MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON MONDAY 13th May 2024
At 2:00PM – 5:00PM

MAIN BOARDROOM
COBBETT HOUSE
OXFORD ROAD CAMPUS

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 18th March 2024 *(enclosed)*

4. Patient Story *(Film)*

5. Matters Arising

6. Group Chairman's Report *(Verbal Report of the Group Chairman)*

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

8. Reports from the Board of Directors' Scrutiny Committees *(Reports of the Group Non-Executive Directors enclosed)*

- Charitable Funds Committee held on 13th March 2024
- EPR Scrutiny Committee held on 27th March 2024
- Audit Committee held on 10th April 2024
- Finance and Digital Scrutiny Committee held on 23rd April 2024
- Quality and Performance Scrutiny Committee held on 24th April 2024
- Workforce Scrutiny Committee held on 24th April 2024
- Organisational Development Scrutiny Committee held on 29th April 2024

9. Operational Performance

9.1 To receive the Integrated Performance Report *(Report of the Group Executive Directors enclosed)*

9.2 To receive the Group Chief Finance Officer's Report M12 *(Report of the Group Chief Finance Officer enclosed)*

10. Strategic Review

10.1 To receive an update on the MFT strategic developments *(Report of the Group Chief Strategy Officer enclosed)*

10.2 To receive the MFT Annual Plan 2024/2025. *(Report of the Group Chief Strategy Officer enclosed)*

11. Governance / Assurance

11.1 To receive a report on Paediatric Audiology Services	*(Report of the Group Chief Nurse Enclosed)*
11.2 To receive the Q4 Patient Experience and Complaints Report	*(Report of the Group Chief Nurse enclosed)*
11.3 To receive the annual Nursing & Midwifery Safer Staffing report	*(Report of the Group Chief Nurse enclosed)*
11.4 To receive the Infection Prevention and Control report, including the vaccination programme	*(Report of the Group Chief Nurse enclosed)*
11.5 To receive a report on the Mental Health Peer Review	*(Report of the Group Chief Nurse enclosed)*
11.6 To receive the annual Clinical Accreditation report	*(Report of the Group Chief Nurse enclosed)*
11.7 To delegate authority to the Audit Committee for sign-off of the MFT Annual Report and Annual Accounts for 2023/24	*(Report of the Group Chief Finance Officer enclosed)*
11.8 To receive and approve MFT's Provider license self-certification	*(Report of the Group Executive Director for Workforce and Corporate Business enclosed)*
11.9 To receive the Board of Directors' Register of Interest	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*

12. Items for consenting following discussion at Scrutiny Committees

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

13. Date and Time of Next Meeting

The next meeting will be held on Monday 8th July 2024 at 2:00pm

14. Any Other Business

NHS Manchester University NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 18th March 2024

(PUBLIC)

Main Boardroom, Cobbett House

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Mark Cubbon (MC)	Group Chief Executive
	Trevor Rees (TR)	Deputy Group Chairman
	Darren Banks (DB)	Group Executive Director of Strategy
	Julia Bridgewater (JB)	Group Deputy Chief Executive
	Nic Gower (NG)	Group Non-Executive Director
	Cheryl Lenney (CL)	Group Chief Nurse
	Toli Onon (TO)	Joint Group Medical Director
	Luke Georghiou (LG)	Group Non-Executive Director
	Mark Gifford (MG)	Group Non-Executive Director
	Chris McLoughlin (CM)	Group Non-Executive Director
	Gaurav Batra (GB)	Group Non-Executive Director
	Angela Adimora (AA)	Group Non-Executive Director
	Damian Riley (DR)	Group Non-Executive Director
	Tim Barlow (TB)	Deputy Group Chief Finance Officer
	Stella Clayton (SC)	Group Director of Workforce and OD
In attendance:	Nick Gomm (NGo)	Director of Corporate Business/ Trust Board Secretary

187/23 Apologies for Absence

Apologies were received from Jenny Ehrhardt and Peter Blythin

188/23 Declarations of Interest

No specific interests were declared for the meeting.

189/23 Minutes of the Board of Director's meeting held on 15th January 2024

The minutes of the Board of Directors' (Board) meeting held on the 15th January 2024 were approved.

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

190/23 Patient Story

CL introduced the filmed patient story which described the experience of two brothers who had used the Living Kidney Sharing Scheme to enable one of them to get the kidney transplant he required.

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

191/23 Matters Arising

KC noted that it was CL's last Board meeting before her departure from the organisation. She thanked her for her contribution over the years she has worked at MFT and wished her all the best for the future.

A number of questions regarding the current conflict in Gaza had been raised by members of the public in advance of the meeting. Three people attended the Board to listen to the Board's responses.

On the provision of medical aid to Gaza, KC described MFT's long history of responding to requests from recognised charitable and humanitarian organisations for provision of suitable surplus supplies to areas of need overseas. There is an agreed process in place with MFT's procurement team. MC added that some clinicians from RMCH are in contact with medics in Gaza to provide advice and support as part of a nationally co-ordinated effort.

On the question of support to staff affected by the conflict, MC explained that MFT provides a comprehensive range of options to support the wellbeing of staff. This includes training to frontline managers in how to support staff to access, and refer staff to, a number of specialist services that can provide specific support. In addition, MFT has a series of Staff Networks and a multi-faith Chaplaincy team, who can provide comfort and guidance to staff.

In response to a specific question regarding MFT's purchasing from Teva, a pharmaceutical company, MC confirmed that MFT do buy supplies from them in line with national guidance and the national framework.

In response to questions regarding some of the specific retail units on MFT sites, MC explained that all retail units are allocated space through the framework in place with the Facilities Management Provider. There is a mix of in-house, independent and recognised brands on MFT sites including 'Have a banana' on the Oxford Road site and League of Friends at NMGH and Trafford. He emphasised the importance of MFT's role in delivering social value and supporting local services and explained that over 26% of MFT suppliers come from Greater Manchester.

192/23 Group Chairman's Report

The Group Chairman presented her verbal report which provided an update on matters of interest which have arisen since the last meeting. She highlighted:

- Events to recognise and celebrate International Women's Day which included the work MFT do to support and promote inclusion for female colleagues.
- Colleague Community Live events at Oxford Road Campus and Wythenshawe. The events were aimed at giving MFT's workforce the opportunity to explore all the services, training opportunities, wellbeing support and resources available to them as part of the MFT Team.
- Samantha Liscio has been appointed as a new Non-Executive director to the Board of Directors following approval by the Trust's Council of Governors.

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

193/23 Group Chief Executive's Report

MC presented his report which provided information on a wide range of issues of relevance to the Board. He highlighted:

- The new MFT organisational strategy, presented for approval later on the meeting's agenda, and thanked all the contributors and advisers to the work including the international experts who provided evidence and advice.
- MFT's Annual Plan for 2024/25 which adopted a bottom up process triangulating activity, finance and workforce this year combined with top down requirements.
- RMCH has been awarded the prestigious title of a Centre of Excellence for the care of children with muscular dystrophy. MC congratulated all involved.
- The Spinal lookback review which has now been completed. MC apologised to all patients and families involved and confirmed that all recommendations from the review would be taken forward.
- Meetings of the Scientific Advisory Board of the Biomedical Research Centre began in February with updates on current work and discussions about future opportunities. MC thanked Ian Bruce for his work in this area and the strong legacy he is leaving behind as he moves to another role. Professor Karen Barton has replaced him.
- A visit by Professor Chris Whitty on the 14/2/24 which focused on how integrated working can improve health outcomes and access to health services.
- Current operational performance shows a 12-13% improvement in Emergency Department performance in 2023/24 despite a 17% increase in attendances and admission. The Hospital@ home service is functioning well with positive feedback from patients and their families. There has been a steady improvement in cancer care performance and elective care is likely to exceed the end of year forecast. MC thanked all staff for the hard work over the year.
- The recent period of industrial action during which MFT focused on rota coverage whilst maintaining as much elective care as possible. Despite that there has been an impact on patient experience and The Trust's finances.
- A 3-year financial recovery plan is being developed to address the Trust's underlying deficit. This will come to a future Board session for approval.
- Group Chief Nurse, Cheryl Lenney, is leaving the organisation. MC thanked her for all the work she has done for MFT and the wider NHS, and the significant impact she has had locally, regionally and nationally.
- Vanessa Gardner will be joining the Board as Chief Delivery Officer from the 2/4/24.
- Stephen Dickson has been appointed as the new Chief Executive of WTWA.
- The sentencing of NMGH security officers following an incident in 2023. MC recognised the disruptive behaviour which security teams often face but emphasised that, in this case, the behaviour of the security officers had been unacceptable and apologised to the patient concerned.

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

194/23 Reports from the Board of Directors' Scrutiny Committees

The Non-Executive Director (NED) Chairs of the Board of Directors' Scrutiny Committees presented their reports which described matters discussed in the last meetings of them.

Strategic Projects Scrutiny Committee held on 24th January 2024
LG, the Committee Chair, highlighted:

- That SPSC is a new committee and it has identified the key capital projects and major service reconfigurations which will be under the scope of the Committee.
- Funding has been confirmed for outline business case development for the NMGH redevelopment programme with discussions ongoing with the national team regarding the total funding of the programme.
- Good progress is being made with MFT's Green Plan but capital funding will be required to meet targets. A bid has been submitted to develop Trafford into becoming first net zero hospital.

Audit Committee held on 7th February 2024
NG, the Committee Chair, highlighted:

- The Committee noted the internal audit report on space utilisation and the management actions being undertaken to address the recommendations.
- The Committee received the internal audit reports on core financial controls, demand and capacity, waste reduction/drug costs, and PFI contract management. All received ratings of significant assurance with minor improvement opportunities identified.
- The Committee discussed the internal audit programme for 2024/25.

Finance and Digital Scrutiny Committee held on 27th February 2024
TR, the Committee Chair, highlighted:

- The Trust's finances continue to be challenging for this year and will remain so in 2024/25 and beyond.
- The Trust's Waste Reduction Programme (WRP) for 2023/24 was delivered in full.
- The Value for Patients programme has got off to good start with £39m identified so far, 94% of which is recurrent.
- The Group CIO report showed that all actions from cyber security audit report had been delivered or were on course to be delivered by the target dates.

Workforce Scrutiny Committee held on 27th February 2024
AA, the Committee Chair, highlighted:

- Substantive recruitment has increased and the target for reducing staff turnover has been exceeded.
- The Committee received the Public Sector Equality Duty report and Gender Pay Gap report, both of which were supported for Board approval at this Board meeting.
- The ongoing staff engagement programme which includes the work being undertaken on culture at SMH.
- The Committee received the Q3 report from both the Guardian of Safe Working and the Freedom to Speak Up Guardian.

Quality and Performance Scrutiny Committee held on 29th February 2024
DR, the Committee Chair, highlighted:

- MRSA incidence within the Trust and the changing role of Infection Prevention and Control (IPC) nurses.
- As highlighted by TO earlier, an additional Never Event has occurred.
- The programme of harm reduction work underway with adoption of a consistent process and method for collecting data. This will improve the way waiting lists are managed in the future and reduce harm.
- The link between perinatal mortality and health inequalities and the work being taken to improve the situation.

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

195/23 Integrated Performance Report (IPR)

Group Executive Directors introduced the sections of the IPR relevant to their portfolios.

TO highlighted:

- The reduction in Never Events this year but the need to retain a zero tolerance approach.
- Work underway by the patient safety team to improve compliance with LocSSiPs with 3500 different procedures likely to be subject to LocSSIPs in the future.
- The improvement seen in the application of NICE guidance. There remain some issues with data availability within Hive to support national audits.
- The CQUIN target regarding flu vaccination is unlikely to be met due to some vaccine hesitancy in staff. This reflects a national trend. AA commented that it would be helpful to recognise hesitancy within some BAME communities, understand the issues, and target different communications to those groups.

CL highlighted:

- The work underway to improve nutrition and hydration.
- The high use of translation and interpretation services wit the highest user being SMH. Some patients have refused to use the service but national guidance advises that friends and family members should not be used as interpreters. The potential of training staff up to be interpreters is being considered.
- The standard applied for re-opened complaints is a MFT one, not a nationally prescribed standard.
- There has been an improvement in compliance with the section 132 mental health metric.
- Compliance with completion of the Oliver McGowan training is currently at 37%

CM added that she attended a number of Safeguarding Assurance Panels and all included detailed consideration of issues relating to mental health and learning disabilities. She thanked CL for the improvement that has been shown over the years in this regard.

MC explained that a mental health peer review has taken place and the report will come to a future Board session.

JB highlighted:

- ED performance was at 70.4% for the year at the end of January but the figures for February was 65%. Internal sharing of best practice is happening and an urgent care summit with external partners is being planned. Virtual ward capacity is improving with 95% achieved last week.
- The cancer backlog was 359 in January against a high of 1200 in November 2022. Last week the backlog was at 245. Ahead of the annual target. This is in the context of 4% more cancer referrals being received by MFT this year than last.
- There are 20,000 fewer people of a waiting list for elective care at MFT than there were at the beginning of the financial year. The target is for no patients to have been waiting for 78 weeks or longer by the end of March 2024 apart from a small number of unavoidable exceptions including patient choice, fitness for surgery, or the shortage of corneal graft availability.
- Performance against the diagnostic standard was 43.9% in January. The unvalidated figure for February is 34% with the aim to get to 30% by the end of March. The figure was 54.4% in August.
- Increasing productivity will be key to further improvement with more opportunities from Hive available.

In response to a question from TR, JB confirmed that processes are in place to monitor the health of patients waiting for elective treatment. TO described the MESH process managed at site level and JE noted that, every 12 weeks, patients waiting for care are reviewed.

In response to a question from GB, JE confirmed that patient feedback has been positive and those suffering from heart failure will be the next group of patients to focus on

In response to a question from AA, it was agreed that the Hospital@Home service would be discussed at a future Board seminar.

SC highlighted:

- The role that WSC plays in overseeing delivery against workforce targets.
- Sickness absence sist at 6.1% against a target of 5.2%. The target for 2024/25 is 5%. Consistent application of policy and use of the Absence Manager system is important reduce absence.
- Level 1 mandatory training compliance remains high but work is still required to raise compliance rates for Levels 2 and 3.
- The 2023 NHS staff survey results are available and MFT's completion rate has risen from 30% to 39%. The engagement score has also increased from 6.5 to 6.8 and responses t the specific Hive questions included in the survey were positive. A strategic retreat is being held at the end of April to fully consider the results and identify actions required to improve for the next survey.

In response to a question from LG, SC confirmed that the themes from the survey are similar to last year's. Any hotspots in specific hospitals/MCSs/LCOs are being addressed. There continue to be some staff stating that they experience discrimination from a race or disability perspective so work continues to investigate and address this.

MC confirmed that the full staff survey report will go to the Workforce Scrutiny Committee. MFT has been flagged as one of the most improved organisations and there has been improvement in all key metrics. However, further improvement is still required. AA commented that the results were a significant achievement and something to be proud of but the key is to deliver on the actions identified

It was agreed to consider the finance element of the IPR within the next item.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the IPR	Mental Health Peer Review to be discussed at a future Board session	KSJ	June 2024
	Hospital@Home to be discussed at a future Board seminar	JB	October 2024
	NHS staff survey results to be discussed at WSC	PB	April 2024

196/23 Group Chief Finance Officer's Report M10

TB introduced the report which presented MFT's financial position as at Month 10 and highlighted:

- The 2023/24 WRP programme was fully achieved with nearly 50% of it recurrent savings.
- There is confidence that the Elective Recovery Fund targets will be met.
- A surplus of £2.4m was delivered in M10 which is lower than the planned surplus of £4.8m.
- The cash position at the end of January 2024 fell below £100m. Trust debtors are being targeted to improve the cash position.
- All the GM capital envelope will be spent. £6m extra has been made available to MFT. The PDC schemes' target will not be met due to delays in decision making by the New Hospital Programme.
- Performance against the Better Payment Practice Code is behind in terms of the number of invoices processed but 1.5% ahead in terms of the value of the invoices.
- In Month 11, a £3.4m surplus was achieved. This is £1.4m less than the target for the month due to the impact of the industrial action. The year to date deficit stands at £35.5m but the aim is still to achieve a breakeven position along with an improved cash position.

KC commended the work of all involved and noted that achievement of a breakeven position would be very impressive considering the current financial context.

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

197/23 Maternity Services' update

CL introduced the report and highlighted:

- After queries raised by MMBRACE, the Trust compliance with the Maternity Incentive Scheme for year 5 has been confirmed. There were some data issues with the initial submission which led to the queries.
- A review of the Trust's maternity services was undertaken by the Maternity System Improvement team in January. Positive feedback has been received with work begun on a small number of recommendations. The Trust has been asked to share good practice on governance and the work to reduce waits for inductions and c-sections. The Local Maternity and Neonatal System has also carried out a review. Feedback is awaited.
- A report on the Trust's proposal to amend the BSOTS will come to a future QPSC.

In response to a question from DR regarding the 43% c-section rate reported, CL explained that there has been an increase in elective c-sections which has reduced emergency c-sections. There are plans to carry out a peer review of c-section rates with a Trust that provides a similar range of services. JE added that, as a specialist maternity centre, MFT will always attract more complex cases and therefore c-section rates are likely to be higher.

In response to section 3.6 in the report, CM confirmed that she had talked to a range of student midwives to better understand their views and the plans in place to improve. CM was interviewed by two members of the Maternity System Improvement Team and confirmed that the feedback had been positive.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report	Report on the Trust's proposal to amend the BSOTS to be discussed at a future QPSC	KSJ	April 2024

198/23 Update on the MFT strategic developments

DB introduced the report which provided an update on strategic developments relevant to MFT. He highlighted:

- The Sickle Cell Hyper-Acute pilot is now operational. It is now called the Sickle Cell Unit following feedback from patients.
- The Targeted Lung Health Checks programme which will see a greater proportion of cancers found ats Stage 1 rather than Stage 3 and 4.
- The disaggregation of urology and ENT services from the previous arrangements within Pennine Acute Hospital Trust. A readiness assessment has been carried out for both services, risks are being managed and the programme is on track for being delivered by the target date.

In response to a question from NG, DB explained that work was ongoing to ensure the money received for funding Community Diagnostic Centres went as far as possible and the Trust was looking at all alternatives for funding once the initial tranche has stopped. The funding requirement is mostly capital.

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

199/23 Update on MFT's Annual Planning Process

DB introduced the report which provided an update on the annual planning process for 2024/25. He highlighted:

- The final submission date for the plan is the 26th April and Board members will be involved in the sign off process. KC confirmed that the exact process for sign off was still to be finalised.
- The plan has been based triangulation of activity, workforce and finance data.
- The final plan will be compliant with national requirements.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report and agreed the proposed process for approval of the final submission to GMICB.	None	n/a	n/a

200/23 MFT Organisational Strategy

DB introduced the report which sought approval of the MFT's new organisational strategy. He highlighted:

- The purpose and scope of document.
- The adoption of the 'Where excellence meets compassion' as the name of the strategy.
- The strategy contains 11 strategic objectives, grouped under five strategic aims, with specific actions identified to deliver the objectives.
- The strategy responds to the needs of the diverse communities served by the Trust and identifies challenges and opportunities.
- The strategy has been developed through extensive engagement and collaboration with internal and external stakeholders.
- To ensure effective delivery, it will be embedded within team and personal objectives across the Trust as well as within governance and assurance systems.

In response to a question from TR, DB confirmed that feedback is being provided to the stakeholders who supported the work. GM ICB colleagues are keen for MFT to take a system leadership role in certain areas including preventing ill health for the GM population.

AA commended the strategy and welcomed the the values and behaviours included in the document.

In response to a question from KC, DB confirmed that a communications strategy would be in place to support delivery of the strategy but there was a need to be conscious of the pre-election period where there needs to be caution with regard to communication activity.

TO note that there needs to be consideration of whether to use the aims or objectives to structure the Board Assurance Framework (BAF) around. MC explained that this would be discussed at a future Board seminar along with detail of how the strategy will be embedded across the Trust.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the 5 year strategy	Discussion on how the strategy will be embedded across the Trust, including within the BAF, to come to a future Board seminar.	DB	June 2024

201/23 Patient Experience and Complaints (Q3)

CL introduced the report and highlighted:

- The need to improve patient communication remains a consistent theme of patient feedback.
- There has been an Increase in completed Fit and Proper Person Test (FPPT) returns and there has been a small dip in MRI and NMGH FTT results.
- WTWA records the highest number of compliments, highest FPPT results, and also the highest number of complaints.
- HealthWatch Manchester has provided feedback following visits to Wythenshawe and MRI Emergency Departments. Recommendations from the visits is being considered by the Executive Director Team (EDT).
- There is a new leadership within the Parliamentary Health Service Ombudsman team. MFT currently only has a small number of cases with them.
- A theme of PALS issues at NMGH regarding discharge has been identified.
- A drive to recruit more volunteers is underway.
- The accreditation process for 2023/24 is now complete. It will begin again in April 2024.
- Work is underway to improve the nutrition and hydration of patients.
- The 'Small Change, Big Difference' fund enables wards/areas/departments to bid for monies of up to £5000 to improve the experience of their patients.

TR explained that he had talked to members of staff who felt that volunteers were put off by the amount of training they had to do. CL explained that, after the full set of mandatory e-learning required when they start, training requirements amount to 70 minutes a year for a volunteer. KC stated that she has been discussing this issue with Gail Meers with a view to holding more face to face sessions.

MG explained that there had been a discussion about volunteering at WSC and noted the consistency of themes raised by complaints and PALS issues. He asked for a breakdown of what comes under the Treatment/Procedure heading in a future report.

DR explained that, on a Senior Leadership Walkround, he heard that the biggest frustration is with the information provided in patient letters and the timeliness of receiving them. NG noted that the Governors had also raised similar concerns. JE explained that the content of letters was being picked up through the health inequalities work. This will be presented at a future Board seminar.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report.	Breakdown of what is covered under the Treatment/Procedure heading to be included in a future report	KSJ	June 2024
	The work to improve the content of patient letters to be discussed at a future Board seminar.	JE	June 2024

202/23 Care Quality Commission's revised approach to regulation

CL introduced the report which described the CQC's revised approach to regulation. She highlighted:

- A presentation on the revised approach had been provided to the Board seminar in February 2024.
- The Trust's Ulysses system will be used to gather evidence for each Quality Statement from hospitals. MCSs, LCOs, and corporate teams.
- The CQC are adopting a more targeted approach to inspections with the current focus appearing to be Emergency Departments.

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

203/23 Board Assurance Framework

SC presented the BAF as at the end of February 2023. She highlighted:

- The BAF presents an analysis of the principal risks most like to impede achievement of the Trust's strategic aims.
- The BAF begins with the executive summary which lists the strategic aims and provides a commentary from each lead Executive as to progress being made. This is followed by an in-depth appraisal of each Principal Risk, identifying the controls and enablers in place to mitigate the risk, and actions to address any gaps. Also identified are the sources of assurance, those which are received on a routine e basis and those which have been received since the BAF was last presented to the Board in November 2023. Actions to address any gaps in assurance are also included.
- The risks relevant to the Quality and Performance Scrutiny Committee, Workforce Scrutiny Committee and Finance and Digital Scrutiny Committee were discussed at their February meetings along with the strategic risks aligned to each principal risk.
- A new set of principal risks will need to be approved to inform monitoring of the delivery of the new MFT organisational strategy. This will be done in line with the review of the Trust's Risk Management Strategy and Framework, the outcome from which will be presented to July's Board for approval.

In response to a question from NG, KC confirmed that NEDs would be included in the process to redesign the BAF.

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

204/23 MFT's Green Plan

JB introduced the report which provided an update on the delivery of MFT's Green Plan. She highlighted:

- The report had been considered in detail at the SPSC, as noted by LG earlier in the meeting.
- The considerable impact which the Trust has on the environment due to its scale and all it delivers.
- The link between the environment and health inequalities.
- The Trust is moving in the right direction but needs to accelerate its progress.
- The ambition for Trafford to be the first net zero hospital in England.

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

205/23 Public Sector Equality Duty Annual Report 2024

SC introduced the report and highlighted:

- The report had been discussed in detail at WSC who have recommended the Board to approve the report for publication.
- The report details how MFT will meet the three aims of the Public Sector Equality Duty

AA commended the report and confirmed the discussion at WSC.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the Public Sector Equality Duty Annual Report for publication	None	n/a	n/a

206/23 Gender Pay Gap annual report

SC introduced the report and highlighted:

- The report had been discussed in detail at WSC who have recommended the Board to approve the report for publication.
- 75% of the Trust workforce is female in workforce but this is not reflected at senior levels of the organisation. As a result, there is a focus on attracting more female talent to senior positions including medical consultants.

AA confirmed that the WSC had recommended the report for approval by the Board.

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

207/23 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 13th May 2024 at 2:00pm

208/23	**Any Other Business** There were no additional items of business.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 18th March 2024		
Action	Responsibility	Completion date
Mental Health Peer Review to be discussed at a future Board session	KSJ	June 2024
Hospital@Home to be discussed at a future Board seminar	JB	October 2024
NHS staff survey results to be discussed at WSC	PB	April 2024
Discussion on how the strategy will be embedded across the Trust, including within the BAF, to come to a future Board seminar.	DB	June 2024
Breakdown of what is covered under the Treatment/Procedure heading to be included in a future report	KSJ	June 2024
The work to improve the content of patient letters to be discussed at a future Board seminar.	JE	June 2024

Board Meeting Date: 15th January 2024		
Action	Responsibility	Completion date
Update on the occurrence of alert organisms to be presented to a future QPSC.	CL	April 2024
Further discussion on Strengthening Leadership, Culture and Engagement at MFT to be held at a future Board meeting.	PB	May 2024 (further discussion to be held at Board Seminar in April 2024)
Report on the updated BSOTS approach to be discussed at a future QPSC	CL	April 2024
Report on the November maternal death to come to a future Board meeting	CL	To be scheduled when ready

Board Meeting Date: 13th November 2023		
Action	Responsibility	Completion date
Hospital@Home programme to be considered at a future QPSC meeting.	JB	To be scheduled
Report on international recruitment to come to a future WSC meeting	CL	Complete

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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Executive
Paper prepared by:	Mark Cubbon, Group Chief Executive
Date of paper:	May 2024
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:	The Group Chief Executive has provided a report which provides an overview of activities at the Trust, the response to current operational pressures, and progress made on strategic objectives. They have outlined issues of current interest to the Board and have shared their top three areas of concern.
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Leo Clifton, Senior Business Manager Tel: 0161 529 0264

The purpose of this report is to provide a general update on matters that the Group Chief Executive Officer (CEO) wishes to highlight to the Board since the last public board meeting. The report is divided into 5 sections:

Contents

1. Strategic Updates

There are several key strategic updates I would like to bring to the Board's attention:

Organisational Strategy Implementation Plan

Following the approval of our MFT strategy, *Where Excellence Meets Compassion,* by the Board of Directors in March, we are now working on our plans to ensure that it is implemented and delivers the benefits it sets out for our patients, staff and communities.

There are a number of different elements to these plans. Firstly, we want to make sure that everyone at MFT is aware of the aims in our strategy and understand their role in helping to deliver it, so we will be working on a programme of communications and engagement to help build that shared purpose. Secondly, it is important that our strategy drives all the other plans that we develop across the organisation, so we will develop a framework and tools to support this. Thirdly, we need to ensure that we have the right oversight arrangements in place to drive forward implementation so we will be reviewing our governance structures to make sure they are fully aligned to our refreshed mission and strategic aims. We are aiming to provide an update to the Board on the progress with implementation in July.

Annual Plan 24/25

We have now finalised our annual plan for 2024/25. The document includes background information about MFT, our priorities and how they align with those of key partner organisations and the financial environment within which we operate. The plan itself describes how each Hospital, MCS, LCO and corporate team are going to take forward the aims and objectives set in the new Organisational Strategy in the coming year against the planning priorities set for 24/25 by NHS England. The Annual Plan is effectively the year 1 delivery plan for our strategy.

Key commitments for the coming year will see the continuation of recovery across our services, delivering further improvements to our waiting times, and making the best use of resources by increasing our productivity and efficiency. None of this will

be possible without our staff and we will continue to prioritise our workforce and improving their experience of working at MFT through delivering on our commitments in the MFT People Plan.

Further detail regarding the Annual Plan will be provided by the Chief Strategy Officer later on the agenda.

Target Operating Model

We are currently reviewing our ways of working to determine if there are things that we need to do differently. When we talk about ways of working, we are considering these under four broad headings; our people and culture, our organisational structure, our processes and governance and how we use data and technology. All of these areas are key to enabling us to work together to deliver high quality care and given the recent publication of our new organisational strategy, we need to make sure we are in the best possible position to deliver on our strategic aims to improve the health and quality of life of our diverse communities.

In all organisations, but particularly those the size of MFT, it is important to periodically reflect on opportunities to strengthen how we work together to improve the effectiveness of the leadership arrangements which support our frontline teams. One important consideration being explored is the best way to bring the leadership of our Hospitals, Managed Clinical Services and Local Care Organisations closer to the MFT executive team. This will help streamline decision making and ensure our local leaders have greater involvement in the running of MFT, as well as the areas they specifically lead with their teams.

Following a series of engagement sessions, we have developed proposals on elements of the operating model which we are seeking feedback through consultation with relevant staff related to the proposed future working arrangements. A dedicated scrutiny committee has been constituted to provide oversight of the process and assurance to our Board of Directors.

Tessa Jowell Centre of Excellence

Dame Tessa Jowell made a statement in the House of Lords in 2018 calling for an improvement in brain tumour outcomes, prior to her sad passing, which led to the establishment of the Tessa Jowell Brain Cancer Mission (TJBCM). This year the TJBCM announced a centre of excellence programme for centres that provide care to paediatric patients with brain cancer. Manchester made a joint application covering the three partner organisations: MFT (RMCH), The Christie (proton therapy and radiotherapy) and the University of Manchester (paediatric neuro-oncology research).

Following a rigorous assessment process which included an application, site visit and expert led interview process, Manchester was one of only five centres awarded excellence status. This designation is testament to all the teams that on a daily basis strive to improve outcomes for our patients, discover new diagnostics and therapies and above all deliver compassionate care and opportunities for research engagement with every child referred to us, not only locally, but from across the

world. Well done to the teams at RMCH and to our partner organisations in their continued efforts to deliver an excellent service which is based on strong organisational and clinical collaboration.

Opening of the new Sexual Assault Referral Centre (SARC)

On 20 March the Chairman and I welcomed Diane Hawkins DL Lord Lieutenant of Greater Manchester and senior representatives from Greater Manchester Police, Greater Manchester Combined Authority and members of HM Judiciary to celebrate the opening of the new SARC in St. Mary's Hospital (SMH). SARC was the first centre of its kind when it originally opened in 1986, and it set the standard for the various centres that have opened since then nationwide.

The new centre has been relocated to Peter Mount Building on the Oxford Road Campus and offers the very best facilities for our staff and the clients they support with brand new suites and technology. It is the only such centre in the country to offer a combination of support, counselling and forensic medical examination to victims of sexual violence, of any age or gender. The opening event was a great opportunity to recognise the success of the service as it enters a new phase.

External Visits & Events

Since the last Board meeting, we have been fortunate to host a number of external visits to MFT sites which help to support the delivery of our strategic aims, facilitate collaborative working and the delivery of our services:

- **Houghton Dunn Fellowship Launch**

  On 5 April Mr Mark Dunn, Trustee of the Houghton Dunn Charitable Trust, visited the Trust for the launch of this year's Houghton Dunn Fellowship which provided funding to support research fellowships for early-career researchers. We were able to hear from several of this year's fellows about the fascinating research projects they have been leading. Thank you to Mr Dunn and the Fellowship for their generosity which is enabling this innovative work to continue which provides a critical bridge to future development and sustained focus on research.

- **Genomics Service Visit**

  On 10 April we were joined by Sir Richard Leese, Chair of GM ICB, Mark Fisher CBE, Chief Executive of GM ICB, and Dr Michael Gregory, Regional Medical Director for NHS England NW who visited our Genomics facilities in St Mary's Hospital for an overview of the pioneering services we provide here at MFT. We met with colleagues from across the Clinical Genomics Service, Rare Conditions Centre and North West Genomic Laboratory Hub for an in-depth overview where the teams demonstrated how the integration of these services provides improved support for our patients and new developments including Pharmacogenomics.

- **Visit from the Director of National Specialised Commissioning Directorate**

  On 30 April we welcomed Mr Mathew Day, Director of Specialised Commissioning at NHS England, for a tour and presentation of the specialist services that MFT provides to patients across the North West including the Advanced Therapies service for Paediatric Haematopoietic Stem Cell Transplantation (HSCT) in RMCH. The visit was a great opportunity to talk through the breadth of specialist provision we deliver as well as some of our key aims and strategic intentions to expand and improve these services in the coming years.

2. Operational Delivery

This section provides a high-level overview of operational delivery and a number of key developments since the last Public Board session:

Performance and Delivery

Reflecting on 23/24 we have made significant improvements for our patients despite facing challenges with periods of industrial action and increased demand across our services.

Across urgent and emergency care we have delivered an 11% improvement on our 4-hour performance across all types for the year compared to 22/23, despite an increase in demand of 9%, meaning more patients have been seen and treated quicker when attending our A&E departments. This has been achieved through a number of improvement initiatives; we have treated 28% more patients through our Same Day Emergency Care (SDEC) departments and have supported 3,800 patients through our new and innovative Hospital at Home service freeing an equivalent of 75 beds which have been utilised for our more acutely unwell patients this winter. Patients have fed back that they are being listened to and feel included in clinical conversations but that we can do more to keep them updated on the latest waiting times.

We have also maintained a good level of ambulance handovers performance, with NMGH being within the top 15 hospitals nationally. We remain committed to delivering the same level of improvement across urgent and emergency care during 24/25 and continue to build upon what we have achieved and learnt in 23/24. Our focus for this year is to continue to work in collaboration with our partners on a system-wide Urgent and Emergency Care recovery plan to advance our improvements further and faster. This will be further developed at a whole system UEC meeting for Manchester and Trafford in June.

Reducing the number of patients on a cancer pathway for over 62 days has delivered an overall positive downward trend, with 71% less patients waiting more than 62 days by March 2024. We have seen an improving trend on our Faster Diagnosis Standard (FDS) in February and March towards the 75% national standard. This year we will continue to focus improvements on reducing time to first

appointments and diagnosis to facilitate achievement of the 62 and 31-day standards for patients and the consistent delivery of the FDS standards.

The significant number of patients with long waiting times for elective procedures that grew through our COVID response has reduced significantly, ending March 24 with 580 patients waiting over 65 weeks and 15 patients waiting above 78 weeks due to patients awaiting corneal grafts, those who have deferred by choice or are medically unfit. Our overall waiting list has reduced by 17,000 over the year, despite industrial action as well as additional activity through the North Manchester disaggregation. The Trafford Elective Hub has been key to our delivery efforts treating more high volume, low complexity cases.

In support of improving our cancer and elective pathways, patients waiting for diagnostic tests have been reduced across all modalities. We have reduced from the number of patients waiting more than 6 weeks from over 50% to 30% at the end of March 24. Throughout this year we have a plan to deliver a further 20% improvement, working towards the delivery of the DM01 standard set by NHS England in the 24/25 Annual Planning Guidance. Our new Community Diagnostic Centre in Harpurhey has provided additional capacity along with productivity improvements including reducing previously high DNA rates.

Further detail regarding the Trust's performance and delivery is provided in the presentation of the Integrated Performance Report.

3. Policy Developments

3.1 - Strategic Policy

NHS England Annual Planning Guidance 2024/25

In March, NHS England published its annual planning guidance which sets out its priorities for the NHS in the coming year and the standards that Integrated Care Boards and individual providers are expected to meet. The priorities remain consistent with previous years, with a focus on, high quality care, health inequalities, reducing waiting times, access to primary care services, access to mental health services and staff experience, retention and attendance. Along with other system partners, we have been working to ensure that our plan for the coming year is in line with the guidance set by NHS England.

Independent Review of Gender Identity Services for Children and Young People

In April, Dr Hilary Cass published the Independent Review of Gender Identity Services For Children And Young People. This review was commissioned by NHS England to make recommendations on how to improve NHS gender identity services and ensure that children and young people who are questioning their gender identity or experiencing gender dysphoria receive a high standard of care.

The report makes a total of 32 recommendation, a summary of which includes:

- Increased capacity of services across the country that can provide evidence-based holistic and individualised care plans for children, young people and their families.
- Separate pathways for pre-pubertal children and their families to support early discussion and support.
- A full programme of research looking at the characteristics, interventions and outcomes of every young person presenting to the NHS gender services. Extension of the puberty blocker trial already announced to include evaluation of psychosocial interventions and masculinising/ feminising hormones.
- Extreme caution around considerations of providing masculinising/ feminising hormones from the age of 16 rather than waiting until individuals reach 18, and discussion of all cases considered for medical treatment at a national MDT.

The report is of particular interest to MFT given our role in supporting the newly established children and young people's gender service for the North West in partnership with Alder Hey. NHS England has noted that its work in developing these services is aligned to the findings of the Cass Report and plans to publish its full implementation plan in response to the report in due course.

Attention Deficit Hyperactivity Disorder (ADHD) Taskforce

NHS England is launching a new ADHD taskforce alongside government to improve care for people living with the condition. The new taskforce will bring together expertise from across a broad range of sectors, including the NHS, education and justice to better understand the challenges affecting those with ADHD and help provide a joined-up approach in response to concerns around rising demand.

The taskforce will look at the challenges faced by those with ADHD such as capacity, medication supply issues, variation in services and a lack of reliable data. It will engage with patients, service providers, Integrated Care Boards, primary care services, local authorities, schools, educational providers, and clinical teams. Taskforce members and terms of reference will be published in the coming weeks and findings will be published later this year.

This is of particular relevance to MFT as we provide an ADHD service which has seen a marked increase in demand and while we are taking steps to mitigate this increase, and to reduce delays to patients as much as possible, we are pleased to see that this is an area that the taskforce is looking to address.

3.2 - Board Governance

Care Quality Commission Well Led assessment guidance

On 8 April, Care Quality Commission (CQC) published guidance for trusts on assessing the well-led key question which has been developed jointly by CQC and NHS England.

The guidance aims to provide a consistent understanding of what it means to be a well-led trust and reflects shared expectations across the regulators. It is structured around the eight quality statements for well-led, as set out under the new single assessment framework, and recognises the impact that good leadership has on staff morale and patient experiences of care. The guidance incorporates key developments in health and care policy and best practice, and includes expectations around system working, freedom to speak up and continuous improvement.

CQC's new trust-wide well-led assessments will have a predominant focus on leadership, culture and governance and will result in new ratings for trusts. The full timeline for the assessments is expected to be published in the summer.

The Executive Director team have considered the guidance and a self-assessment against the new quality statements will be undertaken to inform a report to be presented to the Board of Directors in September 2024.

The guidance can be found here.

4. Quality

Care Quality Commission Quarterly Strategic Meeting

On 11 April 2024 Ms Ann Ford, Deputy Chief Inspector at the CQC and Ms Alison Chilton, Deputy Director of Operations (North) attended a strategic meeting with myself and members of the Executive Team. The meeting was an opportunity for us to share with the CQC our new organisational strategy and the progress we have made over the past year in terms of workforce, quality improvements, performance against constitutional standards and financial sustainability. The CQC team members responded positively to the information we shared and were particularly interested in our views on increasing the diversity of our leadership, inclusivity across our workforce and how we are working to reduce health inequalities. During the meeting we heard an update regarding the CQC's new Single Assessment Framework which has now gone live nationally. Within this there is a much greater emphasis on hearing from staff, communities, and patients as well as a focus on a risk-based approach to inspection. I would like to thank our CQC colleagues for their time and ongoing engagement with the Trust.

NHSE Maternity Review

Following the Maternity services inspection of Saint Mary's Managed Clinical Services (SM MCS) by the Care Quality Commission (CQC) in March 2023, resulting in a subsequent Section 29A Waring Notice and change to the overall ratings of the service; SM MCS met the national threshold for a Maternity Safety Support Programme Diagnostic Review. This Diagnostic review took place between 22-26 January 2024. The purpose of the exercise was an assurance review and to provide any opportunities for the visiting team to share support.

High level feedback was received by a presentation to the Trust and key external stakeholders on 6 February which was predominately positive and acknowledged the prompt and appropriate response SM MCS had taken to the immediate CQC

concerns. The resulting report has referenced many improvements that commenced immediately post the CQC visit, and noted the significant progress made. The Diagnostic Review Team have shared that they were impressed with the improvement achieved by the Trust; changes were described as visible, appreciated by staff, and becoming embedded.

The report is now being reviewed through our internal governance structures with any immediate actions being progressed and a post diagnostic, multi-stakeholder Rapid Quality Review is planned for June 2024 which will confirm if any further level of monitoring is required.

Mental Health Review

Board members will be aware that in our efforts to ensure that we were in the best possible position to support the successful implementation of our Mental Health, Strategy which was approved by the Board in November, we invited colleagues from Mersey Care to undertake a peer review of the arrangements we have in place to support delivery.

We have recently received the final Mental health, Learning Disabilities and Autism Peer Review which assessed the governance and care provision for individuals receiving mental health care within our organisation. The full report and briefing paper are presented as agenda item 10 of the Board of Directors meeting. The report outlined several commendable practices as well a number of recommendations for improvement. The review noted the acknowledgement and willingness of MFT staff to improve the care and experience of patients presenting with a mental health illness and the involvement of the safeguarding team as areas of good practice. Areas of improvements suggested recommendations for oversight, governance, and application of the Mental Health strategy along with improving collaborative work with GMMH.

This comprehensive review has been shared with our hospitals/MCSs/LCO and an action plan has been developed, the progress and outcomes from the recommendations will be overseen and delivered by the Mental Health Subgroup. The findings from the report will support a discussion at a Board development session scheduled for June 2024.

I extend my gratitude to our colleagues at Mersey Care for their time, diligent review and the invaluable insights provided, which will guide improvements across MFT.

5. Finance and Workforce

Financial Recovery Plan

The Trust was able to deliver its full 5% waste reduction target in 2023/24 which was a key enabler to delivering a breakeven position for the year amid challenging financial circumstances. This was a significant achievement which will provide an important foundation for our financial recovery efforts, although significant challenges remain for 24/25 in order to deliver an ambitious plan for a further 5.4% reduction in costs, around £148M, through our Value for Patients programme.

Our multi-year Financial Recovery Plan is now at an advanced stage of development and will be presented to the Finance and Digital Scrutiny Committee at the end of May to support a further review at the Board Seminar in June. It has been developed alongside our Organisational Strategy and reflects MFT's strategic aims and objectives. A core principle will be the delivery of a breakeven position in 24/25 through delivery of the opportunities identified through the detailed benchmarking which has been undertaken in developing the Financial Recovery Plan.

Leadership Update

Joint Group Chief Medical Officer

As Board members are aware Professor Jane Eddleston, our Joint Group Chief Medical Officer, will be retiring from her role at the end of May after a long and notable career with MFT. Recruitment to the substantive position is likely to take a number of months, so I have put temporary arrangements in place for the next six months.

I have asked Professor Bernard Clarke, current Group Associate Medical Director for Professional Matters, to take on the role of acting Joint Group Chief Medical Officer alongside the existing Joint Group CMO, Miss Toli Onon. Bernard will take up the position on 1st June and will join our Executive Team and Board of Directors while covering the post.

Additionally, I am delighted to announce that Jane will continue to support the Trust in an advisory capacity on several key workstreams for a fixed term period until the role is filled substantively; this will include providing clinical oversight of the Hive programme as well as the Research and Innovation, and Genomics workstreams which Jane has played a critical role in developing over recent years.

Consultant Appointments

Since our last Board meeting in March, 31 consultants have been appointed to roles within the following specialties: Consultant in Anaesthesia, Burns & Plastic Surgery, Cardiothoracic Anaesthesia, CAMHS Psychiatry, Community Paediatrics, Emergency Medicine, Gastrointestinal Histopathologist, General and Colorectal Surgery, General Medicine, Genitourinary Radiology, Geriatrics, Gynaecologist – Endometriosis, Hand Surgery, Histopathology, Infectious Diseases, Musculoskeletal Radiologist, Obstetrics, Otolaryngology ,Paediatric Anaesthesia, Paediatric Emergency Medicine, Paediatric Haematology, Paediatric Respiratory Medicine, Radiologist with Thoracic and/or Cardiothoracic Interest, Rehabilitation Medicine – Amputee Rehabilitation, Respiratory Physician-with interest in Thoracic Oncology, Trauma and Orthopaedic Surgeon, Limb Reconstruction

We continue to attract a high calibre of candidates and provide a development programme for consultants who are newly appointed to their positions following their time as Junior Doctors.

6. Top three concerns

The current top three concerns I would like to highlight to the Board are:

Delivery of our annual plan (24/25)

The scale of improvement required this year to deliver our annual plan remains significant across activity, workforce, operational performance and financial delivery. It will be crucial to maintain close monitoring on the delivery of our commitments and we are reviewing the structures of the various forums that support this oversight to ensure our processes are effective and agile. Plans will be risk focused and monitored through our Accountability Oversight Meetings supported by Integrated Performance Reporting. We have adopted a “bottom-up” approach to annual planning this year, with capacity and demand modelling informing activity planning aligned with the key aims and objectives in our new Organisational Strategy.

The above concern is reflected in all principal risks in the Board Assurance Framework.

Capital Constraints

Our Trust faces limitations on capital spending due to the current cash reserves and the GM Capital Departmental Expenditure Limit (CDEL) envelope, which grants permission for capital expenditures. The share of the 24/25 GM CDEL envelope for MFT is £27.6m, and the Trust remains in discussion with NHSE to ensure that the capital that was agreed within the business case for the dissolution of Pennine Acute Trust is received in full. Should this be supported, the total envelope is still below the expenditure the Trust had requested for key schemes planned for the year. The schemes which have not currently been approved within this total envelope will be the subject of close monitoring through the Trust’s Strategic Capital Group to manage any associated risks.

The above concern is reflected in principal risks 2 and 6 in the Board Assurance Framework.

Financial challenges across GM

The GM system is under significant financial pressure and remains in discussions with NHSE about the financial plan for 2024/25. Once actions are taken to mitigate the financial challenges, this could pose a potential risk to the delivery of the Trust’s annual plan which is underpinned by various assumptions with interdependencies across the system.

The above concern is reflected in principal risk 2 in the Board Assurance Framework.

Agenda Item 8

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Chairs of the Board of Directors' Scrutiny Committees
Paper prepared by:	Nick Gomm, Director of Corporate Business/ Trust Board Secretary
Date of paper:	May 2024
Subject:	Reports from the Board of Directors' Scrutiny Committees
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 Scrutiny Committees monitor and scrutinise delivery of all of the Trust's strategic aims.
Recommendations:	The Board of Directors is asked to note the Scrutiny Committee reports.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Board Secretary Tel: 0161 276 6262

NHS
Manchester University
NHS Foundation Trust

Extraordinary Charitable Funds Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Charitable Funds Committee (CFC) for consideration by the Board. The agenda for the meeting is attached.

Committee meeting date	13/3/24
Committee Chair	Kathy Cowell

KEY ESCALATION AND DISCUSSION POINTS

ALERT (matters to be escalated to the Board/Committee receiving this report)

The Committee received the Charitable Funds Finance Report. The balance between funds held in restricted funds and the Trust-Wide General Purposes Fund, and the costs for handling the number of existing funds, is being considered.

CFC approval is now required for any cases requiring funding of over £50K.

ASSURE

ADVISE

The Charity's External Audit Strategy Memorandum was presented to the Committee by Mazars, the Trust's External Auditor.

The first draft of the revised Charity strategy for 2024- 2027 was discussed including the Charity cash flow forecast for that period. A further draft will be considered at the next meeting.

As part of the discussion about the Charity's future direction, the advantages and disadvantages of an independent charity were considered.

A 'MyCharities' account has been established in order to enable the Charity's Annual Report and Accounts to be submitted via the designated portal.

The Charity investment strategy was reviewed and it was decided to transfer a portion of the funds into more 'liquid' funds.

The new Charity website has now gone live (mftcharity.org.uk).

RISKS

ACTIONS (actions required of the Board/Committee receiving this report)

The Board is asked to note the committee's discussions.
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LEARNING

Meeting agenda

CHARITABLE FUNDS COMMITTEE

WEDNESDAY 13TH MARCH 2024 at 9:30AM – 11:30PM

MAIN BOARDROOM, COBBETT HOUSE

AGENDA

1.	Apologies for Absence		
2.	Declarations of Interest		
3.	Minutes of the Charitable Funds Committee held on 28th November 2023 and the Extraordinary Charitable Funds Committee on 31st January 2024	(enclosed)	All
4.	Matters Arising (if not covered under the main agenda heading):		
5.	To receive the External Audit Planning memorandum for the MFT Charity for 2023/24	(enclosed)	David Hoose (Mazars)
6.	To receive Charitable Funds Finance Report • Progress on the deficit in the Trust-wide General Purpose fund • Proposed actions to address MFT's cash flow projection • Guidance on restricted and unrestricted funds	(enclosed)	Jenny Ehrhardt
7.	Chair's Action - Notification of contracts for Charity Commission Online Service	(enclosed)	Jenny Ehrhardt
8.	To receive proposals for MFT Charity's investment strategy	(enclosed)	Jenny Ehrhardt
9.	To receive an update on the MFT Charity Strategy	(enclosed)	Tanya Hamid
10.	To receive the Charities Fundraising Report • Approach to receiving funds from sources indirectly connected to gambling	(enclosed)	Tanya Hamid
11.	Proposals for approving charitable funds over £50k	(enclosed)	Tanya Hamid
12.	National Breast Imaging Academy Appeal – Progress and Next Steps	(enclosed)	Tanya Hamid

13.	To receive an update report on the Benefits and disadvantages of an independent charity	(enclosed)	Jenny Ehrhardt
14.	To receive updates / proposals for Charitable Funding Support	(enclosed)	
	14.1 To receive an update on the Schwartz Round programme including fundraising plans	(enclosed)	Katherine Potier
15.	To review the Charitable Funds Committee work programme	(enclosed)	Kathy Cowell
16.	Minutes of the Charitable Funds Investment Sub-Committee held on 31st January 2024	(enclosed)	Nick Gomm

17. **Date and Time of Next Meeting**

The next meeting will be held on **Tuesday 30th July 2024** at **2:00pm**

NHS
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EPR Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the EPR Scrutiny Committee for consideration by the Board of Directors. The agenda for the meeting is included.

Committee meeting date	27/3/24
Committee Chair	Gaurav Batra

KEY ESCALATION AND DISCUSSION POINTS

ALERT

ASSURE

Deloitte presented their Gateway 6 assurance report. All recommendations have been accepted and work is underway to address them.

An extra £1.7m of cashable benefits has been achieved through the Hive deep dives. The assumptions for future cash releasing benefits have been tested. Hive-related cost-avoidance benefits are also being identified and recorded.

The Committee received a report on the work to ensure data quality within Hive. Over 200 issues have been resolved over the last year. Governance structures have been streamlined to enable a better proactive approach to data quality issues moving forward. The Internal auditors will be looking at data quality issues as part of their 2024/25 work programme.

ADVISE

The Hyperdrive pilot takes place on the 8th April, followed by a full roll out. This will enable access to additional capabilities within the system.

Work is underway to link the planned Electronic Bed Management System to Hive.

New predictive functionality within Hive, called Nebula, will be piloted to look at any themes within the cohort of patients who do not attend appointments.

Hive's 'Care Companion' functionality which will be implemented in Maternity. This will provide gestational hypertension patients with a series of tasks to carry out to better monitor their own health.

A pharmacogenetic pilot called Pioneer is underway in the Genomics department which will enable clinical decision support using pharmacogenetics; allowing the tailoring of medication based on a patient's genes.

Discussion are underway to consider the benefits of an Epic Connect partnership. Further discussion about this matter will be held at the Board seminar in June.

RISKS

Hive programme risks continue to be managed within the programme's governance structure.

ACTIONS (actions required of the Board/Committee receiving this report)

To note

LEARNING

Learning regarding optimal use of Hive continues to be shared between services under the oversight of the Programme Board, supported by the Pathway Councils and the Design Authorities.

Meeting agenda

EPR Scrutiny Committee

Wednesday 27th March 2024
at 2:00pm – 4:00pm
MAIN BOARDROOM
COBBETT HOUSE
A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	To receive the EPR Scrutiny Committee minutes of the meeting held on Tuesday 12th December 2023	*(enclosed)*	
4.	To receive the Deloitte Gateway 6 Assurance Review	*(Presentation & enclosed)*	*Deloitte*
5	To receive the Management Response to Deloitte Gateway 6 Assurance Review	*(Presentation)*	*Julia Bridgewater*
6.	To receive the report of the EPR Implementation and Benefits Realisation Programme Board	*(enclosed)*	*Julia Bridgewater*
7.	To receive a report on Hive Benefits including: Update on the January & February deep dive exercises	*(enclosed)*	*James Allison*
8.	To receive a report on Data Quality Workstreams	*(enclosed)*	*Julia Bridgewater*
9.	To receive an update on Epic connect proposals	*(enclosed)*	*Sarah McGovern/ Dave Pearson*
10.	To receive an update on the future plans, handover and transition of the EPR Scrutiny Committee	*(verbal)*	*Julia Bridgwater / Nick Gomm*
11.	To consider the EPR Scrutiny Committee work programme (inc. key areas of focus and future progress)	*(enclosed)*	*Gaurav Batra*
12.	Any other business		
13.	The next meeting will be held on **Tuesday 25th June 2024 at 10:00am**		

NHS Manchester University NHS Foundation Trust

Audit Committee Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Audit Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	10th April 2024
Committee Chair	Nic Gower

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Committee received the internal audit reports on Medical Temporary Staffing (including NMGH) and Resilient Discharge and discussed with managerial leads the actions being undertaken to address the recommendations.

ASSURE

The Committee received the internal audit reports on Risk Management and the Board Assurance framework; Clinical Service Reconfiguration; and Mental Capacity Act and Deprivation of Liberty Safeguards. All received ratings of significant assurance with minor improvement opportunities identified.

ADVISE

The Committee received an update on the progress made so far in producing the Trust's annual report for 2023/24.

The Committee received a report detailing current compliance rates for declarations of interest across the Trust. The Standards of Business Conduct & Hospitality policy is under review and the Committee considered the proposed changes prior to the final version being approved at the Audit Committee in June.

The Committee received the draft Head of Internal Audit draft opinion for 2023/24 and the Internal Audit Plan, and Charter, for 2024/25.

The Committee received the External Audit Progress report, and approved the External Audit Strategy Memorandum, for 2023/24.

The Committee received an update on the investigation into the Trust's historical engagement with a contractor.

The Committee received a report on the spend on consultancy contracts during 2023/24.

The Committee received the Local Counter Fraud Service's 2023/24 annual report for 2023/24 and their draft work plan for 2024/25.

The Committee received a report on losses and special payments for the period 1/4/23 to 29/2/24.

The Committee received a report on tenders waived for the period 1/10/23 to 29/2/24.

The Committee received the Committee reports from all the Board's Scrutiny Committees.

RISKS

Audit reports provide external assurance on the strengths of controls in place in specific areas of the Trust's business and recommend actions to address and gaps in controls.

ACTIONS

The Board is asked to note the work of the Audit Committee.

LEARNING

Learning from internal audit and counter fraud reports is shared across the organisation.

Agenda of meeting:

AUDIT COMMITTEE

to be held on Wednesday 10th April 2024 at 10.00am – 12:00pm

Main Boardroom, Cobbett House Oxford Road Campus

A G E N D A

1.	Apologies for Absence		
2.	Declarations of Interest		
3.	To receive and approve the Minutes of the Audit Committee meeting held on 7th February 2024	*(enclosed)*	All
4.	Matters Arising		
5.	To receive an update on the progress of the 2023/2024 Annual Report	*(enclosed)*	Nick Gomm
6.	To receive a report on MFT's Declarations of Interest (including proposed amendments to the Standards of Business Conduct, Gifts & Hospitality policy)	*(enclosed)*	Nick Gomm
7.	Review of Contractor Usage:		
	• Specific Case	*(verbal)*	Jenny Ehrhardt
	• KPMG Review	*(verbal)*	Rob Jones
8.	Internal Audit		
	8.1 To receive the Internal Audit Progress Report including resolution plan and timeframe for deferred management actions	*(enclosed)*	Harriet Fisher (KPMG)
	8.2 To receive the draft 2023/24 Head of Internal Audit Opinion	*(verbal)*	Harriet Fisher/ Rob Jones (KPMG)
	8.3 To approve the draft 2024/25 Internal Audit Plan, including the Internal Audit Charter	*(enclosed)*	Harriet Fisher (KPMG)

9.	External Audit		
	9.1 To receive the External Audit Progress Report	*(enclosed)*	Karen Murray (Mazars)
	9.2 To approve the 2023/24 External Audit Strategy Memorandum	*(enclosed)*	Karen Murray (Mazars)
10.	Local Counter Fraud Specialist		
	10.1 To receive the Local Counter Fraud Specialist's 2023/24 annual report	*(enclosed)*	Suki Pooni (Grant Thornton)
	10.2 To receive the Local Counter Fraud Specialist's draft work plan (2024/25)	*(enclosed)*	Suki Pooni (Grant Thornton)
11.	Consultancy Approvals	*(enclosed)*	Jenny Ehrhardt
12.	Items for Noting and/or Information		
	12.1 Losses and Special Payments for 1st April 2023 to 29th February 2024	*(enclosed)*	Rachel McIlwraith
	12.2 Tenders Waived for the period 1st January 2024 to 29th February 2024 and process improvement plans	*(enclosed)*	Simon Walsh
13.	To receive a report on self-assessment of the Audit Committee's performance for 2023/24	*(enclosed)*	Nick Gomm
14.	To receive the Audit Committee work programme	*(enclosed)*	Nic Gower

15. MFT Board Scrutiny Committee Reports:

15.1 Group Risk Oversight Committee held on 23rd January 2024

15.2 Quality and Performance Scrutiny Committee held on 29th February 2024

15.3 Workforce Scrutiny Committee held on 27th February 2024

15.4 Finance and Digital Scrutiny Committee held on 27th February 2024

15.5 EPR Scrutiny Committee held on 12th December 2023

15.6 Strategic Projects Scrutiny Committee held on 24th January 2024

16. Date and Time of Next Meeting:

The date of the next meeting is to be confirmed.

NHS
Manchester University
NHS Foundation Trust

Finance and Digital Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Finance and Digital Scrutiny Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	23rd April 2024
Committee Chair	Trevor Rees

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Committee received the current draft of the 2024/25 financial plan. The current forecast deficit was £23m but the aim was to reach a breakeven forecast by the time of submission following discussions with GM ICB and further consideration of the Value for Patients' programme. There are a number of assumptions and risks contained within the forecast position.

The activity plan is set at 108% (by value) of the 19/20 position.

There has been a large increase in the costs of energy contracts due to the previous fixed-price contracts ending in 2023/24.

The Value for Patients (VFP) target for 2024/25 will be £148m should a breakeven forecast be submitted. So far, £105m of VFP ideas have been received but these are at various levels of development.

The capital programme for 2024/25 is significantly restricted. The potential impact on service delivery and developments was discussed with a further report to be considered at the next Strategic Projects scrutiny Committee meeting.

Providing the expected income is received, and the VFP programme delivers in full, there should be no need for cash support during the year.

ASSURE

The Trust has achieved a breakeven position for 2023/24 with the Waste Reduction Programme delivering in full against its target of £136.5m. The cash position at year end was £134m and the capital programme was delivered in line with expectations.

ADVISE

The Committee received the Group Chief Information Officer's report which highlighted a range of issues including: ongoing delivery against the actions required following the IT outage at Wythenshawe Hospital (which are tracked by the Group's EPRR Committee); an update on cyber security developments; IG mandatory training compliance rates; the restructure of the Trust's digital department; confirmed achievement of all year 1 deliverables within the Digital strategy; and the digital aspects of the Trust's capital programme for 2024/25.

The Committee received an update on the Trust's ledger replacement programme.

The Committee approved the Trust's submission for the 2023/24 national cost collection programme.

The Committee discussed and supported a proposal for the extension of a Trust contract for cath labs prior to approval at the Board of Directors in May.

RISKS

The Board considered the strategic risks relevant to the Committee: MFT/004492, MFT005198, and MFT/005092

It was agreed to consider the number and scope of the strategic risks in a future report to the Group Risk Oversight Committee.

ACTIONS (actions required of the Board)

The Board is asked to note the discussions on the Finance and Digital Scrutiny Committee and the extremely challenging financial context within which the Trust, and the wider NHS, is currently operating.

LEARNING

Learning from successful waste reduction initiatives are shared between hospitals/MCSs/LCOs to maximise the opportunities for the VFP programme in 2024/25.

Learning from external organisations and peer benchmarking is being used to inform the VFP programme and the Financial Recovery Plan.

Meeting agenda

Finance & Digital Scrutiny Committee

Tuesday 23rd April 2024 2.00pm – 4:00pm
MAIN BOARDROOM, COBBETT HOUSE
A G E N D A

1.	Apologies		
2.	Minutes of the Finance & Digital Scrutiny Committee Meeting held on 27th February 2024	*(enclosed)*	*Trevor Rees*
3.	Matters Arising	*(enclosed)*	*Trevor Rees*
4.	To receive an update on strategic risks relevant to the FDSC including escalations from Group Risk Oversight Committee	*(enclosed)*	*Jenny Ehrhardt*
5.	MFT performance against Finance Metrics within the Integrated Performance Report	*(enclosed)*	*Jenny Ehrhardt*
6.	Chief Finance Officer's Report M12	*(enclosed)*	*Jenny Ehrhardt*
7.	2024/25 Financial Plan	*(enclosed)*	*Jenny Ehrhardt*
8.	Value for Patients Programme	*(enclosed)*	*Vanessa Gardener*
9.	Chief Information Officer's Report	*(enclosed)*	*Adam Dunlop*
10.	Ledger replacement project progress report	*(enclosed)*	*Edd Berry / Joel Perkins*
11.	2023/24 National Cost Collection	*(enclosed)*	*Jenny Ehrhardt*
12.	To receive the FDSC work programme	*(enclosed)*	*Trevor Rees*
13.	Cath Labs MES	*(enclosed)*	*Jenny Ehrhardt*
14.	The next meeting will be held on **Tuesday 25th June 2024 at 2:00pm**		

NHS Manchester University NHS Foundation Trust

Quality and Performance Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Quality and Performance Scrutiny Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	24/04/24
Committee Chair	Damian Riley

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Committee received a report on the increase in the presence of alert organisms across the Trust. The themes from incident review were explained and the work underway was presented. This includes Infection Control Walkabouts, with the Group Chief Nurse, associate Chief Nurse and local Infection Control doctors and an IPC summit will be held.

ASSURE

The Committee received the Strategic Risk Exposure report. It was noted that work was underway to review the Risk Management Framework and Strategy to ensure a more dynamic approach to risk management is embedded across the Trust.

The Committee received a progress report with regard to the embedding of PSIRF across the Trust. An important focus of the work is on ensuring there is a patient safety culture in place across all areas of the Trust.

The Committee received the IPR for operational performance which contained the data as at the end of February 2024. 4 hour performance was 69.5% for the year, marking a 10% improvement from 22/23 and establishing MFT as one of the most improved trusts nationally. This is despite seeing a 9% increase in attend. The cancer 62-day backlog has shown a positive trend since September, with March performance reporting 241 against the year-end target of 267. The overall waiting list has reduced by 18,000 (April 2023 – February 2024) despite the impact of industrial action and activity transferred through the North Manchester disaggregation. Long waits exceeding 78weeks reduced from a cohort of c10,000 at the start of the year to 17 at year-end, and 65 weeks from around 143,000, to 632, While diagnostics remains challenged there has been an 18% improvement since the start of the year, with February reporting 34.2%.

The Committee received the IPR for Quality and Safety with key messages highlighted by the Group Chief Nurse. Medication safety in relation to discharges was discussed with a further report will come to QPSC in 4 months. The implementation of the revised Learning From Deaths Policy (including the conduct of SJRs) has not progressed as expected and this has been escalated to the Group's Learning from Deaths Committee for further work.

The Committee received a report of medical devices and their maintenance. The total number of devices for MFT is in the region of 80,000. Each area receives an inspection visit at least once a year. In the case of more complex areas such as Theatres, NICU and PICU, they may receive two inspection visits to allow for greater coverage and improved capture rates.

Saint Mary's Hospital provided an update on maternity safety compliance highlighting a number of key pieces of work including: the work to include compliance with resuscitation training targets, the learning from the recent LMNS visit and MNSI programme, and other key data from the maternity dashboard. NHSE

report into Saint Mary's has now been received and discussions are underway to arrange a re-visit by the CQC to review the Section 29 notice given last year. It was agreed that a report on progress with an amended BSOTS process would come to a future QPSC.

ADVISE

A business case is in development to procure a document management system that better meets the needs of the Trust. The current policy review is prioritising those relevant to clinical risk.

The final report into the infected blood inquiry is due in May 2024. MFT has been supporting the inquiry responding in a timely manner when requested and ensuring any emerging learning is being acted upon.

The Covid inquiry continues. The inquiry is focusing of 22 acute hospitals of which MRI is on. The Trust is supporting the inquiry as requested and will continue to do so.

The Committee received a report on the development of an Electronic Bed Management System. External funding is available but only for one. Discussion are ongoing regarding delivery times and the period of time which the funding is allocated for.

The Committee received a progress report on the Hospital@Home programme from the LCOs' Medical Director. About 4000 patients have now been through the service in the past year and >95% would have required an in-patient stay if service hadn't been in place. Patient outcomes have been shown to be better than for those who have had an in-patient stay. Patient experience is positive too.

RISKS

The Committee considered the strategic risk exposure report which presented the risks relevant to the Committee, namely: 006352, 007090, 005930, 006469, 006470, 006467, 006475, 004322, 007067, 000363, 001150, 002842, 004430, 005198, 006864, 006712, 006422, 005527, 004303, 007396.

ACTIONS (actions required of the Board)

To note the discussions at QPSC.

LEARNING

The Committee discussed a learning case study which considered the impact on the prevention and reduction of violence against staff linked to increased number of mental health presentations. Work is underway to raise staff awareness as well as looking at ways to prevent violent actions through the use of body cams. The importance of considering the work across the whole hospital estate was discussed.

In addition, examples of Trust-wide learning were highlighted in a number of reports in front of the Committee.

Agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Quality & Performance Scrutiny Committee

Wednesday 24th April 2024 at 10.00am – 1:00pm

Main Boardroom, Cobbett House, ORC

A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	Case study of learning	*(presentation)*	*Kimberley Salmon-Jamieson / Bev Fearnley*
4.	Minutes of the Quality & Performance Scrutiny Committee held on 29th February 2024	*(enclosed)*	*All*
5.	Matters Arising • Update on BSOTS work	*(verbal)*	*Kimberley Salmon-Jamieson*
	• Update on IBI	*(verbal)*	*Bev Fearnley*
	• COVID 19	*(verbal)*	*Bev Fearnley*
6.	To receive the Performance Quality and Safety Strategic Risk Exposure report	*(enclosed)*	*Bernard Clarke*
7.	To receive a progress report on the Patient Safety Incident Response Framework (PSIRF)	*(enclosed)*	*Bernard Clarke*
8.	**Performance Items for Scrutiny and Assurance:**		
	8.1 MFT performance against operational performance metrics within the Integrated Performance Report and the AOF	*(enclosed)*	*Vanessa Gardener*
	8.2 To receive an update report on Electronic Bed Capacity Management System	*(enclosed)*	*Vanessa Gardener*
	8.3 To receive a report on Medical Devices	*(enclosed)*	*Gareth Adams*

8.4	To receive a report on the Hospital at Home Programme	*(enclosed)*	*Julia Bridgewater / Sohail Munshi*
8.5	To receive the draft Performance and Activity Plan for 2024/2025	*(enclosed)*	*Vanessa Gardner*

9. **Quality Items for Scrutiny and Assurance:**

9.1	MFT performance against Quality and Safety metrics within the Integrated Performance Report	*(enclosed)*	*Bernard Clarke/ Kimberley Salmon-Jamieson*
9.2	To receive an update on the presence of alert organisms across the Trust	*(enclosed)*	*Kimberley Salmon-Jamieson*
9.3	To receive an update report on maternity compliance	*(enclosed)*	*Alison Haughton Sarah Vause*

10. To review the QPSC Work Programme *(enclosed)* *Damian Riley*

11. To note the following Committees held meetings:

11.2	Group Quality and Safety Committee held on 15th February 2024	*(enclosed)*
11.2	Group Cancer Committee held on 26th March 2024	*(enclosed)*
11.3	Operational Excellence Board for the period March 2024	*(enclosed)*

12. The next meeting will be held on Wednesday 26th June 2024 at 10:00am

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Workforce Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the Workforce Scrutiny Committee for consideration by the Board of Directors. The agenda for the meeting is included.

Committee meeting date	24/4/2024
Committee Chair	Angela Adimora

KEY ESCALATION AND DISCUSSION POINTS

ALERT

There remains a focus on reducing staff absence which remains high at 5.9%. The 2024/25 operating plan is predicated on a reduction of absence to 5%.

ASSURE

In the 2023 NHS Staff Survey results, the Trust staff engagement score is 6.8 compared to 6.5 in 2022. All scores in every area/question have shown a statistically significant improvement since 2022. Positive scores were also seen in responses to the Hive-specific questions. Assurance was taken by confirmation of an action plan being in place to enable improvements

The current staff turnover rate is 11.2% which is significantly below the national average. Assurance was taken that actions are in place to support retention and turnover.

Mandatory training compliance levels have shown a general improvement over the last 6 months. Level 1 Mandatory compliance for March 2024 achieved against target at 93.1%. However, further attention is needed in relation to levels 2 & 3 compliance which remain below target at 84.6%, although this is improving month on month.

Work is ongoing to increase the representation of BAME staff in 8A and above posts as they are currently under-represented at these pay grades.

The Group Chief Nurse presented the Nursing and Midwifery Revalidation Annual Report for 2023/24. There were no lapses in revalidation over the year and assurance was provided that there was appropriate support in place to support colleagues throughout the revalidation process and consequences of not adhering to the process was clear to all.

ADVISE

The Committee discussed a film which included interviews with two female security officer who work at MFT. They highlighted their enjoyment of the role, the challenges faced by being female in a stereotypical male occupation, and the value of International Women's Day.

Improvements are being made with the mandatory training compliance of medical trainees who are substantively employed by another Trust (Lead Employer model).

An organisational change consultation is set to launch on May 2nd, 2024. This is to support the work to embed a new operating model within MFT.

The Committee received a report regarding the Local Clinical Excellence Awards for this year. A competitive process has been reintroduced this year and a total of 686 LCEAs were allocated to 617 applicants. 32 consultants were unsuccessful in their application.

As of 12th April 2024, MFT is a respondent in 38 Employment Tribunal Claims. The cases are spread across the hospitals/MCSs/LCOs /Corporate in a manner consistent with the sizes of their workforce.

The MFT People Plan will be refreshed in 2024/2025 to complement the new MFT Organisational Strategy over a 3–5-year timescale.

In line with the broader work to embed the strategy and refine MFT's operating model, the work programme of the WSC will be reviewed prior to the next meeting taking place.

RISKS

The workforce-related strategic risks are currently being reviewed for presentation to the next meeting of the Committee.

ACTIONS (actions required of the Board/Committee receiving this report)

To note the discussions of the WSC.

LEARNING

Learning from last year's annual planning as led to a more detailed and accurate annual planning approach this year

Agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Workforce Scrutiny Committee

Wednesday, 24th April 2024 at 2.00pm – 4.00pm

Main Boardroom, Cobbett House, ORC

A G E N D A

1.	Apologies		
2.	Staff Story		
3.	Declarations of Interest		
4.	Minutes of the Workforce Scrutiny Committee held on 27th February 2024	*(enclosed)*	*All*
5.	Matters Arising (if not included on the Main Agenda)		*All*
	Items for Scrutiny and Assurance		
6.	To receive the report of the Group Executive Director of Workforce & Corporate Business:	*(enclosed)*	*Peter Blythin*
7.	To receive key findings from MFT's Staff Survey (2023) and a progress update on staff engagement plans/initiatives	*(enclosed)*	*Yvon Poland*
8.	To receive the MFT performance against workforce metrics included in the Integrated Performance Report	*(enclosed)*	*Lindsey Fair*
9.	Annual report on the MFT's Local Clinical Excellence Awards	*(enclosed)*	*Bernard Clarke*
10.	To receive the annual Nurse & Midwifery Revalidation Report	*(enclosed)*	*Kimberley Salmon-Jamieson*
	Work Programme Governance Items		
11.	To receive the annual Workforce Scrutiny Committee Work Programme	*(enclosed)*	*Committee Chair (Angela Adimora)*

12. **Items for Noting**

To note the following meetings held:

12.1	Workforce & Education Committee meetings 23rd February 2024 (22nd March 2024 – stood down)	*(enclosed)*	*Committee Chair (Angela Adimora)*
12.2	Medical Directors' Workforce Board meetings held on 25th January 2024 and 29th February 2024	*(enclosed)*	*Committee Chair (Angela Adimora)*

13. **Any Other Items**

Any Other Business *All*

14. **Date of Next Meeting**

The next meeting is to be held on
Wednesday 26th June 2024 at 2.00pm
in the Main Boardroom, Cobbett House.

NHS Manchester University NHS Foundation Trust

Organisational Development Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the Organisational Development Scrutiny Committee for consideration by the Board of Directors. The agenda for the meeting is included.

Committee meeting date	29/4/2024
Committee Chair	Mark Gifford

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Following a series of engagement sessions, proposals have been developed on elements of the organisation's operating model. Feedback is being sought through consultation with relevant staff. An engagement portal has been established for affected staff to access during the consultation phase.

ASSURE

The Committee was reminded that the proposals have been driven by the new Strategy which was signed off by the Board and also reflect significant engagement and research which included Leadership seminars, Council of Governor discussions, Well Led Review, Staff Survey as examples.

The Committee was assured that legal requirements and employment best practice was being followed and early engagement with staff was seen as positive and a sign of the way change will be carried out. In advance of the staff consultation, engagement has taken place with staff side organisations including Managers in Partnership.

ADVISE

The Committee noted the ODSC's terms of reference which had been agreed by the Board of Directors earlier on the 29th April 2024.

RISKS

The programme risks were presented to the Committee including the need to minimise any risk to delivery of the operational performance requirements for this year.

The Committee noted that many risks were contained in the Trust's risk registers and, in addition to scrutiny at the ODSC, would be overseen by other Scrutiny committees and the Board. This is important as patient care and staff wellbeing were at the forefront of the changes.

ACTIONS (actions required of the Board/Committee receiving this report)

To note the discussions of the ODSC.

LEARNING

Learning from previous staff consultations has informed the current process.

Agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Organisational Development Scrutiny Committee

Monday 29th April 2024 at 4:15pm – 5:15pm

MS Teams

A G E N D A

1.	Welcome / introductions		*Mark Gifford*
2.	Declarations of interest		*Mark Gifford*
3.	Terms of Reference	*(enclosed)*	*Julia Bridgewater*
4.	Organisational development programme overview	*(presentation)*	*Julia Bridgewater*
5.	Staff consultation document	*(enclosed)*	*Sarah McGovern*
6.	Any other business		
7.	Next meeting - TBC		

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Delivery Officer
Paper prepared by:	Group Executive Directors
Date of paper:	May 2024
Subject:	Group Integrated 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 provide high quality, safe care with excellent outcomes and experience To be the place where people enjoy working, learning and building a career To ensure Value for our patients and communities by making best use of our resources
Recommendations:	The Board of Directors is asked to accept the content of the report, noting the scrutiny of the report provided by, and the associated deliberations of, the relevant Scrutiny Committees, which are undertaken with specific reference to the strategic risk exposure of the Trust
Contact:	Name: Vanessa Gardner, Group Chief Delivery Officer Tel: 0161 276 6328

Integrated Performance Report
Data period to 31st March 2024

Introduction

The report provides the Board with an integrated focus on key performance indicators relating to quality and safety, operational performance, workforce and finance. The report is designed to enable the Board to consider a range of metrics (including those monitored through the national contract and those locally derived) in the context of insight and assurance in relation to the:

- effectiveness of the controls and enablers in place to ensure improvement in the quality of care and operational efficiency aligned to the Trust's Strategic Aims, it is a key source of assurance to support the Board Assurance Framework.
- compliance with CQC fundamental standards across all the domains of quality and safety
    - Safe: patients, staff and the public are protected from abuse and avoidable harm.
    - Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.
    - Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.
    - Responsive: services are organised so that they meet people's needs.
    - Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
- core principles contained in the NHS Constitution of:
    - Equality of treatment and access to services
    - High standards of excellence and professionalism
    - Service user preferences
    - Cross community working
    - Best Value
    - Accountability through local influence and scrutiny

The Board's consideration will be supported by exception reports from relevant Scrutiny Committees where an area of performance is giving rise for concern, or where a significant improvement has been achieved.

Board Integrated Performance Report: Navigation Panel	
	Strategic Aims and Key enablers
	How we understand performance and escalate any risks identified
	Integrated Performance overview
	Quality and Patient Safety: Patient Safety Executive Summary
	Quality and Safety: Effectiveness Executive Summary
	Quality and Patient Safety: Caring Executive Summary
	Quality and Patient Safety: Responsiveness Executive Summary
	Performance: Executive Summary
	Workforce: Executive Summary
	Finance Executive Summary

Work with partners to help people live longer, healthier lives

Provide high quality, safe care with excellent outcomes and experience

Be the place where people enjoy working, learning and building a career

Ensure Value for our patients and communities by making best use of our resources

Deliver world-class research and innovation that improves people's lives.

Our enablers 2024/25

Trust Strategy
Quality and Safety Strategy 2022/25
Patient Safety Plan 2024/5
Effectiveness Plan 2023/24
High Priority Audit Plan
What Matters to me
Mental Health Strategy
End of life care strategy
Inequalities strategy
Financial Plan
Operational Plan 24/25
People Plan
Carer's strategy

Understanding our performance

We use the objectives within our key enablers (our strategies and plans) to help us identify measures of success. Our measures of success are metrics (qualitative and quantitative) that are designed to help us make better decisions about how to improve services and to help us identify and monitor the effectiveness of our response to risks to the delivery of our strategic aims. We use this data to

- Provide measurable results to demonstrate progress towards outcomes
- Identify areas needing attention and opportunities for improvement
- Support continuous improvement.

Our measures of success will develop to include

- System-level measures of community wellbeing and population health including reductions in avoidable deaths for treatable conditions, improved mental health and
- Trust level proxies for improved health outcomes such as avoidable admissions to hospitals, lengths of hospital stay, and patient safety
- Personal health outcomes to our patients, primarily relating to measures of responsiveness
- Resource utilisation
- Organisational processes and characteristics that support evidence that systems to support high-quality people centred care
- Patient and carer experiences of, for example, shared decision-making, care planning, communication and information sharing, and care co-ordination.

How we understand our performance and escalate any risks identified

Measuring our Performance

We, where possible and appropriate, use the identification of Special Cause Variation in our data to understand our performance. We use four specific tests in our data to look for unexpected variation in our Statistical Process Control Charts. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach. Also included, where benchmarking data is available (for instance through national or locally derived standards) an indication of compliance with those standards. A summary of the action status is also provided aligned to each indicator.

The table below provides a summary of the symbols used within this integrated performance report.

Compliance

Target being met	
Target not met	
For information, no target set or target not due	

Variation

Common cause – no significant change	
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	
Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	

Assurance

Variation indicates Inconsistently passing and falling short of the target	
Variation indicates consistently (P)assing the target	
Variation indicates Consistently (F)alling short of the target	

Action Status

Active surveillance – continue to observe in order to better understand the current position	
Improvement – continue actions to support improvement until steady state achieved	
Deterioration or maintained underperformance – instigate or review actions to ensure drivers of current position are mitigated	
Steady state – continue to monitor achievement of level of performance which is satisfactory, and which requires no intervention to maintain	

Escalating performance concerns

Using the four SPC rules and outcomes of our benchmarking , we use an Alert, Advise and Assure model to ensure that both risks and improvements associated with performance are escalated appropriately using the Trust's risk escalation framework, through the Trust's Governance Infrastructure. Risks identified through the assessment of and assurance associated with any element of performance that may have an impact on the delivery of the Trust's Strategic Objectives are reflected within the Trust's Board Assurance framework.

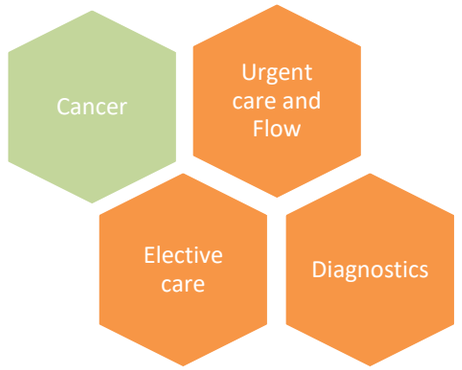
Alert	Advise	Assure

Integrated Performance Report Overview

Quality and Safety

QPSC considered the performance associated with all quality and safety domains as presented in the Integrated Performance report. The Committee considered in detail key areas of strategic risk including compliance with maternity standards, the Trust's never event profile and infection prevention and control. The Committee received assurance in relation to previously escalated risks in relation to mixed sex accommodation breaches and management of medical devices

Operational Performance



QPSC considered all operational excellence domains and the progress made in 23/24. QPSC received an update on our 24/25 performance and activity plans and were assured on the planning process and understood the scale and areas of challenge.

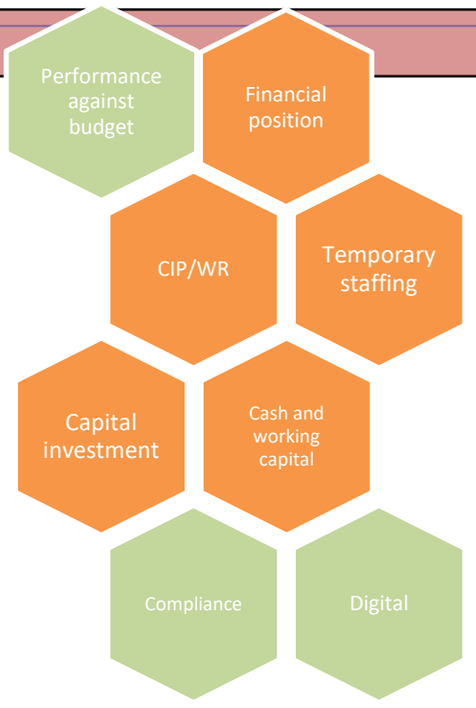
The continued requirement for improvement in delivering our commitments was subject to scrutiny by the committee, with assurance that associated risks are mitigated to support delivery.

Workforce

The workforce component of the IPR was considered in detail at the Workforce Scrutiny Committee. Staff absence remains an area of focus as it is currently at 5.9%. Current staff turnover is 11.2% which is below the national average. The recent NHS staff survey results saw the staff engagement score increase to 6.8 from 6.5. Other areas showed a statistically significant increase as well. Work is ongoing to increase the representation of BAME staff in Band 8A and above posts. The strategic risks relevant to workforce are currently being reviewed.

Finance

FDSC received the end of year position and the current draft of the 24/25 plan. The Trust has achieved a breakeven position for 2023/24 with the Waste Reduction Programme delivering in full against its target of £136.5m. The 24/25 financial plan is being completed with the aim of delivering a breakeven forecast. The Value for Patients target for 24/25 is £148m. £105m of Value for Patients initiatives have been proposed but they are at different stages of development The activity plan for 24/25 is set at 108% of the 19/20 position. The capital programme for 24/25 is significantly restricted.



Quality and Safety: Patient Safety Executive Summary

Key Performance Metric

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Oversight	S1					Serious Incidents Requiring Investigation (reported in Month) per 1,000 occupied bed days	local	6
	S2					Never Events	National	6
	S3					Notifiable patient safety incidents: Non-notifiable incidents (ratio)	Local	6
System reliability	S4					National patient safety alerts over deadline	National	6
	S5					Surgical Safety Checklist compliance	Local	6
	S6					LocSSIP Compliance	Local	6
	S7					Attributable Reportable organism infections	National	6
	S8					Maternity dashboard indicators alerting	New	6
	S8					Compliance with patient specific assessments	New	6
	S9					PSIRP related safety profiles alerting	Local	6
	S10					Safety Critical Policies-out of date	Local	6
PSIRP 23/24	S11					Patients waiting for access to care who experience associated harm	Local	7
	S12					Notifiable incidents related to surgical procedures	Local	7
	S13					Notifiable incidents related to invasive procedures	Local	7
	S14					Notifiable incidents related to a patient with a mental health concern	Local	7
	S15					Notifiable incidents related to medication safety	Local	7
	S16					Notifiable incidents related to Ergonomic design	Local	7
	S17					Notifiable incidents related to Discharge	Local	7
	S18					Notifiable incidents related to the effective assessment and management of risk (Falls etc)	Local	7
Learning and culture	S19					Prevention of future deaths notifications	Local	8
	S20					% patient safety risks not mitigated exceeding the deadline for mitigation	New	8
	S21					Culture: People Promise: We each have a voice that counts (staff survey 2022)	National	8

Joint Group Medical Directors' and Chief Nurse's Summary

At its meeting on the 24th April the Group Quality Performance and Scrutiny (QPSC) considered the overview of patient safety insight, improvement and assurance along with key reports on specific topics. The Trust continues to review and refine the metrics it is using to understand the safety of the care provided as it transitions to the Patient Safety Incident Response Framework

.

The Committee considered the following escalations related to the intelligence within the IPR:

- The Committee was provided with an update on two **external inquires** – the Infected Blood Inquiry and the COVID19 Inquiry. Assurance was received that learning was being identified and acted upon as soon as it emerged.
- **Never Event profile-** The Committee has requested a detailed overview paper at its next meeting reviewing learning from never events experienced during 2023/24
- **Mental Health-** the Committee acknowledged the increasing impact of mental health presentations on services, including considering a case study on the impact of Mental health on violent incidents. It was noted that this will be picked up in the Mental Health committee work
- The Committee took assurance that there was a robust process in place for the inspection of **medical devices** and noted the improvement in compliance related to this
- **Medicines safety-** the Committee noted that key areas for improvement activity 24/25 have been identified by the Medicines Safety Committee, noting that the Group Quality and Safety Committee would focus on these areas for improvement at its meeting in June 2024. In particular Committee noted the work being undertaken on discharge medications
- **Infection prevention control**-The Committee received an escalation of concern in relation to Hospital Acquired Infection (23/4) and were informed of a plan to hold a Trust-Wide summit to explore learning and opportunities for improvement.
- **Maternity standards** – an update was received on maternity compliance against a number of different standards. Assurance was received that robust governance processes were in place and work underway to embed learning.
- The Committee requested further insight in relation to how the Trust Safety Oversight System operates to generate themes and **trends from safety intelligence**, also noting the update detailed review of harm associated with delays in access to care and treatment scheduled for its August meeting (related to strategic risk 006352).

Principal Risk

No.	Description	Strategic Risks	Highest scoring
1.	Failure to maintain essential standards of quality, safety, and patient experience	3	20

Risk Profile

Group Wide Risk Profile

Key Component Strategic risks		Score
006352	Clinical quality impact of non-delivery of constitutional standards	15
007090	Optimising Human/system interaction (patient safety)	16
005930	Meeting national maternity recommendations	8

Quality and Safety: Effectiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation/ data	Assurance	Action status	Indicator	Indicator Type	Page
Outcomes	E1					Hospital Standardised Mortality Ratio (HSMR)Rolling 12mth	National	10
	E2					Hospital Standardised Mortality Ratio		10
	E3					Hospital Standardised Mortality Ratio (HSMR) Crude Mortality (Trust)	National	10
	E4					Summary Hospital-Level Mortality Indicator (SHMI) QUARTERLY	National	10
	E5					% of deaths screened	National:	10
	E6					Structured Judgement Reviews resulting in a Hogan Score of 3 or below	Local	10
	E7					National audits: Outlier status	National	10
	E8					National Audits (CQC Profile) recording outcome worse than expected	Regulator: No data	10
	E9					Local Audits –limited assurance		10
	E10					30 day readmission rate	Local	10
	E11					% NICE Guidance: Evidence of implementation	Local	11
	E12					% policy and clinical guidance in date	Local	11
	E13					National Audit case ascertainment	Local	11
	E14					% high priority local audits discontinued	Local	11
	E15					CQUIN 1: Flu vaccinations for frontline healthcare workers	CQUIN (prioritised)	11
	E16					CQUIN 2:Supporting patients to drink, eat and mobilise after surgery	CQUIN (prioritised)	11
	E17					CQUIN 3: Timely communication of Medicines changes to community pharmacists	CQUIN (prioritised)	11
	E18					CQUIN 4:Prompt switching of intravenous (IV) antimicrobial treatment	CQUIN (prioritised)	11
	E19					CQUIN 5: Identification and response to frailty in emergency departments	CQUIN (prioritised)	11
	E20					CQUIN Composite (all other indicators	CQUIN (prioritised)	11

Joint Group Medical Directors' Summary

At its meeting on the 24th April 2024, the Group Quality Performance and Scrutiny Committee were alerted to a number of areas of focus identified from the exception report provided from the Group Quality and Safety Committee. The included:

- The Committee considered a risk originally identified in 2022 that assurance in relation to **implementation of NICE guidance** across the Trust had been sub-optimal. Following the implementation of a new process for managing NICE guidance and a review of the Risk Management System (Ulysses) the Committee was informed that data suggested progress continues to be made regarding assessment and compliance.

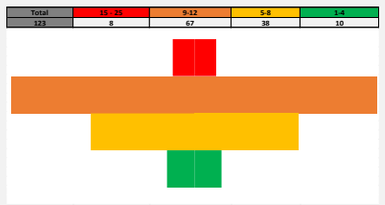
- The Committee noted the ongoing risk in relation to **policy governance** across the Trust. The issue is compounded by weaknesses in the current Trust policy management solution. The Committee were informed that the business case to procure a document management system is in development. There is fortnightly reporting to the Executive Director Team Committee relating to the status of policy harmonisation and review and a new working group has been established to deliver a focused plan of improvement

- The Committee noted that hospital/MCS/LCO have not delivered against their respective **clinical Audit forward plans** with a number of audits on the local plans not started in 2023/24, noting the impact of operational pressures, and the volume of audits on the plans. The Committee noted that there continues to be an issue in relation to participation in national audits (case ascertainment and data validation) following Hive implementation and has asked for an update to be provided at the next meeting. Weekly meetings are now in place with Informatics and the clinical audit managers to agree data sets for the various audits with the view of building automated reports to support submission .

- The Committee were alerted to issues with the implementation of the revised **Learning From Deaths Policy** (including the conduct of SJRs) and its escalation to the Group Learning from Deaths Committee for further review and action, and the ongoing alignment of the effectiveness related governance with the revised Trust strategy- the Acute Care Board. Resuscitation Committee, the Clinical Practice Oversight Committee etc.

Risk Profile

Group Wide Risk Profile



No.	Strategic Risks	Risk Score
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	12

Quality and Safety: Caring Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Oversight						Friends and Family test (response rate)	Local	13
						What Matters to Me (Overall Score)	Local	13
						Mixed sex accommodation breaches	National	13
						Upheld complaints (rate)	Local	13
						Formal Complaints received	Local	13
						Re-opened complaints (rate)	Local	13
						Ombudsman referred complaints	Local	13
Culture						National Adult Inpatient Survey (2022): Composite metric (Results received – currently embargoed)	Local	13
						Excellence / Compliments Received	Local	14
						Innovation (metric to be agreed at Quality & Patient Experience Forum)	Local	14
Learning and						Improvement Priorities	Local	14
						National Children and Young People's Inpatient and Day Case Survey (2020) Composite metric	Local	13
						Urgent and emergency care survey 2022; Composite metric	Local	13
						National Maternity Survey (2022) (an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts)	Local	13

Risk Profile

Under development post Quality & Experience Forum

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Chief Nurse's Summary

The Committee noted the content of the quality dashboard relating to the caring domain. Whilst no items were specifically escalated for discussion, is was noted that the metrics contained are under review to ensure that they continue to be applicable and provide Committee with the information it needs to be assured that the services we deliver are caring.

Highlights from within the report include:

- A decrease in the number of **Friend and Family Test** returns submitted for the reporting period (a decrease of 133 from February to in March 2024). The percentage positive score also decreased for the second month in March 2024 to 90.38% from 91.97% in February.

- The overall **What Matters To Me score** for MFT increased to 93.00% in March, in comparison to 92.86% in February 2024, all areas obtained overall scores above the minimum threshold of 85% for the third month running.

- **Mixed sex accommodation breeches** were noted through quality and safety committee as breaches continue to relate to the inability to discharge patients from critical care areas at the point a patients is ready for step down. Hospital leadership teams were directed to focus on improving performance though their patient flow programs.

- The Complaints Department received 201 **new formal complaints** in March 2024 in comparison to 206 received in February 2024. 24 more complaints were received in March 2024 than March 2023. PALS complaints have remained static. Appointment delays, treatment/procedure and communication were the overriding theme of new concerns. A deep dive into treatment and procedure has been commenced to establish if there is any themes relating to clinical pathways or services. There is work underway to relook at these metrics to ensure that Committee is sighted on key compliance metrics for the complaints service as well as proxy outcome measures..

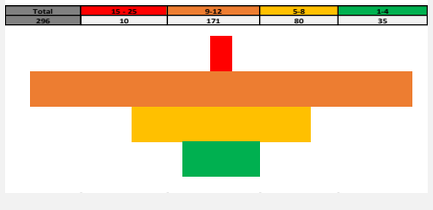
- **Adult IP survey** fieldwork has been extended which the impact is that report will be delayed. All other surveys due for release late summer.

- **Bee Brilliant** Q1 was launched in April as part of the 24/25 QI program, the focus for Q1 is communication.

Quality and Safety: Responsiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation/Assurance	Action status	Indicator	Indicator Type	Page
Oversight					Deaths with a Hogan score of <3 (Protected characteristics)	Local	18
					NI/Red complaint Protected characteristics	Local	18
					NI/Red complaint: Discharge/transfer	Local	18
					Duty of Candour compliance	Statutory	18
System Reliability					7DS compliance	National	18
					Accessible Information standard compliance	Local	18
					Clinical Accreditation	Local	18
					PLACE Outcomes	National	18
					Access to timely care/assessment and treatment	National	18
					% ReSPECT forms reviewed at each encounter	Local	19
Mental Health Strategy					Mental Health Act 1983 (MHA) compliance: Section 132: % Provision of information to patients	Local	19
					Mental health training compliance	Local	19
					NI/Red Complaint (Mental health concern)	Local	19
					Mental health in acute Trusts: Quality standard compliance – Number of patients on s136 who remain in ED greater than 12 hours (not trolley wait)	Local	19
					Number of patients (over age 18 years) where Deprivation of Liberty Safeguards standards have been applied		19
LD Strategy					% of people with a Learning disability or who are autistic who have evidence of reasonable adjustments in place	Local	19



No.	Strategic Risks	Risk Score
6469	Urgent & Emergency Care – ED & Patient Flow	16
6470	Scheduled Care Inpatient and Outpatient Backlog	16
6475	Cancer Pathway Delays	12
6467	Diagnosis Delay – patients >6 weeks from referral to diagnostic test	15

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Joint Group Medical Directors' and Chief Nurse's Summary

The Committee noted the content of the quality dashboard relating to the responsive domain. Whilst no items were specifically escalated for discussion, is was noted that the metrics contained are under review to ensure that they continue to be applicable.

Highlights from within the report include:

Duty of Candour compliance remains an area of significant development aligned to the implementation of the PSIRF, with a revise policy and training opportunities in place. The risk in relation to this area of patient engagement is recognised across the Trust with each Site/MCS/LCO proactively mitigating the risk through enhanced monitoring and dedicating specific staff for enhanced oversight.

The **clinical accreditation** programme 24/25 commenced in April with the first areas validated .

The Committee noted that the Safeguarding Committee has direct oversight of the **Safeguarding (level 3) training compliance** where improvements are evident, but continuous improvement required to meet Trust target.

Mental Health: The peer review undertaken by Mersey Care has been received. A detailed improvement plan has been developed and will be overseen by the mental health subgroup. The mental health subgroup is undergoing a comprehensive revamp under the leadership of the Group Deputy Chief Nurse.

In addition, the Committee received an update on the outcomes of the review into the **Hospital at Home** Service. It noted the improved outcomes for patients, especially in relation to avoided bed days, readmission and mortality, that the service had evidenced and further noted that a business case was in development to extend the service further.

Operational Performance: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Urgent care and Flow	P1	✗	L	H	✓	A&E 4 hour standard	National	
	P2	✗	L	F	✓	Ambulance handover within 15 mins	National	
	P3	✗	L	F	✓	Ambulance handovers over 60 mins	National	
	P4	i	L		◎	Hours lost in month due to delayed handovers	Local	
	P5	✗	H	F	✓	Number of AED waits > 12 hours	National	
	P6	✗	H	?	✓	Number of A&E DTA waits ≥ 12 hours	National	
	P7	i	H		◎	UEC referrals	Local	
	P8	✗	H	F	✗	No clinical reason to reside	National	
	P9	✗	L	?	◎	Cancer 2WW Performance (all)	National	
Cancer	P10	✗	L	F	✗	Cancer 31 day Performance	National	
	P11	✗	L	F	✗	Cancer 62 day performance	National	
	P12	✓	L	?	✓	Cancer Backlog reduction	National	
	P13	✗	L	?	✗	Cancer Faster Diagnosis	National	
Elective	P14	✓	L	P	✓	RTT total list size	Local	
	P15	✗	L	F	✓	RTT>78 week waiters	National	
	P16	✗	~	?	◎	Elective Inpatient Activity	Local	
	P17	✓	~	?	◎	Elective Outpatient Activity	Local	
	P18	✗	H	?	✓	Patients Discharged to PIFU	National	
	P19	✗	~	?	✓	Theatre Utilisation	Local	
Diagnostics	P20	i	H		◎	Diagnostics (DM01) total list size	Local	
	P21	✗	L	F	✗	Diagnostics (DM01) waits > 6 weeks	National	

Chief Operating Officer's Summary

We concluded 23/24 with a 4hour performance of 69.5% for the year, marking a 10.5% improvement from 22/23 and establishing MFT as one of the most improved trusts nationally. This is despite seeing a 9% increase in attendances over the same period. Although we aimed to deliver 76% performance in March, escalating demand on our urgent care system, led to a reported performance of 67.9% for the month. Our winter plans are all fully mobilised and in March we implemented further tests of change to support flow across hospitals. We have streamed 28% more patients through our Same Day Emergency Care (SDEC) pathway between October and March and supported 3,800 patients through our hospital at home programme compared to the same period in 22/23 Our plans to expand capacity through the Hospital at Home programme and on-going improvements to our front door coupled with bolstering of reablement support are initiatives to drive further improvements in 24/25.

The cancer 62-day backlog has shown a positive trend since September, with March performance reporting 241 against our year end trajectory of 267. Overall we experienced a 4% increase in cancer demand during 23/24, maintaining sustained high levels since the summer, remaining at 5500 per month in the last quarter of 23/24. MFT is performing above trajectory for 31-day against the combined cancer standard and Faster Diagnosis Standard (FDS) improved to 74.9% against the national 75% standard in February. Our focus on improvement is aimed at reducing time to first seen and diagnosis, which will facilitate achievement of the 62 and 31-day standards.

Our overall waiting list has reduced by 17,000 (April – March), notwithstanding the impact of industrial action and activity transferred through the North Manchester disaggregation. Long waits exceeding 78weeks reduced from a cohort of c10,000 at the start of the year to 15 at year-end, and over 65 weeks from around 143,000, to 560, despite the impact due to industrial action. Complexity (particularly in relation to Corneal transplants), patient choice and short term medical illness contribute to a handful of long waits but this is reducing. Improvement schemes such as patient self-scheduling, Theatre utilisation and predictive analytics schemes to reduce DNAs are underway to improve productivity in 24/25.

Diagnostics whilst still challenged has shown an 18.4% improvement since the start of the year, with March reporting 32.3%. This has been as a result of additionality through insourcing and the increasing capacity and optimisation of our Community Diagnostic Centres. This and other additionality will continue to be required into 24/25 to meet March 25's trajectory of 10%.

Group Wide Risk Profile

No.	Strategic Risks	Score
6469	Overcrowding and Flow Delays across Urgent Care Pathways	16
6470	Eliminating our longest waits >65 weeks for scheduled care admitted and non-admitted	16
6475	Delays to diagnosis and treatment for patients on a Cancer Pathway	12
6467	Delays to diagnosis with patients waiting >6 weeks for diagnostic tests	15

Workforce: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Workforce capacity	W1					Establishment WTE	Local	8
	W2					Staff in Post WTE	Local	8
	W3					Vacancy WTE	Local	8
	W4					Vacancy Percentage	Local	8
	W5					Temporary Staffing WTE	Local	8
	W6					Temporary Staffing Cost	Local	8
Looking after our people	W7					Attendance Percentage	Local	9
	W8					Call Back & Return to Work Compliance %	Local	9
	W9					Level 1 Mandatory Compliance Percentage	Local	10
	W10					Level 2 & 3 Mandatory Compliance Percentage	Local	10
	W11					Appraisal – Non Medical Compliance Percentage	Local	10
	W12					Appraisal – Medical Compliance Percentage	Local	10
Belonging	W13					Staff Engagement Score	Local	11
	W14					*% of BME in Medical and Dental pay scales*	Local	11
	W15					% BME in band 8a and above roles	Local	11
	W16					*% BME in band 7 and below*	Local	11
	W17					*% Disability in Medical and Dental pay scales*	Local	11
	W18					*% Disability in band 8a and above roles*	Local	11
	W19					*% Disability in band 7 and below*	Local	11
Future focus	W20					*Turnover %*	Local	12
	W21					*Retention/Stability %*	Local	12

Director of Human Resource's Summary

As of March 2024, the Trust attendance rate was 94.1%. Levels of absence remain high, above pre-pandemic levels and are reflective of a challenging operational context. Our 24/25 operating plan is predicated on a reduction of sickness absence to 5%. A comprehensive programme approach to absence prevention and attendance management is underway. Each Hospital/ MCS/ LCO/ Corporate area has a bespoke target and plan to drive local action. The programme design is holistic to address the breadth of factors which lead to reduced attendance (cultural, procedural, environmental, operational) and will be data driven to ensure measurable improvement at pace.

Workforce turnover (12-month average) has seen a large improvement to 11.2% in March 2024, which is below out internal target of 12.6%. Stability/retention percentage is also showing an improvement on last month at 88.6. Our work in relation to retention will continue across 24/25 to ensure this improvement is sustained, with a particular focus on staff experience and career pathways.

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory compliance for March 2024 achieved against target at 93.1%. However, further attention is needed in relation to levels 2 & 3 compliance which remain below target at 84.6%, although this is improving month on month. A review of mandatory training is underway focusing on both quick win enhancements to improve engagement and more fundamental changes regarding categorization, length of training to assess time spent versus outcome/value.

Appraisal compliance is also showing a general improvement over the last 12 months. Non-medical appraisal compliance for March 2024 was 79.2% against a 90% target. Medical appraisal compliance for March 2024 was 92.2%, which is achieving against a 90% target. Sites continue to drive local compliance and our new digital appraisal is due to launch summer 2024 following a design consultation period and pilot.

Our key metrics in relation to the theme of 'Belonging' show a mixed picture. Key areas to improve on include our staff engagement score which is currently 6.6 for March 2024 against a target of 6.8, and % BME staff in Band 8a and above roles which is currently 10.9% for March 2024 which is much lower than the BME population of Greater Manchester at 23.6% (reported by ONS) and our patient demographics with BME representing 29%. Organisation wide changes to staff engagement and inclusion are starting to drive some improvements in relation to this metric, as evidenced by our recent staff survey results. MFT's culture programme is progressing with the recruitment and training of 86 Change Agents, a refresh of our values, implementation of high impact ED&I actions, and an ongoing board development programme.

The Workforce agenda remains a strategic priority for the Trust, particularly in relation to staff experience / engagement, and workforce productivity and efficiency. Following the release of the MFT Organisational Strategy and NHSE Long Term Workforce Plan, the MFT People Plan is currently being refreshed to ensure it continues to deliver against organisational priorities.

Risk Profile

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to sustain an effective and engaged workforce	1	15

Finance: Executive Summary

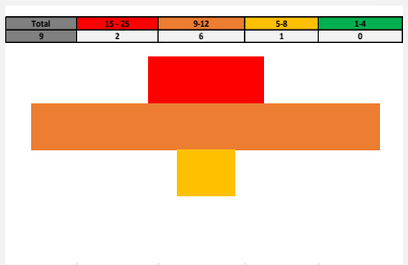
Focus	Ref	Status	Variation	Assurance	Action Status	Indicator	Indicator Type
I&E	F1	✓	H	?	✓	Financial performance against budget YTD (£'000s)	External
Pay Expenditure	F2	✗	H	F	✗	Total pay expenditure against budget YTD (%)	Internal
	F3	✗	H	F	✗	Consultant spend - variance to budget YTD (%)	Internal
	F4	✗	H	F	✗	All other Medics spend - variance to budget YTD (%)	Internal
	F5	✓	~	P	✓	Agency spend compared to total pay expenditure YTD (%)	Internal
	F6	✗	H	F	✗	Bank spend compared to total pay expenditure YTD (%)	Internal
Non Pay Expenditure	F7	✗	H	F	✗	Drugs - variance to budget YTD (£'000s)	Internal
	F8	✗	H	F	✗	Clinical Supplies - variance to budget YTD (£'000s)	Internal
Income	F9	✓	H	P	✓	Income including Elective - variance to income in finance plan (£'000s)	Internal
WRP	F10	✓	~	P	✓	WRP - variance to plan (£'000s)	Internal
Capital	F11	✓	H	?	✓	Capital expenditure (GM plan) - variance to plan YTD (%)	Internal
	F12	✗	L	F	✗	Capital expenditure (total plan) - variance to plan YTD (%)	Internal
Cash	F13	✗	L	F	✗	Cash balance - variance to plan in month (%)	Internal
BPPC	F14	✓	H	P	⇄	Performance against Better Payment Practice Code in month (% by value)	External

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain financial sustainability	1	15

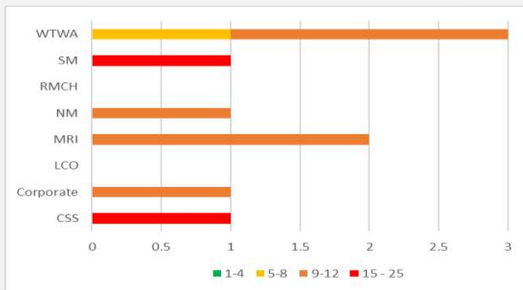
Risk Profile

Group Wide Risk Profile



No.	Strategic Risk	Score
5092	Capital finance	15

Site/MCS/LCO Risk Profile



Director of Finance's Summary

MFT reports a surplus of £223k, against an original breakeven plan, at the end of the 2023/24 financial year. At month 11 the Trust was forecasting a deficit of £11.0m which was based on a £5.0m operating deficit plus a Control Total adjustment for PDC payable of £6.0m as a result of the IFRS16 on PFI costs technical accounting adjustment. These deficits have been mitigated due to release of a favourable outcome on a rates provision.

Key risks to delivery of the plan for 2023/24 were:

• industrial action taken by various staff groups, which disrupted the ability to deliver elective recovery and also caused increased costs over the strike days. These strikes and their resolution was outside of the Trust's control, however, these costs were fully funded by NHSE and ERF targets were adjusted down to account for the lost activity. Ultimately this issue has caused minimal financial impact to the Trust.

• Ongoing high sickness levels which have remained stubbornly high have impacted on planned reductions in temporary pay and, although the Trust has done an excellent job on reducing Agency expenditure (see below), spend on Bank pay costs was £125.3m, some £36.8m above plan.

• The Trust set an internal improvement target to reduce staff turnover, thereby reducing the impact of the difficulties that persist across the NHS in recruiting all levels of staff across a range of staff groups, however, staff turnover rates remain unmoved with the need for temporary staffing remaining.

• High inflation levels, especially over the first two quarters had a huge impact on non pay costs with circa 5% being funded in National allocations whilst rates were above 10%.

Key achievements in 2023/24 have been:

• Agency pay has reduced to 1.6% of total pay against the National target of 3.7% and the internal target of 2.5%. This reflects expenditure of £28.3m against a plan of £40.4m – favourable by £11.1m

• The VfP programme was delivered in full, at £136.4m, which is highest ever target delivered by MFT and is a remarkable achievement given the industrial action taken over the year

• Achievement against the breakeven plan overall despite significant operation and clinical pressures throughout the year

• Delivery of the Capital plan within allocation

• The majority of sites delivered the agreed year end forecasts.

Capital:

For the year to 31st March 2024, total expenditure was £106.7m against a plan of £139.9m, an underspend of £33.2m – representing an underspend against a number of PDC schemes, namely the New Hospital Programme as a result of delays in funding approval and the TIF scheme where there has been national team approval to defer £6.8m of funding into 2024/25. Expenditure included within the GM envelope was £62.1m and in line with the GM approved plan of £62.1m.

Agenda Item 9.2

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 2024
Subject:	Financial Performance for Month 12 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:	Maintaining Financial Sustainability for both the short and medium term.
Recommendations:	• Continuing strong financial governance and control into 2024/25 is essential as the Trust continues to operate in a very challenging operational and financial environment. • With the changes in the funding regimes, more than ever it is of paramount importance that decisions are not made that commit the Trust to new recurrent expenditure without the appropriate level of scrutiny and authorisation. • The Board is recommended to note the Month 12 I&E, Cash and Capital 2023/24 outturn positions for the Trust.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan and associated risk**	MFT reports a surplus of £223k, against an original breakeven plan, at the end of the 2023/24 financial year. At month 11 the Trust was forecasting a deficit of £11.0m which was based on a £5.0m operating deficit plus a Control Total adjustment for PDC payable of £6.0m as a result of the IFRS16 on PFI costs technical accounting adjustment. These deficits have been mitigated due to release of a favourable outcome on a rates provision. Key risks to delivery of the plan for 2023/24 were: • industrial action taken by various staff groups, which disrupted the ability to deliver elective recovery and also caused increased costs over the strike days. These strikes and their resolution was outside of the Trust's control, however, these costs were funded by NHSE and ERF targets were adjusted down to account for the lost activity. Ultimately this issue has caused minimal financial impact to the Trust. • Ongoing high sickness levels which have remained stubbornly high have impacted on planned reductions in temporary pay and, although the Trust has done an excellent job on reducing Agency expenditure (see below), spend on Bank pay costs was £125.3m, some £36.8m above plan. • The Trust set an internal improvement target to reduce staff turnover, thereby reducing the impact of the difficulties that persist across the NHS in recruiting all levels of staff across a range of staff groups, however, staff turnover rates remain unmoved with the need for temporary staffing remaining. • High inflation levels, especially over the first two quarters had a huge impact on non-pay costs with circa 5% being funded in National allocations whilst rates were above 10%. Key achievements in 2023/24 have been: • Agency pay has reduced to 1.6% of total pay against the National target of 3.7% and the internal target of 2.5%. This reflects expenditure of £28.3m against a plan of £40.4m – favourable by £11.1m • The VfP programme was delivered in full, at £136.4m, which is highest ever target delivered by MFT and is a remarkable achievement given the industrial action taken over the year • Achievement against the breakeven plan overall despite significant operation and clinical pressures throughout the year • Delivery of the Capital plan within allocation • The majority of sites delivered the agreed year end forecasts
1.2	**Run Rate**	It is difficult to compare the final month of the financial year with the run rate since there are a number of adjustments to both income and expenditure that do not occur in the other months. In March 2024 expenditure was £286.4m which is an increase of £59.5m compared to the month 11 value of £226.9m. This is predominantly driven by the year end pension liability of £60.5m, which is fully offset by the same value of income. In addition, there is the accrued cost of the March 2024 Consultant pay award of £1.2m (the inclusion is a national requirement), which is also fully covered by the income.

1.3	**Cash & Liquidity**	As at the 31st March 2024, the Trust had a cash balance of £133.7m which is an increase of £20.1m from the £113.6m cash balance at the 29th February 2024. The 31st March closing cash balance is marginally lower than the forecast of £138.5m. The key driver of the £9.2m reduction against the £142.9m planned cash value at 31st March 2024 is working capital balances compared to plan.
1.4	**Capital Expenditure**	The capital plan is reflective of the 2023/24 capital plan submission to GM. For the year to 31st March 2024, total expenditure was £106.7m against a plan of £139.9m, an underspend of £33.2m – representing an underspend against a number of PDC schemes, namely the New Hospital Programme as a result of delays in funding approval and the TIF scheme where there has been national team approval to defer £6.8m of funding into 2024/25. Expenditure included within the GM envelope was £62.1m and in line with the GM approved plan of £62.1m In relation to IFRS 16 CDEL, published NHSE guidance confirmed an uplift in the 2023/24 CDEL allocation for the impact of IFRS 16 but that it will no longer be ring fenced. The 2023/24 plan submission totalled £45m, however, the level of the GM allocation remained subject to formal approval. For the year to 31st March 2024, IFRS 16 capital spend totalled £12.2m, an underspend of £0.2m against the submitted forecast to GM of £12.4m. In addition to this in year spend, the reported position for 2023/24 also reflects a £16.8m credit in relation to an immaterial adjustment identified during the 2022/23 year-end accounts finalisation; this has been approved by the national team to be transacted as a 2023/24 in year item rather than a prior period adjustment.
1.5	**Update to FDSC paper**	The figure for Impairments has been updated since the FDSC paper to reflect final remeasurement of the Trust's building assets principally arising from the revaluation of these assets by the District Valuer. The net change reduces the impairment figure from £75.1m to £32.3m. Impairments are a non-operating adjustment and therefore have no impact on delivery against the Trust's control total. More detail is shown on page 5.

Financial Performance

Income & Expenditure Account for the period ending 31st March 2024

I&E Category	NHSE Plan M12 £'000	Year to date Actual - M12 £'000	Year to date Variance £'000
INCOME			
Income from Patient Care Activities			
NHS England and NHS Improvement	948,185	965,202	17,017
ICBs	1,388,350	1,423,234	34,884
NHS Trust and Foundation Trusts	4,619	5,423	804
Local authorities	37,267	39,534	2,267
Non-NHS: private patients, overseas patients & RTA	11,694	11,044	(650)
Non NHS: other	17,520	21,215	3,695
Sub -total Income from Patient Care Activities	**2,407,635**	**2,465,652**	**58,017**
Research & Development	75,322	85,283	9,961
Education & Training	89,468	98,511	9,043
Misc. Other Operating Income	85,499	161,232	75,733
Other Income	**250,289**	**345,026**	**94,737**
TOTAL INCOME	**2,657,924**	**2,810,678**	**152,754**
EXPENDITURE			
Pay	(1,608,470)	(1,719,105)	(110,635)
Non pay	(925,342)	(978,545)	(53,203)
TOTAL EXPENDITURE	**(2,533,812)**	**(2,697,650)**	**(163,838)**
EBITDA Margin	**124,112**	**113,029**	**(11,083)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(72,516)	(62,017)	10,499
Interest Receivable	6,718	9,560	2,842
Interest Payable	(52,290)	(105,987)	(53,697)
Gain / (Loss) on disposal of PPE	0	(254)	(254)
Gain / (Loss) on Investment	0	98	98
Dividend (as calculated)	(6,024)	0	6,024
Surplus/(Deficit) before adjustments	**0**	**(45,571)**	**(45,571)**
IFRS 16 on PFI impact	0	53,766	53,766
IFRS 16 on PFI impact - PDC adjustment	0	(7,972)	(7,972)
Adjusted Surplus/(Deficit) for CT purposes	**0**	**223**	**223**
Surplus/(Deficit) as % of turnover	**0.0%**	**0.0%**	
Impairment	**(123,360)**	**(32,337)**	**91,023**
Non operating Income	**5,600**	**1,243**	**(4,357)**
Depreciation - donated / granted assets	**(2,294)**	**(1,425)**	**869**
Surplus/(Deficit) after non-operating adjustments	**(120,054)**	**(32,296)**	**87,758**

The Trust has delivered an adjusted surplus of £0.2m against the breakeven plan for the 2023/24 financial year. This is better than the forecast at month 11 of an £11.0m deficit, delivered in month 12 due to a favourable outcome in relation to a rates provision.

The report that was tabled at Finance & Digital Scrutiny Committee reported an impairment value of £75.1m, being the full year cost prior to reflection of the revaluation of building assets, completed by the District Valuer for the year end accounts. This revaluation exercise has resulted in the reversal of £50.4m impairment charges recognised in prior years. Offsetting this there has been an increase of £7.6m against impairments due to completion of the detailed impairment reviews on the 23/24 capital expenditure. The 23/24 impairment figure has therefore reduced by a net £42.8m to £32.3m.

Non-operating adjustments now reflect a £32.3m deficit, £87.8m favourable to plan.

Income

The £152.8m YTD positive variance is driven by:

- A credit for the year end pension liabilities of £60.5m, offset by an equivalent value in expenditure (this is an annual adjustment that occurs every March)
- £25.3m of national funding to cover IA costs/income loss – also offset in expenditure
- £1.2m of income included for the March costs of the revised Consultant pay award – offset by an equivalent value in pay expenditure
- £32.7m patient care income above plan - £1.4m favourable ERF performance (against 100% plan) and £5.0m reduction in UEC funding, offset by contract variations (current and prior year) of £22.0m, CPT income (£9.0m), and deferred income and Non Contract Activity of £4.1m
- £33.6m 'Other operating income' including £10.0m deferred income releases, £9.0m additional HEE funding with the remaining £14.6m relating to salary recharges/SLAs, car parking, and other non patient care income.

Pay

The £110.6m adverse variance is predominantly driven by:

- A debit for the year end pension liabilities of £60.5m, offset by an equivalent value in income (this is an annual adjustment that occurs every March)
- £22.4m of Industrial Action pay costs, which is offset by national funding
- £1.2m included to cover the March costs of the revised Consultant pay award – offset by an equivalent value in income
- Activity and vacancy related staffing pressures across various sites resulting in premium staffing costs - bank expenditure is above plan by £36.8m, although offset by a reduction in agency expenditure of £12.1m
- Prior year spending decisions resulting in reduced budgets.

Non Pay

The Trust was required to calculate and apply the YTD impact of IFRS 16 to its PFI assets in month 9 and there have been further adjustments each month – the full year impact of the implementation of the new standard is £53.8m which NHSE have adjusted for so there is no impact to the Trust's control total. This adjustment has also led to the PDC dividend calculation summing to nil payable, due to a reduction in net assets. This reduction in cost was reflected in the YTD deficit to month 10 but for months 11 and 12 this reduction has been adjusted out of the control total calculation, as with the change to the Unitary Payment, which results in an £8.0m adjustment to the 'adjusted control total'.

The expenditure against non pay categories is adverse to plan by £41.9m YTD (including interest, dividends and depreciation). The key variances YTD are:

- Clinical Supplies costs are adverse to plan by £16.6m driven by inflation and activity. This is partially offset by General Supplies which is favourable to plan by £10.5m
- Drugs costs adverse to plan by £24.9m, partially offset by CPT income
- Outsourcing costs are adverse to plan by £12.1m supporting activity to reduce waiting lists
- Costs related to leasing are adverse to plan by £5.7m
- Depreciation and Amortisation are under plan by £10.5m - primarily on NMGH IT assets and Radiology assets
- Adverse variances across other non pay categories, primarily due to excess inflationary pressures, account for the remaining difference

Analysis by Site

The 23/24 outturn position of each MFT Site is shown below against the final Control Total (CT). The table below is not a full view of the overall Trust position, as it excludes the Trust's income and some central costs including financing.

Site	Control Total 23/24 @ M12	YTD Budget	YTD Actual	YTD Variance	YTD Variance	*Previous Months YTD Variance*
	£000	£000	£000	£000	%	*%*
CSS	383,948	383,948	391,161	(7,213)	(1.9%)	*(2.4%)*
LCO	153,080	153,080	151,429	1,650	1.1%	*0.4%*
MREH	52,486	52,486	52,755	(269)	(0.5%)	*0.8%*
MRI	353,545	353,545	386,181	(32,636)	(9.2%)	*(8.8%)*
NMGH	154,442	154,442	163,279	(8,837)	(5.7%)	*(6.2%)*
RMCH	267,748	267,748	287,224	(19,476)	(7.3%)	*(6.3%)*
SMH	195,955	195,955	203,052	(7,097)	(3.6%)	*(4.8%)*
UDHM	15,780	15,780	15,720	60	0.4%	*0.4%*
WTWA	429,626	429,626	455,757	(26,131)	(6.1%)	*(6.2%)*
Total Hospitals/MCS/LCO	**2,006,610**	**2,006,610**	**2,106,558**	**(99,948)**	**(5.0%)**	***(5.1%)***
Corporate	242,279	242,279	223,201	19,078	7.9%	*6.6%*
Estates & Facilities	195,762	195,762	195,670	92	0.0%	*0.1%*
Total Corporate and E&F	**438,041**	**438,041**	**418,871**	**19,170**	**4.4%**	***3.7%***
Total All Sites	**2,444,651**	**2,444,651**	**2,525,429**	**(80,778)**	**(3.3%)**	***(3.5%)***
Memo: IFRS 16 on PFI impact (exc from E&F)	0	0	53,766	(53,766)		

All CT adjustments requested by the Sites were supported except for some relating to cost-pass through drugs and devices. The reason for this is that a significant proportion of these drugs and devices fall under the Trust's block contract arrangement with Commissioners, with no further funding received. In this respect these expenditure items would show a genuine difference to income and therefore are adverse to forecast. The total CT adjustments requested but not transacted for these items at the year end was £29.9m. The total adverse variance to plan across the Sites adjusting for this would be £50.9m. Group flexibilities and other mitigations closed this gap to achieve breakeven for the year.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year was a Waste Reduction target totalling £60.9m with a further £75.5m to be delivered through schemes developed at Trust level, resulting in a total requirement of £136.4m.

The tables below outlines the 23/24 outturn position against the planned savings by workstream and by Site. The Trust has achieved full delivery of the £136.4m target, however, a larger proportion of this was delivered through non-recurrent means, which has an impact on expenditure in 24/25. The outturn included £65.2m (47.8%) of non-recurrent savings compared to the planned £21.8m (16.0%). For 2024/25 all Trusts have a recommended cap on non-recurrent savings of 25% of total.

MFT Summary

Workstream	Savings to Date				Forecast 23/24 Position			
	Plan (YTD) (YTD) £'000	Actual (YTD) (YTD) £'000	Variance (YTD) (YTD) £'000	Financial BRAG (YTD)	Plan (YTD) (23/24) £'000	Actual (23/24) £'000	Variance (23/24) £'000	Financial BRAG (YTD)
Admin and clerical	6,042	5,937	(106)	98%	6,042	5,937	(106)	98%
Budget Review	6,568	6,568	6,568		6,568	6,568	0	100%
Contracting & income	8,631	8,680	49	101%	8,631	8,680	49	101%
Hospital Initiative	6,071	6,161	90	101%	6,071	6,161	90	101%
Length of stay	1,139	1,121	(18)	98%	1,139	1,121	(18)	98%
Non Pay Efficiencies	3,740	3,735	(5)	100%	3,740	3,735	(5)	100%
Outpatients	91	91	0	100%	91	91	0	100%
Pharmacy and medicines management	3,039	4,129	1,090	136%	3,039	4,129	1,090	136%
Procurement	8,262	8,090	(172)	98%	8,262	8,090	(172)	98%
Theatres	93	93	0	100%	93	93	0	100%
Workforce - medical	6,981	6,888	(93)	99%	6,981	6,888	(93)	99%
Workforce - nursing	5,448	3,858	(1,590)	71%	5,448	3,858	(1,590)	71%
Workforce - other	2,849	2,904	55	102%	2,849	2,904	55	102%
Informatics	3,437	3,812	375	111%	3,437	3,812	375	111%
Total (L3 or above)	**62,392**	**62,067**	**(324)**	**99%**	**62,392**	**62,067**	**(324)**	**99%**
Trust Initiative	74,024	74,349	325	100%	76,152	74,349	(1,803)	98%
MFT Total	**136,416**	**136,416**	**0**	**100%**	**136,416**	**136,416**	**0**	**100%**

Summary against Target M1-12	M12	YTD
Target	15,462	136,416
Actuals (L3 or above)	14,036	136,416
Variance to Target	- 1,426	0

Summary against Target 23/24	Actual
Target	136,416
Actuals/Forecast (L3 or above)	136,416
Variance to Target	0

Financial BRAG

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

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

Hospital/MCS	23/24 Target	23/24 Actual	23/24 Variance	23/24 % Variance
Corporate	5.0	6.7	1.8	35%
CSS	12.6	12.4	(0.2)	-2%
EYE	1.7	2.0	0.3	16%
Dental	0.6	0.4	(0.2)	-34%
LCO	3.8	5.0	1.1	30%
MRI	9.1	9.3	0.2	2%
NMGH	4.6	4.6	(0.0)	-1%
RMCH	6.2	3.8	(2.5)	-40%
St. Mary's	5.8	6.7	0.9	15%
WTWA	11.4	11.3	(0.1)	-1%
Hospital/MCS/LCO Total	**60.8**	**62.1**	**1.3**	**2%**
Trust (Group)	75.6	74.3	(1.3)	-2%
MFT Total	**136.4**	**136.4**	**(0.0)**	**-0%**

Statement of Financial Position

	M12 22/23 £000	M12 23/24 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	11,368	12,325	957
Property, Plant and Equipment	1,060,570	1,087,296	26,726
Investments	858	806	(52)
Trade and Other Receivables	17,315	18,330	1,015
Total Non-Current Assets	**1,090,111**	**1,118,758**	**28,646**
Current Assets			
Inventories	25,374	27,596	2,222
NHS Trade and Other Receivables	99,984	78,203	(21,781)
Non-NHS Trade and Other Receivables	57,409	64,221	6,812
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	240,943	133,687	(107,256)
Total Current Assets	**423,920**	**303,917**	**(120,003)**
Current Liabilities			
Trade and Other Payables: Capital	(36,707)	(37,382)	(675)
Trade and Other Payables: Non-capital	(437,418)	(353,706)	83,711
Borrowings	(36,700)	(43,476)	(6,776)
Provisions	(29,276)	(16,975)	12,300
Other liabilities: Deferred Income	(51,880)	(33,744)	18,136
Total Current Liabilities	**(591,981)**	**(485,284)**	**106,697**
Net Current Assets	**(168,061)**	**(181,367)**	**(13,306)**
Total Assets Less Current Liabilities	**922,050**	**937,391**	**15,341**
Non-Current Liabilities			
Trade and Other Payables	-	-	-
Borrowings	(495,308)	(722,697)	(227,389)
Provisions	(11,423)	(9,232)	2,191
Other Liabilities: Deferred Income	(2,804)	(3,826)	(1,022)
Total Non-Current Liabilities	**(509,535)**	**(735,755)**	**(226,220)**
Total Assets Employed	**412,515**	**201,636**	**(210,879)**
Taxpayers' Equity			
Public Dividend Capital	471,920	537,401	65,481
Revaluation Reserve	163,396	184,669	21,273
Income and Expenditure Reserve	(222,801)	(520,434)	(297,633)
Total Taxpayers' Equity	**412,515**	**201,636**	**(210,879)**
Total Funds Employed	**412,515**	**201,636**	**(210,879)**

There has been a £26.7m increase in the carrying value of Property Plant and Equipment from £1,060.6m as at 31st March 2023 to £1,087.3m as at 31st March 2024. The increase is predominantly due to the annual revaluation applied in March 2024 resulting in a £71.7m increase and by in-year capital additions (including right of use assets) of £100.8m, partially offset by depreciation of £60.9m and impairment of £81.8m.

Inventories have increased from £25.4m as at 31st March 2023 to £27.6m as at 31st March 2024. This is driven by the recognition of £2.4m of medical devices that were reclassified as inventories in month 8, and a small balance offsetting this movement resulting from the year end stock count adjustments.

The NHS trade and other receivables are showing a decrease of £21.8m from £100.0m at 31st March 2023 to £78.2m at 31st March 2024. This is primarily made up of a £51.8m decrease in central accrued income for the 2022/23 pay award which is offset by a £19.0m increase in sales ledger balances, an £8.7m increase in central accrued income and a £1.5m increase in accrued income relating to clinical and scientific services.

The Non-NHS trade and other receivables have increased from £57.4m at the 31st March 2023 to £64.2m at 31st March 2024, this movement primarily reflects a £6.7m increase in sales ledger balances and a £1.5m increase in PDC dividend receivable.

Consistent with prior years, capital activity towards the end of the 2023/24 financial year resulted in a year end capital creditors balance of £37.4m. The capital creditor balance has increased in the approach to the 2023/24 year-end as a number of the capital schemes complete. This is forecast to unwind over the first few months of 2024/25.

Since the 2022/23 year-end, there has been a reduction in non-capital trade and other payables of £83.7m, primarily driven by a reduction of £51.0m in accruals following the settlement of the pay award. There was also a £23.5m decrease in GRNI accruals following the detailed balance sheet review exercise in 2023/24 and a £10.3m decrease in accruals relating to estates and facilities.

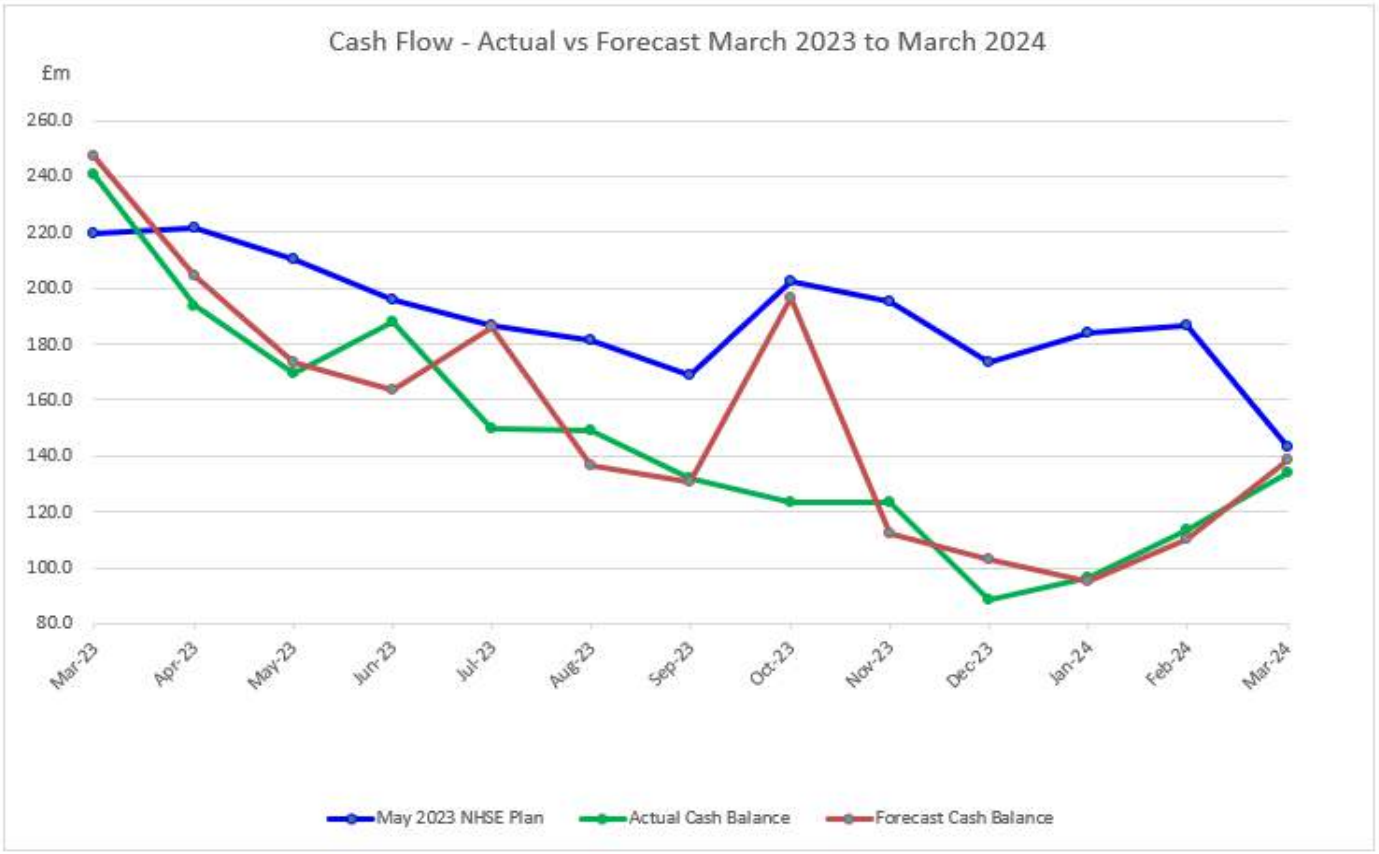
Deferred income included in current and non-current liabilities has decreased from £54.7m at the 31st March 2023 to £37.6m at 31st March 2024; a movement of £17.1m. This is primarily made up of a £10.2m reduction in central deferred income and an £8m reduction relating to research and innovation deferred income balances.

Provisions have decreased from £40.7m as at 31st March 2023 to £26.2m as at 31st March 2024. This reduction is primarily made up of a £13.1m release of provisions held relating to business rates and a £2m release of provisions relating to managed equipment services.

As noted in the month 9 report, this year sees the application of the DHSC requirement for NHS bodies to apply IFRS 16 measurement principles to PFI liabilities effective from 1st April 2023. It should be noted this is a technical accounting change in the financial element of the Trust's two PFI schemes (i.e., the PFI schemes at Wythenshawe and ORC) only and has no impact on the cash payments being made to these PFI operators. For the Trust, the accounting impact as at month 12 is a £276.9m increase in the PFI creditor balance within borrowings. This resulted in a £219.5m charge to the Income & Expenditure reserve. As noted in the section above on financial performance, there has also been a £53.7m increase in expenditure that NHSE has subsequently adjusted out for control total reporting purposes as has the PDC dividend charge benefit of £8.0m as a result of the reduction in net assets.

The brought forward balance sheet presented in the February 2024 report included a prior period adjustment which has now been reversed and reflected as a 2023/24 in-year item in the March 2024 report and NHSE return. The impact on the I&E is £nil as the corresponding entry has been recognised in the I&E reserves balance. The amendment to the treatment of this adjustment has been discussed and agreed with both NHSE and the external audit team at Mazars and relates to an adjustment to opening leases of £16.8m. This has also resulted in a reduction in lease liabilities within borrowings in 2023/24 that has offset the increase noted above relating to the implementation of IFRS16 for PFI liabilities. The remaining decrease in borrowings is as a result of other borrowing repayments.

Cash Flow



As at 31st March 2024, the Trust had a cash balance of £133.7m. This is an adverse variance of £4.8m compared to the closing cash forecast of £138.5m. The variance to forecast is driven by payroll cash spend being £8.7m higher than forecast, which is largely driven by the payment of Clinical Excellence awards, and the delayed receipt of £6.5m from GMMH that was forecast to be receipted in March but was not received until April. This was offset by the VAT return of £7.0m being submitted earlier than forecast and a capital cash underspend relating to project RED of £2.6m.

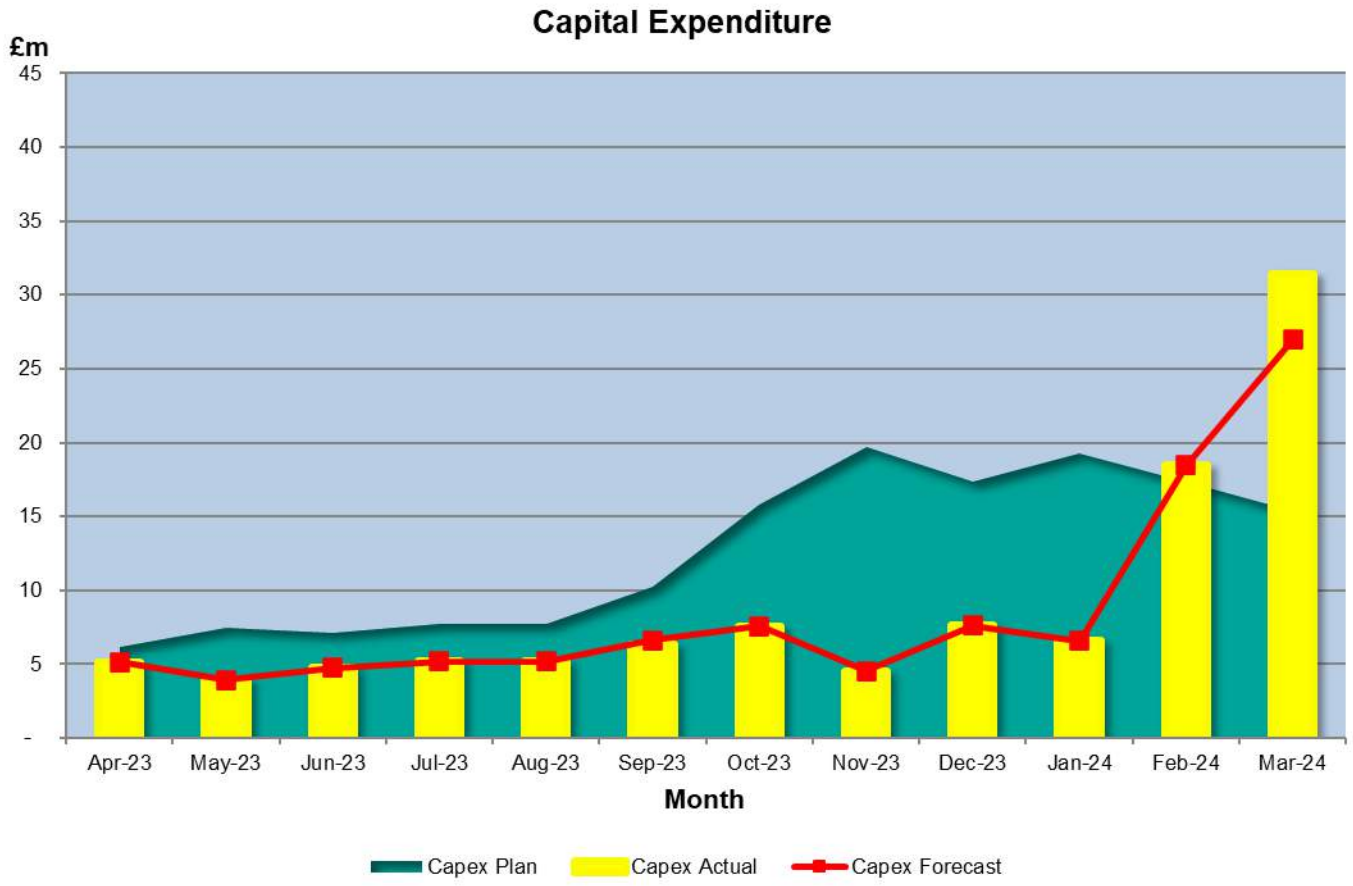
As at 31st March 2024 cash is £9.2m lower than the original plan of £142.9m cash at the end of March, principally reflecting working capital variances and the year-to-date EBITDA deficit position.

There is continued work ongoing to increase the visibility of cash forecasts and balances within the organisation and ensure there is focus on cash management. The Financial Services team will continue to work with the Capital, Accounts Payable, Accounts Receivable, Group Finance and Central Income teams in the monthly Cash Flow Review Group and Cash Management meetings to refine the forecast based on all information available.

As part of this work, the daily cash balance is reported within the finance team and there is a weekly review of the ongoing validity of month-end forecast assumptions, and a monthly cash update report is being provided to EDT for further testing and scrutiny. In addition, a process is being implemented to manage the timing and value of supplier payment runs, whilst working through the implications on the Better Practice Payment Code (BPPC) performance.

	Jan-24		Feb-24		Mar-24	
Highest in month cash balance (£m)	252.5	As at 15/01/2024	283.3	As at 15/02/2024	305.2	As at 18/03/2024
Lowest in month cash balance (£m)	93.1	As at 29/01/2024	96.4	As at 31/01/2024	113.7	As at 29/02/2024
Month-end cash balance (£m)	96.3		113.6		133.7	

Capital Expenditure



In the year to 31st March 2024, £106.7m of capital expenditure has been incurred against a revised plan of £139.9m, an underspend of £33.2m. Expenditure included within the GM envelope was £62.1m against the revised GM approved plan of £62.1m.

The £33.2m underspend is primarily driven by:

- £33.5m New Hospital Programme (NHP) due to delays in funding approval;
- £6.8m on TIF due to delays in the scheme. The Estates team's 2023/24 full year forecast was £2.1m against the original plan of £8.9m and received approval from the national team that the £6.8m underspend could be deferred into 2024/25; and
- £5.1m reduced spend on charity funded equipment.

These underspends have been partially offset by overspends, notably:

- £6.1m of external funding for the TLHC, National Institute for Health and Care Research, National Breast Imaging Academy and CDC schemes (Trafford and North Spoke);
- £3.1m PDC funding for the genomics programme; and
- £5.3m PDC funding for the LED lighting programme.

The Trust's capital plan is reflective of the 2023/24 capital plan agreed by GM and totals £139.9m. For the year ended 31st March 2024, expenditure included within the GM envelope was £62.1m and therefore in line with the GM approved plan.

In relation to IFRS 16 CDEL, published NHSE guidance has confirmed an uplift in the 2023/24 CDEL allocation for the impact of IFRS 16 but that this CDEL will no longer be ring fenced.

The IFRS 16 plan submission totalled £45m, however, the level of CDEL cover did not receive final NHSE regional approval. Consequently, CDEL approval for new leases was limited to leases already inflight at 31st March 2023 (totalling £8m) and those that were emergency in nature.

The submitted full year forecast to GM for spend against the IFRS 16 capital allocation was £12.4m, this is a reduction of £32.7m compared with the £45m submitted plan. The reduction primarily relates to the delay in approval noted above, managed equipment services leases (with lower than planned contract terms or being assessed to be outside of IFRS 16) and leases no longer required.

For the period up to 31st March 2024, IFRS 16 capital spend totalled £12.2m, an underspend of £0.2m against the submitted forecast of £12.4m. In addition to this in year spend, the reported position also reflects a £16.8m credit in relation to an immaterial adjustment identified during the 2022/23 year-end accounts finalisation; this has been approved by the national team to be transacted as a 2023/24 in year item rather than a prior period adjustment.

Aged Debt

The Accounts Receivable ledger and bad debt provision remain under scrutiny, and the Accounts Receivable team are continuing to work though the settlement of balances with other GM providers.

Sales ledger invoices remaining unpaid at the end of March 2024 stand at £64.6m; an increase of £7.1m from the closing February 2024 position of £57.6m. This increase is driven predominantly by an increase in the 0–30 day balance increase of £6.9m, including £3.0m due from the Christie, £1.0m due from UK Health & Security and £1.1m from the NCA.

Invoices due >90 days has increased during the month, showing a rise from £28.3m in February 2024 to a closing balance at the end of March 2024 of £30.3m. Invoices that have dropped into the >90 days category during March include £0.8m for GMMH, £3.3m for NCA and £0.7m for Bolton NHS FT.

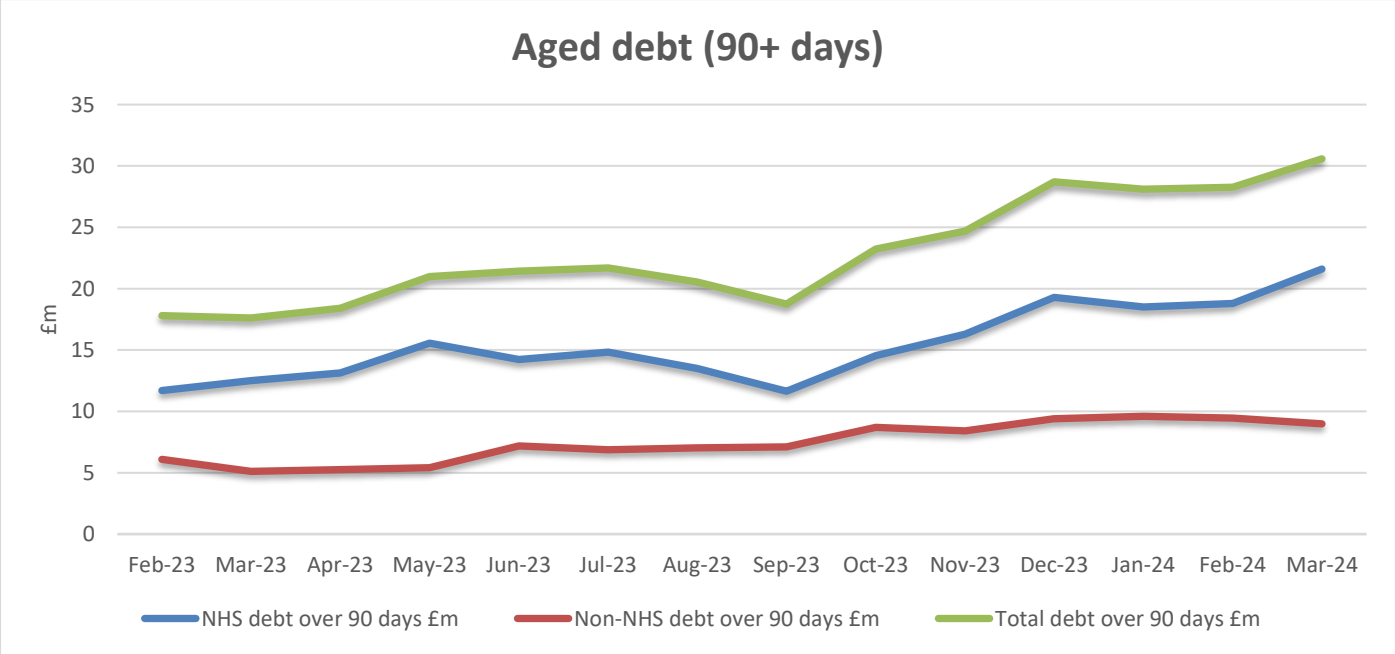
This >90 days value comprises 47.3% of the total outstanding balance. The value of invoices due over 90 days as a percentage of the total value of invoices outstanding decreased slightly by 1.8% in March 2024.

The finance teams are making significant progress in the monthly reviews with NCA colleagues to clear aged, disputed invoices on both the Accounts Payable (AP) and Accounts Receivable (AR) ledgers and are also in regular dialogue with GMMH colleagues. The review meetings with NCA are scheduled to restart at the end of April following the submission of the year end accounts. As at the end of March 2024, the majority of the aged GMMH invoices relate to 2022/23 charges for property rental income at WTWA. The Trust received a payment of £6.2m from GMMH on the 2nd April 2024.

The AR team review the >90 days debt with the hospitals/MCSs in their monthly debt reviews and are continuing to develop the invoice register to log SLAs and other regular billing cycles to support the collection of debt and the management of disputes.

The balance outstanding that is over one year old has increased during March 2024 by £0.6m with a closing balance at the end of the month of £7.7m. The AR team are continuing to make progress with their action plan focussing on the ten highest value 90+ day balances with support from hospital / corporate colleagues.

Month/Year	0-30 days £,000	30-60 days £,000	60-90 days £,000	90 + days £,000	Grand Total £,000	90 days + %
Feb 2024	17,782	3,843	7,691	28,280	57,596	49.1%
Mar 2024	24,729	7,592	1,754	30,621	64,695	47.3%
Movement	**6,947**	**3,748**	**(5,938)**	**2,342**	**7,100**	**(2%)**



Better Payment Practice Code

NHSE placed a renewed focus on all organisation's performance against the Better Payment Practice Code (BPPC) targets in 2021/22, with scrutiny initially falling on the worst performers. This remains an area of focus into 2023/24. The target for all NHS organisations is to pay 95% of invoices within payment terms.

NHSE require BPPC numbers to be provided in the monthly returns for 2023/24. An extract of MFT's submission for year to date at month 12 is shown below, along with a comparator to the values for the previous month.

Better Payment Practice Code (BPPC)	YTD to 29/02/2024 By Number	YTD to 29/02/2024 By £'000	YTD to 31/03/2024 By Number	YTD to 31/03/2024 By £'000
Non NHS				
Total bills paid in the year	273,395	1,379,499	306,492	1,534,424
Total bills paid within target	254,835	1,342,453	285,821	1,492,964
Percentage of bills paid within target	**93.2%**	**97.3%**	**93.3%**	**97.3%**
NHS				
Total bills paid in the year	8,446	252,790	9,510	277,372
Total bills paid within target	5,826	230,349	6,541	253,155
Percentage of bills paid within target	**69.0%**	**91.1%**	**68.8%**	**91.3%**
Total				
Total bills paid in the year	281,841	1,632,289	316,002	1,811,796
Total bills paid within target	260,661	1,572,802	292,362	1,746,119
Percentage of bills paid within target	**92.5%**	**96.4%**	**92.5%**	**96.4%**
Target	95.0%	95.0%	95.0%	95.0%
Distance from target	***(2.5%)***	***1.4%***	***(2.5%)***	***1.4%***

The Trust finishes the financial year reporting similar numbers to the previous few months, falling short of the target 'by number of invoices paid' by 2.5% and better than the 95% target by 1.4% for 'by value of invoices paid'. Both measures have moved very little over the course of the financial year.

It should be noted that the stronger focus on cash management has resulted in a reduction in the performance of the BPPC, due to the need to manage creditor payments in line with cash availability and the likelihood is that this will continue in 24/25 with cash balances falling.

Performance against payment of the inter-NHS invoices remain the main problem, both by number and by value because of disputed invoices and delays in the approvals processes. Work is ongoing to improve these processes.

Agenda Item 10.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Strategy Officer
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	May 2024
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: Caroline Davidson, Director of Strategy Tel: 0161 276 8976

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 Developments

2.1. NHS England Board Appointments

NHS E has announced the appointment of two new associate non-executive directors. As associates, they will attend board meetings but not have a vote. Suresh Viswanathan is chief operating officer at Nationwide Building Society and has 35 years of experience in the banking sector, with a focus on technology and operations. Tanuj Kapilashrami is chief strategy and talent officer at Standard Chartered Bank and previously worked at HSBC for 17 years, as well as holding other non-executive director posts, including for Sainsbury's.

2.2 Appointment of National Clinical Directors

The NHS has appointed its first ever national clinical director for women's health. Dr Sue Mann, a consultant and lead for women's health in City and Hackney, North East London, has been appointed to the role which will help implement the Women's Health Strategy alongside supporting the roll out of women's health hubs across England.

Six other National Clinical Directors have also been appointed or reappointed including

- Dr Lesley Kay – National Clinical Director for Musculoskeletal
- Dr Jeremy Isaacs – National Clinical Director for Dementia
- Dr Thomas Downes – National Clinical Director for Older People and Integrated Personalised Care.
- Dr Tony Avery – National Clinical Director for Prescribing
- Professor Ramani Moonesinghe – National Clinical Director for Critical and Perioperative Care
- Professor Matt Inada-Kim – National Clinical Director for Infection and Antimicrobial Resistance

3. Regional and Local Developments

3.1 GM ICB Leadership and Governance

The Leadership and Governance review of the Greater Manchester Integrated Care Board which was supported by Carnall Farrar (CF) was completed in May 2023. The recommendations included, amongst others, strengthening operational planning and simplifying and clarifying the GM operating model and streamlining the governance. All eight recommendations were assigned to an Executive Lead for implementation. Updates on progress have been brought to this Board, in particular where they relate to the operating model which describes how the whole of the Integrated Care System works, including the role of providers like MFT. A formal review of progress is now going to be undertaken and reported to the ICB in July 2024.

3.2 GM ICB 2024/25 Budget and Annual Plan

GM ICB is required to submit a draft and a final financial plan to NHSE on 21 March and 2 May respectively covering the whole of the ICS including the NHS providers such as MFT. The draft submission was based on a system revenue deficit of £298m. In order to reduce the deficit the ICB identified the following priorities for the whole of the ICS:

- The continuation and further embedding of grip and control.

- A systematic reduction in dependency on the independent sector.
- A commitment to commence a review, within 2024/25, of every commissioned service.
- To agree and implement the clinical services strategy.
- Restrictions on further service growth.
- An expectation of challenging CIPs for both providers and the ICB with 75% of these
- values delivered recurrently as a minimum
- A running cost and operating cost target reduction for the ICB in line with the
- reduced allocation.
- A requirement to reduce the use of temporary staffing and agency spend to 3.2%.

Alongside this a GM level Operational Plan has been developed that describes the activities that NHS GM will undertake in 2024/5, including the information required by NHSE to demonstrate how the national NHS objectives (including detail of finance, activity, performance, and workforce) will be met within the context of the GM Integrated Care Partnership (ICP) Strategy.

Further work has been undertaken since 21 March to reduce the financial deficit for the final submission to NHSE. Following the final submission and close down of the 24/25 planning process, a 2–3-year sustainability plans is to be developed by the ICB and providers to address what are described as the triple deficit, that is a population health deficit, a performance and quality deficit and an underlying financial deficit.

3.3 Specialised Commissioning Delegation

The NHS England Board has now approved plans to fully delegate the commissioning of appropriate specialised services to Integrated Care Boards in the East of England, Midlands and the North West regions of England from April 2024.

Work has been undertaken in the North West to support the delegation of a 'segmentation of services' that are 'ready and suitable for ICS delegation'. Services have been categorised as being suitable for decision making at single-ICS level; and those that will require multi-ICS collaboration across all three NW ICSs. 59 services with a value of £13.6bn have been identified as suitable for single-ICB or multi-ICB leadership. Decisions about those services categorised as single-ICB leadership will be made by GM ICB and those services categorised as multi-ICB level will be considered by the North West Specialised Services Joint Committee.

These arrangements will be reviewed regularly to ensure they are effective and remain fit for purpose.

4. MFT Developments

- ***Community Diagnostic Centres (CDC)***

The North Manchester Community Diagnostic Centre (CDC) Spoke in Harpurhey opened on 22 April 2024. The new setting is now hosting lung function and sleep studies and will in future provide ophthalmology diagnostics delivered by MREH. CDCs provide local access to a range of tests and scans, avoiding the need to travel to a main Hospital site and reducing waiting times. They can result in faster diagnosis and play an important role in addressing health inequalities by providing improved access for patients who have difficulties in using traditional hospital-based services.

- ***NMGH Redevelopment***

Nationally the third programme business case (PBC3) is being considered by the Treasury. Following this it is anticipated that the Trust will receive a revised capital envelope for the NMGH scheme. Once we receive this and the Hospital 2.0 guidance (standardised design for future hospitals) is published, the full Outline Business Case refresh will commence. In the meantime work is underway to define the programme plan, establish the governance arrangements and recruit team members.

Phase two of the Target Operating Model development has just been completed. This has focused on defining the clinical vision and patient pathways for Medicine, Clinical and Scientific Services, Women's and Childrens Managed Clinical Services in the new hospital.

- ***Disaggregation of Services from Northern Care Alliance (NCA)***

Disaggregation of the ENT and Urology services was successfully achieved on 8th April 2024. This means that for ENT and urology, MFT now provides services for the patients within the catchment of North Manchester General Hospital and patients within the Northern Care Alliance (NCA) catchment area will now be treated on NCA sites.

- ***Christie Pathology Partnership (CPP) Cytogenetics Laboratory Transfer***

The CPP Cytogenetics Laboratory which is based at The Christie is to come under the management of the NHS E Genomics Laboratory Hub. A transfer date of the 1 June has been agreed. Bringing cytogenetics under the direct control of the GLH represents a further step in the consolidation of genomic testing across the region.

- ***Targeted Lung Health Checks***

The Targeted Lung Health Check screening programme expanded in April with the two new mobile scanners going live resulting in a total of four scanners delivering the TLHC programme across GM.

Significant progress has also been made with the business case for increasing capacity for diagnostics and treatment so that we can meet the expected rise in demand that will result from the screening programme.

- ***Gender Identity Development Service***

RMCH is working in partnership with Alder Hey Children's Hospital to create and run a 'north hub' of a new national Gender Identity Development Service for Children and Young People. The hub will focus initially on the safe transfer of children and young people who are currently under the care of the provider whose service is being decommissioned. The new service went live on 2 April 2024.

- ***Cardiac services***

On the 8 April, the 5th cardiac theatre successfully transferred from MRI to Wythenshawe. This was achieved as a result of close collaborative working across WTWA, CSS and MRI. Key to the success of this is the move is the implementation of Enhanced Recovery After Surgery (ERAS), which is an expedited pathway for Cardiac Surgery patients. This has now started and further work is in train to optimise the service and deliver the full benefits.

5. Recommendations

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

Agenda 10.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Strategy Officer
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	May 2024
Subject:	MFT Annual Plan 2024/25
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 2024/25 MFT Annual Plan
Contact:	Name: Caroline Davidson, Director of Strategy Tel: 0161 276 6038

1. Introduction

The purpose of this paper is to seek approval from the Board of Directors for the MFT 2024/25 Annual Plan.

The Annual Plan sets out what we intend to do in the coming year in order to deliver our priorities and contribute to those of our key partners. Our priorities are based on the aims and objectives we set out in our MFT Strategy, which have in turn have been shaped by the priorities of NHS England and of our key partners, in particular the Greater Manchester (GM) Integrated Care System (ICS) and Manchester and Trafford Localities.

The plan describes the planning context and the key actions for the Hospitals, MCSs, LCOs and corporate teams in 2024/25. The planning process behind the document involved detailed calculations of the level of activity that we will need to deliver to achieve NHS performance standards, the numbers of staff required to deliver the activity and deliver on our other plans such as our service developments and quality initiatives and the associated financial plan that shows how this can all be achieved within our budget.

Our key plans for the coming year are recovering our core services, in particular tackling waiting lists and times, and making the best use of our resources by increasing our productivity and efficiency. We will also continue to prioritise our workforce and improving their experience of working at MFT through delivering on our commitments in our MFT People Plan.

The MFT Annual Plan (attachment A) summarises the key actions that the Hospital, MCS, LCOs and corporate teams intend to take in 2024/25, formatted to show the contribution that each will make to delivering the Trust's strategic aims.

2. MFT Annual Planning Process 2024/25

A single planning process commenced last summer to produce three outputs:

- MFT Annual Plan 2024/25
- Hospital/Managed Clinical Service/Local Care Organisation/corporate team 2024/25 Annual Plans
- MFT submission to GM ICB for the Greater Manchester 2024/25 Operational Plan.

Key features of the process adopted for the 2024/25 planning round included:

- The development and iteration of planning guidance based on consistent MFT assumptions, draft interim NHS E guidance and final NHS E guidance

- Alignment of the planning process with existing recovery, productivity and improvement work.

- Triangulation of planning across finance, activity and workforce

- Bottom-up capacity plans developed at Hospital/MCS/LCO level for first time based on workforce and adjusted for other constraints such as physical resources.

The MFT final submission to GM ICB setting out our contribution to the Greater Manchester 2024/25 Operational Plan was made on 24 April (activity, workforce and limited financial submission) and 26 April 2024 (full finance submission).

The MFT Annual Plan, which brings together the Hospital, Managed Clinical Service, Local Care Organisation and corporate team Annual Plans is attached at attachment A for approval.

It should be noted that due to the timing of the production of the 2024-25 Annual Plan, feedback on the financial plan has not yet been received from NHSE. Therefore, the financial plan could be subject to change.

3. Monitoring Delivery

Delivery of the plans will be monitored throughout the year through the Accountability Oversight Framework (AOF), a quarterly Annual Plan review and the six-monthly Hospital / Managed Clinical Service / Local Care Organisation Reviews. Risks to delivery will be managed trough the routine risk management processes and the Board Assurance Framework. An in-depth year-end review of the Annual Plan will be undertaken in December and presented to the Council of Governors.

4. Recommendations

The Board of Directors is asked to approve the 2024/25 MFT Annual Plan.

NHS
Manchester University
NHS Foundation Trust

Manchester University NHS Foundation Trust

2024-25 Annual Plan

Where
Excellence
Meets
Compassion

Contents

Introduction

This Annual Plan describes what we are going to do in 2024/25 – how we are going to respond to the immediate challenges facing MFT as well as making progress towards delivering our longer-term mission and strategic aims.

It links closely to the new MFT Organisation Strategy, effectively being the year 1 delivery plan for the strategy.

In 2023/24 we produced, for the first time, a single strategy for MFT that covers everything that we do as an organisation. It is called Where Excellence Meets Compassion and can be found at https://mft.nhs.uk/trust-strategy-2024-29-where-excellence-meets-compassion/

The development of the strategy began in 2023. Following a number of changes since MFT was formed back in 2017 including the Covid pandemic, changes to the way the NHS is organised and the addition of both North Manchester General Hospital and the Trafford Local Care Organisation (LCO) to the MFT family, this felt an opportune time for us to consider what we need to do and how we need to work differently in the future. We wanted a single strategy for our organisation that would help to provide the clarity we need for ourselves, our communities and our partners about what we are trying to achieve and where we will focus our efforts over the next five years.

We worked with our staff, patients and community groups and our partners in the health and care system to think through how, given the challenges that we face and the opportunities that exist, we are going to work differently in order to deliver our mission. Through this process our new strategy Where Excellence Meets Compassion was produced. It was approved by the Board in March 2024.

The strategy is based on our mission to ***work together to improve the health and quality of life of our diverse communities.*** It sets out:

1. Five strategic aims and the difference that we will make in delivering them.
2. Eleven objectives that describe the things that we will do in the coming years to deliver our aims.
3. Specific actions under each objective that we will prioritise as we deliver our strategy.

A graphic summarising the strategy is set out on page 8.

The aims, objectives and actions will shape the work that we do over the next five years as an organisation, both as teams and as individuals and you will see in this document how we plan to take forward each of the aims in 2024/25.

This document also sets out who we are, our mission and aims – what we want to achieve (p7), our values – how we will behave (p10), and the context within which we are operating – the priorities of our partner organisations and how they align with our plans (p13) and the financial environment within which we are operating (p16). The final section describes the arrangement for monitoring and managing delivery of the plan (p42).

Who We Are

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)
Royal Manchester Children's Hospital (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)
Saint Mary's Managed Clinical Service (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 Manchester University Foundation Trust (MFT).

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

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

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

Wythenshawe, Trafford, Withington and Altrincham (WTWA) Hospitals
Wythenshawe is an acute teaching hospital and provides specialist services including cardiac services, heart and lung transplantation, respiratory conditions, breast care services. Trafford Hospital is home to the Manchester Elective Orthopaedic Centre as well as specialist rehabilitation services. Withington and Altrincham hospitals principally provide out-patients services.

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

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

Manchester Local Care Organisation (MLCO)
Manchester Local Care Organisation (MLCO) provides NHS Community Health and Adult Social Care services.

Trafford Local Care Organisation (TLCO)
Trafford Local Care Organisation (TLCO) provides Trafford's NHS Community Health and Adult Social Care services.

Research and Innovation (R&I)
Research and Innovation (R&I) create, develop and trial new innovations, treatments and services for our patients, local communities and the wider population.

Our Mission, Aims and Objectives

Our mission is to work together to improve the health and quality of life of our diverse communities.

Below this are five aims that underpin the achievement of our mission. They describe the outcomes that we want to achieve for our communities, patients and the people we work with over the next five years.

Our aims are ambitious and some will take more time to deliver than others and some will be prioritised over the early years of the strategy (years 1 and 2) and others over years 3 to 5.

To help deliver our aims we have agreed 11 objectives and identified a small number of priority actions under each objective. These actions do not cover everything that we are doing as an organisation, but they will be our areas of focus in the coming years as we believe they will make the biggest difference.

Whilst our objectives and actions refer to specific services and programmes of work, they also provide a framework to guide all our plans across the whole of MFT. Different objectives and actions might be more relevant for some of our teams than others, but everyone across our organisation should see something in the strategy that reflects the important work they do at MFT.

Work with partners to help people live longer, healthier lives

More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way.

We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.

We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place.

Provide high quality, safe care with excellent outcomes and experience

More people recommending MFT as a place to be treated.

We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.

We will strengthen our specialised services and support the adoption of genomics and precision medicine.

We will continue to deliver the benefits that come with our breadth and scale, using our aunique range of services to improve outcomes, address inequalities and deliver value for money.

Be the place where people enjoy working, learning and building a career

More people recommending MFT as a place to work.

We will make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential.

We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.

Ensure value for our patients and communities by making best use of our resources

Make the biggest possible difference with the resources we have by delivering our financial plans.

We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.

We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.

Deliver world-class research & innovation that improves people's lives

More people participating in and benefitting from world-class research and innovation.

We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.

We will apply research and innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide.

Our Values

The way that we 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.

We are **compassionate** | We are **curious** | We are **collaborative** | We are **open and honest** | We are **inclusive**

Because we are compassionate we will…

- Care about people, focusing on the needs of all our patients and staff.
- Reduce our impact on the environment.
- Support local people and the local economy in our role as a large local employer and consumer.

Because we are we are curious we will…

- Use digital technology and other innovations to improve the way we work for patients and our colleagues.
- Use data, insight and evidence to inform the way we deliver services and make decisions.

Because we are collaborative we will…

- Involve patients and our communities in the planning and delivery our services.
- Work together as one team across MFT.
- Work together with partners across Greater Manchester.
- Use our influence locally and nationally to the benefit of our patients, our communities and our partners.

Because we are open and honest we will…

- Listen and respond to feedback from staff, patients, communities and partners.
- Celebrate our successes.
- Be honest about where things can be better and share learning to make improvements.

Because we are always inclusive we will…

- Address health inequalities, ensuring everyone can get the care they need and the best possible outcomes whatever their identity or background.
- Build a diverse workforce at all levels in which everyone can belong, and which reflects the people who use our services, helping us to deliver better care and build trust with our communities.

Context

As part of a wider health and care system it is important that what we do aligns with the aims and objectives of our partner organisations.

The following describes the priorities for NHS England and Greater Manchester Integrated Care System.

NHS England

The overall priority for 2024/25 remains the recovery of core services and productivity following the COVID-19 pandemic. To improve patient outcomes and experience we are required to:

Maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.	**Improve quality and safety and addressing inequalities.**
Improve ambulance response and Accident and Emergency (A&E) waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24.	**Address urgent and emergency care.**
Reduce elective long waits and improve performance against the core cancer and diagnostic standards.	**Improve access – reducing waiting lists and times.**
Make it easier for people to access community and primary care services, particularly general practice and dentistry.	**Improve access to primary and community services.**
Improve access to mental health services so that more people of all ages receive the treatment they need.	**Improve access to mental health services.**
Improve staff experience, retention and attendance.	**Improve staff experience.**
Plan and deliver a balanced net system financial position.	**Improve productivity.**

Context

Greater Manchester Integrated Care System

The Greater Manchester Integrated Care Strategy sets out the plan to improve the health and wellbeing of the population. It sets out 6 missions, 4 outcomes and 10 high-level commitments which are summarised below.

Six 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.

Four 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.

Ten '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.

However, the system is currently facing what is described as a "triple deficit": a financial deficit, a performance deficit and a population health deficit. The deficits will be tackled over the next three years by a longer term sustainability plan.

For 2024/25 the focus will be on:

- Localities driving population health improvement and prevention at scale.
- Providers delivering core standards and planning for activity, workforce, and finance to improve productivity through the NHS operational planning process.
- NHS Greater Manchester (GM) commissioning driving the changes needed.

Alignment with National Health Service England and Greater Manchester

The graphic below shows how the NHSE priorities and the missions of the Greater Manchester integrated care strategy align with our strategic aims.

Finance

The process to agree the financial plan for 2024-25 has been complex this year given the ongoing challenges in Greater Manchester in terms of operational delivery and associated financial position.

Overall, there is little change in the income envelope between this year and last with the tariff uplift and planned Elective Recovery Fund (ERF) overperformance being offset by the efficiency requirement in the tariff.

The implication of this 'flat cash' environment is that high levels of cost reduction through the Value for Patients (VfP) programme are required to achieve the financial plan for 2024-25. The level of non-recurrent delivery in both VfP and other one-off benefits in 2023-24 have resulted in an extremely challenging underlying position going into 2024-25.

It should be noted that due to the timing of the production of the 2024-25 Annual Plan, feedback on the MFT financial plan has not yet been received by NHSE. Therefore, the financial plan could subject to change.

2024-25 Income and Expenditure Plan

The Trust has sought to develop a realistic plan for the entirety of 2024-25 to enable financial governance and control moving into the new financial year.

The plan position is currently for a £16.5m deficit. This is made up of a Trust surplus of £3.6m plus the impact of a technical Private Finance Initiative accounting change which is required nationally and equates to -£20.1m. Discussions are ongoing with NHSE to agree how this should be reflected in the overall financial position.

The plan position has been derived from a combination of top-down and bottom-up work throughout the Trust.

Control Totals have been allocated across the organisation based on the respective Hospital / MCS / LCO / Corporate forecast outturn after adjustments for non-recurrent elements and 2024-25 Value for Patients (VfP) allocation. This is to recognise the financial impacts following the contracting approach moving from PbR, to the payment mechanism adopted under COVID and the current hybrid payment mechanism of a fixed envelope with a partially variable ERF. It also recognises the change in operational requirements and the impact of high inflation levels over the past three years.

Whilst there remain further productivity opportunities across the organisation, it was felt that a focus on historic deficits may very well distract from the work required to develop and implement long term sustainable operational and financial plans. Thus, the approach taken removes the historic deficits and provides a control total that all respective parts of the Trust can recognise and own.

The assumptions set out above result in the Income & Expenditure financial plan for 2024-25, as summarised below. (Note the 2023-24 position is as per pre-audited 2023-24 year end position).

Finance

Extract from Income and Expenditure 2024-25 Plan

I&E Category	2023-24 Pre-Audited Position	2024-25 Plan £'m
Patient Care Income	2,526	2.506
Other Operating Income	286	273
Total Income	**2,811.9**	**2,779.4**
Employee Expenses	(1,719)	(1,674)
Operating expenses excluding employee expenses	(1,074)	(1,135)
Total Expenditure	**(2,793)**	**(2,810)**
Operating Surplus / (Deficit)	**18.49**	**(30.4)**
Total Finance Costs	**(96.58)**	**(58.2)**
Surplus / (Deficit) for the Year	**(78.1)**	**(88.6)**
Adjusting Items		
Impairments	32.3	82.4
Remove capital donations / grants / peppercorn lease I&E impact	0.2	(0.8)
Adjust PFI revenue costs to UK GAAP basis	45.8	(9.5)
Total Adjustments	**78.3**	**72.1**
Adjusted financial performance surplus / (deficit)	**0.2**	**(16.5)**
PFI Accounting Impact		20.1
Adjusted financial performance surplus / (deficit) excluding PFI Accounting Impact	**0.2**	**3.6**

Value for Patients Efficiency Requirement

The overall Trust savings requirement through the Value for Patients programme is £148.0m which represents c5% of total expenditure. Individual Hospitals / MCSs / LCOs / Corporate teams have initially been required to find savings of c.2.5% of their expenditure budgets. This equates to £62m in total. The remaining £86m is to be found from efficiencies related to MFT-wide schemes and is currently being allocated to those areas where there are efficiency opportunities.

Capital Planning 2024-25

The total draft capital programme for MFT for 2024-25 is £122.5m. It is made up of three categories: Public Dividend Capital (PDC) which is cash-backed nationally, International Financial Reporting Standard 16 (IFRS 16) leases which are funded by MFT and Capital Departmental Expenditure Limit (CDEL) which is funded by MFT but must comply with a GM allocated Trust envelope. Within the plan, there is an assumption that £16.2m of PDC funding will be allocated to MFT by NHS England to cover capital costs associated with North Manchester General Hospital following the acquisition in 2021, but this has not yet been confirmed.

Allocation of the GM CDEL and IFRS 16 lease envelopes have been subject to a GM prioritisation process. Currently, GM has not submitted a compliant capital plan and so there is a risk that further changes to the MFT allocations will be proposed.

Significant prioritisation of MFT's internal plan has been required to reach a position complying with the GM envelope requirements, and the mitigations of the risks associated with schemes which have not been prioritised are undergoing regular review.

Summary of 2024-25 Capital Plan

	£'000
CDEL	
GM Envelope	27,600
Assumed PAHT CDEL	16,200
Total GM CDEL Allocation	**43,800**
RAAC Allocation	8,793
Total CDEL Allocation	**52,593**
PDC	
CDC	13,535
NHP	13,964
TIF	6,770
Diagnostics	3,241
PDC Total	**37,510**
IFRS 16 Leases	**31,341**
PFI Capital Charges (UK GAAP)	**1,008**
Total Capital	**122,452**

Finance

2024-25 Cash Flow – Main Assumptions

The Trust's planned cash flow for 2024-25 recognises repayment commitments against existing Department of Health loans and Private Finance Initiative liabilities, and investment in the capital programme. There is an overall cash deterioration of £50.8m to a closing cash position as of the 31st March 2025 of £82.9m. In arriving at this position, we have assumed a £3.6m surplus and that VfP will be achieved resulting in reduced costs, there are no significant working capital movements (other than the release of £20m from the balance sheet to support the position), net operating costs are evenly profiled throughout the year, and capital creditors and impairment are in line with the profile in previous years.

The capital programme requires that PDC cash draw down takes place throughout 2024-25, in relation to the New Hospitals Programme, Community Diagnostics Centre, Targeted Investment Funding (TIF) schemes and Diagnostics schemes.

Extract of Cash Flow Statement for 2024-25 Plan

Movements	2024/25 £m
Opening Cash and Bank 01/04/2023	**133.7**
Operating Deficit	(30.4)
Depreciation	74.5
Impairments	82.4
Movements in Working Capital	(17.8)
Total CDEL Allocation	**108.7**
Asset Purchases	**(139.9)**
PDC Received	**62.5**
Loan Repayments	(11.5)
Lease Repayments	(15.7)
Interest Paid	(38.7)
PFI Repayments	(21.0)
Interest Recieved	4.8
Finance Costs	**(82.1)**
Net Cash Movement	**(50.8)**
Closing Cash and Bank 31/03/2024	**82.9**

Finance

2024-25 Balance Sheet – Main Assumptions

The material movements in the trust balance sheet over the financial year 2024-25 arise from the capital expenditure described above adding c.£144m of asset to the balance sheet, offset by £157m depreciation and impairments of assets. The planned reduction in payables is driven by a reduction in both capital creditors and accruals, with higher capital creditors in April 2024 following expenditure in March forecast to reduce over the year.

Extract of Balance Sheet from 2024-25 Plan

Category	Opening 01/04/2024 £m	Closing 31/03/2025 £m	Movement £m
Tangible and Intangible Assets	1,099.6	1,086.8	(12.8)
Investments	0.8	0.8	0.0
Non-Current Receivables	18.3	18.3	0.0
Non-Current Assets	**1,118.7**	**1,105.9**	**(12.8)**
Inventories	27.6	27.6	0.0
Recievables	142.4	140.9	(1.5)
Non-Current Assets Held for Sale	0.2	0.2	0.0
Cash and Bank	133.7	82.9	(50.8)
Current Assets	**303.9**	**251.6**	**(52.3)**
Payables	(390.9)	(343.8)	47.1
Borrowing	(43.5)	(36.2)	7.3
Provisions and Other Liabilities	(50.7)	(51.7)	(1.0)
Current Liabilities	**(485.1)**	**(431.7)**	**53.4**
Borrowings	(722.7)	(737.2)	(14.5)
Provisions and Other Liabilities	(13.1)	(13.1)	0.0
Non-Current Liabilities	**(735.8)**	**(750.3)**	**(15.5)**
Total Net Assets Employed	**201.7**	**175.5**	**(26.2)**
PDC	537.4	599.9	62.5
Revaluation	184.7	184.7	0.0
I&E Reserve	(520.4)	(609.1)	(88.7)
Total Taxpayers Equity	**201.7**	**175.5**	**(26.2)**

Finance

Key risks to achievement of 2024-25 Plan and mitigations

The plan as set out in this paper carries a significant level of risk. Some mitigations have been identified, and work is ongoing to strengthen and further develop mitigations. The risks and mitigations are summarised in the table below.

Risk	Detail	Mitigations
Value for Patients	Delivery of the required waste reduction programme on a recurrent basis. The scale will require at least containment of staffing costs.	The Value for Patients (VfP) programme has identified some £100m of opportunities for development to date, work continues to identify further schemes. Further pressures will only be agreed when there is funding certainty. Some contributions will inevitably be non-recurrent.
Income	Income assumptions are subject to change as negotiations with commissioners continue.	Ongoing discussions with commissioners to agree a confirmed position with regular review in year to identify any risks and develop mitigations.
Expenditure	The Trust does not have contingency funding ringfenced for in year pressures	Funding for pressures will require prioritisation within existing budgets, or agreement of additional funding from commissioners where appropriate. The position will be reviewed on a monthly basis and mitigations identified.
Cash	It is anticipated cash support could be required in the second half of the year	Cash management group established to maximise cash receipts into the organisations.
Capital	Availability of capital envelope to support the delivery of operational priorities.	Involvement in internal and external capital prioritisation processes from key stakeholders, position reviewed on a monthly basis. Engaging locally and nationally to identify any in year capital funding opportunities and applying where appropriate.
Patient Safety & Experience	Patient safety and experience maintained in context of significant change management / VfP programme.	Quality Impact Assessments will be carried out for all VfP plans as in previous years.

Greater Manchester System Risk

Following a robust and challenging planning process, GM has reached a position where the system has submitted a c.£217m deficit financial plan. This is as a result of 6 of the 9 Trusts and the GM ICB submitting deficit plans (MFT's plan is for a surplus excluding the PFI accounting impact). There is recognition that most Trusts are holding a significant amount of financial risk within plans.

Work is still ongoing to improve this position to a level which is accepted by NHSE. There is a collective responsibility of all organisations in the system to manage financial risk across the system, 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 across the system and ensuring all capacity is being used as efficiently as possible

The individual Trust and system financial risks and mitigations will be managed through the system, with the governance currently being finalised.

Closing Summary

The financial plan for 2024-25 along with its component parts and material risks and mitigations is set out above. The plan submitted is for a £3.6m deficit (excluding the £20.1m impact of the PFI accounting treatment) on a control total basis. To achieve this position, the overall 2024-25 financial delivery challenge faced by the Trust is currently to achieve £148m of Value for Patients efficiency savings and all areas across MFT to operate within their allocated control totals. It is recognised that this is a significant challenge alongside delivering the performance requirements.

The Trust's liquidity position has deteriorated over the last year, and there is a risk that revenue cash support will be required in the second half of the year if there is significant deterioration from the financial plan assumptions. The proposed capital programme for 2024-25 is £122.5m but with a substantially reduced GM envelope allocation in comparison to the MFT internal requirement and a requirement to supplement this with PDC backed capital. Mitigations have been identified for the risks to delivery of the financial plan and will be reviewed and developed on a monthly basis.

Priorities and Plans for 2024/25

Each Hospital, Managed Clinical Services (MCS), Local care Organisation (LCO), and Corporate Area have identified their priority actions for meeting each of the five aims in 2024/25.

Work with partners to help people live longer, healthier lives

We will work together with patients, our communities and our partners – in primary care, localities, Local Authorities, and the Voluntary and Community and Social Enterprise sector for example – to support healthy living in its widest sense and prevent illness in a joined-up way.

Each Hospital, Managed Clinical Service, Local Care Organisation, and corporate area has identified their priority actions for meeting this aim in 2024/25.

North Manchester General Hospital

- We will understand current inequalities and develop plans to address them.
- We will develop collaborative plans with key partners, including non-Manchester localities in our catchment area, and address health inequalities and advance priority areas of integration.
- We will embed improving access & reducing health inequalities as core principles of all service change design.

Manchester Royal Infirmary

- We will lever our strong collaborative partnerships within and outside MFT to improve patient pathways, reduce delays and enhance social value.
- We will implement our transformation plan to make a step change in how we deliver services, digitally enabled and tackling health inequalities and empowering patients.
- We will sustain hospital compliance with the relevant EPRR Core Standards and promotion and engagement in the EPRR strategy.

Manchester Royal Eye Hospital

- We will ensure that MREH is integral in developing a Greater Manchester wide Ophthalmology strategy from community to tertiary services, developing and using tools such as the Primary Eyecare Glaucoma Service.
- We will support the delivery and development of ophthalmic services in East Manchester.
- We will continually collaborate with our ophthalmic partners to provide support for patients with visual impairment.

Wythenshawe, Trafford, Altrincham and Withington Hospitals

- We will embed improving access & reducing health inequalities as core principles of all service change design.
- We will work across the system with partners to implement an expanded targeted lung health screening programme across Greater Manchester.

Clinical & Scientific Services

- We will lead the delivery of the Community Diagnostic Centre Programme on behalf of the Trust.
- We will reduce the environmental impact of CSS services.
- We will reduce health inequalities in CSS service delivery.

University Dental Hospital of Manchester

- We will embrace digital transformation across a range of Dental services, to improve patient experience and reduce costs and meet Trust Net Zero targets.

Royal Manchester Children's Hospital

- We will deliver the NW Women and Childrens Case for Change.
- We will address Children & Young People's Inequalities (CORE20PLUS5).
- We will implement Child and Adolescent Mental Health Services Home and Rapid response crisis teams and integrated pathways to enable timely access to services.
- We will lead the equitable recovery of children waiting for treatment across Greater Manchester.

1

Work with partners to help people live longer, healthier lives

Manchester Local Care Organisation

- We will continue to roll out the data led approach to closing health inequalities in agreed CORE20PLUS5 areas for both adults and Children and Young People (CYP).
- We will support the development of Virtual Wards and delivery of priorities identified though both the Childrens Clinical and Professional Advisory Group and the Manchester Children and Young People's Reform Programme.
- We will support the Long Term Conditions programme in Manchester and identification of improved clinical and professional pathways.
- We will support the redesign thinking around urgent care and discharge pathways with a Home First ethos in partnership with all hospital sites, and include the drive to establish a robust Hospital at Home (H@H) offer.

Trafford Local Care Organisation

- We will work with Primary Care Networks, Public Health and the Voluntary and Community, Faith and Social Enterprise (VCSFE) sector to support the adoption of a Population Health Management methodology.
- We will explore options to enable Community Health and Adult Social Care services to demonstrate how they will contribute to reducing carbon emissions.
- We will, through Neighbourhood Teams, work with communities in our neighbourhoods to deliver targeted approaches to health and care challenges.

Saint Mary's Managed Clinical Service

- We will deliver the Inequalities Action Plan.
- We will deliver programmed activity to support the work of the NHS Race & Health Observatory Learning Action Network.

Corporate Nursing

- We will work with associate directors in Integrated Care Boards to provide assurance around learning and involvement.
- We will continue to support net zero carbon plan through the gloves off campaign.

Group Digital Services

- We will integrate with a range of databases in order to exploit, and contribute to, broader care records (e.g. Greater Manchester care record, Local Healthcare and Care Record Exemplars platform).
- We will collaborate with partners, Manchester City Council and the voluntary sector to ensure digital solutions are tailored to the needs of our regional population and support the Greater Manchester Digital Inclusion ambitions.
- We will establish health inequalities as a data science "pillar" in the clinical data science unit with collaborations with University of Manchester, Manchester City Council, and Manchester Metropolitan University.

Estates and Facilities

- We will support the Trust's Climate Emergency Response Board to lead the Green Plan priorities including a 10% year on year reduction in our carbon footprint.
- We will introduce Sustainability Impact Assessments.
- We will deliver the North Manchester General Hospital masterplan development including the wellbeing hub.

1

Work with partners to help people live longer, healthier lives

Medical Directors

- We will work collaboratively with Manchester and Trafford Councils to deliver the Health Inequalities programme, including further development of the Health Inequalities dashboard to enable informed and effective decision-making.
- We will build on wellbeing pilots to continue to develop our understanding of the characteristics and location of patients who fail to take up their screening opportunities, including joint work at Primary Care Network level and with faith / ethnic groups.
- We will continue primary / secondary care interface work with Manchester & Trafford GPs, to reduce delays for patients and optimise pathways.

Research and Innovation

- We will support our commercial strategic partners to co-create research and innovation solutions to health needs.
- We will enter into one new commercial strategic partnership per year.
- We will attract optimum partners to co-locate, especially in the family of CityLabs developments on site.
- We will have regular communication with University of Manchester, Health Innovation Manchester and Greater Manchester, Integrated Care System for GM and the wider health ecosystem in the region.
- We will link with other Trusts using the EPIC electronic patient record .
- We will maintain our position in the top 5 nationally for recruitment to clinical trials (1st nationally in 2022-23).

Group Strategy

- We will co-ordinate work across MFT on our role as an anchor institution.

Chief Delivery Officer Team

- We will support the reduction in health inequalities.

Finance and Procurement

- We will work closely with Greater Manchester trusts,Greater Manchester ICB and Northwest partners to support with financial sustainability both locally and to the wider health economy.
- We will engage with both local and national groups to support the development of finance and procurement national initiatives, digitalisation, future strategy, and workforce.

2

Provide high quality, safe care with excellent outcomes and experience

We will engage our communities and patients in the planning and delivery of our services, finding new ways of delivering equitable, safe, high-quality care. We will take pride in delivering excellent local and specialised services, organising ourselves so that we can provide the best possible care across the whole of MFT to address health inequalities.

Each Hospital, Managed Clinical Service, Local Care Organisation, and corporate area has identified their priority actions for meeting this aim in 2024/25

North Manchester General Hospital

- We will focus on recovery and improvement including reducing 52 week waits, national priorities & ensuring clinical prioritisation.
- We will deliver the remaining complex service disaggregation to agreed timescales in partnership with Northern Care Alliance and MFT colleagues and support the formation and stabilisation of single services led by Managed Clinical Services.
- We will deliver patient safety initiatives to decrease harm.
- We will ensure that all patients have a clearly documented "Responsible Clinician" throughout their Hospital inpatient admission and that we meet the 7-day standards for emergency admission assessment.
- We will oversee the workplan and key performance metrics for patients who are vulnerable. The What Matters To Me data themes will be reviewed and a patient experience improvement program will be developed. Themes from the National Inpatient survey will be analysed to ensure work programs are aligned to feedback from the survey.

Manchester Royal Infirmary

- We will use systematic processes for safety and improvement, gathering and acting on insights, with a focus on:
  > infection prevention and control
  > Emergency Department patient safety & experience
  > responding to patients' mental health needs
  > renal dialysis capacity
  > timely revascularization treatment pathways
  > systematic use of insights to reduce the impact of human factors on safety.
- We will deliver safe and effective patient pathways with a focus on reducing waiting times, improving discharge processes and delivering constitutional standards.
- We will enhance patient experience and involvement ensuring the patient and family voice is heard with specific focus on: Pain Management, Communication, Food.
- We will deliver the expected Care Quality Commission quality standards for a Well Led organization.
- We will develop our centres of excellence and networks in vascular, renal, haematology, liver medicine, major trauma and colorectal surgery to ensure optimal care for patients across Greater Manchester and beyond.

Manchester Royal Eye Hospital

- We will deliver a robust Eye Emergency Department at Manchester Royal Eye Hospital.
- We will improve access to reduce the number of long waiting patients, especially for Follow Up appointments.
- We will ensure safe effective care delivery – Patient Safety Incident Response Plan & Barcode Medication Administration (BCMA).
- We will safely address equipment obsolescence.
- We will ensure our services are accessible for all and communicate with our patients in a way that all can understand.
- We will ensure continuous quality improvement is embedded in our services.
- We will support the sustainability of Ophthalmic services across Greater Manchester through standardised pathways and single point of referral for cataracts.

2

Provide high quality, safe care with excellent outcomes and experience

Wythenshawe, Trafford, Altrincham and Withington Hospitals

- We will embed the Safety Differently / Patient Safety Incident Response Framework.
- We will utilise learning and share best practice to reduce avoidable healthcare acquired infections.
- We will improve waiting times for elective care.
- We will deliver the patient experience agenda through improvement approaches grounded in the 'What Matters To Me' framework.
- We will deliver the agreed cardiac surgery strategy.

Clinical & Scientific Services

- We will embed the Patient Safety Incident Response Framework.
- We will improve patient experience through targeted projects identified through patient engagement.
- We will continue to improve turnaround times for diagnostic services in Imaging and Histopathology to meet trajectories for delivery of national targets.
- We will expand the National Breast Imaging Academy.
- We will improve patient safety and quality by identifying unwarranted variance and developing targeted improvement projects, embedding a Quality Improvement approach within services.

University Dental Hospital of Manchester

- We will ensure safe effective care delivery – Patient Safety Incident Response Framework compliance (through Clinical Effectiveness).
- We will ensure our services are accessible by all and communicate with our patients in a way that all can understand.
- We will capture and utilise patient feedback to provide patients the opportunity to comment on care provision and quality.
- We will ensure continuous quality improvement is embedded in our services.

Royal Manchester Children's Hospital

- We will embed shared learning, oversight and insight processes across RMCH managed clinical service, in the Patient Safety Incident Response Plan.
- We will implement patient and public involvement and engagement strategy.
- We will embed "Speak to Sister" and "Chat to Charge Nurse" – empowering families to raise concerns.
- We will implement HIVE documentation relating to reasonable adjustments for neurodiversity.
- We will implement mealtime standards for children and young people.

Manchester Local Care Organisation

- We will implement the Patient Safety Incident Response Framework in the Local Care Organisation.
- We will lead the design of a MFT Sickle Cell, Thalassemia and Rare Anaemia service strategy.
- We will design and mobilise an integrated Learning Disability service model through an aligned commissioning and service plan.

Trafford Local Care Organisation

- We will implement the Patient Safety Incident Response Framework in the Local Care Organisation.
- We will work with partners to develop an action plan in response to areas identified during the Trafford special educational needs and disabilities (SEND) inspection.

2

Provide high quality, safe care with excellent outcomes and experience

Saint Mary's Managed Clinical Service

- We will progress in line with the action plan on implementing the three-year delivery plan for maternity and neonatal services.
- We will achieve UKAS accreditation for the Sexual Assault Referral Centre.
- We will improve access for patients and delivery of national planning maximum waiting time standards.
- We will ensure induction of labour pathway enables women to be transferred to the Delivery Unit within 24 hours. No women waiting over 48 hours.
- We will develop ctDNA testing capabilities.
- We will attend the Sexual Assault Referral Centre (SARC) Annual Conference.
- We will deliver the Genome England Newborn Screening Project.

Corporate Nursing

- We will deliver improvement plans that maintain regulatory compliance.
- We will oversee and assure performance on healthcare acquired infections.
- We will monitor and assure performance on safety metrics within the Integrated Performance Report.
- We will oversee improvements in the care of patients with Mental Health Illness.
- We will undertake What Matters to Me program and surveys consistently with patient overall satisfaction with quality of service over 85%.
- We will launch the Nursing Midwives and Allied Health Professionals strategy.
- We will optimize Patient experience by using Quality Impact Assessments during transformation and service change.

Group Digital Services

- We will accelerate change management capabilities to achieve a cultural shift to new digital ways of working.
- We will put governance in place to ensure focus on key Hive Stabilisation priorities and transition to optimisation priorities.

Estates and Facilities

- We will prioritise the backlog programme against reduced capital allocation.
- We will review and update existing Estates and Facilities safety systems policies and plans with the aim of developing user friendly guidance documents / protocols for wider Estates and Facilities Divisional Team.
- We will deliver a flexible and responsive estate, able to deliver against service delivery strategies - Re-establish a group wide digitally supported Space Utilisation Committee collaboratively with key stakeholders.
- We will ensure excellence in capital delivery across all sites, regardless of delivery model.
- We will ensure operational excellence in delivery of Facilities Management services at each site.
- We will develop a Facilities Management Strategy incorporating National Standards of Healthcare Cleanliness and National Standards of Healthcare Food and Drink.

Medical Directors

- We will develop a strategy for future use of robotic assisted surgery including platforms, training and Research & Innovation.
- We will deploy intelligent triage of Patient Treatment Listsbased on risk factors from Harm Reviews.

2

Provide high quality, safe care with excellent outcomes and experience

Research and Innovation

- We will expand the Clinical Research Facility to North Manchester General Hospital.
- We will have 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.
- We will advance the setup of the new Eye Research Centre.
- We will advance access to research imaging, especially in the Children's Hospital.
- We will transition into and operate the North West Regional Research Delivery Network of the National Institute of Health and Care Research.
- We will implement a new five-year R&I strategy from 01/04/24.

Clinical Governance

- We will continue to implement the NHS Patient Safety Strategy, including Patient Safety Incident Response Framework, across the Trust.
- We will continue to strengthen our approach to learning from deaths.
- We will focus on Waiting Safely.
- We will strengthen our approach to quality oversight and assurance.
- We will improve the patient experience of legal processes, including inquests.
- We will improve the engagement of patients and families in response to incidents.

Group Strategy

- We will oversee delivery of the MFT strategy and annual plans.
- We will lead the development and delivery of single service/site optimisation plans.
- We will deliver the final phase of North Manchester General Hospital disaggregation and integration.

Chief Delivery Officer Team

- We will support safe delivery of operational performance and quality standards.
- We will continue with support to embed HIVE to drive clinical and operational change.
- We will support delivery of operational performance and quality standards using robust data to inform our decision making.
- We will support the reduction of unwarranted variation across the system.
- We will support in the development of robust plans – i.e. Annual, Improvement, recovery, finance and resilience plans.
- We will apply rigorous improvement science to inform and guide improvement.

Finance and Procurement

- We will ensure funding is made available to support patient safety priorities.
- We will deliver the best finance and procurement service possible to support frontline services focus on patient care.
- We will be mindful of the impact on patients in financial decision making and reporting.
- We will support the organisation through change with good quality financial information and analysis.
- We will support the reconfiguration and alignment of services under the Managed Single Service and site optimisation programmes.

3

Be the place where people enjoy working, learning and building a career

We will listen to our colleagues and make sure they feel supported by acting on their feedback. We will embrace diversity and strive for inclusion so that all our communities can trust us and everyone feels that they can truly belong at MFT. We will offer people different ways to start and develop their career with us.

Each Hospital, Managed Clinical Service, Local Care Organisation, and corporate area has identified their priority actions for meeting this aim in 2024/25.

North Manchester General Hospital

- We will develop and deliver a range of initiatives to support our staff through delivery of the NHS Long Term Workforce Plan.
- We will create a vibrant & inclusive culture that builds on the identity of North Manchester to improve the delivery of NMGH and MFT People Plans.

Manchester Royal Infirmary

- We will optimise our leadership at all four levels through clarity of expectations and behaviours across MFT with targeted leadership and talent development programmes.
- We will strengthen local engagement at team level, embedding inclusive leadership practice as a responsibility for all leaders, creating a climate of belonging to embrace difference and ensure well being.
- We will use insight from trauma informed care, create an environment of civility for our staff, enforcing zero tolerance of violence and aggression.
- We will focus on a differentiated risk-based approach to workforce key performance indicators targeting clinical service units / staff groups most at risk.

Manchester Royal Eye Hospital

- We will support the culture work programme within the Hospitals and enable the change agents to deliver / train and develop.
- We will review Equality Diversity and Inclusion and develop key actions and activities to promote and embed this approach.
- We will review the process for the recruitment and retention of staff across all staff groups, including the approach to attraction.
- We will maximise the opportunities to Train, Retain and Evolve our workforce, including a focus on the outcomes from the General Medical Council Survey.

Wythenshawe, Trafford, Altrincham and Withington Hospitals

- We will build the capacity and capability of our diverse workforce.
- We will maintain a focus on attendance management underpinned by health & wellbeing initiatives.

Clinical & Scientific Services

- We will ensure the delivery of the CSS People Plan priorities.
- We will continue to develop CSS leaders and enhance support for managers.
- We will develop a workforce pipeline for specific areas of concern.
- We will create opportunities for local recruitment and access to careers for local residents and those who may be excluded from healthcare careers through traditional training routes.

University Dental Hospital of Manchester

- We will support the culture work programme within the Hospitals and enable the change agents to deliver / train and develop.
- We will review the Equality, Diversity and Inclusion approach and develop key actions and activities to promote and embed this approach.

3

Be the place where people enjoy working, learning and building a career

- We will uphold the values and behaviours of the Trust and demonstrate compassionate leadership in the work that we all undertake.
- We will ensure that the appropriately trained staff are in post via dental training opportunities.

Royal Manchester Children's Hospital

- We will support the MFT Culture Programme with RMCH Managed Clinical Service and enable change agents to train and deliver the programme.
- We will review the Equality, Diversity and Inclusion approach across RMCH Managed Clinical Service and develop key actions and activities to promote and embed this approach.
- We will model the way and uphold the MFT Values and Behaviours demonstrating compassionate leadership across RMCH Managed Clinical Service.

Manchester Local Care Organisation

- We will work with Manchester City Council to promote employment and career development opportunities in Manchester Local Care Organisation and to ensure a proactive approach is taken to filling.
- We will work with Manchester City Council Business Intelligence teams to develop data analysis to improve understanding of drivers of staff turnover and to promote employment support offers to help reduce avoidable turnover.
- We will Deliver our Operational Development Plan to reinforce strengths-based leadership and improve staff engagement, including embedding the refreshed 'A Different Conversation' Appraisal Framework and delivering the Freedom to Lead 2024 event.

Trafford Local Care Organisation

- We will work with Trafford Council Resourcing Teams to promote employment and career development opportunities in Trafford Local Care Organisation to ensure a proactive approach is taken to filling vacancies.
- We will work with Trafford Council Business Intelligence teams to develop data analysis to improve understanding of drivers of staff turnover and to promote employment support offers to help reduce avoidable turnover.
- We will deliver our Operational Development Plan to reinforce strengths-based leadership and improve staff engagement, including embedding the refreshed 'A Different Conversation' Appraisal Framework and delivering the Freedom to Lead 2024 event.

Saint Mary's Managed Clinical Service

- We will deliver against the key themes of Saint Mary's People Plan.
- We will provide strong leadership which delivers an inclusive and compassionate culture.
- We will drive improvements in Staff Engagement, Recognition and Experience.

Corporate Nursing

- We will provide visible Nursing Midwifery and Allied Health Professionals leadership culture across all sites and services.
- We will develop opportunities for professional development through national Continuous Professional Development funding streams.
- We will support Hospitals and Managed Clinical Services around workforce redevelopment.

Group Digital Services

- We will implement the Group Informatics Management of Change to drive enhanced service delivery while continuing to develop the skills and knowledge of our staff with the aim of improving retention and attracting talent.
- We will adopt the principles of co-production through 'User-centred' design throughout the service life-cycle to develop products / services in agile and inclusive ways while piloting throughout with patients and carers.
- We will agree and deliver a Hive Training Plan: Strategy.
- We will develop a digitally advanced and empowered workforce through high quality training for our staff while finding new ways to attract new digital talent.

3

Be the place where people enjoy working, learning and building a career

Medical Directors

- We will undertake Medical Engagement Scale baseline survey followed by medical engagement work programme.
- We will have a joined-up approach with Hospitals and Managed Clinical Services and junior doctor recruitment to address gaps and reduce bank and agency spend.
- We will develop and deliver the strategy attract and retain locally employed and Specialist, Associate Specialist and Specialty Doctors doctors, aligned to the MFT careers hub.
- We will work with Hospitals and Managed Clinical Services to reduce temporary staffing spend, including through effective recruitment strategies.

Research and Innovation

- We will continue to deliver staff engagement and equality, diversity and inclusion initiatives which show Research and Innovation at the top of staff survey responses.
- We will combine Research and Innovation assets and resources into a new staff training strategy with the leadership to deliver it.
- We will review systems to support Nursing Midwifery, Allied Health Professionalss in Research & Innovation from our recruitment strategy to the support provided to those pursuing Research & Innovation careers.

Workforce

- We will review and refresh MFT People Plan in line with the NHS Long Term Workforce Plan and Equality Diversity and Inclusion High Impact publication.
- We will review and promote wellbeing education and initiatives to support staff health and reduce absence as outlined in the Wellbeing Strategy.
- We will develop long term workforce gap analysis as part of MFT refreshed planning process to determine the size and shape of our future workforce, and provide a framework for resourcing and educational commissioning requirements.

Clinical Governance

- We will continue to develop the Legal Services Team.
- We will review patient safety team structure.

Chief Delivery Officer Team

- We will use performance reporting and data to inform workforce change.
- We will provide values based leadership and subject matter expertise.
- We will drive collaborative leadership strategies.
- We will encourage and support sharing practice and learning.
- We will support teams to use improvement methods to improve staff experience.

Finance and Procurement

- We will support the future workforce through finance apprenticeships and development roles.
- We will ensure everyone in the finance team has a good quality and timely appraisal, with support for individual career aspirations.
- We will work to maintain level 2 Future-Focused Finance accreditation.
- We will support non-finance colleagues in their understanding of the finance agenda through Finance and Clinical Educator excellence.
- We will continue on the success of our bi-annual finance team away days to focus on strategic priorities and health and wellbeing.

4

Ensure value for our patients and communities by making the best use of our resources

We will make the biggest possible difference to people's lives as one of the most productive NHS providers, finding ways to continually improve our services. We will deliver on our financial plans, making the best use of our people's time, technology and our buildings.

Each Hospital, Managed Clinical Service, Local Care Organisation, and corporate area has identified their priority actions for meeting this aim in 2024/25.

North Manchester General Hospital

- We will deliver our allocated Control Total.
- We will deliver the Value for Patients programme with a continued focus on value-based healthcare, including HIVE related benefits and reducing health inequalities.
- We will embed services within the agreed financial envelope and deliver expected efficiencies.
- We will work effectively with the Hive team and keep practitioners to improve and develop working practice and clinical opportunities.
- We will introduce Tracking – which will reduce reliance on disposable products /improve material management in Ophthalmology theatres.

Manchester Royal Infirmary

- We will use our robust performance framework to ensure the best use of our resources, optimizing productivity and utilisation.
- We will decompress our bed base to ensure clinical and operational resilience of our services and sustain an effective balance between emergency / urgent / escalated and planned service demands.
- We will safely move into the first phases of our Project RED and theatres capital developments effectively managing the operational impacts.

Manchester Royal Eye Hospital

- We will address the underlying deficit through cost reduction.
- We will support digital workflows by integrating all imaging modalities into the Ophthalmology Picture Archiving and Communication System and reducing download times for images, to increase patient throughput.
- We will embrace digital transformation to improve patient experience and reduce costs and meet Trust Net Zero targets.

Wythenshawe, Trafford, Altrincham and Withington Hospitals

- We will support front line services to effectively manage their financial resources.
- We will maintain a robust financial controls environment to demonstrate grip and control.

Clinical & Scientific Services

- We will deliver CSS wide Value for Patients programme.
- We will deliver the Imaging Transformation programme, following the outputs of an efficiency review.

University Dental Hospital of Manchester

- We will start to address the underlying deficit through identifying opportunities to reduce costs.
- We will support financial savings with investment to deliver transformative digital workflows.
- We will safely address equipment obsolescence and replacement.
- We will reduce reliance on disposable products and plastic waste, use of precious metals.

4

Ensure value for our patients and communities by making the best use of our resources

Royal Manchester Children's Hospital

- We will deliver our Transformation, productivity and achieving value programme using HIVE to standardise RMCH Managed Clinical Service wide working across urgent, elective, outpatient, Child and Adolescent Mental Health Services, complex discharge care and length of stay.
- We will deliver MFT Value for Patients programme and control total across RMCH Managed Clinical Service.
- We will deliver intraoperative Magnetic Resonance Imaging / Paediatric Emergency Department stage 2 full business case for approval and mobilisation.

Manchester Local Care Organisation

- We will deliver our Control Total inc. agreed Value For Patients plans.
- We will develop a future plan for community services estates.
- We will refresh the Section 75 agreement between MFT and Manchester City Council.
- We will continue to implement the Community Health Transformation Programme delivering a core standardised Community Health service and pathways based on understanding of need.
- We will develop and deliver a digital improvement and transformation plan.

Trafford Local Care Organisation

- We will deliver our Control Total inc. agreed Value For Patients plans.
- We will develop a future plan for community services estates.
- We will refresh the Section 75 agreement between MFT and Trafford Council.
- We will continue to implement the Community Health Transformation Programme delivering a core standardised Community Health service and pathways based on understanding of need.
- We will develop and deliver a digital improvement and transformation plan.

Saint Mary's Managed Clinical Service

- We will ensure the delivery of Value for Patients.
- We will ensure the Hive Benefits Realisation supports Transformation.
- We will ensure the spending control and delivery of services is in line with the control total.
- We will explore future options for the Department of Reproductive Medicine services.

Corporate Nursing

- We will support Value for Patients program with delivery of agreed targets.
- We will maintain oversight and control of Nursing Midwifery and Allied Health Professional pay rates across the organisation.
- We will further align digital opportunities to support patient experience.

Group Digital Services

- We will optimise the way our digital services are delivered including workforce and resources.
- We will lead the decommissioning of legacy systems across MFT to support the realisation of Hive Business Case benefits and delivery of Value for Patients targets.
- We will ensure there are processes in place to monitor, track and oversee financial and non-financial benefits in the HIVE business case.
- We will work with Blood Transfusion to oversee implementation of a new Laboratory Information System and associated pathways.
- We will ensure there is a robust plan in place to maximise use of MyMFT.
- We will work with community services to agree future plans for a community electronic patient record.

4

Ensure value for our patients and communities by making the best use of our resources

Estates and Facilities

- We will create a group wide Estates & Facilities Commercial Strategy.
- We will formalise the approach to ensuring best use of our estate and the governance to oversee a strategic estates masterplan.
- We will be excellent in contract management, with a specific focus on management of the two Private Finance Initiative contracts.
- We will ensure delivery of Citylabs 4.0 at the Oxford Road Campus.

Medical Directors

- We will optimise use of Hive to help deliver business case benefits.
- We will continue to develop a consistent approach to implementing Getting It Right First Time principles and recommendations across key single services, overseen by a monthly programme board including High Volume Low Complexity surgical specialties (ENT, General Surgery, Urology, T & O, Gynae and Ophthalmology).
- We will implement job planning approach and policy, including agreed action plan to improve productivity and efficiency.
- We will support the further development and utilization of the Trafford Elective Hub.

Research and Innovation

- We will implement single process across all MFT to manage research income from Principal Investigator activity in projects, replacing legacy Trust arrangements, and rationalise / automate further processes.

Clinical Governance

- We will reduce unwarranted legal spend.

Chief Delivery Officer Team

- We will drive the process to support the delivery cashable and productivity benefits through Value for Patients by using Improvement methods and approach
- We will support the process to maximise delivery of Hive benefits and operational sustainability.
- We will support workforce sustainability programmes to use robust data and improvement methods to improve retention of staff and reduction of temporary staffing, where clinically appropriate.
- We will progress benchmarking and opportunity analysis to ensure we fully and effectively utilise our resources.

Finance and Procurement

- We will support operational and clinical teams to deliver services within budgets.
- We will ensure decision making is supported by appropriate governance and robust financial control
- We will ensure Hospitals control totals are delivered and allow the trust to achieve its overarching financial plan.
- We will improve efficiency in the finance and procurement function through automation.
- We will support the application of capital grants to deliver environmental sustainability.

5

Deliver world-class research and innovation that improves people's lives

We will work with our diverse communities and our teams to make sure that research and innovation helps us to address the challenges that we face, and that we improve the diversity of those involved. We will make it easier for colleagues to take part, with more people leading research and exploring careers as clinical academics. We will apply the research, innovation and technology that we do to improve the services that we deliver.

Each Hospital, Managed Clinical Service, Local Care Organisation, and corporate area has identified their priority actions for meeting this aim in 2024/25.

North Manchester General Hospital

- We will develop and appoint new academic posts across different professions at NMGH.
- We will align the NMGH Research, Discovery and Innovation plan for 2022-25 with the MFT plan: Focus on widening participation and engagement across all staff group.

Manchester Royal Infirmary

- We will enhance development opportunities in research and innovation for our staff.

Manchester Royal Eye Hospital

- We will create a Research Hub at Manchester Royal Eye Hospital with access to imaging and appropriate support staff to expand the number of clinical trials undertaken.
- We will develop, research and audit an active Nursing and Midwifery and Allied Health Professionals workforce in line with the research strategy.

Wythenshawe, Trafford, Altrincham and Withington Hospitals

- We will work to establish a framework to support our investigators with the time, space and infrastructure to deliver high quality research.
- We will increase Nursing Midwifery and Allied Health Professional research awareness and promote capacity building opportunities to embed research in practice.

Clinical & Scientific Services

- We will work collaboratively with the Research department to create capacity in CSS services to support research and reduce backlogs.
- We will support the development of the Nursing, Midwifery and Health Professions research strategy.
- We will explore and embed innovative new technologies and Artificial Intelligence into services.

University Dental Hospital of Manchester

- We will work effectively with the Hive team and key practitioners to improve and develop working practice and clinical opportunities.
- We will enable integration across all Dental / Oral & Maxillo Facila Surgery labs and development of 3-D printing.

Royal Manchester Children's Hospital

- We will deliver Children's Research 2025 and Kidsdigilabz programme for 2023-25.
- We will deliver the hosting and pipeline of research and commissioned services for Advanced Therapies.

5

Deliver world-class research and innovation that improves people's lives

Manchester Local Care Organisation

- We will develop relationships and work programmes with Manchester Metropolitan University to look at evaluation of neighbourhood working and prevention strategies across the Local Care Organisation.
- We will continue to promote the Local Care Organisations research champions forum and | raise the profile of research across Local Care Organisations teams.

Trafford Local Care Organisation

- We will develop relationships and work programmes with Manchester Metropolitan University to look at evaluation of neighbourhood working and prevention strategies across the Local Care Organisations.
- We will continue to promote the Local Care Organisations research champions forum and raise the profile of research across Local Care Organisations teams.

Saint Mary's Managed Clinical Service

- We will establish the Research and Innovation Forum.
- We will ensure that Sexual Assault Referral Centres maintains a prominent position nationally, at the forefront of the sexual violence research agenda.

Corporate Nursing

- We will further develop Nursing, Midwifery and Allied Health Professions clinical academic activity through Manchester Clinical academic centre.
- We will support grant applications to support Nursing, Midwifery and Allied Health Professions research.
- We will align research knowledge and activity into the key objectives of the Nursing, Midwifery and Health Professions workforce.

Group Digital Services

- We will build, certify (ISO 270001) and accredit MFT's Trusted Research Environment for digital innovation and research.

Medical Directors

- We will launch the new five-year Research and Innovation strategy in April 2024.

Research and Innovation

- We will acquire and develop existing space for dedicated clinical research delivery.
- We will acquire new major items of research equipment.
- We will fully operate new physical assets including the Research Van and the Anti-Microbial Resistance Research Laboratory.

Group Strategy

- We will co-ordinate the relationship with Health Innovation Manchester.

Finance and Procurement

- We will implement a new financial ledger to improve processes and efficiency throughout the finance function.

Monitoring and Managing Delivery

Delivery of the plan will be monitored in the following ways:

Accountability Oversight Framework (AOF) – the Accountability Oversight Framework is the way in which MFT ensures that the constituent Hospitals, Managed Clinical Services and Local Care Organisations are delivering on their plans so that at Group level we are achieving our MFT targets. Key metrics are distilled from the Hospital / Managed Clinical Services / Local Care Organisations Annual Plans and form the basis of the Accountability Oversight Framework. 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.

Quarterly Review – a review of progress in the delivery of all aspects of the Hospital / Managed Clinical Services / Local Care Organisations and MFT plans is undertaken on a quarterly basis. This is a more in-depth review of the delivery of all of the actions within the annual plans to ensure that they are producing the planned outcomes. Where they are not, plans are reviewed and refreshed.

Annual Review – a year-end review of the Annual Plan is undertaken in December to assess how Hospitals, Managed Clinical Services, Local Care Organisations and corporate departments delivery of their plans Performance in December is used to project year end performance and the outcome of the assessment is presented to the Council of Governors. This forms the basis of the 'look back' that is undertaken with the Governors in preparation for planning for the next year.

Other ways in which the plans are monitored include:

Performance Review – a review of performance of the Hospitals / Managed Clinical Services / Local Care Organisations, including the delivery of their plans takes place twice a year between the Executive Director Team and the senior leadership team from each Hospital / Managed Clinical Service/ Local Care Organisation.

Board Assurance Report – The Board Assurance Report monitors the risks around the delivery of our strategic aims and objectives at Group level. It is presented at each formal meeting of the Board of Directors.

Glossary

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
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
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
VfP	Value for Patients
WTWA	Wythenshawe, Trafford, Withington & Altrincham

Agenda Item 11.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Dr Beverley Fearnley, Group Director of Clinical Governance
Date of paper:	May 2024
Subject:	Paediatric Audiology Services - CQC enquiry response
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:	Providing high quality, safe care with excellent outcomes and experience
Recommendations:	The Board of Directors are asked to approve the information included in this report before sharing with the CQC as required.
Contact:	Name: Dr Beverley Fearnley, Group Director of Clinical Governance Tel: 0161 276 4512

1. Background

A CQC enquiry (see appendix 1) was received by Manchester University NHS Foundation Trust (MFT) on 8th April 2024 requesting that the organisation provide Board assurance with respect to the provision of Paediatric Audiology Services across MFT and confirmation of the services' United Kingdom Accreditation Service (UKAS) Improving Quality in Physiological Services (IQIPS) accreditation status.

UKAS is the accreditation body for the United Kingdom appointed by the government to assess services against agreed standards. Accreditation is the independent verification that an organisation is competent to provide services such that the users have confidence in the outcomes. IQIPS is not yet mandated.

MFT has four Paediatric Audiology Services managed across three hospital sites / managed clinical services / the LCO:

i. Manchester Royal Infirmary (MRI): Paediatric Audiology Services at MRI (Peter Mount building), Royal Manchester Children's Hospital, Trafford Hospital and Altrincham Hospital
ii. Clinical Scientific Services (CSS): North Manchester Paediatric Audiology Services (at North Manchester General Hospital) and South Manchester Paediatric Audiology (at Withington Hospital)
iii. Local Care Organisation (LCO): Community Audiology

These sites were asked to use a standard template to provide an update for CQC and that is described in the following sections. Evidence mentioned in the detailed responses has not been included in this report but will be provided in the response to the CQC**.**

2. Summary Position

The trust has four has Paediatric Audiology Services, delivered across three hospital sites / managed clinical services / the LCO. Of those:

- Two have UKAS IQIPS accreditation status (MRI and South Manchester CSS)
- Two are working towards UKAS accreditation status, with the intention to apply for this in early 2025 (North Manchester CSS and the LCO)

3. Detailed response - Manchester Royal Infirmary

The MRI managed Paediatric Audiology Services sits within the Head and Neck Clinical Service Unit (CSU). The scope of the service includes hearing assessments, hearing aid fitting and management and speech testing for all ages 0-18 years. In addition, complex paediatric audiology includes hearing assessments of newborns referred for newborn hearing screening (ABR). This service covers all paediatric patient pathways for 0–18 year olds.

The MRI managed paediatric audiology service has provided the following responses to the questions asked by the CQC in their letter of 8th April 2024:

1. Has the service achieved IQIPS accreditation, include if there were any improvement recommendations made?	Yes: The service received confirmation of their maintained accreditation status from UKAS on 12th December 2023. This accreditation status is valid until 28th February 2025. The next planned visit is September 2024 (no specific date confirmed). The last UKAS accreditation visit advised on 3 mandatory findings – the first two findings relating to adults specifically so do not apply to the MRI managed Paediatric Service. The third finding was a departmental wide finding in relation to logging of non-conformities and was responded to as required with the relevant updated Nonconformity SOP (included in the CQC evidence bundle). The confirmation of accreditation, dated 12th December 2023, advised that all the improvement of actions/proposals raised from the visit had been cleared or accepted and there were no outstanding actions relating to the assessment and therefore the service accreditation was maintained. The MRI accreditation documentation is enclosed within the appendix of this this briefing and includes: • UKAS Maintenance of Accreditation confirmation – 12th December 2024 • UKAS Assessor feedback on improvement actions – 12th December 2024 •
2. Is the service registered for IQIPS?	Yes, as detailed above
3. Is Service working towards IQIPS accreditation?	N/A – Accredited service
4. What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about?	N/A – Accredited service
5. The expected timeline for gaining accreditation?	N/A – Accredited service

6. The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.?	The MRI service has not had any incidents relating to patients of the service who have suffered detriment due to missed diagnosis.
7. If service is not UKAS IQIPS accredited, • **The Service should provide an external evidence-based assessment of their provision, to be included in the assessment report when responding to CQC**	N/A – Accredited service

4. Detailed response - Clinical Scientific Services (CSS)

Audiology services at North Manchester General Hospital (NMGH) and Withington Community Hospital (WCH) / Wythenshawe Hospital (WH) sit in the Division of Allied Health Professions (AHPs), within Clinical & Scientific Services (CSS) a managed clinical service (MCS) at MFT. Both Audiology Teams are working together to harmonise Standard Operating Processes (SOPs) to improve communication and the standard of care provided. This standardised approach was introduced based on best practice to prevent variation in care across Adult and Paediatric Audiology Services

The Paediatric Audiology Service at NMGH provides full Paediatric Audiological assessment and Rehabilitation from Newborn (referred from the Newborn Hearing Screen Programme (NHSP) to 18 years of age. This includes Bone Anchored Hearing Aid (BAHA) service and Paediatric to Adult transition service. The Audiology Department is based in NMGH. Clinics are offered at NMGH Audiology Department, Newton Heath Health Centre, Woodville Health Centre, and Harpurhey Health Centre.

North Manchester Responses

1. Has the service achieved IQIPS accreditation, include if there were any improvement recommendations made?	The North Audiology Paediatric Service have not yet obtained UKAS IQIPs accreditation. An audiology lead was appointed in October 2023 to support this process
2. Is the service registered for IQIPS?	The service is not yet registered for IQIPS. The service aims to be registered by early 2025.

3. Is Service working towards IQIPS accreditation?	The North Audiology Paediatric Service have completed the UKAS IQIPs Benchmarking Assessment and are actively working towards accreditation as a service in early 2025. The Benchmarking Assessment has been provided as evidence of IQIPS progress.
4. What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about?	Following an initial baseline assessment and benchmarking, the North Audiology Service have identified current evidence and areas for development in preparation for IQIPs assessment. The service is now at the stage of gathering evidence and presenting an application for accreditation by early 2025
5. The expected timeline for gaining accreditation?	The North Audiology Service aim to go undergo UKAS IQIPS assessment in early 2025 as an extension to scope with the South Manchester Audiology Service.
6. **The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support**.?	A review of incidents from April 2023 to March 2024 identified 7 reported incidents across the North Audiology Service regarding delay in diagnosis. The incidents were validated as: • 3 incidents = No harm • 4 incidents = Slight harm • 1 incident = Moderate harm.
7. **If service is <u>not</u> UKAS IQIPS accredited**, **a. The Service should provide an external evidence-based assessment of their provision, to be included in the assessment report when responding to <u>CQC</u>** **b. Has the service competed the UKAS benchmarking tool for provider of audiology services considering accreditation to help understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it?**	This has not yet been completed and the expected date will be early 2025. The North Audiology Service submit all diagnostic Auditory Brainstem Response tests (ABR's) for external peer review to the Greater Manchester ABR network. This provides further quality assurance over the standard of ABR provision. The 'Midlands' baseline self-assessment Tool was completed in October 2023 for the NHS England National Paediatric Improvement Plan initial service review and has been included as part of this assurance report.

The South Manchester Audiology Department is based in WCH, and the department has satellite clinics in Wythenshawe Forum. The South Manchester Audiology Service do not provide a full diagnostic and rehabilitative Paediatric Service. The service completes ABR diagnostic assessment for NHSP along with behavioural assessments for Paediatric ENT clinics. The service does not provide Paediatric preschool assessment, school age assessment or paediatric hearing rehabilitation such as hearing aid provision.

South Manchester Responses

1. Has the service achieved IQIPS accreditation, include if there were any improvement recommendations made?	The South Paediatric Audiology Service achieved UKAS IQIPs accreditation at the last assessment in November 2023. A return assessment visit is due in May 2024. The current IQIPs certificate has been provided as evidence for this assurance report.
2. Is the service registered for IQIPS?	Yes, as detailed above
3. Is Service working towards IQIPS accreditation?	N/A – Accredited service
4. What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about?	N/A – Accredited service
5. The expected timeline for gaining accreditation?	Reassessment in May 2024.
6. The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.?	A review of incidents from April 2023 to March 2024 identified 1 reported incident regarding a delay in diagnosis. This was not a direct incident for the South service and was reported by the Community Paediatric Audiology team. The incident was scored as Level 1=No harm.
7. If service is not UKAS IQIPS accredited, **a. The Service should provide an external evidence-based assessment of their provision, to be included in the assessment report when responding to CQC**	The UKAS IQIPS accreditation with external assessment and review was achieved in November 2023. The South audiology service submit all diagnostic ABR's for external peer review to the Greater Manchester ABR network providing further quality assurance over the standard of ABR provision

b. Has the service competed the UKAS benchmarking tool for provider of audiology services considering accreditation to help understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it?	

5. Detailed response - Local Care Organisation (LCO)

There is one centrally managed Audiology service in Childrens Community Health Services (CCHS). This is provided on multiple sites.

The service has scheduled a meeting with NMGH Audiology to discuss the IQIPS process and how they can help and support each other in the accreditation journey.

The CCHS Audiology Service has provided the following responses to the questions asked by CQC in their letter of 8th April 2024.

1. Has the service achieved IQIPS accreditation, include if there were any improvement recommendations made?	The service is not IQIPS accredited.
2. Is the service registered for IQIPS?	The service is not yet registered for IQIPS and expects to register in July 2024 following the attendance at the IQIPS course 10th-11th July 2024. The service has up to 40 months from the date of registration to make the formal application for the accreditation visit. After registration the service will be given an IQIPS contact for support, available to answer questions/ queries /discussions as required.
3. Is Service working towards IQIPS accreditation?	Although not yet registered, over the last 2 years the service has been working through the IQIPS standards within the available capacity. This is ongoing work.

4. What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about?	There are 5 modules to the IQIPS standard 2023 (Appendix 2), the service has been working through the first three modules, although there is still work to be done in addressing gaps, creating additional evidence such as audits, templates, Standard Operating Procedures (SOPs) etc. Below are the compliance figures against the first three modules: Leadership: 55% compliant Clinical: 87% compliant Patient Experience: 99% compliant Safety; to be commenced. Facilities/resources; to be commenced. The service has not yet started the safety and facilities/resources modules however it is anticipated consider that they will be mostly compliant for both, and any gaps will be addressed.
5. The expected timeline for gaining accreditation?	Provisionally, the service expects to be in the state of readiness in 10 - 12 months (July 2025) to then proceed with the formal application for accreditation. The service is limited by its small leadership capacity to be able to achieve accreditation in a shorter timescale.
6. **The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support**.?	The service has not had any incidents where a child has suffered detriment due to missed diagnosis.
7. **If service is <u>not</u> UKAS IQIPS accredited**, **a. The Service should provide an external evidence-based assessment of their provision, to be included in the assessment report when responding to <u>CQC</u>**	The service has complied with requests for quality assurance data from the ICB via the GM Diagnostic Lead. 2 sets of quality assurance data, Paediatric Audiology Quality Improvement Tool (Appendix 4a) submitted in October 2023 and the Paediatric Audiology Service Quality Assessment Tool, PASCAT (appendix 4b) submitted in February 2024, have been submitted to the GM Diagnostics Lead. The service is awaiting a response / recommendation from NHSE following a review of this data. In the meantime, the service has completed a review of the evidence submitted using the Midland Scoring System to gauge the outcome. Within this tool the service have evaluated positively for each of the key lines of enquiry (KLOE) apart from the audit KLOE. In recognition of this outcome, the service has now

b. Has the service competed the UKAS benchmarking tool for provider of audiology services considering accreditation to help understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it?	appointed 2 clinical audit leads, and implemented an audit calendar with regular audits informed by the PASCAT data. The service are making good progress with the number of audits, having completed seven in the last six months. The benchmarking tool is completed by the IQIPS team for a service who are in a state of readiness and is an in-depth detailed analysis of any gaps and issues remaining. The service has completed a gap analysis tool for the IQIPS modules that they have been working through. This has identified the gaps compared to the requirements of the IQIPS standard and this has been used to focus the work. (Appendix 5). To reach IQIPS accreditation the service will require a commitment to finance and to training.

6. Recommendations

The Board of Directors are asked to accept the information included in this report before sharing with the CQC in response to the requested enquiry.

Appendix 1: CQC Letter 08042024

The independent regulator of health and social care in England

8 April 2024

Dear colleague,

Re: Paediatric audiology services

As you may be aware, an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that:

- 527,898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.
- Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear:

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

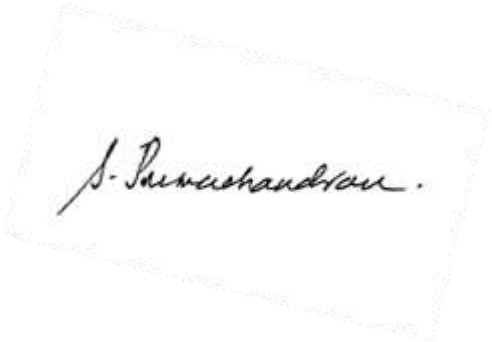
The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

Please send your responses to Terri Salt, the lead senior specialist for this work, by email to terri.salt@cqc.org.uk. Terri can also be contacted if you have any questions or queries about this letter.

Yours sincerely,



Prem Premachandran MBE
Medical Director
Care Quality Commission

Agenda Item 11.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Emma Burton, Assistant Chief Nurse, Quality & Patient Experience Sarah Cosgrove, Head of Nursing, Quality & Patient Experience Claire Horsefield, Patient Services Manager
Date of paper:	May 2024
Subject:	Quality and Patient Experience Report: Quarter 4, 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:	To improve the experience of patients, carers and families.
Recommendations:	The Board of Directors are asked to note the content of this report.
Contact:	Name: Emma Burton, Assistant Chief Nurse, Quality and Patient Experience Tel: 0161 276 8862

QUARTER 4, QUALITY & PATIENT EXPERIENCE REPORT

2023/24

1. Introduction

1.1 This report relates to Patient Services activity across Manchester University NHS Foundation Trust during Quarter 4 (Q4), 1st January to 31st March 2024.

1.2 We are committed to delivering safe, effective and person-centred care. The use of feedback is central to ensuring delivery of these aims and the trust offers a variety of approaches which allow people to choose a feedback mechanism that best suits their needs. These include:

- Friends and Family Test (FFT)
- What Matters to Me Survey (WMTM)
- NHS website and Care Opinion
- In writing by letter / email, or telephone via PALS / Complaints
- Face to face with our staff and volunteers
- Via the Clinical Accreditation process
- National Surveys

1.3 This feedback provides the trust with a rich source of patient experience whilst also offering insight into what matters to patients and service users. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered and is beneficial to help prioritise where to focus efforts on action planning.

1.4 The report presents a rounded picture of patient experience providing information on all aspects of patient experience, good and less positive. Where poor experience is reported, actions are then taken to ensure improvements are made and are featured in the report. All feedback is shared with the relevant Hospitals/MCS/LCO to enable relevant teams to identify areas for improvement based on patient and service user feedback.

1.5 The Trust receives patient feedback from a wide range of different mechanisms such as Annual National Survey results, the Trust's local Quality Care Round (QCR) data, FFT and WMTM Patient Experience survey feedback, Clinical Accreditation and Quality Assurance Reviews, along with incidents, complaints, PALS and compliments.

1.6 This data, along with feedback from Interpretation and Translation Services (ITS) and other sources provides the opportunity for the Hospitals/Managed Clinical Services (MCS)/Local Care Organisations (LCO) to analyse, identify areas for improvement, compare findings and correlate themes. Where themes correlate, early indication and intelligence to act on the data helps to reduce risks and prevent harm. Similarly, patient feedback has a close correlation with patient complaints, and understanding the nature of complaints provides the opportunity for learning lessons from lived experience of our services and is an effective way of improving patient care.

1.7 This report provides the following:

- An overview and summary of activity and brief thematic review.
- A summary of improvements achieved, and those planned to ensure learning from Patient Services activity is embedded in everyday practice.
- Supporting information referred to throughout the report is included in the appendices.

2. Key Messages

2.1 During Quarter 4 2023/24: **Positive**

- 22 Clinical Accreditation Validations completed.
- MFT achieved above 85% in all WMTM domains.
- MFT had an overall 5% increase in WMTM survey responses since the previous quarter (1,269).
- MFT had an overall 1.32% increase in FFT survey responses (706).
- 27 new volunteers commenced employment at MFT.
- 4,383 volunteer hours were undertaken by volunteers.
- 3 Lived Patient Stories have been documented with a further 4 being developed to be shared across MFT to provide learning and celebration.

2.2 During Quarter 4 2023/24: **Less positive**

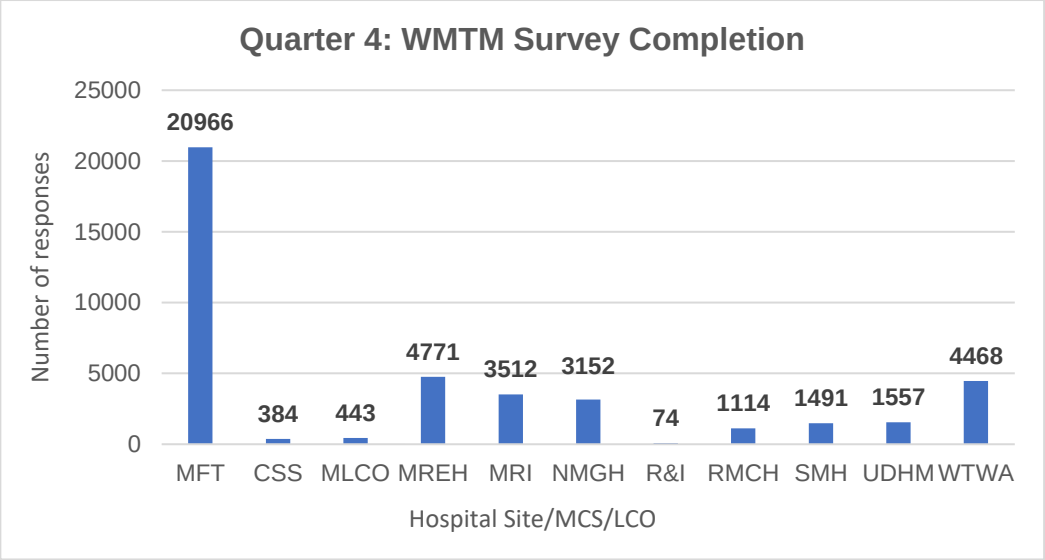
- MFT had a 10.1% increase in PALS concerns (2157).
- MFT had a 21.8% increase in formal complaints (106).
- MFT had an overall % Good FFT score of 91.02% which has decreased by 1.23% since Q3.

3. Patient Feedback

What Matters To Me (WMTM) and Quality Care Round (QCR)

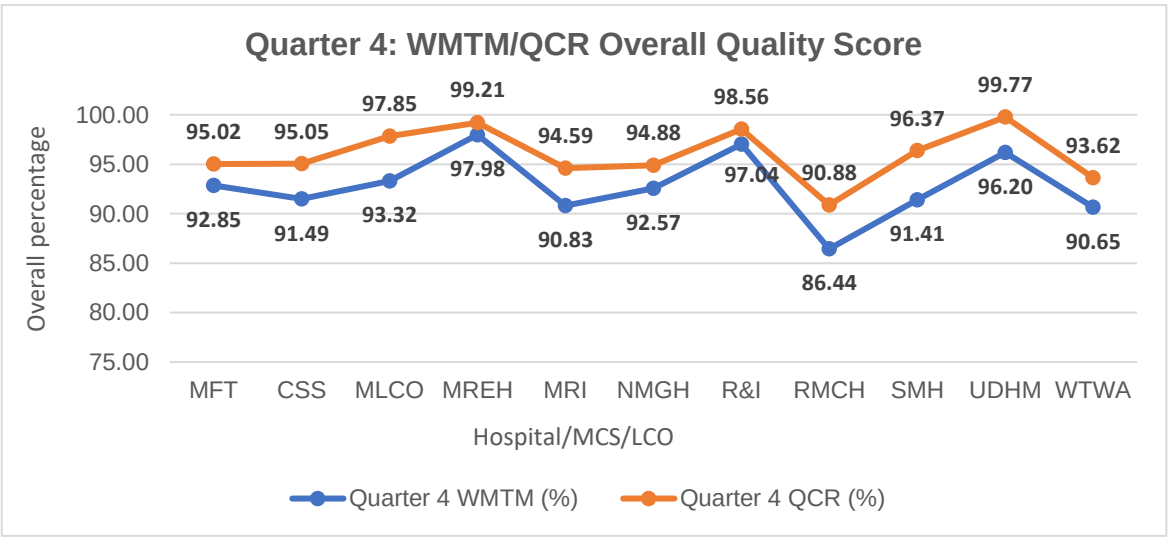
3.1 The Trust WMTM and QCR results alongside other available quality, safety, and patient experience data provide teams with a triangulated view of an area; identifying elements that require improvements, but also areas of strength and outstanding practice.

3.2 **Graph 1** below shows that in Q4, 20,966 WMTM surveys were completed in comparison to 19,697 received in the previous quarter. This shows an increase of 5% (1,269) with Manchester Royal Eye Hospital (MREH) completing the greatest number with 4,771, closely followed by Wythenshawe, Trafford, Withington and Altrincham (WTWA) with 4,468.



Graph 1: Total Number of WMTM Responses, Q4 2023-24.

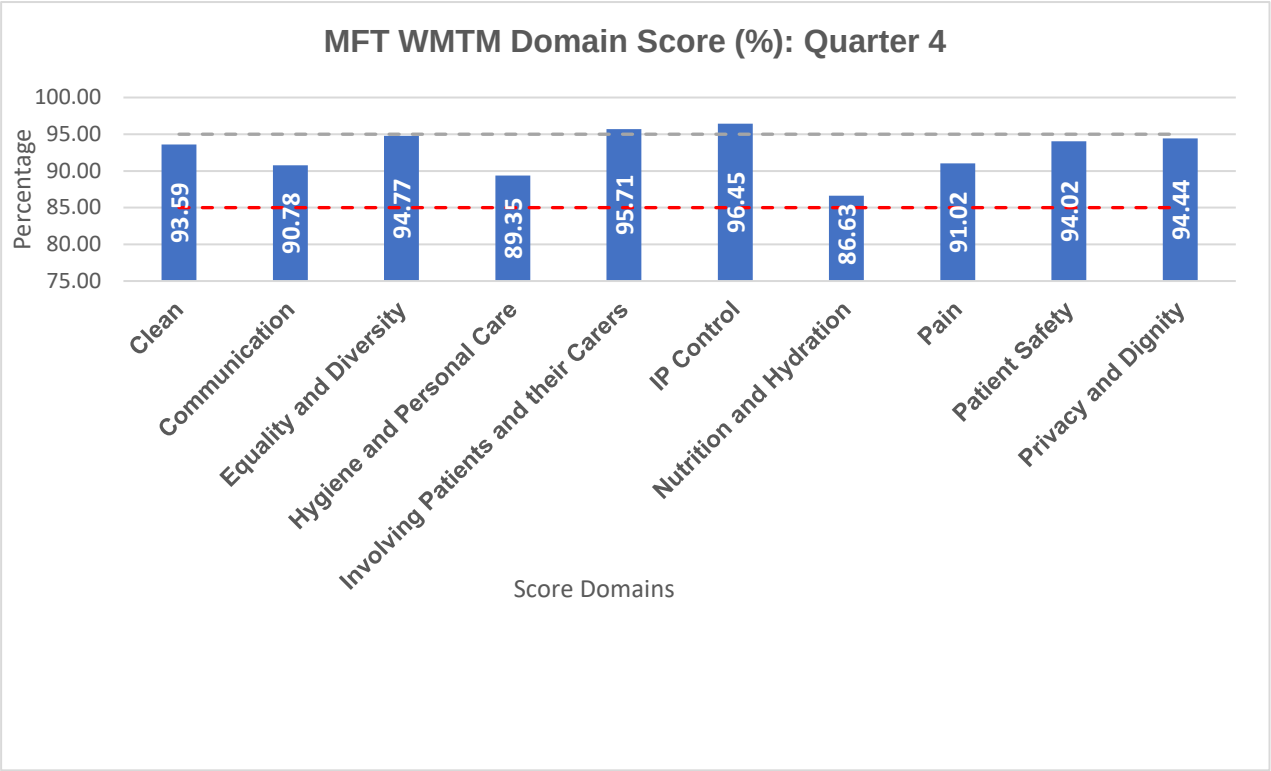
3.3 **Graph 2** shows the overall quality score for WMTM and QCR by Trust and Hospitals/MCS/LCO. The 85% WMTM threshold was exceeded by all Hospitals/MCS/LCO. The highest score was achieved by MREH (97.98%), and the lowest score was noted in the Royal Manchester Children's Hospital (RMCH) (86.44%).



Graph 2: Overall Quality Score for WMTM and QCR, Q4 2023-24.

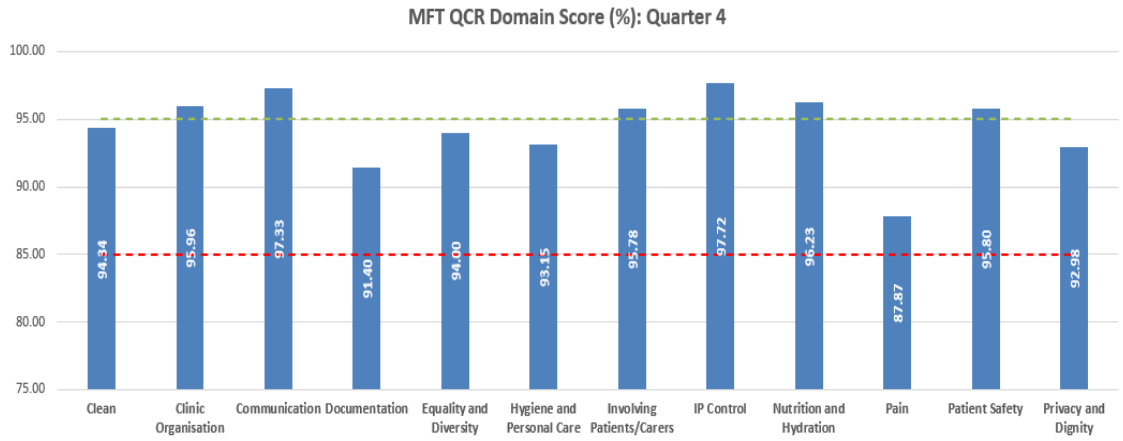
3.4 During Q4, two domains achieved 95% against the threshold of 85% in relation to 'Involving Patients and Carers' and 'Infection Prevention Control' receiving 95.71% and 96.45% respectively. See **Graph 3** below.

3.5 The lowest scoring domain during Q4 was 'Nutrition and Hydration' which scored 86.63%. The Professional Practice Matron launched the mealtime matters standards in March 2023 with actions to address this feedback.



Graph 3: Breakdown of MFT Domain scores for WMTM, Q4 2023-24.

3.6 Similarly, during Q4, the Trust achieved above 85% in all QCR domains. The highest scoring QCR domain was 'Infection Prevention Control' (97.72%) and the lowest scoring domain was 'Pain' (87.87%). See **Graph 4**.



Graph 4: Breakdown of MFT Domain scores for QCR Q4, 2023/24.

3.7 During Q4, the top three positive feedback WMTM themes by Hospital/MCS/LCO remained unchanged with 'Emotional and Physical Support', 'Friendliness' and 'Compassion' remaining the top themes. Further breakdown per Hospital/MCS/LCO, can be found in **Appendix 1**.

3.8 The top three negative feedback WMTM themes by Hospital/MCS/LCO during Q4 were 'Waiting', which correlates with the concerns and complaints received in PALS regarding appointment delays. The other two areas for negative feedback related to

'Food and Beverage' and 'Pain'. Further breakdown per Hospital/MCS/LCO can be found in **Appendix 2.**

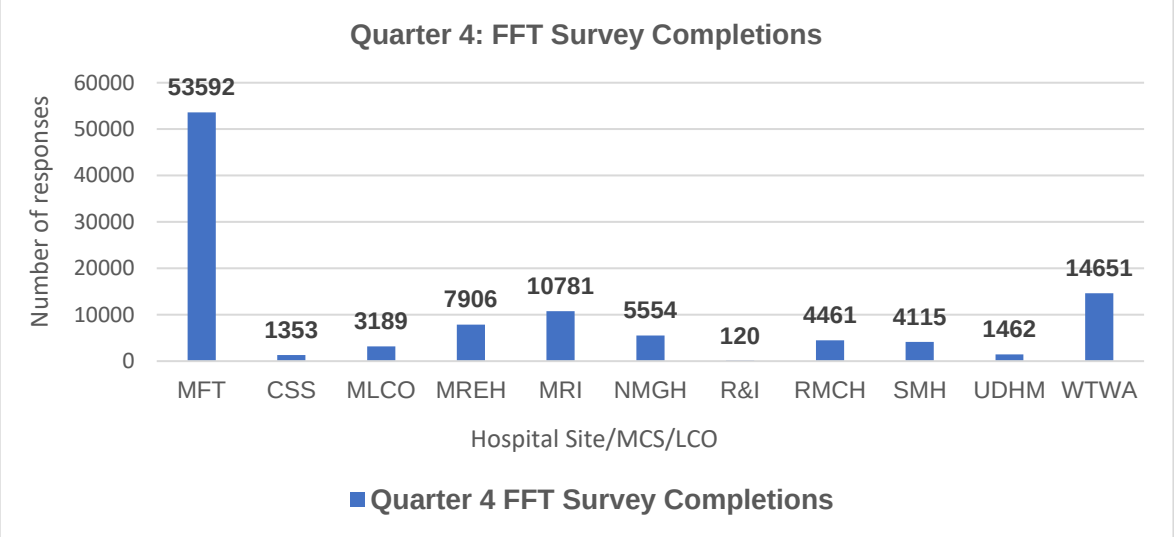
Friends and Family Test

3.9 FFT provides a mechanism for patients who receive NHS care or treatment to have their say by rating their experience from good to poor. The FFT Results are analysed and used locally to drive improvements.

3.10 The score is a simple comparison of the percentage of those completing the test who would recommend their care experience and rate the scores as 'good' and 'very good', against the percentage of those who would not recommend the care experience and rate the scores as 'poor' or 'very poor'.

3.11 Throughout 2023/24 wards and departments have focused on increasing the volume of FFT responses collected to ensure, greater statistical significance and increased confidence in the feedback of information to apply improvements across the Trust.

3.12 In Q4, there was an increase in FFT responses from the previous quarter with 53,592 FFT responses collected across MFT, compared to 52,886 in Q3, representing an increase of 706 responses (1.33%). **Graph 5** shows the number of responses collected by each Hospital/MCS/LCO in Q4.

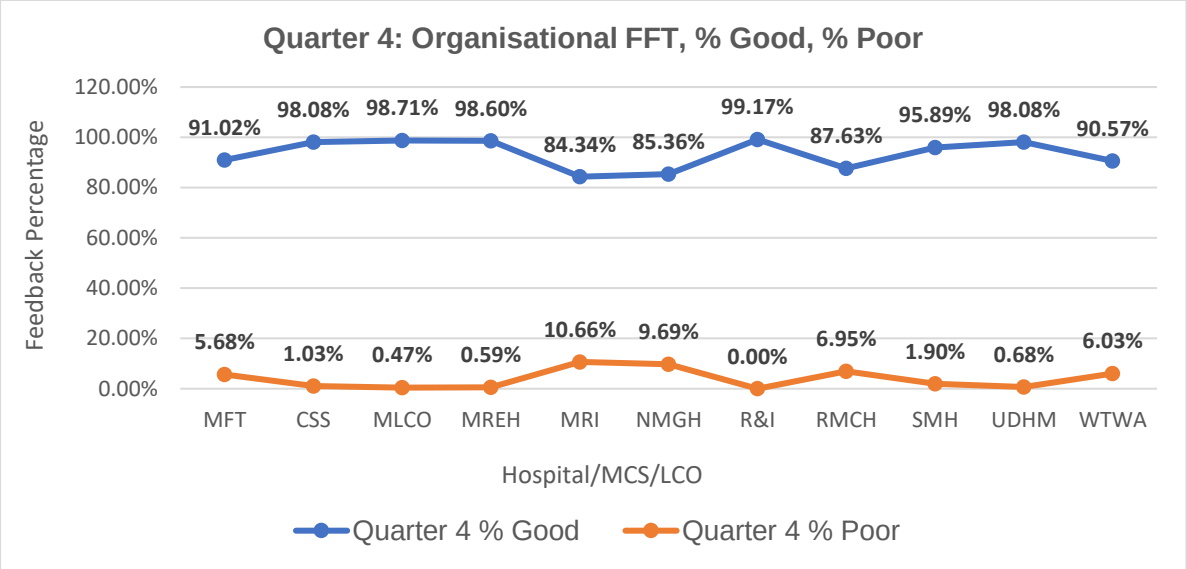


Graph 5: Total Number of FFT Responses Q4, 2023/24.

3.13 The overall percentage of 'good' FFT scores for Q4 was 91.02%. This shows a decrease of 1.62% in comparison to 92.52%. in Q3, 23/24.

3.14 **Graph 6,** below, shows the Trust overall FFT results where patients have rated their experience between 'good' and 'poor' as a percentage. The 95% target was exceeded by Clinical Scientific Services (CSS), Local Care Organisation (LCO), MREH, Research & Innovation (R&I), Saint Mary's Hospital (SMH) and University Dental Hospital of Manchester (UDHM). Of note the same hospitals exceeded the 95% benchmark

throughout 2023/24. Manchester Royal Infirmary (MRI), North Manchester General Hospital (NMGH), Royal Manchester Children's Hospital (RMCH) and WTWA score below the 95% target.



Graph 6: Overall FFT results showing patient ratings as percentages for Good or Poor scores for Q4 2023/24.

3.15 The Trusts overall top three positive feedback FFT themes reported during Q4, were, 'Friendliness', 'Professional and Competent' and 'Emotional and Physical Support'. Further breakdown per Hospital/MCS/LCO, can be found in **Appendix 3**.

3.16 The Trusts top 3 negative feedback FFT themes reported during Q4 were 'Waiting', which correlates with WMTM and PALS concerns in relation to 'appointment delays', 'Pain' and 'Emotional and Physical Support'. Further breakdown per Hospital/MCS/LCO, can be found in **Appendix 4**.

NHS Website and Care Opinion Feedback

3.17 The NHS Website and Care Opinion are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

3.18 The standard procedure is that all NHS Website and Care Opinion comments are received by the Patient Experience Team and shared with the relevant Hospital/MCS/LCO.

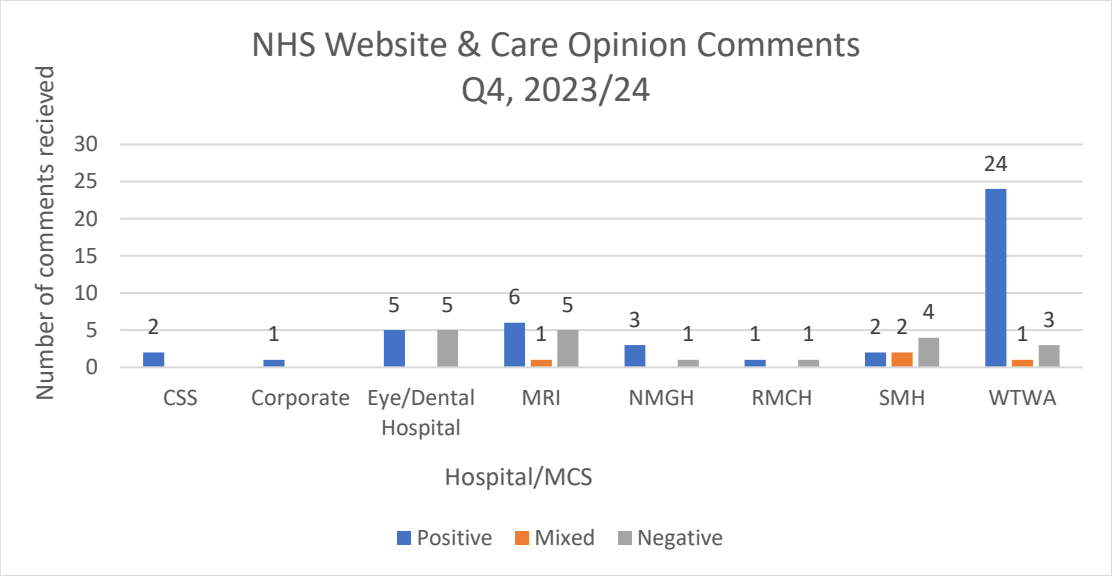
3.19 During Q4 the standard procedure for logging NHS Website comments has been enhanced, allowing for more in depth analysing and reporting of comment data. This enhancement now enables triangulation of patient feedback themes alongside PALS and Formal Complaints.

3.20 New guidance and response templates are currently being developed and this framework will support improvements in the content and quality of responses. The implementation of this new guidance is anticipated during Q1, 2024/25.

3.21 Negative and mixed comments require a response for publication form the associated team within five working days. Each Hospital/MCS/LCO has designated staff members to support the provision of a response to the patient experience team. The responses are then quality assured prior to posting on the NHS Care Opinion website.

3.22 All responses to negative comments include a Ulysses reference number, to assist the PALS team to identify whether any further action is required and offer to the person posting the comment to contact the PALS tea should they require any further support.

3.23 During Q4, a total of 67 comments were received via the websites of which 44 (66%) were positive, 19 were negative (28.3%) and four were mixed (6%). The number of Care Opinion and NHS Website comments by category and hospital/MCS/LCO are detailed in **Graph 7** below.



Graph 7: NHS website and Care Opinion comments received in Quarter 4, 2023/24.

4. National Surveys

4.1 National Maternity Survey 2023

The results of the NHS Maternity Survey (2023) were published by the Care Quality Commission (CQC) on 9th February 2024.

There was a total of 2,194 patients at MFT invited to take part in the survey in comparison to 1,138 in 2022. Of the 2,194 patients invited, 811 (38%) responded. This shows an increase of 71.4% (338) in comparison to 473 respondents in 2022.

The CQC requested and financed a 'boosted sample' for the 2023 survey. This means that in addition to the usual sampling period in February, they also added in all deliveries from mothers who identified an ethnic origin from January and March 2023.

The Trust's average overall experience score across all areas was 7.4. This is a 0.1% decrease when compared to 7.5 in 2022 and 2021.

The survey demonstrated that the results were predominantly inconsistent when compared to other NHS Trusts. However, it was noted that there had been improvement across two areas namely: 'Start of your pregnancy' and 'Antenatal Check-Ups'.

5. Patient Advice and Liaison Services (PALS)

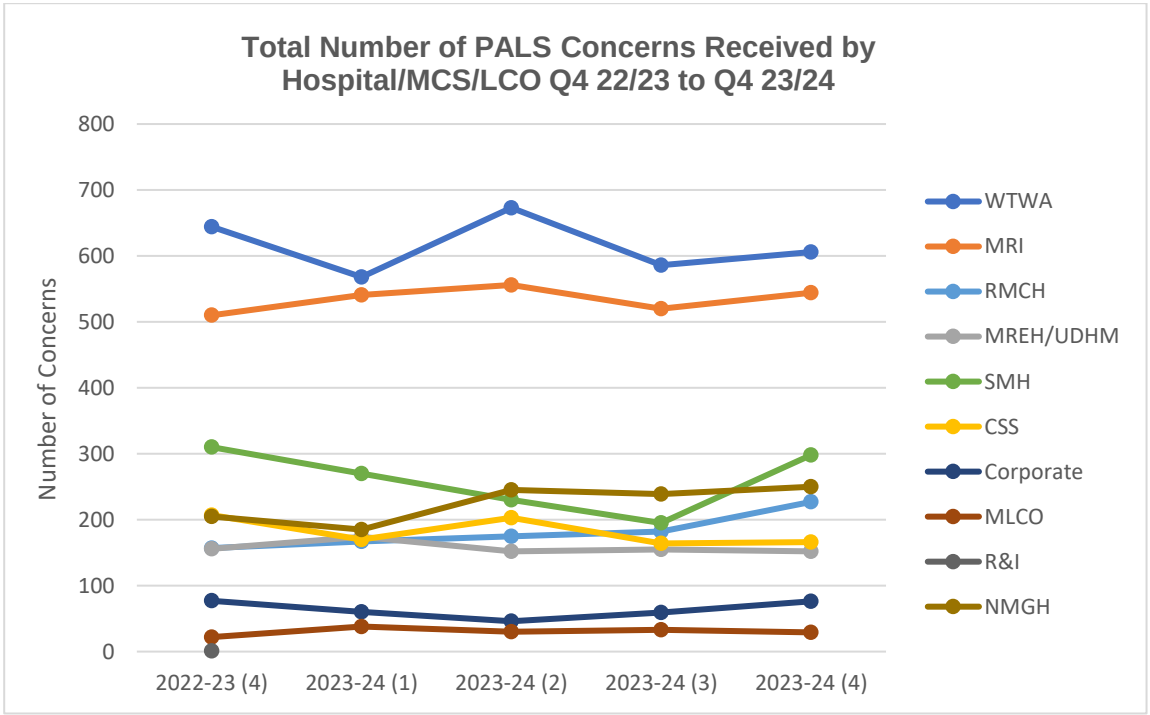
PALS data and themes

5.1 There was an increase of 10.08% in PALS concerns with 2,348 PALS concerns being received in Q4 compared to the 2,133 received in Q3, 2023/24.

5.2 **Graph 8** below shows the number of concerns received by each Hospital/MCS/LCO each quarter. WTWA and MRI received the greatest number of PALS concerns, receiving 606 and 544 respectively.

5.3 Saint Mary's Hospital (SMH) experienced the greatest percentage increase in PALS concerns, receiving 37 (52.8%) more than in Q3; in relation to 'Appointment Delays/Cancellations' and 'Communication'. Corporate Services and RMCH also experienced large increases in PALS concerns of 28.8% and 24.7% respectively.

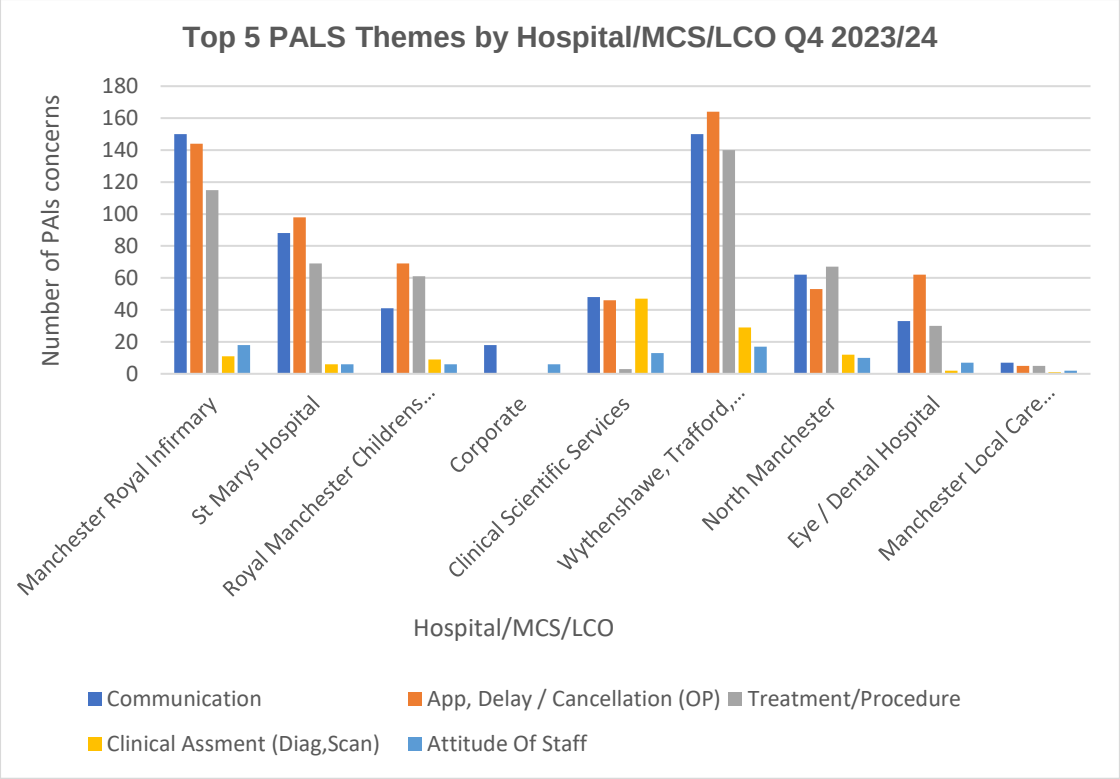
5.4 LCO and MREH/UDHM concerns decreased during Q4, receiving 12.1% and 1.9% fewer than in Q3.



Graph 8: PALS Concerns Received by Hospital/MCS/LCO Q4 2022/23 – Q4, 2023/24

5.5 **Graph 9** shows the distribution of the main PALS themes and indicate that the greatest proportion of PALS concerns in Q4 relate to 'Appointment Delays/Cancellations', followed by 'Communication'. PALS concerns relating to both themes have increased by over 20% during Q4.

5.6 PALS concerns relating to Clinical Assessment (Diagnostics/Scans) reduced by the highest number of all categories, with 31.5% fewer PALS received relating to this category during Q4.



Graph 9: Themes of PALS concerns received by Hospital/MCS/LCO Q4, 2023/24

PALS responsiveness and Key Performance Indicators (KPI)

5.7 During Q4, 93.33% of PALS cases were closed within 10 working days. As seen in **Table 1,** PALS responsiveness has exceeded 90% for four consecutive quarters.

	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Resolved in 0-10 days	1945	1998	2239	2070	2168
Resolved in 11+ days	220	173	127	179	155
% Resolved in 10 working days	**89.84%**	**92.03%**	**94.63%**	**94.04%**	**93.33%**

Table 1: Closure of PALS concerns within timeframe Q4, 2022/23 – Q4, 2023/24.

5.8 **Table 2** shows the number of PALS concerns that were escalated to formal complaints and vice-versa. There was a decrease in the number of PALS concerns being escalated

to formal complaints and a large increase in the number of formal complaints de-escalated to PALS.

5.9 To further improve on this and ensure concerns are resolved as quickly as possible, PALS and the Complaints Department commenced training sessions in December 2023 on local resolution, direct to the services, wards and departments across the Trust. Since training commenced there has been a reduction of formal complaints, deescalating these to PALS concerns as evidenced in **Table 2**. In addition to this, a review of the Complaints Triage process is currently being undertaken. This will ensure cases are processed through the most suitable route (PALS or Complaints) at the outset.

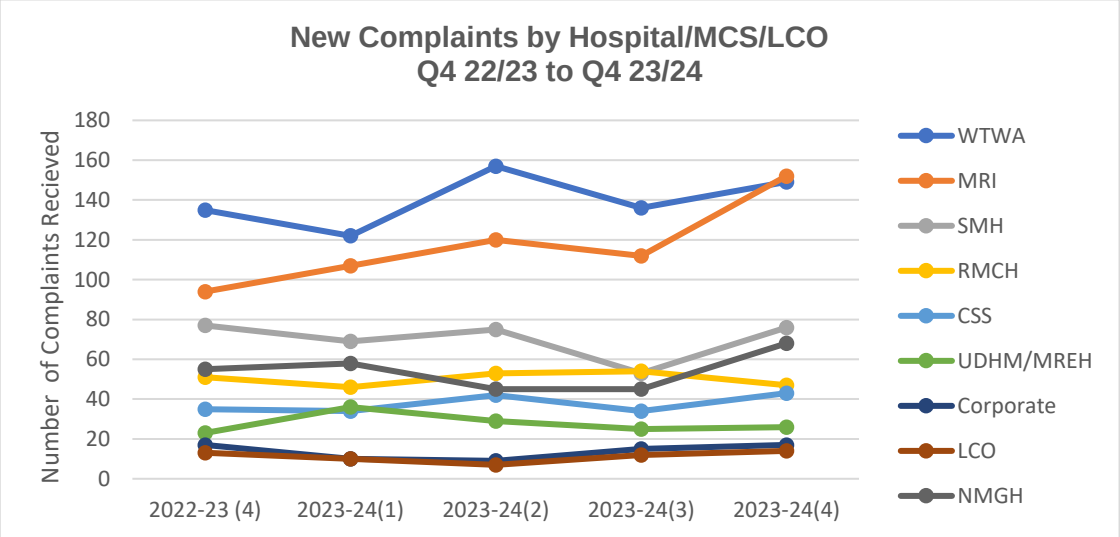
	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of PALS cases escalated to formal Complaints	11	14	26	24	11
Number of formal Complaints de-escalated to PALS	11	27	45	36	76

Table 2: Number of PALS concerns escalated to formal complaints and complaints de- escalated to PALS concerns Q4, 2022/23 – Q4, 2023/24.

6. Formal Complaints

Complaint data and themes

6.1 There was an increase of 21.8% in complaints in Q4, with 592 new complaints being received compared to the 486 received the previous quarter. **Graph 10** shows the number of complaints received by each Hospital/MCS/LCO.



Graph 10: New Complaints Received by Hospital/MCS/LCO/Corporate Services Q4, 2022/23 – Q4, 2023/24.

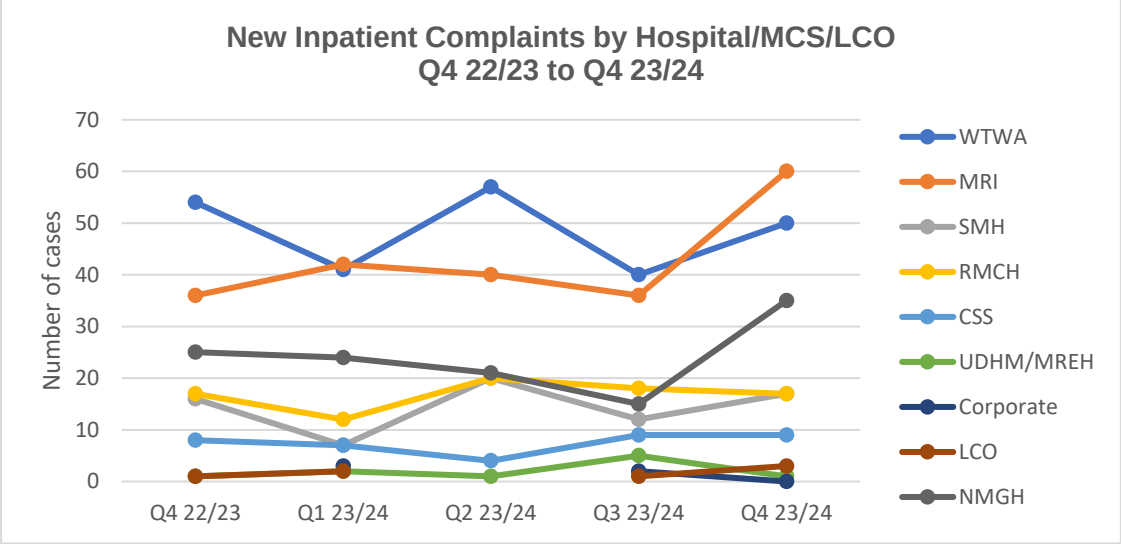
6.2 MRI and WTWA received the greatest number of complaints, receiving 152 and 149 respectively. The number of complaints received by MRI increased by 43% during Q4, this relates to a rise of inpatient complaints relating to 'Communication' 'Attitude of Staff' and 'Clinical Assessment (Diagnostics/Scans').

6.3 NMGH complaints increased by the greatest percentage across the Trust during Q4, with a 51% rise (68 in Q4 compared to 45 in Q3). This was driven by a rise in inpatient complaints relating to 'Treatment and Procedure' 'Security' and 'Medication Errors'.

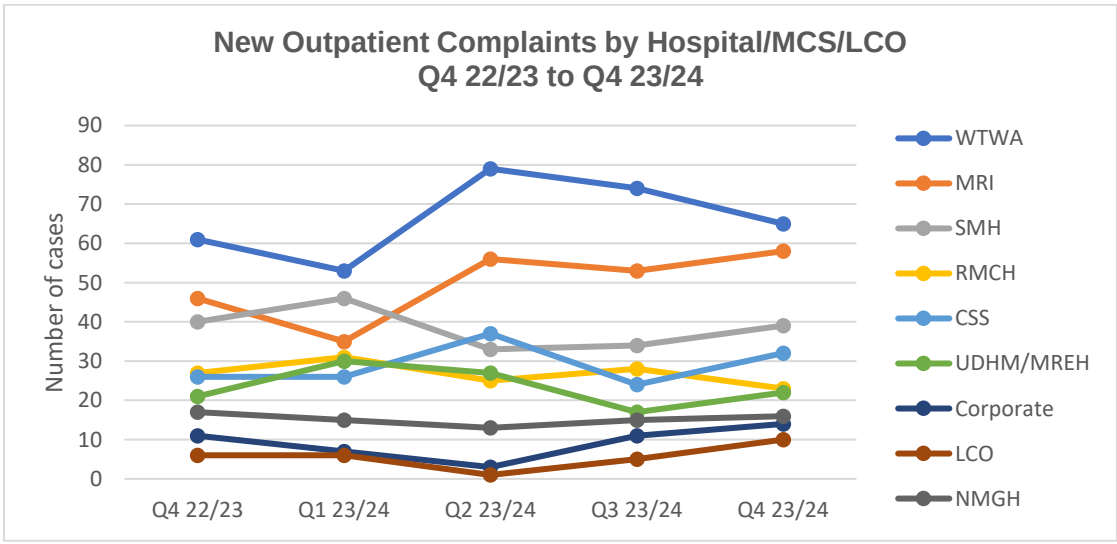
6.4 SMH also experienced an increase in complaints (36%), these are attributable to rises in complaints relating to 'Communication', this is similar to the increase in PALS concerns in SMH which also relate to 'Communication'.

6.5 RMCH was the only hospital to have a reduction in complaints which decreased by 13% in Q4.

6.6 **Graphs 11** and **12** illustrate the number of new complaints relating to inpatient and outpatient services during Q4. Of the 592 new complaints received 47.1% related to outpatient services.



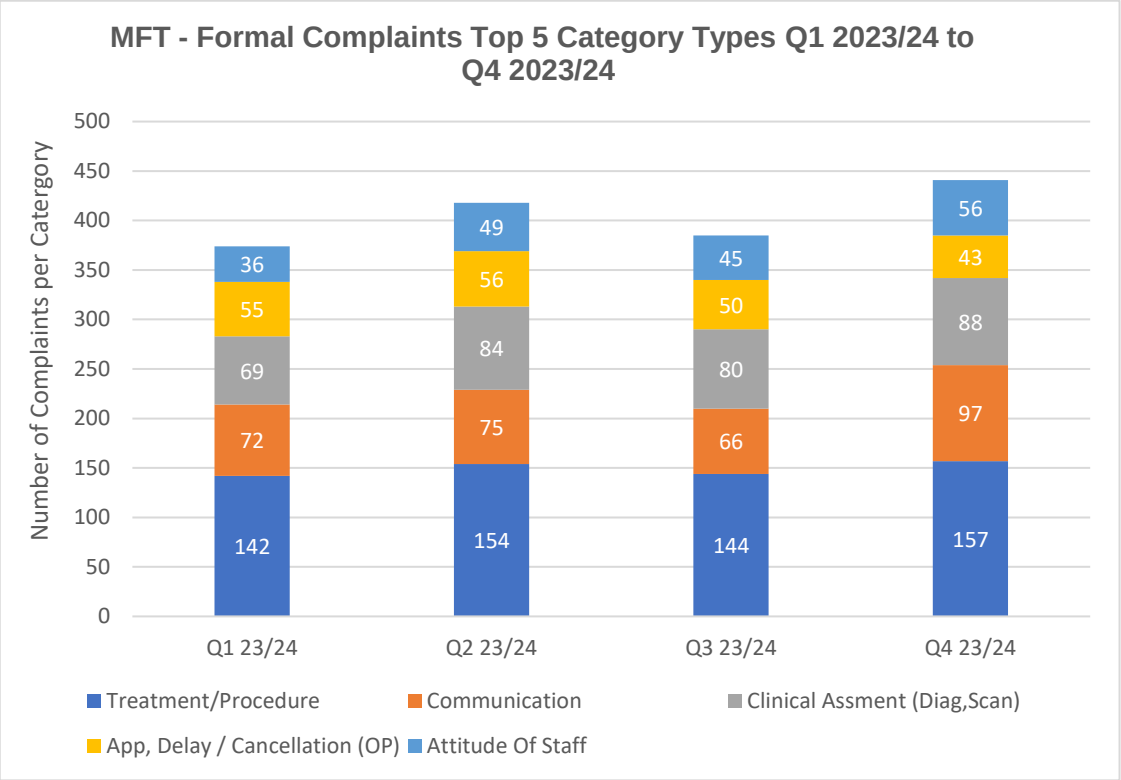
Graph 11: New Inpatient Complaints Received by Hospital/MCS/LCO/Corporate Services Q4, 2022/23 – Q4, 2023/24.



Graph 12: New Outpatient Complaints Received by Hospital/MCS/LCO/Corporate Services Q4, 2022/23 – Q4, 2023/24.

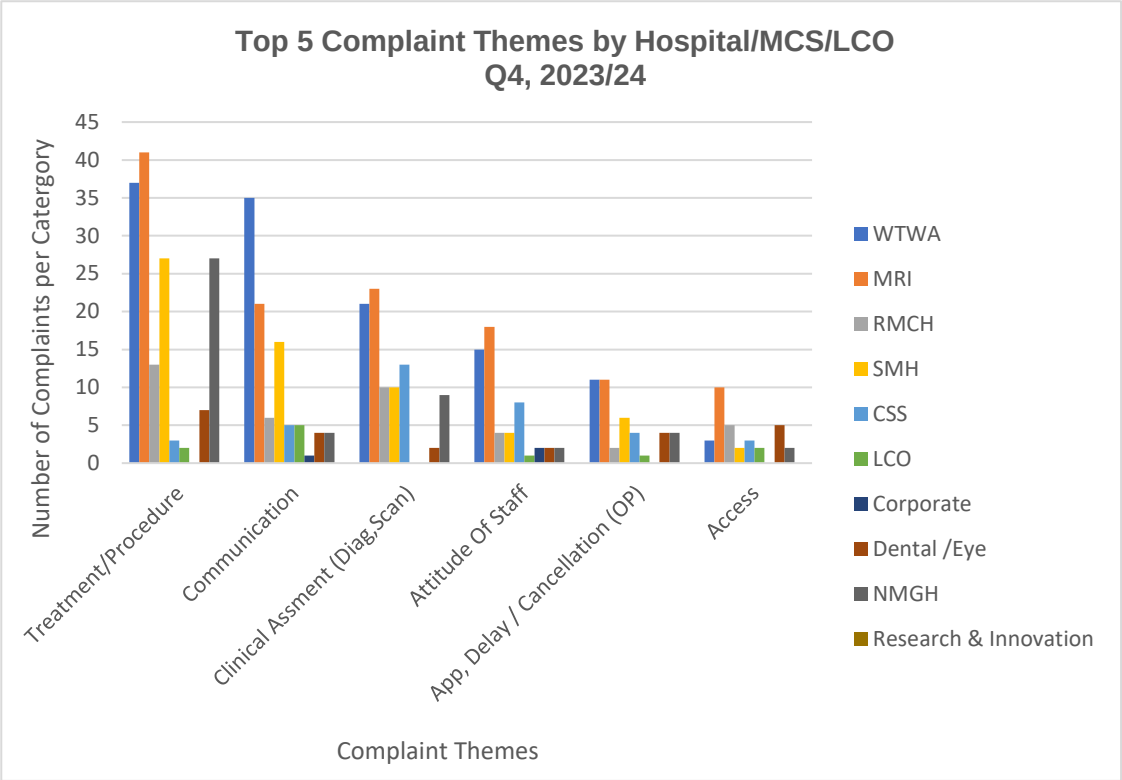
6.7 The opportunity to learn from complaints is an effective way of improving patient care and experience. By applying categorisation and theming to the complaints received, the teams work to improve the quality of care where themes emerge, or where practice is identified as requiring improvement.

6.8 During Q4 'Treatment/Procedure', 'Communication' and 'Clinical Assessment (Diagnostics/Scans)' remained the top three themes of complaints in Q4 (**Graph 13**). These have consistently been the top three themes for 23/24. The same themes are identified in PALS Concerns also with an increase (20% in the last quarter related to communication & treatment/procedure however there has been a reduction of PALS concerns related to clinical assessment.



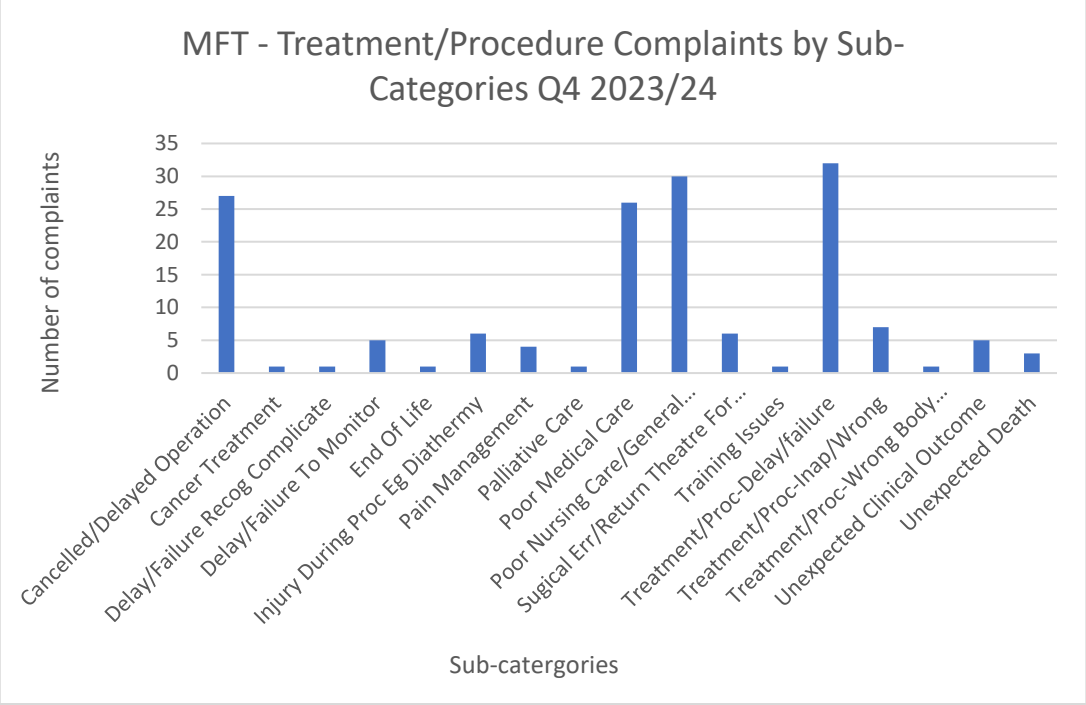
Graph 13: Top Primary Complaint Themes Q1, 2023/24 – Q4, 2023/24.

6.9 **Graph 14** below shows the distribution of the top five themes by Hospital/MCS/LCO/Corporate Services in Q4.



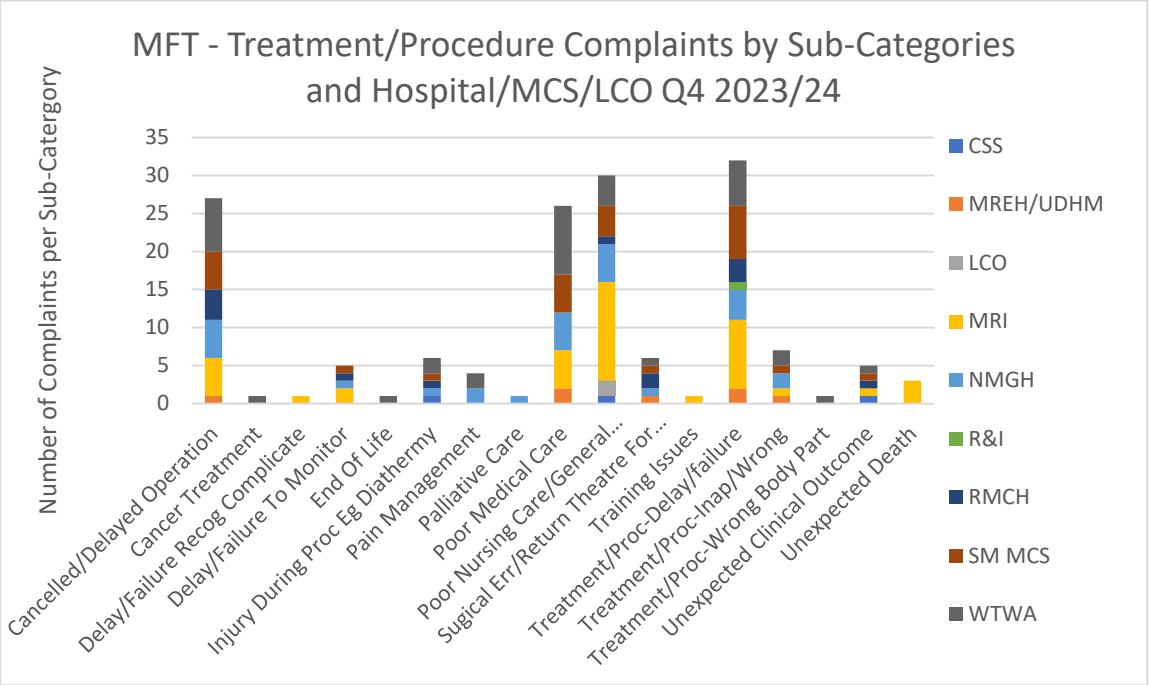
Graph 14: Top 5 themes by Hospital/MCS/LCO/Corporate Services Q4, 2023/24.

6.10 'Treatment/Procedure' was the main theme of complaints across the Trust during Q4, being the primary category for 157 complaints (26.5% of all complaints). **Graph 15** demonstrates the main sub-categories were 'Treatment/Procedure – Delay/Failure', 'Cancelled/Delayed Operations' and 'Poor Nursing Care' or 'Poor Medical Care'.



Graph 15: Treatment/Procedure complaints subcategory 23/24

6.11 **Graph 16** below shows the breakdown of 'Treatment/Procedure' complaints by Hospital/MCS/LCO. 40% of the complaints regarding 'Poor Medical Care' were attributable to WTWA, whilst MRI accounted for 30% of the complaints regarding 'Poor Nursing Care'. Complaints due to 'Cancelled/Delayed Operations' and 'Treatment/Procedure – Delay/Failure' were mainly split between WTWA, MRI and SM MCS.



Graph 16: Treatment/Complaints by Hospital/MCS/LCO for Q4 23/24

6.12 A deep dive is required to further understand the context behind the categories and triangulate this with patient experience data to identify areas of opportunity to change process or provide focused quality improvement support.

Complaints responsiveness and KPI

6.13 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. This indicator was met during Q4, with all 592 complaints acknowledged on time. **Table 3** demonstrates the complaints acknowledgment performance over the past five quarters.

	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Number of 3 day acknowledgements completed	541	531	566	550	600
Number of breaches	1	1	0	0	0

Table 3: Complaints Acknowledgement Performance Q4, 2022/3 – Q4, 2023/24.

6.14 Against the Trust's target of 90%, the Trust achieved closure of 87.4% of complaints within the agreed timescale, representing a decrease in comparison to the previous quarter, as seen in **Table 4**. This decrease is mainly due to SMH responding to 62.1% of complaints on time during Q4.

6.15 The complaints team have introduced weekly KPI meetings with Hospital/MCS/LCO teams to identify delays in complaint responses and offer support with barriers and escalation to the senior leadership team if required. This will be monitored by the complaints manager and measured against a reduction in timeframe for resolved complaints.

6.16 NMGH responded to 100% of complaints within the agreed timescale during Q4, with WTWA and CSS also achieving compliance, with 99.3% and 97% respectively.

	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Resolved in 0-25 days	343	356	345	336	348
Resolved in 26-40 days	62	71	75	70	68
Resolved in 41+ days	115	93	104	86	115
Total resolved	**520**	**520**	**524**	**492**	**531**
Total resolved in timescale	**463**	**461**	**468**	**446**	**464**
% Resolved in agreed timescale	**89.0%**	**88.7%**	**89.3%**	**90.7%**	**87.4%**

Table 4: Comparison of complaints resolved by timeframe Q4, 2022/23 – Q4, 2023/24.

Outcomes from complaint investigations

6.17 Often complaints relate to more than one issue. In conjunction with the Hospitals/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 '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'.

6.18 During Q4, 70 (13%) of the complaints investigated and responded to were upheld, 352 (66%) were partially upheld and 109 (21%) were not upheld. The main themes of upheld complaints were the same as the top three complaint themes during the quarter.

Table 5 demonstrates the outcome status of all complaints between Q4, 2022/23 and Q4, 2023/24.

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld
Q4 22/23	520	58	365	97
Q1 23/24	520	60	379	81
Q2 23/24	524	59	383	82
Q3 23/24	492	54	365	73
Q4 23/24	531	70	352	109

Table 5: Outcome of MFT complaints Q4 2022/23 – Q4 2023/24.

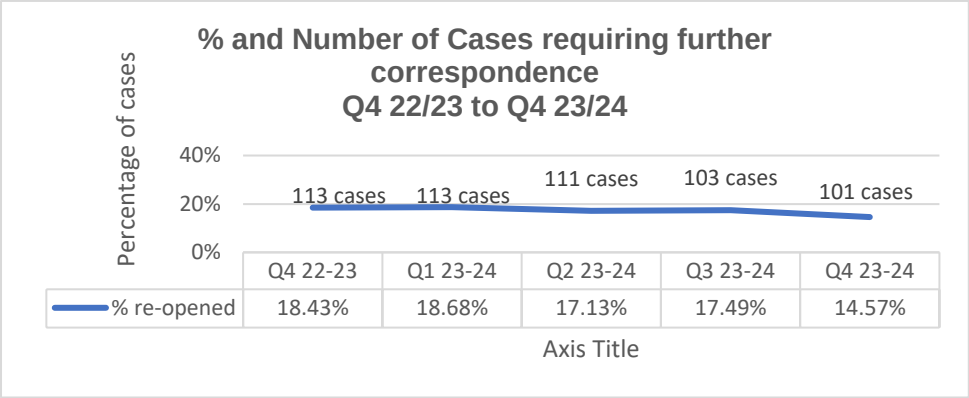
Reopened Complaints

6.19 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 fully address all issues satisfactorily.
- The complainant expresses dissatisfaction with the response.

6.20 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q4, 14.57% of complaints were reopened (101 cases in total) against the Trust tolerance threshold of 20%. This is a reduction from the 17.47% of complaints reopened in Q3 (105 cases in total).

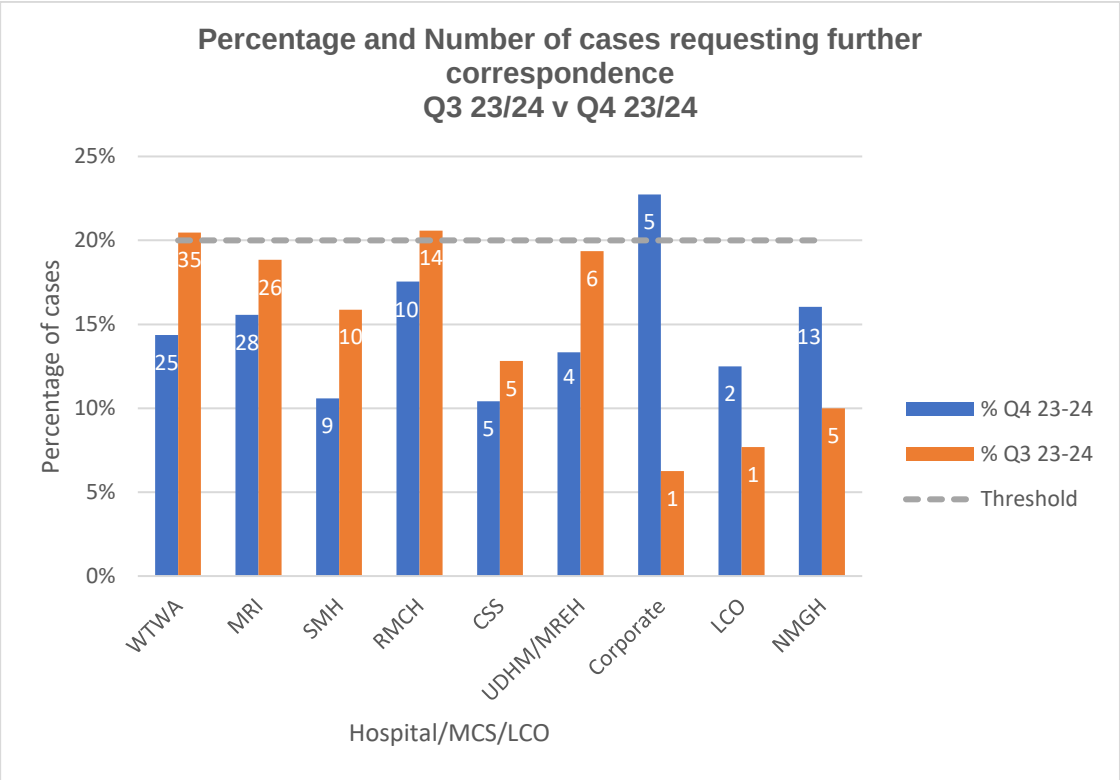
6.21 **Graph 17** demonstrates the percentage of complaints re-opened from Q4, 2022/23 – Q4, 2023/24. The primary reason for complaints being re-opened (49 of the 101) is attributed to the 'complaint response not fully addressing all issues/unresolved issues. Further detail of the primary reasons by Hospital/MCS/LCO/Corporate Services for the complaint being re-opened during Q4 can be found in **Appendix 5**.



Graph 17: Total re-opened complaints Q4, 2022/22 – Q4, 2023/24

6.22 The Complaints Team have continued to run training sessions on conducting complaint investigations and writing responses, which has contributed to an improvement in the quality of responses and a corresponding decrease in re-opened complaints across the Trust.

6.23 As depicted in **Graph 18**, the 20% threshold was exceeded by Corporate Services (22.7%). The Complaints Team and Head of Nursing for Quality and Patient Experience are focussing efforts on Corporate Services complaints to address responsiveness and the quality of responses, to improve this during 2024/25.



Graph 18: Percentage of re-opened complaints by Hospital/MCS/LCO/Corporate Services, Q3 2022/23 – Q4, 2023/24

7. Parliamentary Health Service Ombudsman (PHSO)

7.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO is not part of the Government, NHSE, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

7.2 The PHSO make final decisions on complaints that have not been resolved by NHSE, UK government departments and other public organisations. The PHSO does this fairly and without taking sides and its service is free. The PHSO considers and review complaints, where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

7.3 During Q4 2023/24 the PHSO opened three new investigations (MRI, WTWA and CSS) and closed two completed investigations.

7.4 The PHSO informed the Trust of one completed investigation which was upheld and was a RMCH complaint. The PHSO identified failings in relation to staff not managing the patient's disabilities, pain and hydration levels. Additionally, failings were identified in an inappropriate discharge from hospital. The PHSO recommended the Trust compensate the patient £950.00 and develop an action plan to address the failings identified, which is currently in development by RMCH.

7.5 The PHSO informed the trust of a second completed investigation which was partially upheld and this relates to a SMH complaint. The PHSO identified failings in relation to consideration not being given to the patient's mental health birth plan and inadequate communication with the patient during their care. The PHSO recommended the Trust send an apology letter to the patient, compensate them £500.00 and explain what the Trust has done or will do to prevent a recurrence of these issues in the future.

7.6 The new PHSO NHS Complaint Standards has been released in Q4. This provides guidance in relation to model complaint handling procedure, providing a consistent approach, and set out how organisations providing NHS services should approach complaint handling. The new Complaint Standards focus on early resolution, identifying learning from complaints and utilising this information to drive quality improvement.

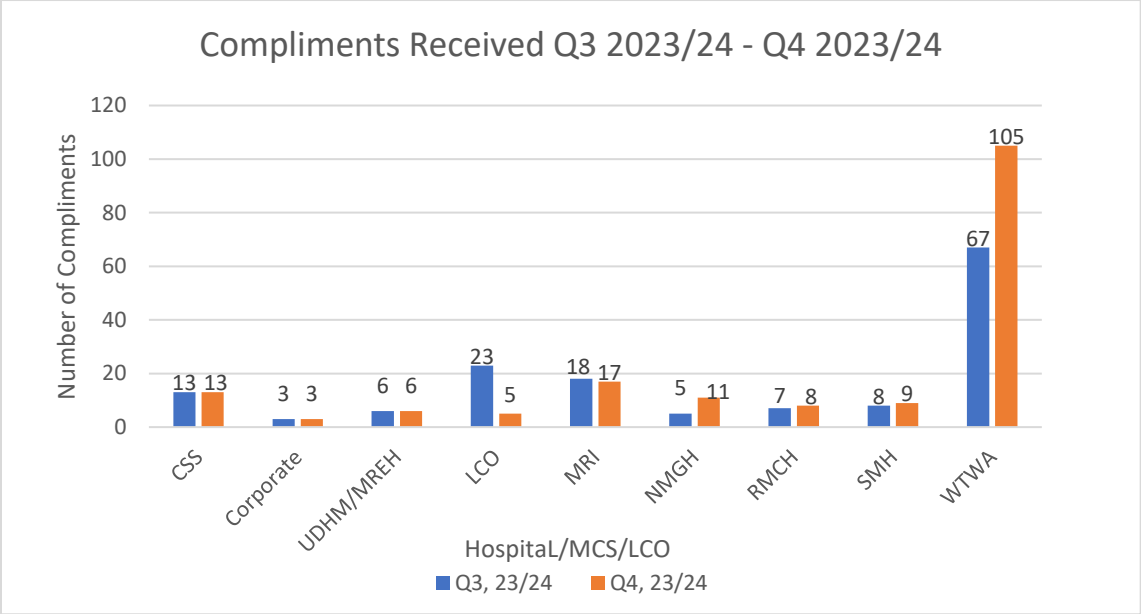
7.7 During Q4, the Customer Services Manager completed the Trust's organisational assessment matrix which places the Trust as having made 'firm progress' on the PHSO handling maturity scale (Level 4 of 5). This demonstrates the Trust has progressed in embedding complaint standards.

8. Compliments

8.1 Compliments received from the public provide valuable feedback and opportunity to learn from positive patient experiences. Positive patient experience feedback explicably correlates to compliments and can be linked to the top positive themes seen in WMTM and FFT.

8.2 It is important to acknowledge only a fraction of the overall compliments received within the Trust are captured and recorded on the Trusts Customer Service Database (Ulysses). The majority of compliments are received verbally (either in person or via the telephone) and as 'thank you cards' directly to staff, which are not logged or tracked by the Hospitals/MCS/LCO.

8.3 **Graph 19** shows the number of compliments, received by members of the public about Hospitals/MCS/LCO. This is recorded on the Trust's Customer Services Database. WTWA recorded the most compliments (105), followed by LCO (17) and CSS (13).



Graph 19: MFT compliments received Q3, 2023/24 vs Q4, 2023/24.

8.4 Examples of compliments received during Q4 2023/24 are included in **Appendix 6**.

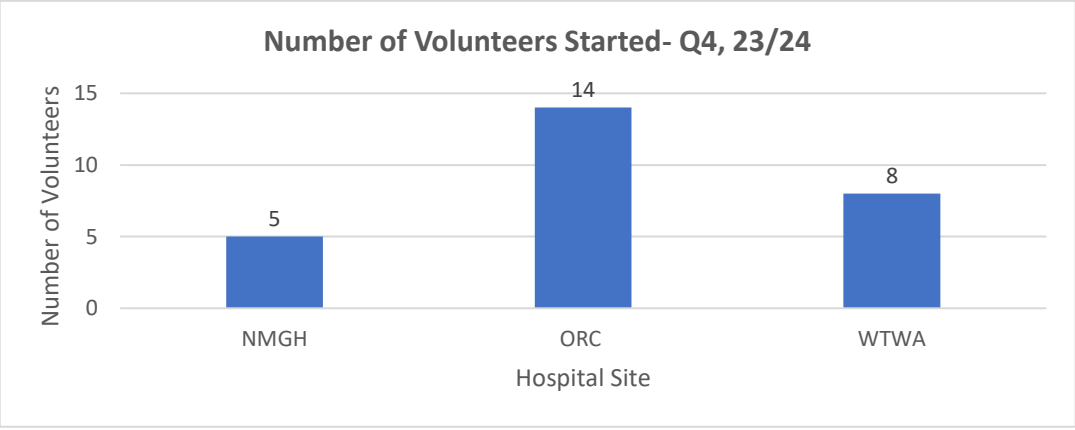
9. Voluntary Services

9.1 **Table 6** shows MFT's volunteering recruitment figures by site. In Q4, 67 applicants were shortlisted, of which 39 (58.2%) were successful.

Site	Shortlisted	Interviewed	Successful	Commenced
NMGH	12	14	10	5
ORC	24	23	13	14
WTWA	31	21	16	8
TOTAL	**67**	**58**	**39**	**27**

Table 6: Recruitment Activity by site.

9.2 **Graph 20** below demonstrates the number of new volunteers commencing in their volunteering role by site during Q4. ORC had the greatest number of new volunteers.



Graph 20: Number of new volunteers commencing in role by site, Q4 2023/34.

9.3 **Table 7** demonstrates the number of hours volunteered across the sites during Q4. Overall, 4,383 volunteering hours were undertaken, this is an increase of 10.9% since Q3. Of the 4,383 hours the greatest were undertaken at WTWA (43%).

9.4

Site	Hours	Volunteers	Average
NMGH	1167	34	34
ORC	1328	89	15
WTWA	1888	101	19
TOTAL	**4383**	**224**	**33.67**

Table 7: Number of hours volunteered, by the number of volunteers

9.5 As in Q3, the greatest number of volunteering hours relates to 'Meet and Greet' across all sites, further breakdown of the distribution of the hours volunteered within each of the Hospital sites can be found in **Appendix 7**.

10. Chaplaincy and Spiritual Care

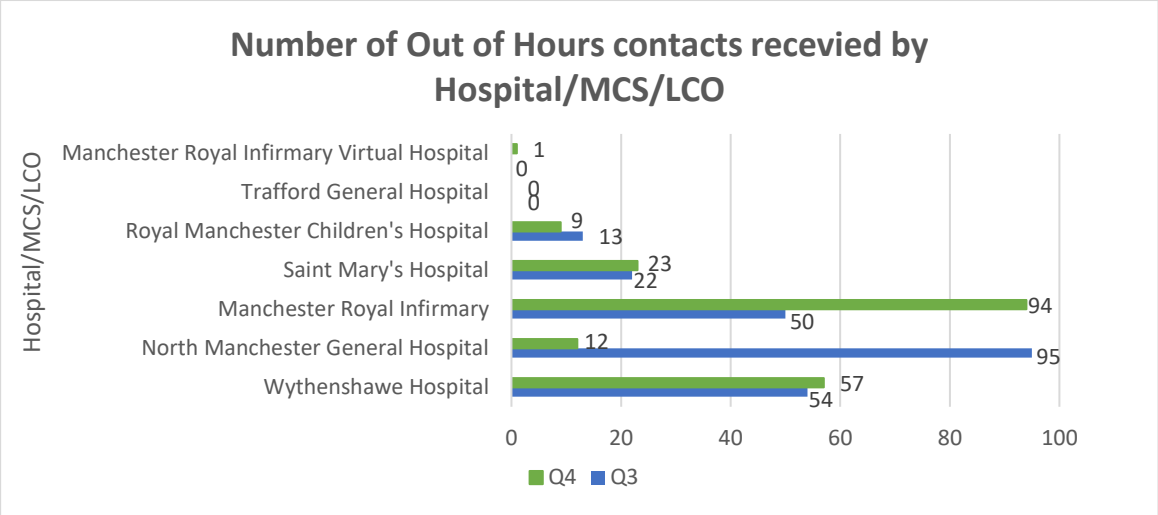
10.1 Chaplains, Assistant Chaplains, and Faith Leaders form part of the multidisciplinary healthcare team, to provide comprehensive care which can significantly improve the overall patient experience by addressing their spiritual care needs.

10.2 In Q4 there was a 2.5% increase from 5,717 Chaplaincy contacts from the previous quarter to 5,863 contacts being received. Overall, the greatest increase in contacts was in the Christian faith with a 20.6% increase being noted compared to the previous quarter.

10.3 MRI received the greatest number of contacts (2153), further breakdown of contacts per Hospital/MCS/LCO can be found in **Appendix 8.**

10.4 It is generally recognised that normal working hours for the Chaplaincy and Spiritual Care team are 08:00 – 16:00 hours, Monday to Friday and Sundays for Christian chaplains. All other times are considered out of hours (OOH) on call Chaplaincy Provisions where appropriate and the Trust's Chaplains will visit a ward, patient area out of hours because of an emergency call out request.

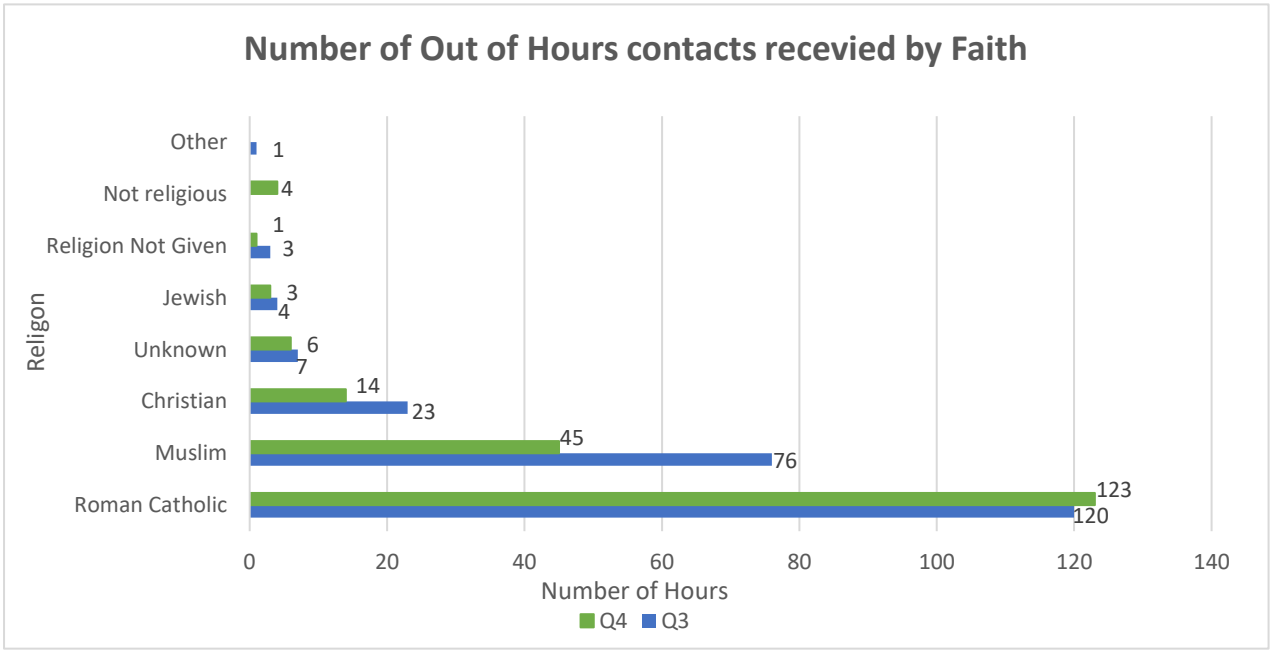
10.5 In Q4 the Trust saw the number of OOH contacts decreasing slightly, with 196 being received compared to 234 in Q3 (16.2% decrease). **Graph 21** shows the number of OOH contacts received from each Hospital/MCS/LCO with MRI receiving the greatest number.



Graph 21: Number of Out of Hours contacts received by Hospital/MCS/LCO, Q3, 23/24 – Q4, 23/24

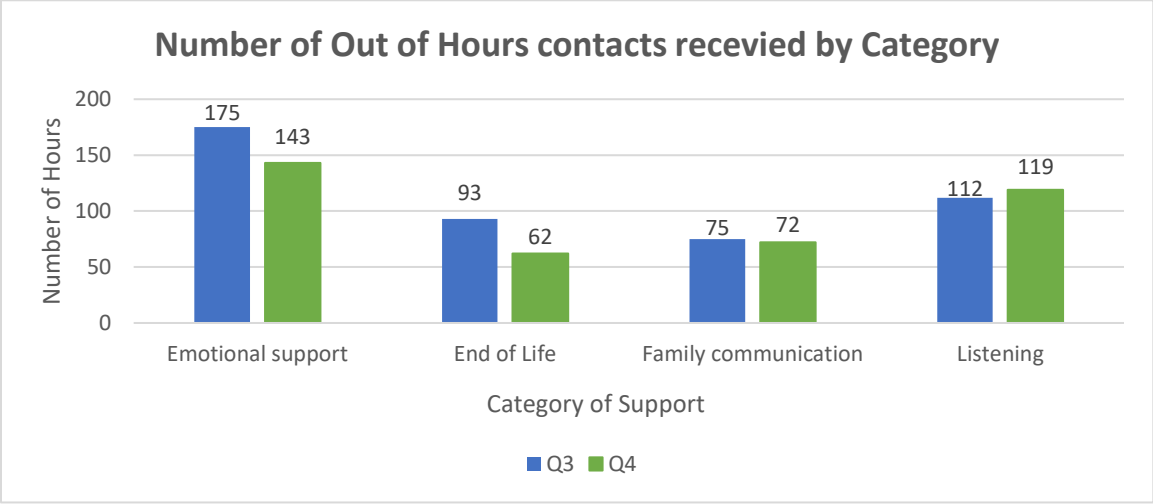
10.6 **Graph 22** shows the number of OOH contacts by faith. Of the 196 OOH requests received, Roman Catholic faith received the greatest number of OOH contacts, 123 (62%). As described above, it is recognised that the primary reason for this increase is that Roman Catholic priests tend to visit clinical areas without a Hive request to see a particular patient/staff member. Overall, the greatest decrease in OOH contacts was in Muslim faith with a 41% decrease being noted compared to the previous quarter.

10.7 It is important to note that the faith recorded is that of the patient, not of the chaplain responding. OOH Muslim faith specific support is provided Friday evening to Monday morning only. At other times the on-call chaplain will respond accordingly.



Graph 22: Number of Out of Hours contacts received by Faith, Q3, 23/24 – Q4, 23/24

10.8 The primary support category for OOH contacts was 'Emotional Support' (**Graph 23**).

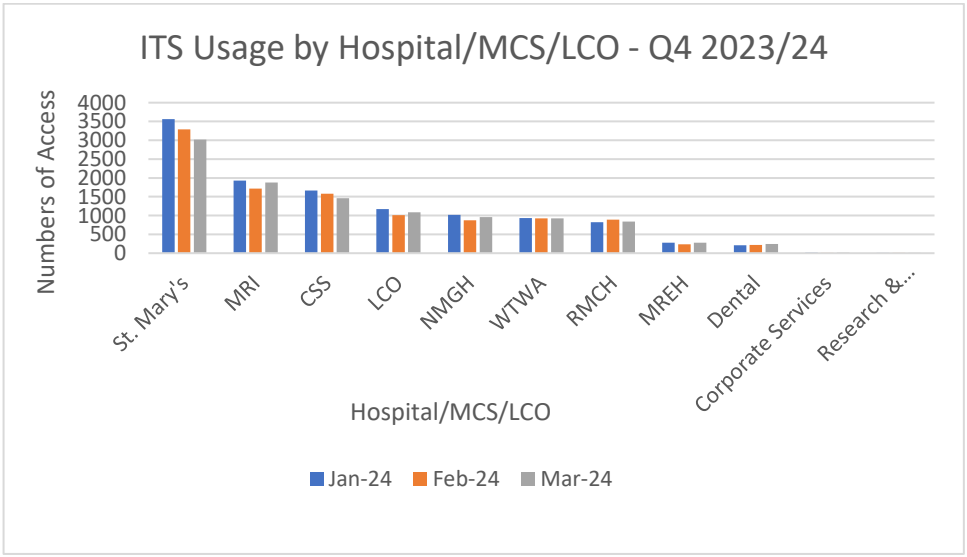


Graph 23: Primary Out of Hours Contact Category, Q3, 23/24 – Q4, 23/24

11. Interpretation and Translation Services (ITS)

11.1 Translation services in patient experience are a critical component to provide effective communication between healthcare providers and patients for quality care and patient safety.

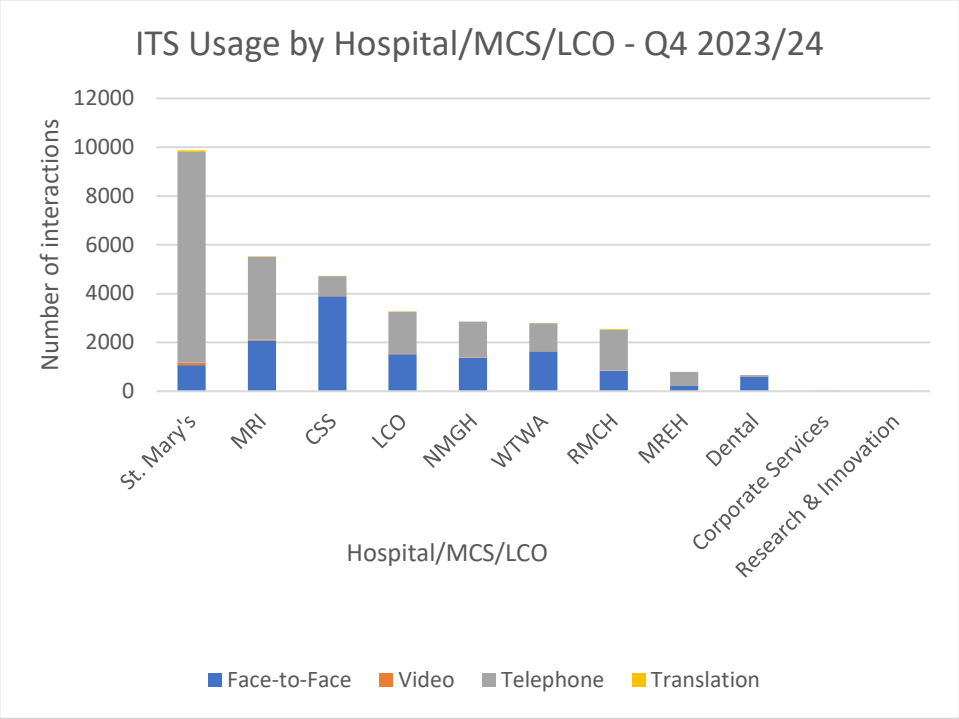
11.2 During Q4, ITS was accessed a total of 33,070 times, an increase of 346 (1.06%) from Q3. **Graph 24** below shows analysis of usage from all Hospitals/MCS/LCO indicating that as in Q4 SMH were the highest user accessing the service 9,868 times, representing 30% of all Trust usage.



Graph 24: Interpretation & Translation Service Usage by Hospital/MCS/LCO, Q4 2023/24.

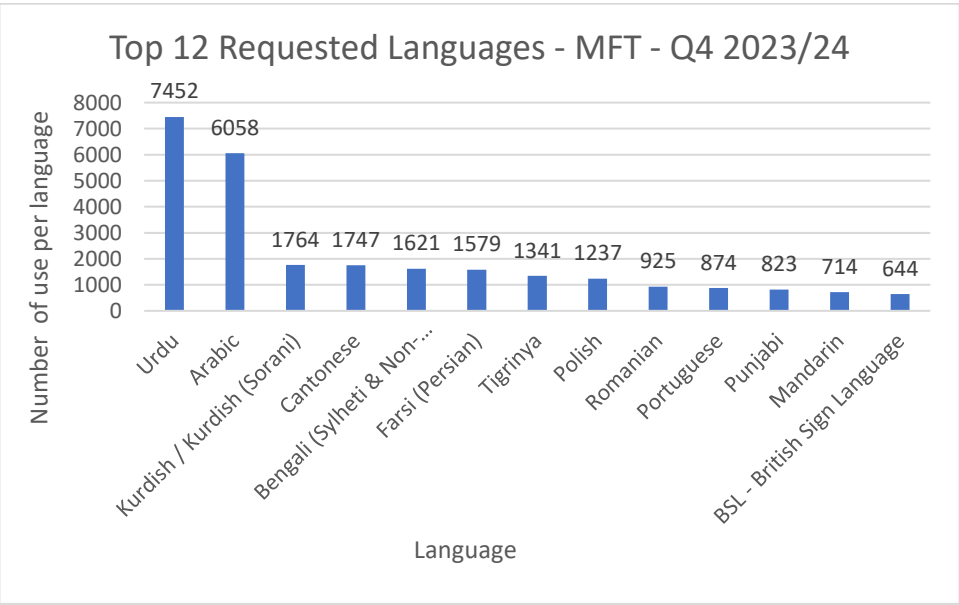
11.3 The most requested service with 19,521 interactions (59%) was telephone interpreting, followed by face to face (13,232, 40%). **Graph 25** shows the distribution of breakdown of service type usage by Hospital/MCS/LCO. SMH remain the highest user of

Telephone Interpretation, using the telephone service 8,812 times (88.38% of their overall usage and 44.57% of all calls made in the Trust).



Graph 25: Distribution of Service Type Usage by Hospital/MCS/LCO, Q3 2023/24.

11.4 As in Q3, of the 107 different Languages/Dialects requested for interpretation, were Urdu and Arabic remained the top two requested languages. Urdu was requested 7,452 times and Arabic 6,058 times. Urdu and Arabic account for 41.00% of all requests in this period (**Graph 26**).



Graph 26: Top 12 languages requested via Face-to-Face, Video and Telephone, MFT, Q4 2023/24.

12. Work Streams/Actions/Learning

Bee Brilliant

Bee Brilliant was delivered in January 2024, the event was led by the Group Chief

12.1 Be Brilliant was delivered in January 2024, the event was led by the Group Chief Allied Health Professional. A total of 629 NMAHP colleagues from across all Hospital/MCS/LCO attended; this included 315 face to face attendees, 217 live stream attendees and 97 roadshow attendees.

12.2 In comparison to the Q3 event, there was a 60% increase from 393 to 629 attendees, resulting in the Q4 Bee Brilliant message being shared with an additional 236 colleagues.

12.3 The event focused on staff wellbeing, and explored the meaning of care, the importance of self-care, and the possible outcomes of ineffective self-care. Understanding and identifying burn out was discussed and a key reminder that spending time for ourselves is not selfish, it is critical to individuals' health and effective care provision. Data from the recent MFT staff survey was shared and colleagues were reminded of the importance of completing. The QI team supported the inclusion of numerous MFT colleague speakers, including physiotherapists, Professional Nurse Advocate (PNA)/Professional Midwife Advocate (PMA), Lime arts team, and a inspirational speaker. This collaboration ensured the event was innovative, thought provoking, inspiring and empowering. Good practice was also shared, including a presentation from Ascot House to celebrate their successful monthly well-being hour initiative, which improved their teams' well-being.

Quality Lead Forums

12.4 The overall purpose of the group is to encourage collaboration of the services across the Hospitals/MCS/LCO. Common themes and best practice are shared in relation to Quality and Patient Experience.

12.5 Following a review of Patient Feedback, Clinical Accreditation Safety Actions and recent audits, the current focus of the group is Nutrition and Hydration, Medications Management and Cleanliness. Feedback and outcomes from this group will be received at the quality and patient experience forum which will in-turn be received by Group Quality and Safety Committee.

Nutrition and Hydration

12.6 Nutrition and hydration continue to be a significant focus at MFT, triangulating data and information from incidents, audits, complaints, and local intelligence.

12.7 The new Mealtime Standards were agreed at NMAHP Professional Board in March 2024, and were launched during Nutrition and Hydration Week, 11th-17th March 2024. To ensure staff and colleagues who are involved in meal services are aware of the

update, a training presentation was developed and made available to all staff through the Hospital/MCS/LCO representatives. To ensure the standards are fully embedded and sustained into practice the group will be undertaking a Trustwide Improving Quality Projects and providing wards and teams with the relevant tools to evidence improvements.

Medications Management

12.8 The Trust Medicines Safety Committee reported an increase in incidents where patients are transferred to different wards / hospitals with the wrong medication, or they are sent to other wards without their medication. In response to this an in-depth scoping exercise was undertaken across all Hospitals/MCS/LCO, which included a staff survey, mapping process exercise and ward observations.

12.9 A briefing paper was presented to the Corporate Director of Nursing, Quality and Patient Experience, and it was decided that the Adult Transfer Policy would be incorporated into this workstream, as it was recognised that both these workstreams will affect the outcome of the safe transfer of patients and their medication. This proposal is to be discussed at Trust Medicines Safety Committee in April 2024.

12.10 The proposed plan has been agreed and the workstream will commence in the near future once the relevant stakeholders have been identified. All progress reports will be shared with the Trust Medicines Safety Committee.

Small change big difference

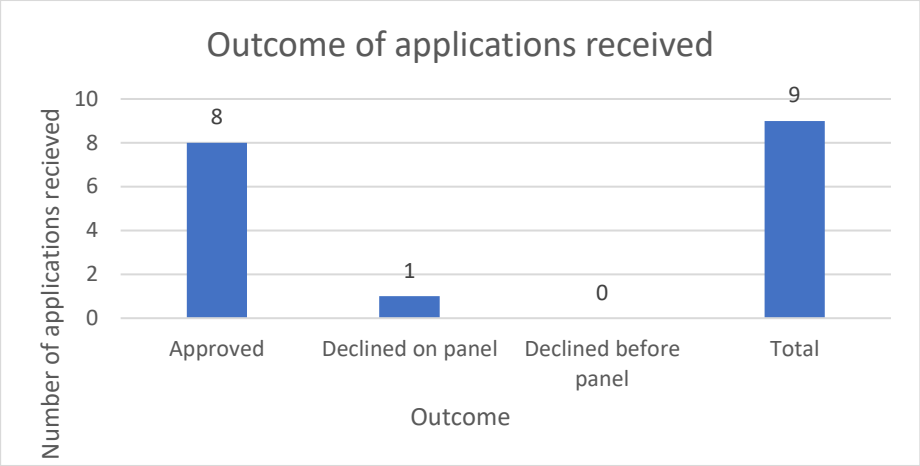
12.11 The Small Change Big Difference (SCBD) program is a service improvement initiative led by the Corporate Director of Nursing for Quality and Patient Experience and managed by the Quality Improvement Team (QI Team) which supports the Trust's 'What Matters to Me' patient experience program.

12.12 SCBD allows all ward/areas/departments to submit applications to fund projects of up to £5000, which are not covered by the wards own budget. In addition, applications to support positive experience for patients with a learning disability will be considered for additional funds of £2000.

12.13 Applications must be based on patient and staff feedback incorporating one or more of the 'What Matter to Me' 'PEOPLE' acronym, 'Positive Communication', 'Environment', 'Organisational Culture', 'Professional Excellence', 'Leadership' and 'Employee Wellbeing', with the aim of improving patient and/or staff experience.

12.14 There has been a total of 9 SCBD applications during Q4. Of the 9 applications, 8 of these were successful and 1 application was declined at panel as they did not fit the outlined criteria. No applications were declined before SCBD panel, (**Graph 27)**.

Allied Health Professional. A total of 629 NMAHP colleagues from across all Hospital/MCS/LCO sites attended and this included 315 face-to-face attendees, 217 live stream attendees and 97 roadshow attendees.



Graph 27: Demonstrates successful SCBD applications per MFT site during Q4.

12.15 A total of £27,215.61 has been awarded to the successful applications during Q4, making a total spend of £127,247.61 for 23/24.

12.16 Examples of successful funding applications, to improve the patient experience during Q4 are.

- Electric couches for patients in the Frailty Assessment Area.
- Armchairs for pregnant women.
- Educational equipment to support the Maternity Support worker Development Programme.
- Updating of seating with enhanced height adjustors for patients.
- Learning and Autism care bags to help patients feel calmer and more relaxed.
- Sensory equipment.

Complaints Review Scrutiny Group (CRSG)

12.17 The CRSG process scrutinises complaints investigated and responded to by MFT and provides an additional level of scrutiny contributing to the learning from these complaints, to improve patient experience and positive change through discussion and reflection.

12.18 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 and Governor, met on four occasions during Q4 reviewing 8 complaints in total.

12.19 The management teams from the Hospital/MCS/LCO presented a case based upon a complaint they had received. Learning and associated actions identified from the cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed.

12.20 Learning from CRSG is discussed at the Quality and Patient Experience Forum to ensure best practice and learning is shared. Examples of how learning from complaints has led to changes that have been applied in practice is provided in **Appendix 8**.

PALS and Complaints

12.21 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.

12.22 Each Hospital/MCS/LCO holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. Examples of how learning from complaints has led to changes that have been applied in practice is provided in **Appendix 8**. The PALS and Complaints team recognise that despite introducing this measure PALS concerns and complaints continue to rise. The team will continue to deliver these forums and have recently introduced local resolution training in the clinical areas to support staff to manage the situation at ward/area level with the aim in reducing formal PALS concerns and formal complaints.

12.23 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.

12.24 During Q4 the Complaints Team finalised and introduced a new Complaints Satisfaction Survey, which can be completed online, via the post or over the telephone, to make it easier for patients and representatives to provide feedback on complaints handling at the Trust.

Patient Stories

12.25 The Patient Experience Team have continued to work closely with Medical Illustrations throughout Q4 building a library of Patient Stories. There were several email requests from colleagues asking for support from the team to facilitate the filming of Patient Stories. These are actively being followed up by the Patient Experience Programme Manager.

12.26 The Patient Stories Database is being categorised by theme and area (hospital/ward). The aim is for there to be a story for each hospital site and for every group of patients (e.g., Veterans, LGBTQ+, BAME, Carers etc).

12.37 During Q4, a further three Patient Stories were shared with the Group Board of Directors: Philip's Story in which he gave an account of being on the PIONEER study after being diagnosed with stage 3 lung cancer; Vincent's Story which detailed his experiences on a very noisy ward at a time when he could not himself speak; and the Roe Brother's Story of using the Kidney Sharing Scheme and encourage others to take part.

12.38 A further four patient stories have been filmed in Q4. An additional two are being edited, while four more have been identified.

Equality and Diversity and Inclusivity (EDI) Monitoring Information

12.39 The collection of Complaint EDI data is important to ensure representation and experiences of individuals from diverse backgrounds are captured. The Trust is committed to ensuring all patients and representatives have equal access to providing feedback on services and having an accessible PALS and Complaints service is fundamental to this.

12.40 The Trust is committed to NHS England's 'Ask, Listen, Do', to improve the experiences and outcomes for children and adults who have autism or a learning disability. PALS and Complaints are represented on the Trust's Disabled People's User Forum and the Learning Disability and Autism Forum, and work closely with the Trust's Equality and Diversity Lead, to gather feedback on barriers to submitting a complaint so the service can be made more accessible to all patients and representatives.

12.41 During Q4, the PALS and Complaints Department worked closely with Trust's Consultant in Public Health, with a focus on health literacy in complaint communications.

12.42 During Q4, a new PALS poster has been created, which is available in different languages and PALS leaflets are also being updated.

12.43 In addition to this, the PALS and Complaints Department continue to establish collaborative working relationships with charitable, voluntary and community organisations, to increase PALS awareness in Greater Manchester.

13 Summary

14.1 As in previous quarters, the themes identified from patient feedback (FFT, WMTM, National Surveys) continue to correlate to the themes identified through complaints. The most common themes identified for improvement across the trust in Q4 are communication, waiting, appointment delays and cancellations, and pain.

14.2 Further work is ongoing to ensure that we are listening and acting on feedback provided by our patients, carers and families. This is monitored through the clinical accreditation programme and the Quality & Patient Experience forum.

14.3 The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns, complaints and provide feedback, as the Trust acknowledges their contribution to improving services, patient experience, and patient safety.

14 Recommendations

14.39 The Board of Directors are asked to note the content of this Quarter 4, 2023/24 Quality and Patient Experience Report and the ongoing work of the Corporate and Hospital/MCS/LCO teams, to ensure that MFT is responsive to concerns and

complaints raised and learns from patient feedback to continuously improve the patient's experience.

14.40 The Board of Directors are asked to agree to receive future quarterly reports in the form of two separate papers. One paper for Complaints and a separate paper for patient experience. The purpose of this would be to provide high level, focused data and information in each paper ensuring measurable actions and outcomes are demonstrated within these.

14.41 The Board of Directors are asked to note the intention to hold a complaints summit with a focus on improving our processes, recognising our current challenges and identifying key actions with measurable outcomes to improve outcomes and experience for patients.

Appendices

Appendix 1

Top 3 Positive WMTM Themes. Quarter 4, 2023/24			
	1	2	3
MFT	Emotional and Physical Support	Friendliness	Compassion
CSS	Professional and Competent	Compassion	Emotional and Physical Support
MLCO	Emotional and Physical Support	Friendliness	Compassion
MREH	Professional and Competent	Friendliness	Compassion
MRI	Emotional and Physical Support	Friendliness	Compassion
NMGH	Emotional and Physical Support	Helpfulness	Compassion
R&I	Friendliness	Compassion	Emotional and Physical Support
RMCH	Friendliness	Compassion	Emotional and Physical Support
SMH	Compassion	Emotional and Physical Support	Friendliness
UDHM	Friendliness	Professional and Competent	Communicating to Patients
WTWA	Friendliness	Compassion	Emotional and Physical Support

Table i: Top 3 Positive Themes based on WMTM feedback captured during Q4 2023/24 by Hospital/MCS/LCO.

Appendix 2

Top 3 Negative WMTM Themes. Quarter 4, 2023/24			
	1	2	3
MFT	Waiting	Food & Beverage	Pain
CSS	Food & Beverage	Pain	Waiting
MLCO	Food & Beverage	Pain	Emotional & Physical Support
MREH	Waiting	Pain	Hygiene
MRI	Waiting	Food & Beverage	Hygiene
NMGH	Waiting	Food & Beverage	Pain
R&I	Pain	-	-

RMCH	Hygiene	Waiting	Emotional & Physical Support
SMH	Waiting	Pain	Hygiene
UDHM	Waiting	Privacy, Dignity & Respect	Hygiene
WTWA	Waiting	Food & Beverage	Pain

Table ii: Top 3 Negative Themes based on WMTM feedback captured during Q4 2023/24 by Hospital/MCS/LCO.

Appendix 3

Top 3 Positive FFT Themes. Quarter 4, 2023/24			
	1	**2**	**3**
MFT	Friendliness	Professional and Competent	Emotional and Physical Support
CSS	Emotional and Physical Support	Friendliness	Compassion
MLCO	Emotional and Physical Support	Compassion	Professional and Competent
MREH	Professional and Competent	Friendliness	Emotional and Physical Support
MRI	Friendliness	Professional and Competent	Emotional and Physical Support
NMGH	Professional and Competent	Emotional and Physical Support	Compassion
R&I	Friendliness	Professional and Competent	Emotional and Physical Support
RMCH	Friendliness	Emotional and Physical Support	Helpfulness
SMH	Friendliness	Emotional and Physical Support	Compassion
UDHM	Emotional and Physical Support	Professional and Competent	Compassion
WTWA	Professional and Competent	Friendliness	Emotional and Physical Support

Table iii: Top 3 Positive Themes based on FFT feedback captured during Q4 2023/24 by Hospital/MCS/LCO.

Appendix 4

Top 3 Negative FFT Themes. Quarter 4, 2023/24			
	1	2	3
MFT	Waiting	Pain	Emotional & Physical Support
CSS	Waiting	Food & Beverage	Emotional & Physical Support
MLCO	Waiting	Emotional & Physical Support	Pain
MREH	Waiting	Facilities	Comfort
MRI	Waiting	Pain	Emotional & Physical Support
NMGH	Waiting	Pain	Emotional & Physical Support
R&I	-	-	-
RMCH	Waiting	Parking	Facilities
SMH	Waiting	Comfort	Food & Beverage
UDHM	Waiting	Pain	Facilities
WTWA	Waiting	Pain	Emotional & Physical Support

Table iv: Top 3 Negative Themes based on FFT feedback captured during Q4 2023/24 by Hospital/MCS/LCO.

Appendix 5

	Disputes Information	New Questions	Not All Issues Fully Addressed/Unresolved issues	Request Local Resolution Meeting	Other	Total
WTWA	3	6	14	2	0	25
MRI	8	6	11	3	0	28
CSS	0	0	4	1	0	5
RMCH	4	2	4	0	0	10
Corporate	0	1	4	0	0	5
LCO	0	1	2	0	0	2
NMGH	4	1	7	0	1	13
SM MCS	3	2	2	1	0	9
UDHM/MREH	2	1	1	0	0	4
Total	**24**	**20**	**49**	**7**	**1**	**101**

Table v: Total re-opened complaints by Hospital/MCS/LCO Q4, 2023/24.

Appendix 6

"Just a note to say thanks to you, your team and the PALS Teams. As my astute wife observed 'you are between a rock and a hard place' in your job'. I would be grateful if you would pass this onto the PALS Team, especially Louise who somehow managed to keep her cool when I was irate with what I was dealing with."
"I want to thank the whole team who were in the A&E Department at that time for the care my mum she received. I would specially like to mention Doctor Molly, Student Doctors KA Wing, and Amelia who were very kind and caring explained everything so my mum knew what was happening and was confident in the care being given. Other team members who made her time there as comfortable as they could were nurse assigned Cheryl and Bethany who provided her with a hot drink and sandwich. It is obviously a very busy stressful area of the hospital but the care given was calm kind and efficient. Thankyou from a grateful daughter."
"I wanted to send my most sincere gratitude to the marvellous staff who delivered my son and looked after him and my wife at North Manchester General Hospital. The staff on the enhanced recovery team and the surgical team were outstanding. The surgical team were amazing reassuring my wife, making her laugh and providing the utmost professional care. The midwives and staff (both day and night shift staff) in the enhanced recovery team - especially Katie and Sarah - were so caring. My wife was completely as ease. Nothing ever seemed too much to ask of them. Whilst it is often said that those you in the medical profession do not have a job but a vocation, I was truly overwhelmed by just how fantastic you are. I was able to leave the hospital on that first evening safe in the knowledge my family were in the best hands. I will be forever grateful. Keep up the marvellous work!"

"I wanted to take a moment to express my deepest gratitude for the prompt response I received from NHS PALS. Your efficiency and dedication to addressing my concerns is truly commendable. Once again, I would like to extend my heartfelt thanks to all the NHS heroes, including the PALS Team and the incredible Midwife, Jen. Your dedication and commitment to providing excellent healthcare is truly inspiring. I am grateful for the exceptional level of care and support I have received."

Table vi: Examples of compliments received during Q4 2023/24 recorded on the Trust's Customer Services Database.

Appendix 7

Category	Activity	Hours	Volunteers
Adult Activity Ward Role	Critical Care	31.84	3
	Ward 1	9.09	1
	Ward 31	29.95	2
	Ward 45	10	2
Bespoke Roles	Complex Patient Programme	3.97	2
	EPL Counsellor	40.22	2
Charitable Organisations	Macmillan Counselling Volunteer	194.97	8
	SPOONS Volunteer	31.5	4
Emergency Department	Paediatric Emergency Department	25.94	3
Events	Midwife Wellbeing Day	5.92	3
Meet & Greet	MRI PALS- Entrance 2	128.45	15
	MREH	113.8	16
	MRI Entrance 1	300.69	28
	Peter Mount Meet & Greet	14.31	2
	RMCH	161.33	20
	SMH	22.03	5
Paediatric Activity Ward Role	Ward 78	61.8	1
	Ward 84	2.44	1
	Ward 85	10.6	2
Patient Services	Chaplaincy	38.95	1
	E-Learning Support	8.74	1
	Pets as Therapy Volunteer	10	2
	Volunteer Office	31.61	2
Training	Face to Face Fire Safety	22	22
Uncategorised Activities	Fire Safety Administrative Assistance	15.36	1
Volunteer Recruitment	Oxford Road Campus- Virtual Interview	2.77	1
Total Hours		**1328.28**	

Number of hours volunteered by role at ORC.

Category	Activity	Hours	Volunteers
Adult Activity Ward Role	Patient Dining Companion	14.85	1
Charitable Organisations	Macmillan Counsellors, TGH	342.89	21

	Macmillan Gardening	75.7	4
	Ticker Club	341.67	16
Emergency Department	Emergency Department	29.9	2
Meet & Greet	Meet & Greet/Face Mask Distribution	768.35	31
Patient Services	Administration	72.54	3
	Chaplaincy	220.93	13
	Pets As Therapy	5	1
Training	Face to Face Fire Safety Training	13	13
	Face to Face Fire Training	3	3
Volunteer Recruitment	Virtual Interview	0.5	1
Total Hours		**1888.33**	

Number of hours volunteered by role at WTWA.

Category	Activity	Hours	Volunteers
Adult Activity Ward Role	Outpatients	17	2
	Ward D5	3	1
	Ward D6	2	1
Charitable Organisations	EZRA	2.89	1
Meet & Greet	Reception Desk	1050.01	31
Paediatric Activity Ward Role	Children's Unit	36	1
Patient Services	Chaplaincy	55.77	3
Total Hours		**1166.67**	

Number of hours volunteered by role at NMGH.

Appendix 8

Site	Q2, 23/24	Q3, 23/24	Q4, 23/24
Manchester Royal Infirmary	1888	2021	2153
Wythenshawe Hospital	1648	1675	1900
North Manchester General Hospital	1204	1287	1016
Royal Manchester Children's Hospital	261	296	315
Trafford General Hospital	162	150	173
Saint Mary's Hospital	185	256	271
MRI Virtual Hospital	33	1	1
Manchester Royal Eye Hospital	12	16	12
Unspecified	1	10	18
Wythenshawe Virtual Hospital	0	5	3
Stockport NHS Dialysis Unit	0	0	1
Total Contacts	**5394**	**5717**	**5863**

Number of contacts received by Hospital/MCS/LCO, Q3, 2023/24

Appendix 9

Reason for complaint	Action Taken
Concerns regarding the long delays in their daughter's surgery at RMCH and lack of communication between referring hospital and RMCH and regarding cancellations.	Divisional Leadership Team will ensure all service line agreements with district general hospitals are delivered by more than one individual consultant to ensure the service does not become over reliant on any one individual. Operational Manager shared concerns and feedback with team to reflect on the impact that short notice cancellations have on patients and their families, and the Clinical Lead discussed the impact of the delay in adding the patient to the waiting list for surgery with Lead Consultant. Operational Manager are revising the referral process from external Trust to RMCH to ensure they are not solely reliant on clinicians and can also be managed by administrative and operational staff going forwards. The Clinical Lead are undertaking a complete review of the Paediatric Orthopaedic Service delivered at the external Trust to address the backlog of referrals and lengthy delays. A long-term Locum for the external service has been secured, who has already begun work on clearing backlogs in triage and clinics. Meetings are ongoing and the Operational Teams from both sites hope to have a plan to reduce backlogs agreed by the start of the 2024/2025 financial year, at which point the revised pathway and service delivery plan will commence.
Concerns raised regarding patient's relative being discriminated against, as they were neurodivergent and questioned if reasonable adjustments were made in an effort to aid communication.	The experience was shared at the Learning and Disability and Autism Delivery Group. The Ward Manager is reviewing the offer of alternative communication, such as video calling. Feedback also shared with staff involved in care, to allow them to reflect on the impact this experience had on the patients.
Concerns raised regarding a patient with coeliac disease being provided with food that caused diarrhoea and sickness. Further concerns regarding the nutrition and hydration care patients received on wards.	The ward commenced a Quality Improvement Project related to nutrition and hydration and mealtime audits completed to ensure patients' nutritional needs are met. Daily Senior Nurse Review will be conducted to include all patients who are nil by mouth. A new mealtime menu is being launched, overseen by the Head of Nursing for Quality. Ward staff to complete nutrition and hydration awareness training.

Concerns regarding staff's attitude, lacking empathy and compassion, when a family requested a viewing of a deceased patient.	Concerns shared with staff at the cross-site Mortuary staff meeting highlighting the importance of positive interactions in contact calls with family members. When booking viewings, a standard phrase will be included to request that if families are unable to attend a viewing they contact the department to cancel the appointment. Mortuary viewing log sheets being updated to include a section for staff to document call backs. Staff encouraged to ensure continuous learning in relation to communication methods, including attendance at Sage and Thyme communication courses.
Concerns regarding a patient's hygiene needs not always met in a timely manner and heel pressure sore not always managed appropriately.	Concerns shared with the ward team and staff asked to document exact times that incontinence pads are changed, to raise awareness and improve continence care on the ward. Daily review with Head of Nursing, Matron and Ward Manager established, to review all vulnerable patients to ensure all aspects of care considered and completed. Ward Manager and Nurse in Charge will conduct daily risk assessment checks and review of actions, to ensure timely implementation are in place for all CVS ward areas. Teaching has been provided on the ward, in relation to pressure care and the management of pressure related injury, including repositioning regimes and care plan documentation. Tissue Viability Nurse Team have provided bespoke wound management training on the ward.

Complaint reasons and actions Q4, 23/24.

Agenda Item 11.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Corporate Director of Nursing (Workforce and Professional Education)
Date of paper:	May 2024
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 note the contents of this paper.
Contact:	Name: Anne-Marie Varney, Corporate Director of Nursing Tel: 0161 276 8862

1 Executive Summary

1.1 This report details the Trusts position against the requirements of the National quality Board (NQB) Safer Staffing Guidelines for Adult Wards (2016)[1] and NHS Improvement (NHSI) Developing Workforce Safeguards Guidance (2018)[2].

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 2023.

1.3 Registered nursing and midwifery staffing levels are positively associated with quality and outcome measures, including mortality, patient, and staff experience. 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. This is pertinent when balancing patient safety, transformation of services and financial efficiency.

1.4 Nationally, nursing and midwifery workforce supply and demand remains a well-recognised challenge within the NHS. Dynamic initiatives in bridging the vacancy gap by the government through increased funding to recruit and train more nurses and midwives has been instrumental in changing the landscape within the workforce position both nationally and locally over the last 2 years. In February 2024 the number of nursing and midwifery vacancies in England was 34,709 (8.4%) which is a reduction of 2.3% from the previous year[3].

1.5 The NMC have reported an increase in registrants joining the register during the same period with an increase of 14,000 (2.5%) additional nurses and midwives joining the register from the previous year. Overseas nurses who have settled in the UK over the last 5 years make up 35% of new registrants[4].

1.6 Since the publication of the NHS Long Term workforce Plan[5], retention of staff within the NHS remains a key priority. Nationally, the most common reasons provided for leaving the NHS in all roles are retirement followed by work-life balance. The number of nurse leavers has risen to 9,977 which is a slight increase from the previous six months (NHSE 2024). Understanding the complex factors associated with staff leaving, is essential in supporting the retention agenda and to continue to reduce vacancy rates.

1.7 In November 2023, 169,547 registered AHPs were working in the NHS in England which was an increase of 8,524 posts nationally from the previous year. Diagnostic

[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] NHS England (2024) NHS Vacancy Statistics England
[4] NMC (2023) The NMC register mid-year update - 1st April - 30th September 2023
[5] NHS England (2023) NHS Long Term Workforce Plan

Radiography had the largest increase in staff at 7.7%. The professional groups with the smallest increase were podiatry and orthoptists at 1.4%[6].

1.8 Nationally, data (January 24) shows a 7% decrease in the number of applicants to undergraduate nursing courses across the UK compared to 2023, particularly in adult nursing and mental health nursing, and 13% decrease in the number of applicants to UK undergraduate midwifery courses. The number of applicants to nursing courses for providers in England decreased by 10% compared to 2023. The biggest decreases were in the number of applicants aged 25-29 years (19%), aged 30-34 years (14%) and those aged 35 years and over (13%). The number of applicants for Midwifery courses for providers in England decreased by 14%. The biggest decrease again was in the mature age range, 30-34 years (26%) and those aged 35 years and over (18%). In the Northwest there has been a reduction in numbers across all fields of nursing compared to 2022/23 starts, this is most obvious in adult nursing where the autumn 2023 intakes were 16% lower than autumn 2022 intakes. Application numbers for midwifery follow similar trends, with a decrease of 13% in applications received from 8,910 to 7,740 in 2023[7].

1.9 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Recruitment numbers for academic year 2023/24 at GM HEI's reflect the national picture somewhat and show, a continued increase in Direct Entry Student Nursing Associates programmes, midwifery, CYP and Mental Health programme remain stable with the same numbers as academic year 2022/23. There is a decline in recruitment numbers for adult nursing (13%)

1.10 Since the previous Board of Directors report the overall nursing and midwifery workforce has continues to improve with the number of registered nursing and midwifery vacancies reducing from 3.8% to 2.0% and sickness and absence has reduced to 6.3% for registered staff and 9.1% for unregistered staff. The turnover of nursing and midwifery staff has continued to improve with the current turnover rate of 10.2%. This has supported an improvement in the average fill rate against planned shifts for both registered (94%) and unregistered nurses (95%) since the last report. The improved workforce position will continue to support the hospitals/MCS to reduce the reliance on temporary staff.

1.11 At the end of March 2024 there were a total of **196.0wte (2.0%)** registered nursing and midwifery vacancies across the Trust which is the lowest vacancy position since MFT was formed. This low vacancy position has been achieved through a combination of successful recruitment programmes and decreasing nursing and midwifery turnover. Registered nursing and midwifery turnover has continued to decrease, down to **10.2%** in March 2024 from **12.1%** in September 2023.

1.12 The Trust's overall nursing and midwifery vacancy rate **(2.0%)** is much lower than the national vacancy rate of **8.4%** and the Northwest vacancy rate of **6.1%**[8]. It is predicted

[6] NHS England (2023) NHS Workforce Statistics
[7] Council of Deans of Health (2024) Briefing: UCAS deadline applicant
[8] NHS England (2024) NHS Vacancy Statistics England

that nursing and midwifery vacancies will decrease by Q3 with the potential to bring vacancies below **150wte (1.5%).**

1.13 At the end of March 2024, the 12-month rolling turnover rate for registered nurses and midwives was **10.2%**, this is a decrease since September 2023 when the rate was **12.1%**. The trust turnover rate is lower than the current national turnover rate for nursing and midwives in acute NHS trusts which is **12.7%**[9].

1.14 Recruiting and retaining nursing and midwifery support staff remains a challenge. At the end of March, the total number of band 2/3 clinical support worker vacancies is **401.9wte (12.3%).** There has been some growth to the band 2/3 workforce of c50wte following a skill mix review in some areas. The vacancy rate is the lowest seen since pre pandemic and has bend supported by a reduction in turnover of **2%**.

1.15 The benefits of Hive EPR will continue to enhance patient safety and experience. The system provides valuable data and reports to enhance the professional judgement and evidenced base to triangulate nursing and midwifery and AHP safe staffing data and decisions with patient outcomes.

1.16 The Safer Nursing Care Tool census in January 2024 has provided assurance that 75% of in-patient establishments are aligned to the recommended level when reviewed through an evidenced base approach. Action taken to resolve any staffing shortfall in the remaining 25% are described in section 6. The census will be repeated in July 2024 and will be used to validate any changes to the staffing models in these areas. The January 2024 census results indicate that 5% 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 unregistered/support skill mix in these areas is high to support the acuity of patients specifically patients with dementia requiring enhanced supervision.

1.17 There has been a continuing focus on nursing, midwifery and AHP development to support staff retention and provide CPD opportunities. It is acknowledged that national CPD funding opportunities may likely reduce overtime and therefore the focus will be to develop sustainable CPD programmes which will support ongoing training and development of staff to support service transformation and leadership.

1.18 The trust has continued with a commitment to increase pre-registration placement capacity for NMAHP undergraduates. The guaranteed job offer for nursing and midwifery final year students demonstrates the ongoing commitment investing in the future of our learners. A commitment to offer these opportunities to AHP graduates is currently being developed.

[9] NHS England (2023) - Workforce Intelligence Portal

2 Introduction

2.1 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[11] Guidance, published in October 2018.

2.2 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 2023.

2.3 Registered nursing and midwifery staffing levels are positively associated with quality and outcome measures, including mortality, patient, and staff experience. 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. This is pertinent when balancing patient safety, transformation of services and financial efficiency.

2.4 This report provides analysis of the Trust's Nursing, Midwifery and AHP workforce position at the end of March 2024. The Hospitals, Managed Clinical Services (MCS) and Local Care organisation (LCO) 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).

3 National Context

Nursing and Midwifery

3.1 Nationally, nursing and midwifery workforce supply and demand remains a well-recognised challenge within the NHS. Dynamic initiatives in bridging the vacancy gap by the government through increased funding to recruit and train more nurses and midwives has been instrumental in changing the landscape within the workforce position both nationally and locally over the last 2 years.

3.2 Data from NHS England show a vacancy rate of 8.4% (34,709) vacancies in February 2024 for registered nurses and midwives, which is a decrease of 2.3% from the same period the previous year when the vacancy rate was 10.7% (43,251) vacancies[12].

3.3 The NMC Register Mid-Year Data Report (September 2023) showed 622.897 nurses, registered with the NMC in England, which is an additional 12,545 and an increase of 2.1% in the previous year. Overseas nurses who have settled in the UK make up 35%

[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] NHS England (2024) NHS Vacancy Statistics England

of new registrants. The number of midwives registered in England with the NMC during this period has increased by 2.8%, with a total of 35,290[13].

3.4 Despite the government successfully achieving the target to recruit 50,000 additional nurses in 2023 within 5 years of the pledge in 2019, the target is not sufficient to cope with the number of hospital admissions leaving substantial demand for the new nurses in the NHS. The constant challenge of supply and demand of NHS staff, has several considerations. The persisting increase in demand is influenced by several factors:

- An aging population with increase in the number of hospital admissions. In the NHS, 70% of bed days are used by people aged over 65.
- NHS staff retirement.
- An increase in nursing workload due to a growing population and post pandemic complexities with increased acuity, dependency, and comorbidities.
- Long term staff sickness absence reported due to anxiety, stress, depression accounting for over 584,800 full time equivalent days lost and amounting to 25.2% of all sickness absence reported in October 2023.
- Recurring industrial strike action over the last 12 months reportedly resulted in over a million appointments (1,333,221 January 2024) been delayed, impacting staffing levels across England[14].

3.5 In 2023 the NHS Long Term Workforce Plan (LTWP) sets out the case for change, taking a more strategic and long-term approach to improving the workforce position, and proposes actions to be taken locally, regionally, and nationally in the short to medium term to address current and future workforce challenges. The LTWP recognised the rising demographic pressures, changing burden of disease, high number of vacancies across the NHS workforce, and the NHS's firm reliance on temporary staffing and international recruitment to fill service gaps to ensure safe staffing levels.

3.6 Since the publication of the LTWP, retention of staff within the NHS remains a key priority. Nationally, the most common reasons provided for leaving the NHS in all roles are retirement followed by work-life balance. The number of leavers has risen to 9,977 which is a slight increase from the previous six months (NHSE 2024). Understanding the complex factors associated with staff leaving, is essential in supporting the retention agenda and to continue to reduce vacancy rates[15].

3.7 In October 2023 Shelford Group, supported by NHS England published a revised Safer Nursing Care Tool (SNCT) for adult inpatient wards and adult assessment units which has been endorsed by the Chief Nursing Officer for England. The revised tool reflects the increased acuity and complexity of adult patients in response to their acute needs and recognising the increased number of patients admitted with mental health conditions requiring enhanced supervision[16].

[13] NMC (2023) The NMC register mid-year update - 1st April - 30th September 2023
[14] NHS England (2024) NHS publishes data following junior doctor strike
[15] NHS England (2023) NHS Long Term Workforce Plan
[16] Shelford Group (2023) Improving adult inpatient wards and adult acute assessment units – getting the right nursing staff in the right place at the right time

Allied Health Professionals

3.8 The findings from the Health Care Professional Council (HCPC) report "Retention rates of first time HCPC registrants[17], 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 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[18].

3.9 The NHS LTWP recognised that paramedics, podiatrists, radiographers, and speech and language therapists are in short supply. Whilst initiatives are ongoing to meet demand, there continues to be shortages within these and several AHP groups including prosthetics and orthotics, orthoptics, and operating department practitioners (ODPs)[19].

3.10 In November 2023, 169,547 registered AHPs were working in the NHS in England which was an increase of 8,524 posts nationally from the previous year. Diagnostic Radiography had the largest increase in staff at 7.7%. The professional groups with the smallest increase were podiatry and orthoptists at 1.4%[20].

3.11 The NHS LTWP summarised the aspiration to increase pre-registration learners and proposed a national AHP figure of an additional 18,822 places[21]. In February 2024, the HEIs and provider trusts in the Northwest have been asked to set out their capacity to accommodate increased learners.

Undergraduate Nursing, Midwifery and AHP Pre-Registration Education Pipeline

3.12 Nationally, data (January 24) shows a 7% decrease in the number of applicants to undergraduate nursing courses across the UK compared to 2023, particularly in adult nursing and mental health nursing, and 13% decrease in the number of applicants to UK undergraduate midwifery courses. The number of applicants to nursing courses for providers in England decreased by 10% compared to 2023. The biggest decreases were in the number of applicants aged 25-29 years (19%), aged 30-34 years (14%) and those aged 35 years and over (13%). The number of applicants for Midwifery courses for providers in England decreased by 14%. The biggest decrease again was in the mature age range, 30-34 years (26%) and those aged 35 years and over (18%). In the Northwest there has been a reduction in numbers across all fields of nursing compared to 2022/23 starts, this is most obvious in adult nursing where the autumn

[17] HCPC (2024) The HCPC publishes analysis of retention rates among registrants who joined the HCPC Register via the international registration route
[18] HCPC (2024) The HCPC publishes analysis of retention rates among registrants who joined the HCPC Register via the international registration route
[19] NHS England (2023) NHS Long Term Workforce Plan
[20] NHS England (2023) NHS Workforce Statistics
[21] NHS England (2023) NHS Long Term Workforce Plan

2023 intakes were 16% lower than autumn 2022 intakes. Application numbers for midwifery follow similar trends, with a decrease of 13% in applications received from 8,910 to 7,740 in 2023[22].

3.13 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration to increase the pre–registration education pipeline. Recruitment numbers for academic year 2023/24 at GM HEI's reflect the national picture somewhat and show, a continued increase in Direct Entry Student Nursing Associates programmes, midwifery, CYP and Mental Health programme remain stable with the same numbers as academic year 2022/23. There is a decline in recruitment numbers for adult nursing (13%).

4. MFT Workforce Position

Nursing and Midwifery Vacancies

4.1 The Trust has continued to benefit from successful domestic and international recruitment programmes. The two programmes have resulted in **963.1wte** registered nurses and midwives joining the organisation since September 2023. On average the Trust have benefited from **137.6wte** domestic and international recruitment starters per month since during this period, resulting in a significant decrease in vacancies in Q3/4.

4.2 At the end of March 2024 there were a total of **196.0wte (2.0%)** registered nursing and midwifery vacancies across the Trust which is the lowest vacancy position since MFT was formed. This low vacancy position has been achieved through a combination of successful recruitment programmes and decreasing nursing and midwifery turnover. Registered nursing and midwifery turnover has continued to decrease, down to **10.2%** in March 2024 from **12.1%** in September 2023.

4.3 The Trust's overall nursing and midwifery vacancy rate **(2.0%)** is much lower than the national vacancy rate of **8.4%** and the Northwest vacancy rate of **6.1%**[23]. 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.

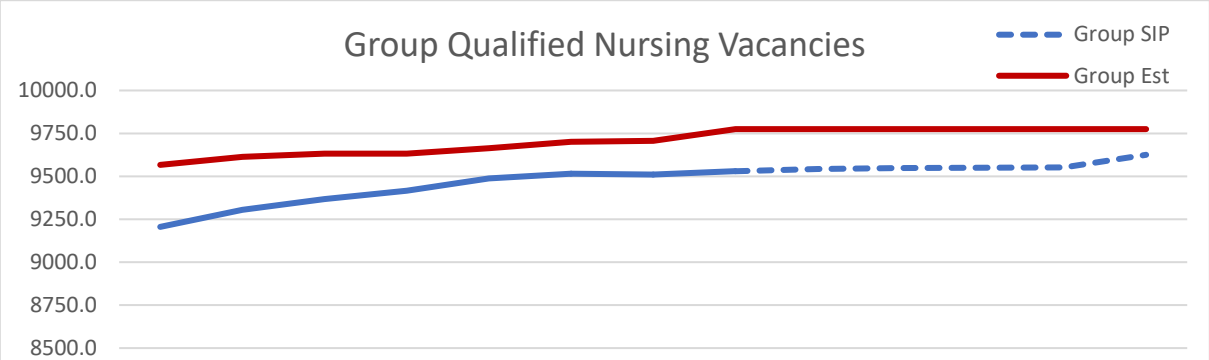
4.4 Workforce modelling undertaken in September 2023 predicted the vacancy position and planned domestic and international campaigns would end the 2023/24 financial year with below **200wte** of which we remain firmly on track.

4.5 Applying the current workforce assumptions in Q1 and Q2 it is predicted that nursing and midwifery vacancies will decrease by Q3 with the potential to bring vacancies below **150wte (1.5%)**. (**Graph 1**). A large proportion of these predicted vacancies will be at band 5.

Graph 1

[22] Council of Deans of Health (2024) Briefing: UCAS deadline applicant

[23] NHS England (2024) NHS Vacancy Statistics England



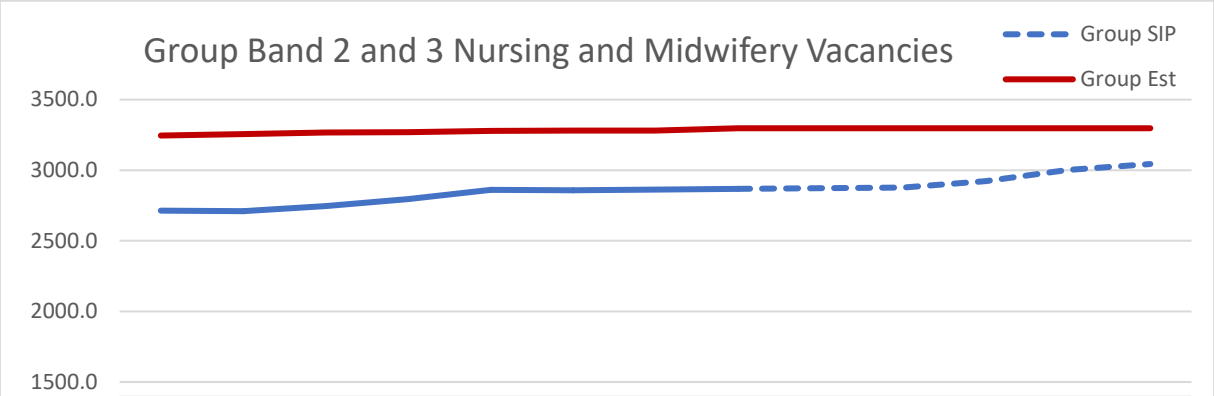
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Group SIP	9205.8	9305.0	9367.6	9416.3	9487.9	9515.3	9510.3	9530.3	9542.3	9548.3	9549.3	9551.3	9625.3
Group Est	9566.7	9613.9	9633.0	9632.8	9663.4	9701.0	9706.3	9774.9	9774.9	9774.9	9774.9	9774.9	9774.9
Group Vac	360.9	308.9	265.4	216.5	175.5	185.7	196.0	244.6	232.6	226.6	225.6	223.6	149.6

4.6 At the end of March the total number of band 2/3 clinical support worker vacancies is **401.9wte (12.3%).** There has been some growth to the band 2/3 workforce of c50wte following a skill mix review in some areas. The turnover rate for band 2/3 support workers is 13.7% which is a reduction of 2% since September 2023. Retention of band 2/3 staff remains a challenge with staff moving into other roles and opportunities in the organisation and competing pay rates offered by external employers.

4.7 Over the last 6 months there has been a steady improvement in reducing the band 2/3 vacancies aided by the slow-down in turnover for this staff group. Following a group wide clinical support worker campaign in Q3 vacancies have reduced by 4.1% (130wte) bringing vacancies down to the pre pandemic position.

4.8 An ongoing programme of nursing assistant and maternity support worker events are in place within the hospitals/MCS. There are currently **180** candidates in the band 2/3 recruitment pipeline due to start by the end of Q1. A group wide recruitment campaign is currently underway with the ambition to recruit 150-200 band 2/3 staff. The event aims to attract local people into healthcare. The Trust is working with Job Centre Plus and local agencies to signpost people to the campaign. It is predicted the trusts vacancy position will improve to **c250wte** by the end of Q2 (**Graph 2**).

Graph 2



	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Group SIP	2713.8	2709.9	2746.2	2795.6	2861.0	2857.9	2862.9	2867.9	2872.9	2877.9	2922.9	3002.9	3043.9
Group Est	3245.6	3256.8	3266.7	3269.5	3279.2	3280.7	3280.7	3297.1	3297.1	3297.1	3297.1	3297.1	3297.1
Group Vac	531.8	546.9	520.5	473.8	418.2	422.8	417.8	429.2	424.2	419.2	374.2	294.2	253.2

Nursing and Midwifery Turnover

4.9 At the end of March 2024, the 12-month rolling turnover rate for registered nurses and midwives was **10.2%**, this is a decrease since September 2023 when the rate was **12.1%**. The trust turnover rate is lower than the current national turnover rate for nursing and midwives in acute NHS trusts which is **12.7%**[24].

Nursing and Midwifery Sickness Absence

4.10 Sickness rates have steadily continued to reduce overall for registered nursing and midwifery staff from **6.8%** in September 2023. However, following annual trend, increases in sickness were encountered in December 2023 and January 2024, these increases have now resumed back to normal level and are currently **6.3%** in March 2024. Rates for band 2 and 3 staff have followed the same pattern and following a peak of **11.2%** in December 2023 are now back down to **9.6%** in March 2024.

4.11 Targeted initiatives have been put in place to support hot spot clinical areas to reduce sickness absence by **2%** as 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 well-being of staff.

Nursing and Midwifery Recruitment

Domestic Recruitment

4.12 Trust wide recruitment initiatives continue to attract newly qualified nurses and midwives and experienced nurses. A guaranteed job offer is in place for all nursing, midwifery students, trainee nursing associates (TNA) and operating department

[24] NHS England (2023) - Workforce Intelligence Portal

practitioners who undertake their final year placements at MFT. 360 students are due to graduate in 2024 are expected to take up posts before the end of Q3.

4.13 Participation at external recruitment events such and Higher Education Institute (HEI) open days continue to showcase MFT as an employer of choice with a range of opportunities for different specialities.

International Recruitment

4.14 The international recruitment (IR) programme has been a strong and reliable pipeline for band 5 nurse recruitment. The total number of international nurses and midwives who join the Trust in 2023/24 is **393wte.** This includes a total of **370** nurses and **23** midwives. Due to the improved vacancy position, the reliance on international recruitment for the next financial year is anticipated to be considerably reduced. A total of 46 nurses are planned to arrive before the end of July 2024. Workforce modelling is being undertaken to map the nursing vacancy trajectory for the following 12-18 months. This work will determine the future international recruitment requirements needed to supplement the domestic recruitment pipeline.

4.15 The international recruitment programme for midwives as part of a NW regional collaboration working in partnership with NHSE and the GM Maternity Network has seen a successful uptake of **23** midwives in 2023/24.

4.16 Since the Trust joined the regional collaborative programme of international AHP recruitment which was launched by NHSE in June 2022 a total of **13** diagnostic radiographers and 9 Occupational Therapists have been recruited.

Nursing Associate Workforce

4.17 There are currently **187** registered nursing associates working across all hospitals and community setting and theatre areas within MFT. There are **103** trainee nursing associates (TNA) across the trust undertaking their training through an apprenticeship or self-funded route. Several nursing associates have gone on to top up their qualification undertaking the self-funded shortened nurse degree programme and obtain their registered nursing qualification.

Nursing Assistants and Maternity Support Worker

4.18 The Trusts Nursing and Midwifery 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** (39%) active learners on the programme at Band 2 level.

Allied Health Professions Workforce

4.19 At the end of March 2024, the AHP vacancy position was **35.6wte (2.1%)** this excludes ODPs as this profession is included in the nursing theatre workforce data. Radiography has the highest vacancy number.

4.20 The leaver rate for registered AHPs was **12.1%** in March 2024. Sickness absence rates for registered AHPs in March 2024 was **4.7%.** This is a very small increase from sickness in September 2023 when the rate was **4.6%.**

4.21 A programme of work to review and develop opportunities for MFT AHP wide rotations. Work is ongoing to include new areas for rotation including research, HEI lecturing and Intermediate Care. AHP colleagues remain committed to rotation and working across boundaries to deliver it.

4.22 AHP apprenticeship provision has continued to grow, with cohort two beginning in occupational therapy (5 learners), Speech & Language beginning in September 2023. A dietetics apprenticeship is due to start in Spring 2024.

Allied Health Professionals Domestic Recruitment Initiatives

4.23 The AHP Forum, in partnership with the widening participation team has continued to deliver AHP career ambassadors to promote the career opportunities. There are now 71 AHP career ambassadors across the organisation (previously 38) who have volunteered 144 hours of time since September 2023 in 4 events. New events were attended at the Museum of Science and Industry and Old Trafford football stadium.

4.24 Four career fairs were held in 2023/24 aiming to attract and boost the domestic pipeline from our local communities. The interactive events hosted 64 school pupils from six local secondary schools and resulted in supporting a further 20 students on work experience with AHP staff across the Trust.

4.25 To encourage applications of new AHP graduates from Higher Education Institutes across Greater Manchester, staff have attended the following events to signpost students to MFT as an employer of choice.

- Trust attendance at the Manchester Metropolitan and University of Salford University's recruitment fairs for final year OT, dietetic, physiotherapy and speech & language therapy students.
- Easy access to targeted recruitment material via QR code.
- Regular use of social media to share recruitment opportunities.

5. Safe Staffing

National Guidance

5.1 Recommendations set out in the Developing Workforce Safeguards Guidelines [25] focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance states organisations must

[25] NHS England (2018) Developing Workforce Safeguards

demonstrate compliance with the key principles of safe staffing, supporting a triangulated approach to decide staffing requirements combining evidence-based tools such as Safer Nursing Care Tool (SNCT) and Birth-Rate Plus (BR+) data to measure patient acuity and dependency, professional judgement and patient outcomes.

5.2 In 2017 the NQB published an improvement resource to achieve safe, sustainable, and productive staffing of maternity services. This resource is designed to be used by those working in clinical settings and leading maternity services. The Guidance endorses Birth-rate Plus (BR+) Midwifery Workforce Planning which is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical need categories. A BR+ study assesses the midwifery workforce on a service based upon the needs of women and records data for a minimum period of 3 months on intrapartum care, hospital and community activity and all other aspects of care provided by midwives from pregnancy through to postnatal care.

Monthly Safe Staffing Report

5.3 The Trust is required to submit a monthly Safe Staffing Unify Report to NHSE detailing actual registered nurse and midwifery staffing levels as a percentage against those that were planned. The average fill rate against planned shifts in April 2024 was 94% for registered nurses and midwives and 95% for unregistered staff**.** The Trust overall has consistently remained above 93% of the planned staffing fill rates for registered staff and unregistered staff.

5.4 The Safe Staffing Unify Report is used internally to inform a monthly nursing and midwifery workforce patient outcome dashboard. The report provides a comparison of nursing and midwifery workforce fill rates against patient outcomes. On review of the planned staffing fill rate, there is no direct correlation found between wards with a lower fill rate and an increase in nurse sensitive indicators (red flags) including patient falls, pressure ulcers and medication errors and omissions of care.

Care Hours Per Patient Bed Days (CHPPD)

5.5 Following Lord Carters review[26] of unwarranted variations in acute hospitals, care hours per patient day (CHPPD) was introduced as a productivity measure of workforce deployment of registered and unregistered nursing and midwifery staff in ward-based settings[27]. Following revised guidance CHPPD will become the principle productivity measure of workforce deployment. The metric will now include all clinical staff groups within the ward establishment and budget who are rostered and contribute to care provision. This ensures skill-mix is well described and the nurse-to patient ratio is considered when deploying staff to provide planned care. CHPPD produces a single comparable figure that represents both staffing levels and patient

[26] NHSE (2023), NHS England » Care hours per patient day (CHPPD): guidance for all inpatient trusts
[30] Carter (2016), Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

requirements and offers the ability to differentiate registered and non-registered clinical staff for deployment and reporting unlike actual hours or patient requirements.

5.6 Using CHPPD at ward level allows managers to compare workforce deployment over time with similar wards in the trust or other trusts to review staff deployment and overall productivity. The measure should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation.

5.7 CHPPD is calculated by taking the actual hours worked over the 24 hours period by all staff on duty and dividing this by the number of patients occupying a bed at midnight.

5.8 CHPPD is published using the data supplied to NHS England via the monthly Safe Staffing Unify Report. There is no national target for CHPPD, however NHSE publish the data on the NHSE Model Hospital[28] portal for Trusts to benchmark the data against other organisations.

5.9 **Table 1** illustrates the recent Trust aggregated CHPPD data against the median level across all NHS Trusts and those within the Shelford Group. The MFT Trust wide average CHPPD level is **9.7** hours per patient against a national average of **8.4** hours and a Shelford average of **9.7** hours indicating that the Trust staffing levels result in a CHPPD level aligned with the Shelford average.

Table 1

CHPPD (Total Nursing & Midwifery Staff)	Dec 2023
MFT	9.7
Shelford	9.7
National	8.4

5.10 CHPPD levels can be calculated at ward levels through the Allocate Health Roster system. The system calculates the number of staff on duty and patients on the ward within a 24-hour period calculating a CHPPD score using. The Allocate SafeCare system is currently used daily across inpatient areas to provide a daily recommended ward staffing ratio based on the acuity of the patients. The SafeCare system calculates the required staffing levels by applying a multiplier (similar to SNCT) for each patient to calculate their acuity.

5.11 NHSE guidance describes the benefits of using CHPPD to support deployment of staff and benchmarking services together with the Nice-endorsed evidenced- based tool such as the SNCT to support establishment setting and reviewing patient acuity (see section 6).

Daily Staffing Review

5.12 The Trust's Safer Nursing & Midwifery Staffing Guidance (version 7) continues to inform the monitoring and escalation of nursing and midwifery staffing risk levels.

[28] NHS England (2024) Model Hospital

Nursing and Midwifery staffing levels within the Hospital/MCS/LCO are reviewed daily in real time using the Allocate System and monitored through the safer 'staffing huddles'. The meetings are chaired by the deputy directors of nursing or deputy and attended by matrons from each area. The meetings are focused on ensuring adequate staffing levels to meet patient acuity and nursing needs on each ward and department. The daily staffing levels are viewed along with bed occupancy and activity, planned and actual staffing levels and patient acuity. The process informs identification of the staffing risk level position for each hospital/MCS and reported to the Directors of Nursing and hospital commanders.

5.13 Staffing escalation above risk level 3 across multiple sites initiates a Director of Nursing safe staffing meeting chaired by the Chief Nurse /deputy to review staffing and patient incidents and identify mitigating actions such as mutual aid between hospital/MCSs. Director of Nursing daily staffing escalation meetings are undertaken during periods of escalation and in response to the trusts EPRR process. This approach was taken during the recent periods of junior doctor industrial action during winter 2023/24. Safe staffing levels (risk level 2) were reported by each hospital/MCS in the majority of cases.

5.14 The demand for enhanced observations of care (EOC) remains high on a daily basis to support vulnerable patients with a variety of condition such as confusion, delirium, and those patient under a section of the Mental Health Act (MHA). The EOC policy has been revised to reduce variation in the approach taken to assess patient need and introduce Director of Nursing approval for additional staff to support EOC. The requirement for ongoing EOC is monitored through the daily staffing huddles and hospital/MCS check and challenge meetings.

5.15 The Chief Nurse has commissioned a review of EOC processes in place across the Trust. The review will focus on the approval process, monitoring and deployment of staff, sharing areas of good practice, looking for opportunities to reduce the reliance on temporary staff and agreeing a standardised approach where appropriate.

Health Roster

5.16 Allocate Health Roster system is utilised across all nursing and midwifery locations to provide transparency on planned shifts, unavailability and safe staffing levels. The system provides managers with instant live information and reporting options relating to staff whereabouts, absences, staffing redeployments and staffing levels. Live rosters and reporting information are a critical source of data to support daily staffing huddles in the organisation. Decisions for staffing shortfalls, staff movement, redeployments and temporary staffing requests including staff to support EOC is taken in the daily staffing huddles and then captured in the rostering system. Utilising the staffing roster templates in the daily staffing huddles applies scrutiny to temporary staffing requests ensuring they do not exceed agreed rota establishments. A risk approach is taken to mitigate requests for additional staff where this cannot be covered through redeployment.

5.17 Additionally, the roster is used to monitor staffing levels against the funded roster template (establishment). A programme of work to review and cleanse existing roster templates which is due to complete in May 2024. Annual planning will then take place in Q1 each financial year to ensure rosters remain aligned to their establishments.

5.18 Roster controls have been introduced to ensure rosters remain aligned to the financial ledger. Any future changes to rosters will now need to be approved by the Director of Nursing and Finance Director. Roster audits are to be introduced to monitor roster financial controls and temporary staffing demand. A new standard operating procedure has been written in collaboration with the Hospital/MCS/LCO teams and will be published in May 2024.

Temporary Staffing

5.19 Temporary staffing continues to be utilised to support staffing levels throughout the Trust. The primary use of bank staff within nursing and midwifery is to cover staff unavailability due to sickness absence and maternity leave. The number of registered and unregistered nursing and midwifery staff unavailable in March was **1400wte.**

5.20 The Trust has worked closely with NHS Professionals over the last 2 years to reduce the reliance on agency staff and high premium rates. The agency cascade process was removed in September 2023 which prevents the use of nursing and midwifery agency bookings across the trust. There is one exception to this process of which a small amount of agency bookings in district nursing due to the short supply of available specialist practitioners in this field. The cost for this supply is below the NHSE agency rate cap. Since the removal of the agency cascade there has been no nursing or midwifery agency supply to any other clinical areas. Bank payrates remain below NHSE cap and aligned to other GM Trusts.

5.21 Monthly check and challenge meetings are held with the hospital/MCS/LCO senior leadership teams to monitor temporary staffing controls and spend. Outcomes from these meetings feed into the weekly EDTC pay metric report and Group Recovery Board.

Staffing Incidents

5.22 In addition to the above pro-active tools which are used throughout the organisation, the Trust has established a staffing escalation system through the incident reporting process, managed through Ulysses Patient Safety Management System (PSMS). Incidents are automatically notified to hospital/MCS senior leadership team when staffing levels fall below a minimum level.

5.23 During October 2023 to March 2024, **1327,** incidents related to staffing were reported. There is no significant reduction in the number of incidents reported overall in comparison to the previous 6 months where a total of 1330 incidents were reported (**Table 2**). The overall incidents in 2023/24 was 1996 which in comparison to the previous 12 months is an increase from 1456 and demonstrates a positive culture of staff reporting. It should be noted, there have been no reported incidents that have resulted in patient harm.

Table 2

Incident Risk Level	Incident period Apr 2023 – Sept 2023	Incident Period Oct 2023 – Mar 2024
Level 1	1231	1146
Level 2	96	178
Level 3	3	3
Level 4	0	0
Overall	**1330**	**1327**

6. Safer Nursing Care Tools

Inpatient Census and Establishment Reviews

6.1 The SNCT is an evidence-based tool and methodology developed by the Shelford Group and NHSE and endorsed by the National institute for Health and Care to support staffing decisions. The tool provides a framework for calculating patient acuity triangulated with professional judgement and assessment of nursing sensitive outcomes (harms) to ensure nursing establishments reflect patient needs in terms of acuity and dependency.

6.2 In October 2023, a revised SNCT adult inpatient tool was relaunched in response to the increasing number of patients requiring enhanced supervision and mental health specialist observation. The tool now incorporates updated patient levels of care descriptors with two additional levels of care (1c and 1d) for one-to-one and two-to-one care, aligned to refreshed nursing resource multipliers. The tool also provides for traditional ward layout and side room configuration. The revised tool takes into consideration the acuity of patients requiring EOC which has not been available previously.

6.3 Two ward census collections have been undertaken in 2023/24 as part of the annual SNCT census cycle in June 2023 and January 2024. The latter census in January was completed utilising the revised tool. Due to the changes in the multipliers and descriptors it is recommended that a minimum of 2 census collections are undertaken before making establishment changes based solely on the census evidence. This does not however prevent an establishment review in areas where patient safety and quality has been compromised. It should be noted, the revised SNCT tool is now more sensitive to the ward environment and patient needs and as such the recommend establishment may increase in areas that routinely carry out EOC or have a large percentage of side rooms. These areas will require a skill mix review following the next census period scheduled for July 2024.

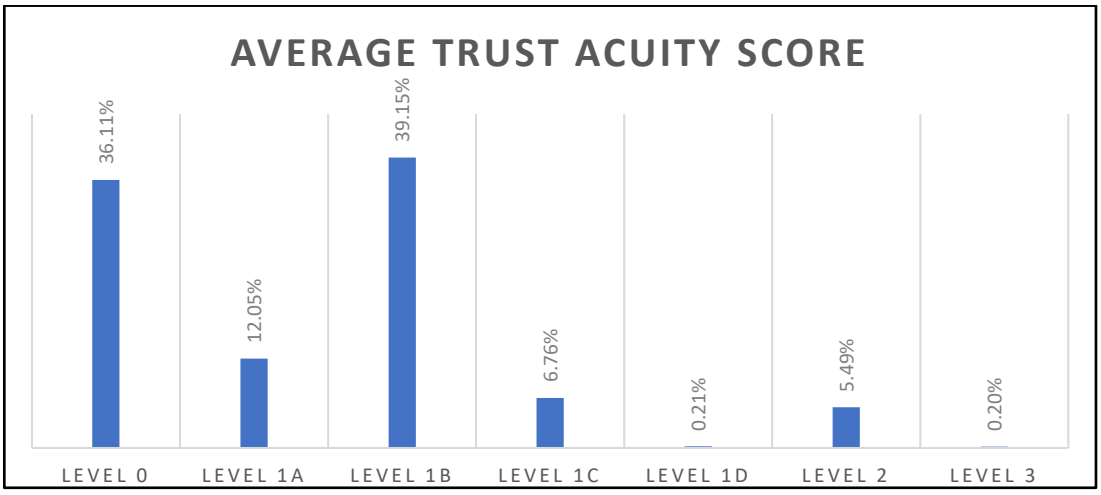
SNCT Analysis

6.4 The bi-annual ward SNCT census collections undertaken in January 2024 included a total of 91 inpatient areas using the revised SNCT descriptors. The census has provided assurance that 75% of in-patient staffing establishments are aligned to the

recommended level when reviewed through an evidenced-base approach. The census collection has identified that the remaining 25% of wards (24 clinical areas) have a funded establishment 10% or more below the SNCT recommenced establishment resulting in an establishment variance across the 24 areas of 111wte. Due to the sensitivity and additional multipliers included in the revised SNCT tool it is recommended a further census is required to validate the outcomes and skill mix as the majority of the variance will be attributed to the number of staff required to support EOC.

6.5 **Graph 3,** presents the overall acuity across in patient wards following the recent SNCT census. The recent census highlights 64% of patients require a high level of nursing support indicated in the number of patient scored as level 1A-2 (Graph 3). Of this number 7% of patients required 1:1/1:2 enhanced observations potentially requiring additional unregistered nursing support.

Graph 3



6.6 The Directors of Nursing continue to review the staffing model across all ward areas triangulating the SNCT data with patient safety data and outcomes. Through the daily staffing meetings, the Directors of Nursing can assess any immediate risk and take a risk approach when considering opportunities to deploy staff to areas that indicate a potential shortfall and support EOC. The SNCT census will be repeated in July 2024 and used to validate any required changes to the staffing models that fall below the recommended safe staffing establishment.

Emergency Department Census

6.7 The Emergency Department Safer Nursing Care Tool (ED SNCT) has been developed by NHSE to support NHS organisations to 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 second ED SNCT census in 2023/24 was completed in each ED during February 2024. **Table 4**

provides a summary of the census results. The census demonstrates that the funded establishment for both NMGH and WTWA is aligned to the recommended establishment (+/- 5%).

6.8 A review is been undertaken to validate MRI ED census results as the recent census supports previous results highlighting a possible staffing shortfall. The review will consider the skill mix requirements to meet the recommended staffing model. Additional temporary staff use has been required across all 3 units to support patient flow in time of escalation.

Table 4

CT results by Hospital Site (WTE)	MRI ED	NMGH ED	WTWA ED
Post	113.1	120.1	145.3
ary Staffing Fill	32.3	18.3	14.2
Monthly Total Fill	145.4	154.1	159.5
Establishment	129.1	135.8	143.4
commendation	145.0	130.0	143.2

Safe Staffing in Maternity Services - Birthrate Plus

6.9 NICE Guideline NG4 Safe Staffing for maternity setting[29] covers safe midwifery staffing in all maternity settings and aims to improve maternity care by advising on staffing levels and actions to take if there are insufficient midwives to meet the needs of women and babies in the service.

6.10 The NHSE Three-Year Delivery Plan for Maternity and Neonatal Services, March 2023, outlines that Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28.

6.11 NG4 requires NHS maternity provider Trusts to undertake a systematic process to calculate the midwifery staffing establishment. Birthrate Plus (BR+) safe staffing toolkit endorsed by the Royal College of Midwives (RCM) is the recommended midwifery workforce planning tool to support review of midwifery staffing levels.

6.12 The use of BR+ was incorporated within NHS Resolution Maternity Incentive Scheme standards (MIS year 5) which was delivered by 1st February 2024.

6.13 Ratio of midwife to birth is important for workforce planning purposes. BR+ calculate ratios of midwife to birth based on individual unit need from their detailed assessment of acuity. Recommended ratios of births to midwives compared with the last 6 months average ratios across SMH sites are outlined in (**Table 5**) below:

[29] NICE (2015) NICE Guideline NG4 - Safe midwifery staffing for maternity settings

Table 5

Site	Recommended Birth: Midwife Ratio	Average Birth: Midwife Ratio Sept 23 to Feb 24
SM ORC	22.2 births:1 Midwife	26 births:1 Midwife
SM Wythenshawe	24.3 births:1 Midwife	28 births:1 Midwife
SM NMGH	23 births:1 Midwife	24 irths:1 Midwife

6.14 Further to the CQC concerns about skill mix and safe staffing, a compliance programme managed through the SMH PMO will ensure sufficient number of skilled and experienced midwifery staff appropriately assess and care for women and mitigate risks in a timely manner.

6.15 Two significant investments were made in the Maternity Services workforce from funding for meeting Saving Babies Lives (SBL) 2 care bundle and the Elective Section Business Case which resulted in a total of 18.93wte new posts from the SBL2 funding and 6.1wte midwifery posts. The additional posts reduce the BR+ gap to 36.08wte.

6.16 The recommended safety critical roles are currently in the recruitment phase and expected to be recruited to by April 2024.These roles combined with the SBL2 and CS business case funding support the BR+ recommended increase in staffing. The maternity division are still waiting agreement of the strengthening safety roles which exceed the BR+ recommendation.

6.17 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.

6.18 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.

Critical Care Staffing

6.19 Guidance for the Provision of Intensive Care Services (GPICS) are used by professional and regulatory bodies to appraise critical care services and staff staffing levels. In terms of GPICS standards the units are compliant with 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).

7 Quality Metrics to Support Safe Staffing

Accreditation

7.1 The annual ward accreditation programme 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. A total of **175** accreditations were undertaken in 2023/24 covering **221** areas. This is an increase of 21 more areas in comparison to 2022/23. These include a total of **133** clinical accreditation and **42** Quality Assurance visit.

7.2 Of the clinical accreditations **9** wards/areas achieved gold accreditation, **97** areas achieved silver, **27** areas achieved bronze, and no areas achieved a White accreditation demonstrating continuous improvement. The innovative reporting capability from HIVE to obtain real time data has furthered the ability to effectively analyse key lines of enquiry domains aligned to the CQC Assessment Framework and ensure safe staffing.

7.3 Triangulating the accreditation outcomes with patient safety data, SNCT recommendations and staffing incidents has illustrated there is no correlation between staffing recommendations and accreditation outcomes. All areas irrespective of staffing recommendations have seen both patient and staffing incidents however only 2 of the 30 areas identified as having staffing establishments below the SNCT recommended levels have achieved a gold accreditation.

8. Workforce Retention Strategies

8.1 Retention of our people is a key national priority of the NHS and MFT. The improving workforce position year on year indicates that MFT is still an employer of choice. Analysis of leavers data indicates that 38% of newly qualified registrants' leave within 2 years of joining the Trust. This is an improvement of 7% compared to the same period in the previous year and is reflective of the improved staff turnover rate. The trusts guaranteed job offer to graduates and the transition to preceptorship programme demonstrates the trusts commitment to invest in our local graduate population.

8.2 The hospitals/MCS and LCOs have each developed local retention plans with the health and wellbeing and development of the NMAHP workforce remaining a key priority with initiatives across each hospital/MCS/LCO to ensure staff are supported whilst at work.

Continued Professional Development

8.3 The Trusts NMAHP Continuing Professional Development Programme (CPD) is continuing to utilise the national funding model available for every nurse, midwife and AHP. This funding has continued for 23/24. 62% of eligible NMAHP workforce currently in post have accessed education that has been allocated CPD points.

8.4 Working closely with hospitals/MCS/LCO senior leaders to ensure CPD funding is utilised to upskill our NMAHP workforce has been a priority for 2023/24. CPD has funded externally provided programmes such as perioperative theatre modules as well as internally provided courses and development of eLearning ensuring the NMAHP workforce have the knowledge and skills to provide quality patient care and support the delivery of waiting list initiatives.

8.5 The NMAHP workforce continue to access higher level apprenticeships, accessing Advanced Clinical Practitioner study, Specialist Community Public Health Nursing, AHP undergraduate training, nurse associate training and leadership and management programmes. There are currently 235 NMAHP staff undertaking health care programmes through apprenticeship funding in addition to traditional fees funded rotes. Going forward for 2024/24 NHSE is advocating the apprenticeship route as the primary option for future programmes.

8.6 The Trusts preceptorship framework for NMAHP supports newly registered NMAHPs to transition from student to registrant. Following review of the MFT Preceptorship Programme against the national preceptorship quality standards, MFT was awarded the National Preceptorship for Nursing, Interim Quality Mark in November 2023. The programme ensures our newly qualified registrants have a comprehensive preceptorship programme and access to CPD, which is essential to ensuring NMAHP are equipped to provide high quality care to our patients and supports workforce retention.

8.7 The Trust has secured funding from NHSE to support a national pilot of the legacy mentor role[30]. 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 12-month pilot commenced in March 2024 at RMCH and NMGH.

8.8 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, following a pilot within CSS and RMCH implementation of the PNA rolled out across the trust. The PNA supports staff through restorative clinical supervision (RCS), career conversations and support improvement projects. Restorative Clinical Supervision addresses the emotional needs of staff. It provides “thinking space”,

[30] NHS England (2024) Legacy mentoring

which reduces stress and burnout and in turn improves staff retention. Currently **132** registered nurses have completed the PNA programme by March 2024, with a further **67** undertaking training.

8.9 Data in relation to the number of restorative supervision sessions (RCS), 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 nursing and midwifery retention strategies.

9. Safe Staffing Summary

9.1 Since the previous Board of Directors report the overall nursing and midwifery workforce has continues to improve with the number of registered nursing and midwifery vacancies reducing from 3.8% to 2.0% and sickness and absence has reduced to 6.3% for registered staff and 9.1% for unregistered staff. The turnover of nursing and midwifery staff has continued to improve with the current turnover rate of 10.2%. This has supported an improvement in the average fill rate against planned shifts for both registered (94%) and unregistered nurses (95%) since the last report. The improved workforce position will continue to support the hospitals/MCS to reduce the reliance on temporary staff.

9.2 A range of domestic recruitment campaigns and sustained, healthy international pipeline has contributed to the improved workforce position. This is in keeping with the national workforce trends and resulting in MFT having one of the lowest vacancy rates across acute Trusts. Reliance on the international recruitment pipeline has reduced over the last 6 months as the vacancy position continues to improve. The guaranteed job offer to local graduates will maintain a domestic pipeline and continue to reduce the reliance and cost on international recruitment over the next 12 months.

9.3 The benefits of Hive EPR will continue to enhance patient safety and experience. The system provides valuable data and reports to enhance the professional judgement and evidenced base to triangulate nursing and midwifery and AHP safe staffing data and decisions with patient outcomes.

9.4 The SNCT census in January 2024 has provided assurance that 75% of in-patient establishments are aligned to the recommended level when reviewed through an evidenced base approach. Action taken to resolve any staffing shortfall in the remaining 25% are described in section 6. The census will be repeated in July 2024 and will be used to validate any changes to the staffing models in these areas. The January 2024 census results indicate that 5% 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 unregistered/support skill mix in these areas is high to support the acuity of patients specifically patients with dementia requiring enhanced supervision.

9.5 The ED SNCT census in February 2024 has provided assurance that the funded establishment for both NMGH and WTWA is aligned to the recommended establishment (+/- 5%). A skill mix review has been undertaken to validate MRI ED census results. Due to the level acuity across the three adult ED departments over the last 6 months a risk approach is taken to determine the skill mix required to safely support patients at time of escalation. The Directors of Nursing will continue to provide oversight on the use of temporary staffing to support the need for additional workforce during these periods.

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9.6 There has been a continuing focus on nursing, midwifery and AHP development to support staff retention and provide CPD opportunities. It is acknowledged that national CPD funding opportunities may likely reduce overtime and therefore the focus will be to develop sustainable CPD programmes which will support ongoing training and development of staff to support service transformation and leadership.

9.7 The Trust has continued with a commitment to increase pre-registration placement capacity for NMAHP undergraduates. The guaranteed job offer for nursing and midwifery final year students demonstrates the ongoing commitment investing in the future of our learners. A commitment to offer these opportunities to AHP graduates is currently being developed.

9.8 A summary of the workforce developments and priorities for the hospitals/MCS/LCO is provided (Appendix 1)

10. Conclusion

10.1 The Board of Directors are asked to receive this paper and note progress of work undertaken to support the nursing, midwifery and AHP workforce plans across the Group.

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

The Hospital/MCS Directors of Nursing are required to provide a quarterly nursing and midwifery workforce and safe staffing 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 Nursing N&M		
	Vacancies WTE	Turnover	Sickness	Vacancies WTE	Turnover	Sickness
WTWA	0.0	9.4%	6.0%	171.6 (16.2%)	13.6%	10.9%
MRI	0.0	9.4%	6.3%	84.2 (9.5%)	15.6%	11.1%
NMGH	0.0	8.6%	6.7%	27.8 (5.0%)	11.1%	8.3%
RMCH	0.0	10.8%	6.5%	66.9 (18.8%)	13.6%	10.5%
MREH	0.0	5.7%	5.2%	1.6 (2.3%)	3.8%	9.5%
CSS	55.3 (5.5%)	11.2%	6.2%	0.0	12.0%	8.4%
SMH Maternity	42.4 (5.5%)	10.0%	5.0%	4.0 (2.2%)	12.7%	11.5%
SMH Nursing	44.7 (6.8%)	11.8%	7.6%	30.8 (26.2%)	15.7%	6.7%
MLCO/TLCO	39.1 (3.7%)	12.4%	7.2%	86.1 (18.8%)	14.4%	8.9%

Table 2 - AHP workforce summary

Hospital / MCS	Allied Health Professionals		
	Vacancies WTE	Turnover	Sickness
WTWA	0.7 (1.3%)	14.6%	5.8%
MRI	1.5 (12.7%)	11.7%	9.8%
NMGH	0.0	0.0%	8.6%
RMCH	0.0	21.2%	7.1%
MREH	0.0	6.9%	19.5%
CSS	7.1 (1.1%)	11.7%	4.2%
SMH	0.0	0.0%	8.0%
MLCO / TLCO	15.6 (3.0%)	12.7%	4.0%

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

WTWA Workforce Summary

1.1 WTWA nursing workforce position has continued to improve over the last 12 months with a successful recruitment strategy attracting domestic and international nurses. However, the hospitals continues to face recruitment & retention challenges around its unqualified nursing assistant workforce. Recruitment events are scheduled throughout 2024 to attract candidates with experience and those who will be new to care. The hospitals have worked with the widening participation team and have introduced the Careers Ambassador programme, and ongoing placement allocations for pre-employment students with an offer of a NA post across WTWA on successful completion of the placement.

1.2 To support the safe transfer of the cardiac surgery provision, nursing establishments are to be increased across cardiac wards and theatres to open 2 additional theatres and staff a 16-bed ward to accommodate the subsequent patient activity. Whilst the transfer of finances is due to be enacted in April 2024, recruitment has commenced to both Cardiac theatres and Ward F2 to reduce delays in the migration of services.

1.3 To support delivery of the elective recovery targets for 2023/24 and beyond, Trafford Elective Hub are required to increase capacity on an incremental basis from the existing 96 weekly sessions over 5 days across 9 theatres to 102.5 sessions over 6 days across 9 theatres during the first quarter of 2024/25. A proposal has been submitted to increase the funded establishment to accommodate the rota extending.

1.4 The Burns Unit incorporates 2 ICU beds, staffed by nurses experienced in both Burns and Critical Care. The relatively small establishment of less than 14wte RN for the ICU beds, leads to a greater impact in nursing shortfall as a result vacancies, maternity leave, or sickness, exemplified by the specialised skillset required to care for this patient group. A task and finish group was established with representation from divisional and corporate colleagues across WTWA, and Clinical and Scientific Services (CSS) to ensure the ongoing safe staffing of the Burns unit. support from critical care colleagues and lines of work sought through NHSP, immediate risks have been mitigated, however an options appraisal has been completed with regards to the longer-term staffing plans and consideration of closing 1 of the Burns ICU beds.

1.5 A full establishment review has been undertaken within the Respiratory Division to align to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines for caring for patients with Non-Invasive Ventilation (NIV), supported by earlier SNCT recommendations. Changes to establishments have been made across A1, A3, Pearce, POU and F3 Lung and financial transactions enacted to support these. This has supported the increase in establishment across A1 to enable a 1:4 nursing ratio on the newly embedded 8 bed Acute NIV Unit.

2. Manchester Royal Infirmary (MRI)

MRI Workforce Summary

2.1 MRI has reduced its vacancy position and improved its retention figures across all areas, and continues to identify workstreams, which improve patient care, reduce reliance on bank spend going froward.

2.2 Safe Nurse Staffing remains a daily focus in the MRI, led by the Workforce Matron, Corporate Head of Nursing, corporate Lead Nurses. MRI's underlying nurse staffing position has continued to improve with reduced level of vacancies, reflected in the reduction of turnover and our continued ability to attract registered staff. Staff at MRI are fully engaged with recruitment and retention opportunities so that we recruit, retain, and develop a skilled and experienced workforce for the future. Improving recruitment and selection processes: Strengthening the recruitment and selection procedures to ensure that the MRI attracts and selects the most suitable candidates. MRI

have developed a recruitment and retention strategy, to promote prioritising the welfare of staff to create a dedicated and motivated workforce.

2.3 Key quality indicators are monitored by CSU Heads of Nursing and Corporate Nursing teams, which include the fundamentals of nursing care. Nutrition and Hydration, medication management, harm free care, infection prevention and documentation. All these areas have robust reporting processes via HIVE, which has increased the visibility of these associated patient pathways, to monitor and review patient care. ED safety is also a priority for the MRI, and the MRI used the MFT ED safety checklist process to provide assurance that patients remaining in the department for over 6 hours have received appropriate review and assessment for their care needs. This is enhanced by the senior nurse review process which is undertaken every 8 hours for patients who have extended stays in the ED over 8 hours.

2.4 MRI has a commitment to develop the nursing workforce through advanced clinical practice, currently employing **50** Advanced Care Practitioners (ACP) across the specialities, with these roles being part of the strategic service development plans within the new models of care. Along with a healthy number of trainees ACPs within the CSU's. 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. An ACP workshop continues, led by a nurse consultant. Safe Nurse Staffing remains a daily focus in the MRI, led by the Workforce Matron, Corporate Head of Nursing corporate Lead Nurses.

2.5 MRI continues to focus on the welfare of staff, and has developed a retention strategy, which promotes staff wellbeing. Offering flexible working where possible & engagement conversation with senior staff.

3. North Manchester General Hospital (NMGH)

NMGH Workforce Summary

3.1 NMGH nursing workforce position has continued to improve over the last 12 months with a successful recruitment strategy attracting domestic and international nurses and improving its retention figures across all areas.

3.2 NMGH qualified and unqualified staff sickness is above MFT target. As a result of this Nurse Managers and HR colleagues hold regular case reviews to aid in the safe return to work or resolution of sickness absence episodes. The hospital's Health and Wellbeing strategy has been a priority, in order 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. Retention is a key objective for NMGH, and the NMGH continue to focus on initiatives that support the development and engagement of nursing staff as part of the NMGH retention strategy.

4. Royal Manchester Children's Hospital (RMCH)

RMCH Workforce Summary

4.1 RMCH nursing workforce position has continued to improve over the last 12 months with a successful recruitment and retention strategy attracting both domestic and international nurses.

4.2 Pediatric theatres continue to have vacancy in registered and un-registered posts which impact upon the total number of theatres that can be opened. The team continue to work closely with HR and Transformation colleagues to optimize overall performance as well and focused attention to a recruitment and retention strategy.

4.3 Ward 83 have consistently experienced high sickness/absence up to 18% of the nursing workforce, work alongside EHW and HR has been in place to improve this position EHW and HR has been in place to improve this position. One of the contributors to the sickness levels identified has been the care of long-term patients and managing complex relationships with family members including recognition and management of conflict. Specific training for this group of staff has been recommended to improve their resilience in managing the complexity.

4.4 SNCT was completed in 12 inpatient areas and ED in February 2024. Investment made following the last SNCT in June 2023 has demonstrated positive impact in wards where variance was reported to be higher.

4.5 Engagement opportunities with preceptees and support to complete preceptorship programme. RMCH participate in We Can Talk National Training and Quality Improvement programme with 100+staff enrolled to support Mental Health training in CYP.

4.6 RMCH to participate in the legacy mentor pilot funded by NHSE with Band 6 commencing in post in April 2024.

4.7 The RMCH Director of Nursing Fellowship Programme was introduced in 2022. The programme supports a small cohort of staff who are 1-2 years post qualified to develop their leadership, research, and transformation skills. Candidates are supported to develop and deliver a transformation project through exposure and coaching. The programme has evaluated positively following the successful completion of 2 cohorts. The next cohort of staff will commence in April 2024.

5. Saint Marys Hospital MCS (SMH)

SMH Workforce Summary (Midwifery)

5.1 There remain challenges nationally in recruitment of the expanding future midwifery workforce and SM MCS will continue to work closely with both HEIs and NHS England to support ongoing work to improve this. Band 5 and 6 nursing and midwifery retention and turnover is a major focus and the Hospital MCS are developing retention plans to reduce the reliance on temporary staff and improve turnover. A team of Band 7 Recruitment and Retention Specialist midwives with a particular focus on reducing

attrition have now been permanently funded by NHSEI and will be part of the substantive establishment after March 2024.

5.2 SM has been successful in implementing an international recruitment programme for with a total of 26 midwives recruited and in the workforce by the end of February 2024. The Division are planning to explore options for further international recruitment in 2024 following the cessation of NHSE funding in March 2024. Gynaecology have successfully employed 12 International Recruited nurses across the service and continue to support a 3rd cohort of IR staff due to arrive in April 2024.

5.3 SM MCS, as part of a wider GM workstream, have increased midwifery training places each year over the last 3 years. This includes learners from Bolton University aimed at providing a cohort of learners who will step of training in the Spring rather than September to provide an additional opportunity for secondary workforce recruitment.

5.4 To support retention the division has developed several rotational opportunities between sites for all staff groups, this also supports the opportunity of provision of mutual aid across sites. SM MCS have been supportive of senior experienced midwives retiring and returning and partial retirement to practice on part time basis. This supports skill mix across the service. 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.

5.5 Following the CQC 29a warning notice and change in the CQC rating SM MCS Maternity Services underwent a Diagnostic Review from the NHSE National Maternity Safety Support Programme (MSSP) team in January 2024. The high-level feedback from the review team was predominantly positive. The prompt appropriate response to the immediate CQC concerns were acknowledged and that there has been significant improvement to the workforce models and deployment of staff to Triage, Induction of labour pathway. The investment received by SM MCS has made a difference to the experience of services users and improved patient flow across the service.

SMH Workforce Summary (Nursing)

Nursing

5.6 SMH nursing workforce position has continued to improve over the last 12 months with a successful recruitment and retention strategy attracting both domestic and international nurses.

5.7 Focus on staff development and career progression has improved the turnover rate within the nursing workforce. A band 6 development programme has been established which aims to enhance nursing skills, create opportunity, and ensure there is a tailor-made support programme for individual nursing staff.

5.8 Newborn Services (NBS) has received additional funding to support additional Professional Nurse Advocates within the service with the intention to follow the pathway used by maternity services in facilitating restorative supervision sessions for the nursing workforce in NBS.

6. Clinical and Scientific Services (CSS)

CSS NMAHP Workforce Summary

6.1 CSS have an established recruitment campaign to recruitment to Band 5 staff nurse posts attracting both domestic and international nurses via a monthly rolling recruitment programme. Recruitment to Band 6 Junior Sister/Charge Nurses remains challenging (nearly all Band 6 Junior Sister/Charge Nurse posts are recruited to via internal development and promotion of Band 5 Staff Nurses), particularly as a result of service developments (and the resultant increase in Band 6 Junior Sister/Charge Nurse posts), and as consequence of the suspension of the Critical Care Course for 18 months during the pandemic (the course is one of the requirements for promotion to a Band 6 Junior Sister/Charge Nurse post). This risk was identified in 2021 (updated Feb 2023) and the units have been working with the Greater Manchester Critical Care Network and Greater Manchester Skills Institute to recover this and increase the number of nurses working in critical care holding a critical care nursing qualification.

6.2 The radiographic workforce faces challenges to recruit. The profession relies on new graduates in the summer to fill junior vacancies for plain film, many of whom move onto other modalities with experience. Specialist roles, in particular Sonographers, and Interventional posts are more difficult to fill as there is a limited pool from which to draw recruitment.

6.3 The Infection Prevention/Tissue Viability team continue to provide a specialist nursing service, working across all MFT hospital and the Manchester and Trafford local care organization settings. The team is led by the Assistant Chief Nurse for IPC+TV, with a total of fifty-nine established team members. There is an acting Head of Nursing in place to support the Assistant Chief Nurse. Lead Nurses and Matrons cover the Hospital sites and Community services. The team also cover MFT HCAI surveillance and Trafford public health posts. The IPC/TV team currently provide a seven-day service, core working hours being 08:00-16:00hr (weekend currently at reduced staff numbers). There are plans in place to expand the provision of a full service at weekends with plans for a business case to be completed. There is also a senior team on call provided to cover weekends and bank holidays (telephone advice). This consists of microbiologists, virologists, and senior IPC/TV nursing leads.

6.4 The MFT Transfusion service are currently reviewing guidelines for the staffing across the sites to ensure there are always 2 TPs on the ORC to support the service as the current staffing model means there are times when the service is reduced because of short notice staffing changes due to sickness absence.

6.5 Within Critical Care and the other Specialist Nurse areas of CSS there is a focus on staff engagement events, to influence the retention of its staff. CSS promote “stay

interviews" and provide opportunities to discuss work life issues with a senior member of staff.

6.6 CSS supports & promotes career development, within Critical Care there has been the launch a Critical Care education strategy and career development pathway in 2023. The career pathway outlines the routes to professional development and promotion with the aim of promoting equal opportunities across the staff groups. This vital career advice and development programme will ensure succession planning.

6.7 AHP professional leads proactively seek workforce feedback through new starter interviews, peer conversations and exit interviews. Stay Conversations were held for Band 5&6 occupational therapists and dietitians in summer 2023 which gathered staff views on retention. These findings have formed an action plan that the respective professional leads are implementing with staff.

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

MREH and UDHM Workforce Summary

7.1 A review of all the nurse staffing establishments was undertaken during 2022, across MREH with additional funding incorporated into the business plan for 2024/25 to support private patient activity on Ward 54 and theatres; Specialist Nursing provision in the Emergency Eye Department; and Evening and Weekend Outpatient Activity. Following a skill mix review a workforce plan to expand the Specialist Nurse (including nurse led injectors), Nurse Practitioner and Advanced Clinical Practitioner, across MREH.

7.2 In January 2024 MREH UDHM reviewed and developed a robust Retention plan with input from HR colleagues. Focusing on the 7 national common retention themes identified in NHS People Plan 2023 & NHS Workforce Plan 2023; Health & Wellbeing, Education, Professional Development and CPD, Engagement, Compassionate leadership, Flexible working, EDI/ Culture 7 and quality improvement. The hospital plan to recruit to a Wellbeing and Resilience Matron role across all MDTs within MREH and UDHM. The intention of the role is to develop well-being and pastoral support programmes to meet the needs of specific nursing and other non-medical clinical staff groups supporting induction, on the job-learning and career development. This will further strength the retention offered.

7.3 Due to a significant, nationally recognised, reduction in the successful recruitment to Dental Nurse Positions, the Senior Nurses have been working closely with MFT Recruitment and workforce teams and have developed a bespoke Dental Nurse Recruitment drive using social media to raise the profile of the Dental Nurse opportunities available within the Hospital for any future recruitment.

7.4 The DCP School has commenced its first Dental Nurse Apprenticeship program since MFT changed its registration to become a main provider. This has enabled the UDHM to deliver the apprenticeship programme to **9.0wte** students employed by the UDHM and **6.0wte** students employed within Primary Dental Care. The school is currently

recruiting for the next cohort of 40 students which will commence the apprenticeship program in March 2024.

8. Manchester and Trafford Local Care Organisation (M/TLCO)

M/TLCO NMAHP Workforce Summary

8.1 The LCO have seen some improvement in their workforce position over the last 12 months however the district nursing service continue to experience issues in managing capacity and demand, reflected in frequent deferrals of patients. Decisions around deferring patients are always taken by senior members of staff to ensure that patient safety is not compromised. The Directors of Nursing and Finance are undertaking work to understand whether this relates to an increase in demand, an increase in acuity or staffing issues within services.

8.2 District Nursing services in the north of the city are carrying Band 5 vacancies across the 4 teams but a rolling vacancy advert offering flexible working plus a review of the induction process appear to be improving recruitment and retention. Band 6 vacancies in North Late Call service are proving problematic to recruit to. The Community Matrons are looking at options such as developing existing Band 5s to prepare them to apply successfully to future Band 6 roles and also a future city-wide service to improve the picture.

8.3 The Children's Complex Care team, which provides care for children with life limiting illnesses (often requiring support for breathing and nutrition) is particularly challenged specifically at times when new referrals to the service are received. The service continues to utilise a small number of speciality trained agency staff to provide care. There has been limited success with recruitment initiatives. The service are exploring potential alternative solutions such as rotational nursing posts with RMCH.

8.4 Nationally Health Visiting (HV's) continues to face recruitment challenges. To address this MFT train approximately 24 HV's annually through the apprenticeship route, to address this workforce gap. Skill mix has been introduced to the service to enhance service provision. The LCO have recently undertaken a health visiting service review to benchmark the service delivery model, roles and caseload size with local providers and Shelford Trusts. The review has highlighted the Trusts delivery model and workforce challenges are similar across each of the Trusts.

8.5 The Learning Disability teams have had several long-term vacancies across all professions which has also had an impact on the nursing teams. The LCO HR team continue to provide focused recruitment support due to the overall vacancy levels, but the service has had recent success in recruiting to Nursing and OT roles.

8.6 Challenges in recruiting to Band 6 posts within the Manchester School Health Services are being addressed by developing new Band 5 rotational posts which give Band 5s the experience of working across different school health teams.

8.7 AHPs are on the Government's list of skilled worker shortage occupations for healthcare list). Challenges are particularly evident across all services including community response for Band 6 posts across OT, PT, Dietetics, SLT and Podiatry.

Recruitment appears to be more challenging for community posts with many posts having to be readvertised multiple times before a successful appointment is made. LCO is working hard on the recruitment & retention agenda, employing “grow your own” initiatives, recruit to turn over and the development of retention strategies.

8.8 AHP’s have been an integral part of the Hospital at Home (H@H) model, which is a significant workforce transformation to deliver acute care in the community. Development opportunities for AHPs have been seen in supporting AHPs to undertake Advanced Clinical Practitioner training (ACP’s) across Manchester which has been supported by the LCO.

8.9 The LCO developed a bespoke training course focusing on culture, staff behaviours and role modelling. The course compliments the MFT leadership offer already in place. Seniors’ leaders within the LCO successfully applied for CPD funding and identified an external organisation to deliver and develop the course. This was predicated on the LCO retaining all programme information and the rights to deliver the course in-house for future cohorts. Several staff completed the leadership course in 2022/23. The LCO has built on this and anticipates that identified staff will also complete the programme during 24/25.

Agenda Item 11.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse, Infection Prevention & Control; Dr Rajesh Rajendran, Associate Medical Director Infection Prevention & Control
Date of paper:	May 2024
Subject:	Infection Prevention and Control Report update on current Healthcare Associated Infections within MFT and subsequent actions taken to reduce rates. The report includes a summary of the Trust-wide vaccination programme.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• Improve patient and staff safety, quality and outcomes. • Improve the experience of patients, carers, and their families. Quality ✓ Safety ✓ Patient Experience ✓
Recommendations:	The Board of Directors are asked: • To note the contents of the report • To agree the next step recommendations for the management and monitoring of Healthcare Associated Infections within MFT and recommendations by the Group Chief Nurse/DIPC, senior Infection Prevention and Control Team, and Group Infection Control Committee (GICC).
Contact:	Name: Michelle Worsley Assistant Chief Nurse Infection Prevention and Control Tel: 0161 276 4042

1.0 Introduction

This paper provides an overview of MFT attributable Healthcare Associated Infection (HCAI) submitted through UK Health Security Agency's (UKHSA) mandatory surveillance system, the Healthcare-Associated Infections Data Capture System (HCAI-DCS) and additional organisms/trends under local surveillance including Carbapenemase-Producing Enterobacterales (CPE) and Vancomycin-Resistant Enterococci (VRE) data.

2.0 Thresholds

The Trust follows the national thresholds from the NHS Standard Contract[1] where a 5% year-on-year reduction has been applied. NHS Standard Contract reduction targets have not been issued to date for 2024/25. As in previous years there remains a zero tolerance for Methicillin Resistant Staphylococcus *aureus* (MRSA) bacteraemia.
Organisms under local surveillance are CPE and VRE, there is currently no national threshold for either organism.

MFT Case thresholds 2023/24	***C. difficile***	***E. coli* (GNBSI)**	***P. aeruginosa* (GNBSI)**	**Klebsiella spp. (GNBSI)**	**Total GNBSI**	**MRSA bacteraemia**
Monthly	14	**17**	**4**	**11**	**32**	**0**
Annual	172	**207**	**42**	**137**	**386**	**0**
Year end reported position	**275**	**300**	**48**	**141**	**486**	**20**

Table 1 2023/24 NHS standard contract thresholds for C.difficile, gram negative blood stream infection (GNBSI) and MRSA bacteraemia

3.0 Summary to date

3.1 Appendix 1 details the numbers of organisms reported by month via the UKHSA HCAI DCS. Red highlight indicates case numbers reported over the threshold, green highlight indicates case numbers reported under threshold.

3.2 Appendix 2 details the MFT position with attributable MRSA bacteraemia within the Shelford Group with MFT ranking worse position for number of cases in 23/24 .

[1] PRN00150-NHS-Standard-Contract-202324-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infect.pdf (england.nhs.uk)

3.3 Appendix 3 notes the **Shelford Group's comparison** of MRSA bacteraemia and additionally highlights MFT's performance in managing Clostridioides difficile (C Difficile) and E.coli cases.
MFT has demonstrated excellent performance on reporting E.coli cases, ranking as the **top performer** within the Shelford Group.
MFT has also demonstrated strong performance for the number of C Difficile cases reported, ranking **third best** within the Shelford Group for 23/24.

4.0 Thematic Analysis

4.1 There has been an increase in the number of MFT attributable MRSA bacteraemia cases reported in 2023/24. As a result, all attributable MRSA bacteraemia cases occurring in April-Dec 23 were reviewed during an IPC deep dive led by IPC medical lead and senior IPC nursing team to establish if there were any commonalities or learning themes.
Compliance with the MRSA Screening and Management Policy was also reviewed.
Common themes across MFT attributable MRSA bacteraemia include:

- Reduced screening compliance.
- Delay in commencement of integrated care pathway.
- Delay in commencing decolonisation therapy in previously known positive patients.
- Delay in taking the blood culture (Sepsis 6).
- Inability/Delay in isolating patients.
- Lack of compliance with IPC principles including hand hygiene and PPE usage.
- ANTT compliance.

We have taken an additional action to plan an IPC summit in May 24, which will engage Site Medical Directors, Directors of Nursing and senior clinical colleagues from across sites and MCS's regarding the increase in HCAI across MFT highlighting emerging themes. This will enable a robust improvement plan to be co designed, owned, and implemented.
Further plans include.

- Implementation of decolonisation therapy without the need for a prescription to ensure timely topical decolonisation.
- ANTT policy update and re-launch of training across the Trust, to include medical clinicians.
- Promotion of Sepsis 6 for timely BC taking
- Peripheral and Central Line policy alignment
- Review of line insertion protocol, including paediatric
- MRSA policy update and drive to include algorithm for MRSA treatment including for high-risk patients.
- Gloves Off Campaign- Point Prevalence feedback & action plan. Re-audit planned for May 2024.
- Trust Wide Deep Clean Programme.

The actions will be manged through Hospital/MCS IPC committees overseen by Group Infection Control Committee (GICC).

4.2 All cases of MFT attributable C. difficile undergo a root cause analysis to establish any common or recurrent themes which are presented as a lapse in care. Examples of these lapse in care include.

- Antimicrobial stewardship

- Delay in isolating patients
- Delay in commencement of integrated care pathways
- Environmental standards compliance including standards of cleaning.

4.3 Until April 2020 reportable Gram-Negative Blood Stream Infections (GNBSI) have been categorised into `attributable` (taken 48 hours post admission) and `non-attributable`, (those taken within 48 hours of admission), and likely to be community acquired.
Recent new thresholds set by NHS England now categorise GNBSI using apportioning criteria factoring in the both Hospital-onset, healthcare associated (HOHA) and Community-onset healthcare associated (COHA).
This recognises the fact that cases previously categorised as 'community cases` may have learning opportunities from recently accessed healthcare provision. This has meant that previously non attributable patient cases, may now be deemed as COHA therefore increasing our attributable figures.
Thematic analysis of GNBSI include.

- Lack of urinary catheter management - Catheter care audit undertaken, and associated improvement plans have been developed.
- Delay in blood culture sampling.
- Inadequate intravenous line documentation.
- ANTT compliance.

The improvements plan from the audit will be monitored through the Hospital/MCS Infection Control Committees reporting into GICC.

4.4 The senior IPC team established a CPE task and finish group to review all aspects of IPC related to CPE outbreaks, cases and contacts. Common themes across MFT CPE outbreaks include:

- Reduced CPE screening compliance.
- Lack of available isolation facilities/delays in isolating patients.
- Lack of basic IPC principles including hand hygiene and PPE use.
- Issues with cleaning and environmental standards.
- Issues with an aged estate.
- Staff education and knowledge.
-

5.0 Actions

The following additional actions have been implemented as a response to increasing numbers of MFT attributable HCAI. It is important to note there is a global rise[2] in the emergence of drug resistant pathogens. MFT are also currently experiencing an increase in gram negative colonisations/infections in our patients.

5.1 Outbreak Control Teams (OCT) comprising senior clinical and IPC team members to oversee any outbreaks have been established (2 or more cases linked by time/place/ typing) ensuring that all aspects are included, and relevant MDT members attend the outbreak meetings an action log is maintained until the closure of the outbreak.

5.2 Subject matter experts have been invited from UKHSA, National bodies and peers to review, have provided comment and advise the OCT on ongoing management of outbreaks. Following the external visit in December, the feedback and reports were incorporated into action plans. The external team did not recommend anything outside of our improvement plans already in place.

[2] Antimicrobial resistance (who.int)

We are currently awaiting the report from the external review of the Neonatal Unit, St Mary`s on the Oxford Road site.

5.3 An in-depth review of all MRSA bacteraemia occurring in 2023/24 has been undertaken to identify risk factors, diagnostics, management, and patient outcomes this was presented to GICC in January 2024.

5.4 Ongoing development of the HIVE system continue to ensure robust reporting and dashboard development to facilitate IPC oversight within the hospitals/MCS, including hand hygiene audit data and antimicrobial stewardship.
The Trust has implemented a live hand hygiene database this year, to provide oversight and assurance on practice to the group infection control and hospital site committees.

5.5 The Covid-19 and seasonal influenza vaccination programme continues yearly within MFT. This includes an autumn booster programme that took place which is an essential activity to support infection prevention and control as part of our winter plans.

The Trust follows and implements recommendations made by the UKHSA and NHS England, within their recently published National Vaccination Strategy. In Greater Manchester, MFT has the 2nd highest uptake rate for frontline healthcare workers, with flu vaccines at 47%.
MFT has the 3rd highest uptake rate for frontline healthcare worker COVID-19 vaccines at 28%.

6.0 Recommendations

6.1 The Board of Directors are asked:

- To note the increase in MFT and national HCAI rates.
- To note the CPE task and finish group recommendations.
- To note the work of the outbreak control management teams.
- To note the year-on-year efforts of the Trust wide vaccination programme.

7.0 Further Recommendation

- Oversight and assurance of improvements to be provided from Hospitals/MCSs to the GICC and IPR processes.
- Hospital/MCS Senior leadership team to develop action plans to include all IPC recommendations.
- Commissioned by the Chief Nurse/DIPC an external review of MFT adherence to National Standards of Cleaning processes will be undertaken during 24/25.

8.0 Summary

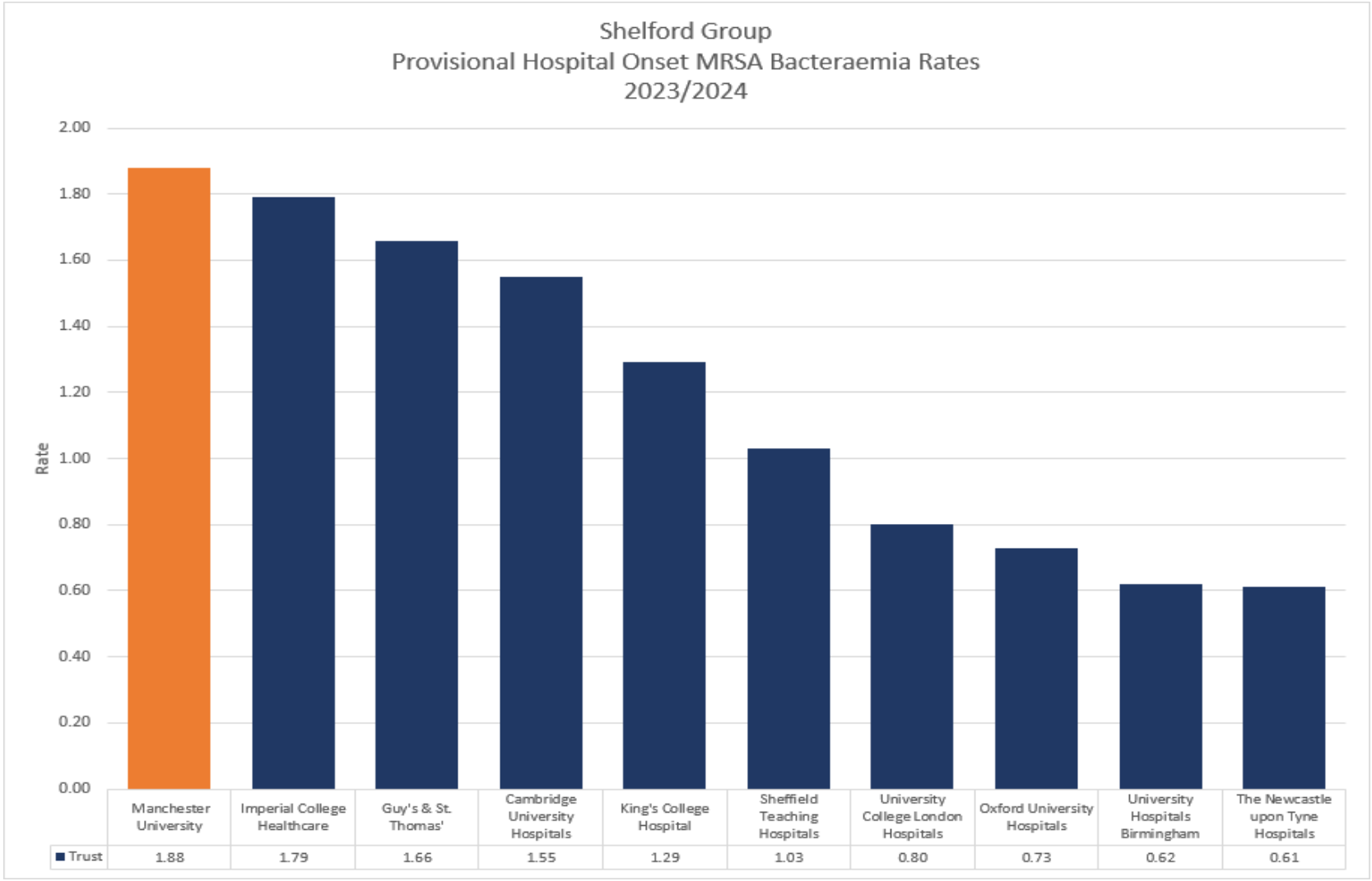
Globally there is an increase in the emergence and spread of drug resistant pathogens. Throughout 2023/24 MFT has experienced an increase in the number of cases of reportable HCAI across the organisation. Strategies to improve compliance are in place, including a planned IPC Summit in June/July.

The MFT vaccine service has closed for this year, with flu champions who were able to continue to vaccinate until the end of February 2024. Uptake rates have been low, with a national decline in seasonal vaccine uptake rates. Nationally it is hoped that the Vaccine Strategy will evolve over the next 2 years to increase future uptake rates.

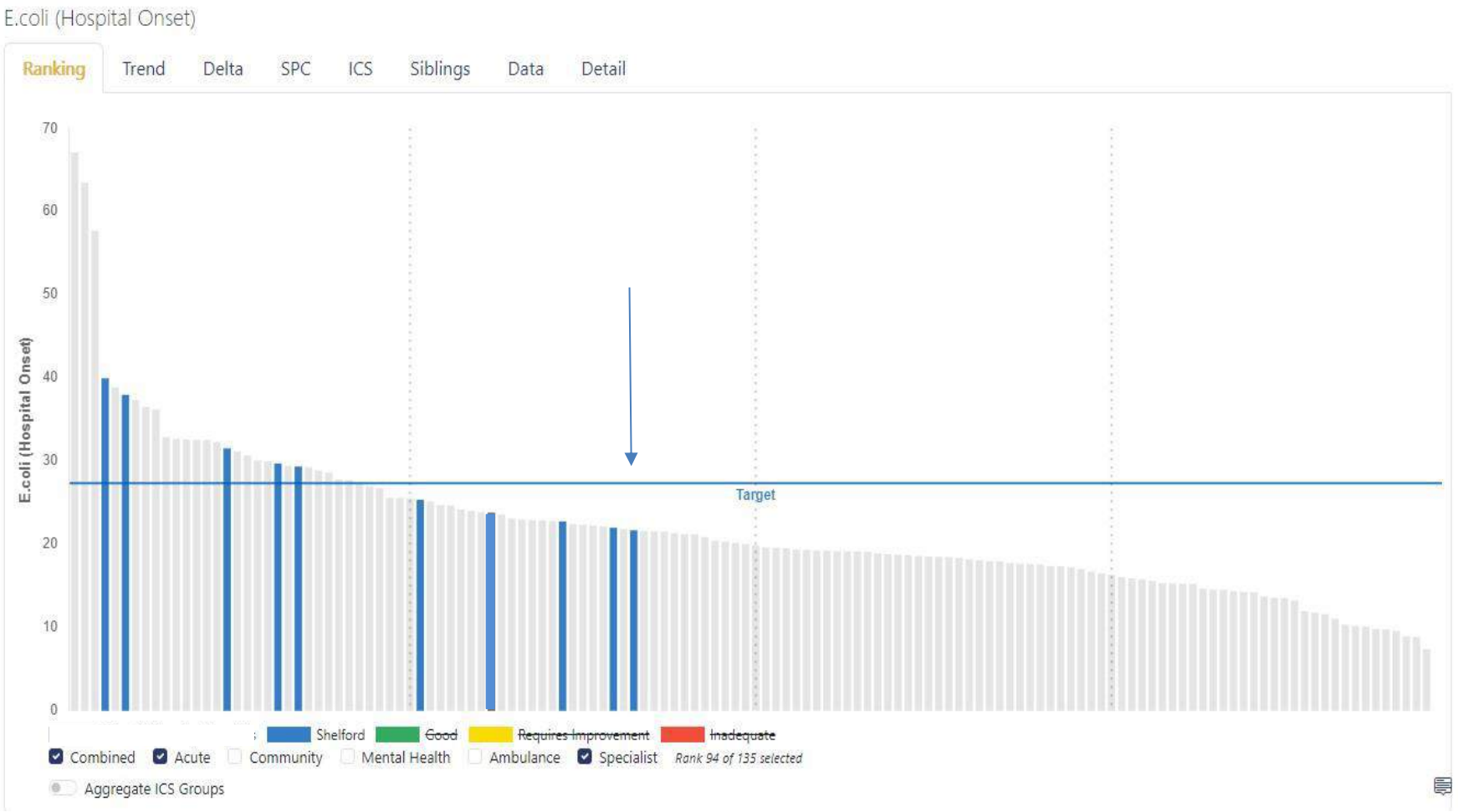
Appendix 1 MFT HCAI organisms reported via the HCAI DCS mandatory system 23/24.

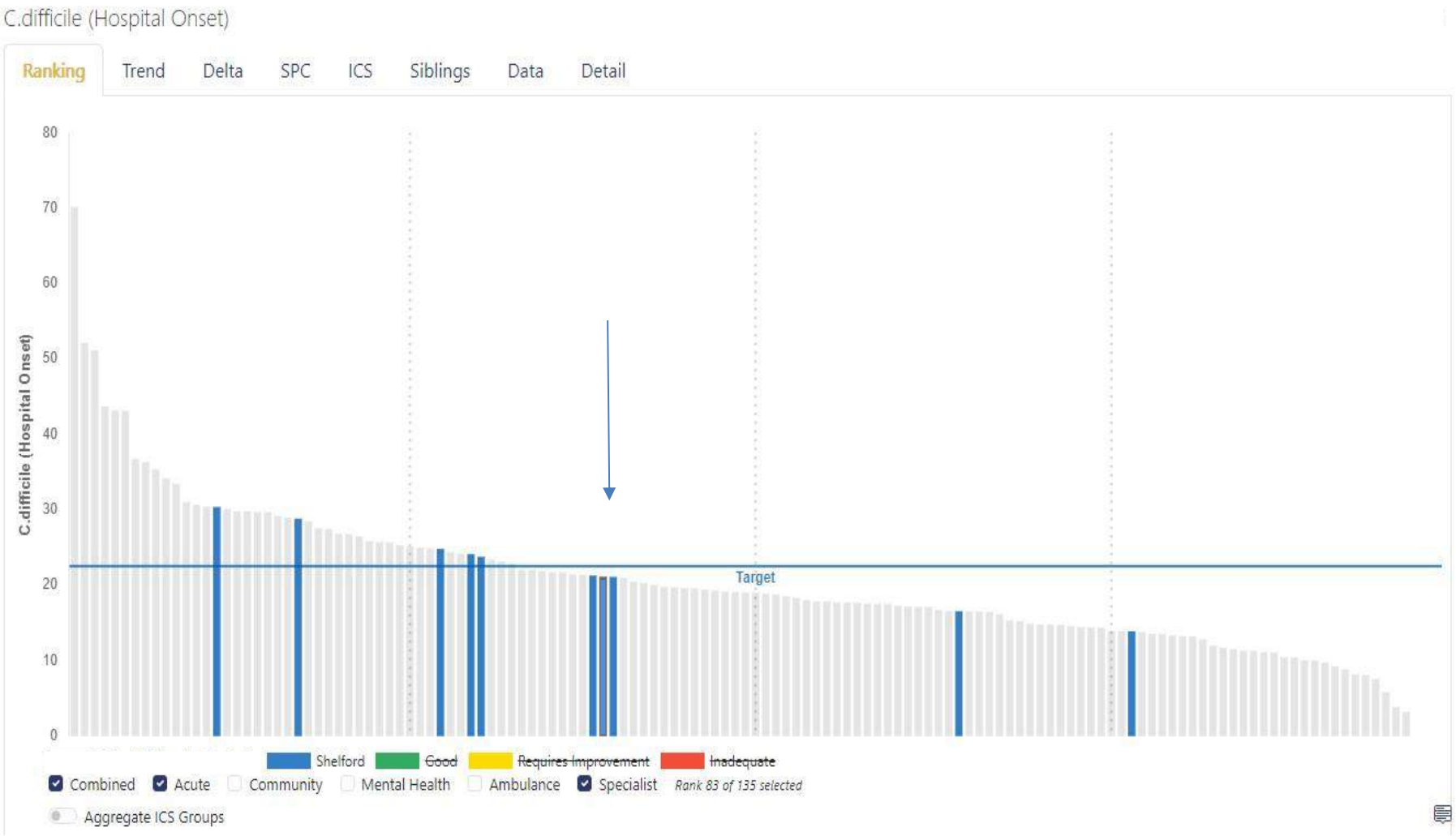
Organism	Annual Threshold	Month threshold	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	Status
CDI Attributable Cases	173	14.4	21	18	22	25	32	27	28	21	20	23	14	24	275	**Over threshold**
Attributable MRSA Bacteraemia	0	0.0	1	2	0	1	1	3	3	0	3	0	4	2	20	**Over threshold**
Attributable MSSA Bacteraemia	No Threshold	-	7	11	8	11	11	7	14	3	12	7	6	11	108	**No threshold**
E. coli Bacteraemia	207	17.3	20	25	19	19	31	20	28	26	26	29	31	26	300	**Over threshold**
Klebsiella sp Bacteraemia	137	11.4	9	17	12	15	11	13	14	11	13	12	5	9	141	**Over threshold**
Pseudomonas Aeruginosa	42	3.5	8	4	6	2	7	3	4	3	5	4	1	1	48	**Over threshold**
Total Gram-negative Bacteraemia	386	32.2	37	46	37	36	49	36	46	40	44	45	37	36	489	**Over threshold**

Appendix 2 Shelford Group provisional (based upon 2022/23 bed days data) MFT attributable MRSA bacteraemia rates.

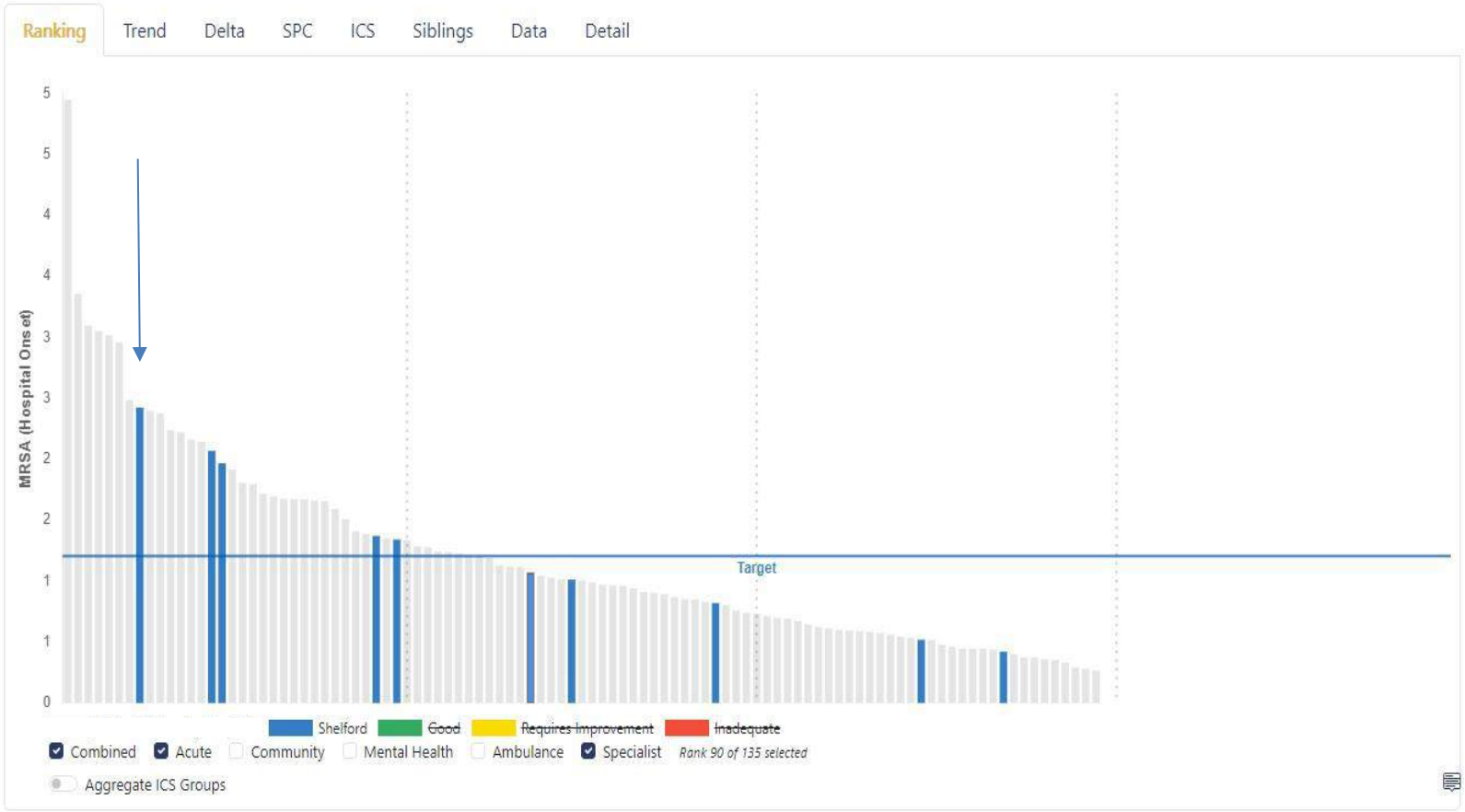


Appendix 3 Shelford Comparison for HCAIs




C.difficile (Hospital Onset)
Ranking
Trend
Delta
SPC
ICS
Siblings
Data
Detail
C.difficile (Hospital Onset)
80
70
60
50
40
30
20
10
0
Target
Shelford
Good
Requires Improvement
Inadequate
Combined
Acute
Community
Mental Health
Ambulance
Specialist
Rank 83 of 135 selected
Aggregate ICS Groups

MRSA (Hospital Onset)



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Agenda Item 11.5

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Chief Nurse
Paper prepared by:	Group Deputy Chief Nurse
Date of paper:	May 2024
Subject:	The outcome of the Peer Review completed by Mersey Care NHS Foundation Trust of the care and support offered to users of Manchester Foundation Trust, who are experiencing acute Mental Health episodes or have a Learning Disability/Autism diagnosis. MFT's response and next steps.
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 seek opportunities to continuously improve and innovate our care services research and teaching. We are compassionate ✓ We are curious ✓ We are collaborative ✓
Recommendations:	The Board of Directors are asked: • To note the findings of the Peer Review as outlined within this report. • To agree the next step recommendations for the management and monitoring of the recommendations through the Safeguarding / Mental Health Governance Structures overseen by Quality and Performance Scrutiny Committee.
Contact:	Name: Cheryl Casey Group Deputy Chief Nurse Tel: 0161 701 0331

1. Introduction

1.1. This report provides the Board of Directors an overview of a peer review carried out by Mersey Care NHS Foundation Trust that was undertaken between December 2023 and January 2024. The final report was received on 12th March 2024. The report is attached in appendix 1.

1.2. The report contains:

- Key highlights (positive and areas for improvement) across a range of focus areas.
- The Mersey Care NHS Foundation Trust Report (Mersey Care) (Appendix 1).
- The recommendations in a Standalone Document (Appendix 2).

The review highlights 62 recommendations that will feed into existing action plans that have been developed by the Mental Health Subgroup and the Learning Disabilities Steering group, overseen by the Group Safeguarding Committee. The recommendations will support the delivery of both group's strategic aims and improvements plans aligned to the MFT Mental Health Strategy 2023-2026 and Our plan for people with learning disabilities and/or autism, their families, and carers 2022–2025.

1.3. The review was led by Sandra O'Hear, Deputy Chief Nurse and Strategic Lead for Safeguarding and CQC, and Donna Robinson, Director of Mental Health and Divisional Director of Mental Health at Mersey Care supported by their team of experienced subject matter expert colleagues, who led on the following key areas:

- Reducing Restrictive Practice
- Safeguarding
- Learning Disability and Autism
- Mental Health Act, Mental Capacity Act and Associated Legal Frameworks
- Patient Engagement and Experience
- Strategy Overview

1.4. All reviewers reported that there was a positive culture and a desire expressed and evidenced at all levels within MFT to offer the best possible care to patients attending the acute hospital services with Mental Health (MH) conditions, a learning disability and/or Autism (LD&A), presentations.

1.5. MFT would like to thank the team at Mersey Care for their time in undertaking the peer review, and for the insightful report produced from which the Trust can continue to develop and mature in the delivery of safe and effective care to patients in the key area of mental health.

2. Background

2.1. MFT is registered with the Care Quality Commission (CQC) to provide regulated activities that relate to mental health:

- Assessment or treatment for persons detained under the Mental Health Act 1983 (all hospital sites).
- Caring for people whose rights are restricted under the Mental Health Act (Child and Adolescent Mental Health Services at Royal Manchester Children's Hospital).

2.3. The Terms of Reference for the review are attached as appendix 1 within the main report.

2.4. The peer review was carried out between December 2023 to February 2024 using the following methodologies:

- A detailed desktop review of relevant MFT documents, policies, and reports
- Peer reviewers conducting both on site visits to services and face to face and virtual meetings with MFT staff.

2.5. The peer review report captured findings in a themed way and included both a general overview and a range of specific focus areas.

3. General Overview / Observations of Lead Reviewers

3.1. Areas identified for 'general overview' included:

- Trust Strategy
- Emergency Department
- Mental Health Liaison Team
- Galaxy House
- Acute Medical Unit (MRI)
- Meeting with Trust Safeguarding Team

3.2. Specific areas of focus included:

- The role of security staff
- Reducing restrictive practice
- North Manchester General Hospital
- Safeguarding
- Learning Disability and Autism Awareness and Practice
- Mental Health Act (MHA) and Mental Capacity Act (MCA)
- Patient Engagement and Experience

3.3. In the following sections of this report, good practice and areas identified for improvement are highlighted.

4. Key highlights

4.1.1 Identification of good practice and areas for improvement together with 62 recommendations are set out within the report in relation to each focused area.

4.1.2 The review noted 2 main themes that gave rise to concern, listed below. Both these areas have been reviewed by the Assistant Chief Nurse for Safeguarding to ensure that they have previously been identified as areas for improvement within the existing safeguarding work plans.

Both areas have improvement plans in place, senior oversight processes for managing operational incidents and activity and are part of the annual safeguarding audit plan of practice.

The two main areas of concerns identified were.

- The use of security guards for therapeutic observation.
- The use of adult wards to detain 16–17-year-olds.

4.1.3 The report captured findings in a themed way as listed below.

5. Good practice and areas identified for improvement are highlighted in each of the areas of focus.

5.1. Focus Area: Trust Strategy

MFT's Mental Health Strategy 2023-2026

Areas of Good Practice

- The Mental Health Strategy 2023-2026 metrics are included in reports to the Board of Directors through the integrated performance reports.
- There is a well-developed strategic plan for people with learning disabilities and/or autism, Our plan for people with learning disabilities and/or autism, their families and carers. 2022–2025 with an associated workplan which is overseen by the Learning Disabilities and Autism Steering group.

Areas for Improvement

- The review acknowledged that MFT's Mental Health Strategy should address the specific challenges that MFT is facing in relation to mental health. The strategy focuses on 5 key aims, with the Mental Health subgroup overseeing the workplan of improvement aligned to these aims.

    - Quality of Care Delivery.
    - Patient Experience
    - Education, Training and Supervision
    - Policies, Protocols and Service Level Agreements
    - Outcomes

5.2. Emergency Department - MRI

Areas of Good Practice

- Children and young people (CYP) who require admission under the care of CAMHS, are also under the care of the general paediatrics medical team who will support any medical treatment required.
- Mental Health Awareness Training is mandatory for all staff and current compliance is 91%.
- Monitoring and use of the MHA and MCA.

Areas for Improvement

- The Mental Health Liaison Team are not based in all departments; they are co-located to ED, they do not have a physical base in ED, therefore are not always present in the area.
- There is a single team (GMMH) covering the 4 hospitals based on the Manchester Oxford Road Campus, the size and scale of the site is significant, and this may present additional challenge/pressure on time.

- The area utilised to hold an individual who has been removed from a public place due to a MH disorder and requires a place of safety (under s136 of the MHA) at the Manchester Royal Infirmary site, is a room that is part of the MH patient's hub. This is not Royal College Psychiatry compliant.
- The current ED environment has no toilet / shower facilities. The entire area is not fit for purpose, there is no natural light, no anti-ligature toilet/shower areas, and no anti-barricade doors in situ.
- Therapeutic observations of patients within ED are carried out by security staff NOT mental health support workers.
- There was a lack of awareness and understanding of the potential impact of Right Care Right Person (RCRP).

5.3. Mental Health Liaison Team

The team are based in offices that are co-located to the ED. The two senior leaders within the team met with and openly answered the reviewers' questions. It was clear to the reviewers that the leaders are passionate and knowledgeable about patient care and mental health issues, and it was also apparent that the leads seemed to work in a way that is somewhat disconnected to the wider GMMH services.

Areas of Good Practice

- The leads described having positive working relationships with all staff and positively collaborating with safeguarding team (MFT facing).
- The leads reported joint planning between MFT and GMMH staff for patient episodes of care– full report on PARIS (MH patient record) with a summary on HIVE system.
- The leads reported that everyone going to a ward has a plan agreed in ED.

Areas for Improvement

- The Mental Health Liaison Team were unclear on KPI monitoring and target (internal) appears to be set at 85% compliance for 4 hours review.
- There is a plan to achieve the Psychiatric Liaison Accreditation Network (PLAN) accreditation, however the reviewers felt this is considerable work and perhaps needs to be balanced and focus on how this will demonstrate a positive impact on service delivery.
- There are differences in the uniforms worn by MH liaison staff and acute staff, and this is causing confusion.
- Safer flow is in use to monitor waits, but this cannot be seen by MFT Executives as it feeds into GMMH Executives. The reviewers found No evidence of sharing this information or access.

5.4. Galaxy House (CAMHS inpatient unit)

Reviewers met with the members of the MDT at Galaxy House for discussion and questions and toured the establishment, including the living areas, day care and school areas.

Galaxy House is a 12 bedded inpatient unit for young people aged 8-18 years. It usually runs at 100% occupancy and all admissions to the unit are planned.

There are clear referral and admission pathways, and the unit accepts local, regional and on occasions national admissions.

Children and young people admitted to Galaxy House are most likely to require treatment for an eating disorder or for Pervasive Arousal Withdrawal Syndrome (PAWS). There is focussed support team input into the paediatric wards, including LD/MH support.

Areas of Good Practice

- There is good skill mix within the MDT establishment including consultants, psychologists, RMN's/ SW's/ LD/PAEDs specialists.
- There is on site access to a school and Occupational Therapy and recreational activities.
- The team reported that there is extensive family involvement.
- The team are well established and recognised – (often feature in Board stories)
- Training for staff is delivered to multiple disciplines to ensure shared knowledge and understanding.
- There are clear governance processes and there is wider engagement with the system (e.g., safeguarding, partnership board attendance)

Areas for Improvement

- Agree priorities and identify outcome measures (both during inpatient stay and post discharge).
- Increase awareness of the service.
- Increase the use of patient and family engagement through experience forms and feedback.

5.5. Acute Medical Unit (AMU) at MRI

Areas of Good Practice

- Proactive and innovative leadership – developing acute staff team and security staff skills to include involvement in several workstreams including:

  Care plans with security bed watch team supporting trauma informed care, improved patient experience, anti-ligature environments, linking in with leads for social prescribing, homeless work and missing persons work.

Areas for Improvement

- Due to age group (younger adults) the area needs more support for education, social skills and activity.

5.6. NMGH ED

Areas of Good Practice

- There was excellent signage and information relating to patient feedback and quality improvements made from this.

Areas for Improvement

- To review staff understanding of the Broset Violence Checklist (a short-term violence prediction tool) to help assess the level of support a person may require.
- Continue to explore ways to ensure the environment meets the needs of patients presenting with mental health illness.

5.7. Meeting with Safeguarding Team

The lead reviewers met with the Assistant Chief Nurse for Safeguarding and other senior safeguarding leads to test out if the responsibility for safeguarding was removed from operations or if, as supporting documentation suggested, it is embedded throughout operational services across the Trust.

Leadership and governance processes are defined, noting that at each of the hospitals there are local Safeguarding Committees, which importantly the safeguarding team are linked into.

Areas of Good Practice

- Safeguarding is referenced by all staff on a frequent basis, this gave the lead reviewers confidence and assurance that the team are regarded as essential, fully involved and accessible to frontline staff and managers and key influencers across the Trust footprint. This is essential to ensure that the Trust can maintain a positive patient safety culture.

6. Areas of Specific Focus

6.1. The reviewers explored in more detail some areas of key focus within MFT, where they have either identified practice that is potentially unsafe, or areas that are high risk and associated with statutory responsibilities.

6.2. Areas for focus were**:**

The role of security staff within the ED's to support MH needs

Areas for Improvement

- There is an over reliance of security staff in observing and monitoring patients within the ED departments.
- There is an opportunity for improved learning through multi-disciplinary reviews of patients observed under the ESSO (enhanced security supervision observation) policy.

Reducing restrictive practice

Areas for Improvement

- Improvements in BILD training for staff identified through a training need analysis.

Environment

Areas for Improvement

- Areas across the Trust are not conducive to caring for patients with Mental Health Illness
- Areas where patients are managed for a period of time have limited offers to meaningful distraction.

Patient Experience

Areas for Improvement

- Work has been undertaken in areas to gain patient experience feedback there could be further improvements in understanding the patients lived experience while in our care.

Culture

Areas for Improvement

- There was a perception from staff that patients have an inequity in care provision compared to patients without mental health illness, training and collaboration would support improvements in this area.

Safeguarding: Performance Reporting and Assurance

Areas for Improvement

- Ensure the audit calendar continues to include MHA & MCA as standard items on the calendar.
- Clarification on and oversight of GMMHs KPIs.

Learning Disability and Autism Awareness and Practice

Areas for Improvement

- Understanding the differing clinical requirements and reasonable adjustments faced by people with Autism (non-LD)
- Sharing outcomes of LeDeR reviews with Trust mortality group to support learning.

Mental Health Act and Mental Capacity Act

Areas for Improvement

- Recommendations noted for associated policy update and inclusion.

Review of the CQC MCA & MHA Inspection Findings (2019)

Areas for Improvement

- Outcomes from the inspection findings to be audited as part of the MH Subgroup annual plan.

7. Ward to Board

7.1. Although the reviewers' impression was that there was synergy from Ward to Board, this was not robustly tested as the review did not include interviews with wider Board members, (including Non-Executive Directors).

7.2. Mental Health provision, monitoring and safeguarding and regulation will be the focus of a Board development session in June 24.

8 Actions undertaken to date.

8.1 Findings and the 62 recommendations from the peer review have been developed and incorporated into the trust wide Mental Health action plan.

8.2 The Mental Health Subgroup is undergoing a comprehensive review and redesign under the leadership of the Group Deputy Chief Nurse to oversee delivery of the recommendations from the report.

8.3 An effectiveness review of the current mental health oversight group and workplan is in progress.

8.4 Dedicated hospital-based leads will be appointed to ensure the effective implementation of the recommendations from the peer review and oversight of quality initiatives including Right Care, Right Person model.

8.5 This structured approach guarantees a robust framework for addressing mental health concerns within our organisation, prioritising personalised and appropriate care for each patient.

8.6 A rapid review of the 2 main themes that gave cause for concerns, security guards to undertake therapeutic observation and the use of adult wards to detain 16–17-year-olds has been undertaken.

Both these areas have dedicated actions as part of the existing workplans and are part of the annual safeguarding audit plan.

9. Monitoring and Reporting Routes

9.1 The peer review has been circulated to hospital senior leadership teams to consider and respond through the Mental Health Subgroup.

9.2 The 62 recommendations from the Peer Review have been incorporated into the existing Trust Mental Health Action Plan.

9.3 The Mental Health Action Plan will be monitored through the Mental Health Sub-Group and reported to the Trust Safeguarding Committee.

9.4 Discussion to be held with GMMH colleagues to share the findings of the report.

10. Recommendations

10.1. The Board of Directors are asked:

- To note the findings of the Peer Review as outlined within this report.
- To agree the next step recommendations for the management and monitoring of the recommendations through the Safeguarding / Mental Health Governance Structures overseen by Quality and Performance Scrutiny Committee.

A Peer Review of the care and support offered to users of Manchester Foundation Trust, who are experiencing acute Mental Health episodes or have a Learning Disability/Autism diagnosis. Review completed by Mersey Care NHS Foundation Trust

January 2024

Review Leads:

Sandra O'Hear, Deputy Chief Nurse and Strategic Lead for Safeguarding & CQC, Mersey Care NHSFT

Donna Robinson, Director for Mental Health Services and Divisional Director for MH division at Mersey Care NHSFT

Contents

EXECUTIVE SUMMARY

Services at Manchester Foundation Trust have been subject to several ‘Deep Dives’ into specific services. Following an internal deep dive into Mental Health services and some relatively recent concerns raised regarding specific care incidents of patients with MH or LD and A, this peer review by Mersey Care was commissioned to support Executive leaders to identify, prioritise and drive sustainable long-term service improvements.

Key issues highlighted during the review relate to the current environment and planned new build Emergency Department; staffing, (with a particular focus on mental health staffing support from GMMH and the use of security staff), leadership and governance arrangements (including escalation); the safeguarding model and how this interacts with the wider system; and strategy policy, legal frameworks and arrangements for the ongoing monitoring of compliance.

In relation to Reducing Restrictive Practice, key issues included: safeguarding arrangements; physical environmental issues; staffing and ‘mobilisation’ between sites and the ED at MRI by the Mental health liaison team; culture and ongoing arrangements to mitigate risk; training; security.

Identification of Good Practice and areas for improvement together with recommendations are set out in relation to each focused area. Several recommendations are associated or linked to more than one area but have been captured in the section where they are most appropriately aligned.

Recommendations are made for two reasons, the first to address any deficits or noncompliance identified, but additionally recommendations are made to enhance practice that is already recognised as Good Practice.

There is a limited amount of information available regarding patient experience and engagement, however the patient improvement lead was knowledgeable and helpful in supplying information during a peer discussion.

The review was led by Sandra O’Hear, Deputy Chief Nurse and Strategic Lead for Safeguarding and CQC, and Donna Robinson, Director of Mental Health and Divisional Director of Mental Health and they were supported by the following team of experienced subject matter expert colleagues, who led on the following key areas (see Appendix A for the full terms of reference):

- Reducing Restrictive Practice – Danny Angus, Associate Director for National HOPE(S) programme.
- Safeguarding – Kevin Redmond, Head of Safeguarding.
- Learning Disability and Autism – Rachel Mayner, Consultant Nurse for LD and A and Dr Alex Cookson, Consultant Clinical Psychologist.
- Mental Health Act, Mental Capacity Act and Associated Legal Frameworks – Stephen Cowling, Deputy Associate Director for Social Care

- Patient Engagement and Experience – Nicky Fearon, Head of Nursing
- Strategy Overview – Helen Benett, Deputy Director of Strategy and Strategic Partnerships.

The report is presented in a narrative format. The information upon which recommendations and conclusions are based is described within the narrative.

The peer review team would like to take this opportunity to thank the Executive and Senior Leadership Teams, front line staff and team managers and leaders (from both MFT, GMMH, and the security department) and patients for their warm welcome, for their openness, and full engagement during the visits to the hospitals.

All reviewers reported that there was a positive culture and a desire expressed and evidenced at all levels within MFT to offer the best possible care to patients attending the acute hospital services with MH or LD and A presentations. As a review team, we are hopeful this peer review will provide additional insights to support ongoing sustainable improvements for people receiving care with mental health difficulties, autistic people and people with a learning disability who access hospitals across the Trust.

1. Background and Scope of Review

Manchester University NHS Foundation Trust (MFT) is one of the largest acute Trusts in the UK, employing over 28 000 staff. It was formed on 1st October 2017 and since then has been responsible for running ten hospitals across seven separate sites, providing a wide range of services from comprehensive local general hospital care through to highly specialised regional and national services.

MFT needs to ensure it has the right strategies, policies, training, and Board to Ward visibility of these services.

To provide assurance and identify any required actions, the Trust requested Mersey Care NHSFT to conduct a peer review of the following (taken from the Terms of Reference):

In our role as a provider of acute healthcare services to people who experience acute mental health episodes, those people with LD&A and CYP who access CAMHS, review and evaluate:

- *Our overall strategy including CAMHS.*
- *Frameworks in place with other providers who support the delivery of Mental Health provision at the Trust, e.g., SLA with Greater Manchester Mental Health Trust.*
- *Policies that support implementation of that strategy/(ies).*
- *Correct application of policies, including application of the Mental Health Act.*
- *Training provision including management of episodes of violence and aggression.*
- *Training compliance.*
- *Board to ward visibility of:*

- *The completion of our statutory requirements.*
- *Metrics and key performance indicators.*
- *Governance and assurance processes and flow through Quality Boards and Committees to the Board of Directors.*

Professor Cheryl Lenney OBE, Chief Nurse at MFT requested via Trish Bennett, Chief Nurse and Deputy Chief Executive of Clinical Services at Mersey Care NHSFT that the review be undertaken as a peer review using the CQC key lines of enquiry framework, by Mersey Care NHS Trust who provide specialist inpatient and community services that support physical and mental health and specialist inpatient mental health, learning disability, addiction, and brain injury services.

Following two initial introductory and set up meetings in November 2023, it was agreed that the review leads for Mersey Care will provide via the Chief Nurse of MFT, a report with associated recommendations to be utilised by the Executive Director Team at MFT to identify any areas of Trust provision which require improvement, with an indication of any associated risks and level of priority.

Terms of Reference were agreed and have been included as Appendix 1

The review team agreed an indicative timescale for completion of a draft report by the end of January 2024. The reviewers would be supported by identified leads from MFT who would provide timely access to documents, responses to questions arising or requests for further information and where required agree a timetable of activities/visits/interviews for members of the review team.

As part of the review, the team will also refer to and review findings and the Trust's self-assessment responses to the CQC's Key Lines of Enquiry (KLoES) in relation to the Assessment and Monitoring - Mental Health (Emergency Departments) to highlight any good practices, identify gaps or make further recommendations.

2. Process and Methodology

The peer review has been carried out using a combined desktop and interview approach, this included a detailed desktop review of relevant Manchester Foundation Trust documents, policies, reports etc and peer reviewers conducting both on site visits to services and face to face and virtual meetings with MFT staff.

To get the best-informed views, and to offer focussed and prioritised feedback for MFT, the lead reviewers have kept oversight of all areas included within the scope of the review, whilst other reviewers have taken a more targeted approach to drill down into the areas where they are able to offer a more subject matter expert opinion.

The peer review also offered the opportunity for a like-for-like look at statutory areas of responsibility such as Safeguarding, application of legal frameworks and identifying good practice that can be shared and learned from to identify where improvement can be made to the arrangements both within MFT and Mersey Care.

The report captures findings in a themed way, to aid understanding and avoid duplication wherever possible.
Good Practice and Areas Identified for Improvement are highlighted in each of the areas of focus.

3. Strategic Overview

It is evident from policy documents and interviews with Executives, Senior Leaders and front-line staff that there is a clear aspiration for Manchester Foundation Trust to offer a good quality of care to all patients whether they present with physical care needs, mental health care needs or learning disability/autism needs. There is a willingness to learn from previous experiences, improve the services offered to patients with mental health or LD/A needs and ensure that there remains a clear focus on staff and patient safety.

Considerable investment has been made into developing a Trust Wide Safeguarding Team that has Executive Leadership and the drive to ensure that patients who are likely to be stereotyped and misunderstood within the context of a large acute hospital base have a voice and the overall aim is to ensure parity of esteem.

3.1 Trust Strategy (including CAMHS)

Work is currently underway to develop MFT's long term strategy, with engagement from key stakeholders.

MFT's Mental Health Strategy[1] was approved by the Board of Directors in November 2023. The Manchester University Hospitals NHS Foundation (MFT) Trust Mental Health Strategy 2023-2026 is an all-age strategy covering children, young people and adults. It is described as having been developed to be applied in all MFT inpatient, outpatient and community settings working in partnership with mental health providers and multi-agency partners.

This 3-year strategy was co-produced with key stakeholders, addresses the policy context and national drivers and sets out five aims:

- Aim 1: Quality of Care Delivery - To improve the quality of care delivered to our patients when they access services at MFT.
- Aim 2: Patient Experience - To ensure that our patients, of any age, have a positive experience measured through a range of metrics agreed in partnership with others.
- Aim 3: Education, Training and Supervision - To ensure our workforce has the right knowledge, skills, and attitude to recognise and care for patients, carers and families with mental health needs.
- Aim 4: Policies, Protocols and Service Level Agreements - To ensure that our staff are supported to deliver evidence-based practice.
- Aim 5: Outcomes - To ensure that we will deliver outcomes that are important to people as well as organisations.

The Mental Health Strategy does not address the specific challenges that MFT is facing in relation to mental health, how delivery of the Mental Health Strategy will mitigate these

[1] MFT Board of Directors papers - Public-BoD-13.11.23-combined-papers.pdf (mft.nhs.uk)

issues and/ or risks and how delivery will be measured. This may be reflected in the implementation plan and monitoring, which is described as done by the MFT Mental Health subgroup. It is positive to see measures on the Mental Health Strategy included in reporting to the Board of Directors (e.g. Nov 2023 Board papers).

In the Mental Health Strategy, it is explained that there are also other trust strategies for dementia, Learning Disabilities, End of Life Care etc. We expect that, once developed, the Trust Strategy will reflect the total/ holistic health needs of all patients including their physical health, mental health, LD/ A, and other needs, to better co-co-ordinate and integrate care.

For the LD/A cohort, MFT have a well-developed strategic plan 'Our plan for people with learning disabilities and/or autism, their families and carers 2022–2025' which details priorities of the Trust to implement key national strategy and improving access to health care for people with a learning disability and autistic people.

The priorities within this strategy have been coproduced with people with lived experience of learning disability and autism and their families and carers, along with members of the LD and a steering group in the Trust. The strategy has been developed in accessible/easy read format in line with accessible information standards.

The strategic plan covers specific areas in relation to ensuring people with LD and Autistic people are offered reasonable adjustments as required to ensure person centred approaches to care.

The 4 key quality improvement priorities within the strategy are aligned with the 'National learning disability standards for NHS Trusts' (NHSI) placing patient experience as the primary objective.

Ø Respecting and protecting rights

Ø Inclusion and engagement

Ø Workforce

Ø Learning disability services standard.

There are some key strategic issues the reviewers recommend being considered in relation to the MH needs and inpatient services for young people aged 16 and 17 (transition) who are subject to MHA detention. More detail and a wider focus on these areas is detailed within the Safeguarding section of the report.

Recommendation 1
The governance arrangements for oversight of delivery of the individual strategies (e.g. mental health and LD/A strategies) should ensure that sufficient attention is given to the interface between services for people with physical, mental health or LD/A care needs and additionally to describe the specific targeted approaches taken to meet the needs of different age groups e.g. 0-5, 5-18, 18-65 and 65 plus. Examples of areas that would benefit from some additional focus on how work is developed and led in areas or age groups that may overlap or have additional needs include transition (16- and 17-year-olds) and Special Educational Needs 0- 25 (SEN).

The developing Trust Strategy should address the holistic needs of patients and identify the priorities of the Trust in relation to integration and co-ordination of care for people with multiple needs (physical health, mental health, LD/ A, and other needs), taking account of the principles of population health management approaches to identifying and meeting needs earlier

4. General Overview from Lead Reviewers

The lead reviewers visited the Manchester Oxford Road Campus to gain a general understanding and overview of the services, meet with Executive and Senior colleagues and visit the areas that have a high volume and/or frequent contact with patients who may present with MH conditions or an LD/A diagnosis.

Feedback for the general overview site visits to the Emergency Department, MH Liaison Team, CAMHS inpatient services and the Acute Medical Unit at MRI captures a narrative opinion regarding both the physical environment and clinical practices directly observed on the day. This narrative also captures information received verbally from clinicians at service/team level in response to questions asked during the visit.

Some of this narrative contradicts findings or observations made later in the report as subject matter experts who conducted more focussed deep dive visits with front-line staff in some instances have witnessed different practices and received conflicting responses. Where this has been noted, this is captured and has been reflected and used when making recommendations.

In January 2023, Manchester University NHS Foundation Trust completed and returned a self-assessment against the CQC Key Lines of Enquiry (KloEs) for the Assessment and Monitoring of Mental Health in Emergency Departments.

The KLoEs are listed in Appendix 2 as they give an overview of the areas where the Trust is required to formally evidence compliance.

The lead peer reviewers have reviewed the documents and supporting evidence and narrative submitted to CQC in relation to the KloEs, but to better understand the context and offer additional recommendations to MFT, the lead reviewers during their visit were mindful of the KloEs and utilised this background to gain insight into the physical operational environment and when meeting and discussing with key leaders, clinical leads, and managers to explore some of the issues in more detail.

In relation to the Self Assessment return, whilst the lead reviewers found this to be a comprehensive response to CQC and noted that it was supported by appropriate evidence in most areas, they would also offer the following additional observations having visited and met with key leaders as part of the visit to the Emergency Department.

4.1 Emergency Department

Areas of Good Practice

- Children and young people (CYP) who require admission under the care of CAMHS, are also under the care of the general Paediatrics medical team who will support any medical treatment required.

- Mental Health Awareness Training is mandatory for all staff and current compliance is 91%. In addition, there is bespoke training delivered to ED/UTC staff in MH triage, referral pathways, risk assessment, MHA, MCA, and ligature risk assessment training.
- The monitoring and use of the MHA and MCA is an area the lead reviewers highlighted as good practice; this has been covered in more detail in a separate section of the report.
- Although there are no MH practitioners from the GMMH MH liaison team working *directly* in the areas, the reviewers were made aware of several staff working in the area (employed by the acute hospital), who had voluntarily been named and identified as individuals who take a lead / focus /ambassador type role for MH – this was clearly articulated at both RN and support worker level on the day of the visit.

Areas Identified for Improvement

- Where it describes in the self assessment document as part of the overview that the Mental Health Liaison Team are based in all departments, this is factually incorrect and is in the opinion of the reviewers a clinical deficit/risk. Whilst, the team are co-located to ED, they do not have a physical base in ED, therefore are not always present in the area.
- During the visit to MH liaison team, the reviewers met with staff from GMMH who also clarified that it is a single team that cover the 4 hospitals based on the Manchester Oxford Road Campus, the size and scale of the site is significant, and this again may present additional challenge/pressure on time.
- The area utilised to hold an individual who has been removed from a public place due to a MH disorder an requires a place of safety (under s136 of the MHA) at the Manchester Royal Infirmary site, is a room that is part of the MH patient's hub. This is not Royal College Psychiatry compliant. More detail is described under Restrictive Practice section.
- The current ED environment has no toilet / shower facilities. (Raised on the day of the visit as an immediate concern) In fact, the entire area is not fit for purpose, there is no natural light, no anti-ligature toilet/shower areas, and no anti-barricade doors in situ. Reviewers were informed of plans for a replacement MH hub area, but the timescales on this are "up to 3 years".
- Therapeutic observations of patients within ED are carried out by security staff NOT mental health support workers. Linking this to the first point above, this potentially leaves the ED Nurse clinically accountable for the MH nursing care 'delivery'. Due to the complexity of this practice, a separate section has been included in the report regarding the role of security staff within the ED's, which is linked to KLoEs CQC MH6 and MH7
- There was a lack of awareness and understanding of the potential impact of Right Care Right Person (RCRP).

Recommendation 2
Consider the location of the MHLT in relation to the ED's and multiple sites that they provide services for on the Oxford Road Campus.
Recommendation 3

Complete a full environmental safety risk assessment, identifying current risks including those outlined above and ensure there is clear mitigation in place to manage risks. Any high-level residual risks to be escalated and included on the Trust's Risk Register /Board Assurance Framework.
Recommendation 4
Consider the current SLA with GMMH, focus should include a review of recommendation 2 and the use of security staff within the ED to carry out ESSO. (This recommendation needs to capture the thinking articulated in detail within later sections as most sections within the report reference the use of security guards).
Recommendation 5
Clarify the leadership for managing and communication the impact and processes in relation to the implementation of Right Care Right Person (RCRP). **(Link with Recommendation 6 as this needs to apply to MFT and GMMH)**

4.2 Mental Health Liaison Team

Although not part of the MFT staff cohort, the reviewers felt that it was essential to meet with and visit the MH liaison team and see where they were based.

The team are based in offices that are co-located to the ED. The two senior leaders within the team met with and openly answered the reviewers' questions. It was clear that the leaders are passionate and knowledgeable about patient care and mental health issues, but it was also apparent that the leads seemed to work in a way that is somewhat disconnected to the wider GMMH services.

Whilst this is understandable in part due to their geographical location and close working with the acute hospitals, it did raise some concerns for the reviewers regarding oversight by the wider MH Trust, and support for the liaison team who for a service covering such a significant area, seemed to be relatively junior in terms of banding and status.

At interview it was established that the Liaison team cover 4 hospitals on the Oxford Road Campus. So, in fact they cover all areas, except the wards on the Childrens Hospital site.

The leads described managing approximately 500 referrals per month, although documentation provided indicates that it is significantly more than 500 per month. The majority of referrals come from ED but there are also a steady number from wards (75/25 split).

Within the team there are 47 WTE's including Mental Health Practitioners, Advanced Health Practitioners, social workers (not AHMPs), nurses, a psychologist plus 3 support workers. There are 2 consultant psychiatrists who provide cover into the wards only. The MDT work Mon- Fri 9-5 plus 1 ward staff Mon-Fri. 3 Later Life and Memory service (LLAMS) 9-5 Mon – Fri and there are 5 practitioners per shift.

The medics will carry out a review of anyone waiting in ED for over 12 hours. In addition, there are 4 hours per week (one session) funded for an Older Adults psychiatrist. There is also a CYP lead.

On an operational basis, there is a shift co-ordinator with oversight but based in Pearl Unit.

The leads described that Triage would be done and referrals received via HIVE, although MFT papers suggest this may also be done by consultants via telephone. They described the process of first contact and described that if observations were required then this would be done via security – but "also patients will have clinical staff allocated and a named liaison staff". It was a little unclear to the reviewers who would retain accountability due to the refence to multiple personnel.

Of note, the reviewers sought the view of the leaders regarding the use of security staff to carry out enhanced observations. The view expressed was that it works well, and that they are a key part of the team. There is no apparent desire from the GMMH leads to alter this as part of the sub-contract arrangements between GMMH and MFT. The language used was of some concern to the reviewers because although the process described is at face value congruent with how Mersey Care may adopt the use of enhanced observations, there were frequent refences made to the use of guards, bed watch and as described in the paragraph above, a lack of clarity regarding accountability and oversight.

The reviewers have identified some areas as potential Good Practice or Areas for Improvement, but it is important to note that as this information is not part of the Trust's data set, this may require further triangulation by the Trust.

The issues regarding security have been pulled out and further emphasised in the section relating specifically to security.

When discussing the awareness and impact of RCRP, the leads for the MH liaison team are trying to prepare for this, but there was no evidence that this is being led by senior managers across either GMMH or MFT.

<u>Areas of Good Practice</u>

- The leads described having positive working relationships with all staff and positively collaborating with safeguarding team (MFT facing).
- The leads reported joint planning – full report on PARIS (MH patient record) with a summary on HIVE system.
- The leads reported that everyone going to a ward has a plan agreed in ED.

<u>Areas Identified for Improvement</u>

- Unclear on KPI monitoring and target (internal) appears to be set at 85% compliance for 4 hours review.
- There is a lot of focus and a desire to achieve the Psychiatric Liaison Accreditation Network (PLAN) accreditation, however the reviewers felt this is a lot of work and perhaps needs to be balanced and focus on how this will demonstrate a positive impact on service delivery,
- There are differences in the uniforms worn by MH liaison staff and acute staff, and this is causing confusion.
- Safer flow is in use to monitor waits, but this cannot be seen by MFT Executives as it feeds into GMMH Executives – No evidence of sharing this information or access.
- Senior management leadership for managing the impact of RCRP within the wider system.

Recommendation 6

Consider reviewing the current SLA with GMMH, to ensure there is a shared understanding and clarity of key responsibilities, to include a review of the shared monitoring of KPI's and other data available to monitor MH patients within acute services, the impact of PLAN accreditation and uniform standardisation. **(Link with recommendation 5 – the impact of RCRP).**

4.3 Galaxy House (CAMHS inpatient unit)

Reviewers met with members of the MDT at Galaxy House for discussion and questions and toured the establishment, including the living areas, day care and school areas.

Galaxy House is a 12 bedded inpatient unit for 8-18 years. It usually runs at 100% occupancy and all admissions to the unit are planned.

There are clear referral and admission pathways, and the unit accepts local, regional and on occasions national admissions.

Children and young people admitted to Galaxy House are most likely to require treatment for an eating disorder or for Pervasive Arousal Withdrawal Syndrome (PAWS). There is focussed support team input into the paediatric wards, including LD/MH support.

Areas of Good Practice

- There is good skills mix within the MDT establishment including consultants, psychologists, RMN's/ SW's/ LD/PAEDs specialists.
- There is on site access to a school and Occupational Therapy and recreational activities.
- The team reported that there is extensive family involvement.
- The team are well established and recognised – (often feature in Board stories)
- Training for staff is delivered to multiple disciplines to ensure shared knowledge and understanding.
- There are clear governance processes and there is wider engagement with the system (e.g., safeguarding, partnership board attendance)

Areas Identified for Improvement

- Agree priorities and identify outcome measures (both during inpatient stay and post discharge)
- Increase awareness of the service
- Increase the use of patient and family engagement and experience forms and feedback. Although the team reported extensive family involvement, this was an area identified by CQC in October 2022 and is still an issue highlighted in discussion with the Trust lead for patient experience.

Recommendation 7

Consider the development of a clear strategy supported by a business plan, a marketing strategy and marketing/communications material – both internal and externally focussed for Galaxy House.

Recommendation 8
Review and strengthen how CYP and their families and carers are engaged in treatment plans and feedback mechanisms – consider accessibility and age-appropriate feedback/engagement methods e.g. texts.

4.4 Acute Medical Unit (AMU) at MRI

The AMU had a welcoming feeling and the staff on duty were engaging and knowledgeable. The managers were highly engaged with conversations and action plans to support patients with MH needs, and they described managing the layout of the ward in the best possible way to ensure good observation, within the limitations of the environment. They described good working relationships and parallel referral and assessment processes. The response times for MH support were dependent on presentation, but usually within 24 hours.

The managers described that the “ideal” length of stay would be around 72 hours but MH patients can stay “for weeks”. Described that this can put pressure on the team as there is an increase in adolescents and self harm type behaviours and associated need for additional ESSO requirements, therefore an increase in security. Proactively the ward managers were developing the skills of the staff team, offering enhanced training in MH areas, such as trauma informed training, managing ligatures, use of ligature knife and competency in ensuring MH rights in accordance with detention.

Areas of Good Practice

- Proactive and innovative leadership – developing acute staff team and security staff skills to include involvement in several workstreams including.
  care plans with security bed watch team supporting, Trauma informed care, improved patient experience, anti-ligature environments, linking in with leads for social prescribing, homeless work and missing persons work.

Areas Identified for Improvement

- Due to age group (younger adults) need more support for education, social skills etc.

Recommendation 9
Review ward establishment and skills mix to consider dedicated RMN links to the ward and additional support required to target support for younger adults.
Recommendation 10
Monitor ward inpatients to establish if there is a potential future requirement for a dedicated MH AMU.

4.5 Meeting with Director of Nursing and Deputy Director of Nursing at MRI

In addition to meeting with the teams from clinical areas, the reviewers met with the Director and Deputy Director of Nursing at MRI to gain insight into the connectivity and

cohesiveness of the perspectives from “ward to board”. Also in attendance was the lead for patient engagement/feedback.

It was noted by the lead reviewers that the Deputy Director of Nursing is an RNM, but expressed a view that he wasn’t up to date with MH practices, so did not take a lead on this area of work. The Senior team shared honestly and openly some examples from a patient experience perspective of where there were shortfalls with care delivered to patients with a MH / LD and A diagnosis. They described ongoing work with GMMH to improve awareness and increase training in this area.

Concerns were raised by all regarding managing the environment from a patient safety perspective e.g., identifying ligature risks, lack of anti barricade doors and recognising that Pearl Unit is not fit for patients who present self injury high risk type behaviours.

Through interview, the lead reviewers established a shared view that there is a disconnect between the MH services at the front-line and the directors’ oversight of activity.

Despite gaining some assurance from the pre-reading of papers by the reviewers, it appears that there are gaps in the oversight of performance measures by the hospital director team at MRI. On delving into this via the face-to-face discussion, there appears to be no daily oversight calls, escalation of long waits process isn’t followed consistently by GMMH and MRI execs have no access to GMMH live data.

Recommendation 11
The Service Level Agreement with GMMH is out of date and requires discussion and review. It may be prudent to review this at MFT executive level with input from Hospital Directors, prior to discussing a renewed SLA with GMMH Executive Directors. (Link to recommendation 6)

4.6 Meeting with Safeguarding Team

The lead reviewers met with the Assistant Chief Nurse for Safeguarding and other senior safeguarding Leads to test out if the responsibility for safeguarding was removed from operations or if, as supporting documentation suggested, it is embedded throughout operational services across the Trust.

Through discussion and questioning, it became apparent that there has been significant investment in safeguarding and there are now 16 “named practitioners” covering 6 sites. Leadership and governance processes are clearly illustrated and each of the hospitals has a safeguarding committee, which importantly the safeguarding team are linked into. Safeguarding is covered in detail in a separate section, but the lead reviewers feel that due to the visibility and awareness of safeguarding that has been referenced by all staff, this is an important area to highlight as Good Practice.

Areas of Good Practice

- Safeguarding is referenced by all staff on a frequent basis, this gave the lead reviewers confidence and assurance that the team are regarded as essential, fully involved and accessible to frontline staff and managers and key influencers across the Trust footprint. This is essential to ensure that the Trust can maintain a positive patient safety culture.

5. Areas of Specific Focus

The lead reviewers have included and explored in more detail some areas of key focus within MFT, where they have either identified practice that is potentially unsafe, or areas that are high risk and associated with statutory responsibilities.

5.1 The role of security staff within the ED's to support MH needs

When referring to the role of security staff within the ED's, the Trust policies and all staff interviewed are clear that there is an expectation of security staff to support clinical departments with issues of violence, aggression and nuisance behaviour, following the Trust's Enhanced Supervision Security Policy (ESSO).

Where this becomes ambiguous and therefore in the view of the reviewers presents several key risks is in relation to the following statements where there is a lack of clarity which may (and from the reviewers' direct observations and questioning, in fact does) lead to inconsistent practices:

- "the role of security is to observe and supervise a patient for the duration of their shift but does not include the personal care for the patient".

- "security ensure that every other option and means of preventing/controlling and defusing a situation is attempted before there is any interaction with a violent person following physical intervention, de-escalation and breakaway techniques".

These statements don't define but they do infer that the security staff are in fact leading rather than supporting clinical staff in departments with the direct MH care and interventions. This is especially because the clinical MH liaison team are not present in the immediate vicinity, nor are they directly supervising the security officers. Security Officers are employed by an external security company and report through to the Estates and Facilities Management Board.

From direct observation of the ED department, the reviewers were immediately struck by the high volume of security staff present to support the presence of 5 patients. The department was being operationally staffed on the day by the acute hospital staff, Reviewers had the opportunity to speak to the Band 5 RN in charge of the area, who presented as very professional and clearly had a good awareness and a passion to support people with a MH condition.

However, the lack of MH staff – either RN's or support workers – within the department where there is clearly a high demand for MH beds and associated long stays in ED was notable. When this was questioned, the reviewers were informed that liaison "come and go" and in fact this was observed in practice when staff attended to review a damaged light (post incident) but left without interacting with the nurse in charge or any of the patients.

This raised several concerns for the reviewers who would wish the Trust to consider the following recommendations:

Recommendation 12
Clarify the role of the MH clinical leads in supervising the security officers in the department? This includes checking on interactions, monitoring the effectiveness of interventions and reviewing observation logs.

Recommendation 13
Clarify what is meant when referring to personal care, what is the definition of this? (For example, who observes a patient with physical health needs – are there two people allocated, one a security and another from a clinical team? If a patient needs to use the toilet or shower, but is on 1:1 observation, who takes over the responsibility for observing (and the associated recording), or again are two people involved?)
Recommendation 14
Clarify what (and who) is inputting into the ED's patient record system (HIVE) with regards to patients' observations?
Recommendation 15
Following on from Recommendations 6 and 11, explore the current appetite or desire from the GMMH leads to alter the security arrangements utilised as part of the sub-contract arrangements between GMMH and MFT. Consider increasing the mental health support worker establishment to reduce the over reliance on security staff to supervise and observe people with mental health difficulties, autistic people and people with a learning disability who may present with distressed behaviours.
Recommendation 16
The language used was of some concerns to the reviewers because although the process of enhanced observations described is congruent with how Mersey Care may adopt the use of supportive observations, there were frequent refences made to the use of guards, bed watch and a lack of clarity regarding accountability and oversight. How will the Trust consider tackling this moving forward?

5.2 Reducing Restrictive Practice

As part of the subject matter expert review relating to reducing restrictive practice, visits to Manchester Royal Infirmary, Emergency Department, Ward AM3 Major Trauma Unit, MRI and North Manchester General Hospital, Emergency Department and the Acute Medical Unit were facilitated.

Whilst in its infancy, it is evident that work to reduce the use of restrictive practices and supporting people in distress is underway across the trust, through the provision of training by a private training provider certified by BILD ACT to ensure the Restraint Reduction Network Training Standards are upheld.

During the review, members of the senior leadership team, nursing staff, the deputy security manager ORC and security staff were open about the challenges they experience and highlighted positive practice across the services. It was also incredibly helpful to talk to people with lived experience receiving care within the hospital.

Some of the information below is also captured in the narrative overview from the lead reviewers, but the focus in this section drills down to the detail of the impact on patients and reducing restrictive practice strategies.

5.2.1 MRI Emergency Department

The Emergency Department had an area specifically for people admitted with a mental health difficulty, autistic people and people with a learning disability who may be placed on

Security Supervision as per the Enhanced Supervision Security Officer(s) (ESSO) policy. The environment was small and dark with no natural light or structure or routine for patients. Patients were asked to remain in their bed space with very little to do whilst awaiting further assessment and/or treatment. During the visit, it was clear several patients wouldn't stay in their rooms and congregated on the small corridor outside the nursing station. There was very little signage, no TV's or activity planners in place to offer meaningful distraction and activity whilst awaiting further assessment and/or treatment.

The 136 suite facility had no clock visible for the patients to know the time of day. The bed trolley in the room was not anti-ligature, which would increase the potential risk to people who are in distress. It was also highlighted there was a lack of stimulus and meaningful distraction for those people supported in the area.

There are no toilet facilities on the unit, resulting in security staff having to escort people next door to the toilet. There was only one toilet within this area which has an anti-barricade mechanism, therefore it was reported this can become an issue for the staff team if the toilet is occupied or out of order. (NB It is also important to note that not all staff were aware of any anti barricade doors as when the lead reviewers asked this question, they were informed that there were no anti-barricade doors).

A patient reported he had been in the area for days and did not know what his plan entailed. He was frustrated by the experience and reported he had not had a shower for a number of days, he was unable to attend to his personal hygiene and there were no meaningful activities on offer or a timetable available to structure his day. It required a senior nurse to ask the nurse in charge and security staff supervising the person as per ESSO policy to support the person to have a shower on the adjacent ward.

There was no specific area to provide people with access to fresh air and exercise in an outside space. This resulted in security staff having to escort people through the triage waiting room to access fresh air outside**.**

There were high levels of staff within the small area including nursing staff, GMMH staff, security staff, and it was also highlighted often police are in the area with people in the 136 suite. This resulted in patients often feeling anxious and overwhelmed.

The staffing plan within the mental health designated area consisted of a registered general nurse, a support worker - often agency staff and on the day of the visit a support worker from GMMH liaison team.

The GMMH liaison nurses are based a distance from the mental health area and during the visit there were no mental health nurses present to support the junior members of staff in the area.

A number of staff reported feeling scared and dreaded being delegated to the mental health area, due to the lack of support. Some staff reported lacking skills and experience in supporting people with mental health difficulties, who may present with distressed behaviours. This resulted in increased anxiety amongst the workforce**.**

It was evident there was a lack of practice leadership to meet the needs of people in distress, this meant that a senior nurse who was facilitating the visit was required to intervene and provide support to junior members of staff.

There were a high number of security staff supervising patient's as per the ESSO policy, wearing full personal safety attire, in the form of stab proof vests. They were stood close to

patients throughout the visit, which led to a patient expressing anxiety of too many people invading his personal space.

Recommendation 17
Explore options to enhance technology within the patient rooms i.e. a TV within ligature free cabinet to distract people from symptoms of their mental health difficulties.
Recommendation 18
Undertake patient experience questionnaires with people admitted to gain an understanding of the areas for improvement and create a 'you said - we did' board to highlight to new patients on the unit that their feedback is valued and acted upon responsively.
Recommendation 19
Place a clock outside the 136 suite for people using the space.
Recommendation 20
Create an activity planner for people using the service consisting of access to fresh air and exercise, attending to personal hygiene and calming and alerting activities to provide distraction.

5.2.2 Security

During discussions with key stakeholders there was evidence of conflict in trying to strike the correct balance between the need to maintain safety and security, and the need to maintain a human rights-based approach in the use of restrictive practices. An example of this was the ESSO policy which allows Security Officers from GSTS governed by the Trust's Security Contract to supervise, observe and deliver restrictive interventions as per the ESSO policy.

It was highlighted during the review, there was an over reliance on the use of the ESSO policy to observe, supervise and manage people with a mental health difficulties, autistic people and people with a learning disability who may display distressed behaviours. It was reported this was due to the lack of nursing staff adequately trained in the safe application of physical intervention.

It was highlighted the security department would benefit from daily multi-agency safety huddles to review people on security supervision as per the ESSO policy, to consider reducing restrictions and identify any additional support required in a timely and proportionate manner.

It was reported following the use of physical intervention by the security officers, the patient is not provided with an opportunity to de-brief to explore their experience and identify any learning to improve the experience of people receiving care.

The security officers uniform includes personal safety equipment in the form of a stab proof vest. This may be required when supporting people with the propensity for extreme aggression, however for the vast majority of people this seems a disproportionate response. It was reported by staff that there had been occasions when members of the public in the hospital have been in the possession of weapons. However, greater understanding of the prevalence of this risk is required.

All security officers are required to wear their full uniform including a stab proof vest, even if the risk assessment identifies the person as low risk of causing harm to others.

The documentation completed by the security officers on duty is comprehensive, however places a risk narrative on the person due to their mental health diagnosis. This is likely to be as a result of a lack of clinical understanding and training in relation to mental health difficulties.

The deputy security manager had a very positive attitude, was reflective and open to new ideas in balancing maintaining good security and improving the experience of people receiving care across the service. It was also highlighted that a number of the security officers had received thank you cards from patients they had supported during their admission to hospital.

Recommendation 21
Consider using a dynamic risk framework to manage the number of security staff within the area as per the ESSO policy.
Recommendation 22
Consider reviewing the job description of support workers within the area to include an activity function to their role.

5.2.3 Training in Reducing Restrictive Practice

The trust has established a plan to implement least restrictive intervention and restraint training across their services. A pilot training programme certified by BILD Act to uphold the restraint reduction network training standards commenced in July 2023. The preliminary feedback from participants has been positive. This is supported by data provided by yearly averages of effective de-escalation during confrontational situations and the use of restrictive interventions since the roll out of the certified training. This information highlights the benefits of using least restrictive options.

The challenges experienced by the trust is understanding the training requirements across the hospital sites for front line clinicians and non-clinical staff. This results in a potential over reliance on security officers to observe, supervise and support people in distress.

It was also highlighted that the trust has made the Oliver McGowan training on Learning Disability and Autism mandatory for all clinical staff. This will ensure the workforce have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability.

Recommendation 23
Increase the number of nursing staff trained at level 3 of the certified training to support people who may require additional support and the application of physical intervention to administer treatment and/or maintain people's safety. A training needs analysis based on the areas with highest demand for ESSO would be helpful to structure thinking around prioritisation of people to undertake the training.
Recommendation 24
Develop a daily multi-agency safety huddle to review people subject to ESSO policy.

Recommendation 25
Consider reviewing the ESSO policy and prevalence of risk to create a risk dynamic approach to wearing full PPE when supporting people with mental health difficulties, autistic people and people with a learning disability.

5.2.4 Lived Experience

During a meeting with the Director of Nursing and senior leadership team, it was highlighted that following the poor experience of an autistic person and their father during admission to the hospital, they have been invited to support the service to consider ways to improve the experience of people receiving care. This is a positive example of transparent practice.

Recommendation 26
Explore options to incorporate further lived experience perspectives, including paid roles, to co-produce improvements at all levels of the service (i.e., design, delivery, governance, and oversight).

5.2.5 Culture

A theme which emerged through talking to members of staff was that people admitted onto the unit with mental health difficulties, autistic people and people with a learning disability were treated differently to those people admitted solely for physical health problems. It was highlighted those people in the mental health area of the Emergency Department don't receive the same level of care and are treated like "second class citizens". This has led to significant anxiety and moral injury amongst the senior nurses in the service.

The stigma attached to people with mental health difficulties often referred to as a risk narrative could potentially perpetuate unhelpful stereotypes and undermine attempts to understand distressed behaviour in terms of its function. This appeared to have created a reactive approach to supporting people in distress with a strong focus on risk management control.

Some staff have reported the use of security staff to supervise and undertake observations of people with mental health difficulties at times led to further conflict due to their responses, attitude and lack of training of supporting people with a mental illness, autistic people and people with a learning disability. It was highlighted such incidents are reported, reviewed and appropriate action is taken.

Recommendation 27
Consider including the person's strengths and positive behaviours within the documentation completed by security officers whilst under ESSO.
Recommendation 28
As above, there is a clinical need to increase the number of nursing staff trained at level 3 of the certified training to support people who may require additional support and the application of physical intervention to administer treatment and/or maintain people's safety. Develop a system and protocol in collaboration with the security department to

ensure there are sufficient staff on duty trained to respond to incidents requiring intervention.
Recommendation 29
Consider peer support workers to work within the designated mental health area of the Emergency Department.
Recommendation 30
Explore these prevailing concerns across the workforce and enhance the support for staff delegated to the mental health area of the Emergency Department.
Recommendation 31
Identify staff to undertake the level 3 certified training to enhance their skills of supporting people who may present with distressed behaviours.

5.2.6 Acute Medical Unit, MRI

Findings from the Subject matter expert triangulate with the lead reviewers in this area. The ward was well organised and highlighted some positive practice in terms of daily psychological input, specifically providing formulations and best practice approaches for nursing staff to apply for people admitted on to the ward with mental health difficulties, people with autism and people with a learning disability.

The ward manager had also creatively used her establishment budget to create a full-time activity worker post to provide meaningful calming and alerting activities for patients on the ward.

There appeared to be an overreliance on the use of security officers to supervise people (as per the ESSO policy) with mental health difficulties and a lack of staff trained to support people in distress, which may involve the application of physical intervention.

5. 3 North Manchester Hospital

5.3.1 Emergency Department

The Emergency Department was extremely busy and there was a number of patients under security supervision as per the ESSO policy, in addition to a number of police officers within the department with patients. Both the security officers and police officers were stood in the corridors observing people in side rooms. There was also a lack of privacy for these patients, as the doors to the side rooms were open for the general public within the area to observe the person.

There was excellent signage within the department which highlighted the work undertaken to get feedback from people using the service and actions taken by the service to improve experience in the form of ‘you said, we did’.

The Head of Nursing and Lead Nurse were very positive, despite challenges they experience and were open to new ideas surrounding supporting people with mental health difficulties who may present with distressed behaviours.

There was an excellent outside space with a seating area and calming ambience within the hospital to provide people access to fresh air and exercise. It was highlighted this space is regularly used by patients and by those supervised by security as per the ESSO policy.

GMMH have a designated area the 'Green Space' which consisted of a couple of rooms and a nursing office. This space was assigned for use for people with mental health difficulties, autistic people and people with a learning disability who have been assessed as being settled. The area was low stimulus, spacious and had good lighting. Despite there being people in the Emergency Department, which appeared extremely busy with people with mental health difficulties on security supervision as per the ESSO policy, no patients were using this designated space during the visit.

Recommendation 32
To review the function of the Green Space managed by GMMH Trust and consider this being adapted for all people who suffer from a mental illness, autistic people and people with a learning disability despite their presentation. This environment is more conducive to providing high-quality, person-centred care for people who are often overwhelmed and require a low stimulus environment.

5.3.2 Acute Medical Unit

The Acute Medical Unit was well led during the visit. The ward manager was very positive, demonstrated good leadership skills, articulated clear plans for improvement and highlighted she was pleased the trust had established a plan to implement least restrictive intervention and restraint training across the service. The ward manager was keen for all her staff to receive level 3 certified training and she had drafted a plan for different grades to undertake the training incrementally.

It was clear the vision was to ensure people who are admitted onto the ward with a mental illness, autistic people and people with a learning disability are supported during times of distress by the staff team with additional support from security, if and when required.

5.3.3 Recording and Reporting

The Trust incident reporting system and the HIVE flowsheets are used to report all episodes of physical restraint or use of restrictive interventions. The newly introduced HIVE flow sheet covers all areas to be reported against following the application of a restrictive intervention, however there is no specific area to record whether the staff team and patient has been offered a de-brief following the incident. This may however be recorded elsewhere.

Recommendation 33
Consider adding an additional tab for staff to record whether the patient and staff team involved in the incident have been offered a de-brief.

5.3.4 Policy

The Trust policy on the Prevention and Management of Restrictive Interventions for Adult Patients clearly set out the Trusts position and covers all areas of relevant legislation and helpful guidance for staff to follow. However, there appears to be a gap in terms of setting

out the importance of making reasonable adjustments as per the Equality Act (2010) to improve care delivery and reduce the likelihood of people becoming distressed.

Through discussions with front line nurses, it was apparent not all were aware of the Broset Violence Checklist to help monitor behaviour changes and assess the level of support a person may require.

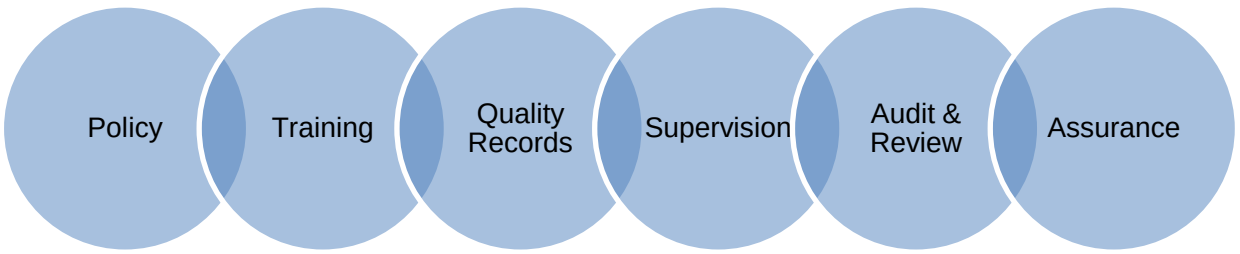
One further area to consider is the use of mechanical restraint under any circumstances as some staff stated that there is a policy, but unaware of the use or application of this policy.

Recommendation 34
To review staff's understanding of the Broset Violence Checklist to help assess the level of support a person may require.
Recommendation 35
To review the trust policy on the Prevention and Management of Restrictive Interventions for Adult Patients and include guidance on making reasonable adjustments as per the Equality Act (2010) to improve care delivery and reduce the likelihood of people becoming distressed.
Recommendation 36
Create an overarching Reducing Restrictive Practice Policy which sets out the Trust position and commitment in delivering upon this important agenda.

6 Safeguarding

Safeguarding and its operational process within the NHS is governed by statutory legislation and monitored through the commissioning standards with regional NHS Integrated Care Boards and the Section 17 (Children Act 1984) annual inspection protocols within multi-agency safeguarding arrangements of local Safeguarding Partnership Boards.

These statutory assurance processes centre on a common set of safeguarding principles that create the scaffold around the organisation and ensure that effective safeguarding practice is led and assured within the Trust. The MFT Peer review focuses on these common features of effective safeguarding service:



Additional Key Lines of Enquiry (KLoE) were also reviewed to provide both Trust's the opportunity to learn from each other's management of common areas of challenge within

safeguarding- particularly the overlap between Safeguarding Children & the delivery of Child & Adolescent Mental Health Services.

. KLoEs include:

- *Commitment & Contribution to Multi-Agency Risk Conference for Domestic Abuse.*
- *Responding to disclosure of non-recent child sexual abuse.*
- *Process in place for CAMHS Crisis / Multi-Agency Breakdown / Disputed Tier 4 Admissions.*
- *Management of Under 18 admissions to Adult Inpatient Wards / Child Visiting.*
- *Management of Pregnancy of Inpatient Service Users.*
- *CAMHS Waiting Lists- Manging identified risk whilst children are on waiting lists.*
- *Transition from CAMHS to Adult Mental Health Services.*

6.1 Safeguarding Policies and Approach

MFT operate a comprehensive suite of policies pertaining to Safeguarding Children & Adults with complimentary policy/procedure regarding Mental Capacity Act obligations. The policies set out how individuals should work together to safeguard and prevent harm to children and adults at risk. The policies are clear and practical, providing a framework for all the Trust services to have arrangements in place to safeguard children and adults at risk.

Subject areas within policies reflect the localised demographic and response to needs specific within the Trust's local community.

The Safeguarding Children and Safeguarding Adults Policies & Procedures provide an understanding of the Trust's process for demonstrating compliance with local and national standards for safeguarding children & adults at risk.

The MFT Safeguarding Team is large, comprising of 104 staff. Whilst providing a corporate service Trust wide, the team is also made up of some key roles that are fully operational and supportive of safeguarding processes within practice. The large staffing resource within MFT Safeguarding Team stretches across a wide geographical service footprint and clinical portfolio of services across the city of Manchester.

The high performance and positive outcomes from the MFT Safeguarding Annual Report demonstrate the value of the Safeguarding Service within the Trust and the multi-agency safeguarding partners across Manchester. Feedback from onsite peer reviewers report a consistent safeguarding awareness amongst staff in practice and a strong safeguarding presence within the operations of the clinical workforce.

6.2 Safeguarding Training - Allocation and Compliance.

It is understood that MFT is not currently compliant across all levels of safeguarding training standards- particularly those connected to safeguarding children compliance. It is recognised that the benchmark for safeguarding compliance is set by Intercollegiate Document for Roles & Responsibilities – Safeguarding Children (2018) & Safeguarding Adults (2019).

The criteria for training content at Safeguarding Children Level 3 and Level 3 Specialist is extremely detailed and presents a challenge to large Trusts requiring staff to complete a lot of training hours to receive training in all areas to be considered truly compliant to the Intercollegiate standards. Like Mersey Care, MFT must be creative and flexible in the methods and delivery of training to a capacity challenged workforce. The Trust's compliance figures present an upward trajectory and demonstrates the proactive commitment towards the highest standards for safeguarding training.

MFT utilise e-learning modules to achieve compliance with the core standards of safeguarding training. The Trust optimise additional taught training modules to provide a targeted and localised provision of training that is relevant and helpful to practice. This is delivered virtually to further support attendance.

The Trust offers an annual safeguarding training schedule through a wide range of bespoke safeguarding subjects. These modules supplement core knowledge from standard e-learning and focused learning/practical skills for practice and areas of study that are relevant to the local needs of communities- as identified in local safeguarding reviews.

6.3 Safeguarding Record Keeping and Clinical Oversight

MFT have introduced a new electronic patient records system (EPRS) The Hive. The Trust have created a set of template safeguarding forms within the system. The records system centralises information related to safeguarding and that allows for the availability of safeguarding risk information to staff live in practice. Template forms used universally across the Trust affords effective data collection to identify safeguarding trends/themes to support improvement to service & practice.

The use of HIVE as the primary system for recording safeguarding activity in clinical practice also allows system reports to support management oversight of performance and recognise the safeguarding cases within their services- and best support staff through line management supervision and in operational risk forums such as safety huddles, handovers, and multi-disciplinary meetings.

6.4 Safeguarding Supervision and Support in Practice

The Trust offer the workforce the provision of a Safeguarding Duty Practitioner available for advice and support between 0830-1630 Monday – Friday. The provision of duty is provided in each of the different hospital sites/divisions with designated safeguarding teams across the service lines.

Think-Family Supervision is delivered periodically across the children and adult workforce- focusing on a blend of safeguarding children and adult case examples and learning themes to strengthen the Think-Family approach expected within the Trust. These sessions can be reactive to the needs within the clinical service or as planned by the safeguarding team in response to lessons learned from audit & review.

The Trust Safeguarding Service invests in the expert knowledge of the safeguarding team through weekly CPD Sessions, referred to as 'Workout Wednesdays' where reflective learning exercises are completed as a service.

6.5 Audit and Application of Lessons Learned.

Safeguarding audit activity reviews the operational safeguarding practice of the workforce and reassures the transference of policy to practice. NHSE/ICB KPI Reporting requirements also entail the submission of audits relating to safeguarding activity within the multi-agency forum.

Commitment to the priorities of 4 local Safeguarding Children & Adult Partnership Boards across Manchester entails audit of practice across local partnerships in order to be assured of thematic areas of practice which align with local priorities such as Harm Outside the Home, Domestic Abuse and Neglect etc.

Safeguarding training contents and themes of supervision are taken from the lessons learned from local and national safeguarding reviews and case examples.

The Trust operate a safeguarding subgroup which relates to Audit & Review, as part of the safeguarding assurance structure to the Trust Board. Audits are completed across the safeguarding teams that govern the different clinical service lines.

6.6 Performance Reporting and Assurance

MFT Safeguarding Assurance Framework operates a first layer of internal safeguarding subgroups, which mirror those of the safeguarding partnership boards. These first layer subgroups report into the Trust wide Safeguarding Assurance Group and follow a trail of assurance directly to the Trust's executive board.

The Trust are required to demonstrate compliance with local and national standards for Safeguarding Children & Safeguarding Adults at Risk. This is monitored by NHSE ICB Commissioning Standards and quarterly Key Performance Indicator reporting. Additional inspection is completed annually under Section 11 (Children Act 1984) and completed by Local Safeguarding Children Partnerships.

6.7 Additional Key Lines of Enquiry:

i. Commitment & Contribution to Multi-Agency Risk Conference for Domestic Abuse. (MARAC).

MFT Safeguarding Teams support 4 MARACs across Manchester. The research and attendance requirements are contained within the Safeguarding Service*. Information relating to Service Users discussed at MARAC is managed by the safeguarding staff which ensures the sharing of crucial risk information with operational services across the Trust. The newly introduced Hive EPRS and template safeguarding forms used universally across the Trust supports the effective information sharing of safeguarding risk.*

ii. Responding to disclosure of non-recent child sexual abuse.

MFT have developed close working relationships with local Independent Sexual Violence Advocates. Where Disclosures of historic sexual abuse triggers connection with ISVA's to ensure the service user is informed and supported. This is particularly helpful in scenarios where a duty to report conflicts with the service users wishes and demonstrates an understanding of the trauma connected to non-recent sexual abuse and the benefit of involving independent support of specialist services.

iii. Management of Under 18 admissions to Adult Inpatient Wards / Child Visiting.

MFT operate a policy that sees children aged 16 admitted to adult inpatient wards. The Trust does have a provision of inpatient services for Children & Young People with admission criteria under 16 years. A conversation with MUCF safeguarding representative recognised the conflict between the exposure to natural risks of adult acute inpatient wards and the statutory obligation to children under 18 to predict & prevent exposure to known factors that can cause emotional and physical harm. This is covered in detail under Areas Identified for Improvement

iv. Management of Pregnancy of Inpatient Service Users.

MFT deliver a wide range of clinical services which brings together maternity and mental health services under its portfolio. Close working links across these crucial service involvements allows for information to be shared easily and strong working relationships between the key health services around mothers, children and families.

Areas of Good Practice

The Safeguarding Peer Review has produced some excellent learning points and opportunities to consider improvements to the processes and arrangements for Safeguarding Children & Adults at Risk (for both MFT and Mersey Care).

- MFT positively deviate from intercollegiate requirements for training to senior managers. This deviation is an uplift to the standards which indicate Level 2 Training for these staffing groups, but MFT allocate on-call bleep holders with an increased level of training allocating these staffing groups to Level 3 Safeguarding Children & Adults. This is similar thinking as in Mersey Care i.e. Both Trusts recognise that the senior leadership are responsible for on-call support and the acute risk circumstances of situations triggering on-call support as potential circumstances for safeguarding concerns.
- Innovative practice was observed in MFT Safeguarding Service practice, demonstrating investment in the CPD and well-being of staff. Level 4 training standards are assigned to the subject matter experts within the safeguarding team and the 'Workout-Wednesday' sessions allow the Trust Safeguarding Team to come together and complete updates to practice learning and thematic reflective exercises. The regularity and validity of learning is easily captured and serves to demonstrate compliance within quarterly KPI data.
- A provision of specialist safeguarding advice and support in practice is delivered by numerous duty practitioners across the different service lines. This is effective, so is not a deficit, but it may be an area that would benefit from further consolidation.

- MFT demonstrate a robust layer of internal safeguarding subgroups which are mirroring those subgroups within the multi-agency safeguarding arrangements and the priorities of the Safeguarding Children & Adult Partnership Boards. Mersey Care demonstrate similar assurance groups relating to Training, Audit & Review but MFT have subgroups relating to operational safeguarding process such as Early Help & Neglect, Domestic Abuse and Impact of Mental Health subgroups that feed into the overarching safeguarding assurance framework within the Trust. Mersey Care demonstrate a similar 'one step away from the board' structure of assurance for safeguarding, but without this first level layer of subgroups.
- MFT have developed effective working relationships with Independent Sexual Violence Advocacy services locally, which plays a key role in a trauma-informed approach to responding to disclosures of historical child sexual abuse. The matter of historical sexual abuse allegations is a challenge for safeguarding who need to reach the correct balance between reporting of public protection risk (from alleged historical perpetrators in the current day) and respecting the wishes and feelings of victims making disclosure about their experience of abuse. Early linking with ISVA can support victims through the process of disclosure, understanding mandatory reporting duties of statutory agencies and generate a maintained sense of control for victims in terms of what happens next. This is recognised as **innovative practice** for managing what is a common challenge within safeguarding.
- The MFT Safeguarding Service protect the clinical workforce from the capacity impact of 4 local MARAC's. Contribution and attendance at MARACs are completed by the Trust Safeguarding Team which ensures the effective exchange of information pertinent to safeguarding from domestic abuse between the Trust's operational services and multi-agency partnership. Within Mersey Care MARAC contribution is coordinated by the Trust Safeguarding Team but the health information contribution and attendance are facilitated by staff within the operational workforce. The Mersey Care model does impact on the clinical demand of operational services and is currently under review due to increased pressures on Operational services. The arrangements for MARAC to be managed operationally is based on the ethos of maintaining safeguarding activity as part of core business and operational practice, as opposed to an add-on process to clinical practice facilitated by others.

Recommendation 37
Although the current approach is effective, there could be potential benefits (efficiencies) for streamlining to one single point of contact for safeguarding for all services within the Trust- rather than different safeguarding teams offering the same duty service for individual service lines.
Recommendation 38
Although the current approach is effective, it is important to ensure that MARAC has the correct involvement from operational services.

Areas Identified for Improvement

The scope of the review demonstrated that MFT and Mersey Care have very similar and high standards in the arrangements across their organisations to ensure safeguarding of children and adults at risk. Manchester University NHS Foundation Trust hold a high esteem for Safeguarding. There are clear frameworks in which the Trust ensures arrangements are in place to safeguarding the children and adults at risk within their communities.

There is one area however that the reviewers would wish to highlight in relation to Safeguarding Children where there is a clear difference in practice, this may be linked to availability of CAMHS beds |(outside of Galaxy House), but reviewers were unable to clearly ascertain this so have added an additional recommendation to ensure the assurance and monitoring processes for escalation are clear.

That key difference of approach is seen within the normalising of admission of children under 18 years to adult inpatient mental health wards. MFT admission criteria involves children over 16 years of age to be automatically admitted to the Adult Inpatient Mental Health Unit. In Mersey Care a child admitted to an adult ward is an event that is not considered normal. An Under 18 Child admission to an adult ward can happen but is not standard practice. When the circumstances play out where that decision is required as the safest temporary option for the child, there is a clear operating process for managing that, including notifying CQC. The approach is to ensure oversight and the practical management and delivery of children's care in an adult environment, with a parallel proactive process to repatriate the child to an appropriate care environment as soon as possible.

Working Together to Safeguard Children (WTG, 2020) refers to 'Harm' as 'ill treatment or the impairment of health and development'. This includes Emotional treatment / experience and development. We know that the adolescent period (16-18) is fraught with emotional and social difficulties, as children are bio-psychosocially and physiologically transitioning from childhood into the -adult stages of their lives. A time when children are resetting their brains, attitudes/values, and behavioural patterns, like sponges to the relationships and environments that they are exposed to.

What we know for sure about the environment of acute Adult Mental Health Wards is that they are designed to accommodate and best support adults that are experiencing mental illness and presenting with inextricable risks to self and others which come as part of a mental health profile requiring admission to an acute inpatient ward. Adult inpatient wards provide a safe and therapeutic environment to adults, to manage behavioural and relationship breakdown, suicidality, severe self-harm, and emotional/ behavioural crisis. By its very nature our Adult Inpatient MH wards creates a conflict / barrier to providing an environment that prevents exposure to emotionally harmful events, modelling and relationships with adults.

This deliberate exposure of children to an environment of adult risk is not obviously in keeping with Children Act (1984)/WTG (2020) obligations to prevent impairment and promote the emotional health, wellbeing, and development of children under 18. This is the rationale for Mersey Care to avoid protocols that see admission of children to adult

wards as normal occurrence and operates an approach which frames these events as a last resort occurrence with a proactive policy for repatriation to age-appropriate environments for care and treatment of children.

Recommendation 39
Review the practice of admitting 16- and 17-year-olds to Adult beds and consider managing this as an 'exception' rather than routine practice.
Recommendation 40
If a 16- or 17-year-old has to be admitted to an adult bed, ensure that rigorous risk management, reporting and monitoring is in place.

7. Learning Disability and Autism Awareness and Practice

7.1 Strategy, Policies and Governance

MFT have developed a strategic plan 'Our plan for people with learning disabilities and/or autism, their families and carers 2022–2025' which has been described in more detail under the Strategy section of the report.

Each hospital within MFT has a learning disability delivery group (LDDG) chaired by Head of Nursing with attendance from the Learning Disability specialist nurses from each hospital and includes people with lived experience of LD and Autism. Community learning disability teams are also invited to the delivery groups. A specific work / delivery plan has been developed for each site including the key deliverables and anything specifically identified for the area.

The Strategic Plan and delivery action plans are monitored through the MFT Learning Disability Steering group (LDSG), which meets quarterly and is chaired by the Director of Nursing with executive leadership from the Group Chief Nurse. Progress against the strategy is also monitored through quarterly reporting to the Group Safeguarding Committee. Specialist LD nurses from each division lead on the development of the quarterly report.

An annual report is also produced outlining the progress against the strategy.

It was evident from discussions with LD safeguarding leads and in reviewing quarterly reports submitted to the Group Safeguarding Committee that significant progress has been made in relation to the key priority areas. During a site visit, LD safeguarding leads were able to provide evidence of quality improvement areas in the Trust aligned with the delivery plans. Further detail below.

The Trust also has a specific policy 'Care of patients with a learning disability in acute hospital setting' which clearly details the requirement of staff supporting individuals flagged as having a learning disability and/or autism including reasonable adjustments check list, care plan and hospital passport. The policy describes the process for assuring completion of this for all patients through daily completion of Quality Care Checklist by the LD safeguarding team and senior nurse review.

The policy further describes the escalation process for any concerns or requirement for additional support or failure to complete required reasonable adjustment process.

Flow charts are available within the policy outlining statutory and trust requirements for all patients either admitted through ED or for a planned admission.

Recommendation 41
The strategy is largely focussed on the care and treatment of children and adults who have a learning disability – primarily based on the learning disability improvement standards. Although many of the principles and implementation would apply to Autistic people (flagging, reasonable adjustments) who do not have a diagnosis of a learning disability, identification of specific actions and development of an implementation plan would support quality improvement and patient experience.

7.2 Training Compliance and Staff Awareness

MFT have implemented mandatory Learning Disability and Autism awareness training (e-learning) and having recently reviewed the training and recent guidance have implemented the Oliver McGowan e-learning package in December 23.' Learning disability and Autism awareness training is reported by exception to the Safeguarding committee for assurance. E-learning compliance prior to this was over 80% on consecutive months not quite reaching 90% target, however monitored with improvement plan in place.

As with other NHS organisations, there is a recognition from MFT that implementation of face-to-face training as part of the tier 2 Oliver McGowan training is a challenge due to the requirement to identify trainers including people with lived experience of learning disability and autism.

In addition to mandatory LD and Autism training for all staff, the LD safeguarding nurses were able to evidence numerous 'bespoke' training sessions delivered to different parts of the trust. A specific area of additional training that has been delivered in several clinical (inpatient and outpatient) areas is mental capacity act training. There is a separate section of the report that covers this in more detail.

Additional training has also been provided for clinical staff regarding reasonable adjustments, on induction training for newly inducted nurses (LD and A) and in specific areas at request re: LD and A. All training is monitored and reported quarterly in reports to Group Safeguarding Committee.

An LD and A resource pack has recently been updated and shared with all clinical areas to ensure clinical teams have access to accessible information and guidance to support person centred approaches to working with people with LD and autism, including information to support effective communication.

PBS training was discussed during the site visit and staff explained that BILD accredited PBS training to Managers at coaching level. They are currently exploring the possibility of roll out wider across the Trust.

Recommendation 42
The Trust to consider additional training regarding Autism for staff within clinical areas.

Recommendation 43
Continue with roll out of PBS training for clinical staff and consideration of PBS champion roles utilising BILD training.

7.3 Learning from Complaints, Incidents and Mortality Reviews

A key area of focus with regards to LD and A, is how services have learned from previous concerns. Quarterly reviews of learning disability incidents including safeguarding incidents are reported into the learning disability steering group and the Group Safeguarding committee as themes for learning and action. It was evident both in discussion with LD leads and in reviewing reports submitted to Group Safeguarding Committee that incidents were reviewed, and lessons learned shared.

Specific action plans are in place following completion of thematic reviews into incidents directly relating to people with learning disabilities which were described by the LD safeguarding team and within Group Safeguarding report. For example, one theme identified was increase in falls for people with a learning disability and had plans to implement an action plan and response in relation to this. The Trust identified a gap in implementation of MCA processes and have provided bespoke training to clinical areas identified.

Recommendation 44
The Trust to share national and local LeDeR reports to the Trust mortality review group and incorporate any recommendations or actions within LD and A implementation plans.
Recommendation 45
Consider support for the Implementation of NHSE ‘Ask, Listen, Do’ as a framework to support concerns, complaints and co-production processes within the Trust.

7.4 Audit of Clinical Care and Patient Journey

The safeguarding learning disability team have led on the completion of quality care audits for all patients with a learning disability within 24 hours of admission. The audit includes assurances that all people with LD admitted to the hospital have a reasonably adjusted care plan in place within 48 hours of admission. Compliance of completion of Quality care audits is monitored within monthly reports to LD steering group and Group Safeguarding committee.

The audit includes assurances that people with LD have a reasonable adjustment care plan, hospital passport uploaded on to the system and clinical pathways, consideration of statutory requirements and including appropriate application of MCA and Dols. If concerns are raised during the audit, contact is made with the respective ward with offer of advice and support for completion. An escalation process for noncompliance is detailed within the trust policy for care and treatment of people with LD and Autistic people.

The LD safeguarding team operate within normal working hours (9-5) however a process is in place for a 'matron' handover every Friday to ensure any concerns are escalated and monitoring continues out of usual working hours at weekends.

The Trust utilise 'point prevalence' audit process and monitor a number of LD specific interventions including:

- Understanding and implementation of MCA principles:
  This audit is completed by the Matron for LD and A with recommendations for improvement areas described within safeguarding reports. Additional training has been provided re: MCA by the LD and A safeguarding leads

- Audit of implementation of hospital passports for people with learning disabilities captured on HIVE clinical records system. The LD safeguarding team check HIVE and all patients admitted daily to ensure that hospital passports have been implemented.

7.5 The Completion of Statutory Requirements - MCA

The Trust currently has a risk on the register in relation to MCA implementation specifically in relation to compliance with statutory requirements relating to individuals who may lack capacity to make decisions. Trust action plan includes an implementation tool regarding decision making and mental capacity. LD safeguarding leads have implemented a programme of training specifically in relation to MCA and decision making for people with LD.

Safeguarding Learning Disability nurses across all sites (band 7 and band 6) provide advice and support to all clinical staff on MCA. Additional and bespoke training has been provided to ensure that clinical staff have an understanding of MCA and best interest decision making.

7.6 HIVE Clinical Record System

MFT have implemented an electronic record system which allows early recognition of specific support needs including reasonable adjustment required. The system is monitored daily by the LD safeguarding leads which enables them to:

- Identify individuals who attend AED and are admitted to a ward.
- LD safeguarding leads run a daily report of any patients flagged as having a learning disability and/or autism.
- Ensure that a reasonable adjustment care plan is in place for people with LD and Autism within 48 hours of admission.
- Provide advice and support as required for individuals who may have additional complexities (e.g.: behaviours that challenge, requiring support re: MCA decision making, specific reasonable adjustments required, liaison with CLDT to support discharge process and health facilitation if required).
- Completion of Quality care checks for all patients with LD and Autism admitted to the Trust within 24 hours.

The HIVE system allows staff to flag patients attending the Trust who have a learning disability and/or autism and data is collated for each area within the Trust. It has been identified that there is a limitation in relation to incorrect flagging and identification of people with LD within the system due to staff knowledge and experience. A plan is in place for the Safeguarding LD nurses to provide bespoke training for clinical staff to support identification.

Staff are required to flag individuals with a diagnosis of a learning disability which automatically requires a reasonable adjustment questionnaire identifying any person centred needs for the individual. A care plan must then be generated detailing individuals needs.

In discussion with staff and LD safeguarding leads for the Trust they recognised limitations in identification and flagging of Autistic adults (non-LD) which is less developed due to difficulties with clinical coding, thus impacting on development and implementation of reasonable adjustment care plans for Autistic people.

Around 80% of the patients with a LD&A who were admitted to the Trust in October 2023 had reasonable adjustment care plans completed. This is positive but there is still work to be done to promote completion for all patients.

The learning disability and Autism team have led on a quality improvement programme to ensure that all people admitted and flagged as having a learning disability or autism have a reasonable adjustment plan in place within 48 hours of admission.

During a site visit the LD team demonstrated the use of the HIVE system and how it is utilised on a daily basis to monitor quality of the patient journey and provide assurances that front facing clinical staff are effectively using the system to support reasonable adjustments being flagged and care plans developed.

Recommendation 46
Build in contact with GP practice to identify if an individual is on the LD register within GP practices for any queries re: identification.
Recommendation 47
Continue to build on progress made to flag all patients admitted to the Trust with a learning disability and/or autism.
Recommendation 48
Consideration of additional autism awareness training to support the increase in flagging Autistic people (non-LD).

7.7 LD Champion Forums

The Trust has an established LD and Autism champions programme with Champions identified in each of the clinical areas. Champions have been identified in each of the clinical areas for both inpatient and community services.

Terms of reference outline the purpose of the champions network and roles and responsibilities of champions including reviewing best practice, dissemination of relevant

information to clinical areas, receiving additional training and providing opportunity to hold case discussions.

There is an expectation that all identified champions are required to attend quarterly Champions forum meetings and share good practice to embed within service delivery. Assurance around the champions network and progress is reported to the LD and A steering group.

Recommendation 49
Given identified gaps in relation to Autism (non-LD) consideration of extending the role to LD and A champions or developing a separate network. Understanding the differing clinical requirements and reasonable adjustments faced by people with Autism (non-LD)

7.8 Interface With Other Services

During a site visit the reviewers had the opportunity to meet with inpatient LD safeguarding leads, the head of nursing for LD and A and the head of nursing for patient quality and experience. They also had opportunity to meet with LD safeguarding nurses and community LD team staff and senior managers.

LD safeguarding leads within the safeguarding team demonstrated close working relationships with community staff who engage with LD steering group and meet weekly to discuss any patients admitted to the hospital who may need support regarding discharge. Incidents are jointly reviewed between both services. Community LD staff confirmed the joint working is well established.

In relation to support from Mental health services for patients attending ED, staff described a positive experience for people with LD presenting in crisis with appropriate support from GMMH mental health liaison team and positive relationships and engagement with the LD safeguarding team if required.

Staff also described an option for support in crisis with the aim of avoiding hospital admission, in line with transforming care. The Trust has what is described as the ‘Green room’ in which people can be supported in the short term with Psychiatric review and active treatment with the aim of safe discharge if crisis is resolved and can be managed in the community.

Staff described some limitations in relation to space within the ED department to support individuals who may be presenting with behaviours that challenge in the absence of a place of safety, however a ‘quiet zone’ has been identified to support specific needs and staff follow admission process to ensure timely admission to a ward and quieter area.

Community staff presented positive work including implementation of DSR and CTR processes under transforming care and a recent review and transformation of the community LD service including clinical pathways, caseload reviews, referral processes and pathways.

During discussion staff discussed some of the ongoing system wide barriers to whole pathway care relating to people with LD and Autism, specifically where individuals may require access to a mainstream mental health bed.

Recommendation 50
As the re-development of the ED department is in planning stages and a recommendation would be to ensure planning includes consideration of specific areas which can be utilised for people with LD and A presenting with behaviours that challenge and/or sensory needs.
Recommendation 51
Following the publication of the acute mental health inpatient services guidance and the national north- west mental health inpatient quality Transformation programme, it would be timely to re-visit and refresh pathways of referral, assessment and intervention into acute mental health inpatient services for autistic adults and adults with a learning disability.

8 Mental Health Act and Mental Capacity Act

8.1 Overview:

This section of the peer review looks at how MFT implements both the Mental Health Act (MHA) and Mental Capacity Act (MCA), including Deprivation of Liberty Safeguards. The review has sought to affirm whether MFT's is discharging its statutory duties, and that this is guided by governance systems and procedures that affirm adherence to the Mental Health Act, Mental Capacity Act and the associated Codes of Practice.

The review has also considered the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fundamental Standards, and most recent CQC inspection report findings.

8.2 MCA & MHA Policy and Governance Arrangements

Manchester University NHS Foundation Trust has a prescribed accountability structure for implementation of Mental Capacity Act 2005 and Mental Health Act 1983.

The Group Chief Executive has overall accountability to ensure the Trust discharges its duties related to Mental Capacity Act 2005 and Mental Health Act 1983. The Group Chief Nurse is the Executive identified to ensure delivery of Statutory regulations. The Head of Nursing for Safeguarding is responsible for the strategic implementation. The Named Nurse for Safeguarding provides clinical leadership. Service managers across the trust are responsible for the workforce implementation. The MHA/MCA Officer develops systems and monitoring.

The accountability framework is clearly established and runs from Executive level right through to operational implementation. The accountability thread into the Executive board is driven via the portfolio of safeguarding service divisions which are aligned to each of the Trust divisional sites/areas. The Trusts safeguarding services are the golden thread for mental health and mental capacity law and governance.

The Safeguarding team monitor, audit and support Mental Health Act, and Mental Capacity Act implementation, governance, training and quality at each site related to their designated area of responsibility.

The Mental Health and Learning Disability divisions of the Safeguarding service facilitate the Trust having the specialisms embedded within its workforce, e.g. Registered Mental Health Nurses and Registered Learning Disability Nurses. These area specialisms

contribute to driving and implementing MHA/MCA law and governance, as well as delivering specialist clinical knowledge.

Each of the Safeguarding divisional service area reports their monthly MCA & MHA assurance data via the AOF (Accountability Oversight Framework) to the designated lead who reports this up into the Trust Board.

Quarterly activity reports also compiled and reported into the Safeguarding Group Committee and again into the Trust Board.

Data identification and collection is relevant to the Acts and areas of statutory responsibility and is able to reflect the detail required to give assurances that the Trust is appropriately discharging its duties and/or identify areas where there may be service gaps.

Since the implementation of the HIVE patient record system in 2022, MCA & MHA data monitoring, storage and reporting systems are reported to have developed and improved. Business support performance dashboards have been developed via the Kalidas system, and there is an ongoing programme of IT transformation driven via the monthly Safeguarding HIVE task and finish group.

Overall, the Trust structure describes a framework with clear lines of accountability, monitoring and reporting structure for MHA/MCA law and governance, which is fit for purpose and is open and transparent.

Recommendation 52
It may be advantageous for the Trust to consider how this governance structure is reflected in the naming convention to better denote areas of responsibility of the Safeguarding services pertaining to mental health and mental capacity law and governance.

8.3 Review of the CQC MCA & MHA Inspection Findings (2019)

CQC reported that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. The trust had an up-to-date policy on consent and mental capacity.

In relation to children and young persons services staff were reported to understand the relevant consent and decision-making requirements of legislation and how this related to young people such as guidance for Mental Capacity Act 2005, Children's Acts 1989 and 2004, Gillick competence 1985 and Fraser guidelines 2006.

The CQC noted areas for improvement within medical services at Royal Manchester Infirmary (MRI). Somes staff knowledge of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 was inconsistent. Although staff knew how to support patients experiencing mental ill health, information about consent for patients who lacked the capacity to make decisions about their care was not always documented.

The CQC noted areas for improvement within Critical care services at Royal Manchester Infirmary (MRI) patients who were acutely unwell were not given deprivation of liberty safeguard assessments.

The CQC noted areas for improvement within Wythenshawe Hospital related to capacity assessments and Deprivation of Liberty Safeguard applications which were not always fully completed particularly in medical wards and the emergency department.

The Pennine Acute Hospitals NHS Trust CQC Inspection report published in February 2020 occurred prior to North Manchester General (NMGH) joining MFT. CQC recommendations for urgent and emergency care / medicine were that the Trust ensured it improves staff understanding of the processes for assessing and recording of mental capacity, appropriately completing Deprivation of Liberty Safeguards and recording of Do Not Attempt Cardio Pulmonary Resuscitation.

During a site visit the subject matter expert peer reviewer followed up the processes for Trust wide audits & monitoring since the 2019 CQC review and found that the above CQC findings and associated action plans were monitored and overseen in the Trust reporting cycle to ensure implementation and obtain internal assurances.

MHA and MCA, including DoIS are a standing item on the audit calendar and audits are led by the Safeguarding team. The audit calendar is annually reviewed to ensure MHA & MCA remain a standard item on the calendar.

Recommendation 53
Ensure the audit calendar continues to include MHA & MCA as standard items on the calendar.

8.4 Review of the MHA Policy

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. The MFT MHA policy should provide sufficient support and guidance for those working within the framework of the Mental Health Act 1983 (Amended 2007).

This subject matter expert peer review has considered the policy in the contexts of the following and provides detailed feedback below:

- MFT MHA policy adherence with MHA and Code of Practice
- MFT MHA policy adherence Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fundamental Standards.
- Current CQC MHA monitoring programme & findings

<u>Positive (good practice) inclusions in the Policy</u>

- MHA policy is in date (version 4) having last been ratified March 2023, and there is a pending review date set as March 2026.
- Policy is available on intranet for staff to access.
- MHA guiding principles are considered within the policy.

- Issues related to children & young people are considered within the policy.
- Interface with Children Act, MCA and Human Rights Act is considered within the policy.
- Receipt, scrutiny, and storage of MHA paperwork is considered in the policy.
- Identification and role of Responsible Clinician is considered within the policy.
- Key MHA sections are considered in policy, S.5(2) holding powers, S.132 patient rights, S.136 detention, S.2 assessment, S.3 treatment, S.4 emergency applications, S.17 leave, including documentation and authorisation, S.19 transfer, S.23 discharge and CTO's. Part 3 MHA and Ministry of Justice (MOJ) has been noted with guidance to seek further advice form Mental health Liaison Team these cases.
- Independent Mental health Advocates have been considered within the policy. Advocacy & Independent Mental Health Advocates (IMHA) and under contract with Voicability as the provider. This contract change followed the annual audit against NICE benchmarking across the whole trust. A review of consistency and advocacy of best interest processes that was tabled for Q4 2022/23 and resulted in the audit calendar.
- MHA administration is overseen by the MHA/MCA Officer, since the introduction of HIVE in 2022, all MCA documentation and section papers are uploaded into the patient record, specific MHA & MCA tab folders are to shortly be implemented. Hard paper copies are also stored locally within local protocols. Audit of compliance since digitalisation of MHA documents is now more streamlined, which also includes patient being notified of rights.
- Data, audits & compliance since the introduction of HIVE in 2022 has improved, the MHA / MCA Officer is able to assess activity much more closely due to the use of the flagging system. MHA data, audits & compliance is part of the annual calendar audit programme.
- MFT has 3 levels of mental health & Mental Health Act training based on role and level of clinical responsibility. Bespoke training for is targeted for receipt and scrutiny of MHA administration/documentation.
- The MHA/MCA Officer has responsibility for the administration, monitoring and coordination of hearings, and associated document/report requests and professional involvement. Flagging system and dashboards are established for monitoring purposes. Additional administration support is also currently being recruited to support the MHA/MCA Officer.
- MHA statutory documentation is available for downloading/printing from the Trust Intranet.
- S.132 patient rights are considered within policy, including appealing section, information in oral & written format and arrangements for First Tier Tribunals (Mental Health).
- Independent Mental health Advocates have been considered within the policy.
- MHA administration Section papers are uploaded into the patient record which allows for a second scrutiny of section papers including assurance that patient rights have been given and recorded. - (scoping exercise November 2022)
- Data, Audits & Compliance Since the introduction of HIVE in September 2022 the MHA / MCA Officers (within the trust safeguarding team) can assess activity much more closely due to the use of the flagging system. (scoping exercise November 2022)

Recommendation 54

(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below)

Suggested additional areas identified for inclusion in policy

- Discharge planning & S.117 After Care: the policy could be enhanced with consideration of chapter 33 MHA CoP. This should also be joined up with Greater Manchester Community Mental Health Transformation developments that have replaced the Care Programme Approach (CPA). **Regulation 17: Good governance**
- S.18 return and readmission of patient Absent Without Leave (AWOL): the policy could be enhanced with guidance on statutory duties in incidence of AWOL. Chapter 28 MHA CoP, details various AWOL circumstances and persons authorised to take patient back into custody, including hospital staff authorised by hospital managers. Reporting to police will need to be considered in context of the newly developed Right Care, Right Person' (RCRP) protocols in Greater Manchester Police. Nearest Relative rights to be informed of AWOL will also need to be incorporated. **Regulation 17: Good governance**
- S.135(2) warrant obtained by the detaining hospital to return an AWOL patient has not been considered within the policy and the governance underpinning this that is required. **Regulation 17: Good governance**
- Nearest Relative Rights have not ben considered within the policy related to right to apply for section, right to object to a section, right to request discharge of section, right to request advocacy, right to be consulted and given information and appointing another Nearest Relative, chapter 4 MHA CoP. **Regulation 17: Good governance**
- The Responsible Clinician power to prevent Nearest Relatives discharge by issuing a barring certificate has not been considered within the policy, Chapter 32 MHA CoP. **Regulation 17: Good governance.**
- Involvement of Carers chapter, including Carers assessment (Care Act 2014) has not been fully considered with the policy, chapter 4 MHA CoP. **Regulation 9: Person centred care.**
- Consent to treatment and interface with MHA and MCA is considered in the policy, however it could be further enhanced with more detail around S.63 and guidance on second opinion approved doctor (SOAD) certificates, chapters 23, 24 & 25 MHA CoP. **Regulation 17: Good governance & Regulation 11: Need for consent.**
- Advance decisions and wishes expressed in advance have not been considered within the policy, chapter 9 MHA CoP. **Regulation 9: Person centred care.**

8.5 Management of the Deprivation of Liberty Safeguards (DOLS) within the Meaning of the Mental Capacity Act 2005 (Amended 2019)

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework to protect vulnerable individuals who are deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights (ECHR) and they lack the mental capacity to consent to such arrangements. The MFT DoLS policy should provide sufficient support and guidance for those working within the framework of the Mental Capacity Act 2005.

This peer review has considered the policy in the contexts of the following and provides detailed feedback below:

- MFT DoLS policy adherence with MCA and Code of Practice
- MFT DoLS policy adherence Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fundamental Standards.

Positive (good practice) inclusions in the Policy

- DoLS policy (version 3.1) is in date, having last been ratified August 2022, and there is a pending review date set as February 2024.
- Policy is available on intranet for staff to access.
- Zone of parental responsibility and Court of Protection for those under 18 years is considered in policy.
- Independent Mental Capacity Advocacy (IMCA) is considered in policy.
- Relevant Persons representative (RRP) is considered in policy.
- European Convention of Human Rights (ECHR) is considered in policy.
- Lasting Power of Attorney (RRP) is considered in policy.
- CQC notification is considered within policy and supporting templates.
- MCA & MHA interface is considered in policy.
- Department of Health and ADASS (Association of Directors of Adult Social Services) guidance is considered within the policy.
- Referral process and supporting documentation/templates are detailed in appendices within the policy, as is the governance for documenting.
- Safeguarding team are identified as Trust support leads should advice and support be required, including key contact details.

Recommendation 55

(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below)

- Patient rights and section 21a application: right to appeal is not overtly referenced and could be included to enhance the policy to ensure that the relevant person and their representative rights are considered. **Regulation 9: Person centred care.**
- Restraint: primary reference/guidance is noted within appendices / templates. The policy could be enhanced with further guidance to consider the legal framework around restriction and restraint, including the distinction between what is protected by Part 1 Section 6 of the Mental Capacity Act, and what requires an authorisation under the DoLS Framework. **Regulation 11: Need for consent.**
- DoLS breaches: the policy could be enhanced with the process for reporting, monitoring and escalating DoLS breaches. Appendices 1, under the heading "following an application" notes MFT has complete it's process, however there is no escalation or monitoring process described. **Regulation 17: Good governance.**
- Appendices 1 referral process: narrative may sit better in main body of the policy and appendices and appendices 1 is presented a guidance flow chart. **Regulation 17: Good governance.**
- Coroners reporting: death whilst subject to DoLS guidance is not considered within the policy if cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the person's death. The

policy would be enhanced by including guidance. **Regulation 17: Good governance.**

- Ferreira case law: policy could be enhanced with reference to patients in acute hospital receiving 'immediately necessary life sustaining medical treatment' not considered to be deprived of their liberty if arrangements have no unusual feature. **Regulation 17: Good governance.**
- Care planning: DoLS care planning is referenced in appendices / templates, the policy could be enhanced by guiding how details of any conditions attached to the authorisation can be implemented and monitored. **Regulation 9: Person centred care.**

8.6 MCA policy adherence with MCA and Code of Practice Liberty Protection Safeguards (LPS) readiness & embedding MCA

This peer review has considered the policy in the contexts of the following and provides detailed feedback below:

Positive (good practice) inclusions in the Policy

- Mental Capacity Act Policy (version 3.1) is in date, having last been ratified August 2021, and there is a pending review date set as August 2024.
- Policy is available on intranet for staff to access.
- MCA 5 principles are considered within the policy.
- Policy provides guidance on assessing capacity, making best interest decisions, including disputes, and documenting assessments in standardised capacity & best interest template, appendices 2 & 3.
- Advance decision, included extended guidance appendices 5, is considered within the policy.
- Attorneys & Court of Protection is considered within the policy.
- Policy considers the Children Act for persons under 18 years and zone of parental consent.
- Policy considers the interface between the Mental Health Act and the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Policy considers the use of Independent Mental Capacity Advocates.
- Policy considers restraint, including interface with common / criminal law.
- Policy considers guidance related to research.

Recommendation 56

(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below)

Fluctuating capacity is not considered within the policy and so could be enhanced by doing so with reference to guidance in MCA CoP.

8.7 Liberty Protection Safeguards (LPS) readiness & embedding MCA

Manchester Foundation Trust has currently stepped down its steering group for LPS implementation, which was on the back of the governments announcement in 2023 to delay LPS implementation within the term of this current government. Greater Manchester LPS steering group has also been dissolved, which MFT were core members, and so since stepping down both implementation groups MFT has not progressed any further work related to LPS readiness.

MFT stepping down it's steering group also reflects organisational responses nationally. However, a recommendation for organisations as part of still preparing for future change and the implementation of LPS, was to continue with progressing work with workforce readiness and embedding MCA in practice.

Mandatory training for MCA & MHA is incorporated into level 3 of Safeguarding training. Targeted training is also available upon request, or when identified via audit, and delivered via the Tool Box training programme developed and delivered by the Safeguarding service to support practical application of MHA & MCA as part of normal business.

Mandatory training compliance figures reported on the day of the site visit (25.01.24) were reported as 95 % MCA, which is in line with Trust target, and 80% MHA, which has been described as remaining on a continuum of an upward trajectory and a workforce plan in place to monitor and deliver the Trust target.

There is a clear system for oversight and support for the workforce at an operational level with the application of MCA & MHA being delivered via the Safeguarding service. Case consultation and advice is also available, which includes the offer of co producing assessments and documents e.g. capacity and best interest assessments where needed.

There is recognition that the frequency of application of MHA and MCA in an Acute Trust may be variable, and that this contributes to findings from some audits in which gaps in quality can be evidenced. A handful of factors were described to be contributors to this, including frequency of opportunities to apply MHA & MCA frameworks routinely in practice in an Acute Trust setting, particularly MHA. The loss of experienced staff, particularly during Covid and the newly recruited oversees staff who come with clinical experience but not the legal framework experience. The current workforce mandatory training offer is appropriately focused on upskilling the workforce and supported by the enhanced targeted training a supportive consultation model.

As part of LPS implementation, MFT workforce plan incorporated training it's Safeguarding workforce as Best Interest Assessors in preparation for the new AMCP (Approved Mental Capacity Professional role. However, since training none have practiced as BIA's.

Recommendation 57
MFT may want to consider the benefits of agreeing a partnership approach with the local authority to permit their staff to be released to practice as BIA as part of LPS readiness, and so further delivering workforce readiness. This could also allow further benefits for MFT if its own BIA's were to prioritise the assessments / breaches for the MFT cases on the days they undertake BI assessments for the local authority.

9. Patient Engagement and Experience

It is acknowledged that gathering meaningful patient experience data is complex and to ensure that it makes a difference to patients at all then it must be clearly aligned with patient engagement and take into consideration the involvement and experience of families and carers.

At MFT Friends and Family test has a low response, it is not widely advertised, and the feedback received is not analysed in any detail from a specific MH or LD and A patient experience perspective.

Currently there is no method of specifically targeting the MH and LD patients who access the ED departments or other areas, to gather their feedback. There is no shared info or shared plan in place to address this or develop this jointly with GMMH.

The Director of Nursing within MRI has engaged an individual to lead on improvement work, particularly to review complex patients on medical wards (two wards are a particular focus, one of these has had a patient on the ward for over 200 days.

Whilst this is a positive step, the peer reviewers would suggest that this needs to have more of a team approach to ensure consistency and a wider impact, moving more from a single person review to develop into a network or team of people to involve in these reviews. This network could include, for example, Learning disability teams, social care leads, mental health team, education, safeguarding , ICB , NHSE , police , voluntary sector, advocacy, IMHA's.

The patient improvement lead was able to describe what appears to be anti-social behaviour and gave an example of the need for one patient to be always supported by 2 security guards for over 100 days. The patient improvement lead acknowledged that the presence and use of security staff may be intimidating, and as such this may in the view of the peer reviewers be counter productive.

From the presenting description this is likely to be a patient with an underlying Leaning Disability and it was reported by the patient improvement lead that there is a theme where patients who present in this way have no care package to enable a safe discharge and there is a lack of traction in arranging discharge which is often due to patients LD and MH presentation, rather than any ongoing requirement for physical healthcare treatment.

The patient improvement lead can demonstrate a good understanding and insight into areas that would benefit from further development with regards to patient experience and engagement but has described that there is no central point in the trust to review patient experience themes either within individual departments or across all sites, this is something that may need further consideration even within the current governance structure.

The patient improvement lead(s) could additionally engage with local voluntary agencies as part of wider transformation. For example, a 16yr old seen in ED, referred on – (rather than signposted) to a voluntary agency, would be more likely to engage – human nature makes it easier to accept help rather than seek help, especially when we feel we have been turned away previously. An organisation specifically for younger people would be more geared up than another more generic service.

This approach could work following ED attendance or hospital admissions with a huge variety of route causes such as homelessness, Armed forces, Dementia, Long term health conditions, bereavement etc. Links to local carers centres.

Recommendation 58
Consider the need for I/T support to develop different modes of collecting feedback e.g. text message sent to targeted patients known to have a MH or LD and A condition a specific number of days post AED attendance.
Recommendation 59
Consider the need for a network of MDT practitioners to be involved in reviewing complex MH or LD and A patients who are inpatients on acute wards.
Recommendation 60
Develop a process to identify at an earlier stage delayed discharges. A systematic and coordinated approach is required to highlight patients who are delayed in being discharged due to a MH or LD and A need, rather than the requirement for ongoing care in an acute hospital. This should also include referrals, support to the individuals (rather than signposting) and a clear escalation process.
Recommendation 61
Consider the need for bringing together feedback and data from multiple sources, such as PALs , complaints, PSIRF, FFT , patient surveys, Mental Health Act feedback ,insight from Healthwatch or similar etc. into a Trust Wide group to gain a fuller understanding and co-ordinate actions in relation to patient engagement and experience.

Conclusion

As captured within the Executive Summary, the overall impression by the peer review of MFT was that the Trust from Ward to Board is keen to ensure that patients with MH, LD or autistic conditions attending any of its services would be treated with parity of esteem.

There is a strong ethos and collective ownership, commitment, and responsibility at all levels within Manchester Foundation Trust to ‘do the right thing’ and not to avoid or minimise their role in treating, caring, and supporting patients regardless of complex presentations.

There was some discrepancy between staff groups in relation to their confidence and skills to manage and intervene when patients become distressed, and this unmanaged distress consequently manifests itself into conflict or aggressive behaviour.

This situation is not aided by the very high use and reliance on security guards for all the reasons described within the body of the report.

In summary, Mersey Care peer reviewers were impressed with the focus and commitment to improve services for patients with MH. LD and autism conditions.

Most recommendations that have been made are to strive to further improve good quality care, but the two main themes that gave rise to concern are the use of security guards to

carry out therapeutic observations and the use of adult wards to detain 16- and 17-year-olds, so we would wish to draw attention to those as the priority areas to review.

Next Steps

Although the reviewers' impression was that there was synergy from Ward to Board, this was not robustly tested as the review did not include interviews with wider board members, (including Non-Executive Directors).

Therefore, as one final point for the Trust Board to consider, it may be beneficial to explore the points included in the above review with Non-Executive, Executive and other Directors to gain a deeper understanding of any gaps in knowledge and awareness, or areas where there are notable differences in perspective between Board and frontline staff.

Thank you for the opportunity to participate in this process and the warm welcomes, responsiveness, and openness throughout.

Recommendation 62
MFT may want to consider the benefits of gaining further assurance of synergy between Ward and Board.

Appendices

Appendix 1	Terms of Reference

Manchester University
NHS Foundation Trust

MENTAL HEALTH, LEARNING DISABILITIES AND AUTISM STRATEGIC REVIEW

TERMS OF REFERENCE

1.SCOPE

MFT is an organisation of significant size and scale which provides support and services to those patients who attend our services experiencing acute mental health episodes (all ages), Children and Young People (CYP) accessing Child and Adolescent Mental Health Services (CAMHS) and people with learning disabilities and autism (LDA). MFT needs to ensure it has the right strategies, policies, training, and Board to Ward visibility of these services.

To provide assurance and identify any required actions, the Trust intends to commission a review of the following:

In our role as a provider of acute healthcare services to people who experience acute mental health episodes, those people with LD&A and CYP who access CAMHS, to review and evaluate:

- Our overall strategy including CAMHS.
- Frameworks in place with other providers who support the delivery of Mental Health provision at the Trust, e.g., SLA with Greater Manchester Mental Health Trust.
- Policies that support implementation of that strategy/(ies).
- Correct application of policies, including application of the Mental Health Act.
- Training provision including management of episodes of violence and aggression.
- Training compliance.
- Board to ward visibility of:
  - The completion of our statutory requirements.
  - Metrics and key performance indicators.
  - Governance and assurance processes and flow through Quality Boards and Committees to the Board of Directors.

2. LEADERSHIP

The Group Chief Nurse will act as the Executive Lead for the review with support from the Group Joint Medical Directors, Group Director of Workforce & Corporate Business. Other colleagues will be co-opted on to, or invited to join, the review process as necessary.

The review will be undertaken as a peer review using the CQC key lines of enquiry framework, by Mersey Care NHS Trust who provide specialist inpatient and community services that support physical and mental health and specialist inpatient mental health, learning disability, addiction, and brain injury services.

3. OUTPUT

The review team will provide a report with associated recommendations to EDT for any areas of Trust provision which require improvement, with an indication of any associated risks and level of priority.

4. REPORTING

The review team will agree a timetable and report to the Group Chief Nurse who will provide regular updates and reports to the EDTC.

Appendix 2	**CQC KLOEs**

CQC Key Lines of Enquiry (KloEs) for the Assessment and Monitoring of Mental Health in Emergency Departments

CQC MH1	Is your ED utilised as a place of safety under the Mental Health Act?
CQC MH2	Do you record the numbers of people assessed under the Mental Health Act within your ED, where it is used as a place of safety, or otherwise?
CQC MH3	In your ED is there a separate room where people with Mental Health problems can be interviewed and assessed?
CQC MH4	If separate rooms are not available in your ED, where do interviews with people with Mental Health problems take place?
CQC MH5	Do staff within your ED receive any specific training in relation to interviewing people with Mental Health problems?
CQC MH6	Is the role of security staff within ED departments clear in terms of dealing with people with Mental Health problems?
CQC MH7	Do security staff within ED receive any specific training in relation to dealing with people with Mental Health problems?
CQC MH8	How many times have patients been kept in your ED due to their Mental Health beyond the end of the S 136 and/or before the MHA assessment was completed? Under what legal authority did you keep them in the department and did any issues arise?
CQC MH9	Does your ED contribute to, and receive the results of, any audits around the MH assessment process and/or joint 72-hour reviews/investigations in relation to MH episodes and incidents?
CQC MH10	What were the results of those audits/investigations, and what has changed/improved as a result?
CQC MH11	Do staff within your ED receive any specific training in relation to the use of Sections 5 4 and 5 2
CQC MH12	If Sections 5 4 and 5 2 are used (in your ED) how is the scrutiny of statutory documentation undertaken?
CQC MH13	What support is available to staff in your ED from Mental Health services?
CQC MH14	Specifically, is a psychiatric liaison service available to your ED and how effective is this? Is this available 24 hours per day?
CQC MH15	Are you aware of any plans to develop designated places of safety within Mental Health services over and above the current location at North Manchester?
CQC MH16	Is there a forum where MFT and Mental Health Trusts meet to discuss issues in relation the ED Departments?
CQC MH17	Is there a local agreement in place which outlines the role of the Mental Health Trust in supporting people with mental health problems within MFT?
CQC MH18	Do you record lengths of stay when your ED is used as a place of safety?
CQC MH19	Does MFT have a Mental Health lead?
CQC MH20	Does the Trust Board receive reports on mental health activity within the Trust?

Appendix 3	Sources of Information

Sources of Information

Visits, interviews, and discussions were held with the following people and teams:

- Cheryl Lenney OBE, Chief Nurse, and MAHSC Honorary Clinical Chair, Visiting Professor of Nursing Manchester Metropolitan University,
- Alison Lynch, Deputy Chief Nurse
- Kevin Hurst, Head of Nursing, Patient Services
- James Rushton, Assistant Director of Nursing, Emergency Dept and Access, MRI.
- ED Team, MRI
- Dawn Pike, Director of Nursing, MRI
- Anthony Johnson, Deputy Director of Nursing, MRI
- Mental Health Liaison Team, GMMH
- Ruth Marshall, Clinical Director CAMHS Team
- Nicola Clibbens, Ward Manager CAMHS Team
- Jane Benson, Matron CAMHS Team
- Ruth Speight, Assistant Chief Nurse Safeguarding
- Claire Howard, Lead Nurse (Acting) Adult Safeguarding and Vulnerable Groups
- Julianna Mian, Lead Nurse AMU Team, MRI
- Donna Corcoran, Ward Manager AMU Team, MRI
- Ashley House, Deputy Security Manager ORC and Security Supervisors
- Security Staff
- Bethany Gilbert, Matron, Major Trauma Team
- Lucy Inight, Ward Manager, Major Trauma Team
- Jill Findlay, Head of Nursing, North Manchester General Hospital Emergency Department
- Kelly Burns, Lead Nurse, North Manchester General Hospital Emergency Department
- North Manchester General Hospital Acute Medical Unit Team
- Sarah Etches: MHA & MCA Officer
- Claire Howard, Names Nurse for Safeguarding
- Carmel McBride, Patient Improvement Lead
- Anthony Wolke - Head of Nursing, Learning Disabilities & Autism
- Nicola Sunderland - Community Learning Disability Matron
- Kathryn Krinks - Head of Nursing: NMGH Corporate Nursing Team
- Lisa Jones - Head of Service Community Learning Disability Service CALDS
- Claire Howard - Lead Nurse Safeguarding Adults and Vulnerable Groups
- Alesha Lewis – LD Safeguarding Nurse

DOCUMENTS	
MH BUNDLE 1 (7 documents)	• MFT Safeguarding Reporting Structure • MFT Safeguarding Committee Terms of Reference • MFT MH Sub-Group Terms of Reference • Last 3 sets of minutes form the MH Sub-Group • Safeguarding Annual Report 2022 - 2023

MH BUNDLE 2
(10 documents)
	• A report from November 2022 that commenced our work to develop the MH Strategy and undertake deep dives, the report was subsequently submitted to:
	  ○ Safeguarding Committee, MH Sub-Group, Medical Directors Forum – before the work commenced in January (coinciding with the CQC request for information (see Bundle 5)
	• Deep Dive Assurance Panels held in September and October this year from all our hospitals/managed clinical services, community organisations.
	  ○ Manchester Royal Infirmary
	  ○ Wythenshawe, Trafford, Withington & Altrincham
	  ○ Manchester Royal Eye Hospital & University ental Hospital of Manchester
	  ○ North Manchester General Hospital
	  ○ Royal Manchester Childrens Hospital / Managed Clinical Service
	  ○ Saint Mary's Hospital / Managed Clinical Service
	  ○ Manchester & Trafford Local Care Organisation

MH BUNDLE 3 (9 documents)	Procedural Documents 7 Strategy • Prevention and Management of Restrictive Interventions for Adult Patients • Safeguarding Children and Young People Policy • Suicide Prevention Policy • Mental Health Act Policy • Deprivation of Liberty Safeguards Policy • MFT Mental Health Strategy • Safeguarding Adults at Risk of Abuse Policy 2 documents that are our current MOU or SLA with GMMH: • SOP MHLT amended August 2021 • Manchester Mental Health Liaison
MH BUNDLE 4 (3 documents)	• A report that went to the Manchester City Council Scrutiny Board relating to CAMHS provision • Our Metrics that go to Board of Directors • Complaints PALS and Complaints data
MH BUNDLE 5 (1 document)	• CQC Assessment and monitoring response
MH BUNDLE 6 (7 documents)	• Care of Patients with Learning Disability/Autism in Acute Care Policy • MFT Learning Disability and Autism Strategy • MFT Learning Disability and Autism Steering Group Terms of Reference • MFT Learning Disability and Autism Steering Group Workplan • Roles and Responsibilities of LD Champions

	• Oliver McGowan Mandatory Training Update Report • Monthly Compliance Data for MH and LD Awareness Training
MH BUNDLE 7 (8 documents)	• Group Safeguarding Committee 21.11.23 – Report to GM Board • Safeguarding Committee November 2023 – Report to MFT Board • Q1 Safeguarding Report • Q2 Safeguarding Report • Safeguarding Quality and Experience Exception Report • Safeguarding Team structure • Safeguarding Audit Calendar 2022/23 • Safeguarding Audit Calendar 2023/24
MH BUNDLE 8 (6 documents)	• Professional Board Report Mental Health Overview of Standards and Assurance • Restrictive Interventions Training Pilot Report • Least Restrictive Intervention and Restraint Training • Integrated Care Pathway Emergency and Urgent Care Departments Self Harm and Suicide audit 2022 • Baseline Assessment for Advocacy • Acute Mental Health Triage Tool in HIVE – HIVE is MFT's Electronic Patient Record (EPR) System (accessed by MFT, GMMH MHLT staff) PARIS is GMMH's EPR System (accessed by MHLT, GMMH and MFT CAMHS staff)

Mental Health Peer Review – January 2024
Recommendations

Trust Strategy (including CAMHS)

There are some key strategic issues the reviewers recommend being considered in relation to the MH needs and inpatient services for young people aged 16 and 17 (transition) who are subject to MHA detention. More detail and a wider focus on these areas is detailed within the Safeguarding section of the report.

Recommendation 1
The governance arrangements for oversight of delivery of the individual strategies (e.g. mental health and LD/A strategies) should ensure that sufficient attention is given to the interface between services for people with physical, mental health or LD/A care needs and additionally to describe the specific targeted approaches taken to meet the needs of different age groups e.g. 0-5, 5-18, 18-65 and 65 plus. Examples of areas that would benefit from some additional focus on how work is developed and led in areas or age groups that may overlap or have additional needs include transition (16- and 17-year-olds) and Special Educational Needs 0- 25 (SEN). The developing Trust Strategy should address the holistic needs of patients and identify the priorities of the Trust in relation to integration and co-ordination of care for people with multiple needs (physical health, mental health, LD/ A, and other needs), taking account of the principles of population health management approaches to identifying and meeting needs earlier

ED Department

Areas Identified for Improvement

- Where it describes in the self-assessment document as part of the overview that the Mental Health Liaison Team are based in all departments, this is factually incorrect and is in the opinion of the reviewers a clinical deficit/risk. Whilst, the team are co-located to ED, they do not have a physical base in ED, therefore are not always present in the area.
- During the visit to MH liaison team, the reviewers met with staff from GMMH who also clarified that it is a single team that cover the 4 hospitals based on the Manchester Oxford Road Campus, the size and scale of the site is significant, and this again may present additional challenge/pressure on time.
- The area utilised to hold an individual who has been removed from a public place due to a MH disorder an requires a place of safety (under s136 of the MHA) at the Manchester Royal Infirmary site, is a room that is part of the MH patient's hub. This is not Royal College Psychiatry compliant. More detail is described under Restrictive Practice section.
- The current ED environment has no toilet / shower facilities. (Raised on the day of the visit as an immediate concern) In fact, the entire area is not fit for purpose, there is no natural light, no anti-ligature toilet/shower areas, and no anti-barricade doors in situ. Reviewers were informed of plans for a replacement MH hub area, but the timescales on this are "up to 3 years".
- Therapeutic observations of patients within ED are carried out by security staff NOT mental health support workers. Linking this to the first point above, this potentially leaves the ED Nurse clinically accountable for the MH nursing care 'delivery'. Due to the complexity of this practice, a separate section has been included in the report regarding the role of security staff within the ED's, which is linked to KLoEs CQC MH6 and MH7
- There was a lack of awareness and understanding of the potential impact of Right Care Right Person (RCRP).

Mental Health Peer Review – January 2024
Recommendations

Recommendation 2
Consider the location of the MHLT in relation to the ED's and multiple sites that they provide services for on the Oxford Road Campus.
Recommendation 3
Complete a full environmental safety risk assessment, identifying current risks including those outlined above and ensure there is clear mitigation in place to manage risks. Any high-level residual risks to be escalated and included on the Trust's Risk Register /Board Assurance Framework.
Recommendation 4
Consider the current SLA with GMMH, focus should include a review of recommendation 2 and the use of security staff within the ED to carry out ESSO. (This recommendation needs to capture the thinking articulated in detail within later sections as most sections within the report reference the use of security guards).
Recommendation 5
Clarify the leadership for managing and communication the impact and processes in relation to the implementation of Right Care Right Person (RCRP). **(Link with Recommendation 6 as this needs to apply to MFT and GMMH)**

Mental Health Liaison Team

Areas Identified for Improvement

- Unclear on KPI monitoring and target (internal) appears to be set at 85% compliance for 4 hours review.
- There is a lot of focus and a desire to achieve the Psychiatric Liaison Accreditation Network (PLAN) accreditation, however the reviewers felt this is a lot of work and perhaps needs to be balanced and focus on how this will demonstrate a positive impact on service delivery,
- There are differences in the uniforms worn by MH liaison staff and acute staff, and this is causing confusion.
- Safer flow is in use to monitor waits, but this cannot be seen by MFT Executives as it feeds into GMMH Executives – No evidence of sharing this information or access.
- Senior management leadership for managing the impact of RCRP within the wider system.

Recommendation 6
Consider reviewing the current SLA with GMMH, to ensure there is a shared understanding and clarity of key responsibilities, to include a review of the shared monitoring of KPI's and other data available to monitor MH patients within acute services, the impact of PLAN accreditation and uniform standardisation. **(Link with recommendation 5 – the impact of RCRP).**

Mental Health Peer Review – January 2024
Recommendations

Galaxy House (CAMHS inpatient unit)

Areas Identified for Improvement

- Agree priorities and identify outcome measures (both during inpatient stay and post discharge)
- Increase awareness of the service
- Increase the use of patient and family engagement and experience forms and feedback. Although the team reported extensive family involvement, this was an area identified by CQC in October 2022 and is still an issue highlighted in discussion with the Trust lead for patient experience.

Recommendation 7
Consider the development of a clear strategy supported by a business plan, a marketing strategy and marketing/communications material – both internal and externally focussed for Galaxy House.
Recommendation 8
Review and strengthen how CYP and their families and carers are engaged in treatment plans and feedback mechanisms – consider accessibility and age-appropriate feedback/engagement methods e.g. texts.

Acute Medical Unit (AMU) at MRI

Areas Identified for Improvement

Due to age group (younger adults) need more support for education, social skills etc

Recommendation 9
Review ward establishment and skills mix to consider dedicated RMN links to the ward and additional support required to target support for younger adults.
Recommendation 10
Monitor ward inpatients to establish if there is a potential future requirement for a dedicated MH AMU.

Meeting with Director of Nursing and Deputy Director of Nursing at MRI

Despite gaining some assurance from the pre-reading of papers by the reviewers, it appears that there are gaps in the oversight of performance measures by the hospital director team at MRI. On delving into this via the face-to-face discussion, there appears to be no daily oversight calls, escalation of long waits process isn't followed consistently by GMMH and MRI execs have no access to GMMH live data.

Recommendation 11
The Service Level Agreement with GMMH is out of date and requires discussion and review. It may be prudent to review this at MFT executive level with input from Hospital Directors, prior to discussing a renewed SLA with GMMH Executive Directors. (Link to recommendation 6)

Mental Health Peer Review – January 2024
Recommendations

The role of security staff within the ED's to support MH needs

Recommendation 12
Clarify the role of the MH clinical leads in supervising the security officers in the department? This includes checking on interactions, monitoring the effectiveness of interventions and reviewing observation logs.
Recommendation 13
Clarify what is meant when referring to personal care, what is the definition of this? (For example, who observes a patient with physical health needs – are there two people allocated, one a security and another from a clinical team? If a patient needs to use the toilet or shower, but is on 1:1 observation, who takes over the responsibility for observing (and the associated recording), or again are two people involved?)
Recommendation 14
Clarify what (and who) is inputting into the ED's patient record system (HIVE) with regards to patients' observations?
Recommendation 15
Following on from Recommendations 6 and 11, explore the current appetite or desire from the GMMH leads to alter the security arrangements utilised as part of the sub-contract arrangements between GMMH and MFT. Consider increasing the mental health support worker establishment to reduce the over reliance on security staff to supervise and observe people with mental health difficulties, autistic people and people with a learning disability who may present with distressed behaviours.
Recommendation 16
The language used was of some concerns to the reviewers because although the process of enhanced observations described is congruent with how Mersey Care may adopt the use of supportive observations, there were frequent refences made to the use of guards, bed watch and a lack of clarity regarding accountability and oversight. How will the Trust consider tackling this moving forward?

MRI Emergency Department

Recommendation 17
Explore options to enhance technology within the patient rooms i.e. a TV within ligature free cabinet to distract people from symptoms of their mental health difficulties.
Recommendation 18
Undertake patient experience questionnaires with people admitted to gain an understanding of the areas for improvement and create a 'you said - we did' board to highlight to new patients on the unit that their feedback is valued and acted upon responsively.
Recommendation 19
Place a clock outside the 136 suite for people using the space.
Recommendation 20
Create an activity planner for people using the service consisting of access to fresh air and exercise, attending to personal hygiene and calming and alerting activities to provide distraction.

Mental Health Peer Review – January 2024
Recommendations

Security

Recommendation 21
Consider using a dynamic risk framework to manage the number of security staff within the area as per the ESSO policy.
Recommendation 22
Consider reviewing the job description of support workers within the area to include an activity function to their role.

Training in Reducing Restrictive Practice

Recommendation 23
Increase the number of nursing staff trained at level 3 of the certified training to support people who may require additional support and the application of physical intervention to administer treatment and/or maintain people's safety. A training needs analysis based on the areas with highest demand for ESSO would be helpful to structure thinking around prioritisation of people to undertake the training.
Recommendation 24
Develop a daily multi-agency safety huddle to review people subject to ESSO policy.
Recommendation 25
Consider reviewing the ESSO policy and prevalence of risk to create a risk dynamic approach to wearing full PPE when supporting people with mental health difficulties, autistic people and people with a learning disability.

Lived Experience

Recommendation 26
Explore options to incorporate further lived experience perspectives, including paid roles, to co-produce improvements at all levels of the service (i.e., design, delivery, governance, and oversight).

Culture

Recommendation 27
Consider including the person's strengths and positive behaviours within the documentation completed by security officers whilst under ESSO.
Recommendation 28
As above, there is a clinical need to increase the number of nursing staff trained at level 3 of the certified training to support people who may require additional support and the application of physical intervention to administer treatment and/or maintain people's safety. Develop a system and protocol in collaboration with the security department to ensure there are sufficient staff on duty trained to respond to incidents requiring intervention.
Recommendation 29
Consider peer support workers to work within the designated mental health area of the Emergency Department.
Recommendation 30
Explore these prevailing concerns across the workforce and enhance the support for staff delegated to the mental health area of the Emergency Department.
Recommendation 31
Identify staff to undertake the level 3 certified training to enhance their skills of supporting people who may present with distressed behaviours.

Mental Health Peer Review – January 2024
Recommendations

NMGH Emergency Department

Recommendation 32
To review the function of the Green Space managed by GMMH Trust and consider this being adapted for all people who suffer from a mental illness, autistic people and people with a learning disability despite their presentation. This environment is more conducive to providing high-quality, person-centred care for people who are often overwhelmed and require a low stimulus environment.

Recording and Reporting

Recommendation 33
Consider adding an additional tab for staff to record whether the patient and staff team involved in the incident have been offered a de-brief.

Policy

Recommendation 34
To review staff's understanding of the Broset Violence Checklist to help assess the level of support a person may require.
Recommendation 35
To review the trust policy on the Prevention and Management of Restrictive Interventions for Adult Patients and include guidance on making reasonable adjustments as per the Equality Act (2010) to improve care delivery and reduce the likelihood of people becoming distressed.
Recommendation 36
Create an overarching Reducing Restrictive Practice Policy which sets out the Trust position and commitment in delivering upon this important agenda.

Additional KLOE

Management of Pregnancy of Inpatient Service Users.

Recommendation 37
Although the current approach is effective, there could be potential benefits (efficiencies) for streamlining to one single point of contact for safeguarding for all services within the Trust- rather than different safeguarding teams offering the same duty service for individual service lines.
Recommendation 38
Although the current approach is effective, it is important to ensure that MARAC has the correct involvement from operational services.
Recommendation 39
Review the practice of admitting 16- and 17-year-olds to Adult beds and consider managing this as an 'exception' rather than routine practice.
Recommendation 40
If a 16- or 17-year-old has to be admitted to an adult bed, ensure that rigorous risk management, reporting and monitoring is in place.

Mental Health Peer Review – January 2024
Recommendations

Learning Disability and Autism Awareness and Practice
Strategy, Policies and Governance

Recommendation 41
The strategy is largely focussed on the care and treatment of children and adults who have a learning disability – primarily based on the learning disability improvement standards. Although many of the principles and implementation would apply to Autistic people (flagging, reasonable adjustments) who do not have a diagnosis of a learning disability, identification of specific actions and development of an implementation plan would support quality improvement and patient experience.

Training Compliance and Staff Awareness

Recommendation 42
The Trust to consider additional training regarding Autism for staff within clinical areas.
Recommendation 43
Continue with roll out of PBS training for clinical staff and consideration of PBS champion roles utilising BILD training.

Learning from Complaints, Incidents and Mortality Reviews

Recommendation 44
The Trust to share national and local LeDeR reports to the Trust mortality review group and incorporate any recommendations or actions within LD and A implementation plans.
Recommendation 45
Consider support for the Implementation of NHSE ‘Ask, Listen, Do’ as a framework to support concerns, complaints and co-production processes within the Trust.

HIVE Clinical Record System

Recommendation 46
Build in contact with GP practice to identify if an individual is on the LD register within GP practices for any queries re: identification.
Recommendation 47
Continue to build on progress made to flag all patients admitted to the Trust with a learning disability and/or autism.
Recommendation 48
Consideration of additional autism awareness training to support the increase in flagging Autistic people (non-LD).

LD Champion Forums

Recommendation 49
Given identified gaps in relation to Autism (non-LD) consideration of extending the role to LD and A champions or developing a separate network. Understanding the differing clinical requirements and reasonable adjustments faced by people with Autism (non-LD)

Mental Health Peer Review – January 2024
Recommendations

Interface With Other Services

Recommendation 50
As the re-development of the ED department is in planning stages and a recommendation would be to ensure planning includes consideration of specific areas which can be utilised for people with LD and A presenting with behaviours that challenge and/or sensory needs.
Recommendation 51
Following the publication of the acute mental health inpatient services guidance and the national north- west mental health inpatient quality Transformation programme, it would be timely to re-visit and refresh pathways of referral, assessment and intervention into acute mental health inpatient services for autistic adults and adults with a learning disability.

MCA & MHA Policy and Governance Arrangements

Recommendation 52
It may be advantageous for the Trust to consider how this governance structure is reflected in the naming convention to better denote areas of responsibility of the Safeguarding services pertaining to mental health and mental capacity law and governance.

Review of the CQC MCA & MHA Inspection Findings (2019)

Recommendation 53
Ensure the audit calendar continues to include MHA & MCA as standard items on the calendar.
Recommendation 54
(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below) Suggested additional areas identified for inclusion in policy • Discharge planning & S.117 After Care: the policy could be enhanced with consideration of chapter 33 MHA CoP. This should also be joined up with Greater Manchester Community Mental Health Transformation developments that have replaced the Care Programme Approach (CPA). **Regulation 17: Good governance** • S.18 return and readmission of patient Absent Without Leave (AWOL): the policy could be enhanced with guidance on statutory duties in incidence of AWOL. Chapter 28 MHA CoP, details various AWOL circumstances and persons authorised to take patient back into custody, including hospital staff authorised by hospital managers. Reporting to police will need to be considered in context of the newly developed Right Care, Right Person' (RCRP) protocols in Greater Manchester Police. Nearest Relative rights to be informed of AWOL will also need to be incorporated. **Regulation 17: Good governance** • S.135(2) warrant obtained by the detaining hospital to return an AWOL patient has not been considered within the policy and the governance underpinning this that is required. **Regulation 17: Good governance** • Nearest Relative Rights have not ben considered within the policy related to right to apply for section, right to object to a section, right to request discharge of section, right to request

advocacy, right to be consulted and given information and appointing another Nearest Relative, chapter 4 MHA CoP. **Regulation 17: Good governance**

- The Responsible Clinician power to prevent Nearest Relatives discharge by issuing a barring certificate has not been considered within the policy, Chapter 32 MHA CoP. **Regulation 17: Good governance.**
- Involvement of Carers chapter, including Carers assessment (Care Act 2014) has not been fully considered with the policy, chapter 4 MHA CoP. **Regulation 9: Person centred care.**
- Consent to treatment and interface with MHA and MCA is considered in the policy, however it could be further enhanced with more detail around S.63 and guidance on second opinion approved doctor (SOAD) certificates, chapters 23, 24 & 25 MHA CoP. **Regulation 17: Good governance & Regulation 11: Need for consent.**
- Advance decisions and wishes expressed in advance have not been considered within the policy, chapter 9 MHA CoP. **Regulation 9: Person centred care.**

Management of the Deprivation of Liberty Safeguards (DOLS) within the Meaning of the Mental Capacity Act 2005 (Amended 2019)

Recommendation 55

(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below)

- Patient rights and section 21a application: right to appeal is not overtly referenced and could be included to enhance the policy to ensure that the relevant person and their representative rights are considered. **Regulation 9: Person centred care.**
- Restraint: primary reference/guidance is noted within appendices / templates. The policy could be enhanced with further guidance to consider the legal framework around restriction and restraint, including the distinction between what is protected by Part 1 Section 6 of the Mental Capacity Act, and what requires an authorisation under the DoLS Framework. **Regulation 11: Need for consent.**
- DoLS breaches: the policy could be enhanced with the process for reporting, monitoring and escalating DoLS breaches. Appendices 1, under the heading “following an application” notes MFT has complete it’s process, however there is no escalation or monitoring process described. **Regulation 17: Good governance.**
- Appendices 1 referral process: narrative may sit better in main body of the policy and appendices and appendices 1 is presented a guidance flow chart. **Regulation 17: Good governance.**
- Coroners reporting: death whilst subject to DoLS guidance is not considered within the policy if cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the person’s death. The policy would be enhanced by including guidance. **Regulation 17: Good governance.**
- Ferreira case law: policy could be enhanced with reference to patients in acute hospital receiving ‘immediately necessary life sustaining medical treatment’ not considered to be deprived of their liberty if arrangements have no unusual feature. **Regulation 17: Good governance.**
- Care planning: DoLS care planning is referenced in appendices / templates, the policy could be enhanced by guiding how details of any conditions attached to the authorisation can be implemented and monitored. **Regulation 9: Person centred care.**

Mental Health Peer Review – January 2024
Recommendations

MCA policy adherence with MCA and Code of Practice Liberty Protection Safeguards (LPS) readiness & embedding MCA

Recommendation 56
(N.B The following suggested amendments to the policy are made only to consider as enhancements as they will strengthen Regulatory evidence as noted below) Fluctuating capacity is not considered within the policy and so could be enhanced by doing so with reference to guidance in MCA CoP.

Liberty Protection Safeguards (LPS) readiness & embedding MCA

Recommendation 57
MFT may want to consider the benefits of agreeing a partnership approach with the local authority to permit their staff to be released to practice as BIA as part of LPS readiness, and so further delivering workforce readiness. This could also allow further benefits for MFT if its own BIA's were to prioritise the assessments / breaches for the MFT cases on the days they undertake BI assessments for the local authority.

Patient Engagement and Experience

Recommendation 58
Consider the need for I/T support to develop different modes of collecting feedback e.g. text message sent to targeted patients known to have a MH or LD and A condition a specific number of days post AED attendance.
Recommendation 59
Consider the need for a network of MDT practitioners to be involved in reviewing complex MH or LD and A patients who are inpatients on acute wards.
Recommendation 60
Develop a process to identify at an earlier stage delayed discharges. A systematic and coordinated approach is required to highlight patients who are delayed in being discharged due to a MH or LD and A need, rather than the requirement for ongoing care in an acute hospital. This should also include referrals, support to the individuals (rather than signposting) and a clear escalation process.
Recommendation 61
Consider the need for bringing together feedback and data from multiple sources, such as PALs , complaints, PSIRF, FFT , patient surveys, Mental Health Act feedback ,insight from Healthwatch or similar etc. into a Trust Wide group to gain a fuller understanding and co-ordinate actions in relation to patient engagement and experience.

Next Steps

Recommendation 62
MFT may want to consider the benefits of gaining further assurance of synergy between Ward and Board.

Agenda Item 11.6

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Emma Burton, Assistant Chief Nurse, Quality & Patient Experience; Caroline Wilson, Corporate Lead Nurse, Quality and Professional Practice; Sarah Cosgrove, Corporate Head of Nursing, Quality and Patient Experience.
Date of paper:	May 2024
Subject:	Annual Clinical Accreditation Report 23/24
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:	To provide an overview and analysis of the 2023-2024 Accreditation Programme and a summary of the changes implemented for the 2024-2025 programme.
Recommendations:	The Board of Directors are asked to note the content of the report.
Contact:	Name: Emma Burton, Assistant Chief Nurse, Quality and Patient Experience Tel: 0161 276 8862

1. Introduction

1.1. The Clinical Accreditation process is part of Manchester University NHS Foundation Trust's (MFT), assurance mechanism for ensuring high-quality care and the best possible patient experience. The process is underpinned by the Improving Quality Programme (IQP) and supported by MFT's Values and Behaviours Framework, the 'What Matters to Me' (WMTM) Patient Experience Programme and the Nursing, Midwifery and Allied Health Professional (AHP) Strategy.

1.2. The Clinical Accreditation Programme demonstrates that MFT has undergone a rigorous process to ensure patients, families and carers are receiving high quality services, delivered by competent staff, in safe environments, whilst providing assurance to commissioners and regulators.

1.3. The Clinical Accreditation process is aligned to the Care Quality Commission (CQC) regulatory standards and Single Assessment Framework. The domains focus on the Key Lines of Enquiry (KLOE) which are Safe, Effective, Responsive, Caring and Well Led).

1.4. The purpose of this paper is to provide the Board of Directors with an overview and analysis of the activity, outcomes and learning from the 23/24 Clinical Accreditation Programme and the Quality Assurance Programme and a summary of the changes implemented to the 24/25 programme.

2. Background

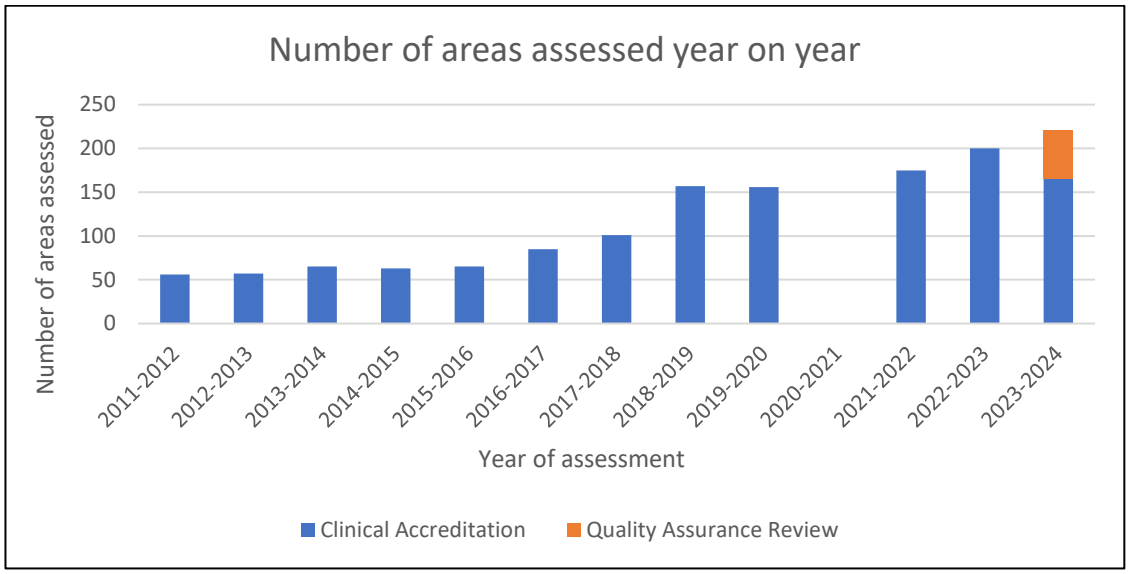
Accreditation Programme

2.1. Since the introduction of the Accreditation Programme in 2011, there has been a year-on-year increase in areas being accredited. **Graph 1 & 2**.

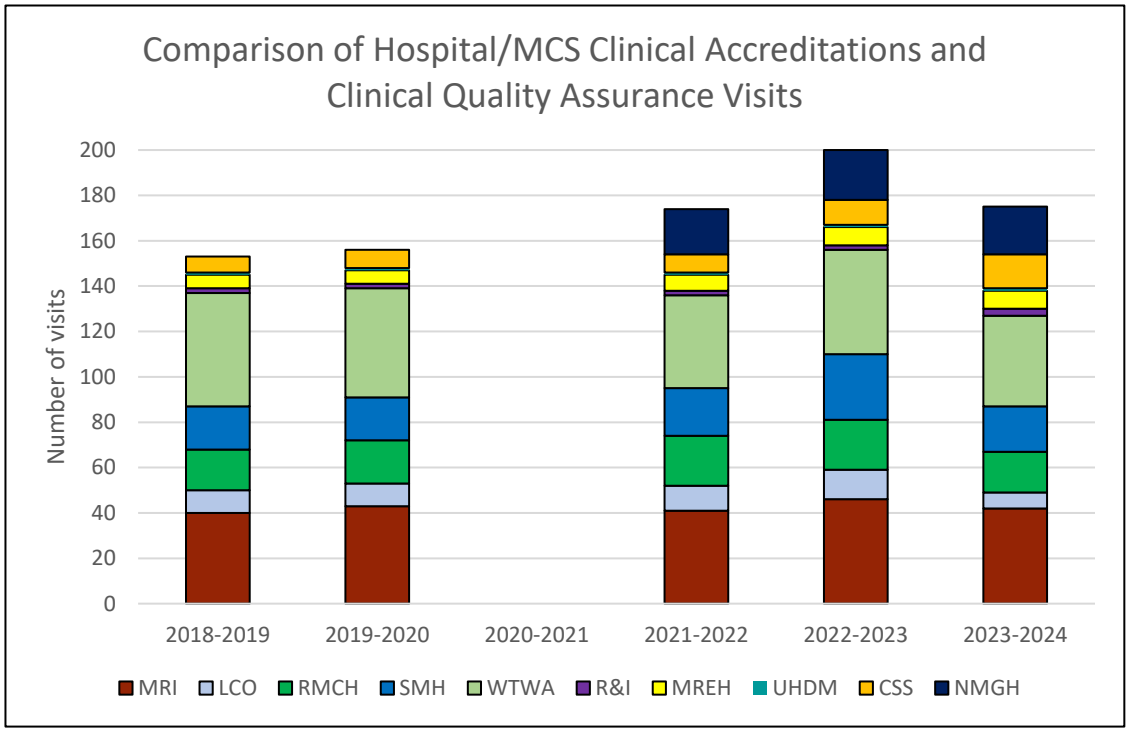
2.2. Following an annual review of areas assessed by the Directors of Nursing for Hospital/ MCS/LCO, the total number of Clinical Accreditations was reduced to 133. Merged Clinical Accreditations were introduced following consultation with the Directors of Nursing. This is to allow oversight of areas based on patient flow through the overall service rather than individual area. These are cross site or for joint areas and provide an overall score as a service. In total, 19 areas were selected for a merged clinical accreditation. This resulted in the Clinical Accreditations covering a total of 166 areas compared to 200 in the 22/23 programme.

2.3. To ensure a bespoke process for areas that do not have a bed base, the Clinical Quality Assurance was designed and introduced for 23/24. The process aligns to the Clinical Accreditation process and CQC KLOE. They accommodate bespoke areas that may not have the standardised data metrics to review.

2.4. Quality Assurance Reviews were completed for 42 non bed base areas, covering a total of 55 areas in 23/24.



Graph 1: Number of areas assessed from 2011-2024 (No Clinical Accreditations occurred in 2020 – 2021 due to the COVID-19 pandemic).



Graph 2: Demonstrates the comparison of Hospital / MCS/ LCO Clinical Accreditations over the last six years. No clinical accreditations occurred in 2020-2021 due to the COVID 19 pandemic.

2.5. Clinical Accreditations were led by the Deputy Chief Nurse, Directors of Nursing/Midwifery, Deputy Directors of Nursing/Midwifery and Assistant Chief Nurses/Chief AHP. A further three team members (minimum) consisted of Head of Nursing, Lead Nurse/Midwife or Lead AHP and a Quality Improvement Manager. Matrons/AHPs were included for some specialist areas where they had the required background experience. The number of staff within the accreditation team increased dependant on the size of the area or complexity.

3. Clinical Accreditation Outcomes for 2023-2024

3.1. Clinical Accreditations completed during 23/24 represented areas from all Hospitals, Managed Clinical Services (MCS) and Local Care Organisations (LCO), including adult and children's inpatient areas, Emergency departments, theatres and in patient community location. The Clinical Quality Assurance visits focused on non-inpatient and specialist areas.

3.2. In total, 175 Clinical Accreditations (133) and Quality Assurance (42) visits were completed during 23/24, covering 221 areas in total. This demonstrates an increase of 21 areas reviewed compared to 22/23.

3.3. Of the 133 areas accredited, the distribution of final awards demonstrated 27 areas (20%) achieved Bronze, 97 areas (73%) achieved Silver and 9 areas (7%) achieved Gold (**Table 1**).

	2022 – 2023		**2023/2024**	
	Number	**Percentage**	**Number**	**Percentage**
Gold	44	22%	9	7%
Silver	98	49%	97	73%
Bronze	58	29%	27	20%
White	0	0%	0	0%
Total	**200**	**100%**	**133**	**100%**

Table 1: demonstrates the distribution of Bronze, Silver and Gold during the 2023-2024 Clinical Accreditation in comparison to 2022-23.

3.4. Of the 42 areas that had a Quality Assurance Review, the distribution of final awards demonstrated that 10 areas (24%) achieved Bronze, 17 areas (40%) achieved Silver and 15 areas (36%) achieved Gold (**Table 2**). No comparison is available for the Quality Assurance as this process was only introduced in 23/24.

	2023-2024 Quality Assurance Review	
	Number	**Percentage**
Gold	15	36%
Silver	17	40%
Bronze	10	24%
White	0	0%
Total	**42**	**100%**

Table 2: demonstrates the distribution of Bronze, Silver and Gold during the 2023-2024 Clinical Quality Assurance Programme (2023-2024 was the first year for the Quality Assurance Programme).

3.5. In comparison to the previous year:

- 36 areas improved their award.
- 66 areas maintained the same award.
- 29 areas demonstrated a deterioration in their award.

	Total 22/23	Total 23/24
Number of areas that improved	29	36
Number of areas that deteriorated	61	29
Number of areas that stayed the same	82	66

Table 3: demonstrates the number of areas that improved, deteriorated, or maintained their Clinical Accreditation Award in 2023-24 compared to 2022-23.

3.6. The number of areas that maintained or improved their Clinical Accreditation Award in 23/24 was 102 (78%) compared with 111 (55.5%) in the 22/23 Clinical Accreditation Programme, an overall increase of 22.5%.

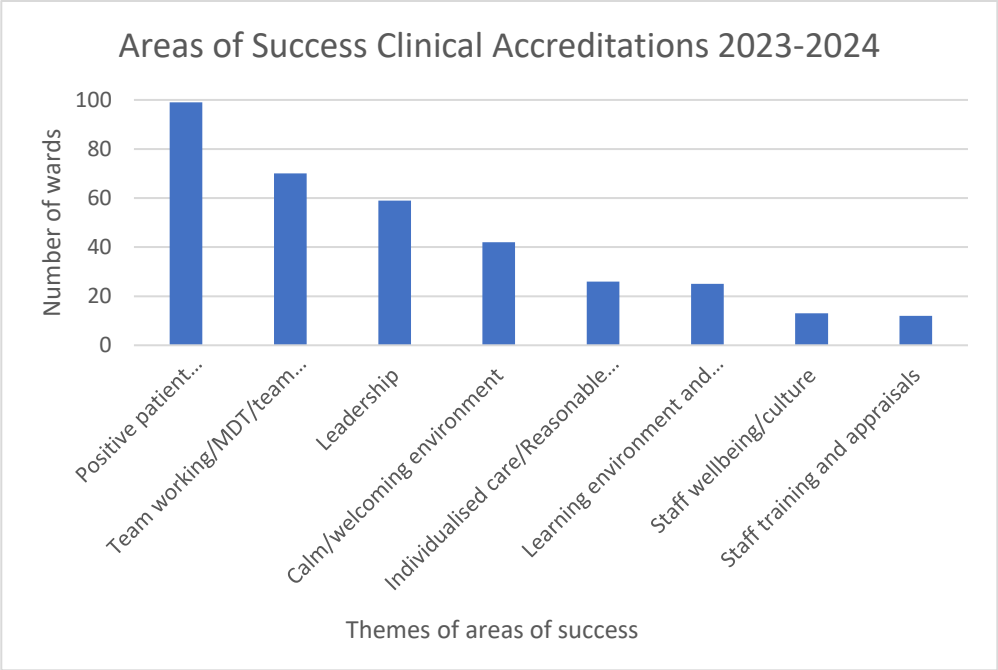
4. Thematic Analysis of the findings of the 23/24 Clinical Accreditation Programme

4.1. Integral to the Clinical Accreditation and the Clinical Quality Assurance process, is the provision of initial feedback to the area being accredited prior to the Accreditation team leaving the area. At the end of the visit, the Clinical Accreditation team identify three areas of success and three areas for improvement. The aim of this is to celebrate successes and provide focus for areas of improvement.

4.2. Additionally, immediate actions were superseded by Safety Actions which is a tool used on both Clinical Accreditations and Clinical Quality Assurance visits. This is in response to issues seen on the day that relate to safety. These are discussed with the area's manager either at the time of observation, if it was an immediate safety concern, or discussed at the end of day alongside the areas for improvement.

Themes of Areas of Success 23/24

4.3. From the 'areas of success' observed during Clinical Accreditation, the top three themes were in relation to positive patient feedback, multidisciplinary team (MDT) working and leadership (**Graph 3**). The top three themes identified in 23/24 were unchanged from 22/23.



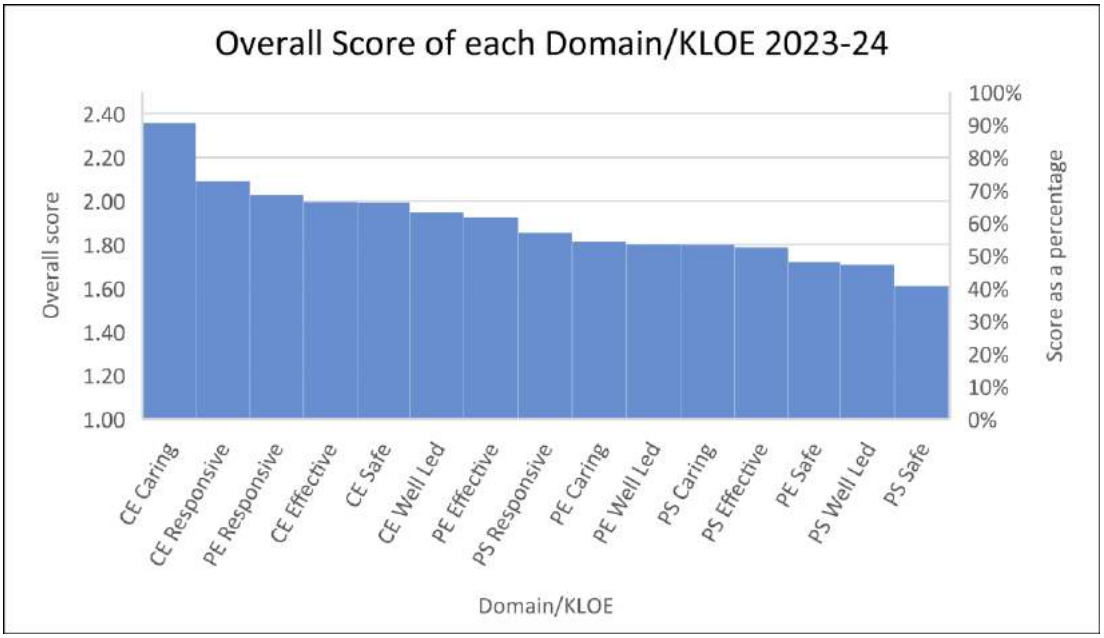
Graph 3: Themes identified as Areas of Success in the Clinical Accreditation Programme 2023-2024.

4.4. From the areas of success observed during the Clinical Quality Assurance visits, the top three themes were in relation to the multidisciplinary team (MDT) working, positive patient feedback and calm and welcoming environment (**Graph 4)**. Not dissimilar to the top three areas of success in the Clinical Accreditation process.

Graph 4: Themes identified as Areas of Success in the Clinical Quality Assurance Programme 2023-2024.

4.5. The Clinical Accreditation process has 15 standards, 5 KLOE standards within each of the three domains of *Clinical Effectiveness*, *Patient Experience* and *Patient Safety*. These standards are scored on the day of the visit.

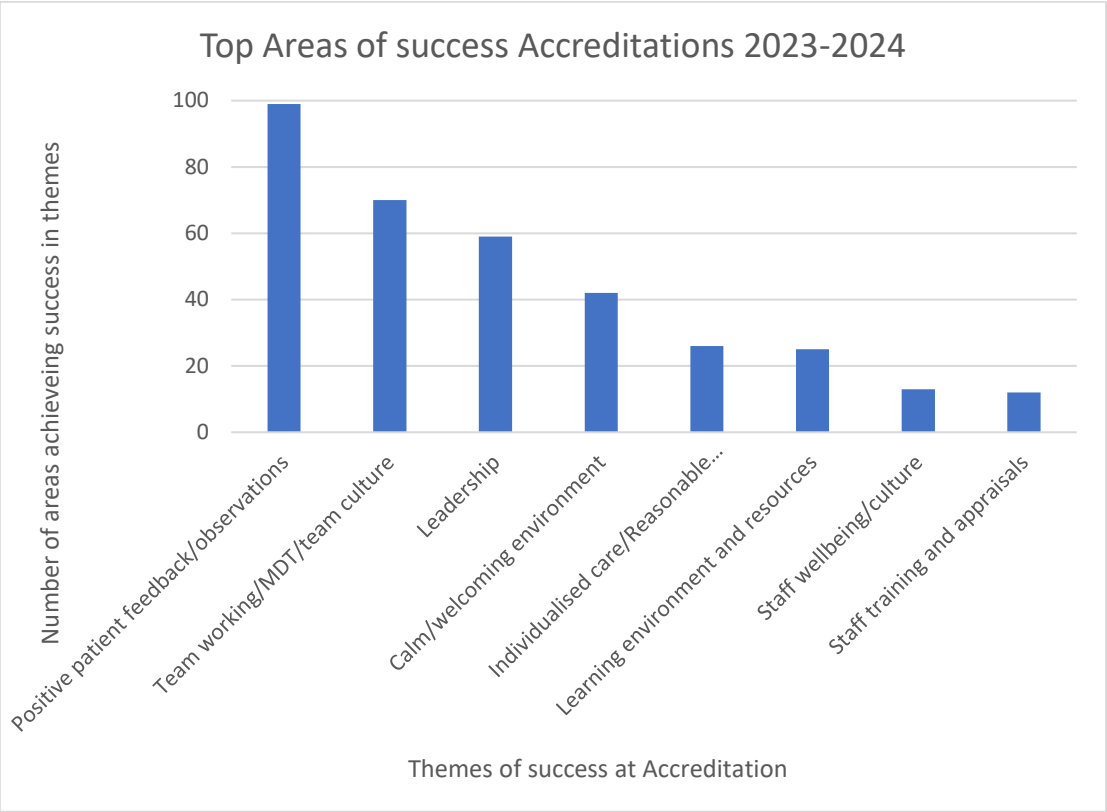
4.6. The three standards that achieved the highest scores within the fifteen Clinical Accreditation standards were Clinical Effectiveness relating to staff wellbeing, new starter support, raising concerns and civility. Clinical Effectiveness relating to positive student environment, complaints, reasonable adjustments and listening to/monitoring patient feedback and Patient Experience relating to communication needs assessment, patients updates about care and patients appearing well looked after. **Graph 5** demonstrates the overall score in relation to the KLOE.



Graph 5: Overall scores of each clinical accreditation standard ranked in order.

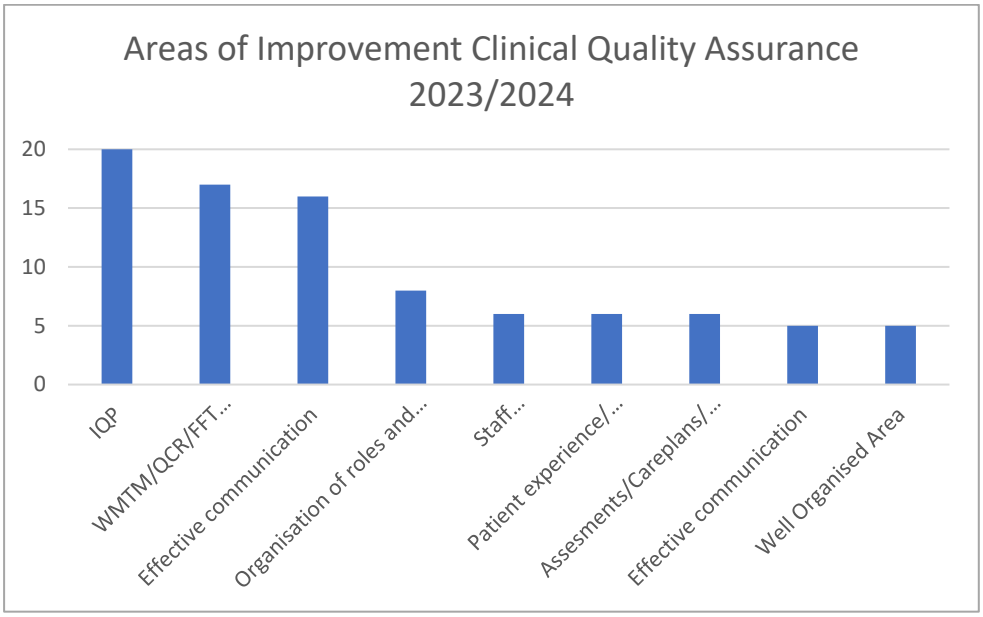
Themes of Areas for Improvement 2022-2023

4.7. From the areas of improvement for Clinical Accreditations, the top 3 themes were in relation to Quality Care Round (QCR)/What Matters to Me (WMTM) data, IQP knowledge/team involvement and mealtime standards (**Graph 6**). For reference, whilst IQP knowledge and team involvement remains a top area requiring improvement for 23/24, when comparing to 22/23 data there is significant evidence of improvement in line with the new IQP training that has been commenced.



Graph 6: Demonstrates the themes identified as areas for improvement in the Clinical Accreditation Programme 2023-2024.

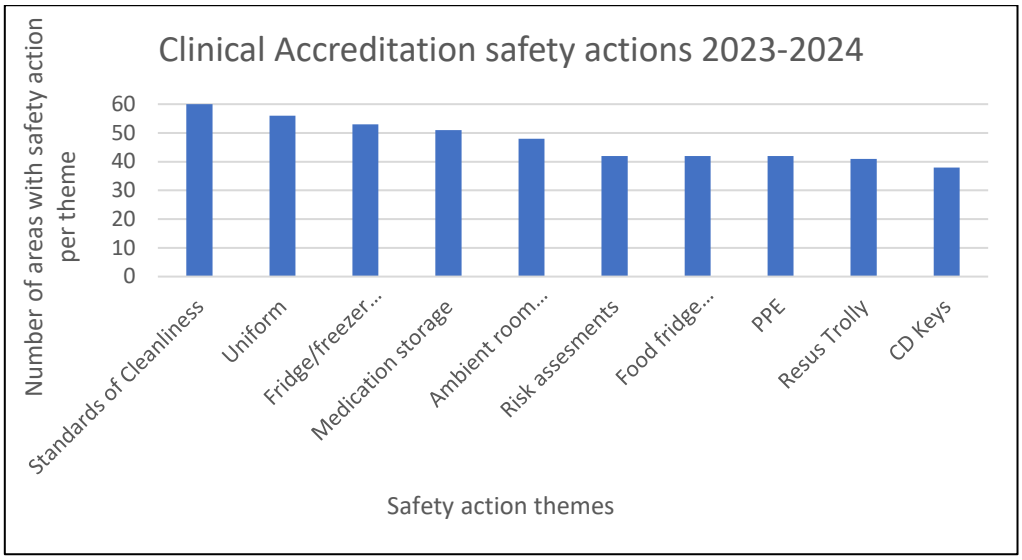
4.8. From the areas of improvement for Clinical Quality Assurance visits, the top 3 themes were not dissimilar to the Clinical Accreditation process and were in relation to IQP knowledge, QCR/WMTM data, FFT collections and Effective Communication (**Graph 7**).



Graph 7: Demonstrates the themes identified as areas for improvement in the Quality Assurance Review Programme 2023-2024.

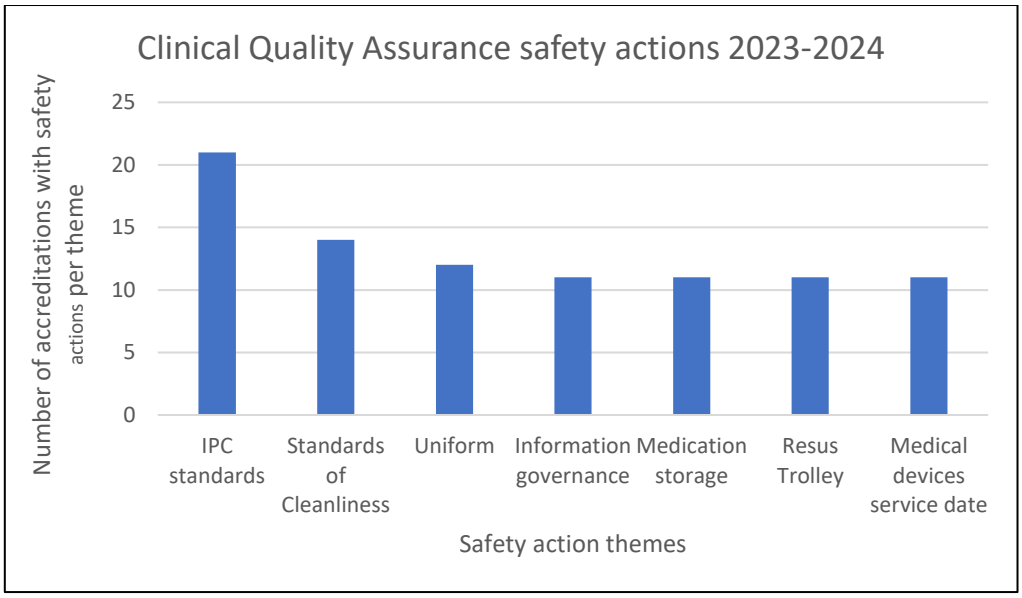
Themes from Safety Actions 23/24

4.9. During the Clinical Accreditations, safety actions identified that could be addressed immediately or within 72 hours were provided in the form of a safety action plan. The top three safety action themes were, standards of cleanliness, uniform standards not being adhered to and medication fridge/freezer temperature monitoring (**Graph 8**). For reference, the top three themes identified in 22/23 were IPC and cleaning standards, risk assessment completion and medication process.



Graph 8: Demonstrates the themes identified as Safety Actions in the Clinical Accreditation Programme 2023-2024.

4.10. During the Clinical Quality Assurance visits Safety Actions were also implemented. Seven common Safety Action themes were identified with the top three relating to IPC standards, standards of cleanliness and uniform standards not being adhered to (**Graph 9**).



Graph 9: Demonstrates the themes identified as Safety Actions in the Clinical Accreditation Programme 2023-2024.

White Areas

4.11. A white area indicates the area accredited is not achieving minimum standards and has no identifiable evidence of active improvement within one or more standards.

4.12. During the 23/24 Clinical Accreditation process, no areas were identified as White compared to 22/23 when 4 areas were preliminary identified as White.

4.13. In the 22/23 accreditations 4 areas were identified as white, these include A&E at MRI, F4 NMGH, Theatres NMGH and OPAL House WTWA. Following a comprehensive White Area Package, these areas went on to be reaccredited as Bronze later during 22/23. The areas then achieved 3 Silvers (F4 NMGH, Theatres NMGH and OPAL house) and bronze (MRI ED) awards in the 23/24 Clinical Accreditation Programme evidencing the benefits of the white area package.

5. Challenges of 2023-2024 Process

5.1. In response to the increase in areas to be assessed the introduction of the Clinical Quality Assurance visit was implemented. This allowed more areas to be assessed within the agreed time frame.

5.2. Clinical Quality Assurance visits were led by Heads of Nursing or Midwifery (HoN/HoM) who had exposure in leading Clinical Accreditations in 22/23, allowing for versatility around capacity.

5.3. Unlike Clinical Accreditations, the Clinical Quality Assurance were presented at validation by the Quality Improvement (QI) Manager who had attended the review.

5.4. To mitigate the variation and subjectivity, the QI team undertook a rigorous process of standardising the questions and scoring matrix. This allowed for a more streamlined and succinct validation process.

5.5. The areas continued to use the CIVICA platform for collecting QCR, WMTM and FFT. The use of HIVE allowed triangulation of observations on the day with the data to ensure a less subjective and robust scoring of standards.

6. Validation

6.1. Validation is an integral part of the Clinical Accreditation process in ensuring consistency of results awarded. The meetings are chaired by the Corporate Director of Nursing for Quality and Patient Experience. In their absence or for their own presentation of a Clinical Accreditation, the Deputy Chief Nurse or Corporate Director of Nursing for Workforce and Education will chair the meeting.

6.2. All validations were completed by January 2024 following the final Clinical Accreditation in December 2023.

6.3. The average number of days between Clinical Accreditation to validation during the 2324 programme was 19 days. This demonstrates an improvement of 15% compared to 28 days during 22/23 against the SOP standard of 14 days (**Table 4**).

April 2023 – January 2024	SOP Standard	Average number of days 2022/23	Average number of days 2023/24	Met the SOP Standard 2022/23	Met the SOP Standard 2023/24
Clinical Accreditation to Validation	14	28	19	32%	47%
Clinical Quality Assurance to Validation	14	n/a	11	n/a	72%

Table 4: Demonstrates the time taken from Clinical Accreditation/Clinical Quality Assurance in relation to the SOP.

6.4. In 22/23 the areas received their validated results from the Clinical Accreditation Lead on average within three days of the validation. However, in 23/24 the validated results were emailed by the QI Manager within 24 hours of validation.

6.5. In 23/24 there were 47 postponed validations compared to 96 in 22/23. The main reason for postponements were changes in availability, only 1 validation could not be completed on the day due to lack of detailed narrative, compared to 7 during the 22/23. Four validations were rebooked due to time constraints on the day compared to 10 in 22/23.

7. Review of the Clinical Accreditation process

Stakeholder Engagement feedback

7.1. Utilising Improving Quality Programme (IQP) methodology, the Corporate Nursing and QI Team, reviewed the 23/24 Clinical Accreditation process based on observations and feedback from numerous stakeholders. These included Clinical Accreditation team members, ward managers and NMAHP colleagues across the Trust.

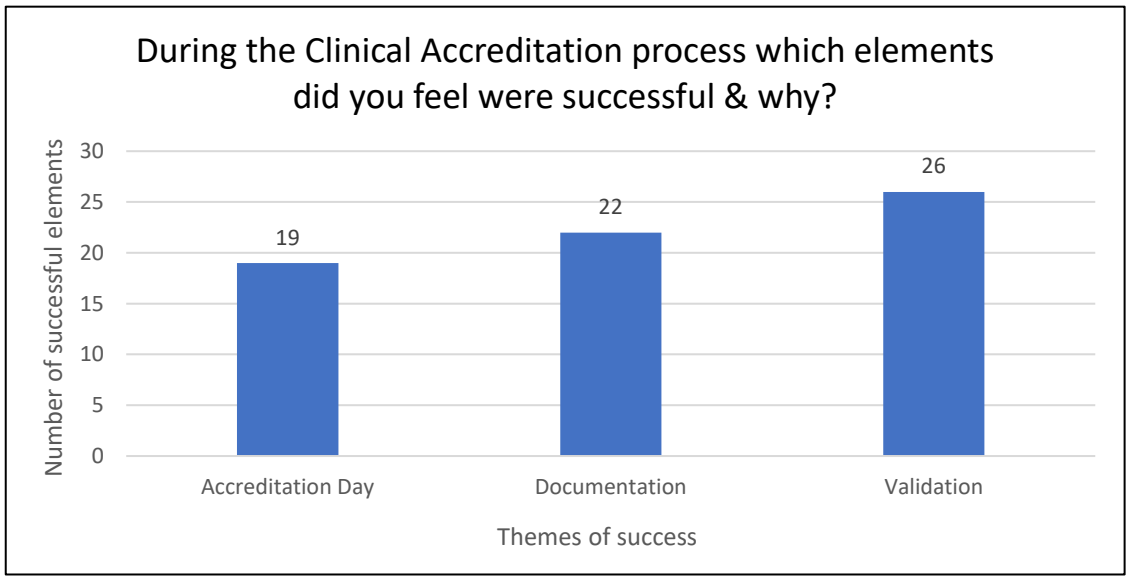
7.2. The QI Team used Survey Monkey to engage with ward managers and their teams subject matter experts and all members of the Clinical Accreditation team to gain feedback on their experience and areas for improvement for the Clinical Accreditation and Clinical Quality Assurance process. The feedback is demonstrated in **Wordle 1.**

Wordle 1: Demonstrates the key themes from ward managers and their teams regarding their experience of their Clinical Accreditation/Clinical Assurance review.

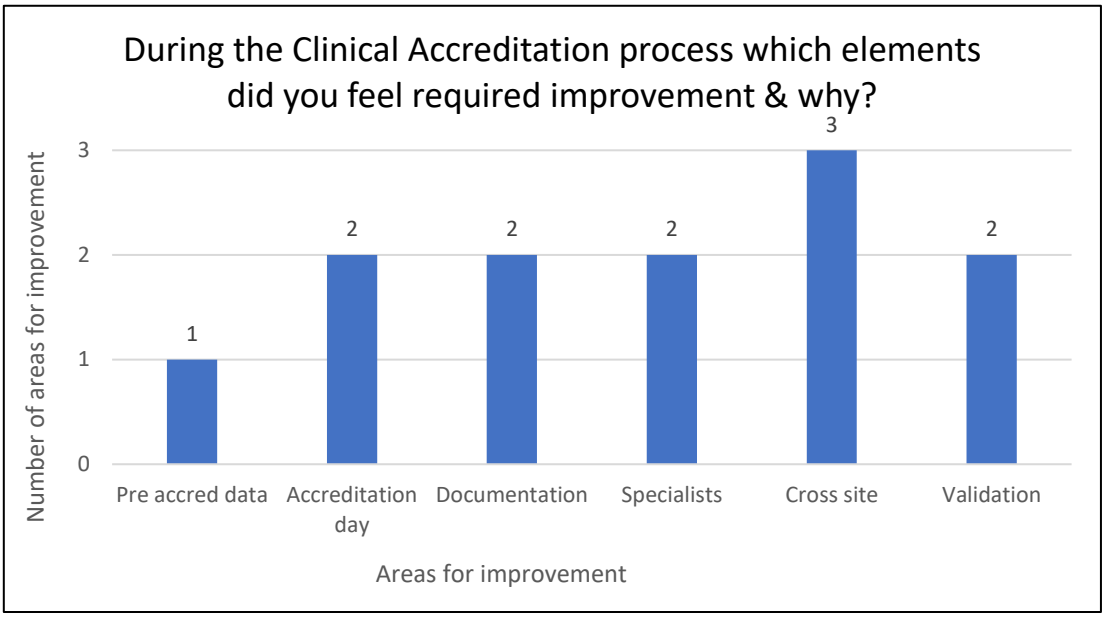
7.3. Feedback was also received from a variety of patients to highlight what they felt would be appropriate for the Clinical Accreditation teams to focus on during Clinical Accreditations and how they would like the information to be obtained. Patients felt that the questions used in during the Clinical Accreditation process 23/24 were relevant, feedback suggested that they liked the fact that the views of patients were obtained on the day of the visit.

Clinical Accreditation Stakeholder Feedback Themes

7.4. The QI Team used Survey Monkey to engage further with subject matter experts and all members of the Clinical Accreditation and Clinical Quality Assurance teams to gain further feedback on their experience and areas for improvement for the Clinical Accreditation and Clinical Quality Assurance.



Graph 10: Demonstrates theme of areas of success from stakeholders 2023/24.



Graph 11: Demonstrates themes for areas for improvement from stakeholders 2023/24.

7.5. Key themes of success indicate that the Clinical Accreditation teams valued the Clinical Accreditation visits and the narrative/documentation being completed on the same day which assisted in the ease of completion. Additionally, feedback gained suggested stakeholders preferred the revised validation process. They also preferred the changes in documentation which reduced subjectivity when scoring (**Graph 10**).

7.6. The QI team recognise the disparity in feedback responses in relation to successes and areas for improvement. Feedback was collated using free-text boxes. It was helpful to receive positive feedback however the team recognise the need for constructive feedback to continually improve the accreditation and assurance process. In response to this the QI team have developed an alternative feedback form for the 24/25 visits to include a key focus on areas for improvement.

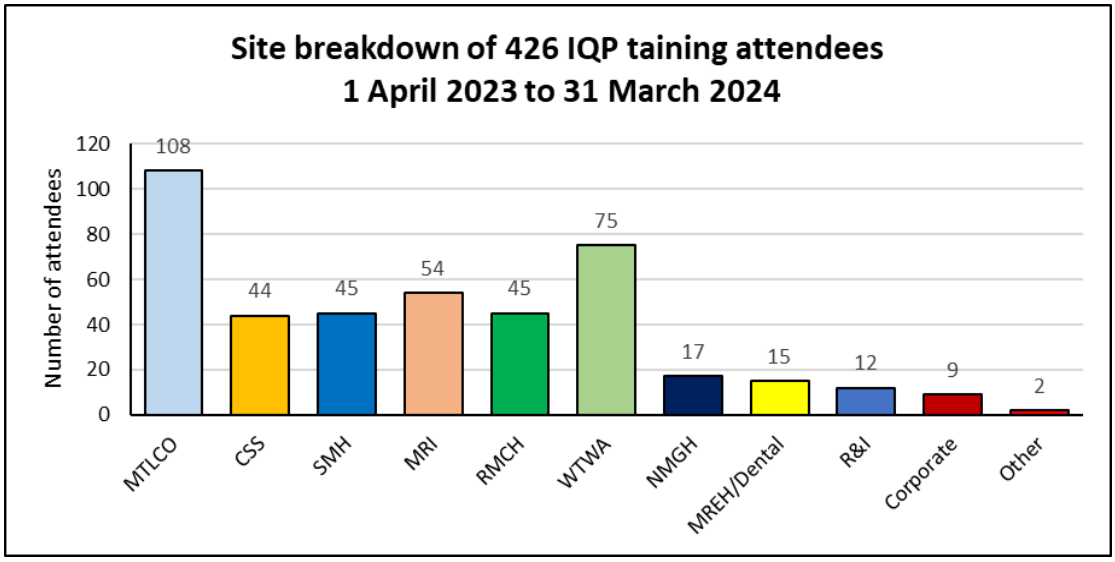
7.7. Key themes of improvement indicate that the Clinical Accreditation teams feel that further improvement is required regarding bespoke cross site documentation and review of the plan of the day (**Graph 11**).

7.8. The Quality Improvement team met with Clinical Accreditation Leads to obtain feedback as demonstrated in **Wordle 2** and provided recommendations based on experiences of the Clinical Accreditation and validation process.

Wordle 2: Demonstrates the key themes of success generated from the Clinical Accreditation leads engagement session.

8. Education and Training

8.1. Gaps in IQP knowledge across the organisation were highlighted during the 23/24 Clinical Accreditation, the QI Team have continued focused IQP training across all sites within MFT in 23/24 and delivered training to 426 members of staff (**Graph 12**), which is 54% increase from 22/23.



Graph 12. Demonstrates IQP training delivered across MFT.

8.2. Following IQP training, a roving support programme was commenced in November 2023 to support staff with their IQP projects. This was well received by the staff and their managers,18 areas received roving support in 2023 across MFT.

8.3. To equip more staff with IQP knowledge and skills, a total of 8 bespoke face to face IQP sessions were provided across different departments in 23/24.

8.4. Five online IQP sessions were also provided in collaboration with the Matron Matters Programme and Team Leader/Senior Clinicians programme.

8.5. Regular meetings with MFT Quality Leads by the QI team continued in 23/24 to encourage shared learning and ensure standardisation of quality improvement and that relevant information is cascaded to enhance information, learning and development.

9. Changes to the Clinical Accreditation and Clinical Quality Assurance Programmes

9.1. Following analysis of the data obtained from the engagement sessions and feedback survey, changes were proposed to the Clinical Accreditation process in readiness for the 24/25 Clinical Accreditation Programme.

9.2. One of the key changes was to ensure increased subject matter expert involvement in Clinical Accreditation to ensure appropriate skills and knowledge base included within the teams.

9.3. The MFT Clinical Accreditation process has been reviewed to align to the new Care CQC Single Assessment Framework incorporating the 'I' and 'We' statements in the new documentation.

9.4. The revised process includes alteration of the Clinical Accreditation scoring process to align to the new CQC scoring matrix.

9.5. To ensure the Clinical Accreditation team are meeting expected MFT standards the Lead of the Clinical Accreditation will ensure all team members are adhering to professional standards for compliance, professional practice and upholding MFT Vision and Values. A new escalation process has been implemented to support the Lead of the Accreditation; this is documented in the revised SOP.

9.6. All questions in the three domains of the Clinical Accreditation calculator have been reviewed and updated with engagement from the relevant subject matter experts. The subjectivity within the scoring has been removed with more focus on evidence on the day, triangulation of data and clinical judgement.

9.7. To improve efficiency the data will be prepopulated and scored automatically in the Clinical Accreditation Calculator prior to the visit. This will ensure a fair and consistent scoring process and aid an efficient validation.

9.8. The plan of the day has been amended to include details of expectations of each team member. A change within clinical effectiveness to include discussion with the staff prior to the ward manager to ensure efficient triangulation of staff and manager feedback during the accreditation visit.

9.9. The data analysis is now completed after the initial observation to remove bias and incorporate an improved triangulation of observation, data, and HIVE reports.

9.10. The portfolio will remain unchanged in 24/25 with a plan to redesign it for 25/26 with focused stake holder engagement and efficient utilisation of Power BI and Hive reports.

A PowerPoint with audio guide will be added to the portfolio channels for the Accreditation Team to utilise.

9.11. An interactive Prezi© IQP board also will be added in the portfolio channels to provide further guidance on improvements and Quality board standards.

9.12. Meal process observation will be amended to align with the new Mealtime Standards.

9.13. For cross site/joint areas, an overall score will be given to the area/service. In addition, and as agreed by the Director of Nursing/Midwifery, the breakdown and score of each area will be visible to assist in identifying areas of good practice and those which require focus.

9.14. To improve the timescale of Clinical Accreditation to areas receiving their result the date of validation will be automatically populated into the diary of the Clinical Accreditation Lead within 14 days of the Clinical Accreditation visit date (subject to change as required).

9.15. Validation of Clinical Quality Assurance will be undertaken by a QI manager and will occur the following week (every Monday) after the visit.

9.16. For Cross site/joint Clinical Accreditations all deputy leads will be expected to attend the validation to support the Clinical Accreditation Lead.

9.17. All Clinical Accreditation team members will be invited and encouraged to attend validation meetings as an opportunity to gain experience and support the process.

9.18. Additional Clinical Quality Assurance within the LCO, that do not fall within the scope of the Clinical Accreditation Programme will be undertaken as peer reviews within LCO. These will be completed using the provided Clinical Quality Assurance documents.

9.19. Bespoke Clinical Accreditation and Clinical Quality Assurance Calculators will be developed to incorporate standards of specialised areas.

9.20. The Clinical Quality Assurance Calculators are to be redesigned to replicate the current LCO calculator which has less subjectivity and has proved efficient in trials with less subjectivity, duplication, and improved consistency in scoring.

9.21. The new scoring system will calculate the total score of each domain, using the new CQC scoring range with the percentage also visible. The front page of the calculator will appear as shown below (**Table 5**).

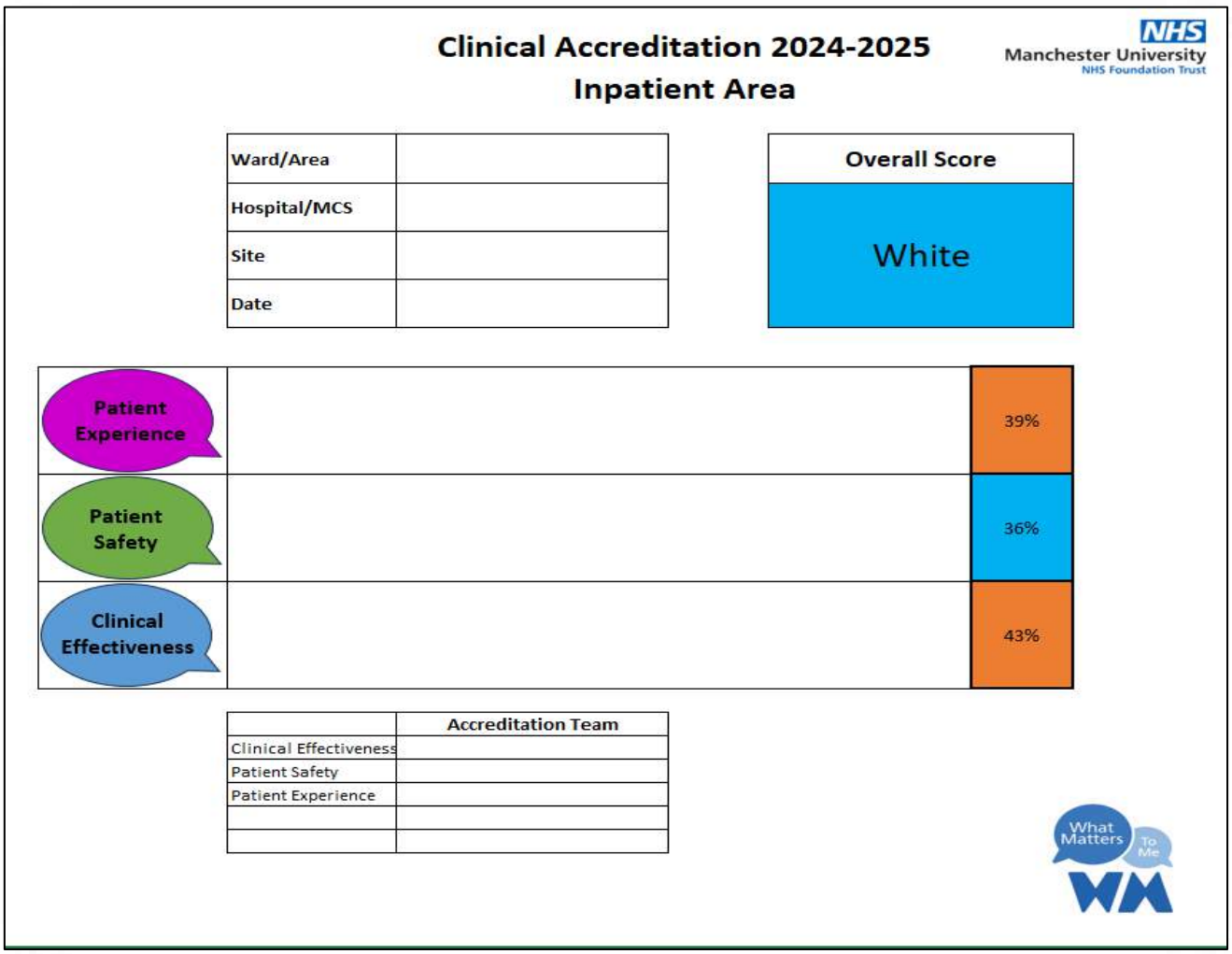


Table 5 Front sheet of the Clinical Accreditation Calculator 20224/2025

10. Next Steps

10.1. There is a clear correlation between the knowledge of IQP methodology, leadership, and the Clinical Accreditation and Clinical Quality Assurance outcome. The IQP team plan to continue to deliver IQP masterclass training to wards and departments to ensure quality improvement methodology is accessible to address areas of improvement identified during the programme.

10.2. The IQP roving programme will continue to deliver individualised support to areas throughout their IQP projects, celebrate successes and identify opportunities to share good practice.

10.3. In addition to identifying areas for improvement, the Clinical Accreditation Programme offers opportunities to celebrate success in the form of “Sparkles of Excellence” to highlight areas of exemplary practice.

10.4. The Clinical Accreditation SOP has been updated to reflect changes made to the Clinical Accreditation process for 24/25.

11. Summary

11.1. The Clinical Accreditation programme for 23/24 successfully completed 133 Clinical Accreditations and 42 Clinical Quality Assurance.

11.2. The Clinical Accreditation programme has built on the successes of previous years' robust scoring mechanism to ensure consistent and standardised scoring throughout the process.

11.3. The Clinical Accreditation programme continues to grow and evolve based on feedback and current evidence base to provide assurance to MFT and alignment to the national agendas.

11.4. Extensive stakeholder engagement during the 23/24 programme has further developed the Clinical Accreditation Programme going forward into 24/25. The data collated in the Accreditation & Assurance visits together with patient feedback, complaints/PALS concerns and national surveys provides an evidence base for continued service improvement. This allows the team to provide the Board of Directors with an effective quality assurance mechanism.

12. Conclusion

12.1. The Board of Directors are requested to note the content of this report and the ongoing work to ensure that the MFT Clinical Accreditation Programme provides an effective assurance mechanism for ensuring high-quality care and the best possible patient experience.

Agenda Item 11.7

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 2024
Subject:	Delegation of approval of the Annual Report and Accounts for 2023/24 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 2023/24 and in light of the approval timetable is asked to delegate the authority for the approval of the Annual Report and Accounts for 2023/24 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 2023/24.

Thus, this paper recommends that the Board of Directors approve the delegation of authority for the approval of the Annual Report and Accounts for 2023/24 to the Audit Committee. This authority to delegate was provided for the 2022/23 approval.

Background

The Trust is required to submit approved Annual Report and Accounts for 2023/24 to NHSE by noon, 28th June 2024. 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 2024 meeting of the Audit Committee to inform the Committee of the processes being followed to produce the Annual Report and Accounts for 2023/24. This paper was noted by the Audit Committee and the committee continues to monitor progress in relation to the 2023/24 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 2024.

Recommendation

The Board of Directors is asked to note the work being undertaken by the Audit Committee on the Annual Report and Accounts for 2023/24 and in light of the approval timetable is asked to delegate the authority for the approval of the Annual Report and Accounts for 2023/24 to the Audit Committee.

Agenda Item 11.8

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 and Trust Board Secretary.
Date of paper:	May 2024
Subject:	NHS England Provider license self-certification
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:	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 is asked to approve MFT's Provider License Self-Certifications for Condition CoS7(3).
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 276 4841

1. Background

1.1 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 NHS England uses for regulating providers of NHS services.

1.2 Up until the end of March 2023, all NHS Foundation Trusts were required to self-certify whether or not they have complied with the conditions of the NHS Foundation Trust Licence, with all governance requirements, and have the required resources available if providing commissioner requested services.

1.3 Following a consultation, a new Provider License was introduced from the 1st April 2023. This removed the requirement for Trusts to self-certify that they have taken all precautions to comply with the license and with all required governance arrangements.

1.4 The requirement for Trusts to self-certify against license condition Continuity of Services (CoS) 7 (Availability of Resources) remains.

2. CoS 7 – Availability of Resources

2.1 License condition CoS 7 states:

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

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 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, that the Licensee will have the Required Resources available to it after taking into account 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 which may cast doubt on the ability of the Licensee to have access to the required resources".*
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".*

4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition: "distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; "Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts; "Required Resources" means such:

a. *management resources including clinical leadership,*
b. *appropriate and accurate information pertinent to the governance of quality*
c. *financial resources and financial facilities,*
d. *personnel,*
e. *physical and other assets including rights, licences and consents relating to their use,*
f. *subcontracts , and*
g. *working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.*

3. MFT's CoS 7 self-certification

3.1 In previous years, MFT has self-certified the license's statement B:

"After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account 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 which may cast doubt on the ability of the Licensee to have access to the required resources".

3.2 The rationale for this position was that the designation of MFT services remained at a 'default position' i.e automatic full designation across all services as inherited in April 2103 when Commissioner Requested Services (CRS) principles were first established and all NHS-funded services were 'grandfathered' into CRS status until 31st March 2016 pending a service-line review by commissioners. In the absence of a full and recurrent commissioner review of MFT services since April 2013, this position has remained with the previous Clinical Commissioning Groups', and now Greater Manchester's Integrated Care Board's (GM ICB), view that the current designation provides stability and protection for services. Given this, it would not be meaningful for MFT in isolation to undertake self-certification work across all services

3.3 As the GMICB have not yet carried out service-line commissioner review, it is proposed to adopt the same approach this year and self-certify the license's statement 3b as in 3.1 above. The following reasons will be given for this:

- The current designation of MFT services as Commissioner Requested Services (CRS) continues to be a 'default' position (i.e. automatic full designation, across all services). Commissioners have yet to complete 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 extended this in light of the MFT merger, ongoing SHS and LCO developments. This position has been maintained following the introduction of Integrated Care 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 to ensure consistency across GM. In the meantime, the view is 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.

- Given this position, MFT is unable to fully self-certify, across all services provided, that either Statement A or Statement C is definitive.

4. Recommendations

The Board is asked to approve MFT’s Provider License Self-Certification for Condition CoS7(3).

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 2024
Subject:	MFT Board of Directors' Register of Interests (April 2024)
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 2024)
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 2024).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(April 2024)

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2024

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) • 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) • Chair of the Audit Committee of GB Taekwondo
Nic Gower	Group Non-Executive Director	• No interests to declare

NAME	POSITION	INTERESTS DECLARED
Angela Adimora	Group Non-Executive Director	• Governor, Salford University • Senior Director of HR Operations, UK & Europe for GXO
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
Damian Riley	Group Non-Executive Director	• No interests to declare
Mark Gifford	Group Non-Executive Directors	• Director (non-renumerated) Diocese of Westminster Academy Trust • CEO & Board member National Citizen Service Trust (public body)

NAME	POSITION	INTERESTS DECLARED
Samantha Liscio	Group Non-Executive Director	• No interests to declare

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2024

NAME	POSITION	INTERESTS DECLARED
Mark Cubbon	Group Chief Executive Officer	• Board Member, Health Innovation Manchester • Shelford Group CEO Group member • Director of Oxford Road Corridor • NHS Employers Policy Board member • Co-Chair of the National Organ Utilisation Sub-Group for Trust Engagement. • Chair of the LGBTQIA+ Network NHS Confederation
Darren Banks	Group Chief Strategy Officer	• 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 Deputy Chief Executive & SRO for Hive Programme	• 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	• Chair of Sub-Committee of the National Finance Leadership Council
Toli Onon	Joint Group Medical Director	• No interests to declare

NAME	POSITION	INTERESTS DECLARED
Kimberley Salmon-Jamieson	Group Chief Nurse	• Dormant company / not trading (KSJ Consultancy Ltd)
Vanessa Gardener	Group Chief Delivery Officer	• No interests to declare
David Walliker	Group Chief Digital and Information Officer	• Governor, Ysgol Penmorfa Prestayn • Honorary Chair, Manchester University

Agenda Item 12.1

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 2024
Subject:	Nursing and Midwifery Revalidation Annual Report 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:	1. Patient safety 2. Patient experience 3. Productivity and efficiency
Recommendations:	The Board of Directors are asked to acknowledge the content of this report and the work undertaken to support revalidation for nurses, midwives and nursing associates.
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 2023 to 31st March 2024.

1. 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 Nursing Associates, 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.

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.

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

2. 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.

3.3 To reflect the fact that revalidation is now embedded and is business as usual revalidation compliance is monitored by the Corporate Director of Nursing, responsible for workforce and education, through the Trusts professional registration reporting and monitoring process. A monthly workforce report generated from the NMC register is utilised to inform the Trust's revalidation assurance process. The Hospital/MCS/LCO Directors of Nursing are responsible for monitoring staff revalidation and supporting staff through the revalidation process.

3.4 The revalidation process is managed through the Trust Revalidation Policy.

3.5 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.

3.6 Any 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. Staff Revalidation – 2023/24

4.1 From review of the Trusts professional registration report 2409 nurses, midwives and nursing associates were required to revalidate with the NMC in 2023/24. There have been no lapses of revalidation during this period.

5. Conclusion

5.1 The Board of Directors are asked to acknowledge the content of this report and the work undertaken to support revalidation for nurses, midwives and nursing associates.