NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 14th November 2022

(PUBLIC)

Conference Rooms 1, 2 and Lounge
Citylabs 1.0

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Mike Deegan (MD)	Group Chief Executive
	Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Julia Bridgewater (JB)	Group Executive Director / SRO Hive programme
	Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	David Furnival (DF)	Group Chief Operating Officer
	Luke Georghiou (LG)	Group Non-Executive Director
	Angela Adimora (AA)	Group Non-Executive Director
	Chris McLoughlin (CM)	Group Non-Executive Director
	Jane Eddleston (JE)	Joint Group Medical Director
	Mrs Gill Heaton (GH)	Group Deputy Chief Executive
	Mr Gaurav Batra (GB)	Group Non-Executive Director
	Mr Darren Banks (DB)	Group Director of Strategy
	Toli Onon (TO)	Joint Group Medical Director
	Cheryl Lenney (CL)	Group Chief Nurse
In attendance:	Mr N Gomm (NGo)	Director of Corporate Services/ Trust Board Secretary

256/22 Apologies for Absence

Apologies were received from Barry Clare and Nic Gower.

257/22 Declarations of Interest

There were no declarations of interest.

258/22 Minutes of the Board of Director's meeting held on 12th September 2022

The minutes of the Board of Directors' (Board) meeting held on the 12th September 2022 were approved. There had been no further questions from Non-Executive Directors regarding the Well Led self-assessment.

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

259/22 Patient Story

CL introduced a film which described the experience of the partner of a woman who sadly passed away following treatment for cancer at Wythenshawe Hospital.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the patient story.	n/a	n/a	n/a

260/22 Matters Arising

There were no matters arising.

261/22 Group Chairman's Report

KC provided an overview of items to note from the previous two months.

Following MD's decision to stand down from his role, KC explained that an international recruitment process had taken place and Mark Cubbon, NHS England's (NHSE) Chief Delivery Officer, had been appointed.

A recruitment process is underway for two new Non-Executive Directors to replace Barry Clare and Sue Bailey. The Council of Governors will receive an update on progress at their meeting on the 23rd November. KC thanked Barry Clare and Sue Bailey for their contribution to MFTR.

Following the appointment of new Governors at the Annual Members' meeting, KC thanked Ann Kerrigan, Lisa Watson, John Cooper, Rachel Koutsavakis, Shruti Garg, James Wilson and Margaret Clarke, for their contribution to MFT during their tenures as Governors.

KC explained that she had initiated a review of Board Governance Structures and processes and that the annual Terms of Reference review for Scrutiny Committees would be delayed until March 2023 to take into account any outputs from the review.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chairman's verbal report.	n/a	n/a	n/a

262/22 Group Chief Executive's Report

MD explained that GH would be leaving MFT in early 2023 and that JB would be taking her place as Group Deputy Chief Executive. DF has been appointed as Group Chief Operating Officer following a national recruitment process.

MD highlighted the success of the implementation of the Hive electronic patient record and the benefits it will bring. He described the operational pressures currently being faced by the Trust in both elective and non-elective care, and the challenging financial environment the Trust is working within.

NIHR Biomedical Research Centre, hosted by MFT and the University of Manchester, has been awarded £59.1m for the next five years. This will translate its discoveries into new treatments, diagnostic tests and medical technologies to improve patients' lives in Greater Manchester and beyond.

MD ended by thanking MFT staff for their dedication and professionalism.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chief Executive's verbal report.	n/a	n/a	n/a

263/22 Board Assurance Report

TO began by highlighting two elements of the Safety section of the Board Assurance report.

There have been 4 new Never events since July 2022. Each has been investigated and a common theme of a lack of adherence to LocSSIP processes has been identified. Hive will help address this as checklists in procedure documentation mean it will not be possible for the intervention to proceed unless all necessary LocSSIP steps are carried out.

Mortality indices data continue to show MFT in a positive light but TO noted that there may be a dip over the Hive implementation period due to its effect on clinical coding and thereby the impact on standardised mortality when not all co-morbidities are documented. She stressed that this would not be a reflection of a reduction in the safety of services, merely a data issue; but the mortality and incident review processes providing learning from deaths would continue and provide that assurance.

In response to a question from KC regarding the Quality and Performance Scrutiny Committee's (QPSC) oversight of Never Events, TO confirmed that they will be discussed at the December meeting and mortality by Site will also be scrutinised at the Learning from Deaths committee. The learning from the events has been shared with the patient safety specialists in each Hospital/MCS/LCO.

CL introduced the patient experience section, noting that the maternity metrics would be covered in her report later on in the meeting. There has been a dip in Friands and Family Test (FFT) responses since May due to an issue with the handheld devices and the impact of the implementation of Hive.

In response to a question from TR regarding FFT, CL confirmed that all patients were encouraged to complete them using handheld devices or through completion of a FFT card. She recognised, however, that during especially busy times, staff may not remember to remind patients. FFT isn't the only way feedback is sought from patients – 'What matters to me' responses, PALS and Complaints, and national survey results are also analysed to identify where improvements can be made.

DF explained that he would cover the Operational Excellence metrics within the Board Assurance Report would be covered in his item later on the agenda.

PB introduced the Workforce metrics and drew attention to current absence rates – c.10% of which are due to Covid. From a mandatory training perspective, there is a current focus on increasing uptake of Level 2 courses in addition to improving non-medical appraisal rates.

AA confirmed that the issue of non-medical appraisal was on the agenda of the next Human Resources Scrutiny Committee (HRSC).

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

264/22 Update on Hive Programme

JB provided an update on the Hive programme.

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. 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.

Following the cessation of the command centre structures, the programme has 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. The stabilisation phase will run from October 22 to March 23 following which there will be a transition to Business as Usual.

Since Go Live, activity through the Hive system has included:

- 265,00 + outpatient contacts
- 70,123 emergency attendances
- 2,200 births
- 2,316,886 laboratory tests
- 170,680 imaging studies
- 26 transplants

Robust external assurance arrangements remain in place with Deloitte providing regular gateway reviews. The final Gateway review (Gateway 5) will take place in late 2022 and early 2023 and will focus on stabilisation success, optimisation and benefits realisation.

Hive risks will be presented at the next Group Risk Oversight Committee with recommendations to downgrade all but the patient safety one.

The MyMFT app has been a great success with over 60,000 patients now signed up to the service with over 200,000 log ins. Patients can see their appointments, review their Imaging and laboratory results with this new mobile app and web portal. Moving forward the functionality will be expanded with some trials underway currently where patients can book appointments, attend online consultations, message their medical team and take greater control of their health.

JB thanked all staff and the Executive Director team for their support throughout the Go Live period and beyond.

KC explained that, on BC's departure from the Trust, GB would take over as Chair of the Electronic Patient Record Scrutiny Committee (EPRSC).

CL commended the huge clinical engagement which had supported the programme with clinical teams now actively considering the benefits which Hive can bring to enable them to work more effectively and efficiently. PB noted that Staff Side had commented on how the programme had been very well run.

CM explained that, on Senior Leadership Walk Rounds, many staff had commented positively about Hive and the benefits it brings.

KC thanked JB for her leadership of the programme.

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

265/22 Update on the Trust's operational performance

Board of Directors' self-certification for elective recovery

DF introduced the report which sought Board ratification of the Trusts responses to questions raised by NHSE to all Trusts with regard to the elective recovery programme.

All GM Trusts are working collaboratively to address the current elective challenge. Some of the questions from NHSE are about specific issues which would not normally be considered in detail at QPSC or the Board of Directors but the QPSC on the 7th December 2022 would look in detail at all matters raised by NHSE.

KC noted that this action from NHSE indicated the pressures on the NHS up and down the country.

Board Decision:	Action	Responsible officer	Completion date
The Board ratified the Charman's and Group Chief Executive's self-certification of compliance with NHS England's elective recovery statements.	None	n/a	n/a

General Update, Performance Standards and Recovery Programme

DF presented the report which provided an update on the Trust's current operational performance as the NHS recovers from the legacy of the pandemic.

Hospitals have continued to be challenged across urgent care pathways throughout Q2 and during October the pressures escalated across the whole of Greater Manchester (GM). MFT was directly affected, to a position where the Adult acute sites were in heightened escalation when reviewed against the GM Urgent and Emergency Care escalation framework. As a result, on 19th October MFT escalated to a command-and-control structure utilising the principles of a 'Business Continuity' incident, involving twice daily escalation meetings chaired by the Group Chief Operating Officer with senior representatives from all Sites.

MFT stepped down from the Group wide command and control arrangements on the 28th October, following a progressive de-escalation of pressures over the period. Sites retained their local escalation procedures with support via the normal on-call arrangements.

Winter funding, supporting implementation of winter wards, additional discharge to assess capacity and acceleration of virtual ward expansion, was approved across the locality in September and due to the pressures, several schemes were expedited in October. In addition, there was system escalation through GM and support provided with out of area delays and mental health assessments.

The emergency pressures have challenged the MFT elective programme resulting in an increased number of elective cancellations. To help mitigate this risk through winter, plans for the use of Trafford have been accelerated, supporting the transfer of activity from MRI, St Mary's, and Wythenshawe from November. This will also support the hospitals focused efforts on reducing the cohort of patients waiting 78+ weeks, alongside the focus on theatre and outpatient productivity. MFT is working with regional and national colleagues as part of the national mutual aid programme to identify independent sector and NHS capacity to treat the 2,135 patients, flagged in the MFT plan as needing to be treated elsewhere due to the capacity constraints.

Cancer has continued to be a priority area with Group Executive oversight to focus on reducing the backlog of patients waiting over 62 days for treatment. Additional capacity has been sourced for those tumour sites that continue to have high volumes of referrals, namely Head & Neck, OMFS, Breast and Skin.

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

In response to a question from TK regarding potential harm to patients, JE explained that any delay in a cancer pathway brings with it potential harm and that it is more likely in lung and lower GI cancers due to the speed of cancer growth in these. Both lung and lower GI cancer are subject to screening programmes. There is a 104 day harm review for all patients on waiting lists and FIT tests are used to assess whether patients require treatment or not.

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

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

CL introduced the report which provided an update on the Infection Prevention and Control (IPC) responses to transmissible infections.

The current R-rate for Covid within the Northwest of England is currently 1.1-1.3 and over the four weeks before the Board meeting there has been an increase in Hospital Onset Covid-19 infections and outbreak numbers.

Since April 2022 4 MRSA bacteraemia have occurred, the cases were alerted in WTWA, NMGH, MRI and RMCH. MFT are currently under the year-to-date threshold for cases of Gram Negative bacteraemia infections. MRI and WTWA have the highest numbers of Clostridium Difficile cases currently. MFT has reported 26 Vancomycin Resistant Enterococcus (VRE) bacteraemia so far in 2022/23. Year to date figures highlight there has been an increase in acquisition of Carbapenamase-producing Enterobacterales (CPE) across MFT with MRI and WTWA accounting for 89% of acquisitions. In all these cases, root cause analyses are undertaken with themes identified and lessons learned to prevent further infections.

From 12th September to 23rd October 2022, MFT clinics have administered 5750 COVID vaccines and from 1st October to 23rd October 2022 MFT clinics have administered 4177 Flu vaccines. This is a slower start than planned for and a wide-scale communications campaign will be launched in the next few weeks.

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

266/22 Group Chief Finance Officer's Report Month 6

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

To September 2022, the Trust has delivered a Year To Date (YTD) deficit of £18.3m against a planned YTD breakeven position. In order to recover the YTD position, it is essential that work on delivery of WRP schemes is given the highest priority and focus across the entire organisation.

In September 2022, total expenditure was £217.2m. This reflects an increase of £16.9m compared to the August figure of £200.3m. This increase was against pay and was due to the AfC pay settlement, including arrears at a cost of £17.6m. Agency pay costs fell £0.7m in September accounting for most of the remaining movement. Income rose by £18.0m with the pay settlement of £17.6m responsible for the majority with favourable increases against Genomics, R&D and E&T income accounting for the balance. Non-pay expenditure was broadly the same as it was in both July and August.

As at 30th September 2022, the Trust had a cash balance of £211m. The cash balance continues to reduce from the 21/22 year-end position, largely due to payments for capital expenditure incurred in the previous year but not settled at the year end. The cash balance at the end of September was higher than forecast by £11m, this was primarily due to lower than forecast cash outflows in relation to current year capital expenditure and working capital differences in relation to delayed receipts for pay award funding and drugs and devices income not included in the cash forecast.

For the period up to 30th September 2022, £38.4m of GM capital envelope expenditure was incurred against the original plan of £31.0m, an overspend of £7.4m. The overspend is primarily due to £13.1m overspend on Hive partially offset by underspends of £1.5m on the IT Disaggregation scheme (due to the impact of NCA outage), £2.0m for two schemes at Trafford General Hospital (Theatres and Power Upgrades) and £0.9m on Project RED. All delayed schemes are expected to recover by year end. The £13.1m overspend on Hive against the GM envelope plan is partially offset by the £9.3m underspend on Hive PDC spend, with the remaining £3.8m overspend due to unbudgeted service provider costs. For the full year, there is no forecast overspend assuming the £15m PDC funding is secured.

JEh explained that NHSE had produced a protocol regarding changes to year-end forecasts and this would be discussed at the next Finance and Digital Scrutiny Committee (FDSC) meeting.

TR explained that all Trusts were working within a difficult financial context currently and noted that MFT's position was relatively positive.

KC confirmed that the FDSC was closely scrutinising the emerging financial challenges.

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

267/22 MFT's Winter Plan

DF presented the report which provided an overview of the Trust's plans for the 2022/23 winter period. The aim of the plans is to ensure that patients are kept safe through the delivery of effective care, as well as maintaining service delivery and reducing length of stay by minimising delays in discharge. The plan also focuses on supporting staff retention and well-being over this period. The plan has been developed in collaboration with system partners.

Each of MFT's Hospitals/MCSs/LCOs, have completed a detailed winter plan. These include a range of initiatives focused on the areas of bed and ward capacity, service enhancements and changes, patient flow and discharge management, communication and working with partners and workforce and staff wellbeing. Winter funding has been granted to support delivery of additional bed capacity (one ward per site), increased virtual ward capacity, and control room support to expedite flow out of hospital. In addition, MFT is maximising the use of Trafford to protect elective capacity supporting the transfer of activity from MRI, St Mary's and Wythenshawe from November.

A number of risks have been identified and mitigated as part of the delivery of the plan, which is overseen by Group Chief Operating Officer, with reporting through MFT Operational Excellence Board. The risks cover the following areas: external partners; elective activity; performance; and staffing.

In response to a question from KC asking whether it was realistic for recruitment of doctors to be part of RMEH's plans, DF explained it was as the recruitment had been planned for a while and was already underway.

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

268/22 Update on strategic developments

DB presented the report which provided an update on strategic issues of relevance to MFT. He began by noting the appointment of Steve Barclay as the new Secretary of Health and Social Care and the make-up of the new DHSC team.

In September 2022, the then Secretary of State, Terese Coffey, described the next steps that the government planned to take in 'Our plan for patients'. The approach described was to trust and empower the NHS to deliver, with a relentless focus on measures that affect most people's experiences of the NHS and social care. Four key areas were identified as priorities for action: ambulances, backlogs, care, doctors and dentists. The plan also reiterated that the Government would be honouring manifesto commitments to build hospitals and recruit clinicians and fix adult social care.

In future, NHS trusts will have to receive Cabinet Office approval for any clinical and non-clinical spending over £10m. This is part of NHSE's wider aim for greater central management and oversight of local commercial operations. It also fits with wider government aim for greater spending restraint. NHS England has also issued new draft guidance on how it intends to use its enforcement powers – now extended to ICBs.

The Greater Manchester Integrated Care Partnership has now agreed terms of reference and membership. It met for the first time on 28 October and will meet quarterly thereafter. The ICP brings together the ICB with the ten local authorities and also includes representatives from the GM Combined Authority, Healthwatch, Public Health, Adult Social Services, Children's Services, LA Chief Executive, GMCA Chief Executive, Primary Care (GP, dentist, pharmacist, and optician), Health Innovation Manchester, Trade Union, voluntary sector, housing and Work and Skills. The Target Operating Model for Greater Manchester ICB which will clarify which functions sit at ICB level and which are to be devolved to place, is not yet finalised.

Following a break to enable teams to focus on HIVE implementation, the work to develop single services is re-starting. Through this work, services delivered across MRI, WTWA and NMGH are being brought together under a single management and leadership structure in order to better facilitate the achievement the benefits of the Single Hospital Service. Single service operating models have now been agreed for cardiac, head & neck, GI medicine, orthopaedics, breast and infectious diseases. A programme of work to implement the new arrangements is being developed.

NHS England partially approved the business case for the expansion of the Community Diagnostic Centre which was developed in partnership with system partners and submitted in July. Funding to extend Withington Community Hospital which would include a purpose□built endoscopy suite was approved and the initial programme of work would see this completed by the end of 2024/25.
MFT has been successful in a bid for capital funding to support the development of the National Breast Imaging Academy at Wythenshawe Hospital. The MFT Charity, along with Prevent Breast Cancer – an independent charity based at Wythenshawe – is currently fundraising for the development of a new building to help train the breast imaging workforce of the future. This award will fund around a quarter of the development and will help to create additional training space and reduce the fundraising target for the charities.

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

269/22 Report on annual planning (2023 / 2024)

DB presented the report which provided an update on the annual planning process for 2023/24.

National guidance has yet to be received but the expectation is that the priorities for 2023/24 will be around achieving access, cancer performance, A&E and ambulance targets. MFT's planning will focus on these areas.

DB proposed that MFT's current vision and strategic aims still reflect the goals of the organisation and should therefore be used as the basis for developing plans for 2023/24.

No timeline has been received at this point for the national planning process but the assumption is that MFT's plan will got to the Council of Governors in February, prior to approval at April's Board of Directors meeting.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report and agreed that the current vision and strategic aims should be the basis for planning for 2023/24.	None	n/a	n/a

270/22 MFT Digital Strategy

JEh presented the report which sought approval of the MFT Digital Strategy (2022-2027).

The strategy sets out a long-term ambition to provide world class clinically safe healthcare for patients/service users and the wider population of GM using advanced digital technology, near/real-time data and innovation. The strategy's vision builds upon the implementation of our EPR. The Trust will connect all care settings and departments with the digital world, creating a data-driven organisation.

The strategy is underpinned by five strategic outcomes:

- Empowered residents, patients/service users and carers
- Consistent delivery of safe high-quality proactive care
- Optimised efficiency and productivity
- Integrated working and joined-up care
- Enhanced efficiency and opportunities within research & innovation

The Digital Strategy is supported by our five-year digital roadmap which sets out the journey of digital transformation through three phases of delivery. This roadmap will evolve throughout the lifetime of the strategy and will set out how patients/service users, clinicians and staff experiences will be enhanced as digital capabilities are deployed and embedded.

KC commended the quality of work which had gone into producing the strategy**.**

Board Decision:	Action	Responsible officer	Completion date
The Board approved the MFT Digital Strategy	n/a	n/a	n/a

271/22 Overarching Research and Innovation Annual Report

JE introduced the Research and Innovation (R & I) Annual report which detailed the progress made from April 2021 to March 2022.

She explained that it had been a very successful year for the R & I team with an increase in funding from the BRC and the CRN. The team has also been accredited as one of the four Health Foundation National Innovation Hubs. This will support adoption and adaptation of novel, proven technologies to improve the health outcomes of the diverse population we serve. The introduction of the Research Van means that research opportunities will now become more accessible to groups at risk of exclusion.

Over the year, 17916 participants were recruited to research studies and 270 new studies were initiated. MFT is the 3rd highest recruiter to research for commercial purposes nationally. JEh noted the case studies on p.21 of the report, namely:

- Testing for Lynch syndrome has been rolled out nationally using the Manchester model
- Avoiding antibiotic-induced hearing loss in babies – Hearing Health
- ManTRa-Diagnostics: taking radiotherapy research into the clinic – Cancer: Advanced Radiotherapy
- Building Relationships with the LGBTQIA+ Community in Greater Manchester – Cancer: PED
- Recruiting underserved populations to an asthma diagnosis study – Respiratory
- Leading innovation with MR-linac technology – Cancer: Advanced Radiotherapy

KC commended the success of the team and thanked all involved for their contribution to the work of MFT.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report and celebrated the achievements of the R & I team.	None	n/a	n/a

272/22 Cervical Screening Provider Lead Annual Report

TO presented the report which covered the NHS cervical screening programme (NHSCSP) activities undertaken by MFT during the period 01 April 2021 to 31 March 2022. The three elements of the cervical screening service provided by the Trust are cervical screening, which includes cytology and virology testing, histology, and colposcopy.

The virology department has achieved successful UKAS reaccreditation in December 2021 and continuously met a 3-day turnaround time despite pandemic related reduced capacity on the analysers and rapid increase in HPV workload during recovery of the screening programme.

Recruitment for the validation of self-sampling for HPV known as the HPValidate study commenced July 2021 and is nearly complete, with results to be reported to NHSE by the end of 2022. Collaborative study with The University of Manchester regarding the validation of urine samples for primary screening is expected to complete at the end of 2023.

Several senior members of the MFT cytology and virology staff are members of prominent national committees relating to cervical screening and have actively contributed towards national NHSCSP publications in this timeframe.

Significant progress has been made in consolidating and updating the framework of colposcopy guidelines and SOPs across the Trust; harmonising key clinical guidance and patient information for ORC and NMGH.

There has been a successful closure of 40 Quality Assurance (QA) recommendations and full recovery of the backlog of colposcopy patients caused by pandemic and gynaecology service reconfiguration in October 2020 was completed in February 2022.

Some key challenges to the service remain, and were outlined in the report, but TO confirmed that the information was not outdated and the histology service and turnaround times had improved considerably over recent times. The vision for the current financial year includes clearing any outstanding quality improvement recommendations and building a resilient and high quality service for the future.

KC thanked TO for the report but commented that it felt like a historical report based on further based on the progress made this year.

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

273/22 Q2 complaints report (2022 / 2023)

CL introduced the report which related to PALS and Complaints activity across MFT for the period July – September 2022/23.

There has been an increase in both PALS enquiries and complaints when compared to the same period in 2021. Complaints regarding in-patient services have seen a particular increase. Wythenshawe Hospital and Manchester Royal Infirmary have seen the highest number of concerns, mainly with regard to people's experience of the Emergency Department and discharge delays.

During this period, 53 (11%) of the complaints investigated and responded to were fully upheld, 357 (73%) were partially upheld and 62 (12.6%) were not upheld.

In response to the focus on 'HIVE Go LIVE', a decision was made to stand down July, August, and September's MFT Complaints Review Scrutiny Group (CRSG). Resumption of the meetings is planned for Q3, 2022/23. However, since then the Group has developed some KPIs for their work and the group will now look at a number of complaints from the same area at the same time rather than just focussing on a single one. Each Hospital/ MCS/LCO also holds regular forums where themes, trends relating to complaints are discussed with focused actions agreed for improvement. Examples of improvements are included in the report

CL noted that the lack of closed cases from the Parliamentary Health Ombudsman was not an area MFT could influence as it was the Ombudsman's responsibility.

KC thanked CL for the report and stated that the included qualitative feedback was very helpful to see.

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

274/22 Maternity services update including Ockenden response

CL presented the report which provided an initial review of East Kent Maternity Review; an update on progress of Immediate and Essential Actions (IEAs) identified to ensure compliance with the Final Report of the Ockenden Review; and provided assurance to the Board of Directors on matters relating to patient safety within maternity services.

Saint Mary's Managed Clinical Service (SM MCS) continues to monitor progress against the 15 IEAs each month and report this to Saint Mary's Quality and Safety Committee (SM QSC) and QPSC. Currently compliance with the IEAs is 74%, which is an increase of 4% since reporting to the Board of Directors in September 2022. It is expected that all provider actions will be completed by December 2022. From December evidence of ongoing compliance for IEAs will also be discussed in detail at the Quality and Performance Scrutiny Committee (QPSC).

Regional Assurance visits across SM MCS regarding actions taken from the IEAs of the Emerging Ockenden report took place in August 2022. The feedback was positive, acknowledging full compliance with all 7 IEA's. The feedback also commented on the progress being made on the final Ockenden report 15 IEAs.

Between 1st August 2022 and 30th September 2022 there were 2843 births across Saint Mary's MCS. Saint Mary's MCS Maternity Division reported 1144 incidents during this period which is a reduction in the overall numbers of incidents reported since the previous Board report in September 2022. All incidents were reviewed through SM MCS governance processes and 1094 were validated as 'no harm', 45 were validated as 'slight harm' and five were validated a 'moderate harm or above'. The five moderate harm or above cases did not highlight any themes and there were no similar incidents within the preceding 12 months.

Since the relaunch of Maternity Incentive Scheme (MIS) Year 4 reporting in May 2022, Saint Mary's MCS have continued to work through the 10 Safety Actions and are currently compliant with all 10 safety actions as of end of October 2022. An updated version of MIS Year 4 was published in October 2022 and has changed the submission date of compliance from 5th January 2023 to 2nd February 2023 which does not impact on Saint Mary's compliance status. Evidence of compliance has been submitted and approved by Saint Mary's Quality and Safety Committee and submitted for approval to the Board of Directors in November 2022 against all Year 4 MIS Safety Actions.

As previously reported to the Board in September 2022, a review of the governance and reporting arrangements has been commissioned by the SM MCS leadership team in recognition of the volume of reporting required to assure the Board on maternity safety. Progress with current reporting mechanisms and accessibility of data is underway. A meeting has been held with SM MCS senior leadership team to provide an update with expected timeframe of improved reporting by January 2023. It is expected that the work will reduce repetition and provide assurance at divisional, hospital and board level and also to external bodies such as CQC, GMEC LMNS and NHS England.

Due to the success of the 'Saving Baby's Lives' initiative, the increase in the number of women visiting Saint Mary's has required a move to a larger venue.

As Board Maternity Safety Champion, CM commented that the governance surrounding maternity services felt robust and she visited all three maternity sites on a regular basis, following the footsteps of service users to understand better the experience of patients.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted: ▪ the initial key actions from East Kent Maternity Review ▪ the Immediate and Essential Actions from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust – the Ockenden Reports ▪ the work in place to ensure the safety of women and babies in Saint Mary's Managed Clinical Service (MCS)	None	n/a	n/a

▪ the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety ▪ the compliance of all 10 safety actions within MIS Year 4.			

275/22 Bi-annual Nursing and Midwifery 'Safer Staffing' report

CL presented the report which details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 20161 , and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance2 , published in October 2018.

It is a national requirement for the Board of Directors to receive this report bi-annually to comply with the CQC fundamental standards as outlined in the well-led framework. The previous report was received by the Board of Directors in March 2022. The report provides analysis of the Trust's Nursing, Midwifery and AHP workforce position at the end of September 2022.

Nationally there was a net increase of 26,403 (3.4%) registered nurses, midwives, and nurse associates reported in March 2022 compared with March 2021. Internationally recruited professionals accounted for 48% of all new NMC registrants. However, despite the number of registered nurses rising, the number of nurse vacancies in England has also risen.

The numbers accepting a place to study nursing or midwifery commencing 2022 has reduced by 9% compared with 2021, however, numbers are still 14% higher compared with 20194 . NHS England in collaboration with the NMC has commenced a programme of work focusing implementing evidence-based interventions to improve retention of nurses and midwives.

There continues to be national shortages in several AHP groups, and most professions have experienced a gradual reduction in overall numbers since January 2022. In addition, it is recognised that AHP services are experiencing increased demand. This is difficult to demonstrate in the absence of an AHP evidence-based safe staffing standard.

Since the previous Board of Directors report, Hive EPR system has been implemented. This has led to an extensive programme of training and offers opportunities for transformation of services and it is expected that it will lead to improvements to patient safety and experience. The system will provide valuable data and reports to enhance professional judgement and evidence-base to triangulate nursing, midwifery and AHP safe staffing data and decisions.

At the end of September 2022 there were 336.5wte (3.6%) registered nursing and midwifery vacancies across the Trust compared with 374.0wte (4.1%) in January 2022, an overall decrease in vacancies of 37.5wte (0.5%). During this time there has been an increase in funded establishment of 133wte. The AHP vacancy position was 100.87wte (5.46%).

The sickness rate at the end of September 2022 for registered nursing and midwifery staff was 7.0% and 10.3% for unregistered staff. This is a significant improvement from the sickness rate in January 2022, an overall reduction of 3.2% for qualified nursing and midwifery staff and 3.4% for unregistered staff. For AHPs there has been an increase from 3.24% in January 2022 to 5.10% in September 2022.

The improvement in nursing and midwifery vacancy position and sickness absence has supported an improvement in average fill rate against planned shifts for both registered nurses and midwives (89.5%) and unregistered staff (90.96%) since the last report.

There are currently 162 domestic nurses and midwives in the recruitment pipeline with confirmed start dates and a further 235 band 5 nurses and midwives expected to start before the end of March 2023. Between January and October 2022, 535 internationally recruited nurses and midwives have commenced work in the Trust. The Trust plans to recruit a further 155 international nurses and midwives by the end of March 2023.

The Trust's Safer Nursing & Midwifery Staffing Guidance (version 5) continues to inform the monitoring and escalation of nursing and midwifery staffing levels. Daily staffing huddles take place in hospitals/MCSs monitoring patient acuity and dependency, and staff attendance and allocation. A risk rating is calculated for each area. Staffing escalation above level 3 initiates a Director of Nursing workforce escalation meeting chaired by the Chief/Deputy Chief Nurse to review staffing and identify mitigating actions such as mutual aid between hospital/MCSs.

During the Hive Go Live implementation period in September 2022, a Chief Nurse Office Hive Command was established to provide system oversight of patient safety processes and risks throughout the go live period, monitoring of patient safety indicators, and safe staffing levels and approval of any deviation from processes in regard to safety. Corporate nursing teams were deployed to support clinical areas and provide additional reassurance to patients and relatives during the go live period.

A SNCT baseline census collection period was undertaken in March 2022 providing assurance that 79% of ward establishments are aligned to the SNCT recommended establishment. The remaining wards require further census data to validate the recommended establishment for these areas. The next SNCT census is scheduled for November 2022 and safe staffing reviews are being planned for the emergency departments (SNCT ED) and community services (CNSST).

Following the publication of the Final Ockenden Report one of the Immediate and Essential Actions concerning workforce stipulates that each maternity provider should have their midwifery establishment calculated utilising Birth Rate Plus (BR+) . A further review has been commissioned by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS) and is expected to commence Q3 2022/2023 that will consider the increased activity on the Wythenshawe site following support of East Cheshire Trust and provide an updated calculation of specialist midwives required on each maternity site.

TR commented that it was important that MFT has robust data so safe care can be evidenced.

CL noted that it feels like the acuity of patients has risen over the last year and this has put more demands on nurses' time. She recognised the need to continue to support staff whilst service pressures are as challenging as they are now and to respond to any issues they may have.

AA commented that blended roles may help with recruitment and retention. CL agreed and explained that nurses at MFT aren't restricted to 12 hour shifts and that flexibility also helps to attract staff**.**

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report.	n/a	n/a	n/a

276/22 Results of the National Cancer Patient Experience Survey (NCPES)

CL presented the report which provided an overview of MFT's results from the NCPES 2021. The survey involved 134 NHS Trusts, out of 107,412 people, 59,352 people responded to the survey, yielding an overall response rate of 55%. MFT's response rate was 48%.

CL summarised the results and explained that the QPSC had already scrutinised them. Results for tumour-specific groups are provided where eleven or more patients have responded. The results demonstrate a small number of responses for those in the younger age ranges, with most questions having none or limited responses from those under the age of 45. The survey results do not show the Ethnic diversity of patients that received the survey. However, with 85% of responders identified as white British, this points to the results as not being reflective of the diversity of recipients of care and treatment at MFT.

The results of the survey are being used to inform service developments and MFT's Cancer Strategy which is currently being developed.

Following further analysis of the results, a detailed action plan will be received and monitored from each tumour-specific team, including those groups where fewer responses were received, through the Cancer Quality and Experience Committee. Where common priorities exist across multiple teams these will be highlighted at the appropriate group and site cancer committees to ensure parity of provision.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report and the opportunity for improvements in patient experience.	n/a	n/a	n/a

277/22 National In-Patient Survey 2021

CL presented the report which presented MFT's results from the Adult National In-patient Survey 2021.

The Adult National In-Patient Survey (NIPS) is a CQC requirement in which feedback is obtained to aid improvement of local services for the benefit of patients and the public based on patient experience. The CQC use the results from this survey in their regulation, monitoring and inspection of NHS acute trusts in England. The results also contribute to the Trust's Quality and Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners.

Adult in-patients from Royal Manchester Eye Hospital, Saint Mary's Hospital and Trafford General Hospital will have been included in the patients invited to take part in the survey, and will be reflected in the overall MFT score, but the number of responses received was insufficient to generate a separate site report.
Nationally, the response rate for the Adult Inpatient Survey 2021 was 39%, this represents a reduced rate of 7% in comparison to the 2020 national rate of 46%. Likewise, the Trust's response rate was 33% (401 respondents), which also represents a reduced rate of 6% in comparison to the Trust's 2020 rate of 39%

For overall experience, the national highest scoring average was 9.4, with the lowest being 7.4. MFT scored 7.9, which is a reduction from the 8.2 the previous year.

The two highest scoring areas for the Trust were 'Respect and Dignity' with a score of 8.9 and 'Doctors' with a score of 8.6. Whilst highest scoring, both scores have fallen from the 2020 scores of 9.2 and 9.0 respectively. Of significance is the very low score for 'Feedback on the Quality of your Care' for the Trust, with a score of 1.9. Whilst this is a very low score, this score demonstrates a 0.5 increase compared to the 1.4 score received in 2020. The report presented these figures alongside those recorded by the highest and lowest scoring Trusts nationally.

The snapshot provided by the National Inpatient Survey results is triangulated with real-time feedback data from the Trust's 'What Matters to Me' (WMTM) Patient Experience Surveys, Friends, and Family Test (FFT) and Quality Care Round (QCR). MFT-wide and local improvement plans are being developed with specific focus on the notably low scores and worst performing areas as detailed within the report. CL pointed to the Action Plan in the appendix of the report which detailed actions being taken.

Board Decision:	Action	Responsible officer	Completion date
The Board of Directors noted the content of the report and supported the ongoing initiatives to deliver transformational improvement.	n/a	n/a	n/a

278/22 MFT EPRR core standards self-assessment (2022 / 2023)

DF presented the report which provided the Board of Directors with the MFT self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2022-23.

There are a total of 64 standards and, additionally, each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 2022 the 'deep dive' topic was evacuation and shelter, and the evaluation was undertaken against 13 specific core standards. These are all being considered during the review of the MFT Evacuation and Shelter Plan. Whilst important to undertake, the deep dive do not contribute towards the overall Trust compliance level.

Several overarching changes have been made to the 2022-23 EPRR Core Standard submission. This includes the addition of a new standard, and revisions or the addition of new evidence requirements to 43 of the 64 standards, preventing direct comparison with the 2021-22 submission. MFT has raised at Local Health Resilience Partnership the short turnaround for changes to Core Standards – received by hospitals in August 2022 with submissions due October 2022. This gave Trusts little time to absorb the new standards / reflect new evidence requests and demonstrate compliance, as the standards should reflect an annual position. MFT are working with partners in GM and NHSE to identify opportunities to improve the process for future submissions.

Based on MFT's self-assessment; 59 of 64 Core Standards were declared as 'fully compliant', resulting in MFT maintaining an overall EPRR assurance rating of 'Substantial' for 2022/2023.

Actions to address the partially compliant standards are in place and will be overseen by the MFT EPRR Committee to ensure delivery, with assurance to the Group Management Board via Committee minutes. Cascade of actions will be undertaken through the MFT EPRR governance structure to local hospital EPRR Forums.

The MFT self-assessment against the NHS England Core Standards for EPRR for the period of 2022-23 was reviewed at the October 2022 Quality and Performance Scrutiny Committee (QPSC). Following discussion, QPSC noted the MFT EPRR statement of compliance for 2022 – 2023 and recommended it to the Board of Directors for approval.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the Statement of Compliance and noted that assurance of delivery of actions would be through MFT's EPRR governance structure.	None	n/a	n/a

279/22 Board of Directors' Register of Interests

PB introduced the report which presented the Board's Register of Interests. The Register is available on the MFT website.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Register of Interests.	None	n/a	n/a

280/22 Annual Medical Revalidation and Statement of Compliance report

TO presented the report which described the progress of the Trust over the last financial year in the management of medical appraisal and revalidation. It has already been considered at HRSC.

At the end of the last appraisal year (31 March 2022), MFT had 2,217 doctors with a prescribed connection and an additional 95 dentists. 94.9% of connected doctors had an appraisal within the year. The Quality Assurance of the process is subject to ongoing review and appraisers are being trained or refreshed to ensure they all meet the required standards. Appraisers were rated as 'Very Good' or 'Good' by 97% of appraisees who submitted feedback. Appraisal rates for clinical fellows and short-term contract holders have increased to comparable levels with other medical staff.

The Trust has been instructed to submit a signed Statement of Compliance to NHS England for 2021/2022. This statement has been approved by HRSC.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report and ratified the HRSC approval of the Annual Statement of Compliance.	n/a	n/a	n/a

281/22 Board Assurance Framework

PB introduced the report which presented the risks which have the most potential to impede MFT's delivery of its strategic aims.

MFT's new Risk Management Framework and Strategy (RMFS) was approved by MFT's Board of Directors in May 2022. It includes a Risk Appetite Statement and ten principal risks. This necessitated a change to the format of the BAF to ensure it is aligned with the RMFS. The new format has been informed by discussions with Non-Executive Directors, Group Executive Directors and Internal Audit. It also reflects recommendations from Internal Audit's review of the BAF earlier this year. At their meeting in October 2022, the Audit Committee reviewed and supported the new format of the BAF.

The BAF will next be presented to the Board in March 2023. Prior to that, the principal risks will be discussed at the relevant Scrutiny Committees and the Group Risk Oversight Committee to maintain oversight of them between Board meetings.

Board Decision:	Action	Responsible officer	Completion date
The Board accepted the latest BAF.	None	n/a	n/a

282/22 Minutes of Board Sub-Committees held in August, September and October 2022

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

- EPR Scrutiny Committee held on 24th August 2022
- Quality and Performance Scrutiny Committee held on 5th October 2022
- Audit Committee held on 18th October 2022
- Human Resources Scrutiny Committee held on 24th October 2022
- Finance and Digital Scrutiny Committee held on 26th October 2022
- Group Risk Oversight Committee *(due to the implementation of Hive, the meeting scheduled on 19th September 2022 was stood down)*
- Charitable Funds Committee *(due to the implementation of Hive, the meeting scheduled on 28th September 2022 was stood down)*

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

283/22 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 9th January 2023 at 2:00pm.

284/22 Any Other Business

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 14th November 2022		
Action	Responsibility	Completion date

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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alfie Nelmes, Head of Information Services
Date of paper:	January 2023
Subject:	Board Assurance Report – November 2022
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board Assurance Report is produced on a bi-monthly basis to inform the Board of compliance against key local and national indicators as well as commenting on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the contents of the report.
Contact:	Name: Alfie Nelmes, Head of Information Services Tel: 0161 276 4878

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(November 2022)

1. Introduction

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

2. Overview

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

The established Accountability Oversight Framework (AOF) process reviews the performance for all MFT Hospitals / MCS and LCOs and is reported into MFT's Quality and Performance Scrutiny Committee.

It was agreed at the start of this financial year that the metrics within both the BAR and AOF, and the scoring logic for the AOF, would benefit from a full-scale review due to the endemic nature of COVID-19 prevalence and its impact on performance, and the need to ensure that domain metrics are aligned to national planning and performance guidance, and NHS Oversight Framework. These changes have now been made and are included.

The Group Chairman is currently undertaking a Board Governance review which will enhance the information coming to the Board of Directors and its Scrutiny Committees to strengthen assurance. As a result, the content and format of this report will change for the next Board of Directors meeting in March 2023.

3. Key Priority Areas

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

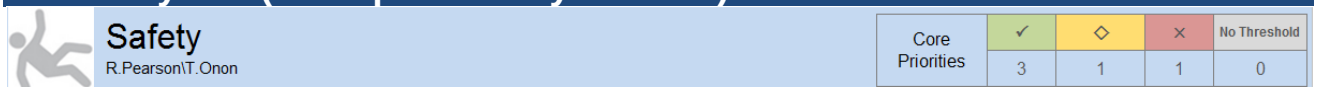
- Safety
- Patient Experience
- Operational Excellence
- Workforce & Leadership

Headline narratives provide context to the above key priority areas, stating current issues, identifying where progress is 'good', identifying future challenges and risks, and commenting on the latest developments around performance of the various indicators. The narrative is provided by the lead Director accountable for the individual priority areas. 'Guidance Notes' are also included to support the interpretation of the data presented each month.

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)



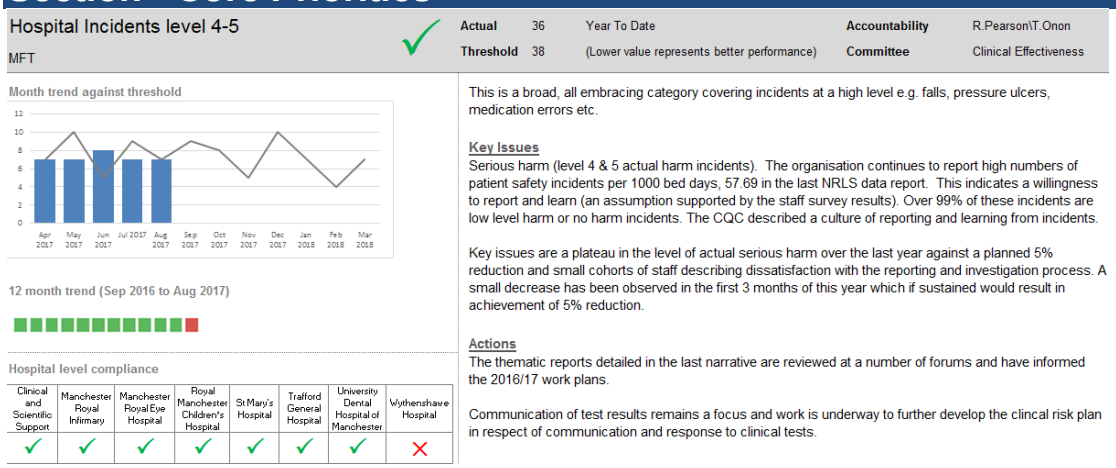
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

November 2022

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	4	0	9	1

Headline Narrative

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

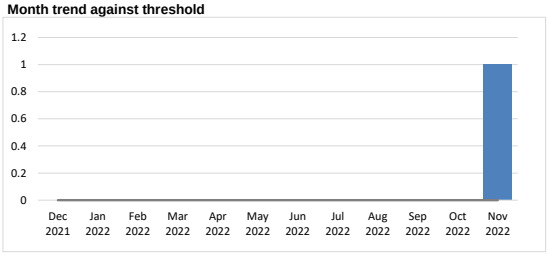
The Trust continues to identify Never Events within its incident profile, however, in relation to benchmarking, the Trust overall demonstrates performance the 'same' as other Trusts when Never Events are analysed as total events with statistical comparison to bed days (NHSI OBIEE NRLS StEIS (26 Mar 2022)). A Trust-Wide risk is being managed strategically which focuses on the optimisation of human/system interaction in the way to understand, respond to and improve patient safety, the proportion of reported patient safety incidents resulting in harm remains consistent with that of other Trusts. The national Patient Safety Incident Response Framework has now been launched and the Trust has developed an implementation plan to support the transformation in the approach to patient safety required.

Safety - Core Priorities

Mortality Reviews - Grade 3 (Review Date) ✕

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

Month trend against threshold



Hospital level compliance

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

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

Key Issues

All deaths where the outcome is judged as probably or definitely avoidable are subject to further evaluation aligned to the Trust's Patient Safety Insight, Learning and Response Policy. The Structured Judgement review process is used proactively where potential learning is identified through complaints, incident management or medical examiner processes. Learning is routinely considered and contextualised through the Trust's safety oversight system. Key issues identified for further evaluation have included the recognition and management of the deteriorating patient and the effective management of Multidisciplinary Team meetings. The mortality portal functionality was affected by the implementation of HIVE, and remains an issue. All incidents with a validated catastrophic outcome (death) are subject to a structured judgement review, as are all unexpected deaths where an incident is suspected. All neonatal and paediatric deaths are subject to a specifcic mortality review process.

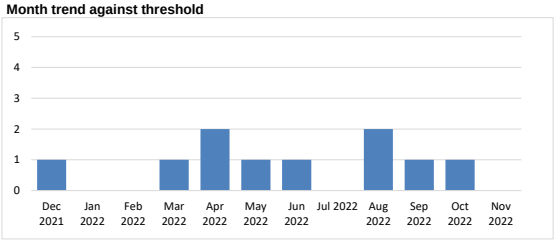
Actions

Optimising transferable high impact learning across MFT remains a key priority for 2022/23. The Safety Oversight System allows for continual triangulation of intelligence. Safety II, learning from when things have gone well, and translating that into the mortality review process is also a key focus. The Annual Learning From Deaths report will be presented to the Group Quality and Safety Committee in February 2023 (The December meeting was stood down), delayed due to the restructuring of agendas during HIVE implementation, it will be presented alongside a refreshed Learning from Deaths Policy. There have been issues identified with the functioning of the mortality portal post HIVE implementation, which is requiring focused action to ensure that the governance of the SJR process and the capture of learning is maintained.

Never Events

Actual	8	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally. There continues to be key themes within the Never Events (and associated near-miss incidents) in relation to communication, the use of checklists, the availability and presentation of guidance, the ergonomics of clinical environment design, the difference between 'work as imagined' (policy) and 'work as done' (clinical practice) and the nature and quality of assurance processes. A further Never Event was reported in September 2022 (SMMCS) and October 2022 (WTWA).

Actions

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

All incidents relating to prevented never events are subject to a high impact learning assessment to increase opportunities for learning. The Trust has a detailed action plan in place relating to the assuring the enduring standards within national alerts (including Never Events). The Never Events reported in September and October involved bedside interventional procedures (wrong patient and wrong site) and related to the lack of recognition of the procedures requiring the application of safety standards. This is a key focus of improvement actions.
The Trust has a patient safety plan (2022/23) which is based on the implementation of the national Patient Safety Incident Response Framework and importantly what we know through our safety oversight system are priority areas for improvement.

> Board Assurance

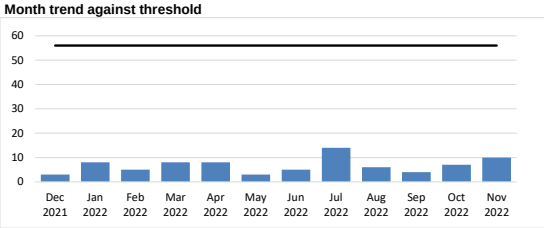
November 2022

Hospital Incident level 4-5

✗

Actual	57	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	56	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	✓
5	11	0	6	1	0	26	8	0

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

Key Issues

There was special cause variation noted with incident reporting across the Trust with a significant increase in October and the number remained above the upper confidence level in November. This increase is driven by the reporting of near miss, low and no harm incidents related to emergent issues with the HIVE system. During October and continuing in November the Trust remained in the HIVE stabilisation phase and the command and control infrastructure was utilised to ensure contemporaneous and proportionate escalation of emergent risk. At a group wide level, 0.12% of incidents were graded as level 4/5 harm between December 2021 and November 2022 (1.15% of incidents being notifiable (3 and above)).

Actions

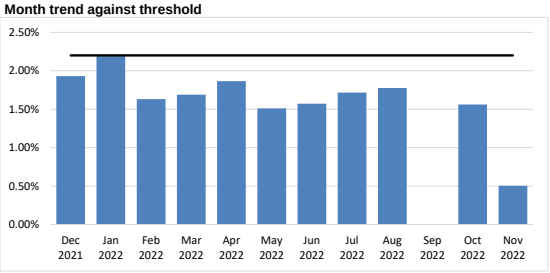
Routine examination of themes and trends through the safety oversight system which has led to additional high impact learning/assurance work in relation to a number of areas including:
- medicines safety
- recognition of bedside invasive procedures
- impact of waiting on patient safety (Urgent and emergency care, PTL, cancer pathways etc)
- recognition and management of deteriorating patients
- the care and treatment of patients admitted whose mental health is poor
- the differential between work as done and work as imagined
- the impact of inequality on patient safety
- patient transfer and discharge

Crude Mortality

✓

Actual	1.59%	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✓	✓	✓	✓	✗	✗	NA
11.55%	2.03%	0.22%	0.29%	0.20%	0.00%	2.81%	3.20%	NA

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

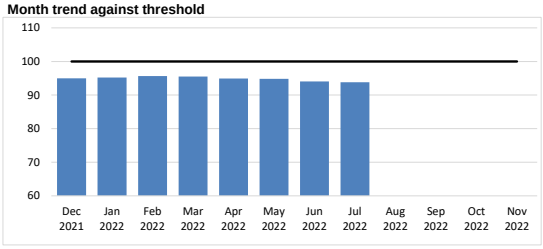
Key Issues

Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment. The effective benchmarking of this data is currently under review, and sites where the threshold is exceeded actively interrogate the data to explore meaningful trends. There is a Trust-wide focus on understanding mortality data in a more sophisticated way through the use of the HED system, enabling scrutiny of a wider range of mortality indicators. The variation in crude mortality will be subject to review at the Learning From Deaths Committee. The areas of non-compliance will be a focus for discussion and assurance at the Group Learning from Deaths Committee.

Summary Hospital-level Mortality Indicator (SHMI) ✓

Actual	93.8	R12m (Aug 21 to Jul 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

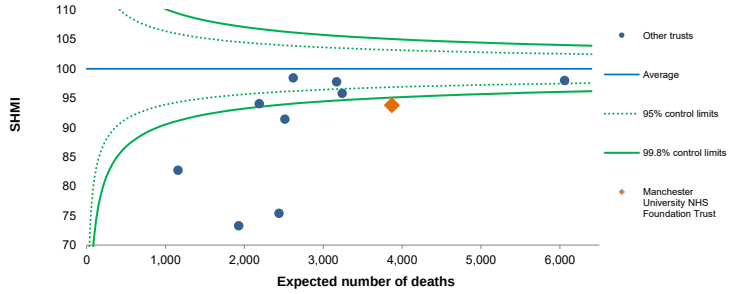
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	✓	NA
NA	95.7	NA	NA	NA	NA	88.6	99.4	NA

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

Progress

Performance across the Trust is well within the expected range. The SHMI at NMGHs currently under review along with the crude mortality rate. RMCH have undertaken a review of their SHMI, and feedback has been provided nationally in relation to the utility of that measure with paediatric, neonatal and maternity patients.

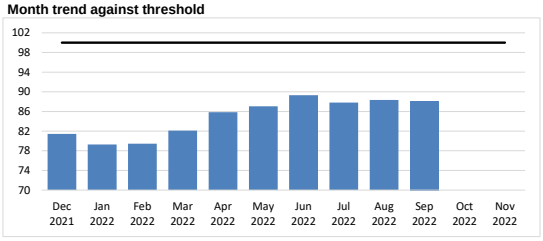
Summary Hospital-level Mortality Indicator for the Shelford Group, Aug 21 - Jul 22



Hospital Standardised Mortality Ratio (HSMR) ✓

Actual	88.1	R12m (Oct 21 to Sep 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	◇	NA
NA	79.7	NA	NA	NA	NA	86.7	103.6	NA

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

HSMR is a metric designed for adult services.

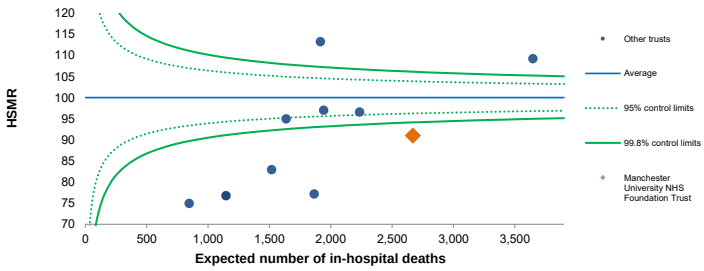
HSMR is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

Hospital Standardised Mortality Ratio for the Shelford Group,Oct 2021 - Sep 2022



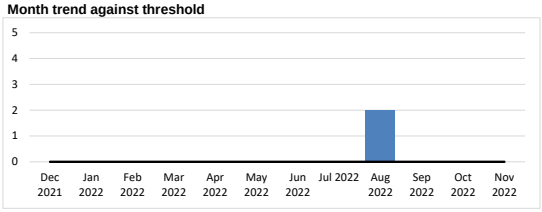
> Board Assurance

November 2022

HM Coroner Prevention of Future Deaths Report

Actual	2	R12m (Dec 21 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

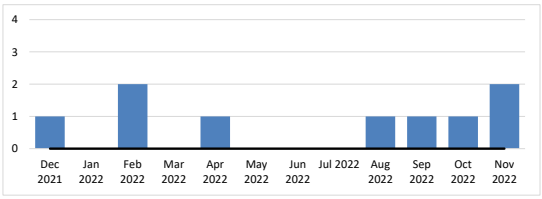
Progress

There were two PFD notifications directed to MFT and responded to during the period 1 August to the present time. One, responded to by the Trust on 3rd October 2022, did not relate directly to patient safety. The second, responded to by the Trust on the 29th October related to a patient death at NMGH in July 2019, whilst under the management of the NCA. The PFD notification was not received until August 2022. The Trust provided assurance in relation to the implementation of the Trust-wide Sepsis policy and the harmonisation of clinical practice across the Trust, directly supported by the implementation of HIVE. Assurance was also provided in relation to mandatory training, trust induction training (particularly for locum and temporary staff).

MRSA Attributable bacteraemia

Actual	6	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Progress

A total of 16 cases have been reported so far in 2022/2023: 6 of which were trust-attributable. There is a zero tolerance approach to trust attributable MRSA bacteraemia. There were 2 trust-attributable MRSA cases reported for November 2022 (MRI). Thematic analysis of the RCA's undertaken this year highlights issues with screening compliance, isolation capacity, compliance with fundamental IPC principles including compliance therapy. Actions taken to improve performance include incorporating integrated care pathways into the flowsheets within HIVE to facilitate completion and prompt staff to comply with supression therapy and screening.

Actions

Thematic analysis of the investigations 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

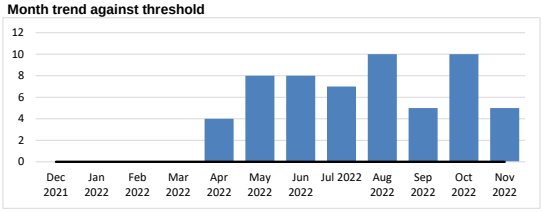
> Board Assurance

November 2022

Reportable organism infections - attributable (MSSA) bacteraemia

Actual	57	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	TBC	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
2	20	8	2	0	0	12	13	0

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

Progress

A total of 162 cases have been reported so far in 2022/2023: 57 of which were trust-attributable. There were 5 trust-attributable MSSA cases reported for November 2022.

Actions

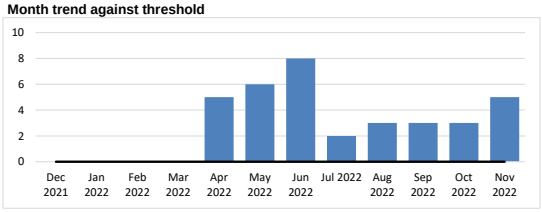
Thematic analysis of the RCAs undertaken this year has identified the following themes:

• Compliance with Trust screening/isolation policies particularly in those clinical areas where isolation facilities are less available.

Reportable organism infections - attributable (VRE) bacteraemia

Actual	35	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✓	✓	✓	✓	✗	✗	✓
2	24	0	0	0	0	4	5	0

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

Progress

A total of 37 VRE bacteraemias have been reported so far in 2022/23. There have been 35 Trust-attributable cases reported so far for 2022/2023. There were 5 trust-attributable cases reported for November 2022. VRE poses a particular threat to immunocompromised, severely ill patients within settings such as critical care and haematology/oncology areas.

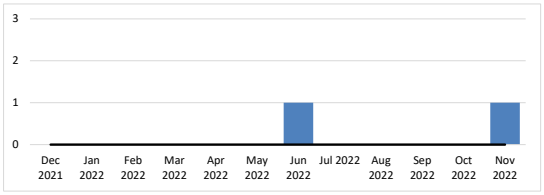
Actions

Thematic analysis of the RCA's undertaken to date include omissions in line care documentation, previous history of VRE colonisation and gut translocation. Actions to improve the rates of bacteraemias include staff education and implementation of line care documentation within the HIVE system and increased screening programme which includes all critical care, haematology and onclogy and vascular patients.

Reportable organism infections -attributable (CPE) bacteraemia

Actual	2	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Progress

There have been 2 trust-attributable cases reported YTD. There was 1 trust-attributable case reported for November 2022. Despite the number of CPE acquisitions identified as a result of increased screening within ares of the Trust (Vascular and Orthopaedic wards at WTWA) this has not increased the rates of bactaeremias. The infection prevention and control team are currently co-ordinating a task and finish group to reveiw CPE acquisition across the Trust. The review will include environmental issues, screening policy, isolation provision and practice issues e.g. AMS and hand hygiene compliance.

Actions

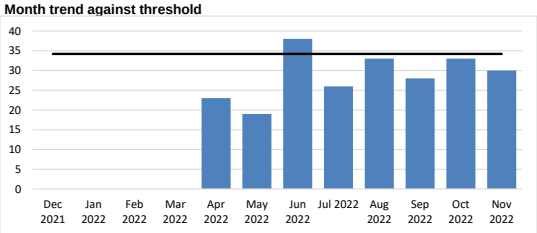
The Task & Finish Group, described above will focus on the following themes from the hospital outbreak meetings:

- Environmental issues
- Patient screening delays
- Lack of available isolation facilities
- Practice issues e.g., hand hygiene compliance, antimicrobial stewardship

Reportable organism infections - attributable (Gram -ve bacteraemia)

Actual	230	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	273	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✓	✓	✓	✓	✗	✓	✓
10	106	32	7	0	0	45	30	0

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

Progress

A total of 230 trust attributable cases have been reported so far in 2022/2023 against a threshold of 273 year to date cases. There were 30 trust-attributable cases reported for November 2022. The Trust are currently under the year to date threshold for GNBSI. Each hospital/MCS have developed a GNBSI reduction plan which was presented to the Chief Nurse/DIPC and is monitored via the hospital Assurance Oversight Framework. A recent catheter care audit has been disseminated to the Directors of Nursing to incorporate the actions into the GNBSI reduction plan.

Actions

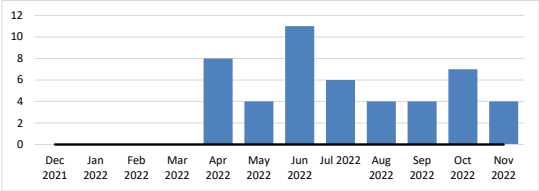
The catheter care audit results have been distributed to the Directors of Nursing to ensure inclusion of the following in the GNSBI reduction action plans.

- 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 catheter urine specimens are obtained at the point of catheterisation

Avoidable admissions to neonatal unit

Actual	48	YTD (Apr 22 to Nov 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	✗	NA	NA	NA	NA	NA
NA	NA	NA	48	NA	NA	NA	NA	NA

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

Progress

Four babies were admitted to the neonatal unit where following multidisciplinary review of care it was judged that the admission could have been avoided. Issues identified include:
- interpretation of the clinical situation
- service pressures resulting in a delay in triage or transfer.

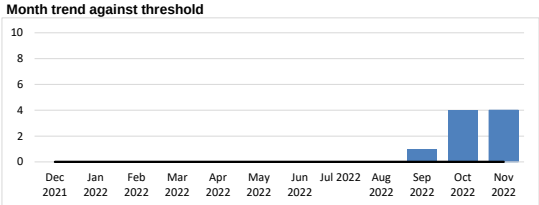
Actions

Following an initial review immediate actions have been put in place for each case. These include:
- daily meeting is held with representation from all three maternity sites to asses service pressures and provide mutual aid as required.
- the Antenatal Assessment Unit relocated enabling the expansion of the ORC Triage unit footprint. A further reaudit of triage processes is planned for Q4 2022-23.

Transfer outside SMH MCS due to capacity / delays

Actual	4	(November 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	✗	NA	NA	NA	NA	NA
NA	NA	NA	4	NA	NA	NA	NA	NA

Saint Mary's MCS instigated four maternity 'diverts' during November, resulting in 26 women being transferred outside of the the MCS due to capacity pressures. Four of the women transferred out are known to have given birth in another unit.

Progress

There have been nine diverts in total since September with four in November. Each divert was due to increased activity and impact on staffing across the MCS with all actions to improve patient flow taken to try and avoid further escalation.
The GMEC Maternity Escalation policy was followed for each divert with a senior midwife maintaining oversight and in contact with NWAS. In line with the GMEC escalation policy the divert status reviewed every 4 hours.

Actions

Midwifery staffing levels closely monitored with daily review and escalation.

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	0	2	2	2

Headline Narrative

40 fewer new complaints were received (178 in total) in November 2022 than in October 2022. This is a signicant decrease, early indications identify a decrease across all complaint categories, however the Patient Experience Team will undertake further analysis of any impact of MyMFT or Hive on complaint volumes / themes.

In November 2022 the percentage of formal complaints resolved in the agreed timeframe was 83%, this is a decrease of 8.5% compared to 91.5% in October 2022.

The Trust overall satisfaction rate for FFT November 2022 increased by of 2.4% to 91.4% when compared to 89% in October 2022.

There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

For both MRSA and CDI trust performance continues to be above the agreed thresholds, and remains under the GNBSI threshold.

There have been 82 trust-attributable CDI reported so far for 2022/2023, against a threshold of 73, 2 trust-attributable MRSA bacteraemia against a threshold of 0 and 140 trust-attributable GNBSI against a trajectory of 170.

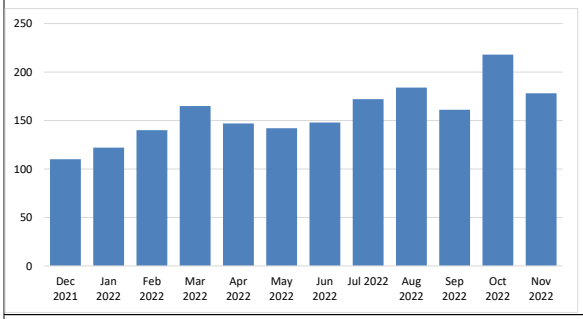
Complaints: Volumes

–

Actual 1350 YTD (Apr 22 to Nov 22) **Accountability** C.Lenney

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

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
69	325	157	183	37	25	321	154	34

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

The chart shows total number of complaints received by month. Monitoring total complaint volumes provides opportunity to compare the KPI on a monthly cadence to quickly draw conclusions, test assumptions and identify focus areas for future improvements.

Key Issues

178 new complaints were received across the Trust in November 2022, this is a decrease of 40 from the 218 received in October 2022.

The highest volume of complaints was attributed to MRI, with 41 (23%) being received, which is a decrease when compared with the 55 received by MRI in October 2022 and slight increase for the 40 in September 2022.

Of the 41 complaints received by MRI, Accident & Emergency and ENT were identified as the main subject specialties, with the top three themes being 'Treatment / Procedure', 'Communication' and 'Clinical Assessment'.

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

Progress

All Hospitals / MCS / LCO have established complaints governance frameworks that focus on the management of complaints, with a view to identifying the learning to inform improvements in complaints themes.

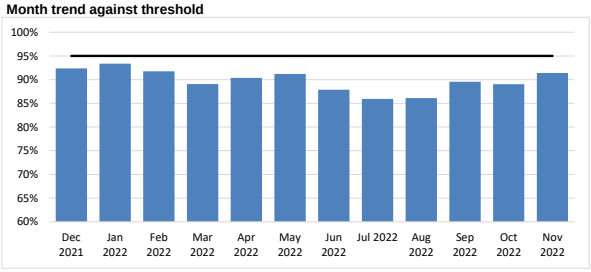
FFT: All Areas: % Extremely Likely and Likely

◇

Actual 91.4% (November 22) **Accountability** C.Lenney

Threshold 95.0% (Higher value represents better performance) **Committee** Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✕	✕	✓	✓	◇	◇	✕	✓
99.7%	88.3%	88.1%	95.5%	95.7%	95.0%	91.2%	85.6%	98.2%

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

Progress

The overall satisfaction rate for FFT for November 2022 was 91.4%, which is an improvment from the previous five months which has ranged from 85%-89%.

There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

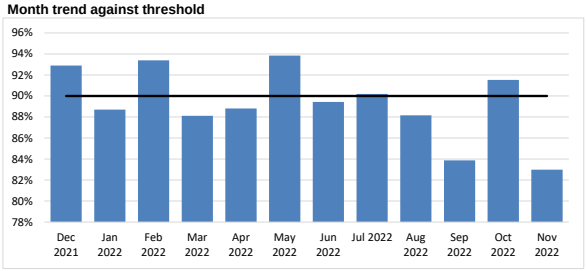
Actions

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

Complaints: Resolved Within Agreed Timeframe

Actual	88.1%	YTD (Apr 22 to Nov 22)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	✓	◇	✓	✗	✓	✓	◇
81.8%	90.9%	97.7%	72.0%	95.2%	67.9%	97.6%	95.0%	81.1%

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

Progress

Work is ongoing with the Hospitals' / MCS's / LCO's management teams, through KPI meetings, to ensure that timeframes that are agreed are appropriate and achieved.

The November 2022 data identifies that 83% of complaints were resolved within the agreed timescales, which is a decrease of 8.5% compared to 91.5% in October 2022 and 83.8% in September 2022.

It should be noted that where the Hospitals / MCS / LCO receive lower numbers of complaints, this can result in high percentages.

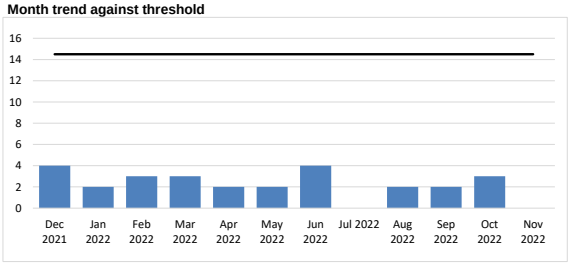
Actions

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

Cdiff: Lapse of Care

Actual	15	YTD (Apr 22 to Nov 22)	**Accountability**	C.Lenney
Threshold	15	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
0	8	0	0	0	0	5	2	NA

Each Clostridium difficile infection (CDI) incident is investigated locally to determine whether the case was linked with a lapse in the quality of care provided to patient. The chart shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient and has been updated following data refresh. Previous BAR reports have identified attributable incidents, the most recent data refresh provides the updated lapse in care information. The aggregate Trust threshold is under review, including review of each hospital/MCSs contribution to the overall figure.

Progress

A total of 202 CDI cases have been reported so far in 2022/2023: 164 of which were trust-attributable against a threshold of 116. 23 trust-attributable CDI cases have been reported for November 2022, greater numbers are reported at MRI and WTWA.
Following investigation, themes identified from the RCA's, which are routinely identified in the Board of Directors IPC report, include:
- access to isolation facilities
- appropriate sampling and documentation
- antibiotic history and prescribing

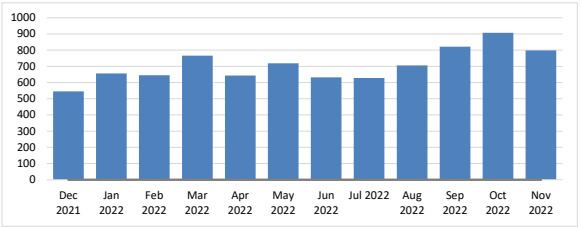
Actions

Actions to improve performance include:
• Incorporating the integrated care pathways within HIVE flowsheets to facilitate completion of documentation
• Early involvement of AMS pharmacists in any local outbreaks of infection to determine appropriate antibiotic usage

PALS – Concerns

Actual	5855	YTD (Apr 22 to Nov 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
454	1396	448	838	356	187	1429	544	88

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

Key Issues

A total of 798 PALS concerns were received by MFT during November 2022, which is a decrease from the 907 received in October 2022.

Of the 798 PALS concerns received in November, the highest volume was attributed to MRI with 184 (23.1% of the total) being received. This is a decrease when compared to the 192 MRI received in October 2022 and 194 in September 2022.

The top three themes for MRI related to 'Appointment Cancellation / Delay (OP)' (62), Communication (65) and 'Treatment and Procedure' (58).

Actions

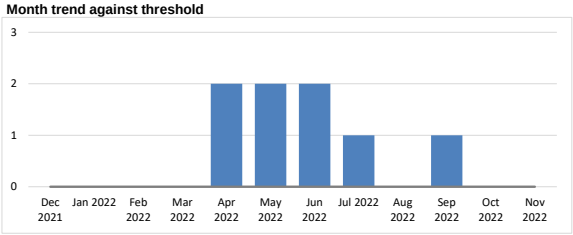
PALS concerns are formally monitored alongside complaints at the weekly meetings within each Hospital / MCS / LCO.

Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 10 days.

PHSO Enquiries

Actual	8	YTD (Apr 22 to Nov 22)	**Accountability**	C.Lenney
Threshold	0	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

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

The number of new PHSO enquires received in November 2022 was 0.

Progress

13 PHSO cases remain open:
- 12 of which are awaiting a provisional report, final report or actions to be completed
- 1 in which WTWA have disputed the PHSO decision and the case remains open and further communications received from the PHSO.

9 PHSO cases remain closed, however they are currently being scoped and awaiting decision.

3 PHSO cases remain closed, however they are currently being considered by the PHSO for early resolution.

Operational Excellence

D.Furnival

Core Priorities	✓	◇	✕	No Threshold
	1	0	14	0

Headline Narrative

Across GM the system has been challenged with emergency pressures during October & November with MFT being significantly affected. As a result the Trust escalated to a command and control structure for a period a time to support actions to enable speedy de-escalation. Significant challenges remain with flow and greater than 100% occupancy is being reported across the adult sites with escalation into elective/daycase and short stay areas. Acuity has increased across a number of pathways and there has been an increase in the number of patients on the no reason to reside list. equally there has been an increasing trend in flu and COVID admissions. Specific challanges have also been experienced across paediatrics with the RMCH seeing record number of attendances through their A&E along with national pressures across paediatric intensive care beds. These pressures have impacted on performance against the 4hr standard and the number of 12hr trolley waits which has increased considerably in October and November along with ambulance handover delays albeit not outwith the wider GM system.

The emergency pressures have challenged the MFT elective programme resulting in an increase in elective cancellations. However, despite these operational pressures, hospitals have continued to focus efforts on treating the clinically urgent and long wait patients with good progress being made on reducing the backlog of patients waiting 62+ days on a cancer pathway and patients waiting above 78+ weeks for a routine appointment. Recovery plans and trajectories are in place to work towards zero patients waiting 78+ weeks by end of March, this will be challenging and MFT are seeking mutual aid and independent sector support to achieve this.

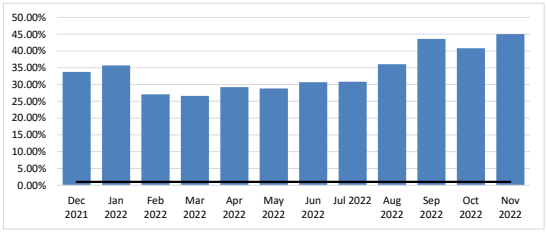
Diagnostics has seen a growing trend with an increase in demand of 3.2% in unscheduled care and with the focus on cancer this is resulting in routine waits being extended and thus a decline in performance. The main pressure areas are across CT, MRI, Echocardiography and Endoscopy. Trajectories and improvement plans have been developed for all DM01 tests to achieve the 6 week standard by March 2024.

Operational Excellence - Core Priorities

Diagnostic Performance ✕

Actual	45.0%	(November 22)	**Accountability**	D.Furnival
Threshold	1.0%	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✕	✕	✕	NA	NA	◇	✕	NA
40.2%	52.2%	67.4%	66.7%	NA	NA	53.7%	42.1%	NA

NB - the % at RMCH and SMH is high due to the small waiting list in this area, the volume of breaches in these areas are marginal

The number of patients waiting over 6 weeks for a range of 15 key diagnostic tests.
Note: The data for October and November 2022 were not submitted nationally.

Key Issues

- Continued increased volumes of unplanned tests linked to Non Elective attendance / admissions increases.
- Pressures remain in CT, MRI, Echo, Endoscopy and Non obstetric ultrasounds.
- MR capacity has been impacted recently at NMGH and MRI site due to the scanners being down for a period of time. Whilst no patients on the cancer pathway were affected the impact has been seen on routine wait times.

Actions

- Trajectories and plans in place for all diagnostic tests to achieve <5% over 6 weeks by March 2024.
- Focus on clinically urgent/cancer with improvements to reporting backlog through additional capacity utilising extra clinical sessions and additional weekend scanning capacity for CT and ultrasounds.
- Weekly task and finish group in place to cleanse and validate lists following data migration into new EPR system (HIVE).
- Plans to implement 7 day booking and scheduling activities to achieve 48hr turnaround time from receipt of referral to scheduling.
- Continued focus on reducing long waits - reviewing requests, validation and improving operational efficiencies.
- Weekly PTL meeting in place to track all patients referred on a cancer pathway.

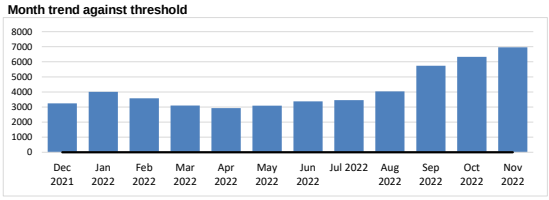
Progress

- Overall waiting list continues to grow linked to growth in Elective waiting list and unscheduled demand, however performance against the 6 week target has shown an improvement in October.
- Focus on a targetted approach to booking / scheduling in conjunction with best principles and Elective Access policy application across a number of sites in key modalities, particularly Endoscopy, CT, Non Obs U/S and MRI.
- Work continues in building an overarching reporting module within Power BI that will enable operational teams easier access to the performance data they need to improve processes following implementation of HIVE.
- Additional endoscopy capacity active through Community Diagnostic Centre commenced in November.

Diagnostic wait > 13 weeks

Actual	6965	(November 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	NA	NA	NA	✗	NA	NA
3686	1201	279	NA	NA	NA	1799	NA	NA

The number of patients waiting over 13 weeks for only one of 15 key diagnostic tests.
Note: The data for October and November 2022 were not submitted nationally.

Key Issues

• Increased volumes of unplanned tests linked to Non Elective attendance / admission increases resulting in increase in routine test waiting times.
• Increase seen since HIVE go live in September, a review of long wait patients is underway with early findings pointing to the way the system is counting planned patient waits, this is being addressed through the weekly Task & Finish Group.

Actions

• Trajectories and plans in place for all diagnostic tests to achieve <5% over 6 weeks by March 2024.
• Weekly task and finish group in place to cleanse and validate lists following data migration into new EPR system (HIVE).
• Plans to implement 7 day booking and scheduling activities to achieve 48hr turnaround time from receipt of referral to scheduling.
• Continued focus on reducing long waits - reviewing requests, validation and improving operational efficiencies.
• Additional weekend imaging capacity to be introduced on the Trafford site from January 23.

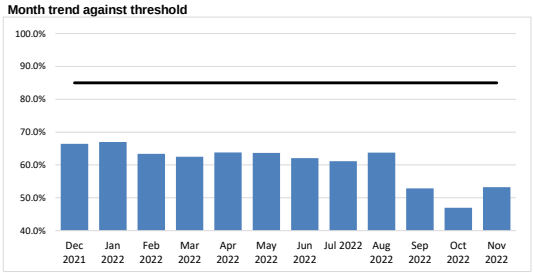
Progress

• Review of long wait patients continuing and managed through weekly Task & Finish Group.
• Tracking and monitoring against trajectories through Elective PMO Hub.

A&E - 4 Hours Arrival to Departure

Actual	50.1%	Q3 (Oct to Nov 22)	**Accountability**	D.Furnival
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	NA	✗	NA	✗	✗	NA
NA	49.1%	48.7%	NA	56.1%	NA	51.1%	49.0%	NA

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

Key Issues

• Delayed handovers of patients alongside the numbers of ambulance holds continues.
• Bed capacity constraints along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge resulting in delays for patients waiting to come into hospital.
• GM and MFT system continue to experience significant demand resulting in capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously.
• Specific challenges have also been felt across paediatrics with RMCH seeing record attendances through their A&E due to current wave of RSV and Strep A along with national pressures across paediatric intensive care beds.
• Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs.

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
• These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include:
- Increase the number of beds available in community for supported discharges
- Increase the number of patients transferred from ED through to SDEC services and transfers direct from NWAS
- Maximise the utilisation of the virtual wards
- Trial of 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 me with the right support
- Deliver the 'Back to Basics' part of the Resilient Discharge programme – ward level discharge planning to increase the number of patients going home

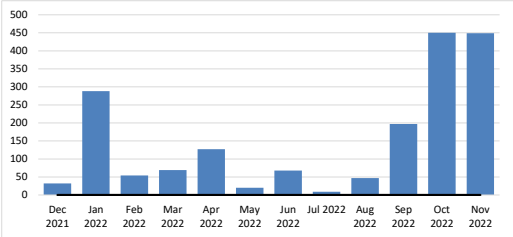
Progress

• Performance against the A&E 4hr standard has remained largely stable through April to August at 62.7%. This dipped in September as a result of the migration to the new EPR system to 53% and has remained static throughout October and November. Whilst this is in part as a result of staff familiarisation with the system the main challenges have been emergency pressures experienced across GM during this time.
• MRI have recently implemented a Transfer & Discharge Unit as part of their winter schemes to facilitate patients awaiting admission or transport home.
• WTWA have expanded their SDEC which has seen an increase in patients bypassing A&E.
• Use of virtual wards has increased, which is supporting admission avoidance and each hospital has a trajectory to increase this further over the coming weeks.

12 hour trolley waits

Actual	449	(November 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	NA	NA	✓	✗	✗	NA
NA	133	14	NA	NA	0	13	289	NA

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

Key Issues

• Significant challenges remain with flow and greater than 100% occupancy is reported across the adult acute sites with escalation into elective/daycase and short stay units.
• Higher than optimal reason to reside patients which restricts bed capacity and flow out of the emergency department has remained stubbornly high with OOH area and mental health patients a particulalr concern.

Actions

• Refreshed and relaunched site escalation flow charts, including the ED and workforce triggers.
• Continued focus supported by the MFT Transformation team to ensure staff familiarisation of the HIVE system in applying consistent approach to timely decision to admit process.
• Refreshed over-arching Urgent Care Improvement Plan and governance & assurance process to support the improvements.
• Organisational escalation SOP in place for the reporting of long waits both in and out of hours.
• Discharge Resilience programme led by the MLCO with Hospitals to improve on delayed discharges and flow out of the hospital.

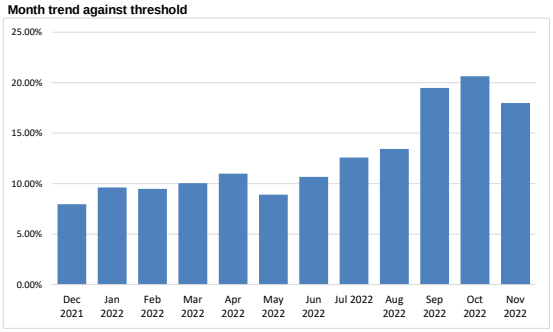
Progress

As a result of significant operational pressures the Trust has reported 450 breaches of the standard as at 30th November. Both North Manchester and MRI continue to report high numbers due to pressures related to bed capacity and flow through the system. Harm reviews are undertaken for all patients, with no harm identified in any of these breaches following RCA. Learning from the root cause analysis undertaken for any breach of the standard has been implemented.

Over 12 hour waits in ED

Actual	18.0%	(November 22)	**Accountability**	D.Furnival
Threshold	2.0%	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	NA	NA	NA	✗	✗	NA
NA	26.6%	7.9%	NA	NA	NA	17.1%	16.7%	NA

% of patients spending more than 12 hours in A&E.

Key Issues

• Delayed handovers of patients alongside the numbers of ambulance holds continues.
• Bed capacity constraints along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge resulting in delays for patients waiting to come into hospital.
• GM and MFT system continue to experience significant demand resulting in capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously.
• Specific challenges have also been felt across paediatrics with RMCH seeing record attendances through their A&E due to current wave of RSV and Strep A along with national pressures across paediatric intensive care beds.
• Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs.

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
• These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include:
- Increase the number of beds available in community for supported discharges
- Increase the number of patients transferred from ED through to SDEC services and transfers direct from NWAS
- Maximise the utilisation of the virtual wards
- Trial of 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 me with the right support
- Deliver the 'Back to Basics' part of the Resilient Discharge programme – ward level discharge planning to increase the number of patients going home

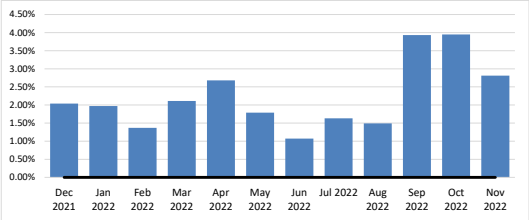
Progress

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

MFT - Ambulance hold % Attend

Actual	2.8%	(November 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	NA	NA	NA	✗	✗	NA
NA	1.7%	NA	NA	NA	NA	0.1%	7.6%	NA

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

Key Issues

• Delayed handovers of patients alongside the numbers of ambulance holds continues.
• Bed capacity constraints along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge resulting in delays for patients waiting to come into hospital
• GM and MFT system continue to experience significant demand resulting in capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously
• Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs.

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.
•These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include:
- Increase the number of beds available in community for supported discharges
- Increase the number of patients transferred from ED through to SDEC services and transfers direct from NWAS
- Maximise the utilisation of the virtual wards
- Trial of 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 me with the right support
- Deliver the 'Back to Basics' part of the Resilient Discharge programme – ward level discharge planning to increase the number of patients going home

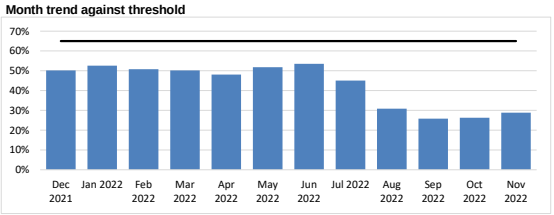
Progress

• Improvement has been seen in November although remains challenges impacted by reduced flow resulting in an increase in patients spending more than 12 hours total time in the deparmtent.

Handover between Ambulance and A&E - within 15 minutes

Actual	28.9%	(November 22)	**Accountability**	D.Furnival
Threshold	65.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	NA	NA	NA	✗	✗	NA
NA	17.4%	NA	NA	NA	NA	32.4%	41.2%	NA

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

Key Issues

• GM and MFT system continue to experience significant demand with capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites in conjunction with system partners and North West Ambulance Service with improving ambulance handover turnaround times.
• Continual review of recording at operational level with feedback to NWAS colleagues to ensure accuracte reporting.

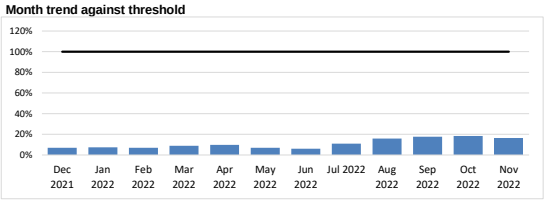
Progress

• Progress is already being made at all sites around process improvement which has contributed to the upturn since May although this has increased in November.
• Accuracy of reporting has been identified as an issue and a rapid improvement process is underway to simplify handover with a turnaround standard operating procedure at all sites being developed jointly with NWAS.
• Full capacity protocols (FCPs) have been reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day.
• Due to the significant pressures the Trust escalated to a command and control structure in October for 10 days and again in November for 4 days to support actions that would enable speedy de-escalation.

Handover between Ambulance and A&E - > 60 minutes

Actual	15.9%	(November 22)	**Accountability**	D.Furnival
Threshold	100%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	NA	NA	NA	✗	✗	NA
NA	21.7%	NA	NA	NA	NA	11.1%	14.3%	NA

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

Key Issues

• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites with improving ambulance handover turnaround times.
• Implementation of virtual ward.
• A detailed assessment of the current utilisation of medical SDEC service has taken place and clear actions have been identified to improve utilisation.

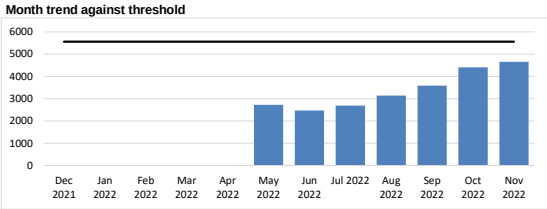
Progress

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

RTT - 78 Weeks (Incomplete Pathways) ✓

Actual	4654	(November 22)	**Accountability**	D.Furnival
Threshold	5561	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✓	✗	✓	✓	✗	✓	✓	✓
70	2041	249	695	74	22	920	583	0

The number of patients waiting over 78 weeks on an incomplete pathway.
Note: The data for October and November 2022 was not submitted nationally.

Key Issues
- Emergency pressures have challenged the elective programme resulting in an increase in number of elective cancellations.
- Familiarisation of the new EPR system by staff and data migration is contributing to a number of data quality issues that may be contributing to the increase in the waiting list. A data cleansing and validation exercise is underway.

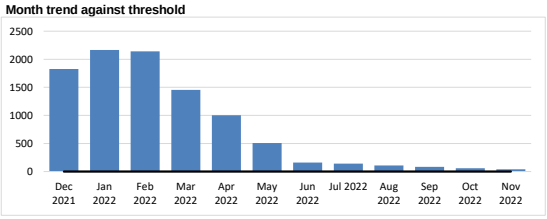
Actions
- Trafford development of a 23hr model to support transfer of long wait patients from MRI, SMH and Wythenshawe
- Capacity and demand modelling
- Understake systematic technical, administration and clinical validations of all patients on an RTT pathway beginning with all patients waiting >52 weeks by end of December

Progress
- Accurate modelling of trajectory by speciality is in place developed in line with hospitals/MCS alongside datasets to support tracking of bookings and current performance is delivering against plans.
- Further reinforcement of booking principles to man mark 78w patients
- Actions and tracking of patient data provided weekly to all hospitals/MCS and this support 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
- Discussions and supporting SOPs provided for pooling of patients where applicable across sub specialities

RTT - 104 Weeks (Incomplete Pathways) ✗

Actual	41	(November 22)	**Accountability**	D.Furnival
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✓	✓	✗	✗	✗	✓
2	7	1	10	0	2	17	2	0

The number of patients waiting over 104 weeks on an incomplete pathway.
Note: The data for October and November 2022 were not submitted nationally.

Key Issues
- Emergency pressures have challenged the elective programme resulting in an increase in number of elective cancellations
- Familiarisation of the new EPR system by staff and data migration is contributing to a number of data quality issues that may be contributing to the increase in the waiting list. A data cleansing and validation exercise is underway.

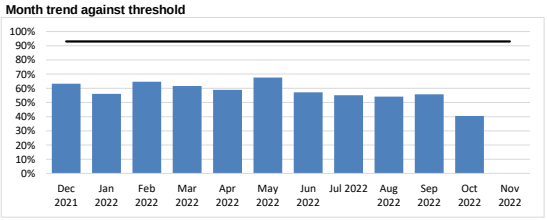
Actions
- The Trust continues to focus on reduction of very long waits in chronological / priority order.
- Daily communications with operational teams to focus on pop ons, with particular focus on dating patients, DQ and transacting outcomes.

Progress
- Long waits have reduced significantly with MFT reporting zero at month end except for patients who are clinically complex, medically unfit or for choice.

Cancer Urgent 2 Week Wait Referrals ✗

Actual	40.5%	Q3 (Oct 22)	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	✗	NA	NA	✗	✗	NA
NA	56.8%	78.3%	90.2%	NA	NA	35.8%	23.1%	NA

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

Key Issues
- Total referrals for suspected cancer have reduced across July and August towards pre covid levels, this seems to have increased again post the summer, especially in breast, with usual fluctuations between tumour sites and months.
- Staff familiarisation with the new EPR system is impacting on performance, seen in October. 2 week wait performance is challenged aross Lower GI at WTWA, Urology and Breast at NMGH.

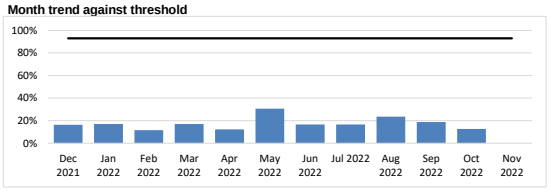
Actions
- Additional weekend and evening clinics and insourcing arrangements in place across Skin, Breast and H&N
- NMGH increased slots by 20 per week in week, have implemented a virtual mastalgia clinic and work on a hot week approach to protect capacity. This will allow for 700 extra slots up to the end of March 23
- Head and neck single point of access across WTWA/MRI for new referrals
- First 14 day workshop for Lower GI planned for December

Progress
- Head and Neck have reduced first wait time to 8 days, Breast is maintaining 2 ww at 14 days and skin is now down to 3 days at WTWA.

Cancer 2 Week Wait breast Symptom

Actual	12.7%	Q3 (Oct 22)	**Accountability**	D.Furnival
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	NA	NA	NA	✗	✗	NA
NA	NA	NA	NA	NA	NA	50.0%	10.4%	NA

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

Key Issues
Demand pressures, support to other providers in GM, impact of Covid19.

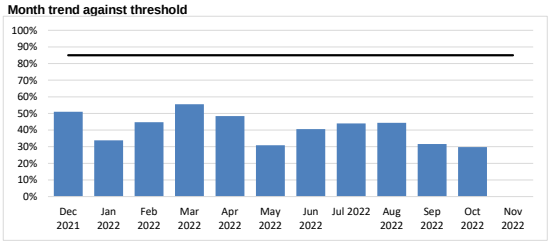
Actions
- All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
- Improvement work as above for 2ww cohort.

Progress
As per 2ww.

Cancer 62 Days RTT

Actual	29.7%	Q3 (Oct 22)	**Accountability**	D.Furnival
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✗	NA	NA	✗	✗	NA
NA	33.3%	NA	30.0%	NA	NA	29.4%	29.2%	NA

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

Key Issues
- Historical underperformance against the standard due to demand pressures, and diagnostic delays
- Demand for cancer pathways has increased to 110% of pre-pandemic levels with some tumour group at peak levels and has increased backlog of patients waiting 62+ days, therefore whilst dealing with the backlog performance will be below standard.

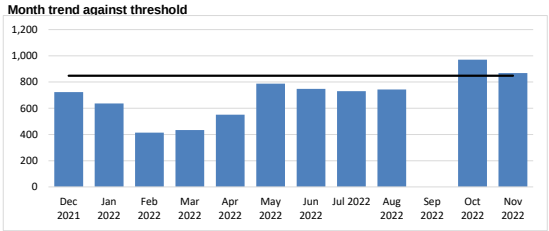
of babies
- Weekly PMO meetings to track progress and actions
- New diagnostic cancer PTL built into Hive to provide a clearer view of pathway patients
- The Urology MFT@Christie model continues, and mutual aid is in place for gynaecology patients as required.
- A review of cancers resources across sites with a view to harmonising practices and roles
- Continued use and focus to utilise IS capacity for endoscopy demand
- Additional clinical capacity in place at weekdays and weekends including resource for the most underperforming tumour groups, Head and Neck, Breast, and Skin.
- A single point of access has now been set up for H&N across MFT and referrals are now being seen at 8 days
- Focused fortnight taken place in November with some capacity still ongoing. This is a GM wide initiative and several schemes were identified over the 2 weeks that increased capacity across a number of tumour sites
- LGI workshop to be held in December

Progress
- Demand has increased to pre-pandemic levels with peaks across tumour groups
- Performance - 62 day performance remains low and is not expected to improve whilst the backlog clears
- 62 day backlog trajectory and plans in place with current performance tracking against plan
- Safety remains a key priority and harm reviews continue to be undertaken for the longest wait patients

Cancer 62 Days Backlog

Actual	869	(November 22)	**Accountability**	D.Furnival
Threshold	848	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	✓	NA	✗	✗	✗	NA
NA	257	NA	75	NA	10	271	256	NA

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

Key Issues
- Pathway delays across diagnostics and clinical review

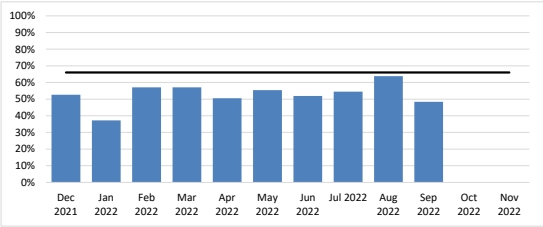
Actions
- Weekly PMO meetings to track progress and actions
- New diagnostic cancer PTL built into Hive to provide a clearer view of pathway patients
- The Urology MFT@Christie model continues, and mutual aid is in place for gynaecology patients as required
- A review of cancers resources across sites with a view to harmonising practices and roles
- Continued use and focus to utilise IS capacity for endoscopy demand
- Additional clinical capacity in place at weekdays and weekends including resource for the most underperforming tumour groups, Head and Neck, Breast, and Skin
- A single point of access has now been set up for H&N across MFT and referrals are now being seen at 8 days
- Focused fortnight taken place in November with some capacity still ongoing. This is a GM wide initiative and several schemes were identified over the 2 weeks that increased capacity across a number of tumour sites
- LGI workshop to be held in December

Progress
- Some increase in the backlog due to early termination of an endoscopy contract which has now been replaced but led to a disruption in service at MRI
- Decrease in some activity at NMGH following disaggregation as above

Cancer Faster Diagnosis

Actual	48.4%	(September 22)	**Accountability**	D.Furnival
Threshold	66.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✗	NA	NA	✗	✓	NA
NA	59.6%	NA	65.3%	NA	NA	62.0%	68.4%	NA

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

Key Issues

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

Actions

- Review of provision of BPTP (Best Practice Timed Pathways)
- Other improvements mentioned in 2ww and 62 day sections also apply to the FDS standard
- Radiology specific PTL and tracker in implementation to reduce TAT - this required further optimisation post Hive implementation

Progress

FDS performance should improve in line with 2ww recovery plans as above for breast and head and neck but further work required on other areas of the diagnostic pathway.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	×	No Threshold
	0	3	6	0

Headline Narrative

Following the successful implementation of Hive Electronic Patient Records (EPR). A full review of the MFT People Plan within the post Hive Go-Live context has now taken place and a People Plan reset campaign is planned for January 2023.

The implemenation of the Kallidus Learning Experience Platform is now progressing at pace, as is the introduction of a new HR Online Advice Portal and Manage Engine Service Desk functionality, all of which are due to will Go-Live in February and March 2023. These initiatives will transform the way staff are able to interact with our core services, making it easier to access the right advice and support at the point of need.

As operational pressures start to increase over the winter period, the Workforce Directorate is maintaining its focus on the wellbeing agenda, absence management, staff retention, and other targeted initiatives.

Work continues to support the stablisation of Hive and the associated workforce transformation.

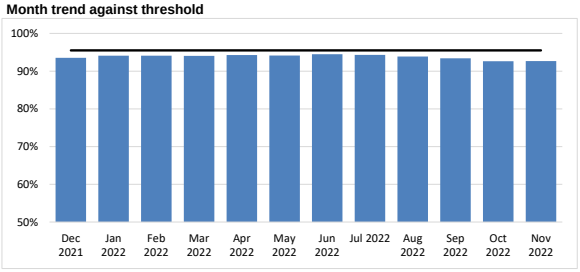
Workforce and Leadership - Core Priorities

Attendance ×

Actual 92.7% (November 22) **Accountability** P. Blythin

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
×	×	×	×	×	×	×	×	×
93.4%	92.1%	93.0%	92.1%	91.7%	93.1%	92.2%	92.7%	92.1%

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

Key Issues

The Group attendance rate for November was 92.7% which is higher than the previous month's figure (92.6%). At the same point last year (November 2021) the attendance rate was 0.7% higher (93.4%).

The latest figures published by NHS Digital show that for July 2022 (the figures for August 2022 will be published in January 2023) the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.8% or 93.2% attendance rate (these figures include all provider organisations and commissioners) and were the highest in England. The London region reported the lowest sickness absence rate in July 2022 at 5.3% or 94.7% attendance rate.

Actions

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

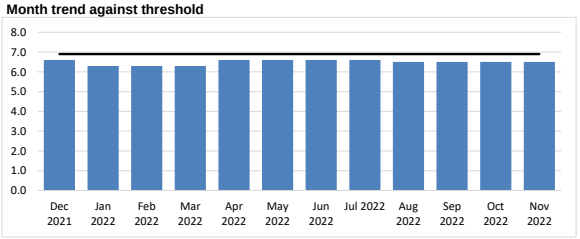
The Absence Manager System is in place across all MFT sites. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers to make best use of the Absence Manager system in the effective management of absence and to support the health and wellbeing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

Engagement Score (quarterly) ×

Actual 6.5 Q3 (Oct to Nov 22) **Accountability** P. Blythin

Threshold 6.9 (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
×	×	×	×	×	×	×	×	×
6.4	6.3	6.5	6.4	6.5	6.5	6.3	6.5	6.8

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

Key Issues

The staff engagement score for the MFT Group is 6.5. No Hospital or MCS has met the target threshold of 6.9 with the Local Care Organisation being the closest at 6.8.

Actions

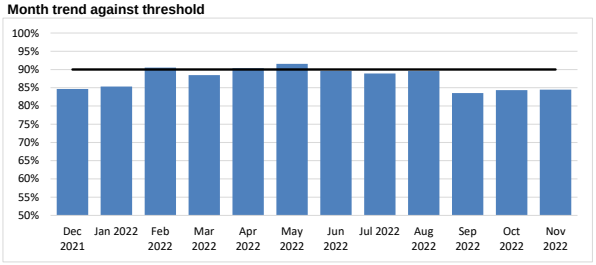
The Staff Engagement team provide organisational and local results and presentations to each site within 3 weeks of the data collection submission. The Staff Engagement and Recognition committee are kept informed of all related activity and are integral in the dissemination of key messaging and associated actions determined by the committee. Staff Engagement scores are shared at local level to enable HRD's to share with divisional leads, managers and leaders to enable them to respond, celebrate and take action in response to the results to demonstrate to staff they are listening in line with the MFT People Plan – We feel valued and heard.

Local activities include showcasing 'You Said, We Did', regular staff engagement meetings, links and support from OD leads and utilising staff forums to share best practice are some of the activities that take place to support a positive working experience for our staff. Group and local action plans are developed to address areas of lower scores.

Appraisal - Medical

Actual	84.5%	(November 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✗	✗	◇	✗	✗	✗	✗	✓
89.4%	84.4%	84.7%	87.5%	84.9%	70.8%	81.4%	83.7%	95.8%

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

Key Issues

Compliance increased by 0.2% across the Group in November 2022. Currently only the Local Care Organisation is meeting the 90% target for this KPI.

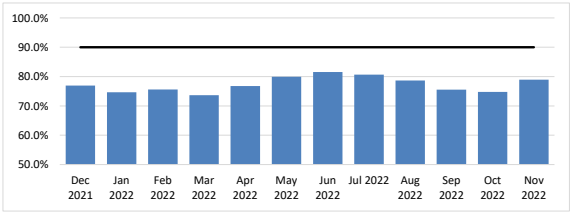
Actions

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

Appraisal - Non-Medical

Actual	79.0%	(November 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	◇
70.1%	80.1%	84.8%	83.2%	83.3%	84.4%	80.8%	81.0%	86.1%

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

Key Issues

Compliance increased by 4.2% across the Group in November 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI. This was last achieved by the Eye Hospital in October 2021 at 90.6%.

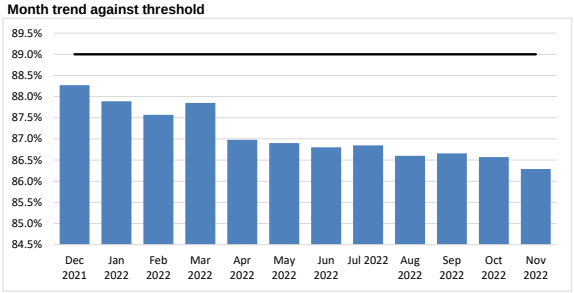
Actions

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

Retention - rolling 12 months

Actual	86.3%	R12m (Dec 21 to Nov 22)	**Accountability**	P. Blythin
Threshold	89.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✗	◇	✗	✗	◇	✗	✗	✗
85.1%	82.2%	84.4%	83.3%	82.5%	88.2%	80.0%	82.9%	82.0%

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

Key Issues

The Group retention rate for November was 86.3% which is 0.3% lower than the previous month's figure. No Hospital or Managed Clinical Service is currently meeting the 89.0% threshold target for this KPI.

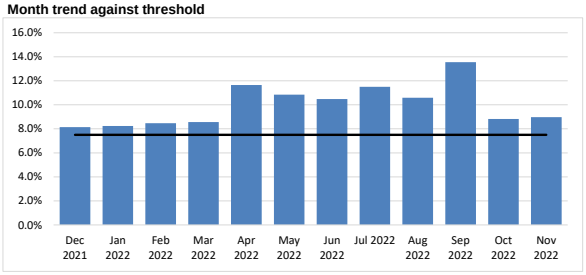
Actions

All Hospitals/MCS/LCO continue to focus on staff turnover with regular staff engagement sessions and facilitating internal moves to mitigate staff leaving the organisation. Workforce Planning to continue sharing the monthly Nursing Leavers Analysis report whilst developing an 'All Staff Groups' version of the report in Power BI.
The Human Resources Scrutiny Committee received a detailed analysis of retention data and approved an action plan to improve staff retention in 2023/24.

All Vacancies

Actual	9.0%	(November 22)	**Accountability**	P. Blythin
Threshold	7.5%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	◇	✗	✗	✗	✗	✗	✓	◇
7.2%	10.0%	12.5%	10.7%	11.3%	20.5%	10.3%	6.8%	9.0%

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

Key Issues

The Group vacancy rate for November was 9.0% which is higher than the previous month's figure (8.8%). Currently both the Clinical and Scientific Services and North Manchester General Hospital are meeting the 7.5% threshold target for this KPI.

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

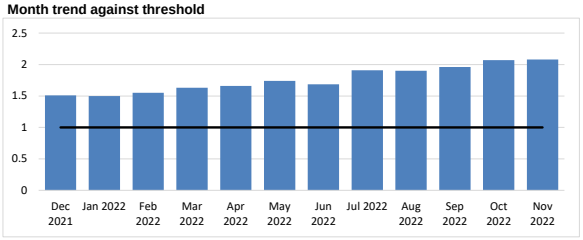
Actions

Work continues at pace to identify and remove blockages within the recruitment process, as a result of the ongoing streamlining programme of work. A key part of this programme is the provision of accurate reports to all Hospitals / MCSs and LCO on vacancies and applicants.

Relative Likelihood of White Staff vs BME Staff being Appointed

Actual	2.08	(November 22)	**Accountability**	P. Blythin
Threshold	1.00	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	◇	✗	✗	✗	✗
1.76	1.60	2.11	1.96	1.32	2.55	1.87	1.70	3.12

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

Key Issues

The Group relative likelihood of white staff being appointed compared to BME staff for November was 2.08 which is higher than the previous month's figure (2.07). No Hospital is currently meeting the 1.00 threshold target for this KPI.

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

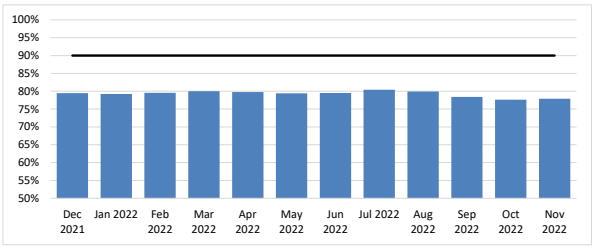
The Trust continues with the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

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

Level 2 & 3 Mandatory Training

Actual	77.9%	(November 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
77.2%	77.4%	75.2%	79.6%	79.3%	80.9%	77.8%	73.0%	83.5%

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

Key Issues

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

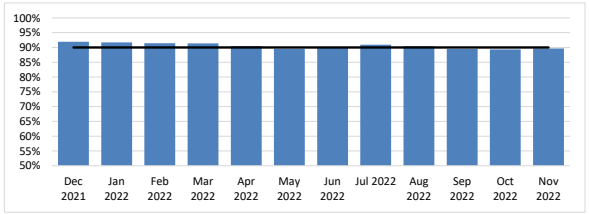
Actions

Work continues to drive compliance through weekly reporting sent to HR staff from all MCS/Hospital sites and Corporate HR and discussions via the Accountability Oversight framework (AOF) meetings. A communication campaign encouraged staff members to 'get ahead' with Mandatory Training prior to Go Live of HIVE.

Level 1 CSTF Mandatory Training

Actual	89.7%	(November 22)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	◇	✓	✓	✓	◇	◇	✓
86.6%	90.8%	88.2%	91.2%	92.1%	92.1%	89.6%	89.5%	91.9%

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

Key Issues

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In August 2022 the aggregate compliance decreased by 0.4% to 89.7%. Only CSS, NMGH, WTWA and RMCH have a compliance score below the 90% Trust target.

Actions

The governance of Mandatory Training has now transferred from the PMO project team into BAU and is now led by the Learning & Development Support Services team. Work continues to drive compliance through weekly reporting sent to HR staff from all MCS/Hospital sites and Corporate HR and discussions via the Accountability Oversight framework (AOF) meetings. A communication campaign encouraged staff members to 'get ahead' with Mandatory Training prior to Go Live of HIVE.

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:	January 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.

2. Hive - Transition from Hyper support to Stabilisation Phase

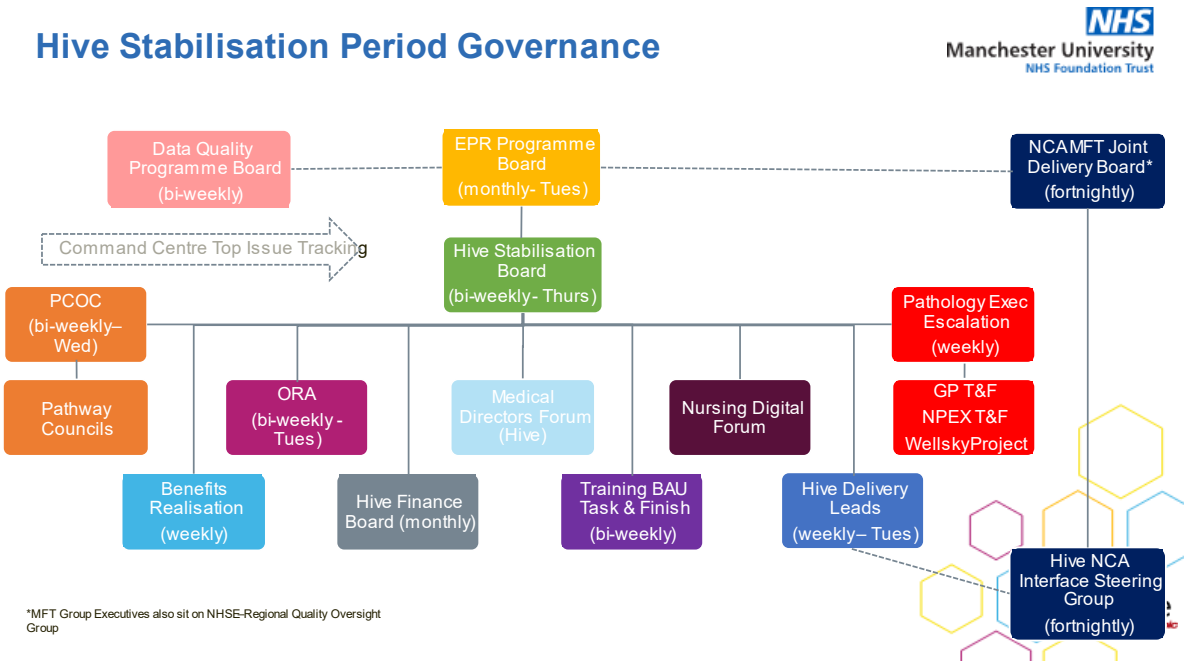
2.1 As reported at the last Board, feedback from outside MFT and from Epic is that this is one of Epic's best *Go Lives* which is an incredible achievement given the size, scale and complexity of the event. MFT have delivered the biggest Go Live in Europe and the second largest globally.

2.2 Hive has replaced four legacy Patient Administration systems, over 300 supporting systems, across ten hospitals including North Manchester General Hospital following its disaggregation from the legacy Pennine Acute Trust. This has meant that **expected** issues/escalations encountered and managed in the Stabilisation Phase have been complex, intense and required robust Board level oversight and management.

2.3 Following Go live, MFT entered a period of hyper support which consisted of:

- Hive Command Centre **24/7,** Chief Nursing Officer Command 24/7 and Hospital/MCS/LCO Command Centres
- 24/7 Hive, Epic and Technical teams in place at Trafford House directed by Hive Command to **resolve risk/issues** across all programme (build, training, technical, transformation)
- Supernumerary **Super Users** providing at the elbow support
- Epic Floor walkers in each Hospital/MCS providing **at the elbow support** and Epic senior leadership support in each command centre

2.4 The hyper support/ command phase was able to be stood down after just **five weeks**, following which the following **Stabilisation Governance Structure** was established. The Stabilisation Board is chaired by the Hive SRO, Julia Bridgewater, and initially met weekly but has now moved to bi-weekly in recognition of the significant progress which has been achieved.



2.5 As expected and **planned for** the Hive teams responded to and **resolved** a huge number of issues and escalations such as:

- Device Integration (e.g. ECG machines)
- Build fixes (Referral routing, scheduling of pre prescribed medications, results routing, consultant pools, medical task list assignments, link to NHS spine)
- Technical & kit (NMGH downtime, WiFi coverage, printing configurations, rover device configuration/access)
- Pharmacy robot integration
- Patient letter distribution and content formulation

- Receipt of laboratory test requests from external NHS Trusts and communication of results to those organisations
- GP communication (changes to their workflows, lab and imaging results)

2.6 A number of **key themes** continue to be overseen by **Pathway Councils** (12 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
- 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.

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, workflow are congruent with the Trust's vertical (Hospital/MCS) and horizontal (Hive) pathways.

2.7 A summary of the Hive activity so far (8th September to 16th December) is as follows:

Metric	Cases
Outpatient Activity	764,095
MyMFT Users/Logins	95,984/1,159,081
A&E Attendances	154,829
Births	4,667
Lab Tests	5,034,176
Imaging Studies	377,226
Theatres Cases	19,940
Pharmacy Transactions	4,957,856
Transplants	65

3. Hive Programme – Stabilisation Phase Update

3.1 The stabilisation phase will run from October 22 to March 23 following which we transition into the Optimisation and Benefits Realisation. The stabilisation phase has been segmented into the following:

- Oct-Dec: Phase 1: Ensuring we are stable and delivering critical safety changes and the highest priority work packages
- Jan-Mar: Phase 2: Commencing implementation of transitional BAU processes and sign off of 2023/24 digital/capital programme

3.2 The following has been achieved in phase 1 of stabilisation:

- 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

3.3 Following engagement with the Royal Eye Hospital 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.

3.4 The REH 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 are planned in for the New Year.

3.5 A formal Central 60 day Post Live Readiness Assessment Day (PLRA) took place on 18th November which focussed Hive Go Live progress in the morning, with the afternoon focused on early optimisation and benefits realisation. Prior to this, a PLRA took place in each Hospital/MCS/LCO, led by their respective Chief Executives, which assessed and provided assurance on local governance arrangements and progress against key stabilisation milestones.

3.6 A key outcome from the Central PLRA was the launch of a programme of work in Outpatients *(Outpatient Sprints)* to support clinical staff personalise their Hive templates to help improve their experience and also to help improve productivity. The Outpatient Sprints are using the success and learning from the REH Sprints.

3.7 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.

3.8 Moving into 2023/24 it is important that the progress made during the Stabilisation Phase continues so that Optimisation and Benefits Realisation can be maximised. It was therefore agreed at the EPR Programme Board on 20th December 2022 that **the existing Executive Organisational Structures for Hive/Informatics will continue until March 2024.** Julia Bridgewater remains SRO for Hive, with the three Corporate Directors (Hive Programme Director, Chief Informatics Officer and Director of Transformation) continuing

to provide leadership in this transitional year. Recruitment will now commence for key roles, starting with the Director of Applications (Hive & Systems), so that recruitment and retention strategy can be implemented to provide a stable and robust infrastructure and in particular so the skills, experience and knowledge of the Hive, informatics and Transformation Team can be retained and developed.

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.

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 will take over the chair of the Scrutiny Committee in January 2023.

4.3 The management of the Hive Programme has had a robust risk management and strategy in place that aligns to and reports 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 Two overall high level risks that have been reported into and managed via GROC. These relate to potential impacts on safety if the programme is not delivered effectively and the risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live. The latter risk was formally downgraded at the November 2023 GROC and the first will be downgraded following sufficient timescale for analysis and review. A formal review will take place in January 2023 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 Group Executive level oversight. These have been managed by the Hive and Group Executive leadership team with close working with the Hospital/Managed Clinical Services.

4.6 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 (which was agreed later than the acute hospitals) 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 Governance process.

5. Communications and Engagement

5.1 As the programme moved into the stabilisation phase in October the communications focus also shifted and aligned to the stabilisation governance plans. Throughout October and November communications aimed to provide staff and stakeholders with transparent and informative updates and support as stabilisation work and critical safety changes took place.

5.2 Regular internal Hive briefings continued to ensure all staff were continuously informed on issues resolution, available support, and system changes. To ensure staff became more aware of the wider stabilisation objectives and activities monthly Hive key message packs were introduced for Hospital teams to cascade and highlight key engagement such as post-live visits, readiness assessments and provide the opportunity to provide more details reflection on successes, support and areas of improvement.

5.3 During the early stage of Hive implementation, alongside supportive stabilisation communications for staff, we also used this time to reinforce Hive benefits, and where possible promote positive experiences to keep the Hive vision at the forefront.

5.4 Below are a selection of early staff testimonials reflecting their positive experience of Hive – shared through internal communications channels and meetings:

Ear, Nose and Throat (ENT) Consultant

I took an emergency patient from ITU to theatre and back again in under 3 hours at ORC earlier this morning and there were no issues at all – Hive worked really well.

It ran smoothly - we could all see the relevant information (even prior to coming in on Haiku) and it felt really controlled. I don't think it's even comparable to our previous systems, just different. It has the capability to work exceptionally.

ENT are not in the hospital on-call so the mobile capability makes it much easier for us to see what we are expecting when we come in, especially as the team had seen the patient earlier that day so we had notes to reference.

Clinical Educator – Digital NMAHP team

Last week I did a clinical shift in Recovery at North Manchester theatres and as an End-User, I found using Hive fantastic.

I quickly ensured my patients were safe on arrival and found that documenting within Optime was well-structured and easy to navigate. Using Hive gave me more time to chat with the patients, as in the past documenting observations every five minutes could submerge us in paperwork.

By looking regularly at the monitor and patient I felt comfortable knowing that the observations were being recorded into Hive, and overall, I felt that I provided a more personalised phase of care to my patients thanks to Hive.

Lead for Hive Clinical Outpatients and parent

An app like this has been a long time coming for a busy family like mine, where both parents are working full time jobs and caring for our daughter, who requires lifelong care. Balancing all of the appointments, letters, tests, diagnostics and occasional cancellations can be quite a challenge to keep on top of, and that's even before considering any follow-up appointments or medication/ dose changes.

MyMFT has streamlined so much of that process and given us the type of shared care setup that we'd always hoped for.

5.5 Saturday 17th December marked 100 days since Hive went live across MFT. To showcase the staff involvement, teamwork and scale of transformation that took place over this period a short reflective video was shared on social media and with staff through internal channels.

5.6 Alongside the video, a 100 Days of Hive infographic was created which highlighted a number of key statistics, facts and figures that span Hive Go Live activities and achievements.

5.7 MyMFT sign up numbers continue to grow with over 95,000 patients now signed up to the portal. MyMFT marketing materials continue to be developed for more targeted audiences highlighting MyMFT benefits relating to proxy access for parents and carers as well as and maternity patients.

5.8 GP communications continued throughout the Stabilisation period to ensure key updates on Hive changes or issues resolution were cascaded efficiently. Regular updates to GP Practices also continued from two dedicated Task and Finish Groups which were made up of both MFT and Primary Care colleagues.

5.9 Online Hive engagement sessions for GPs, which began in early October, continued throughout November. Sessions focused on changes for GPs moving from T-Quest to ICE, referral changes, targeted support from the Division of Laboratory Medicine and a MyMFT learning session

6. Transformation

6.1 Post Go Live the Transformation Team have been focussed on embedding the new ways of working across the pathways

6.2 It is essential that 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.

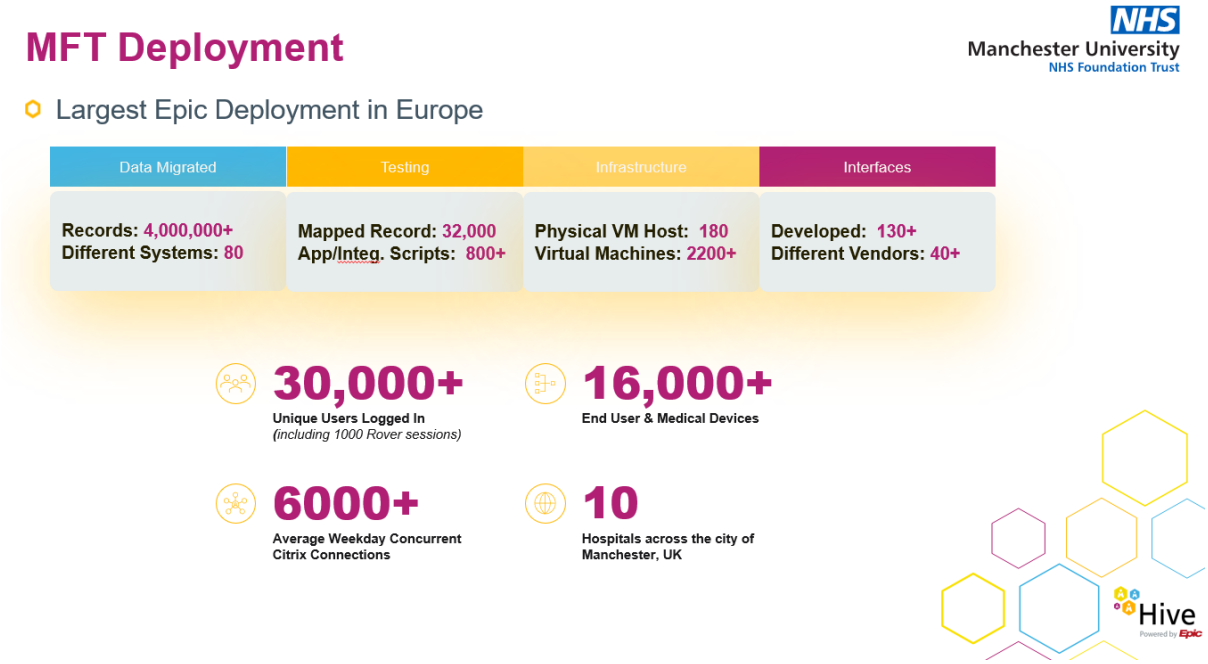
6.3 The Transformation team are key members of the Pathway Councils and are supporting the prioritised change activities – primarily focused on stabilisation at this stage.

6.4 The Transformation work plan is also being informed by the Post Live Readiness Assessment (PLRA) process which is a valuable forum for prioritising stabilisation and optimisation priorities

6.5 Following the 60 Day Post Live Readiness Assessment (PLRA) Transformation have taken a lead on a key priority stabilisation area – to improve the flow through outpatient clinics. The launch of the Outpatient Sprint project of work took place the last week of November 2022 with 'Sprint 1' commencing on the 5th of December, running through to the end of January 2023. This change programme clearly aligns and supports the productivity challenge relating to the non-admitted pathway and will link through to the Elective PMO with the outputs.

7. Technical Deployment

7.1 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. The scale of the overall Hive programme is unprecedented (Europe's largest and second largest globally) and the technical team have been reviewing the overall achievements on delivery – a summary is as follows:



7.2 The technical teams continue to support from Trafford House (Hive command Headquarters) building stronger relationships with the Hive application teams to work collaboratively to resolve issues as they arise. The benefits seen of technical support on the ground across all hospitals continues to be undertaken by the IT Operations team and the relationships built with the Digital Matrons through the End User Device lead have been handed over to the IT Operations Leads across all sites.

7.3 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

8. Benefits Realisation

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

8.2 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.

8.3 The intensity of planning was scaled down immediately prior to go-live to allow hospital/ MCS and corporate areas to focus on a safe and smooth implementation. At mid-October 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.

8.4 These proposals aligned with emerging stabilisation governance and suggested the set-up of two benefit realisation oversight forums to further drive planning and management of Administration & Clerical (A&C), Information Services programmes of work. Operational Productivity benefits will be driven through already established committees.

8.5 An A&C benefits forum was constituted and had a first meeting in early December 2022, attended with representatives from all Hospital / MCS sites and with Group Human Resources, and Chief Operating Officer Team representation. The forum will

- Oversee development, delivery and monitoring of administration and clerical benefits resulting from Hive implementation
- Ensure there are appropriate data inputs and reporting outputs to evidence planning and successful delivery
- Collate identified emergent benefits for planning and successful delivery.

8.6 Initial conversations have been held with Trust's Chief Informatics Officer regarding the Information Services benefits forum with a plan to hold an initial meeting in January.

8.7 Work has continued to review and further develop a benefit register for all types of benefit, including the identification of appropriate key performance indicators to measure delivery of the benefit post Hive implementation.

8.8 An update on cash releasing benefits will be provided to the December EPR Implementation & Benefits Realisation Programme Board. Of an assumed £4.0m of benefits in Quarter 4 of FY22/23 (re-baselined from original Full Business Case), £2.5m is currently in planning. The value of plans could increase as a result of ongoing work associated with Legacy Informatics, Laboratory and Splinter IT systems.

8.9 In terms of non-financial and emergent benefit planning and delivery, matters are being taken through, amongst other forums, the Pathway Council Oversight committee.

8.10 The fifth and final Gateway Review is currently being planned with MFTs EPR external assurance partner – Deloitte. 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 analyse the benefits programme, progress against cash and non-cash leasing benefits and consider if MFT is using national and international learning on delivery outcomes.

9. Next Steps

9.1 The Hive Programme is now nearing the end of Phase 1 of Stabilisation Phase, following Go Live on 8th September 2022, and the focus for Phase 2 (January to March 2023) will be to ensure governance, organisation structures and capital plans are firmly in place as we move to Optimisation and Benefits Realisation.

9.2 Hive Programme Director, Chief Informatics Officer and Director of Applications will now implement the Transitional Organisational Structure agreed at the EPR programme Board.

9.3 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.*

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

10. Recommendation

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Operating Officer
Paper prepared by:	Rob Jepson, Group Director of Estates and Facilities Claire Igoe, Group Associate Director of Sustainability
Date of paper:	January 2023
Subject:	To provide an update on progress of delivery of the 2022 – 2025 Green Plan
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Green Plan update report is produced on an annual basis to update the Board on progress and performance and highlight any key risks and issues. This work aligns with the MFT strategic aim to work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda.
Recommendations:	The Board is asked to note the contents of this report and endorse the additional priorities for the CERB to develop and deliver.
Contact:	Name: Rob Jepson, Group Director of Estates and Facilities Tel: 0161 276 6128

Introduction

Following the publication of 'Delivering a Net Zero National Health Service' in October 2020, a new Green Plan 'Code Green' was produced, and Board approved in January 2022, superseding the 2018-2023 Sustainable Development Management Plan. Having a Green Plan in place is a requirement of the NHS Standard Contract, the NHS Long Term Plan, the NHS Provider Licence and the NHS Operational Planning and Contracting Guidance amongst numerous other key strategic documents.

There are two key targets within the plan:

- For the emissions we control directly (the NHS Carbon Footprint), net zero by 2038 (e.g. energy, waste, anaesthetic gases)
- For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045 (e.g. supply chain and staff, patient and visitor travel)

There is a strong link between health inequalities and net zero, and reducing environmental impact is a core requirement of an Anchor organisation. As the largest NHS Trust in England, MFT also has a key role to play in system leadership.

Background

The 3-year plan outlines a carbon budget which should not exceed 398 ktCO2e [1] by 24/25 year end. There are 10 areas of focus within the plan, with 15 headline objectives and 52 supporting projects. The Green Plan has been widely cited as exemplar, including by members of the national team.

A comprehensive annual sustainability report is produced annually, and publicly shared via the MFT internet pages. Governance is overseen by the Climate Emergency Response Board, chaired by David Furnival, this group focuses on a selection of key strategic priorities from the Green Plan. There is also a Sustainability Steering Group in place, chaired by Claire Igoe with representation from a cross-section of clinical and non-clinical thematic and specialty sustainability leads.

Nationally, a Greener NHS Team is in place, and co-ordinates a regional programme of priorities, outlined in a Memorandum of Understanding. These requirements are a subset of the national strategy and performance is measured via a quarterly data collection. Trust level reporting has expanded significantly to capture national insights and intelligence from Greener NHS dashboards.

Qualitative Performance

Highlights from the current programme are presented below.

- Wythenshawe Hospital has been the MFT test site for decommissioning a Nitrous Oxide manifold. 'Mini mobile manifolds' are now rolled out for use in theatres and

1 kilotonnes of carbon dioxide equivalent - Overall emissions are given as a single figure, measured in megatonnes or kilotonnes of carbon dioxide equivalent (MtCO2e or KtCO2e), by weighting non-carbon dioxide gases by their global warming potential (GWP)

overall this is predicted to save 2,300 tCO2e per year. Plans are in place to scale up at ORC and NMGH in 2023.

- MFT's sustainability work has been showcased nationally and internationally.
- A short video was produced featuring Nick Watts, NHS Chief Sustainability Officer visiting MFT's sustainability programmes and this was premiered at the NHS Confederation annual conference.
- We hosted the Western Australian Government during a research visit to improve their sustainable healthcare portfolio.
- Work to promote sustainable travel has included installation of three new cycling shelters, targeted travel offers and personalised travel planning for NMGH staff, over 120 free on-site bike maintenance sessions for staff and in December a DfT funded e-bike pilot launched at Wythenshawe offering free rentals for staff.
- Launched 'Green Impact' sustainability accreditation scheme in Nov to support and celebrate departmental sustainability projects and have launched two behaviour change campaigns: Active Travel Challenge (walking and cycling) and Working Together, Saving Together (energy saving).
- 100% of paper purchases are now recycled paper products (up from historical average of 65%), and a 73% reduction in overall paper demand has been recorded since the launch of HIVE (compared to 19/20 baseline).

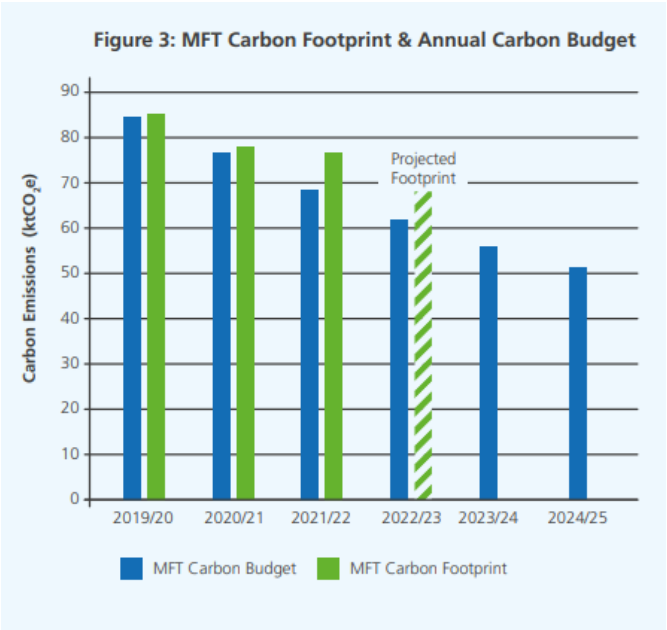
Quantitative Performance

Whilst positive progress has been made in some areas, carbon reductions are not taking place at the scale and pace required. If we exceed the carbon budget set out in this Green Plan, the task will become more challenging in future, with any overshoot being carried forward.

By the end of 2021/22, cumulative carbon emissions were 8% greater than modelled in order to meet the budget. By September 2022, a 4% reduction has been achieved, however, this would need to rise to 19% by year end to bring us back on track.

In terms of the carbon footprint, energy accounts for 75% of emissions and is the most significant opportunity.

Figure 3: MFT Carbon Footprint & Annual Carbon Budget



A KPI dashboard is used to track progress, and the latest version is shown in the appendix. Headline Trends include:

- MFT Carbon Footprint for Q2 22/23 has reduced by 0.8% compared to Q2 21/22, at 17.1 ktCO_2e. Following the pattern on Q1 22/23, these emissions are the lowest for Q2 since the baseline year (Figure 3), representing a 19% reduction from estimated 19/20 Q2 emissions. However, to be on track with our carbon budget, we would have liked 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 as part of the PSDS scheme, combined with mild weather conditions. These changes have resulted in 1,222 tCO_2e 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 tCO_2e), 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%). [2]
- 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 historic average. As a result, 22/23 is averaging the highest monthly waste output since baseline 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).

Next Steps

With a strengthened governance process, MFT is in a good position to make progress. Those key interventions that will deliver at pace and scale need to be accelerated and this will require widespread support from across the organisation and its key partners. The Climate Emergency Response Board (CERB) is now well established, and their work programme will need to be regularly reviewed. It is suggested that the below priorities are added to the remit of the CERB to support the required acceleration of progress.

- 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

2 Upon further investigation, there has been a 2% increase in operations in Q1 and Q2 which will account for some of the increase. There has been a much higher than expected increase in stock levels of nitrous oxide and desflurane (large restocking of nitrous oxide at Wythenshawe in Q2 and desflurane was automatically reordered due to low stock levels despite agreement to discontinue use). This suggests a requirement for wider stakeholder engagement in Trust Green Plan initiatives.

- 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

Recommendations

The Board is asked to note the contents of this report and endorse the additional priorities for the CERB to develop and deliver.

APPENDIX

Theme	KPI	Unit	Q1 2022/23	Q2 2022/23	2022/23 Year to Date	2021/22 Year to Date	YtD Trend (22/23 vs 21/22)
Carbon	MFT Carbon Footprint	tCO_2e	18,559	17,131	35,690	37,323	↓ 4%
	Community Carbon Footprint	tCO_2e	Measured annually	Measured annually	Measured annually	12,440*	N/A
	Supply Chain Carbon Footprint	tCO_2e	Measured annually	Measured annually	Measured annually	162,912*	N/A
	MFT Carbon Footprint Plus	tCO_2e	Measured annually	Measured annually	Measured annually	214,844*	N/A
	Normalised MFT Carbon Footprint	*Kg CO_2e/patient contact*	*33.66*	*33.07*	*33.37*	*32.46*	↑ 3%
Utilities	Natural Gas Consumption	kWh	45,518,363	34,600,024	80,118,386	87,843,939	↓ 9%
	Electricity Consumption	kWh	17,511,587	20,032,322	37,543,909	38,676,541	↓ 3%
	On-site Renewable Generation	kWh	Measured annually	Measured annually	Measured annually	65,457*	N/A
	Water Consumption	m^3	181,892	188,597	370,490	382,604	↓ 3%
	Normalised Energy & Water Carbon Footprint	*Kg CO_2e/patient contact*	*26.39*	*24.87*	*25.66*	*26.63*	↓ 4%

Medical & Anesthetic Gases	Volatile Anaesthetic Gases	tCO_2e	267	136	402	248	↑ 62%
	Medical Gases	tCO_2e	2,947	3,324	6,271	4,522	↑ 39%
Waste	Total Waste	Tonnes	2,113	2,114	4,227	4,049	↑ 4%
	Healthcare Waste	Tonnes	927	913	1,840	1,902	↓ 3%
	Healthcare Reuse & Recycling	Tonnes	24	13	37	35	↑ 5%
	Non-Healthcare Waste	Tonnes	709	715	1,424	1,214	↑ 17%
	Non-Healthcare Reuse & Recycling	Tonnes	453	472	926	897	↑ 3%
	Normalised Total Waste	*Kg waste/patient contact*	*3.83*	*4.08*	*3.95*	*3.52*	↑ 12%
Travel	Total Fleet Mileage	km	Measured annually	Measured annually	Measured annually	639,839*	N/A
	Total Business Travel Mileage	km	Measured annually	Measured annually	Measured annually	2,315,484*	N/A
	Modelled Staff Commuting Mileage	km	Measured annually	Measured annually	Measured annually	77,490,982*	N/A
	Modelled Patient & Visitor Travel Mileage	km	Measured annually	Measured annually	Measured annually	42,157,128*	N/A

MANCHESTER 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:	January 2023
Subject:	General update, performance standards and Recovery Programme
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors is 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 2766121

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 3 areas: -

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

2. EXECUTIVE SUMMARY

Hospitals have continued to be challenged across urgent care pathways throughout November and December, escalating across GM. At the time of writing, week commencing 19th December, MFT alongside all other Trusts in GM declared an OPEL Level 4 , which is the highest level of escalation as a result of emergency and urgent care pressures, this coincided with the week of the ambulance industrial action on Wednesday, 21st December. MFT enacted a command and control structure during these times and utilised 'Business Continuity Incident' principles to support and coordinate activities for de-escalation of the situation. These pressures are demonstrated through the performance against a number of key metrics with 4hr standard remaining challenged. Equally delays in ambulance handover impacted by reduced flow resulting in an increase in patients spending more than 12 hours total time in the department.

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 and is tracking to trajectory. 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
- coordinating 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 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 has remained largely stable through April to August at 62.7%. This dipped in September as a result of the migration to the new EPR system to 53% and has remained static throughout October and November. Whilst this is in part as a result of familiarisation with the system the main challenges have been emergency pressures experienced across GM during this time. MFT has been significantly affected and as a result the Trust has escalated to a command and control structure in October and again in November to support actions that would enable speedy de-escalation.

Significant challenges remain with flow and greater than 100% occupancy is being reported across the adult acute sites with escalation into elective/ daycase and short stay units. Acuity has increased across a number of pathways and there has been an increase in the number of patients on the no reason to reside list, which remains stubbornly high. Equally there has been an increasing trend in flu and COVID admissions. Specific challenges have also been felt across paediatrics with RMCH seeing record attendances through their A&E due to current wave of RSV and Strep A along with national pressures across paediatric intensive care beds.

Ambulance handover performance remains challenged, impacted by reduced flow resulting in an increase in patients spending more than 12 hours total time in the department.

Hospitals continue to focus efforts on improving flow out of the department and ensuring patient safety is maintained. The MRI have recently implemented a Transfer & Discharge Unit as part of their winter initiatives which runs across the 7 days to facilitate patients awaiting admission or transport home from an outpatient clinic or ambulatory care setting and patients being discharged from ward areas. WTWA have strengthened and expanded their SDEC pathways which has seen an increase in patients bypassing A&E. The use of virtual wards has increased and each hospital has a trajectory to increase this further over the coming weeks.

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

Ongoing Actions:

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

- Increase in the number 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
- 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

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

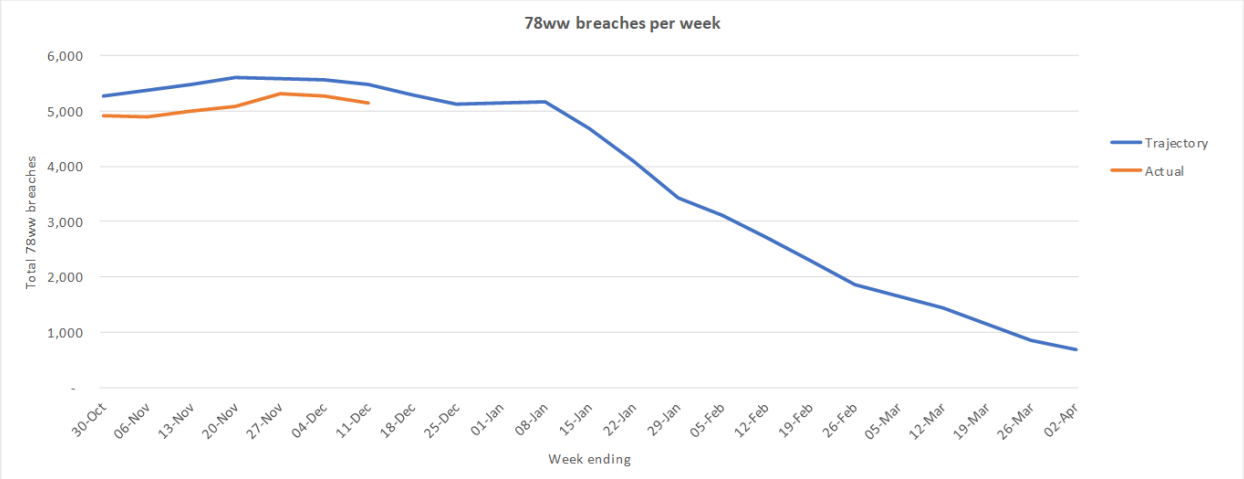
4. ELECTIVE ACCESS

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 sustaining the position of zero 104+ week waits except for those patients who are clinically complex, medically unfit or patient choice. New supporting guidance has been issued by the national team to aid providers in managing their waiting lists in relation to patient choice, this has been circulated to operational teams to assist them with patient pathway management.

Significant progress has been made with Trust Sites focusing on reducing long-wait backlogs even further with clearance required for 78-week-wait patients by March 2023. It is recognised that delivering the 78-week-wait target will be challenging and the Trust continues to work with Independent Sector Providers (ISPs) to support delivery and are part of the National Mutual Aid programme. The below chart provides the current position on 78 week waits against trajectory which is tracking against plan.

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	12-Mar	19-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																
Actual 78ww breaches	Variance	- 355	- 476	- 473	- 527	- 275	- 297	- 317																

Ongoing Actions:

Improvement plans are in place and an Elective PMO hub has recently been established to track and monitor delivery.

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
- Further reinforcement of booking principles to man mark 78w patients
- Actions and tracking of patient data provided weekly to all hospitals/MCS and this support 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
- Discussions and supporting SOPS provided for pooling of patients where applicable across sub specialities

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 reporting for this programme has been through the Covid R&R Group and will move to the new Operational Excellence Board that has been established from November, both of which feed through to Group Committees / Board for oversight. 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.

- **PIFU** - MFT is achieving 1.4% of patient initiated follow ups (PIFU) against a target of 5% by March 2023, meaning between 1,500 and 2,000 patients are being placed on a PIFU pathway monthly. We currently have approximately 14,000 active PIFU patients.
- **Virtual Triage / Advice & Guidance** - Pre-HIVE MFT implemented virtual triage in services accounting for 85% of GP referrals, this supported Advice & Guidance with c1,500 referrals being re-directed or provided with specialist advice through this route each month. Hive go-live has rapidly expanded this to include all referrals (GP referrals account for <50% of all MFT referrals) and services that had not adopted virtual triage. Data from Hive go-live is being validated but initial indications are that there has been a step change increase in Advice & Guidance and referrals being returned.
- **MyMFT patient portal** - was launched as part of the Hive go-live. This supports better patient communications, with patients able to access letters, appointment information and results through the portal. Future functionality will allow patients to change their appointments through the portal giving patients greater control of their care, but this has not yet been launched.
- **Virtual consultations** - Hive has moved video consultations from the Attend Anywhere platform to Microsoft Teams, which is integrated with the MyMFT app, improving the patient experience.
- **Menopause Pilot** - As part of a drive to use new technology to reduce secondary care demand, MFT are piloting the use of a menopause clinical decision-making app that could allow patients to receive Hormone Replacement Therapy (HRT) treatment much faster than otherwise. Both initiatives are being targeted at the existing waiting list to avoid inequity of access in the first instance, and as part of the Super September initiative.
- **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. Please note the deadlines have been extended by 3 weeks for each cohort, against the original deadline set out by the Tier 1 letter.
- Through contract with Health Care Communications we have successfully contacted approximately 30,000 patients. At the time of writing, 6-7% 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 has seen a growing trend and a deteriorating performance that is impacting on delays to diagnosis and treatment. Long waits are specifically evident across MRI and CT with reporting capacity being the main challenge. Similarly, Echocardiograms are also reporting long waits impacted by workforce shortages which is being mitigated in part 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 turn around times for urgent suspected cancer diagnostics.

Trajectories and improvement plans are in place to support turn around 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 during 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 an 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
- Maximise use of Community Diagnostic Centres for Imaging and Endoscopy

CANCER

Current Position

The table overleaf provides the latest published performance data for cancer. Total referrals for suspected cancer have reduced across July and August towards pre covid levels, this seems to have increased again post the Summer, especially in breast, with usual fluctuations between tumour sites and months.

It should be noted that the submissions for September and October are incomplete following HIVE go live, whilst staff are familiarising themselves with the system. A refresh of the data and further validation is being carried out . Staff have had further training on completing relevant target fields in Hive and a suite of validation reports is being built for more timely transaction and review.

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 NMGH Breast, Urology, Gynaecology and H&N along with Colorectal at WTWA site.

Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-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%
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%
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%
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
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%
MFT Faster Diagnosis (75% target)	36.9%	58.7%	56.4%	46.9%	56.0%	42.9%	55.1%	61.0%	54.2%	61.8%
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%
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%

There has been good progress on reduction of the cancer 62 day backlog with a 31% reduction over the last 6 weeks. November month end position was 869 against 849. Trajectories and recovery plans have been reset across hospitals/MCSs and daily tracking is in place through the Elective PMO hub.

On-going Actions

- Weekly PMO meetings to track progress and actions
- New diagnostic cancer PTL built into Hive to provide a clearer view of pathway patients
- The Urology MFT@Christie model continues, and mutual aid is in place for gynaecology patients as required.
- A review of cancers resources across sites with a view to harmonising practices and roles
- Continued use and focus to utilise IS capacity for endoscopy demand.
- Additional clinical capacity in place at weekdays and weekends including resource for the most underperforming tumour groups, Head and Neck, Breast, and skin.
- A single point of access has now been set up for H&N across MFT and referrals are now being seen at 8 days
- Focused fortnight taken place in November with some capacity still ongoing. This is a GM wide initiative and several schemes were identified over the 2 weeks that increased capacity across a number of tumour sites.
- LGI workshop to be held in December

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse & Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse (ACN) Infection Prevention and Control/Tissue Viability Alison Lynch, Group Deputy Chief Nurse
Date of paper:	January 2023
Subject:	Update on the Infection Prevention and Control response to COVID-19, including: • Nosocomial Infections • Updated National Guidance • COVID-19 and Seasonal Influenza vaccination programmes
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Safety Patient Experience
Recommendations:	The Board of Directors are asked to note the content of this report 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 On 14th April 2022 existing national COVID-19 guidance was withdrawn and replaced with the National Infection Prevention and Control Manual (NIPCM) for England[1] The document has been implemented within England to support compliance with the ten criteria within the Health and Social Care Act 2008[2].

2.2 The NIPCM is non pathogen specific and is based upon the standard infection control principles. The principles include:

- The fundamental IPC measures necessary to reduce the risk of transmitting infections
- Additional precautions, namely transmission-based precautions (TBP) required when caring for patients with known or suspected pathogens.

2.3 The Infection Prevention principles in place at MFT are based on the NIPCM and other published guidance, including the Hierarchy of Controls[3] 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.

2.4 The NIPCM is published in the context that while COVID-19 is circulating across the UK, and will continue to do so, reported infections in communities are far lower than at peaks during the pandemic.

2.5 Furthermore, the level of vaccinations and the less virulent strains mean that whilst hospitals remain under pressure due to the additional burden of COVID-19 there are significantly fewer Covid related admissions to critical care.

2.6 The IPC Board Assurance Framework[4] (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. Section 3 of this report provides further detail on the IPC BAF.

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[1] National Infection Prevention and Control Manual for England (2022)

[2] Health and Social Care Act (2008)

[3] Hierarchy of Controls: Elimination. Substitution. Engineering Controls. Administrative Controls. Personal Protective Equipment (PPE).

[4] NHSE Infection prevention and control board assurance Framework V1.11 November 2022

2.7 Since 5th September 2022, in line with updated NHSE/I guidance COVID-19 testing in periods of low prevalence[5], routine asymptomatic testing in hospital and care home settings has paused, this includes asymptomatic adult patients and asymptomatic healthcare staff. NB., exceptions exist for identified immunocompromised in-patient areas, where weekly screening has continued for both patients and staff.

2.8 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.

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

3.1 The IPC BAF has been regularly reviewed by the Board of Directors and by the Group Infection Prevention and Control Committee since its introduction in June 2020.

3.2 As reported previously to the Board of Directors, the IPC BAF is now incorporated into the Board of Directors BAF as an assurance document. The 10 key lines of inquiry described with the IPC BAF are included at Appendix 1

3.3 Following the IPC BAF's most recent iteration published on 30th November 2022, the IPC team are leading a further extensive review, taking into account all IPC related risks and mitigating actions. Following this review, a report will be received by Group Infection Prevention and Control Committee in January 2023.

3.4 For assurance, a summary of evidence against the key lines of enquiry described 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 NICPM.
- The Trust has a plan in place, led by the Director of Estates and Facilities, to implement the National Standards of Healthcare Cleanliness[6], 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)[7], 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).
- 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

[5] COVID-19 testing in periods of low prevalence 24th August 2022

[6] National Standards of Healthcare Cleanliness 2021 NHS PAR271

[7] NHSE A Rapid Review of Aerosol Generating Procedures: Assessment of the UK AGP list conducted on behalf of the UK IPC Cell June 2022

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.
- 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.

4. Healthcare Associated Infections

4.1. COVID-19

Omicron BA.5 remains the dominant COVID-19 variant in the UK. BA.4 and BA.5 are more transmissible and can evade immunity from prior infection and vaccination. However, vaccines remain effective at reducing the risk of hospitalisation with these subvariants in comparison to the original Omicron variant BA.2.

4.2. R-Rate

The current R-rate within the Northwest of England, at 9th December 2022 was 0.9 to 1.2[8]. The latest growth rate is +1% 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, however it is worth noting that the current R-rate for London is 0.9 to 1.1, with their highest being 1.2 to 1.6 in December 2021.

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. Over the previous 4 weeks we have seen an increase in HOCI numbers across the organisation, indicating nosocomial transmission.

[8] The R value and growth rate. www.gov.uk/guidance/the-r-value 9th December 2022

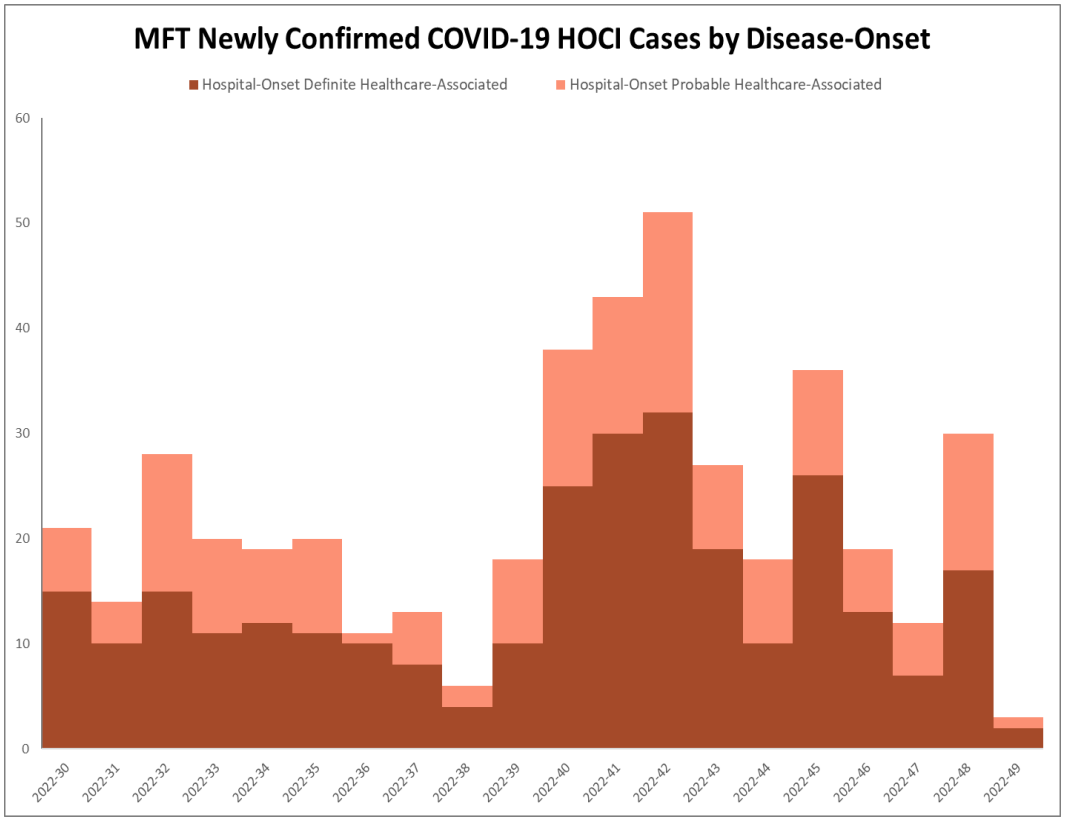


Chart 1 Newly confirmed hospital onset COVID- 19 cases across MFT

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 July 2022 and then declined throughout August and September. Outbreak numbers again increased from October 2022 reflecting the rise in HOCI cases within the organisation. Outbreaks have reduced in November 2022.

Month	Number of COVID-19 outbreaks
July 2022	28
August 2022	12
September 2022	7
October 2022	31
November 2022	6

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 virus A, B, C and D. Influenza A and B can cause Influenza epidemics which occur within the autumn/winter season. The current national

surveillance reports indicate that reported a sharp increase in positive swabs have increased to 14.3%[9]. Those most affected are within the 15–44-year-old age group.

4.7 Globally, the increase in Influenza cases may be related to relaxation of measures in place intended to respond to the COVID-19 pandemic, and the low proportion of the global population vaccinated against Influenza. Additionally, there has been little natural influenza infection for the past 2 years. As a result, herd immunity against currently circulating viruses is probably substantially lower compared with previous years.

4.8 Outbreaks of Influenza have occurred at MFT since October 2022, 2 outbreaks were within the Manchester Royal Infirmary (MRI) and 1 outbreak within an intermediate care facility at the Manchester Local Care Organisation (MLCO). An outbreak is 2 or more cases within the same ward/department within a 14-day period and can include both patients and staff. All outbreaks are presented at the hospital local Infection prevention outbreak meeting or the accountability meeting where actions are discussed and implemented.

5 Other Healthcare Associated Infection (HCAI)

5.1 The Trust is committed to reducing incidents of avoidable HCAI. Chart 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	5	0
Clostridioides (previously known as Clostridium) *difficile* infection	215	196	132	174
Gram Negative Bacteraemia	299	304	234	410
Vancomycin Resistant Bacteraemia	34	31	33	N/A

Chart 2 Reportable HCAI's since April 2022

[9] National flu and COVID-19 surveillance reports accessed 12/12/22

5.2 MRSA bacteraemia

Since April 2022 **6** 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 is being developed to monitor compliance, and to highlight clinical areas where supportive action to prevent infection is required.

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 33 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
- Increased microbiology team ward rounds in place to increase awareness of need to respond to positive screening in those areas described above.

5.5 Carbapenemase-producing Enterobacterales (CPE)

Year to date figures highlight there has been an increase in acquisition of CPE across MFT. The Manchester Vascular Centre and Ward A9 at WTWA have experienced outbreaks of CPE acquisition and 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,
- 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 review of the newly refreshed IPC BAF, including ensuring alignment to the NIPCM, is being presented to the Group Infection Prevention and Control Committee in January 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.
- 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.

7. MFT 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 MFT Vaccine service provides the Moderna (Spikevax) Bivalent and Pfizer Bivalent vaccines for the Autumn Booster.

7.3 Current vaccination levels (December 22)

Staff COVID-19 vaccinations

- 8658 (30.2%) of Frontline Healthcare workers have had their Autumn booster vaccination at an MFT clinic[10]
- 10,213 (44.9%) of Frontline Healthcare workers have had their Autumn booster vaccination at any internal or external provider[11]

Staff seasonal influenza vaccines

- 8213 (28.7%) of staff have received their flu vaccine at an MFT clinic[12]
- 10848 (43.9%) of Frontline Healthcare workers have had flu vaccination at any internal or external provider[13]

[10] At 15th December 2022 via MFT Power BI Dashboard
[11] At 15th December 2022 via North West Weekly Activity Dashboard
[12] At 15th December 2022 2022 via MFT Power BI Dashboard
[13] At 15th December 2022 via North West Weekly Activity Dashboard

7.4 The national target for frontline healthcare workers is to offer:

- 100% of staff access to the flu vaccine (MFT have reached this target), with a CQUIN of 70-90% uptake, and
- 100% offer of COVID-19 boosters to all staff.

7.5 Nationally, the uptake figures amongst healthcare workers is currently 48.3%, in the Northwest the uptake is 44.2%[14].

- Greater Manchester ICB: 44.1%
- Cheshire & Merseyside ICB: 46.2%
- Healthier Lancashire & South Cumbria: 40.3%

7.6 In 2021-2022, MFT saw a reduced influenza vaccine uptake with 60.5% of frontline healthcare workers, opting to be vaccinated, this was a reduction from 81.01% of staff vaccinated in 20-21.

7.7 A coordinated and creative engagement plan has been implemented to ensure that all people offered the vaccine have the information required to make an informed decision. This includes accessible Q&A sessions, either via MS Teams, distributed video's, and direct conversations in the workplace.

7.8 Led by Employee Health & Well-being (EHW), the Vaccination Engagement Group continues to meet monthly, involving hospital/MCS/LCO and corporate vaccination leads, EHW, pharmacy, communication teams, staff-side representation, and network representatives (BAME, EDI, LGBT+).

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

7.10 An information pack has been provided to managers to support them in holding wellbeing discussions with staff who have not accepted or declined the offer of vaccination and the hospitals have been offered bespoke training sessions for managers to support them with this.

7.11 The hospital/MCS/LCO senior leadership teams are using the Power BI Dashboard, to drill down to specific areas where a 'roving clinic' will improve uptake.

8 MFT COVID-19 and Seasonal Influenza Patient Vaccination Programme

8.1 Specific patient cohorts are 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, pending external funding agreement.

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

[14] At 15th December 2022 via North West Weekly Activity Dashboard

- 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
- 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

8.3 As MFT has 'hospital hub+' status, we were once again asked to open vaccine appointments to members of the public through the National Booking System (NBS). 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.

8.4 The NBS appointment system also allows people (including MFT staff) to book vaccine validation appointments, where overseas vaccinations can be added to their NHS record.

9 Vaccination Summary

9.1 The COVID-19 and Seasonal Influenza vaccination programme commenced in September and October 2022 respectively.

9.2 Uptake is low nationally and regionally.

9.3 MFT have actions in place, described through this paper, to improve uptake. These include:

- Increase in roving clinics to improve ease of access to vaccination
- Use of manager well-being discussions to encourage staff to have their vaccinations
- A series of engagement events to help alleviate any outstanding concerns staff may have in respect of vaccination.

10 Recommendations

10.1 The Board of Directors are 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

10 Key Lines of Inquiry in the Infection Control Board Assurance Framework November 2022

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

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

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

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

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

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

7. Provide or secure adequate isolation facilities

8. Secure adequate access to laboratory support as appropriate

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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Head of Group Reporting & Financial Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	January 2023
Subject:	Financial Performance for Month 8 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 8 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 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 November 2022, the Trust has delivered a 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, it is essential that work on delivery of WRP schemes is given the highest priority and focus across the entire organisation. Also, in November the ICB for Greater Manchester put itself and all providers into a 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. This was discussed in detail at the Finance & Digital Scrutiny Committees in October and December.
1.2	**Run Rate**	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, 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.
1.3	**Cash & Liquidity**	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, this was primarily due to lower than forecast cash outflows relating to trade creditors.
1.4	**Capital Expenditure**	The Trust will operate within the agreed GM final capital allocations (the "envelope") 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 last month, 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.

Financial Performance

Income & Expenditure Account for the period ending 30th November 2022

I&E Category	NHSI Plan M8	Year to date Actual - M8	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	597,807	610,685	12,878
Clinical commissioning groups	823,930	841,270	17,340
NHS Trust and Foundation Trusts	2,552	2,281	(271)
Local authorities	23,758	23,838	80
Non-NHS: private patients, overseas patients & RTA	6,328	7,238	910
Non NHS: other	5,936	7,973	2,037
Sub -total Income from Patient Care Activities	**1,460,311**	**1,493,284**	**32,973**
Research & Development	43,559	45,535	1,976
Education & Training	54,408	57,219	2,811
Misc. Other Operating Income	56,317	57,325	1,008
Other Income	**154,284**	**160,079**	**5,795**
TOTAL INCOME	**1,614,595**	**1,653,363**	**38,768**
EXPENDITURE			
Pay	(948,727)	(1,021,557)	(72,830)
Non pay	(577,502)	(585,822)	(8,320)
TOTAL EXPENDITURE	**(1,526,229)**	**(1,607,379)**	**(81,150)**
EBITDA Margin	**88,366**	**45,984**	**(42,382)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(54,618)	(35,271)	19,347
Interest Receivable	400	2,156	1,756
Interest Payable	(32,595)	(31,159)	1,436
Gain / (Loss) on Investment	0	0	0
Dividend	(1,554)	(1,554)	0
Surplus/(Deficit) for GM position	**0**	**(19,844)**	**(19,844)**
Gain / (Loss) on Investment	0	795	795
Surplus/(Deficit) against internal breakeven plan	**0**	**(19,049)**	**(19,049)**
Surplus/(Deficit) as % of turnover	**0.0%**	**-1.2%**	
Impairment	**(64,754)**	**(52,854)**	**11,900**
Non operating Income	**2,438**	**2,634**	**196**
Depreciation - donated / granted assets	**(841)**	**(844)**	**(3)**
Surplus/(Deficit) after non-operating adjustments	**(63,157)**	**(70,908)**	**(7,751)**

For month 8, November 2022, the Trust has delivered a YTD deficit of £19.1m against a planned YTD breakeven position.

There is a favourable variance against income YTD to month 8 of £38.8m, with £22.7m 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 £3.3m, Genomics contract variations of £1.7m, CPT drugs income £0.3m, Vaccine Booster income of £0.6m and winter funding included in month 8 of £0.6m. In addition, Education & Training income is above plan by £2.8m YTD, R&D income £2.0m ahead, with non-NHS income favourable YTD by £2.0m. 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 well above plan YTD to month 8 by £72.8m, reflecting the profile of the revised plan, although £22.7m can be attributed to the AfC pay award uplift backed by income, as described above. The main reasons for the remaining gap are pay pressures due to sickness and vacancies across the Trust sites, accounting for £25.2m adverse variance and under-delivery against the WRP target of £16.4m, most of which is sitting against pay related codes. The continued cost of bank and agency pay remains well above plan and agency above the Trust's cap.

However, agency expenditure decreased to £2.3m in month, which was a decrease of £1.3m compared to last month's cost of £3.7m, with YTD spend at £25.1m which is adverse to the plan by £5.8m.

The table below shows agency expenditure against the plan YTD and the month 6 forecast outturn by staff group. There is a gap of 19.7% to the "cap" (including the capitalised agency costs) that will need closing before the year end if the Trust is to be within the agency cap.

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	1,120	15,730	(14,610)	1,680	22,374	(20,694)
Nursing & Midwifery Staff	287	2,116	(1,828)	431	2,610	(2,179)
Scientific, Therapeutic & Technical Staff	1,025	3,649	(2,623)	1,537	5,443	(3,906)
Clinical Support Staff	79	1,247	(1,168)	119	1,773	(1,654)
Non Clinical Staff	353	2,314	(1,961)	352	2,914	(2,562)
*Budget changes internal vs external plan**	*16,384*	*0*	*16,384*	*25,205*	*0*	*25,205*
Total	**19,250**	**25,056**	**(5,806)**	**29,325**	**35,113**	**(5,788)**

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 with the expectation that plans were drawn up to reduce agency expenditure, and subsequent forecasts, within these limits.

Non-pay expenditure decreased by £2.5m in month 8 with the majority of this being related to a higher level of balance sheet flexibilities included in the position compared to month 7. There were offsetting movements between Depreciation and Interest Payable (adverse) and Clinical Supplies and Services (favourable) due to the IFRS 16 adjustment that was made in month 7.

Overall, the Trust is reporting a month 8 position that is £0.8m better than at month 7, £2.0m better than at month 6 and £3.1m better than at month 5. This reflects a surplus against the in-month break-even plan of £0.1m. The run rate implied by a deficit of £19.1m, YTD to month 8, would lead to an outturn deficit of £28.7m (an improvement over month 7's £32.7m and month 6's £36.6m) but there remains the need to focus on delivering the WRP savings in 22/23.

In November the ICB for Greater Manchester put itself and all providers into a Financial Recovery footing and requested all providers deliver a 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 MFT would deliver Best Case of a breakeven position, Most Likely, £10.4m deficit and Worst Case, £50.8m deficit. The presentation that formed the basis of this submission was discussed at Finance & Digital Scrutiny Committee in October, and further discussed in December.

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 £61.3m against schemes that have progressed to L3 or higher on WAVE. This reflects an adverse variance of £0.6m compared to the plan against L3 or higher schemes. This falls short of the overall YTD target of £77.7m by £16.4m, meaning that the Trust continues to 'play catch up'.

The schemes delivering savings in month 8, plus others at L3 or above that have not yet begun, are forecast to deliver £93.5m of savings by the end of the year, a deficit of £23.7m compared to the Trust target of £117.2m – this reflects an improvement of circa £2.8m compared to the forecast at month 7.

MFT Summary

Workstream	Savings to Date				Forecast 22/23 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	120 10.535	Financial BRAG	Plan (22/23) £'000	Act/F'cast (22/23) £'000	Variance (22/23) £'000	Financial BRAG
Admin and clerical	703	679	(24)	97%	1,166	1,167	1	100%
Budget Review	2,662	2,665	3	100%	3,805	3,804	(1)	100%
Contracting & income	3,328	3,310	(18)	99%	4,368	4,350	(18)	100%
Hospital Initiative	7,465	7,420	(45)	99%	11,295	11,381	86	101%
Length of stay	651	654	3	100%	1,086	1,090	3	100%
Non Pay Efficiencies	1,183	1,161	(22)	98%	2,838	2,808	(30)	99%
Outpatients	50	39	(11)	78%	75	64	(11)	85%
Pharmacy and medicines management	2,190	2,185	(5)	100%	3,090	3,076	(14)	100%
Procurement	2,308	2,005	(303)	87%	3,828	3,382	(446)	88%
Theatres	106	106	0	100%	212	212	(0)	100%
Workforce - medical	1,117	1,082	(35)	97%	1,719	1,713	(6)	100%
Workforce - nursing	2,482	2,313	(169)	93%	3,861	3,692	(169)	96%
Workforce - other	2,957	2,957	(0)	100%	4,262	4,262	(0)	100%
Informatics	181	181	0	100%	713	713	0	100%
Total (L3 or above)	**27,384**	**26,758**	**(626)**	**98%**	**42,318**	**41,714**	**(604)**	**99%**
Trust Initiative	34,522	34,522	1	100%	51,784	51,784	(0)	100%
MFT Total	**61,906**	**61,280**	**(626)**	**99%**	**94,102**	**93,498**	**(604)**	**99%**

Summary against Target M1-8	YTD
Target	77,710
Actuals (L3 or above)	61,280
Variance to Target	- 16,430
Lost opportunity (value of schemes below L3)	4,007
Variance to target if all schemes delivered as plan	- 12,423

Summary against Target 22/23	Act/F'cast (22/23)
Target	117,246
Actuals/Forecast (L3 or above)	93,498
Variance to Target	- 23,748
Value of schemes below L3 (M9-12)	6,529
Variance to target	- 17,219

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	4.6	(0.9)	-17%
CSS	13.3	8.4	(5.0)	-37%
Eye	1.2	0.8	(0.4)	-33%
Dental	0.9	0.2	(0.6)	-72%
LCO	7.9	3.3	(4.5)	-57%
MRI	6.8	8.0	1.2	17%
NMGH	4.4	2.9	(1.5)	-34%
RMCH	8.5	5.7	(2.8)	-33%
St. Mary's	3.9	3.3	(0.6)	-14%
WTWA	13.1	4.4	(8.7)	-66%
Hospital/MCS/LCO Subtotal	**65.5**	**41.7**	**(23.7)**	**-36%**
Trust	51.8	51.8	0.0	0%
MFT Total	**117.2**	**93.5**	**(23.7)**	**-20%**

Statement of Financial Position

	31-Mar-22 £000	30-Nov-22 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	16,107	11,619	(4,488)
Property, Plant and Equipment	798,636	925,738	127,102
Investments	870	870	0
Trade and Other Receivables	15,657	15,252	(405)
Total Non-Current Assets	**831,270**	**953,480**	**122,210**
Current Assets			
Inventories	21,809	23,584	1,775
NHS Trade and Other Receivables	26,500	66,082	39,582
Non-NHS Trade and Other Receivables	61,879	72,148	10,269
Non-Current Assets Held for Sale	2,510	210	(2,300)
Cash and Cash Equivalents	319,112	205,877	(113,235)
Total Current Assets	**431,810**	**367,902**	**(63,908)**
Current Liabilities			
Trade and Other Payables: Capital	(43,000)	(19,960)	23,040
Trade and Other Payables: Non-capital	(339,849)	(361,203)	(21,354)
Borrowings	(24,001)	(33,547)	(9,546)
Provisions	(52,636)	(38,623)	14,013
Other liabilities: Deferred Income	(59,360)	(78,546)	(19,186)
Total Current Liabilities	**(518,846)**	**(531,879)**	**(13,033)**
Net Current Assets	**(87,036)**	**(163,978)**	**(76,942)**
Total Assets Less Current Liabilities	**744,234**	**789,502**	**45,268**
Non-Current Liabilities			
Trade and Other Payables	1	-	(1)
Borrowings	(371,694)	(484,051)	(112,357)
Provisions	(13,903)	(13,158)	745
Other Liabilities: Deferred Income	(2,386)	(3,650)	(1,264)
Total Non-Current Liabilities	**(387,982)**	**(500,859)**	**(112,877)**
Total Assets Employed	**356,251**	**288,643**	**(67,608)**
Taxpayers' Equity			
Public Dividend Capital	408,780	411,288	2,508
Revaluation Reserve	97,411	97,412	1
Income and Expenditure Reserve	(149,940)	(220,057)	(70,117)
Total Taxpayers' Equity	**356,251**	**288,643**	**(67,608)**
Total Funds Employed	**356,251**	**288,643**	**(67,608)**

Movements in the Statement of Financial Position reflect the capital programme expenditure and accruals movements which continue to affect 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.

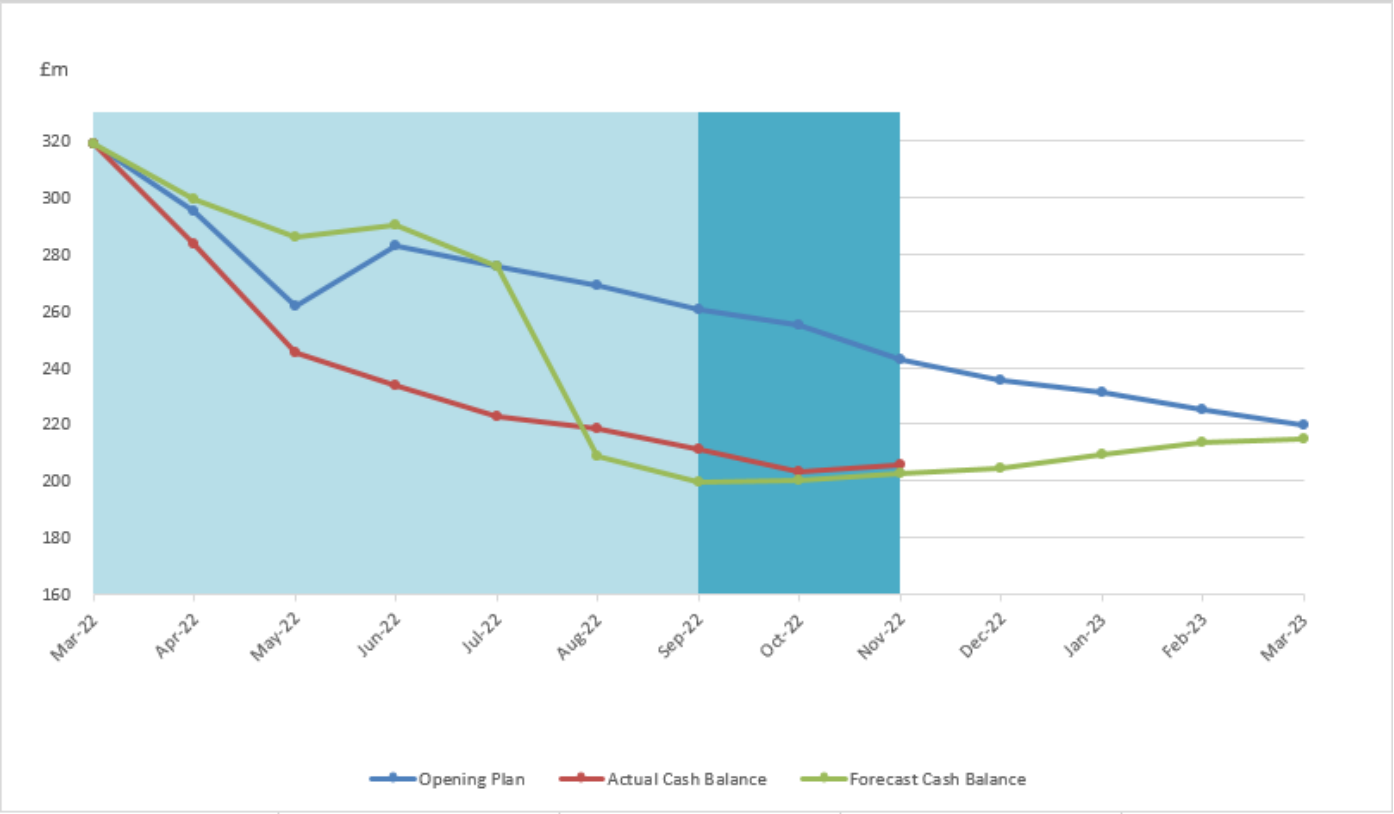
During the year there has been an increase in other receivables driven by an increase in central and CSS accrued income. Although trade and other receivables have increased since 31st March 2022, they have decreased in month 8. The majority of this in-month movement is due to a reduction in central accrued income of £15m, with most of this being ICB balances (£13.4m).

During the year there has also been an increase in non-capital trade and other payables driven by an increase in central accruals. Trade creditors have continued to increase in month 8. The majority of this in-month movement is due to an increase of £4.6m relating to pharmacy accruals and an increase of £4.4m relating to children's services' accruals. Invoicing issues at NHS supply chain resulted in an understatement of central trade payables of approximately £3.5m, which were accrued locally to ensure no exposure.

Deferred income has also increased since 31st March 2022, primarily due to the receipt of quarterly HEE income in advance, £6m of which has been recognised in month 8. £3m of deferred income relating to non-patient care income received in advance has also been recognised in month 8, resulting in an in-month reduction of deferred income of approximately £9m.

The 1st April 2022 opening balance for right of use assets was updated in October to reflect the October IFRS 16 submission to NHSE. Following discussions with NHSE and Mazars regarding the treatment of existing managed equipment service (MES) contracts, the opening balance for right of use assets (ROU) has been reduced from £228m to £142m. A similar adjustment has been made to the lease liabilities included as current and non-current borrowings. The subsequent reduction during this financial year in interest and depreciation is offset by a corresponding increase in supplies and services costs with a net impact of £0.5m reduction in charges.

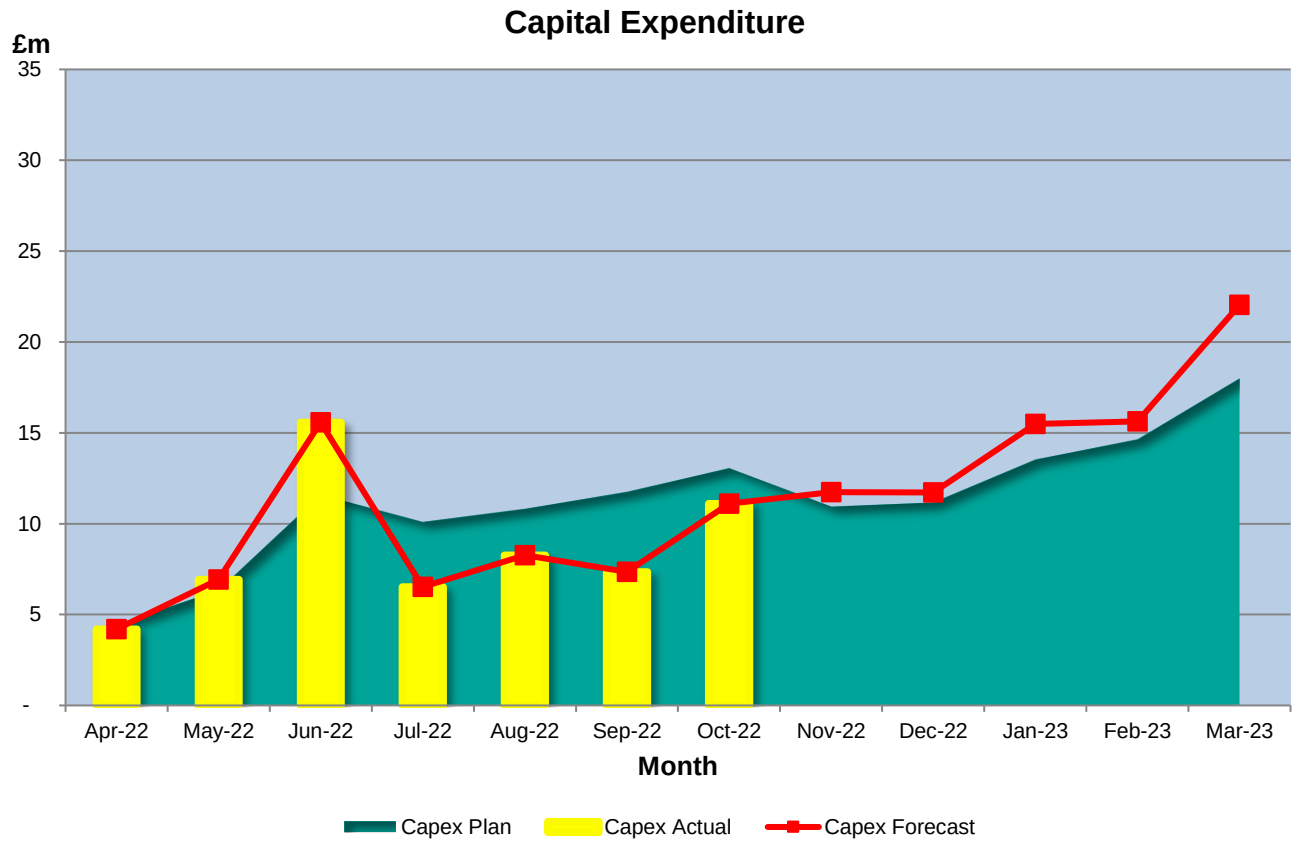
Cash Flow



As at 30th November 2022, the Trust had a cash balance of £205.7m. The cash balance is broadly static in Month 8 following months of continued reductions in the cash balance. Whilst there is a slight improvement in the cash balance this month it is largely due to a reduction in sales ledger balances since October (£15m), and offset by a reduction in deferred income (£9m).

The £205.7m cash balance as at 30th November is higher than the £202.5m forecast primarily due to lower than forecast cash outflows relating to trade creditors (£3m).

Capital Expenditure



In the period to 30th November 2022, £69.5m of capital expenditure has been incurred against the updated plan of £79.0m, an underspend of £9.5m.

The underspend is driven by:

- £3.2 underspend relating to timing slippage in the NHP project.
- £4.0m underspend for two schemes at Trafford (Theatres and Power Upgrades) due to initial timing delays.
- £1.4m underspend on the PDC Digital Pathology scheme that is still to start.
- £1.2m underspend on the TIF scheme due to timing slippage.
- £1.1m underspend on IT Disaggregation due to the impact of NCA outage.
- £1.0m underspend on Project RED due to initial timing delays.

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

- £3.0m overspend on Hive – this is due to increases in service provider costs, though it is expected that this will be managed within the overall Hive capital budget for 2022/23.
- £1.0m overspend on the Health & Safety backlog incurred ahead of plan.
- £0.9m overspend on the Data Centre due to earlier than planned hardware delivery.
- £0.7m overspend on the GMCA decarbonisation grant scheme, where additional funding has been secured.

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 full year, there is no forecast overspend in either the total capital plan or the GM envelope, assuming the £15m PDC funding is secured.

For the period up to 30th November, £52.3m of GM envelope expenditure was incurred against the original plan of £43.4m, an overspend of £8.9m. The overspend is materially made up of £15.2m for Hive but is partially offset by underspends, as noted above on Trafford Theatres and Power Upgrades, Project RED and IT disaggregation. All delayed schemes are expected to recover by year end. £12.2m of the Hive overspend relates to the £15m assumed Hive PDC funding which is still to be secured within GM.

The Trust will operate within the agreed GM final capital allocations. These assume that £15m of the HIVE programme will be funded by PDC capital funding. As reported to the Board on 13th June 2022, whilst MFT have agreed to adopt this reporting position, if the £15m is not obtained by means of PDC, all other provider Trusts in GM have agreed to limit their expenditure to ensure there is sufficient funding and CDEL cover to finalise the HIVE programme. A bid of £12.1m is currently in progress to secure the majority of this funding requirement.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	January 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 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).

The terms of reference were published on 6 December 2022. The review will focus on how the health and care system can achieve a balance between greater autonomy and robust accountability, including how transparent data sharing with DHSC and across the health and care system can drive improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the Care Quality Commission (CQC) can be enhanced in system oversight.

Interim findings will be delivered on 16 December and inform NHS England's planning guidance for 2023-24 which is expected to be published by 23 December. 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.

Elective Recovery Taskforce

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
- the NHS can use existing capacity in the independent sector to reduce the backlog
- to improve communication and collaboration between the NHS and independent sector

The taskforce is expected to make recommendations to the Government in early 2023.

Delegation of Specialised Commissioning

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

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.

3. Regional Issues

Greater Manchester Integrated Care System (ICS)

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.

Trafford Urgent Care Review

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.

4. MFT issues

New Hospitals Programme – NMGH

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 will not be shared with each scheme until February because of the need for ministerial approval of the budget.

Speaking in parliament on the 6th of December, health secretary Steve Barclay, said the cost of the projects included in the New Hospitals Programme had "inflated significantly" and added there was a need for "grip" and standardisation to make the programme affordable. The more detailed implications of this and the MPRG for the NMGH scheme are not yet understood.

MFT Single Services

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.

5. Actions / Recommendations

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Karen Hawley, Freedom to Speak Up Guardian
Date of paper:	January 2023
Subject:	Freedom to Speak Up Annual 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:	This report is aligned with the Trust's vision to: Excel in quality, safety & patient experience and attract, develop & retain great people. The report is also aligned to the Trust's Values: • Everyone matters • Working together • Dignity & Care • Open & Honest
Recommendations:	The Board of Directors is asked to: • Note the 2021/22 Annual Freedom to Speak Up Report. • Note the breadth of work delivered by FTSU during the period.
Contact:	Name: Karen Hawley, Freedom to Speak Up Guardian Tel: 07964900492

1. Purpose

1.1 The purpose of this report is to provide the Board of Directors with a summary of the Freedom to Speak Up Annual Report, which covers the period between the 1st April 2021 to the 31st March 2022. The report also provides an update from the annual report of the National Guardian's Office (NGO) to allow national comparisons and context.

2. Background

2.1 The roles of Freedom to Speak Up (FTSU) Guardians and the National Guardian's Office (NGO) were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC. FTSU Guardians help protect patient safety and the quality of care, improve the experience of staff, and promote learning and improvement. They do this by ensuring that workers are supported in speaking up and that issues raised are used as opportunities for learning and improvement. They work within their organisations to help ensure that barriers to speaking up are addressed and a positive culture of speaking up is fostered.

2.2 The NGO recommends that senior leaders receive a report from the FTSU Guardian at least twice a year to provide assurance in relation to speaking up at the Trust. The FTSU Guardian provides this assurance to the Trust, via a quarterly report to the Human Resources Scrutiny Committee.

3. Executive Summary

3.1 The FTSU Annual Report for the period between the 1st April 2021 to the 31st March 2022 (attached at Appendix 1) was presented to the Human Resources Scrutiny Committee on 24th October 2022 to provide assurance in relation to the work of FTSU during 2021-2022.

3.2 The key points to note are as follows:

- 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. In April 2021, The NGO's Office produced a new "Guidance for Developing FTSU Champion and Ambassador Networks" which outlines the role of FTSU Champions and the distinction with the FTSU Guardian role.

- 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. Comparison numbers from previous years are also provided. The report details the themes of cases raised and compares the figures to national data.

- 36% (46 cases) of the cases raised had an element of bullying and harassment.

- 23% (30 cases) of the cases included an element of patient safety. 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.

- 14% (18) of cases had an element of worker safety. This was largely related to staff wellbeing and inability to take breaks with staff feeling vulnerable regarding workloads and numbers of patients.

- During 2021-22 there has been a refresh of the FTSU marketing and communications. The establishment of a full time FTSU Guardian now allows for increased visibility of FTSU. Information is provided about the activities during FTSU month held in October.

- New eLearning is available via the MFT learning hub. 'Speak Up' is for all workers and covers what speaking up is and why it matters. 'Listen Up' is aimed at anyone in a line management role and focuses on listening to concerns and understanding the barriers which can exist for people to speak up.

4. Recommendations

4.1 The Board is asked to:

- Receive the 2021/22 Annual FTSU Report.
- Note the breadth of work delivered by FTSU during the period.

Appendix 1

Manchester University
NHS Foundation Trust

Freedom to Speak Up Annual Report

April 1st 2021 to 31st March 2022

1. Purpose of Report

1.1 The purpose of this report is to provide the Board of Directors with an overview of the work of the Manchester University NHS Foundation Trust (MFT) Freedom to Speak Up (FTSU) Team over the period 1st April 2021 to 31st March 2022. The report also provides an update from the annual report of the National Guardian's Office (NGO) to allow national comparisons and context.

2. Background

2.1 The roles of FTSU Guardians and the NGO were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC.

2.2 FTSU Guardians help protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. They do this by ensuring that workers are supported in speaking up and that issues raised are used as opportunities for learning and improvement. They work within their organisations to help ensure that barriers to speaking up are addressed and a positive culture of speaking up is fostered.

3. Outline of Roles / Responsibilities for FTSU

3.1 A full time FTSU Guardian has been in post at MFT since 4th May 2021.

3.2 The FTSU Guardian works impartially and independently and is supported by the Group Deputy Chief Executive, Gill Heaton. A Non-Executive Lead also supports the programme. Until December 2021, this was Ivan Bennett and from the beginning of 2022, Gaurav Batra has held this position. The Director of Corporate Workforce, Nick Bailey provides formal leadership to the FTSU Guardian.

3.3 The FTSU Guardian is also supported by a network of FTSU champions. The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. In April 2021, The NGO's Office produced a new "Guidance for Developing FTSU Champion and Ambassador Networks" which outlines the role of FTSU Champions. Their role is to raise awareness of FTSU by being visible and accessible, role modelling the values and behaviours associated with speaking up and listening up, provide signposting and support to individuals who need to raise concerns and to escalate issues that must be acted on involving safety or safeguarding.

3.4 The NGO recommends a clear distinction between the roles of the Champion and Guardian and that "only FTSU Guardian's, having received National Guardian's Office training and registered on the NGO's public directory, should handle [speaking up] cases".

4. Champion Expansion & Development

4.1 During 2021-22, targeted recruitment was undertaken to increase the diversity of the FTSU champion network and to extend the reach of FTSU across MFT. The FTSU programme is supported by a network of 54 champions from a variety of clinical roles

and backgrounds, including representation from night staff. 25% of the FTSU champions identify as being from Black, Asian, and Minority Ethnic backgrounds. The network also has Champions who are part of the Disability Staff Network and the LGBTQ+ network.

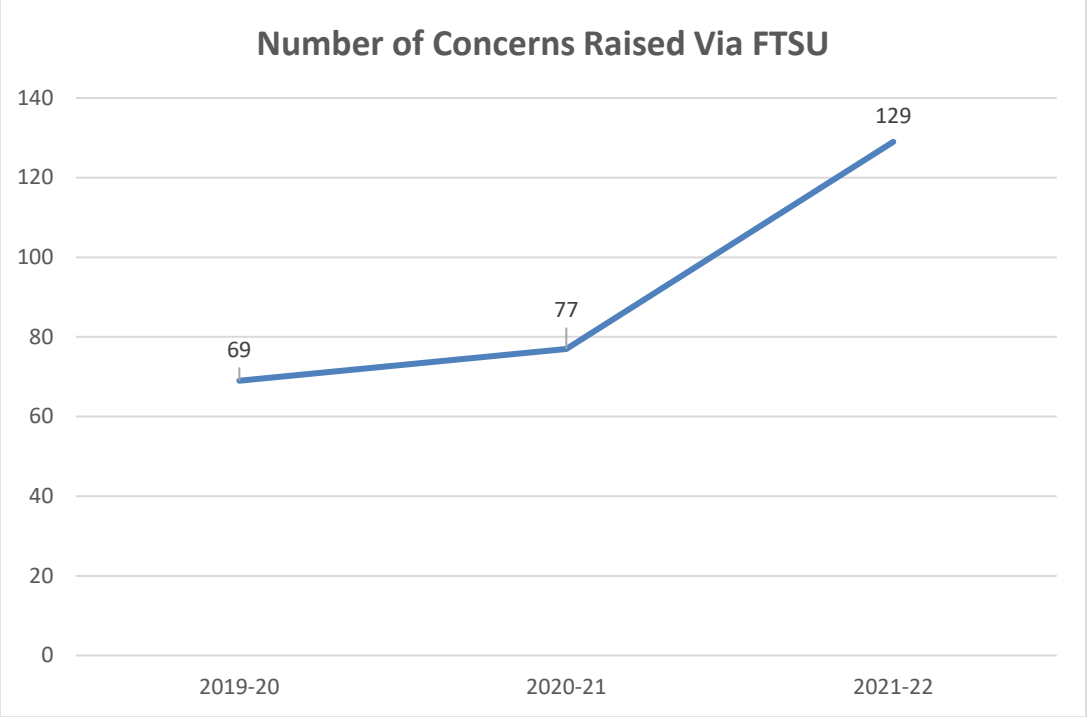
4.2 The following table provides information in relation to location of Champions. Further applications continue to be received and work will be ongoing to ensure parity of Staff: Champion ratios across each organisational area.

Location/Number of Champions 01/06/22		
Organisational Area	**Number of Champions**	**Ratio of Champions to Staff**
Corporate/R&I	7	1: 490
CSS	9	1: 529
Eye/Dental	5	1: 210
Local Care Organisation	5	1: 590
MRI	9	1: 421
NMGH	5	1: 355
RMCH	3	1: 838
SMH	2	1: 1421
WTWA	10	1: 465

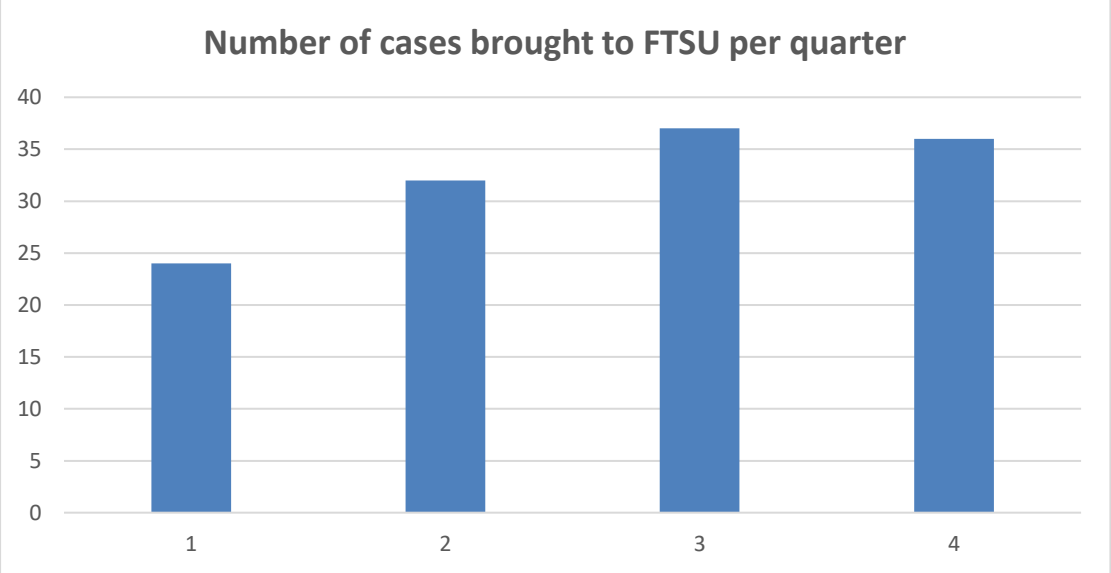
4.3 To support champions in having FTSU Conversations, there is a rolling programme of bespoke training which has been arranged with Organisational Development. Sessions focus on 'Managing Expectations', 'Coaching & Listening' and 'Courageous Conversations'.

5. Assessment of Cases raised via FTSU.

5.1 During 2021-22, with the establishment of a full time FTSU Guardian, there has been an increase in the number of concerns raised via FTSU. The graph below shows that 129 concerns were reported to the FTSU Team during this period. Comparison numbers from previous years are also provided:



5.2 The graph below illustrates the number of concerns which were reported to FTSU each quarter during 2021/22:



5.3 The table below illustrates the data for the nationally reportable elements of the cases raised to FTSU each quarter at MFT during 2021/2022:

Nationally Reportable Data	Q1	Q2	Q3	Q4

Number of cases raised anonymously	1	0	2	4
Number of cases with an element of patient safety/quality	6	6	11	7
Number of cases with an element of bullying or harassment	7	10	12	17
Number of cases where people indicate that they are suffering detriment as a result of speaking up	2	3	2	3
Number of cases with an element of worker safety	2	2	11	3

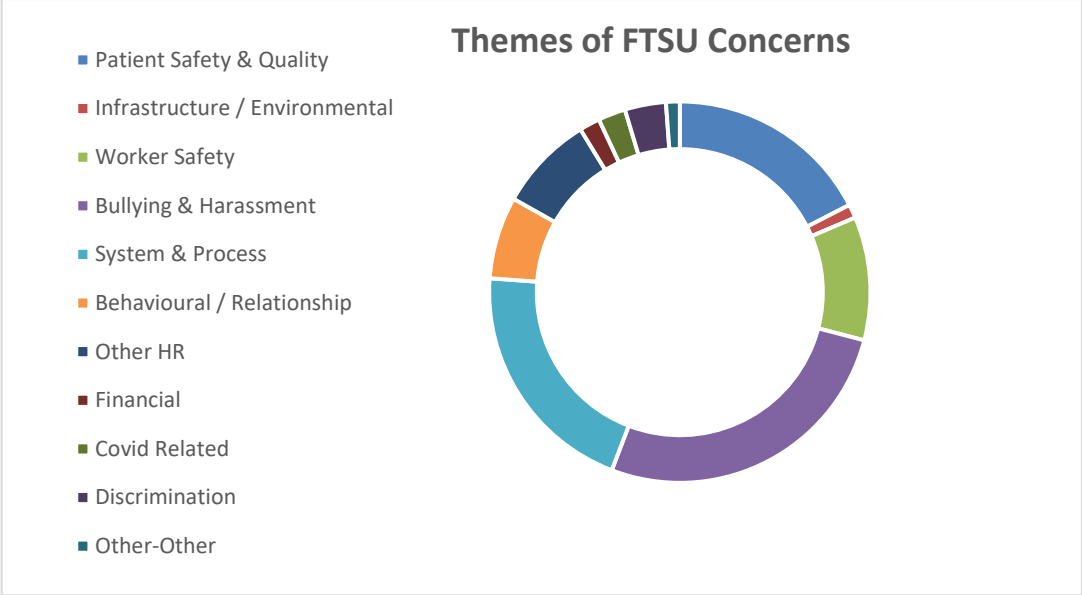
5.4 36% (46 cases) of the cases raised had an element of bullying and harassment. This is slightly increased from the percentage of cases raised to FTSU at MFT during the same period in 2020/21 (previously 34%). Nationally, 32.3% of cases raised included an element of bullying & harassment and this was increased from the previous year figure of 30%.

5.5 The FTSU Guardian contributes to the Trust-Wide Task & Finish Group for Workplace Harassment, Bullying & Abuse and has provided input to the MFT Civility Training to ensure staff are aware of the FTSU programme as a source of support for reporting concerns.

5.6 23% (30 cases) of the cases included an element of patient safety. This compares with the national figure of 19%. Themes of concerns which have been raised via FTSU at MFT have included equipment, internal transfer of patients, staffing levels, skill mix, patient flow, patient waiting times and isolated concerns related to clinical management.

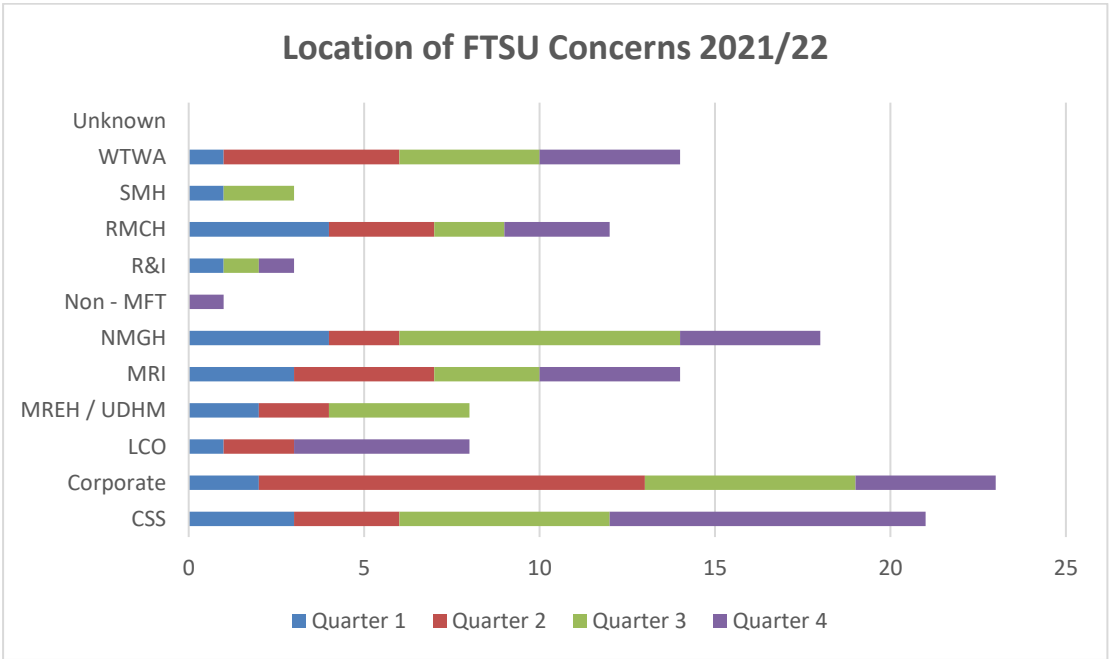
5.7 This year, the NGO introduced a new category of worker safety in response to concerns raised during the pandemic. Nationally, worker safety was a strong theme related to the impact of reduced staffing levels which were included in patient safety concerns, increased workload and staff wellbeing. 13.7% of cases nationally had an element of worker safety. At MFT, the figure was similar with 14% (18) of cases having an element of worker safety. This has largely been related to staff wellbeing within an environment of reduced staffing and inability to take breaks with staff feeling vulnerable regarding workloads and numbers of patients.

5.8 The following chart demonstrates the themes for all the concerns raised via FTSU during 2021/22 (note that each case may have multiple themes):



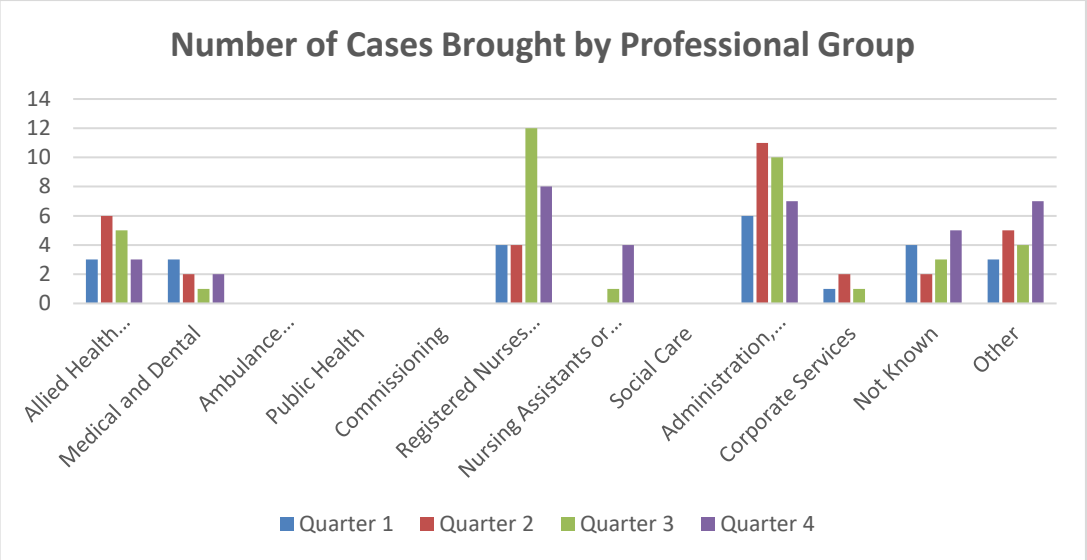
5.9 The FTSU Guardian escalates and reports themes of concerns raised to Senior Leadership Teams across the Trust and to the Group Daily Patient Safety Huddle to help triangulation of themes.

5.10 The following chart illustrates the location of concerns at MFT. There is a notably bigger number of concerns which have been raised via staff within Corporate areas. This has been largely because of several listening events which have been carried out for Estates and Facilities Staff at the North Manchester site as requested by their leadership team at that location.



5.11 The following graph illustrates the professional groups who have raised concerns to FTSU at MFT during 2021/22. The top two staff groups who have raised concerns to

FTSU are Registered Nurses and Midwives along with Administrative, Clerical, Maintenance and Ancillary staff.



5.12 There are many routes to speaking up at MFT and FTSU should be viewed as an alternative route for when the usual means of raising concerns are too challenging or have failed. In the majority (53%) of cases the FTSU Guardian or Champions have provided signposting for people who need to raise concerns. In the remainder of cases (47%), concerns have been escalated to the Senior Leadership Team via the FTSU Guardian for the following reasons:

- Fear of raising the concern independently.
- Individual's wanting to maintain confidentiality due to fear of detriment or ruining relationships.
- A perception of concerns not being listened to or welcomed previously.
- Significant concerns about an individual's wellbeing.
- Unsatisfactory response when concerns raised via incident reporting and speaking to the line manager.

6. FTSU User Feedback

6.1 FTSU request feedback from individuals after a case has been closed. The responses to one question; "Given your experience of speaking up, would you speak up again?" are required to be collected for the NGO. 100% of responders answered "yes" to this question during 2021/22.

6.2 As part of the feedback, FTSU asks responders to rate how satisfied they were with the service from the FTSU team. The rating scale uses numbers from 0 (very unsatisfied) to 10 (very satisfied). The average response was 9.4.

6.3 The comments received included the following:

6.4 Some of the feedback received made suggestions for improvement including publicising the accessibility of FTSU more and a suggestion to advertise the breadth of issues people can come forward with.

7. Raising Awareness of FTSU during 2021/22

7.1 During 2021-22 there has been a refresh of the FTSU marketing and communications with new posters, banners, business cards and logo being produced.

7.2 The establishment of a full time FTSU Guardian now allows for increased visibility of the FTSU Guardian at various departmental meetings and other professional forums across the Trust.

7.3 The FTSU Guardian has built close working relationships with key stakeholders including the OD team, Health & Wellbeing, Guardian of Safe Working, Governance and Safety, HR teams across MFT, EDI and all the Senior Leadership Teams.

7.4 FTSU have a regularly updated intranet page and provide features via iNews including 'Meet the Champion' articles and news items such as the launch of FTSU eLearning. There are also ongoing twitter updates from the team including local and national FTSU news.

7.5 The lead FTSU Guardian and local champions have proactively engaged with staff during walk arounds.

7.6 eLearning packages 'Speak Up' (for all staff) and 'Listen Up' (for those in line management roles) are available via the MFT learning hub.

7.7 FTSU information has been linked on the junior doctor's induction portal and is part of the Preceptorship programme across the Trust.

7.8 Staff awareness of FTSU is included as a question in the accreditation process.

8. Freedom to Speak Up Month

8.1 National Freedom to Speak Up Month is held annually in October. It was an opportunity to raise awareness of how much speaking up is valued at MFT.

8.2 The national theme was Speak Up, Listen Up, Follow Up. The month was launched via an article within 'MFT Time' with promotion of the 'Speak Up' and 'Listen Up' eLearning platforms available on the Learning Hub. The article also included an endorsement from Gill Heaton:

"Here at MFT we want all staff to feel able to speak up. We want to embed our values of being Open & Honest and that Everybody Matters. Everybody should feel able to raise a concern or make a suggestion for improvement and know that they will be thanked for doing so. Speaking Up provides us with opportunities to learn and enables us to improve the experiences of our patients and staff. We are raising awareness of Freedom to Speak Up in October, but we need to make sure speaking up is 'business as usual' at any time here at MFT" Gill Heaton, Group Deputy Chief Executive, MFT.

8.3 A FTSU quiz was circulated, and teams used this as a basis for Speak Up, Listen Up, Follow Up conversations.

8.4 A FTSU video was also launched and can be viewed here: https://vimeo.com/nicecatmedia/download/617904337/03e0fd7354

8.5 Staff across MFT were asked to have conversations about Speaking Up, Listening Up and Following Up, and to make a pledge to celebrate Speak Up Month. There was great engagement from staff across the Trust. Pledges were made by staff during FTSU walk rounds and many of the pledges were shared on Twitter. A selection is shown in the collage below:

9. Engagement with the National Guardian's Office

9.1 There is regular attendance at the Regional FTSU Guardian network meetings.

9.2 The FTSU Guardians have attended webinars available via the NGO and attended the NGO Conference. Both have provided opportunities for learning and sharing best practice.

10. Key Actions for 2022-2023

10.1 To continue to support a culture whereby speaking up is business as usual and contributes to continued learning, the deliverables for FTSU over the next 12 months are proposed as follows:

- Continue to expand and develop a diverse network of FTSU Champions across the Trust.

- Ensure the MFT Raising Concerns Whistleblowing Policy is aligned with the upcoming updated national policy.

- Embed a consistency of response, documentation and escalation of concerns raised via FTSU via a Standard Operating Procedure.

- Continue to develop staff skills and knowledge around speaking up, listening up and following up.

- Monitor numbers of concerns, FTSU proactive demands and the capacity of Guardians to guide further development of the FTSU service.

- Monitor the diversity of individuals who approach FTSU to ensure all staff feel to use this route to raise concerns if other routes have failed or feel too challenging.

- Continue to work with the National Guardian's Office and Regional FTSU Network to learn from and share best practice.

- Work with the Comms team to promote anonymised transparency of FTSU learning and themes.

11. Conclusion

11.1 The MFT FTSU team has expanded over the past year. Since the recruitment of a full time FTSU Guardian, there has been an ability to increase FTSU communications and proactive work, and this has resulted in an increased number of concerns received via this route. FTSU works in partnership across MFT to support a culture where all staff feel safe to speak up, they are listened to, and matters raised are used for learning.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Kathryn Murphy, Director of Nursing and Midwifery, SM MCS Dr Sarah Vause Medical Director SM MCS
Date of paper:	January 2023
Subject:	Maternity Services Assurance Report, incorporating the findings from a review at Saint Mary's position in relation to the East Kent Maternity Review and the required actions; and a Maternity Incentive Scheme (MIS) Safety Action update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept ✓ • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation and teaching To improve patient safety, clinical quality and outcomes To improve the experience of patients, carers and their families
Recommendations:	The Board of Directors is asked: • To note the information provided in this report in relation to: - The review of SM MCS in comparison against the East Kent Maternity Review - The work in progress to strengthen compliance and support learning and assurance in relation to maternity safety • To approve Group Chief Executive signing of the declaration of SM MCS compliance of all 10 safety actions within MIS Year 4
Contact:	Name: Alison Haughton, Acting CEO, St Marys MCS Tel: 0161 276 6124

1. Executive Summary

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

- Review of Saint Mary's Managed Clinical Service (SM MCS) in relation to the findings of the East Kent Maternity Report[1] '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)[2]

1.2. Table one provides an overview of the SMH MCS position against the 4 key findings of the East Kent review.

1.3. 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.

1.4. Evidence of ongoing compliance for IEAs is now discussed in detail at QPSC bi-monthly.

1.5. 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
- Develop a new maternity and neonatal quality and safety meeting

1.6. 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. A presentation has been provided to the Board of Directors as evidence of compliance and approval for Trust Chief Executive Officer to sign ahead of submission to NHS Resolution (NHS R) is requested.

1.7. 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] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf
[2] https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf

1. External Maternity Reviews and Assurance reporting

East Kent Report – Reading the signals (2022)[3]

Background

1.1. On 19th October 2022 the East Kent Independent Report of maternity services at Queen Elizabeth - The Queen Mother Hospital and the William Harvey Hospital was published. The report found suboptimal clinical care which led to significant harm, with 8 missed opportunities at Board level to effectively address concerns. Overall, the review concluded that had care been different in 97 cases, maternal and neonatal morbidity and mortality could have been different, including 45 neonatal deaths which may have been avoided.

1.2. In investigating East Kent maternity services and their missed opportunities, the report acknowledged the previous recommendations from other inquiries such as Ockenden[4] [5]; Mid Staffordshire NHS Foundation Trust Public Inquiry[6] and the Kirkup Report (2015)[7] and chose not to repeat a list of recommendations for providers.

1.3. The rational for this change in reporting style was based around the consideration that this approach would be unlikely to break free of a pattern of reporting which has yet to reduce poor clinical outcomes across maternity services.

1.4. As such the report identified 4 key actions which need to be addressed by external bodies such as NHS England, RCOG, RCM, Health Education England.

1.5. Whilst awaiting the progress and actions from external bodies, Saint Mary's Manged Clinical Service (SM MCS) have reviewed the 4 key actions identified within the report and compared these against the current services across the 3 maternity sites, providing a critical analysis of SM MCS overall maternity position, and identifying actions which may improve maternity care within SM MCS.

Key Action 1 Monitoring Safety Performance – finding signals among the noise

1.6. The report acknowledged the significant amount of maternity data collection and onward reporting within maternity services, however, considers that most are process measures and provide limited information regarding safe maternity services. Those which are clinical have dubious significance or are high level and may conceal events susceptible to clinical intervention, such as perinatal mortality. The report stressed that Trusts must look at internal data as a measure of maternity services in addition to the regional and national benchmarks and monitor variation between sites (where appropriate) to avoid the risk of unknowingly concealing maternity concerns when reporting an overall position.

1.7. The report drew specific attention to the use of caesarean section rates being monitored at local, regional and national level as a key performance indicator with limited clinical data to support this as a measure of a safe maternity service. The report recommends a review of current national maternity

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf
[4] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[5] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

measures, which can be risk adjusted and are accessible in a timely manner. There is also a requirement for the national team to analyse and present data in a way that shows outcomes linked to random variation and outcomes which would not be attributable to random variation.

Key Action 2 Standards of clinical behaviour – technical care is not enough

1.8. The report stressed that kindness and compassion when providing care should be treated as equally important as technical skills and clinical competence. Failing to meet basic standards of professional behaviour impacts on colleagues, care pathways and the trust of those receiving care. The report highlights that lack of compassion can significantly impact on the wellbeing of a woman and often leads to unnecessary long-term harm. Unkindness, particularly after a safety incident, can compound and prolong the harm caused by the incident itself.

1.9. The report stated that it was difficult to comprehend this lack of compassion which is such an integral part of the caring profession. The report highlights that the influence of senior/experienced staff members have a significantly greater impact than classroom training. When junior staff members are exposed to poor behaviours from those senior/more experienced, their standards begin to drop. Failure to address this issue has the potential to create a negative cycle of declining standards.

1.10. The report requires that all staff, particularly those in leadership roles, acknowledge and accept their role in influencing positive behaviour within the workplace, and are aware of the risk of harm caused when negative behaviour exists. Professional behaviour and compassionate care must be embedded as part of continuous professional development.

Key Action 3 Flawed team working – pulling in different directions

1.11. Effective MDT working, where clinicians bring their own skills and experience in a coordinated approach, is essential in providing safe, high quality maternity services. The report highlights that in almost every failed maternity service to date, flawed teamworking was a significant finding, often being at the heart of the problems identified.

1.12. Flawed team working occurs when there is divergence of objectives of different staff groups. In maternity care this divergence can occur between midwives and obstetricians in relation to the appropriateness of interventions and the desire for promote vaginal birth.. The report highlighted that a team without common purpose can rapidly descend into conflict, inappropriate hierarchies and power plays.

Key Action 4 Organisational behaviour – looking good while doing badly

1.13. The report states that the default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation, which led to responses of denial, deflection, concealment and aggression when challenged by external bodies, such as the Care Quality Commission (CQC). This type of response prevents learning and improvement and can compound the harm caused to families who have already suffered.

1.14. The report highlights concerns where Trusts fail to engage, both internally with concerns being raised by senior staff members, and externally with CQC, CCG's and HSIB, as a significant red flag for the safety of maternity services.

Comparison of East Kent Findings with the SM MCS position

1.15. The table below provides an overview of the issues found within East Kent and the current position within SM MCS by comparison.

Key Action	East Kent Findings	SM MCS position

Monitoring Safety Performance	Inappropriate use of high-level maternity information	Acknowledges regional and national data but does not use this to report to Board of Directors. SM MCS focusses on internal data across 3 maternity sites to review clinical outcomes and areas for improvement/action. External benchmarking used as appropriate through governance processes.
	False reassurance	
	Avoidance of internal data findings	
	Deflection and defence of the position rather than addressing the cause.	SM MCS undertake practice reviews within 72 hours (rapid reviews), which support timely intervention to reduce the risk of identified safety concerns reoccurring. Themes from incident reviews, along with actions/learning, have been included within the bi-monthly maternity assurance report to the Board of Directors since December 2021. SM MCS provide data nationally and meet the reporting required within the maternity incentive scheme (MIS) which includes MSDS data submission, PMRT reporting and MBRRACE, along with reporting compliance for HSIB and ENS. Learning from incidents is shared locally, reporting high level incidents (such as never events) to group Quality Performance Scrutiny Committee, and regionally through GMEC LMNS, with a quarterly review of data to monitor regional trends/themes/share learning. SM MCS focusses on internal data across the 3 maternity sites to review clinical outcomes and areas for improvement/action and does not place key performance indicators on clinical outcomes, such as mode of birth.
	At East Kent, there was a drive to maintain lower than average caesarean section rates	Caesarean section is a mode of delivery that support maternal and infant safety taking into consideration physical and psychological safety factors. SM MCS have a planned caesarean section pathway in place with women able to opt for Caesarean section without a medical indication. Over the last five years there has been a year-on-year increase in planned caesarean sections on all three maternity sites. Caesarean section rates are no longer used as a key performance indicator within SM MCS and have not been for several years. In line with NHSE recommendations this metric has also been removed from the Group Patient Safety Profile
Standards of clinical behaviour	Lack of compassion and kindness between staff and with women.	When reviewing feedback, specifically formal complaints and PALS from women and families, themes of poor staff attitude is considered. Work is underway to review complaint themes and link with HR to support addressing values and behaviours across SM MCS
	Poor staff behaviours not addressed	After the merger of legacy CMFT and legacy UHSM, the Senior Leadership Team became aware of cultural differences which led to an investigation across the sites into Governance and Workforce. The findings of this work generated a significant number of actions which have been monitored and closed

		Learning from the merger we have applied some of the learning as a result of acquisition of North Manchester to address any behaviours within the MDT that are consistent with the management of change.
	Inability to challenge consultant behaviours	Behaviours within the workforce have been identified in some areas and the Clinical Head of Division for Maternity has undertaken a restructure of site based clinical leadership across the MCS to address behaviours that may adversely impact on the way the MDT functions going forwards. We recognise that this is often the outcome of significant change and are working to develop a more positive culture with the clinical teams.
Flawed teamworking At East Kent there was conflict between staff groups, with dysfunctional working within the multidisciplinary team and a lack of vision for maternity services.	Staff conflict was not addressed; staff feeling vulnerable and afraid to escalate clinical concerns for fear of criticism/bullying;	Given the significant changes that have occurred across the MCS there have been some examples of staff conflict within SM MCS and feelings of vulnerability due to constant change in leadership and organisational reporting. Work has begun to address this and to support staff; progress is being monitored within the maternity division. Site based listening events have been completed and Leadership support has been reviewed and development plans commenced
	Junior medics were highlighted as having the lowest morale, with limited support in the clinical environment.	SM MCS received the latest GMC survey in September 2022, with several negative outlier metrics on all three sites. On the North Manchester site there was a reduction of 'red' outlier indicators to 6 from 10 in the 2021 report. Despite the improvement Health Education England Northwest (HEE NW) have recommended to the GMC that the North Manchester (NM) unit is placed in enhanced monitoring measures in view of the long-standing problems on this site. SM MCS have an action plan for each site to address concerns raised by trainees via GMC survey. This is monitored through the governance structures and wil be reported through to the Groups Quality and Performance Committee and HR Scrutiny committee. Oxford Road and Wythenshawe remain at level 1 risk assessment. HEE NW intend the monitoring to be supportive to SM MCS in keeping the focus on improvement. There will be further reviews of action plans for all sites, where it is anticipated that the actions put in place will demonstrate sustainable improvement measures. A meeting is planned with the Saint Mary's Senior Leadership team, the Postgraduate Medical Education Team and members of the Group Executive team on 12th January 2023, followed by a formal HEE NW visit later in 2023.
	It was evident that midwives were encouraged to see themselves as 'defenders against medicalisation',	SM MCS acknowledge this risk to practice based decision making. Appropriate decision making is reviewed during practice reviews, with examples used as learning aids during mandatory training updates. There have been no examples of harm caused within

	supporting 'normal birth' without appropriate risk assessment.	SM MCS because of midwives prioritising normal birth against best available evidence. RE-Birth terminology is being implemented to remove 'normal' from maternity services. In response to meeting the immediate and essential action in Ockenden[8], SM MCS incorporated a formal risk assessment at each maternity contact to support informed decision-making. This reduces the risk of women not being provided care appropriate to their needs and supports choice of place of birth as part of their birth plan.
Organisational behaviour At East Kent the Trust Board failed to engage with external bodies who raised concerns and refused to accept criticism of the maternity services.	Failure to monitor actions/learning from internal reviews	SM MCS is supported by the Board of Directors to ensure open and honest reporting. Board level safety champions have been in place since the publication of the Ockenden emerging report and all SM MCS Senior Leadership Team have a direct line of reporting to an MFT Executive Director. MFT has established relationships with external bodies and is responsive to any findings shared. MFT has internal governance frameworks in place to support monitoring and assurance. Robust governance processes are in place and continue to be strengthened to support monitoring and learning from internal reviews.
	Failure to acknowledge CCG and monitor trends of increasing serious incidents	There have been no occasions of failing to acknowledge ICB (CCG) concerns relating to serious incidents. SM MCS actively engage with all external bodies in an open and honest manner. There have been no occasions where feedback has been received regarding non-engagement. SM MCS accept scrutiny where it is applied as this supports future learning, not only for SM MCS but also for learning throughout GMEC LMNS and beyond.
	Failure to acknowledge CQC concerns with leadership and poor clinical outcomes	There have been no leadership concerns raised by CQC. There have been several changes across the 3 maternity sites of SM MCS in recent years, which have led to some changes within the senior leadership structure. During this time, there has been stability with both the Medical Director and Director of Nursing and Midwifery being in post since the merger into Manchester Foundation Trust in 2018. The leadership on all 3 maternity sites has been strengthened to have a site based Clinical Director on each site coordinated and led by a Clinical Head of Division across SM MCS, providing consistency in approach. Similarly, there is also a dedicated Head of Midwifery and Deputy Head of Midwifery on each maternity site to lead the midwifery teams, many of whom have commenced in leadership posts as part of succession planning, demonstrating commitment to develop the clinical teams from within.
	Failure to address bullying and inappropriate staff behaviour when identified	SM MCS maternity division action any concerns raised regarding bullying and inappropriate behaviour, with no examples of where this was not addressed appropriately. Work is ongoing to address inappropriate staff behaviours with culture work being undertaken with site teams.

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

		Freedom to speak up is positively promoted across the MCS through champions
	Failure to acknowledge the comparison of themes identified in Morecambe Bay Investigation (2015) and required actions	SM MCS reviewed the Kirkup Report (2015) against current maternity services at the time of publication and completed an action plan. In July 2021 as part of a submission of evidence within Ockenden assurance reporting to NHS England the maternity position was reviewed again with no concerns identified at that time.
	Failure to address findings within Royal College of Obstetricians (RCOG) report regarding lack of consultant engagement within clinical care and outcomes	N/A
	Failure to be open and honest about severe failings in care following a neonatal death, many of the failings had been identified in previous reports ignored by the Trust Failure to engage with HSIB	SM MCS provides assurance to the Board of Directors that mandatory reporting, as required by the maternity incentive scheme, MBRRACE, HSIB and StEIS, continues with no examples of any missed data, nor of any occasions of data being manipulated to reflect an inaccurate view. Safety champions receive the HSIB reports and undertake safety walkarounds. Future safety meetings will include data extrapolated from the safety dashboard

Table 1 – Review of SM MCS position against findings within East Kent Report

Saint Mary's MCS position - ongoing work

1.16. Whilst the maternity assurance report contained the reporting metrics required to meet national recommendations, it ultimately led to large bi-monthly maternity reports where pertinent information to the Board of Directors may not have been as easily identified. In June 2022, SM MCS acknowledged that the report could be improved to improve Board assurance.

1.17. This was a proactive approach taken before the findings from East Kent were published to ensure that appropriate information (the signals) regarding maternity services would be submitted to the Board of Directors and would 'reduce the noise'.

1.18. In July 2022 Saint Mary's MCS commissioned an external review of governance processes which compared all national requirements, including the national maternity review[9], Kirkup report[10], Ockenden and latest CQC inspections within maternity services, against current assurance reporting

[9] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

at divisional level, MCS level and to the Board of Directors. An update on progress of this review was provided to the Board of Directors in November 2022.

1.19. The review, which completes in December 2022, has supported:

- The improvement of maternity dashboards, which now have specific data required to provide assurance at each organisational level and monitors areas of highest clinical impact. These dashboards, to be shared with the Board of Directors in January 2023, will be embedded into Maternity Division governance processes using data from the newly implemented electronic patient record (Hive). The dashboards will support clinical teams to monitor and interpret data more easily and facilitate appropriate escalation from the clinical areas up to the Board of Directors as appropriate.

- The executive summary dashboard will be reported to the Board of Directors bi-monthly within the maternity assurance report, with an example of the first iteration in section 5.

- A new maternity and neonatal quality and safety meeting is planned to commence in Q4 22/23, with the maternity dashboards as a standing agenda item. This quarterly meeting will have Board level maternity and neonatal safety champions in attendance, along with SM MCS maternity and neonatal safety champions and will provide ongoing assurance and escalation in maternity and neonatal services.

1.20. Further recommendations will be identified within the completed report and an overview will be provided to the Board of Directors in March 2023 as part of the improved maternity assurance report.

1.21. SM MCS are confident that the recommendations, some of which are already being implemented, will continue to improve the governance processes, and provide assurance to the Board of Directors of the safety and quality within maternity and neonatal services.

1.22. SM MCS also acknowledge that there is a risk that the findings relating to staff attitude at East Kent could exist in any clinical area, and a quality and safety workshop is planned in January 2023 for all five divisions within SM MCS to review their position, learning from each other to support solutions which will mitigate the risks and improve both staff working relationships and the care provided to women, babies, and families. Operational and HR colleagues will be involved in this workshop.

1.23. There is work required on all three maternity sites to address behaviours as a result of significant change, with both midwifery and obstetric teams. The maternity division with SM MCS is currently developing an overall ‘SM MCS East Kent Review Action Plan’ to address all areas of concern (a draft has been provided in Appendix 2). Progress will be monitored at Divisional Quality and Safety Committee (QSC), and as part of ongoing assurance to SM QSC and Board level Maternity Safety Champions.

1.24. Culture, as highlighted in in Key Action Area 2, 3 and 4, remains a golden thread to be addressed and improved. This was a similar theme from within the Kirkup Report (2015) and SM MCS will undertake a review of all three sites and report the current compliance position to Divisional QSC in January 2023. A review of the current vision for maternity services will also be undertaken to ensure that all staff, regardless of role, are clear and share the common purpose for providing safe, quality maternity care.

Summary

1.25. SM MCS has not identified any similar themes within Key Action 1 (monitoring safety performance) or Key Action 4 (organisational behaviour).

1.26. Work is required to address themes observed within Key Action 2 (standards of clinical behaviour) and Key Action 3 (flawed teamworking) and the SM MCS East Kent Review Action Plan (Appendix 2) is expected to be finalised at the Divisional QSC in December 2022.

2. The Final Ockenden report

2.1. The Final Ockenden report[11], published in March 2022 identified **15 IEAs** with 97 separate elements, with progress provided to the Board of Directors bi-monthly, and to Quality Performance and Scrutiny Committee.

2.2. There are currently 12 outstanding actions (4 within Clinical Science Services (CSS) and 8 within SM MCS) and are expected to be completed by Q4 22/23. This is an extension to previously expected completion dates due to Hive builds, completion of business cases or further recruitment required to achieve required staffing levels.

2.3. It is important to note that one action, which relates to consultant neonatal staffing to BAPM requirements may not be met by Q4 22/23. Recruitment continues to fill this staffing gap and is reviewed as a risk on SM MCS risk register (MFT/04714 currently scored at 12).

3. Maternity Self-Assessment Tool (MSAT)[12]

3.1. Saint Mary's MCS remain committed to complete all provider led actions required with overall compliance over 92%, and an expected completion date of February 2023. A further update will be provided to the Board of Directors in March 2023.

4. Ongoing assurance reporting to QPSC

4.1. In December 2022, Saint Mary's MCS presented an update of Workforce Training Ockenden[13] IEA 3 to Group Quality and Performance Scrutiny Committee (QPSC).

4.2. The next paper will be submitted to QPSC in February 2023 and will provide an update on a further Ockenden IEA, which will include actions taken to become complaint, evidence, current compliance status and ongoing reporting pathways.

5. Patient Safety

5.1. 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.

5.2. Appendix 1 illustrates a screen shot of the live maternity dashboard executive summary which uses SPC charts to identify areas of concern or variation.

5.3. Due to low numbers, it is not possible to have an SPC charts for maternal deaths. In October 2022 there was one maternal death within Manchester Royal Infirmary. The woman, who had been receiving care for a pregnancy of unknown viability within the Division of Gynaecology, had been admitted with chest pain, experienced cardiac arrest and received further treatment for blockage of

[11] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

[12] https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

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

a heart vessel and was transferred to intensive care where she sadly died. The case has been reported to MBRRACE-UK and the internal review is ongoing.

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

5.5. There has been a rise in admissions to the neonatal unit, and whilst this is currently within control limits (expected natural variation), increased monitoring of this metric is in place.

5.6. Focus remains on the percentage of term neonatal admissions which were **avoidable**.

5.7. Across SM MCS there was an increased number of avoidable admissions in June 2022 which has since improved and is now within accepted control limits. The metric will continue to be each month (Fig 1).

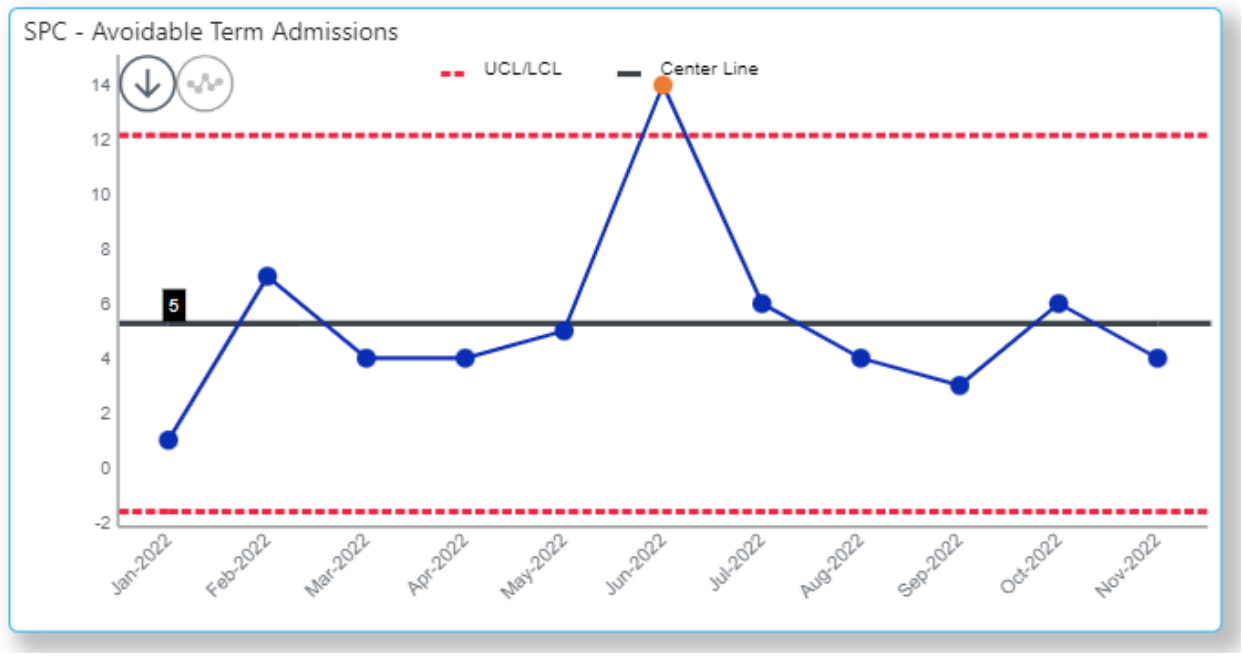


Fig 1 – SPC for Avoidable Neonatal Admissions ≥37 weeks gestation across SM MCS

5.8. A report for avoidable admissions, which identifies any themes and actions required, as part of ongoing reporting for Maternity Incentive Scheme (MIS) Year 4 has been provided to the Board of Directors in Appendix 3.

5.9. It is acknowledged that currently reporting the total number of admissions to the neonatal unit on the executive summary provides limited value or assurance. As such, this will be amended for March 2023 Board of Directors report and will provide the percentage of avoidable term admissions in the executive summary.

5.10. The aim is to have circa 200 metrices on the maternity dashboard and currently there are 35 metrices in place. These 35 metrics have been prioritised in line with external reporting requirements. In line with new reporting for the dashboard, there were 2 metrics which demonstrated cause for concern and have been escalated in SM MCS. (Fig 2 and Fig 3).

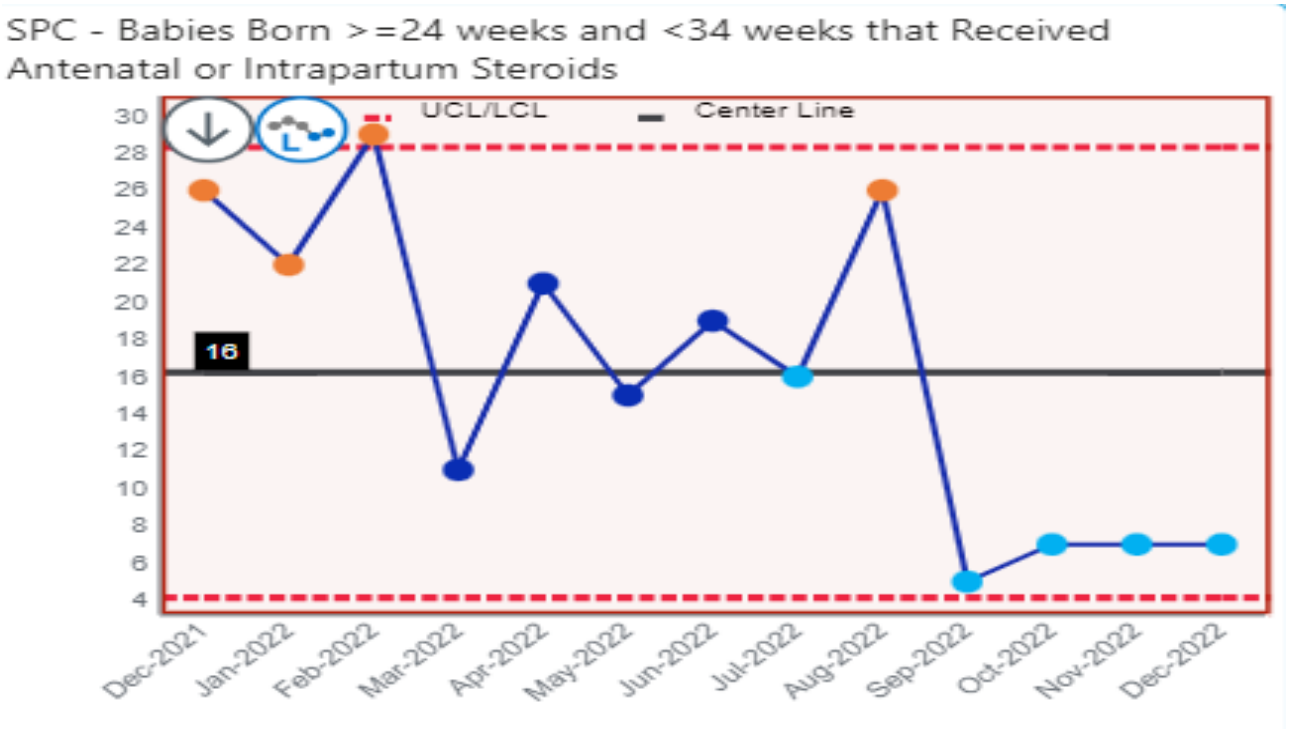


Fig 2 – SPC for number of babies in receipt of antenatal/intrapartum steroids across SM MCS

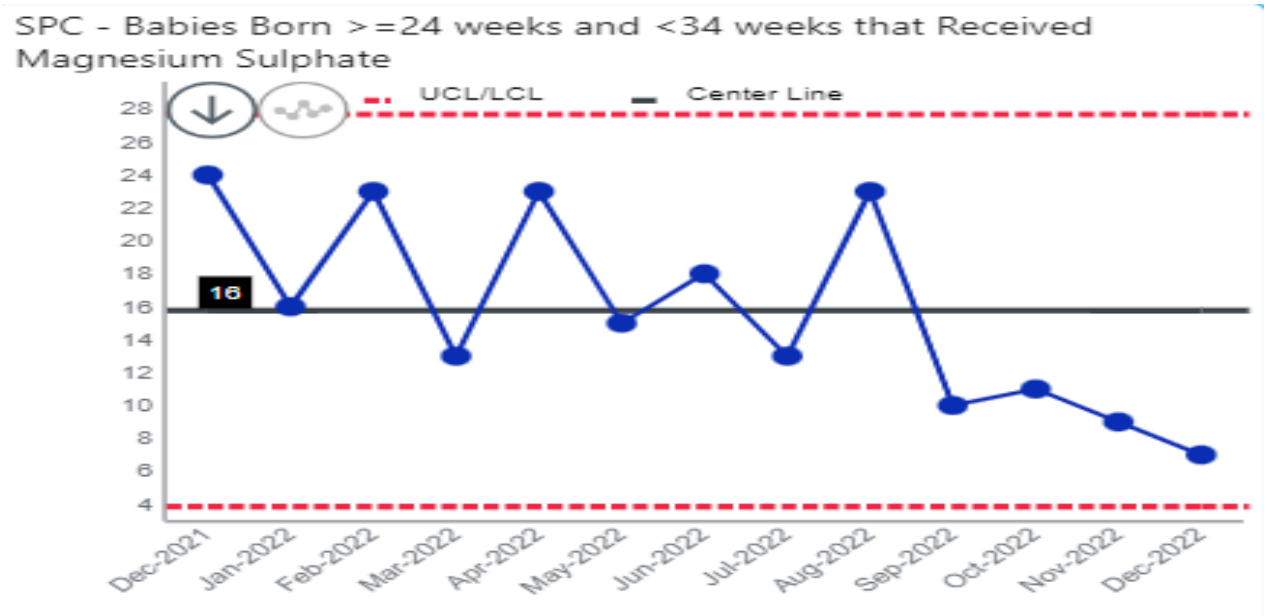


Fig 3 – SPC for number of babies whose mothers were in receipt of magnesium sulphate antenatally across SM MCS

5.11. Both metrics have been reviewed to understand why there has been a decline in administration of medications which improve neonatal outcomes in preterm infants.

5.12. Initial analysis suggests that this is an incorrect documentation issue following Hive implementation rather than a reduction in the administration of medicine. Work continues to support clinicians to document appropriately, with targeted education in intrapartum areas.

5.13. Work is also being undertaken with data analysts to identify how data extraction from the medication administration report (MAR) could be used to provide accurate reporting going forwards.

5.14. The metrics will be monitored monthly and escalated further if there is no improvement.

6. Maternity Incentive Scheme (MIS) Year 4

6.1. As reported to the Board of Directors in November 2022, Saint Mary's MCS are fully compliant with all 10 safety actions. Table 2 provides an overview of the Saint Mary's MCS current Year 4 MIS compliance.

Safety Action	**Indicator/ standard**	Current position Nov 2022
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Compliant
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Compliant
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Compliant
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliant
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Compliant
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Compliant

Table 2 Year 4 MIS compliance

6.2. On 16th December NHS R published the MIS Year 4 declaration form. This along with a presentation of overall compliance has been submitted to the Board of Directors to approve and to support the Trust Chief Executive Officer to sign prior to submission of SM MCS compliance on 5th February 2023 to NHS Resolution.

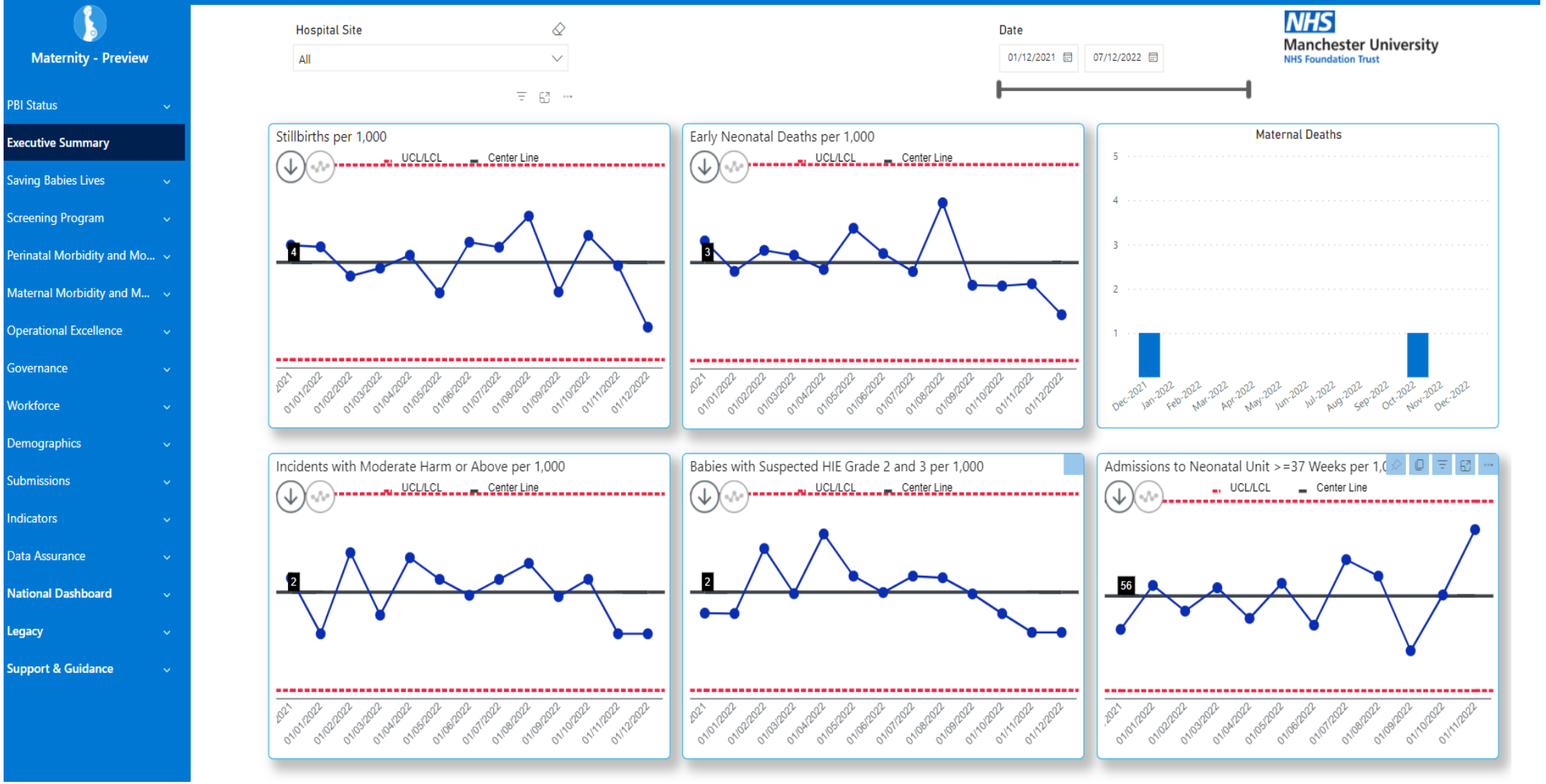
7. Recommendations

7.1. It is recommended that the Board of Directors:

- note the information provided in this report in relation to:
  - the review of SM MCS in comparison against the East Kent Maternity Review

    - the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety
- approve CEO signing of the declaration of SM MCS compliance of all 10 safety actions within MIS Year 4.

Appendix 1 – Maternity Dashboard



(NB. The live dashboard provides numerical values when hovered over, the black line and box provide the current mean)

Appendix 2 SM MCS East Kent Review Action Plan Draft December 2022

Key Action	Action	Lead	Deadline	Progress
Monitoring Safety Performance	Embed maternity dashboard to all QSC and divisional meetings	HoM, CHoD, DD	January 2023	
Monitoring Safety Performance	Commence Maternity and neonatal quarterly meeting	CHoD's for maternity and neonates	Q4 22/23	
Standards of clinical behaviour	Add staff culture and attitude as a risk on SM MCS risk register	Governance Lead, Maternity Division	January 2023	
Standards of clinical behaviour	Commence discussions with HR Team regarding change in culture and positive staff behaviours across the MDT	HoM, ChoD and DD with HR Team	January 2023	
Standards of clinical behaviour	Monitor themes from complaints overall, with specific focus to staff attitude, with monitoring at weekly SM MCS complaints meeting	Assistant Director of Quality and Safety, SM MCS	January 2023	
Standards of clinical behaviour	Undertake staff culture survey specific to working relationships to get a benchmark, and repeat in 6 and 12 months to monitor impact of changes	HoM, ChoD and DD with HR Team	Q4 22/23	
Standards of clinical behaviour	Consider change to appraisal process to support ongoing reflection of values and behaviours specific to the feedback received from	HoM, ChoD and DD with HR Team	Q4 22/23	

	women and families			
Standards of clinical behaviour	Review the actions required within the Kirkup report (2015) against all 3 maternity units, which actions created to address any issues identified	Governance Lead, Maternity Division	January 2023	
Flawed teamworking	Share widely the re-birth terminology now being used within SM MCS	HoM and ChoD	January 2023	
Flawed teamworking	A review the current vision for maternity services to provide safe, quality maternity care.	HoM, ChoD and DD	Q4 22/23	
Flawed teamworking	Share learning from culture work at North re postnatal ward	HoM, ChoD and DD	Q4 22/23	

Appendix 3

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
Paper prepared by:	Jen Sager, Associate Head of Midwifery, Saint Mary's Managed Clinical Service
Date of paper:	8th November 2022
Subject:	Quarterly Report of Transitional Care pathway and Avoidable admissions to Neonatal Unit 1st July to 30th September 2022 (Q2 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 • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality, and outcome • Improve the experience of patients, carers, and families
Recommendations:	The Committee is requested to accept and note the details in the report.
Contact:	Name: Jen Sager, Associate Head of Midwifery Email: jen.sager@mft.nhs.uk

1. Background and Purpose

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

2. Introduction

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[14] to reduce admission of full-term babies to neonatal care.

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

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

2.4. Saint Mary's MCS 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, which has been 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 or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding.

3.2. During Quarter 2 2022/23 one baby, who met the current Transitional Care admissions criteria, was admitted to the neonatal unit due to the requirement of nasogastric tube feeding as this is currently not provided on the postnatal wards at North Manchester. (Table 1)

3.3. There were no babies, who met current TC admission criteria admitted to the neonatal unit in Q2 2022/23 as a result of not receiving transitional care because of staffing or capacity issues.

3.4. **Table 1**

Site	July 2022	August 2022	September 2022
ORC	0	0	0
Wythenshawe	0	0	0

[14] 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

North Manchester	0	1	0

3.5. The COVID19 pandemic has not changed the provision of TC across the Saint Mary's MCS during Q2 2022/23.

3.6. 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.

3.7. 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.

4. Review of term admissions to the Neonatal Unit using the Avoiding Term Admissions to 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 July to 30th September 2022, there were 14 avoidable term admissions across Saint Mary's MCS. 2 babies on the Oxford Road site, 6 on the Wythenshawe site and 6 on the North Manchester site. This is a reduction from Q1 22/23 when there were 22.

4.5. The Avoidable Admissions to Neonatal Unit report for Q2 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 14 avoidable admissions to the Neonatal Unit:

- 3 babies were admitted due to respiratory conditions
- 1 baby was admitted due to hypoglycaemia
- No babies were admitted due to jaundice
- 4 babies were admitted due to perinatal hypoxia-ischaemia (2 for suspected Hypoxic-ischaemic encephalopathy (HIE) and 2 for low cord ph's)
- 1 baby was admitted due to hypothermia

4.7. None of the reviews identified an increase in admissions for specific ATAIN metrics during Q2 2022/23.

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

- Not following guidance/policy (sepsis, NNU admission criteria, escalation)
- Requirement of Nasogastric Tube feeding
- Requirement of additional transitional care to be provided on postnatal ward

4.9. Work remains ongoing to support nasogastric tube feeding on the postnatal wards at Oxford Road and North Manchester as part of a wider workstream to harmonise transitional care pathways across SM MCS (Appendix 1).

4.10. Each review, where required generates specific actions, and these are logged via the risk management system, and monitored at 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 January 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 2 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 November 2022

	Action	Lead	By When	Status
1	Develop action plan to address ATAIN audit compliance	ATAIN Champions, supported by Deputy Heads of Midwifery	December 2021	Complete
2	Develop ATAIN audit compliance report for ongoing review at quarterly maternity Services Divisional Quality and Safety meeting	ATAIN Champions	December 2021	Complete
3	Develop a harmonised MCS report to capture themes and learning from unexpected admissions to neonatal unit	DHoM's Maternity Services Division	April 2022	Complete
4	Harmonise Transitional Care model across Saint Mary's MCS	Neonatal Matron and Inpatient Matron at North Manchester to work with Lead Nurse for Newborn Service to fully implement TC model	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
5	Harmonise Transitional Care Guidance across Saint Mary's MCS	Lead Nurse for Neonatal Service and DHoM's to lead in harmonisation of TC guideline on all sites	June 2022 extended to July	Complete
6	Full review of themes for admission to NNU at Wythenshawe	Lead Midwife for Governance, DHoM Wythenshawe, Clinical Director Wythenshawe	August 2022	Complete. Shared with DQSC

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