MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON TUESDAY 9th MAY 2023
At 2:00pm

Main Boardroom
Cobbett House

A G E N D A

1. Apologies for absence

2. Declarations of Interest

3. To approve the minutes of the Board of Directors' meeting held on 13th March 2023 — *(enclosed)*

4. Matters Arising

5. Patient Story — *(Film)*

6. Group Chairman's Report — *(Verbal report from the Group Chairman)*

7. Group Chief Executive's Report — *(Report of the Group Chief Executive)*

8. **Operational Performance**

8.1 To receive an update report on MFT's current operational performance against national standards and planning requirements — *(Report of the Group Executive Director of Strategy enclosed)*

8.2 To receive the Group Chief Finance Officer's Report (including end of year position) — *(Report of the Group Chief Finance Officer enclosed)*

8.3 To provide an update on the Hive Programme — *(Report of the Deputy Group Chief Executive Enclosed)*

8.4 To receive reports from the Chairs of the Board of Directors' Scrutiny Committees — *(Verbal reports from Group Non-Executive Directors)*

9. **Strategic Review**

9.1 To receive an update on strategic developments — *(Report of the Group Executive Director of Strategy enclosed)*

9.2 To receive the MFT Annual Plan 2023/2024 — *(Report of the Group Executive Director of Strategy enclosed)*

10. Governance

10.1 To delegate authority to the Audit Committee for sign-off of the MFT Annual Report and Annual Accounts for 2022/2023 *(Report of the Group Chief Finance Officer enclosed)*

10.2 To receive the Q4 complaints report *(Report of the Group Chief Nurse enclosed)*

10.3 To receive the annual Nursing and Midwifery Revalidation report *(Report of the Group Chief Nurse enclosed)*

10.4 To receive the annual Nursing and Midwifery Safer Staffing report *(Report of the Group Chief Nurse enclosed)*

10.5 To receive an update on the CQC Saint Mary's oversight arrangements *(Report of the Group Chief Nurse enclosed)*

10.6 To receive and approve the NHSI FT self-certification requirements *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.7 To receive an update report on the NHS Staff Survey *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.8 To receive the Board Assurance Framework *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.9 To ratify the Scrutiny Committees' Terms of Reference *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.10 To receive the Board of Directors' Register of Interests *(Report of the Group Executive Director for Workforce and Corporate Business)*

10.11 To note the following Committees held meetings:

10.11.1 Group Risk Oversight Committee held on 20th March 2023
10.11.2 Charitable Funds Committee held on 28th March 2023
10.11.3 Audit Committee held on 12th April 2023
10.11.4 Quality and Performance Scrutiny Committee held on 18th April 2023
10.11.5 Human Resources Scrutiny Committee held on 18th April 2023
10.11.6 Finance and Digital Scrutiny Committee held on 25th April 2023
10.11.7 EPR Scrutiny Committee held on 26th April 2023

11. Date and Time of Next Meeting

The next meeting will be held on Monday 10th July 2023 at 2:00pm

12. Any Other Business

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 13th March 2023

(PUBLIC)

The meeting was held 'virtually' via Microsoft Teams

DRAFT

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Trevor Rees (TR)	Deputy Group Chairman
	Angela Adimora (AA)	Group Non-Executive Director
	Darren Banks (DB)	Group Director of Strategy
	Gaurav Batra (GB)	Group Non-Executive Director
	Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Julia Bridgewater (JB)	Group Deputy Chief Executive
	Jane Eddleston (JE)	Joint Group Medical Director
	Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	David Furnival (DF)	Group Chief Operating Officer
	Nic Gower (NG)	Group Non-Executive Director
	Gill Heaton (GH)	Acting Group Chief Executive
	Cheryl Lenney (CL)	Group Chief Nurse
	Toli Onon (TO)	Joint Group Medical Director
	Damian Riley (DR)	Group Non-Executive Director
	Mark Gifford (MG)	Group Non-Executive Director
In attendance:	Nick Gomm (NGo)	Director of Corporate Business/ Trust Board Secretary

47/23 Apologies for Absence

Apologies were received from Luke Georghiou and Chris McLoughlin

48/23 Declarations of Interest

No specific interests were declared for the meeting.

49/23 Minutes of the Board of Director's meeting held on 9th January 2023

The minutes of the Board of Directors' (Board) meeting held on the 9th January 2023 were approved.

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

50/23 Patient Story

CL introduced a filmed patient story regarding someone who had received treatment and care for sickle cell disease at MFT.

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

51/23 Matters Arising

There were no matters arising.

52/23 Group Chairman's Report

KC explained that the meeting was being held over MS Teams due to the junior doctors' industrial action which is taking place. Group Executive Directors need to be able to come in and out of the meeting, as required, to attend to business in the Incident Command Centre which has been set up for the period of industrial action.

KC noted the sad passing of Peter Mount, who was Chairman of Central Manchester University Hospitals NHS FT from 2001 to 2014. Peter made an incredible contribution to what has become MFT, improving services for patients and communities.

KC introduced MFT's new Non-Executive Director, Mark Gifford (MG), who joined on the 28th February. Mark is currently Chief Executive of the National Citizens Service and has held senior roles in large, complex, and very successful organisations.

KC congratulated the staff of First Steps nursery on their 'Good' rating from Ofsted, described a week of activities related to MFT's Apprenticeship programme, and highlighted plans to celebrate 75 years of the NHS.

KC ended by noting that this would be GH's last Board meeting before she retires and thanked her for her contribution to the NHS and MFT.

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

53/23 Group Chief Executive's Report

GH thanked KC and welcomed MG to the Board.

MFT continues to work within a challenging environment but progress is being made on improving MFT's operational performance in a number of areas.

The CQC carried out an inspection of MFT's maternity services the week before the Board meeting and CL will update the Board on progress over the coming weeks.

DRAFT

The day of the Board is the first day of the junior doctors' industrial action and MFT has taken all necessary steps to minimise the impact of patients and to a maintain safe services during the period of disruption. An Incident Command Centre has been established, led by our Group Executive Directors, and this will remain in place throughout the duration of the industrial action.

GH highlighted key issues on the meeting agenda and thanked staff for their continued dedication and professionalism amidst the challenging circumstances the NHS is working within.

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

54/23 Update on the Board Governance Review

KC presented an update on the Board governance review which was initiated in the Autumn of 2022. She described the scope of the review, and the rationale for it, and described some of the initial ideas for improvement.

As a result of the review, the Board Assurance Report (BAR), which has previously come to each meeting, will be replaced by an Integrated Performance Report at the May meeting. The format of the Board Assurance Framework will also be reviewed and will come to the May meeting instead of this meeting.

In the absence of the BAR at this meeting, KC asked DR, AA, and TR to give an overview of the assurance received at the Quality and Performance Scrutiny Committee (QPSC), Human Resources Scrutiny Committee (HRSC), and Finance and Digital Scrutiny Committee (FDSC) meetings in February 2023.

DR explained that the QPSC had considered in detail the metrics measuring the operational performance of the Trust, with a particular focus on diagnostic metrics; the ongoing work in improving theatre utilisation; a presentation from Saint Mary's regarding compliance with the Maternity Incentive Scheme year 4 safety actions; implementation of the Patient Safety Incident Response Framework; and how quality was assured from insourced services. He explained that, from June, the meetings would be lengthened to allow more in-depth discussion, and patient stories would be heard at the beginning of each meeting.

AA explained that at HRSC they had analysed the key workforce metrics for the organisation; discussed the actions being taken to mitigate the impact of the industrial action; approved the Gender Pay Gap report and Equality, Diversity, and Inclusion reports (both of which are on the Board meeting agenda); and considered the internal audit report on apprenticeships.

TR explained that the focus at FDSC had been on three items: the financial out-turn position, including the achievements of the Waste Reduction Programme (WRP) for 2022/23; the Chief Information Officer's report; and the financial plan for 2023/24 which shows that MFT will be working in a very challenging financial context in the next financial year.

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

DRAFT

55/23 Update on Hive Programme

JB presented the report which provided an update on implementation of the Hive programme. She began by noting that it had been six months since Go-live and it had been viewed as one of the most successful implementations of an Electronic Patient Record (EPR) in the history of the NHS. Deloitte had concurred with this view.

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

Considerable progress has been made since the programme moved from the hyper support/command to the Stabilisation Phase. The Stabilisation Governance has matured and continues to be overseen by JB. This governance will continue to be in place moving into 2023/24 to ensure progress continues and priorities are delivered. The EPR Scrutiny Committee (EPRSC), now chaired by GB, has begun to focus on benefits realisation.

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

There were five overall high-level risks that have been reported into and managed via GROC: potential impacts on safety if the programme is not delivered effectively; the risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live; management of complex pathways at North Manchester General Hospital; the inclusion of the Local Care Organisation into the Hive Programme (which was agreed later than the acute hospitals); 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.

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

JE explained how the clinical benefits of Hive are already being seen. There has been a 78% positive patient identification at bedside which has averted serious incidents.

GB explained that, at the last EPRSC, Deloitte had referred to the programme as an exemplar and that the implementation was largely stable now with some work still to go.

NG reiterated Deloitte's words and noted the importance on carefully selecting what the focus should be as the programme continues to ensure the capacity is focused on the most impactful things.

KC noted that, when on a recent Senior Leadership Walk Round, she had been struck by the enthusiasm shown by staff with regard to Hive and the way it had improved the way they work.

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

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56/23 Update on the Trust's operational performance

General Update, Performance Standards and Recovery Programme

DF introduced the report which provided an update on the current operational position and progress with delivery of the Trust's Recovery Programme.

Across emergency care pathways Hospitals have seen pressures easing slightly since mid-January, supported by lower attendances and winter wards being fully mobilised. This has resulted in an improvement in a number of performance metrics, with the 4hr A&E standard reporting 60.4% at the end of January, an increase of 9% from December, and ambulance handover delays >60 minutes also reporting a significant reduction. Occupancy levels remain high and 'No reason to reside' numbers have remained relatively static at 330 since December, against a target of 240. Transformation work continues through enhancing Same Day Emergency Care (SDEC) services, increasing virtual ward capacity, and roll out of the 'back to basics' part of the Resilient Discharge programme, all of which improve ambulance handovers, reduce the time patients spend in A&E, and increase flow out of hospitals. A focus for the 2023/24 plan is to work with partners in Manchester and Trafford to find solutions for those patients who use urgent and emergency care most frequently.

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

The junior doctors' industrial action has impacted on delivery of the 78-week target with 600 appointments for those patients likely to be cancelled over the 3-day period. This has been highlighted to NHS England at a regional and national level.

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

MFT has recently been moved from segment 2 to segment 3 of the NHSE Accountability Framework. The segmentation change is based on several areas of challenge and the requirement to move the organisation into the national recovery programme as a 'Tier 1' provider for both Elective and Cancer recovery. Work is underway with GMICB and the NHSE regional team to establish the exit criteria.

DF reiterated that QPSC goes through all the detail behind the performance metrics at their meetings.

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

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

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

Following the IPC BAF's most recent iteration published on 30th November 2022, the IPC team undertook a full review of all risks related to the control of infection prevention and control, specifically related to the National Infection Prevention and Control Manual. The BAF was presented in Appendix 1 of CL's report.

COVID remains a feature in MFT's hospitals and PCR testing is still in place for patients being discharged to care homes. Face mask adherence from members of the public on hospital premises is proving difficult to enforce due to the perception that COVID has gone away. There were 161 cases of Hospital Onset COVID-19 Infection (HOCI) in February which is slightly lower than trajectory. There were 32 COVID outbreaks across MFT in February.

CL described the current position for all other Healthcare Associated Infections (HCAI) in MFT's hospitals – MRSA bacteraemia, C-Diff, Gram negative bacteraemia (GNSBI), Vancomycin Resistant bacteraemia (VRE), and Carbapenemase-producing Enterobacterales. Of these, the VRE numbers are higher than expected.

MFT's vaccination programme has resulted in rates of 50% for flu and 47% for COVID. This is in line with the national average but lower than hoped for.

DR complimented the IPC BAF and asked questions regarding the rates of GNSBI and the link to catheter issues; the FR1 and FR2 audits; and the impact of a lack of available side rooms for patients.

CL explained that MFT is approximately at threshold for GNSBI with lots of work underway to minimise infection. Catheter issues are relevant but are not the only cause. Sedexo are responsible for carrying out FR1 and FR2 audits and are frequently contacted to ensure they happen. There is evidence of patient-to-patient transmission due to the lack of side rooms. The issue is on the risk register and regularly monitored. Risk assessments are carried out on individual patients and group risk assessments occur for patients in bays. The issue is particularly relevant at NMGH. Future hospital builds will have mainly single rooms.

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

57/23 Group Chief Finance Officer's Report Month 10

JEh introduced the report which provided an update on MFT's financial position. She explained that further financial controls had been applied in January to support the year end position.

To January 2023, the Trust has delivered a Year to Date (YTD) deficit of £13.2m against a planned YTD breakeven position. This reflects an in-month surplus of £6.0m. This is a significant improvement compared to previous months, driven by an increase in income and the release of prior year provisions which are no longer needed. The Trust has also put in place a number of actions to manage costs ahead of the new financial year in April.

In November, the GMICB put itself and all providers into an informal Financial Recovery footing and requested all providers deliver a reforecast demonstrating three scenarios, Best/Most Likely/Worst, as a result The Trust presented a case which detailed, subject to a series of assumptions, that we would deliver Best Case, a breakeven position; Most Likely, £10.4m deficit; and Worst Case, a £50.8m deficit. At month 10, the Trust anticipates achievement of the breakeven scenario, as planned.

In January 2023, total expenditure was £211.4m, almost exactly the same as the December figure of £211.6m. Pay costs increased slightly, by £0.6m, to £127.7m, offset by a small decrease of £0.8m in non-pay expenditure, with various offsetting adverse and favourable variances across the expenditure categories. Income increased by £5.8m, to £217.4m, following an increase of £4.7m in month 8, offsetting expenditure pressures. This increase has primarily been driven by contract variations, such as for Community Diagnostic hubs, and additional income received from Health Education England.

As at 31st January 2023, the Trust had a cash balance of £177m. The cash balance has remained reasonably static compared to the balance of £175m at 31st December 2022. The cash balance at the end of January was lower than forecast by £32m, primarily due to higher than forecast cash outflows relating to payables, and lower than forecast cash inflows relating to income received in month. It is anticipated that there will be an increase in cash at the end of February due to a ‘catch up’ in income received.

The Trust’s element of the final GM capital submission is a total plan value for 2022/23 of £136.4m, with the GM envelope component being £68.6m. For the period up to 31st January 23, total expenditure was £87.8m against a plan of £103.8m - an underspend of £15.9m. Expenditure included within the GM envelope was £51.8m against the original plan of £54.7m - an underspend of £2.9m. The forecast for year end is that this underspend will be rectified, and the Trust will deliver its capital plan.

As previously reported to the Board, the IFRS 16 guidance issued by NHS England in October 22 confirmed that the 2022/23 capital expenditure incurred because of the adoption of IFRS 16 will be managed against a national “ringfenced” IFRS 16 CDEL allocation for the Trust. This totalled a plan value of £139.8m for 2022/23. This was reduced to £32.6m for the month 10 forecast, reflecting the impact of the delayed NHS guidance until over halfway through 2022/23; updated assumptions on the managed equipment service (MES) contracts; and significant delays in the supply chain.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the Month 10 position against the 22/23 plan and Cash and Capital positions for the Trust.	None	n/a	n/a

58/23 Update on strategic developments

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

Rt Hon Patricia Hewitt, former Secretary of State for Health and current chair of the Norfolk and Waveney Integrated Care Board (ICB), has been commissioned to lead an independent review into the efficiency, autonomy, and accountability of Integrated Care Systems (ICSs). The final report is due to be completed by 15 March 2023. A stakeholder update produced in January 2023 outlined some principles emerging from the review.

The NHSE Priorities and Operational Planning Guidance set out three key tasks for 2023/24: recover our core services and productivity; make progress in delivering the key ambitions in the Long-Term Plan (LTP); and continue transforming the NHS for the future. Plans are to be submitted at ICB level. Draft plans were required for 23 February and final plans are to be

submitted to NHS England by 30 March 2023.

All 10 GMICB localities are required to confirm their governance arrangements to NHS GM before the end of the March 2023, in particular the terms of reference for their locality board. Trafford and Manchester have agreed their preferred governance models and they will be submitted to GM ICB for approval.

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

MFT's 2023/24 annual planning process is underway. This covers the development of the over-arching MFT annual plan; the annual plans of the Hospitals, Managed Clinical Services, Local Care Organisations, and corporate departments; and the completion of the GM ICS operational plan templates that are collated to form the GM Operating Plan and are submitted to NHSE. Two annual planning events have been held with the Council of Governors, one looking back at delivery against the 22/23 plan, and one looking forward, reviewing the priorities for 23/24 identified by each of the Hospitals, Managed Clinical Services and Local Care Organisations. A draft overarching MFT Annual Plan will be circulated to the Council of Governors for comment in early March and be brought to the Board for sign-off in May.

Managed Single Services are being established for all MFT's priority services. A tracker for monitoring progress has been developed and is reviewed regularly through the Accountability Oversight Framework.

DR welcomed the work on developing single services, and paid tribute to the work of the teams involved.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.	None	n/a	n/a

59/23 Q3 Complaints Report

CL presented the report and described the following:

- activity for Complaints and PALS across the Trust
- an overview and brief thematic analysis of complaints raised
- feedback received through Care Opinion and NHS Websites
- improvements achieved, and those planned to ensure learning from complaints is embedded in everyday practice.
- the Complainants' Satisfaction Survey and planned improvement activity Equality and Diversity information and planned improvement activity

NG explained that the MFT's Complaints Scrutiny Group samples one or two complaints each month to check they have been handled currently and lessons are being learned. He noted that there is a risk in relying on monitoring percentages at a Group level as these can hide variance between Hospitals/MCSs/LCOs. He also pointed out that even if numbers of complaints are low, each represents a poor experience from a patient's point of view. He added that it can be sometimes difficult to fully learn from complaints across an organisation of the scale of MFT.

CL agreed with NG on all points but noted the value in learning from broader themes of complaints across the whole Trust. JE agreed, supporting a 'walking in your shoes' approach and encouraging more use of patient groups to inform service improvement.

In response to a question from DR regarding face-to-face meetings with complainants, CL confirmed that these included clinicians.

NG noted the value in effective written communication when dealing with complaints and CL agreed, explaining that staff training was in place but that it is sometimes difficult to communicate clearly when complex clinical procedures are involved. JE described work underway with GPs on improving the clarity of discharge letters. AA added that the 'tone of voice' in letters was important.

GH reiterated that, often, the best way to deal with complaints was face to face meetings with the relevant health professional as written responses can appear to be lacking in empathy.

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

60/23 Maternity services update including the Q3 Avoidable Term Admission into Neonatal (ATAIN) report 2022/2023

CL presented the report which provided an update on progress, and ongoing monitoring of compliance, with the Immediate and Essential Actions (IEAs) from both reports of Donna Ockenden. It also provided assurance to the Board of Directors on matters relating to patient safety within maternity services, including compliance with the recently updated Year 4 Maternity Incentive Scheme - specifically including Safety Action 3 - and evidence of bi-monthly detailed discussion at the Trust's QPSC. She also referenced the current planned CQC inspection of MFT's maternity services.

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

The maternity and neonatal dashboard is available for use in maternity services to provide consistent and timely access to maternity and neonatal data. Progress continues to embed the new dashboard at divisional and hospital level. Having the ability to access data across the 3 sites has enabled SM MCS to note variation and provide support and enhanced monitoring where required.

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

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

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

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

DRAFT

mitigation to support safety.

Evidence of compliance of Year 4 MIS Safety Actions has been submitted to NHS Resolution. A presentation has been received by the QPSC.

CL concluded by drawing the Board's attention to the information in the appendices to the report which included the Maternity dashboard and minutes from Saint Mary's Quality and Safety Committee.

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

61/23 Annual Equality, Diversity and Inclusion (ED&I) report

PB presented the annual ED&I report. The statutory deadline for publication of the report is 31st March 2023.

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

The annual ED&I report has been approved by the Group Equality Diversity and Human Rights Committee and was discussed in detail at the HRSC in February 2023.

AA commented that it was an incredibly comprehensive report and stressed the importance of being able to measure the benefits of the work and to build on what has worked well.

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

62/23 Gender Pay Gap annual report

PB presented the report on MFT's Gender pay gap and noted that it had been discussed in detail at the HRSC.

Organisations with 250 or more employees are mandated under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, to report annually on their gender pay gap. As one of the largest acute NHS Trusts in England which employs over 28,000 staff, Manchester University NHS Foundation Trust (MFT) is required to publish information relating to its gender pay gap under six specific metrics. These are detailed in the report which is required to be published annually on the Trust website.

He highlighted table 5 in the report which showed the work which was till required and highlighted the impact of the Clinical Excellence Awards (CEAs) on the figures.

AA reiterated the level of discussion at HRSC and noted that TO had described in detail the work which was underway to mitigate the impact of the CEAs. Questions which had emerged after HRSC had been responded to by PB outside of the meeting.

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

63/23 Minutes of Board Sub- Committees held in January and February 2023

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

- Group Risk Oversight Committee held on 16th January 2023
- ERP Scrutiny Committee held on 25th January 2023
- Audit Committee held on 1st February 2023
- Quality and Performance Scrutiny Committee held on 14th February 2023
- Human Resources Scrutiny Committee held on 21st February 2023
- Finance and Digital Scrutiny Committee held on 28th February 2023

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

64/23 Date and Time of Next Meeting

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

65/23 Any Other Business

There were no additional items of business.

DRAFT

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 13th March 2023		
Action	Responsibility	Completion date
There were no actions raised.		

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

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

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

DRAFT

Agenda Item 7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Executive
Paper prepared by:	Mark Cubbon, Group Chief Executive
Date of paper:	May 2023
Subject:	Group Chief Executive 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 provides an overview of current issues of relevance to delivery of the Trust's Strategic Aims
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Julie Gwilliam, Senior Executive Assistant Tel: 0161 276 4755

1. Introduction

In my report to each Board meeting, I will be highlighting current and emerging issues of relevance to Board members, to support specific updates provided by other members of the Group Executive Director team.

2. My first month at MFT

Since joining the Trust at the beginning of April, I have been hugely impressed by the knowledge and expertise of the staff I have met, and the incredible work undertaken in all MFT's Hospitals, Managed Clinical Services, Local Care Organisations and Corporate Services. I am honoured to have been appointed as Group Chief Executive and I relish the opportunity to lead MFT into the next stage of its development.

For the year ahead, there are four key areas I have asked colleagues across MFT to focus on:

- Reducing delays for patients who are referred to or attend any one of our sites for treatment, while striving to deliver high quality, effective and safe care
- Managing our resources effectively and living within our means
- Ensuring that each member of staff has the support required to do their job to the best of their abilities
- Maximising the impact of Research & Innovation so that our patients can benefit from innovative technologies and treatments which deliver better outcomes.

We will do this by:

- Delivering our plans which drive improvements for patients
- Working to address the long-standing inequalities faced by so many of our communities
- Listening and acting on feedback from staff about improvements we can make with them, at work
- Continuing to be guided by the MFT Values, which bring to life our belief that Together Care Matters:
    - Dignity and Care
    - Everyone Matters
    - Working Together
    - Open and Honest

Having visited all ten of our hospitals and spent the day with our Manchester Local Care Organisation, I have had the opportunity to talk directly to colleagues and see examples of the fantastic work they do every day for our patients. It will probably be no surprise to Board colleagues that everyone I have met has been incredibly welcoming.

I have initiated a series of organisation-wide engagement sessions which will run over the weeks and months ahead, to hear more about what works well across the Trust, but also talk about the areas where we can improve. Crucially, colleagues will be involved in the planning and implementation of agreed changes throughout the year ahead.

3. Operational performance overview

I join the Trust at a time when we need to apply a significant focus on the safe reduction of our elective waiting list, which built up during the pandemic and is not yet reducing quickly enough. We will continue to prioritise access for patients who require urgent treatment and those who have waited the longest. This builds on the enormous effort throughout last year to reduce the number of long-waiting patients, but the year ahead will require a further scaling up of activity to deliver the improvements we need to make for our patients.

To improve timely access for Urgent Care there is also a need to ensure we improve flow through our hospitals, enabling patients to be safely discharged when they are medically fit. This will involve work within each of acute hospitals, our LCO teams, and with our health and social care partners in Manchester, Trafford and beyond.

Throughout 2022/23 there was a 48% reduction from its peak in September in the number of patients waiting longer than 62 days to commence their treatment for cancer. We will continue to reduce this backlog throughout the year, while we deliver improvements against the 75% faster diagnosis standard within 28 days.

A new Integrated Performance Report is in development to support the triangulation of Quality, Performance, our Workforce, and our Finances. This is expected to be ready in time for the July meeting of the Trust Board.

The Group Chief Operating Officer's report on today's agenda details our performance against our key operational targets and provides more detail on the work we are doing to improve our position.

As at the end of March 2023:

- 62.9% of patients attending our emergency departments were seen within 4 hours, 3164 patients spent more than 12 hours in the department, and 6,260 were admitted for further care.
- 38% of our ambulance handovers were completed within 15 minutes and 5% took over 60 minutes
- Our 62-day backlog stood at 274 against a plan of 267
- 973 patients have been on a waiting list for elective care for more than 78 weeks
- We have 41,785 on our diagnostic waiting list of which 49% are over 6 weeks.

Our Executive Director Team closely monitors our performance and our progress in delivering improvement, and assurance is provided to the bi-monthly Quality and Performance Scrutiny Committee. We also monitor the contributions from each of our Hospitals, Managed Clinical Services and Local Care Organisations through our Accountability Oversight Framework.

4. Industrial Action

The Junior Doctors' industrial action held 11-15th April was the most challenging yet and I am grateful for the enormous effort from senior clinicians and leaders across MFT, to ensure that the services we maintained during that period remained safe.

This period of action had a significant effect on our planned activity and while our clinical and operational teams worked together to minimise the impact on patients as much as possible, but this has led to thousands of patients having their care rescheduled. Preventing future industrial action of this nature is a matter to be resolved between the relevant Unions and Government but, in the meantime, we will continue to support all colleagues at MFT to deliver the best possible care for our patients. I am incredibly grateful for everyone's continued hard work, dedication, and professionalism.

5. Maternity services: CQC inspection

In early March, the CQC undertook a routine, unannounced inspection of the maternity services provided by MFT at North Manchester General Hospital, Saint Mary's Hospital and Wythenshawe Hospital. Following the inspection, which considered the 'Safe' and Well Led' domains of the CQC's Single Assessment Framework, we received a Section 29A Warning Notice, allowing 3 months to address their concerns with delays in triage; delays in elective caesarean section and induction of labour; and the numbers of staff available, and their skill mix.

As a result, we have immediately put in place an action plan to address the issues raised. We have increased staffing levels in key areas and improvements to the availability of operating theatres will come into place in May.

The Saint Mary's Managed Clinical Service (MCS) team is being supported and delivery of the action plan monitored closely through a dedicated Oversight Group chaired by the Group Deputy Chief Executive and Group Chief Nurse. This time-limited group reports into the Executive Director Team meeting and the Board of Directors' Quality and Performance Scrutiny Committee.

We are taking immediate learning from this situation to strengthen to our existing governance and assurance processes, bringing in additional external expertise and scrutiny as required, to support our improvement efforts.

The inspection report is not yet finalised, and we expect to receive the full report in June. In the meantime, we are engaging proactively with the CQC, our local Integrated Care Board, and NHS England, to inform them of our progress in addressing the issues they have raised.

Further detail of the inspection, and the actions underway, are covered in the Group Chief Nurse's report later on today's agenda.

6. Greater Manchester Integrated Care System (ICS)

Since I joined MFT, there has been extensive engagement with colleagues across Greater Manchester, as we finalise the GM operating and financial plan for 23/24. I have seen a real desire from colleagues to build on the collaboration which already exists to across the Integrated Care Partnership (ICP), among Providers, and with Place Based leads, to secure delivery of the agreed plan.

7. Top three concerns

In summary, the top three concerns I would highlight to the Board are:

- The scale of our elective 'backlog' is one of the most significant across the NHS and the risk of further Industrial Action throughout the year, has the potential to pose significant delivery risk to our plans. We will use every opportunity to increase our productivity and apply mitigations as necessary to deliver our plans.
- The financial plan for 23/24 presents a further challenge for the year ahead and there is a need for a multi-year recovery plan which is in development. The primary objective for this plan is to set out a timeframe and opportunities, for MFT to get to recurrent balance and address our underlying deficit.
- The early findings fed back to us in the CQC 29a Warning Notice were unexpected and we are taking immediate steps to ensure our broader assurance systems and processes are working as effectively as they should.

The above concerns are reflected in the Trust Board Assurance Framework.

8. Recommendation

The Board of Directors is asked to note this report.

Agenda Item 8.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Group Chief Operating Officer Team
Date of paper:	May 2023
Subject:	Performance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors 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

As the Board of Directors will be aware, an integrated performance report is in development and will be available for a future Board meeting. This integrated report will cover performance in its widest sense in terms of clinical quality, patient experience, workforce and financial sustainability, for example.

The quality and safety of care that we provide to our patients remains our top priority. The purpose of this briefing is to provide an overview of the commitments and progress that the organisation is making specifically in terms of ensuring timely access to our services for our patients, focusing on 4 priority areas:

- **Elective care** and the approach to treating patients who have been waiting the longest
- **Urgent care**, specifically Emergency Department performance and flow
- **Cancer** waiting times
- **Diagnostic** waiting times

2. EXECUTIVE SUMMARY

One of the greatest performance challenges that we face currently as an organisation is to reduce the time that our patients are waiting for **planned (elective) care**. There continues to be concerted efforts across MFT to shorten waiting times, however many patients are still waiting longer than we and they would want. The good progress made in reducing our longest waits has unfortunately been significantly impacted by the recent industrial action despite our best efforts to mitigate the loss of operating lists and clinics. There were therefore 973 patients waiting more than 78 weeks at the end of April, which was around 300 more than had been planned. Notwithstanding further operational pressures, we remain committed to reducing this number to zero by the end of June and to continue work towards no patients waiting more than 65 weeks by April 2024, in-line with national expectations.

Work continues to validate all our waiting lists to ensure that the patients on our lists still require their procedures and that they are communicated with throughout. A deep-dive on elective care is scheduled, led by Group Executives, Hospital / MCS / LCO Chief Executives and the relevant Corporate Directors. Arrangements have also been made to provide dedicated leadership to Trafford General as our elective care hub site to reduce waiting times and increase productivity.

Our hospitals have seen **urgent care** pressures easing slightly since mid-January with a reduction in the number of attendances and additional wards being opened. This has resulted in improved waiting times for patients in our emergency departments and a reduction in handover delays with ambulance crews. Whilst 60% of patients waited 4 hours or less in our emergency departments in the final quarter of last year, this is still significantly below the national standard of 95% and the minimum expectation for 2023/24 that at least 76% of patients are seen within 4 hours.

Challenges remain with flow through our hospitals; admission rates from emergency departments are relatively high (reflecting the increased acuity of patients attending our hospitals) as are bed occupancy rates. The number of patients with 'no reason to reside' in our hospitals (i.e. are clinically ready for discharge) has remained stubbornly static at around 330 since December against a target of 240.

The National delivery plan for recovering urgent and emergency care has recently been published and outlines by 5 objectives:

- Increasing Capacity – making best use of existing capacity by improving flow
- Growing the workforce – increasing the size of the workforce and supporting staff to work flexibly with patients
- Improve discharge – working jointly with all system partners
- Expanding and better joining up health and care outside hospital
- Making it easier to access the right care

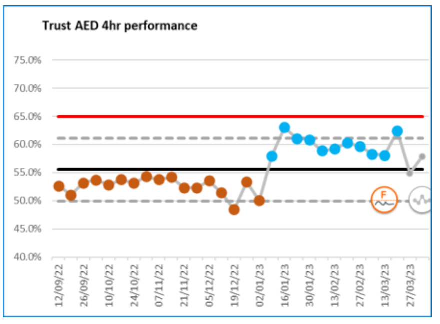
Our targeted transformation work continues through enhancing Same Day Emergency Care (SDEC) services, increasing virtual ward capacity and roll out of the 'back to basics' part of the Resilient Discharge Programme across all wards. A locality wide strategy is in development too through a data-driven process to reset our priorities and continue to deliver improvements for our patients.

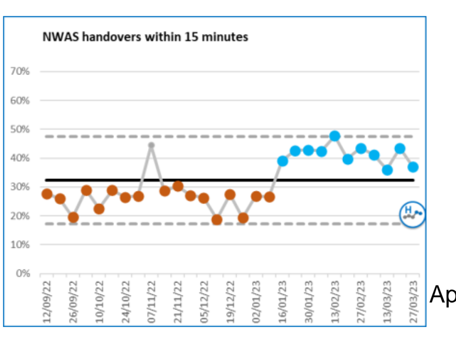
There has been good progress made on reducing the number of patients with suspected **cancer** waiting over 62 days for their treatment. At the end of April there were 274 patients against a plan of 267 with the industrial action again having an impact on work to reduce this number further. The total waiting list for patients on suspected cancer pathways has, though, reduced by 48% since its peak in September, which means patients are being diagnosed and treated faster than previously despite there being more than double the number of referrals compared to previous years.

The number of patients waiting for **diagnostic tests** has seen a growing waiting list trend since September with a significant increase in the number of patients waiting for CT, MRI and non-obstetric ultrasound scans (NOUS) as well as audiology tests. Additional capacity has been in place through Community Diagnostic Centre programme and weekend scanning to support a reduction in the overall waiting lists. There has been a focus on supporting timely diagnosis for patients on cancer pathways, with improvements seen in MRI and CT from an average of 13 days to 8 days. A dedicated taskforce has been established to ensure that recent improvements continue.

3. URGENT CARE AND FLOW

Urgent Care Current Position





Ap

Key Messages

- Performance improved against the 4hr standard during our last quarter of 22/23. With a year end performance in March 23 reporting 62.9%.
- Lower attendances and mobilisation of winter wards and increase in virtual ward capacity have supported this position
- High occupancy rates continue to be a challenge across our Acute Adult Hospitals
- Emergency admission through the department remain high with a conversion rate of around 17.2% of all attendances
- Acuity remains high across several pathways
- The number of patients remaining in hospital on the no reason to reside list remains significantly higher than the expected level.
- Ambulance handovers within 15 minutes has shown an improvement through the last quarter of the year
- MFT recognise their contribution and commitment to achieving the national expectation of ambulances response times for Cat 2 to an average of 30 mins over 23/24

Key Performance Indicator	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Four Hour Performance	64.7%	63.5%	62.1%	61.1%	63.1%	52.9%	53.0%	53.2%	51.6%	60.4%	59.3%	62.9%
EME Admissions	9,783	9,832	9,947	9,688	9,102	9,165	7,401	6,739	6,940	6,940	6,490	6,260
EME Admissions via AED	7,855	8,002	8,014	7,632	7,430	7,310	6,976	6,396	6,441	6,051	6,136	5,643
4 to 12 hour waits post DTA	3,462	2,828	3,273	3,646	3,629	2,964	4,083	4,011	3,564	3,041	3,212	3,155
12 hour waits post DTA	127	21	68	9	47	197	450	449	523	524	162	102
Total waits in AED over 12 hours	3,183	2,947	3,335	3,972	3,714	5,219	5,939	5,337	5,681	3,715	3,311	3,164
Ambulance HOLDS	153	108	66	92	85	210	209	172	138	44	19	36
Handover Delays over 60 minutes	508	387	760	599	669	657	667	609	762	291	287	274
No Reason To Reside (snapshot)	299	301	351	348	394	344	351	381	348	325	384	330

Key Actions:

- **MFT Urgent and Emergency Deep Dive** session has been held with the Group CEO, Executive Directors and Hospital/MCS CEOs to provide a different focus on identifying key actions to ensure delivery of the 23/24 UEC commitments
- **Improve flow through ED and Ambulance Handover and turnaround pathways** - Increase in the number of patients transferred from the emergency departments through to Same Day Emergency Care (SDEC) services and transfers direct from North West Ambulance Service into SDEC - Focus of the SDEC work programme is to standardise the SDEC pathways across MFT, taking shared learning from MFT, Greater Manchester (GM) and NWAS services to maximise the diversion of appropriate patients from the ED front door to SDEC services.
- **Maximise the utilisation of the virtual wards** - Focus of the Virtual Ward work programme is supporting the development of the speciality specific virtual wards models and pathways to access (including the Hive pathway build) in order to maximise the utilisation of the virtual ward 'beds' for the patients of Manchester and Trafford.
- **Delivery of the Resilient Discharge Programme** – Focus of the Resilient Discharge Programme is to improve ward level discharge planning and increase the number and types of beds available in community for supported discharges
- **Development of our UEC Urgent Care Strategy** – a series of workshops have been held over January and February to develop our Manchester and Trafford Urgent Care Strategy. A refresh of our vision and key principles have been agreed. Development of the strategy and delivery plan are expected to be finalised by September 2023.

4. ELECTIVE ACCESS

ELECTIVE PROGRAMME

Key Messages

- Elective Care programme continues to focus on the management of clinically urgent (P2) patients, and long waits.
- Hospitals have been proactively managing and reducing the very longest waiting patients in line with trajectories submitted to GM / NHSE
- As at the end of March 23 the total number of patients waiting over 78 weeks reported 973 of which 13 were over 104 weeks against a target of 675. The Junior Doctor Industrial Action impacted significantly on our ability to deliver to plan with high numbers of cancellations or lost capacity due to consultants covering a 24/7 rota over this period.

- For 23/24 our commitment in line with national expectations is to treat all patients waiting beyond 78+ weeks by end of Q1 and waiting over 65+ weeks by March 2024.

Figure 1: Long wait Q1 Cohort

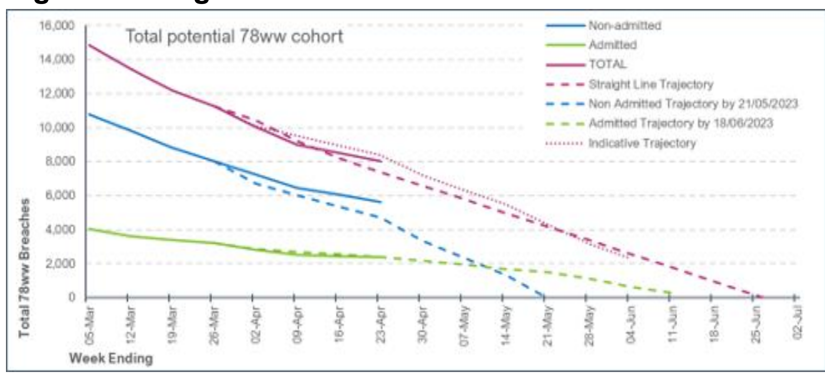


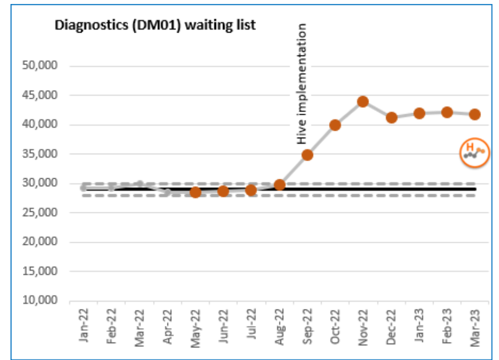
Figure1 shows the total potential cohort of both non admitted and admitted and the straight-line trajectory in place to achieve zero by end of Quarter 1.

The risk specialities are ENT, OMFS, Gynaecology and Urology and represent almost 50% of the overall cohort.

Key Actions

- **Theatre Utilisation / Productivity** - 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.
- **Getting it Right First Time** - focusing on improving our performance and managing variation for the delivery of basket of day case surgery (BADS) procedures and high volume, low complexity (HVLC) procedures. The Trust has engaged and welcomed the NHSE GIRFT team who undertook a visit to the Trafford site at the start of November and are planned to return w/c 24th April 2023.
- **Elective Deep Dive** – Planned for the 5th May 2023 between the Group CEO, Executive Directors and Hospital/MCS Chief Executives to focus on sustainable solutions for delivering a reduction in long waits
- **Mutual aid** – MFT continue to work with GM and National partners to focus on maximising external system wide capacity
- **Validation** – To date over 112,000 patients have been contacted, which has resulted in a 10% removal rate from the waiting lists, following clinical review.
- **Outpatient Utilisation/Productivity** - Focused on improving the performance rate of Patient Initiated Follow-up (PIFU) to the 5% target and manage improvements in Pre referral Advice and guidance on a specialty-by-specialty basis to improve performance to 16%. Work continuing on reviewing demand, increasing clinic capacity and job planning.

DIAGNOSTICS



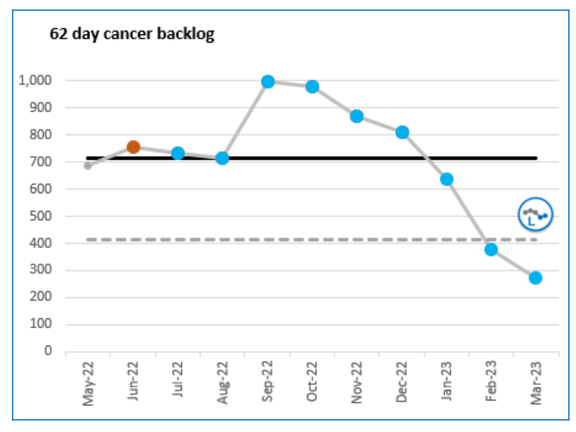
Key Actions:

Key Messages

- Diagnostics performance continues to be challenged with increasing demand, particularly on unscheduled care by 3.2%.
- Waiting list has increased since September 2022 which coincided with the go live of the new EPR system.
- Taskforce established to investigate.
- Following the work of the Taskforce the waiting list has since stabilised since December.
- Published position for March 23 is 41,785 of which 49% are over 6 weeks.
- National expectation is to achieve <5% over 6 weeks by March 2024 and MFT are currently working on plans to deliver this.

- **Reporting Capacity** - Additional reporting capacity continues through utilising extra clinical sessions
- **Timely vetting of patients** - key priority area and work to ensure 'in team' vetting rotas in place to certify cross cover arrangements is on-going.
- **Additional Capacity** - weekend capacity in place for ultrasound scanning and endoscopy.
- **Community Diagnostic Centres** – work to maximise the use of the CDC for MR and CT scans, along with additional capacity for Endoscopy.

CANCER



Key Messages

- Significant progress on reducing the number of patients waiting over 62 days ending the year at 274 against a target of 267.
- Total referrals for suspected cancer have risen to circa 5000 per month since December but have risen in March to just under 5500.
- Referrals across GM remain at 127% of the pre covid average and MFT has followed that trend.
- Increase in backlog following the recent Industrial action

Table 2 – Cancer Performance Jan 22 – Feb 23

Measure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
MFT Two week wait breast symptomatic (93% target)	12.6%	30.6%	16.3%	16.6%	23.5%	18.9%	12.7%	19.2%	40.3%	75.6%	79.8%
Two week wait performance Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
MFT Two week wait performance (93% target)	53.0%	61.6%	57.2%	55.1%	54.1%	43.9%	40.5%	54.2%	63.5%	67.8%	79.5%
MFT Two week wait Activity	3,624	4,446	4,182	4,705	5,043	3,924	4,557	5,487	4,081	4,468	4,451
MFT Faster Diagnosis (75% target)	46.9%	56.0%	42.9%	55.1%	61.0%	54.2%	61.7%	65.2%	67.5%	64.9%	75.7%
MFT 31 day Performance (96% target)	88.5%	84.1%	84.9%	86.2%	85.2%	77.8%	78.2%	87.7%	80.4%	65.4%	85.1%
MFT 62 days performance (85% target)	48.6%	30.9%	40.6%	44.0%	44.4%	32.6%	29.7%	37.6%	44.2%	33.9%	47.4%

Key Actions

- **Independent Sector Capacity** - Continued use and focus for endoscopy demand.
- **Additional Capacity** – weekdays and weekend including 164 extra clinic slots being provided in head and neck for the remainder of April, additional nurse led clinics in the GI specialties and weekend clinics in gynaecology planned.
- **Lower GI** - standard use of FIT guidance across group agreed and work on going to have a single point of access for referrals along with standardised clinical protocol for triage.
- **Gynaecology** - working towards fulfilling the Best Practice Timed Pathway (BPTP) in the longer term and addressing capacity deficit and backlog reduction in the short term
- **Rapid Diagnostic Programme** - navigators in place to ensure rapid pathways remain and use of Community Diagnostic Capacity further as one stop clinics. Likely pathways for further improvement include neck lump and sarcoma.
- **Head and neck** - weekly trans nasal esophagoscopy clinic has been established following a trial earlier in the year, which will speed up the diagnostic pathway for a cohort of patients and reduce demand on theatre slots. One stop diagnostic is being developed.
- **MFT wide Cancer strategy -** has been drafted and framework to delivery is currently in progress
- MFT are engaged with the **GM Teledermatology** and **Single Queue Diagnostic programmes.**

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.

Agenda Item 8.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Deputy Director of Group Financial Reporting & Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	May 2023
Subject:	Financial Performance for Month 12 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 are recommended to note the Month 12 position and the achievement of the Control Total, pre the final audit position, against the 22/23 plan and final Cash and Capital position 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 was 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 was further reflected in the way funding flows were to work in 22/23 as was the move away from the COVID funding regime that was still in place in H2 2021/22. Income related to COVID formed a very small part of the total income allocation in 22/23, and there was a greater focus on funding elective recovery (through the ERF). Overall, there was 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. Over the course of 2022/23 there have been factors outside of the Trust's control that have impacted on elective recovery, such as industrial action by various staff groups, continued high sickness levels, in part due to the prevalence of Covid, especially in the early part of the year, and difficulties in recruiting that persist across the wider NHS for certain clinical staff groups. At the financial year end, to 31st March 2023, the Trust has delivered a surplus of £0.1m against the plan to breakeven. This reflects an in-month surplus of £6.7m. The achievement of the control for 2022/23 has relied heavily on the contribution of non-recurrent support (additional non-recurrent income, non-recurrent savings within the WRP and review of balance sheet.
1.2	**Run Rate**	In March 2023 total expenditure was £324.9m, an in-month increase of £97.8m, although this includes two large year-end adjustments for pension liabilities of £58.5m (a normal year-end adjustment) and for the assumed non-consolidated additional AfC pay award of £51.8m, relating to the now rejected settlement of the nurse's strike action. These adjustments are reflected by an equal amount of income. Excluding these adjustments there has been a reduction in expenditure reported in month 12 of £12.5m, compared to the monthly run rate, however, much of this has been through the use of non-recurrent actions in order to achieve the planned breakeven figure for the year. The impact on run rates is such that there will be an expected increase in the first months of 2023/24 when the Trust has limited ability to mitigate expenditure through these non-recurrent means.
1.3	**Cash & Liquidity**	As at 31st March 2023, the Trust had a cash balance of £241m. The cash balance has remained reasonably constant compared to the balance of £245m at 28th February 2023. The cash balance at the end of March was broadly in line with the £248m forecast – the key reason for the reduction being higher than forecast trade creditor payments.
1.4	**Capital Expenditure**	The Trust has operated within the agreed GM final capital allocations (the "GM envelope"). GM approved an increase to MFT's 2022/23 envelope following the approval of PDC bids for Frontline Digitisation across GM resulting in a £8.5m increase to the original plan of £68.6m. For the year ended 31st March 2023, total envelope expenditure was £77.1m and therefore in line with increased envelope approved by GM. The Trust's total capital plan value for 2022/23 was £136.4m. For the year ended 31st March 2023, total expenditure was £150.97m against this plan, an overspend of £14.6m. £8.5m of the overspend relates to the approved increase to the GM

		envelope and the remainder predominantly relates to PDC funding awarded during the year additional to that included in the plan. As previously reported to the Board, the IFRS 16 guidance issued by NHS England in October 2022 confirmed that the 2022/23 capital expenditure incurred due to the adoption of IFRS 16 would be managed against a national “ringfenced” IFRS 16 CDEL allocation for the Trust, this totalled a plan value of £139.8m for 2022/23. For the year ended 31st March 2023, Right of Use (ROU) Assets charged against IFRS 16 CDEL total £25.1m, reflecting the impact of the delayed NHS guidance until over halfway through 2022/23, updated assumptions on the managed equipment service (MES) contracts and significant delays in the supply chain and lease commencement process.

Financial Performance

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

I&E Category	NHSI Plan M12	Year to date Actual - M12	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	896,711	937,290	40,579
Clinical commissioning groups	1,235,895	1,282,319	46,424
NHS Trust and Foundation Trusts	3,825	6,763	2,938
Local authorities	35,637	35,465	(172)
Non-NHS: private patients, overseas patients & RTA	9,496	10,100	604
Non NHS: other	8,907	4,561	(4,346)
Sub -total Income from Patient Care Activities	**2,190,471**	**2,276,498**	**86,027**
Research & Development	65,309	69,755	4,446
Education & Training	81,799	93,264	11,465
Misc. Other Operating Income	83,362	208,083	124,721
Other Income	**230,470**	**371,103**	**140,633**
TOTAL INCOME	**2,420,941**	**2,647,601**	**226,660**
EXPENDITURE			
Pay	(1,425,860)	(1,636,343)	(210,483)
Non pay	(858,215)	(912,454)	(54,239)
TOTAL EXPENDITURE	**(2,284,075)**	**(2,548,797)**	**(264,722)**
EBITDA Margin	**136,866**	**98,804**	**(38,062)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(86,379)	(53,624)	32,755
Interest Receivable	600	4,673	4,073
Interest Payable	(48,756)	(46,612)	2,144
Gain / (Loss) on Investment	0	0	0
Dividend	(2,331)	(3,879)	(1,548)
Surplus/(Deficit) before gain / (loss) on investments	**0**	**(638)**	**(638)**
Gain / (Loss) on Investment	0	783	783
Surplus/(Deficit)	**0**	**145**	**145**

Surplus/(Deficit) as % of turnover	**0.0%**	**0.0%**	
Impairment	**(107,033)**	**(69,281)**	**37,752**
Gain / (Loss) on Absorption	**0**	**(5,461)**	**(5,461)**
Non operating Income	**5,289**	**3,023**	**(2,266)**
Depreciation - donated / granted assets	**(1,371)**	**(1,285)**	**86**
Surplus/(Deficit) after non-operating adjustments	**(103,115)**	**(72,859)**	**30,256**

For the financial year end, to 31st March 2023, the Trust has delivered a surplus of £0.1m against a planned breakeven position.

The favourable year end income variance of £226.7m has increased considerably from the previous month's position of a favourable £128.8m but is mainly down to some large nationally driven year-end adjustments:

- Transfer of pension liabilities from income to pay as part of the normal year end process for £58.5m
- Inclusion of the potential cost of the strike settlement related non-consolidated AfC pay award offer, as required by NHSE, of £51.8m
- PPE notional income for stock from DHSC of £4.1m
- Contract variations of £2.9m
- £1.3m additional income received against capital charges
- £0.8m income for national CEA awards

All the above are netted off by an equal value of expenditure.

In addition to these movements is a reduction of £12.9m due mainly to holding deferred income and accruals, plus a repayment of £8.6m for GM that was paid to us in error in month 11.

The year-end variance against pay expenditure was £264.9m; an adverse movement between month 11 and 12 of £107.2m. The variance to the original plan reflects the profile of the revised plan, although £35m can be attributed to the original 2% AfC pay award uplift which is backed by income and increases related to other income streams as noted above. The movement between months is primarily due to inclusion of the pension liability year end adjustment and the assumed strike related non-consolidated AfC pay award, with the remaining favourable movement due to inclusion of additional balance sheet flexibility.

The year-end outturn against agency expenditure was adverse to the original plan of £29.3m by £9.7m – 33% over target. The month 12 reported expenditure was £0.5m lower than in month 11, at £3.2m, which is exactly as per the YTD run rate. Reasons for the adverse performance against target were the persistence of Covid related absences, especially during the first half of the financial year, continued difficulty in recruiting substantively to certain clinical staff groups and industrial action taken through several unions.

Non-pay expenditure reduced by £9.4m from the high in month 11 of £99.2m, which was due to adverse movements in accrual costs of £14.3m, driven by an overpayment from GM that required repayment in month 12. Excluding the one-off corrections, there was an adverse movement across the sites of £6.0m between month 11 and month 12 with drug costs increasing by £32.9m, establishment costs increasing by £1.7m and purchase of healthcare from non-NHS bodies increasing by £1.6m with the drive to reduce waiting lists and recover some of the shortfall on elective activity. Offsetting these was a favourable movement in the Depreciation charge at the year-end of £3.9m relating to transferring IT assets from the North Manchester disaggregation work and a favourable movement in the balance sheet.

The final PDC charge for 22/23 is higher than the planned £2.0m by £1.9m caused by an increase in valuation of the Trust estate, which is linked to the general inflation rates that have been higher than anticipated over the past several months.

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 final position gainst the planned savings. On a consolidated basis all areas together have achieved the target delivery of £117.2m; although the shortfall in delivery through cost reduction has been met by non-recurrent balance sheet flexibility in order to achieve this.

MFT Summary

Workstream	Savings to Date Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Forecast 22/23 Position Plan (22/23) £'000	Act/F'cast (22/23) £'000	Variance (22/23) £'000	Financial BRAG
Admin and clerical	1,185	1,187	1	100%	1,185	1,187	1	100%
Budget Review	4,407	4,386	(21)	100%	4,407	4,386	(21)	100%
Contracting & income	4,490	4,525	35	101%	4,490	4,525	35	101%
Hospital Initiative	11,583	11,657	73	101%	11,583	11,657	73	101%
Length of stay	1,200	1,203	3	100%	1,200	1,203	3	100%
Non Pay Efficiencies	3,061	3,032	(30)	99%	3,061	3,032	(30)	99%
Outpatients	75	75	0	100%	75	75	0	100%
Pharmacy and medicines management	3,232	3,205	(27)	99%	3,232	3,205	(27)	99%
Procurement	3,971	3,361	(610)	85%	3,971	3,361	(610)	85%
Theatres	212	212	0	100%	212	212	0	100%
Workforce - medical	1,692	1,537	(155)	91%	1,692	1,537	(155)	91%
Workforce - nursing	9,613	10,085	472	105%	9,613	10,085	472	105%
Workforce - other	4,769	4,769	(0)	100%	4,769	4,769	(0)	100%
Informatics	1,017	1,017	0	100%	1,017	1,017	0	100%
						-		
Total (L3 or above)	**50,509**	**50,251**	**(258)**	**99%**	**50,509**	**50,251**	**(258)**	**99%**
Trust Initiative	51,784	66,995	15,211	129%	51,784	66,995	15,211	129%
MFT Total	**102,292**	**117,246**	**14,953**	**115%**	**102,292**	**117,246**	**14,953**	**115%**

Summary against Target M1-12	YTD
Target	117,246
Actuals (L3 or above)	117,246
Variance to Target	- 0
Lost opportunity (value of schemes below L3)	7,445
Variance to target if all schemes delivered as plan	7,444

Summary against Target 22/23	Act/F'cast (22/23)
Target	117,246
Actuals/Forecast (L3 or above)	117,246
Variance to Target	- 0
Value of schemes below L3 (M13-12)	7,445
Variance to target	7,444

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.

Hospital/MCS	22/23 Target	22/23 Actual/Forecast	22/23 Variance	% Variance
Corporate	5.5	4.9	(0.6)	-11%
CSS	13.3	8.4	(5.0)	-37%
Eye	1.2	0.8	(0.4)	-34%
Dental	0.9	0.2	(0.6)	-72%
LCO	7.9	8.6	0.7	9%
MRI	6.8	10.2	3.3	49%
NMGH	4.4	2.9	(1.5)	-34%
RMCH	8.5	5.8	(2.7)	-31%
St. Mary's	3.9	3.8	(0.0)	-0%
WTWA	13.1	4.6	(8.5)	-65%
Hospital/MCS/LCO Subtotal	**65.5**	**50.3**	**(15.2)**	**(23%)**
Trust	51.8	67.0	15	29%
MFT Total	**117.2**	**117.2**	**0.0**	**0%**

Statement of Financial Position

	31-Mar-22 £000	31-Mar-23 £000	Movement in Year £000
Non-Current Assets			
Intangible Assets	16,107	11,369	(4,738)
Property, Plant and Equipment	798,636	1,060,166	261,530
Investments	870	858	(12)
Trade and Other Receivables	15,657	17,318	1,661
Total Non-Current Assets	**831,270**	**1,089,711**	**258,441**
Current Assets			
Inventories	21,809	25,374	3,565
NHS Trade and Other Receivables	26,500	100,604	74,104
Non-NHS Trade and Other Receivables	61,879	56,004	(5,875)
Non-Current Assets Held for Sale	2,510	210	(2,300)
Cash and Cash Equivalents	319,112	240,943	(78,169)
Total Current Assets	**431,810**	**423,135**	**(8,675)**
Current Liabilities			
Trade and Other Payables: Capital	(43,000)	(36,307)	6,693
Trade and Other Payables: Non-capital	(339,849)	(436,529)	(96,680)
Borrowings	(24,001)	(36,700)	(12,699)
Provisions	(52,636)	(29,379)	23,257
Other liabilities: Deferred Income	(59,360)	(51,880)	7,480
Total Current Liabilities	**(518,846)**	**(590,795)**	**(71,949)**
Net Current Assets	**(87,036)**	**(167,661)**	**(80,625)**
Total Assets Less Current Liabilities	**744,234**	**922,051**	**177,817**
Non-Current Liabilities			
Trade and Other Payables	1	-	(1)
Borrowings	(371,694)	(495,308)	(123,614)
Provisions	(13,903)	(11,423)	2,480
Other Liabilities: Deferred Income	(2,386)	(2,805)	(419)
Total Non-Current Liabilities	**(387,982)**	**(509,535)**	**(121,553)**
Total Assets Employed	**356,251**	**412,515**	**56,264**
Taxpayers' Equity			
Public Dividend Capital	408,780	471,920	63,140
Revaluation Reserve	97,411	163,396	65,985
Income and Expenditure Reserve	(149,940)	(222,801)	(72,861)
Total Taxpayers' Equity	**356,251**	**412,515**	**56,264**
Total Funds Employed	**356,251**	**412,515**	**56,264**

Property, Plant and Equipment includes a £110m increase in buildings following the results of the revaluation review and is driven by the annual increase in building indexation and a national review of estates build costs that are carried out by the Valuation Office on a periodic basis. The capital programme expenditure is also reflected in the increase in Property, Plant and Equipment.

NHS trade and other receivables increased significantly at 28th February 2023 and again at 31st March 2023. The March movement relates to the recognition of accrued income relating to the proposed pay offer of £51.8m in March 2023. There has also been a significant increase in central accrued income of £10.3m in 2022/23 of which £8.1m relates to central accrued income from NHSE in March 2023.

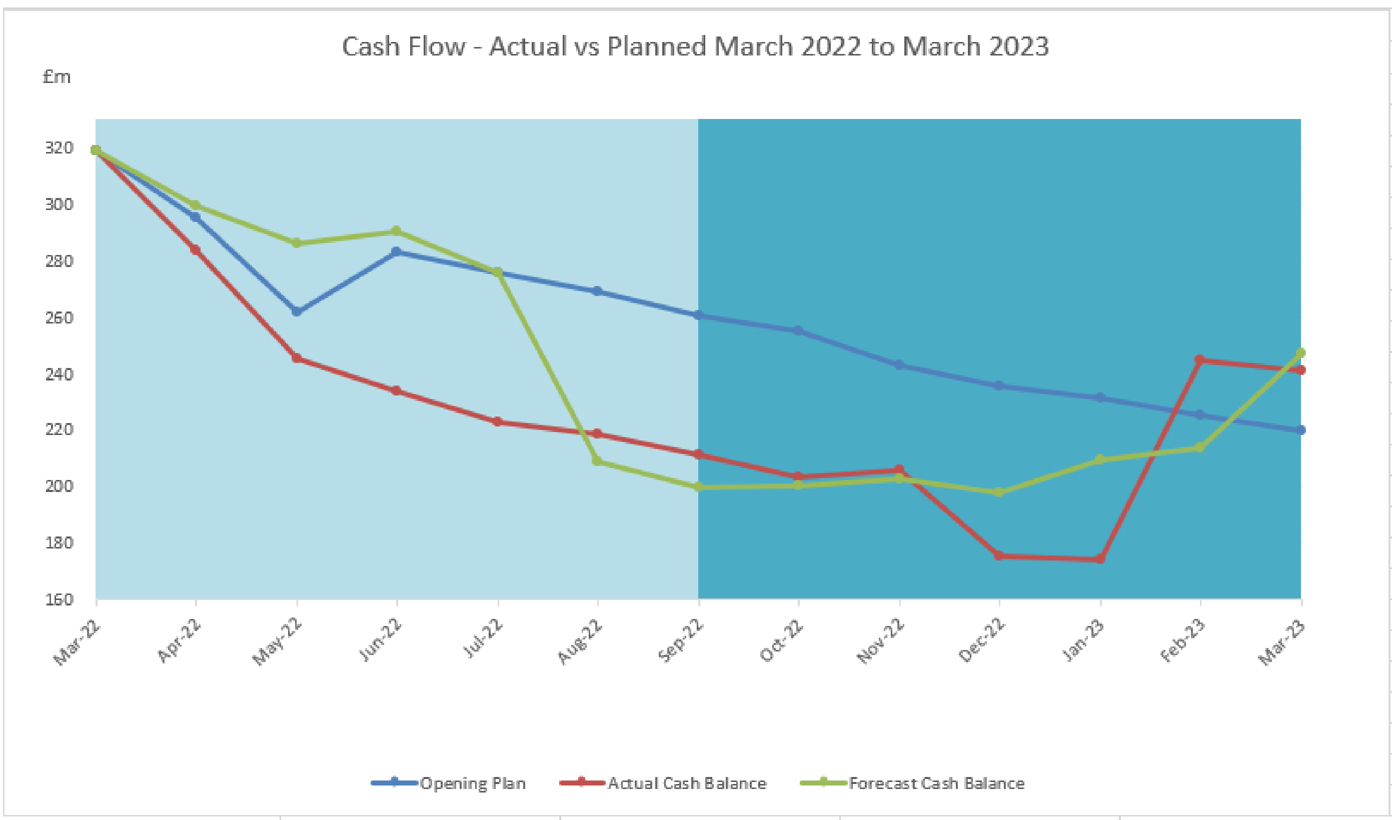
Non-NHS trade and other receivables have decreased since 31st March 2022 largely as a result of a reduction in central accrued income of £5.2m. Non-NHS trade and other receivables has also decreased compared with the £76.2m balance at 28th February 2023, the majority of this movement relates to a decrease of central accrued income of £17.6m, this includes £11.7m relating to NHSE, £3.7m relating to out of envelope funding and £5.9m relating to ICB income.

During the year there has also been an increase in non-capital trade and other payables, primarily driven by the recognition of accrued expenditure of £51.8m relating to the proposed pay offer. There has also been an increase of £23m relating to amounts owed to suppliers as a result of the recent change to payment policy initiated by NHSE, in reverting back to pre-covid policy of supplier payments being made to agreed payment terms as opposed to immediate payment terms.

Deferred income has decreased from £62m at 31st March 2022 to £55m as at 31st March 2023, predominantly due to the movement in HEE income received in advance.

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

Cash Flow

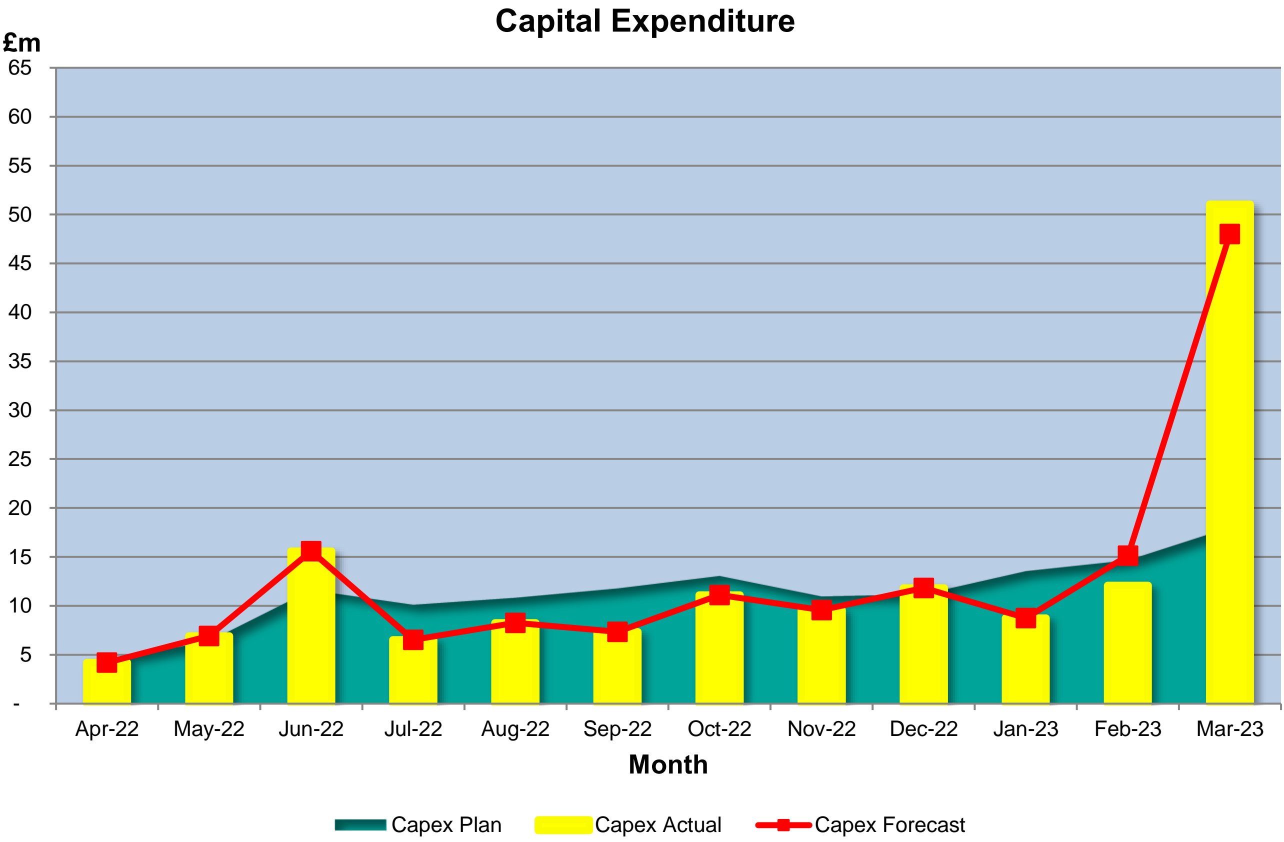


As at 31st March 2023, the Trust had a cash balance of £241m. This has remained reasonably consistent compared to the balance of £245m as at 28th February 2023. This slight reduction is primarily due to loan repayments of £1.8m and the payment of PDC dividends of £0.8m made in March 2023.

The cash balance at the end of March 2023 was lower than forecast by £7m, this was primarily due to payments to suppliers being £17m higher than forecast, and cash outflow relating to capital spend being £8m lower than forecast.

The capital expenditure in March 2023 resulted in a closing capital creditors balance at 31st March 2023 of £36.3m. Capital expenditure for the year 2022/23 is in line with forecast and the majority of the cash impact of the closing capital creditor will unwind during the first quarter of 2023/24.

Capital Expenditure



The Trust's total capital plan value for 2022/23 is £136.4m. For the year ended 31st March 2023, total expenditure was £151.0m against this plan, an overspend of £14.6m. The overspend is primarily driven by:

- Additional PDC funding in relation to £5.5m Digital Pathology; £3.3m Relocatable MR & CT scanner; £1.6m Imaging MRI scanner; and £1.2m CT scanner for targeted lung health checks.
- £5.6m high risk equipment allocated following additional GM envelope allocation.
- £3.0m on the Hive Programme due to additional service provider costs that were not identified when setting the budget. Key drivers for the variance have been complexities in the technical activities.
- A further £1.5m on the Hive Programme due to the plan assuming PDC cover to fund an element of the Hive Programme (£15m PDC cover in total for 2022/23). This overspend was covered by GM's approval of an increase to MFT's 2022/23 envelope to cover the £15m risk.
- £2.9m on Estates health and safety backlog expenditure which includes the additional work required on the North Manchester theatres.

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

- £2.1m Trafford Theatres due to a required change in plan that will be incorporated in the 2023/24 work planned on the TIF, though with no additional cost impact.
- £2.3m credit from the sale of Stretford Memorial Hospital.
- £2.4m reduction in the CDC (PDC funded) due to a change in the yearly profile that is in line with the GM capital allocation for CDC.
- £2.0m underspend on charity funded equipment that is now forecasted not to be donated before year-end.

GM approved an increase to MFT's allocation of the 2022/23 GM envelope from £68.6m to £77.1m following the approval of PDC bids for Frontline Digitisation across GM. As well as providing CDEL cover for £2.9m of the £15m Hive expenditure (that was assumed to be covered by PDC funding in the plan), MFT have also received CDEL cover for a further £5.6m. The sale of Stretford Memorial Hospital has resulted in £2.3m additional GM envelope CDEL cover for 2022/23. Utilising the remaining contingency value of £0.8m alongside the £2.3m credit from the sale of the Stretford Memorial Hospital and the £5.6m of extra GM CDEL, this gave a total of a further £8.7m available to spend on capital.

The Strategic Capital Group approved the £8.7m to be utilised as follows:

- £4m on medical equipment (i.e., all the high-risk equipment and an element of medium risk);
- Cover for the £3.0m overspend on Hive.
- £0.9m on Estates NM Backlog.
- £0.8m on accelerated 2023/24 IM&T devices.

For the year ended 31st March 2023, total GM envelope expenditure was £77.1m and therefore in line with increased envelope approved by GM.

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

Following a review of the new leases expected to be started before year end, a revised forecast has resulted in a significant reduction from the planned position of £139.8m to a full year forecast outturn of £28.3m in month 11. For the year end to 31st March 23, ROU assets charged against the IFRS 16 CDEL allocation total £25.1m. The key reasons for the reduction against the original plan are as follows:

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

Agenda Item 8.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive/Hive SRO
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	May 2023
Subject:	Update on the HIVE programme
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The 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 Deputy Chief Executive / Hive / SRO 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 Deputy Chief Executive has been providing **dedicated Executive level oversight** and leadership for the Hive Programme and will continue to do so, ensuring optimisation and benefits realisation are achieved.

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

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

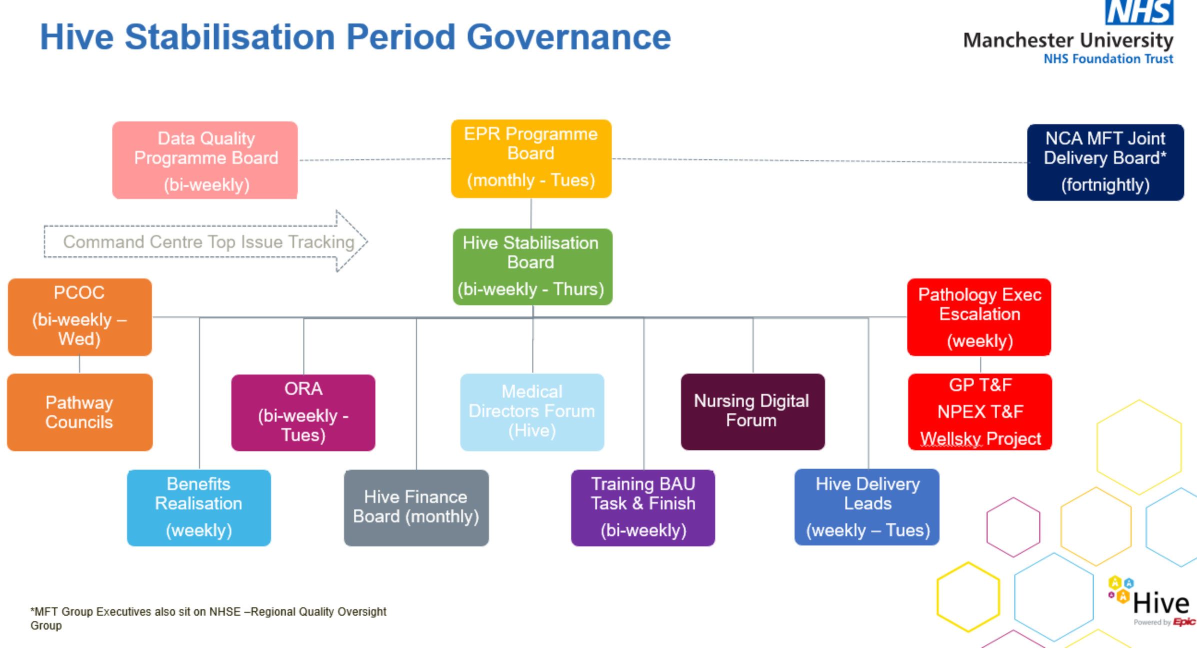
1.7 Following the cessation of the command centre structures, the programme moved into the **Stabilisation Phase** with supporting governance structures stood up to ensure the organisation continues to support staff with the transition and so that early benefits can be realised.

1.8 We are now at a critical juncture as Hive will now become the key enabler for MFTs ambitious digitally enabled **Transformation Programme**. MFT now has all the components in place to deliver this single Trust wide ***Clinically led, Operationally delivered and digitally enabled*** **strategy.**

1.9 This paper provides an update on key progress in the Stabilisation phase since the last Board and outlines the priorities for 2023/24 including the changes in governance as Hive pivots from a programme of work to the key enabler for our Transformation Strategy

2. Hive Stabilisation Phase Update

2.1 Considerable progress has been made so far during the Stabilisation Phase. The Stabilisation Governance as outlined below continues to be overseen by the Hive Senior Responsible Officer (Julia Bridgewater) and is further maturing with the pending formation of the Hive Delivery Authorities.



2.2 The Hive Delivery Authorities will be responsible for delivering the agreed workplan (Hive build, training and transformation) which have been prioritised via the Pathway Councils, the **Pathway Council Oversight Committee** (PCOC) and other organisational committees to ensure that **priorities are delivered to ensure MFT meets its 2023/24 plan.** The detailed governance arrangements for the Hive Delivery Authorities are currently being worked up to ensure they fit within, support and align to the overall MFT operating model.

2.3 Throughout life of the Hive Programme, Deloitte have been providing external assurance to the Board via formal gateway reviews. The fifth and final Gateway review report will be submitted to the EPR Scrutiny Committee on 26th April 23. The scope of the final Gateway review was to: consider initial progress since Go Live, governance for optimisation delivery and progress on benefits retaliation (see section 9).

2.4 It is important to note Deloitte, highlight the design and implementation of a **single, digital transformation strategy** as their key recommendation i.e. ensuring that there is a single governance process in place to manage MFTs new digitally enabled operating model. The launch of the Delivery Authorities aligns to this recommendation and will help provide a **single route for prioritisation and delivery of the MFT 23/24 Plan** and a firm platform for future delivery.

2.5 We are now at a critical juncture in the overall journey as Hive has moved from a programme of work to the **central platform** for the delivery of MFTs safety, workforce, research, productivity and efficiency **transformation**. The recent urgent care pressures have clearly demonstrated the power of the tools and data now available to support patient flow and it is essential that the opportunities that now exist for transforming our theatre and outpatient programmes are seized. The overall operating framework for 2023/24 is the most challenging for the last decade however, with **Hive as the vehicle for change and transformation**, MFT looks uniquely placed to navigate this challenge and those that follow in the years to come.

2.6 A key escalation theme since December 23 has related to the **Administration Workstream**, where a number of escalations in relation to Hive build and training of staff have been addressed. To ensure effective management and oversight, a muti-disciplinary team (MDT) was established with representation including Hive Applications, Business Intelligence, Group Performance and Data Quality.

2.7 The consolidated issues being overseen by this MDT are tracking for completion by the end of April 23 following which a **continuous development plan** will be delivered which has been informed by a root and branch review of the workflows. This will ensure that some of the temporary solutions to escalations which have been implemented can be resolved by new and refined Hive build and supported by staff training.

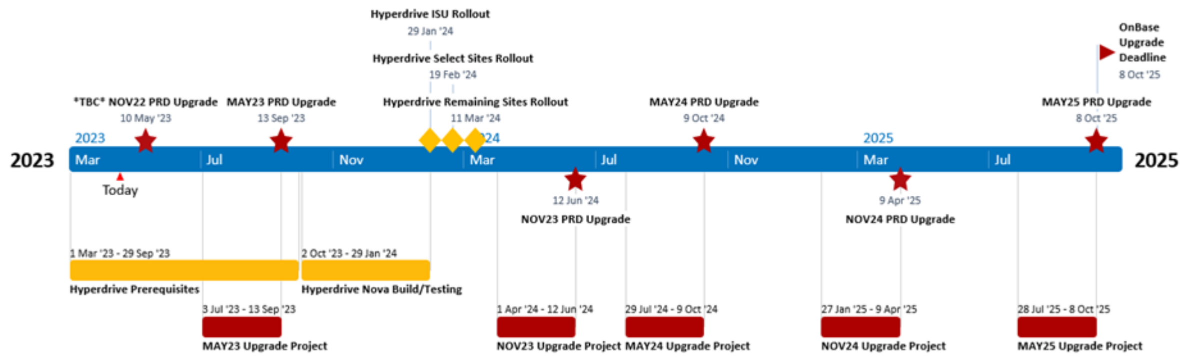
2.8 MFT went live using the May 2022 version of Epic's software. Epic release quarterly upgrades of their software and MFT has committed to taking a minimum of two upgrades each year. This is important to ensure that we have the latest and most enhanced functionality for our staff.

2.9 MFT will **upgrade to the November 22** version of Epic in May 23. Significant planning and testing of the upgrade version has already taken place to ensure it is compliant to MFT bespoke workflows and to assess the timing and duration of downtime that will be required for the transition. The date and time of the upgrade will be agreed shortly when all testing has been completed.

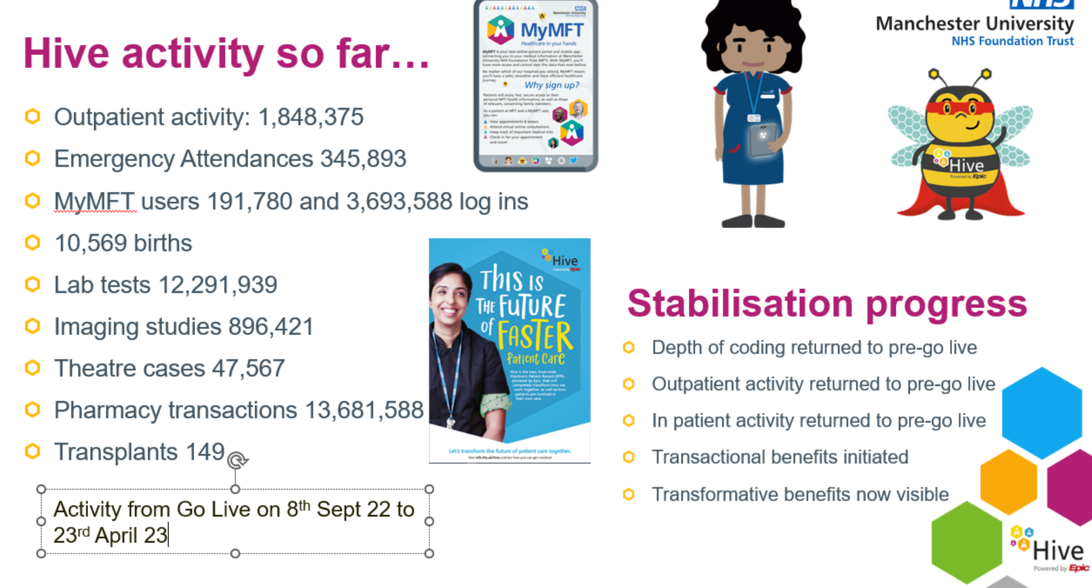
2.10 Planning has also been initiated for the delivery of **Epic Hyperdrive**. Hyperdrive is Epic's new lightweight and web-enabled client application replacing the Classic Hyperspace. MFT must complete the move to Hyperdrive in line with the Epic EPR upgrade programme as future releases of Epic upgrades will become non-conformant with the legacy Hyperspace. High level benefits of Hyperdrive for end-users and the organisation include:

- A more readily available functionality enhancements & future upgrade process
- A potential to provide future reduction in required licences
- A more streamlined access to the Hive EPR
- Improved opportunities for device integration

2.11 Project Board governance is established for Hyperdrive which will report into the Stabilisation Board with progress updates. In line with the Hive team stabilisation priorities, below is the current timelines for delivering the Hyperdrive project in the 23/24 financial year, aiming completion by March 24.



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



3. Training – Stabilisation progress Update

3.1 Training teams across Hive and other systems continue working with all stakeholder groups to develop **Future State Training**. The team have been trained in the production of eLearning and lesson plans across the professions have been signed off with stakeholders. The team are now working on bringing the training materials into an eLearning format so that they are of a higher standard and easier to access.

3.2 Over the next three months the remaining materials will be signed off and launched within the Learning Management system across each profession. The Training Team will work closely with the Workforce systems team to deliver this.

3.3 The Hive training team also supported a personalisation campaign aimed at improving **Outpatient productivity** and spent time on site sitting with key clinicians in clinic and supporting them in better utilising ‘short cuts’ and in system tools to help them speed up their documentation during clinics. The learning from these sessions was then put into a training video that has been cascaded out by Transformation for the whole Trust.

3.4 The training team made a valuable contribution to the **Junior Doctor Industrial Action** response by using learning from the first six months of Go Live to support consultants cover rotas and key tasks. Seven bespoke training sessions were delivered which focused on the high risk and complex workflows on Hive. The sessions were very well received and feedback was positive. In addition, the Hive training team spent time in the Hospital command centres during the days of industrial action so that real time support was in place as required and also supported the 24/7 support rotas.

3.5 The training materials used for the Junior Doctor Industrial Action will also be useful resources for induction and Hive refresher training moving forward and have been made available to all staff on the Trust’s Learning Management System.

3.6 A **Thrive training programme workshop** will take place in May to finalise the principles of the MFT thrive training strategy. The overall aim of the Thrive Training Strategy will be to provide an ongoing 'skills ladder' for staff so they can continue to develop and improve their mastery of the system. This will help improve workforce experience whilst improving efficiency. Learning from best practice, such as the **Matron Masterclass** developed across the Group Nursing team and the Digital Nursing Midwifery and Allied Health Professional Team (NMAHP), will be used as a platform to build upon.

4. Governance and Risk Management

4.1 Robust external assurance arrangements have remained in place with Deloitte providing regular gateway reviews. The final Gateway review (Gateway 5) which has reviewed initial progress since Go Live, governance for optimisation and benefits realisation was undertaken in March 23. The report will be presented to the EPR Scrutiny Committee on 26th April.

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 Gaurav Batra, Non-Executive Director will continue to oversee the programme. The Deloitte External Assurance Reports have been reported to this committee.

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

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

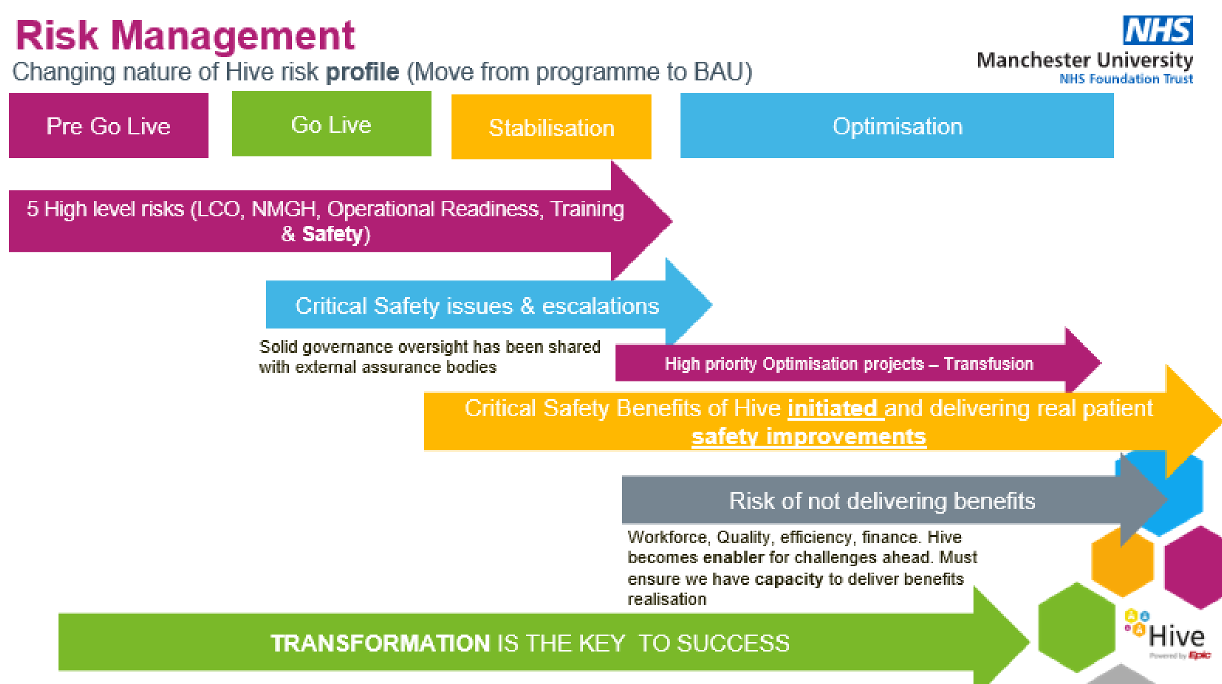
- Potential impacts on safety if the programme is not delivered effectively
- The risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live.
- Management of complex pathways at North Manchester General Hospital
- The inclusion of the Local Care Organisation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

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

Four of the five risks were formally downgraded at the November 2022 GROC, with the remaining high-level risk (Potential impacts on Patient Safety) downgraded at the March 2023 GROC.

4.5 The high priority optimisation project outlined in the schematic below relates to **Blood Transfusion.** Implementation of the third-party system was moved to optimisation before Go Live as it was not safe to proceed and the legacy laboratory system was retained. The workarounds that are required as a result are proving difficult for both laboratory and clinical staff. Given the substantive solution will take approximately 12 months to deliver, a review of the current workarounds has taken place with a number of recommended actions required for implementation. Given this risk affects all stakeholders and needs to be managed and overseen across teams, the risk has been escalated to a level 15 (high level) on the Trust Risk Register and has been reported into GROC ensuring Board level oversight.

4.5 As progress in the Stabilisation phase continues, the risk profile is changing as demonstrated by the schematic below. The risk of not delivering the benefits on workforce, quality, efficiency and finance is now being closely managed as outlined in section 9.



4.6 As shown in the above schematic we are now starting to see the safety benefits of Hive and these include:

- Improvements in medicines administration related to positive patient recognition at the bedside and bar code check of medicines prior to administration
- Staff are now using Best Practice Advisories (pop ups on the system to advise staff of key clinical impacts for consideration) in their clinical decision making.
- Late time critical medication administration has reduced from 25% to 9% since Go-Live
- Aliging individual patients to their next intervention has led to significant improvements for patients who have a suspected Cancer diagnosis

- Accessibility of drug charts through Hive has reduced time from prescription to administration due to ability to virtually prescribe.
- Reduced reporting turnaround time for endoscopy and bronchoscopy tests.
- Clinic letter turnaround time is currently < 7 days.
- Using Hive to support No Reason to Reside (NRTR) live tracking – allows complex discharges to be expedited on the day
- Patient Lists automatically populating from the record reduces the need for manual data input during board round – supporting the SAFER model
- Improvement in results acknowledgement performance of ~10% (now 79%)
- Real time patient updates available in ED - single screen track board, shows warning and trends to support patient safety
- Hive enables the identification of all patients who are on a research trial
- Hive has provided the platform to deliver clinical and operational realtime data in dashboards eg the maternity dashboard; triage dashboards; ward whiteboards; deteriorating patient dashboard. This functionality offers real time patient safety value as well as operational relevant data to assist flow

5 Communications and Engagement

5.1 The Communication and engagement workstream has continued to have a high priority, ensuring staff and stakeholders receive regular transparent updates and support as stabilisation work and critical safety changes take place.

5.2 Throughout February, March and April, the communications team continued to run a *'How Hive Helps'* internal campaign to support staff in making their Hive experience more efficient. This campaign is a key component of the ongoing Outpatient Improvement Programme led by the transformation team. The campaign has grown to support improvements in other settings too, including Inpatients.

5.3 March 2023 marked six months since the Hive Go Live milestone which presented an opportunity to highlight some early benefits alongside reflections on lessons learned and the Hive journey so far. This content was shared internally through benefit infographics and animations and externally by the Hive Programme Team at this year's *Digital Health Rewired Conference.*

5.4 The Hive leadership team shared our EPR journey at *Rewired* with the digital health community and highlighted our progress since go live and the lessons learned along the way. The session received praise for the transparent reflections shared and through this engagement the programme has receive varied insight requests from other Trusts and organisations.

5.5 As dedicated Task and Finish Groups work to improve Hive processes the team are supporting to communicate the progress focusing on key areas of improvement including Discharge and After Visit Summaries, Discharge Medication, and Consults (internal handovers). Outputs generated include "You Said, We Did" issues resolution documents, new flowsheets and simple screen shot guides of changes made.

5.6 March saw the first meeting of the *MFT North Manchester Locality Forum* which aims to support an effective and efficient interface between MFT (specifically NMGH), and the localities the Trust serves and delivers patient pathways across (including Salford, Bury, Heywood, Middleton and Rochdale, Oldham and Manchester).

5.7 The ambition of the group is to support the delivery of the best possible care to the NMGH catchment population, by fostering cooperation between MFT and the localities. Communications representative from both Group/Hive Communications and NMGH Communications are included to ensure a joined up and effective approach to communications for this cohort is developed.

6 Technical Update

6.1 The Hive Technical team have continued to support the system and the project team have completed the transfer of responsibilities into the Informatics business as usual structure within the IT Operations and IT Infrastructure teams. To ensure comprehensive oversight continues, a **dedicated Technical lead** will continue to aid collaboration and cross team working with the Hive Programme. The lead will also support the Director of Technology with broader escalations and service improvements across the Technical team.

6.2 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. This has enabled and will continue to support a dynamic and fast response to any escalations from clinical and operational leads.

6.3 Access & Identity – The team have worked with Medical Education team to refine the access and training process for new and rotating junior doctors and tested this with the April intake of staff. Further enhancements and improvements will take place for the upcoming May rotations.

6.4 Community Midwives – A task and finish group is continuing to support the community midwife teams and support with escalations with our partner providers across the Greater Manchester health and social care arena.

6.5 Network Issues – A full review is being undertaken on the network issues that have been experienced over the last month, this is being completed with support from external advisors to ensure the solutions implemented are fit for purpose. Communications will be provided out to the Trust on the timescales and what improvements will be seen once the plan for improvements is agreed.

6.6 The Technical team continue to provide support where workflow issues are identified ensuring that solutions are supported in real time where possible and to help inform workflow improvement programmes such as Blood Transfusion.

7 Transformation

7.1 As outlined at the start of this report, we are now at a critical juncture as Hive moves from a programme to being the key enabler in our ambitious clinically led, operationally delivered, digital enabled **transformation strategy.**

7.2 As progress on into the stabilisation continues, work has taken place to align the Transformation work programmes across Hive and Group Transformation. This workplan is focused in the **Operational and Clinical priorities** of the organisation as well as the Hive benefits. The focus for Transformation is no longer about implementing Hive but is about delivering the priorities of the organisation with Hive as a key enabler.

7.3 The priorities for the Transformation plan are identified through:

- Post Live Readiness Assessments (PLRAs) and Hive Pathway Councils
- Annual planning operational and clinical priorities and plans
- Hive Benefits Realisation Business Case

and are focused on safety, efficiency and productivity improvements

7.4 The Transformation plans are aligned to Urgent and Emergency Care, Outpatients, Theatres and Day Case elective pathways, and Diagnostics. These plans will use the learning from Hive to provide a provide robust *Board to Ward* oversight ensuring that there is clear direction, accountability and most importantly support in place to provide the right **culture and environment for sustained improvement and delivery.**

7.5 In March 2023, to support in particular the outpatient improvement workstream, and also patient experience, there has been a focus on the **MyMFT** (The Hive Patient App/Portal functionality and future strategy.

7.6 A MyMFT workshop was held on the 21st of March 23 with representation from across the whole Trust including medical, nursing and AHP leads, Hospitals/MCS CEOs, Transformation, Hive and Epic subject matter experts. The outputs of the workshop delivered the indicative priority order for enhanced feature development; including functions such as self scheduling and enhanced digital communication methods, and the establishment of a monthly operational steering group with greater operational representation from each site, which will be tasked with overseeing the MyMFT strategy development, prioritisation and delivery.

8 Benefits Realisation

8.1 The affordability of the Hive programme is dependent upon the Trust's ability to realise cash releasing benefits from the transformation of its clinical and patient administration services.

8.2 An update on cash releasing benefits was provided to the April EPR Implementation & Benefits Realisation Programme Board. Of an assumed £4.0m of benefits in Quarter 4 of

FY22/23 (some programmes having been re-baselined from original Full Business Case), c.£1.9M has been delivered. An element driving this slippage relates to timing of expected delivery, rather than whether the benefit is deliverable.

8.3 For the FY23/24 Waste Reduction Programme, Hive related plans currently equate to a value of c£10.6M against an expected £19.3M, based on a combination of Full Business Case (FBC) and re-baselined values.

8.4 Two benefit realisation oversight forums continue to support the alignment of Stabilisation Governance. These are being used to further drive planning and management of Administration & Clerical (A&C), and Information Services programmes of work. Focused attention will be paid to support Outpatients, Theatres and Shadow IT elements of the Benefits Programme.

8.5 A productivity and efficiency workshop took place on 27th March with attendance from the Hospital CEOs and Hospital/MCS teams that supports the alignment of Hive benefit realisation with operational planning and transformation delivery. Outputs from this workshop are currently being developed.

8.6 There is continued focus on reporting of benefits using hive. At an organisational level the focus remains on further developing reporting that supports both operational and benefit level reporting.

8.7 Work is continuing to capture emergent benefits and the identification of appropriate key performance indicators to measure delivery of the benefit post Hive implementation in conjunction with Pathway Council Oversight Committee (PCOC). This work is being undertaken alongside the Transformation activity underpinning the change projects that support Hive benefit realisation as well as delivering operational planning priorities. Work is being undertaken in partnership with the Trust Communications team to showcase some of the initial identified benefits, which will be included as part of the Hive Insights and Early Benefits Report.

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

8.9 A key recommendation of the Deloitte report suggests additional focus is given to factoring non-cash releasing benefits into assessment of the programme return on investment. Work to develop the process of assessing and monitoring these benefits is underway, identifying and aligning transformation projects that support the operational planning and delivery of qualitative benefits for FY23/24. It is imperative that these productivity benefits are measured, delivered, and tracked through governance oversight bodies such as the pathway councils and PCOC.

9 Next Steps

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

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

9.3 As outlined at the start of this report we are now at a critical and exciting juncture in the overall Hive journey as Hive has moved from a programme of work to the **central platform of the delivery** of MFTs safety, workforce, research, productivity and efficiency transformation.

9.4 The recent urgent care pressures have clearly demonstrated the **power of the tools and data now available** to support patient flow and it is essential that the opportunities that now exist for transforming our theatre and outpatient programmes are seized.

9.5 The overall operating framework for 2023/24 looks like it will be the most challenging for the last decade however, with Hive as the vehicle for change and transformation, MFT looks uniquely placed to navigate this challenge and those that follow in the years to come

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

10 Recommendation

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

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	May 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: Tom Rafferty, 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

2.1 Review of Integrated Care Systems

The report of the review if integrated care systems undertaken by Rt Hon Patricia Hewitt, former secretary of state for health and current chair of the Norfolk and Waveney Integrated Care Board (ICB) was published on 4 April 2023. It is broken down into four sections:

- From focussing on illness to promoting health.
- Delivering on the promise of systems.
- Unlocking the potential of primary and social care and building a sustainable, skilled workforce.
- Resetting our approach to finance to embed change.

The report recognises that without investment, workforce and leadership development, recurrent and multi-year funding, reduction of duplicative or unnecessary data requests, and effective planning systems will be unable to achieve their potential.

The review makes several recommendations of significance:

- Fewer central targets (no more than ten national priorities).
- A limited number of ICS targets should carry equal weight to national targets and local outcomes.
- Enable a shift towards upstream investment in prevention.
- Multi-year funding
- Payment mechanism flexibility
- Defining accountabilities - ICBs to be the default mechanism for delivery of national support and intervention).
- Data availability
- An enhanced role for CQC in systems.
- Reconsider the Running Cost Allowance cut
- Total budget share for prevention should increase by at least 1% over the next five years

2.2 Three year delivery plan for maternity and neonatal services

Following on from a number of recent independent reports, NHS England has published a 3 year plan to make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. Building on recent independent reports Services are being asked to concentrate on the following four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

The plan also sets out respective responsibilities of trusts, ICBs and NHS England. There are a number of asks of providers and their boards which will require careful review.

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3. Regional and Local

3.1 Greater Manchester Integrated Care Partnership Strategy 2023-28

The GM ICP Strategy was approved by the GM ICP at the end of March 2023. The ICP is required to produce a 5 year strategy to improve the health and wellbeing of its population to which the ICB must pay regard when developing its plans.

The strategy has been co-developed with involvement of people and organisations from across the health and care system, including the VCSE sector, as well as patients and the public. The table below summarises the 6 missions, 4 outcomes and 10 high-level commitments outlined in the strategy.

6 Missions
▪ Strengthen our communities ▪ Help people get into – and stay in – good work ▪ Recover core NHS and care services ▪ Help people stay well and detect illness earlier ▪ Support our workforce and our carers ▪ Achieve financial sustainability
4 Outcomes
▪ Everyone has an opportunity to live a good life ▪ Everyone has improved health and wellbeing ▪ Everyone experiences high quality care and support where and when they need it ▪ Health and care services are integrated and sustainable
10 'Commitments'
▪ Ensure our children and young people have a good start in life ▪ Support good work and employment and ensure we have a sustainable workforce ▪ Play a full part in tackling poverty and long-standing Inequalities ▪ Help to secure a greener Greater Manchester with places that support healthy and active lives ▪ Help individuals, families and communities feel more confident in managing their own health ▪ Make continuous improvements in access, quality, and experience – and reduce unwarranted variation ▪ Use technology and innovation to improve care for all ▪ Ensure all our people and services recover from the effects of the COVID-19 pandemic as effectively and fairly as possible ▪ Manage public money well to achieve our objectives ▪ Build trust and collaboration between partners to work in a more integrated way

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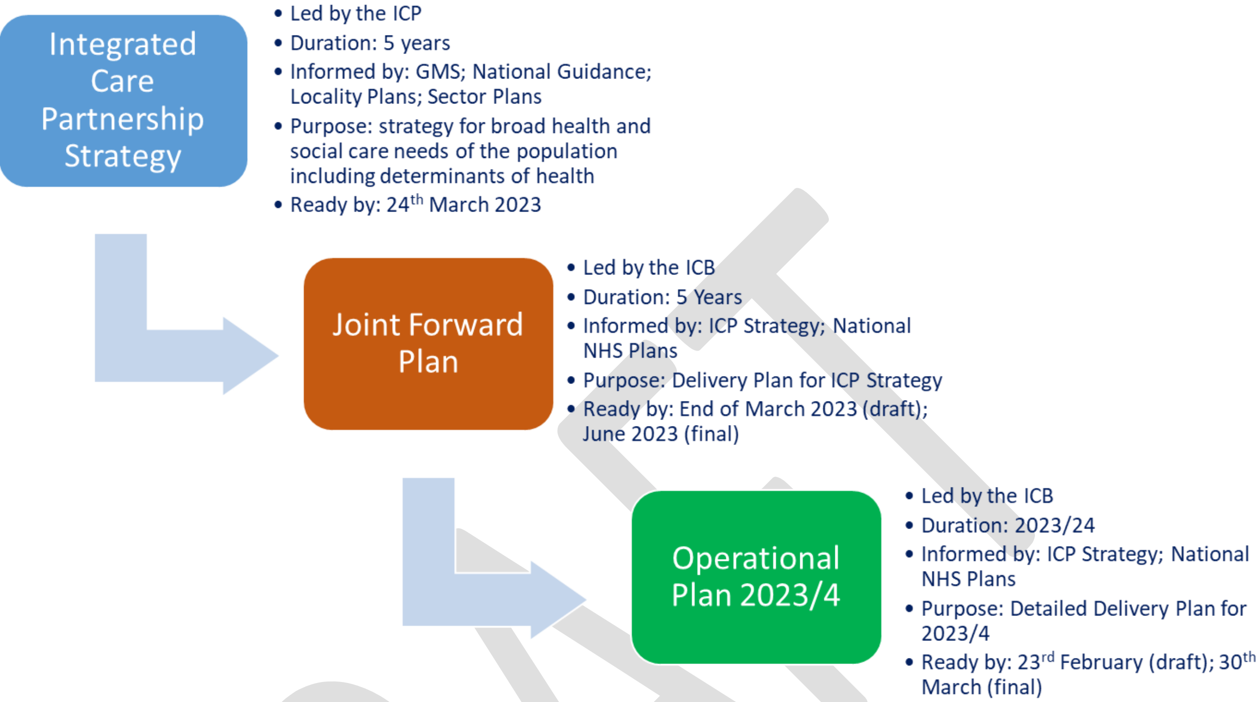
3.2 *GM ICB Joint Forward Plan*

As referenced above, each ICB is required by NHS England to produce a 5-year Joint Forward Plan (JFP) that sets out how it will exercise its functions. The figure below sets out how the ICP Strategy fits with the GM ICB Joint Forward Plan and annual operating plans.



The approach to developing the JFP is to build on existing locality plans and the strategies from the ICB system boards (e.g. Mental Health, Elective Reform, UEC). The draft JFP is to approved by the ICB meeting on 21 June ahead of submission to NHSE.

3.3 GM Operating Plan 23/24

The Greater Manchester ICB submitted its annual operating plan to NHS England at the end of March, in-line with the national timetable. Along with a number of other ICSs, NHS England have asked GM to re-submit a further iteration of the plan by the end of April with the expectation that the forecast deficit and growth in workforce numbers both reduce. As a result, there will be further iterations of the MFT annual plan before it is finalised.

3.4 GM Sustainable Services Programme

The first GM Sustainable Services Programme Board is due to meet in April. It will be one of 11 'system boards' reporting directly to the ICB. The MFT Chief Executive will chair the meeting and act as SRO for the programme. The purpose of the programme is to address services that are identified as unsustainable and avoid the negative impact that unplanned service failure can have on patients, the public and the health and care system. Currently, there is work underway on ophthalmology and dermatology as part of the programme.

3.5 GM Specialised Commissioning Priorities

Planning Guidance for 2023/24 requires ICBs to identify at least three transformation priorities for delivery in-year which role model integrated commissioning of pathways that include both specialised and non-specialised service elements. The 4 proposed GM priorities are set out below, as well as the longlist of wider priorities on which work is still expected to progress:

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Priorities for delivery in 23/24

- Renal Service Transformation Programme (RSTP)
- Enabling faster lung cancer diagnostic pathways across GM
- Neurorehabilitation – integrated case management
- Major Trauma

Wider Priorities

- Cardiology Transformation Programme
- Mental Health Care, Education and Treatment Reviews
- Paediatric Intensive Care – Long Term Ventilation (LTV)
- HIV
- Neurosciences transformation Programme
- Neurology – transforming elective care
- Vascular Transformation Programme
- Gynae Cancer – implementation of the GM model of care and GM service specification
- Urological Cancer Surgery

4. MFT Developments

4.1 Gender Identity Dysphoria Service

Following a decision by NHS England to commission regional Gender Identity Dysphoria services (GIDS), The Royal Manchester Children's Hospital is working with Alder Hey Children's Hospital and Leeds NHS Trust to develop the Phase 1 service for the North of England. Work is underway to develop patient pathways alongside work by the national NHS England team on a proposed clinical model.

4.2 Sickle Cell Disease

The adult haemoglobinopathy service has been invited by NHS England to submit a funding bid to pilot, along with services in London, a new model for the management of sickle cell crisis. The aim is to provide patients across GM and the North West with more rapid access to specialist advice and care including admission, if necessary, on a 24/7 basis, wherever they live, and bypassing their local emergency department. The MRI team is working with the LCO to incorporate improved community support and follow up into the proposal. The developing model has been warmly received by the commissioner and by patient/community representatives and has support from the ICB and GM acute trusts. The deadline for submission is 5 May.

4.3 Haemophilia

NHS England have also issued a tender for comprehensive haemophilia centres to bid to be designated to provide gene therapy for haemophilia, on a regionalised basis. The first product is expected to be commissioned later in 2023–24, with others to follow. This disease-based way of commissioning ATMPs appears to be a new approach for NHS England and may be replicated as cell and gene therapies become available to treat other conditions. The deadline for a response is 10 May.

4.4 North Manchester General Hospital

Activities to disaggregate NMGH from the legacy PAHT continue. A further 10 Service Level Agreements (SLAs) were successfully disaggregated and ceased on 31st March 2023. This means that MFT is now providing these services without need for input from the Northern Care Alliance (NCA). Plans are underway to disaggregate a further 23 SLAs on 30th September 2023.

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Several services require commissioner approval to disaggregate because they involve a change in the location of services for patients. Commissioner approval has now been received for the disaggregation of Gastroenterology, Cardiology, Rheumatology and Urology (6 low volume pathways). Commissioners agreed with the recommendation made jointly by MFT and NCA that these changes do not constitute substantial variation. Exit planning is now underway for these services. Work has commenced with the NCA to seek commissioner approval to Phase 3 complex services which includes ENT, Urology, Trauma & Orthopaedics and DEXA scanning. Proposals will be jointly presented to Scrutiny Committees and commissioners in the affected localities in the summer.

Work to develop the future Target Operating Model for Urgent & Emergency Care, Surgery and Outpatients for the redeveloped NMGH site have started as part of plans to prepare for a refresh of the Outline Business Case. The Target Operating Models will describe how these core functions will be delivered in the new hospital including considerations of appropriate estate, workforce, digital applications, FM and equipment. This will provide invaluable information to inform the next stage of redevelopment plans.

4.5 University Dental Hospital Manchester

MFT colleagues are working with the University of Manchester to develop a strategic outline case for a new dental hospital given the age and condition of the current building. A series of 4 workshops is planned to inform the SOC, the first of which is taking place on 2 May. The workshops are likely to conclude by September with a SOC being finalised towards the end of 2023.

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Agenda Item 9.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	May 2023
Subject:	MFT Annual Plan 2023/24
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to approve the 2023/24 MFT Annual Plan
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 2786 5676

1. Purpose

The purpose of this paper is to seek approval from the Board of Directors for the MFT 2023/24 Annual Plan.

2. Background and Context

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

The plan is also shaped by the priorities set by NHS England (NHS E) and the plans of our partners, in particular the Greater Manchester (GM) Integrated Care System (ICS).

Our work this year will continue to be dominated by the need to recover from the COVID-19 pandemic, tackling the backlogs and increasing our productivity, as well as addressing those longer-term goals such as playing our part in tackling health inequalities.

Key to all of this this is our people and we will maintain focus on our workforce and delivering the MFT People Plan.

Other key workstreams this year will be:

- Optimising patient care and delivering benefits to our staff and the organisation through our **Hive programme**
- Developing **single services** so that patients receive the same standards of care, whichever site they are treated on.

The MFT Annual Plan (attachment A) summarises the key actions that the Hospital, MCS, LCOs and corporate teams intend to take in 2023/24, formatted to show the contribution that each will make to delivering the Trust's strategic aims.

3. MFT Annual Planning Process 2023/24

A single process was established to:

- Develop Hospitals / MCS / LCOs annual plans, including activity plans, for 23/24 that set out what each Hospital /MCS plans to deliver and how they plan to do it, within their allocated resources.
- Develop the MFT level Annual Plan for 23/24 that brings together the Hospital / MCS / LCOs and corporate team plans under each of the Trust strategic aims
- Complete the MFT element of the GM/national Operational Plan submission including financial, activity and workforce information.

4. Financial Planning

The process to agree the MFT financial plan for 2023-24 has been complicated and resource intensive, a process fed by returns from the Hospitals, MCS, LCO and Corporate teams has delivered a “bottom up” finance plan which was triangulated locally by SLT’s with operational and workforce plans and as described above also at a Group and GM System level. MFT financial plan, subject to Board Approval, in 23/24 is to deliver a break-even financial position by March 2024.

Budgets have been agreed and allocated to all parts of the organisation and will be reported on through the monthly financial reporting cycle. Of particular focus in 23/24 will be the WRP that stands at some £136m (22/23 £117m) and the supporting operational productivity and efficiency measures to drive elective activity to an average of 103% of 19/20 levels, there is significant risk on the financial plan and regular meetings have been established to ensure appropriate support and scrutiny is in place.

5. Monitoring Delivery

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

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

6. Recommendations

The Board of Directors is asked to approve the 2023/24 MFT Annual Plan.

Attachment A – 2023/24 MFT Annual Plan

Attachment A

Manchester University NHS Foundation Trust

2023/24 Annual Plan

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1. Introduction

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

Our vision describes our aspirations for the next 5 years and is the framework for the development of our annual plans; it is the golden thread that ensures that the whole of the organisation is working towards the same long-term goals.

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

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

This is underpinned by our strategic aims, which are:

- *To focus relentlessly on improving access, safety, clinical quality and outcomes*
- *To improve continuously the experience of patients, carers and their families*
- *To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best*
- *To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future*
- *To use our scale and scope to develop excellent integrated services and leading specialist services*
- *To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve*
- *To achieve and maintain financial sustainability*
- *To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda*

Our plans are shaped by our own internal existing long-term strategies such as our People Plan and in particular our Group and Clinical Service Strategies that set out the roadmap for the development of our service over the coming 5 years. Our plans are also influenced by the priorities set by NHS England (NHS E) and the plans of our partners, in particular the Greater Manchester (GM) Integrated Care System (ICS). These, and their alignment with MFT strategic aims, are described in more detail in section 3.

Our work this year will continue to be dominated by the need to recover from the COVID-19 pandemic, tackling the backlogs and increasing our productivity, as well as addressing those longer-term goals such as playing our part in tackling health inequalities.

Key to all of this this is our people and we will be maintaining our focus on our workforce and prioritising staff health and wellbeing. Other key streams of work this year will be optimising our Electronic Patient Record (EPR) to deliver benefits for patients and staff and developing single services so that patients receive the same standards of care, whichever site they are treated on.

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2. Manchester University NHS Foundation Trust - who we are

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

Our services are delivered through the following management units:

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

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

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

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

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

- ***Wythenshawe, Trafford, Withington and Altrincham (WTWA)*** – WTWA is an acute teaching hospital and provides specialist services including cardiac services, heart and lung transplantation, respiratory conditions, breast care services across Wythenshawe, Trafford, Withington and Altrincham hospitals.

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

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

- ***Local Care Organisation (LCO)*** – the LCO provides community and out-of-hospital care in Manchester (MLCO) and Trafford (TLCO).

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Our Vision

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

VISION

Our vision is to improve the health and quality of life of our diverse population by building an organisation that:
Excels in quality, safety, patient experience, research, innovation and teaching,
Attracts, develops and retains great people, and;
Is recognised internationally as leading healthcare provider

STRATEGIC AIMS

- To focus relentlessly on improving access, safety, clinical quality and outcomes
- To improve continuously the experience of patients, carers and their families
- To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best
- To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future
- To use our scale and scope to develop excellent integrated services and leading specialist services
- To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve
- To achieve and maintain financial sustainability
- To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda

Our Values

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

Our Vision

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

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

Our Values

Together Care Matters

Everyone Matters
Working Together
Dignity and Care
Open and Honest

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

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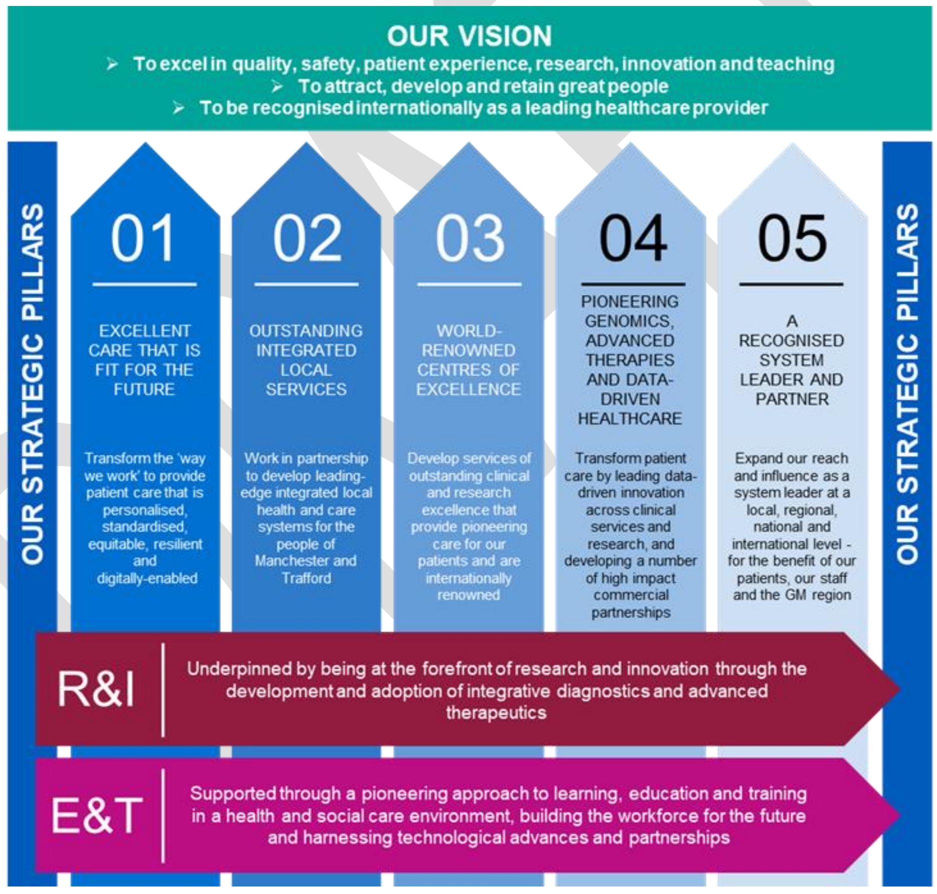
Our Group and Clinical Service Strategies

The Single Hospital Service for the city of Manchester was created to improve services for patients and create rewarding roles for our staff. In order to agree how best to reshape our services to deliver these benefits, we produced an MFT ***Group Service Strategy*** and a series of individual ***Clinical Service Strategies.*** These strategies were developed through extensive engagement with internal and external partners and stakeholders and were completed in 2019. Given the very significant changes that have taken place since then, in particular the Covid pandemic, the establishment on Integrated Care Systems and the implementation of our EPR, we have undertaken a refresh of the Group Service Strategy.

The refreshed ***Group Service Strategy*** sets out, at a high level, our vision for how services should develop over the next five years. The graphic below shows the pillars of the strategy and describes what we want to achieve under each pillar.



The ***Clinical Service Strategies*** which sit within the framework of the Group Service Strategy describe in more detail the development path for individual services over the next 5 years.

This Annual Plan describes the actions that we need to take in 2023/24 in order to progress both the Group and individual Clinical Service Strategies.

3. Context

NHS E National Objectives for 2023/24

Area	Objective
Urgent and emergency care	• Improve A&E waiting times so that at least 76% of patients wait no more than four hours by March 2024 with further improvements in 2024/25 • Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 • Reduce adult general and acute bed occupancy to 92% or below
Community health services	• Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard • Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care	• Make it easier to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently have an assessment the same or next day according to clinical need • Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 • Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 • Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) • Deliver the system specific activity target (agreed through the operational planning process)
Cancer	• Continue to reduce the number of patients waiting over 62 days • Meet the cancer faster diagnosis standard by March 2024, so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days • Increase the % of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	• Increase the % of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% • Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	• Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury • Increase fill rates against funded establishment for maternity staff
Use of resources	• Deliver a balanced net system financial position for 2023/24
Workforce	• Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	• Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) • Increase the number of adults and older adults accessing IAPT (Improving Access to Psychological Therapies) treatment • Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services • Work towards eliminating inappropriate adult acute care out of area placements

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	• Recover the dementia diagnosis rate to 66.7% • Improve access to perinatal mental health services
People with a learning disability and autistic people	• Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 • Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under-18s are cared for in an inpatient unit
Prevention and health inequalities	• Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 • Increase the percentage of patients aged between 25 and 84 years with a CVD (Cardiovascular disease) risk score greater than 20% on lipid lowering therapies to 60%. • Continue to address health inequalities on the CORE20PLUS5 approach

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GM Integrated Care Strategy

The purpose of the Integrated Care System is to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The GM Integrated Care Partnership (ICP) Strategy was approved by the GM ICP in March 2023. The ICP is required to produce a 5 year strategy to improve the health and wellbeing of its population to which the ICB must pay regard when developing its plans.

The strategy has been co-developed with involvement of people and organisations from across the health and care system, including the VCSE sector, as well as patients and the public. The table below summarises the 6 missions, 4 outcomes and 10 high-level commitments outlined in the strategy.

6 Missions
▪ Strengthen our communities ▪ Help people get into – and stay in – good work ▪ Recover core NHS and care services ▪ Help people stay well and detect illness earlier ▪ Support our workforce and our carers ▪ Achieve financial sustainability
4 Outcomes
▪ Everyone has an opportunity to live a good life ▪ Everyone has improved health and wellbeing ▪ Everyone experiences high quality care and support where and when they need it ▪ Health and care services are integrated and sustainable
10 'Commitments'
▪ Ensure our children and young people have a good start in life ▪ Support good work and employment and ensure we have a sustainable workforce ▪ Play a full part in tackling poverty and long-standing Inequalities ▪ Help to secure a greener Greater Manchester with places that support healthy and active lives ▪ Help individuals, families and communities feel more confident in managing their own health ▪ Make continuous improvements in access, quality, and experience – and reduce unwarranted variation ▪ Use technology and innovation to improve care for all ▪ Ensure all our people and services recover from the effects of the COVID-19 pandemic as effectively and fairly as possible ▪ Manage public money well to achieve our objectives ▪ Build trust and collaboration between partners to work in a more integrated way

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The table below shows how the NHS E objective and the missions of the GM Integrated Care Strategy align with our strategic aims.

MFT Strategic Aims	NHS E Objectives	GM Integrated Care Strategy
To focus relentlessly on improving access, safety, clinical quality and outcomes To improve continuously the experience of patients, carers and their families	Urgent and emergency Care Community health Services Elective care Cancer Diagnostics Maternity Mental health	Recover core NHS and care services
To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future	Workforce	Support our workforce and our carers
To use our scale and scope to develop excellent integrated services and leading specialist services		Help people stay well and detect illness earlier
To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve		
To achieve and maintain financial sustainability	Use of resources	Achieve financial sustainability
To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	Prevention and health inequalities	Helping people get into – and stay in - good work Strengthen our communities

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4. Priorities and Plans for 2023/24

Taking into account all of the internal and external context and drivers, the Hospitals, Managed Clinical Services (MCSs), Local Care Organisations (LCOs) and corporate teams have identified their priorities and developed plans that will enable them to deliver on those priorities over the coming year.

The following tables set out what we plan to do across the Hospitals, MCSs, LCOs and corporate departments to take forward each of the MFT strategic aims.

This is a summary only of a set of very detailed plans that describe what will be done by when, what will be achieved in terms of outcomes, how the plans will be staffed and show how they can be afforded within our funding.

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

MFT wide plans

Corporate Nursing • Deliver an effective IPC Strategy to support continued focus on prevention and control of other healthcare acquired infections • Deliver an effective IPC Strategy to support ongoing recovery from COVID-19 and continued focus on prevention and control of other healthcare acquired infections • Deliver excellence in Patient Experience through the MFT quality and patient experience programme underpinned by integration of quality and safety governance and data, and digital transformation	**Group Informatics** • Informatics will provide direct support to Hive optimisation and activities which require dependency and enablement from functional areas • Deliver year 1 activities of the digital strategy via 23/24 Digital Portfolio activities • Support the engagement with patient groups and users via MyMFT and the delivery of Hive EPR functionality
Medical Directors • Progress Health Inequalities work via Health Inequalities Group and Strategy • Maximise our input as an Anchor Institution • Continue focus on MESH/GIRFT via Trafford Elective Hub	**Research and Innovation** • Ongoing support for development of research aspects of the Trust-wide Rare Conditions Centre and the Informatics/Research and Innovation initiative the Clinical Data Science Unit • All clinical trials to be built in Hive with electronic prescribing by 31st March 2024 • Expansion of Clinical Research Facility to North Manchester General Hospital
Workforce • Through delivery of the People Plan we will provide the training, learning and skills for all our staff to conduct their roles professionally and effectively • Through the Equality Diversity and Inclusion Team we work across the Trust to ensure we are compliant with Accessible Information Standards, ensuring all patients can effectively access health literature • The EDI Team will support the development of the Health Inequalities Strategy • Through the inclusion of Workforce Wellbeing within the Health Inequalities Strategy, this recognises that the wellbeing of our staff, improves the health and wellbeing of our communities	**Chief Operating Officer Team** • Lead and support Hospital/MCS to undertake waiting list validation activity • Lead and support the Transformation programme relating to urgent care services at the ED front Door- supporting patients to access the right services when presenting at ED • Development of the SDEC and Ambulance handover pathways • Lead and support the hospitals to deliver Theatre Productivity programme • Lead and support the hospitals to deliver the Outpatient improvement programme • Support the delivery of the Back to Basics Programme • Continue to deliver improvements to reduce diagnostic waiting times for patients (DM01 basket of diagnostics), and cancer pathways • To meet national requirements to support the GM Endoscopy network objective • Continued delivery of the Elective Recovery PMO to support hospitals and MCS's in reducing long wait backlogs • Drive a programme of improvement to achieve best timed pathways for cancer • With system partners, develop an Urgent Care Strategy across Manchester & Trafford locality • Ensure Trust compliance with NHSE EPRR Core standards and the Civil Contingencies Act
Clinical Governance • Implement the Trust-wide Quality and Safety Strategy 2022-25	**Hive** • Establish and embed the Hive Governance structures ensuring they are aligned to provide a single Trust wide digitally enabled transformation strategy

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• Implement the National Patient Safety Strategy in full to optimise patient safety learning through the delivery of the Trust's Patient Safety Profile and Plan aligned to the Trust-Wide Quality and Safety Strategy • To understand and reduce unwanted variation in outcome across the organisation for similar services • To continue achieving high standards of health and safety through the provision of healthy working environments, safe working practices and safe people working therein • Ensure and assure compliance with CQC fundamental standards of Quality and Safety • Implement a strategic approach to becoming outstanding (CQC) across all domains	• Work with all Trust Hospitals/MCS/LCO corporate teams to ensure Hive benefits are realised
Estates and Facilities • Delivering Compliance, Safety & Efficiency • Maintaining a Sustainable and Accessible Estate	

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Hospital / MCS / LCO plans

NMGH	**WTWA**
▪ Optimise standards of infection, prevention and control ▪ Delivery of safety initiatives aligned to the MFT objectives of decreasing harm, enhanced staffing establishments to meet national recommended ratios of activity and acuity ▪ Targeted reduction in Hospital Standardised Mortality Ratios and Summary Hospital-level Mortality Indicator, focus on sustaining a culture that avoids never events and avoidable death through the Hospital Quality and Safety programme ▪ 7-day Standards: Focussed improvement to 14hr standard ▪ HIVE: Implementation planning and benefits realisation to drive improvements in performance, quality and safety ▪ Delivery of Urgent Care Action Plan reporting progress updates through NMGH Recovery Assurance Board that includes targeted plans to deliver improvements in key standards ▪ Referral to treatment: Recovery and improvement including reducing 104 week waits and ensuring clinical prioritisation ▪ Cancer Performance: Improvement in attainment of key standards and maintaining access for patients through cancer services disaggregation process	• Develop and deliver WTWA Patient Safety Incident Response Framework • Implement the recommendations from the WTWA safety review • Ensure robust processes are in place to monitor and maintain safety of patients in the Emergency Department • Continue to deliver improvements in relation to cancer performance
MRI • Use systematic processes for safety, gathering and acting on safety insights via our Insight Cell, with a focus on: ○ infection prevention and control ○ emergency department safety ○ mental health medicines administration and storage ○ Hive safety metrics ○ renal dialysis capacity • Deliver safe and effective patient pathways with a focus on reducing waiting times, improving discharge processes and delivering constitutional standards	**CSS** • Continue to implement and realise the benefits of Hive • Use Hive data to improve safety and better understand our services • Continued recovery – outpatients and elective programmes • Rapidly improve cancer diagnostic turnaround times • Embed the National Patient Safety Incident Response Framework • Develop and start to take forward strategic plans for pathology services, including the provision of new laboratory facilities • Embed a culture of continuous improvement
MREH • Reduce the delays in waiting times for treatment in line with national guidance and, where possible, at pace • Using the optimisation benefits in HIVE – risk stratifying and prioritising patients waiting for follow up review • Achieving gold accreditation across all areas • Continuation and development of improvement Boards to drive transformation • Provide specialties with regular detailed activity and performance reports to support productivity and efficiency • Provide services with regular detailed quality and safety performance reports to support quality improvement and improving safety	**UDHM** • Reduce the delays in waiting in line with national guidance • Retain gold accreditation for the dental hospital • Undertake space review analysis across all sites to identify opportunities for increased capacity for undergraduate activity • Explore how we provide sedation both at UDHM and other sites - how we best deliver sedation in the appropriate environment • Provide specialties with regular detailed activity and performance reports to support productivity and efficiency • Review the model of care for emergency dental services

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• Full review of space across all sites to maximise capacity and support productivity • Investigate the development of a play specialist role for clinic H • Re-design of the pre operative assessment pathways and department • Improve diabetic patient access to specialist nursing advice and support	
MLCO • Deliver the Resilient Discharge Programme enabling flow through Urgent Care pathways • Virtual Wards - Build on work to embed Virtual Wards and Hospital@Home across Manchester enabling flow and supporting admission avoidance • Deliver the LCO Community Health Services Strategy focused on reducing the variation in and between and ensuring equality and equity of access and provision of our Community Health services in Manchester • Mobilise pathways for Respiratory and Vascular (agreed through Clinical and Professional Advisory Group), exploring opportunities for closer working across secondary care, community and primary care colleagues • Ensure Community services continue to meet quality. safety and performance standards; delivering AOF priorities and monitor ASC performance through the ASC performance report • Increased understanding of patient experience from use of Friends and Family Test and What Matters To Me • Deliver Patient Safety Incident Response Framework Plan in line with MFT Group timescales for 2023/24 • Deliver phase 4 of Better Outcomes Better Lives focused on prevent, reduce, delay and support people to remain at home	**TLCO** • Deliver the Resilient Discharge Programme enabling flow through Urgent Care pathways • Virtual Wards - Build on work to embed Virtual Wards and Hospital@Home across Trafford enabling flow and supporting admission avoidance • Deliver the LCO Community Health Services Strategy focused on reducing the variation in and between and ensuring equality and equity of access and provision of our Community Health services in Trafford • Mobilise pathways for Respiratory and Vascular (agreed through Clinical and Professional Advisory Group), exploring opportunities for closer working across secondary care, community and primary care colleagues • Ensure Community services continue to meet quality. safety and performance standards; delivering AOF priorities and monitor ASC performance through the ASC performance report • Increased understanding of patient experience from use of Friends and Family Test and What Matters To Me • Deliver Patient Safety Incident Response Framework Plan in line with MFT Group timescales for 2023/24 • Mobilise the TLCO Target Operating Model
SMMCS • Prioritise access standards, as per national guidance, that help improve quality and outcomes • Increase elective caesarean section capacity • Delivery of the maternity safety agenda including development of maternity dashboard • Reviewing maternity scanning and outpatient service provision • Achieve UKAS Accreditation for Sexual Assault Referral Centre (SARC)	**RMCH** • CQC Improvement programme for safety, quality and patient experience • Expand Children's Virtual Wards across respiratory, neonatal jaundice, fluids, chemotherapy and specialist services to support children to be in the right place • Implement city wide 'Complex Care' approach enabling earlier discharge and care at home • Implement Getting it Right First Time programme across RMCH MCS with a focus on Paediatric surgery and urology, trauma and orthopaedics and ear, nose and throat • Work together with Manchester and Trafford urgent and emergency care partners to develop CYP element of UEC strategy • Implement RMCH MCS medication safety strategy for children • Continue to learn from past harm, embed the mortality review process and year on year reduction in level 4 and 5 harms

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

MFT wide plans

Corporate Nursing • Deliver excellence in Patient Experience through the MFT quality and patient experience programme underpinned by integration of quality and safety governance and data, and digital transformation	**Group Informatics** • Provision of Digital live services to LCO, Hospitals, MCS and partners • Improve prioritised infrastructure activities within the MFT locations and in support/enablement of Estates projects • Connect care settings to enhance information sharing and improved outcomes for patients
Medical Directors • Make improvements to Urgent and Emergency Care patient flow • Continue focus on Hive training for medical workforce and My MFT • Launch the Medical Examiners service in the community	**Research and Innovation** • Acquire and develop existing space for dedicated clinical research delivery • Full operation of new physical assets including Research Van and the Anti-Microbial Resistance Research Laboratory • Acquire new major items of research equipment
Estates and Facilities • Prioritising Patient Experience	**Chief Operating Officer Team** • Support the development and roll out of MyMFT delivery across the MFT services • Development of Booking and Scheduling principles • Further development of the unification of Booking and Scheduling services across MFT
Hive • Agree a strategy for the development of MyMFT so that it delivered stepped changes to experience of our patients	

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Hospital / MCS / LCO plans

NMGH • MFT ward accreditation: Expand to all areas and further develop ward-based learning processes • Fully embed What Matters to Me framework at NMGH • Patient experience focus: Evaluate high impact roles to support improving patient experience with full alignment to workplans and key indicators	**WTWA** • Align Improving Quality projects to patient survey/accreditation feedback • Improve access and the patient experience when accessing urgent & emergency care • Put plans in place to reduce avoidable healthcare acquired infections • Deliver improvements to drive down waiting lists for elective care • Improve recognition of patients with a Learning Disability making reasonable adjustments to optimise care
MRI • Enhance patient experience and involvement in care and service delivery ensuring the patient and family voice is reflected within our services	**CSS** • Explore innovative ways to engage and involve patients in care, including use of the new MyMFT system • Prepare for CQC inspection • Embed a culture of continuous improvement
MREH • Expand and develop our relationships with external partners such as Henshaw's and the Royal National Institute of Blind People • Provide services with regular detailed quality and safety performance reports to support quality improvement and improving safety	**UDHM** • Provide services with regular detailed quality and safety performance reports to support quality improvement and improving safety • Work with the Estates and Facilities Department to agree a life cycling programme of work to minimise risk, maintain safe services and enhance patients and staff experience
MLCO • Further integrate our approach working with partners in Neighbourhoods, documented in Neighbourhood plans • Support MCC to mobilise the Think Family approach including 3 locality (North, Central and South) Family hubs • Agree joint plans (INTs) with PCNs to address agreed Population Health Management priorities, assess and monitor impact • Undertake a review of ASC in-house provider services • Develop Dementia vision and Action Plan for ASC services to deliver the best care and support for people pre and post-diagnosis • Carers Manchester – deliver targeted support and pro-active referrals	**TLCO** • Continue to reform and develop Homecare • Mobilise the Trafford Neighbourhood model delivering closer alignment of community Health and Social care, with primary care, Mental Health, Voluntary, Community and Social Enterprise • Implement recommendations from the Learning Disability Review
SMMCS • Increase patient involvement with a focus on coproduction • Link digitally with service users • Increase patient involvement in service development working in collaboration with Maternity Voices Partnership • Relocate SARC to Peter Mount	**RMCH** • Develop an RMCH Patient and Public involvement/ engagement strategy • Expand volunteering across RMCH with wayfinding and family support volunteers • Introduce “Speak to Sister” and “Chat to Charge Nurse” – empowering families to raise concerns

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

MFT wide plans

Corporate Nursing • Further develop and deliver programmes to support a highly skilled workforce	**Group Informatics** • Adopt additional and new digital tools to aid delivery and support managers and teams with new skills training • Continue to develop the skills and knowledge of our staff with the aim of improving retention and attracting talent • Create Informatics competency frameworks by professional cohort which will aid the development of staff and teams and identify succession planning
Medical Directors • Develop the Medical & Dental Workforce strategy 2023-28 • Implementation of 2 x Trust-wide recruitment rounds for junior doctors; recruited to 2 year posts • Mentoring scheme for new Consultants • Implementation of Medical Workforce Race Equality Standard (MWRES)	**Research and Innovation** • Continue to deliver staff engagement and equality, diversity and inclusion initiatives which show Research and Innovation at the top of staff survey responses • Combine Research and Innovation assets and resources into a new staff training strategy with the leadership to deliver it
Workforce • Refresh MFT Leadership and Culture Plan deliverables as part of the MFT People Plan • Refresh of the MFT EDI Strategy (Diversity Matters 2024-28) • Wellbeing Strategy in support of People Plan. • Freedom to Speak Up – Self Assessment • Continue to lead the implementation of our Armed Forces Strategy to ensure opportunities for veterans are available and current serving members have access to the appropriate support	**Estates and Facilities** • Supporting a Diverse Workforce
Chief Operating Officer Team • Development of Transformation development and skills training for roll out across organisation • Development of Admin and clerical teams' skills and training in all aspects of patient access management including RTT and soft skills • To work with hospitals to support the development of skills, capabilities, and the career pathway for operational staff	**Hive** • Establish the Hive BAU training and thrive training programme

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Hospital / MCS / LCO plans

NMGH ▪ Create vibrant and inclusive culture - introduce activities to address systemic barriers that exist for staff from minority ethnic groups ▪ Improve our staff engagement methodologies: we will build on the identity of NMGH to improve the retention of staff	**WTWA** • Continue to promote and support staff health and wellbeing • Look at improving how we effectively engage with our workforce, listen to and act on their feedback
MRI • Enhance engagement at team level, embedding a climate of belonging to embrace difference and ensure well being • Enforce zero tolerance of violence and aggression to our staff	**CSS** • Short and medium term workforce plans for key areas • Increase advanced clinical practice roles and leadership development opportunities • Expand apprenticeship opportunities
MREH • Development of flexible working agenda that supports staff needs, whilst meeting the needs of the service • Expansion of Civility Saves Lives Programme • Promote inclusion, Equality and Diversity within MREH • Full review of hospital communication plan and governance structures	**UDHM** • Creation of a sustainable workforce strategy to attract and retain staff across University Dental Hospital Manchester and maximising the skills of the current workforce • Development of flexible working agenda that supports staff needs, whilst meeting the needs of the service • Expansion of Civility Saves Lives Programme • Full review of hospital assurance, communication and governance structures
MLCO • Deliver all staff Freedom 2 Lead event (May 2023) • Continue to undertake staff engagement approach on agreed themes and topics, collating and acting on feedback	**TLCO** • Deliver all staff Freedom 2 Lead event (May 2023) • Continue to undertake staff engagement approach on agreed themes and topics, collating and acting on feedback
SMMCS • Innovative and proactive approaches to recruitment and retention • Positive staff engagement • Culture of compassionate leadership	**RMCH** • Implement RCPCH Progress curriculum (Sept 2023) through rota / workforce redesign and MCS medium term action plan which supports paediatric speciality training and continues to improve trainee and trainer experiences • Continue to expand health and wellbeing initiatives across MCS and team level and ensure recruitment campaigns demonstrate strong commitment to workforce diversity • Develop longer term workforce transformation plan for general and specialist paediatric services

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To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future

MFT wide plans

Medical Directors • Implement Medical and Dental Workforce Strategy 2023 – 2028 • Continued focus on development of Hive training for medical workforce new starters - in particular, rotating junior doctors	**Group Informatics** • Informatics will develop and implement a People plan to improve the staff and user experience
Workforce • Deliver MFT People Plan • Through delivery of the People Plan we will provide the training, learning and skills for all our staff to conduct their roles professionally and effectively • Develop a Wellbeing Strategy in support of People Plan	**Research and Innovation** • Deliver successful first cohort of Houghton Dunn pump-priming fellowships enabling roll out of second cohort
Estates and Facilities • Supporting a Diverse Workforce	**Chief Operating Officer Team** • Development of Transformation development and skills training for roll out across organisation

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Hospital / MCS / LCO plans

NMGH ▪ Review and strengthen our development offer for staff: Develop and deliver a range of initiatives to support our staff	**WTWA** • Continue to ensure that staff appraisals are carried out in a timely manner and contain an agreed personal development plan for all staff • Continue to value diversity in the workplace and implement improvements based on the workforce racial equality standards
MRI • Optimise our service level leadership (level 3) through our leadership and talent development programmes • Proactively manage absence	**CSS** • Focus on health and wellbeing of staff • Prioritise digital enablement and skills development
MREH • Revised induction plan for all staff to ensure staff are supported and informed as they begin their role	**UDHM** • Development of induction programme for newly appointed consultants and career development • Explore leadership development opportunities for Clinical Leads and Associate Medical Directors
MLCO • Continue to support our staff through the People Plan (recruitment, retention, attendance, appraisal, mandatory training and workforce development) • Continue to embed equality, diversity and inclusion into service design, delivery and impact approach • Continue to support our staff through 'Let's Talk about Race' and implement the allyship model • Deliver year 2 of the LCO Allied Health Professionals strategy focused on workforce and service development • Focused workforce support: reducing vacancies through bespoke attraction strategy and strengthening connections to local communities, improve recruitment processes and reducing avoidable absence by proactive health and wellbeing support and effective case management	**TLCO** • Continue to support our staff through the People Plan (recruitment, retention, attendance, appraisal, mandatory training and workforce development) • Continue to embed equality, diversity and inclusion into service design, delivery and impact approach • Continue to support our staff through 'Let's Talk about Race' and implement the allyship model • Deliver year 2 of the LCO Allied Health Professionals strategy focused on workforce and service development • Focused workforce support: reducing vacancies through bespoke attraction strategy and strengthening connections to local communities, improve recruitment processes and reducing avoidable absence by proactive health and wellbeing support and effective case management
SMMCS • Continuing development of the Equality, Diversity and Inclusivity Network • Workforce strategy implementing new roles in Genomic Medicine • Non consultant doctor workforce sustainability in Maternity • Embedding Senior Leadership Team Structure in SARC	**RMCH** • Deliver our MFT and RMCH people plan - ' All here for you' and engagement strategy with focus in 2023-24 on recognition, communication and workforce ideas and improvement programme • Retain focus on mandatory training and appraisals

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

MFT wide plans

Medical Directors • Ensuring the training needs of junior doctors is built into design of singles services at MFT	**Group Informatics** • Deliver Digital live services and a portfolio of service improvement and change activities to Informatics services and in support of Trust, hospital, MCS and LCO priorities • Support the continued development of the MFT single hospital service strategy and implementation
Workforce • Through the EDI Team we will lead on the pathways for homeless patients, working across the Trust and partners	**Research and Innovation** • We expect to host from April 2024 the revised and merged local networks forming the North West Regional Research Delivery Network of the NIHR
Estates and Facilities • Developing a Flexible, Digitally Enabled Estate	**Chief Operating Officer Team** • Supporting the development and implementation of Hive pathways to support single services development utilising Transformation support as required • Support delivery of the Cancer Strategy • Cancer capacity and demand modelling to work towards delivery of best-timed pathways
Group Strategy • Implementation of single services in priority specialties • Attainment of commissioner approval to implement changes • Develop strategic plans for Urgent & Emergency Care • Develop strategic plans for Elective Care • Develop strategic plans to deliver Integrated Care • Development of MFT Rare Conditions Centre • Development of a plan for ATMPs • Development of a long-term plan for genomics • Strategy to enhance resilience of specialised services • Complete the expansion of the GM HCDP service • Support the set-up and implementation of the GM Sustainable Services programme • Establish strategic approach to robotic surgery and other surgical techniques	

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Hospital / MCS / LCO plans

NMGH ▪ Implementation of single services priority areas ▪ Delivery of safe and effective disaggregation plans ▪ Navigate commissioner decision-making and assurance processes for the complex services ▪ Redevelopment: Support completion of an Outline Business Case and RIBA Stage 2 refresh ▪ Evolve our relationships with the non-Manchester localities in our catchment	**WTWA** • Deliver the agreed cardiac strategy for MFT • Further develop the managed single services across MFT to include urology and breast services • Expand the cardiac and trauma & orthopaedics managed single services to incorporate services at NMGH
MRI • Lead the creation of centres of excellence in; Vascular, head & neck, GI medicine/surgery and rheumatology through single services across MFT	**CSS** • Continue to develop integrated Managed Clinical Services - realising the benefits of NMGH integration • Support NMGH redevelopment process • Support wider MFT Single Hospital programme • Support the development of a GM Vascular hub model, Trafford Elective Hub development • Continue to contribute to GM network development (Pharmacy, Pathology and Imaging) and deliver system transformation priorities for 23/24
MREH • Lead on the GM 'Sustaining Ophthalmology Services' programme • Support development of a new model for GM Retinopathy of Prematurity (ROP) services via work lead by the NW Neonatal ODN • Engage with the planning process for NMGH • Development of shared care models with Community Eyecare Services	**UDHM** • Achieve a shared strategy with the UoM for the development of a new hospital • Engage with the planning process for the redevelopment of NMGH • Agree the model for the Cary's Bannister Dental Unit with UoM colleagues • Progress plans with North Manchester to deliver a single service for dental laboratories • Develop the Special Care Dentistry service
MLCO • Design a clinical service strategy for community health services • Continue to work with GM commissioners to test / implement the proposed new service specification for community dental services • Design an MFT service strategy for Sickle Cell and Thalassemia • Embed PHM into the INT service model and wider neighbourhood working • Mobilise the refreshed INT service model - agree closer working alignment with partners • Support Primary Care (PCNs) through INT model and work through the Manchester Provider Collaborative	**TLCO** • Design a clinical service strategy for community health services • Through mobilisation of the Neighbourhood programme, agree closer working alignment with Primary Care Networks • Embed the delivery and monitoring of impact PHM into neighbourhood model • Complete delivery of phase 2 Community Diagnostic Centre phlebotomy expansion programme
SMMCS • Strengthen the Regional Genomic Medicine Network • With commissioners, co-design an assisted conception service that is fit for the future • Develop specially commissioned terminations services for women with complex medical co-morbidities • Establish the robotic programme for Gynaecology services • Clinical and office space requirements including Acute Assessment Unit / Triage • Secure, conclude and operationalise a single site estate solution for Connect North West	**RMCH** • Lead the equitable recovery of children waiting for treatment across Greater Manchester and the North West through standardised protocols and prioritisation, access to hubs, and clinically designed optimal pathways and treatment • Deliver RMCH MCS Transformation and achieving value programme using HIVE to standardise MCS wide working across urgent, elective, outpatient, CAMHS, complex discharge care and length of stay • Develop stage 2 HSCT / Gene Therapy expansion business case to deliver pipeline of advanced therapies research and commissioned services • Intraoperative MRI full business case MFT approval and mobilisation

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• Work collaboratively with partners to identify potential funding streams to enable to the implementation of Genedrive technology across all three sites for Newborn services	• Develop the clinical role of RMCH and specialist regional partners in children’s specialist commissioning and multi-ICB governance

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

MFT wide plans

Corporate Nursing • Continue to build on NMAHP research activity	**Group Informatics** • Informatics will continue to support R&I activities, Clinical Data Science Unit and Genomic services development
Estates and Facilities • Maximising Partnership Opportunities	**Research and Innovation** • Update R&I equality, diversity and inclusion plans to reflect new Trust strategy and align with the University of Manchester's strategy • Address health inequity, including initiatives within existing NIHR infrastructure (Applied Research Collaborative, Biomedical Research Centre, Clinical Research Facility) and revised or new NIHR infrastructure (North West Regional Research Delivery Network, Medtech and In vitro diagnostics Co-operative)

Hospital / MCS / LCO plans

NMGH ▪ Improve Clinical Trial Access: Demonstrate year on year growth of patients recruited to National Institute of Health and Care Research funded studies ▪ Develop a NMGH Research, Discovery and Innovation plan for 2022-25: Focus on widening participation and engagement across all staff groups ▪ Innovative Academic Posts: Develop and appoint new academic posts across different professions	**WTWA** • Set up and deliver our expanded NIHR Manchester Biomedical Research Centre and Clinical Research Facility • Begin to utilise the enriched date within HIVE for research and innovation • Increase NMAHP research activity with evidence of research embedded in practice
MRI • Develop our research and innovation portfolio and people as core to providing excellent clinical services	**CSS** • Support the development of Pharmacogenetics research • Support ATMPs service expansion • Increase research capacity and delivery within each division
MREH • Develop training opportunities in-house and regionally, for all staff • Deliver the Educational Team Philosophy to ensure all (non-medical) healthcare professionals have the knowledge and skills to ensure they can deliver high standards of safe and effective care • Development of the Eye Research Centre	**UDHM** • Continue to develop the research portfolio across University Dental Hospital Manchester
MLCO • Agree LCO Digital strategy priorities, working with Manchester City Council / MFT and Manchester Integrated Care Partnership to mobilise, including technology-enabled care and further roll out of automation opportunities • Understand benefits of HIVE implementation, roll out to bed base and scope options to extend / develop a community EPR	**TLCO** • Agree LCO Digital strategy priorities working with Trafford Council / MFT to mobilise inc. technology-enabled care and further roll out of automation opportunities • Support the digital portal in ASC • Understand benefits of HIVE implementation, roll out to bed base and scope options to extend / develop a community EPR
SMMCS • Re-establish MCS Research and Innovation Oversight Forum • Utilise HIVE to enhance recruitment and data gathering for research studies	**RMCH** • Deliver Children's Research 2025 programme for 2023-24: Mobilising The Manchester Children's Research Centre, launch children's research, technology and innovation group, deliver Biomedical Research Council research projects for children

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

MFT wide plans

Medical Directors	**Research and Innovation**
• Continue work on Health Inequalities via HIG and Strategy, working with Trust and LCO partners	• Commercial: - Support our strategic partners - One new partnership per year - Attract optimum partners to co-locate on site • Non-commercial: - Regular communication with University of Manchester, Health Innovation Manchester, Integrated Care System for GM Consistent approval processes across Manchester - Link with other Epic Trusts (EPR) - Supply paid R&I services to other Trusts
Workforce • As an Anchor Institute we deliver Widening Participation programmes to recruit from diverse communities across Manchester and Trafford • Through the Health Inequalities Strategy, the Wellbeing of the MFT Workforce (28,000) is recognised as a key pillar of tackling health inequalities. As a consequence, the delivery of our Wellbeing Strategy will seek to address health inequalities	**Estates and Facilities** • Maximising Partnership Opportunities • Maintaining a Sustainable and Accessible Estate • Ensure MFT can deliver the large scale estates decarbonation programs that have been designed for the North Manchester and Wythenshawe masterplans, the Trafford net zero project and the for the Oxford Road Campus
Group Strategy • Support NMGH Redevelopment • NMGH disaggregation • Progress plans for a new dental hospital • Pursue financial flexibilities for Wythenshawe masterplan • Support emerging specialised commissioning policy and implementation • Ongoing network and partnership development • Group lead for Health Innovation Manchester • Support development of ICS arrangements • Support development of locality arrangements	

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Hospital / MCS / LCO plans

NMGH ▪ Understand current inequalities and develop plans to address them ▪ Collaborative planning: Develop plans with key partners to address health inequalities and advance priority areas of integration ▪ Service change: Embed improving access and reducing health inequalities as core principles of all service change design	**WTWA** • Work with partners across the system to improve access to diagnostic testing via the community diagnostic centres • Work across the system with partners to implement an expanded targeted lung health screening programme across Greater Manchester
MRI • Ensure we fully meet the CQC's Well Led key lines of enquiry • Work effectively with our partners within and outside MFT to improve care, especially to address inequalities • Focus on creating conditions for high performance in our priority areas • Ensure hospital compliance with relevant EPRR Core Standards and promotion and engagement in the EPRR strategy	**CSS** • Increase local recruitment through widening participation • Decrease environmental impact of CSS services • Community Diagnostic Centre community engagement programme
MREH • Develop a green agenda and action plan, with identified leads to drive forward local improvements	**UDHM** • Develop a green agenda and action plan, with identified leads to drive forward local improvements • Undertake a health inequality review • Promote inclusion, Equality and Diversity within UDHM
MLCO • Support the delivery of MFT Health Inequalities strategy aligning hospital leads to the development of Neighbourhood PHM priorities • Mobilise and assess the impact of the PHM methodology (diabetes, hypertension, Winning Hearts and Minds and bowel cancer screening) to improve health inequalities • (Support) North Manchester strategy delivery, ensuring PCNs (North), VCSE and community partners are engaged in the design and delivery • Understand opportunities to support zero carbon in community services through the LCO Climate Change group • Mobilise the Making Manchester Fairer – Kickstarter programme - for work and health	**TLCO** • Support the delivery of MFT Health Inequalities strategy aligning hospital leads to the development of Neighbourhood PHM priorities • Agree approach (Living well in my community programme) to mobilise PHM methodology to improve health inequalities through Neighbourhood Population Health Plans • Understand opportunities to support zero carbon in community services through the LCO Climate Change group • Oversee the agreement and delivery of joint population health plans through the Living Well in my Community programme to address agreed PHM priorities, assess and monitor impact through co production groups
SMMCS • Explore opportunities for the green agenda through active participation on the Climate Emergency Board • Continue to develop education offering at SARC	**RMCH** • Deliver NW-wide network of excellence services which improve children's health and wellbeing including cardiology, healthy weight, surgery, Long Term Ventilation, Major Trauma, Covid, Burns and mobilise Northern early adopter for Gender Identity Dysphoria • Collaborate with the MLCO on Children's Sickle Cell, Thalassemia and Rare Anaemias strategy and wider opportunities to integrate children's urgent and planned care across community, primary care and acute settings • Co-develop national transformation programmes with the Children's Hospital Alliance to ensure equal and increased access for children in urgent and emergency care alternatives, specialist bed and elective capacity

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	• Host NW children's ODNs and finalise case for change proposals in children's critical care, surgery and cancer with NHSE specialist commissioners

This Finance Section of the Annual Plan is Draft pending Board Approval

5. Finance

Introduction

This section summarises the income and expenditure plan, capital programme and cash flow management plans as part of the Financial Plan for 2023-24, these will be submitted to the ICB and NHSE on the 4th May 2023, in accordance with their agreed timetable. The process to agree the financial plan for 2023/24 has been complicated but has sought to triangulate throughout the internal plans and with those of the ICB and the expectations of NHSE.

The financial regime for 2023/24 is once again focused on the recovery of elective activity, reduction of waiting lists that have reached historic highs, the continued drive to prevent hospital admissions and the focus on early supported discharge. Overall, there is little change in the income envelope between this year and last with the tariff uplift and Elective Recovery Fund (ERF) increase being offset by the efficiency requirement in the tariff and the complete cessation of COVID funding.

The implication of this 'flat cash' environment is, with significantly increasing levels of inflationary pressure and a workforce still not back to sickness levels experienced prior to COVID is the requirement to deliver historic high levels of cost reduction through the waste reduction programme (WRP) to achieve the financial plan balance for 23/24, the figure for this new financial year is some £136m compared to the required figure in 22/23 of £117m.This new requirement is also in the context of a continued range of workforce implications from strike action and ongoing health and wellbeing concerns.
MFT within the ICS plan will submitted a breakeven plan, which is subject to the Board approval, the constituent parts of that plan are detailed below.

2023-24 Income and Expenditure Plan – for submission 4th May

	2022/23 Actual	2023/24 Plan
Statement of Comprehensive Income	**£m**	**£m**
Operating income from patient care activities	2,386.2	2,345.7
Other operating income	264.5	258.8
Total Income	**2,650.6**	**2,604.5**
Employee expenses	(1,636.9)	(1,521.3)
Operating expenses excluding employee expenses	(1,036.1)	(1,156.7)
Total Expenses	**(2,673.0)**	**(2,678.0)**
Operating Surplus/(Deficit)	**(22.4)**	**(73.5)**
Net Finance Costs	(50.5)	(46.6)
Suplus/(Deficit) for Period as per Accounts	**(72.9)**	**(120.1)**
Add back all I&E impairments/(reversals)	74.7	123.4
Surplus/(Deficit) before impairments and transfers	**1.9**	**3.3**
Remove capital donations/grants/peppercorn lease I&E impact	(1.7)	(3.3)
Adjusted financial performance Surplus/(Deficit)	**0.1**	**(0.0)**

***2022/23 Actual subject to audit**

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The Trust has sought to develop a realistic and triangulated plan considering the Operations, Workforce and Finance requirements for this year. There has been a period of significant uncertainty regarding the level and allocation of funding available to the Trust which has only very recently been concluded. This has been to an extent further complicated by the key element of performance recovery and the costs associated with the expected activity levels as the Trust moves further onto activity recovery beyond 78 weeks waits to see and treat those patients waiting for firstly 65 weeks and then more than 52 weeks.

The fundamental shift away from Payment by Results (PbR) during COVID as a basis for Commissioner payment has been somewhat modified in the strengthening of the Aligned Payment and Incentive scheme and yet that is within the retention of an overall block amount of income available to the Trust, as set out in guidance for 23/24.

The MFT breakeven plan position has been derived from bottom-up work throughout the Group, helped this year by further extension of the "Anaplan" budgeting tool introduced in 22/23 and in arriving at the breakeven position the following approach has been taken.

The underlying position for 22/23 has been adjusted for the following items;

- Non-recurrent other costs (including Single Hospital Services (SHS)) removed
- Adjustments to the control total for other large one off or exceptional items (where outturn doesn't reflect a typical run rate) an example would be Drugs that are Cost Pass Through (CPT).
- Re-instatement of non-pay costs to support the recovery of operational activity
- And allowance withing the envelope available for some investments and service developments
- And the retention of an activity reserve for use by the organisation to support further elective recovery gains.

This approach was considered to provide a reasonable and realistic financial baseline position for allocation of the 23/24 controls totals. Hospitals, LCO and MCSs and Corporate were requested to confirm the full year effect of approved service developments and previously approved business cases. Additionally, the full year effect of the planned increased investment in the EPR programme has been included. These developments are in addition to the expected increase in CPT Drug expenditure which is matched by assumed income. These developments have been reviewed through an approvals process and prioritised into Control Totals at a Hospital level and corporate level and shared with our teams.

The level of inflation applied to expenditure is highlighted below as this is a material impact this year in the context of the plan and the consequential WRP requirement, the funded element in tariff is not sufficient to cover off the impact of increased inflationary pressures being faced by the Trust.

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Inflation impact 23/24

2023/24 £m	Description	Notes
55.3	**Funded tariff inflation @ 2.9%**	
(30.8)	Pay Inflation cost @ 2%	Rate of increase provided by NHSE. Includes PFI staff.
(3.6)	Drugs inflation at 1.3% (NHSE guidance) - likely to be higher.	Inflation as per NHSE guidance. Actual cost is likely to be higher than this - not picked out individual costs from hospitals/MCSs.
(11.9)	Capital Charges increase**	Imputed from Provider Finance Return (PFR) form.
1.3	Funding for capital charges	Additional funding received from commissioners
(17.2)	PFI inflation - contracts uplifted by March 2023 RPI index of 13.84%	Based on latest PFI information.
(9)	Utilities increase (eg. Gas fixed price ends 31/3/23)	Gas, electricity, water based on latest market positions
(22)	Non-Pay Inflation	This is as per our procurement team analysis on increase in costs across non pay as opposed to adding up proposed increases across all areas.
(93.1)	**Total inflation**	
(37.9)	**Net Impact included in 23/24 plan**	

***excluding depreciation on leased assets*

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Waste Reduction Plan Requirement

The value of required Waste Reduction for 23/24 based in the assumptions above is in the order of £136m. This increase is due to several factors already discussed but also due to delivery of the previous year's WRP in part through non-recurrent means. Hospitals / MCS / LCO and Corporate have been set a WRP of some £60m. The residual gap of £76m to the actual WRP target will need to be addressed through among other actions, further system funding, internal efficiencies, increased productivity, and a review of the balance sheet. Delivery of this level of WRP is unprecedented and is therefore one of the material risks in achieving the 2023/24 financial plan.

Capital Plan 2023/24

The total capital programme for MFT for 2023/24, which is provided below at a summary level and is currently a submission of £152m, GM ICB have agreed for providers to submit a plan that exceeds the envelope provided on the basis that

further funding is assumed to come nationally for MFT and NCA and providers receive a share of targeted funding held in reserve by NHSE. In our plan we have agreed a level of operational capital below the overall submission level to allow our Digital and E&F team to continue to work on delivery of critical IMT and E&F projects. At the time of writing, we are still waiting for an announcement on the quantum of capital for the New Hospital Programme, and in the interim we continue work within the envelope previously agreed.

Capital Expenditure 2023/24 Plan – for submission 4th May

Area	2022/23 Plan	2022/23 FOT	2023/24 Plan May Submission
	£k	£k	£k
Equipment Total	1,437	5,613	
Contingency	0	48	
IM&T Internal schemes	27,757	33,466	
Estates Internal schemes	39,373	40,273	
Stretford Memorial Hospital disposal credit against CDEL		(2,300)	
MFT requested utilisation of GM Envelope	**68,567**	**77,100**	**73,440**
Indicative share of GM Envelope			
Oversubscription against GM Envelope			
IM&T External schemes	15,743	12,335	0
Estates Externally Funded	6,319	6,837	18,718
Equipment Externally Funded	4,319	15,524	1,300
PFI	8,114	8,114	8,295
New Hospital Programme	28,044	28,044	43,835
Estates/Equipment charity funded	3,685	746	5,600
Estates Grant funded	1,603	2,253	0
Total Externally funded	**67,827**	**73,852**	**77,748**
Total Capital Expenditure	**136,394**	**150,952**	**151,188**

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Cash and Balance Sheet

2023/24 Cash Flow - main assumptions

The Trust's planned cash flow for 2023/24 recognises repayment commitments against existing DH loans and PFI liabilities, and investment in the capital programme. There is an overall cash deterioration of £98m to a closing cash position as of the 31st March 2024 of £142m. In arriving at this position, we have assumed a breakeven position and that WRP, will be achieved and that cash position allows for the release capital creditors at year end reducing across months 1 to 4 and is included in asset purchases figure.

This Finance Section of the Annual Plan is Draft pending Board Approval

The capital programme requires that PDC cash draw down takes place throughout 2023/24, in relation to the New Hospitals Programme enabling works and Lease repayments include the effects of IFRS 16 changes, and subsequent reduction in rental costs through I&E.

Extract of Cash Flow statement from revised plan – for submission 4th May.

Movements	Revised Plan 2023/24 £m
Opening Cash and Bank	**240.9**
Operating Deficit	(69.2)
Depreciation	74.8
Impairments	123.4
Interest Payments	(52.4)
Working capital movement	(43.4)
Operating Cash	**33.2**
Asset Purchases	**(157.2)**
PDC Received	**63.9**
Interest received	7.1
Loans received	0
Loan repayments	(11.5)
Lease repayments	(12.7)
PFI repayments	(13.2)
PDC Dividend paid	(7.5)
Finance Costs	**(37.9)**
Net Cash Movement	**(98.0)**
Closing Cash and Bank	**142.9**

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2022/23 Balance Sheet - main assumptions

The material movements in the Trust balance sheet over the course of 23/24, arise from some additional £152m asset additions and borrowings in year as result of IFRS 16 have been added for 22/23. The capital creditors which are high at 1/4/23 following expenditure in M12, will reduce over the first 4 months of 23/24 and there are reductions in both receivables and payables which reflects the inclusion of the imputed pay offer provided at 31/3/23. As detailed above there are several significant cash outflows in year to support to operating position, Capital investment plans in 2023/24, paying down 22/23 capital creditors (noted above) and the recurrent PFI loan and Lease repayments leading to a closing cash position of £142.9m.

This Finance Section of the Annual Plan is Draft pending Board Approval

Extract of Balance Sheet from revised plan – for submission 4th May.

Category	Draft accounts Opening 2023/24 £m	Revised Plan M12 2023/24 £m
Tangible and intangible assets	1,071.9	1,070.0
Investments	0.9	0.9
Non-current receivables	17.3	17.3
Non-Current assets	**1,090.1**	**1,088.2**
Assets held for sale	0.2	0.2
Inventories	25.4	25.4
Receivables	156.6	110.8
Cash and Bank	240.9	142.9
Current assets	**423.1**	**279.3**
Payables	(473.3)	(381.2)
Borrowings	(36.7)	(33.2)
Provisions and other liabilities	(81.2)	(76.2)
Current liabilities	**(591.2)**	**(490.5)**
Borrowings	(495.3)	(506.4)
Provisions and other liabilities	(14.2)	(14.2)
Non-current liabilities	**(509.5)**	**(520.7)**
Total net assets employed	**412.5**	**356.3**
PDC	471.9	535.8
Revaluation Reserve	163.4	163.4
I&E reserve	(222.8)	(342.9)
Total Taxpayers Equity	**412.5**	**356.3**

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This Finance Section of the Annual Plan is Draft pending Board Approval

Key Risks associated with the 2023/24 financial plan

Key risks to achievement of 2023/24 Plan and mitigations

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

Description	Assumption	Worst Case £m	Most Likely £m
Performance against 103% Elective target	Maximum risk to Elective income if exit 2022/23 performance is continued	(62.0)	(30.0)
WRP not delivered in full	High risk/unidentified schemes aren't delivered	(60.0)	(30.0)
BMA Rate Card Consultants	Only included at PFB agreed rates, not full BMA rates	(20.0)	(3.0)
Inflation in excess of plan	Minimal non pay inflation has been included in the plan	(15.0)	(2.0)
Additional capacity required to deliver 103% of elective activity	Potential risk if productivity and efficiency challenge isn't met	(20.0)	0.0
Industrial Action	Impact of future IA will impact costs which cannot be mitigated in year. Cost of cover on strike days c.£800k	(5.0)	(2.0)
Regulatory Action	No additional cost assumed once national supply ends	(5.0)	(2.0)
Total		**(187.0)**	**(69.0)**

The difference between the Worst Case and most Likely scenarios are in response to the risk mitigations put in place by the organisation during the final quarter of 22/23 and in ongoing further mitigations required in 23/24.

System risk – MFT as part of the GM ICS

Following a robust and challenging planning process, GM has reached an agreed system position assuming achievement of respective local WRP / CIP plans. Additionally, the achievement of a ICS plan will require the delivery of a wider system efficiency.

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

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

There is a further risk to GM in that the full value of ERF has been assumed as income, which requires delivery of cost-weighted activity levels at an average delivery of 103% of 2019/20 levels and an elective performance that delivers 107% by March 2024. If this level of activity is not delivered, the potential loss of ERF will add to the system efficiency requirement.

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These local and wider system risks and their mitigations will be managed locally through the monthly Finance and Productivity meetings and through the Group Recovery Board.

6. Monitoring Delivery

Annual Review

A year-end review of the Annual Plan will be undertaken in December. Hospitals, MCSs, LCOs and corporate departments have identified their priority actions for each strategic aim. These will be used to track progress. Performance in December will be used to assess projected year end performance. This will be presented to the Council of Governors.

Other mechanisms for monitoring delivery of the plans throughout the year include:

Quarterly Review

A review of progress in delivery of all aspects of the plan will be undertaken on a quarterly basis. We are reviewing the governance arrangements but it is proposed that this will take place through Group Management Board.

Accountability Oversight Framework (AOF)

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

Board Assurance Report

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

Hospital / MCS / LCO Review

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

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Glossary of Abbreviations

A&E	Accident & Emergency
AOF	Accountability Oversight Framework
ASC	Adult Social Care
ATMP	Advanced Therapy Medicinal Products
BAU	Business As Usual
CAMHS	Child and Adolescent Mental Health Services
CQC	Care Quality Commission
CPT	Cost Pass Through
CSS	Clinical Scientific Services
CYP	Children and Young People
ED	Emergency Department
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response (EPRR)
ERF	Elective Recovery Fund
GIRFT	Getting It Right First Time
GM	Greater Manchester
HCDP	Haematology Cancer Diagnostic Partnership
ICB	Integrated Care Boards
ICP	Integrated Care Partnership
ICS	Integrated Care System
INT	Integrated Neighbourhood Teams
IPC	Infection Prevention and Control
LCO	Local Care Organisations
MCC	Manchester City Council
MCS	Managed Clinical Service
MESH	Manchester Elective Surgical Hub
MFT	Manchester University NHS Foundation Trust
MLCO	Manchester Local Care Organisation
MREH	Manchester Royal Eye Hospital
MRI	Manchester Royal Infirmary
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research

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NMAHP	Nursing, Midwifery and Allied Health Professionals
NMGH	North Manchester General Hospital
ODN	Operational Delivery Network
PbR	Payment by Results
PCN	Primary Care Network
PFI	Private Finance Initiative
PHM	Population Health Management
PMO	Programme Management Office
RCPCH	Royal College of Paediatrics and Child Health
RIBA	Royal Institute of British Architects
R&I	Research & Innovation
RMCH	Royal Manchester Children's Hospital
RTT	Referral to treatment
SARC	Sexual Assault Referral Centre
SDEC	Same Day Emergency Care
SHS	Single Hospital Services
SMMCS	Saint Mary's Managed Clinical Service
TLCO	Trafford Local Care Organisation
UDHM	University Dental Hospital of Manchester
UOM	University of Manchester
VCSE	Voluntary Community and Social Enterprise
WRP	Waste Reduction Programme
WTWA	Wythenshawe, Trafford, Withington & Altrincham

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Agenda Item 10.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Jenny Ehrhardt, Group Chief Finance Officer
Date of paper:	May 2023
Subject:	Delegation of approval of the Annual Report and Accounts for 2022/23 to the Audit Committee
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term.
Recommendations:	The Board of Directors is asked to note the work being undertaken by the Audit Committee on the Annual Report and Accounts for 2022/23 and in light of the approval timetable is asked to delegate the authority for the approval of the Annual Report and Accounts for 2022/23 to the Audit Committee.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

The purpose of this paper is to report to the Board of Directors the extent of ongoing work of the Audit Committee in applying an appropriate level of governance and scrutiny in relation to the process to prepare, review and subject to this recommendation approve the Annual Report and Accounts for 2022/23.

Thus, this paper recommends that the Board of Directors approve the delegation of authority for the approval of the Annual Report and Accounts for 2022/23 to the Audit Committee. This authority to delegate was provided for the 2021/22 approval.

Background

The Trust is required to submit approved Annual Report and Accounts for 2022/23 to NHSE by noon, 30th June 2023. The Board of Directors are required to approve the Annual Report and Accounts, however there is no meeting of the Board of Directors that aligns with the sign off requirements of NHSE.

A paper was taken to the February 2023 meeting of the Audit Committee to inform the Committee of the processes being followed to produce the Annual Report and Accounts for 2022/23. This paper was noted by the Audit Committee and the committee continues to monitor progress in relation to the 2022/23 year-end process at its meetings.

To meet the reporting timetable, which has a deadline before the next full meeting of the Board of Directors, the Board is requested to delegate its authority to the Audit Committee to review and approve the Annual Report and Accounts for the financial year ended 31 March 2023.

Recommendation

The Board of Directors is asked to note the work being undertaken by the Audit Committee on the Annual Report and Accounts for 2022/23 and in light if the approval timetable is asked to delegate the authority for the approval of the Annual Report and Accounts for 2022/23 to the Audit Committee.

Agenda Item 10.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Sarah Cosgrove, Corporate Head of Nursing, Quality and Patient Experience Claire Horsefield, Patient Services Manager Niall Bancroft, Customer Services Manager
Date of paper:	May 2023
Subject:	Complaints and PALS Report: Quarter 4, 2022/23
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board of Directors is asked to note this Complaints and PALS report, including information relating to Q4, 2022/2023, on the following topics: • Complaints and PALS activity • Brief analysis of identified themes • Summary of achievements and improvements planned • Overview of complainants' satisfaction survey
Recommendations:	The Board of Directors is asked to note the content of the report
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

1. Introduction

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaint activity across Manchester University NHS Foundation Trust (MFT) during Q4 (Quarter 4, 1st January – 31st March) 2022/23.

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

1.3 This report provides:

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

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

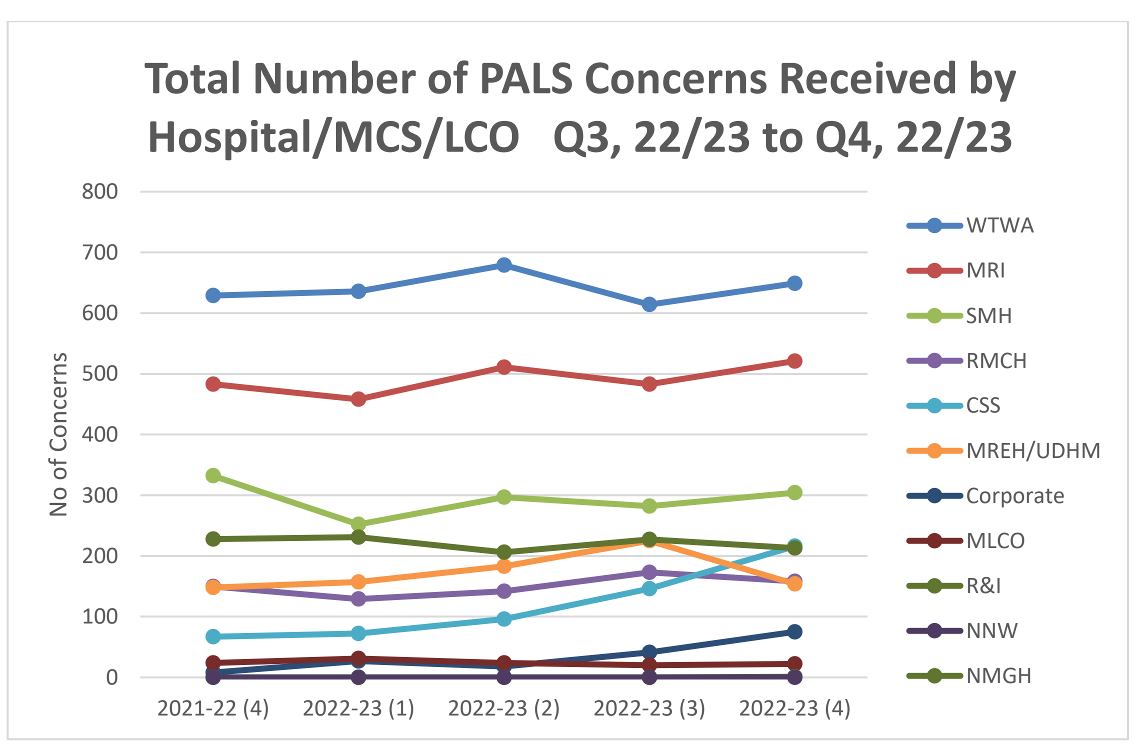
2. An overview of PALS and Complaints activity Q4, 2022/23

- 2,313 PALS concerns were received in comparison to 2,208 received in the previous quarter, an increase of 4.8% (105). This is also an increase of 11.8% (244) from the 2069 received in Q4, 2021/22.
- 516 new complaints were received in comparison to 549 received in the previous quarter, a decrease of 6.4% (33). This is, however, an increase of 20.8% (89) from the 427 received in Q4, 2021/22.
- Of the 516 new complaints received, 166 related to inpatient service, which is equal to the previous quarter. Of note, this is an increase of 19.4% from the 139 complaints relating to inpatient services for the same period in Q4 2021/22.
- Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) received the greatest number of complaints with 139 being received during this quarter; an increase of 13.9% (17) in comparison to the 122 WTWA received in the previous quarter. Of the 139 complaints received at WTWA, the main themes were 'Treatment/Procedure' and 'Clinical Assessment'.
- 99.6% of complaints were acknowledged across the Group within 3 working days.
- The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 87.1% of complaints were responded to within this agreed timescale compared to 88.5% in the previous quarter.
- 61 (11.6%) complaints investigated were upheld, 364 (69.2%) were partially upheld and 100 (19.0%) were not upheld (please refer to Section 5.3).

- The Parliamentary and Health Service Ombudsman (PHSO) closed 1 case during Q4 22/23, which was upheld. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) are currently completing the actions and recommendations from this. The PHSO did not open any new cases for investigation during this quarter. Details of the 'open' PHSO cases are set out in **Appendix 1, Table 1**.
- There was a total of 117 (15.9%) re-opened complaints received, compared to 111 (14.1%) the previous quarter, and 74 (17.9%) in Q4, 21/22
- 44 virtual or face-to-face complaint local resolution meetings were held. This is a 18.9% increase compared to the 37 held previous quarter, and a 63.0% increase from the 27 held in Q4, 21/22.

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

3.1 In Q4, 2022/23 the Trust saw an increase of 4.8% in PALS concerns from the previous quarter, with 2,313 PALS concerns being received compared to the 2,208 received in Q3. **Graph 1** below shows the number of concerns received by each Hospital / MCS / LCO each quarter. WTWA and Manchester Royal Infirmary (MRI) received the greatest number of PALS concerns, receiving 649 and 521 respectively. Overall, the greatest increase in PALS concerns, compared to the previous quarter, was seen in Clinical Scientific Services (CSS) (47.9%), driven by a large increase in concerns related to 'Delays in Diagnostic Scans' and 'Communication'. The University Dental Hospital Manchester/Manchester Royal Eye Hospital (UDHM/MREH) saw the greatest decrease in PALS concerns (31.6%), due to a reduction in concerns related to 'Communication' and 'Appointment Delays/Cancellations'. Further detail is provided in **Appendix 1, Table 2**.

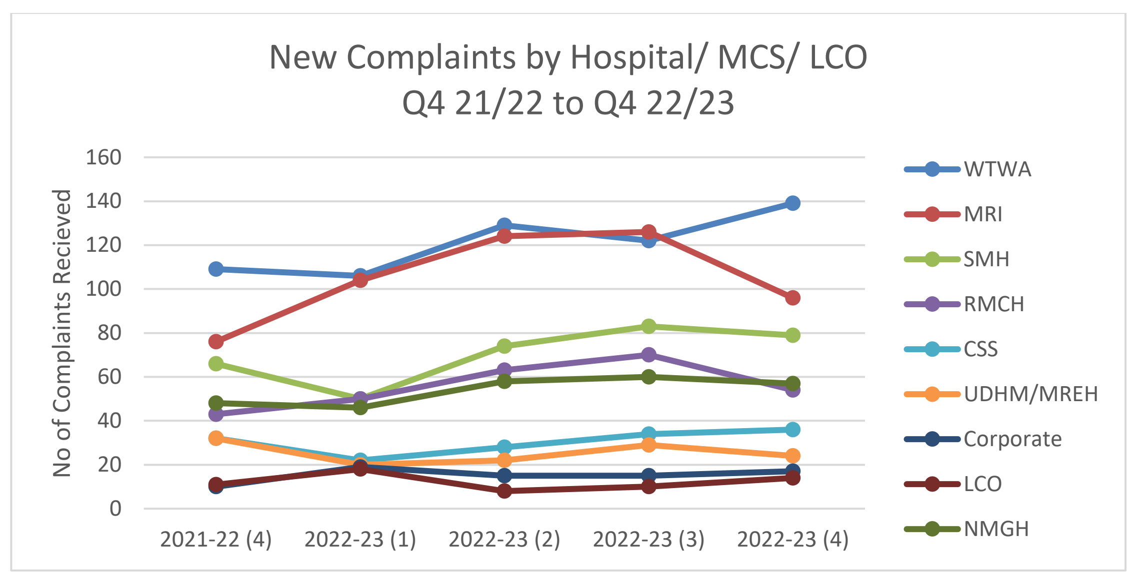


Graph 1: PALS Concerns Received by Hospital/MCS/LCO

3.2 The Trust noted a decrease in complaints with a 6.4% decrease being noted in Q4, with 516 new complaints being received compared to the 549 received in Q3. **Graph 2** below shows the number of complaints received by each Hospital/MCS/LCO/Corporate Services each quarter. Further detail is provided in **Appendix 1, Table 3**.

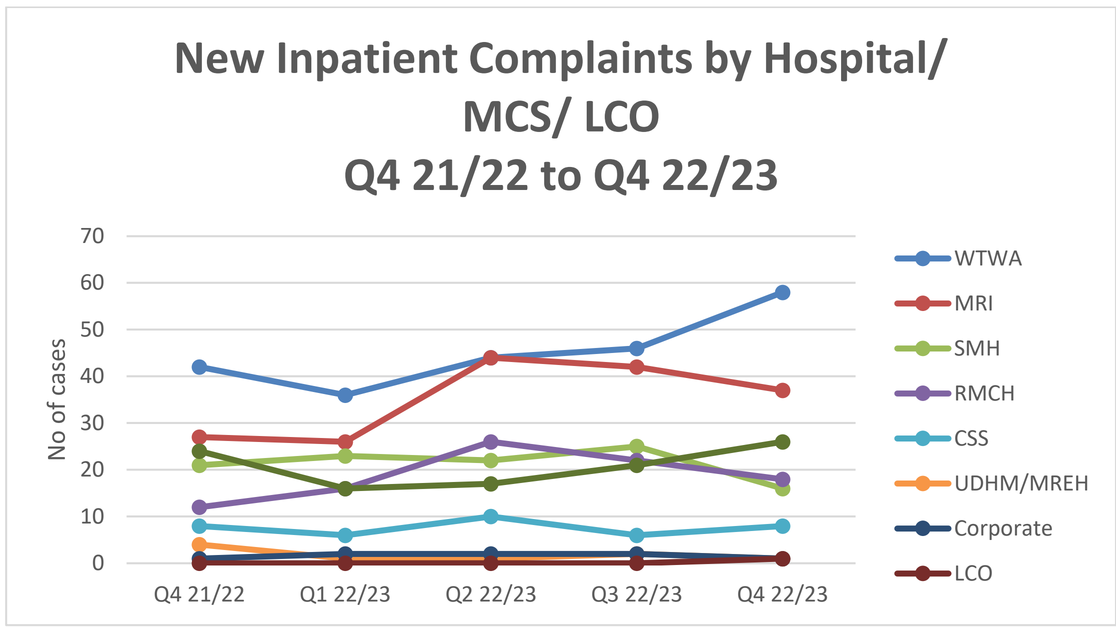
3.3 WTWA and MRI received the greatest number of complaints, receiving 139 and 96 respectively. WTWA have seen an increase in complaints received in Q4, driven by an increase in inpatient complaints related to 'Treatment/Procedure' and outpatient complaints relating to 'Appointment Delay/Cancellations'; however, MRI's complaints have reduced, with the largest decrease (44.4%) being in relation to complaints about 'Communication'.

3.4 Saint Mary's Hospital Managed Clinical Service (SMH) have experienced a 58% (29) increase in complaints received, between Q1, 22/23 and Q4, 22/23. The greatest increase has been in outpatient complaints (77.3%), mainly in relation to 'Communication' and 'Access to Service'.

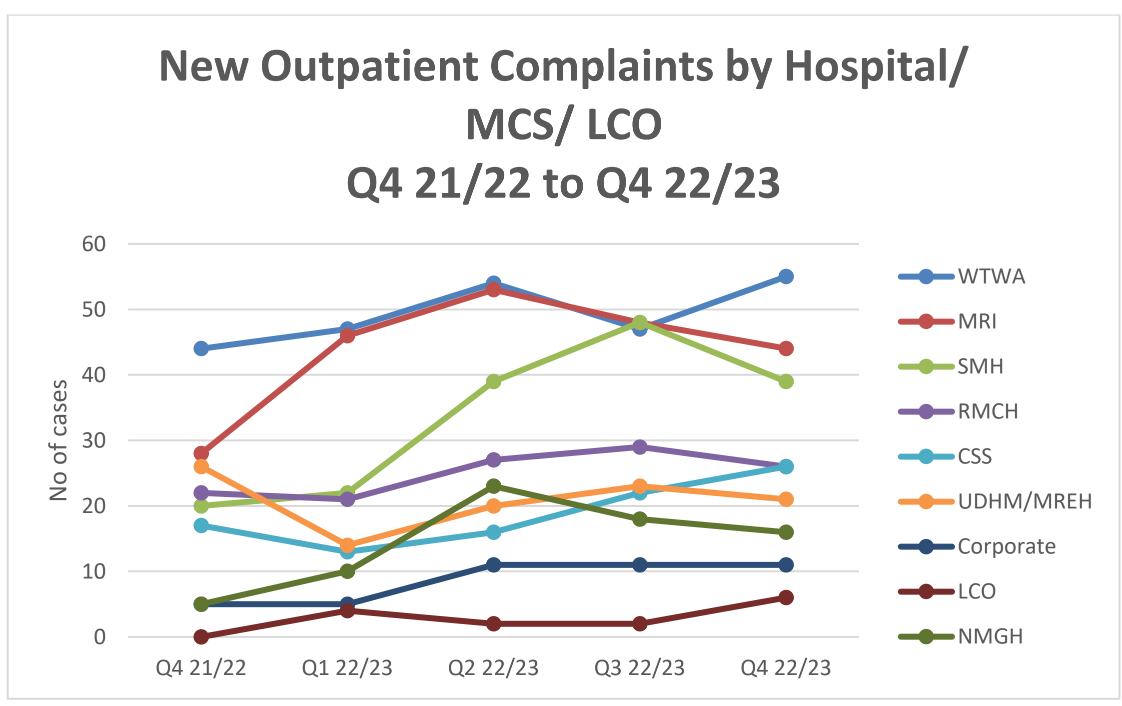


Graph 2: New Complaints Received by Hospital/MCS/LCO/Corporate Services

3.5 **Graphs 3 and 4** illustrate the number of new complaints relating to inpatient and outpatient services during Q4, 2021/22 – Q4, 2022/23. Of the 516 new complaints received, 47.3% (244) related to outpatient services; however, there was a 1.6% decrease in the number of outpatient complaints received compared to Q3, whilst inpatient complaints remained static.



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



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

3.6 Under the NHS Complaints Regulations (2009) there is a requirement that all new complaints are acknowledged within 3 working days of receipt of the complaint, MFT are committed to achieving this in 100% of cases. Regrettably, the Trust did not meet this indicator during Q4, 2022/23. **Appendix 1, Table 4** demonstrates the complaints acknowledgment performance. 505 (99.6%) eligible complaints were formally acknowledged within 3 working days of receipt, during Q4; however, 2 cases were not acknowledged within the 3 working day timeframe and were both formally acknowledged 4 working days after receipt.

3.7 One failing occurred when the Complaints Secretary was on leave and there was an oversight from a Complaints Facilitator. To address this issue, additional training on the management of the complaints email inbox has been provided to all Complaints Facilitators. In addition to this, the PALS and Complaints Manager and Customer Services Manager are undertaking a review of the process for managing the complaints inbox. In addition, to streamline the process a new Standard Operating Procedure will be developed detailing the process.

3.8 The second failing was due to a single member of staff failing to complete their list of day 3 acknowledgements. This is an isolated incident.

4.0 PALS and Complaints resolved within agreed timescales

4.1 Against the Trust's target of 90%, the trust achieved closure of 87.1% of complaints within the agreed timescale, representing a decrease in comparison to the previous quarter. **Appendix 1**, **Table 5** provides the comparison of complaints resolved within the agreed timeframe during the last five quarters. To improve the compliance with complaint response deadlines, the structure of the weekly Hospital/MCS/LCO/Corporate Services Complaints KPI meetings has been standardised across the Trust. Hospitals/MCSs/LCO/Corporate Services are monitoring their Complaints KPIs to enable timely updates to be provided to the Corporate Complaints Team, with any delays and breaches of deadlines escalated to senior management.

4.2 During Q4, 90% of PALS cases were closed within 10 working days. This is an increase from the 83% rate seen in Q3, and 88% in Q2. Improvements have been supported by the implementation of the PALS and Complaints Escalation Standard Operating Procedure, with timely escalation of cases to senior management ensuring that escalation is undertaken prior to the approaching deadline. In addition to this, weekly Hospital/MCS/LCO/Corporate Services PALS Key Performance Indicator (KPI) meetings have recently been introduced, to improve responsiveness to PALS concerns.

5.0 Outcomes from Complaint Investigations

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

5.2 Often complaints relate to more than one issue. In conjunction with the Hospital/MCS/LCO/Corporate Services investigating teams, the Corporate Complaints team review each of the issues raised to determine what happened. If failings are found in all the issues raised, and substantive evidence (evidence based on which a fact is proven) is identified to support the complaint, then the complaint is recorded as fully upheld. If failings are found in one or more of the issues, but not all, the complaint is

recorded as partially upheld. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as not upheld.

5.3 During Q4, 61 (12%) of the complaints investigated and responded to were fully upheld, 364 (69%) were partially upheld and 100 (19%) were not upheld. Q4 saw an increase in the percentage of complaints being fully upheld and not upheld, with a reduction in those being partially upheld. **Appendix 1, Table 6** demonstrates the outcome status of all complaints between Q4, 2021/22 and Q4, 2022/23. The main themes of fully upheld complaints were 'Treatment/Procedure' and 'Communication'. The PALS Team Leaders and Customer Services Manager are currently reviewing and updating the PALS training, to include customer service and local resolution, to help staff in the Hospitals/MCSs/LCO address communication issues and locally resolve these, thus reducing the number being escalated to formal complaints.

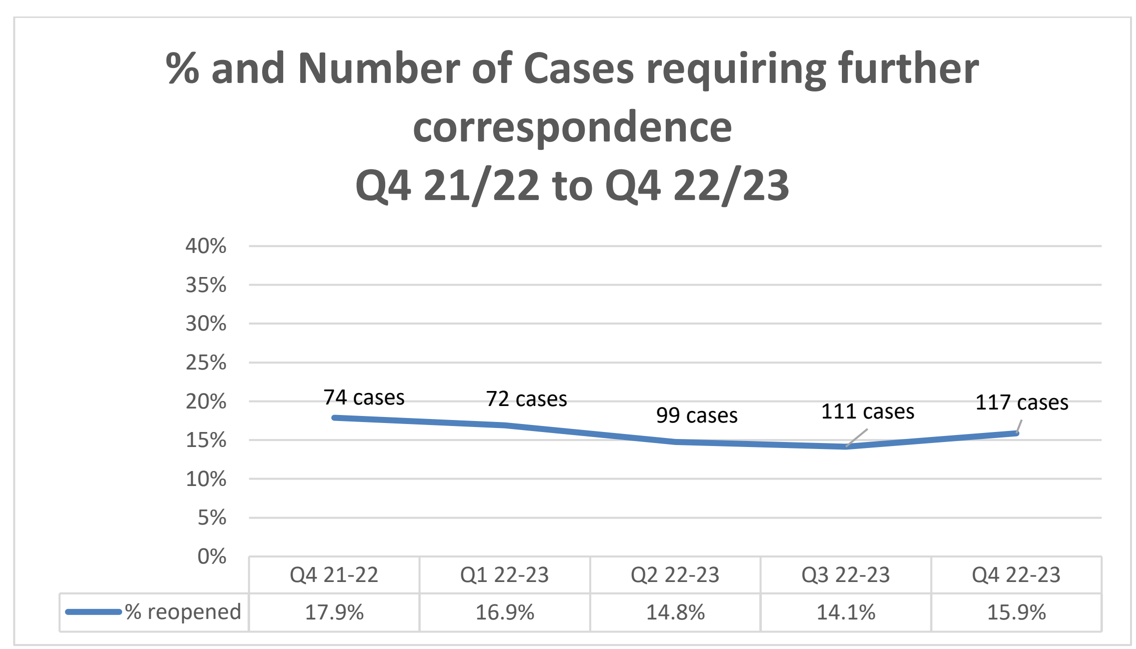
6.0 Re-opened complaints

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

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

6.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q4, 15.9% of complaints were reopened (117 cases in total) against the Trust tolerance threshold of 20%. In the previous quarter, 14.1% of complaints were reopened (111 cases in total).

6.3 **Graph 5** demonstrates the percentage of complaints re-opened from Q4, 2021/22 – Q4, 2022/23. **Appendix 1, Table 7** provides an overview of the primary reasons for the complaint being re-opened by Hospital/MCS/LCO/Corporate Services during Q4.



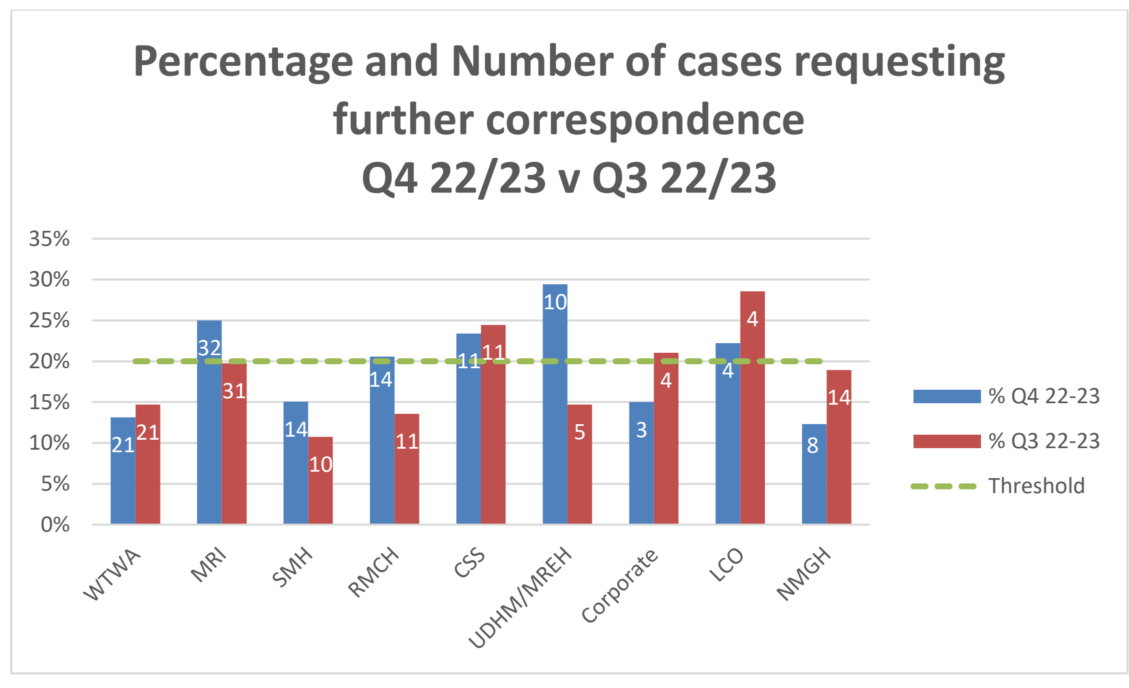
Graph 5: Total re-opened complaints Quarter 4, 2021/22 to Quarter 4, 2022/23

6.4 In 50 of the 117 complaints requiring re-opening in Q4 2022/23, the primary reason was due to the 'complaint response not addressing all issues', with MRI and Royal Manchester Children's Hospital (RMCH) receiving the greatest number for this reason, 15 and 10 respectively. To address this, the Complaints Team are delivering Complaints Investigation and Response Letter Writing Training Programme across the Trust, to improve the quality of complaint responses and reduce the number of re-opened complaints.

6.5 The 20% threshold was exceeded by UDHM/MREH (29.4%), MRI (25%), CSS (23.4%), Manchester and Trafford Local Care Organisations (LCO) (22.2%) and RMCH (20.6%) **(Graph 6).**

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

6.7 During 2023/24, the Corporate Complaints Team letter writing training programme is being updated, in line with the new PHSO complaints standards framework, and will continue to be delivered to staff from all Hospitals/MCSs/LCO/Corporate Services, to improve the quality of complaint investigations and responses and reduce the number of re-opened complaints.

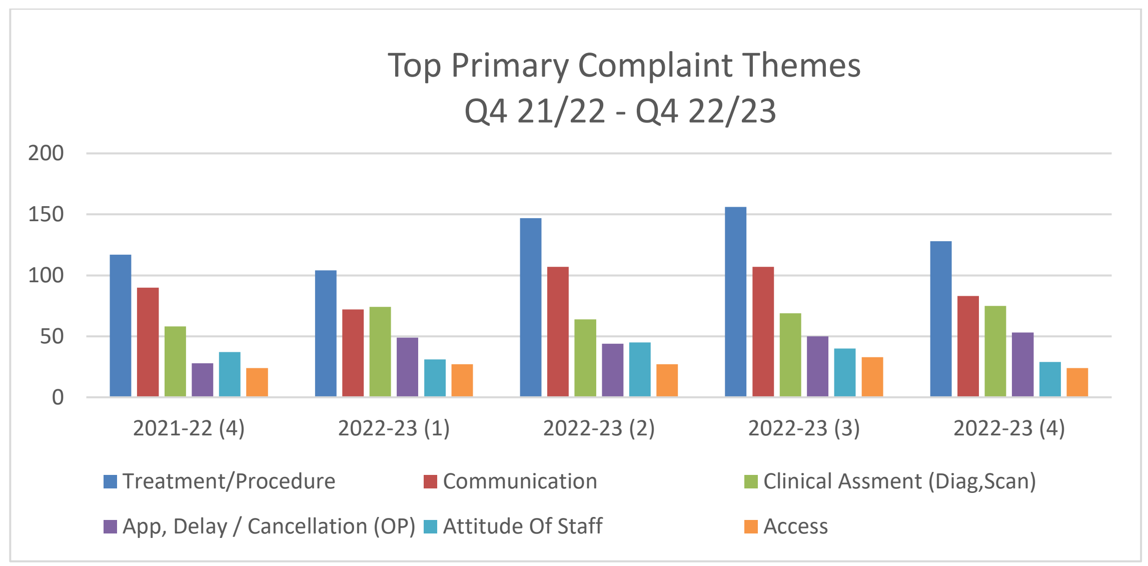


Graph 6: Percentage of re-opened complaints by Hospital/MCS/LCO/Corporate Services, Quarter 4, 2022/23

7.0 Brief thematic overview of complaints

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

7.2 During Q4, 2022/23, the top 5 primary categories remained unchanged with 'Treatment / Procedure' and 'Communication' remaining the top two categories **(Graph 7)**.



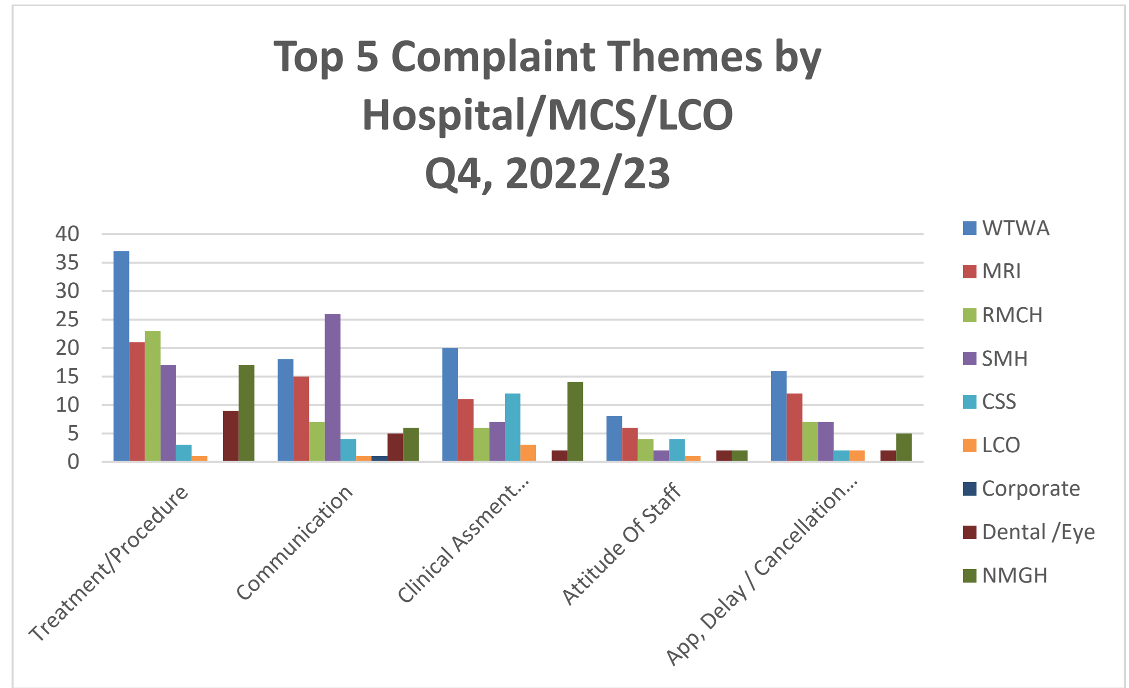
Graph 7: Top Primary Complaint Themes Q4, 2021/22 to Q4, 2022/23

7.3 WTWA received the most complaints relating to 'Treatment / Procedure' (37), whilst SMH received the most complaints relating to 'Communication' (26).

7.4 Some examples include:

- A patient's wound re-opening, due to issues with the sutures post-surgery.
- A patient receiving upsetting results via a copy of a letter to their GP, rather than in a clinic setting.
- A patient being disturbed by staff turning lights on in a ward bay to carry out a procedure.
- A patient information leaflet not including appropriate information on potential side-effects from surgery.

7.5 **Graph 8** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q4, 2022/23.



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

8.0 Learning from Complaints

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

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

8.3 During Q4, 2022/23 the Complaints Review Scrutiny Group (CRSG), chaired by the Corporate Director of Nursing for Quality and Patient Experience and supported by a Non-Executive Director, met twice. The management team from: CSS (Radiology) and North Manchester General Hospital (NMGH) (Emergency and Urgent Care) each presented a case in January 2023, and SMH (Obstetrics) and the RMCH (Surgery/Theatres) each presented a case in February 2023. Learning and associated actions identified from the 4 cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed.

9.0 Hospital/MCS/LCO Learning from complaints

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

9.2 An example of how learning from complaints has led to changes being applied in practice, is a Gap analysis being undertaken, within SMH Gynaecology, of the service provision against Greater Manchester Bereavement Standards. This was following

concerns raised regarding patient post-natal care following a miscarriage. As a result of this, additional resources have been implemented into the Bereavement Team and additional training for memory making has been provided, and charitable funding received, to improve the bereavement room for patients.

9.3 In the District Nursing Service, within the LCO, concerns were raised in relation to the management of pressure damage. Following a complaint investigation, lessons were learned and dedicated Tissue Viability Nurse Educations now provide wound care education to staff within the service, and all patients with a wound now have a weekly review with a Registered Nurse.

9.4 Learning from complaints relating to 'Communication' was a focus of Bee Brilliant, during events held at Oxford Road Campus on 19th April 2023; NMGH on 21st April 2023; and Wythenshawe Hospital on 25th April 2023. Bee Brilliant is a quality initiative launched by the Trust to focus communication messages to all staff within the Trust. All staff get a call to action to improve patient care and clinical quality, by inspiring and motivating staff.

10.0 Quality Improvements during Q4, 2022/23 included:

10.1 Advanced telephone system

10.1.1 A new advanced telephone system was implemented in the PALS and Complaints Department in March 2023. This new system was identified as being necessary, as a result of feedback from complainants, and has been implemented to improve telephone access to the PALS and Complaints Department and responsiveness to calls.

10.1.2 The new telephone system provides the PALS and Complaints Manager and the Customer Service Manager with a 'live' electronic dashboard to monitor the number of calls into the service, and the responsiveness. This allows performance to be monitored, and any proactive support and improvements made as deemed necessary.

10.1.3 Regrettably it is to early to provide a report on the impact of the system, however the live oversight of the calls has provided opportunities to manage situations proactively.

10.2 Enhanced Equality Diversity and Inclusion (EDI) data quality collection

10.2.1 The complaints EDI monitoring form, **Appendix 1, Form 1**, has been updated to capture the protected characteristics under the Equality Act, and in line with data fields on HIVE.

10.2.2 EDI data is now collected direct from HIVE when the patient is the complainant, following advice and approval from the Trust's EDI and Information Governance Teams, to improve the data collection percentage.

10.3 Re-instatement of Trust-wide Complaints Co-ordinators Meeting

10.3.1 The Trust-wide Complaints Co-ordinators Meeting has been re-instated, on a bi-monthly basis, with the first meeting held in February 2023. These meetings are a forum for complaints handling good practice to be shared amongst Hospitals/MCSs/LCO/Corporate Services and to improve collaborative working between Complaints Teams across the Trust. This need was identified due to

disparities in the management of complaints across the Trust and an increase in the number of complaints requiring cross-site investigation.

10.3.2 Improved collaboration and standardised processes will improve communication between the Hospital/MCS/LCO/Corporate Services complaints staff and reduce the number of response deadline breaches, when multi-site input is required.

10.4 Complaints audit and performance dashboard

10.4.1 A monthly audit of the complaints process has been developed and implemented during March 2023. The results formulate the complaints performance dashboard. The Customer Services Manager then uses this information to identify any occasions when the correct complaints handling process has not been followed, such as gaps in documentation or delayed notifications or calls not being returned in a timely manner. Reviews of the audit data and dashboard highlight areas where additional support/training is required, which the PALS and Complaints Manager and Customer Services Manage then implement accordingly.

10.5 Hospital/MCS/LCO/Corporate Services Complaint KPI meetings

10.5.1 Weekly Hospital/MCS/LCO/Corporate Services Complaints KPI meetings now include PALS, as well as Complaints, and the structure of these meetings has been standardised across the Trust. This will ensure all Hospitals/MCSs/LCO/Corporate Services are monitoring their Complaints and PALS KPIs and enable timely updates to be provided to the Corporate Complaints Team. Since these improvements have been made, there has been an associated increase in the number of PALS cases being responded to within 10 working days.

10.6 PALS awareness

10.6.1 PALS was advertised in 'MFT Time' in February 2023, to raise staff awareness of PALS and how PALS can support both patients / relatives, and staff alike. Staff were informed that PALS is one team, covering all Hospitals/MCSs/LCO/Corporate Services which come under MFT. The PALS inpatient process was also re-iterated, which involves linking in with the Head of Nursing and the Ward Management Team, to quickly address issues raised by patients or their representatives to achieve local resolution. Staff were also informed of the different ways patients, their representatives or staff can contact PALS, with an emphasis on in person and via telephone, in addition to written communications.

10.6.2 During Q4, 2022/3 the PALS Team Leaders attended Heads of Nursing Forums across the Hospitals/MCSs/LCO and Team Leader/Senior Clinician Training Programmes, to raise staff awareness of PALS and their freedom to actively seek feedback to improve services and seek local resolution. PALS Team Leaders will continue to attend these forums and training programmes, throughout 2023/24, and are available to meet with patients and their representatives in person at Receptions and in departments/wards.

11.0 Education

11.1 PALS and Complaints Training

11.2 During Q4, 2022/3 the Complaints Team delivered six sessions of the Complaints Investigation and Response Letter Writing Training Programme, with over 50 attendees. Further training is planned to be delivered to across all Hospitals/MCSs/LCO/Corporate Services in 2023/24, with a full timetable to be published on the Trust's learning hub.

12.0 Complaints Satisfaction Survey

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

12.2 In Q4, 336 complaints satisfaction surveys were distributed to complainants across all MFT Hospitals/MCSs/LCO/Corporate Services at the closure of the complaint.

12.3 Feedback from complainants, during Q4, included concerns regarding difficulties contacting PALS via telephone and compliments for the support and re-assurance provided by PALS staff during difficult times for patients and relatives.

12.4 Following receipt of this feedback, the PALS and Complaints Manager and Customer Service Manager undertook a thorough review of the case handling and identified areas for learning. As a result of this, a new telephone system has been implemented and there will be a change in process to how voicemails and calls are returned directly by the PALS and Complaints handlers, to increase responsiveness to calls.

13.0 Continuing Planned Improvements

13.1 Continued areas for improvement and development during 2023/24 include:

- Update of PALS and Complaints sections of MFT website and creation of a new online PALS contact form.
- Update of PALS and Complaints leaflets, posters, and banners.
- 'Ask, Listen, Do' commitment - improving the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service.
- Implementation of changes to the Complaints Process in accordance with the new PHSO Complaints Standards, to be enforced in April 2024.
- Exploration of the introduction of a PHSO/Complaints 'upheld' Learning Sub-Group.
- Exploration of the introduction of a Patient and Public Involvement Complaints Focus Group.
- Establish collaborative working relationships with charitable, voluntary and community organisations, to increase PALS awareness in Manchester.
- Re-open PALS office at Trafford General Hospital.
- Audit of PALS process to identify areas for improvement.
- Exploration of electronic document signing, to improve consent request process.

- Training sessions on Ulysses' Customer Services module to be delivered by Complaints Team Leaders.

14.0 EDI Monitoring Information

14.1 The collection of EDI data is shown in **Appendix 1, Table 11**. As in previous quarters, collection of this information remains inconsistent. As detailed above, this information can now be pulled from HIVE to improve the collection proportion.

14.2 There was a decrease of 6.0% in the collection of 'overall' data. There is also continued evidence of the ongoing need to improve reporting on 'disability', 'religion' and 'sexual orientation', with only 5.2%, 23.4% and 20.5% being received respectively due to patients and their representatives opting not to declare this.

15.0 Patient Experience Performance Dashboard

15.1 To assist with triangulation of patient feedback, Friends and Family and What Matters to Me (WMtM) is also reviewed regularly.

15.2 The WMTM survey is administered via a hand-held electronic device and asks patients a series of questions about their recent experience. These MFT surveys are based on the questions within the National Patient Experience surveys and ask patients about their experiences in the following themed categories:

- Clean Environment
- Infection Control
- Patient Safety
- Pain Management
- Privacy and Dignity
- Involving Patients and Carers
- Patient Satisfaction
- Clinic Organisation
- Staff Communication

15.3 Following the implementation of CIVICA the volume of patients providing feedback has risen and the information gained via this platform is utalised to make localised improvements (**Appendix 1, Table 12**)

16.0 Conclusion and recommendations

16.1 This report provides a concise review of matters relating to Complaints and PALS during Q4, 2022/23. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place, to both improve the responsiveness of the Trust to complaints and the quality of responses provided, with appropriate actions implemented to address lessons learned because of patient feedback.

16.2 The Board of Directors are asked to note the content of this Q4, 2022/23 Complaints Report and the ongoing work of the Corporate and Hospital/MCS/LCO/Corporate Services teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of cases open at the PHSO as of 31st March 2023

Hospital / MCS / LCO	Cases	PHSO Investigation Progress
MRI (5)		
Inpatient Medical Specialties	1	Awaiting Provisional Report
Cardio-Vascular Specialties	1	Scoping
Cardio-Vascular Specialties	1	Awaiting Provisional Report
Emergency Assessment & Access	1	Scoping
Emergency Assessment and Access	1	Request for Early Dispute Resolution
WTWA (9)		
Urgent Care	1	Awaiting Final Report
Medical Specialties	3	Scoping
Trauma and Orthopaedics	1	Scoping
Respiratory	1	Scoping
Complex Health & Social Care	1	Scoping
Urgent Care	1	Scoping
Ambulatory Care	1	Scoping
RMCH (2)		
Surgery 1	1	Scoping
Complex Medicine	1	Scoping
SMH (2)		
Obstetrics	1	Awaiting Provisional Report
Obstetrics	1	Scoping
CSS (1)		
Critical Care	1	Scoping
UDHM (1)		
Oral Surgery	1	Scoping
MREH (1)		
Ophthalmology	1	Awaiting Provisional Report
TOTAL	**21**	

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

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
WTWA	629	636	679	614	649
MRI	483	458	511	483	521
RMCH	150	129	142	173	158
UDHM/MREH	148	157	183	225	154
SMH	332	252	297	282	304
CSS	67	72	96	146	216
Corporate	8	27	18	41	75
LCO	24	31	24	20	22

Research & Innovation	0	0	0	0	1
NMGH	228	231	206	227	213
Grand Total	**2069**	**1993**	**2156**	**2211**	**2313**

Table 3: Number of Complaints received by Hospital/MCS/LCO/Corporate Servives Q4 2021/22 – Q4 2022/23

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
WTWA	109	106	129	122	139
MRI	76	104	124	126	96
RMCH	43	50	63	70	54
UDHM/MREH	32	20	22	29	24
SMH	66	50	74	83	79
CSS	32	22	28	34	36
Corporate	10	19	15	15	17
LCO	11	18	8	10	14
NMGH	48	46	58	60	57
Total	**427**	**435**	**521**	**549**	**516**

Table 4: Complaints Acknowledgement Performance

3 Day Target	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Number of 3 day acknowledgements completed	424	462	533	567	505
100% acknowledgement	100%	100%	100%	99.6%	99.6%

Table 5: Comparison of complaints resolved by timeframe: Q4 2021/22 – Q4 2022/23

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Resolved in 0-25 days	280	291	329	370	352
Resolved in 26-40 days	37	46	52	66	61
Resolved in 41+ days	61	76	90	114	113
Total resolved	**378**	**413**	**471**	**550**	**526**
Total resolved in timescale	**340**	**375**	**419**	**487**	**458**
% Resolved in agreed timescale	**89.9%**	**90.8%**	**89.0%**	**88.5%**	**87.1%**

Table 6: Outcome of Complaints, Q4 2021/22 – Q4 2022/23

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request
Q4 21/22	378	43	248	81	6
Q1 22/23	413	46	285	77	5
Q2 22/23	471	53	351	63	4
Q3 22/23	550	57	421	72	0
Q4 22/23	526	61	364	100	1

Table 7: Re-opened Complaints by Hospital / MCS / LCO Q4 2022/23

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Disputes information	Other	Total
WTWA	2	7	7	5	0	21
MRI	1	7	15	5	4	32
SMH	0	7	5	1	1	14
CSS	0	4	2	2	3	11
RMCH	0	2	10	2	0	14
UDHM/MREH	0	0	4	3	3	10
Corporate	0	1	2	0	0	3
LCO	0	2	1	1	0	4
NMGH	2	2	4	0	0	8
Grand Total	**5**	**32**	**50**	**19**	**11**	**117**

Table 8: Closure of PALS concerns within timeframe Q4 2021/22 – Q4 2022/23

	Q4,21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Resolved in 0-10 days	1776	1846	1810	1923	2042
Resolved in 11+ days	177	203	256	402	234
% Resolved in 10 working days	91%	90%	88%	83%	90%

Table 9: Number of PALS concerns taking longer than 10 days to close by Hospital / MCS / LCO Q4 2021/22 – Q4 2022/23

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
WTWA	36	56	81	96	49
MRI	44	53	60	99	64
RMCH	25	13	21	35	19
UDHM/MREH	0	8	10	27	9

SMH	39	30	47	35	28
CSS	16	16	11	25	15
Corporate	8	14	6	13	14
LCO	6	1	2	5	4
NMGH	5	11	18	67	31
Grand Total	**179**	**202**	**256**	**402**	**234**

Table 10: Number of PALS concerns escalated to formal investigation Q4 2021/22 – Q4 2022/23

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
No of cases escalated	13	13	15	20	10

Table 11: Equality and Diversity Monitoring Information Q4 2021/22 – Q4 2022/23

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Disability					
Yes	32	28	32	27	15
No	13	17	17	11	12
Not Disclosed	382	390	472	511	489
Total	**427**	**435**	**521**	**549**	**516**
Disability Type					
Learning Difficulty/Disability	2	1	0	0	1
Long-Standing Illness or Health Condition	29	13	20	19	7
Mental Health Condition	9	5	7	5	3
No Disability	0	0	0	1	0
Other Disability	3	3	9	5	2
Physical Disability	10	6	7	8	10
Sensory Impairment	2	1	5	5	8
Not Disclosed	372	406	473	506	485
Total	**427**	**435**	**521**	**549**	**516**
Gender					
Man (Inc Trans Man)	172	184	201	226	210
Woman (Inc Trans Woman)	249	247	315	316	299
Non-binary	0	0	0	0	0
Other Gender	0	0	1	4	1
Not Specified	6	4	2	3	5
Not Disclosed			2		1
Total	**427**	**435**	**521**	**549**	**516**
Sexual Orientation					
Heterosexual	100	58	129	92	80
Lesbian / Gay/Bi-sexual	3	9	3	5	6
Other	3	7	16	14	9

Do not wish to answer	15	9	11	18	11
Not disclosed	306	352	362	420	410
Total	**427**	**435**	**521**	**549**	**516**
Religion/Belief					
Christianity	65	48	75	54	54
Buddhist	0	0	1	0	1
Do not wish to answer	12	6	16	4	8
Muslim	9	5	11	11	9
No religion	51	43	53	59	40
Other	3	3	3	6	3
Sikh	0	0	1	1	0
Jewish	0	0	4	3	3
Hindu	0	3	1	3	3
Not disclosed	286	327	356	406	395
Humanism	1	0	0	1	0
Paganism	0	0	0	1	0
Total	**427**	**435**	**521**	**549**	**516**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	3	1	0
Asian Or Asian British - Indian	1	5	6	2	5
Asian Or Asian British - Other Asian	3	4	5	5	6
Asian Or Asian British - Pakistani	5	6	10	11	11
Black or Black British – Black African	4	8	6	6	5
Black or Black British – Black Caribbean	4	11	5	7	8
Black or Black British – other Black	4	4	1	2	3
Chinese Or Other Ethnic Group - Chinese	1			1	2
Mixed - Other Mixed	4	1	1	4	1
Mixed - White & Asian	1		3	2	1
Mixed - White and Black African		1	1		
Mixed - White and Black Caribbean	2	1	2	4	1
Not Stated	100	85	112	109	105
Other Ethnic Category - Other Ethnic	7	5	4	8	10
White - British	153	145	180	200	183
White - Irish	9	6	3	4	5
White - Other White	8	11	10	7	9
Not disclosed	120	141	169	176	161
Total	**427**	**435**	**521**	**549**	**516**

Table 12: Patient Experience Performance Dashboard Q3 22/23 – Q4 22/23

Performance Dashboard

		Current Month		Feb-23		Jan-23		Dec-22		Nov-22		Oct-22	
		Responses	Overall %	Responses	Overall %	Responses	Overall %	Responses	Overall %	Responses	Overall %	Responses	Overall %
What Matters to Me (WMTM)	CSS	105	92.66	119	91.20	100	92.41	114	92.18	101	92.16	64	91.10
	MLCO	65	90.00	70	92.32	50	88.98	17	89.30	13	89.44	4	92.97
	MREH	500	94.69	396	95.51	424	97.86	244	98.59	357	98.27	182	98.84
	MRI	763	90.52	564	89.64	528	88.99	411	90.03	376	89.72	173	85.48
	NMGH	660	88.94	573	89.35	210	91.08	226	90.89	296	90.61	304	85.72
	R&I	59	96.34	45	93.53	24	92.97	14	93.93	31	88.87	13	98.21
	RMCH	411	84.17	308	84.15	322	84.25	173	85.07	188	81.15	121	79.37
	SMH	286	89.52	231	88.79	289	88.82	173	89.42	183	89.19	161	87.62
	UDHM	271	95.88	116	95.55	201	95.06	73	97.16	98	96.30	49	96.37
	WTWA	828	91.62	730	92.43	678	93.38	477	93.81	609	93.50	341	91.58
	MFT Total	3948	90.01	3152	90.05	2826	90.53	1922	90.91	2252	90.77	1412	88.22

		Current Month			Feb-23			Jan-23			Dec-22			Nov-22			Oct-22		
		Responses	Good	Poor	Responses	Good	Poor	Responses	Good	Poor	Responses	Good	Poor	Responses	Good	Poor	Responses	Good	Poor
Friends and Family Test (FFT)	CSS	438	96.80	2.05	354	98.31	0.56	399	97.74	1.00	260	97.69	1.54	301	99.67	0.00	312	97.44	1.60
	MLCO	768	98.31	0.91	528	98.67	0.38	372	99.46	0.27	377	99.73	0.00	239	97.91	0.84	252	98.81	0.40
	MREH	1823	96.43	1.21	1535	95.18	1.43	1944	95.88	1.08	948	95.04	2.43	1189	95.54	1.93	1009	94.85	2.08
	MRI	2828	82.96	12.45	2761	83.30	11.12	2563	82.68	11.39	1237	87.63	8.57	1612	87.84	7.51	1136	84.07	11.09
	NMGH	1651	85.16	9.51	1248	86.86	7.93	1427	88.16	7.43	466	85.41	11.16	623	85.55	7.87	691	82.34	11.72
	R&I	76	97.37	0.00	42	100.00	0.00	35	94.29	0.00	27	96.30	0.00	55	90.91	0.00	19	100.00	0.00
	RMCH	1318	90.59	5.92	1225	88.41	7.02	1141	90.10	5.78	491	87.98	8.55	662	88.07	8.76	486	80.86	13.99
	SMH	1039	95.57	2.98	828	94.93	2.17	1252	94.89	2.72	387	89.66	5.17	812	95.32	2.71	666	87.84	8.56
	UDHM	567	98.24	1.06	305	92.79	5.57	443	94.13	3.61	209	94.74	1.44	376	95.48	2.39	400	95.75	2.50
	WTWA	4466	92.01	4.72	3174	90.89	5.58	3704	93.41	3.73	1986	92.65	4.63	2449	93.10	4.21	1764	91.33	5.56
	MFT Total	14974	90.93	5.83	12000	89.94	6.08	13280	91.32	5.11	6388	91.67	5.35	8318	92.15	4.65	6735	89.46	6.93

		Current Month	Feb-23	Jan-23	Dec-22	Nov-22	Oct-22
		Complaints Received	Complaints Received	Complaints Received	Complaints Received	Complaints Received	Complaints Received
Complaints	CSS	13	12	11	11	7	16
	MLCO	4	7	3	3	3	4
	MREH	8	3	6	3	5	8
	MRI	33	28	35	33	41	51
	NMGH	19	18	20	14	23	24
	R&I	0	0	0	0	0	0
	RMCH	18	19	15	26	24	20
	SMH	27	26	26	21	27	35
	UDHM	3	2	2	4	3	6
	WTWA	54	50	35	37	39	46

Form 1: Equality and Diversity Monitoring Form

Equality and Diversity monitoring information	
We are committed to ensuring that everyone has access to the NHS complaints process. We would like your help to do this by answering a few questions about your background, and returning this form in the enclosed pre-paid envelope or via email. We would like you to answer all the questions, but if you prefer not to answer a question that is ok. This information is requested from the person making the complaint only (whether you are the patient, relative or a representative complaining on behalf of the patient).	
Age	
Please indicate your sex	☐ Male (including trans man) ☐ Female (including trans woman) ☐ Non-binary ☐ Prefer not to answer ☐ Other (please specify below) ……….……………..
Please select the option which best describes your sexual orientation	☐ Heterosexual / straight ☐ Gay / lesbian ☐ Bisexual ☐ Don’t know ☐ Prefer not to answer ☐ Other sexual orientation not listed above (please specify below) …………………….
Please indicate your marital status	☐ Single ☐ Married / civil partnership ☐ Divorced / person whose civil partnership has been dissolved ☐ Widowed / surviving civil partner ☐ Separated ☐ Prefer not to answer
Do you consider yourself to have a disability?	The Equality Act 2010 defines a disabled person as anyone who has a physical or mental impairment, which has a substantial and long term effect on their ability to carry out normal day to day activities. ☐ No disability ☐ Physical impairment ☐ Sensory impairment ☐ Mental health condition ☐ Dementia ☐ Learning disability / difficulty ☐ Long-standing illness or health condition ☐ Prefer not to answer ☐ Other (please specify below) ……………………….
Please indicate your religion or belief	☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Judaism ☐ Islam ☐ Sikhism ☐ No religion ☐ Prefer not to answer ☐ Other (please specify) …………………..

Please state your primary language	
Please state your nationality	
Please select the option which best describes your ethnic origin	White ☐ British ☐ Irish ☐ Other white background (please specify below) .... Mixed Race or Dual Heritage ☐ White Asian ☐ White / Black African ☐ White / Black Caribbean ☐ Other mixed race or dual heritage background (please specify below) .... Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Chinese ☐ Pakistani ☐ Other Asian background (please specify below) .... Other Ethnic Group: ☐ Other ethnic group (please specify below) .... Black or Black British ☐ African ☐ Caribbean ☐ Other black background (please specify below) .... ☐ Prefer not to answer

Agenda Item 10.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Corporate Director of Nursing Karen Sutcliffe, Head of Nursing, Professional Education & Development
Date of paper:	May 2023
Subject:	Nursing and Midwifery Revalidation Annual Report 2022/23
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust Vision &Values and Key Strategic Aims:	1. Patient safety 2. Patient experience 3. Productivity and efficiency
Recommendations:	The board are asked to note the content of this paper and actions taken to support Nurses, Midwives and Nursing Associates across the Trust to meet the Nursing & Midwifery Council statutory revalidation requirement.
Contact:	Name: Anne-Marie Varney, Corporate Director of Nursing Tel: 0161 276 8862

1. Introduction

1.1 This paper provides an annual overview of Nursing and Midwifery Professional Revalidation at MFT, describing the current practice and assurance systems in place to support nurses, midwives and nursing associates to meet the Nursing and Midwifery Council's (NMC) revalidation requirements.

1.2 This paper reports the Trust's revalidation activity from 1st April 2022 to 31st March 2023.

2. Background

2.1 Since April 2016, nurses and midwives have been required to undergo a three-yearly process of revalidation to demonstrate that their practice is in line with the Nursing and Midwifery Council (NMC) professional standards of practice.[1] Following the regulation of the Nursing Associate role, this profession is also required to undertake revalidation every 3 years.

2.2 Revalidation is the process that nurses, midwives, and nursing associates need to follow to maintain their registration with the NMC. The process requires the registrant to reflect on their current practice and to demonstrate that they are meeting the standards set out in The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC, 2018).

2.3 All registrants receive formal notification from the NMC 60 days before their revalidation submission deadline. This enables the registrant to collate their portfolio of evidence which demonstrates they have met the requirements for revalidation. The portfolio of evidence must contain:

- 450 practice hours or 900 if renewing two registrations (for example as a nurse and midwife)
- 35 hours of Continuing Professional Development, including 20 hours of participatory feedback
- Five pieces of practice related feedback
- Five written reflective accounts
- Reflective discussion
- Health and character declaration
- Professional indemnity arrangement

2.4 Confirmation that a registrant has met the required standard occurs through a standardised confirmation process set by the NMC by another NMC registrant.

[1] Nursing and Midwifery Council (NMC), 2018, The Code: professional standards of practice for nurses, midwives and nursing associates

2.5 It is the individual nurse, midwife and nursing associate's professional responsibility to ensure that they meet the revalidation standards. However, the Trust has a responsibility to support registrants in meeting revalidation requirements, thereby assuring that their practice is safe and effective. Staff who are unable to meet the NMC requirements are required to apply on an individual basis to the NMC for a personal extension.

3. Current Situation

3.1 Revalidation is now well embedded within the nursing and midwifery profession having been a requirement since 2016. Nurses and midwives are encouraged to maintain a portfolio of evidence and feedback in preparation for revalidation.

3.2 Nursing associates, who registered with the NMC since January 2019 are required to revalidate every three years, in line with nursing and midwifery. 15 nursing associates have successfully revalidated since April 2022.

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

3.4 If member of staff fails to meet the revalidation requirement, their registration remains active for one month, prior to their registration expiring. In this situation the Trusts Professional Registration Policy would come into effect.

4. Staff Revalidation – 2022/2023

4.1 The total number of nurses, midwives and nursing associates who are employed by the Trust and have revalidated with the NMC in 2022/2023 is **2798** out of a total of **2802**. The remaining **five** registrants who have not revalidated have requested an extension to revalidate from the NMC which has been granted. The Corporate Director of Nursing will monitor the conditions of this extension to ensure the nurses remain 'live' on the NMC register during this period.

5. Revalidation Work Programme

5.1 As revalidation has been a NMC requirement since 2016, the process should now be considered business as usual. NMC validation is monitored through the monthly professional registration report which is shared with the Directors of Nursing highlighting the status of their nursing and midwifery workforce for each Hospital/MCS/LCO.

6. Conclusion

6.1 The Board of Directors are asked to acknowledge the content of this report and accept this as an annual update on the status of NMC revalidation.

Agenda Item 10.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Corporate Director of Nursing (Workforce and Professional Education)
Date of paper:	May 2023
Subject:	Safer Staffing –To provide the Board of Directors with the bi-annual Nursing, Midwifery and Allied Health Professional (AHP) Safer Staffing 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:	Impact of report on key priorities and risks to give assurance to the Board that's its decisions are effectively delivering the Trust's strategy in a risk aware manner. 1. Patient Safety 2. Patient Experience 3. Productivity
Recommendations:	The Board of Directors are asked to receive this paper and note progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group
Contact:	Name: Anne-Marie Varney, Corporate Director of Nursing Tel: 0161 276 8862

1. Executive Summary

1.1 This report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[2], published in October 2018.

1.2 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 November 2022. This report provides analysis of the Trust's Nursing, Midwifery and AHP workforce position at the end of **March 2023**.

1.3 The contribution of the NHS workforce is key to the success of the national restoration and recovery plans. The Government manifesto in 2019 committed to increasing the number of registered nurses in England with a target of 50,000 more nurses by 2024[3]. The programme is currently on target to deliver at least an additional 50,000urses by March 2024.

1.4 The NMC Register Mid-Year Data Report identified a net increase of **13,144 (1.7%)** new nurses, midwives, and nursing associates registered in September 2022 compared with April 2022[4]. The NMC report highlights a significant factor for the rise in new registrants is the contribution of internationally trained professionals who account for **82%** of new registrants in England during this period. Between February 2022 and January 2023, a total of **21,060** nurses were recruited nationally and **3,034** recruited within the Northwest region[5]. The number of midwives registered with the NMC has also increased by **1.7%** during the last 12 months and there continues to be a gradual increase in the number of first-time registered midwives.

1.5 Whilst the number of registered nurses has risen, the number of nurse vacancies in England has remained static. Data published by NHS Digital in March 2023 shows a national vacancy rate of **10.8%** at 31st December 2022 within the registered nursing staff group (equivalent to **43,619** vacancies). This is an increase of 0.6% or approximately 4000 vacancies over the past year. This trend results from workforce supply not keeping pace with growth in nurse establishment with providers reporting this growth is in line with increased patient acuity and service redesign in response to new targets and recovery programmes post the covid-19 pandemic[6].

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[1] National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe sustainable and productive staffing

[2] NHS Improvement (2018) Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing

[3] Department of Health (2022) 50,000 nurses programme: delivery update

[4] The Nursing and Midwifery Council (2022) The NMC register mid-year update

[5] NHS England (2020) NHS people plan

[6] Kings Fund (2022) Is the NHS on track to recruit 50,000 more nurses?

1.6 In November 2022, 102,503 registered AHPs were working in the NHS in England which was an increase of **2200 (2.1%)** AHPs from the previous year[7] with Speech and Language Therapy having seen the largest increase in staff of 22.8%. The only professional groups not to have experienced an increase in staff are Dietetics 4.3% decrease, Physiotherapy 0.5% decrease and Osteopathy 2.0% decrease.

1.7 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Predicted recruitment numbers for academic year 2023/24 at GM HEI's show an increase in adult nursing **(11.7%),** midwifery **(12%)** and a **50%** increase in Direct Entry student Nursing Associates. Overall, AHP pre-registration programme recruitment is predicting slight increases in Physiotherapy and podiatry. Occupational Therapy will increase with two new programmes starting at Manchester Metropolitan University (MMU) and University of Bolton (UoB) in September 2023. Other programme recruitment remains stable but there does appear to be a reduction in recruitment to Psychology programmes

1.8 The Trust workforce position has continued to improve over the last 6 months. Both domestic and international recruitment programmes have resulted in **888.0wte** registered nurses and midwifes joining the organisation. The Trust has benefited from an average monthly nursing and midwifery starters rate of **126.9wte** since September 2022. The total number of nurses and midwives joining the Trust in 2022/23 is **1395.3wte**.

1.9 This improved workforce position, is supported by the number of internationally recruited nurses and midwives recruited via the well-established overseas recruitment campaign. The total number of international nurses and midwives joining the Trust in 2022/23 is **522wte.**

1.10 At the end of March 2023 there were a total of **348.6wte (3.7%)** registered nursing and midwifery vacancies across the Trust which remains static with the September 2022 vacancy position. However, during this time the nursing workforce has grown more than this movement suggests. Recruitment has kept pace with turnover and increases in funded establishment (47.1wte) demonstrating an overall improving picture that is expected to continue throughout 2023 due to the numbers in the domestic and the international recruitment pipeline. The Trust's overall nursing and midwifery vacancy rate **(3.7%)** is much lower than the national vacancy rate of **10.8%** and the Northwest vacancy rate of **7.3%**[8].

1.11 At the end of March 2023, the 12-month rolling turnover rate for registered nurses and midwives was **13.1%**, this is an increase since September 2022 when the rate was **12.4%**. The trust turnover rate is lower than the current national turnover rate for nursing and midwives in acute NHS trusts which is **14.7%.**[9]

[7] NHS Digital (2022) NHS Vacancy Statistics England

[8] NHS Digital (2023) NHS Vacancy Statistics England

[9] NHS Digital (2023) NHS vacancy statistics England

1.12 Sickness rates had continued to reduce from **10.2%** for registered nursing and midwifery staff and **14.0%** for unregistered staff in Q3. At the end of March 2023, rates reduced to **6.4%** and **9.6%** for unregistered staff.

1.13 There are **110** domestic nurses and midwives in the recruitment pipeline expected to start before the end of June 2023. This number will increase in Q3 when the Trust sees the largest number of graduate nurses, midwives and AHP starters.

1.14 At the end of March 2023, the AHP vacancy position was **43.5wte (2.7%).** The turnover rate for registered AHPs was **8.9%** in March 2023. Sickness absence rates for registered AHPs in March 2023 was **4.7%.** This is a decrease from sickness in September 2022 when the rate was **5.2%.**

1.15 At end of March 2023, band 2 and band 3 nursing and midwifery support worker vacancies totalled **460.2wte (14.7%).** During this period there has been an increase in starters however the continued leaver rates have slowed the impact to our vacancy position. It is anticipated now that the band 2 management of change process has drawn to a conclusion and the opportunity for staff to progress to a band 3 position, we predict a reduction in leaver rates and estimate a reduction in vacancies over the next 6 month. There has been initial evidence of this trend since December 2022.

1.16 Launched in May 2022, the band 2/3 NA and MSW management of change (MOC) process was undertaken to determine the number of band 2 clinical support staff who were undertaking clinical duties and working in roles aligned to agenda for change band 3. Staff were given the opportunity to put forward evidence to demonstrate they are currently working to a band 3 job description. Since the launch **1,661 (77.5%)** existing band 2 staff have demonstrated they are undertaking clinical duties and have been aligned to a band 3 role. The MOC has now concluded. **483 (22.5%)** staff who were eligible to undergo a skills assessment will remain in band 2 positions. These staff have been given the opportunity to upskill and move into band 3 roles in the future.

1.17 The bi-annual ward Safer Nursing Care Tool (SNCT) census collections were undertaken in March and November 2022. The results have provided assurance that **90%** of ward establishments are aligned to the SNCT recommended establishment. This is an improved picture (**6%**) from the census results taken prior to the pandemic and reflect the investment in nursing posts in areas that were found to fall under the recommended safe staffing threshold.

1.18 Following the November 2022 census collection 13 clinical areas were shown to have a funded establishment 10% or more below the SNCT recommenced establishment. 8 of these areas were also highlighted as falling below the recommended funded establishment following the March 2022 census. The Directors of Nursing are reviewing these findings and taken action to align the establishment sin these areas with the recommendations. It should be noted that post pandemic the patient acuity has increased in these areas which indicates a requirement for an increased establishment.

1.19 NICE guidance for safe midwifery staffing for maternity settings recommends a systematic process is undertaken to calculate the midwifery staffing establishment. Birthrate plus is a toolkit which is endorsed by NICE and the Royal College of Midwives

as the recommended methodology for Midwifery workforce planning. A review of the workforce across Greater Manchester was commissioned by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS). SM MCS received the report in April 2023 and are considering the recommendations to inform the workforce model at each site. A detailed report will be provided to the Board of Directors once this has been finalised.

1.20 Further to the CQC inspection where concerns were raised about skill mix and safe staffing, there is in place a compliance programme of which workforce and safe staffing is an integral workstream. Progress on these workstreams will be managed through the SMH PMO. The service will be taking actions to ensure sufficient numbers of skilled and experienced midwifery staff appropriately assess and care for women and mitigate risks in a timely manner.

1.21 A summary of the workforce positions and safer staff assurance for the Hospitals/MCS/LCOs in included (Appendices).

1.22 The Board of Directors are asked to receive this paper and note progress of work undertaken to support the Trusts workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.

1. Introduction

1.1 The bi-annual, comprehensive safer staffing report is provided to the Board of Directors outlining the Nursing, Midwifery and Allied Health Professions staffing capacity and compliance. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)[10], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[11], published in October 2018.

1.2 It is a national requirement for the Board of Directors to receive this report bi-annually on staffing to comply with the CQC fundamental standards as outlined in the well-led framework. The previous Nursing, Midwifery and AHP Safer Staffing Report was received by the Board of Directors in November 2022.

1.3 Registered nursing and midwifery staffing levels are positively associated with quality and outcomes measures including, mortality, patient, and staff experience[12]. For safe and effective staffing, the health and care service must have the right numbers, with the right skills, in the right place and at the right time[13]. This is pertinent in the wake of the COVID-19 pandemic as the Trust emerges with a focus on restoration and recovery of services whilst implementing an ambitious digital transformation requiring an effective and efficient workforce.

1.4 This report provides analysis of the Trust's Nursing, Midwifery and AHP workforce position at the end of March 2023. The Hospitals and Managed Clinical Services (MCS) present their workforce positions and plans in quarterly board reports to their Hospital/MCS Board. A summary of these reports is included in this report (Appendices).

2. National Context

Nursing and Midwifery

2.1 Data published by NHS Digital in March 2023 shows a national vacancy rate of 10.8% at 31st December 2022 within the registered nursing staff group (equivalent to 43,619 vacancies). This is an increase of 0.6% or approximately 4000 vacancies over the past year.

2.2 The contribution of the NHS workforce is key to the success of the national restoration and recovery plans. The Government manifesto in 2019 committed to increasing the number of registered nurses in England with a target of 50,000 more nurses by 2024[14].

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[10] National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe sustainable and productive staffing
[11] NHS Improvement (2018) Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing
[12] Ball JE and Griffiths P (2021) Consensus Development Project (CDP): An overview of staffing for safe and effective nursing care. Nursing Open. Vol. 9, No. 2, pp872-879.
[13] Royal College of Nursing (2017) Safe and effective staffing: nursing against the odds
[14] Department of Health (2022) 50,000 nurses programme: delivery update

The programme is currently on target to deliver at least an additional 50,000 nurses by March 2024.

2.3 International recruitment continues to feature as a significant part of the workforce supply strategy within NHS organisations in line with the NHS People Plan. Between February 2022 and January 2023, a total of 21,060 nurses were recruited nationally and 3,034 recruited within the Northwest region[15].

2.4 The NMC Register Mid-Year Data Report identified a net increase of 13,144 (1.7%) nurses, midwives, and nursing associates registered in September 2022 compared with April 2022[16]. The NMC report highlights a significant factor for the rise in registrants is the contribution of internationally trained professionals who account for 82% of new registrants in England during this period.

2.5 The number of midwives registered with the NMC has increased by 1.7% from 40,165 in April 2022 to 40,855 in September 2022 and there continues to be a gradual increase in the number of first-time registered midwives.

2.6 In December 2022, it was reported that over 54,297 nurses had joined the NHS in England during the previous year. However, there remains a significant workforce challenge with 49,507 nurses leaving active service during the same period. This is substantially more than during the previous five years and has led to the national leavers rate rising to 11.5%. The largest increase in numbers leaving was seen among the younger nurses, two thirds of leavers were under 45 years of age[17].

2.7 Whilst the number of registered nurses has risen, the number of nurse vacancies in England has remained static. NHS England reported a vacancy rate of 10.8%, equivalent to 43,619 vacancies at the end of December 2022[18]. This trend results from workforce supply not keeping pace with growth in nurse establishment with providers reporting this growth is in line with increased patient acuity and service redesign in response to new targets and recovery programmes post the covid-19 pandemic[19]. The number of leavers to the NHS in the last quarter has exacerbated this.

2.8 Retention of staff is complex with factors often outside of the control of the workplace. In many cases reason for leaving is not reported. Nationally, the most common reasons provided for leaving the NHS in all roles are retirement followed by work-life balance[20]. In quarter one and two of 2022 there were 129,990 leavers in the NHS in comparison to 229,620 across the whole of 2021[21], if current trends do not reduce in the coming months, the number of leavers in 2022 will have surpassed 250,000 for the first time since workforce statistics of this nature were collated. Understanding the complex

[15] NHS England (2020) NHS people plan
[16] The Nursing and Midwifery Council (2022) The NMC register mid-year update
[17] NHS Digital (2022) NHS vacancy statistics England April 2015 - December 2022 experimental statistics
[18] NHS Digital (2022) NHS vacancy statistics England April 2015 - December 2022 experimental statistics
[19] Kings Fund (2022) Is the NHS on track to recruit 50,000 more nurses?
[20] Nuffield Trust (2022) Peak leaving? A spotlight on nurse leaver rates in the UK
[21] NHS Digital (2023) Reasons for leaving, staff movements by organisation and group

factors involved in staff leaving is essential in supporting staff retention and reducing vacancy rates.

2.9 Based on the current evidence, NHSE are focusing on two important principles[22] which support the retention of nurses and midwives; with a commitment to improving staff retention by at least 2% by 2025, the equivalent of 12,400 additional nurses[23]. These are targeted interventions for different career stages and acknowledgment that high impact actions are more effective than single actions which will inform organisational actions.

2.10 The NHSE Nursing and Midwifery retention self-assessment tool enables organisations to undertake a self- assessment against the high impact interventions which include flexible working and retirement options, benefits and rewards, developing a menopause strategy, implementation of the national preceptorship framework and legacy mentoring schemes. This will then inform local evidence-based retention improvement plans.

2.11 NHSE launched the National Preceptorship Framework for Nursing[24] in October 2022 outlining a national framework of support newly registered nurses to transition from student to registrant. Work is being currently undertaken in relation to midwifery and AHP preceptorship frameworks to ensure midwives and AHP's receive high quality preceptorship and foundation support as they transition to employment.

Allied Health Professionals

2.12 The findings from the Health Care Professional Council (HCPC) report "Retention rates of first time HCPC registrants"[25], published in January 2023, were initially analysed to inform the ongoing work in relation to preceptorship. Further analysis found that, whilst just under 94 % of new HCPC registrants remain registered for at four years, 5.75% (equivalent to 1 in 18) of all new AHP registrants deregistered within four years with deregistration rates varying between the AHP professions. This has wider implications for employers, higher education institutions and other stakeholders and needs to be considered as part of the wider workforce planning and retention context.

2.13 The NHS Long Term Plan recognised that paramedics, podiatrists, radiographers, and speech and language therapists were in short supply and whilst work is ongoing there continues to be shortages in these and several other AHP groups including prosthetics and orthotics, orthoptics, and operating department practitioners (ODPs)[26].

2.14 In November 2022, 102,503 registered AHPs were working in the NHS in England which was an increase of 2200 (2.1%) AHPs from the previous year[27]. Speech and Language therapy seen the largest increase in staff of 22.8%. The only professional

[22] NHS England (2023) Looking After Our People - Retention
[23] NHS England (2023) NHS Long Term Plan
[24] NHS England (2022) National preceptorship programme
[25] HCPC (2023) The HCPC publishes analysis of retention rates among its health and care professionals
[26] Health Education England (2021) AHP careers awareness strategy 2021-22
[27] NHS Digital (2022) NHS Vacancy Statistics England

groups not to have experienced an increase in staff are Dietetics 4.3% decrease, Physiotherapy 0.5% decrease and Osteopathy 2.0% decrease.

3. Undergraduate Nursing, Midwifery and AHP Pre-Registration Education Pipeline

1.1 The University and Colleges Admission Services (UCAS)[1] January deadline data reports a reduction in numbers of people applying for places on nursing and midwifery programmes commencing academic year 2023/24, with nursing reporting a 20% reduction compared to 2022 although there is a slight increase of 1% from international students. Midwifery applications to date show a 24.5% reduction in applications compared to January 2022. Applications for undergraduate programmes are still open and more updated data will be available in June 2023. HEIs have suggested the current number of applications is more in line with pre pandemic levels.

1.2 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Predicted recruitment numbers for academic year 2023/24 at GM HEI's show an increase in adult nursing **(11.7%),** midwifery **(12%)** and a **50%** increase in Direct Entry student Nursing Associates. Overall, AHP pre-registration programme recruitment is predicting slight increases in Physiotherapy and podiatry. Occupational Therapy will increase with two new programmes starting at MMU and UoB September in September 2023. Other programme recruitment remains stable but there does appear to be a reduction in recruitment to Psychology programmes.

1.3 A MFT Learning Strategy is being developed to provide a framework and programmes of work together to support the NMAHP pre-registration and post-registration education agenda. The focus will be to ensure MFT is seen as a first post destination for newly qualified NMAHP workforce.

4. MFT Workforce Position

Nursing and Midwifery Vacancies

4.1 For the last six months there has continued to be improvements in the accuracy of our financial ledger system. This is the result of ESR and financial data cleanse and the introduction of the new finance reporting system Anaplan.

4.2 The Trust workforce position has continued to improve over the last 6 months. Both domestic and international recruitment programmes have resulted in **888.0wte** registered nurses and midwifes joining the organisation. The Trust has benefited from an average monthly nursing and midwifery starters rate of **126.9wte** since September 2022. The total number of nurses and midwives joining the Trust in 2022/23 is **1395.3wte.**

4.3 This improved workforce position, is supported by the number of internationally recruited nurses and midwives recruited via the well-established overseas recruitment

[1] UCAS (2022) 2022 Cycle applicant figures

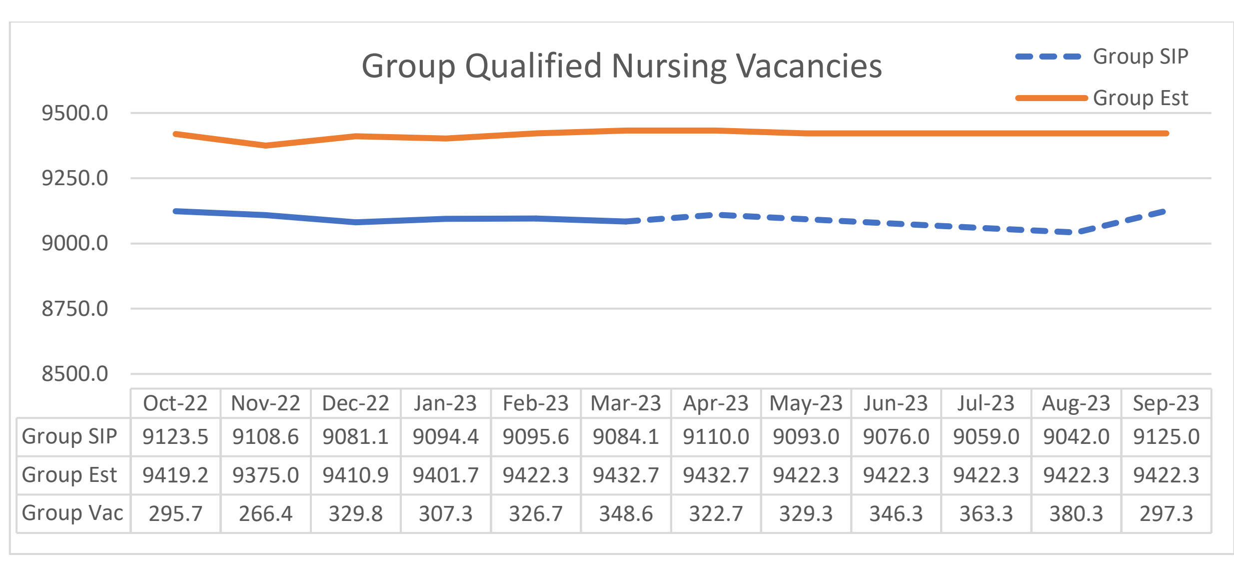
campaign. The total number of international nurses and midwives joining the Trust in 2022/23 is **522wte.**

4.4 At the end of March 2023 there were a total of **348.6wte (3.7%)** registered nursing and midwifery vacancies across the Trust which remains static with the September 2022 vacancy position and a small increase of 0.1%. However, during this time the nursing workforce has grown more than this movement suggests. Recruitment has kept pace with turnover and increases in funded establishment (47.1wte) demonstrating an overall improving picture that is expected to continue throughout 2023 due to the numbers in the domestic and the international recruitment pipeline.

4.5 The Trust's overall nursing and midwifery vacancy rate **(3.7%)** is much lower than the national vacancy rate of **10.8%** and the Northwest vacancy rate of **7.3%**[28]. On-going work within each hospital/MCS to align the ledger to establishments is being led by the Directors of Nursing/Midwifery and Directors of Finance to continue to ensure the accuracy of the workforce data in relation to vacancies.

4.6 Applying the workforce assumptions above and reducing the reliance on international recruitment (annual funded recruitment plan reduced to 360 nurses per year) recent workforce modelling predicts we will likely start to see an increase in vacancies in the next six months, potentially by August 2023 vacancies will have increased to **380.3wte (4%)** (**Graph 1**). A large proportion of these predicted vacancies will be at band 5, **258.1wte (5.2%).** We anticipate from September 2023 to see renewed reductions to vacancies when our large intakes of students finish their courses and start in the trust.

Graph 1



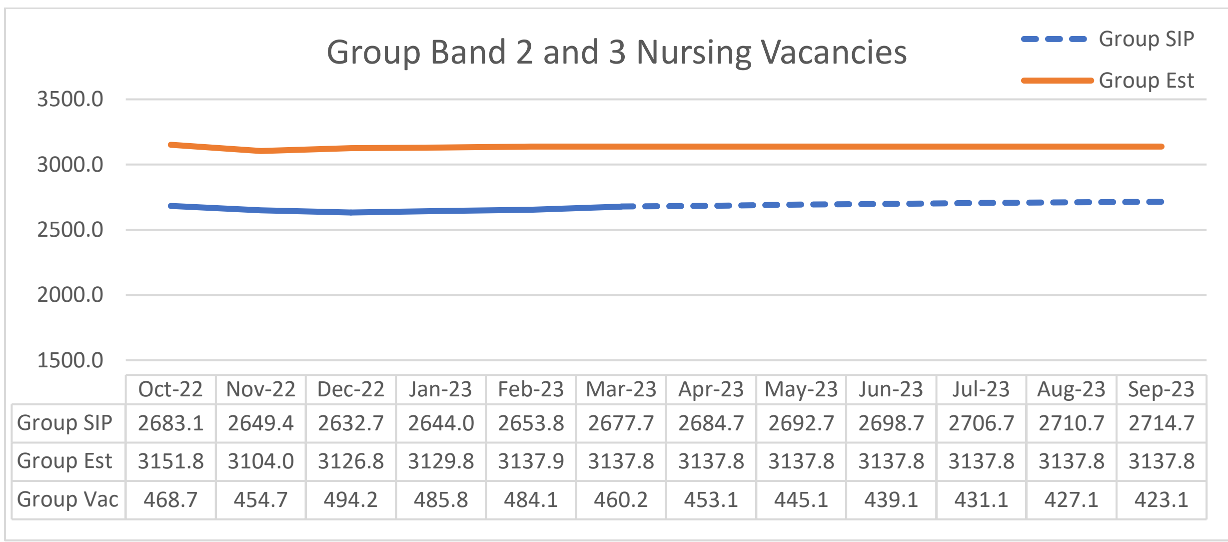
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Group SIP	9123.5	9108.6	9081.1	9094.4	9095.6	9084.1	9110.0	9093.0	9076.0	9059.0	9042.0	9125.0
Group Est	9419.2	9375.0	9410.9	9401.7	9422.3	9432.7	9432.7	9422.3	9422.3	9422.3	9422.3	9422.3
Group Vac	295.7	266.4	329.8	307.3	326.7	348.6	322.7	329.3	346.3	363.3	380.3	297.3

4.7 At end of March 2023, band 2 and band 3 vacancies totalled **460.2wte (14.7%).** During this period there has been an increase in starters however the continued leaver rates have slowed the impact to our vacancy position. It is anticipated now that the band 2 management of change process has drawn to a conclusion and the opportunity for staff

[28] NHS Digital (2023) NHS Vacancy Statistics England

to progress to a band 3 position, we predict a reduction in leaver rates and estimate a reduction in vacancies over the next 6 month.There has been initial evidence of this trend since December 2022 (**see Graph 2**).

Graph 2



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Group SIP	2683.1	2649.4	2632.7	2644.0	2653.8	2677.7	2684.7	2692.7	2698.7	2706.7	2710.7	2714.7
Group Est	3151.8	3104.0	3126.8	3129.8	3137.9	3137.8	3137.8	3137.8	3137.8	3137.8	3137.8	3137.8
Group Vac	468.7	454.7	494.2	485.8	484.1	460.2	453.1	445.1	439.1	431.1	427.1	423.1

Nursing and Midwifery Turnover

4.8 At the end of March 2023, the 12-month rolling turnover rate for registered nurses and midwives was **13.1%**, this is an increase since September 2022 when the rate was **12.4%.** The trust turnover rate is lower than the current national turnover rate for nursing and midwives in acute NHS trusts which is **14.7%.**[29]

Nursing and Midwifery Sickness Absence

4.9 Sickness rates had continued to reduce from **10.2%** for registered nursing and midwifery staff and **14.0%** for unregistered staff in Q3. At the end of March 2023, rates reduced to **6.4%** and **9.6%** for unregistered staff.

4.10 On review of the reasons recorded for sickness absence, for both registered and unregistered nursing and midwifery staff, throughout the last six months the primary reason has remained as anxiety/stress accounting for **24.46%** of registered absences and **29.85%** of unregistered absences.

4.11 Targeted initiatives to support hot spot clinical areas to reduce sickness absence by 2% identified in the annual workforce plan. These include improved utilisation of Absence Manager, additional training, HR and EHW case conference discussions for long term sickness and absence prevention focusing on wellbeing of staff.

5. Nursing and Midwifery Recruitment

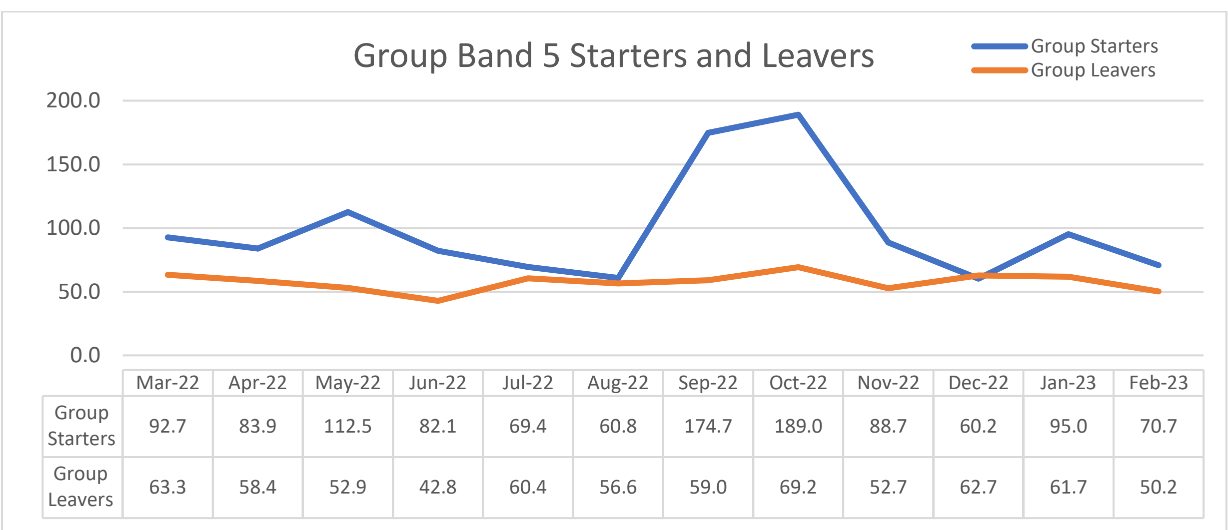
[29] NHS Digital (2023) NHS vacancy statistics England

Domestic Recruitment

5.1 There are currently **110** domestic nurses and midwives in the recruitment pipeline expected to start before the end of June 2023. This number will increase in Q3 when the Trust sees the largest number of graduate nurses, midwives and AHP staters.

5.2 Currently an average of **87.5wte** band 5 starters per month are required to maintain our current registered vacancy position, this considers the current number of leavers **57.5wte** per month on average and the staff moving into senior roles through internal recruitment throughout the year. The below graph shows how band 5 nursing and midwifery and starters have joined and leavers have left the trust in the last 12 months **(Graph 3).**

Graph 3



	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Group Starters	92.7	83.9	112.5	82.1	69.4	60.8	174.7	189.0	88.7	60.2	95.0	70.7
Group Leavers	63.3	58.4	52.9	42.8	60.4	56.6	59.0	69.2	52.7	62.7	61.7	50.2

5.3 In the last twelve months we have averaged **98.6wte** band 5 starters per month. Whilst the nursing and midwifery vacancy position across the trust remains low the dependency on international recruitment will reduce to 30 international nurses arriving each month from April 2023. The Trust will need to increase the annual domestic pipeline by at least **150wte** nurses to maintain the current vacancy position. This assumption is based on an improved/static turnover position. A domestic resourcing strategy is being developed to deliver targeted recruitment events focusing on increasing the domestic pipeline.

5.4 The trust is currently averaging **64.3wte** nursing assistant starters, on average **40.8wte** staff members leave the organisation each month. It is recognised our current number of starters needs to be increased if we are to reduce our vacancy position, however it should also be noticed if we successfully see a reduction in turnover due to the completion of management of change process and band 3 progression referenced in section 4.8, the current starter numbers will be sufficient to decrease the vacancy position. Opportunities for hospital/MCS led recruitment events are ongoing and scheduled throughout the year supported by corporate led events promoting the new workforce model and increase the pipeline.

International Recruitment

5.5 The international recruitment (IR) programme continues to be a strong and reliable pipeline for band 5 nurse recruitment. The total number of international nurses and midwives joining the Trust in 2022/23 is **522wte.** There are 180 international nurses due to arrive in the first half of 2023/24. The number of international recruited nurses planned for 2023/24 is 360wte.

5.6 To support recovery and restoration plans the Trust has been promoting theatre roles and offers theatre training and development opportunities for internationally recruited nurses without previous theatre experience. This approach has seen **24** theatre nurses recruited and deployed since September 2022.

5.7 The Trust has been successful in implementing an international recruitment programme for midwives as part of a NW regional collaboration working in partnership with NHSE and the GM Maternity Network. The first cohort of midwives joined MFT in November 2022 with a total of **10** midwives recruited so far. An additional **10** midwives are expected to arrive before the end of December 2023.

5.8 Since the Trust joined the regional collaborative programme of international AHP recruitment which was launched by NHSE in June 2022 a total of **10** diagnostic radiographers have been recruited. Work is underway to recruit **10** occupational therapists in the next 6 months through the collaborative. The first occupational therapist arrivals are due at the end of April 2023.

Nursing Associate Workforce

5.9 There has been a total of **345** nursing associates complete their programme in MFT since January 2017. Several nursing associates have gone onto complete further qualifications and there are **40** now working or being recruited into band 5 positions in MFT. Currently, there are **186** registered nursing associates working across the hospitals, community settings and theatre areas. In addition, there are **138** trainee nursing associates (TNA) across the trust undertaking their training through the apprenticeship in addition to the self-funded route.

Nursing Assistants and Maternity Support Workers

5.10 Launched in May 2022, the band 2/3 NA and MSW management of change (MOC) process was undertaken to determine the number of band 2 clinical support staff who were undertaking clinical duties and working in roles aligned to agenda for change band 3. Staff were given the opportunity to put forward evidence to demonstrate they are currently working to a band 3 job description. Since the launch **1,661 (77.5%)** existing band 2 staff have demonstrated they are undertaking clinical duties and have been aligned to a band 3 role. The MOC has now concluded. **483 (22.5%)** staff who were eligible to undergo a skills assessment will remain in band 2 positions. These staff have been given the opportunity to upskill and move into band 3 roles in the future.

5.11 The Trusts Clinical Support Worker Development Programme for Nursing Assistants (NA) and Midwifery Support Workers (MSW) was launched in June 2022. The programme focuses on the fundamentals of care and clinical skills competency training and assessment. Staff new to the Trust are required to attend the programme before transitioning to a band 3 post. There are **667** active learners on the programme.

Allied Health Professions Workforce

5.12 At the end of March 2023, the AHP vacancy position was **43.5wte (2.7%)** this excludes ODPs as this profession is included in the nursing theatre workforce data.

5.13 The turnover rate for registered AHPs was **8.9%** in March 2023. Sickness absence rates for registered AHPs in March 2023 was **4.7%.** This is a decrease from sickness in September 2022 when the rate was **5.2%.**

5.14 A programme of work has been established to review and develop opportunities for MFT AHP wide rotations. A mapping questionnaire to establish current rotations across acute sites, LCO, adults, children's and corporate workforce has provided discovery insight. Specific areas for exploration included a framework for consistent rotational offer & support, staff experience and rotation clusters. Rotation models are now being designed with consideration of HR and budget factors. Following model piloting, assuming beneficial, approval for delivery will be formalised following due process.

5.15 As part of ongoing actions to promote AHP careers, AHP apprenticeship provision has grown, with **11** occupational therapy, **2** physiotherapy and **2** podiatry apprentices recruited across CSS and the LCO attending Sheffield Hallam University and the University of Salford. Scoping work is in the early stages with regards speech and language therapy and dietetics apprenticeship provision.

5.16 Work continues to refine the AHP staffing dashboard to ensure data reporting is reflective of the current workforce. In collaboration with the Chief AHP, planned work on standardising position titles across the professions has commenced. An update will be provided in the next Board of Directors paper.

5.17 There is national and regional work being undertaken in relation to the operating department practitioner (ODP) role, understanding career pathways and development opportunities for ODPs and in relation to attraction into pre-registration programmes. this work is being progressed through the trust Theatre Workforce Group. HEE and the College of ODPs have commissioned a national benchmarking survey in relation to ODP practice education within the profession. This work will transition into existing work upskilling the theatre workforce to meet service recovery plans and increased activity

AHP Domestic Recruitment Initiatives

5.18 The AHP Steering Group, in partnership with the widening participation team, identified the need to establish and grow AHP career ambassadors to promote the opportunities of becoming a registered AHP at MFT. There are now 38 AHP career ambassadors across the organisation who have volunteered 81.5 hours of time during 2022/2023.

Data is being collected to identify the number of students who then go onto study for a AHP profession.

5.19 Two career fairs were held in 2022/23 aiming to attract and booster the domestic pipeline from our local communities. The interactive events hosted 60 school pupils from local secondary schools and resulted in supporting a further 20 students on work experience with AHP staff across the Trust.

5.20 Occupational therapy is listed as a profession on the government's shortage occupational list. At the Trust, as seen nationally, the OT profession has one of highest vacancy rates across the AHP professions. To support bolstering the competitive domestic pipeline several initiatives have occurred, including:

- A successful targeted marketing campaign and recruitment strategy using the Trust's 'all her for you,' which resulted in a fivefold increase in suitable occupational therapist (OT) applicants and successful recruitment of four candidates
- Trust attendance at the University of Salford University's recruitment fair for final year OT students, showcasing the opportunities within the Trust, and facilitated direct recruitment of five new graduates
- Appointing 11 individuals to the newly created OT apprenticeship programme

6. Safe Staffing

6.1 Recommendations set out in the Developing Workforce Safeguards Report[30] focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing[31]. The guidance states organisations must demonstrate compliance with the key principles of safe staffing, supporting a triangulated approach combining evidence-based tools such as Safer Nursing Care Tool (SNCT)[32] and Birth-Rate Plus (BR+)[33], data, professional judgement and outcomes that are based on patient needs, acuity, dependency, and risks.

6.2 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.

6.3 The daily operational staff review process informs identification of the staffing escalation position and the identification of any red flag staffing events[34].

[30] NHS Improvement (2018) Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing
[31] NHS England (2018) Developing workforce safeguards
[32] The Shelford Group (2019) Safer Nursing Care Tool
[33] Birthrate Plus 1996 - 2022
[34] NICE (2014) Safe Staffing for nursing in adult inpatient wards in acute hospitals

6.4 Annual ward accreditation is established as routine to support patient safety, quality and patient and staff experience recognising good practice and supporting learning and improvement initiatives. The accreditation assessment follows the CQC key lines of enquiry with safe staffing, patients' safety and leadership falling under the well led domain. This provides rich data to triangulate with safe staffing indicators. Over 200 accreditations were undertaken in the last 12 months with **44** wards/areas achieving Gold accreditation, **98** areas achieving Silver, **53** areas achieving Bronze and **3** areas currently achieving White waiting a reaccreditation. Triangulating the accreditation outcome with the workforce indicators shows no correlation as nursing vacancies in these areas are between **0 - 5%.**

6.5 The implementation of HIVE, in September 2022, and it's associated reporting capability is an innovative tool which will add to our ability to analyse nurse sensitive indicators, in relation to patient harms, to mitigate risks and ensure safe staffing levels.

6.6 The Trust is required to submit a monthly Safe Staffing Unify Report to NHSI detailing actual registered nurse and midwifery staffing levels as a percentage against those that were planned. The average fill rate against planned shifts in March 2023 was 91.6% for registered nurses and 92.53% for unregistered staff**.** In comparison, the fill rate in September 2022 was 89.5% and 90.96% respectively when sickness absence rates were higher.

6.7 Temporary staffing has continued to be utilised to support staffing levels throughout the Trust. Weekly NHS Professionals (NHSP) temporary staffing huddles ensure maximisation of engagement between Hospital/MCS/LCOs and NHSP. Opportunities to maximise our temporary staffing bank fill remains the priority with NHSP. The average fill rate for registered nurses and midwives is 55.1% in the last quarter, and 75.6% for unregistered staff. The Trust has worked closely with NHSP over the last 2 years to reduce the reliance on agency staff and high premium rates. The agency usage for nursing and midwifery has fallen below 2% for the last 12 months.

Daily Staffing

6.8 The Trust's Hospital/MCS daily staffing levels are assessed across each shift to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. The daily staffing level of staffing requirements including bed occupancy, planned staffing and staffing attendance are undertaken by senior nursing and midwifery staff at their daily 'staffing huddles' within each hospital/MCS.

6.9 The Allocate SafeCare Tool is utilised in real time within the staffing huddles to match ward staffing levels with patient acuity, providing control and assurance from bedside to board. During the staffing huddle, safe staffing levels are discussed and, utilising professional judgement, resources are managed based upon patients' acuity and dependency, quality and safety indicators and issues that may affect patient safety and experiences. When staffing escalation and risk levels are found to be greater than level 3 the Directors of Nursing will come together to review the staffing risks across the trust and explore opportunities for mutual aid to areas with unresolved staffing challenges.

6.10 In addition to the above pro-active tools which are used throughout the organisation, the trust has established a staffing red flag system through the incident reporting process. Managed through the trusts incident system Ulysses, incidents are automatically escalated to hospital/MCS senior leadership team when staffing levels fall below a minimum level resulting in delays in care has been logged.

6.11 Staffing red flag incident reporting has increased in the last six months which is reflective of the drive to increase awareness of their function, below provides an overview of staffing incidents in the last months and their actual impact level (Table 1). 95% of recorded incidents in the last 6 months have resulted in delays in care.

Table 1

Incident Actual Impact	Incidents Period April 2022 – September 2022	Incident Period October 2022 – March 2023
Level 1	1148	1270
Level 2	242	186
Level 3	0	0
Level 4	0	0
Overall	1398	1456

6.12 In order to ensure safe staffing across the trust in response to an increase in staff absence rates during the winter period 2022 and with the recent industrial action; a command-and-control approach has been taken, with senior representation to escalate, respond and provide assurance in relation to patient safety and safe staffing.

Safer Nursing Care Tool (SNCT)

6.13 The SNCT is an evidence-based tool[35] and methodology used to calculate the recommended staffing establishments across inpatient wards and incorporates a staffing multiplier to ensure nursing establishments reflect patient needs in terms of acuity and dependency.

6.14 Two ward census collections will be undertaken in 2023/24 as part of the annual SNCT census cycle. This will also enable a more targeted approach to be taken to those ward areas previously showing as not within their funded establishments.

6.15 The next ward SNCT census is scheduled for June 2023. This census will provide a clear depiction of the progressive impact of implementing HIVE that offers a robust system with a positive contribution to safeguards, quality improvements and opportunities for the triangulation of data and professional judgement to support evidenced-based decision making, thus supporting the principles of safer staffing, and achieving optimal nurse staffing levels.

[35] Shelford Group (2019) Safer Nursing Care Tool

6.16 The Emergency Department Safer Nursing Care Tool (ED SNCT)[36] has been developed by NHSE to support NHS organisations measure patient acuity and/or dependency, applying evidence-based methodology and decision making on setting nursing establishments across both adult and paediatric ED areas. The ED SNCT census is scheduled to be undertaken in each ED during May and June 2023.

6.17 The Community Nursing Safer Staffing tool (CNSST) has been introduced as a GM Workforce collaborative and the first census collection undertaken in March 2023. The CNSST sets out safety standards for district nursing workforce and will provide a recommended nursing workforce model for each district nursing team based on patient acuity and caseload.

SNCT Analysis

6.18 The bi-annual ward SNCT census collections were undertaken in March and November 2022. The results have provided assurance that **90%** of ward establishments are aligned to the SNCT recommended establishment. This is an improved picture (6%) from the census results taken prior to the pandemic and reflect the investment in nursing posts in areas that were found to fall under the recommended safe staffing threshold.

6.19 Following the November 2022 census collection 13 clinical areas were shown to have a funded establishment 10% or more below the SNCT recommenced establishment. 8 of these areas (highlighted) were also highlighted as falling below the recommended funded establishment following the March 2022 census. It should be noted that post pandemic the patient acuity has increased in these areas which indicates a requirement for an increased establishment.

6.20 The Directors of Nursing have reviewed the SNCT recommendation for these wards triangulating nurse sensitive indicators; patient safety (harms) and quality (ward accreditation, complaints, and patient feedback) with existing staffing levels. The outcome from this review has revealed an increase in 1 or more indicators and as such supports the SNCT census outcomes. Table 2 describes the actions taken following this review.

Table 2

Hospital	Ward	Funded Establishment Pre-SNCT WTE	SNCT Recommended Establishment WTE	Action
MRI	AMU & Ward 6	124.9	146.4	Ward 6 to revert to a medical ward and as such AMU staffing establishment will be adequate for the acuity of patient group
NMGH	C3	24.4	27.4	Business case in development to support service reconfiguration – establishment based on legacy surgical model now medical ward

[36] Shelford Group (2021) Launch of the ED SNCT tool

NMGH	C4	19.4	27.5	Business case in development to support service reconfiguration – establishment based on legacy surgical model now medical ward
RMCH	Ward 85	46.5	52.6	Bed reconfiguration and change to ward speciality Census to be repeated in June 2023 to validate result
WTWA	Ward 11	33.9	42.3	Establishment increased to 44wte
WTWA	Ward 2	36.5	44.4	Establishment increased to 45wte
WTWA	F12	37.3	47.4	Census to be repeated in June 2023 to validate result
WTWA	A2	33.8	46.0	Change to patient cohort and acuity since last SNCT June census will provide new baseline
WTWA	A1	34.3	46.0	Respiratory Division - Funded establishment does not reflect the increase in acuity number of patients requiring NIV post Covid – business case is being finalised to support the uplift in establishment See A1
WTWA	A3	35.5	41.3	
WTWA	A7	36.4	41.8	Number of patients requiring enhanced observation of care has increased across both areas. Skill mix review underway across the Division with plan to reallocate establishment to A7 and F14 from areas that have a funded establishment above SNCT recommendation
WTWA	F14	34.6	41.5	
WTWA	Doyle & Wilson	49.3	60.8	Inpatient bed base increased during winter pressures and at time of last census. SMT considering a reduction of in-patient beds post winter. Additional staff provided through NHSP bank

Safe Staffing in Maternity Services - Birthrate Plus

6.21 NICE guidance for safe midwifery staffing for maternity settings recommends a systematic process is undertaken to calculate the midwifery staffing establishment. Birthrate plus is a toolkit which is endorsed by NICE and the Royal College of Midwives as the recommended methodology for Midwifery workforce planning. A review of the workforce across Greater Manchester was commissioned by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS). SM MCS received the report in April 2023 and are considering the recommendations to inform the workforce model at each site. A detailed report will be provided to the Board of Directors once this has been finalised.

6.22 Further to the CQC inspection where concerns were raised about skill mix and safe staffing, there is in place a compliance programme of which workforce and safe staffing is an integral workstream. Progress on these workstreams will be managed through the SMH PMO. The service will be taking actions to ensure sufficient numbers of skilled and experienced midwifery staff appropriately assess and care for women and mitigate risks in a timely manner.

6.23 SM have received notification that the services at East Cheshire are aimed to be reinstated from June 2023. SM MCS will continue monitor the impact this has on both activity and staffing requirements on the Wythenshawe site.

6.24 The implementation of the Better Births agenda in relation to the Continuity of Care (MCoC) workstreams was challenged in the final Ockenden Report. As noted previously reporting targets were removed in September 2022 which was subsequently confirmed in the Maternity Incentive Scheme Year 4 update in

October 2022. As such risk assessments which considered safe maternity staffing are undertaken by SM MCS every 3 months to review the continuity teams. Following risk assessment, 6 of the 7 MCoC team have been paused. SM MCS anticipate the final team will also be paused in Q1 due to the continued challenges in recruiting to the workforce.

1.4 SM MCS acknowledges the benefits of continuity of MCoC for vulnerable women and will be using a modified approach to continue and enhance the Antenatal Continuity of Care for women from minority ethnic groups along with those women residing in the most deprived areas of the city. This work will then be the basis of the longer term offer for all women accessing care across the MCS. The major change in provision to ensure safety will be that SM MCS will not be following the NHSE model of including intrapartum care in the continuity of care core offer.

7. Workforce Retention Strategies

7.1 The NHS People Plan[37] highlights the importance of looking after our people to support and grow the future NHS workforce. The organisational Nursing and Midwifery retention plan has been developed in partnership with HR and builds on the outputs from the MFT People Plan, to support a vision that together we can make MFT a great place to work. The plan focuses on NHSEs targeted workforce retention actions which are most likely to have the greatest impact on job satisfaction and retention of nurses and midwives. These include flexible working and retirement options, benefits and rewards, developing a menopause strategy, implementation of the national preceptorship framework and legacy mentoring schemes[38].

7.2 The retention work plan is being monitored closely and reviewed considering new initiatives and data. Data will continue to be collected from various sources, for example the MFT 2022 Staff Survey results (published March 2023) which shows staff satisfaction in relation to morale (which includes intention to leave the organisation) and we work flexibly scoring similarly when compared to 2021 both with a 30% trust response rate. This will enable retention initiatives to be analysed and evaluated against retention data, looking at the benefits versus cost effectiveness.

7.3 In the last 12 months, the most common reasons given for staff leaving the organisation are work-life balance and relocation. These reasons are given by 51% of staff leaving. Of all staff leaving the Trust, 43% are within their first two years of service at the Trust.

7.4 The revised trust multi-professional preceptorship programme for newly qualified nurses, midwives and AHPs has been mapped against the national preceptorship framework[39]. The policy and communication plan for the launch in Spring 2023 are being finalised. The revised programme includes health and wellbeing and early career conversations. Next steps will include evaluating the programme and applying for the National Preceptorship Interim Quality Award. Retention data for newly qualified nurses, midwives and allied health professionals will be analysed over the next 12

[37] NHS England (2020) NHS People Plan
[38] NHS England (2023) Looking After Our People - Retention
[39] NHS England (2022) National Preceptorship Framework for Nursing

months to understand in greater detail their experience. This work links closely with the transition to practice agenda and attracting newly qualified nurses, midwives and AHPs to MFT as a first post destination.

7.5 Funding from NHSE will support the pilot of the legacy mentor role[40]. The legacy mentor role ensures the valuable experience of colleagues late in their career is not lost through retirement and provides coaching, mentoring and pastoral support to staff who are at the start of their careers or who are newly appointed into the NHS. With approximately a third of the NHS workforce currently near the end of their career, the role ensures that valuable experience of colleagues is not lost through retirement. This supports the retention of experienced staff and the health and well-being of staff at the beginning of their careers. The pilot will be evaluated with feedback provided at the next Board of Directors paper.

Continued Professional Development

7.6 In September 2020, the Trust launched a programme of work to support nursing, midwifery and AHPs continuing professional development (CPD) utilising the national funding model available for every nurse, midwife and AHP[41]. This funding has been extended for a fourth year. **65%** of eligible NMAHP workforce currently in post have accessed education that has been allocated CPD points. (This figure has been adjusted to account for new starters and leavers to the trust)

7.7 Programme development has included leadership, mentoring, upskilling, and workforce transformation training delivered by differing providers in various formats. The programmes support clinical speciality training and personal development ensuring staff have the knowledge and skills required to support and lead service recovery and growth within various settings.

7.8 Work is underway to ensure sustainability and continuous promotion of MFT CPD education and training. This will be addressed by the continued utilisation of MFTs Subject Matter Experts in sharing knowledge and skills and the showcasing of excellent practice via corporately led & local programmes of training and education. The Trust continues to develop, and quality assure CPD programmes, maximising the CPD investment and widening access to training programmes in the future.

7.9 All trust developed education programmes are in the process been transferred onto the Kallidus system allowing information & digital data to be available for regular reporting. Hive has been integrated into the content of education programmes. Next steps include how the reporting and information contained in Hive can be used to identify training needs and to develop programmes utilising this knowledge to support clinical teams.

[40] NHS England (2023) Legacy Mentoring
[41] HM Treasury (2019) career boost for almost half a million frontline NHS staff

Health and Wellbeing of NMAHP Workforce

7.10 The health and wellbeing of the NMAHP workforce remains a key priority with initiatives across each hospital/MCS to ensure staff are supported whilst at work and links with the trust nursing and midwifery retention strategy.

7.11 The Professional Nurse Advocate (PNA) programme was launched by the CNO in 2021 in response to the pandemic recovery to support the wellbeing of our nursing workforce. The PNA supports staff through restorative supervision with a recommended target of 1:20 PNA to registered nurse ratio by 2025[42].

7.12 To meet this ratio, and to ensure all registered nurses have access to a PNA, a minimum of **437** PNAs are required across the organisation. Currently **73** registered nurses have completed the PNA programme by March 2023, with a further **53** undertaking training. An additional **51** are awaiting a programme start date. The focus is on ensuring training places are prioritised to those hospitals/MCS with poor uptake of the role, for example MRI and WTWA, who both have **14%** of their required PNAs, compared to CSS with **70%.**

7.13 Data in relation to the number of restorative supervision sessions, career conversations and improvement projects supported by PNAs is reported monthly to NHSE. Themes raised from restorative clinical supervision is being collated, with feeling supported in role, staff movement and teamwork, burnout and wellbeing, support following clinical incidents and preceptorship/new starter being the top six. This feedback is now being triangulated with retention data to inform the trust nursing and midwifery retention strategy.

8. Safer Staffing Summary

8.1 Since the previous Board of Directors report, Hive EPR system has been implemented. This significant event has led to an extensive programme of training and offers opportunities for transformation of services and fundamentally 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.

8.2 The SNCT census in November 2022 has provided assurance that **90% (98/113)** of inpatient ward establishments are aligned to the recommended level when reviewed through an evidence-based approach. Actions take to resolve any staffing shortfall in the remaining 10% are described in table 2 (section 7.2). The census will be repeated in May 2023 and used to validate any changes to the staffing model in these areas. The 22/23 SNCT census results indicates that **18%** of inpatient wards have a funded establishment >10% above the recommended. The staffing model in these areas will continue to be reviewed by the Directors of Nursing however, it should be noted that the registered nursing skill mix in these areas has been reduced to create more unregistered/support posts. The primary reason in doing so is to create more unregistered

[42] NHS England (2021) Professional Nurse Advocate

staff to support the acuity of patients specifically patients with dementia requiring enhanced supervision.

8.3 The planned SNCT census and BR+ along with the introduction of SNCT ED and CNSST will provide timely insight into the current acuity and dependency levels and provide validation of establishments.

8.4 The overall nursing and midwifery workforce position has been maintained. The number of registered nursing and midwifery vacancies has remained static **3.7%** and sickness absence has reduced to **6.4%** for registered staff and **9.6%** for unregistered staff. This has supported an improvement in average fill rate against planned shifts for both registered **(91%)** and unregistered nurses **(93%)** since the last report. Temporary staffing managed by NHS Professionals supports staffing shortfalls with the average fill rate being **65%** for registered and **75%** for unregistered staff.

8.5 The staffing position has improved, however, there is an increase in turnover of nurses and midwives since the last report **(13.4%)** from a larger cohort of staff, highlighting the importance of implementing evidence-based retention strategies and maintaining both domestic and international recruitment pipelines**.** Hospitals and MSCs have implemented a range of retention initiatives to support health and wellbeing, staff development and enhance leadership (Appendix 1).

8.6 A range of domestic recruitment campaigns and a sustained, healthy international pipeline have both contributed to the increase of nursing staff in post despite the challenges of increasing funded establishment and turnover rates. This is in keeping with the national workforce trends, however MFT have not experienced a vast increase in vacancies.

8.7 The Trust has significantly increased pre-registration NMAHP placement opportunities for nursing, midwifery and AHP students and has been integral to the implementation of a tool to effectively manage the utilisation of learning environments.

8.8 There has been a continued focus on delivering CPD opportunities for nursing, midwifery and AHP staff, particularly to support recovery and restoration following the pandemic. Staff health and wellbeing remains important with progression of initiatives such as PNA and Health and Wellbeing Champion roles.

8.9 A summary of the workforce positions and safer staff assurance for the Hospitals/MCS/LCOs is provided (Appendix 1).

9. Conclusion

9.1 The Board of Directors are asked to receive this paper and note progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.

Appendix 1	Hospitals/ Managed Clinical Services/ Local Care Organisation NMAHP Workforce Report Summary

1. The Hospital/MCS Directors of Nursing are required to provide a quarterly nursing and midwifery workforce report to their hospital boards. A summary of these reports follows, together with an updated workforce position.

Table 1- Nursing and Midwifery workforce summary

Hospital / MCS	Registered N&M			Unregistered N&M		
	Vacancies WTE	Turnover	Sickness	Vacancies WTE	Turnover	Sickness
WTWA	45.2 (2.4%)	13.1%	6.5%	118.8 (12.9%)	22.7%	12.0%
MRI	20.7 (1.3%)	11.2%	6.7%	136.8 (16.9%)	16.9%	11.6%
NMGH	31.4 (3.9%)	14.6%	6.5%	70.2 (14.8%)	17.0%	6.5%
RMCH	0	11.1%	5.9%	40.2 (15.9%)	18.5%	9.1%
MREH	0	7.1%	8.3%	5.7 (10.5%)	19.1%	12.0%
CSS	3.8 (0.4%)	11.4%	5.5%	11.3 (13.6%)	12.5%	9.1%
SMH Maternity	45.9 (6.2%)	14.3%	7.0%	21.6 (12.6%)	17.3%	8.0%
SMH Nursing	57.7(8.9%)	16.5%	6.7%	22.8 (26.0%)	17.3%	8.2%
MLCO/TLCO	143.9 (13.3%)	16.4%	6.6%	57.5 (20.4%)	15.7%	7.6%

Table 2 AHP workforce summary

Hospital / MCS	Allied Health Professionals		
	Vacancies WTE	Turnover	Sickness
WTWA	4.0 (7.7%)	13.1%	5.1%
MRI	0	0.0%	2.3%
NMGH	0	0.0%	7.3%
RMCH	0	18.9%	6.0%
MREH	1.1 (5.8%)	6.4%	1.4%
CSS	29.2 (3.1%)	5.9%	4.7%
SMH	0	0.0%	13.1%
MLCO / TLCO	9.2 (1.9%	14.1%	4.2%

2. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

WTWA Workforce Position

2.1 At the end of March 2023, there were a total of **45.2wte (2.4%)** registered nursing vacancies across WTWA compared to **50.1wte (2.6%)** in September 2022. This is a decrease of **4.9wte (0.3%)** nursing vacancies.

2.2 WTWA have welcomed **186.0wte** newly recruited nurses since September 2022. Namely due to domestic recruitment events and opportunities successfully recruiting **108.0wte** nurses. In addition to this **78.0wte** international nurses were also recruited.

2.3 The 12-month rolling turnover at the end of March 2023 for all registered staff at WTWA was **13.1%** and **14.8%** for band 5 staff. This has increased by **1.3%** and **0.8%** respectively since September 2022.

2.4 There are currently **69** Band 5 domestic nurses in the pipeline, including **33** experienced nurses and **36** student nurses. Additionally, there are **5** Trainee Nursing Associates who have been allocated posts.

2.5 In March 2023, there were a total of **118.8wte (12.9%)** nursing assistant vacancies across WTWA compared to **186.8wte (20.1%)** in September 2022. The 12-month rolling turnover for Band 2 unregistered was **22.7%** in March 2023 which has been a static position throughout the 12 months**.** WTWA continue to have the highest level of turnover in this staff type but have successfully managed to decrease vacancies despite this.

2.6 There are currently **50** nursing assistants in the recruitment pipeline, including **9** who are due to start in post by the of end of May 2023. This pipeline will support WTWA to continue to see decreases in vacancy levels.

2.7 Sickness absence within the nursing staff group at WTWA was **7.2%** for registered staff and **13.4%** for unregistered in September 2022. The sickness rate has slowly improved. In March 2023 there were **6.5% (0.7% lower)** for registered staff and **12.0% (1.4% lower)** for unregistered staff. Stress, anxiety, and depression remains the highest absence reason within the nursing staff group, followed by musculoskeletal.

WTWA Workforce Initiatives to Support Growth and Retention

2.8 Nursing Assistant recruitment remains the biggest workforce challenge for WTWA. Since the introduction of the Band 3 workforce opportunities WTWA have seen some growth in the recruitment pipeline however the number of leavers remains high. It is recognised that there are specific demographic challenges to recruiting and retaining band 2/3 nursing assistants across the WTWA sites. A targeted recruitment and retention plan is being developed to consider these challenges and improve attraction and retention.

2.9 In November 2022, the Trafford Elective Hub (TEH) was established as part of the Trust's strategy for managing the backlog of patients waiting for elective surgery, with a longer-term vision for it to be the Trust's centre of choice for 'high volume low complexity' elective surgery. TEH was formed from existing services at Trafford Hospital, including Pre-op Assessment Clinic, Theatres and Ward 12. Whilst there have not been any substantive changes to the staffing establishments or structures across Theatres and Ward 12, the development of TEH has led to an expansion of the surgical specialities operating at TEH to include ENT, Head and Neck, Gynaecology, General Surgery, Urology and Breast. Additional training has been provided to ward and theatre staff and several clinical pathways and standard operating procedures have been developed. TEH has a dedicated operational, clinical, and nursing leadership team, but remains integrated into the WTWA arrangements and strategy for maintaining safe staffing.

2.10 The WTWA Corporate Nursing Portfolio of Offer was launched in January 2023, which clearly outlines the workforce, professional development, and wellbeing support that the team offer to the Divisions, including the business as usual (BAU) offer and any additional support available.

2.11 To support the recruitment process, the WTWA Workforce Matron working with the Divisional "Keeping in Touch" and recruitment leads resolve and action any recruitment issues promptly. The introduction of Keeping in Touch guidance and a New Starter pack supports this work. The WTWA Workforce team work closely with the Trust Pre-employment team, supporting **3** cohorts of pre-employment students since September 2022, resulting in **7** students undertaking nursing assistant roles across WTWA.

WTWA AHP Workforce

2.12 AHPs in WTWA are employed directly in specialist multi-disciplinary teams. Operating Department Practitioners (ODP) work in WTWA but are fully integrated into the nursing workforce data. The vacancy rate in March 2023 for AHPs (excluding ODPs) was **7.7%,** this equates to **0.7%** decrease from September 2022, with a 12-month rolling leavers rate of **13.1%**.

3. Manchester Royal Infirmary (MRI)

MRI Workforce Position

3.1 At the end of March 2023, there were a total of **20.7wte (1.3%)** registered nursing vacancies across MRI compared to **33.8wte (2.1%)** in September 2022. The low vacancy levels have been successfully maintained despite high turnover levels. During this period MRI have welcomed **68.0wte** internationally recruited nurses with further cohorts planned and **98.3wte** domestic recruits.

3.2 The 12-month rolling turnover at the end of March 2023 for all registered staff at MRI was **11.2%** and **12.5%** for band 5 staff. Overall registered staff turnover has remained static since September 2022, band 5 turnover has increased by **0.7%** from 11.8% in September 2022.

3.3 There are currently **20** Band 5 domestic nurses in the pipeline. Additionally, there are **8** Trainee Nursing Associates who have been allocated posts.

3.4 In March 2023, there were a total of **136.8wte (16.9%)** nursing assistant vacancies across MRI compared to **134.7wte (16.5%)** in September 2022. The 12-month rolling turnover for unregistered nursing staff is **16.9%**. There are currently **49** nursing assistants in the recruitment pipeline with regular recruitment events planned over the next 3 months. Since the band 2/3 MOC was introduced, MRI have converted 80% of their band 2 posts to band 3. It is expected that the changes the workforce model and band 3 opportunities will support attraction and retention of this staff group.

3.5 Sickness absence within the nursing staff group at MRI is **6.7%** for registered staff and **11.6%** for unregistered staff. After the high levels of sickness experienced through winter, MRI sickness levels follow trend and have decreased from September 2022 by **0.3%** for registered staff and **2.3%** for unregistered staff.

MRI Workforce Initiatives to Support Growth and Retention

3.6 The Deputy Director of Nursing and CSU Heads of Nursing continue to work with the HR teams to review absence trends within nursing to understand and implement interventions to improve attendance within this staff group. Several workstreams have been implemented to focus on staff health and wellbeing. Increasing availability of Mental Health First Aiders and identified wellbeing leads to ensure staff feel safe to speak up when work stresses cause staff to feel pressured, threatened, or anxious and supporting various initiatives across the multi-professional workforce for example the 'Time for Tea, Time for me' initiative.

3.7 In addition to ongoing work around rostering compliance and working with NHSP to ensure accurate information on nurse staffing fill rates, the 23/24 MRI workplan includes the implementation of Workforce Matron listening events with newly qualified nurses and midwives and to explore the development of allied health professional posts to support safer ward staffing and a blended skill mix/workforce.

3.8 MRI has a longstanding commitment to developing advanced clinical practice roles. Currently, there are 50 Advanced Clinical Practitioners (ACP) across the specialities, with these roles part of the strategic service development plans within the new models of care. The MRI has a dedicated ACP lead, who is working closely with the CSU Heads of Nursing to ensure consistency with job plans, and wider engagement and understanding of their role within the CSU's.

4. **North Manchester General Hospital (NMGH)**

NMGH Workforce Position

4.1 At the end of March 2023, there were a total of **31.4wte (3.9%)** registered nursing vacancies across NMGH, although this is an increase from zero vacancies in September 2022, this has been a successful period for NMGH as they have already recruited to **36%** of the increased establishment of **48.9wte** for registered nursing that was introduced in December 2022 whilst maintained turnover levels.

4.2 NMGH has continued to welcome internationally recruited nurses, with a further **39.0wte** joining NMGH since September 2022. In addition to this **49.7wte** domestic recruits have started at NMGH with an additional 8 due to start in the next 3 months.

4.3 Registered nurse turnover has seen an overall decrease of **0.9%** from **15.5%** in September 2022 down to **14.6%** in March 2023. Turnover for staff at band 5 level is **14.5%** down by **1.9%** from **16.4%** in September 2022.

4.4 In March 2023, there were a total of **70.2wte (14.8%)** nursing assistant vacancies across NMGH compared to **55.9wte (11.8%)** in September 2022. This is an increase in wte vacancies due to current turnover rates at **16.7%.** There are currently **23** nursing assistants in the recruitment pipeline with more recruitment events planned. Local events are planned with opportunities at band 2 and band 3 for existing and new staff.

4.5 Current sickness absence is **6.5%** for registered staff and **6.5%** for unregistered staff. Positively both sickness rates have seen large decreases **2.2%** for registered staff from **8.7%** in September 2022 and **2.6%** for unregistered staff from **9.1%.**

NMGH Workforce Initiatives to Support Growth and Retention

4.6 Nurse retention is a key objective for the senior nursing team with continuing focus on initiatives that support the development and engagement of nursing staff. NMGH's Health and Well-Being Strategy has been a priority to support staff being healthy and happy within the workplace. Wellbeing Huddles have been implemented across all clinical and non-clinical areas, and Schwartz Rounds are now held monthly. This work is supported with the employment of a well-being practitioner. Initiatives around improving communication on lessons learned following incidents and the rotation of staff working in the acute medical unit and the emergency department continue.

4.7 NMGH has a commitment to developing advanced clinical practice roles and non-medical prescribers (NMP). Currently employing 8 Advanced Clinical Practitioners (ACP), six currently in training and an additional three trainee posts planned for 2023/24. NMGH is seeking to support 15 nursing staff to complete the NMP programme in 2023/24. Growth of these advance roles will ultimately enhance patient experience and outcomes.

5. Royal Manchester Children's Hospital (RMCH) MCS

RMCH Staffing Position

5.1 In March 2023 there were no vacancies across RMCH. This is a result of a prolonged period of low turnover combined with effective recruitment both locally in the hospital and aguaranteed job offer to newly qualified nurses trained at local HEIs. It is predicted the position will change from March 2023 onwards, with Band 6 vacancies across a number of areas and an increase in band 5 turnover.

5.2 The 12-month rolling turnover for registered nurses at the end of March 2023 is **11.1%** which is an increase of **0.2%** from **10.9%** in September 2022. For band 5 registered nurses there has been an increase of **2.0%**, from **13.1%** in September 2022 to **15.1%** in March 2023.

5.3 In the domestic registered pipeline, there are currently **10** nurses allocated to RMCH, and who will commence in post in Q2. RMCH has welcomed **13** internationally recruited paediatric nurse since September 2022 and continue to factor into their recruitment plans. RMCH main source of recruitment remains through the domestic pipeline, successfully welcoming **109.0wte** since September 2022.

5.4 In March 2023, there were a total of **40.2wte (15.9%)** nursing assistant vacancies across RMCH compared to **29.9wte (12.0%)** in September 2022. Partly due to a small increase in establishment in Q3 and the ongoing challenging turnover level is **18.5%.**

5.5 Sickness absence within the nursing group at RMCH is **5.9%** for registered nursing which is a slight improvement **(0.6%)** from the September 2022 position and **9.1%** for unregistered nursing, down **3.0%** from **12.1%**.

RMCH Workforce Initiatives to Support Growth and Retention

5.6 A proposal to commissioners has been made that 14 PHDU Beds and 19 PICU beds are commissioned at RMCH all year round to reflect the current un-commissioned activity. However, additional funding through a change in commissioned beds will not immediately achieve sufficient staff requiring ongoing recruitment especially considering new staff joining are likely to be 100% newly qualified from September 2023 onwards.

5.7 A workforce review of Paediatric Theatres was completed in November 2022, in conjunction with a review of the service model requirement. The review concluded in an action plan to progress recruitment to all posts and improve retention. Following the review, the Theatre Team and Divisional Team have worked with the Transformation Lead, HR and the Trust Resourcing team on initiatives to overcome the vacancy gaps within the department, for example monthly engagement sessions, focus on well-being initiative, civility project, band 5 staff supported to complete the anaesthetic course and leadership and development support for the senior nursing team, in relation to behaviours in the workplace.

5.8 To support recruitment and retention the senior team lead by the Director of Nursing with support from the RMCH MCS Director of Human Resources and Organisational Development have worked closely to deliver on key actions, for example, individual recruitment campaigns for bespoke areas such as Theatres, Haematology and Oncology and Paediatric Critical Care with an aim to attract experienced nurses, support in the delivery of open days including paediatric and CAMHS nursing, allied health professionals, nursing associates and inclusive of community colleagues and reviewing exit interviews trends.

5.9 The RMCH Wellbeing Matron working closely with HR officer for RMCH/MCS and SMH with a specific focus on staff Well Being / calendar events / sharing of employee health and wellbeing initiatives. Wellbeing events planned for the next few months include; 'On your feet Britain' to encourage staff in desk jobs to join team members to take a walk and get some fresh air, Gratitude Month of March, Stress Awareness Month in April, Admin Professionals Day, Great Manchester Run, Mental Health Awareness Day and Nurses Day in May.

6. Manchester Royal Eye Hospital (MREH) and University Dental Hospital of Manchester (UDHM)

MREH and UDHM Workforce Position

6.1 At the end of March 2023, there continued to be no registered nursing vacancies in MREH. There are also no current vacancies in UDHM**.** Since September 2022 MREH have welcomed **6.0wte** internationally and **2.5wte** domestically recruited nurses. There was a total of **5.7wte (10.5%)** nursing assistant vacancies in MREH.

6.2 The 12-month rolling turnover has remained static. At the end of March 2023 was **7.1%** for registered nursing and **19.1%** for unregistered nursing.

6.3 Sickness absence including covid related absences within the nursing staff group for MREH has seen an increase of **2.3%** for registered nursing up to **8.3%** and for unregistered nursing **12.0%** up from **9.7%** in September 2022. For UDHM the current sickness levels remain static at 7**%.** The hospital have commenced joint HR and senior nurse weekly Attendance Meeting with managers to help reduce short term absence and provide direction and support to managers supporting staff through their period of absence.

MREH and UDHM Workforce Initiatives to Support Growth and Retention

6.4 MREH engagement in the MFT recruitment campaigns with tours of MREH provided to showcase Ophthalmology services. MREH have plans to attend the next ORC recruitment event due in April 2023 and repeat the previous process.

6.5 MREH has embraced the Nursing Associate training programme and the development of this role within the hospital services' establishments. Following establishment reviews further nursing associate positions have been created by the conversion of band 2 and 5 positions across OPD, W54, W55 and Day case areas. Significant work has been undertaken to enhance the skills of the Nursing Associates and to ensure the role is safely and appropriately embedded within the nursing workforce.

6.6 Whilst it is recognised that there are nurse and dental nurse staffing challenges nationally, it is widely accepted that retention of staff is a key focus of workforce planning. Several initiatives have been introduced/ are in the process of development intended to positively contribute to retention rates at MREH and specifically the enhancement of staff education and development.

AHP Workforce

6.7 Orthoptic staff are the predominant AHP group in MREH. There are very small number if vacancies **1.1wte** (5.5%) for AHP at MREH at the end of March 2023**.**

7. Clinical and Scientific Services MCS (CSS)

CSS Workforce Position

7.1 At the end of March 2023 CSS have a small number of vacancies **3.8wte (0.4%)**. This continues to be significantly lower than the reported national vacancy rates in critical care units across England.

7.2 Within CSS the rolling 12-month turnover for registered nurses up to the end of March 2023 was **11.4%** which is a **2.2%** increase from September 2022 at **9.2%**. Increases have also been seen in the band 5 nursing workforce where turnover is currently **13.0%**.

7.3 There are currently **17** registered nurses in the domestic pipeline allocated to CSS, in addition to this CSS remain committed to a supply of IR nurses over the next 12 months as vacancies arise.

7.4 Sickness absence within the nursing staff group for CSS was **5.5%** for registered nursing down by **2.1%** since September 2022 and **9.1%** for unregistered nursing up by **0.4%** since September 2022.

CSS Workforce Initiatives to Support Growth and Retention

7.5 Guidance for the Provision of Intensive Care Services (GPICS)[43] are used by professional and regulatory bodies to appraise critical care services and staff staffing levels. This includes during the Care Quality Commission (CQC) inspections and annually during the GM Critical Care Network Peer Review.

7.6 In terms of GPICS standards the units are compliant with most nurse staffing standards (ratios of nurses to patients per shift, coordinators and support nurses per shift, numbers of clinical education nurses and use of agency staff). However, the GPICS standards require a minimum of 50% of registered nurses to hold a post-registration critical care qualification. As only NMGH Critical Care is compliant with this standard (57%) a recovery plan has been agreed with the GM Skills Institute with a trajectory to achieve the standard by September 2023 .Progress at February 2023 shows an improved picture with current intakes planned to meet the trajectory. This issue is detailed in the Risk Register for each unit.

7.7 Ongoing work around harmonising interventional radiology pathways, policies and protocols on all three sites and support with HIVE optimisation stage continues.

7.8 Exploring options for cross site nursing on call cover to support NVIR on call service at both Wythenshawe and ORC sites. Developing a service model and commencing a consultation for cross site on call cover.

7.9 Work is ongoing to continue to address staff satisfaction and well-being and building on several well-established initiatives including 'Thoughtful Thursday' (staff served coffee and cake in a socially distanced environment), 'Reflective Rounds'/'Wellbeing Sessions' (weekly meetings led by both nursing and medical staff to provide an opportunity

[43] Intensive Care Society and The Faculty of Intensive Care Medicine (2022) Guidelines for the provision of intensive care services. Version 2.1

to share how they feel, to reflect on challenging situations, focus on the emotional impact) and staff exercise and walking events.

7.10 The 'Stay Interviews' continue to be promoted and are providing staff with an opportunity to discuss with a Matron, issues in relation to Work/Life Balance and approaches to more flexible working and these have been rolled out across the units/depts.

7.11 Professional Nurse Advocates (PNA) are available within all critical care units and some of the other departments working to deliver restorative supervision to the teams in group as well as 1:1 session. The PNAs have developed a PNA toolkit which is being utilised by the rest of the Trust and being promoted nationally and which was presented at British Association of Critical Care Nurses Conference in Belfast in October 2022.

CSS AHP Workforce

7.12 In CSS, AHPs work in the AHP Division (Physiotherapists, Occupational Therapists, Dietitians, and Speech and Language Therapists), and the Imaging Division (Radiographers). The number of AHP vacancies in March 2023 were **29.2wte (5.29%)** in the AHP Division and **42.7wte (11.4%)** in the Imaging Division. This is a reduction in vacancies in the AHP Division (**75.0wte)**, but a similar position in the Imaging Division **(43.7wte)** compared with May 2022.

7.13 In March 2023, the 12-month turnover rate for the AHP Division was **5.4%** and the sickness absence rate was **4.0%.** In the Imaging Division the 12-month turnover rate was **7.0%** and the sickness absence rate was **5.5%.**

7.14 Key retention activity is around the impact of the recruit to turnover strategy, the introduction of Band 5 rotation posts within Adult SLT and ongoing work to ensure future posts are attractive to current and future staff, internationally recruited occupational therapists programme with review of learning to inform other professions

7.15 Planning to stabilise winter pressure expansion of AHP roles in medicine and frailty units to ensure continued funding and staff retention.

7.16 The AHP Division risks relating to insufficient AHP staffing across various sites/services are reviewed each month at the AHP Quality & Safety Board, AOF meeting and escalated to the CSS Quality and Safety Board as required.

7.17 The Society and College of Radiographers does not have a tool kit to calculate safe staffing requirements by modality, however this will become a key outcome of the new Northwest Radiographic Workforce Strategy with the development of a safe staffing toolkit by Imaging modality. Other key actions include the development of support workers in Imaging lead by the Society and College of Radiographers and NHSE/I incorporating a career escalated framework from Band 2 – Band 8 and continuing the international recruitment programme for a range of modalities with the next cohort of Radiographers starting with in April 2023.

8. St Mary's Hospital MCS

SM MCS Nursing Workforce Position

8.1 The SM MCS static over the last 6 months with **17.92wte (7.7%)** registered nursing vacancies in gynaecology and **31.9wte (8.2%)** in Newborn services. The 12-month rolling turnover at the end of March 2023 for all registered nursing at SMH was **16.5%** which is an increase of **1.4%** since September 2022. There are currently **14** domestic nurses in the pipeline and planned arrivals of international nurses over the next 3 months.

8.2 In March 2023, there were a total of **22.8wte (26.0%)** unregistered nursing vacancies across SMH. Recruitment events are planned over the next 3 months to address these vacancies.

8.3 Sickness absence within the nursing staff group is **6.7%** for registered staff and **8.2%** for unregistered.

SM MCS Nursing Workforce Initiatives to Support Growth and Retention

8.4 Compared to 2021/2022 there is a strengthened nursing leadership model in Gynaecology with further additional specialist nursing provision in the pipeline. This will continue to be reviewed along with staffing job plans into 2023/24 to ensure the leadership hierarchy supports transformational change, the gynaecology recovery programme and allows for a robust succession plan and alignment with service provision at North Manchester General Hospital.

8.5 In addition to changes made to support an improvement in Theatre Utilisation as part of the elective recovery plans to reduce waiting times and reduce the elective recovery backlog, the acquisition of specialist nurse led roles, including Menopause Specialist and Endometriosis has provided additional resource to the elective recovery plan. Further plans are aimed to increase the nurse led provision in the outpatient's department supporting urogynaecology, and hysteroscopy specialities to reduce the waiting list for review and treatment.

8.6 With the ongoing challenge of recruiting and retaining a skilled workforce to deliver services, a thematic review has been undertaken to establish the reason for staff leaving the organisation. A Matron for Education, Quality and Workforce to take drive forward educational strategy and quality metrics within Gynaecology has been recruited and the senior team are developing an action plan to address the three key themes highlighted form the review; workplace stress, not involved in delivering changes and education and training.

8.7 To meet the workforce challenges within Newborn Services service a proactive recruitment strategy including some success in attracting experienced nurses. continuing to promote the diversity of roles within the service via social media campaigns to attract external candidates has been taken. Other initiatives to support retention and create a mobile workforce include the development of a Band 5-6 development programme

and support recruitment into Band 6 posts and rotational opportunities between sites for all staff groups.

8.8 Following recommendations of the Neonatal Critical Care Review (NCCR)[1] the division have received funding to provide additional workforce within AHP provision across all sites, including the introduction of an Occupational Therapist and Clinical Psychologist. This investment will enable the division to equitably provide the highest quality therapy services to all those infants who require it.

SM MCS Midwifery Workforce Position

8.9 At the end of March 2023, there were a total of **45.9wte (6.2%)** registered midwife vacancies across SMH compared to **90.7wte (12.5%)** in September 2022. This is a decrease of **44.8wte (6.3%)** following the number of graduate midwives who started in SM MCS during Q3.

8.10 The 12-month rolling turnover at the end of March 2023 for all registered midwifery staff at SMH was **14.3%** this has increased by **0.9%** since September 2022 **13.4%**.

8.11 There are currently **7.8** registered midwives in the domestic pipeline and **10** international midwives due to arrive in the trust in the next 6 months.

8.12 In March 2023, there were a total of **21.7wte (12.6%)** maternity support worker vacancies across SMH. Attraction and retention of this staff group is expected to improve following the introduction of the band 3 maternity support worker role.

8.13 Sickness absence within the midwifery staff group is **7.0%** registered midwives and **8.0%** for maternity support workers.

SM MCS Midwifery Workforce Initiatives to Support Growth and Retention

8.14 SM MCS have launched a guaranteed job offer to 80wte student midwives in their final 6 months of training, 50 students to date have confirmed posts. An external recruitment open day is also planned in May 2023 to increase the pipeline.

8.15 SM MCS was successful in securing an extension to the initial funding of £150,000 from NHS England for 12 months for 2023/24 to support midwifery retention and a midwifery retention team is now established in post.

8.16 SM MCS have seen an increase in baseline establishments in 2022/23 with an additional 7.6WTE posts from the Saving Babies Lives (SBL) NHSE funding. These posts include SBL champions, Specialist Smoking Cessation Midwives, Specialist Midwives in electronic foetal monitoring and Specialist Pre-Term Labour Midwives

[1] Implementing the Recommendations of the Neonatal Critical Care Transformation Review. NHS England and NHS Improvement. 2019

8.17 The Professional Midwifery Advocates have facilitated restorative supervision sessions for the midwifery workforce which have been rostered to support staff attending. Clinical Restorative Supervision sessions have also continued to be offered to the student midwives in partnership with the Universities of Manchester and Salford.

8.18 SM MCS have listened to staff and engaged with them through staff surveys and listening events. Feedback has been provided through the "You said We did" initiative which has focussed on equipment to support staff in their everyday work. Saint Mary's MCS has also been supported by the Organisation, Training and Development team to gain further feedback from staff and formulate an action plan to support staff health and wellbeing. This includes a programme of work at North Manchester to develop and sustain a positive and compassionate workplace culture.

8.19 New midwives have been supported before commencement of employment with keeping in touch sessions, meeting the teams and networking with other new employees both face to face and virtually.

9. Manchester and Trafford Local Care Organisation (M/TLCO)

M&TLCO Workforce Position

9.1 At the end of March 2023, there were a total of **143.9wte (13.3%)** registered nursing vacancies across the M&TLCO. This is an increase of **21.3wte (1.9%)** vacancies in September 2022.

9.2 **81.0%** of the vacancies are attributed to services managed by MLCO, predominantly in the District Nursing workforce teams and **19.0%** managed by the TLCO. Across M/TLCO the turnover for March 2023 for registered nursing is **16.4%** which is a decrease of **0.8%** since September 2022 when turnover was **17.2%**.

9.3 There are currently **18** registered nurses in the domestic pipeline for M/TLCO.

9.4 In March 2023, there were a total of **57.5wte (20.4%)** unregistered nursing vacancies across M/TLCO. The expansion of the band 3 workforce across the LCO is expected to support attraction and retention of staff in these roles.

M/TLCO Allied Health Professional Workforce

9.5 In March 2023 there were **9.2wte (1.9%)** AHP vacancies across the M/TLCO with a 12-month leavers rate of **14.1%**. The sickness absence rate for AHPs is **4.2%**

9.6 The LCO AHP teams have adapted the MFT Staffing Risk Assessment Matrix and Escalation Process to make specific to their service areas based on current staffing levels. This allows staffing levels to be monitored and escalated as required.

M/TLCO Workforce initiatives to support growth and retention

9.7 It is recognised that there is a workforce challenge within district nursing services across M/TLCO due to mismatch between capacity and demand, vacancies, and staff absence. There are similar challenges within M/TLCO health visiting and school health services that reflects national and regional shortages in these specialities. Additional community nursery nurses have been employed to support health visiting services and bridge the workforce gap in this area.

9.8 The LCOs are working with the resourcing team to develop bespoke attraction campaigns for the District Nursing Services across Manchester and Trafford. The first campaign went live for two weeks from February 7th, 2023. This important project was identified from the District Nursing Stabilisation Programme and has led to a number of significant improvements in LCO recruitment material. This campaign has resulted in 6 Band 6 and 8 5 posts being filled. Learning from the event is being applied to other services which would benefit from bespoke attraction strategies.

9.9 The LCO are considering opportunities to develop the clinical support worker workforce to support hospital admission prevention this work will include training to allow support workers to support patients in their home with medications. The long terms ventilation service is developing a training and competency programme to allow support staff to care for ventilated patient in their homes

9.10 There are a range of workforce challenges for M/TLCO AHPs including difficulty recruiting to community based AHP positions and AHPs leaving for private practice. Predominately, vacant posts arise due to AHPs seeking promotion or due to retirement. Despite these challenges initiatives have been implemented that support recruitment and retention. These include upskilling senior rehabilitation assistants, option of rotational posts that include linking with CSS AHP division, creating band 5 to band 6 transitional roles, OT apprenticeships and expanding the AHP ACP workforce.

Agenda Item 10.5

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Alison Haughton, CEO Saint Mary's Managed Clinical Service Jen Sager, Assistant Director of Quality and Safety
Date of paper:	May 2023
Subject:	Saint Mary's Response to Care Quality Commission Inspection feedback
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept ✓ • Assurance • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	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 significant concerns identified by the CQC; the actions being taken by the Trust and the Saint Mary's MCS in response and, the governance structure now in place to gain assurance and monitor improvement. • Confirm that the information received provides adequate assurance of progress of the maternity improvement plan.
Contact:	Name: Alison Haughton, CEO, Saint Mary's MCS Tel: 0161 276 6124

1. Background

1.1. In July 2022, the Care Quality Commission (CQC) recognised that maternity services across the country were facing significant challenges and announced their intention to inspect all NHS acute hospital maternity services which had not been inspected and rated since April 2021. The programme aimed to provide an up-to-date view of the quality of hospital maternity care across the country and gain a better understanding of what was working well to support learning and improvement at a local and national level.

2. Inspection of Saint Mary's Managed Clinical Service (SM MCS) Maternity Services

2.1. The CQC announced an inspection of Manchester Foundation Trust (MFT) maternity services provided through SM MCS on Friday 3rd March 2023 to commence on site on the 7th of March. Data relating to the 'safe' and 'well led' CQC domains was submitted over the inspection period.

2.2. The CQC inspected SM MCS maternity services at each of the three sites between the 7th and 9th March 2023 with a focus on specific locations each day:

- Saint Mary's Oxford Road (7th March)
- Saint Mary's Wythenshawe (8th March)
- Saint Mary's North Manchester (9th March)

2.3. The CQC interviewed a wide range of staff and conducted focus groups with clinical staff from each location including Board Maternity Safety Champions, clinical leads, the SM MCS senior leadership team and members of the Maternity Voices Partnership (MVP - user group). Interviews were completed by 29th March 2023.

3. Outcome of the inspection

3.1. On 23rd March 2023 the Trust was notified that the CQC had formed the view that the quality of health care provided by the maternity services required significant improvement in the following areas:

- **Triage**: The service did not operate effective and timely triage process to protect women, birthing people, and newborns.
- **Delays**: The service did not facilitate timely access to appropriate treatment and birth settings for women, birthing people, and newborns.
- **Staffing**: The service did not always have enough sufficiently skilled and experienced midwifery and medical staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner.

3.2. A regulation 29A (warning notice) was issued to MFT (appendix 1) The maternity services are required to make the significant improvements identified above regarding the quality of healthcare by 23rd June 2023.

3.3. The CQC provided further feedback to the Trust on the 5th of April 2023, reaffirming the contents of the warning notice and providing early high-level positive feedback relating to:

- an open positive culture amongst all staff and examples of staff appropriately challenging across roles and grades.
- an effective and inclusive service for women from HMP Styal, working with prison staff to maintain privacy and dignity for women and birthing people.
- Positive service working with the MVP to actively reach out to the local Jewish community.
- Across the MCS the model the Midwifery research team had implemented in which they conduct a range of research projects as well as delivering care to high-risk women and birthing people attending specialist clinics, thereby embedding research within clinical practice

3.4. Initial briefings have been provided to the MFT Board of Directors, Quality and Performance Scrutiny Committee, Group Quality and Safety Committee, the Local Maternity and Neonatal System on behalf of the ICB, GM Integrated Care Board and the Northwest Regional Chief Midwife on behalf of NHSE.

3.5. It is likely that the warning notice will be published when the final CQC report is published which is unlikely to be in the usual 12-week time frame. The CQC have noted that due to the scale of the services at MFT this may be delayed.

4. Response – governance structure, workstreams and action plan

4.1. A governance structure and project management office have been established to provide executive oversight, receive assurance, and apply scrutiny of the effectiveness of actions being taken by SM MCS, including the scrutiny by external stakeholders and regulators.

4.2. An Executive led Maternity Oversight Group (MOG), co- chaired by the Chief Nurse and Deputy Chief Executive, has been established to oversee and assure the response of SM MCS. The MOG meets alternate weeks. The group has external stakeholders and MVP in the membership.

4.3. The SM MCS Operational Delivery Group, chaired by the Saint Mary's MCS CEO, meets weekly and reports fortnightly into the Maternity Oversight Group using exception reports related to the progress of each of three workstreams.

4.4. Three workstreams (Triage, No Delays and Safer Staffing) corresponding to the concerns identified have been developed which report to the Operational Delivery Group. The workstreams have identified Director leads from the Senior Leadership Team and each report weekly on progress into the Operational Delivery Group.

4.5. SM MCS have developed and submitted a comprehensive CQC compliance action plan related to the specific concerns. The Compliance Action Plan was submitted to the CQC for review on 31st March 2023. The CQC have acknowledged the plan.

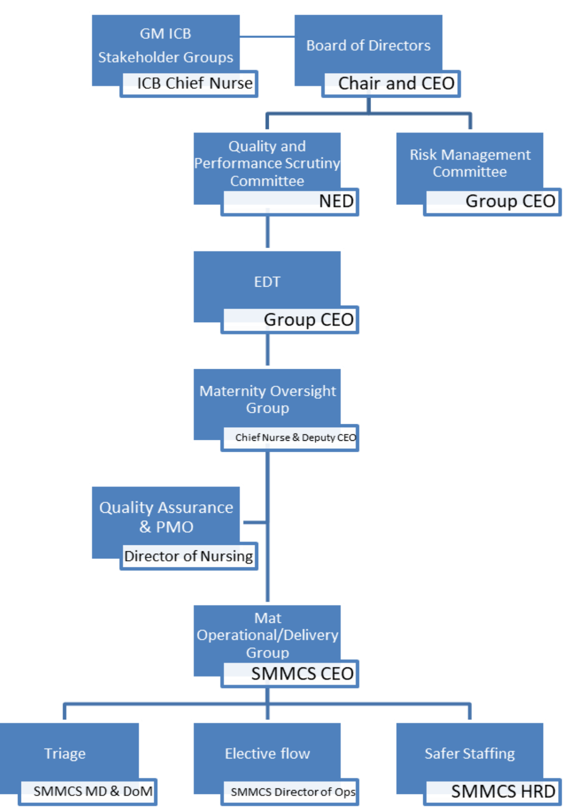
4.6. The action plan corresponds with the timescale for compliance (23rd June 2023) set by the CQC.

4.7. The Project Management Office (PMO) is tracking the completion of actions and SM MCS have set up the PMO to coordinate the response and work of the workstreams, namely triage, flow and safer staffing. Focus has been on implementing the action plan and identifying indicators/measures of success and collating evidence to provide assurance to the Board of Directors and the Regulators.

4.8. The compliance action plan has been submitted to the CQC and an update plan is programmed for 27th April.

4.9. The MOG accepted the plan and have requested evidence of improvement at the next meeting on the 26th of April.

Governance structure



5. Progress: Maternity Triage

5.1. Concerns raised regarding maternity triage related to:

- Delays in initial triage assessment and subsequent medical review
- Oversight in Maternity Triage waiting area

5.2. SM MCS have made several changes within maternity triage over the last 12 months due to concerns regarding clinical capacity and these are on the risk register with score of 12 (MFT/006717).

5.3. SM MCS have focussed on monitoring incidents where harm has occurred and have been reassured due to the low number of incidents reported where harm has been caused due to delays in care.

5.4. Immediate actions have included additional telephone lines into triage, placing a midwifery support worker into the triage waiting area to provide direct observation of women waiting to be seen, and directing women to be seen in the correct triage unit. Recruitment for additional MSW's is ongoing with interviews taking place on 11th May.

5.5. SM MCS acknowledge that insight and more focused attention on the number of delays which occur and the level of risk this carries, needs to improve.

5.6. Several metrics are in development to support the clinical team with direct overview of activity throughout the 24hr period. This will support the development of a visible triage dashboard. This is intended to support timely escalation to address potential delays as they arise.

5.7. The maternity triage dashboard will enable the maternity division to see where their interventions are resulting in improvement and provide assurance to SM MCS senior leadership team and the Board of Directors.

5.8. Some 'Measures of success' metrics require data obtained from the electronic record system (Hive) e.g., timeliness of initial triage, whilst others require manual data collection e.g., audit of telephone calls to triage. Data analysts are supporting the extraction of data to enable ongoing monitoring of metrics. Support from the Hive/Clinical informatics team has been well received and a first cut of indicators have been identified.

5.9. One of the measures of success is to address concerns that there was insufficient oversight in the maternity waiting area which, based on incidents reviewed by the CQC, led to SM MCS not always being aware of women choosing to leave prior to review or being unaware of those who may have left the unit. The main reason for self-discharge is women experiencing senior medical review delays after being seen by a midwife.

5.10. As part of the update to the maternity triage guideline, there will be a review of current categorisation for medical clinical assessment to ensure the categorisation is appropriate. The measures set out below will be reviewed by the informatics team to provide a series of SPC charts or run charts as appropriate

Action 1.2 Time to Triage

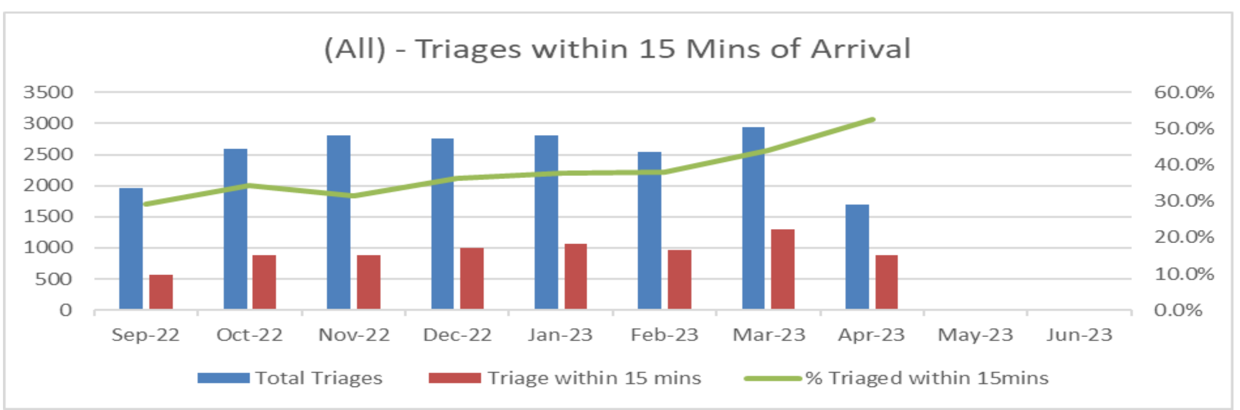


Fig 1: Attendees to maternity triage and time to receive initial triage by midwife (BSOTS target)

(All)	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total Triages	1968	2593	2803	2751	2800	2550	2945	1690		
Triage within 15 mins	573	890	884	999	1058	968	1294	888		
% Triaged within 15mins	29.1%	34.3%	31.5%	36.3%	37.8%	38.0%	43.9%	52.5%	0	0

Action 1.12 Number of patients who self-discharge

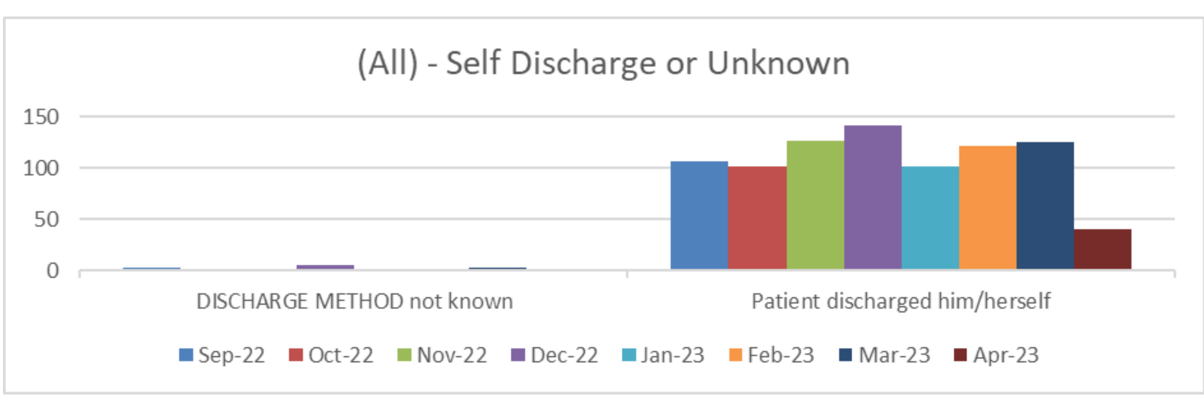


Fig 2 Attendees to maternity triage who leave without medical review

(All)	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Patient Self Discharge	107	102	127	142	101	121	125	40	0	0
Unknown Discharge method	3	1	1	6	2	0	3	1	0	0
Total	110	103	128	148	103	121	128	41	0	0

Action 1.1 Improve compliance with appropriate triage outcome categorisation

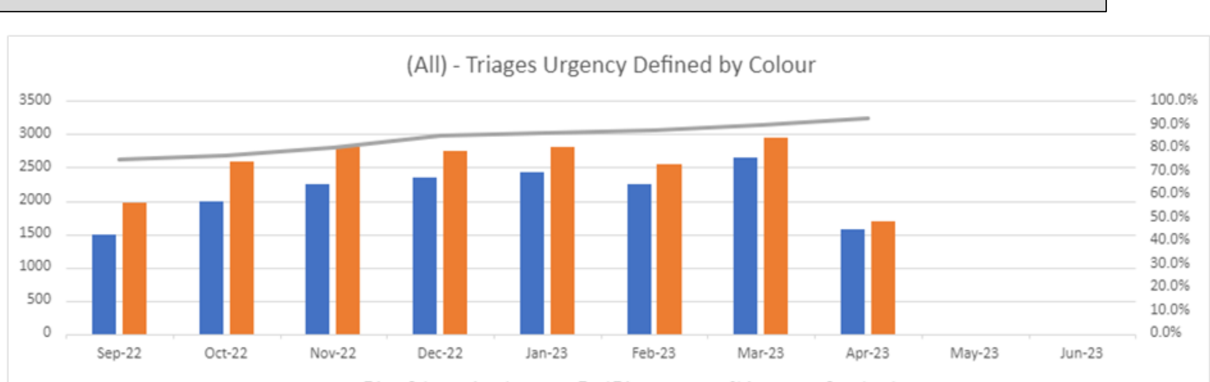


Fig 3 current categorisation following initial triage assessment. (Demonstrates improving compliance with BSOTS categorisation)

(All)	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Triage Colour assigned	1484	1992	2245	2347	2430	2241	2651	1572		
Total Triages	1968	2593	2803	2751	2800	2550	2945	1690		
% Assessment Completed	75%	77%	80%	85%	87%	88%	90%	93%	0%	0%

6. No Delays

6.1. Concerns were raised regarding delays in care/pathway:

- Category 3 Caesarean sections being delayed
- Delays in transfer for induction of labour pathways
- Delays in pain relief (predominantly epidural analgesia)

6.2. Category 3 caesarean sections are defined as when there is no maternal or fetal compromise but there is a plan for caesarean section within 24 hours. At present these predominantly take place as unplanned caesarean sections and timings are dependent on clinical activity/acuity and therefore subject to change.

6.3. As the demand for Elective C Section has increased there is a deficit in the number of planned elective lists required to meet demand. Additional capacity has been achieved utilising ECLs however, there has been a reduction in the take up of the weekend lists. An immediate proposal has been put to the executive team whilst the business case to identify the long-term sustainable model is finalised for early May. The immediate model is recognised as a short-term solution due to the workforce and financial requirements.

6.4. Indicators are currently in development to capture delays for category 3 Caesarean sections.

6.5. SM MCS have highlighted delays within the induction of labour pathway which is assessed with a current risk score of 12 on the maternity risk register (MFT/006383).

6.6. Whilst delays in the induction pathway are monitored via the maternity update status report 3 times a day, this does not provide sufficient insight into the overall number of delays which occur and the level of risk this may carry.

6.7. To address this several metrics are in development to support the clinical team with direct overview of induction of labour pathway delays.

Action 2.2 Zero reported delays over various time frames (aim is no longer than 48hrs)

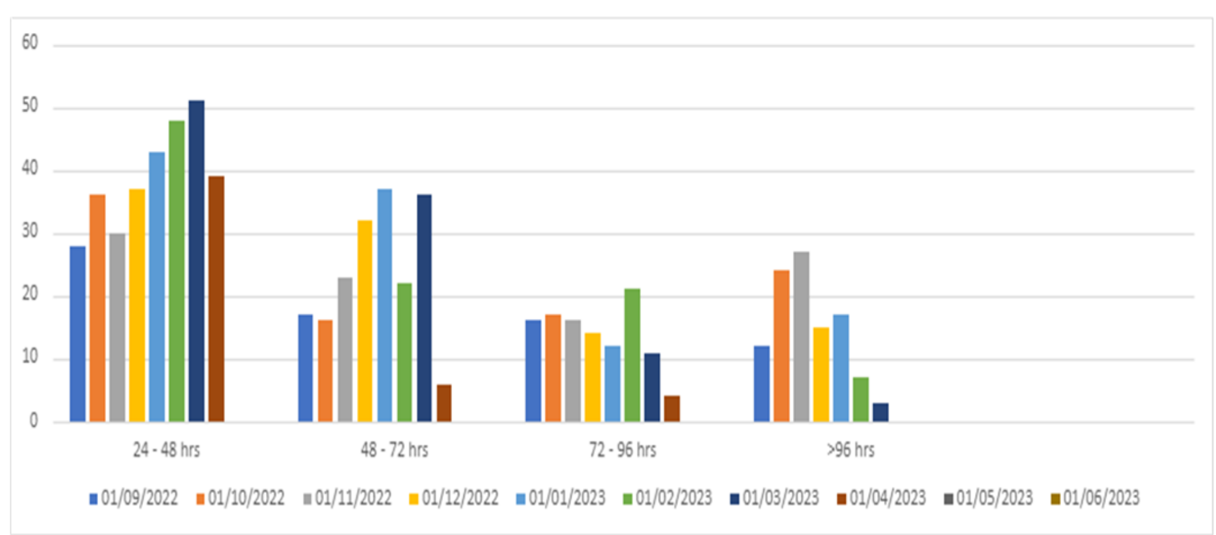


Fig 4. IOL delays

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
24 - 48 hrs	28	36	30	37	43	48	51	39
48 - 72 hrs	17	16	23	32	37	22	36	6
72 - 96 hrs	16	17	16	14	12	21	11	4
>96 hrs	12	24	27	15	17	7	3	0

7. Measures in development (w/c 1st May 2023)

7.1. There are several measures in development which will be used to assess progress.

1. Time to theatre for 3rd/4th degree tears
2. Time to medical assessment
3. One to one care labour
4. Complaints data – reduction in complaints re waiting times/delays
5. Fill rate for telephone triage role
6. Reduction in women birthing on antenatal ward
7. Reduction in women waiting for IVO.
8. Waiting time for epidural

7.2. Further measures which will take longer to build include the wait for category 3 caesarean section, but the team are looking at putting manual monitoring in place

8. Safer Staffing

8.1. Specific concerns were raised regarding midwifery and medical workforce related to:
1. Midwifery staffing, including dedicated midwifery telephone triage role
2. Medical staffing allocation on maternity triage
3. Birth rate plus staffing tool not completed since April 2021

8.2. Midwifery staffing is registered on the maternity risk register with a score of 15 (MFT/005896).

8.3. Despite the mitigation in place, to use temporary staff and recruit to turnover there are still a significant number of midwifery vacancies. Insight into shift fill rate and management could be improved. A focused recruitment campaign is planned and a plan to review the work of the retention midwives to look in detail as to why staff are leaving.

8.4. A dedicated role for telephone triage highlighted by the inspectors was not a role previously provided. SM MCS are also looking at telephony systems which will provide answer phone and call waiting facilities.

8.5. Since w/c 24th March 100% of telephone triage shifts have been filled.

8.6. A midwifery support worker (MSW) shift is in place to support intentional rounding and increase visibility of women in triage waiting area. Fill rates for these shifts are not always optimal and other staff have to be drafted in to support from other areas. SM MCS is looking at a more permanent substantive solution.

8.7. Midwifery workforce updates are provided monthly on each maternity site to the leadership teams, and provide current information related to SM MCS Midwifery recruitment and retention.

8.8. SM MCS midwifery workforce meets the recommended establishment from the Birth Rate plus report, received in April 2021. The revised Birth Rate plus data has now been received (18th April 2023) by the SLT and is being analysed

8.9. At the end of March 2023, there were a total of 45.9wte (6.2%) registered midwife vacancies across SMH compared to 90.7wte (12.5%) in September 2022. This is a decrease of 44.8wte (6.3%) following the number of graduate midwives who started in SM MCS during Q3. However, the 12-month rolling turnover at the end of March 2023 for all registered midwifery staff at SMH was 14.3% this has increased by 0.9% since September 2022 from 13.4%. What this tells us is that there is a pattern of recruitment in September/October annually, with a sustained number of leavers each month resulting in associated deficits in numbers from May onwards.

8.10. There are currently 7.8 registered midwives in the domestic pipeline and 10 international midwives due to arrive in the trust in the next 6 months.

8.11. In March 2023, there were a total of 21.7wte (12.6%) maternity support worker vacancies across SMH.

8.12. Sickness absence within the midwifery staff group is 7.0% registered midwives and 8.0% for maternity support workers.

8.13. SM MCS have launched a guaranteed job offer to 80wte student midwives in their final 6 months of training, 50 students to date have confirmed posts. An external recruitment open day is also planned in May 2023 to increase the pipeline.

8.14. SM MCS was successful in securing an extension to the initial funding of £150,000 from NHS England for 12 months for 2023/24 to support midwifery retention and a midwifery retention team is now established in post.

8.15. SM MCS have seen an increase in baseline establishments in 2022/23 with an additional 7.6WTE posts from the Saving Babies Lives (SBL) NHSE funding. These posts include SBL champions, Specialist Smoking Cessation Midwives, Specialist Midwives in electronic foetal monitoring and Specialist Pre-Term Labour Midwives

8.16. The reasons for increased vacancy are retirement, moving closer to home, moving to a smaller unit, or travelling abroad.

8.17. Enhanced NHSP and agency shifts support the current vacancies and are monitored on a weekly basis by the Heads of Midwifery.

8.18. Medical staffing is monitored 3 times each week to address when staffing is suboptimal.

8.19. SM MCS are currently reviewing current medical staffing models to determine what further support is required within maternity triage to address delays in timely medical review.

8.20. There is currently no national tool for obstetric staffing within maternity services. It is expected that a national obstetric staffing tool will be developed by the Royal College of Obstetrics and Gynaecology. When complete, SM MCS will use this tool to review current obstetric workforce establishment and take steps to address any shortfall in workforce if gaps are identified.

8.21. Incidents remain actively monitored and staff are aware to report on any occasion when staffing impacts on ability to provide safe care.

8.22. On site maternity bleep holders provide a 24-hour supernumerary overview with clear escalation pathways in place if staffing levels do not meet activity and acuity requirements.

8.23. Work is underway to regularly extract the incident reporting data to provide further insight and monitoring related to staffing concerns.

8.24. All available indicators are monitored weekly within the SM MCS Operational Delivery Group to ensure improvement is being made.

9. External Engagement

9.1. Meetings have been held:
CQC – acknowledged receipt of a compliance plan. Agreed a mid-point review w/c 22nd May on site
Feedback from Regional Chief Midwife and ICB leads from LMNS confirmed an offer from the national team to review the Maternity Self-Assessment Tool once it is complete and to provide any advice or guidance in a supportive manner without commencing the Maternity Service Support Programme.

10. Wider Assurance

10.1. The Board have received regular assurance reports on progress against Ockenden requirements, East Kent report and Maternity Incentive scheme. These have been appropriate and have reported predominantly the outcomes from maternity services both internally and to external bodies which are evidenced by data.

10.2. The Quality and Performance Scrutiny committee have received detailed reports against the Ockenden compliance plan.

10.3. The Group Risk Management Oversight committee has seen the risks associated with maternity services in a composite risk form. The composite risk has meant that the detail in each individual risk, the mitigation and the oversight of the mitigation was not visible to the committee. The revised approach to governance including managing risks and the provision of the revised Integrated Performance Report (previously BAR) to assure the Board will address these issues.

10.4. A review of SM MCS governance was commissioned and presented to the SLT in November 2022 due to concerns raised by the Chief nurse that the increased maternity reporting and responses to national agencies was not visible at the MCS Q&S committee. The implementation of those recommendations is now part of the overall compliance plan.

10.5. The Group CEO has asked for a scoping of key risk areas where there is a need for additional assurance based on the CQC KLOE. The question asked is, could this be an issue for the Trust outside of maternity services?

10.6. As a result of a wider review of key risks on the register alongside intelligence such as complaints and performance the initial review has focused on developing a short programme of review in the following areas, complemented by several deep dives led by the Group CEO. Board members are sighted on these areas.

- Urgent and Emergency Care
- Diagnostics (MR/CT/ECHOE)
- Mental Health
- Management of P2s (paediatrics and cardiology)

- Procedural Safety (never events)
- Maternity (in progress)

All the above have had a risk profile and plans are being developed, for example undertaking a CQC type inspection to provide assurance on current processes or actions for the services to respond to.

11. Communications

11.1. NHSE have advised that they will watch and monitor our improvement plan but have not recommended that we are referred to the national maternity support programmes at this point.

11.2. The LMNS will receive regular reports on behalf of the ICB and attend the Maternity Oversight Group to monitor progress.

12. Recommendations

12.1. The Board of Directors is asked to:

- Note the significant concerns identified by the CQC; the actions being taken by the Trust and the Saint Mary's MCS in response and, the governance structure now in place to gain assurance and monitor improvement.
- Confirm that the information received provides adequate assurance of progress of the maternity improvement plan.

12.2. Further detailed progress reports will be provided to the Board.

Agenda Item 10.6

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business / Trust Secretary
Date of paper:	May 2023
Subject:	NHSI FT Self-Certification Requirements (2023)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (previously Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence.
Recommendations	The Board of Directors is asked to approve NHSI FT Self-Certifications for Condition G6(3), G6(4) & CoS7(3) and note progress with Self-Certificate FT4(8)
Contact	Name: Nick Gomm, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

NHSE FT Self-Certification Requirements (2023)

1. Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHSI (Monitor) uses for regulating providers of NHS services.

All NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services and have complied with governance requirements.

MFT has an NHS Provider Licence (**No. 130164**). This year (2023), in keeping with NHSI guidance (updated in March 2019), the Trust is required to self-certify the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - **Condition G6(3)** & **Condition G6(4)**
- The provider has complied with required governance arrangements - **Condition FT4(8)**
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service - **Condition CoS7(3)**

A new NHS Provider license came into force in April 2023. However, this year's self-certification requirements are based on the license in place during 2022/23. Responsibility for assessing compliance with the new Provider license will move from NHS England to Integrated Care Boards for next year and we await guidance on how that will be done.

2. NHSI Foundation Trust Self-Certification

2.1 Self-Certification - Condition G6(3) & Condition G6(4)

Not later than two months from the end of the Financial Year, the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Recommendation: Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6(3)' self-certification is formally signed-off as "Confirmed".

Recommendation: In keeping with the requirements of Condition G6(4), the Trust will publish its self-certification - Condition G6(3) - by 30th June 2023.

2.2 Self-Certification - Condition FT4(8)

The Board of Directors is required to self-certificate "Confirmed" or "Not confirmed" to a number of governance-related statements and set-out any risks and mitigating actions

planned for each one within the NHSI self-declaration template. Appendix B contains the statements and the supporting evidence of compliance.

Recommendation: Based on the evidence highlighted in Appendix B, it is recommended to the Board that the Condition FT4(8) self-certification is formally signed off as 'Confirmed'.

Recommendation: In keeping with the requirements of FT 4(8). The Trust will publish its self-certification – Condition FT4(8) by 30th June 2023.

2.3 Self-Certification - Condition CoS7(3)

Not later than two months from the end of the Financial Year, the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" one of the following three declarations about the resources required to provide 'Commissioner Requested Services' (CRS):

A. After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account of distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

B. After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below (Appendix C), that the Licensee will have the Required Resources available to it after considering, in particular (but without limitation), any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in Appendix C) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

C. In the opinion of the Directors of the Licensee, the Licensee will not have the required Resources available to it for the period of 12 months referred to in this certificate.

(Footnote: Providers do not need to state the other two are not confirmed)

Recommendation: Based on the statement of main factors considered in Appendix C, it is recommended to the Board that **Declaration B** within the Condition CoS7(3) Self-Certification is formally signed-off as **"Confirmed".**

APPENDIX A

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

• Throughout the period of the COVID pandemic, the Trust has been meticulous in maintaining the integrity of Board and related governance arrangements and processes. This has involved an on-going assessment of existing arrangements to judge what should continue, what could be modified and what could be stood down to ensure compliance with infection prevention rules and government guidance on meetings. Attention was paid to the advice proffered by NHSE about Board governance and associated reporting.
 	
• Board meetings and Scrutiny Committees have been maintained throughout 2022/23, with some taking place 'virtually'. All decisions about the construct of meetings and business agenda were taken with the full endorsement of the Group Chairman. The Group NED briefings which were introduced at the outset of the Pandemic have been replaced with monthly written briefings, supplementing the Chairman's weekly bulletin to NEDs, as the impact of the pandemic has reduced.
 	
• The Operations portfolio has led the MFT pandemic response from Wave 1 through to the current recovery phase. This has been driven through the use and development of MFT's Emergency Preparedness, Resilience & Response (EPRR) plans and protocols, with a clear regime of daily and weekly meetings, ensuring the Trust services were adapting in line with the pandemic response. EPRR plans and protocols have also been used during 2022/23 to manage the impact of the episodes of industrial action.
 	
• The MFT Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance and Digital Scrutiny Committee, and the Group Risk Oversight Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance, and finance. The EPR Scrutiny Committee has overseen the successful introduction of the Hive Electronic Patient Record in September 2023.
 	
• A programme of Board Seminars, Group NED Developments Sessions and Group Management Board Development Sessions provide an opportunity for 'deep dives' into specific topics/themes.
 	
• During 2022/23, the Board of Directors approved a new Risk Management Framework and Strategy, agreeing 10 principal risks to achievement of MFT's Strategic Aims and approving the Group Risk Appetite Statement.
 	
• The Group Risk Oversight Committee (GROC) is informed by the Governance structure as a whole and ensures that high level risks are overseen by the Board of Directors. The Committee is Chaired by the Group CEO, attended by the Group Executive Director Team, Hospital/MCS/LCO CE's and open to all Group Non-Executive Directors. The Committee reviews the management of risk and reports on organisational risk profile at each meeting supported by a schedule of reports across the year on:
 	
  • New risks at level ≥15 – single report detailing management and oversight arrangements
  • Group wide risks at ≥15 – single report detailing management and oversight arrangements
  • Risks escalated for review/support by Hospitals/MCS/LCO where further mitigation is outside of the control of the Hospital/MCS/LCO (for example a national tariff issue) – single report detailing management and oversight arrangements.
 	
• The Trust's Single Operating Model is underpinned by the Accountability Oversight Framework which contributes to the overarching Board Governance Framework, enabling the Group Board of Directors to fulfil its obligations and effectively run the organisation. The AOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives, and operational plan, and incorporates the key elements overleaf:

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- Fosters a culture of devolved decision making and accountability.
- Sets out how the Group Board of Directors and Hospitals/MCS/LCO will interact.
- The framework supports the principle of earned autonomy in high performing Hospitals/MCS/LCO and the support provided to challenged sites.
- An annual performance agreement process will formally capture the contribution of each Hospital/MCS/LCO to Group corporate objectives and targets for the year.
- The framework operates a process of performance review, led by the Group Executive Team, which assesses the performance and risk of each Hospital/ MCS/LCO in delivering its plans and objectives and meeting agreed KPIs.
- Enables the corporate functions to identify potential support needs, by theme, as they emerge, allowing tailored support packages to the specific needs of each Hospital/ MCS/LCO, and drawing on expertise from across the corporate functions.

- The Trust AOF process incorporates 6 domains: Safety, Patient Experience, Operational Excellence, Finance, Workforce & Leadership, and Strategy. The process provides a holistic and transparent process for the monitoring of Hospital/MCS/LCO performance, all domains are equally weighted except for 'Safety' which is the override for monthly Hospital/MCS/LCO AOF scores.

- To support the AOF, monthly cycle a performance dashboard for each Hospital/MCS has been developed which captures in one place the overarching Hospital/MCS/LCO AOF score, individual domain scores and performance against the KPIs which form each domain. During 20223/23, the AOF process was stood down during August-October 2022 to prioritise safe Hive implementation, and again March 2023 as a result of industrial action. In December, they were reduced and the detail of performance was addressed during the Hospital/MCS/LCO review meetings.

- The Trust has a well-established Improving Quality Programme (IQP) and Accreditation process in place which examines performance across four domains; leadership and culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver, or gold. Areas that consistently achieve a Gold rating become eligible for an Excellence in Care Award providing a Gold rating is achieved in all domains. Patient experience survey data and quality of care data is used along with Accreditation outcomes to drive continuous improvement. The Quality and Performance Scrutiny Committee and the Board of Directors receives an Annual Accreditation Report, including details of the learning gained from the process.

- The Trust has in place a staffing escalation process to ensure the appropriate deployment of nursing and midwifery staff to support the needs of patient groups. An electronic e-rostering system is used to ensure that the planning and management of nursing and midwifery staffing across the Trust is effective and safe. During the pandemic response, this process was further enhanced by the implementation of Pandemic Safe Staffing Guidelines, which enabled close monitoring and escalation of the impact of the pandemic on nursing and midwifery staffing and a supported a Group-wide response where required.

- Governors hold Group Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that MFT does not breach the terms of authorisation. Governors receive Governors monitor the performance of MFT via the main Council of Governors meetings, Chairman's surgeries, and learning and development sessions.

- A comprehensive suite of evidence from MFT's Hospitals/ MCSs/ LCOs in support of this Self-Certification has been gathered through the Annual 'Well Led' Self-Assessment process.

APPENDIX B

Self-Certification Condition FT4(8) - Corporate Governance Statement Requirements

Statement 1:
The Board is satisfied that Manchester University NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Evidence:
The Group Chief Executive, as the Accounting Officer of the Trust, formally signs the Annual Governance Statement detailing how the Trust has maintained a sound system of internal control which supports the achievement of the Trust's policies, aims and objectives whilst safeguarding public funds and departmental assets. The Annual Governance Statement outlines the role of each Executive Board Member; the committee structure; how the Trust manages its risks and compliance with its Provider Licence.

The Annual Governance Statement is submitted to the Trust's External Auditors who provide assurance of MFT's compliance to NHSI (the 2022/23 Annual Governance Statement will be reviewed by the External Auditors in May 2022).

The Head of Internal Audit is required to produce an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

The Board of Directors completes a written return on external interests. This is updated twice a year and presented to the Board and made public on the Trust's website (latest update presented to the Board of Directors Public Meeting on 9th May 2023). Any conflicts of interest are declared on a regular basis and decisions on appropriate action are taken as these arise. Improvement is required on the compliance rates of interest declarations.

Statement 2:

The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.

Evidence:

Adherence to national guidance & policies on corporate governance is reviewed and updated (as required) at the Audit Committee. An overview of guidance is provided by auditors in updates received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee.

During 2020/21, the MFT Constitution itself was reviewed, with input from an independent Legal Adviser, three years following the formation of the new Manchester University NHS FT in October 2017. The reviewed and updated MFT Constitution (February 2021) was subsequently presented to the MFT Council of Governors for approval on 10th February 2021 and MFT Board of Directors on 8th March 2021. The Constitution will be reviewed again in the 2023/24 financial year to consider recent legislative changes.

Compliance with the new FT Code of Governance was assessed during 2022/23 with the results informing the Board Governance review initiated by the Chairman in the Autumn of 2022.

For the Trust's Well Led self- assessment process in 2022, all Hospitals/MCSs/LCOs were asked to self-assess themselves against the Well Led Key Lines of Enquiry (KLOEs) using a consistent template. An initial analysis of the returns from the Hospitals/MCSs/LCOs was carried out and evidence against the KLOEs at a Group level were added, informed by a Well Led assessment

which was collated for the CQC dynamic monitoring of Medicine divisions in Autumn 2021. Group Executive Directors were then be asked to allocate a current Group-level self-assessment for the KLOE categories which most fit their area of responsibility. The Trust's internal auditors, KPMG, were then asked to review the self-assessment to provide assurance that the conclusions reached are justified by the evidence amassed. The results of the exercise were reported to the Board of Directors in September 2022. Following that, Hospitals/MCSs/LCOs were asked for a progress report on their development in November 2022.

An external Well Led developmental review will be undertaken during 2022/23 to assess current arrangements and identify development opportunities.

Statement 3: The Board is satisfied that Manchester University NHS Foundation Trust implements:

a) Effective board and committee structures.
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees.
c) Clear reporting lines and accountabilities throughout its organisation.

Evidence

The Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance and Digital Scrutiny Committee, EPR Scrutiny Committee, and the Group Risk Oversight Committee) receive regular reports and supporting data analysis covering finance, performance, workforce, patient safety, patient experience and clinical quality.

The Scheme of Reservation and Delegation (updated May 2022) describes clearly the matters reserved for the Board and those matters which are delegated to sub committees.

Each Group Executive Director has clearly defined accountabilities and responsibilities as outlined in the Annual Governance Statement and the Scheme of Delegation. The Terms of Reference of each Committee, ratified by the Board in May 2023, describe the delegated authority and reporting lines within the organisation.

Statement 4: The Board is satisfied that Manchester University NHS Foundation Trust effectively implements systems and/or processes:

a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively.
b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations.
c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern).
e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making.to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.
f) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery.
g) to ensure compliance with all applicable legal requirements.

Evidence

Data is used throughout the Trust to triangulate quality/safety, workforce and financial indicators, which are monitored at Group level by the Board of Directors and its Scrutiny Committees. The introduction of the Hive EPR has enhanced the quantity and timeliness of data available.

The Trust's Single Operating Model is underpinned by the Accountability and Oversight Framework (AOF), which contributes to the overarching Board Governance Framework, enabling the Group Board of Directors to fulfil its obligations and effectively run the organisation. The AOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives and operational plan, and incorporates the key elements below:

- Fosters a culture of devolved decision-making and accountability
- Sets out how the Group Board of Directors and Hospitals/MCSs/LCOs will interact
- The framework supports the principle of earned autonomy in high performing Hospitals/MCSs/LCOs and the support provided to challenged sites
- An annual performance agreement process will formally capture the contribution of each Hospital/MCS/LCO to Group corporate objectives and targets for the year
- The framework operates a process of performance review, led by the Group Executive Team, which assesses the performance and risk of each Hospital/ MCS/LCO in delivering its plans and objectives and meeting agreed Key Performance Indicators (KPIs)
- Enables the corporate functions to identify potential support needs, by theme, as they emerge, allowing tailored support packages to meet the specific needs of each Hospital/MCS/LCO, and drawing on expertise from across the corporate functions.

The Trust's AOF process incorporates six domains: Safety, Patient Experience, Operational Excellence, Finance, Workforce & Leadership and Strategy. The process provides a holistic and transparent process for the monitoring of Hospital/MCS performance; all domains are equally weighted, except for Safety, which is the override for monthly Hospital/MCS/LCO AOF scores.

To support the AOF monthly cycle, a performance dashboard for each Hospital/MCS/LCO has been developed that captures in one place the overarching Hospital/MCS/LCO AOF score, individual domain scores and performance against the Key Performance Indicators that form each domain. During 20223/23, the AOF process was stood down during August-October 2022 to prioritise safe Hive implementation, and again March 2023 as a result of industrial action. In December, they were reduced and the detail of performance was addressed during the Hospital/MCS/LCO review meetings.

The Trust's Risk Management Framework and Strategy (RMFS) was reviewed during 2021/22 and the latest version was approved by the Board of Directors in May 2022. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored and managed appropriately. It defines how risks are linked to one or more of the Trust's strategic operational objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust. A new Risk Appetite Statement was approved by the Board in July 2022.

The Trust's RMFS also provides the Trust with a framework that identifies risk and analyses its impact for all hospitals and services for significant projects and for the organisation. The completion of Equality Impact Assessments is part of this process.

The Audit Committee monitors assurance processes and seeks assurance across all risks to provide independent assurance to the Board of Directors that risks have been properly identified and appropriate controls are in place. The risk appetite is determined by the Board and monitored by the Audit Committee to ensure that the risks faced are consistent. Internal and external audit services are used to investigate any areas of concern.

The Board has designated a Joint Group Medical Director and the Group Chief Nurse as the lead Executives and Joint-Chairs of the Quality & Safety Committee. This Committee sets the strategic direction for quality and safety for MFT. It is responsible for developing the

organisational strategy for quality and safety in line with national/international evidence-based practice and standards.

This Committee also ensures that MFT has the structures, systems and processes it needs in order to achieve its key clinical objectives, and that they are monitored and performance-managed. A significant amount of work has continued to develop clinical effectiveness indicators across all our Hospitals, MCSs and LCOs.

The Trust has a well-established Quality & Performance Scrutiny Committee (QPSC) that provides assurance on the Trust's work on quality (Patient Safety & Patient Experience) and performance (all key performance measures, excluding Workforce & Finance). The Committee is chaired by a Group Non-Executive Director, who identifies areas that require more detailed scrutiny, arising from national reports, Board Reports, the Board Assurance Report, patient feedback and public interest issues.

The Human Resources Scrutiny Committee (HRSC), chaired by a Group Non-Executive Director, reviews MFT's People Plan and monitors the development and implementation of the key workforce deliverables. At each meeting, it monitors key workforce metrics for assurance purposes.

The Finance and Digital Scrutiny Committee (FDSC), chaired by a Group Non-Executive Director, examines the incidence, nature and potential impact of emerging or identified significant financial risks to the Group's ongoing position and performance, either in-year or forward-looking. It also examines the Trust's ongoing response to national issues, policies and directives in relation to finance. It seeks and receives additional levels of assurance not routinely available within the confines of regular ongoing Group Board of Directors papers and discussion, together with scrutinising the specific turnaround or mitigation plans as developed, presented to and approved by the Group Board of Directors, in relation to managing the scale and impact of the identified risks. The FDSC also oversees all matters regarding informatics, data, analytics and information technology in the Trust. This includes how risks to data security are being managed and controlled.

The Board Assurance Framework (BAF) outlines the key strategic aims of the Trust and associated risks with plans to achieve aims and mitigate risk. Key workstreams associated with this are also monitored through the QPSC, HRSC and FDSC.

Reports provided by the Group Executive Directors are reviewed by the Board at each meeting to monitor the key metrics for patient safety, operational excellence, patient experience, and workforce. Monthly performance monitoring is also undertaken as part of the Trust's Accountability Oversight Framework (AOF) process, whereby Group Executive Directors review key metrics and delivery plans for each Hospital/MCS and LCO. Any hazard identified is analysed against its severity and the likelihood of it occurring. This determines the overall risk ranking and ensures there is a common methodology across the organisation. The strategy clearly sets out the individual and corporate responsibilities for the management of risk within MFT.

The Hospitals, MCSs, LCOs and corporate divisions systematically identify, evaluate, treat and monitor action on risk on a continuous basis. This work is then reported back through the local and corporate risk management and governance frameworks. This also connects the significant risks (those appraised at level 15 or above on the risk framework) to the organisational objectives and assesses the impact of the risks. The outcome of the local and corporate review of significant risk is communicated to the Group Risk Oversight Committee so that plans can be monitored. All Hospitals, MCS and LCO report on all categories of risk to both the Group Risk Oversight Committee and Quality & Safety Committees.

The Group Risk Oversight Committee undertakes further evaluation of the risks presented and their action plans and updates the Assurance Framework, so that at any given time, the significant risks to the organisation are identified. RMFS processes are closely aligned, and the Assurance Framework is dynamic and embedded in the organisation.

All identified risks within the organisation are captured in the Risk Register, managed within the Ulysses system. This also contains the detailed risk assessments and resulting action plans associated with the external assurance sources detailed under 'review of effectiveness'. The Board is therefore able to monitor progress against such action plans. Risk assessment is a fundamental management tool and forms part of the governance and decision-making process at all levels of the organisation. The Joint Group Medical Directors and Group Chief Nurse work closely on the alignment of patient safety and the patient experience. Clinical risk assessment is a key component of clinical governance and forms part of the Risk Register.

MFT has established arrangements to advise and engage with both the Manchester and Trafford Health & Wellbeing Scrutiny Committees when there are proposed service changes that may impact on the people who use our services. The Trust endeavors to work closely with patients and the public to ensure that any changes minimise the impacts on patients and public stakeholders.

MFT's Council of Governors is informed of proposed changes, including how any potential risks to patients will be minimised. The Director of Clinical Governance (and supporting Group Executive Directors) makes regular reports to the Governors on the position against Trust risks scored at 15 or above.

Governors, Group Executive Directors, and Group NEDs have attended forward planning meetings in Quarters 3 & 4 2022/23. At these sessions, performance against the priorities set for 2022/23 was reviewed and based on this, the Annual Plan for 2023/24 will be presented to the Board in May 2023. The MFT vision, strategic aims and key priorities for the coming year set the framework within which Hospital / MCS / LCO Annual Plans and the Trust operational plan were developed. This in turn formed the basis for setting objectives for individual members of staff. In this way the Trust ensures that all that it is doing is geared towards the delivery of its high-level vision and strategic aims.

Statement 5: The Board is satisfied that the systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:

a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided.
b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations
c) the collection of accurate, comprehensive, timely and up to date information on quality of care.
d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care.
e) that Manchester University NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and considers as appropriate views and information from these sources; and
f) that there is clear accountability for quality of care throughout Manchester University NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to Board where appropriate.

Evidence:

During 2022/23, the Trust approved an enhanced Quality and Safety Strategy that strengthened its arrangements for Quality Governance to support the implementation of the National Patient Safety Strategy, with the implementation of a Patient Safety Management System, which enables effective patient safety insight, oversight, management, learning, improvement and assurance. This systematic approach to understanding and assuring patient safety is being implemented throughout the Trust.

The Board of Directors includes two Group Joint Medical Directors and the Group Chief Nurse who are all supported by a number of suitably qualified deputies. One of the Non-Executive Directors is from a clinical background and has held Medical Director roles in other NHS organisations. The Board of Directors (Group Executives and Group Non-Executive Directors)

take part in Senior Leadership Walk Rounds across all Trust sites to assess how information from the Board is being received and implemented at ward level ('Board to Ward').

At each meeting, the Board considers reports regarding the quality of care provided to the Trust's patients. The increased level of reporting to the Board on actions to address complaints, 'Never Events', and safe staffing levels are all evidence of the Boards continued focus on quality improvement.

The Board is supported by the QPSC which receives assurance on all matters to do with quality and safety, including patient experience. During 2022/23 it received reports on:

- AOF summary reports and dashboard
- Never Events
- Patient Safety Incident Reporting, Management and Associated Learning
- Patient Safety Incident Response Framework
- MRI's Nutrition & Hydration Improvement Initiatives
- The Ockenden Report and MFT's Action Plan
- Decontamination
- Maintenance of Medical Equipment (MEAM)
- The NHS Resolution Maternity Incentive Scheme
- Annual Accreditation Report
- Annual Infection Prevention Control (IPC) Report
- Annual Complaints Report
- Annual Safeguarding Report
- Patient Experience Reports (including patient surveys)
- NHS Resolution Updates
- BAF risks aligned to the QPSC

Quality Impact Assessments (QIA) are examined and approved as part of each Hospital/MCS/LCO own Gateway Review process. Following which, a desktop review will be carried out at a Group level by the Chief Nurse, Joint Medical Director, Chief Operating Officer and Executive Director of Workforce & Corporate Business. The purpose being to review hospital scoring and documentation of mitigating actions to reduce the impact risk.

All project plans must include a range of Key Performance Indicators (KPIs), both financial and non-financial, that link to the quality of services or patient experience. These indicators inform a QIA to determine whether the project can go ahead based on the risk posed.

The executive team and corporate divisions, led by the Group Chief Nurse and Group Joint Medical Directors, provide oversight to the QIA process. Hospital/MCS/LCO Medical Directors and Directors of Nursing review and monitor the progress of projects to ensure that the standards of quality and patient experience are maintained.

The Trust has had an annual Accreditation process in place since 2011, which examines performance across four domains; culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver, gold or diamond. The Board of Directors receive regular reports on accreditation outcomes.

The Trust has a comprehensive monthly dashboard for in patient, day case and outpatient areas, which on a monthly basis triangulates patient feedback, ward manager quality care ward round reviews with other data such as Friends and Family Test feedback and falls/pressure ulcer incidents. This information is reviewed on monthly basis and informed improvement work as part of the culture for continued improvement.

The Trust participates in national and local clinical audits. Reports from which are submitted to the relevant committees and groups.

Statement 6: The Board of Manchester University NHS Foundation Trust is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Evidence

During 2022/23, a new Group Chief Executive was appointed following an extensive international recruitment process and an appointment process involving stakeholder panels and an interview panel which included national and regional NHS leaders, in addition to a Governor and a Non-Executive Director.

The Trust has a stable Group Executive Director Team with a track record in developing organisations as a leading centre for integrated health, teaching, research and innovation. The Group Medical Directors, Group Chief Finance Officer and the Group Chief Nurse are appropriately professionally qualified and accountable to their professional body (in addition to the Trust). The Group Executive team are supported by suitably qualified deputies, who meet fortnightly at the Corporate Directors meeting, and by the senior leadership teams of each of the Hospitals/MCSs/LCOs.

The Group NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance and healthcare. They are appraised by the Group Chairman on an annual basis. The Chairman undertakes a 360° appraisal facilitated by an external assessor. Appraisal reports of the Group Chairman and Group Non-Executives are provided to Governors.

MFT's future workforce requirements are driven by a clear vision and strategic aims. MFT is continuously reviewing its workforce and OD programme in the light of the NHS People Plan and developing organisational form and strategy. The MFT People Plan has been developed in the context of the National People Plan, regional priorities, existing Trust strategies and our COVID-19 response and recovery. MFT's high level workforce requirements are planned through the Trust's People Plan that is submitted to Health Education England. HR Directors work with the wider Hospital/MCS/LCO leadership and HR and OD teams, clinicians and managers within to develop their local workforce plans.

The Trust has in place a staffing escalation process to ensure the appropriate deployment of nursing and midwifery staff to support the needs of patient groups. An electronic e-rostering system is used to ensure that the planning and management of nursing and midwifery staffing across the Trust is effective and safe.
A Mandatory training programme is in place for all staff. It received a positive assessment from internal audit during 2022/23.

In addition to monitoring key workforce metrics at all meetings, the Board of Directors and the HRSC receive regular and frequent reports throughout the year including those form the Guardian of Safe Working and the Freedom to Speak Up Guardian.

Training of Governors

The Board is satisfied that during the financial year most recently ended, the Trust has provided, and continues to develop the necessary training to its new Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

APPENDIX C

Self-Certification Condition CoS7(3) - Commissioner Requested Services (CRS) Requirements

CRS Definition:
Services that will be subject to regulation by NHSI (Monitor) in the course of a licensee's operations; and, Location Specific Services, which is a subset of CRS that, in the event of a provider failure, must be identified and kept in operation at that specific locality.

- The current designation of MFT services as CRS continues to be a 'default' position (i.e. automatic full designation, across all services). Commissioners have again postponed a full and recurrent review of MFT services to make a proper and considered CRS designation.

- In effect, the current CRS designation remains inherited from the position in April 2013, when CRS principles were first established. At that point in time, the FT licence saw all NHS-funded services "grandfathered" into CRS status (pending service-line review) until 31st March 2016.

- In March 2016, the Manchester CCGs decided to extend that position through until at least October 2017. Since then, Manchester CCG has extended this in light of the MFT merger, ongoing SHS and LCO developments. This position has been maintained following the introduction of Integrated Cre Boards in July 2022. Given this, it would not be meaningful for MFT in isolation to undertake self-certification work across all services

- It has remained the CCGs', and now GM ICB's, ultimate intention to work with MFT to identify a revised list of CRS designated services. In the meantime, the view was that the current default designation provides stability and protection for services even though Commissioners remain able to re-procure or transfer services, as has been the case for time to time during the period since April 2013.

- In 2020/21 and 2021/22 there was no formal requirement to sign off full contract documentation between providers and commissioners. Due to the impact of COVID-19. With addressing COVID-19 and subsequent focus on elective recovery, any potential to review the list of CRS services has been severely constrained. With the introduction of GM ICB, to ensure consistency across GM, it is likely this will be considered during future contract negotiations.

- Given this position, MFT is unable to fully self-certify, across all services provided, that Option **A** or Option **C**are definitive.

Agenda Item 10.7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Peter Blythin, Executive Director of Workforce and Corporate Business
Date of paper:	May 2023
Subject:	National Staff Survey
Purpose of Report:	Indicate which by ✓ • Information to note • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The National NHS Staff Survey results are one of the primary methods by which MFT measures how well it supports the staff well-being and experience. This is essential to maintaining improved organisational performance.
Recommendations:	The Board of Directors is asked to: • Consider the strengths, improvements and areas for development following the 2022 Staff Survey Results. • Endorse the actions being taken in response to the survey results.
Contact:	Name: Peter Blythin Group Executive Director of Workforce and Corporate Business Tel: 0161 276 4795

1.0 Background and Context

1.1. The 2022 NHS Staff Survey results are based on staff in post and organisational structures as of 1st September 2022.

1.2. Since 2021, the survey questions have been aligned with the NHS People Promise, which sets out in the words of NHS staff the things that would most improve their working experience.

1.3. Survey questions are categorised into 7 People Promise elements and 2 themes of *staff engagement* and *morale* and are now comparable to 2021 data. These elements and themes include 21 sub-scores and 111 contributing questions.

1.4. The 2022 survey used the same methodology and timings as in previous years. All questions and key indicators reported in 2021 were retained to maintain comparability of trend data.

1.5. National reporting for 2022 includes results by Trust / Hospital / MCS /LCO and Corporate / R & I, at a People Promise element and a theme level for staff engagement and morale with question-level reporting provided at Trust Level. The national report also includes benchmarked data for individual questions at Trust level.

1.6. Five years of trend data is provided by the Survey Coordination Centre (SCC) at Trust level from 2018 to 2022.

1.7. Additional question-level reporting is available at Hospital / MCS / LCO/ Corporate level through an electronic results portal. This provides for a more granular analysis across a range of variables (e.g., protected characteristics, departments).

1.8. The national benchmark group for MFT in 2022 is "Acute and Acute and Community Trusts' with 124 organisations within the group.

1.9. The 2022 Staff Survey results were published nationally on 9th March 2023.

2.0. Response Rate

2.1. MFT ran a census survey mode in 2022. There were 8,304 completed surveys, giving a response rate of 30.2% (30% in 2021). The median response rate for the benchmark group was 44%.

2.2. Survey questions in 2022 are measured against the seven *People Promise* elements and two 'themes' staff engagement and morale. Questions not covered by these themes are reported individually. Appendix 1 outlines the overall staff engagement scores compared with national benchmarking data.

2.3. For context the SCC does not report on the statistical significance of differences between trust and sector key theme scores. However, MFT is within 0.2 of the sector average score for four of People Promise elements, with *We work flexibly* reporting the greatest difference of 0.4 and *We always learning* within 0.3. *We are safe and healthy* is within 0.1.

2.4. Reports at Hospital / MCS / LCO/ Corporate level (ESR level 3) are provided by the SCC for Key Themes only. Appendix 4 shows the overall staff engagement scores by Hospital / MCS / LCO/ Corporate comparing 2021 and 2022 data. Note there is no comparison for Charitable Funds due to confidentiality threshold.

3.0 Key Highlights

3.1. The Trust staff engagement score is 6.5 compared to 6.7 in 2021.

3.2. MFT is below the sector average score for 5 of the 7 NHS People Promise elements and 2 of the themes with "We are safe and healthy" and "We are always learning" staying the same as 2021. Details are shown in the table in section 4 below.

3.3. As part of the *We are safe and healthy element* there is a -2.0% difference compared to the benchmarking group, with MFT reporting at 26.1% compared to 28.1% in staff personally experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public.

3.4. *Staff engagement* and *morale* themes have both shown a statistically significant change with *morale* at 5.4 in 2022 compared to 5.5 in 2021.

3.5. For questions contributing to the Workforce Race and Equality Standards (WRES) the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months has declined for both white and all other ethnic groups since 2021. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion has declined for white staff and improved for all other ethnic groups. The percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months has shown an increase for white staff and a decline for all other ethnic groups.

3.6. For questions contributing to the Workforce Disability Equality Standards (WDES), there has been a decrease in the percentage of staff with a long-term condition experiencing harassment, bullying and abuse from managers 22.3% to 21.6% and from other colleagues from 29.9% to 27.1% However, there has been a decline for both those with and without a long-term condition who believe that MFT provides equal opportunities for career progression or promotion.

3.7. For 2022 seven local questions relating to Hive were introduced as a baseline to track workforce related benefits which can then be measured pre and post Hive implementation through the annual staff survey.

4.0. Individual Survey Questions

4.1. The 2022 survey scoring questions have been grouped within the People Promise elements and *staff engagement* and *morale* themes.

4.2. The 7 People Promise elements and themes have 111 scoring questions, with 21 sub-scores.

4.3. Of the 111 comparable questions the questions below have shown an improvement with the remainder of the questions showing a decline or remaining the same.

4.4. Within the theme "morale" the question *"I often think about leaving the organisation"* has risen from 34.9% in 2021, to 38.7% in 2022. For those staff considering leaving their current job the table below outlines the percentage of staff and their most likely destination.

	2021	2022
I would want to move to another job within this organisation	13.4%	12.1%
I would want to move to another job in a different NHS Trust/organisation	20.0%	20.7%
I would want to move to a job in healthcare, but outside the NHS	4.8%	7.2%
I would want to move to a job outside healthcare	8.1%	10.5%
I would retire or take a career break	9.9%	8.8%
I am not considering leaving my current job	43.8%	40.6%

4.5. All nine staff engagement questions have shown a decline, as have the thirteen morale questions.

4.6. Local questions in relation to Hive have been included in 2022 to ensure there is a baseline from the implementation of Hive. Each question has been designed to ensure longitudinal data can be tracked. The table below shows the questions and responses for 2022.

	Positive score	Negative score	Neither agree/ disagree
Hive has helped me plan ahead and be more organised in the way I work	15%	46%	40%
Hive has helped me to free up time to concentrate on the things that matter most in my job	11%	53%	36%
Hive makes MFT a more modern and attractive place to work	29%	32%	39%
Hive has helped me to feel more satisfied in my job	11%	50%	40%
Hive has helped me to produce information and data faster in my job	20%	44%	37%
Hive has enabled me to have more career development opportunities available at MFT	8%	51%	40%
Hive has helped me to cover services across the whole of MFT rather than where I am based	17%	40%	43%

Note all percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

5.0. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

5.1. The table below summarises the scores for the questions that contribute to the Workforce Race Equality Standard with the number of respondents in brackets.

Question	White		All other ethnic groups	
	2021	2022	2021	2022
Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months	26.4% (6,347)	25.3% (6,309)	27.1% (1,431)	27.4% (1,782)

Staff experiencing harassment, bullying or abuse from staff in the past 12 months	25.0% (6,357)	24.2% (6,316)	32.8% (1,433)	29.9% (1,785)
Staff believing that the organisation provides equal opportunities for career progression or promotion	57.1% (6,354)	54.8% (6,316)	39.9% (1,437)	42.2% (1,781)
Staff experiencing discrimination at work for manager/team leader or other colleagues in past 12 months	7.5% (6,331)	8.1% (6,280)	21.7% (1,430)	19.6% (1,764)

5.2. The table below summarises the scores for the questions that contribute to the Workforce Disability Equality Standard with the number of respondents in bracket.

Question	**With LTC/illness**		**Without LTC/illness**	
	2021	**2022**	**2021**	**2022**
Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months	32.8.% (1,827)	30.3% (1,870)	24.5% (5,941)	24.4% (6,267)
Staff experiencing harassment, bullying or abuse from manager in the past 12 months	22.3% (1,822)	21.6% (1,868)	11.4% (5,909)	11.4% (6,237)
Staff experiencing harassment, bullying or abuse from other colleagues in the past 12 months	29.9% (1,805)	27.1% (1,852)	17.9% (5,860)	17.8% (6,202)
Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.5% (886)	46.5% (826)	44.9% (1,954)	44.5% (2,010)
Staff believing that the organisation provides equal opportunities for career progression or promotion	48.2% (1,839)	44.6% (1,873)	55.3% (5,946)	53.9% (6,270)
Staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	32.8% (1,344)	31.4% (1,418)	21.7% (2,995)	21.6% (3,271)
Staff satisfied with the extent to which their organisation values their work	30.8% (1,820)	30.1% (1,862)	42.5% (5,862)	40.9% (6,239)

5.3. The percentage of staff, from 1,118 responses, who identified with a long-lasting condition or illness stated MFT had made reasonable adjustments was 63.8%, compared to 64.4% (1,042 respondents) in 2021.

5.4. The overall staff engagement for staff with a long-term condition or illness was 6.0 compared to the organisational average of 6.5.

6.0. Action Plans and Next Steps

6.1 Staff Survey response plans have taken a different approach to previous years to recognise the accelerated shift required on staff experience. This includes number of strategic workshops held with senior leaders from across the Trust to work as a collective group team. This way of working has enabled leaders, to consider at a group level, what needs to change to deliver a sustainable shift in staff experience. It has also increased the focus on getting the foundations right for everyone as the ‘critical path’ to improving staff experience.

6.2 The HR Scrutiny Committee on 18th April 2023 discussed the detail and received assurances about the action’s being taken to support a programme of work over the coming months centred on a ‘listening well’ organisational strategy.

6.3. The approach taken is based on NHS England Listening Well Guidance best practice.

6.4 The staff survey 2022 themes around meaningful listening and engagement and the opportunity to use digital enablement tools to support deeper, faster and more inclusive communication and engagement with everyone have been included in the plan. The plan also outlines four key enablers to accelerate our listening well plans. These are; the use of Menti.com an interactive conversation tool to engage and promote staff participation, the use of the MFT Big conversation brand to talk about what is really important for our staff, the use of regular surveys on our internal *OpenDoor* platform for targeted engagement and capitalise the use of our unique recognition system 'Shout Outs' as a means to celebrate and engage our staff as culture ambassadors around six areas:

i. Equity & Inclusion,
ii. Goals & Performance,
iii. Learning & Innovation,
iv. Teamwork,
v. Vison & Values
vi. Support & Compassion - our culture measurement areas of staff experience.

6.5 The Organisational Engagement Plan is currently being finalised and will be discussed at the next HRSC in June 2023.

6.6 Work is also underway to assess local Equality, Diversity, and Inclusion data for each Hospital / MCS / LCO / Corporate Service to understand the lived experience of staff with protected characteristics.

6.7. The 2022 results will be included in Accountability Oversight Framework discussions being led by the Group Chief Operating Officer with the support of Group Executive Directors.

6.8. To support a consistent approach to action planning and goal setting, a revised 'Staff Survey Action Plan Playbook' has been circulated. This support leaders and managers to work through a four-stage process in developing their plans.

6.9. Work will continue locally across the Hospitals / MCSs / LCO / Corporate Services to create 'a feel-good factor' for staff. Priority work will focus around staff recognition and acknowledging staff for their contributions to the Trust. Examples initiatives include, employee / team / leader of the month, staff awards, newsletters celebrating staff achievements, celebration of professional days, and staff thank you cards from Hospital / MCS / LCO Corporate Services Senior Leadership Teams. Further examples include festivals of belonging, wellbeing rooms, Kindness Weeks, allyship training and 'Let's Talk about Race' workshops to foster an inclusive culture.

7.0. Recommendations

7.1. The Board is requested to:

- Consider the strengths, improvements and areas for development following the 2022 Staff Survey Results.

- Endorse the actions being taken in response to the survey results.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Director of Corporate Business / Trust Secretary
Date of paper:	May 2023
Subject:	Board Assurance Framework (April 2023)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	A clear and effective Board Assurance Framework (BAF) enables the organisation to monitor the principal risks which are most likely to impact upon delivery of our Strategic Aims.
Recommendations:	The Board of Directors is asked to accept the latest BAF (April 2023) which is aligned to the MFT Strategic Aims.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Secretary Tel: 0161 276 4841

1. Background / Introduction

1.1 Significant risks to achieving the Trust's key strategic aims are reported to the Group Risk Oversight Committee (GROC) and through other established governance routes, dependent on the risk rating.

1.2 The Board Assurance Framework (BAF) presents the risks which have the most potential to impede MFT's delivery of its strategic aims. These risks are overseen by the relevant Board Scrutiny Committees.

1.3 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. To reflect the RMFS, a new format for the BAF was developed and presented for the first time to the Board of Directors in November 2022.

1.4 Since that Board meeting, the principal risks have been presented and reviewed at their relevant Scrutiny Committees and have been used to provide the context for discussions at those meetings.

1.5 In January and March 2023, the GROC noted the Board Assurance Framework and reviewed the strategic risk register, considered individual strategic risks in line with its work programme, and considered proposals from Group Executive Directors and Hospital/MCS/LCO Chief Executives for additions/amendments to strategic risks.

1.5 This report presents the BAF for April 2023 (Appendix A). It includes any changes to strategic risks, or additions/amendments to the detail under each principal risk, which have been approved through the processes outlined above.

1.6 In July 2023, the Board of Directors will receive the annual review of the RMFS and will be asked to confirm the Risk Appetite Statement for the next year. The Board of Directors will also be requested to review the principal risks to ensure that they continue to cover the risks most likely to impede delivery of MFT's Strategic Aims.

1.7 The design and format of the BAF, and the way in which strategic risks are reported to the Board, will be enhanced following the conclusions of the review of the RMFS to ensure better oversight for the Board of Directors and its Scrutiny Committees. This will include acting on any recommendations from Internal Audit's annual review of the BAF which is currently underway.

2. Recommendations

2.1 The Board of Directors is asked to accept the latest BAF (April 2023) which is aligned to the MFT Strategic Aims.

Board Assurance Framework: 2023/24

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic aims. Assurance is secured through a range of sources, within a robust governance process. The Board achieves this primarily through the work of its scrutiny committees, through audit and other sorts of independent review, and by the systematic collection and analysis of performance data. The Board Assurance Framework is a live document that will continue to be populated and amended as risks and assurances associated with the organisational objectives are identified

Strategic Aim	Scrutiny Committee	Principal risks aligned to strategic aims	Individual strategic risks aligned to Principal risks		Risk appetite for Strategic Aim
			No. of risks	Highest rated	
To focus relentlessly on improving access, safety, clinical quality and outcomes	Quality and Performance Scrutiny Committee	1. Failure to maintain the quality of services	7	20	Strongly averse to any risk
		2. Failure to sustain an effective and engaged workforce	2	20	
		3. Failure to maintain operational performance	14	20	
		9. Failure to meet regulatory expectations, and comply with laws, regulations, and standards.	15	20	
		10. Failure to continually learn and improve the quality of care for patients	2	20	
To improve continuously the experience of patients, carers and their families	Quality and Performance Scrutiny Committee	1. Failure to maintain the quality of services.	7	20	Strongly averse to any risk
		3. Failure to maintain operational performance	14	20	
		8. Failure to maintain a safe environment for staff, patients and visitors	6	20	
		9. Failure to meet regulatory expectations, and comply with laws, regulations, and standard	15	20	
To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	Human Resources Scrutiny Committee	2. Failure to sustain an effective and engaged workforce	2	20	Open to taking opportunistic risk
To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future	Human Resources Scrutiny Committee	2. Failure to sustain an effective and engaged workforce	2	20	Open to taking opportunistic risk
To use our scale and scope to develop excellent integrated services and leading specialist services	Board of Directors	5. Failure to deliver the required transformation of services	0	N/A	Significant appetite to exploit opportunistic risk
		7. Failure to deliver the benefits of strategic partnerships	0	N/A	
To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve	Board of Directors	7. Failure to deliver the benefits of strategic partnerships	0	N/A	Significant appetite to exploit opportunistic risk
To achieve and maintain financial sustainability	Finance and Digital Scrutiny Committee	4. Failure to maintain financial sustainability	1	15	Strongly averse to any risk that could result in non-compliance with standards
		6. Failure to achieve sustainable contracts with Commissioners	4	16	
To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	Board of Directors	5. Failure to deliver the required transformation of services	0	N/A	Significant appetite to exploit opportunistic risk
		7. Failure to deliver the benefits of strategic partnerships	0	N/A	

MFT's Principal risks			
1	Failure to maintain the quality of services	6.	Failure to achieve sustainable contracts with Commissioners
2	Failure to sustain an effective and engaged workforce	7.	Failure to deliver the benefits of strategic partnerships
3	Failure to maintain operational performance	8.	Failure to maintain a safe environment for staff, patients and visitors
4.	Failure to maintain financial sustainability	9.	Failure to meet regulatory expectations, and comply with laws, regulations, and standards
5.	Failure to deliver the required transformation of services	10.	Failure to continually learn and improve the quality of care for patients

Principal risk 1: Failure to maintain the quality of services

Oversight Committees	
	Quality and Performance Scrutiny Committee
	Group Risk Oversight Committee

Risk appetite

We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk.

Strategic risk(s)

Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress
MFT/001150	Safe storage of medicines	16	20	8	4	↓
MFT/005182	Optimising human/ system interaction to ensure patient safety	20	20	4	4	↔
MFT/005930	Response to national maternity recommendations	15	15	10	5	↔
MFT/005480	HIVE implementation related risk to clinical outcomes	12	15	8	5	↓
MFT/004492	Informatics resource capacity	16	16	8	4	↔
MFT/000363	Malicious attacks to IT systems	15	15	10	10	↔
MFT/006352	Clinical Risk relating to delays in patients accessing diagnostics and treatment	15	15	9	6	↔

Controls

Vision, Values and Behavioural Framework
Annual Operational Plan
Quality and Safety Strategy
Annual Plan
Patient Safety Profile and Plan (PSIRP)
Risk Management Strategy and Framework
Quality Strategy
Safety Oversight System
Incident management policy
Infection Prevention and Control Standards, policy and accountability infrastructure
Long wait harm review process
Patient Experience Strategy
IQP programme
Informatics strategy (incl Cyber security)

Information governance infrastructure
Quality improvement collaboratives
CQC improvement programme
Performance (RTT/ECS/Cancer) benchmarking
PLACE assessments
Freedom to Speak Up programme
Clinical Accreditation Scheme
Workforce: Safe staffing escalation matrix and risk triggers, appraisal, mandatory training, sickness absence benchmarking
Patient safety alert management process
Medical Examiner System
NICE guidance implementation programme
Safety critical policies

Internal audit programme relevant to controls
National Audit Programme
Health and safety related policies
Structured Judgement Review Programme
LeDeR Programme
Policy and Procedure compliance benchmarking
Quality Governance infrastructure
Safeguarding Governance, policy and accountability infrastructure
Human factors academy
Compliments, complaints and concerns policy
WMTM patient experience programme
Business case being developed for quality improvement at Saint Mary's
Governance underway for 5 potential 'high risk' areas.
Review underway of quality of insourced providers

Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Implementation of external recommendations	Implementation of revised policy, governance and assurance framework	30/6/23	On track
Safety Critical Policies-governance and review sub-optimal	Action plan to address in place (monitored by IGRC)	30/9/22	Compromised
Availability and use of system reliability measures to identify potential risk-aligned to informatics capacity risk 004492	Risk assessment with clear action plan to undertaken-interim patient safety profiles for areas of high risk in place	31/5/23	New
National patient safety training offer not fully formalised	Local training provision to meet identified need in place	31/3/23	Complete
Mental Health Strategy not yet fully implemented	The Trust's Mental Health Strategy has been in development since November 2022. Extensive consultation of the Strategy has delayed its ratification to June 2023.	30/05/23	Compromised
Internal Audit-CQC compliance action response (NMGH) partial assurance	Management led action plan to address gaps in assurance in place	31/8/23	New
CQC inspection Maternity-significant improvement required (safe domain)	Executive led action plan in place to address requirements	23/6/23	New

Routine Sources of Assurance

Site/MCS/LCO assurance

Minutes of Site/MCS/LCO Quality and Safety Committees/risk/performance committees
Accountability Oversight Framework
Escalation of risks to Quality and Safety Committee from site/MCS/LCO governance
Placement satisfaction benchmarking (medical students)
Safe Staffing Reports
Clinical accreditation outcome
Annual Safeguarding workplan
Mandatory training compliance reports
IQP output and assurance

Group assurance

Patient Safety Profile
Bi-annual NMAHP safe staffing report
Integrated Risk Profile
Annual Safeguarding report
Safeguarding Adults Annual Assurance statement
Annual Clinical Audit Report
Annual Learning from Death report
Infection Prevention and Control Report
Health and Safety Annual report
EPRR Core standards
Clinical Accreditation annual report
Minutes of relevant Group Committees
Annual report/Quality account
IPC Board Assurance Framework (next iteration in draft format)
Maternity dashboard (in development)
Integrated Performance Report (in development)

External Assurance

Internal Audit
CQC-Dynamic monitoring/inspections
NHSE-Maternity scrutiny
National inpatient survey
GIRFT
Section 11 audit (safeguarding)
Cyber security assurance
Data Security Protection Toolkit
IPC Assurance Framework
Quality Account/Annual report: external review
ICS quality review

Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Internal Audit-risk management strategy-Significant assurance with opportunity for improvement	Action plan in place-focused on operalisation of the RMFS	31/5/23	New
CQC inspection Maternity-effectiveness of Board reporting and escalation	Executive led action plan in place to address requirements	23/6/23	New
Internal Audit-Learning from harm-significant assurance	Policy review aligned to PSIRF implementation	31/5/23	New
Real time quality assured quality and safety data	Implementation of HIVE	31/3/23	Complete
Understanding of the impact of inequality on the safety of patients	Programme of work in place to address optimising insight	31/3/23	Complete
IQP programme	Ensure embedded in all areas	31/3/23	Complete
NICE Guidance implementation	Revised assurance process to be implemented	30/6/23	On track

Principal risk 2: Failure to sustain an effective and engaged workforce

Oversight Committees	
	Human Resources Scrutiny Committee
	Group Risk Oversight Committee

Risk appetite

We are strongly averse to any risk where it involves potential exposure to significant harm for our people. We are open to taking opportunistic risk in improving the recruitment and retention of a diverse inclusive workforce, recognising the challenging recruitment environment

Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress
MFT/005182	Optimising human/ system interaction to ensure patient safety	20	20	4	4	↔
MFT/004003	Staff psychological wellbeing	15	15	10	5	↔

Controls

NHS People plan MFT People Plan NMAHP Safe Staffing Escalation Policy and risk framework Safer Nursing Care Tool (SNCT) census E-roster KPIs Workforce KPIs Values and Behaviours Framework Diversity and Inclusion Strategy Workforce policies and procedures Workforce governance structure Accountability Oversight Framework Medical Directors Workforce Board NMAHP Professional Board Diversity and Inclusion groups and networks	Informatics Strategy Equality, Diversity and Human Rights Strategy Freedom to Speak Up Workforce Predictive modelling Staff-side multi-union liaison programme Workforce electronic management systems Mentorship and coaching Top Leaders Programme Flexible working policy Freedom to Speak Up Programme Rostering Policy EHW Service Staff Appraisal Talent Management / Talent Board	Mandatory Training programme Workforce plans Job Planning Policy Operational Plan Leadership and Culture strategy Domestic and international recruitment strategies Guardian of Safe Working Risk management strategy and framework Mutual Aid MoU Staff Health & Safety risk assessments Health and Safety Policies and procedures HR Scrutiny Committee Board Wellbeing Guardian

Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Formal Employee Health and Wellbeing Strategy	Strategy being developed. Currently out for consultation with supporting diagnostic tool.	30/6/23 (changed from 31/3/23)	On track
Policy profile development	Policy profile under review	31/3/23	Complete

Routine Sources of Assurance

Site/MCS/LCO assurance	Group assurance	External Assurance
Workforce dashboards Daily safe staffing huddles (nursing and midwifery) Safe staffing risk escalation process Accountability Oversight Framework Job plan status reports Roster confirm and challenge bar Staff appraisal Personal objective setting	Monthly Nursing and Midwifery workforce dashboards Bi-annual Safer Staffing reports to BoD Safer Nursing Care Tool used to support annual inpatient establishment reviews 7DS joint assurance group and action plan GoSW reports Integrated risk profile Workforce Race Equality Standard Workforce Disability Equality Standard Annual NMC Revalidation report Regulatory assurance framework and map Minutes of relevant Group Committees Annual report/Quality account IPC Board Assurance Framework (next iteration in draft format) Integrated Performance Report (in development)	GMC survey Staff survey Model Hospital Workforce planning return (NHSE) Monthly safe staffing reporting to NHSE (Nursing and midwifery) NHSE monitoring reports (medical workforce) Annual Report audit

Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Allocate Medical Workforce solution	Roll out to be completed	31/3/24	On track (target date changed to March 2024 from March 2023)
Limitations of GoSW reports	Reports to be expanded (non-training grade)	31/3/23	Complete

Principal risk 3: Failure to maintain operational performance	Oversight Committees	Quality and Performance Scrutiny Committee
		Group Risk Oversight Committee

Risk appetite

We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk. We will be cautious about any risk that could compromise data quality or data security in the context of performance and reputational risks; and we commit to continuous improvement in these areas.

Strategic risk(s)		Risk score: Current	Initial	Residual	Target	Progress
MFT/006469	Urgent care and flow	16	16	8	8	↔
MFT/000694	-Paediatric ED physical and staffing capacity (RMCH)	16	16	12	8	↔
MFT/006475	Cancer Pathways	12	12	8	8	↔
MFT/006467	Diagnostic delays	16	16	8	8	↔
MFT/001253	-Adult Histo-pathology provision	20	20	8	8	↔
MFT/00467	-Paediatric MR scanner	16	16	4	8	↔
MFT/006470	Scheduled care	16	16	8	8	↔
MFT/002263	-Cardiac Surgery Capacity	15	15	5	8	↔
MFT/005559	-Thoracic surgery capacity	15	15	8	8	↔
MFT/003018	-Paediatric Haematology/Bone Marrow Transplant, Benign Haematology and Oncology Services	16	16	4	4	↔
MFT/004432	Renal dialysis capacity	16	16	4	4	New
MFT/005198	NMGH critical estate building infrastructure	20	16	8	8	↔
MFT/005482	HIVE implementation related risk to clinical outcomes	12	15	9	6	↓
MFT/004492	Informatics resource capacity	16	16	8	8	↔

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Annual Plan MFT recovery programme (including response and recovery group) Performance management frameworks GM networks EPRR policies and plans Business Continuity plans EPRR governance framework Trust Access Policy Quality and Safety Strategy ICS engagement Strategic Oversight Framework	Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking Performance Governance infrastructure Risk management framework and strategy Health and Safety Related Policies Clinical Policies/Guidance Health inequalities Elective PMO hub Enhancement of Trafford Elective Hub	Health Informatics/Business Intelligence function Data Quality Governance infrastructure Digital strategy Technical Design Authority Training programme in place for key Operational and Clinical Systems Recovery Plans/Contingency Plans for critical systems Data Centre & Health Informatics reporting infrastructure Regular data back-ups and checks on the integrity of the back-ups	Operational Excellence governance and framework to oversee delivery and coordination of activities in UEC and Elective care across MFT	Framework being developed and new governance arrangements planned	15/5/23 (changed from 31/3/22)	On track

Routine Sources of Assurance			Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance	**Group assurance**	**External Assurance**	Management of elective waiting lists/slot utilisation	Programme in place to ensure MFT treats most clinically urgent cases first Trafford elective hub Theatre improvement workstream in place to maximise TGH Theatres GIRFT relaunched and governance in place led by group Medical Directors for HVLC & Day case opportunities	10/5/23 (changed from 31/3/23)	On track
Capacity and delivery plans Risk profiles Performance committee minutes Risk management committee minutes Accountability Oversight Framework Trajectories	Weekly response and recovery group Routine Committee reports aligned to delivery of the Trust's access policy Minutes of relevant Group Committees Integrated Group Risk Profile Accountability Oversight Framework Integrated Performance Report (in development) Group Recovery Board	Internal Audit Peer review GIRFT NHSE approval of Trust Access Policy Implementation of and adherence to national and regional guidance in relation to clinical prioritisation, IPC measures, safety netting and monitoring of waiting lists Annual report/Quality Account ICS performance review	Training on access policy to be robust and mandated for all staff.	Compliance report in development Training programme refreshed and mandated through e-learning modules	30/6/23 (changed from 31/3/23)	On track
			Measuring health inequalities impact on performance to identify areas of focus	Programme of work in development, with focus initially on urgent care and cancer	30/6/23 (changed from 31/3/23)	On track
			Visibility and tracking of Performance HIVE	Data validation and reconciliation and dashboards in development Dashboards in development through Informatic Services	31/5/23 (changed from 31/3/23)	On-going

Principal risk 4: Failure to maintain financial sustainability	Oversight Committees	Finance and Digital Scrutiny Committee Audit Committee Group Risk Oversight Committee

Risk appetite

A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective and given the challenging financial and operational environment that currently exists across the NHS, it is inevitable that a higher level of risk is inherent in these areas. We are mindful that there must be consideration of the balance of risk across all domains, hence financial risk is considered alongside all others.

Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress
MFT/005092	Compliance with control total	20	15	10	10	↑

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Agreement of the Annual plan by Board/ICB and NHSE/I Hospital control level financial targets including WRP targets established and signed off by EDT and Hospitals Accountability oversight framework Financial Control policy infrastructure SFIs/Standing Orders and Scheme of Delegation Trust electronic financial system reflects the approved SFIs and Scheme of Delegation Monthly/Bimonthly finance reviews take place of Hospital financial performance Business Case sign-off process	The Finance and Digital scrutiny committee contributes to the development of the annual financial plan (including oversight of WRP) and receives quarterly assurance on progress. The committee receives regular finance reports including forecasts and challenges performance and targets The committee reviews and approves the Trust's financial and operational plans prior to submission to the Board and ICB and regulators	Regular attendance at GM and regional meetings which includes scrutiny of GM finance and Trust finance	Weaknesses in controls identified through external audit, internal audit and counter fraud. Gaps caused by overall system pressure are emerging. Pressures on Control Totals resulting from workforce shortages, leading to greater use of higher cost Bank and agency, insourcing arrangements, collective action such as BMA rate card and refusal to offer ECL's, allied to activity pressure to recover pre COVID activity levels mean that Hospital Control Totals and WRP savings are not achieved or only achieved non recurrently and thus MFT fails to achieve its control total. Pressure on Group control total arising from GM ICB deficit position for 23/24 and apportionment methodology for savings.	Control weakness with associated actions are logged and a defined programme is established, monitored and reviewed New pressures emerging have seen tightening of expenditure controls, now extended to all frontline services and supporting services but remain subject to QIA. Ongoing work to support hospitals and corporate in achievement of targets by new control totals for 23/24 and enhanced review through regular Finance and Productivity meetings, early intervention if "off plan" Established Finance and Productivity Board under the Group CEO and extended support to WRP process with additional resources and senior input	22/23 Control Total March 2023 23/24 Control Total March 2024	Complete for 2022/23 In progress

Routine Sources of Assurance: Site/MCS/LCO assurance	Group assurance	Independent assurance	Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Finance governance infrastructure is replicated in all operating units with a qualified Finance Director as part of each operating units Senior Leadership Team. The SLT of each unit receives a finance report providing a summary of all financial performance metrics at regular meetings The SLT receives a report on progress to achieve WRP/Cost Improvement Programmes across the operating unit The CEO of each unit signs off and supplies to Group a monthly result and forecast pack. SLT attend finance reviews and AOF meetings	Monthly finance reporting to Audit Committee, GMB, FDSC and BoD Annual Report includes Financial budget that is triangulated with Operations and Workforce requirements and subject to QIA The Finance and Digital Scrutiny Committee meets on a bi-monthly schedule with an agreed annual workplan in place, The Chief Finance Officer is the Executive Lead for the committee. Established Finance and Productivity Board under the Group CEO and extended support to WRP process with additional resources and senior input. GMB is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide financial assurance to the Board In accordance with the Trust's Risk Policy, the Group Risk Committee receives a report on high-level financial risks, and can access all risk status through the Ulysses on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF • All operational risks associated with finance & performance are also monitored through the GMB The Audit Committee receives an update on trust-wide policies related to the duties of the committees and on the implementation of recommendations from internal audit reviews The respective committees complete a self-assessment against its work in respect of the agreed Terms of Reference and Workplans Group Recovery Board Integrated Performance Report (in development)	Monthly reporting to ICB and regular holding to account meetings Monthly NHSE reporting and reviews Head of Internal Audit opinion External Audit reviews, Value for Money conclusion and external audit/going concern opinion Internal Audit Assessment of controls and regular reviews reported to Audit Committee and Counter Fraud Service Assessment Reviews by HMRC Additional external review commissioned to ensure all WRP opportunities have been identified.	Weaknesses in assurance identified through external audit, internal audit and counter fraud. Gaps caused by system pressure are emerging Pressures on Control Totals resulting from workforce shortages, leading to greater use of higher cost Bank and agency, insourcing arrangements, collective action such as BMA rate card and refusal to offer ECL's, allied to activity pressure to recover pre COVID activity levels mean that Control Totals and WRP savings are not achieved or only achieved non recurrently Pressure on Group control total arising from GM ICB deficit position for 23/24 and apportionment methodology for savings.	Assurance weakness with associated actions are logged and a defined programme is established, monitored and reviewed New pressures emerging have seen tightening of expenditure controls, now extended to all frontline services and supporting services but remain subject to QIA. Ongoing work to support hospitals and corporate in achievement of targets by new control totals for 23/24 and enhanced review through regular Finance and Productivity meetings, early intervention if "off plan" Established Finance and Productivity Board under the Group CEO and extended support to WRP process with additional resources and senior input	22/23 Control Total March 2023 23/24 Control Total March 2024	Complete for 2022/23 In Progress

Principal risk 5: Failure to deliver the required transformation of services	Oversight Committees	Group Risk Oversight Committee

Risk appetite

We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients.

Strategic risk(s)	Risk rating				
	Current	Initial	Residual	Target	Progress

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Transformation programme structures at System and Trust level including Programme Board and workstream groups Annual Plan MFT Clinical Services Strategy MFT Single Service Group Group Service Strategy Committee (GSSC) Single Service Development Assurance Process			Ensuring Group Transformation plans and local hospital/MCS are aligned	Clear prioritisation of focus areas via Operational Readiness Authority	Ongoing	On track
				Establishment of MFT Transformation Network	Nov 22	Complete
				Aligning Transformation to the new Hive Delivery Authorities when established	April 2023	On track

Routine Sources of Assurance			Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance	**Group assurance**	**External assurance**				
Operational Readiness Authority Pathway Councils Hospital/MCS Post Live Readiness Assessments, including post live metrics	Hive Stabilisation Board EPR programme Board End of year reviews Pathway Council Oversight Committee Post Live Readiness Assessments, including post live metrics Single Service Boards established Single Service management arrangements in place Year-end Annual Plan review Minutes of GSSC	Deloitte – Hive Gateway reviews				

Principal risk 6: Failure to achieve sustainable contracts with Commissioners

Oversight Committees	
	Financer and Digital Scrutiny Committee
	Group Risk Oversight Committee

Risk appetite

We believe that all regulatory standards, including clinical, professional and financial standards, are the minimum that we need to achieve to be outstanding; we are strongly averse to any risk that could result in non-compliance with standards, or poor clinical or professional practice. We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients.

Strategic risk(s)		Risk rating				
		Current	Initial	Residual	Target	Progress
MFT/006469	Urgent care and flow	16	16	8	8	revised
MFT/006475	Cancer Pathways	12	12	8	8	revised
MFT/006467	Diagnostic delays	16	16	8	8	revised
MFT/006470	Scheduled care	16	16	8	8	revised

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Clinical services strategy Annual plan Internal/external review for service reconfiguration to strengthen key specialised services Strategic clinical network engagement NHSE/Shelford group engagement Risk management framework and strategy	Involvement in operational delivery networks (QSIS) Partnership group membership ICS engagement Quality Surveillance review process	National clinical service specifications	Compliance with national clinical service specifications where derogations are not in place.	Risk stratified review of compliance with national service specifications	Ongoing	On track
			Impact of changes to funding/commissioning (ICB/population based)	Engagement with NHSE/NW region and Shelford Group	31/3/24	On track
			NHSE portfolio of national service reviews	Regular dialogue in place reviews	Ongoing	On track

Routine Sources of Assurance			Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance	**Group assurance**	**External assurance**	Specialised services dashboards	GSSC to review dashboards	30/9/23	On track
Accountability oversight framework	Single hospital service governance Specialised service quality and performance dashboards	Quality surveillance reviews				

Principal risk 7: Failure to deliver the benefits of strategic partnerships	Oversight Committees	Group Risk Oversight Committee

Risk appetite

We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk. We are open to taking opportunistic risk associated with the implementation of emerging technology. However, we seek to minimise exposure to cyber risk. We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients.'

Corporate/Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Direct involvement in establishment of ICS Governance MFT Representation on ICS Boards and Groups Regular attendance at ICS meetings Involvement in development of GM Joint Forward Plan Involvement in development of locality governance arrangements Representation on locality Boards and Groups	Regular attendance at locality board meetings Engagement with PFBMFT Representation on PFB Groups MFT clinical service strategy Partnership Boards Group Service Strategy Committee (GSSC)		There is no comprehensive map of GM/PFB/locality groups to ensure prospective coverage of key meetings	Documentation of groups and MFT representation for all GM ICS/PFB /locality groups	30/06/23 (changed from 31/03/23 and 1/12/22)	On track

Routine Sources of Assurance: Site/MCS/LCO assurance	Group Assurance	External assurance	Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
	MFT reps in key roles in ICS MFT reps in key roles in PFB Terms of reference for partnership boards Minutes of GM ICB and ICP Minutes of locality Boards Minutes of GSSC Minutes of Partnership Board meeting Regular reporting to Board and committees on ICS development and activities GM ICB Joint Forward Plan GM ICP Integrated Care Strategy	MFT Clinical service strategy approved by GM Partnership	There is no single document showing GM ICS groups and MFT reps	Create live database of GMICS meetings and MFT reps	30/06/23 (changed from 31/03/23 and 30/12/22)	On track
			There is no list of key strategic partner Trusts	Create live database of key partner Trusts including details of any formal governance for the partnership	30/06/23 (changed from 31/3/23)	On track

Principal risk 8: Failure to maintain a safe environment for staff, patients and visitors	Oversight Committees	Quality and Performance Scrutiny Committee
		Group Risk Oversight Committee

Risk appetite

We believe that all regulatory standards, including clinical, professional and financial standards, are the minimum that we need to achieve to be outstanding; we are strongly averse to any risk that could result in non-compliance with standards, or poor clinical or professional practice. We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety. We are strongly averse to any risk where it involves potential exposure to significant harm for our people.

Corporate/Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress
MFT/005182	Optimising human/ system interaction to ensure patient safety	20	20	4	4	↔
MFT/001253	Adult Histo-pathology provision	16	16	4	4	↔
MFT/005198	NMGH critical estate building infrastructure	20	16	8	8	↔
MFT/000694	Paediatric ED physical and staffing capacity (RMCH)	16	16	12	8	↔
MFT/004430	Asbestos management and controls	16	16	4	4	↔
MFT/000213	Fire stopping	15	15	5	5	↔

Controls			Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Health and Safety policies and procedures Health and safety governance infrastructure Business Continuity Plans Risk management strategy and framework Maintenance regimes Authorising engineers in place for critical services Proactive risk management system to continuously measure and monitor risk and prioritise investment and allocation of resource	Comprehensive Planned Preventative Maintenance Programme (ensuring the Estate, Plant, Infrastructure and Equipment is safe, compliant and utilised to its maximum capacity and full lifecycle) Reactive Maintenance to ensure the Estates, Plant, Infrastructure & Equipment are returned to use in a timely manner Governance structure and processes established to monitor passive fire protection (PFP)	Priority risk based annual Capital Bids to improve the Estate and upgrade Plant, Infrastructure Equipment etc. Scheduled Site level reporting and monitoring Estates operational strategy Site and group-based specialist teams responsible for fire safety, asbestos management, medical gases and other regulated activity.	Out of date asbestos surveyors and management plans	MFT Asbestos Management Plan ratified and in date. Further works required to ensure plan is implemented by contractors and wider key stakeholders. Surveys programme across acute sites underway and new management actions can be compiled on completion of these. Training programme in place and delivery of different levels of asbestos awareness training in progress	30/11/23	On track
			NHS funding for NMGH not yet approved. Delivery of NHP dependent on national timelines.	Continue to develop NHP cohort 3 FBC for approval Re-development works on site currently	Dependent on national timelines	On track
			Asset management and Planned Preventative Maintenance (PPM) tasks recorded on different systems at NMGH	Review of PPMs and GAP Analysis to be carried out.	31/10/23	On track
			Controls broader than fire stopping. Gaps in fire safety training, remedial works completion following fire risk assessments; fire stopping PPM compliance assurance; evacuation risk assessments	Fire safety risk assessment programme in place; fire stopping programme in place; review fire PPMs required. Risk MFT/000213 is currently under review and updated risk to capture broader fire safety management is being developed.	29/12/23	On track

Routine Sources of Assurance: Site/MCS/LCO assurance	Group assurance	Independent Assurance	Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Certification relating to remedial actions (building regulations) health and safety Committee minutes	Premises Assurance Model Health and Safety Committee (operational/strategic) minutes Estates Department Performance & Assurance Framework Monthly Directorate Statutory Compliance Group Assurance Meeting Capital Planning (scrutiny and overview of the Trust's planned maintenance) PEOC	Independent certification of remedial actions where required Internal Audit Programmes External Accreditation	MRI do not currently have an operational health and safety committee	MRI have established a Health and Safety Forum	31/12/22	Complete
			Range of outstanding remedial work identified through external audit	Infrastructure schematics updated in relation to outstanding remedial works	31/3/24	On track
			PEOC does not formally report via a Scrutiny Committee	Reporting route agreed	1/2/23	Complete

Principal risk 9: Failure to meet regulatory expectations, and comply with laws, regulations, and standards	Oversight Committees	All relevant scrutiny committees Group Risk Oversight Committee

Risk appetite

We believe that all regulatory standards, including clinical, professional and financial standards, are the minimum that we need to achieve to be outstanding; we are strongly averse to any risk that could result in non-compliance with standards, or poor clinical or professional practice.

Corporate/Strategic risk(s)		Risk rating				
		Current	Initial	Residual	Target	Progress
MFT/001150	Safe storage of medicines	16	20	8	4	↓
MFT/005182	Optimising human/system interaction to ensure patient safety	20	20	4	4	↔
MFT/002842	Decontamination service	16	16	12	8	↔
MFT/005930	Response to national maternity recommendations	15	15	10	5	↔
MFT/000363	Malicious attacks to IT systems	15	15	10	10	↔
MFT/004003	Staff psychological wellbeing	15	15	10	5	↔
MFT/005092	Compliance with control total	15	15	10	10	↔
MFT/005198	NMGH critical estate building infrastructure	20	16	8	8	↔
MFT/004430	Asbestos management and controls	16	16	4	4	↔
MFT/000213	Fire stopping	15	15	5	5	↔
MFT/0006352	Clinical Risk relating to delays in patients accessing diagnostics and treatment	15	15	9	6	↔
MFT/006469	Urgent care and flow	16	16	8	8	↔
MFT/006475	Cancer Pathways	12	12	8	8	↔
MFT/006467	Diagnostic delays	16	16	8	8	↔
MFT/006470	Scheduled care	16	16	8	8	↔

Controls		Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Risk management strategy and framework Policy and procedure infrastructure covering all legislation Assurance Framework and map External visits register	Site and group based specialist teams responsible for regulated activity (e.g. fire safety, asbestos management, medical gases) Nominated individuals in place across the Trust as required by legislation	Policy governance	Trust-wide review required	31/12/22	Compromised
		Policy and guidance accessibility	Review of current solution required	31/12/22	Complete
		Policy and guideline accessibility	Requires improved electronic management system-procurement supporting potential tender process	31/7/23	New
		Consent policy	Requires review in light of EPR implementation-policy out for final consultation	30/11/22	Complete
		Assurance Framework and Map-limited engagement with Sites/MCS/LCO	Additional resource identified to support site/MCS/LCO implementation	30/5/23	New
		CQC Maternity inspection-controls supporting Board and scrutiny committee sub-optimal (including data)	Review of assurance reporting and escalation to Board and Scrutiny Committees	30/5/23	New

Routine Sources of Assurance			Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO	**Group assurance**	**Independent assurance**	Effectiveness of application of the MCA (internally)	Audit of compliance	31/3/23	On track-outcome awaited
Quality and risk governance infrastructure-Committee meetings and risk escalation Health and Safety Compliance Auditing	Annual reporting schedule External visits register reporting Annual Governance Statement Annual Health and Safety report Annual Safeguarding report Annual Infection Prevention & Control Report Infection Prevention & Control Board Assurance Framework Data Security Protection toolkit High Priority Clinical Audit Programme Clinical Audit Annual report Assurance framework and map Annual HTA report	Regulator visits and inspections External audit opinion of Annual Governance Statement QSP self-declaration Annual DSP Toolkit submission Internal audit programme	Application of Duty of Candour: timeliness and quality	Review completed-improvement plan to be developed and implemented	31/3/23	Complete-reporting to Patient Safety Committee in May 23
			Health and Safety Compliance auditing	Electronic solution developed and implemented	31/12/22	Complete
			Mental Health Strategy not yet fully implemented	The Trust's Mental Health Strategy has been in development since November 2022. Extensive consultation of the Strategy has delayed its ratification to June 2023.	30/5/2023	Compromised

Principal risk 10: Failure to continually learn and improve the quality of care for patients	Oversight Committees	Quality and Performance Scrutiny Committee Group Risk Oversight Committee

Risk appetite

We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk. We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients.

Corporate/Strategic risk(s)		Risk rating: Current	Initial	Residual	Target	Progress
MFT/005182	Optimising human/ system interaction to ensure patient safety	20	20	4	4	↔
MFT/006352	Clinical Risk relating to delays in patients accessing diagnostics and treatment	15	15	9	9	new

Controls		Gaps/weaknesses in Controls	Action being taken to address gaps/weaknesses	Target date	Progress
Workforce: training, operational management, supervision, appraisal and professional development Vision, Values and Behavioural Framework IQP Programme Patient Experience Strategy Getting it Right First Time programmes Clinical Accreditation Programme Compliments, complaints and concerns policy WMTM patient experience programme Quality improvement collaboratives BRC / Research & Innovation / MCAC	Safety Oversight and Management System Clinical Ethics Committee Equality Committee Human Factors Academy Patient safety programmes Learning from success Systems approach to investigations Risk assessment for changes in practice Policies and Procedural documents Clinical Audit	The Trust does not use a standardised approach e.g., Failure mode and effects analysis (FMEA) when transforming and improving services	Quality and Safety Strategy has been approved and a consistent approach to improvement is key to its implementation	June 23	On track
		The limitations of clinical audit mean that the impact of human factors and ergonomic design on the effectiveness of implementation of controls is not fully evaluated	A consensus building workshop is being held to align the clinical audit work to the assurance framework/mapping workstream	March 23	Revised completion (impact of IA) May 23
		Quality improvement interventions are not co-ordinated, systematic or resourced in a Trust wide way	Quality and Safety Strategy has been approved and a consistent approach to improvement is key to its implementation	June 23	On track

Routine Sources of Assurance: Site/MCS/LCO assurance	Group assurance	External Assurance	Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Board self-assessment and Well Led governance reviews Learning from deaths annual report Accreditation process	Board self-assessment and Well Led governance reviews Research and Innovation Annual Report Learning from Deaths annual report Monthly patient safety profile Annual Patient Experience report Quarterly & Annual Complaints reports H & S annual report Clinical Accreditation annual report Quality Account Ockenden action plan progress report Annual clinical audit report AOF	Well led governance reviews Internal audit of the effectiveness of controls aligned to quality of care National patient surveys NHS staff survey Auditor review of Annual Report CQC dynamic monitoring and inspection process GIRFT Regulator visits and inspections Internal audit programme	Real time data to understand variation in outcomes	Realisation of benefits of HIVE	31/3/23	On track
			Availability and use of system reliability measures to identify potential risk-aligned to informatics capacity risk 004492	Risk assessment with clear action plan to undertaken-interim patient safety profiles for areas of high risk in place	31/5/23	On track
			Development of the Clinical Accreditation Programme to ensure underpinned by HIVE data across all domains	Workshop to take pace February 2023, SOP to be agreed. Clinical Accreditation Programme cycle to commence April 2023.	31/3/23	Complete

Board assurance framework legend

Descriptors	
Principal risk	What could prevent the Strategic Objective from being achieved?
Target risk score	Target risk score based on risk appetite
Initial risk score	Risk score with existing controls without the application of any mitigation or additional controls
Residual risk score	Risk score when planned mitigation effectively applied
Current risk score	Risk score at time of population of BAF based on effectiveness of existing controls and application of mitigation
High Level Controls	What controls/systems do we have in place to assist/secure delivery of the objectives?
Gaps in controls	Are there any gaps in the effectiveness of controls or systems?
Sources of assurance	Where can we gain evidence in relation to the effectiveness of the controls/systems which we are relying on?
Positive assurance	What evidence have we of progress towards or achievement of our strategic objective?
Negative assurance	What evidence have we of progress towards our strategic objectives being compromised?
Gaps in Assurance	Where can we improve the evidence about the effectiveness of one or more of the key controls/systems which we are relying on?
Rationale for assurance level	A description of the reason for the decision in relation to assurance level agreed by the assuring committee
Risk Appetite	The level of risk the organisation is prepared to tolerate in relation to the secure delivery of each individual strategic objective

Risk Appetite statement (2022-2023)

The Board of Directors recognises that the Trust's long-term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community and our strategic partners, is dependent upon the delivery of our strategic objectives. A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective and given the challenging financial and operational environment that currently exists across the NHS, it is inevitable that a higher level of risk is inherent in these areas. We are mindful that there must be consideration of the balance of risk across all domains, hence financial risk is considered alongside all others. Therefore:

- We hold patient safety in the highest regard and are strongly averse to any risk – clinical, operational, data quality, workforce or related to strategic partnerships – that might jeopardise safety; we will continuously benchmark and research the safety and effectiveness of the care we provide with a focus on identifying and eliminating unwarranted variation that drives risk.
- We believe that all regulatory standards, including clinical, professional and financial standards, are the minimum that we need to achieve to be outstanding; we are strongly averse to any risk that could result in non-compliance with standards, or poor clinical or professional practice.
- We are strongly averse to any risk where it involves potential exposure to significant harm for our people.
- We will be cautious about any risk that could compromise data quality or data security in the context of performance and reputational risks; and we commit to continuous improvement in these areas.
- We are open to taking opportunistic risk in improving the recruitment and retention of a diverse inclusive workforce, recognising the challenging recruitment environment.
- We are open to taking opportunistic risk associated with the implementation of emerging technology. However, we seek to minimise exposure to cyber risk.
- We have a significant appetite to exploit opportunistic risk where positive gains can be anticipated, particularly in relation to promoting and delivering clinical service transformation, in research, innovation and in finance for the benefit of our patients.'

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business/ Trust Board Secretary
Date of paper:	May 2023
Subject:	Update on the Review of the Board of Directors Sub-Committees Terms of Reference
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Assurance • Approval ✓ • Ratify ✓
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of robust and comprehensive Governance Framework, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to: Ratify the Terms of Reference of the following sub-committees of the Board of Directors following their review and approval at the relevant Committees: ▪ Audit Committee ▪ Charitable Funds Committee ▪ EPR Scrutiny Committee ▪ Finance and Digital Scrutiny Committee ▪ Workforce Scrutiny Committee (previously HR Scrutiny Committee) ▪ Quality and Performance Scrutiny Committee ▪ Group Risk Oversight Committee Approve the Terms of Reference of the Remuneration Committee. Any changes proposed following review at the next meeting will come to a future meeting of the Board of Directors for ratification.
Contact:	Name: Nick Gomm, Director of Corporate Business/ Trust Board Secretary Tel: 0161 276 4841

1. Introduction

The Board of Directors is asked to approve a selected number of Board of Directors Sub-Committees' Terms of Reference (ToR) following their review during April 2023.

The annual review of the ToR was due in November 2022 but was postponed due to the ongoing Board Governance review led by the Chairman. They are presented for approval today and will be reviewed again once the outputs from the Board Governance review and the proposed external Well Led development review takes place later this year

2. Terms of Reference

Following review and approval at the Committee to which the ToRs equate, the following ToRs are now recommended by the relevant Board Sub-Committees for Board ratification:

- Audit Committee (Appendix A)
- Charitable Funds Committee (Appendix B)
- EPR Scrutiny Committee (Appendix C)
- Finance and Digital Scrutiny Committee (Appendix D)
- Workforce Scrutiny Committee (previously HR Scrutiny Committee) (Appendix E)
- Quality and Performance Scrutiny Committee (Appendix F)
- Group Risk Oversight Committee (Appendix G)

The Remuneration Committee has not met during this cycle of meetings and so there has not been an opportunity for Committee review. The existing Terms of Reference are presented here for Board approval today (Appendix H). Any changes proposed as a result of review at the next Committee meeting will come to a future meeting of the Board of Directors for ratification.

The Group Management Board Terms of Reference will be reviewed at their meeting in May and will come to the Board meeting in July for ratification.

3. Recommendation

The Board of Directors is asked to:

Ratify the Terms of Reference of the following sub-committees of the Board of Directors following their review and approval at the relevant Committees:

- Audit Committee
- Charitable Funds Committee
- EPR Scrutiny Committee
- Finance and Digital Scrutiny Committee
- Workforce Scrutiny Committee (previously HR Scrutiny Committee)
- Quality and Performance Scrutiny Committee
- Group Risk Oversight Committee

Approve the Terms of Reference of the Remuneration Committee. Any changes proposed following review at the next meeting will come to a future meeting of the Board of Directors for ratification.

Appendix A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Audit Committee has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the Committee/Group will consist of Group Non-Executive Directors. At least one Committee member should be a qualified accountant and have recent and relevant financial experience.

The Committee shall have sufficient skills to discharge its responsibilities. At least one Committee member should have recent and relevant financial experience. The Group Chairman shall not chair nor be a member of the Committee.

Only members of the Audit Committee have the right to attend meetings, but the Group Chief Finance Officer, Trust Board Secretary, Head of Internal Audit of the Group, representatives of the External Auditors, and representatives of the local Counter Fraud service shall generally be invited to attend meetings of the Audit Committee.

Group Executive Directors and/or staff shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

The Group Chairman may be invited to attend meetings of the Audit Committee as required.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

3. QUORACY

No business should be transacted at the meeting unless the Committee Chair (or nominated deputy) and three further members are present.

4. FREQUENCY OF MEETINGS

Meetings shall be held at least four times per year, with additional meetings scheduled when necessary.

The external and internal auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Group Executive Directors present.

5. OVERVIEW

The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Group Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions. Examples of key reference/source documents include Board Minutes & Reports, Board Sub-Committee Minutes, Board Assurance Framework, AOF Dashboard, ntegrated Performance Report, Internal & External Audit Reports.

The Audit Committee shall provide the Group Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes, and risk management across the whole of the Group activities, both generally and in support of the annual governance statement.

The Group Board of Directors is responsible for ensuring effective financial decision-making, management and internal control including:

- Management of the Group's activities in accordance with statute and regulations
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

6. SCOPE AND DUTIES

Financial Statements and the Annual Report

Monitor the integrity of the financial statements of the Group and any other formal announcements relating to the Group's financial performance, reviewing the significant financial reporting judgements contained in them.

Review the annual statutory accounts, before they are presented to the Group Board of Directors, in order to consider their compliance, objectivity, integrity and accuracy. This review will cover but is not limited to: the meaning and significance of the figures; notes and significant changes; areas where judgement has been exercised; adherence to accounting policies and practices; explanation of estimates or provisions having material effect; the schedule of losses and special payments; any unadjusted statements; and any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

Review the annual report and annual governance statement before they are submitted to the Group Board of Directors to consider compliance, objectivity, integrity and accuracy.

Review each year the accounting policies of the Group and make appropriate recommendations to the Group Board of Directors.

Review all systems of control including accounting and reporting systems that support the production of the annual report before review by the Group Board of Directors,

Internal Control and Risk Management

Review the Group's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

Review and maintain an oversight of the Group's general internal controls and risk management systems, liaising with separate sub-committees as required.

Review processes to ensure appropriate information flows to the Audit Committee from executive management and other Group committees in relation to the Group's overall internal control and risk management position.

Review the adequacy of the policies and procedures in respect of all counter-fraud work.

Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

Whistleblowing

Review arrangements that allow staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

Corporate Governance

Monitor corporate governance compliance (e.g. compliance with terms of the license constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

Internal Audit

Conduct an annual review of the provision of internal audit services taking into consideration relevant UK professional and regulatory requirements.

Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

Oversee on an ongoing basis the effective operation of internal audit in respect of: adequate resourcing; its coordination with external audit; meeting relevant internal audit

standards; providing adequate independent assurances; it having appropriate standing within the foundation trust.

Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

External Audit

Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

In line with MFT's Constitution, the Council of Governors is responsible for appointing or removing the external auditor and will work with the Audit Committee in agreeing the criteria for this. To support them in this task, the Audit Committee should:

- provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees.
- make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with internal audit and any other external regulatory body who may contribute to the formation of the audit opinion.

Assess the external auditor's work and fees each year and, based on this assessment, to make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor.

Oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

Develop and implement a policy on the engagement of the external auditor in regard to the supply non-audit services, taking into account relevant professional rules and ethical guidance.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. In so doing this the Committee will: Consider the provision of the Counter Fraud (CF) service, Ensure the CF service is adequately resourced; Review and approve the annual CF work plan. Review the periodic CF status reports; and Review and approve the CF annual report.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

Review on behalf of the Group Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution and standards of business conduct; including maintenance of registers.

Examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

Review the operation of, and proposed changes to, the Group Scheme of Delegation.

Other

Review performance indicators relevant to the remit of the Audit Committee. Examine any other matter referred to the Audit Committee by the Group Board of Directors and initiate investigation as determined by the Audit Committee.

Develop and use an effective Assurance Framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these Terms of Reference.

Review the work of all other Group committees in connection with the Audit Committee's assurance function.

Consider the outcomes of significant reviews carried out by other bodies including, but not limited to, regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

The Committee will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. AUTHORITY

The Audit Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

The Audit Committee is authorised by the Group Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Audit Committee.

The Audit Committee is authorised by the Group Board of Directors to obtain outside legal or other independent professional advice. The Committee is authorised by the Group Board of Directors to request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

8. REPORTING

The minutes of all meetings of the Audit Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Group Board of Directors. The submission to Group Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

The Group's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

As part of the Group's annual performance review process, the Committee shall review its collective performance and that of its individual members.

9. REVIEW

These Terms of Reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

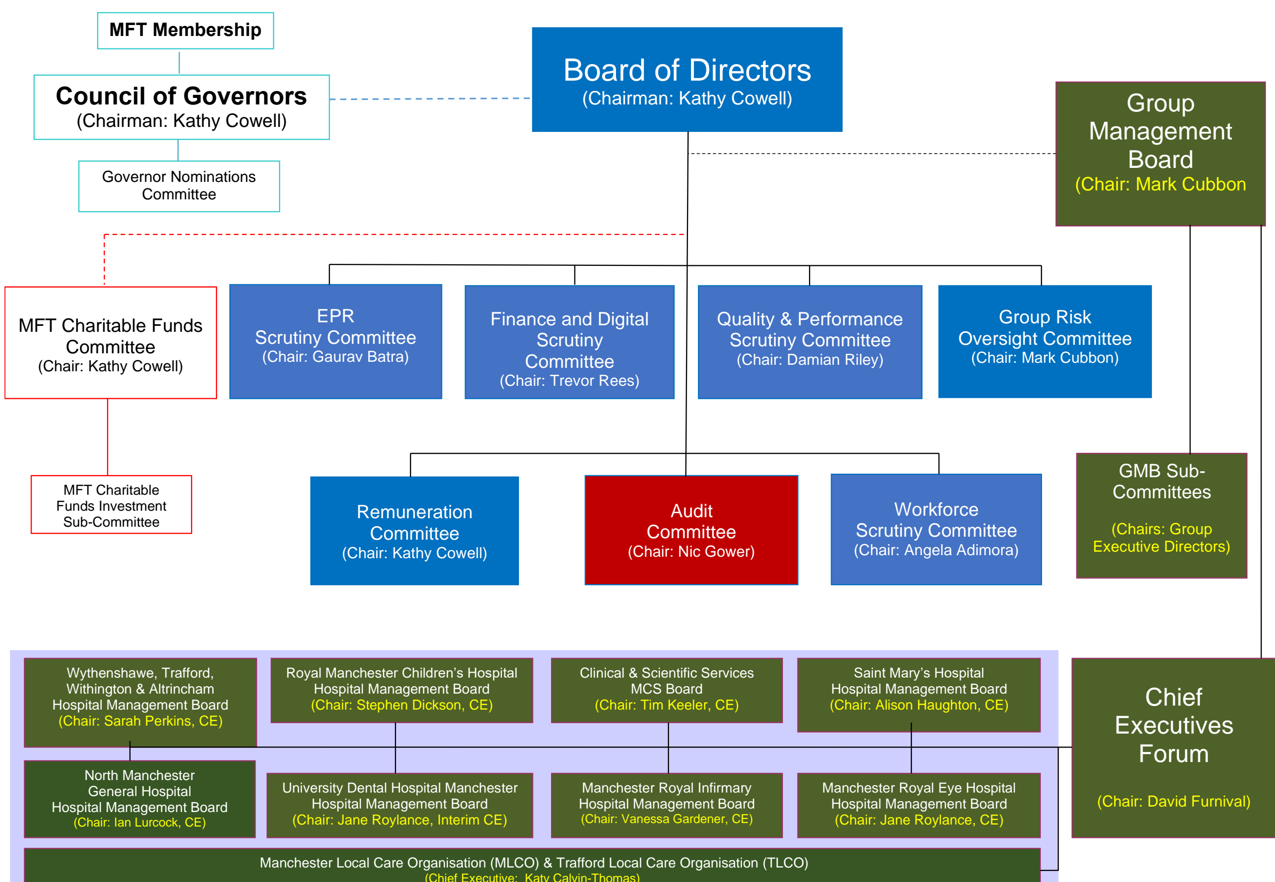
These Terms of Reference will be measured against the following key performance indicators:

- Listed members or nominated deputies will attend at least 75% of the meetings each year.
- An Audit Committee work programme will be developed on an annual basis with measurable outputs.
- Training needs of the committee will be identified and relevant training provided
- An Audit Committee Annual Report will be incorporated within the Trust's Annual Report & Accounts

11. SUB-COMMITTEES/SUB-GROUPS

The Committee has no sub-committees or sub-groups.

12 . REPORTING STRUCTURE CHART (see overleaf)


MFT Membership
Council of Governors
(Chairman: Kathy Cowell)
Governor Nominations Committee
Board of Directors
(Chairman: Kathy Cowell)
Group Management Board
(Chair: Mark Cubbon
MFT Charitable Funds Committee
(Chair: Kathy Cowell)
EPR Scrutiny Committee
(Chair: Gaurav Batra)
Finance and Digital Scrutiny Committee
(Chair: Trevor Rees)
Quality & Performance Scrutiny Committee
(Chair: Damian Riley)
Group Risk Oversight Committee
(Chair: Mark Cubbon)
MFT Charitable Funds Investment Sub-Committee
Remuneration Committee
(Chair: Kathy Cowell)
Audit Committee
(Chair: Nic Gower)
Workforce Scrutiny Committee
(Chair: Angela Adimora)
GMB Sub-Committees
(Chairs: Group Executive Directors)
Wythenshawe, Trafford, Withington & Altrincham Hospital Management Board
(Chair: Sarah Perkins, CE)
Royal Manchester Children's Hospital Hospital Management Board
(Chair: Stephen Dickson, CE)
Clinical & Scientific Services MCS Board
(Chair: Tim Keeler, CE)
Saint Mary's Hospital Hospital Management Board
(Chair: Alison Haughton, CE)
Chief Executives Forum
(Chair: David Furnival)
North Manchester General Hospital Hospital Management Board
(Chair: Ian Lurcock, CE)
University Dental Hospital Manchester Hospital Management Board
(Chair: Jane Roylance, Interim CE)
Manchester Royal Infirmary Hospital Management Board
(Chair: Vanessa Gardener, CE)
Manchester Royal Eye Hospital Hospital Management Board
(Chair: Jane Roylance, CE)
Manchester Local Care Organisation (MLCO) & Trafford Local Care Organisation (TLCO)
(Chief Executive: Katy Calvin-Thomas)

Appendix B

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Charitable Funds Committee (CFC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the Charitable Funds Committee will consist of:

- Group Chairman
- All Group Non-Executive Directors
- All Group Executive Directors

Other members will be co-opted on to, or invited to attend, the Committee as necessary.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- Group Chairman
- Three Group Non-Executive Directors
- Two Group Executive Directors

4. FREQUENCY OF MEETINGS

The Committee will meet not less than four times a year.

5. OVERVIEW

The Charitable Funds Committee has been established by the Group Board of Directors, being the Trustee of the charitable funds to make and monitor arrangements for the control and management of charitable funds. The Trustee has ultimate responsibility for all decisions made but also has delegated the scope and duties to the Committee.

6. SCOPE AND DUTIES

The scope and duties of the Committee are:

- To apply all charitable funds in accordance with charity law, including but not limited to the Charities Act 2011,as amended by the Charites Act 2022, the NHS Charities Acts 1960 and 1993 (or any statutory re-enactment or modification of them) to ensure that decisions on the use and/ or investment of such funds is restricted by the objectives and powers defined in the Declaration of the Trust governing the funds or in any special trust included within them.

- To ensure that the Group policies and procedures for charitable funds investments are followed.

- To make decisions involving the sound investment of charitable funds consistent with prudent investment and ensuring compliance with:

  - The Trustee Act 2000
  - The Charities Act 2011, as amended by the Charities Act 2022
  - The Charities (Protection and Social Investment) Act 2016
  - Terms of the Funds' Governing documents

- To receive at each meeting reports for ratification from the Group Chief Finance Officer on investment decisions and actions taken through delegated powers.

- To oversee and monitor the functions performed by the Group Chief Finance Officer as defined in Standing Financial Instructions.

- To monitor the progress of the Group's Charity.

- To receive the minutes of the Charitable Funds Investment Sub Committee

- To approve all charitable fund expenditure in excess of £100,000. Expenditure above £50,000 is reviewed annually (Policy in situ for the administration of grant applications below this value)

- To ensure the MFT Charity adheres to the Charity Commission / Fundraising Regulator Code of Conduct

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. DELEGATED POWERS AND DUTIES OF THE GROUP CHIEF FINANCE OFFICER

The Group Chief Finance Officer has prime responsibility for the Group's Charitable Funds as defined in the Group's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Group Chief Finance Officer are to:

- Administer all existing charitable funds
- Arrange for the creation of any new charitable funds including the preparation of governing documents
- Be responsible for the management of investment of funds
- Ensure appropriate banking services are available to the Charity
- Prepare reports including the Annual Accounts

8. AUTHORITY

All decisions relating to the Charity's investment lie entirely with its Trustee. It may not lawfully delegate this responsibility to anyone.

The Charitable Funds Committee retains control of the investment policy. Where it does delegate discretionary power in respect of an investment, it must ensure:

- the scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it
- that there are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently
- that they review regularly the performance of the person or persons exercising the delegated power
- that where an investment manager is appointed, that the person is regulated under the Financial Services and Markets Act 2000.
- that acquisitions or disposals of a material nature must always have written authority of the Charitable Funds Committee or the Chairman of the Charitable Funds Committee in conjunction with the Group Chief Finance Officer or nominated deputy.

The banking arrangements for the charitable funds will be kept entirely distinct from Manchester University NHS Foundation Trust's other funds.

Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations.

The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

The Charitable Funds Committee will develop an investment policy and monitor adherence to it.

Except where a specific fund's governing document does not allow for pooling, all funds should be pooled for investment purposes. The Charitable Funds Committee shall decide on the basis for applying accrued income to individual funds in line with Charity Commissioner Guidance.

The Charitable Funds Committee should obtain professional advice to support its investment activities as appropriate.

The Charitable Funds Committee shall regularly review reports of the Investment sub-committee with regard to investment performance to consider how the funds under the Charity's control can achieve the appropriate market return for the risk profile agreed.

9. REPORTING

The Committee will provide a report/minutes to the Board of Directors after each meeting.

The Committee will receive minutes from the Charitable Funds Investment sub-committee after each of its meetings.

10. REVIEW

These Terms of Reference will be reviewed at least annually.

11. KEY PERFORMANCE INDICATORS

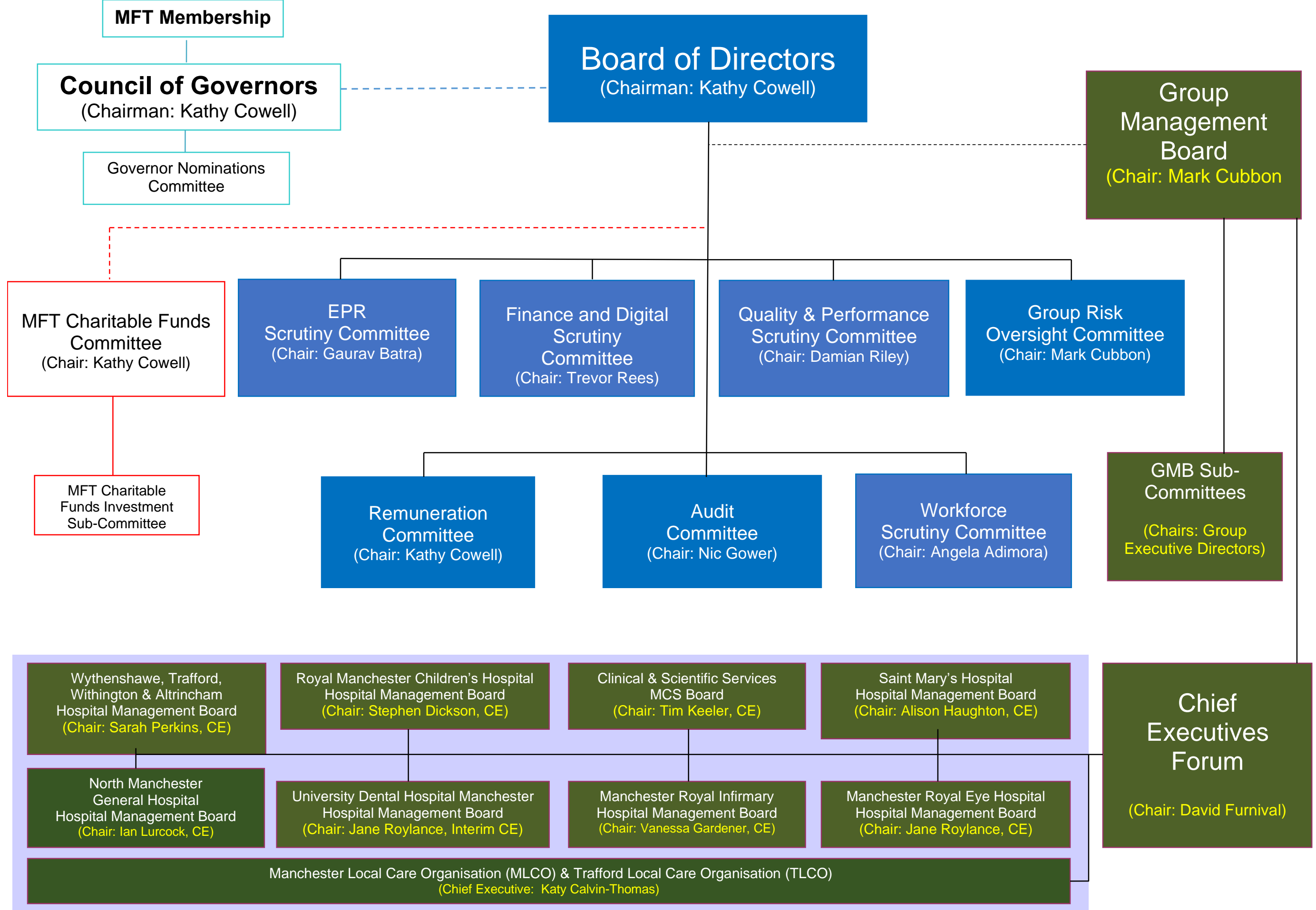
These Terms of Reference will be measured against the following key performance indicators:

- 75% attendance of all listed members
- 100% of scheduled meetings take place
- a committee work programme is in place
- training needs of the participants will be identified and relevant training provided
- the Charitable Funds Annual Report and Accounts will be published in a timely manner.
- the Annual Report of the MFT Charity will detail the achievements of the previous year.

11. SUB-COMMITTEES/SUB-GROUPS

The Charitable Funds investment sub-committee will report to this Committee.

12 . REPORTING STRUCTURE CHART (see overleaf)


MFT Membership
Council of Governors
(Chairman: Kathy Cowell)
Governor Nominations Committee
Board of Directors
(Chairman: Kathy Cowell)
Group Management Board
(Chair: Mark Cubbon
MFT Charitable Funds Committee
(Chair: Kathy Cowell)
EPR Scrutiny Committee
(Chair: Gaurav Batra)
Finance and Digital Scrutiny Committee
(Chair: Trevor Rees)
Quality & Performance Scrutiny Committee
(Chair: Damian Riley)
Group Risk Oversight Committee
(Chair: Mark Cubbon)
MFT Charitable Funds Investment Sub-Committee
Remuneration Committee
(Chair: Kathy Cowell)
Audit Committee
(Chair: Nic Gower)
Workforce Scrutiny Committee
(Chair: Angela Adimora)
GMB Sub-Committees
(Chairs: Group Executive Directors)
Wythenshawe, Trafford, Withington & Altrincham Hospital Management Board
(Chair: Sarah Perkins, CE)
Royal Manchester Children's Hospital Hospital Management Board
(Chair: Stephen Dickson, CE)
Clinical & Scientific Services MCS Board
(Chair: Tim Keeler, CE)
Saint Mary's Hospital Hospital Management Board
(Chair: Alison Haughton, CE)
Chief Executives Forum
(Chair: David Furnival)
North Manchester General Hospital Hospital Management Board
(Chair: Ian Lurcock, CE)
University Dental Hospital Manchester Hospital Management Board
(Chair: Jane Roylance, Interim CE)
Manchester Royal Infirmary Hospital Management Board
(Chair: Vanessa Gardener, CE)
Manchester Royal Eye Hospital Hospital Management Board
(Chair: Jane Roylance, CE)
Manchester Local Care Organisation (MLCO) & Trafford Local Care Organisation (TLCO)
(Chief Executive: Katy Calvin-Thomas)

Appendix C

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

EPR SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The EPR Scrutiny Committee (EPRSC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the EPRSC will consist of:

- Group Non-Executive Director (Chair)
- Group Non-Executive Directors
- Group Executive Directors

The Hive Programme Director, Chief Information Officer, together with such other EPR and IM&T Directors as may be reasonably required, will also attend each meeting.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

Other members will be co-opted on to, or invited to attend, the EPRSC as necessary.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- Chair (or nominated deputy)
- Two Group Non-Executive Directors
- Two Group Executive Directors

4. FREQUENCY OF MEETINGS

The EPRSC will meet every three months.

5. OVERVIEW

The Committee will review the delivery of the EPR Programme through the EPR Implementation and Benefits Realisation Programme Board including:

- oversight of the implementation of the Epic EPR through the EPR Programme Plan to agreed milestones in accordance with the Board-approved Business Case;

- oversight of the delivery of the Benefits Plans within the agreed Full Business Case;

- oversight of clinical and operational adoption including management of change for Phase 2 post Go-Live to ensure continuous quality improvement for benefits realisation.

- oversight of the EPR Epic Contract;

- monitoring of EPR Programme risk register;

- monitor delivery of the EPR Communications & Engagement programme;

- gain assurance about the overall governance arrangements of the EPR programme and undertake regular and appropriate review of the effectiveness of these arrangements;

- explore the potential impact of emerging or identified significant risks in relation to EPR Programme delivery, implementation and realisation of associated benefits and report to other relevant scrutiny committees or the Board Directors as appropriate.

6. SCOPE AND DUTIES *(This section details the scope of the Committee/Group and all its duties)*

The scope and duties of the Committee are:

- To monitor the delivery of the EPR Programme; scrutinise performance against the key deliverables and review actions and mitigation plans including timescales.

- Meetings will focus on key deliverables against EPR Programme milestones and detailed scrutiny of specific risks.

- To monitor the benefits realisation plans and the readiness of the organisation to deliver benefits to plan and timescale pre and post Go-Live of the EPR.

- To receive and consider assurance reports from external bodies.

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. AUTHORITY

The EPRSC is empowered to examine and investigate any activity within the Group or Hospitals/MCSs/LCOs pursuant to the above scope and duties.

8. REPORTING

The EPRSC will provide a report/minutes to the Bord of Directors and the Audit Committee after each meeting.

9. REVIEW

These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

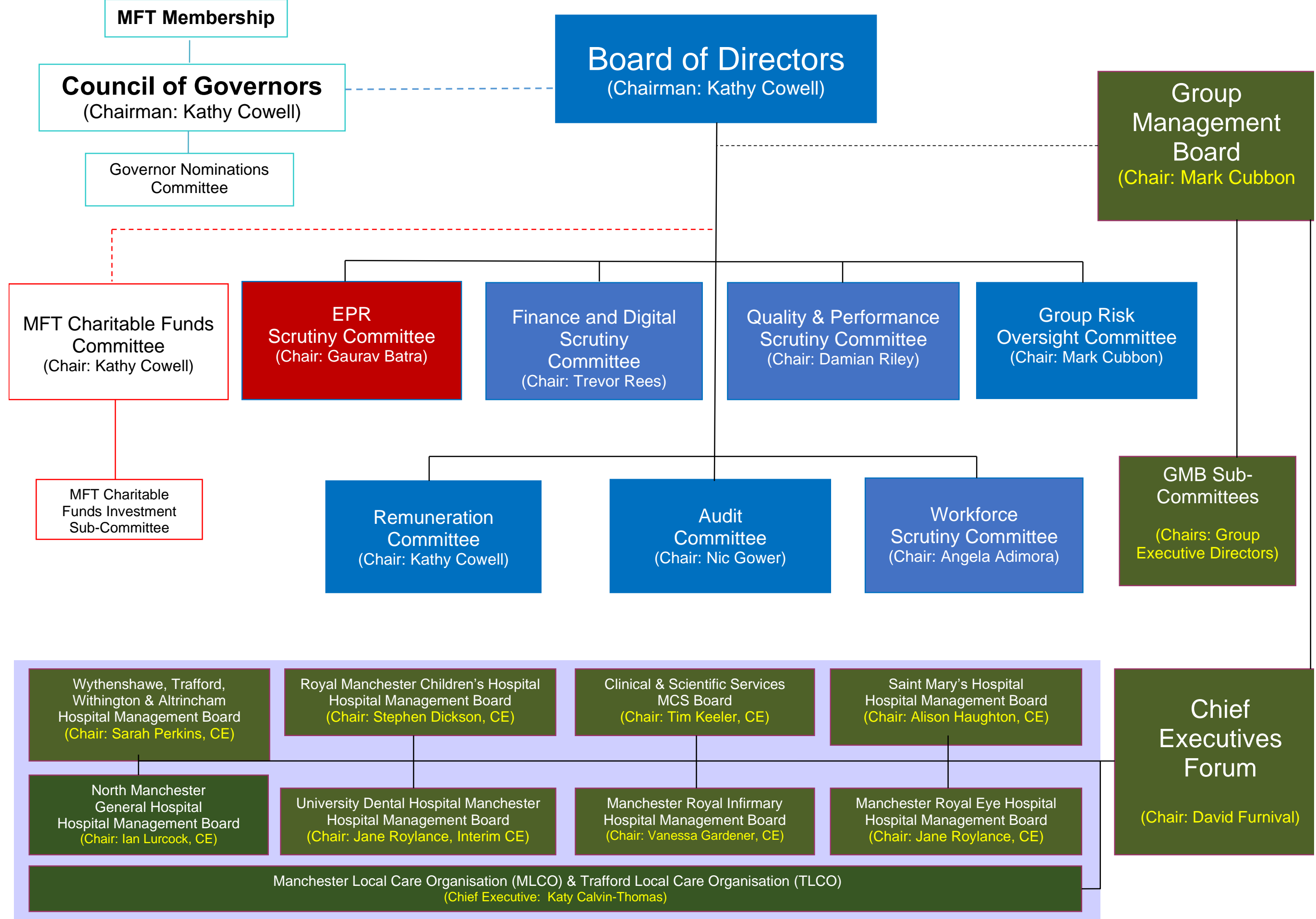
These Terms of Reference will be measured against the following key performance indicators:

- 66% attendance of all listed members or nominated deputy
- 100% coverage of duties over a 12 month period
- 100% of scheduled meetings take place
- a Committee work programme is in place
- training needs of the participants will be identified and relevant training provided

11. SUB-COMMITTEES/SUB-GROUPS

Updates from the EPR Implementation and Benefits Realisation Programme Board will be provided to the Committee at each meeting.

12 . REPORTING STRUCTURE CHART



Appendix D

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

FINANCE AND DIGITAL SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Finance and Digital Scrutiny Committee (FDSC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the FDSC will consist of:

- Group Non-Executive Director (Chair)
- Group Non-Executive Directors
- Group Chief Finance officer (or nominated deputy)
- Chief Information Officer (or nominated deputy)
- Joint Group Medical Director
- Group Chief Nurse
- Group Executive Directors

Either a Joint Group Medical Director or Group Chief Nurse will be present at each meeting to ensure there is clinical input into the discussions at the Committee.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

Other members will be co-opted on to, or invited to attend, the FDSC as necessary.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- Chair (or nominated deputy)
- Two Group Non-Executive Directors
- Group Chief Finance Officer (or nominated deputy)
- A least two Group Executive Directors in total

4. FREQUENCY OF MEETINGS

The FDSC will meet every two months.

5. OVERVIEW *(This section concisely describes the main purpose of the committee*)

The Finance and Digital Scrutiny Committee will examine the incidence, nature, and potential impact of emerging or identified significant financial and digital risks or issues with regard to

the Group's on-going financial and digital position and performance, be it retrospective, in-year or forward-looking.

The Finance and Digital Scrutiny Committee will seek assurance on the Trust's ongoing response to national policies, directives, and emergencies in relation to all Trust finance and digital matters including adherence to relevant Constitutional standards.

The Committee will have oversight of all matters regarding finance, informatics, data, analytics, and information technology in the Trust apart from matters specific to the stabilisation of, and benefits realisation from, the Hive Electronic Patient Record system which will be considered at the EPR Scrutiny Committee.

The Finance and Digital Scrutiny Committee will seek and receive additional levels of assurance not routinely available, within the confines of regular on-going Group Board of Directors papers and discussion, together with scrutinising the specific plans including any turnaround or mitigation plans as developed, presented to, and approved by the Group Board of Directors, in relation to managing the scale and impact of those plans and any identified risks.

6. SCOPE AND DUTIES

The scope and duties of the Committee are:

To review the Trust's annual financial plan and longer term financial and digital strategy.

To review at each meeting the financial and digital performance in achieving the respective targets in between meetings

To review on a regular basis the Trust's Waste Reduction Programme as a subset of the performance requirements of the Trust

To provide for appropriate scrutiny of the Trust's response to national policies, directives, and emergencies in relation to all Trust finance and digital matters and associated implementation plans and/or recovery programmes.

To provide the Group Board of Directors with a means of gaining additional assurance on the Group's plans for managing significant identified financial and digital risks.

To provide opportunity for in-depth exploration of the incidence, nature, and potential impact of emerging or identified significant financial and digital risks, to the Group's on-going position and performance.

To review the specific turnaround and/or mitigation plans presented to and approved by the Group Board, for management of these risks, focusing particularly on:

- The scale, impact and timing of the turnaround or mitigation actions proposed, in relation to the scale and impact of the identified risks.

- The development of additional or complementary actions arising from in-depth exploration of the risks and action plans so far identified.

- Monitoring, reporting and examination of progress in relation to the approved actions in place.

To monitor, and seek assurance on, the development and delivery of Trust strategies and work programmes concerning all financial, informatics, data, analytics, and information technology, including cyber security.

To receive additional levels of assurance on the implementation of approved plans.

To consider business cases and waiver requests in detail ahead of Board approval.

To report to the Group Board of Directors, the level of additional assurance received in relation to the risks under review.

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. AUTHORITY

The FDSC is empowered to examine and investigate any activity within the Group or Hospitals/MCSs/LCOs pursuant to the above scope and duties.

8. REPORTING

The FDSC will provide a report/minutes to the Board of Directors and the Audit Committee after each meeting.

9. REVIEW

These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

These Terms of Reference will be measured against the following key performance indicators:

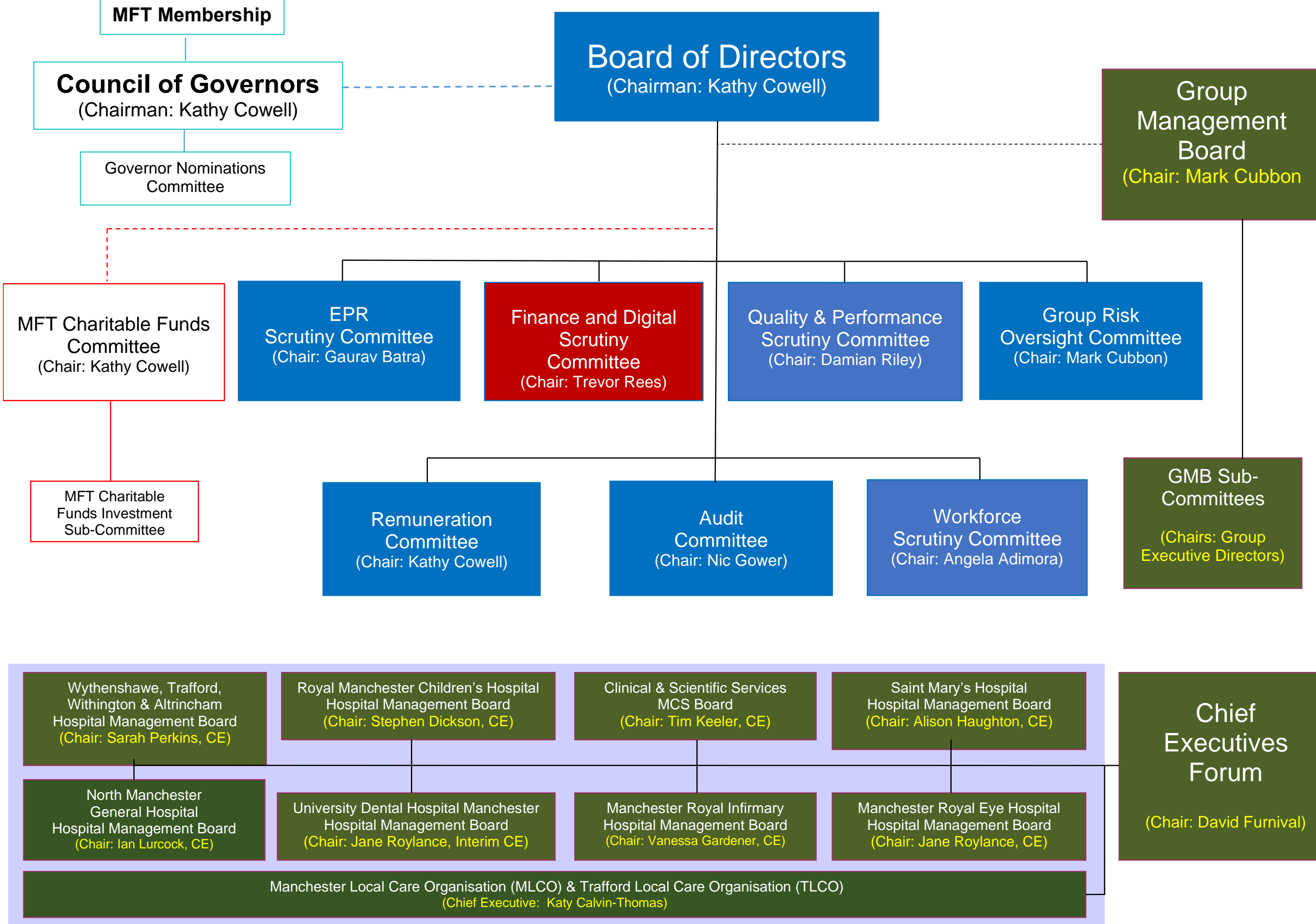
- That the agenda of the Committee reflects identified escalations of all financial and digital risk scores above ‘15’ in the Group’s risk register, or adverse in-year financial performance against plan in excess of 1% of annual total income and this is reported to the Board.
- The level of information provided to, and review undertaken by the Committee enables the Group Board of Directors to gain additional assurance, regarding the implementation of appropriate plans to mitigate risks and/or turn around deviations from planned performance, to maintain or restore acceptable overall financial and digital delivery as determined by the Group Board.
- The level of information provided to, and review undertaken by the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of appropriate mitigation plans to address identified forward financial and digital risks
- 66% attendance of all listed members or nominated deputy
- 100% coverage of duties over a 12 month period
- 100% of scheduled meetings take place

- a Committee work programme is in place
- training needs of the participants will be identified and relevant training provided

11. SUB-COMMITTEES/SUB-GROUPS

Reports/minutes from the Group Informatics Strategy Board will be provided to the Committee within reports considered at each meeting

12 . REPORTING STRUCTURE CHART



APPENDIX E

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

WORKFORCE SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Workforce Scrutiny Committee (WSC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the Committee/Group will consist of:

- Group Non-Executive Director (Chair)
- Group Non-Executive Directors (NEDs)
- Group Executive Director of Workforce and Corporate Business
- Group Chief Nurse
- Joint Group Medical Director

Other members will be co-opted on to, or invited to attend, the Committee/Group as necessary. These will include:

- Group Director of HR (or nominated deputy)
- Corporate Directors and their leadership teams, as required
- Hospital/MCS/LCO Chief Executives and their leadership teams, as required
- Other Trust employees or, agents of the Trust as required.

The Trust Board Secretary (or nominated Deputy) shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. The Group Executive Director of Workforce & Corporate Business or nominated deputy will also be available to advise the Chair and Committee members.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- NED Chair (or nominated deputy)
- Two further Group NEDs
- Two Group Executive Directors

4. FREQUENCY OF MEETINGS

The Committee will meet not less than every two months

5. OVERVIEW

The Committee will review the Group's People Plan and scrutinise risks associated with delivery. The Committee will seek assurance that appropriate mitigation is in place to manage those risks and that appropriate links are made to the Board Assurance Framework.

Specifically, the Committee will scrutinise delivery of:

- MFT People Plan
- All principal Workforce and Organisational Development Strategies and delivery plans including Health and Wellbeing
- The Trust's response to National Emergencies, Policies and Directives; paying particular attention to issues relating to the Workforce.
- Equality, Diversity and Inclusion Strategy.
- Statutory or regulatory requirements relating to workforce
- Adherence with relevant Constitutional standards

Areas which require more detailed scrutiny arising from Group Board Reports or emerging or identified significant risks will be addressed by the Committee as required.

6. SCOPE AND DUTIES

The scope and duties of the Committee are:

- To monitor implementation of the Group People Plan ensuring appropriate scrutiny of risks as identified in the Board Assurance Framework. This to include examination of mitigating actions.
- To scrutinise Workforce Key Performance Indicators to understand performance and gain assurance that plans are being implemented.
- To explore the potential impact of identified or emergent workforce risks.
- Provide for appropriate scrutiny of the Trust's response to National Emergencies, Policies and Directive(s); paying particular attention to issues relating to the Workforce and associated Implementation Plans and/or Recovery Programme(s).
- To review annual reports relating to workforce to gain assurance that workforce initiatives are well executed and relevant to the overarching strategic direction of MFT.

7. AUTHORITY

The WSC is empowered to examine and investigate any activity within the Group or Hospitals/MCSs/LCOs pursuant to the above scope and duties.

8. REPORTING

The WSC will report to the Board of Directors after each meeting and provide minutes of each meeting to the Audit Committee.

The Group Workforce and Education Committee and Medical Workforce Board will provide reports/minutes to the WSC after each meeting.

9. REVIEW

These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

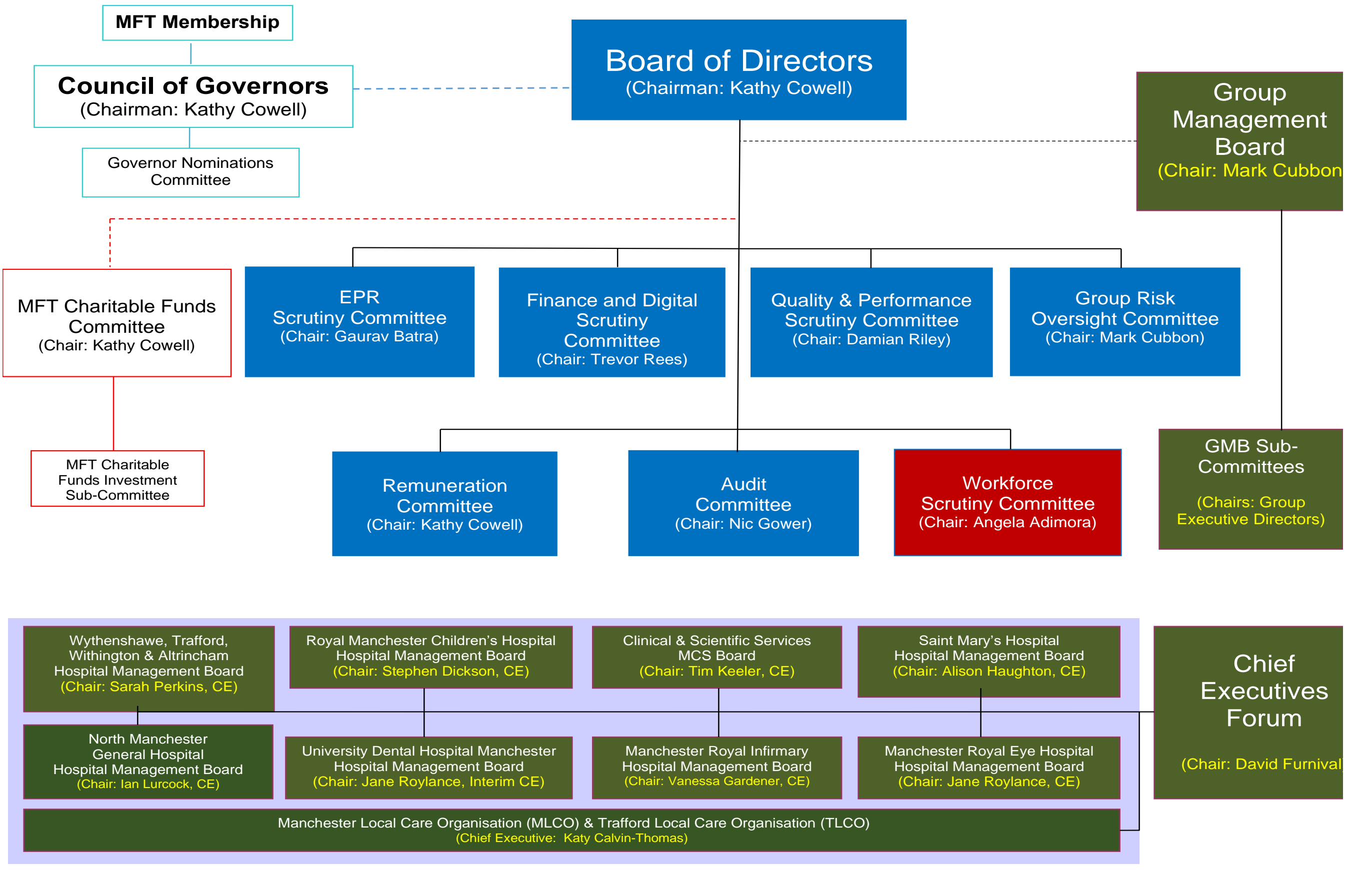
These Terms of Reference will be measured against the following key performance indicators:

- 66% attendance of all listed members or nominated deputy
- 100% coverage of duties over a 12 month period
- 100% of scheduled meetings take place
- a Committee/Group work programme is in place
- training needs of the participants will be identified and relevant training provided
- The level of information provided to the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of turnaround and mitigation plans to address identified workforce risks.
- 100% submission of reports to the Board of Directors

11. SUB-COMMITTEES/SUB-GROUPS

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

12 . REPORTING STRUCTURE CHART



APPENDIX F

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE SCRUTINY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Quality and Performance Scrutiny Committee (QPSC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the Committee/Group will consist of:

- Group Non-Executive Director – Chairman
- Group Non-Executive Directors
- Joint Group Medical Directors
- Group Chief Nurse
- Group Chief Operating Officer

All other Group Executive and Non-Executive Directors will be entitled to attend meetings of the Committee

Other members will be co-opted on to, or invited to attend, the Committee/Group as necessary. These will include:

- Corporate Directors and their leadership teams, as required
- Hospital/MCS/LCO Chief Executives and their leadership teams, as required
- Other Trust employees, or, agents of the Trust, as required.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members. The Joint Group Medical Director/s, Group Chief Nurse, and Group Chief Operating Officer will also be available to advise the Chair and Committee members.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- NED Chairman (or nominated deputy)
- Two further Group NEDs
- Two Group Executive Directors

4. FREQUENCY OF MEETINGS

The Committee will meet every two months.

5. OVERVIEW

The Accountability Oversight Framework (AOF) ratings will be reported to the Group Executive Director Team and an overview report will be presented to the Quality & Performance Scrutiny Committee. The AOF performance is summarised to the Group Management Board via the Chief Operating Officer's (COO) Report.

The Group Audit Committee will review the adequacy of underlying 'Quality & Performance' controls and assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. However, internal or external audits of clinical process or outcomes will be reviewed at the Quality & Performance Scrutiny Committee.

The Quality & Performance Scrutiny Committee will seek assurance on an exception, or, as required basis on the Group's work on Quality (Patient Safety, Clinical Effectiveness & Patient Experience) and Performance (all key performance measures excluding Workforce & Finance) and associated Implementation Plans and Recovery Programme(s).

The Committee will be chaired by a Group Non-Executive Director and it will identify areas that require more detailed scrutiny arising from: a suite of internal metrics, the AOF, the Group Integrated Performance Report, the Board Assurance Framework (BAF), the Trust's ongoing response to National Emergencies, Constitutional Standards, National Policies, National Directives, National Reports, NHS Regulators, internal and external audits with a clinical focus, patient /service user feedback and public interest issues. The chair will also be advised of any emergent issues such as an unannounced regulatory review which may lead to a requirement for urgent assurance.

6. SCOPE AND DUTIES

The scope and duties of the Committee are:

- Provide for appropriate scrutiny of the Trust's ongoing response to National Emergencies, Policies and Directive(s); paying particular attention to issues relating to Quality & Performance.

- To review information on the Group Integrated Performance Report & AOF where exceptions and/or emerging issues have been identified, paying particular attention to the Patient Safety, Patient Experience & Performance Strategic Aims and Key Priorities.

- To make recommendations to other fora on action required in response to the Group Integrated Performance Report, the ongoing COVID-19 National Emergency and /or the Group Risk Register.

- To receive summary reports on the key findings and recommendations of level 5 actual harm incidents and Never Events and seek assurance Hospital / Managed Clinical Service (MCS)/ LCO action plans.

- To consider any relevant risks within the Group Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee, or, the Group Board of Directors, as appropriate.

- To undertake a regular (annual as a minimum) review of Group Board Safety and Quality metrics to ensure the right areas of concern are presented.

- To receive progress reports on key safety and quality work programmes.

- To receive progress reports on MFT's work to address health inequalities

- To receive summary information on themes arising from complaints and concerns and consider the responses by Hospital / MCS / LCO and corporately as determined by the committee.

- To review the Group's Operational Performance against its Annual Plan and to monitor any necessary corrective planning and action.

- To consider regulatory reports on an exception basis where the Trust has services that require improvement or are subject to regulatory action

The Committee will use the following reference sources to decide on areas of scrutiny: Group Risk Management Committee: Group Quality & Safety Committee; Group Safeguarding Committee; Hospital/MCS CEO Forum; Group Infection Control Committee; Group Cancer Committee; the Accountability & Oversight (AOF) Dashboard; the Group Board Assurance Framework (BAF) and Integrated Performance Report and also CQC Regulatory Reports; internal and external clinical audits; national reports; public interest reports; reports from voluntary organisations serving health and social care such as Patients Association and Health Watch.

7. AUTHORITY

The QPSC is empowered to examine and investigate any activity within the Group or Hospitals/MCSs/LCOs pursuant to the above scope and duties.

8. REPORTING

The QPSC will report to the Board of Directors after each meeting and provide minutes of each meeting to the Audit Committee.

The QPSC will receive reports/ minutes from Group Risk Management Committee, Infection Control Committee, Quality and Safety Committee, Cancer Board, Informatics Strategy Board, and Operational Excellence Board.

9. REVIEW

These Terms of Reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

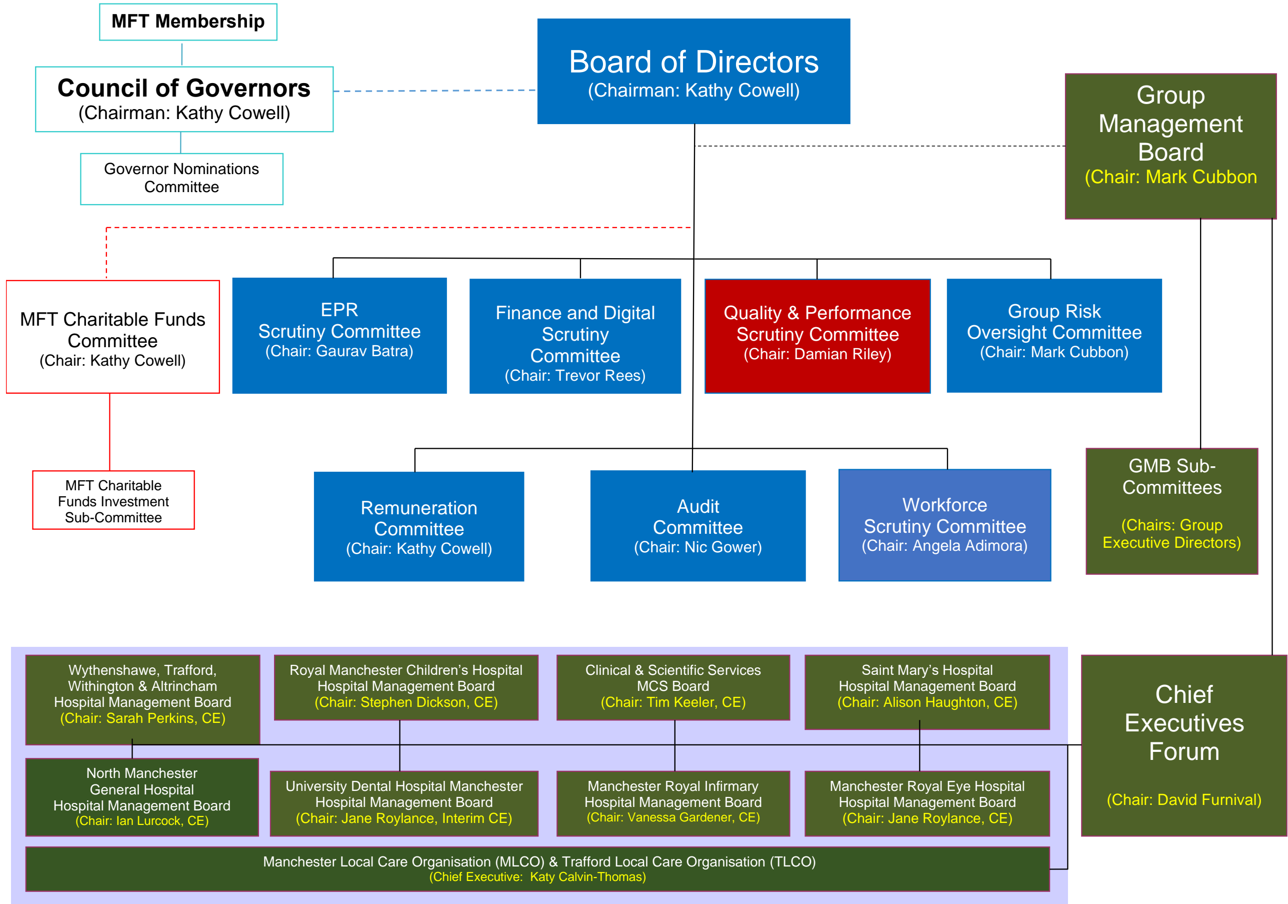
These Terms of Reference will be measured against the following key performance indicators:

- 75% attendance of all listed members or nominated deputy
- 100% coverage of duties over a 12-month period
- 100% of scheduled meetings take place
- a Committee/Group work programme is in place
- training needs of the participants will be identified and relevant training provided
- The level of information provided to the Committee enables the Group Board of Directors to gain additional assurance regarding the implementation of turnaround and mitigation plans to address identified workforce risks.
- 100% submission of reports to the Board of Directors

11. SUB-COMMITTEES/SUB-GROUPS

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

12 . REPORTING STRUCTURE CHART (see overleaf)



APPENDIX G

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

GROUP RISK OVERSIGHT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors has established a Committee of the Board to be known as the Group Risk Oversight Committee ('the Committee')

2. MEMBERSHIP

Group Chief Executive (Chair)
Joint Group Medical Directors
Group Chief Nurse
Group Chief Finance Officer
Group Executive Director of Workforce and Corporate Business
Group Chief Operating Officer
Hospital/MCS/LCO Directors
Group Director of Corporate Business and Trust Board Secretary
Group Director of Clinical Governance
Corporate Directors as required

In attendance, Internal Audit representative (as required)

3. ATTENDANCE AT MEETINGS

3.1. Non-Executives of the Trust may attend the Committee and will be provided with copy papers in advance of each meeting

3.2. The Committee may require the attendance of any Trust employee or agent of the Trust

3.3. A quorum shall consist of eight members including a minimum of one Executive Director and one Hospital/MCS/LCO Director

4. FREQUENCY OF MEETINGS

4.1. Every two months and at other times as may be necessary

5. OVERVIEW

5.1. The Committee will review and report on the overall risk profile of the organisation and ensure that effective assurance mechanisms are in place in relation to the mitigation in place

5.2. The Committee will approve the process for the management of risk, communicated through the Group Risk Management Framework and Strategy, and set the tone and appetite for risk across the Group

6. SCOPE AND DUTIES

6.1. To provide an assurance to the Board of Directors that risks of all types are identified, and controlled to an acceptable level, and to advice the Board on significant risks (those with a score of 15 or above and other risks as determined by the Committee)

6.2. To receive the Trust Risk Register and any significant risks identified through other reports

6.3. To receive routine assurance from the outcome of each Scrutiny Committee that the relevant Principal Risk(s) and component strategic risks have been considered in the context of the effectiveness of controls in place (using the sources of assurance identified in the BAF as part of the routine business of those Committees)

6.4. To ensure the outcome of the consideration of the strategic risk register and any risk escalation or proposed downgrade at the Group Risk Oversight Committee is used to update the BAF

6.5. The Committee will review reports on the following:

- New risks at level ≥15 – standard report detailing management and oversight arrangements
- New and scheduled aggregated risks comprised of interdependent/interrelated risks
- New and scheduled risks related to Single Hospital Services
- Risks escalated for review/support by Hospital/MCS/LCO where further mitigation is outside of the control of the Hospital/MCS/LCO (for example a national tariff issue)
- Level ≥15 risks in Hospital/MCS/LCO with an AOF score of 6

6.6. The Committee may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues

6.7. To provide a forum for consultation between all professions on methods for assessing risks of all types in a consistent fashion and to propose levels of tolerance for Board of Directors' approval

6.8. To provide the Board of Directors with the Group Risk Management Framework and Strategy for its approval

6.9. To raise awareness and understanding of risk management at all levels and among all professions in the Trust

6.10. Based upon the reporting and assurance framework, advise the Board of Directors on risk considerations relevant to the agreement of strategic objectives and investment priorities

6.11. To agree and oversee the methodology for treating risks for use by operational management and to propose the relationship between this and the business planning process

6.12. To ensure that there is an effective mechanism for reporting significant risks to the Board or senior management in a timely fashion (outside the usual reporting mechanism)

6.13. To ensure that there are effective mechanisms for reporting risks to the appropriate bodies both internally, for example –

- Pharmacy
- Employee Health and Wellbeing
- Medical equipment

Externally for example –

- Care Quality Commission
- NHS E
- Greater Manchester Integrated Care Board
- Medicines Healthcare products Regulatory Agency
- Health and Safety Executive

6.14. To investigate and propose longer term risk indicators and report in progress against them to the Board of Directors

6.15. To ensure an effective mechanism for escalating issues from Trust groups to the appropriate Committee of the Board of Directors and the Board Assurance Framework

6.16. To provide the Board of Directors with an assurance that the risk is well managed. This should be enacted through the work of the Integrated Governance and Risk Committee demonstrating the effective implementation of the Risk Management Framework and Strategy, and the consideration of annual Internal Audit opinion

6.17. To ensure that systems are in place which improve all practice appropriately as a consequence of risk assessment, incidents, complaints, by reporting on:

- The method for ensuring the full range of risks is encompassed
- Accountability for aspects of risk management and internal control
- Any high-level risk associated with progress on completing baseline self-assessments of local and national standards, and generating subsequent action plans

6.18. To ensure an effective mechanism for reporting risk issues to all levels of management and staff

6.19. To receive a report of the Integrated Governance and Risk Committee

6.20. To receive a report of the Trust Strategic Health and Safety Committee

7. DOCUMENT REVIEW

7.1. The Committee will be responsible for the review and submission of the following documents:

7.1.1. The Group Risk Management Framework and Strategy

8. RELATIONSHIPS AND REPORTING

8.1. The Committee report shall be considered at the next Board of Directors' meeting

8.2. The Committee report shall be considered at the next Trust Audit Committee

8.3. The Committee may request formal reports from any other Trust Committee when relevant

8.4. The Committee will work closely with both the Audit Committee and other Board sub-Committees to provide assurance to the Board of Directors that there are effective systems of internal control

9. AUTHORITY

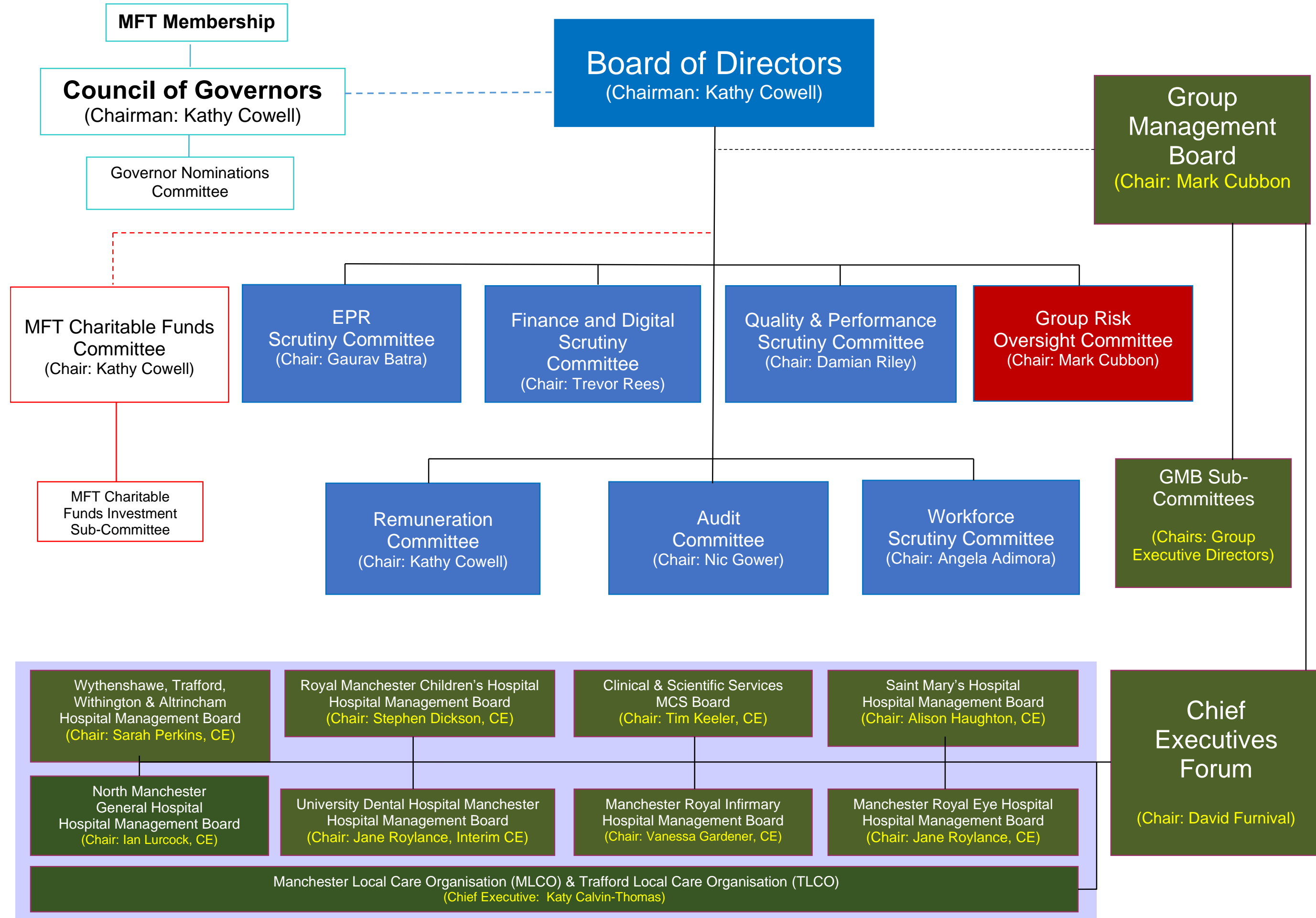
9.1. The Committee is empowered to examine and investigate any activity withing the Trust pursuant to the above scope and duties

10. KEY PERFORMANCE INDICATORS

10.1. These Terms of Reference will be measured against the following key performance indicators:

10.1.1. 75% attendance of all listed members or nominated deputy
10.1.2. Presentation of the Group Risk Management Framework and Strategy
10.1.3. Presentation of risk management in detail in the Annual Report
10.1.4. Contribution to the Annual Governance Statement
10.1.5. Documented discussion at each meeting of risk referral
10.1.6. Annual Report for Health and Safety Committee

11. REPORTING STRUCTURE CHART



APPENDIX H

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Committee has been formally constituted by the Manchester University NHS Foundation Trust Group Board of Directors in accordance with its Standing Orders and will report to the Group Board of Directors.

2. MEMBERSHIP

2.1 The Committee shall comprise:

- Group Chairman of the Group Board of Directors
- All Group Non-Executive Directors

2.2 No business should be transacted at a meeting unless the Chair and three Group Non-Executive Directors are present.

2.3 The Group Chairman of the Group Board of Directors shall be Chairman of the Committee and if unavailable for a meeting, the Group Deputy Chairman of the Group Board of Directors shall chair the meeting.

3. ATTENDANCE AT MEETINGS

3.1 The Group Chief Executive Officer and the Group Executive Director of Workforce and Corporate Business will join the Committee when discussing other Group Executive Directors, or,other designated individuals and/or staff groups.

3.2 The following participants are required to attend meetings of the Remuneration Committee.

- Trust Board Secretary.
- The Committee shall require the attendance of any Director or member of staff as required.

3.3 The Trust Board Secretary (or Nominated Deputy) shall be the secretary to the Committee and shall attend to take minutes of meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 The Committee shall meet at least once per annum.

5. OVERVIEW

5.1 The Remuneration Committee has been established by the Group Board of Directors to receive annual performance summaries for the Group Chief Executive and Group Executive Directors, and, ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales.

5.2 In line with the Department of Health & Social Care Guidance and best practice the Remuneration Committee will seek to ensure that all compensation decisions taken are fair and equality of opportunity, diversity and inclusion impacts are considered.

6. SCOPE AND DUTIES

6.1 The scope and duties of the Committee are:

- To receive the annual performance summaries for the Group Chief Executive and the Group Executive Directors
- To determine the framework or broad policy for the remuneration of the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc.) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.
- To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.
- To advise on, and oversee, contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.
- To understand the equality impacts of the decisions the Committee makes by having in each paper:
    - A breakdown on the impact of remuneration and changes to remuneration by protected characteristics in each pay paper.
    - Standard cover sheet including a section about how the author has consider equality and any actions taken to mitigate.
- To consider the impact of any gaps in representation on decision making.

7. AUTHORITY

7.1 The Remuneration Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

7.2 The Committee will make satisfactory arrangements to ensure it receives, when necessary, advice on remuneration levels elsewhere in the NHS, with due reference to national policy and guidance, as well as trends and developments in areas of benefits and terms and conditions of employment.

8. REPORTING

8.1 The Remuneration Committee shall ensure that the Group Board of Directors' emoluments are accurately reported in the required format in the Group's Annual Report.

9. REVIEW

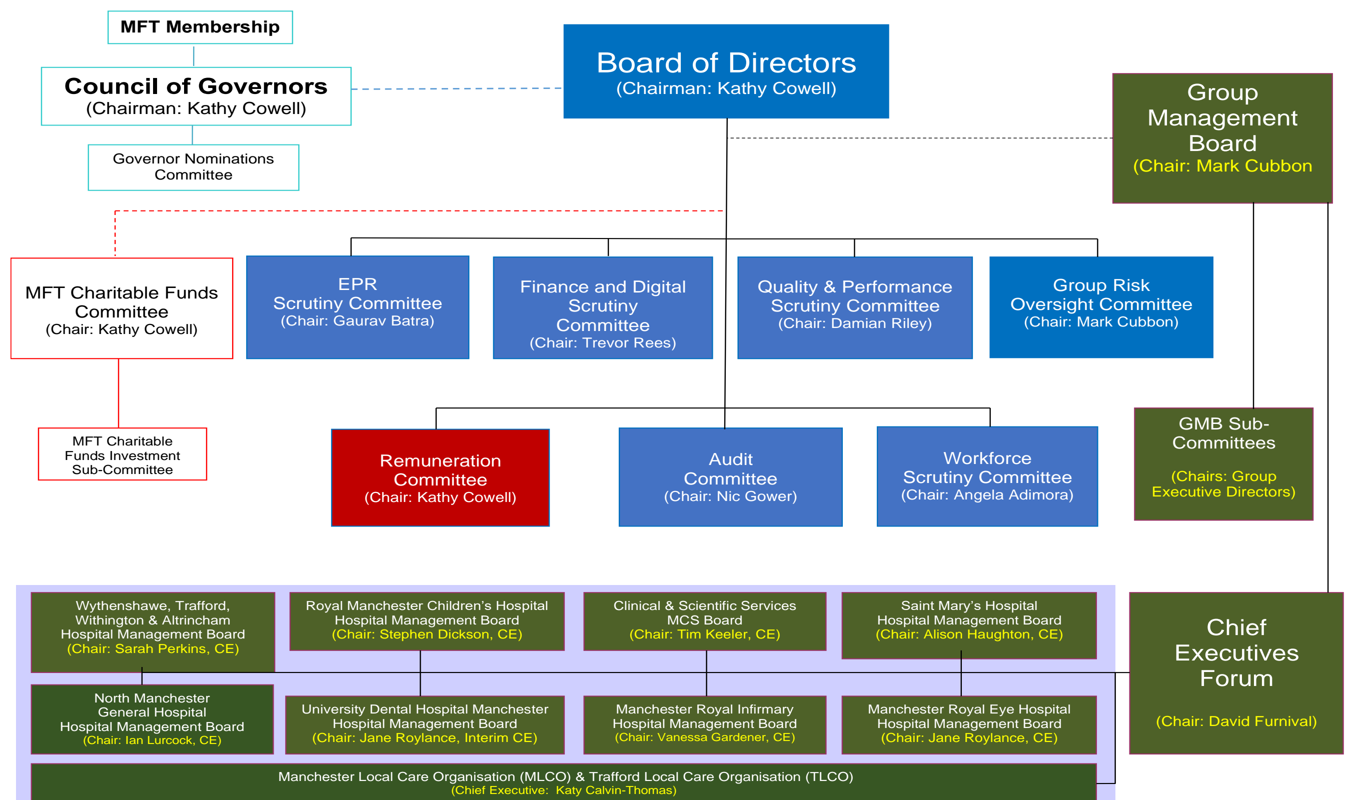
9.1 The Terms of Reference of the Committee will be reviewed at least annually.

10. KEY PERFORMANCE INDICATOR

10.1 These Terms of Reference will be measured against the following key performance indicator:

- 75% attendance of all listed members.

11. REPORTING STRUCTURE CHART



Agenda Item 10.10

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Director of Corporate Business/ Trust Board Secretary
Date of paper:	May 2023
Subject:	MFT Board of Directors' Register of Interests (April 2023)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The MFT *'Constitution'* and *'Standing Orders for the Practice & Procedure of the Board of Directors'* requires the Board of Directors to provide a Register of Interests.
Recommendations	The Board of Directors is asked to note the MFT Board of Directors' Register of Interests (April 2023)
Contact	Name: Nick Gomm, Director of Corporate Business/ Trust Board Secretary Tel: 0161 276 4841

1. Introduction

In line with the MFT constitution and standing orders, the Board of Directors is required to hold a Register of Interests and review it every 6 months.

The register must include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive members.

The Register is available to the public on MFT's website.

2. Recommendation

The Board is asked to note the MFT Board of Directors' Register of Interests (April 2023).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(April 2023)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – APRIL 2023

NAME	POSITION	INTERESTS DECLARED
Kathy Cowell OBE DL	Group Chairman	Chairman of the Trust's Charity Member of the General Assembly, The University of Manchester Member Manchester Academic Health Science Centre Vice Chair Cheshire Young Carers Mentor on the Aspirant Chairs Programme (NHSI) Member of the QVA's mentoring panel (Cheshire) Chairman of Totally Local Company Deputy Lieutenant for Cheshire Chairman of the Hammond School (Chester) People Ambassador for Active Cheshire Vice President, St Ann's Hospice Member of Manchester Health & Wellbeing Board Member of Integrated Care Partnership Board
Trevor Rees	Group Deputy Chairman / Group Non-Executive Director	Treasurer/Trustee (Manchester Literary and Philosophical Society) Independent Co-opted member (Audit Committee at University of Manchester (not a Board Member) Non-Executive Director of Totally Local Company, Stockport (3-year Term) Chair of the Audit Committee of GB Taekwondo
Nic Gower	Group Non-Executive Director	Director Furness Building Society [NED]
Angela Adimora	Group Non-Executive Director	Governor, Salford University Senior Director of HR Operations, UK & Europe for GXO

NAME	POSITION	INTERESTS DECLARED
Professor Luke Georghiou	Group Non-Executive Director	Deputy President and Deputy Vice-Chancellor, University of Manchester Non-Executive Director of Manchester Science Partnerships Ltd Non-Executive Director, Manchester Innovation Factory Non-Executive Director, Northern Gritstone Investment Company Chair of Board of University of Manchester Worldwide Limited
Chris McLoughlin OBE	Group Non-Executive Director / Senior Independent Director (SID)	Executive Director of People and Integration Director of Children's Services, Stockport Metropolitan Borough council Member of Association of Director of Children's Services Ltd Chair of Greater Manchester Start Well & School Readiness Board Chair of Greater Manchester Children and Young People Health and Wellbeing Executive Member of Greater Manchester Integrated Care Partnership
Gaurav Batra	Group Non-Executive Director	Chairman, Bolesworth Estate (comprising directorships of the following entities): Bolesworth Holding Company 1 Bolesworth Holding Company 2 Bolesworth Investment Company Bolesworth Estate Company Chairman, Stockport Sports Trust Director IE8 Limited (Strategic Consultancy) Chairman, Think Energy Group Ltd
Damien Riley	Group Non-Executive Director	No interests to declare

NAME	POSITION	INTERESTS DECLARED
Mark Gifford	Group Non-Executive Directors	Director (non-renumerated) Diocese of Westminster Academy Trust CEO & Board member National Citizen Service Trust (public body)
Mark Cubbon	Group Chief Executive Officer	• Advisory Board Member NHS Elect • Board Member, Health Innovation Manchester
Gill Heaton OBE	Group Deputy Chief Executive	• Co-Chair of the Manchester Provider Collaborative Board • Co-Chair of the Trafford Provider Collaborative Board
Darren Banks	Group Executive Director of Strategy	• Spouse – Chief Finance Officer, Wrightington, Wigan & Leigh NHS FT • Board Member, The Corridor, Manchester
Peter Blythin	Group Executive Director of Workforce & Corporate Business	• No interests to declare
Julia Bridgewater	Group Chief Operating Officer	• Foundation Director of Multi Academy, All Saints Catholic Collegiate
Professor Jane Eddleston	Joint Group Medical Director	• Clinical lead for the NHS England Rehabilitation after Critical Care Programme • GM Partnership Joint Medical Executive lead for Acute Care
Jenny Ehrhardt	Group Chief Finance Officer	• Former Trustee and Treasurer – Faculty of Medical Leadership & Management (to June 2022) • Chair of Sub-Committee of the National Finance Leadership Council

NAME	POSITION	INTERESTS DECLARED
Professor Cheryl Lenney OBE	Group Chief Nurse	• Spouse – Director of Workforce & Organisational Development, Manchester Local Care Organisation
Miss Toli Onon	Joint Group Medical Director	• No interests to declare
David Furnival	Group Director of Operations	• Spouse - Chief of Regulatory Compliance and Improvement, NWAS