MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON MONDAY 15TH JANUARY 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 13TH November 2023 *(enclosed)*

4. Patient Story *(Film)*

5. Matters Arising

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

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

8. Reports from the Board of Directors' Scrutiny Committees

- Audit Committee held on 8th November 2023
- Charitable Funds Committee held on 28th November 2023
- EPR Scrutiny Committee held on 12th December 2023
- Finance and Digital Scrutiny Committee held 19th December 2023
- Quality and Performance Scrutiny Committee held on 19th December 2023
- Workforce Scrutiny Committee held on 20th December 2023

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 M8 *(Report of the Group Chief Finance Officer enclosed)*

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

11. To receive an update on Annual Planning 2024/2025 *(Report of the Group Chief Strategy Officer enclosed)*

12. Governance

12.1 To receive a report on 'Strengthening Leadership, Culture and Engagement at MFT' *(Report of the Group Executive Director of Workforce & Corporate Business enclosed)*

12.2 To receive a Maternity Services update and year 5 Maternity Incentive Scheme (CNST) *(Report of the Group Chief Nurse enclosed)*

13. To approve the Infection Prevention and Control strategy *(Report of the Group Chief Nurse enclosed)*

14. Items for consenting following discussion at Scrutiny Committees

14.1 Freedom to Speak Up annual report *(Report of the Deputy Group Chief Executive enclosed)*

14.2 EPRR statement of compliance *(Report of the Deputy Group Chief Executive enclosed)*

15. Date and Time of Next Meeting

The next meeting will be held on Monday 11th March 2024 at 2:00pm

16. Any Other Business

NHS Manchester University NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 13th November 2023

(PUBLIC)

Main Boardroom, Cobbett House

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

142/23 Apologies for Absence

Apologies were received from Luke Georghiou and Cheryl Lenney

143/23 Declarations of Interest

No specific interests were declared for the meeting.

144/23 Minutes of the Board of Director's meeting held on 11th September 2023

The minutes of the Board of Directors' (Board) meeting held on the 11th September 2023 were approved

All due actions have been completed.

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

145/23 Patient Story

AL introduced a filmed patient story which portrayed the experience of a patient on ward at MRI. He had experienced some issues with noise on the ward but emphasised the kindness and competence of the staff who cared for him.

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

146/23 Matters Arising

There were no matters arising.

147/23 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. They included:

- The decision to hold Board meetings away from the Oxford Road Campus to improve access for a wider range of staff and stakeholders.
- The ongoing conflict in the middle east and the support available to staff affected by it.
- The recent long service awards events.
- Recognition of the contribution of overseas staff, with two of MFT's overseas staff having been invited to a royal reception.
- MFT's Charity's Carols in the City event being held on the 14th December.

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

148/23 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 development of MFT's new organisational strategy informed by presentations from a range of external experts.
- The recent improvement in some operational performance metrics with more detail being available in the Integrated Performance Report.
- The impact of the recent industrial action. There are no future periods of industrial action planned currently.
- The steady progress being made to improve MFT's financial position with more detail available in the Group Chief Finance Officer's report.
- The recent successful recruitment of a new Group Chief Nurse and a Group Chief Digital and Information Officer. The recruitment process for a Group Chief Delivery Officer is currently underway.
- A recent workshop looking at violence, aggression and sexual assault where front line workers described their experiences and actions required to improve the current situation.
- The Winter Plan which will be discussed later in the meeting.
- MFT's NIHR bid to have formal designation as Healthtech Research Centre has been successful. It will be formally announced later in the day.

- A letter has been received from NHS England (NHSE) with regard to 2023/24 financial plans. MFT are reviewing their plans in light of it and will respond to NHSE within their deadline.

MG described a recent Senior Leadership Walkround where staff had described that they felt they were being listened to and had given, as examples, the work on food provision, and violence and aggression. KC noted that staff members had provided similar feedback at a Lime Arts event last week.

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

149/23 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.

Audit Committee held on 13th September 2023
NG, the Committee Chair, highlighted:

- External auditors had no substantive item on the agenda due to the time of the year.
- Internal audit reports on insourcing and nursing/midwifery recruitment were received with both showing a need to ensure that relevant policies are adhered to.
- Counter fraud had nothing significant to report.

Charitable Funds Committee (CFC) held on 13th September 2023 and 26th September 2023 Highlighted:
KC, the Committee Chair, highlighted:

- The challenging circumstances faced by the Charity following the pandemic were discussed.
- The value of the Charity's investment funds have reduced but this is forecast to be a temporary position.
- The Charitable Funds' annual report was approved.
- There was £904K expenditure on charitable activities between the 31/5/23 and 30/8/23.
- A Charity strategy day was held and a development plan is currently being worked upon. Actions will include the reinstatement of the Fundraising Board.
- Fundraising for the National Breast Imaging Academy at Wythenshawe Hospital has begun.

EPR Scrutiny Committee (EPRSC) held on 27th September 2023
GB, the Committee Chair, highlighted**:**

- The Hive programme remains in the stabilisation phase
- Any unplanned downtimes to Hive had been successfully responded to, with lessons being learned to prevent future incidents.
- Benefits realisation from Hive is ongoing.
- The Outpatients Hive Delivery Chair presented to Committee regarding improvements delivered, noting that clinical leadership was at the fore in their work and Quality Impact Assessments (QIAs) were conducted in advance of any changes.
- A patient journey was presented which identified progress made from presentation to discharge with the potential of further opportunities to improve.
- Deloitte will provide one further review to provide the programme and the Committee with external assurance.

JE explained that 1300 patients have been able to reschedule appointments following the introduction of 'ticket scheduling'. She added that there had now been just short of 300,000 sign-ups to the MyMFT app.

Strategic Projects Scrutiny Committee (SPSC) held on 18th October 2023
TR, on behalf of Committee Chair LG, highlighted**:**

- As it was the first meeting of SPSC, the terms of reference, purpose, scope and work programme for the Committee were discussed.
- An update on the NMGH redevelopment programme was received.
- MFT's range of PFI programmes was discussed, including opportunities and risks.
- MFT's strategic alliances, including Bruntwood, were presented to the meeting.

Workforce Scrutiny Committee (WSC) held on 24th October 2023
AA, the Committee Chair, highlighted:

- A staff story regarding violence in workplace – on average three members of MFT staff are assaulted every day.
- Increasing incidence of staff absence due to illness.
- The reason for the growth in staff costs during this financial year.
- Mandatory training compliance is rising.
- The results of a review of the Employee Health and Wellbeing service and future actions.
- The continuing positive relationship with staff side within the context of recent industrial action.

Quality and Performance Scrutiny Committee (QPSC) held on 24th October 2023
DR, the Committee chair, highlighted:

- A presentation from a clinical team on their learning and actions following a Never Event
- A report on potential harm to patients due to long waits. There has been no evidence of harm so far.
- A rise in the incidence of some healthcare associated infections.
- Progress made in delivery of MFT's health inequalities programme.
- Support for the Trust's draft Mental Health and Carers strategies.
- At the next meeting, a deep dive into the medicines' safety risk will be undertaken.

Finance and Digital Scrutiny Committee (FDSC) held on 31st October 2023
TR, the Committee Chair, explained a further meeting had been held since the report included in the Board papers. From that meeting (31/10/23), he highlighted:

- An in-depth discussion on the Trust's financial position, as covered by JEh's report later on the agenda. This included the reasons for the increase in staffing costs in Months 4 and 5 this year.
- Progress with delivery of the 2023/24 waste reduction programme (WRP) and planning for 'Value for Patients, the re-branded 2024/25 programme.
- Current cyber security risks.

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

150/23 Integrated Performance Report (IPR)

AL explained that the actions within the IPR had been considered at the relevant Board Scrutiny Committees.

TO introduced the 'Safety' section of the IPR. She highlighted:

- The new PSIRF policy and the agreement of plans for each Hospital, Managed Clinical Service and LCO.
- The continued focus on eliminating Never Events through a focus on human factors.

From the 'Effectiveness' section, TO highlighted:

- There would be a review of the 'Effectiveness' metrics to enable better insight.
- The assurance provided by the 'Learning from Deaths' report and the work required to improve further including meeting with the GM coroners to develop better joint working arrangements.

From the 'Caring' section, AL highlighted:

- The ongoing triangulation of patient experience information to identify positive areas and those where further work is required. The latter include improving medication provision and communications with patients.
- There is a focus on improving food provision this week to coincide with the national 'Malnutrition Week.'

JB introduced the 'Operational Performance' section of the IPR and highlighted:

- The impact of the recent industrial action on performance
- The 62 day cancer backlog is down to 338
- The aim is to meet the faster diagnosis 75% target by year end with the potential of further funding from GM Cancer to support delivery.
- The need to reduce the overall size of the waiting list in order to meet the 78-week and 65-week targets for this financial year. Increased use of Trafford Elective Hub is key to this and theatre productivity there is currently 82%.
- Urgent and Emergency care performance has been better than the national average in September but there has been increased demand throughout October. External support, including from Newton Europe, has been helpful to identify potential improvements. Consistent delivery is required across all MFT's hospitals.

CM praised the work of the Trafford Elective Hub following the Board members' tour prior to the meeting starting.

AA commented that the 21 metrics being monitored for operational performance, and the plans in place where delivery was not in line with forecast, provided confidence for the delivery of the end of year targets.

In response to a question from TR regarding whether the focus on long waiters was disadvantaging others, JB explained that a balance is being struck with clinical prioritisation a fundamental part of decision making.

In response to a point from AA regarding patient choice, JB explained that patient choice is facilitated where possible and there are a number of patients who are keen to be on 'short-notice' waiting lists.

PB introduced the 'Workforce' section of the IPR and highlighted:

- The 12.6% target for staff turnover has been met
- Appraisal compliance is static and will continue to be monitored through Workforce Scrutiny Committee

AL explained that the compliance target for level 2 safeguarding training has been achieved. Oliver MacGowan training will be introduced from December

KC agreed for the 'Finance' section of the IPR to be discussed during the next item on the agenda.

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

151/23 Group Chief Finance Officer's Report M6

JEh presented MFT's financial position as at Month 6 2023/24 and reminded the Board that the 'best case' forecast for 2023/24 was breakeven with the 'most likely' case currently a £50m deficit. Both the 'best' and 'most likely' cases assume a national funding mechanism is agreed for costs and lost income related to Industrial Action which to date has not been confirmed.

JEh highlighted:

- The breakeven plan relies on achieving an historic high WRP target of £136.4m, which currently poses an estimated financial risk of circa £20m to the Trust. At the end of October, £117.5m had been identified. Quality Impact Assessments are conducted for all relevant schemes.
- Year to date the Trust is £6.3m (4%) behind the ERF plan. Within this position the impact of industrial action in the financial year is a loss of c£7m of activity, therefore without industrial action the Trust would be marginally ahead of plan.
- At the end of September, the Trust has delivered a deficit of £65.2m against a planned deficit of £28.2m, being adverse by £36.9m YTD. This reflects an in-month deficit for September 2023 of £12.7m which is driven primarily by a change in NHSE guidance to report actual delivery against the elective plan.
- MFT's cash balance is £132m at the end of September. FDSC is monitoring the cash position closely.
- For month 7, MFT achieved a £2.8m surplus against forecast.

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

152/23 MFT's Winter Plan, including the Covid-19 Vaccination programme and Flu Vaccination programme

JB introduced the report which detailed MFT's Winter Plan for 2023/24. The plan prioritises patient safety with staff wellbeing a key element of the plan. It has been discussed and supported at Operational Delivery Board, Executive Director Team Committee (EDTC), and QPSC.

JB highlighted:

- COVID remains a key issue to contend with.
- The importance in managing healthcare-associated infections.
- The surge plans in place to manage peaks in demand.
- The ramping up of the Hospital@Home programme.

DR commended the plan and confirmed the support of the QPSC. He welcomed the flexibility of the plan and noted that the most challenging period would be over Christmas and into the new year. He agreed with KC's suggestion for QPSC to consider the Hospital@Home programme at a future meeting.

DB highlighted the ongoing discussions with system partners regarding a more co-ordinated approach to winter planning. Next year, the aim is to have a single, system-wide winter plan.

MC highlighted the importance of support the health and wellbeing of staff working within urgent and emergency care pathways; EDTC's work to develop a process for monitoring risk in Emergency Departments; and the benefits which will come from the introduction of the single Electronic Bed Management System across MFT.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the approach and process for the development of MFTs 2023/24 Winter Plan.	Hospital@Home programme to be considered at a future QPSC meeting.	JB	February 2024

153/23 Update on the MFT strategic developments

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

- The new statutory guidance setting out how the Provider Selection Regime, the new rules governing the procurement of healthcare services in England, will be applied. DB welcomed the changes.
- The proposed operating model for Greater Manchester ICB which includes the identification of commissioning responsibilities and system and locality levels.
- The expansion of the Targeted Lung Health Checks Programme and MFT's work to develop the business case which addresses the estate, workforce, diagnostic and treatment requirements to ensure a detailed transitional plan is in place to launch extended lung cancer screening services across GM.

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

154/23 Mental Health Strategy

AL introduced the report which presented MFT's proposed Mental Health Strategy. She explained that it was an all-age strategy which had been developed in collaboration with a wide range of partners and stakeholders. There had been a rigorous discussion of the strategy at QPSC and implementation will be overseen by the Mental Health sub-group.

DR confirmed that QPSC was recommending the strategy for Board approval.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board approved MFT's Mental Health Strategy	None	n/a	n/a

155/23 Carers' Strategy

AL introduced the report which detailed the proposed approach to improving support for carers. It has been developed with partners and stakeholders and there is a plan in place to deliver the strategy. The aim is to launch the strategy on Carers Rights Day on the 23/11/23.

DR confirmed the support of QPSC for the Strategy. He noted the need for the Carers' Strategy to dovetail with other existing strategies and the opportunity to link with primary care to ensure early identification of carers.

AA noted that both the Mental Health and Carers' strategies needed to consider the requirements and experiences of staff.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board approved the Carers' Strategy	None	n/a	n/a

156/23 Amendments to the Standard Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)

JEh introduced report which proposed changes to MFT's SFIs and SORD for approval and explained that they had been considered at CFC and the Audit Committee

NG confirmed that the Audit Committee recommended the amendments for approval by the Board.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the amendments to SFIs and SORD.	None	n/a	n/a

157/23 Patient Experience report

AL introduced the report which presented a triangulated picture of patient experience across the Trust including information taken from PALS concerns, complaints, feedback from the Friends and FFT, patient surveys, 'What Matters to Me' (WMTM) and the Clinical Accreditation process.

AL highlighted:

- The increase in response rates from WMTM and FTT surveys
- Waiting times/lists are a theme from the WMTM surveys. Work is ongoing with services to improve communication with patients while on a waiting list or waiting in Emergency Departments and how to stay healthy while on a waiting lists. JE added that there is work to identify how MyMFT can be used to keep patients updated as to progress with their treatment.

In response to a question from KC regarding complaints not being resolved at the first attempt, AL explained that the Patient Experience team were holding sessions with complaint responders to improve the content and consistency of responses. These sessions are targeted at teams/services where there appear to be issues. NG added that there are a relatively small amount of complaints which are reopened and there are reasons why this may happen that aren't down to management actions.

MG commended the contents of the report, highlighting the Bee Brilliant initiative. In response to his question regarding the theme of pain management, AL explained that medication provision for patients was being looked at, particularly in RMCH where parents are reporting issues on behalf of their children.

AA noted the link between Bee Brilliant and the Dignity at Work policy and AL confirmed that the connection had been made.

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

158/23 Bi-annual Safer Staffing report

AL introduced the report which detailed the Trust's position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 20161 , and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance , published in October 2018.

AL highlighted:

- The current vacancy levels for nurses and midwives and the current recruitment campaign to address them.
- The Birthrate+ programme.
- The range of work underway to improve the health and wellbeing of staff.
- A review of the Nursing, Midwifery and Allied Health Professions strategy which is being informed through discussions with staff.
- 98% of areas across the Trust met the standards within the safe nurse staffing tool.
- The support provided by by senior nurses, midwives and AHPs for teams under pressure.
- Work considering the optimal skill mix within teams.
- The pipeline of midwives into the Trust.
- The potential of Professional Nurse Advocates.

PB confirmed that the report had been discussed at WSC.

CM stated that the Trust should be proud its international recruitment system. Discussions at a GM level have shown that other organisations could learn from MFT's approach. KC asked for an item on international recruitment to come to a future WSC meeting

JEh confirmed that she and DB had had discussions with GM ICB regarding funding Birthrate+.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report.	Report on international recruitment to come to a future WSC meeting	CL	February 2024

159/23 Learning from Deaths Annual report

TO introduced the Learning from Deaths annual report which summarised the key learning identified from mortality review completed for 2022/23. MFT's policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring. The report has been considered in depth at QPSC.

TO highlighted:

- The robust medical examiner process in place at the Trust and the role they play in the review process.
- The work to align the process with the Structured Judgement Review tool.
- The way the report is formatted by site but learning will be amalgamated and used across the whole Trust.
- Ongoing work with MFT's legal team to refine the policy for contributing to inquests to ensure consistency across the Trust.

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

160/23 Action on health inequalities at MFT

JE introduced the report which introduced report which described progress being made on the health inequalities agenda across the Trust.

JE highlighted:

- The characteristics of the local population and the identified impact of language and deprivation on outcomes.
- The work underway between the LCOs and primary care to analyse the data regarding DNAs for bowel and breast screening.
- An audit of data sent to GPs identifying high HbA1c patients to see if patients have been followed up in primary care.
- The Health and Wellbeing strategy and how it is helping staff by providing opportunities for health checks and promoting opportunities for financial advice and support.
- A request from the respiratory team to begin recording data regarding the presence of damp in patients' homes on Hive.
- The next iteration pf the dashboard will include a focus on DNAs in cancer care.

PB commended the report and explained how staff have been responding very positively to the developments described by JE. Uptake of the rewards and benefits offer to MFT staff is increasing and staff are powerful advocates for the benefits available. JE agreed and noted that there were plans to extend the extension of the Citizens Advice service to the NMGH and Wythenshawe sites.

MG noted the role MFT can play in influencing public policy through use of the data available to the Trust. AA agreed, highlighting the changing shape of the communities MFT serves and the power of the data to inform the ways services evolve.

JE described how the data has led to a greater offer of evening appointments across MFT.

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

161/23 Research and Innovation Annual report

JE introduced MFT's Research and Innovation Annual Report for 20223/23. She drew attention to the highlights listed on pages 317-319 of the Board pack including the example of the 'Flash' blood glucose monitoring which now features in NICE guidance. She described the ongoing work to increase capacity and capability within MFT to contribute to the work and explained that an announcement regarding the hosting arrangements for the Northwest Research Delivery Network is expected later on in the week. Funding for MFT has increased from the CRF and doubled from the BRC. MFT also led on the Innovation Accelerator initiative for GM.

KC highlighted the role which the MFT charity has played in supporting research and innovation activity including one donor providing funding for sic research posts.

MC welcomed the report, noting the breadth of activity which MFT delivers and the opportunity to use that capacity and capability to address some of the more significant challenges currently being faced.

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

162/23 MFT Board of Directors' Register of Interests (October 2023)

PB presented the Register if Interests for Board members.

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

163/23 Board Assurance Framework

PB introduced the report which presented the latest Board Assurance Framework (BAF). He drew attention to the controls, mitigating actions and sources of assurance for each principal risk and noted that it had been presented to the Audit Committee the week before the Board meeting.

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

164/23 Group Risk Oversight Committee Terms of Reference

TO introduced the report which presented amended terms of reference for the Group Risk Oversight Committee.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the terms of reference	None	n/a	n/a

165/23 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 15th January 2023 at 2:00pm

166/23 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: 13th November 2023		
Action	Responsibility	Completion date
Hospital@Home programme to be considered at a future QPSC meeting.	JB	February 2024
Report on international recruitment to come to a future WSC meeting	CL	February 2024

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

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

Agenda Item 7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Executive
Paper prepared by:	Mark Cubbon, Group Chief Executive
Date of paper:	January 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 Development

Work continues to develop the organisational strategy for MFT with extensive engagement work underway with both internal colleagues and external stakeholders. We have benefitted from the insights of external speakers who were invited to share their views on key issues and opportunities that the strategy may need to consider. During November and December, we welcomed Dr Jennifer Dixon (Chief Executive, The Health Foundation), Professor Dame Helen Stokes Lampard (Professor of GP Education, Birmingham Medical School), Dr Habib Naqvi (Chief Executive, NHS Race and Health Observatory), Professor Bola Owalabi (Director, Health Inequalities NHS England). Discussions covered a wide range of topics from health and racial inequalities to artificial intelligence and population health trends.

Colleagues from across MFT have been joined by representatives from patient groups and the wider health and care system, including the voluntary, charitable and social enterprise sector, in a series of reference groups that have helped to develop the strategy and bring different perspectives. Further engagement will take place in January and February before the strategy is finalised ahead of the March Board meeting.

Further details of the development of the Trust's organisational strategy will be provided by the Group Chief Strategy Officer later on the agenda.

National Institute for Health and Care Research (NIHR)

MFT has been awarded the hosting of the new NIHR North West Regional Research Delivery Network (NW RRDN) from 1 October 2024. The network will provide strategic funding for health and care research delivery, such as Clinical Research Nurses, and supports a network of research leadership within medical specialties and other areas. One of 12 regional RRDNs which form part of the national NIHR Research Delivery Network, NW RRDN will merge a wealth of expertise and experience from the existing NIHR Greater Manchester and North West Coast Local

Clinical Research Networks to form a single service covering the whole region of more than seven million people.

MFT has been awarded almost £3m from the NIHR to create the NIHR Manchester University NHS Foundation Trust HealthTech Research Centre (MFT-HRC). One of 14 new HRCs across England, MFT-HRC will transform urgent and emergency care by developing new technologies for the detection, diagnosis and monitoring of disease, and embedding these technologies to shape the future of health and care services. The MFT-HRC builds on the success of our Diagnostics and Technology Accelerator (DiTA) which was established in 2018 with the support of the MFT Charity. A core principle of the work is to ensure these health technologies benefit the diverse populations of Greater Manchester and the wider UK and are effective regardless of an individual's background or personal circumstances.

Hospital at Home

The development of our Hospital at Home service provides a key aspect of our plans to mitigate the increased pressures we see on our Emergency Departments and acute wards throughout the winter period. The service enables more effective utilisation of our virtual ward capacity, helping us discharge patients to community settings earlier whilst maintaining effective clinical oversight for their continuing care. For our patients, being cared for in their own home environment provides an improved experience and quality of live.

We continue to expand the service across our hospital sites and local communities. Alongside the team supporting Manchester Royal Infirmary, an additional service is now operational at North Manchester General Hospital and additional community-based capacity has been put in place to support Wythenshawe Hospital ahead of a full launch.

Evaluation of the work so far indicates the service is providing capacity equivalent to 70 Hospital beds in the community per month, increasing to around 120 per month by the end of March 2024. This provides a safe alternative to caring for people in hospital, crucial to help reduce occupancy levels at our sites which has increased by 3% since April 2023. We plan to continue to build capacity during the next financial year, subject to ongoing evaluation of the impact and benefits of the service.

Alongside the additional capacity we are also seeing improvements in patient outcomes for those using the service; between 85% to 90% of the patients referred to Hospital at Home remain at home after discharge rather than returning to hospital. The team are now working on more dynamic means to capture feedback from patients and staff relating to the service in order to provide assurance that this new model of care provides an improved experience and identify any areas for improvement.

External Visits

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:

- **Dr Habib Naqvi - Director of the NHS Race and Health Observatory**

- We were fortunate to welcome Dr Habib Naqvi on 23 November who provided a presentation on the work of the Race Observatory to a group of colleagues with representation from our Group Executive Team and each hospital, MCS and LCO. Dr Naqvi shared insights in to the importance of securing further improvements in Equality, Diversity and Inclusion which will be an important priority within our future strategy as well as providing insights into the Workforce Race Equality Standard (WRES) at a separate session on the same day.

- **Richard Barker - Regional Director for the North East and Yorkshire and North West regions**

- On 28 November we welcomed Richard Barker, Regional Director and Dr Michael Gregory, Regional Medical Director from NHS England for a short visit of the Oxford Road site followed by session where our teams provided an update on progress to deliver the annual plan as well as an overview of Research and Innovation portfolio, Hive EPR rollout and our work on health inequalities.

- **Professor Bola Owolabi – Director of the National Healthcare Inequalities Improvement Programme**

- On 30 November we welcomed Professor Bola Owolabi who led an in-depth workshop with a variety of leaders from across the Trust, sharing insights into strategies for tackling Health Inequalities including the use of the Core 20+5 framework. The session highlighted a variety of best practice approaches being implemented across the country and in a separate afternoon session our teams were able to share some of our own innovative programmes of work to address inequalities.

- **Rt Hon Andrew Stephenson MP, Minister of State in the Department of Health and Social Care visit to Trafford General Hospital and Lung Health Check team**

- On 1 December, the Minister of State Andrew Stephenson attended Trafford General Hospital to visit the Trafford Elective Hub and hear about our work on Community Diagnostic Centres.

- Mr Stephenson was with us again on 18 December when he visited the Etihad Stadium to review our provision of targeted Lung Health Checks.

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:

Accountability Oversight Framework (AOF)

The Trust is conducting a periodic review of the reporting suite that supports our Accountability Oversight Framework (AOF) to ensure alignment to the style and format of the Integrated Performance Report (IPR) used at Board. Our informatics and performance teams are working closely with senior leaders from hospitals/MCSs/LCO on the development of updated documentation which will refresh our overarching Performance and Accountability Framework for the Trust. Once agreed by the Executive Director Team, this will be presented at a future meeting of the Board of Directors for Approval.

Performance and Delivery

In Urgent and Emergency care, year to date 4-hour performance at the end of November across all types was 71.7% against a trajectory of 66.8%. We have seen a 4% drop in performance over the last 3 months as winter pressures start to increase with attendances rising by 7.4% on the same period last year. Overall, we saw a marked improvement in 4-hour performance between April and November which stands at 71.7% compared with 59.1% over that period in 2022, a 12.6% increase in performance during a period where we recorded a 3.1% increase in attendances.

Ambulance handover within 15 mins during November was 47.1%, against a 65% target, impacted by surges in attendance and reduced flow. Similar trends have been observed across the country. Performance relating to the 30-minute contractual turnaround time has improved significantly this year with average turnaround time for the 2023 calendar year at 31.6 minutes compared with 43.7 minutes during 2022. Further, North Manchester General Hospital recorded the best ambulance turnaround times in the country during November following sustained improvement throughout the year.

A key element of our winter plans is the clinically led expansion of our Hospital at Home service which supports increased use of virtual ward capacity. November occupancy was recorded at 71.3% against a national plan of 80%. Plans are in place to increase occupancy throughout the January with further expansion of the service planned for 24/25 as outlined in the previous section of this report.

Cancer 62-day backlog has been on an improving trend since September, with November’s position at 333 against a plan of 345. Performance against the 62-day standard for October reported 50.1% which is 10% behind our plan of 60%. The latest data available for the Faster Diagnosis Standard (FDS) is for October, where month end performance was 65.7% against a trajectory of 76.8%. This performance has been driven by a sustained increase in referral rates whilst we continue to reduce the existing backlog.

For elective care, MFT have made good progress on reducing the overall waiting list by circa 27k since April, although progress has been impacted by sustained periods of industrial action. The November month-end position reported 442 patients waiting over 78-weeks against a trajectory of 517 and 5,522 65-week waits against a trajectory of 6,579. Focus continues to be applied to reducing the longest waits

consistent with our aim to eliminate 78-week waits by end of December with the exception of those patients who are exercising choice, medically unfit and a small number of corneal grafts where there is a known national shortage of graft material. Periods of Industrial action in December and January will further challenge this position as it has been necessary to reschedule a small number of patients with longer waiting times, although the most clinically urgent and longest waits are being protected as far as possible.

Our 6-week diagnostic performance at end November was 45.5% against a plan of 44.5% but is showing an improving trend. Difficulties recruiting to certain key roles presents a significant issue coupled within an increase in unscheduled care and demand. To support our plans, we are working to increase the capacity and utilisation of our Community Diagnostic Centres with a new scanner being mobilised from January.

Further detail regarding the Trust's performance and delivery is provided in the presentation of the Integrated Performance Report by the Deputy Chief Executive later on the agenda.

Winter Pressures

The new national Operational Pressures Escalation Levels (OPEL) framework was published in August asking Trusts to adopt a national common framework for assessing and communicating operational pressures. The aim is to improve communication through standardisation of escalation processes across teams, increasing the speed of system response.

The Group Performance team led work with hospitals to update local plans, scoring and action cards and the development of processes to collate, oversee and submit OPEL scores to the ICB; the framework was implemented across our hospitals/MCSs/LCOs a month earlier than the national deadline. MFT's escalation and flow policy was updated to support effective decision making and system responsiveness to pressures. As an example of the process in action, RMCH have seen increased levels of Respiratory Syncytial Virus (RSV) presentations which have exceeded last year's peak. Command and Control processes were mobilised at Group level to assure on hospital actions taken and identify appropriate system-wide response and support, liaising closely with Manchester & Trafford LCO and GM to ensure appropriate patient flow from acute into community, leading to de-escalation as quickly as possible.

Hospitals continue to mobilise their winter plans and have been implementing additional virtual ward capacity at pace to avoid admissions and reduce length of stay, where appropriate and possible, alongside the opening of surge capacity.

Industrial Action

Further periods of industrial action in December and January by Junior Doctors have increased the pressures and risks to service delivery during our busy winter period. As a consequence, tested plans for managing the situation have been reactivated

including detailed review of rosters to allow the senior medical workforce to cover the duties of the Junior Doctors to support the maintenance of safe clinical care.

Initial evaluation of the December strike action indicates 2,300 patient appointments required cancellation and re-booking. This represents around 7% of expected business as usual activity. Every effort was made to avoid impact to patients undergoing cancer treatment, urgent cases and those with the longest waiting times, there was unfortunately some impact on these groups of patients, although all planned dates have been rescheduled for the earliest date available.

3. Finance and Governance

NHSE Letter regarding Industrial Action Costs

In November 2023, NHS England identified funding to support the costs of industrial action which had taken place between May to October 2023, and following this announcement issued a written request to all trusts and ICBs to submit a forecast outturn for the 23/24 financial year. In response the Trust undertook an extensive review of its forecast financial plan for the remainder of 23/24 which had previously been presented to the Board and FDSC and discussed with the ICB as part of the GM turnaround work. This resulted in a revised forecast being submitted to the ICB within national timelines.

The Trust continues to aim for a break-even position in line with our financial plan, although achieving our forecast position requires sustained progress to key initiatives including achievement of Elective activity targets for each month from December-March, full delivery of the Waste Reduction Plan, and reduction in the underlying expenditure run-rate through improved controls implemented in Autumn 2023.

Forecasts were submitted prior to the announcement of the most recent period of industrial action which is likely to lead to increased costs and a reduction in elective activity and income.

Waste Reduction Programme – 2024/25

As of the end of November, MFT's 23/24 Waste Reduction Programme anticipates achieving a projected delivery of £132.7m against a target of £136.4m, indicating 97% attainment. We continue to forecast full delivery of the plan by the end of the year. This will signify the most substantial delivery in seven years of MFT Turnaround Programmes.

Moving forward, the Trust will shift focus from Waste Reduction towards a ‘Value for Patients’ approach during planning for 24/25. This strategic shift underscores the commitment to empower clinical leaders in to push ahead with efficiency initiatives, aligning with the strong clinical leadership in place to realise the benefits of Hive.

On December 4th, a Value for Patients workshop was convened with participation from Group Executives and Senior Leadership teams from each Hospital/MCS/MLCO. The workshop centred on identifying ‘at scale’ and ‘local’

opportunities to support delivery of what we expect to be substantial efficiency requirements for 2024/25.

Financial Recovery Plan

In December, the Finance and Digital Scrutiny Committee (FDSC) received a presentation on the development of MFT's multi-year Financial Recovery Plan. A key area of focus was the scale of underlying deficit that the Trust is carrying forward into 24/25 as well as the significant amount of benchmarking undertaken, using a wide range of sources, to help identify opportunities to reduce costs. The scale of savings necessary to achieve a breakeven position presents a significant challenge for the organisation, with substantial reductions in the overall pay bill required, particularly the use of some forms of temporary staffing. Continued focus on improving the productivity of our services will also be central to the delivery of the plan.

The draft Financial Recovery Plan will undergo further work in January through Executive Director Committee and Group Management Board, before being presented to FDSC in February and for approval at the March meeting of the Board of Directors.

4. Workforce

Leadership Update

We have successfully appointed to two Board-level positions within our Executive Director Team:

- Kimberley Salmon-Jamieson, currently Chief Nurse & Deputy Chief Executive of Warrington and Halton Teaching Hospitals NHS Foundation Trust, will be joining us as Chief Nursing Officer at the beginning of April 2024.
- David Walliker, currently Chief Digital and Partnership Officer of Oxford University Hospitals NHS FT, will be starting in our new post of Group Chief Digital and Information Officer at the end of April 2024.

Formal communications to the Trust Board and MFT wider leadership team will follow as induction details are finalised.

Staff Survey

The Trust has received initial, high-level reporting on the feedback received for the 2023 National Staff Survey where we have improved our response rate of 39.5%, a 9.5% rise from the previous year with 2,867 more staff participating. Although the full detail of the returns is not yet available, we are hopeful that this increase in participation is linked to proactive work undertaken to address key issues identified in the 2022 survey.

Consultant Appointments

Since our last Board meeting in November, 21 consultants have been appointed to roles within the following specialties: Acute and General Internal Medicine, Adult Learning Disability, Anaesthesia, Cardiac and Lung Transplant Surgeon, Cardiothoracic Anaesthesia, General Medicine, Haematology, Histopathology, Intensive Care Medicine, Paediatric Emergency Medicine, Paediatric Radiology, Paediatric Respiratory Medicine, Paediatric Spinal Surgery, Psychiatry and Urology. 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.

5. Top three concerns

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

Financial Position

The Trust's financial position has improved over recent months, with November's results showing a surplus of £17.2m, bringing the year-to-date deficit to £45.1m against a planned deficit of £19.0m. As outlined above, significant work is ongoing to continue the progress we have made over the final months of the year. The Trust remains committed to achieving a break-even position although that position carries significant risks, not least of which are the continued costs of industrial action which include direct costs of covering the action, reduced income associated with activity lost, and additional expenditure for recovery of lost activity.

Winter and Operational Delivery

While we have prepared well for the winter period, the increase in demand for our services and the additional risks noted in this report, present additional delivery risks to our elective, urgent and diagnostic trajectories.

Industrial Action

The additional risks associated with increased period of industrial action, particularly during the peak winter period, pose additional patient safety risks, and has caused additional disruption for patients who have had their elective care appointments rescheduled.

The above concerns are reflected in principal risks 1, 2, and 7 within the Trust Board Assurance Framework and Strategic Risk Register.

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:	January 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 4841

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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	8th November 2023
Committee Chair	Nic Gower

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Committee received the internal audit report on cyber security which identified a number of improvements required. A progress report will be provided to the Finance and Digital Scrutiny Committee in December 2023.

The Committee received the internal report on data quality risks in completing and reporting on the Malnutrition Universal Screening Tool (MUST). It identified four required improvements which will be implemented with the support of the Hive system.

ASSURE

The Committee received the internal audit report which studied the processed in place for clinicians to introduce a new theatre product to their area in the Trust. The audit's conclusions were positive with some minor opportunities for improvement.

The Committee received a follow up report showing progress in delivering against the recommendations of the audit, presented at September's Audit Committee meeting, into the recruitment of nurses, midwives and nursing assistants.

The Committee received the Counter Fraud Progress Report from the Trust's Counter Fraud Service.

ADVISE

The Committee reviewed the Register of Sealing for the 2022/23.

The Committee approved the MFT Charity's Annual Accounts for submission to the Charity Commission. They had already been approved at the Charitable Funds Committee in September 2023.

The Committee received the External Auditor's progress report which presented the early progress being made for the 2023/24 audit.

The Committee noted the Losses and Special Payments report for the period 1/4/23 to 30/9/23.

The Committee noted the summary of tenders' waived for the period 1/8/23 to 30/9/23.

The Committee received summary reports from the recent round of Scrutiny Committee meetings.

RISKS
The Committee reviewed the current Board Assurance Framework noting that a new principal risk infrastructure would be required when the new organisational strategy is launched in April 2024.
ACTIONS
The Board is asked to note the discussion points from the meeting of the Audit Committee on the 8/11/23.
LEARNING
Learning from internal audit reports is disseminated to relevant parts of the Trust.

Agenda of meeting:

AUDIT COMMITTEE

to be held on Wednesday 8th November 2023 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 13th September 2023	*(enclosed)*	All
4.	Matters Arising • Consideration of assurance (action from FDSC)		
5.	To receive MFT's Register of Sealing	*(enclosed)*	Nick Gomm
6.	To review the Board Assurance Framework	*(enclosed)*	Nick Gomm
7.	To receive the Charity's Annual Accounts	*(enclosed)*	Jenny Erhardt
8.	Internal Audit (KPMG)		
	8.1 To receive the Internal Audit Progress Report	*(enclosed)*	Harriet Fisher (KPMG)
	8.2 To receive a verbal update on the work to address the recommendations from the Internal Audit report on 'Insourcing recommendations'	*(verbal)*	Harriet Fisher (KPMG)

8.3	To receive an improvement plan to take forward the Internal Audit recommendations for the Recruitment of Nursing and Midwifery Staff	*(enclosed)*	Peter Blythin
9.	External Audit (Mazars)		
9.1	To receive the External Audit Progress Report	*(enclosed)*	Karen Murray (Mazars)
10.	Local Counter Fraud Specialist		
10.1	To Receive the Local Counter Fraud Specialist progress report	*(enclosed)*	Suki Pooni (Grant Thornton)
11.	Items for Noting and/or Information		
11.1	Losses and Special Payments for the period to 30th September 2023	*(enclosed)*	Rachel McIlwraith
11.2	Tenders Waived for the period to 30th September 2023	*(enclosed)*	Rachel McIlwraith
12.	To receive the Audit Committee work programme	*(enclosed)*	Nic Gower

13. MFT Board Sub-Committees since the last Audit Committee meeting:

13.1 Finance and Digital Scrutiny Committee held on 5th September 2023

13.2 Charitable Funds Committee held on 13th September 2023 and 26th September 2023

13.3 Group Risk Oversight Committee held on 18th September 2023

13.4 EPR Scrutiny Committee held on 27th September 2023

14. Date and Time of Next Meeting:

The next meeting will be held on **Wednesday 7th February 2024**
at **10:00am**

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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	28/11/23
Committee Chair	Kathy Cowell

KEY ESCALATION AND DISCUSSION POINTS

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

Whilst the Charity as a whole remains in positive balance, the Trust Wide General Purposes Fund remains in a negative balance so the CFC discussed a range of options to address the deficit over the long term. The finance and charity teams will carry out further analysis and engagement prior to a further proposal being presented for approval at the Committee.

Charitable funding was approved for a Youth Service Worker, a Citizen's Advice Outreach Service 2 year pilot, the RMCH Rooftop Project, and the creation of five new Houghton Dunn Fellowships. Funding for the additional equipment required to implement minimally invasive mitral surgery service was approved subject to confirmation that the senior leadership team at WTA had approved the bid.

ASSURE

The Committee received a report detailing the financial performance of the Charity up until the end of October 2023.

ADVISE

The CFC received a presentation regarding the KidsDigiLabz programme which seeks to improve the care and patient experience for children using MFT's services through innovative use of digital technologies including VR and 3D modelling and printing.

The CFC investment sub-committee will be considering the Charity's funds' investment strategy at their meeting in January 2024.

RISKS

n/a

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

To note this report.

LEARNING (any learning which needs to be shared, how it will be shared, and who with)

Meeting agenda

CHARITABLE FUNDS COMMITTEE

TUESDAY 28th NOVEMBER 2023 at 2:00PM – 4:00PM

MAIN BOARDROOM, COBBETT HOUSE

AGENDA

1.	Apologies for absence		
2.	Declarations of Interest		
3.	Minutes of the Charitable Funds Committee held on 13th September 2023 and the 26th September 2023	(enclosed)	All
4.	Matters Arising		
5.	To receive a report of the KidsDigiLabz Event taken place on 15th September 2023	(presentation)	Johnny Kenth / Adam Hepden / Indi Banerjee
6.	To receive Feedback on the Charity Strategy and Cash Flow modelling	(enclosed)	Tim Barlow
7.	To receive the Charities Fundraising Report • Examples of the impact the Charity has had • Presentation on the new Charity Website	(enclosed)	Angela Rowe
8.	To receive Charitable Funds Finance Report • Charity running costs • Process for CFC approval of Charity spend	(enclosed)	Jenny Ehrhardt
9.	To receive an update report on unrealised losses on investments	(enclosed)	Richard Hogger
10.	To receive updates / proposals for Charity Funding Support:		
10.1	To receive a request for Minimally Invasive Mitral Valve Surgery (MIMS)	(enclosed)	Jenny Ehrhardt
11.	To review the Charitable Funds Committee work programme	(enclosed)	Kathy Cowell
12.	Date and Time of Next Meeting The next meeting will be held on **Tuesday 19th March 2024** at **2:00pm**		

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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	12th December 2023
Committee Chair	Gaurav Batra

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Following the data quality issues which have been escalated and resolved during stabilisation, the outputs of the root and branch review and the data quality workstream have been combined to form a single programme of work to resolve the current known issues. So far 45,000 episodes of care have been validated and patient appointments have been brought forward where they have been identified to have been waiting longer than national mandated RTT timescales. Data validation, including random selection of cases and targeting of areas where issues are suspected, will continue (as occurred pre-Hive) but is expected to reduce as time goes on as the root causes of: data transfer, build/workflow issues and training is addressed. This is a significant programme of work which is expected to take 6 -12 months before a return to business as usual. .

There is under-delivery of the cash-releasing savings being delivered from the programme. There are 2 'deep dive' events planned for the new year which will focus on how to improve this situation for each element of the Hive programme, with a particular focus on outpatients, theatres and closure of laboratory and legacy systems.

Issues with Wi-fi at NMGH remain but progress is being made through the work being carried out by informatics and estates team.

ASSURE

The revised governance of programme is functioning well with the Hive programme fully embedded with the improvement workstreams.

Full deployment of the Hyperdrive implementation will be completed by mid-June 2024. The system has been fully updated to the most current specification prior to Hyperdrive being installed.

Deloitte will be undertaking their 6th external review of the programme and their report will come to the EPRSC in March 2024.

There are some services which are not using Hive in an optimal way. An MDT from the Hive programme is visiting specialities across the Trust to support services to develop their capability in using Hive.

Work is underway to ensure that clinical coding is accurately reflecting activity undertaken. This should impact positively on MFT's financial position.

The DNA rate across MFT has fallen to 8.6% with the figures for MyMFT users much lower.

ADVISE

The programme remains in stabilisation phase with opportunities, and areas of concern, being addressed as they are identified.

Liaison is continuing with Epic to resolve some issues with the reporting function within the system.

A contract has now been signed with Haemonetics to implement the SafeTrace Blood Transfusion Laboratory Information Management System (LIMS).

Work is underway to ensure that the planned MFT-wide electronic bed management system is fully synchronised with Hive.

Discussions are ongoing with regard to MFT being an Epic Connect site and the potential benefits to patients, MFT, and the wider NHS.

RISKS

There was no change in the scoring of the risks associated with the Hive programme.

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

To note the discussion of the EPR Scrutiny Committee held on 12/12/23.

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

Tuesday 12th December 2023
at 10:00am – 12:00pm

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 Wednesday 27th September 2023	*(enclosed)*	*All*
4.	To receive the report of the EPR Implementation and Benefits Realisation Programme Board	*(enclosed)*	*Julia Bridgewater*

5	To receive a report on the Epic Connect model	(enclosed & presentation)	*Julia Bridgewater*
6.	To consider the EPR Scrutiny Committee work programme (inc. key areas of focus and future progress)	*(enclosed)*	*Gaurav Batra*
7.	Any other business		
8.	The next meeting will be held on **Wednesday 27th March 2024 at 2:00pm**		

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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	19th December 2023
Committee Chair	Trevor Rees

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Committee received the Chief Finance Officer's update on the financial position for month 8 (November):

- The financial position for November 2023 is a £17.2m surplus, £12.3m ahead of plan.
- The YTD position up to the end of November 2023 against control total is a £45.2m deficit, £26.2m behind the plan.
- After non-operating adjustments, the YTD position is an £81.9m deficit against a plan of £100.6m deficit.

MFT remain committed to achieving break-even at year end with a forecast £11.6m deficit the current most likely scenario.

The Committee received the latest version of the Trust's forward-looking Financial Recovery Plan. There is a very significant underlying deficit across the Trust and planning is underway to identify opportunities to address it.

ASSURE

The Committee received a positive update on the completion of actions resulting from the recommendations of the interna audit report into cyber security.

The Committee received an update on delivery of the Waste Reduction Programme for 2023/24. Currently, £133.7m delivery is forecasted against a target of £136.2m.

Planning for the 'Value for Patients' programme for 2024/25 has begun with £17m already identified. |A workshop has been held with senior leaders to identify change programmes which will deliver significant savings to contribute towards a likely target of £136m for the year.

ADVISE

The Committee received the finance elements of the Integrated Performance Report, and the Financial Performance report, for Month 7 (October).

The GM capital envelope is now agreed with MFT receiving £52m (against an original plan of £78m). Planned spend is £55m and the difference between this and the £52m is covered.

The Committee received the Group Chief Information Officer's report which described ongoing delivery against the actions required following the IT outage at Wythenshawe Hospital, and increase in IG mandatory training compliance, and staff consultation underway for changes in the Informatics team structure.

The national cost collection report for 2022/23 was noted by the Committee.

RISKS

The Committee received the strategic Risk Exposure Report which presented the relevant principal risks for the Committee and the strategic risks which are linked to them.

ACTIONS (actions required of the Board)

The Board is asked to note the discussions on the Finance and Digital Scrutiny Committee and the 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 to deliver a break-even position for 2023/24 and beyond.

Meeting agenda

Finance & Digital Scrutiny Committee

Tuesday 19th December 2023 at 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 31st October 2023	*(enclosed)*	*Trevor Rees*
3.	Matters Arising	*(enclosed)*	*Trevor Rees*
4.	To receive the Finance and Digital strategic risk exposure report	*(enclosed)*	*Jenny Ehrhardt*
5.	MFT performance against Finance Metrics within the Integrated Performance Report	*(enclosed)*	*Jenny Ehrhardt*
6.	Chief Finance Officer's Report - M7 • Update M8 • MFT 23/24 Forecast position December 2023	*(enclosed)*	*Jenny Ehrhardt*
7.	Chief Information Officer's Report • Action plan from Cyber Security Internal Audit	*(enclosed)*	*Dan Prescott*

8.	Waste Reduction Programme and progress report on value for patients 24/25	*(enclosed)*	*Julia Bridgewater / James Allison*
9.	National Cost Collection – post submission	*(enclosed)*	*Jenny Ehrhardt*
10.	Financial Recovery Plan	*(Presentation)*	*Jenny Ehrhardt*
11.	To receive the FDSC work programme	*(enclosed)*	*Trevor Rees*

12. To note the following Committee meetings:

    12.1 Group Informatics Strategy Board
    (The meeting held on 25th October 2023 had been stood down)

13. The next meeting will be held on
    Tuesday 27th February 2024 at 2:00pm

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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	19th December 2023
Committee Chair	Damian Riley

KEY ESCALATION AND DISCUSSION POINTS

ALERT

OPEL 4 has been declared for short periods over the last month due to increased demand. Mutual aid / diverts are not usually available because all GM Trusts are in a similar position. Daily system calls are now taking place.

Harm reviews are taking place across MFT for patients waiting for care with improvement actions undertaken as required.

A Never Event has taken place, the second of the year. No harm was experienced by the patient and all required reporting has taken place. The Committee will receive a further update on this once the full analysis has taken place.

Urgent Care: Hospitals are mobilising their winter plans and they are functioning as planned despite high demand on Emergency Departments. The urgent care improvement programme is being implemented, including maximising Hospital at Home/Virtual wards and SDEC. Hive is being used to identify medication requirements for those waiting for care, in particular those with Parkinson's disease.

Elective recovery: The Trust remains committed to achieving the elective recovery targets but the junior doctors' industrial action in December and January will have an impact. Each period of industrial action leads to c.2500 rescheduled appointments. The improvement workstreams are making progress with improvement in theatre usage evident. Gynaecology services provide the biggest risk to delivery of the 65ww target for the end of March 2024 with mutual aid being sought outside of GM as there is no suitable capacity within the local system.

Cancer services: the work to reduce the 62-day backlog is ahead of plan and performance against the faster diagnosis target improved in November.

Diagnostics: The year-end diagnostics target is now going to be difficult to achieve due to the lack of the additional funding which had been requested.

ASSURE

The Committee received the EPRR statement of compliance subject to approval at the Board of Directors in January.

The Committee received a report regarding NICE guidance compliance. A review of all guidance has taken place and processes are now in place for addressing new guidance as it is received. Work is underway on legacy guidance not yet applied to identify actions required.

Work continues to standardise LOCSSIPS within Hive.

The Committee received a report on compliance with safeguarding training. Levels 1 and 2 are meeting expected levels of compliance with work underway to ensure Level 3 compliance also does. Actions include modifying the training and ensuring staff have the time available to them to complete the training despite operational pressures.

ADVISE

A new metric regarding discharge readiness has been included in the Integrated Performance Report (IPR). It measures patients whose discharge has been delayed by more than 1 day. MFT is 1 of 90 Trusts nationally who have the ability to record and monitor this.

Two frailty assessment beds have opened at the MRI.

The Trust will be implementing a new electronic bed capacity management system, funded by national sources. MFT will be monitored against a suite of nationally set operational metrics when once up and running. Will also want to use some locally derived quality metrics.

The Committee received a report on non-RTT waiting lists in the community and for CAMHS. Each service looking at ways of reducing waiting times and conversations underway with commissioners with regard to autism services and SARC. Metrics will be included to be included in the IPR, once data quality issues are resolved, enabling ongoing monitoring by the QPSC.

The Committee received the Acute Deterioration and Resuscitation Annual Report , presented by the new Resuscitation lead for the Trust.

RISKS

The Committee received the Strategic Risk Exposure Report. The composite risk rating for the principal risks relevant to the Committee remain the same. Mitigating actions for the risk related to cryogenics are on track for completion in early January.

ACTIONS (actions required of the Board)

To note the discussion held at the QPSC on 19/12/23 and receive the revised EPRR statement of compliance at their meeting in January 2024.

LEARNING

The learning from the management of a complex safeguarding case, described within the patient story presented to the Committee, has been shared across the Trust.

Hospitals/MCSs/LCOs share best practice between each other at the Operational Excellence Board.

Agenda

Quality & Performance Scrutiny Committee

Tuesday 19th December 2023 at 9.00am – 12:00pm

MAIN BOARDOOM
COBBETT HOUSE

A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	Case study of learning	*(presentation)*	*Cheryl Lenney*
4.	Minutes of the Quality & Performance Scrutiny Committee held on 24th October 2023	*(enclosed)*	*All*
5.	Matters Arising		*All*
6.	To receive a report on the Acute Deterioration and Resuscitation Annual Report 2022-2023	*(enclosed)*	*Steve Jones*
7.	To receive the Performance Quality and Safety Strategic Risk Exposure report	*(enclosed)*	*Alison Lynch*
8.	**Performance Items for Scrutiny and Assurance:**		
	8.1 MFT performance against operational performance metrics within the Integrated Performance Report and the AOF	*(enclosed)*	*Julia Bridgewater*
	8.2 To receive a report on the Electronic Bed Capacity Management System	*(enclosed)*	*Julia Bridgewater*
	8.3 To receive a report on Improvement workstreams	*(enclosed)*	*Julia Bridgewater*
	8.4 To receive a report on Community and CAMHS waits	*(enclosed)*	*Julia Bridgewater*
	8.5 To receive a revised statement of Emergency Preparedness Resilience and Response (EPRR) compliance	*(enclosed)*	*Julia Bridgewater*
	8.6 To receive a report on Safeguarding Training compliance on Ward Staff levels 2&3	*(enclosed)*	*Cheryl Lenney*
	8.7 To receive a progress report on NICE guidance	*(enclosed)*	*Toli Onon*

9.	**Quality Items for Scrutiny and Assurance:**		
	9.1 MFT performance against Quality and Safety metrics within the Integrated Performance Report	*(enclosed)*	*Toli Onon / Cheryl Lenney*
	9.2 To receive an update on the serious incident that occurred in March 2023	*(verbal)*	*Cheryl Lenney*
	9.3 To receive the Cervical Screening Provider Lead annual report	*(enclosed)*	*Toli Onon*
	9.4 To receive the strategic risks from Group Risk Oversight Committee:		
	• Blood transfusion	*(enclosed)*	*Julia Bridgewater*
	• Safe storage of medicines	*(enclosed)*	*Charlotte Skitterall*
	9.5 To receive a report on maternity safety compliance	*(enclosed)*	*Alison Haughton Sarah Vause*
10.	To approve the Infection Prevention & Control Strategy (2023-2026) for recommendation to the MFT Board of Directors	*(enclosed)*	*Cheryl Lenney*
11.	To note the terms of reference for the peer mental health review	*(enclosed)*	*Cheryl Lenney*
12.	To review the QPSC Work Programme	*(enclosed)*	*Damian Riley*
13.	To note the following Committees held meetings:		
	13.1 Group Risk Management Committee held on 20th November 2023	*(enclosed)*	
	13.2 Group Infection Control Committee held on 18th October 2023	*(enclosed)*	
	13.3 Group Quality and Safety Committee held on 19th October 2023	*(enclosed)*	
	13.4 Group Cancer Committee held on 26th September 2023	*(enclosed)*	
	13.5 Group Safeguarding Committee held on 21stNovember 2023	*(enclosed)*	
	13.6 Operational Excellence Board for the period November 2023 - December 2023	*(enclosed)*	
14.	The next meeting will be held on Wednesday 28th February at 10:00am		

NHS Manchester University NHS Foundation Trust

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	20th December 2023
Committee Chair	Angela Adimora

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The Trust is experiencing high staff absence rates at present with some services as high as 16%. Support to under-pressures services is being provided from across the Group.

ASSURE

The Committee received an update on delivery of the Workforce Digital Strategy with positive progress being made with the Workforce Services Helpdesk, People Place, digital maturity, and roster reviews.

Work has been undertaken to address the recommendations from the internal audit into nursing and midwifery recruitment.

The Committee received the Guardian of Safe Working's report for quarter 2 of 2023/24.

The Committee received the Freedom to Speak Up Guardian's quarter 2 report for 2023/24.

The Committee received an update on actions, under 6 themes, in response to the staff survey results from 2022 and the internal engagement which has occurred since. Each theme is led by an Executive Director and informed by a series of strategic retreats. Staff survey completion has increased by 9% for the 2023 survey when compared to the 2022 one.

The latest bout of junior doctors' industrial action began on the day of the meeting. There had been no safety concerns reported but the high staff absence rates due to illness are adding to the challenges. Preparations have begun for the next bout of action in January.

ADVISE

There is currently 87.7% compliance across the Trust core mandatory training against target of 90%. The new learning management system is working well. The accessibility of modules to people with differing needs is being looked at through a user engagement approach.

Health and Wellbeing services remains a priority. A wide range of opportunities for staff are available and the priority is to promote these effectively across the Trust.

Progress is being made with delivering the Apprenticeship Strategy now the Trust has 'Provider' status.

Further workforce controls are being implemented as part of response to GM turnaround. The focus remains on ensuring patient safety and some positions are exempt from vacancy controls in order to reduce bank/agency costs.

The Committee received an update on the actions being taken to address violence and sexual assault against the workforce. SARC are providing a direct service to any staff affected by sexual assault. Data collation and reporting is being strengthened to enable more robust and targeted action.

The Committee received the Lime Arts 6-monthly update.

The Committee received an overview of medical training opportunities provided at MFT and the changes made since the pandemic. The result from the GMC survey are being used to inform where additional work is required to improve the medical trainee's experience.

RISKS

The Committee received an analysis of all workforce risks across the Trust. Reports will come to each meeting in the future.

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

To note the discussions of the Workforce Scrutiny Committee.

LEARNING

Learning from successful workforce initiatives continues to be shred across the Trust, overseen by the Workforce and Education Committee.

Agenda

Workforce Scrutiny Committee

Wednesday, 20th December 2023 at 13.00pm – 15.00pm

A G E N D A
Main Boardroom, near Cobbett House Reception, ORC

1.	Apologies		
2.	Declarations of Interest		
3.	Minutes of the Workforce Scrutiny Committee held on 24th October 2023	*(enclosed)*	*All*
4.	Matters Arising (if not included on the Main Agenda)		*All*
	Items for Scrutiny and Assurance		
5.	To receive the report of the Group Executive Director of Workforce & Corporate Business	*(enclosed)*	*Peter Blythin*
6.	To receive the MFT performance against workforce metrics included in the Integrated Performance Report	*(enclosed) To follow*	*Peter Blythin*
7.	To receive the Workforce Digital Strategy 6-monthly progress Report	*(enclosed)*	*Claire Macconnell*

8.	Update progress report on Mandatory Training	*(enclosed)*	*Claire McConnell*
9.	To receive an update on Nursing and midwifery recruitment internal audit progress report	*(enclosed)*	*Susie Philips*
10.	To receive the Lime Arts Mid- Year Review Report 2023	*(enclosed)*	*Nick Bailey*
11.	To receive a progress report on 'Violence at Work' project	*(enclosed)*	*Nick Bailey*
12.	Updates on strategic risks relevant to workforce including escalations from Group Risk Oversight Committee	*(enclosed)*	*Nick Bailey*
13.	To receive a report on Medical Workforce Education opportunities: - Feedback received as part of Deanery and DMC surveys. - Actions take to address issues identified as part of the recent GMC survey.	*(enclosed)*	*Toli Onon*
	Work Programme Governance Items		
14.	Guardian of Safe Working Quarterly Report (Q2)	*(enclosed)*	*Karen Fentem*
15.	Freedom to Speak Up Quarterly report (Q2) - Including key findings from FTSU investigation	*(enclosed)*	*Andrew Lloyd*
16.	To receive a progress report on staff engagement & experience plans/initiatives including an update on MFT's current Staff Survey and Quarterly National Staff Pulse Survey Results	*(enclosed)*	*Peter Blythin/ Yvon Poland*
	Items for Noting		
17.	To receive the Workforce Scrutiny Committee Work Programme	*(enclosed)*	*Committee Chair (Angela Adimora)*
18.	To note the following meetings held:		
	18.1 Workforce & Education Committee meeting held on 27th October	*(enclosed)*	*Committee Chair (Angela Adimora)*
	18.2 Medical Directors' Workforce Board meetings held on 26th October 2023	*(enclosed)*	*Committee Chair (Angela Adimora)*

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alison Lynch, Deputy Group Chief Nurse
Date of paper:	January 2024
Subject:	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:	The report details progress in meeting performance targets which are key to the delivery of the Trust's strategic aims.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Alison Lynch, Deputy Group Chief Nurse Tel: 0161 276 4738

Manchester University
NHS Foundation Trust

Integrated Performance Report

Executive Summary

Reporting period to 30th November 2023

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 have oversight of 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 , who routinely scrutinize the assurance and mitigation of risk in relation to the metrics where an area of performance is giving rise for concern, or where a significant improvement has been achieved.

Integrated Performance Report Navigation Panel

Delivering our Strategic Aims

Our Strategic aims	Our enablers 2023/24																
	Quality and Safety Strategy 2022/25	Patient Safety Plan 2023/24	Effectiveness Plan 2023/24	High Priority Audit Plan	What Matters to me	Mental Health Strategy	End of life care strategy	Urgent and Emergency Care Strategy	Inequalities strategy	Financial plan	Operational Plan 23/24	People Plan	Carer's strategy				
To focus relentlessly on improving access, safety, clinical quality and outcomes	●	●	●	●	●	●	●	●	●		●		●				
To improve continuously the experience of patients, carers and their families	●				●	●	●		●		●		●				
To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	●										●	●					
To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future											●	●					
To use our scale and scope to develop excellent integrated services and leading specialist services											●						
To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve											●						
To achieve and maintain financial sustainability										●	●						
To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	●	●	●	●	●		●		●		●		●				

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 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	

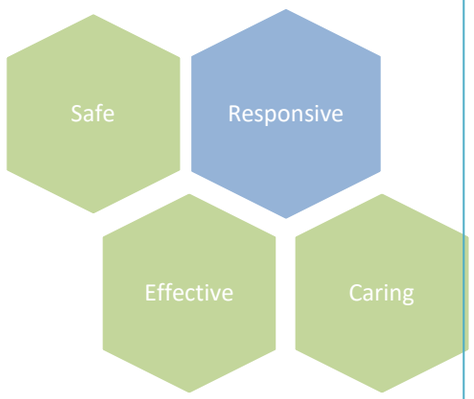
Escalating performance concerns

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

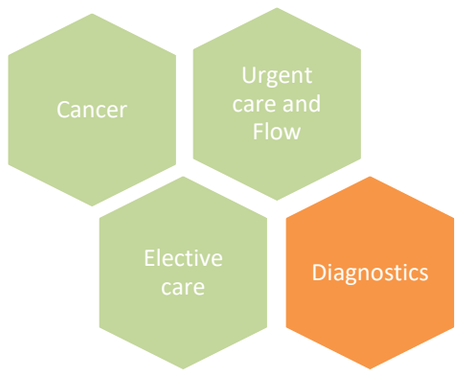
Integrated Performance Report Overview

Quality and Safety



The quality and safety component of the IPR was considered in detail at the Quality and Performance and Scrutiny Committee. The QPSC received specific escalations for consideration and scrutiny in relation to our approach to understanding and learning from clinical harm experienced by patients waiting for access to care and treatment. The work underway supporting localisation of LocSSIPs and implementation of NatSSIPS 2 and overall compliance with surgical safety checks across the Trust was noted. The QPSC noted that there had been a deep dive into reported attributable MRSA bacteraemia cases and the scrutiny in place to identify areas for learning and improvement.

Operational Performance



The performance component of the IPR was considered in detail at the Quality and Performance Scrutiny Committee

QPSC considered all operational excellence domains with a focus on non RTT waiting lists. QPSC sought assurance on mobilising winter plans to support winter pressures.

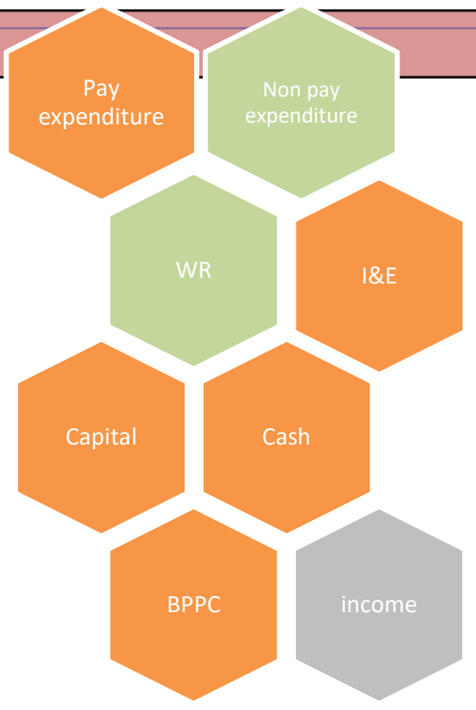
The continued requirement for improvement in delivering our commitments was subject to scrutiny by the committee, with assurance that associated risks are mitigated to support delivery.

Workforce

The workstreams related to the workforce element of the IPR were considered in detail at the Workforce Scrutiny Committee on the 20/12/23. Absence rates are currently high with support for under-pressure services being provided from across the Trust. The WSC received assurance on delivery of the Workforce Digital Strategy and progress with the actions being taken following last year's staff survey.
The Q2 reports from the Freedom to Speak up Guardian and the Guardian of Safe Working were also discussed in detail.

Finance

FDSC considered the finance component of the IPR, with a focus on the year to date I&E position, capital position, and the cash balance and forecast.
The challenges to year end delivery of the breakeven plan were discussed in detail
The Committee received the latest version of the Trust's forward-looking Financial Recovery Plan. There is a very significant underlying deficit across the Trust and planning is underway to identify opportunities to address it.



Quality and Safety Report

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	
	S6					LocSSIP Compliance	Local	
	S7					Attributable Reportable organism infections	National	6
	S8					Maternity dashboard indicators alerting	New	6
	S8					Compliance with patient specific assessments	New	
	S9					PSIRP safety profiles alerting	Local	6
	S10					Safety Critical Policies-out of date	Local	
PSIRP 23/24	S11					Patients waiting for access to care who experience associated harm	Local	
	S12					Notifiable incidents related to surgical procedures	Local	
	S13					Notifiable incidents related to invasive procedures	Local	
	S14					Notifiable incidents related to a patient with a mental health concern	Local	
	S15					Notifiable incidents related to medication safety	Local	
	S16					Notifiable incidents related to Ergonomic design	Local	
	S17					Notifiable incidents related to Discharge	Local	
	S18					Notifiable incidents related to the effective assessment and management of risk (Falls etc)	Local	
Learning and culture	S19					Prevention of future deaths notifications	Local	10
	S20					% patient safety risks not mitigated exceeding the deadline for mitigation	New	10
	S21					Culture: People Promise: We each have a voice that counts (staff survey 2022)	National	10

Joint Group Medical Directors' and Chief Nurse's Summary

The Quality Performance and Scrutiny Committee (QPSC) considered the safety component of the IPR in detail, noting that Site/MCS/LCO patient safety performance reports, and subsequently the Trust-wide patient safety reports continue to be iteratively developed to support the Trust's transition to the Patient Safety Incident Response Framework. It noted that while this work is being undertaken, the Trust's Patient Safety Oversight System continues to ensure active surveillance and integration of patient safety intelligence, alongside the development of key measures of success aligned to identified patient safety priorities. The QPSC considered the summary of the intelligence considered and contextualised through the safety oversight system reflected in the IPR, receiving reports on an exceptional basis from the Group Quality and Safety Committee, where it is alerted to opportunities for high impact learning and areas of actual, emergent or latent risk. The Committee is also advised of action taken to ensure optimal approaches to learning. It assures the committee in relation to the effective mitigation of risk to patient safety and the outcomes of those actions. Where relevant the committee is updated about regional and national initiatives. 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, with the development of appropriate safety improvement plans across the Trust to support the delivery of the Patient Safety Incident Response Plans, and along with this development will be the identification of measures of success. The QPSC received specific escalations for consideration and scrutiny:

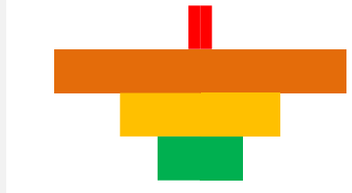
- approach to understanding and learning from clinical harm experienced by patients waiting for access to care and treatment (it has requested a detailed report at its next meeting)
- The work underway supporting localisation of LocSSIPs and the implementation of NatSSIPS 2 and overall compliance with surgical safety checks across the Trust
- capturing the reliability with which patient specific assessments are performed
- Ongoing challenges with the governance of safety Critical policies (and the development of a Simulation Strategy in part to support
- Safe and effective discharge
- Understanding inequity- approach to strengthening insight
- Incidents involving patients with a mental health concern
- Medicines safety incidents
- Resuscitation and management of the deteriorating patient- the Commitee received the annual report
- There has been a deep dive into the reported attributable MRSA bacteraemia. This will go to Group ICC and Q&PS. Executive level scrutiny continues led by the DIPC.

The planned response and required assurance for these areas of escalation were considered in detail.

1.	Failure to maintain essential standards of quality, safety, and patient experience	4	20

Risk Profile

Group Wide Risk Profile



No.	Strategic Risks	Risk Score
1150	Controlled drug storage	12
7090	Human System interaction	20
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	12

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

Joint Group Medical Directors' Summary

The Quality and Safety Strategy 2022-25 has acted as an enabler for the Trust to review its performance within the Effectiveness domain with a different lens than previously. The focus on insight as led to the initiation of a programme of work to identify the correct, proportionate and relevant metrics to measure progress to achieving the objectives identified in the Effectiveness plan. The metrics presented in the current version of the IPR are traditional and focus on mortality, the management of external recommendations, the key controls in place (clinical policies and guidance), performance in national audit and the national CQUIN scheme.

Utilising data from Hive and also in an aggregated and benchmarked format in the Healthcare Evaluation Data (HED) the indicators are currently under review to support a more integrated approach to outcome data, with a clear focus on understanding and eliminating unwarranted variation.

The Quality and Performance Scrutiny Committee received three important areas for escalation from the data available:

Recognising that the process for managing NICE guidance in the past had been suboptimal, a revised process has been in place since January 2023. This revised process has demonstrated an improvement in the assurance and compliance status. In addition, an assurance exercise has been completed in relation to previously published guidance within the Ulysses system. A risk-based approach is going to be utilised for all legacy guidance (pre January 2023) without a completed baseline assessment tool where there is a concerning theme identified through a review of Healthcare Evaluation Data (HED) or highlighted by the Trust Safety Oversight System (SOS), the incident profile and where any gaps in assurance have been identified. The Committee received a detailed assurance paper in relation to this.

There continues to be a potential issue in relation to case ascertainment, data validation and participation in relation to national audits post HIVE implementation. This has been escalated to Informatics team and is reflected on the Risk Register.

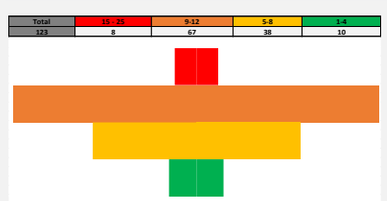
A number of policies will be expiring in January 2024, all policy authors have been notified.

Principal Risk

No.	Description	Strategic Risks	Highest scoring
1.	Failure to maintain essential standards of quality, safety, and patient experience	2	15

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	15
						What Matters to Me (Overall Score)	Local	15
						Mixed sex accommodation breaches	National	15
						Upheld complaints (rate)	Local	15
						Formal Complaints received	Local	15
						Re-opened complaints (rate)	Local	15
						Ombudsman referred complaints	Local	15
Learning and Culture						National Adult Inpatient Survey (2022): Composite metric (Results received – currently embargoed)	Local	15
						Excellence / Compliments Received	Local	16
						Innovation (metric to be agreed at Quality & Patient Experience Forum)	Local	16
						Improvement Priorities	Local	16
						National Children and Young People's Inpatient and Day Case Survey (2020) Composite metric	Local	15
						Urgent and emergency care survey 2022; Composite metric	Local	16
						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	16

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 **Friends and Family (FFT)** response rate is monitored, as is the % of those who would recommend our services. There has been a marked increase in the number of FFT returns submitted. In November there were 18,725 and increase of 147 from October 2023 . The % positive score increased in November from 92.58% in October 2023 to 92.88% in November. The % negative score decreased in November 2023 from 4.63% in October 2023 to 4.32% in November. Feedback is provided directly to clinical areas, there is no special cause variation noted. In the LCO, FFT is also utilised less due to the nature of services delivered in people's homes. The LCO have introduced QR codes that can be accessed in homes and clinics. Analysis of themes and learning are monitored through the Patient Experience Forum. Active surveillance also includes What Maters to Me (WMTM) and Quality Care Round (QCR).

There has been a decrease in the number of **What Matters to Me** (WMTM) in November 2023, compared to October 2023 (-2.03%). In November 2023 6983 WMTM surveys were completed, compared to 7,125 in October and 5755 in September 2023.

WMTM Nutrition and Hydration data for November 2023 shows an overall score of 86.763% compared to 87.02% in October 2023. In comparison QCR was 95.47% in November, compared to 96.02% in October. This correlates with the decrease seen in Safety Actions related to Nutrition and Hydration during October in clinical accreditations.

Mixed Sex accommodation breaches have occurred in critical care areas, where exemptions are in place that support delivery of single sex critical care services in mixed sex environments. At the point of discharge, the exemption is no longer applicable, and a 'breach' is said to occur if we have been unable to discharge a patient to a step-down area. There were 56 mixed sex breached in November , the reason for delay was availability of step-down beds.

In November 2023 there was an decrease in the number of **formal complaints** received. There were 161 received in November compared to 176 in September and 180 in October; themes in November remained static and included concerns raised about Treatment / Procedure and Communication.

MFT has seen a slight decrease in the number of complaints that were upheld. There were 5 in November and 9 in October 2023. An initial review of the themes has identified communication, treatment and procedure and appointment delay (outpatients) as the top three themes throughout the last 12 months. Analysis is led by the Corporate Complaints Team to identify specific learning and inform action planning, which will be monitored through the Patient Experience Forum.

In November 2023 there was a decrease in the number of **reopened complaints**. 5 were received in November compared to 9 in October and 25 in September 2023. A complainant may be dissatisfied with our response for a number of reasons; key themes in November were noted to be unresolved issues and the complainant disputing the information provided within the complaint response letter, which in turn raised further questions. The Corporate Complaint Team continue to lead focussed training (quality of response and investigation) to further reduce the rate at which complaints are re-opened, but more importantly to ensure that when concerns are raised there is good resolution and learning that can be spread across all sites.

Compliments are recorded through our electronic reporting systems. Compliments are sent directly to the clinical area; however, the themes are not scrutinised. There were 136 compliments received in May, 54 in June, 44 in July, 53 in August, 72 in September, 43 in October and 67 in November 2023. Compliments are recorded in several areas; Ulysses, NHS choices and directly to clinical areas. Work continues to centralise the process.

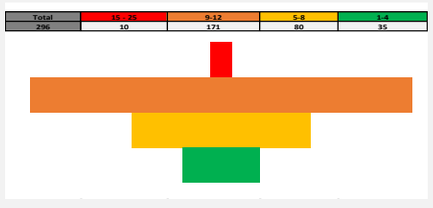
The results of the 2022 **National In-Patient survey** were published in September 2023. MFT's overall experience was scored at 7.8. In comparison to similar organisations, the lowest score was 7.4 and highest 9.3, with the average being 8.1. This is a reduction from 7.9 in the previous year.

The **Maternity Survey** embargoed results were released in September; MFT's overall positive ranking in comparison to the overall positive score of every other organisation (61 in total) that ran the survey was 27th. The Quality & Experience Forum will agree and monitor the hospital action plans

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 responsiveness metrics have been further scrutinised, data quality issues in respect of patients subject to **s136 of the Mental Health Act who wait longer than 12 hours in ED** have been identified, therefore this metric is paused until the review is completed (due end December 2023)

A theme of **complaints related to discharge or transfer** is medicines management and end of life, or palliative care discharges. The End of Life Care Groups and Discharge Task and Finish Group are focusing on improvements.

Duty of Candour compliance is an area of significant development aligned to the implementation of the PSIRF, with a revised 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.

Since 1st April **123 accreditations and 36 Quality Assurance Visits have taken place.**

Compliance with **s132 of the Mental Health Act 1983 h**as deteriorated in month, targeted support from the MH Act Administrator and Hive teams is underway to understand the systems and barriers to achieving compliance in this key area.

Mental Health Training compliance is achieved at Level 1 (Mandatory) at 92.07%, Level 2 compliance has improved in month to 61.15% from 58.66% (an additional 700 staff trained).

Oliver McGowan training commenced on 1st December and was expected to be at 0%, however is at 0.43% as people have achieved training in another organisation.

There were no **red complaints or incidents relating to Mental Health Concerns** in September 2023.

There is oversight of a range of safeguarding indicators through the Group Safeguarding Committee and the AOF. **Deprivation of Liberty Safeguards** standard monitoring shows good compliance with urgent application to the Supervisory Body in appropriate timescales in all 336 cases. However, 0 cases were approved by the Supervisory Body, care and treatment was subsequently provided under the Mental Capacity Act (MCA) Best Interest Process for those who still required to remain in our care.

In respect of **Learning Disability / Autism and Quality Standard Compliance**. Awareness has been raised through the Safeguarding Committee and LD Steering Groups, and supported by Hive processes. Of those patients who required a reasonable adjustments through care planning, there has been a decrease in compliance, noted through the AOF processes, 54 out of 74 patients had plans in place within 48 hours of admission.

Plans are in place to achieve **Levels 3 adult and children's Safeguarding Training,** the Group Safeguarding Committee continue to remind hospitals/MCS/LCO of the requirement.

Operational Performance Report

Operational Performance: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Urgent care and Flow	P1	✗	H	F	✓	A&E 4 hour standard	National	
	P2	✗	H	?	✓	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	✗	L	F	✓	Number of AED waits > 12 hours	National	
	P6	✗	L	?	✓	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	✗	~	F	✗	Cancer 62 day performance	National	
	P12	✗	~	?	✓	Cancer Backlog reduction	National	
	P13	✗	~	?	✗	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	✓	H	P	◎	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	✗	H	F	✗	Diagnostics (DM01) waits > 6 weeks	National	

Chief Operating Officer's Summary

Across urgent care our year-to-date performance stands at 71.7%, surpassing our plan of 66.8%. Over the past three months performance has been reducing marginally, along with increases in the average time to treatment and ambulance handovers. Since September, we have seen a slight drop in performance as winter pressures start to increase with attendances rising by 7.4% YTD on the same period last year. MFT is ranked 56 out of 122 providers nationally against the 4hr standard. Winter plans are being mobilised with a focus on streaming, triage, increasing capacity through Same Day Emergency Care and Urgent Treatment Centres. GM remains in TIER1 for Urgent Care, with MRI receiving external support from ECIST, GIRFT and Newton Europe. Newton Europe have completed a diagnostic of urgent care and flow which has identified opportunities across the whole pathway from admission avoidance to discharge. A new discharge ready date metric has been introduced nationally that measures the time between a patient no longer meeting the criteria to reside and their actual date of discharge. In November, MFT discharged 6713 patients of which 12% of patients were discharged >1 day after their discharge ready date, equating to 197 beds every day throughout November accommodating patients who no longer required an acute hospital stay.

Cancer 62-day backlog is on a positive trend since September, with November performance reporting 333 against a plan of 345. New performance standards are now in place for 31 and 62-day pathways, with MFT performing at 79.9% and 46.7% respectively. Performance against the Faster Diagnosis Standard for October is behind plan, driven by increased referral rates and diagnostic delays. Focus on 62 and 31day performance remains and improvement schemes are being embedded that include enhanced clinic capacity, theatre optimization, insourcing and additional clinician resource.

MFT have made good progress on reducing the overall RTT waiting list by c27k since April. Our focus continues on reducing our longest waits with the priority of eliminating 78 weeks by end of December except where patients exercise choice or are waiting a corneal graft, which is a national supply issue. The further industrial action periods announced for December and January will challenge MFTs commitment to reduce 65 weeks by end of March and we are working with GM Providers to de-risk plans through mutual aid offers.

Diagnostics whilst challenged is showing an improving trend with November reporting 45.1% against a plan of 44.5%. Improvement workstream and supporting actions are in place with additional capacity through community diagnostic centres and weekend insourcing to support. Funding requests were submitted nationally to support delivering 25% over 6 weeks by end of March but this unfortunately has not been approved and therefore delivering the 25% remains a risk

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain operational performance	4	16

Risk Profile

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 Report

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 November 2023, the Trust attendance rate was 93.8%. Each Hospital/ MCS/ LCO/ Corporate area has a bespoke target and plan to reduce sickness absence. Areas of focus include case management approach, review of long term cases, improving compliance with policy via the Absence Management system, and continued focus on both preventative and supportive Health & Wellbeing activity. Any adverse affects continue to be managed via flexible workforce deployment approaches (e.g. use of bank, additional shifts) and close operational planning in relation to activity, maintaining patient safety.

Workforce turnover (12-month average) has seen an improvement of 0.2% to 12.4% in November 2023, which is an improvement against our internal target of 12.6%. Stability/retention percentage is also showing an improvement on last month at 87.9% (improvement of 0.2%). Vacancy rate is also improving month on month, currently at 10.5% against a target of 7.5%. The ongoing delivery of our MFT People Plan continues to support staff retention and we anticipate this improved position to continue.

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory compliance for November 2023 achieved against target at 92.6%. However, further attention is needed in relation to levels 2 & 3 compliance which remain below target at 83.2%, although this is improving month on month. Appraisal compliance is also showing a general improvement over the last 12 months. Non-medical appraisal compliance for November 2023 was 83.7% against a 90% target. Medical appraisal compliance for November 2023 was 88.7%, which is achieving against 90% target. HR Directors continue to lead local improvement plans with Trust level oversight via the Assurance Oversite Framework (AOF) to recover our compliance position. A review of mandatory training content is ongoing to streamline and reduce time to train.

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 6.5 for November 2023 against a target of 6.8, and % BME staff in Band 8a and above roles which is currently 10.7% for November 2023 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%. Staff engagement and inclusion continues to be a key focus areas in 2023. Key initiatives include CEO Listening Events, Big Conversation, Staff Retreat, Staff Survey, 'Inclusionist' campaign, and 6 High Impact ED&I Actions - – all of which we anticipate will deliver improvements.

The Workforce agenda remains a strategic priority for the Trust, particularly in relation to staff experience / engagement, and workforce productivity and efficiency. The MFT People Plan refresh is underway to ensure it continues to deliver against organisational priorities.

Given the financial constraints across GM, pay controls remain a key priority, with Workforce WTE and pay expenditure being closely monitored against plan.

Risk Profile

Principal Risk

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

Finance Report

Finance: Executive Summary

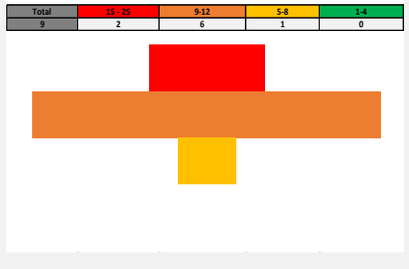
Focus	Ref	Status	Variation	Assurance	Action Status	Indicator	Indicator Type	Page
I&E	F1	✗	L	F	✗	Financial performance against budget YTD (£'000s)	External	
Pay Expenditure	F2	✗	H	F	✗	Total pay expenditure against budget YTD (%)	Internal	
	F3	✗	H	F	✗	Consultant spend - variance to budget YTD (%)	Internal	
	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	✓	~	?	👁	Drugs - variance to budget YTD (£'000s)	Internal	
	F8	✗	H	F	✗	Clinical Supplies - variance to budget YTD (£'000s)	Internal	
Income	F9	✗	L	?	👁	Income inlcuding Elective - variance to income in finance plan (£'000s)	Internal	
WRP	F10	✓	~	P	👁	WRP - variance to plan (£'000s)	Internal	
Capital	F11	✗	L	F	✗	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	✓	HA	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

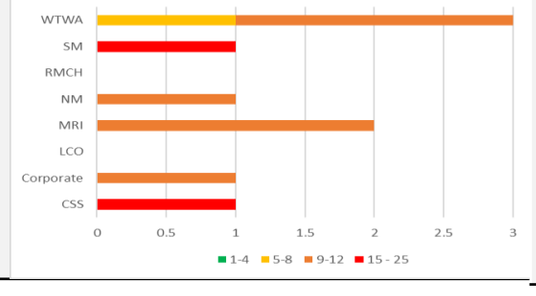
Risk Profile

Group Wide Risk Profile



No.	Strategic Risk	Score
5092	Capital finance	15

Site/MCS/LCO Risk Profile



Director of Finance's Summary

The financial regime for 2023/24 continues the focus on recovery of elective activity, reduction of waiting lists that have reached historic highs across the NHS and the continued drive to prevent unnecessary hospital admissions. There is now increased scrutiny on the finances of Greater Manchester in particular following the move into SOF3 with mandated support, with monthly Performance meetings and scrutiny of MFT's finances increasing as a result.

Key risks to delivery of the plan for 2023/24 are further industrial action (IA) by various staff groups, which has the impact of disrupting the ability to deliver elective recovery and also causes increased costs over the strike days; these strikes and their resolution is outside of the Trust's control. National funding for IA has been agreed to cover costs up to the end of November 2023, and MFT is anticipating receipt of £15.9m. This will be reported in the M8 financial position.

It also must be noted that the breakeven plan relies on achieving an historic high WRP target of £136.4m, which currently poses an estimated financial risk of circa £18m to the Trust.

The YTD position is driven primarily by the £8.2m reduction in ERF funds, cost of industrial action at £15.9m, inflationary pressures in non pay and higher levels of outsourced activity than planned. The Trust has instigated a wide range of actions, which are reported through the Group Recovery Board.

As at the 31st October 2023, the Trust had a cash balance of £123.3m which is a reduction of £8.6m from the £132.0m cash balance at the 30th September 2023. Cash remains lower than the plan (£202.1m at 31st October), reflecting the cash impact of the overall income and expenditure deficit against plan and some timing differences compared to assumptions for the receipt of commissioner income.

For the period up to 31st October 2023, total capital expenditure was £38.2m against a plan of £62.2m, an underspend of £24.0m. Expenditure included within the GM envelope was £23.3m against the submitted plan of £29.4m, an underspend of £6.1m. The full year forecast for the total capital programme is £111.7m which is a £39.5m reduction to plan.

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:	January 2024
Subject:	Financial Performance for Month 8 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 is essential as the Trust is operating in a very challenging operational and financial environment. • Board members should note the latest internal forecast position which highlights that there are several material risks to the achievement of plan, these are detailed at section 1.5, and materially include the additional cost associated with the drive to meet national performance targets, the costs and lost income associated with industrial action and the as yet undelivered gap on WRP. • 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 8 I&E position, the Forecast against the 23/24 plan and Cash and Capital positions for the Trust.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan and associated risk**	The financial regime for 2023/24 continues the focus on recovery of elective activity, reduction of waiting lists that have reached historic highs across the NHS and the continued drive to prevent unnecessary hospital admissions. There is now increased scrutiny on the finances of Greater Manchester in particular following the move into SOF3 with mandated support, with monthly Performance meetings and scrutiny of MFT's finances increasing as a result. Key risks to delivery of the plan for 2023/24 are continued industrial action by various staff groups, which has the impact of disrupting the ability to deliver elective recovery and also causes increased costs over the strike days; these strikes and their resolution is outside of the Trust's control. Other workforce concerns include the ongoing high sickness levels which the Trust has 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. It also must be noted that the breakeven plan relies on achieving an historic high WRP target of £136.4m, which currently poses an estimated financial risk of circa £3.7m to the Trust. Delivery of activity remains a key risk to the financial plan as Elective Recovery Funding is at risk if we do not achieve our activity targets. Year to date the Trust is £5.3m behind the ERF plan. The full year risk associated with under-delivery of ERF is in the region of £8m, although over achievement of £8.8m is assumed within the "best case" forecast of break-even. At the end of month 8, year to date to 30th November 2023, the Trust has delivered a deficit of £45.1m against a planned deficit of £19.0m, being adverse by £26.1m YTD. An in-month surplus of £17.3m has been reported, although this has been largely delivered by income of £15.9m to cover the YTD direct pay costs of industrial action. The YTD position is driven primarily by the £5.3m under-delivery of ERF activity, temporary staffing premium pay costs, inflationary pressures in non-pay and higher levels of outsourced activity than planned. The Trust has instigated a wide range of actions, which are reported through the Group Recovery Board, and included within the Forecast section of this paper, to address the financial position.
1.2	**Run Rate**	In November 2023 expenditure was £228.5m which is an increase of £5.8m compared to the month 7 value of £222.7m. This is predominantly driven by non-pay expenditure, which has increased by £4.7m due to an increase in CPT drugs expenditure of £2.4m (offset by income) and £2.0m against supplies costs. Pay costs increased also, primarily against bank – these increases reflect the fact that there were more working days in November than in the previous months.
1.3	**Cash & Liquidity**	As at the 30th November 2023, the Trust had a cash balance of £123.1m which is a reduction of £0.2m from the £123.3m cash balance at the 31st October 2023. Cash remains lower than the planned cash balance of £195.2m at 30th November 2023. This reflects the cash impact of the overall income and expenditure deficit against plan and also working capital balances compared to plan, largely as a result of

		timing differences compared to assumptions for the receipt of commissioner income.
1.4	**Capital Expenditure**	The capital plan is currently reflective of the as yet not agreed 2023/24 capital plan submission by GM and is still awaiting approval by NHSE. The Trust's element of the submission, with GM agreement, is a total plan of £151.2m, with the GM envelope component being £73.4m. To advance the capital programme whilst the allocation of the GM envelope is finalised, the Executive Directors Team (EDT) have authorised the MFT Capital leads to spend £55.5m on the GM envelope schemes; (representing £61.1m expenditure less £5.6m CDEL credits available from VAT recovery and historical accruals). This value is anticipated to be MFT's element of the GM capital envelope, and significant focus is being placed on delivery at this level of capital programme. For the period up to 30th November 2023, total expenditure was £42.7m against a plan of £81.9m, an underspend of £39.2m. Expenditure included within the GM envelope was £26.1m against the submitted plan of £38.5m, an underspend of £12.4m. The full year forecast for the total capital programme is £111.7m which is a £39.5m reduction to plan. In relation to IFRS 16 CDEL, recently published NHSE guidance has 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 current plan submission totals £45m, however, the level of the GM allocation is still subject to approval. For the period up to 30th November 2023, IFRS 16 capital spend totalled £3.2m. The full year forecast for IFRS 16 capital is £28.9m which is a £16.1m reduction to plan.

1.5	**Forecast Outturn and Risks to delivery**	There are several material risks to delivery of the 23/24 breakeven plan, which have been considered as part of the regular review of the forecast year end position. The run-rate forecast scenario exercise has been updated based on Month 8, with proposed best case (plan, breakeven), the most likely (between a breakeven and £11.6m deficit) and worst-case forecasts based on a series of assumptions of delivery against individual risks and opportunities. All three of these scenarios **do not include** the financial impact of the December and January industrial action. The key risks and opportunities recognised within this forecast are; <u>Risks</u> - Further cost pressures – loss of commissioner income, inflationary costs and pay award costs - Delivery of the Trust's WRP target - Support from the ICB for recognition of coding improvements driving income from April onwards - Support from NHSE for additional income <u>Opportunities</u> - Use of further flexibilities available - The impact of additional control measures being put in place. - Delivery of the Trust's activity and income plans However, there remain other risks to the Trust's delivery, which are harder to quantify but which would have a financial impact: - Sickness absence levels remaining high, failure to deliver the 2% reduction target - Turnover levels remaining high, failure to deliver the 1.5% reduction target - The direct cost impact of industrial action - The loss of activity and therefore income as a result of industrial action - The cost of delivering waiting time targets where these have been impacted by industrial action The most significant external risk not included within the forecast remains the GM "system risk" of £130m which is within the ICB's plan. This currently does not have a material plan identified to cover the savings required and so there is a risk that GMICB shares this savings target out to all providers. This additional risk could not be mitigated within MFT.

Financial Performance

Income & Expenditure Account for the period ending 30th November 2023

I&E Category	NHSE Plan M8	Year to date Actual - M8	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	631,012	632,781	1,769
ICBs	920,713	928,511	7,798
NHS Trust and Foundation Trusts	3,129	3,646	517
Local authorities	24,848	25,800	952
Non-NHS: private patients, overseas patients & RTA	7,837	7,165	(672)
Non NHS: other	11,806	14,301	2,496
Sub -total Income from Patient Care Activities	**1,599,344**	**1,612,204**	**12,860**
Research & Development	50,220	51,209	989
Education & Training	59,646	60,820	1,174
Misc. Other Operating Income	57,273	62,693	5,420
Other Income	**167,139**	**174,722**	**7,583**
TOTAL INCOME	**1,766,483**	**1,786,926**	**20,443**
EXPENDITURE			
Pay	(1,078,535)	(1,100,640)	(22,105)
Non pay	(625,609)	(656,967)	(31,358)
TOTAL EXPENDITURE	**(1,704,144)**	**(1,757,607)**	**(53,463)**
EBITDA Margin	**62,339**	**29,319**	**(33,020)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(47,483)	(42,455)	5,028
Interest Receivable	4,858	6,639	1,781
Interest Payable	(34,712)	(34,462)	250
Gain / (Loss) on disposal of PPE	0	(254)	(254)
Gain / (Loss) on Investment	0	103	103
Dividend	(4,016)	(4,016)	0
Surplus/(Deficit) before gain / (loss) on investments	**(19,014)**	**(45,126)**	**(26,112)**
Surplus/(Deficit) as % of turnover	**-1.1%**	**-2.5%**	
Impairment	**(82,240)**	**(36,216)**	**46,024**
Gain / (Loss) on Absorption	**0**	**0**	**0**
Non operating Income	**2,066**	**390**	**(1,676)**
Depreciation - donated / granted assets	**(1,378)**	**(943)**	**435**
Surplus/(Deficit) after non-operating adjustments	**(100,566)**	**(81,895)**	**18,671**

For the year to 30th November 2023, the Trust has delivered a deficit of £45.1m against a planned deficit of £19.0m, an adverse variance of £26.1m.

The position after non-operating adjustments is a £81.9m deficit, £18.7m favourable to plan, due to lower than anticipated impairments linked to slow progress against the New Hospitals Programme (NHP) capital scheme due to delays in national approvals.

Income

Year to date income is favourable to plan by £20.4m after receipt of £15.9m for the direct pay costs YTD of industrial action.The Aligned Payment Incentive monies (API), also referred to as ERF, are below plan by £5.3m, however, this is an improvement of £2.9m since month 7.

The other main reasons for the variance are:

- Allocations for UEC funding has been reduced by £3.6m
- Over-performance against CPT drugs of £1.3m (offset by an increase in expenditure)
- Over-performance against CPT devices (inc CAR-T) of £0.4m (offset by an increase in expenditure)
- Private Patient income is £1.5m behind plan
- E&T and R&D income are favourable to plan by £2.2m, primarily due to release of deferred income
- Overseas patient income and RTA income are a combined £0.8m favourable to plan
- Contract variations account for a further £2.3m favourable variance YTD
- Deferred income utilised YTD is £2.5m
- Non operating income variances account for an increase of £5.4m

In relation to ERF income, there remains a risk of circa £8m against the full year plan for elective activity since, although the YTD value has been included in month 8, assumption of full delivery of the original elective plan in each month Dec-March is assumed in the breakeven forecast, which together with coding improvements would drive an over-performance of c£8.8m as a result of the national changes to the elective plan.

Pay

Staffing costs are adverse to the restated plan by £22.1m YTD to month 8. The main reasons are:

- Industrial Action (IA) costs of £15.9m (now offset by income)
- Bank staff expenditure is adverse to plan by £22.9m YTD due to cover for vacancies and sickness and enhanced care nursing requirements
- Expenditure against agency staff is £5.8m favourable to plan, reflecting the Trust shifting cost to more cost effective bank staff
- Excluding the costs of IA from substantive staff reflects a favourable variance of £10.2m linked to vacancies across the majority of the staff groups
- Under-delivery of WRP targets across the Sites and the impact of prior year spending decisions also accounts for a proportion of the variance.

The work with PA Consulting in both the “pay” and “controls” workstreams are looking to address the non-IA overspends and seeking to deliver additional WRP in-year, and additional controls are in place to reduce this overspend.

Non Pay

The expenditure against non pay categories is adverse to the restated plan by £24.5m YTD (including interest, dividends and depreciation). The key variances YTD are:

- Clinical Supplies costs are adverse to plan by £6.8m driven by inflation and activity

- Drugs costs are adverse to plan by £8.1m of which the majority relates to CPT drugs. Work is ongoing to align CPT income to expenditure by area and ensure both income and expenditure is categorised apporpriately to align with commissioner funding.
- Outsourcing costs are adverse to plan by £2.5m supporting activity to reduce waiting list numbers
- Costs related to our Premises are above plan by £3.0m
- WRP balances unachieved account for a £9.0m adverse variance
- General Supplies adverse to plan by £3.3m
- Depreciation is lower than plan by £4.8m
- Variances across other non pay categories account for the remaining favourable £3.4m difference

Costs are forecast to further increase across some of these categories, such as Clinical Supplies and Drugs, as the year progresses as a result of actions to improve 78ww and 65ww numbers. This will not, however, bring in further income but if delivered will mitigate the risk around activity linked income that is already in the plan.

Financial Forecast as at Month 8

As noted in previous months the Trust has undertaken a top-down forecast scenario exercise based on Month 8 run rate, which describes a best and most likely scenario forecast outturn:

		Best Case	Most Likely
Ref	**Category**	**Breakeven**	**£9m deficit**
		£'000	**£'000**
1	**Run Rate Year End position @ M8**	(67,689)	(67,689)
2	Non-Recurrent items to M8 - Removed extrapolation	(1,874)	(1,874)
3	**Corrected for non-recurrent/IA costs**	**(69,563)**	**(69,563)**
4	Further pressures	(3,600)	(3,600)
5	Non-Recurrent Flexibilities/Balance Sheet (Exclude AL Accrual) not yet in position	4,800	4,800
6	Annual Leave Accrual	10,400	10,400
7	Clinical Income above extrapolation - assumes delivery of current commissioner plan.	5,348	5,348
8	Additional ERF income if deliver above revised 100% plan	8,727	8,727
9	WRP Delivery change from extrapolated value to deliver full plan	12,818	12,818
10	Deferred income review	7,520	7,520
11	Additional Control measures to reduce run rate	8,086	8,086
12	Review of Group Budgets	6,463	6,463
13	Consideration of further B/S flexibility - reviewed on a monthly basis	4,000	0
14	External Support requested from NHSE/ICB	5,000	0
15	**Forecast**	**(0)**	**(9,000)**

Key Assumptions

Many of the key assumptions have not changed from previous months

Ref 7,8 – 103% ERF activity is delivered in Dec - Mar and so MFT receives additional income above the current plan (note ERF is currently £5.3m behind plan YTD, so assumption that this is recovered plus activity relating to an additional £8.8m is delivered by year end).

Ref 11 - additional actions to reduce the current run rate are required by sites.

Ref 13 – 14 these assumptions are currently very high risk and work is ongoing to mitigate this risk. In addition, delivery of Ref 14 requires support from NHSE/GM ICB.

It should be noted that the scenarios assume that any material pressures for winter or other unanticipated financial impacts are mitigated. Very importantly, the scenarios **do not include** the financial impact of the Junior Doctors' Industrial Action, anticipated to be incurred in December 2023 and January 2024. Based on the impact of IA earlier in the year, this could be be c.£6m of expenditure, and c.£2m income impact which is related to lost activity. The impact of recovering lost activity, particularly relating to achieving the waiting time targets is also excluded and is difficult to quantify.

Further, as previously reported, the GM ICB holds a "system risk" of £130m in its plan, for which there is currently no agreed plan. There is therefore a risk that the ICB chooses to share this additional savings ask amongst providers and consequently MFT is asked to make additional savings. This would not be possible to deliver given the extent of the potential risks and ranges set out above.

Waste Reduction Programme

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

The tables below outline the month 8 23/24 YTD position against the planned savings. The Board is reminded that the phasing of the Waste Reduction Programme is skewed towards the later part of the year, with lower delivery anticipated during Q1, rising in Q2 and again for Q3 and Q4. Against this plan, on a consolidated basis, the Trust has achieved above the target delivery of £74.6m by £7.8m, delivering £82.4m YTD. Of this, £37.3m (45.3%) is non recurrent. Current forecasts show a shortfall in full delivery of the 23/24 programme of £3.7m – a sizeable improvement on the adverse £17.5m forecast in month 7 with further Group relaetd schemes now identified. Work is ongoing to identify further schemes to close this gap.

MFT Summary

Workstream	Savings to Date				Forecast 23/24 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG (YTD)	Plan (YTD) (23/24) £'000	Act/F'Cast (23/24) £'000	Variance (23/24) £'000	Financial BRAG (YTD)
Admin and clerical	3,837	3,837	0	100%	5,686	5,686	(0)	100%
Budget Review	2,593	2,593	2,593		4,991	4,991	(0)	100%
Contracting & income	5,285	5,343	58	101%	8,035	8,093	58	101%
Hospital Initiative	9,789	10,220	432	104%	18,993	19,425	432	102%
Length of stay	743	743	0	100%	1,115	1,115	(0)	100%
Non Pay Efficiencies	2,474	2,473	(0)	100%	3,842	3,842	(0)	100%
Outpatients	59	59	0	100%	91	91	(0)	100%
Pharmacy and medicines management	1,402	1,678	276	120%	2,268	2,512	244	111%
Procurement	4,326	4,361	35	101%	8,211	8,252	42	101%
Theatres	62	62	0	100%	93	93	(0)	100%
Workforce - medical	4,424	4,369	(55)	99%	6,877	6,782	(95)	99%
Workforce - nursing	3,323	2,245	(1,078)	68%	5,392	3,828	(1,564)	71%
Workforce - other	2,040	2,096	55	103%	2,633	2,688	55	102%
Informatics	1,749	1,749	0	100%	2,781	2,781	(0)	100%
Total (L3 or above)	**42,107**	**41,829**	**(278)**	**99%**	**71,007**	**70,178**	**(829)**	**99%**
Trust Initiative	32,460	40,570	8,110	125%	62,555	62,555	0	100%
Unidentified	-	-	0		2,854		(2,854)	
MFT Total	**74,567**	**82,399**	**7,832**	**111%**	**136,416**	**132,733**	**(3,683)**	**97%**

Summary against Target M1-8	YTD
Target	74,567
Actuals (L3 or above)	82,399
Variance to Target	7,832
Lost opportunity (value of schemes below L3)	1,247
Variance to target if all schemes delivered as plan	9,080

Summary against Target 23/24	Act/F'Cast
Target	136,416
Actuals/Forecast (L3 or above)	132,733
Variance to Target	- 3,683
Value of schemes below L3	2,710
Variance to target (all schemes)	- 973

Financial BRAG

at a detailed level there will be a range of ratings within each theme. An example is Divisional Non Pay where Corporate is risk rated green where as the overall scheme is risk rated

- 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/Forecast	23/24 Variance	23/24 % Variance
Corporate	5.0	5.4	0.4	8%
CSS	12.6	11.4	(1.2)	-9%
EYE	1.7	2.0	0.3	17%
Dental	0.6	0.4	(0.2)	-34%
LCO	3.8	3.8	0.0	0%
MRI	9.1	9.2	0.1	1%
NMGH	4.6	4.3	(0.3)	-7%
RMCH	6.2	4.2	(2.0)	-33%
St. Mary's	5.8	6.1	0.3	5%
WTWA	11.4	10.3	(1.1)	-10%
Hospital/MCS/LCO Total	**60.8**	**57.0**	**(3.8)**	**-6%**
Trust (Group)	75.6	75.8	0.1	0%
MFT Total	**136.4**	**132.7**	**(3.7)**	**-3%**

Statement of Financial Position

	M12 Restated 22/23 £000	M08 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	11,369	10,501	(867)
Property, Plant and Equipment	1,044,865	1,011,958	(32,907)
Investments	858	961	103
Trade and Other Receivables	17,318	17,897	579
Total Non-Current Assets	**1,074,410**	**1,041,317**	**(33,093)**
Current Assets			
Inventories	25,374	27,898	2,524
NHS Trade and Other Receivables	100,604	93,755	(6,848)
Non-NHS Trade and Other Receivables	56,004	58,404	2,399
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	240,943	123,147	(117,796)
Total Current Assets	**423,135**	**303,414**	**(119,721)**
Current Liabilities			
Trade and Other Payables: Capital	(36,707)	(17,024)	19,684
Trade and Other Payables: Non-capital	(436,632)	(381,947)	54,686
Borrowings	(36,267)	(34,998)	1,269
Provisions	(29,276)	(27,902)	1,374
Other liabilities: Deferred Income	(51,880)	(67,814)	(15,933)
Total Current Liabilities	**(590,762)**	**(529,683)**	**61,079**
Net Current Assets	**(167,627)**	**(226,269)**	**(58,641)**
Total Assets Less Current Liabilities	**906,782**	**815,048**	**(91,734)**
Non-Current Liabilities			
Trade and Other Payables	-	-	-
Borrowings	(479,935)	(460,191)	19,744
Provisions	(11,423)	(11,220)	203
Other Liabilities: Deferred Income	(2,805)	(2,804.6)	-
Total Non-Current Liabilities	**(494,162)**	**(474,215)**	**19,947**
Total Assets Employed	**412,620**	**340,833**	**(71,787)**
Taxpayers' Equity			
Public Dividend Capital	471,920	482,016	10,096
Revaluation Reserve	163,396	163,396	0
Income and Expenditure Reserve	(222,696)	(304,579)	(81,883)
Total Taxpayers' Equity	**412,620**	**340,833**	**(71,787)**
Total Funds Employed	**412,620**	**340,833**	**(71,787)**

There has been a £32.9m decrease in the carrying value of Property Plant and Equipment from £1,044.9m as at 31st March 2023 to £1,012.0m as at 30th November 2023. The decrease is due to depreciation of £43.3m, impairment of £36.2m, partially offset by in-year capital additions (including right of use assets) of £46.1m.

Inventories have increased from £25.4m as at 31st March 2023 to £27.9m as at 30th November 2023. This is driven by the recognition of £2.4m of medical devices that have been reclassified as inventories in month 8.

NHS trade and other receivables have decreased slightly from £100.6m at the 31st March 2023 to £93.8m at 30th November 2023. This is primarily due to the receipt of cash funding relating to the pay award of £51.8m, which is offset by an increase in clinical negligence scheme prepayments of £7.4m and an increase in accrued income relating to Clinical and Scientific Services of £5.6m. There have also been increases in central accrued income relating to industrial action support (£15.9m), drugs from NHS England (£7.0m), income received from Pennine Care FT (£3.2m) and from other NHS organisations (£4.0m).

Non-NHS trade and other receivables have increased from £56.0m at the 31st March 2023 to £58.4m at 30th November 2023. This movement is driven by an increase in trade receivables on the sales ledger of £5.3m, and a £1.3m increase in accrued income relating to Health Innovation Manchester. This was offset by a £4.2m decrease in prepayments relating to Hive.

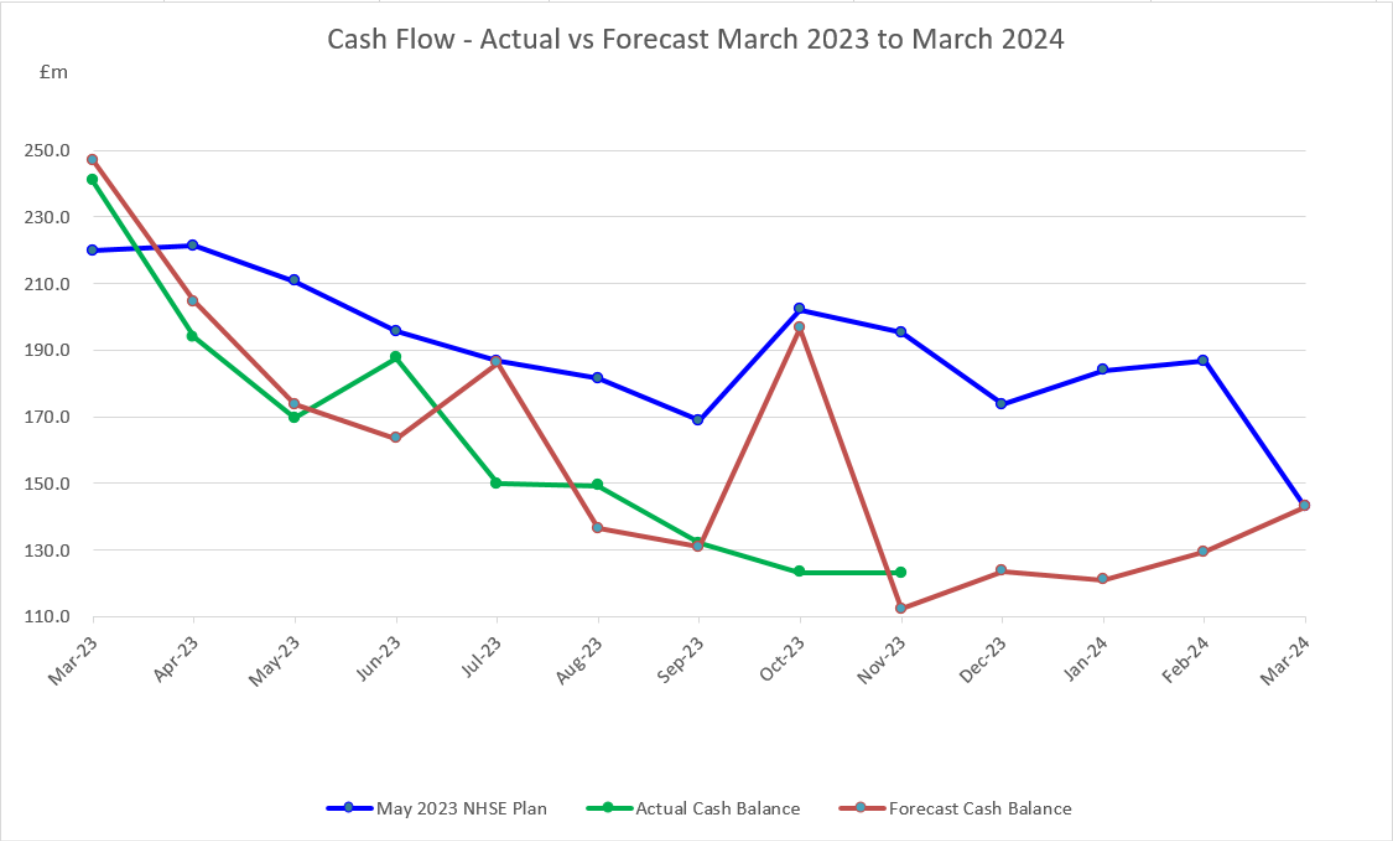
The escalation of capital activity towards the end of the 2022/23 financial year resulted in a high year end capital creditors balance. This has started to unwind in 2023/24 as a high value of invoices and payments are processed, resulting in a reduction in capital creditors from £36.7m at the 31st March 2023 to £17.0m at 30th November 2023, with a corresponding reduction in cash.

Since the year-end, there has been a reduction in non-capital trade and other payables, primarily driven by a reduction of £50m in accruals following the settlement of the pay award. There has also been a £1.4m decrease in central payables relating to Allocate agency costs, a £0.9m decrease in Public Dividend Capital dividends payable and a £0.6m reduction in taxes payable since the 31st March 2023.

Deferred income has increased from £54.7m at the 31st March 2023 to £70.6m at 30th November 2023. This movement is made up of the recognition of income in advance relating to Health Education England of £16.5m and ICBs of £4.3m. This was offset by a £2.8m decrease relating to surge funding and a £2.2m reduction relating to research grants.

As previously reported, the 2022/23 year-end process resulted in two restatements of M12 2022/23 figures- the opening balance sheet has been restated for two reclassifications in relation to capital payable to receivables (£0.8m) and between capital and non-capital payables (£3.2m). In addition, in month 7, as per guidance issued by NHSE, a prior period adjustment was processed relating to the balances reflected for leases on first adoption of IFRS 16 on 1st April 2022 - the net effect of this adjustment was to increase M12 2022/23 net assets by £0.1m.

Cash Flow



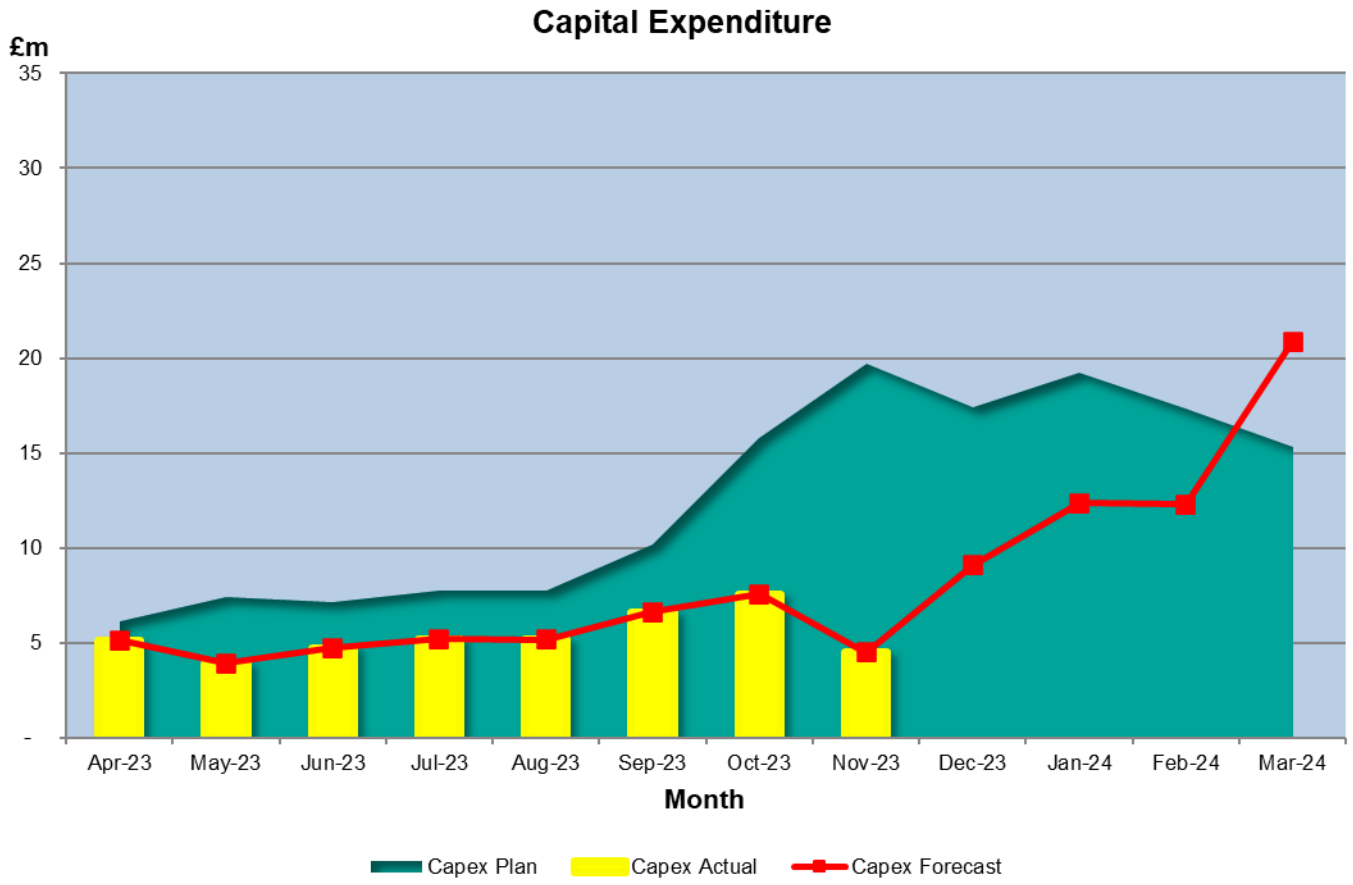
As at 30th November 2023, the Trust had a cash balance of £123.1m. This is a reduction of £0.2m compared to the cash balance at 31st October 2023 of £123.3m.

The key drivers of the £73.5m variance to the 30th November 2023 plan balance of £202.1m are the year to date £32.0m EBITDA adverse variance against plan and a net capital cash overspend of £6.9m (predominantly as a result of lower than forecast PDC drawdowns). Working capital movements are also £34.6m adverse to plan resulting in a lower than planned cash balance largely as a result of the timing of the receipt of commissioner income.

The future monthly cash balance is re-forecast each month. The cash balance at 30th November 2023 was higher than forecast by £10.8m, this was as a result of several factors including the income received from Greater Manchester ICB being £5m above forecast which was driven by funding relating to urgent and emergency care. Other drivers behind the variance to forecast include payments to NHS Professionals being £3.2m under forecast due to the timing of invoices and a net capital cash underspend of £2m. The assumptions underpinning the forecast are subject to an ongoing review and scrutiny to ensure they remain valid.

The finance team are working to review and improve the cash forecasting and monitoring processes and are reporting and reviewing cash balances and expected movements on a daily basis.

Capital Expenditure



In the period to 30th November 2023, £42.7m of capital expenditure has been incurred against a plan of £81.9m, an underspend of £39.2m. Expenditure included within the GM envelope was £26.1m against the original plan of £38.5m, an underspend of £12.4m.

The £39.2m year to date underspend is primarily driven by:

- £19.8m New Hospital Programme due to delays in funding approval;
- £8.1m Project RED due to delivery delays; the Estates team are reviewing the project to confirm the ability to spend to the approved plan by year end;
- £5.7m IM&T schemes that have been delayed due to late approvals;

The Trust's current total capital plan value for 2023/24 is £151.2m. £73.4m of this plan relates to the Trust's allocation against the GM envelope component and is still subject to approval. Whilst the GM envelope remained under discussion, the Trust authorised capital leads to spend £55.5m in relation to the in-flight and contractually committed capital schemes, alongside other schemes requiring approval to avoid operational delays and a possibility of being unable to complete capital schemes within the 2023/24 financial year. This includes the intraoperative MR scanner (iMRI) in RMCH, the hybrid theatre in the MRI and the labs life cycling on ORC.

At the time of writing this report, it has been agreed with GM to update the 2023/24 forecast for the GM envelope to £51.7m. However, this remains subject to agreement and approval at GM level. Thus, with the approvals through EDT, the full value of the anticipated envelope has been committed, and will require further management to remain within the now-approved envelope value.

The current 2023/24 full year forecast for the total capital programme is £97.6m, this is a reduction of £53.6m compared with the £151.2m submitted plan relating primarily to the following:

- £29.5m reduction in the North Manchester Hospital Programme (NHP) due to the delay in the approval for its Phase 2 enabling works bid;
- £21.7m reduction in the GM envelope as agreed with GM (whilst noting that formal approval of the GM envelope is still to be received); and

These underspends have been partially offset by an additional £4.4m of external funding for the TLHC, NIHR and Community Diagnostic Centre (CDC) schemes.

In relation to IFRS 16 CDEL, recently 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 current IFRS 16 plan submission totals £45m, however, the level of CDEL cover is subject to GM approval. Consequently, CDEL approval for new leases is being limited to leases already inflight at 31st March 2023 (totalling £8m) until final approval is received. Any impact this has on the continued operational performance of the Trust will also be assessed and action taken as necessary. In the period to 30th November, IFRS 16 capital spend totalled £3.2m.

The current full year forecast for spend against the IFRS 16 capital allocation is £28.9m, this is a reduction of £16.1m compared with the £45m submitted plan. The reduction primarily relates to managed equipment services leases (with lower than planned contract terms or being assessed to be outside of IFRS 16) and leases no longer required.

Agenda Item 10

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:	January 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 GSSC in relation to strategic issues of relevance to MFT. The content here will also form the basis of the update provided to the MFT Board of Directors regarding strategic developments.

2. National Developments

2.1. Patient choice guidance

NHS England has assumed responsibility for the regulation of ICBs in relation to patient choice. In recent years NHS England has strengthened its commitment to patient choice. New guidance outlines how commissioners, providers and primary care referrers can meet their obligations in relation to choice as set out in the NHS Constitution for England.

Commissioners need to ensure where a patient requires a physical health elective referral for a first outpatient appointment and any subsequent treatment that is required, to a consultant or a member of a consultant's team, the patient can choose:

- Any clinically appropriate provider that holds a qualifying NHS Standard Contract with any ICB or NHS England, for the service which the patient needs
- Any clinically appropriate team led by a named consultant employed or engaged by that provider.

Legal duties to offer choice of healthcare provider and team do not apply in certain circumstances, such as referrals for urgent and emergency care, suspected cancer, maternity services or Local Authority commissioned services.

Providers of elective care have specific responsibilities to ensure legal rights to choice operate effectively. Providers are required to

- Describe and publish all acute GP Referred Services in the NHS e-Referral Service (e-RS) so that they are visible to referrers and patients to support informed choices.
- Give advice to referrers on potential referrals, and on the care of service users more generally. This can help referrers understand if a referral is clinically appropriate for their patient.
- Accept all clinically appropriate referrals for that service where legal rights to choice apply.

2.2. Delegation of Specialised Commissioning

As reported to the Board in October, NHS England was planning to delegate commissioning responsibilities for a large proportion of specialised services to Integrated Care Boards (ICBs) from April 2024. Whilst the expectation had been that all ICBs would receive delegated authority for specialised commissioning from April 2024, a number of ICBs across the country signalled that they were not yet prepared to take on these responsibilities and sought a delay.

The NHS England Board met on 7 December and approved recommendations for:

- Full delegation to ICBs in the East of England, Midlands and the North West regions of England; and

- One more year of statutory joint commissioning arrangements between NHS England and ICBs in the South West, South East, London and the North East and Yorkshire regions of England.

Regardless of delegation status, NHS England will remain the accountable commissioner for the entire portfolio of specialised services and maintain responsibility for setting consistent national standards, services specifications and clinical access policies.

2.3 Chief Medical Officer's Annual report 2023 - Health in an Ageing Society

This report, produced by Professor Sir Chris Whitty, Chief Medical Officer for England, looks at the issue of an ageing population. It concentrates on how we can improve the quality of life in an adult's later years, and makes a number of recommendations, some of which are summarised below.

Older age is becoming increasingly geographically concentrated, and services to prevent disease, treat disease and provide infrastructure need to plan on that basis. Resources should be directed towards areas of greatest need, which include peripheral, rural and coastal regions of the country. The NHS, social care, central and local government must start planning more systematically on the basis of where the population will age in the future, rather than where demand was 10 years ago. This includes building or adapting housing and transport to be appropriate for an older population.

Central and local government have the principal responsibility for environmental factors which can delay or prevent the probability of early ageing. Making it easy and attractive for people to exercise throughout their lives is one of the most effective ways of maintaining independence into older age. Reducing smoking, air pollution and exposure to environments that promote obesity are other examples where the State has a major role to play in delaying or preventing ill health and disability over a lifetime and into older age.

Delaying disease to the greatest possible extent, to delay the period of disability in older age, should be the aim of public health and medicine. Science is continuously developing new tools to help do this, but we are often extremely poor at maximising the use of the tools we have. This 'secondary prevention' is predominantly the responsibility of the NHS but is currently under-prioritised. It is essential that we prioritise secondary prevention and screening services, and do more to extend these services to groups with reduced access and historically low uptake.

The medical profession needs to respond to the growth of multimorbidity. The single most important way to achieve this is to recommit to maintaining generalist skills as doctors specialise. NHS organisations also need to minimise the probability that the same person has to attend multiple clinics for a predictable cluster of diseases.

The health and care needs of older adults are often not recognised because the relevant data are not systematically collected or aggregated in one place. To plan appropriately, organisations including the NHS, Office for National Statistics (ONS), and central and local government need systematically to collect and share data on the health and care needs of older adults, including by ethnicity, sex and other protected characteristics.

In relation to research, it should be unacceptable to have exclusion criteria based on older age or common comorbidities. Research into multimorbidity, frailty and mental health needs to be accelerated and social care research needs to be a core component of health research programmes. The lack of inclusion of social care in health research is a significant gap.

3. Regional and Local Developments

3.1 Pennine Acute Disaggregation: Phase 3 Approvals

GM ICB discussed and approved the output of the substantial variation assessments for each of the Phase 3 complex service disaggregation proposals. These services are Dexa Scanning, Ear, Nose and Throat (ENT) Services, Urology, and Trauma and Orthopaedics (T&O).

3.2 GM plans for Improving the Primary/Secondary Care Interface

In May 2023, NHS England published a joint NHS and DHSC Delivery Plan for Recovering Access to Primary Care. The plan covers empowering patients, implementing new Modern General Practice Access approach, building capacity and cutting bureaucracy.

The cutting bureaucracy work stream is being led by NHS GM Chief Medical Officer. An integral part of cutting bureaucracy is improving the primary – secondary care interface. Nationally, practices estimate they spend 10% to 20% of their time on interface work. Reducing time spent by practice teams on work generated by issues at the primary-secondary care interface will allow practice teams more capacity to focus on patients' clinical needs.

The national delivery plan suggests work to cut bureaucracy is carried out by focusing on four key areas:

- Onward referrals - if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them
- Complete care - Trusts should ensure that patients are issued with fit notes for the appropriate length of time and discharge letters should highlight clear actions for GPs.
- Call and recall - NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments.
- Clear points of contact - providers should establish single routes for general practice and secondary care teams to communicate rapidly, e.g. single outpatient department email for GP practices or primary care liaison officers in secondary care

GM ICB plan to develop a multi-year approach to clinical integration that cuts bureaucracy and improves the interface by strengthening relationships at place through communication, understanding of each other's roles and a shared commitment to make improvements in this area.

A cross system working group of clinical leaders has been established to agree the scope of ambition for GM and to drive the delivery of this work, chaired by the Chief Medical Officer. Membership of the group includes stakeholders and leaders from across localities from primary and secondary care. MFT is represented by Toli Onon, Medical Director. The working group has identified key actions in each of the 4 areas.

In addition each locality is being supported to establish its own local working group so that local partnerships to build on existing professional relationships and communication pathways and share good practice and find solutions to problems.

4. MFT Developments

4.1. Vascular services

The Vascular service case for change and model of care have now progressed through Stage 1 of the NHS England assurance process, with the Clinical Senate panel review on 28 November and assurance meeting with NHS England NW on 6 December.

The clinical senate was broadly supportive of the case for change and model of care. They were particularly supportive of:

- The proposed development of a vascular network model;
- Standardisation of whole system pathways incorporating improved access for complex cases system wide;
- Intentions to focus on education, training workforce development; and
- Seeking opportunities for research and future service development.

The NHS England team were also supportive of the proposals and the documentation. The next step will be the completion of a pre-consultation business case.

4.2. Cardiac services

The cardiac service case for change and model of care have also progressed through Stage 1 of the NHS England assurance process.

Feedback from the clinical senate was positive, with support for a compelling case for change. They noted the high-quality documentation submitted and strong engagement with staff at this early phase.

Whilst we continue to follow the assurance process for the permanent move, there is a need to enact a temporary move of the cardiac theatre sooner due to the challenges to the service regarding the cardiac anaesthesia rota at the Manchester Royal Infirmary. This temporary move is being managed through the Cardiac Managed Single Service Board which is meeting fortnightly to ensure that this can be enacted on the 8th April. Consultation with the affected staff has commenced.

4.3. Sickle Cell Hyperacute Unit Pilot

The nationally funded pilot sickle cell hyperacute unit (HAU) opened with a soft launch for patients contacting the existing triage line in the week of 18 December; plans are in place for full implementation from mid-January. This will be the first of the three national pilots nationally to open.

Building on the development of the HAU, MFT has in a separate bid secured NHSE funding for a parallel pilot to extend community pathway. This will be provided by the LCO's Sickle Cell and Thalassaemia Community Service and deliver integrated home to hospital care.

4.4 Community Diagnostic Centre

Work to open the North Manchester CDC 'spoke' is on track for the early part of 2024. A workshop has been held to look at the role of care navigator and how they might support patients in order to address health inequalities. CDC Care Navigators are already working across Manchester and Trafford to involve and engage communities, identifying ways access and experience can be improved, particularly for groups that are most disadvantaged. They have successfully reduced non-attendance through direct engagement with service users to understand barriers to access.

4.5 Disaggregation of NCA/MFT Services

A Complex Disaggregation Oversight Group which will report into the group Single Service Board has been established. The group will oversee the disaggregation of those NMGH services that are still to transfer into MFT from Northern Care Alliance (NCA). They include Urology, ENT, Trauma and Orthopaedics and Pathology as well as the outstanding elements of Cardiology, Gastroenterology, Rheumatology and General Surgery the majority of which disaggregated on 1st October 2023.

ENT and Urology will disaggregate in April 2024. Trauma and Orthopaedics will disaggregate in October 2024. Discussions are continuing with the NCA regarding the scope and timeframes for the disaggregation of colorectal services. Interventional radiology is expected to disaggregate in 2025.

4.6 NHS Race & Health Observatory and Institute for Healthcare Improvement Maternal and Neonatal Health Learning Action Network

Saint Mary's Managed Clinical Service has successful bid to become part of the NHS Race & Health Observatory (RHO) \ Institute for Healthcare Improvement (IHI) and the Health Foundation (HF) Maternal and Neonatal Health Learning Action Network (LAN) which aims to close the gap seen in maternal mortality and morbidity between women from different ethnic backgrounds.

The LAN will drive clinical transformation and enable system-wide change to improve the outcomes for maternal health. The networks are not time-limited and will continue until the problem has been addressed.

4.7 Sexual Assault Referral Centre

The Saint Mary's Sexual Assault Referral Centre (SARC) has successfully completed its relocation to the Peter Mount Building from the Old Saint Mary's Building. SARC's new home includes additional facilities which can support the delivery of a modern SARC service, including forensic suites that comply with The United Kingdom Accreditation Service (UKAS) requirements and a dedicated 'Court Link' suite that allows trial witnesses to give evidence remotely in a more comfortable environment.

4.8 Targeted Lung Health Checks

The screening programme has now expanded in Wigan. The programme is currently behind trajectory, however with Wigan now online and the programme looking to expand into Wythenshawe in the new year activity levels are expected to pick back up.

Discussions continue with GM Cancer Alliance and NHSE colleagues in relation to resourcing the increased demand for diagnostics and treatment anticipated as targeted lung screening expands.

5 Recommendations

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

Agenda Item 11

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:	January 2024
Subject:	Annual Planning Process 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:. – Note the revised annual planning process – Note the progress to date – Note the next steps – Agree the suggested process for approval of the final submissions to Greater Manchester ICB.
Contact:	Name: Darren Banks, Group Chief Strategy Officer Tel: 0161 276 5676

1. Introduction

The annual planning process is the means by which we develop:

- MFT Annual Plan
- Hospital/ Managed Clinical Service (MCS) / Local Care Organisation (LCO) and corporate team Annual Plans, and
- Our contribution to the Greater Manchester Integrated Care System Operational Plan (which is subsequently submitted to NHS England).

The process we are adopting has been revised for 2024/25. The new process brings our activity, financial and workforce planning closer together to further strengthen the triangulation across the three areas. Other changes include establishing an Executive Director led Annual Planning Oversight Group and bringing the process forward to start earlier in the year.

The purpose of this paper is to outline the revised process, the timeline for 2024/25 as it currently stands (pending publication of the planning guidance from NHS England), progress to date in implementing the new process and the next steps.

2. Background

The annual planning process adopted last year was reviewed with Hospitals, MCSs, the LCO and corporate teams to identify what worked well and where improvements could be made. The findings and a proposed revised process for future planning cycles were presented to, and approved by, the Group Service Strategy Committee and subsequently agreed by the EDT Committee (EDTC). The following are the key changes that have been made:

- Bring forward the process so that the development phase begins in July and the delivery phase, that is the production of the plans, begins in October.
- Integrate all planning activities for 2024/25 into a single process
- Establish an Executive Director led Annual Planning Oversight Board to bring together all of our planning and ensure workforce, finance and activity planning is aligned so that all internal plans and submissions to Greater Manchester ICB are triangulated.
- Develop Hospitals / MCS / LCOs level integrated bottom-up capacity plans. This means calculating the level of activity that can be delivered through our workforce and physical resources. These will then be reviewed to identify where productivity improvements can be made. The Hospital / MCS / LCO level plans will then be aggregated into an overarching MFT plan.
- Four ‘cuts’ i.e. three drafts (cuts 1-3) and a final version (cut 4) of the plans will be produced. Cuts 3 and 4 will align with the draft and final submissions to Greater Manchester ICB.

3. Timeline and Assurance

The high-level timeline and a table showing the assurance and approval arrangements for the process are set out in attachment A. A detailed programme plan sits below this that aligns the requirements of all of the annual planning and related processes including:

- Production of Operational Plan templates for NHS England
- Development of MFT Annual Plan
- Development of Hospital/MCS/LCO Annual Plans
- Financial planning and budgeting
- Workforce planning
- Value for patients
- Capital planning.

It is important to note that the timeline is still subject to change as we do not yet have confirmation of the external deadlines. These will not be available until the NHS E Operational Planning Guidance and GM planning guidance are published which is now expected to be in January 2024.

There will be regular updates to the Workforce, Finance and Quality and Performance Scrutiny Committees where Board members will have the opportunity to review and query the approach and the plans in more detail. An exceptional meeting of the Chairs of the Scrutiny Committees is to be held in March to review the overall plan and provide assurance on the triangulation of the workforce, finance and activity plans and the impact on quality. Board members will then be familiar with the process adopted and content by the time the plan is presented for final for sign-off.

4. Progress to Date

The Annual Planning process began in July with the development of the of the planning guidance which set out the assumptions, timeline and process for workforce planning, financial planning and budgeting, value for patients programme development and capital planning.

The Annual Planning Oversight Board was established in August and has been meeting on a regular basis. It is chaired by the Group executive Director of Strategy. It is attended by the CFO, Deputy CEO and the Executive Director of Workforce and Corporate Business (representing the three key elements of the plan - finance, activity and workforce) and the Chief Nurse to ensure any impact on quality is considered. The Director of Digital Delivery will join the group in due course. Other members of the group are Hospital/MCS/LCO CEO, Director of Finance, Strategy Lead, Director of Operations, HR Director and Director of Nursing reps.

Production of annual plans started in October, Hospitals / MCS / LCOs and corporate teams have commenced the development of integrated bottom-up capacity plans, workforce planning, financial planning and identification of priorities for 2024/25. A model to estimate demand i.e. the activity required in order to deliver our targets for 2024/25 has been produced.

Cuts 1 and 2 plans have been completed and submitted and work on cut 3 has commenced.

5. Next Steps

The next steps are to:

Review national and GM planning guidance and align MFT guidance. We do not anticipate that this will result in any significant changes.	5 January
Complete cut 3	29 January
Submit draft plan to GM ICB	5 February
Update Scrutiny committees on approach and progress to date	February
Hold CoG Forward Planning Workshop	6 February
Circulate draft Annual Plan to CoG for comment	29 February
Complete cut 4	4 - 8 March
Exceptional meeting of Scrutiny Committee Chairs	March - TBC
BoD update	11 March
Submit final plan to GM ICB	18 March
Update Scrutiny committees on progress to date	April
GMB sign off Annual Plan	13 May
BoD approval of final Annual Plan	27 May

Given the deadlines, we will require that the final submission to Greater Manchester ICB is approved by the Chairman as 'Chairman's action' prior to Board approval of the final Annual Plan in May. Board members will by this stage be familiar with and have had the opportunity to review and query the plans though the Scrutiny Committees as set out in section 3 - Timeline and assurance.

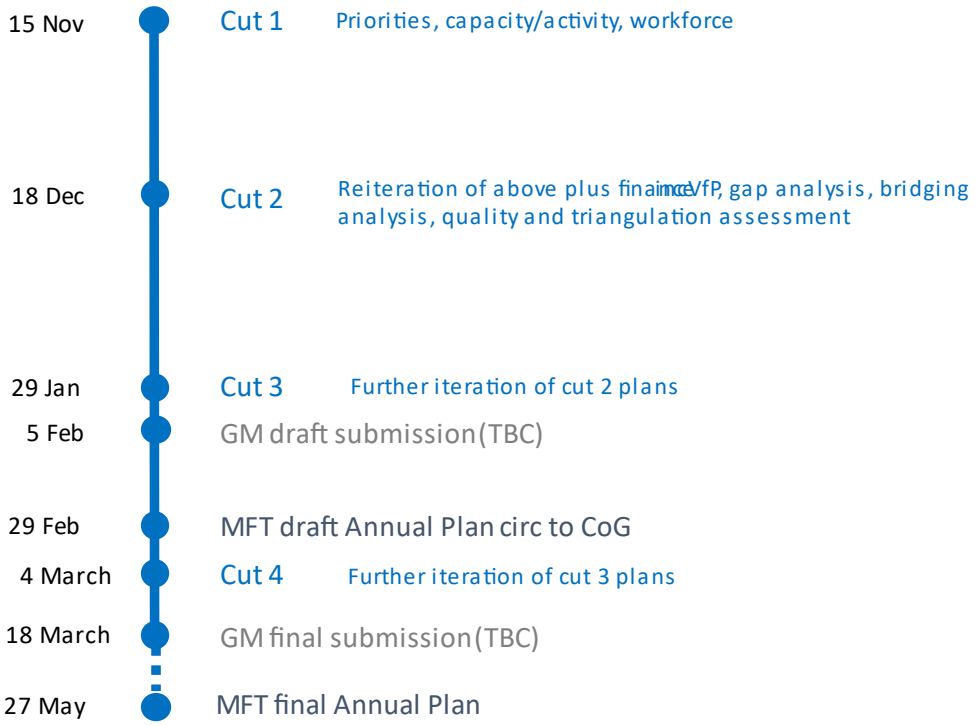
6. Actions/recommendations

The Board is asked to:

- Note the revised annual planning process
- Note the progress to date
- Note the next steps
- Agree the suggested process for approval of the final submissions to Greater Manchester ICB.

Attachment A

Annual Planning 2024/25 - high level timeline



Annual Planning 2024/25 - Assurance and Sign-off

Meeting	Date	GM submission	MFT Annual Plan
EDTC	1 February	EDTC sign off draft submission	
Deadline for GM draft submission *	5 February	CEO/Chair sign off draft submission	
Finance & Digital Scrutiny Committee	27 February	Update	Update
Workforce Scrutiny Committee	28 February	Update	Update
Q&P Scrutiny Committee	28 February	Update	Update
Exceptional meeting of Scrutiny committee chairs	March	Review of the MFT plan - assurance re triangulation	

BoD	11 March	Update	Update
EDTC	14 March	Review and sign off final submission	
Deadline for GM final submission *	18 March	CEO/Chair sign off final submission	
Finance & Digital Scrutiny Committee	23 April		Update
Workforce Scrutiny Committee	24 April		Update
Q&P Scrutiny Committee	24 April		Update
GMB	13 May		GMB sign off draft
BoD	27 May		BoD sign off final

Agenda Item 12.1

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. Yvon Poland, Group Head of Organisational Development, Learning & Education.
Date of paper:	January 2024
Subject:	Development of Leadership, Governance, Culture and Engagement at MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To enable delivery of organisational strategic aims the Trust is focused on developing its cadre of leaders and fostering a culture in which staff feel valued and engaged.
Recommendations:	The Board is asked to note this report and support actions identified.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 276 4841

1. Purpose

1.1.The report provides an overview of work underway or planned to build on the strengths of the existing approach to leadership development, the evolution of our governance arrangements, and to foster a culture in which staff thrive and feel able to contribute within an active staff engagement framework. Elaboration of each element is as critical to the development of MFT and it is to the successful implementation of our emerging organisational strategy.

1.2. All of this to be viewed in the context of the challenges NHS Trusts face in meeting the demand for elective and urgent care, in achieving financial sustainability and at the same time satisfying statutory requirements placed on the NHS.

2. Context

2.1 Significant work is already underway to develop an MFT organisational strategy aimed at ensuring we are in the best possible place to address the challenges we face and to maximise the opportunities we uniquely have to continue as a leading NHS organisation.

2.2 It is in this context that MFT has a positive track record in the development of its leaders and has led the way with several initiatives which have helped to attract, nurture, and develop leaders across the Trust. Building on this work we have reviewed the approach to the development of our leaders, considering the leadership skills, approach and development needs for the future.

2.3 As good practice all NHS organisations are required to periodically assess how ‘Well Led’ they are, ensuring they have effective ways of working, supported by appropriate systems and processes. MFT has therefore, reviewed its progress annually against the national Well Led requirements which has been subject to internal audit review.

2.4 As one of the largest and most complex NHS organisations MFT has grown significantly over recent years. For this reason it has been important that the Trust’s operating model is kept under review to ensure it is efficient, effective and agile enough to respond to changes in the internal and external operating environment.

2.5 It is essential that we have the right approach to staff engagement so we can create the appropriate culture for strategy implementation and one in which staff can thrive. In line with this a significant amount of staff engagement has already been undertaken to inform our future direction, ways of working and the organisational climate.

2.6 A variety of perspectives from inside and outside the organisation have been sought throughout this year to inform our emerging strategy, our day-to-day delivery, and the key priority themes which are set out in more detail in this paper.

3. Developing Our Leaders

3.1 From the outset, a core part of the Group Chief Executive Officer Engagement Plan has been to strengthen the involvement of the broader leadership community to help shape our future strategy, organisational development, and culture. A series of development sessions have taken place including a dedicated senior Leadership Summit in September. The summit confirmed a commitment to further collective and inclusive leadership as a means of designing and delivering the emerging organisational strategy. Incorporation and refresh of the existing MFT People Plan was agreed as an essential feature of the work.

3.2 To help progress the work leadership summits will take place every six months to consider the development of the senior leadership community in support of the successful implementation of our new organisational strategy. These events will be complemented by a series of leadership development sessions throughout the year accessible to a broader range of leaders and include muti-profession leadership development across the Trust.

3.3 Our talent management model is evolving and will be instrumental to our success. Attracting new talent to MFT will always be important, but it is essential that we are able to identify and nurture those with leadership potential within MFT. This will ensure we have the breadth of leadership skill and talent consistent with our values so we are in the best possible position for the future. We need to embrace the diversity of talent we have across the organisation and ensure there is greater diversity within our most senior leadership community.

3.4 On a specific element Professor Michael West CBE will be supporting our leadership development programme, with the Compassionate Leadership ethos being central to our approach. This is consistent with the priorities set out in the Messenger review , the NHS People Plan, and the premise that effective leadership and well developed staff impacts positively on the quality of care provided for patients.

4. Ensuring our operating model and governance arrangements are agile and effective

4.1. Our current operating model was created in 2017 when MFT was formed. Since then, MFT has increased in size with the incorporation of North Manchester General Hospital, making the Trust one of the largest in the NHS. While our scale provides many opportunities, it also creates complexity.

4.2. Many of our services are among the largest in the NHS and our approach to deliver the benefits associated with this scale will be critical to drive improvements in efficiency, productivity, and outcomes.

4.3. There have been significant changes in the external environment since the creation of MFT, which have driven new ways of working and much stronger partnership working across Greater Manchester. The need for deeper collaboration at locality level will be essential to provide more 'joined up' care for patients and to maximise the benefits from the partnerships across Manchester and Trafford.

4.4. To build on our annual Well Led assessments we have undertaken an externally supported developmental review against the NHS England Well Led guidance. This has been helpful in gaining a broader set of perspectives which have informed the recommendations set out in this paper.

5. Culture and Engagement

5.1. A series of listening events were held during the summer and formed a series of one-hour sessions led by the Group Chief Executive Officer. The sessions concentrated on four strategic priority areas - workforce, productivity, finance, and quality & patient safety.

5.2 Staff were invited to submit questions and to have open conversations. Over 1,500 staff participated in these sessions from all areas of the Trust and themes were collated to inform improvement opportunities for the future.

5.3. To complement the listening well series two '*MFT big conversations'* were added to promote staff experience and to gather further feedback on what matters to staff. The first covered digital leadership and included a month-long campaign to engage the entire organisation. This included masterclasses, focus groups, and a survey on what we need to do next as an organisation to build digital capacity / capability to improve staff and patient experience.

5.4. The second conversation was themed 'collective leadership'. This included materials to aid local conversations between managers and staff on what collective leadership means to them. A masterclass led by Michael West CBE, attended by over four hundred staff, discussed the importance of compassionate leadership as a precursor to collective and inclusive leadership.

5.5. Building on the expertise and commitment of the current leadership teams the aim is to foster a collective leadership approach reinforced by an explicit set of values and behaviours expected of staff.

6.0. Responding to the feedback we receive

6.1. Continuing the theme of listening to staff, and partly in response to the 2022 national staff survey results, four Staff Experience Strategic Workshops were held to focus on key points of feedback from the survey. Senior leaders and staff side representatives collaborated in the exercise.

6.2. The first, held on 3rd March, and themed *'A Call to Action'* considered points made by staff as to what could be improved. The second, held on 20th April 2023, was themed *'Breakthroughs'* revealing six priority areas:

- Food provision
- Car parking & transport
- Flexible working
- Colleague Community
- Management support offer
- Stretch opportunities.

6.3. The third, held on the 24th July, was themed '*Creating Advocacy Through Staff Stories'* and discussed updates on priority programmes along with a spotlight on food provision, car parking and transport. These were areas flagged by staff as issues to improve first.

6.4. The fourth event, held on 23rd November, was themed *'Driving Improvements'* with a spotlight on flexible working and colleague community (wellbeing and support) together with reflections on the 2023 National Staff Survey campaign.

6.5. To reflect the importance of moving the dial on staff experience, a new Staff Experience Oversight Board chaired by the Group Executive Director of Workforce & Corporate Business has been established. The detail on how this integrates with the strategic retreat programmes of work is outlined in appendix 1.

6.6 Data triangulation from all listening and engagement events has informed the next engagement series aimed at building future culture. To help ensure the work is as inclusive as possible circa eighty change agents from across the workforce are being inducted to support strategy, culture, and values conversations with colleagues. The outputs will culminate in a culture activity roadmap to drive further improvements as well as supporting the launch and deployment of the emerging organisational strategy.

6.7. Intelligence drawn from other staff engagement sessions (such as staff side feedback, local survey work at Hospital, Managed Clinical Services and Local Care Organisation levels together with initiatives led by Group Executive Directors, including Group Chief Nurse engagement sessions) has been used to inform the overarching culture and strategy work. This includes an assessment of the Trust Well Led arrangements against the national framework and compliance with the NHS England Equality, Diversity, and Inclusion High Impact Actions. With regard to the latter the Trust is engaged with a cross section of staff networks to inform a refresh of the Equality, Diversity and Inclusion Strategy, *Diversity Matters*.

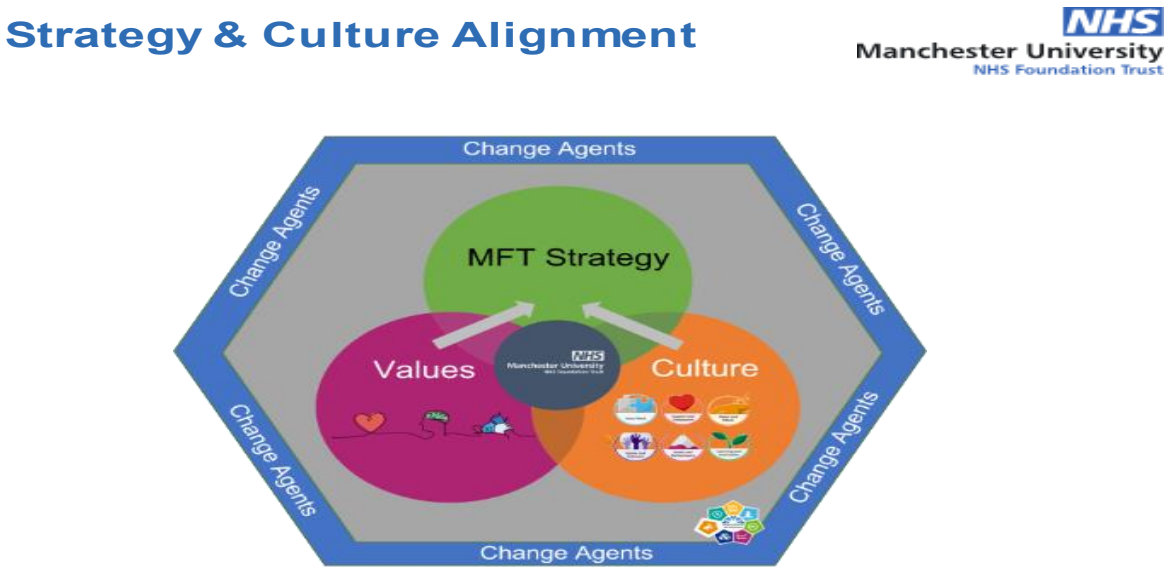
7.0 Organisation level approach and response to priority themes

7.0. A robust triangulation of data points, gathered as part of the organisation engagement series has produced themes to foster a culture in which staff feel valued, engaged, and empowered to deliver improvements in their area of work.

7.1. Themes have been mapped to the evidence base for culture measurement as outlined in NHS England's Culture and Leadership programme. This is to assist in ensuring that measurement is linked back to a positive impact in organisational performance. So that Group Executive Directors prioritise the highest impact areas now, themes have been overlaid with the strategic organisational change model - Burke Litwin.

7.2. As outlined in the Burke Litwin model, taking a deliberate and strategic approach to the top three impact areas without delay will have the greatest impact on cultural change. The three alignment areas are Strategy, Leadership & Organisational Climate (culture). Strategy, culture, and our values must be interconnected for the Trust to succeed in implementing the organisational strategy.

7.3. Culture is an expression of the way we work together and will determine our success in implementing the strategy. The next organisational engagement series therefore will concentrate on culture and be designed to enable staff-led change to co-create that culture for the future. Wrapped around strategy and culture are our values which guide everyday actions and behaviours. Through the strategy development work, we have undertaken a refresh of our existing organisational values, with the support of our colleagues and patient representatives. The diagram below describes the interconnections.



7.4. These themes will be refined further as part of the next organisation engagement series running from January to June 2024.

To inform this work the Board of Directors spent time at a development session in December to identify six areas of priority to help synchronise work on strategy, culture, and values. The first three are.

- Strategy development & deployment
- Leadership & culture
- Organisational operating model.

7.5. These will inform programmes, underway or planned, to finalise the organisational strategy, progress leadership development and shape a culture which helps make MFT a great place for staff to work, train and feel valued. This in turn will inform the structures, systems and processes which reinforce strategy delivery, the required operating model, and the required cultural climate.

7.6. The next three areas will ensure the Trust continues to have effective operating structures, systems and processes allied to good governance and strategy delivery. This will include active stakeholder engagement underpinned by a strong sense of collaboration.

- Board governance and assurance systems
- Workforce
- Improvement at scale.

7.7. Ensuring the Trust has a defined methodology to enable improvement at scale is seen as an essential component to success.

8.0. Overseeing the implementation of this programme of work

8.1. The successful implementation of the above activities will require more than an action plan and will become the MFT organisational development plan. The actions which underpin each of the six themes are:

Theme 1: Strategy development and deployment

Recommendations

- Ensure that external partners are consulted on the new 18-month plans and five-year strategy for the organisation.
- Take into consideration net zero and 2050 for the group strategy.
- Ensure all Hospital/Managed Clinical Services and Local Care Organisations and enabling strategies are in line with the overall group strategy.
- When approved, the new trust group strategy should be communicated widely, both within the organisation and externally.
- Develop a new strategic communications strategy and plan, with input from key stakeholders, aligned with the new group strategy.
- Conduct a strategic stakeholder mapping and analysis exercise and develop an engagement plan to be used by the group leadership, bringing in site and managed service leadership.
- Ensure that the Trust links its performance management and appraisal processes to the new strategy.

Key actions / completion date. Principal Lead – Group Executive Director of Strategy

- Develop MFT organisational strategy with delivery plan by end of April 2024.
- Develop a performance management framework to monitor delivery of the Strategy by end of May 2024.

5. Theme 2: Leadership and culture

Recommendations

- Emphasise the principles and practice of compassionate leadership in its leadership and management training at all levels.
- Put in place an outcome-orientated board development programme that deploys a development-by-doing approach.
- Review FTSU arrangements and ensure that investment in the guardian service is commensurate for a trust of this size.
- Undertake further work to understand better the barriers to speaking up and the experience of people who have raised concerns.
- The leadership should ensure that they preside over a culture were speaking up for patients and staff safety is business as usual.
- Senior leaders at site, managed clinical service and local care organisation should understand the ‘golden thread’ of board assurance.

Key actions / completion date. Principal Lead – Group Executive Director of Workforce & Corporate Business

- Leadership development initiatives for 2024/25 confirmed by the end of March 2024.
- Board development programme in outlined by end of January 2024 and agreed by the Board in March 2024.
- Complete the current culture organisation engagement series and produce a report by end of June 2024.
- Review of FTSU arrangements and actions agreed by end of February 2024.

6. Theme 3: Organisation design

Recommendations

- Chief Executive reviews the current configuration of main management units (sites, managed clinical services and local care organisations) and whether the arrangements remain optimal.
- Review whether the corporate strategy functions should have capacity for the whole trust or if Hospital/LCO/MCS require this service locally.
- At site level a means should be found to introduce independent constructive challenge into assurance meetings.
- Assurance groups with uni-professional memberships (e.g. drawn from clinical professions only) should be avoided.
- Review the communications and engagement structure.

Key actions / completion date. Principal Lead - Group Executive Director of Strategy

- Develop a refreshed Trust operating model complete with a sequenced action plan to deliver the model by end of April 2024.
- Building on the work already in place develop an enhanced strategic communications and engagement strategy by February 2024.

7. Theme 4: Board governance and assurance

Recommendations

- Assurance work of the board and committees, through the annual cycle of business, should be demonstrably driven by the BAF.
- Committee agendas and papers should be agreed by the committee chair and executive lead, as informed by the BAF.
- Annual review of board committees should include a board view on how well the committee concerned satisfied the assurance role delegated to it by the board.
- Board committees should include seminar sessions in their annual work programme.
- The Board should review the number of committees reporting into it and their work programmes.

- Board committees should not have management groups reporting into them.
- Non-executives should be assigned to specific committees.
- Group Risk Oversight Committee should formally report into the executive, rather than the board.
- Review the assurance groups operating across the trust – their effectiveness, fitness for purpose and opportunity cost.
- Ensure scrutiny and constructive challenge within the management boards and committees of its hospitals and managed clinical services.
- Arrangements for hospital management boards to report upwards to the group should be clarified.
- Assurance systems should consciously cater for the needs of staff with responsibilities beyond the organisation such as the Caldicott Guardian and the chief pharmacist.
- Committee chairs and executive leads should together develop the agendas, accept supporting papers and agree on who should be asked to attend committee meetings, informed by the BAF.
- Local action plans for each site arising from the risk management tabletop review should be implemented promptly and in full and a plan should be developed and implemented at group level to address the common factors across sites.
- Continue to develop its board assurance framework and ensure that it is prominent in board and committee agendas and shapes the work of those meetings.
- Terms of reference should be specific about who is a member of each committee and their responsibility to participate.
- Each of the ten principal risks covered by the board assurance framework should be owned by a single executive director, rather than the two or three that is currently the case.

Key actions / completion date. Principal Lead – Group Executive Director of Workforce & Corporate Business

- Review Board assurance processes and structures including scope, format, membership, and frequency of Board Scrutiny Committees in outline by end of February 2024 ready for Board consideration in March 2024.
- Assess management assurance structures and processes in light of new operating model (see theme 3 above) by end of June 2024.
- Implement recommendations from risk management tabletop review by end of April 2024.

8. Theme 5: Workforce

Recommendations:

- Develop a major organisational development programme for all staff in managerial positions, with a particular focus on middle management.
- Accelerate completing a structured approach to succession planning.
- Ensure that services to support employee wellbeing are fully staffed and that the range of services on offer are widely communicated across the trust.

- Step up efforts to promote ethnic diversity in its workforce and leadership cohort, starting by reviewing the effectiveness of the work done to date in this area.

- Review the working of the staff networks and consider the optimal structure for these and the resources which they require to operate effectively.

- Staff who participate in assurance meetings, particularly at middle management level, should be trained and developed to understand and service the trust's assurance system.

- Include the practicalities of risk management in the core competency of divisional, care group and middle management.

- Create guidance for managers to protect time for employees to participate in training and study during busy periods.

Key actions / completion date. Principal Lead – Group Executive Director of Workforce & Corporate Business

- Diversity Matters Strategy (Equality, Diversity, and Inclusion) refreshed by the end of April 2024 and submitted to the Board in May 2024.

- Ensure the staff network structure and engagement processes remain fit for purpose by the end of March 2024.

- Refresh learning and development policy by the end of April 2024.

- Build on existing arrangements to refresh and scale up the approach for leadership and management development by April 2024.

- Deliver engagement plan for Talent Enablement Strategy by the end of May 2024.

9. Theme 6: Improvement at scale

Recommendations:

- Ensure the Trust is able to complete important national and corporate clinical audits either by allocating more resources to the clinical audit process or by applying more stringent criteria that prioritise the most important audits.

- Regularly revisit a sample of approved and implemented waste reduction programmes to assess their actual impact on quality and to provide assurance on the effectiveness of the quality impact assessment process.

- Ensure at a consistent and appropriate level of resources to support data analysis, performance reporting and data quality is in place in each of the organisations within the group.

- Take advantage of the momentum of the Hive implementation to undertake an organisational change programme understanding and using data.

Key actions / completion date. Principal Lead – Group Deputy Chief Executive

- Review the arrangements for handling national and local clinical audits as part of the refresh of clinical governance systems and make recommendations to the Quality and Safety Scrutiny Committee by the end of March 2024.

- Continue the quality impact assessment processes associated with the assessment of waste reduction and associated activities seeking opportunities for any improvements to the processes by the end of February 2024.

- Complete the current Integrated Performance Reporting System and maintain a continuous improvement focus on the use of data and associated reporting to the Board and scrutiny committees by the end of March 2024.

- Successful recruitment to the Group Director of Improvement position – appointee commences in post April 2024.

- Development of organisation-wide improvement strategy, approach, and implementation plan, by end of July 2024.

- Derive the adoption of improvement methodology across Trust, supported by an organisational development programme by April 2025.

10.0. Roadmap

10.1. As outlined above, strategy, culture and values alignment will set the tone for the sustainability and reputation of the Trust. Vitally, staff-led change is central to co-creating future culture. Details of a roadmap produced to reflect such integration can be found in appendix 2.

10.2. As part of this approach activities fronted by the Group Chief Executive Officer, supported by Group Executive Directors and other senior leaders, will continue at pace throughout 2024. Outputs to support the confirmation of Trust values will be used to inform the definitive version of the organisational strategy - and its deployment - by making explicit the actions and behaviours expected of senior leaders, line managers and staff more generally.

10.3. Any consequential revisions required of governance processes or the Trust's operating model will be addressed as part of an ethos of continuous improvement for the benefit of patients and staff.

10.4. This work will be reported to the Board of Directors for approval.

11. Conclusion

11.1. Work outlined above is designed to enable a positive leadership environment, healthy culture, meaningful staff engagement and constructive stakeholder relationships such that the Trust can effectively deploy the emerging organisational strategy. It also highlights the importance the Board of Directors places on workforce, leadership, and governance.

11.2. A progress report will be shared with the Board in May 2024.

12. Recommendations

12.1. The Board is asked to:

12.1.2 Note the report and support actions identified.

12.1.3 Agree to the submission of a progress report to the March Board meeting.

Appendix 1 – Staff Experience Oversight Board and Strategic Retreat Integration

Staff Experience Oversight

NHS
Manchester University
NHS Foundation Trust

Governance	Q3 2023			Q4 2024			Q1 2024			Q2 2024		
	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT
Staff Experience Oversight Board												
Strategic Retreat Workshops												
Strategic Retreat priority projects sub Groups												
Staff Engagement Steering Group												

Staff Experience Oversight Board
Bimonthly

Strategic Retreat Workshops
Quarterly

Strategic Retreat sub Groups
Frequency Determined by Leads

Staff Engagement Steering Group
Monthly

A call to Action (March)

Breakthroughs (April)

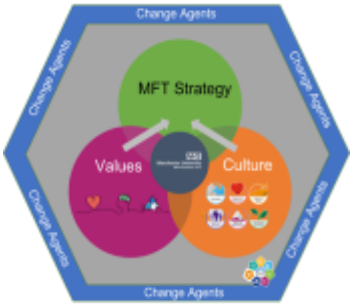
Creating advocacy (July)

Staff Stories campaign (August-October)

Driving Improvements (November)

Appendix 2 – Strategy & Culture Integrated Roadmap

The Roadmap: Strategy & Culture



Scoping
Understanding key organisational data

Discovery
Delivery of Focus Groups, Trolley Dashes to hear from the staff voice.

MFT Strategy Design Completed

Delivery
Implement our programmes and priority initiatives which were prioritised during the design work.

1 — Listening well events, key engagement activities & Report

4 — CEO Kick off

Values – high level themes

Data Consolidation

Analysis of Data

Synthesis event 'sense making'

6

Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr -Jun | Jul Aug Sept | Oct+

Recruitment | Onboarding Change Agents – Training offer | MFT Big Conversation – Strategy & Culture | Strategy & Culture Focus Groups & Trolley Dashes | Culture Focus Groups & Trolley Dashes | Synthesis | Design Groups

2 — **Engage**
Planning and recruiting the Change Team

3 — **Building Readiness**
Developing the Change Team
An MFT Big Conversation (Strategy & Culture)

5 — **Design**
Drawing insights from the discovery phases.

Phase 1– in line with MFT Strategy Creation

Phase 2 – Post MFT Strategy Launch

**2 and 3 are a new innovation in the use of deeper readiness and engagement reflecting our scale and reach*

Agenda Item 12.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nures
Paper prepared by:	Sarah Vause, Medical Director
Date of paper:	January 2024
Subject:	Maternity Services Assurance Report (Reporting for October and November 2023) Including update for Maternity Incentive Scheme Year 5
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation, and teaching. To improve patient safety, clinical quality, and outcomes. To improve the experience of patients, carers, and their families.
Recommendations:	The Committee is asked to note the following: • Assurance on matters relating to patient safety within maternity services, highlighting the use of the Maternity Safety Dashboard. • Summary of Maternity Incidents (Level 3 Harm and above) and Healthcare Safety Investigation Branch referrals • The update on compliance with the Maternity Incentive Scheme Year 5.
Contact:	Name: Sarah Vause, Medical Director Tel: 0161 701 6560

1. Executive Summary

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

- An update on progress following the 2023 Care Quality Commission (CQC) inspection.
- An executive summary of the maternity and neonatal dashboard
- Details of incidents graded as moderate harm or above that occurred in October and November 2023, and the shared learning.
- Details of cases eligible for referral to the Maternity and Newborn Safety Investigation (MNSI) (previously undertaken by Healthcare Safety Investigation Branch (HSIB)) in October and November 2023, and shared learning.
- Avoidable Term Admissions to the Neonatal Unit for Quarter 2, 2023/24.
- Progress report for Maternity Incentive Scheme (MIS) Year 5.
- Feedback from staff obtained during the monthly Safety Walkarounds.
- The maternity perinatal scorecard.

1.2. An **update on progress following the CQC inspection** was presented to and was reviewed by, the Quality and Performance Scrutiny Committee a subcommittee of the Board of Directors in December 2023. The initial improvements have been sustained, but metrics in relation to Triage have plateaued, and at a lower level on the Oxford Road Campus (ORC) than on the other two sites. Additional initiatives have been sought to achieve further improvements.There has been a reduction in staff turnover and all Core mandatory training compliance is above 90%.

1.3. The **maternity and neonatal dashboard** is reviewed monthly and provides consistent and timely access to maternity and neonatal data across the three sites. This enables the leadership team of Saint Mary's Managed Clinical Service (SM MCS) to consider any variation in processes or outcomes and provide support and enhanced monitoring where required. On review of data for October and November, no metric requires escalation.

1.4. Between October 1st 2023 and November 30th 2023 there were five **incidents reported in the moderate, major, or catastrophic harm category**. Details of these, together with the learning from them, have been presented to the Quality and Performance Scrutiny Committee. Themes included the importance of effective communication and timely clinical review.

1.5. There were two **referrals to MNSI** in October 2023 of babies who required therapeutic cooling, and one maternal death in November 2023. Full multidisciplinary review is being undertaken.

1.6. On all sites the number of term babies admitted to the neonatal unit is below the national threshold of 6% set by NHS England. In Quarter 2 of 2023 there were 19 **Avoidable Term Admissions to the Neonatal Unit**. All have a detailed multidisciplinary review and progress in relation to the action plan is monitored.

1.7. Subject to final approval at Board of Directors, SM MCS have met all required standards of **Maternity Incentive Scheme Year 5**.

1.8. **Safety walkrounds** have highlighted the need for improved WiFi connectivity, estates work within the Manchester Birth Centre and clarification of the process for requesting interpreters.

1.9. All metrics on the **perinatal scorecard** are within expected parameters, with none requiring escalation

1.10. The Board of Directors is asked to note the work ongoing to ensure the safety of women and babies across SM MCS.

2. Care Quality Commission (CQC)

2.1. SM MCS provide regular updates to the Board of Directors on progress made on triage processes, delays in elective pathways and reduction in staffing identified during the unannounced Care Quality Commission (CQC) inspection of Saint Mary's Managed Clinical Services (SM MCS) Maternity Services in March 2023 and subsequent Section 29a Warning notice. These concerns formed part of the final CQC inspection reports published in July 2023.

2.2. Updates are provided to both executive committees through Group Quality and Safety Committee and Maternity Oversight Group meetings chaired by MFT Chief Nurse and Executive Maternity Safety Champion and the Board of Directors Group Quality and Performance Scrutiny Committee.

Triage

2.3. Following the CQC inspection, measures were put in place to reduce waiting times at the different stages of the woman's triage pathway. These included:

- Increased midwifery staffing
- Increased Tier 2 medical staffing
- Strengthened escalation processes
- Proactive deflection of women (when appropriate) to other sites within the SM MCS
- Increased visibility of the categorisation / prioritisation of women and their waiting times.
- Increased oversight of women waiting in the area

2.4. In October and November, the proportion of women across SM MCS seen for initial triage within 15 minutes of arrival (BSOTS standard) has remained at 58-59% . When the NICE standard of 30 minutes from time of arrival to initial triage is considered, SM MCS is achieving >80%, with noted improved performance at North Manchester and Wythenshawe, who are consistently achieving >90% each month. Improvement has plateaued at a lower level at SM Oxford Road and different approaches are under consideration and have been piloted to improve the performance at ORC.

2.5. Since the introduction of the workstream there has been an overall reduction across the MCS in the number of women who take their own discharge from 3.6% (91 women) in February 2023. Although this had fallen to below 2%, there has been an increase in October and November. This is predominantly on the ORC. In November across the SM MCS 2.7% of women on triage took their own discharge (1.8% at North Manchester, 4.0% at ORC and 0.9% at Wythenshawe). An audit has been performed of all women who took their own discharge in the month of September 2023. Of the 60 women 57 were incident reported; 59 had a follow up appointment made (not needed for one woman); 49 had a follow up telephone call documented and 5 of the 11 who did not have a call documented had a follow up appointment the following day.

2.6. To achieve further improvement in the metrics members of the Triage Working Group visited Liverpool Women's Hospital to seek further initiatives.This was a productive visit and a consideration of the approaches/good practice undertaken at Liverpool Women's hospital is under review. A pilot project relating to a pathway for women presenting with reduced fetal movements has concluded, with the analysis showing a 25 minute reduction in waiting times on the ORC. This pathway will be implemented on the ORC as the triage unit with the highest acuity. Discussions with the team who developed BSOTS, regarding modifications to the pathways are ongoing.

No Delays

2.7. SM MCS has focused on reducing the delays women were experiencing during either the induction of labour pathway or category 3 ceasarean section pathway. Investment agreed by the Board of Directors have resulted in an increase in theatre capacity and have enabled SM MCS to achieve significant improvement in waiting times, which has had a positive impact in waiting times for those on induction of labour pathways.

2.8. During October and November 2023 there were five exceptions of women waiting more than 72 hours to continue the induction of labour process each month. This occurred during a heightened level of activity at SM MCS and all appropriate care and monitoring took place during this increased wait to maintain safety for the women.

2.9. Significant improvements have been made to induction of labour waiting times between February 2023 and the end of November 2023; no women have been waiting more than 96 hours.

Staffing

2.10. During the CQC inspection concern was raised that an increased number of incidents were reported related to midwifery staffing, particulary around the receipt of 1:1 care in labour. Other concerns related to recruitment, retention and compliance with mandatory training.

2.11. A review of 1:1 care in active labour demonstrates consistent performance over 98% of the time This performance has improved to > 99%.

2.12. There has been stabilisation in midwifery staffing of band 5 and band 6 vacancies since June 2023 and on 31st October 2023 there were 55.1 wte vacancies. Turnover has reduced significantly during the period June to October for band 5 and 6 midwives from 16% in June to 13.6% in October. 55 newly qualified midwives and four band 6 midwives have commenced in September, October and November, along with seven international midwives.

2.13. A further 36.33 wte newly qualified midwives, seven band 6 midwives and six whole time equivalent (wte) international midwives will commence between December and March 2024 (subject to confirmed start dates).

2.14. The service continues to recruit to turnover based on an approximate leavers figure of seven wte midwives per month across the MCS. This will be closely monitored over the coming months to reflect changes in turnover. Based on 7 wte leavers per month the service may have a residual 16.45 wte vacancies by the beginning of March 2024. Whilst an active recruitment campaign is ongoing to attract all levels of midwives to the service the supply chain remains challenging.

2.15. There is a continued focus on achieving compliance with Core Mandatory Training Levels 1, 2 and 3 and Maternity Specific Skills Training.

2.16. At the end of November 2023, Core Level 1 training has maintained compliance above the 90% target and is currently 94.89%. Overall compliance for Level 2 & 3 training is 90.55% again, above the 90% target.

2.17. Due to the planned increase in establishment following the Birth Rate Plus 202/23 review the percentage vacancies will increase until the additional posts are recruited to however the underlying rate is positive.

3. NHS England Three-year Delivery Plan for Maternity and Neonatal Services

3.1. As previously reported to the Board of Directors, NHS England released a Three-year Delivery Plan for Maternity and Neonatal Services in Mach 2023. SM MCS has developed an action plan which was approved by SM Quality Safety Committee (SMQSC) in November 2023 and incorporates outstanding actions from the final Ockenden Report, which also includes the recommendation to complete the maternity self assessment tool (MSAT)[1].

3.2. In August 2023, following receipt of the CQC reports in July, SM MCS provided an updated position on MSAT, along with evidence, to the regional Chief Midwifery Officer, as requested by the Maternity Oversight Group. In October 2023, the regional midwifery office agreed with SM MCS reported position and confirmed that SM MCS were currently compliant with 162 out of 168 elements within MSAT.The NHS England national team will undertake a diagnostic review against SM MCS improvement journey in January 2024.

3.3. The Three Year Delivery action plan will be monitored at the Joint Maternity and Newborn Services Divisional Quality Safety Committee and progress will be provided through SMQSC and onwards to the Board of Directors as part of the Maternity Assurance update.

4. Patient Safety

4.1. The governance processes in place within SM MCS provide assurance in respect of patient safety to the SM MCS leadership team. This includes external reviews of all

[1] https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

incidents classified as moderate and above that are reported monthly to the LMNS Patient Safety Special Interest Group.

Maternity and Neonatal Dashboard

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

Appendix 1, illustrates an image of the live maternity and neonatal dashboard executive summary which now includes escalation levels to alert the Maternity Services Division of an increase in perinatal morbidity and mortality. Escalation levels support increased scrutiny at a divisional level to determine if a full review is required. Within October and November 2023 there were no areas of escalation with the matenrtiy dashboard, with all data within expected parameters.

4.3. Perinatal data is also submitted monthly to GMEC LMNS and forms part of the GMEC Maternity Dashboard enabling comparison with other maternity providers within GMEC.

4.4. Following a request raised by GMEC LMNS noting an increase in the number of stillbirths at ORC in June 2023 and the number of early neonatal deaths at ORC in July 2023, detailed reviews (from January to August 2023) are being undertaken to identify any additional themes and to ensure that the learning has been identified. This is alongside the routine quarterly perinatal mortality (PMRT) report.

4.5. Early information indicates that whilst there has been an increase at ORC during 2023 when compared to 2022, this is largely due to a significant increase in medical terminations of pregnancy. An update of the reviews will be presented to the Joint Maternity and Newborn Services Divisional Quality Safety Committee in January 2024 and shared with the Safety Champions.

4.6. There are expected natural fluctuations in stillbirths and early neonatal deaths between months and a review of the maternity dashboard does not indicate any special cause variation within SM MCS. A review into the stillbirth data at each maternity site within SM MCS has also been undertaken to ensure any deviations are monitored and further reviewed as required.

4.7. Both the SM MCS position and each maternity site position has been provided in the Perinatal Scorecard (Appendix 9). There are no metrics flagging within the scorecard for escalation to Board of Directors.

4.8. In November a full review of the stillbirth data has highlighted small inconsistencies with the stillbirth data reported due a mistake in the coding logic that pulls the the data from Hive; this was amended in December 2023. Following this a data assurance SOP

is being developed by the Maternity Division to examine and validate the stillbirth data and other key metrics prior to publication on the dashboard. A risk assessment of the data quality, along with required mitigations, has been undertaken and has been presented at SM MCS Risk Oversight Committee and is on the the risk register at level 12 (risk number MFT/006311) until the data assurance SOP is implemented.

4.9. A data quality check has been undertaken of all stillbirths between January 2023 to the end of December 2023 acrossthe MCS (excluding termination of pregnancy) and the rate was calculated atr 4.12/1000 births in 2023 in comparison to 3.91/1000 births in 2022.

Summary of Maternity Incidents (level 3 harm and above) and Maternity and Newborn Safety Investigations (MNSI, formally known as HSIB) in October and November

4.10. In October and November 2023, a total of 5 cases were reported in the moderate, major, or catastrophic harm category. All cases have received High Impact Learning Assessments (HILA) which have supported initial learning and appropriate response for further review of care in line with Patient Safety Incident Response Framework (PSIRF). All families have received Duty of Candour.

4.11. All five of these case have been presented in detail at the Quality Performance and Scruntiy Committee in December 2023 and the respective themes and learning shared with the committee.

4.12. In addition to the specific learning in each case, all five cases have identified the importance of effective communication and ensuring timely review by the most appropriate clinicians. This links directly to the ongoing education programme related to the Each Baby Counts toolkit that encourages a systematic approach to communicating within and between team and use of escalation tools. The Each Baby Counts toolkit is included in the maternity mandatory training programme. Effective communication and escalation continue to be tested within the simulation sessions held across SM MCS.

4.13. In October 2023 there were two referrals to Maternity & Newborn Safety Investigation programme (MNSI which replaces HSIB) for babies with suspected hypoxic ischaemic encephalopathy who were actively cooled.Only one case was considered as moderate harm.

4.14. There was one maternal death reported in November 2023 for a woman receiving care within the Gynaecology inpatient ward. A multi-professional High Impact Learning Assessment (HILA) review has been completed and discussed at the SM MCS Incident Panel. As care was provided across primary care, and multiple services within Manchester Foundation Trust, a full review of care has been commenced. A MNSI referral has been made.

4.15. All cases have been presented and discussed at the SM MCS Incident Panel with escalation to Group Serious Incident Review and Investigation Panel as required.

5 Maternity Incentive Scheme (MIS) Year 5

5.1 MIS Year 5 was launched on 30th May 2023 and revised on 1st July 2023 with the submission to report compliance due by 1st February 2024 at 12 noon.

5.2 On November 2023 NHS Resolution published the MIS Year 5 declaration form to be signed by the CEO on behalf of the Trust Board and by the Accountable Officer for the Integrated Care System (ICS) following the presentation of overall compliance by SM MCS.

5.3 Table 1 provides an overview of the predicted SM MCS compliance against the MIS Year 5 Safety Actions:

Table 1: SM MCS predicted compliance against the 10 Safety Actions

Action No.	Maternity safety action	Compliant
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

5.4 The Board is asked to note the following in relation to MIS Year 5:

- **Safety Action 1**: Perinatal Mortality Review Tool (PMRT)

- Q2 2023/24 PMRT report submitted to Trust Board of Directors (Private) for Board meeting in January 2024.

➢ **Safety Action 2**: Maternity Services Data Set (MSDS)

- 10 of 11 MSDS related CQIMs were achieved. One was not, due to an inaccuracy in reporting in July 2023 regarding Continuity of Carer. However SM MCS remain complaint with year 5 MIS Safety Action 2 as in line with the guidance continued engagement monthly with NHS Digital can be evidenced

➢ **Safety Action 3**: Transitional Care services

- The Q2 2023/24 Avoidable admissions to the Neonatal Unit and Transitional Care Report has been completed (Appendix 2).
- There has been a slight increase in the number of avoidable term admissions to the neonatal unit, from 13 in Quarter 1 to 19 in Quarter 2; however there was no special cause variation.
- SM MCS did not exceed the national target of term admissions set by NHS England of a 6% admission rate. Wythenshawe had an admission rate of 4%, ORC (excluding planned surgical admissions) had an admission rate of 6% and North Manchester had an admission rate of 5.45%.
- A Task and Finish Group is in place to support the implementation of enhanced transitional care at the North Manchester site. The implementation date has been extended to 29th February 2024 as the business case is being progressed
- SMMCS can report full compliance with Safety action 3 .

➢ **Safety Action 4**: Medical and Neonatal Nursing Workforce planning

- A review of the obstetric medical workforce has been completed and shared with the Board level Safety Champions. An action plan was developed to address the shortfalls (Appendix 3).
- A review of the Neonatal Medical workforce has been completed and shared with the Board level Safety Champions. An action plan has been developed as the British Association of Perinatal Medicine (BAPM) standards are not met in full. An action plan was developed to support achieving compliance with Tier 2 doctor establishment and the consultant on call rota (Appendix 4).
- The neonatal nursing workforce action plan was developed following the 6-monthly review of the nursing workforce (Appendix 5).
- This meets the requirements for compliance with Safety action 4.

➢ **Safety Action 5**: Midwifery Workforce planning.

- SM MCS has completed a review of the funded midwifery staffing based on BirthRate+ (BR+) and identified a gap between funded establishment and BR+ recommendations. There has been an agrement to revise the midwifery establishment in line with BR+ recommendations.
- Workforce updates are provided monthly on each maternity site, to continually provide staff with accurate information related to recruitment and retention.
- An action plan was developed following any incident where one to one care in labour was not provided. This was presented to Maternity Safety Champions and will be monitored at divisional quality and safety committee (Appendix 6)

- In November 2023, SM MCS midwifery vacancy rate was 52.47 WTE across the three maternity sites. There are 54.22 WTE posts in offer which are expected to be in post by February 2024 and is expected to cover the current vacancy factor.
- This meets the requirements for compliance with Safety action 5.

➢ **Safety Action 6**: Saving Babies' Lives Care Bundle version 3 (SBLv3)

- SM MCS are required to achieve 50% in each of the six elements of this care bundle and 70% overall.
  Three of the elements were confirmed to have achieved 100% with a further one achieving 96%
- One element achieved 90% and one element 80%
- SM MCS submitted progress and confirmation of compliance against the implementation plan to the LMNS in December 2023 as all elements were above the minimum 50% and the overall position for all 5 elements was 96%

➢ **Safety Action 7**: Listening to women, parents and families

- SM MCS has maintained monthly meetings with the Maternity Voices Partnership (MVP) and evidence is being provided by the MVP that they are prioritising hearing voices from bereaved families and those from women from black and ethnic minority backgrounds.
- The CQC maternity survey action plan has been reviewed with the MVP. A thematic review of free text data from the Maternity Survey has also been undertaken and actions developed from the themes identified. These actions have also been shared with the MVP (Appendix 7).

➢ **Safety Action 8**: Maternity Specific Training

- Compliance for all staff groups is above 90%, as shown in Table 3 below with plans
- in place to ensure compliance is maintained.
- SM MCS has developed the Training Needs Analysis (TNA) in line with Version 2 of the Core Competency Framework. The TNA has been agreed by the Safety Champions (including executive safety champions) and the LMNS/ ICB.

Table 3: Training compliance for MIS Year 5

Staff Group	MDT Emergency Skills	Fetal Surveillance Training	CTG competency assessment	Neonatal Resuscitation
Midwives	96%	96%	93%	95%
Consultant Obstetricians	97%	97%	95%	
Trainee Obstetricians	96%	92%	91%	
Midwifery Support workers	99%			
Consultant Anaesthetists	98%			
Trainee Anaesthetists	97%			

- **Safety Action 9**: Maternity and Neonatal Safety and Quality**.**
  - Following publication in November 2023 of a review by Sands and Tommy's[2] regarding better Board oversight, a further review of the perinatal quality surveillance model was undertaken.
  - Following this review, it has been proposed, and agreed at SM MCS Safety Champions meeting by Executive and Non-Executive Safety Champions, that to further strengthen MFT Board oversight:

    - A bi-monthly report will be submitted to SM MCS Quality and Safety Committee with key reporting on perinatal data as required by NHSR MIS
    - A bi-monthly report will be received at SM Maternity Safety Champions meeting
    - A bi-monthly report on perinatal data will be received at Group Quality and Safety Committee
    - Items for escalation/scrutiny will be received at a bi-monthly Group Quality and Performance Scrutiny Committee (GQPSC) (sub committee of Board of Directors) as a standing agenda item
    - Subsequently an exception report will be submitted bi-monthly to the Board of Directors as a standing agenda item

  - The site based Maternity Safety Champions continue to undertake monthly walkarounds across all three maternity sites. Themes from these walkarounds, along with actions, are communicated back to staff via the Maternity Safety Champion poster (please see Appendix 8), with the following concerns being raised by staff in October and November 2023:

    - Poor K2 connectivity: additional computer workstations installed with the support of the Digital Midwife.
    - Manchester Birth Centre roof leaking: estates commenced work in September 2023 to complete the repair.
    - Staff at ORC unsure of the process for requesting interpreters when women are having elective procedures: the process was clarified and communicated to the clinical teams.

  - The Perinatal Quality Scorecard (capturing the minimum dataset required by MIS Year 5 Safety Action 9) is shared monthly at SM QSC and is an agenda item on each Maternity Safety Champions meeting and is provided in Appendix 9.
  - SM MCS has completed the Score Survey and the action plan has been shared with the Board level Safety Champions.
  - SM MCS claims scorecard data has been reviewed alongside incidents and complaints and used to agree targeted interventions aimed at improving patient safety in October 2023. This is reflected in the Trust's Patient Safety Incident Response Plan.

- **Safety Action 10**: Compliance with submission of all qualifying cases to HSIB/Maternity & Neonatal Safety Investigations (MNSI) and NHS Resolution's (NHSR) Early Notification Scheme **.**

[2] Sands_Tommys_Joint_Policy_Unit_JPU_Report_Board_oversight_Nov_2023.pdf

- Following completion of the MIS year 5 reporting period on the 7th December 2023 SM MCS are 100% compliant, reporting all qualifying cases to HSIB/MNSI and to NHSR EN Scheme from the 30th May 2023 to 7 December 2023 (Appendix 10).

6. Recommendations

6.1 Further to the discussion at the Board Quality and Performance subcommittee, it is recommended to the Board that the Board of Directors:

- Note the information provided in this report in relation to the work in place to ensure the safety of women and babies in SM MCS following feedback from CQC inspection.
- Note the work in progress to strengthen training compliance and support learning and assurance in relation to maternity safety.
- Approve the action plans developed in relation to the midwifery, nursing and medical workforces.
- Approve the Training Needs Analysis.
- Confirm compliance with MIS Year 5 Safety Actions.

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Appendix 1 – Maternity Dashboard (30th November 2023)

Please note, during the recent review of SM stillbirth data some anomalies in the data on the dashboard were noted, due to double counting of some of the logic, for this reason the stillbirth data above is not accurate. This has been addressed and will be reflected accurately on the dashboard from next month.

Appendix 2: ATAIN report Q2 2023/24

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Saint Mary's Quality and Safety Committee

Report of:	Professor Edward Johnstone, Clinical Head of Division, Obstetrics, Saint Mary's Managed Clinical Service Beverley O'Connor, Sarah Owen and Esme Booth, Heads of Midwifery, Saint Mary's Managed Clinical Service Victoria Bateman, Divisional Director
Paper prepared by:	Gill Furey, Lead Midwife for Governance, Saint Mary's Managed Clinical Service
Date of paper:	December 2023
Subject:	Quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit 1st July to 30th September 2023, Q2 2023/24 as required in Safety Action 3, Year 5 Maternity Incentive Scheme
Purpose of Report:	Indicate which by **(tick as applicable-please do not remove text)** • Information to note ✓ • Support ✓ • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality, and outcome • Improve the experience of patients, carers, and families
Recommendations:	The Committee is requested to accept and note the details in the report.

Contact:	Name: Gill Furey, Lead Midwife for Governance, Saint Mary's Managed Clinical Service Email: gill.furey@mft.nhs.uk

1. Background and Purpose

1.1. This paper provides a quarterly update to Board of Directors, as required by Maternity Incentive Scheme (MIS) Year 5 to comply with Safety Action 3 (sections b and c) and is submitted to Saint Mary's Quality and Safety Committee as part of Saint Mary's MCS perinatal surveillance model, which ensures Maternity, Neonatal and Board level safety champion oversight.

2. Introduction

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[3] to reduce admission of full-term babies to neonatal care.

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

2.3. It is critical for services to undertake robust reviews and learn lessons to reduce the number of mothers and babies who are separated after birth, and it is on this foundation that audits of TC are included as Safety Action 3 of year 5 MIS.

2.4. Saint Mary's MCS provides transitional care activity on all three maternity sites and, in accordance with the British Association of Perinatal Medicine (BAPM) principles, meet the standard set by NHS Resolution Maternity Incentive Scheme Year 5.

2.5. Saint Mary's MCS has a single harmonised TC guideline which was jointly developed by maternity and neonatal teams. The guideline has been reviewed by the maternity and neonatal teams to support the implementation of enhanced TC at the Oxford Road Campus (ORC) (nasogastric tube feeding) and North Manchester (nasogastric tube feeding and caring for babies requiring treatment who have Neonatal Abstinence Syndrome (NAS)) and meets the requirements in Safety Action 3 within MIS Year 5. This meets MIS year 5 Safety Action 3 (section a)

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

2.6. The enhanced elements of TC have been implemented at ORC and the date for implementation of the enhanced elements at North Manchester has been extended to 29th February 2024 to support completion of the required business case.

3. Audits of Transitional Care (TC) provision from 1st July to 30th September 2023.

3.1. As required by Year 5 MIS Safety Action 3, this quarterly review details the number of admissions to the neonatal unit (NNU) which met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding.

3.2. There were no babies, who met current TC admission criteria, admitted to the neonatal unit in Q2 2023/24 as a result of not receiving TC because of staffing or capacity issues or requirement of nasogastric tube feeding.

3.3. Quarterly TC activity audits including the action plan are provided to SM MCS Maternity and Neonatal Safety Champion for all three sites and meets MIS Year 5 Safety Action 3, (sections b and c) requirements.

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

3.5. There remain difficulties in extracting HRG 4/XA04 activity data to support TC activity from the Electronic Patient Record (EPR) system. As such, the audit for Q2 2023/24 continues to use both Hive and manual data to complete Q2 2023/24 reporting. Informatics are supporting efforts to be able to completely extract the data from EPR. Work is ongoing.

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

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

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

4.2. Documentation audits occur monthly by ATAIN champions and compliance is monitored on a monthly basis at Maternity Services Divisional Quality and Safety meeting and quarterly at the Joint Neonatal and Maternity Quality and Safety meeting. This meets MIS year 5 Safety Action 3 (sections b and c).

4.3. A weekly multidisciplinary review of unexpected admissions to the neonatal unit occurs on each maternity site, highlighting themes, actions, learning and whether the admission could have been avoided.

4.4. In the period 1st July to 30th September 2023 there were 19 term admissions across Saint Mary's MCS which were considered avoidable following multidisciplinary review. Eight babies on the Oxford Road site, six babies on the Wythenshawe site and five babies on the North Manchester site.

4.5. The Avoidable Admissions to Neonatal Unit report for Q2 2023/24, including themes for each avoidable admission and lessons learned, is monitored quarterly at Site Obstetric Quality and Safety Committee.

4.6. On review of specific ATAIN metrics above in 4.1, of the 19 avoidable admissions to the Neonatal Unit:

- 6 babies were admitted due to respiratory conditions.
- 4 babies were admitted due to hypoglycaemia.
- 0 babies were admitted due to early onset jaundice.
- 6 babies were admitted due to perinatal hypoxic ischaemia.
- 0 babies were admitted due to hypothermia.

4.7. Themes identified outside of the metrics in 4.1 include:

- One baby required admission for a surgical review.
- One baby had a low cord pH and was admitted for observation.
- One baby was admitted for observation following a fall at birth.

4.8. Each review, where required, continues to generate specific actions and these are logged via the risk management system, and monitored monthly at the Site Obstetric Quality and Safety Committee.

4.9. Further scrutiny is then applied at the quarterly Joint Maternity and Neonatal Divisional Quality and Safety Committee.

4.10. SM MCS did not exceed the national target of term admissions set by NHS England of a 6% admission rate. Wythenshawe demonstrated an admission rate of 4%, ORC (excluding planned surgical admissions) demonstrated an admission rate of 6% and North Manchester demonstrated an admission rate of 5.45%. Although it is recognised that Quarter 2, saw a slight increase from Quarter 1 in the number of avoidable term admissions to the neonatal unit, there was no special cause variation.

5. Action Plan

5.1. An overall ATAIN action plan, as required by MIS year 5 Safety Action 3 (section c) is provided in Appendix 1.

5.2. The action plan in Appendix 2 pertains to the detailed actions following the multidisciplinary review of any avoidable admissions to the neonatal unit. This meets MIS year 5 Safety Action 3 (section b).

6. Conclusion

6.1. Following approval at SM MCS Quality and Safety Committee, this paper will be submitted for Board Level review.

6.2. In accordance with the perinatal surveillance model, following approval, this paper will be shared with Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS) and onwards to Integrated Care Board (ICB). This meets MIS year 5 Safety Action 3 (section c).

6.3. Saint Mary’s MCS has maintained full compliance during Q2 2023/24.

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Appendix 1: ATAIN Action Plan

Action plan for MIS Safety Action 3

Key

Work not started	Work ongoing	Work completed

Recommendation	Action	Lead	Due Date	Update
A. Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care	Revise the current Saint Mary's MCS harmonised Saint Mary's MCS TC guideline which was jointly developed by maternity and neonatal teams to ensure that this meets the additional requirements in Safety Action 3 within MIS Year 5.	Inpatient Matrons, Saint Mary's MCS.	Completed	Guideline update by maternity and neonatal teams.
	Develop business case to support an explicit staffing model for TC at Saint Mary's North Manchester.	Esme Booth, Head of Midwifery, Saint Mary's North Manchester, and Alison O'Doherty, Head of Nursing for Newborn Services.	29.02.2024	Business case being developed. Deadline extended from 31.12.2023
	Present business case to Saint Mary's Senior Leadership Team for approval.	Esme Booth, Head of Midwifery, Saint Mary's North	29.02.2024	Business case in progress – extension

		Manchester, and Alison O'Doherty, Head of Nursing for Newborn Services.		agreed as awaiting full approval. Deadline extended from 31.12.2023
	With the support of the stakeholders, develop an action plan to support increased provision of TC at Saint Mary's, North Manchester.	Esme Booth, Head of Midwifery, Saint Mary's North Manchester, and Alison O'Doherty, Head of Nursing for Newborn Services.	29.09.2024	Date extended as approval in progress. Deadline extended from 31.12.2023
B. A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/ HoM) and operational lead) as well as the Trust Board, LMNS and ICB.	Complete monthly ATAIN documentation audits.	ATAIN Champions	Start: September 2023	Commenced September 2023 and ongoing
	Monitor compliance on a monthly basis at Maternity Services Site Quality and Safety meeting	Deputy Heads of Midwifery	Completed	Commenced and added to monthly agenda
	Monitor compliance on a quarterly basis at Joint Newborn and Maternity Services Divisional Quality and Safety meeting.	Quadrumvirate – Division of Maternity Services and Division of Newborn Services	Start: October 2023	Added to meeting agenda
	Ensure Avoidable Admissions to Neonatal Unit report, including themes for each avoidable admission and lessons learned, is monitored monthly at Site Obstetric Quality and Safety Committee, and produce quarterly report at the Joint Newborn and	Deputy Heads of Midwifery	Start: September 2023	Added to meeting agenda and ongoing

	Maternity Services Quality and Safety Committee			
	Ensure Avoidable Admissions to Neonatal Unit, including themes for each avoidable admission and lessons learned, is monitored quarterly at hospital Quality and Safety Committee	Esme Booth, Head of Midwifery, Saint Mary's North Manchester	Start: September 2023	Quarterly report submitted to SM MCS QSC - ongoing
	Ensure quarterly TC activity audits are provided to SM MCS Safety Champion meeting	Newborn services Clinical Head of Division	Start: October 2023	Added to Safety Champions meeting agenda and report shared - ongoing
	Following approval of the Quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit share with Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS) and onwards to Integrated Care Board (ICB).	Esme Booth, Head of Midwifery, Saint Mary's North Manchester	Completed	Q1 2023/24 report submitted
C. Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the	Review the guideline to ensure that TC pathway is aligned to ensure that babies between 34+0 and 36+6 are included and aligned to BAPM Transitional Care Framework to Practice.	Inpatient Matrons, Saint Mary's MCS.	Completed	Reviewed guideline reviewed by the maternity and neonatal teams
	With the support of the stakeholders, deliver the action plan in full to support	Esme Booth, Head of Midwifery, Saint Mary's North	29.02.2024	Action extended to support full approval

BAPM Transitional Care Framework for Practice for both llate preterm and term babies. There should be clear, agreed timescale for implemnenting this pathway.	the increased provision of TC at Saint Mary's, North Manchester in line with action for Standard B.	Manchester and Alison O'Doherty, Head of Nursing for Newborn Services.		process and implementation at North Manchester.
	Implement nasogastric tube feeding in the postnatal areas at Saint Mary's, Oxford Road	Lisa Sharpen, Deputy Head of Midwifery, Saint Mary's Oxford Road	Completed	Implemented at Oxford Road Campus

Appendix 2 – Action Plan

Action Plan

Action Plan Name: ATAIN Action Plan

Action plan Creation Date: 15/11/23

Accountable Officer: Patient Safety Midwives (Wendy Knight, Claire Clough, Meg Hyslop-Peart, Hannah Burton)

Responsible Officer: Deputy Heads of Midwifery (Lisa Sharpen, Lisa Dennison, Emily McClure, Emma Coulton)

Latest Update Date: 15/11/23

Completed	
Delayed with manageable risk	
Delayed with risk	
On track	
Not started	

Admission Theme	Site	Action Description	Start Date	Review Date	Action Owner	Status	Updates
Asphyxia	ORC	Staff updated at team meetings on issue within HIVE with regards to buddy/fresh eyes not saving if done too close	1st May 2023	1st Jun 2023	Fetal Monitoring Midwife		Completed

		together (within same minute) staff made aware to check documentation saves. Issue escalated to Digital Matron, unable to amend in HIVE, staff to complete in separate minutes.					
Asphyxia	ORC	Refresh Reminders on when to complete CTG reviews/ fresh eyes in person reviews and to ensure staff check that reviews done close together save within HIVE.	1st Jun 2023	1st Jul 2023	Fetal Monitoring Midwife		Completed
Asphyxia	ORC	Add to Risky Business Newsletter and core huddles regarding frequency of CTG reviews and fresh eyes in person review	1stJun 2023	1st Jul 2023	Ward Manager of Delivery unit		Completed
Asphyxia	ORC	Add to Instagram page reminders around frequency of Fresh Eyes/Buddying	1st Jun 2023	1st Jul 2023	Fetal Monitoring Midwife		Completed
Asphyxia	MCS	To add Intelligent Intermittent Auscultation (IIA) into the audits for quarter 2: 1. Appropriate risk assessment undertaken prior to commencing IIA 2. IIA used appropriately in the 1st stage of labour 3. IIA used appropriately in the 2nd stage of labour 4. Escalation appropriate when concerns with IIA present	1st Jun 2023	1st Jul 2023	Labour ward managers and Birth Centre Managers and consultant midwife		Completed
Asphyxia	North	Gap analysis to be conducted, to ascertain the implementation of holistic reviews in all areas of birth	1st Jul 2023	1st Aug 2023	Labour Ward Matron		Completed
Asphyxia	ORC	Add to Risky Business Newsletter and Core Huddles regarding frequency of CTG reviews and fresh eyes in person review	1st Aug 2023	1st Sept 2023	Delivery Suite Manager		Completed
Asphyxia	MCS	To remind all doctors to complete a flowsheet/ navigator in doctors view, when asked to review a CTG in both Antenatal and Intrapartum settings and to use the correct flowsheet	1st Aug 2023	1st Sept 2023	Labour Ward Obstetric Leads		Completed
Asphyxia	MCS	Create a risk assessment flowsheet within Hive which ensures correct method of fetal monitoring is advised.	1st Jul 2023	1st Jan 2024	Fetal Monitoring Lead Midwives and Birth Centre Managers		Completed

Asphyxia	ORC	To request staff to incident report when a review which is a buddy/ fresh eyes does not save so that the MRN number is able to be shared with Digital Midwife Matron who can follow this issue up with HIVE.	1st Jul 2023	1st Aug 2023	Delivery Suite Managers		Completed
Asphyxia	Wyth	Send survey to Band 5 and Band 6 midwives to understand what the barriers are to achieving CTG reviews and fresh eyes/in person reviews. To share this data to Intrapartum team and create action plan.	1st Aug 2023	31st Aug 2023	Patient Safety Midwife		Completed
Asphyxia	Wyth	Data impacted by Band 7 sickness. Data shared at Band 7 meeting. Plan to escalate to ward manager, bleep holder or intrapartum matron if cannot achieve 30-minute review following admissions.	1st Aug 2023	14th Aug 2023	Patient Safety Midwife		Completed
Asphyxia	North	Investigating why co-ordinator reviews are not always taking place, where it has not been met noted that it did not occur.	1st Aug 2023	1st Sept 2023	Patient Safety Midwife		Completed
Asphyxia	North	To utilise Core Huddles to advise staff to access Managers/ Maternity Bleep holders/Specialist Midwives to complete hourly buddy/fresh eye reviews in labour. This should show an improvement in Q3 2023-2024. Encourage Coordinator reviews to be completed by 2nd Band 7 during handovers/ward rounds.	1st Aug 2023	1st Sept 2023	Deputy Labour Ward Manager		Completed
Asphyxia	MCS	Create master spreadsheet to look at incident themes for incidents relating to IIA	1st Jun 2023	1st Jul 2023	Patient Safety Midwife		Completed
Asphyxia	MCS	GMEC Fetal Monitoring in labour Version 3 guideline to be ratified in principle	1st Sept 2023	1st Oct 2023	Fetal Monitoring Midwife		Completed
Asphyxia	Wyth	Communicate with all band 7 coordinators, that women admitted to Delivery Suite while awaiting ARM or acceleration of their labour still require review within 30 minutes.	1st Oct 2023	31st Oct 2023	Delivery Suite Matron		Completed
Asphyxia	Wyth	Develop and circulate posters to advise that band 5 midwives to complete fresh eyes reviews with another band 5 midwife if these aren't consecutive and/ or escalation of concerns has already taken place.	1st Sept 2023	30th Sept 2023	Patient Safety Midwife		Completed

Asphyxia	MCS	Hive to build navigators for: New CTG flowsheets based on New Fetal monitoring in labour guideline. Hive to build flowsheets for structured risk assessments	1st Aug 2023	1st Jan 2024	Fetal Monitoring Midwife		Ongoing
Hypoglycaemia	Wyth	To link in with diabetic midwife at Wythenshawe and create action plan to improve hand expression compliance by 36 weeks.	1st Aug 2023	31st Aug 2023	Patient Safety Midwife / Diabetic Midwife		Completed
Hypoglycaemia	North	To discuss the data collected relating to hypoglycaemia at SOQS and ensure this is most pertinent information.	1st Sept 2023	1st Oct 2023	Patient Safety Midwife		Completed
Hypoglycaemia	MCS	Discuss removal of this audit standard as is well embedded in practice. Discuss with diabetic consultant leads to see if data is required.	1st Sept 2023	30th Sept 2023	Patient Safety Midwife		Hand expression advice by 36 weeks gestation no longer reported as part of the ATAIN audit.
Hypoglycaemia	Wyth	Establish data for infant feeding, amendment to hypoglycaemia guideline to improve clarity around timing of first feed in at risk infant.	1st Sept 2023	30th Nov 2023	Infant Feeding Midwife		Completed
Hypoglycaemia	Wyth	Wythenshawe - Transitional care link to create an education board on the delivery unit focusing on the importance of early feeding.	1st Sept 2023	30th Sept 2023	TCU Lead / Patient Safety Midwife		Completed
Hypoglycaemia	MCS	Delivery Suite Education Midwives to support staff with caring for “at risk” babies appropriately	1st Oct 2023	31st Dec 2023	Delivery Suite Education Midwives		Ongoing with new starters

Jaundice	ORC	For education around babies with darker coloured skin. IQP work for improving compliance on daily checks with jaundice.	1st Sept 2023	1st Oct 2023	Postnatal Ward Managers		Completed
Jaundice	MCS	Infographic guide for midwives to support documentation of jaundice checks – shared at all three sites.	1st Aug 2023	1st Sept 2023	Patient Safety Midwives		Completed
Jaundice	Wyth	NIPE and night shift postnatal midwives to complete flowsheets to improve compliance	1st Aug 2023	31st Aug 2023	Postnatal Ward Manager		Completed
IT	MCS	Risk Assessment Navigators are currently being built within HIVE to support identification of the most appropriate method for fetal monitoring at the start of labour and throughout labour for hourly risk assessments during IIA.	1st Aug 2023	30th Nov 2023	Fetal Monitoring Midwife		Awaiting HIVE build, design completed
TC	ORC	Ongoing work at ORC to introduce Nasogastric Tube Feeding on the postnatal wards.	1st Sept 2023	30th Nov 2023	Inpatient Matron and Matron for Newborn Services		Completed
Human Factors	MCS	Review of cluster incidents in relation to the theme of 'Loss of Situational Awareness' and 'Delay in delivery'	1st Oct 2023	31st Oct 2023	Patient Safety Midwives		Completed
Human Factors	MCS	Amend the Behaviours Workshop, to focus on local themes of situational awareness, lack of escalation, delay in birth, team communication. To consider the pathway from pathological CTG to birth, to highlight the barriers which are currently occurring between these two instances and develop plans to overcome them.	1st Oct 2023	1st Mar 2024	Fetal Monitoring Midwives		Ongoing
Asphyxia	MCS	Amend fetal surveillance education to include considerations for when passive time is appropriate in 2nd stage and expectations following fetal scalp stimulation.	1st Oct 2023	1st Mar 2024	Fetal Monitoring Midwives		Ongoing
Human Factors	MCS	Safety discussions with staff to identify barriers to safe care and identify contributory factors to loss of situational awareness.	1st Oct 2023	1st Nov 2023	Fetal Monitoring Midwives		Completed
Human Factors	MCS	Feedback findings of staff stress, fatigue and acuity to Intrapartum Matron and Labour Ward Lead	1st Oct 2023	1st Oct 2023	Patient Safety Midwives		Completed

Human Factors	MCS	Retention midwives asked to support with Stress Workshops regarding theme identified within avoidable admissions to NICU in Q2	1st Oct 2023	1st Nov 2024	Staff Retention Midwives		Ongoing
Ethnicity	MCS	Review theme found in quarter 2 of black mothers being overrepresented within the avoidable admissions and look for common denominators within these. To link in with Cultural Safety and Ethnic Minority Engagement Midwife to create robust actions for any similarities found.	1st Oct 2023	1st Nov 2024	Patient Safety Midwives		Completed
Communication	MCS	Exploration of availability of face-to-face interpreters during care in labour	1st Nov 2023	31st Jan 2024	Cultural Safety and Ethnic Minority Engagement Midwife		Ongoing
Ethnicity	MCS	Liaise with Maternity Clinical Educator with Acute Care Team regarding education around theme identified regarding recognition and delay in treatment of amber/red flags, being linked to women of Black ethnicity. Acute Care Team are also reviewing data trends with regards to ethnicity.	1st Nov 2023	31st Jan 2024	Acute Clinical Care Midwife		Completed
Communication	MCS	Standardisation of Ward Round documentation to ensure clear representation of the patient's voice +/- interpreter and thorough medical/obstetric assessment including sepsis flags.	1st Nov 2023	1st Dec 2024	Labour Ward lead consultants		Ongoing
Ethnicity	MCS	To review ethnicity trends monthly and finalise data within the quarter.	1st Nov 2023	1st Mar 2024	Patient Safety Midwives		Ongoing
Asphyxia	MCS	To include Intelligent Intermittent Auscultation within ATAIN Audits	1st Jul 2023	31st Jul 2023	ATAIN Champions		Completed
IT	MCS	Introduction of Smart texts in HIVE to support risk assessments of all Women/ Birthing people presenting in labour to ensure correct method of fetal monitoring is utilised.	1st Jul 2023	30th Aug 2023	ATAIN Champions		Completed
Asphyxia	MCS	Introduction of one full day of mandatory training for Fetal Surveillance	1st Jan 2023	1st Apr 2023	Lead Midwife for Education		Completed

Asphyxia	MCS	One day of mandatory training for Fetal Surveillance included in Core Competency Framework Version 2, Competency Module 1- Saving Babies Lives care bundle.	1st Jul 2023	19th Oct 2023	Lead Midwife for Education		Completed
Policy	MCS	Focused individual feedback provided to midwives and doctors regarding not following policy.	1st Jul 2023	30th Jun 2023	Line Manager		Completed
Policy	MCS	To ensure that all obstetric doctors who are booking a woman's caesarean section prior to 39 weeks gestation record their discussion with women around the risk of Transient Tachypnoea of the Newborn (TTN).	1st Jul 2023	31st Aug 2023	Clinical Head of Division		Completed
Policy	MCS	To provide individual feedback to ensure that obstetric doctors counsel women who are booked for caesarean section prior to 39 weeks gestation regarding the offer of intramuscular steroids.	1st Jul 2023	31st Jul 2023	Obstetric Lead for Elective Caesarean sections North Manchester		Completed
Respiratory	North	Implementation of Enhanced Recovery Pathway 3 days per week at North Manchester to support effective planning of timely elective caesarean sections.	1st Jul 2023	1st Sept 2023	ERP manager Inpatient Matron Consultant Obstetrician		Completed
Respiratory	North	Risk of TTN not documented / discussed consistently. To be discussed with new Trainees and reinforced with consultants	1st Sept 2023	1st Oct 2023	Consultant Obstetrician		Completed
Respiratory	North	Targeted individualised feedback following no counselling for TTN.	1st September 2023	1st Oct 2023	Patient Safety Midwife/Fetal Monitoring Lead		Completed
Temperature	ORC	Commence IQP work on Delivery Unit about early postnatal care and documentation, emphasis on the energy triangle.	1st Sept 2023	1st Oct 2023	Delivery Suite Manager		Completed
Temperature	ORC/Wyth	To attach infographic to thermometers to prompt temperature checks within first hour.	1st Sept 2023	1st Oct 2023	Delivery Suite Managers		Completed
Temperature	MCS	To share 'all things neonates' IQP work- which relates to education around thermoregulation with maternity teams.	1st Aug 2023	1st Sept 2023	Patient Safety Midwives		Completed

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Appendix 3: Obstetric Workforce Action Plan

Saint Mary's Managed Clinical Service Action Plan Template

Action Plan Name:	Safety Action 4
Action Plan Creation Date:	1st June 2023
Action Plan Monitoring Approach:	*Describe which Board \ Committee \ Group will monitor the action plan*
Latest Update Date:	13th September 2023

Reason for the Action Plan: *The action plan montiors actions taking place to meet Safety Action 4 MIS Year 5.*

Action Reference	Theme	Action	Action Owner	Deadline	RAG	Status	Updates	Date Closed	Comment
1.1	Safety Action 4 - Element 1	With support from temporary medical staffing undertake an audit from 1st Feberuary - 31st July of all locum shifts filled and review if the doctor completeing the shifts was complaint with the RCOG guidance and safety action 4 element 1.	Vicky Rawlinson	31st August 2023	Green	Closed	Audit completed.	31st August 2023	No Comments.
1.2	Safety Action 4 - Element 1	Create a process for rota coordinators to follow to ensure all locums meet RCOG guidance.	Vicky Rawlinson	31st August 2023	Green	Closed	Process written and agreed.	31st August 2023	No comments
1.3	Safety Action 4 - Element 1	Temporary medical staffing to write a communication to all locum junior doctors who are registered with the internal bank to advise them of the RCOG guidance and requirement to have an eligability certificate if they are no longr on the training scheme and haven't worked for the trust in the past 5 years or do not work for the Trust at the point of the shift taking place.	Kerry Owen	30th September 2023	Amber	In progress	Kerry Owen to provide an update on circulation of the communication. 17.10.23: Communication written and being reviewed by divison.		Update to be provided w/c 18th September
1.4	Safety Action 4 - Element 1	Process in place to ensure all agency locums have the eligability certificate in place.	Kerry Owen	30th September 2023	Green	In progress	Following release of the RCOG guidance in February 2023 all agencys have confirmed they are working to the new guidance and all agency locums have the eligability certificate. As part of providing assurance a process will be agreed to ensure this is checked when agency locums are agreed.		Update to be provided 18th September.
2.1	Safety Action 4 - Element 2	Review of the induction process for all long term locums who have been used between 1st February and 31st July. Idenitfy gaps against the RCOG guidance.	Vicky Rawlinson	31st August 2023	Green	Closed	Audit completed. 4 locums in total were utilised during this period.	31st August 2023	
2.2	Safety Action 4 - Element 2	Review our current induction process across all sites and ensure there is a standardised template in place which meets the RCOG guidance. Agree a central place to store inductions for the future.	Vicky Rawlinson	31st August 2023	Green	Closed	Induction papeerwork reviewed and updated.	31st August 2023	
3.1	Safety Action 4 - Element 3	Review of Consultant rota's across North Manchester and Wythenshawe to identify any non-compliance with compensatory rest.	Vicky Rawlinson	31st August 2023	Green	Closed	Review of rota's undertaken with Consultant Rota Leads on each site and areas of non-compliance identified. Detail wihtin the report.	31st August 2023	
3.2	Safety Action 4 - Element 3	Undertake an audit across Wythenshawe and North Manchester to monitor non-compliance for compensatory rest and the frequency at which it is taking place.	Vicky Rawlinson	31st December 2023	Green	In progress	Audit put in place and consultants requested to log any calls during their on-call when compensatory rest would not be achieved.		
3.3	Safety Action 4 - Element 3	Ensure there is a clear process in place for when compensatory rest is not achieved and that consultants follow this to ensure activity is stepped down the following day or incident reports are submitted.	Vicky Rawlinson	31st December 2023	Green	In progress	SOP to be written and submitted to DQSC		
3.4	Safety Action 4 - Element 3	Redesign the North Manchester rota to ensure compensatory rest can be achieved for consultant rota. Case for investment to be written to outline additional consultant requirement.	Ed Johntone/Vicky Rawlinson	30th November 2023	Green	In progress	Review of job plans and PA's available at NM being completed. New rota plan and roster in development.		
3.5	Safety Action 4 - Element 3	Redesign the Wythenshawe rota to ensure compensatory rest can be achieved for consultant rota. Case for investment to be written to outline additional consultant requirement.	Elaine Church/Vicky Rawlinson	30th November 2023	Green	In progress	Initial draft rota's have been developed. Case for investment to be written.		
3.6	Safety Action 4 - Element 3	Case for investment to be presented to SLT.	Victoria Bateman/Ed Johnstone.	31st December 2023	Green	In progress	Case for investment to be written.		

Appendix 4: Neonatal Workforce Action Plan

Standard	Description	Compliance	More information/plan of action
Activity based standards (SM ORC activity 22/23 - 5634 intensive care days and 7912 births)			
Tier 2 compliance if more than 2500 IC (XA01Z) days per year	Two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.	No	SMH has over 5000 ICU days but only has single Tier 2 cover overnight. In order to be compliant, 14 tier 2 doctors are required. The need for 1 tier 2 doctors overnight has been recognised as being a point of vulnerability, and numbers have been increased 12 from September 2023, whereupon there will be 2 Tier 2 doctors rostered to work 5 nights out of 7. Further provision of 2 tier doctors is required and a business case is being developed. No funding source has yet been identified for these posts. Business case in progress to increase the WTE Tier 2 Medical Rota to 14 at SMH Oxford road site, requiring 2.0 WTE additional doctors to meet BAPM requirements, taking account of annual leave and study leave etc.
Tier 3 on-call rota	On-call rota should not be more onerous for more than 1 in 6 on-calls	No	WTWA consultants currently do 1 in 5 on-calls. This has been recognised, and a business case is being developed in partnership with RMCH by whom the consultants are employed. This will enable an on-call rota of 1:6. Business case in progress with RMCH to increase the on-call distribution to 1:6 for the neonatal on-calls at Wythenshawe site.

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Appendix 5: Neonatal Nursing Action Plan

Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Lead	Timescales	Monitoring	RAG
Recruitment of registered nurses in line with BAPM and DH Toolkit recommendations with regards to safe staffing levels against patient ratios	a) Proactive recruitment, supported by finance to recruit to turnover to September 2023. Ensure activity is reviewed in line with recruitment. b)Ensuring applications shortlisted in timely way and assessment panels and interview panels set up in advance and to keep to weekly timetable schedule c) Work with the corporate workforce team to support recruitment of international nurses, continue to recruit B4 to support blended workforce. d) Weekly review of the establishment to monitor starters and leavers, monthly meetings with finance to ensure accurate budget management. e) Utilise funding from NCCR for quality role to support education/governance. f) There is a requirement to increase nurse staffing on the North Manchester site in order to meet National BAPM standards and ensure compliance with stipulations in the NHSE designation to be an LNU (including admission gestational age which is currently 29 weeks at NMGH as opposed to the stipulated 27 weeks). The required staffing resource will also facilitate provision of an in-reach service to the maternity wards, further supporting care delivery in the most safe and appropriate	a) Sustained improvement to BAPM standards to maintain safe staffing at the cot side. b) Quality roles enabled to consistently deliver quality agenda e.g. education, infant feeding, risk management	a) Reflected in compliance recorded by clevermed system	AOD/LF	Ongoing	Working with SLT to enable recruitment to turnover to September 2023 in order to recruit experienced neonatal nurses, including international nurse recruits.	

	environment. g) The Division is currently preparing a business case requesting financial investment and support, without which it is not possible to increase staffing levels. The NWNODN has indicated that they would support a business case being submitted to Specialist Commissioners to facilitate this development.						
Ensure the recruitment process minimises the time to hire	a) Weekly review meetings to review IR and domestic recruitment. b)Support interviews for IR and domestic recruits to ensure right calibre of nurse recruited to NBS c) Work with corporate recruitment team and IR specialist team to ensure timely start dates	a) Recruitment in line with Trust standards b) Keeping in touch events to reduce withdrawal rates for domestic recruits.	a) Reduced withdrawal rates b) Staff in post within timeframe.	AOD/LF/ Recruitment	Ongoing	HoN attends monthly workforce committee, feedback given in monthly SM MCS workforce committee and professional forum. Workforce paper presented at Newborn Services business meeting for discussion.	

Develop a recruitment media strategy in order to attract a broader range of candidates and develop the brand of the division and the Trust	a) Work with recruitment and HR colleagues to develop brand and showcasing NBS as the employer of choice. Aim to attract experienced neonatal nurses and the unique offer from within NBS. b) Attendance at SMH and site-specific recruitment events to showcase Newborn Services. c) Continue to develop innovative Recruitment Solutions such as use of social media e.g. Twitter. d) Work with NWNODN Workforce Lead to develop network campaign to attract neonatal nurses into the profession.	a) Brand reflects Divisional vision and values	a) Recruitment campaigns. b) Minutes of workforce meeting	AOD/LF/VB	Ongoing	Successful recruitment of experienced nurses.	
Review of roles to manage skill mix and encourage innovative roles.	a) Utilise funding received from Ockenden, to increase AHP provision across the service. Including the introduction of a clinical psychologist and occupational therapist. These roles will enhance the patient experience and work in unison with nursing staff. b) support international nurse recruits to attend a shortened Foundation in Neonates (FiN) course to support fast track to QIS. c) Bridging the gap between Foundation in Neonates (FIN) Course and QIS to support staff development and expertise. d)To support staff on completion of QIS, a buddy system has been developed to support consolidation of staff knowledge post QIS, to support retention.	a) Implementation of new roles and associated competencies. b) Working with NWNODN to fast-track IR through FIN and go on to QIS c) review of available QIS courses underway with NWNODN and NBS to increase number of courses available throughout the year to support more staff through course to meet national standards	a) Increase in staff undertaking QIS b) Increase of percentage of staff QIS within NBS c) Increase in nurse associates within NBS	AOD/LF	Ongoing		
Monitoring of Staffing levels to ensure levels are in line with acuity	a) Daily review of BAPM requirements with quality roles redeployed to cot side care where required and review of available mutual aid within the MCS	a) Clear review of staffing on a weekly basis. b) Report of staffing and gaps to monthly workforce group.	a) Daily status reports b) Monthly Reports	AOD/MD/SD/LF	Complete- for ongoing monitoring	Ensuring that the relevant meetings go	

	b) Monthly SMH workforce committee meeting, to monitor vacancies and to provide assurance around recruitment plans. c) Twice weekly staffing meetings with HoN, Lead Nurse, Matron team and Directorate Manager to review staffing levels across the MCS, identify greatest need to provide mutual aid where able. d) Weekly review with DD of staffing e) staffing risks on risk register and reviewed / escalated appropriately f) Use of NCCR monies to increase establishment in line with NHSE/I recommendations g) Weekly review meetings with Lead Nurse and HoN h) Twice weekly Senior Leadership huddle to discuss areas of concern/escalation.	c) Weekly monitoring of data on the Clevemed nursing data.	c) Clevemed Staffing data			ahead and any issues escalated in a timely and appropriate was to support safe staffing levels at the cot-side.	

Review of Exit Interview process and understanding of why staff leave	a) Lead nurse/Matron for Education meets with all members of staff that submit resignation/intention to leave NBS to establish reason. b) Develop action plan for feedback given which the service can influence. E.g. education pathway and support, culture c) Leavers are included in the workforce paper which is shared at business meeting and the SMH N&M workforce committee and workforce and education committee (WEC).	a) Understand the reasons for leaving Newborn Services so that any issues can be highlighted and acted upon.	a) Report any improvement work in the Workforce Committee Exception Report. b) Work with HRBP and Wellbeing Advocate to identify strategies for improving staff experience within NBS.	AOD/LF with HR support	Ongoing	Staff report reasons for leaving are not directly related to staff experience, volume of staff leaving to travel. Leavers are included in the workforce paper which is shared at business meeting and the SMH N&M workforce committee and workforce and education committee (WEC).	

Retention Rate	a) Listening events for staff across the MCS to support staff and understand the factors that are causing staff to leave. b) Weekly SHINE walkarounds carried out by matron and senior team across MCS, listening to staff concerns. c) Flexible working culture, lead by Lead nurse and reviewed on a case by case basis. d) Supporting staff to rotate across the MCS, staff enabled to move to units to support their health and wellbeing. e) Band 6 development programme to support recently promoted staff into role, with buddy system. f)B7 away days facilitated with OD&I team to explore belonging, civility and develop a NBS charter. g) B6/7 monthly meetings for updates and practice development. h) stay surveys and menti meter readings to be commenced across NBS.	a) Over 89% Target for retention Staff report positive experiences of their membership of the workforce b) positive staff survey feedback.	a) Score on Accountability Framework greater than 89% a)Score on staff survey greater than 3.8	AOD/LF	ongoing	Current level above target at 3.0%. Increased in Q4 but has slowed down. All staff have RTW completed and all LTS staff have review in line with Trust policy	
Training and development opportunities are taken up and positively evaluated by all staff	a) Provide opportunities for staff development and equity of access to employment opportunities and training. b) Review funding for continuing education ensuring allocation of CPD monies. c) Ensure all staff are facilitated to maintain mandatory competencies and monitor compliance.	a) Yearly Training Needs Analysis (TNA) completed, and training delivered.	a) Service specification of 70% staff QIS attained. b) Compliance maintained across all areas of core levels	AOD/LF/VB	Monthly	a) Increased numbers to 20 per cohort twice yearly released to support attendance on QIS course.	

Attendance to be monitored and in line with Trust target	a) Weekly absence monitoring meetings. b) Dedicated Band 7 absence leads across the MCS c) Monthly Compliance meeting to review with Director of HR	a) Absence below the target of 3.6%	a) Absence levels below target	AOD/LF/VB	Monthly	Current level above target at 3.6%. Increased in Q2 onwards 2021. All staff have RTW completed and all ITS staff have review in line with Trust policy	
To gain support from the NWNODN in relation to training and education of staff, supporting increased numbers through QIS	a) Seek support from Network for funding to support staff through QIS b) To meet with Network to review QIS courses run throughout the year c) Proposed Network staffing group to review educational needs of units across GM d) Submit NCCR returns with support from Network e) Explore opportunity to be a North West provider of QIS training, as part of the NBS (NEST) education academy.	a) Improved compliance to QIS standards. B) Ability to release more staff to attend QIS courses.	a)Service specification of 70% staff QIS attained. b) Improved cot-side numbers as able to spread QIS training through the year.	AOD/LF	Ongoing	Network Steering Group	

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Appendix 6: Action Plan – one-to-one care in labour

Appendix 1: Red Flag Events action plan

Completed
Delayed with manageable risk
Delayed with risk
On Track
Not started

Red Flag Event	Action	Deadline	Action owner	Status	Update
Lack of one-to-one care in labour	Include an educational update on the recognition and management of preterm labour in the annual mandatory training programme	31/05/23	Lead Midwife for Education		Included in the annual mandatory training programme
	Strengthen midwives understanding of the escalation process where there is a delay in transferring women to a delivery unit who are in labour	30/09/23	Ward Managers		Escalation process revisited with staff.
	Utilise the quality improvement programme to improve care for women on the antenatal wards to support the importance of listening to women and share the findings and action plan at the Site Obstetric Quality and Safety Committee meeting	30/09/23	Inpatient Matrons		Initial findings presented to SOQS in September 2023 with action plan to be developed and subsequent audit to demonstrate improvement over time and fed back to SOQS in September 2023.
	Utilise the Quality Bus to provide an educational update on the recognition and management of preterm labour and share lessons learnt	30/09/23	Lead Midwife for Education		completed
	Communicate the need to ensure that all Matrons and mangers are aware of the importance of changing the cause group when	31/10/23	Lead Midwife for Governance		October 23: Email sent to the clinical teams and reinforced at the local risk meeting.

	incidents entered as RF- Unable to provide 1-1 care in labour do not relate to intrapartum care				
	Share the findings of Phase 2 Listening to women QI project.	31/01/24	Inpatient Matrons		
Additional actions					
Reduce midwifery vacancies to support clinical care in all areas	Implement a robust recruitment programme to ensure vacancies are filled in a timely manner	Ongoing	HOM's		Rolling advert and recruitment programme to support maintaining the establishment in all clinical areas
	Support staff wellbeing	Ongoing	HOM's		Recruitment and retention team in place across the MCS to support staff and develop supportive initiatives
	Support staff development and progression	31/12/22	HOM's		Succession plan developed to support staff to progress and maintain leadership across the MCS

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Appendix 7: CQC Maternity Survey Action Plan & Thematic Review of Free Text from Maternity Survey

NHS Maternity Survey 2021

COMPLIANCE PLAN

1 2 3 4 5

Status Key	
	Complete
	On track
	Delayed with manageable risk
	Delayed with risk
	Not started

Objective ID: 1
Title: Inclusivity

Component compliance issues	PE1 - Improve engagement with representative population of service users, inclusive of age, ethnicity, deprivation index, LGBTQ+	Measures of success	Reduction in complaints relating to communication issues caused by language barriers
	PE2 - Improve accessibility in 10 most common languages for our demographic		Improved WMTM feedback

Impact

Local Clinical Service	SMMCS Maternity all locations	System	
Site/MCS/ LCO	Saint Mary's MCS	Clinical Network	
Trust-wide		Other	

Leadership		Start date:	
Accountable	Alison Haugton		
Responsible	Kathy Murphy	Completion date:	Aug-23
Governance			
Monitoring	SM Quality and Safety Committee	Assurance due:	Aug-23
Assurance	SM MCS Operational Delivery Group/ SM MCS Management Board		

Actions

Ref	Description	Responsible	Start	End	Status	Comments	Completion Date
	Short Term Actions						
1.1	Confirm current availability of languages and match to demographic within MCS	SO	Apr-23	30/06/2023			Jun-23
	Medium Term Actions						
1.2	Engage with MVPs to raise awareness within all service user demographics	BOC/KW	Apr-23	30/08/2023			Jun-23
1.3	Utilise social media and all media platforms to promote awareness of languages available and increased engagement	BOC/KW	Apr-23	30/08/2023		MVP's and Saint Mary's MCS social media platforms updated.	Jun-23

Objective ID: 2
Title - Postnatal Care

Component compliance issues	PE3 - Reduce delays in Discharges	Measures of success	Improvement in FFT and WMTM metrics relating to delays on Postnatal discharge
	PE4 - Improve access to Midwifery postnatal support		Reduction in complaints/PALS and WMTM regaridng debrief availability
	PE10 - Availability of a de-brief following birth allowing women the opportunity to ask questions about labour & birth		

Impact

Local Clinical Service	SMMCS Maternity all locations	System	
Site/MCS/ LCO	Saint Mary's MCS	Clinical Network	
Trust-wide		Other	

Leadership		Start date:	
Accountable	Alison Haugton		
Responsible	Kathy Murphy	Completion date:	Aug-23
Governance			
Monitoring	SM Quality and Safety Committee	Assurance due:	Aug-23

Assurance	SM MCS Operational Delivery Group/ SM MCS Management Board			Assurance due:	Aug-23		

Actions

Ref	Description	Responsible	Start	End	Status	Comments	Completion Date
	Short Term Actions						
2.1	Paper to the board requesting support to increase the number of band 3 MSWs to develop a 'discharge team' to support flow and expedite appropriate discharges	HoMs	Apr-23	31/07/2023		Paper regarding Band 3's was submitted to SLT- declined at present as funding not available.	Jul-23
2.2	Working with Pharmacy to review current TTO process	Inpatient Matron	Apr-23	31/07/2023		Inpatient Matrons continue to work pharmacy teams particularly at North Manchester and Wythenshawe	Jul-23
2.3	Review of medical obstetric staffing to consider availability of dedicated obstetric consultant oversight of inpatient ward rounds	CHoD	Apr-23	31/07/2023		Review completed. Business case in draft to increase medical staffing	Jul-23
	Medium Term Actions						
2.4	Linked to the above action incorporating Band 3 MSWs to support postnatal discharges and flow to allow for timely to the postnatal ward from intrapartum settings and release of midwifery time.	HoMs	Apr-23	30/09/2023		With workstream lead for final QA	
2.5	Re-launch antenatal education will empower women to feel ready for the postnatal period	LD	Apr-23	30/09/2023		With workstream lead for final QA	
2.6	Advertise the postnatal padlets through posters with QR codes	Inpatient Matrons	Apr-23	30/09/2023		With workstream lead for final QA	
2.7	Share feedback with midwifery teams	DHoMS	Apr-23	30/09/2023		With workstream lead for final QA	
2.8	Roll out of obstetric de-brief proforma to all sites	MCS Clinical Leads	May-23	31/12/2023			
2.9	Educating postnatal midwives about their roles & responsibilities to support women to understand their birth experience	Inpatient & Community Matrons	Jun-23	31/12/2023			

Objective ID: 3
Title: Environment

Component compliance	PE3 - Improve cleanliness of hospital rooms or ward areas	Measures of success	Improved Cleanliness Audits
			Reduction in complaints/feedback regarding cleanliness

Impact

Local Clinical Service	SMMCS Maternity all locations	System	
Site/MCS/ LCO	Saint Mary's MCS	Clinical Network	
Trust-wide		Other	

	Leadership	Start date:	
Accountable	Alison Haugton		
Responsible	Kathy Murphy	Completion date:	May-23
	Governance		
Monitoring	SM Quality and Safety Committee	Assurance due:	May-23
Assurance	SM MCS Operational Delivery Group/ SM MCS Management Board		

Actions

Ref	Description	Responsible	Start	End	Status	Comments	Completion Date
	Immediate Actions						
3.1	Undertake regular SHINE walk rounds and prompt escalation of concerns to Sodexo	DHoMs	Apr-23	31/05/2023		completed	May-23
3.2	Arrange meetings with Ward Managers and Sodexo supervisors/matrons to support learning and actions for improvement working collaboratively	Inpatient & Intrapartum Matrons	Apr-23	31/05/2023		completed	May-23

Objective ID: 4
Title - Infant Feeding

Component compliance issues	PE6 - Improve out of hours breast feeding support	Measures of success	Increased breastfeeding rates at birth
	PE7 - Improve antenatal education on infant feeding		Increased breastfeeding rates at discharge from hospital
			increased skin to skin rates

						increased breastfeeding rates at discharge from community care	
Impact							
Local Clinical Service	SMMCS Maternity all locations	System					
Site/MCS/ LCO	Saint Mary's MCS	Clinical Network					
Trust-wide		Other					
Leadership		Start date:					
Accountable	Alison Haugton						
Responsible	Kathy Murphy	Completion date:	Dec-23				
Governance							
Monitoring	SM Quality and Safety Committee	Assurance due:	Dec-23				
Assurance	SM MCS Operational Delivery Group/ SM MCS Management Board						
Actions							
Ref	**Description**	**Responsible**	**Start**	**End**	**Status**	**Comments**	**Completion Date**
Immediate Actions							
4.1	Review current process for out of hours infant feeding support and appropriate signposting and follow-up pathway to be developed and communicated to women and staff members	IFC	Apr-23	30/06/2023		Complete-Infant feeding training has been reviewed and now included in MDT so all midwives will be compliant and information boards in all areas	Jun-23
Medium Term Actions							
4.2	Re-launch antenatal education across the MCS	IFC	Jun-23	31/12/2023			
4.3	Consideration to dedicated lead for antenatal education	IFC	Jun-23	31/12/2023			
4.4	Consideration to be given to virtual platforms and pre-recorded classes	IFC	Jun-23	31/12/2023			
4.5	Continue to work towards BFI accreditation	IFC	Jun-23	31/12/2023			

Objective ID: 5
Title: Choice & Empower

Component compliance issues	PE8 - Improve the offer of choice to women for place of birth	Measures of success	Improvement in WMTM data
	PE9 - Improve empowering women to raise concerns during labour & birth – and listening when they do		Reduction in complaints regarding not being listened to

Impact							
Local Clinical Service	SMMCS Maternity all locations	System					
Site/MCS/ LCO	Saint Mary's MCS	Clinical Network					
Trust-wide		Other					
Leadership		Start date:					
Accountable	Alison Haugton						
Responsible	Kathy Murphy	Completion date:	Oct-23				
Governance							
Monitoring	SM Quality and Safety Committee	Assurance due:	Oct-23				
Assurance	SM MCS Operational Delivery Group/ SM MCS Management Board						
Actions							
Ref	**Description**	**Responsible**	**Start**	**End**	**Status**	**Comments**	**Completion Date**
Short Term Actions							
5.1	Finalisation of 'Birth Choices' patient information leaflet	KW	Apr-23	30/06/2023		complete	Jun-23
5.2	Posters to increase awareness of leaflet and choices available	Antenatal and Community Matrons	Apr-23	30/06/2023		With workstream lead for QA	
5.3	Clear posters to advise how to raise concerns	Intrapartum Matrons	Apr-23	30/06/2023			Jun-23
5.4	Monitor themes of complaints	DHoMS	Apr-23	30/06/2023		Themes monitored. Poster provided to all staff members regarding outcomes	Apr-23
Medium Term Actions							
5.5	Raise awareness and provide education in the form of civility workshops to all staff	MS	Jun-23	31/10/2023		With workstream lead for QA	

Thematic Review of Free Text from CQC Maternity Survey

Action Reference	Site	Action Description	Start Date	Review date	Action Owner	Status
Triage – reduce delays. Ensure that all women are triaged within 30 minutes of arrival.	Saint Mary's Managed Clinical Service (SM MCS)	Increase midwifery and maternity support worker establishment in maternity triage departments across SM MCS.	Birth Rate plus paper submitted. Current staffing levels supported by NHSP. Paper submitted November 2023	31st March 2024	Heads of Midwifery	
Triage – reduce delays. A high number of women attend Triage with reduced fetal movements (RFM), causing anxiety for those women who are not seen in a timely manner but also impacting upon the waiting times for other women.	Oxford Road Campus (ORC)	Women attending with RFM are seen on a separate pathway and do not attend Triage. Now reviewing data following trial.	24th July 2023 to 31st October 2023	31st March 2024	Deputy Heads of Midwifery	
Women in early labour and established labour not feeling listening to.	SM MCS	An MCS improving quality project has commenced supporting the recognition and care of women in early labour. The desired outcome is to support the women to have their concerns listened to and for our midwives to feel able to appropriately support women.	11th December 2023	29th February 2024	Matrons for inpatient and intrapartum services	

		This project will be presented at the Site Quality and Safety meeting.				
Antenatal wards – delays within the induction of labour (IOL) process.	SM MCS	Workstreams have commenced to support the reduction of delays across SM MCS. Daily Flow meetings have been implemented twice per day to provide oversight of activity and any delays across the MCS. This allows for women to be offered transfer to another site where acuity may result in a delay in the IOL process.	15th May 2023	Completed – twice daily Flow Meeting's now embedded as business as usual (BAU).	Heads and Deputy Heads of Midwifery, Divisional Director	
Antenatal wards – lack of information regarding the IOL process	SM MCS	Current IOL leaflet to be assessed and amended to ensure accessibility and clarity around information given to women	1st November 2023	31st March 2024	Consultant Midwife	
All areas – maternity areas visiting policy	SM MCS	There is a plan to commence work with MVP's to review women's preferences regarding visiting times on the inpatient wards. Trust visiting policy currently under review – consideration being given to open visiting for partners. Focus on reviewing visiting for women in early labour and on induction pathways of care to ensure that they have appropriate support at all times.	18th December 2023	31st March 2024	Matrons for Inpatient Services	
Postnatal wards / Enhanced recovery pathway – delays with discharges.	SM MCS	Workstream commencing with a focus on improving the discharge pathway. Pilot for midwifery facilitated	18th December 2023	29th February 2024	Transformation Midwife/Intrapartum	

		discharges to be commenced in December 2023			Matrons and Inpatient Matrons	
Labour Ward - lack of availability of remifentanil for women in labour.	North Manchester	Remifentanil to be offered as a form of pain relief from 4th December 2023, providing women with additional analgesia options	30th April 2023	4th December 2023	Intrapartum Matron	
Postnatal wards – lack of infant feeding support	SM MCS	Posters to be introduced to all postnatal wards, advising that the infant feeding team can be requested at any time	29th November 2023	11th December 2023	Inpatient Matrons	
Postnatal wards – lack of infant feeding (IF)support	SM MCS	Embed daily IF ward rounds on a Monday – Friday and ensure documentation within women's records by the IF team.	29th November 2023	8th January 2024	Inpatient Matrons	
Antenatal services – lack of parent education in the antenatal period	SM MCS	Parent education to be commenced following appointment of parent education coordinator. The education programme has been co-produced with the MVP.	Commenced in role 04th September 2023 Programme of parent education commences by 31st December 2023	February 2024 to review SMART action plan progress	Parent Education Co-Ordinator	

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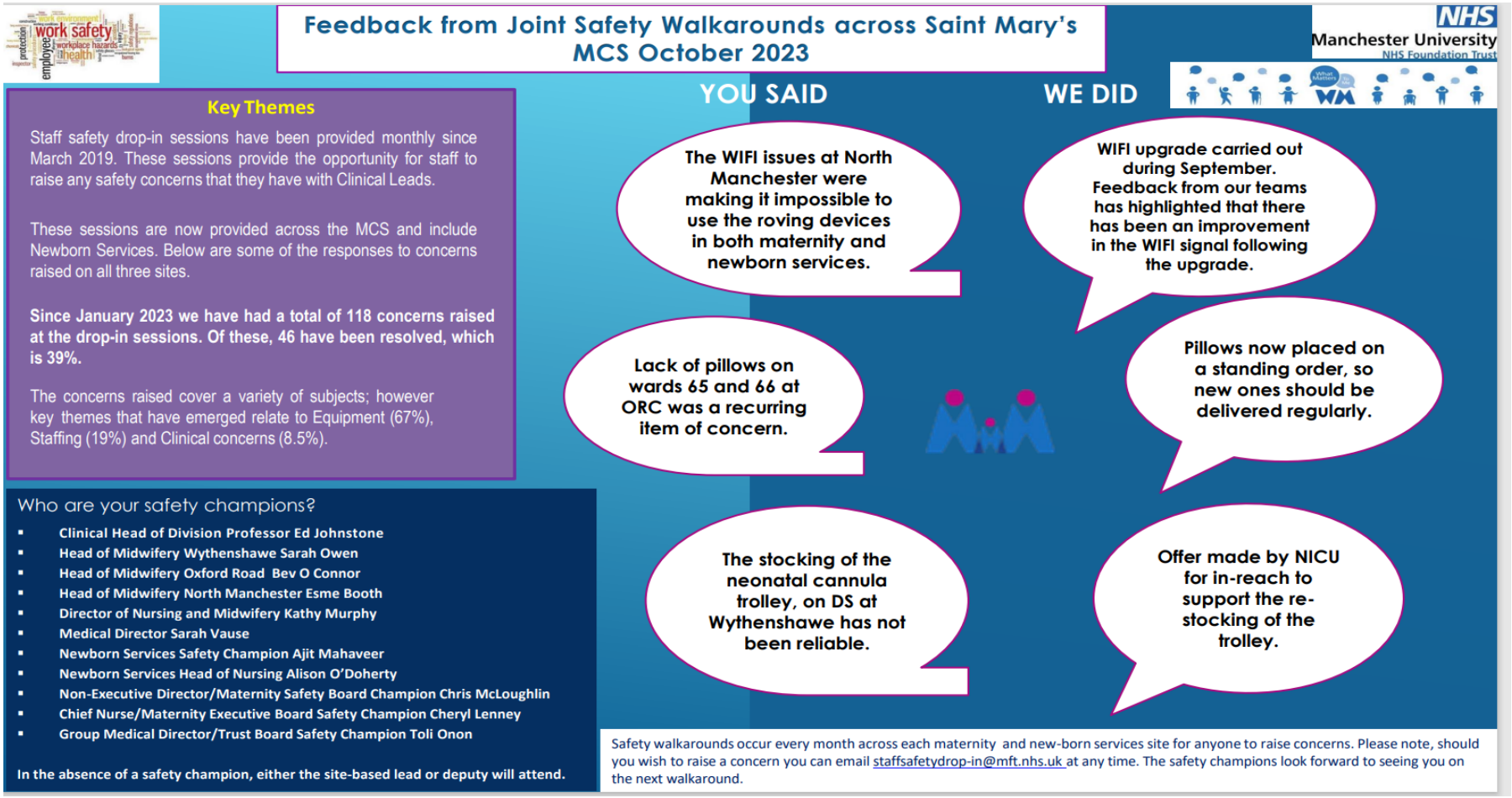
Appendix 8: Feedback from staff (October 2023)



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Appendix 9: Maternity Perinatal Scorecard

CQC Maternity Ratings March 2023	Overall	Safe	Effective	Caring	Responsive	Well Led
	Requires Improvement	Inadequate				Requires Improvement

Staff survey	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	79.1
Proportion of specialty trainees in O&G with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (reported annually)	83.7

Summary

- The data is validated each month and shared via the Q&SC process; this report contains the data to September 2023
- Maternity incidents are reported separately via the governance reports presented at Q&SC
- All HSIB referrals are reviewed by MDT to identify lessons learnt and mitigate any risks

Major PPH > 2.5litres	Term admissions to NNU	Stillbirths
• Incidents monitored monthly • Major PPH quality improvement work undertaken • Lessons learnt shared across the MCS	• All term admissions reviewed to identify if the admission was avoidable and identify lessons learnt. Themes identified and shared via divisional meetings. • MatNeoSip quality improvement programme in progress to reduce term admissions	• Perinatal Mortality Review Tool used to complete MDT review for all stillbirths • All stillbirths are incident reported and reviewed by the MDT to identify lessons learnt. • Overview presented via the divisional QSC meetings. • Deep dive in progress to identify themes

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			GMEC monthly average (Sep 23)	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Perinatal	1:1 care in labour	Percent	91.05	99.29	99.00	99.9	99.8	99.8	98.9	98.1	99.8	99.9	99.7	99.1	
	3rd/4th degree tears	Percent	2.24	2.00	1.63	2.57	1.58	2.03	3.1	2.92	3.69	2.32	2.53	2.66	
	Obstetric haemorrhage > 2.5L **	Rate per 1000	4.39	5.9	7.9	2.9	5.6	9.7	6.2	9.6	5.41	6.9	7.7	7.0	
	Term admissions to NNU	Rate per 1000	58.01	68.92	66.88	52.82	62.84	59.52	62.7	59.48	61.21	49.91	48.47	53.68	
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	17.05	9.85	11.01	9.28	15.71	11.60	11.55	11.89	14.06	9.98	7.46	9.2	
	Stillbirth number	Rate per 1000	3.39	7.03	7.08	2.85	7.86	6.18	7.49	4.27	5.36	4.56	3.73	4.6	
	Neonatal Deaths	Rate per 1000	2.53	2.11	6.29	6.42	1.57	2.32	2.18	4.99	3.83	3.04	2.24	1.53	
Patient Experience	Number of formal complaints	Number		12	10	13	11	9	8	9	23	9	7	9	
	Maternity Unit diverts	Number		0	0	0	0	0	0	0	0	0	0	2	
Training	Emergency skills and drills	Percent of staff trained		89.76	84.53	81.05	63.58	78.96	80.5	84.9	89.34	94.43	90.0	96.9	
	CTG training	Percent of staff trained		87.77	85.39	85.02	82.33	84.21	87.7	88.7	90.55	94.59	91.6	99.5	
	CTG competency assessment	Percent of staff assessed		79.80	77.40	79.39	79.39	67.80	88.1	73.3	86.60	95.50	89.1	93.5	
Coroner Reg 28 made directly to the Trust				No	No	No	No	No	No	No	No	No	No	No	
HSIB/ CQC concern or request for action				No	No	No	Yes	No	No	No	No	No	No	No	
StEIS reported incidents				2	2	2	4	3	1	2	0	3	3	3	

Incidents with moderate harm or above	3	2	2	4	6	8	2	2	4	4	1	
HSIB referrals	0	1	1	1	3	0	3	0	2	2	1	

Paper Reference:

Appendix 10: MIS Safety Action 10 Confirmation

Manchester University NHS Foundation Trust

SAINT MARY'S MANAGED CLINICAL SERVICE

Divisional Quality and Safety Committee

Report of:	Maternity Governance Team	
Paper prepared by:	Gill Furey, Lead Midwife for Governance	
Date of paper:	December 2023	
Subject:	Maternity Incentive Scheme: Safety Action 10	
Purpose of Report:	Indicate which by ✓ (tick as applicable-please do not remove text)	
	Information to note	✓
	Support	
	Resolution	
	Approval	✓
	Ratify	
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality and outcome • Improve the experience of patients, carers and families	
Recommendations:	The Committee is requested to accept and note the details in the report	
Contact:	Name: Gill Furey Email: gill.furey@mft.nhs.uk	

EXECUTIVE SUMMARY

This paper provides an update on progress with the Maternity Incentive Scheme (MIS) Safety Action 10.

> *Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?*

Saint Mary's Managed Clinical Service (MCS) can confirm compliance for all qualifying cases from 6 December 2022 to 30 September 2023. Saint Mary's MCS expects to be complaint for all qualifying cases up to and including 7 December 2023.

BACKGROUND

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. This work is supported through the maternity incentive scheme. NHS Resolution manages the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The scheme for Year 4 builds on previous years to evidence both sustainability and ongoing quality improvements.

The safety actions described are considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50% by 2025. As in previous years Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund (which is 10% of their premium) and will also receive a share of any unallocated funds.

The scheme was relaunched in May 2023 for Year 5 and was later updated in July 2023.

Responsibility for investigating eligible cases transferred from the Healthcare Safety Investigation Branch to the Maternity and Newborn Safety Investigation programme on 1st October 2023. The purpose of the MNSI remains the same as for HSIB.

SAFETY ACTION 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) / Maternity and Newborn Safety Investigation programme (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Safety action 10 requires:

1. Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.

2. Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.

3. For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:

    i. The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme.
    ii. There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

1. REPORTING QUALIFYING CASES TO HSIB/ MNSI

Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or,
- Was therapeutically cooled (active cooling only) or,
- Had decreased central tone AND was comatose AND had seizures of any kind.

Once HSIB/MNSI have received notification from Saint Mary's MCS they triage the cases and advise which investigations they will be progressing to full investigation.

Saint Mary's MCS can confirm that 100% of all qualifying cases have been referred to HSIB/MNSI from 6 December 2022 to 7 December 2023.

2. REPORTING QUALYFYING EN CASES TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME

Saint Mary's MCS developed and agreed a process with the Legal Department and submit a referral form to the legal team once HSIB/MNSI have confirmed acceptance of the case. The Legal Department notifies NHS Resolution, via the Claims Reporting Wizard, of all qualifying EN cases.

SM MCS can confirm that from 6 December 2022 to 7 December 2023, 100% of cases have been reported to NHS Resolution's Early Notification Scheme.

Families who decline investigation by HSIB can request an EN investigation and these cases will be reported to the EN Team via the Claims Reporting Wizard.

SM MCS have not had any family decline HSIB/MNSI investigation and request an EN investigation.

The final HSIB/MNSI report is shared with the EN Team and uploaded to the Claims Reporting Wizard by the Legal Department.

SM MCS can confirm that 100% of reports received from 6 December to 7 December 2023 have been uploaded to the Claims Reporting Wizard (CRW) by the Legal Department.

3 A. INFORMING FAMILIES ON THE ROLE OF HSIB AND NHS R EN SCHEME

Standard: To complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement.

This is completed by the Legal Department on receipt of the NHS R referral form from Maternity Services and has been completed for 100% of qualifying cases reported to HSIB/MNSI from 6 December 2022 to 7 December 2023.

3 B. COMPLIANCE WITH DUTY OF CANDOUR

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20

In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB/MNSI and NHS Resolution.

The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

Saint Mary's MCS can confirm that the Duty of Candour has been completed for 100% of qualifying cases from 6 December 2022 to 7 December 2023. This includes informing families of the incident and the initial findings of the multidisciplinary review, offering an apology, explaining the investigation processes (HSIB/MNSI, EN Scheme and any internal investigations), and providing a point of contact for support (Family Liaison Officer).

An initial apology and explanation are offered face to face, where possible, and by telephone if this cannot be achieved, with follow up by letter which is translated into an appropriate language where required.

The final HSIB/ MNSI report is shared with the family by HSIB/MNSI, and the family are offered a tripartite meeting with the Trust and HSIB/MNSI to discuss the findings. If the family decline the tripartite meeting Saint Mary's MCS offers the family a meeting to discuss the findings and their care. HSIB/MNSI also provide the report in the relevant language where required.

CONCLUSION

Saint Mary's MCS is compliant with all requirements within Safety Action 10.

Agenda Item 13

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse & Director of Infection Prevention Control
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse, IPC/TV Dr Raj Rajendran, Associate Medical Director, IPC
Date of paper:	January 2024
Subject:	Infection Prevention Control Strategy 2023 – 2026
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 IPC Strategy underpins the Patient Experience and Quality and Safety strategies by continuing to reduce HCAI and embedding infection prevention into everyday practice.
Recommendations:	The Board of Directors are asked to support and approve the IPC Strategy 2023-26
Contact:	Name: Michelle Worsley, Assistant Chief Nurse, IPC/TV Tel: 0161 276 4042

NHS
Manchester University
NHS Foundation Trust

Manchester University NHS Foundation Trust

Infection Prevention & Control Strategy *2023-2026*

Contents

Foreword

Our patients, their loved ones, families, and visitors expect to experience a high standard of safe care when admitted to the hospital setting.

This IPC Strategy underpins our Patient Experience and Quality & Safety strategies. Aligned to our plans to reduce Healthcare Associated Infections (HCAI), the Strategy outlines our intention to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe.

The acquisition of an HCAI remains a major cause of avoidable patient harm and has been shown to pose a serious risk to patients, staff and visitors in health care settings. HCAIs are seen to directly affect patients and their families and carers in several ways – not only in severe illness, pain, and anxiety, but also in reduced quality of life and loss of earnings or change in circumstances.

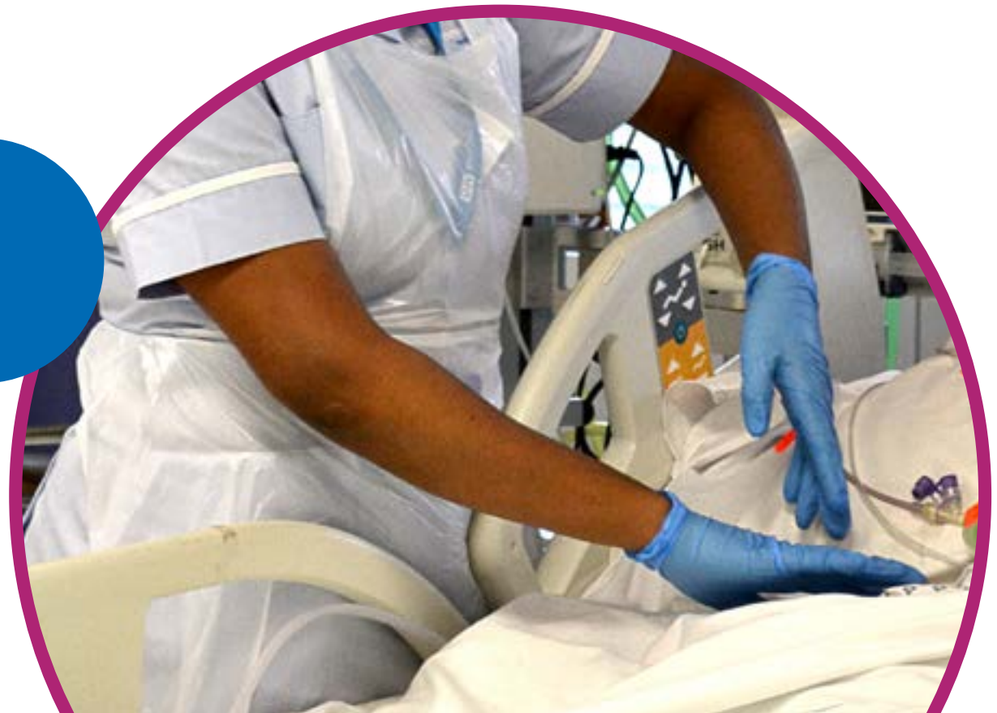
I am delighted therefore to present our 3-year Infection Prevention & Control Strategy, which sets out the strategy for infection prevention and control activity for the next three years and identifies the way we will continue to reduce HCAI by embedding infection prevention into everyday practice, and in doing so comply with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance (2015).

Professor Cheryl Lenney OBE
Chief Nurse

Background to the Trust

Manchester Foundation Trust (MFT) was formed in October 2017 and employs over 28,000 staff. The Trust is responsible for running a group of 10 hospitals and providing Community Services across the city of Manchester and Trafford to over 750,000 people. The Trust is the single biggest provider for specialist services in the Northwest of England providing tertiary and quaternary services across the Northwest and beyond.

It is estimated that 300,000 patients a year in England acquire a healthcare associated infection[1]. In England, respiratory tract infections (pneumonia and other respiratory infections) account for 22.8% of all HCAIs, urinary tract infections for 17.2%, surgical site infections (SSI) for 15.7%, clinical sepsis for 10.5%, gastrointestinal infections for 8.8% and bloodstream infections for 7.3% (National Institute of Clinical Excellence, 2014)[2].



Strategy Aim

Our aim is to continually strive to reduce avoidable infections and to ensure that services delivered across MFT are provided in safe and clean environments that are fit for purpose and that best practice is acknowledged and adopted by all.

The Strategy Aim aligns to the Trust's Strategic Aims:

- To excel in quality, safety, patient experience, research, innovation, and teaching
- To attract, develop and retain great people
- Build workforce resilience, reduce variation in practice and continuously improve
- Identify lessons learned from COVID-19 pandemic and embed and sustain good IPC practices across MFT
- To ensure Infection Prevention and Control is everyone's responsibility and to embed IPC into daily practice.

1. NICE (2012 – updated 2017), Healthcare Associated Infections: Prevention and control in primary and community care (CG139)
2. NICE (2014), Infection prevention and control Quality Standard [QS61], April 2014, Introduction

Delivering our Aim through Six Strategy Goals

1. Training, education and development of our workforce to deliver the best possible care and treatment.
2. Managing the risks associated with viral infections including High Consequence Infectious Diseases (HCID).
3. Maintaining a safe, clean environment.
4. Embedding and developing Infection Prevention and Control research and innovation.
5. Developing Surveillance of Infection – utilising digital platforms to drive improvement.
6. Antimicrobial Stewardship.

The implementation and monitoring of this strategy will be overseen by the Group Infection Prevention & Control Committee with an annual review of progress which will form part of the annual report to the GIPCC.

Goal 1: Reducing Health Care Associated Infections (HCAIs)

Healthcare-associated infections can develop either as a direct result of healthcare intervention (such as medical or surgical treatment) or from transmission within a healthcare setting. Healthcare-associated infections arise across a wide range of clinical conditions and can affect people of all ages. They can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life.

Although nationally and locally significant progress has been made year on year in the number of patients developing serious infections such as Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridioides difficile (C.diff) the reduction of HCAIs remains a key priority.

The emergence of an increasing trend of antimicrobial resistance is seen as an urgent issue to address and one where the prevention of infection is paramount to support reducing the demand for antibiotics, not only globally but also in our own local systems.

Three-year priorities

- To expand current surveillance of HCAI using robust information technology to determine areas of concern for targeted intervention.
- To provide clear and concise guidance, that is easily accessible to all healthcare workers.
- To develop IPC training for all staff using diverse methods and working in collaboration with the Greater Manchester network, local universities and UKHSA.
- To focus on patient education to improve awareness on infection prevention.
- To develop audit and monitoring tools to provide assurance.

Delivering our Aim through Six Strategy Goals

Goal 2: Managing the risks associated with viral infections including High Consequence Infectious Diseases (HCID)

The autumn winter months are associated with increased risk of respiratory viral infection, including Influenza and RSV. Nosocomial acquisition poses a significant risk to patient care in terms of increased morbidity and mortality as well as disruption to elective services. These risks can be mitigated with robust IPC practices supported by effective testing that is minimally disruptive to patient flow.

Three-year priorities

- To develop accurate and accessible surveillance mechanisms to assist with activity monitoring and planning.
- To develop single high-level integrated plans or policies that cover all sites and include all potential HCIDs/ scenarios, in conjunction with clinical colleagues. This should include all patient groups, the HCID testing pathway and all HCIDs.
- To develop pathways to facilitate patient flow for example, rapid testing for COVID-19, Influenza and RSV and for all HCID (where possible) for all symptomatic patients being admitted to the Trust.
- Develop escalation plans with key stakeholders to respond to increasing numbers of admissions and develop dynamic risk assessment based on community prevalence, vaccine uptake (where relevant) and hospitalisation rates to inform dynamic IPC policy and procedure.
- To support the executive teams, develop plans to manage major incidents and incidents of HCID.

Goal 3: Maintaining a Safe Environment – Estates & Facilities

The formation of MFT has resulted in the acquisition of various estates that are of different ages and have varying needs in terms of maintenance. In addition, there are several new projects being developed within MFT that will require IPC advice on the building design, validation, and commissioning of such projects.

The IPC team will work with the Estates & Facilities teams to contribute to the IPC requirements to maintain a safe environment for care.

Three-year priorities

- The IPC Team will provide specialist advice and expertise to support strategies for associated services such as decontamination, ventilation water safety and soft facilities management.
- To ensure that the existing estate and new builds meet national standards, and considers emerging evidence in line with preparedness to deal with future HCAI's.
- To ensure that the estates strategy complies with best practice IPC requirements and the evidence bases, including water safety.
- To support monitoring and ensure compliance with all accreditation and regulatory agency.

Delivering our Aim through Six Strategy Goals

Goal 4: Developing Research & Innovation

The importance of research and innovation within IPC will be essential to developing the service fit for thee future. The IPC team will look to develop local research opportunities as well as collaborating with external providers nationally on both quantitative and qualitative research projects.

Three-year priorities

- To establish an IPC Research Group to explore research opportunities for patient benefit, involving patients and other stakeholders.
- To review the research portfolio and develop local research priorities in infection prevention and control.
- To identify and support multi-professional, collaborative infection prevention and control research opportunities across all care settings in MFT.
- To share and promote the appropriate implementation of research findings locally and nationally.
- To contribute to national projects, national strategies, and system transformation.

Goal 5: Surveillance

Robust and timely surveillance is one of the building blocks to having an effective IPC service. There is a need to embrace novel approaches to collating, analysing, and distributing data which has shown demonstratable improvement on patient safety and health outcomes.

The introduction of the electronic patient record system (HIVE) in September 2022, will facilitate advanced capabilities (i.e., device surveillance, surgical site infection, screening compliance).

Three-year priorities

- To broaden and enhance ongoing surveillance to proactively manage the risk of infection.
- To collaborate with the informatics team to monitor compliance with screening, identification of HCAI and management of outbreaks.
- To extend the use of surveillance within the LCO's to provide seamless care.
- To work collaboratively with UKHSA and NHS North West.

Goal 6: Antimicrobial Reduction

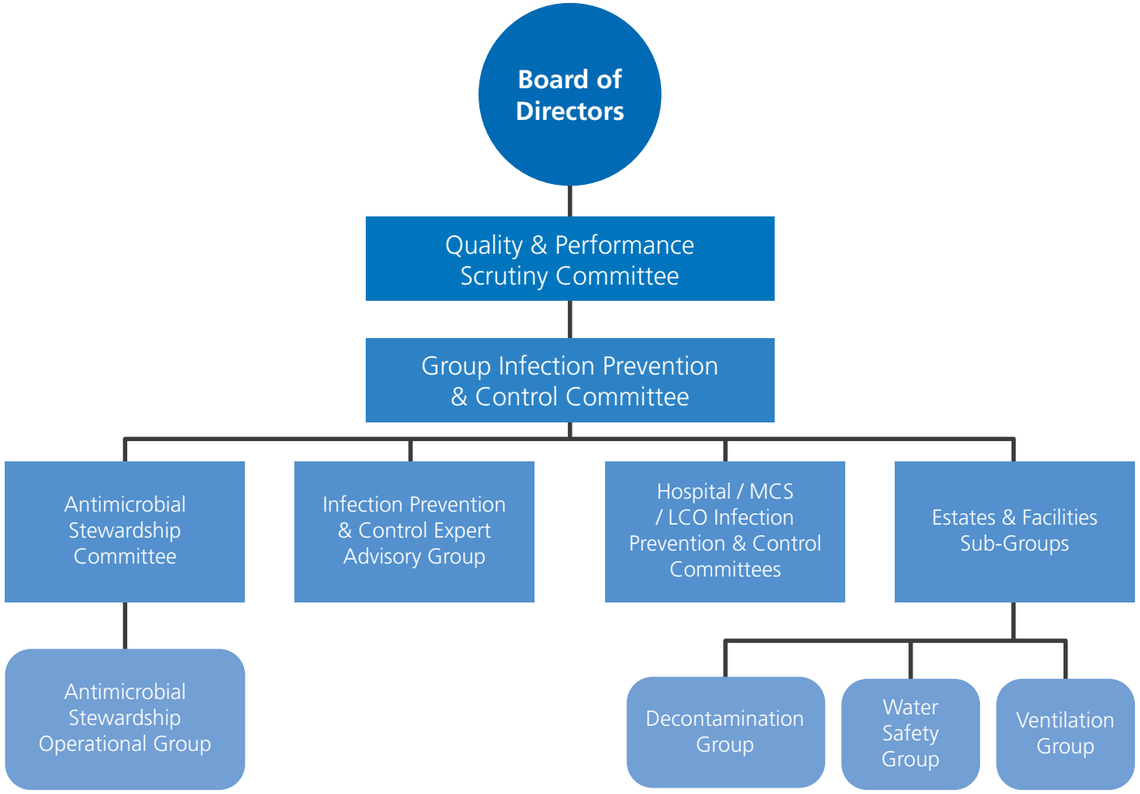
Our aim is to support delivery of strategies to reduce inappropriate antibiotic prescribing, and to ensure that patients who need antimicrobials are given individualised infection management. We will use the most effective treatment to reduce the development of antimicrobial resistance and address variation in practice to support robust IPC standards.

Three-year priorities

- To ensure that patients who need antimicrobials are given individualised infection management, using the most effective treatment.
- To contribute to reduction in antimicrobial resistance in Manchester and Trafford.
- To optimise the use of existing antimicrobial agentsTo reduce the inappropriate use of antimicrobials across MFT.
- To support the development of research and innovation in antimicrobial use.
- To develop a team of AMS Champions across MFT who will facilitate the delivery of the AMS Strategy.

Strategy Governance

The Strategy will be monitored by the Group Infection Prevention & Control Committee.



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Agenda Item 14.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive Officer / Executive Lead for Freedom to Speak Up
Paper prepared by:	Andrew Lloyd , Freedom to Speak Up Guardian
Date of paper:	January 2024
Subject:	Freedom to Speak Up Annual Report 22/23.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Working Together Everyone Matters Dignity & Care Open & Hones
Recommendations:	The Board of Directors is asked to note the FTSU Annual Report 22/23
Contact:	Name: Andrew Lloyd, Freedom to Speak Up Guardian Tel: 07964 900 492

MFT Freedom to Speak Up Annual Report

1st April 2022, to 31st March 2023

1. Purpose of Report

1.1 The purpose of this report is to provide the Board of Directors with an overview of the work of the Manchester University NHS Foundation Trust (MFT) Freedom to Speak Up (FTSU) Team over the period 1st April 2022 to 31st March 2023.

2. Background

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

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

3. Outline of Roles / Responsibilities for FTSU

3.1 MFT has 1.1 WTE FTSU Guardians who work impartially and independently and have been supported throughout 2022-23 by the Senior Lead for FTSU and Group Deputy Chief Executive, Gill Heaton. A Non-Executive Lead also supports the program; Gaurav Batra has held this position during 2022-23. The Director of Corporate Workforce, Nick Bailey provides formal leadership to the FTSU Guardian.

3.3 The FTSU Guardian is also supported by a network of FTSU champions. The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. Their role is to raise awareness of FTSU by being visible and accessible, role modelling the values and behaviours associated with speaking up and listening up, provide signposting and support to individuals who need to raise concerns and to escalate issues that must be acted on involving safety or safeguarding.

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

4. Champion Expansion & Development

4.1 During 2022-23, there has been ongoing expansion of the FTSU network of FTSU Champions across MFT. There are now 67 Champions accessible to support staff. The following table provides information in relation to location of Champions. Further applications continue to be received and work will be ongoing to ensure parity of Staff : Champion ratios across each organisational area, with a continued aspiration that areas will have a least 1 champion per

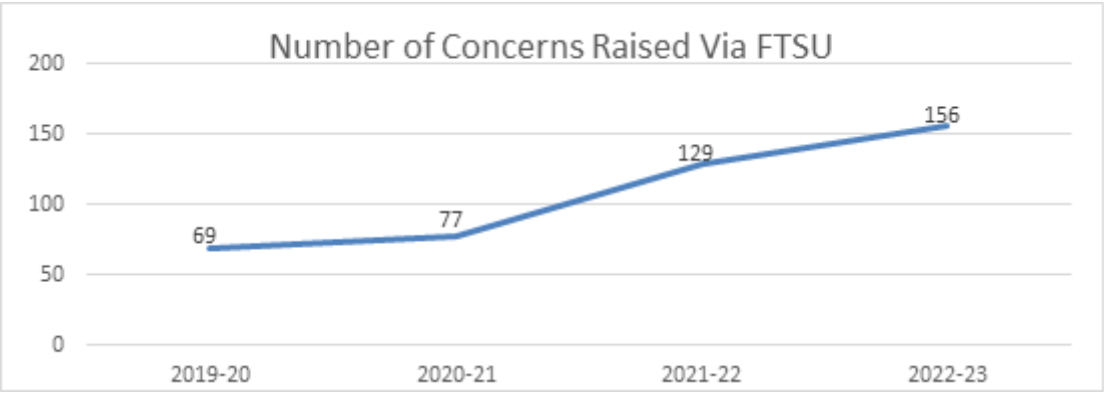
250 staff by 2024. Staff are informed they can contact any Champion across MFT regardless of role or location.

Organisational Area	Number of Champions	Ratio of Champions to Staff
Corporate/R&I	10	1: 343
CSS	14	1: 340
Eye/Dental	3	1: 279
LCO	5	1: 590
MRI	11	1: 344
NMGH	5 (includes Jo Williamson, FTSU Guardian, 0.1 WTE)	1: 355
RMCH	4	1: 629
SMH	4	1: 710
WTWA	11	1: 465

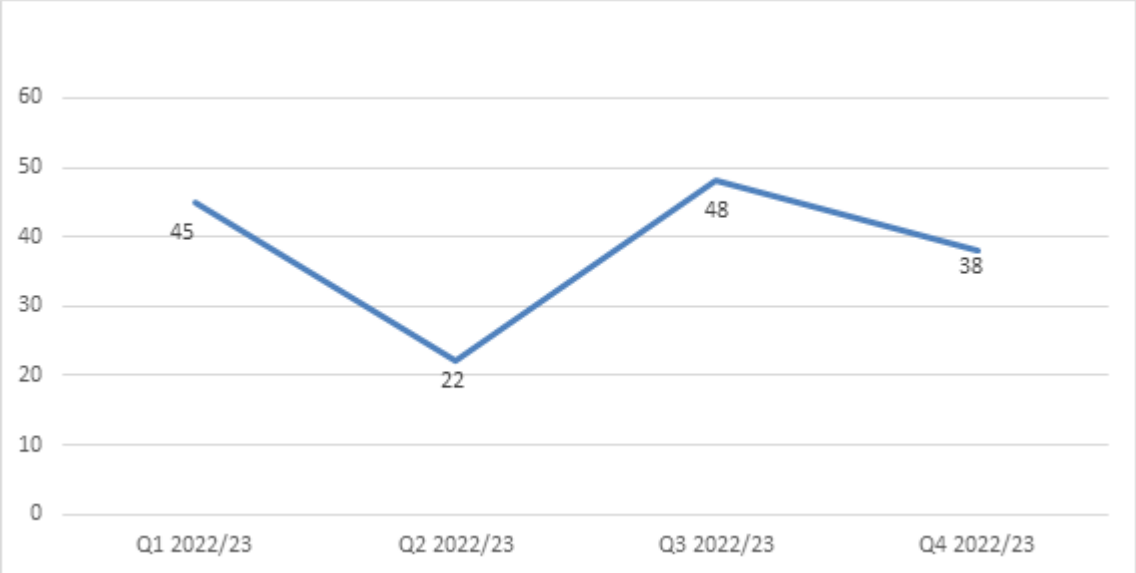
4.3 To support champions in having FTSU Conversations, there is a rolling programme of bespoke training which has been arranged with Organisational Development. Sessions focus on 'Managing Expectations', 'Coaching & Listening' and 'Courageous Conversations'. The champions have also been offered training from the EDI team in how to support staff report hate crime.

5. Assessment of Cases raised via FTSU.

5.1 During 2022-23, there has been an increase in the number of concerns raised via FTSU. The graph below shows that 156 concerns were reported to the FTSU Team during this period. Comparison numbers from previous years are also provided:

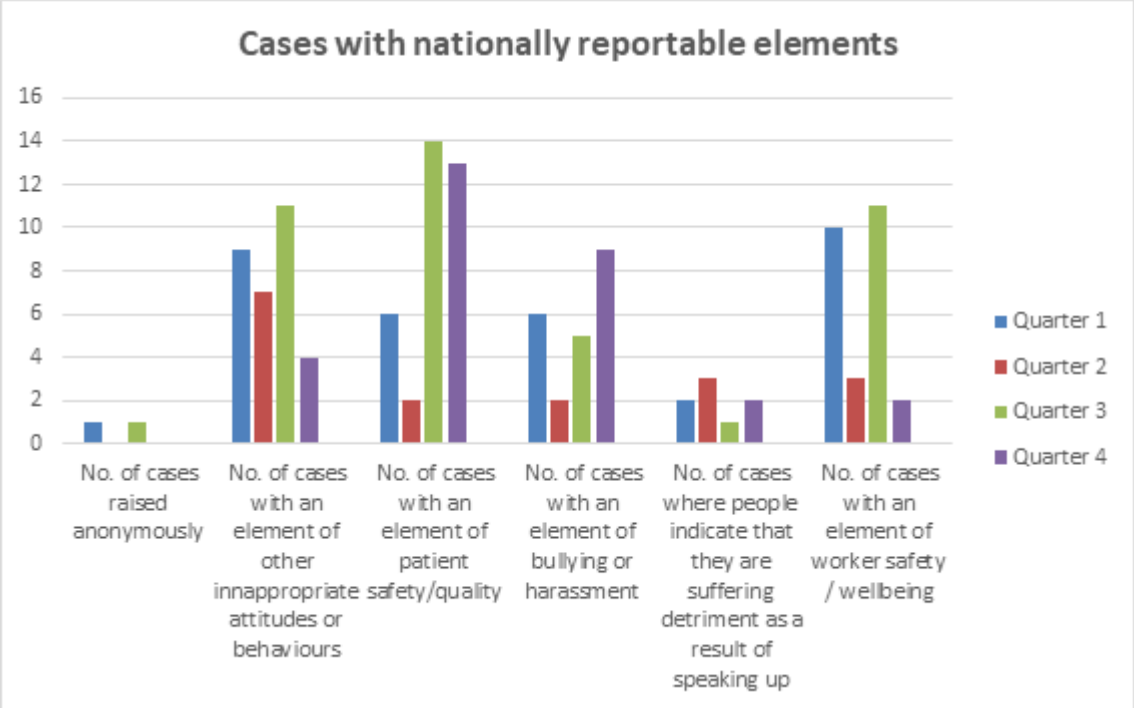


5.2 The graph below illustrates the number of concerns which were reported to FTSU each quarter during 2022/23:



5.3 There is a reduction in contacts received by FTSU during Q2 (22 contacts). This is attributed to Hive Go-Live. Until the launch date, the number of cases was showing a similar upwards trend, but between 8th September and 30th September only one concern was raised to FTSU.

5.3 The graph below illustrates the data for the nationally reportable elements of the cases raised to FTSU each quarter at MFT during 2022/2023:

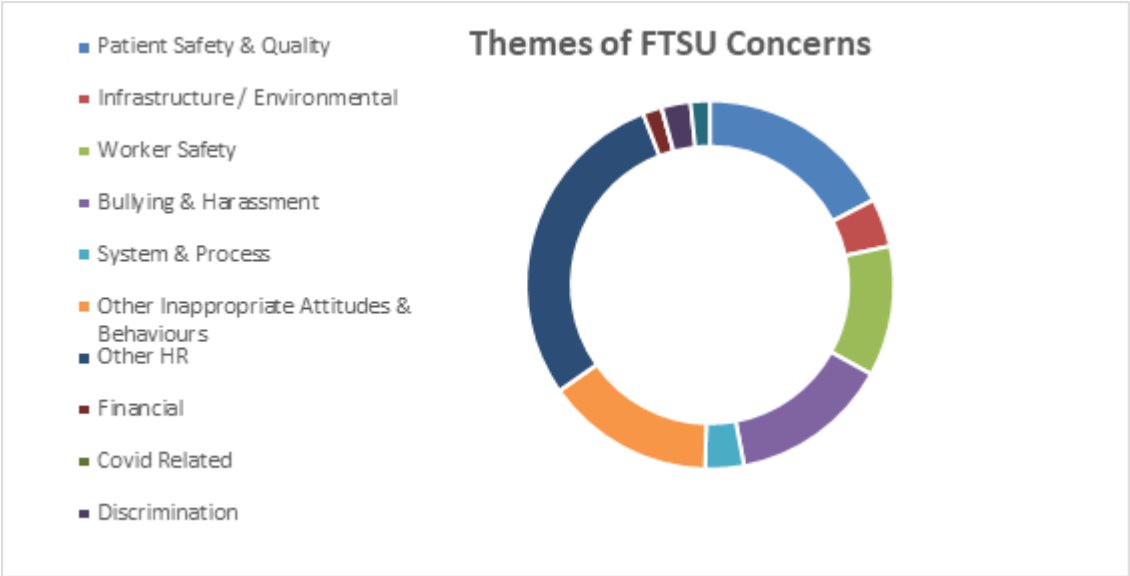


5.4 36% (56) of the FTSU cases raised at MFT had an element of bullying and harassment.

5.5 23% (30) of the cases included an element of patient safety. Themes of concerns which have been raised via FTSU at MFT have included cultures impacting on patient safety, provision of suitable discharge placements and environments for complex CAHMS patients, staffing levels and skill mix, staff training and development, intensity of work and volume of patients impacting on levels of care which can be provided, triage waiting times in ED, difficulties referring to other specialties, environmental issues, nutrition and hydration issues, waiting times for adults with learning difficulties to receive specialist dental treatment, out of date IT equipment, issues with medical devices and isolated concerns related to clinical management. All concerns have been escalated to the relevant senior teams.

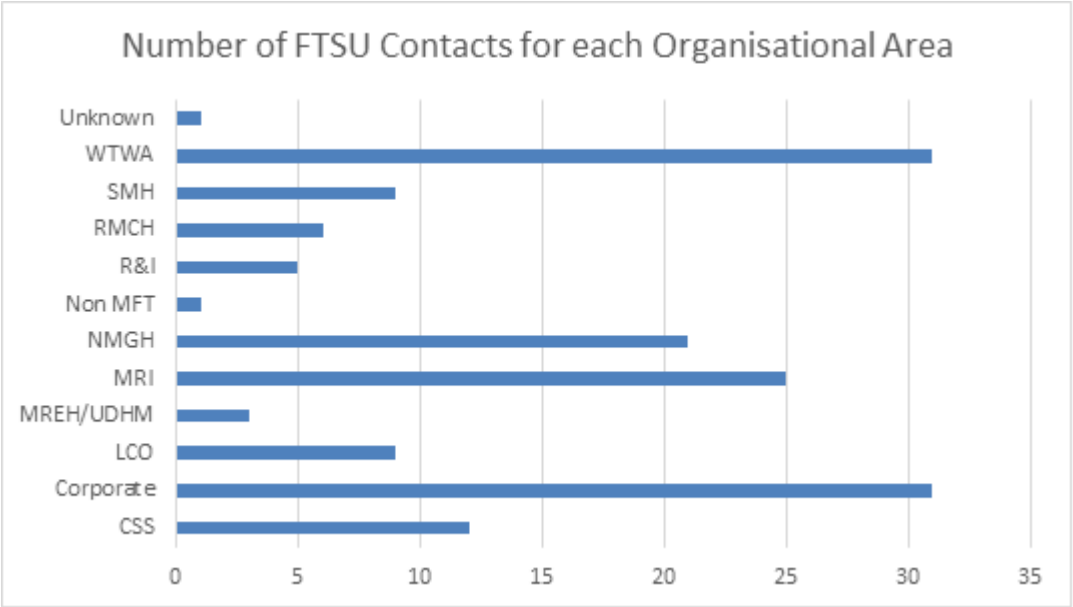
5.6 14% (22) of cases raised to FTSU at MFT had an element of worker safety / wellbeing. This has largely been related to staffing and workloads impacting staff morale and wellbeing. There have also been issues raised related to organisation of rotas, temperature of working environments and working with a risk of anger / violence from patients and visitors.

5.7 The following chart demonstrates the themes for all the concerns raised via FTSU during 2022/23 (note that each case may have multiple themes):

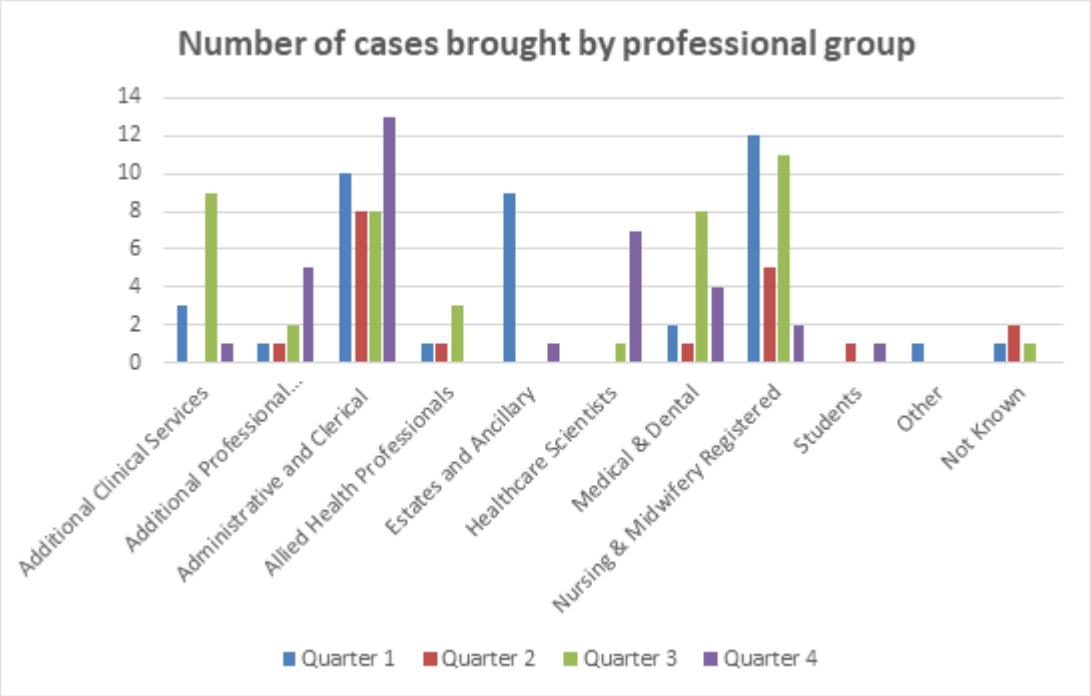


5.8 The FTSU Guardian escalates and reports themes of concerns raised to Senior Leadership Teams across the Trust and to the Group Daily Patient Safety Huddle to help triangulation of themes.

5.9 The following chart illustrated where contacts have been made across MFT.



5.10 The following graph illustrates the professional groups who have raised concerns to FTSU at MFT during 2022/23. This shows a spread across all professional groups. Registered Nursing & Midwifery Staff and Administrative & Clerical Workers make up the groups who have contacted FTSU more frequently.



5.11 There are many routes to speaking up at MFT and FTSU should be viewed as an alternative route for when the usual means of raising concerns are too challenging or have failed. The following reasons are cited by staff as being barriers to them raising concerns using the usual routes of escalation:

- Fear of detriment – examples have included worry about the consequences for their employment, fear of being treated differently, fear of bullying behaviours getting worse.
- A perception of concerns not being listened to or welcomed previously.
- Fear of exposing protected characteristics
- Concerns have been raised previously but there has been no satisfactory response or concerns are ongoing

Fear and futility have been reported in the National Guardian's Office Annual report 2021-22 as being the main reasons people stay silent and it is essential that our managers and leaders respond to concerns with a growth mindset, one where concerns are welcomed and seen as an opportunity for learning and improvement. People who raise concerns should routinely be informed as to how the matter has been handled, while respecting confidentiality as needed.

6. FTSU User Feedback

6.1 FTSU request feedback from individuals after a case has been closed. Individuals can now complete the questionnaire anonymously. The responses to one question; "Given your experience of speaking up, would you speak up again?" are required to be collected for the NGO. 75% of responders

answered “yes” to this question, 11% of responders answered “maybe” and 14% answered “no” during 2022/23.

6.2 As part of the feedback, FTSU asks responders to rate how satisfied they were with the service from the FTSU team. The rating scale uses numbers from 0 (very unsatisfied) to 10 (very satisfied). The average response was 9.4 (range 1-10)

6.3 Below provides an example of some of the qualitative comments received:

“Safe listening space that empowered me to take next steps that I felt were right”

“Supportive and helped me to explore options to manage my concern without feeling any pressure…helped me to calm my initial frustration and upset at the situation”

“Non-judgemental, showed empathy and support in a safe environment”
“The support was welcome, and the guardian was very compassionate and understanding of the issues raised. The response from the leadership team was reassuring”

“Felt supported with practical advice”

“The Guardian worked with me to aim for a solution/raising the issue to somebody I felt comfortable speaking to in my place of work”

“FTSU was easy to access, there was a quick response from my FTSU Champion who provided a lot of reassurance and support”

“FTSU has provided incredible support to me and my team and worked so hard to make my voice heard, so much that it was finally heard”

6.4 Where people had answered “No” or “Maybe” to the question as to whether they would speak up again, the themes have included:

- Being dissatisfied with the response following the investigation into the concern (issues not felt to have been addressed, missing the point, investigation not felt to have been handled appropriately).
- Confidentiality not being maintained during the escalation of the concern.
- The process of feedback about how the concern has been handled has taken too long.

These themes highlight the importance of following up and providing feedback in a timely and frequent way during the process of investigation and the importance of clear communication and handling of any investigation once it has passed from FTSU to ensure that people feel the issues they raise have been addressed appropriately. It is important to also provide clarity where it may become inadvertently clear who has spoken up due to the detail of the issue.

7. FTSU Policy, Guidance, and Reflection and Planning Tool

7.1 Together with NHS England, the National Guardian's Office has published its new and updated national Freedom to Speak Up Policy.

7.2 NHS England state that organisations should adopt this policy, adding their own local information where applicable to ensure those who work in the NHS know how to speak up and what will happen when they do. It is designed to be inclusive and support resolution by managers wherever possible.

7.3 To align with the recommendation, the existing MFT "Raising Concerns At Work and Whistleblowing Policy" is in the process of being amended to reflect the changes to the new national policy.

7.4 The Freedom to Speak Up Guidance published in 2022 will help leaders turn the policy into a healthy and supportive Speak Up, Listen Up and Follow Up culture.

7.5 The guide is designed to be used by any senior team or board in any organisation that delivers NHS commissioned services. This audience has been chosen because it is the behaviour of senior leaders that has the biggest impact on organisational culture and behaviours.

7.6 The accompanying reflection tool is designed to identify strengths and any gaps and review the FTSU arrangements against the guide. It sets out statements for reflections designed for people in the Board or Senior Leadership Team. It also helps to identify the high-level actions which will be taken to develop FTSU arrangements to help the FTSU Guardian and senior lead for FTSU conduct more detailed planning.

7.7 NHSE is asking all trust boards to be able to evidence by the end of January 2024:

- An update to their local Freedom to Speak Up policy to reflect the new national policy template.
- Results of their organisation's assessment of its FTSU arrangements against the revised guidance
- Assurance that it is on track implementing its latest FTSI improvement plan.

7.8 The reflection tool will be utilised at MFT to provide a gap analysis and contribute to an ongoing development plan.

8. FTSU eLearning

8.1 'Speak Up' eLearning has been part of MFT Mandatory training since September 2022. To date, 11,840 staff have now completed this training.

8.2 'Listen Up' and 'Follow Up' eLearning is available via the MFT Learning hub. These are not currently part of mandatory training and uptake has been very low.

8.3 'Listen Up' eLearning is recommended to be completed by any person in a line management role. The purpose of this training is to focus on listening to concerns and understanding the barriers to speaking up.

8.4 'Follow Up' is the final eLearning module and completes the full package of training developed by HEE and the National Guardian's Office (NGO) – Speak Up, Listen Up & Follow Up. This final module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to, and action taken.

8.5 The National Guardian's Office expects that senior leaders (including executive and non-executive directors, lay members and governors) will complete all three modules 'Speak Up', 'Listen Up' and 'Follow Up'.

8.6 It is recognised that while the introduction of mandatory training in speaking up is a positive step forwards in embedding a speaking up culture, this will not change culture. Support and follow up for staff when they speak up is essential to building a positive and inclusive speaking up culture, one where people feel psychologically safe to speak up. There has been low uptake of 'listen up' training ny managers and leaders across MFT. Further work will be done to explore the best way of improving the uptake of this training, including consideration of including it as part of MFT Mandatory Training.

9. National Guardian's Office 100 Voices Campaign

9.1 An MFT case study has been written and shared with the NGO and this was published as part of their 100 Voices Campaign. "Speaking Up Improves Health and Safety and Team Morale" is a great demonstration of the positive action which can happen when staff speak up about their place of work and the difference it can make.

10. Freedom to Speak Up Month 2022

10.1 Freedom to Speak Up Month in October provided an opportunity to raise awareness of how much we value speaking up at MFT. This year's theme was 'Freedom to Speak Up for Everyone' with each week having specific focus. Added to the weekly themes, staff were invited to take part in 'Wear Green Wednesdays' throughout October to show their visible support for Freedom to Speak Up. Stories from some of the FTSU Champions were shared and focused on why they volunteer to do this role.
A video was circulated via trust-wide comms and twitter showing Gill Heaton, FTSU Exec Lead talking about why speaking up is important at MFT. The video can be viewed via this link: https://www.veed.io/view/eab8270a-b533-4d5f-8575-f85f5a2302b4/showcase?renderId=85ef8e53-ce48-43fb-a1a0-cac896c98030

10.2 The theme during week 1 was #SpeakUpforSafety. This highlighted the importance of speaking up about anything that is impacting on patient or staff

safety, along with the importance of staff feeling psychologically safe to speak up. ‘Speak Up’ and ‘Listen Up’ eLearning was promoted during this week and a case example was shared demonstrating the outcomes following an MFT staff member speaking up about staffing levels, equipment issues and health and safety.

10.3 Week 2 focused on #SpeakUpforCivility. This was about connecting with colleagues and being civil to those around is. The following message from Civility Saves Lives was promoted: “Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice”.

To support FTSU month, the OD team ran 8 Civility Workshops throughout October, open to all staff across MFT. There were 177 places offered and 88 people attended the sessions. The message during week 2 also focused on being kind to ourselves. Links to Health and Wellbeing support and resources at MFT was shared via Trust-wide comms.

10.4 #SpeakUpforInclusion during week 3 focused on promoting inclusion and breaking down barriers so everyone feels valued and safe to speak up and be heard. The “Be. Inclusive” campaign at MFT was promoted via Trust-wide Comms and Twitter. Information about the support available from Staff Networks was also shared.

10.5 Week 4 brought the themes together for #SpeakUpforEveryone. This summarised the activities during the month and information was shared related to the National Guardians’ office. A video was circulated via Trust Comms and twitter. This showed John Osuagwu speaking about his role as a FTSU champion and why it’s important that people feel able to speak up. This can be viewed via the following link:
MFT Freedom to Speak Up - John.mp4 on Vimeo

10.6 Freedom to Speak Up month coincided with Black History Month. A virtual session was held within the LCO to bring the two campaigns together organised by the LCO FTSU Champions. FTSU Guardian, Jo Williamson, also attended the Trust’s Black History Month Workshop on 27th October to present ‘Freedom to Speak Up as a Positive Action’ and a FTSU stall was set up during the ‘This is me’ exhibition.

10.7 Throughout the month there was increased visibility of FTSU during walk rounds and listening events.

11. Conclusion

11.1 The MFT FTSU team has continue to expand over the past year with a diverse network of champions supporting the 1.1 WTE FTSU Guardians across MFT.

The number of cases raised with FTSU has continued to increase. The new FTSU policy supports staff and, along with mandated Speak Up training for all staff, this helps to support the development of a speaking up culture.

Moving forward, embedding the listening up and following up aspects will be essential in ensuring staff can speak up without fear and knowing their concerns have been used for learning and improvement.

Agenda Item 14.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive
Paper prepared by:	David Furnival, Director of Special Projects
Date of paper:	January 2024
Subject:	EPRR Assurance Process Revised Statement of Compliance
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors is asked to approve the rating of Partial compliance against the EPRR core standards 2023/24.
Contact:	Name: David Furnival, Director of Special Projects Tel: 0161 276 6718

2023/24 MFT EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE CORE STANDARDS SELF-ASSESSMENT

1. INTRODUCTION

The purpose of this report is to provide the Board of Directors with the MFT revised self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2023/24.

2. CONTEXT

The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2012 underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with NHS England EPRR guidance.

Under the CCA 2004 Acute Providers are Category 1 responders, which are recognised as being at the core of emergency response and are subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The minimum requirements Acute Providers must meet are set out in the NHSE Core Standards for EPRR, which are in accordance with the CCA 2004 and the Health and Social Care Act 2012. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, comprising key documents of:

- Statement of compliance
- Associated action plan
- EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.

There are a total of 62 standards and there are 4 levels of compliance:

Full	**Substantial**	Partial	Non-Compliant
Compliant with **all** standards	The organisation is **89-99%** compliant	The organisation is **77-88%** compliant	The organisation is compliant with **76% or less**

This year a new element has been added to the process with a regional ‘check and challenge’ approach being undertaken with each organisation and this followed the initial MFT submission in October 2024.

3. 2023/24 COMPLIANCE

MFT has undertaken a robust review of the initial self-assessment and the feedback from the regional ‘check and challenge’ process. Following this review process, the Trust has identified several elements that would strengthen the Trusts EPRR delivery in future years. The impact of this review has been to increase the number of partial compliances against the 62 standards to 13 in final submission. This reflects a revised compliance score of 79% (partial compliance).

MFT receiving a rating of ‘Partial’ should not be perceived as a poor assurance rating, as a Trust MFT are delivering against each NHS Core Standard for EPRR. It does indicate there are opportunities for the Trust to further improve over a period, through the implementation and monitoring of effective action plans.

A breakdown of the 2023-24 submission is as follows:

- Full compliance with 49 of the 62 standards
- Partial compliance with 13 standards
- Non-compliance with 0 standards

Actions to address the partially compliant standards are in place as outlined in Appendix A. The action plan will be overseen by the MFT EPRR Committee to ensure delivery, with assurance to the Group Management Board via Committee minutes. Cascade of actions will be undertaken through the MFT EPRR governance structure to local Hospital/MCS/LCO EPRR Forums.

In addition, external oversight and peer review of provider EPRR self-assessments and associated action plans, is provided through the Local Health Resilience Partnership. It should be noted, Greater Manchester's Integrated Care Board can 'check and challenge' MFTs EPRR Core Standard submission with 48 hours' notice.

The revised MFT self-assessment against the NHS England Core Standards for EPRR for the period of 2023/24 was reviewed at the December 2023 Quality and Performance Scrutiny Committee (QPSC). Following discussion, QPSC noted the MFT EPRR statement of compliance for 2023/24 and recommended it to the Board of Directors for approval.

4. RECOMENDATIONS

The Board of Directors are asked to

- Approve the MFT EPRR statement of compliance for 2023/24,
- Note the assurance of delivery of actions and future improved compliance through the MFT EPRR governance structure.

Greater Manchester Local Health Resilience Partnership (LHRP)

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2023-2024

STATEMENT OF COMPLIANCE

Manchester NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core Standards self-assessment tool.

Where areas require further action, Manchester NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

J C Bridgewater.

Signed by the organisation's Accountable Emergency Officer

16/11/2023

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisation's Annual Report

Appendix A – Partial Compliant Standards

Domain	Standard	Detail of standard	MFT further work to be undertaken in 2023/24 and for the 2024/25 submission
Governance	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements Board, no less than annually.	Evidence submitted to the Board will be strengthened to include the following: Training & exercising incidents since the last report including lessons learned.
Governance	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • identified risks • outcomes of any assurance and audit processes the work programme should be regularly reported upon and shared with partners where appropriate	The workplan will be strengthened to demonstrate clear evidence of being driven by risk assessments/registers.
Duty to maintain plans	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	This area will be strengthened by the risk assessment being tested regularly and shared appropriately with those required to use them. Further detail will be added on any equipment requirements and further staff training required.
Command and control	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	The current evidence will be collated into an "on call pack" or handbook which is updated at least annually.

Domain	Standard	Detail of standard	MFT further work to be undertaken in 2023/24 and for the 2024/25 submission
Training and exercising	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	The current training will be updated and directly aligned to the National Occupation Standards for the individual roles.
Training and exercising	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	The exercises will be updated to better link between the Trust risk profile and the exercise i.e., reason for exercise is that the issue has a high-risk score.
Training and exercising	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Training will be strengthened as will the evidence reporting of training undertaken by staff. The reports to the committees will be updated to include the training numbers split by Hospital / MCS.
Response	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. Has 24-hour access to a trained loggist(s) to ensure support to the decision maker	The decision logging SOP has been drafted and will be ratified by the EPRR Committee. New logbooks that withstand legal scrutiny are being sourced.

Domain	Standard	Detail of standard	MFT further work to be undertaken in 2023/24 and for the 2024/25 submission
Warning and informing	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident, or business continuity incident.	A work programme has been created to ensure closer collaboration with the MFT communications team. This will also ensure the appropriate evidence can be extracted from plans.
Cooperation	**LHRP Engagement Analysis/Assessment**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	The current GM SOP identifies a single GM Trust representative to attend the LHRP. Responses could be strengthened by increased representation. The EPRR team will work with the AEO and senior leadership to strengthen representation at the LHRP.
Business Continuity	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	The EPRR team are exploring auditing services for business continuity including developing better links with similar sized organisations to reduce the need for external consultancy services.
Business Continuity	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	BCMS effectiveness will be tested within the exercises plan with lessons identified for continuous improvement included in the lessons management system.

Domain	Standard	Detail of standard	MFT further work to be undertaken in 2023/24 and for the 2024/25 submission
Hazmat/CBRN	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments.	Current training will be updated and aligned to a set of minimum standards and reviewed by partner agencies experts.