MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON MONDAY 13TH MARCH 2023
At 2:00pm

The meeting will be held virtually via Microsoft Teams

A G E N D A

1.	Apologies for absence	
2.	Declarations of Interest	
3.	To approve the minutes of the Board of Directors' meeting held on 9th January 2023	*(enclosed)*
4.	Patient Story	*(Film)*
5.	Matters arising	
6.	Chairman's report	*(Verbal Report of the Group Chairman)*
7.	Chief Executive's report	*(Verbal Report of the Group Chief Executive)*
8.	**Operational Performance**	
8.1	To receive an update on the Board Governance Review	*(Report of the Group Chairman enclosed)*
8.2	To provide an update on the Hive Programme	*(Report of the Group Executive Director, SRO for Hive Programme enclosed)*
8.3	To receive an overview on the Trust's operational performance	
8.3.1	General Update, Performance Standards & Recovery Programme	*(Report of the Group Chief Operating Officer enclosed)*
8.3.2	Update on Infection Prevention and Control including the COVID-19 Vaccination Programme and Flu Vaccination Programme	*(Report of the Group Chief Nurse enclosed)*
8.4	To receive the Group Chief Finance Officer's Report Month 10	*(Report of the Group Chief Finance Officer enclosed)*
9.	**Strategic Review**	
9.1	To receive an update on strategic developments	*(Report of the Group Executive Director of Strategy enclosed)*

10. Governance

10.1 To receive the Q3 Complaints report *(Report of the Group Chief Nurse enclosed)*

10.2 To receive an update on Maternity Services, including the Q3 Avoidable Term Admission into Neonatal (ATAIN) report 2022/2023 *(Report of the Group Chief Nurse enclosed*

10.3 To receive the annual Equality, Diversity and Inclusion (ED&I) report *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.4 To receive the Gender Pay Gap annual report *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.5 To note the following Committees held meetings:

- 10.5.1 Group Risk Oversight Committee held on 16th January 2023
- 10.5.2 EPR Scrutiny Committee held on 25th January 2023
- 10.5.3 Audit Committee held on 1st February 2023
- 10.5.4 Quality and Performance Scrutiny Committee held on 14th February 2023
- 10.5.5 Human Resources Scrutiny Committee held on 21st February 2023
- 10.5.6 Finance and Digital Scrutiny Committee held on 28th February 2023

11. Date and Time of Next Meeting

The next meeting will be held on Tuesday 9th May 2023 at 2:00pm

12. Any Other Business

Agenda Item 3

NHS Manchester University NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 9th January 2023

(PUBLIC)

Main Boardroom, Cobbett House

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Trevor Rees (TR)	Deputy Group Chairman
	Mike Deegan (MD)	Group Chief Executive
	Angela Adimora (AA)	Group Non-Executive Director
	Darren Banks (DB)	Group Director of Strategy
	Gaurav Batra (GB)	Group Non-Executive Director
	Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Julia Bridgewater (JB)	Group Executive Director / SRO Hive programme
	Jane Eddleston (JE)	Joint Group Medical Director
	Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	David Furnival (DF)	Group Chief Operating Officer
	Luke Georghiou (LG)	Group Non-Executive Director
	Nic Gower (NG)	Group Non-Executive Director
	Cheryl Lenney (CL)	Group Chief Nurse
	Toli Onon (TO)	Joint Group Medical Director
	Damian Riley (DR)	Group Non-Executive Director
In attendance:	Nick Gomm (NGo)	Director of Corporate Business/ Trust Board Secretary
	Karen Hawley (KH)	Freedom to Speak Up Guardian

285/22 Apologies for Absence

Apologies were received from Gill Heaton and Chris McLoughlin

286/22 Declarations of Interest

GB declared that he has recently been appointed Chair of Think Energy. The published Board of Directors' Register of Interests will be updated accordingly.

287/22 Minutes of the Board of Director's meeting held on 14th November 2022

The minutes of the Board of Directors' (Board) meeting held on the 14th November 2022 were approved. It was noted that Trevor Rees was present at that meeting.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the minutes.	n/a	n/a	n/a

288/22 Patient Story

CL introduced a film in which a patient described her experience of treatment for a detached retina at Manchester Royal Eye Hospital.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the patient story.	None	n/a	n/a

289/22 Matters Arising

There were no matters arising.

290/22 Group Chairman's Report

KC began by introducing new Non-Executive Director, Damian Riley, who will be Chair of the Quality and Performance Scrutiny Committee (QPSC).

The process of recruiting to the final NED vacancy on the Board of Directors is underway with a view to having someone in post by the time of the next Board in March.

On the 30th November, KC chaired the 11th Young People's Open Day event. More than 300 school pupils attended alongside young members, parents, governors, and staff. The focus of the event was to provide young people with information about a wide range of employment and involvement opportunities in the NHS, advice on staying healthy, and how you can become a member of MFT.

Health Education England has awarded the Work Experience Gold Quality Standard to MFT. This new award confirms that the Trust's work experience offer to potential future recruits meets all standards demanded by the scheme.

On the 1st December, Jane Eddleston, staff from Saint Mary's, and MFT's respiratory team hosted a visit by Professor Sir Chris Whitty, the Chief Medical Officer to discuss the success of two pioneering smoking cessation schemes – our CURE inpatient smoking cessation programme and our Smokefree Pregnancy Programme, both of which were cited in the NHS Long Term Plan. Sir Chris said that the visit had been extremely useful and commented on the value of the joined-up approach by MFT with regional partners to deliver these public health benefits.

In December, KC joined MFT's Disability Engagement Group and our Diverse Abilities Network to mark Disability History Month - which saw Cobbett House lit up in purple as part of an international campaign to mark the contribution of people with disabilities.

On the 15th December, KC hosted MFT's Carols in the City service at Manchester Cathedral in the first fully in-person event since Christmas 2019. Also that week, KC attended a performance of the music created by the young people involved in a music project led by Dr Paul Abeles, working with MFT's CAMHS team.

KC noted the tremendous demand on MFT's services at present and thanked the workforce for the dedication and professionalism they show every day of the week under very challenging circumstances.

KC ended by congratulating MFT's members of staff who were recognised in the New Year's Honours List. Charlotte Skitterall, Group Chief Pharmacist, received an MBE for service to pharmacy and Dr David Manghama Consultant Pathologist and MRI, received an MBE for services to forensic science.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chairman's verbal report.	None	n/a	n/a

291/22 Group Chief Executive's Report

MD explained that it had been an exceptionally challenging two months for the whole of the NHS since the last Board of Directors' meeting, recognising the difficulties for the public as they have tried to access the care that they need and have often faced long waits and crowded wating areas. He described the frustration for MFT staff when they can't provide the desired patient experience and assured the Board that everyone is doing everything they can to make sure that patients receive the best possible care.

MD talked the Board through the agenda of the meeting, highlighting the DF's Operational Performance Report, CL's Infection Prevention and Control (IPC) and Maternity reports, and JEH's finance report. He recognised the success of the Hive programme and explained how significant benefits were being realised.

Finally, MD thanked the extraordinary efforts of the workforce at this time and noted that the Freedom to Speak Up report on the Board provides an example of one way in which staff views drive improvements throughout MFT.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chief Executive's verbal report.	None	n/a	n/a

292/22 Board Assurance Report

KC introduced the Board assurance report, noting that there would be in-depth discussions on each area throughout the Board meeting. She explained that the content and the format of the report was in the process of being revised to enhance the assurance the Board receives across all key areas.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Board Assurance Report	None	n/a	n/a

293/22 Update on Hive Programme

JB provided an update on the Hive programme, explaining that it had been 123 days since Go-live. The programme is now in the stabilisation phase which marks the start of the transition to Hive being the key vehicle for facilitating clinically-led digital transformation and realisation of safety, efficiency and workforce benefits.

Achievements so far in phase 1 of stabilisation include:

- Governance structures designed, implemented, and embedded
- Hive on-call support supported processes, designed, implemented and refined to meet
- service needs
- Review of Hive teams' capacity to deliver stabilisation and optimisation
- Launch of 6-month project group to oversee Hive Training as it transitions to business
- as usual
- Epic Post Go-live visit completed with associated priorities and actions agreed
- Launch of dedicated programme of work in Royal Eye Hospital (REH) delivered via
    - agile project management approach using 'sprint methodology'
- Review of benefits realisation programme to ensure early benefits are delivered

Two overall high-level risks have been reported into, and managed via, the Group Risk Oversight Committee (GROC). These relate to potential impacts on safety if the programme is not delivered effectively and the risk of Hospitals/MCSs/LCOs not being operational ready for Go-live. The latter risk was formally downgraded at the November 2023 GROC and the former will be downgraded following sufficient timescale for analysis and review. A formal review will take place in January 2023 and this will be presented to both GROC and also the Quality and Safety Committee. There were three other specific high level Hive risks that were reported into GROC were also downgraded at the November 2023 GROC. These were the management of complex pathways at North Manchester General Hospital, the inclusion of the Local Care Organisation into the Hive Programme, and training. Each of these risks had dedicated mitigations in place prior to Go-live which were reported into GROC and managed through the Hive Programme's governance processes.

The Transformation work plan post Go-live is aligned to the operational priorities of the organisation with Hive being a key enabler to deliver. To that end, the Director of Transformation has brought the Hive Transformation team and the MFT Group Transformation team together and is aligning the work programmes of; Urgent Care, Outpatients, Elective Recovery and Booking and Scheduling.

JB noted how Hive had helped the organisation manage the current operational challenges – by enabling clinicians and managers to have visibility across the whole of MFT, analysing discharges, enabling better service delivery, and informing the transfer of staff to areas which were particularly challenged. She also described how the MyMFT application was enabling patients to be more informed about, and involved in, decisions about their care.

KC noted the continuing importance of clinical involvement in the programme and thanked JB and her team for their work.

In response to a question from KC regarding patient letters, JB explained that Hive was helping ensure letters were clearer and more consistent but noted that it was also supporting digital ways of communicating with patients. JE followed up by explaining that the GP group which has been established is developing more consistent referral letters to further improve communications across the health system.

AA commended the reflective video and infographics which had been produced and JB noted how effective the communications and engagement support to the programme had been.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the progress made since Go-live completion and the significant progress made in the first phase of stabilisation.	None	n/a	n/a

294/22 MFT's Green Plan

DF introduced the report which provided an update on progress made during year 1 of delivery of MFT's Green Plan which was approved at the Board of Directors in January 2021.

A Key Performance Indicator (KPI) dashboard is used to track progress. Headline trends include:

- MFT's Carbon Footprint for Q2 22/23 has reduced by 0.8% compared to Q2 21/22, at 17.1 ktCO2e. These emissions are the lowest for Q2 since the baseline year (2019/20) representing a 19% reduction. However, to be on track with the Trust's carbon budget, the aim was to see a 27% reduction in 22/23 Q2 emissions compared to baseline year.
- Energy emissions still dominate the MFT Carbon Footprint, responsible for 75% of the emissions. In Q2, gas consumption has reduced by 7.8% compared to Q2 of 21/22, while electricity consumption has only risen 0.6%. These changes are likely as a result of the new energy efficient infrastructure installed at various sites, combined with mild weather conditions. These changes have resulted in 1,222 tCO2e comparative savings.
- Anaesthetic and medical gas emissions have increased to a large extent by 59% in Q2 22/23 compared to Q2 21/22 (an additional 1,280 tCO2e), almost entirely a result of increased nitrous oxide and Entonox use. Desflurane use has reduced from a proportional rise last quarter: consumption is now 3.6% as a proportion of sevoflurane (by volume), compared to 8.7% in Q1 22/23 and 4.2% in Q2 21/22 (the national target is no higher than 5%). Upon further investigation, there has been a 2% increase in operations in Q1 and Q2 which will account for some of the increase.
- Weight of waste generated has increased by 2.6% compared to Q2 21/22, with a shift towards generating more domestic waste, and less clinical waste. While monthly clinical waste generation has varied above and below historic average, the generation of domestic waste throughout 22/23 has remained consistently above the historic average. As a result, 22/23 is averaging the highest monthly waste output since 2019/20. Domestic waste weights are likely to have remained high in Q2 22/23 due to HIVE (both preparation & shift in processes after Go-live).

The Climate Emergency Response Board (CERB) is now well-established and DF sought endorsement for the addition of new priorities to the CERB's work programme. The new priorities are to:

- Continue to support the CERB and embedded Green Plan objectives around the reduction in energy consumption, waste, and use of anaesthetic gases
- Support the development and roll out of a Sustainability Impact Assessment (integrated into a holistic impact assessment if preferred) to ensure that all business cases, service reconfigurations and other key organisational changes incorporate Green Plan requirements into decision making
- Incorporate sustainability requirement into job descriptions and include sustainability objectives into all leadership appraisals and high-carbon impact service areas
- Integrate carbon savings into the Trust Waste Reduction programme to capture results from existing measures and use as a mechanism to identify and drive further improvements
- Develop a comprehensive learning programme covering all staff and student groups, and consider mandating training where appropriate
- Embed sustainability messaging into leadership communications so there is a clearer top-down mandate, helping to create a culture where staff are more strongly encouraged to take local ownership as part of their day job, and we become less reliant on enthusiasts

GB commented that it was encouraging to see a multi-disciplinary team in place to drive the green agenda across the Trust. Really good progress has been made but there is lots to do and it would be helpful to have more clarity on the big areas to tackle.

In response to a question from TR regarding whether suppliers are impeding progress in delivery of the plan, DF explained that there had been a significant change over the last 8 years and suppliers, such as PFI companies, now work to their own green agenda and are driving positive change throughout their supply chain.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the contents of this report and endorse the additional priorities for the CERB to develop and deliver.	None	n/a	n/a

295/22 Update on the Trust's operational performance

General Update, Performance Standards and Recovery Programme

DF introduced the report which provided an update on the current operational position and progress with delivery of the Trust's Recovery Programme. He explained that the Trust had stepped down from OPEL 4 on the 6th January. MFT had enacted a command and control structure during the OPEL 4 period and utilised 'Business Continuity Incident' principles to support and coordinate activities for de-escalation of the situation. There continue to be daily meetings to monitor the situation as required and weekly Operational Excellence Board meetings.

DF explained that hospitals have been challenged across urgent care pathways throughout November and December, with escalating pressures across GM. The operational pressures are demonstrated through the performance against all of the key UEC metrics remaining challenged. The focus has been on maintaining clinical safety during the period.

Despite the emergency pressures Hospitals/MCSs have continued their efforts to ensure cancer and long wait patients are being treated. There has been good progress on reducing the backlog of patients waiting over 62 days for treatment on a cancer pathway, with a 31% reduction in the overall backlog during November. Trajectories and plans for 78 weeks have been revised which has reduced the residual number of patients waiting at the end of March. Current 78-week performance is delivering against plan and the total cohort of potential 78ww to end of March continues to reduce.

To support hospitals in tracking delivery and progress against plans an elective PMO hub has been established at group level. Focused actions through the PMO are supporting:

- validation of patients over 52+ weeks –
- coordination of mutual aid and independent sector transfers
- improvements in productivity and utilisation of theatres

Diagnostics has seen a growing waiting list trend with an increase in demand of 3.2% in emergency (unscheduled) care and a focus on cancer that is resulting in routine waits being extended. Improvement plans and trajectories are in place with additional weekend, extra clinical sessions and outsourcing in place to support a reduction in the overall waiting list size.

Across all key performance indicators work continues to bed in the new HIVE system, alongside validation and reconciliation of activity since data migration. Therefore. the data provided at this time is caveated.

DF commended the immense efforts from all MFT staff in maintain the care to patients during the very challenged period.

PB explained that staffing levels were still challenging with c.2600 staff absent from work on the day of the Board of Directors' meeting. There is ongoing work to address this, including focused work with trade unions and the full range of employee health and wellbeing programmes.

AA confirmed that they would continue to monitor the workforce situation through the Human Resources Scrutiny Committee (HRSC).

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the contents of the report and associated actions being undertaken to support safe and timely urgent/emergency and elective access for patients.	None	n/a	n/a

Update on the COVID-19 Vaccination Programme and Flu Vaccination Programme

CL presented the report which provided updates on national and regional Infection Prevention and Control guidance, the IPC Board assurance framework (IPC BAF), the current situation with Healthcare Associated infections (HCAI) of COVID-19 and other organisms, and the COVID-19 and seasonal influenza vaccination programmes.

CL explained that, on 14th April 2022, existing national COVID-19 guidance was withdrawn and replaced with the National Infection Prevention and Control Manual (NIPCM) for England. The infection prevention principles in place at MFT are based on the NIPCM and other published guidance, including the Hierarchy of Controls, with an emphasis on local decision making using a risk-based approach. These principles are reflected in MFT policies and procedural documents that have been developed by the IPC team. The MFT Chief Nurse and senior IPC team continue to contribute to national and regional discussions on infection prevention and control matters including COVID-19 and other HCAI.

The IPC BAF, updated on 30th November 2022, provides a framework for systematic review of the ten criteria within the Health and Social Care Act 2008. Since its inception, MFT has used the IPC BAF to identify supporting evidence, potential gaps in assurance and mitigating actions, and more latterly as a method to self-assess compliance with the NIPCM. For assurance purposes, CL highlighted the evidence against the key lines of enquiry within the IPC BAF, namely:

- Plans are in place to ensure appropriate placing of patients with respiratory conditions, with risk assessments based on the Hierarchy of Needs. The Assistant Chief Nurse for IPC is currently ensuring standardisation of the pathways in line with the NICPM.
- The Trust has a plan in place, led by the Director of Estates and Facilities, to implement the National Standards of Healthcare Cleanliness, monitored at the Group Infection Prevention and Control Committee.
- Trust policies and procedures are aligned to standard infection prevention control (SIPC) standards, and also aligned to transmission-based standards (TBS).
- Following extensive review of the evidence provided within the NHSE Rapid Review of Aerosol generating procedures (AGPs), and supported by the Clinical Advisory Group, MFT has removed some procedures previously considered to be aerosol generating.

- Face masks (FRSM) continue to be available in clinical areas, including in atria where some outpatient activity is conducted (for example in the Manchester Royal Eye Hospital). MFT meets national guidance regarding PPE and staff are provided with more resistant masks and equipment should they request it.
- Infection Prevention and Control training is mandatory for staff at level 1, and at level 2. Over 140 members of staff have enrolled on the Infection Prevention and Control Development Programme, including staff whose roles are not considered to be clinical. Training compliance is monitored at individual hospital/MCS/LCO level, with oversight at Group level.
- Patients discharged to care homes are tested for COVID-19 using PCR testing, 48 hours prior to their discharge, supporting appropriate and safe discharges.
- Dashboards are being developed with Hive, to support monitoring of IPC and AMS practice.
- The COVID-19 testing guidelines have been updated to reflect the pause which commenced on 5th September 2022 for asymptomatic staff and patients.
- There is an antimicrobial Stewardship Group in place, oversight mechanisms are being developed through Hive. The Group Chief Nurse is a member of the GM Integrated Care System Antimicrobial Reduction Board, contributing to system wide plans to reduce antibiotic usage.

CL noted that flu numbers across the Trust are now levelling out but Covid numbers continue to rise in both adults and children. Swift action is taken whenever outbreaks occur. The vaccination data within the report has changed since the time of writing and now about 50% of staff have been vaccinated. MFT have actions in place to improve uptake including: an increase in roving clinics to improve ease of access to vaccination; use of manager well-being discussions to encourage staff to have their vaccinations; and a series of engagement events to help alleviate any outstanding concerns staff may have in respect of vaccination.

In response to a question from KC regarding Carbapenemase-producing Enterobacterales, CL explained that there has been an increase noted in the vascular unit in the MRI and the hospital has recently carried out an IPC summit to address issues and raise staff awareness**.**

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the content of the report and the actions taken to prevent and reduce the spread of infection across all health care facilities.	None	n/a	n/a

296/22 Group Chief Finance Officer's Report Month 8

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

To November 2022, the Trust has delivered a year-to-date (YTD) deficit of £19.0m against a planned YTD breakeven position. This reflects an in-month surplus of £0.1m. In order to recover the YTD position, work on delivery of WRP schemes is given the highest priority and focus across the entire organisation.

In November, the GMICB put itself and all providers onto a Financial Recovery footing and requested all providers deliver a re-forecast demonstrating three scenarios, Best/Most Likely/Worst. As a result, the Trust presented a case which detailed, subject to a series of assumptions, that we would deliver a break-even position for Best Case, a £10.4m deficit for Most Likely, and a £50.8m deficit for Worst case. This was discussed in detail at the Finance & Digital Scrutiny Committees in October and December 2022.

In November 2022, total expenditure was £206.8m. This reflects a decrease of £2.1m compared to the October figure of £208.9m. Pay costs increased by £0.5m, in part due to the back pay associated with the VSM pay award being paid in month, but this was offset by £2.6m of reductions in non-pay expenditure, mainly due to some technical adjustments releasing flexibilities. Income was almost the same as in October at £206.9m with some offsetting movements between income from patient care activities and other income.

As at 30th November 2022, the Trust had a cash balance of £205.7m. The cash balance is broadly static following months of continued reductions, which is reflected by a reduction in sales ledger balances. The cash balance at the end of November was higher than forecast by £3m, primarily due to lower-than-forecast cash outflows relating to trade creditors.

The Trust will operate within the agreed GM final capital allocations which assumes £15m of the HIVE programme will be funded by PDC capital funding. £10.9m of National Frontline Digitisation PDC funding has been identified in support of this, and the Trust is currently securing this through the submission of an investment agreement.

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 30th November 2022, total expenditure was £69.5m against a plan of £79.0m, an underspend of £9.5m. Expenditure included within the GM envelope was £52.3m against the original plan of £43.4m, an overspend of £8.9m. For the full year, there is no forecast overspend assuming the £15m PDC funding is secured.

As reported to the Board of Directors in November 2022, the IFRS 16 guidance from NHS England was received in October and confirmed that, for 2022/23 only, capital expenditure incurred because of the adoption of IFRS 16 will be managed against a national "ringfenced" IFRS 16 CDEL allocation for the Trust, this totalled £139.8m for 2022/23. Work is continuing with the hospitals/MCS/LCO to progress leases required for 2022/23 already within their revenue budgets, and to agree a forecast requirement for CDEL - this will be reported to the Board and the FDSC at future meetings.

In response to a question from LG regarding whether a £10m deficit remained most likely following this month's deterioration in the financial situation, JEh confirmed that it was but the current operational pressures presented some risks to achieving it.

MD noted that there were lots of factors at play which influence the current financial situation but MFT is still aiming at a £10m deficit or better.

TR confirmed that the Finance and Digital Scrutiny Committee (FDSC) were closely monitoring the financial position and recognised that it would be a good achievement to deliver the Most Likely or Best Case scenarios.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Month 8 position against the 22/23 plan and cash and capital positions for the Trust.	None	n/a	n/a

297/22 Update on strategic developments

DB introduced the report which provided an update on strategic issues nationally, regionally, and within MFT.

Rt Hon Patricia Hewitt, former secretary of state for health and current chair of the Norfolk and Waveney Integrated Care Board (ICB), has been commissioned by Jeremy Hunt, Chancellor of the Exchequer and Health and Social Care Secretary Steve Barclay, to lead an independent review into the efficiency, autonomy and accountability of Integrated Care Systems (ICSs). A first draft of the full report will be completed by 31 January 2023 with the final report submitted no later than 15 March 2023.

The Government has established an Elective Recovery Taskforce, chaired by Care Minister Will Quince, to "reduce waiting times for patients and eliminate waits for routine care of over a year by 2025". The taskforce will focus on how the NHS can better commission from the independent sector; how the NHS can use existing capacity in the independent sector to reduce the backlog; and how to improve communication and collaboration between the NHS and independent sector The taskforce is expected to make recommendations to the Government in early 2023.

NHS England is proceeding with plans to delegate responsibility for the commissioning of some specialised services to Integrated Care Boards, although this will now not happen formally until April 2024. The current proposal is for all but the most specialised services to be delegated either to single-ICB or multi-ICS (e.g. North West) level. Work is underway PDF page 98 at both a GM and regional level to design the appropriate governance arrangements to support the discharge of these new powers. Shadow arrangements are likely to be put in place during 23/24 in readiness for formal delegation from 2024. MFT is involved in discussions about this at a national and regional level.

The 10 localities across Greater Manchester are working to confirm the governance arrangements for their locality board which will exercise the functions delegated from GM. There is an expectation from GM that locality boards are established by the end of this calendar year and will act as a committee of the NHS GM Integrated Care Board (ICB). The Manchester Partnership Board and Trafford Locality Board will act at the locality boards for Manchester and Trafford respectively. The functions for which localities will receive delegated budgets include local service transformation and the local delivery of primary care. There are a range of wider "distributed" functions for which budgets will sit centrally in the ICB but on which localities will be able to draw as appropriate.

The Greater Manchester ICB, working with the Trafford locality, is undertaking a review of local urgent care services that is expected to run until the summer of 2023. The purpose of the review is to ensure that services are simple to navigate, joined-up and meet the needs of all of the population both now and in the future. The first step will be to undertake a needs assessment which is expected to be completed in the coming months. This will include a process of public engagement to help to understand the needs of the people who access services and their views on what good urgent care looks like.

The national New Hospitals Programme team presented the Programme Business Case II to the Treasury Major Projects Review Group (MPRG) on 6 December 2022. Feedback from this was shared with all schemes in the programme on Monday 12th December. The key message was that individual feedback is not likely to be shared with each scheme until February because of the need for ministerial approval of the budget.

Single Service implementation is progressing, and Managed Single Service Boards are being established for all priority services. The management change for urology was enacted on 1st December – urology is now an MFT Single Service under the management of WTWA.

DR commented that the creation of the Urology single service showed the advantages of MFT's Group model and commended DB and the team for their work on this.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	None	n/a	n/a

298/22 Freedom to Speak Up annual report

PB began by giving an overview of the Freedom to Speak Up programme and then introduced KH, MFT's Freedom to Speak Up Guardian (FTSU) to speak to the report and stressed the important independence of her role.

KH explained that the FTSU Annual Report is for the period between the 1st April 2021 to the 31st March 2022 and was presented to the Human Resources Scrutiny Committee on 24th October 2022. A full time FTSU Guardian has been in post at MFT since 4th May 2021. The Guardian is supported by a growing and diverse network of FTSU champions.

During 2021-22, there has been an increase in the number of concerns raised via FTSU. 129 concerns were reported to the FTSU Team during this period. 36% (46 cases) of the cases raised had an element of bullying and harassment and 23% (30 cases) of the cases included an element of patient safety, and 14% (18) of cases had an element of worker safety. The latter cases were largely related to staff wellbeing and inability to take breaks with staff feeling vulnerable regarding workloads and numbers of patients. Themes of concerns which have been raised via FTSU have included equipment, internal transfer of patients, staffing levels, skill mix, patient flow, patient waiting times and isolated concerns related to clinical management.

GB, the FTSU NED lead, underlined the importance of the work and the need to maintain the impetus of the programme.

In response to a question from TR, KH stated that concerns and themes are matched to the relevant Hospital/MCS/LCO and that she works closely with the Human Resources' Directors at each to resolve presenting issues. She added that, as a result of this, there is a work underway with Emergency Departments at the moment.

CL welcomed the increased numbers of concerns raised over the year as it showed that staff were becoming more aware of the FTSU role and purpose. AA agreed and added that it was important to ensure that line managers were continuing to carry out their pastoral role with their staff and not relying on FTSU champions to deal with issues when they emerge.

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

299/22 Maternity services update including MFT's response to the East Kent Report 'Reading the Signals'

CL introduced the report which provided:

- a review of Saint Mary's Managed Clinical Service (SM MCS) in relation to the findings of the East Kent Maternity Report1 'Reading the Signals'
- the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety, with ongoing monitoring of compliance and progress with Ockenden Immediate and Essential Actions (IEAs)
- assurance to the Board of Directors on matters relating to patient safety within maternity services and compliance with the recently updated Year 4 Maternity Incentive Scheme (MIS)

Saint Mary's Managed Clinical Service (SM MCS) continue to monitor progress against the 15 Ockenden Final Report IEAs each month and report this to Saint Mary's Quality and Safety Committee (SM QSC) and Group Quality and Performance Scrutiny Committee (QPSC). Currently compliance with the IEAs is 77%, which is an increase of 3% since reporting to the Board of Directors in November 2022. To support the embedding of Hive and accurate data capture, it is expected that all provider actions will be completed by March 2023 rather than December 2022 as originally planned. Evidence of ongoing compliance for IEAs is now discussed in detail at QPSC bi-monthly.

The review of the governance and reporting arrangements is near completion with progress being made to improve maternity data and develop a robust dashboard for monitoring, reporting and onward escalation; improve reporting to the Board of Directors to strengthen assurance of quality and safety in maternity services; and develop a new maternity and neonatal quality and safety meeting.

Evidence of compliance of Year 4 MIS Safety Actions has been submitted and approved by Saint Mary's Quality and Safety Committee and confirmed as meeting all requirements.

CL explained that the CQC are inspecting all maternity services. MFT has commissioned an external review of Saint Mary's governance which has been presented to the Saint Mary's Board. A dashboard has been created to enhance monitoring of performance, quality, and safety and it is expected to have a suite of over 200 indicators in place by the end of March 2023. 34 metrics are now visible on the dashboard and being utilised in practice, CL highlighted some examples of the new metrics which were present in the report.

DR commended the comprehensive and candid nature of the report and asked about progress made against the actions included. CL described how the differences in culture across MFT had been highlighted through the work to develop a single Trust-wide maternity service. There has been a focus on NMGH, ensuring more staff are working in maternity services there, and engaging with staff to improve the service.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the information provided within the report and approved the declaration of SM MCS compliance of all 10 safety actions within the MIS year 4 for signing by the Group Chief Executive.	Progress on maternity services' culture work to be presented to a future HRSC.	CL	April 2023

300/22 Minutes of Board Sub- Committees held in November and December 2022

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

- Group Risk Oversight Committee held on 21st November 2022
- ERP Scrutiny Committee held on 30th November 2022
- Quality Performance and Scrutiny Committee held on 7th December 2022
- Human Resources Scrutiny Committee held on 13th December 2022
- Charitable Funds Committee held on 20th December 2022
- Finance and Digital Scrutiny Committee

Board Decision:	Action	Responsible officer	Completion date
The Board noted the minutes	n/a	n/a	n/a

301/22 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 13th March 2023 at 2:00pm

302/22 Any Other Business

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 9th January 2023		
Action	Responsibility	Completion date
Progress on maternity services' culture work to be presented to a future HRSC.	C. Lenney	Complete *(Included on the HRSC work programme)*

Mrs Kathy Cowell, OBE DL
Group Chairman …… *Signature* …../……../……. *Date*

Mr Nick Gomm
Director of Corporate Services / ……. *Signature* …../……../……..
Trust Board Secretary *Date*

Agenda Item 8.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chairman
Paper prepared by:	Director of Corporate Business / Trust Board Secretary
Date of paper:	March 2023
Subject:	Board Governance Review
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:	A strong and effective governance structure supports MFT to deliver its strategic aims, and meet its statutory responsibilities, in an effective, efficient, and accountable way.
Recommendations:	The Board of Directors is asked to note the progress made with the Board Governance Review and receive a further report at its meeting in May 2023.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Secretary Tel: 0161 276 4841

1. Introduction

This report updates the Board of Directors (Board) on the progress of the Board Governance Review, initiated by the Group Chairman in the Autumn of 2022.

2. Background

2.1 Following the lengthy period of disruption caused by the pandemic, a Board Governance Review was commenced to ensure that:

- The Board retains sufficient oversight of all MFT's business.
- The Board's Scrutiny Committees have clear responsibilities, appropriate membership, and reflect NHSE requirements and MFT's Scheme of Reservation and Delegation.
- The information provided to Scrutiny Committees is sufficient for them to deliver their duties.
- MFT's Board governance is in line with the requirements of the new Code of Governance and the CQC Well Led framework.

2.2 The review is considering:

- The scope, membership, and chairing of Scrutiny Committees.
- The work programmes of the Board and Scrutiny Committees.
- The format of agendas for the Board and Scrutiny Committees.
- How information flows from Scrutiny Committees to the Board, and from the Group Management Board and its committees through to Scrutiny Committees and the Board of Directors.
- The roles, responsibilities, and expectations of NEDs.
- The way in which Governors function in line with their new responsibilities within the 2022 Code of Governance.
- Existing policies and processes which support good governance e.g. Standards of Business Conduct.

3. Progress and next steps

3.1 During November and December 2022, discussions were held with Group Executive and Non-Executive Directors to inform the work. Improvement opportunities identified included:

- Strengthening assurance through use of the enhanced information available from Hive.
- Increasing consideration of the health inequalities, and diversity and inclusion matters, within Board and Committee reports.
- Spending more time on strategy at Board and Scrutiny Committees
- Increasing the awareness of Non-Executive Directors with regard to the work of individual Hospitals/MCSs/LCOs.
- Strengthening the reporting from Scrutiny Committees to the Board, and from Group Management Board and its sub-committees to the Scrutiny Committees.
- Increased visibility at Board or Scrutiny Committee level of some areas of MFT's work, for example estate development and research/innovation.
- Board development sessions including both Executive and Non-Executive Directors.
- Changes in the scope of some Scrutiny Committees.
- Improved use of the time and expertise of Non-Executive Directors.
- Ensuring that MFT's Governors receive sufficient information in order to be able to deliver their role effectively.
- Increasing the visibility of the work of Greater Manchester's Integrated Care System, and MFT's contribution to it, within reports.

3.2 It was also identified that there is a need to enhance the information presented to the Board which provides assurance on current performance across the key areas of Operational Excellence, Quality and Safety, Workforce, and Finance. Up until now, that has been provided through the Board Assurance Report, presented at each Board meeting. It was felt that the format and content of this report could be improved so a piece of work is already underway to improve this. This will lead to a new Integrated Performance Report being presented to the Board at its next meeting in May. In the absence of the Board Assurance Report for this meeting, the Non-Executive Director Chairs of the Quality and Performance, Human Resources, and Finance and Digital Scrutiny Committees will provide a verbal report on the matters discussed at their meetings during February.

3.3 The Board Assurance Framework (BAF), which was due to be presented at today's Board, will be reviewed in light of the new Integrated Performance Report referred to in 3.2 above. This will ensure that the two reports complement each other and provide the necessary assurance to the Board to enable it to carry out its duties. The BAF will therefore next be presented to the Board at May's meeting.

3.4 Following the engagement work, a plan is being drawn up which will be discussed with the new Group Chief Executive during March. A further report describing the proposed actions, and seeking approval for any changes to the Terms of Reference for the Scrutiny Committees, will be presented at the next meeting of the Board in May 2023.

4. Recommendations

4.1 The Board of Directors is asked to note the progress made with the Board Governance Review and receive a further report at its meeting in May 2023.

Agenda Item 8.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director Senior Responsible Officer for Hive Programme
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	March 2023
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 since Go Live completion and the significant progress made in the first phase of Stabilisation.
Contact:	Name: Julia Bridgewater, Group Executive Director Senior Responsible Officer for Hive Programme 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 now has an Electronic Patient Record (EPR) solution, **Hive**, which will support 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 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 From September 2021, Julia Bridgewater, Group Chief Operating Officer has been providing dedicated Executive level oversight and leadership for the Hive Programme.

1.5 Following the two-year design, implementation testing and training phase, which was supported by robust programme management, Hive **went Live on 8th September 2022**. The Go Live was overseen by a full Group Executive led 24/7 command structure.

1.6 Following Go Live, the command structures were in place for five weeks ensuring a successful, safe and efficient transition by providing real time escalation and support to all Hospitals/Managed Clinical Services and the Local Care Organisation.

1.7 Following the cessation of the command centre structures, the programme moved into the Stabilisation Phase with supporting governance structures stood up to ensure the organisation continues to support staff with the transition and so that early benefits can be realised.

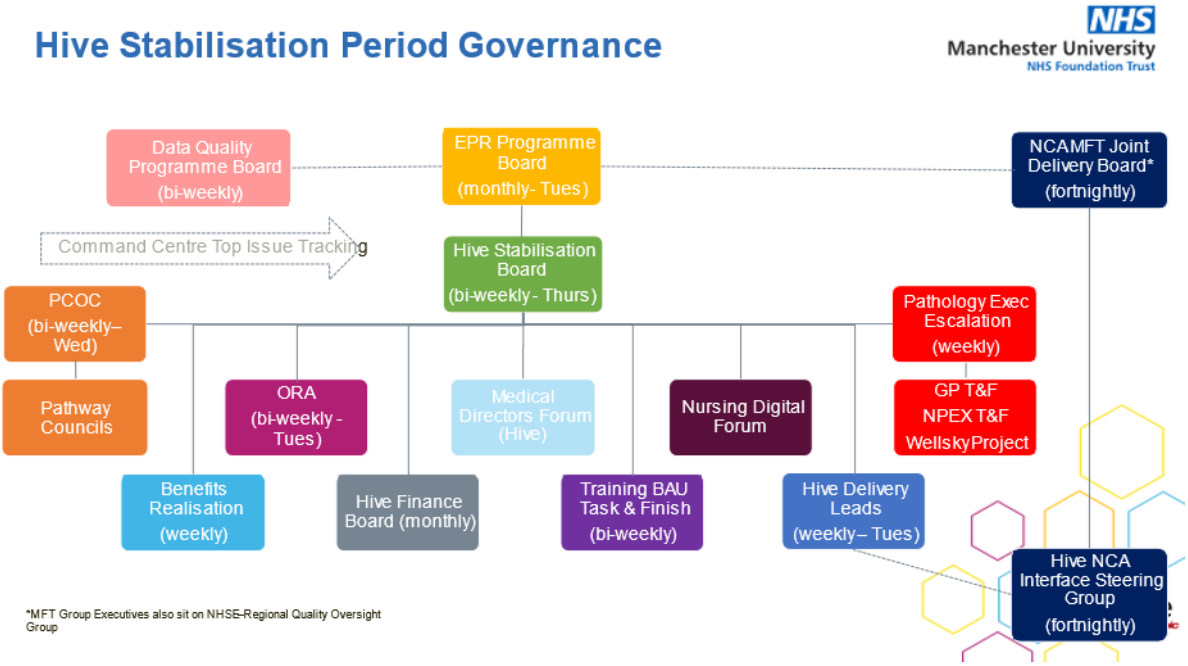
1.8 This paper provided an update in key progress in the Stabilisation phase since the last Board and outlines the planning for 2023/24.

2. Hive Stabilisation Phase Update

2.1 As reported at the last Board, feedback from outside MFT and from Epic is that this is one of Epic's best *Go Lives* which is an incredible achievement given the size, scale and complexity of the event. MFT have delivered the biggest Go Live in Europe and the second largest globally. This however does not mean the work is complete, the stabilisation phase has been intensive with the Hive, Informatics, Transformation and Hospital/MSC teams working in union to address escalations and the stabilisation priorities.

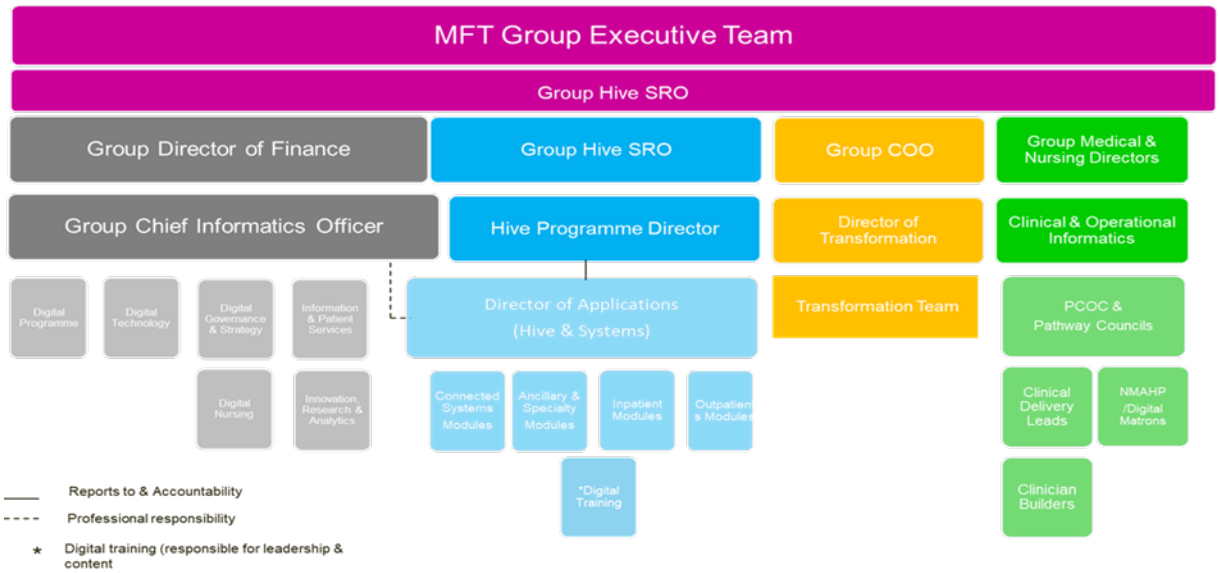
2.2 MFT have begun to share the learning from the Implementation, Go Live and Stabilisation Phase with other NHS organisations who are planning EPR procurements and implementations. This is aimed to ensure that areas of good practice can be replicated and equally important, areas where improvements could have been achieved are shared.

2.3 Considerable progress has been made since the programme moved from the hyper support/command to the Stabilisation Phase. The Stabilisation Governance as outlined below has matured and continues to be overseen by the Hive Senior Responsible Officer (Julia Bridgewater). This governance will continue to be in place moving into 2023/24 to ensure **progress continues and priorities are delivered**.



2.4 A key priority in the Stabilisation phase and an issue heighted by Epic as vital for delivery before the end of December 2022 was the agreement on the Hive/Informatics/Transformation organisational structures to oversee the programme moving into 2023/24. Clearly this is essential to ensure the organisation has the best platform to deliver the Hive Benefits.

2.5 Given the scale, complexity, journey of culture change and transformation that is required to deliver these benefits – a transitional organisational leadership structure has now been agreed. This transitional structure will ensure that the successful leadership partnership between Informatics/Hive/Transformation continues and further develops the ***Clinically led, Operationally delivered, Digital enabled strategy***.



2.6 A number of **key themes** continue to be overseen by **Pathway Councils** (20 clinically led groups made up of the full set of professional and administrative groups from across all Hospitals/MCS/LCO) and bespoke task and finish groups:

- **Depth of training** & understanding of workflows (impacts on flow, discharge, user engagement)
- **Pharmacy** - medication pathway workflow compliance and financial reconciliation
- **Data quality & reporting** (legacy data transferred into Hive, reporting & tracking). The Group executive team is working closely with national colleagues to ensure reporting priorities and agreed and delivered.

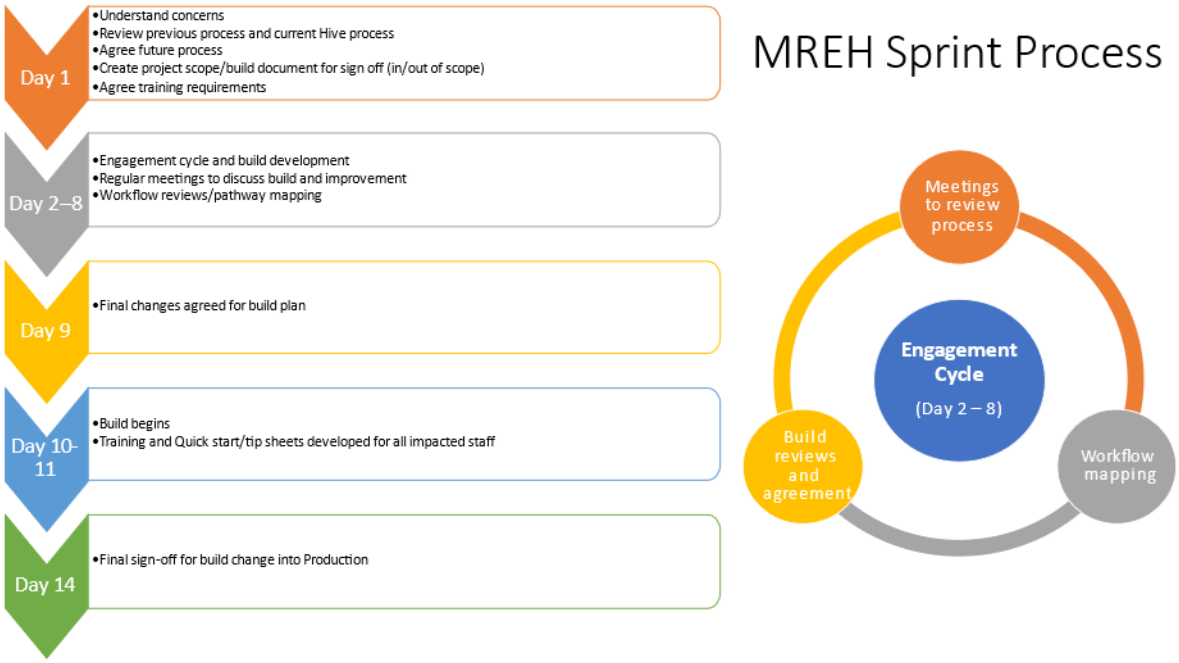
2.7 The Pathway Councils report into the **Pathway Council Oversight Committee** (PCOC), which is chaired by the Joint Group Medical Director, which ensures any decisions on build and workflow are congruent with the Trust's vertical (Hospital/MCS) and horizontal (Hive) pathways.

Key progress which has been achieved and enhanced since the last Board is as follows:

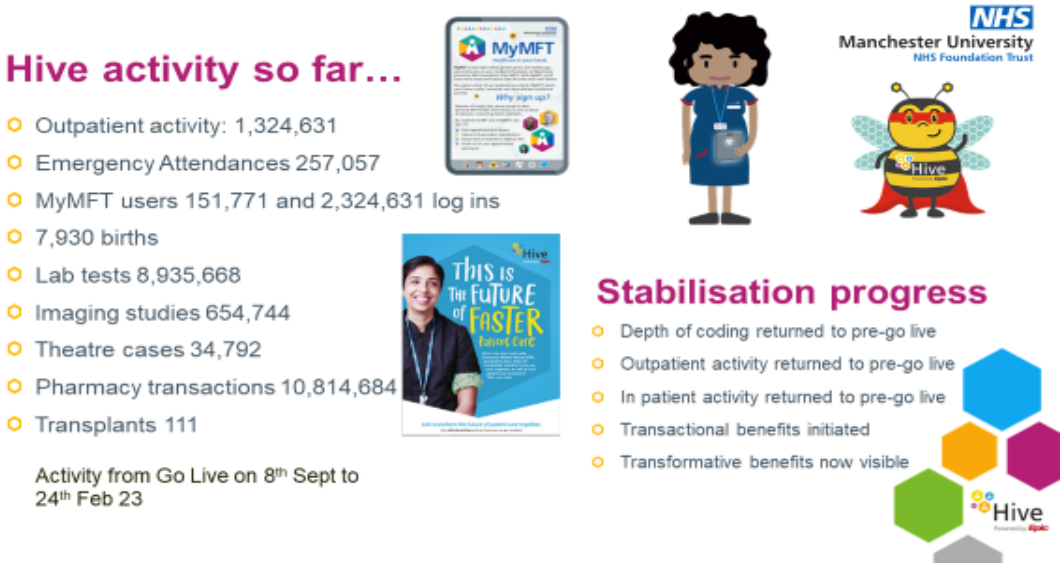
- **Governance** structures designed, implemented, and embedded
- **Hive on-call** support supported processes, designed, implemented and refined to meet service needs
- Review of **Hive teams' capacity** to deliver stabilisation and optimisation
- Launch of 6-month project group to oversee **Hive Training** as it transitions to **Business as Usual**. The group is on track to deliver the new training for 2023/24
- Epic **Post Go Live Visit** completed with associated priorities and actions agreed
- Delivery of dedicated programme of work in Royal Eye Hospital (REH) delivered via agile project management approach using '**Sprint Methodology'** and learning from this has informed the **Outpatient Improvement Project**
- Review of **benefits realisation programme** to ensure early benefits are delivered
- Inpatient and Outpatient **activity** is back to pre- Go Live levels
- **Depth of coding** is back to pre-Go Live levels

2.8 Following engagement with the Royal Eye Hospital (MREH) clinical and management teams, it was agreed that a set of four 'Hive Sprints' would take place prior to the end of 2022. These are led by the Group Medical Director and supported by the Hive applications and transformation teams. Following their success and to ensure progress continues these were extended into the new year so that final priorities and learning from earlier sprints could be realised.

2.9 The MREH Sprints are focussing on the speedy turnaround of digital solutions to the clinical and operational areas of improvement identified. The approach requires a multi-disciplinary team from the Eye Hospital to agree and prioritise the requirements. In addition to the digital enhancements, the changes require Hospital ownership to operationalise. Learning from this approach is being applied to the Outpatients area of work, initially aiming to introduce improvements through quick wins for the largest number of users. Further refinements have now been implemented as outlined in section 7 - Transformation. The REH Sprint process followed the following methodology:



2.10 A summary of the Hive activity so far and stabilisation headlines is as follows:



2.11 A formal Central **120 day Post Live Readiness Assessment Day** (PLRA) took place on 10th February which was divided into two parts. **Part one** focussed on the **overall programme** updates including: Pathway Council Oversight Committee, Digital nursing, Training, Outpatient Improvement Programme and Reporting/Business Intelligence. **Part two focused on benefits realisation.** Hospitals/MCS presented key learning from the early benefits, and these are summarised in section 7. Prior to this, a PLRA took place in each Hospital/MCS/LCO, led by their respective Chief Executives, which assessed and provided assurance on progress against key stabilisation milestones and benefits realisation workstreams.

2.12 MFT led a **Health inequalities workshop** in January which was attended by many different stakeholders from the health economy. Hive has now provided the data and functionality to help inform, in a way that was not possible before, analysis of how health provision delivery differs amongst our diverse population, and this will inform MFTs priorities on this vital objective. Initially focus will be on Outpatients.

2.13 The Stabilisation phase marks the start of the transition from the from the Hive being a programme to the key vehicle **for facilitating our clinically led digital transformation** and delivery of our full safety, efficiency and workforce benefits realisation.

3. Training – Stabilisation progress Update

3.1 Training teams across Hive and Informatics have been working with a number of stakeholder groups to address Future State Training. The Go Live training which involved the majority of the staff groups undertaking significant hours of face-to-face training. Since go live MFT has used Just In Time Training for all new starters and the programme of work will replace this.

3.2 The training team are actively working with **Subject Matter Experts** to support the development and sign off of materials for training. The new training offer will be simpler and more standardised offering core content with additional 'bolt on' content to cover some of the more specialised areas.

3.3 There have also been a number of pieces of work undertaken to support **bespoke training** where a need has been recognised. In areas such as Cancer, RTT (Referral to Treatment Pathways), Personalisation and prescribing. The Hive team have taken a new approach partnering with the organisation's experts to deliver more comprehensive training in these areas where the focus is on the subject matter as well as the use of the Hive system. An example of this is Outpatient Improvement Programme work where the training and transformation teams have put together a personalisation package to support Consultants using Hive in Outpatients.

3.4 Training work continues to grow and many of the bespoke training approaches feed well into MFT's desire to create a **Thrive training** programme with a focus on staff who have already done the new starter trainer but can have additional training experiences to further support their adoption of Hive and their efficiency in system. The principles of the Thrive approach are being worked up and this will launch in 2023/24.

3.5 **The Clinical builder** programme has now been launched which will see clinicians from across all Hospitals/MCS/LCO undergo formal Epic training and certification to build and develop Hive content. A number of staff have already been fully certificated. This will facilitate dynamic service development (within a structured governance framework) to ensure benefits can be iteratively realised without the need of a Hive analyst whose time can be freed up on larger progarmmes of work. Clinical builders have shown to also drive clinical engagement with the analyst team ensuring a truly **clinical led digitally enabled transformation.**

3.6 **The Power User** Training programme has also been initiated. Power users are staff who use Hive at its optimum level, sharing and developing others, taking personalisation of the system to another level and helping facilitate local autonomy. Power users gain their expertise via 18 personalistion classes, the completion of exercises and assessments and via the submission of a change project. MFT aims to develop a **vibrant community** of builders and power users across the organistion.

3.7 The Hive Training team have also been supporting the programme of work to ensure robust and safe service delivery in the event of the planned **Junior doctor strike action**. In addition to training and provisioning on the system, the team will also support the command centres which will be stood up to ensure any escalations can be responded to in real time.

4. Governance and Risk Management

4.1 Robust external assurance arrangements remain in place with Deloitte providing regular gateway reviews. The final Gateway review (Gateway 5) has now been confirmed to take place in February and March 2023 and will focus on stabilisation success, optimisation and benefits realisation. The report will be presented to the April 2023 EPR Scrutiny Committee. Deloitte are on track with their interviews and documentation analysis and will ensure learning from other EPR implementations (UK and International) informs their recommendations.

4.2 Given the size and complexity of the programme, the standalone EPR Scrutiny Committee which has met on a bi-monthly basis chaired by Barry Clare, Non-Executive Director will continue to oversee the programme. The Deloitte External Assurance Reports are reported to this committee. Gaurav Batra, Non-Executive Director has now taken over the chair of the Scrutiny Committee with the first meeting under his leadership took place on 25th January 23.

4.3 The management of the Hive Programme has had a robust risk management and strategy in place that continues to align to and report directly into the Trust Group Risk Oversight Committee (GROC). This has enabled clear executive ownership on Hive risks and also ensured that the risks were assessed and mitigated in line with interdependences on all the other Trust workstreams.

4.4 As reported at the last Board meeting, there were five overall high level risks that have been reported into and managed via GROC. These were as follows:

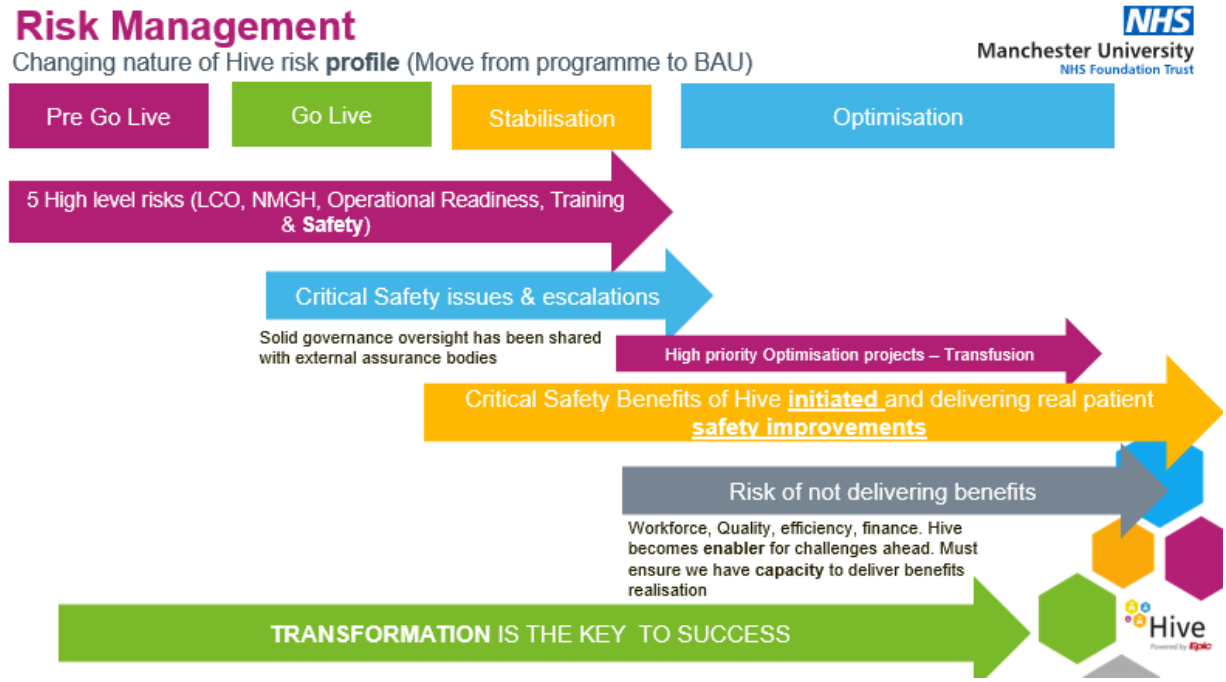
- Potential impacts on safety if the programme is not delivered effectively
- The risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live.
- Management of complex pathways at North Manchester General Hospital
- The inclusion of the Local Care Organisation into the Hive Programme (which was agreed later than the acute hospitals
- Training

Each of these risks had dedicated mitigations in place prior to Go Live which were reported into GROC and managed through the Hive Programme Governance process.

Four of the five risks were formally downgraded at the November 2023 GROC, with the remaining high-level risk (Potential impacts on Patient Safety) scheduled to be downgraded following sufficient timescale for analysis and review. A formal review is currently taking place accordingly and this will be presented to both GROC and also the Quality and Safety Committee.

4.5 As part of the Go Live Hyper Acute/Command Phase, which was in place 24/7 for five weeks following Go Live, and the new Stabilisation Phase Governance all issues/escalations related to Hive implementation have had and continue to have Group Executive level oversight. These are managed by the Hive and Group Executive leadership team with close working with the Hospital/Managed Clinical Services.

4.6 As progress in the Stabilisation phase continues, the risk profile is changing as demonstrated by the schematic below. The risk of not delivering the benefits on workforce, quality, efficiency and finance is now being closely managed as outlined in section 8.



5. Communications and Engagement

5.1 As the programme moved into the second phase of the Stabilisation Period in early 2023 the communications approach has moved to align closely with the current priorities with a focus on sharing best practice and early benefits.

5.2 In February, a new **'How Hive Helps'** campaign to support staff in making their Hive experience smoother and more efficient. This campaign aligns to the ongoing Outpatient Improvement Programme led by the Transformation Team which aims to ensure the spread of best practice for personalisation to support efficiency.

5.3 The focus of the first ‘How Hive Helps’ topic encourages staff to utilise Hive’s range of personalisation options and Smart Tools, which are designed to save Hive users time in clinic when performing regular tasks such as updating patient notes or ordering medication.

5.4 A suite of materials for staff has been produced including short demos, guidance posters, and testimonials from staff who are already advocates of personalisation. ‘How Hive Helps’ is an ongoing campaign and will showcase more easy-to-digest tips and guidance for staff over the coming months.

5.5 Work has begun on the creation of a ***Hive Insights and Early Benefits Report*****.** The report, which is planned to launch in Q1 of 2023/24, aims to showcase the unique journey of an Epic Go Live at the UK’s largest Foundation Trust by highlighting the early benefits that have been realised through testimonials and case studies, whilst demonstrating key achievements and lessons learned.

5.6 The report will draw on and be guided by Hive's overarching ‘***Clinically led, Operationally delivered, Digitally enabled’*** approach highlighting the wide-spread involvement in Hive’s implementation. The report will also provide a great opportunity to illustrate the beneficial features and outputs that Hive brings to staff and patients, such as MyMFT, clinical data and the use of digital devices.

5.7 As the Hive Training Team develop their Future State/Business as Usual training offer, the Communication Team are working to develop staff facing communications to support the rollout of the new training offer and grow staff knowledge and understanding.

5.8 MyMFT patient portal sign up numbers continue to grow with ~150k patients (end Feb) now signed up to the online portal and mobile app. A MyMFT information and support session was held for the MFT Council of Governors on 1st February to build understanding and gain feedback. A further workshop is planned for internal and external stakeholders on 21st March.

6 Technical Deployment

6.1 The Hive Technical team have continued to support the system and the project team are making good progress in the transfer of responsibilities into the Informatics business as usual structure. Teams across IT Operations and IT Infrastructure continue to refine and improve on processes, ensuring that the good elements learned from Go-Live are embedded and built upon. There is a continued focus on issues arising from the processes in place for Access and Identity with a new review being undertaken to improve the turnaround on requests and ensuring a right first-time approach is taken.

6.2 Technical teams have led a multidisciplinary approach to supporting clinical teams with understanding how to utilise the technology deployed and how to support more efficient workflows. The collaboration between technical, Hive application and digital clinical teams enabled resolutions to workflow issues, with the following being achieved:

- Continued education for end users on what is possible on each device in the workflows
- Continued support for areas which have network connectivity issues to put in place alternative solutions

- Alternative device solutions being proposed to alleviate access to a device challenge

7 Transformation

7.1 Post Go Live the Transformation Team have been focussed on embedding the new ways of working across the pathways. The Transformation team are key members of the Pathway Councils and are supporting the prioritised change activities – which are focussed on stabilisation and benefits realisation

7.2 A particular area of focus has been the launch of the Outpatient Improvement Programme. The initial diagnostic work established that there was a significant opportunity for quick wins by utilizing Hive to automate repetitive tasks. A communications and engagement campaign was launched during week commencing 27th February ('Tips and Tricks to Save You Clicks') which includes short video tutorials and testimonials from clinicians who are already benefiting from this functionality. This campaign will be endorsed and promoted through the appropriate clinical and managerial structures. The aim is to increase the number of early adopters and create a critical mass such that the benefits of this functionality spread swiftly across MFT.

7.3 The initial outpatient diagnostic work is now complete and has established that the other required solutions are best categorized into training, technical, transformation and build solutions. There is a need to prioritise and manage the progress of this work and the Outpatient Improvement Programme will report into the Outpatients Programme Steering Committee to achieve this.

7.4 The Group Hive Post Live Readiness Assessment on 10th February included a 'Share and Learn' session where Hospitals/MCS shared good practice and early benefits, highlights included:

- MREH summary of Outpatient Sprints and streamlining of correspondence to Qualified Teachers of the Visually Impaired.
- WTWA dermatology taking and uploading of patient photos into Hive to improve patient safety by reducing the risk of wrong site surgery.

- SMH development of maternity and neonatal safety dashboard to provide executive team with overview of key safety metrics.
- CSS projects to reduce medicine spend and manage laboratory demand, where information from Hive will enable efficiency savings.
- RMCH 5% increase in theatre utilisation through more efficient scheduling and access to clinical information in real time.
- MRI insights into Barcode Medicine Administration: 36 critical administration errors have been avoided since October.
- NMGH use of patient flow dashboards to improve ED performance and reduce length of stay.

7.5 As outlined in the section 4 – the risk profile is now shifting to the risk of not delivering the Hive benefits from the risk of initial implementation. The PLRA demonstrated the excellent start which has been made in delivery of early benefits and the key to the success in full delivery will be enacting Trust Wide transformational change. Leadership from the transformation team is essential to this objective and the benefits section below (section 8) demonstrates the close working of all the teams.

8 Benefits Realisation

8.1 Review and planning work continues between Group and Hospital / MCS teams on key programmes of early implementing cash-releasing benefits including: Automation, redesign and process change in clinical administration and outsourced typing; Informatics legacy systems shutdown; Electronic Document Management Storage; and paper-lite operations.

8.2 In October 2022 proposals were submitted to the EPR Implementation & Benefits Realisation Programme Board ("EPR Programme Board") aimed at reviewing and strengthening plan development and workstream focussed oversight governance committees.

8.3 Two benefit realisation oversight forums have since been set up to support the alignment of emerging stabilisation governance. These are being used to further drive planning and management of Administration & Clerical (A&C), and Information Services programmes of work. Operational Productivity benefits are currently being driven through already established committees.

8.4 An A&C benefits forum was constituted in December 2022, three meetings have been held to date with attendance from all Hospital / MCS sites and with Group Human Resources, and Chief Operating Officer Team representation. The forum is progressing forwards with the following:

- Development, delivery and monitoring of administration and clerical benefits resulting from Hive implementation
- Ensuring there are appropriate data inputs and reporting outputs to evidence planning and successful delivery

8.5 The Informatics services benefits forum was constituted in January 2023, and two meetings have been held with attendance from relevant workstream leads. The forum is progressing forwards with a scheduled plan to decommission legacy systems.

8.6 Work has continued to review and further develop a benefit register for all types of benefits, including emergent benefits and the identification of appropriate key performance indicators to measure delivery of the benefit post Hive implementation. This register development work has been completed alongside the Transformation activity underpinning the change projects that support benefit realisation.

8.7 There is continued focus on the development of a benefits dashboard in partnership with Information Services and Hive Business Intelligence. A prioritisation and scoping exercise of additional build requirements was completed in December, and work is continuing to be progressed through the Business Intelligence Domain Groups workstreams, with meetings progressing in January and February .

8.8 As part of the February Post Go Live Readiness Assessment, Hospitals / MCS presented updates on benefits realisation, as well as the plans for 23/24 planning. The case studies presented will be included as part of the Hive Insights and Early Benefits Report, which is due to be published in May.

8.9 An update on cash releasing benefits was provided to the February EPR Implementation & Benefits Realisation Programme Board. Of an assumed £4.0m of benefits in Quarter 4 of FY22/23 (some programmes having been re-baselined from original Full Business Case), £1.7M is currently expected to be delivered. An element driving this slippage relates to timing of expected delivery, and plans are being developed in 23/24 to partially recover this value.

8.10 In terms of non-financial and emergent benefit planning and delivery, regular discussions are taking place via the Pathway Council Oversight Committee, with continued feedback on clinical changes expected to be provided to the benefits team. Details of such benefits will be also included as part of the Hive Insights and Early Benefits Report referenced in section 5.

8.11 The fifth and final Gateway Review is currently being planned with MFTs EPR external assurance partner – Deloitte and is scheduled to take place in March 2023. This will focus on reviewing the Hive Organisational and Governance Structures to ensure they are best placed to oversee benefits delivery. The review will also consider planning and development of the benefits programme; progress against cash and non-cash releasing benefits and consider if MFT is using national and international learning to maximise delivery outcomes.

9 Next Steps

9.1 The Hive Programme is now nearing the end of Phase 2 of Initial Stabilisation Phase, following Go Live on 8th September 2022, and the focus moving into 23/24 will be to ensure that Optimisation and Benefits Realisation are delivered.

9.2 September 8th represented the beginning of a process of continuous improvement in to improve patient safety, patient experience and our workforce experience. Hive will now facilitate this transformation programme which is: ***Clinically led, Operationally Delivered and Digitally Enabled.***

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

10 Recommendation

10.1 The Board of Directors is asked to note the progress made since Go Live completion and the significant progress made in the first phase of Stabilisation.

Agenda Item 8.3.1

0MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Operating Officer
Paper prepared by:	Group Chief Operating Officer Team
Date of paper:	March 2023
Subject:	Performance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	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

1. PURPOSE

The purpose of this briefing is to provide an overview of the Manchester Foundation Trust (MFT) ongoing recovery to the COVID pandemic, including operational planning, performance, and improvement / transformation activities focusing on 4 areas: -

.

- Patient Safety, including Emergency Department and flow
- Cancer performance
- Approach to treating long-wait patients
- Diagnostic waits

2. EXECUTIVE SUMMARY

Across emergency care pathways Hospitals have seen pressures easing slightly since mid January which has been supported by lower attendances and winter wards now fully mobilised. This has resulted in an improvement in a number of performance metrics, with the 4hr A&E standard reporting 60.4% at the end of January, an increase of 9% from December and ambulance handover delays >60 minutes also reporting a significant reduction. Occupancy levels remain high and no reason to reside numbers have remained relatively static at 330 since December against a target of 240. Transformation work continues through enhancing Same Day Emergency Care (SDEC) services, increasing virtual ward capacity and roll out of the 'back to basics' part of the Resilient Discharge programme, all of which improve ambulance handovers, reduce the time patients spend in A&E and flow out of hospitals.

Hospitals/MCSs have continued their efforts to ensure cancer and long wait patients are being treated. There has been good progress on reducing the backlog of patients waiting over 62 days for treatment on a cancer pathway, with a 39% reduction in the overall backlog since November. The plan is to return to pre-pandemic levels and MFT are on track to deliver this by the end of March. Equally, there has been good progress on reducing the number of potential 78 week waits by end of March. Whilst the number of breaches is tracking above plan. the total potential cohort is reducing in line with the straight line trajectory. Mutual aid continues to be sort for the known residual number of patients waiting by the end of March. The elective PMO continues to support hospitals in tracking delivery and progress against plans. Validation of patients over 52+ weeks is on-going with circa 80,000 patients being contacted to date which has resulted in a 10% removal rate.

Diagnostics has seen a growing waiting list trend since September as a result of an increase in demand of 3.2% in emergency (unscheduled) care and a focus on cancer. There has been a significant increase in the number of patients waiting for CT, MRI, NOUS and Audiology since September. This is being investigated through the dedicated Taskforce group set up to cleanse the DM01 following HIVE data migration. Improvement plans and trajectories are in place with additional weekend, extra clinical sessions and outsourcing in place to support a reduction in the overall waiting list size. Good progress has been made in improving the turnaround times for CT and MRI scan for patients on a cancer pathway, from 13 days to 8 days since September

Across all key performance indicators work continues bedding in the new HIVE system alongside validation and reconciliation of activity since data migration and therefore data needs to be caveated.

3. URGENT CARE AND FLOW

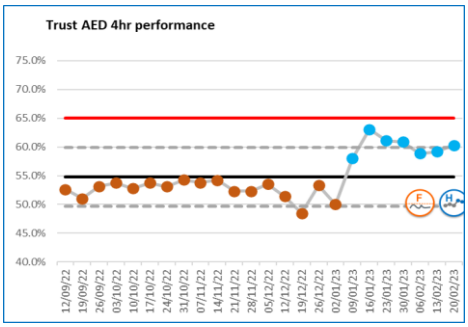
Urgent Care Current Position

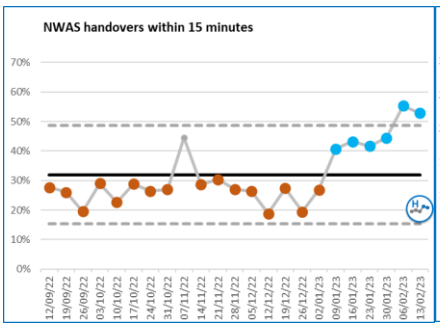
Performance against the A&E 4hr standard had remained largely stable April through to August following which performance had dropped to circa 53%, it remained fairly static to the end of November and dipped marginally in December as a result of emergency pressures across GM during this time.

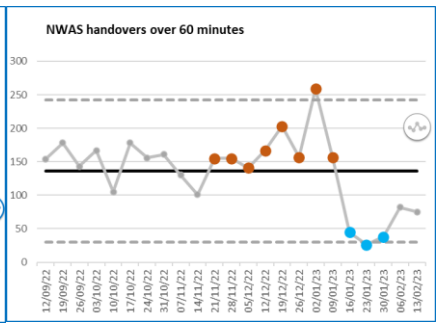
More recently, emergency pressures have reduced with overall attends in January reducing circa 15% on December's level of 41,410 to 35,092. Ambulance handover delays and holds have dropped back to levels last observed in November 2021. However, challenges remain with flow and high occupancy rates are still being reported across the adult acute sites, levels of emergency admission through the department remain high with a conversion rate of around 17.2% of all attendances, the average conversion rate for the year to date is 17.6%. Acuity remains high across several pathways and the number of patients on the no reason to reside list remains at a sub optimal level.

Hospitals continue to focus efforts on improving flow out of the department and ensuring patient safety is maintained.

Key performance Indicator	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
A&E 4 Hour Access	95%	63.8%	63.5%	62.1%	61.1%	63.1%	52.9%	53.0%	53.2%	51.6%	60.4%
A&E GM 4 hour Access	95%	61.4%	62.8%	60%	60.8%	61.3%	59.5%	54.1%	53.2%	52.4%	60.6%
12 hour DTA breaches	0	127	21	68	9	47	197	450	450	780	524
> 12 hours total time in dept.	<2%	8.0%	6.5%	7.7%	9.2%	9.6%	11.1%	13.4%	12.4%	13.3%	10.1%
NWAS handover delays 30-60 mins	<5%	12.5%	11.5%	11.6%	13.5%	14.5%	15.0%	15.8%	14.1%	14.6%	13.3%
NWAS handover delays 60 mins+	0	508	387	760	599	669	657	667	609	762	291
No Reason To Reside	240	299	301	351	348	394	344	376	351	348	325







Ongoing Actions:

The Transformation work programme continues with the below areas of focus:

- Increase in the number and types of beds available in community for supported discharges
- Increase in the number of patients transferred from ED departments through to SDEC services and transfers direct from NWAS into SDEC
- Maximise the utilisation of the virtual wards
- Trial full capacity protocol at the MRI
- Test of change with Primary Care and ED workflows for patients to reduce demand with
  - GP supporting triage process in ED to deflect away from front door - MRI
  - Establish Virtual Ward for SDEC and respiratory pathway – WTWA
  - GPs in same day care unit at NMGH

- Delivery of the Resilient Discharge Programme – key priorities
    - Deliver the 'Back to Basics' part of the Resilient Discharge programme – ward level discharge planning to increase the number of patients going home with the right support
    - Increase in the number and types of beds available in community for supported discharges

Urgent Care forward plan and strategy:

- In February 2023 a system wide urgent care workshop was undertaken. This workshop, with provider and ICB organisation participation, focused on
    - Identifying the immediate priorities in the next 6 months (capturing the above focus areas of the Transformation work programme)
    - Identifying the mid to long term priorities
    - Workforce considerations and actions required
    - Supporting Urgent Care High Intensity users
- The outcomes of this workshop are being used to develop the urgent care strategy for Manchester and Trafford which will be overseen and ratified by the Manchester and Trafford Urgent Care Board

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 whilst reducing the risk associated with delays in handover and MFT's reputation
- Improve flow out of Emergency Departments across the 24-hour period

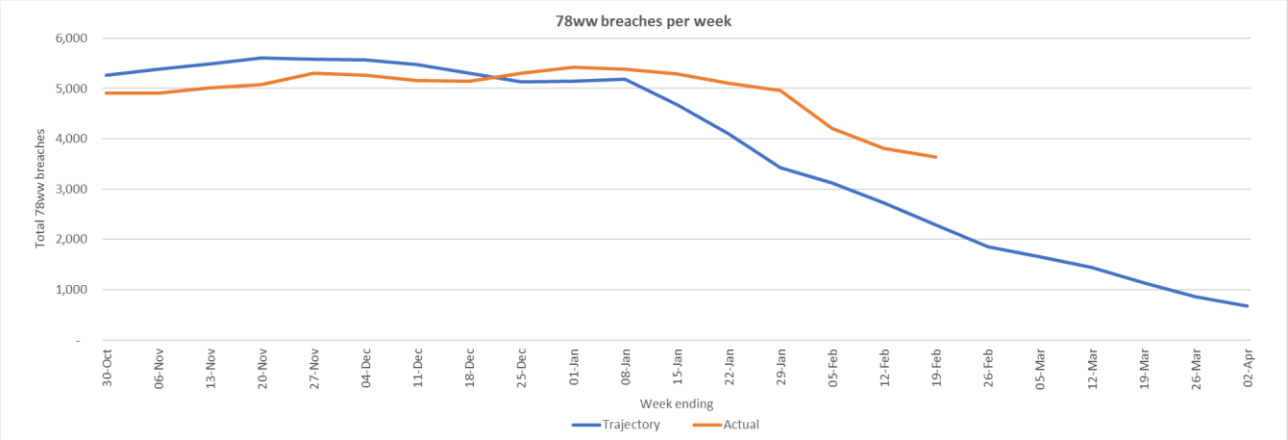
4. ELECTIVE ACCESS

ELECTIVE PROGRAMME

The Elective Care programme continues to focus on the management of clinically urgent (P2) patients, cancers, and long waits. Hospitals have been proactively managing and reducing the very longest waiting patients in line with trajectories submitted to GM / NHSE to reduce maximum waits down to 78 weeks by March 31st, 2023. The volume of very long waits (104 weeks+) continues to fall, although patients exercising choice or suffering from short term medical illness issues has proved stubborn to eradicate completely. New supporting guidance has been issued by the national team to aid providers in managing their waiting lists in relation to patient choice, this guidance, along with system changes to enable new functionality has been incorporated into an operating process that has been circulated to operational teams to assist them with patient pathway management to ensure the Trust delivers against expectations.

The 78ww cohort of patients is a reducing trend but slower than expected against trajectory, as shown in the chart overleaf. The key reason for this is due to less non-admitted removals in early January than planned (combination of capacity challenges and not all activity leading to clock stops e.g., need for diagnostics and follow-ups on more pathways than anticipated). However, the total cohort of potential 78 week patients is reducing, in line against a straight line trajectory. Delivering the 78-week-wait target is challenging and the Trust continues to work with Independent Sector Providers (ISPs) to support delivery and are part of the National Mutual Aid programme.

CHART: Number of 78ww, all MFT per week



Category	Pathway type	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb	05-Mar	######	######	26-Mar	02-Apr
Actual 78ww breaches	Trajectory	5,264	5,378	5,483	5,608	5,579	5,561	5,471	5,300	5,130	5,149	5,177	4,675	4,097	3,419	3,116	2,722	2,290	1,848	1,651	1,437	1,142	859	675
Actual 78ww breaches	Actual	4,909	4,902	5,010	5,081	5,304	5,264	5,154	5,142	5,297	5,419	5,381	5,287	5,100	4,955	4,208	3,802	3,634						
Actual 78ww breaches	Variance	- 355	- 476	- 473	- 527	- 275	- 297	- 317	- 158	167	270	204	612	1,003	1,536	1,092	1,080	1,344						

Ongoing Actions:

An Elective PMO hub was established in November to track and monitor delivery of 78w patient cohort and support hospitals/MCS with reporting and data to support booking of patients in the correct order.

Elective PMO – managed by the COO Directorate to provide specific focus on patient booking and productivity across all hospitals/MCS for the 78w patients and 62day cancer patient challenges.

- Accurate modelling of trajectory by speciality is in place developed in line with hospitals/MCS alongside datasets to support tracking of bookings within the 78w cohort
- Weekly meetings in place attended by Senior leadership team from the hospitals and where required for certain specialities, these have been twice a week.
- Further reinforcement of booking principles to man mark 78w patients supported with data sets to ensure correct patient booking
- Daily booking file sent to all hospitals/MCS to track their patients throughput and identify % booked and un-booked
- Data quality issues highlighted and managed through the PMO where applicable to 78w patient cohort
- Actions and tracking of patient data provided weekly to all hospitals/MCS and this supports the communication within the hospitals/MCS internal PMO
- Reporting is in place to identify future bookings, outpatient outcomes, patients validated and breakdown of patients cohorts booked, to support hospitals/MCS in managing their trajectories
- Mutual aid tracking and requests coordinated through the PMO to track progress
- Support with managing patients on Digital mutual aid system in place

Theatre Utilisation / Productivity - The elective programme continues to focus on supporting sites to treat both long waiting and clinically urgent patients across MFT, a key aspect of this is increasing theatre capacity through maximising productivity and increasing utilisation across all sites, and the development of Trafford as a MFT Surgical Hub.

MFT already has programmes of work, agreed standards and processes in place to support improvements in utilisation, including the 6, 4, 2 booking and scheduling process for theatres. Hospital Chief Executives and Directors of Operations oversee delivery of these as business-as-usual processes as discussed through the covid R&R Group in November.

In addition, MFT is utilising Trafford site as a pilot site for the implementation of best practice in theatre utilisation, as well as implementation of a 23-hour model. The programme to date has been focused on:

- Demand and capacity planning,
- Establishing robust and detailed theatre data from Hive,
- Development of the 23-hour model.

In support of this work the Trust has engaged the NHSE Getting It Right First Time (GIRFT) team who undertook a visit to the Trafford site at the start of November. Routine utilisation information for Trafford has been reported on a weekly basis through the governance structure noted above.

MFT transformation resource is being utilised to support all of the programmes related to theatre utilisation and productivity. In addition, it is also focused on maximising use of external system-wide capacity such as Independent Sector and GM hub capacity at Rochdale and the Christies.

Expected outcomes:

- Improved and timely theatre scheduling resulting 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.

OUTPATIENTS

The programme is focused on delivery of key areas of national planning requirements, internal development areas, and consideration of new best practice and NHSE initiatives. The programme reports into the Operational Excellence Board and is focused on the following.

The programme is focused on delivery of key areas of national planning requirements, internal development areas, and consideration of new best practice and NHSE initiatives. The main focus over recent months have been on the validation programme in line with the NHSE requirements as follows:

- **Validation** - NHSE set out in its letter dated 25th October 2022, requirements for organisations to undertake systematic technical, administrative and clinical validation of all patients on an RTT pathway between now and next April 2023, with deadlines as follows:
    - Cohort 1 RTT, over 52 weeks at 31 March 2023, not validated in previous 12 weeks, by 13th January
    - Cohort 2 RTT, over 26 weeks at 31 March 2023, not validated in previous 12 weeks, by 10th March
    - Cohort 3 RTT, over 12 weeks at 20 April 2023, not validated in previous 12 weeks, by 12th May

  Progress of delivery against these requirements is through the Operational Excellence Board. Through contract with Health Care Communications we have successfully contacted approximately 80,000 patients. At the time of writing, 10% of patients wish to be removed from the waiting list. The Trust is using this approach to identify those patients who would be willing to travel as part of mutual aid and utilising independent sector capacity.

DIAGNOSTICS

Diagnostics performance continues to be challenged with increasing demand contributing to delays to diagnosis and treatment. Long waits are specifically evident across MRI and CT with reporting capacity being the main challenge. Similarly, Echocardiograms continue to report long waits impacted by workforce issues which, in the short term is being mitigated by staff undertaking additional activity through weekend working. There has been an increase in demand on diagnostics of 3.2% in unscheduled care and a focus on cancer is resulting in routine waits being extended. Some improvements have been seen in the turnaround times for CT and MRI scans for patients on a cancer pathways from 15 to 8 days since September.

Trajectories and improvement plans are in place to support turnaround times for patients on a cancer pathway along with plans to reduce to <5% over 6 weeks by March 2024 across all DM01 tests.

On-going Actions:

- Additional reporting capacity has been maintained since November by utilising extra clinical session that has supported a reduction in the overall size of the waiting list for patients on a cancer pathway.
- Timely vetting of patients is a key priority area and work to ensure 'in team' vetting rotas in place to ensure cross cover arrangements is on-going
- Routine imaging capacity is being converted into cancer slots to deliver additional 35 scanning slots per week
- Additional weekend lists for ultrasound scanning
- Weekend insourcing for Endoscopy
- GM initiative to have a focused month in March on improving diagnostic waits whereby MFT have plans to increase weekend capacity through Community Diagnostic Centres for MR and CT scans, along with additional capacity for Endoscopy.
- Focused work on recording practices and policies has been carried out over the last 6 weeks culminating in the appropriate removal of some 4,000 erroneous pathways. The work is ongoing with a refocus on system interaction, training on the use of the PTL in relation to day to day use in terms of admin teams (validation of waits) and further indepth review of growth across several modalities.

CANCER

Current Position

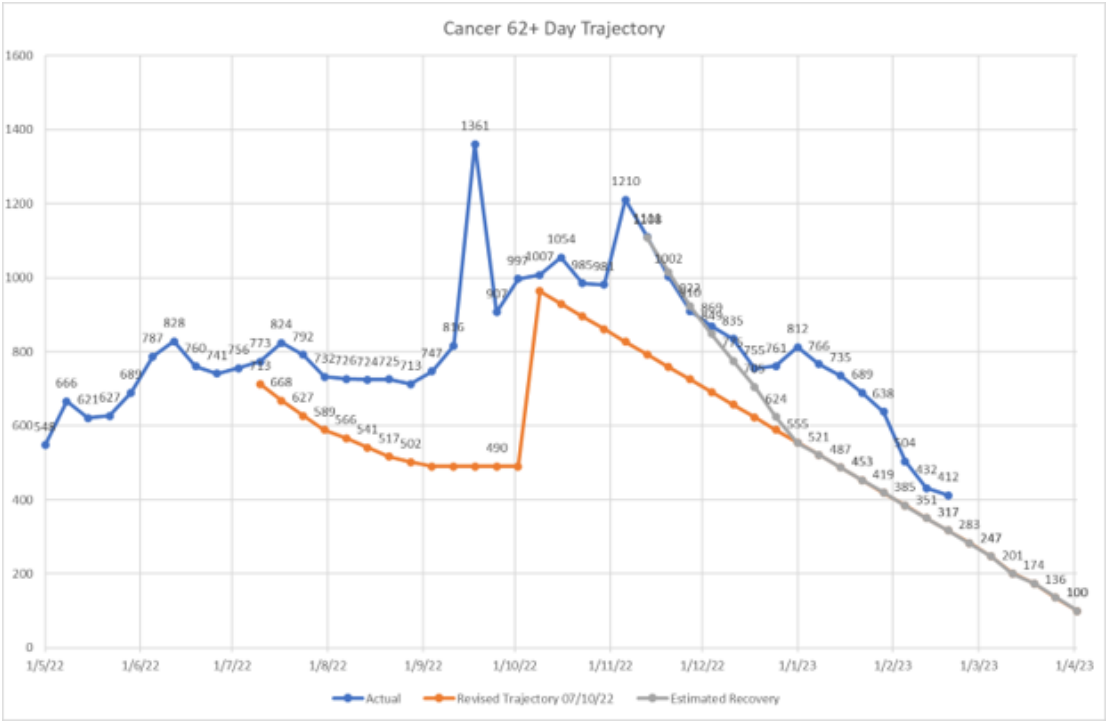
The table provides the latest published performance data for cancer. Total referrals for suspected cancer have risen in October and November, the usual drop over December and a rise again in January, with usual fluctuations between tumour sites and months. Referrals across GM remain at 127% of the pre covid average and MFT follows that trend.

It should be noted that the submissions since Hive go live are incomplete. Staff have had further training on completing relevant target fields in Hive and a suite of validation reports has now been built which will allow a resubmission of a complete data set.

Monitoring and delivery against plans are being discussed through the PMO hub where Hospital teams are providing updates on their 14 day performance along with 62+ day. All sites are delivering against the 14 day standard with the exception of prostate urology at NMGH, Gynaecology and H&N at NMGH along with Colorectal surgical appointments at WTWA site. All have seen reduction in waiting times over recent weeks.

Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
MFT Two week wait breast symptomatic (93% target)	17.0%	11.6%	17.0%	12.6%	30.6%	16.3%	16.6%	23.5%	18.9%	12.7%	19.2%	40.3%
Two week wait performance Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
MFT Two week wait performance (93% target)	56.1%	64.6%	61.6%	53.0%	61.6%	57.2%	55.1%	54.1%	43.9%	40.5%	54.2%	63.5%
MFT Two week wait Activity	3,827	4,318	4,584	3,624	4,446	4,182	4,705	5,043	3,924	4,557	5,487	4,081
MFT Progress to 7 days (% under 7 days)	22.8%	21.0%	18.3%	18.4%	19.8%	17.0%	18.4%	20.9%	9.0%	12.0%	21.6%	26.3%
MFT Faster Diagnosis (75% target)	36.9%	58.7%	56.4%	46.9%	56.0%	42.9%	55.1%	61.0%	54.2%	61.7%	65.2%	67.5%
MFT 31 day Performance (96% target)	74.6%	87.2%	91.0%	88.5%	84.1%	84.9%	86.2%	85.2%	77.8%	78.2%	87.7%	80.4%
MFT 62 days performance (85% target)	33.8%	44.8%	55.5%	48.6%	30.9%	40.6%	44.0%	44.4%	32.6%	29.7%	37.6%	44.2%

There has been excellent progress on reduction of the cancer 62 day backlog demonstrated in the chart below. Trajectories and recovery plans have been reset across hospitals/MCSs and daily tracking is in place through the Elective PMO hub. MFT submitted an ambitious stretch target for March 23 of 100 – the national requirement was to reach the pre covid 267 position, in which MFT are on track to deliver.



On-going Actions

- Weekly PMO meetings to track progress and actions
- New PTL built into Hive to provide a clearer view of pathway patients for CSS – also provides an online portal for escalation from cancer services teams.
- The Urology MFT@Christie model continues, and mutual aid is in place for gynaecology patients as required.
- Continued use and focus to utilise IS capacity for endoscopy demand.
- Additional clinical capacity in place at weekdays and weekends
- 2 LGI workshops have been held with further follow up booked – standard use of FIT guidance across group agreed.
- Gynae workshop planned early March, work with referral centres has taken place.
- Review of areas with Rapid diagnostic programme navigators in place to ensure rapid pathways remain and use of CDC capacity/further use of one stops considered. Likely pathways for further improvement include neck lump and sarcoma.

Expected Impact:

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

5. 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.

Agenda item 8.3.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse and Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse (ACN) Infection Prevention and Control/Tissue Viability Alison Lynch, Group Deputy Chief Nurse
Date of paper:	March 2023
Subject:	Update on the Infection Prevention and Control response to COVID-19, including: • Nosocomial Infections • Updated National Guidance • Infection Prevention & Control Board Assurance Framework • 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 is asked to note the content of this report and the actions taken to prevent and reduce the spread of infection across all health care facilities.
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
- IPC Board Assurance Framework
- Healthcare associated infections (HCAI) of COVID-19 and other organisms
- The COVID-19 and seasonal influenza vaccination programmes

2. Update on National and Regional Guidance

2.1. The National Infection Prevention and Control Manual for England[1] has been updated and published on 23rd February 2023 to include additional guidance on:

- The use of oversleeves
- Guidance on the management of blood and body fluid spills
- An update to reflect the change the status (no longer considered a High Consequence Infections Disease) of mpox and change of name (previously monkeypox)

2.2. A revised National IPC Board Assurance Framework is currently in draft form and expected to be published in March 2023.

3. Infection Prevention and Control Board Assurance Framework (IPC BAF)

3.1. Following the IPC BAF's most recent iteration published on 30th November 2022, the IPC team undertook a full review of all risks related to the control of infection prevention and control, specifically related to the National Infection Prevention and Control Manual.

3.2. The IPC BAF helps providers to assess against the NIPCM as a source of internal assurance. The IPC BAF is presented at Appendix 1, providing assurance to the Board of Directors that organisational compliance has been systematically reviewed and that systems and processes are in place to support the Trust to respond in an evidence-based way to maintain the safety of patients, service users, and staff.

3.3. For assurance, a summary of evidence against the key lines of enquiry described against 10 key lines of enquiry set out in the IPC BAF is provided below:

- Plans are in place to ensure appropriate patient placing of patients with respiratory conditions, with risk assessments based on the Hierarchy of Needs. The Assistant Chief Nurse for IPC is currently ensuring standardisation of the pathways in line with the updated NICPM.
- The Trust has a plan in place, led by the Director of Estates and Facilities, to implement the National Standards of Healthcare Cleanliness[2], monitored at the Group Infection Prevention and Control Committee.

[1] National Infection Prevention and Control Manual for England V2.4 Published 23rd February 2023
[2] National Standards of Healthcare Cleanliness 2021 NHS PAR271

- Trust policies and procedures are aligned to standard infection prevention control (SIPC) standards and aligned to transmission-based standards (TBS).
- Face masks (FRSM) continue to be available in clinical areas, including in atria where some outpatient activity is conducted (for example in the Manchester Royal Eye Hospital).
- Infection Prevention and Control training is mandatory for staff at level 1, and at level 2. Over 140 members of staff have enrolled on the Infection Prevention and Control Development Programme, including staff whose roles are not considered to be clinical. Training compliance is monitored at individual hospital/MCS/LCO, with oversight
- Patients discharged to care homes are tested for COVID-19 using PCR testing, 48 hours prior to their discharge, supporting appropriate and safe discharges.
- Ongoing development of HIVE dashboards, to support monitoring of IPC and AMS practice.
- The COVID-19 testing guidelines have been updated to reflect the pause which commenced on 5th September 2022 for asymptomatic staff and patients.
- There is an antimicrobial Stewardship Group in place, oversight mechanisms are being developed through Hive. The Group Chief Nurse is a member of the GM Integrated Care System Antimicrobial Reduction Board, contributing to system wide plans to reduce antibiotic usage.

4. Healthcare Associated Infections

4.1. COVID-19

The UKHSA technical briefing[3] provides updated analysis of epidemiological and genomic data relating to the SARS-CoV-2 variants currently circulating within the UK. The analysis shows the current circulating strain is BQ.1. Two subvariants CH.1.1 and XBB.1.5 have shown growth advantage and are likely to become the next dominant strain within the UK. Neither are designated variants of concern by UKHSA, and vaccination remains an effective defence.

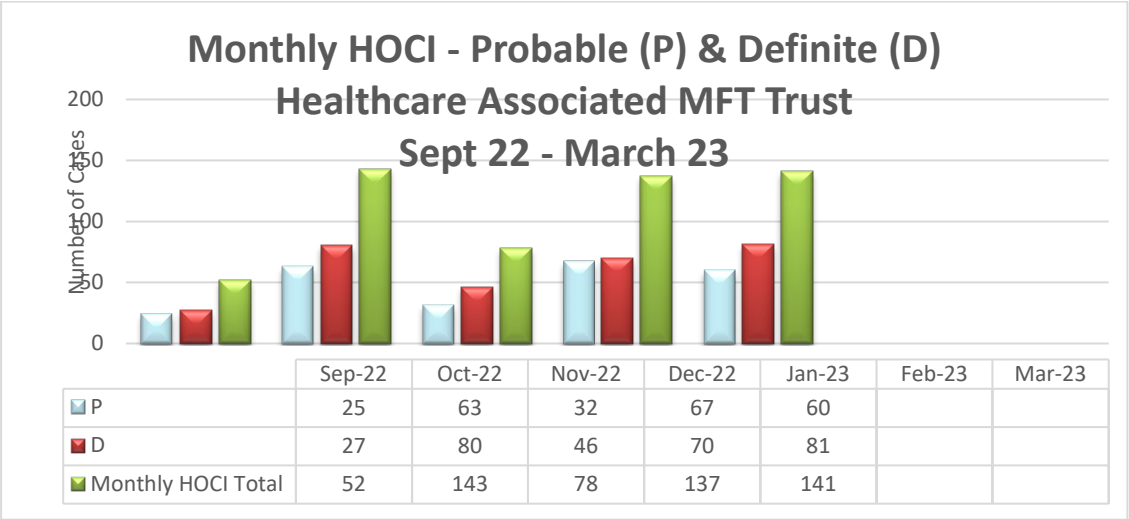
4.2. R-Rate

The current R-rate within the Northwest of England, 13th February 2023, was 1.0 to 1.2[4]. The latest growth rate is 0% to 3% per day. The highest R-rate for the Northwest was in January 2002, at 1.2 to 1.6. The R-rate figures are no longer collected nationally, and interpretation of the estimates need to be considered in context with variability across the region i.e. there may be a cluster of cases in one area of a region which may impact the R rate.

4.3. Hospital Onset COVID-19 Infection (HOCI)

HOCI are defined as a COVID-19 infection occurring on or after day 8 of admission to hospital. Since December there has been an overall reduction in HOCI cases within MFT with a slight upturn in the last 2 weeks. It is likely this is linked to the growth advantage of the latest variants. Chart 1 below are MFT HOCI cases per month.

[3] Covid-19 variants identified in the UK- latest updates accessed 11/02/2023
[4] The R value and growth rate. www.gov.uk/guidance/the-r-value 13/02/2023



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
P	25	63	32	67	60		
D	27	80	46	70	81		
Monthly HOCI Total	52	143	78	137	141		

Chart 1 MFT monthly total of HOCI both probable (>day 8) and definite (>day 15) cases

4.4 **Outbreaks of COVID-19 infection**

Table 1. shows outbreaks of HOCI, which are 2 or more cases occurring within the same ward/department within a 14-day period, peaked in October 2022 however these have since reduced.

Month	Number of COVID-19 out-breaks
October 2022	31
November 2022	6
December 2022	10
January 2023	9

Table 1 Numbers of outbreaks reported to NHSE/I by month

4.5 **Management of COVID-19 outbreaks**

When an outbreak is declared, control measures are implemented, and monitored daily for 28 days in line with the Trust Outbreak Policy. All outbreaks are presented at the hospital local Infection prevention outbreak meeting or the accountability meeting where actions are discussed and implemented. Daily updates on outbreaks are circulated across the Trust, with each outbreak is reported to NHSE/I.

4.6 **Other respiratory infections (Influenza)**

There are 4 types of Influenza viruses A, B,C and D. Influenza A and B can cause Influenza epidemics which usually occur within the autumn/winter season. The current national surveillance reports[5] indicate that reported Influenza positive swabs continue to decrease, the 15-44 year age group remain the most affected group.

4.7 There were **13** outbreaks of Influenza in December 2022, 9 outbreaks were limited to single bays and therefore the remainder of the ward remained operational. There were 3 full ward closures, each ward remained closed for 1 day and 1 ICT (Gorton Parks) remained closed for 10 days prior to environmental cleaning and reopening. All outbreaks are presented at the hospital local Infection Prevention outbreak meeting or the accountability meeting where actions were discussed and implemented.

[5] Weekly national Influenza and COVID-19 surveillance report accessed 15/02/23

5 Other Healthcare Associated Infection (HCAI)

5.1 The Trust is committed to reducing incidents of avoidable HCAI. Table 2 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
Meticilin Resistant *Staphylococcus aureus* Bacteraemia	12	10	11	0
Clostridioides *difficile* Infection	215	196	193	174
Gram Negative Bacteraemia	299	304	390	410
Vancomycin Resistant Bacteraemia	34	31	43	N/A

Table 2 Reportable HCAI's since April 2022

5.2 **MRSA bacteraemia**

Since April 2022 **11** MRSA bacteraemia have occurred, the cases were alerted in WTWA, NMGH, MRI and RMCH. A root cause analysis (RCA) investigation is undertaken for each case, led by the clinical teams and supported by the IPC team. RCA reports are presented at hospital level accountability meetings which are chaired by the hospital Director of Nursing. Thematic analyses of the RCAs undertaken this year has identified the following themes:

- Compliance with Trust screening/isolation policies particularly in those clinical areas where isolation facilities are less available.
- Compliance with fundamental IPC principles i.e., MRSA screening
- Compliance with suppression therapy

Actions taken to make improvement include:

- Integrated care pathways have incorporated within HIVE Flowsheets to prompt staff to comply with suppression therapy and screening.
- A HIVE Infection Prevention and Control dashboard available to monitor compliance, and to highlight clinical areas where supportive action to prevent infection is required.
- MRSA bacteremia Task and Finish group implemented to review all bacteremiae and develop recommendations to improve care and compliance.

5.3 **Gram Negative bacteraemia (GNSBI)**

The year-to-date threshold for cases of GNSBI is being achieved. Each Hospital/MCS has developed a Gram-negative bacteraemia action plan. The action plans have been presented to the Group Chief Nurse/Director of IPC and are monitored via the hospital infection prevention control groups. The catheter care point prevalence audit, undertaken in August 2022, demonstrated the following themes:

- Catheters not always removed within agreed timeframes
- Lack of catheter passport for those with long term catheter

- Catheter specimens of urine (CSU) not always obtained and sent to the laboratory, at the point of insertion

Actions taken to make improvement include:
The catheter care audit results have been distributed to the Directors of Nursing to ensure inclusion of the following in the GNSBI reduction action plans.

- Catheter removal dates to be clearly documented within care plans
- Early identification of patients with long-term catheters to enable passports to be put in place
- Staff education to ensure CSUs obtained at the point of catheterisation

5.4 **Clostridioides (previously known as Clostridium) *difficile* infection** (CDI) cases RCA are presented at the hospital accountability meetings. Identification of lapse in care data is determined retrospectively upon RCA review. MRI and WTWA have the highest numbers of CDI cases currently. Lapse in care themes identified this year include;

- Lack of available isolation facilities
- Failure to sample appropriately
- Lack of documentation

Actions taken to make improvement include

- Integrated care pathways are now incorporated within Hive flowsheets to prompt staff to comply with CDI requirements of isolation and appropriate therapy.
- Direct involvement of AMS pharmacist in all local outbreaks of infection, resulting in more robust responsive antibiotic audit, leading to immediate actions in outbreak areas.

5.5 **Vancomycin Resistant Enterococcus (VRE)**
Areas such as Critical Care and Haematology/Oncology currently screen for Vancomycin Resistant Enterococcus (VRE) colonisation in patients upon admission as VRE pose a particular threat to severely ill patients in settings such as intensive-care units (ICUs) and oncology wards. Critical Care MCS and the Haematology wards at MRI currently have the highest numbers of VRE bacteraemia. All cases of VRE bacteraemia undergo a root cause analysis with a report presented at hospital level accountability meetings chaired by the hospital Director of Nursing. MFT have reported 43 VRE bacteraemia to date this year, themes identified within the RCAs include:

- Intravenous line care documentation omissions
- Previous history of VRE colonisation, including identification of colonisation in the gastro-intestinal tract, which if not identified and decolonisation in place, can lead to gut translocation (where gut flora crosses the mucosal barrier into normally sterile sites due to disease)

Actions taken to make improvement include

- Integrated care pathways are now incorporated within Hive flowsheets to prompt staff to comply with intravenous line care
- Increased screening programme to identify colonisation and respond appropriately by isolation and management
- Increased microbiology team ward rounds in place in those areas described above.

5.6 **Carbapenemase-producing Enterobacterales (CPE)**

Year to date figures highlight there has been an increase in acquisition of CPE across MFT. The Manchester Vascular Centre (MVC) and Ward A9 at WTWA have experienced outbreaks of CPE acquisition. The MVC continue to see ongoing transmission of CPE. Outbreak management plans are in place that are overseen at hospital level outbreak meetings chaired by the senior nursing teams. The MRI and WTWA account for the majority of CPE acquisitions to date. It is important to note, that despite the number of acquisitions, MFT have reported only one CPE bacteremia to date. The senior IPC team are currently co-ordinating a task and finish (T&F) group to review CPE management across MFT.

Themes identified from the hospital outbreak meetings:

- Environmental issues
- Patient screening delays
- Lack of available isolation facilities
- Practice issue i.e. HH compliance
- Antimicrobial stewardship

Actions taken to make improvement include

The CPE task and finish group has developed workstreams, with specific focus on:

- antimicrobial prescribing
- cleanliness of the environment and monitoring
- standard IPC practice
- screening

6 Infection Prevention and Control Summary

6.1. Actions are in place to prevent, control and monitor infections a summary of those described within this paper is included below:

- A further review of the IPC BAF will be undertaken, following receipt of the updated version, which is expected in March 2023
- Focussed actions are in place to make improvements based on findings from investigating individual cases relating to healthcare acquisition or attributed infections, including through thematic review, task and finish groups, and GNBSI action plans.
- Task and Finish group in place to establish reduction strategy for MRSA bacteremia and CPE acquisition.
- An End of Year IPC Review is planned for each hospital/MCS, an overview of IPC actions, incidents and themes will be presented to the Chief Nurse (DIPC) and the IPC team in April 2023.

7 COVID-19 and Seasonal Influenza Staff Vaccination Programme

7.1. The MFT COVID-19 booster programme commenced on 12th September 2022, with the Seasonal Flu programme commencing on 1st October 2022.

7.2. The Booster programme ended on 12th February 2023. All booster vaccines are on hold until further guidance is issued.

7.3. MFT staff COVID-19 vaccinations

- 9389 (32.7%) of current MFT Frontline Healthcare workers have had their Autumn booster vaccination at an MFT clinic[6]
- 11,007 (48.7%) of MFT Frontline Healthcare workers have had their Autumn booster vaccination at any internal or external provider[7]
- 100% of staff have been offered a vaccine

7.4. MFT staff seasonal influenza vaccines

- 9483 (33.1%) of current MFT staff have received their flu vaccine at an MFT clinic[8]
- 12,197 (49.7%)[9] of Frontline Healthcare workers have had flu vaccination at any internal or external provider
- 100% of staff have been offered a vaccine

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

- 100% of staff access to the flu vaccine, with a CQUIN of 70-90% uptake, and
- 100% offer of COVID-19 boosters to all staff.

7.6. The seasonal influenza vaccination season commenced on 1st October and will end on 28th February 2023.

7.7. During 2022/23 a lower uptake rate for Flu vaccines has been noted. Early information suggests an element of vaccine weariness coupled with a mild flu season 2021/22. Increased influenza admissions this season have not significantly impacted on vaccine uptake.

7.8. Work has commenced to collate end of season data from staff groups, staff forums, affiliate stakeholder groups and flu leads to enhance the programme for next season.

7.9. Manager well-being conversations, improved communication, and direct offers of local flu and COVID vaccinations in clinical areas have been in place to support staff to take up the offer of vaccination.

7.10. 479 Manager Wellbeing Discussions have been undertaken this season so that staff without a recorded vaccination can be better risk assessed within the workplace.

7.11. In preparation for the 2023/24 season the Manager Surveillance dashboard will be re-launched with improved capabilities for COVID-19 and influenza vaccine status.

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

8.1. Specific patient cohorts were included in the provision offered by the MFT vaccine service as part of the programmes in place and have been extended to the end of February 2023 for COVID-19 vaccines.

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

- Local maternity services offering flu-only vaccination in Saint Mary's Hospital and Managed Clinical Services ante-natal clinics during Flu season
- Designated Patient Areas during Flu season

[6] At 7th February 2023
[7] Data received 2nd February 2023 (data to 29th January 2023)
[8] At 7th February 2023
[9] Data received 2nd February 2023 (data to 29th January 2023)

- RMCH vaccine services offering vaccines to:
  - Paediatric outpatients that meet the criteria for seasonal flu vaccination and have been referred in due to complex vaccination needs and accepted by the Royal Manchester Children's Hospital operational group
  - Paediatric inpatients aged 12-17 in an at-risk group
  - Paediatric outpatients aged 12-17 in an at-risk group and have been referred in due to complex vaccination needs and accepted for vaccination by the RMCH vaccine operational group
  - Paediatric inpatients and outpatients aged 5-11 in an at-risk group

9. Greater Manchester

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

9.2. As MFT has 'Hospital Hub+' status, the Trust were once again asked to open vaccine appointments to members of the public through the National Booking System (NBS). These sessions currently run alongside our staff and patient provision to enable our local population to access their primary course, booster or spring booster vaccine if eligible.

9.3. The NBS appointment system also allows people to book vaccine validation appointments. This enables people to have overseas vaccines added to their NHS record.

9.4. From 1st March 2023 these services will no longer be available to the public at MFT, pending any updates on funding for these services from GM/NHSE.

10. Recommendations

10.1 The Board of Directors is asked to note the content of this report and the actions taken to prevent and reduce the spread of infection across all health care facilities.

Appendix 1

Infection Prevention and Control board assurance framework

1. Systems 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 their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections. ○ a multidisciplinary team approach is adopted with	A Winter plan is in place that describes, escalation and management based on modelled activity (including COVID-19, RSV and other seasonal pressures). POCT testing is in place in appropriate settings for patients with respiratory symptoms: ED / assessment areas that support triage / placement of patients depending on presentation and pathogen Risk assessments in place, supported by the IPC Senior Team (Associate Medical Director Assistant Chief Nurse), daily assessment and situational guidance is in place using an MDT approach that considers the Hierarch of Controls.	Some individuals may present at hospitals as asymptomatic patients The pausing of asymptomatic screening may mean infectious patients are not identified Unpredictability of COVID-19, Influenza and other seasonal infections may mean a potential conversion to critical care / increased burden in general and acute beds	Patient placement guidance in place All symptomatic patients admitted via ED are screened for respiratory infections All clinical areas undertake a risk assessment using Hierarchy of Controls where there is an increased risk of transmission Pathways in place to screen elective patients prior to surgery Screening of patients prior to admission to community in-patient facilities and recorded in patients notes Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)

hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. ○ Further reassessed where there is a change or new risk identified e.g. changes to local prevalence ○ the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. ○ risk assessments are carried out in all areas by a	Plans include increasing capacity to support respiratory pathogen restrictions that assess staff safety, patient placement and patient flow through anticipated surge in admissions, with specific regard to respiratory infection Clinical Sub-Groups / Clinical Advisory Groups are in place to oversee adjusted or adapted systems and processes approved within hospital settings. A set of IPC principles in response to the seasonal infections have been put in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. GM Gold Command has an overview of escalation through situational reporting. IPC teams / microbiology and virology teams support risk assessments, and have the skills, competence and required expertise		Application of National Infection Prevention and Control manual for England guidance via standard and transmission-based precautions Hospital Outbreak Control policy in place Policy for Isolation of Infectious Patients De-escalation of infectious patients' guidance in place in line with national recommendation to support recovery of elective programme and patient flow whilst still maintaining all IPC measures and keeping staff and patients safe. Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution Non-compliance is addressed locally in with local processes for escalation when there is an identified risk. Staff fit testing data now included in electronic staff record (ESR) held by individual

competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. ○ Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. ○ resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). ○ the application of IPC practices within the NIPCM is monitored ○ e.g. 10 elements of SICPs ○ the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. ○ the Trust Board has oversight of incidents/outbreaks and	IPC team provide a 7 day service across the organisation to support the clinical teams. On call microbiology team provide IPC support out of hours. An update of the number of outbreaks and infections is received by the Board of Directors Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement to comply with agreed pathways. Transfers occur only if clinically justified. Daily data collection/submission reported externally is validated and checked for accuracy by the Chief Nurse/DIPC. Resources that support staff to comply with IPC practices are in place (education, training, estates and facilities, supported by a clear governance structure)		hospitals for oversight and governance

associated action plans. ○ the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	Monitoring systems are in place for hand hygiene, donning and doffing training, and cleaning and decontamination. The IPC BAF is presented at every Board of Directors Meeting, Group Infection Control Committee and will undergo scrutiny at the Quality and Performance Scrutiny Committee as part of the main Trust Board Assurance Framework. The Board of Directors receive a report on the impact of COVID-19, including information on outbreaks and action planning. There are 2 types of fit masks available across the Trust. Any additional requirements are made on an individual basis (eg respirator hoods).		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and	National standards of healthcare cleanliness implemented in April 2021 via a multi-disciplinary project team including IPC, E&F and clinical staff. Variation process in place if a department require a risk category revision. Efficacy audits assess if risk category/specification is appropriate Technical audits of cleaning taking place to assure standards. A rectification process is included should the standards not be achieved. Enhanced cleaning implemented in liaison	Old estate unable to provide good ventilation in some areas Local weather conditions may make it difficult to maintain internal temperature if door and windows are open Staff may not use cleaning products effectively.	Enhanced cleaning specifications in place for clinical and non-clinical areas Trust Policy for working safely based on UKHSA guidance is in place Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have been put in place across all sites to meet UKHSA (ex PHE) guidance. Staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas, including detailed instruction on how to make and store cleaning product FR1 & FR2 audits will be prioritised along with areas of

staff are appropriately trained.
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
  ○ patient isolation rooms
  ○ cohort areas
  ○ donning & doffing areas – if applicable
  ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails.
  ○ where there may be higher environmental contamination rates, including:
  ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting.
• The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of
	with IPC upon declaration of outbreak. This is detailed in cleaning policy and outbreak meetings initiated by IPC.
	
	All surface cleaning (with exception of floors) currently utilises chlorine-based product.
	
	Any supply issues would be escalated to Trust Procurement and IPC. Alternative products would be IPC instructed and approved
	
	Cleaning Policy ratified at the Estates and Facilities Board in January 2022 and submitted to the Group Infection Control Committee for noting
	
	Changes to room function are assessed and agreed through an MDT approach supported by IPC, Estates and Facilities teams and implemented once appropriate risk assessment completed.
			known concerns/outbreak areas
			
			Trust ventilation engineers consulted prior to purchasing any technologies.

these as outlined in the National Standards of Healthcare Cleanliness
• A terminal clean of inpatient rooms is carried out:
  ○ when the patient is no longer considered infectious
  ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens).
  ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
 	
• reusable non-invasive care equipment is decontaminated:
  ○ between each use
  ○ after blood and/or body fluid contamination
  ○ at regular predefined intervals as part of an equipment cleaning protocol
  ○ before inspection, servicing, or repair equipment.
 	
• compliance with regular cleaning regimes is monitored including that
	Cleaning twice daily and providing additional enhanced cleaning in high risk/outbreak areas. Cleaning standards are routinely monitored, local action plans in place to resolve issues, including where more frequent cleaning schedules are in place (for example, side rooms, cohort areas, and outbreak wards) in accordance with UKHSA guidance.
	
	E and F/PFI partners and IPC Team have reviewed cleaning frequencies in line with updated guidance.
	
	Terminal clean sign-off processes are in place
	
	Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution.
	
	Decontamination of patient shared equipment in outbreak/high risk		

of reusable patient care equipment. • Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigatein adequate ventilation systems wherever possible.	areas is undertaken using a combined solution of detergent and 1,000ppm available chlorine (Chlor-clean tablets) Electronic equipment is cleaned with a detergent wipe followed by 70% isopropyl alcohol wipe used in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities. Staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas. Group Estates and Facilities Decontamination Policy is in place. UKHSA guidance is adhered in line with decontamination in outbreak situation. Use of HPV/UVC in addition to UKHSA		

	guidance is deployed in high flow areas such as ED MFT authorised engineers undertaken assessment of ventilation systems in all areas of the trust where AGP are carried out and departmental managers are aware of the air exchange rates required following AGP and systems in place locally to manage the dilution time within vacated rooms. Ventilation system monitoring and management is undertaken in conjunction with Estates and facilities and Sodexo. Regular window opening undertaken in areas of the trust where no mechanical ventilation system is in place. Window fans installed in some areas to facilitate air dilution. Alternative technologies utilised to increase air		

	exchange rates in various areas across the Trust i.e. window fans and air scrubbing systems to facilitate patient safety and flow in areas undertaking AGP's. Ventilation engineers input in all areas where there is a potential to affect air flow		

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions

Systems and process are in place to ensure that:
• Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated
• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented - Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
• The use of antimicrobials is managed and monitored:
  ○ To optimize patient outcomes
  ○ To minimize inappropriate prescribing
  ○ To ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial/-stewardship-start-smart-then-focus are followed
	The new Group wide MFT AMS Committee (AMC), has developed an AMS vision and strategy. The AMC meets on a quarterly basis and is supported by 3 new subgroups which provide assurance in areas of guideline development, education and training and quality improvement, audit and research.
	
	The AMC provides assurance to the Medicines Optimisation Board and the Group Infection Prevention and Control Committee.
	
	The AMC has senior representatives from each hospital/MCS including medical, nursing and pharmacy. Each hospital/MCS has a reporting and dissemination structure for AMS in place.
	
	The AMC oversees the development and review of the MicroGuide app which ensures
		Access to all data as surveillance officer support is ad hoc
		
		Clarification on risk assessment for unintended consequences of other pathogens being sought
			HIVE/EPIC implementation will improve information sharing/ communication.
			
			Surveillance officer support sought.
			
			Consumption data and accuracy has been discussed with the Regional AMS lead.
			
			HIVE/EPIC has enhanced Trust reporting of antimicrobial consumption.

• Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:
  ○ Total antimicrobial prescribing;
  ○ Broad-spectrum prescribing;
  ○ Intravenous route prescribing;
• Adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources
• Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).
	that the right antimicrobial is selected and used. Usage data for Microguide is monitored by the AMC.
	
	Monthly point prevalence audits on each sites reported via the AMC to all hospitals/MCS's.
	
	AMS ward rounds by an infection specialist.
	
	Acute care team monitor sepsis data including access to prompt antimicrobial treatment if sepsis is suspected.
	
	Microbiology support available 24 hours a day.
	
	Antimicrobial prescribing advice available from pharmacy 24 hours a day
	
	Consumption data of antimicrobial usage.
	
	Monthly ACTION (prescribing standards) audits on all ward areas.
	
	AMS audit forward plan which is monitored by the Quality Improvement and Research Group.		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented. • Patients being accompanied in urgent and emergency care	NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed The Trust Interim Visiting Policy has been updated to support lifting in visiting restrictions across the Trust from 8th June 2022, based upon 'Visiting Healthcare Inpatient setting during the COVID-19 pandemic guidance. Visitors are reminded to adhere to NHS requirements to wear a FRSM unless exempt, they no longer need to undertake an LFT test, to practice good hand hygiene and to wear PPE where indicated. Hand sanitisation stations at entrance & exits to Trust to minimise risk of cross infection	Lack of concordance in some patients/visitors	Visiting policy available via Trust intranet and information published on the MFT website Local information displayed at hospital entrances and ward/department entrances where FRSM need to be donned prior to entry.

(UEC), outpatient or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene, and cough etiquette. The use of facemasks/face coverings should be determined following a local risk a s s e s s m e n t • if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptom of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other	Policy reviewed following further guidance using the toolkit and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission All ward areas have clear signage in relation to visiting guidance based on individual risk for that area. ED is currently reintroducing the family liaison role in order to take a proactive approach to family liaison and updates.		

care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escort should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in- ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving receptionstaff, immediately on their arrival. • the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management/placement • triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • patients in multiple occupancy rooms with suspected or confirmed respiratory infections	Agreed triage questions, undertaken by trained staff, ensures that patients are screened for COVID-19 symptoms / respiratory symptoms on admission All patients streamed through a respiratory/non-respiratory pathway in ED's, with infection status communicated. Testing of symptomatic patients either at admission or at any time throughout their hospital stay. Elective admissions as per Trust guidance, which includes routine screening at days 1,3 and 5/7 for immunocompromised patients. Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place.	Environmental issues and age of estate Not all patients/visitors are willing/able to comply Some patients may present with no respiratory symptoms but may be infectious	Patient placement guidance in place All symptomatic patients admitted via ED are screened for COVID-19, data is reviewed daily Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement. External transfers occur only if clinically justified Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation. Side room usage is regularly reviewed to ensure patients

are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated. • (unless in a single room/isolation suite). • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated. • only required if single room accommodation is not available. • patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation • if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	FRSM available for all patients and visitors, all patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise Patient information posters are in place Advice information is provided to patients/ parents /carers and families around mask wearing in ward department areas (includes moving around the ward) Posters in clinical areas encouraging patients to wear face coverings. Staff actively encourage patients to wear face coverings when outside of their bed space and offer a replacement on regular intervals. Staff request patients to wear a face covering when moving between departments.		who require a side room are prioritised appropriately. There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups and prioritisation of side room

• The use of facemasks/face coverings should be determined following a local risk assessment. • patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy. • Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and reported via reporting structures.	Patient pathways are compliant with Infection Prevention and Control guidance and limit internal patient movement unless where clinically justified (for individual patient and wider patient safety based on Hierarchy of Controls). Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. Principles that support RSV/COVID Surge Response Plan highlight requirement for protective		

	isolation for vulnerable groups and prioritisation of side room A set of IPC principles are in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance /recommendations for all staff commensurate with their duties. • training in IPC measures is provided to all staff, including: the correct use of PPE • all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM); • adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk • gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous	All staff are required to undertake mandatory IPC training provided to all staff including at induction and then annually via the Trust mandatory training programme which includes ○ Hand hygiene training ○ PPE usage ○ How to don and doff PPE ○ PPE Infection Control Policy in place Donning and doffing videos available on the Trust intranet based on national guidance PPE and Hand Hygiene compliance audited monthly and audit results are shared with Directors of Nursing for action if required. Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS, Trustwide database in place	Staff may not complete annual mandatory training as required. Wards and departments may not submit compliance audits on time Staff may not comply with IPC policies	Staff training compliance report distributed to all service leads for monitoring and action where required. PPE and Hand hygiene audit compliance report distributed to all Directors of Nursing for review and action as required. Escalation process in place for noncompliance with IPC policies Freedom to Speak Up guardian in place to support escalation of concerns IPC nursing team provision increased to 7 days across all acute sites On call microbiology support for IPC related enquiries provided out of hours.

membranes is anticipated or in line with SICP's and TBP's.
• hand hygiene is performed:
  • before touching a patient.
  • before clean or aseptic procedures.
  • after body fluid exposure risk.
  • after touching a patient; and
  • after touching a patient's immediate surroundings.
 	
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)
 	
• staff understand the requirements for uniform laundering where this is not provided for onsite.
	Hand Hygiene Policy and ANTT Policy in place
	
	Guidance displayed in public areas
	
	Regional COVID-19 prevalence reviewed by Clinical Sub-Group and used to inform PPE practice.
	
	Daily monitoring of other HAIs to identify outbreaks.
	
	Local population, regional and national surveillance intelligence is presented by Trust expert virology team
	
	A member of the Health Protection Team is a committee member of the Group Infection Control Committee
	
	Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at:
	  ○ High Level Infection Control Meeting
	  ○ Clinical Sub-Group /Advisory Groups
			Prompt response to clusters/outbreaks of infection
			
			Communications team distribute information and guidance in various formats to reach all MFT staff
			
			Ability to use FFP3 masks where risk elimination is reduced
			
			Increased Microbiologist and AMD support
			
			Expert Virology support
			
			Staff advised on how to launder uniforms in accordance with NHSE guidance
			
			FRSM masks worn in all patient facing wards and departments.
			
			Additional Hand hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas.

	○ Trust Testing Strategy Group The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. Surveillance of all new patient cases of COVID-19 are reported in a timely manner All new patient results reviewed and acted upon by IPC and clinical teams Outbreak Policy in place		Pre-emptive risk assessment to manage high risk patients before results are known.

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with	Advice information is provided to patients/parents/carers and families around mask wearing in ward department areas (includes moving around the ward) Posters in clinical areas encouraging patients to wear face coverings. Staff actively encourage patients to wear face coverings when outside of their bed space and offer a replacement on regular intervals. Staff request patients to wear a face covering when moving between departments. Patient pathways are compliant with Infection Prevention and Control guidance and limit internal patient movement unless where clinically justified (for individual patient and wider patient safety based on Hierarchy of Controls). Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC	Lack of available side rooms for isolation of infectious patients Lack of concordance amongst some patients or visitors with IPC requirements.	Risk assessments undertaken to support patient placement Risk assessments undertaken to support patient placement when symptomatic of an infection when infectious status unknown

confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment to develop specific plan of care to mitigate risk Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. A set of IPC principles are in place that, using a risk based / balanced approach, acknowledges changes in practice in specific circumstances to support whole site safety. These principles align to the Final Draft North West Regional IPC Principles to support the delivery of 'Living with COVID' using current IPC guidance and Hierarchy of Controls' published 11th April 2022. IPC principles continue to be applied when caring for the deceased		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • patient testing for infectious agents is undertaken promptly and in line with national guidance. • staff testing protocols are in place for the required health checks, immunisations and clearance • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home	UKAS accredited PHE laboratory conducting testing for NW of England based on Oxford Road Campus. Testing undertaken through the laboratory is in accordance with UKHSA guidance Posters to support training for staff on how to take a swab Laboratory result turnaround times measured and a planned programme of monitoring in place. COVID-19 Testing, Streaming and Stepdown Guidelines are in place that supports staff in decision making / patient placement. Screening for other potential infections continues	Asymptomatic testing paused in both staff and patients with the exception of high-risk patients There may be delays in transporting off site specimens to the laboratory for processing	Additional transport available to transfer specimens to the laboratory for processing HIVE EPR system ensures patients laboratory results are available in real time to clinicians with Best Practice advice provision applicable to the result. COVID-19 patient testing in line with- COVID-19 Testing in periods of low prevalence Guidance for the testing of patients prior to discharge to Nursing/care home/ intermediate care facility in place

are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID- 19) testing for adult social care services - GOV.UK (www.gov.uk) • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	An assessment has been made against UK Health and Safety Agency (UKHSA) recommendations for changes to COVID-19 infection prevention and control in the management of elective procedure patients.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies. • policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM • PPE stock is appropriately stored and accessible to staff when required as per NIPCM	Resources that support staff to comply with IPC practices are in place (education, training, estates and facilities, supported by a clear governance structure) Monitoring systems are in place for IPC practices, local action plans are held to improve where required. Changing facilities are not in place in all areas of the Trust, break areas are identified. Outbreak policy in line with UKHSA (ex PHE) guidance COVID-19 Outbreaks contained and reported to NHSE/I using IIMARCH (Information, Intent, Method, Administration, Risk Assessment, Communication, Humanitarian issues) documentation and daily sitrep reports	Staff changing facilities are not available in all areas	Increase in IPC support to hospitals when wards are repurposed i.e. COVID-19 wards, Influenza cohort wards Prompt response to clusters/outbreaks of infection Staff advised on how to decontaminate uniforms in accordance with NHSE guidance Uniform Policy in place Incident reporting system in place to support any clinical incidents around PPE availability

	Other outbreaks of infection are contained and are reported locally All waste associated with suspected or positive infectious cases handled and stored as per NICPM guidance Staff follow Trust waste management policy Healthcare waste e-learning module is mandatory for all clinical staff, based on waste management policy. All bins are labelled to indicate which streams they have been designated for. Materials management team assess and manage stock levels Update on stock levels circulated to DIPC/IPCT and reviewed through the Recovery and Response Group.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
• staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.
• bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.
• staff understand and are adequately trained in safe systems of working commensurate with their duties
• a fit testing programme is in place for those who may need to wear respiratory protection.
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  • lead on the implementation of systems to monitor for illness and absence.
  • facilitate access of staff to treatment where necessary
	Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8
	
	Bank and agency staff are supported to follow IPC advice through local induction and on-boarding
	
	COVID-19 specific e-learning is in place, including donning and doffing of PPE, and RPE where required.
	
	All MFT staff complete a COVID-19 self-risk assessment, electronically stored
		Staff may not uptake seasonal Influenza /COVID-19 vaccination or booster	Absence monitoring and follow up and contact by line manager
			
			Escalation plan in place for staff who do not uptake vaccination
			
			Vaccination Lead within the organisation to oversee the vaccination programme
			
			Staff vaccination compliance reports cascaded via line management structure
			
			Staff Fit testing data recorded on electronic database
			
			Staff are fit tested for 2 types of FFP3 masks

and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination. • encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM. • a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who	Staff who are working remotely can also access support. Details of all EHWB Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely. EHW/OH advice and support is availabe to managers and staff 7 days a week. Absence manager process in place to support staff absence for any infection. Staff vaccination programme in place MFT are the GM lead for the nMAB (anti-viral programme), any member of staff who would be eligible would receive this although not as routine nor related to work activity. Daily staffing process are in place to manage safe and effective staff deployment		

fall into these categories should follow the same deployment advice as permanent staff. • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • testing policies are in place locally as advised by occupational health/public health. • NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) • staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • fit testing is repeated each time a different FFP3 model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • those who fail a fit test, there is a record given to and held by	HR policies in place for symptomatic staff to report on absence manager system. HR policies in place for staff to report on sickness absence via the Absence Manager system. All Trust protocols comply with National guidance and are kept under constant review. HR advice and support is provided to managers. Regular comms and briefings ensure that staff are aware of policies and procedures as well as the support available to them. Trust policy aligns with national guidance regarding the management of healthcare staff with a respiratory infection Manager well-being sessions are in place to support staff in respect of vaccination. Staff are locally trained by staff who are trained and assessed as competent to do so.		

employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care	There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly There are Trust Policies in place based on national guidance agreed with HR and EHWB to ensure that those who have failed fit testing are redeployed The Trust has extended fit testing to include 2 alternative FFP3 respirators. Reasons for fail to fit test are recorded and escalated where appropriate		

settings. This system should include a centrally held record of results which is regularly reviewed by the board. • staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.			

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Head of Group Reporting and Financial Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	March 2023
Subject:	Financial Performance for Month 10 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 Sustainability for both the short and medium term
Recommendations:	The Board of Directors is recommended to note the Month 10 position against the 22/23 plan and Cash and Capital positions for the Trust.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 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 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 income allocation in 22/23, with a greater focus of funding on Elective recovery (ERF). 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. The Trust submitted a plan to NHSE in June 22 which delivers a break-even position at year-end, as part of the GM ICS overall break-even submission. This includes additional funding from NHSE of £28.8m to MFT to partially offset inflationary pressures. This additional funding was awarded across England with several conditions, including delivering break-even, staying within the agency cap, seeking approval from NHSE for Consultancy expenditure above £50k per contract and for all new non-clinical agency expenditure and includes mandatory internal audit work on the Trust's financial processes. To January 2023, the Trust has delivered a YTD deficit of £13.2m against a planned YTD breakeven position. This reflects an in-month surplus of £6.0m. This represents a significant improvement compared to previous months, driven by an increase in income and the release of prior year provisions which are no longer needed. The Trust has also put in place a number of actions to manage costs ahead of the new financial year in April. In November the ICB for Greater Manchester put itself and all providers into an informal Financial Recovery footing and requested all providers deliver a reforecast demonstrating three scenarios, Best/Most Likely/Worst, as a result The Trust presented a case which detailed, subject to a series of assumptions, that we would deliver Best Case, a breakeven position, Most Likely, £10.4m deficit and Worst Case a £50.8m deficit. At month 10 the Trust anticipates achievement of the breakeven scenario, as planned.
1.2	**Run Rate**	In January 2023 total expenditure was £211.4m, almost exactly the same as the December figure of £211.6m. Pay costs increased slightly, by £0.6m, to £127.7m, offset by a small decrease of £0.8m in non-pay expenditure, with various offsetting adverse and favourable variances across the expenditure categories. Income increased by £5.8m, to £217.4m, following an increase of £4.7m in month 8, offsetting expenditure pressures. This increase has primarily been driven by contract variations, such as for Community Diagnostic hubs and additional income received from HEE.

1.3	**Cash & Liquidity**	As at 31st January 2023, the Trust had a cash balance of £177m. The cash balance has remained reasonably static compared to the balance of £175m at 31st December 2022. The cash balance at the end of January was lower than forecast by £32m, primarily due to higher than forecast cash outflows relating to payables and lower than forecast cash inflows relating to income received in month. It is anticipated that there will be an increase in cash at the end of February due to a catch up in income received.
1.4	**Capital Expenditure**	The Trust will operate within the agreed GM final capital allocations (the "envelope"). GM have approved an increase to MFT's 2022/23 envelope following the approval of PDC bids for Frontline Digitisation across GM. As well as providing CDEL cover for £2.9m of the £15m Hive expenditure (that was assumed to be covered by PDC funding in the plan), MFT have also received CDEL cover for a further £5.6m. 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 January 23, total expenditure was £87.8m against a plan of £103.8m, an underspend of £15.9m. Expenditure included within the GM envelope was £51.8m against the original plan of £54.7m, an underspend of £2.9m. The forecast for year end is that this underspend will be rectified and the Trust will deliver its capital plan. As previously reported to the Board, the IFRS 16 guidance issued by NHS England in October 22, confirmed that the 2022/23 capital expenditure incurred because of the adoption of IFRS 16 will be managed against a national "ringfenced" IFRS 16 CDEL allocation for the Trust, this totalled a plan value of £139.8m for 2022/23. This was reduced to £32.6m for the month 10 forecast, reflecting the impact of the delayed NHS guidance until over halfway through 2022/23; updated assumptions on the managed equipment service (MES) contracts; and significant delays in the supply chain.

Financial Performance

Income & Expenditure Account for the period ending 31st January 2023

I&E Category	NHSI Plan M10	Year to date Actual - M10	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	747,259	767,041	19,782
Clinical commissioning groups	1,029,912	1,058,323	28,411
NHS Trust and Foundation Trusts	3,189	3,401	212
Local authorities	29,697	28,828	(870)
Non-NHS: private patients, overseas patients & RTA	7,912	8,939	1,027
Non NHS: other	7,421	10,750	3,329
Sub -total Income from Patient Care Activities	**1,825,391**	**1,877,282**	**51,891**
Research & Development	54,445	57,262	2,817
Education & Training	68,104	74,732	6,628
Misc. Other Operating Income	70,292	72,994	2,702
Other Income	**192,841**	**204,988**	**12,147**
TOTAL INCOME	**2,018,232**	**2,082,270**	**64,038**
EXPENDITURE			
Pay	(1,187,036)	(1,276,405)	(89,369)
Non pay	(718,568)	(735,913)	(17,345)
TOTAL EXPENDITURE	**(1,905,604)**	**(2,012,318)**	**(106,714)**
EBITDA Margin	**112,628**	**69,952**	**(42,676)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(70,369)	(46,558)	23,811
Interest Receivable	500	3,327	2,827
Interest Payable	(40,817)	(38,992)	1,825
Gain / (Loss) on Investment	0	0	0
Dividend	(1,942)	(1,667)	275
Surplus/(Deficit) before gain / (loss) on investments	**0**	**(13,938)**	**(13,938)**
Gain / (Loss) on Investment	0	768	768
Surplus/(Deficit)	**0**	**(13,170)**	**(13,170)**
Surplus/(Deficit) as % of turnover	**0.0%**	**-0.7%**	
Impairment	**(83,069)**	**(71,258)**	**11,811**
Non operating Income	**3,272**	**2,634**	**(638)**
Depreciation - donated / granted assets	**(1,086)**	**(1,058)**	**28**
Surplus/(Deficit) after non-operating adjustments	**(80,883)**	**(83,620)**	**(2,737)**

For month 10, January 2023, the Trust has delivered a YTD deficit of £13.2m against a planned YTD breakeven position.

There is a favourable variance against income YTD to month 10 of £64.0m, with £27.1m of this due to the 22/23 AfC pay settlement which was agreed above the planned 2% at the start of the financial year. The remainder is primarily due to Cost Pass Through (CPT) / variable cost model device income higher than plan by £4.6m, Genomics contract variations of £5.3m, CPT drugs income £0.8m, Vaccine Booster income of £1.0m and winter funding included of £1.9m. In addition, Education & Training income is above plan by £6.6m YTD after a sizeable increase in month 10, R&D income £2.8m ahead, with non-NHS income favourable YTD by £3.3m. Increases in Other Operating Income accounts for the remaining difference. All cost pass-through movements are also reflected in non-pay expenditure making the impact nil to the Trust's control total.

Pay expenditure remains materially above plan YTD to month 10 by £89.4m, reflecting the profile of the revised plan, although £27.1m can be attributed to the AfC pay award uplift backed by income, as described above and increases related to other income streams noted above. The main reasons for the remaining gap are pay pressures due to sickness and vacancies across the Trust sites, under-delivery against the WRP target of £14.1m, most of which is sitting against pay related codes, and continued capacity pressures across the hospitals causing increased use of temporary staffing. The continued cost of bank and agency pay remains well above plan and agency above the Trust's cap.

The agency expenditure was £3.3m in month 10, which is broadly close to the average over the last two quarters. Although this has fallen from the month 9 figure of £3.9m, which was the highest monthly agency cost recorded at MFT, which was due to a catch up of cost related to month 8. YTD spend is now at £32.2m which is adverse to the plan by £10.6m, with a forecast outturn of £8.7m adverse to the NHSE cap.

The table below shows agency expenditure against the plan YTD and the month 10 forecast outturn by staff group. There is a gap of 29.6% to the "cap" (including the capitalised agency costs) that will not be recovered before the year end. Reasons for this remain the difficulties in recruiting to some staff groups, bed pressures and sickness levels, which remain high compared to pre-Covid levels.

Agency Expenditure by Staff Category

Agency Staff Category	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000
Medical Staff	1,848	20,886	(19,037)	2,128	24,914	(22,786)
Nursing & Midwifery Staff	359	2,529	(2,170)	431	2,925	(2,494)
Scientific, Therapeutic & Technical Staff	1,281	4,582	(3,301)	1,537	5,376	(3,839)
Clinical Support Staff	99	1,323	(1,223)	119	1,512	(1,393)
Non Clinical Staff	353	2,854	(2,502)	352	3,277	(2,925)
*Budget changes internal vs external plan**	*17,603*	*0*	*17,603*	*24,757*	*0*	*24,757*
Total	**21,544**	**32,174**	**(10,630)**	**29,325**	**38,004**	**(8,679)**

Budget at staff category level differs to cap due to budget transfers from agency staff codes

Group Finance have calculated an apportionment of the cap for each hospital/MCS/LCO, Corporate and Estates and Facilities, which was communicated to them in August 2022 with the expectation that plans were drawn up to reduce agency expenditure, and subsequent forecasts, within these limits.

Progress against the agency cap by site is shown below.

Agency Expenditure by Site

Site	YTD Cap £000	YTD Actual £000	YTD Variance £000	Annual Cap £000	Forecast Outturn £000	Forecast Variance £000
CSS	4,406	6,617	(2,212)	5,874	7,995	(2,121)
LCO	529	853	(324)	705	1,000	(295)
MREH	348	464	(116)	464	557	(93)
MRI	2,176	2,724	(549)	2,901	3,087	(186)
NMGH	6,292	11,132	(4,841)	8,389	13,371	(4,982)
RMCH	1,196	1,827	(631)	1,595	2,036	(441)
SMH	827	1,499	(672)	1,102	1,789	(687)
UDHM	0	21	(21)	0	26	(26)
WTWA	3,379	4,890	(1,511)	4,505	5,608	(1,103)
Research & Innovation	74	58	17	99	69	30
Corporate	890	1,066	(176)	1,186	1,274	(88)
Estates & Facilities	529	1,023	(494)	705	1,192	(487)
Sub-total	20,644	32,174	(11,530)	27,525	38,004	(10,479)
Capitalised Agency Costs*	900	0	900	1,800	0	1,800
Total	**21,544**	**32,174**	**(10,630)**	**29,325**	**38,004**	**(8,679)**

Non-pay expenditure decreased by £0.9m in month 10 with several offsetting small variances across the expenditure categories, nothing much above £1m either adverse or favourable, and staying broadly consistent with month 9.

Overall, the Trust is reporting a month 10 position that is £6.0m better than at month 9 and the best in-month performance this financial year. This reflects a surplus against the in-month break-even plan of £6.0m and a YTD deficit of £13.2m. The run rate implied by this YTD deficit would lead to an outturn deficit of £15.8m , however, there is confidence that the gap to breakeven can be closed over the remaining two months of the financial year through additional WRP to be delivered and use of remaining balance sheet flexibility.

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 £83.4m against schemes that have progressed to L3 or higher on WAVE. This reflects an adverse variance of £8.8m compared to the plan against L3 or higher schemes. This falls short of the overall YTD target of £97.5m by £14.1m, meaning that the Trust continues to 'play catch up'.

The schemes delivering savings in month 10, plus others at L3 or above that have not yet begun, are forecast to deliver £101.1m of savings by the end of the year, a deficit of £16.2m compared to the Trust target of £117.2m – this reflects an improvement of £0.8m compared to the forecast at month 9.

MFT Summary

Workstream	Savings to Date Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Forecast 22/23 Position Plan (22/23) £'000	Act/F'cast (22/23) £'000	Variance (22/23) £'000	Financial BRAG
Admin and clerical	955	944	(11)	99%	1,188	1,189	1	100%
Budget Review	3,700	3,700	0	100%	4,407	4,386	(21)	100%
Contracting & income	3,899	3,878	(21)	99%	4,490	4,525	35	101%
Hospital Initiative	9,456	9,464	8	100%	11,583	11,657	73	101%
Length of stay	881	884	3	100%	1,086	1,090	3	100%
Non Pay Efficiencies	2,031	2,005	(26)	99%	2,879	2,849	(30)	99%
Outpatients	63	63	0	100%	75	75	0	100%
Pharmacy and medicines management	2,628	2,618	(9)	100%	3,069	3,055	(14)	100%
Procurement	3,081	2,638	(443)	86%	3,895	3,318	(577)	85%
Theatres	159	159	0	100%	212	212	(0)	100%
Workforce - medical	1,398	1,255	(143)	90%	1,697	1,542	(155)	91%
Workforce - nursing	7,955	8,344	389	105%	9,613	10,085	472	105%
Workforce - other	3,616	3,616	(0)	100%	4,269	4,269	(0)	100%
Informatics	647	647	0	100%	1,017	1,017	(0)	100%
						-		
Total (L3 or above)	**40,469**	**40,215**	**(254)**	**99%**	**49,481**	**49,269**	**(212)**	**100%**
Trust Initiative	43,153	43,153	0	100%	51,784	51,784	(0)	100%
MFT Total	**83,622**	**83,368**	**(254)**	**100%**	**101,265**	**101,052**	**(212)**	**100%**

Summary against Target M1-10	YTD
Target	97,478
Actuals (L3 or above)	83,368
Variance to Target	- 14,110
Lost opportunity (value of schemes below L3)	5,320
Variance to target if all schemes delivered as plan	- 8,790

Summary against Target 22/23	Act/F'cast (22/23)
Target	117,246
Actuals/Forecast (L3 or above)	101,052
Variance to Target	- 16,194
Value of schemes below L3 (M11-12)	2,707
Variance to target	- 13,486

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	5.5	4.8	(0.7)	-12%
CSS	13.3	8.3	(5.0)	-38%
Eye	1.2	0.8	(0.4)	-35%
Dental	0.9	0.2	(0.6)	-73%
LCO	7.9	8.1	0.2	3%
MRI	6.8	9.9	3.0	45%
NMGH	4.4	2.9	(1.5)	-34%
RMCH	8.5	5.8	(2.7)	-32%
St. Mary's	3.9	3.8	(0.0)	-0%
WTWA	13.1	4.6	(8.6)	-65%
Hospital/MCS/LCO Subtotal	**65.5**	**49.3**	**(16.2)**	**-25%**
Trust	51.8	51.8	0	0%
MFT Total	**117.2**	**101.1**	**16.2**	**14%**

Statement of Financial Position

	31-Mar-22 £000	31-Jan-23 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	16,107	11,619	(4,488)
Property, Plant and Equipment	798,636	938,966	140,330
Investments	870	843	(27)
Trade and Other Receivables	15,657	15,187	(470)
Total Non-Current Assets	**831,270**	**966,615**	**135,345**
Current Assets			
Inventories	21,809	24,157	2,348
NHS Trade and Other Receivables	26,500	50,256	23,756
Non-NHS Trade and Other Receivables	61,879	65,537	3,658
Non-Current Assets Held for Sale	2,510	210	(2,300)
Cash and Cash Equivalents	319,112	177,239	(141,873)
Total Current Assets	**431,810**	**317,398**	**(114,412)**
Current Liabilities			
Trade and Other Payables: Capital	(43,000)	(21,405)	21,595
Trade and Other Payables: Non-capital	(339,849)	(346,454)	(6,605)
Borrowings	(24,001)	(42,578)	(18,577)
Provisions	(52,636)	(34,433)	18,203
Other liabilities: Deferred Income	(59,360)	(46,064)	13,296
Total Current Liabilities	**(518,846)**	**(490,934)**	**27,912**
Net Current Assets	**(87,036)**	**(173,535)**	**(86,499)**
Total Assets Less Current Liabilities	**744,234**	**793,080**	**48,846**
Non-Current Liabilities			
Trade and Other Payables	1	-	(1)
Borrowings	(371,694)	(492,434)	(120,740)
Provisions	(13,903)	(10,872)	3,031
Other Liabilities: Deferred Income	(2,386)	(3,650)	(1,264)
Total Non-Current Liabilities	**(387,982)**	**(506,956)**	**(118,974)**
Total Assets Employed	**356,251**	**286,124**	**(70,127)**
Taxpayers' Equity			
Public Dividend Capital	408,780	421,509	12,729
Revaluation Reserve	97,411	97,412	1
Income and Expenditure Reserve	(149,940)	(232,797)	(82,857)
Total Taxpayers' Equity	**356,251**	**286,124**	**(70,127)**
Total Funds Employed	**356,251**	**286,124**	**(70,127)**

The capital programme expenditure and accruals movements continue to increase the Property, Plant and Equipment value in the accounts, resulting in a YTD increase in Property, Plant and Equipment and a reduction in cash and capital payables. This movement is accelerating as we approach the year end.

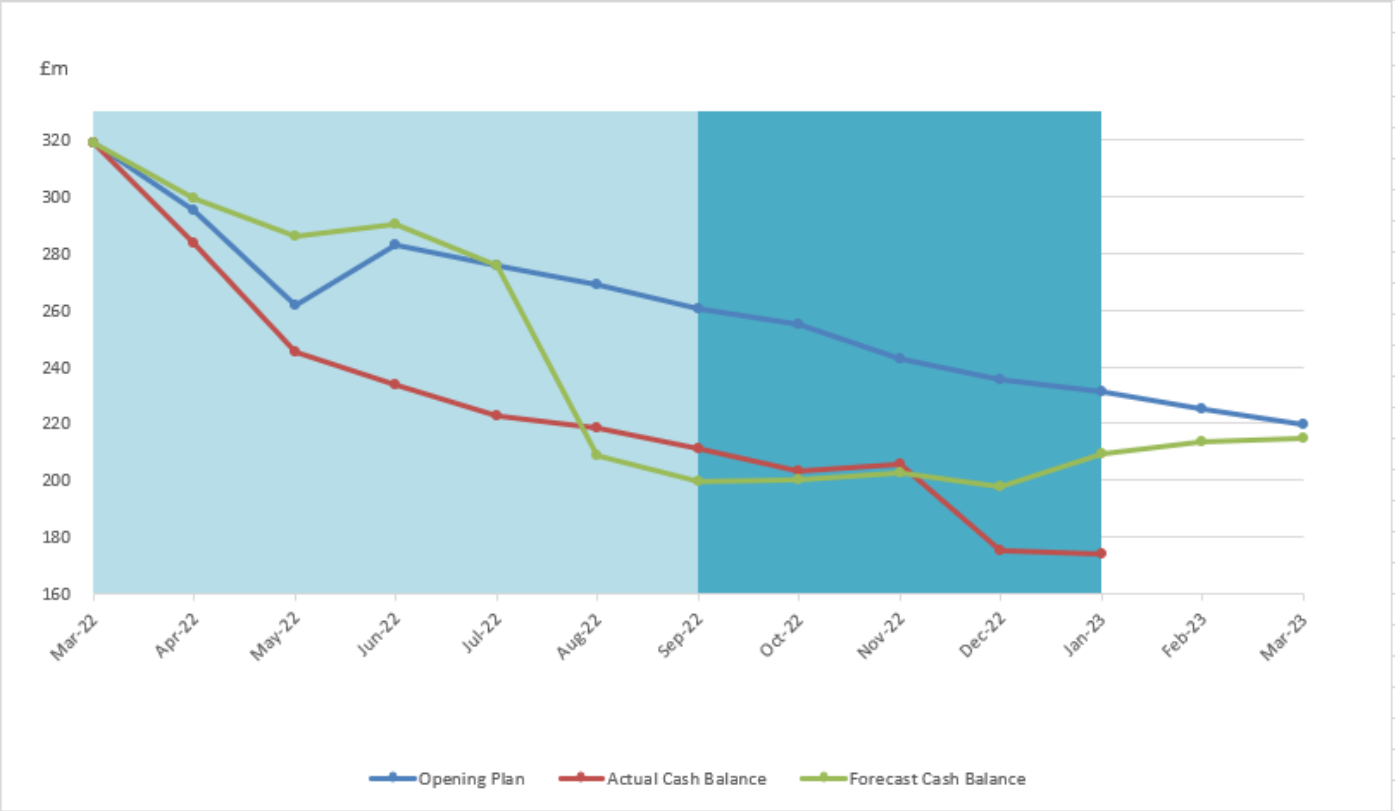
Although NHS trade and other receivables have increased significantly since 31st March 2022, they have decreased from £58m as at 31st December 2022 to £50m as at 31st January 2023. This movement is due to a reduction in central accrued income of £12m offset by an increase in trade receivables of £5m.

During the year there has also been an increase in non-capital trade and other payables, primarily driven by an increase in central accruals and pharmacy related payables. Although trade creditors have increased since 31st March 2022, they have decreased in month 10 by £5m (from £352m as at 31st December 2022 to £346m as at 31st January 2023. The majority of this in-month movement is due to a decrease of £9m relating to NHSP related creditors (as a result of the payment and cancellation of invoices) offset by an increase in the purchase ledger control account of £6m (as a result of changes in the payment policy).

Deferred income has decreased from £62m at 31st March 2022 to £50m as at 31st January 2023, primarily due to the receipt of quarterly HEE income in advance of £4.2m to date and £2.3m of prior year balances brought forward. The reduction from £65m as at 31st December 2022 to £50m as at 31st January 2023 principally reflects £7.3m of HEE income recognised in month 10. These reductions are partially offset by increases arising from £2.6m of income from NHSE Specialised and £3m of income from the ICB which was deferred in M10. Other NHS income of £5.9m also reduces the impact of the HEE deferred income movement.

The 1st April 2022 opening balance for right of use (ROU) assets was updated in October 2022 to reflect the October IFRS16 submission to NHSE. Following discussions with NHSE and Mazars regarding the treatment of existing managed equipment service (MES) contracts, the opening balance for these ROU assets reduced from £228m to £142m. A similar adjustment has been made to the lease liabilities included as current and non-current borrowings. The resulting reduction to forecast interest and depreciation in 2022/23 is offset by a corresponding increase in supplies and services costs with a net impact on income and expenditure of £0.5m (reduction in charges).

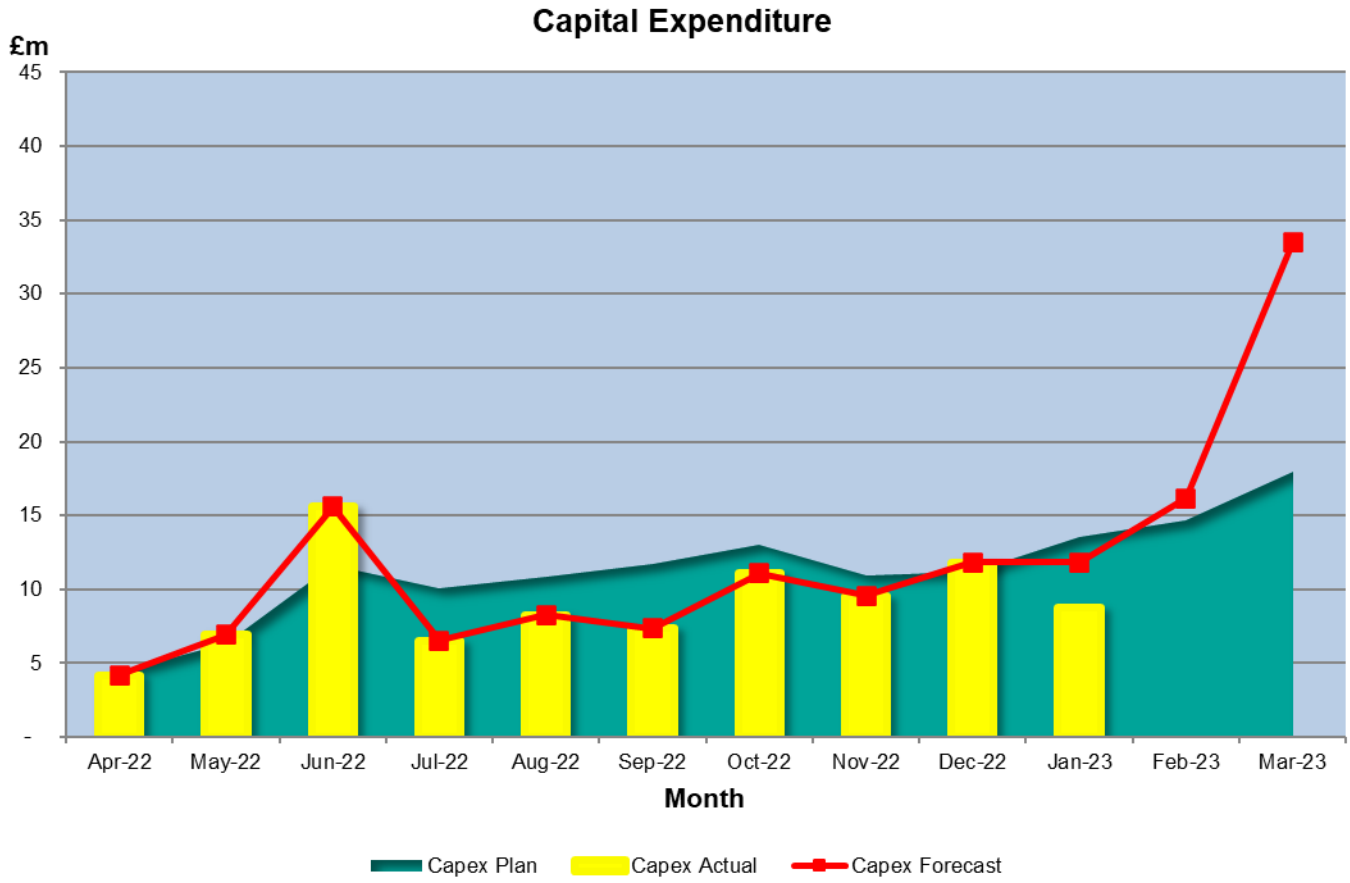
Cash Flow



As at 31st January 2023, the Trust had a cash balance of £177m. This is reasonably static compared to the balance of £175m as at 31st December 2022.

The cash balance at the end of January 23 was lower than forecast by £32m, this was primarily due to higher than forecast cash outflows to NHS Supply chain (£3m), NHS Professionals (£3m), Lloyds Pharmacy (£7m), Siemens (£3m) and Northumbria Healthcare (£2m). In addition to this, we receipted lower than forecast cash inflows relating to income from HEE recognised in month (£7m), as there was a timing difference between us recognising the income in our position and the cash being received.

Capital Expenditure



In the period to 31st January 2023, £87.8m of capital expenditure has been incurred against the updated plan of £103.8m, an underspend of £15.9m.

The underspend is primarily driven by:

- £5.3m for two schemes at Trafford (Theatres and Power Upgrades) due to initial timing delays.
- £2.3m credit from the sale of Stretford Memorial Hospital which gives rise to the opportunity for additional capital expenditure not included in the agreed plan.
- £2.8m relating to timing slippage in the NHP project.
- £2.5m on the TIF scheme due to timing slippage.
- £1.9m on the PDC Digital Pathology equipment due to delays finalising the contract but it is anticipated to be signed in February with all costs incurred by year-end.
- £1.5m underspend on charity funded equipment that is now forecasted not to be donated before year-end.
- £1.2m on Project RED due to initial timing delays.
- £0.8m on IT Disaggregation due to the impact of NCA outage but work is expected to be in line with plan by year-end. A further £0.2m savings are confirmed and have been allocated to contingency

These underspends have been partially offset by a number of overspends, notably:

- £3.0m on the Hive Programme due to additional service provider costs that were not identified when setting the budget. Key drivers for the variance have been complexities in the technical activities.
- A further £1.0m on the Hive Programme due to the plan assuming PDC cover to fund an element of the Hive Programme (£15m PDC cover in total for 2022/23). This overspend is now covered by GM's approval of an increase to MFT's 2022/23 envelope to cover the £15m risk;

- £2.0m on Estates health and safety backlog expenditure which includes the recent additional work required on the North Manchester theatres. Backlog spend is expected to be in line with plan by year-end.

The Trust's total capital plan value for 2022/23 is £136.4m. £68.6m of this plan relates to the Trust's allocation against the GM envelope component.

For the period up to 31st January 23, £49.5m of GM envelope expenditure was incurred against the original plan of £54.7m, an underspend of £5.1m. The underspend is materially made up of Trafford Theatres and Power Upgrades, credit for Stretford Memorial Hospital disposal, and Project RED, these are partially offset by £4.1m for Hive. All delayed schemes are expected to recover by year end.

GM have approved an increase to MFT's 2022/23 envelope following the approval of PDC bids for Frontline Digitisation across GM. As well as providing CDEL cover for £2.9m of the £15m Hive expenditure (that was assumed to be covered by PDC funding in the plan), MFT have also received CDEL cover for a further £5.6m. The sale of Stretford Memorial Hospital has resulted in £2.3m additional GM envelope CDEL cover for 2022/23. Combined with the £5.6m noted above, there is therefore a further £7.9m available to spend.

It is planned that this £7.9m is utilised as follows:
- £4m on medical equipment (i.e all the high risk equipment and an element of medium risk);
- Cover for the £2.8m overspend on Hive; and
- £1.1m on accelerated IM&T and Estates capital (subject to confirmed delivery by 31st March 2023).

In terms of the spend not covered by the GM envelope, the 2022/23 full year forecast spend is £73.7m compared with the NHSE submitted plan of £67.8m. The increase in the forecast is due to additional PDC funding received in-year that was not included in the plan.

As previously reported to the Board, the IFRS 16 guidance issued by NHS England in October 22, confirmed that the 2022/23 capital expenditure incurred because of the adoption of IFRS 16 will be managed against a national "ringfenced" IFRS 16 CDEL allocation for the Trust, this totalled a plan value of £139.8m for 2022/23.

Following a review of the new leases expected to be started before year end, a revised forecast has resulted in a significant reduction from the planned position of £139.8m to a full year forecast outturn of £32.6m. The key reasons for this reduction are as follows:

1. The delay in the guidance from the centre. As this not being received until over halfway through 2022/23, new leases were not started given the risk of not having sufficient CDEL cover.
2. Assumptions about the managed equipment service (MES) contracts – at the time the capital plan was agreed it was decided that a cautious approach was taken on the element of leases contained within the MES, the application of IFRS 16 and their planned renewals. These have now been reviewed in detail and the assumptions updated.
3. Significant delays in the supply chain, notification from the centre and the time taken for leases to commence.

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	March 2023
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

Review of Integrated Care Systems

Rt Hon Patricia Hewitt, former secretary of state for health and current chair of the Norfolk and Waveney Integrated Care Board (ICB), has been commissioned to lead an independent review into the efficiency, autonomy and accountability of Integrated Care Systems (ICSs). The final report is due to be completed by 15 March 2023.

In an update to stakeholder published in January she outlined some headline principles:

1. Giving “local leaders space and time to lead”
2. Collaboration – including asking for more ”joining up between [the Department of Health and Social Care], [the Department for Levelling Up, Housing and Communities], [NHS England] and other national bodies to mirror the integration within ICSs”
3. A limited number of shared priorities
4. Proportionate support for systems, meaning “less intervention for mature systems delivering results within budget; more intervention and support for systems facing greater challenges”
5. Balancing freedom with accountability, and
6. Enabling the use of timely, relevant, high-quality and transparent data.

She also announced the establishment of five workstreams to be led by senior health and care figures:

- Prevention and population health management
- Integration and place
- Autonomy, accountability and regulation
- Productivity and finance
- Digital and data

The productivity and finance workstream is being led by Penny Dash (chair, North West London Integrated Care Board) and Sir Richard Leese (chair, Greater Manchester Integrated Care Board).

NHS E Priorities and Operational Planning Guidance

The NHS E Priorities and Operational Planning Guidance set out three key tasks for 2023/24:

- Recover our core services and productivity
- Make progress in delivering the key ambitions in the Long-Term Plan (LTP), and
- Continue transforming the NHS for the future.

NHSE has specified a range of “national NHS objectives” and associated key actions that will help deliver the objectives that all systems are required to implement. These cover key areas such as urgent and emergency care, elective care, cancer, diagnostics, community service and primary care. See attachment A.

Plans are to be submitted at ICB level. Draft plans were required for 23 February and final plans are to be submitted to NHS England by 30 March 2023.

3. Regional Issues

Greater Manchester Integrated Care System (ICS)

All 10 localities are required to confirm their governance arrangements to NHS GM before the end of the March 2023 in particular the terms of reference for their locality board.

Trafford and Manchester have agreed their preferred governance model which will be submitted to GM ICB for approval.

Delegation of Specialised Commissioning

NHS England has confirmed its intention to delegate responsibility for the commissioning of the majority of specialised services to ICBs from April 2025. Shadow commissioning arrangements at an ICB level and a regional level will be put in place during 24/25 although the formal commissioning responsibilities will remain with NHSE during this time. MFT is working with ICB and other provider colleagues on the establishment of these new commissioning arrangements.

4. MFT issues

Annual Planning

The 2023/24 annual planning process is underway. This covers the development of the over-arching MFT annual plan, the Hospital, Managed Clinical Service, Local Care Organisation and corporate departments annual plans and the completion of the GM ICS operational plan templates that are collated to form the GM Operating Plan and are submitted to NHS E.

We have held two annual planning events with the Council of Governors, one looking back at delivery against the 22/23 plan and one looking forward reviewing the priorities for 23/24 identified by each of the Hospitals, Managed Clinical Services and Local Care Organisations.

A draft overarching MFT Annual Plan will be circulated to the Council of Governors for comment in early March and be brought to the Board for sign-off in April/May.

MFT Single Services

The development of single clinical services brings together services that were previously provided separately on the MRI, Wythenshawe and NMGH sites, into one service with one leadership team and one management structure. It enables us to create larger clinical teams and is an important enabler for delivering the benefits of the single hospital service. Managed Single Services are being established for all priority services. A tracker for monitoring progress has been developed and is reviewed regularly through the Accountability Oversight Framework.

5. Actions / Recommendations

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

Attachment A

National NHS Objectives 2023/24

Area	Objectives	Actions
Urgent and emergency care	• Reduce A&E waiting times to >76% of patients being seen within 4 hours by March 2024 • Cat. 2 ambulance response time to average of 30 minutes • Reduce G&A bed occupancy to <92%	• Increase physical bed capacity to winter 2022/23 funded levels • Reduce medically fit to discharge patients • Increase ambulance capacity • Reduce handover delays
Community health services	• Meet 70% 2-hour UCR standard • Reduce unnecessary GP appointments and streamline direct patient access	• Increase UCR referrals from all key routes • Expand direct access and self-referral systems including ophthalmology, falls response, physiotherapy, audiology, weight management, podiatry and wheelchair equipment services
Primary care	• Improve accessibility to GP practice and ensure appointments within 2 weeks • Continue trajectory of 50 million more appointments by March 2024, • Continue recruitment of ARRS roles • Recover dental activity	• Ensure GP practices are easily contactable • Transfer lower acuity care away from GP/111 by improving pharmacy participation in the Community Pharmacist Consultation Service
Elective care	• Eliminate 65+ week waits by March 2024 • Deliver the system-specific activity target	• Reduce OPFU in line with ambition for 25% reduction by March 2024 • Meet 85% day case and theatre utilisation expectations • Offer meaningful choice and use of alternative providers through DMAS if long waiting time
Cancer	• Continue to reduce patients waiting >62 days • Meet the cancer faster diagnosis standard by March 2024 for 75% of patients being diagnosed within 28 days • Increase % of stage 1 and 2 diagnoses in line with 75% early diagnosis ambition by 2028	• Implement and maintain priority pathway changes for lower GI, skin and prostate cancer • Increase and prioritise diagnostic/treatment capacity, for a 25% increase in diagnostic capacity and 13% increase in treatment capacity • Expand TLHC programme and ensure sufficient capacity to meet increased demand • Commission services for progress on early diagnosis
Diagnostics	• Increase 6 week diagnostic text in line with 95% ambition by March 2025 • Deliver activity to support plans addressing backlogs and waiting time ambition	• Maximise pace of roll-out of additional diagnostic capacity, delivering second year of CDC investment plan • Deliver minimum 10% improvement in pathology and imaging networks productivity by 2024/25 • Increase GP direct access
Maternity	• Progressing towards reducing stillbirth, neonatal/maternal mortality and serious intrapartum brain injury • Increase fill rates for maternity staff	• Deliver actions from final Ockenden report • Ensure all receive a personalised care plan and are supported to make informed decisions • Implement LMNS/ICB action plans to reduce access inequalities
Use of resources	• Deliver balanced net system financial position	• Meet 2.2% efficiency target and improve levels of productivity by developing plans to deliver savings and raise productivity, reduce costs and improve inventory management
Workforce	• Improve staff retention and attendance	• Systematic focus on all elements of the NHS People Promise
Mental health	• Improve access to services in line with national ambition of 345,000 additional individuals aged 0-25 • Achieve 5% year on year increase in those supported by community services	• Increase expenditure on services by more than allocation growth • Develop workforce plan supporting delivery of mental health ambition with ICS partners

	• Recover dementia diagnosis to 66.7% • Improve access to perinatal services	• Improve data to evidence transformation and impact of services
Learning disabilities and autistic people	• 75% of those on GP learning disability registers receiving annual health check and action plan by March 2024 • Reduce reliance on inpatient care	• Improve size and accuracy of GP Learning Disability registers • Develop workforce plans to support objective delivery • Implement improvements in diagnostic pathways
Prevention and health inequalities	• Increase percentage of those with hypertension treated to 77% by March 2024 • Increase % of those with CDV risk score >20% on lipid lowering therapies to 60% • Continue to address health inequalities	• Update prevention of ill-health plans • Continue to deliver against five strategic priorities for health inequalities

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, Patient Services Manager Niall Bancroft, Customer Services Manager
Date of paper:	March 2023
Subject:	PALS and Complaints Report: Quarter 3, 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:	The Board of Directors is asked to note this Complaints and PALS report, including information relating to Q3, 2022/2023, on the following topics: • Complaints and PALS activity • Brief analysis of identified themes • Summary of achievements and improvements planned • Overview of complainants' satisfaction survey
Recommendations:	The Board of Directors is asked to note the content of the report
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

1. Introduction

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaint activity across Manchester University NHS Foundation Trust (MFT) during Q3 (Quarter 3, 1st October – 31st December) 2022/23.

1.2 Our aim is to provide timely resolutions when people raise concerns or complaints about their experiences of the care they have received. We aim to remedy the situation as quickly as possible, ensuring the individual is satisfied with the response they receive. Learning from complaints provides a rich source of information to support sustainable change.

1.3 This report provides:

- A summary of activity for Complaints and PALS across the Trust.
- An overview and brief thematic analysis of complaints raised.
- A summary of feedback received through Care Opinion and NHS Websites.
- A summary of improvements achieved, and those planned to ensure learning from complaints is embedded in everyday practice.
- A summary of the Complainants' Satisfaction Survey and planned improvement activity.
- Equality and Diversity information and planned improvement activity.
- Supporting information referred to throughout the report is included at **Appendix 1**.

1.4 The report refers to all Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) across the MFT Group.

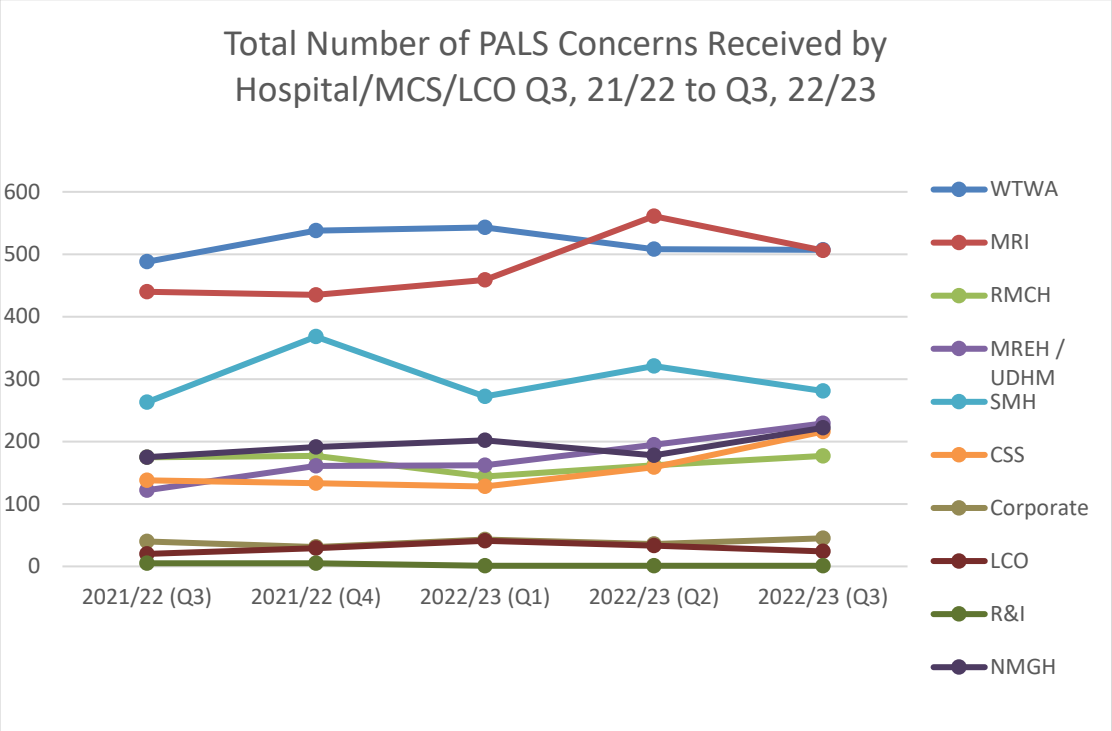
2. An overview of PALS and Complaints activity Q3, 2022/23

- 2,208 PALS concerns were received in comparison to 2,154 received in the previous quarter, an increase of 2.5% (54). This is also an increase an increase of 18.3% (342) from the 1866 received in Q3, 2021/22.
- 558 new complaints were received in comparison to 520 received in the previous quarter, an increase of 7.3% (38). This is also an increase of 39.8% (174) from the 384 received in Q3, 2021/22.
- Of the 558 new complaints received, 171 related to inpatient services. This shows an increase of 1.2% (2) in comparison to 169 received in the previous quarter. Of note this is an increase of 58.3% from the 108 complaints relating to inpatient services for the same period in Q3 2021/22.
- Manchester Royal Infirmary (MRI) received the greatest number of complaints with 128 being received during this quarter; an increase of 5.0% (6) in comparison to the 122 MRI received in the previous quarter. Of the 128 complaints received at MRI, the main themes were 'Treatment/Procedure' and 'Communication'.
- 99.6% of complaints were acknowledged across the Group within three working days.
- The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 90% of complaints were responded to within this agreed timescale compared to 88.6% in the previous quarter.
- 56 (10%) complaints investigated were upheld, 427 (77%) were partially upheld and 72 (13%) were not upheld (please refer to Section 5.3).

- The Parliamentary and Health Service Ombudsman (PHSO) did not close any cases during this quarter. The PHSO opened 1 new case for investigation. Details of the 'open' PHSO cases are set out in **Appendix 1, Table 1**.
- There was a total of 112 (20%) re-opened complaints received, compared to 92 (19%) the previous quarter.
- 37 virtual or face-to-face complaint local resolution meetings were held. This is a 9% increase compared to the 34 held previous quarter, and a 185% increase from the 13 held in Q3, 21/22.

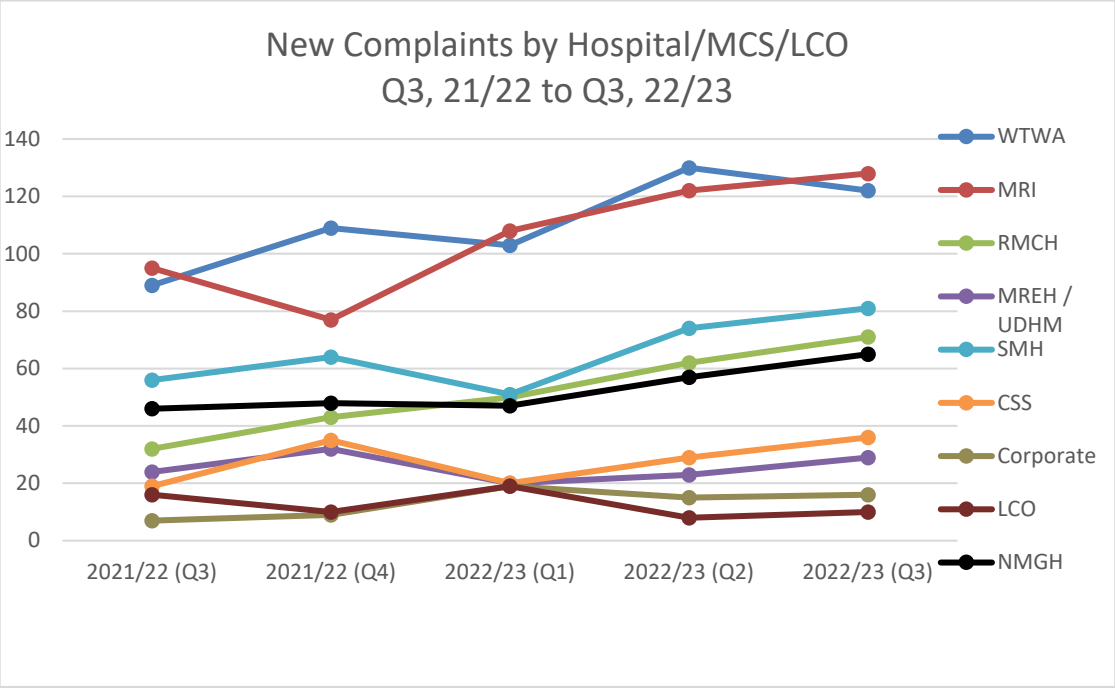
3.0 An overview and brief thematic analysis of PALS and Complaints contacts

3.1 In Q3, 2022/23 the Trust saw an increase of 2.5% in PALS concerns from the previous quarter, with 2,208 PALS concerns being received compared to the 2,154 received in Q2. **Graph 1** below shows the number of concerns received by each Hospital / MCS / LCO each quarter. Wythenshawe, Trafford, Withington and Trafford (WTWA) and Manchester Royal Infirmary (MRI) received the greatest number of PALS concerns, receiving 507 and 506 respectively. Overall, the greatest increases in PALS concerns, compared to the previous quarter, were seen in Clinical Scientific Services (36%) and North Manchester General Hospital (NMGH) (25%). Further detail is provided in **Table 2, Appendix 1**.



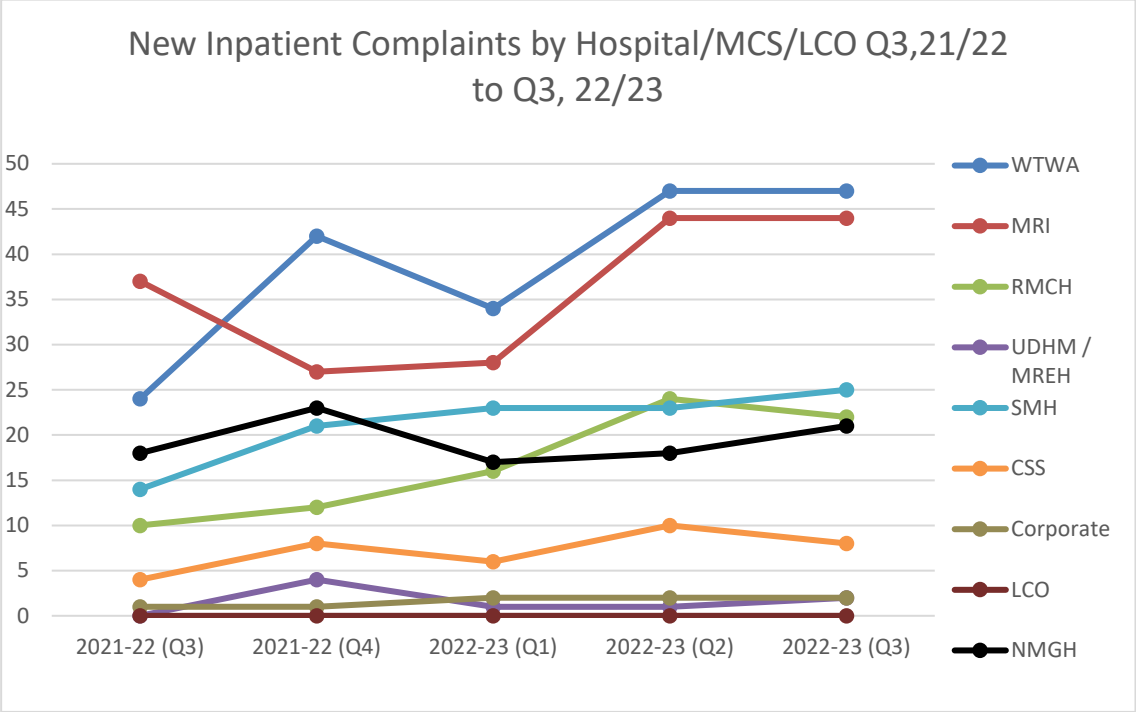
Graph 1: PALS Concerns Received by Hospital/MCS/LCO

3.2 As in Q2, 2022/23, the Trust noted a further increase in complaints with a 7.3% increase being noted in Q3 with 558 new complaints being received compared to the 520 received in Q2. **Graph 2** below shows the number of complaints received by each Hospital / MCS / LCO each quarter. MRI and WTWA received the greatest number of complaints, receiving 128 and 122 respectively. Further detail is provided in **Table 3**, **Appendix 1**.

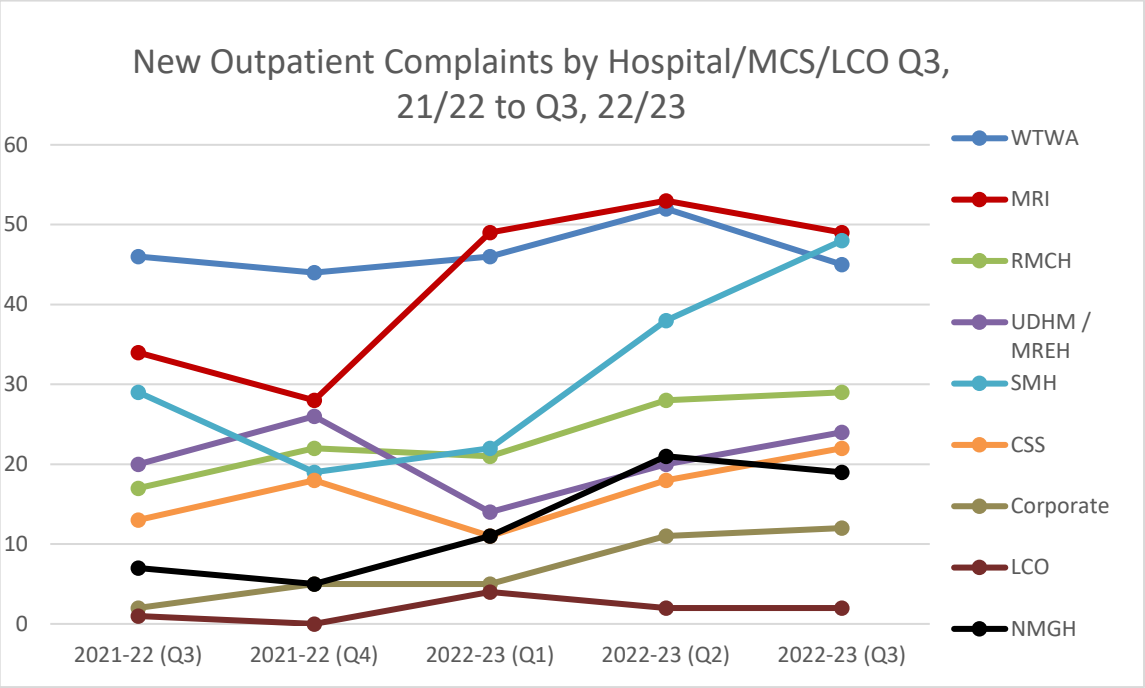


Graph 2: New Complaints Received by Hospital/MCS/LCO

3.3 **Graphs 3 and 4** illustrate the number of new complaints relating to inpatient and outpatient services during Q3, 2021/22 – Q3, 2022/23. Overall, the greatest increase in complaints relates to outpatient services (7). Of the 558 new complaints received, 45% related to outpatient services.



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



Graph 4: Number of new complaints relating to outpatient services by Hospital/MCS/LCO

3.4 Under the NHS Complaints Regulations (2009) there is a requirement that all new complaints are acknowledged within three working days of receipt of the complaint, MFT are committed to achieving this in 100% of cases. Unfortunately, this indicator was not met during Q3, 2022/23. Out of the 558 complaints acknowledged during Q3, two cases were not acknowledged within the three working day timeframe. Failings relate to:

- A case handler not being assigned to the case during the Triage process until Day 4.
- A complaint correspondence being mistakenly considered as part of an ongoing complaint rather than a 'new' complaint.

In both cases, the complainants were contacted, and apologies provided and accepted. **Appendix 1, Table 4** demonstrates the complaints acknowledgment performance.

4.0 PALS and Complaints resolved within agreed timescales

4.1 Against the Trust's target of 90%, the trust achieved closure of 90% of complaints within the agreed timescale, representing a slight increase in comparison to the previous quarter. **Appendix 1**, **Table 5** provides the comparison of complaints resolved within the agreed timeframe during the last five quarters.

4.2 The oldest complaint case closed during Q3 was registered within Corporate Services, Information Governance on 3rd May 2022 and was at 129 days when it closed on 4th November 2022. The implementation of HIVE contributed to the delay on the Trust's overall response time, as a detailed review was required as part of the complaint investigation to seek assurances that the data transfer to HIVE had not unintentionally undone the previous separation of blended records. The complainant was kept updated and was fully supported throughout this process.

4.3 The oldest complaint case open at the end of Q3, 22/23 at 178 days was within Saint Mary's Hospital (SMH). The complaint involved a midwifery care review following the death of a baby. The complainant has been kept updated and fully supported throughout the process, and the final response is expected to be sent in February 2023.

4.4 During Q3, 96.2% of PALS cases were closed within the Trust's 15-day deadline. This is a decrease from the 97.1% rate seen in Q2, and 97.2% in Q3, 2021/22. To support improvements the PALS and Complaints Escalation Standard Operating Procedure has been implemented with timely escalation of cases to senior management ensuring that escalation is undertaken prior to the approaching deadline. In addition to this, weekly Hospital / MCS / LCO PALS KPI meetings have been introduced to support improvement in the responsiveness.

5.0 Outcomes from Complaint Investigations

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

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

5.3 During Q3, 56 (10%) of the complaints investigated and responded to were fully upheld, 427 (77%) were partially upheld and 72 (13%) were not upheld. **Appendix 1, Table 6** demonstrates the outcome status of all complaints between Q3, 2021/22 and Q3, 2022/23. The main theme of upheld complaints was 'Treatment/Procedure'.

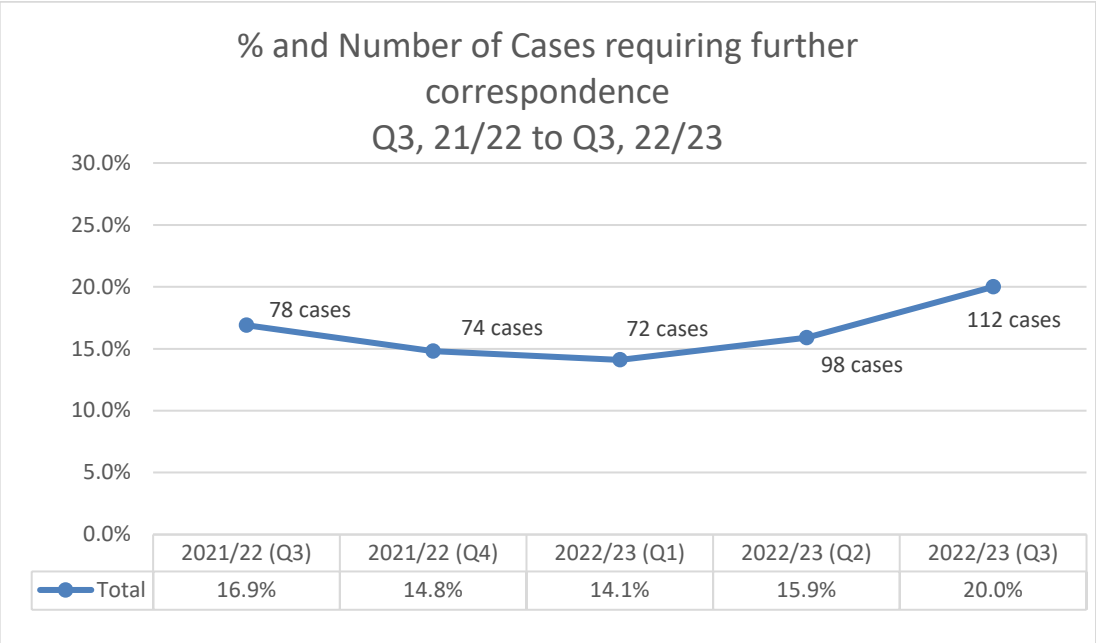
6.0 Re-opened complaints

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

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

6.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q3, 20% of complaints were reopened (112 cases in total) against the Trust tolerance threshold of 20%. In the previous quarter, 15.9% of complaints were reopened (98 cases in total).

6.3 **Graph 5** demonstrates the percentage of complaints re-opened from Q3, 2021/22 – Q3, 2022/23. **Appendix 1, Table 7** provides an overview of the primary reasons for the complaint being re-opened by Hospital / MCS / LCO during Q3.



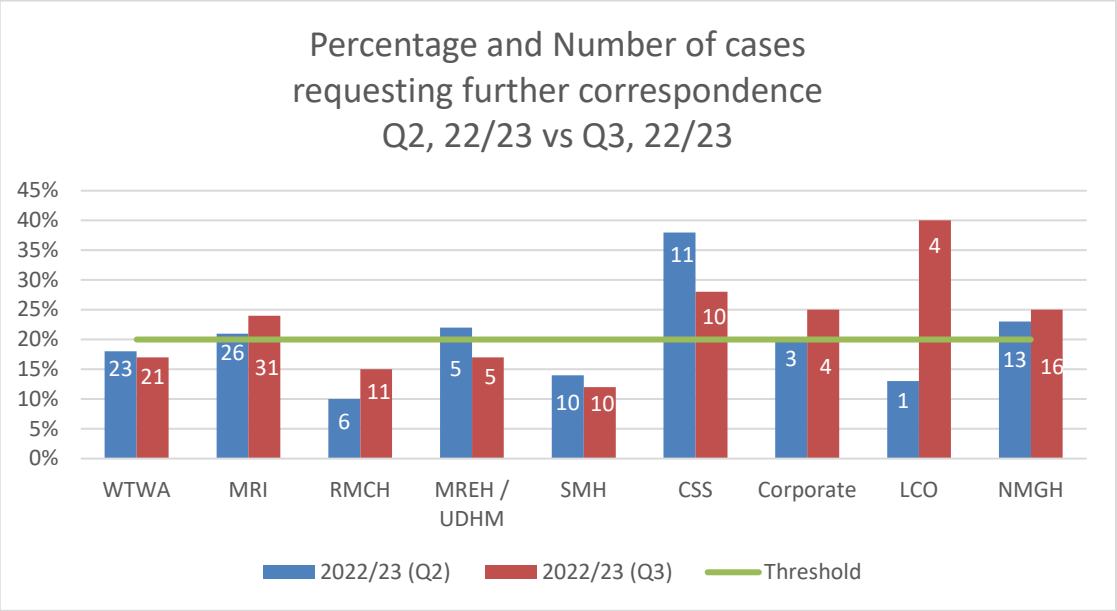
Graph 5: Total re-opened complaints Quarter 3, 2021/22 to Quarter 3, 2022/23

6.4 In 52 of the 112 complaints requiring re-opening in Q3 2022/23, the primary reason was due to the 'complaint response not addressing all issues', with MRI and NMGH receiving the greatest number, 14 and 12 respectively.

6.5 The 20% threshold was exceeded by the Local Care Organisation (LCO) at 40%, CSS at 28%, Corporate and NMGH at 25%, and MRI at 24% **(Graph 6).**

6.6 Small fluctuations in the total number of complaints received in a Hospital / MCS / LCO or Corporate Services can result in large percentage changes for those areas where the overall number of complaints are low, which is the case for CSS, University Dental Hospital Manchester / Manchester Royal Eye Hospital (UDHM/MREH), Corporate Services and the LCO.

6.7 During Q4, the Corporate Complaints Team letter writing training programme will focus on the Hospitals / MCSs / LCO who have received the greatest number of re-opened cases, to offer support to improve their complaint response and reduce the number of re-opened complaints.

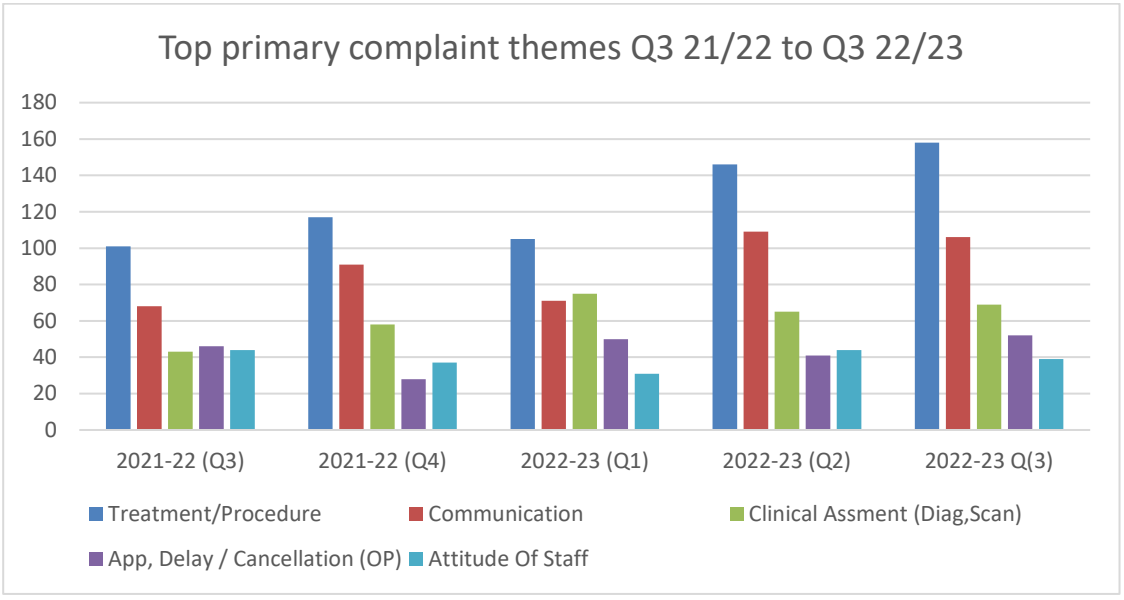


Graph 6: Percentage of re-opened complaints by Hospital/MCS/LCO, Quarter 3, 2022/23

7.0 Brief thematic overview of complaints

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

7.2 During Q3, 2022/23, the top 5 primary categories remained unchanged with 'Treatment / Procedure' and 'Communication' remaining the top two categories **(Graph 7)**.



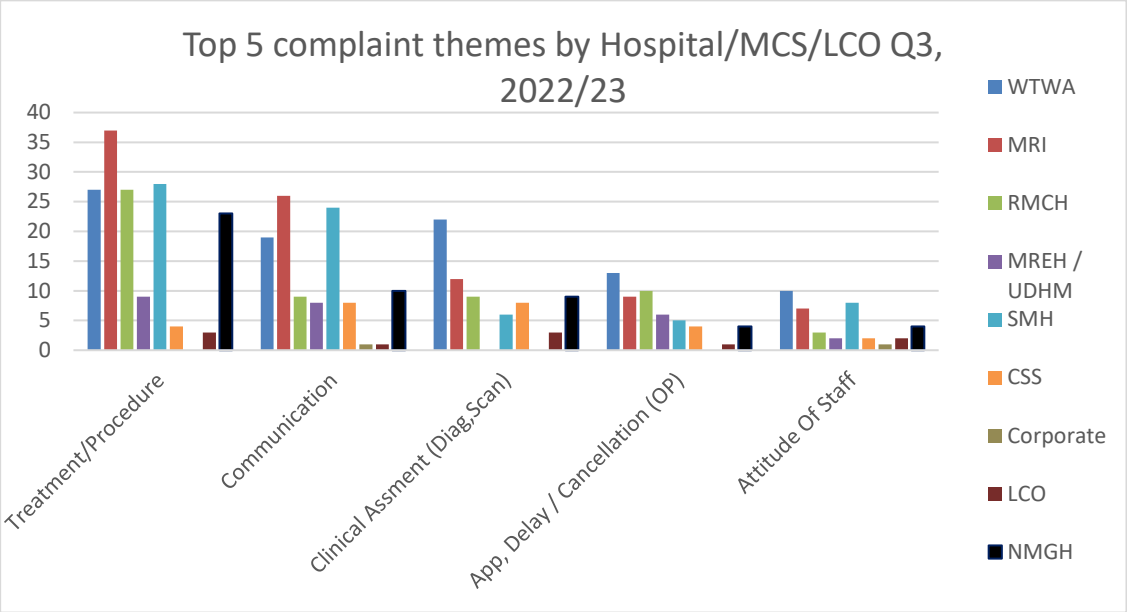
Graph 7: Top Primary Complaint Themes Q3, 2021/22 to Q3, 2022/23

7.3 MRI received the most complaints relating to 'Treatment / Procedure' (37) and 'Communication' (26)

7.4 Some examples include:

- A letter sent to a patient containing incorrect information regarding treatment.
- A patient receiving upsetting results over the telephone rather than a clinic setting.
- A patient experiencing a delay in staff responding to them seeking help and assistance via the call bell.
- An inpatient experiencing a delay in being monitored and receiving personal care.

7.5 **Graph 8** below shows the distribution of the top 5 themes by Hospital / MCS / LCO in Q3, 2022/23.



Graph 8 Top 5 themes by Hospital/MCS/LCO in Q3, 2022/23

8.0 Care Opinion and NHS Website feedback

8.1 The Care Opinion and NHS Websites are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about the patient experience between patients, and people who provide health services.

8.2 All NHS Website and Care Opinion comments are received by the Corporate Patient Experience Team (PET) and shared with the relevant Hospital / MCS / LCO. Responses are required for publication within five working days. Designated senior staff within each Hospital / MCS / LCO review the comments and provide a response for publication. **Table 9** below provides examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q3.

Quarter 3, 2022/23
Wythenshawe Hospital – Nightingale Centre
“I attended the one stop clinic- I received my appointment in 10 days. I was seen promptly by the doctor, then I had an ultrasound and then I saw the doctor again, absolutely incredible. Everyone from staff on reception to the nurses and the

doctors were kind and helpful. We are unbelievably lucky to have such an amazing service in the NHS."

Response

Thank you for taking the time to share your positive feedback on the NHS website regarding your care received at Wythenshawe Hospital. It is always good to read such positive words in response to the conscientious work of our staff and efficiency of the service being provided. We have forwarded your message on to the Head of Nursing and all the staff involved. The Patient Experience Team.

University Dental Hospital of Manchester – Oral Surgery Outpatients

"First visited this place in November 2021. It was agreed what procedures I would need. I went back to my personal dentist to get my gums cleaned out to then find this dental hospital had took me off their books. Fast forward to July I had to act as an admin because this place just didn't want to know at all. I finally got a letter sent to me this week to come in. They have a phobia of being on the phones it seems because it's impossible to get through so rather than ring me and ask what date is convenient they just sent me a random date in which it conflicts with my working hours. Cancelled the appointment and now here I am for two hours this morning trying to get through on the phone and they just won't pick up. Utterly useless and would advise people to steer well away! How can you treat people like this. It's now been a year and I am no closer to getting my surgery done. Appalling how you treat your customers."

Response

We are very sorry to receive your comments and concerns via the NHS Choices website about your experiences in October 2022.

In response to your comments, I can tell you that your concerns have been escalated to the administrative team to ensure that staff are aware of the importance of answering the telephones. The hospital has been experiencing significant issues with our telephone systems and we are working closely with the Telecommunications team in an attempt to get these resolved as soon as possible. We would like to apologise for the inconvenience and the frustration that this may have caused you.

Alternatively, if you would like to contact us directly to change, cancel or chase up an appointment you can email us via: dental.appointmentbooking@mft.nhs.uk our staff will be more than happy to assist you.

It is difficult to respond to all the posts in a full way often because of a lack of detailed information, therefore if you would like to discuss this with us in more detail, please feel free to contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@cmft.nhs.uk

North Manchester General Hospital – Ward J3
“My uncle was on Ward J3 for 3 days. Unfortunately he was put on the pathway [sic] but your nurse was amazing. She was so caring and gentle with him. She got us drinks, chairs, anything we needed. We couldn’t have asked for a kinder person for him to have in his last hours. It needs to be recognised how amazing she was with us. The whole family really do appreciate the care she showed over 3 horrendous days.”
Response
Thank you for your positive comments posted on the NHS website regarding the care your uncle, you and your family received at North Manchester on Ward J3. It was very kind of you to take the time to write and share your experience at what must be a difficult time for you. We strive to deliver compassionate care and it is very kind of you to acknowledge this. Your comments will be shared with the clinical team who will appreciate your feedback. Thank you again for your comments. The Patient Experience Team.
Manchester Royal Infirmary – Accident and Emergency
“Attended the A and E today as I had illness overnight making critical treatment difficult to take. I thought the staff were brilliant, but the department is overstretched. Wish there was a side room for very poorly patients being ill with pain and sickness. To wait in the chairs were hard for the poorly people to sit on especially as the wait times were 13 hours. Cannot fault the staff though they were great.”
Response
Thank you for your positive comments posted on the NHS website regarding the care you received at MRI in A&E. 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 the hard work and dedication of our staff. We are very sorry to hear that all aspects of your attendance did not meet the high standards that are expected for our patients. Please accept our apologies for the long waiting time. At present, MRI, like all Emergency Departments (ED’s) across the UK are experiencing high volumes of patients presenting, and whilst the ED and the wider hospital have taken steps to redirect patients to the most appropriate service (including same/next day Urgent Treatment Centre appointments, Same Day Emergency Care and Patient Initiated Follow Up) at times there is an imbalance between our ability to see patients in a timely manner, particularly those of lower acuity. We would also like to assure you that the Emergency Department is currently undergoing a £45 million redevelopment project to improve the facilities for its patients and staff, which will address the concerns you raise. Should you wish to discuss your experience with us further please contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@mft.nhs.uk.
Manchester Royal Infirmary – Sexual Health (Hathersage)

"The booking system and response to home tests is absolutely awful. I sent a sample in that wasn't tested, no response as to why this happened. Then comes the difficult task of speaking to someone. They will not answer the phone for ages and when they do they are absolutely unhelpful. They also shut down at lunch and phones stop working even if their working hours on the site say they are open. When you try to explain the difficulties in booking online, they tell you to try 7 to 8 times!!! I have been using this service for years and years and this is the absolute worse it got. This is not Covid's fault and I am certain the patient numbers haven't increased this much! It's really the complete lack of concern for the patients that is alarming. Very bad indeed."
Response
Dear patient We apologise for the difficulties you have experienced when trying to use our booking system and home testing kits. We release slots online Monday to Friday at 8:30am and 12:00pm. We do appreciate however that demand for our services is sometimes greater than our capacity and it can take more than one attempt to secure an appointment. For patients who have no online access we advise them to contact their local clinic directly to arrange an appointment. With regard to your home testing kit, if you could contact us via thenorthernISH.enquiries@mft.nhs.uk with your personal details (name, DOB and telephone number) we will be able to investigate what has happened. We have had administration staffing issues over the last few months which has impacted on our ability to answer our phones in an acceptable timeframe. These issues are being addressed and we are hopeful there will be a significant improvement very soon. As a service we are always looking to improve and will use your feedback to support this.

Table 9: Examples of Care Opinion/NHS Website Postings and Reponses Q3 2022/23

8.3 This quarter a total of 61 comments were received via the websites, of which 27 (44.3%) were positive, 27 were negative (44.3%) and 7 were mixed (11.4%). The number of Care Opinion and NHS Website comments by category; 'positive', 'negative', and 'mixed', are detailed in **Appendix 1**, **Table 10.**

9.0 Learning from Complaints

9.1 This section of the report provides examples of improvements made in response to feedback from complaints. Further detail is provided in Section 10, which outlines the opportunities being explored to support learning and transformation through shared vision, and positive change through open dialogue and reflection.

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

9.3 During Q3, 2022/23 the Complaints Review Scrutiny Group (CRSG), chaired by the Corporate Director of Nursing for Quality and Patient Experience and supported by a Non-Executive Director, met twice. The management team from: SMH (Gynaecology) and the Royal Manchester Children's Hospital (RMCH) each presented a case in November 2022, and MREH and UDHM each presented a case in December 2022. Learning and associated actions identified from the 4 cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed. Some examples of outcomes from the 4 cases discussed are provided in **Table 11** below:

Hospital / MCS / LCO	Learning	Actions
RMCH	We learnt that: • There was a need for a review of policy for safe insertion and maintenance of NG, OG and NJ tubes in infants and children	• Policy reviewed to ensure it is fit for purpose. • Policies and Guidelines Team shared policy via email, once ratified, and uploaded to policy hub. • Education Team to provide ongoing training to ensure staff are working in line with newly revised policy.
SMH (Gynaecology)	We learnt that: • There was poor communication around provision of care for LGBT patients.	• Review of template letters to ensure correct method of addressing both patient and partner. • All staff within Reproductive Medicine to be made aware of the National Ambulance LGBT Network Tool Kit.
MREH	We learnt that: • There are long waits in Clinic H at MREH.	• Outpatient improvement project to review Hive letters and ensure patients' expectations are being managed, regarding wait times in clinics.

		• Outpatient Department Matron to commence waiting room intentional rounding, to improve patient experience during busy clinics in Clinic H. • Task and Finish Group to review usage and capacity of Clinic H. • Small Change Big Difference to be considered for additional funding for diversional therapy tools. • Investigate, and included in annual plan, whether it is possible to fund a Play Therapist.
UDHM	We learnt that: • An undergraduate dentist sent incorrect communications regarding a discharge decision to a patient	• Undergraduate dentists to be informed, during induction, of their responsibilities, which tasks are within their remit, and which tasks need review / approval by their tutor, and to ensure that undergraduate dentists regularly meet with their tutors to discuss their roles and responsibilities.

Table 11: Actions identified at the Trust Complaints Scrutiny Group during Q3, 2022/23

10.0 Hospital / MCS / LCO Learning from complaints

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

10.2 Detailed below, in **Table 12,** are some examples of how learning from complaints has led to changes that have been applied in practice.

Hospital / MCS / LCO	Reason for complaint	Action Taken
LCO (Social Communication Pathway)	Concerns received regarding length of time a child waited for a speech and language therapy assessment, the environment the child was seen in, the ability for the service to support both parents with the treatment plan rather than requesting only one parent attending the sessions and the language used to discuss potential diagnoses and the impact this may have on families.	Clinic room environments reviewed to support a more welcoming environment for children. Clinic team's approach reviewed, when both parents are equal care givers to ensure continuity of care. A review took place of the approach around having discussions with parents and making onward referrals to the Social Communication Pathway.
MREH	Concerns relating to incorrect details regarding a telephone appointment, contained within a patient appointment letter and incorrect contact numbers provided for appointment teams.	All booking letters have been checked and corrected as part of the transition to HIVE. Booking Clerks and team have been reminded of the importance of accuracy and to ensure the check that the appointment details in letters are correct prior to posting. MREH Administrative Teams have been reminded of the correct telephone numbers to provide to patients who need to contact the Appointment Booking Team.
UDHM	Concerns regarding patient voicemail messages left by a patient not being responded to by the Administration Team.	The process for reviewing telephone voicemails has been reviewed by the Directorate Manager. The Directorate Manager is devising a Standard Operating Procedure (SOP) for the Administration Team, to describe the expected standards for responding to messages left by patients and the recording of this communication into the Electronic Patient Record (EPR) system (HIVE).

CSS (Imaging)	Concern regarding a delay in the reporting of scan for a patient with liver cancer. Imaging aims to report routine scans within 30 days; however, the patient's scan report took 89 days.	An action plan for reducing the backlog in Radiology reporting is being developed by the Head of Division. Backlog in reporting to be documented on the Division of Imaging risk register.
CSS (Division of Laboratory Medicine)	Concern regarding a delay in the patient's GP receiving the results of the skin biopsy.	Samples will be sent to an external company to perform part of the sample processing. This is already underway and has led to a significant improvement in processing times. The daily workload within the Histopathology laboratory reviewed, to determine the staff available to complete this work. Where it is seen that work cannot be completed within an appropriate timeframe, these cases will be sent to an external company for processing. The Department's recruitment strategy reviewed within the Histopathology laboratory, to identify different ways of finding potential candidates to fill vacant posts.
WTWA (Cardiac)	Concerns regarding poor palliative care and end of life care, during a patient's inpatient stay on the ACCU.	Refresher end of life training for all the nursing staff on the Acute Coronary Care Unit (ACCU), provided by the Palliative Care Team. This included medication management for symptom control and communication with patients and their families. The Ward Manager for the Acute Coronary Care Unit has reiterated the importance of effective communication with the nursing staff on the Unit and she has requested for all nursing staff to complete the Trust's Sage and Thyme communication training in the coming months. The importance of assisting relatives in distressing situations has been reiterated to the nursing staff on the Acute Coronary Care Unit, and the nursing staff who

		were on duty have been asked to reflect on this situation.
NMGH (Urgent Care)	Concern regarding a patient being left in the corridor for 25 hours and lack of updates.	ED are introducing new pathways to help improve patient flow into the hospital, so patients can be seen in a cubicle rather than being nursed on the corridor. Patient Liaison Officer introduced to improve communication between staff, patients and their families.
RMCH	Concerns raised regarding a patient's care, specifically lack of hydration, pain relief and aftercare within Paediatric Dental Care Services. Concern regarding staff's lack of awareness and appropriate management of patient's disabilities.	Matron has spoken to ward teams regarding complainants' experiences and about learning improvements. Play Therapist to work with the patient to support them with ongoing treatment at RMCH. Clinical Lead for Dental Services has: • Liaised with colleagues in Paediatric Maxillo-Facial team to ensure improved communication during handover • Liaised with colleagues in the Pain Management Team regarding improving the level of service being offered. • Discussed the poor experiences the complainant and patient had at the next audit and teaching 'ACE' day with the wider Dental team.
MRI (Emergency Assessment and Access)	Concern regarding a sickle cell patient not receiving timely pain relief.	The Emergency Department (ED) team are working closely with colleagues from Haematology and are developing a pathway to ensure they provide a higher standard of timely care to patients with sickle cell disease including analgesia as per individual patients care plans. Patient Controlled Analgesia (PCA) machines are available in ED.

		Following the implementation of HIVE, it is now easier to review patients individual care plans.
SMH (Gynaecology)	Concerns raised in respect of telephones not being answered and timely calls not being made to patients.	Morning handover on Gynaecology Ward now includes an additional section to discuss any calls taken from patients overnight, to ensure they have the appropriate follow-up required. Secretaries in Outpatients now exploring all communication methods when cancelling patients to ensure they are notified and do not attend. Patient App is to be implemented to improve patient contact with the Department of Reproductive Medicine.

Table 12: Examples of the application of learning from complaints to improve services, Q3 2022/23

11.0 Quality Improvements during Q3, 2022/23 included:

11.1 Complaints Review Scrutiny Group (CRSG)

11.1.1 During Q3, 2022/23 the MFT Complaints Review Scrutiny Group (CRSG) resumed, following its postponement during Q2, 2022/23 due to the implementation of HIVE. To assist with CRSG lending itself to improve patient experience, quality improvements to CRSG were completed and it is now operating under a new Terms of Reference and Standard Operating Procedure.

11.1.2 Under the new Terms of Reference and Standard Operating Procedure, CRSGs are now held on a monthly basis with teams from a different Hospital / MCS / LCOs each presenting a complaint each month, with a designated action plan created for each respective Hospital / MCS / LCO, based on the discussions of the meeting regarding the complaint. The presenting Hospitals / MCSs / LCO team then attend CRSG the following month, to provide an update on their action plans; should the action plans not have been completed, the Hospitals / MCSs / LCO are invited to attend a future meeting to provide assurance that all actions have been completed.

11.1.3 PALS and Complaints data for each respective Hospital / MCS / LCO and the directorate that is the subject of the complaint presentation is now presented at each CRSG. This data provides a summary of the number of complaints and PALS concerns received, the compliance with response deadlines, PHSO cases, Friends and Family Test data and What Matters to Me information.

11.1.4 These improvements to the CRSG provide greater assurance that complaints and PALS cases are being handled effectively and efficiently, and highlight any areas of concern to ensure appropriate support can be put in place.

11.2 Advanced telephone system

11.2.1 Work continued during Q3, 22/23 drafting the script for the advanced telephone system, which will be implemented in Q4, 22/23.

11.3 Launch of the PALS and Complaints In house E-Learning Customer Service – Module 2 package

11.3.1 During Q3, module 2 was launched on the Trust's learning platform. This continues to be advertised through the Trust's communication channels and attendance data and user feedback will be reviewed in Q4, 22/23 and on an ongoing quarterly basis.

11.4 Complaint Local Resolution Meeting (LRM) process

11.4.1 In order to streamline the process for both the Hospitals / MCSs / LCO, updates were made to the LRM process. In line with the improvements, the responsibilities were communicated to all involved staff and, following a review of the effectiveness of the change, the Standard Operating Procedure will be updated for approval.

11.5 Enhancing secure methods of sending recordings and letters electronically

11.5.1 A secure method of sending confidential information to complainants, via email, was implemented to reduce delays in the complaints process caused by external Royal Mail issues and the receipt of signed consent, and reducing the potential for information governance data breaches.

11.6 Development of 'third party' Ulysses report

11.6.1 During Q3, a new Ulysses report was developed to capture all ongoing complaints that require the input of another trust / organisation. This will be implemented during Q4 and provide an oversight of all joint-complaint cases. It will also allow the PALS and Complaints Manager can ensure cases are being managed correctly and can escalate any cases whereby there are external delays, to reduce the number of extension requests and breaches of response deadlines, whilst improving the timeliness of complainants receiving multi-trust complaint responses.

11.7 Hospital / MCS / LCO contact lists

11.7.1 In order to increase responsiveness to PALS concerns, by ensuring the correct staff are being notified of PALS concerns, a new Microsoft Teams Group has been established, so that contact lists can be updated in real time.

11.8 Development of new and updated Standard Operating Procedures

11.8.1 During Q3, work commenced on reviewing and updating the Corporate Complaints Team Standard Operating Procedures, to streamline processes and improve efficiency. This work will be finalised during Q4.

11.9 National Customer Service Week

11.9.1 National Customer Service Week (NCSW) ran from Monday 3rd to Friday 7th October 2022, as an opportunity to raise aware of the vital role customer service plays in the UK. The PALS Teams celebrated customer service across the Trust, by placing stands outside the PALS offices at the MRI and Wythenshawe Hospital.

12.0 Education

12.1 PALS and Complaints Training

12.1.1 During Q3, 2022/3 the PALS and Complaints Managers delivered complaints investigation training session to staff within the Local Care Organisation (LCO). Further training is planned to be delivered to all other Hospital and MCSs in Q4.

12.1.2 During Q3, 2022/3 the Corporate Complaints Team Leaders delivered a further 6 sessions of the letter writing training programme for those staff who wish to improve their complaint response writing skills.

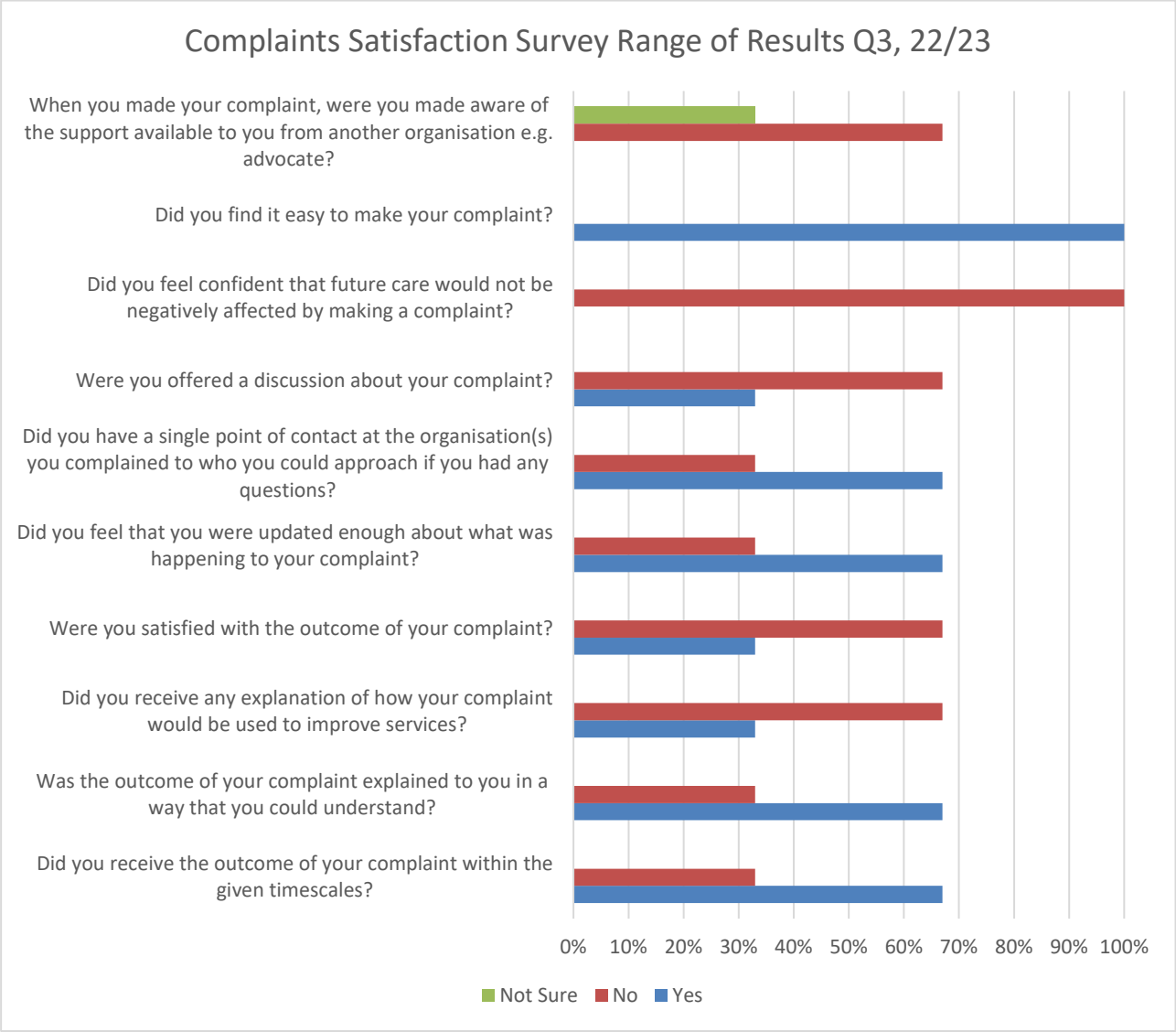
13.0 Complaints Satisfaction Survey

13.1 Understanding the experience of the complainant, during and after a complaint investigation, is considered good practice. By asking the complainant about their experiences about the quality of the services they have received, the Trust can use this feedback to make changes and improve our processes and procedures.

13.2 In Q3, only a minimal number of surveys, based on the 'My Expectations' paper, were distributed to complainants across all MFT Hospital's / MCS's / LCO at the closure of the complaint. As a result of this, only 3 completed questionnaires were returned, the results are shown in Graph 9 below.

13.3 Surveys are distributed to complainants at the closure of the complaint; however, vacant posts within the Administration Team resulted in a minimal number of surveys being sent out during Q3. As a result, only 3 responses were received. The surveys not sent out during Q3 will be retrospectively distributed during Q4. In order to improve the number of surveys being sent out, a new Standard Operating Procedure is being developed to share the responsibilities of this task and the Administration Team vacancies have been appointed to.

13.4 It is important to note that due to the low response rate of 3, each answer attributes to a 33.3% score within the survey.



Graph 9: Complaints Satisfaction Survey results for Q3, 2022/23

13.3 The following are examples are feedback from complainants, received via during Q3 2022/23:

"The reply contained conflicting reports on my experience."

"Staff member in the Complaints Department was very polite and professional."

"After being advised to call North Manchester General Hospital, I left lots of messages with the clinics and PALS, but nobody got back to me"

"The Complaints Facilitator failed to contact me within a reasonable timeframe and failed to make the necessary arrangements for a local resolution meeting, as requested."

"I was given the complaints telephone number by Switchboard, but after twice confirming it was a new complaint and about Wythenshawe Hospital, I was cut off."

"I would just like you to know that I have had fantastic help, advice, and service from your PALS Team at Wythenshawe Hospital. They have gone the extra mile to help and advise me. The Team Leader has been amazing and had gone over and above everything expected of her; she has helped me through this process so much, always telephoning me back when she said she would, advising me, listening to me. She was so sincere and caring."

14.0 Continuing Planned Improvements

14.1 Continued areas for improvement and development during Q4 2022/23 include:

- Update of PALS and Complaints sections of MFT website and creation of a new online PALS contact form
- Standardisation of weekly PALS and Complaints KPI meetings across all Hospitals / MCSs / LCO
- 'Ask, Listen, Do' commitment - Improving the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service
- Heightening of PALS and Complaints training across Hospitals / MCSs / LCO
- Optimising learning from Complaints via Quality and Patient Experience Forum
- Optimising learning from Complaints via Education
- Enhancement of collection of Complaints Satisfaction Surveys and active sharing of learning
- Exploration of the introduction of a PHSO/Complaints 'upheld' Learning Sub-Group
- Development of dedicated PALS Volunteer role
- Enhancement of collection of Equality and Diversity data
- Raising staff awareness of PALS and provide training in their freedom to actively seek feedback to improve services and seek local resolution
- Re-introduction of Trust-wide Complaint Co-ordinator meetings
- Affina – staff development programme

15.0 Equality and Diversity Monitoring Information

15.1 The collection of equality and diversity data is shown in **Appendix 1, Table 17**.

15.2 Improved collection was found in relation to 'overall' data, with an increase of 6%; however, continued evidence of the ongoing need to improve reporting on 'disability', 'religion' and 'ethnicity' was identified; only 22%, 26% and 47% being received respectively.

15.3 The Customer Services Manager and PALS and Complaints Managers continue to explore ways of improving the collection of this data.

16.0 Conclusion and recommendations

16.1 This report provides a concise review of matters relating to Complaints and PALS during Q3, 2022/23. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place.

16.2 The Board of Directors are asked to note the content of this Q3, 2022/23 Complaints Report and the on-going work of the Corporate and Hospital / MCS / LCO teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of cases open at the PHSO as of 31st December 2022

Hospital / MCS / LCO	Cases/s	PHSO Investigation Progress
MRI (7)		
Manchester Heart Centre	1	Awaiting Final Report
Cardiovascular Specialty	1	Awaiting Provisional Report
GI Medicine & Surgery	1	Awaiting Final Report
In-Patient Medical Specialties	1	Awaiting Provisional Report
Emergency Assessment & Access	1	Awaiting Provisional Report
Emergency Assessment and Access	1	Scoping
Cardiovascular Specialty	1	Scoping
WTWA (6)		
Medicine (Medical Specialties)	2	Scoping
Emergency Assessment and Access	1	Scoping
Emergency Assessment and Access	1	Scoping
Ambulatory Care	1	Scoping
Complex Health and Social Care	1	Waiting scope of investigation from the PHSO
RMCH (2)		
CAHMS	1	Awaiting Provisional Report
Complex Medicine	1	Scoping
SMH (4)		
Obstetrics	1	Awaiting Provisional Report
Obstetrics	1	Scoping
Gynaecology	1	Scoping
Newborn Intensive Care	1	Scoping
CSS (0)		
UDHM (1)		
Oral Surgery	1	Awaiting Final Report
MREH (1)		
Ophthalmology	1	Scoping
LCO (3)		
Dermott Murphy Continuing Care Unit	1	Scoping
Specialist Nursing & Partnership Group	1	Scoping
Delamere House	1	Request for ‘Early Dispute Resolution’
TOTAL	**24**	

Table 2: Number of PALS concerns received by Hospital / MCS / LCO Q3 2021/22 – Q3 2022/23

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
WTWA	488	538	543	508	507
MRI	440	435	459	561	506
RMCH	175	177	144	162	177
UDHM/MREH	122	161	162	195	229
SMH	263	368	272	321	281
CSS	138	133	128	159	216
Corporate	40	31	43	36	45
LCO	20	29	41	33	24
Research & Innovation	5	5	1	1	1
NMGH	175	191	202	178	222
Grand Total	**1866**	**2068**	**1995**	**2154**	**2208**

Table 3: Number of Complaints received by Hospital / MCS / LCO Q3 2021/22 – Q3 2022/23

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
WTWA	89	109	103	130	122
MRI	95	77	108	122	128
RMCH	32	43	50	62	71
UDHM/MREH	24	32	20	23	29
SMH	56	64	51	74	81
CSS	19	35	20	29	36
Corporate	7	9	19	15	16
LCO	16	10	19	8	10
NMGH	46	48	47	57	65
Total	384	427	437	520	558

Table 4: Complaints Acknowledgement Performance

3 Day Target	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
Number of 3 day acknowledgements completed	384	427	437	520	558
100% acknowledgement	100%	100%	100%	100%	99.6%

Table 5: Comparison of complaints resolved by timeframe: Q3 2021/22 – Q3 2022/23

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
Resolved in 0-25 days	329	287	299	347	390

Resolved in 26-40 days	49	34	41	53	59
Resolved in 41+ days	103	57	77	90	122
Total resolved	**481**	**378**	**417**	**490**	**571**
Total resolved in timescale	**371**	**342**	**380**	**434**	**514**
% Resolved in agreed timescale	**77.1%**	**90.5%**	**91.1%**	**88.6%**	**90.0%**

Table 6: Outcome of Complaints, Q3 2021/22 – Q3 2022/23

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q3 21/22	384	53	339	75	9	4	0	2
Q4 21/22	427	42	243	74	13	5	1	0
Q1 22/23	437	42	283	76	10	5	0	0
Q2 22/23	520	53	357	62	6	9	2	1
Q3 22/23	555	56	427	72	0	0	0	0

Table 7: Re-opened Complaints by Hospital / MCS / LCO Q3 2022/23

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Dissatisfied with response	MP Query	Total
WTWA	1	3	9	8	0	21
MRI	1	5	14	10	1	31
SMH	2	6	2	0	0	10
CSS	2	2	4	2	0	10
RMCH	2	3	5	1	0	11
UDHM/MREH	0	1	3	1	0	5
Corporate	1	0	2	1	0	4
LCO	0	0	1	3	0	4
NMGH	0	2	12	2	0	16
Grand Total	**9**	**22**	**52**	**28**	**1**	**112**

Table 10: Care Opinion / NHS website postings by Hospital / MCS / LCO in Q3 2022/23

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q3 22/23			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	4	9	1
WTWA	8	3	2
CSS	2	3	0
Corporate	0	1	1

UHDM/MREH	2	6	0
LCO	0	0	0
RMCH	0	0	1
SMH	5	4	2
NMGH	6	1	0
Grand Total	**27 (44.3%)**	**27 (44.3%)**	**7 (11.4%)**

Table 14: Closure of PALS concerns within timeframe Q3 2021/22 – Q3 2022/23

	Q3,21/22	Q4,21/22	Q1 22/23	Q2 22/23	Q3 22/23
Resolved in 0-10 days	1702	1783	1872	1839	1965
Resolved in 11+ days	213	178	202	265	409
% Resolved in 10 working days	**88.9%**	**90.9%**	**90.3%**	**87.4%**	**82.7%**
% Resolved in 15 working days	**97.2%**	**98.7%**	**98.4%**	**97.1%**	**96.2%**

Table 15: Number of PALS concerns taking longer than 15 days to close by Hospital / MCS / LCO Q3 2021/22 – Q3 2022/23

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
WTWA	15	6	7	7	17
MRI	16	8	12	17	29
RMCH	9	5	2	11	6
UDHM/MREH	1	2	1	0	5
SMH	0	2	3	10	15
CSS	1	1	5	5	2
Corporate	3	1	1	4	4
LCO	1	1	0	1	1
NMGH	8	0	2	5	11
Grand Total	**54**	**26**	**33**	**60**	**90**

Table 16: Number of PALS concerns escalated to formal investigation Q2 2021/22 – Q2 2022/23

	Q3 21/21	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
No of cases escalated	22	12	13	9	19

Table 17: Equality and Diversity Monitoring Information Q3 2021/22 – Q3 2022/23

Disability	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
Yes	24	34	27	29	44
No	15	16	14	17	76
Not Disclosed	345	377	396	481	437

Total	**384**	**427**	**437**	**527**	**557**
Disability Type					
Learning Difficulty/Disability	0	2	1	0	0
Long-Standing Illness or Health Condition	10	28	11	16	19
Mental Health Condition	6	9	4	6	4
No Disability	0	0	0	0	1
Other Disability	4	2	0	7	4
Physical Disability	1	8	5	7	8
Sensory Impairment	1	2	0	5	5
Not Disclosed	362	376	416	486	516
Total	**384**	**427**	**437**	**527**	**557**
Gender					
Man (Inc Trans Man)	151	175	188	201	231
Woman (Inc Trans Woman)	229	246	248	320	319
Non-Binary	0	0	0	0	0
Other Gender	0	0	0	0	4
Not Specified	4	6	1	4	3
Not Disclosed	0	0	0	2	0
Total	**384**	**427**	**437**	**527**	**557**
Sexual Orientation					
Heterosexual	63	92	51	110	91
Lesbian / Gay/Bi-sexual	1	3	10	3	5
Other	0	0	2	1	2
Do not wish to answer	4	9	8	7	17
Not disclosed	316	323	366	406	442
Total	**384**	**427**	**437**	**527**	**557**
Religion/Belief					
Buddhist	0	0	0	1	0
Christianity (All Denominations)	44	64	42	71	54
Do Not Wish to Answer	4	12	5	8	4
Muslim	10	8	5	9	10
No Religion	20	40	40	48	59
Other	0	4	2	3	6
Sikh	0	0	0	1	1
Jewish	3	0	0	4	4
Hindu	1	0	3	0	3
Not disclosed	301	298	340	382	414
Humanism	1	1	0	0	1
Paganism	0	0	0	0	1
Total	**384**	**427**	**437**	**527**	**557**
Ethnic Group					
Asian Or Asian British -	3	1	1	4	1

Bangladeshi					
Asian Or Asian British - Indian	3	1	4	5	4
Asian Or Asian British - Other Asian	3	3	5	5	5
Asian Or Asian British - Pakistani	7	6	7	9	11
Black or Black British – Black African	7	4	9	4	6
Black or Black British – Black Caribbean	6	6	10	3	7
Black or Black British – other Black	3	3	4	1	2
Chinese Or Other Ethnic Group - Chinese	1	1	0	0	1
Mixed - Other Mixed	2	4	2	1	3
Mixed - White & Asian	0	2	0	3	1
Mixed - White and Black African	1	3	0	3	0
Mixed - White and Black Caribbean	1	0	0	2	4
Not Stated	98	93	86	297	114
Other Ethnic Category - Other Ethnic	0	10	5	4	6
White - British	104	148	139	174	198
White - Irish	4	9	2	2	4
White - Other White	12	7	8	10	7
Not disclosed	129	126	155	0	183
Total	**384**	**427**	**437**	**527**	**557**

Agenda Item 10.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Kathryn Murphy, Director of Nursing and Midwifery, Saint Mary's MCS Jen Sager, Associate Head of Midwifery, Saint Mary's MCS
Date of paper:	March 2023
Subject:	Maternity Services Assurance Report, including update to Safety Action 3 NHSR Maternity Incentive Scheme Year 4
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation, and teaching To improve patient safety, clinical quality, and outcomes To improve the experience of patients, carers, and their families
Recommendations:	The Board of Directors is asked to note the information provided in this report.
Contact:	Name: Alison Haughton, Chief Executive, Saint Mary's MCS Tel: 0161 276 6124

1. Executive Summary

1.1. In line with current reporting framework this paper provides:

- An update on progress and ongoing monitoring of compliance with Ockenden Immediate and Essential Actions (IEAs) from both reports of Donna Ockenden[4] [5]
- Assurance to the Board of Directors on matters relating to patient safety within maternity services including compliance with the recently updated Year 4 Maternity Incentive Scheme[6], specifically including Safety Action 3, and evidence of bi-monthly detailed discussion at the Trust Quality and Performance Scrutiny Committee.

1.2. A review of governance and reporting arrangements was completed in December 2022 and shared through an Interactive Leaders Forum, held in January 2023. A series of recommendations have been agreed Saint Mary's Senior Leadership Team.

1.3. The maternity and neonatal dashboard is available for use in maternity services to provide consistent and timely access to maternity and neonatal data. Progress continues to embed the new dashboard at divisional and hospital level.

1.4. Having the ability to access data across the 3 sites has enabled SM MCS to note variation and provide support and enhanced monitoring where required.

1.5. There has been an increase in stillbirths across all 3 sites in December 2022, reviews of which have not highlighted concerns with care provided attributed to harm. Whilst there has been an increase in stillbirths this remains within normal control limits. A deep dive has commenced to apply further scrutiny to ensure that any learning is identified and actioned.

1.6. Q3 2022/23 report on avoidable term admissions to the neonatal unit has been provided to the Board of Directors in line with MIS reporting requirements. An enhanced level of site scrutiny is being applied at the site level following a small rise in avoidable term (>=37 weeks gestation) admissions to the neonatal unit.

1.7. Maternity safety champion walkarounds continue, with staff vacancies remaining a theme from feedback received. There are currently 39.7 WTE midwifery vacancies across SM MCS. An active recruitment plan is in place and NHSP/agency are being used to cover shifts where required.

1.8. Training is currently below expected 90% compliance, ranging from 74.5-89.9%. Trajectories are in place to support improvement for all staff to be trained, with monthly reporting to DQSC and mitigation to support safety.

1.9. Evidence of compliance of Year 4 MIS Safety Actions has been submitted to NHS Resolution. A presentation has been received by Group Quality Performance Scrutiny Committee (GQPSC).

[4] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review
[5] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[6] https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf

1.10. The Board of Directors are asked to note the work ongoing to ensure the safety of women and babies across Saint Mary's MCS.

1. The Final Ockenden report

1.1. The Final Ockenden report[7], published in March 2022 identified **15 IEAs** with 97 separate elements, with progress provided to the Board of Directors bi-monthly.

1.2. As of 23rd February 2023, there are currently 7 outstanding provider led actions (4 within Clinical Science Services (CSS), 2 within SM MCS and 1 at group level).

1.3. One action, which relates to having services users involved in the complaints process will be led at group level with the implementation of Patient and Public Involvement (PPI) group scheduled into the Corporate Patient Experience Team's 2023/24 workstreams/objectives.

1.4. In Spring 2023, NHS England intend to release a 'single delivery plan' that will incorporate both Ockenden reports, and the themes identified in the report relating to The Queen Elizabeth The Queen Mother Hospital and the William Harvey Hospital [8] (East Kent Report). The expectations of maternity services providers in respect of this report are unclear.

2. The Maternity Self-Assessment Tool

2.1. Saint Mary's MCS remain committed to complete all actions required within the Maternity Self-Assessment Tool (MSAT)[9], as part of Ockenden IEA's. The MSAT was expected to complete in February 2023. 3 outstanding actions are due to complete:

- A maternity strategy which is co-produced: Whilst there has been some delay due to the time/capacity of Maternity Voices Partnership (MVP) chairs, this is expected to be completed by Summer 2023
- A bespoke maternity risk strategy: A decision has been made to align the SM MCS risk strategy with the recently agreed MFT Group risk strategy, which will incorporate maternity. Expected completion by May 2023
- Updated Annual Plan: Specific metrics have been included in the draft annual plan for 2023/24. Expected completion April 2023

2.2. All other actions within MSAT have been completed, with an overall compliance rate of approximately 98%.

.

3. Ongoing assurance reporting to Quality and Performance Scrutiny Committee

3.1. As part of the ongoing monitoring and assurance process agreed in February 2023, Saint Mary's MCS presented an update of Enhancing Safety Ockenden[10] IEA 1 to the Group Quality and Performance Scrutiny Committee (QPSC). This highlighted an area of partial

[7] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
[8] https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
[9] https://www.england.nhs.uk/publication/maternity-self-assessment-tool/
[10] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

compliance in relation to ensuring external reviews took place when parents decline Health Safety Investigation Branch (HSIB) investigations.

3.2. The maternity division are looking to work in collaboration across the NW regional maternity system to identify capacity to support this external review process and expected to be compliant with this action by March 2023. Confirmation of compliance will be provided to SM MCS Quality and Safety Committee in April 2023.

3.3. A further Ockenden IEA will be submitted to QPSC in April 2023 inclusive of actions taken to achieve compliance, evidence, current compliance status and ongoing reporting pathways.

4. Patient Safety

External Review of assurance in maternity services

4.1. The final report of an external review was shared at SM MCS Interactive Leaders Forum in January 2023.

4.2. The report contains 31 recommendations for which an action plan has been developed with nominated leads from SM MCS Senior Leadership Team.

4.3. Three main themes of the report include:

- data
- workforce
- business function

4.4. SM MCS will provide regular reports to the Board of Directors on progress against the recommendations.

4.5. As described in January 2023 Board of Directors paper, the new Maternity and Neonatal Quality and Safety Committee was commenced in Q4 2022/23. A meeting took place in February 2023 to scope and agree the committee's terms of reference. These were then approved at the February 2023 Safety Champions meeting by divisional, MCS and Board level safety champions. An inaugural meeting of the new committee will take place in Q1 of 2023/24 and occur quarterly thereafter.

Maternity and Neonatal Dashboard

4.6. In line with the newly launched maternity dashboard, an executive summary of specific reporting metrics has been developed to provide clear and concise reporting of perinatal outcomes and provides the Board of Directors with clinical outcome data related to stillbirths, neonatal deaths, suspected hypoxic ischaemic encephalopathy grade 2 and 3, maternal deaths and admissions to the neonatal unit.

4.7. Appendix 1 illustrates a screen shot of the live maternity dashboard executive summary which now includes escalation levels to alert the Maternity Division of an increase in perinatal morbidity and mortality. These escalations are to support increased scrutiny at a divisional level to determine if a full review is required.

4.8. In December there was an increased number of stillbirths across SM MCS, reviews of which have not highlighted any concerns that the care provided attributed to harm.

4.9. Charts 1, 2 and 3 demonstrate that whilst there has been an increase in stillbirths in December 2022, this is within controls limits for all 3 sites.

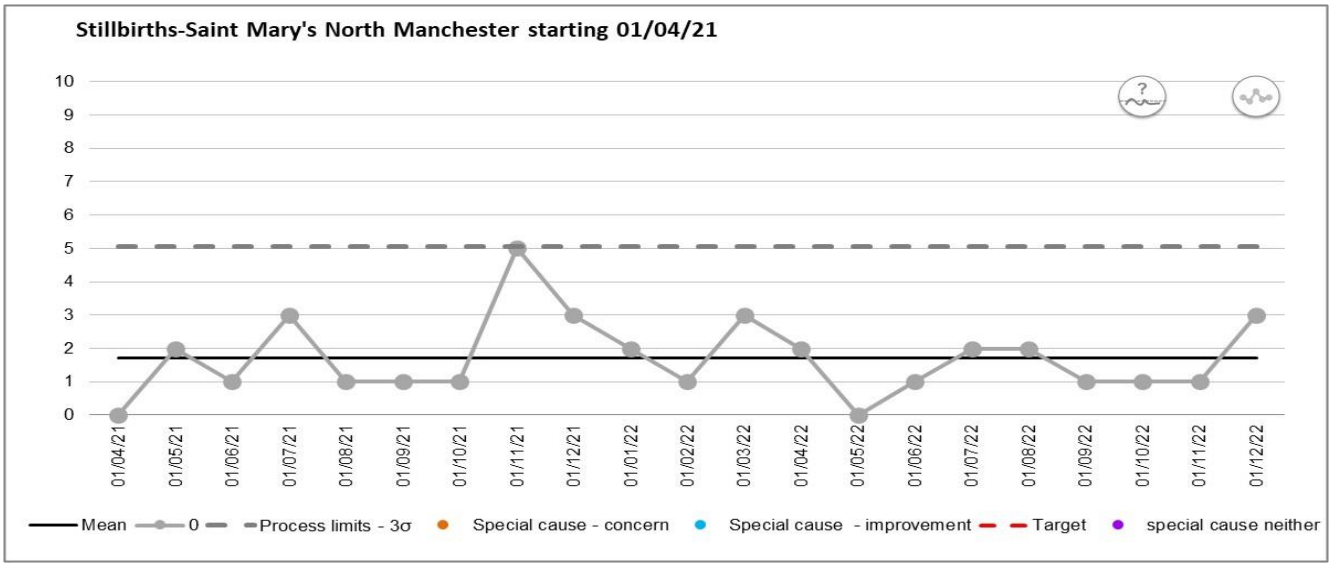


Chart 1: SPC – Saint Mary's North Manchester

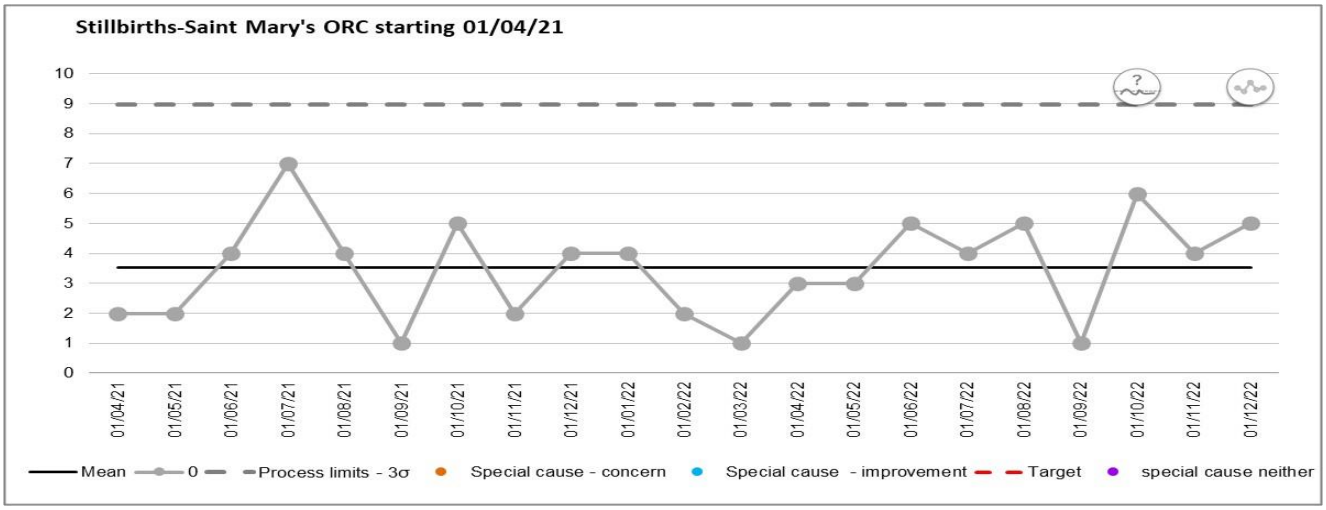


Chart 2: Saint Mary's Oxford Road Campus

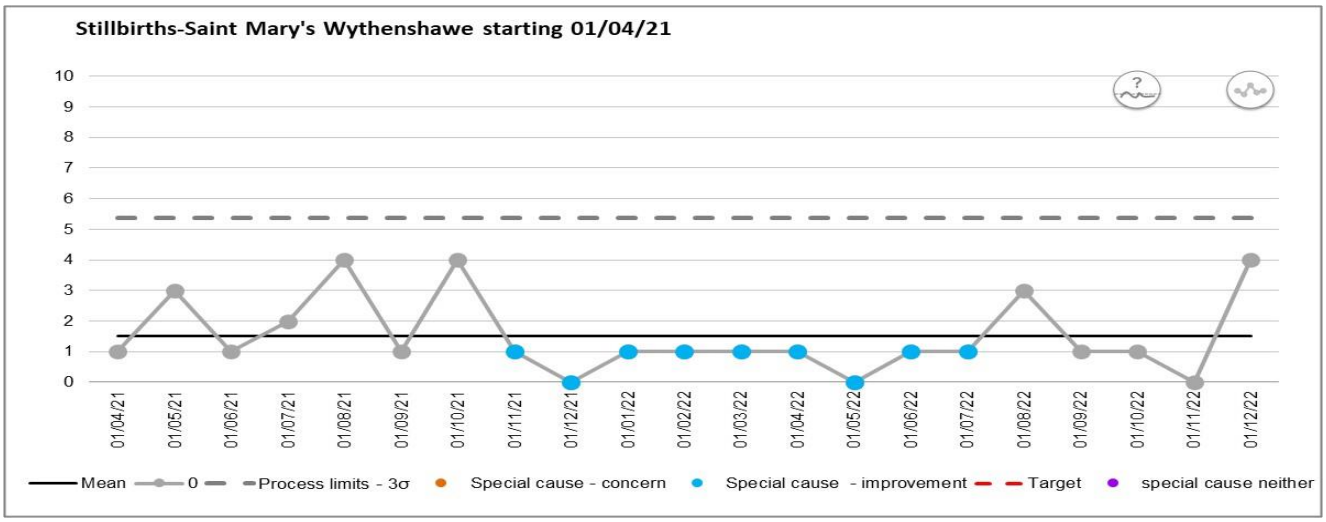


Chart 3: SPC – Saint Mary's Wythenshawe

4.10. There are no points for escalation on the executive summary, as all remaining metrics are within excepted limits.

4.11. As described to the Board of Directors in January 2023, the executive summary focusses on avoidable term admissions to the neonatal unit, rather than overall term admissions.

4.12. A small rise has been noted in avoidable term (>=37 weeks gestation) admissions to the neonatal unit. In Q2 2022/23 there were 13 (5.8%) avoidable admissions compared to 18 (7.5%) in Q3 2022/23. Avoidable term admissions remain within control limits (expected natural variation, see charts 4-6) for all sites however increased monitoring of this metric is in place.

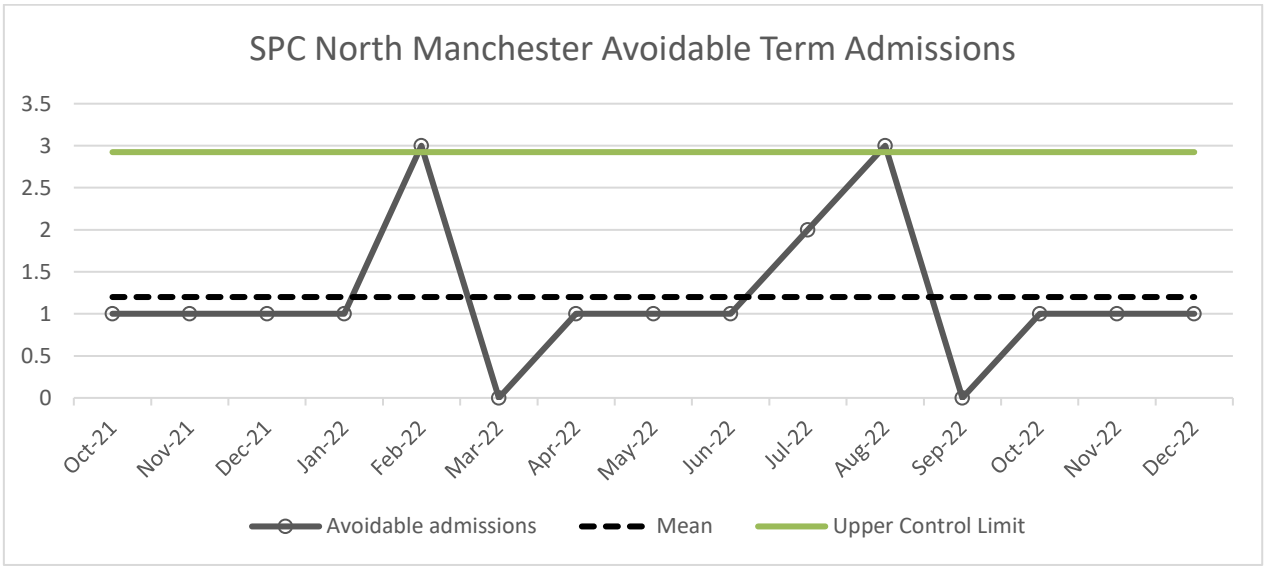


Chart 4: SPC – Saint Mary's North Manchester

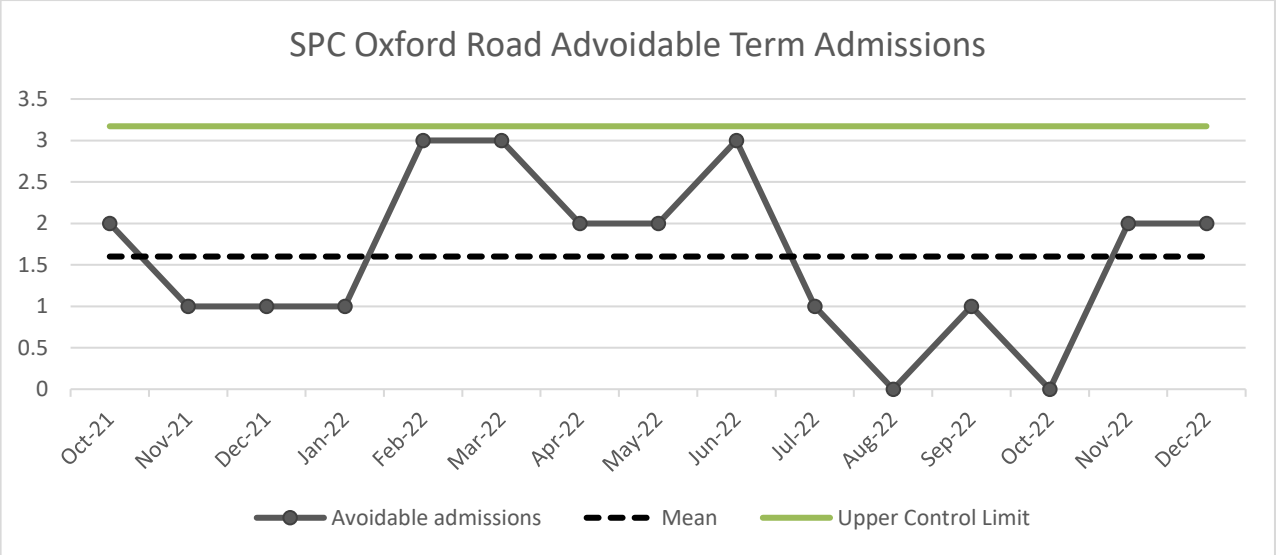


Chart 5: Saint Mary's Oxford Road Campus

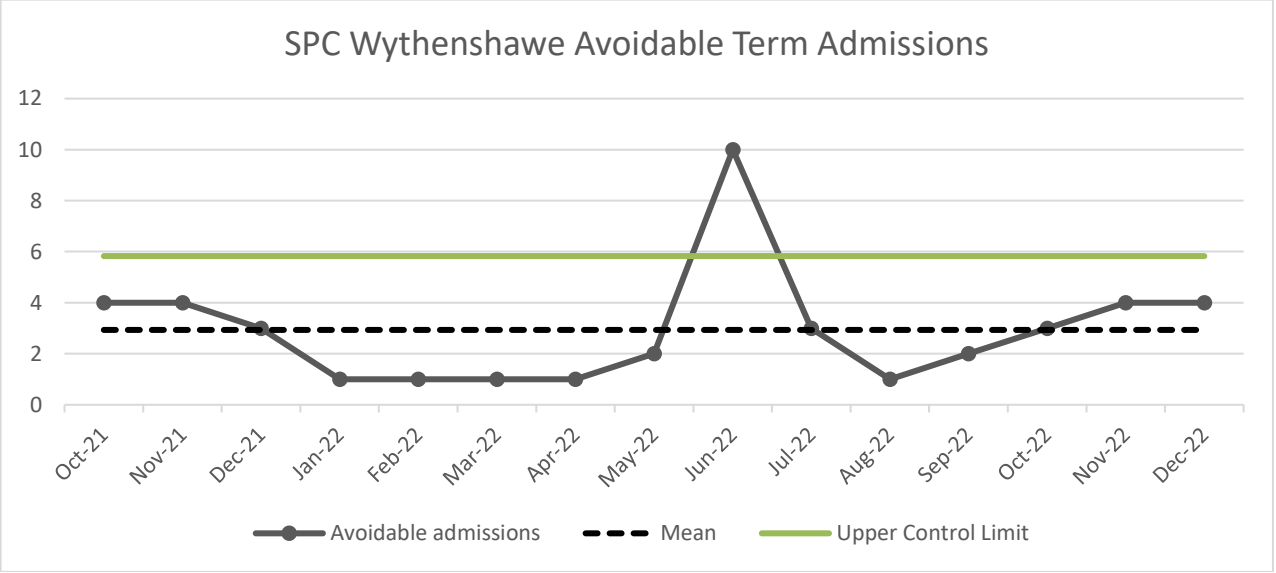


Chart 6: SPC – Saint Mary's Wythenshawe

4.13. A report relating to avoidable admissions, which identifies any themes and actions required, as part of ongoing reporting for Maternity Incentive Scheme (MIS) Year 4, is provided to the Board of Directors in Appendix 2.

4.14. The development of the dashboard provides a way for SM MCS to drill down into individual site variation. Whilst the overall numbers of avoidable term admissions remain low, the average monthly admissions rate is higher on the Wythenshawe site than the other 2 sites.

4.15. An enhanced level of site scrutiny is being applied at the site level with monthly reporting to the Divisional Quality and Safety Committee.

Summary of Maternity Incidents (Level 3 Harm and above) and Healthcare Safety Investigation Branch referrals

4.16. In December 2022 and January 2023, a total of 4 cases were reported in the moderate, major, or catastrophic harm category. All cases are subject to ongoing High Impact Learning Assessment (HILA) review.

- 1 case was related to a lack of holistic review and risk assessment - major harm
- 1 case was related to neonatal facial trauma following forceps birth - moderate harm
- 1 case related to bowel injury following unplanned caesarean section - moderate harm
- 1 case was related to inappropriate decision-making – catastrophic harm

4.17. Of the above 4 cases there had been no themes and no similar incidents within the preceding 12 months.

4.18. There were no referrals to HSIB in December 2022 and 1 case referred in January 2023, which related to CTG interpretation.

4.19. Work remains ongoing to improve fetal surveillance monitoring interpretation. Improved training, in line with best available evidence, has been created and increases fetal surveillance training from half day training to 1 whole day commencing in March 2023.

5. Maternity Incentive Scheme (MIS) Year 4

5.1. SM MCS submitted full compliance of MIS Year 4 to NHS Resolution on 28th January 2023. Confirmation of receipt of this submission has been received. SM MCS are now awaiting the outcome from NHS Resolution regarding reimbursement of part of the CNST contribution.

5.2. MIS Year 5 is expected to be launched in Spring/Summer 2023. SM MCS will continue to submit quarterly reports as required to Board of Directors to maintain compliance.

5.3. The Q3 2022/23 Perinatal Mortality Review report has been provided to Board of Directors (Private) board due to the small number of cases which may make individuals identifiable.

6. Safety Champion update

Walkarounds

6.1. The site based maternity safety champions continue to undertake monthly walkarounds across all 3 maternity sites. Themes from these walkaround, along with actions, are communicated back to staff via the maternity safety champion poster (Appendix 3). A theme of maternity staffing being below expected levels was identified.

Workforce

6.2. Workforce updates are provided monthly on each maternity site, to continually provide staff with accurate information related to recruitment and retention.

6.3. Current vacancies in midwifery establishment are provided in Table 1.

Site	Vacancy at end of January 2023 (WTE)
Oxford Road	23.01
North Manchester	10.56
Wythenshawe	6.13
Total	**39.7**

Table 1 – Midwifery Vacancies across SM MCS

6.4. Work remains ongoing to reduce vacancies including:

- International recruitment – 3 WTE have successfully commenced in post, a further 2 are currently in the UK training for Objective Structured Clinical Examination (OSCE) exams and will shortly commence in post upon successful completion. A further 5 are expected to be in post before the end of December 2023**.**
- There are rolling adverts for band 5 and 6 midwives across the inpatient and community areas of SM MCS.
- All vacant midwifery shifts are available to NHSP/agency in all areas across SM MCS
- Recruitment and Retention midwives in post to support staff wellbeing.
- Scrutiny continues to be applied at SM MCS level at the Nursing and Midwifery Workforce Committee.

Training

6.5. Due to the requirements to backfill unexpected sickness and current staffing vacancies, at the end of January 2023 training compliance is below 90% (Table 2).

Site	Core Level 1	Core Level 2/3	MDT Emergency Skills	Fetal Surveillance Training	Neonatal Resuscitation
Oxford Road	88.86%	68.1%	88.5%	91.2%	87.8%
North Manchester	88.28%	70.0%	92.3%	85.7%	78%
Wythenshawe	87.77%	75.85%	90.1%	90.4%	89.3%
Total	**88.12%**	**74.47%**	**89.9%**	**89.7%**	**86.1%**

Table 2 – Training compliance for SM MCS January 2023 (including MIS Year 4 requirements)

6.6. Training trajectories are in place, with a focus to improve across all sites and staff groups. These are monitored monthly at Divisional Quality and Safety Committee (DQSC), with additional weekly site-based meetings to ensure that there is continued progress to maintain trajectories set.

6.7. The individual staff group compliance is monitored by the Clinical Head of Division (CHoD) at DQSC.

6.8. To mitigate risks associated with non-compliance for training, steps have been taken to ensure those providing intrapartum care maintain compliance n with emergency skills, fetal surveillance, and neonatal resuscitation.

7. Recommendations

7.1. It is recommended that the Board of Directors:

- note the information provided in this report

Appendix 1 – Maternity Dashboard

Appendix 2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Saint Mary's Quality and Safety Committee

Report of:	Professor Edward Johnstone, Clinical Head of Division, Obstetrics, Saint Mary's Managed Clinical Service Beverley O'Connor, Sarah Owen and Esme Booth, Heads of Midwifery, Saint Mary's Managed Clinical Service Victoria Bateman, Divisional Director
Paper prepared by:	Jen Sager, Associate Head of Midwifery, Saint Mary's Managed Clinical Service
Date of paper:	February 2023
Subject:	Quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit 1st October to 31st December (Q3 22/23) as required in Safety Action 3, Year 4 Maternity Incentive Scheme
Purpose of Report:	Indicate which by **(tick as applicable-please do not remove text)** • Information to note • Support • Accept x • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality, and outcome • Improve the experience of patients, carers, and families
Recommendations:	The Committee is requested to accept and note the details in the report.

Contact:	Name: Jen Sager, Associate Head of Midwifery Email: jen.sager@mft.nhs.uk

1. Background and Purpose

1.1. This paper provides a quarterly update to Board of Directors, as required by Maternity Incentive Scheme (MIS) Year 4 to comply with Safety Action 3 (sections b, e, f and g), and is submitted to Saint Mary's Quality and Safety Committee as part of Saint Mary's MCS perinatal surveillance model, which ensures Maternity, Neonatal and Board level safety champion oversight.

2. Introduction

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[11] to reduce admission of full-term babies to neonatal care.

2.2. Transitional Care (TC) services support care of vulnerable babies within the maternity setting to reduce avoidable admissions to neonatal services and minimise separation of mothers and their babies.

2.3. It is critical for services to undertake robust reviews and learn lessons to reduce the number of mothers and babies who are separated after birth, and it is on this foundation that audits of TC are included as Safety Action 3 of year 4 MIS.

2.4. Saint Mary's MCS provides transitional care activity on all 3 maternity sites and, in accordance with the British Association of Perinatal Medicine (BAPM) principles, meet the standard set by NHS Resolution Maternity Incentive Scheme Year 4.

2.5. As previously reported, Saint Mary's MCS had separate site specific guidelines regarding TC. These have been replaced by a single harmonised Saint Mary's MCS TC guideline in April 2022, which was jointly developed by maternity and neonatal teams. This meets MIS year 4 Safety Action 3 (section a).

3. Audits of Transitional Care (TC) provision for April 2022 to June 2022 (Q1 22/23)

3.1. As required by Year 4 MIS Safety Action 3, this quarterly review details the number of admissions to the neonatal unit which met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues

[11] https://www.england.nhs.uk/wp-content/uploads/2021/03/reducing-harm-leading-to-avoidable-admission-of-full-term-babies-into-neonatal-units-summary.pdf

or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding.

3.2. There were no babies, who met current TC admission criteria, admitted to the neonatal unit in Q3 2022/23 as a result of not receiving transitional care because of staffing or capacity issues or requirement of nasogastric tube feeding.

3.3. The COVID-19 pandemic has not changed the provision of TC across the Saint Mary's MCS during Q3 2022/23.

3.4. In addition, SM MCS also audit all transitional care activity to capture current capacity and demand for transitional care and capture Healthcare Resource Groups (HRG) 4/XA04 activity.

3.5. Quarterly TC activity audits are provided to SM MCS Neonatal Safety Champion for all 3 sites and meets MIS Year 4 (sections b, d and e) requirements.

3.6. There has been a delay in extracting HRG 4/XA04 activity data to support TC activity audits for Q3 following the implementation of the new Electronic Patient Record (EPR) system. It is expected this will soon be resolved and a report on both Q3 and Q4 will be available by April 2023.

4. Review of term admissions to the Neonatal Unit using the Avoiding Term Admissions Into Neonatal units (ATAIN) framework

4.1. The ATAIN programme aims to reduce admissions to the Neonatal Unit by identifying and acting upon practice issues promptly to demonstrate improvements in care. Focusing on:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia)
- Hypothermia

4.2. Documentation audits occur monthly by ATAIN champions and compliance is monitored on a quarterly basis at Maternity Services Divisional Quality and Safety meeting. This meets MIS year 4 Safety Action 3 (section c).

4.3. A weekly multidisciplinary review of unexpected admissions to the neonatal unit occurs on each maternity site, highlighting themes, actions, learning and whether the admission could have been avoided. This meets MIS year 4 Safety Action 3 (section f).

4.4. In the period 1st October 2022 to 31st December 2022, there were 18 term admissions across Saint Mary's MCS which were considered avoidable

following multidisciplinary review. 4 babies on the Oxford Road site, 11 babies on the Wythenshawe site and 3 babies on the North Manchester site.

4.5. The Avoidable Admissions to Neonatal Unit report for Q3 2022/2023, including themes for each avoidable admission and lessons learned, is monitored quarterly at Site Obstetric Quality and Safety Committee.

4.6. On review of specific ATAIN metrics above in 4.1, of the 18 avoidable admissions to the Neonatal Unit:

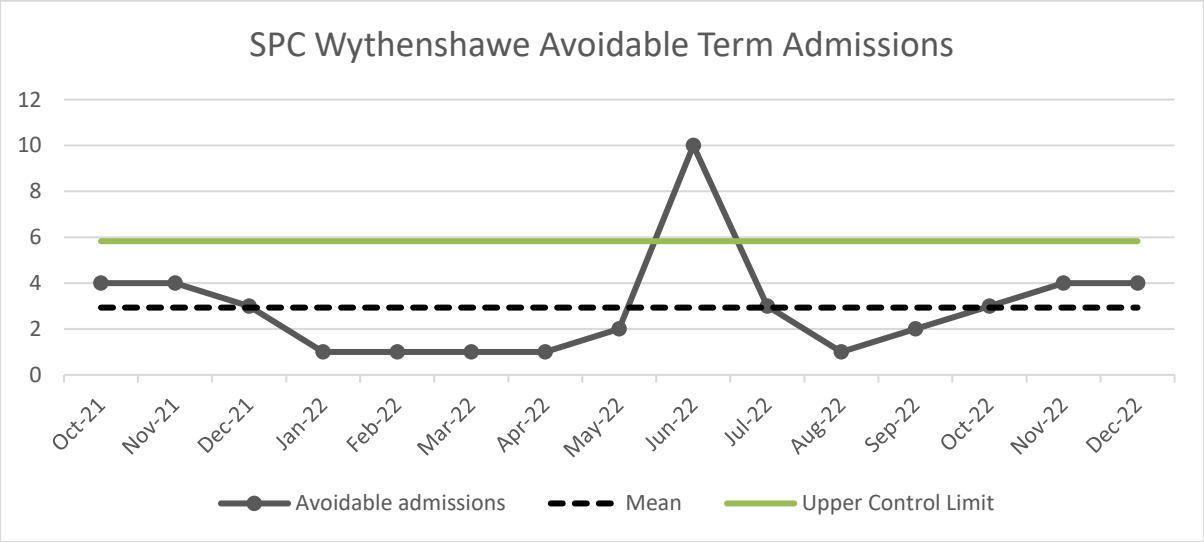
- 0 babies were admitted due to respiratory conditions
- 2 babies were admitted due to hypoglycaemia
- 0 babies were admitted due to early onset jaundice
- 4 babies were admitted due to perinatal hypoxia-ischaemia
- 2 babies were admitted due to hypothermia

4.7. None of the reviews identified an increase in term admissions for the 5 ATAIN metrics (see 4.1), during Q3 2022/23.

4.8. Themes identified outside of those metrics in 4.1 include:

- Not following guidance/policy (sepsis, NNU admission criteria, escalation)
- Delays in transfer / decision for birth
- Inappropriate classification of CTG

4.9. The maternity and neonatal dashboard has identified individual site variation. Whilst the overall numbers of avoidable term admissions remain low, the average monthly admissions rate is higher on the Wythenshawe site than the other 2 sites. An enhanced level of site scrutiny is being applied at the site level with monthly reporting to the Divisional Quality and Safety Committee.



4.10. Each review, where required, generates specific actions and these are logged via the risk management system, and monitored at the Site Obstetric Quality and Safety Committee.

5. Action Plan

5.1. An overall ATAIN action plan (Appendix 1), as required by MIS year 4 Safety Action 3 (section g) is in place with the progress on harmonisation of TC model and review of increased avoidable admissions now included.

6. Conclusion

6.1. Following approval at SM MCS Quality and Safety Committee, this paper will be submitted to the Board of Directors for Manchester Foundation Trust as part the Maternity Assurance report in March 2023.

6.2. In accordance with the perinatal surveillance model, following approval, this paper will be shared with Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS) and onwards to Integrated Care Board (ICB). This meets MIS year 4 Safety Action 3 (section h).

6.3. Saint Mary's MCS has maintained full compliance during Quarter 3 of 2022/2023. Appendix 2 provides clear overview of compliance of MIS Year 4 Safety Action 3.

Appendix 1 of ATAIN

Action plan for MIS Safety Action 3 – Reviewed February 2023

	Action	Lead	By When	Status
1	Harmonise Transitional Care model across Saint Mary's MCS	Neonatal Matron and Inpatient Matron at North Manchester to work with Lead Nurse for Newborn Service to fully implement TC model	December 2022 Extended to March 2023	Full workforce review and business case required for TC model at North Manchester. Work ongoing. Review InReach service to include /ng tube feeding at ORC. – Work ongoing
2	Harmonise Transitional Care Guidance across Saint Mary's MCS	Lead Nurse for Neonatal Service and DHoM's to lead in harmonisation of TC guideline on all sites	June 2022 extended to July	Complete
3	Full review of themes for admission to NNU at Wythenshawe	Lead Midwife for Governance, DHoM Wythenshawe, Clinical Director Wythenshawe	August 2022	Complete.

Appendix 2 of ATAIN

Indicator/ standard Safety Action 2	Compliant Yes/No
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Yes
c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	Yes
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	Yes
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	Yes
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	Yes
g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.	Yes
h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting	Yes

Appendix 3

Feedback from Safety Walkarounds across Saint Mary's MCS December 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 171 concerns raised at the drop-in sessions. Of these, 47 have been resolved, which is 27.5%.

The concerns raised cover a variety of subjects, however key themes that have emerged relate to Equipment (46%), Staffing (34.5%) and Clinical concerns (11%). Concerns relating to Hive account for 20.5% of those raised recently.

Who are your safety champions?

- Clinical Head of Division Professor Ed Johnstone
- Head of Midwifery Wythenshawe Sarah Owen
- 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

In the absence of a safety champion, either the site-based lead or deputy will attend.

YOU SAID	WE DID
Concerns at Wythenshawe about digital confidence when Hive was implemented.	Additional training and support provided for specific members of staff.
Lack of sonicaids on AAU at ORC.	Department supplied with three sonicaids, which meets requirements.
Concern raised in Triage/DCAU at Wythenshawe about the national shortage of Fetal Fibronectin cassettes to support TPTL pathway.	Approval obtained to use actimpartus tests. A residual stock of these was left over when Fibronectin was introduced.

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.

Agenda Item 10.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Bailey, Director of Corporate Workforce Costel Girboiu, General Management Officer Harriet Prust, Programme Manager
Date of paper:	March 2023
Subject:	Equality, Diversity, and Inclusion Annual Report 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 statutory deadline for the ED&I Annual Report is 31/3/2023. Not publishing the report by this deadline risks the Trust failing to uphold its value of being open and honest about progress on the Diversity Matters Strategy and delivery of the Public Sector Equality Duty. The ED&I Annual Report represents the current progress made against the objectives of the Diversity Matters Strategy. It is a collaborative endeavour involving Hospitals, Managed Clinical Services, Local Care Organisations, Research, Community Services, and Corporate Services, which reflects the Trust's 'Working Together' value.
Recommendations:	The Board of Directors is asked to approve the publication of the report in accordance with the public sector equality duty obligations.
Contact:	Name: Nick Bailey, Director of Corporate Workforce Tel: 0161 276 4796

1. Purpose

1.1 The purpose of this report is to present the Board of Directors with the Equality, Diversity and Inclusion Annual Report for 2022, and to gain approval for publication of the report before the end of March 2023.

2. Context

2.1 As a public authority, Manchester University NHS Foundation Trust (MFT) is obliged under the Equality Act 2010 to comply with the Public Sector Equality Duty. This obligation sits alongside a public authority's duty not to unlawfully discriminate. The Public Sector Equality Duty is a duty on public authorities to consider how their policies or decisions affect people who are protected under the Equality Act.

2.2 To comply with the Public Sector Equality Duty, MFT must demonstrate and have due regard to:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity between people who share a protected characteristic and those who don't.
- Fostering and encouragement of good relations between people who share a protected characteristic and those who don't.

2.3 MFT must also:

- Publish equality information at least once a year to show how they've complied with the equality duty.
- Prepare and publish equality objectives at least every four years.

3. Current Position

3.1 MFT has developed a four-year equality, diversity and inclusion strategy – 'Diversity Matters 2019 – 2023', which outlines the Trust's equality objectives of : improved patient access, safety and experience; a representative and supported workforce, and inclusive leadership.

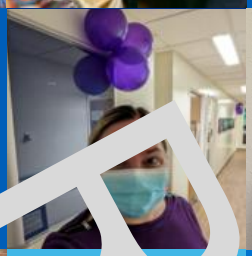
3.2 The attached Equality, Diversity and Inclusion Annual Report 2022 is MFT's annual update on those objectives and demonstrates the actions that the Trust has taken in the past year in compliance with their public sector equality duty. The report is a collaborative endeavor involving Hospitals, Managed Clinical Services, Local Care Organisations, Research, Community Services, and Corporate Services.

3.3 The report has been approved by the Group Equality Diversity and Human Rights Committee and the Human Resources Scrutiny Committee. The report is now presented to the Board of Directors to gain final approval for publication of the report before the end of March 2023.

4. Recommendation

4.1 The Board of Directors is asked to endorse the publication of the report in accordance with the public sector equality duty obligations.





NHS
Manchester University
NHS Foundation Trust

Diversity Matters

Equality, Diversity and Inclusion Annual Report

January - December 2022

disability confident EMPLOYER

NHS
Manchester University
NHS Foundation Trust

Contents

NHS
Manchester University
NHS Foundation Trust

Foreword

The third and penultimate year of MFT's Diversity Matters Strategy saw its implementation marked by major challenges and also significant milestones in the Trust's history. In the context of recovering from the COVID-19 pandemic and mounting pressures on our services, the Trust oversaw the implementation of the EPIC Hive electronic patient record, an improvement project which unifies how we manage and provide patient care across all of our ten hospitals.

Through these increasing challenges, it has become more important than even ever to come together as a collective and support each other to deliver the best patient care we can. Throughout these challenges, staff have proven once again to be dedicated, working through daily challenges while adapting to an unfamiliar system in order to best serve Greater Manchester's population.

To deliver the Trust's Diversity Matters Strategy, several efforts were made in key strategic areas.

Patient access, safety and experience have been enhanced through a range of activities designed to identify and correct potential health inequalities. In the past year, the Health Inequalities Group structured the Trust's approach to reducing inequalities through the development of a dashboard to improve data gathering. Additionally, patient access to their healthcare records will become easier through the MyMFT app, a platform designed to empower patients and their carers to participate more actively in their care.

A representative and inclusive workforce is at the core of the Diversity Matters Strategy, with initiatives launched and revised to provide better support to staff wellbeing and representation. The 'Removing the Barriers' Programme, launched to balance representation of Black, Asian, and Minority Ethnic (BAME) staff at senior levels, has seen improvements including an expansion pilot to the E3 secondment scheme. In addition, to create a more accessible and inclusive workplace, a task and finish group carried out plans to improve the provision of reasonable adjustments.

Lastly, no change is delivered without inclusive and compassionate leadership equipped with the skills and tools to create a working culture that enables staff to be their best. This year, a range of activities were delivered as part of the Be.Inclusive initiative designed to promote a culture of kindness and openness across all levels of the organisation.

Whilst we have made great progress this year, we must also acknowledge that there are areas that we need to improve upon in the following year. We are committed to working together as a Trust to address inequalities wherever they may arise and provide the best possible outcomes to both patients and staff.

Whilst we have made great progress this year, we must also acknowledge that there are areas that we need to improve upon in the following year. We are committed to working together as a Trust to address inequalities wherever they may arise and provide the best possible outcomes to both patients and staff.

Peter Blythin - Group Executive Director of Workforce & Corporate Business

NHS
Manchester University
NHS Foundation Trust

Context

Manchester University NHS Foundation Trust (the Trust) is the largest NHS Foundation Trust in England, employing over 28,000 staff. It was formed on 1st October 2017 and since then has been responsible for running a family of ten hospitals and community services across Manchester and Trafford across seven separate sites.

It provides a wide range of services from comprehensive local general hospital care through to highly specialised regional and national services.

We are the primary provider of hospital care to approximately 750,000 people in Manchester and Trafford, and the single biggest provider of specialised services in the Northwest of England. The Trust is also the lead provider for a significant number of specialised services. These specialist services include Breast Care, Vascular, Transplantation, ECMO[1], Cardiac, Respiratory, Urology Cancer, Paediatrics, Women's Services, Ophthalmology and Genomic Medicine.

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

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

This report details our performance during 2022 against the objectives of Diversity Matters, the Trust's equality, diversity, and inclusion strategy 2019-2023. It contains examples of practice from across the Trust's hospitals, managed clinical services, local care organisations and corporate services. The report will also cover areas of significance this year, such as the implementation of the new Trust-wide electronic patient record – Hive, which has and will continue to shape the discussion around equality, diversity, and access to healthcare in a digital world.

The report meets the Trust's statutory duty under the Equality Act 2010 to report on performance against equality objectives annually. It details the diversity of our patients, staff, leadership and governance for equality, diversity, and inclusion.

[1] extracorporeal membrane oxygenation – A pump which circulates blood through an artificial lung that oxygenates the blood.

NHS
Manchester University
NHS Foundation Trust

Our Hospital Sites

Manchester Royal Infirmary

Saint Mary's Hospital

Royal Manchester Children's Hospital

Manchester Royal Eye Hospital

University Dental Hospital of Manchester

Wythenshawe Hospital

Trafford General Hospital

Withington Community Hosptial

Altrincham Hospital

North Manchester General Hospital

Manchester Local Care Organisation

Trafford Local Care Organisation

Clinical and Scientific Services

This report details our performance during 2022 and contains examples of practice from across the Trust's Hospitals, Managed Clinical Services (MCS), the Local Care Organisations (LCOs) and Corporate Services. It details the diversity of our patients, staff, leadership and governance for equality, diversity, and inclusion.

If you require this information in an alternative format or would like to enquire about further details on information presented in this report please contact the Equality, Diversity and Inclusion Team: equality@mft.nhs.uk

Section One

Diversity Matters

The Diversity Matters Strategy

In 2019, the Trust published ***Diversity Matters***, its four- year equality, diversity, and inclusion strategy for 2019-2023. ***Diversity Matters*** outlines the Trust's ambition to be the best place for patient quality and experience, and the best place to work. ***Diversity Matters*** is central to the Trust achieving its vision of 'improving health and well-being for our diverse population'. If you would like to access the complete Diversity Matters Strategy you can do so by clicking here.

Diversity Matters provides a framework for action focussing on three aims:

- Improved patient access, safety, and experience.
- A representative and supported workforce.
- Inclusive leadership.

These aims are underpinned by a set of objectives for focus of activity over the four years. The aims and underpinning objectives are outlined in the table below.

NHS
Manchester University
NHS Foundation Trust

Diversity Matters Strategy Objectives

Improved patient access, safety and experience

We will:

- Consider how our decisions will affect equality and reduce unfavourable effects.
- Know who uses our services by equality and their experiences and reduce any differences that we find.
- Carry on working towards the Accessible Information Standard.
- Make sure that people with learning disabilities and autism get treatment, care, and support.
- Be the first Trust in the country to deliver Pride in Practice. This is recognition from the LGBT Foundation.
- Make our wayfinding and signage easier.

The results we are aiming for:

- Everyone who needs to can use Trust services.
- Individual people's health and care needs are met.
- When people use Trust services,they are free from harm.
- People report positive experiences of Trust services.

A representative and supported workforce

We will:

- Consider how our decisions will affect equality and reduce unfavourable effects.
- Know who our staff are by equality and their experiences and reduce any differences that we find.
- Take a zero-tolerance approach to bullying, abuse, and harassment.
- Work towards being a Disability Confident Lead employer.
- Increase ethnic diversity at Board and senior management levels.

The results we are aiming for:

- Staff are free from harassment, bullying and physical violence.
- Staff believe that the Trust provides equal opportunities.
- Staff recommend the Trust as a place to work and receive treatment.

Inclusive leadership

We will:

- Board members and senior leaders will champion equality and diversity. Some examples include:

✓ Talk about equality, diversity and inclusion.

✓ Engage their staff.

✓ Understanding how our decisions will affect equality and reduce unfavourable effects.

✓ Have equality, diversity and inclusion objectives in their local delivery plans.

✓ Use inclusive Leadership competencies in recruitment and appraisal.

The results we are aiming for:

- Board members and senior leaders demonstrate their commitment to equality, diversity, and inclusion.
- Board and Committee papers will identify equality-related impacts and how unfavourable effects will be reduced.

Section Two

Our Patients

Manchester University NHS Foundation Trust

Strategic Aim – Improved Patient Access, Safety & Experience

The first strategic aim is to improve service user access, safety, and experience. The Trust is continually seeking to provide patients, their carers, families, and service users with an experience of our services which is inclusive and accessible.

Objective 1: Consider how our decisions will affect equality and reduce unfavourable effects

The Trust considers how its decisions will affect equality in a variety of ways. These include equality impact assessment, consulting with diverse patients on decision making, and strategically interrogating our data through the Health Inequalities Group. This section details the activities that were carried out in 2022 towards achieving these objectives.

The Health Inequalities Group

In 2021, The Trust established a Health Inequalities Group to bring together the various programmes of work the Trust is developing focused on or related to health inequalities.

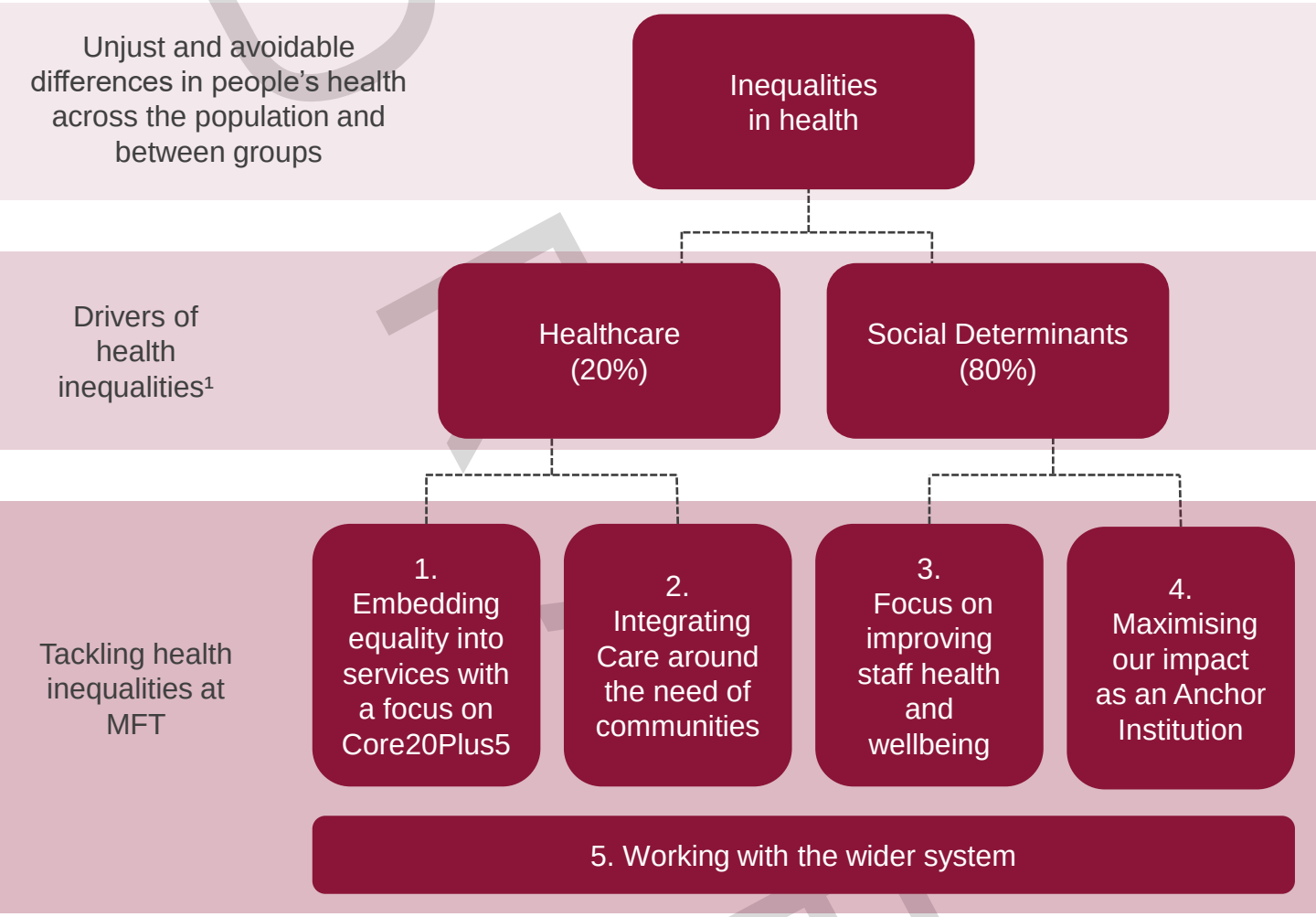
During 2022 the Health Inequalities Group agreed on how it would structure the Trust's approach to Health Inequalities with an emphasis on reducing inequalities in access, outcomes and experience. How the Trust's clinical services are delivered is vital to addressing health inequalities; the Health Inequalities Group has emphasised that this delivery must be equitable, proportional to patient needs, and easier to navigate and access. A key aspect of the Health Inequalities Group's work during 2022 has been understanding data relating to access, outcomes, and experience through a health inequalities lens. As a result, the Trust has been developing a health inequalities dashboard to enable better monitoring of this data, the dashboard will be completed in 2023.

As the largest acute Trust in England and one of the biggest employers in Greater Manchester, the Trust has a broader role in reducing health inequalities. One of these roles is as an anchor institution, adding significant value to served communities through employment practices and procuring goods and services that benefit local communities. The Trust already delivers significant value in this way. However, in 2022, a sub-group of the Health Inequalities Group was formed to help maximise the delivery of social value, with one area of focus being social value procurement.

The Trust is committed to tackling health inequalities and this agenda is likely to grow through 2023 and the next Equality, Diversity and Inclusion Strategy.

NHS
Manchester University
NHS Foundation Trust

A Framework for tackling health inequalities at MFT



1. Source: Institute for Clinical Systems Improvements – Going Beyond Walls: Solving Complex Problems (2014)

Health Inequalities In Digital Technology

The NIHR Applied Research Collaboration Greater Manchester (ARC-GM) which is hosted by the Trust, supported a work programme tackling digital health inequities for the Pankhurst Institute. Research into digital health inequalities will contribute to technology equity and inform continuous improvement. As the Trust undergoes a rapid digital transformation, so will the tools and approaches to analysing and tackling digital health barriers.

NIHR | National Institute for Health Research

Manchester
Digital
Pain Manikin

Case Study – The Digital Manikin

Pain is more common among ethnic minority groups in Greater Manchester than among white British residents. Differences in pain treatment and outcomes may partly be explained by differences in people's pain beliefs and reporting behaviour (i.e., when, how, and to whom people report their pain).

The Manchester Digital Pain Manikin is a research programme which investigated the feasibility and acceptability of daily pain self-reporting. The study looked at people with chronic pain across different ethnic backgrounds who used smartphone apps to self-report their pain management. Studies have shown that pain is more common among ethnic minority groups in Greater Manchester than among white British residents. Differences in pain treatment and outcomes may partly be explained by differences in people's pain beliefs and reporting behaviour, such as how and to whom people report their pain.

By applying the Health Equity Impact Assessment for Digital Health (HEIA-DH), the study arrived at the following conclusions:

- The project's budget, planned activities, and timelines should reflect the need for additional support to increase participation from underserved populations.
- Interactive discussions with people of working age across different ethnic minority groups are needed to help us further improve the app design and wider acceptance of our app.
- To further improve and promote wider acceptance of the app design, interactive discussions should be held with people of working age across different ethnic minority groups.
- Members of underserved target groups should be engaged more actively during the planning phase. This can help with approaching communities for recruitment and with developing participant-facing materials.
- A wider variety of approaches are required to promote participation in research from ethnic minority groups. For example, older people whose first language is not English may prefer to listen to study information or watch a video rather than read it. Audio-visual study materials, such as instructions on how to use the Manchester Digital Pain Manikin, could be included in the app.

The next step will be applying the HEIA-DH to other digital health technologies developed at the University of Manchester and improving the Pain Manikin's purpose to tackle pain for all patients.

Equality Impact Assessments (EqIAs)

As a world-class healthcare provider, we strive to provide safe high-quality care to all our patients. As part of this mission, we must consider the impact of our decisions on protected characteristic and socially excluded groups. The Trust has an organisational approach to how these equality impact assessments (EqIA) are conducted and recorded. Conducting EqIAs assists us in reducing health inequalities, enhancing practice and improving service user experience. EqIAs also provide evidence for legal compliance with the Equality Act, 2010, by documenting equality deliberations and conclusions.

On average, the Trust carries out more than 350 EqIAs each year. This year the introduction of Hive, our new electronic patient record, saw a wide range of EqIAs undertaken in order to ensure the implementation of the system advanced equality for our patients, visitors and staff. Another area of high activity for EqIA in 2022 has been harmonisation of policies and guidelines across the established Single Hospital Service in Manchester following the addition of North Manchester General Hospital to the Trust. This has enabled us to consider how best to ensure equity when delivering services across Manchester for our diverse population.

The following case studies evidence how EqIAs have been utilised in 2022 to ensure our decisions reduce health inequalities and advance of equality.

Case Study – Waiting List Validation Standard Operating Procedure

Waiting List Validation involves contacting patients on a waiting list for their first appointment to confirm if they wish to remain on the waiting list or be removed. Patients who don't need treatment generally do not inform the Trust about their circumstantial changes, such as:

- Their symptoms may have improved.
- They may not need the treatment.
- They may have moved away from the area.
- They may have their treatment done at another healthcare provider.

Removing these patients from the waiting list reduces unnecessary delays and can help to mitigate health inequalities. Greater Manchester has some of the most deprived areas in the UK, with higher overall levels of waiting per head of population associated with areas of more significant deprivation.

To ensure that removing patients from waiting lists did not create health inequalities, an equality impact assessment was undertaken to identify negative impacts and create actions to mitigate disadvantages. The following areas were identified and acted upon.

Staff contacting patients digitally has the potential to negatively impact older patients who are less likely to own a smartphone or have internet access. Therefore, staff should use non-digital communication based on patients' circumstances, for example, paper letters.

Patients with visual, hearing and/or sensory impairment, learning difficulties, and mental health conditions may not be able to communicate or engage effectively with the process of waiting list validation. Staff should ensure that the communication needs of the patients are recorded as a part of an initial clinical assessment or the clinical referral. If this information is unavailable, a letter will be sent to the GP to assess and identify this information. Staff involved with the clinical review before removing a patient from the waiting list should meet those requirements to manage the clinical risk effectively.

Pregnancy status may not be evaluated at the initial assessment or referral. However, there may be a future risk as the pregnancy progresses. If the patient is on the waiting list for longer, where relevant, staff should ask the patient about the pregnancy status. Future clinical risks relevant to this characteristic should be assessed and recorded before removing a patient from the waiting list.

Patients without a fixed address are less likely to have a mobile phone (e.g. homeless people and the traveller communities). When undertaking a waiting list validation exercise, services should consider their procedures for contacting socially excluded groups such as refugees and homeless people. These patient groups can be excluded from waiting list validation if necessary.

Case Study – Laboratory Haematology – Clinical and Scientific Services

Many serious adverse events following a blood transfusion are unpredictable and can disproportionally impact patients from diverse backgrounds and with complex needs. The Laboratory Haematology department undertook an Equality Impact Assessment (EqIAs) which analysed the protected characteristic groups which could be at a higher risk of adverse transfusion reactions. The groups they identified are below:

Older patients with a low tolerance for anaemia require a higher haemoglobin threshold. It was recommended that transfusion practitioners set individual thresholds and haemoglobin concentration targets for older patients who need regular blood transfusions for chronic anaemia.

Patients with learning disabilities and/or sensory impairments were identified as being at risk of not being able to communicate their needs effectively pre, during and post transfusion. A recommendation was given to identify patients Accessible Information Standard requirements before the transfusion, with carers to be involved if required.

Patients whose gender identity is not the same as their sex assigned at birth may have additional special requirements for blood components. Gender is used to produce test reference ranges to check if a patient is within the normal range. Many laboratories have computer systems that automatically interpret the results and produce reference ranges. Clinicians need to ensure that the patient's record is kept up to date to include the clinically relevant history of the patient's birth sex. There is a risk of an incorrect or missed critical result if decisions are made based on a reference range aligned with the patient's gender identity rather than their sex.

These actions have been put in place continuing to ensure that our diverse population receive high quality safe care. Clinical awareness of the patients' diverse needs can ensure a more accurate and high-quality service, supporting the Trust to meet our strategic aim of improving patient access, improvement and experience.

Disabled People's User Forum

The Equality, Diversity and Inclusion Team run a patient forum called the Disabled People's User Forum. The purpose of the Disabled People's User Forum is to listen to the views and experiences of disabled people and enable them to influence decision making within the Trust ensuring we understand how these decisions will impact disabled people. This aims to improve the access to, experience of, and quality of health care for disabled people within our hospitals and community services.

Some of the key consultations with the Disabled People's User Forum in 2022 have included:

- Reception Check-In Kiosks – The Forum gave their views on the best way to make the new reception check-in kiosks accessible for all.

- Accessible Toilets within Hospitals – Due to accessible toilets often being out of use during the night, the forum was consulted on the most preferential way to ensure that the toilets were being used for their intended purpose and available for disabled people. After discussion, the most preferential solution was the use of a radar key, which are commonly owned by disabled people, to open the toilets during night hours. The Estates & Facilities Team will be implementing this in 2023.

- MyMFT App – The Forum gave feedback on the new MyMFT App, suggesting ways to make it most accessible to patients.

- Involving Patients in Patient Safety – Feedback from this consultation was fed into the ongoing review of all MFT policies across all the Hospitals within MFT.

- Accessible Information Standard – The Forum have been involved in the ongoing rollout of the new Hive system, specifically on how to make it accessible for all patients. This has led to the implementation of mandatory stops for staff to ensure that the correct details of what a patient needs regarding communication are. These include Braille, BSL, Easy Read and Large Font to name a few.

- The Forum has also given a variety of feedback on ways to improve general accessibility within Hospitals. Discussions were held around the amount/size of signage, waiting area seating/space, correct use of colour contrast, updating of clocks etc.

Objective 2: Know who uses our services, by equality and their experiences, to reduce any differences that we find

Through equality monitoring, the Trust aims to reduce any unfavourable outcomes of service users with protected characteristics. We achieve this by gathering and analysing patient data and identifying areas of improvement. The following are examples of how understanding the diversity of the Trust's patient population, action has been taken to improve patient experience, access, and safety in 2022.

Our Approach to Rolling Out the Equality Delivery System (EDS3)

The Equality Delivery System (EDS) is a mandatory equality assessment framework designed by NHS England to address health inequalities and measure equality performance. The main aim of EDS is to produce better outcomes for people using and working in the NHS. In addition, it gathers evidence that demonstrates compliance with the Public Sector Equality Duty (PSED) of the Equality Act (2010) and the commissioning contract.

NHS England refreshed EDS in 2022, with the launch of EDS version 3 (EDS3). EDS3 is an equality delivery system that aims to achieve three goals:

1. Patient outcomes that are relevant to access, safety, experience and needs.
2. Workforce health and well-being.
3. Inclusive leadership.

Within the three goals, there are eleven standards or outcomes against which we assess and grade our equality performance.

EDS3 will unify the Trust's approach to implementing and monitoring equality standards and mitigate risks, such as inconsistent data collection and varying interpretations of standards. EDS will provide further benefits, such as Trust-wide ownership over equality and diversity standards, improved benchmarking and shared practice across the various departments, and more data-led assessments in identifying key areas of improvement.

The Trust is currently undergoing implementation of the EDS3 framework with plans to publish the EDS Annual Report in March 2023.

MyMFT
Healthcare in your hands

NHS
Manchester University
NHS Foundation Trust

Improving Patient Communication with the MyMFT Portal

MyMFT is an online portal and mobile app that provides patients and service users greater access and control over their healthcare and health information. MyMFT was launched in September 2022, before this a rapid decision group was created to oversee every step of the portal's development, to ensure patient safety, efficiency and suitability for our population's diverse needs. Though the portal has now launched MyMFT is constantly developing to meet emerging needs, with features being thoroughly tested and rolled out on an ongoing basis.

Since launch the MyMFT team has been monitoring the use of the portal and surveying those using it, early results are showing benefits and increased efficiency for staff and patients including:

- 28% of medical staff reported saving 4-6 minutes per appointment where patients had chosen to take advantage of the pre-appointment questionnaire feature.
- A patient survey showed that 95% of those who used the patient portal reported utilising the built-in messenger function instead of making a phone call. Additionally, 61% reported sending messages instead of opting for an in-person visit.
- In general, patients who used secure messages were 7-10% less likely to schedule an office visit while also making 14% fewer phone calls than patients who did not use the portal.
- Another survey found that 73% of clinicians agreed that the portal improved patient/clinician communication.

With results showing a good start, the Trust must also consider the impact on disadvantaged groups and service users with diverse needs. To ensure the portal is appropriate for our diverse population, an equality impact assessment was conducted with recommendations for improving the portal's features, including:

- Non-digital alternatives will remain in place and be integrated into Hive for patients with difficulties accessing the portal. For example, the option to print out a discharge summary will still be present. Patients can also still be sent reminders and appointment letters through the post or via text messages, where requested.
- MyMFT is designed to be intuitive for patients of all ages, backgrounds, and abilities. With the proxy access feature in MyMFT, family members or caregivers, with the patient's consent, can access the patient's data directly through their own account to help manage their healthcare if needed. Patients can share access to their records by sending an invite directly from their MyMFT account or requesting the healthcare team do so through Hive.
- The portal will also be available in English and Arabic at go-live. Work is underway to explore additional languages as part of optimisation efforts post go-live.

Homeless Health

Challenging COVID-related service pressures have meant that MFT's Homelessness Working Group was temporarily stood down from meeting, although the successful Homelessness Information Seminar that took place on 23 June 2022 did manage to engage with over 80 colleagues and keep the issue of homelessness response across MFT on the agenda.

The MFT Homelessness Working Group will start meeting again in 2023 and will meet quarterly over the year, as this will allow Working Group members time to both participate and progress any actions that arise from the meetings. The Working Group will now be chaired by Nick Bailey, Director of Corporate Workforce at MFT. The meetings will take place on Microsoft Teams, to allow colleagues from different MFT sites and partner organisations to attend.

Gender-Neutral Drafting Within R&I Documents – R&I Team

The MFT Research & Innovation (R&I) team believe that conducted studies should be inclusive to all members of society, and therefore, the documentation relating to R&I activity should be no different.

To reflect the diverse needs of our stakeholders, an R&I working group created guidance to encourage the use of inclusive language in documents relating to Trust-sponsored research, with a view to increasing inclusive research participation. One example of this is the gender neutral-drafting guidance, which is available on the Trust's intranet for all staff.

Following its creation, the guidance has been publicised by R&I senior leadership via the regular R&I communication channels, as well as by the Trial Coordinators Network and individual R&I staff members.

The impact of the guidance on Trust-sponsored research documentation is measured by the R&I EDHR Group, through regular liaison with the R&I Sponsorship Team and Principal Investigators (PIs).

Case Study - MFT Senior Adult Service – Older Person Assessment and Liaison (OPAL) Service

The Older Person Assessment and Liaison (OPAL) service provides a consultant-led multidisciplinary assessment of older patients with clinical frailty and multiple health conditions. The service covers A&E, Orthopaedics, Surgery and Thoracic Oncology, and other relevant service areas. The assessment includes physical and mental health conditions.

The assessment also identifies patients from inclusion health groups to prevent health inequalities and promote shared decision making, reduce post- operative complications and ensure a safe and effective discharge.

To further support older patients with accessing care, the Trust also has services in the community including rehabilitation, nursing home care management, NHS continuing care long-stay beds, and community services to support recently discharged patients or those at risk of hospital admission.

In a particular case, a 78-year-old patient with a history of cerebral Palsy and schizophrenia was admitted to Wythenshawe Hospital following a fall. The patient was diagnosed with a fractured neck of femur, requiring an operation. The OPAL Team provided a holistic assessment, to manage the patient's fragility.

The patient was transferred to OPAL House, a service for older frail people that require functional, cognitive, and social assessments to support recovery and to ensure safe discharge into the community. The OPAL Team provided a supportive and encouraging environment to support recovery.

Pre-discharge, the OPAL Team also conducted home visits to ensure safe and effective continuity of care; and a functional environment available, this includes providing equipment to use at home.

Saint Mary's Hospital – Improving Access to Care for Black, Asian & Minority Ethnic Service Users

Manchester University NHS Foundation Trust was approached by the Health Scrutiny Committee to demonstrate how we are working collaboratively to address the wider health inequalities facing Manchester Black, Asian and Minority Ethnic (BAME) service users and other disadvantaged communities who make up a significant proportion of our city's population. The three areas the Trust was asked to consider were elderly care, the first 1000 days of a child's life, and managing long-term conditions.

A Consultant Midwife and Research Champion, supported by a Specialist Midwife for Public Health, provided a case study on the work undertaken on improving maternal and neonatal outcomes for women from Black, Asian and Minority Ethnic groups that qualified for the first 1000 days of a child's life category.

The Local Maternity System and Maternity Voices Partnerships were used to prioritise and implement the three actions set out by the Chief Medical Officer to help address these issues, which included a Public Health Agenda supporting maternal well-being across maternity services, a Public Health Specialist Midwife focusing on modifiable risk factors to improve outcomes, and embedding public health and prevention across the maternity pathway.

The Spiritual Care & Chaplaincy Service

The Spiritual Care and Chaplaincy Service (SCCS) vision is to transform how spiritual care is understood in our Trust's hospitals, with the intent to be a world-class service rooted in evidence-based practice, research, and learning.

SCCS oversaw a range of activities throughout 2022 aimed at providing a service which is inclusive and supportive, with an overall increase in its various areas of activity.

The following are some of the results found in the past year:

- Referrals made to SCCS saw an increase of 3,226, or 61% compared to the previous year.
- The service provided 13,328 patient visits, with the three top sites being the Manchester Royal Infirmary (5,894), Wythenshawe Hospital (2,718), and North Manchester General Hospital (1,356).
- The out-of-hours service saw 591 calls being made in 2022.
- Welfare funerals are provided by the spiritual care service, with 132 conducted in 2022.

The SCCS team was crucial in developing the Trust's knowledge, skills, and practice through the delivery of spiritual care throughout the trust. The Team has conducted a range of educational activities, including more than 600 online induction sessions delivered to nurses and midwives, continuous expert training in compassionate communication to 50 medical students, training provided to 20 Specialist Critical Care Nurses, and 3 members of the legal team trained in spiritual assessment and early intervention, to name a few. The team is looking to expand their educational elements and provide more training to staff in 2023 to support staff in providing appropriate care for our diverse population.

Research is also an important aspect of the team's focus, with direct involvement in multiple research areas. One example is LiSHoRe (Listen, Share, Hold, Respond), a research study investigating pandemic-related psychospiritual experiences of Black, Asian, and Ethnically diverse NHS Staff. The study contributes to the national strategy for providing spiritual care and support in major health disasters. For its research contributions, SCCS won the Greater Manchester Health and Care research awards for best contribution to research outside the NHS in September 2022.

With an outlook toward the future, the team is keen on addressing a range of initiatives. This includes revisiting the structure and provision of its services across the Trust, reviewing national guidelines, and analysing census data, and promoting an equality, diversity and inclusion champion on the board for belief and religion.

SCCS will also look to embed spiritual care as a core modality to whole person health, harmonise its strategy across the trust, develop highly clinical chaplains across specialities, and future-proof service development ready for the next ten years.

The Spiritual Care and Chaplaincy Service is an essential in enabling the Trust to provide more inclusive and compassionate care to patients of all faiths and beliefs, and a determined partner in constantly increasing the quality of our services.

Case Study – The Manchester Sickle Cell and Thalassaemia Service Steering Group

In 2022 the Manchester Sickle Cell and Thalassaemia (MSCT) Service Steering Group has been working to improve patient care across community services and the Clinical Haematology Centre at Manchester Royal Infirmary.

The improvements made within the MSCT Service are informed by the findings of the national 'No One's Listening' inquiry, which presented some of the shortcomings of the healthcare sector in providing care for patients who are affected by sickle cell and thalassaemia. Improvements that have been implemented in 2022 to improve patient care include:

- The Manchester Sickle Cell and Thalassaemia Centre on Denmark Road needed refurbishments which began in 2022 and will continue in 2023 to improve the environment for both staff and patients.

- The Community Sickle Cell Team has increased its staffing levels to better enable the delivery of safe and effective care.
- The Community Sickle Cell Team has also re-established and strengthened its links with other Trust services such as haemoglobinopathy, enabling more joined-up care for patients.

- The Manchester Sickle Cell and Thalassaemia Centre now has a ‘one-stop shop’ approach in place including voluntary sector partners to reduce the number of visits patients need to make.

In addition to the work already underway Manchester Local Care Organisation (MLCO) is developing a proposal for a voluntary sector-led community engagement group. This is being funded by the Trust charity and will build on the national engagement events held in Manchester in 2021 to better understand the issues faced by people living with sickle cell and thalassaemia and their families.

The engagement will ultimately lead to the development of a service strategy for sickle cell and thalassaemia that has been coproduced by staff, people living with sickle cell and thalassaemia, and the voluntary and community sector. Procurement of a voluntary sector organisation to lead this work is underway and work will start in 2023.

Through these combined efforts, the Trust aims to strengthen the bonds between specialist and community sickle cell and thalassaemia services to continue to improve patient care.

Case Study – The Jim Quick Ward at Wythenshawe Hospital

Opened in 2002, the Jim Quick ward, named after one of its early patients, offers specialised care for patients undergoing heart and lung transplants and support for their families and loved ones.

In 2022, the ward had to find solutions to provide the best possible care to a patient under the age of 18, which was an unusual occurrence for a ward that usually caters to adults. Due to needing an urgent heart transplant, the patient was admitted to the ward as the safest place for them to be, which led to heightened anxiety due to a foreign environment.

The ward staff provided care that wasn't only clinically appropriate but also fit for the needs and lifestyle of a young person. In the first instance, the patient was reviewed by a multidisciplinary team of professionals to assess their needs and circumstances. For example, a social worker engaged early in the patient's stay to assess their home environment and suitability. Additionally, the ward psychologist assessed mental health and any underlying needs the patient might have. One of the results of these assessments was the patient engaging with the Chaplaincy Team for spiritual care.

The ward staff also provided a range of adjustments to help the patient adapt to the ward stay. Some of the adjustments included:

- The patient being cared for in a side room, which allowed for a family member to be present. Additionally, the ward staff provided a bed for the family member to rest or spend the night.
- The family member given access to a temporary accommodation, allowing for privacy and access to facilities such as a bathroom with a shower.
- The patient receiving protected time with minimum interruptions to focus on tasks such as studying or having calls with family or friends.
- The patient's friends being allowed protected time in the day room to socialise without interruptions and to minimise the anxiety around visiting in a hospital environment.

Case Study – The Jim Quick Ward at Wythenshawe Hospital - **Continued**

These efforts resulted in the patient and their family feeling safe and cared for in an otherwise foreign environment which helped mitigate the initial anxieties. The patient received a successful heart transplant and recovered in the same ward before being discharged approximately four weeks after the surgery.

The patient and their family expressed gratitude to the staff for their care and compassion, and for adapting to their circumstances to provide a safe space in preparation for a difficult procedure. The Trust believes in Dignity and Care as one of its core values, that good quality care extends to being compassionate and doing whatever is necessary to provide a comfortable and dignified environment for the patients to feel safe and well cared. The Jim Quick Ward Team embody the Trust values and beliefs by going the extra mile for every one of their patients, despite their age or background.

Case Study - The Long-Term Conditions Programme: Diabetes

The Long-Term Conditions (LTCs) programme has two key objectives: shifting care and support upstream into neighbourhoods and communities and reducing the long-standing inequalities in Manchester.

COVID-19 significantly impacted healthcare services and continues to have a disproportionate effect on people from minority ethnic communities and people living with chronic diseases such as type 2 Diabetes. For instance, the pandemic interfered with the annual GP checks and hospital outpatient appointments that are a vital part of the care for people with diabetes. As services are reimagined and redesigned in new digital forms, it is more important than ever that we do not further exacerbate existing inequalities.

Using data collected in primary care, the LTC programme can analyse differences in diabetes prevalence and hospital activity in a neighbourhood or primary care network by ethnicity. Using a population health management approach, it established a project to tackle entrenched inequalities in diabetes outcomes. The initiative has identified people from an African Caribbean Black British background in one of our neighbourhoods for early adoption of this change in approach.

Through the project, the programme engaged with the Caribbean African Health Network (CAHN) and BHA for Equality to inform on a series of focus groups with Black British diabetes patients from the neighbourhood to gather feedback on their experiences of care and support. From these conversations, a shared understanding emerged of the vital elements that support people with diabetes to remain healthy and well, which the LTC team supports and encourages. In addition, current services and provisions can be analysed and given consideration to the changes that need to happen. Working with people and community groups will enable the programme to co-create and deliver an action plan of change to improve health outcomes and reduce diabetes inequalities.

Although the project is ongoing, the feedback and contribution from local patients and community groups have been positive and focused on making substantive changes to improve people's diabetes care, support and outcomes.

Through the remainder of the year, additional focus groups are planned. The feedback will continue to inform action plans to tackle the identified inequalities in type 2 diabetes outcomes.

Objective 3: Carry on Working Towards the Accessible Information Standard (AIS)

The Accessible Information Standard (AIS) is a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The AIS is national requirement for all health and social care providers so that they can improve services by providing information that people with disability, impairment or sensory loss can easily read or understand, and communicate easily with the services they use.

Accessible Information Standard Progress to Date

What we have achieved in 2022:

- The AIS has been integrated into the new Electronic Patient Record system Hive.
- Staff have received training to ask patients if they have any accessible information requirements.
- A patient's AIS requirements can now be recorded in the Hive system, using the national AIS codes.
- Any AIS needs are flagged on Hive, so that they are easily visible to staff for future letters and appointments.
- Appointment letters ask patients to contact us in advance if they have any accessible information requirements.
- The Local Care Organisations began a pilot in November 2022 to implement AIS in their local systems.

What's Next?

Whilst the Trust has made significant progress in implementing the AIS at all hospital sites in 2022, as this is still a new process work continues to standardise and implement AIS.

In 2023 the Trust will continue to build on this foundation by:

- Actioning feedback from patients and staff to improve the current AIS workflow.
- Ensuring all staff can record AIS requirements consistently.
- Continuing to work collaboratively to ensure that patient appointment letters can be provided in accessible formats.
- Continuing to ensure that patients are able to request communication support ahead of appointments.

Objective 4: Make Sure People with Learning Disabilities and Autism Receive Treatment, Care and Support

The Trust is committed to ensuring that patients and service users with a diagnosis of learning disability (LD) and/or autism receive appropriate and high-quality care when accessing our services. For this reason, in June 2022, we implemented a Learning Disability and Autism Strategy - "Our plan for people with learning disabilities and/or autism, their families and carers 2022-2025". The strategy focuses on four key priorities:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce
4. Learning disability Service Standards

The strategy priorities closely align with the NHS Improvement's LD improvement standards for NHS Trusts, Greater Manchester's Strategy, and feedback from the MFT Patient and Carer Forum.

The plan for improvement includes the following aims:

- Personalised care for patients with LD and/or autism admitted to the Trust's hospitals/Managed Clinical Services.
- Reasonable adjustments care plans in place for patients with LD and/or autism.
- Delivery of mandatory training and specialist support for staff to have the skills and tools to communicate with patients effectively.
- Ensuring processes are in place for consistent use of hospital passports.
- Access to LD and autism champions to support staff and patients in all wards.

The Chair of the LD and Autism Steering Group oversees the delivery of the strategy by working closely with members of the steering group and Local LD Delivery Groups to ensure that information is shared widely, and feedback is utilised to carry out improvement work.

Case Study – Learning Disability and Safeguarding Team

On one occasion, a patient required a Magnetic Resonance Imaging (MRI) scan, which required the patient to drink a set amount of fluid before the procedure. The community learning disability (LD) team contacted the LD and autism safeguarding team for support and advice to ensure that the patient's MRI scan was successful.

The LD and autism safeguarding team contacted the Radiology Department to gain further insight into the requirements for the MRI scan. Contact was then made with the patient's parent to understand the reasonable adjustments required to enable the patient to access the intervention. As a result, the team provided a longer appointment time and a quiet area for the patient and parent to sit and support the fluid intake necessary for the scan. Additionally, the parent could bring along objects for distraction therapy. The LD and autism safeguarding nurse was able to attend the appointment to support the patient and ensure adequate fluid intake aiding the successful scan.

The patient drank the fluid with support from the parent and the specialist team, which enabled the scan to be carried out. The learning disability and autism safeguarding team provided distraction and further encouragement to aid the safe administration of the fluid.

The experience was greatly received by both the patient and the parent, with formal feedback received in an email. This positive outcome supported further successful encounters with the hospital.

The LD and autism safeguarding team has since liaised with the community team to review more cases which may require input/reasonable adjustments. The LD and autism safeguarding team have since been empowering staff within those areas to undertake adjustments in care planning for their patients.

Case Study – University Dental Hospital of Manchester's Transfer of the Complex Special Care List to the Dental Sedation Suite (DSS)

Patients referred to the special care clinic present with a wide range of complex needs, including learning disabilities (LD) and autism coupled with severe dental anxiety. This group of patients are vulnerable, especially if they require conscious sedation to facilitate
dental treatment.

Supporting patients with their fear and anxiety is challenging. Effective communication and rapport with carers/family are crucial to tailoring a plan that fits their needs. Occasionally, with some of our complex care patients, their fear, vulnerability, and anxiety are heightened, possibly due to past experiences, which can lead to a loss of trust in the dentist providing their care.

The University Dental Hospital of Manchester (UDHM) successfully transferred the complex special care list from UDHM to the Dental Sedation Suite (DSS) based within the Manchester
Royal Infirmary (MRI). The UDHM provides a dedicated service for patients with a wide range of additional needs and employs a dedicated Consultant for Special Care Dentistry.

The decision to transfer the service from the main UDHM site to the DSS was based on providing reasonable adjustments for patients with health and welfare needs before and after dental treatment. In addition to delivering a gold-standard patient experience, UDHM sought to provide a more efficient and improved service for its patients.

The DSS team provides a supportive care package that considers future treatment planning for patients with complex needs, including dental anxiety and LD.

For example, patients with significant dental anxiety are provided with a calmer non-dental waiting area to reduce anxiety levels. In addition, the suite offers a recovery room to clerk patients in and uses a quiet space to alleviate patients' anxiety before treatment. Consideration is also given to service users with mild to severe systemic diseases and a high body mass index (BMI) indicator of 40+, with access to supportive services within the broader hospital team.

Moving the service to the main hospital site also presented opportunities to provide more holistic and integrated care to patients with diverse needs. For instance, patients needing haematology plans before and after treatment can access the Trust's Haematology department, located at the same hospital site. The proximity also allows for closer coordination with theatre teams and departments such as oral surgery and maxillofacial, facilitating a more comprehensive multidisciplinary team approach to patient care.

The transfer to the MRI allowed for more seamless service across multiple specialities. Patients reported increased satisfaction with the service's ease of use and the consideration given to their needs, with feedback consistently staying above 95%. The DSS is keen to facilitate a broader dental nursing team approach within the department and share the knowledge and skills amongst the team. In addition, the department has identified LD and autism champions who are providing critical support in promoting the newly developed LD and autism care plan for use within the dental outpatient setting.

Case Study – Royal Manchester Children's Hospital – Focused Support Team for Young People with Mental Health Needs and Learning Difficulties

The Focused Support Team (FST) is a specialised team based at the Royal Manchester Children's Hospital (RMCH) which provides a range of specialist support and care to children and young people with learning disabilities (LD), autism, and mental health needs prior to and during hospital admission. The team is made of LD, paediatric and mental health nurses, and care support workers.

The team provides crucial support to the hospital for children in need of specialised input, through a range of activities, such as bespoke training to care professionals within the trust, individualised care plans and risk assessments, therapeutic interventions, working collaboratively with extended MDTs, facilitating effective communication methods, and identifying and supporting with the implementation of reasonable adjustments for planned or unplanned admissions.

The ‘Was not Brought’ Programme’

FST has been involved in 'Was not Brought', a programme commissioned to understand the reasons behind children and young people with neurodiversity not attending appointments.

Through liaison with the group informatics department, appointment data was obtained, and the team has contacted thirty-five families to gather information on reasons for not attending outpatient appointments, with themes having been developed that can be turned into actions to support them. For example, one of the themes that arose from the data collection was improper signage and facilities for children who need a wheelchair. The team are now working with outpatient areas to implement improvements to the outpatient waiting areas to include visuals and better signposting of wheelchair-accessible waiting spaces.

Other themes included service and staffing barriers, and lack of resources such as lack of toys or quiet waiting area, which the team are working on addressing.

The team has developed links within the hospital and community services to increase awareness of FST and has seen an increase in the number of children and young people and their families asking for support. A range of support has been developed for parents or carers and young people accessing the site, including providing supportive visuals for their route to departments and implementing reasonable adjustments, which have all seen positive responses.

Since the start of the programme, 'Was not Brought' was nominated for a Health Service Journal (HSJ) award across the eleven hospitals that make up the Children's Hospital Alliance (CHA). FST is proud to represent Manchester University NHS Foundation Trust together with the Children's Hospital Network in recognition for our paediatric services.

Mobile Sensory Trolleys and Working Across Multiple Sites

As a managed clinical service, Royal Manchester Children's hospital must ensure equal opportunities for care across its numerous units in the Greater Manchester area. Through the ‘Was not brought’ programme, FST received funding to improve services, and as part of their mission of ensuring equitable patient experience across multiple sites, they opted for purchasing four mobile sensory trolleys. They are called Voyagers and offer an alternative resource to areas with limited access to a sensory room, they enable a flexible approach to the use of space in departments without impacting the delivery of clinical services. The input from the various teams enables collaborative working relationships and a more harmonious service offer across multiple sites.

Conclusions

In the last year, the Focused Support Team won the Equality, Diversity and Inclusion Champion award at RMCH, showcasing their dedication on improving the quality of care for young adults with specialised needs, and their unwavering support to the children's hospital clinical teams. Moving forward, the team is eager to continue challenging pre-established norms and culture, providing support for young people in acute settings, foster deeper relations with parents/carers and community services, and embed data at the heart of their mission to provide each patient with tailored plans and individual support. With the implementation of Hive, the Trust's new electronic patient record, FST is eager to utilise its various digital tools to better target young people with mental health, autism, and learning disability needs and reduce the number of unfavourable outcomes, such as reduced attendance rates for outpatient appointments.

Case Study – Saint Mary's Hospital and Safeguarding

The Saint Mary's Managed Clinical Service (MCS) Safeguarding Operational Group was set in place to report to the Group Safeguarding Meeting. Specialist Midwives provide care for a wide range of vulnerable and at-risk pregnant groups, such as learning disabilities, drug and alcohol misuse, mental health concerns, Asylum Seekers, Black, Asian and Minority Ethnic service users, young parents, chronic and long-term health issues, safeguarding issues, and domestic abuse.

Exception reports identify compliance with level 2 and 3 safeguarding training with divisional action plans to maintain compliance. Incidents related to Safeguarding are reviewed and discussed at these meetings and the learned lessons are shared widely within the MCS.

Learning Disabilities Standards

All clinical areas support patients with vulnerabilities, learning disabilities, and/or autism needs with individual care plans, use of the patient passports, and link with the trust's learning disability nurse for additional support.

In addition, resource boards are available on wards for staff covering dementia, learning disabilities, and deprivation of liberty.

So far, these initiatives have received widespread positive feedback from families of people with learning disabilities and other protected characteristics. Mental Health and Maternal Mental Health awareness weeks were well supported across all Divisions. To further support vulnerable service users, Saint Mary's Sexual Assault Referral Centre (SARC) has appointed an independent sexual violence advisor (ISVA) with a specialism in Learning Disabilities.

Objective 5: Be the First Trust in the Country to Deliver Pride in Practice

The Manchester University Foundation Trust (MFT) Equality Diversity and Inclusion Strategy 2019-2023 contained an original commitment to work towards the Trust becoming the first NHS Hospital Trust to achieve the LGBT Foundation Pride in Practice award, which ensures that all lesbian, gay, bisexual and trans people have access to inclusive healthcare that understands and meets the needs of our communities.

Since the Trust's Equality, Diversity and Inclusion Strategy was published, the NHS introduced the National NHS Rainbow Badge Accreditation Scheme, which is an assessment and accreditation model that allows NHS Trusts to demonstrate their commitment to reducing barriers to healthcare for LGBT people, whilst evidencing the excellent work they have already undertaken. The Trust has reprioritised the original commitment and is now working towards achieving Gold Status in the Rainbow Badge Accreditation Scheme.

Working Towards the NHS Rainbow Badge Initiative

The National Lesbian, Gay, Bisexual, Trans Gender (LGBT) Survey described a situation where LGBT+ communities nationally had poorer experiences and major concerns about accessing healthcare. At least 16% of survey respondents who accessed or tried to access public health services said they had a negative experience because of their sexual orientation. In addition, at least 38% said they had a negative experience because of their gender identity.

To improve health outcomes for our local LGBT+ communities, the Trust was proud to be part of a vanguard of ten NHS trusts to pilot the new NHS Rainbow Badge Trust Accreditation Model. The Accreditation Model was commissioned by NHS England. The Trust worked in partnership with and was able to build on its existing, strong relationship with the LGBT Foundation, which delivered the pilot.

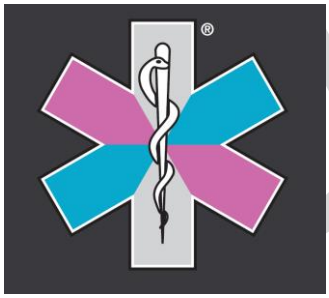
The NHS Rainbow Badge Pilot was focused on enabling trusts to improve patient care and staff experience. Participation in the pilot involved:

- Policy review
- Questionnaire assessment
- Staff and service user surveys

The Trust was assessed as achieving bronze status in the pilot NHS Rainbow Badge Accreditation Round and has adopted the assessment's recommendations in an improvement plan. Some of the key actions the Trust will be taking include:

- Implementing a transgender inclusion policy that covers staff and patients.
- Creating online LGBT+ resources for staff to access information relevant to specific services.
- Promoting the use of pronouns.

Work has begun on the reassessment process to enable the Trust to achieve silver award status in the next round of submissions to the National NHS Rainbow Badge Accreditation Scheme.



Case Study – The Trans Toolkit for Acute Care

Building on the successful professional development resource created in 2020 the Trans Toolkit for Acute care is an additional volume to help acute healthcare staff provide exceptional care to trans people. The original resource comprised four books and this new volume allows a further variation to the toolkit to be available. The Trans Toolkit for Acute Care is being provided in collaboration with the National Ambulance LGBT+ Network.

The final project is likely to be an A5 book size and PDF versions can be made available online. All versions will contain the weblink and QR code access to the Continuing professional development (CPD) elements. The first chapter will be an introduction into some of the challenges trans people and staff face in acute.

The second chapter will cover general advice for all staff to improve care provided to Transgender service users and patients. The third chapter will be more specific guidance for departments where more complex issues may arise for trans people and staff. The fourth and final chapter will be explaining some of the trans specific services available and relevant advice for those services.

The ownership and copyright of the final product would be jointly owned by the National Ambulance LGBT+ Network and Manchester University NHS Foundation Trust. The outcome will be a deeper understanding and knowledge for all staff on the care needs of trans service users and patients. Increased confidence for staff when dealing with trans people in acute care and more compassionate care for trans people within the Trust's acute care settings.

Objective 6: Making Our Wayfinding and Signage Easier

The Trust strives to work closely with patients, their families, carers, and service users to constantly improve our wayfinding and signage to make journeying to and from hospitals and between hospitals and community service as easy and effective as possible. The following are some of the actions taken in 2022 to ensure better access.

AccessAble

There over 14.6 million disabled people and 5.4 million carers in the UK. In a healthcare context, a large proportion of the Trust's patients, visitors and staff will have accessibility requirements. A lack of information regarding the accessibility of our sites, may mean people do not try to access a service at all or that they have a poor experience when they do.

In 2018, MFT partnered with AccessAble to undertake accessibility surveys of our ORC and WTWA estates and create online access guides. The online guides provide information about access in and around our sites (wards, departments, car parks, toilets, restaurants etc.) and include measurements, facts and photographs. Each guide is created through an in-person assessment by a trained AccessAble surveyor.

The information included in the guides is useful to disabled people with different needs and perspectives but can also be of use to anyone who needs to know about the accessibility of our sites.

The Trust's Estates and Facilities Accessibility Team have recently commissioned AccessAble to undertake additional accessibility surveys and create access guides for North Manchester General Hospital and our Community properties. To make sure that the guides are up to date and show all the right information, they are fully reviewed each year by dedicated departmental leads. AccessAble then resurvey the area and update the guides, as necessary. Small ad-hoc changes can be made via an online guide itself at any time and by anyone.

Since August 2019 we have been monitoring the use of the AccessAble online guides and from October 2019 we were able to monitor the number of individual users. On average, over the past 30 months, the Trust's access guides were viewed by 5496 individuals per month evidencing that they are a useful resource for our disabled community.

AccessAble
Your Accessibility Guide

Wayfinding

The Estates and Facilities Team, in partnership with Sodexo, have been working hard to improve all aspects of wayfinding to ensure it is simple, accessible and as accurate as possible.

The new Oxford Road Campus (ORC) wayfinding scheme is based on wider and more noticeable use of the ORC hospital colours (**Maroon** – MRI, **Blue** – SMH, **Yellow** – MREH and **Green** – RMCH) and improvement of the identification of zones A to N. These zones and colours have always been part of ORC wayfinding but have not been utilised in the obvious way that they are now.

Trafford and Wythenshawe hospitals also use specific colours and zones to help patients navigate the buildings.

At ORC, each lift along Hospital Street now has a large letter attached to it to denote the zone you are in. Staircases and lift lobbies have been painted in hospital colours and improved signage and floor directories have been installed to improve our patients, visitors and staff understanding of where they are in relation to where they need to be.

The feedback we receive from our patient and service user groups is that the walls along the main building often display information that is confusing, promotes staff-only messages and is not relevant to ensuring our patients and service users get to where they need to be. All public corridor walls are continually cleansed to ensure the information displayed is appropriate, accessible and useful.

The wayfinding team work continually to ensure all the Trust's site maps are accurate and kept as up-to-date as possible to reflect the ever-changing landscape of the Trust.

Section Three

Our Staff

Strategic Aim – A Representative and Supported Workforce

As one of the largest Trusts in the country and one of the largest employers in the Greater Manchester Area, the Trust understands the importance of valuing the diversity of staff. A representative workforce is one of the Trust's biggest strengths, and it constantly strives to improve conditions, listen to staff voices, and build equity. Through increased representation and stronger delivery of equality standards, the Trust aims for a happy workforce offering the best quality care throughout its services.

Objective 1: Consider how our decisions will affect equality and reduce unfavourable effects

The Trust considers how its decisions will affect equality in a variety of ways. These include conducting equality impact assessments and consulting with staff engagement groups on decision-making by setting out action plans for delivering better outcomes for staff groups with protected characteristics. This section details the activities that were carried out in 2022 towards achieving these objectives.

Case Study – Staff Living with COVID-19

The COVID-19 pandemic brought a set of unique challenges that impacted not only patients but also the staff providing the care. Due to high infection rates, the Trust and the entire NHS workforce saw an increased risk of infection, which led to lower levels of staffing due to sickness. The Trust required a solution to ensure staff were protected against the risk of infection, and to minimise transmission.

As a result, the Trust developed a 'Staff Living with COVID' policy that looked at providing guidance on how to best mitigate the risk of infection and best practices on how both staff and their departments can manage the illness in case of infection.

The guidance set out how MFT staff, workers and students should continue testing for COVID-19 and the revised pay arrangements for COVID-19 absences. The Trust developed this guidance based on Government guidance from UK Health Security Agency (UKHSA) and NHS England. In order to mitigate health inequalities and provide a more supportive solution, an equality impact assessment was carried out that identified the following risks:

- Older staff members are at a higher risk of developing COVID-19 and also face the risk of developing more severe versions of the illness. Older people are more likely to be frail and have comorbidities and underlying health conditions. These factors mean that people in these groups are at higher risk of poorer outcomes.
- Staff with learning disabilities or mental conditions might struggle to understand the guidance or access help.
- Black and Asian Minority Ethnic (BAME) staff are at higher risks of developing COVID-19 in part due to lower levels of vaccine uptake.

The Trust developed guidance for departments to carry out a number of activities to support staff, including a standardised COVID-19 Risk assessment to capture any underlying risks and factor in any needs the staff member might have. The guidance also included measures to provide regular testing amongst clinical staff and free testing for all staff who were symptomatic. Staff with disabilities also received support through their managers, departments, and working groups across the Trust to better capture their needs. Additionally, the policy also set out a transition process to return to a standard working pattern and ensure staff are supported throughout the process.

The Trust is committed to ensuring staff have safe working conditions and that their underlying risks and individual needs are met. The policy is an example of actions we have taken to mitigate risks and to understand how different people groups might be disproportionately affected by illness and how to best support them in a fair and equitable manner.

Case Study – A fair and inclusive Recruitment Process

The Trust understands that staff are the most important and valuable resource and that good recruitment practices significantly contribute to the well-functioning of the organisation. To develop a fair recruitment process, a policy was developed that incorporated fairness and equality at the core of its values. For instance, there are occasions whereby a 'positive action' approach may need to be adopted to support under-represented groups to overcome disadvantages in competing with other applicants.

The purpose of the policy is to promote and maintain fair and effective recruitment and selection procedures across the Trust and to ensure they are carried out to an agreed standard, comply with legislation, follow best practice guidance, contribute to effective risk management, provide equality, act responsibly and meet the requirements of the NHS Employment Check Standards.

An equality impact assessment was conducted to capture the risks and needs of potential candidates with protected characteristics. The following themes emerged from the assessment:

- Certain protected characteristics, such as age, gender, sexual orientation, or pregnancy status can negatively impact the candidates' likelihood of receiving job offers. To tackle this, the equality information is not visible to recruitment managers at any point of the application or selection process, with the specific aim to remove bias against minority groups. In addition, the policy states that any shortlisting or interviews must be undertaken by at least two people to reduce the risk of bias.
- People with disabilities may have difficulties in using online forms or engaging with the recruitment process. The Trust has a process in place to provide paper applications upon request, and a process to capture reasonable adjustments in the selection methods. Additionally, the Trust also operates a Guaranteed Interview Scheme for applicants who identify with a disability and meet all essential shortlisting criteria.

- Candidates who identify as Black, or Asian Minority Ethnic (BAME) are statistically less likely to be appointed from shortlisting compared to their white counterparts. To mitigate this, the policy adheres to the 'Removing the Barriers' Programme, a set of initiatives which aim to provide more employment opportunities for BAME staff, especially at more senior levels. For example, the E3 secondment scheme is an initiative designed to give ring-fenced secondment opportunities to BAME staff at banding level 8a and above.

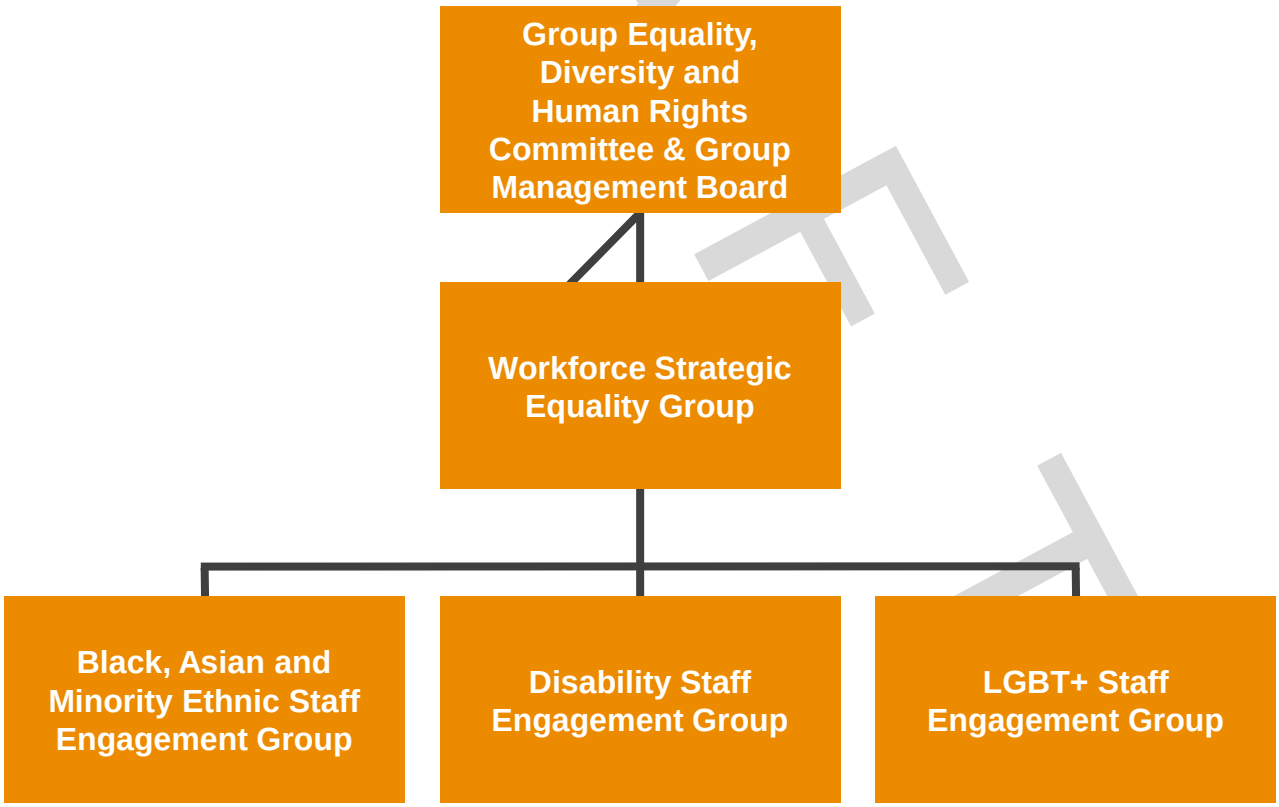
- Applicants from lower socio-economic backgrounds may be reluctant to apply for employment with the Trust. The Widening Participation Programme seeks to mitigate this through a range of activities which includes internships in association with local colleges, partnerships with local and national organisations, and use of Government initiatives such as the Kickstart programme.

Providing a more inclusive and equitable recruitment process that takes into consideration the candidates' needs and identities enables the Trust to become a more inclusive and diverse workplace. These efforts are consistently monitored through updated action plans, collaboration with staff engagement groups, and publication of workforce data reports such as the Workforce Race and Disability Equality Standards. The Trust is committed to continuously improving our processes to mitigate inequalities and be a fairer employer.

Staff Engagement Groups

During the COVID-19 pandemic the Trust implemented a new governance structure to ensure that staff from protected characteristic groups could feedback their experiences and that improvements to support them could be agilely put in place. As the intensity of the pandemic subsided a review of this governance structure was conducted and found that the model had been so useful that it would become part of business as usual at a monthly frequency to ensure that lived experiences can shape and inform workforce equality priorities and initiatives.

We now have three staff engagement groups covering four protected characteristics: disability, race, and sexual orientation and gender reassignment. These three groups provide a forum to understanding issues of concern for diverse staff groups, escalating issues, and codesign of solutions. The groups are chaired by a HR Director and report into the Workforce Strategic Equality Reference Group which focuses on the cross-cutting themes from the groups and ensures appropriate escalation and action. The Workforce Strategic Equality Reference Group is chaired by the Group Executive Director of Workforce and Corporate Business.



Case Study – Disability Staff Engagement Group

The Disability Staff Engagement Group has had many positive achievements in 2022, but possibly the one action that impacts on the greatest number of disabled staff is the changes that have been made to Blue Badge Disabled Parking at Trust car parks. During 2021 the Disability Staff Engagement Group was consulted by the Car Parking Team regarding how disabled access to suitable parking could be achieved/improved, the Group shared feedback on multiple occasions and the Car Parking Team worked on implementation.

A year on from this consultation and the Trust has seen the implementation of an improved new system for disabled parking which properly accommodates the needs of disabled colleagues. Staff who are Blue Badge Holders can now park in on-site car parks for free and more disabled parking bays have been made available for use.

For staff to gain appropriate reasonable adjustments in car parking the Accessibility Adjustments Panels (AAP) has also put in place to ensure that there is a fair and transparent process for car parking reasonable adjustments.

All these changes have been welcomed and celebrated by the Disability Staff Engagement Group, who will continue to work with the Car Parking Team to ensure that new innovations in car parking in 2023 are accessible to disabled staff.

The Disability Staff Engagement Group has highlighted the importance of direct ongoing communication with staff who fall under the Equality Act, 2010 definition of disability, to understand and tackle the barriers that are being encountered within the workplace. The Disability Staff Engagement Group looks forward to continuing to play a key role in influencing decision making to improve workforce disability equality as throughout 2023.

Objective 2: Know Who Our Staff are by Equality and their Experiences, and Reduce any Differences that We Find

Understanding the Trust's workforce by protected characteristics is crucial to making decisions that will improve working conditions and staff satisfaction rates and promote fairness. A workforce that feels valued and represented reflects upon the care we provide to our diverse patient base.

Through the Trust's annual reporting and analysis of staff protected characteristics data, it aims to make informed decisions on how to best support staff and reduce any discrepancy between staff member groups with protected characteristics

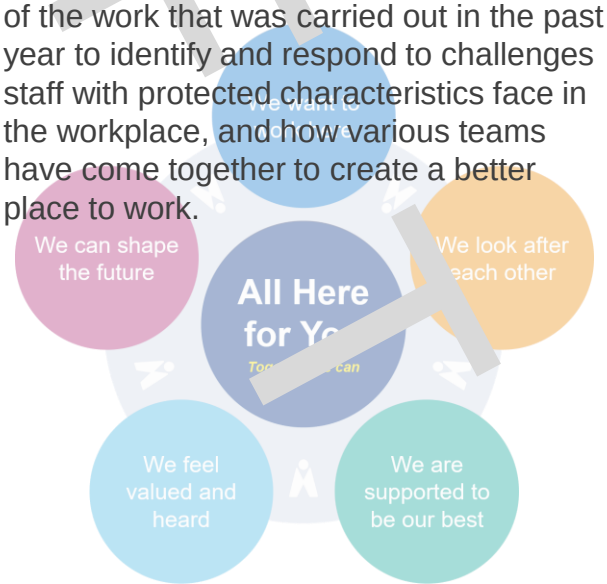
The MFT People Plan

The MFT People's Plan was created to set a new vision for the Trust and its workforce, embedding equality, diversity, and inclusion at the core of its principles. The strategy sets out five themes, with input from a wide range of stakeholders to shape its structure, ranging from ward staff to senior leaders and diverse staff engagement groups. The five themes are as follows:

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

The core principles of the strategy focus on staff and how a culture of inclusion and belonging can be fostered through collaboration and an open and transparent working environment. Through staff feeling represented and empowered to make decisions, the Trust aims to provide the best possible care through a motivated and engaged workforce.

The following sections are some examples of the work that was carried out in the past year to identify and respond to challenges staff with protected characteristics face in the workplace, and how various teams have come together to create a better place to work.



Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is a national report that the Trust is required to publish annually. It consists of a series of indicators that aim to assist Trust's to ensure Black, Asian and Minority Ethnic staff have equal access to career opportunities and receive fair treatment in the workplace. You can find the Trust's most recent WRES report on our website, click here.

In 2022 the Trust has continued to focus on increasing ethnic diversity at Agenda for Change (AfC) bands 8a and above. The 2021 WRES report indicated that the deliberate focus on improving the ethnic diversity of the AfC structure had shown positive results. This year's report shows further improvement in the number of Black, Asian and Ethnic Minority staff employed at band 8a and above; total of 45 more (206 compared to 161 in 2020/21) Black, Asian and Minority Ethnic staff members.

Whilst this is an improvement there is still work to be done to achieve an ethnically representative workforce at senior levels.

This work is brought together under the Removing the Barriers Programme. More detail about the Removing the Barriers Programme can be found on page 67.

According to the Trust's NHS National Staff Survey results, staff from Black, Asian, and Ethnic Minority backgrounds are disproportionately more likely to experience bullying, harassment, and abuse. As a result, the Trust has implemented a zero-tolerance bullying, harassment, and abuse strategy to address these findings. The plan also incorporates the Choose Kindness Campaign, designed to promote positive behaviours at all levels of the organisation. In addition, several Trust hospitals and services held listening events to engage with staff in response to staff survey findings.

During 2023 in addition to the WRES report the Trust will be exploring the production and publication of a Medical WRES report to ensure that staff in medical and dental roles also have equal access to career opportunities and receive fair treatment in the workplace.

Medical Workforce Race Equality Standard

Indicators for the medical workforce in terms of race equality standards were first published in July 2021 for NHS organisations to address inequalities that specifically cover the medical and dental workforce. This way, the Trust can target the specific issues and areas of action concerning the medical and dental workforce.

The 2022 report highlights the following statistics:

- 41.9% of the medical and dental workforce in NHS Trusts and CCGs in England are from a Black, Asian, or Minority Ethnic (BAME) background, compared to 14% BAME in the population.
- The number of BAME doctors has increased by 21.1% since 2017. Over the same period, the number of white doctors has increased by 2.4%, confirming the increasing diversity of the medical and dental workforce in the NHS.
- BAME doctors are:
    - Underrepresented in Consultant grade roles.
    - Overrepresented in other doctor grades and doctors in training.
    - Underrepresented in academic positions.
- BAME doctors reported a worse experience than their white colleagues when it comes to harassment, bullying, abuse and discrimination from staff.
- BAME doctors have worse exams outcomes and regulation issues (e.g., referrals to the GMC)

To tackle the highlighted issues, the report outlines several key areas of action, which include setting targets and timelines for reducing ethnic disparity in representation at consultant, clinical director and academic levels, narrowing the ethnicity gap in the appointment of consultants after shortlisting, and having senior officers in organisations include performance objectives for measurable delivery of diversity outcomes as part of appraisals, to name a few.

A Task and finish group has been established to review the areas for action and carry out duties such as gathering data to establish the Trust's baseline, Reviewing current Trust policies to identify areas of improvement and communicating the Trust's progress against the MWRES objectives.

The Task and Finish group will further update the progress of the action plan to the Group Workforce Strategy Quality Reference Group as well as the Group Equality, Diversity, and Human Rights Committee as appropriate.

Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enable the Trust to compare the workplace and career experiences of disabled and non-disabled staff. We are required to annually publish a WDES report and action plan. You can find the Trust's most recent WDES report on our website, click here.

In 2022 our WDES report showed that more disabled staff had declared their disability on our Electronic Staff Record (ESR); an increase from 3% to 4% of our overall workforce. This remains well below the Trust's results from the NHS National Staff Survey where the disability declaration level is 19%. The Trust remains committed to amplifying the voice of the Disabled workforce and continuing to engage with staff through the well-established Disabled Staff Engagement Group and the Diverse Ability Staff Network. These groups have already contributed to valuable work to creating a culture where disability declaration is positive, and it is clear that we need to build on this foundation in 2023.
The number of staff reporting that the Trust has made adequate adjustments to enable them to carry out their work has reduced in 2022; from 70% to 64%.

The Trust remains committed to ensuring that all staff who require reasonable adjustments receive these promptly, and the Reasonable Adjustments Task and Finish Group is leading on a solution that will be launched in 2023. You can find out more about this solution on page 65.

In addition, the Trust will continue to partner with ACAS to provide bespoke webinars to increase awareness and understanding of reasonable adjustments. This work will include developing resources and dedicated spaces on the staff intranet to support disabled staff.

According to the Trust's NHS National Staff Survey results, disabled staff are disproportionately more likely to experience bullying, harassment, and abuse. As a result, the Trust has implemented a zero-tolerance bullying, harassment, and abuse strategy to address these findings. The plan also incorporates the Choose Kindness Campaign, designed to promote positive behaviours at all levels of the organisation. In addition, several Trust hospitals and services held listening events to engage with staff in response to staff survey findings.

In 2023 the Trust will continue to monitor disabled staff experiences and provide solutions to improving the experience of our disabled workforce.

Gender Pay Gap Report

The Gender Pay Gap report is a statutory obligation as part of the Public Sector Equality Duty to ensure organisations monitor and evaluate plans to tackle differences in pay between men and women.

The Gender Pay Gap represents average differences in the pay between men and women in an organisation. By calculating the values between the mean (average) and the median (the mid-value of a range of values), we can determine our performance in closing the gender pay gap. By dividing the mean or median pay value for men by the value for women, a positive number indicates that men's average pay is more significant than women's, whereas a negative value indicates the opposite.

As a public sector organisation, the Trust is legally required to report on seven metrics, which are the following:

- Mean gender pay gap.
- Median gender pay gap.
- Mean bonus gender pay gap.
- Median bonus gender pay gap.
- The proportion of men in the organisation receiving a bonus payment.
- The proportion of women in the organisation receiving a bonus payment.
- The proportion of men and women in each quartile pay band.

The Agenda for Change pay bands result in little difference between the pay of men and women in the NHS. However, the Trust continues to monitor the gender pay gap while seeking to narrow the differences, particularly in analysing the process and impact of bonus pay and the Local Clinical Excellence Awards (LCEA), thus ensuring the awards are accessible and open to all senior medical and dental staff.

This year, the LCEA's open registration process has been stood down in agreement with NHS England as part of the COVID-19 Recovery Programme. The LCEA will return to its open registration system in 2023, which will provide an opportunity to compare this year's figures and determine the impact of the LCEA on bonus pay.

Staff Networks

The Trust recognises the importance of having a happy and supported workforce which in turn reflects upon the quality of the care provided. In keeping with this principle, we are committed to promoting a diverse and inclusive space through providing a framework for staff to form communities within our workforce. Our Staff Networks provide a place for staff to come together and address the diversity of causes and issues important to them.

The Trust currently has the following Staff Networks:

- Black, Asian, and Minority Ethnic (BAME) Staff Network
- Lesbian, Gay, Bisexual and Transgender (LGBT+) Staff Network
- Diverse Abilities Staff Network

The purpose of these Staff Networks is to provide a supportive peer group and a safe space for staff who share a protected characteristic to discuss their experiences and concerns. The Staff Networks also aid the Trust in gaining better understanding of the issues and inequalities faced by staff in the workplace, and they also provide support for the Trust in achieving its duty with regards to statutory obligations as outlined in the Equality Act 2010.

The Black, Asian & Minority Ethnic (BAME) Staff Network

The MFT Black, Asian & Minority Ethnic Staff Network is proud to join other Staff Networks and staff members in providing our colleagues with a safe space to form a community.

One of the Networks priorities is to make the dream of inclusion a reality in every phase of the working lives of the Trust's staff. We cannot afford to wait to evidence inclusion through policies, practice, verifiable outcomes, attraction, retention, and culture indicators in the workplace.

The Black, Asian & Minority Ethnic Staff Network supports several initiatives designed to tackled inequalities in the workplace, such as the Removing the Barriers Programme and the Be.Inclusive at MFT Campaign.

A member meeting was held earlier this year titled: "The progress of Workforce Race Equality Standard at MFT". It was evident from the meeting that there is more work needed to promote equality and inclusion in the workplace.

The Black, Asian & Minority Ethnic Staff Network are committed to doing our part in bringing Black, Asian and Minority Ethnic staff voices to forefront of the equality, diversity, and inclusion conversations being held both within the Trust and nationally.

The Diverse Abilities Staff Network

The staff Diverse Abilities Network aims to work closely with members and allies to promote common causes, tackle misconceptions, educate colleagues and raise awareness of diverse abilities across our workforce.

The Network brings together staff and allies with diverse abilities to meet and discuss their individual needs and share experiences of living and working with diverse abilities.

The Network's Committee promotes a sense of belonging through various resources and activities designed to bring together people with diverse needs. One example is the "Safe Space" monthly Teams meeting, a confidential space open to members and allies.

The Network also provides a "Buddy-Up" system, which introduces two members who can talk through 'What Matters to Me' in a confidential, mutually beneficial way.

The "Safe Space" also provides an opportunity to highlight individual concerns, compliments, or challenges, which can be raised through the network Chair anonymously raised at the Disability Engagement Group. This vital mechanism ensures the staff's Diverse Abilities Voice is heard and can inform the work of the Trust.

The Network has already given feedback to the Disability Staff Engagement Group on their views on 'What Matters to Me". There is also a range of resources for staff with various disabilities, including a wiki on Neurodiversity.

The LGBTQ+ Staff Network

In 2022 the LGBTQ+ Staff Network has been able to focus on the main theme of creating a sense of community for LGBTQ+ staff.

Our focus is to refresh all our communications shared within the network using the skills of our members to create more interactive and appealing newsletters as well as enhance our virtual space on dedicated Microsoft Teams and Twitter channels.

To help prioritise workstreams, specific interest groups were created to help interested members use their expertise and passions to help to bring the work of the LGBTQ+ Staff Network to life.

A great example of this being the social group who have planned and hosted many social evenings throughout the year including a themed Eurovision Song Contest viewing party and a Halloween event. A key part of the success of such events has been to work with other networks that staff belong to, which saw a great attendance for the Eurovision party when members of a Greater Manchester Cycling Club 'Pride Out' joined the event.

We hope that during 2023/24 we will be able to add more variety to the events to cover the varied interests of all members throughout the Network.

LGBT+ Staff Network

Case Study - Widening Participation Team

The MFT Widening Participation Team aims to increase and diversify our workforce through targeted engagement with our local communities.

As one of the largest employers in the Manchester local authority, the Trust has a civic duty as an anchor organisation to support local organisations by developing a 'home grown' model that addresses short- and long-term recruitment challenges.

In support of the Trust and NHS people plans, we aim to tackle health inequalities and support health and wellbeing of our local population through addressing the social determinants of health, such as unemployment and low income, and support local people into good jobs, in line with the 'Building Back Fairer' Marmot report. Diversity and Inclusion is at the heart of the Widening Participation team, with efforts being made to provide equal opportunity to our diverse wider community.

The Widening Participation team aims to achieve these ambitious objectives through 3 main areas of activity:

- Insight
- Experience
- Employability

Insights and Experience

The COVID-19 pandemic had a long-lasting impact on health services, including our Widening Participation offer, which also impacted face to face Work Experience, having it suspended since March 2020 – two full financial years.

This year, we pivoted our offer to virtual and in-school/college delivery to still support aspiring healthcare students. In the efforts to expand virtual opportunities, we saw a 568% increase in virtual work-related learning placements and in-college work experience for 5th year medics in schools.

100% of learners who undertook a virtual placement and responded to our survey agreed or strongly agreed that they feel more confident and informed on their health and social care careers of choice, and out of 1257 total participants, 62% declared themselves as Black, Asian or Minority Ethnic, and 8% declared having a disability.

Employability

Our Pre-Employment Programme supports local unemployed people into jobs within the Trust. It is a nine-week programme consisting of four weeks college-based training at the Manchester College and a work placement that lasts for 30 hours a week for five weeks. We work with numerous referral partners to support learners in a variety of placements, including Nursing Assistants, Laboratory Assistants, and Pharmacy Assistants. This year, we saw an increase of 96 learners starting placement, representing a 770% increase. Out of those, 92% progressed to employment. 51% of participants were from areas which are within the top decile of the Indices of Multiple Deprivation. 90% of participants were from the top 4 deciles.

Kickstart is a flagship Department for Work and Pensions (DWP) programme launched in December 2020 to counter the impact of the pandemic on young people's employment prospects. The pandemic disproportionally affected young people's employment outcomes. The Kickstart scheme aimed to have employers create new six-month fixed term roles for 16–25-year-olds who are in receipt of universal credit and in return, DWP contributes to the young person's salary, employer contributions, and onboarding costs. From January 2021 to April 2022, we saw 53 young people supported. To date, 26 young people have completed their six-month contract. Out of those, 19 have remained in employment with the Trust, with 5 moving to a higher band, and 3 moving to bank work.

Supported Internships are employment-based study programmes for 16- to 24-year-olds with special educational needs and disabilities. The Trust now hosts circa 40 interns a year across NMGH, Trafford, Oxford Road, and Wythenshawe sites, making it one of the largest employer hosts in the country. Out of the 40 interns, 45% identified as Black, Asian or Minority Ethnic, aiding in our mission to provide equality of opportunity for students from diverse backgrounds. The September 2021-2022 cohort are the first in three years to undertake all their learning in their Trust classrooms and undertake hospital placements, with a predicted 50-60% of learners to gain paid employment at the end of the programme.

Veterans and Armed Services

The Widening Participation team is leading on activities designed to support The Armed Forces Community, including serving personnel, reservists, veterans, and their families. The Trust has received several accreditations in recognition for our commitment to our armed forces, such as the silver award for the Ministry of Defence (MoD) Employer Recognition Scheme (ERS), NHS Employers Step into Health (SiH) Pledge, and the Veterans Covenant Healthcare Alliance (VCHA). The Widening Participation Team continue to engage and build partnerships with numerous external partners and organisations in order to further develop our support to our Armed Forces.

What's Next for the Widening Participation team?

Despite its many achievements, The Widening Participation team strives to constantly improve opportunities for Greater Manchester's various communities. As part of this plan, we look towards developing a plan to tackle the main issues identified in 2022. Some of those actions involve:

- Continuing to grow the Careers Ambassador pool and their contribution to career engagement activity.
- Restart Face to face Work Experience programmes and improve processes in line with national best practice.
- Increase the number of local people supported into work via pre-employment programmes.
- Improve employment outcomes for people who come to the Trust via Supported Internships and increase work with Supported Employment providers.
- Review processes and documentations to ensure these are efficient, safe, and reflect continuous improvements made.

Objective 3: Take a Zero-Tolerance Approach to Bullying, Harassment and Abuse

Bullying and harassment in the workplace can have serious negative effects on the well-being of employees, which can lead to poor patient experience. It can lead to decreased productivity, increased absenteeism, and high turnover rates. The Trust is committed to creating a safe and respectful work environment for all employees. By taking steps to prevent and address bullying and harassment, improvements can be made to staff mental health and job satisfaction and create a more positive and inclusive work culture. The following are some of the initiatives led in 2022 to combat these issues.

The Choose Kindness campaign

Choosing kindness is not just important for fostering good relationships between colleagues, it is also crucial to delivering high quality care. Research has shown that bullying and harassment have significant impacts on clinical outcomes.

When facing bullying and harassment, staff reduce their quality of work by 38%, while 80% spend time worrying about the rudeness. And it can also impact on patients, as statistics show that 25% of staff who experience bullying, and harassment take out their frustrations on service users.

Additionally, the 2022 Workforce Race and Disability Equality Standard reports indicate that staff with protected characteristics face disproportionally more bullying and harassment than their peers.

For instance, in the last year, disabled staff experienced a percentage increase in experiencing harassment, bullying or abuse from patients or the public by 7%, compared to 5% for non-disabled staff. The figures for staff who identify as Black, Asian, or Minority Ethnic also saw a similar increase of 7%.

The action plan, “Choose Kindness; zero tolerance to workplace harassment and bullying”, has been developed through conversations over the period of a year at Trust-wide groups and in hospitals and managed clinical services, and by looking at research literature and examples of what other organizations are doing.

The plan includes actions to support staff who experience harassment and bullying and actions to help all team, including managers, to understand the behaviours to look out for and their response.

MFT Open Door

Part of the Choose Kindness campaign is the MFT Open Door system, a recognition platform which allows colleagues to send everyone a short survey that will give staff a chance to get involved and share their views. These surveys provide instant feedback and quick responses to teams' questions and conversations.

In 2022, the Choose Kindness campaign provided a range of resources, such as 'How to Handle Workplace Bullying, Harassment and Abuse resource pack', and sharing a range of support available across the trust. Additionally, the 'Kindness Pledge' has been introduced together with multiple resources to display in prominent positions. The pledge is designed to remind colleagues to choose kindness at work when possible. Resources are also available such as training sessions and workshops, including the Management Brilliance Portal, and through the MFT Policy Hub, including information on Dignity at work, raising concerns and whistleblowing, and a guide on how to handle bullying, harassment, and abuse.

Enact

The Trust has also partnered with Enact Solutions to deliver innovative training workshops for our staff. The virtual and live-stream seminars last 3 hours and are supported by a blend of highly skilled facilitation, dramatised scenes, multimedia filmed material and various experiential exercises.

The sessions aim to provide the skills for staff to start open, positive, and honest conversations with staff about problematic interpersonal behaviours at work. They are scheduled to run from October 2022 to March 2023.

Teams across the trust have been provided with a range of resources to help utilise the campaign. These include resources on how to be kind to oneself, the behaviours displayed in work, taking the Kindness Pledge to make kindness the norm in the workplace, and providing information on the benefits of kindness amongst colleagues.

Let's Talk About Race and Racism

The 'Let's Talk About Race and Racism' Workshops are two-hour-long facilitated sessions launched in March 2022 designed to create a shared understanding of the definitions and concepts of race and racism. They are an opportunity to provide a safe and supportive space for all staff to hold conversations with colleagues about the impacts of racism. Additionally, they support staff in understanding racial bias, inequalities, and the effects of racism by exploring lived experiences.

The racial inequality experienced by Black, Asian and Minority Ethnic staff is well evidenced. The discussions aim to raise awareness of these inequalities, promote reflection on the issues raised, and create a shared understanding of the experience of colleagues in the organisation and society as a whole.

So far, ten facilitators have been trained in the first course in March 2022. In 2023, we plan to increase the number of workshops offered and promote more facilitator recruitment to lead on these sessions.

Case Study – Clinical and Scientific Services Anti-bullying and Harassment

The MFT Antibullying and Harassment group, led by a Clinical and Scientific Services (CSS) representative, developed an engagement pack for Kindness Day and Antibullying and Harassment Week in November 2022. The information was designed to help teams hold conversations on what kindness looks like and how to develop a more positive culture.

The pack was distributed via the Trust intranet and utilised across several CSS teams to enable reflection on various topics. Some subjects included identifying incivility and discussing how individuals and teams can pledge to contribute to kinder cultures at work.

As a result, one team identified that certain uncivil behaviours had become more frequent over the last few years. The team leader held a session to explore the pressures that could lead to an uncivil culture and the impact on individuals, the team, and patients. The results enabled the team to pinpoint observed acts of incivility and consciously avoid such behaviours by making individual and team pledges to commit to a civil culture.

Freedom to Speak Up

The Freedom to Speak Up (FTSU) team at MFT provides an alternative route to staff who need to speak up about anything impacting patient safety or their experiences at work. Some topics can include bullying and harassment or concerns with inappropriate attitudes and behaviours.

FTSU supports a culture whereby speaking up is business as usual for all workers. Alongside the FTSU Guardian, staff can access a diverse FTSU champion network of more than 60 staff members who volunteer to raise awareness on speaking up. FTSU Champions or Guardians can be the first port of call for staff who need advice and support to speak up.

The team created multiple resources for staff and teams to better understand the importance of speaking up about experiences, and how senior leaders and managers can promote an effective Freedom to Speak Up culture. For instance, 'Speak Up' eLearning became mandatory training for all workers at the Trust in September 2021.

In November 2022, an updated Freedom to Speak Up Policy was launched to align with the National Policy for Freedom to Speak Up. The policy is designed to be inclusive and support resolution by managers where possible.

Freedom to Speak Up Month in October provided an opportunity to raise awareness of how much we the Trust values speaking. This year's theme was 'Freedom to Speak Up for Everyone', each week focusing on a different theme. Week three was about promoting inclusion and breaking down barriers so everybody feels safe to speak up and be heard. The Be.Inclusive Campaign and support from the Staff Networks were instrumental in promoting speaking up among our diverse workforce.

From April 2021 to March 2022, FTSU received 129 cases, with 36% including elements of bullying and harassment. Once raised to FTSU, staff are listened to and supported. In most cases, the support consists of signposting advice, which may include speaking with line managers, HR, or other teams. In some cases, the FTSU Guardian escalates these concerns on behalf of the staff member. The FTSU Guardian helps staff to facilitate the speaking up process where needed. In all cases, staff will receive well-being support and resources.

Hate Crime Reporting

Agreement had been made in 2020 that specifically identified departments/sites across MFT will join in rolling out hate crime reporting activity throughout that year but this was paused due to COVID. Proposals to restart this work were presented to MFT's Workforce Strategic Equality Group in October 2022, where it was agreed that the programme of engagement and working to rollout hate crime reporting processes across MFT would begin from January 2022.

An extensive and visible information campaign had been developed with striking and non 'traditional NHS' imagery being featured. There is both patient/visitor information and staff specific information available that states that hate crime or hate incidents towards staff, patients and visitors will not be tolerated at MFT hospitals. Improving reporting processes and data capture on hate crimes and hate incidents will also be undertaken across the organisation.

Objective 4: Work Towards Being a Disability Confident Lead Employer

The Disability Confident scheme is a government scheme that helps employers recruit and retain great people, and to:

- Challenge attitudes and increase understanding of disability.
- Draw from the widest possible pool of talent.
- Secure high-quality staff who are skilled, loyal, and hard working.
- Improve employee morale and commitment by demonstrating fair treatment.

The scheme also helps employees identify those employers who are committed to inclusion and diversity in the workplace. There are 3 levels: Disability Confident Committed (level 1), Disability Confident Employer (level 2), and Disability Confident Leader (level 3). The Trust is currently a Disability Confident Employer and work is in progress to achieve a Disability Confident Leader.

The Trust continues to recognise the huge talent disabled staff bring to the organisation and is committed to recruiting and retaining disabled people and ensuring that disabled staff are given opportunities to fulfil their potential and realise their aspirations. The Trust subscribes to the social model of disability recognising that people are disabled because of institutional and social barriers and works to remove these barriers.

In 2022 the Trust had continued to ensure that disabled staff are given a fair recruitment opportunity through the “Guaranteed Interview Scheme”, which guarantees an interview to disabled candidates who meet the essential criteria for the role.

This year, our Workforce Disability Equality Standard has identified various areas of improvement designed to reduce the barriers and negative experiences of disabled staff. Our Diverse Abilities Network and Disability Staff Engagement Group have contributed to an action plan to address these areas and the Disability Staff Engagement Group receives quarterly updates on progress.

Reasonable Adjustments Task and Finish Group

A key focus in improving the experience and retention of disabled staff has been the provision of reasonable adjustments. The Reasonable Adjustments Task and Finish Group have been working on creating a Trust-wide solution after consulting with disabled staff and finding that their experience of reasonable adjustments was inconsistent, and they felt that effective reasonable adjustments were the most important thing in retaining disabled staff.

The preferred solution was to create a digital reasonable adjustments profile that will sit on the employee's Empactis digital record so it can remain consistent if managers change or roles change but be flexible to meet the needs of disabled staff. To create the digital reasonable adjustments profile funding is required to make changes to Empactis, to enable this innovation the Reasonable Adjustments Task and Finish Group applied for the 2022 Workforce Disability Equality Standard (WDES) Innovation Fund; a national fund that looks to fund a handful of innovative work programmes in NHS organisations to improve the WDES metrics.

The Digital Reasonable Adjustments Profile was awarded funding in September 2022 and since then the Trust has been working to achieve the following by March 2023:

- Finalisation of the content of the Reasonable Adjustments Profile with a group of multidisciplinary professionals and disabled members of staff.
- Build of the Reasonable Adjustments Profile in the Empactis System.
- Pilot of the Reasonable Adjustments Profile with a range of managers and staff for feedback.
- Develop and sign-off a Reasonable Adjustments Policy with guidance on how to use the Reasonable Adjustments Profile.
- The launch of the Reasonable Adjustments Profile and Policy to all staff.
- Monitoring of the take up of the Reasonable Adjustments Profile.

In 2023, the Trust will also continue to partner with ACAS to deliver bespoke webinars to increase the awareness and understanding of reasonable adjustments to support the launch of the Reasonable Adjustments Profile.

Objective 5: Increase Ethnic Diversity at Board and Senior Management Levels

It is now well known that companies who have ethnically diverse executive and senior teams perform better in terms of profits and efficiency. In the NHS it has been found that leadership bodies which are significantly unrepresentative of their local communities, such as NHS Trust Boards, will have more difficulty ensuring that care is genuinely patient centred – with resultant failings in the provision or quality of services to specific local communities that have particular health needs, including Black, Asian and Minority Ethnic communities and patients.

With this in mind, the Trust is focused in ensuring that our workforce, and particularly our leadership is representative of our diverse communities. Reflecting on our Workforce Race Equality Standard (WRES) metrics when the Diversity Matters Strategy was being developed it was clear that our leadership had a significant underrepresentation of Black, Asian and Minority staff at Agenda for Change band 8a and above. This objective has sought over the lift of the Diversity Matters Strategy to address this underrepresentation, the focused action to achieve this being the Removing the Barriers Programme.

Removing the Barriers Programme

The Trust's Removing the Barriers Programme comprises actions reduce under-representation of Black, Asian, and Minority Ethnic staff at bands 8a and above by addressing the systematic barriers to progression and empowering staff.

To achieve this aim, the Programme consists of the following Schemes:

- Diverse Recruitment Panels Scheme
- E3 Ring-Fenced Secondments Scheme
- Reciprocal Mentoring Scheme
- Talent and Development Scheme (new in 2022)

Autumn 2022 marks two years since the Removing the Barriers Programme was first launched and some progress has been seen in the overall percentage representation of Black, Asian and Minority Ethnic Staff in Agenda for Change (AfC) bands 8a and above, as shown in Table 1. However, this small increase does not yet achieve the aim of an ethnically representative workforce which would be a representation at each band of 21.75%.

To evaluate the first two years of the Removing the Barriers Programme a steering group will be convened in early 2023 to discuss the impact made so far, how to transition elements of the Schemes into business as usual, and ultimately how to go from good to great to achieve the Removing the Barriers Programme aim.

AfC Band	% BAME Staff (2018-2019)	% BAME Staff (2021-2022)	Difference
8a	9.36%	12.37%	+ 3.01%
8b	5.52%	6.34%	+ 0.82%
8c	4.20%	4.98%	+ 0.78%
8d	2.74%	5.71%	+ 2.97%
9	0.00%	0.00%	-0.00%
VSM	2.00%	5.06%	+3.06%

Table 1. Comparison of Workforce Race Equality Standard data over the time period of the Removing the Barriers Programme

Diverse Recruitment Panels Scheme

The Diverse Recruitment Panels Scheme aims to improve the equity of our interview and assessment centre processes by ensuring ethnic diversity on recruitment panels. In September 2020, the Trust introduced a mandatory requirement for all interviews and assessment centres for roles at Bands 8a and above to have at least one member from a Black, Asian, or Minority Ethnic background on the interview or assessment centre panel.

To facilitate this requirement the Trust invited Black, Asian and Minority Ethnic Staff to become part of a pool of people able to be requested to join interview and assessment centre panels. The model has worked well with current compliance with the mandatory requirement at 87%, and the feedback from both managers and Removing the Barriers members being positive. In 2023 we will be exploring the impact the introduction of this requirement has had on our Workforce Race Equality Standard indicator 2.

Case Study - Meet Aatar - Central Specimen Reception Manager

What Interested you about becoming a member of the Diverse Recruitment Panels Scheme?

"I wanted to take positive action and support the drive to move towards a more diverse workforce, reflective of the Manchester population.
Prior to the scheme, I had never been interviewed by a panel member with a Black, Asian or Minority Ethnic background, so I wanted to change this for other people and hopefully this will help improve the interview experience as a whole"

What resources did you find useful in supporting you when you became a member of the scheme?

"An initial group meeting and presentation helped convey the background for the scheme, but also the expectations of the members. There was a lot of supporting material and helpful members meetings to discuss shared experiences, ask questions and provide feedback. The feedback forms after the initial interviews were particularly useful, as suggestions I made were taken on board to help improve the process going forward"

Why do you believe the Diverse Recruitment Panels Scheme is important?

"Having a diverse panel brings a range of ideas and lived experiences which has a positive impact on the recruitment process.
Having a panel member of Black, Asian or Minority Ethnic background makes the interview process more inclusive and also helps demonstrate the commitment of the Trust to increase diversity amongst senior roles"

E3 Ring-Fenced Secondments Scheme

The E3 Ring-Fenced Secondments Scheme aims to address organisational barriers to Black, Asian and Minority Ethnic staff progression through three inter-related components of experience, exposure and education. E3 provides Black, Asian and Minority Ethnic staff the opportunity to gain experience, exposure and education through ring-fenced secondment opportunities.

In late 2021 a review of the E3 Ring-Fenced Secondments Scheme was undertaken as part of the year 1 Removing the Barriers Programme report and identified that the Trust was missing opportunities for E3 secondments which was delaying progress of the Programme's aims.

After a period of significant engagement with stakeholders the E3 Expansion Pilot was designed and launched in November 2022 to address these findings. The E3 Expansion Pilot aims to increase the number of E3 Ring-Fenced Secondments offered to Removing the Barriers Programme members and will be evaluated against it's aims in April 2023.

Whilst there is further that the Ring-Fenced Secondments Scheme can go, the members of staff who have been on an E3 secondment have fed back that the experience has been extremely valuable and has been instrumental in their career progression both within and outside the Trust.

Case Study – Meet Ann – Nurse Manager

What made you decide the E3 secondment was for you? How would you describe it to someone who is unsure?

"I saw the programme as a fantastic opportunity and was keen to gain further Exposure, Education and Experience, through an E3 Ring-Fenced Secondment opportunity. An E3 Ring-Fenced Secondment is a formal stretch assignment that enables members of staff to evidence their capabilities when applying for a senior leadership role in the future"

What experience have you gained from the E3 secondment?

"The experience I have gained during the E3 secondment has been phenomenal. I had the opportunity to oversee all wards in a completely different environment at the Nightingale. I gained broad new experiences such as setting up catering teams and training MOD staff on documentation they were not familiar with. The secondment has provided me with the understanding of the challenges Matrons face. I reported to more senior managers along with the Chief Nurse, and that coaching and guidance has supported my development massively. This will allow me to provide even better patient care and decision-making in my role."

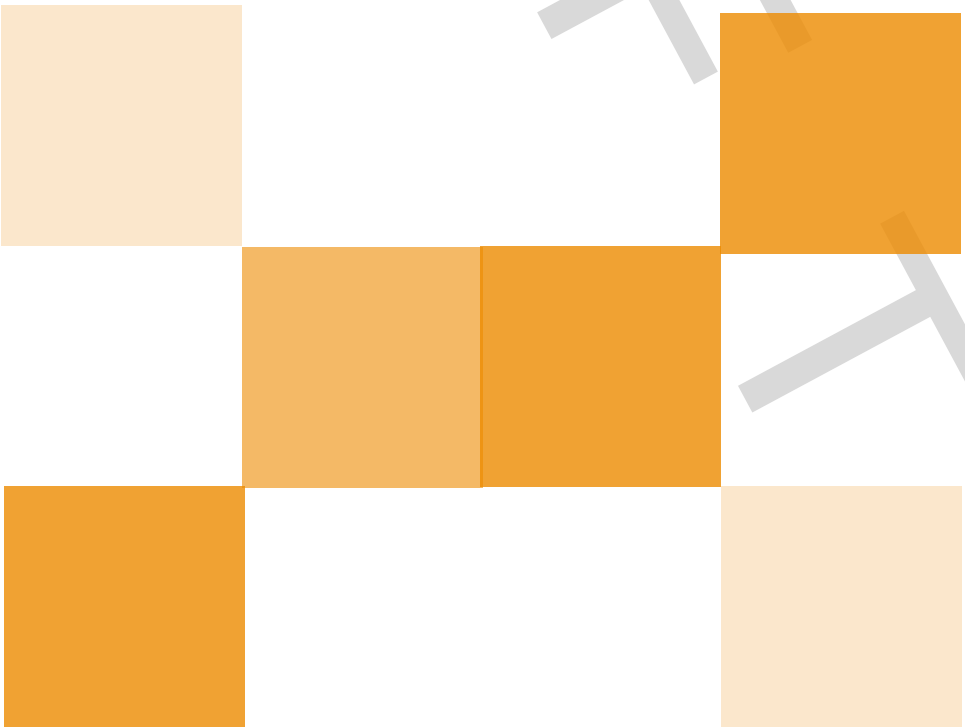
Why do you believe the E3 Ring-Fenced Secondment Scheme is important?

"Without the E3 secondment, I would not have gained as many opportunities to support my career progression. With the experience I have gained to date in my NHS career, along with the exposure, education and experience I have now gained as part of the E3 Ring-fenced Secondment, I am looking forward to applying for a substantive Matron post soon."

The Reciprocal Mentoring Scheme

The Reciprocal Mentoring Scheme pairs a senior leader at the Trust with a Removing the Barriers Programme member in a 12-month mentoring relationship. These relationships drive symbiotic learning that recognises the vital contribution of lived experiences and professional expertise to create a system that reflects our values. The following case studies share the experiences of two staff members involved in different reciprocal mentoring relationships.

The Reciprocal Mentoring Scheme is now seeing more relationships come to the end of their 12-month lifetime due to the maturity of the Scheme, and in 2023 will be focusing on monitoring outcome measures as well as beginning new mentoring relationships.



Case Study – Meet Doris – Advanced Clinical Practitioner

What interested you about becoming a member of the Reciprocal Mentoring Scheme?

"I saw the Reciprocal Mentoring Scheme as a powerful way to partner with senior leadership within the Trust and influence peer and decision-making at the board level. I feel this is a wonderful opportunity to share my lived experiences with a senior Trust member and in turns tap into their wealth of knowledge and experiences in order to further my career."

How do you feel the reciprocal mentoring partnership has supported you in your own professional development?

"Being matched to the most amazing mentor helped. I was able to talk freely about what is important to me, what my weak points were and even personal issues which might have affected my career. I received plenty of guidance and my mentor's lived experiences were important to understanding and observing board activities and the ways in which politics and power work at conscious and unconscious level. These interactions with my mentor have led to greater self-awareness and given me confidence in talking to and influencing my peers within my network"

How do you feel the scheme is supporting and embedding cultural diversity in the Trust?

"The scheme helps to build a partnership between ethnic minority staff members and senior leaders within the Trust, enabling collaborative working to change the system and make it more inclusive.
This is done in reciprocal mentoring through the sharing of lived experiences, networking, and Shadowing"

Case Study – Reciprocal Mentoring Scheme Senior Leadership Team Testimony

Zara Pain HR Director shares her reflections from being part of the Reciprocal Mentoring Scheme and shares the benefits to becoming a reciprocal mentor.

“MFTs Reciprocal Mentoring Scheme has created an open and confidential dialogue on racial inequalities and has helped me to enhance my understanding of the potential cultural barriers faced by the Clinical and Scientific Services’ (CSS) Black, Asian and Minority Ethnic Staff. I have found reciprocal mentoring to be a mutually beneficial relationship where we learn from each other, and I have certainly grown both personally and professionally as a result. The mutuality of reciprocal mentoring breaks down barriers and prejudices, allowing for mentoring relationships to dispel hierarchical and racial biases.”

Section Four

Inclusive Leadership

Strategic Aim – Inclusive Leadership

Our third strategic aim is Inclusive Leadership. The Trust understands that inclusive leaders recognise and value the unique perspectives and experiences of all staff and create opportunities for all to contribute and succeed. This can foster a sense of belonging and engagement among team members and leads to increased creativity, innovation, and collaboration.

While there is a clear role for senior managers to deliver the Equality, Diversity and Human Rights agenda, the Trust also recognises the importance of every member of staff feeling empowered to practise inclusive leadership across the organisation and throughout all levels of decision-making.

Through inclusive leadership, the Trust aims to attract and retain a diverse workforce, which will ultimately benefit the quality of our care.

Inclusive Leadership Training

A core element of the Trust's People Plan is building an inclusive and diverse workforce which can only be achieved if the managers and leaders are trained to be equipped with the tools and skills to place diversity at the heart of their decision-making. Leadership is not just a title, it is the collection of the depth and breadth of the insight, perspective, communication skills and life experiences that encompass the individual, which is why the Trust's leadership strategy is closely tied to the core elements of the MFT People Plan.

The Trust's Leadership and Culture strategy outlines the approach to developing inclusive and compassionate leaders, and it covers three core principles:

Compassionate Leadership - The interaction between leaders and their team, where at the heart support and wellbeing is a central principle.

Inclusive Leadership - Where everyone regardless of role is seen as a valued contributor and are fully responsible for their contribution to success.

Staff Engagement - Creating an environment of trust, where all staff are empowered to drive improvement, thrive and operate at their best.

In essence, these principles underpin an organisational culture:

- Where everyone takes responsibility for ensuring high-quality, continually improving and compassionate care
- That is shared in teams and where there is a continual focus on the development of team working
- Where leaders work together across boundaries prioritising patient care overall and not only in their area of responsibility
- That is consistent in its approach — characterised by authenticity. openness, curiosity, kindness, appreciation and above all compassion

The strategy is delivered through a range of measures and campaigns, including:

•Staff Survey questions around organisational culture
- CQC Key Lines of Enquiry
- Coaching support for Senior Leaders
- Line Manager frameworks
- Learning Circle Programme which supports line managers
- Self-guided learning for executives
- King's Fund Talent Programme - fostering real-time and practical models of theoretical implementation for Very Senior Managers and aspiring leaders and managers.
- Pearson Leadership Programmes for Newly Appointed Consultants Programme and Clinical Leaders
- MFT Academy, which provides a range of resources such as ‘Line Managers as Coaches’ courses.
- Reciprocal Mentoring scheme, part of the Removing the Barriers Programme

We are constantly updating the training and resources available to staff and leaders to provide a more inclusive and comprehensive training experience and to find areas of improvement within our current portfolio. The following sections are some examples of the measures we are taking to encourage leadership at all levels of the organisation and to prepare managers to lead with empathy and compassion.

Case Study – Clinical and Scientific Services Inclusive Leadership

The Clinical and Scientific Services (CSS) is a Managed Clinical Service (MCS) with a hugely diverse workforce of nearly 5,000 staff including Allied Health Professionals, Doctors, Nurses, Radiographers, Pharmacists, Technicians, Healthcare and Biomedical Scientists, Engineers, and Administrative and Support colleagues working across every site in the Trust.

We take great pride in the diversity of our professions and workforce. That is why we recognise the value of each profession their role in supporting the treatment of our patients. CSS celebrates each profession on dedicated celebration days and encourage a sense of community across the board.

CSS is proud to have a diverse workforce, both in profession and cultures which brings a richness to the MCS. After reflecting on conversations with leaders throughout CSS, the team realised that additional training around inclusive leadership should be added to existing training, particularly sessions around leadership theory and leading through change.

In 2022 the team updated the training and engagement offers of both sessions to include inclusive communication models and preferences that international recruits have in how they are led. This has been piloted in two areas to assess impact and quality of training.

Leaders who have joined the updated sessions fed back that the training has helped them to understand their own behaviours and assess how they could engage with their teams in a more effective and inclusive way.

The team have realised that many of the leadership practices can be biased to UK/Western preferences and by looking at inclusive leadership practices they were able to update the training to better skill leaders throughout CSS.

CSS intends to continue to design all future training Leadership training with diversity and inclusion in mind.

Be.Inclusive at MFT

Be.Inclusive at MFT

All staff have a contribution to make for equality, diversity, and inclusion to flourish. Which is why the Trust has launched its Be.Inclusive at MFT Campaign as a call to action for all 28,000 staff to become Inclusionists and get involved in the Trust's inclusion journey. Be.Inclusive will help to create inclusive services and workplace environments by promoting a sense of belonging for staff and by meeting the diversity of our patients. The campaign was launched May 2022 to coincide with the Equality, Diversity and Human Rights Week, and it comprises of three inter-related workstreams Learn, Celebrate, and Inspire illustrated in the diagram below.

The campaign has been endorsed by NHS Employers, with Paul Deemer, Head of Diversity and Inclusion at NHS Employers providing a few words:

"NHS Employers are delighted to support and endorse the Be.Inclusive campaign at Manchester University NHS Foundation Trust. We know that diversity is a fact and inclusion is an act – and this campaign is a fantastic example of how each one of you can make a small – but collectively significant – difference to the working lives and health outcomes of your staff and patients."

Every single act, every single action is valuable. These actions together will build an inclusive culture where all colleagues and patients are welcomed and safe to be who they are.

To date, we have more than 1,500 colleagues signed up to be MFT Inclusionists – people dedicated to playing an active role in promoting inclusion. Below are three case studies submitted to the Be.Inclusive newsletter in 2022 showing how staff across the Trust are being leaders on equality, diversity and inclusion in their areas.

Case Study – Why Wearing the Badge Makes a Difference

The Genomic Nurse Lead for adults, shared a story of how one of our patients, whilst attending an appointment, felt welcome at our Trust.

The patient had noticed staff wearing the NHS rainbow badge and said it made him feel safe to disclose that he was accompanied by his same-sex partner. As badges and lanyards are visible, they're a simple but effective way to show patients that we're welcoming of their diverse care needs and to show all colleagues that we value them and embrace their diversity. It also reminds us that we all belong and have our place in the Trust.

Be.Inclusive encourages our staff to wear their lanyards and badges to show their support for equality, diversity and inclusion.

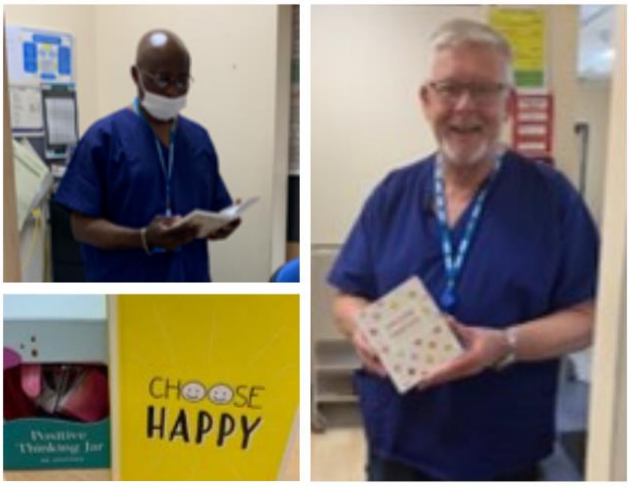
Figure 1 Karen Hawley, Freedom to Speak Up (FTSU) Guardian wearing her Be.Inclusive Badge, together with the FTSU lanyard and the NHS Rainbow Badge

Case Study – Saint Mary's Hospital Newborn Intensive Care Unit

Being an Inclusionist is about promoting inclusion so that our staff feel they belong as their authentic selves. To date 115 members of staff from across Saint Mary's Hospital have signed up to support the campaign.

An example of good practice includes the Practice Education Team at the Newborn Intensive Care Unit (NICU) – Oxford Road Campus, have created a 'Where is home map' to show the diversity of the team working across the Newborn Services.

Case Study – ‘Thought of the Day’ at Morning Huddle



During the pandemic, Anita Taylor - Staff Nurse at Withington Community Hospital, discussed with her team, which expressed their need for positive news. She then brought to work a book of positive sayings with a 'Thought of the Day' to be read at each morning huddle.

Members of the team took turns reading 'thoughts' which led to positive feedback, including that it gave a positive start to the day and distracted from the worries colleagues might have brought into work. This small practice has allowed for some positive reinforcement at the beginning of the workday and led to colleagues finding comfort and a sense of belonging. Even small actions can have significant positive impacts on people when done with compassion and empathy.

Section Five

Celebrating Diversity

Celebrating Diversity at Manchester University Foundation Trust

In the past year, the Trust celebrated diversity through a range of events that brought communities together and helped foster a culture that embraces what makes everyone different. Through celebrations, the Trust strives to foster an inclusive culture enriched by the diversity of Greater Manchester's communities and workforce. The following are some of the events and activities conducted during celebrations in 2022.

Ramadan

On Saturday 2nd of April, we celebrated the holy month of Ramadan with our colleagues.

During the holy month of Ramadan, which occurs on the ninth month of the lunar-based Islamic calendar, all Muslims are required to abstain from food and drink from dawn to dusk for 30 days.

Fasting, which is one of the five fundamentals of Islam, is a form of worship that is performed by the intentional abstinence from food, drink, smoking and sexual activity between dawn and sunset.

Fasting seeks to develop in one a sustained consciousness of God (Taqwa). By freeing one from preoccupation with physiological needs the heart and mind have greater freedom to reflect and meditate upon deeper spiritual matters, such as a person's relationship with the Creator and the creation.

This year, the Spiritual Care and Chaplaincy Team created multiple resources, including a guide to Ramadan and a patient and workforce guidance to aid colleagues throughout the celebration.

Equality, Diversity and Human Rights Week

Equality, Diversity and Human Rights (EDHR) Week is the national platform for health and care organisations to highlight their work to create a fairer and more inclusive NHS. This year, between the 9th and 13th of May 2022, we had an opportunity to reflect on, showcase, promote, and celebrate the amazing work around Equality, Diversity, and Inclusion.

We celebrated through various activities and resources, including an article sent to all staff reflecting on the highlights of the past year's work on equality, diversity, and inclusion. The week also coincided with the launch of our Be.Inclusive campaign, which aims to promote the creation of a more inclusive and open workplace culture within the Trust's departments.

The various teams across the Trust celebrated by updating information boards and leading focus groups around the Be.Inclusive campaign. Additionally, the HR teams organised bake sales and focus groups with various departments.

Manchester Pride 2022

In 2022 the LGBTQ+ Staff Network were able to represent Manchester University NHS Foundation Trust and the wider NHS at the Manchester Pride Parade.

Coordinating the entry for several Greater Manchester NHS Trusts it was a truly collaborative event working with colleagues from Networks throughout Manchester to celebrate LGBTQ+ staff and allies throughout the NHS.

The Trust was represented by over 60 colleagues who marched alongside around 200 wider NHS colleagues in Trust LGTBQ+ Staff Network t-shirts waving progress pride flags branded with the Trust logo thanks to further collaboration with corporate sponsors.

The LGBTQ+ Staff Network was delighted to win the ‘Best in Public Sector’ parade entry which reinforced the cheers and beautiful reactions the NHS received from the tens of thousands of people who lined Manchester’s streets to watch this year's parade.

The LGBTQ+ Staff Network is already planning our 2023 entry and is exploring other pride events across Greater Manchester where the Trust can be represented.

South Asian Heritage Month

In 2022, the Trust celebrated South Asian Heritage Month for the third year, with this year's theme being Journeys of Empire.

It was a chance to celebrate, acknowledge and learn about the incredible ways in which South Asian communities have helped to shape the UK.

The Black, Asian & Minority Ethnic Staff Network celebrated South Asian Heritage Month with a quiz night and shared communications to increase the awareness of the month amongst Trust staff.

East and Southeast Asian Heritage Month

This September marked the second East and Southeast Asian Heritage Month, and we wanted to celebrate the contributions that people from this region have made to the NHS and the UK.

Manchester is a super diverse city and has the greatest proportion of residents from East and Southeast Asia in the UK. We serve a lot of those residents at the Trust and many of our staff have strong connections by birth and/or heritage to East and Southeast Asia.

This year our Joint Group Medical Director, Toli Onon, was interviewed for our internal Trust newsletter about what East and Southeast Asian Heritage Month means to her.

Toli spoke about her family's journey from Inner Mongolia to America and finally settling in Leeds and finding a balance between integrating into British society and being proud of her heritage.

'People should value your identity for whatever it is you bring. And that's not just about ethnicity and race, that's about sexuality, about gender, about religion or being secular. We want to be part of a society where we really value people's diversity genuinely. It's great we are marking this day and I hope all people of East and Southeast Asian take pride in doing so'.

Diwali

.

Diwali is the biggest and one of the most important festivals in Hindu religion. It is also an important festival in both the Jain and Sikh religions. The festival represents the victory of light over darkness, knowledge over ignorance, good over evil, and hope over despair.

Diwali is celebrated for up to five days, but the main festival night of Diwali coincides with the darkest, new moon night of the Hindu Lunisolar month – Kartik. In the Gregorian calendar, this year Diwali fell on the 24th of October

People dress in their finest traditional clothes and may place decorations in their homes, light up diyas (lamps and candles). Family and friends get together, where sweets and vegetarian meals are prepared and shared. Performing prayers and religious rituals are also part of the celebrations. The appropriate way to express best wishes to Hindu, Sikh or Jain for Diwali is to say ‘Shubh Deepawali’.

The Trust is working with the dharmic communities to ensure Diwali celebrations in 2023 are representative of our diverse communities.

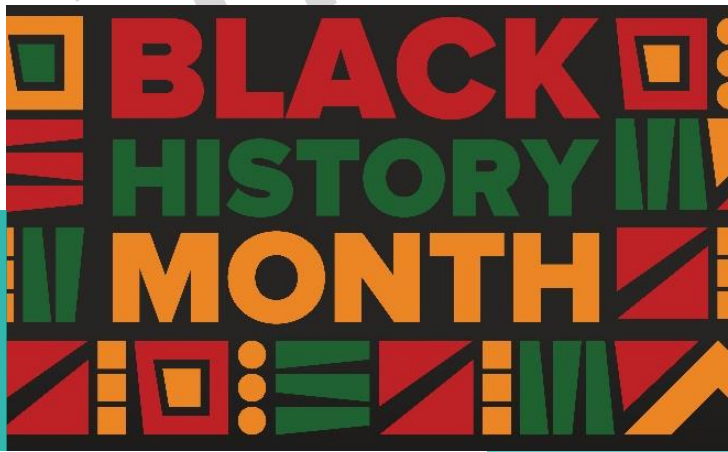
Black History Month

In October 2022, we celebrated Black History Month. This year the theme was Time for Change Action not words. Throughout October, the focus was set on the continued achievements and contributions of Black people to the UK and around the world. It was also a time for continued action to tackle racism, reclaim Black history and ensure that Black history is represented and celebrated all year round.

'To get to know a better tomorrow, we can't just focus on the past. We can acknowledge and learn from it, but to improve the future, we need action, not words. We need to come together to achieve a better world for everyone.' - Black History Month Organisation, 2022

To celebrate this year the Black, Asian and Minority Ethnic Staff Network ran a programme of events in October including a forum on what Black History Month means in the NHS, a Lime Arts Studio Workshop, Cultural Day (This is me!) Exhibitions, a Black History Month quiz, and a Positive Actions Workshop was attended by Mayor of Greater Manchester Andy Burnham who spoke about the importance of an ethnically diverse workforce in Manchester.

To celebrate in the community colleagues across the LCO also put on an array of events across the city to celebrate Black History Month. These events included a display of African-Caribbean items such as beads, outfits and currency, staff stories and poem recitations, a discussion with the Freedom to Speak Up team on bullying and harassment, and a Black African History and Carnival virtual session.



Disability History Month

In 2022, from the 16th of November to the 16th of December we celebrated UK Disability History Month. It is a time to create a platform that focuses on the history of disabled people's struggle for equality and human rights, and to celebrate the contributions of disabled people to society.

For Disability History Month 2022, we celebrated our disabled colleagues and reflected on how far we have come regarding supporting disability in the workplace.

A resource pack was created and released to coincide with the start of the month. The resource pack contained information on Trust programmes related to workforce disability equality, for example, the reasonable adjustments task & finish group, Diverse Abilities Network, and Disability Staff Engagement Group.

The resource pack also sought to increase awareness in general around workforce disability equality, sharing information on important topics such as the social model of disability and how to self-update demographic information on our Electronic Staff Record.

On Friday 3rd December 2022, MFT celebrated Purple Light Up Day during Disability History Month, with staff encouraged to wear something purple to show their support for our disabled colleagues. Hospital sites across the city were lit up in purple and members of the Disability Staff Engagement Group joined the Chairman, Kathy Cowell, for a photograph to mark the occasion.

Hanukkah

The 18th of December 2022 marked the beginning of the Jewish festival of Hanukkah (or Chanukah), which means “dedication”. It commemorates the miracle of light that occurred when Judah rededicated the Temple to the Hebrew God. This eight-day celebration involves the lighting of a Menorah (nine-candle candelabra) over eight days.

During this celebration, it became important to consider colleagues and patients who may be celebrating. Staff were encouraged to avoid scheduling evening appointments for outpatients and allowing inpatients to light an electric candle or attend the Menorah lighting ceremony. Managers were asked to be flexible with colleagues who wished to be at home in the evenings to light the candle.

> *“The truth is that Chanukah is relevant for everyone and even in the USA where state and religion are separate, the lighting of the Menorah is allowed in public places.*
>
> *The reason for this, is because the Menorah represents the basic fight which we all have in our lives. The challenge of spirit over material, light over darkness, awareness that there is something deeper than our superficial awareness.*
>
> *Sometimes we need to be reminded (which Chanukah helps us), that we have a very limited control in our lives and there is something hidden in the background directing things for our good.”*
>
> **The Trust’s Rabbi**

Section Six

Governance

Manchester University NHS Foundation Trust

Celebrating Diversity at Manchester University Foundation Trust

The Trust's equality, diversity and human rights governance includes the Group Equality, Diversity and Human Rights Committee that reports to the Group Quality and Safety Committee. Each hospital, managed clinical service, community services, and corporate service has an equality, diversity and inclusion group that feed into the Group Equality, Diversity and Human Rights Committee. The local equality, diversity and inclusion groups are chaired by a member of the Senior Management Team and supported by local Equality and Diversity Coordinators.

A Health Inequalities Group has been established that reports to the Group Equality, Diversity and Human Rights Committee. The Health Inequalities Group leads the Trust's work to tackle health inequalities.

A Workforce Strategic Equality Group has been in place since the start of the COVID-19 Pandemic. The initial purpose of the Group was to ensure that the decisions about safeguarding and supporting staff during COVID-19 were informed by and co-produced with diverse staff groups. The Group's remit has widened to issues of workforce equality more broadly.

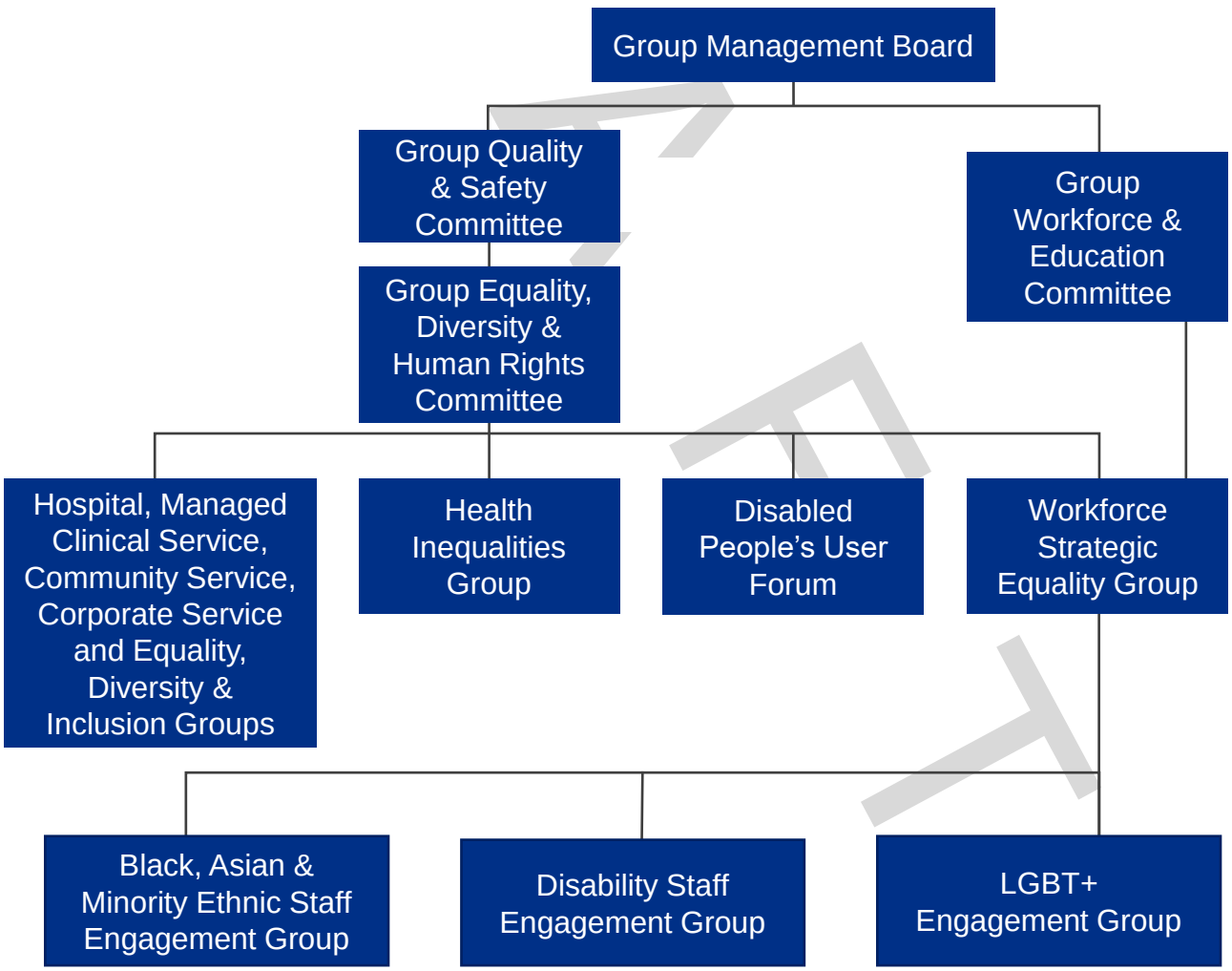
Staff Engagement Groups provide a mechanism for regularly hearing the lived experiences of staff to shape and inform workforce equality priorities and initiatives. The Groups offer a way of rapid design when needed and a way of understanding issues of concern and escalating issues. The Staff Networks sit on the Staff Engagement Groups providing linkages with Network members.

Our Disabled People's User Forum comprises current and past patients and members from the voluntary sector of and for disabled people. The Forum provides a mechanism for consulting with disabled people on service improvements and changes to understand the disability equality implications and ensure disability-inclusive environments and services.

Group Equality, Diversity and Human Rights Committee (GEDHRC)

The Trust's governance structure shown below is built on the principle of leadership. A Group Equality, Diversity and Human Rights Committee (GEDHRC) leads on promoting the culture and positive conditions for equality, diversity, and human rights to flourish within the Trust.

The GEDHRC identifies and shares good practice from within and out with the Trust. It oversees the development and implementation of approaches that require group wide consistency and monitor progress. The GEDHRC provides assurance to the Group Quality and Safety Committee and through that Committee to the Board of Directors.



Meet the Equality, Diversity and Inclusion Team

The Group Equality, Diversity and Inclusion Team is responsible for leading on developing, delivering, and reviewing Diversity Matters, the Trust's equality, diversity, and inclusion strategy 2019-2023. The purpose of the Group Equality, Diversity and Inclusion Team is to build the knowledge and confidence of staff across the Trust to realise the Trust's aims of:

- Improved patient access, safety, and experience.
- A representative and supported workforce.
- Inclusive leadership.

The Team carries out its purpose as follows:

- Translates legislation and national advice, guidance and standards and legislation into policy and practice.
- Provides advice and assistance in response to enquiries.
- Provides advice and quality assurance about equality impact assessment.
- Runs programmes of work with hospitals, managed clinical services, and community services.
- Designs, commissions, and delivers training.
- Creates learning resources.
- Analyses the Trust's performance on service and workplace equality, diversity and inclusion and translates this into continuous improvement actions.
- Benchmarks with other Trusts and organisations to bring the best of practice into the Trust and share Trust best practice.
- Produces the Trust's statutory reports. You will find these reports on the Trust's website.
- Runs the Trust's Staff Engagement Group and supports staff networks, you will find information about these on the equality page of the staff intranet site.
- Runs the Trust's Disabled Peoples' User Forum.
- Supports Equality, Diversity, and Inclusion Groups in hospitals, managed clinical services and community services.
- Partners with organisations in Manchester. Greater Manchester and the North-West and beyond to work in systems.

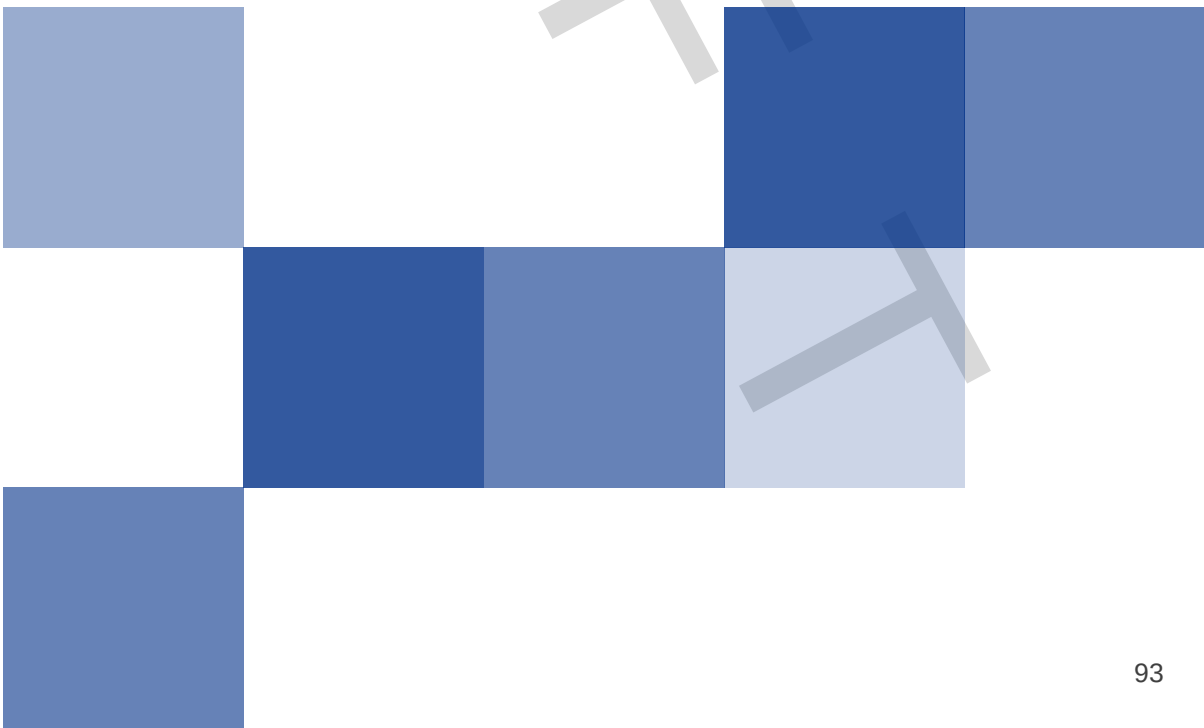
Conclusion

To deliver the Trust's equality, diversity and inclusion ambition, a four-year roadmap was developed as part of Diversity Matters. The roadmap is intended to identify the implications of the Strategy for the Trust's hospital and managed clinical services, community, and corporate services.

The Trust is on track to achieving its third year's actions outlined in the roadmap. However, more progress is needed in the following areas:

- tackling health inequalities including equality monitoring.
- increasing diversity in senior leadership.
- maintaining focus on tackling harassment, bullying and abuse.

The Trust is a fantastic organisation in a fantastic city, but that doesn't mean we can't do better — of course we can! But we can be proud of what we've accomplished in these challenging times and commit ourselves with humility to taking the next steps.

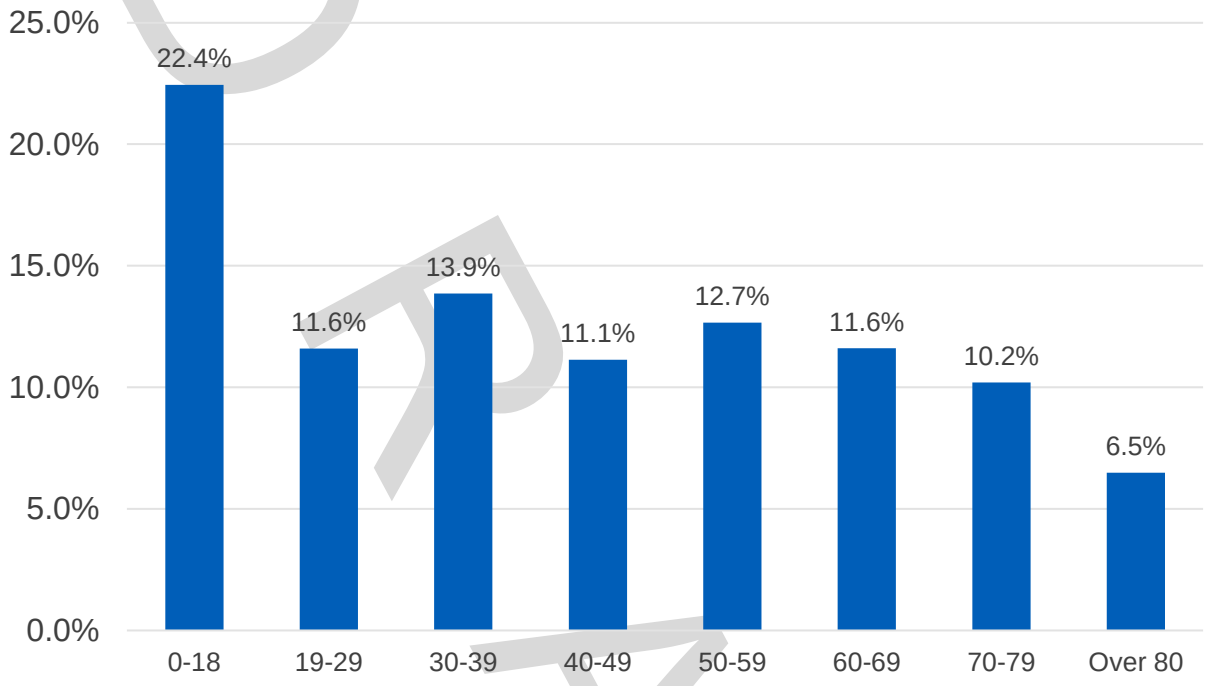


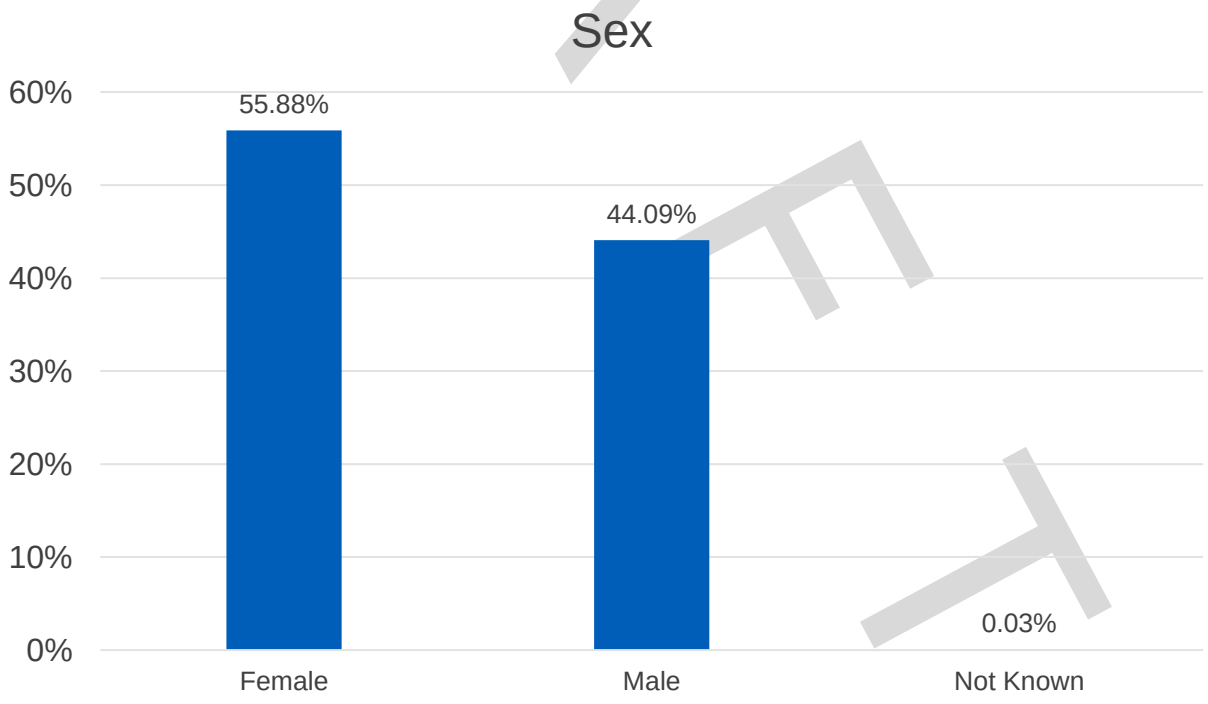
Annex 1

The Diversity of Our Patients

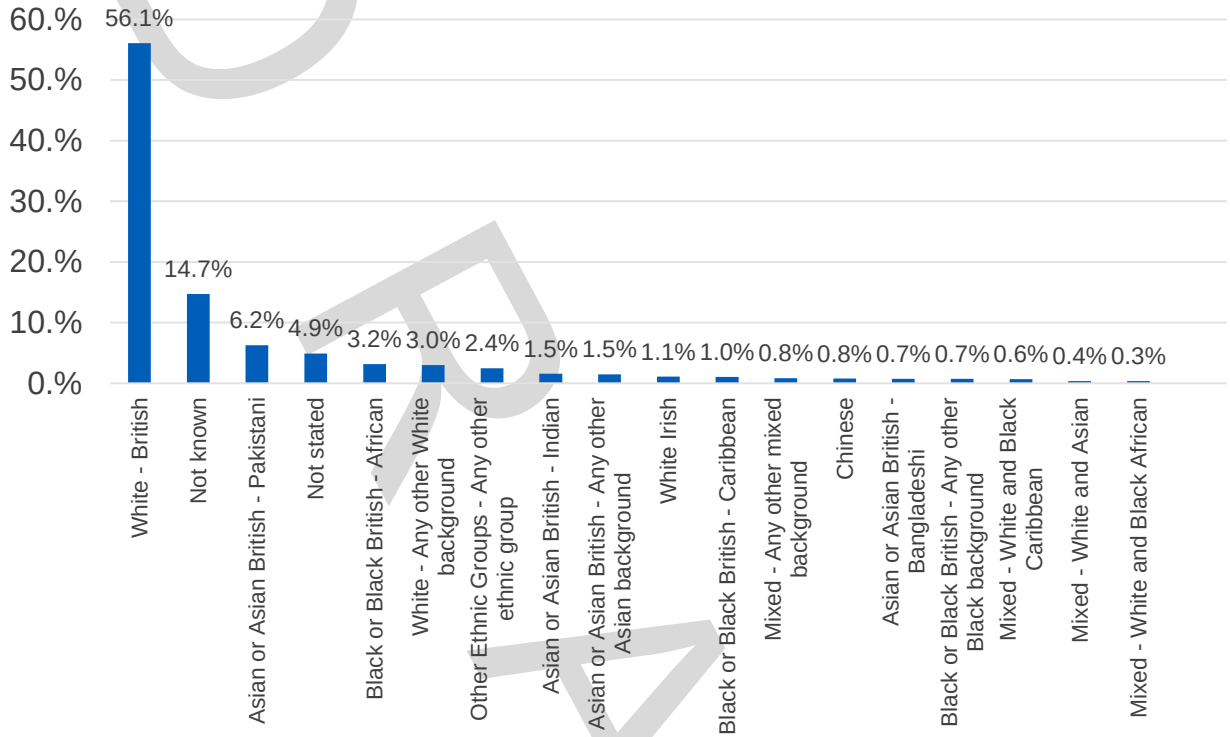
As a Trust, we recognise the diversity of the communities we serve, as everyone using our services has different needs and backgrounds. To provide safe and effective healthcare, we must continue to monitor demographic data to understand how the population changes over time.

The following charts provide information detailing the diversity of our service users in 2022 by the protected characteristics currently collected across each of our sites.

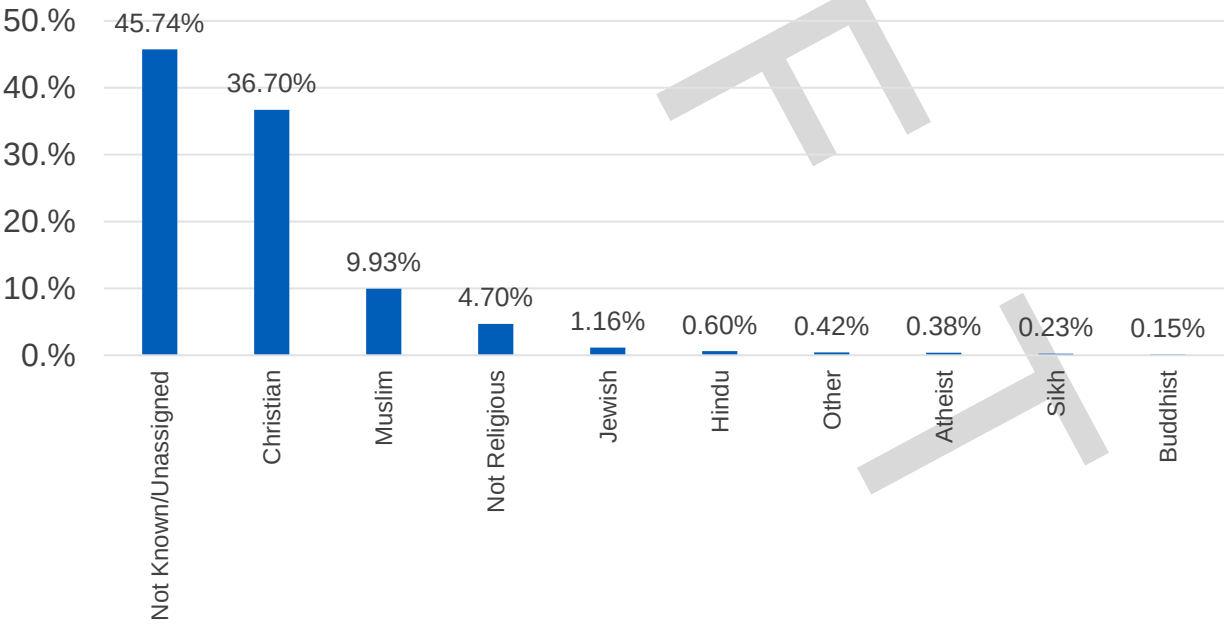

Age
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
22.4%
11.6%
13.9%
11.1%
12.7%
11.6%
10.2%
6.5%
0-18
19-29
30-39
40-49
50-59
60-69
70-79
Over 80


Sex
60%
50%
40%
30%
20%
10%
0%
55.88%
44.09%
0.03%
Female
Male
Not Known

Ethnicity



Religion or Belief

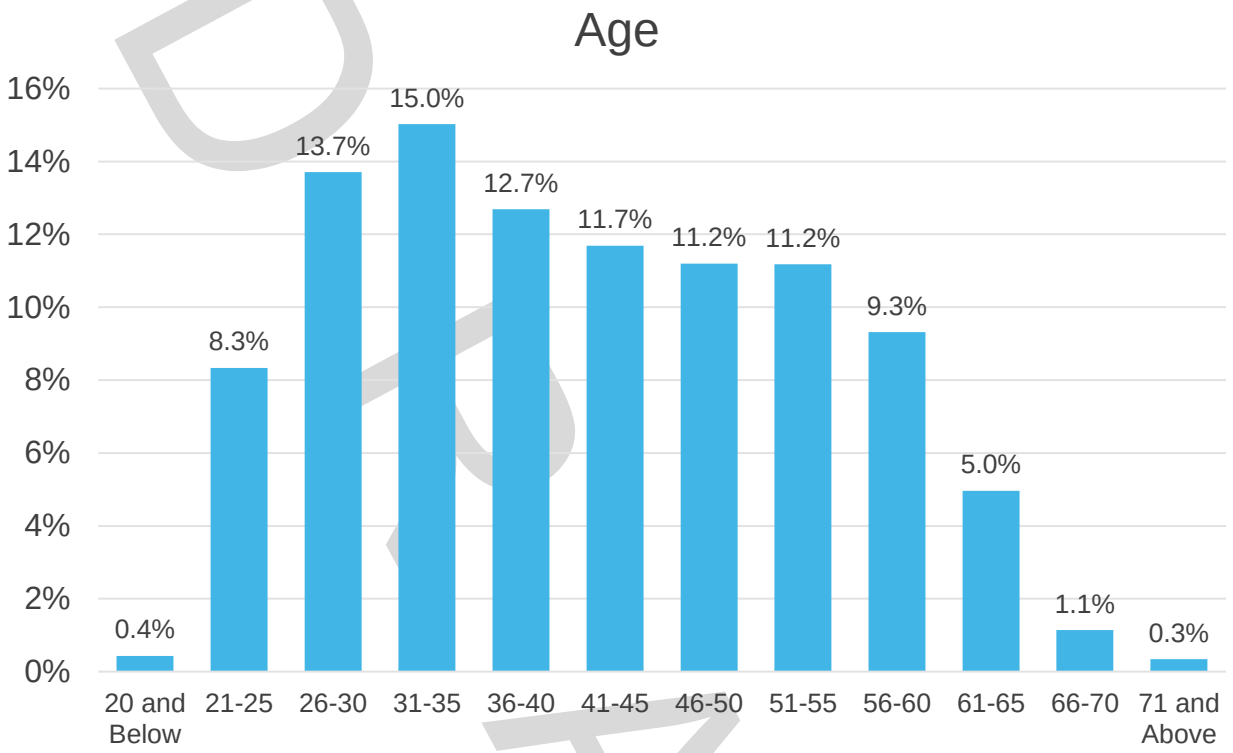


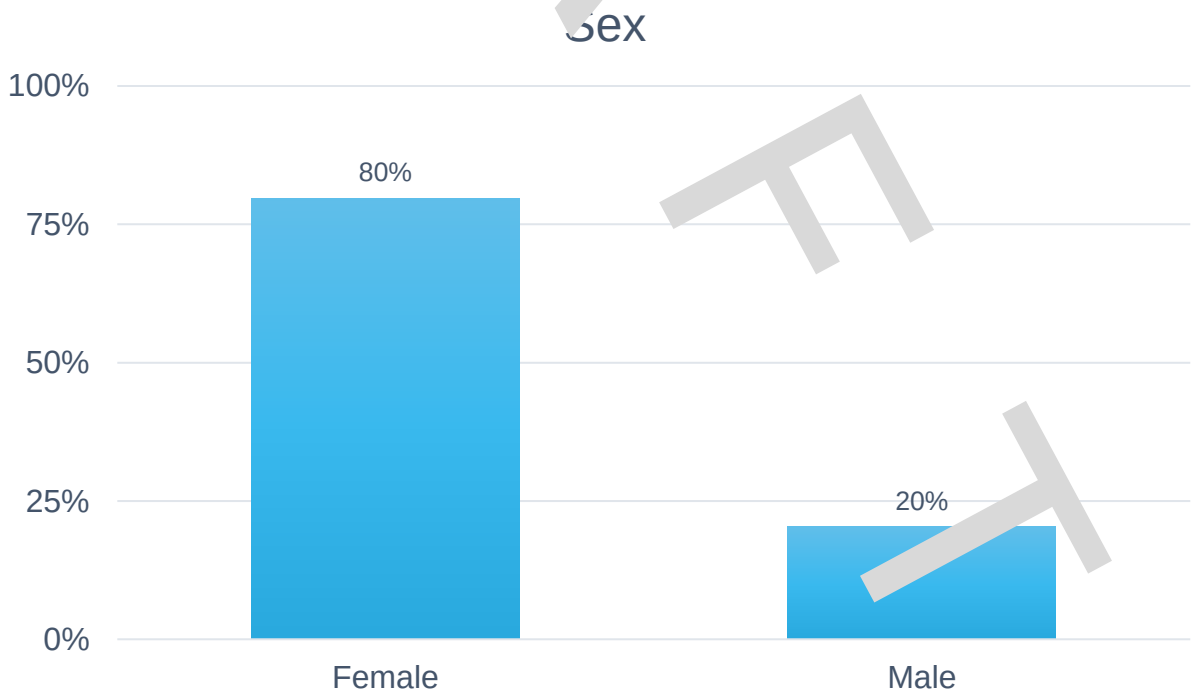
Annex 2

The Diversity of Our Staff

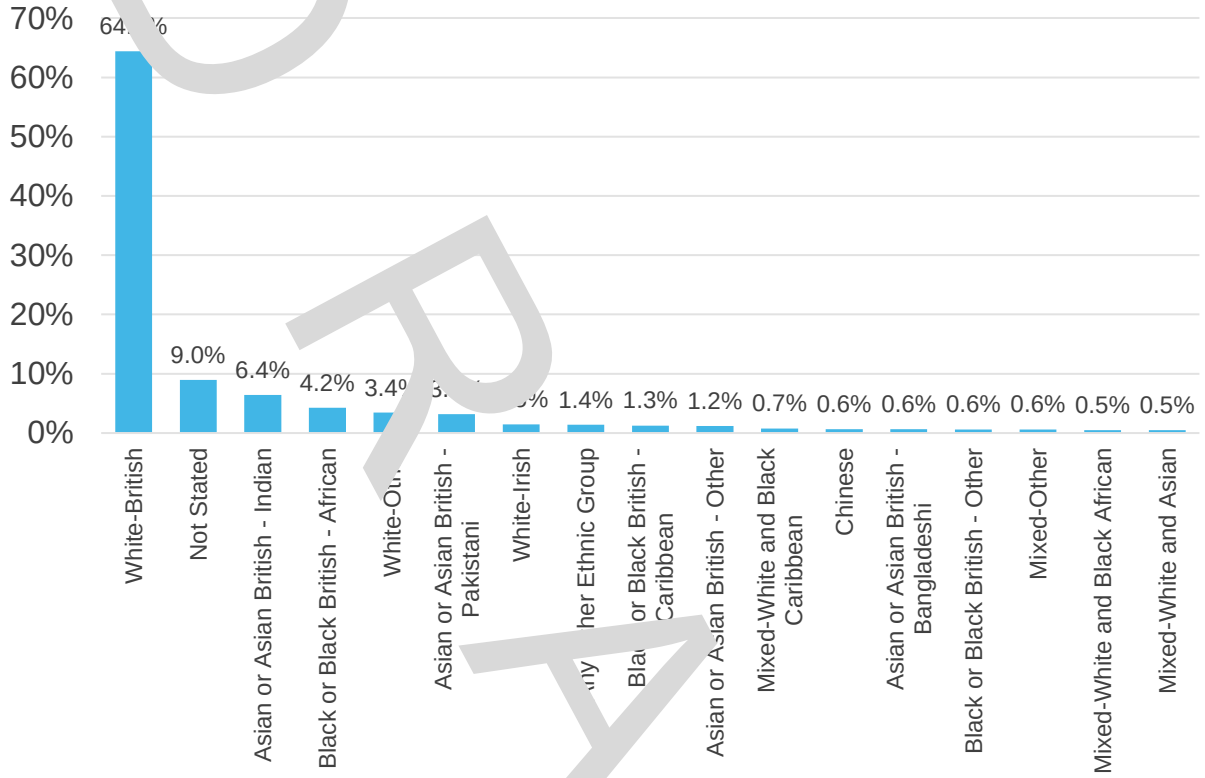
NHS
Manchester University
NHS Foundation Trust

The Trust recognises the importance and benefits of a diverse workforce, and is committed to creating an inclusive, accessible, and fair workplace for all employees. The Trust values the contribution of all employees and recognises that diversity of experience, skills and knowledge supports the delivery of the best possible services. The following tables provide a demographic breakdown of the Trust's workforce by protected characteristic in the past year.

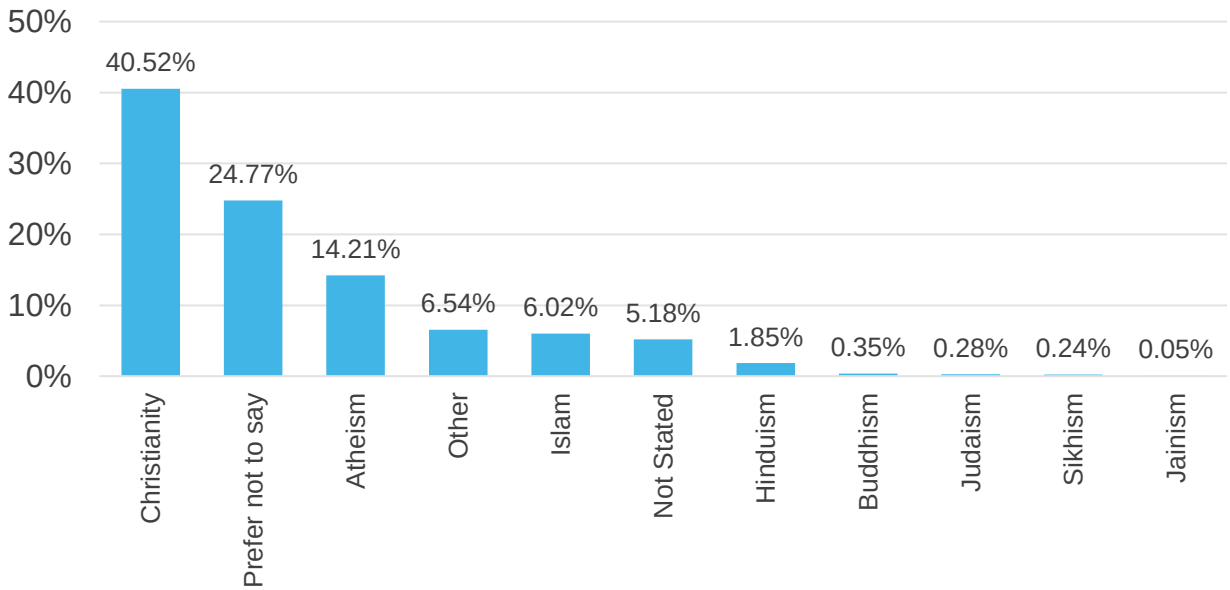

Age
16%
14%
12%
10%
8%
6%
4%
2%
0%
0.4%
8.3%
13.7%
15.0%
12.7%
11.7%
11.2%
11.2%
9.3%
5.0%
1.1%
0.3%
20 and Below
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
71 and Above


Sex
100%
75%
50%
25%
0%
80%
20%
Female
Male

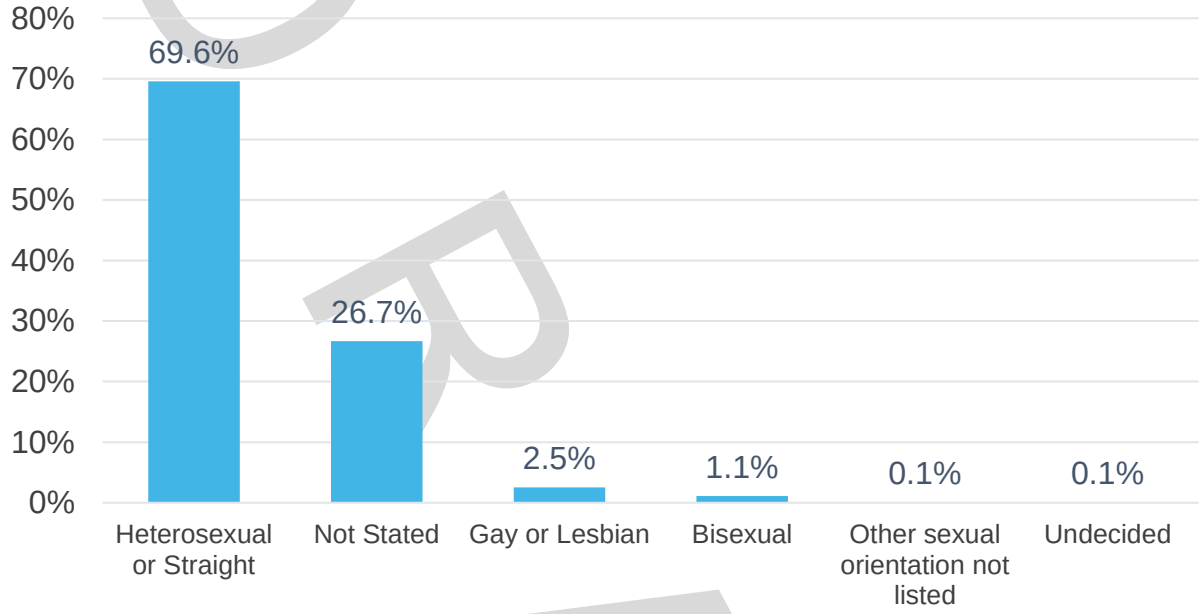
Ethnicity



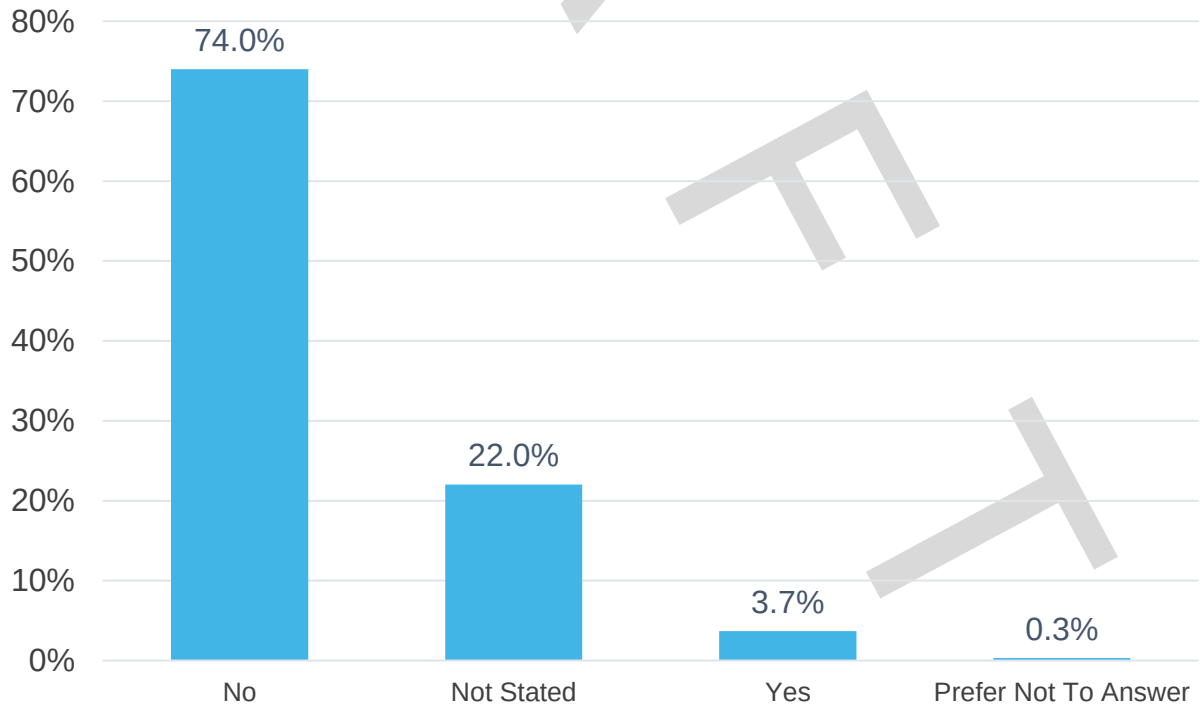
Religion or Belief



Sexual Orientation



Disability



Annex 3

Additional Resources

Equality, Diversity & Inclusion at MFT

www.mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Healthwatch Trafford

www.healthwatchtrafford.co.uk

Healthwatch Manchester

www.healthwatchmanchester.co.uk

Equality and Human Rights Commission

www.equalityhumanrights.com

Government Equalities Office

www.gov.uk/government/organisations/government-equalities-office

NHS Employers Diversity and Inclusion

www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce

Manchester Health & Care Commissioning Equality Information

www.mhcc.nhs.uk/about-us/equality-diversity

Greater Manchester Health and Social Care Partnership

www.gmhsc.org.uk

NHS England Equality Hub

www.england.nhs.uk/about/equality/equality-hub

Gender Pay Gap

Each year the Trust continues to review its pay by gender to see if there is any difference in pay between men and women. The Trust's latest Gender Pay Gap Report can be found at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Work Race Equality Standard (WRES)

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS healthcare providers, through the NHS standard contract. The Trust publishes a WRES Report each year and use the data within the report to inform actions to advance the equality of opportunity for Black, Asian, and Minority Ethnic staff at the Trust. You can view the latest WRES Report at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Work Disability Equality Standard (WDES)

Implementation of the Workforce Disability Equality Standard (WDES) is a requirement of public sector organisation to report against a set of ten metrics to identify variation in the experience of Disabled employees. The Trust publishes its WDES Report each year and uses the data to inform a set of actions to improve inclusivity and accessibility.

You can view the latest WDES Report at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Please contact the Trust's Equality and Diversity Team with any enquiries about the Diversity Matters Strategy.

Email: Equality@mft.nhs.uk

Annex 4

Glossary

ACAS – The Advisory, Conciliation and Arbitration Service

AIS – Accessible Information Standard

BAME – Black and Asian Minority Ethnic

CCG – Clinical Commissioning Groups

CPD – Continuing Professional Development

CQC – Care Quality Commission

CSS – Clinical and Scientific Services

DPUF – Disabled People's User Forum

ED&I – Equality, Diversity, and Inclusion

EDHR – Equality, Diversity and Human Rights Week

EDS – Equality Delivery System

EqIA – Equality Impact Assessment

ESR – Electronic Staff Record

FTSU – Freedom to Speak Up

GEDHRC – Group Equality, Diversity and Human Rights Committee

GMC – General Medical Council

GPG – Gender Pay Gap

LCEA – Local Clinical Excellence Awards

LGBTQ+ - Lesbian, Gay, Bisexual, Trans, Queer + Community

MCS – Managed Clinical Service

MFT – Manchester University NHS Foundation Trust

MREH – Manchester Royal Eye Hospital

MRI – Manchester Royal Infirmary

NIHR – National Institute for Health and Care Research

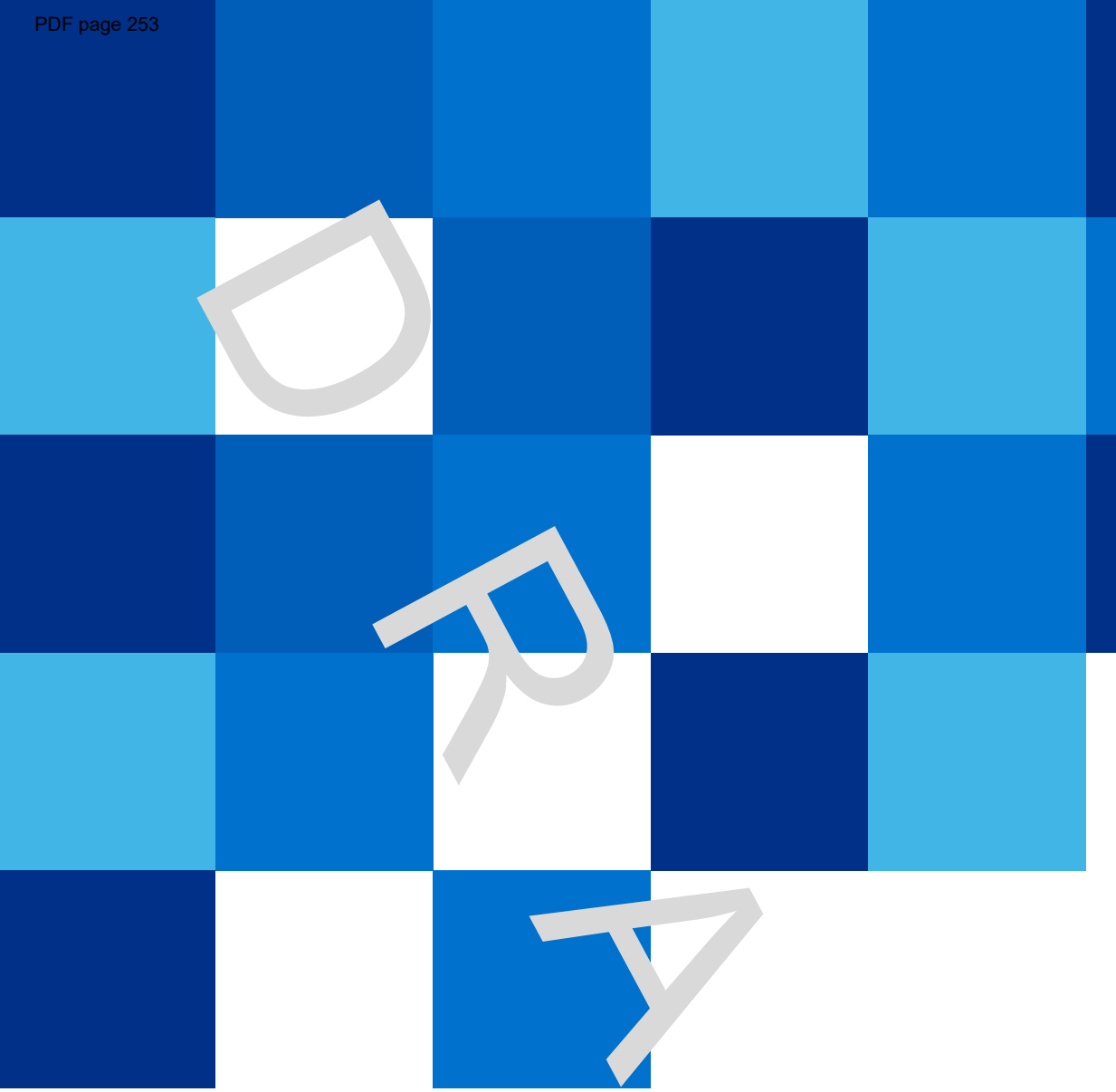
RMCH – Royal Manchester Children's Hospital

UDHM – University Dental Hospital of Manchester

WDES – Workforce Disability Equality Standard

WRES – Workforce Race Equality Standard

WTWA – Wythenshawe, Trafford, Withington, Altrincham hospitals



Agenda Item 10.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Nick Bailey, Director of Corporate Workforce
Date of paper:	March 2023
Subject:	Gender Pay Gap Annual Report 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 statutory deadline for publication of the 2022 Gender Pay Gap Report and submission of the data to the national portal is 31/3/2023. Not publishing the report and submitting the data by this deadline risks the Trust failing to uphold its value of being open and honest about progress on the Diversity Matters Strategy and the gender pay gap.
Recommendations:	The Board of Directors is asked to approve the publication of the report in accordance with the Public Sector Equality Duty obligations.
Contact:	Name: Nick Bailey, Director of Corporate Workforce Tel: 0161 276 4796

Manchester University
NHS Foundation Trust

1. Purpose

1.1 The purpose of this report is to present the Board of Directors with the Annual Gender Pay Gap Report for 2022, and to gain approval for publication of the report before the end of March 2023.

2. Context

2.1 Organisations with 250 or more employees are mandated under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, to report annually on their gender pay gap. As one of the largest acute NHS Trusts in England which employs over 28,000 staff, Manchester University NHS Foundation Trust (MFT) is required to publish information relating to its gender pay gap under six specific metrics. These are detailed in the attached report which is required to be published annually on the Trust website.

3. Current Position

3.1 The attached Gender Pay Gap Report has been approved by the Group Equality Diversity and Human Rights Committee and the Human Resources Scrutiny Committee and is now presented to the Board of Directors to gain final approval for publication before the end of March 2023.

4. Recommendation

4.1 The Board of Directors is asked to approve the publication of the report in accordance with the Public Sector Equality Duty obligations.

NHS
Manchester University
NHS Foundation Trust

Gender Pay Gap Report 2022

Introduction

This report sets out the Manchester University NHS Foundation Trust Gender Pay Gap data for 2021-2022, provides analysis of the data, and explains the actions being undertaken to address the gap.

The Gender Pay Gap shows the differences in the average pay between men and women working in the same organisation. The data in this report is based on the UK Government's methodology for calculating difference in pay between female and male employees, considering full pay relevant employees of Manchester University NHS Foundation Trust (MFT).

The Gender Pay Gap is calculated using the mean (average) and the median (the mid value of a range of values) earnings of men and women expressed as a percentage of men's earnings. In reporting the Gender Pay Gap a positive value indicates that the average pay for men is greater than for women, whereas a negative value would indicate the opposite.

This report includes:

- An overview of the gender pay gap reporting requirements.
- MFT gender pay gap data 2022 and analysis.
- MFT additional workforce gender pay analysis.
- MFT response to gender pay gap data 2022 and priority actions.

Background

Organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The requirements of the mandate within the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, are to publish information relating to pay for six specific measures as detailed in this report.

Manchester University NHS Foundation Trust (MFT) is one of the largest acute Trusts in England, employing over 28,000 staff. It was formed on 1st October 2017, and since then has been responsible for running a group of hospitals and community services across several separate sites, providing a wide range of services from comprehensive local general hospital care through to highly specialised regional and national services. From 1st April 2021 North Manchester General Hospital was the tenth hospital to join the Group. This report is reflective of the fifth year of the new organisation.

As of 31st March 2022, MFT employed 22,161, 79.56% (22,161) women and 20.44% (5,695) men. This is approximately the same proportions as in 2021's report when the workforce was 79.4% women and 20.6% men.

National Reporting Requirements

There are six calculations that an organisation is required to publish, these are outlined in Table 1 below.

Table 1: Gender Pay Gap reporting requirements.	
Mean gender pay gap.	The difference between the average of men's and women's hourly pay.
Median gender pay gap.	The difference between the midpoints in the ranges of men's and women's pay. All salaries in the sample are lined up separately for men and women in order from lowest to highest, and the middle salary is used. The figure is the difference of these two middle points.
Mean bonus gender pay gap.	The difference between the mean bonus payments made to relevant male employees and that paid to relevant female employees. For MFT this refers to local and national clinical excellence awards.
Median bonus gender pay gap.	The difference between the median bonus payments made to relevant male employees and that paid to relevant female employees. For MFT this refers to local and national clinical excellence awards.
Proportion of males and females receiving a bonus.	The proportions of relevant male and female employees who were paid a bonus payment. For MFT this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band.	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

In reporting the Gender Pay Gap a positive value indicates that the average pay for men is greater than for women, whereas a negative value would indicate the opposite.

Public sector organisations must publish their Gender Pay Gap information by the 31st of March each year using pay data from a snapshot a year before the reporting deadline. The data in this report is reflective of a snapshot taken in 2022. The data sources for MFT's reporting against the Gender Pay Gap reporting requirements are Electronic Staff Records (ESR), the Trac Recruitment System and the MFT Clinical Excellence Awards (CEA) Portal.

Not included within the scope of MFT's Gender Pay Gap reporting are:

- Any member of staff not on Electronic Staff Record (ESR) or staff who are not on Retention of Employment (RoE) contracts managed through Sodexo.
- Junior Doctors who are managed through the Deanery.
- Volunteers.

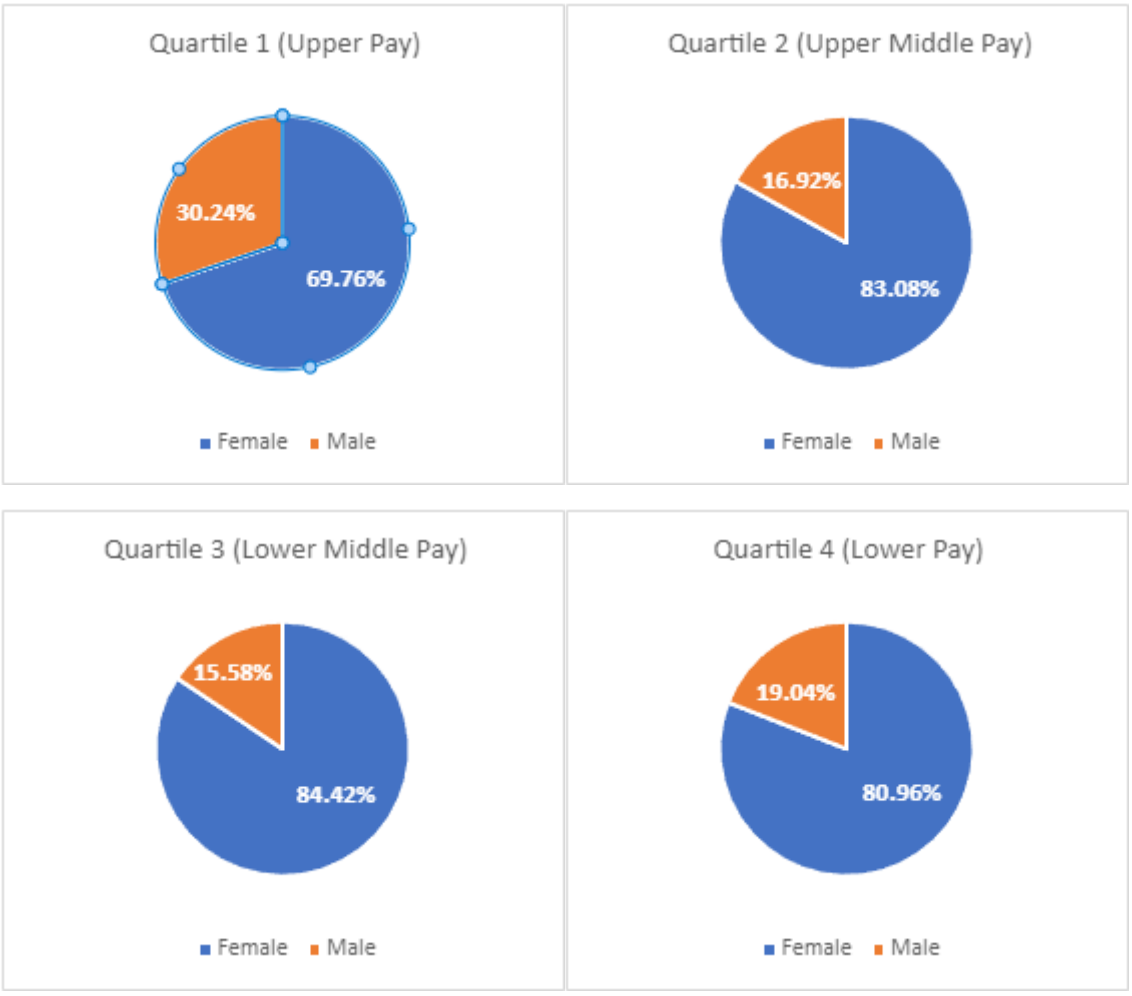
MFT Gender Pay Gap Data 2022

MFT's 2022 Gender Pay Gap data for the national reporting requirements is set out in Table 2 below and Figure 1 on page 4. Table 2 also compares the MFT Gender Pay Gap data from April 2021 to April 2022.

Table 2: MFT's Gender Pay Gap data 2022.

Reporting Year	MFT 2022	MFT 2021
Mean gender pay gap.	24.92%	24.17%
Median gender pay gap.	5.43%	12.25%
Mean bonus gender pay gap.	30.28%	30.94%
Median bonus gender pay gap.	50.00%	33.33%
Proportion of males and females receiving a bonus.	Male: 4.17% (246) Female: 0.57% (130)	Male: 4.55% (235) Female: 0.62% (123)
Proportion of males and females in each quartile band.	See Figure 1 below.	N/A

Figure 1 – MFT workforce profile of males and females in each quartile band.



Quartile band changes from 2021 to 2022:

- Quartile 1 (upper pay) – female increase of 1.77% from 2021
- Quartile 2 (upper middle pay) – female decrease of 2.52% from 2021
- Quartile 3 (lower middle pay) – female decrease of 2.25% from 2021
- Quartile 4 (lower pay) – female increase of 3.27% from 2021

Analysis of the MFT Gender Pay Gap data

- There has been a decrease in the Median Gender Pay Gap of -6.82% compared to the previous year. This suggests that women are earning more on median average than in 2021. This figure can be influenced by a few people moving to different pay points in the same band due to the nature of the calculation.

- The Mean Gender Pay Gap has seen a small increase of 0.75% compared to 2021. This calculation is influenced by a small number of highly paid male medical professionals and Very Senior Managers (VSM) which negatively effects the Gender Pay Gap percentage. An example of this is the average Male salary at MFT is £40,000 whereas some males are earning 7 times this amount. This increases the overall Mean Gender Pay Gap. For the Mean Gender Pay Gap to change significantly there would need to be proportionately more women in the top quartile of the workforce.

- For the purposes of Gender Pay Gap reporting, Clinical Excellence Awards (CEAs) local and national are considered as bonus pay. Only medical and dental consultants are eligible for CEAs. The Mean Bonus Gender Pay Gap has remained almost the same in 2022 from the previous year. There has been an increase in the Median Bonus Gender Pay Gap of 16.67%, this increase is due to one staff member moving into a different bonus bracket.

- There has been a slight increase in men (11) and women (7) receiving a CEA in 2022, but proportionately the likelihood of both genders receiving a bonus has slightly decreased. Men remain more likely than women to receive a CEA.

- Compared to MFT's overall workforce profile of 79.54% female and 20.48% male, the lower pay quartile (4) is roughly proportionate, the middle pay quartiles (2 and 3) show a slight over establishment of female staff, and the upper pay quartile (1) shows an over establishment of male staff. Compared to 2021's data for the quartiles of pay there has been an increase in the proportion of female staff in the upper pay and lower pay quartiles (1 and 4), and a decrease in the proportion of female staff in the upper middle pay and lower middle pay quartiles (2 and 3). This shows a trend to a workforce that is more representative of the workforce profile across all quartiles.

MFT additional workforce gender pay analysis

The majority of the NHS workforce is covered by a transparent and fair pay system called Agenda for Change (AfC), helping to ensure that staff receive the same pay for the same work. The staff groups that are not covered by AfC are doctors, dentists, and very senior managers (VSMs).

To better understand our Gender Pay Gap at MFT in addition to the national Gender Pay Gap reporting requirements we also investigate the impact of our medical and dental workforce on the Gender Pay Gap. This analysis is set out in Table 3 below.

Table 3: MFT Gender Pay Gap excluding the medical and dental workforce 2022

Workforce Group	MFT	MFT Excluding Medical & Dental Workforce
Mean gender pay gap.	24.92%	4.94%
Median gender pay gap.	5.43%	0%

The data in Table 3 shows that MFT's Gender Pay Gap is significantly reduced when the medical and dental workforce is removed from the calculations, with the Median Gender Pay Gap indicating no pay gap between genders.

Previous year's analysis has shown that a key driver in the medical and dental workforce that increases MFT's Gender Pay Gap is the proportion of male consultants. MFT therefore also monitors the gender profile of our consultant workforce, this can be seen in Table 4 below.

Table 4: MFT Consultant Workforce by Gender 2019-2022

Year	2019-2020		2020-2021		2021-2022	
	Actual	%	Actual	%	Actual	%
Male	743	60.0%	753	59.2%	840	58%
Female	495	40.0%	521	40.8%	607	42%

This data shows that although the proportion of male staff in consultant posts is significantly higher than the proportion of male staff in the general workforce profile (20.48%), there is a slow trend increasing the proportion of female consultants in the workforce.

MFT response to Gender Pay Gap data 2022

In 2022 MFT's Gender Pay Gap data has shown small changes when compared to the 2021 data. A key underlying driver to the MFT Gender Pay Gap remains that there are more males in the upper pay quartile, particularly amongst the medical and dental workforce. To narrow MFT's Gender Pay Gap requires increasing the proportion of female staff in the upper pay quartile, particularly female consultants, to reflect the MFT workforce gender profile. This year there has been an increase in female staff in the upper pay quartile. This continues the previous trend that the number of females in the upper pay quartiles is progressively improving each year, which will support in narrowing MFT's Gender Pay Gap.

MFT applies the national NHS pay frameworks of Agenda for Change (AfC) and conditions for medical and dental staff. This means that job descriptions are evaluated using the national job evaluation system to determine appropriate pay bandings and assure equal pay for equal roles. This system reduces the risk of any equal pay issues arising.

MFT's action plan to address the findings of the Gender Pay Gap Report 2022 are outlined in Table 5 below.

Table 5: MFT Gender Pay Gap actions 2022

Action	By when	Responsible Team
Monitor the Gender Pay Gap data to ensure that the organisation is taking appropriate action to reduce the Gender Pay Gap.	Quarterly	Equality, Diversity and Inclusion Team, and Group Equality Diversity and Human Rights Committee
Enact the MFT People Plan, which provides opportunity to take action to increase the gender diversity at the Trust. (This includes an inclusive recruitment framework, succession planning and talent management.)	December 2023	Human Resources
Track the process and impact of the local Clinical Excellence Awards (CEAs) to ensure that the awards are accessible and open to all consultants.	On reinstatement of local CEAs	Medical Workforce Team

Encourage and support consultant applications to the national Clinical Excellence Awards.	Ongoing	Medical Workforce Team