NHS
Manchester University
NHS Foundation Trust

Board of Directors (Public)

Date: Monday 20th January 2025
Time: 2:00pm – 4:00pm
Location: Main Boardroom, Cobbett House, ORC

Items marked with an asterisk have been discussed at the relevant Board Committee

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chairman	
2.	**Declaration of interest** (verbal)	Meeting admin	Chairman	
3.	**Patient Story**			
4.	**Minutes of the previous meeting** (11th November 2024)	Meeting admin	Chairman	
5.	**Action Log**	Discussion	Chairman	
6.	**Matters Arising**	Discussion	Chairman	
7.	**Trust Chair's report (verbal)**	Discussion	Chairman	
8.	**Trust Chief Executive's report**	Discussion	CEO	
9.	**Assurance Reporting**			
9.1	Integrated Performance Report	Discussion	Executive Directors	
10	**Strategic aim 1: Work with partners to help people live longer, healthier lives**			
10.1	Research, Innovation and Population Health Board Committee (04/12/24) escalation and assurance report	Discussion	NED (LG)	
10.2	Strategic Developments	Discussion	CSO	
10.3	Update on the delivery of MFT's Green Plan*	Discussion	CDO	

11	**Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience**			
11.1	Quality, Safety and Performance Board Committee (18/12/24) escalation and assurance report	Discussion	NED (DR)	
11.2	Cervical Screening Provider Lead Annual Report*	Discussion	JCMO	
11.3	Maternity Patient Survey*	Discussion	CNO	
11.4	Urgent Care patient survey results*	Discussion	CNO	
11.5	Maternity Incentive Scheme*	Discussion	CNO	
11.6	Mental Health Scheme of Delegation*	Approval	CNO	
12	**Strategic aim 3: Be the place where people enjoy working, learning and building a career**			
12.	People Board Committee (18/12/24) escalation and assurance report	Discussion	NED (AA)	
13	**Strategic aim 4: Ensure value for our patients and communities by making best use of resources**			
13.1	Finance Board Committee (17/12/24) escalation and assurance report	Discussion	NED (TR)	
13.2	Chief Finance Officer's report*	Discussion	CFO	
13.3	Digital and Estates Board Committee (03/12/24) escalation and assurance report	Discussion	NED (SL)	
13.4	North Manchester Redevelopment Programme	Discussion	CFO	
14.	**Any Other Business** (verbal)	Discussion		
15.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: 10th March 2025				

Agenda Item 4

Manchester University NHS Foundation Trust

Board of Directors (Public)

11th November 2024

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Mark Cubbon (MC)	Group Chief Executive
	Trevor Rees (TR)	Deputy Group Chairman
	Darren Banks (DB)	Group Chief Strategy Officer
	Julia Bridgewater (JB)	Group Deputy Chief Executive / Interim Chief People Officer
	Nic Gower (NG)	Group Non-Executive Director
	Kimberley Salmon-Jamieson (KSJ)	Group Chief Nursing Officer
	Toli Onon (TO)	Joint Group Chief Medical Officer
	Luke Georghiou (LG)	Group Non-Executive Director
	Mark Gifford (MG)	Group Non-Executive Director
	Chris McLoughlin (CM)	Group Non-Executive Director
	Angela Adimora (AA)	Group Non-Executive Director
	Samantha Liscio	Group Non-Executive Director
	David Walliker (DW)	Group Chief Digital and Information Officer
	Vanessa Gardener (VG)	Group Chief Delivery Officer
	Matt Bonam	Group Non-Executive Director
In attendance:	Nick Gomm (NGo)	Director of Corporate Services/ Trust Board Secretary
	Anne Bracegirdle (AB)	Deputy Chief Finance Officer
	Stella Clayton (SC)	Deputy Chief People Officer

1.	**Apologies for absence and confirmation of quoracy**
Apologies were received from Marcus Thorman, Bernard Clarke, Norma French.	
2.	**Declarations of Interest**
No interests were declared	

3.	Patient Story

KSJ introduced the patient story which described the experience of a service user from the Hospital at Home service.

Decision	Action	Lead	Complete / date for completion
The Board noted the patient story	None	n/a	n/a

4.	Minutes of previous meeting held on 9th September 2024

The minutes of the Board of Directors' (Board) meeting held on the 9th September 2024 were approved with the amendment that DR was present at the meeting. A typographical error was also highlighted for correction.

5. Action Log

Action	Lead	Complete / date for completion
Report on the Cancer survey results to come to future Board meeting	KSJ	Complete – on the agenda for this meeting.
Further report on 'Strengthening Leadership, Culture and Engagement' to be presented to the Board in March 2025.	Chief People Officer	March 2025
A service user of the Hospital@Home service to feature in a patient story at a future Board meeting	KSJ	Complete – on the agenda for this meeting.
Report on the November maternal death to come to a future Board meeting	CL	To be scheduled when ready

6.	Matters arising

There were no matters arising.

7.	Group Chairman's Report

KC provided her verbal report and drew attention to:

- It is JB's last Board meeting prior to her stepping down as a Board member.
- The Annual Members' Meeting which took place on the 25th September.
- The new Organ Donation mural on the Oxford Road Campus.
- The new RMCH roof garden, funded by MFT charity and helped by the fundraising efforts of Hughie and Freddie.
- The building of the National Breast Imaging Academy at Wythenshawe Hospital with the Duchess of York becoming a Trustee of the Prevent Breast Cancer charity.
- National awards received by two of MFT's midwives.
- The charity meal to celebrate the launch of the Children's Research Institute.

- The 210th birthday of Manchester Royal Eye Hospital.
- Black History month and the Diwali celebrations held at the Trust.
- The Armistice events at Wythenshawe Hospital, Manchester Royal Infirmary (MRI) and North Manchester General Hospital (NMGH).

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

8.	Group Chief Executive's Report

MC introduced the Group Chief Executive's report and drew attention to:

- The national Darzi review and the development of the new 10-year NHS plan.
- MFT's winter planning and the important role of the Hospital at Home service within it.
- Implementation of the Right care, Right place programme and the role which KSJ and the nursing teams have played in it.
- MFT has moved out of NHS England's (NHSE) Tier 1 for cancer delivery.
- Notification from the Maternity and Newborn Safety Investigation (MNSI) programme that MFT has addressed all its responsibilities and their query has been closed down.
- MFT's new operating model is now in place and the benefits of having Clinical Groups' Chief Executives at the Trust Leadership Team meetings.
- MFT's new strategy, policy and working arrangements to address violence and aggression against staff.
- MFT has signed up to the national Sexual Safety Charter.
- His appreciation of JB for all her work in the Trust and across the NHS over the many years of service she has given.
- His appreciation of Bernard Clarke for acting as interim Joint Chief Medical Officer and to Marcus Thorman for acting as interim Chief Finance Officer.
- Dr Sohail Munshi has been appointed as the new Joint Chief Medical Officer.
- Claire Wilson, the new Chief Finance Officer, joins the Trust in December.
- Meera Nair, the new Chief People Officer, joins the Trustin February.
- His three main current concerns: Finances, Winter pressures, and Organisational Change.
- The New Hospital Programme and the close work with the national team to promote NMGH's case.

MG congratulated the Executive team for involvement in the development of the 10-year NHS plan and the opportunity to contribute the views of MFT and local people. As chair of the Organisational Development Board Committee (ODBC) he explained that they had considered the communications and support being provided to staff to mitigate the risks of the organisational change programme.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

9.1	Integrated Performance Report (IPR)

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

DR noted that the metrics related to quality, safety and performance had been discussed in detail at the Quality, Safety and Performance Board Committee (QSPBC).

It was noted that a detailed discussion on performance had taken place at the Private Board meeting earlier in the day in addition to the discussions at each relevant Board committee.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

10.1 Strategic Developments

DB introduced the report and drew attention to the new leadership at the CQC; MFT's role in addressing population health challenges across Greater Manchester (GM); and the 2025/26 planning process which had started in September with learning taken from last yea's process.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

10.2 Socioeconomic Duty

TO presented the report which proposed the voluntary adoption of the Socio-Economic Duty, ensuring that the rights of economically disadvantaged groups are protected in decision making and strategy development, alongside those groups already protected in law through the Equality Act 2010. Existing equality impact assessment process will support the process.

MG welcomed the development and proposed that the Research, Innovation and Population Health Board Committee (RIPHBC) played a role in overseeing the work. KC agreed and asked for it to be included on their work programme.

NG also welcomed the development and commented that some further work was require don the financial implications of adopting the duty.

MB noted the advantages of providing more care in people's home and the need to be aware of potential digital exclusion as technology plays a greater role in people's care. NG added that there are a number of organisations addressing digital exclusion and there were opportunities to build links with them.

Decision	Action	Lead	Complete / date for completion
The Board approved the adoption of the socioeconomic duty.	Socioeconomic duty to be included on the work programme of the RIPHBC	NGo	March 2025

11.1	Quality, Safety and Performance Board Committee (QSPBC) escalation and assurance report

DR introduced the 'Alert, Advise, Assure' (AAA) report from October's QSPBC meeting and highlighted the following items discussed at the meeting:

- The relevant IPR metrics, drawing attention to the improvement in the metrics for diagnostics, cancer treatment target and elective activity. The Committee has requested a deep dive on the full clinical audit process.
- The maternity safety report, the Perinatal Mortality Review tool (PMRT), the new induction of labour pathway, and the changes to homebirth service.
- Deep dives on the harm review process and compliance with duty of candour requirements.
- Learning from deaths.
- Use of surgical safety checklists with a further report requested in six months' time.
- The positive results from the lates cancer patient experience survey.
- The Q2 patient experience and complaints reports.

SL commented that the IPR's benchmarking of MFT with other Trusts was very useful.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

11.2	MFT Winter Plan

VG introduce the report which described MFT's Winter Plan for this year which has been developed with partners across the health and care system. The Plan has been developed around four pillars of work: System and MFT Coordination throughout winter; Looking after our patients & our staff; Creating the capacity to meet the demand; and Robust communications. The role of the Hospital at Home service will be key.

AA welcomed the health and wellbeing of staff being linked to the Plan.

TR asked if ambulances can direct people to the Hospital at Home service and VG explained that there would be a 'test of change' of this in January. MC added that they can already do this and also can refer people to their GP practice.

CM thanked colleagues for their work and commended the collaboration between different organisations and the fact that it was a system-wide plan.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

11.3	EPRR core standards

VG introduced the report which provides an overview of Manchester Foundation Trust's self-assessment against the 2024/25 EPRR core standards and summarises the

discussions held during the GM EPRR inspection visit regarding supporting evidence and EPRR risks.

For the 2024/25 EPRR assurance process, MFT declared an overall compliance rating of 'Substantial', having self-assessed as 94% compliant with the core standards and evidence provided. Following the submission on 30th September and the inspection visit on 9th October, the Trust has achieved a rating of 94%.

VG and KC thanked the teams involved.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and the 'substantial' rating achieved.	None	n/a	n/a

11.4 Annual provider self-assessment

TO presented the report which presented the Trust's self-assessment report (SAR) in a number of areas relating to education and training for all healthcare learners. The exercise is a NHSE requirement for all Trust in England.

MFT has prepared this year's SAR involving senior leads in Non-Medical Allied Health Professionals(NMAHPs), Medical Education, Pharmacy, Organisational Development/ Workforce and Clinical Governance. There is only one exception report, with regard to pharmacy.

DR welcomed the report and asked about the ability to ensure funding for placements flows through to support front line services' training costs. TO explained that, regretfully, it is not possible to separate out the funding in that way. MC agree that unpicking funding is difficult but may be easier with new funding for additional placements.

Decision	Action	Lead	Complete / date for completion
The Board approved the return.	None	n/a	n/a

11.5 Q2 Complaints Report

KSJ introduced the report and explained it had been presented and discussed at October's QSPBC. The report was the most positive it has been for some time but there remained some issues to resolve within the Royal Manchester Children's Hospital (RMCH).

KC welcomed the increase in PALS activity to resolve issues promptly.

DR confirmed that there would be a deep dive on complaints at a future QSPBC meeting with a focus on patient communications which often appears as a theme in complaints.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and supported the recommendations.	None	n/a	n/a

11.6	**Q2 Patient Experience Report**

KSJ introduced the report and explained it had been presented and discussed at October's QSPBC. The PLACE results will be triangulated with the patient survey results so there is one programme of work address learning from both.

KC noted that a new involvement strategy was in development and it will be shared with Governors for their review.

LG asked about benchmarking information and KSJ explained that it was available for the national survey results and the PLACE assessments but there was an ambition to develop it further through internal benchmarking between MFT's Clinical Groups.

MC highlighted the potential for real-time feedback to improve MFT's responsiveness.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and supported the recommendations.	None	n/a	n/a

11.7	**Cancer Patient Survey**

KSJ introduced the report which presented MFT's results in the national cancer patient experience survey. The results were positive with the Trust receiving its highest score for 5 years. The report had been considered at October's QSPBC meeting.

Decision	Action	Lead	Complete / date for completion
The Board noted the report	None	n/a	n/a

12.1	**People Board Committee Escalation and Assurance Report**

AA introduced the 'Alert, Advise, Assure' (AAA) report from October's QSPBC meeting and highlighted the following items discussed at the meeting:

- Progress made in delivering on the management actions in the response to the internal audit report on long-term staff sickness.
- Learning from employment tribunals.
- The Nursing and Midwifery safer staffing reports.
- The Widening Participation annual report.

- The Workforce Race Equality and Disability Equality Schemes' annual reports which were approved for publication at the Committee.
- The work to reduce violence against staff in the Trust.
- The Guardian of Safe Working's annual report.
- A report on the staff vaccination programme.

Decision	Action	Lead	Complete / date for completion
The Board noted the update	None	n/a	n/a

12.2	**Workforce Race Equality Standard / Workforce Disability Equality Standard**

SC introduced the report which presented the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports for 2023-24. The WRES data provides a comparison between staff from Black, Asian, and Minority Ethnic (BAME) backgrounds and white staff, while the WDES data compares staff with disabilities to those without. The Trust level data was submitted to the NHSE in May 2024, with a report of findings and actions published at the end of October 2024 following approval at the People Board Committee in October 2024.

The WRES data shows that tall indicators are going in the right direction. Last year's report showed that respondents wanted more opportunities for career progression and that indicator has improved this year.

The WDES data shows an increase in staff declaring themselves as disabled but the reported figure remains lower than that reported by MFT staff in the national staff survey.

SC explained that the Diversity Matters strategy would be reviewed within the coming months.

KC noted the need to build staff member's confidence in declaring themselves as disabled. MC agreed and explained that disability is under-recorded nationally but there is a need to understand what is getting in the way of people declaring their disability. AA advised that there may be some concern over how the data is used and that it would be important top address this with in any communication campaign.

CM welcomed the increase in people from Black, Asian and Minority Ethnic (BAME) communities within senior management positions at the Trust.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and ratified the approval of the People Board Committee for publication of the WRES/WDES reports.	None	n/a	n/a

12.3	Staff Vaccination Programme

SC introduced the report which provided an update in relation to the workforce seasonal flu vaccination campaign, the decisions regarding COVID-19 workforce vaccinations and the vaccination of key staff in for pertussis (whooping cough). 21% have received the flu vaccination so fare with low uptake so far amongst BAME colleagues. There is no requirement for staff to receive the Covid vaccine this year.

AA emphasised the need to understand the views of BAME colleagues and the reasons for the low uptake.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and supported the vaccination programmes described.	None	n/a	n/a

12.4	Biannual Safe Staffing Report (Nursing)

KSJ introduced the report and explained it had been presented and discussed at October's QSPBC, and will be on a quarterly basis from now on. She explained that the data will need run for three or four times to ensure its reliability and enable comparison.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

12.5	Biannual Safe Staffing Report (Midwifery)

KSJ introduced the report and explained it had been presented and discussed at October's QSPBC, and will be on a quarterly basis from now on. The report presents a positive picture of staffing levels.

AA noted that there would be a further report on the culture work being undertaken at St Mary's Managed Clinical Service at the December meeting of People Board Committee.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

13.1	Finance Board Committee (FBC) Escalation and Assurance Report

TR introduced the 'Alert, Advise, Assure' (AAA) report from October's FBC meeting and highlighted the following items discussed at the meeting:

- The proposal for insourced capacity to deliver the Project 108% vision.
- The system proposal for external support to improve the functioning of the urgent care system in Manchester.
- The business case for the expansion of robotic-assisted surgery at the Trust.
- The Trust's insurance arrangements.
- The Chief Finance Officer's report for M6.
- Progress being made in delivery of the Value for Patients' programme which is slightly behind forecast at present but a record level of schemes have been identified and the risk-adjusted forecast is positive.
- The national cost collection submission report.

Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a

13.2 Chief Finance Officer's Report M6

AB introduced the report and explained it had been presented and discussed at October's FBC. In terms of the forecast outturn, the Trust is still expecting to deliver the £3.6m surplus plan but there is recognition that a significant reduction in run rate is required. Key workstreams which will have a significant impact on either reduction of expenditure or maximisation of income at pace have been identified and work is ongoing to implement at pace. Discussions are continuing with NHSE and GM ICB in relation to funding to cover cost pressures as a resul the junior doctors' Industrial Action in June/July 2024 and the shortfall on anticipated funding to cover the national pay award.
The Trust cash position remains an area of focus and a programme is in place to maximise the income received. The capital plan is currently £22m behind plan but it is expected to be delivered in full by year-end.

Decision	Action	Lead	Complete / date for completion
The Board noted the report	None	n/a	n/a

13.3 Standing Financial Instructions (SFIs) & Scheme of Delegation (SoD)

AB introduced the report which presented the Trust's SFIs and SoD for approval. They had been reviewed at November's Audit and Risk Committee and changes had been made in response to feedback.

NG noted the importance of the documents and the changes made as a result of the Trust's new operating model. significant change as a result of changing to operating model. Very important documents which show how we manage risk. Discussed at Audit and Risk Committee and changes suggested have been amended.

KC asked for the SFIs and SoD to be held under reviewed by the Audit and Risk Committee and for them to discuss them again in three months' time.

Decision	Action	Lead	Complete / date for completion
The Board noted the report	Audit and Risk Committee to further review the SFIs and SoD in April 2025.	NGo	April 2025 – on work programme.

14.1 Research and Innovation Annual Report

TO introduced the Research & Innovation (R&I) Annual Report 2023/24 which collates updates, stories and metrics from across the trust and its hosted R&I infrastructure, to demonstrate impact on driving positive change in health and care for all and delivering world-class research and innovation that improves peoples' lives. The report covers the period from 01 April 2023 to 31 March 2024.

Following ratification of this Report, a fully designed version will be produced for wider publication and dissemination across MFT and MFT R&I channels.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and approved it for publication.	None	n/a	n/a

15.1 Charitable Funds Committee (CFC) Escalation and Assurance Report

KC introduced the 'Alert, Advise, Assure' (AAA) report from September's FBC meeting.

The Board was requested to approve the changes proposed to the working names of the charities and to approve the decision to support the construction of a Medicinema on the Oxford Road site.

It was asked that 'Manchester' is added to the working names of the Royal Eye Hospital and the University Dental Hospital.

Decision	Action	Lead	Complete / date for completion
The Board noted the report and approved the changes to the working names of the Charity and supported the construction of a Medicinema on the Oxford Road site.	'Manchester' to be added to the working names of the Royal Eye Hospital and the University Dental Hospital.	NGo	December 2024

15.2 Audit and Risk Committee (ARC) Escalation and Assurance Report

NG introduced the 'Alert, Advise, Assure' (AAA) report from September's ARC meeting and drew attention to the internal audit reports discussed.

NG explained that there had been a further ARC meeting on the 6th November and the report from that would be presented at the next Board meeting.

Decision	Action	Lead	Complete / date for completion
The Board noted the report	None	n/a	n/a

15.3	**Board of Directors' Register of Interest**

KC drew attention to the Register of Interests for the Board of Directors. The Register is presented to the Board twice a year.

Decision	Action	Lead	Complete / date for completion
The Board noted the report	None	n/a	n/a

16.	**Any Other Business:** There were no additional items of business.
17.	**Meeting Evaluation** MC noted that a number of the reports presented had been discussed in detail previously at the Board committees and KC welcomed this as evidence that the Board committees are functioning effectively.
18.	**Date and time of next meeting:** 20th January 2025, 2pm

Action log from meeting

Socioeconomic duty to be included on the work programme of the RIPHBC	NGo	March 2025
Audit and Risk Committee to further review the SFIs and SoD in April 2025.	NGo	April 2025 – on work programme.

Incomplete actions from previous meetings

Further report on 'Strengthening Leadership, Culture and Engagement' to be presented to the Board in March 2025.	Chief People Officer	March 2025
Report on the November maternal death to come to a future Board meeting	CL	To be scheduled when ready

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Trust Chief Executive Report	**Agenda Item 8**
Presented by:	Mark Cubbon, Trust Chief Executive	
Prepared by:	Leo Clifton, Senior Business Manager	

Meetings where content has been discussed previously	Trust Leadership Team Committee
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion

Executive summary / key messages for the meeting to consider

The Trust 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.

Recommendation(s)

The Board of Directors is asked to note this report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐

PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • Strategic objective 3, 8 and 6 in the Board Assurance Framework.	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • None.	

Main report

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

Contents

Full content of the report is included as Appendix A.

Appendix 1 – Full report Content

1. Work with partners to help people live longer, healthier lives

10-Year Plan engagement

The Government has started the process to develop its 10-Year Plan for the NHS in England, which is expected to be published in the spring, and have established a number of national groups to support policy development. MFT is well-represented on these groups with executive directors and members of the wider leadership team involved with work on areas such as digital, life sciences, finance and enabling change. The Chair also represented the Trust at a regional engagement event, led by senior Department of Health and Social Care officials and the NHS England Regional Director on 20 November alongside other senior leaders from across the region.

Whilst there is good alignment between our organisational strategy, Where Excellence Meets Compassion, and the themes emerging from the national work so far; we are looking at areas in which we may want to focus on over the coming year as part of our annual planning process, particularly in light of the Government's three "shifts" towards prevention, community care and digitisation.

Winter planning and system collaboration

Throughout December, the Trust implemented a Countdown to Christmas campaign working with Clinical Groups and system partners. This initiative aimed to ensure that suitable patients were safely discharged home in time for Christmas. As a result, bed occupancy on Christmas Eve and into Christmas Day decreased to 83% for General and Acute beds, improving patient flow across our hospitals and ensuring timely admissions for those in need. Our 'Starting Strong in 2025' rapid improvement campaign will continue to ensure there remains a focus on patient safety, reducing days away from home and support discharges before lunch whilst winter pressures continue.

The MFT co-ordination centre has been ensuring the Winter Plan is implemented and throughout the Christmas and New Year Period have hosted daily quality, safety and oversight meetings, joined by partners from Manchester and Trafford Local Authorities, to ensure risks were being managed across the system. Greater Manchester system leaders convene three times a week to address local challenges and collaboratively respond to fluctuations in demand.

2. Provide high quality, safe care with excellent outcomes and experience

Operational delivery

This section provides a high-level overview of operational delivery and a number of key developments since the last Board meeting. Our current performance is outlined in the Integrated Performance Report.

Urgent care

This year we aim to achieve a 78% performance for the 4-hour target across all types by March 2025 from our April 2024 position of 68%. For the month of November performance was 64% against a plan of 72.7%. Ambulance handover within 15 mins during November was 40.9%, against a plan of 65%, with average times increasing to 21 minutes from 19 in October. Both metrics represent a deterioration against plan driven by an increase in type one emergency attendances, which were 3% above planned levels, as well as the impact of seasonal illnesses and infections. This included an increase in respiratory syncytial virus (RSV) which increased pressure in our children's emergency department.

Our focus over December, as always, was on patient safety and ensuring robust clinical oversight of processes are in place to keep the patients waiting for emergency care safe in our departments. In December we also saw an increase in the number of patients occupying beds in our hospitals with 'no criteria to reside', which rose to 300 patients against our planning assumption of 240 patients across all our sites. Occupancy of our Hospital at Home service also increased, with occupancy of 94.6% achieved in December and allowing more of our patients to receive treatment in their own homes.

Elective care

The November month end position for patients waiting over 65-weeks reported was 192 higher than our planned trajectory. The largest cohort of patients waiting over 65 weeks remains in our gynaecology services, in particular the Urogynaecology sub-specialty, where additional capacity has been sourced to see and treat more patients over the coming months. Leadership teams are confirming final plans for the clearance and sustainable elimination of 65-week waits in this specialty and across all our waiting lists to ensure patients receive timely planned care.

Cancer care

The 62-day Cancer backlog for November was 297 against a plan of 213. The latest reported month for 62 day and the Faster Diagnosis Standard (FDS) is October, where 62-day performance was 58.2% against a plan of 65.1%, and FDS performance was 76.2% against a plan of 74%. Whilst continued progress against the diagnostic cancer pathway is positive, there is much more to do to improve waits for cancer treatment on the 62-day

pathway. The largest contributors to the current position are in the lung, breast and urology tumour groups, where additional activity is planned for the remainder of the financial year to support pathway improvement and to ensure patients can be booked for cancer surgery, in particular, within 62 days.

Diagnostics

Performance for the month of November across all DM01 modalities was 17.8% against a plan of 17.9%. Particular progress has been made in improving waiting times in the sleep and echo modalities, contributing to continued achievement of performance against plan. As we look towards quarter four, there is more to do to achieve the step change to deliver our trajectory of 10% by March 2025, and we will be concentrating our efforts on children and young people's imaging waits, as well as in complex MRI and CT demand.

Productive Series

MFT is one of four organisations across England participating in the Modern Productive Series. On 2 December, a launch event was held where the four provider teams came together to identify and explore opportunities to enhance productivity across the NHS. At its core, productivity is about using our resources in the most efficient and careful way to achieve the best outcomes for patients.

Whilst we have several improvement workstreams in place, we have chosen to use the productive series to drive further productivity across outpatients by focusing on leveraging predictive analytics to address high DNA (Did Not Attend) rates, particularly among vulnerable patient cohorts experiencing health inequalities. By using a detailed algorithm to predict DNAs which will drive targeted follow-up actions, we aim to improve outpatient productivity and patient experience. Initial pilots have demonstrated the potential for significantly improving access for our patients, with a focus on refining processes to support translation, transportation, and accessibility for at-risk groups. This initiative reflects MFT's commitment to reducing health inequalities and enhancing service efficiency. Programme support is in place until March and we are planning our first plan do study act (PDSA) cycle in mid-January.

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

One MFT – implementing our operating model

On the 30 September 2024, our six new Clinical Group's went live, delivering our commitment to implement our Accountability Framework and ensuring that each Clinical Group has clear and consistent ways of working led by their new Senior Leadership Teams. This new model is now in place and is already enhancing our ability to improve care, supporting us to manage performance and work collaboratively as One MFT.

Work to review our corporate services and how they provide effective support to the organisation and our new Clinical Groups is also progressing well. Where required, staff are currently being consulted on proposed changes to our corporate functions which will directly inform our new design and ways of working.

With our new Clinical Group Senior Leadership Teams (SLT) in place, each SLT will now be reviewing their own, wider leadership structures to ensure that we have the right model to support our frontline teams to deliver high-quality care effectively. Further information will be shared with the Board as this work progresses.

Staff survey

The NHS Staff Survey 2024 closed on 29 November. Throughout the live fieldwork period, weekly updates were provided to leadership teams to help drive engagement and ensure colleagues were aware of their opportunity to take part. Support from Workforce and Organisational Development teams facilitated a collaborative approach, with regular updates and problem-solving sessions. Paper surveys were extended in 2024 to include a pilot group of Health Care Assistants, District Nurses, and Community Health Visitors. The unvalidated response rate for 2024 was 45.1%, an increase of 5.65% compared to 2023, and a 15.1% increase from 2022.

Sexual Safety Charter

In September 2023 MFT became one of the early signatories to the NHS England Sexual Safety Charter, taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and committing to ten core principles and actions to help achieve this. In support of this commitment, we hosted a senior leader workshop in November 2023 to increase awareness and support. Since this time, the Trust has provided Executive support to overseeing the delivery of Sexual Safety Charter throughout 2024, this has seen the development of a Sexual Safety Policy; awareness raising and training across a range of cohorts and professions; the development of an Executive supported Women's Staff Network; and specialist training to our Freedom to Speak Up Guardians to enable them to take reports of inappropriate sexual behaviour.

Events and celebrations

There were a number of events and celebrations taking place over the period since our last meeting that I would like to highlight:

- **Young People's Event** – Young People's Event – On 27 November, our annual Young People's Event attracted over 500 students from local schools and colleges. This key part of our Foundation Trust engagement programme allowed attendees to learn about our services, join MFT as members, connect with our Youth Forum, or

apply to become volunteers. These events are crucial for inspiring young people to future careers in the NHS as well as strengthening links to our local community.

- **MFT Disability and Employment Conference** – On 3 December, we held our first Disability and Employment Conference, organised by the Diverse Abilities Staff Network and Disability Engagement Group. The event brought together 80 Senior Leaders and colleagues to raise awareness of disabilities and drive meaningful change to improve the experience of our staff. The Trust's Equality, Diversity, and Inclusion (EDI) Team, Public Health Specialty Registrar, and Employee Health and Wellbeing Service highlighted ongoing efforts to support disabled staff. This was followed by a panel where disabled colleagues shared their experiences, leading to actionable commitments to create a more inclusive workplace. We now plan to repeat the event each year and to continue to progress with actions agreed during the discussions.

- **Visit from the NHSE Director of Transformation and Secondary Care** – On 13 December we welcomed Dr Vin Diwakar, NHSE Medical Director for Transformation and Secondary care, to the Oxford Road campus meeting with member of the wider leadership team and clinicians across the Trust. The visit provided an opportunity to highlight some of the innovative work going on at MFT including our Hive EPR Programme and the associated digital transformation initiatives this has enabled. During the site tour Dr Diwakar visited Ward 83 at RMCH, the Neonatal Intensive Care Unit at St Mary's Hospital, as well as the Renal and Frailty Units at the MRI where our clinical teams were able to demonstrate our improvement and transformation activities in practice and the positive impact for our patients.

- **Hospital at Home Symposium** – On 28 November the we hosted our third Hospital at Home Symposium at City Labs. The event was led by Dr Sohail Munshi, who has provided clinical leadership for the programme prior to commencing his new executive role in December. This provided an opportunity to celebrate what the service has achieved, listen to stories from our teams, and explore opportunities for further developments. Around 80 staff from across acute, community, primary care and partner organisations attended, and there were dedicated sessions focusing on links with the North West Ambulance Service and palliative care services. The symposium also showcased the growing strength of our "One MFT" approach between acute and community teams, which is central to the success of Hospital at Home.

- **NHS Genomic Healthcare Summit** – On 12 December, NHS England brought together NHS leaders, policymakers, industry partners, and other stakeholders to explore the latest advances in genomic medicine and its application in clinical care. I provided a brief presentation on the approach here in the North West and some of the key achievements of the NHS Genomic Medicine Service in 2024 as well as opportunities for the future. Professor Siddharth Banka and Professor Bill Newman were also presenting at the event on behalf of MFT in relation to Rare and Inherited Disease and Pharmacogenomic testing respectively.

Consultant appointments

Since our last Board meeting in November, 19 consultants have been appointed to roles within the following specialties: Burns & Plastic Surgery, Colorectal Surgery, Devices and Heart Failure, Emergency Medicine, General Medicine, Geriatrics, Histopathology, Luminal Gastroenterology, Nephrology, Obstetrics and Gynaecology, Oral Maxillofacial Surgeon, Paediatric Neurology, Transplant Cardiologist. There have also been 14 Locum Consultant appointments in the following specialties: Acute Medicine, Anaesthesia, ENT Surgery, General Medicine, Obstetrics and Gynaecology, Paediatric Anaesthesia, Paediatric Intensive Care, Paediatric Respiratory Medicine, Respiratory Physician, Trauma and Orthopaedic Surgeon, Hand and Wrist, Vascular Interventional Radiology.

MFT continues to draw in exceptionally qualified candidates for consultant positions who are not only attracted by our exceptional services, but they also welcome our established development programme specifically for new consultants transitioning from their positions as Resident Doctors.

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

Annual planning

Work to produce our plans for the next financial year is well underway, with Clinical Groups and corporate teams undertaking activity, financial, workforce and strategic planning. Whilst, at the time of writing, the annual NHS England planning guidance document has not yet been published, the MFT planning process started in October and a range of technical submissions will be submitted to NHS Greater Manchester by the end of March. The contents of these will be discussed at the relevant Board Committees earlier that month. Following those meetings, a triangulation meeting will take place between the Chairs of the Finance Board Committee, Quality and Safety Board Committee, and People Board Committee prior to submission.

This is the first annual planning round to have been undertaken since our organisational strategy was approved by the Board in March. As part of this year’s process, Clinical Groups and corporate teams are being asked to set out how they plan to support delivery of the relevant actions from our strategy. Executive Management Committees will be asked to review draft plans as part of their role in providing assurance to Board Committees on the delivery of our strategy. The final MFT plan will be presented to a meeting of the Board of Directors at the appropriate time in line with planning guidance.

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

Greater Manchester Commercial Research Delivery Centre (GM CRDC)

MFT has been awarded over £4.7 million from the National Institute for Health and Care Research (NIHR) to host the Greater Manchester Commercial Research Delivery Centre (GM CRDC) for the next seven years. One of 20 new research hubs across the UK to accelerate research into the next generation of treatments, it will build on MFT's successful experience of hosting one of the largest NIHR portfolios in the country. GM CDRC will increase access for our large and diverse communities to help shape, design, and participate in cutting edge commercial research studies to tackle the health inequalities that exist across GM. It will also bring more investment and create new job opportunities for local people whilst enhancing Greater Manchester's reputation for clinical research excellence.

MFT-led trial into lupus Chimeric Antigen Receptor T-cell (CAR-T) cell therapy

A patient at the MRI was the first person in the UK to receive an innovative treatment for the most serious form of lupus, an autoimmune condition which can cause damage to the heart, lungs, joints, brain, or kidneys. MFT Researchers hope that the one-off Chimeric Antigen Receptor T-cell (CAR-T) therapy will reduce, or even remove, the need for life-long medication for patients with severe lupus. The International Phase 1 study, CARLYSE, delivered at the NIHR Manchester Clinical Research Facility (CRF) at MRI is the first in the UK to assess the potential of CAR-T therapy to treat a disease other than cancer.

National study into youth worker services for young people with long-term conditions

Nursing, Midwifery and Allied Health Professionals (NWAHP) Researchers at MFT, in collaboration with The University Manchester, have been awarded more than £700k to lead UK-first research into youth worker services for young people with long-term conditions (LTCs). Funded by the NIHR, the research will investigate how current youth worker services for children and young people with physical or mental health LTCs are organised, provided, and experienced across the UK. Findings from the 30-month study will be used to develop guidance on the best way of providing youth worker services for young people with LTCs in the NHS and other healthcare settings, benefiting the health and wellbeing of young people, and tackling health inequalities.

6. Strategic Updates and Policy Developments

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

NHS operating model

NHS England has written to all trusts and Integrated Care Boards to provide an update on the evolution of the NHS' operating model, which will include an updated NHS Oversight and Assessment Framework and a new NHS Performance, Improvement and Regulation Framework. The letter sets out four actions that will guide the refresh of the current operating framework:

- Simplify and reduce duplication, clarifying roles and responsibilities.
- Shift resources, time and energy to neighbourhood health.
- Devolve decision-making to those best placed to make changes.
- Enable leaders to manage complexity at a local level.

An NHS System Development and Reform programme has been established which will include a regular advisory group, including chairs and chief executives, to help develop the implementation plan. MFT leaders are already contributing to the programme and will continue to support and monitor developments and convey key outcomes to the Board of Directors as the process continues.

Elective Reform Plan

Earlier this month, the Government and NHS England jointly published plans to deliver the commitment made to achieve the 18-week elective care Referral-to-Treatment (RTT) standard by March 2029. In the first instance, each trust will be required to improve its current performance against the standard by 5 percentage points.

The plan aims to do this through:

- Empowering patients, giving them more choice and control over their care, including increased use of the NHS app.
- Working more productively – and differently – to deliver more care. This will include more surgical hubs and direct access to diagnostic tests for GPs, for example.
- Delivering care in the right place, improving the referral process and care pathways. This will include greater use of advice and guidance and Patient Initiated Follow-up (PIFU), for example.
- Aligning the way elective care is funded, and performance is overseen. This will include incentives (e.g. capital funding) for those trusts who deliver, for example.

We are now working to reflect the commitments and requirements set out in the plan in our plans for the coming year.

Devolution White Paper

In December, the Government published the English Devolution White Paper (*Power and partnership: Foundations for growth*) which outlines plans to expand devolution to combined authorities and regional mayors. The aim is to address regional inequalities and drive economic growth. As well as new powers in areas such as transport, housing, skills and employment, the White Paper outlines a new duty for mayors and combined authorities in relation to health improvement and health inequalities. Mayors will also be expected to be considered for roles as co-chair of Integrated Care Partnerships, as is already the case in Greater Manchester.

Health and social care have always been central to devolution in Greater Manchester and the White Paper offers an opportunity to build on the work we have already done, particularly around our Local Care Organisations and Integrated Neighbourhood Teams. We will be working with colleagues at the GM Combined Authority and across the system to consider how further opportunities around devolution might help us to improve the health and quality of life of our diverse communities.

Innovation Ecosystem Programme

The report of the Innovation Ecosystem Programme was published on 28 November, with proposals as to how all partners in innovation systems can collaborate, prioritise and align activities to better meet the needs of patients and the public. Specific recommendations include alignment of innovation activities with national priorities, aligned innovation funding across the NHS and national bodies, improved oversight of the testing and adoption of innovation and the development of capacity and capability in local systems. Whilst the report aims to inform the forthcoming NHS 10-year Plan, as well as the Government's Innovation and Adoption Strategy and Life Sciences Sector Plan, it encourages regional networks to start testing its recommendations through existing budgets and structures.

NHS management regulation

The Department of Health and Social Care (DHSC) has opened a public consultation on proposals to regulate NHS managers via a public consultation. The consultation includes questions on the scope of regulation, the establishment of a regulatory body, the introduction of a professional duty of candour for NHS managers and appropriate accountability arrangements. The consultation runs until 18 February.

NHS England: The Insightful Provider Board

In November 2024, NHS England published guidance to help provider boards consider their approach to handling and acting on the information they receive; the leadership behaviours and culture of the board and how these can affect the information it receives and the actions it takes; and metrics that can support the board to better understand the

organisation's performance. The guidance can be found here and should be considered alongside the Code of Governance for NHS providers which can be found here.

We have introduced a number of changes to our governance and reporting arrangements in the autumn of 2024, including the introduction of a new Integrated Performance Report, and have been embedding them over the last three months. We will be reviewing the arrangements in February and March of this year and will be considering the 'insightful provider board' guidance as part of that exercise.

7. Leadership Updates

Chief Finance Officer

Claire Wilson started in her role as our substantive Chief Finance Officer (CFO) on 9 December. Claire's previous role was as CFO for NHS Cheshire and Merseyside and has held senior financial leadership roles across acute, specialist, and primary care organisations in the Northwest. Claire joins us at a critical time in terms of the financial position both here in Greater Manchester and across the NHS and will be helping to lead our efforts to maintain financial stability whilst delivery the best value for our patients and maximising opportunities to improve our productivity and commercial ambitions.

Commercial Director

Wes Dale started in the role of Commercial Director on 6 January. Wes will be coordinating the development of the Trust's commercial strategy and will be working closely with clinical and operational colleagues to deliver on our strategic ambitions in innovation and commercial development. Wes joins us from the Christie Hospital having previously worked in research and innovation both locally and at a national level at NHS England.

8. Top three concerns

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

Winter pressures

Demand for urgent and emergency care services continues in line with predicted levels, with patient attendances marginally above forecasted levels. However, pressure has been building, as flu and seasonal viruses have been rising throughout November and December. As we enter the final quarter of the year, our efforts are fully focused on ensuring patient safety and timely access to care in our emergency departments. This work is supported by ongoing improvement initiatives and additional improvement support at Wythenshawe and North Manchester and the System UEC Care Closer to Home Programme.

The above concern is reflected in strategic objective 3 in the Board Assurance Framework.

Financial position

At the end of December, the Trust reported a year-to-date deficit of £32.4m against its plan of £3.7m deficit, an adverse variance to plan of £28.7m. The Trust remains committed to delivering its financial plan for the year and so has taken several steps to accelerate the impact of its Value for Patients (VFP) programme over the final 3 months of the year. Delivering this alongside continuing to manage our operational pressures over winter is a risk which we are managing closely through enhanced management and governance processes. A key aspect of our focus in delivering this year's position is improving the underlying financial position of the Trust in line with our financial recovery strategy. We are therefore keen to ensure that we maximise the improvements we make which are recurrent and that the work to determine our VFP programme is a continuous process with a plan in place for 2025/26 before the start of the new financial year. The report of the Chief Finance Officer elsewhere on the agenda provides further detail.

The above concern is reflected in strategic objective 8 in the Board Assurance Framework.

Organisational change

As referenced earlier in this report, the work to refresh our operating model is progressing well and yet, we know that any process of change can be unsettling for individuals and teams. In recognition of this we continue to strengthen the dedicated programme team to ensure appropriate support is in place, including a bespoke programme of leadership development and regular communications and engagement activity. Alongside the dedicated Organisational Development and Health & Wellbeing Support in place to support colleagues, we have also developed an online "One MFT" resource hub on the MFT staff intranet for colleagues across the Trust to read about key updates, access support and raise queries.

The above concern is reflected in strategic objective 6 in the Board Assurance Framework.

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Integrated Performance Report (IPR)	**Agenda Item 9.1**
Presented by:	Chief Delivery Officer Chief Nursing Officer Joint Chief Medical Officers Chief Finance Officer Chief People Officer	
Prepared by:	Director of Performance and Planning (performance) Director of Clinical Governance (quality and safety) Deputy Chief People Officer (workforce) Deputy Director of Financial Reporting & Planning (finance)	
Meetings where content has been discussed previously	Board Committees	
Purpose of the paper Please check **one** box only:	☒ For approval ☐ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider
Members of the Board are requested to note the updates provided in the Trust Integrated Performance Report (IPR).

Recommendation(s)	
The Trust Board is asked to: • Note the performance assurance provided	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • All strategic risks	
Care Quality Commission domains Please check **all** that apply	☐ Safe ☐ Effective ☐ Responsive	☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A	

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

Manchester University
NHS Foundation Trust

MFT Integrated Performance Report

Public Board
January 2025, reporting October / November 2024

Manchester University
NHS Foundation Trust

Structure of this document

*Note: data supplied is the most recent available data received and approved by Board Sub-committees and covers the period October – November

Measuring our performance

Manchester University NHS Foundation Trust

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.

Manchester University
NHS Foundation Trust

Provide high quality, safe care with excellent outcomes and experience – operational performance

Trust IPR Metric Assurance Summary

Manchester University
NHS Foundation Trust

Operational Performance

Key Oversight Performance Metrics						
Focus	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type
Urgent care and Flow	✗	~	?	✗	A&E 4 hour standard	National
	✗	~	F	✓	Ambulance handover within 15 mins	National
	✗	L	F	✗	Ambulance handovers over 60 mins	National
	✗	L	F	✓	Number of A&E waits > 12 hours	Regional
	✗	~	F	✗	Number of A&E DTA waits ≥ 12 hours	National
	✓	~	?	✓	General & Acute Bed Occupancy	National
	✗	~	?	✓	Days away from home (NC2R)	National
	✗	~	F	👁	21+ Day length of Stay	National
	✗	~	?	✓	Virtual ward - hospital @ Home	National
	✓	~	?	✓	Thrombolysis < 60 minutes	National
	✗	~	F	👁	Admission to stroke ward < 4 hours	National
	✗	~	?	👁	Stroke Audit Score	National

Key Oversight Performance Metrics						
Focus	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type
Cancer	✓	~	?	✓	Cancer 31 day Standard	National
	✗	~	?	✗	Cancer 62 day standard	National
	✓	~	?	✓	28 day Faster Diagnosis	National
	✗	~	?	✓	Cancer 62 day backlog reduction	National

Key Oversight Performance Metrics						
Focus	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type
Elective	✗	~	F	✗	RTT total list size	Local
	✗	~	?	✓	RTT >52 week waiters	National
	✗	~	?	✓	RTT>65 week waiters	National
	✓	~	?	✓	Elective Inpatient Activity	Local
	✓	~	?	✓	Elective Outpatient Activity	local
	✗	L	F	✓	Diagnostics (DM01) total list size	Local
	✓	L	F	✓	Diagnostics (DM01) waits>6 weeks	National

Executive summary

Manchester University
NHS Foundation Trust

Operational Performance

Variation

Compliance

	Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Special Cause Improvement	• Diagnostic waiters over 6 weeks		• Ambulance handovers> 60 mins • Diagnostic total waiting list size • Total waits > 12 hours
Common Cause	• 28 Day Faster Diagnosis standard • Cancer 31 days • G&A Bed Occupancy • Elective inpatient activity • Elective outpatient activity • Thrombolysis < 60 minutes	• No Criteria To Reside • Days away from home (NC2R) • Virtual Ward – Hospital @ Home • Cancer backlog reduction • RTT 52 week waits • RTT 65 week waits	• A&E 4Hr performance • Ambulance handovers <15 mins • 12 hr decision to admit breaches • 21+ day LOS • RTT total list size • Stroke Audit Score • Admission to stroke ward < 4hrs • 62-day standard
Special Cause Concern			

Consistent assurance can be provided in:
- Elective activity levels, which remain consistently above plan – a critical underpinning factor in our ability to treat as many patients as we safely can.
- The cancer faster diagnosis standard and 31 days standard – where we are consistently achieving plan
- Diagnostic six week performance (DM01)

Significant improvement has been made year to date in the following areas, despite non-compliance with October target:
- Diagnostic waiting list size
- Ambulance handover delays / turnaround times
- Patients waiting over 65 and 78 weeks – where numbers have significantly reduced year to date but remain above plan for 65 week waits

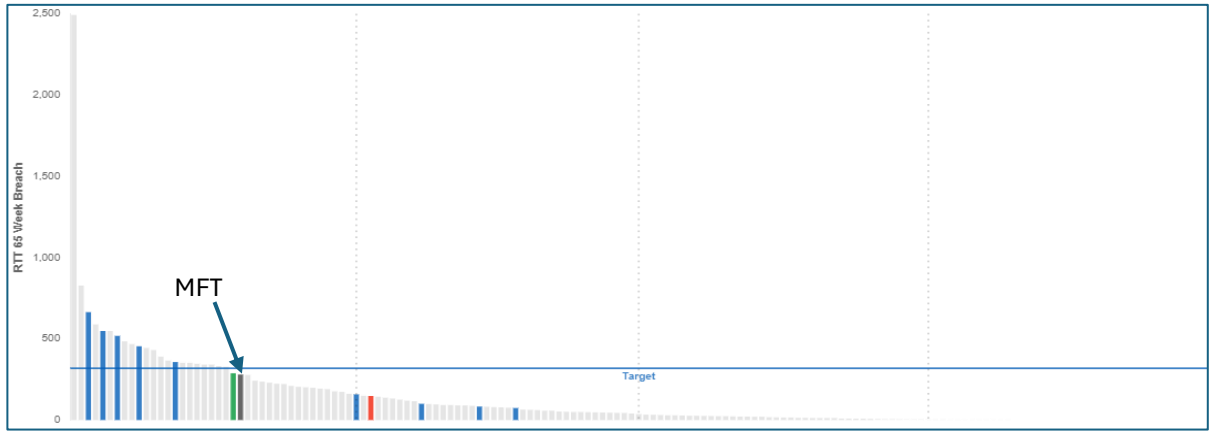
Particular risk is evident in the achievement of:
- The cancer 62 day standard – where performance remains consistently below plan
- A&E four-hour performance, which has deteriorated versus prior month and is not meeting planned levels

National Benchmarking Constitutional Standards

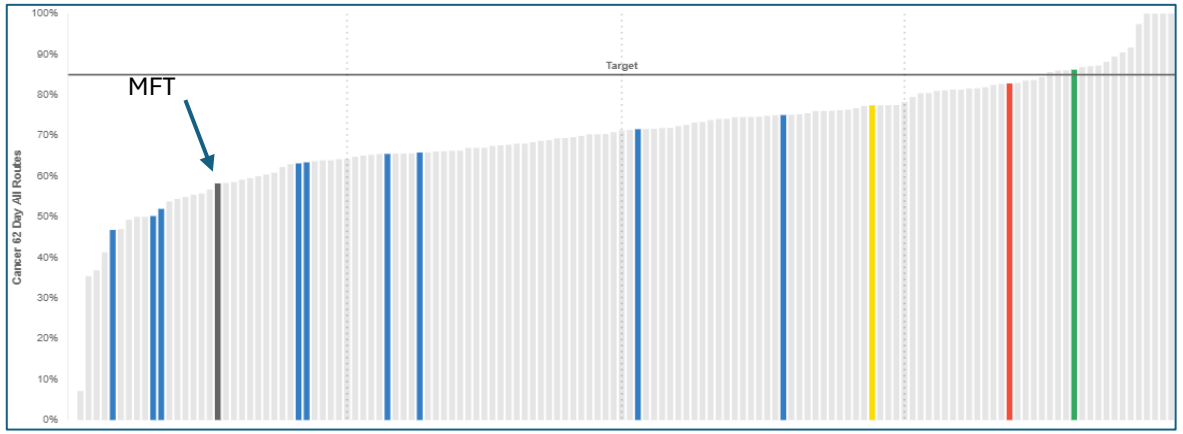
Manchester University
NHS Foundation Trust

Operational Performance

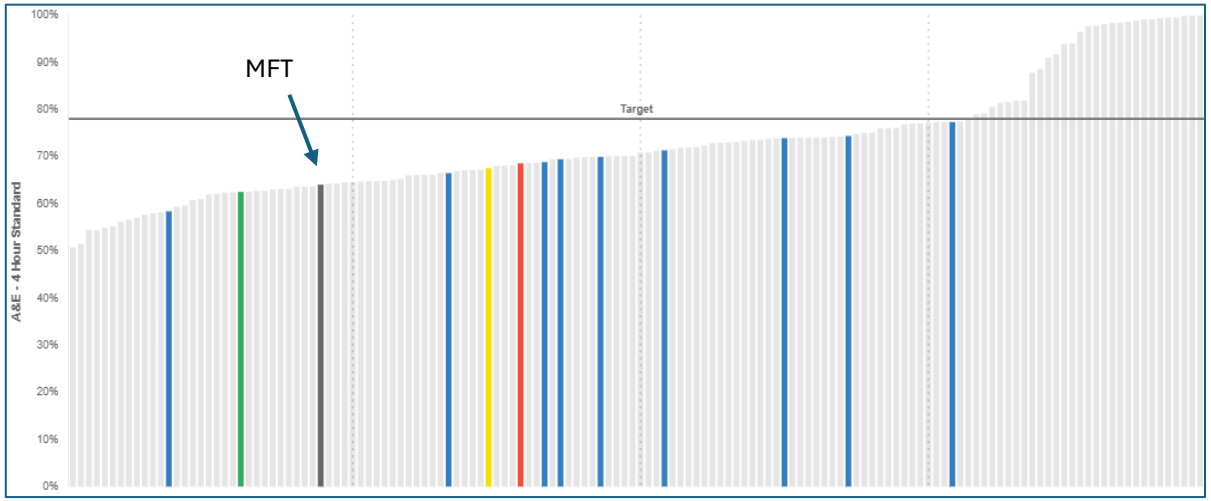
RTT 65-Week reduction



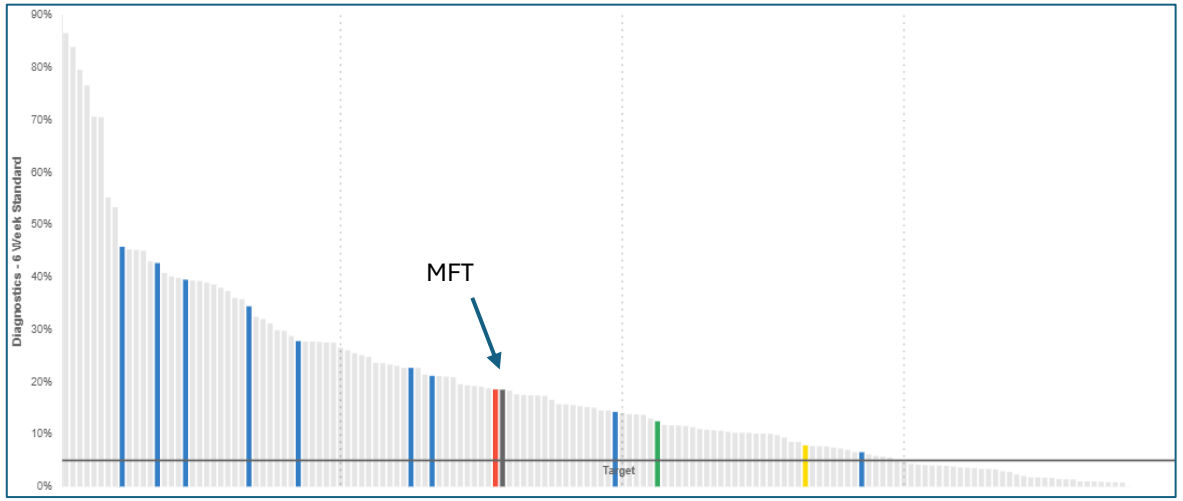
Cancer 62-day standard



Emergency department 4 hour standard



Diagnostic 6 week standard



Manchester University
NHS Foundation Trust

Provide high quality, safe care with excellent outcomes and experience – quality and safety

Trust IPR Executive summary

Manchester University NHS Foundation Trust

Quality and Safety

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Incident Reporting & Safety Culture	For monitoring:				Ratio Notifiable: Non notifiable Patient Safety Incidents
					No incidents per 10,000 bed days
					No incidents (moderate + harm) per 10,000 bed days
					No incidents (low/no harm) per 10,000 bed days
					Incidents of violence / disruptive behaviour (moderate + harm)
		Non-SPC			Number of never events in month
		Non-SPC			Duty of Candour Compliance
Harm Free Care		Non-SPC			Surgical safety checklist compliance
					Attributable pressure ulcers (grade 3-4)
					Falls per 10,000 bed days (level 5 harm)
					Falls per 10,000 bed days (level 4 harm)
	Under review				VTE screening compliance
					Incidents relating to delays on waiting lists (moderate + harm)
					Incidents relating to delays in follow ups (moderate + harm)
Infection, Prevention & Control					Trust attributable MRSA bacteraemia
					Trust attributable *C. Diff* infections
					Gram negative infection – *E. Coli*
					Gram negative infection – *Klebsiella*
					Gram negative infection – *Pseudomonas*
Maternity					Neonatal deaths per 1,000 live births (standard <4%)
					Still births per 1,000 live births (excluding TOP, standard < 6%)
		Non-SPC			Maternal deaths

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Maternity		Non-SPC			Incidents accepted by MNSI for investigation
					Patient Safety incidents (maternity moderate harm and above, standard <4)
		Non-SPC			% of avoidable admissions of term babies to neonatal units (standard < 6%)
		Non-SPC			Category 3 caesarean deliveries cancelled on the day (standard <10)
					% Initial Midwifery Triage assessment within 15 mins (standard 90%)
					% Delays over 96 hours on induction of labour pathway (standard 0)
					% Delays >72 hours and <96 hours on induction of labour pathway (standard 2%)
					% Delays >48 hours and <72 hours on induction of labour pathway (standard 15%)
					% Delays >24 hours and <48 hours on induction of labour pathway (standard 25%)
					% Transferred on induction of labour pathway <24 hours (standard 60%)
					% Delays >24 hours for transfer for augmentation (standard 20%)
					Births outside appropriate birth setting (standard 4)
		Non-SPC			% Maternity specific training compliance (aggregated, standard >90%)
		Non-SPC			Achieving Maternity Incentive Scheme Actions (standard 10)
Learning from Deaths		Non-SPC			Prevention of Future Deaths notices
		Non-SPC			Hospital standardised mortality ratio (HSMR) (rolling 12 month)
		Non-SPC			Crude mortality rate (12 mth rolling)
		Non-SPC			Standardised healthcare crude mortality indicator (SHMI)

* Further safety metrics in development

Trust IPR Executive summary

Manchester University NHS Foundation Trust

Quality and Safety

Focus	Compliance	Variation	Assurance	Action Status	Indicator
LFD cont.	Not yet available				Number of spells with palliative care coding
	Not yet available				Number of deaths with identified learning disability
		Non-SPC			Number of LEDER referrals
Safeguarding		Non-SPC			Number of patients with DoLs
		Non-SPC			Number authorised DoLs notified to CQC
					Training – Safeguarding Children L1
					Training – Safeguarding Adults L1
					Training – Safeguarding Children L2
					Training – Safeguarding Adults L2
					Training – Safeguarding Children L3
					Training – Safeguarding Adults L3
Mental Health Strategy					MHA compliance – section 132 – provision of information to patients
		Non-SPC			Patients subject to MHA detention missing from hospital care
					Training – Mental Health L1
					Training – Mental Health L2
	Metric under development – MH Group overseeing process of development				Number inappropriate admissions of MH patients to inpatient wards
					Number inappropriate admissions of MH patients to inpatient wards >48hr LoS
					Number inappropriate admissions of MH patients to inpatient wards >7 day LoS
	Under development				Number of patients detained under section 136 > 24 hours

Focus	Compliance	Variation	Assurance	Action Status	Indicator
LD strategy					Training – Oliver McGowen on line training
					% of people with LD / autism who have evidence of reasonable adjustment within 48 hours of admission
Patient Experience					Single sex compliance breaches
		Non-SPC			What Matters to Me (overall score)
		Non-SPC			Admitted - Friends and Family test - Response rate
		Non-SPC			Admitted - Friends and Family test - % good or very good
		Non-SPC			A&E- Friends and Family test - Response rate
		Non-SPC			A&E - Friends and Family test - % good or very good
		Non-SPC			Maternity - Friends and Family test - Response rate
		Non-SPC			Maternity - Friends and Family test - % good or very good
		Non-SPC			Outpatients- Friends and Family test - Response rate
		Non-SPC			Outpatients - Friends and Family test - % good or very good
		Non-SPC			Community - Friends and Family test - Response rate
		Non-SPC			Community- Friends and Family test - % good or very good
					Number of formal complaints opened in last month
					Number PHSO complaints
					Number reopened (not new) complaints in last month
		Non-SPC			Closed complaints in month (theme)
Safer staffing					Care hours per patient day
		Non-SPC			Ratio of actual : planned hours (excluding maternity)
		Non-SPC			% of maternity triage shifts where actual midwifery staffing = planned (>95%)

* Further safety metrics in development

Executive summary

Manchester University NHS Foundation Trust

Quality and Safety

Variation	Assurance: Achieving standard	Assurance: Inconsistently Achieving standard	Assurance: Not Achieving standard	
Special Cause Improvement	• Duty of Candour Compliance • Maternity Triage staffing • Delivery unit staffing • MIS compliance • Avoidable term admission to NNU • Maternity specific training	• Augmentation of labour pathways • Induction of Labour pathway delays • Maternity incidents – moderate harm and above • Births outside intrapartum setting • Maternity specific training		• 100% Compliance with DOC stage 1 for standard dates in November 2024.
Common Cause	• No incidents (moderate + harm) per 10,000 bed days • Falls per 10,000 bed days (level 4 and 5 harm) • HSMR (rolling 12 month); HSMR ratio – crude mortality; SHMI • Still birth rates; • Neonatal death rates • Maternity FFT; All FFT • Safeguarding children & Adults training L1 and L2 • Mental health training L1 • Pressure ulcers • Care hours per patient day • Actual v planned staffing (excl. Maternity)	• Number of never events in month • Incidents relating to delays on waiting lists (moderate + harm) • Incidents relating to delays in follow ups (moderate + harm) • Surgical safety checklist compliance • Gram –ve bacterial (all) • Complaints • WMTM overall score	• Initial maternity triage assessment • MRSA Bacteraemia • MHA compliance (S132) provision of information to patients • % of people with LD / autism with reasonable adjustment within 48 hours of admission	• HSMR (rolling 12 month) for August = 89.29 (this means there were fewer observed deaths than predicted by national algorithms) • MRSA bacteremia - 5 cases compared to 11 for same period in 2023 • 95 % patients with LD/ autism with reasonable adjustments in November
Special Cause Concern	• No incidents per 10,000 bed days • No incidents (low/no harm) per 10,000 bed days		• Number of never events in month • C. difficile infections • Safeguarding children training L3 • Safeguarding adults training L3 • Mental Health Act training L2 • Oliver McGowen E-learning	• Incidents per 10,000 bed days have (positive) special cause variation for last 2 years data • 7 Never events in the last 12 months, 3 since April 2024 – number of different themes identified across multiple different clinical groups • 30 C. difficile infection cases in October • Safeguarding L3 training currently at 82% • MHA training compliance is currently at 79% • Oliver McGowen training compliance improving in line with planned trajectory

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Trust IPR Metric Assurance Summary

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Workforce

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Workforce capacity	W1					Establishment WTE	Local
	W2					Staff in Post WTE	Local
	W3					Vacancy WTE	Local
	W4					Vacancy %	Local
	W5		H	F		Temporary Staffing WTE	Local
	W6		H	F		Temporary Staffing Cost	Local
Looking after our people	W7		L	F		Attendance %	Local
	W8		L	F		Call Back & Return to Work Compliance %	Local

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Belonging	W9		H	P		Level 1 Mandatory Compliance %	Local
	W10		H	F		Level 2 & 3 Mandatory Compliance %	Local
	W11		L	F		Appraisal – Non Medical Compliance %	Local
	W12		H	P		Appraisal – Medical Compliance %	Local
	W13			F		Staff Engagement Score	Local
	W14		H	P		*% of BME in Medical and Dental pay scales*	Local
	W15		H	F		% BME in band 8a and above roles	Local
	W16		H	P		*% BME in band 7 and below*	Local
	W17					*% Disability in Medical and Dental pay scales*	Local
	W18		H			*% Disability in band 8a and above roles*	Local
	W19		H			*% Disability in band 7 and below*	Local
Future focus	W20		L	P		*Turnover %*	Local
	W21		H	P		*Retention/Stability %*	Local

Executive summary

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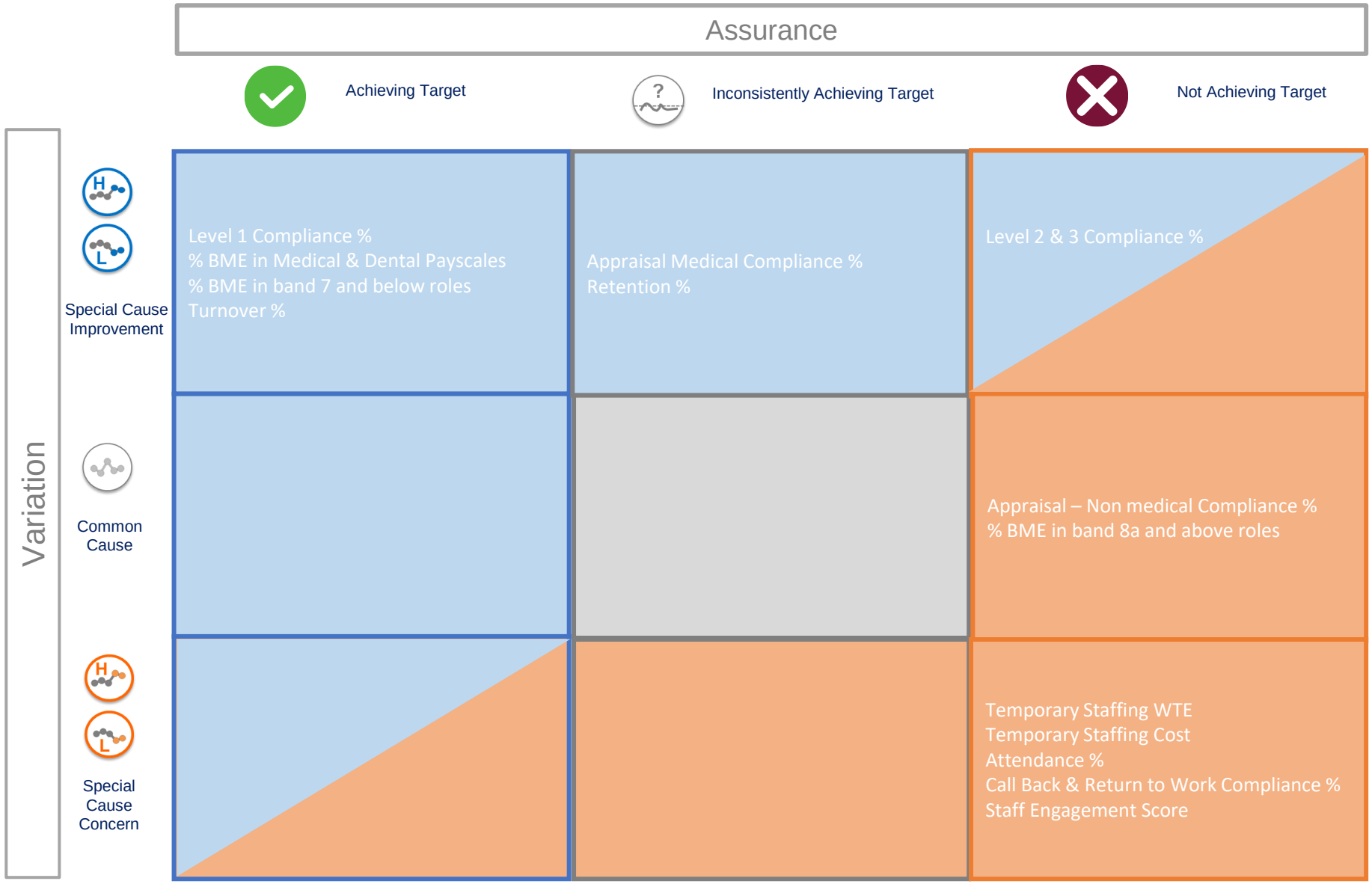

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory compliance for November achieved against target at 94.1%. However, ongoing attention is needed in relation to levels 2 & 3 compliance which remain below target at 87.0%, although this is an improvement from the beginning of the year. A review of mandatory training is ongoing focusing on both quick win enhancements to improve engagement and more fundamental changes regarding categorisation, length of training to assess time spent versus outcome/value.

As of November 2024, the Trust attendance rate was 93.5%. Levels of absence remain high, above pre-pandemic levels and are reflective of a challenging operational context. Our 24/25 operating plan is predicated on a reduction of sickness absence to 5%. A comprehensive programme approach to absence prevention and attendance management is underway. Each Clinical Group has a bespoke target and plan to drive local action. The programme design is holistic to address the breadth of factors which lead to reduced attendance (cultural, procedural, environmental, operational) and will be data driven to ensure measurable improvement at pace.

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Metric Assurance Summary – Finance

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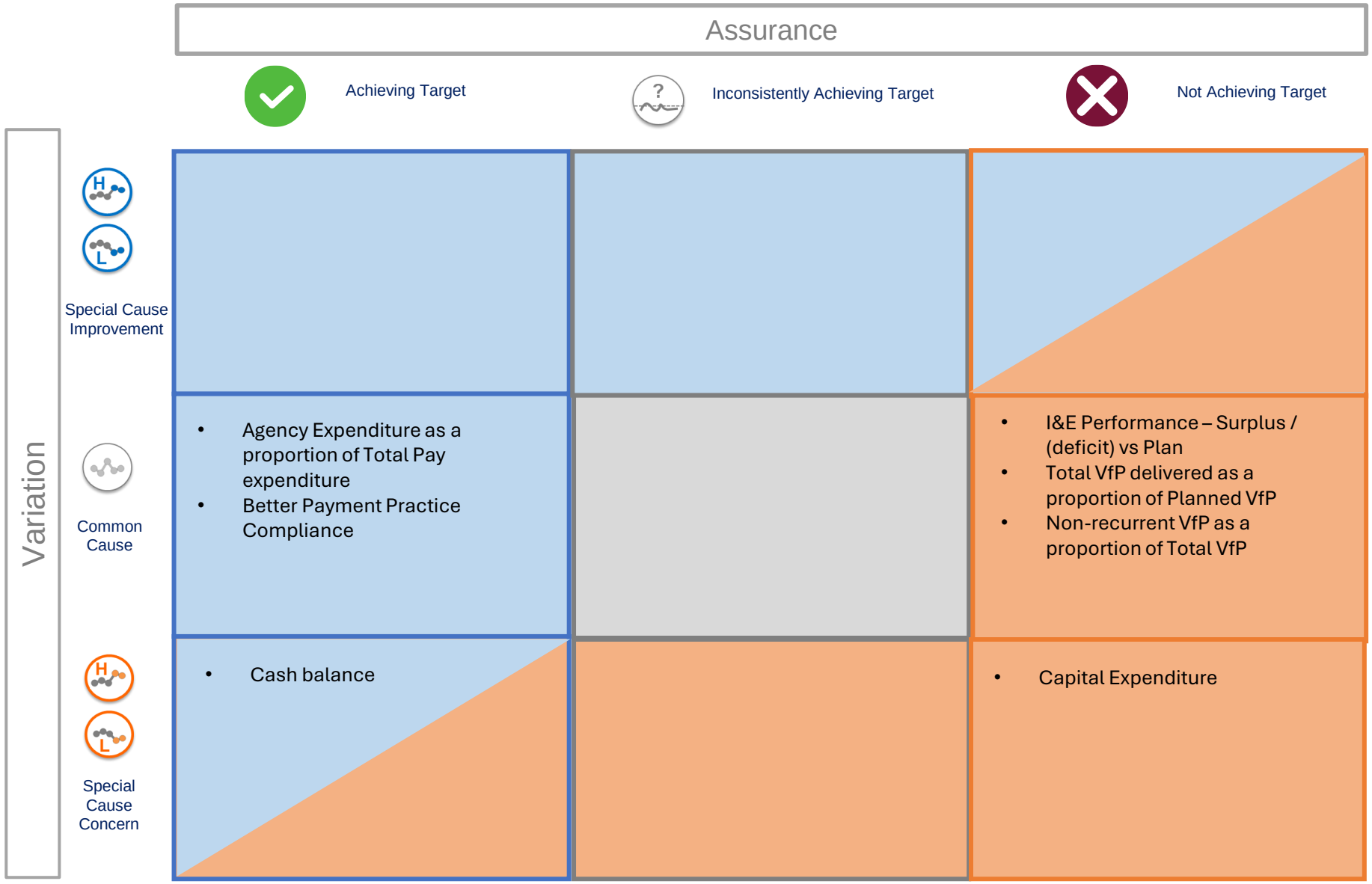
Key Oversight Performance Metrics						
Focus	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type
	✗	~	F	✗	Income and Expenditure Surplus / (Deficit) vs Plan YTD	National
	✓	~	P	⇄	Agency expenditure as a proportion of Total Pay expenditure YTD	National
	✗	~	F	✗	Total VfP delivered as a proportion of Plan YTD	Local
	✗	~	F	✗	Non recurrent VfP as a proportion of Total VfP YTD	National
	✓	~	P	⇄	BPPC performance vs target YTD	National
	✗	L	F	✗	Capital expenditure vs Plan YTD	National
	✓	L	P	👁	Cash balances above the level where a working capital loan would be required	National

Executive summary

Manchester University
NHS Foundation Trust

Financial performance



Consistent assurance can be provided on:

- Agency pay expenditure at less than 0.8% of total pay – the National target is 3.2%
- BPPC compliance for invoices paid by value consistently above the 95% target

Cash balances remain above plan but need careful monitoring. Monthly surpluses need to be delivered for the remainder of the year if the Trust is to ensure Cash remains on plan.

Alerts for:

- I&E performance YTD at £30.9m deficit (£28.1m adverse to plan)
- Total VfP delivered below target by £2.1m with NR delivery at 51% against a limit of 25%
- Capital spend remains well below plan and the CRL with GM allocations not yet agreed and slippage against CDC Withington, TIF schemes and the NHP at NMGH – all three are under review with plans to get back on track

Agenda Item 10.1

Manchester University NHS Foundation Trust

Escalation and Assurance Report

Research Innovation and Population Health Board Committee (RIPHBC)

Report to: Board of Directors
Report from: Luke Georghiou, Non-Executive Director and Chair of RIPBHC
Date of meeting: 4/12/24

Key escalation and discussion points from the meeting
Advise:
This was the first meeting of the RIPBHC, a committee established following the recent governance review to oversee progress towards delivering strategic objectives 1, 2, 10 and 11 of the MFT strategy. The committee received a presentation from the Joint Chief Medical Officer providing an overview of the work currently being delivered, and planned, across the Trust to improve the population's health and address health inequalities. The governance supporting this area of work is being reviewed and refined to ensure clarity of reporting routes. Metrics will be developed for 2025/26 and 2026/27, and for the longer term, so progress can be tracked in delivering the Trust's strategic objectives and the actions aligned to them. Clinical groups are mapping their activity related to population health so a Trust-wide picture of existing activity can be developed. The Committee received an update on the deployment of the Trust's R & I strategy. A review of the Trust's approach to commercial research, and of R & I systems and processes at the Trust, will be undertaken. The outputs of these reviews, and the requirements of the new NHS 10-year plan, will be used to develop the strategy further during 2025. The committee received an update on the work of the NIHR Biomedical Research Centre with preparations underway for the next round of funding. The Trust's new Green plan is currently being consulted upon and will be discussed at the next committee meeting prior to approval being sought at the Board meeting in March 2025.
Assure:
The Committee received the annual update of delivery of the Trust's Green Plan. MFT's carbon footprint is 75,117 tonnes CO2e, down 3.6% since 22/23 and 13% down since the baseline year of 2019/20. Carbon per patient contact is 25.5kg CO2e, down from 31.0kg in 22/23, despite a 17% increase in inpatient contacts. However, improvement is still required to deliver the targets within the Green Plan targets with the Trust's carbon footprint exceeding the annual target despite the improvements made.

Report approved by: Luke Georghiou, Non-Executive Director and Chair of RIPHBC

Agenda

Manchester University NHS Foundation Trust

Research, Innovation and Population Health Board Committee

Date: 4th December 2024
Time: 12pm – 2pm
Location: Boardroom

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Welcome and Introduction** (Verbal)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising**	Discussion	Chair	
6.	**Assurance Reporting** 6.1 Board Assurance Framework	Discussion	Chair	
Strategic aim 1: Work with partners to help people live longer, healthier lives				
7.	7.1 Overview of population health programmes	Discussion	SM	
	7.2 Health inequalities overview (including R & I health inequalities work)	Discussion	SM	
	7.3 MFT Green Plan annual report	Support	RJ	
Strategic aim 5: Deliver world class research and innovation that improves people's lives				
8.	8.1 R & I strategy deployment	Discussion	IM	
	8.2 NIHR Biomedical Research Centre	Discussion	IM	
Committee business				
9.	**Escalation report**	Approval	Chair	
10.	**Workplan Review**	Meeting admin	Chair	

11.	**Any Other Business** (verbal)	Discussion		
12.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	

Date of next meeting:
5th March 2025- 10:00-12:00 pm

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Board of Directors (Public)
Monday 20th January 2025

Paper title:	Strategic Development Update	**Agenda Item** 10.2
Presented by:	Tom Rafferty, Acting Chief Strategy Officer	
Prepared by:	Tom Rafferty, Acting Chief Strategy Officer	
Meetings where content has been discussed previously	Service Strategy and Planning Management Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider (300 words max)

The paper outline strategic developments including:

- At a national level:
- The Evolution of the NHS Operating Model
- English Devolution White Paper
- The Innovation Ecosystem Programme
- Proposals to Regulate NHS Managers

- At a regional and local level:
- The Annual Planning Process for 25/26
- The Refresh of Locality Plans in Manchester and Trafford

- At MFT
- The North Manchester General Hospital Redevelopment and New Hospitals Programme
- Developments at the North Manchester Community Diagnostic Centre site in Harpurhey
- Sickle Cell Improvement Pilots
- Chemotherapy Closer to Home for Children and Young People
- Single Service Management Arrangements

Recommendation(s)

The Board of Directors is asked to:

- Note the updates in relation to strategic developments nationally, regionally and across MFT

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: •	
Care Quality Commission domains Please check **all** that apply	☐ Safe ☐ Effective ☐ Responsive	☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: •	

Main report (2000 words maximum - please use appendixes for all further information)

1. Introduction

The purpose of this paper is to update the Board of Directors in relation to strategic issues of relevance to MFT.

2. National Developments

2.1. Evolution of the NHS Operating Model

NHS England have written to all Trusts and ICB's to provide an update on the evolution of the operating model. This document provides a comprehensive overview of the changes to the operating model of the NHS aimed at enhancing efficiency, patient care, and overall service delivery.

The letter sets out four actions that will guide the refresh of the current operating framework in line with the Darzi recommendations:

- **Simplify and reduce duplication**, clarifying roles and responsibilities and being clear on the place of performance management.
- **Shift resources, time and energy to neighbourhood health**, creating momentum that makes clear the role of the provider sector in neighbourhood health and how to work with local partners.
- **Devolve decision-making** to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
- **Enable leaders to manage complexity at a local level**, supporting leaders with new strategic commissioning frameworks to include national best practice.

NHS England reference the intention to create self-managing, self-improving systems, as set out in the Hewitt review. The goal is to give more freedoms for the top performing systems – those who are improving population health, reducing inequalities, delivering high patient satisfaction and effective use of resources. These high performers will work with NHS England to help shape policy, frame national best practice and drive improvement

The NHS Performance, Improvement and Regulatory Framework will have clear guidelines for interventions in organisations struggling with quality, finance, or access, ensuring transparency and consistency. An independent diagnostic process will be used to accurately assess and analyse the root causes of issues within organisations, providing targeted insights for improvement.

2.2. English Devolution White Paper

In December, the Government published the English Devolution White Paper (*Power and partnership: Foundations for growth*) which outlines plans to expand devolution to combined authorities and regional mayors. The aim is to address regional inequalities and drive economic growth. As well as new powers in areas such as transport, housing, skills and employment, the White Paper outlines a new duty for mayors and combined authorities in relation to health improvement and health inequalities. Mayors will also be expected to be considered for roles as co-chair of Integrated Care Partnerships, as is already the case in Greater Manchester.

A task and finish group is being established including senior civil servants and Greater Manchester colleagues to develop plans to go further with devolution off the back of the White Paper. Its focus will be on employment support (including prevention), housing and transport, business support, skills and training for people aged 16-19. The intention is for the group to finish its work by the Spring and for its output to inform the next spending review, as well as the forthcoming devolution legislation.

Linked to this work, the GM Combined Authority is convening a group, including the MFT Trust Chief Executive, to develop plans for a ‘Prevention Demonstrator’. This will build on the GMCA Living Well work which aims to offer integrated services at a neighbourhood level, including health and care, housing, financial and employment support.

2.3. The Innovation Ecosystem Programme

NHS England has released a report into the Innovation Ecosystem Programme’s (IEP) and summarises the findings from the last 18 months and recommends a package of actions to move forward.

The report notes that the NHS is at a critical juncture, facing both significant challenges and tremendous opportunities through innovation. The key message from the IEP to all partners

is to collaborate, prioritise and align to better meet the needs of patients and the public. The report's recommendations are broken down into four areas.

i. **Setting the direction:** The innovation ecosystem and the NHS must be aligned to support the transformation of healthcare and the government's health and growth missions.

ii. **Structures and tools for delivery:** Accountability, oversight and leadership at all levels. This must be supported by standardised tools, policy and guidance for the key enablers of innovation testing and adoption, to support confident local decision-making.

iii. **People, skills and capabilities:** Build the skills, capabilities, capacity and culture required to prepare the NHS workforce for future ways of working and to help them collaborate confidently with patients and citizens, industry and academia.

iv. **Acceleration:** Alongside action to redesign the architecture and wiring of innovation, the programme partners should work together to mobilise major geographies behind current priorities – working with centres across the UK that have shown excellence in innovation development and adoption.

Whilst the report aims to inform the forthcoming NHS 10-year Plan, as well as the Government's Innovation and Adoption Strategy and Life Sciences Sector Plan, it encourages regional networks to start testing its recommendations through existing budgets and structures.

2.4. Proposals to Regulate NHS Managers

The Department of Health and Social Care (DHSC) is seeking views on options for regulating NHS managers via a public consultation. The DHSC aims to strengthen the accountability of NHS managers to support patient safety.

The consultation is part of the government's commitment to introduce professional standards and regulation for NHS managers. This initiative is driven by an intention to enhance the accountability and transparency of NHS management, ultimately aiming to improve patient care and safety. The consultation covers questions regarding:

- **Scope of Regulation** - The consultation seeks views on which managers should be in scope for a future regulatory system, ensuring that the regulation is comprehensive and effective.
- **Regulatory Body** - It discusses the potential establishment of a regulatory body that would oversee the implementation and enforcement of professional standards for NHS managers.
- **Professional Standards** - The consultation highlights the need for clear and robust professional standards that NHS managers must adhere to, ensuring consistency and high-quality management across the NHS.
- **Duty of Candour** - It proposes the introduction of a professional duty of candour for NHS managers, which would require them to be open and honest about mistakes and issues in healthcare provision.
- **Accountability** - The consultation emphasises the importance of holding NHS managers accountable for addressing concerns related to patient safety and healthcare provision, ensuring that they take appropriate actions to resolve issues.

This consultation is open for feedback until 18 February 2025.

3. Regional and Local Developments

3.1. Annual Planning Process

The annual planning process for the financial year 25/26 is underway, although the publication of the national planning guidance document, which is usually published before Christmas, was delayed into the new year. The work within MFT to develop our plans for next year has already been underway for a number of months, however.

The annual plan for MFT will be submitted to NHS Greater Manchester and incorporated into an overall plan for GM which the ICB will submit to NHS England at the start of April. The Board will be engaged with development and approval of the MFT annual plan, which will detail performance, workforce and financial plans for the coming year, in the coming months.

As with previous years, the Boad will receive an MFT annual plan for approval which, in addition to the required submissions to NHS England, will detail the actions teams across MFT are planning to support the delivery of our MFT strategic aims. This is the first planning round to take place since the approval of our MFT strategy *Where Excellence Meets Compassion* in March 2024. The final plan will come to the May meeting of the Board of Directors for approval.

3.2. Locality Plans

MFT colleagues have been working with system partners in the Manchester and Trafford localities on the processes to update the respective Locality Plans. The Trafford Locality Plan was approved by the Trafford Locality Board in December following a development process led by the locality team.

All localities in Greater Manchester are now required to develop local Financial Sustainability Plans. Work will now continue in Trafford to ensure that this supports the delivery of the refreshed Trafford Locality Plan. In Manchester, the intention is to have a single plan which serves as both the refreshed locality plan and Financial Sustainability Plan. Following discussion at the Manchester Partnership Board, the Manchester plan will focus on the further development of the neighbourhood model in which the Manchester Local Care Organisation, along with primary care and other system partners, will have a significant role to play.

4. MFT Developments

4.1. NMGH Redevelopment

The outcome of the national review into the New Hospitals Programme is expected to be shared by the end of January 2025. Until then the capital envelope and programme for NMGH is unclear.

In the meantime, a ‘consensus option’ has been developed with MFT colleagues and system partners, and approved by the through NMGH Redevelopment Programme Board. This provides the basis for the ‘preferred way forward’ in a refreshed business case and is the first fully costed option agreed since the original outline business case in 2021.

4.2. Community Diagnostic Centres (CDCs)

Building work to install the Imaging Unit at the North Manchester CDC site in Harpurhey commenced at the end of November. The units are expected to open in April 2025 and will

supplement the services that are already operational on-site, including ultrasound, heart and lung diagnostics and ophthalmic testing.

4.3. Sickle Cell Improvement

Pilot funding has been secured to the end of 25/26; the original funding was only agreed to the end of September 2025. Work continues across MFT and with GM commissioners to build the case for ongoing funding for both acute and community services once the pilot ends.

4.4. Chemotherapy for Children and Young People

The North West Cancer Alliances have supported a pilot for new models to deliver chemotherapy to children and young people at home and or in the community. The pilot will mobilise over the next 6 months and will include the trial of a children's chemo bus – a mobile unit that will help to deliver safe an effective care closer to people's homes and reduce the significant travel burden and associated cost for families who leave further away from the Royal Manchester Children's Hospital.

4.5. Single Service Arrangements

Following the MFT Operating Model review and the establishment of our six Clinical Groups, new leadership arrangements for a number of our managed single services will come into effect from 1 April 2025. Both the Oral Maxillofacial Surgery (OMFS) & Oral Surgery MSS and Trauma & Orthopaedics (T&O) MSS will be led by the North Manchester General Hospital SLT. An Ear, Nose and Throat (ENT) and Audiology Single Service will be led by the Manchester Royal Infirmary, whilst plans for a Preoperative Assessment Single Service led by Clinical and Scientific Services are in development.

5. Recommendations

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

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

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Board of Directors (Public)
Monday 20th January 2025

Paper title:	MFT Green Plan – Annual Report	**Agenda Item 10.3**
Presented by:	Vanessa Gardener, Chief Delivery Officer	
Prepared by:	Rob Jepson, Director of Estates & Facilities	
Meetings where content has been discussed previously		
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider (300 words max)

The 2023/24 Annual Sustainability Report monitors and celebrates the environmental sustainability successes at MFT throughout the financial year. It reflects the breadth of activity within our 10 areas of focus, and documents progress towards our net zero objectives during the penultimate year of the current Green Plan.

Overall:

- MFT Carbon Footprint is 75,117 tonnes CO_2e, down 3.6% since 22/23 and 13% since our baseline year 2019/20.
- Carbon per patient contact is 25.5kg CO_2e, (31.0kg in 22/23), despite 17% increase in patient contacts.
- Not far enough fast enough – fourth consecutive year core carbon footprint has exceeded annual target. Budget requires 10% reductions year on year. Overshoot mirrors the wider context of GMCA, where emissions are consistently and significantly exceeding the region's carbon budget

Recommendation(s)

The Board of Directors is asked to:

- Note the progress to date against the current Green Plan (2022-2025)
- Members are invited to contribute to the new Green Plan consultation.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • MFT/005752 – Delivery of Green Plan	
Care Quality Commission domains Please check **all** that apply	☐ Safe ☐ Effective ☐ Responsive	☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • NHS England Standard Contract (section 18)	

Main report (2000 words maximum - please use appendixes for all further information)

Introduction

MFT declared a climate emergency in 2019, and since then work has been ongoing to reduce the carbon footprint. The MFT Green Plan 2022-2025 is the current overarching sustainability strategy, which has two main objectives:

- To achieve a net zero MFT Carbon Footprint by 2038 (those emissions we can directly control)
- To achieve a net zero MFT Carbon Footprint Plus by 2045 (those emissions we can directly control and indirectly influence)

2023/24 Carbon Summary

MFT Carbon Footprint

The Trust's "Carbon Footprint" (directly controlled emissions) has reduced 3.6% since 2022/23 to 75,117 tCO_2e.

- Energy continues to be the largest component, making up 84% of the carbon footprint, however gas and electricity use have both reduced marginally compared to last financial year, leading to a small saving of 77 tCO_2e despite an increase in the carbon intensity of the national electricity grid.
- The largest carbon savings were achieved from the reduction in use of pure Nitrous Oxide as a result of decommissioning nitrous oxide manifolds at multiple hospital sites.

The anaesthetic and medical gases footprint is 1,850 tCO_2e less than last financial year (18% reduction).

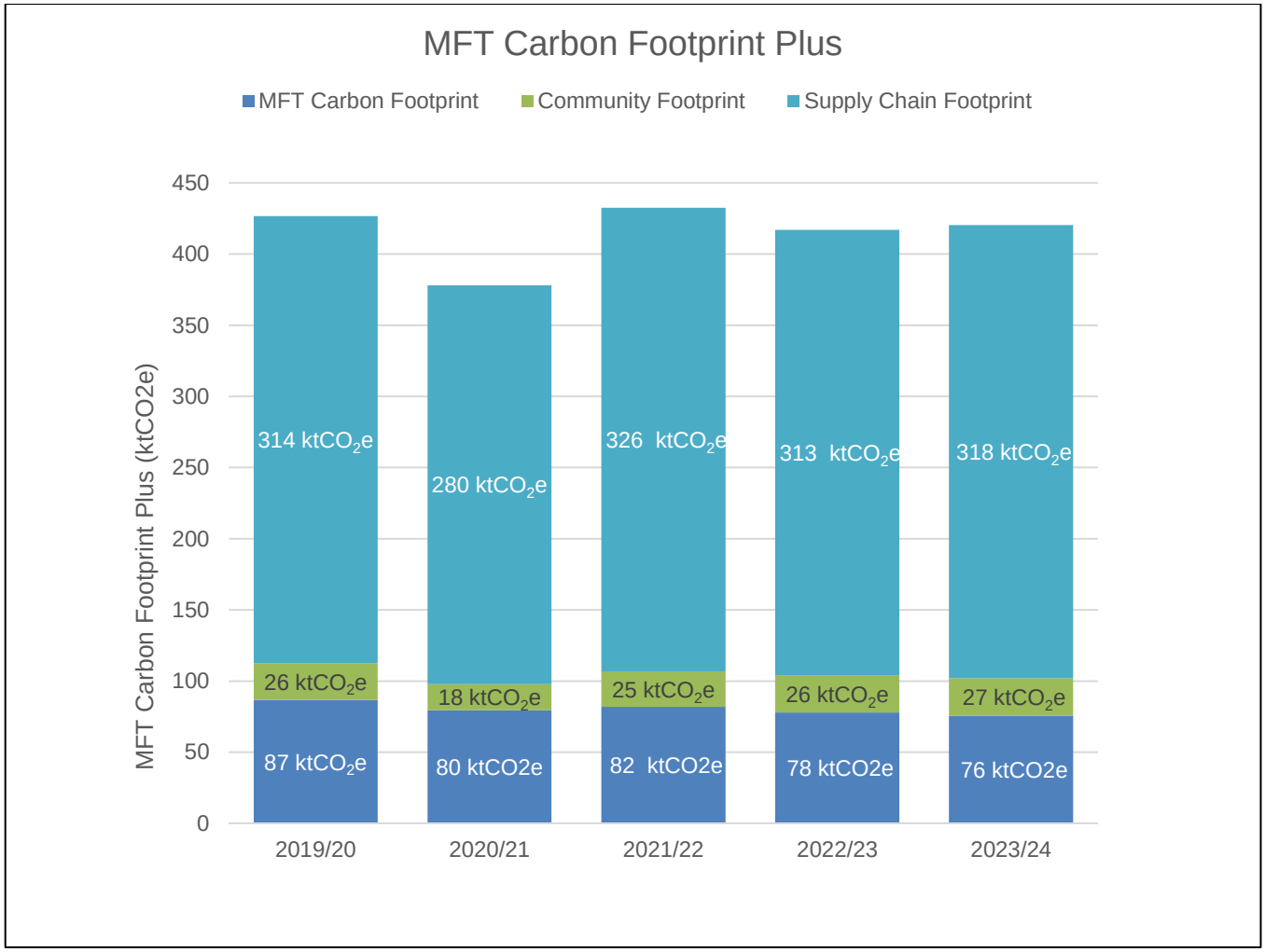
- Waste tonnage has increased by 0.7%, but a change from last year in carbon factor methodology for general domestic has led to a large carbon reduction.
- The total business travel distance by rail and air has increased, whereas vehicular business travel distance (the largest part of our business travel footprint) has reduced. As a result, the business travel and transport portion of the carbon footprint has increased by 7.5%.

Overall, during the Green Plan period the “carbon footprint” has successfully been reduced by 13%.

MFT Carbon Footprint Plus

The Trust’s “Carbon Footprint Plus” (which includes community and supply chain emissions in addition to the directly controlled emissions) was 420,011 tCO_2e.

- The largest contributor is the Supply Chain footprint, which is 76% of the Carbon Footprint Plus. The categories of spend with the highest associated carbon are construction, medical instruments and equipment, and business services.
- The “carbon footprint plus” progress from the baseline year can be seen in Figure 1, however, the methodology to calculate the supply chain element is not designed for year-on-year comparison, but rather to demonstrate scale.
- The number of patient contacts in 2023/24 increased by 17% and associated carbon emissions per patient contact have decreased (now 25.5kg CO_2e compared to 31.0 kgCO_2e in 21/22), demonstrating that resources are being used more efficiently.



Sustainability Achievements in 2023/24

In 2023/24 there have been excellent examples of sustainable action across the ten areas of focus in the Green Plan:

<u>Sustainable models of care</u>

- Hospital@Home service growing
- IPC have appointed sustainability leads
- £98k grant to develop sustainable framework for Trafford elective hub, this will provide a framework for other elective hubs across the NHS

<u>Digital transformation</u>

- 14 million fewer sheets of paper bought in first year of HIVE

<u>Supply Chain and Procurement</u>

- 2,800 walking aids (around 20%) were returned by patients to physio departments, rather than being disposed
- 30% of procurement staff have completed sustainability training

<u>Medicines</u>

- Anaesthetists headed a multi-disciplinary project team to decommission medical gas manifolds, reducing nitrous oxide usage and wastage and saving over 2,000 tonnes CO_2e
- The Trust purchased zero desflurane ahead of NHS England expectations

Food & Nutrition

- The ‘Food as Medicine’ campaign has sought to improve recovery rates and reduce the carbon intensity of food for patient stays

Estates and Facilities

- £5.3m secured from National Energy Efficiency Fund to upgrade lighting across sites
- Tiger waste facilities has been rolled out at Wythenshawe and NMGH reducing cost and the carbon intensity of clinical waste treatment

Travel & Transport

- Healthy Travel Strategy launched
- NMGH cycle hub opened with 90+ parking spaces as part of multi-storey car park development

Climate Change Adaptation

- Trust’s Adverse Weather Plan now includes climate change related events

Green Spaces and Biodiversity

- Trust-wide biodiversity assessment completed, and included nine recommendations to improve quality and value of green spaces
- 50kg of honey was extracted from our MFT rooftop beehives

Workforce, Networks & Systems Leadership

- The first Sustainable MFT conference was held in March 2024, and brought together board members, senior leadership, sustainability leads, and those engaged in sustainable action
- *Time To Act* brand identify was launched to promote the Sustainable MFT agenda and aid in staff awareness
- Sustainability Policy ratified in April 2023

Carbon Budget

The carbon budget relates to those emissions we directly control (MFT Carbon Footprint). It is a science-based limit for the maximum emissions that can be emitted on the pathway to reach net zero carbon by 2038/39. It adopts the approach that we emit no more than our ‘fair share’ of global emissions. The current interim budget spans from our baseline year in 2019/20 until the end of the current Green Plan in 2024/25.

- With one year remaining in this carbon budget period, we have emitted an additional 46,609 tCO2 e than budgeted and used 99% of our interim budget.
- By the end of 2024/25, we will have overshot the interim carbon budget for 2019/20 to 2024/25 and eaten into the carbon budget for the next interim period.

Further work is needed to understand how the current interim budget overshoot affects the long-term carbon budget.

Summary

Sustainable actions are expanding across the Trust, and staff have a greater understanding of the link between healthcare and the climate crisis.

Many of the projects in this year’s report were not initially started as sustainability projects. Instead, the sustainability co-benefits were discovered during delivery or after the project

concluded, demonstrating that the sustainability agenda aligns perfectly with other priorities identified by MFT and the wider NHS. Improved patient experience and outcomes have consistently gone hand in hand with lower carbon activity, delivering value for money (turnaround) and quality improvement (transformation).

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

Agenda Item 11.1

Manchester University NHS Foundation Trust

Escalation and Assurance Report
Quality, Safety and Performance Board Committee

Report to: Board of Directors
Report of: Damian Riley, Non-Executive Director and Chair of QSPBC
Date of meeting: 18/12/24

Key escalation and discussion points from the meeting
Alert:
The committee discussed the evidence related to year 6 of the Maternity Incentive Scheme and was satisfied with the evidence provided and supported the self-declaration of compliance being presented to the Board of Directors for approval. The committee supports the Mental Health scheme of delegation being presented to the Board of Directors for approval.
Advise:
The IPR metrics for performance were discussed and it was noted that there had been an improvement in performance against a number of metrics. An underperformance against the following metrics was reported to the committee with the corrective actions being taken identified and discussed: • A&E 4-hour standard – winter plans are in place; additional support is in place to support delivery of the improvement plan at Wythenshawe Hospital and additional support will commence at NMGH in February 2025. The Newton Europe programme is now branded as the 'Care Closer to Home' programme and has had its soft launch with the full launch taking place in February 2025. • 62-day cancer waits – the required treatment numbers to deliver to plan have been modelled for Q4 with individual targets for clinical teams. £1.7m has been received from the GM Cancer Alliance to support delivery of the plans overall this year. • Elective waiting list growth – there is a focus on validation, proactive communications and timely booking processes. • Diagnostic waiting times for CT scans - largely due to cardiac CT and children's MRI rates. Agreed recovery plans are in place. The IPR metrics for quality and safety were discussed: • The 50% reduction in MRSA incidences was noted and the themes associated with the reduction in MRSA bacteria discussed. The Trust remains above the zero standard and work continues on the identified themes to achieve further reduction. • External expert training has been commissioned to support delivery the Oliver MacGowan training requirements. • A 'no harm' Never Event has occurred, related to application of the surgery checklist. A review of all Never Events and themes continues. • A programme of work continues with regard to sepsis recording in Hive. Sepsis management data on 'Public View' is positive and shows MFT are below the lower control level. • The maternity 'C-section' staffing business case referred to in the IPR has been funded.

The committee discussed the issues and risks associated with renal dialysis capacity. Following work across GM, the demand and capacity has been stabilised and the risk is being successfully mitigated. Additional capacity should be available, including through supporting patients to self-dialyse, in the summer/autumn of 2025 with the aim to downgrade the risk at this stage.

The Medical Director of the WTWA Clinical Group presented to the committee regarding a notification from the PHSO regarding treatment of a long-standing complaint. The matter will be further discussed at the Board meeting in January 2025. The action plan is in place and programmes of work have continued to support the recommendations.

The committee discussed the perinatal mortality review report for Q2 prior to it being presented to the Board in January 2025.

The committee considered the Palliative Care and End of Life report. A centralised team for palliative care is being established to ensure equitable service provisions across the Trust for patients and their families and to also support staff. The results from the national audit of palliative care are expected in early 2025.

The committee received an update on non-RTT waiting lists and discussed the action plan, which has been in place since September 2024, to reduce the waiting times.

An external report into the Trust's PSIRF arrangements has been commissioned and completed. The results will be discussed at the QSPBC meeting in February 2025. Combined quality indicators for 2025/26 will be developed with Board members, colleagues, and Governors.

The committee received an update on current and planned service developments in the Trust.

The committee received a report on the activity of the Trust's legal services departments. The Trust is an outlier for PFDs due to a different approach taken by a local coroner.

Assure:

The committee undertook a deep dive into the Trust's CAMHS service which delivers well against the performance standards. A CQC unannounced visit to Galaxy House found considerable good practice, ten recommendations were made of which seven have been completed and the remaining three are in progress. A peer review of CAMHS was undertaken by Mersey Care in January 2024 and delivery of recommendations, including Hive and estates developments, are being overseen by the Trust's Mental Health Group. Work is ongoing with partners to address the increase in demand on the neuro-diversity pathway with a 'waiting well' offer in place for those awaiting treatment. 25% of the referrals into CAMHS over the last year were for patients with neuro-diversity issues.

The committee undertook a deep dive into decontamination and received positive assurance on delivery of the actions being taken to mitigate all the associated risks.

MFT has not been identified as an outlier in comparison with national results from the national maternity survey, scoring positively with regard to patient communication with staff and choice of where patients can have their baby. A number of workstreams are in place to act on the learning from the results.

The results of the national Urgent Care Survey (2024) that takes place every two years were considered. MFT is at the national average for most areas and above national average for 'Dignity and Respect'. 'Pain Management' and 'Food and Drink' remain areas of focus with actions being delivered to improve the patient experience in these areas aligned to the National Inpatient Survey work programmes and PLACE programmes of work.

The committee discussed the Cervical Screening Provider Lead annual report. Historical backlogs have been cleared and the Oxford Road Campus is showing full compliance for waiting time standards.

From the Board Assurance Framework (BAF), the Committee received updates from lead Executive Directors regarding progress with the actions required to deliver strategic objectives 3, 4 and 5 of the MFT strategy. These are included in the BAF presented to the Board of Directors at its January meeting.

Risks discussed at the meeting

The strategic risks relevant to the committee were discussed. It was confirmed that a review of all strategic risks is underway with the exercise being completed by the end of March 2025.

Report approved by: Damian Riley, Non-Executive Director and Chair of QSPBC

Agenda

Manchester University NHS Foundation Trust

Quality, Safety and Performance Board Committee

Date: Wednesday 18th December 2024
Time: 10:00am – 1:00pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	10:00am
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	10:00am
3.	**Minutes of the previous meeting** (30th October 2024)	Meeting admin	Chair	10:00am
4.	**Action Log**	Discussion	Chair	10:00am
5.	**Matters Arising**	Discussion	Chair	10:00am
6.	**Assurance Reporting** 6.1 Risk Report 6.2 Integrated Performance Report 6.3 Board Assurance Framework	 Discussion Discussion Discussion	 BF VG/KSJ/TO VG/KSJ/TO/DB	 10:05am 10:10am 10:15am
Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience				
7.	7.1 Hot topic – PHSO response and action plan	Discussion	SB / KSJ	10:20am
	7.2 Deep dive - Decontamination	Discussion	RW /KSJ	10:30am
	7.3 Deep dive – CAMHS and Community Services	Discussion	JB-S / KSJ	10:40am
	7.4 Maternity safety reporting – including PMRT	Discussion	KM / KSJ	10:50am
	7.5 Maternity Incentive Scheme	Discussion	KM / KSJ	11:00am
	7.6 Annual maternity patient survey results	Discussion	KSJ	11:10am

	7.7 Urgent care patient survey results	Discussion	KSJ	11:20am
	7.8 Palliative Care and End of Life report	Discussion	KSJ	11:40am
	7.9 Update report on non-RTT waiting list	Discussion	VG	11:50am
	7.10 Update on Renal Dialysis capacity, including dialysis at home	Discussion	VG	12:00pm
	7.11 Progress report on the Trust and Clinical Group Patient Safety priorities	Discussion	TO / KSJ	12:10pm
	7.12 Cervical Screening Provider Lead update	Discussion	TO	12:20pm
	7.13 Legal Services Activity Report	Discussion	TO	12:25pm
	7.14 Update report on service developments (strategic objectives 4 and 5)	Discussion	DB	12:30pm
Good governance				
8.	Mental Health Scheme of Delegation	Support	KSJ	12:40pm
Committee business				
9.	**Escalation report**	Approval	Chair	12:50pm
10.	**Workplan Review**	Meeting admin	Chair	12:55pm
11.	**Any Other Business** (verbal)	Discussion		12:55pm
12.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	12:55pm
Date of next meeting: Wednesday 26th February 2025 at 10:00am				

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	NHS Cervical Screening Programme – Cervical Screening Provider Lead Annual Report (2023-2024)	**Agenda Item 11.2**
Presented by:	Miss Toli Onon, Joint Chief Medical Officer	
Prepared by:	Dr B Schaefer, Consultant Gynaecologist / Cervical Screening Provider Lead MFT	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee – 18 December 2024	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider

This report covers the NHS cervical screening programme (NHS CSP) activities during 2023-2024. The three elements of the Cervical Screening Service provided by MFT are Cervical Screening which includes Cytology and Virology testing, Histology and Colposcopy.

During 2023/24 there have been major improvements in specimen turnaround times across MFT laboratories, particularly in the Cytology Department. As such, there has been significant improvement of the Colposcopy performance data for the ORC site with full compliance for waiting time standards and, significantly, historic backlogs have been cleared.

Ongoing challenges include the processing of the Cytology workload and meeting the expected turnaround times for activity, amid national staffing challenges. As well as operational staffing challenges, leadership pressures will be encountered as we move into 2024/25, and interim arrangements are positioned whilst longer term leadership is being developed.

Moving into 2024/25, a key priority is establishing the longer term Cervical Clinical leadership role. Service harmonisation and optimisation through HIVE is also a focus. The team has made significant progress in improving performance and quality standards, particularly with respect to specimen turnaround times in both Cytology and Histopathology. There has also been notable advancement in addressing outstanding recommendations from the last Cervical Screening Quality Assurance visit in March 2023, and in resolving the backlog of cases for the National Cervical Cancer Audit.

Recommendation(s)

The Board of Directors is asked to:

- note the recovery and performance achievements achieved across 2023/24

- note the workforce and leadership challenges across Cytology and the Screening Programme

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☐
HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☒
VfP objective 2	☒	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate, or operational risks: • MFT005845: Cervical Cytology Continuity of Service	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☐ Responsive	☐ Caring ☐ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • N/A	

Main report

Please see attached as Appendix A the NHS Cervical Screening Programme – Cervical Screening Provider Lead Annual Report (2023-2024).

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
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Be the place where **people enjoy working**, learning, and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients, and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant, and well-run organisation

APPENDIX A

Manchester University
NHS Foundation Trust

NHS Cervical Screening Programme
Cervical Screening Provider Lead Annual Report
Manchester University NHS Foundation Trust
April 2023 – March 2024

B Schaefer
Consultant Gynaecologist, Cervical Screening Provider Lead, Manchester University NHS Foundation Trust

Introduction

This report covers the NHS Cervical Screening Programme (NHS CSP) activities undertaken by Manchester University NHS Foundation Trust (MFT) during the period 01 April 2023 to 31 March 2024. The three elements of the Cervical Screening Service provided by the Trust are Cervical Screening which includes Cytology and Virology testing, Histology and Colposcopy.

The Key Performance Indicators (KPIs) for each of these elements are listed against the National Standards for the relevant specialty (please see references on Page 19).

Key achievements

- Major improvement of specimen turnaround times for all laboratories, especially the Cytology laboratory
- Successful optimisation of the physical and virtual Cytology laboratory environment (all Consultant Biomedical Scientist microscopes have cameras for taking images for MDT, further optimisation of the Laboratory Information Management System LMS, auto-authorisation of HPV negatives implemented Spring 2023, employment of a Specimen Reception Manager) with subsequent improvements in quality and efficiency
- Cervical Sample Taker Database (CSTD) has been reviewed and updated with more user-friendly reports for service users as well as the local Screening and Immunisation team
- Completion of the HPV validate study with several scientific publications in peer reviewed journals and continued participation in research (i.e. ACES Study) which will inform National Screening Policy
- Significant improvement of the Colposcopy performance data for the ORC site with full compliance for waiting time standards
- Full compliance of all team members with NHS CSP 20 x MDT attendance requirements
- Clearance of historic backlog of cervical cancer audit cases completed
- Successful closure of 84% of QA recommendations from the 2023 QA visit (37/44), with at least another three on track for closure by October 2024

Key challenges

- Managing the Cytology workload and preserving the currently excellent turnaround times despite ongoing staffing issues at all levels, but especially NHS CSP qualified reporting staff and planning for the expected departure of the Clinical Lead as well as several Consultant Biomedical Scientists in 2024/25
- Developing the interim and long-term plan to enable continuity of the Cervical Screening Programme following retirement of the lone Cervical Clinical Lead for Cytology in September 2024
- Managing the Histopathology workload and further improving Histopathology turnaround times despite the significant longstanding capacity issues in both current Histopathology laboratories due to several Consultant Histopathologist vacancies
- Coping with the ongoing issues with the functionality of the new IT system HIVE in Colposcopy (despite regular optimisation meetings with the HIVE team), which caused continued reduction in clinic capacity compared to pre-HIVE levels through extensive additional administrative burden to clinicians during patient encounters, inability to provide 100% accurate statutory data returns and contributed to several screening incidents, all creating additional work pressures on the clerical, clinical and leadership teams
- Stabilisation of the performance of the NMGH Colposcopy Unit following long term sickness of two key team members and structural problems within the local admin team
- Achieving NHS CSP mandated individual screening caseload for all Colposcopists and Histopathologists

Vision for 2024/25

- Successful transition of the Cervical Clinical Lead role to a new long term leadership team after retirement of the current incumbent in Q2 2024/25
- Further exploration of the ‘Genius’ assisted screening technology in the Cytology laboratory, which will help in maintaining TATs; in preparation for this, the new Hologic staining protocol has already been validated
- Expansion of the existing Histopathology team to ensure continuing/increasing compliance with National KPIs despite increasing workload; creation of a work environment which facilitates successful recruitment and retention of highly skilled clinical and administrative staff, which is particularly important in view of the national shortage of Histopathologists
- Addressing the issues caused by the NMGH Histopathology work processed at the Royal Oldham laboratory (delay in patient result notification and screening incidents through the need to manually upload the results to the HIVE database; concerns around the quality of the reports raised in screening incidents at the point of writing this report
- Being able to optimise the HIVE Colposcopy component to a level where all required data can be reliably generated without the need for extensive manual data validation, and where it has truly a positive and timesaving impact on clinician admin processes
- Successful recruitment to the Deputy Lead Colposcopist role

1. Individual Service Reports

1.1. Cytology and Virology service

Manchester University NHS Foundation Trust hosts one of eight departments in England providing Cytology and Virology services for HPV primary screening within the NHS CSP. Manchester Cytology Centre reported approximately 450,000 samples between April 2023 and March 2024. The laboratory is fully accredited to the International Standard ISO 15189.2012. The Screening service is provided by the Cytology and Virology departments based within the Clinical Sciences Centre at Manchester Royal Infirmary. The laboratory hosts sample reception and processing and has a large 'screening room' where microscopy is undertaken by Biomedical Scientists and Cytology Screeners. Electronic requesting and reporting are in place and is used by the majority of GP Practices and Colposcopy departments. The department supports samples taken in Extended Access Clinics, thus helping to improve uptake of cervical screening. Secure electronic links are in place to the Colposcopy Units throughout the North West of England (Greater Manchester/Lancashire and Cumbria/Cheshire and Merseyside) in order to arrange a direct referral from the laboratory for patients needing further investigation following their screening test.

Cervical samples taken as part of the NHS CSP are processed by the Cytology and Virology departments in accordance with the National HPV primary screening protocol https://www.gov.uk/government/publications/human-papillomavirus-hpv-primary-screening-protocol

A single named Clinical Lead is responsible for NHS CSP related activities undertaken in both the Cytology and Virology departments. Senior staff across the Trust hold regular meetings to discuss operational and clinical issues. Senior staff take an active part in Programme Board meetings across the region and attend meetings hosted by the Regional SQAS team e.g. laboratory leads and CSPL meetings. Several senior staff have contributed towards National NHS CSP publications during this period and are members of prominent National committees relating to cervical screening. Screening activities are coordinated by two Consultant Biomedical Scientists who provide clinical support for the Trust CSPL.

The laboratory has exclusively reported Thin Prep (Hologic) Liquid Based Cytology (LBC) samples since July 2019, following conversion from Surepath Technology, HPV primary testing is provided by the Virology department using the Roche 480 pre-analytics and the Roche Cobas 8800 automated platform.

Cervical Sample Taker Database (CSTD)

- The Cytology laboratory holds the Regional Cervical Sample Taker Database (CSTD) which is the central record of sample taker training and is also capable of producing personal performance reports on demand to both Practice Managers and individual Sample Takers. The CSTD has been reviewed and updated with more user-friendly reports for our service users and SITs

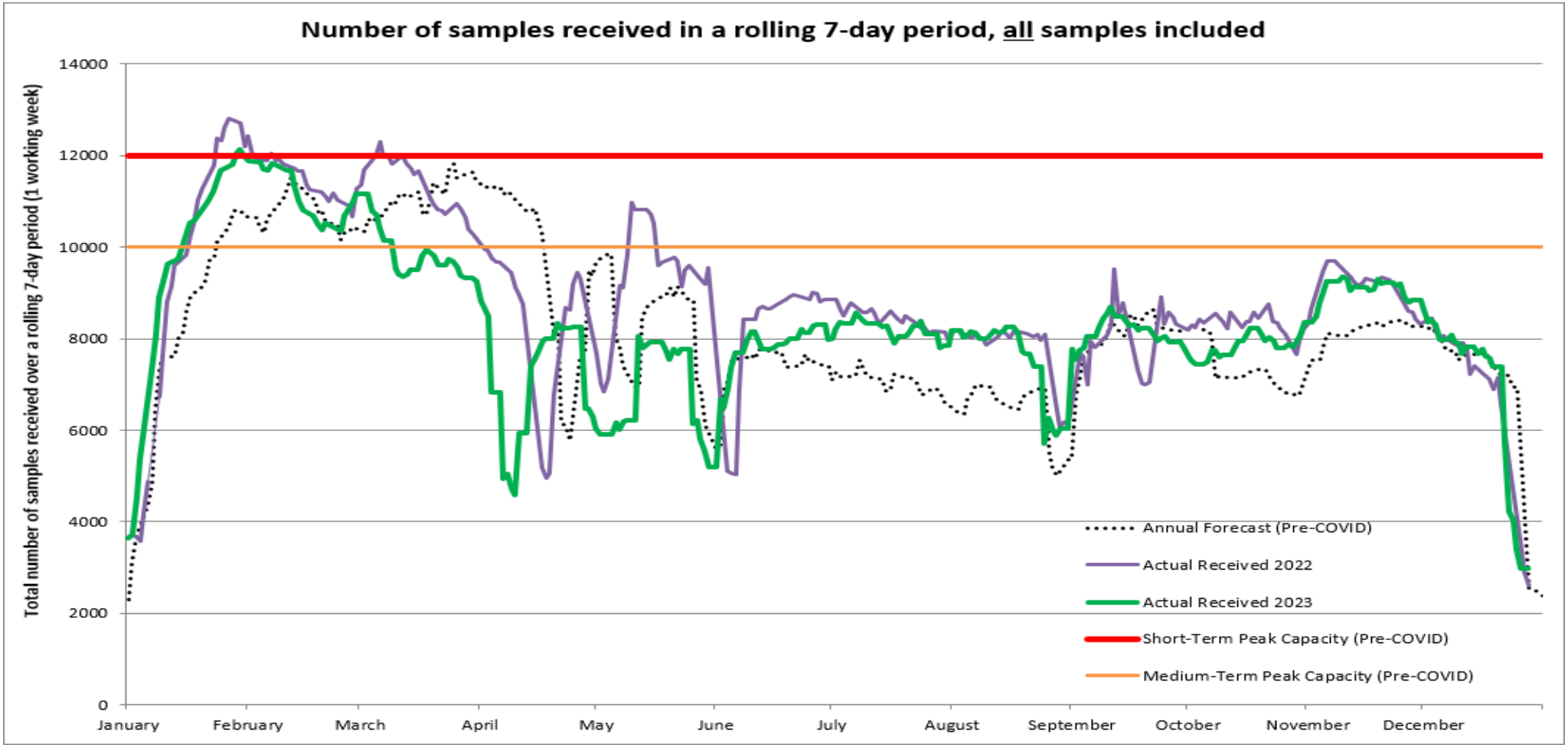

Number of samples received in a rolling 7-day period, all samples included
Total number of samples received over a rolling 7-day period (1 working week)
14000
12000
10000
8000
6000
4000
2000
0
January
February
March
April
May
June
July
August
September
October
November
December
Annual Forecast (Pre-COVID)
Actual Received 2022
Actual Received 2023
Short-Term Peak Capacity (Pre-COVID)
Medium-Term Peak Capacity (Pre-COVID)

Table 1. Cytology Key Performance Indicator (KPI) data April 2023 – March 2024

KPI – Apr 2023 – Mar 2024	Standard	Reference	MFT Value	Comment
Samples received by laboratory	35,000 (min)	KC61	424797	
Primary screener workload	3,000 slides screened (min)	Annual return	15/17	x2 staff on long term absence
Primary screener sensitivity for high-grade dyskaryosis	>95%	Annual return	17/17	
Primary screener sensitivity for all grades of dyskaryosis	>90%	Annual return	17/17	
Checker workload	750 slides screened (min)	Annual return	4/5	x1 checker on long term absence
Consultant workload	750 cases reported (min)	Annual return	9/10	x1 Consultant Pathologist. Joined the team part way through the year
All non-medical staff to undertake three days of NHS CSP approved update training every three years	100%	**1	100%	All staff attended NHS CSP update courses
Turnaround time for results from date of sample collection to delivery of report	% of samples reported by laboratory within 14 days	KC61	88.48%	An improvement compared with the previous reporting period
External Quality Assurance (EQA) of the Laboratory Service	All Cytology staff must participate in the Gynae EQA scheme	BAC	100%	
	The Cytology department must participate in the Technical EQA scheme (Staining quality)	BAC	Participated in four rounds of the external TEQA scheme run during 2023/24	
	The Virology department must participate at least one EQA scheme for the molecular detection of HPV	UKNEQAS QCMD	Virology participates in the UKNEQAS and QCMD scheme, no problems identified	UKNEQAS 3 x yearly QCMS annual
% of samples reported as inadequate	Between 0.3 – 4.7% (2020/21 statistical bulletin) - ** mix of Cytology PS and HPV PS	KC61	0.48% ** all HPV primary screening samples; 3.0% when calculated for samples with Cytology recorded	
Positive predictive value (PPV) of Cytology:	Between 72.8 – 92.4%	KC61	84.25%	Stats Bulletin 2020/21 Note: Calculated for the period Apr 22 – Mar 23 as

KPI – Apr 2023 – Mar 2024	Standard	Reference	MFT Value	Comment
% of women referred with high-grade Cytology or worse, whose biopsy is reported as CIN2 or worse				data is collected retrospectively to allow time for follow up
Referrals Value (RV): Number of women referred to Colposcopy to detect one CIN2 or worse lesion	Between 2.1 – 4.4%	KC61	4.09%	Stats Bulletin 2020/21
Mean CIN score	N/A	KC61	1.49%	
Abnormal Predictive Value (APV)	Between 6.6 – 20.3%	KC61	8.74%	Stats Bulletin 2020/21
All cases of invasive cervical cancer diagnosed in the Trust must be audited in line with National guidance	100%	**2	Yes	
Number of women lost to follow up after failsafe	<5%	KC61	4.12%	Stats Bulletin 2020/21 Note: Calculated for the period Apr 22 – Mar 23 as data is collected retrospectively to allow time for follow up

References

**1 http://www.britishcytology.org.uk/resources/BAC_Code_of_Practice2015_-_2017_update.pdt

**2 https://www.gov.uk/government/publications/cervical-screening-auditing-procedures

Outcomes of Colposcopy referrals to assess laboratory failsafe

The review period for this report is 01 April 2023 to 31 March 2024. A total of 25,237 direct referrals to Colposcopy were made by the laboratory, an increase of 5% compared with the preceding annual period. Direct referrals were made to 25 Colposcopy Units in Greater Manchester/Lancashire and Cumbria/Cheshire and Merseyside. The recorded Histologic/Colposcopic outcomes allow sufficient time for the failsafe enquiries to be completed and information to be gathered for up to 12 months after the referral to Colposcopy has been made. The laboratory failsafe enquiries during that period included a monthly failsafe spreadsheet issued to each Colposcopy department. The category ‘outcome known, none of the above’ includes patients who did not attend or refused Colposcopy, Colposcopy delayed e.g. pregnancy. The category ‘no outcome available’ includes patients who moved away or used private healthcare for further investigation.

Table 2 shows the outcome of referrals to ORC and NMGH Colposcopy Units 01 April 2023 – 31 March 2024

Outcome after failsafe enquiries completed	Total referrals	Cancer or CGIN	CIN3/CIN2	CIN1/HPV	Bx-> No CIN or HPV	Bx-> Inadequate	Colposcopy NAD/no Bx	Outcome known, none of the above	No outcome available
Oxford Road Campus	2231	27	382	612	21	30	1056	85	9
NMGH Campus	803	8	111	171	21	20	390	46	6

Clinical audit of updated laboratory failsafe protocol

The Cytology department migrated its laboratory failsafe process from Masterlab to Cyres during April 2021. Following this change, the department completed a clinical audit of its updated laboratory failsafe process, and the audit achieved compliance level 'significant.' A partial follow up audit was completed during September 2023, and this showed full compliance (100%).

Virology

HPV testing is carried out in the Virology department which is fully accredited to the International Standard ISO 15189:2012. The last UKAS visit was on 21/22 March 2023 and 29/31 March 2024 and continuous accreditation was granted. Testing is performed using the Roche P480 automated systems for pre-analytics and Roche Cobas 8800 analysers for detection. Other tests such as COVID, Chlamydia and viral loads run on the same instruments alongside HPV with no capacity issues reported. Virology continuously turnaround HPV testing within three days, as per the Service Level Agreement between Cytology and Virology. There have been no stock supply issues in the past year and an onsite engineer is available Monday to Friday to support instrument maintenance and unplanned downtime. Virology participates in two EQA schemes; an inter-laboratory exchange scheme with three other Roche screening sites and carries out daily IQC on each of the instruments with no issues identified.

The closedown report for HPValidate was submitted to DHSC on 22 November 2023 and clinical and operational manuscripts are in preparation. Cytology and Virology in collaboration with The University of Manchester continue to be involved in the validation of urine samples for primary screening with this study (ACES) expected to complete at the end of 2025. The main findings for urine HPV testing for CIN2+ detection in a Colposcopy referral population was published recently. The results from ACES and HPValidate will feed into the National Programme for consideration in a wider evaluation.

Publications during 2023/24

1. L Connor, K Cuschieri, A Sargent (June 2023). The self-sampling journey; technical considerations and challenges www.HPVWorld.com 232
2. M Whittaker, JC Davies, A Sargent, M Sawyer, EJ Crosbie. *BJOG.* 2024;131:669-708 A comparison of the carbon footprint of alternative sampling approaches from cervical screening in the UK: A descriptive study

3. S Huntington, KP Sudhir, V Schneider, A Sargent, K Turner, EJ Crosbie, EJ Adams. *BMJ Open* 2023; 13:e068940. Two self-sampling strategies for HPVprimary cervical cancer screening compared with clinician-collected sampling: and economic evaluation
4. JC Davies, A Sargent, E Pinggera, S Carter, C Gilham, P Sasieni, EJ Crosbie. *BJOG.* 2024;00:1-9. Urine HR HPV testing as an alternative to routine cervical screening: A comparative diagnostic accuracy study of two urine collection devices using a randomised study design trial

Staffing – key changes

New staff members

- x2 Consultant Cytopathologist locums
- a locum Cytoscreener for eight months
- new Specimen Reception Manager
- failsafe admin team now fully established
- specimen reception MLA team establishment increased in Summer 2023, permitted to become temporarily over-established at periods of high activity and to recruit to % staff turnover

Departing staff members

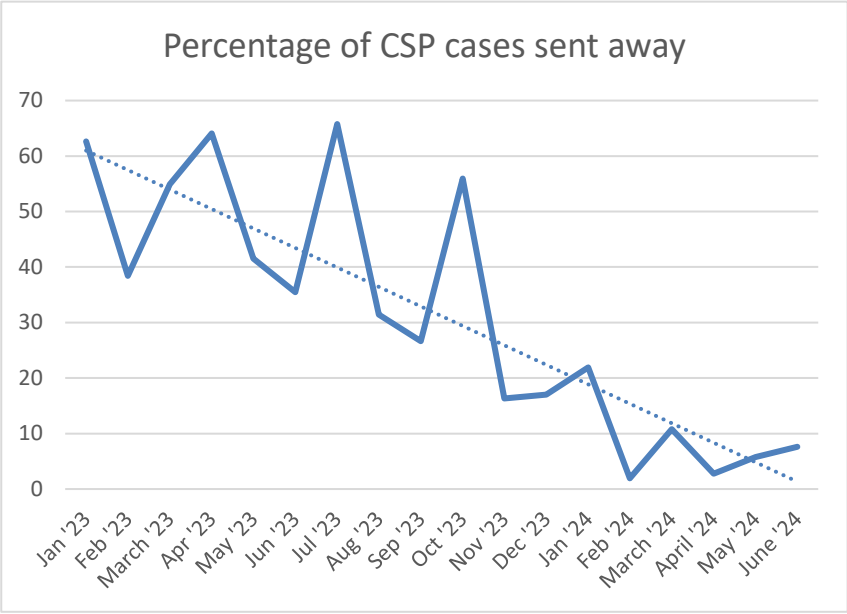
- x5 Advanced and Consultant BMS

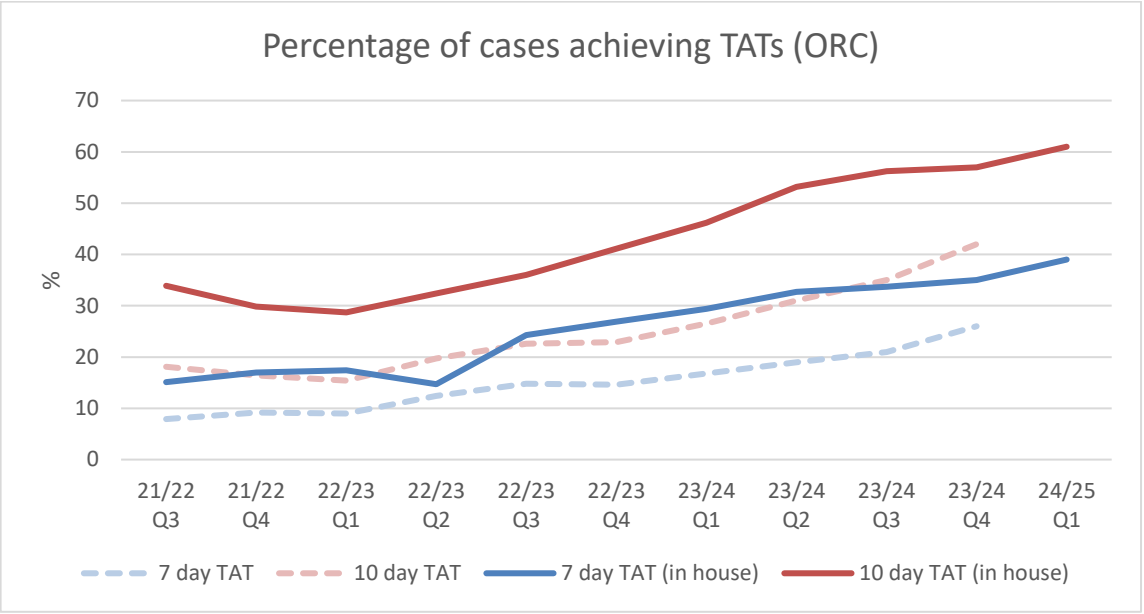
1.2. Histopathology

1.2.1. St Mary's Oxford Road

The Histopathology service for biopsies taken at St Mary's Hospital and Trafford General Hospital is based at Oxford Road (ORC). Manchester Royal Infirmary (2,124 cases in the year to Q1 2024/25). While it has been supported by two locum consultants over the last 12 months, they are unfortunately leaving in August 2024 along with one of the substantive gynae pathology consultants. This represents a loss of 12 gynae reporting PAs. Following these departures, of the six remaining substantive posts, there will be three solely reporting gynaecological histopathology samples with an overall WTE of 4.5 gynae consultants.

Despite significant workload pressures, noticeable improvements in both turnaround times and proportion of outsourced cases were made, primarily due to the aforementioned locum support and in-house prioritisation of cervical screening work.





Consultant understaffing in the context of an increase in workload volume and complexity remains the root cause of non-achievement of the national targets.

A business case by the consultant body in support of two additional substantive gynae pathologists (looking across several different measures of workload) has been submitted over a year ago but has been put on hold pending a review of the new RCPath points system; there are significant misgivings among the consultant body around this system, which have been made clear.

In terms of Estates, the renovation of a hard tissue laboratory has allowed for additional dissection benches to be installed, and the team is currently in the process of shortlisting applicants for a Specialty Doctor post to relieve the dissection burden on consultant pathologists (thereby releasing reporting time).

The number of cervical screening cases outsourced over the last year has significantly decreased (from ~40% to <10%, see graph), however with the upcoming consultant departures it is likely that these numbers will start to increase again; significant associated costs both financially and in terms of time for both consultant and secretarial staff are likely to be incurred.

Furthermore, a re-banding exercise of current secretarial posts at Oxford Road is underway with indications that several secretaries will be down banded; there is considerable upset among the secretarial staff and a real risk of losing exemplary employees. This risk has been emphasised to management and the overall outcome of this exercise is awaited. The transfer of work from North Manchester General Hospital continued to be postponed; ORC would not have capacity to report this work if it were to be transferred without additional supporting PAs. On

a more positive note, several more recommendations have been closed following our successful SQAS inspection in March 2023; outstanding recommendations remain around achieving turnaround times and minimum reporting numbers. Quarterly CSP consultants' meetings continue and are well received, all in-house consultants are up to date with eLearning, and audits of dataset completion and clinical requesting have all yielded positive outcomes.

Performance Indicators for Histology

KPI	Standard	Reference	St Mary's ORC Value	Comment
% of biopsy results available to requester	80% within 7 days 90% within 10 days	NHS CSP	34.7% within 7 days (14.6% last year) 54.1% within 10 days (22.9% last year)	The improvements over the last 12 months are unlikely to be maintained unless the vacant PAs are filled (12 gynae reporting PAs). Additional improvements would only be possible through further recruitment as per business case previously submitted to management
All Histology Consultants must participate in EQA	All Pathologists participate in the National Gynaecological Pathology EQA scheme	NHS CSP	All consultants participate	
All Histology Consultants must undertake update training related to their role in the NHS CSP	All Pathologist undertake eLearning module every 2 years	NHS CSP	All consultants are up to date	
Laboratory participates in the UKNEQAS Technical EQA	Laboratory participates in the UKNEQAS General Cellular Pathology Technical EQA scheme		Laboratory participates	Visits as per standard arrangements

All Pathologists use the agreed subset of report codes

Substantive Pathologist	Biopsies	Loops	7-day TAT (%)	10-day TAT (%)	Normal / HPV (%)	CIN1 (%)	CIN2 (%)	CIN3 (%)	CGIN (%)	Invasive (%)	Inadequate (%)	Total cases (Target =150)
A	343	124	52.0	71.9	17.9	33.7	25.7	20.5	1.1	1.1	0.9	**467**
B	263	68	18.1	51.4	21.8	41.7	20.9	14.4	0.6	0.6	1.5	**331**
C	184	23	27.1	50.2	17.1	54.6	20.0	7.8	0.5	0	1.0	**207**
D	58	35	2.2	22.6	36.3	35.2	9.9	17.6	1.1	0	2.2	**93**
E	325	119	73.9	89.9	12.2	42.8	26.1	13.7	1.1	4.1	0	**444**
F	156	24	31.7	60.6	8.4	45.3	30.7	12.8	2.2	0.6	0.6	**180**
G	151	38	35.4	48.7	32.8	27.4	23.1	15.1	0	1.6	1.6	**189**

1.2.2. Histology (Wythenshawe)

The Wythenshawe Histopathology laboratory does not currently contribute to the processing and reporting of cervical biopsies taken at St Mary's due to major staffing and workload shortfalls. The Wythenshawe lab provides the Cervical Histopathology Services to Tameside General Hospital and the total cervical workload of the Wythenshawe lab only includes Tameside biopsies (462 cases in the year to Q1 2023/24).

Four pathologists currently share the gynae histopathology workload at Wythenshawe, which includes one new part time appointment to the team over the last year. Each of the pathologists also works across other specialties, varying proportions of their job plan given to gynae histopathology, ranging from 2.5%$ to 17.5% of the gynae workload. Following the appointment of the new consultant, all CSP work is currently kept in-house. Laboratory staff shortage has affected the turnaround times.

All Pathologists use the agreed subset to report codes

Substantive Pathologist	Biopsies	Loops	7-day TAT (%)	10-day TAT (%)	Normal / HPV (%)	CIN1 (%)	CIN2 (%)	CIN3 (%)	CGIN (%)	Invasive (%)	Inadequate (%)	Total cases (Target =150)
A	87	39	33.3	61.9	41.4	17.2	12.9	25	0.9	2.6	7.9	**126**
B	140	49	8.5	24.3	60.2	14	11.3	12.4	0.5	1.6	1.6	**189**
C	57	33	22.2	43.3	50	13.4	13.4	22	0	1.2	8.9	**90**
D	77	11	13.6	37.5	37.9	35.6	19.5	4.6	0	2.3	1.1	**88**

Performance Indicators for Histology

KPI	Standard	Reference	Wythenshawe Value	Comment
% of biopsy results available to requester	80% within 7 days 90% within 10 days	NHS CSP	12.5% within 7 days 27.8% within 10 days	Significant lab staffing pressures have led to a severe deterioration in TATs
All Histology Consultant staff must participate in EQA	All Pathologists participate in the National Gynaecological Pathology EQA scheme	NHS CSP	All staff participate	
Laboratory participates in the UKNEQAS Technical EQA	Laboratory participates in the UKNEQAS General Cellular Pathology Technical EQA scheme		Laboratory participates	Visits as per standard arrangements

1.3. Colposcopy Service

1.3.1. SMMCS ORC

The number of Colposcopists currently standards at 14 consultants and four Nurse Colposcopists. After a period of vacancy lasting 10 months, a new Lead Colposcopist, Ms Mrinal Shah, has been appointed in Summer 2023; the role of the Deputy Lead Colposcopist is currently vacant. A Deputy Nurse Colposcopist is now in post. The capacity issue from previous years caused by the merger between ORC, Wythenshawe and Trafford Units as well as the post-pandemic recovery period, have been fully resolved (despite the impact of the frequent episodes of Resident Doctor industrial action on planned clinical activity), and this is evidenced in the performance data below, which showed significant improvements in all areas from those of the previous financial year.

The Colposcopy admin team currently consists of a Team Manager, three Band 4 Lead Patient Pathway Coordinators, three Band 3 Patient Pathway Coordinators and a Band 4 CSPL Support and MDT Coordinator. Despite a number of challenges with recruitment, all posts within the Colposcopy admin team have now been successfully filled.

The HIVE EPR system was implemented on 08 September 2022, and although the team is now at a stage where the required quarterly data returns as well as the individual annual colposcopy audit can be broadly generated, there are still ongoing inaccuracies in the data due to the inability to capture the information for colposcopic treatments performed under general anaesthetic, and the extensive and time consuming manual data validation by the Lead Nurse Colposcopist and other members of the admin and managerial staff is regularly required before any submission date, which has led to regular breaches of the National submission deadlines. There has been good support by the HIVE team through attending weekly meetings with Colposcopy and management to resolve these issues, but because a number of components have to be built by other teams and changes are complex and could potentially impact other services, progress is slow.

The new software remains unnecessarily time consuming in daily clinical use and contributed to clinical as well as screening incidents in 2023/24 (see Item 4).

Performance Indicators for Colposcopy

KPI	Standard	Reference	ORC Values	Comment
Waiting times				
ALL referrals	99% offered appt within 6 weeks	No. 20 No. 25	96.7%	
Low-grade dyskaryosis	99% offered appt within 6 weeks	No. 20 No. 25	95.74%	
High-grade dyskaryosis (> moderate dysk.)	93% offered appt within 2 weeks	No. 20 No. 25	99.9%	
Results of colposcopy visit communicated to patient	90% within 4 weeks	No. 20	82.67%	
All patients to receive results within 8 weeks of attendance	100%	No. 20	99.26%	
DNA rate for new patients	<15%	No. 20	4.42%	
DNA rate for return for treatment patients	<15%	No. 20	3.91%	
DNA rate for follow up patients	<15%	No. 20	1.77%	

1.3.2. SMMC NMGH

The NMGH Colposcopy team currently consists of five consultants based at NMGH and two Nurse Colposcopists from Oxford Road Campus, one of them being the Lead Nurse Colposcopist, who provide 2.5 clinics/week as an outreach service, and which supported the harmonisation of working practices. A sixth consultant has transferred her colposcopy activity from ORC to NMGH in March 2024.

The admin team consists of two Colposcopy Clerks who also double up as receptionists for Colposcopy as well as all other gynae clinic posts, as well as a new member of staff starting May 2023 and a dedicated receptionist.

2023/24 has seen the worst Colposcopy performance data for NMGH in 15 years.

The causes for this were an unfortunate coincidence of planned and unplanned long-term sickness of two clinicians leading to a sudden capacity loss of ~35% over 3-4 months in Q2/3, as well as the need to reduce elective activity to facilitate emergency cover due to repeated Resident Doctor industrial action (NMGH has a fraction of the consultant workforce of ORC and therefore was disproportionately affected). Furthermore, the newly appointed admin team lacked experience and, despite completion of the bespoke induction programme for Colposcopy administration, there were difficulties in managing the residual capacity efficiently, or timely escalation of capacity issues, and limited awareness of all NHS CSP 20 admin related standards, which led to several screening incidents.

fortunately, the experienced Colposcopy Clerk who left at the beginning of this financial year had chosen to return in April 2024, and we expect a return to the previously high administrative standard for 2024/25.

Following the return of key members of the Colposcopy team in Q3 and with the support of the ORC Colposcopists, extra ad hoc capacity was generated which helped to address the backlog and ensure all referrals for cytological abnormalities were seen in the required timeframe by the end of the financial year, although some of the clinical indication referrals continue to be booked outside the require time due to chronic lack of capacity and lack of funds to increase clinician sessions.

In addition to the Trust wide issues with HIVE, some performance aspects have specifically impacted the NMGH site through the incomplete devolution from NCA services i.e. the Histopathology samples continue to be processed at the Royal Oldham laboratory, the results are sent to the MFT lab and then manually uploaded to HIVE. This not only led to ongoing avoidable delays in patient result notification and management but has also resulted in screening incidents around errors in transcribing the diagnosis from one system to another and occasional failure to upload histology results altogether with subsequent delays in patient management.

Performance Indicators for Colposcopy

KPI	Standard	Reference	ORC Values	Comment
Waiting times				See narrative above
ALL referrals	99% offered appt within 6 weeks	No. 20 No. 25	67.45%	
Low-grade dyskaryosis	99% offered appt within 6 weeks	No. 20 No. 25	63.27%	
High-grade dyskaryosis (> moderate dysk.)	93% offered appt within 2 weeks	No. 20 No. 25	86%	
Results of colposcopy visit communicated to patient	90% within 4 weeks	No. 20	80.74%	*delay in histology results being uploaded from Oldham lab
All patients to receive results within 8 weeks of attendance	100%	No. 20	96.3%	*delay in histology results being uploaded from Oldham lab/need for MDT discussion pre-communication and management
DNA rate for new patients	<15%	No. 20	5.82%	
DNA rate for return for treatment patients	<15%	No. 20	5.97%	
DNA rate for follow up patients	<15%	No. 20	4.94%	

2. Multidisciplinary team (MDT) meetings and operational meetings

The Colposcopy MDT meets once per month to ensure the timely management of difficult cases and discordant results. Currently, the MDT for NMGH and ORC are on the same Teams invite but in sequential timeslots on the same day due to logistical reasons around histopathology input from the laboratory at Royal Oldham, but once all histopathology is reported by MFT, these are anticipated to merge completely.

Attendance at MDT meetings is recorded. MDT decisions on each case are recorded in patients' HIVE records, on the laboratory IT system and in the MDT action sheet implemented by our new MDT Coordinator.

The current financial year has seen full compliance with the frequency of MDT meetings as well as attendance of all relevant staff groups; as a consequence, a longstanding QA recommendation has been finally closed.

Trust wide CSPL operational management meetings are held quarterly and attended by the CSPL team, the lead colposcopist, nurse colposcopist, colposcopy clinic coordinator, women's services business manager, lead cytopathologist, lead virologist, lead histopathologist, the laboratory management and all interested members of the team to discuss performance, staffing, audits and issues incidents. Regular Trust wide colposcopy operational meetings have also been reinstated in November 2023 and are attended by the colposcopy leadership team and admin as well as any interested clinician, the gynae operational management and governance.

3. Audits

3.1. Service user satisfaction surveys

A Trust wide Colposcopy Patient Satisfaction survey has been commenced in January 2023; the initially intended duration was 4-6 weeks, but due to very low participation this was extended to three months. The report is completed awaiting ratification by the governance department at the point of writing this report and will be presented in Autumn 2024. The as yet unpublished results suggest overall high levels of satisfaction with the service on both sites.

3.2. Cervical cancer audit

This year, the CSPL team managed to successfully clear the backlog of historic cervical cancer audit cases, which resulted in closure of the respective recommendation from the 2023 QA action plan in April 2024.

During the 12-month period between 01 April 2023 and 31 March 2024, a total of 34 patients were newly diagnosed with cervical cancer at MFT.

All cases have been registered with the National audit team. 26 of these cases have had their reviews completed or do not require a review. Eight are undergoing reviews or their files were pending MDT discussion at the point of writing this report.

Five of the 26 patients whose files are complete were eligible for and offered disclosure of the audit findings. So far, none of the patients require a Duty of Candour meeting.

Only 32% (n=11) of the patients with a new cervical cancer diagnosis participated regularly in cervical screening; 67% (n=23) had either never participated in cervical screening or were lapsed attenders. In recognition of this problem, a joint project with the Greater Manchester Screening and Immunisation team and the Cancer Commissioner is underway to share these findings with key stakeholders and targeted education projects for areas with a particularly high incidence of non-screen detected cancers.

Tumour histology: 23 (67%) of cases were squamous cell carcinoma and 8 (23%) were adenocarcinoma. Three cases were rare cancer types (1 Neuroendocrine, 1 Adenoid Basal Carcinoma, 1 Adenosquamous Carcinoma).

An overview over the screen and non-screen detected cases by tumour stage at diagnosis can be found below.

Cancer stage	Screen detected	Non-screen detected
1a1	8	5
1a2	0	1
1b1	0	0
1b2	2	1
1b3	0	2
2a	0	0
2b	1	2
3b	0	0
3c1	0	2
3c2	0	4
4	0	2
4a	0	2
4b	0	1
Not known	0	1

3.3. Other audits

Audit title	Audit Lead(s)	Audit No.	Timescale	Date completed	Outcomes/Action plan
Use of the cervical loop reporting dataset	Tom Pilkington (ORC)		Feb – Apr 2023	Dec 2023	100% in-house biopsy reports contained a fully complete dataset (36% for outsourced cases – dataset & reporting SOP forwarded)
Use of the cervical biopsy reporting dataset	Iman Borghol (Wythenshawe)		Jan – Sept 2023	Jan 2024	100% in-house biopsy reports contained dataset, 78% full complete

Audit title	Audit Lead(s)	Audit No.	Timescale	Date completed	Outcomes/Action plan
Audit to assess improvements in use of histopathology request form following modifications to Beaker	Tom Pilkington (ORC)		Sept 22 – Apr 24	Jun 2024	Improvement in correct ordering practice, from 60% in 2022 to 95% in 2024
Partial re-audit of Laboratory Failsafe (Cytology)	Steve Burrows		Sept 2023	Oct 2023	Full compliance
Re-audit of Colposcopy MDT frequency and participation	Birgit Schaefer / Liz Phillips	11173	Apr 22 – Mar 23	Dec 2023	100% compliant with frequency, 78% with participation (improved from 66%)
Audit of time to treatment of the cervix following histological confirmation of high-grade abnormality (HGCIN/HGCGIN)	Joanne Wood	10916	Apr 2023	Dec 2023	Limited assurance -42% of treatments completed within 3/52, 96 within 8/52

4. Incidents

A total of 16 screening incidents were recorded for 2023/24:

- 8 for Cytology and 1 for Virology; 6 of which were successfully closed at the time of writing this report, with the most common themes around patient identification errors, incorrect patient recall being applied by the laboratory and HPV test being reported as invalid in error
- 6 for Colposcopy, 4 of which are successfully closed; the key themes were treatment delay/incorrect treatment advice and delay in management due to outstanding histology results from external reporting agencies
- 1 for Histopathology relating to mislabelled slides leading to an unnecessary colposcopy treatment

5. Regional quality assurance site visit

All services involved in cervical screening at MFT received a formal Quality Assurance visit by SQAS/NHS England over several days in March 2023.

A total of 44 recommendations were made, of which 37 have been successfully closed at the point of writing this report (August 2024). Of the remaining seven, we expect the evidence to achieve successful closure for four of them to be submittable by October 2024; one recommendation requires the end of 2024/25 year data for completion, and the two remaining are recommendations around Histopathology staffing and caseload which are likely to remain open due to the longstanding difficult consultant staffing situation within the Histopathology department (see Item 1.2).

The full report can be found at Appendix 1.

6. Summary

The team has made outstanding progress in improving performance and quality standards, especially with regards to the specimen turnaround times in both Cytology and Histopathology. There has also been excellent progress in closing outstanding recommendations from the last Cervical Screening Quality Assurance visit in March 2023 and in resolving the backlog of the National Cervical Cancer Audit cases.

However, in 2024/25 MFT will face unprecedented challenges in mitigating the impact of the department of multiple experienced members of the team, most notably the Clinical Lead for Cytopathology, and in a background of a National shortage of these specialty areas (Cytopathology as well as Histopathology), it is especially important that the Trust focuses on creating a working environment which ensures it attracts and retains skilled and experienced staff.

Support from the senior management team is required to ensure that there is adequate administrative support for clinical processes as well as leadership roles as stipulated in the National Cervical Screening Services Specification, and that the virtual and clinical environment supports efficiency and clinical excellence in all departments.

Acknowledgement

I would like to thank and acknowledge all clinical leads and team members who supported me with their specialist expertise in the relevant sections of this report and without whom I would not have been able to collate this document.

LINKS TO REFERENCES

Cervical screening HPV testing and Cytology Services	https://www.gov.uk/government/publications/cervical-screening-laboratory-hpv-testing-and-cytology-services
Cervical screening programme and Colposcopy management	https://www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management
BAC	http:///www.britishcytology.org.uk/resources/BAC_Code_of_Practice_2015_-_2017_update.pdf
RCPath	https://www.rcpath.org/resourceLibrary/key-performance-indicators-in-pathology---recommendations-from-the-royal-college-of-pathologists-.html
No. 25	https://www.england.nhs.uk/wp-content/uploads/2017/04/Gateway-ref-07846-180913-Service-specifiction-No-25-NHS-Cervical-screening.pdf
UKNEQAS	http://www.ukneqas.org.uk/
QCMD	https://www.qcmd.org/

Abbreviations

CSPL	Cervical Screening Provider Lead
CSTD	Cervical Sample Taker Dataset
KPI	Key Performance Indicator
LBC	Liquid Based Cytology
NHS CSP	NHS Cervical Screening Programme
TAT	Turnaround Time
SQAS	Screening Quality Assurance Service

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Appendix 1

MSF CSP recommendations handover meeting 01/08/2024

Present:
MFT: Jacqueline Medlock (Cytology Laboratory Manager); Birgit Schaefer (CSPL); Miles Holbrook (Cytology Lead); Joanne Wood (Nurse Colposcopist MFT); Thomas Pilkington (Histology Lead); Sehrish Chaudhry (Lead BMS); Emma Feakes (Interim Directorate Manager, Gynaecology); Elizabeth Phillips (CSPL support); Chris Evans (BMS)

NHS GM: Pam Southcombe (SIC – GM SIT); Coral Higgins (Cancer Reform Manager)

SQAS: Emma Johnson (SQAA); Jane McFarlane (QAA); Sabina Kharam (Quality Improvement Lead SQAS – Observer); Jane Docherty (Quality Improvement Lead SQAS – Observer)

No	Recommendation	Trust progress	Evidence required	Update 01/08/2024 – SQAS notes
8	Develop and implement a sustainable plan for medical consultant cytology staffing, including succession planning and the formal appointment of a deputy for the Lead Cytopathologist	Progress 15.12.23 – of the 2 locum consultant Cytopathologists appointed, one has passed the NHS CSP CHHT and has now commenced in0house assimilation to NHS CSP reporting. Recruitment is ongoing now the CHHT results for the 2023 cohort are known to attempt to recruit any other recently successful candidates. To submit evidence to SQAS when Dr Chau receives her certificate and commences reporting	Workforce plan and confirmation of appointment of Deputy	Workforce plan in place being monitored by Commissioners, Deputy appointed. Discussed with Screening and Immunisation team (Sarah Pountain). In agreement can CLOSE Concern raised re closure by Miles Holbrook as there is not resilience within the team EJ explained that as long as the Trust workforce plan is being monitored keeping open would not provide any extra leverage CLOSURE agreed
20	Implement and monitor a sustainable plan to achieve 14-day turnaround times for cervical screening results	Progress 15.12.23: - Recruitment has completed in specimen reception - Overtime for reporting has been in force at all levels - Mutual aid from the Wolverhampton service was in force - focused approach to queue management by senior BMS	Recovery plan supported by data submission and evidence of achievement	Evidence of recovery plan seen and TATs now within target. Sustained performance since Jan 2024 – CLOSURE agreed with SIT

No	Recommendation	Trust progress	Evidence required	Update 01/08/2024 – SQAS notes
		staff and increased admin support now in place - currently TAT is within target; this needs to be sustained into Q4 **Evidence submitted 20.12.23**		
23	Implement and monitor a sustainable plan to achieve key performance indicators for turnaround times for histopathology samples in NHS Cervical Screening Programme	John Hayes is involved in this improvement plan and will report back to QA in the next week or two. The Gynae Path team has put together a business case for three additional gynae consultants with a second draft submitted to management following edits. The business case will be incorporated into improvement plan. John to submit to Emma Johnson	Recovery plan supported by data submission and evidence of achievement	Although data showing improvement in TATs – TP explained that workforce issues mean it will be difficult to maintain improvements. Urology work is being relocated at Wythenshawe from 2 urogynaecologist release 1.5PAs gynae time which should help. Advert out for gynae consultant. Consultants' concerns re capacity have been raised with senior management (J Hayes). No plans for further recruitment until analysis using RCPath point system has been undertaken. EJ and SP to pick up with John Hayes. REMAIN OPEN and handover to Commissioners
27	Make sure that all histopathologists, including locums, report a minimum of 150 specimens arising from the NHS Cervical Screening Programme (NHS CSP)	These are being monitored. This recommendation is unlikely to be closed due to a combination of part time working and cross specialty reporting. We require all our gynae pathologists to report CSP cases to allow for resilience in the rota and to maintain skill in reporting cervical histology. Of the 5 pathologists at the Oxford Road site who have been in post a full year, 3 of them met the target (of the remaining two, one reported 145 cases and the other is a previous CSP Lead with ample experience). There are no significant discrepancies in reporting profiles, and everyone is up to date with eLearning/CPD	Data submission showing number of NHS CSP specimens reported by histopathologist in the period April 2023 to March 2024	Oxford Road site achieving target with the exception of 1 pathologist, issue at Wythenshawe as not enough cases. Consultants at Wythenshawe reporting on more specialties than Oxford Road, so not have capacity to take on CSP work from Oxford Road. Update on digital reporting, technical delay to 'go-live' (date now mid-August). No date for clinical 'go-live' yet. Trust not meeting 150 thresholds for all consultants – REMAIN OPEN and handover to Commissioners. EJ suggested to consider adding this to Trust risk register

No	Recommendation	Trust progress	Evidence required	Update 01/08/2024 – SQAS notes
33	Capture data/information about individuals treated under general anaesthesia in theatre and document a failsafe process for results	Solution developed within the HIVE weekly progress meetings. Not captured until recorded on outpatient procedure form. The service has weekly meetings and did get further last Monday with this. No further update. **Provide update by 29.02.24**. Form agreed and in build, awaiting confirmation of this to be in the 'live' HIVE environment	Standard operating procedure and confirmation of that treatments under general anaesthesia are recorded in KC65 data return	Theatres – no link to KC65 on HIVE for LETZ (only colposcopy). No failsafe in theatre. REMAIN OPEN and handover to Commissioners
37	Implement a process to accurately capture data on patients that do not attend (DNA) their colposcopy appointment and undertake a DNA audit	EF working on data compiled and audit in initial draft	Standard operating procedures and DNA audit	Audit almost complete – will send to SQAS for review tomorrow (02.08.24) then to CLOSE in agreement with SIT via email POST MEETING: draft audit shared with SQAS. SQAS awaiting final version
40	Ensure that all Colposcopists see a minimum of 50 new NHS Cervical Screening Programme (NHS CSP) referrals a year	Quarterly checks re compliance with caseload. PPC prioritising and clinicians making adjustments. Spreadsheets implemented which is updated monthly to monitor	Data submission showing number of new NHS CSP referrals for each colposcopist in the period Apr 2023 – Mar 2024	Regular updates on new referrals being shared with individual clinicians but for some meeting threshold is impacted by other clinical activity. REMAIN OPEN and handover to Commissioners
41	Audit outcomes of individuals conservatively managed for CIN2	Audit in progress – MS	Audit results and action plan	Audit not yet complete – has now been handed over as audit lead on leave. EJ will contact Trust in 2 weeks for update. Will handover if still incomplete at this point
44	Make sure that colposcopy patient survey results are available by colposcopy unit and that action plans are completed	Started this week 02.01.24 – to be shared with Lisa at NMGH for circulation	Patient survey results and completed action plan	Audit not yet complete – has now been handed over as audit lead on leave. EJ will contact Trust in 2 weeks for update. Will handover if still incomplete at this point

Manchester University NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Maternity Survey Results, 2024	**Agenda Item 11.3**
Presented by:	Kimberley Salmon-Jamieson, Chief Nursing Officer	
Prepared by:	Emma Dodd, Assistant Chief Nurse for Quality & Patient Experience	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee 18th December 2024	
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider

The Maternity Survey Care is an annual survey focusing on the experiences of patients who have accessed Maternity Services between 18th April-18th July 2024.

- Antenatal care was positive with 98% of respondents having enough time to ask questions, felt listened to by the midwives and treated with dignity and respect.
- 92% of respondents were offered a choice on where to have the baby which is 8% above the national average.
- During inpatient stay and labour 98% of respondents said staff introduced themselves and were spoken to in a way they could understand. SMH achieved below the national average in this section in relation to partners or companions being involved scoring 91% (3% lower than national average).
- In the post-natal period, respondents felt they were treated with kindness and understanding scoring 93%. The only section below national average relates to partners being able to stay at 41%.
- The response rate for the survey was 33% (with patients aged 31-35 years old making up 42% of respondents, 57% of respondents identified as white British with 37% from other ethnic groups.
- MFT have not been identified as an outlier in comparison with national results.

Recommendation(s)

The Board of Directors are asked to:

- Support the ongoing workstreams to improve patient care and experience and have oversight of the issues highlighted at Clinical Group level.
- Note the Chief Executive and Director of Nursing and Midwifery for Specialist Hospitals to share the results with the Senior Leadership team to develop action plans which will form part of the AOF review.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: •	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • CQC regulation 9: Person centred care • CQC regulation 14: Meeting nutritional and hydration needs	

Main report

The National Maternity Survey is an annual survey developed by the CQC and considers experience of adults over the age of 16 who have accessed Maternity Service between 1st- 29th February 2024 (sample period) with fieldwork (surveys) being sent between 1st May and 31st August 2024.

The CQC use the results build an understanding of risk and quality of services. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, the CQC use the results alongside other sources of people's experience data to inform targeted assessment activities[1]

[1] https://www.cqc.org.uk/publications/surveys/maternity-survey

Maternity Survey Results

Overview

Maternity services based at St Mary's, Wythenshawe Hospital and North Manchester Hospital were included in the survey. A total of 1184 people eligible to respond with a response rate of 33% (3) which is a decrease of 5% in responses from the previous year and 7% lower than the national average.

Image 1 highlights improvement and areas where scores have declined in comparison to the previous 2023 survey. Of note there were improvements in relation to patients care during labour and birth, being involved in discussions and feeling listened to. The most declined areas relate to the general theme of communication with midwives and medical staff.

Most improved scores	Trust 2024	Trust 2023
C12. Felt concerns were taken seriously (during labour and birth)	83%	77%
F18. Felt GP talked enough about mental health during postnatal check-up	77%	71%
C5. Involved enough in decision to be induced	89%	85%
C4. Given information / advice on risks of induced labour	73%	69%
C11. Not left alone when worried (during labour and birth)	74%	69%

Most declined scores	Trust 2024	Trust 2023
F5. Felt midwives aware of medical history (postnatal)	73%	78%
B6. Felt midwives or doctor aware of medical history (antenatal)	85%	89%
D3. Able to get help when needed (after the birth)	86%	90%
D4. Given enough information (in hospital after birth)	85%	89%
D5. Treated with kindness and understanding (in hospital after birth)	93%	96%

Image 1: Maternity Services improved and declined scores in comparison to 20223 results

Between the sampling period of April-July St Mary's Managed Clinical Service maternity division (SM MCS) received 31 complaints in relation to the top three themes of communication, clinical assessments and treatment & procedures in keeping with the results. SM MCS has an overarching Patient Experience Action Plan which captures feedback from complaints, FFT, WMTM, CQC Maternity Survey and Patient Surveys to ensure SM MCS implements women led changes throughout the service.

Quality Improvement work has included:

- Improving the information available to women to support informed choice and management of expectations surrounding the Induction of Labour pathway.
- Introduction of planned work forward view meetings and daily acuity & flow meetings has helped to reduce waiting times on elective pathways throughout the service
- A new initiative called 'Gone in One' has enabled focussed work on analgesia in the postnatal period by ensuring staff revisit the effectiveness of pain relief provided within one hour following administration
- Improved staffing models and focussed work on Maternity Triage pathways has helped to reduce waiting times for all women.
- Specialist training for maternity staff focussing on personalised care plans and listening women and families throughout the staff induction period and focussed sessions for existing staff has re-highlighted the importance of listening to women.

Antenatal Care

Overall patient's fed back that during the antenatal period they felt listened to by midwives and had enough time to ask questions, scoring above the national average at 98%. Maternity services also scored 7% above the national average in relation to patients being offered a choice of where to have their baby scoring 92%. MFT met the national average (95%) in relation to being asked about their mental health needs and scored 85% for being given enough support, slightly below the national average of 88%. Nationally more women felt they were asked about their mental health during antenatal check-ups (76% said they were 'definitely' asked compared with 75% in 2023). There has been steady improvement seen in this question area over the past five years.

SM MCS have embedded Perinatal Mental Health Teams across the service which includes a lead consultant and Band 7 Specialist Midwives who lead a team of band 6 specialist midwives to deliver a robust service.
Hive supports midwives to ensure that all women are asked about their mental health during booking for pregnancy care and each subsequent antenatal contact. Mental Health Personalised Care Plans support all healthcare professionals to be informed of any woman's mental health history and requirements to support open discussion at each pregnancy contact. Implementation of PMH red flags utilised on Hive continues to support appropriate sharing of information between clinicians.

When analysed by hospital site in relation to patients being offered a choice of where to have their baby only North Manchester fell below the average Trust score at 86% however this remains 2% above the national average. Of note in relation to having enough time to ask questions and being listened to NMGH scored the highest at 100%.
Patients feeling that their midwives or doctors were aware of their past medical history was one of the most declined scores (85%) in comparison to 2023 (89%), this is compared to a national average of 87%, of note SM MCS achieved above the Trust and national average scoring 89%. Despite the top 5 declined scores relating to communication all maternity services across the hospital sites achieved above 98% in relation to patients being spoken to in a way they can understand and above 96% for being involved in their care.SM MCS ensure system wide learning across maternity services through IQP projects spanning across the services.

MFT met the national average in relation to having confidence and trust in staff at 95% at notably high at Wythenshawe at 98%. This is reflected relation to being treated with dignity and respect with Wythenshawe achieving 99% and SM Oxford Road (SM ORC) meeting the national average of 98%.

Image 2 highlights the areas requiring improvement focused on which areas should be prioritised and managed closely. The areas identified as requiring prioritisation are in relation to mental health support (95%) antenatally despite meeting the national average and to also focus on patients being spoken to in a way they can understand which achieved 1% less than the national average of 99%, as identified above workstreams are already underway to address these.
Three elements were identified as requiring close management these relate to giving enough information about where to have the baby (78% against a national average of 82%), midwives and doctors being aware of past medical history (85%) and parents being provided with relevant feeding formation (81% against a national average of 84%).

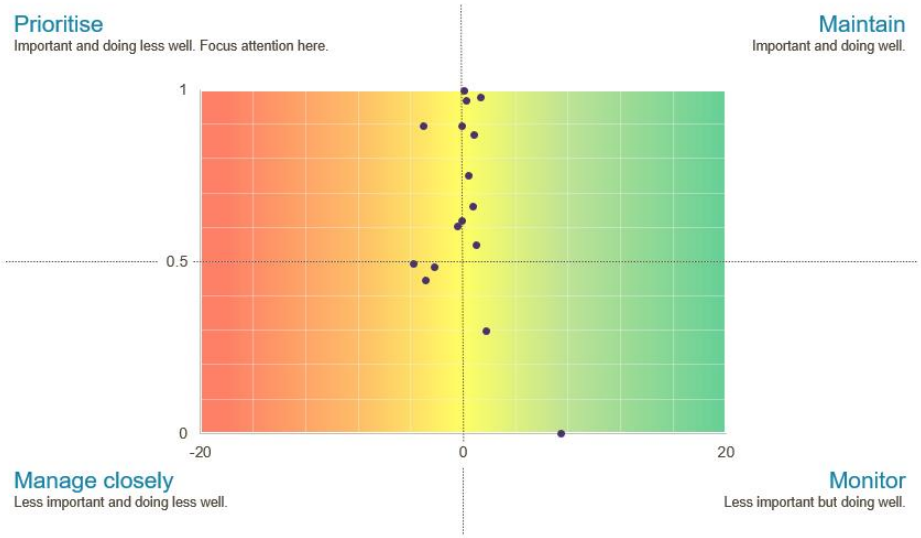


Image 2: Antenatal Improvement Map

Labour and Birth of Your Baby

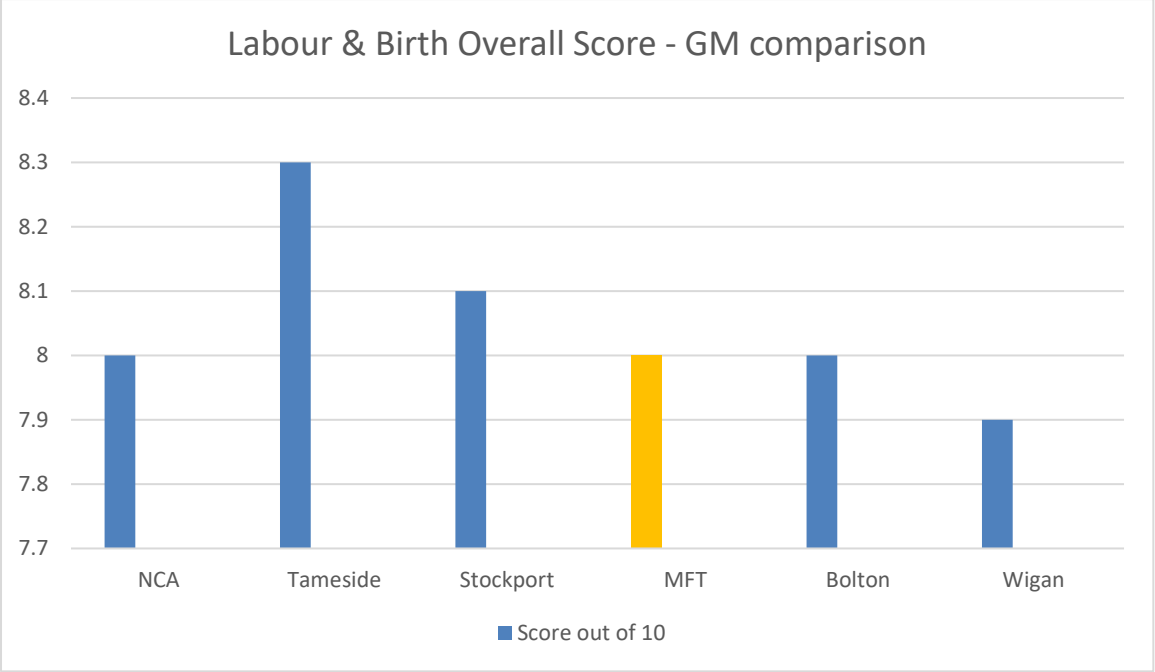
A total of 18 questions were asked in this section, MFT scored above the national average in relation to concerns being taken seriously (83%), professionals did everything they could to manage pain (87%) and the ability to get help when needed 95%. The question with the most consistent score across all 3 sites related to patients being able to get help when needed during birth and labour scoring 95% overall and all 2 sites were within 1% of this all meeting or scoring above the national average of 94%.

The only questions which scored 'lower than expected' was in relation to partner/companion being involved in birth, scoring 91% which is 3% lower than the national average. When analysed by site NMGH met the national average of 94% with the lowest scoring site being SM ORC at 89%.

SM MCS is working collaboratively with Dad Matters, a UK based charity championing the emotional safety and well being of fathers and their families. Following a protracted gap in provision during and following Covid, SM MCS have encouraged re-engagement with Dad Matters to be visible on each of the sites to encourage families to access support.

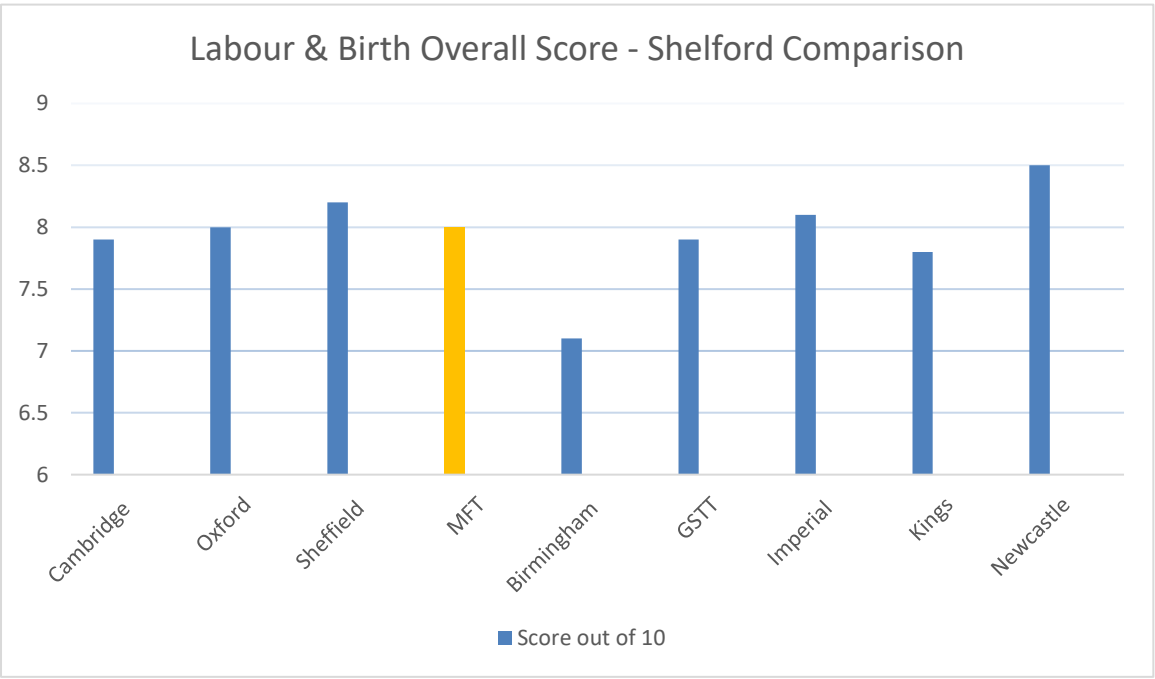
SM MCS have piloted a new 24 hour visiting policy for birth partners (described in full below), supporting birth partner engagement in all aspects of the care provided.

Work described above relating to personalised care plans and listening women and families emphasises inclusion of the whole family.



Graph 1: Overall score GM comparison

Graph 1 provides a comparison to other GM Trusts for the whole of this section**.** MFT scored positively in comparison to other GM Trust on question C6 – being given appropriate advice and support at the start of labour (83%) with only Stockport scoring similar. MFT scored lower than NCA, Stockport and Bolton in relation to partners and companion being involved during labour and birth.

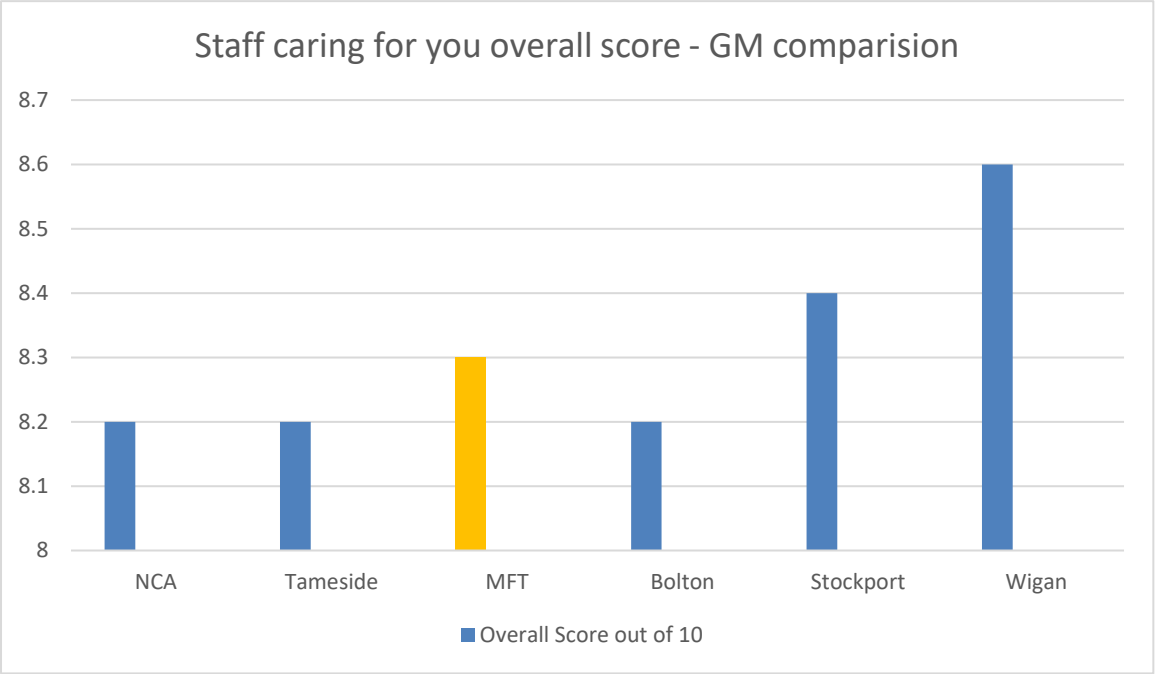


Graph 2: Shelford Comparison * No UCL data available for this section

<u>Staff Caring for You during labour and birth</u>

Overall, MFT were above the national average relating to being treated with dignity and respect (97%) and having the ability to ask questions afterwards about labour and birth (76%), scoring 1% above average respectively. Maternity services also met the national average for being treated with kindness and compassion (97%) and having confidence and trust in staff (95%).

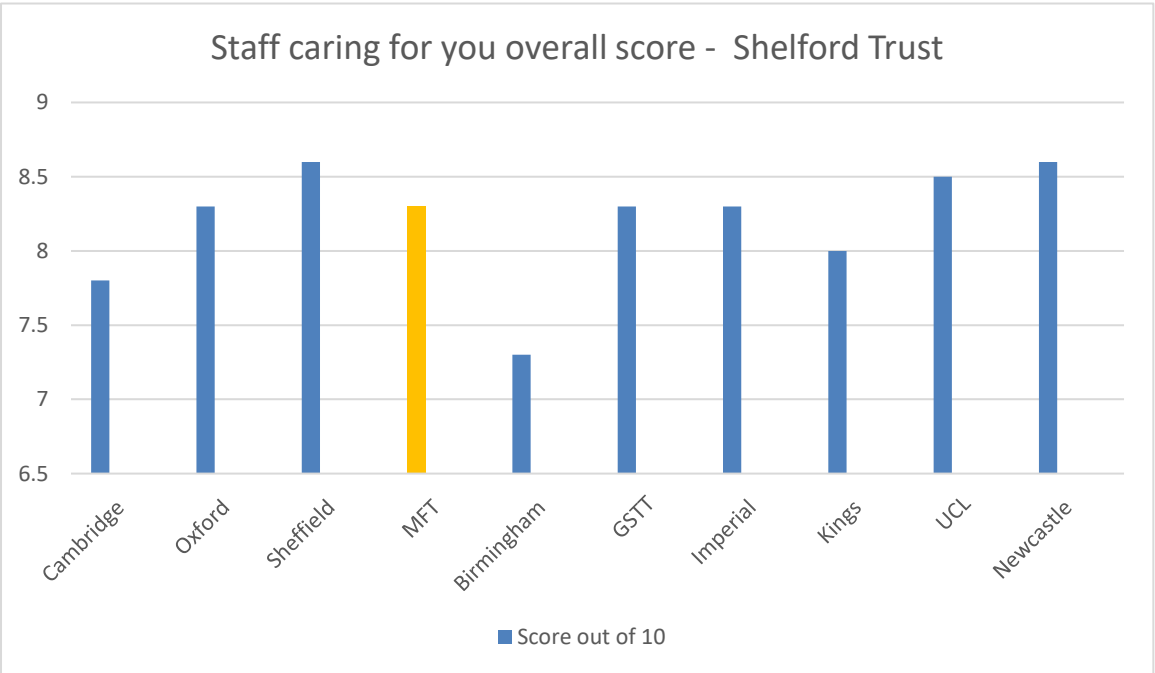
MFT scored 92% for midwives and doctors working well together during labour again a national average of 93%, Wythenshawe was the only site to meet the average. Overall MFT scored 97% in relation to patients being spoken to in a way they could understand with SMH ORC and Wythenshawe achieving over this and meeting the national average of 98%.



Graph 3: GM comparison

Graph 3 shows Wigan achieving above other GM Trusts for this section. Wigan scored notably high in relation to patients not being left alone when worried, clear communication and attention during labour.

Graph 4 shows the comparison against other Shelford Trusts, with only Sheffield, UCL and Newcastle's overall care score above MFT.



Graph 4: Shelford Trust comparison

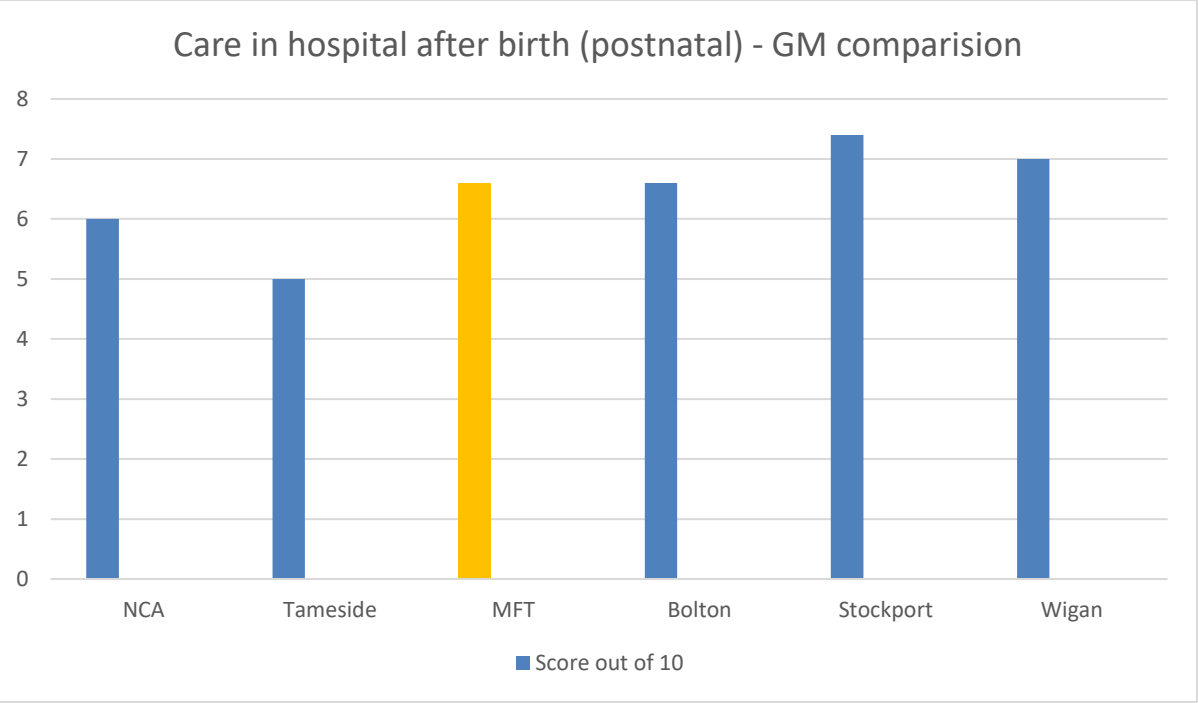
Care in Hospital After Birth (Postnatal)

MFT scored 66% regarding patients being discharged without delay, this is 8% above the national average, notably NMGH scored significantly higher at 77%. MFT were the highest scoring in GM and across Shelford for this question. When compared to antenatally, MFT scored 3% above the national average on midwives asking about post-natal mental health at 96%. Positive scores meeting or above the national average were met by all three sites for all postnatal mental health questions.

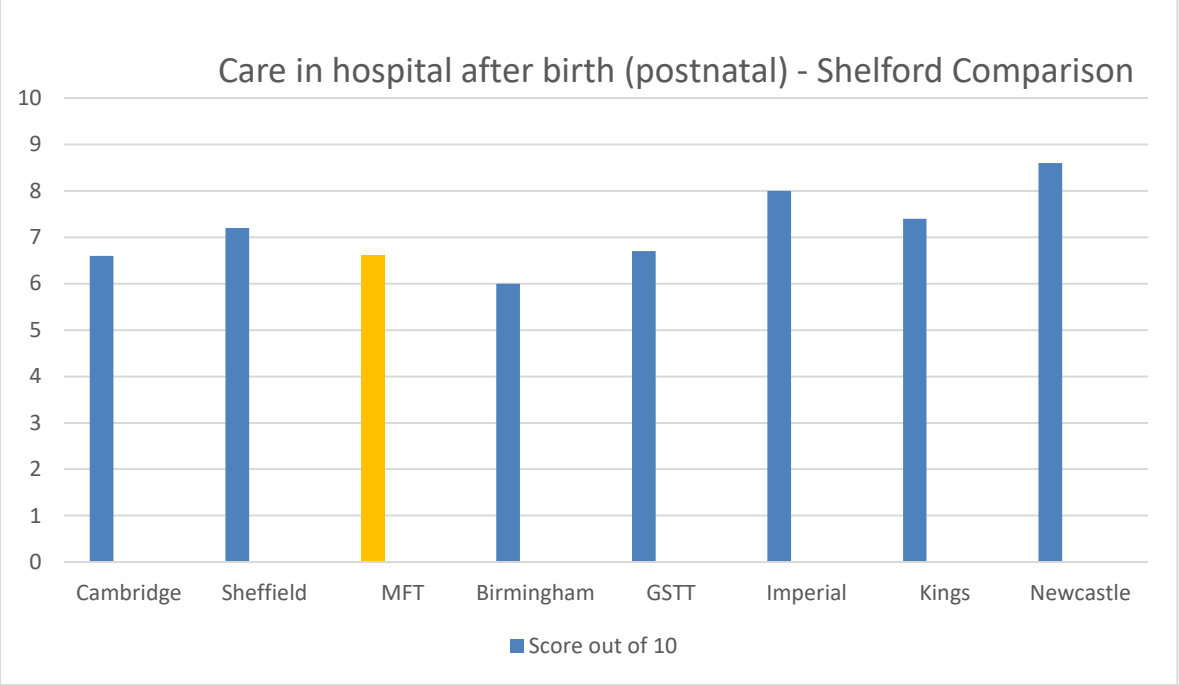
The national average was met in relation to being treated with kindness and understanding after birth (93%) and feeling that decisions on how to feed their baby were respected by midwives scoring 95%.
SM MCS works hard to ensure women are supported to make informed decisions about how they choose to feed their baby. SM MCS has a dedicated Infant Feeding Team who are available to support women whilst inpatients and provide postnatal specialist 1:1 support where required. All healthcare professionals complete regular mandatory training updates to ensure the advice they provide is appropriate and evidence based.
To further improve the service SM MCS provides, Maternity and Newborn Services are in the process of achieving Baby Friendly Initiative Accreditation in line with the NHS 3 year plan.

MFT scored 'lower than expected' at 41% for partners being able to stay in hospital as long as they wanted after birth, this is against the national average of 67%. The service also scored low in relation to seeing the midwife as much as they wanted postnatally. In June 2024 following collaboration with the Maternity Neonatal Voice Partnership Chairs, SM MCS piloted 24hour open visiting for one birth partner within all areas of maternity. The overarching feedback from this pilot was very positive, SM MCS is currently collating the feedback into the new visiting model to ensure the final version is representative of the woman's voice.

Graph 5 shows the overall results for postnatal care across GM. Stockport achieved the highest score in GM, on review they scored high in relation to attention after birth and partners length of stay.



Graph 5: GM comparison



Graph 6: Shelford Comparison *To note no data available for UCL or Oxford for this section of the survey

Image 3 highlights the areas requiring improvement during labour and postnatally. The areas requiring prioritisation include the themes of sharing of information and providing advice to patients, being able to get help when required and partner/companion support during birth and postnatally as highlighted above. Only two areas were recommended to manage closely this relation to being sent home when worried (89%) and not being left alone during labour and birth (74).

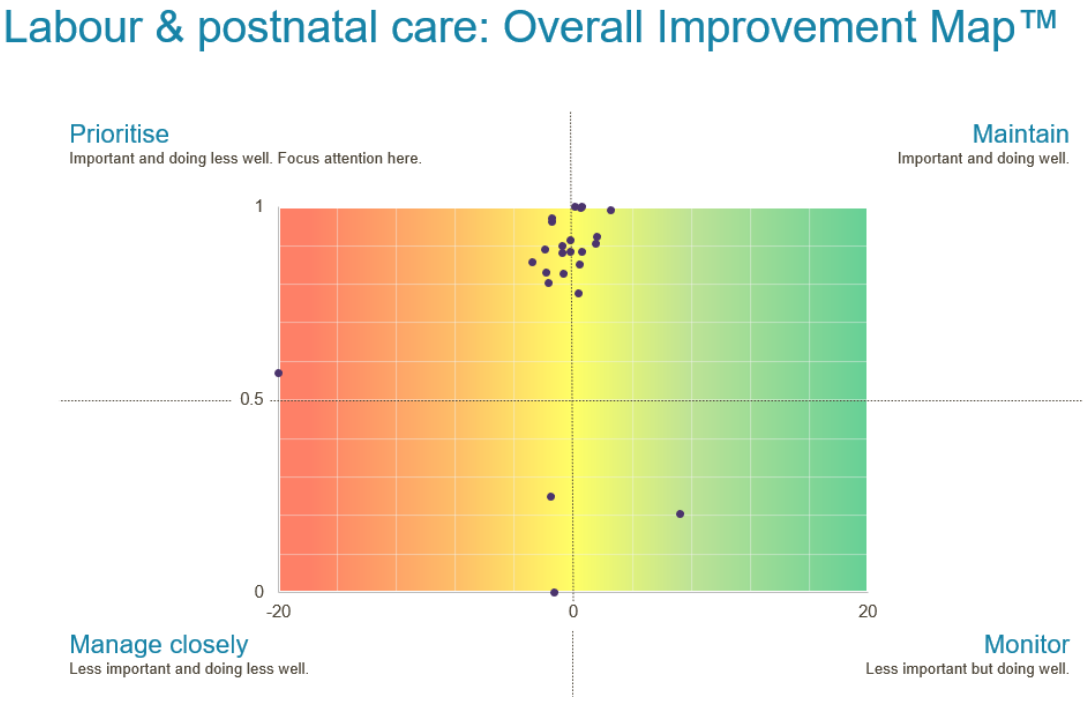


Image 3: Overall Improvement map for labour and postnatal care

Summary

This report provides an overview of patient experiences in MFTs Maternity Services. The report highlights areas requiring improvement and demonstrates the work already ongoing to continually improve patient experience.

Next Steps

- Report shared with the Senior Leadership Team in the Specialist Hospital.
- The Director of Nursing and Midwifery to develop action plan and identify opportunities for maternity system wide learning.
- The Director of Nursing and Midwifery will contact Shelford hospitals with high scores to identify improvement workstreams as learning opportunity.
- SM MCS Patient Experience team will develop and action plan in response to the survey. The action plans are updated monthly, tracking progress of actions and adding any new areas for improvement.
- Action plans are presented and monitored through Maternity Divisional Quality & Harm Free Care Committee.
- Additionally, actions from this most recent CQC Maternity Survey will be tracked through the Maternity Operational Delivery Group chaired by the Director of Nursing & Midwifery.

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Urgent and Emergency Care National Survey Results, 2024	**Agenda Item 11.4**
Presented by:	Kimberley Salmon-Jamieson, Chief Nursing Officer	
Prepared by:	Emma Dodd, Assistant Chief Nurse for Quality & Patient Experience	

Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee 18th December 2024
Purpose of the paper Please check **one** box only:	☐ For approval ☒ For support ☒ For discussion

Executive summary / key messages for the meeting to consider

This report provides a detailed analysis of the results of the National Urgent and Emergency Care survey against regional, national and Shelford group benchmarking, intelligence from these reports have been shared to support the existing Urgent and Emergency care (UEC) workstreams and identify further areas for improvement plans to strengthen the quality of care.

The National Urgent and Emergency Care is a bi-annual survey focusing on the experiences of patients who have accessed and Emergency Department or Urgent Care Centre between 18th April-18th July 2024.

- Nationally results from this survey show people are having poor experiences of urgent and emergency care services. This applies more so for people using Accident & Emergency (A&E) services, with Urgent Treatment Centre (UTC) patients generally reporting a more positive experience.
- The Trust scored above the national average for dignity and respect in both the Emergency Department and Urgent Care Centres.
- It is recognised that the Trust scores lower than national average in relation to pain management and food in drink in both A&E and urgent care departments. These scores align with the results of the National Adult Inpatient Survey and Internal patient feedback through What Matters To Me (WMTM).
- The response rate for both sections of the survey is below 25%, although improved from the 2022 survey, this does not provide an accurate overview of the experience of most patients attending these departments.

Recommendation(s)

The Board of Directors are asked to:

- Note the report has been shared at the Urgent and Emergency Care Task and Finish Group and Trust Leadership Team Committee.

- Note that the QS&PCB are receiving updates and progress reports via the Quality and Safety Management Committee.
- Note the Chief Executives have shared results with clinical group SLTs to develop action plans which will form part of AOF reviews.
- Support the suggested next steps and ongoing workstreams to improve patient care and experience with oversight of the issues highlighted at Clinical Group level.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☒
HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • n/a	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • CQC assessment for core services: Urgent and Emergency services. • CQC regulation 9: Person centred-care • CQC regulation 14: Meeting nutritional and hydration needs	

Main report

The National Urgent and Emergency Care Survey is a bi-annual survey developed by the CQC and considers experience of adults over the age of 16 who have accessed an Emergency Department or Urgent Care Centre between 18th April-18th July 2024.
The CQC made changes to 30 questions from the 2022 survey therefore previous comparison are not available for all responses.

The report is divided into two sections:

- Type 1 - Accident & Emergency Departments
- Type 2 - Urgent Care Centre and Minor Injury Centres.

Emergency Department Results

Manchester Royal Infirmary, North Manchester Hospital and Wythenshawe Hospital were all included in the survey. A total of 55 questions were asked, with 913 people eligible to respond with a response rate of 24% (216) which is an increase of 8% from the previous year, however lower than the national average of 30%. Of the 55 questions asked only 31 of the questions received enough responses to be scored.

Image 1 highlight improvement and areas where scores have declined in comparison to the previous 2022 survey. Of note there was significant improvement of 23% in relation to patient being able to get help with their condition and symptoms and improvement in relation to follow up care. The most declined areas are in relation to discussions of tests required and the results.

Most improved scores	Trust 2024	Trust 2022
Q15. Able to get help with your condition or symptoms from a member of staff	52%	29%
Q32. Able to get food and drink while in A&E	68%	53%
Q40. Staff discussed potential further care	73%	60%
Q39. Told who to contact if worried	88%	78%
Q10. Enough privacy when discussing condition with receptionist	89%	84%

Most declined scores	Trust 2024	Trust 2022
Q29. Understood results of tests	80%	90%
Q28. Understood why tests were needed	88%	92%
Q20. Doctor or nurse discussed anxieties or fears about condition or treatment	73%	77%
Q25. Given enough privacy when being examined or treated	96%	99%
Q21. Had confidence and trust in the doctors and nurses	91%	94%

Image 1: Emergency Department improved and declined score in comparison to 2022 results

Image 2 shows MFT's overall ranking compared to other hospitals nationally with A&E departments.

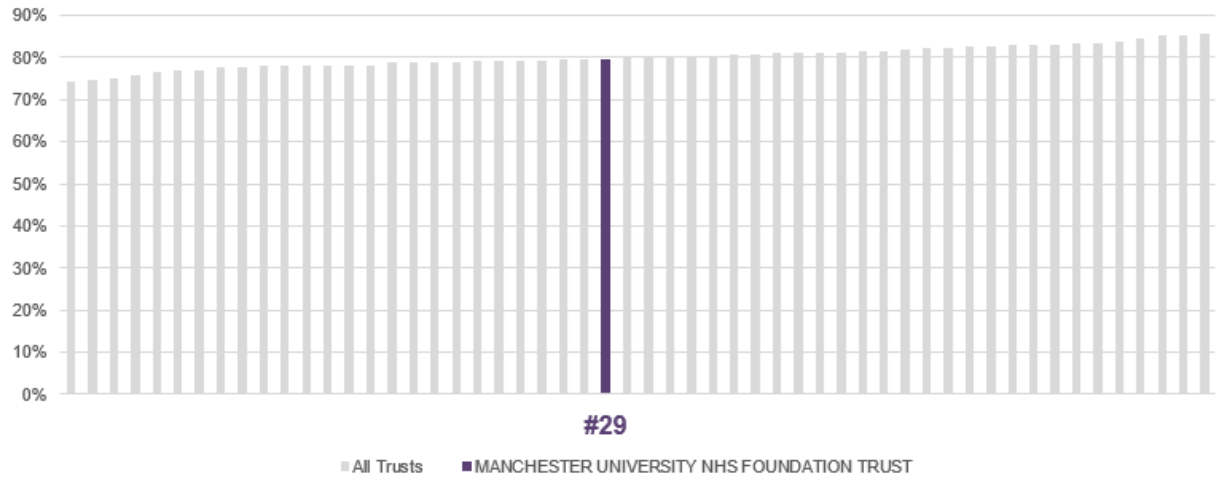


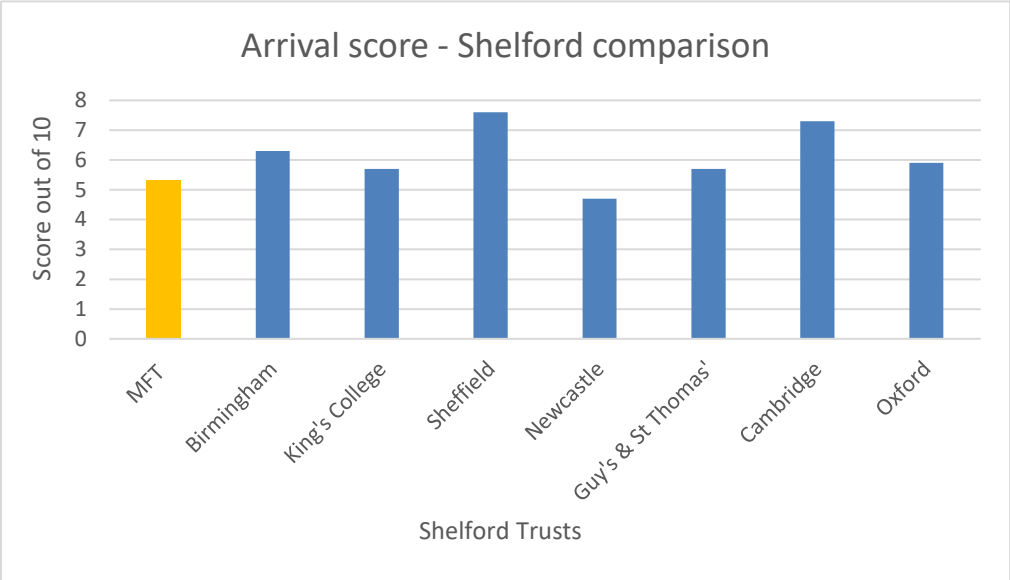
Image 2: MFT ranking compared to NHS Trusts with Type 1 A&E department

Arrival

Arrival looked at communication with patients who were waiting with an ambulance crew, ensuring they have had the reason for delays explained. MFT scored 5.3, limited comparison to GM Trusts is available due to lack of responses for NCA, Tameside and Bolton however MFT scored above Stockport (5.1) and Wigan (5.0).

In comparison to Shelford Trusts MFT's score was average with Sheffield and Cambridge being the only Trust's achieving a score above 7. No data is available for UCL or Newcastle for this section.

Nationally 61% of patients reported ambulance handovers within 15 minutes, 23% waited between 16 minutes to 1 hour and 17% waited more than 1 hour. The Urgent and Emergency Care task and finish group led by the Chief Nursing Officer has a workstream focused on accelerated admissions to improve consistency and oversight, this includes the use of escalation spaces to improve efficiencies when patients arrive at the department.



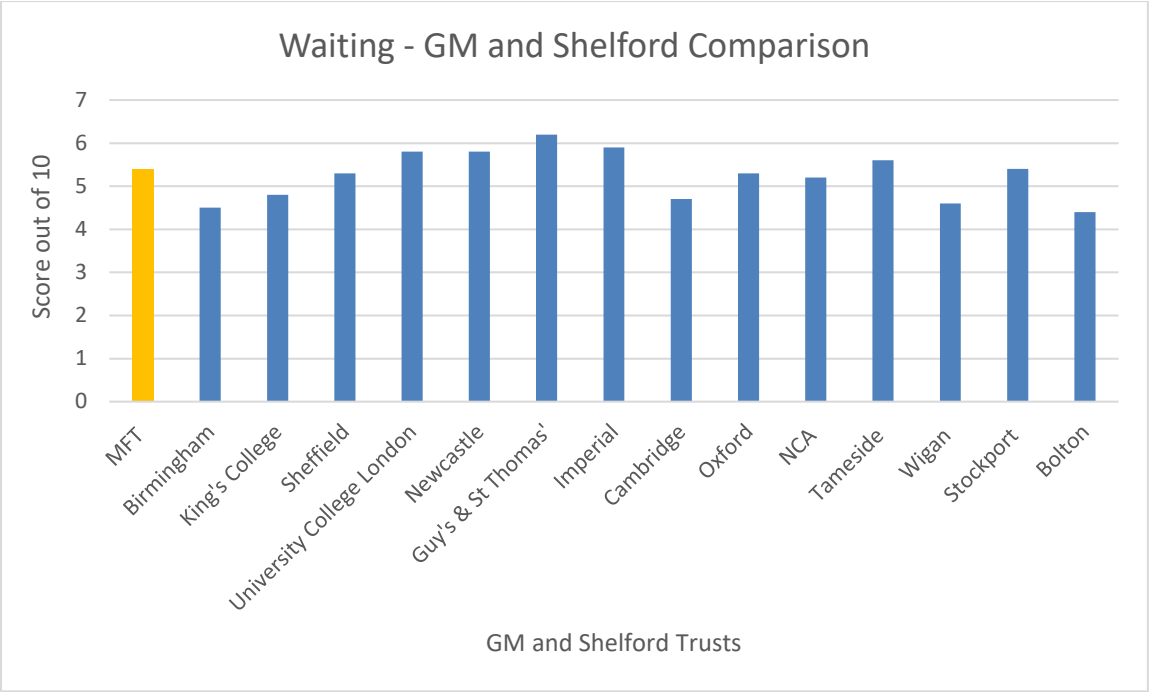
Graph 1: Shelford Comparison Arrival to hospital

Waiting Times & Privacy

MFT scored 5.4 overall for the 4 questions in this section. The highest score is 9.1 for patients being informed what would happen next after the first assessment, meeting the national average, this was also met in relation to patients being informed about waiting time (3.0), being kept updated (4.3) and help from staff whilst waiting (5.3).

When analysed by site MRI scored above the national average with 9.5. Wythenshawe scored 'somewhat worse than expected' with 8.7. Wythenshawe introduced an improvement project in June 2024 to improve waiting times. Following a review, the Triage Team staffing was rearranged to support peak times with the shift time changed to 10.00 – 18.00. the change has reduced the Triage time from 19 minutes to 15 minutes or below, in keeping with national targets. In addition, the introduction of a streaming Nursing Assistant role has reduced waiting time and improved patient flow and patient communication.
North Manchester have introduced Emergency Department (A&E) Trackers. Their role is to monitor the flow of patients through the department, ensuring that patients are in the correct waiting area which also provides an opportunity to update patients on waiting times and answer any queries.

MFT scored the second highest in GM with only Tameside scoring 0.2 above and similar to Shelford Trusts'.

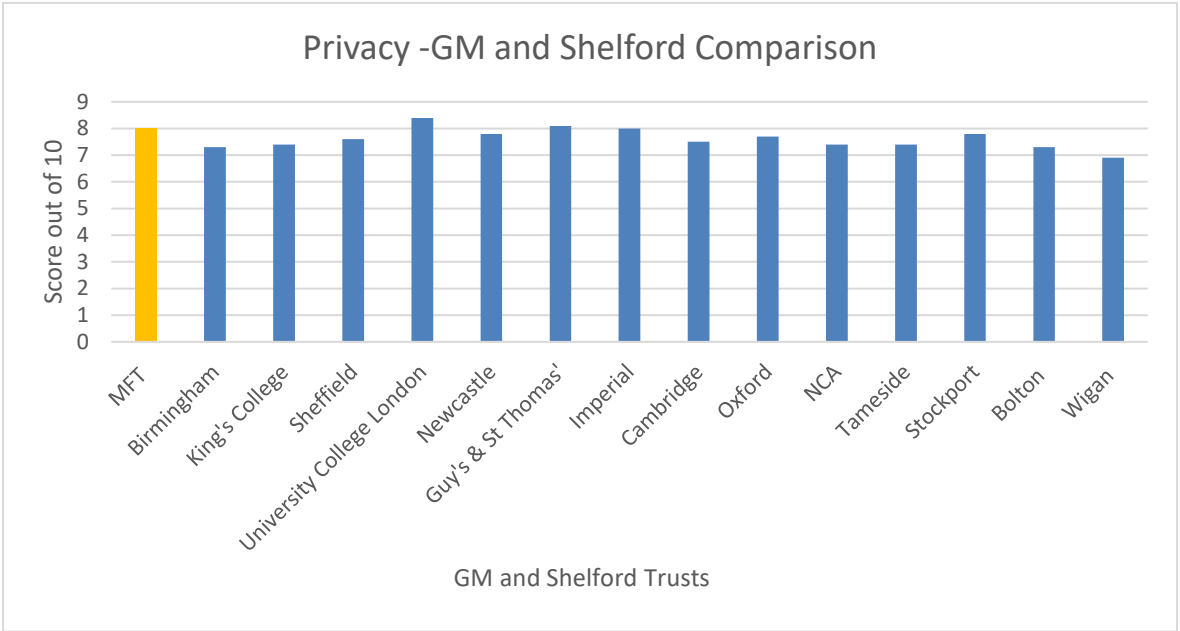


Graph 2: Waiting comparison

Privacy

MFT scored above the national average for this section for both questions, with an overall score of 8.0. These questions related to being given enough privacy when discussing their condition with the receptionist (7.3) and being given enough privacy when being examined or treated (8.7). When analysed by site, all three departments scored above the national average, with NMGH notably performing 'better than expected' regarding patients being given enough privacy when being examined or treated (8.9).

In comparison to GM and Shelford only University College London scored above MFT by 0.1.



Graph 3: Privacy GM and Shelford Comparison

Doctors & Nurses

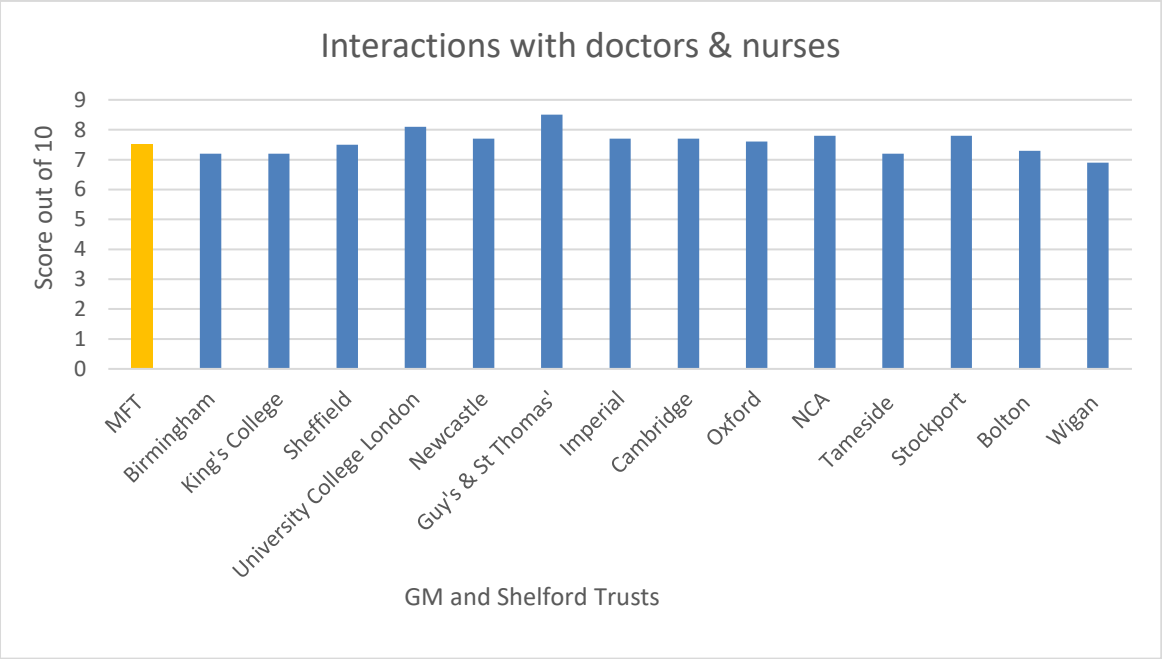
Overall MFT scored 7.5 for this section and above the national average in key questions related to patient care. These included explaining the patient's condition and treatment in a way that was easily understood (7.7), actively listening to what patients had to say (8.5), and ensuring

that family members, friends, or carers had enough opportunity to talk to a doctor or nurse (7.3). Additionally, MFT met the national average for providing enough time to discuss the patient's condition and treatment (7.7).

MFT scored lower than the national average for 2 questions relating to discussing anxieties and fears about the patient's condition or treatment, with a score of 6.0, which is 0.1 below the national average, and having confidence and trust in the doctors and nurses examining and treating the patient, with a score of 7.9, which is 0.2 below the national average.

When analysed by site, NMGH and Wythenshawe scored above the national average of 6.1 in relation to discussing anxieties and fears, with the lowest scoring site being MRI at 5.5. In terms of having confidence and trust in the doctors and nurses, Wythenshawe had the lowest score at 7.6.

In comparison to GM and Shelford Trusts, MFT received a similar overall score with UCL (8.1), GSST (8.5), NCA (7.8) and Stockport (7.8) scoring above.

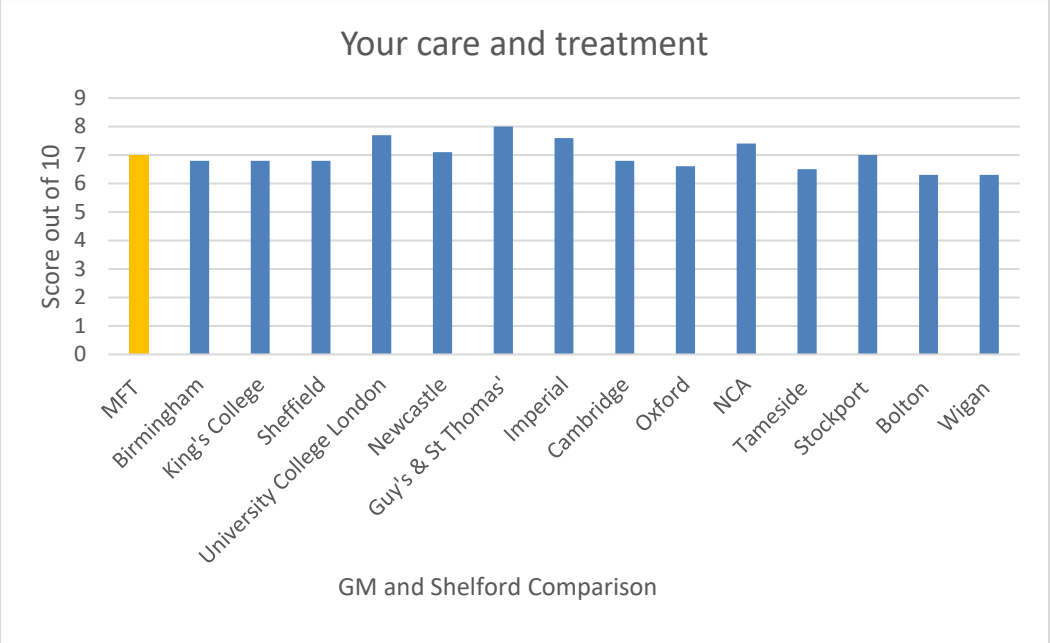


Graph 3: GM and Shelford comparison – Doctors and Nurses

Your care, treatment and tests

MFT scored 7.0 for Care and Treatment and 7.3 relating to communication about tests, these scores are similar to the national average. A total of five questions were asked in these sections, with MFT scoring above the national average in two areas. These areas were helping patients with taking medication for pre-existing conditions (7.5) and involving patients in decisions about their care and treatment (8.0). The national average was met for involving patients in decisions about their care and treatment (8.0) with North Manchester scoring 'better than expected' for this question at 8.4, although MRI scored the lowest at 7.5 this is still marginally above the national average.

MFT scored below the national average 5.4 regarding hospital staff helping to control patients' pain, this is reflective of the patient experience data in the Adult Inpatient Survey and What Matters to Me data. As part of the action plan from the inpatient survey several workstreams have been developed to address this, of significance for A&E departments are the development of dashboard for risk assessments, which highlighted when patients pain has been assessed and flags to the senior nurse in charge when a patients pain re-assessment is overdue or outstanding.

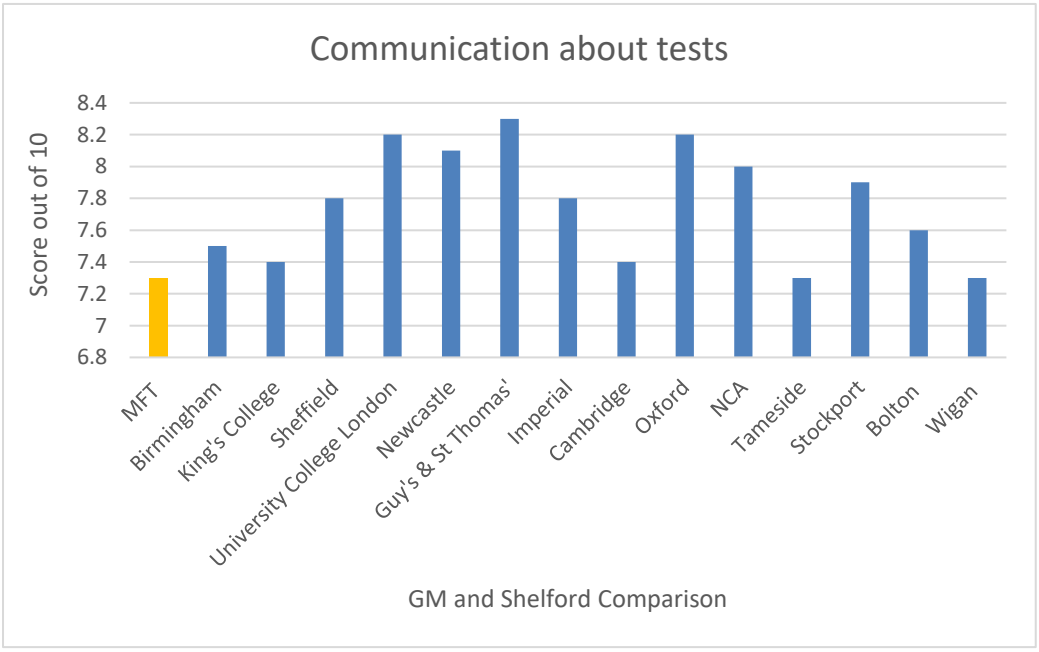


Graph 4: GM and Shelford comparison about care and treatment

Overall, MFT scored below the national average at 7.3 in relation to communication about tests. MFT received a score of 7.7 for staff explaining to patients why they needed tests in a way they could understand, which is 0.2 below the national average. Notably, Wythenshawe scored higher at 8.0 and MRI scored the lowest at 7.1.
The current process at MRI is that all results are discussed with the patient by the clinician. However, if a patient leaves the department prior to formal discharge, the clinician refers for follow-up in the community or advises the patient to return to the department.

MFT scored 6.9 for staff explaining the results of tests in a way that patients could understand before leaving A&E, which is below the national average of 7.5. Notably, MRI and Wythenshawe both scored 6.8, while NMGH achieved the highest score at 7.6.

In comparison to GM, MFT scored the same as Tameside and Wigan at 7.3 and the lowest across the Shelford Trusts for this section.



Graph 5: GM and Shelford comparison - Tests

Hospital Environment and Facilities

Only 2 questions were asked in relation to the environment with an overall score of 6.4. The 2 questions in this section looked at patients feeling safe around other patients or visitors with MFT scoring 0.5, which is 0.3 below the national average. When compared by site North Manchester met the national average, achieving a score of 8.0. In contrast, MRI recorded the lowest score by site, at 6.9, indicating room for improvement when compared to both the national average and other sites within MFT.

MRI are undergoing rebuild (Project RED) and is currently operating in a footprint which is over an expansive segregated space, staff are present in the department to communicate with patients and a trial has been commenced with security staff to have body worn cameras to protect staff and patients. Areas within the department have applied for and been successful at Small Change Big Difference (SCBD) to improve the environment of Mental Health and LD areas to ensure patients feel safe.

The second question which scored the lowest and worse than expected was in relation to being able to get food or drinks whilst in A&E, scoring 5.2 which is 1.0 lower than the national average. When analysed by site NMGH was the highest scoring site at 5.4 with the lowest scoring site being MRI at 4.9. This is reflective of the findings of the national adult inpatient survey and a Food and Drink steering group has been developed to ensure a key focus on this workstream to look to improve access and facilities relating to food and drink across the organisation.

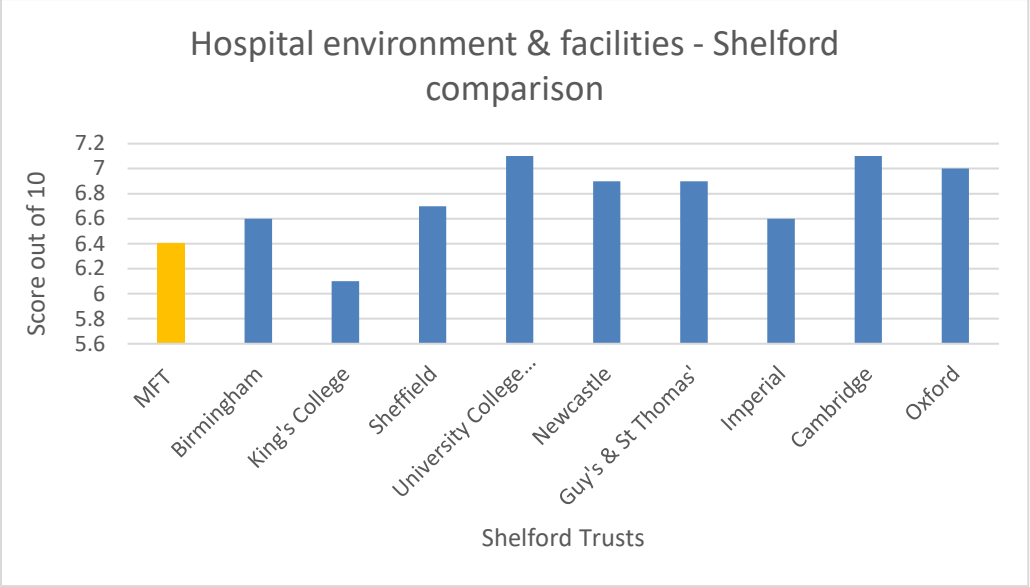
The NMGH Divisional Lead for Nutrition and Hydration is the ED Matron, and they are an active member of the Nutrition and Hydration Delivery Group together with 4 champions in the department. The team are working on the following improvement projects:

- Development of the Housekeeper and Nursing Assistant roles to include regular drinks rounds during the day and night. Hydration stations are available throughout the department.
- A dedicated kitchen area has been implemented which also has a stock of cereals and condiments.
- Snack boxes and chips are available on request, with a progression of work to provide soup and gravy (gravy requested by patients).
- WMTM has seen a consistently high score of 96% and above when asked if offered enough to drink and FFT showing a steady decrease in negative comments in comments regarding food and drink since summer 2024 and an increase in positive comments.

In MRI, the Department Housekeeper conducts walk rounds to offer tea/coffee and toast early/mid morning. Sandwiches and meal vouchers are available for patients to receive a hot meal from the hospital restaurant 24 hours a day. In addition, there is a snack machine located in the corridor near ED for mobile patients as well as WH Smith, Greggs and Costa Coffee.

As with NMGH and MRI, Wythenshawe Hospital offer warm and cold drinks, breakfast and snack as required.

Overall for this section MFT scored similar to all other Trusts in GM however were notably lower than other Shelford Trusts. On analysis this relates to the question on food and drink, it is recognised MFT were the lowest scoring nationally in the inpatient survey for this section.



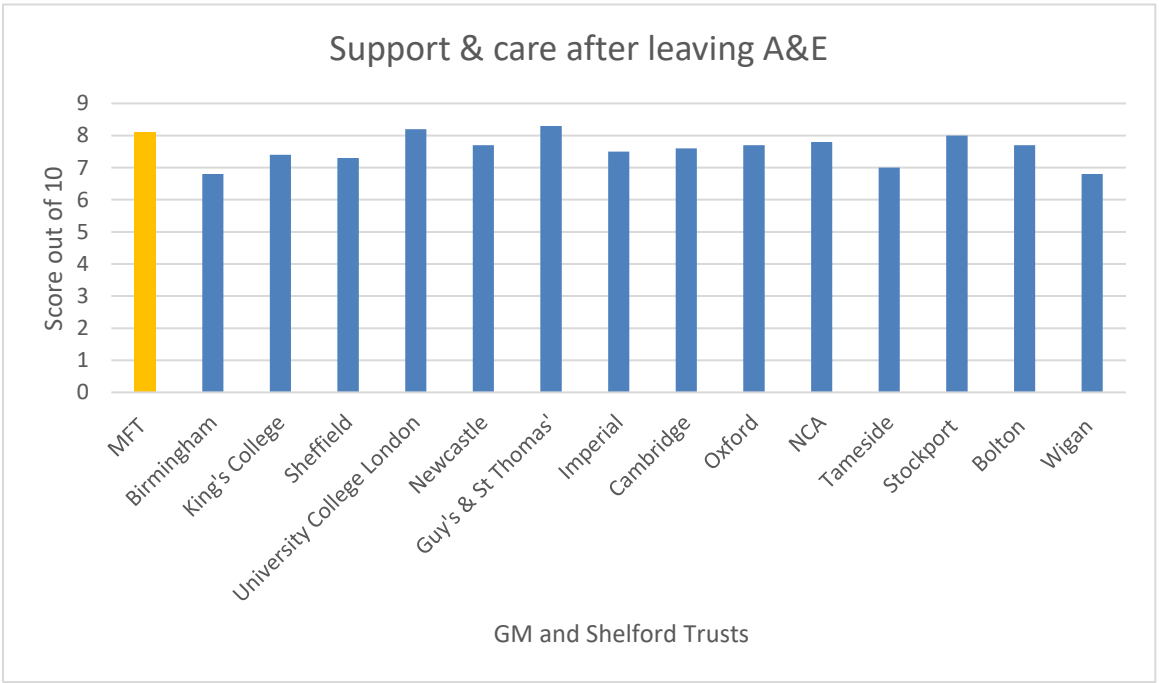
Graph 6:Shelford comparison of the hospital environment

Support and care after leaving A&E

MFT scored above the national average in both questions within this section with overall score of 8.1. One question scored "better than expected" nationally was related to hospital staff informing patients about who to contact if they were worried about their condition or treatment after leaving A&E. MFT achieved a score of 8.8, which is 0.8 higher than the national average, reflecting strong performance in this area. Notably, Wythenshawe Hospital scored the highest within MFT, achieving a score of 9.1, which was also deemed "better than expected."

The second question related to staff discussing further referrals following discharge from A&E with a score of 7.5, meeting the national average.

When compared to other Trusts in GM, MFT achieved the highest score and in comparison to other Shelford Trusts only UCL scored above by 0.1.



Graph 7: GM and Shelford comparison - support after A&E

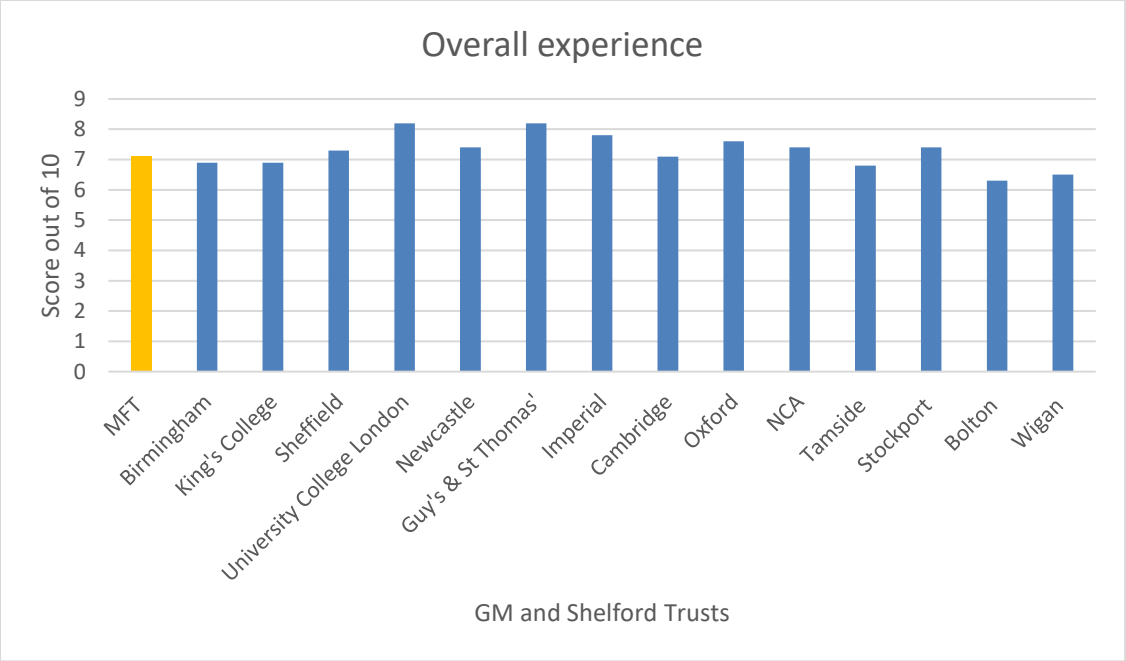
Respect and dignity

The national average was met in relation to respect and dignity (8.3). When analysed by site NMGH scored above the national average, scoring 8.7, with the lowest scoring site being Wythenshawe at 8.0. This is comparable with other Trusts within GM and Shelford.

Information & Overall Experience

MFT scored 7.1 in relation to overall patient experience, which is 0.2 below the national average. Both MRI and NMGH scored 7.3, aligning with the national average. The lowest-scoring site was Wythenshawe, which scored 6.9, slightly below the national average. These scores suggest that while MFT's overall patient experience is generally positive, there are areas for improvement, particularly at Wythenshawe.

Graph 8 highlights MFT scoring similar to GM Trusts for overall experience and in comparison to Shelford Trusts scored average with UCL and GSTT achieving the highest scores above 8.0.



Graph 8: GM and Shelford comparison for overall experience

Image 3 highlights the spread of responses and provides areas of key priority. These relate to pain management, communication needs being supported, feeling safe in the department and medication management.

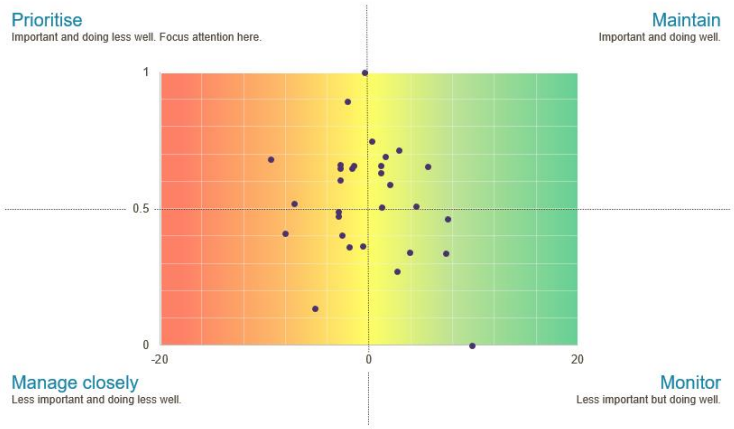


Image 3: Emergency Department Improvement Heatmap

Urgent Care Centres & Minor Injuries Units

Manchester Royal Infirmary, North Manchester Hospital, Wythenshawe Hospital and included Trafford General Hospital were all included in the survey. A total of 52 questions were asked, with 571 people eligible to respond with a response rate of 22% (127) which is an increase of 3% from the previous year however lower than the national average of 27%. Of the 55 questions asked only 28 of the questions received enough responses to be scored.

Most improved scores	Trust 2024	Trust 2022
Q19. Family, friends, or carer able to talk to a professional	91%	84%
Q17. Health professional discussed anxieties or fears about condition or treatment	81%	75%
Q37. Staff discussed potential further care	82%	77%
Q25. Understood why tests were needed	93%	89%
Q15. Understood explanation of condition and treatment	96%	93%

Most declined scores	Trust 2024	Trust 2022
Q36. Told who to contact if worried	77%	100%
Q13. Spent under 4 hours in A&E	79%	88%
Q7. Enough privacy when discussing condition with the receptionist	84%	90%
Q40. Overall A&E experience	79%	82%
Q27. Staff helped control pain	72%	74%

Image 4: UTC – Improved and most declined scores 2024

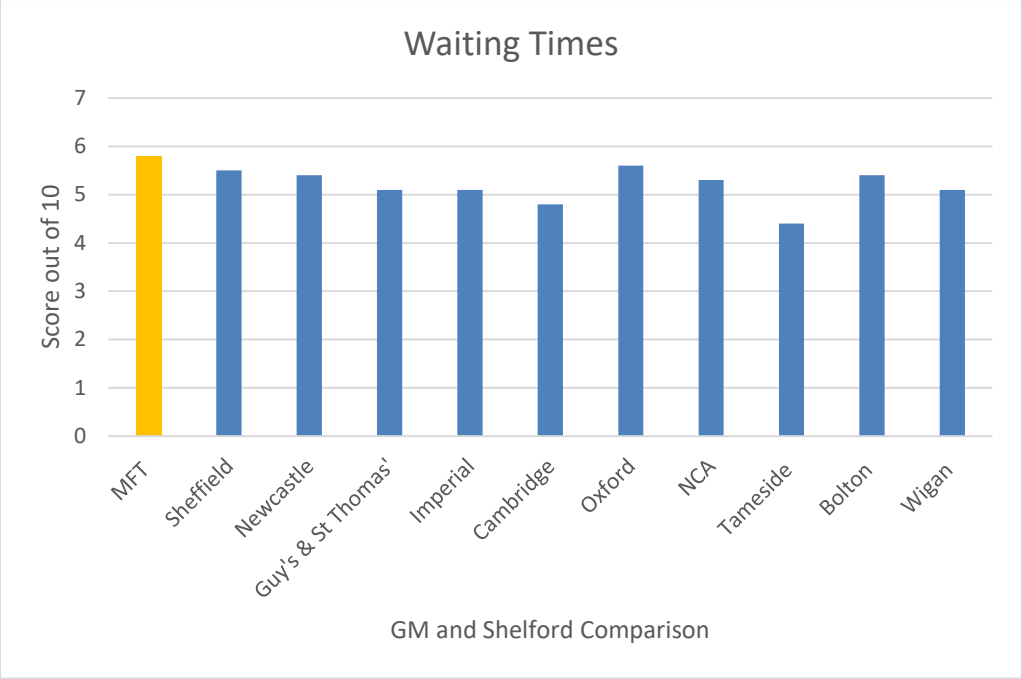
Of note no comparable data is available for Birmingham, Kings College, University College London or Stockport Hospitals for Type 3 Urgent Treatment Centres (UTC).

Waiting & Healthcare Professionals

A total of four questions were asked in this section with MFT achieving above the national average in three key areas. The Trust scored 9.7 in relation to health professionals telling patients what would happen next after their first assessment, reflecting excellent communication and clarity. MFT also scored above the national average in two other areas: patients were informed about how long they would have to wait to be examined or treated, with a score of 4.4, and patients were able to get help with their condition or symptoms while waiting from a member of staff, with a score of 5.2.

Only one question scored equal to the national average, which was in relation to patients being kept updated on how long their wait would be. MFT scored 4.0, which aligns with the national average. While this score reflects satisfactory performance in keeping patients informed about wait times, there may be room for improvement in providing more consistent or frequent updates.

MFT were the highest scoring in GM and across the Shelford Trusts in relation to waiting times in the UTC.



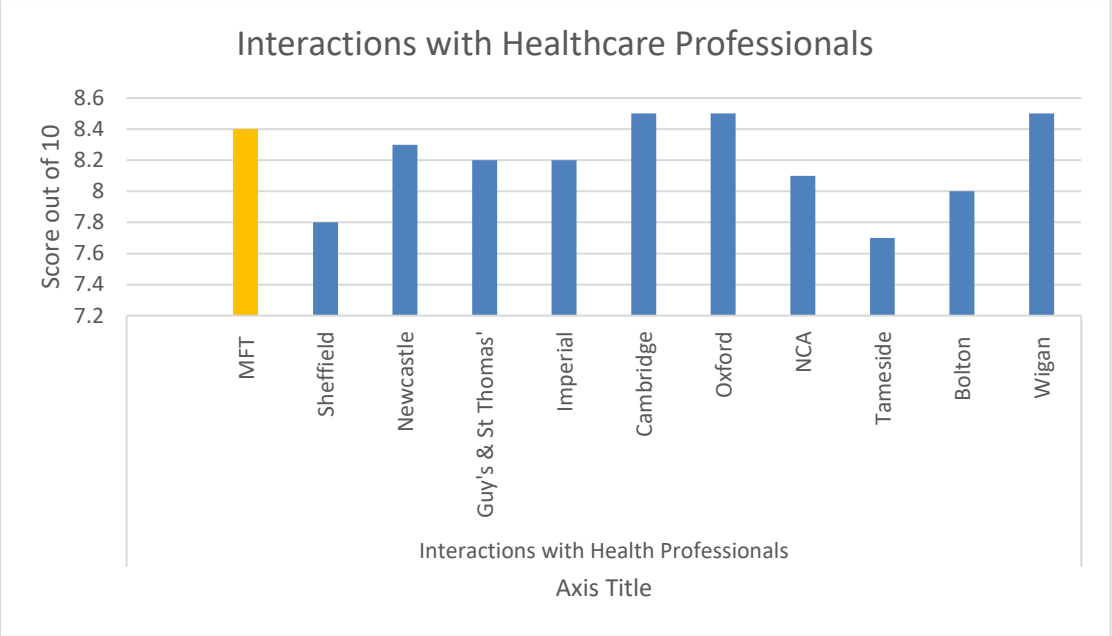
Graph 9: GM and Shelford comparison - Waiting times

Overall, MFT scored above the national average in several key areas related to patient interactions with health professionals. The Trust scored 8.7 for health professionals explaining the patient's condition/treatment in a way they could understand, reflecting clear and effective communication. MFT also scored 8.8 for confidence and trust in the health professional examining or treating the patient. Additionally, the score of 8.4 for family members, friends, or carers having enough opportunity to talk to a health professional suggests a supportive environment for patient relatives.

Interactions with health professionals were also in line with the national average (8.7), with patients indicating that they had enough time to discuss their condition and treatment with a health professional and that health professionals listened to what patients had to say. These results demonstrate MFT's commitment to fostering positive, communicative, and supportive relationships between patients and healthcare staff.

The only question that scored lower than the national average was related to health professionals discussing any anxieties or fears about the patient's condition or treatment. MFT scored 7.0, which is 0.1 lower than the national average. This suggests that while health professionals are generally engaging with patients about their concerns, there may be opportunities to improve in addressing anxieties or fears more effectively. Enhancing communication in this area could help to further reassure patients, reduce their stress, and improve their overall experience with care.

The overall score for this section was 8.4. In comparison to GM and Shelford Trusts only Cambridge and Wigan scored above MFT at 8.5.



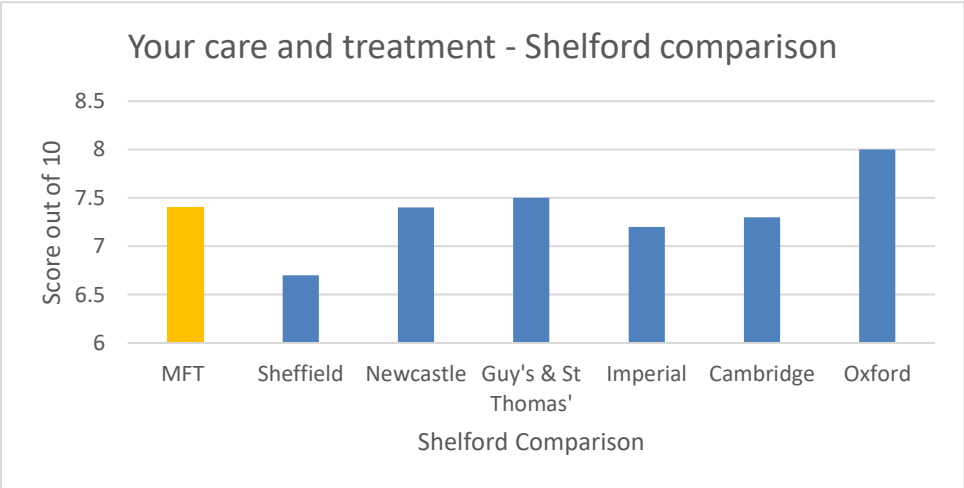
Graph 10: GM and Shelford comparison – Interactions

<u>Your care, privacy, treatment and tests</u>

MFT scored 8.1 for privacy, 7.4 for care and treatment and 8.8 for explanation about tests overall. Each section was made up of 2 section and MFT scored above the national average relating to members of staff explaining why patients needed tests in a way they could understand (8.5), scoring 0.2 above the national average. MFT scored equal to the national average in relation to patient's thinking the staff helped control their pain, scoring 6.3. This contrasts with the results for A&E.

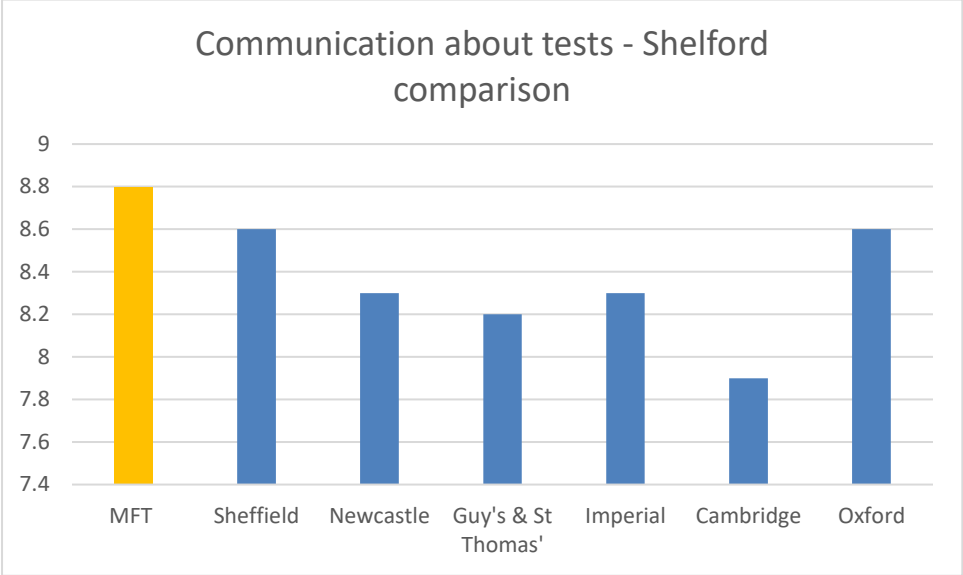
When compared to the national average of 7.1, MFT scored 0.3 lower in relation to patients being given enough privacy when discussing their condition with the receptionist. However, MFT performed positively in relation to giving patients enough privacy when being examined or treated at 9.4, which is above the national average of 9.3. MFT did not receive any formal complaints or PALS concerns relating to privacy within any of the UTC departments during the sampling period.

MFT scored above GM Trusts for care and treatment and communication about Tests with only Bolton scoring higher in relation to privacy. Graph 11 shows MFT compared to other Shelford Trusts, Oxford achieved higher being the only Trust to achieve above 8 for this section.



Graph 11: Shelford comparison - Care and treatment

Graph 12 demonstrates MFT achieving the highest score in the Shelford Group, scoring at least 0.2 above all the other Trusts.



Graph 12: Shelford comparison - Test results

Pain & Medications

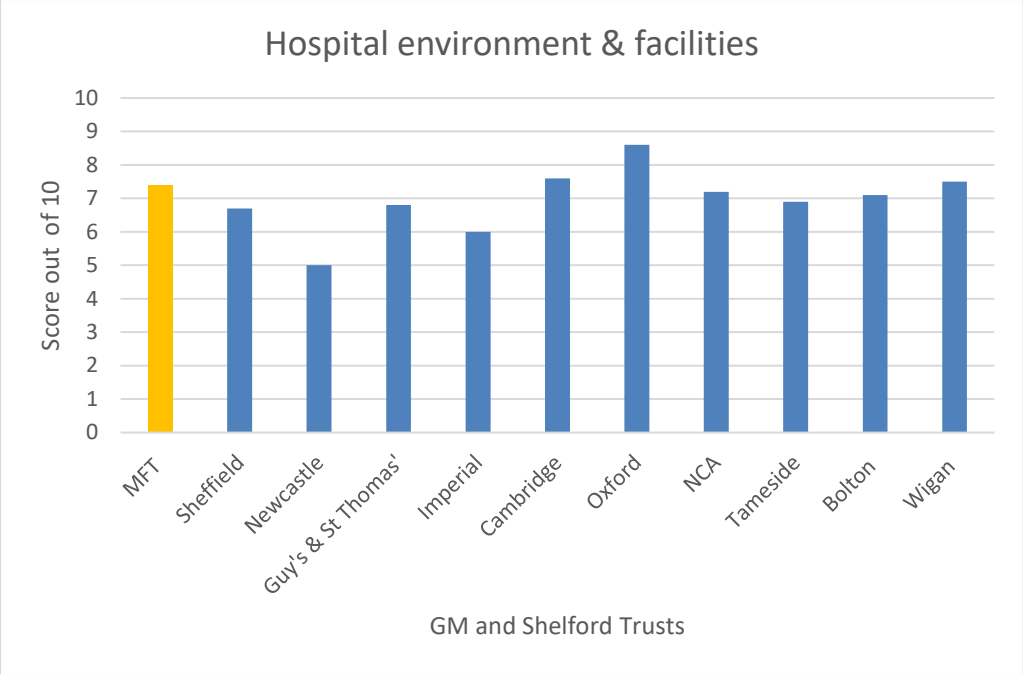
The score for management of pain as a Trust was 72% which is 5% higher than achieved for A&E service, this result is against a national average of 76%. To note Manchester Royal Infirmary achieved above Trust and national average at 80%.
In relation to new medication being prescribed in the department only 88% of patients overall felt they were provided enough information against a national average of 94%.

Environment and Facilities

MFT scored 7.4 overall for this section and is above the national average in relation to patients being able to access food or drink scoring 6.5, this is in contrast to the experience of patients in the A&E department and provides an opportunity for the clinical teams to review access to these facilities within their departments.
In relation to patients feeling safe within the department and not threatened by other patients and visitors the UTCs scored 8.3, this is higher than the experience of patients in the emergency department but is 0.5 lower than the national average.

All areas have developed intentional rounding and senior review to establish effective communication links. In addition, Security Team visibility has helped support the MDT in alleviating fears and anxiety within the department although it is recognised this support is more widely available in the Emergency Departments.

Graph 13 demonstrates how MFT scored against other GM and Shelford Trusts. Oxford (8.6) scored above MFT and Wigan marginally at 7.5.



Graph 13: GM and Shelford comparison - Environment

Information to support recovery at home

In this section, MFT did not score above the national average on any of the four questions. Specifically, the Trust received a score of 4.5 for providing information about new medication patients were to take home, indicating a significant area for improvement in medication-related communication. Additionally, MFT scored 8.5 for both patients' understanding of the information they were given on how to care for their condition at home, and for feeling able to care for their condition based on the information provided by health professionals. While these scores reflect a level of competence in patient education, they do not exceed the national average, highlighting the need for further enhancement in these areas to ensure patients feel fully supported in managing their care after discharge.

The staff in the UTC departments have MDT support from IAT, pharmacy, Alcohol and Mental Health teams, Hospital at Home, Crisis Response and Frailty teams with written information by means of leaflets in multiple languages for a wide range of presentations and minor illnesses. There is opportunity to utilise these functions to improve patients experience in relation to treating their condition at home.

The only area where MFT performed at the national average was in relation to health professionals providing patients with information on how to care for their condition at home, where it received a score of 8.2.

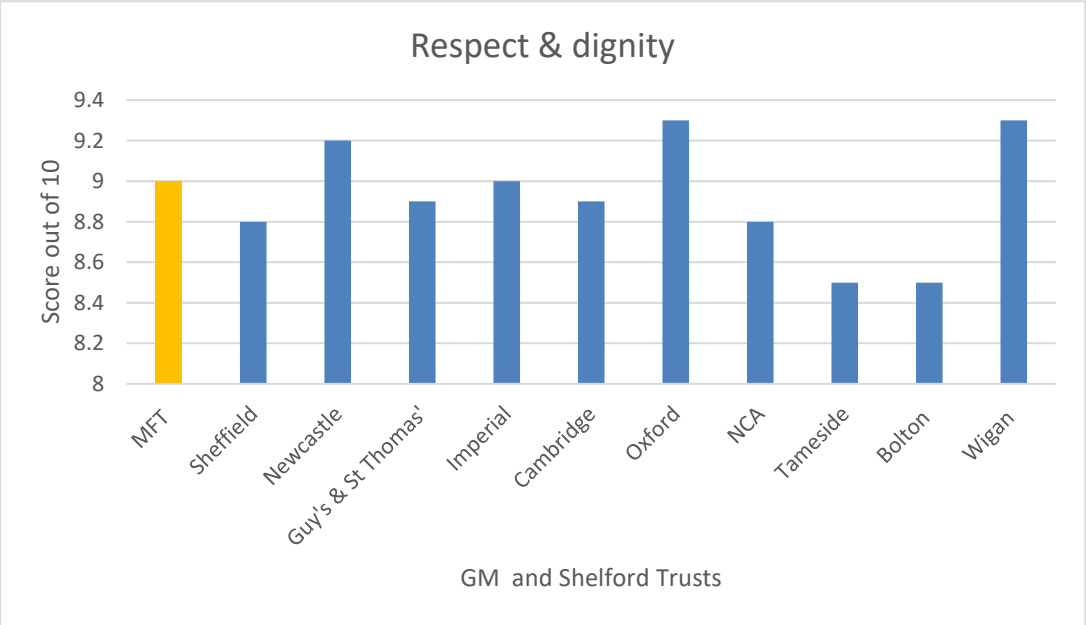
Support and care after leaving the Urgent Care Centre

The overall score for this section was 8.1, with 2 related questions. MFT scored 8.4, which is above the national average in relation to staff discussing with patients whether they needed further health or social care services after leaving the Urgent Treatment Centre. This indicates strong communication and follow-up care planning to ensure patients' ongoing needs are addressed. However, the Trust's performance in the remaining question, which asked whether staff informed patients about who to contact if they were worried about their condition or treatment after leaving the Urgent Treatment Centre was lower scoring 7.8, which is below the national average of 8.2.

Respect and dignity

Overall, MFT met the national average, scoring 9.0. However, it is important to note that this represents a decrease of 0.5 from 2022, when the trust scored 9.5 indicating an opportunity to review process and areas for improvement as well as challenges that have emerged over the past 2 years to see a decrease in score.

In comparison to other Trusts, Wigan scored the highest at 9.3 with all other GM trusts scoring below this and below MFT. Newcastle (9.2) and Oxford (9.3) also scored highest across the Shelford Trusts.

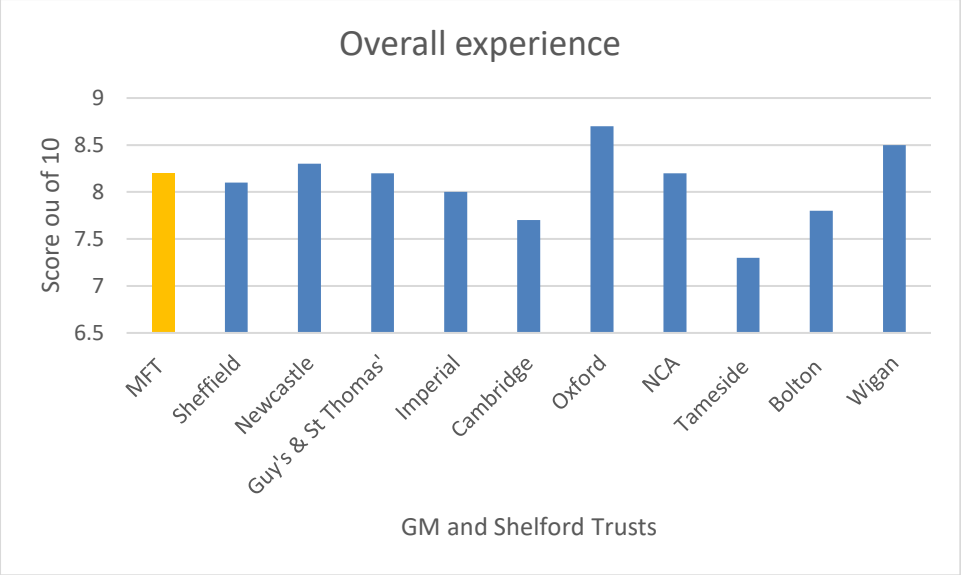


Graph 14: GM and Shelford comparison – Respect and dignity

Information and Overall Care

In this section, MFT scored 8.2, which is slightly below the national average of 8.3, it is worth noting that this score represents a small improvement of 0.1 compared to the 2022 survey, when the Trust scored 8.1.

Wigan and Oxford achieved the highest scores when compared to both GM and the Shelford Trusts, as shown in **Graph 15**. These Trusts stand out for their strong performance in the areas assessed, surpassing the other Trusts in their respective regions.



Graph 15: GM and Shelford comparison – Overall experience

The Chief Nursing Officer has introduced an UEC Task and Finish Group with the Directors of Nursing, Assistant Chief Nurse for Quality and Patient Experience and Chief Nursing Information Officer. This group has several workstreams currently focused on:

- Accelerated admissions – utilising TES recommendations to utilise escalation spaces, corridor care and accelerated admissions.
- HIVE/ Quality and Safety metrics – To enable workstreams to provide improved digital workflow and oversight of patients experiencing extended stays in ED. Safety checklist trackboards have been developed with safety compliance audit tool in development.
- Long length of stay reviews to improve consistency and oversight for patients who stay in ED for longer than 6 hours with the introduction of intentional rounding and senior nurse reviews.
- Patient Experience - the development of compliance audits to ensure patient safety, audit of matron or senior nurse reviews, EWS compliance audit , nutrition and hydration audit and the introduction of a bespoke 'What Matters to Me' patient experience survey for A&E and UTC departments.
- Staff Health and Wellbeing – reviewing the results from the staff survey, compliance audits, assessing the number of complaints/PALS and incidents. Reviewing staff sickness and absence and peer to peer assessments.

Summary

This report highlights some areas requiring improvement in both A&E and UTC, **Image 4** highlights the overall priorities to focus on include pain management and patients feeling safe around the other patients/visitors in the department which is also reflected in the A&E results. A further area for priority includes patients feeling they were able to discuss their anxieties or fears about their condition or treatment. There are learning opportunities between the two departments in regard to scores meeting or achieving above the national average for communication about tests and treatment and care.

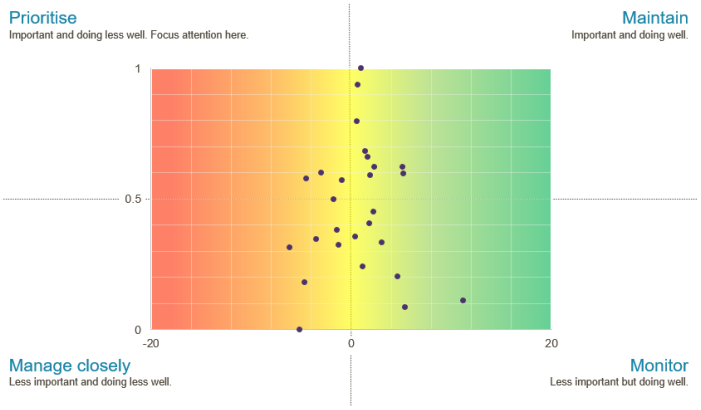


Image 4: UCC Improvement Heatmap

Next Steps

- Workstreams will continue to be monitored through the Urgent and Emergency Care (UEC) task and finish group led by the Chief Nursing Officer.
- Link themes identified for improvement to the Adult Inpatient Survey and PLACE results, reporting clinical group action plans through the Quality & Patient Experience forum.
- Chief Executive and Directors of Nursing to utilise the results and heat maps to identify areas for MFT system wide learning priorities to inform the mock CQC assessments for A&E and UEC departments and identify appropriate reporting and monitoring mechanisms.
- Clinical Groups track the detail of the action plans in their respective Management Meetings with a deeper understanding of the position at ward level and oversight/ assurance.
- Development of a bespoke ‘What Matter to Me Survey’ for Urgent and Emergency Care departments to provide ‘live’ patient experience feedback data.
- Key focus on survey promotion for the 2026 to yield wider responses to gain meaningful feedback.

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

Manchester University NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Maternity Incentive Scheme Year 6	**Agenda Item 11.5**
Presented by:	Chief Nursing Officer	
Prepared by:	SHCG Director of Nursing and Midwifery Assistant Director of Quality and Safety SM MCS	
Meetings where content has been discussed previously	Quality, Safety, Performance Board Committee (QSPBC) SHCG Quality and Safety Committee Saint Mary's Managed Clinical Service (SM MCS) Quality and Safety Committee SM MCS Maternity Divisional Quality and Safety Committee. SM MCS Maternity Divisional Management Board Maternity and Neonatal Safety Champions	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The following report provides the expected compliance with all 10 Safety Actions in the NHS Resolution (NHS R) Maternity Incentive Scheme (MIS) Year 6[1].

Safety Action	Compliance at end of reporting period 30th November 2024
1 – PMRT	Achieved – subject to MBRRACE triangulation
2 – MSDS	Achieved – confirmed by NHSE triangulation
3 – Transitional Care	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards.
4 – Medical Workforce	Achieved – with action plans in place
5 – Maternity Workforce	Achieved – with action plan in place
6 – SBLCBv3	Achieved – confirmed by LMNS triangulation
7 – MNVP	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards
8 – Training	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards

[1] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
[3] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

9 – Safety Champions	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards
10 – MNSI/ENS	Achieved – subject to NHSR triangulation

Recommendation(s)

The Board of Directors is asked to:

- Note: The expected compliance with the requirements for all 10 Safety Actions.
- Note: The action plans for:
  - Safety Action 4: Obstetric and neonatal nursing workforce
  - Safety Action 5: Providing one-to-one care in labour
  - Safety Action 7: Updated CQC maternity survey action plan.
- Receive: MIS presentation (appendix 1)
- Support: completion of the self-declaration of compliance and onward submission to the Greater Manchester and Eastern Cheshire Local Maternity Neonatal System (GMEC LMNS) for approval by Greater Manchester Integrated Care Board Accountable Officer (GM ICB AO) in January 2025 prior to submission to NHS Resolution on 3rd March 2025 (by 12 noon).

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives

The work contained with this report contributes to the delivery of the following strategic objectives (see key below)

LHL objective 1	☒	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • MFT/006917: Achieving MIS Year 6. Score 8.	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • NHS Resolution Maternity Incentive Scheme (MIS) Year 6	

Main report

Maternity Incentive Scheme (MIS) Year 6

In line with reporting requirements for MIS Year 6 and the perinatal quality surveillance model (PQSM), SM MCS can confirm expected compliance with all 10 Safety Actions. The detailed requirements for each safety action have been monitored weekly by the maternity division with assurance provided to GMEC LMNS at regular touch points throughout the reporting period.

The Board of Directors is asked to note the following:

- Safety Action 1 Perinatal Mortality Review Tool – standard expected to be met
  - 132/132 (100%) eligible perinatal deaths from 8th December 2023 have been reported to MBRRACE-UK within seven working days. As reported to QSPBC in October 2024 MBRRACE-UK excluded three perinatal deaths from the compliance figures for MIS Year 6.
  - For the 50 completed PMRT reviews, 50 sets (100%) of parents had their views sought and they were given an opportunity to raise their questions.
  - 87/88 (98.9%) of PMRT reviews were started within two months (requirement 95%).
  - 50/50 (100%) of reports have been published within six months (requirement 60%).
  - Quarterly reports have been submitted to MFT Private Board of Directors, including action plans and discussed with the Board level Maternity and Neonatal Safety Champions.
  - Compliance with Safety Action 1 is externally validated by MBRRACE-UK and the details above have been confirmed by the Maternity Division with the report available to date on the MBRRACE-UK portal.

- Safety Action 2 Maternity Services Data Set (MSDS) – standard met
  NHS England have confirmed that SM MCS was compliant with the data quality standards relating to activity in July 2024 (see Appendix 2).

- Safety Action 3 Transitional Care – standard expected to be met
  - Following a review of the Transitional Care guideline with GMEC LMNS it was noted that the SM MCS guideline described transitional care for babies with a birthweight above 1800g. The British Association of Perinatal Medicine (BAPM)[2] admission criteria require transitional care to be provided for eligible babies with a birthweight above 1600g. SM MCS Maternity and Newborn Services amended the guideline in November 2024 and can confirm that it meets the BAPM requirements.
  - As required by year 6 reporting SM MCS presented a progress update on the quality improvement (QI) project aimed at reducing term admissions to the neonatal unit with a diagnosis of hypoglycaemia to GMEC LMNS on 4th November 2024 and to the Board level maternity and neonatal safety Champions on 29th November 2024.

- Safety Action 4
  Clinical workforce for obstetric, anaesthetic, neonatal medical and neonatal nursing workforces- standard expected to be met.

  Obstetric Staffing
  - An audit for the standards relating to the obstetric workforce was completed in October 2024 and this identified three standards that were not fully compliant:

[2] https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017

- All short term locum doctors on the Tier 2/3 rota have worked in the maternity unit and are on a postgraduate training programme or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility (CEL) to undertake short-term locums.
  There were two occasions out of 641 shifts worked where the locum doctor did not have the required certificate of eligibility (CEL). Action taken to address: Once identified no further shifts were booked for this doctor. Medical Workforce have amended their process to include sharing the CEL with the maternity division.

- Trusts/organisations should implement the RCOG guidance on engagement of long-term locums.
  The audit demonstrated the documentation of the discussion of the locum doctor's capabilities could be improved for three of the eight locum doctors who held a long-term locum post during the audit period (February to August 2024).
  Action taken to address: the maternity division has strengthened the process for discussing and documenting a doctor's capabilities for those undertaking a long-term locum post. This revised process is supported by the Junior Doctor Rota Lead.

- The third element relates to Consultant Obstetrician attendance at specified clinical situations; on three occasions a senior trainee attended instead of a consultant.

  - In line with MIS year 6 reporting requirements to support providers achieve safety action 4 it is acceptable for an action plan to be developed and submitted which addresses the areas for improvement. SM maternity division action plan is provided in Appendix 3. This has been shared with GMEC LMNS.

  Anaesthetic staffing
  - SM MCS can confirm that there is a duty anaesthetist immediately available for the obstetric unit 24 hours a day with clear lines of communication to the consultant.

  Medical neonatal staffing
  - An audit for the standards relating to the neonatal medical workforce has been completed and SM MCS can confirm that the neonatal medical workforce is compliant with the BAPM standards and therefore an action plan is not required.

  Neonatal nursing staffing
  - SM MCS has shared the twice-yearly neonatal nursing report with Workforce & Education Committee. In line with MIS year 6 reporting requirements for the elements not in line with all BAPM nurse staffing standards, an action plan has been developed (Appendix 4) which has been shared with GMEC LMNS for onward submission to North West Neonatal Operational Delivery Network (NWNODN)

- Safety Action 5 Midwifery workforce - standard expected to be met.
  In the line with the requirement to meet this standard SM MCS has shared as a minimum the twice-yearly midwifery staffing oversight report with the SM MCS Workforce & Education Committee and onwards to the Trust Board of Directors and relevant sub board committees. This was shared on 13th May 2024 and 11th November 2024.

Birthrate +, which is a validated staffing tool, has been used to calculate the required Midwifery and Maternity Support worker establishment. SM MCS can confirm that this meets the current funded establishment.
The requirement for 100% compliance with the supernumerary status of the labour ward coordinator has been achieved.

MIS Year 6 requires all women to receive one-to-one care in active labour. On occasions when this is not met, it is expected for providers to develop an action plan to address learning identified.

SM Maternity division monitor the occasions when/if one-to-one care in active labour was not met and review the care provided to identify areas for improvement. The reviews have highlighted that the woman's experience is negatively impacted by not receiving one-to-one care in active labour although there were no cases of harm, and all women affected were offered a debrief. To meet the reporting requirements for MIS year 6 an action plan has been developed (Appendix 5) which has also been shared with GMEC LMNS.

- Safety Action 6 Saving Babies' Lives Care Bundle v3(SBLCB) - standard has been met.
  SM MCS has an agreed plan in place to fully implement SBLCBv3 and has continued the quarterly QI discussions with GMEC LMNS via the planned assurance meetings which took place in March, June and September 2024.

  In line with the requirements of Safety Action 6 SM MCS has shared a case study relating to preterm birth and the importance of optimisation at the GMEC LMNS SBLCB Champions' meeting in November 2024.

  Following the September assurance meeting, GMEC LMNS provided confirmation in November 2024 that SM MCS has met all requirements for MIS Year 6 Safety Action 6 (Appendix 6).

- Safety Action 7 Listening to women - standard expected to be met.
  SM MCS can evidence working in partnership with the Maternity and Neonatal Voices Partnership (MNVP). The MNVP have supported the development of the CQC maternity survey action plan which has been shared with GMEC LMNS.

- Safety Action 8 Training - standard expected to be met.
  The standard for MIS Year 6 is to demonstrate compliance >90% for all relevant staffing groups for the required maternity specific training modules, as shown in Tables 1 & 2 below. The division can confirm the training database period is now locked down.

Table 1: Maternity specific training compliance

Maternity specific training modules overview Reporting period up to 29th November 2024 (12 consecutive months) for SM MCS						
Core training module required	**Percentage of eligible staff who are compliant with training**					
	Midwives	Obstetric Consultants	Obstetric Trainees	Anaesthetic Consultants	Anaesthetic Trainees	MSW
M1 & 2 E4 Fetal physiology (IIA and CTG) & SBL (1 day)	98%	97%	96%			
M2 CTG competency assessment	97%	97%	96%			
M2 IIA competency assessment	96%					
M3,4 & 5 MDT maternity emergencies (1 day)	96%	97%	99%	96%	98%	95%
M 6 Neonatal Life Support	95%					

Table 2: SM MCS Newborn Services' neonatal life support compliance

Time Period Reporting period up to 29th November 2024 (12 consecutive months) for SM MCS				
Core training module required	**Percentage of eligible staff who are compliant with training**			
	Neonatal Nursing	ANNP	Neonatal Consultants	Neonatal Trainees
NMGH				
M 6 Neonatal Life Support	93.3%	92.3%	100%	98.7%

- Safety Action 9 Board assurance - standard expected to be met.

  Monthly Safety walkarounds led by the Safety Champions have been undertaken in line with MIS Year 6 and PQSM. There have been no recurrent themes raised by the staff and all issues have been acted on and feedback has been provided to staff regarding the actions taken to resolve these issues (Appendix 7).

- Safety Action 10 Reporting to the Maternity and Newborn Safety Investigations (MNSI)- standard expected to be met.

  SM MCS has reported eligible cases to MNSI, completed duty of candour and ensured that families have received information about the NHS R Early Notification Scheme.
  In line with internal governance, the MFT Legal Department have confirmed that all eligible cases have been notified to NHSR Early Notification Scheme via the Claims reporting wizard.

Submission to the LMNS

GMEC LMNS require providers to submit evidence for their review and to gain assurance of compliance against each safety action, to enable GM ICB CEO to approve the Trust Board submission. SM MCS can confirm all evidence to meet MIS Year 6 requirements has been uploaded onto the NHS Futures platform before 30th November 2024 and met with GMEC LMNS on 17th December 2024 who confirmed all evidence has met the required standards.

Next Steps

Subject to approval from Board of Directors, that SM MCS have provided assurance of compliance against all 10 safety actions within MIS Year 6, the Trust Board declaration form will be signed by MFT CEO. Following which a letter from MFT CEO to provide assurance will be submitted to the GM ICB AO. Following approval from GM ICB AO, and by 3rd March 2025 (by 12 noon) the completed Board Declaration form will be submitted to NHS Resolution by SM MCS.

Appendix 1: Presentation

Appendix 2: NHS England confirmation of compliance with Safety Action 2

Appendix 3: Obstetric workforce action plan

Appendix 4: Neonatal workforce action plan

Appendix 5: One-to-one care in labour action plan

Appendix 6: GMEC LMNS confirmation of compliance with Safety Action 6

Appendix 7: Safety walkaround poster

Appendix 1: Presentation. Attached separately.

Appendix 2: NHS England confirmation of compliance with Safety Action 2

CNST MIS Safety Action 2 Scorecard - Year 6

Also containing **Maternity and Neonatal Programme MSDS Data Quality Priorities (not CNST-assessed)**

Last Updated: **24 October 2024**

NHS England

This scorecard has been updated to support the second safety action of the **Maternity Incentive Scheme Year 6** which is: **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

Only records which passed validation at the Strategic Data Collection Service (SDCS) are included.
Submitters will have been notified of record rejections at the time of submission and can review the data by downloading the pre-deadline extract.
This scorecard contains a summary and more detailed breakdown of each trust's progress against the criteria given below. Feedback on this scorecard can be provided to maternity.dq@nhs.net

A separate 'Other Data Quality priorities' page has also been included in this dashboard. It is important to note, measures on that page are for information purposes only and will not be assessed as part of the Maternity Incentive Scheme.

Criteria

The documentation for CNST MIS Year 6 can be found here.
The full construction for each of the CQIMs and other measures is available within the metadata file published in the guidance hub

The below table lists the criteria for the CNST MIS Year 6 Safety Action 2. **The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.**

Criteria	Construction
1. **CQIMs**: Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in this "CNST Scorecard" which accompanies the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. The final data for July 2024 will be published during October 2024.	Count of the number of CQIMs where the provider has met the requirements of all the associated data quality criteria. **Assessment:** Where this is 10 or more = 'Pass'. If this is less than 10 = 'Fail'. *Please note that CQIM Breastfeeding 6 to 8 weeks and CQIM Readmissions do not form part of the assessment criteria.*
2. **Ethnicity:** July 2024 data contains valid ethnic category (Mother) for at least 90% of women booked in the reporting period. 'Not stated', 'missing' and 'not known' are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001 / MSD101)	**Numerator**: Number of MSD101 records in the reporting period with an antenatal appointment in the reporting period, with a corresponding record in MSD001 where EthnicCategoryMother is recorded. **Denominator**: Number of MSD101 records in the reporting period with an antenatal appointment in the reporting period. **Assessment:** Where a provider achieves 90% or higher = 'Pass', otherwise = 'Fail'

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 6: Safety Action 2

NHS England

The table below summarises the number of criteria met by each maternity service provider, by month. For Y6, there are two criteria to meet on MSDS data submission.
This scorecard will be updated and published each month.

The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.
As July 2024 is the CNST MIS SA2 assessment month, provisional August figures have not been included to minimise the risk of confusion. Provisional figures will be included again from next month.

Assessment Month: Final data

Organisation Name
MANCHESTER UNIVERSITY NHS FOUNDA..

Notes:

All figures are Final and **the CNST MIS Y6 SA2 assessment is on Final July 2024 data.**

Provisional figures will be included again from November, with the publication of final August and provisional September data.

All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Organisation Name	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	2	2	2	2	2	2

Organisation Name
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Reporting Period
July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	1295	1330	97.4		Passed
CQIMDQ15	1270	1270	100.0		Passed
CQIMDQ16	1185	1270	93.3		Passed
CQIMDQ24	1185	1185	100.0		Passed
CQIMApgar	15	1185		14	Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	765	1150	66.5	Passed
CQIMDQ08	1150	1315	87.5	Passed
CQIMDQ09	1295	1330	97.4	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	1295	1330	97.4		Passed
CQIMDQ11	180	1295	13.9		Passed
CQIMDQ12	20	1295	1.5		Passed
CQIMPPH	20	1295		14	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ06	1295	1330	97.4		Passed
CQIMDQ22	1270	1270	100.0		Passed
CQIMDQ23	1185	1270	93.3		Passed
CQIMPreterm	85	1295		66	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	1295	1330	97.4		Passed
CQIMDQ15	1270	1270	100.0		Passed
CQIMDQ16	1185	1270	93.3		Passed
CQIMDQ18	655	1270	51.6		Passed
CQIMDQ20	30	625	4.8		Passed
CQIMTears	30	625		45	Passed

Notes: **The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.**

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	1295	1330	97.4	Passed
CQIMDQ15	1270	1270	100.0	Passed
CQIMDQ16	1185	1270	93.3	Passed
CQIMDQ18	655	1270	51.6	Passed
CQIMDQ26	1270	1270	100.0	Passed
CQIMDQ27	1725	1725	100.0	Passed
CQIMDQ28	820	1725	47.5	Passed
CQIMVBAC	20	165	12.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	1295	1330	97.4	Passed
CQIMDQ31	1315	1315	100.0	Passed
CQIMDQ32	1205	1315	91.6	Passed
CQIMDQ33	1315	1315	100.0	Passed
CQIMDQ34	660	1315	50.2	Passed
CQIMDQ36	1295	1295	100.0	Passed
CQIMDQ37	575	1295	44.4	Passed
CQIMDQ38	1310	1315	99.6	Passed
CQIMDQ39	1165	1295	90.0	Passed
CQIMRobson01	15	145	10.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	180	285	63.2	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	200	240	83.3	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	1725	1330	129.7	Passed
CQIMDQ04	1635	1725	94.8	Passed
CQIMDQ05	115	1635	7.0	Passed
CQIMSmokingBooking	115	1635	7.0	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	1295	1295	99.2	Passed
CQIMSmokingDelivery	90	1285	7.0	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	1695	1725	98.3	Passed

Other non-CNST Data Quality Priorities

Organisation Name: MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Reporting Period: July 2024

Measures on this page are for information purposes only, and will not be assessed as part of the Maternity Incentive Scheme.

From the publication of June 2024 data, we introduced a new site code recording data quality measure.
Further Data Quality measures will be added to this page in future in accordance with Maternity and Neonatal Programme priorities.

The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

Continuity of Carer Data Quality measures

MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	1450	1490	97.3	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	5	5	100.0	Passed

Birth Site Code Recording Data Quality measure

Actual Site of Delivery recorded

Indicator	Numerator	Denominator	Rate	Result
ActualDeliverySiteDQ	1300	1315	98.9	Passed

This new metric specifically looks at the Organisation Site Identifier of actual place of delivery (OrgSiteIDActualDelivery) field in the MSD401 Baby's Demographics and Birth Details table. This is the organisation site identifier of the baby's actual place of birth. Site code level data will enable more granular MSDS analysis including de-duplication of birth records, and also assist MBRRACE-UK in producing more effective peer comparison groups that take into account different levels of care.

The data to be recorded in this field should be either a 5-digit alphanumeric ODS code for a valid site that was open and active on the birth date, or one of the three valid default codes for Home (ZZ201), In transit (ZZ777), or Non-NHS organisation (ZZ888). ODS site codes can be found using the ODS Search Portal. This guidance also applies for the other SiteID fields in the MSDS.

The required pass rate for the Birth Site Code Recording Data Quality measure is 90%.

Denominator: All births reported by a trust in the reporting month
Numerator: From the denominator, the number of births where a valid MSD401.OrgSiteIDActualDelivery is recorded

Appendix 3: Obstetric workforce action plan

Action Reference	Theme	Action	Action Owner	Deadline	RAG	Status	Updates	Comment
1.1	Safety Action 4 - Element 1	With support from temporary medical staffing undertake an audit from 9th February - 31st August of all locum shifts filled and review if the doctor completing the shifts was complaint with the RCOG guidance and safety action 4 element 1.	Liz Gatrell	31/10/2024		Complete	SOP in place following MIS yr 5	all sites
1.2	Safety Action 4 - Element 1	A process for rota coordinators was implemented for MIS yr 5 - review underway to ensure compliance.	Liz Gatrell	31/08/2024		Complete	Audit complete. Medical Workforce reminded to ensure compliance when completing locum booking	all sites
1.3	Safety Action 4 - Element 1	Temporary Workforce to send through copy of ARCP or CEL where appropriate to assure Division of compliance	Madeleine Hesp	31/10/2024		Complete		all sites
2.1	Safety Action 4 - Element 2	Review induction pack and completion of checklist	Liz Gatrell	30/11/2024		Complete		all sites
2.2	Safety Action 4 - Element 2	Audit of compliance with support from temporary workforce and junior doctor rota lead	Liz Gatrell	30/09/2024		Complete	Process to be strengthened to ensure robust evidence is available	all sites
2.3	Safety Action 4 - Element 2	Junior doctor rota lead to ensure all locums called to discuss clinical capabilities prior to commencing in post	Katy Sanders	31/10/2024		Complete	KS to email confirmation once discussed with doctor	all sites
3.1	Safety Action 4 - Element 3 - Although not measured action plan in place	Undertake an audit across North Manchester to monitor non-compliance for compensatory rest and the frequency at which it is taking place.	Liz Gatrell	30/09/2024		Complete	Audits carried out Oct/Nov 23 and July/Aug 24 at North Manchester	North
3.2	Safety Action 4 - Element 3	Recruitment process underway to increase the on-call rota at Wythenshawe	Vicky Rawlinson	30/11/2024 Extended to 31/01/25		In progress	Consultants' interviews taking place 8/11/24 Unable to recruit to all posts – vacancies back on Trac	All sites
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	31/01/2025		In progress	SOP to be ratified Dec 24	MCS SOP Wythenshawe/North

3.4	Safety Action 4 - Element 3	Redesign the North Manchester rota to ensure compensatory rest can be achieved for consultant rota	Edward Johnstone/Vicky Rawlinson	01/02/2025		Pending	Review of job plans and PAs available at NM being completed. New rota plan and roster in development.	North
4.1	Safety action 4 - Element 4	Obtain data from informatics from 1st February-31st July 2024 to validate compliance of consultant attendance.	Edward Johnstone	31/08/2024		Complete	Audit complete	all sites
4.2	Safety action 4 - Element 4	For cases of non-compliance, when procedure performed with indirect onsite supervision by senior trainee's, trainees or consultants to document indirect supervision in the patient notes	Edward Johnstone	30/11/2024		Complete	Shared by CHOD to all obstetric staff	all sites

Appendix 4: Neonatal Nursing action plan

Action Reference	Theme	Action	Action Owner	Review Date	RAG	Status	Updates	Date Closed
1	**Recruitment**							
1a	North Manchester Nurse Staffing	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 environment.	Alison O'Doherty, Head of Nursing/ Sara Derbyshire, Divisional Director	Jan-25		Open	The Division has prepared a Statement of Case which has been presented to the Specialist Hospitals Clinical Group on the 11th November. An outline business case has been commenced and sent to Director of Nursing and Midwifery who has asked for amends. The Divisional Director for Newborn Services and Head of Nursing are continuing to progress the Business Case which requests 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.	
1b	Band 5 Staff Nurse	Continue to recruit to turnover in the Band 5 establishment through Guaranteed Job Offer programme and Domestic Recruitment. Through proactive recruitment the division are planning to be at full establishment and all candidates in post by March 2025. To participate in the trust programme, supporting NA and AP to commence training scheme to become qualified nurses and continue to be employed by Newborn Services.	Louise Frampton, Lead Nurse	Mar-25		Open	Newborn Services continue to recruit to turnover and have no vacant posts in Band 5 (30.85 WTE in pipeline).	
1c	Band 6 Junior Sister	Continue to recruit to vacancies within Band 6 establishment. Work with recruitment team/HR team to undertake some focused work to attract external Band 6s.	Louise Frampton Lead Nurse	Jan-25		Open	Following recent successful Band 6 interviews there are 3 WTE vacancies in the Band 6 establishment. Plan to go out to	

							advert to in October 2024 to fill remaining vacancies.	
1d	Band 7 Senior Sister	Continue to recruit to vacancies within Band 7 establishment.	Louise Frampton Lead Nurse	Jan-25		Open	Plan to advertise Band 7 posts in October 2024.	
2	**Education and Training**							
2a	Skills Inventory Competency Assessment Document	Skills inventory and competency assessment document to be developed to recognise nurses joining Newborn Services with previous intensive skills to be assessed to work in intensive care before commencing QIS training	Victoria Beech Matron for Education	Aug-24		Closed	Document reviewed and signed off by the Head of Nursing. Plan to pilot with experienced IR nurses to work in intensive care area.	Aug-24
2b	Continue to support increased numbers of staff to complete QIS.	a) To improve the QIS numbers across the Division, Newborn Services are continuing to support 20 nurses to attend the QIS course twice yearly. b) Compliance to QIS 70% standard is monitored through the Divisional Business Meeting.	Victoria Beech Matron for Education	Mar-25		Open	Staff allocated to attend the course in September 2024 and February 2025. Funding received from NHSE to support additional learners on the QIS.	
3	**Operational Management/ Safe Staffing**							
3a	Monitoring of Staffing levels to ensure levels are in line with acuity	a) Daily staffing meeting to review BAPM staffing requirements with quality roles redeployed to cot side care where required and review of available mutual aid across the Division. b) Daily flow meeting with Maternity Services to discuss activity, capacity and demand for neonatal cots. c) Staffing data inputted into Badgernet by the Neonatal Shift Coordinators to monitors staffing levels against acuity and dependencies. d) Follow Safer Staffing Policy to assess whether the unit is open, case by case or closed/escalation depending on BAPM staffing requirements. e) Fortnightly activity meetings to review activity and any declined activity based of safer staffing requirements.	Louise Frampton, Lead Nurse	Nov-24		Closed		Nov-24

Appendix 5: One to one care in labour action plan.

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

Action Reference	Action Description	Deadline	Action owner	Status	Update
Maternity Services should support timely transfer to the delivery unit / birth centre.	Revisit the escalation process with all inpatient staff to ensure prompt escalation to support timely transfer to the Delivery Unit	31/10/2024	Intrapartum and Inpatient Matrons		**September 2024:** Process to be revisited with all staff via core huddles and team meetings. **Closed October 2024**: escalation process revisited and IQP developed and in progress to support further improvements.
	Audit compliance with of the red transfer pathway across within all inpatient areas and present the findings and action plan (if required) to the Site Obstetric Quality and Safety Committee (SOQS) meeting.	31/01/2025	Intrapartum and Inpatient Matrons		**September 2024:** MCS wide audit planned.
Maternity Services should review the process for transferring women from Maternity Triage to the antenatal ward to ensure appropriate care is provided based on a recent assessment.	Consider the development of an antenatal transfer navigator to ensure that appropriate risk assessments are completed prior to transfer from Maternity Triage.	31/01/2025	Maternity Triage Managers		**September 2024**: Intrapartum Matron and Triage Ward Managers liaise with Digital Midwife regarding the proposed development of an antenatal transfer tool.
Maternity Services to implement a standardised process for reviewing all births outside the delivery unit across the MCS.	Provide assurance that the standardised approach to incident review has been embedded to ensure that lessons learnt are shared.	30/09/2024	Ward Managers / Matrons.		**September 2024:** Tracker and proforma completed within 24 hours of the incident and details accessed to support the monthly highlight reports and the monthly report to SOQS.
Maternity Services should review the process for effective communication between NWAS and the maternity unit. (Saint Mary's ORC)	Revisit procedures surrounding the use of the red phone to ensure communication with the Maternity Unit and NWAS is standardised. Ensure that appropriate advice for transfer is adhered to.	30/09/2024	Intrapartum Matron		**September 2024:** Procedure regarding the use of the NWAS red phone has been discussed at Intrapartum Band 7 meetings for Saint Mary's ORC. Intrapartum Matron in communication with Consultant Midwife for NWAS to discuss any concerns as they arise/ following NWAS audit.
Maternity services should ensure that woman voices are heard and changes to clinical presentation assessed and acted upon within a timely manner.	Develop a process to capture feedback from woman who experience a birth outside of Labour Ward and include the feedback in the quarterly report to SOQS for	31/11/2024	Maternity Triage / Antenatal Ward Managers		**September 2024**: De-brief added to the proforma to capture women's experience and provide an opportunity to share any concerns / de-brief. Details to be included in the quarterly report from Q2 2024/25 and to be presented to SOQS November 2024.

	assurance of adaptive care provision.				
Maternity services to ensure that all staff are supported in the holistic assessment and recognition of labour for all gestations.	Consider a focused workstream surrounding recognition and management of labour and the importance of holistic reviews and not only relying on cervical dilatation to inform decision making.	31/10/2024	Maternity Triage / Antenatal Ward Managers /Matrons		**September 2024**: Ward Managers and Intrapartum/Inpatient Matrons to meet with Preterm Midwife to discuss an additional educational programme to support staff in the recognition of preterm labour. **October 2024:** Preterm Midwife undertaking additional education with the ward staff.
Maternity Services to provide assurance that correct advice is provided, and the guidance is followed during periods of deflect / divert across the MCS to assure safe provision of woman care.	Ward managers to ensure prompt review of advice provided and woman experience during periods of deflect or divert to identify lessons learnt are shared	31/08/2024	Maternity Triage Managers.		**September 2024:** robust review process implemented to review all births outside a maternity unit during a period of deflect/ divert, including lessons learnt and action planning.
	Consider an educational update for staff relating to the deflect processes.	30/11/2024 Extended 31/1/2025	Maternity Triage Managers.		**September 2024:** Ward Managers to consider adding education regarding this process to the ward orientation pack. **December 2024**: Work ongoing to develop escalation triggers for deflect/divert, educational update will follow this being agreed through governance process, Deadline date extended to reflect this
Maternity Services should review the processes for managing effective pain relief on the antenatal ward and supporting the early identification of labour.	Undertake an improving quality programme (IQP) to review care provided to women requiring analgesia on the antenatal ward.	31/01/2025	Ward 65 Ward Manager		**September 2024:** IQP commenced

Appendix 6: GMEC LMNS confirmation of compliance with Safety Action 6

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?

Reporting period: 2 April 2024 until 30 November 2024

Provider: MFT

Date of 1st Assurance Meeting	Date of 2nd Assurance Meeting	Date of 3rd Assurance Meeting
04/03/2024*	25/06/2024	18/09/2024

Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.

Is the LMNS confident requirement has been met? Yes ☒ No ☐

Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?

Is the LMNS confident MIS Year 6 requirements have been met? Yes ☒ No ☐

Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?

Note: It is a GMEC LMNS requirement to present, discuss and share learning relating to the SBLCBv3 to neighbouring trusts via GMEC LMNS SBL Champions Network Meeting.

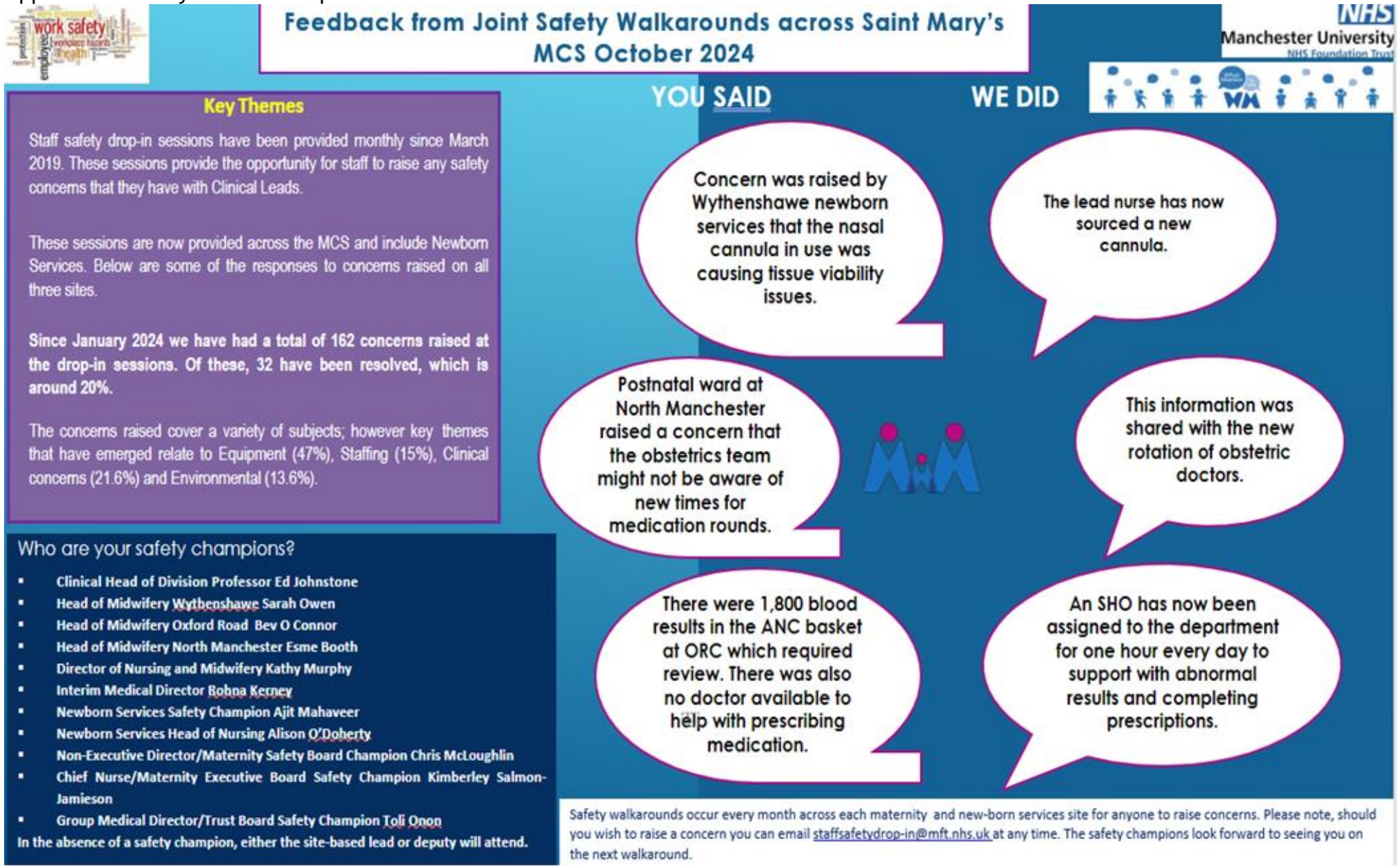
Has this been provided by their SBL Champion? Yes ☒ No ☐ Date Provided: 10/09/2024

X

Eileen Stringer
Clinical Lead Midwife

Date signed: 15/11/2024

Appendix 7: Safety Walkaround poster



NHS
Manchester University
NHS Foundation Trust

Maternity Incentive Scheme Year 6

Manchester University NHS Foundation Trust

Maternity Safety
Maternity Incentive Scheme Year 6

Safety Action	Compliance at end of reporting period 30th November 2024
1 – PMRT	Achieved – subject to MBRRACE triangulation
2 – MSDS	Achieved – confirmed by NHSE triangulation
3 – Transitional Care	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards.
4 – Medical Workforce	Achieved – with action plans in place
5 – Maternity Workforce	Achieved – with action plan in place
6 – SBLCBv3	Achieved – confirmed by LMNS triangulation
7 – MNVP	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards
8 – Training	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards
9 – Safety Champions	Achieved – LMNS checkpoint on 17th December 2024 confirmed all evidence has met the required standards
10 – MNSI/ENS	Achieved – subject to NHS R triangulation

Current status

At the end of the reporting period for MIS Year 6, the maternity and neonatal divisions with SM MCS have meet all 10 Safety Action standards.

2 of the 10 safety actions have received validation to confirm compliance.

The remaining 8 safety actions have been reviewed by GMEC LMNS at a final check point meeting on 17th December 2024, who have approved the MFT submission and will support sign off from the ICB Accountable Officer.

2 safety actions are subject to further external triangulation following submission by 3rd March 2025.

Next Steps

As outlined in the detailed report submitted alongside this presentation, SM MCS request MFT Board of Directors support MFT Chief Executive Officer to sign MFT's declaration of compliance with all 10 Safety Action standards required for MIS Year 6.

Once signed, this will be submitted for ICB Accountable Officer by end of January 2025 to support submission to NHS Resolution by 3rd March 2025.

Manchester University NHS Foundation Trust

Maternity Safety
Maternity Incentive Scheme Year 6

Safety Action 1: Perinatal Mortality Review Tool

Saint Mary's MCS achieved compliance for Year 6

- 100% of all eligible perinatal deaths have been notified to MBRRACE-UK within 7 working days (requirement 100%). 3 cases were confirmed by MBRRACE to be excluded from reporting.
- 97.5 % of all eligible PMRT cases have been started within 2 months (requirement 95%)
- 100% of parents have been informed and views/questions/concerns have been sought and all have been reviewed using PMRT (requirement 95%)
- 100% of all eligible PMRT cases since 30th May 2023 have been published within 6 months (requirement 60%)
- Quarterly PMRT reports submitted to the Board of Directors (Private) meeting (Q1 November 24 and Q2 January 2025).

This Safety Action is externally validated by MBRRACE-UK/PMRT from the data extract following submission in March 2025.

Safety Action 2: Maternity Services Data Set

Saint Mary's MCS achieved compliance for Year 6

- 11 out of 11 CQIMs met (requirement 10/11)
- 98% of MSDS data in July contained a valid ethnic category for women booked (requirement 90%).

This Safety Action has been externally validated by NHS England and provided a certificate of validation

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Maternity Safety
Maternity Incentive Scheme Year 6

Safety Action 3: Transitional Care and Avoiding Separation

Saint Mary's MCS has achieved compliance for Year 6

- Transitional care activity is provided on all 3 maternity sites with harmonised transitional care pathways in place.
- Quality Improvement Projects have been shared twice with Maternity and neonatal safety champions and LMNS

Safety Action 4: Effective Clinical Workforce Planning

Saint Mary's MCS has achieved compliance for Year 6

- Audit completed to review compensatory rest in line with RCOG.
- Audit completed for consultant attendance completed.
- Saint Mary's MCS have a duty anaesthetist available for obstetrics 24 hours a day on all 3 maternity sites.
- Compliant with BAPM standards for Neonatal Medical workforce.
- Bi-annual neonatal nursing staffing reports completed March and September 2024 and submitted to BoD. Action plan submitted to meet BAPM standards for neonatal nursing.

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Maternity Incentive Scheme Year 6

Safety Action 5: Effective Midwifery Workforce Planning

Saint Mary's MCS achieved compliance for Year 6

- BR+ completed in March 2023 and funded to the recommended establishment.
- Bi-annual staffing reports completed March and September 2024 and submitted to BoD.
- On each maternity site, Saint Mary's MCS have 1 supernumerary coordinator in charge of the labour ward on each shift and an escalation process to cover any occasion where the coordinator is not available.
- Providing one to one midwifery care remains the highest priority to maintain safety and is achieved >99% of the time. Action plan has been submitted and progress monitored for occasions when this is not met.

Safety Action 6: Saving Babies Lives Care Bundle v3

Saint Mary's MCS achieved compliance for Year 6

Saint Mary's are making good progress with implementation of SBLV3.

- SM MCS has attended the quarterly LMNS meetings and are progressing towards full implementation in line with the LMNS agreed trajectories.
- GMEC LMNS have provided confirmation that all required target have been met and achieve MIS standards for Year 6.

Manchester University NHS Foundation Trust

Maternity Safety
Maternity Incentive Scheme Year 6

Safety Action 7: Listening to women, parents and families

Saint Mary's MCS achieved compliance for Year 6

- Saint Mary's MCS have an MNVP Lead for each maternity site, who is funded to support required activities.
- Annual work programmes have been approved via GMEC LNMS and prioritise engaging with women from areas of high social deprivation and those from Black, Asian and minority ethnic backgrounds.
- An action plan is in place to address findings within CQC Maternity Survey and is monitored by safety champions quarterly.

Safety Action 8: Training

Saint Mary's MCS achieved compliance for Year 6

- Saint Mary's have a 3-year training programme which includes all 6 core modules of the core competency framework
- A Training Needs Analysis (in line with national requirements is in place)
- Between 8th December 2023 and 30th November 2024, Saint Mary's MCS achieved >90% for all relevant staff groups

	Midwives	Consultant Obstetrician	Trainee Obstetrician	MSW	Consultant Anaesthetist	Trainee Anaesthetist
CTG Competency Assessment	96%	96%	96%			
Fetal Surveillance	96%	97%	94%			
IIA Competency Assessment	95%					
CTG Monitor Training	95%					
Maternity Emergencies	94%	93%	96%	93%	95%	98%
Immediate Neonatal Life Support	92.5%					

Manchester University NHS Foundation Trust

Maternity Safety
Maternity Incentive Scheme Year 6

Safety Action 9: Maternity and Neonatal Safety and Quality

Saint Mary's MCS achieved compliance for Year 6

Saint Mary's MCS report quality and safety metrics bi-monthly via the updated perinatal quality surveillance model to Trust board and onwards to GMEC LMNS and includes:

- Moderate and above harm incidents and areas for learning/improvement feedback from Safety Champion walkarounds
- Staffing within maternity services and training compliance
- Minimum perinatal data set

Safety Action 10: MNSI reporting

Saint Mary's MCS achieved compliance for Year 6

- Saint Mary's MCS have reported 100% of all qualifying cases to MNSI and NHS R Early Notification Scheme (ENS) within the reporting period 8th December 2023 to 30th November 2024.
- For each case the family involved have received information regarding the role of HSIB and ENS
- 100% cases, where required, complied with Regulation 20 of the Health and Social Care Act 2008 in respect of duty of candour.

This Safety Action is externally validated by NHS Resolution following submission in March 2025

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	**Delegation of Statutory Functions of the Manchester University NHS Foundation Trust in relation to patients detained under the Mental Health Act. (MHA)**	**Agenda Item 11.6**
Presented by:	Kimberley Salmon Jamieson, Chief Nursing Officer	
Prepared by:	Cheryl Casey, Deputy Chief Nursing Officer Dr Beverley Fearnley, Director of Clinical Governance Andy Craggs, Matron Safeguarding Mental Health Ruth Speight, Assistant Chief Nurse Safeguarding Sarah Etches, Mental Health Act /Mental Capacity Act Manager	
Meetings where content has been discussed previously	Quality Safety and Performance Board Committee 18th December 2024	
Purpose of the paper Please check **one** box only:	☒ For approval ☐ For support ☐ For discussion	

Summary

The Delegation of Statutory Functions in relation to patients detained under the Mental Health Act is provided in Appendix A.

This document outlines the processes by which the Board of Directors ensures compliance with the Trust's statutory responsibilities under the MHA, in alignment with the MHA Code of Practice and statutory regulations.

Key Highlights:

Devolved Responsibilities:
The scheme of delegation defines the Trust's responsibilities for implementing the MHA at the service level across Clinical Groups. It is supported by the Trust's MHA Policy, which provides operational guidance for staff in applying the MHA.

Impending Legislative Changes:
A new Mental Health Bill is expected to be presented to Parliament soon. This may require further review and adjustment of the delegation framework to reflect changes in statutory requirements.
Registered Hospitals: The following hospitals are registered with the Care Quality Commission to assess or treat patients detained under the MHA 1983:

Manchester Royal Infirmary
Royal Manchester Children's Hospital
Royal Manchester Eye Hospital

Saint Mary's Hospital
Wythenshawe Hospital
Trafford General Hospital
North Manchester General Hospital

Within these hospitals, the Trust holds the authority to detain patients, ensuring primary responsibility for meeting the requirements of the MHA.

Collaborative Care:
The delivery of care and treatment for detained patients is conducted in partnership primarily with the Mental Health Liaison Team from Greater Manchester Mental Health NHS Foundation Trust (GMMH).
This partnership operates under the Mental Health Liaison Service Operational Procedure, which aligns with the Manchester Mental Health Liaison service specification, overseen by the Greater Manchester Integrated Care Board Manchester Locality.

Stakeholder Consultation and Legal Review:
The Scheme of Delegation has undergone extensive consultation with the Mental Health Subgroup, Trust Safeguarding Group, Child and Adolescent Mental Health Service, and GMMH.
External legal validation was provided by Paul Allerston, Partner Solicitor-Advocate at Hill Dickinson LLP, specialising in Healthcare and Public Law.
This robust framework ensures the Trust's compliance with statutory requirements, supports clinical teams in the delivery of care, and prepares for anticipated legislative updates.

Training
Following on from the Board of Directors training in 2024, further training for Senior Leadership Team and colleagues across MFT is being planned. An ongoing propgramme of training is under development and appropriate professional refresher course.

Recommendation(s)

The Board of Directors is asked to

- Review and approve that this Delegation of Statutory Functions of the Manchester University NHS Foundation Trust in relation to patients detained under the Mental Health Act and support this report for approval.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**Yes** Due regard has been given to the nine protected characteristics of the Equality Act (2010). Certain groups are more to experience behavioural disturbance due to mental health conditions, for example dementia, psychosis or anxiety. Specific sedation guidance has been developed in relation to maternity and pregnancy protected characteristic with respect to perinatal mental health concerns

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☒	LHL objective 2	☒
HQSC objective 1	☒	HQSC objective 2	☐

HQSC objective 3	☒	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: **MFT/001674 Mental Health Act (Risk Score 9)** If a patient is not detained appropriately under the Mental Health Act 1983, patients may be placed at risk and the organisation exposed to a legal review**.**	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • The Care Quality Commission have a regulatory duty to monitor how the Trust exercises its powers and discharge its duties when patients are detained in hospital or are subject to community treatment orders or guardianship.	

Appendix A: Delegation of Statutory Functions of the Manchester University NHS Foundation Trust in relation to patients detained under the Mental Health Act

Table of Contents

1 Introduction and Purpose

1.1 This Scheme of Delegation is documented in reference to the Mental Health Act (MHA) 1983 (as amended by the 2007 Act) and the Code of Practice to the MHA as revised in 2015. The MHA is an all-age legal framework.

- Sections referred to are sections of the Mental Health Act (MHA) 1983.

1.2 In England, NHS hospitals are managed by NHS trusts and NHS foundation trusts. For these hospitals (including acute/non-mental health hospitals), the 'Trusts' themselves are defined as the 'hospital managers' for the purposes of the MHA.

1.3 In Manchester University NHS Foundation Trust (MFT) the following hospitals are registered with the Care Quality Commission (CQC) for the regulated activity of assessment and treatment for persons detained under the MHA. North Manchester General, Wythenshawe, Trafford, Royal Manchester Children's, St Mary's, Manchester Royal Eye Hospital, and Manchester Royal Infirmary.

1.4 The Code of Practice requires in Chapter 37, that arrangements for who is authorised to take which decisions should be set out in a Scheme of Delegation. For an NHS foundation trust "the hospital managers" means the Trust itself, i.e. the Trust Board of Directors is required to approve the Scheme of Delegation. Unless the MHA or regulations[1] say otherwise, the Trust Board may delegate their functions under the MHA to nominated officers of the trust. This document describes the Scheme of Delegation which is summarised in the table in Appendix 1.

1.5 The 'Trust' Board retains responsibility for the performance of all hospital managers' functions exercised on their behalf under Chapter 37 of the Code.

1.6 The Trust must exercise Chapter 38 of the code to ensure hospital managers' have power of discharge in relation to unrestricted detained patients and patients on community treatment orders.

1.7 The 'Trust' has the authority to detain patients under the MHA. The Board of Directors in their role as hospital managers have the primary responsibility for ensuring that the requirements of the Act are followed through the Scheme of Delegation. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

[1] The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 and / or any other Regulations associated with delegation of functions'

1.8 In limited circumstances, for example in Galaxy House. the Trust responsibility extends to patients subject to section 17A – Community Treatment Orders (CTO), even if those patients are not actually being treated at one of the hospitals. The Mental Health Trust Responsible Clinician retains responsibility for patients with a CTO receiving care at MFT. A CTO would only be initiated by Galaxy House Responsible Clinicans at MFT (MFT Consultant Child and Adolescent Psychiatrist).

1.9 Regulation 3[2] provides that any document, or application for admission, which is to be served on the Trust, may either be sent by post, delivered personally to the Trust or via electronic documentation, to any person authorised by the Trust to receive such documents. These documents include: -

- Medical recommendations and applications from the Approved Mental health Professional (AMHP) which constitute the authority for a patient's detention.
- A form H1 (Section 5(2)) authorising the emergency detention of a patient. This will only commence once received by a registered nurse, midwife or authorised member of staff.
- A form H5 is completed by the Responsible Clinician for renewing the authority for detention under section 20.
- A notice of intention to make an order for discharge under Section 23.

Appendix 2 provides a key of the MHA sections.

1.10 The time limits imposed by the Act, mean that it is important the above documents are passed on expeditiously by the authorised staff who receive them on behalf of the Trust, to the officers who will be responsible for their receipt, scrutiny and rectification of documents and storage. Any Registered Nurse or Midwife can accept the MHA paperwork from the Approved Mental Health Professional (AMHP).

1.11 Documents that represent and confirm the legal authority to detain and treat the patient must be retained by the Trust through its records retention and destruction policy[3], commencing on the date on which the person to whom they relate ceases to be a hospital inpatient.

1.12 The Responsible Clinician[4] (RC) is defined as an 'Approved Clinician' with overall responsibility for the case of the patient in question. At MFT the Responsible Clinician would usually be a Mental Health Liaison Team (MHLT) Consultant Psychiatrist provided by Greater Manchester Mental Health NHS Foundation Trust (GMMH). This service provision is articulated in the Manchester Mental Health Liaison Service Specification and Mental Health Liaison Service Operational Procedure – Manchester

[2] Regulations 3 2008 were amended by The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 to enable documentation to be received electronically.
[3] Retention of Data, Off-site Archiving and Destroying Documents ratified by Sponsorship and Governance Oversight Committee 11th January 2022.
[4] The Responsible Clinician must be a clinician approved by the Secretary of State Section 12ZA/section 12ZB or the Welsh Ministers and registered as an Approved Clinician

and Trafford Services. The exception is an inpatient at Galaxy House when this would be a Child and Adolescent Consultant Psychiatrist. The Responsible Clinician has certain powers and duties under Part II and III of the Act, including in respect of hospital patients, including the power to:-

- Grant leave of absence under section 17
- Discharge
- Bar discharge by the nearest relative
- Renew authority for detention
- Authorise care and treatment

1.13 When the Responsible Clinician is not available and urgent action is required, another clinician registered as an Approved Clinician, should exercise the functions of the nominated Responsible Clinician. The patient's usual Responsible Clinician should normally undertake the examinations and reports authorising renewal under Section 20, which can be made at any time during the preceding two-month period.

2 Roles and Responsibilities under the Scheme of Delegation of Statutory Functions of MHA

2.1 Receipt of documents authorising the Trust to detain a patient

Overall responsibility for the scrutiny and proper receipt of the documents is the responsibility of the MHA Manager in the MFT Safeguarding Mental Health Team or the Mental Health Act Administrator if Galaxy House.

The nurse in charge of the ward/department/unit to which the patient is to be admitted to and detained, is authorised to receive the application and medical recommendations that constitute the authority for the Trust to detain the patient. This may be delegated to a band 5 Registered Nurse/Midwife or above and uploaded/stored as per MFT Mental Health Act Policy. The MHA Manager or Administrator will then scrutinise the paperwork.

Within 12 hours after the detention, these documents must be uploaded into the HIVE electronic patient record and stored in the designated area per site (refer to MFT MHA Policy and Receipt of Section Papers Flow Chart). The Safeguarding Mental Health Team or Mental Health Act Administrator if Galaxy House, are deputised by the Trust to scrutinise the documents using the MHA Detention Document Scrutiny Checklist included in the MHA policy, to ensure that errors or omissions do not invalidate the detention of the patient.

2.2 Receipt of reports under Section 5(2) authorising the detention of a patient not previously liable to be detained.

Under Section 5(2), the MFT medical doctor or their nominated deputy (Foundation Year 2 or above) in charge of the patient's treatment, concludes that an application for detention can be made, a form H1 in line with the MHA policy must be completed. In such cases the patient may be detained in hospital for a period of 72 hours from the time when the report is accepted. The Nurse in Charge or delegate (Band 5 or

above registered nurse or midwife) are responsible for accepting the Section 5(2) report. The doctor and nurse are responsible for informing the Mental Health Liaison Team/CAMHS of the application immediately as per the MHA Policy.

2.3 Reports renewing authority for detention under section 3 (Section 20)

Section 20 Detention renewal must be completed by the Responsible Clinician The initial authority for the detention of a patient under Section 3 lasts for six months, as does the first renewal. Subsequent renewals are for one year. The Responsible Clinician must review the need for continued detention periodically.

The Safeguarding Mental Health Team or the MHA Administrator at Galaxy House will scrutinise and ensure that the provisions of the Act are complied with in respect of the review of patients under Section 20 and section 20A.

2.4 Discharge of a patient (Section 23)

The Responsible Clinician has the authority to discharge patients from detention following the completion of a section 23 discharge form stating the patient is no longer detained under the MHA.

2.5 Discharge of a patient (Section 25)

Relatives are required to give 72 hours' notice in writing of their intention to exercise their powers of discharge. During office hours (Monday to Friday 08.30-1630) the Safeguarding Mental Health Team or Mental Health Administrator if Galaxy House are authorised to receive these documents. Out of hours this authority is delegated to the Nurse in Charge of the ward.

On receipt of the notice of intention to discharge the Responsible Clinician and or MHLT must be contacted so that he/she may consider issuing a report barring discharge within 72 hours of the document being received.

The Responsible Clinician must, if he/she issues a report barring discharge under Section 25, deliver this report to the Safeguarding Mental Health Team or Mental Health Act Administrator or their deputy within the 72-hour time limit.

2.6 Transfer of Patients (Section 19)

The Trust has delegated the authority given under Regulation 7 to the patient's Responsible Clinician, or in his absence to the Nurse who is at the time in charge of the ward. This is completed in line with the MHA policy.

2.7 Amendment of application for admission and supporting medical recommendations (Section 15)

The Trust has authorised the Safeguarding Mental Health Team or the Mental Health Act Administrator if Galaxy House to consent on its behalf to the amendment of these documents. Current statutory versions of the forms must be used.

2.8 Referral to Mental Health Review Tribunal (Section 68)

The Trust has delegated authority to the Safeguarding Mental health team or Mental Health Act Administrator if Galaxy House, to carry out the functions of the Hospital Managers under section 68, for the referral of patients under Part II and III of the Act to a Mental Health Review Tribunal, where such a hearing has not been requested by the patient or his/her nearest relative and where the case has not been referred to the Tribunal by the Secretary of State within the specified time limits.

Where a Tribunal hearing has been arranged, the Safeguarding Mental Health Team or Mental Health Act Administrator if Galaxy House are authorised by the Trust to inform health and local authorities and request the provision of reports.

2.9 Section 136 Police Emergency Powers.

Section 136 allows a police officer to remove a person from a public place. That person must “appear to a police officer to be suffering from mental disorder and to be in immediate need of care or control.” The section 136 commences on arrival at the place of safety (emergency department).

The MFT nurse or doctor must complete a referral to MHLT on arrival in the ED or as soon as a patient is medically fit for assessment.

The GMMH MHLT should initiate and arrange the mental health assessment required under section 136 MHA in parallel with MFT physical health care processes.

The section 136 provides compulsory detention to a place of safety for up to 24 hours for a Mental Health Act assessment by medical practitioner and an AMHP.

Where the person’s state of physical health precludes completion of the assessment of their mental health within the initial 24 hour period of detention under section 136, the assessing doctor from the MHLT may extend the duration of the section 136 by a period of 12 hours in order to allow the mental health assessment to be completed.

Police are responsible for the safety of a patient on a section 136. If an Emergency Department allows the police to leave, they take on this responsibility and should be confident they have staff and resources to deal with the risk of the patient absconding.

2.10 The provision of Information (Section 132)

All Staff are authorised for the purposes of section 132 of the Act, authorised by the Trust, to carry out the requirement of the Trust, to provide written and oral information to detained patients of their legal position and rights, as soon as practicable following the detention when it is safe and appropriate according to the patient’s condition. It is also their delegated responsibility to ensure that records are kept of the information

given, that in circumstances the information is given appropriately and that where possible, it is understood by the patient.

The duty to inform the patient's nearest relative in writing is delegated to the Safeguarding Mental Health Team or Mental Health Act Administrators and their deputies. The duty under Section 133 to inform the nearest relative, (if practicable/appropriate), at least seven days before the patient's discharge, is delegated to the patient's Responsible Clinician.

2.11 Management responsibilities

Senior Managers and Team leaders are responsible for:

i. Providing this information to all new (applicable) staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes this Scheme of Delegation of Statutory Functions in relation to patients detained under the MHA and the MHA policy.

ii. Ensure that their staff know how and where to access the current version of the MHA policy, via intranet.

2.12 Training requirements:

The Safeguarding Mental Health team are responsible for implementing training programmes for all staff involved in the delegation process to ensure that they understand the legal framework, the specific duties they are responsible for and the implications of their actions.

3 Equality Impact Assessment

Due regard has been given to the nine protected characteristics of the Equality Act (2010). The evidence base indicates certain groups are more vulnerable to experience behavioural disturbance due to mental health conditions, for example, dementia, psychosis or anxiety. Specific sedation guidance[5] has been developed in relation to maternity and pregnancy protected characteristic with respect to perinatal mental health concerns.

Training provided through the mental health mandatory and bespoke training programme at all levels will increase knowledge and awareness in relation to behavioural disturbance, with implied focus on prevention, through early identification of clinical condition or unmet need. This will ensure staff are aware of the potential for direct discrimination or indirect discrimination in relation to this patient cohort. The training includes consideration of cultural impact on behaviours ensuring staff have developed an awareness of cultural competency through training packages.

[5] Mental Health in Pregnancy ratified by Medicines Management Committee 17th December 2021

4 Consultation, Approval and Ratification Process

4.1 This scheme of delegation of statutory functions of the MHA has been developed in collaboration with key stakeholders across MFT through the Mental Health Subgroup and Group Safeguarding Committee, this includes medical and nursing colleagues as well as Greater Manchester Mental Health NHS Foundation Trust and MFT Child and Adolescent Mental Health Services.

4.2 The Scheme of Delegation will be presented to the Board of Directors for approval, following approval at the Quality, Safety and Performance Board Committee.

4.3 Dissemination of the scheme of delegation will be achieved by posting on the Trust intranet site and cascaded through all Directors of Nursing and Medical Directors via Trust Safeguarding Group.

5 Implementation

The Mental Health Subgroup is responsible for oversight of the implementation of this scheme of delegation receiving assurance reports from Clinical Groups on the implementation of the scheme of delegation of statutory functions of the MHA through incident reporting and monitoring of the application of the MHA policy.

The Safeguarding Mental Health Team will conduct an annual review of the scheme of delegation to ensure it remains effective and compliant with current legislation and best practice. This will be completed through the safeguarding mental health audit programme, reported to the Trust's Mental Health subgroup and Safeguarding Quality and Learning subgroup.

6 Associated Trust Documents

MFT Mental Health Act Policy ratified by Group Safeguarding Committee 7th March 2023.

Retention of Data, Off-site Archiving and Destroying Documents ratified by Sponsorship and Governance Oversight Committee 11th January 2022.

Mental Health in Pregnancy ratified by Medicines Management Committee 17th December 2021

7 References and Bibliography

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Legislation.gov.uk. (2022). *The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008*. [online] Available at: https://www.legislation.gov.uk/uksi/2008/1184/contents/made.

11 Appendices

Appendix 1: Delegation of Statutory Functions in Manchester University NHS Foundation Trust in relation to patients detained under the Mental Health Act (MHA) Summary Table.

Appendix 2: Common Mental Health Act Sections Summary Table

Appendix 1: Delegation of Statutory Functions in Manchester University NHS Foundation Trust in relation to patients detained under the Mental Health Act (MHA) Summary Table.	
Regulated activity	**Person (or group) with delegated authority**
Receipt of documents authorising detention including receipt of documents and recording of detention.	MFT[6] Registered Nurse or Midwife on the ward where the patient is detained.
Scrutiny of documents authorising detention including receipt of documents and recording of detention.	MFT Safeguarding Mental Health Team or MHA Administrator in Galaxy House.
Section 136 Police Emergency Powers	Police officer to take a patient to a place of safety Police are responsible for the safety of a patient on a section 136. If the MFT Emergency Department allows the police to leave, they take on this responsibility and should be confident they have staff and resources to deal with the risk of the patient absconding. The MFT nurse or doctor must complete a referral to the Mental Health liaison Team (MHLT). The GMMH MHLT initiate and arrange the mental health assessment required under section 136 MHA, by a medical practitioner and an AMHP.
Section 5(2) authorising the detention of a patient not previously liable to be detained.	MFT Medical Doctor FY2 or above, on duty providing patient's medical treatment.
Reports renewing authority for detention (Section 20)	GMMH[7] Responsible Clinician MHLT Consultant Psychiatrist or MFT and Adolescent Consultant Psychiatrist in Galaxy House
Discharge of a patient (Section 23)	GMMH Responsible Clinician (or nominated deputy) MHLT Consultant Psychiatrist or MFT and Adolescent Consultant Psychiatrist in Galaxy House
Receipt of Discharge of a patient by Nearest Relative (Section 25)	Monday to Friday 8.30 -4.30 Safeguarding Mental Health Team or Mental Health Administrator if Galaxy House are authorised to receive notice of intention to discharge. Out of hours this authority is delegated to the Nurse in Charge of the ward. On receipt of the notice of intention to discharge the Responsible Clinician and/ or MHLT must be contacted by the person receiving notification
Transfer of Patients (Section 19)	MFT Nurse in charge or ward manager or senior nurse/midwife on duty.
Amendment of application for admission and supporting medical recommendations (Section 15)	Safeguarding Mental Health Team or the Mental Health Act Administrator if Galaxy House
Reference to Mental Health Review Tribunal (Section 68)	Referral actioned by Safeguarding Mental Health Team or MHA Administrator if Galaxy House
The provision of Information (Section 132)	All Medical Staff, all Registered Nurses (includes 132 rights and how to access an independent mental health advocate (IMCA)).

[6] Manchester University NHS Foundation Trust
[7] Greater Manchester Mental Health NHS Foundation Trust (GMMH) Mental Health Liaison Team (MHLT)

Appendix 2: Common Mental Health Act Sections Summary Table.

Section	Type of Order	Detail	Length of Section
Section 5(2) **Doctors Holding Power**	A patient who is **admitted** to the Trust is wanting to leave hospital. There are suspicions that they are suffering from a mental disorder, requiring further mental health assessment	Application is made by the doctor in charge of the patient's treatment (or their nominated deputy)	Section 5(2) lasts for up to 72 hours, although the intention would be to conclude the assessment as quickly as possible for the MHA assessment team. There is no right of appeal under Section 5(2). Patient must be informed of their rights and updated about the likely arrival time of the MHA assessment team.
Section 2	A Mental Health Act '**assessment'** order Used when a patient who is admitted to the Trust is suspected of having a mental disorder. Patient is unwilling to stay voluntarily to receive the mental health assessment. Treatment may be given to manage behavioural symptoms of the disorder, such as sedative medication.	Must be agreed by 2 doctors. one of them must be a 'Section 12 approved' doctor. The Section 2 requires both medical recommendations to agree that detention is necessary to assess mental health state and reduce risk of harm to self or others. An approved mental health professional (AMHP) or someone's nearest relative (rarely) can then apply to hospital managers for an individual to be admitted under Section 2	Up to 28 days from the time that section 2 papers agreed. This Section cannot be renewed. If further detention is needed this must be done under Section 3 of the Act.

Section 3	Allows for an admitted patient to be detained for treatment under the MHA. Applications from nearest relatives are very rare. Allows for treatment of the patient's mental disorder, as well as any condition which is a direct consequence of their mental disorder.	Must be agreed by 2 doctors one of them must be a 'Section 12 approved' doctor. must agree that someone should be detained for treatment in the interests of their health or safety, or for the protection of others. An approved mental health professional (AMHP) or someone's nearest relative can then apply to hospital managers for an individual to be admitted under Section 3	Up to 6 months
Section 15	Time limited process to allow for amendment of section papers if a rectifiable error has been identified.		
Section 17	Allows a patient detained by another provider service to be admitted to the Trust for care of their physical health. The responsibility for the patient's detention and treatment under the MHA remains with the detaining organisation. MHLT will provide review of admitted patients and liaise with the RC from the psychiatric hospital. OR Section 17 leave must be granted by the RC before a patient detained to MFT can be allowed to leave the ward/hospital/hospital grounds depending on where they are specifically detained to.		
Section 19	Transfers the responsibility of a detained patient to a different Trust		
Section 20	Detention renewal by the Responsible Clinician		
Section 23	Discharge from detention by the Responsible Clinician		

Agenda Item 12

Manchester University NHS Foundation Trust

Escalation and Assurance Report
People Board Committee (PBC)

Report to: Board of Directors
Report from: Angela Adimora, Non-Executive Director and Chair of PBC
Date of meeting: 18/12/24

Key escalation and discussion points from the meeting
Advise:
The committee heard a staff story from a Director of Finance at a Clinical Group and discussed his experience at MFT including the potential for unconscious bias with the use of verbal and numerical reasoning tests for those for whom English is a second language. The committee considered the workforce-related metrics within the Integrated Performance Report (IPR). Sickness absence, and consequently temporary staffing costs, remain above target. A comprehensive and holistic programme approach to absence prevention and attendance management is in place with each Clinical Group owning a bespoke target and action plan to drive local action. The committee discussed the Chief People Officer's report which provided an update on the Trust's organisational development programme; the Trust's apprenticeship programme; and attendance management including an internal audit review of special leave provision. At the time of the meeting, the national staff survey response rate was at c.45%. Validated data is still awaited and will be presented to the next committee meeting. The committee discussed progress being made in delivery of the workforce digital strategy. A focus has been on digital improvements to recruitment and on-boarding and MFT is one of 13 organisations nationally to automate payroll processes. New Power BI reports are available to better understand team absences. Progress with delivery of the Trust's organisational development programme was presented to the committee. The collective leadership approach is underway with staff voting on what the Trust's priorities should be from 22 improvement actions identified by the Trust's change agents. Over 400 people have been on the Compassionate Leadership programme and 650 staff have attended the Civility Saves Lives training.
Assure:
The committee received a detailed update from the Specialist Hospitals Clinical Group on the cultural work which has been underway in Saint Mary's Managed Clinical Service (SMMCS). The national Perinatal Culture and Leadership Programme has been completed with executive team coaching also continuing. Another culture survey has been completed by staff with the results awaited. SMMCS has hosted three visits by the Local Maternity and Neonatal System with positive feedback received from them. The recruitment and retention of midwives remains an area of focus and a promotional campaign has been launched to increase the number of Freedom to Speak Up champions within maternity services.

The committee received an update in the work to embed the national violence prevention and reduction standards. 16 are now declared as fully compliant and 16 as partially compliant. Work continues to embed the approach and increase the level of training across the Trust's workforce.

The committee received the Freedom to Speak Up Guardian's Q2 report which shows the highest level of activity yet facilitated by the newly expanded team. 82 concerns were raised during the quarter. Staff wellbeing and bullying and harassment were the highest reported issues.

The committee received the Guardian of Safe Working's Q2 report. 240 exception reports (ERs) were submitted by 113 doctors in Q2, which is 20 more ERs than the number reported in Q1). High workload accounted for 50% of the ERs received.

From the Board Assurance Framework (BAF), the Committee received updates from lead Executive Directors regarding progress with the actions required to deliver strategic objective 6 and 7 of the MFT strategy. These are included in the BAF presented to the Board at its January meeting.

Risks discussed at the meeting

Two new strategic risks were presented for discussion at the meeting prior to approval at the Trust Risk Oversight Committee

Report approved by: Angela Adimora, Non-Executive Director and Chair of the PBC.

Agenda

Manchester University
NHS Foundation Trust

People Board Committee

Date: Wednesday, 18th December 2024
Time: 2:00pm – 4:00pm
Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	2.00pm
2	**Declaration of interest** (verbal)	Meeting admin	Chair	2.00pm
3	**Minutes of the previous meeting** (30th October 2024)	Meeting admin	Chair	2.00pm
4	**Action Log**	Discussion	Chair	2.05pm
5	**Matters Arising**	Discussion	Chair	2.05pm
6.	**Assurance Reporting**			
	6.1 Risk Report	Discussion	Chief People Officer/ Director of Clinical Governance	2:10pm
	6.2 Integrated Performance Report	Discussion	Director of Corporate Workforce	2.15pm
	6.3 Board Assurance Framework	Discussion	Director of Corporate Workforce	2.20pm
Strategic aim 3: Be the place where people enjoy working, learning and building a career				
7.	7.1 Staff story (film)	Discussion	Chief People Officer	2.25pm
	7.2 Chief People Officer report	Discussion	Chief People Officer	2.30pm
	7.3 Cultural work at St Mary's Managed Clinical Service outcome report	Discussion	Interim Clinical Group Chief Executive Officer	2.35pm

			– Specialist Hospitals	
	7.4 People Plan update (verbal)	Verbal Update	Deputy Chief People Officer	2.45pm
	7.5 Staff Survey	Discussion	Interim Director of Organisational Development & Inclusion	3.00pm
	7.6 Workforce Digital Strategy progress report	Discussion	Deputy Chief People Officer	3.20pm
	7.7 Violence Prevention and Reduction Standards	Discussion	Director of Corporate Workforce	3.25pm
	7.8 Organisational Development programme update (P1, P2, P3) including leadership diversity review	Discussion	Interim Director of Organisational Development & Inclusion	3.30pm
	7.9 Freedom to Speak Up Quarterly Report (Q2)	Discussion	Freedom to Speak Up Guardian	3.40pm
	7.10 Guardian of Safe Working Quarterly Report (Q2)	Discussion	Guardian of Safe Working	3.45pm
Good governance				
Committee business				
8.	**Escalation report**	Approval	Chair	3.55pm
9.	**Workplan Review**	Meeting admin	Chair	3.55pm
10.	**Any Other Business** (verbal)	Discussion	All	4.00pm
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	4.00pm
Date of next meeting: Wednesday, 26th February 2024				

Manchester University NHS Foundation Trust

Escalation and Assurance Report
Finance Board Committee

Report to: Board of Directors
Report from: Trevor Rees, Deputy Chairman and Chair of Finance Board Committee
Date of meeting: 17th December 2024

Key escalation and discussion points from the meeting
Alert
The committee discussed the risks to the forecast outturn and supported the position that the Trust would continue to plan for a £3.6m but noted that this was dependent on the income due for industrial action, pay awards, and ERF funding being received in line with the commitments received from funding bodies earlier in the financial year, from which the forecast was determined. The committee considered and supported the following reports which are being presented to the Board for approval: • PFI market testing proposal – the committee supported option 2a. • Surgical robots contract award – the committee supported the use of Chair's action to sign the contract in advance of the Board meeting. • Sleep service equipment and consumables contract – the committee supported the contract award.
Advise:
The committee received the Chief Finance Officer's report and the finance elements of the Integrated Performance Report and discussed in detail the current financial position and the risks to achieving the forecast outturn position including the likelihood of the funding for the national pay award being insufficient to cover the costs of the award for MFT. Actions being taken to redeem the position were noted. The committee received the Value for Patients' programme update. £87.5m has been delivered against a plan of £89.5m. £169.2m of schemes have been identified (across all stage gates) against a full year forecast delivery of £143m. Work continues to identify opportunities and to increase the proportion of recurrent savings over non-recurrent savings. Planning for 2025/26 is underway with the outputs of cut 1 being analysed. Clinical Groups are holding workshops during December and January ahead of cut 2 at the end of January.
Assure:
From the Board Assurance Framework (BAF), the committee received updates from lead Executive Directors regarding progress with the actions required to deliver strategic objective 8 of the MFT strategy. This is included in the BAF presented to the Board at its January meeting.
Risks discussed at the meeting
The committee discussed the strategic relevant to the committee's scope.

Report approved by: Trevor Rees, Deputy Chairman and Chair of Finance Board Committee

Agenda

NHS
Manchester University
NHS Foundation Trust

Finance Board Committee

Date: 17th December 2024
Time: 2:00pm
Location: Main Boardroom, Cobbett House, ORC

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Minutes of the previous meeting** (29th October 2024)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising**	Discussion	Chair	
6.	**Assurance Reporting**			
	6.1 Risk Report	Discussion	CW/MT	
	6.2 Integrated Performance Report	Discussion	CW/MT	
	6.3 Board Assurance Framework	Discussion	CW/MT	
Strategic aim 4: Ensure value for our patients and communities by making best use of resources				
7.	7.1 Chief Finance Officer's report M8 • National pay award • Forecast outturn review and approval	Discussion	CW/MT	
	7.2 Value for Patients programme update	Discussion	VG/MHS	
	7.3 PFI market testing	Support	RJ	
	7.4 Surgical robots contract award	Approval	CW/MT	
	7.5 Sleep service equipment and consumables contract Award	Approval	CW/MT	

Committee business				
8.	**Escalation report**	Approval	Chair	
9.	**Workplan Review**	Meeting admin	Chair	
10.	**Any Other Business** (verbal)	Discussion		
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: 25th February 2025				

Manchester University
NHS Foundation Trust

Board of Directors (Public)
Monday 20th January 2025

Paper title:	Chief Finance Officer's Report – M8	**Agenda Item 13.2**
Presented by:	Claire Wilson, Chief Finance Officer	
Prepared by:	Ann Bracegirdle, Deputy Chief Finance Officer	

Meetings where content has been discussed previously	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion

Executive summary / key messages for the meeting to consider (300 words max)

- The financial position against control total (CT) for November 2024 in month is a **£6.3m surplus, £3.9m favourable** to plan and YTD a **£30.9m deficit**, **£28.1m** adverse to plan against the CT. The month 8 favourable variance is largely driven by income over-performance relating to a prior year benefit.
- After non operating adjustments, the month 8 position is a **£0.7m deficit** against a plan of a £4.2m deficit (YTD £**68.5m deficit** against a £57.9m plan, a **£10.5m adverse variance**).
- **The YTD position includes costs/income loss of £3.2m associated with junior doctor industrial action in June and July and c.£4m YTD pressure for the nationally agreed pay award.**
- The month 8 and YTD position includes the impact of 24/25 pay awards with arrears split over October and November and movements in estimated accruals accounting for the favourable in month pay variance.
- The majority of the YTD overspend relates to undelivered VfP and operational pressures.

Recommendation(s)
The Board of Directors is asked to: • Note the contents

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key overleaf)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☒
VfP objective 2	☐	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☐
Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: •		
Care Quality Commission domains Please check **all** that apply	☐ Safe ☐ Effective	☐ Caring ☐ Well-Led	

	☐ Responsive	
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: •	

Main report (2000 words maximum - please use appendices for all further information)
See attached report

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation**	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part

that improves people's lives	**R&I – objective 2**	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation

NHS
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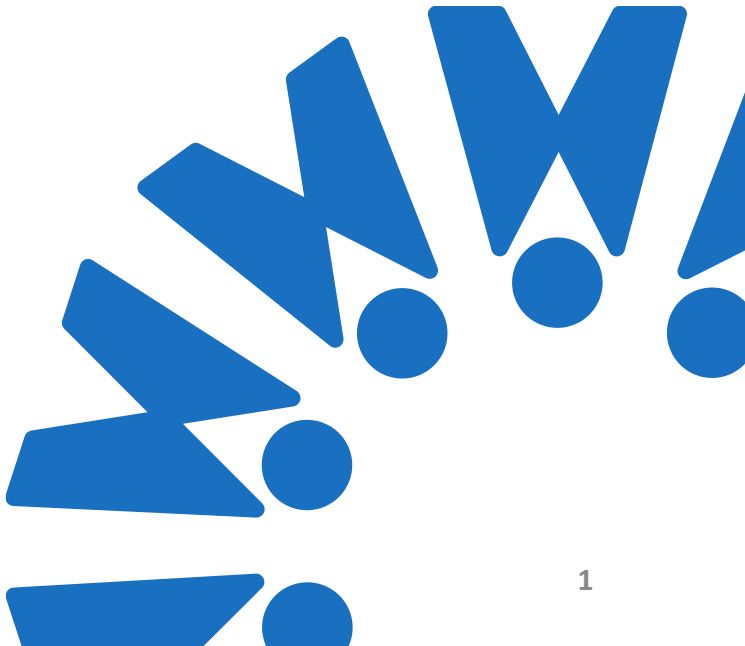
CFO Report M8 2024/25

Manchester University NHS Foundation Trust



Executive Summary

NHS
Manchester University
NHS Foundation Trust

Page	Area	Narrative
	Overview	The Trust's revenue plan for 2024/25 is a challenging £3.6m surplus. This is supported by a requirement for delivery of £148m of Value for Patients (VfP) savings - 5.0% of operating expenditure.
3 - 11	Income & Expenditure	The in month position is a £6.3m surplus, £3.9m favourable to plan. YTD, there is a £30.9m deficit, adverse to plan by £28.1m. This is driven by c. £6m estimated under-funding of annual pay awards, £3.2m linked to Industrial Action costs in June and July, under-delivery against the budget reducing elements of the VfP programme, insourcing and high use of non-pay to deliver activity above planned levels. The forecast for year end is to deliver the plan, but with a high level of risk - the risks are noted on page 16.
12	VfP	YTD delivery of £87.5m, against a plan of £89.5m, adverse to plan by £2.0m.
13 - 14	SoFP, Cash & Liquidity	Cash balance of £90.9m to 30th November 2024, favourable to plan by £13.9m reflecting variances on prior year income and timing differences on pay award funding – these are partially offset by impact of YTD deficit, adverse timing differences on supplier payments, and shortfall in PDC income of £16.2m.
15	Capital	GM allocation remains unconfirmed although £10m CDEL of the £16.2m expected for the Pennine Acute Hospital Trust acquisition (PAHT) has been confirmed by NHSE; further confirmation if this will be cash backed is being sought. YTD expenditure of £47.8m, an adverse variance of £26.7m with £5.2m GM envelope on NMGH backlog held back due to the uncertainty in relation to the PAHT funding, and £13.8m delays to the PDC funded schemes with CDC Withington, TIF scheme and NHP currently behind plan. With the exception of the NHP, the PDC schemes are anticipated to deliver to the plan by year end.
16 - 17	Risk and Mitigations	There are some material risks which could impact on delivery of the 2024/25 financial plan. Work is ongoing to identify and implement mitigations should these risks materialise.

Income & Expenditure – Month 8 2024/25

Manchester University NHS Foundation Trust

In month 8 there is a favourable variance to plan of £3.9m and an adverse variance year to date of £28.1m against the control total.

The in-month position for pay expenditure is skewed by the arrears for pay awards in M8.

Income (note there is £4.8m of NR central flexibility supporting the position YTD to M8)

The YTD **£29.5m** favourable variance (in month favourable variance of **£5.5m**) to plan is largely driven by:

- Over-performance against CPT Drugs and Devices of £11.5m
- Over-performance against the ERF target of £9.0m offset by under delivery of £2.2m against Project 108 and £0.2m associated with losses due to Junior Doctor's IA cost. There is also a £3.7m benefit from ERF over-performance in 2023/24.
- Contract variations, Private Patients, RTA income and other changes to contractual income accounts for an adverse variance of £3.5m YTD
- E&T income favourable by £5.0m and R&I income £1.8m favourable to plan
- Other income variances to plan totaling a favourable £3.9m YTD for commercial income

Pay Variance (note there is £0.3m of NR central flexibility supporting the position YTD to M8)

The YTD **£28.2m** adverse variance (in month favourable variance of **£1.3m**) to plan is driven by:

- YTD costs for the 24/25 pay awards are **c.£4.0m higher** than income received to cover them (this has reduced from M7 following further review of income assumptions and analysis of actuals).
- Under-performance against the YTD VfP target and pressures associated with operational delivery.
- YTD Junior Doctor's industrial action costs of **£3.0m**

Non-pay Variance (note there is £15.4m of NR Central flexibility supporting the position YTD to M8)

The YTD **£32.4m** adverse variance (in month **£3.5m**) to plan is predominantly driven by:

- Under-performance against the YTD VfP
- Clinical Supplies over-spends, excluding CPT Devices and undelivered VfP, of £10.9m
- Over-spends against CPT Drugs and Devices by £11.5m (offset by income) with a further adverse £6.8m against drugs held within the block contract
- Other variances on Insourcing/Outsourcing (adverse £12.2m), reagent costs, premises and legal fees.

I&E Category	2024/25	Current Month - M8			YTD		
	Original Plan £'000	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Actual £'000	Variance £'000
NHS England	516,172	48,575	50,045	1,470	347,624	359,556	11,932
ICBs	2,028,343	169,666	171,370	1,704	1,352,110	1,358,837	6,727
NHS Trust and Foundation Trusts	3,530	295	345	50	2,358	2,407	49
Local Authorities	44,561	3,720	3,720	(0)	29,680	29,680	0
Non-NHS: private patients, overseas patients & RTA	11,491	954	639	(315)	7,651	6,131	(1,520)
Non NHS: other	9,704	782	907	125	6,236	7,752	1,517
Income from Patient Care Activities	**2,613,801**	**223,992**	**227,027**	**3,035**	**1,745,658**	**1,764,363**	**18,705**
Research & Development	88,965	8,137	9,839	1,702	56,419	58,260	1,841
Education & Training	95,163	7,930	7,985	55	63,442	68,427	4,985
Misc. Other Operating Income	106,186	8,836	9,530	694	70,847	74,825	3,978
Other Operating Income	**290,314**	**24,903**	**27,354**	**2,451**	**190,708**	**201,512**	**10,804**
Total Income	**2,904,115**	**248,895**	**254,380**	**5,485**	**1,936,366**	**1,965,875**	**29,509**
Staffing Costs	**(1,758,151)**	**(150,736)**	**(149,407)**	**1,329**	**(1,178,561)**	**(1,206,735)**	**(28,174)**
Drugs	(294,701)	(24,558)	(22,134)	2,424	(196,465)	(202,786)	(6,321)
Supplies and Services - Clinical	(267,886)	(22,500)	(28,506)	(6,006)	(178,114)	(205,694)	(27,580)
Insourcing & Outsourcing Costs	(26,335)	(2,196)	(4,785)	(2,589)	(17,550)	(29,727)	(12,177)
Premises & Establishment Costs	(85,099)	(7,092)	(6,672)	420	(56,727)	(55,129)	1,598
Supplies and Services - General	(12,130)	(962)	(1,574)	(612)	(8,296)	(10,405)	(2,109)
PFI Charges	(76,340)	(6,348)	(6,950)	(602)	(52,515)	(53,762)	(1,247)
Lease Expenditure	(9,931)	(729)	(62)	667	(7,015)	(6,228)	787
Depreciation & Amortisation	(72,219)	(6,286)	(5,449)	837	(47,195)	(43,023)	4,172
Other	(231,991)	(19,510)	(17,585)	1,925	(153,092)	(142,628)	10,464
Non Pay Costs	**(1,076,632)**	**(90,181)**	**(93,717)**	**(3,536)**	**(716,969)**	**(749,381)**	**(32,412)**
Total Operating Expenditure	**(2,834,783)**	**(240,917)**	**(243,125)**	**(2,208)**	**(1,895,530)**	**(1,956,116)**	**(60,586)**
EBIT Margin	**69,332**	**7,978**	**11,256**	**3,278**	**40,836**	**9,759**	**(31,077)**
Interest & Dividends	**(58,237)**	**(2,852)**	**(2,194)**	**658**	**(46,552)**	**(42,710)**	**3,842**
Surplus / (Deficit) before adjustments	**11,095**	**5,126**	**9,061**	**3,935**	**(5,716)**	**(32,951)**	**(27,235)**
Adjust PFI revenue costs to UK GAAP basis	(7,476)	(2,634)	(2,717)	(83)	2,991	2,097	(894)
Surplus / (Deficit) for CT purposes	**3,619**	**2,492**	**6,344**	**3,852**	**(2,725)**	**(30,854)**	**(28,129)**

Interest and Dividends

The YTD favourable variance of **£3.2m** (in month **£0.5m**) is due to interest receivable above plan relating to cash balances

Year End Forecast Outturn – Month 8 2024/25

Manchester University
NHS Foundation Trust

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	FOT
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Income	(232,180)	(230,661)	(234,292)	(241,959)	(238,553)	(240,103)	(293,748)	(254,380)	(243,887)	(249,109)	(245,627)	(246,307)	(2,950,805)
Staffing Costs	146,110	142,889	144,529	144,000	144,100	143,326	192,374	149,407	150,345	151,164	151,176	150,653	1,810,073
Non Pay	95,271	92,964	88,503	92,793	88,737	94,044	103,351	93,717	98,360	96,388	96,138	89,739	1,130,007
Financing Costs	26,359	2,282	2,236	2,448	2,421	2,355	2,415	2,194	2,903	2,945	2,657	3,149	54,364
Surplus / (Deficit) before adjustments	**(35,560)**	**(7,474)**	**(976)**	**2,718**	**3,295**	**378**	**(4,393)**	**9,061**	**(7,721)**	**(1,388)**	**(4,345)**	**2,766**	**(43,639)**
Adjust PFI revenue costs to UK GAAP basis	20,927	(2,838)	(1,782)	(3,144)	(3,244)	(2,275)	(2,830)	(2,717)	(2,690)	(2,690)	(2,690)	(2,690)	(8,663)
Surplus / (Deficit) Adjusted (Unmitigated)	**(14,633)**	**(10,312)**	**(2,758)**	**(426)**	**51**	**(1,897)**	**(7,223)**	**6,344**	**(10,411)**	**(4,078)**	**(7,035)**	**76**	**(52,302)**
Total Mitigations	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9,707**	**10,729**	**18,416**	**20,550**	**59,402**
Total Additonal Costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(800)**	**(900)**	**(900)**	**(900)**	**(3,500)**
Mitigated Forecast Outturn	**(14,633)**	**(10,312)**	**(2,758)**	**(426)**	**51**	**(1,897)**	**(7,223)**	**6,344**	**(1,504)**	**5,751**	**10,481**	**19,726**	**3,600**

Year End Position

- The Trust is planning on delivering the £3.6m surplus plan, but there is recognition that significant action needs to be taken to deliver this.
- To date, £20.5m of central flexibility has been used to support the financial position, and there is minimal remaining to support the remainder of the year.
- The table on Slide 5 provide a breakdown of the mitigations, and a risk assessment of best, most likely and worst case delivery.
- Delivery of the £3.6m plan assumes the following:
  - Pressures as a result of the 2024/25 pay award and 2023/24 revised medical pay award are funded
  - Industrial Action costs incurred in June and July 2024 are funded
  - £4m of funding agreed with GM ICB during the 2024/25 planning period is funded
  - ERF income can be delivered above the original plan
  - Mitigating actions to reduce the expenditure run-rate are implemented
  - Reductions to commissioner funding are only agreed if costs can be reduced to mitigate any financial impact.

Year End Forecast Outturn – Month 8 2024/25

Manchester University NHS Foundation Trust

Mitigations/Additional Costs	FOT £000s	RAG	Best £000s	Most Likely £000s	Worst £000s
Unmitigated Forecast	(52,302)		(52,302)	(52,302)	(52,302)
Additional Costs/Mitigations					
Additional Estate related non clinical income	5,500		5,500	3,000	0
Clinical income -prior year	2,100		2,100	2,100	2,100
ERF - current year	10,000		10,000	5,000	1,000
Non-clinical income reforecast	2,000		2,000	2,000	2,000
Central Reserves	2,400		2,400	2,400	2,400
Clinical Groups Balance Sheet Review	10,000		10,000	5,000	1,000
Control Environment / Accelerated workstreams	8,938		8,938	2,000	1,000
Alternative theatre consumables procurement - VAT saving	3,000		3,000	0	0
Income for Pay Award funding gap	6,000		6,000	0	0
Industrial Action funding	3,200		3,200	2,400	0
Additional Mitigations to reduce run rate	6,264		6,264	3,000	0
Total Mitigations	**59,402**		**59,402**	**26,900**	**9,500**
Additional Costs	(3,500)		(3,500)	(3,500)	(3,500)
Total Mitigations/net of costs	**55,902**		**55,902**	**23,400**	**6,000**
Year End Forecast	**3,600**		**3,600**	**(28,902)**	**(46,302)**

Actions to Support Financial Recovery

- A Task and Finish Group led by the Director of Financial Improvement has been set up to drive forward at pace actions which will have maximum impact in reducing the run rate over the remainder of the year.
- All actions have executive leads
- A fortnightly meeting has been established with the Executive Director SROs of schemes, chaired by the Deputy CEO to support the progression of the implementation of the mitigating schemes.
- Mitigations to the YTD run rate include:
  - Review of all centrally held budgets that support the clinical areas with the move to 6 Clinical Groups
  - Additional income assumed for the costs of industrial action, insurance claims and other income
  - Delivery of further ERF income through acceleration of activity recovery
  - Implementation of VfP above current run rate – more planned in the final four months of the year
  - Opportunities to renegotiate or change contracts to reduce costs
  - Implementation of increased pay and non-pay controls to reduce run rate
  - Review of accruals and provisions held to identify any amounts that are not required
- If the recovery actions don't get implemented at pace, then there will be a significant risk to delivery of the year end plan.

National Pay Award Update – Month 8 2024/25

Manchester University
NHS Foundation Trust

- The impact of the total 2024/25 pay settlement has been estimated as **£131.5m**, based on current staff in post (as at September 2024), which includes the back-pay element for some staffing groups for 2023/24.
- This has been compared to the assumed funding for pay award in-year, which is **£121.6m**. This includes an assumption of **£1.5m** funding from Local Authorities for staffing in LA commissioned services (as per GM ICB guidance)
- This results in an estimated gross shortfall of **£9.9m**. Planning assumptions estimated a shortfall of **£4.0m** which was included in the 24/25 plan (ie as part of the VfP requirement).
- This results in an incremental in-year unfunded pressure as a result of the final pay award settlement of **£5.9m**.
- The recurrent cost of the 2024/25 pay award, excluding non-recurrent back pay, is estimated at £125.3m, with a potential recurrent pressure of **£21.7m** if non-recurrent funding of £17.7m received in 2024/25 is not allocated in 2025/26.

	24/25 £m	Recurrent £m
Total Cost	**131.5**	**125.3**
NHS Funding	120	102.1
Assumed LA Funding	1.5	1.5
Total Funding	**121.5**	**103.6**
Total Pay Award Pressure	**-10**	**-21.7**
Adjust for 2.1% planning assumption	4	4
Incremental Settlement Pressure	**-5.9**	**-17.7**

Drivers of the £5.9m 24/25 Pressures	WTE	£m
PFI	924	0.8
Security	140	0.4
UoM	32	0.6
Hosted resident doctors (50% HEE funded)	962	4.2
Total	**2058.0**	**5.9**
LA funding at risk		1.5
Pressure if LA funding not received		**7.4**

MFTs pressure is driven by:

- our relative size (significantly bigger than other GM Trusts)
- the number of staff not on our payroll and not funded through the CUF (Cost Uplift Factor) for whom we receive either non-recurrent funding, or funding at 50% from HEE.

Income & Expenditure – Run Rate

Manchester University
NHS Foundation Trust

I&E Category	Apr-24 £'000	May-24 £'000	Jun-24 £'000	Jul-24 £'000	Aug-24 £'000	Sep-24 £'000	Oct-24 £'000	Nov-24 £'000	YTD £'000	Average £'000
Income from Patient Care Activities	209,316	208,134	208,083	219,079	213,456	213,166	266,103	227,027	1,764,363	220,545
Other Operating Income	22,864	22,526	26,210	22,880	25,096	26,937	27,645	27,354	201,512	25,189
Total Income	232,180	230,660	234,292	241,959	238,553	240,103	293,748	254,380	1,965,875	245,734
Staffing Costs	(146,110)	(142,889)	(144,529)	(144,000)	(144,100)	(143,326)	(192,374)	(149,407)	(1,206,735)	(150,842)
Non Pay Costs	(95,271)	(92,964)	(88,503)	(92,793)	(88,737)	(94,044)	(103,351)	(93,717)	(749,381)	(93,673)
Total Operating Expenditure	(241,381)	(235,853)	(233,032)	(236,793)	(232,837)	(237,370)	(295,726)	(243,125)	(1,956,116)	(244,514)
EBIT Margin	(9,201)	(5,192)	1,260	5,166	5,716	2,734	(1,978)	11,256	9,759	1,220
Interest & Dividends	(26,359)	(2,281)	(2,236)	(2,448)	(2,421)	(2,355)	(2,415)	(2,194)	(42,710)	(5,339)
Surplus / (Deficit) before adjustments	(35,560)	(7,474)	(976)	2,718	3,295	378	(4,393)	9,061	(32,951)	(4,119)
Surplus / (Deficit) for CT purposes	(14,633)	(10,312)	(2,758)	(426)	51	(1,897)	(7,223)	6,344	(30,854)	(3,857)
	(6.3%)	*(4.5%)*	*(1.2%)*	*(0.2%)*	*0.0%*	*(0.8%)*	*(2.5%)*	*2.5%*	*(1.6%)*	*(1.6%)*
I&E Excluded from CT	(4,038)	(6,921)	(2,645)	(4,681)	(5,106)	(4,209)	(2,924)	(7,080)	(37,604)	(4,701)
Surplus / (Deficit) after CT excluded items	(18,671)	(17,233)	(5,403)	(5,107)	(5,055)	(6,106)	(10,147)	(736)	(68,458)	(8,557)

- M8 income is higher than the YTD average due to inclusion of the uplift for annual pay awards (the new norm) plus prior year ERF monies of £3.7m.
- Staff costs in month 8 are affected by seven months of arrears payments for the Resident Drs and VSMs pay awards plus the band 8 to band 9 additional scale points offset by release of estimated accruals to cover these costs made in month 7 – there is an in month benefit of £3.2m due to this. The impact of the pay awards makes comparison to previous months difficult, however, costs are not reducing as planned due to slower implementation of VfP and additional costs incurred for operational pressures.
- Non pay costs in month 8 are on the YTD average with CPT drugs costs falling but clinical supplies costs rising (lab consumables, blood products, consultancy costs for Teneo and PA Consulting), and Insourcing costs due to Project 108 increased.
- The interest and dividends averages are skewed by the profile of the PFI technical accounting adjustment. Both interest payable and interest receivable show favourable month on month variances to plan. Proactive cash management has supported maximising interest.

Workforce – Month 8 2024/25

Manchester University NHS Foundation Trust

Expenditure

Staff Group	Month 8						YTD					
	Budget (£'000)	Substantive (£'000)	Bank (£'000)	Agency (£'000)	Total Actual (£'000)	Variance (£'000)	Budget (£'000)	Substantive (£'000)	Bank (£'000)	Agency (£'000)	Total Actual (£'000)	Variance (£'000)
Consultant	**26,521**	*25,559*	*768*	*456*	**26,783**	(262)	**202,088**	*202,592*	*8,074*	*3,584*	**214,249**	(12,161)
Career Grade Doctor	**8,315**	*9,952*	*328*	*133*	**10,412**	(2,098)	**47,223**	*49,513*	*2,434*	*907*	**52,855**	(5,632)
Trainee Grade Doctors	**15,036**	*19,744*	*1,316*	*247*	**21,307**	(6,271)	**81,845**	*80,262*	*15,262*	*2,413*	**97,936**	(16,091)
Registered Nursing Midwifery	**43,270**	*41,008*	*2,733*	*17*	**43,758**	(488)	**357,931**	*323,667*	*28,089*	*62*	**351,817**	6,113
Support to Nursing	**12,355**	*10,286*	*2,271*	*0*	**12,557**	(202)	**97,101**	*82,368*	*19,448*	*(4)*	**101,813**	(4,712)
Healthcare Scientists	**7,096**	*6,327*	*156*	*29*	**6,513**	583	**52,981**	*47,353*	*1,119*	*217*	**48,689**	4,291
Support to STT HCS	**2,821**	*2,551*	*54*	*4*	**2,609**	212	**21,245**	*19,951*	*532*	*52*	**20,534**	710
Allied Health Professionals	**8,533**	*8,124*	*18*	*(26)*	**8,116**	417	**68,441**	*63,311*	*379*	*1,823*	**65,513**	2,928
Support to AHPs	**456**	*412*	*3*	*0*	**415**	41	**3,678**	*3,226*	*28*	*1*	**3,255**	424
Other Scientific and Theraputi	**6,974**	*6,238*	*141*	*0*	**6,379**	595	**51,070**	*47,729*	*1,412*	*66*	**49,208**	1,862
Support to Clinical	**11,005**	*(8,551)*	*601*	*26*	**(7,924)**	18,929	**94,456**	*60,890*	*4,879*	*252*	**66,022**	28,434
Infrastructure Support	**11,350**	*17,504*	*41*	*0*	**17,545**	(6,195)	**104,559**	*128,037*	*322*	*131*	**128,491**	(23,932)
Nightingale Staffing Costs	**0**	*0*	*0*	*0*	**0**	0	**0**	*0*	*0*	*0*	**0**	0
Dental Staff	**284**	*262*	*0*	*0*	**262**	22	**2,271**	*2,131*	*0*	*0*	**2,131**	140
Dental Support	**9**	*8*	*0*	*0*	**8**	1	**69**	*60*	*0*	*0*	**60**	9
Apprenticeship Levy	**517**	*668*	*0*	*0*	**668**	(151)	**4,133**	*4,161*	*0*	*0*	**4,161**	(28)
Reconcile to Original Plan*	**(3,805)**					(3,805)	**(10,530)**					(10,530)
Grand Total	**150,736**	***140,089***	***8,431***	***887***	**149,407**	**1,329**	**1,178,561**	***1,115,251***	***81,979***	***9,505***	**1,206,735**	**(28,174)**

** Reporting is against the Original Plan submitted to NHSE, this row adjusts to offset internal budget movements and uplifts for new income streams*

WTE

Staff Group	Month 8					
	Budget (WTE)	Substantive (WTE)	Bank (WTE)	Agency (WTE)	Total Actual (WTE)	Variance (WTE)
Consultant	**1,710**	*1,538*	*46*	*18*	**1,602**	107
Career Grade Doctor	**727**	*805*	*26*	*4*	**836**	(108)
Trainee Grade Doctors	**1,481**	*1,369*	*141*	*15*	**1,525**	(45)
Registered Nursing Midwifery	**9,894**	*9,071*	*504*	*3*	**9,578**	316
Support to Nursing	**4,080**	*3,446*	*649*	*0*	**4,096**	(16)
Healthcare Scientists	**1,304**	*1,211*	*26*	*6*	**1,244**	61
Support to STT HCS	**1,014**	*965*	*12*	*1*	**978**	36
Allied Health Professionals	**1,809**	*1,690*	*3*	*12*	**1,705**	103
Support to AHPs	**167**	*152*	*1*	*0*	**153**	14
Other Scientific and Theraputi	**1,353**	*1,230*	*25*	*0*	**1,255**	97
Support to Clinical	**3,049**	*2,502*	*175*	*7*	**2,685**	365
Infrastructure Support	**4,110**	*3,585*	*11*	*0*	**3,595**	515
Nightingale Staffing Costs	**0**	*0*	*0*	*0*	**0**	0
Dental Staff	**86**	*80*	*0*	*0*	**80**	6
Dental Support	**4**	*3*	*0*	*0*	**3**	1
Apprenticeship Levy	**0**	*0*	*0*	*0*	**0**	0
Grand Total	**30,787**	***27,647***	***1,621***	***66***	**29,334**	**1,453**

- Pay costs are favourable to plan in M8 by **£1.3m (**YTD adverse by **£28.2m)** compared to the original plan submitted to NHSE although primarily due to the arrears, estimated accruals and uncertainties around the pay award costs over months 7 and 8.
- Infrastructure Support staff hold the bulk of the negative budgets for unidentified VfP targets. Support to Clinical held accruals for the Pay Awards, released in M8.
- Medical staff costs make up the majority of the adverse variance caused by premium pay costs (ECLs/WLIs and agency) plus industrial action costs in June and July.
- Whilst worked WTE remain lower than plan, this is because WTE reductions associated with pay VfP plans have not been transacted in full. Consequently, this results in a higher WTE budget in comparison to the corresponding expenditure (£) budget.

Workforce – Total Pay Run Rate

Manchester University
NHS Foundation Trust

Run Rate - Cost

Staff Group	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	YTD £'000	Average £'000
Consultant	26,761	25,023	26,939	25,254	25,166	25,400	32,924	26,783	**214,249**	26,781
Career Grade Doctor	6,302	6,067	6,018	5,998	6,167	5,816	6,074	10,412	**52,855**	6,607
Trainee Grade Doctors	10,719	10,404	10,076	11,310	11,355	10,659	12,106	21,307	**97,936**	12,242
Registered Nursing Midwifery	42,060	42,479	42,362	42,068	41,720	40,994	56,376	43,758	**351,817**	43,977
Support to Nursing	12,356	12,678	12,304	12,243	11,981	12,526	15,169	12,557	**101,813**	12,727
Healthcare Scientists	5,885	5,780	5,769	5,876	5,965	6,113	6,789	6,513	**48,689**	6,086
Support to STT HCS	2,384	2,409	2,367	2,457	2,473	2,510	3,326	2,609	**20,534**	2,567
Allied Health Professionals	8,288	7,758	7,504	7,827	8,001	8,035	9,984	8,116	**65,513**	8,189
Support to AHPs	430	389	386	379	376	382	498	415	**3,255**	407
Other Scientific and Theraputi	5,758	6,240	5,926	5,954	5,938	5,825	7,188	6,379	**49,208**	6,151
Support to Clinical	8,001	8,487	7,621	7,983	8,001	8,027	25,826	-7,924	**66,022**	8,253
Infrastructure Support	16,384	14,410	16,489	15,887	16,198	16,285	15,294	17,545	**128,491**	16,061
Dental Staff	259	261	261	262	256	253	318	262	**2,131**	266
Dental Support	7	7	7	7	7	7	8	8	**60**	8
Apprenticeship Levy	517	496	502	494	496	495	494	668	**4,161**	520
Grand Total	**146,110**	**142,889**	**144,529**	**144,000**	**144,100**	**143,326**	**192,374**	**149,407**	**1,206,735**	**150,842**
Normalising Adjustments	6,039	7,555	4,866	6,008	6,600	7,136	(39,732)	3,155	**1,627**	203
Normalised Pay Costs	**152,149**	**150,444**	**149,395**	**150,008**	**150,700**	**150,462**	**152,642**	**152,562**	**1,208,362**	**151,045**
Plan	**142,914**	**142,362**	**141,412**	**138,837**	**138,847**	**138,846**	**184,607**	**150,736**	**1,178,562**	**147,320**

** The normalised pay costs have been amended back to M1 for the impact of the pay award arrears included in M7*

Run Rate - WTE

Staff Group	Month 1 WTE	Month 2 WTE	Month 3 WTE	Month 4 WTE	Month 5 WTE	Month 6 WTE	Month 7 WTE	Month 8 WTE		Average WTE
Consultant	1,560	1,569	1,553	1,572	1,569	1,585	1,605	1,602		**1,577**
Career Grade Doctor	861	850	838	821	811	813	832	836		**833**
Trainee Grade Doctors	1,518	1,501	1,480	1,487	1,553	1,562	1,544	1,525		**1,521**
Registered Nursing Midwifery	9,371	9,485	9,413	9,398	9,314	9,420	9,479	9,578		**9,432**
Support to Nursing	4,156	4,274	4,112	4,132	4,039	4,241	4,033	4,096		**4,135**
Healthcare Scientists	1,190	1,162	1,169	1,191	1,200	1,212	1,234	1,244		**1,200**
Support to STT HCS	930	925	925	951	966	987	972	978		**954**
Allied Health Professionals	1,670	1,685	1,667	1,660	1,664	1,684	1,708	1,705		**1,680**
Support to AHPs	164	148	147	145	143	145	150	153		**149**
Other Scientific and Theraputi	1,274	1,313	1,285	1,284	1,281	1,251	1,247	1,255		**1,274**
Support to Clinical	2,707	2,783	2,705	2,741	2,714	2,729	2,695	2,685		**2,720**
Infrastructure Support	3,568	3,545	3,573	3,587	3,583	3,590	3,629	3,595		**3,584**
Nightingale Staffing Costs	0	0	0	0	0	0	0	0		**0**
Dental Staff	83	84	84	83	81	80	80	80		**82**
Dental Support	3	3	3	3	3	3	3	3		**3**
Apprenticeship Levy	0	0	0	0	0	0	0	0		**0**
Grand Total	**29,057**	**29,327**	**28,955**	**29,053**	**28,923**	**29,301**	**29,212**	**29,334**		**29,145**
Plan	**30,897**	**30,737**	**30,656**	**30,723**	**30,712**	**30,657**	**30,752**	**30,787**		**30,740**

- Staff costs in month 8 are above the average normalised run rate by £1.5m – the average has increased due to MFT becoming the host for an expanded Research & Development Network (RRDN) but is offset by increased income.
- Arrears for the annual pay awards backdated to April 2024 were paid to AfC staff, Consultants and Other medical staff in month 7 and in month 8 arrears were paid to Resident Doctors, VSMs and to B8 – B9 staff for additional scale points. Month 8 arrears were offset by release of accruals made in month 7.
- June (M3) and July (M4) included the impact of the Junior Drs Industrial Action at £2.4m and £0.6m respectively.
- The RRDN impact on staff was to add 62 WTE from month 7 onwards.
- Worked WTE remain broadly consistent although it was anticipated o reduce in order to deliver the mitigations required to achieve the financial plan for the year.

Bank Staff

Manchester University
NHS Foundation Trust

Bank Run Rate - Cost

Staff Group	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	YTD £'000	Average £'000
Consultant	903	1,091	1,206	995	1,094	853	1,164	768	**8,074**	1,009
Career Grade Doctor	246	285	236	283	388	355	315	328	**2,434**	304
Trainee Grade Doctors	2,043	1,716	1,663	2,719	2,493	1,758	1,554	1,316	**15,262**	1,908
Registered Nursing Midwifery	3,052	3,347	3,434	3,035	2,924	3,466	6,097	2,733	**28,089**	3,511
Support to Nursing	2,350	2,672	2,444	2,398	2,228	2,703	2,383	2,271	**19,448**	2,431
Healthcare Scientists	157	176	108	178	178	151	16	156	**1,119**	140
Support to STT HCS	61	70	57	68	75	75	70	54	**532**	66
Allied Health Professionals	52	64	26	39	76	36	69	18	**379**	47
Support to AHPs	3	6	2	4	6	2	2	3	**28**	3
Other Scientific and Theraputi	219	236	140	170	151	218	136	141	**1,412**	177
Support to Clinical	637	660	629	616	582	656	499	601	**4,879**	610
Infrastructure Support	24	57	45	47	55	74	-19	41	**322**	40
Nightingale Staffing Costs	0	0	0	0	0	0	0	0	**0**	0
Dental Staff	0	0	0	0	0	0	0	0	**0**	0
Dental Support	0	0	0	0	0	0	0	0	**0**	0
Apprenticeship Levy	0	0	0	0	0	0	0	0	**0**	0
Grand Total	**9,746**	**10,380**	**9,989**	**10,552**	**10,249**	**10,346**	**12,286**	**8,431**	**81,979**	**10,247**

Bank Run Rate - WTE

Staff Group	Month 1 WTE	Month 2 WTE	Month 3 WTE	Month 4 WTE	Month 5 WTE	Month 6 WTE	Month 7 WTE	Month 8 WTE		Average WTE
Consultant	50	59	49	58	56	50	54	46		**53**
Career Grade Doctor	20	27	22	26	28	28	23	26		**25**
Trainee Grade Doctors	173	170	168	193	222	178	151	141		**175**
Registered Nursing Midwifery	495	576	528	518	480	575	499	504		**522**
Support to Nursing	692	783	671	703	626	772	588	649		**685**
Healthcare Scientists	25	27	14	28	31	23	27	26		**25**
Support to STT HCS	14	17	11	16	20	19	18	12		**16**
Allied Health Professionals	10	12	5	8	14	7	13	3		**9**
Support to AHPs	1	2	1	2	2	1	1	1		**1**
Other Scientific and Theraputi	34	38	33	23	27	34	30	25		**30**
Support to Clinical	181	198	165	180	165	188	172	175		**178**
Infrastructure Support	2	6	10	9	12	17	11	11		**10**
Nightingale Staffing Costs	0	0	0	0	0	0	0	0		**0**
Dental Staff	0	0	0	0	0	0	0	0		**0**
Dental Support	0	0	0	0	0	0	0	0		**0**
Apprenticeship Levy	0	0	0	0	0	0	0	0		**0**
Grand Total	**1,697**	**1,916**	**1,676**	**1,764**	**1,683**	**1,890**	**1,586**	**1,621**		**1,729**

- Bank costs in month 8 have fallen by £3.9m from month 7 but is mainly due to the £3.2m accrued for YTD pay award arrears last month.
- Arrears will be paid to bank staff in December so the difference between estimated accrued costs and actual costs will be seen in the numbers next month.
- Comparisons to last month and to the YTD average are difficult due to these pay award arrears, in month increases and estimated accruals, plus arrears for pay uplifts applied in 23/24, which should not form part of the 24/25 figures were also paid.
- WTE figures are unaffected by the pay award costs and can be compared. Use of medical staff has fallen slightly but there has been an increase in Nursing support staff use in month 8.

Agency Staff

Manchester University
NHS Foundation Trust

Agency Run Rate - Cost

Staff Group	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	YTD £'000	Average £'000
Consultant	420	404	426	460	433	504	481	456	**3,584**	448
Career Grade Doctor	106	116	107	104	104	102	135	133	**907**	113
Trainee Grade Doctors	183	395	301	314	322	350	300	247	**2,413**	302
Registered Nursing Midwifery	6	11	4	17	-5	2	11	17	**62**	8
Support to Nursing	-2	0	-1	-1	0	0	0	0	**-4**	0
Healthcare Scientists	10	19	72	41	-1	16	31	29	**217**	27
Support to STT HCS	5	8	25	13	-11	3	4	4	**52**	6
Allied Health Professionals	674	27	-92	274	455	295	215	-26	**1,823**	228
Support to AHPs	0	0	0	1	-1	0	0	0	**1**	0
Other Scientific and Theraputi	21	10	13	14	5	6	-3	0	**66**	8
Support to Clinical	38	84	17	28	28	-2	33	26	**252**	32
Infrastructure Support	1	0	24	87	26	-1	-6	0	**131**	16
Nightingale Staffing Costs	0	0	0	0	0	0	0	0	**0**	0
Dental Staff	0	0	0	0	0	0	0	0	**0**	0
Dental Support	0	0	0	0	0	0	0	0	**0**	0
Apprenticeship Levy	0	0	0	0	0	0	0	0	**0**	0
Grand Total	**1,463**	**1,076**	**897**	**1,353**	**1,355**	**1,275**	**1,201**	**887**	**9,505**	**1,188**

Agency Run Rate - WTE

Staff Group	Month 1 WTE	Month 2 WTE	Month 3 WTE	Month 4 WTE	Month 5 WTE	Month 6 WTE	Month 7 WTE	Month 8 WTE		Average WTE
Consultant	15	15	16	16	16	19	17	18		**16**
Career Grade Doctor	3	4	6	4	4	4	6	4		**4**
Trainee Grade Doctors	18	22	19	20	27	22	18	15		**20**
Registered Nursing Midwifery	1	1	0	2	0	1	2	3		**1**
Support to Nursing	0	0	0	0	0	0	0	0		**0**
Healthcare Scientists	3	5	16	7	-4	5	6	6		**6**
Support to STT HCS	1	1	10	4	-5	0	1	1		**1**
Allied Health Professionals	23	31	27	25	21	20	16	12		**22**
Support to AHPs	0	0	0	1	0	0	0	0		**0**
Other Scientific and Theraputi	4	3	3	3	1	1	-1	0		**2**
Support to Clinical	9	22	-4	12	10	-4	7	7		**8**
Infrastructure Support	0	0	0	2	1	0	0	0		**0**
Nightingale Staffing Costs	0	0	0	0	0	0	0	0		**0**
Dental Staff	0	0	0	0	0	0	0	0		**0**
Dental Support	0	0	0	0	0	0	0	0		**0**
Apprenticeship Levy	0	0	0	0	0	0	0	0		**0**
Grand Total	**76**	**103**	**93**	**97**	**70**	**68**	**72**	**66**		**81**

- Agency staff costs for MFT are very low by both national and regional standards and account for just 0.79% of total pay costs YTD (£9.5 million of a total £1.2 billion).
- Agency costs in month 8 have fallen to £0.9m and are below the YTD average by £0.3m.
- The primary driver was a correction to AHP costs with actual invoices replacing accruals. Processes will need to be reviewed as the monthly profile of costs is volatile.
- WTE numbers are broadly consistent, but slightly lower than the preceding three months and there has been a distinct fall in use since the beginning of the financial year.

Value for Patients – Month 8 2024/25

Manchester University NHS Foundation Trust

Site	YTD Original Plan £'000	YTD Plan schemes >L3 £'000	YTD Actual £'000	YTD Variance to Plan £'000	YTD Variance to >L3 £'000	Annual Forecast Original Plan £'000	Annual Forecast Plan schemes >L3 £'000	Annual Forecast Actual / Forecast £'000	Annual Forecast Variance to Plan £'000	Annual Forecast Variance to >L3 £'000
CSS	13,855	10,406	11,256	(2,599)	851	23,144	21,074	20,891	(2,253)	(183)
LCO	5,297	5,405	5,359	62	(46)	8,839	8,840	8,795	(45)	(45)
MREH	1,459	1,503	1,511	52	8	2,380	2,034	2,050	(330)	16
MRI	10,380	9,036	7,414	(2,966)	(1,622)	17,278	14,268	12,253	(5,025)	(2,015)
NMGH	5,034	3,980	3,965	(1,068)	(15)	8,403	6,377	6,340	(2,063)	(37)
RMCH	7,015	3,081	2,858	(4,156)	(223)	11,707	4,523	4,048	(7,660)	(475)
SMH	7,183	6,487	6,227	(956)	(259)	12,002	9,843	9,632	(2,370)	(210)
UDHM	544	884	884	341	0	906	982	989	83	7
WTWA	12,915	10,549	10,494	(2,421)	(55)	21,553	18,416	18,417	(3,136)	1
Total - Clinical Sites	**63,682**	**51,331**	**49,970**	**(13,712)**	**(1,361)**	**106,212**	**86,356**	**83,414**	**(22,798)**	**(2,941)**
Corporate exc Informatics	4,124	5,601	5,540	1,416	(61)	6,683	7,577	7,509	826	(68)
Informatics	6,013	8,143	8,655	2,642	512	9,019	13,803	13,824	4,805	22
Estates & Facilities	8,025	2,272	2,272	(5,753)	0	12,037	11,785	11,785	(252)	0
Total - Support Services	**18,162**	**16,015**	**16,466**	**(1,696)**	**451**	**27,739**	**33,165**	**33,119**	**5,380**	**(46)**
Cross-cutting Schemes*	7,682	21,026	21,026	13,344	0	14,048	26,453	26,453	12,405	0
Grand Total	**89,526**	**88,373**	**87,463**	**(2,063)**	**(910)**	**148,000**	**145,974**	**142,987**	**(5,014)**	**(2,987)**

**Review and revision of the cross-cutting themes will be undertaken between months 8 and 9 with the Plan and Actuals likely to reduce*

Non-recurrently delivered VfP above target	YTD Max target of total %	YTD Actual Non-recurrent VfP %	YTD Variance to target %
CSS	25.0%	37.8%	(12.8%)
LCO	25.0%	63.5%	(38.5%)
MREH	25.0%	43.2%	(18.2%)
MRI	25.0%	4.6%	20.4%
NMGH	25.0%	23.9%	1.1%
RMCH	25.0%	64.3%	(39.3%)
SMH	25.0%	57.9%	(32.9%)
UDHM	25.0%	75.5%	(50.5%)
WTWA	25.0%	43.5%	(18.5%)
Corporate exc Informatics	25.0%	21.3%	3.7%
Informatics	25.0%	83.9%	(58.9%)
Estates & Facilities	25.0%	42.0%	(17.0%)
Cross-cutting Schemes	25.0%	57.2%	(32.2%)
Total (by exception)	**25.0%**	**47.6%**	**(22.6%)**

- YTD delivery against the VfP programme, as per Wave, shows **£87.4m** – adverse to plan by **£2.0m**.
- The forecast shown is based on identified schemes above level 3 and equates to £143.0m, adverse to plan by £5.0m
- A total of £148.0m of schemes have been identified, with £143m forecast to deliver by year end. Work continues to progress schemes to support delivery of the full target.
- The national target placed a cap of 25% non-recurrent VfP in 24/25 – YTD 47.6% of identified schemes are non-recurrent – an improvement over the M7 position of 49.4%. Any non recurrent delivery will result in an increased underlying pressure moving into 2025/26.
- Work is ongoing to increase the year end forecast delivery (see slides 4-5).

Statement of Financial Position

Manchester University
NHS Foundation Trust

	M8 vs 23/24 closing Balance Sheet			At M8		
	Mar-24 £'000	Actual £'000	Movement £'000	Plan £'000	Actual £'000	Variance £'000
Non-Current Assets						
Intangible Assets	12,325	10,679	(1,646)	12,361	10,679	(1,682)
Property, Plant and Equipment	1,074,674	1,041,318	(33,356)	1,081,880	1,041,318	(40,562)
Investments	806	806	(0)	806	806	0
Trade and Other Receivables	18,330	18,353	23	18,331	18,353	22
Total Non-Current Assets	1,106,136	1,071,156	(34,980)	1,113,378	1,071,156	(42,222)
Current Assets						
Inventories	27,596	29,841	2,245	27,596	29,841	2,245
NHS Trade and Other Receivables	78,203	86,562	8,359	78,203	86,562	8,359
Non-NHS Trade and Other Receivables	64,221	63,782	(439)	88,333	63,782	(24,551)
Non-Current Assets Held for Sale	210	210	0	210	210	0
Cash and Cash Equivalents	133,687	90,890	(42,797)	77,054	90,890	13,836
Total Current Assets	303,917	271,285	(32,632)	271,396	271,285	(111)
Current Liabilities						
Trade and Other Payables: Capital	(37,382)	(15,017)	22,365	(10,729)	(15,017)	(4,288)
Trade and Other Payables: Non-capital	(353,706)	(349,745)	3,961	(340,369)	(349,745)	(9,376)
Borrowings	(43,476)	(41,135)	2,341	(37,975)	(41,135)	(3,160)
Provisions	(16,975)	(10,378)	6,597	(16,975)	(10,378)	6,597
Other liabilities: Deferred Income	(33,744)	(58,144)	(24,400)	(33,744)	(58,144)	(24,400)
Total Current Liabilities	(485,284)	(474,419)	10,865	(439,792)	(474,419)	(34,627)
Net Current Assets	(181,367)	(203,134)	(21,767)	(168,396)	(203,134)	(34,738)
Total Assets Less Current Liabilities	924,769	868,022	(56,747)	944,982	868,022	(76,960)
Non-Current Liabilities						
Trade and Other Payables	0	0	0	0	0	0
Borrowings	(722,697)	(719,995)	2,702	(744,135)	(719,995)	24,140
Provisions	(9,232)	(9,360)	(128)	(9,232)	(9,360)	(128)
Other Liabilities: Deferred Income	(3,826)	(3,826)	(0)	(3,826)	(3,826)	0
Total Non-Current Liabilities	(735,755)	(733,181)	2,574	(757,193)	(733,181)	24,012
Total Assets Employed	**189,014**	**134,841**	**(54,173)**	**187,789**	**134,841**	**(52,948)**
Taxpayers' Equity						
Public Dividend Capital	537,401	553,783	16,382	584,473	553,783	(30,690)
Revaluation Reserve	177,882	177,882	(0)	184,669	177,882	(6,787)
Income and Expenditure Reserve	(526,269)	(596,824)	(70,555)	(581,353)	(596,824)	(15,471)
Total Taxpayers' Equity	189,014	134,841	(54,173)	187,789	134,841	(52,948)
Total Funds Employed	**189,014**	**134,841**	**(54,173)**	**187,789**	**134,841**	**(52,948)**

M8 24/25 vs Month 12 23/24

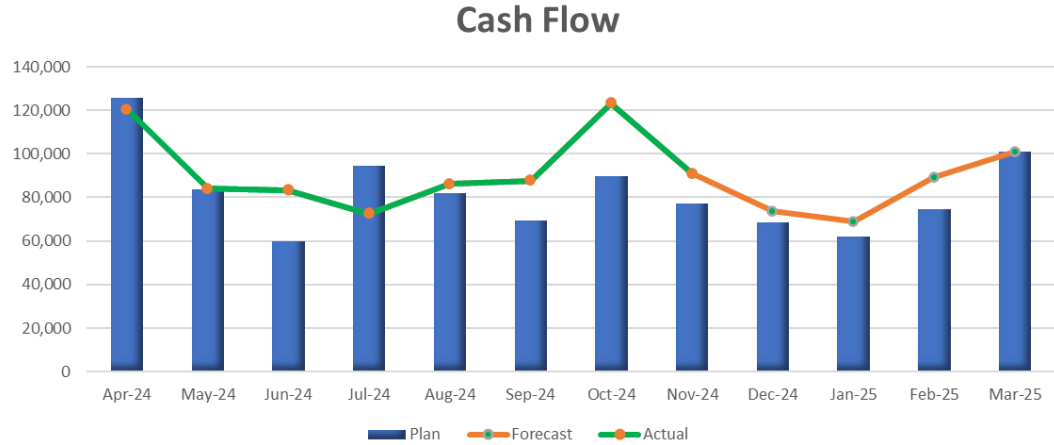
- Property, plant & equipment value has decreased by £33.4m due to depreciation and impairments YTD, partially offset by capital additions.
- The increase in NHS trade receivables of £8.4m is driven by an increase in prepayments relating to the Clinical Negligence NHSR scheme and receivables relating to research.
- Capital trade and other payables have decreased by £22.4m following the unwind of the high 23/24 year-end capital activity. The non-capital balance has decreased by £4.0m which is driven by a reduction in GRNI accruals offset by an increase accruals relating to pharmacy.
- The £6.6m reduction in provisions is driven by confirmed in-year reductions of £5.5m from the estates and managed equipment services provisions.
- Other liabilities: deferred income has increased by £24.4m. This is driven by an increase in income received in advance from HEE of £21.4m. There has also been an increase of £3.8m of income received in advance relating to low volume activity (LVA).

Cash & Liquidity

Manchester University
NHS Foundation Trust

Cash Metrics	YTD to M8 Original Plan	YTD to M8 Actual	YTD to M8 Variance
Days in month	30	30	
Operating Expenditure in month	234,631	237,675	(3,044)
Days Cash	**9.9**	**11.5**	**1.6**
Monthly Low		82,123	
Monthly High		300,723	

	2024/25 (£k)
Opening cash as at 1st April 2024	**133,687**
w/cap movements	(28,604)
Capital movements	(2,380)
PFI, lease and loan receipts and repayments	(39,422)
Operating position inc interest	37,692
Closing cash as at 31st March 2025	**100,973**



Key Messages

At the end of November 2024, the cash position is £90.9m against the plan of £77.1m, favourable by £13.9m.

- Favourable variances include:
  - Income received for prior year settlements (CPT drugs and devices, ERF, CEAs)
  - Income uplift for the consultant contract changes
  - Income received relating to pay award
  - CNST Maternity Incentive Rebate and settlement of prior year invoices
- Adverse variances include:
  - Delayed receipt of expected PDC related to capital support for the PAHT transaction – this is a timing difference and is expected to reverse in future months.
  - Impact of the YTD deficit position
  - Payments to Lloyds are over plan by £21m driven by the payment of prior year invoices
  - Other timing differences of supplier payments - these are expected to reverse in future months.
  - Pay expenditure relating to the pay award

Capital

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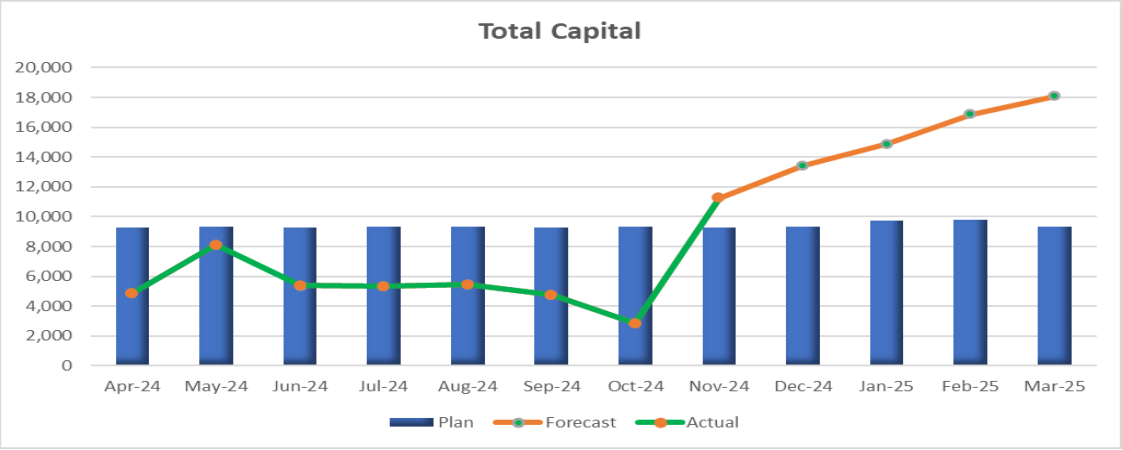

	Current Month - M8			YTD			Forecast		
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	FOT @ M8 £'000	Variance £'000
GM Envelope	4,383	7,108	2,725	35,064	24,235	(10,829)	52,593	46,378	(6,215)
Total Capital	9,293	11,236	1,943	74,520	47,926	(26,594)	112,734	111,151	(1,583)
IFRS 16 CDEL	2,612	(16)	(2,628)	17,188	209	(16,979)	31,341	11,533	(19,808)

- **MFT's 2024/25 capital plan is a total of £144.1m** including IFRS16 capital expenditure. The GM envelope component is expected to be £46.4m and includes £10m confirmed CDEL cover for capital requirements associated with the Pennine Acute Hospital Trust (PAHT) acquisition in 2021.
- **GM Envelope** – YTD plan of £35.1m, actual spend of £24.2m – underspend of £10.8m due to delayed spend on capital schemes whilst awaiting the confirmed allocations for 24/25 from GM and the national allocation for PAHT, delays on the RAAC scheme and initial delays in ordering high-risk medical equipment whilst completing risk prioritisation across all clinical groups.
- **Total capital spend** – YTD plan of £74.5m, actual of £47.9m – underspend of £26.6m principally driven by the £10.8m noted above plus delays to the CDC Withington project (£6.8m), TIF scheme (£3.7m - although still scheduled to complete in 24/25), and delays in funding approvals in the NHP project (£3.0m). Discussions continue with the national NHP team to confirm the year end capital position
- **IFRS 16 lease capital spend** YTD plan at £17.2m, actuals of £0.2m (noting this includes a £1m CDEL credit following an exit from a property lease). The underspend is a consequence of two MES agreements slipping to 25/26, the requirement for GM approval on a lease-by-lease basis and time taken to complete onboarding after approval of new leases. 2024/25 full year forecast is £11.5m.

Risks and Mitigations

- Year-to-date, **£20.5m** of central flexibility has been released into the position with a further **£3.1m** from the Sites in month 8. There is minimal flexibility available to support any unexpected pressures for the remainder of the year.
- Urgent action is required to support a significant reduction in run rate to enable the Trust to deliver the 2024/25 financial plan of a £3.6m surplus.

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Risk	Mitigation/Action Being Taken	Timescale	Owner
Expenditure run rate doesn't reduce to deliver 24/25 financial plan	• Enhanced expenditure controls require urgent implementation • Temporary staffing expenditure requires a reduction by 25% reduction from November 2024 • 2% of all posts to be held until 31st March 2025 • Implementation of reduction of hourly rate for bank enhanced nursing rate • Implementation of enhanced controls to ensure consistency in application of local override of temporary medical staffing rates • Only exceptional use of admin bank or agency, approved through Executive led Vacancy Control Panel.	Ongoing	Director of Financial Improvement/All Executive Directors
Nationally Agreed Pay Award – currently full year c.£6m pressure, although calculation of cost and funding is extremely complex	• Continued analysis to test assumptions. • Most of the pay awards were paid in M7 and M8, but arrears for bank staff and UoM Consultants remain estimated • Discussions ongoing with GM ICB in relation to funding assumptions • National escalation.	31st December 2024	Chief Finance Officer Marcus Thorman
Additional costs incurred to deliver performance targets	• Activity and Productivity performance is addressed at the MFT's Group Recovery Board which is chaired by the Trust Chief Executive • Any additional costs required to deliver activity are approved through Trust Leadership Team meeting and a funding source is confirmed.	Ongoing	Chief Delivery Officer Vanessa Gardener Chief Finance Officer Marcus Thorman
ERF Income – assumption of c.£20m above plan is not delivered	• Plans for implementation of coding improvements to be reviewed and action plans to deliver including timescales confirmed • Areas of expected over-performance to be reviewed and plans to deliver this implemented.	31st January 2025	Chief Delivery Officer Vanessa Gardener Chief Digital Information Officer David Walliker
Different ICB approaches and general commissioning changes resulting in income reductions, currently extremely high risk.	• Discussions with the GM ICB and Specialist Commissioners and therefore NHSE continue to ensure all funding anticipated is received	31st December 2025	Chief Finance Officer Marcus Thorman

Risks and Mitigations (continued)

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Risk	Mitigation/Action Being Taken	Timescale	Owner
Assumed £4m of income agreed with GM ICB interim CFO (Kathy Roe) is not funded	• Discussions ongoing to confirm this funding will be received	20th December 2024	Chief Finance Officer Marcus Thorman
Industrial Action – Receipt of £3.2m funding to cover costs incurred	• Discussed at MFT POM monthly POM meetings • Further discussions with GM ICB to confirm funding will be allocated to MFT as the cost cannot be mitigated internally	20th December 2024	Chief Finance Officer Marcus Thorman
Scarcity of capital could impact on operational delivery and patient safety	• £10m of CDEL allocation with agreed from NHSE in relation to PAHT acquisition (shortfall of £6.2m for which internal mitigations are being identified). Full engagement with GM wide capital process • Trust Strategic Capital group to meet on a monthly basis (previously quarterly) to monitor expenditure and review prioritisation • Monthly review of any alternative sources of funding for capital expenditure	Ongoing	All Executive Directors
Reduction in Trust cash will require the Trust to access revenue support funding	• Cash management group established to support maximisation of Trust cash balances • Focus on the management of debtors	Ongoing	Chief Finance Officer Marcus Thorman

Agenda Item 13.3

Manchester University NHS Foundation Trust

Escalation and Assurance Report
Digital and Estates Board Committee (DEBC)

Report to: Board of Directors
Report from: Sam Liscio, Non-Executive Director and Chair of DEBC
Date of meeting: 3/12/24

Key escalation and discussion points from the meeting
Alert
A strategic risk had been raised temporarily due to a significant network outage impacting Hive. The strategic risk has now been stepped down following remediating actions which have permanently resolved the problem. A complete review of the core IT infrastructure will now take place. The outage has caused a number of impacts including a performance dip and increased staff costs due to the people resource and expertise required to fix this issue. The EPRR processes worked well with all disciplines working together to fix the issue. The incident review and lessons learnt will be considered at a future meeting of this committee.
Advise:
Estates: • An external estates utilisation review has been commissioned and has been underway for two months. Community estate is being looked at first with a review of the acute estate beginning in January. • The committee received an update on plans for the redevelopment of North Manchester General Hospital (NMGH). A decision on the future of the New Hospital Programme is expected by the government in January 2025. • The committee received an update on estates priorities for 2024/25 and the progress being made. Capital and backlog funding remain an issue. A risk register is in place and the committee heard that there was no direct risk on patient safety as a result of the backlog. Work on fire prevention at NMGH is ongoing and proceeding to plan. *Digital:* • The blood transfusion system changes will be implemented from March 2025. • Multi-factor authentication (MFA) is now fully embedded across MFT.
Assure:
The Committee received assurance that the development of a digital strategic delivery plan was on track and would be completed in time for mobilisation from April 2025. External support is being provided by Gartner. A progress tracking document will be developed for the Committee to use for monitoring purposes. Residual actions from the internal audit continue to be delivered. Those yet to be completed do not increase any digital vulnerability for the organisation.

Hive benefits' tracking continues with no system developments required within Hive to address risks. Cash-releasing benefits are tracked through the Value for Patients programme and work is underway to identify the process for monitoring non cash-releasing benefits.

The digital team are on track to over-achieve against their 9.5% Value for Patients target.

From the Board Assurance Framework (BAF), the Committee received updates from lead Executive Directors regarding progress with the actions required to deliver strategic objective 9 of the MFT strategy. This is included in the BAF presented to the Board at its January meeting.

Report approved by: Sam Liscio, Non-Executive Director and Chair of the DEBC.

Agenda:

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Digital and Estates Board Committee

Date: Tuesday 3rd December 2024
Time: 10am – 12pm
Location: Main Boardroom, Cobbett House, ORC

Agenda

	Item	Purpose	Lead	Time
1.	**Apologies for absence & confirmation of quoracy** (verbal)	Meeting admin	Chair	
2.	**Declaration of interest** (verbal)	Meeting admin	Chair	
3.	**Welcome and Introduction** (verbal)	Meeting admin	Chair	
4.	**Action Log**	Discussion	Chair	
5.	**Matters Arising**	Discussion	Chair	
6.	**Assurance Reporting** 6.1 Board Assurance Framework	Discussion	Chair	
Strategic aim 4: Ensure value for our patients and communities by making best use of resources				
7.	7.1 Digital strategy overview	Discussion	DW	
	7.2 Chief Digital and Information Officer's report	Discussion	DW	
	7.3 Update on Hive programme (including Epic connect)	Discussion	DW	
	7.4 Update on response to cyber security internal audit	Discussion	DW	
	7.5 Director of Estates and Facilities' report	Discussion	RJ	
	7.6 Overview of estates priorities for 2024/25	Discussion	RJ	
	7.7 Estates utilisation overview	Discussion	RJ	

	7.8 Update on NMGH development programme	Discussion	MT	
Committee business				
8.	**Escalation report**	Approval	Chair	
9.	**Workplan Review**	Meeting admin	Chair	
10.	**Any Other Business** (verbal)	Discussion		
11.	**Meeting Evaluation** (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 6th March 2025 at 10:00am				

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Board of Directors (Public)
Monday 20th January 2025

Paper title:	North Manchester Redevelopment Programme	**Agenda Item 13.4**
Presented by:	Claire Wilson, Chief Finance Officer	
Prepared by:	Michelle Humphreys, Director of Strategic Projects	
Meetings where content has been discussed previously	North Manchester Redevelopment Programme Board Trust Leadership Team Committee	
Purpose of the paper Please check **one** box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The NMGH Redevelopment Programme is part of the national New Hospital Programme (NHP) which was launched in 2019 by the previous government. The Trust submitted two Outline Business Cases (one for Redevelopment and one for Digital as instructed by Joint Investment Committee) in January 2021 proposing the wholescale redevelopment of the site costed at £693m. Whilst the Trust has been able to progress with significant enabling works projects, the business cases for the main scheme have not progressed due to the need for alignment with the emerging New Hospital Programme approach.

The new government is now reviewing the New Hospital Programme and the Trust awaits the outcomes which are expected soon. Progress of the business case, programme milestones and estimated completion date for the NMGH scheme has dependencies linked to confirmation of budget envelope, delivery programme and design scope.

Recommendation(s)

The Board of Directors is asked to:

- Note the progress on site at North Manchester General Hospital.
- Note the current significant uncertainties on the capital envelope and timescales for the redevelopment, expected to be clarified through the outcomes of the government review.
- Note the expected onward steps required by the New Hospital Programme once clarity on a delivery programme is shared with the Trust.
- Note the work of the North Manchester Strategy Board to maximise partnership working to deliver the most effective change for the residents of North Manchester.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your report what action has been taken to address this) ☒ **No**

Relationship to the strategic objectives			
The work contained with this report contributes to the delivery of the following strategic objectives (see key below)			
LHL objective 1	☐	LHL objective 2	☐
HQSC objective 1	☐	HQSC objective 2	☐
HQSC objective 3	☐	PEW objective 1	☐
PEW objective 2	☐	VfP objective 1	☐
VfP objective 2	☒	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☐

Links to Trust Risks	The work contained with this report links to the following strategic, corporate or operational risks: • NMGH Infrastructure Risk MFT/005198 (20)	
Care Quality Commission domains Please check **all** that apply	☒ Safe ☐ Effective ☐ Responsive	☐ Caring ☐ Well-Led
Compliance & regulatory implications	n/a	

Main report

1.0 Introduction

The NMGH Redevelopment Programme is part of the government's New Hospital Programme which was launched in 2019. Following the approval of the Strategic Outline Case, the Trust submitted two Outline Business Cases (one for Redevelopment and one for Digital as instructed by Joint Investment Committee) in January 2021 proposing the wholescale redevelopment of the site.

The business cases for the main scheme have not progressed due to the need for alignment with the emerging New Hospital Programme's 'Hospital 2.0 standardisation' approach from early 2021 onwards. Trusts within the programme were assured that whilst there would be initial delays to design progress due to the need to develop a national standardised design approach, the completion date of 2030 could still be achieved based on a quicker construction timetable.

2.0 Progress at NMGH

Whilst the main scheme proposals have not been able to progress, the Trust has successfully delivered significant enabling works on site, aligned to the endorsed masterplan and to ready the site for the new build project including;

- The construction of North Manchester House, a new modular office facility
- The decant and demolition of the former Trust HQ Victorian building
- Handover of the former Trust HQ site to GMMH to facilitate the construction of the new North View facility
- The decant and demolition of the former Limbert House
- Construction of the new 960 space Multi Storey Car Park
- Delivery of over £19m of social value outcomes from these enabling works including employment for 632 local people, 396 weeks of apprenticeship training and over £18m spent in the Greater Manchester supply chain.

The next steps for enabling works include a proposed 'Outpatients Building' to facilitate the move of the remaining services from the identified new build site.

3.0 Government's review of the New Hospital Programme

The Trust now awaits the outcomes of the government's national review of the New Hospital Programme (NHP) which are expected shortly. The review outcomes are expected to provide clarity on investment profile and the phased delivery of the 25 schemes within the scope of the review. It is understood that the outcome of the review will deliver a phased delivery plan based on the national budget allocated to the programme with the seven hospitals fully affected by RAAC (Reinforced Autoclaved Aerated Concrete) taking priority. As well as financial constraints, the construction market's capacity to deliver significant schemes concurrently will also be a factor in the phased programme.

4.0 Anticipated Next Steps

The Trust anticipates that a scheme specific delivery programme would include a number of key gateways to move through, known as Progressive Development, based on the adoption of the Hospital 2.0 approach, understood to include:

- Completion and sign off of the NHP Demand & Capacity Model for NMGH
- Endorsement of the Trust's Model of Care/Target Operating Model
- Completion and sign off of the NHP Schedule of Accommodation template
- Commencement of the NHP 'Design Guardian' process, i.e. the adoption of Hospital 2.0 design
- Agreement of the range of options to be considered in the Outline Business Case, informed by knowledge of a budget envelope for the scheme
- Detailed Outline Business Case process driven through NHP's Progressive Development process
- Alignment to NHP's Main Works Contractor Framework (procurement not yet commenced)

Once clarity on programme, budget and H2.0 Products are established, the Trust will work with NHP to agree a set of milestones and an Outline Business Case programme alongside a request for Programme Fees to support delivery. Ultimately, without an agreed budget envelope, delivery programme and design scope the main scheme will not tangibly progress and a completion date cannot be estimated.

5.0 North Manchester Strategy Partnership

The Trust is a key member of the North Manchester Strategy Board (NMSB) chaired by Cllr Bev Craig, Leader of Manchester City Council. The NMSB takes the lead on the wider North Manchester regeneration programme including the major residential programme Victoria North, seeking to maximise investment to address health inequalities and to deliver tangible economic regeneration to this part of the City.

The aims of the North Manchester Strategy align closely with the Trust's own Anchor Organisation objectives and by working closely with civic partners, outcomes will be supported and amplified by a shared understanding of the challenges, co-design of service transformation, a place-making ethos and the creation of long term opportunities for local people.

6.0 Recommendations

The report recommends that the Board;

- Note the progress on site at North Manchester General Hospital.
- Note the current significant uncertainties on the capital envelope and timescales for the redevelopment, expected to be clarified through the outcomes of the government review this month.
- Note the expected onward steps required by the New Hospital Programme once clarity on a delivery programme is shared with the Trust.
- Note the work of the North Manchester Strategy Board to maximise partnership working to deliver the most effective change for the residents of North Manchester.

Strategic objectives (Key)

Work with partners to help people live **longer, healthier lives**	**LHL objective 1**	Work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.
	LHL objective 2	Improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place
Provide **high quality, safe care** with excellent outcomes and experience	**HQSC objective 1**	Provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.
	HQSC objective 2	Strengthen our specialised services and support the adoption of genomics and precision medicine
	HQSC objective 3	Continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Be the place where **people enjoy working**, learning and building a career	**PEW objective 1**	Make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential
	PEW objective 2	Offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here
Ensure **value for our patients** and communities by making best use of our resources	**VfP objective 1**	Achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.
	VfP – objective 2	Deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships
Deliver world-class **research & innovation** that improves people's lives	**R&I – objective 1**	Strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part
	R&I – objective 2	Apply research & innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide
Good governance	**GG**	Deliver a safe, legally compliant and well run organisation