clinical triage and demand management protocols. 5.6. Cancer Workstream focus: Endoscopy capacity, implementation of rapid diagnostic centres, implementation of best practice pathways, continued roll out of the Living with and Beyond Cancer programme and the Cancer Excellence Programme both of which were in place prior to covid, linking in with GM Cancer and GM Surgical Cancer Hub. 5.7. Diagnostics: is incorporated within a number of recovery workstreams, in addition, the Trust is linking into GM structures for Diagnostics. 5.8. Workforce is a key element to all recovery workstreams, with HR representatives on these groups to ensure the workforce implications are considered and addressed.	David Furnival	Ongoing throughout 2021/22	6.1 Improved flow through ED departments maximising the use of appointments within the UTC services, and streaming patients to SDEC services 6.2 Additional discharge to assess capacity has been commissioned to improved flow and minimise the number of patients in beds who do not meet the criteria to reside 6.3 Use of Trafford as a green site and reallocation of theatres based on 104ww demand: ensuring that specialties with the largest elective backlogs and long-waiters can access theatre capacity 6.4 Maximising the use of the Independent Sector to reduce long waiting routine patients 6.5 Patient Initiated Follow Up: implemented PIFU in>50 specialties in order to support patient choice and ensure patients are only followed up in outpatients where this is needed. 6.6 Virtual Triage: implementing consultant-led electronic triage of all GP referrals to ensure patients are seen right place, first time, reducing levels of inappropriate first appointments and maximising the efficiency of non-admitted pathways.	15 (3X5)

2	**Strategic Aim: To focus relentlessly on improving access, safety, clinical quality and outcomes**

PRINCIPAL RISK (MFT/004513): Under delivery of activity / capacity which will impact on achievement of national operational standards for urgent and elective care, including cancer and diagnostics, due to issues of demand pressures, capacity, workforce and estate constraints, and ongoing incidence of Covid across our hospitals / MCS. This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284). Following the merger of North Manchester General Hospital and MFT in April 2021, work continues to disaggregate residual service – CONTINUED

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
	has been superseded by Response & Recovery Meetings 10/21 to support MFTs revised Senior Operational Corporate Structure 1.11 Governance and reporting structure in place to support the Recovery Programme, with a Response & Recovery Group established, and routine reporting into the MFT Executive Team. 1.12 MFT Board and Committee activity and performance reporting in place 1.13 MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.14 Patient Access Policy 1.15 MFT EPRR Policies and Plans to support organisational response to Major Incident and Business Continuity incidents 1.16 MFT EPRR Governance Framework including: • MFT EPRR Committee • Hospital Site Forums • MFT EPRR annual assurance statement, against the national core standards for EPRR which underpin the Trust compliance with the Civil Contingencies Act. Associated action plans in place, and reporting / assurance against these has been provided to the Trust Quality and Performance Scrutiny Committee, with delivery of action monitored through the MFT EPR Committee. 1.17 Audits are routinely undertaken, by internal and external audit, around the national constitutional standards to provide assurance of performance reporting to the Board of Directors. 1.18 Covid contact tracing 1.19 Vaccination programme 1.20 Transformation plans on Urgent Care and Flow and elective workstreams have been implemented and continue to be developed 1.21 H2 planning submission 11/21 to continue to support recovery of activity and therefore delivery of performance								

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

PRINCIPAL RISK (What is the cause of the risk?): If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm

Enabling Strategy:
QUALITY & SAFETY STRATEGY

Group Executive Lead:
CHIEF NURSE

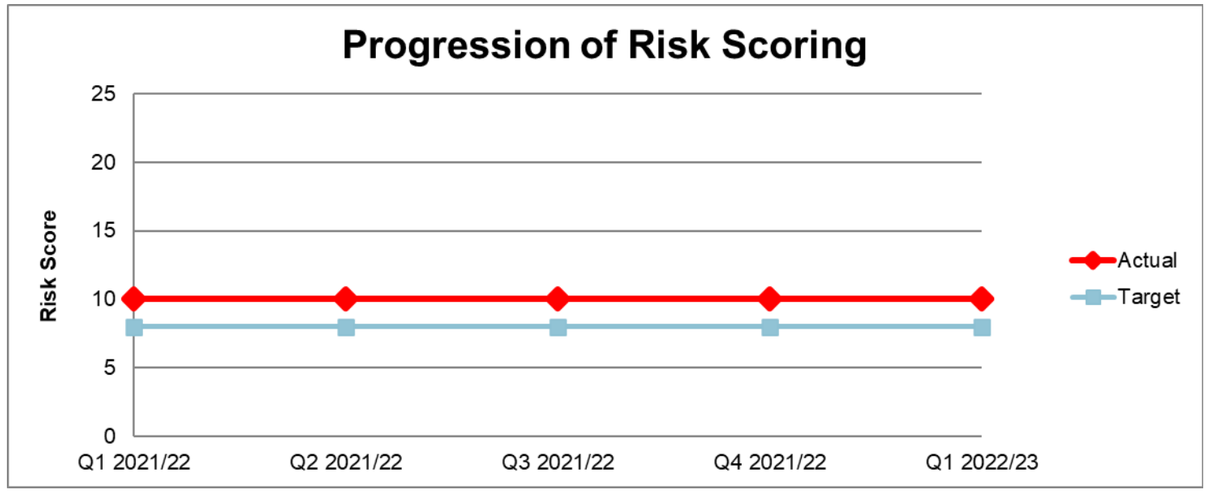
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Adults and children at risk of abuse or neglect may come to harm**
2. **Failure to comply with statutory and regulatory safeguarding standards**

Associated Committee:
SAFEGUARDING COMMITTEE

Scrutiny Committee:
QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Lead:
DEPUTY CHIEF NURSE /ASSISTANT CHIEF NURSE (SAFEGUARDING)



Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x impact *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/ Healthcare Professionals accountable for safeguarding within each hospital/MCS/LCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at all levels of the safeguarding Partnership Arrangements to support statutory duty to cooperate. A7. Safeguarding adults and children's training programme in place as per Intercollegiate guidance underpinned by learning from Adult and Children Practice Reviews/DHRs. A8. Safeguarding Supervision process in place. A9. Learning Disability flag in place to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend.	B1. Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) are of inconsistent quality B2. DoLS applications are often not authorised by Local Authority due to lack of capacity B3. Level 3 Safeguarding training compliance is below the required threshold of 90% B4. The Trust is not yet compliant with the changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult safeguarding training	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/LCO annual Safeguarding Work Programme, monitored by Safeguarding Team. C3. Annual Hospital/MCS/ LCO safeguarding assurance processes, observed by NED, to assess compliance with CQC and statutory requirements. C4. Completion of SCR actions - reported to the Safeguarding Committee. C5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. C6.Submission of safeguarding adults Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data	C3 Annual assurance process stepped down during Covid-19 response.	**10 (2x5)**	B1. Deliver MCA and DoLS training to relevant staff through Level 3 Adult Safeguarding Training B1. Audit the quality of MCA assessments and DoLS applications B2. Submit DoLS applications in accordance with statutory requirements B3. Deliver targeted safeguarding training to meet Intercollegiate requirements B4. Hospitals/MCS/ LCO to deliver agreed trajectories B5. Develop Business Case to increase capacity to meet patient needs B6. Finalise and launch a System-wide LD and/or autism Strategy B6. Deliver the Trust's LD work plan	Assistant Chief Nurse (Safeguarding)	March 2021	A11.CPiS system is in place across all urgent care settings in the Trust in all areas except for maternity triage at NMGH, Wythenshawe hospital and Oxford Road Campus. Assurance however can be provided that there are robust processes in place at each site to ensure child protection information is shared prior to the implementation of the system through HIVE in September 2022. During the IT outage in NMGH in May the CPiS system was not accessible, and a business continuity plan was implemented. Restoration of CPiS system at NMGH has identified that it is not consistently used in NMGH ED and there is ongoing plan to address this The EPIC / HIVE team have advised that CP-IS will be integrated into HIVE. B1. Training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) is delivered as part of the Adult Safeguarding Level 3 training (compliance is shown at B3 below). Additional bespoke MCA training is being delivered and podcasts on the Mental Capacity Act are available to all staff on the safeguarding intranet site. At the end of Q4 **71%** of staff who are mapped to level 3 Adult Safeguarding training had completed the training In addition staff can access face to face and online MCA/DoLs seminars, available at WTWA, ORC and NMGH monthly The Mental Capacity Act policy and Deprivation of Liberty Safeguards policy were reviewed 2021/22. The Safeguarding Audit Calendar includes review of the application of the DoLS process across the hospitals/MCS/LCO. Audits completed in 2021/22 identified that further development work is required to ensure consistent application of the DoLS processes across the Trust. These can be booked through the Trust Learning Hub. Two Mental Capacity/Mental Health Officers are in post – a part of their role is to monitor the quality of the DoLS applications submitted to the Local Authority and to support staff training. NMGH use the Evolve system to support DoLS applications which was impacted by the NMGH IT outage in May 2022 and the Ulysses system used across the remaining MFT footprint was implemented for DoLS applications as part of the business continuity plan. B2. The number of DoLS completed and appropriately sent to the LA has improved by nearly 50% (figures taken from audit completed December 2021). At the end of Q4 only **4** DoLS applications were authorised from **1088** applications with **609** applications still awaiting assessment. A process has been agreed with Manchester LA for an urgent notification system to escalate DoLS referral for specific cases. This is highlighted by the Trust safeguarding team where there is evidence of increased levels of restriction, with continuous level of supervision for the patient. The aim is Manchester LA DoLS manager is able to escalate the BIA assessment to confirm or rescind the DoLS in response to the specific request. B3 and B4 - Role requirements/competencies have been matched in accordance with the revised Intercollegiate Guidance. Improvement plans have been developed and implemented by the Directors of Nursing to improve compliance. Overall safeguarding training compliance at the end of Q4 was **87.85%** compared to a Trust target of 90% and a CQC target of 85%. Level 3 safeguarding training is available online with a participatory workbook to evidence learning. Level 3 safeguarding children's training increased to **71%** at the end of 2021/22 Level 3 safeguarding adult training has increased to **71%** at the end of 2021/22. The safeguarding and learning and development teams are working with an external provide to develop a revised safeguarding training package with an online content that includes virtual/participatory learning. This package is expected to be completed in Quarter 2 2022/23. B5. Following a successful business case to expand LD Specialist Nurse capacity and recruitment to North Manchester General Hospital, 3xband 7 and 3xband 6 posts have been recruited to. The LD Safeguarding team is currently fully recruited – This risk can now be closed. B6 The strategy "Our plan for people with learning disabilities and/or autism, their families and carers 2022-2025 was agreed at Group Safeguarding Committee on 24/05/22 and is being launched week of 20/6/22 This risk can now be closed.	**8 (2x4)**

2	**Strategic Aim: To focus relentlessly on improving access, safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?): If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm

CONTINUED

Inherent Risk Rating Likelihood x IImpact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
	A11. Child Protection Information Sharing System (CP-IS) in place in all relevant areas except SMH maternity services. A12 AOF monitoring (LCO) A13 Business Continuity in Place (BCP)	B5. LD Specialist Nurse Capacity is very limited B6. LD and/or Autism Strategy not yet finalised B7 IT Outage on the NMGH site affecting access to clinical records	C10. Annual safeguarding audit programme C11. Safeguarding supervision data C12 BCP reviewed weekly.			C3. Undertake table-top review of Hospital/MCS/LCO safeguarding assurance documents and evidence and scrutinise any areas of concern. C12 Continue to review the BCP to provide assurance/progress			C1 2022/23 Annual Report has been completed by the safeguarding team – This risk can now be closed C2 All Hospital Safeguarding Workplans are reported to MFT Quality and Learning Group quarterly C3. The Hospital/MCS/LCOs are required to provide evidence/assurance of compliance with CQC Regulation 13 through the completion of an annual assurance template/document. The Assistant Chief Nurse- Safeguarding, Quality and Patient Experience meets with the Directors of Nursing to seek/provide assurance of compliance. Any gaps/lack of assurance are escalated to the Group Deputy Chief Nurse for further scrutiny/challenge. The CQC Regulation 13 Self Assessments for 2021 have been completed for all areas. C5 Section 11 audit has been submitted to Manchester Safeguarding Partnership in Q1 2022/23 C6 Adult Assurance has been submitted to Manchester Safeguarding Partnership in Q1 2022/23 C10 Revised Safeguarding Audit programme agreed at Group Safeguarding Committee 24/05/22 C12 In May 2022 the IT outage at NMGH raised a significant risk to the Trust as information was not available to Trust staff to complete safeguarding risk assessment and planning, and the Trust was not able to complete reports to external safeguarding reviews within timescales. The Business Continuity plan was implemented. With systems now restored the risk has reduced with a lower level of risk as not all information recorded on the records paper has been uploaded to electronic patient records to date. The backlog of safeguarding information sharing is being reviewed and addressed.	

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

PRINCIPAL RISK (What is the cause of the risk?):
If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Inability to use public, staff or clinical areas as intended, leading to inability to provide treatment as planned**
2. **Potential impact for harm to staff, patient of public**

Enabling Strategy:
QUALITY & SAFETY STRATEGY
ESTATES STRATEGY

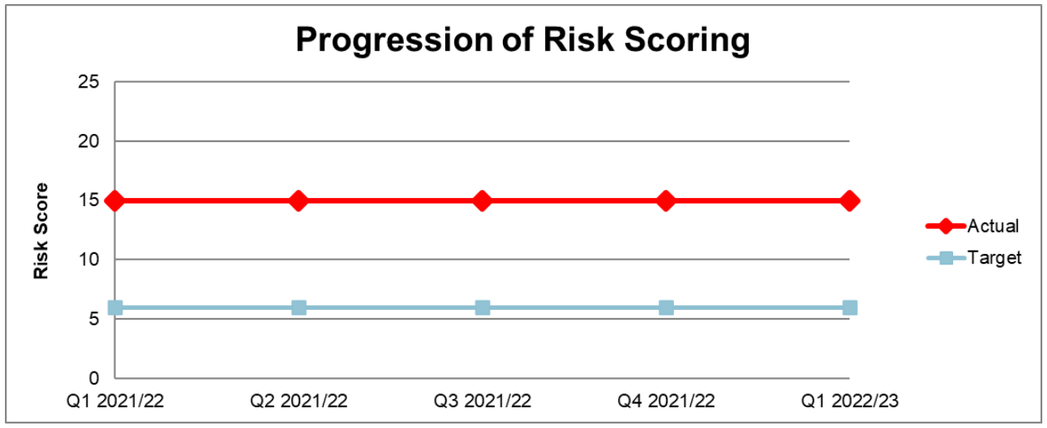
Group Executive Lead:
CHIEF OPERATING OFFICER

Associated Committee:
CEO FORUM

Scrutiny Committee:
QUALITY AND PERFORMANCE

Operational Lead:
GROUP DIRECTOR OF ESTATES AND FACILITIES

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Likelihood /Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood/Impact *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure is maintained to the required level A.4 Internal & external reviews of systems and processes to highlight gaps and required actions	B.1 Not all maintenance regimes have been adhered B.2 Not all infrastructure schematics accurately represent the 'as built' estate B.3 Given above points redundancy systems may not operate as planned B.5 Some controls are reactionary, based on minimising impact should an issue occur	C.1 Ongoing certification (internal or external as required) of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects. C.2 Schematics are being updated on a periodic basis to reflect the as built environment C3. Authorising Engineers in place for all life-critical services that provide external independent assurance reports on a periodic basis	D.1 Survey and remedial works take a significant period to complete & until complete full assurance cannot be gained. D.2 Some schematics remain outdated in the review period and the update process will take several years to complete D.3 The external audits highlighted areas of further work which is being carried out but full assurance cannot be gained until works are complete	15 (3x5)	D.1 Complete surveys and agree programme of remedial works by site and infrastructure system D.2 Infrastructure schematics updated in line with the survey and remedial work D.3. Undertake compliance audits across MFT estate	Group Director of Operations	Assurance task complete Remedial actions will run for a prolonged period (circa 24 months)	Survey and remediation work ongoing Schematics being updated on an as needed basis Fire compliance risk now being shared at a Hospital level Significant work ongoing with ProjectCo; Sodexo and Equans to enhance record keeping and Trust access to records as required. Workstream in place with Sodexo & Project Co at Wythenshawe to improve Trust access to maintenance records Compliance audit complete at ORC and being arranged at Wythenshawe	**6 (3x2)**

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

PRINCIPAL RISK (What is the cause of the risk?):
If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Compromised patient care**
2. **Adverse patient experience**
3. **Increased complaints**
4. **Failure to comply with NHSI regulatory standards**
5. **Inability to recruit well trained nursing and midwifery staff further compounding the staffing issue**
6. **Inability to offer a quality training experience to students**

Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

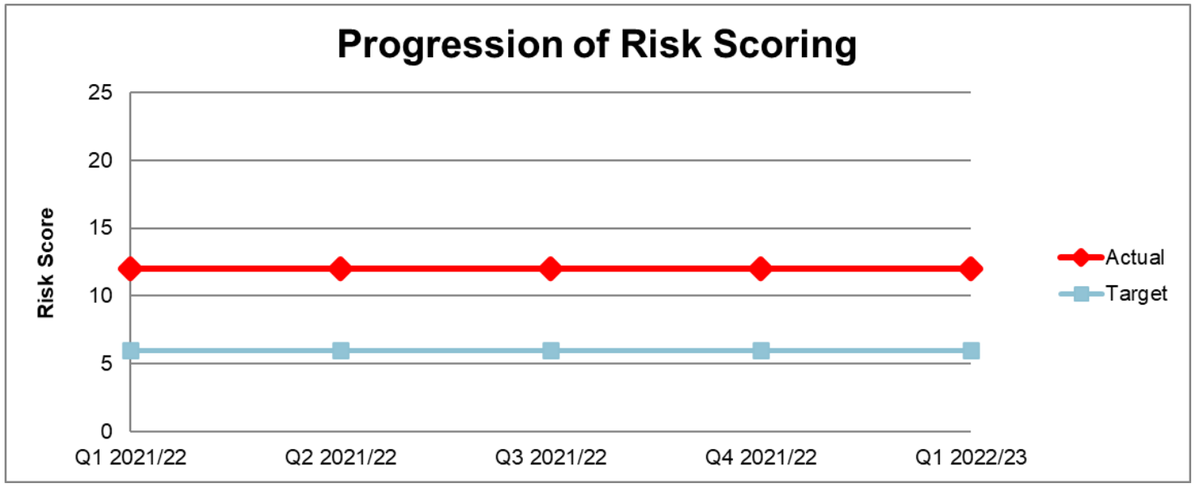
Group Executive Lead:
CHIEF NURSE

Associated Committee:
NMAHP PROFESSIONAL BOARD

Scrutiny Committee:
HR SCRUTINY COMMITTEE

Operational Lead:
CORPORATE DIRECTOR OF NURSING (WORKFORCE & EDUCATION)

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood /Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood /Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood /Impact *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A1. Reports on controls to- NMAHP Professional Board, Clinical Risk Management Committee and HR Scrutiny Committee, Board of Directors and Group Management Board A2. Domestic and International recruitment campaigns A3. Hospital/MCS workforce dashboards A4.Hospital/MCS Nursing and Midwifery retention strategies A5. e roster KPIs and dashboard A6. Daily safe staffing huddles and staff deployment based on acuity and dependency A7. Temporary staffing supply to support staffing demands and patient/service needs aligned with financial controls A8. Triangulation of workforce establishment data with clinical quality metrics A9. Developing and embedding new roles within the Nursing workforce. A10. Establishments reviews undertaken through SNCT census data collections A11. Corporate retention work schemes A12. Pandemic workforce recovery programme A13. Hospital/MCS and Group level pandemic escalation metrics and plans to manage workforce supply	B1 Nationally recognised shortage of domestic nurses B2 Uncertainty due to the long-term impact of CV19 on clinical workforce and long term absence	C1 Programme of domestic and international recruitment campaigns C2 Monthly NHSI safe staffing reporting C3 E Rostering - Roster confirm and challenge meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff C4 Absence manager - monitoring absence and trends to inform workforce requirements C5 Nursing Associates role provides additionality and support to registered nursing workforce C6 Bi-annual Safer Staffing reports to Board of Directors Group Management Board, HR Scrutiny Committee, NMAHP Professional Board, Risk Management Committee. C7 Monthly Nursing and Midwifery workforce dashboards, recruitment pipeline and vacancy trajectories C8 Hospital/MCS AOF workforce KPI's C9 Safer Nursing Care Tool (SNCT) census data to support annual inpatient workforce establishment reviews. C10 Safe staffing guidance and staffing escalation process to support risk assessment and escalation	D1 Variation in staffing levels and workforce supply within the hospitals MCS/ MLCO. D2 realign establishment data with reconfigured clinical areas and services post pandemic	**12** **4x3**	E1 Domestic and international recruitment campaigns resulting in substantive appointments of both nurses and midwives E2 International recruitment programme to support pandemic recovery plans E3 Nursing and midwifery workforce supply to address workforce requirements, reduce vacancies and support capacity demand post pandemic. E4 Reduce turnover and improve retention rate in band 5 roles. E5 Review all in-patient ward areas' staffing establishments following reconfiguration of hospital/MCS service models E6 Reduce staff absence, focus on staff health and wellbeing E7 Finance programme to realign establishment data with reconfigured clinical areas and services post pandemic	Chief Nurse' s Team	November 2020	1 Programme of local and overseas recruitment events planned for the next 12 months, trusts marketing campaign refreshed 2 The Trust has met last years target to recruit 575 international nurses by the end of March 2022, In readiness for HIVE, a further 176 arrivals in Q1. An additional 350 nurses are expected to arrive throughout the year. 3 The registered nurse and midwifery vacancy rate continues to improve and has reduced to 4.3% in May 2022 4 There are currently 400 graduate nurses and 92 graduate midwives who will start in post before the end of December 2022. 5. 12 month rolling turnover rate for nursing and midwifery remains static - 11-12% 6. Directors of Nursing undertaking baseline establishment reviews to support reconfiguration of ward/department area. 7. Review of midwifery services across SM MCS through both Birthrate plus and the Maternity Continuity of Care Workforce Tool to determine future maternity workforce model 8. Safe staffing census data was collected in November and March, with further census planned for Q2 2022 to inform in patient ward establishment reviews following 3 census periods. Implementation plans for SNCT for ED are currently being drafted and development of a Community SNCT is underway. 9. Nursing and midwifery managers are working closely with NHS Professionals to ensure adequate bank and agency supply to cover increased sickness absence rates. 10. Twice daily staffing escalation meetings in place across the trust to undertake twice daily staffing risk assessment and completion of hospital staffing sitrep. 11 Weekly DONs staffing escalation meeting – chaired by DepCN 12. Hospitals/MCS continue to focus on programmes to support staff health and well-being 13. Nursing Assistant / Maternity Support Workforce development programme has been launched to improve the quality of training for the unregistered workforce and includes fundamentals of care and clinical skills.	**6** **3x2**

Strategic Aim: **To focus relentlessly on improving access, safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?): **Failure to deliver medical workforce workstreams (consolidated risk)**

Enabling Strategy:
WORKFORCE STRATEGY

Group Executive Lead:
JOINT GROUP MEDICAL DIRECTORS

RISK CONSEQUENCES (What might happen if the risk materialises?):

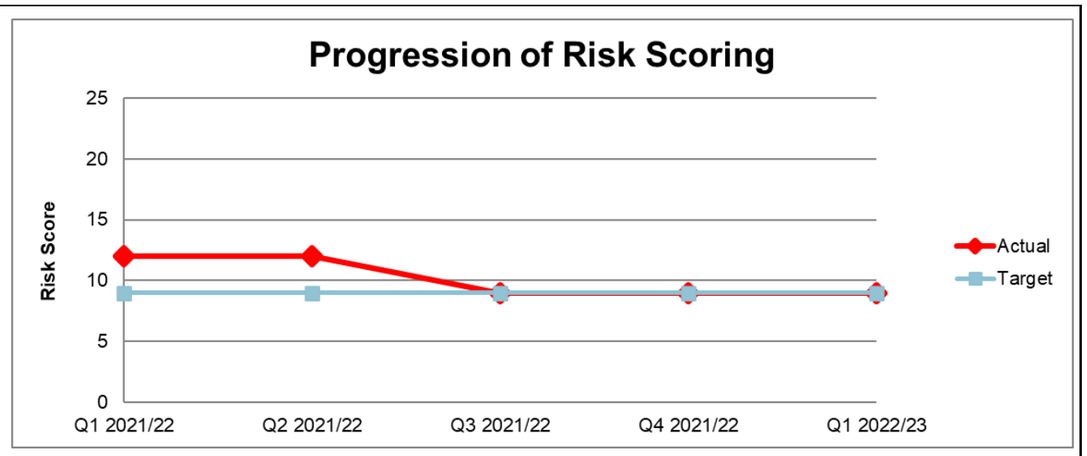
1. **Patient safety & quality of care risk if unable to fill medical shifts/vacancies**
2. **Inequity of care delivered at weekends v weekday**
3. **Loss of control on medical agency & internal bank spend**

Associated Committee:
WORKFORCE & EDUCATION COMMITTEE

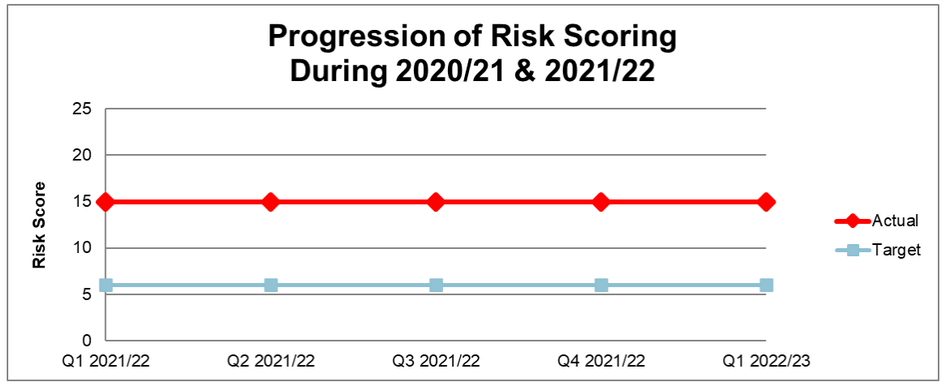
Scrutiny Committee:
HUMAN RESOURCES SCRUTINY COMMITTEE

Operational Lead:
CHIEF OF STAFF / GROUP ASSOCIATE DIRERCTOR OF WORKFORCE

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
12 (3X4)	A1. Group Executive Sponsors of Medical Workforce Workstreams A2. Hospital/MCS Executive teams A3. HR Scrutiny Committee oversight A4. Finance scrutiny committee oversight A5. Hospital Review meetings A6. Accountability Oversight Framework (AOF) A7. Medical Directors' Workforce Board A8. Workforce Systems Programme board A9. LNC Liaison A10.Job Planning & Medical Leave Policy A11.Medical Workforce Electronic systems (job planning, rotas etc) A12.Internal Turnaround governance programme including WAVE A13.Management of Direct Engagement supplier A14. 7DS Joint Assurance Group A15. 7DS action plan A16. Locum and agency dashboards A17. Guardian of Safe working (GOSW)	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Key medical workforce processes (job planning, leave etc) require alignment across Group) B3. Medical Workforce systems not fully rolled out across Group B4. Medical workforce dashboards not fully in place and information not shared between systems B5. No electronic means of recording the 7DS standards.	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**9 (3X3)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Roll out new MFT job plan policy and leave policy B2. Develop job plan training guide for clinical leaders B2. Provide regular reports on job plan status to Hospitals/MCS B3. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. (and D1) Develop and roll out new dashboards for Medical temporary staffing B5. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment D2. Develop GOSW reports to include non training grade vacancies	Group Medical Directors Team & Group HR Directors Team	March 2022	B1. New bank supplier *Go Live* went smoothly in Nov 2020 & will be rolled out to NMGH by Sept 22. MFT Tier 2 GMC sponsorship continues with **increased** international recruitment. 80 additional int. drs starting in August 2022. New single contract for locally employed junior doctors **agreed & launched** for new starters B2. MFT Job Planning Policy approved in Jan 2020. Roll out delayed by Covid. Job planning restarted with target date for all to be completed by end of Mar 22 B2. Job plan training guide to support roll out **developed** & refined for Covid recovery Monthly reports sent to hospitals/MCS on job plan status and bi-weekly 'heat maps' **now sent** B3. Project team in place for roll out of Allocate Medical Workforce systems. Completion by March 22 delayed by Covid however will be completed before Hive *Go Live* in Sept 22. B5. 7DS standard now i**ncluded** in Patientrack and reporting will be available in Q1 22/23 D1. Complete - Updated dashboards rolled out & be further improved with Power-Bi functionality D2. Full link to vacancies will be available when Allocate rotas fully rolled out	**9 (3X3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF FINANCE OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.** 2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.** 3. **Financial damage.** 4. **Reputational damage.** 5. **Staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Scrutiny Committee: **Group Risk Oversight Committee/ Finance and Digital Scrutiny Committee** Operational Lead: **GROUP CHIEF INFORMATICS OFFICER (ACTING)** Material Additional Supporting Commentary (as required): Please note there is a national mandate that Cyber risk scoring remains at 15, despite work being undertaken to reduce severity.	

Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
20 (4x5)	• Internal technical Informatics governance in place including Cyber focussed Group • Group Information Governance in place to monitor compliance • Technical tools in place to monitor and preventing threats • Active member of National and Advisory groups (Care Cert) • Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	• Effective and integrated Executive governance and oversight	• Implementation and monitoring of the Group Informatics Cyber Security Action Plan through trust committees • National tools used for monitoring, and detection of threats • Regular reporting against national 4 key metrics	• Papers and minutes from Cyber group • Further developed detailed monthly reporting • Stakeholder engagement plan on cyber threats • Dedicated expertise in place • Clear Cyber Security Strategy and roadmap	15 (3x5)	• (A1) Robust implementation and monitoring of the Group Informatics Cyber Security Action Plan • (A2) Recruitment to appropriate senior resource • (A3) Development of strategy • (A4) Agree the contents of Monthly Report. • (A5) Accreditation of Cyber Essentials • (A6) Terms of Reference in place for Cyber Board	Group Chief Informatics Officer	Ongoing	• (A1) Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. • (A1) Ongoing work with Hive implementation team to review and monitor the Business Continuity plans to inform adjustments to the disaster recovery plan with additional support brought in • (A1) support provided to NCA during recent outage and validation of MFT processes that no additional action required • (A2) Job Description created for Chief Information Security Officer ahead of panel review • (A3) External provider procured, KPMG to develop Cyber strategy and roadmap including audit to ensure MFT are aligning to industry best practise standard. • (A4) Metrics agreed and reported via FDSC, acknowledging some areas require further work to complete but have target dates • (A5) Number of NHS Digital recommendations completed	**6 (2x3)**

Strategic Aim: **To focus relentlessly on improving access, safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?):
The Trust fails to effectively deliver the Hive EPR transformation programme and realise the clinical and operational benefits across the organisation.

Enabling Strategy:
MFT CLINICAL SERVICES STRATEGY

Group Executive Lead:
GROUP CHIEF OPERATING OFFICER

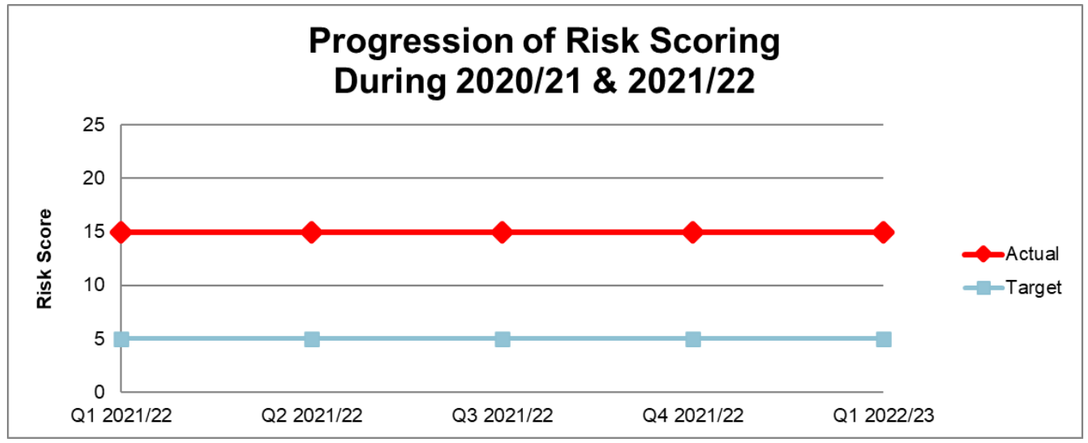
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Poor patient experience, patient safety, quality of care and outcomes
2. Reduction in staff morale.
3. High unwarranted variation in clinical and administrative management and operational processes.
4. Failure to meet the Trust objective of achieving financial stability by failure to realise the benefits case.
5. The Trust would remain at a low and worsening level of digital maturity.
6. Organisational reputational damage experienced

Associated Committee:
EPR PROGRAMME BOARD

Scrutiny Committee:
EPR SCRUTINY COMMITTEE

Operational Lead:
HIVE EPR PROGRAMME DIRECTOR



Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x impact *"Based on successful impact of Controls to mitigate the risk"*
20 (4x5)	• EPR Task and Finish Committee approved the Full Business Case on the 18th May 2020. • Robust contractual and commercial arrangements in place with the contract signed on the 19th May 2020. • EPR Governance Framework defined and approved by Trust Board EPR Task and Finish Committee. Board of Directors involvement in scrutiny committee • Terms of Reference defined and approved for EPR Implementation and Benefits Realisation Board. • Internal Audit commissioned to carry out Hive Programme Risk Assurance • Introduction of an IT Literacy framework to support rapid adoption of the solution. • Implementation of a data quality and migration strategy. • Implementation of end-user training strategy. • External Assurance Review reports commissioned to conduct 5 reviews across Programme lifetime. • Clinical Hazard assessments in place in line with clinical safety standards DCB 129 and 160 • Operational Readiness Authority established to oversee all readiness activities supported by revised Hospital operational boards • Staff Availability Task and Finish group established led by Group Executive Director of Workforce and Corporate Business to ensure staff are released appropriately for training/testing • Go-Live strategy in developed • Transformation plan in place • Testing plan in place and testing has commenced • Extensive review of Programme risks and refreshed programme management approach including robust highlight reporting and series of Risk Summits in place	• Training room gap in control and deployment team now closed • New Gap which is currently being mitigated relates to capacity of Hospital/MCS teams to complete data migration work. • New Gap – completion of full training booking by staff	• Attendance at engagement activities with key stakeholders and subject matter experts representing all areas of the Trust and patient community • Detailed Financial reports on capital and revenue spend against the planned business case Technical Scheme. • EPR Implementation and Benefits Realisation Board minutes and papers and attendance report demonstrating representation • EPR Scrutiny Committee papers and minutes • Internal audit reports to Audit Committee • External Assurance Review reports commissioned to conduct 5 reviews across Programme lifetime.	• Successful completion of testing plan • Completion of interfaces to enable go-live	15 (3x5)	• Transformation change activities implemented to schedule • Communication and Engagement Strategy activities delivered to plan • Detailed tracking of financial spend against business case • Delivery of staff Availability task and finish group action plan • Successful completion of testing strategy and actions • Successful completion of data migration strategy and actions • Completion of staff training registrations and class attendance • Plan for making existing systems ready for data migration, including addressing relevant data quality issues, and engagement with system users	Group Chief Operations Officer/SRO	Ongoing	• Actions against recommendations of Gateway 1, 2 and 3 External Assurance report completed • Gateway 4 report expected late start of July 2022 • Operational Readiness activities progressing via Operational Readiness Authority and Hospital Operational Readiness Boards, Operational Readiness Leads identified and inducted • Communications and engagement Strategy formulated and in operation to support operational readiness • Face to face engagement events, equipment and system demos in progress • Transformation Roadshows in progress • Benefits Review Phase 2 complete • Risk review complete and new programme management approach implemented • Technical Dress Rehearsal commenced (tests all equipment is Hive Ready) • Go Live Readiness Assessments for each Hospital at 120,90,60 & 30 days pre Go Live	5 (1x5)

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

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation

Enabling Strategy:

QUALITY AND SAFETY STRATEGY

PATIENT EXPERIENCE AND INVOLVEMENT STRATEGY

NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:

CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Adverse patient experience**
2. **Increased complaints**
3. **Failure to comply with regulatory standards**
4. **Damage to Trust reputation**

Associated Committee:

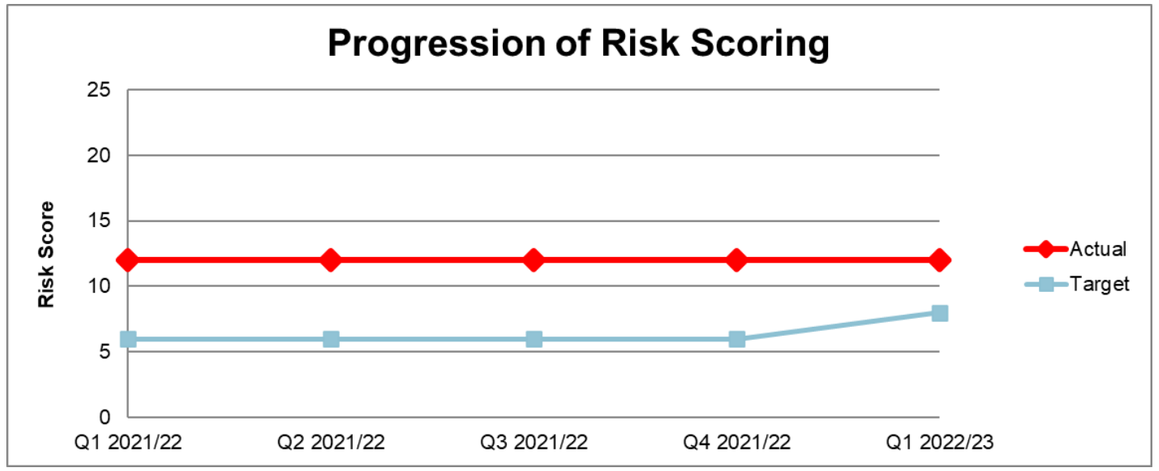
QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Scrutiny committee:

QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

Operational Leads:

DEPUTY CHIEF NURSE, ASSISTANT CHIEF NURSE (SAFEGUARDING, QUALITY & PATIENT EXPERIENCE), HEAD OF NURSING (QUALITY & PATIENT EXPERIENCE)



Inherent Risk Rating Likelihood /Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood/Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood/ Impact *"Based on successful impact of Controls to mitigate the risk"*
12 (3X4)	A1. Corporate and hospital/MCS/ LCO Quality governance and delivery structures. A2. Patient Environment of Care Group oversees delivery of work programme and monitors impact. A3. Contract monitoring focused on patient experience outcomes. A4. Monitoring and reporting systems in place for complaints, concerns and compliments. A5. MFT Compliments, Complaints and Concerns Policy A6. Complaints management guidance provided to Hospitals/Managed Clinical Services/LCOs. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation programme. A11. Nutrition and Hydration Strategy A12. Quality and Patient Experience Forum	B1. WMTM patient experience programme not fully embedded in all areas. B2. IQP not fully embedded in all areas. B3. Nutrition and Hydration Strategy not fully embedded in all areas. The strategy is due for review which is underway in Q4. B4. Patient Experience & Involvement Strategy not fully embedded. B5 Food handling training not fully rolled out to comply with the EHO. E-Learning module will be available at Level 1 for all clinical staff involved in Patient Dining. recommendations	C1. Internal quality assurance processes Clinical Accreditation programme, Quality Reviews, Senior Leadership Walkrounds, Unannounced CQC action walkrounds with annual Accreditation/ assurance report to BoD C2. AOF metrics reporting C3. Quarterly and annual complaints reports C4. Quality of Care Round (QCR) data C5. WMTM patient experience survey data C6. National patient survey data/reports C7. Regulatory inspection processes C8. Friends and Family Test data C9. Joint compliance audits with Sodexo	C1. Senior Leadership Walkrounds paused in March 2020 and again in September 2020 to minimise COVID-19 transmission. Re-commenced in May 2021. A10/C1. Accreditation process paused during COVID-19 response – recommended in May 2021. A7/C2 AOF metric reporting limited during COVID-19 response – recommenced in May 2021. C5. Gaps in WMTM survey data collection during Covid-19 pandemic response. Data collection restarted in May 2021 C8. FFT stood down nationally during Covid-19 pandemic response – now recommenced.	**12 (3X4)**	B1. Patient Experience Matron to support areas where WMTM is not yet embedded B2. Quality Improvement Team to roll out IQP training to support areas where IQP is not yet embedded B3. WTWA, MRI and RMCH to establish local nutrition groups B3. SMH, MREH and CSS to establish nutrition as a standing agenda item within quality and safety meetings B3. Hospitals/MCS/LCOs to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met B4. Embed Patient Experience & Involvement Strategy B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO-Completed in Q2 and will be rolled out in November B6 PALS, Patient Experience & Volunteers Service to develop and embed virtual visiting service.	Chief Nurse' s Team	March 2021	B1 Patient experience teams have supported areas to embed WMTM across MFT Hospitals. Following completion of surveys and a pilot run, WMTM is due to be rolled out within the LCO adults. The new digital platform CIVICA was implemented IN April 2022. B2..The QIT team have reviewed the data and outcomes of the 2020/21 accreditations to identify areas that require teaching, training and support. An IQP training package is being developed with OD Drop in IQP clinics are to be re-established. Regular meetings with hospital quality teams and corporate quality teams have been established to ensure wards are supported. B1. Following successful completion of the Always Events[R] Programme, Always Events will become part of the WMTM Framework. New areas commencing the programme will be monitored and shared through the Quality and Patient Experience Forum. Work will commence post HIVE to identify further Always Event areas. B3. A multidisciplinary Nutrition and Hydration Oversight Committee has been established as a sub-group of the Quality & Safety Committee. Hospital/MCS/LCO/E&F nutrition and hydration activity is also monitored at the Patient Environment of Care and Quality and Patient Experience Forums. Group Lead Nurse for Quality and Professional Practice and Matron for Professional Practice in post and will support improvement activity. December 2021's, Bee Brilliant Campaign focused on Professional Excellence in Nutrition and Hydration B.4 The Patient Experience & Involvement Strategy 2020-2023 was launched in Q2, 2020/21 and work is ongoing in hospitals/MCS/LCOs to implement the strategy.	**8 (2X4)**

3	**Strategic Aim: To improve the experience of patients, carers and their families**

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation - CONTINUED

Inherent Risk Rating Likelihood /Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood/Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood/ Impact *"Based on successful impact of Controls to mitigate the risk"*
	A14 Environmental Health Officer (EHO) inspections A15 Interim Covid-19 Visiting Policy (implemented in March 2020) revised in October 2020 sets out actions to maintain a positive patient experience. MFT Visiting Policy revised in April 2021	B6 Visiting restricted since March 2020 to reduce Covid-19 transmission. Visiting Policy reviewed 16th April 2021 and visiting restrictions lifted in April 2021 B7. Patient Environment of Care (PEOC) stood down during Q3, 2020/21 due to Covid-19. POEC meetings restarted 22 February 2021	D2. Variation in AOF patient experience scores across the Trust			C1. Roster Matrons onto clinical shifts to support quality standards. C2 Develop revised patient experience AOF metrics to monitor progress during the Covid-19 recovery period. C1 Implement alternate temporary assurance process agreed by Professional Board whilst Accreditation programme paused. Full accreditation programme recommenced.			B5 A food safety level 1 training package was completed and approved in 2021. Additional comments from the EHO to further enhance the e-learning package were forwarded to the PWO in January 2022 for approval. Awareness of the food safety training was highlighted in the December 2021's Bee Brilliant Campaign, Professional Excellence in Nutrition and Hydration, with a "Call to Action" for all staff to complete the training Food safety level 1 training. Development of Level 2 Food Safety training commenced in January 2022. The 'Food Safety in the Clinical Environment' Policy was launched in August 2021. Mealtime standards stipulate that the mealtime process is led by a registered nurse and this standard is checked during ward accreditations. B6 Visitors policy updated and visiting recommenced in line with IPC measures. C1. Matrons continue to be rostered to work alongside clinical staff to support quality standards. Senior Leadership Walk arounds were recommenced May 2022. 174 accreditations undertaken in 2021/22 At the end of Q1 2022/23 33% of accreditations rostered for completion had been undertaken. C2 AOF reporting re-established in May 2021. C5 Data collection restarted in May 2021 C4,5&6: CIVICA digital platform was implemented April 2022 to capture FFT, WMTM and QCR all on one platform. All areas were issued an I-Pad for completion of FFT, WMTM and QCR. Data collected reviewed as part of the accreditation process. D1. Patient Environment of Care (PEOC) Bi-monthly meetings commenced, and actions agreed and logged. . D2 The Hospital's/MCS's/LCO's action plans exception reports are monitored on an ongoing basis.	

3	**Strategic Aim: To improve the experience of patients, carers and their families**

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation - CONTINUED

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**		B6 Visiting restricted since March 2020 to reduce Covid-19 transmission. Visiting Policy reviewed 16th April 2021 and visiting restrictions lifted in April 2021 B7. Patient Environment of Care (PEOC) stood down during Q3, 2020/21 due to Covid-19. POEC meetings restarted 22 February 2021	D3 Limited evidence that all staff involved in food handling processes comply with relevant level of food hygiene training		**12** **4X3**	C1 Review process and re-introduce Senior Leadership Walkrounds in defined areas from April 2021 C4,5&8. Re-establish QCR, WMTM and FFT data collection processes. New Patient Experience Platform Provider CIVICA contract agreed in Q3 2021/22 D1. Review and deliver Patient Environment of Care work programme. D2. Develop and deliver Hospital/MCS/LCO action plans to drive improvement supported by corporate services as required. D3. Develop and deliver food handling training to relevant staff, including level 2 training as indicated.	Chief Nurse' s Team	March 2021	Quality and Performance Scrutiny Committee	D3 The 'Food Safety in the Clinical Environment Policy' was ratified at the ICP Committee on 13/01/21. A 'Policy on a Page' document was developed and distributed to provide a summary of the key aspects of the policy. The Policy was launched during Nutrition & Hydration week which was 14th-20th June 2021 and re-enforced during Nutrition and Hydration week 14th -20th March 2022. A food safety level 1 training package was completed and approved in 2021. Additional comments from the EHO to further enhance the e-learning package were forwarded to the PWO in January 2022 for approval. Awareness of the food safety training was highlighted in the December 2021's Bee Brilliant Campaign, Professional Excellence in Nutrition and Hydration, with a "Call to Action" for all staff to complete the training Food safety level 1 training. Development of Level 2 Food Safety training commenced in January 2022. The 'Food Safety in the Clinical Environment' Policy was launched in August 2021. Mealtime standards stipulate that the mealtime process is led by a registered nurse and this standard is checked during ward accreditations. Clinical areas have commenced 'patient brought in food' fridge temperature monitoring. B5 A food task and finish group has been established with E&F and nursing membership and focuses on compliance with the regulatory requirements. A 'Food Safety in the Clinical Environment' Policy has been developed. A Patient food fridge monitoring booklet has been completed and distributed. A Food safety training sub-group has been established to enable compliance with the EHO recommendations. A patient visitor food safety sub-group has been established. B6 Virtual visiting services were established in August 2020. Despite visiting being recommenced in line with current IPC measures, technology is now part of every day practice performed the ward staff. B6. We have signed an MOU with SJA to launch the SJA cadet program. C1. Alternate temporary assurance processes were implemented whilst full accreditation programmes were not possible (due to the pandemic), which included observation of clinical areas, assessment of all quality and safety data and assurance meetings between the Directors of Nursing and the Group Chief Nurse/Deputy Chief Nurse. The full/revised accreditation programme recommenced in May 2021. C1. The Senior Leadership Walkrounds recommenced in May 2022. C2 The AOF patient experience metrics have been revised and monitoring continues. C4,5&8 The New Patient Experience Platform, CIVICA, tyo collate FFT, WMTM and QCR data was implemented April 2022 C6 The National Inpatient, Children & Young People's, Maternity and Cancer survey results have been reviewed and work in line with the feedback commenced.	**6** **3x2**

Strategic Aim: To achieve and maintain financial sustainability

PRINCIPAL RISK (What is the cause of the risk?):
Risk that revised funding arrangements in place from April 2022 are providing insufficient funds to meet the expenditure required to deliver operational requirements, meaning the Trust has had to bridge a funding gap with a WRP of £117m.

RISK CONSEQUENCES (What might happen if the risk materialises?):

Failure to deliver the required WRP and breakeven identified in the internal financial plan will potentially put the Trust and the ICS in breach of the national requirement for the ICS to breakeven. Not delivering a breakeven plan will ultimately have a detrimental impact on Trust cash.

Enabling Strategy:
MFT CONSTITUTION & LICENCE REQUIREMENTS

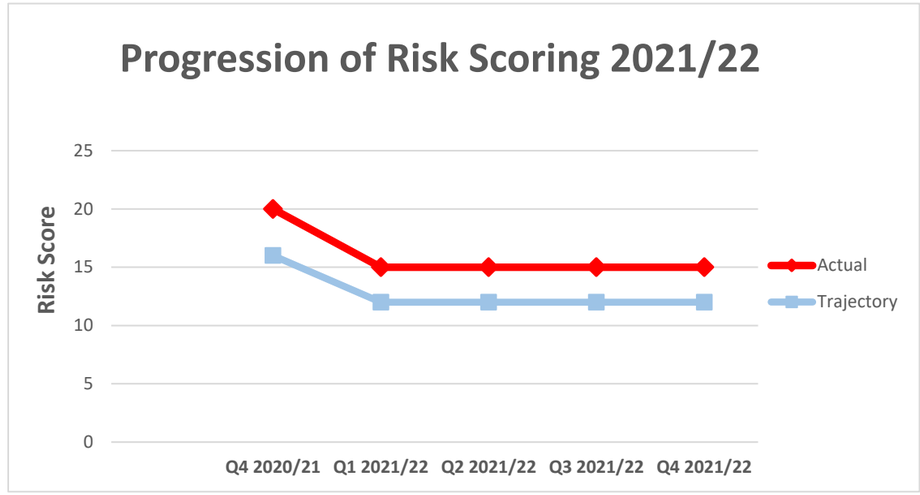
Group Executive Lead:
CHIEF FINANCE OFFICER

Associated Committee:

Scrutiny Committee:
FINANCE AND DIGITAL SCRUTINY COMMITTEE

Operational Leads:
GROUP FINANCE AND HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1. The budget and planning framework has been maintained linked to BAU processes to establish hospital level financial targets and requirements for improvement as set out in WRP requirements A.2. Ongoing financial assessment and control through the AOF regime A.3. Monthly review of financial performance against Control Totals and Forecasting Outturn from M2 as part of the Finance Accountability Framework. A.4. Regular review and updates of Hospitals/MCS/LCO and Corporate financial performance to ensure WRP and recovery plans are developed with financial sustainability as a key part of the planning A.5. Progressing implementation of EPR system to support and drive changes and appropriate standardisation of clinical care and operational support processes A.6. Additional targeted Financial and Operational actions and controls have been established through and owned by EDT members.		C.1. An extensive framework of review, challenge and escalation is fully embedded and understood within the organisation C.2. Hospitals/MCS/LCO are assigned an AOF rating against the finance domain based on their forecast performance and the proportion of non-recurrent WRP relative to recurrent, which determines the level of progress recognised, intervention and support required, with regular reviews consisting of Hospital/MCS/LCO CEO/FDs and Group COO and CFO, the timing of which is dependent on the Finance Accountability Framework rating for the relevant area. C.3. Trust-wide monthly finance reported to GMB, FDSC and Board in line with timing of meetings	None	15 (5x3)	MFT will need to continue to work on delivery of its WRP, review the level and requirement for provisions on its Balance Sheet MFT will have to play a material role in ensuring all other members of the ICS of which MFT are a significant part reduce their deficits and the ICS targets additional funding and systemwide savings	Group Chief Finance Officer / Hospital/MCSLCO CEO and FDs	Ongoing throughout the year	As at end of June 2022, plans have been submitted in line with NHSI requirements. Reasonable initial progress has been made on delivery of WRP.	**12 (4x3)**

4	Strategic Aim: **To Achieve Financial Sustainability**

PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity than its ambition.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF INFORMATICS OFFICER (GCIO)

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Inability to deliver against Trust strategies.**
2. **Inability to deliver benefits associated with transformational programmes of work.**
3. **Poor patient care and or experience.**
4. **Reputational damage.**
5. **Financial loss.**
6. **Low staff morale.**

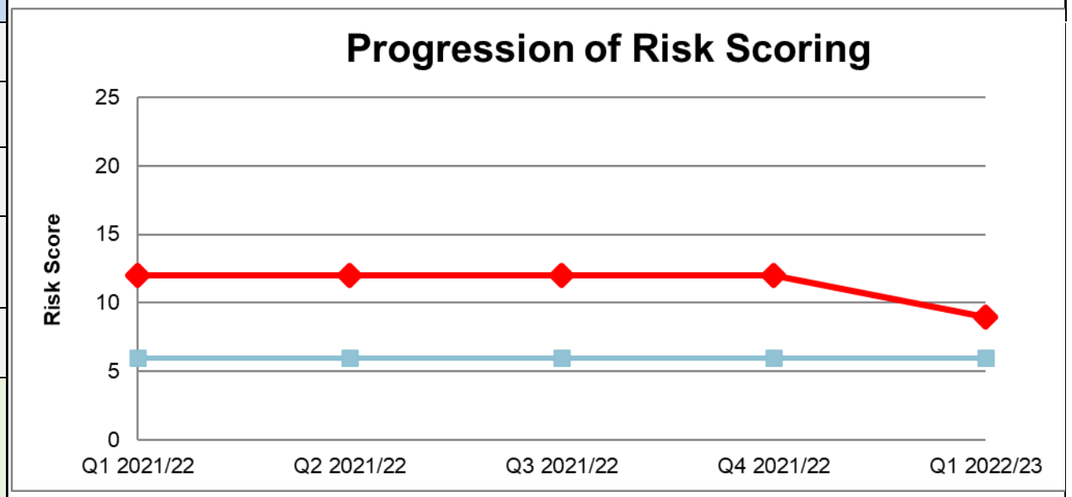
Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Scrutiny Committee:
Group Risk Oversight Committee/EPR Scrutiny Committee/Finance and Digital Scrutiny Committee

Operational Lead:
Group CIO, Corporate Directors, and Hospital CEOs.

Material Additional Supporting Commentary (as required):

- Following Covid-19 and recovery plans Informatics continue to have significant resourcing pressures especially on Information Services
- Increased demand on Information services to support modelling work and changes to information reporting requirements at a GM and National level



Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGRESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	• Informatics governance framework completed and revised governance structure and associated processes implemented including revised terms of reference for new Portfolio Board • Integrated governance with workforce for related strategies • Integration Steering Group monitoring of Informatics PTIP Plan. • Capital Management and Monitoring Group monitoring and Capital Strategic Group supporting planning and delivery of the capital programme • EPR Governance Framework defined and approved by Trust Board EPR Task & Finish Committee. • EPR Implementation & Benefits Realisation Programme Board Terms of Reference defined. • EPR Task Full Business Case approved • Finance and Digital Scrutiny Committee • GM Digital Transformation Board and GM CIO Providers		• HIMSS digital maturity Index and publication of results and GM developed digital maturity assessment and plan • Capital Planning financial spotlights, delivery, and review/summary capital plans • Programme plan and close down documentation of COVID recovery stream to deliver digital solutions • Formal internal Informatics assurance risk documentation • Informatics PTIP Reporting for NMGH • Regular board updates to Hospitals and Group Corporate services including operational readiness work programme in place to support cultural change • An extensive framework of review, challenge and escalation is in place for the EPR programme including external assurance • Finance and Digital Scrutiny committee review of papers/progress and validation of BAF.	• Refreshed Informatics Strategy (post EPR delivery) and future state organisational structures • Demand Management - process in place with clear responsibilities • Benefits Realisation – Qualitative and Quantitative across Informatics programmes .	**9 (3x3)**	• (A1) Successfully deliver Hive EPR including all related activities • (A2) Develop and implement target operating model for future state post Hive to embed further digital improvements • (A3) Implement and monitor a robust demand management process and structure to ensure a continued focus on trust strategies. • (A4) Refresh the Informatics Digital strategy to ensure it reflects latest requirements including ICS compliance • (A5) Initiate benefits management tracking through Group Informatics Portfolio Board to ensure digital maturity is continually monitored and validated • (A6) Ensure every investment request references the impact on digital maturity	Group Chief Informatics Officer	Ongoing	• (A1) Hive programme progressing to plan. • (A2) Future state plans drafted but delays to formalising overall timescales • (A3) Baseline portfolio plan in place and revised timeframe to implement fully resourced function from April 23. • (A4) Digital Strategy has completed extensive engagement and now approved at GIPB and is on target to be signed off at BoD in September • (A6) Detailed engagement with GM to ensure strategy reflects digital maturity capabilities including plans to deliver HIMSS level 7.	**6 (3x2)**

Strategic Aim: **To use our scale and scope to develop excellent integrated services and leading specialist services**

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of Service**
2. **Reduction in a range of services (offered within GM and across NHS)**
3. **Damage to reputation**
4. **Loss of staff**
5. **Reduction in research opportunities**

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES, GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

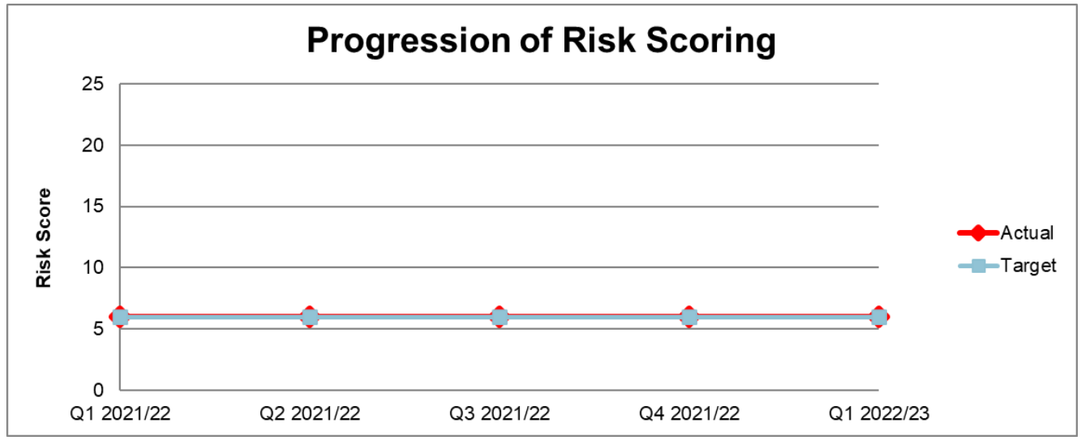
Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Scrutiny Committee:

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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9 (3x3)	A.1 Internal/Annual review process for service reconfiguration to strengthen key specialised services (QSIS) (High) A.2 Active involvement in strategic clinical networks (eg cardiac, cancer) (Medium) A.3 Regular discussions with NHS England and foundation trust colleagues through the Shelford group (High) A.4 Active involvement in Operational Delivery Networks (High) A.5 Regular meetings with NHSE (Medium) A.7 Early notification of consolidation expected through national representation on clinical reference groups (Low) A.8 Partnership groups not meeting however in regular dialogue with NHSEI regarding service changes related to COVID (High)	B.1 Management capacity within corporate hospital and MCS teams to identify ongoing risks and issues against each of our specialised services (as flagged through quality surveillance reviews and other national and local reviews). B.2 Lack of Group wide review of compliance against all aspects of national clinical service specifications. B3 Lack of performance information on specialised services B4 Impact of changes to funding and commissioning of services (ICB. Pop based)	C1 Award of: • National tender for Auditory Brainstem Implantation - one of only two providers in the country. • CAR-T designation for adults and children • Northern Paediatric MS service (MFT lead with Alder Hey and Newcastle), Genomics Lab Hub C.2 Outcome of 19/20 quality surveillance reviews. 87 services achieved 100%, 53 services achieved 80-99% compliance (note 20/21 21/22 process suspended due to COVID). C.3 Outcome of Peer Reviews C.4 AOF Domain provides assurance that services are consistently delivering against milestones providing a view of strategic progress/ maturity C.5 Process for the identification of strategic development risks developed for GSSC	D.1 No Gaps in assurance.	**6 (2x3)**	B.2 Annual surveillance reviews are unlikely to go ahead this year. The annual Trust wide review is expected recommence 22/23 subject to NHSE requirements .	Group Governance Team	Subject to NHSE	Ongoing	**6 (2x3)**
						B.2 Plans to address areas of non-compliance continue to be included in Hospital/ MCS plans for 20/21. Delivery of this may be affected and therefore any residual issues will be included in 22/23 plans.	Hospitals / MCS	Ongoing	Ongoing	
						B.2 Any National specialised services under review by NHSE to be analysed / risk rated by the strategy team as part of the corporate team's regular risk management process.	Group Strategy Team	As necessary	As necessary	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews.	Group Strategy Team	Ongoing	Ongoing	
						A.1 Continued review of single service progress across MFT e.g. single governance, single clinical teams through COVID reviews.	Hospitals / MCS/Group	Ongoing	Underway	
						B3 Specialised services dashboards to be reviewed by GSSC.	Hospitals / MCS	Q4 21/22	Underway	
						B4 Ongoing discussions with NHS (NW Region and through Shelford) on the impact of the proposed changes in 22/23. MFT engaged with NHSE at a technical level	Group Strategy Team	Ongoing	Ongoing	

Strategic Aim: **To use our scale and scope to develop excellent integrated services and leading specialist services**

PRINCIPAL RISK (What is the cause of the risk?): If we do not respond appropriately to the move to working as part of an Integrated Care system we may not be able to develop our services as set out in our clinical service strategy.

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

RISK CONSEQUENCES (What might happen if the risk materialises?):

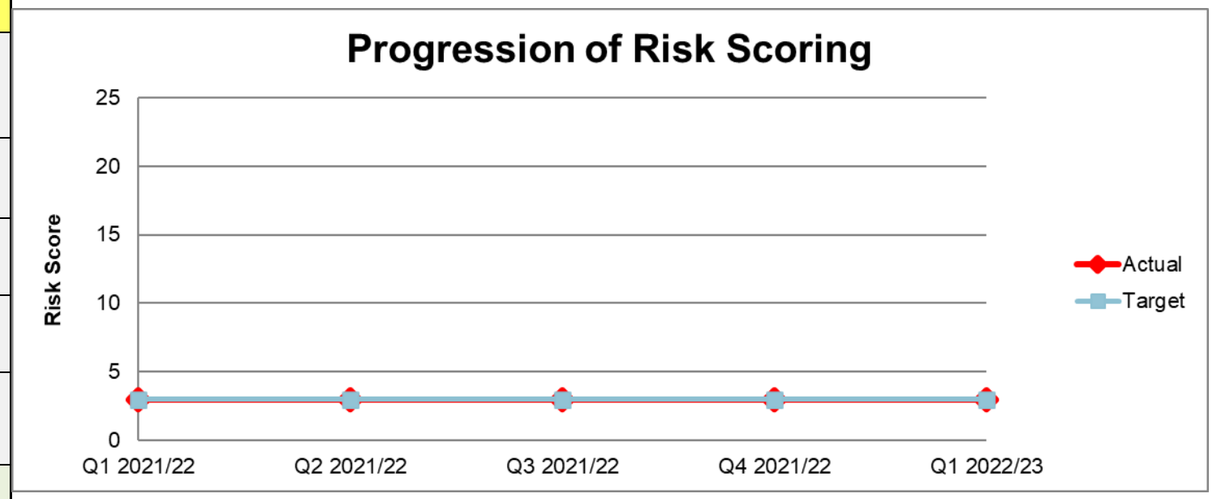
1. We would be unable to develop our services as set out in our clinical service strategy and deliver the improvements to the quality of our services and the health of the patients that we serve that we aspire to.

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Scrutiny Committee:

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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8 (2X4)	A.1 MFT involvement in establishment of ICS governance A.2 MFT representation on ICS boards and groups. A.3 MFT engagement with PFB which enables providers to engage as a group within GM A.4 MFT involvement in development of locality governance arrangements A.5 MFT representation on locality ICP Board and groups A.6 MFT clinical service strategies developed viewed in line with GM aims and approved by GM	B.1 Documenting and ensuring representation on all relevant GM ICS groups B.2 Documenting and ensuring representation on all relevant PFB groups B.3 Documenting and ensuring representation on all relevant locality groups	C.1 Agreement that PFB leads on elective care, emergency care and cancer on behalf of ICS C.2 GM recovery plan completed by PFB on behalf of ICS C.3 MFT leading development of GM level ophthalmology plans C.4 RMCH leading GM recovery planning for acute childrens services for GM	D.1 ICB approval of any changes to MFT clinical strategies D.2 ICB approval of clinical strategy related service changes D.3 ICB approval of MFT Cancer strategy D.4 ICB approval of CDC business case D.5 Final locality governance arrangements agreed that appropriately involve MFT	3 (1x3)	B.1 Ensure MFT representation on all relevant GM groups	MFT Strategy team	Q2 2022/23	Mapping of all meetings and MFT coverage underway	3 (1x3)
						B.2 Ensure MFT representation on all relevant PFB groups	MFT Strategy team	Q2 2022/23	Mapping of all meetings and MFT coverage underway	
						B.3 Ensure MFT representation on all relevant locality groups	MFT Strategy team	Q2 2022/23	Mapping of all meetings and MFT coverage underway	

2	**Strategic Aim: To use our scale and scope to develop excellent integrated services and leading specialist services**

PRINCIPAL RISK (What is the cause of the risk?): If we do not respond appropriately to the move to working as part of an Integrated Care system we may not be able to develop our services as set out in our clinical service strategy. CONTINUED

Inherent Risk Rating Likelihood x Impact *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Likelihood x Impact *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	PROGESS	Target Rating Likelihood x Impact *"Based on successful impact of Controls to mitigate the risk"*
						D.1 Review and update MFT group clinical service strategy	MFT Strategy team	Q2 2022/23	Review underway	
						D.2 Progress approval process for single service changes	MFT Strategy team	Q4 2022/23	Process underway	
						D.3 Complete MFT Cancer Strategy	MFT Strategy team	Q2 2022/23	Strategy in drafting phase	
						D.4 Progress development of CDC plans	MFT Strategy team	Q2 2022/23	National template submitted MFT business case being developed	
						D.5 Finalise locality governance arrangements in Manchester and Trafford	MFT Strategy team	Q1 2022/23	MFT working with Manchester and Trafford to develop governance arrangements	

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

PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT.

Group Executive Lead:
GROUP EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES

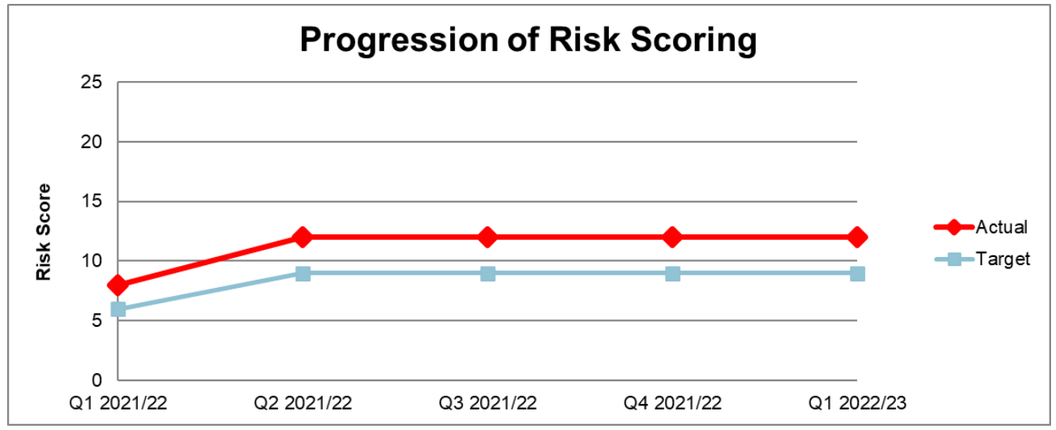
1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**

Associated Committee:
WORKFORCE & EDUCATION COMMITTEE
HR SCRUTINY COMMITTEE

Scrutiny Committee:
HR SCRUTINY COMMITTEE

Operational Leads:
GROUP DIRECTOR OF HR
CORPORATE WORKFORCE DIRECTOR

Material Additional Supporting Commentary (as required):



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16 (4x4)	A.1 A framework of workforce policies and standard operating procedures to support consistent, best practice people management. A.2 Trust Governance structure – inc. Human Resources Scrutiny Committee & Workforce Education Committee A.3 AOF monitoring A.4 Mandatory Training Programme embedded A.5 Workforce Plans A.6 MFT Operational Plan A.7 Equality, Diversity and Human Rights Strategy agreed & Group and Hospital / MCS Committees in place A.8 Workforce Technology strategy (informatics strategy) A.9 Leadership and Culture Strategy A.10 The Covid-19 recovery programme established to support Trust wide recovery A.11 MFT People Plan A.12 Freedom to Speak Up Reporting Mechanism A.13 Workforce predictive modelling	B.1 Policy development programme has not concluded B.2 Key workforce system are not in place for all staff groups and all sites. B.3 Apprenticeship delivery programme to be embedded B.4 Workforce plans are still in development, linking to activity/ demand & recovery planning. B.5 SOPs are under-development for a number of workforce processes. B.6 Real time, establishment control not in place B.7 Vacancies impact upon service delivery, staff wellbeing and development opportunities	C.1 Trust Workforce KPI monitoring e.g. absence, turnover, ER cases, etc C.2 Trust external and internal audit reports C.3 Staff survey and pulse checks C.4 Regulatory and statutory inspection processes and standards C.5 Internal quality assurance processes (Ward accreditation, Quality Review) C.6 AOF C.7 External accreditations C.8 Hospital / MCS /LCO reviews C.9 ISG Board reviews and PTIP progress C.10 Performance against agreed objectives for the Executive Director of Workforce and Corporate Business C.11 HR Scrutiny Committee assurance reports C.12 Freedom to Speak Up reviews C.13 Calendar of activities developed to support staff to make an informed decision in relation to COVID-19 vaccinations. C.14 Workforce Education Committee monitoring report. C.15 People plan performance dashboard. C.16 Predictive workforce modelling is currently monitored against actuals	D1. Workforce metrics are limited due to ongoing finalising digitalisation of processes D2. Workforce metrics are not fully triangulated with other data sets e.g. finance, clinical D3. Collaborative Staff side negotiations on policy development. D4. Medium / long-term impact of the Pandemic on the workforce	**12 (4x3)**	B.1 Complete policy review programme B.2 Continued oversight of Mandatory Training Steering Group to provide ongoing oversight. B.3 Continued alignment of Workforce Technology Framework with Informatics Strategy B.4. Continued oversight of Apprenticeship Steering Group to fully embed new delivery model. B.5 Development of workforce planning strategy B.6 SOP development oversight by Senior Leadership Team B.7 In conjunction with Informatics and Finance, explore data warehousing to enable real time, establishment control D1 Ongoing implementation of digital processes D2 Progress data warehousing approach to workforce data to enable data triangulation D.3 Development of policy implementation plan.	Workforce Team	March 2023	***B.1 Policy programme continues – strategy currently being developed to agree progression of key policies.*** ***B.3 Following a successful national funding bid, the implementation of eRostering for AHPs/HCSs is now underway and the Medical rollout is progressing. Development of the Empactis Health Manager system is on track with the management referral processes being piloted. Case Manager system development is also progressing as per plan.*** ***Following the acquisition of NMGH, work also has commenced to begin the introduction of MFT rostering and absence systems to improve workforce grip.*** ***B.5 The Apprenticeship Steering Group and Operational Delivery Group has been embedded and 98% of the Ofsted actions completed, with associated evidence. In May 2022, a Standard Verifier Audit of the Apprenticeship Service was carried out and the following areas of good practice were identified:*** - ***Management of the Internal Quality Assurance (IQA) process and coordination of the assessment and IQA activities.*** - ***The Continuing Professional Development (CPD) events and documentation of the staff development.*** - ***Improvements in the quality of assessments.*** - ***Good application of professional discussions with learners.*** ***The KMPG Apprenticeship Audit was also recently concluded, and although the final report is yet to be received, verbal feedback was positive indicating significant assurance***	**9 (3x3)**

2	**Strategic Aim: To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best**									
PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT – CONTINUED										
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**EXISTING CONTROLS** *"What controls/systems are currently in place to mitigate the risk?"*	**GAPS IN CONTROLS** *"What Controls should be in place to manage the risk but are not?"*	**ASSURANCE** *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	**GAPS IN ASSURANCE** *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	**Current Risk Rating Impact / Likelihood** *"With Controls"*	**ACTION(S) REQUIRED** *"Additional actions required to bridge gaps in Controls & Assurance"*	**RESPONSIBILITY**	**COMPLETION TIMESCALE**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
	A.14 Employee Health & Wellbeing Service Delivery model. A.15 Mandatory Vaccination Programme delivery plan developed and being implemented.		C.17 Staff networks established - BAME, LGBT and Disability providing effective engagement and involvement in workforce topics. C.18 Employee Relations Group. C.19 Mandatory Vaccination Task and Finish Group and PMO. C.20 Addition of a senior post i.e., Corporate Director of workforce to lead on EHW/ED&I, Rewards etc						***D2. The MFT People Plan has now been launched. A governance structure has been established and a performance dashboard is in place. 37% of deliverables within the dashboard have now been completed.***	