

Board of Directors (Public)

Date: Wednesday 30th July 2025

Time: 2:00pm – 5:00pm

Location: Main Boardroom, Cobbett House, Oxford Road Campus

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	Trust Chair	
2.	Declaration of interest (verbal)	Meeting admin	Trust Chair	
3.	Patient Story			
4.	Minutes of the previous meeting (21 st May 2025)	Meeting admin	Trust Chair	
5.	Action Log	Discussion	Trust Chair	
6.	Matters Arising	Discussion	Trust Chair	
7.	Trust Chair's report (verbal)	Discussion	Trust Chair	
8.	Trust Chief Executive's report	Discussion	Trust CEO	
9.	Assurance Reporting			
9.1	Board Assurance Framework *	Discussion	Deputy CEO	
9.2	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 (22/05/25) escalation and assurance report	Discussion	NED (LG)	
10.2	Strategic Developments	Discussion	Deputy CEO	
11	Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience			
11.1	Quality, Safety and Performance Board Committee (25/06/25) escalation and assurance report	Discussion	NED (DR)	
11.2	Annual Safeguarding Report*	Discussion	Deputy CEO/ CNO	

11.3	Annual Complaints Report*	Discussion	Deputy CEO / CNO	
11.4	Annual Patient Experience Report*	Discussion	Deputy CEO / CNO	
11.5	Annual Infection Prevention Control Report*	Discussion	Deputy CEO / CNO	
11.6	2025/26 MFT Winter Plan*	Discussion	CDO	
12	Strategic aim 3: Be the place where people enjoy working, learning and building a career			
12.1	People Board Committee (25/06/25) escalation and assurance report	Discussion	NED (AA)	
12.2	Safer Staffing Report (nursing) *	Discussion	Deputy CEO / CNO	
12.3	Safer Staffing Report (midwifery and newborn services)*	Discussion	Deputy CEO / CNO	
13	Strategic aim 4: Ensure value for our patients and communities by making best use of resources			
13.1	Audit and Risk Committee (24/06/25) escalation and assurance report	Discussion	NED (NG)	
13.2	Finance Board Committee (24/06/25) escalation and assurance report	Discussion	NED (TR)	
13.3	Digital and Estates Board Committee (18/06/25) escalation and assurance report	Discussion	NED (SL)	
13.4	Chief Finance Officer's report*	Discussion	CFO	
14.	Any Other Business (verbal)	Discussion	Trust Chair	
15.	Meeting Evaluation (verbal)	Meeting admin	Trust Chair	
Date of next meeting: Wednesday 1 st October 2025 at 2:00pm, NMGH				



Board of Directors (Public)		
21st May 2025		
Present:	Kathy Cowell (Chair) (KC) Mark Cubbon (MC) Trevor Rees (TR) Darren Banks (DB) Kimberley Salmon-Jamieson (KSJ) Toli Onon (TO) Sohail Munshi (SM) Matt Bonam (MB) Luke Georghiou (LG) Mark Gifford (MG) Chris McLoughlin (CM) Angela Adimora (AA) Damian Riley (DR) Vanessa Gardener (VG) Tom Rafferty (TRa) Meera Nair (MN) Claire Wilson (CW)	Trust Chair Trust Chief Executive Deputy Trust Chairman Interim Deputy Chief Executive Interim Deputy Chief Executive / Chief Nursing Officer Joint Chief Medical Officer Joint Chief Medical Officer Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Chief Delivery Officer Acting Chief Strategy Officer Chief People Officer Chief Finance Officer
In attendance:	Nick Gomm (NGo)	Director of Corporate Services/ Trust Board Secretary

1.	Apologies for absence and confirmation of quoracy
Apologies were received from Sam Liscio, Nic Gower, David Walliker, Chris McLoughlin, Mark Gifford. It was noted that TR would be joining the meeting late due to representing the Board at a Staff Awards ceremony.	
2.	Declarations of Interest
No interests were declared.	

3.	Patient Story			
KSJ introduced the patient story which described the experience of a patient who had been cared for in ICU at MFT.				
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 10 th March 2025			
The minutes of the Board of Directors' (Board) meeting held on the 10 th March 2025 were approved as a true record of the meeting.				
5.	Action Log			
Title of 'Workforce' section in the IPR to be changed to 'People'		MN	May 2025. Complete.	
Audit and Risk Committee to further review the SFIs and SoD in April 2025.		NGo	June 2025 – on work programme. Moved from April to June 2025 to enable time for review. <i>NB following the meeting the item was moved to the September meeting to allow consideration of any implications from the NHS 10-year plan.</i>	
6.	Matters arising			
There were no matters arising.				
7.	Trust Chair's Report			
KC provided her verbal report and drew attention to: • The Great Manchester Run – 350 colleagues running for MFT charity as part of the Blue Wave. • MFT's Women's Staff Network Discovery Event – heard the experiences from women who work in the Trust. • Current estate developments – Withington CDC, Citilabs 4, Trafford Decarbonisation • MFT Charity campaign 'Together we can achieve great things'				
KC noted that it was Like Georghiou's last meeting and thanked him for his service on the Board of MFT.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a

8.	Trust Chief Executive's Report		
TR joined the meeting during this item.			
MC introduced the Trust Chief Executive's report and drew attention to:			
• The NMGH redevelopment programme which is being scaled up to deliver the work required within the agreed timeline. Conversations remain ongoing with the New Hospital Programme team. • Current operational performance which VG will cover in the Integrated Performance Report (IPR). • Phase 3 of the MFT programme which is enhancing clinical leadership and making sure the right capacity and culture are embedded within teams. • The 2025/26 Annual Plan which TRa will describe later in the agenda. • New leadership team appointments – Chief Executive of the CSS Clinical Group, Chief Executive of the LCO/UDHM Clinical Group and Chief Executive of the MRI Clinical Group.			
Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a
9.1	Integrated Performance Report (IPR)		
Trust Executive Directors introduced the sections of the IPR relevant to their portfolios.			
VG drew attention to:			
• Changes to the format of the IPR to provide clear and transparent data on our performance against annual plan. • IPR outlines our final position in March 2024/5 for operational performanceConsistent delivery last year was observed for: • our 2 hour crisis response target, community waiting list size and bed occupancy • Despite falling short of our plan, significant improvement was made with improving trend for the following: ○ UEC 4 hour performance - 6 percentage point improvement from March last year to March this year with 3000 more of our patients seen within 4 hours ○ 177% reduction in patients waiting over 65 weeks – 560 patients waiting to 33 of which 23 patients were waiting for corneal graft tissue which there is a shortage nationally ○ 4 percentage point improvement in RTT from 47% to 51% in the last quarter equating to 5000 less patients waiting over 18 weeks to be seen ○ 21 percentage point reduction in patients waiting over 6 weeks for a diagnostic test, equating to 7000 fewer patients waiting ○ 15 percentage point reduction in patients waiting over 62 days for cancer treatment meaning 97 more patients treated / month under 62 days • Performance improvement programmes are in place and monitored at the Quality, Safety and Performance Board Committee (QSPBC). but significant improvement still to be made this year.			
KC noted that the Board members discussed the IPR at each of the Board Committee meetings.			

KSJ drew attention to:

- The way the metrics, and improvement plans, are reviewed at each relevant part of the Trust's governance structure with oversight at QSPBC.
- Two delays in duty of candour have occurred and the patients and families have now been communicated with. Processes have been strengthened within the CSS Clinical Group.
- Safeguarding levels 2 and 3 training compliance levels are improving and remain behind target.
- New sepsis metrics have been included in the IPR following feedback at the last Board meeting.

TR noted that the LCOs had also not met the Duty of Candour target and KSJ explained that improvement had been shown in the LCOs and that there was confidence that would continue.

SM drew attention to:

- VTE screening compliance improvement is being seen and progress is expected to continue.
- The Medicines Management metrics covering all areas of medicines optimisation which require scrutiny.

MN drew attention to:

- Areas of consistent success including the reduction of vacancies.
- Areas of underperformance – levels 2 and 3 mandatory training, temporary staffing (a decline in performance over the last 2 months), and sickness absence (which remains high but end of year performance has been better than anticipated).
- Actions are in place to improve performance against all indicators and these monitored by the People Board Committee.

CW drew attention to:

- The IPR shows the Month 12, therefore year-end, position.
- The financial plan was fully achieved for 2024/25.
- The Value for Patients (VfP) target was met in full.
- The capital plan was achieved in line with the forecast. The plan wasn't delivered in full because of an agreement with GMICB to restrict sending part way through the year.
- The cash position is £40m below plan due to one payment missing from commissioners. This payment had been received by the time of the Board meeting.

LG congratulated CW and her team for delivery of the financial plan and asked whether other comparator Trusts had achieved similar results. CW explained that she was not fully aware of other Trusts' positions but that 2025/26 will see much more transparency in financial reporting across the NHS, as referred to by MC earlier in the meeting.

TR commented that it was positive that the full IPR was now being discussed in the Public Board meeting and it indicated MFT's commitment to transparency. He also noted that all sections are discussed in detail at the relevant Board committees as the Escalation and Assurance Reports indicate.

KC highlighted the governance developments, including the new IPR, which have taken place over the last 6 months and thanked the whole organisation for supporting the work.

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

10.1	Strategic Developments		
TRa introduced the report which provided an update on recent strategic developments including: • GMICB’s work on Major Trauma Centre provision and the Cardiac/Vascular service change assurance process where work is ongoing with system partners. • The focus on neighbourhood integrated care which will feature in the NHS 10-year plan. • The disaggregation of services from the former Pennie Acute Hospital Trust is coming to an end and has been achieved successfully through effective partnership work with the NCA. • MFT would be responding to an upcoming Genomics tender opportunity. • A consultation from NHS England to change the way in which activity levels would be managed between providers and commissioners. The previous ‘cap’ on elective care income was to be removed but there would still be a fixed level of funding available at a system level. The process to agree activity plans for the year ahead with commissioners was ongoing. • The model ICB Blueprint published by DHSC/NHSE.			
Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a
10.2	Delivering our strategy Where Excellence Meets Compassion – Year 1 Progress Report		
Matt Bonam joined the meeting during this item			
TRa presented the annual update on progress in delivering the MFT strategy and highlighted key achievements during the year under each strategic aim. He drew attention to: • The work which has taken place to embed the strategy across the Trust. • The new governance and assurance arrangements are aligned with strategy delivery. • Metrics to measure delivery of Strategic Aims 1 and 5 are in development and will be discussed at the relevant Board committees.			
KC emphasised the importance of triangulating evidence and DB noted that the Board Assurance Framework would be discussed in public at future meetings.			
In response to a question from LG, TRa confirmed there were no significant areas of concern but that areas have been identified where further work is required, or where the Trust has further ambitions, and that these were reflected in the priorities for this financial year.			
MC noted that the strategy was developed at a point of time and would need to develop as national requirements change. Processes are now in place to escalate metrics through the governance structure when certain triggers are met.			
SM noted that sharing the strategy with front line workers has helped them understand the vision and ambition of the Trust.			

AA noted that the improvement in staff engagement and the NHS staff survey results for 2024 were positive indicators of progress being made.

Decision	Action	Lead	Complete / date for completion
The Board noted the progress made during 2024/25 against the aims set out in the MFT strategy 'Where Excellence Meets Compassion'.	None	n/a	n/a

10.3 MFT Annual Plan

TRa introduced the report which sought approval for MFT's Annual Plan for 2025/26. He outline that:

- There was no requirement to publish the plan but MFT has chosen to create an accessible document for all stakeholders.
- The plan describes the next steps in delivery of the MFT strategy over the coming year.
- The comments which had been received from Governors and which had informed the final version. The plan will be shared with the Council of Governors in July.

AA welcomed the plan and suggested that the names of the staff pictured in the plan could be included to support recognition. TRa agreed to look into this and consider whether appropriate consent had been given to support this.

In response to a question from MB, TRa explained that the previous report presented what had been delivered by last year's annual plan and he would consider how progress could be reported more publicly at this time next year. MC suggested that it may be more accessible to make a film rather than create a written document.

KC noted that the content would provide useful information for the Annual Members' Meeting in September and TRa agreed to support the event as required.

Decision	Action	Lead	Complete / date for completion
The Board approved the Annual Plan	Check consent to publish names of staff members with pictures included in the plan.	TRa	July 2025

10.4 MFT's Green Plan 2025 – 2028

VG introduced the report which sought approval for the refreshed MFT Green Plan. The refreshed plan encompasses all areas of Trust activity, examining sustainability across ten areas of focus. VG drew attention to:

- Since 2019/20 carbon emissions per patient contact have decreased by more than 30% from 32.0kg CO₂e to 22.5kg CO₂e.
- Reduced the carbon footprint of medical gases by over 70% by decommissioning the wasteful nitrous oxide systems. A great example of a multi-disciplinary project delivering cost savings and big environmental benefits.

- We have secured more than £30m grant funding to support the decarbonisation of the MFT Estate, including technologies to decarbonise heat, improve the efficiency of our buildings and generate power on-site through Solar PV.
- The plan will be published in the summer and promoted to staff and the general public.

TO noted that the Trust now has a cohort of GIRFT fellows, one of whom is presenting her GIRFT work on sustainability at the NHS Expo. Her work has included reducing waste by considering the contents of surgical trays and will now adopt the same approach to orthopaedic equipment. TO also that the impact on sustainability of robotic-assisted surgery will need to be considered in the future.

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

11.1 Quality, Safety and Performance Board Committee (23/04/25) escalation and assurance report

DR presented the escalation and assurance report from the QSPBC meeting held on the 23/04/25 and drew attention to the following matters discussed:

- The Committee's scrutiny of the IPR and the focus on cancer metrics.
- The reduction in C.diff rates.
- The improvement in diagnostics performance and a report considered by the Committee which described the work to reduce waits for MRI scans for children.
- The reports on the Trust's Ethics Committee and the Genomics service.
- The re-launch of the Trust's Home Birth service

DR also noted that the following reports on the agenda (11.2, 11.3, and 11.4) had been discussed in detail.

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

11.2 Q4 Complaints Report

KSJ introduced the report, discussed at QSPBC in April 2025, and drew attention to:

- The improvement in response times with 93% of complaints resolved within the agreed timescale.
- The increase in PALS and Complaints cases which was usual for the period covered by the report as a result of winter pressures
- Informal resolution training was being delivered to key colleagues in the Trust.

DR confirmed that the report was discussed in detail at QSPBC.

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

11.3	Q4 Patient Experience Report			
KSJ introduced the report, discussed at QSPBC in April 2025, and drew attention to: • The national survey results contained in the report. Themes shared by the surveys are being identified and action plans are being developed and implemented. • The ongoing work to development the Trust Involvement and Experience strategy • A number of user groups are being established including a Stoma Group. DR confirmed that the report and highlighted the work being done on improving nutrition and hydration which appears to be leading to an improvement in patient feedback about these areas. MB noted the positive impact on staff morale from the ‘Small Changes, Big Difference’ work observed through Senior Leadership Walkrounds (SLWRs). Significant impacts are being achieved through little expenditure.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report and supported the recommended next steps.		None	n/a	n/a
11.4	Annual Clinical Accreditation Report 2024 – 2025			
KSJ introduced the report, discussed at QSPBC in April 2025, and drew attention to: • The 192 clinical accreditations and quality checks which have taken place • The realigned scoring mechanism which has been put in place. • The notable improvement in a number of areas. • Infection control/cleaning and medical devices remain areas requiring further focus. • Productivity measures are included in the accreditation programme. VG noted the discussion in QSPBC regarding making the process more multi-disciplinary than it is presently. The methodology used reflects the improvement methodology being embedded across the Trust. KC noted that discussions during SLWRs show how staff are aware of what they need to do to improve the rating for their ward. She also noted that community services are requesting to become involved. In response to a question from AA, KSJ confirmed that learning is shared between ward managers within Clinical Groups and sessions are planned for later in the year which will bring the different Clinical Groups together to share learning.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report and supported the revised Clinical Accreditation and Quality Assurance processes.		None	n/a	n/a

11.5	Safe Staffing report (nursing)			
KSJ introduced the report, discussed at PBC in April 2025, and drew attention to: - The finance 'accelerator schemes' which are enabling efficiencies to be found - The small amount of spend on agency staff. - The reduction in AHP rates of pay. - Turnover 8.1 – OK. - Sickness remains at 6.2% for nursing and 9.4% for support workers. - There had been a reduction in use of Bank colleagues but that has increased recently. - The Trust has joined a National Improvement Collaborative around safe staffing. AA confirmed that the report had been discussed in detail at the People Board Committee (PBC).				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a
11.6	Safer Staffing report (midwifery and newborn services)			
KSJ introduced the report, discussed at PBC in April 2025, and drew attention to: - The Trust is compliant with Birthrate+ standards. - KSJ had explained the Red Flags issue highlighted in the report with PBC members. - The compliance of the Newborn services division with Quality in Specialty (QIS) would be boosted through support for up to 40 nurses to attend a QIS course annually. AA confirmed that the report had been discussed in detail at the PBC meeting in April 2025.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a
12.1	People Board Committee (PBC) (23/04/25) Escalation and Assurance Report			
AA presented the escalation and assurance report from the PBC meeting held on the 23/04/25 and drew attention to the following matters discussed: - The Trust's apprenticeship programme and the opportunities to benefit further from engagement with apprentices. - The MFT People Promise and the project underway to better understand, and act upon, the views and preferences of AHPs. - The revalidation achievements of nurses and midwives across the Trust. The total number of lapses of revalidation per Clinical Group during 2024/25 is only 0.5% of the total required to revalidate. - Staff sickness absence remains an ongoing issue and will be a features of discussions at PBC over the coming year.				

Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a
13.1	Audit and Risk Committee (09/04/25) escalation and assurance report			
The Board noted the report in the absence of the Audit and Risk Committee Chair who was unable to attend the Board meeting.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a
13.2	Finance Board Committee (22/04/25) escalation and assurance report			
TR presented the escalation and assurance report from the Finance Board Committee (FBC) meeting held on the 22/04/25 and drew attention to: • The 2025/26 financial plan which will present another challenging year for the Trust with a high VfP target. a plan. • The 2024/25 outturn position was supported by more non-recurrent savings than desired. • The discussion on potential commercial opportunities available to the Trust. • The strategic risks discussed at the meeting and the links to the strategic risks under the Digital and Estates Board Committee. DB explained that the risk of duplication of strategic risk was being addressed at the Trust Risk Oversight Committee.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a
13.3	Chief Finance Officer's report			
CW presented the CFO report and drew attention to: • The year-end results are subject to audit. • Delivery of the financial plan was achieved through delivery of the VfP programme and the income from the Elective Recovery Fund.. • Reporting of underlying financial position to FBC would be enhanced. • The Financial Recovery Plan was being refreshed in light of the current position and national policy changes. • The Trust's cash position will be an area for focus in 2025/26.				
Decision		Action	Lead	Complete / date for completion
The Board noted the report.		None	n/a	n/a

13.4	Delegated authority to Audit & Risk Committee for Annual Report / Annual Sign-off		
CW presented the report which sought approval from the Board of Directors to delegate approval of the annual accounts and the annual report to the Audit and Risk Committee.			
Decision	Action	Lead	Complete / date for completion
The Board noted the report and delegated approval of the annual accounts and the annual report to the Audit and Risk Committee.	None	n/a	n/a
14.	NHSE Provider Licence self-certification		
DB presented the report which sought approval for self-certification for Condition (CoS7(3)) using 'Statement B' due to the continuing absence of a revised list of Commissioner Requested Services from commissioners.			
Decision	Action	Lead	Complete / date for completion
The Board approved MFT's Provider License Self-Certification for Condition CoS7(3).	None	n/a	n/a
15.	Board of Directors' Register of Interests		
DB presented the Board of Directors' Register of Interest.			
AA noted that she will amend her entry to include details of her current employer.			
Decision	Action	Lead	Complete / date for completion
The Board noted the report.	None	n/a	n/a
16.	Any Other Business		
KC reiterated her thanks to LG for all the work he has undertaken at the Trust.			
18.	Date and time of next meeting: 30 th July 2025		
Action log from meeting			
Action	Lead	Complete / date for completion	

Check consent to publish names of staff members with pictures included in the plan.	TRa	Complete
Incomplete actions from previous meetings		
Audit and Risk Committee to further review the SFIs and SoD in April 2025.	NGo	September 2025 – on work programme.

Public Board of Directors Wednesday 30th July 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 <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The Trust Chief Executive has shared a report which provides an overview of activities at the Trust, an overview of operational delivery, and progress made on strategic aims and 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: All strategic objectives in the Board Assurance Framework.		
Care Quality Commission domains Please check <u>all</u> 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:

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Full content of the report is included as Appendix A.

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

NHS 10 Year Plan Launch

The 10-Year Health Plan for England was launched on Thursday 3 July 2025. The plan sets out a comprehensive vision for how the service will develop over the next decade. It has been informed by thousands of staff and members of the public giving their thoughts and submitting their ideas.

The plan outlines three radical shifts – from treatment to prevention, from hospital to community, and from analogue to digital. It also describes a new transparency around quality of care, changes to the NHS operating model and a different approach to NHS finances, a new 10 Year People Plan, a renewed focus on research, innovation and the life sciences; all of which are designed to support the scale of change required and deliver the three shifts at pace.

Our MFT strategy aligns well with the 10-Year Plan, with our aims and objectives reflecting many of the plan's key themes. For example, our Local Care Organisations are supporting the shift of care into the community through their integrated neighbourhood teams; we have stepped up activities across MFT working with partners to support healthy lives and prevent ill-health; our Genomic Medicine service already delivers some of the ground-breaking tests and clinical services that the Plan aims to scale over the next decade; we are continually building on our digital and data capabilities through our Hive programme, and we are a leading provider of research and innovation in life sciences.

That said, the 10 Year Plan offers opportunities to go further. We will therefore be looking to refresh our strategy to ensure that we make the most of these opportunities. The refreshed strategy will form the basis of our priorities over the coming decade which will in turn be the basis of our annual plans for 2026/27 and subsequent years. This will be the mechanism through which we deliver our existing plans, and the shifts described in the 10 Year Plan.

A more detailed delivery plan is expected in the late Autum which will outline more specific expectations for providers, and we have already kickstarted a process to review our MFT strategy which will be a key topic for future Board discussions to agree any proposed amendments.

Neighbourhood Health Services

The 10 Year Plan makes neighbourhood health services a cornerstone of the NHS over the next decade. This is an area in which colleagues across Greater Manchester have led the way nationally and we are already working with local authority and Integrated Care Board colleagues on how we develop our neighbourhood services further.

In Manchester, our teams are working together to develop the next phase of delivery for neighbourhood services, including the potential for further alignment with mental health, alignment of primary care, The Live Well programme and accelerating the shift of care from hospital into the community. A blueprint is in development and scheduled to be complete by the Autumn.

In Trafford, partners recognise the opportunities to further expand integrated Multi-Disciplinary Teams (MDT) across health and care and target support to residents with the most complex health and care needs. A pilot of the MDT approach commenced in June in central Trafford, with a view to expanding across the borough by the start of 2026/27.

Abdominal Aortic Aneurysm Screening

The Abdominal Aortic Aneurysm (AAA) screening programme has reached a new milestone, achieving its highest ever uptake rate of 79.95%. A potentially life-threatening condition, AAA's, often develop without early symptoms and screening can help identify the condition early and allow safer and more effective interventions as well as peace of mind for those with a negative screening result. This encouraging performance has exceeded the national standard of 75% and demonstrates the effectiveness of targeted interventions focused on health equity. The success stems from unprecedented collaboration with community organisations, local healthcare and grassroots services specifically targeting the most deprived areas. These partnerships have addressed traditional barriers to screening participation, including transport challenges, work flexibility, and cultural sensitivities. Community champions, faith leaders, and local voluntary organisations have played crucial roles in building trust and encouraging attendance. Actor Craig Cash has produced [a powerful video](#) which we hope will raising further awareness of this vital, life-saving service.

Casgevy Gene Therapy

Manchester Royal Infirmary and the Royal Manchester Children's Hospital are two of only seven centres in the country designated to provide a new gene therapy, Casgevy, for the treatment of adults and older children with genetic blood disorders. This therapy was approved by NICE for thalassaemia in August 2024 and, more recently, for sickle cell disease. It is the first treatment using the CRISPR gene editing technology to be commissioned for the NHS and the MRI has treated the first patient in the country.

Mr Tim Chronis was infused with his genetically edited cells in May and was featured on BBC Northwest Tonight at the start of July. There are now a total of 9 adults and children who have started the work-up for this groundbreaking treatment across MFT.

Collaboration with Primary Care on care pathways

Encouraging progress has been made on a number of primary care interface priorities since the last Board of Directors meeting. On 24 June, medical Fit Notes were launched in

Hive. This new feature allows MFT clinicians to create medical Fit Notes in real time, removing the longstanding historical requirement for patients to attend their GP to get a note after a hospital appointment or admission. In addition to improving the patient experience, the change will also help to reduce the level of demand on our valued community and primary care colleagues, allowing them to improve access for their patients.

An *Onwards Referral* pilot has also been completed in the MRI, in Nephrology and Cardiology. The aim is to improve the process for patients who require support from multiple specialties for a single related condition. This has negated the requirement for MFT clinicians to request new referrals from a patient's GP, and improves speed of access for patients as well as reducing an unnecessary administrative burden on GPs and their teams. Following the success of the pilot, this is now going to be rolled out across the Trust.

Finally, an overarching Programme Board is being set up to progress the Diabetes Pathfinder Programme. The aim of the work is to move from hospital to community-based care and directly aligns to the ambitions set out in the NHS 10-year plan. By September 2025, the programme will have developed a proposed community-based model of care across Manchester and Trafford.

Successful Disaggregation of Services at North Manchester General Hospital

The disaggregation of NMGH catchment activity from the former Pennine Acute Hospital Trust (PAHT) has been a long and complex programme that commenced at the point of the transaction in April 2021. MFT and the Northern Care Alliance (NCA) have collaborated to agree, plan and implement the appropriate approach to each service. Disaggregation of a series of 'complex' services has required a change in location of patient care requiring even greater planning and care to ensure a safe transition. This is now close to completion with the safe disaggregation of Trauma & Orthopaedics on 1 April 2025.

Trauma & orthopaedics has been the most complicated service to date due to the highly interconnected model of care delivered under PAHT (elective orthopaedics led by the NCA at Fairfield General Hospital and trauma care at NMGH led by MFT) and the requirement to plan this separately for the four sub-specialties of elective orthopaedics. Learning from previous phases has meant that this was delivered on time and without issue. The final service to be agreed and disaggregated is colorectal cancer, on which a decision is planned at the July MFT / NCA Joint Delivery Board.

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

Operational Delivery

- **Urgent Care**

This year we aim to achieve 78% performance for the 4-hour target across all types by March 2026. For the month of June performance was 71.3% against a plan of 73.9%.

Ambulance handover within 15 mins during June was 47.4%, against the national standard of 65.0%, which the Trust is planning to achieve by March 2026. Average handover time in June was 17.68 minutes against the Trust's plan for the month of 19.10 minutes and compares well to the NHS average in May 2025 of 27 minutes 58 seconds.

As we enter the summer period, and following the publication of the NHS plan for urgent and emergency care in June, teams across MFT are focusing on the range of actions, interventions and oversight required to improve our urgent and emergency care performance for patients, with a particular focus on meeting the Trust's plan for the 4-hour standard through changes to our workforce model overnight, optimisation of our same day emergency care services and faster flow to wards where patients require admission.

- **Elective Care**

The most recent reported data for elective care is May, when the month end position for 18-week referral to treatment (RTT) reported 52.38% performance against our plan of 50.72%. We reported 8,208 patients waiting over 52-weeks for elective treatment against our plan of 7,964. 23 patients (7 of which were patients waiting for corneal graft tissue) were waiting over 65-weeks at the end of May against a planned trajectory of 0, excluding corneal grafts.

It is positive to see improvements in 18-week RTT performance from our position of 48% in December 2024, when our improvement initiatives were invigorated in anticipation of the launch of the national Elective Reform Programme in January; but we have more to do across all our services to recover waiting times further, ultimately aiming to restore the constitutional standard of 92% performance by March 2029. The Care on Time programme, which I will elaborate on further in the next section, is our primary approach to drive improvements to elective care pathways across MFT.

- **Cancer Care**

Our performance against the 62-day standard for June reported 65.5% against a plan of 63.8%. The latest data available for the Faster Diagnosis Standard (FDS) is for May, where performance was 75.2% against a trajectory of 76.7%.

In May we saw a reduced performance against plan for the FDS standard which was driven by the urology and gynaecology tumour groups, where additional capacity is in place over the summer to improve access, as well as clinically-led pathway improvement work through our Trust-wide cancer improvement collaborative.

Performance against the 62-day standard continues to improve, driven by continued improvements in our high-volume treatment areas of lung and breast, where additional theatre and outpatient capacity as well as streamlining of the suspected cancer pathway have contributed to faster access to treatment.

- **Diagnostics**

Performance for the month of May across all DM01 modalities was 14.2% against a plan of 12.5%. This deviation from planned performance was driven by increased waiting times for sleep studies and echocardiograms, as well as urological diagnostic tests. Actions taken to recover the position from June onwards include additional scan capacity at weekends, further use of our community diagnostic centres for tests where this is possible, and offering patients access to tests at alternative MFT hospital sites where waits are shorter.

Winter Planning

The Trust continues to experience sustained operational pressures associated with increased demand for inpatient and emergency services each year over the winter period. While performance during over the winter in 2024–25 demonstrated areas of improvement across several domains, further progress is required this year to deliver against the Trust's planned Urgent and Emergency Care (UEC) performance trajectories.

The Trust's Winter Plan, presented to Board at today's session, provides a strategic framework for the delivery of safe, effective care during periods of heightened demand. It outlines the operational and clinical mitigations in place to manage risk, maintain flow, and support staff wellbeing. The plan has been reviewed in the context of the NHS England and Department of Health's UEC Plan for 2025–26, published on 6 June, to ensure alignment with national priorities and mandated actions.

Subject to Board approval, the Winter Plan, and its more detailed underlying operational plans, will undergo scenario-based stress testing in September 2025 in collaboration with system partners. This exercise will test the resilience of the plan under a range of demand and capacity scenarios and inform any further refinements required ahead of implementation.

Care on Time

The Care on Time programme continues to drive forward our elective recovery and reform ambitions, with a strong focus on reducing waiting times and improving patient experience through transforming pathways of care. The programme was formally launched on 30 April and over the past quarter progress has been made on developing our plans and aligning

to the Trust's 2025/26 elective delivery commitments to improve our 18-week referral to treatment performance.

Specific focus has been on developing and expanding our advice and guidance service working with GPs, to streamline referrals and reduce unnecessary outpatient appointments. Progress is being made on implementation of our Waiting Safely framework across clinical groups, which was approved through our Quality, Safety & Performance Board Committee in June. Digital solutions to support validation and risk stratification of patients waiting are in development that will improve clinical triage and management of patients whilst awaiting care and a patient access and coordination programme is being initiated streamline our booking and scheduling processes and standardise referral and waiting list management. We are already seeing improvements in our 18-week RTT performance as I outlined above, and we expect this to accelerate as these new initiatives are taken forward.

Care Closer to Home

The Care Closer to Home programme continues to make strong progress in delivering the target benefit to reduce acute occupancy, focused initially on Manchester Royal Infirmary site, and improve long term care outcomes for patients. We have seen promising early results including:

- acute demand has reduced by 50 beds, resulting in a reduction in long emergency department waits for admission and an occupancy of 50 fewer beds than the 2024 baseline.
- reduced demand for long-term bedded care after an acute stay, with demand for intermediate care up by 25% resulting in better long-term outcomes for users (who would previously have gone directly to a long-term care setting).

These benefits will support preparation and management of pressures as part of the Trust and system's Winter Plan. The development of system visibility tools, utilising data from both MFT and Manchester City Council to identify areas of pressure or opportunity to redirect demand, is also a key element of the programme.

The third system-wide Urgent and Emergency Care Collaborative took place on 14 July 2025 where progress on the Care Closer to Home was shared alongside work underway in primary care, mental health and patient engagement. The collaborative event also provided the opportunity to further develop the strategic direction for urgent and emergency care including a focus on Single Point of Access and community provision.

Complimenting this work, the second test of Call Before Convey initiative took place from 16- 27 June 2025. During the test, 47% of calls received by the dedicated clinical team were redirected to alternative care provision including Crisis Response, Hospital @ Home and Same Day Emergency Care. The next steps are to work towards establishing a single

access point, including developing the long-term staffing model, job planning, associated costs, and the core skillset required to run this as a business-as-usual model, aiming to improve service accessibility by eliminating confusion and streamlining referrals from both ambulance teams and GPs.

Home Birth Service Reinstated

We are pleased to confirm that the home birth service was reinstated on 30 April, facilitated by a dedicated Homebirth team model for women who are eligible to receive midwifery led care. During the first 2 months of the reinstatement of the service, 5 women have birthed at home. Monitoring of success measures, such as documentation audits, outcome data and patient experience, will continue with a first detailed review planned at end of July. The Homebirth Service was suspended in October 2024 due to challenges with the wider community midwifery rota and vacancies. During the period the Homebirth Service was inactive, recommendations and learning from both internal and external reviews were implemented. Significant work has been undertaken to strengthen the service offer to women and achieve a safe, equitable home birth service for women and their families across Manchester. All women who expressed their preferred choice for a home birth throughout the suspension were supported and all mothers and babies are well, with no adverse outcomes were identified.

Robotic Surgery

MFT earlier this year expanded its robotic surgical programme with four new Da Vinci systems now operational at Wythenshawe Hospital, MRI, St Mary's, and Trafford hospitals. Implementation and training were delivered on schedule with a phased deployment from January to June. The programme is already delivering patient benefits such as reduced hospital length of stay and quicker recovery times, in addition to improved experience for surgeons and theatre teams

On Tuesday 8 July, we were delighted to welcome Lord Patrick Vallance, Minister of State for Science, Research and Innovation, to the Royal Manchester Children's Hospital to demonstrate the Versius robotic system, which our surgeons have described as a 'game changer' for the care of children. RMCH is part of a national research trial using the new technology in paediatric urology surgery and the trial is already demonstrating significant improvements to patient care.

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

One MFT – Phase Three Implementation

Work to refresh our operating model, looking at our Clinical Group leadership structures is progressing well. Following the issuing of our consultation outcome report on the 19 June the Trust has now moved into the implementation phase of the programme. This involves supporting our people through assessment for roles where appropriate and also focusing

on the range of non-people changes that are required to ensure a safe and well managed 'go live' date for our new operating model on the 6 October.

Consultation activities benefited from significant staff engagement, with written feedback, 1:2:1 and group feedback sessions and input from our stakeholders offering counter proposals which have been carefully considered. We are grateful for the engagement of our staff, stakeholders and staff side with these proposals which have been much improved through this input.

Addressing health inequalities and prevention with our colleagues

Our work to embed prevention into clinical care continues to progress and is timely given the release of the 10-year plan, which highlights this as a priority for provider organisations. During August, we will complete the first stage of development in Hive for the Social Determinants of Health module which allows clinicians to easily capture social and lifestyle information about patients and enables referrals to partner organisations who can offer ongoing support. This will build on our successful work to date on Smoking Cessation (CURE), with Citizens Advice and with Growth Company for employment advice. As of June 2025, our in-house Citizens Advice offer has generated over £1m financial benefit for our patients. We are also now consistently seeing more than 200 referrals per month from our MSK service and wider clinical teams into Growth Company for employment advice, addressing the Government's Work and Health priority.

The Prevention Working Group is developing training resource for staff and ensuring MFT have easy to access referral pathways in place with the right partners. A comprehensive roll out of the programme for pilot specialties is being planned for the autumn. MFT is also working through what an onsite Wellbeing Hub could look like at our larger sites, bringing together partner organisations in a physical space and providing a connection point for patients with community support and the LiveWell centres that are being developed across GM.

Medical Engagement Survey

MFT conducted a bespoke medical engagement survey in January and February 2025 which has been able to compare our results with over 175 surveys across other health organisations. MFT's overall score was 'medium', and the full outcome report has been shared with every medical and dental staff member. The results have been reviewed according to Clinical Group, site, specialty and grade which will allow MFT to focus on sharing good practice and reviewing themes for improvement. Over the course of the summer, a series of independent facilitated listening events are taking place, which are open to all medical and dental staff to help inform the development of the MFT medical engagement improvement plan. This will be completed by September and will support the wider Trust cultural change programme and launch of Phase 3 of the OneMFT programme, which will further strengthen the value of clinical leadership across MFT.

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:

- **Kings Honours Awards for MFT Colleagues:** we were delighted to hear that that three of our MFT colleagues were awarded OBEs in the King's Birthday Honours list in June:
 - **Mark Gifford** was awarded for his contribution to public service in his position as CEO of the First Choice Homes Oldham Housing Association and previous role with the National Citizen Service.
 - **Professor Andrew Rowland**, a consultant paediatrician at RMCH, received his OBE for services to safeguarding and the protection of children's rights.
 - **Kathy Murphy**, Director of Nursing and Midwifery within our Specialist Hospitals Clinical Group, received her OBE for services to midwifery leadership.

Congratulations to all three for receiving this well-deserved recognition.

- **Visit from MCC Councillors** – On Monday 7 July we welcomed Cllr Bev Craig, Leader of Manchester City Council, and Tom Stannard, Chief Executive of the Council to North Manchet Hospital (NMGH) to hear more about our ambitious £1.5 billion redevelopment, part of the Government's New Hospital Programme. Cllr Craig was joined by fellow councillors from across Manchester on a visit which included a tour of the hospital and discussions with senior Trust leaders on the need for modern, purpose-built facilities. The visit was a great opportunity to share our joint vision for the NMGH site and locality with elected officials from across the city.

Consultant Appointments

Since our last Board meeting in March, there have been 68 Consultant appointments in the following specialties: Acute Medicine, Anaesthesia, Associate Hospital Dean for Communication Skills, Cancer Geneticist, Cardiologist with an interest imaging, Colorectal Surgery, Diabetes and Endocrinology/GIM, Gastroenterologist, General Surgery & Benign Upper Gastrointestinal Surgery, Geriatric Medicine, Gynaecologist, Hand and Wrist Trauma and Orthopaedics Surgeon, Immunologist, Infectious Diseases, Intensive Care Medicine, Luminal Gastroenterology, Medical Examiner, Nephrology, Oncoplastic and Gender Affirming Breast Surgery, Oncoplastic Breast Surgeon, Ophthalmologist with Special Interest Oculoplastic, Orthodontics, Paediatrics, Radiologist with Thoracic and/or Cardiothoracic Interest, Reproductive Medicine, Respiratory Medicine, Trauma & Orthopaedic - Foot and Ankle Surgery, Trauma & Orthopaedic- Knee & Fracture Neck of Femur Surgery, Trauma and Orthopaedic Surgeon, Limb Reconstruction.

There have also been 13 Locum Consultants appointed to roles within the following specialties: Anaesthesia, Burns & Plastic Surgery - DIEP Breast Consultant, Burns & Plastic Surgery- Skand General Plastic, Cardiac Surgery and Cardiothoracic Transplantation, Cardiothoracic Anaesthesia, Critical Care, Infection/Clinical Scientist, Obstetrics and Gynaecology, Oral and Maxillofacial Surgery, Respiratory Medicine.

MFT continues to draw in exceptionally qualified candidates for consultant positions who are not only attracted by our exceptional services, but who 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

Value for Patients Programme Update

As of 9 July, the Trust has made good progress in developing its Value for Patients (VfP) programme, which aims to deliver sustainable improvements in care quality and efficiency. We have now identified £166.5 million worth of schemes, exceeding our target for the year of £165.8M, and demonstrating a Trust-wide commitment to transformation and improving the value of our service delivery for patients. This reflects a solid foundation, though continued effort is needed to convert our full breadth of schemes into delivery over coming weeks. Clinical Groups are actively working to refine and further mature these plans and ensure they are ready for implementation.

At the end of Month 3, we have delivered £20.7 million of savings, significantly ahead of our £15.6 million target for this point in the year (133%). This early overperformance is a positive indicator of momentum, but sustaining this pace will require consistent focus, leadership, and cross-organisational collaboration.

Looking ahead, our challenge is twofold: to maintain delivery against our ambitious targets and to mature the remaining pipeline of schemes. This will involve not only technical planning but also cultural and operational alignment across services. The VfP programme is a key enabler of our long-term financial sustainability and clinical excellence, and we remain committed to embedding it as a core part of how we work.

Microsoft Partnership

In May, the Trust officially launched a strategic partnership with Microsoft, with an inaugural workshop hosted between MFT Digital Services and teams from Microsoft to focus on aligning our strategic priorities. Three key focus areas were agreed for future collaboration; ambient technology, model ward, and infrastructure.

We are already trialling the use of 'Ambient Listening', where Microsoft artificial intelligence software has been used to automatically transcribe and document patient consultations. The rapid expansion of this pilot will likely be the first major deliverable of this strategic partnership, and we have seen a high level of enthusiasm from medical colleagues to engage with the pilot. Reducing the administrative burden for our clinicians will enable them to focus primarily on the consultation and discussion with the patient, enhancing patient experience and potentially freeing up clinical time.

Our model ward plans will be developed to complement the North Manchester General Hospital redevelopment programme, and we have three proofs of concepts in development focussing on digital wayfinding, early supported discharge and predictive analytics to identify opportunities for discharge to community care and will enable the shift from 'hospital to community' outlined in the 10-year health plan. Additionally, MFT will work with Microsoft to deploy Fabric, Microsoft's data analytics tool, which will support clinically led and data-driven decision making across the Trust. We will provide further updates to the Board on these exciting developments as they progress over the coming months.

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

NIHR Manchester CRF Announces New Director

Professor Ben Parker, Consultant Rheumatologist at MFT, has been appointed as the new Director of the MFT-hosted National Institute for Health and Care Research (NIHR) Manchester Clinical Research Facility (CRF). The NIHR Manchester CRF is the largest in the country, with six facilities across Greater Manchester including sites at MRI, RMCH, NMGH and Wythenshawe Hospitals, and plays a leading role nationally and internationally in advancing early phase and experimental medicine research. It is also central to our efforts to improve health outcomes and address health inequalities across the region

NIHR CRDC Now Live

The NIHR Greater Manchester Commercial Research Delivery Centre (GM CRDC) officially launched on 1 April 2025. One of 21 CRDCs across the UK, they have been established to enhance the speed and efficiency of commercial clinical research delivery in the UK, boosting the global competitiveness of the UK life sciences sector and contributing to the health and wealth of the nation. Working with partners in primary and secondary care across Greater Manchester, GM CRDC will increase patient-centred commercial research activity, improve access to commercial research opportunities, and expand capacity and capability to conduct commercial research across the city-region.

6. Strategic Updates and Policy Developments

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

Review of patient safety across the health and care landscape

The report of the review into patient safety across the health and care landscape undertaken by Dr Penny Dash, Chair NHSE, was published on 7 July 2025. The review found that, whilst there has been greater focus on safety over the last 5 to 10 years, this has resulted in only limited improvements in the overall quality of care.

The main recommendations include enhancing the role of the National Quality Board, with a national quality strategy to be developed, and changes to the national bodies overseeing quality and safety. The work of the Local Healthwatch is to be brought together with the engagement functions of ICBs and providers to ensure patient and wider community input into the planning and design of services. The report recommends that far greater attention should be given to how providers deliver high quality care and how commissioners hold them to account, with technology, data and analytics playing a far more significant role in supporting quality of health and social care.

This is consistent with the 10 Year Plan which places a great deal of emphasis on patient experience and outcomes, with far more transparency of the quality of care delivered by individual providers.

NHS Oversight Framework

The new NHS Oversight Framework for 25/26 was published on 26 June 2025. It sets out how NHS England will assess integrated care boards (ICBs) and NHS providers in 2025/26. NHS England will place every provider into a segment indicating its level of delivery from 1 (high performing) to 5 (low performing). Segment 5 is for the most challenged organisations that require the most support to improve. The assessment will help to determine how NHS England works with organisations throughout the year and how they can support improvement where required.

The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHS England may use its regulatory powers to intervene where a provider's performance falls below an acceptable standard and/or where there are concerns regarding governance. The framework will be reviewed in 2026/27 to incorporate work to implement the new ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

NHS Urgent and Emergency Care Plan

The 2025/26 Urgent and Emergency Care (UEC) Plan was published on 6 June 2025. It outlines a system-wide strategy to improve patient outcomes and operational resilience across NHS urgent and emergency services. It prioritises seven key areas including: reducing ambulance handover delays, improving A&E performance, reducing the number of patients waiting over 12 hours for admission or discharge, enhancing mental health crisis care, improving discharge processes, and increasing timely care for children. The key aim of the plan is to significantly improve UEC services for patients and staff this winter and we will ensure that our system-wide winter plans are in line with these requirements. Our Care Closer to Home programme is a significant enabler in the Trust's response to the plan, helping enable patients to be cared for in the community wherever

possible, and getting them home quickly and safely when a hospital stay is required. The MFT Winter Plan will be presented to the Board later on the agenda and reflects the wider work we are doing to prepare for winter and improve the outcomes and experience of people accessing our UEC services.

Health inequalities and equality legal duties

NHS England have published a reference document for NHS organisation which informs NHS Foundation Trusts, NHS Trusts and Integrated Care Boards about their legal duties in respect of equality and health inequalities. The document, which can be found [here](#), also provides a range of resources and practical tools. MFT has well-established programmes in place for both Equality, Diversity and Inclusion and Health Inequalities. They will be reviewed in light of this guidance with any developments being reported through to the People Board Committee and the Research Innovation and Population Health Board Committee.

Board oversight and staffing in NHS clinical trials

On 3 2025, NHS England published a letter (available [here](#)) from the National Clinical Transformation Director setting out best practice in the oversight and staffing of clinical research. Among the requirements is the establishment of board-level reporting of research activity and income, with scrutiny of the UK Clinical Research Delivery (UKCRD) programme site level performance metrics for study set-up. The letter commits to NHS England publishing guidance on income and activity reporting later in 2025. The Research, Innovation and Population Health Board Committee will continue to oversee the Trust's Research and Innovation activity, and its work programme will be reviewed in light of this and any forthcoming guidance.

7. Leadership Updates

Departure of Joint Chief Medical Officer and Interim Arrangements

Dr Toli Onon, our Joint Chief Medical Officer and Responsible Officer, will be taking up the position of Chief Inspector of Hospitals for the Care Quality Commission in September. Toli's association with our legacy organisations goes back many years; having been a medical student at Manchester Royal Infirmary in 1986, a resident doctor at Wythenshawe Hospital from 1993 and been appointed as a Consultant Gynaecologist in 2003.

Having been in her current role with MFT since 2017, Toli's contribution as Joint Chief Medical Officer has been pivotal in many of our key successes. Toli has helped ensure that we have always had a very strong medical voice on the Board of Directors and combined her leadership role with her continued clinical work at Saint Mary's Hospital. I am pleased to say that Toli will continue weekly outpatient clinics with us after she takes up her CQC role.

The process to recruit to the substantive Joint Chief Medical Officer (JMCO) position to work alongside Dr Sohail Munshi has already commenced. Professor Matt Makin, current Medical Director at our NMGH Clinical Group will be supporting in the role of JMCO until the substantive appointment is made and Professor Bernard Clarke will be providing interim support as Responsible Officer (RO).

Appointment of Communications and Engagement Director

I am pleased to confirm the appointment of Michelle Smith to the new role of Director of Communications and Engagement. Michelle is currently Director of Communications and Engagement at University Hospitals Leicester NHS Trust and will bring with her a wealth of experience, having worked in a number of senior communications and engagement roles across the country.

Michelle joins us at an important and exciting time. Her expertise in strategic communications will be invaluable as we take forward our MFT strategy and our new OneMFT operating model. She will also play a key role in strengthening our stakeholder engagement, including our communities, staff and partners, the importance of which has grown further with the launch of the 10 Year Plan. Michelle will join us in September and will be a full member of our Trust Leadership Team.

Departure of Director of Research & Innovation

Professor Rick Body will be stepping down from his role as Director of Research and Innovation (R&I) in September to take up a new position as Chair of the Interventional Procedures Advisory Committee at the National Institute for Health and Care Excellence (NICE). I would like to congratulate Rick on this notable national appointment and thank him for the passion and commitment he has brought to the role over the last five years. He has helped secure many achievements for MFT and I wish him every success in his new role. Rick will also continue in his clinical role as Consultant in Emergency Medicine here at MFT as well as Professor of Emergency Medicine at the University of Manchester.

We will begin the process to appoint a new Director of R&I in the coming weeks, and in order to integrate the leadership of R&I into the day-to-day running of MFT, the role will also become a formal member of the Trust Leadership Team. This is a critical time for MFT as we consider how we play an even greater role in the national and international arena, taking forward the opportunities set out in the 10-Year Health Plan and in the recently published Life Sciences Strategy for the UK, which you can find [here](#).

8. Top three concerns

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

Financial Position

MFT is committed to delivering break-even position for 2025/26 in line with the second year of our financial recovery plan. In order to support this, delivery of a challenging £166m Value for Patients programme is required. Extensive work continues to develop and mature schemes to deliver this level of savings, and increased capacity is still in place to support clinical and operational colleagues to develop implementation plans at pace. There is also a significant focus and senior capacity supporting management of the Trust's cash position to maximise cash receipt into the organisation.

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

One MFT Programme

Assessment centres are planned through July as we assess, where required, staff in scope of consultation for the new roles that are available in our future structures. A detailed and robust assessment centre process is in place to support this work, with Clinical Group SLTs and Corporate Directors sitting on assessment centre panels. Industrial action planned in July presents a risk to the delivery of our assessment centre schedule, and we are looking at mitigations, including additional panels in early August and shifting back of dependent activities so that impact is limited.

Partnership working with staff side through this assessment centre period will be key, ensuring that we follow due process and support our staff. We know that development activities will be required to ensure our appointed leadership teams are prepared and supported to deliver from the 6 October; ensuring everyone has the required skills to thrive in their new roles. A complete package of OD support is being developed, with delivery commencing in August to support staff with training, development and cross organisation networks that will enable them to deliver within these new roles.

The above concern is reflected in strategic objective 5 and 6 in the Board Assurance Framework.

Industrial Action

The announcement of new episodes of Industrial Action from Resident Doctors present significant operational challenges. Whilst we will do everything we can to minimise the impact, it is likely to mean that some patients experience delays to their treatment which will also pose risks to delivery of our already challenging performance trajectories. There is a financial consequence to each period of action which will exacerbate the challenges we face in delivery of our financial recovery plan and Value for Patients programme. Our

teams taking take all reasonable steps to reduce the impact on our patients and I would like to thank all staff who have been involved in those preparations, particularly our senior medical team, for their continued support through this period.

The above concern is relevant to all of the strategic objective 3, 6, and 8 in the Board Assurance Framework.

Public Board of Directors

Wednesday 30th July 2025

Paper title:	Board Assurance Framework	Agenda Item 9.1
Presented by:	Deputy Trust Chief Executive	
Prepared by:	Executive Directors Director of Corporate Business / Trust Board Secretary	
Meetings where content has been discussed previously	Quality, Safety, and Performance Board Committee People Board Committee Finance Board Committee Digital and Estates Board Committee Research, Innovation and Population Health Board Committee	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider
The Trust's Board Assurance Framework (BAF) has been designed to provide Board members with assurance regarding progress in delivering the strategic objective. This report presents the BAF for July 2025. All sections have been presented to the Board Committees responsible for oversight of the relevant strategic objectives during May and June 2025. Changes since the last BAF presented to the Board in May 2025 are highlighted within the document.

Recommendation(s)
The Board of Directors is asked to discuss the contents of the BAF and the 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 strategic risks aligned to each strategic objective are included within the relevant sections of the BAF.		
Care Quality Commission domains Please check <u>all</u> 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

1.1 A Board Assurance Framework (BAF) enables the Board of Directors to receive assurance on progress being made in achieving the organisation's strategic objectives. MFT has eleven strategic objectives and a number of 'priority actions' have been identified as the means to deliver those objectives. The BAF should be considered by Board members alongside the Integrated Performance Report and the other reports being presented at today's meeting, to assess progress being made in delivering the strategic objectives of the Trust.

1.2 Each Board committee has responsibility to monitor progress in delivery of the Trust's strategic objectives and all sections of the BAF have been discussed at the relevant Board Committee. The only changes between the versions presented to Board Committees, and the content of the whole BAF included with this report are related to actions which were due for completion after the Board Committees but before today's Board.

1.3 Since the Quality, Safety and Performance Board Committee took place in June 2025, the Chief Nursing Officer has reviewed the actions being undertaken to deliver the strategic objectives relevant to her work. Eleven new actions have been identified:

- Ensure an annual MNVP 15 steps visit to each Maternity and Neonatal unit across the MCS, tacking improvements with patient and family collaboration.
- Engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.
- Embed co-production principles across the Maternity Department to inform work on reducing health inequalities.
- Undertake work with both clinical and administration teams across Maternity Services to ensure all communication considers health literacy principles and considers digital literacy levels
- Scale up patient engagement including 'in-time' feedback, action and improvement
- Develop a modern, innovative, digital patient experience proposal
- Develop, new and innovative ways of improving 'real time' and 'in time' patient experience and fast track improvements, with patient design
- Further develop the role of patient representatives and maturation of the Patient Experience Forum
- Build on our refreshed connections with Healthwatch, Community Partnership Groups, Community Faith Groups, Manchester Community Central and other local VCSE groups to support improved patient experience and patient involvement
- Develop links with National Voices, Think Local, Act Personal and Coalition for Personal Care

- Further develop a network of patients and community groups in priority pathways to further develop enhanced patient and family experience, dementia, EOL and speciality pathways
- Use Experts by Experience in 20% of pathway and new development programmes

These actions will be included in the next version of the BAF discussed at the QSPBC meeting in October 2025 and the Board of Directors in November 2025.

1.4 At the Board of Directors meeting in May 2025, it was agreed that the BAF would be presented to the Board at every other meeting. The Strategic Risks element of the BAF will continue to be presented at every Board Committee meeting to ensure frequent oversight of those risks most likely to impede delivery of the Trust's strategic objectives.

1.5 The Trust Risk Oversight Committee approves the strategic risks which are included in the BAF. At each meeting, the Audit and Risk Committee receives the minutes and the escalation report from the Trust Risk Oversight Committee in order to support their role in overseeing risk management processes within the Trust.

2. Recommendations

3.1 The Board of Directors is asked to discuss the contents of the BAF and the assurance provided.

STRATEGIC AIM 1	WORK WITH PARTNERS TO HELP PEOPLE LIVE LONGER, HEALTHIER LIVES	GM mission	Improve quality and safety and addressing inequalities	Date of update	July 2025	Integrated Performance Report reference	N/A

Linked Strategic Objectives	We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.	We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so that people are cared for in the most appropriate place.
Lead Executive Directors	Joint Chief Medical Officer	Joint Chief Medical Officer Chief Delivery Officer Chief Strategy Officer
Board Committees	Research, Innovation and Population Health Board Committee Board	Digital and Estates Board Committee
Management Committee(s)	Population Health Management Committee	Digital Management Oversight Committee Delivery Oversight Management Committee

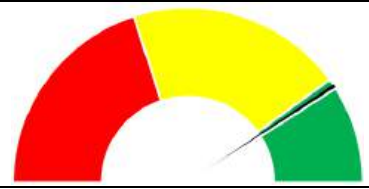
PRIORITY ACTIONS 2025/26				
Strategic objective	2025/26 priority actions	Evidence of delivery	Action being taken	Completion date
We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.	Increase secondary prevention activity across the trust to improve health and address inequalities.	MMU appointed to lead on evaluation of PHM approach.	Deliver population health management with a continued focus on hypertension. Work with MMU to evaluate the impact of PHM approach and refine approach further based on findings.	30/09/25
		Initial bowel cancer audit complete by PH registrar		
		Over 1,500 now trained in Health Literacy in the organisation. Community of practice is now well established and meeting every 6 weeks to drive the work forward. Clinical Groups leading their own work to improve written comms.	Lead development of consistent out of hospital pathway for diabetes with system partners	31/12/25
		Data quality deep dive completed for PHMC in Feb-25. IPR metrics drafted.	Continue to work towards becoming a health literate organisation, reducing barriers to access for our residents	Complete 31/03/26
		Citizens advice well-established – funding renewed for North. Wythenshawe and MRI added services. Seeking longer term funding from charities.	- Updated programme plan for 25/26 through health literacy community of practice. - Self-assessment of health literate performance completed in three specialties - Health literacy to feature in Clinical Group Annual Plans for 2026/27	
		WorkWell grant received from GMCA to support employment advice in MSK pathways – commenced Dec-24. Damp and mold referral continue and being expanded to Health Visitor service.	Increase the number of public health interventions through developing and delivering on an organisational wide approach to MECC which each CG can adopt/adapt, tracking key metrics and developing key supporting infrastructure.	31/03/26
		Work undertaken with a number of key partners to ensure patients can access social support while on a care pathway; including Growth Company for employment support, Citizens Advice for benefits and	Work with CGs on a series of agreed priorities around supporting care closer to communities which will include areas of focus around a community diabetes service (MRI), proactive respiratory MDTs with primary care (NMGH) and care of residents in care homes (WTWA) as well	31/03/26

		financial advice and Manchester Council for support around housing.	as looking at neighbourhood level services through INTs and partnerships (LCOs).	
			Ongoing work to develop or broaden referral pathways and support with other key partners such as BeWell for social prescribing, The Trafford neighbourhood hubs and Manchester Active.	31/03/26
We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so that people are cared for in the most appropriate place.	Increase the range of integrated services offered to people in the community, moving care out of a hospital setting where possible to help address health inequalities.	Increase in community activity and decrease in community waiting list through 2024/25 evident in Trust IPR. Reduction in community waiting times with delivery of 52WW trajectory evident in Trust IPR. Video comms for ward staff completed with nursing colleagues. Metrics agreed using NHS self-assessment tool. Progress made in NHSE self-assessment submission in Sept 24 with MFT moving from level zero to level 1 for fit notes and points of contact. Onward referral pilot to launched in Q3 for Cardiology and Nephrology Review of MFT discharge letters completed including medication information with Primary care stakeholders and improvements implemented which have now been built into Hive to ensure they are across all specialties. Progress made in working relationship with LMCs with regular engagement sessions in place with Clinical Group MDs so priorities for improvement are agreed and actioned.	Ensure that the progress is made on the 4 priorities outlined by NHSE on the National Primary Secondary Care Interface Programme (Onward Referral, Complete Care, Call/Recall & clear Points of Contact): • Electronic fit notes built into Hive & policy launched • MyMFT Business case implementation phase 1 complete. • Improvements delivered on all four workstreams in NHS self-assessment criteria for PSCI	Complete 31/12/25 31/03/26
			Undertake a review of the current engagement governance with MFT and Primary Care and implement revised arrangements to streamline ensuring improved strategic and operational arrangements	31/12/25
			Series of community scheme investments agreed with GM ICB as part of 2025/26 planning round across pressured areas e.g. gynaecology and ENT.	Go-live from Q2 2025/26
			Plan in place to reduce paediatric waits in diagnostics approved at Delivery Oversight Management Committee 17/04 which includes use of alternative pathways e.g. play therapy and expansion of capacity with a second scanner at the Wythenshawe site	Go-live from Q1 2025/26

STRATEGIC RISKS

Strategic Risk:	INABILITY TO REDUCE HEALTH INEQUALITIES (MFT/008393)					Description	If there a lack of agreed data sets, dashboards, leadership capacity and supporting governance, then priorities cannot be agreed, interventions designed and monitored, This could result in compromise progress being made on reducing health inequalities for our patients and their families with associated workforce, finance & reputational issues.				
Risk Lead	Chief Medical Officer	Initial rating	12	Current rating	12	Target rating	9	Target date	31/03/26	Change since last BAF	N/A - New risk
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Agree full data collection as mandatory in Hive, build rules in Hive, provide staff training and engagement/comms.						Joint Chief Medical Officer			Complete – plan for implementation being finalised.		
Agree IPR metrics at PHMV, build dashboards and implement into IPR.						Joint Chief Medical Officer			30/06/25 – Draft IPR agreed, digital support required for metric development		
Develop new Population Health AMD roles in CGs. Recruit to Oral Public Health Consultant.						Joint Chief Medical Officer			30/11/25		
Review MFT procurement contracts to establish what social value/population health projects, funding etc has been contractually agreed by the supplier and put a process in place for ensuring delivery						Joint Chief Medical Officer			31/07/25		

Strategic Risk:	DELIVERY OF GREEN PLAN (MFT/005752)					Description	If there is not strategic leadership and staff engagement throughout MFT then we will be unable to deliver the ambitions within the Plan resulting in damage to the Trust's reputation, failure to meet the net zero target by 2038 and contribute to climate change.				
Risk Lead	Chief Medical Officer	Initial rating	12	Current rating	12	Target rating	6	Target date	31/03/26	Change since last BAF	N/A - New risk
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Updated version of the MFT Green Plan is approved/ratified by the MFT Board of Directors.						Associate Director of Sustainability			Complete		
GPOG Chair to appoint thematic leads from GPOG Membership						Chief Executive, WTTA Clinical Group			Complete		
Staff engagement programmes to be agreed for embedding within Clinical Groups' Annual Planning Process.						Joint Chief Medical Officer			Complete		

ASSURANCE RATING			
Strategic Objective	Rating	Change since last BAF	Rationale
We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.		Rating increased from 7 to 9	Substantial and numerous different workstreams underway to achieve this.
We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so that people are cared for in the most appropriate place.		Rating increased from 7 to 8	Platform now in place to make stepped change in this workstream but this will still require capacity support from corporate teams such as Improvement and Delivery to ensure pace and sustainability can be improved for transformation required.

Key

Assurance category (dial colour)	Rating range	Definition
Substantial (Green)	9-10	The scope of assurance noted on the current BAF demonstrate that we are meeting our trajectories for delivery of the strategic objective and any risks are well understood and managed.
Adequate (Yellow)	5-8	The scope of assurance noted on the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective but there is assurance that there is little risk in achieving them.
Limited (Red)	1-4	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from trajectories for delivery of the strategic objective and, where there are plans in place, there are significant risks to achieving them.
None	0	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

STRATEGIC AIM 2	PROVIDE HIGH QUALITY, SAFE CARE WITH EXCELLENT OUTCOMES AND EXPERIENCE	GM mission	Recover core NHS and care services	Date of update	July 2025	Integrated Performance Report reference	See page 8 of the IPR

Linked Strategic Objectives	We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.	We will strengthen our specialised services and support the adoption of genomics and precision medicine.	We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.
Lead Executive Directors	Chief Nursing Officer Joint Chief Medical Officer Chief Delivery Officer	Chief Strategy Officer	Chief Strategy Officer
Board Committees	Quality, Safety and Performance Board Committee	Quality, Safety and Performance Board Committee	Quality, Safety and Performance Board Committee
Management Committee(s)	Quality and Safety Management Committee Delivery Oversight Management Committee	Service Strategy and Planning Management Committee	Service Strategy and Planning Management Committee

PRIORITY ACTIONS 2025/26				
Strategic objective	2025/26 priority actions	Progress made/evidence of delivery	Action being taken	Completion date
We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.	Improve the way in which we involve patients and the public in how we plan and deliver our services.	Patient Safety Partner role descriptions approved	Patient Experience team to complete scoping exercise of VCSE partners across GM to develop a care map to support with coproduction and design.	30/09/25 (changed from June 2025 in last BAF)
		Increased focus on triangulation of patient experience and other patient safety data in Patient Safety Group and Patient Safety Oversight & Assurance Group and review of FFT and opportunities to increase feedback in near / real time.	Patient Involvement Strategy currently being finalised, including broader use of involvement partners and volunteers across the Trust looking at widening participation in patient experience with specific roles aligned to projects and co-production projects, working in partnership to maximise our offer across Manchester and supporting carers work across MFT.	30/09/25 (changed from June 2025 in last BAF)
		Delivered patient experience training using newly developed toolkit.	Patient Safety Partner training, support and funding to be established	September 2025
		Developed bespoke questionnaires to understand areas of challenge at St Mary's and RMCH.	To build a senior leadership observational walk round process.	September 2025
	Embed the safety framework, empowering and training colleagues with the skills to improve safety.	Initial training delivered to colleagues during March, including Senior Leadership Teams.	Soft launch of processes using national tools	July 2025 (changed from May/June 2025 in last BAF)
		Level 1 and level 2 training available on learning hub - being promoted as part of wider comms	Agreed to commence in line with go-live of new clinical governance structures.	
		MFT first formal PSII delivered. Learning currently being shared.	Additional training sessions to be confirmed during June / July (post phase 3 roll out) plus additional training for Executives in Patient Safety Oversight	June / July 2025
		Associate Director of Clinical Governance (Patient Safety & Complaints) appointed 10/06/25 – start date start of September 2025.	Patient Safety Academy to be reviewed once Patient Safety team in place	September 2025 onwards (changed from August 2025 in last BAF)

		Additional training sessions for staff confirmed for September/October following implementation of phase 3 of ONE MFT programme.		
	Continue to reduce waiting times.	Continued improvement in long waits for elective care, with these having been virtually eliminated across the Trust as at March 2025. Improvement is evident in overall 18-week performance, though benchmarking in the IPR highlights that this is from a low base relative to the NHS average and regional peers. Continued improvement visible in diagnostic waits, where waiting times over 6 weeks have reduced from 33% of the waiting list in April 2024 to delivering our month 1 plan of 13.2% in April 2025 Cancer waits continue to be longer than plan but have improved, with the total number of patients being treated over 62 days reducing by 23% from April 24 to 25, and 64.9% of patients treated within 62 days in April. This remains a continued area of focus for improvement. Waits in our emergency department stabilised in April, with 70.5% of patients being admitted, treated or discharged within 4 hours	Care Closer to Home programme to support admission avoidance and provision of non-elective care in the most appropriate setting	Ongoing throughout 2025/26
We will strengthen our specialised services and support the adoption of genomics and precision medicine.	Continue the development of Genomic Medicine across MFT and beyond so that we build on our position as a national leader	Ongoing engagement with system partners to review the model of Major Trauma for Greater Manchester. Progressing work to develop pre-consultation business cases for Cardiac and Vascular services. Estates works underway to expand the range of specialist genomics testing. MFT has submitted its response to the NHS England market engagement process for the regional Genomics Medicine Service.	Complete short-term actions following GM Major Trauma review and agree long-term model with system partners.	September 2025 (changed from June 2025 in last BAF)
			Finalise pre-consultation business cases with a view to completion of assurance process by Dec 2025	December 2025 (changed from June 2025 in last BAF)
			Implement on-site ctDNA testing.	October 2025
			Complete estate works to support broader consolidation of Genomic testing.	August 2026 (changed from December 2025 in last BAF)
			Respond to forthcoming NHS England tender for regional Genomic Medicine Services.	August 2025
			Develop plan to expand pharmacogenomic testing across MFT.	December 2025
We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address	No linked priority actions	Successful disaggregation of Trauma and Orthopaedic (T&O) services from Northern Care Alliance (former Pennine Acute services) on 1 April 2025. Implementation of new single services across MFT for Oral Maxillofacial Surgery (OMFS), Ear Nose and Throat	Finalise repatriation of remaining orthopaedic activity following completion of estates work to provide additional theatres at Trafford Elective Surgical Hub.	September 2025
			Agree plan for disaggregation of Colorectal Surgery.	July 2025

inequalities and deliver value for money.		(ENT), Audiology and new leadership arrangements T&O from 1 April. Single service for Preoperative Assessment went live in May 2025.	Agree next phase of work through the Single Services Programme and identify priority specialties.	August 2025 (changed from May 2025 in last BAF)

STRATEGIC RISKS

Strategic Risk	IMPACT OF UNDER-DELIVERY OF OUR ANNUAL PLANS (MFT/008126)					Description:	If we do not maximise the efficiency of how we operate and deliver on the productivity increases and pathway transformation schemes planned for the year ahead, then we will not deliver on the performance commitments outlined in our plans. This will result in MFT not meeting the performance standards and ambitions around patient care and experience we have set ourselves, with potential for increased regulatory oversight and poorer access to care for patients.				
Risk Lead	Chief Delivery Officer	Initial rating	15	Current rating	15	Target rating	6	Target date	01/11/25	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Enhance Trust-wide action plans to improve performance across UEC, cancer, RTT and diagnostics.						Director of Performance and Planning			Complete		
Oversee delivery of the Trust recovery plans for constitutional standards to ensure performance improvement required is delivered.						Director of Performance and Planning			Complete		
To develop a `waiting safely' framework to include, waiting list stratification, smarter intelligence, harm review processes and strategies to support safer waiting for patients (including a consideration of inequalities), including a focus on the wellbeing of staff.						Director of Elective and Cancer Care			Complete		
To design revised approaches to waiting list management and referral management to better safeguard patients through our processes.						Director of Elective and Cancer Care			30/9/25 (30/6/25 in previous BAF))		

Strategic Risk	FAILURE TO EMBED A CULTURE OF CONTINUOUS IMPROVEMENT (MFT/008234)					Description	If staff are not appropriately skilled and don't have time dedicated to improvement then we will be unable to able to embed a culture of continuous improvement resulting in reduced staff engagement, lower patient satisfaction and a decline in service quality.				
Risk Lead	Chief Delivery Officer	Initial rating	12	Current rating	12	Target rating	6	Target date	31/1/28	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Produce and deliver a comprehensive Communications and Engagement Plan for Improvement.						Director of Improvement			Complete		
Dosing Formula to be broken down for each Clinical Group.						Director of Improvement			Complete		
Heads of Improvement to develop training plan in agreement with Clinical Group SLTs.						Director of Improvement			31/7/25 (30/4/25 in previous BAF)		
Engagement with Clinical Group and Corporate Senior Leadership Teams						Director of Improvement			Complete		
Improvement Roadmap to be drafted for discussion and development at MFT Executive and Board Seminar						Director of Improvement			Complete		
Deliver 90 minute 'Leading for Improvement' session at MRI Leadership Forum.						Director of Improvement			Complete		
Develop and deliver Improvement Pathfinder training once per month March - July 2025.						Director of Improvement			Complete		
Advertise and recruit to vacancies						Director of Improvement			Complete		

Strategic Risk	THE CLINICAL IMPACT OF THE RISK ASSOCIATED WITH UNDER-DELIVERY OF CONSTITUTIONAL STANDARDS (MFT/006352)					Description	If patients do not receive timely assessment, diagnostics, care and treatment then they will experience a sub-optimal health (physical, psychological and social) outcome, resulting in increased likelihood of ongoing impairment, disability or death, reduced likelihood of a full functional and asymptomatic recovery and reduction in their activation in their own care.				
Risk Lead	Joint Chief Medical Officer	Initial rating	15	Current rating	12	Target rating	6	Target date	30/09/25	Change since last BAF	No change
Risk quantum: Linked risks											
Reference	Title					Current risk rating				Clinical Group/ Corporate Service	
MFT/004322	Renal Dialysis Capacity does not meet current demand resulting in delays in delivering/commencing treatment, with a risk of potential harm and a poor experience for patient.								x	MRI Clinical Group	
MFT/000141	MRI Cardiac Catheter Lab Refurbishment and Equipment								x	WTWA Clinical Group	
Risk Treatment											
Action						Lead				Due Date	
To develop a `waiting safely' framework to include, waiting list stratification, smarter intelligence, harm review processes and strategies to support safer waiting for patients (including a consideration of inequalities), including a focus on the wellbeing of staff.						Director of Elective and Cancer Care				Complete	
Clinical Groups to undertake self-assessment of current readiness for implementing the Waiting Safely Framework - including understanding current triage processes						Director of Clinical Governance				30/9/25	
To identify existing tools and data to support clinicians to triage effectively and to undertake the elements of the waiting safely framework						Director of Clinical Governance				31/7/25	
To agree the communication methods and standards with patients and clinicians (including primary care)						Director of Clinical Governance				30/9/25	
To roll out use of the waiting safely framework across MFT, using the self-assessment to phase this						Director of Clinical Governance				31/3/26	
To develop additional tools to support risk stratification, utilising wider determinants to support early identification of those who may need prioritisation outside usual processes						Director of Clinical Governance				31/3/26	
To develop innovative solutions to support clinical / MDT capacity to identify the need for clinical harm reviews, including the use of AI technology to support patient led conversations						Director of Clinical Governance				30/9/25	

Strategic Risk	IMPLEMENTATION OF THE PATIENT SAFETY LEARNING FRAMEWORK (MFT/008173)					Description	If there is inconsistent prioritisation of training attendance and understanding of the patient safety learning framework then there will be limited colleague take up of training and skills to deliver the framework, resulting in reduced experience for patients and their families, inconsistent application of the patient safety framework and missed opportunities for learning and improving patient safety.				
Risk Lead	Chief Nursing Officer	Initial rating	16	Current rating	12	Target rating	6	Target date	01/04/26	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Develop a communications strategy aligned to other OD work.						Director of Clinical Governance			Complete		
Creation of a single accessible workspace for templates and guidance.						Director of Clinical Governance			31/07/25 (30/04/25 in previous BAF)		
Review and update the existing plan.						Director of Clinical Governance			31/08/25 (30/06/25 in previous BAF)		
Review and update existing policy and guidance						Director of Clinical Governance			31/08/25 (30/06/25 in previous BAF)		
Deliver refresher training to Board of Directors.						Director of Clinical Governance			31/10/25 (30/06/25 in previous BAF)		
MFT to implement PSIRF standard templates and approaches						Director of Clinical Governance			31/08/25(30/06/25 in previous BAF)		
Develop ongoing programme of training (Patient Safety Academy)						Director of Clinical Governance			30/09/25		

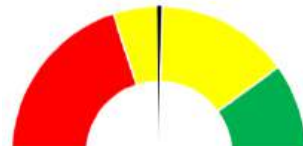
Strategic Risk	IMPLEMENTATION OF GREATER MANCHESTER RIGHT CARE RIGHT PERSON PROGRAMME PHASE 2. (MFT/008182)					Description	If there is an increase in the number of patients with physical and or mental health needs transferred from the police service to the healthcare setting following the implementation of the right care, right person programme then capacity will reduce resulting in increased waiting times and patient safety risks.				
Risk Lead	Chief Nursing Officer	Initial rating	12	Current rating	12	Target rating	4	Target date	31/7/25	Change since last BAF	Target date extended from 1/6/25
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Escalation process in place. Escalation monitored daily by safeguarding mental health team and reported 3 time a week to RCRP Task and Finish Group identified escalation representatives. Escalation process reviewed in line with changes to system wide working.						Lead Nurse - Safeguarding Adults and Vulnerable Groups			Complete		
RCRP training to provide workforce with knowledge and skills to consistently apply RCRP implementation plan which includes: Policy for the Prevention and Management of Missing Patients (adults and children) application; Lone Worker policy application; and Operational Readiness plan phase 1 and 2						Lead Nurse - Safeguarding Adults and Vulnerable Groups			Complete		
Phase 2 RCRP implementation plan to be delivered by RCRP task and Finish group chaired by Assistant Chief Nurse Safeguarding.						Assistant Chief Nurse - Safeguarding			31/07/25 (changed from 30/06/25 in previous BAF)		
Section 136 Task and Finish group implementation plan to support the emergency department workforce to deliver a safe and legal handover of the Mental Health section 136 patients from the police to emergency departments. The Group will: develop Section 136 standard operating procedure guidance; provide training on the guidance; develop an operational implementation plan to evaluate and receive assurance that guidance is consistently implemented.						Assistant Chief Nurse - Safeguarding			31/07/25 (changed from 30/06/25 in previous BAF)		
The safeguarding mental health team to review all missing incidents on a daily basis and any missing incidents where policy is not applied the ward or department are contacted and supported in local application of policy. A SITREP to be shared weekly with the RCRP escalation group and escalated to Clinical Groups Director of Nursing if the policy is not consistently applied.						Assistant Chief Nurse - Safeguarding			30/09/25 (01/08/25 in previous BAF)		

Strategic Risk	SAFE DISAGGREGATION OF COMPLEX SERVICES (MFT/007342)					Description	If disaggregation of NMGH catchment activity from the former PAHT and subsequent integration into MFT is not managed effectively, then patient safety could be compromised, patients could be lost between organisations or experience longer waiting times resulting in a negative impact on patient experience and safety, responsiveness of services, financial stability and health inequalities.				
Risk Lead	Chief Strategy Officer	Initial rating	12	Current rating	6	Target rating	2	Target date	31/12/25	Change since last BAF	No change
Risk quantum: Linked risks											
Reference	Title					Current risk rating				Clinical Group/ Corporate Service	
MFT/006954	Disaggregation of NMGH from the NCA						x			CSS Clinical Group	
MFT/005450	Disaggregation impact							x		NMGH Clinical Group	
Risk Treatment											
Action						Lead				Due Date	
Approved exit plan for T&O						Director of Strategy				Complete	
Approved plan for colorectal cancer						Director of Strategy				31/07/25 (changed from 28/03/25 in previous BAF)	
T&O - completion of 3 month post disaggregation review						Director of Strategy				25/07/25	

Strategic Risk	MAJOR TRAUMA (MFT/008405)					Description	If Major Trauma services are reconfigured to a single site, then the sustainability and quality of care provided to adult and paediatric services may be impacted resulting in MFT needing to vary its capacity, workforce, service provision or ways of working.				
Risk Lead	Chief Strategy Officer	Initial rating	12	Current rating	12	Target rating	8	Target date	31/03/26	Change since last BAF	Target rating reduced from 9 to 8. Target date changed from 30/11/25 to 31/03/26.
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead				Due Date	
Queries raised re. ICB process						Interim Deputy Chief Executive				Complete	
Strong proposal including the reasons and the benefits of maintaining the two centre provision and collaborating to address the peer review concerns through the now set up joint operation delivery group between MFT and NCA.						Director of Strategy				30/09/25 (changed from 30/06/25 in previous BAF)	
Submit a strong MFT single major trauma centre option on ORC that will deliver all the major trauma standards with minimal additional cost to the system						Director of Strategy				30/09/25 (changed from 30/06/25 in previous BAF)	
Strengthen adult and overall MFT major trauma governance with good Clinical Group SLT oversight and clear line of sight to MFT executives and the MFT Board.						Director of Strategy				Complete	

Strategic Risk	VASCULAR SERVICE CHANGES IN GREATER MANCHESTER (MFT/008406)					Description	If a single arterial site at MRI is not agreed and implemented to agreed timelines, then a sustainable service for GM may not be delivered resulting in MFT needing to vary its capacity, workforce or plans with an impact on cost, quality or sustainability of services.				
Risk Lead	Chief Strategy Officer	Initial rating	9	Current rating	9	Target rating	6	Target date	30/09/25	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Undertake internal planning workshop						Director of Strategy			Complete		
Integration planning workshop to be held post-preferred option confirmation						Director of Strategy			Complete		
To work with the specialist commissioners and NCA to determine the clinical and activity models at Salford Royal in order to assess whether capital investment is and to determine the clinical model in line with GIRFT and clinical leaders across site and the resources required within the overall Network Model and to define the activity volumes.						Director of Strategy			30/07/25		
To identify and manage the risks associated with the achieving the target deadline						Director of Strategy			Complete		

Strategic Risk	GENOMICS CAPITAL INVESTMENT IMPACTS UPON PRODUCTIVITY (MFT/008409)					Description	If there is insufficient capital funding and/or appropriate facilities available to support planned developments of Genomics services at MFT then the productivity of laboratory services will be limited resulting in an inability to meet growing demand, a loss of future income and reduced benefits to local patients of hosting a centre of excellence. (new description of risk)				
Risk Lead	Chief Strategy Officer	Initial rating	9	Current rating	9	Target rating	6	Target date	31/03/26	Change since last BAF	Target rating reduced from 9 to 6, Target date extended from 03/06/25)
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
A business case is in development which explores procurement options for managed service automation system which uses revenue instead of capital funding. Implications for IFRS16 are being explored to understand the viability of this option. However, the revenue option is likely to require further investment and it is understood that there is no new commissioned income for this service in 2025/26. MFT representatives continue to flag the risk of lack of capital to strategic commissioners to highlight the importance of capital to the national programme for genomic expansion, and MFT's ability to respond to this.						Chief Strategy Officer			31/07/25 (changed from 24/03/25 in last BAF)		
Establish a working group to oversee the various Genomics estates projects to support consolidation, including commissioning of CityLabs 1.0 site to support ctDNA, 5th Floor SMH works to accommodate Whole Genome Sequencing and Cytogenetics transfer and automation of both Manchester and Liverpool labs.						Chief Strategy Officer			31/08/26		

ASSURANCE RATING			
Strategic Objective	Rating	Change since last BAF	Rationale
We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience wherever they are treated.		No change	Continued improvement visible and evident in treatment waiting times. In the first quarter of 2025/26 we have seen 4 never events. In all instances a Patient Safety Incident Investigation has been commissioned. Whilst these Never Events happened across different Clinical Groups, within different specialities and were in different situations, it is important that the Trust retains close oversight of when these types of incidents occur and what is happening to prevent them. To support this there is robust governance surrounding Never Events, both at a local (Clinical Group) level and Trust wide. Patient Safety surveillance data continues to highlight issues in sepsis screening, VTE compliance, w and safeguarding Level 3 compliance, with recovery plans being commissioned. A review is underway looking at the management of patients with mental health in ED.
We will strengthen our specialised services and support the adoption of genomics and precision medicine.		No change	Ongoing work to agree position regarding GM Major Trauma model across system partners. Proposed changes to NHS England and ICBs may impact assurance changes processes. Good progress on Genomics. Further clarity on future model for Regional Genomic Medicine service provided through market engagement exercise, although to be confirmed through tender process. Dependence on estates works. Positive developments regarding automation and pharmacogenomics.
We will 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.		No change	Good progress with disaggregation of former Pennine Acute services. Successful implementation of single services changes.

Key

Assurance category (dial colour)	Rating range	Definition
Substantial (Green)	9-10	The scope of assurance noted on the current BAF demonstrate that we are meeting our trajectories for delivery of the strategic objective and any risks are well understood and managed.
Adequate (Yellow)	5-8	The scope of assurance noted on the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective but there is assurance that there is little risk in achieving them.
Limited (Red)	1-4	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from trajectories for delivery of the strategic objective and, where there are plans in place, there are significant risks to achieving them.
None	0	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

STRATEGIC AIM 3	BE THE PLACE WHERE PEOPLE ENJOY WORKING, LEARNING AND BUILDING A CAREER	GM mission	Support our workforce and our carers	Date of update	July 2025	Integrated Performance Report reference	See page 130 of the IPR

Linked Strategic Objectives	We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff experience by embracing diversity and fairness, helping everyone to reach their potential.	We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.
Lead Executive Directors	Chief People Officer	Chief People Officer
Board Committees	People Board Committee	People Board Committee
Management Committee(s)	Workforce and Education Management Committee	Workforce and Education Management Committee

PRIORITIES				
Strategic objective	Priority actions	Evidence of delivery	Action being taken	Completion date
We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff experience by embracing diversity and fairness, helping everyone to reach their potential.	Deliver our ongoing culture change programme, building an inclusive organisation where everyone has a sense of value and belonging.	Discovery phase of the Collective Leadership & Culture Programme scoped.	Alignment of the 22 recommendations into refreshed MFT People Plan	1 August 2025
		Culture community of 150 staff members.	Workshop held in June led by CPO to review the MFT People Plan	
		55 support and learning experience delivered	Creation of a Civility Collaborative and relaunch of materials in alignment with August 2025 Civility Week.	31 August 2025
		155 engagement sessions across MFT footprint		
		22 high level recommendations for culture change based on the staff voice.	Launch a Leadership Behaviors Survey using Open door	1 October 2025
		First MFT prototype Cultural Inclusion Dashboard	Alignment and creation of a Culture Dashboard incorporating NHS People Promises and Cultural Pillars	31 October 2025
		Supported two major NMAHP Chief Nurse engagement sessions.		
		Implemented the Culture Ambassador Badge programme over 5500+ Badges awarded.	Alignment to the Medical Engagement Programme and OD Support to the Joint Chief Medical Officers.	31 December 2025
		Delivery of two Civility Masterclasses with total attendance reaching over 600+ staff members.		
		MFT Civility Toolkit and Resource Portal.	Alignment and support to the Patient Safety Incident Response (PSIRF) Leadership, Change and Culture Task & Finish Group.	31 March 2026
		Delivery and evaluation of the R&I Cultural System Thinking Development Programme (B7)		
		Development of the Staff Network Forum in partnership with EDI.	Alignment and support with the What Matters to Staff (WMTS) Programme.	31 March 2026
		Scoped and Designed the Joint Chief Medical Officers Leadership Forum Development Programme.		

		Proud to be Ops with Change Agents and OD. Change Agents supported the testing of Improvement Pathfinder Training in partnership with the service improvement team.	Alignment and co-development for the Staff Networks.	31 March 2026
	Deliver an improved operating model for the Trust through the OneMFT programme	This change programme is focused on supporting the organisation to transition to the One MFT Operating Model. - Phase 1 – Clinical Group Chief Executives and their Senior Leadership Teams (SLT) - Phase 2 – Corporate Services - Phase 3 – Clinical Leadership	<i>Phase 1</i> Clinical Groups. Bespoke senior leadership team development for the next 12 months. Corporate Services Strategy and Improvement. OD activities are now being scheduled in the diary. Strategy has a dedicated leadership session planned for April 2025. Full day leadership development sessions have now taken place for all Clinical Group Chief Executives and their Senior Leadership Teams except Manchester and Trafford LCO and University Dental Hospital of Manchester	31 December 2025
			<i>Phase 2</i> OD support offer has been developed for Corporate Services Signposted resources and delivery of workshops for those impacted. Bespoke OD sessions have been delivered for Strategy in April and May 2025. A follow up meeting is taking place w/c 14th July to determine what additional support is available. Medical workshop is now in train with a workshop that took place on Friday 11th July. Follow up output report to follow. OD sessions with the medical workforce will continue to be delivered in house by the Corporate OD team. NMAHP and Workforce and OD – Discussions underway between the Chief Nursing Officer and Chief People Officer	31 December 2025
			<i>Phase 3</i> OD support offer being designed to support the triumvirate which consists of the clinical, nursing and operational lead: Clinical Leadership Working Group – this has nominated senior stakeholders from across the clinical workforce with representation from Medical, AHP, Pharmacist, Nursing etc The Workforce OD Team have developed an interactive brochure outlining the Phase Three OD support offer Power of Three Workshops have now been commissioned with the North West Leadership Academy. These workshops will be co-designed with the Clinical Groups and will commence in	31 December 2026

			September. Meetings are now in place with the delivery team to work out logistics and delivery plan. Co design will take place and meetings with Clinical Group Executives and Clinical Working Group are now being put in place. Corporate Skills Training – work underway with the OD Team and Corporate Function Executives to design and develop a schedule of corporate skills training delivered by subject matter experts. A schedule for sessions is being developed. Induction – Design work for the induction programme is currently in progress with key elements such as the time commitment and session approach to be formally agreed with Trust Executives and Clinical Group Executives. An options paper is being developed to outline potential approaches and to facilitate consensus on the preferred way forward. It is proposed the paper is presented to the Chief Executives huddle meeting on 21st July 2025. Further detail will be shared with Delivery Group following this meeting. The Leadership Development Programme is now under review for scope and design work. Scoping is currently underway as to the best approach through the utilisation of the apprenticeship levy/collaboration with universities	
We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.	Embed fair and inclusive recruitment practices that promote diversity at all levels, target under-represented groups, and ensure that careers in healthcare are open to all. Improve representation of people from an ethnic minority background at senior levels Work with managers to ensure proactive and efficient processes are in place for recruitment, onboarding and induction, so that all vacancies are filled as swiftly as possible. Develop a tailored approach for	Clinical Group and MFT Vacancy Control Panels. Vacancies that have passed through current vacancy controls are advertised as quickly as possible across all our standard platforms. Booking and Scheduling recruitment campaign, specifically focused on candidates new to the NHS and targeted partnership working with local community groups. Dedicated Immigration Service team to best support those with a temporary right to work, in line with the current Home Office regulations. New process for Corporate Induction embedded into the recruitment processes. Interactive candidate onboarding booklet for new medical staff specifically those from overseas. Scoping digital identity checking completed ahead of implementation in Quarter 2. Dedicated VSM / Executive Director talent team, offering a unique and bespoke service to each vacancy. Apprenticeship entry level roles	Refine the vacancy control processes to minimise delays but retain maximum robustness Vacancy Control process have been reviewed to include a weekly Clinical Group risk assessment of all posts. Posts are only advertised externally by exception (if specialist in nature) and are approved by the weekly MFT Executive Director led VCP. All band 7 + posts held for re-deployment or only advertised for 6/12 FTC/secondment. Weekly re-deployment panel in place.	Commenced April 2025 Review end Q2 Complete Assess impact Q3
			Further develop our People Place contents relating to right to work and immigration information Workshops held at the end of June led by the CPO to develop the revised People Plan. Currently being shared, the Change Agents are being commissioned to further lead engagement on ambition. Communication shared regarding the impact of the changes to immigration. Scoping exercise under way to assess the impact for MFT. Agreement to recruit locally.	Commenced April 2025 Review end Q2 Complete Assess impact Q3

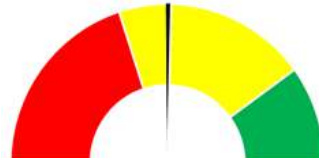
	colleagues joining from overseas		Support the Corporate Nursing and Nursing and Midwifery teams in the Clinical Groups in their annual student recruitment specifically supporting with the Guaranteed Interview approach (alternative to the Guaranteed Job Offer approach of previous years).	Commenced April 2025 Review end Q2
			Undertaking a review of current recruitment practices to identify opportunities where we can improve fair and inclusive practices.	Commencing September 2025 Review end of Q3
			Exploring through our Staff Networks we may be able to advertise our vacancies targeting under-represented groups at all levels including senior levels.	Commencing July 2025 Review end of Q3
			Supporting with the relaunch the Removing The Barriers Programme, which aims to increase the number of ethnically diverse staff into senior positions	Commencing September 2025 Review end of Q3
			Working in partnership with the E D and I Team and local communities to propose the development of an Inclusive Recruitment Framework	Commencing September 2025 Review end of Q3
			We will continue to review processes to identify opportunities to further improve time to hire whilst still recruiting safely. Specifically in July 2025 we implemented digital ID checking.	Commenced May 2025 Review end Q2
			Further review the current approach to colleagues joining from overseas to identify any opportunities to improve.	Commencing September 2025 Review end of Q3
			Develop an entry level apprenticeship programme for Band 2/3 Business Administration roles and Customer Service roles	From September 2025
			Develop a Health and Social Care Worker apprenticeship entry and on-boarding scheme	From September 2025

STRATEGIC RISKS

Strategic Risk	MAXIMISING THE EFFICIENCY AND EFFECTIVENESS OF WORKFORCE SYSTEMS AND PROCESSES (MFT/008201)					Description	If the Trust is unable to fully utilise the functionality of workforce systems and embed workforce policies and processes, then our ability to optimise workforce deployment, evidence-based performance and ensure employment law is adhered. Resulting in poor staff experience, resource inefficiencies, potential breaches of legislation and negative impact on our organisational reputation.				
Risk Lead	Chief People Officer	Initial rating	9	Current rating	9	Target rating	6	Target date	31/03/26	Change since last BAF	No change
Risk quantum: Linked risks											
Reference	Title				Current risk rating				Clinical Group/ Corporate Service		
MFT/008331	Inadequate IT records system and systems provision in the EHW service, which is significantly impacting on service delivery and clinical safety.						x		Trust-wide		
MFT/008425	Completion of workforce appraisals						x		Trust-wide		
MFT/008425	Digitalisation and automation						x		Trust-wide		
Risk Treatment											
Action						Lead				Due Date	
Masterclasses and additional training offers. New 'handbooks' for Workforce Systems on People Place.						Chief People Officer				1/08/25	
Digital maturity reassessments to inform workforce systems service improvement plans - improved relationship/ account management model						Chief People Officer				1/08/25	
Working with GM partners in relation to : Recruitment; Chatbot; ESR; Occupational Health Looking to see areas of collaboration and shared services						Chief People Officer				1/08/25	

Strategic Risk	SUSTAINING A SAFE AND SUPPORTIVE WORK PLACE CULTURE (MFT/008200)					Description	If the Trust is unable to embed national standards on creating an inclusive culture, equality, diversity and compassionate leadership as described in the MFT people plan, then we will have created a workplace environment where people feel unsafe and unsupported resulting in poor morale and wellbeing, high absence, difficulties in recruitment and retention which could compromise staff experience, affect the quality of patient care and services, and organisation reputation.				
Risk Lead	Chief People Officer	Initial rating	9	Current rating	9	Target rating	6	Target date	31/03/26	Change since last BAF	No change
Risk quantum: Linked risks											
Reference	Title					Current risk rating				Clinical Group/ Corporate Service	
MFT/0068423	Delivery of effective apprenticeship programme						x			Trust-wide	
MFT/008422	Recruitment and attraction as an employer of choice							x		Trust-wide	
MFT/008425	Completion of workforce appraisals							x		Trust-wide	
MFT/008424	Corporate and Clinical Group induction and on-boarding							x		Trust-wide	
MFT/008428	Employee relations							x		Trust-wide	
MFT/008427	Digitalisation and automation							x		Trust-wide	
MFT/008426	Mandatory training compliance							x		Trust-wide	
MFT/001689	Trust employed resident doctor mandatory training compliance							x		Trust-wide	
MFT/008507	Employee Health and Wellbeing Service - Insufficient Resources to support infectious diseases outbreak management							x		Trust-wide	
MFT/008429	Sickness Absence								x	Trust-wide	
MFT/006690	Management posts at all levels not representative of the local community the hospital serves.								x	Trust-wide	
Risk Treatment											
Action						Lead				Due Date	
People Plan completion and sign off.						Deputy Chief People Officer				31/10/25 (changed from 30/06/25 in last BAF - workshop held and draft outcomes for socialising due)	
New Staff Network plan to improve diverse engagement						Acting Director of Organisational Development and Inclusion				30/06/25	
Chief People Officer to chair Violence Prevention/Sexual Safety Working Group to monitor and deliver actions						Director of Learning and Development				30/06/25	
Review of process with options presented to Chief Nurse and Chief People Officer to decide model.						Deputy Chief People Officer				31/10/25	
Complete MFT EDI Strategy - Diversity Matters						Acting Director of Organisational Development and Inclusion				31/10/25	
Complete the Violence Reduction Standard, develop clear governance via Chief People Officer, report in line with Trust Violence Prevention Charter and Policy compliance, report of patient restrictions due to behaviour to staff.						Director of Learning and Development				10/08/25	
Each Clinical Group should demonstrate positive action to protect staff in the workplace - incl violence, abuse, and sexual safety						Clinical Group Directors of Workforce				10/08/25	
Review of mandatory training, overseen through NHSE is taking place. This will report on the activity to the Mandatory Training Steering Group						Director of Learning and Development				01/04/26	
Deep dive and review of sickness absence process and issues led by Chief People Officer						Deputy Chief People Officer				01/04/26	

Strategic Risk	ORGANISATIONAL CHANGE (MFT/008430)					Description	If the Trust is unable to fully deliver large scale (OneMFT) organisational change safely and efficiently to timescales, then our ability to effectively support our leaders and teams to continue to deliver to performance expectations, under financial constraints is compromised. This may result in poor staff morale, the loss of the talent and skills required to lead organisational change, and negative impact on the quality of patient care and services and organisation reputation.				
Risk Lead	Chief People Officer	Initial rating	9	Current rating	12	Target rating	4	Target date	31/03/26	Change since last BAF	Target rating reduced to 4
Risk quantum: Linked risks											
Reference	Title					Current risk rating				Clinical Group/ Corporate Service	
MFT/008422	Recruitment and attraction as an employer of choice							x		Trust-wide	
Risk Treatment											
Action						Lead				Due Date	
Streamline the redeployment policy through improved vacancy control measures						Deputy Chief People Officer				Complete. Weekly VCP in place within clinical Group and Executive led MFT Panel. Weekly Re-deployment panel in place	
HR professional conducting on-going review of legislation to ensure policy is compliant						Chief People Officer				01/10/25	

ASSURANCE RATING			
Strategic Objective	Rating	Change since last BAF	Rationale
We will make sure that our staff feel valued and supported by listening well and responding to their feedback. We will improve the experience of all our staff experience by embracing diversity and fairness, helping everyone to reach their potential.		No change	Significant and well-regarded programmes in place for improving the experience of our workforce. Comprehensive and dedicated programmes in place for OneMFT. Range of transferable and accessible programmes for leadership and management. Further work to do on embedding ED&I and development of the Staff Networks
We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.		No change	Comprehensive recruitment plans in place under a robust vacancy control process. Evidence of widening participation and implementation of corporate onboarding and Induction programmes. Work planned to enhance inclusivity at the point of attraction within the local communities to ensure underrepresented groups are able to easily access employment at MFT.

Key

Assurance category (dial colour)	Rating range	Definition
Substantial (Green)	9-10	The scope of assurance noted on the current BAF demonstrate that we are meeting our trajectories for delivery of the strategic objective and any risks are well understood and managed.
Adequate (Yellow)	5-8	The scope of assurance noted on the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective but there is assurance that there is little risk in achieving them.
Limited (Red)	1-4	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from trajectories for delivery of the strategic objective and, where there are plans in place, there are significant risks to achieving them.
None	0	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

STRATEGIC AIM 4	ENSURE VALUE FOR OUR PATIENTS AND COMMUNITIES BY MAKING THE BEST USE OF OUR RESOURCES	GM mission	Achieve financial sustainability	Date of update	July 2025	Integrated Performance Report reference	See page 166 of the IPR

Linked Strategic Objectives	We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.	We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.
Lead Executive Directors	Chief Finance Officer Chief Delivery Officer	Chief Digital and Information Officer Chief Delivery Officer
Board Committees	Finance Board Committee	Digital and Estates Board Committee
Management Committee(s)	Finance and Commercial Management Committee Delivery Oversight Management Committee	Digital Management Oversight Committee Delivery Oversight Management Committee

PRIORITY ACTIONS 2025/26				
Strategic objective	2025/26 priority actions	Evidence of delivery	Action being taken	Completion date
We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money	Improve our productivity and increase commercial income to deliver our financial plan	Delivery of 2025/26 Value for Patients target which includes delivery of productivity and efficiency opportunities identified by NHSE.	Clinical Group/Corporate Department financial plans triangulated with workforce and activity plans with formal sign-off processes agreed.	August 2025 (changed from April 2025)
		Delivery of year 2 of financial recovery.	Executive led VfP 'Sprints' ongoing with all Clinical Group-/Corporate teams (including commercial opportunities) to fast-track identification and implementation of VfP	Complete
		Delivery of activity plan, including elective recovery income.	Implementation of revised 'One MFT' Trust governance to enhance operational and clinical leadership across the Trust to enhance accountability and delivery of Clinical Group/Corporate financial plans.	October 2025
		Manage any additional cost pressures in year through robust budgetary control processes.	Increase commercial income in 2025/26.	April 2026
		Senior finance support increased for Value for Patients programme		
		Additional temporary capacity for VfP project management started in April 2025 for 12 weeks to support identification of schemes and strengthening delivery plans		
		Continuous Improvement lead commenced in post in May 2025.		
		Commercial Development Opportunities for 2025/26 identified.		

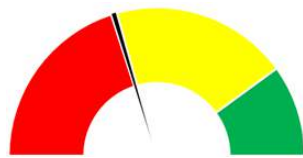
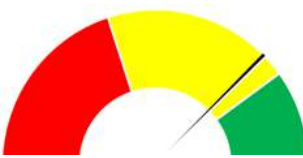
We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.	Progress plans to redevelop the NMGH campus, delivering a refreshed OBC whilst making best use of existing estate across MFT	Plans in place to deliver a completed NMGH OBC by Q3 25/26 to ensure progress is maintained towards a 27/28 construction commencement date. Estates Optimisation Workplan that evidences the opportunities derived from the MFT Estates Review aimed at reducing estates costs and increasing the utilisation of MFT owned estates. Dedicated team working on the NHP for North Manchester with allocated resources and a team structure proposed to finalise the project. Data and digital strategy shared.	Recruit a NMGH development team that can support OBC delivery	July 2025
			Analyse the details of NHP Hospital 2.0 guidance that will inform the cost and construction methodology for the NMGH redevelopment.	August 2025
			Structured strategy on estates optimization that details the timelines for immediate estate rationalisation and a masterplan for Wythenshawe, ORC and Commercial partnerships across MFT.	July 2025
			Create specific workplans for non-clinical space utilisation that ensures best use of the estate.	July 2025
			Informed KPIs for collecting, maintaining and actioning utilisation data for the MFT estate.	Complete
			Reduction in estates running costs contributing to MFT VFP program.	Ongoing
			New digital team structure defined for delivery of next phase of NMGH programme.	November 2025
	Implement plans to ensure that we are a data-driven organisation	Data strategic delivery plan approved and published.	Create AI and Data Academy.	March 2026
	Level-up digital maturity in our Local Care Organisations and community services	Production of business case for the LCO EPR replacement initiated.	Finalise business case for LCO EPR ready for approval through governance structures.	August 2025 (changed from June 2025 in the last BAF)

STRATEGIC RISKS											
Strategic Risk	IMPLICATIONS OF NATIONAL RESTRICTIONS ON CAPITAL RESOURCE					Description	If we continue to experience restrictions to capital resource then we will be unable to invest in our infrastructure, medical equipment and digital assets resulting in adverse impacts on service delivery, the safety of our estate for staff and patients and our ability to deliver our strategic ambitions.				
Risk Lead	Chief Finance Officer	Initial rating	6	Current rating	20	Target rating	4	Target date	31/3/27	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Capital is part of the annual business planning process. Clinical Group business plans include identification of capital requirements. Annual business planning process to review the funding required to manage Estates / Digital related operational risks. Capital Plan / cost pressures listing ensures capital investment considers critical infrastructure risks. Approval of the plan signed off by the Trust Board. Project management / governance arrangements include project risk identification / escalation to ensure existing projects run to time / budget. Ongoing management of the agreed plan to be through Capital Management Monitoring Group (CMMG) and Strategic Capital Group (SCG) reporting to TLTC and Trust Board.						Chief Finance Officer			31/03/27		
Engagement at national level and application to other sources of funding e.g. TIF, CDC funding Engagement in ICS process to ensure the funding requirements and priorities of MFT are clear and set out the consequences of not meeting these requirements.						Chief Finance Officer			31/03/27		

Strategic Risk	DELIVERING FINANCIAL SUSTAINABILITY IN THE MEDIUM TERM					Description	If we are unable to achieve our value for patients target, generate sufficient income or manage cost pressures then we would be unable to deliver financial sustainability in the medium term resulting in insufficient cash to meet expenditure obligations and regulatory intervention.				
Risk Lead	Chief Finance Officer	Initial rating	20	Current rating	20	Target rating	10	Target date	31/3/27	Change since last BAF	No change
Risk quantum: Linked risks											
Reference	Title				Current risk rating				Clinical Group/ Corporate Service		
MFT/007992	Finance Risk 24/25							X	Specialist Hospitals Clinical Group		
MFT/000067	CSS Delivery of Financial Plan						X		CSS Clinical Group		
MFT/007553	Financial Control total							X	Corporate Services		
Risk Treatment											
Action					Lead				Due Date		
MFT will need to continue to work on delivery of its detailed financial recovery plans through Group Recovery Board by impacting directly on the issues highlighted of operational performance, workforce cost, system weaknesses and structural change in the Trust and in the wider GM system.					Chief Finance Officer				31/03/27		

Strategic Risk	INABILITY TO PROVIDE A FULLY COMPLIANT ESTATE RELATING TO ESTATES INFRASTRUCTURE AND SERVICES AND FULLY COMPLY WITH STATUTORY SAFETY LEGISLATION					Description	If we do not have sufficient funding and appropriately qualified and experienced workforce then we will not have a fully compliant and safe estate resulting in a deterioration in the condition of the estate, financial implications, impact on staff, patient and public health, safety and wellbeing and experience and an increase in regulatory involvement.				
Risk Lead	Chief Delivery Officer	Initial rating	20	Current rating	20	Target rating	5	Target date	31/3/30	Change since last BAF	No change since last Committee meeting
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Review and agree backlog maintenance program for 25/26 -including rolling program/schemes.						Director of Estates and Facilities			Complete		
Review findings of external Estates Review to be taken to the Digital and Estates Board Committee to review the outcome.						Director of Estates and Facilities			Complete		
Review dates of previous six facet/condition surveys and program in next round of surveys.						Director of Estates and Facilities			Complete		
Review/audit of helpdesk jobs closed to determine jobs are closed on system without solving.						Director of Estates and Facilities			30/09/25		
Link all E&F 'owned' infrastructure/building/statutory risks to this risk and map out risks as 'corporate or operational' and map to new MFT Clinical Groups.						Director of Estates and Facilities			30/09/25 (changed from 30/06/25 in last BAF)		
Establish a minimum safe staffing numbers per E&F service/function to ensure baseline of qualified and experienced trades persons is monitored and shortages highlighted.						Director of Estates and Facilities			31/10/25		
Review E&F strategy for careers engagement and events to widen opportunities for recruitment.						Director of Estates and Facilities			30/09/25		
E&F chair/attend Space Utilization Committee to ensure structured approach to space utilisation is followed to support infrastructure upgrades/lifecycles.						Director of Estates and Facilities			31/03/26		
Actively encourage more E&F colleagues to become mental health first aiders through E&F Team Briefings.						Director of Estates and Facilities			Complete		
All E&F teams/departments will have in place a stress team/department risk assessment.						Director of Estates and Facilities			30/09/25		
Training of the E&F H&S Team to support earlier and unsupervised review of CCTV footage to aid in incident investigations.						Director of Estates and Facilities			31/03/26		
Ensure Patient Experience is included in the ToR/agenda of Estates & Facilities Management Board relating to E&F Infrastructure / estates issues						Director of Estates and Facilities			Complete		

Strategic Risk	CYBER SECURITY RISK - TRUST IT					Description	If the security for the IT infrastructure including IT network, IT hardware and software is not robust or not kept up-to-date, then there may be vulnerabilities to allow a malicious or cyber-security attack resulting in loss of access to systems, or loss of data, or unauthorised access to data which will cause harm to individuals (patients and staff) and will impact on patient care, compliance / regulatory risk, financial and reputational damage.				
Risk Lead	Chief Delivery Officer	Initial rating	20	Current rating	20	Target rating	15	Target date	31/12/25	Change since last BAF	No change
Risk quantum: Linked risks											
No linked risks											
Risk Treatment											
Action						Lead			Due Date		
Programme of testing and improvement in place monitored and overseen by relevant Management and Board Committees.						Chief Digital and Information Officer			Ongoing		

ASSURANCE RATING			
Strategic Objective	Rating	Change since last BAF	Rationale
We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.		No change	There are currently VfP plan of £134.4m planned against a target of £165.8m, of which a significant proportion are still in development.
We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships. (ESTATES)		N/A	There are items relating to the NMGH redevelopment that have not yet been informed by the NHSE New Hospitals National Programme and are needed to ensure delivery of these aims by MFT. If national timescales to provide information/decisions changes MFT will not deliver against the proposed timescales.
We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships. (DIGITAL)		N/A	Several strategic partnerships in place including Microsoft, MD Clone.

Key

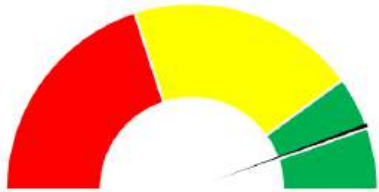
Assurance category (dial colour)	Rating range	Definition
Substantial (Green)	9-10	The scope of assurance noted on the current BAF demonstrate that we are meeting our trajectories for delivery of the strategic objective and any risks are well understood and managed.
Adequate (Yellow)	5-8	The scope of assurance noted on the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective but there is assurance that there is little risk in achieving them.
Limited (Red)	1-4	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from trajectories for delivery of the strategic objective and, where there are plans in place, there are significant risks to achieving them.
None	0	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

STRATEGIC AIM 5	DELIVER WORLD-CLASS RESEARCH AND INNOVATION THAT IMPROVES PEOPLE’S LIVES	GM mission	n/a	Date of update	July 2025	Integrated Performance Report reference	See page 176 of the IPR

Linked Strategic Objectives	We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.	We will apply research and innovation, including digital technology and artificial intelligence, to improve people’s health and the services we provide.
Lead Executive Directors	Joint Chief Medical Officer	Joint Chief Medical Officer
Board Committees	Research, Innovation and Population Health Board Committee	Research, Innovation and Population Health Board Committee
Management Committee(s)	Research and Innovation Management Committee	Research and Innovation Management Committee

PRIORITY ACTIONS 2025/26				
Strategic objective	2025/26 priority actions	Evidence of delivery	Action being taken	Completion date
We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.	Grow the volume and value of our research and innovation activity.	Launch in April of NIHR Greater Manchester Commercial Research Delivery Centre hosted at MFT. Development of new Manchester Child Health Research Institute at RMCH. Plan for bid to NIHR Capital Call 2025 for physical research resources 14 May 2025.	External review of research project set up processes to be conducted on site first week May 2025 with report and recommendations by end of month for immediate implementation.	30 August 2025
	Improve the strategic alignment between MFT and our university partners	Agreement with the University of Manchester and NHS Trust partners to reform the Manchester Academic Health Science Centre and continue past the end of its formal designation by NHS England on 31 March 2025.	Reach agreement with wider system partners for continuation of reformed Academic Health Science Centre for initial three years, with new model operational from 1 July 2025.	1/10/25 (changed from 1/07/25 in last BAF)
We will apply research and innovation, including digital technology and artificial intelligence, to improve people’s health and the services we provide.		Formal launch in May 2025 of new R&I/Digital initiative, the Innovative Technology Adoption Programme (iTap), aiming to rapidly review and support the adoption of new technologies which will increase efficiency of work across MFT.	iTap is an ongoing programme of work.	Complete, programme launched.

STRATEGIC RISKS											
Strategic Risk:	LOSS OF NIHR AWARD AND FUNDING FOR APPLIED RESEARCH COLLABORATION FOR GREATER MANCHESTER (MFT/008400)					Description	If the NIHR ARC bid submitted by MFT on behalf of GM is of insufficient quality or does not meet NIHR requirements, then the bid for the NIHR ARC will be unsuccessful resulting in reputation harm with partners and a less comprehensive suite of research services for the patients in Greater Manchester and beyond.				
Risk Lead	Joint Chief Medical Officer	Initial rating	8	Current rating	8	Target rating	8	Target date	30/09/25	Change since last BAF	No change
Risk quantum: Linked risks											
Linked risks											
Risk Treatment											
Action						Lead			Due Date		
Engagement with system partners to communicate the high performance of the NIHR Applied Research Collaboration in Greater Manchester over the course of this funding cycle and the high quality of the bid submitted for the new funding round.						Chief Finance Officer			05/09/25		

ASSURANCE RATING			
Strategic Objective	Rating	Change since last BAF	Rationale
We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.		No change	Substantial and numerous different workstreams underway to achieve this.
We will apply research and innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide.		No change	Substantial workstreams underway to achieve this.

Key

Assurance category (dial colour)	Rating range	Definition
Substantial (Green)	9-10	The scope of assurance noted on the current BAF demonstrate that we are meeting our trajectories for delivery of the strategic objective and any risks are well understood and managed.
Adequate (Yellow)	5-8	The scope of assurance noted on the current BAF indicates that there is some deviation from trajectories for delivery of the strategic objective but there is assurance that there is little risk in achieving them.
Limited (Red)	1-4	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from trajectories for delivery of the strategic objective and, where there are plans in place, there are significant risks to achieving them.
None	0	The scope of the assurance noted on the current BAF demonstrates that there is material deviation from the planned trajectory for delivery of the strategic objective and no plans in place to recover the position.

Public Board of Directors

Wednesday 30th July 2025

Paper title:	Integrated Performance Report (IPR)	Agenda Item 9.2
Presented by:	Chief Delivery Officer Chief Nursing Officer Joint Chief Medical Officers Chief Finance Officer Chief People Officer Chief Digital & Information 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) Managing Director, R&I	
Meetings where content has been discussed previously	Board Committees	
Purpose of the paper Please check <u>one</u> 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).

As reported at the last meeting, metrics for the following domains have been agreed and have been in this IPR:

- Research and Innovation

Metrics for the Population Health domain have now been agreed and will be included in subsequent IPRs

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

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**

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

MFT Integrated Performance Report

All domains
July 2025 – reporting April and May data



Structure of this document

3	Introduction to SPC measurement and icons used
4	Performance against Trust SOF3 exit criteria
5	Provide high quality, safe care with excellent outcomes and experience – quality and safety
92	Provide high quality, safe care with excellent outcomes and experience – operational performance
127	Be the place where people enjoy working, learning and building a career
161	Ensure value for our patients and communities by making the best use of our resources
171	Deliver world-class research & innovation that improves peoples lives

Measuring our performance

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.

SOF3 exit criteria

Current performance against relevant areas of the Single Oversight Framework (SOF) segment 3 exit criteria – to be replaced with the new National Oversight Framework (NOF) from July 2025 reporting

Domain	SOF exit criteria	Domain ownership	Update
Elective recovery	Meeting 65-week trajectory – 2 quarters	Performance	April performance was a reduction to 32 patients waiting over 65 weeks (9 of which were not corneal grafts), versus the plan of 0 excluding corneal grafts.
	78 weeks – 0 other than explicitly agreed exceptions – corneal grafts and gender reassignment	Performance	April performance was 0 x 78ww
Cancer	• The 28-day Faster Diagnosis Standard • 62-day referral to treatment standard • 31-day decision to treat to treatment standard	Performance	Latest performance: March 28 days FDS – 76% (actual) vs 77% (plan) 31-day standard - 88.5% (actual) vs 85% (plan) 62-day standard - 63.3% (actual) vs 70% (plan)
Maternity (specialist hospitals only)	• To demonstrate delivery for two consecutive quarters of the following indicators which relate to the three areas identified in the section 29a CQC warning notice • Delays • Staffing	Quality	In April 2025, Maternity services demonstrated delivery of the required indicators for 2 consecutive quarters, meeting SOF3 exit criteria.

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



Trust IPR Executive Summary – June 2025

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Incident Reporting & Safety Culture					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)
					Number of never events in month
					Duty of Candour Compliance
Harm Free Care					Surgical safety checklist compliance
					Attributable pressure ulcers (grade 3-4)
					Falls per 1000 bed days (level 4 & 5 harm)
					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 – <i>E. Coli</i>
					Gram negative infection – <i>Klebsiella</i>
					Gram negative infection – <i>Pseudomonas</i>
					Maternal deaths

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Maternity					Incidents accepted by MNSI for investigation
					Patient Safety incidents (maternity moderate harm and above, standard <4)
					% of term admissions to neonatal unit (standard < 6%)
					Category 3 caesarean deliveries cancelled on the day (standard <10)
					% Initial Midwifery Triage assessment within 15 mins (standard 90%)
					% Initial Midwifery Triage assessment within 30 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%)
		Non-SPC			% Transferred on induction of labour pathway <24 hours (standard 60%)
					% Delays >24 hours for transfer for augmentation (standard 20%)
					Births outside of intrapartum birth setting
		Non-SPC			% Maternity specific training compliance (aggregated, standard >90%)
		Non-SPC			Achieving Maternity Incentive Scheme Actions (standard 10)
					Number of babies with suspected HIE Grade 2/3
					MNSI/NHSR/CQC/Coroner Reg 28

* Further safety metrics in development

Trust IPR Executive summary – June 2025

Quality & Safety

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Safeguarding					Number of patients with DoLs
					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
					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
					Number of patients detained under section 136 > 12 hours
LD Strategy					% of people with LD / autism who have evidence of reasonable adjustment within 48 hours of admission

* Further safety metrics in development

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Patient Experience					Single sex compliance breaches
					What Matters to Me (overall score)
					Friends & Family Test – Inpatient/Day Case
					Friends & Family Test – Emergency Department
					Friends & Family Test - Outpatient
					Friends & Family Test – Community Services
					Friends & Family Test – TP1 - Antenatal Care
					Friends & Family Test – TP2 - Birth
					Friends & Family Test – TP3 – Care on Postnatal Ward
					Friends & Family Test – TP4 – Postnatal Community Provision
					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)
					% Complaints resolved in agreed timescale
					Patient Advice & Liaison Service Concerns
					Care hours per patient day
					Ratio of actual : planned hours (excluding maternity)
		Non-SPC			% of maternity triage shifts where actual midwifery staffing = planned (>95%)
Safer staffing					

Trust IPR Executive Summary – June 2025

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Sepsis 7					Medical Review On Time
					Oxygen Administered
					Blood Cultures Taken
					Antibiotics Administered
					Lactate Taken
					IV Fluid Bolus Administered
					Urine Output Measured
Pharmacy					% of Critical Medication Administrations Omitted
					% of Critical Med Omissions due to Medicines Unavailable
					% of Antimicrobial Omissions
					Controlled Drugs Audit Compliance
					Safe & Secure Handling of Medicines Audit Compliance
					% of Patients on O2 who had an O2 prescription
					24-hour Admissions Medicines Reconciliation
					48-hour Admissions Medicines Reconciliation

* Further safety metrics in development

Focus	Compliance	Variation	Assurance	Action Status	Indicator
Learning from Deaths					Number of deaths with identified learning disability
		Non-SPC			Number of LEDER referrals
					Hospital standardized mortality ratio (HSMR) (rolling 12 month)
					Crude mortality rate (12 mth rolling)
					Standardised healthcare crude mortality indicator (SHMI)
					Prevention of Future Deaths

Executive Summary

Assurance



Achieving standard



Inconsistently Achieving standard



Not Achieving standard



Special Cause Improvement



Common Cause



Special Cause Concern

Maternity triage < 30 mins Safeguarding Children L1 & 2 Safeguarding Adults L1 & 2 Mental Health L1 Complaints resolved within timescales Maternity staffing		Sepsis 7 - Urine output monitored Maternity triage < 15 mins Safeguarding Children L3 Safeguarding Adults L3 MHA – provision of information to patients Mental Health L2 Patients with LD with reasonable adjustments WMTM (overall)	Consistent assurance can be provided in: - Improvements in maternity triage, safeguarding children and adults training at level 1 and 2, maternity staffing and resolution of complaints within agreed timescales - Assurance relating to 11 out of 14 maternity metrics measured in the IPR
Sepsis 7 – Oxygen administered MRSA Still births per 1000 live births Incidents of moderate + maternal harm Term admissions to neonatal unit Induction pathway delays Augmentation of labour pathway delays Births outside intrapartum setting Babies with HIE grade 2 or 3 FFT – Inpatients, community, outpatients Care Hours Per patient day Ratio of planned : actual staffing	Duty of Candour compliance Prevention of Future Deaths reports	Pressure ulcers c diff rates Category 3 caesareans Sepsis 7 – Medication review on time, Blood cultures taken, Antibiotics administered, lactate taken, IV fluid bolus administered Controlled drug audit compliance Safe & Secure medicines audit compliance % patients on O2 with prescription 24 hour medicines reconciliation 48 hour medicines reconciliation Authorized Deprivation of Liberty Standards Patients under S136 detained > 24 hrs Mixed sex breeches FFT - ED	Improvement has been made in the following areas: - Safeguarding children and adults L3 training, mental health level 2 training and mental health and LD metrics including provision of information to patients detained under a S136 and reasonable adjustments being made for patients with learning disabilities.
		Never events VTE screening compliance Patients detained under MHA missing from care	Particular risk is evident in the achievement of: - Never events – there are three recorded in this period - VTE screening, VTE workplan has been implemented performance has increased from 74% to 82%. - Sepsis 7 and medicines safety metrics

Number of incidents per 1,000 bed days – comparison of incidents with harm v no/low harm

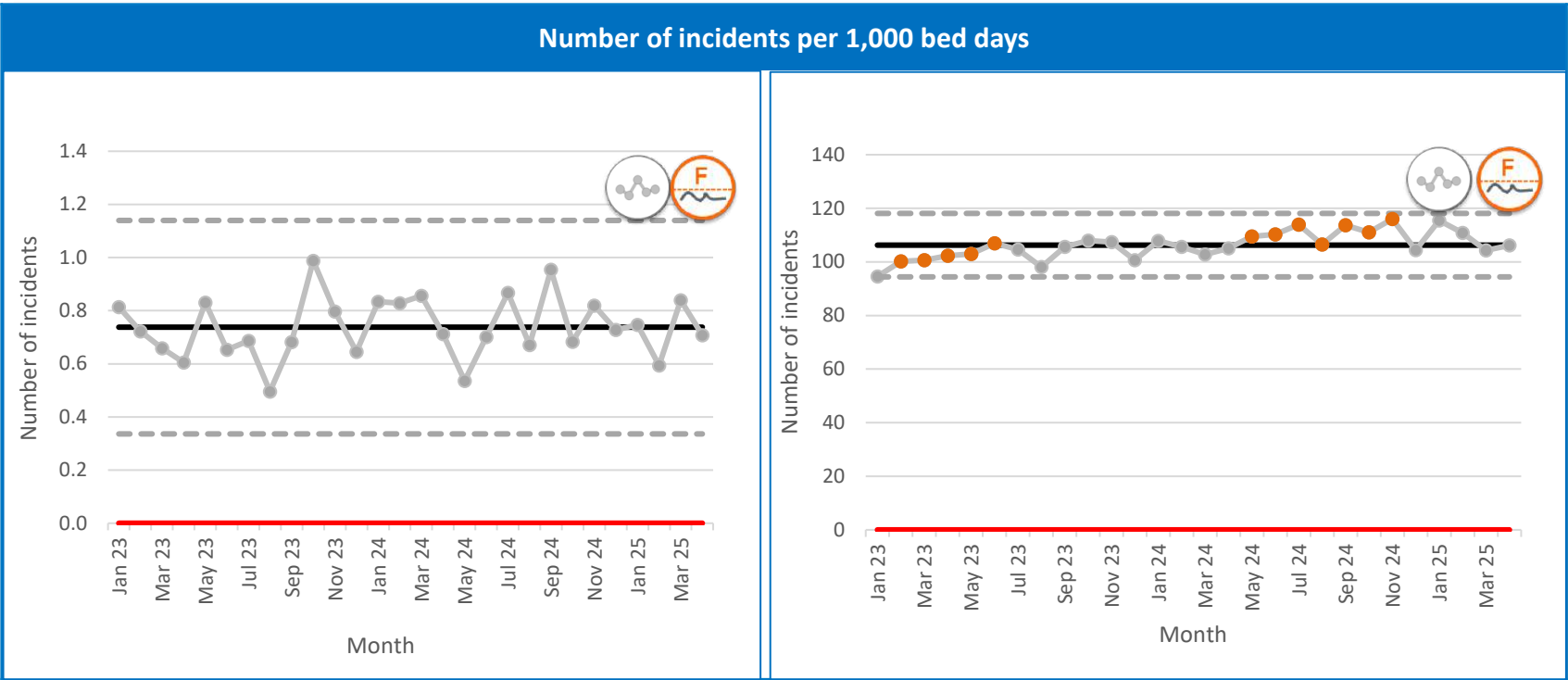
Advise

Not SOF3 metric

Apr-25	Target

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
WTWA	2032 18
Specialist	1893 5
MRI	1681 16
NMGH	947 6
LCO & Dental	845 3
CSS	636 5



Updates since previous month

Trends of no/low harm remaining static

Current issues

No issues identified

Key dependencies

Surveillance data analysis identifies priority safety concerns (e.g. medicine safety) for targeted improvement workstreams

Reporting culture initiatives support embedding a strong patient safety culture

Future actions

Development to the risk management system (Ulysses) which will streamline incident reporting and strengthen the reporting culture. Oversight provided by the Patient Safety Group

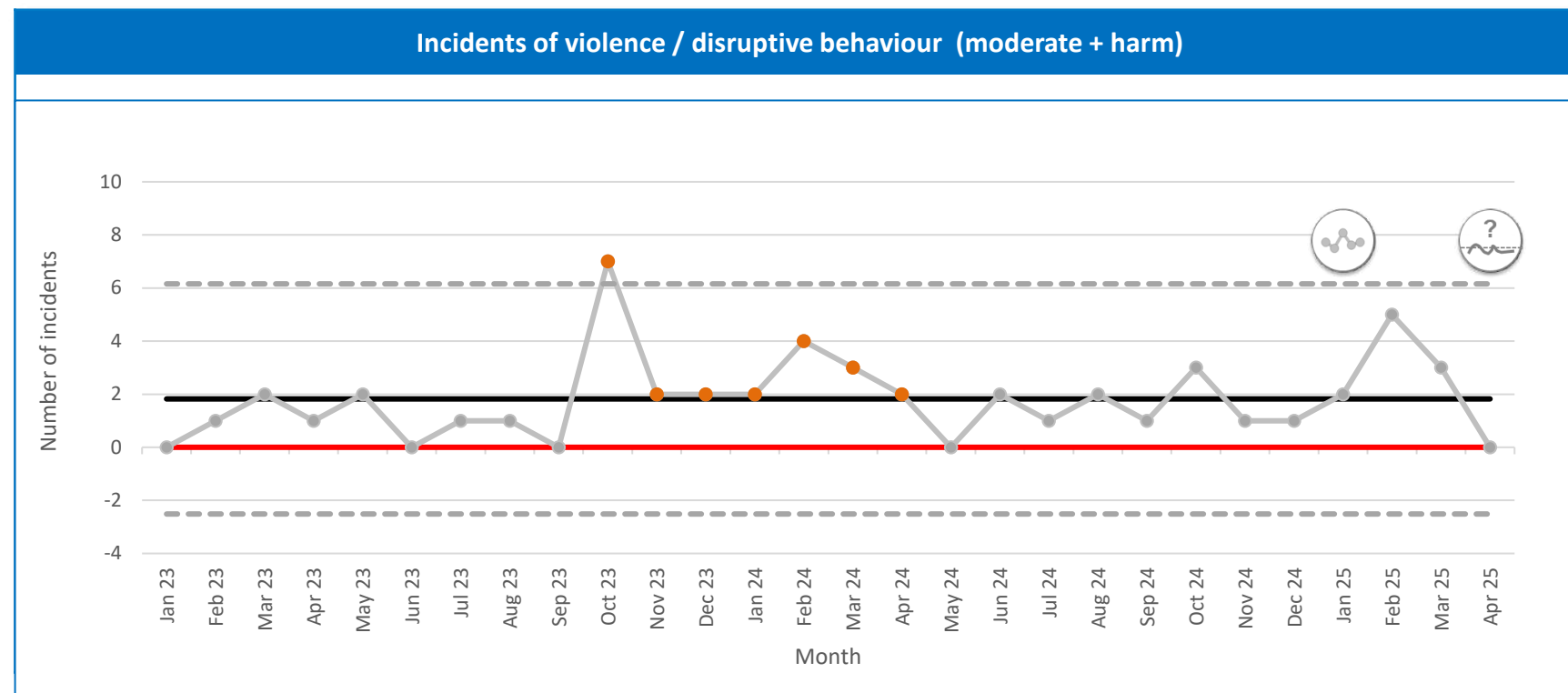
Incidents of violence / disruptive behaviour (moderate + harm)

Advise Not SOF3 metric

Apr-25	Target
0	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
MRI	0
WTWA	0
NMGH	0
Specialist	0
LCO & Dental	0
CSS	0



Updates since previous month

No moderate or above harm incidents of violence / disruptive behaviour reported in April 25
There has been an increase in reports of low / no level harm incidents (not included in this graph)

Key dependencies

Active surveillance completed on violence / disruptive incident categories to support identified areas of interest and continue for identification of themes

Current issues

Ongoing monitoring to assess if the trend toward low/no-harm reporting continues

Future actions

Violence Prevention and Sexual Safety Meeting overseeing more detailed performance dashboard, improvement plans and actions
Clinical Groups focus on positive behavior training for clinical colleagues

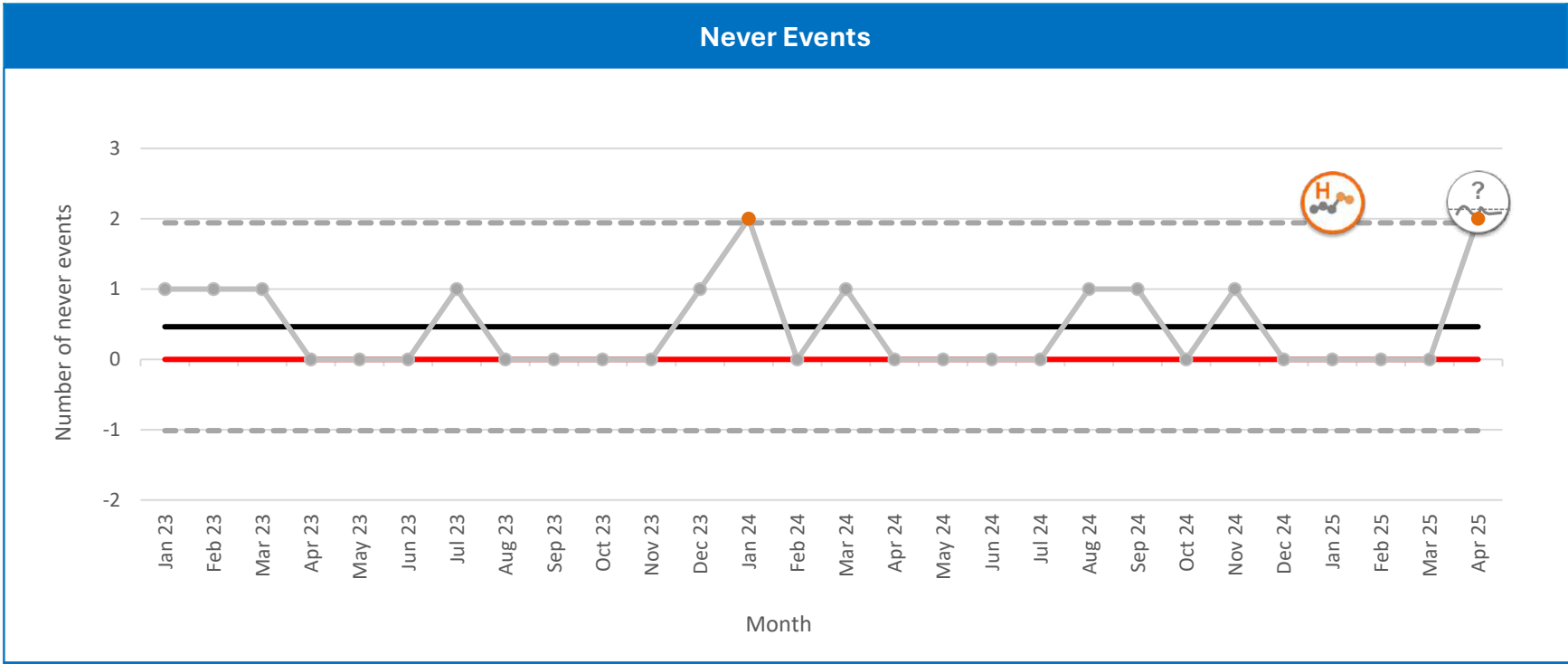
Never Events

Alert	Not SOF3 metric

Apr-25	Target
2	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview (12 months)		
Specialist		2
MRI		2
NMGH		1
CSS		1
LCO & Dental		
WTWA		



Updates since previous month
2 Never Events reported in April 2025

Key dependencies
Ongoing work on surgical safety (NatSSIPs and LoCSSIPs) through LOCSIP Steering Group. Cultural work around Patient Safety Cultures overseen by the Patient Safety Group

Current issues
The 2 Never Events report in April 25- involved a surgical wrong Implant/prosthesis in a total knee replacement knee and a retained foreign object post procedure due to a retained central line guidewire

Future actions
Initial review by the Clinical Groups of safety checks identified no immediate safety concerns Incident Investigations initiated into the Never Events Progress monitored via the Patient Safety Assurance and Oversight Group

Duty of candour compliance

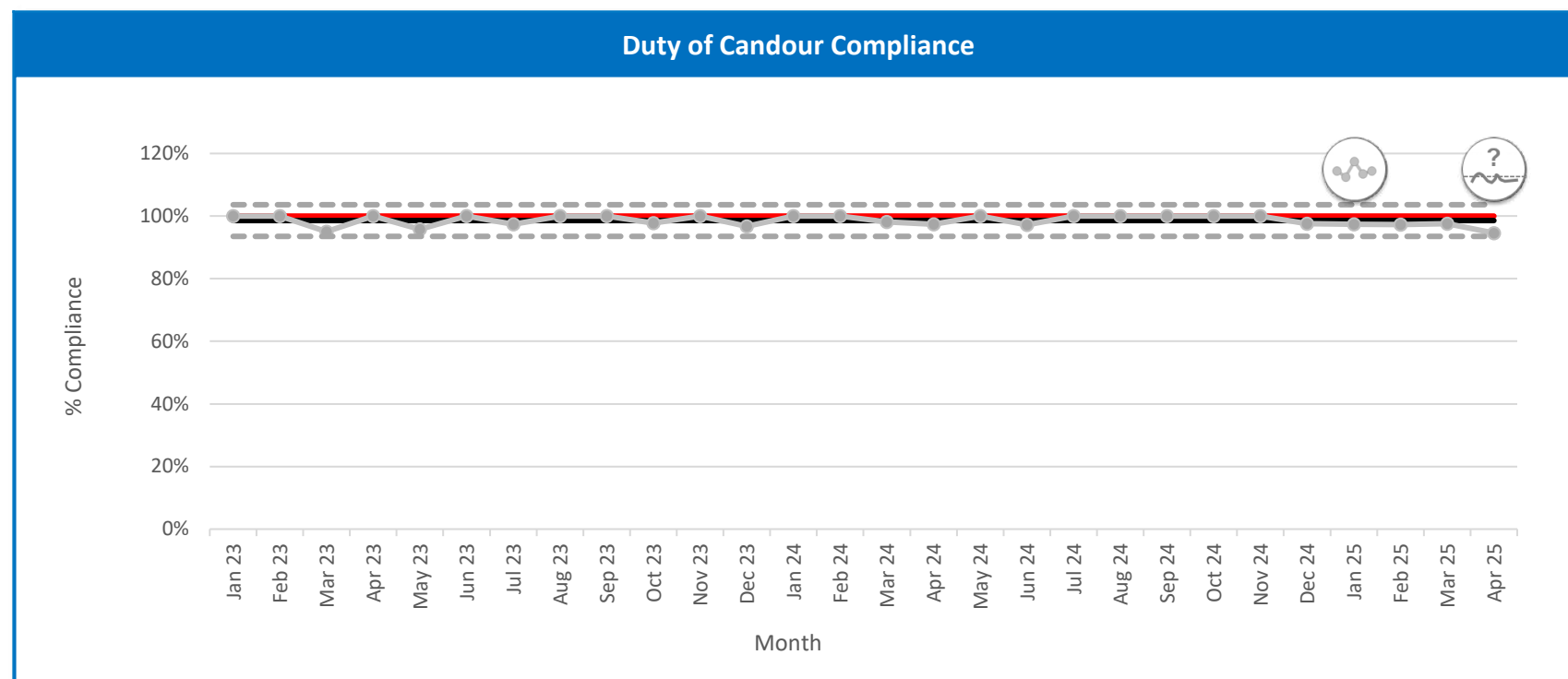
Alert Not SOF3 metric

Apr-25	Target
94.59%	100%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

WTWA		100.0%
MRI		100.0%
Specialist		100.0%
NMGH		100.0%
LCO & Dental		100.0%
CSS		50.0%



Updates since previous month

April 25 compliance for DoC Stage 1 is at 94.59%; Monitoring of ongoing DoC at Patient Safety Oversight and Assurance Group and local Clinical Group governance processes

Key dependencies

Presentation of DoC data under review as SPC not considered the most appropriate format. Also looking at move to reporting statutory as well as professional DoC

Current issues

No new cases no complete –a rolling 12 month figure so includes historic incomplete cases. Robust local oversight in place

Future actions

DoC standard to be reviewed – currently set at 10 days. The updated policy, aligned with national guidance will revise the 10 day standards to reflect individual patient/family circumstances. Ratification expected by the end of August

Surgical safety checklist compliance

Advise

Not SOF3 metric

Apr-25

Target

N/A

Compliance

Variance

Assurance

Actions



Clinical Group Overview

This indicator is measured at Trust level.

Surgical safety checklist compliance

	Fully Complete	Complete Unsigned	Fully Missing
Safety Check 1	86.63%	0.39%	12.98%
Safety Check 2	85.87%	0.29%	13.84%

	Missing	N/A or Complete
In AN Room Missing	29.52%	70.48%
Who Verified Counts Missing	12.76%	87.24%

	Fully Complete	Complete Unsigned	Fully Missing
Sign-In Compliance	95.59%	0.65%	3.76%
Sign-Out Compliance	95.47%	0.73%	3.80%

Updates since previous month

HIVE provides a point-in-time metric, limiting longitudinal comparison

Key dependencies

Surgical safety workshop took place in June—workstreams to support more meaningful monitoring mechanisms identified

Current issues

Data would indicate non-compliance in a number of areas Whilst no specific incidents raised, this data will be considered as part of review of recent Never Events

Future actions

Audits, surveillance, and safety culture initiatives continue
A dedicated workstream—focused on strengthening communication, enabling challenge, and fostering a positive safety culture in theatres—agreed at Patient Safety Oversight group June 25

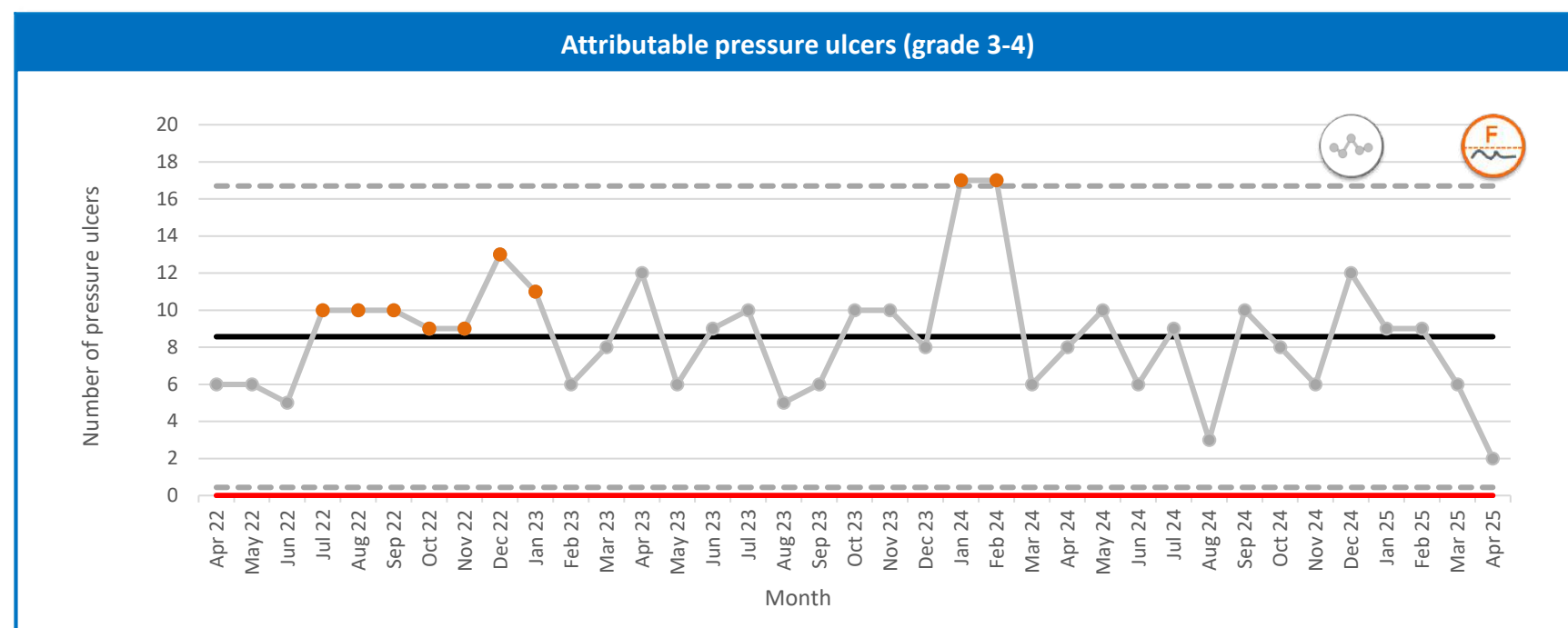
Attributable pressure ulcers (grade 3-4)

Advise Not SOF3 metric

Apr-25	Target
2	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
LCO & Dental	1
WTWA	1
CSS	
MRI	
NMGH	
Specialist	



Updates since previous month

Improving rates within MLCO

Current issues

Quality improvement work undertaken in Trafford and Northern locality has seen an improvement in the numbers of reportable PU3/4
Patient was palliative care and had contractures leading to PU3/4, care was appropriate

Key dependencies

National Wound Care Strategy recommendations

Future actions

Continued implementation of Quality Improvement work

Falls per 1,000 bed days (level 4 & 5 harm)

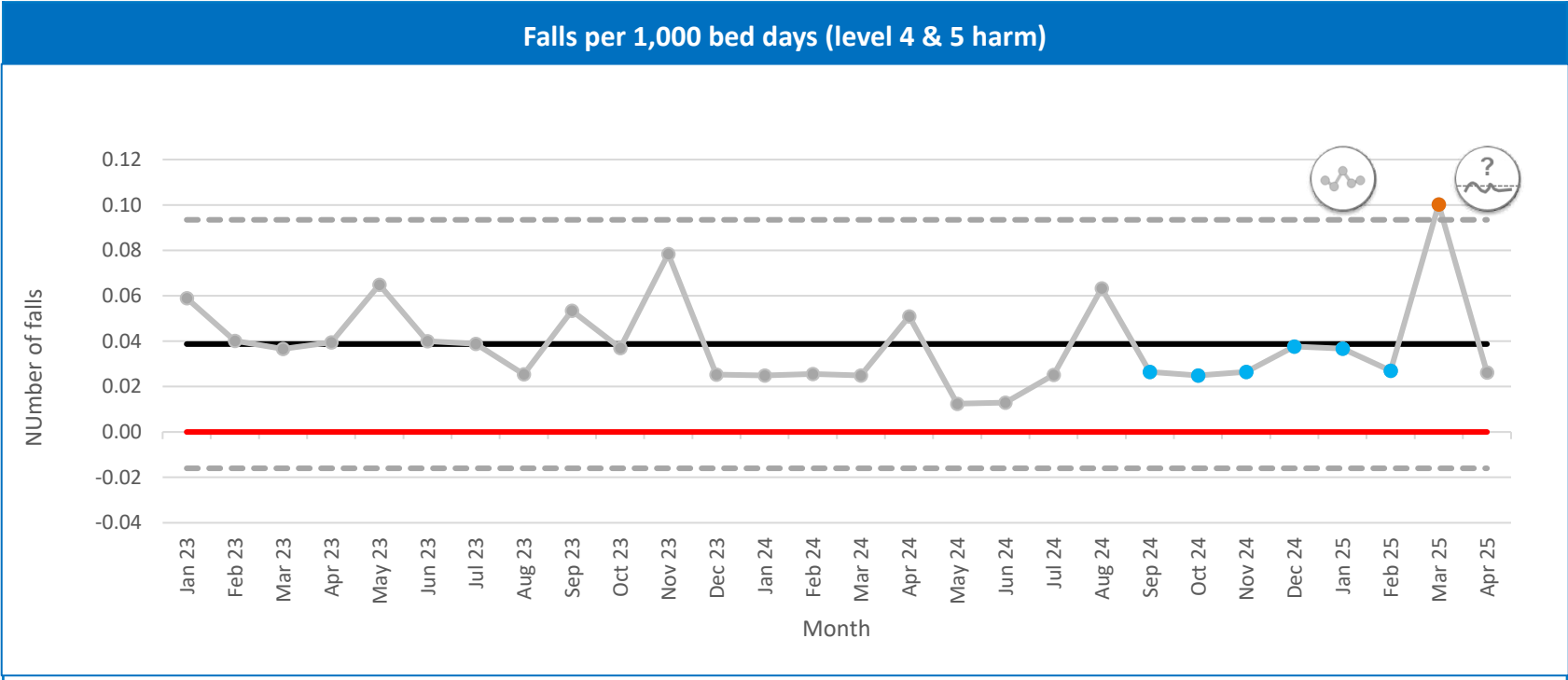
Alert

Not SOF3 metric

Apr-25	Target
2	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview		
WTWA		1
NMGH		1
MRI		
Corporate		
Specialist		
LCO & Dental		



Updates since previous month

The 4 and 5 harm falls for April 25 are in the expected variance level, following a rise in such incidents in March 2025

Key dependencies

Appropriate completion of falls risk assessments, recognition of lying and standing blood pressures and capacity assessments are key areas of focus for improvement work

Page 19

Current issues

All moderate harm fall incidents have been reviewed under the PSIRF process.
Themes- Delirium assessments, Lying and Standing Blood Pressure measurements, Pain assessments and Polypharmacy

Future actions

Thematic reviews -Clinical Group's (WTWA, NMGH, LCO) with improvement plans in place. Peer to peer site visits commenced. Workshop planned to approve post falls review in line with PSIRF principles-July

VTE screening compliance

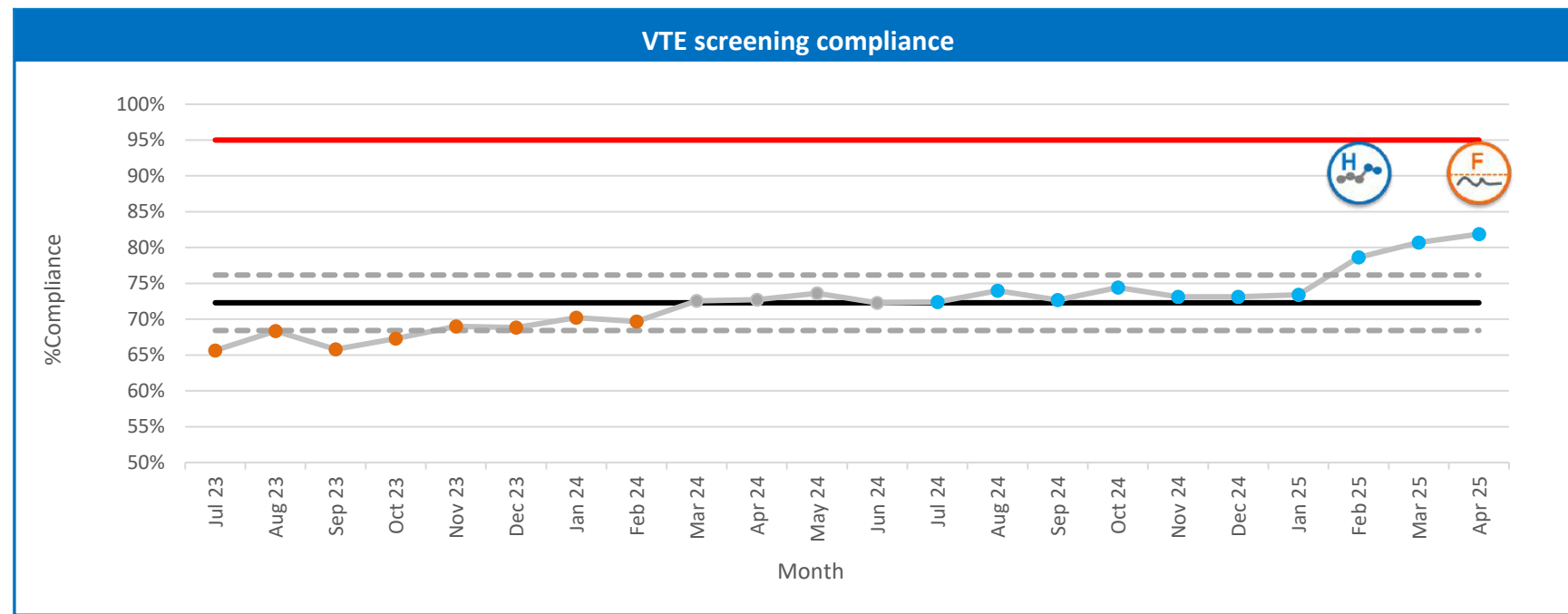
Alert Not SOF3 metric

Apr-25	Target
81.87%	95%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

MREH	96.18%
SMH	94.87%
TGH	91.54%
NMGH	90.02%
WYTH	81.67%
MRI	80.48%
RMCH	33.33%



Updates since previous month

VTE workplan has been implemented
performance has increased from 74% to 82%

Key dependencies

HIVE and Digital Teams capacity to support
development of live surveillance functionality

Current issues

VTE Dashboards - under development (3-6 month completion date)
No link between VTE assessment and prescription
Marked underreporting of number of HAT (Hospital Acquired Thrombosis)

Future actions

New formal links with St George's Hospital who are an exemplar site for VTE
VTE Buddy with St George's HIVE and Digital Teams
VTE workshop on 26th June

Incidents relating to delays on waiting lists (moderate + harm)

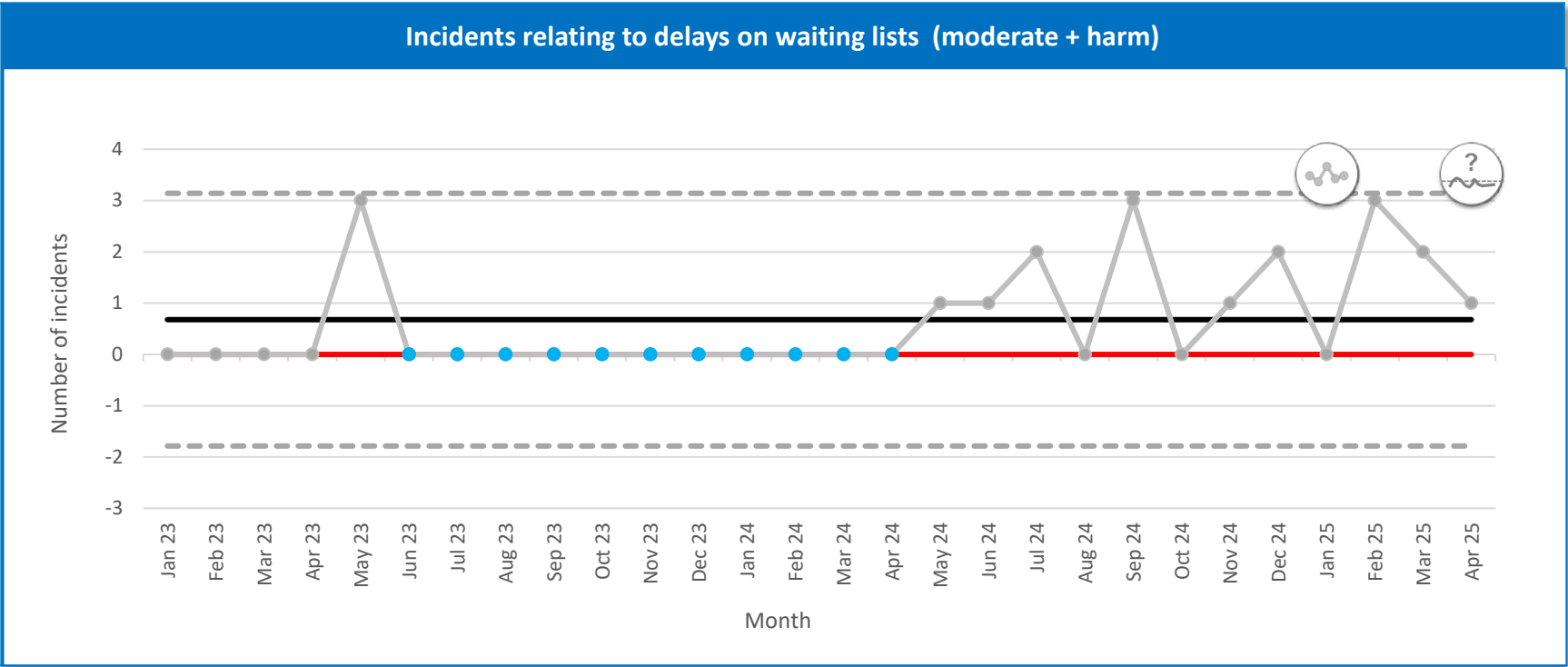
Advise

Not SOF3 metric

Apr-25	Target
1	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
WTWA	1
MRI	
Specialist	
NMGH	
LCO & Dental	
CSS	



Updates since previous month

1 incident identified with moderate or above harm reported in April 2025

Key dependencies

Productivity and efficiency work driving reductions in waiting lists

Current issues

Overall linked to delays in reporting and diagnostic pathways, especially with in lung cancer/cardiac specialties

Future actions

Waiting Safely Framework approved on 08/05/25. Next steps:

- undertake a self-assessment of readiness to implement
- Identify/ implement tools to support risk stratification

Incidents relating to delays in follow ups (moderate + harm)

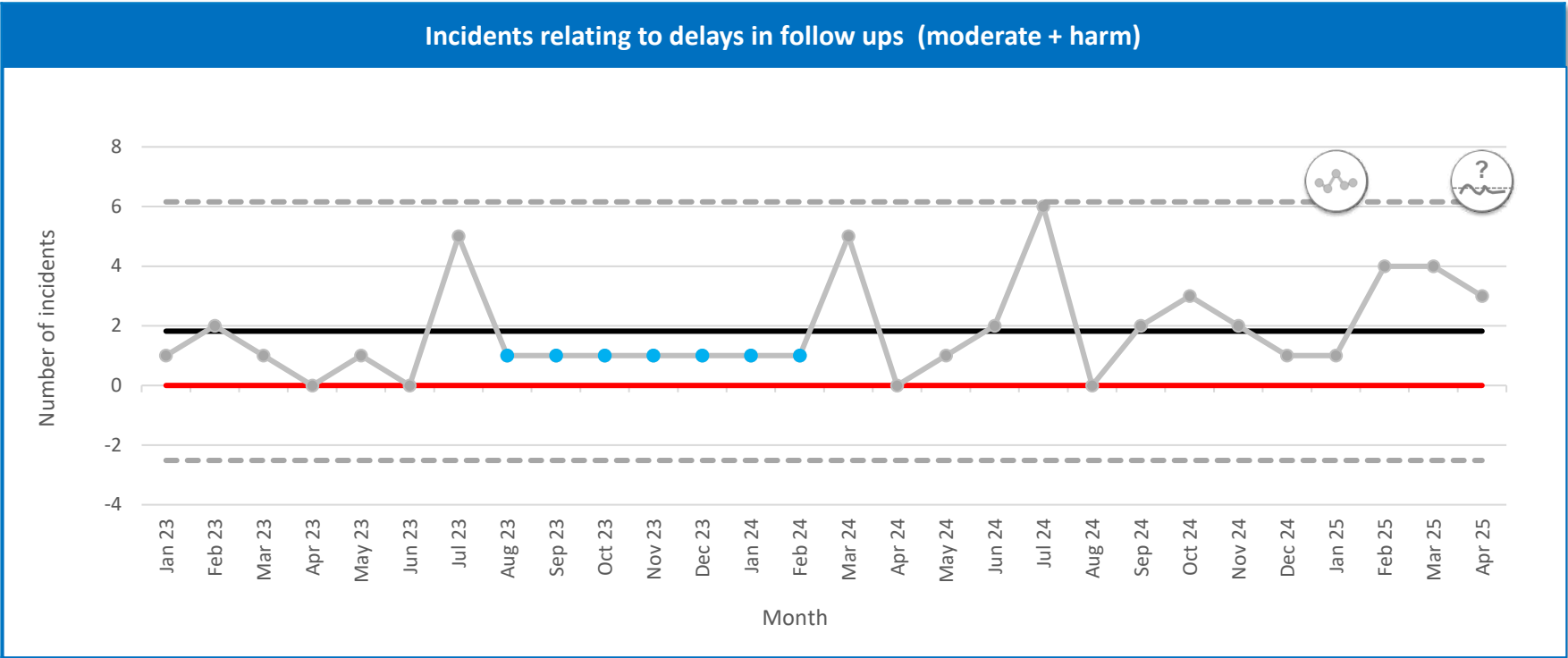
Advise

Not SOF3 metric

Apr-25	Target
3	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview		
MRI		1
Specialist		1
WTWA		1
LCO & Dental		
NMGH		
CSS		
Corporate		



Updates since previous month

3 incidents identified in April. No trends identified with incidents occurred in different specialties / pathways

Key dependencies

Productivity and efficiency work driving reductions in waiting lists (including follow up activity)

Current issues

No issues identified from March 2025 data

Future actions

Waiting Safely Framework approved May 2025.
Next steps:

- undertake a self-assessment of readiness to implement
- Identify/ implement tools to support risk stratification

MRSA bacteraemia

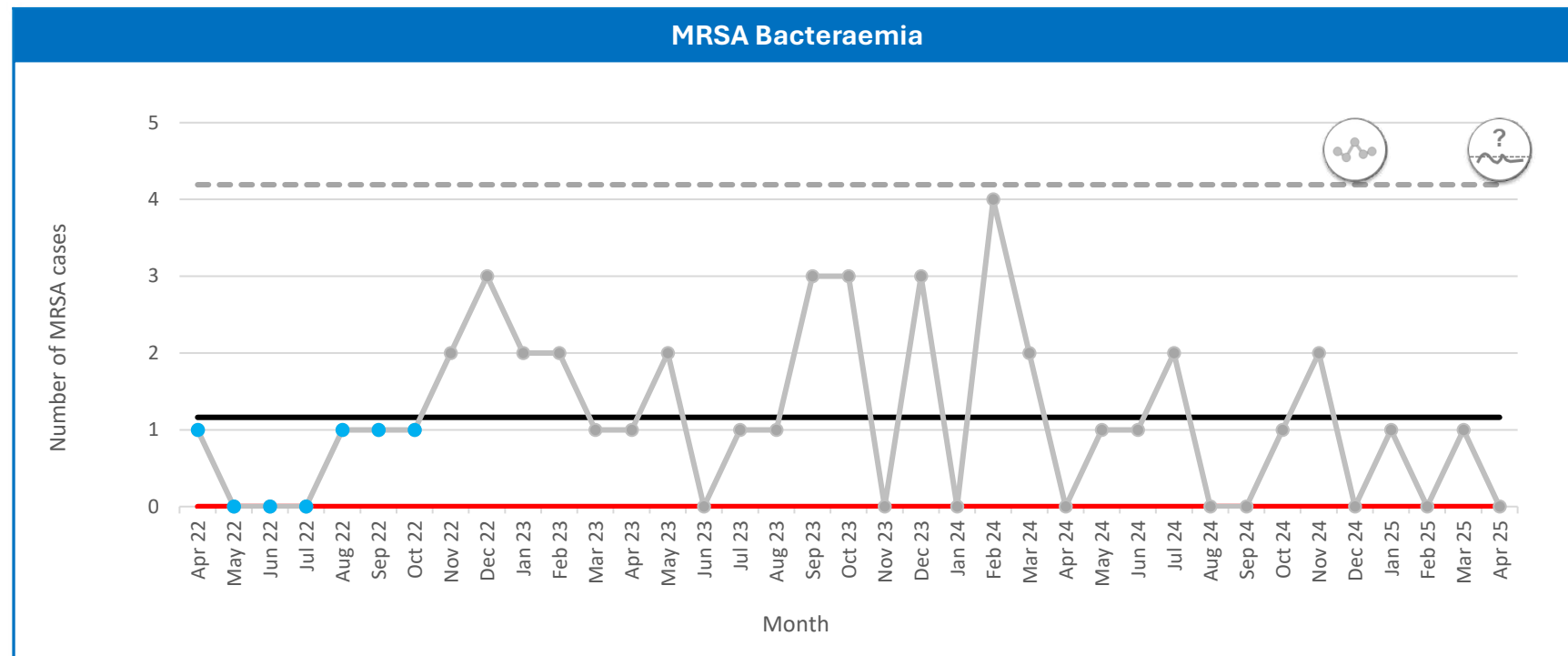
Advise	SOF3 metric

Apr-25	Target
0	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist	0
MRI	0
WTWA	0
CSS	0
NMGH	0
LCO & Dental	0



Updates since previous month

No MRSA bacteraemia occurred in April

Key dependencies

Compliance with Vascular Access Device policy
Compliance with screening
Zero tolerance approach to MRSA bacteremia- UKHSA

Current issues

Peripheral vascular access
Administration of decolonisation therapy provision

Future actions

Continue screening in line with policy
Clinical Group oversight of compliance
ANTT practical assessments 69.93% compliance
ANTT Theoretical assessment 85.58% compliance

Clostridioides difficile infection

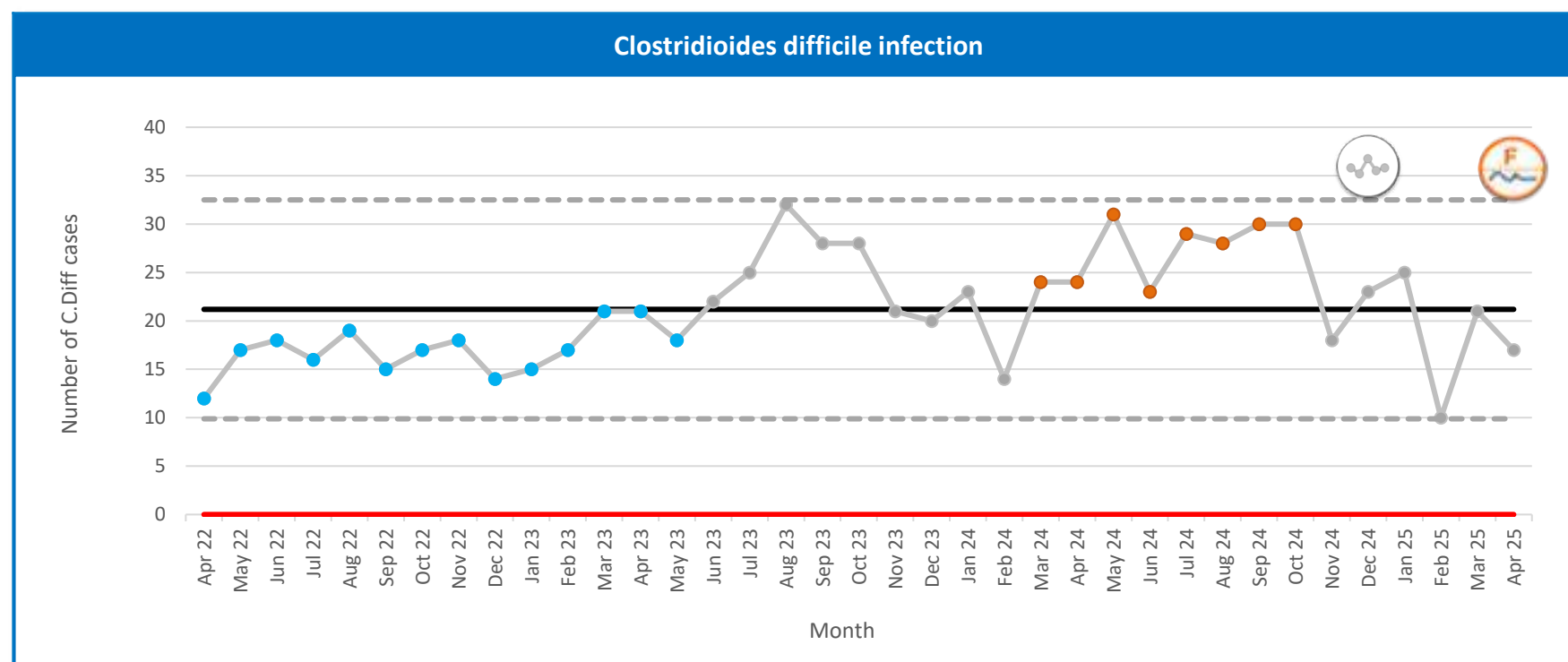
Advise	SOF3 metric

Apr-25	Target
17	0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

WTWA	9
CSS	3
NMGH	2
MRI	2
Specialist	1
LCO & Dental	0



Updates since previous month

Reduction in cases in April

Key dependencies

Compliance with Antimicrobial Stewardship guidance
Compliance with CDI policy sampling recommendation

Current issues

Compliance with antimicrobial stewardship
Sampling delays
Compliance with Bristol Stool Chart documentation
Lack of isolation facilities

Future actions

Management of antimicrobial stewardship, development of AM dashboard within Hive
Guideline review to reduce prophylactic use of broad-spectrum antibiotics
Annual audit in Q3 of compliance with National Standards of Cleanliness

Gram negative infection – E. Coli

Advise

Not SOF3 metric

Apr-25

Target

25

0

Compliance

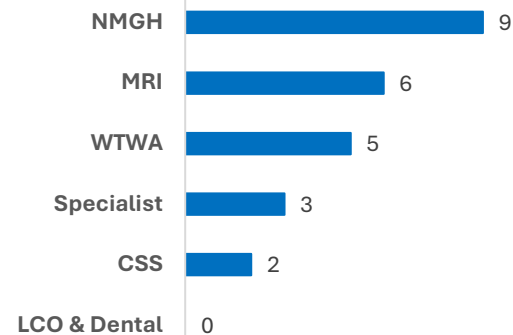
Variance

Assurance

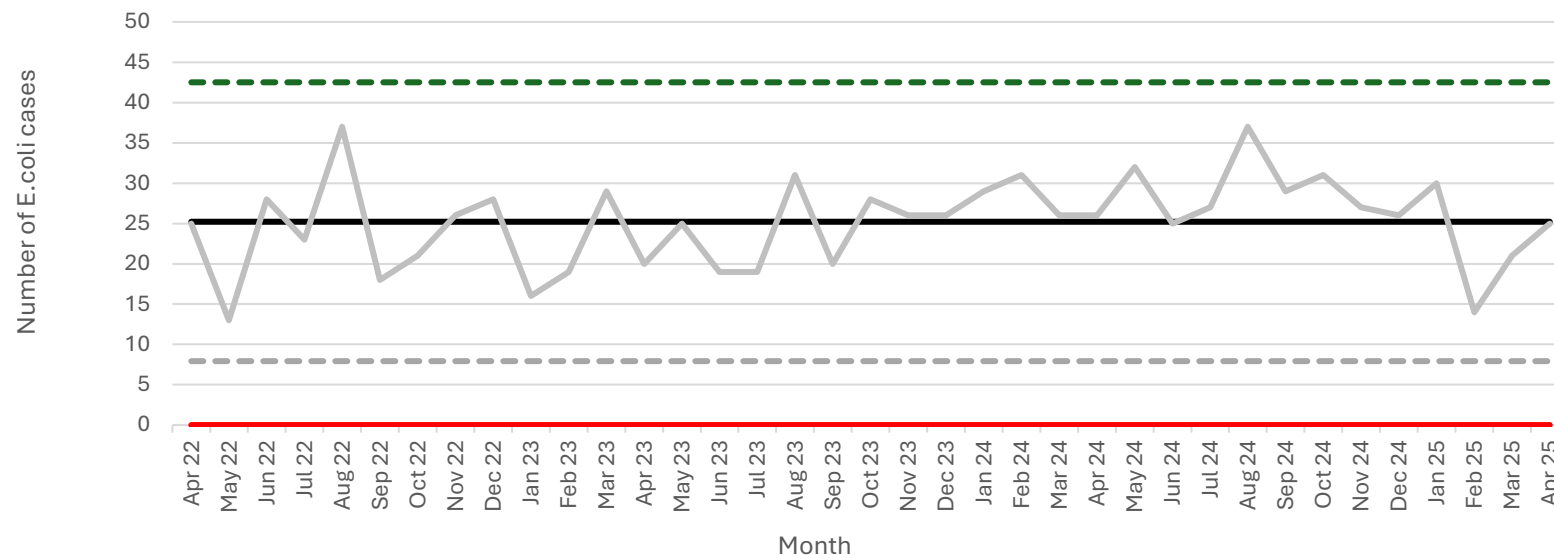
Actions



Clinical Group Overview



Gram negative infection – E. Coli



Updates since previous month

Rise continuing since February – "Deep dive" into contributing factors-June

Current issues

Compliance with urinary catheter care and vascular access devices

Key dependencies

Adherence to Urinary Catheter Care policy
Good management of intravascular devices

Future actions

Clinical Group action plans relating to urinary catheter care and vascular access devices to guide targeted interventions and support improvements in practice

Gram negative infection – Klebsiella

Advise

Not SOF3 metric

Apr-25

Target

13

0

Compliance

Variance

Assurance

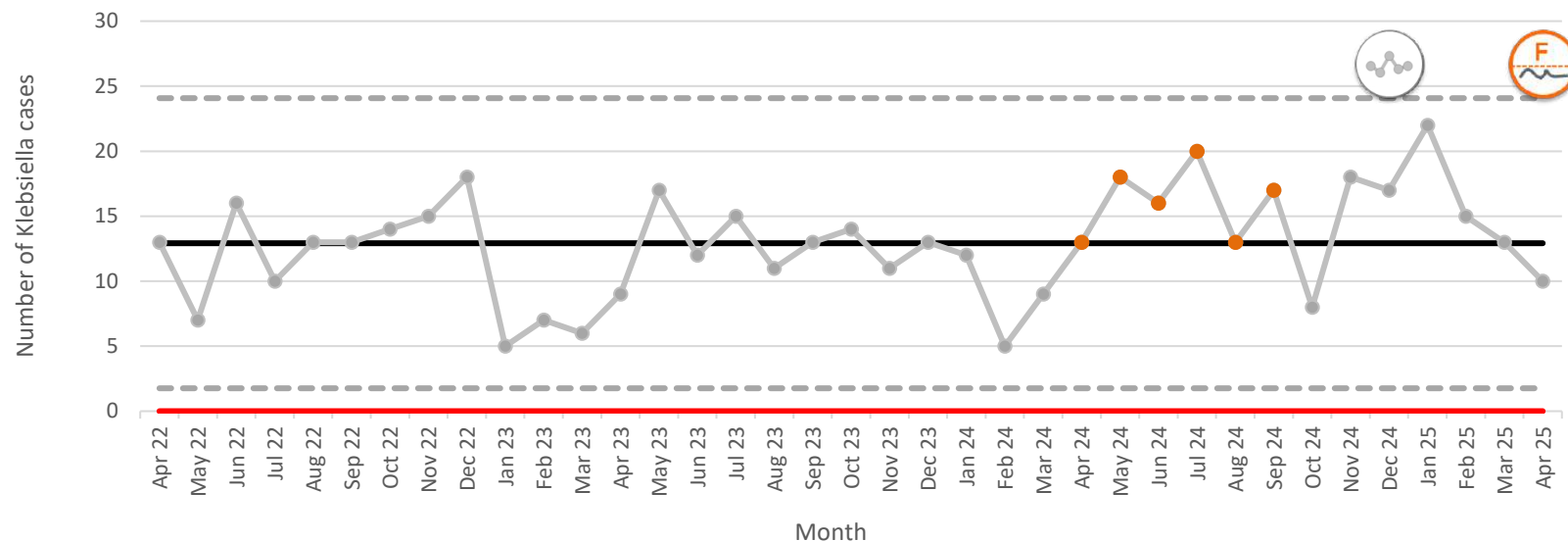
Actions



Clinical Group Overview

MRI	5
Specialist	2
CSS	2
NMGH	1
WTWA	0
LCO & Dental	0

Gram negative infection – Klebsiella



Updates since previous month

Reduction in cases from March

Current issues

Clinical Group action plans relating to urinary catheter care and vascular access devices are in place, with a focus on improving compliance and reducing associated risks

Key dependencies

Adherence to Urinary Catheter Care policy
Good management of intravascular devices

Future actions

Clinical Group action plans address urinary catheter and vascular access device care, to drive consistent compliance-Reporting to Trust Infection Control Committee

Gram negative infection – Pseudomonas

Advise

Not SOF3 metric

Apr-25

Target

5

0

Compliance

Variance

Assurance

Actions



Clinical Group Overview

CSS 3

MRI 1

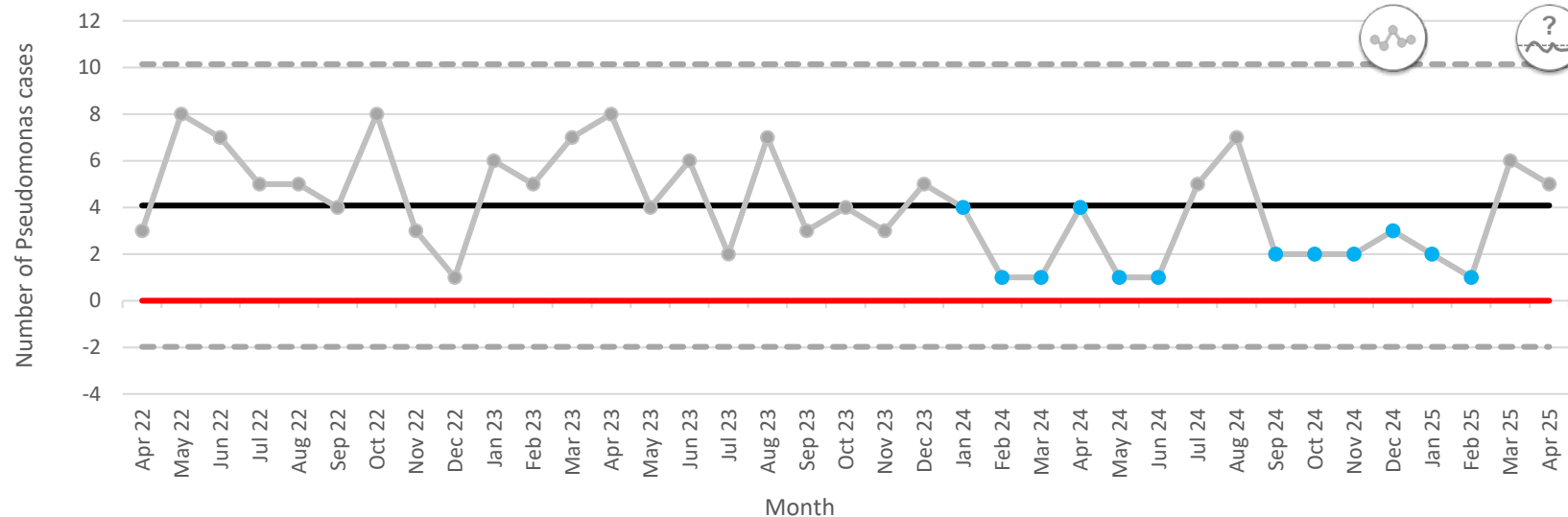
Specialist 1

NMGH 0

WTWA 0

LCO & Dental 0

Gram negative infection – Pseudomonas



Updates since previous month

Cases above threshold from February

Current issues

All patients are complex immuno-compromised-susceptible to environmental pseudomonas infection

Key dependencies

NHS Standard Contract 2025/26 Minimising Clostridioides difficile and Gram Negative Blood stream Infections (GNBSI)

Future actions

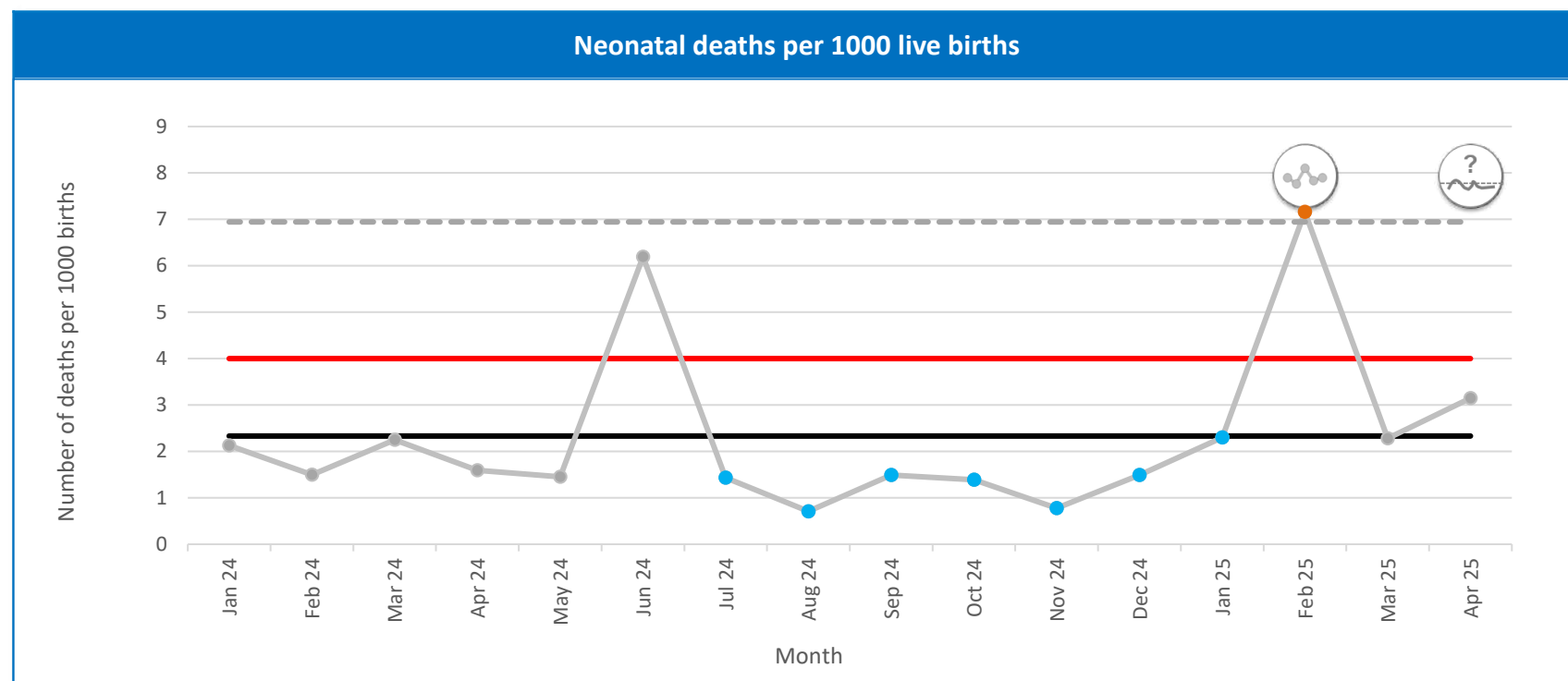
Assurance compliance with all IPC policies and procedures with immunocompromised patients-Trust Infection Prevention Control Committee Audit Plan

Neonatal deaths per 1000 live births

Assure			
Apr-25		Target	
3.15		<4 per 1000 births	
Compliance	Variance	Assurance	Actions

Clinical Group Overview

Specialist



Updates since previous month

4 neonatal deaths (NND) in April 2025.
3 early neonatal deaths for babies with known antenatal complications and expected poor prognosis. 1 neonatal death following surgical transfer to ORC

Key dependencies

MNSI referral for all cases which meet the national reporting criteria.
Incidents with moderate harm and above

Current issues

No care issues identified from the initial reviews
No deaths in this reporting period met the MNSI criteria for referral

Future actions

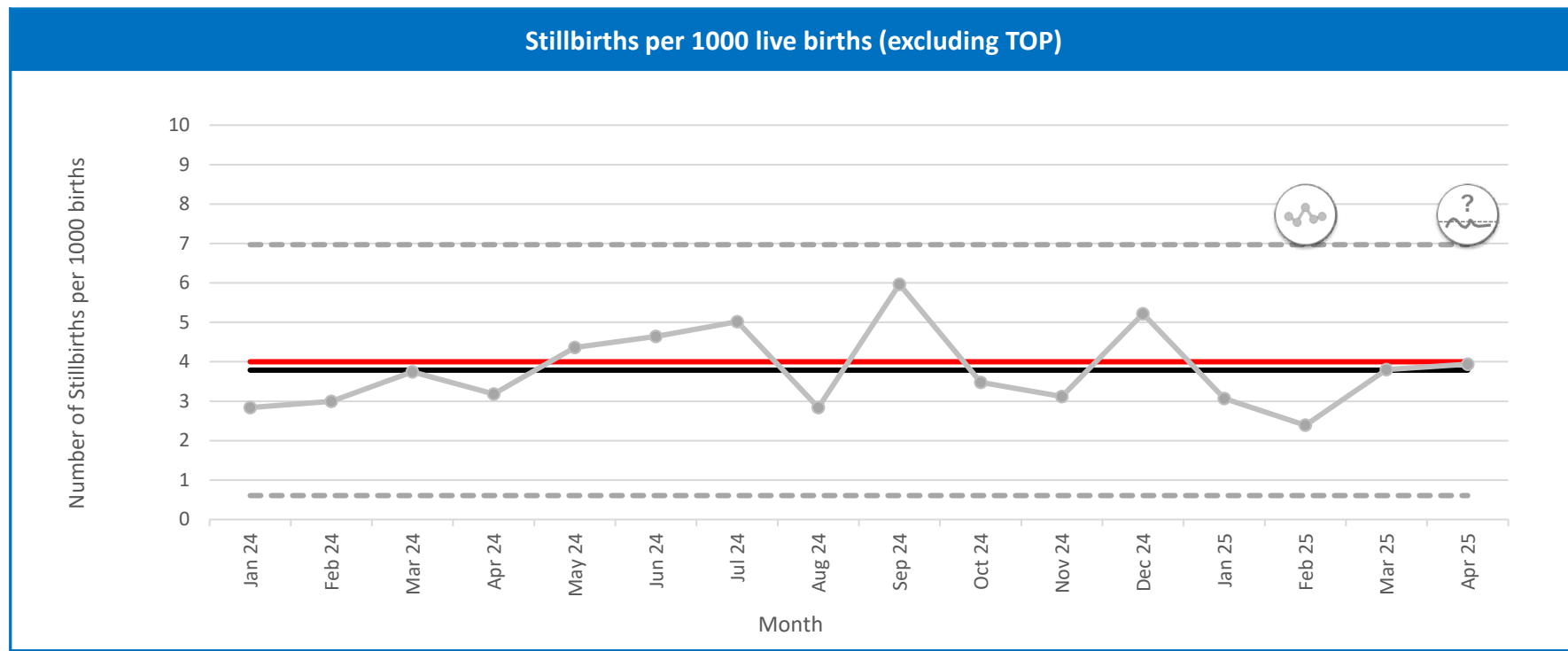
Continue active surveillance using incident reporting for all NND and extract learning from PMRT reviews Bespoke care pathways for women with previous NND into dedicated specialist clinic

Stillbirths per 1000 live births (excluding TOP)

Assure			
Apr-25	Target		
3.94	<4 per 1000 births		
Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist



Updates since previous month

4 stillbirths in April 2025. Reduction in number of stillbirths at North Manchester from 4 in March to 1 in April 2025

Current issues

No care issues identified from the initial reviews. All deaths occurred between 27 and 31 weeks gestation

Key dependencies

Incidents with moderate harm and above.
MNSI referrals when met criteria

Future actions

Continue active surveillance

Number of maternal deaths

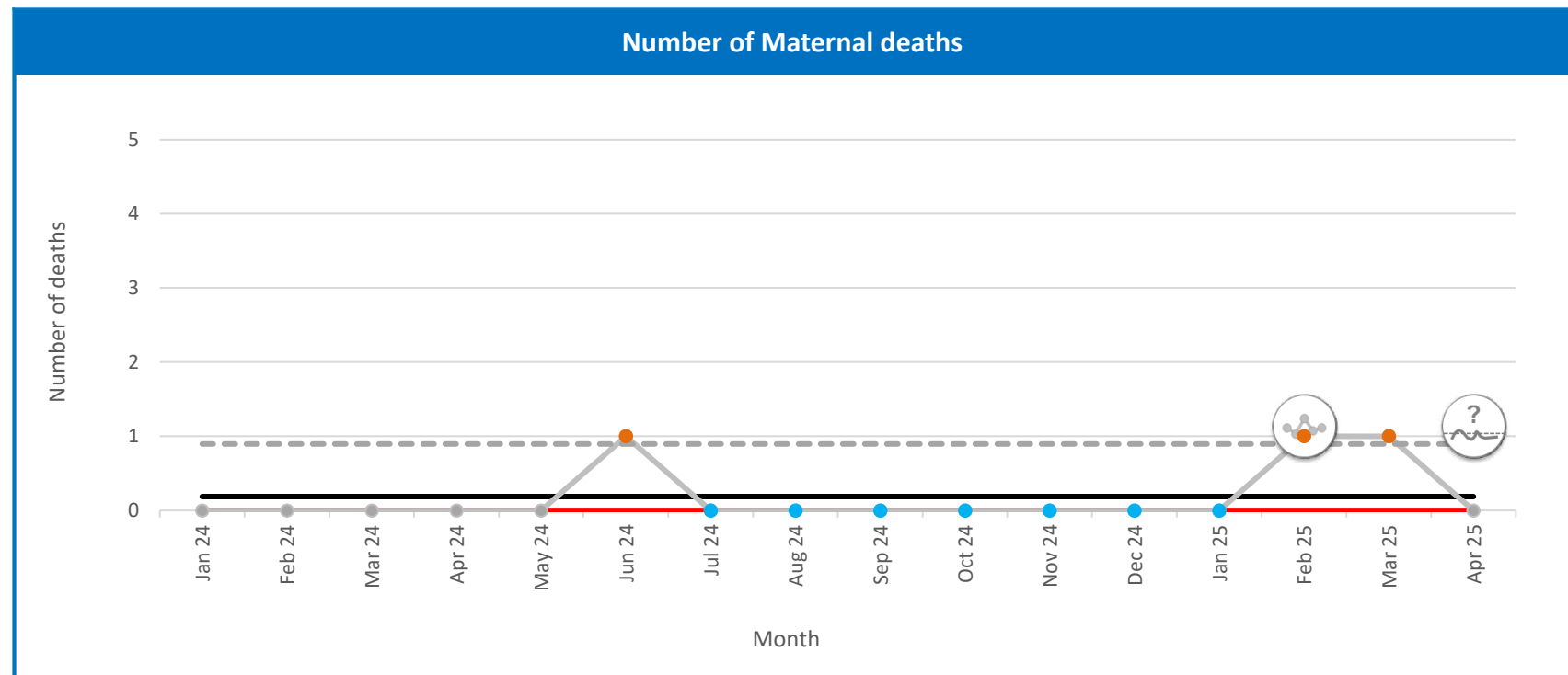
Assure

Apr-25 Target
0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist



Updates since previous month

No maternal deaths in April 2025

Current issues

Not applicable

Key dependencies

MNSI referrals

Future actions

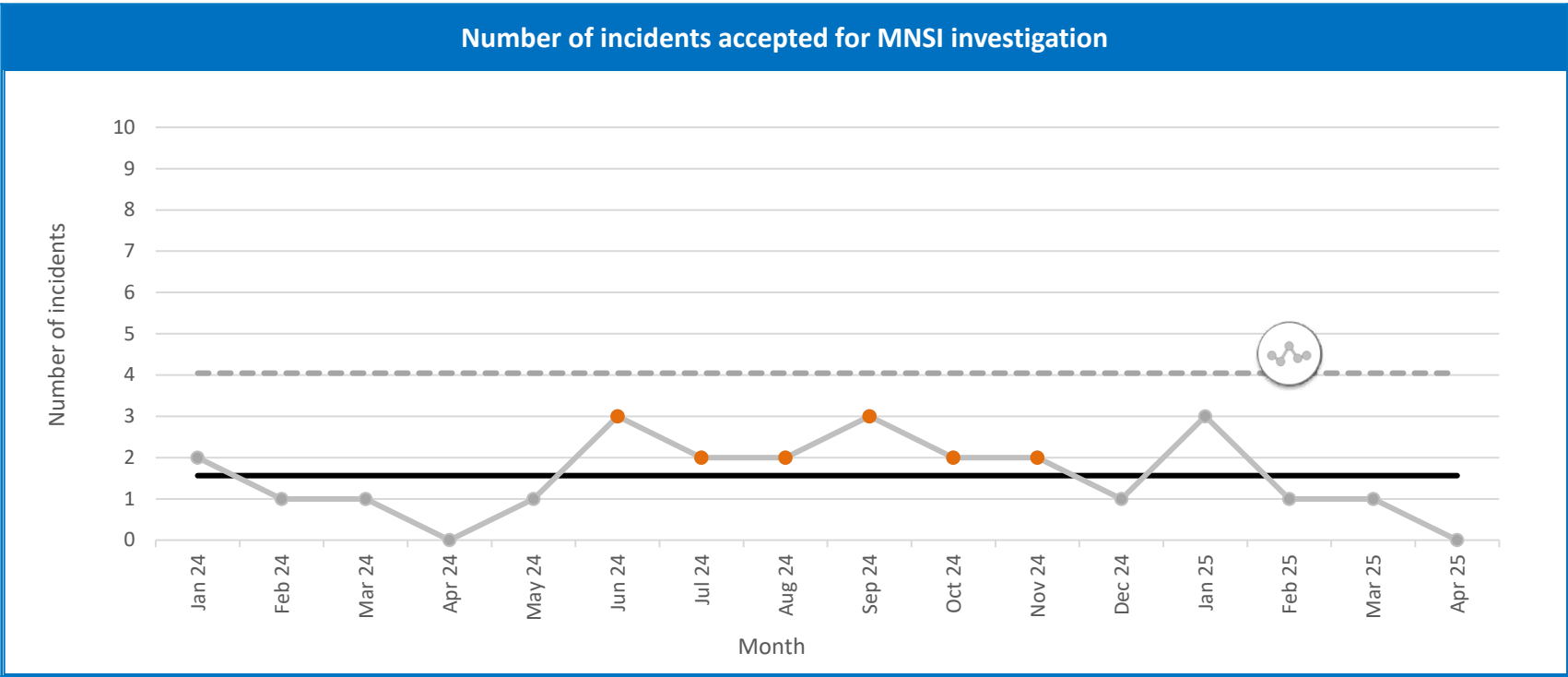
SHCG working with local Maternity and Neonatal system Maternal Mortality Group to identify and subsequently support any actions required to address the increase in maternal deaths across the region linked to none maternity specific cause

Number of incidents accepted for MNSI investigation

Assure	
Apr-25	Target
0	

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview
Specialist



Updates since previous month
There were no eligible cases for referral to MNSI in April 2025

Current issues
Not applicable

Key dependencies
Not applicable

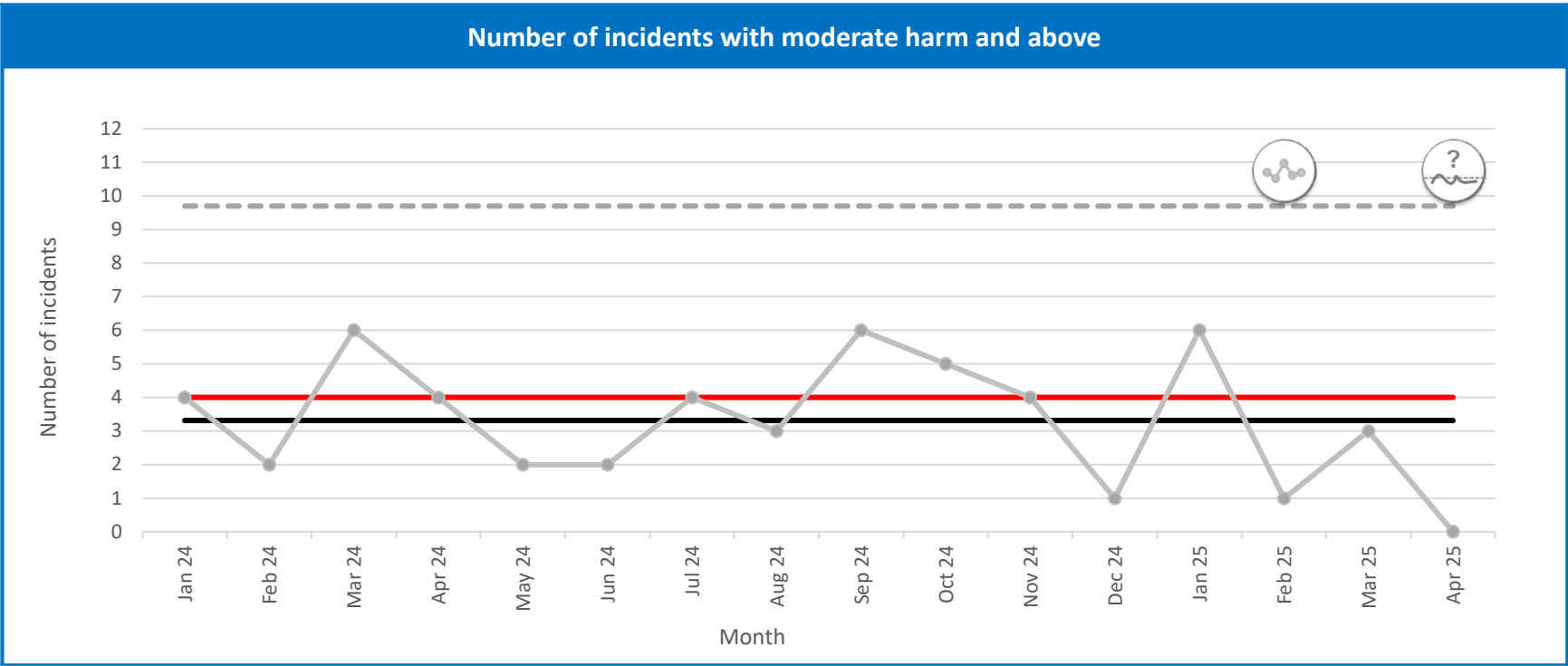
Future actions
Not applicable

Number of incidents with moderate harm and above

Assure	
Apr-25	Target
0	<4

Compliance	Variance	Assurance	Actions

Clinical Group Overview
Specialist



Updates since previous month
No incidents with moderate harm of above in April 2025

Current issues
Not applicable

Key dependencies
Incident reporting Complaints

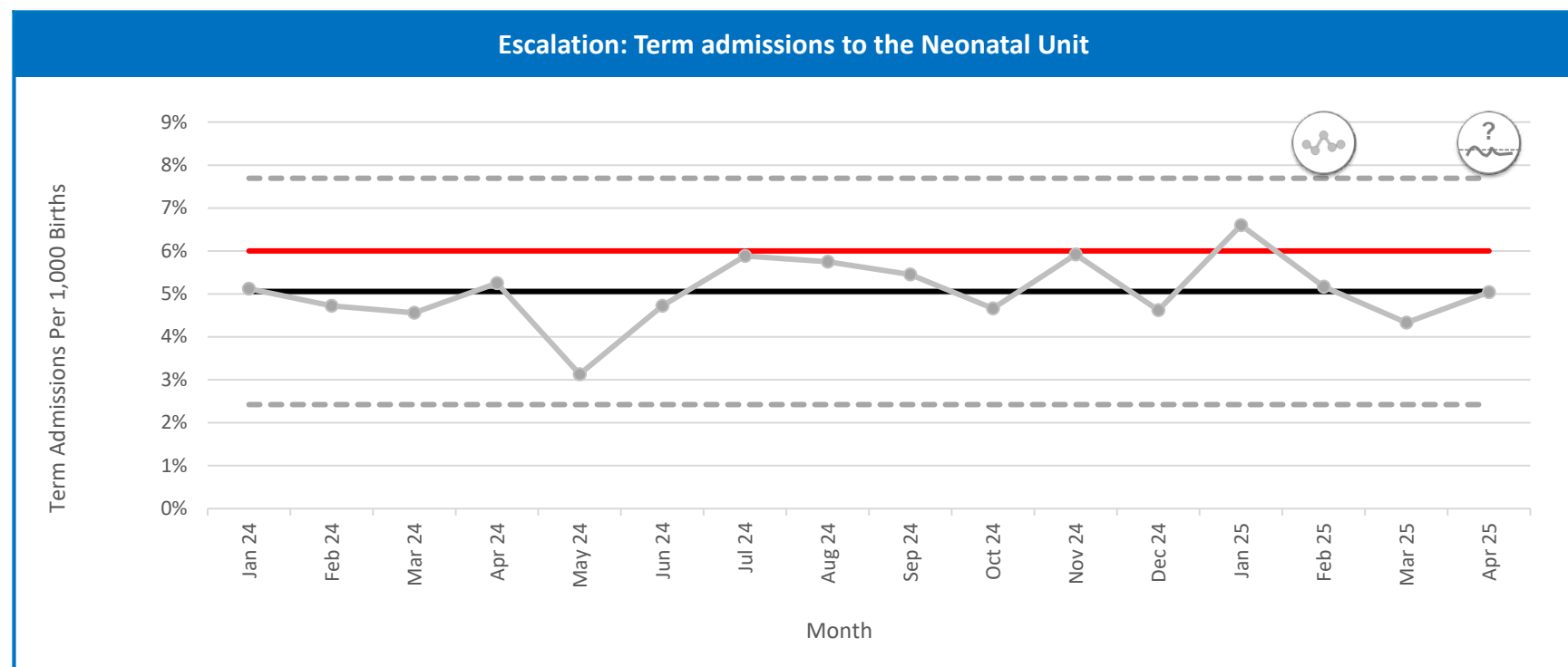
Future actions
Continue active surveillance

Escalation: Term admissions to the Neonatal Unit

Assure			
Apr-25		Target	
5.04		<6% (60 per 1000)	
Compliance	Variance	Assurance	Actions

Clinical Group Overview

Specialist



Updates since previous month

Improvement in overall admissions has been maintained
Two avoidable admissions

Key dependencies

Availability of Transitional Care
Number of planned/ surgical admissions at Oxford Road Campus

Current issues

Two steroid doses not administered, and the absence of a holistic review resulted in a missed opportunity for earlier delivery

Future actions

QI project to support sustained reduction in the number of avoidable term admissions

Category 3 Caesarean sections cancelled on the day

Advise

Apr-25

Target

12

<10 per month

Compliance

Variance

Assurance

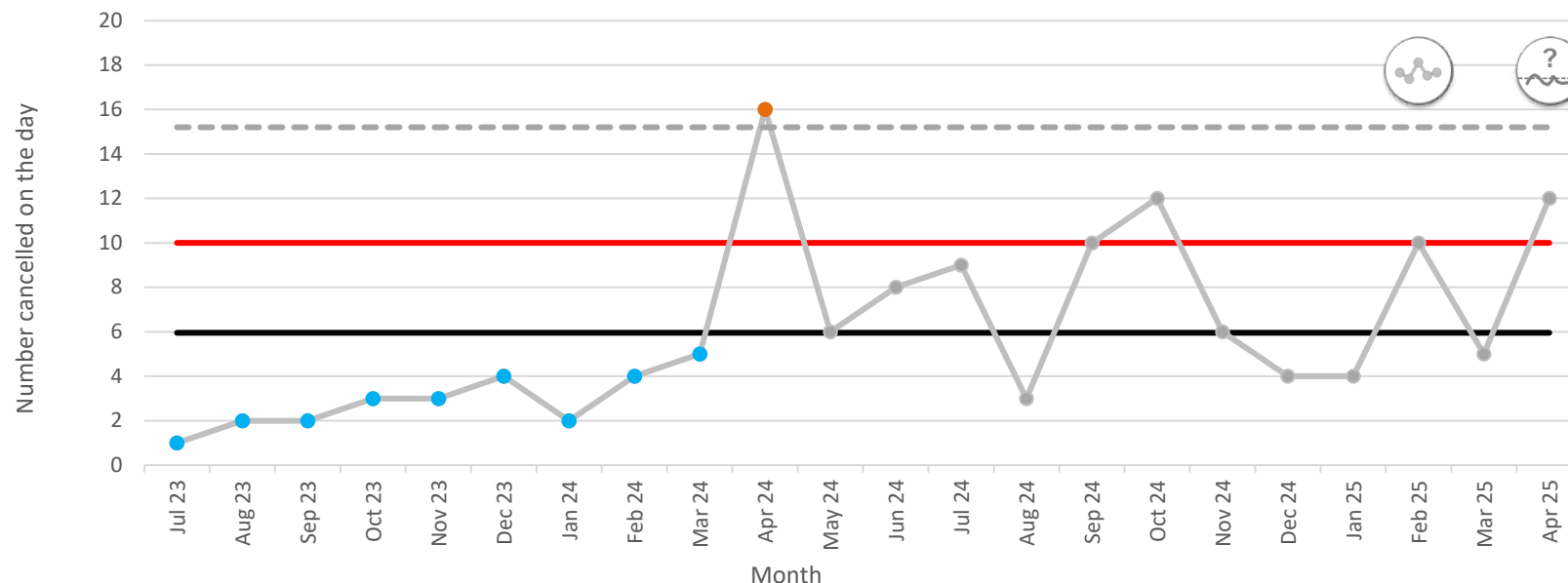
Actions



Clinical Group Overview

Specialist

Category 3 Caesarean sections cancelled on the day



Updates since previous month

Impact of delivery unit activity and acuity and prioritizing care resulting in delayed category 3 lower segment caesarean section (LSCS)

Key dependencies

Elective caesarean section capacity

Current issues

Delays incorrectly documented – validation work commenced in Q1

Future actions

Process for listing category 3 LSCS reviewed Q1 to ensure all elective capacity is maximized
Theatre workstream in place to improve oversight of documentation of the theatre pathway to improve data quality

Initial assessment time (Maternity Triage -15 mins)

Advise	

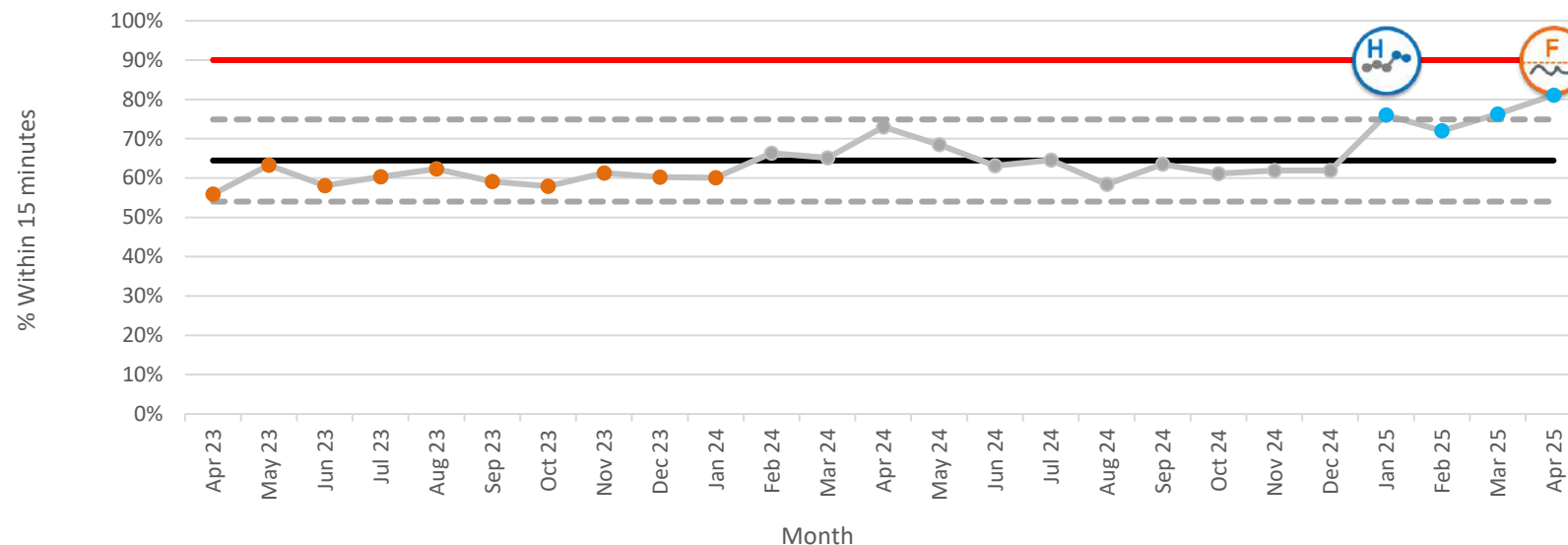
Apr-25	Target
81.1%	>90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist

Initial assessment time (Maternity Triage -15 mins)



Updates since previous month

Further improvement from 76% in March to 81.1% in April
The Manchester Triage Model (MMAT)- KPIs continue to demonstrate safety is being maintained

Key dependencies

Maternity Triage staffing and activity

Current issues

SM ORC piloted the impact of a Band 7 coordinator role on flow the outcome of which demonstrated a positive improvement in time of triage. If the business case is not supported there is a risk improvement will not be sustained

Future actions

Support for permanent Band 7 role approved in principle- formal business case to be submitted to SHCG Investment panel and Finance panel in August 2025

Initial assessment time (Maternity Triage -30 mins)

Assure

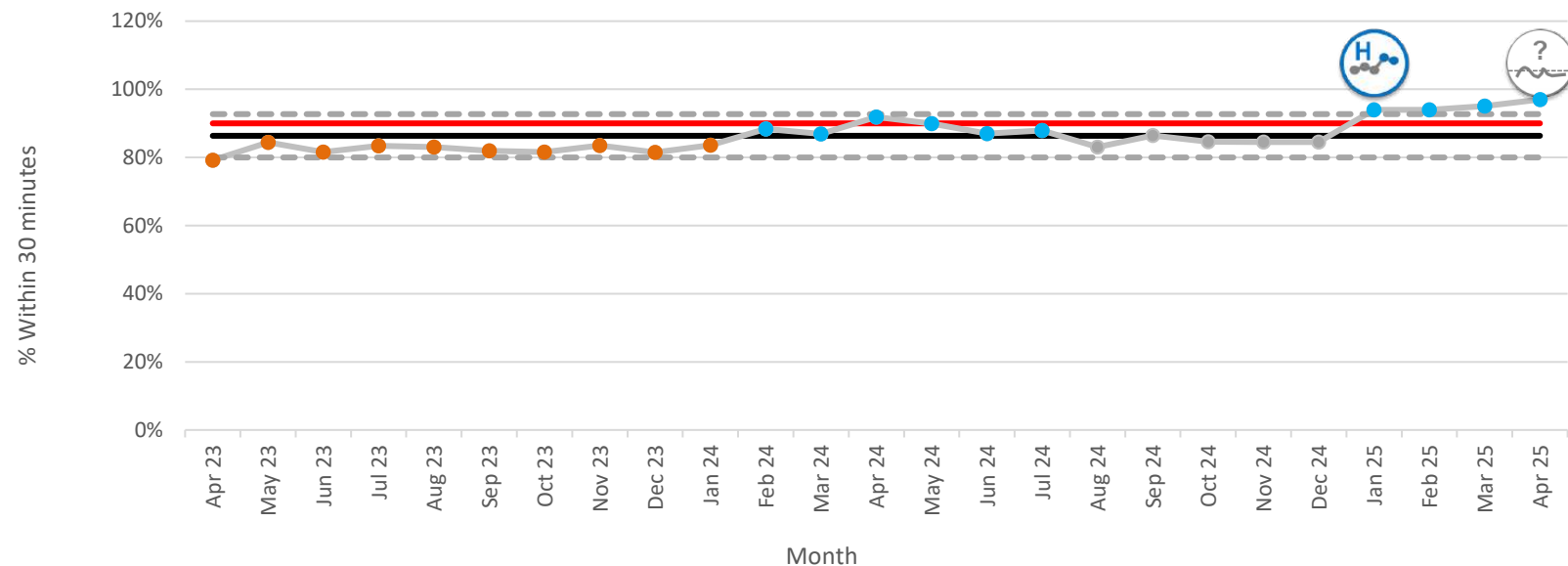
Apr-25 Target
97% **>90%**

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist

Initial assessment time (Maternity Triage -30 mins)



Updates since previous month

Continued improvement seen during April 2025

Current issues

SM ORC piloted the impact of a Band 7 coordinator role on flow the outcome of which demonstrated a positive improvement in time of triage. Risk improvement will not be sustained if Business Case is not supported

Key dependencies

Initial assessment within 15 minutes

Future actions

Support for permanent Band 7 role approved in principle- formal business case to be submitted to SHCG Investment panel and Finance panel in August 2025

Induction pathway delays

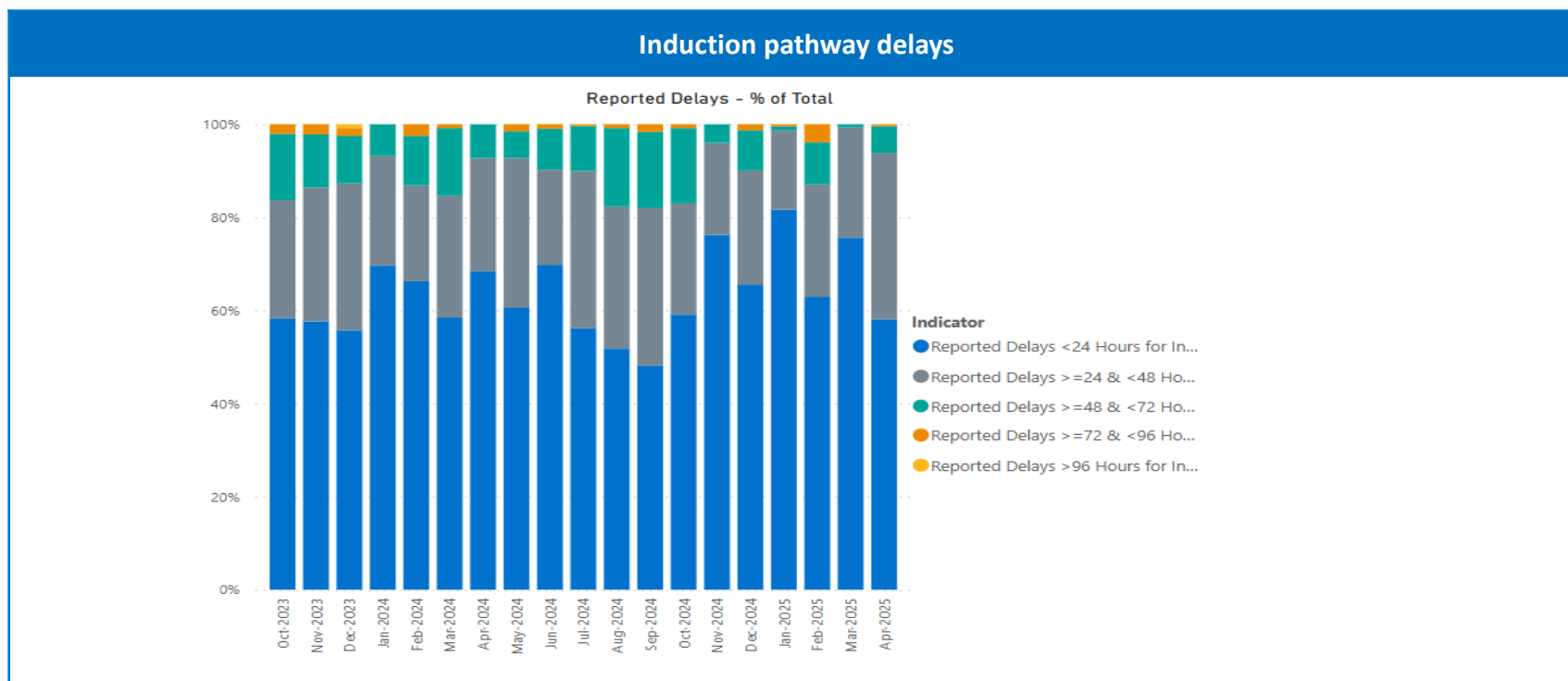
Advise

Apr-25	Target
61.36%	60%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist



Updates since previous month

0 delays over 96 hours, 1 delay over 72 hours
 38% transferred >24 <48 hours against 25% target
 61.63% transferred < 24 hours
 No cases of avoidable harm due to a delay in transfer

Key dependencies

Augmentation of labour pathway

Current issues

Activity and acuity impacting on timely transfer – resulting in reduced compliance for both <24 hour and >24 <48 hour metrics

Future actions

A review of a recent change to the Induction methodology will be undertaken in May to ascertain impact on flow

Augmentation of labour pathway delays

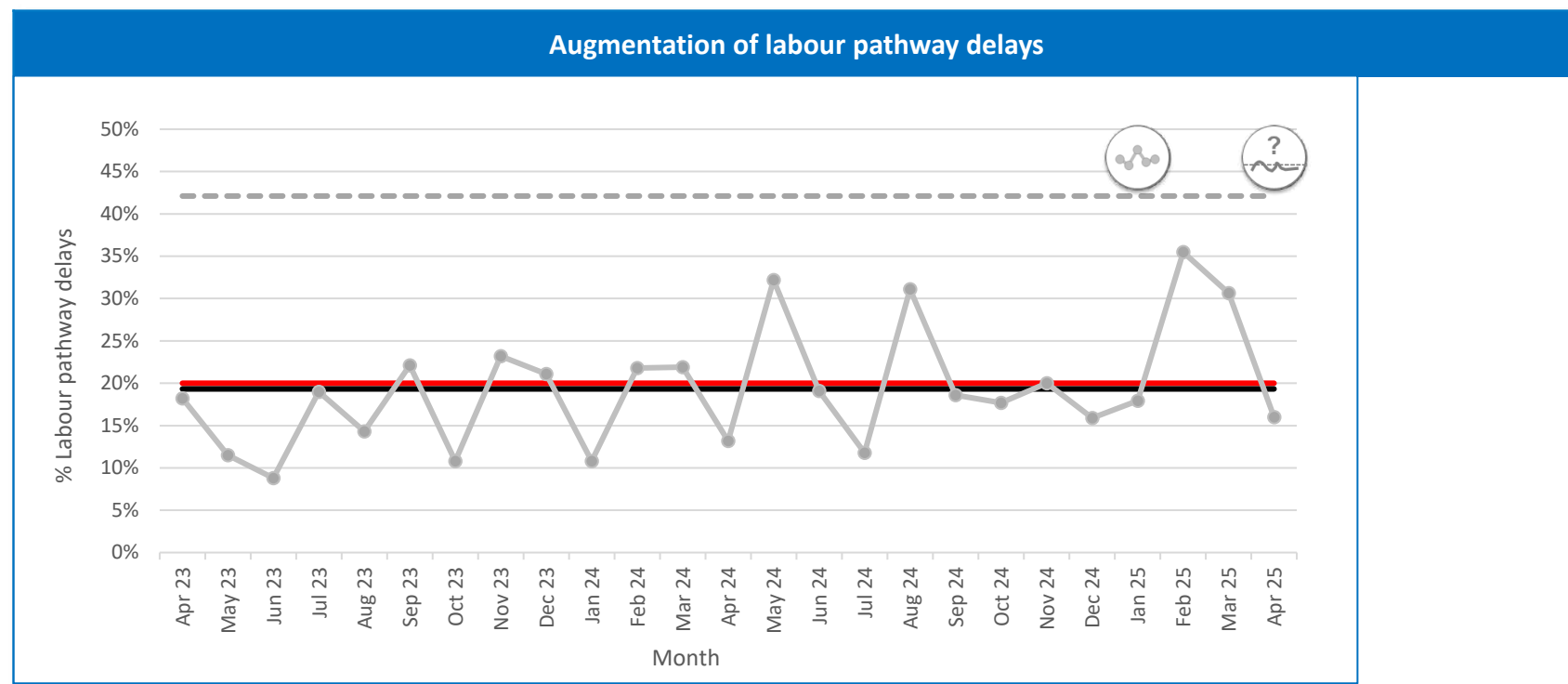
Assure	

Apr-25	Target
16%	<20%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist



Updates since previous month

Improvement from 30.6% in March 2025

Current issues

Increased activity and acuity impact on delays experienced

Key dependencies

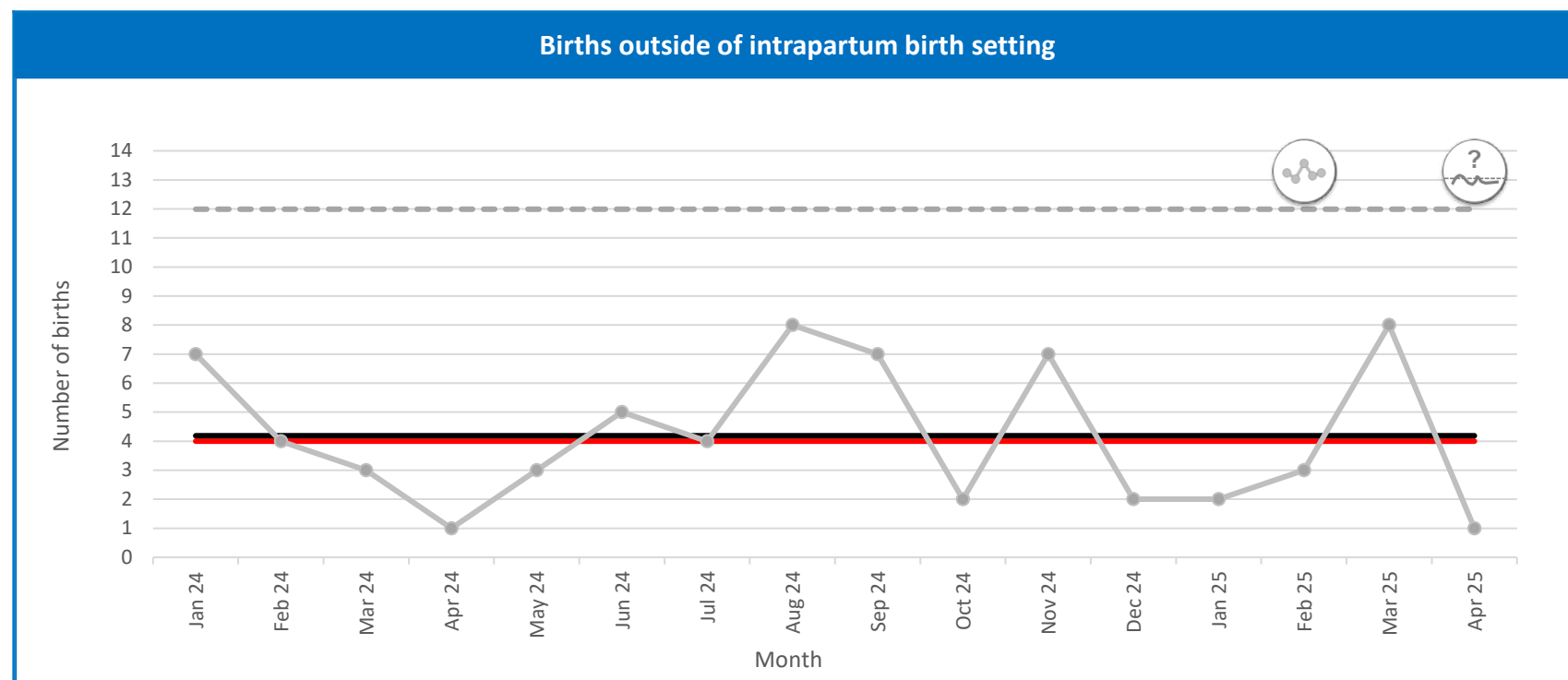
Induction pathway delays
Delivery unit capacity

Future actions

Monitoring and escalation continues via twice daily flow meetings and redeployment of staff if appropriate. Capacity across the MCS utilized-offer of alternative sites. Maintain current oversight processes

Births outside of intrapartum birth setting

Assure			
Apr-25		Target	
1		<4 per month	
Compliance	Variance	Assurance	Actions
Clinical Group Overview			
Specialist			



Updates since previous month

1 birth which occurred in the ORC atrium with midwifery support following a call to the maternity unit

Current issues

No care issues identified. Mother and baby transferred to the appropriate care setting when safe to do so and subsequently discharge home well

Key dependencies

Complaints and incident linked to birth outside Delivery Unit (DU)

Future actions

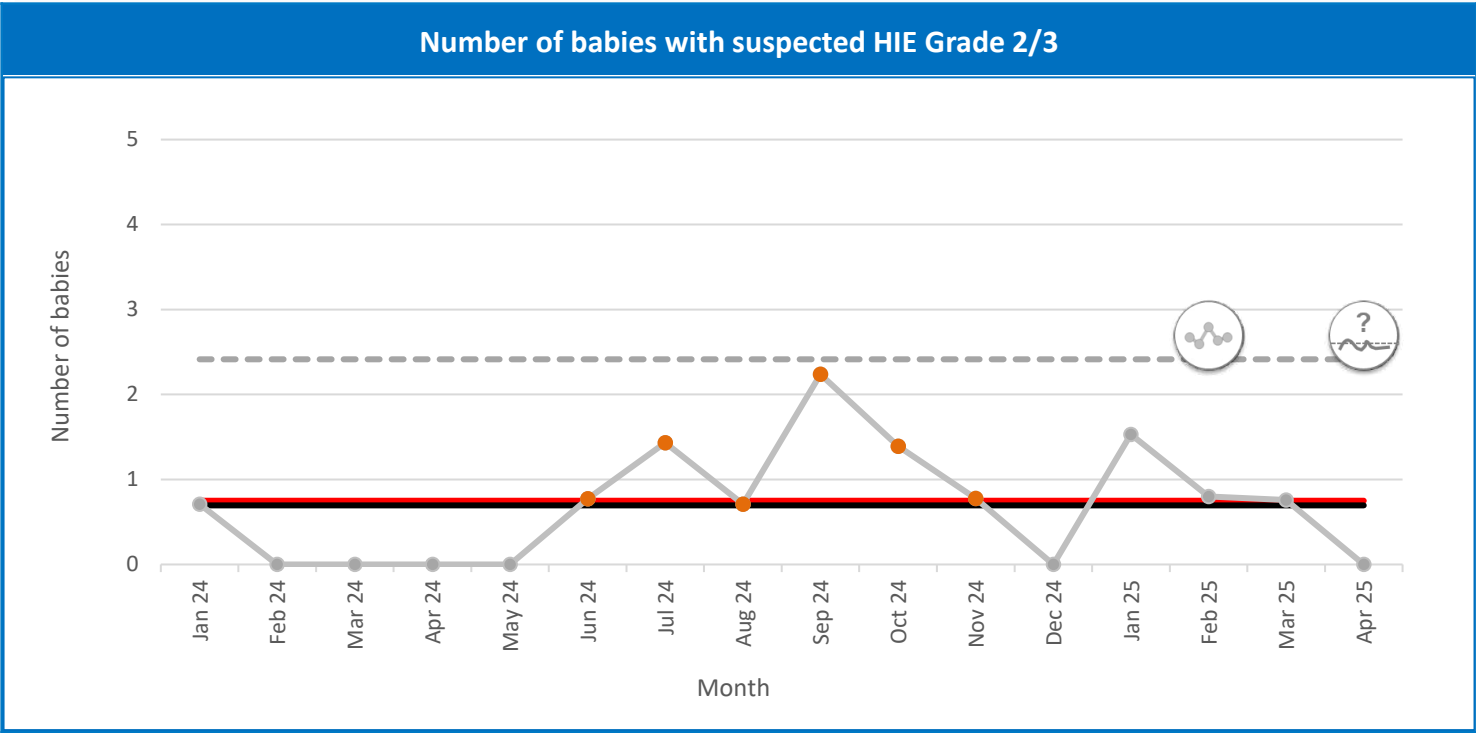
Continue timely review of cases and gaining feedback from women of their experience which is considered at Operational Delivery Group. No complaints received re birth outside DU in April

Number of babies with suspected HIE Grade 2/3

Assure	
Apr-25	Target
0	<0.75 per 1000

Compliance	Variance	Assurance	Actions

Clinical Group Overview
Specialist



Updates since previous month
No cases in April 2025

Current issues
Not applicable

Key dependencies
Term admissions to NICU Maternity and Newborn Safety Investigation referrals

Future actions
Continue active surveillance

MNSI/NHSR/CQC/Coroner Reg 28 or other organization with a concern or request for action made directly to Trust

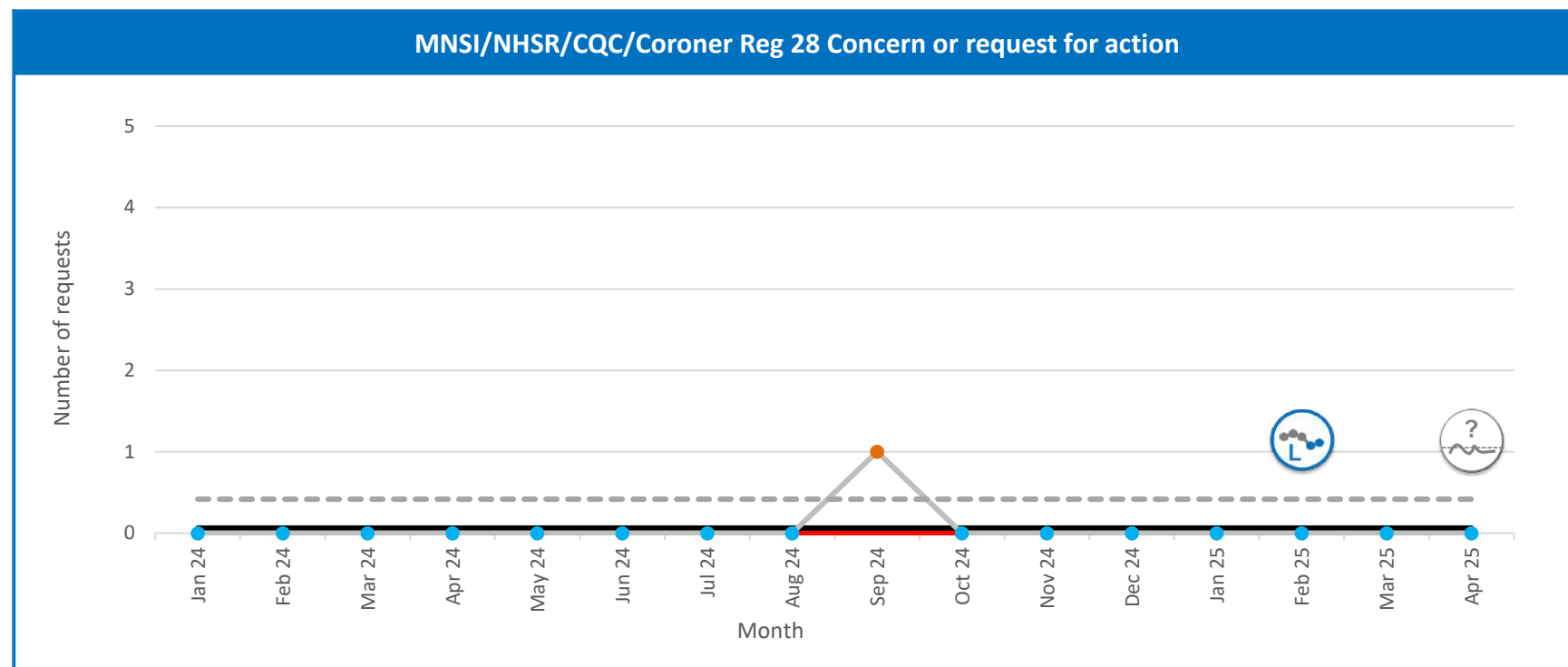
Assure

Apr-25 Target
0 0

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist



Updates since previous month

No concerns raised in April 2025

Current issues

Not applicable

Key dependencies

Not applicable

Future actions

Not applicable

Number of patients with Deprivation of Liberty Safeguards (DoLS)

Advise

Not SOF3 metric

Apr-25

Target

314

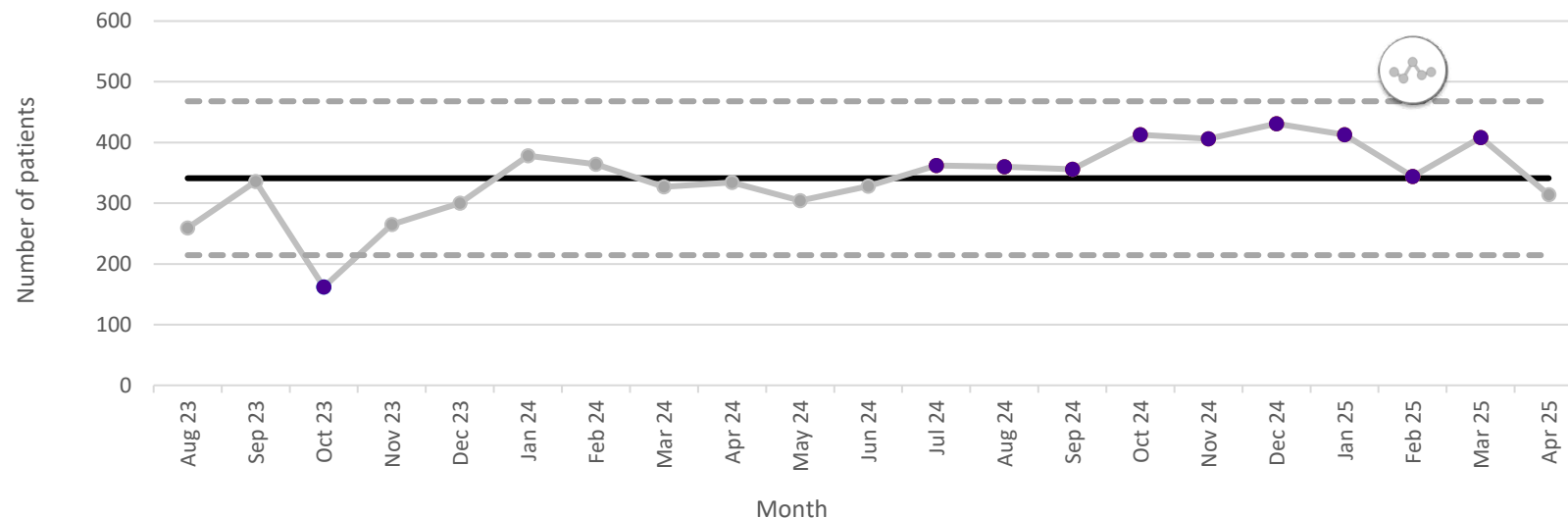
-

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

NMGH	116
MRI	102
WTWA	96
Specialist	
LCO & Dental	
CSS	

Number of patients with DoLS



Updates since previous month

DoLS applications have decreased to 314 this month

Current issues

Audit data and DoLS tracking indicates appropriate DoLS applications are completed, in line with Trust policy

Key dependencies

DoLS application data is scrutinized weekly at a DoLS partnership meeting by the MFT Safeguarding Team with the Manchester Local Authority best interest assessment (LA BIA) team to promote completion of the DoLS

Future actions

The DoLS policy has been reviewed and is under review by the Trust Safeguarding Group. The revised policy has been developed in consultation with the Trust Legal and Local Authority teams to review application of statutory criteria

Number of authorised DoLS

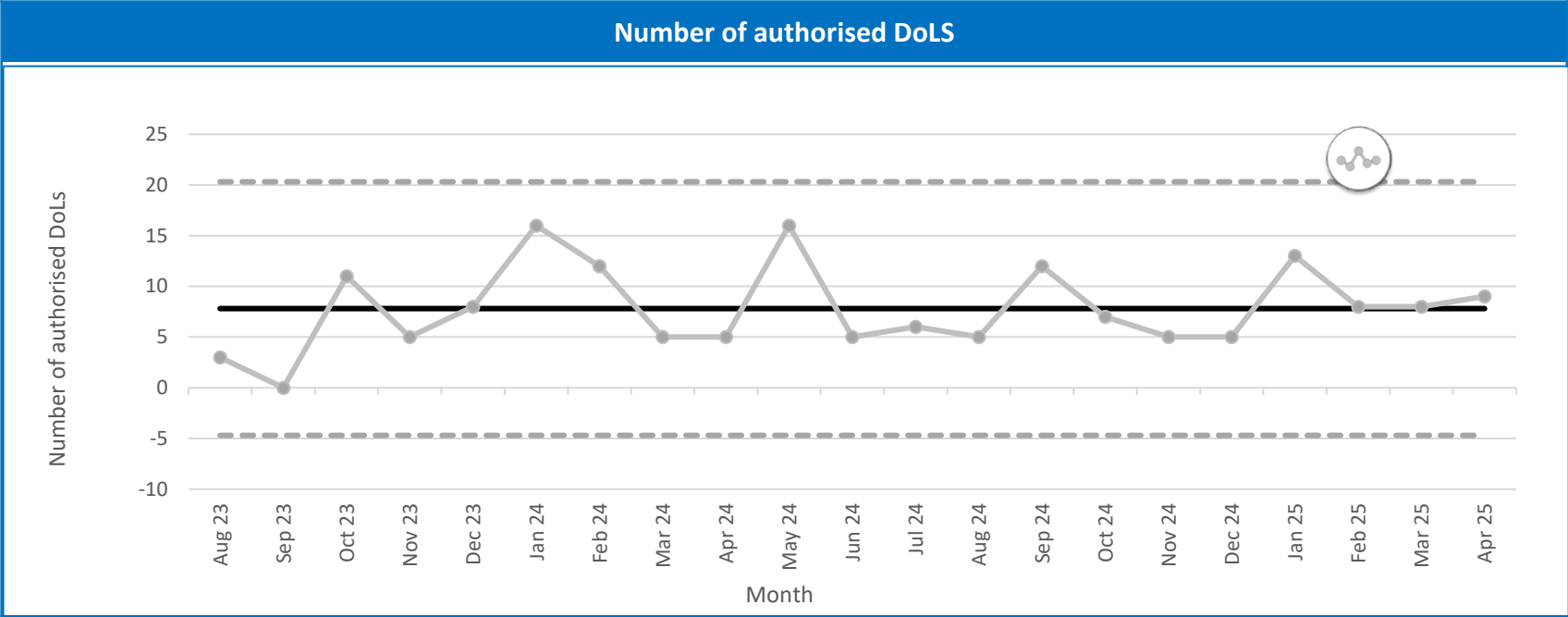
Advise

Not SOF3 metric

Apr-25	Target
9	-

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
MRI	6
NMGH	2
WTWA	1
LCO & Dental	
CSS	
Specialist	



Updates since previous month

9 DoLS were completed by the Local Authority Best Interest Assessment Team and notified to the CQC by MFT

Key dependencies

DoLS data scrutinized weekly at a DOLS partnership meeting by the MFT Safeguarding Team with the Manchester Local Authority best interest assessment team

Current issues

1 % of MFT DoLS applications authorised by the Local Authority
Low authorisation rate escalated to Local Authority
National data indicates 19% of standard authorisations are authorised in 21 day statutory timescales

Future actions

Manchester Local Authority in partnership with MFT are completing a “deep dive” into the DoLS applications led by MFT to review barriers to authorisation in Q4. MFT DoLS policy is has been reviewed in line with recent case law

Training – safeguarding children L1

Assure	Not SOF3 metric

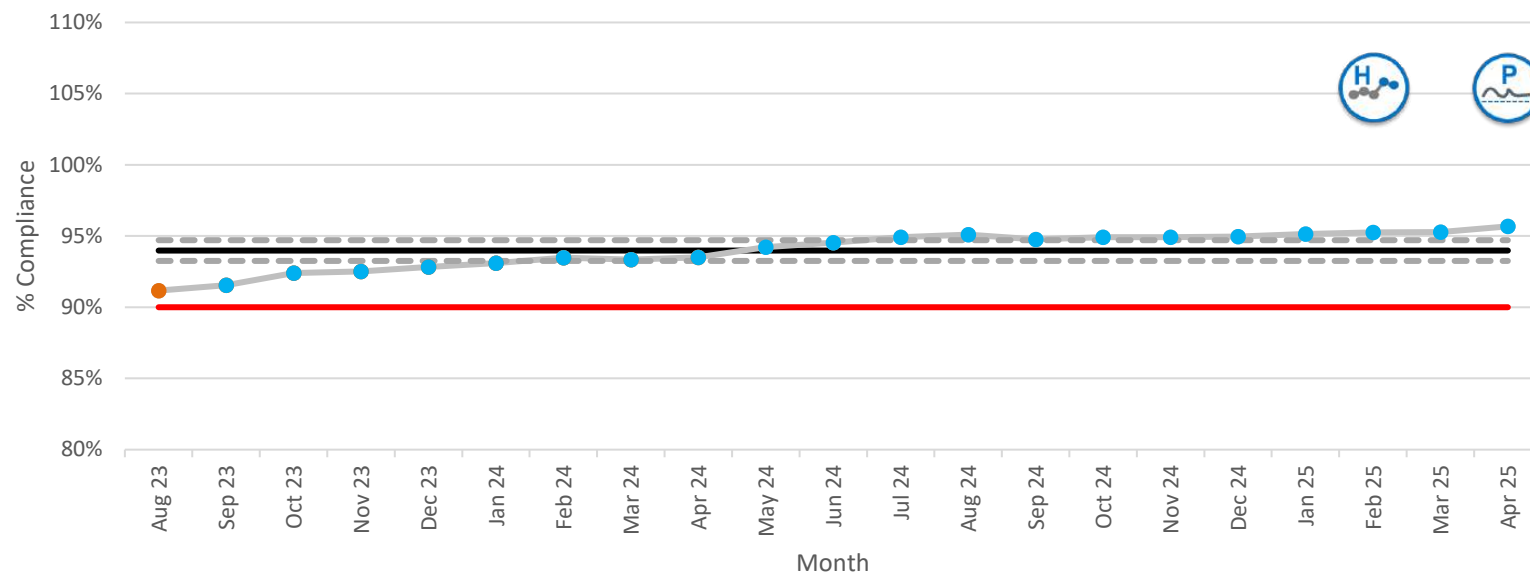
Apr-25	Target
95.68%	90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

Specialist	96.20%
LCO & Dental	96.11%
NMGH	95.94%
MRI	95.94%
CSS	95.09%
R&I	94.85%
WTWA	94.38%

Training – Safeguarding Children L1



Updates since previous month

Expected standard consistently met

Current issues

Not applicable

Key dependencies

Reported and overseen by to Trust Safeguarding Group

Future actions

Continue to monitor performance

Training – safeguarding adults L1

Assure

Not SOF3 metric

Apr-25

Target

95.70%

90%

Compliance

Variance

Assurance

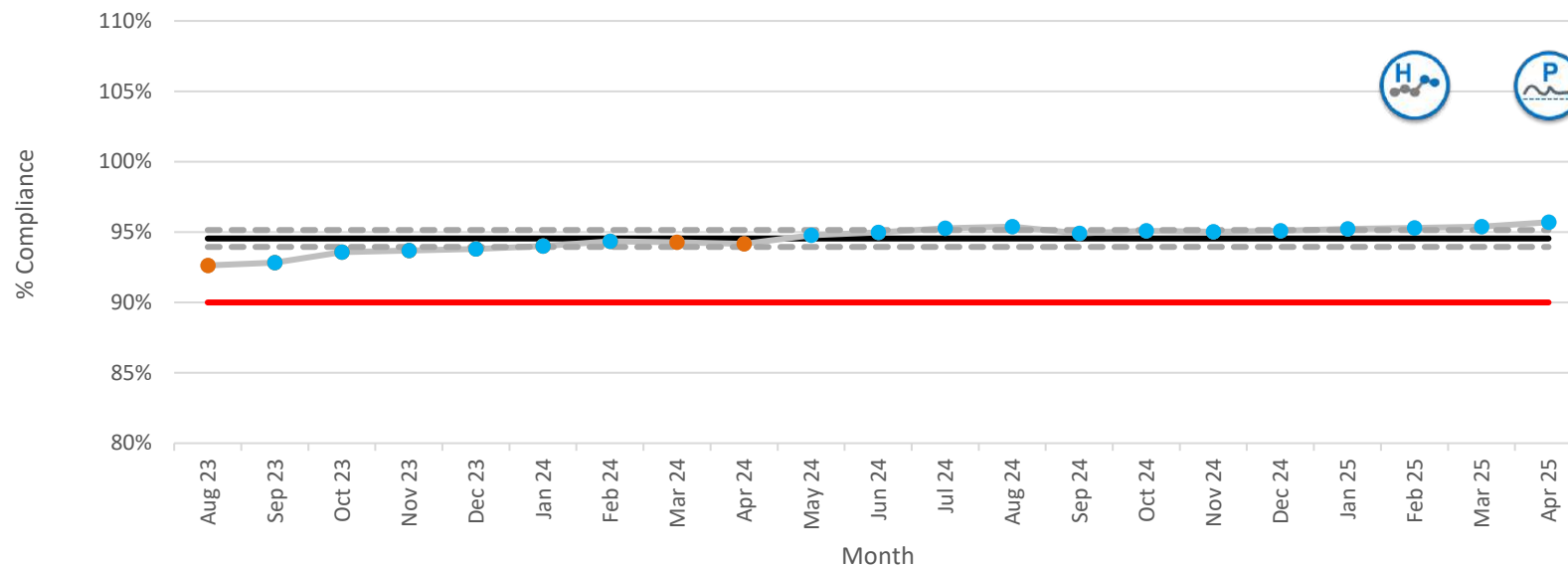
Actions



Clinical Group Overview

Specialist	96.29%
NMGH	95.98%
LCO & Dental	95.86%
MRI	95.84%
CSS	95.17%
R&I	95.12%
WTWA	94.52%

Training – Safeguarding Adults L1



Updates since previous month

Expected standard consistently met

Current issues

Not applicable

Key dependencies

Reported and overseen by to Trust Safeguarding Group

Future actions

Continue to monitor performance

Training – safeguarding children L2

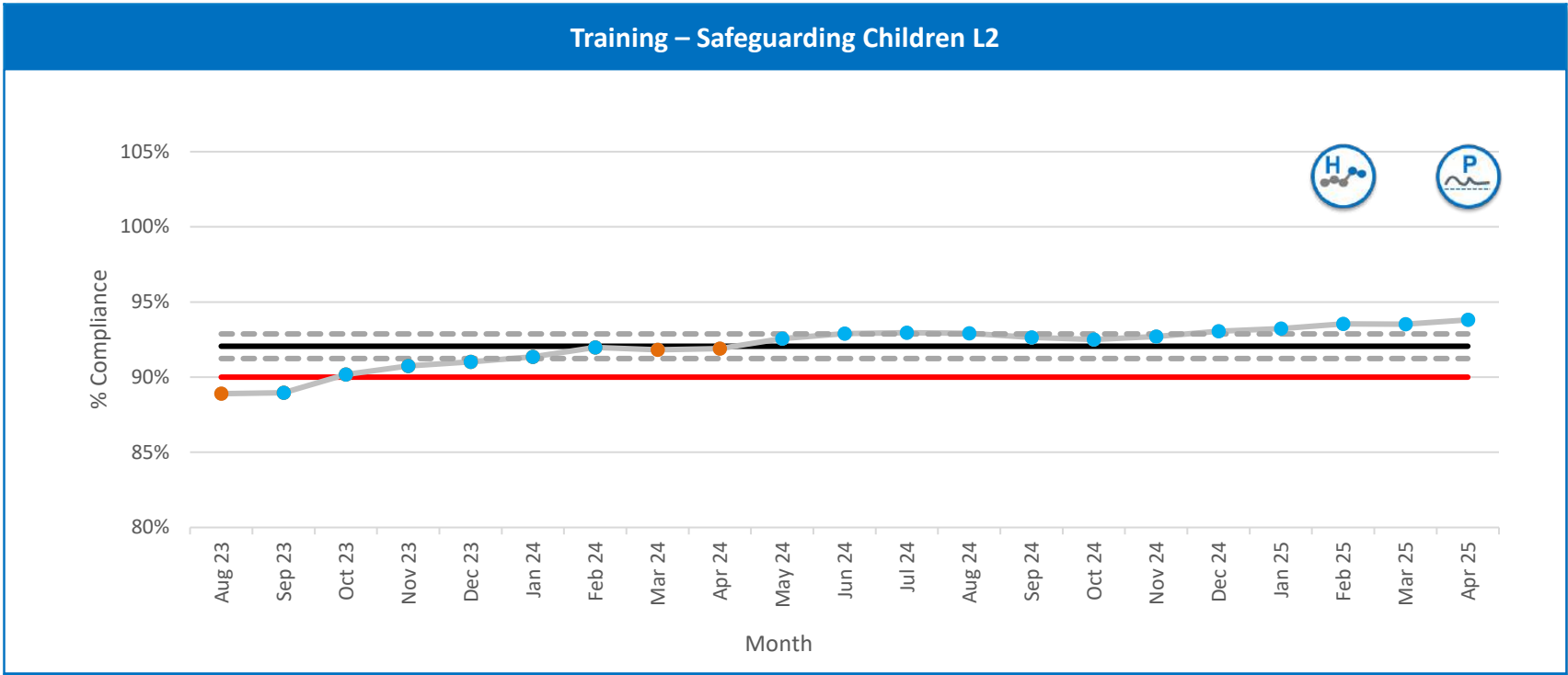
Assure

Not SOF3 metric

Apr-25	Target
93.81%	90%

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
R&I	96.03%
LCO & Dental	94.97%
NMGH	94.88%
Specialist	94.82%
MRI	94.74%
CSS	92.32%
WTWA	92.12%



Updates since previous month

Expected standard consistently met

Current issues

Not applicable

Key dependencies

Reported and overseen by to Trust Safeguarding Group

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Future actions

Continue to monitor performance

Training – safeguarding adults L2

Assure

Not SOF3 metric

Apr-25

Target

93.80%

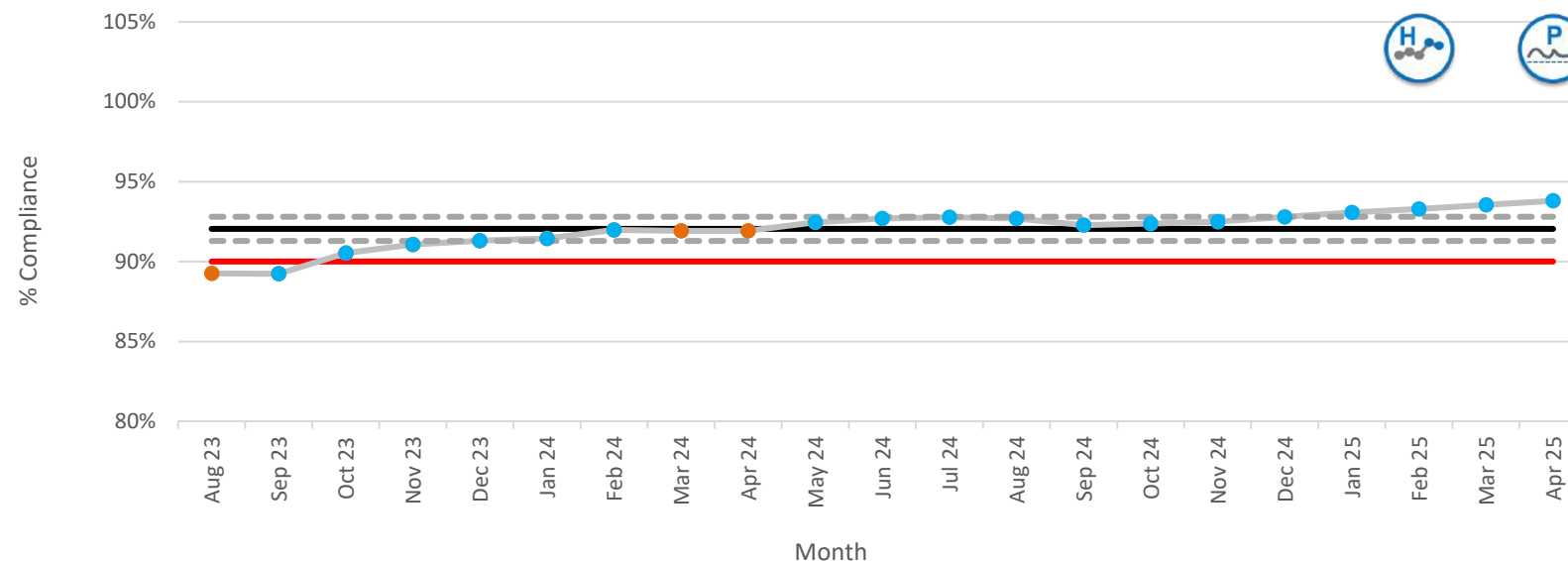
90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

R&I	95.70%
MRI	94.77%
NMGH	94.67%
LCO & Dental	94.26%
Specialist	93.57%
CSS	92.57%
WTWA	92.37%

Training – Safeguarding Adults L2



Updates since previous month

Expected standard consistently met

Current issues

Not applicable

Key dependencies

Reported and overseen by to Trust Safeguarding Group

Future actions

Continue to monitor performance

Training - safeguarding children level 3

Alert

Not SOF3 metric

Apr-25

Target

84.05%

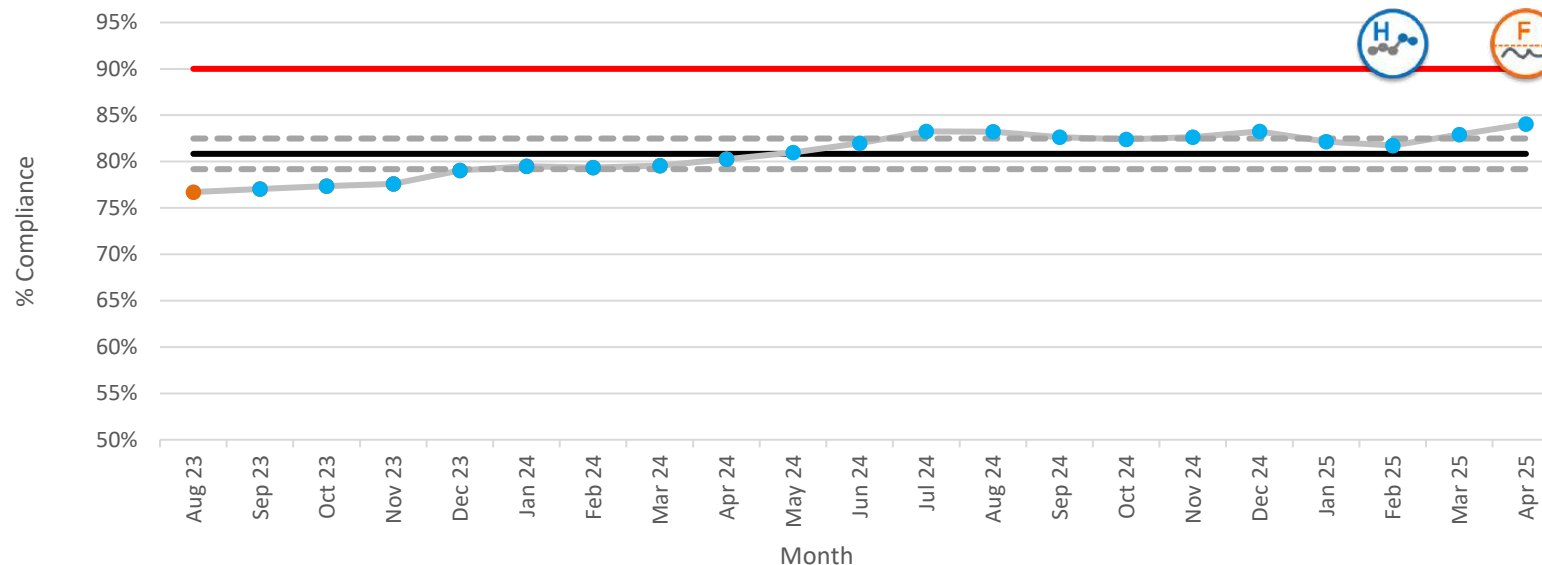
90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

LCO & Dental	88.49%
Specialist	88.43%
MRI	81.60%
CSS	81.59%
R&I	76.44%
NMGH	72.17%
WTWA	70.06%

Training - Safeguarding Children Level 3



Updates since previous month

Improving training trajectory (3% increase in compliance in 2 months)
Trust standard not met

Current issues

Nursing and midwifery workforce compliance – 86%
AHP workforce compliance 88%
Medical and Dental workforce compliance 66%

Key dependencies

The Trust Safeguarding Group and Clinical Group Safeguarding Groups oversee compliance and delivery of the Level 3 safeguarding training improvement plan

Future actions

Medical and Nursing Directors continue to oversee improvement plans for NMAHP, Medical and Dental workforce in Clinical Groups reported to Trust Safeguarding Group
Trust Leadership Team-Discussions with CG CEOs
Review of training content to support improved compliance -Aug 2025

Training - safeguarding adults Level 3

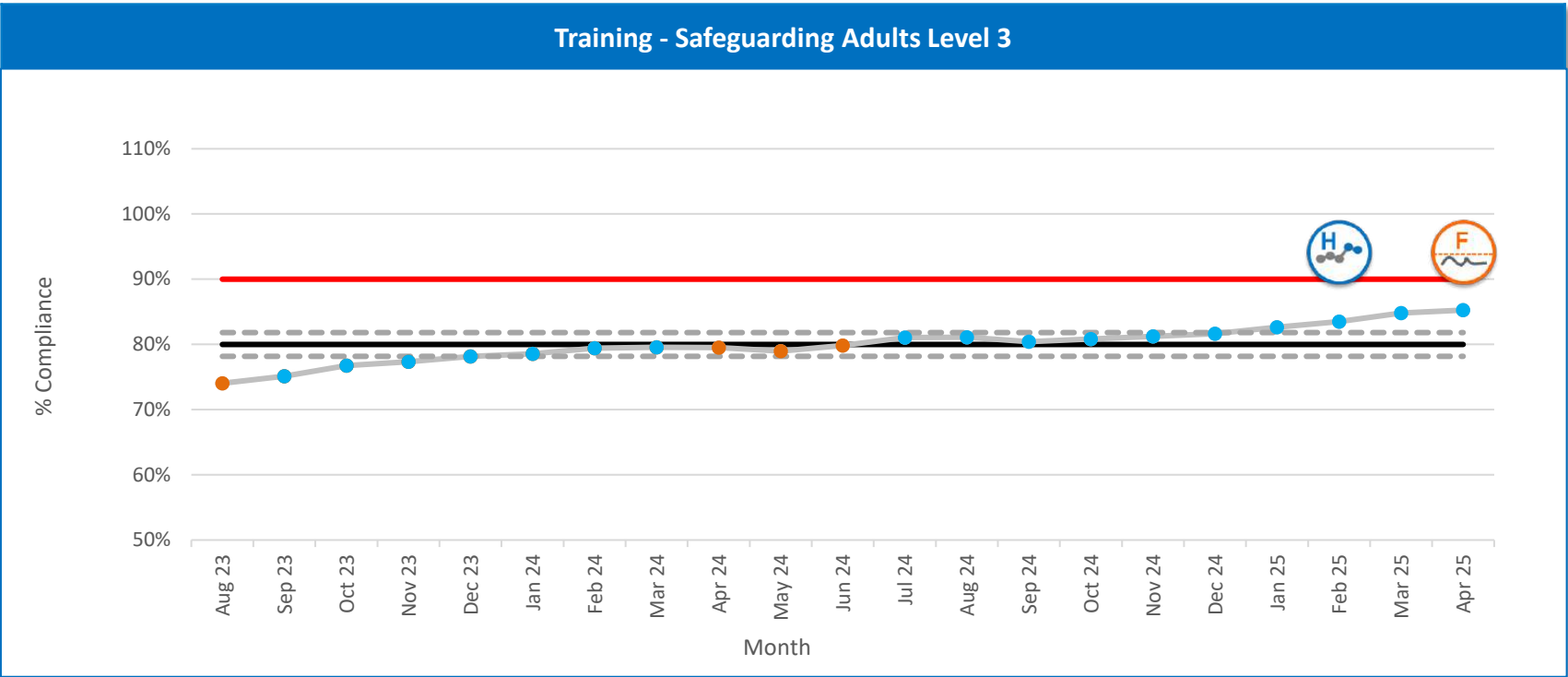
Alert

Not SOF3 metric

Apr-25	Target
85.26%	90%

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
Specialist	91.21%
LCO & Dental	88.79%
R&I	87.00%
NMGH	84.78%
MRI	84.33%
CSS	84.01%
WTWA	80.04%



Updates since previous month

Improving training trajectory (2% increase in compliance in 2 months)

Trust standard not met

Key dependencies

Trust Safeguarding Group oversees the implementation of the level 3 safeguarding training improvement plan

Page 49

Current issues

Nursing and midwifery workforce compliance – 89%

AHP workforce compliance 89%

Medical and Dental workforce compliance 65%

Future actions

Medical and Nursing Directors continue to oversee improvement plans for NMAHP, Medical and Dental workforce in Clinical Groups reported to Trust Safeguarding Group

Trust Leadership Team-Discussions with CG CEOs

Review of training content to support improved compliance -Aug 2025

MHA compliance – section 132 – provision of information to patients

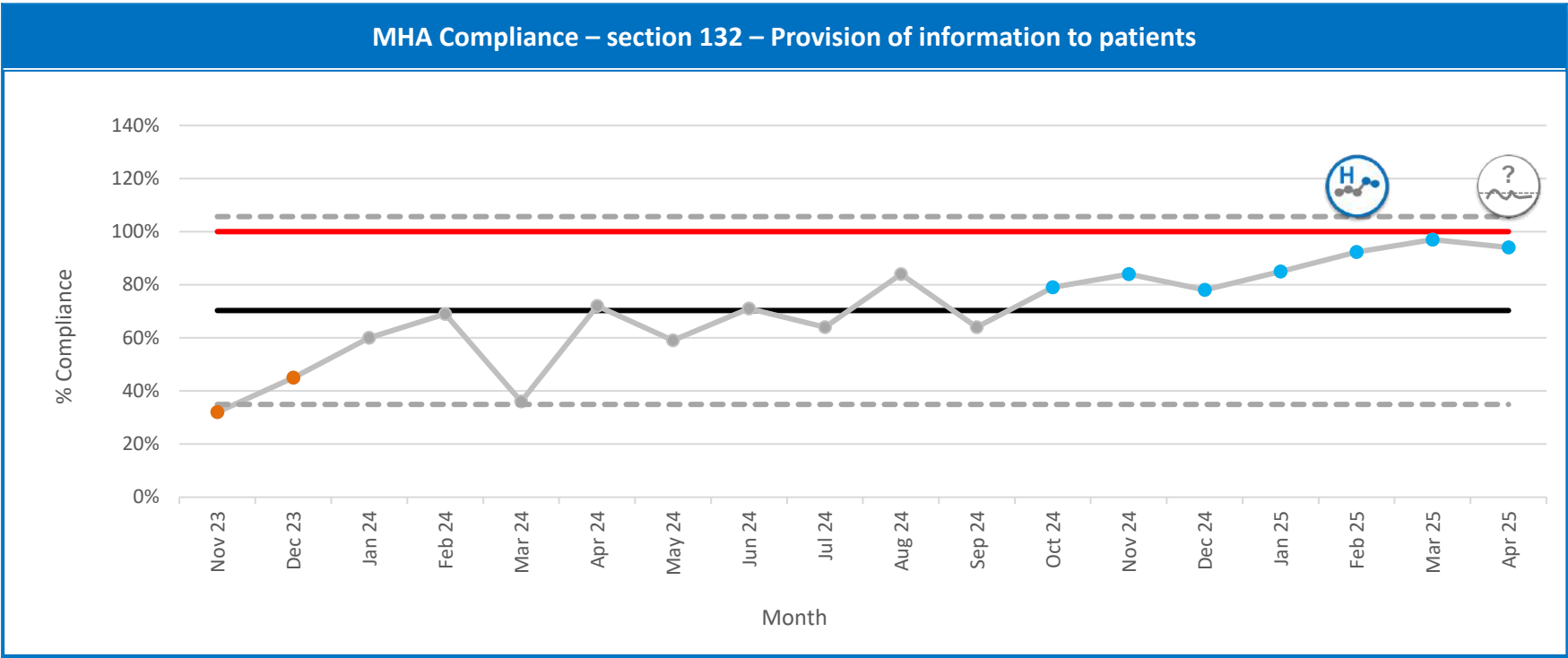
Alert

Not SOF3 metric

Apr-25	Target
94%	100%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
NMGH		100.00%
CSS		100.00%
MRI		94.29%
WTWA		92.31%
Specialist		88.89%
LCO & Dental		



Updates since previous month

94% of patients had received their rights following detention under the Mental Health Act. Continues to be improving trajectory of compliance

Key dependencies

Application of the Mental Health Act

Current issues

65 out of 69 patients detained under a Mental Health Act section received rights within statutory timescales. Assurance review by the Mental Health Act Manager, gaps in compliance is immediately escalated to the ward team for resolution
Followed up and monitored by the Trust Mental Health Act Manager

Future actions

A revised Mental Health Act Training programme to increase knowledge and skills in application of the Delegation of Statutory Functions of the Trust for patients detained under the Mental Health Act Clinical Groups SLT and senior nursing teams being prioritised for the training

Patients detained under MHA missing from hospital care

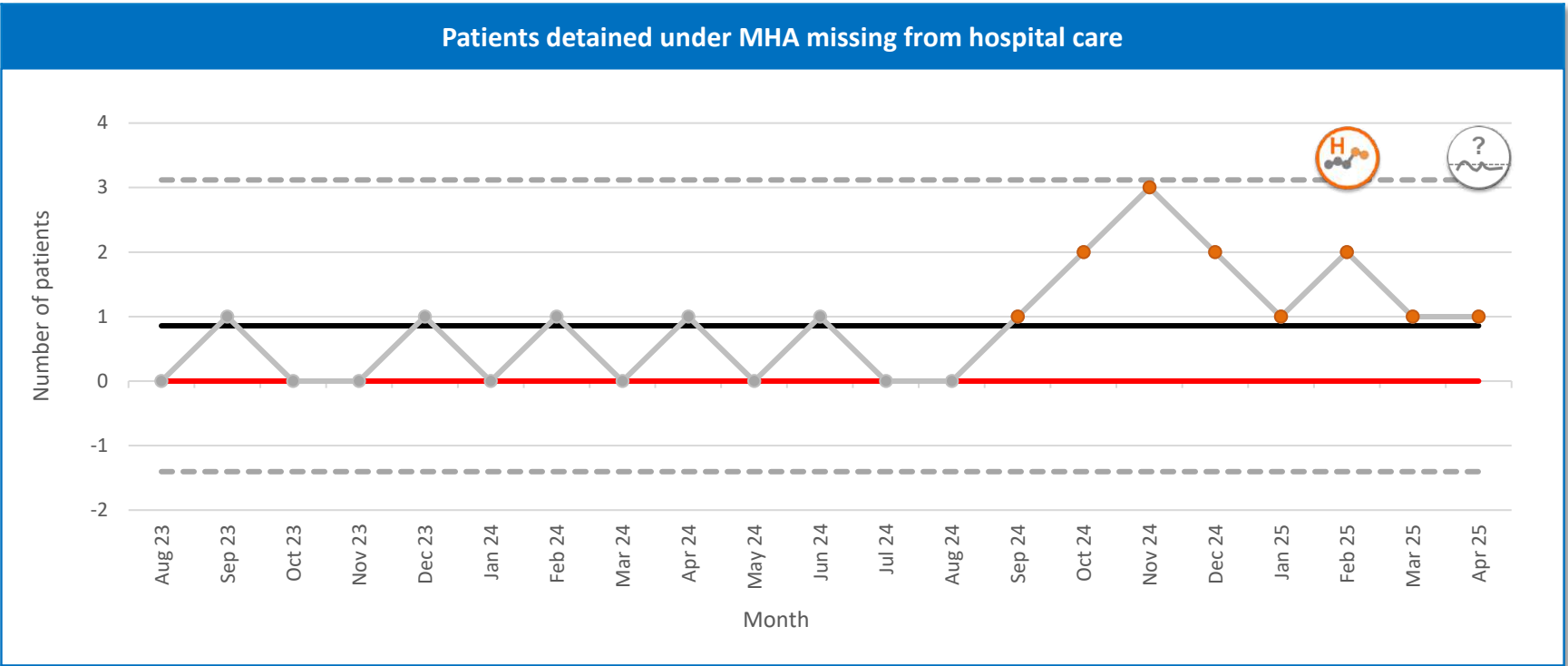
Alert

Not SOF3 metric

Apr-25	Target
1	0

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
NMGH		1
MRI		0
Specialist		0
WTWA		0
LCO & Dental		0
CSS		0



Updates since previous month

There was 1 patient missing from care whilst detained under a MHA section. The patients was located

Key dependencies

Application of The Prevention and Management of Missing Patient Policy is overseen by the Right Care Right Person Task and Finish Group, reporting to the Mental Health subgroup

Current issues

Clinical Groups are focused on delivering least restrictive interventions; however, this can present challenges in supervising patients under detention, occasionally resulting in patients leaving clinical areas.

Future actions

Supporting staff with positive behaviour training and continuing to escalate to Mental Health Trust colleagues to facilitate timely transfers of patient to the right care facility

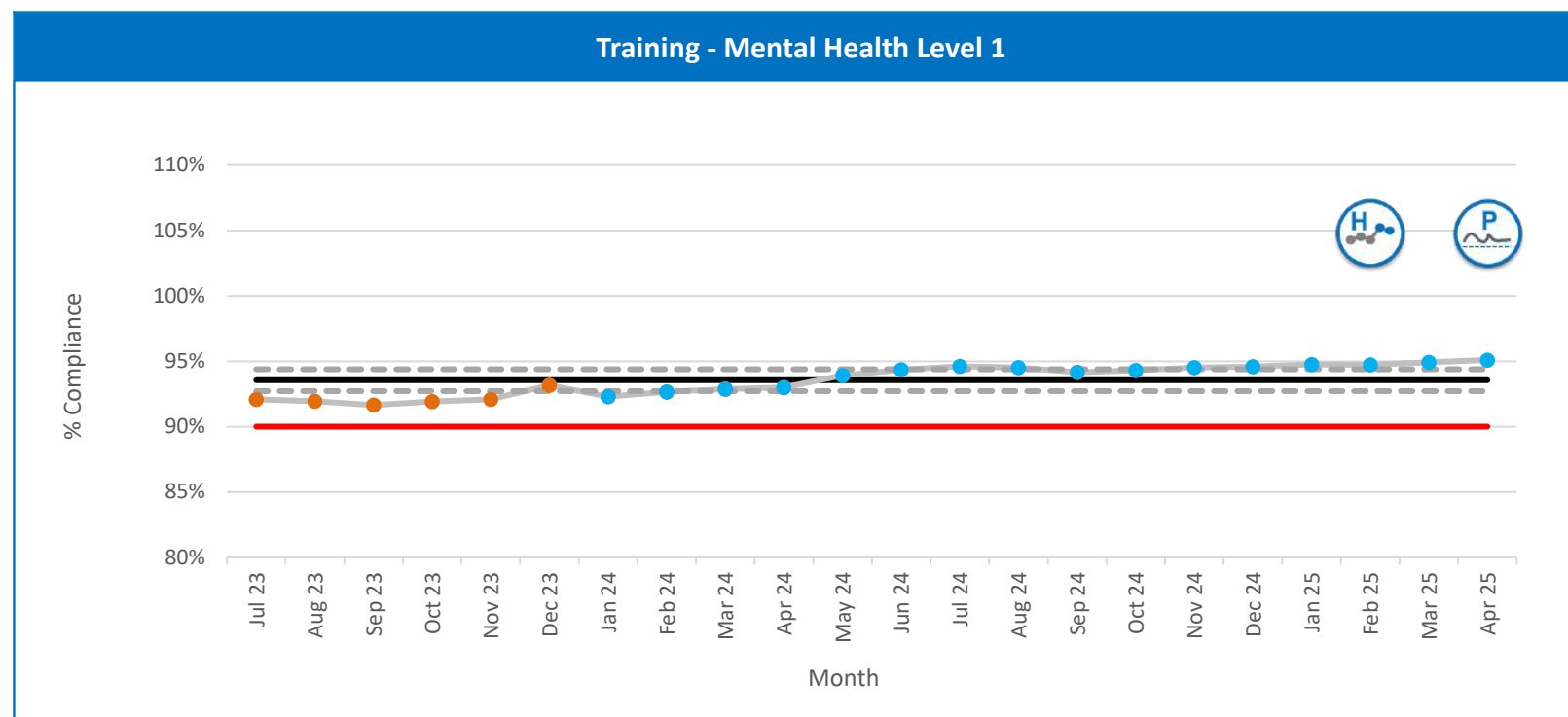
Training - mental health level 1

Assure Not SOF3 metric

Apr-25	Target
95.01%	90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
NMGH	96.20%
Specialist	95.73%
LCO & Dental	95.67%
MRI	94.65%
CSS	94.47%
R&I	94.17%
WTWA	93.71%



Updates since previous month

Training compliance standard is consistently met

Key dependencies

Training compliance is reported to the Mental Health Subgroup

Current issues

Not applicable

Future actions

Continue to monitor performance

Training - mental health level 2

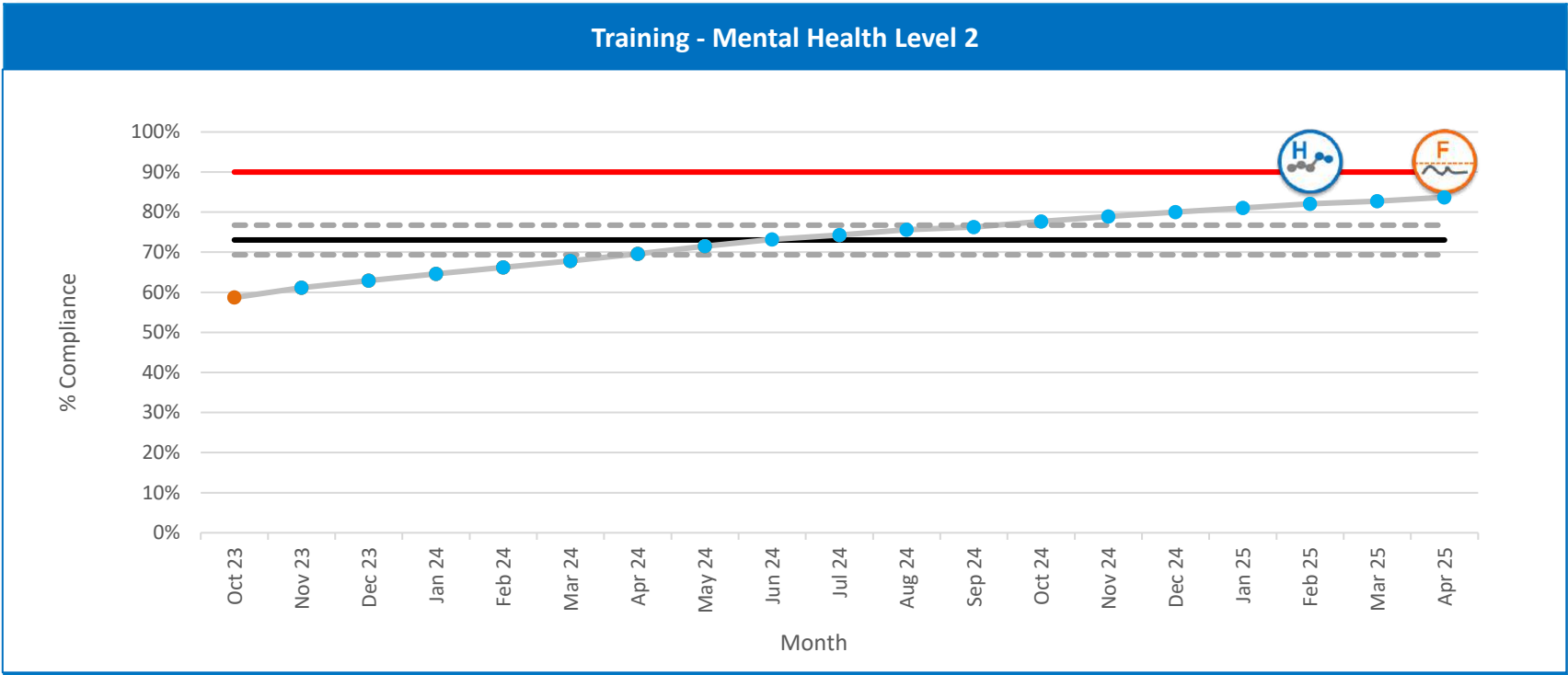
Alert

Not SOF3 metric

Apr- 25	Target
83.71%	90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
NMGH	94.54%
R&I	93.40%
MRI	86.17%
LCO & Dental	84.35%
Specialist	83.80%
WTWA	82.15%
CSS	77.36%



Updates since previous month

Compliance in mental health level 2 training has increased by 1.7 % this month

Key dependencies

Level 2 Mental Health training performance will continue to be monitored through the Mental Health Subgroup as part of the Mental Health Improvement Plan

Current issues

Mental Health Level 2 training is 83.71% and not meeting the Trust 90% compliance standard
CSS currently reports the lowest Clinical Group compliance, highlighting a need for targeted support and oversight

Future actions

Clinical Groups have been requested to produce detailed trajectories and improvement plans to address training performance.-August 2025
Improvement plans will be tracked and monitored through the Mental Health Subgroup

Number of patients detained under section 136 > 24 hours

Advise

Not SOF3 metric

Apr-25

Target

5

0

Compliance	Variance	Assurance	Actions

Clinical Group Overview

NMGH

MRI

WTWA

Specialist

CSS

LCO & Dental

3

2

Number of patients detained under section 136 > 24 hours

Month	Number of patients detained
Dec 23	9
Jan 24	7
Feb 24	9
Mar 24	8
Apr 24	11
May 24	15
Jun 24	5
Jul 24	13
Aug 24	23
Sep 24	17
Oct 24	10
Nov 24	9
Dec 24	5
Jan 25	13
Feb 25	14
Mar 25	10
Apr 25	5

Updates since previous month

5 out of 25 patients detained under a section 136 of the Mental Health Act remained ED over 12 hours

Current issues

A Section 136 Mental Health Act SOP has been ratified and implemented across all EDs, with operational readiness checklists completed to confirm training and communication with all registered nurses and medical and dental staff

Key dependencies

The Mental Health Subgroup is overseeing the section 136 improvement work

Future actions

A Nursing ED Mental Health Escalation Pathway has been developed to support nurses in managing escalation processes for patients awaiting mental health admission. The pathway will be presented to the Mental Health Subgroup in June for ratification following consultation

Page 54

% of people with LD / autism who have evidence of reasonable adjustment within 48 hours of admission

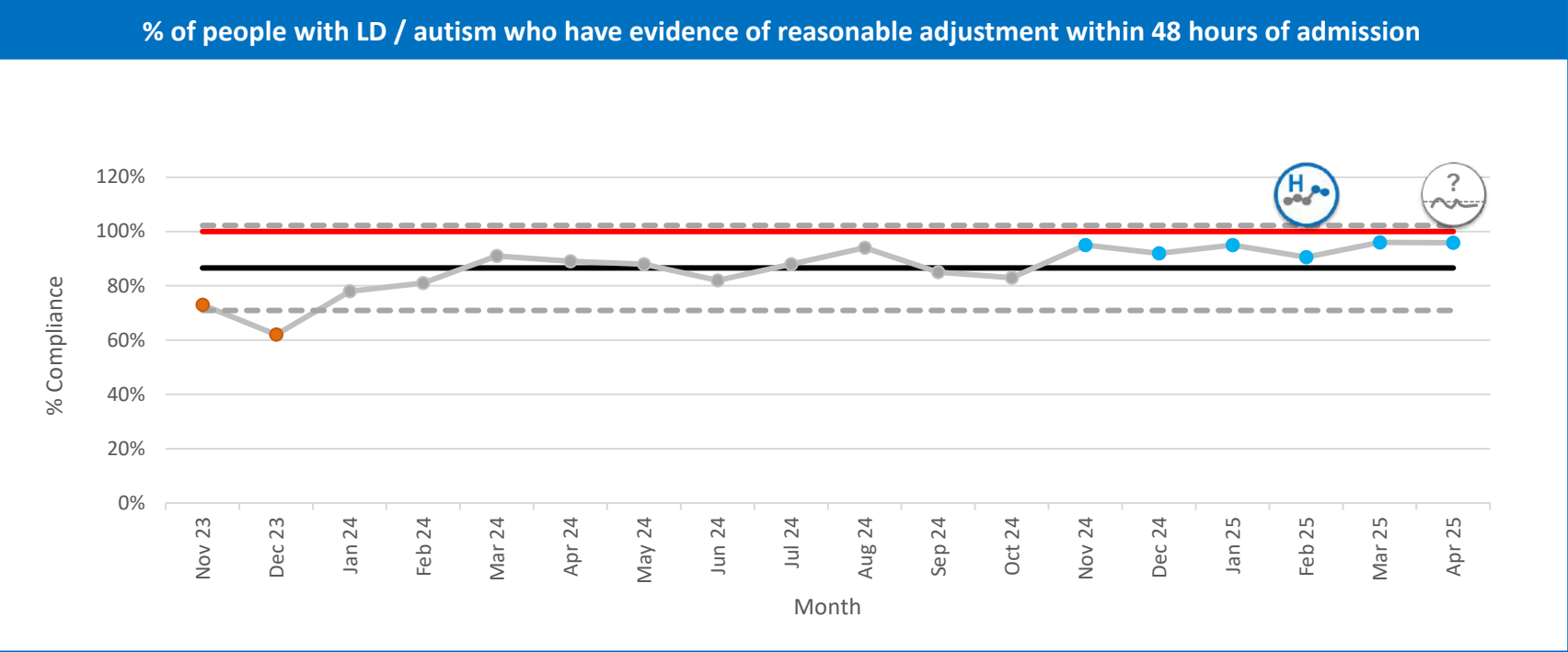
Alert

Not SOF3 metric

Apr-25	Target
95.83%	100%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
Specialist		100.0%
WTWA		100.0%
NMGH		95.2%
MRI		92.5%
CSS		80.0%
LCO & Dental		



Updates since previous month

Increasing compliance with trajectory compliance since November 2024 being over 90%

Key dependencies

Monitoring of performance of completed reasonable adjustments overseen by the Learning Disability Steering Group

Page 55

Current issues

Of 120 patients with a learning disability admitted to MFT hospitals, 5 had no documented evidence of reasonable adjustments in the Hive record. Quality checks are conducted within 48 hours of admission for all patients with an LD/A flag to support appropriate care delivery

Future actions

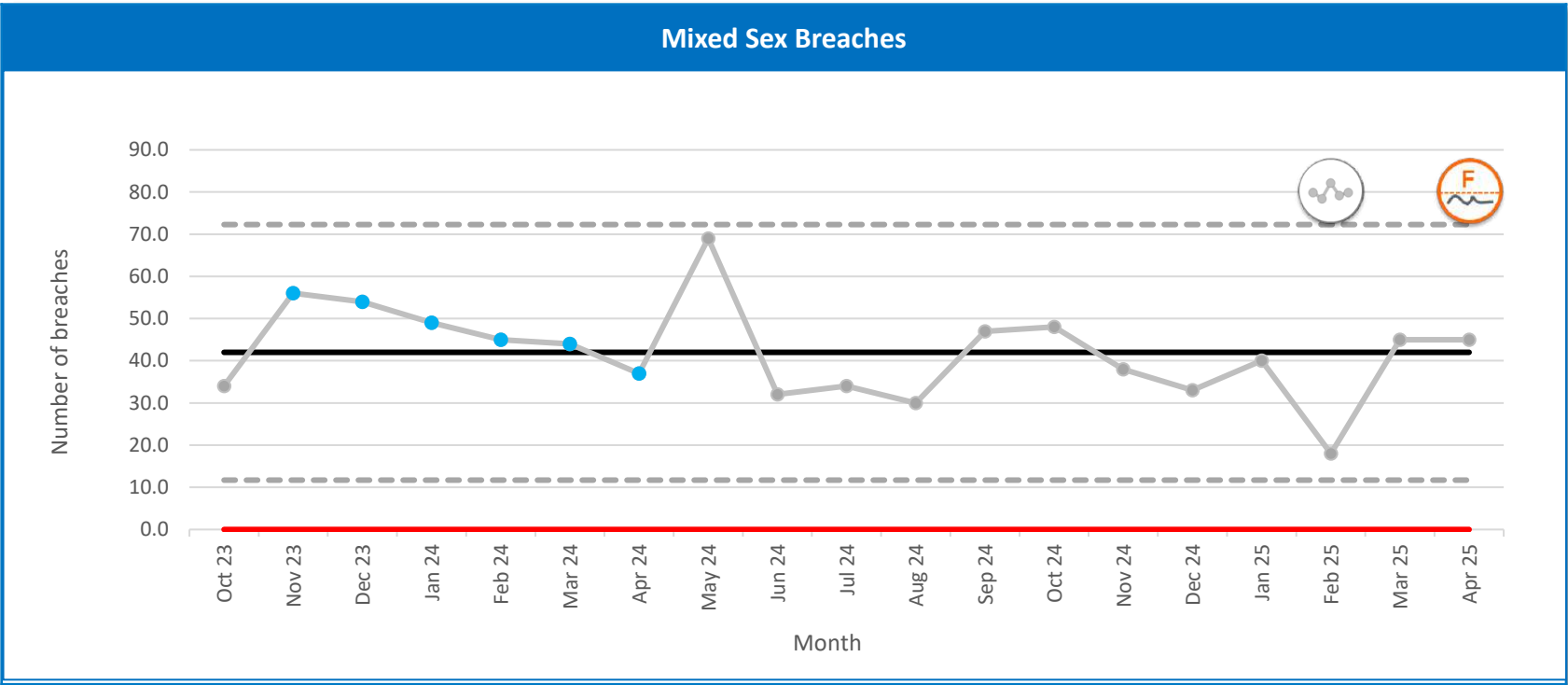
A point prevalence and mapping exercise has been completed in RMCH (June 2025) to inform data collection for assurance reporting, as RMCH is not currently included in routine reporting

Mixed sex breaches

Alert	Not SOF3 metric
Apr-25	Target
45	0

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
MRI	26
WTWA	10
NMGH	9
Specialist LCO & Dental CSS	



Updates since previous month

Increase of 27 breaches this month (^23 in MRI)

Key dependencies

Operational capacity and flow

Current issues

Mixed Sex breaches occur in critical care areas, where breach justification ceases (24 hours post decision to discharge/step down from critical care)

Future actions

Active surveillance ongoing and focused on identifying early contributing factors to the Trust standard not being met

What matters to me (Overall score)

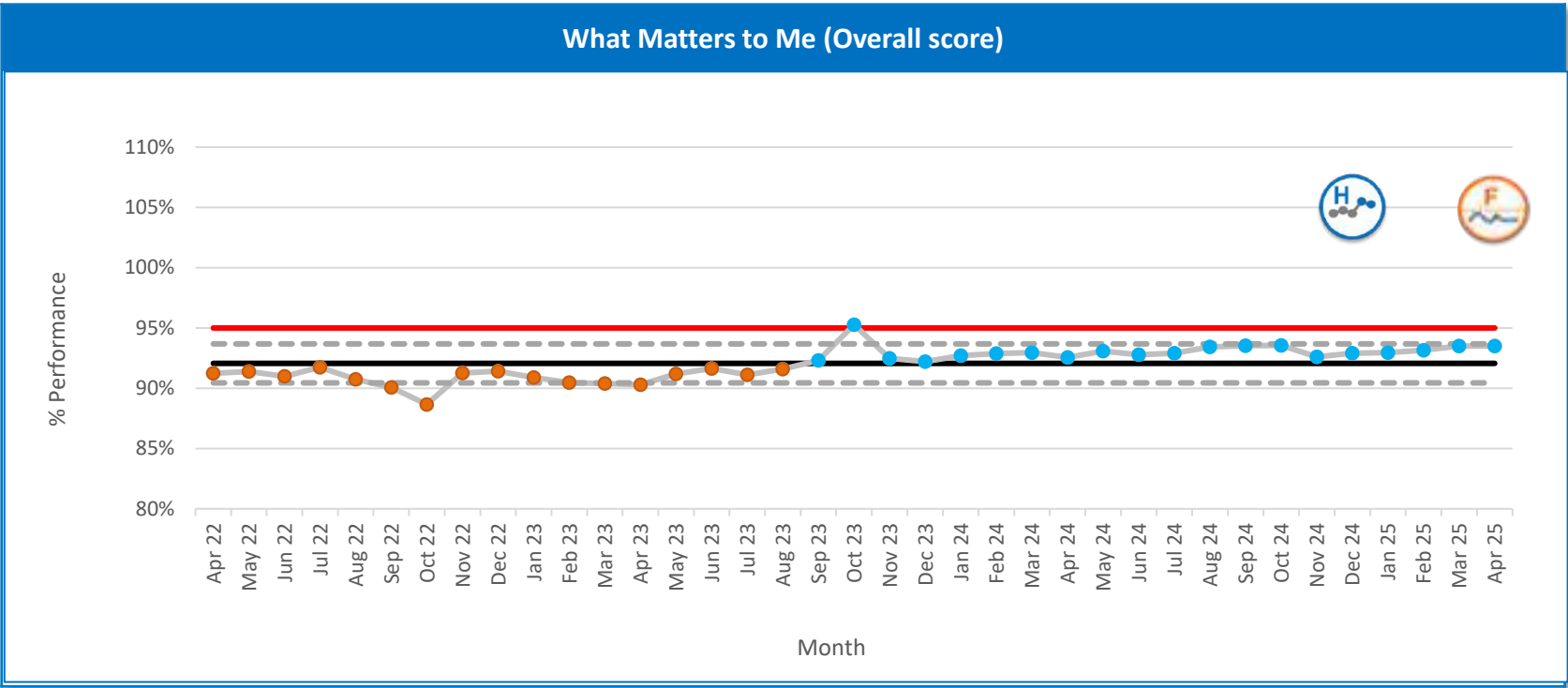
Alert

Not SOF3 metric

Apr-25	Target
93.50%	95%

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
Specialist	96.10%
LCO & Dental	96.02%
WTWA	93.54%
NMGH	92.23%
MRI	91.75%
CSS	90.94%



Updates since previous month

Increase in the overall satisfaction (0.34%)

Key dependencies

Quality and Patient Experience Teams within Clinical Groups hold regular meetings to review QCR, WMTM, and FFT response rates and scores. Positive outcomes reinforce staff engagement and progress against patient experience objectives, supporting a culture of continuous improvement

Current issues

Wi-Fi and connectivity issues reported in parts of the organization, impacting access to digital patient experience data collection

Future actions

Revised RMCH survey went live in March 2025. The Adult Inpatient survey is next to launch, with the go-live date pending confirmation

Friends & family test – Inpatient/Day case

Assure

Not SOF3 metric

Apr-25

Target

95.75%

95%

Compliance

Variance

Assurance

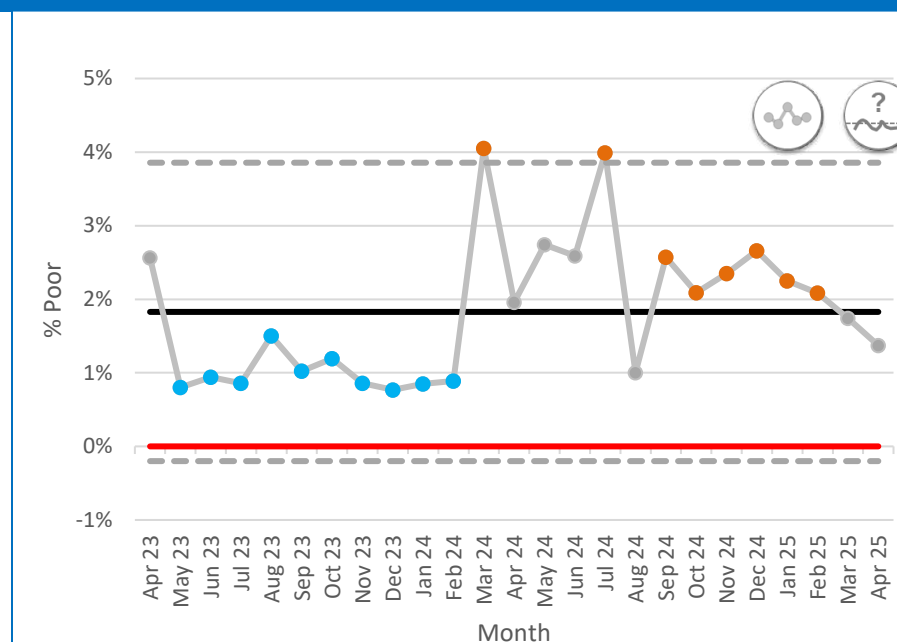
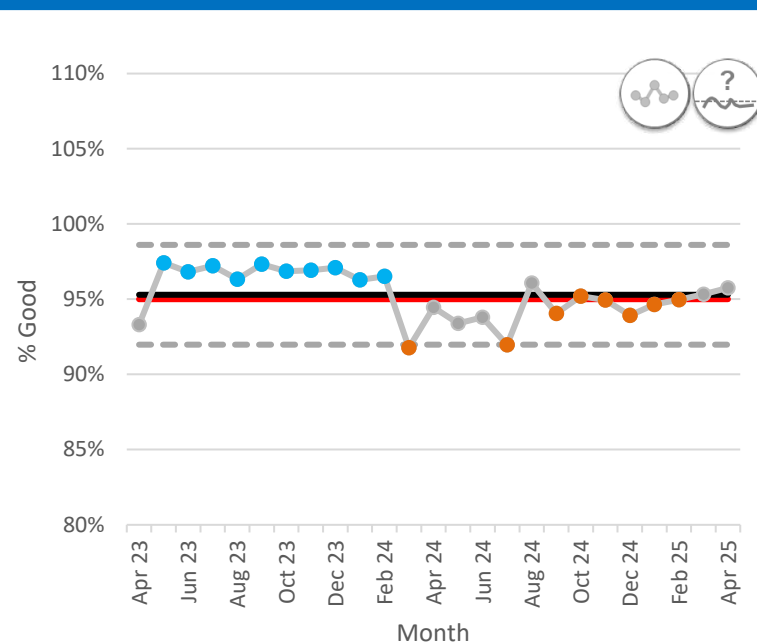
Actions



Clinical Group Overview

IP	% Good	% Poor	Total Responses	Response Rate
LCO & Dental	100.00%	0.00%	9	50.00%
CSS	98.69%	0.00%	153	60.71%
NMGH	97.25%	0.79%	1018	41.65%
Specialist	95.95%	1.82%	1211	31.89%
WTWA	95.10%	1.34%	1570	30.09%
MRI	95.07%	1.57%	1786	18.47%

Friends & Family Test – Inpatient Performance



Updates since previous month

Submission volumes and overall satisfaction have increased, with all Clinical Groups reporting satisfaction rates above 95%

Key dependencies

Quality Patient Experience Team, supported by Trust Patient Experience Officers, will continue to work with Clinical Groups to maintain or improve patient experience scores, tailored to the needs of each area

Page 58

Current issues

Ongoing Wi-Fi connectivity issues in parts of the Trust continue to affect access to data collection systems, contributing to reduced staff engagement and participation in key processes

Future actions

Variability in response rate across clinical groups, ranging from 18.47% (MRI) to 60.71% (CSS), highlighting a need for continued engagement efforts. A redesigned patient experience feedback survey, now incorporating FFT as the first question, is being implemented to support improved response rates and data quality

Friends & family test – Emergency Department

Alert

Not SOF3 metric

Apr-25

Target

83.89%

95%

Compliance



Variance



Assurance



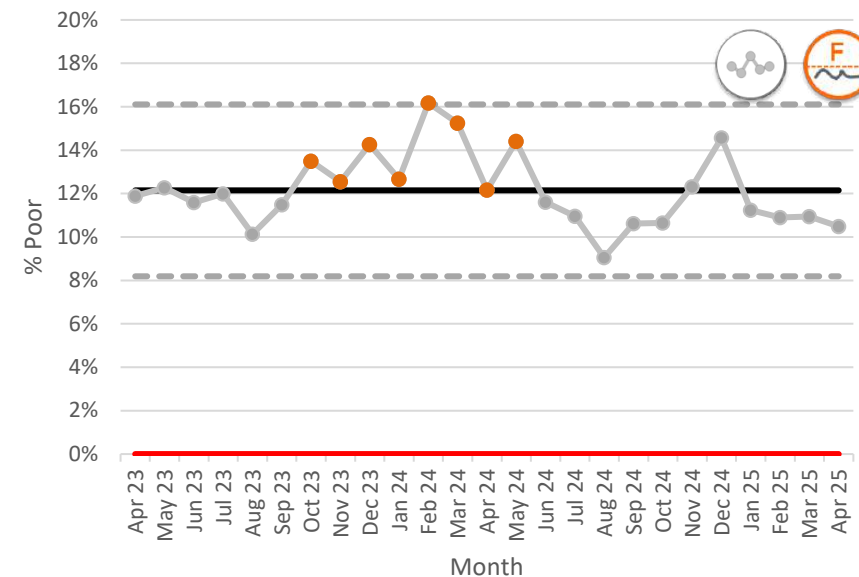
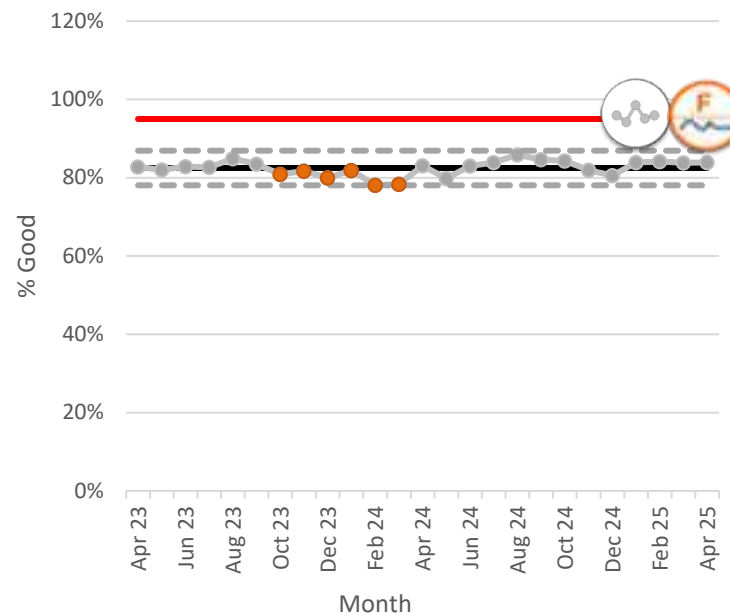
Actions



Overview

ED	% Good	% Poor	Total Responses	Response Rate
UDHM	100.00%	0.00%	18	19.15%
MREH	96.94%	1.02%	392	15.48%
WTWA	96.23%	9.16%	1866	13.28%
SMH	86.11%	5.56%	36	3.87%
RMCH	85.81%	10.23%	303	7.06%
NMGH	81.15%	12.09%	976	9.47%
MRI	79.82%	13.16%	1908	15.71%

Friends & Family Test – ED Performance



Updates since previous month

Decrease in overall satisfaction (0.24%) there has been a positive increase in overall response volumes
Trends monitored through Clinical Group IPRs to inform improvement actions and engagement strategies

Key dependencies

As part of the UEC workstreams a specific WMTM survey will be developed for ED departments provide detailed feedback to improve overall WMTM and FFT scores

Current issues

Overall themes include 'waiting'.
Work is being undertaken to reduce the wait time in ED and increase patient flow across the Trust

Future actions

Education from the Patient Experience Team remains a key theme across Clinical Groups, and the Volunteer Service continues to provide support within departments

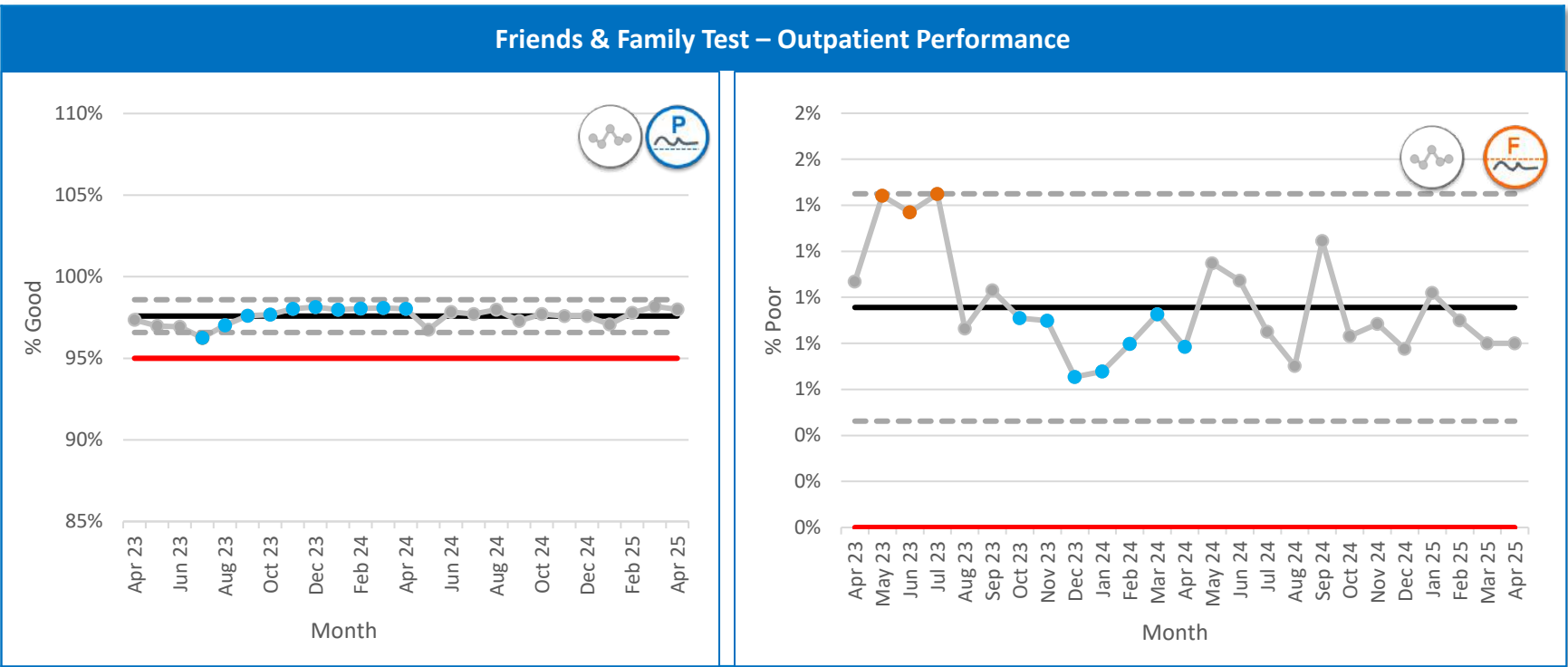
Friends & family test – Outpatient

Assure	Not SOF3 metric

Apr-25	Target
97.99%	95%

Compliance	Variance	Assurance	Actions

Clinical Group Overview			
OP	% Good	% Poor	Total Responses
LCO & Dental	99.14%	0.00%	348
NMGH	98.67%	0.27%	377
MRI	98.28%	0.53%	2262
CSS	98.12%	0.26%	390
WTWA	98.09%	1.28%	941
Specialist	97.28%	1.20%	1915



Updates since previous month

The data evidences a consistently positive score for outpatient departments with all Clinical Groups consistently achieving above the 95% target

Key dependencies

Effective communication, timely scheduling, staff engagement, and reliable digital systems remain key dependencies—aligned to the overarching objective of improving patient engagement and satisfaction in outpatient services

Current issues

No current issues. The outpatient areas in Clinical Groups improve and sustain patient experience and patient satisfaction scores

Future actions

The Patient Experience Team has delivered education on the value of patient feedback. Volunteers are supporting FFT completion in departments, including promoting use of the MTMFT app to improve response rates and satisfaction scores

Friends & family test – Community Services

Assure	Not SOF3 metric

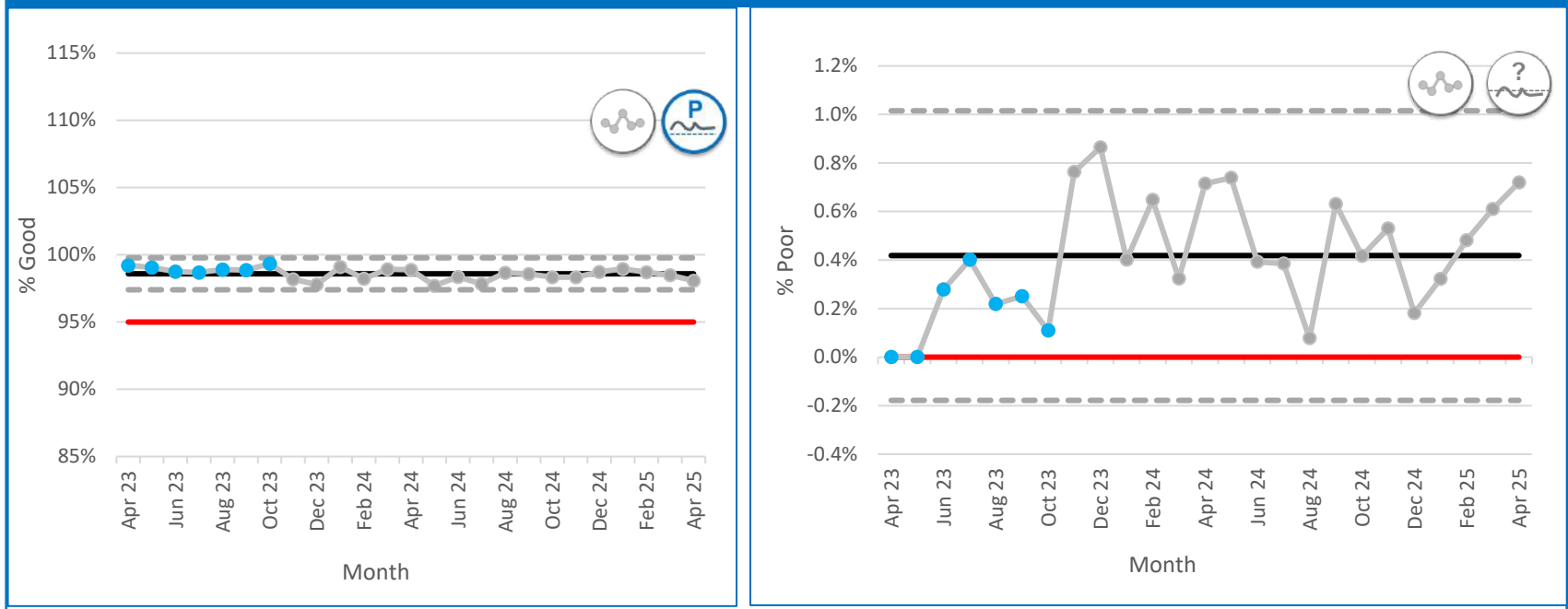
Apr-25	Target
98.08%	95%

Compliance	Variance	Assurance	Actions

Service Overview

Community	% Good	% Poor	Total Responses
Specialist Services	100.00%	0.00%	47
Community Nursing Services	98.43%	0.39%	511
Rehabilitation & Therapy Services	98.32%	1.26%	238
Community Healthcare Other	97.77%	0.74%	404
Community Inpatients	96.61%	0.00%	59
Children & Family Services	87.50%	12.50%	8

Friends & Family Test – Community Performance



Updates since previous month

Compared to previous months, there has been a decline response volumes across Community Services influenced by the implantation of a mid point cut off date for data submission in University Dental Hospital Manchester

Key dependencies

Review of FFT completion as part of the Clinical Accreditation process

Current issues

Wi-Fi connectivity issues in the bed base areas for the LCO. Wi-Fi booster devices have been fitted in the bed-based areas and FFT cards/QR codes are predominantly used in patients' homes

Future actions

Further actions include continued promotion of the survey to improve response volumes and representation, supported by staff engagement and volunteer assistance

Friends & family test –TP1 – Antenatal Care

Assure

Not SOF3 metric

Apr-25

Target

95.14%

95%

Compliance

Variance

Assurance

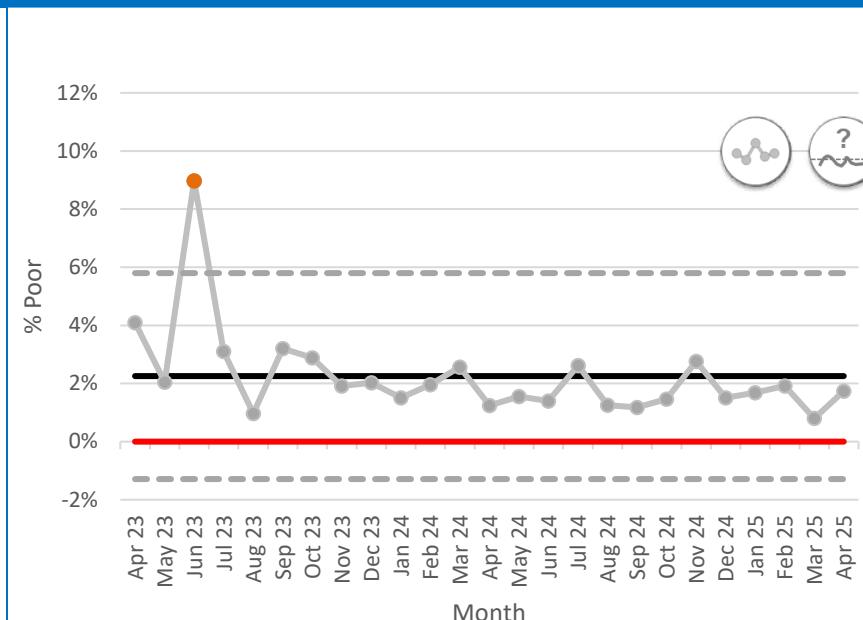
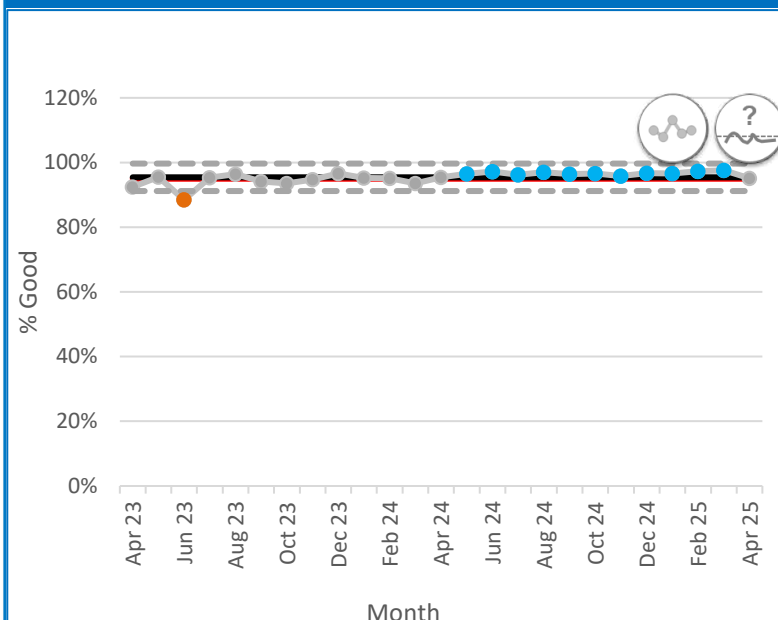
Actions



Site Overview

TP1	% Good	% Poor	Total Responses
TGH	100.00%	0.00%	27
NMGH	97.14%	0.95%	105
WYTH	94.83%	3.45%	58
SMH	91.84%	2.04%	98
LANCE BURN (Salford)	-	-	0
Overall	95.14%	1.74%	288

Friends & Family Test – Antenatal Care



Updates since previous month

The data indicates an improving picture. All areas above or just below the Trust Target of 95% with only two areas receiving poor feedback

Key dependencies

Continue to work with Maternity Network Voices Partnership to gain feedback to improve services

Current issues

Not applicable

Future actions

A new Patient Experience survey is in the final stages of development which will focus on a woman's antenatal journey. It is anticipated that the FFT survey will be incorporated, in addition to existing modes of collection, and provide an increase in responses

Friends & family test –TP2 – Birth

Assure

Not SOF3 metric

Apr-25

Target

98.52%

95%

Compliance

Variance

Assurance

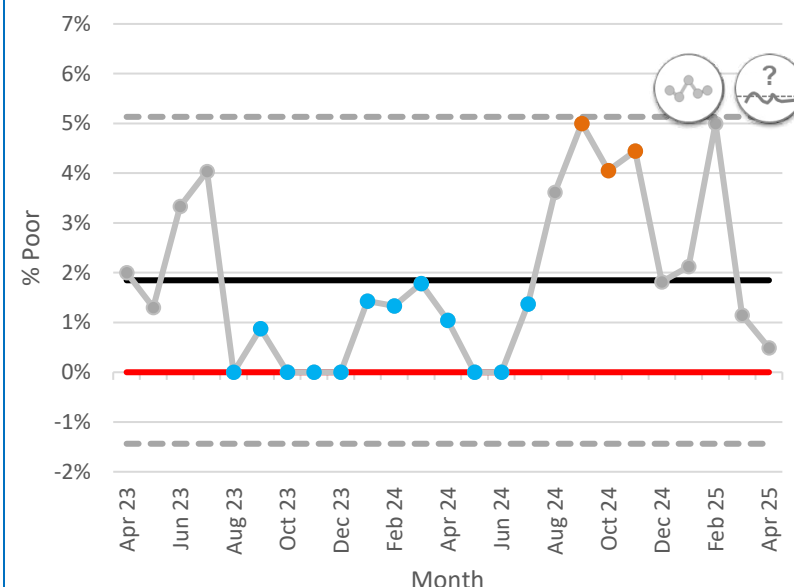
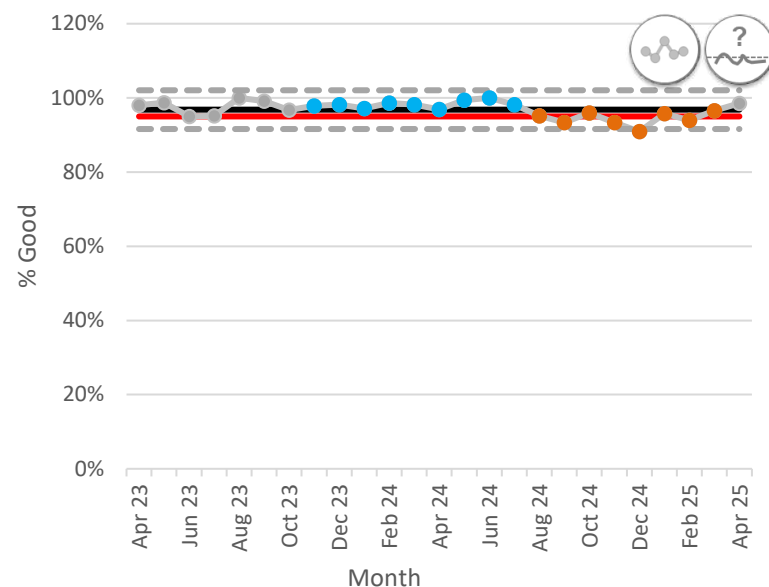
Actions



Site Overview

TP2	% Good	% Poor	Total Responses	Response Rate
WYTH	100.00%	0.00%	86	8.70%
NMGH	97.75%	0.00%	89	12.20%
SMH	96.43%	3.57%	28	1.85%
Overall	98.52%	0.49%	203	6.32%

Friends & Family Test – Birth



Updates since previous month

The response rate has increased by over 3% from the previous month and the overall satisfaction has increase by 2%

Current issues

Collecting feedback from maternity patients presents challenges The immediate post-partum period can be a sensitive time for new mothers, making them reluctant to provide feedback or find the time to do so

Key dependencies

Review of FFT completion as part of the Clinical Accreditation process and to review the woman's journey overall

Future actions

A new Patient Experience survey is in the final stages of development which will focus on a woman's Birth & Postnatal journey, to be received following discharge. It is anticipated that the FFT survey will be incorporated, in addition to the current modes of collection, and provide an increase in responses

Friends & family test –TP3 – Care on Postnatal Ward

Assure

Not SOF3 metric

Apr-25

Target

95.06%

95%

Compliance

Variance

Assurance

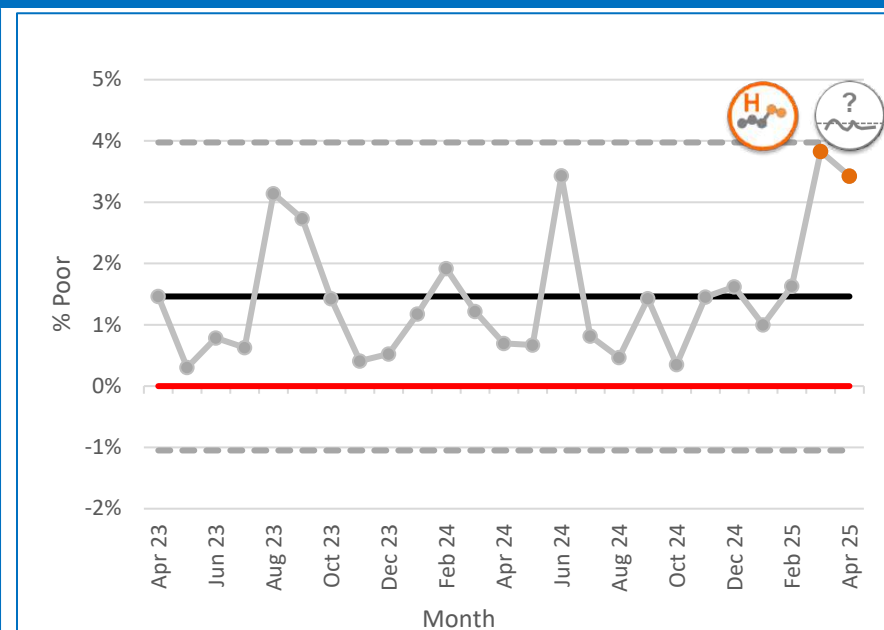
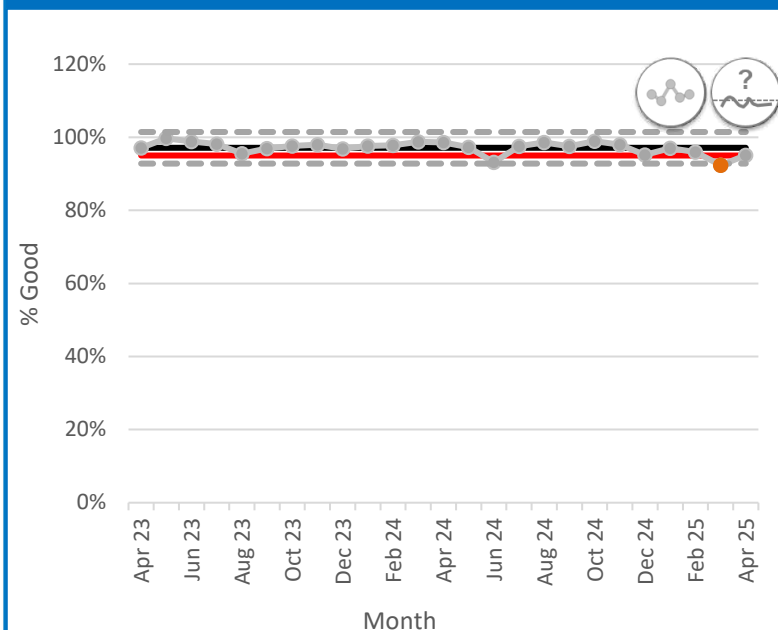
Actions



Site Overview

TP3	% Good	% Poor	Total Responses
WTWA	99.17%	0.00%	120
NMGH	95.83%	4.17%	24
ORC	93.48%	4.66%	322
Overall	95.06%	3.43%	466

Friends & Family Test – Care on Postnatal Ward



Updates since previous month

Friends & Family Test for care on the Postnatal Ward achieved 95.06% good responses in April meeting the 95% standard
Increase in positive responses and a corresponding decrease in negative feedback in comparison to March data

Key dependencies

Review of FFT completion as part of the Clinical Accreditation process and to review the woman's journey

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Current issues

Collecting feedback from maternity patients presents challenges. The immediate post-partum period can be a sensitive time for new mothers, making them reluctant to provide feedback or find the time to do so

Future actions

A new Patient Experience survey is in the final stages of development which will focus on a woman's Birth & Postnatal journey, to be received following discharge. It is anticipated that the FFT survey will be incorporated, in addition to the current modes of collection, and provide an increase in responses

Friends & family test – Maternity TP4 – postnatal community provision

Assure

Not SOF3 metric

Apr-25

Target

100%

95%

Compliance

Variance

Assurance

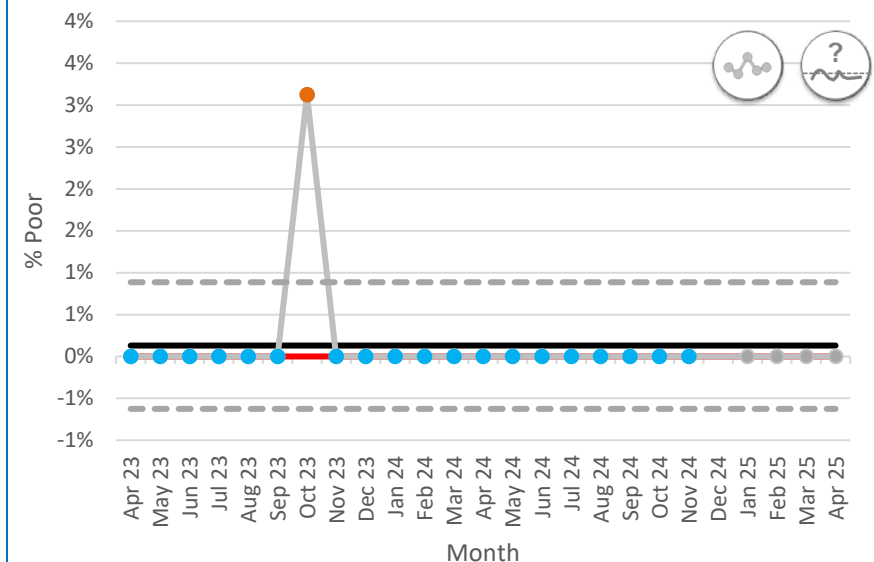
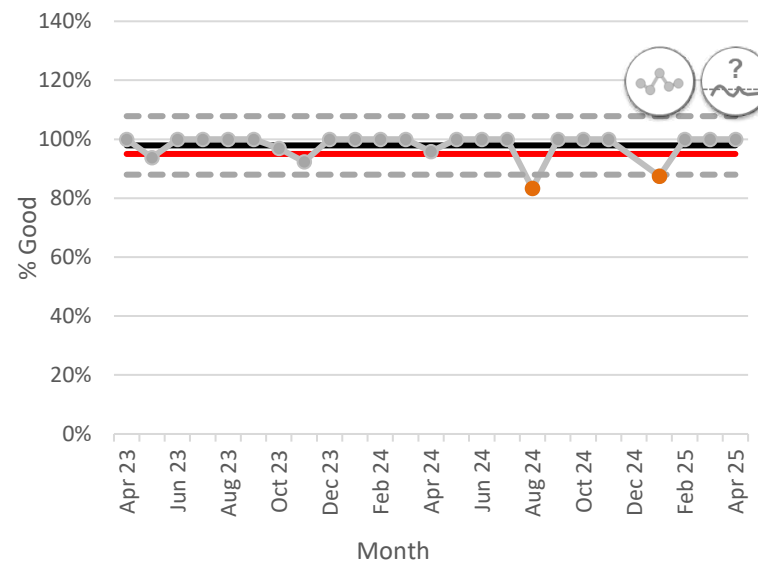
Actions



Site Overview

TP4	% Good	% Poor	Total Responses
NMGH	100%	0%	1
ORC	100%	0%	3
WTWA	-	-	0
Overall	100%	0%	4

Friends & Family Test – Postnatal Community Provision



Updates since previous month

All submitted responses reported no poor service
Overall submission rates remain low and require improvement

Current issues

There has been a continued decline in the number of responses within maternity since July 2024 despite an increased focus during Q4 supporting women to complete FFT at home, using QR codes and cards

Key dependencies

Review of FFT completion as part of the Clinical Accreditation process and to review the woman's journey overall

Future actions

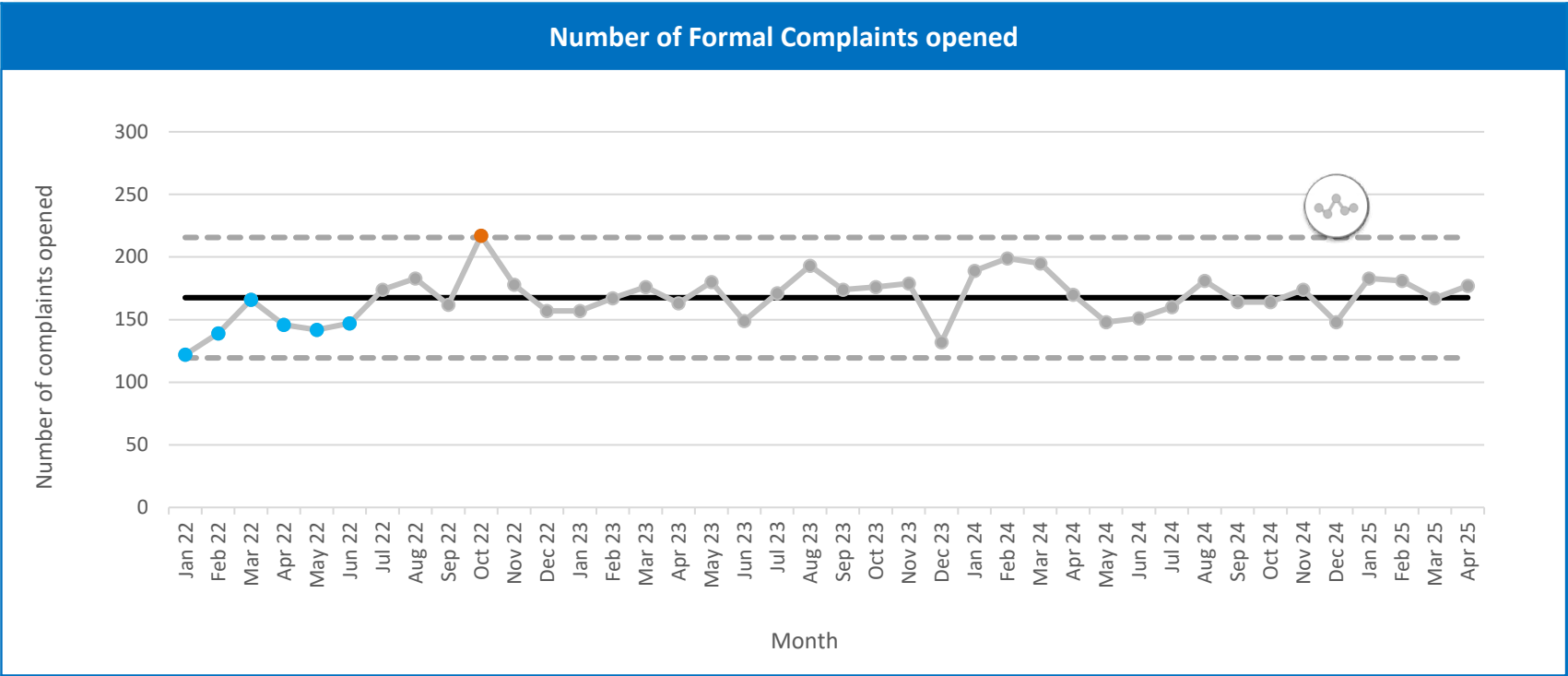
A new Patient Experience survey is in the final stages of development which will focus on a woman's Birth & Postnatal journey, to be received following discharge

Number of formal complaints opened

Advise	Not SOF3 metric
Apr-25	Target
177	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	61
WTWA	38
MRI	34
NMGH	21
CSS	10
LCO & Dental	5



Updates since previous month
177 received in April 2025 compared to 167 in March 2025 The volume of formal complaints opened has remained stable with no significant increase or reductions observed
Key dependencies
Continued engagement from the Clinical Groups in relation to identify opportunities to de-escalate and resolve complaints early whilst achieving positive outcomes for patients and relatives

Current issues
Increased number of complaints relating to communication, which could be resolved through early senior compassionate engagement
Future actions
A Trust-wide roll-out of a standardized approach to complaint handling and early resolution is underway, following ratification of the updated Complaints Policy. Clinical Groups are monitoring performance and implementing local action plans to support consistent delivery

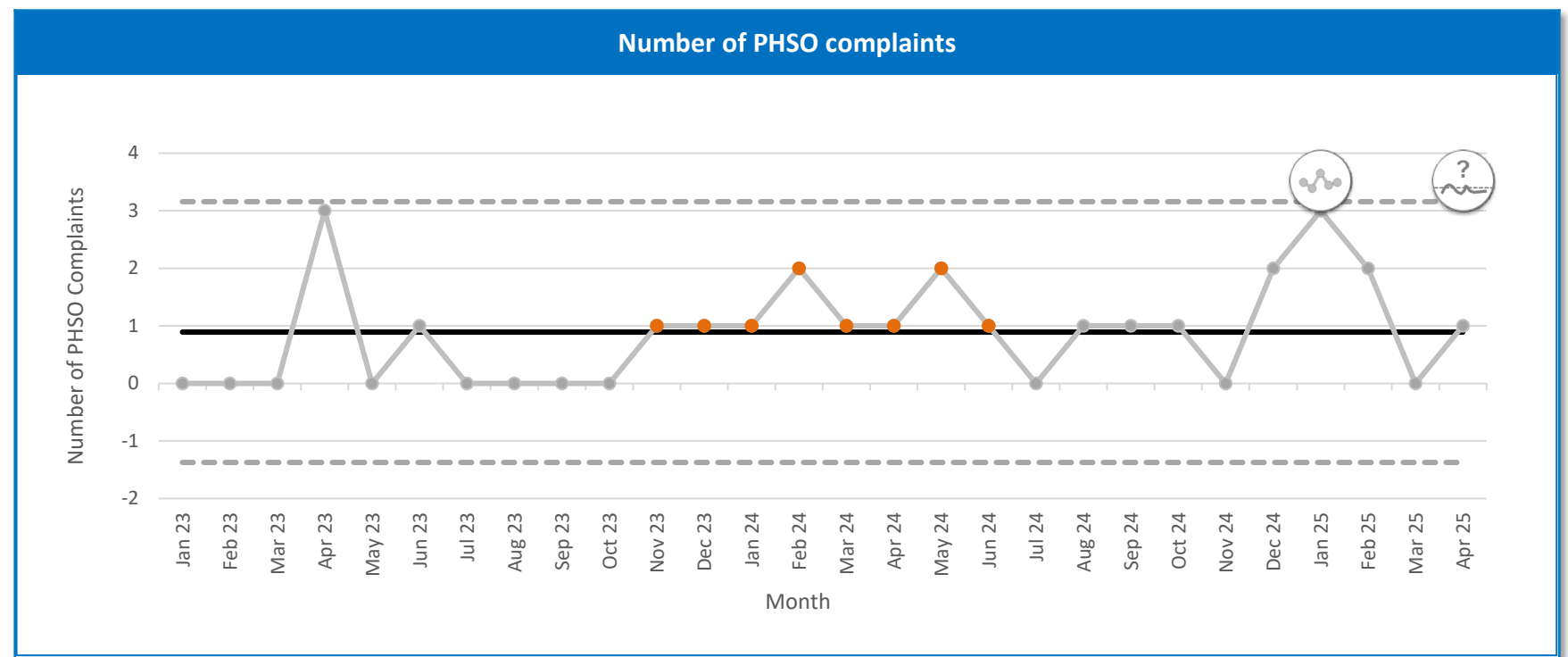
Number of PHSO complaints

Advise Not SOF3 metric

Apr-25	Target
1	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	1
MRI	
LCO & Dental	
NMGH	
WTWA	
CSS	



Updates since previous month

The Parliamentary and Health Service Ombudsman (PHSO) commenced an investigation into one Specialist Hospitals complaint in April

Current issues

Not applicable

Key dependencies

Clinical Groups remain actively engaged to meet required for PHSO responses

Future actions

Complaints Management Team attending the PHSO stakeholder event in June to strengthen local resolution processes and prevent cases escalating to the PHSO

Number of reopened (not new) complaints

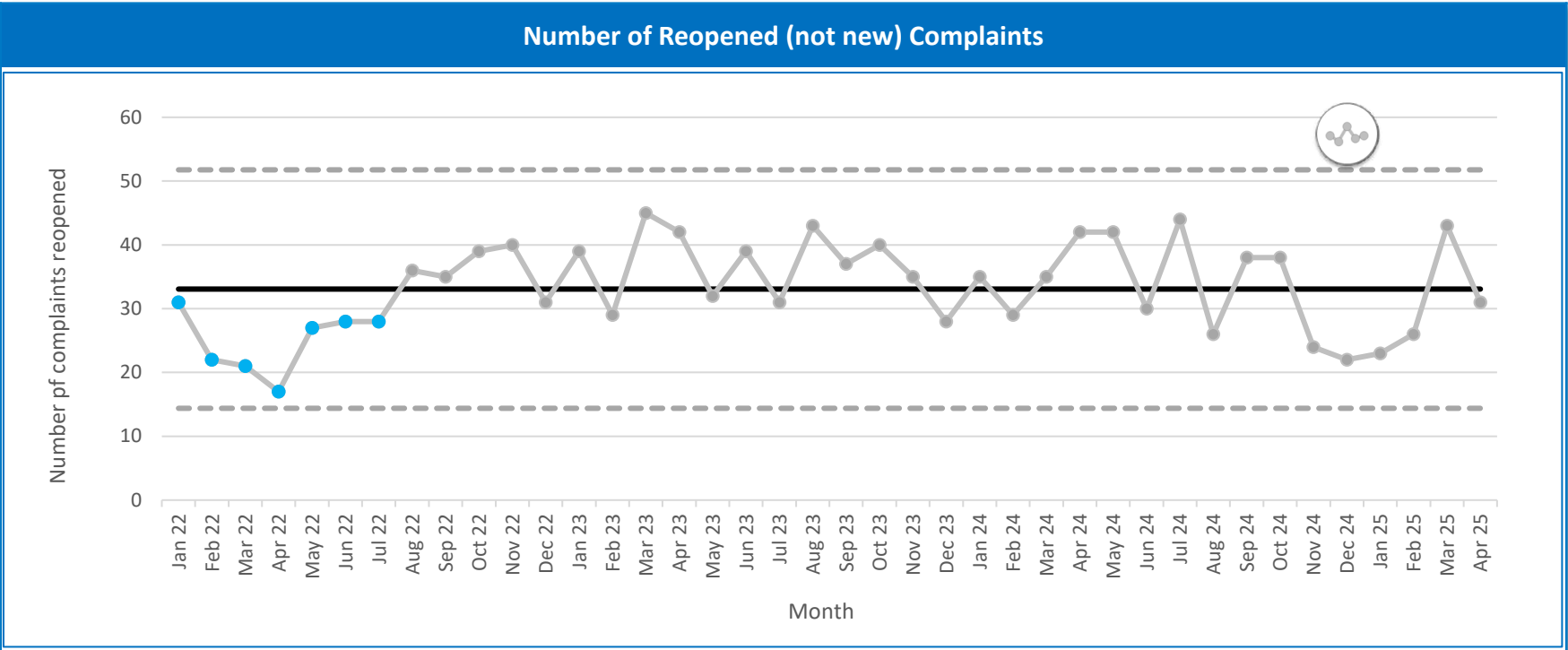
Advise

Not SOF3 metric

Apr-25	Target
31	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	9
WTWA	7
NMGH	6
MRI	3
LCO & Dental	3
CSS	2
Corporate	1



Updates since previous month

The number of re-opened complaints decreased from 43 in March to 31 in April. Specialist Hospital continues to report the highest number of re-opened complaints- improvement plan presented to the Complaints Scrutiny Panel in June

Key dependencies

PALS and complaints training-1052 colleagues attended early resolution training 24/25- monthly session planned 25/26-tracked by Complaints Management team
 Increase in number of complaint local resolution meetings (LRMs) to compassionately engage with patients and families and resolve complaints first time

Current issues

Majority of re-opened complaints due to new questions being raised following the complaint investigation indicating a need to strengthen the clarity and completeness of original responses

Future actions

Re-opened complaint responses reviewed in Complaints Review Scrutiny Group (CRSG) -identify opportunities for shared learning and improvement
 Clinical Group attend CRSG to present plans and review impact

Closed complaints in month (theme)

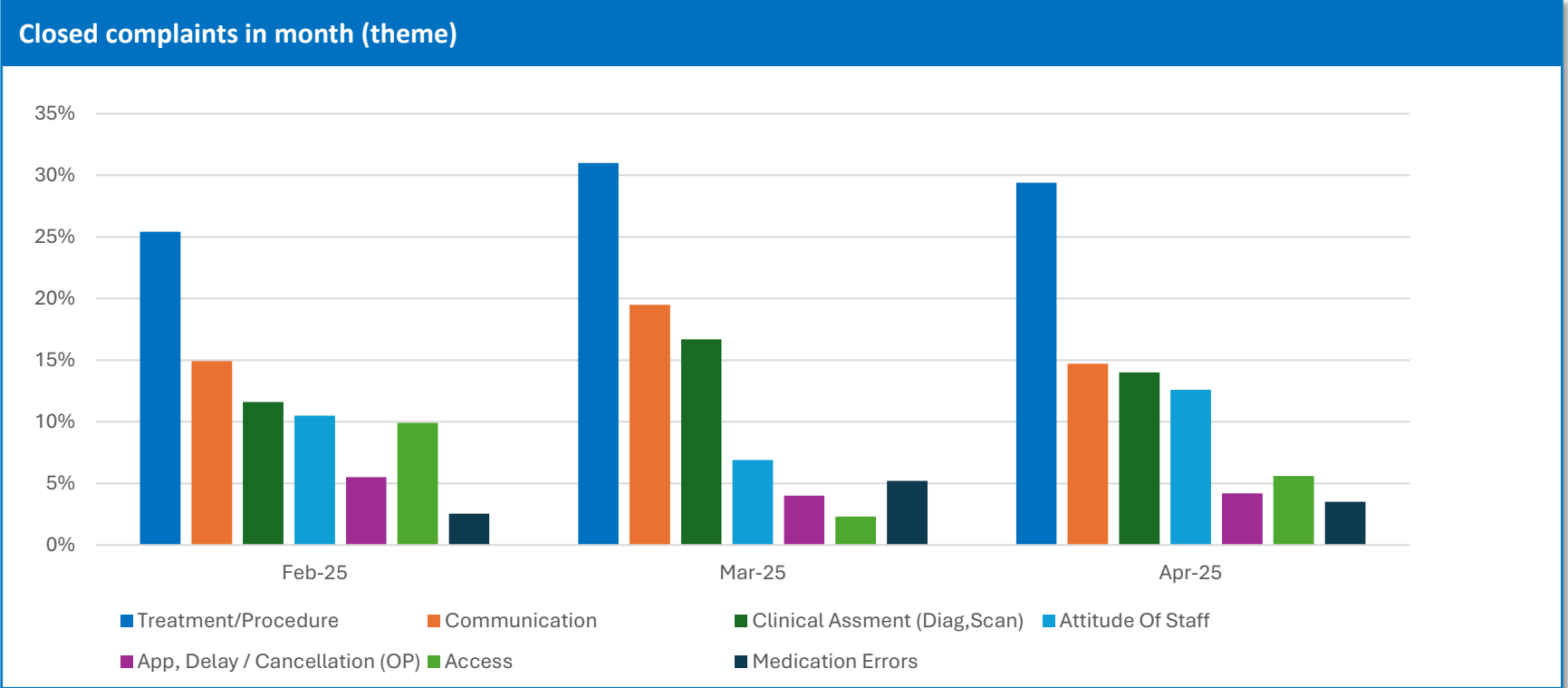
Advise

Not SOF3 metric

Apr-25	Target
N/A	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview



Updates since previous month

April 2025, 'Treatment/Procedure' remained the most common theme among closed complaints, reduced from March

Attitude of Staff increased compared to the previous month

Key dependencies

Trust wide learning from complaints shared through weekly patient safety panel

Digital First Appointment Project

Page 69

Current issues

Increase in complaints related to staff attitude and access to services

Staff engagement and communication training continue across Clinical Groups

Future actions

PALS and Complaints Management to collaborate with Patient Experience Team to identify further opportunities to improve staff communication and engagement with patients and families, in addition to Civility Saves Lives and Sage and Thyme communication training

% Complaints resolved in agreed timescale

Advise

Not SOF3 metric

Apr-25

Target

93.01%

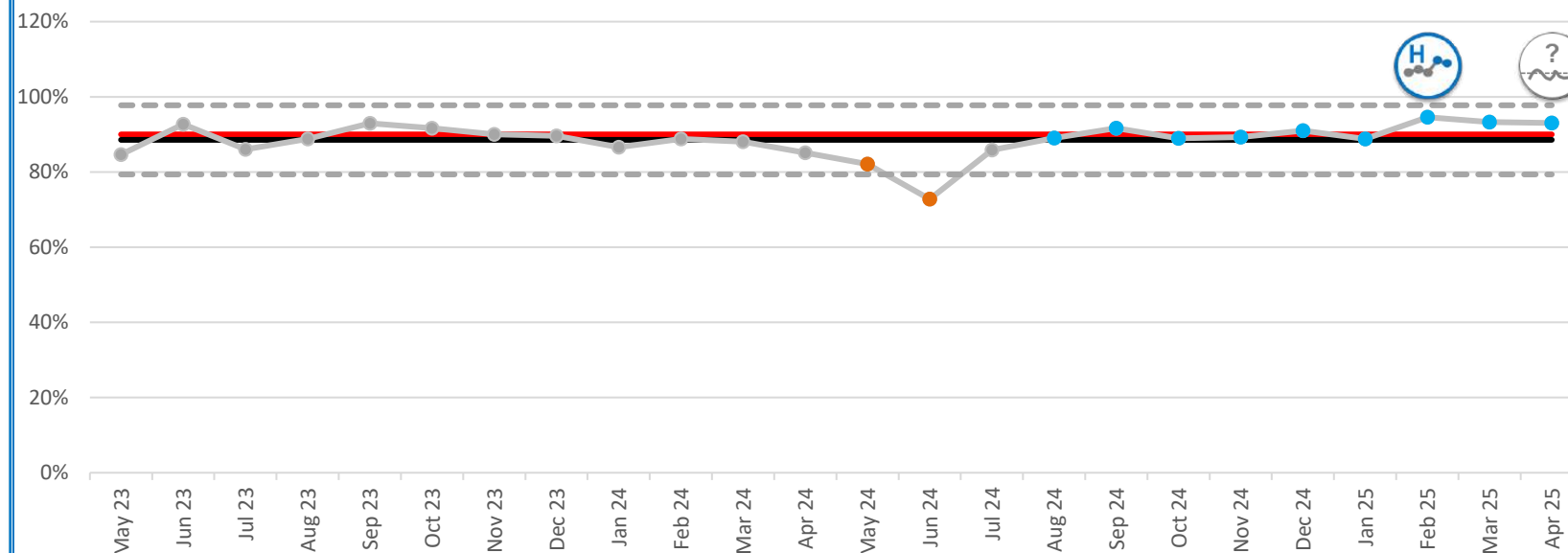
90%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

CSS	100.00%
LCO & Dental	100.00%
MRI	100.00%
WTWA	100.00%
NMGH	96.15%
Specialist	77.42%
Corporate	33.33%

% Complaints resolved in agreed timescale



Updates since previous month

Meeting Trust standard. Specialist Hospital performance is below Trust standard
Corporate performance of 33% relates to 3 complaints in Information Governance-escalated to the Deputy Chief Informatics Officer-complaints closed

Key dependencies

Collaboration across teams, supported by regular monitoring and escalation through Clinical Group IPRs

Current issues

Corporate complaints cover all departments; performance issue in April was a result of 3 complaints that exceeded timescale within the Information Governance Department

Future actions

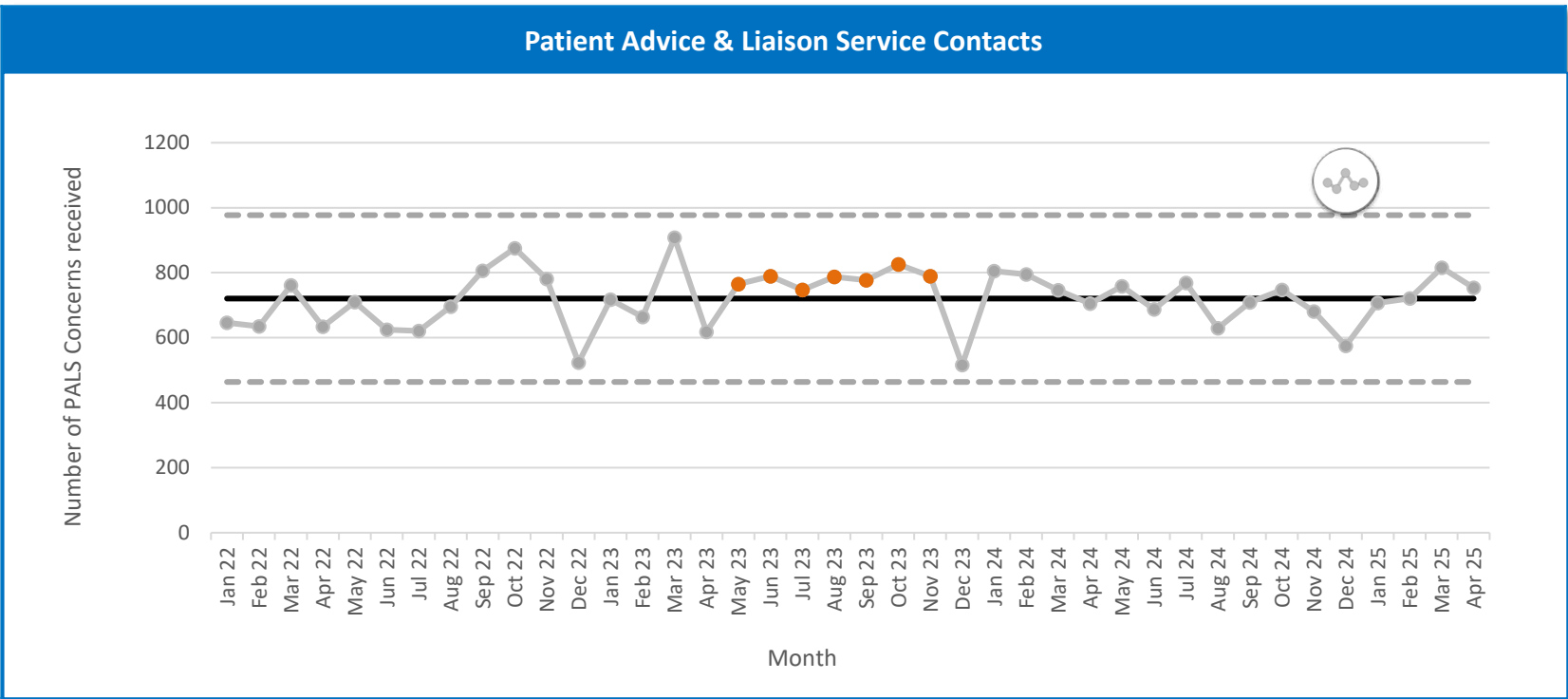
Information Governance complaints are being managed through a completion plan with weekly monitoring in place. Early escalation to the Chief Nursing Officer (CNO) is initiated where delays or risks to timeliness are identified

Patient advice & liaison service contacts

Advise	Not SOF3 metric
Apr-25	Target
754	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	227
MRI	166
WTWA	152
NMGH	102
CSS	59
LCO & Dental	27



Updates since previous month

There was a decrease in the number of PALS contacts, with 754 received in April (decreased from 815 in March) which could indicate improved resolutions at point of care

Current issues

Patients and families signposted to PALS for some concerns which could be resolved directly by staff at ward/department level

Key dependencies

PALS early resolution training -1052 colleagues attended early resolution training 24/25- monthly session planned 25/26-tracked by Complaints Management team
Digital First Appointment Project

Future actions

PALS Team continue to deliver local resolution and de-escalation training, and PALS and Complaints Manager to deliver awareness and engagement sessions with senior colleagues

Care hours per patient day

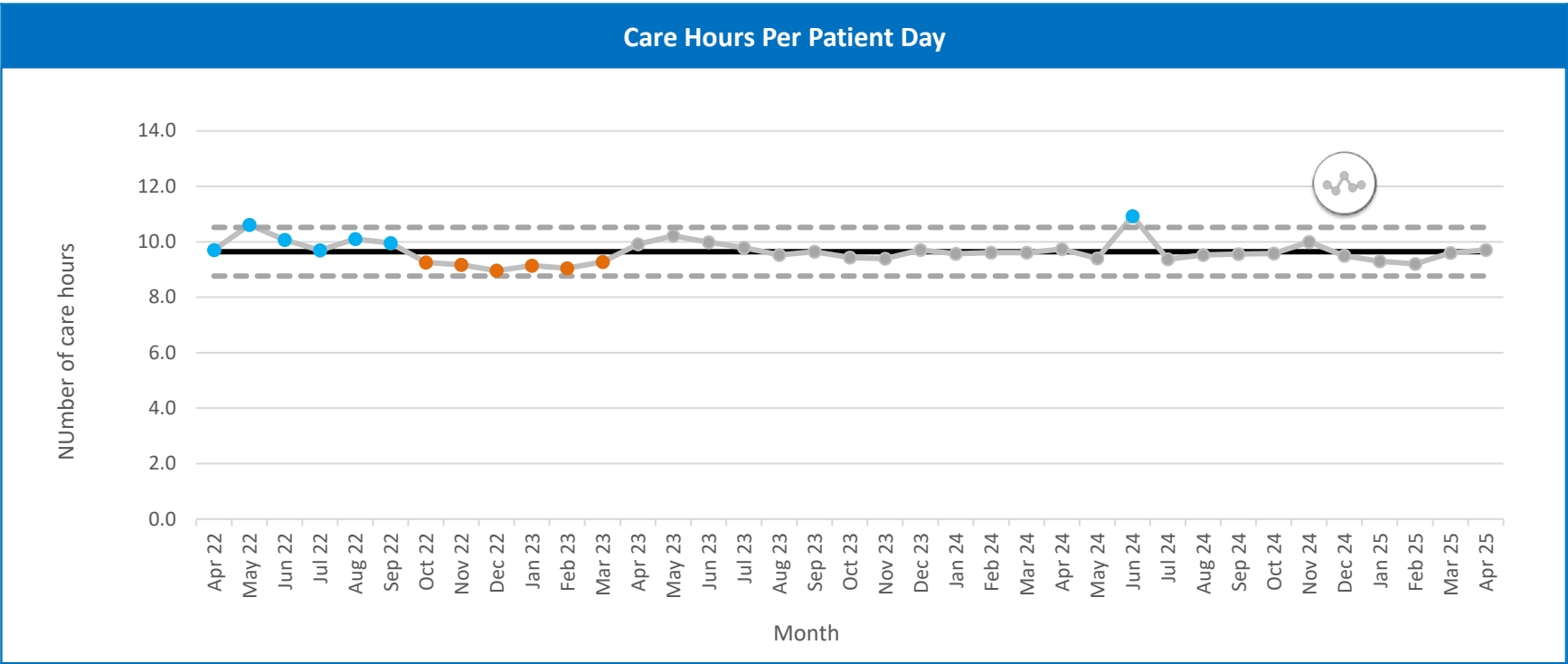
Assure

Not SOF3 metric

Apr-25	Target
9.7	9.5

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
CSS	34.9
RMCH	14.0
SMH	11.6
NMGH	10.4
MREH	9.2
MRI	9.0
WTWA	7.6
LCO &...	



Updates since previous month

Benchmarked against latest available Shelford average of 9.7 hours (Jan 2025 – latest available).

Key dependencies

CHPPD must be considered alongside safety, quality and professional judgement. Does not take account of bed capacity above funded establishment. CSS / RMCH / SMH have higher staff: patient ratios.

Current issues

None identified

Future actions

Continue to monitor

Ratio of actual : planned hours (excluding maternity)

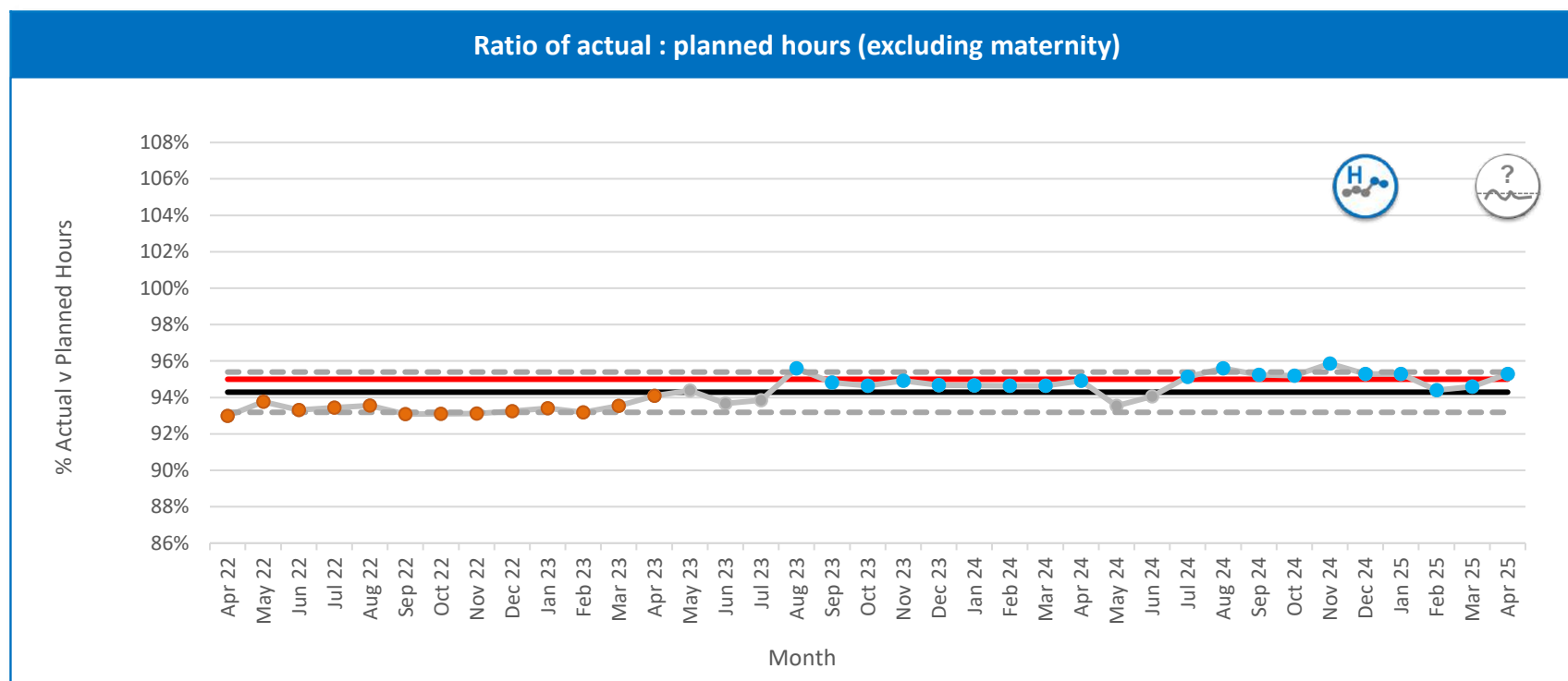
Assure Not SOF3 metric

Mar-25	Target
95.30%	95%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

CSS	100.0%
SMH	97.6%
NMGH	97.3%
MRI	94.9%
WTWA	94.0%
RMCH	93.0%
MREH	92.7%
LCO & Dental	



Updates since previous month

Achieved Trust standards following 2 months below target

Current issues

Fill rates at MREH (1 ward), RMCH and WTWA confirmed no safety concern incidents were reported in areas with low fill rate

Key dependencies

Registered nurse vacancy position at 2.1% against Shelford average of 5.8% (Feb 2025). Nursing Support Worker vacancy rate at 12.0% against Shelford average of 10.3% (Feb 2025)

Future actions

Maintain recruitment pipeline for Spring and Autumn 2025 graduates, continue unregistered recruitment events at Clinical Groups and widening participation programme

Sepsis 7 - Medical review on time

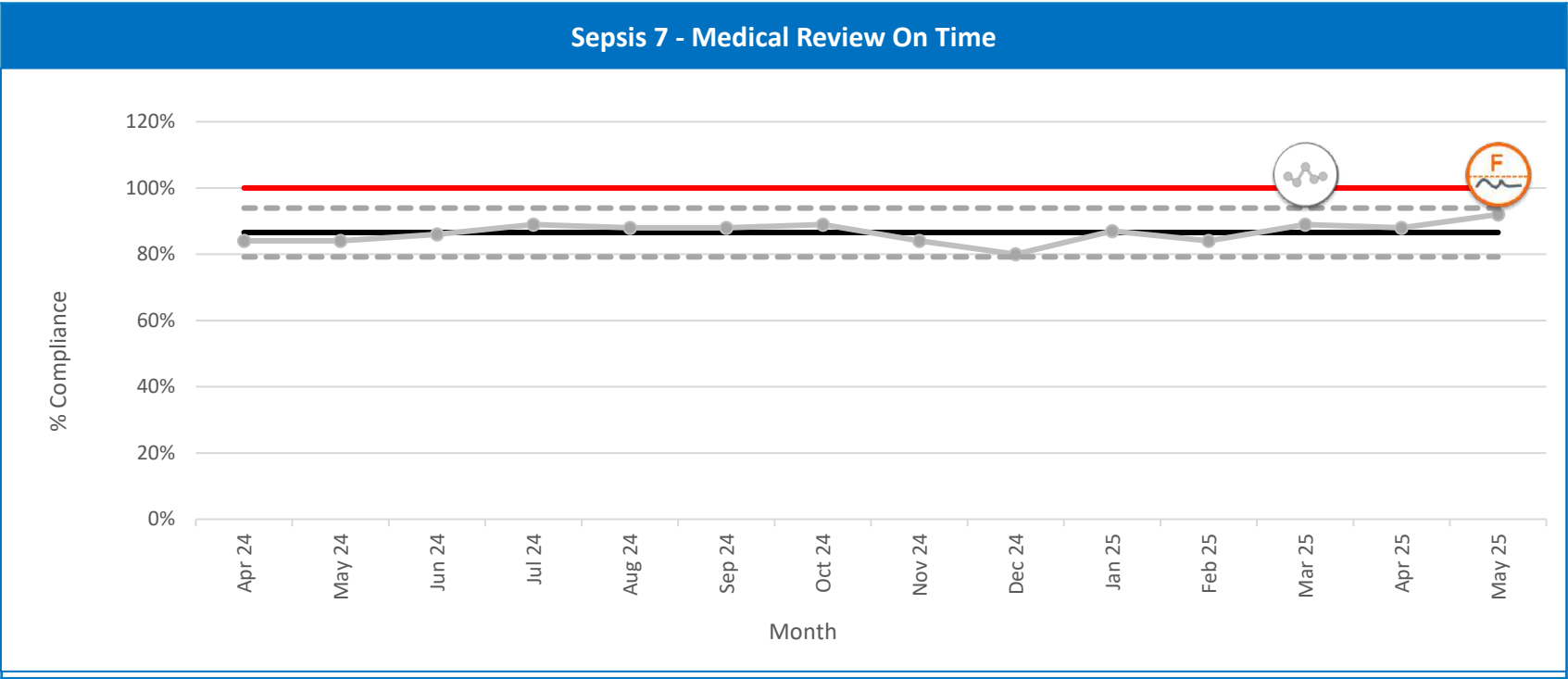
Advise

Not SOF3 metric

May-25	Target
92%	100%

Compliance	Variance	Assurance	Actions

Clinical Group Overview	
NMGH	95%
Specialist	91%
WTWA	91%
MRI	90%
LCO & Dental	
CSS	



Updates since previous month

The data indicates that the overall percentage score has remained below the expected Trust standard-100%

Key dependencies

Early Warning Scores (EWS) must be accurately measured to ensure timely escalation and review.

Automatic alerting not in place reliant on manual processes for alerting medical teams

Current issues

Manual alerting for deteriorating patients in place

Clarity of roles and accessibility of parent clinical teams.

Inconsistent training on induction for medical teams

Future actions

Monitor compliance and share results with trust sepsis group for wider dissemination to clinical groups Q&S.

Continue to incident cases of delayed antibiotics to allow areas to address factors that influence prescription delays

Sepsis 7 - oxygen administered

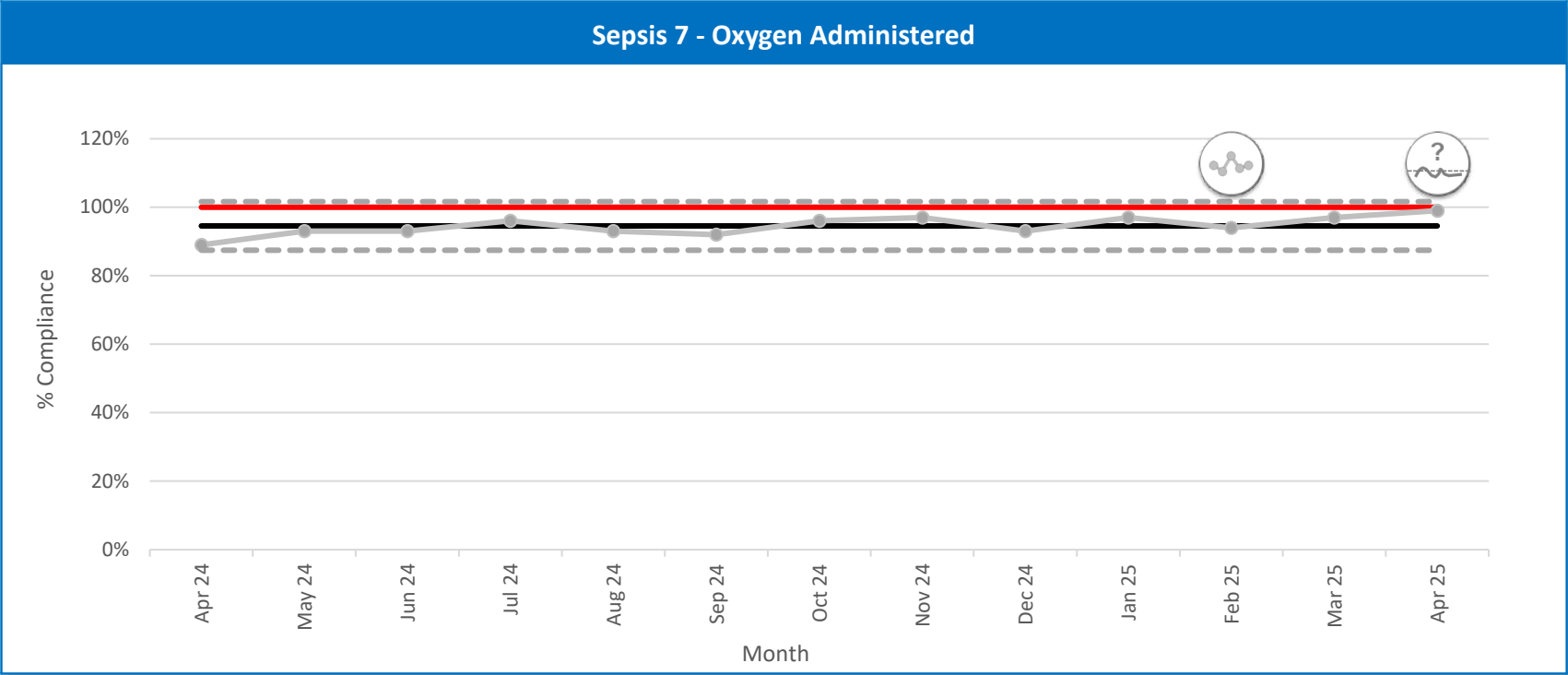
Assure

Not SOF3 metric

May-25	Target
100%	100%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
WTWA		100%
Specialist		100%
MRI		100%
NMGH		100%
LCO & Dental		
CSS		



Updates since previous month

The data indicates that the overall percentage score has met the expected trust standard-100%

Key dependencies

Incomplete clinical observation documentation will cause variations to the overall early warning score, which may lead to underscoring not reflecting the actual patient acuity

Current issues

Not applicable

Future actions

Development of Trust wide Early Warning Score point prevalence audit to enable a “deep dive” into compliance standards, to support improvement work. Date Q4 2025/ 2026

Sepsis 7 - Blood cultures taken

Advise

Not SOF3 metric

May-25

Target

89%

100%

Compliance

Variance

Assurance

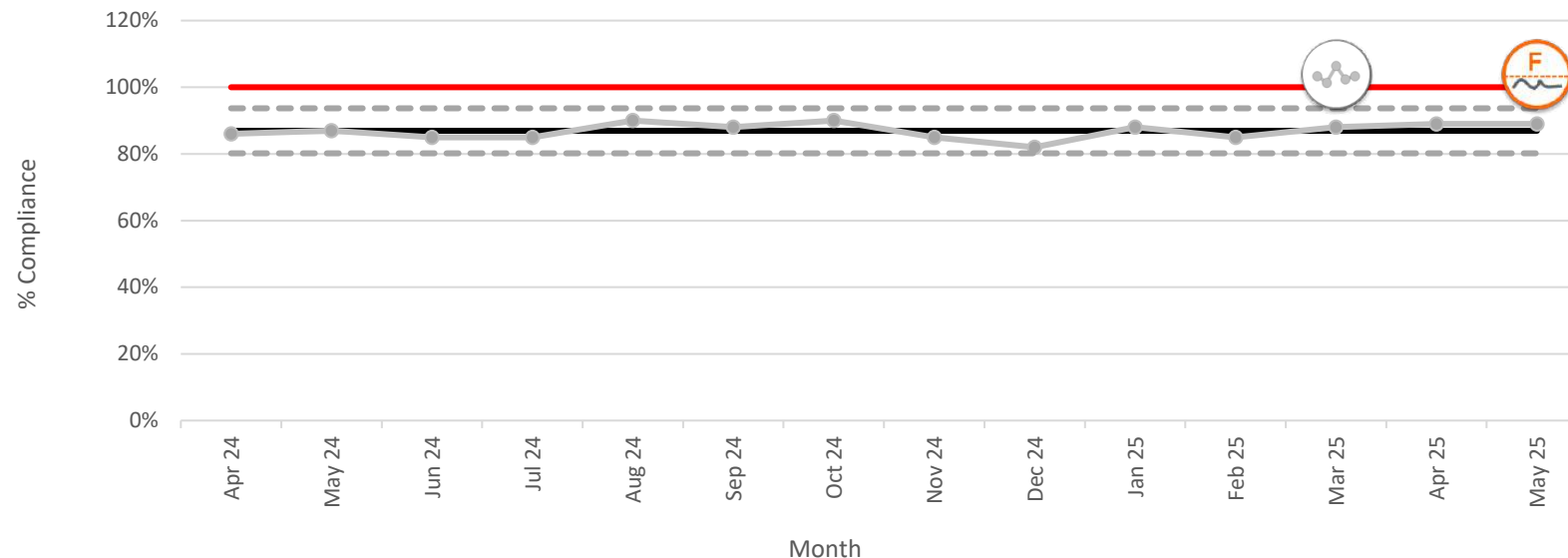
Actions



Clinical Group Overview

NMGH	95%
WTWA	92%
Specialist	88%
MRI	80%
LCO & Dental	
CSS	

Sepsis 7 - Blood Cultures Taken



Updates since previous month

The data indicates that the overall percentage score has remained below the expected trust standard-100%

Key dependencies

Blood cultures remain the primary diagnostic test available to detect BSI, ascertain the causative organism, and direct the most appropriate antimicrobial to treat the infection

Current issues

Blood cultures not always taken in sepsis cases or are delayed/taken after antibiotic administration
Process review planned for Q3/4 to identify causes

Future actions

Share results with Trust Sepsis Group for wider dissemination to clinical groups Q&S. Relevant staff undertake blood culture training as part of the trust IV therapy course. Workshop being undertaken to identify factors for delay and action

Sepsis 7 - antibiotics administered

Advise

Not SOF3 metric

May-25

Target

82%

100%

Compliance

Variance

Assurance

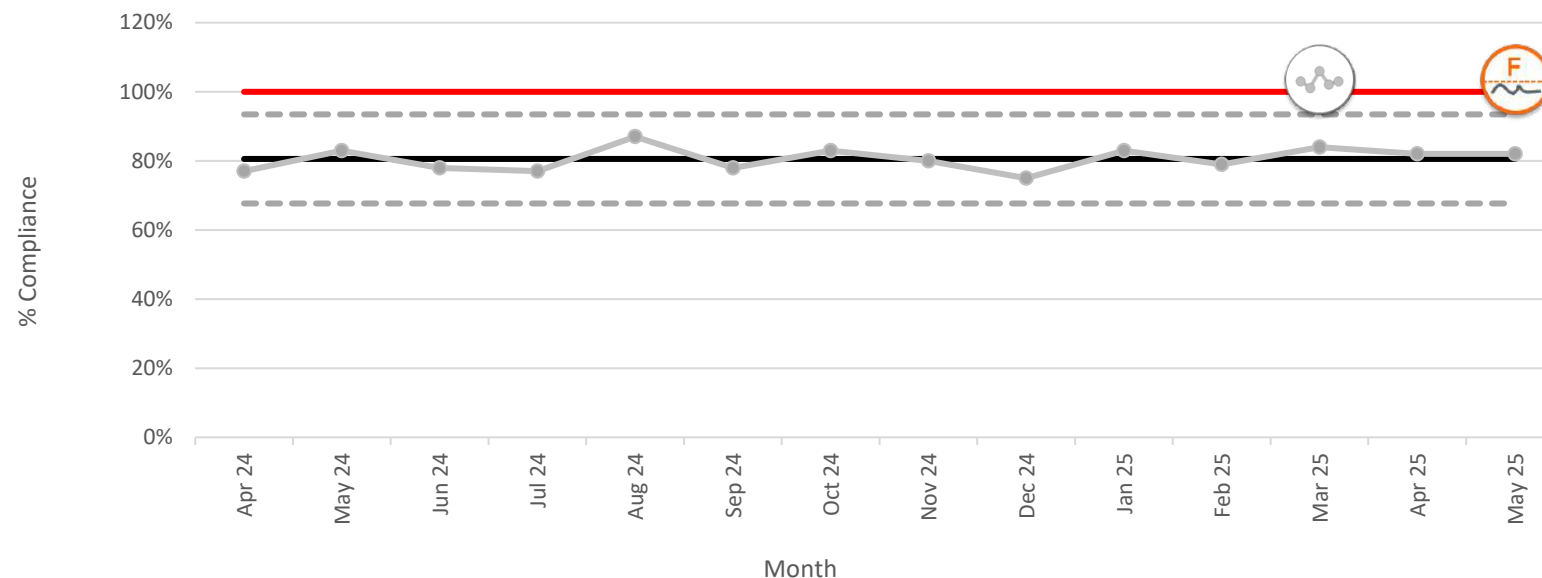
Actions



Clinical Group Overview

Specialist	85%
WTWA	81%
NMGH	80%
MRI	80%
LCO & Dental	
CSS	

Sepsis 7 - Antibiotics Administered



Updates since previous month

The data indicates that the overall percentage score has remained below the expected trust standard-100%

Key dependencies

Delay in antibiotics can be influenced by several factors - timely medical review, communication to nursing staff, availability of IV trained staff and delay in gaining IV/IO access

Current issues

Delay in the administration of antibiotics can be from prescription delay, administration delay or a combination of both. Process map and workshop- June 25

Future actions

Continue incident reporting cases where antibiotics have not been administered in set time standards, "Deep dive" and observations required of process, with workshop for multidisciplinary discussions and review of process to identify action and learning

Sepsis 7 - lactate taken

Advise

Not SOF3 metric

May-25

Target

89%

100%

Compliance

Variance

Assurance

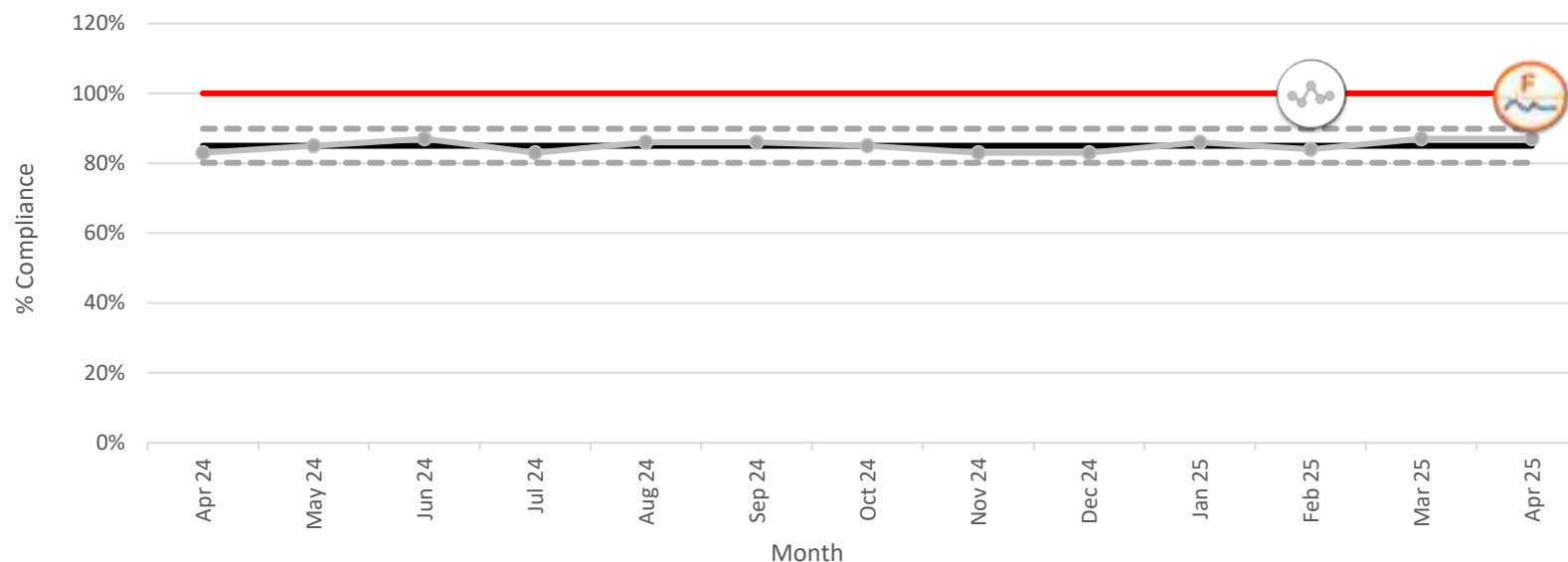
Actions



Clinical Group Overview

NMGH	100%
WTWA	89%
Specialist	87%
MRI	80%
LCO & Dental	
CSS	

Sepsis 7 - Lactate Taken



Updates since previous month

The data indicates that the overall percentage score has remained below the expected trust standard-100%

Current issues

Lactate measurement not always undertaken or is delayed in sepsis cases. Missed/delayed lactate measurement is most seen in inpatient areas rather than Emergency Departments

Key dependencies

Lactate is a marker to aid in the diagnosis and management of sepsis and septic shock, including need for fluid resuscitation and ICU review
Require trained and competent staff with access to Point of Care testing

Page 78

Future actions

Focus training for nursing colleagues to utilise Point of Care testing.
Review of locations of analysers to ensure ease of access, overseen by sepsis group.
Multi disciplinary training of lactate as a marker of deterioration-delivery plans developed Q3

Sepsis 7 - IV fluid bolus administered

Advise

Not SOF3 metric

May-25

Target

93%

100%

Compliance

Variance

Assurance

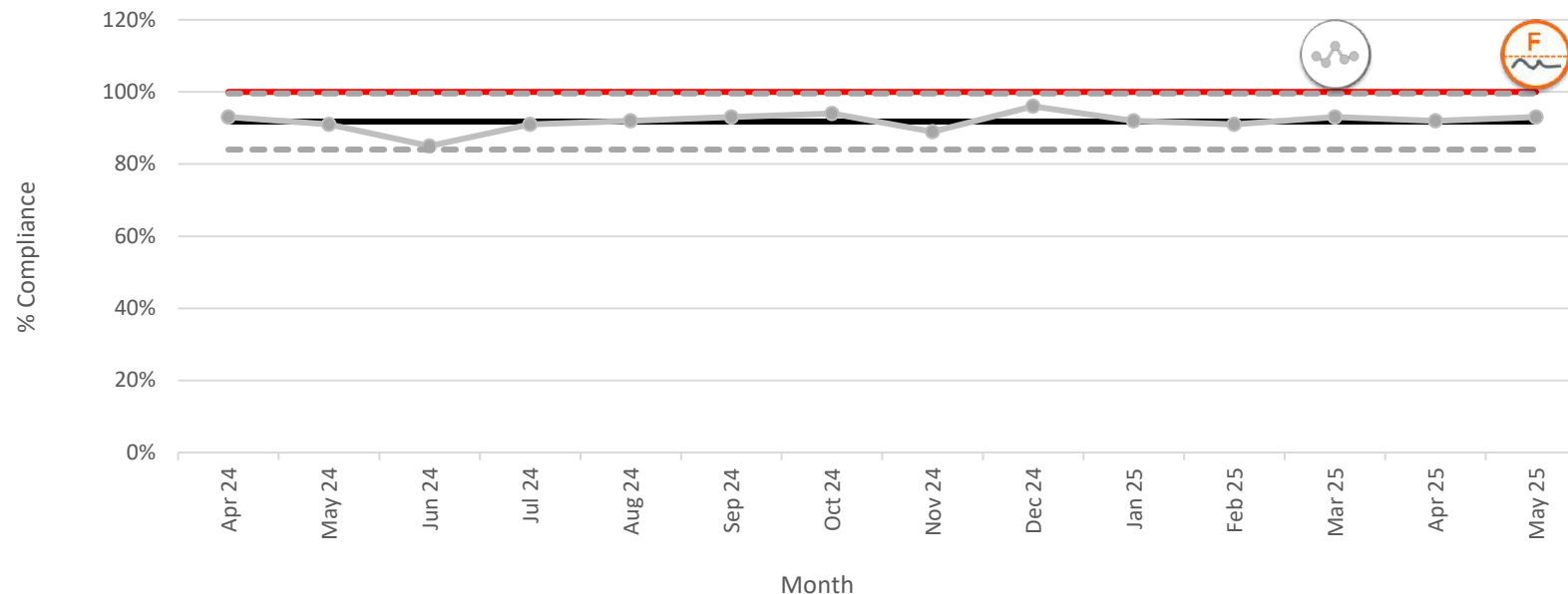
Actions



Clinical Group Overview

MRI	100%
Specialist	92%
NMGH	92%
WTWA	87%
LCO & Dental	
CSS	

Sepsis 7 - IV Fluid Bolus Administered



Updates since previous month

The data indicates that the overall percentage score has remained below the expected trust standard-100%

Key dependencies

Requires precise fluid balance monitoring and accurate clinical observations. Requirement of trained and competent prescribers and close monitoring of impact

Current issues

IV fluids not always administered in a timely manner in septic patients with raised lactate or signs of hypovolemia. Prescription of IV fluids on HIVE not always completed in emergency situations

Future actions

Monitor compliance and share results with Trust Sepsis Group for wider dissemination to clinical groups Q&S. Increase multi disciplinary attendance to Trust Sepsis Group to support shared learning and practice

Sepsis 7 - urine output measured

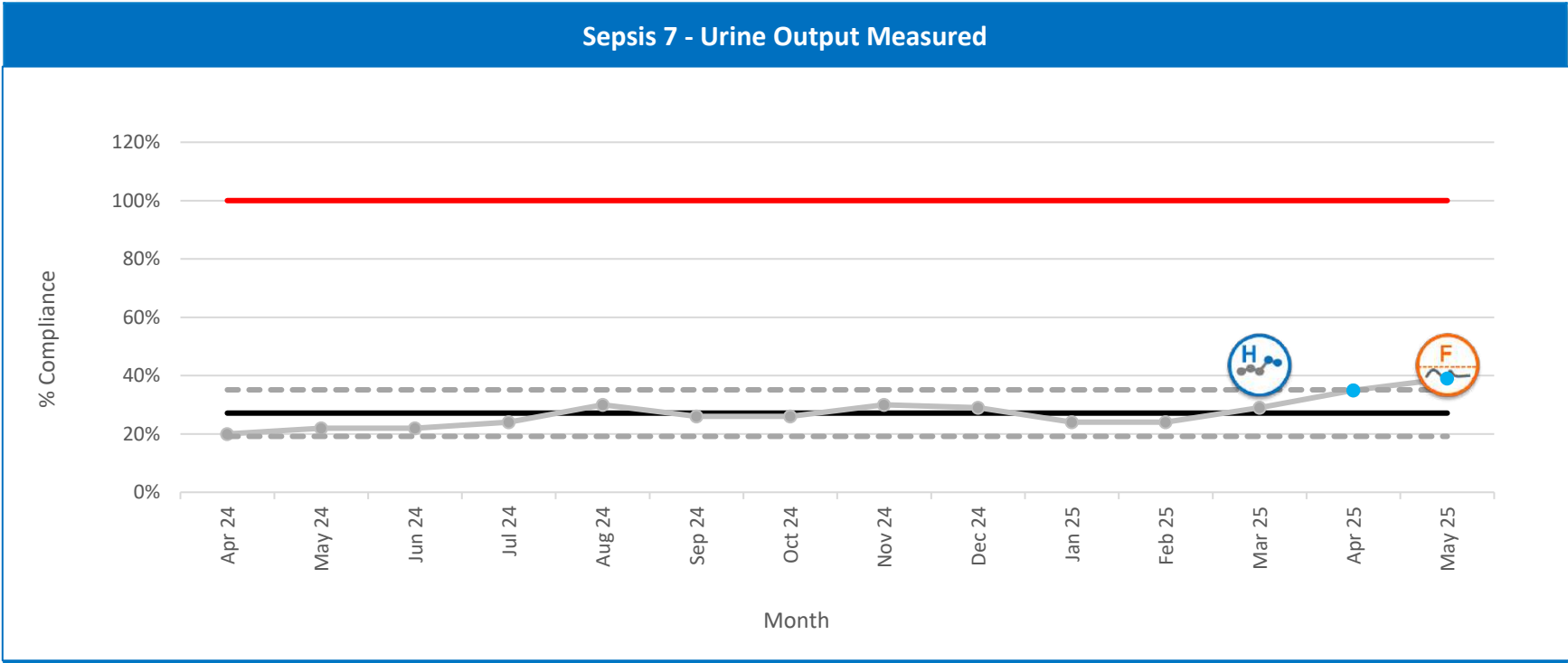
Advise

Not SOF3 metric

May-25	Target
39%	100%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	44%
MRI	40%
WTWA	38%
NMGH	35%
LCO & Dental	
CSS	



Updates since previous month

The data indicates that the overall percentage score has remained below the expected trust standard-100%

Key dependencies

Requires precise fluid balance monitoring and accurate clinical observations. Requirement of trained and competent prescribers and close monitoring of impact
Enable the early detection of Acute Kidney Injury

Page 80

Current issues

Monitoring of urine output is below standard across all clinical groups audited

Future actions

Acute Care team working with Clinical Groups over seen by Acute Care board– changes include improvements to the Hive fluid balance process, improvement of compliance reporting, targeted training and supported quality improvement projects

% of critical medication administrations omitted

Alert Not SOF3 metric

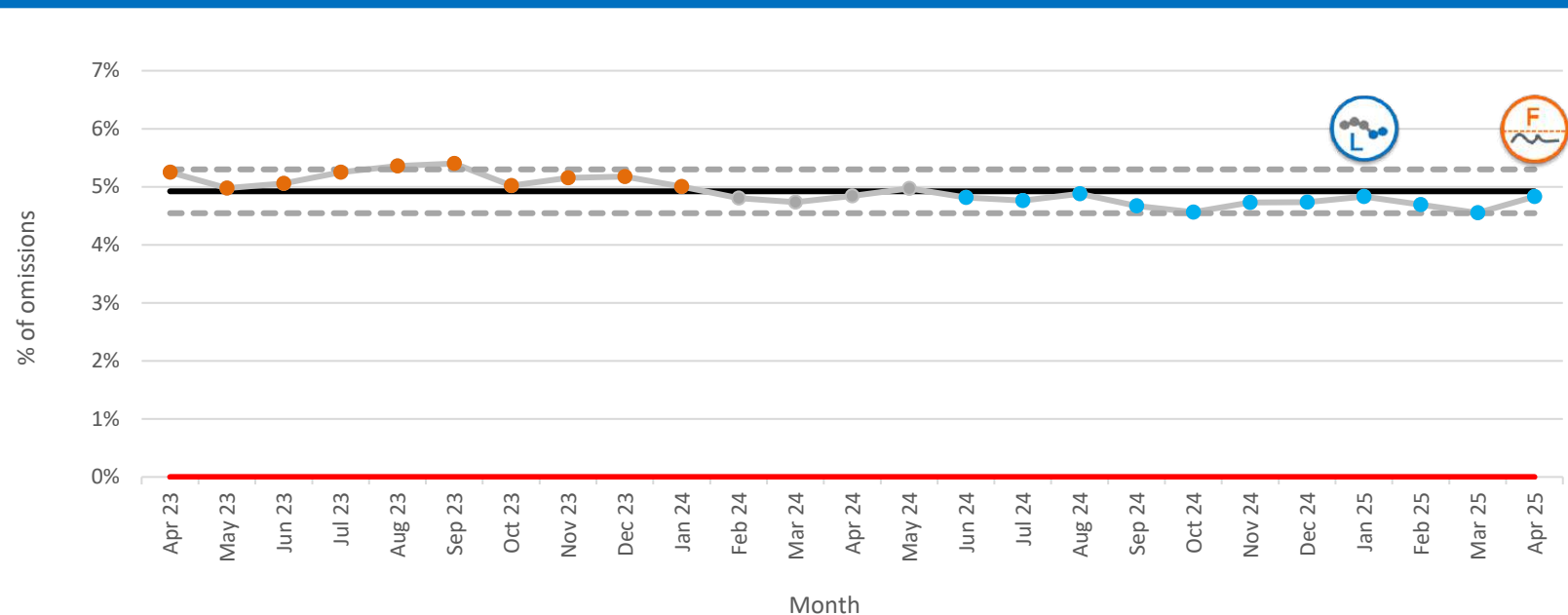
Apr-25	Target
4.83%	0%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

MRI	5.81%
WTWA	4.70%
NMGH	4.59%
Specialist	2.49%

Percentage of Critical Medication Administrations Omitted



Updates since previous month

Special cause variation for improvement continued

Key dependencies

IT request for power BI dashboard outstanding-Chief Pharmacist working with Digital Team to resolve
GM project to increase use of patients own medicines to support Trust improvement. Regular stock list reviews in clinical areas.
Processes for accessing critical medicines during and out of hours
Education of staff on critical medicines

Current issues

Delays in critical medication can impact on patient pathways

Future actions

Focused improvement workstreams are in progress
Quality Improvement projects planned in Q3-Led by Medicines Safety Group

% of critical med omissions due to medicines unavailable

Alert

Not SOF3 metric

Apr-25

Target

0.37%

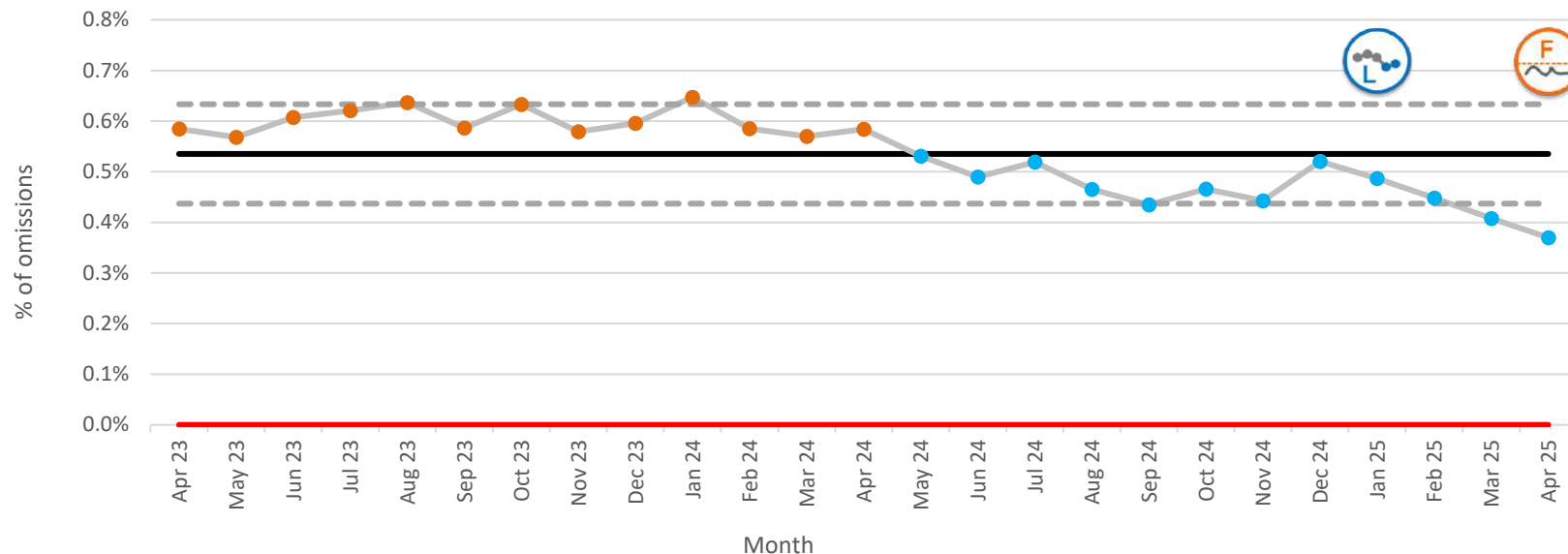
0%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

MRI		0.47%
NMG		0.46%
WTWA		0.29%
Specialist		0.24%

Percentage of Critical Med Omissions due to Medicines Unavailable



Updates since previous month

Special cause variation for improvement continued
Stock list review are underway for ORC

Current issues

Focused work ongoing to reduce critical medicine omissions due to 'drug unavailable'

Key dependencies

IT request for power BI dashboard outstanding- Chief Pharmacist escalating to Digital Team

Future actions

Detailed action plan are being developed that addressed requirements at each site. CG plans to be approved at Trust Medicine Safety Group in August
QI project planned-Led by Pharmacy Colleagues

% of antimicrobial omissions

Alert

Not SOF3 metric

Apr-25

Target

1.81%

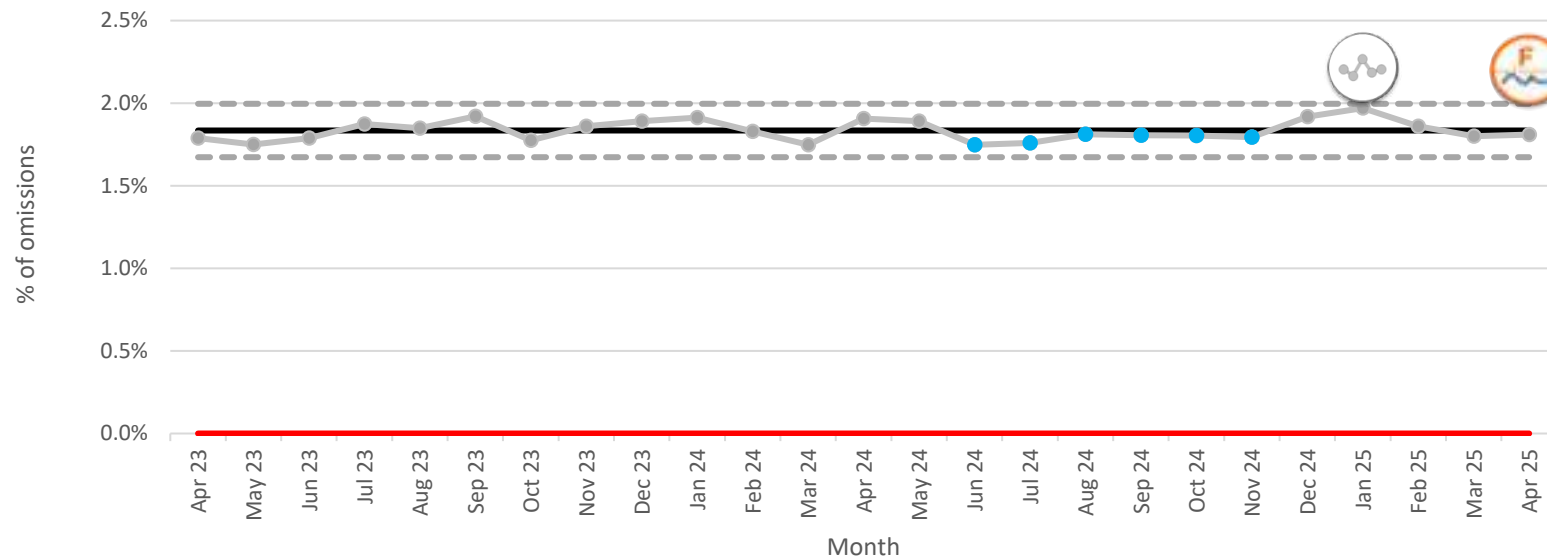
0%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

WTWA		2.09%
MRI		1.81%
Specialist		1.48%
NMG		1.40%

% of Antimicrobial Omissions



Updates since previous month

No significant change

Current issues

Antimicrobial omissions continue to account for approximately 40% of critical medicine omissions

Key dependencies

Regular stock list reviews in clinical areas
Processes for accessing critical medicines during and out of hours
Education of staff on critical medicines

Future actions

AMS team to undertake "deep dive" of data to identify areas to focus improvement work-Q3

Controlled drugs audit compliance

Alert

Not SOF3 metric

Q4 24-25

Target

95.5%

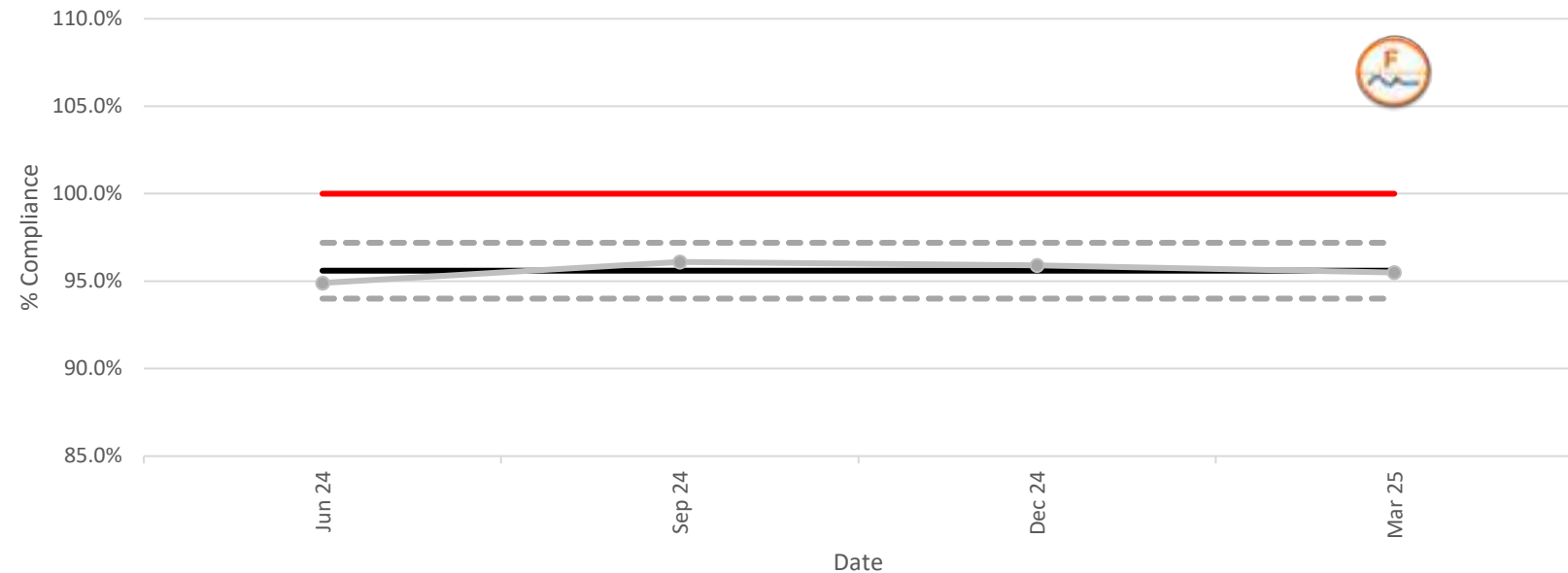
100%

Compliance	Variance	Assurance	Actions
			

Hospital Overview

LCO	99.1%
NMGH	98.7%
SHM	97.1%
CSS	97.0%
MREH/UDHM	96.5%
WYTH	96.3%
RMCH	95.5%
TGH	92.2%
MRI	92.2%

Controlled Drugs Audit Compliance



Updates since previous month

Audits conducted quarterly
Each Clinical Group provided assurance report to the Controlled Drugs Governance Group in May outlining actions to address gaps in compliance
MRI and Trafford reported the lowest compliance- targeted support

Key dependencies

Inconsistent documentation of the volume of controlled drug infusions administered in Hive prevents accurate audit of wastage

Current issues

Gaps in compliance for documentation: crossing out in CD registers and documentation of waste of part used syringes

Future actions

Mandatory training to outline documentation standards requested

Safe & secure handing of medicines audit compliance

Alert

Not SOF3 metric

Q4 24-25

Target

95.0%

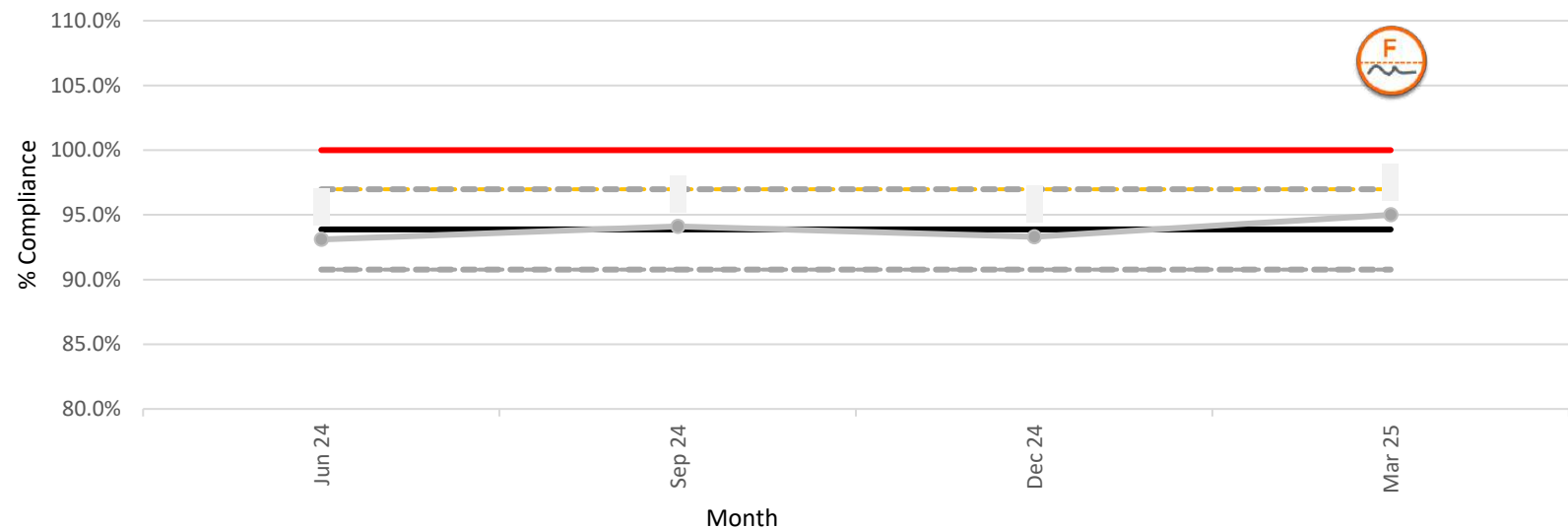
100%

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview

R&I	100.0%
LCO	98.3%
MREH/UDHM	96.6%
NMGH	96.4%
MRI	96.2%
CSS	94.7%
WYTH	94.4%
RMCH	94.2%
SHM	92.7%
TGH	89.3%

Safe & Secure Handing of Medicines Audit Compliance



Updates since previous month

Audits conducted quarterly - no additional data this month. Each Clinical Group presented an assurance report to the Trust Medicines Safety Group in May outlining actions to address gaps in compliance

Key dependencies

Estates issues – temperature control in treatment rooms
Daily ward checks-issues reported and escalated to Estates and Facility Department for prompt resolution
Reviewed as part of Clinical Accreditation

Current issues

Room and fridge temperature monitoring and documentation of action taken

Future actions

Outcome of NMGH documentation of temperature monitoring pilot will be submitted and reviewed in June-Medicines Safety Group oversight

% of Patients on O₂ with a O₂ prescription

Alert

Not SOF3 metric

May25

Target

46%

100%

Compliance

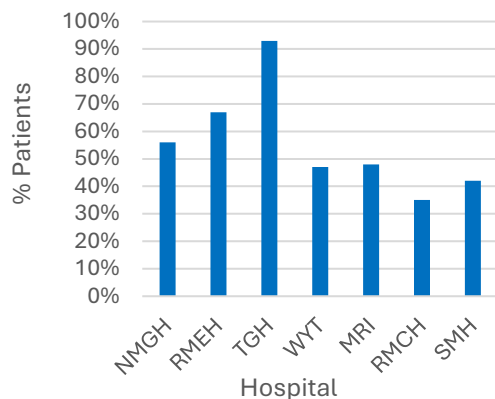
Variance

Assurance

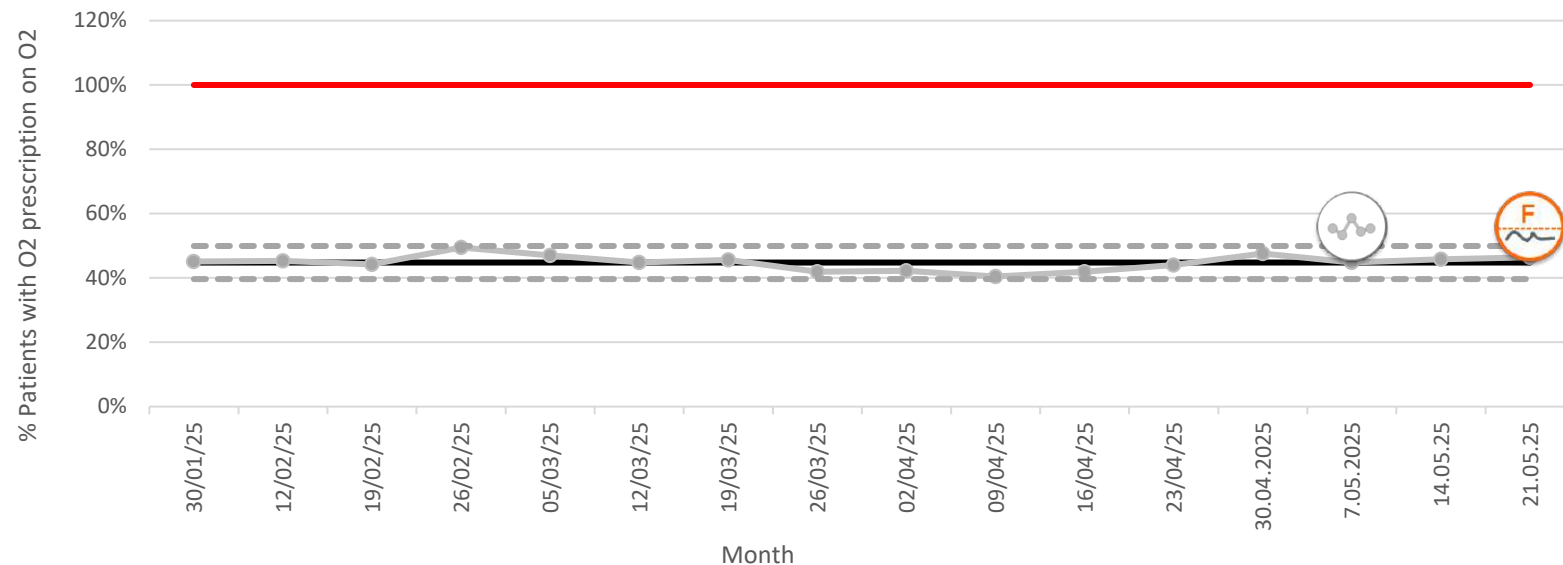
Actions



Hospital Overview



% of Patients on O₂ who had an O₂ prescription



Updates since previous month

No change in compliance

Current issues

Trust Joint Medical Director supporting finalisation of guidelines

Key dependencies

Clinical lead to be identified to support development of oxygen strategy within the Trust including HIVE build-
Trust Joint Group Medical Director Supporting

Future actions

Guidelines to be ratified-Q3/4

24-hour admissions medicines reconciliation

Alert

Not SOF3 metric

Apr-25

Target

58%

95%

Compliance

Variance

Assurance

Actions



Clinical Group Overview

MRI 85%

NMGH 60%

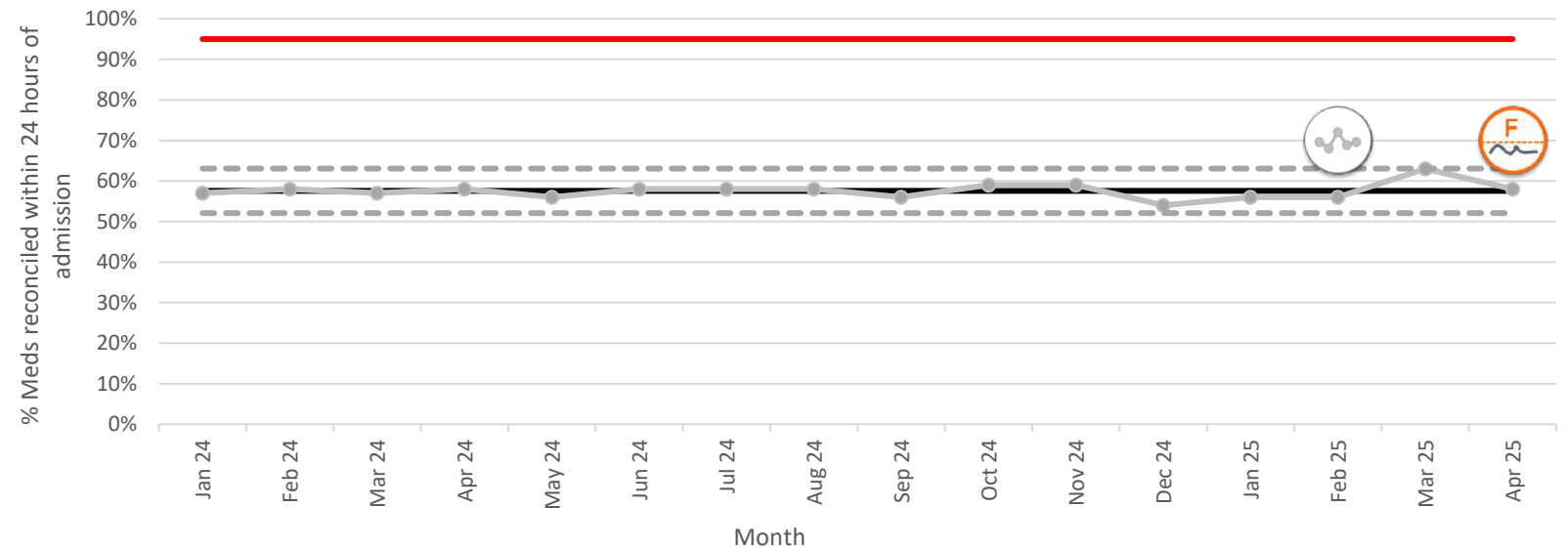
WTWA 50%

Specialist 35%

CSS

The LCO & Dental

24-hour Admissions Medicines Reconciliation



Updates since previous month

MFT results reduced in April 2025
 Indepth review of results for Pharmacy Service locations Tues-Fri demonstrates compliance between 74-86% (limited Pharmacy weekend/bank holiday service effects results (Sat/Sun/Mon))

Current issues

SMH results are below other Clinical Groups, following discussion at SMH Q&S it was agreed to progress a Business Case to increase Pharmacy staffing within SMH. Scoping underway to review weekend pharmacy

Key dependencies

Workforce/resource dependencies

Future actions

Review of weekend service scoping at ORC
 SMH business case development

48-hour admissions medicines reconciliation

Alert

Not SOF3 metric

Apr25

Target

75%

95%

Compliance

Variance

Assurance

Actions



Clinical Group Overview

MRI 97%

NMGH 73%

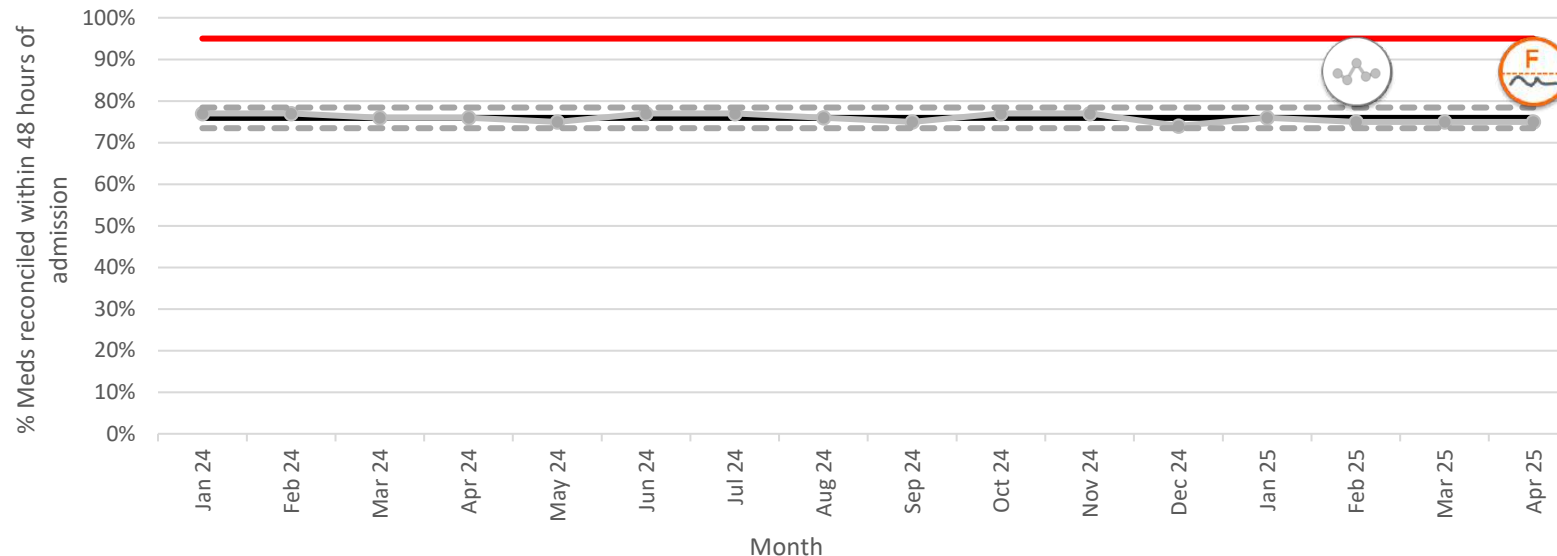
WTWA 73%

Specialist 47%

CSS

The LCO & Dental

48-hour Admissions Medicines Reconciliation



Updates since previous month

MFT results consistent in April . Indepth review of results for Pharmacy service locations Tues-Fri demonstrates compliance between 92-99% (limited Pharmacy weekend/bank holiday service effects results (Sat/Sun/Mon)

Key dependencies

Workforce/resource dependencies

Current issues

SMH results are below other Clinical Groups, following discussion at SMH Q&S it was agreed to progress a Business Case to increase Pharmacy staffing within SMH. Scoping underway to review weekend pharmacy

Future actions

Review of weekend service scoping at ORC
SMH business case development

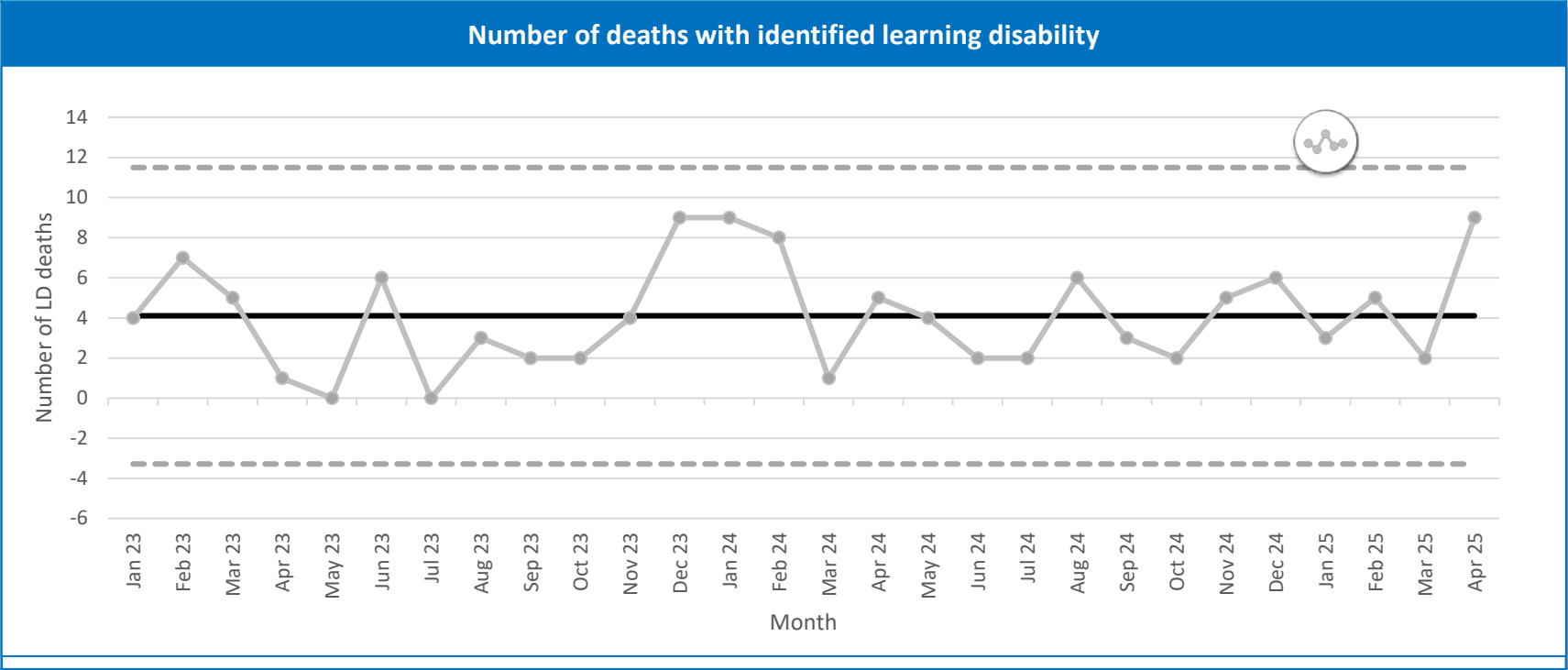
Number of deaths with identified learning disability

Advise

Not SOF3 metric

Apr-25		Target	
9			
Compliance	Variance	Assurance	Actions
			

Clinical Group Overview		
WTWA		3
CSS		2
MRI		2
NMGH		2
Specialist	0	
LCO & Dental	0	



Updates since previous month

There were 9 deaths of patients with a learning disability in April 2025

Key dependencies

All deaths of patients with a learning disability are reviewed according to Leder criteria and reported to the Integrated Care Board for review

Current issues

Structured judgement review completed for all deaths of person with LD, increase in deaths in April being reviewed

Future actions

As part of the review of Learning From Deaths(LFD) processes, work is underway to improve the triangulation of learning from LeDeR reviews with broader learning outcomes overseen by LFD Group

Number of LeDeR referrals

Advise

Not SOF3 metric

Apr-25

Target

9

Compliance

Variance

Assurance

Actions



Clinical Group Overview

WTWA 3

CSS 2

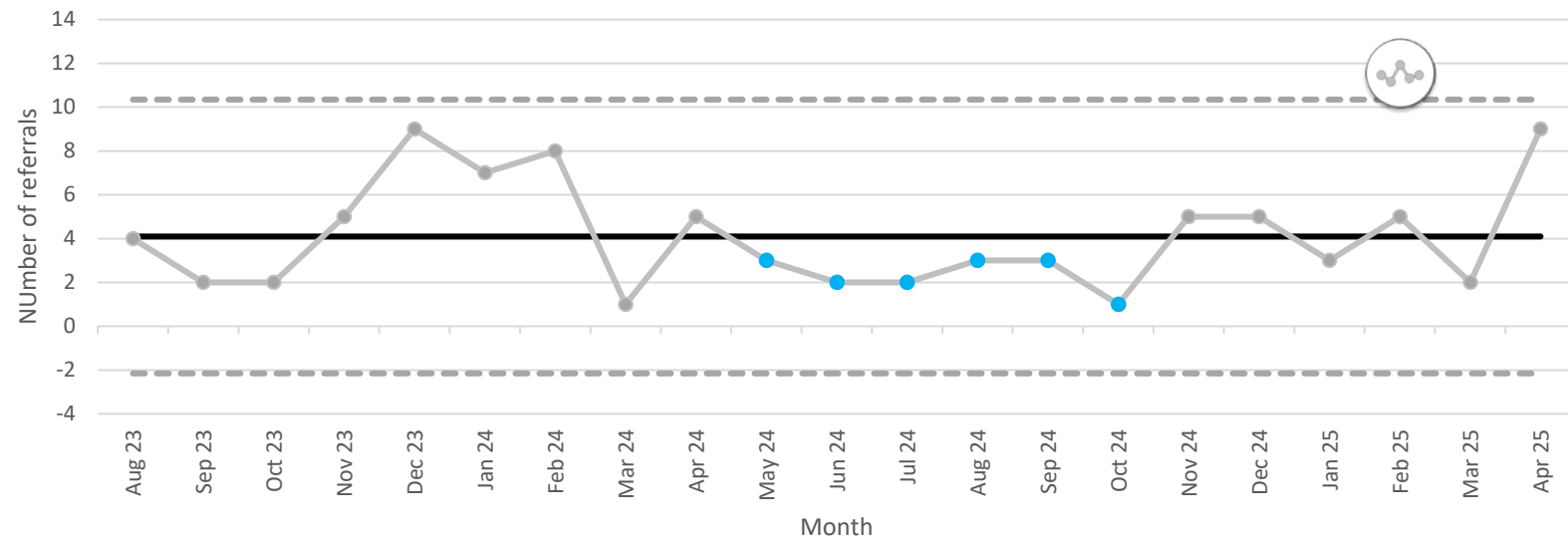
MRI 2

NMGH 2

Specialist 0

LCO & Dental 0

Number of LEDER referrals



Updates since previous month

9 deaths of patients with learning disability in April
9 meeting the LeDeR criteria

Key dependencies

Learning from LeDeR is reported quarterly to the

- Learning Disability Steering Group
- Learning from Deaths Group

Reporting to Trust Safeguarding Committee

Current issues

Current LeDeR improvement work focused on

- Improvement of documentation of DNCPR decision making
- Guidance and training to enhance workforces' knowledge and skills in application of the Mental Capacity Act
- Policy Guidance and training to support Mental Capacity Assessments

Future actions

Incorporate learning from LeDeR into ReSPECT training to be progressed by learning disability and education teams (Q1/2 2025)

Hospital standardised mortality ratio (HSMR) (rolling 12 month)

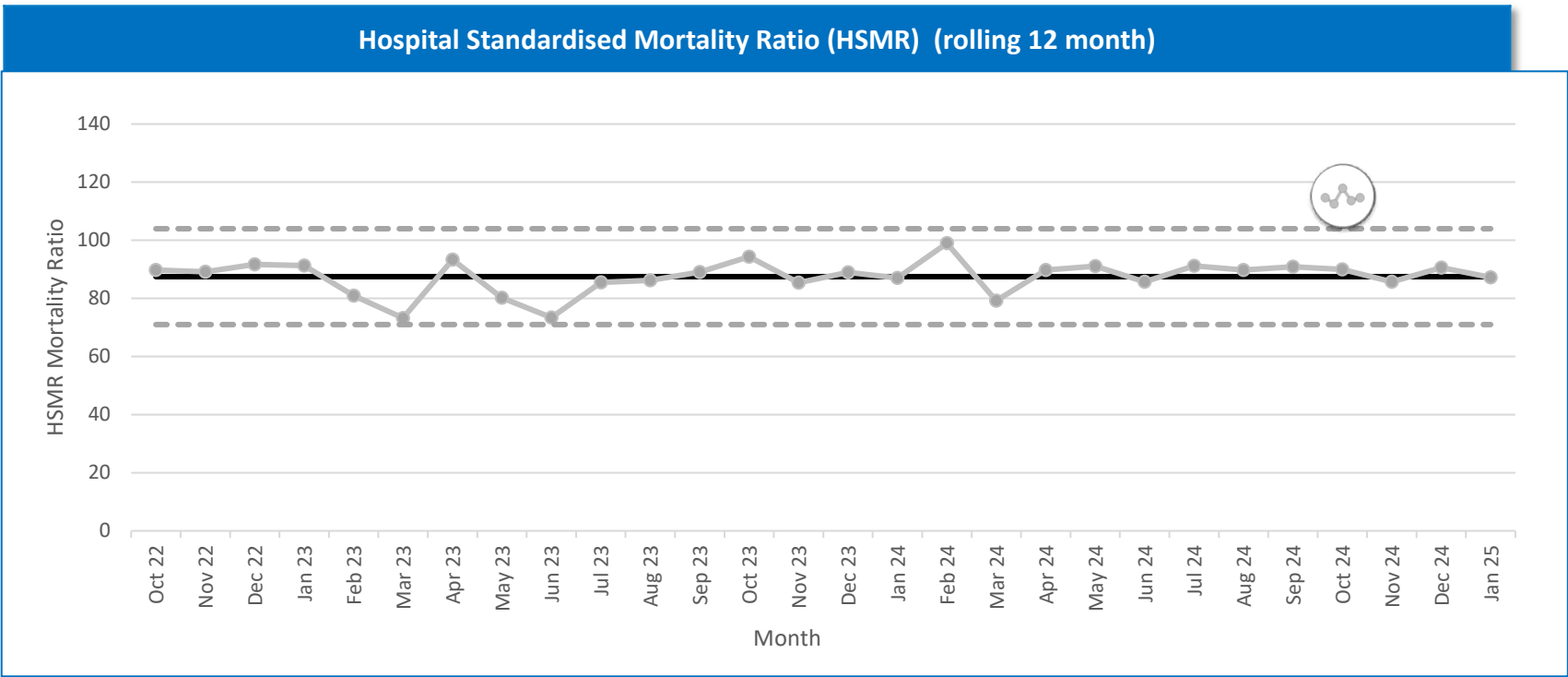
Advise

Not SOF3 metric

Jan-25	Target
87.22	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	132.11
MRI	88.15
NMGH	88.25
WTWA	86.98
LCO & Dental	
CSS	



Updates since previous month

MFT is within the expected range and aligned to Shelford Peers. MFT recorded a ratio of 87.22 in Jan 2025 (latest validated available in HED); a slight fall from December 24

Key dependencies

Continued monitoring a for any arising issues

Ensuring coding and data quality standards are maintained and improved

Data is always significantly retrospective due to external validation processes

Current issues

No issues identified

Future actions

Trust review of Learning from Deaths in MFT underway including the harmonising processes across MFT, optimise our learning, and ensure we fulfil our statutory obligations

Crude mortality rate (12 month rolling)

Advise

Not SOF3 metric

Jan-25

Target

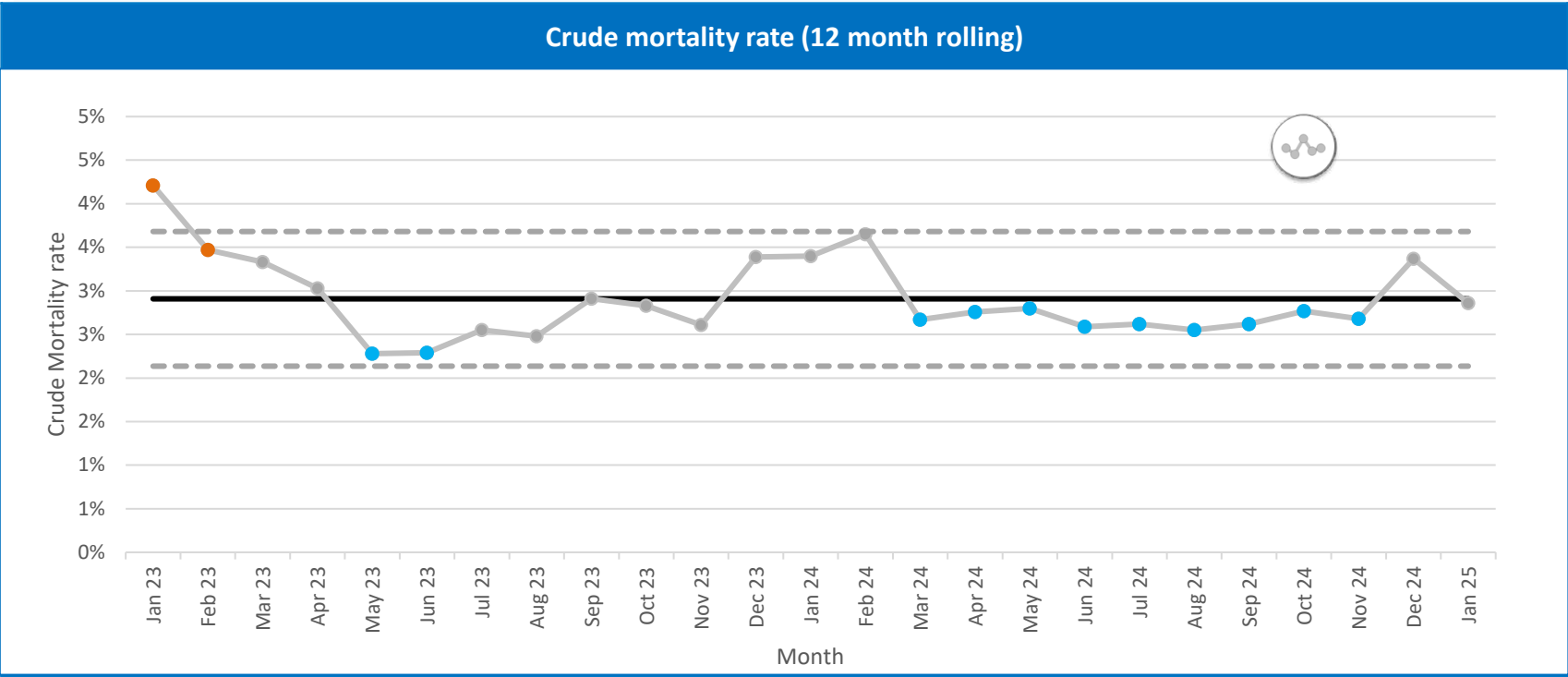
2.86%

N/A

Compliance	Variance	Assurance	Actions

Clinical Group Overview

NMGH	4.38%
MRI	2.72%
WTWA	2.69%
Specialist	0.83%
LCO & Dental	
CSS	



Updates since previous month

The latest validated data for January shows a small decrease to 2.86% within the expected variance

Key dependencies

Ensuring coding and data quality standards are maintained and improved
 Data is always significantly retrospective due to external validation processes

Current issues

No Issues identified

Trust review of Learning from Deaths in MFT underway including the harmonizing processes, optimizing learning, and ensuring we fulfil our statutory obligations

Standardised healthcare mortality indicator (SHMI)

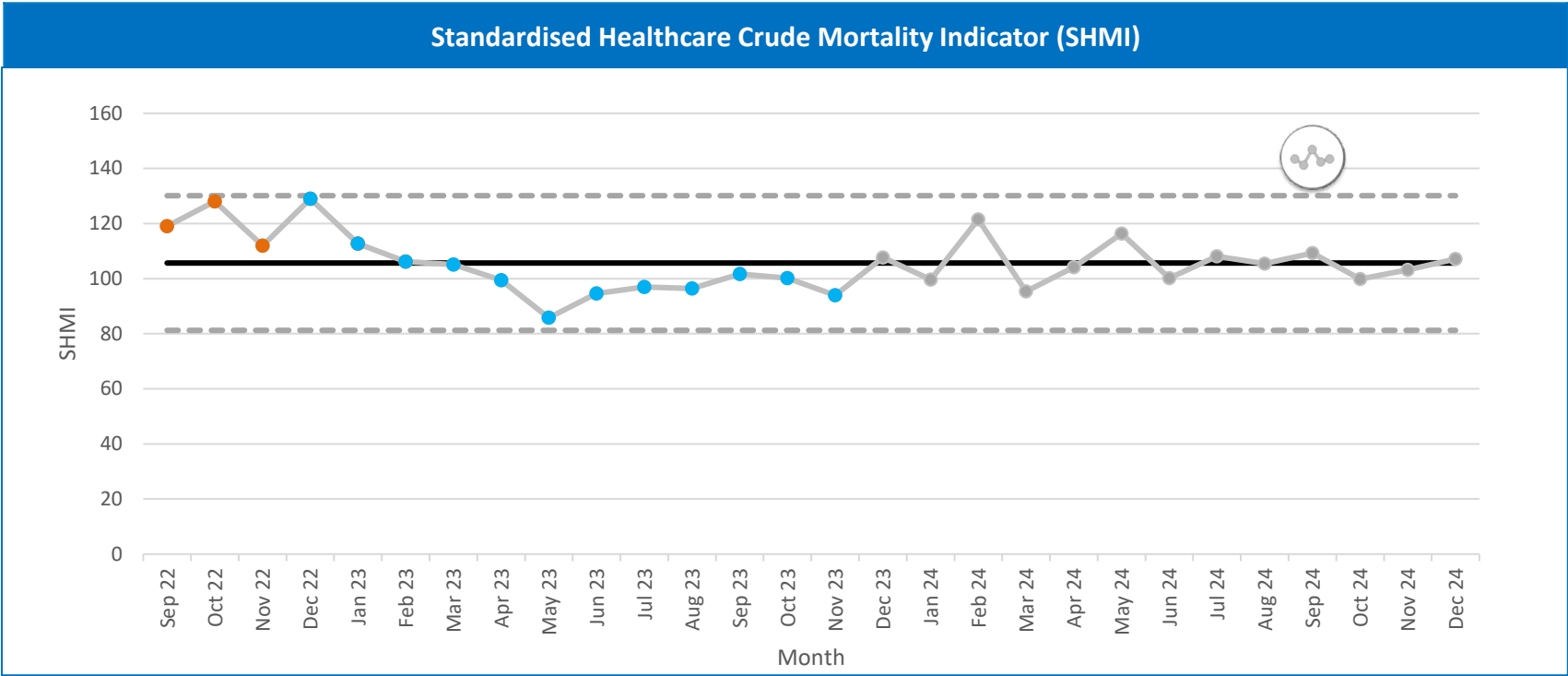
Advise

Not SOF3 metric

Dec-24	Target
107.18	N/A

Compliance	Variance	Assurance	Actions
			

Clinical Group Overview	
Specialist	135.84
MRI	101.18
NMGH	115.99
WTWA	101.47
LCO & Dental	
CSS	



Updates since previous month

MFT is within the expected range; and aligned to our Shelford Peers. MFT recorded a validated ratio of 107.2 in December 2024 (latest available in HED)

Current issues

No issues or alerts within the Dec 24 data

Key dependencies

- Continued monitoring for any arising issues
- Ensuring coding and data quality standards are maintained and improved
- Data is always significantly retrospective due to external validation processes

Future actions

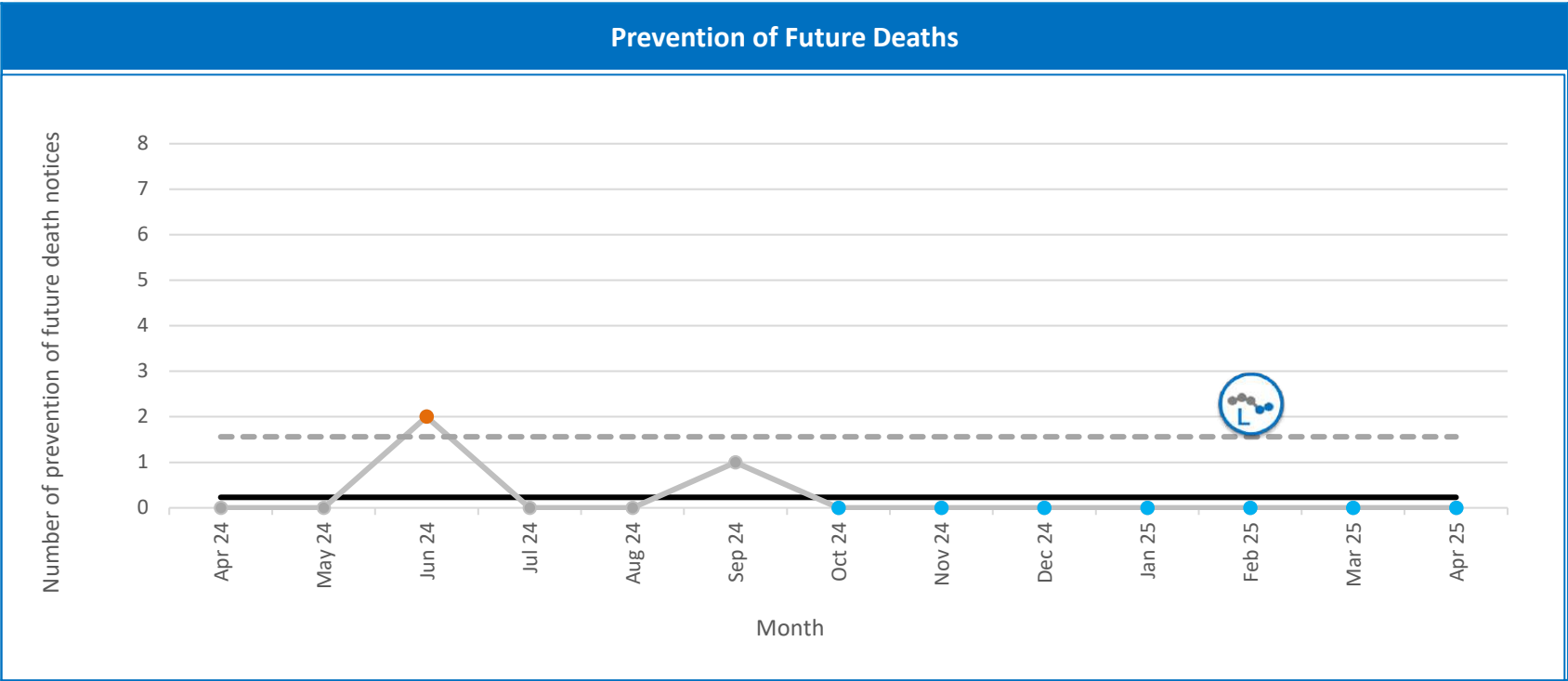
Trust review of Learning from Deaths in MFT underway including the harmonising processes across MFT, optimise our learning, and ensure we fulfil our statutory obligations

Prevention of Future Deaths

Assure	Not SOF3 metric
Apr-25	Target
0	0

Compliance	Variance	Assurance	Actions

Clinical Group Overview (12 months)	
MRI	2
WTWA	1
Specialist	
NMGH	
LCO & Dental	
CSS	



Updates since previous month
No PFD reports have been issued between September 2024 and end of April 2025

Key dependencies
Ongoing work relating to the continuous improvement of assurance/learning statements to mitigate the Coroner needing to issue PFD reports due to issues the Trust is able to resolve

Current issues
Not applicable

Future actions
Learning from PFD reports is shared though a variety of mechanisms, including the weekly Patient Safety Oversight and Assurance Group and reporting of weekly surveillance of national PFDs to inform internal assurance

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



Trust IPR Metric Assurance Summary

Key Oversight Performance Metrics

Focus	Compliance	Variation	Assurance	Action status	Performance	Plan/Target	Indicator	Indicator Type
Urgent care and Flow					73.9%	78.0%	A&E 4 hour standard	National
					52.5%	65.0%	Ambulance handover within 15 mins	National
					29	0	Ambulance handovers over 60 mins	National
					3.2%	2.0%	Number of A&E waits > 12 hours	Regional
					101	0	Number of A&E DTA waits ≥ 12 hours	National
					91.8%	92.0%	General & Acute Bed Occupancy	National
					94.2%	92.0%	General & Acute Bed Occupancy – Adults	National
					74.2%	92.0%	General & Acute Bed Occupancy – Paediatrics	National
					327	240	Days away from home (NC2R)	National
					501	430	21+ Day length of Stay	National
					87.2%	80.0%	Virtual ward - hospital @ Home	National
					64.0%	60.0%	Thrombolysis < 60 minutes	National
					43.0%	60.0%	Admission to stroke ward < 4 hours	National
					75.0%	70.0%	Stroke Audit Score	National

Trust IPR Metric Assurance Summary

Key Oversight Performance Metrics								
Focus	Compliance	Variation	Assurance	Action status	Performance	Plan/Target	Indicator	Indicator Type
Elective					193,535	165,849	RTT total list size	National
					8,466	5,248	RTT >52 week waiters	National
					33	0	RTT >65 week waiters	National
					51.5%	92.0%	RTT 18 week performance %	National
					17,323	15,297	Elective Inpatient Activity	Local
					197,803	179,488	Elective Outpatient Activity	local
					27,641	19,953	Diagnostics (DM01) total list size	Local
					11.7%	10.0%	Diagnostics (DM01) waits >6 weeks	National
					37.9%	10.0%	Diagnostics - CYP DM01 6 week performance	Local
					17,605	24,711	Community Performance – Community Total Waiting List	Local
					95.0%	85.0%	Community Performance – Crisis Response	Local
					88.3%	96.0%	Cancer 31 day Standard	National
Cancer					58.6%	64.9%	Cancer 62 day standard	National
					76.2%	76.0%	28 day Faster Diagnosis	National
					211	202	Cancer 62 day backlog reduction	National

Executive Summary

		ASSURANCE			
					No Target
VARIATION	 		Number of patients waiting over 12 hours post DTA RTT - Total waits over 52 weeks RTT - Total waits over 65 weeks Diagnostics (DM01) 6 week performance RTT - Total Incomplete waiting list Cancer 62 day Standard Community Total Waiting List Size		Handovers over 45 minutes
	 Some	General & Acute Occupancy - Paediatrics	Accident & Emergency 4hr % Accident & Emergency total attends General & Acute occupancy (total) Ambulance handovers > 60 minutes Virtual ward - Hospital @ Home % of patients waiting over 12 hrs total time in department Average handover time (mins) Cancer 28 day FDS RTT - 18 week performance Diagnostics (DM01) waiting list General & Acute Occupancy - Adults Elective Inpatient and Outpatient Activity	Ambulance handovers < 15 minutes Cancer 31 day performance Cancer backlog reduction	
	 	Community Urgent care (crisis services) Diagnostics - CYP DM01 6 week < 18 yrs	Days away from home - NC2R		

Consistent assurance can be provided in:

- Community waiting list size, which continues to reduce
- G&A bed occupancy – overall, which continues to meet planned levels
- DM01 6 week performance – with significant improvements noted and delivery to plan in April
- Activity levels, which meet plan at M1

Significant improvement has been made in the following areas:

- 18ww performance – where we can see significant improvement and achievement of plan at M1
- RTT 52 week waits – where we can see a significant reduction and delivery ahead of plan in April
- The cancer 62 day standard, which is reporting a significant improvement but remains below planned levels

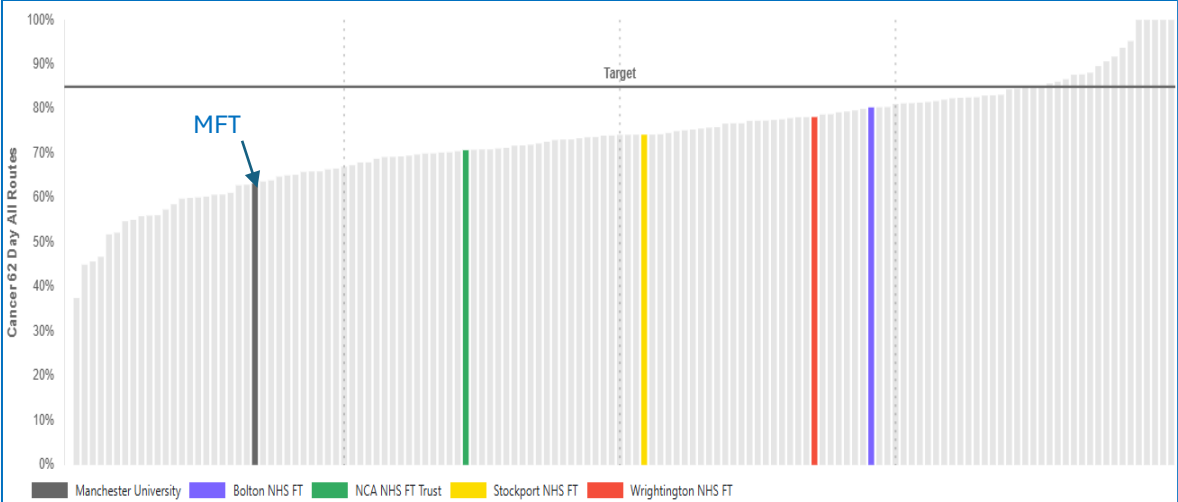
Particular risk is evident in the achievement of:

- Days Away from Home – which is demonstrating a significantly declining trend and is above the planned level at M1
- Hospital @ Home utilisation, which is below plan

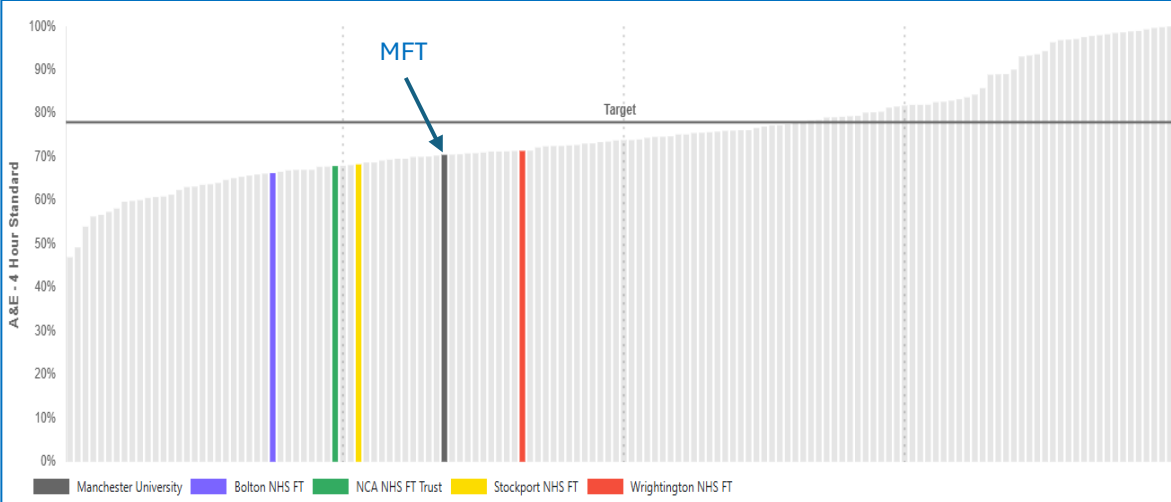
RTT 18-Week Standard (March)



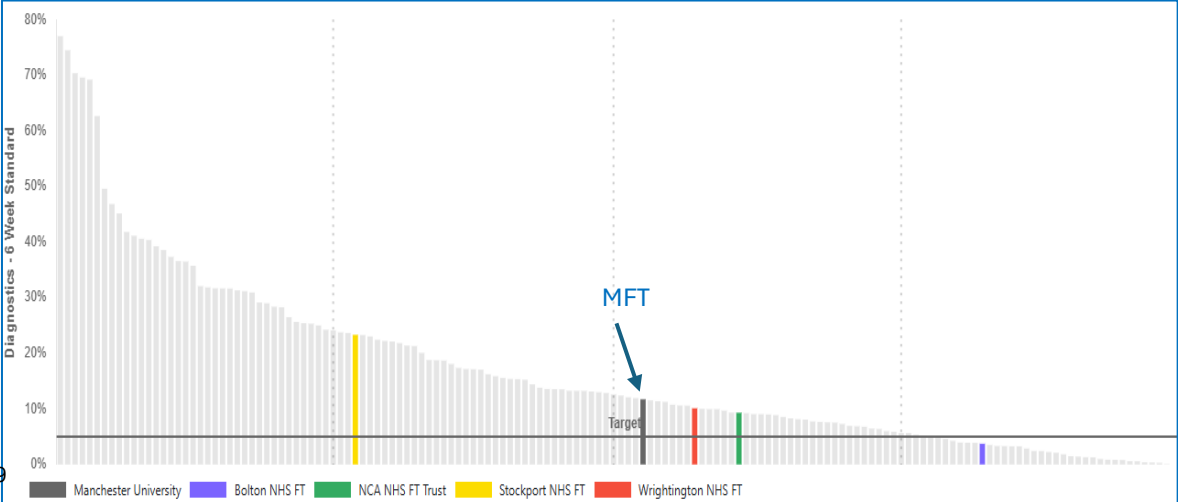
Cancer 62-day standard (March)



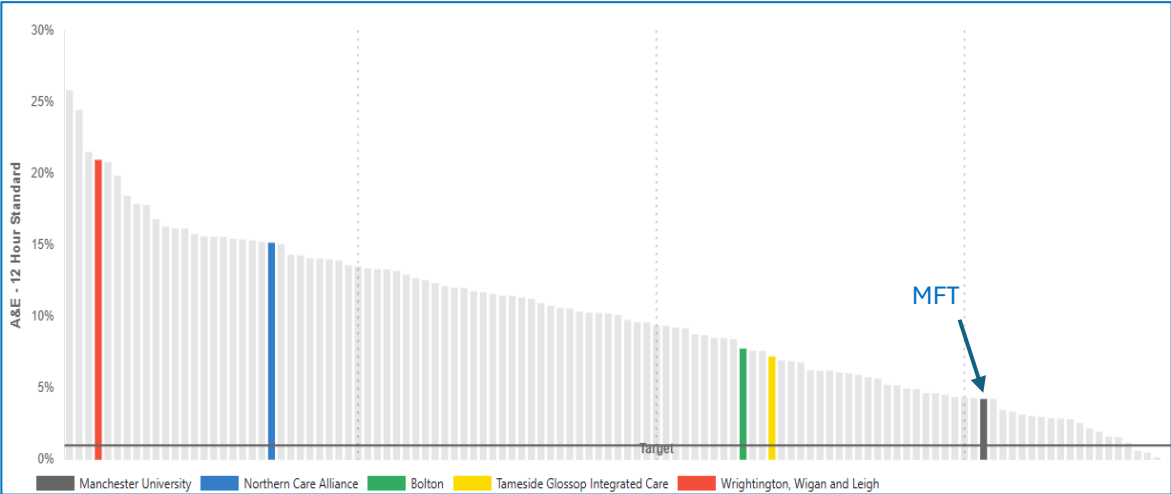
Emergency department 4-hour standard (April)



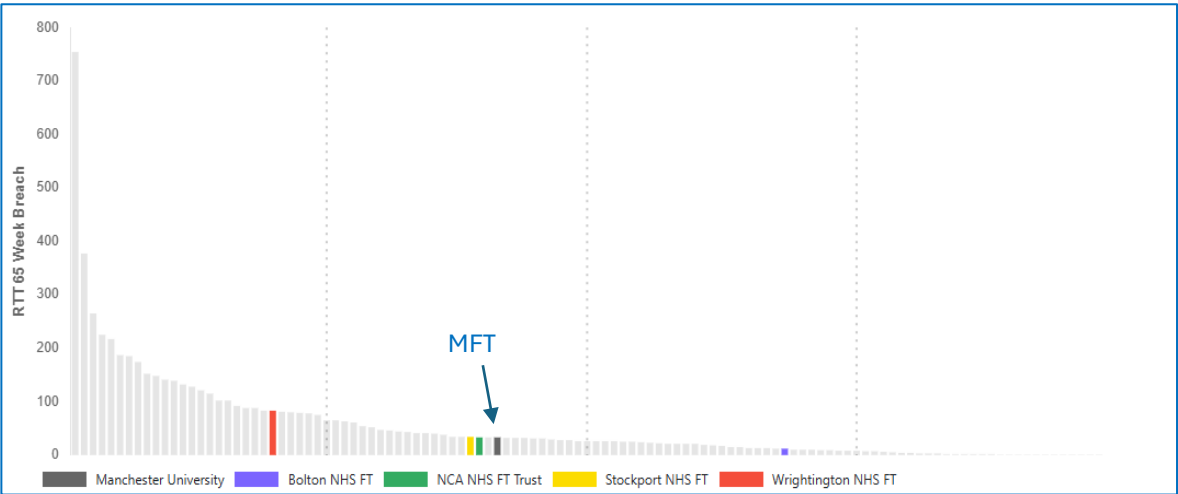
Diagnostic 6-week standard (March)



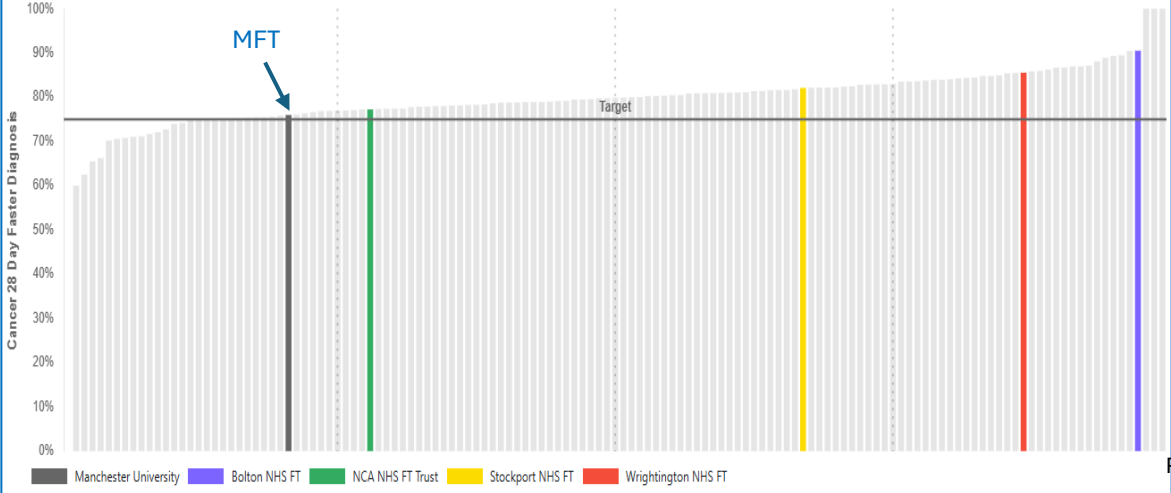
>12 Hours in ED (March)



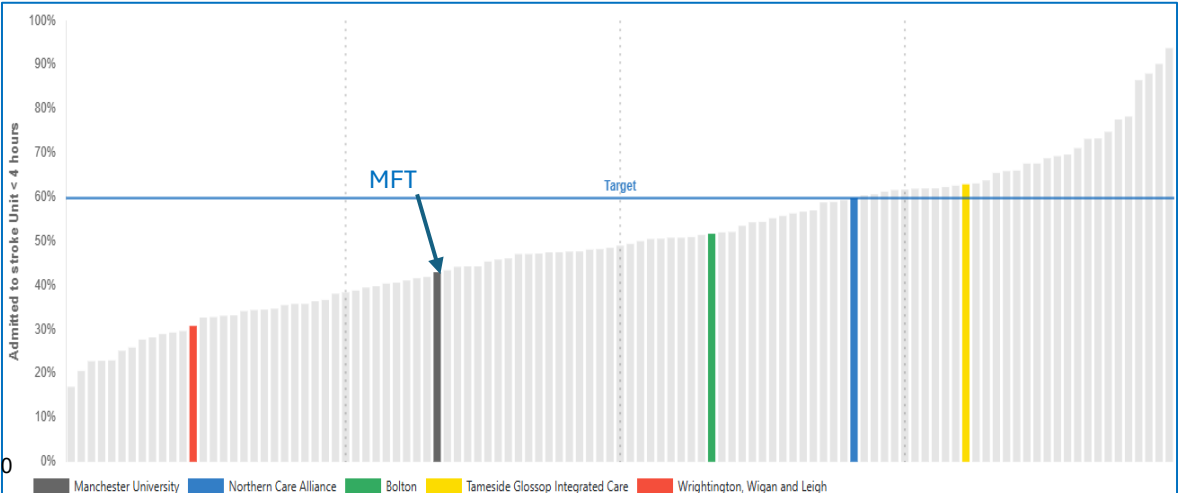
RTT 65 Week (March)



Cancer FDS standard (March)



Thrombolysed <1hour (Q2)



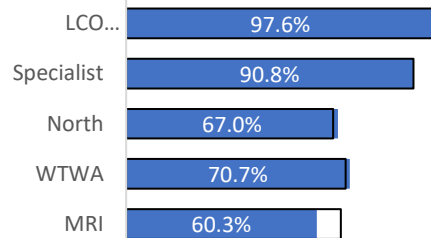
A&E Four Hour Standard

Alert	SOF3 metric

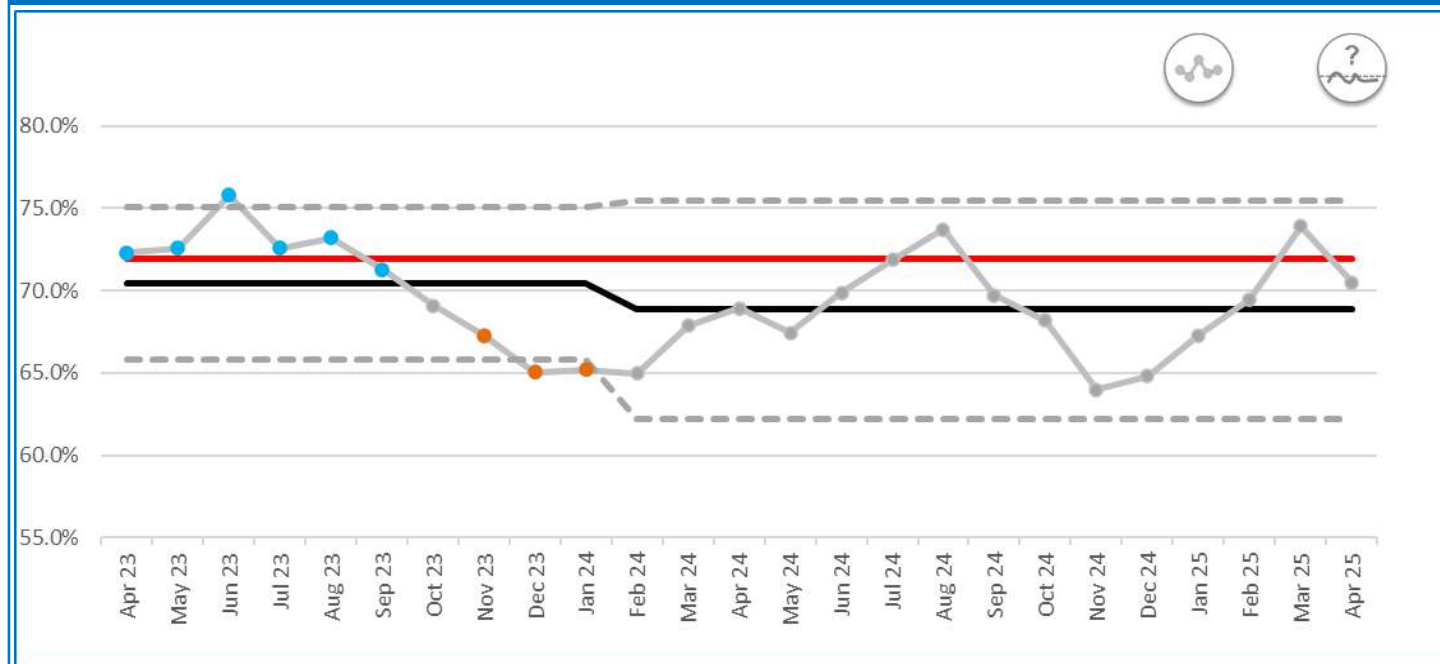
Apr-25	Plan
70.5%	71.9%

Compliance	Variance	Assurance	Actions

Clinical Group Overview



AED Four Hour Standard



Updates since previous month

Attendances in April marginally above plan (0.5%) – 43,674 vs 43,453 with 4hr breaches 5.6% above plan (12,872 vs 12,187), with overall performance -1.4% variance to plan.

Key dependencies

Streaming to Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC)
Utilisation of Hospital @ Home (H@H)

Current issues

Sustained heightened volume of No Reason to Reside patients across acute sites impeding flow.

Future actions

Increasing use of SDEC across all sites
“Home for Lunch” programme at WTWA
Pre-planned additional resident shifts for pressured shifts at Manchester Royal Infirmary (MRI)

North West Ambulance Service (NWS)

Handovers within 15 minutes

Advise

Apr-25

Plan

48.9%

65.0%

Compliance

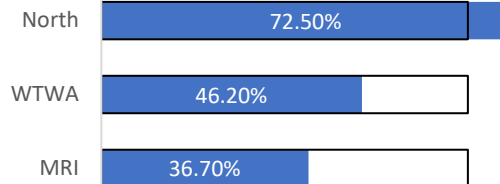
Variance

Assurance

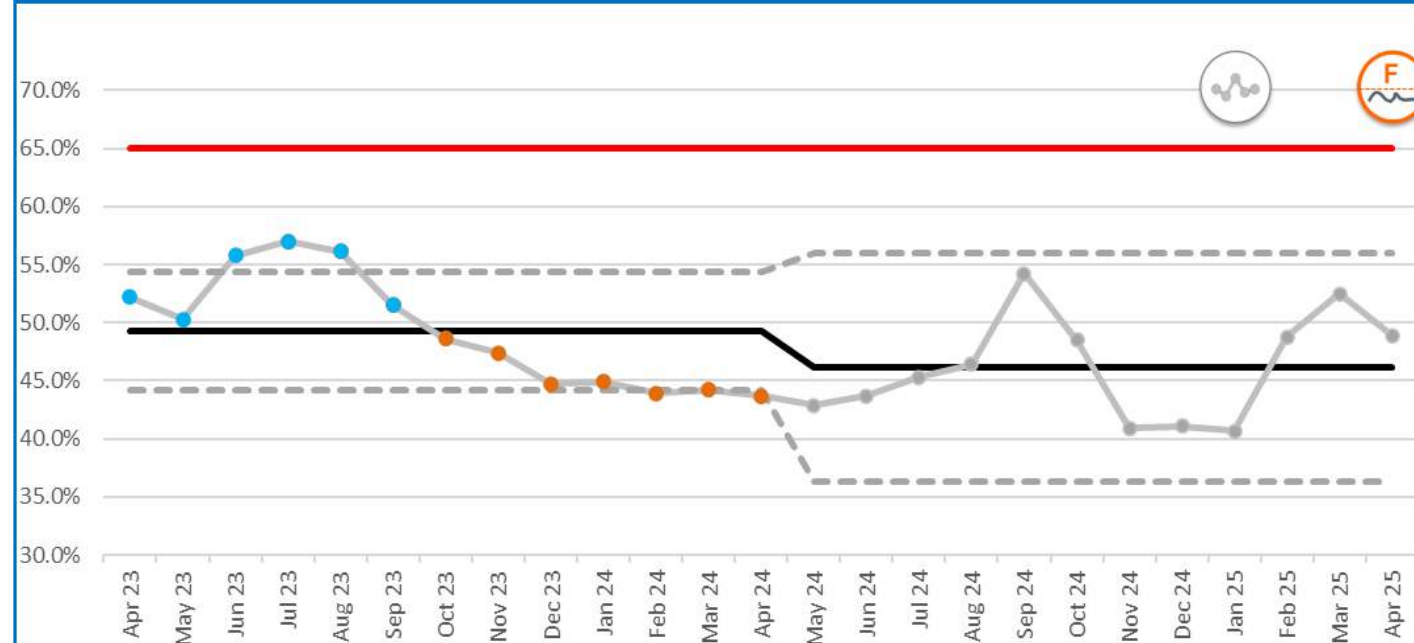
Actions



Clinical Group Overview



NWAS handovers within 15 minutes



Updates since previous month

Average turn-around and handover times increased to 26.3mins (25.8 prior month) and 17.5 mins (16.9 prior month) respectively. NWAS average across GM was 34.8 minutes for turnaround.

Key dependencies

'Hospital ambulance screen' compliance is 90.3% an increase from 89.4% in March, indicating assurance on accuracy of performance data

Current issues

MRI and WTTA have the longest handovers / turnaround times linked to increased conveyances and department / wider bed occupancy. Manchester Foundation Trust (MFT) remains the highest performing Trust in GM.

Future actions

Continued focus on ambulance handover processes with ambition to sustain best performance in GM. Project with NWAS to undertake call before convey to reduce ambulance conveyance

North West Ambulance Service (NWS)

Handovers > 45 minutes

Advise

Apr-25

Plan

100

Compliance



Variance



Assurance



Actions



Clinical Group Overview

WTWA

53

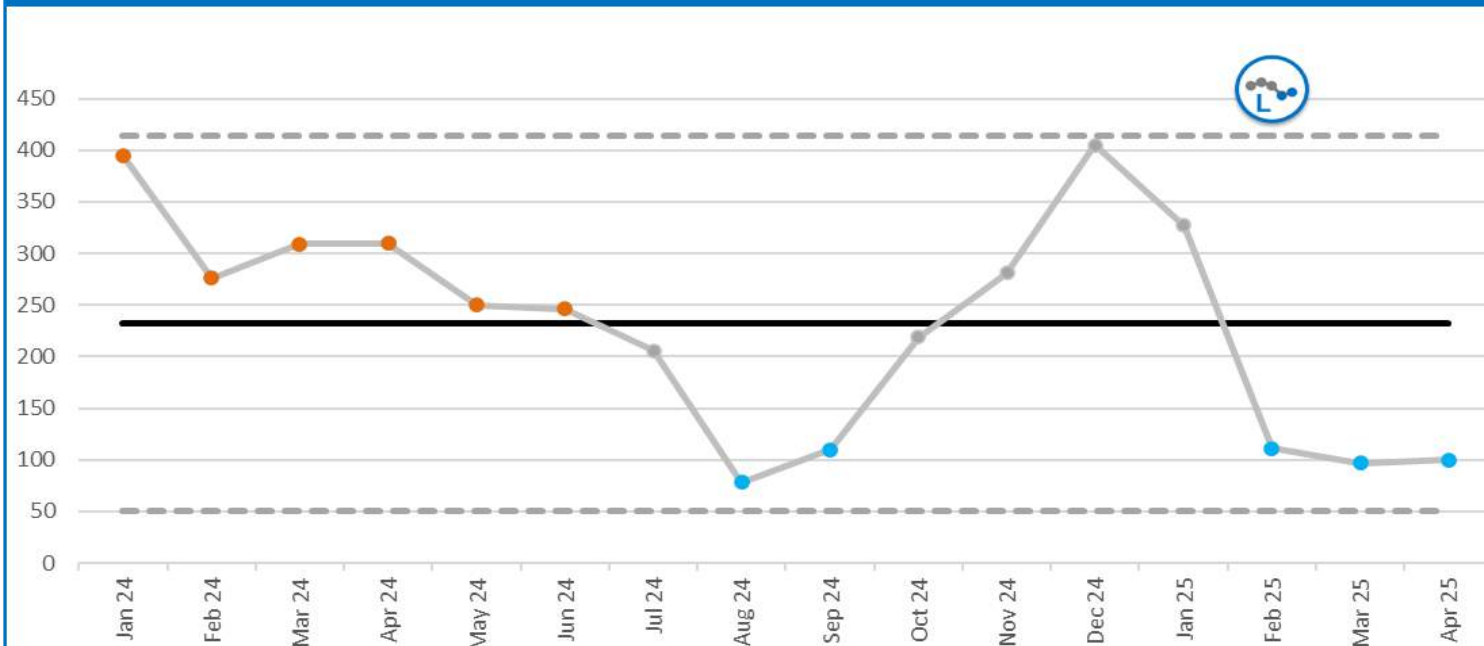
NMGH

8

MRI

39

NWAS handovers greater than 45 minutes



Updates since previous month

- New metric in 2025/26 planning guidance (to reduce greater than 45 minute handovers)
- MFT has shown a significant reduction in >45 minute handovers since February 2025

Current issues

MRI and WTWA have the longest handovers / turnaround times linked to increased conveyances and department / wider bed occupancy. Manchester Foundation Trust (MFT) remains the highest performing Trust in GM.

Key dependencies

HAS (hospital ambulance screen) compliance is 90.3% an increase from 89.4% in March, indicating a return to recording improvements noted from December.

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Future actions

Continued focus on ambulance handover processes with ambition to sustain best performance in GM. Project with NWAS to undertake call before convey to reduce ambulance conveyance

Ambulance Handovers over 60 minutes

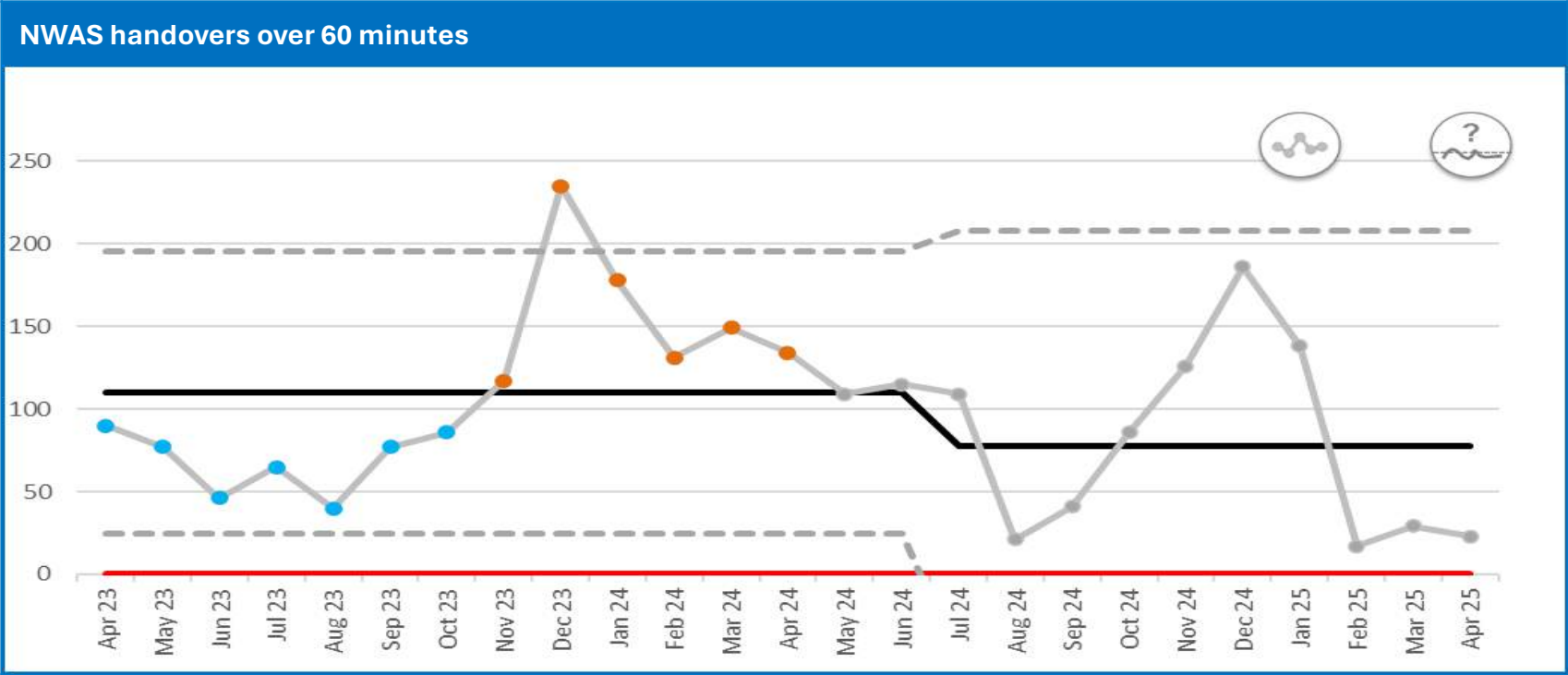
Advise

Apr-25	Plan
24	0

Compliance	Variance	Assurance	Actions

Clinical Group Overview

North	7
WTWA	9
MRI	8



Updates since previous month

Latest reported position for April was 24 delays over 60 minutes. The previous high of 235 was reported in December 23.

Key dependencies

Conveyance volumes within expected thresholds, HAS (hospital ambulance screen) compliance 90%+ (recording / reporting impact) good flow out of dept to receiving wards

Page 104

Current issues

Breaches driven by high acuity on transfer, particularly at the MRI site. Direct transfers to a Cath Lab for percutaneous coronary intervention (PCI) are the most frequent driver of a 60+minute handover breach.

Future actions

"Think 15" protocol in place to ensure standardised approach to safety and escalation. MFT Co-ordination Centre track (in hours) ambulance handovers real time and support review where a breach has occurred out of hours

Total waits over 12 hours in department as a % of all patients

Advise

SOF3 metric

Apr-25

Plan

4.2%

6.6%

Compliance

Variance

Assurance

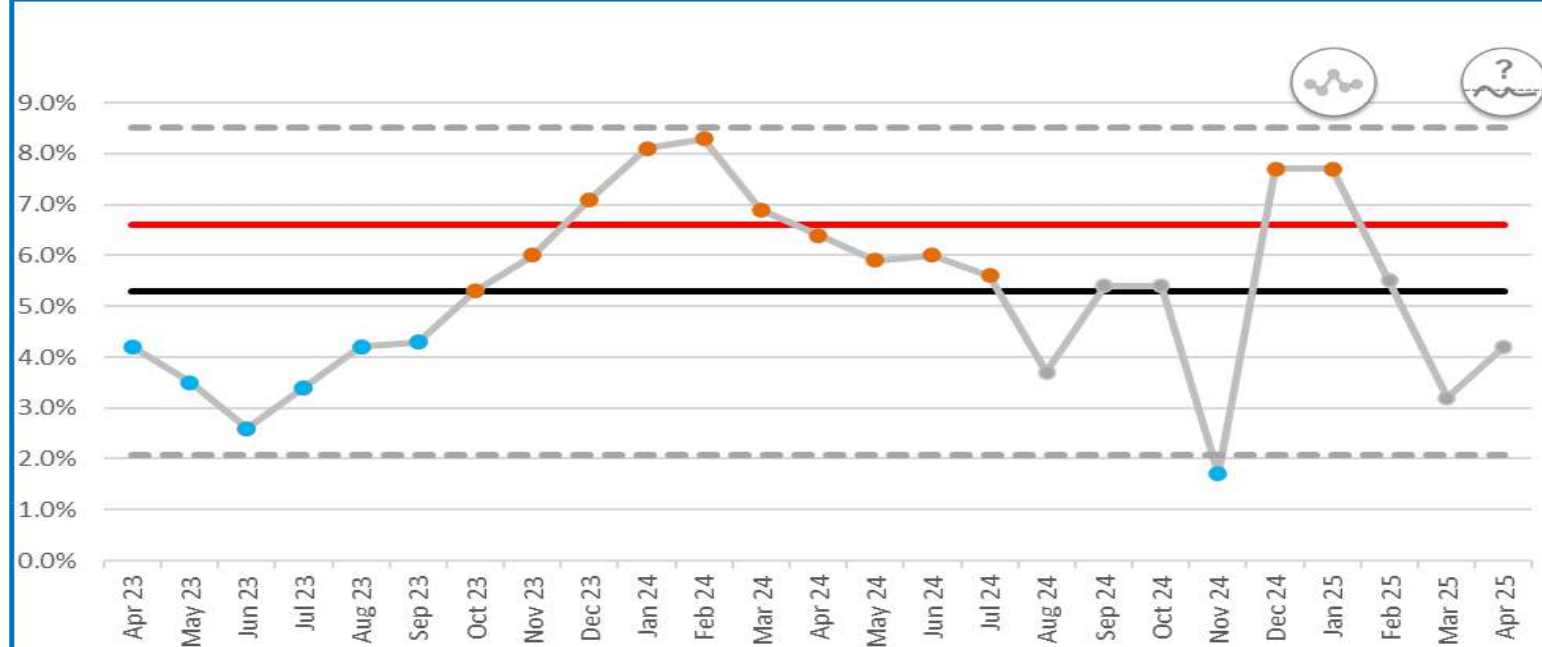
Actions



Clinical Group Overview

MRI	4.7%	5.8%
WTWA	10.0%	2.1%
North	8.1%	4.2%
Specialist	0.0%	0.0%
LCO Dental	0.0%	2.4%

Total time in department over 12 hours



Updates since previous month

A marginal increase seen in number of patients waiting over 12 hours to 4.2% vs the 6.6% standard, as performance continues with normal variation, but is still below planned levels. Mental health delays contributed 54% of the total (55)

Key dependencies

General & Acute (G&A) occupancy levels at or below 92% with levels of no reason to reside pts in line with plan and optimal utilisation of same day emergency care services

Page 105

Current issues

High levels of bed occupancy particularly within receiving wards – see slide 14
Mental health demand within Emergency Departments (ED).

Future actions

Ongoing escalation processes through MFT Coordination Centre

Number of patients waiting over 12 hours post DTA

Alert

SOF3 metric

Apr-25	Plan
101	0

Compliance

Variance

Assurance

Actions

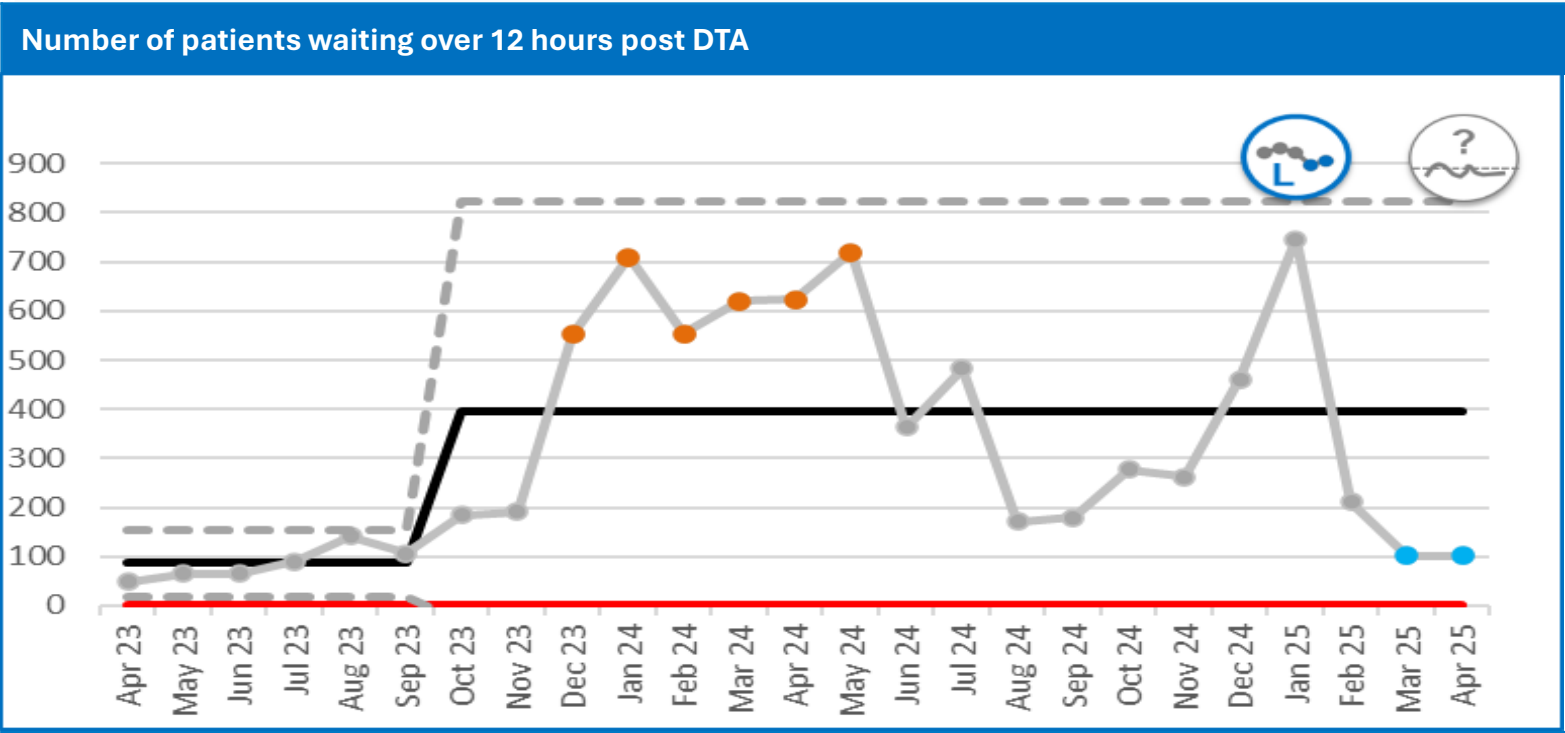
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Clinical Group Overview	
MRI	48
WTWA	43
North	10
Specialist	0
LCO Dental	0



Updates since previous month

Overall significant improvement continues for patients waiting more than 12 hours from decision to admit to admission to a ward, with 101 for April (101 in March).Mental health delays contributed 54% of the total (55)

Key dependencies

G&A bed occupancy levels were above 92% on average, with levels of no reason to reside pts in line with plan and optimal utilisation of same day emergency care services

Page 106

Current issues

High levels of bed occupancy particularly within receiving wards.
Mental health demand within EDs

Future actions

GMMH, GM Locality and MFT Co-ordination centre review all MH patients as a PTL
Ongoing escalation processes through MFT Coordination Centre

General & Acute Bed Occupancy – overall

Assure

Apr-25

Plan

92.5%

92.7%

Compliance

Variance

Assurance

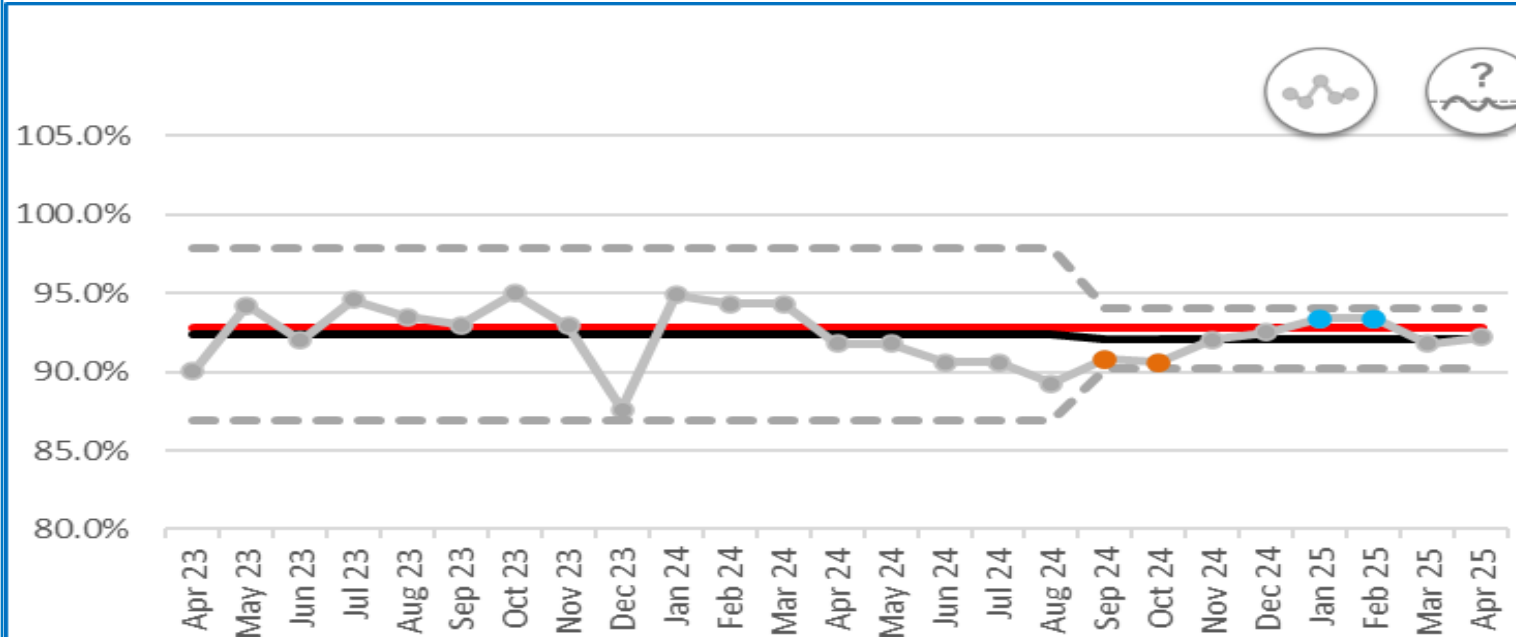
Actions



Clinical Group Overview

MRI	98.02%	97.6%
WTWA	90.70%	89.1%
North	90.80%	98.8%
Specialist	88.80%	81.6%

General & Acute Occupancy



Updates since previous month

Occupancy levels are variable across all sites with MRI, WTWA and Specialist sites having occupancy above plan. Trust marginally below plan. LCO drive to reduce NC2R patents

Key dependencies

- Non elective demand
- Discharge capacity
- Urgent and Emergency Care improvement plan

Current issues

Occupancy has remained high post the winter period with little variation between acute sites. Suboptimal rates of patients with 'No Reason to Reside' (NR2R) continues to impact overall occupancy despite performing well in discharging patients on their discharge ready date (87.2% vs national 85.6%)

Future actions

Revised process for reporting beds in real-time has been signed off and implemented. Care Closer to Home programme supporting work to reduce acute Length of stay

General & Acute Bed Occupancy – Adults

Advise

Apr-25

Plan

93.6%

Compliance

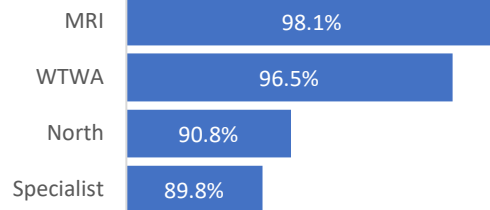
Variance

Assurance

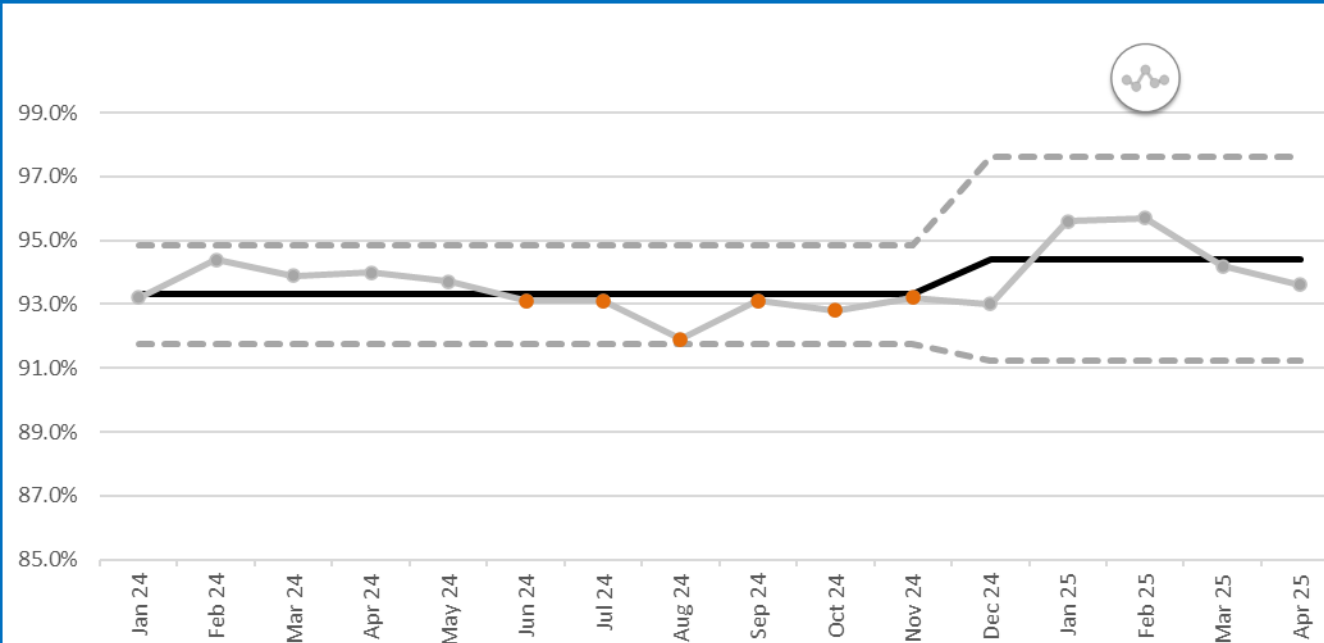
Actions



Clinical Group Overview



G&A Occupancy



Updates since previous month

MRI and WTWA both experienced prolonged high levels of occupancy in month, overall occupancy reduced due to lower levels in specialist capacity.

Current issues

Increased volumes of patients residing past EAD date adding to already high numbers of patients with a length of stay greater than 21 days.

Key dependencies

- Low staff absence levels
- Attendances in line with plan
- Admission thresholds within expectation

Future actions

Continued focus on utilising H@H capacity and ward reviews of those patients passed their EAD with a view to expedited discharge and repatriation

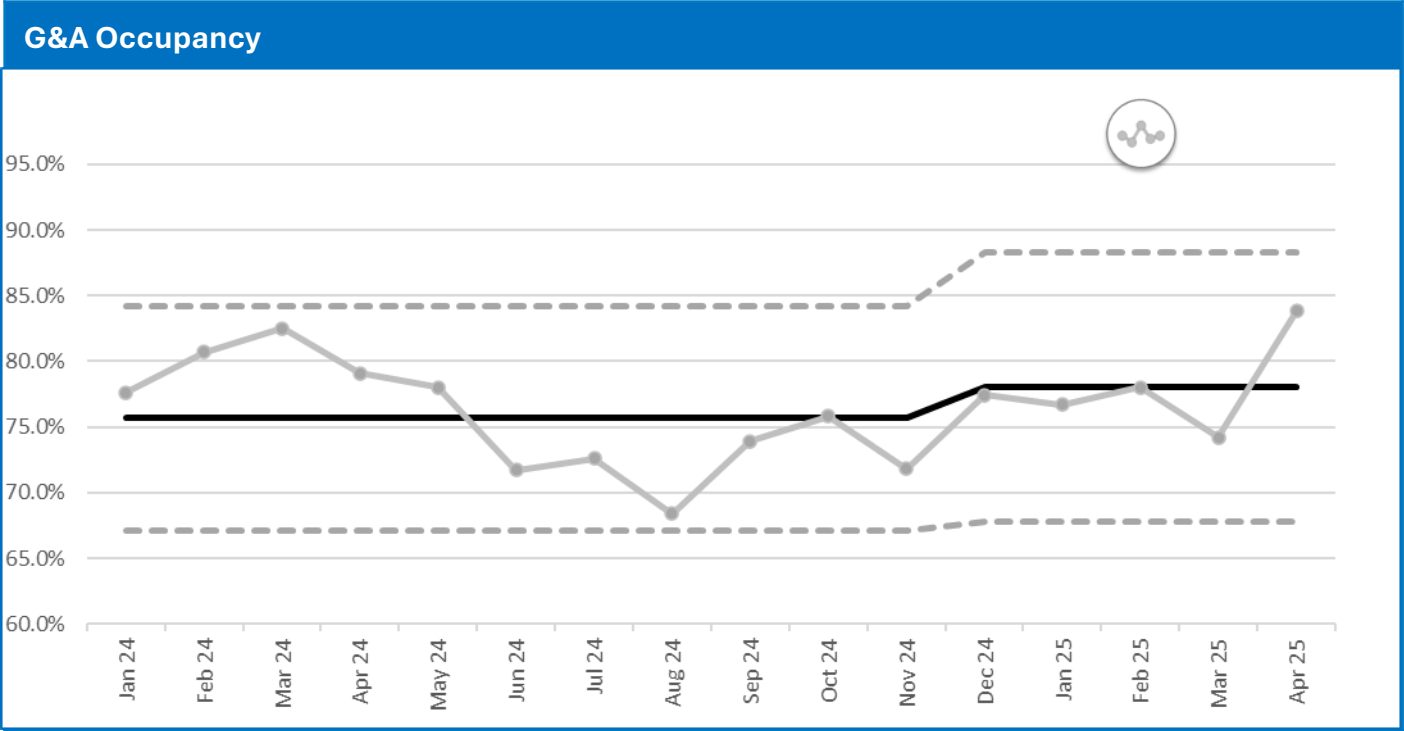
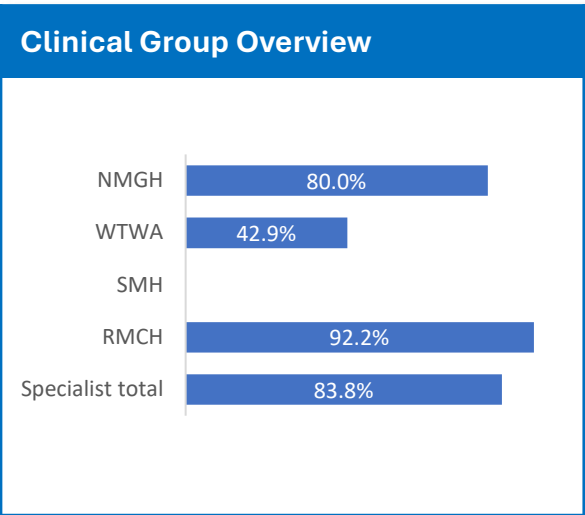
General & Acute Bed Occupancy – Paediatrics

Advise

Apr-25Plan

83.8%

Compliance	Variance	Assurance	Actions



Updates since previous month

Occupancy levels remain at sustainable levels. Average occupancy being reduced by low occupancy at WTWA; highest occupancy continues at Royal Manchester Children’s Hospital (within Specialist Hospitals)

Current issues

Long length of stay patients at RMCH requiring repatriation or with ongoing complex care needs

- ### Key dependencies
- Low staff absence levels
 - Attendances
 - Respiratory illnesses

Future actions

Programme streamlining paediatric admissions, with heightened reviews and escalations for long length of stay patients
Continued focus on utilising H@H capacity

Days Away From Home (No Reason to Reside)

Advise

Apr-25

Plan

305

296

Compliance

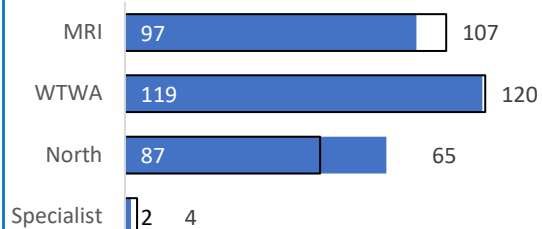
Variance

Assurance

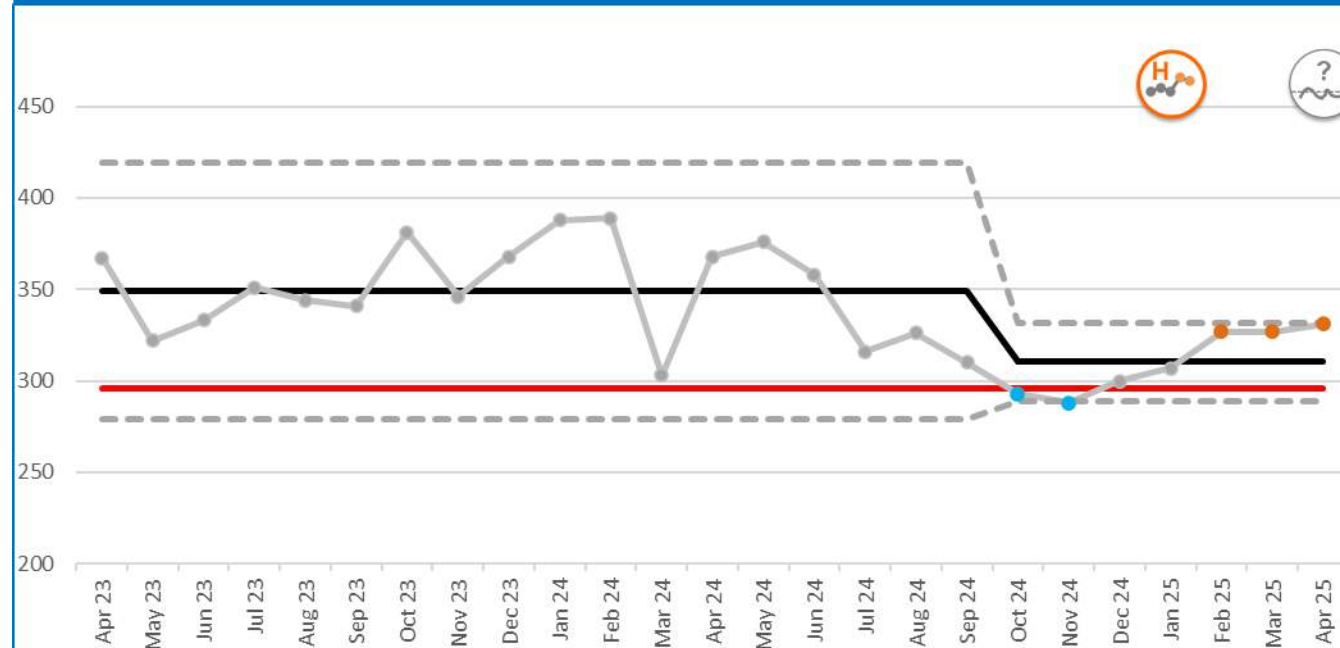
Actions



Clinical Group Overview



Days Away from Home – no reason to reside (NR2R)



Updates since previous month

Performance is showing statistically significant deterioration. Plan has not been met with inconsistent improvement across clinical groups.

Current issues

MLCO P2 and P3 pressures have impacted on the 70 Manchester target and daily churn
Increase in delays across March given the focused ward work being undertaken across NMGH which has increased churn in some pathways.

Key dependencies

Care Closer to Home and Prism workstreams
Attendance rates
Availability of in-reach and support services

Future actions

Revised trajectory being submitted and reviewed by TLTC on 24th April
Manchester social care interventions have been agreed to support recovery

Hospital @ Home – Virtual Ward

Advise

Apr-25

Plan

78.1%

81.0%

Compliance

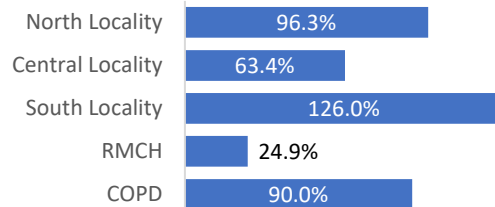
Variance

Assurance

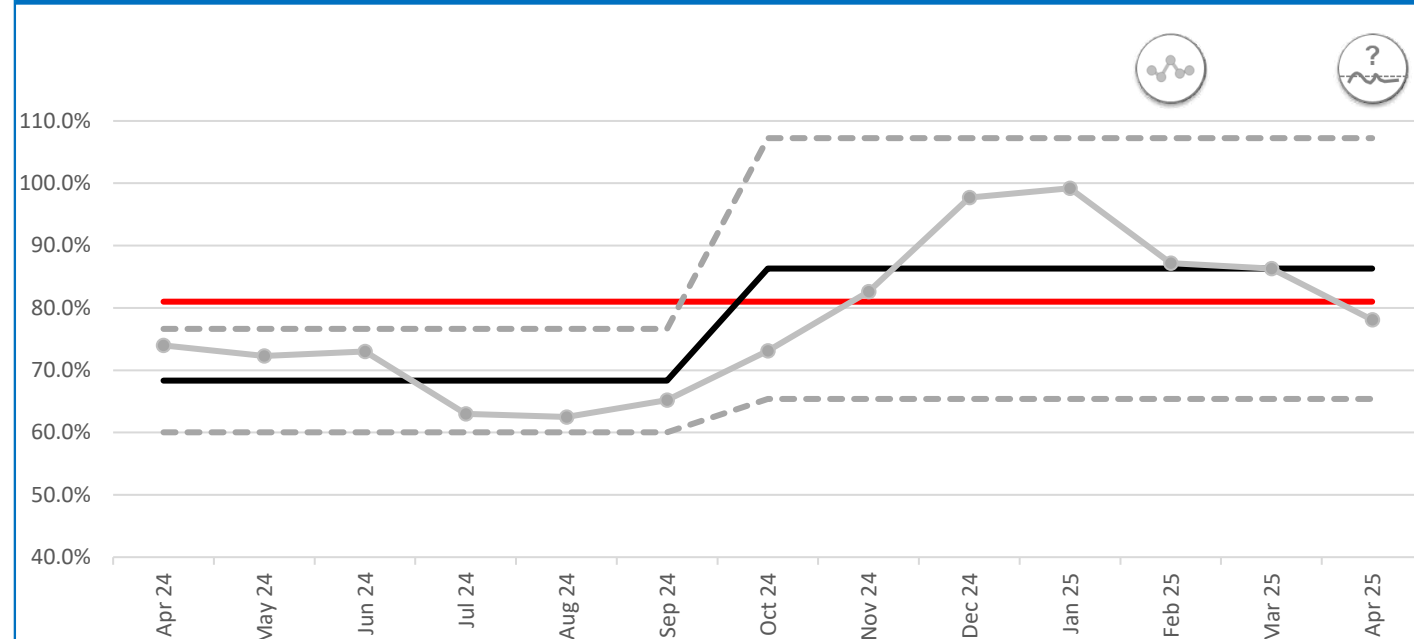
Actions



Clinical Group Overview



Virtual Ward



Updates since previous month

Performance is below plan for the month, despite over-delivery in the South locality.

Current issues

Community workforce pressures for ACPs across North and South are a risk to sustaining current capacity, with review taking place in Q1.

Key dependencies

Clinical leadership models in place to support H@H utilisation and awareness across all localities
Maintaining manageable level of acuity to ensure utilisation

Future actions

Continued push to increase referrals from step up and down routes, in reach work continuing to increase referrals and occupancy

Stroke performance – Thrombolysis

Assure

Dec-24

Plan

64%

60.0%

Compliance

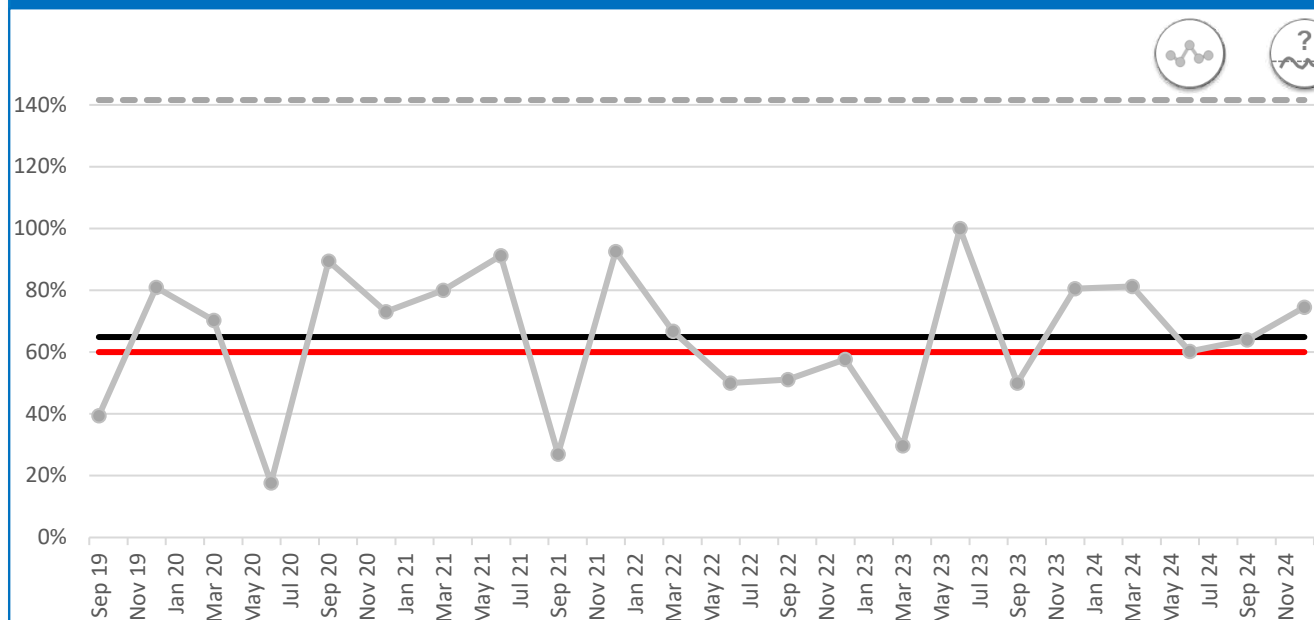
Variance

Assurance

Actions



Thrombolysis within 60 minutes



Note: stroke data is available quarterly in arrears and the most recently available data is displayed here (Dec 24)

Updates since previous month

Performance is in common-cause variation with latest position placing MFT within the 2nd Quartile nationally, mid-range amongst the Shelford group and 4th out of 6 within GM.

Escalation capacity being utilised to facilitate step-downs, and in-reach model has been developed to ensure improved stroke input at WTWA

WTWA and MRI have been collaborating to establish a joint model and new pathways for stroke services, supported by the Trust Strategy Group and in conjunction with the GM Stroke Network

Future actions

Joint working between MRI and WTWA clinical groups continues with an aim to deliver increased stroke capacity through bed utilisation and length of stay improvement work; initial strategic development proposal due to MFT Strategy Group in July 2025

Stroke performance – Admissions to Stroke unit (4hrs)

Alert

Dec-24

Plan

56.0%

60.0%

Compliance



Variance



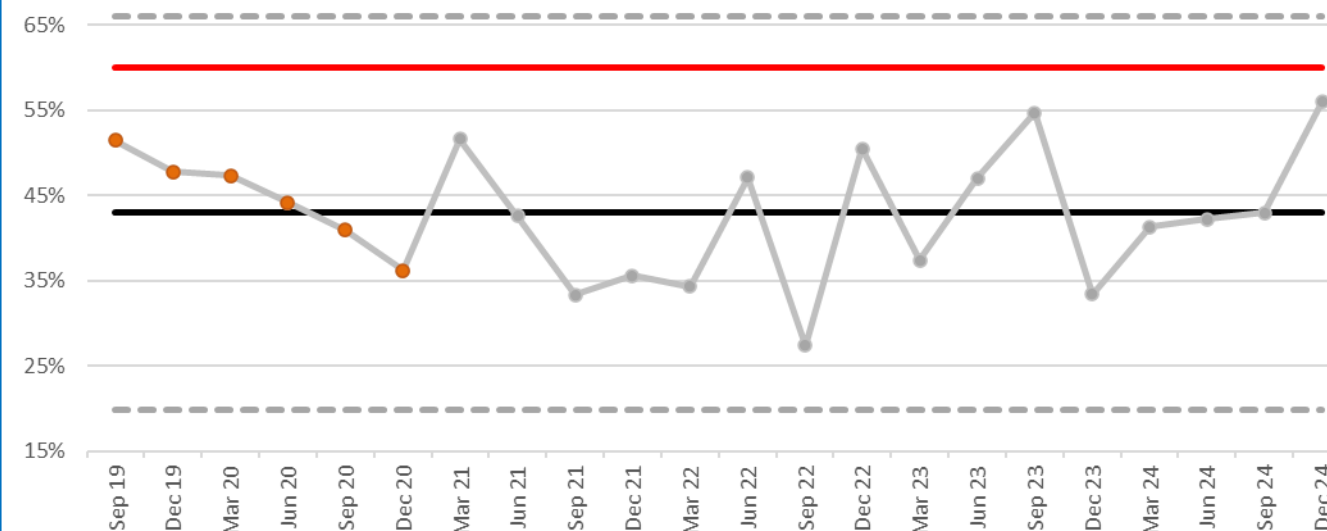
Assurance



Actions



Admission to Stroke unit within 4 hours of emergency presentation



Note: stroke data is available quarterly in arrears and the most recently available data is displayed here (Dec 24)

Updates since previous month

MFT sits in the 2nd quartile of national performance with a ranking of 68, mid range of Shelford providers and 5th out of 6 within GM in Q3 24/25. Performance shows common-cause variation.

Escalation capacity being utilised to facilitate step-downs, and in-reach model has been developed to ensure improved stroke input at WTWA

WTWA and MRI have been collaborating to establish a joint model and new pathways for stroke services, supported by the Trust Strategy Group and in conjunction with the GM Stroke Network

Future actions

Joint working between MRI and WTWA clinical groups continues with an aim to deliver increased stroke capacity through bed utilisation and length of stay improvement work; initial strategic development proposal due to MFT Strategy Group in July 2025

Cancer 31-day Standard

Advise	SOF3 metric
Mar-25	Plan
88.5%	85.0%

Compliance	Variance	Assurance	Actions

Clinical Group Overview			
MRI	83.93%	85.0%	
WTWA	90.68%	85.0%	
North	100.00%	85.0%	
Specialist	84.62%	85.0%	

Cancer – 31 days Standard

Cancer 31 day performance

Date	Performance (%)
Apr 23	79.0
May 23	80.0
Jun 23	80.0
Jul 23	81.0
Aug 23	87.0
Sep 23	79.0
Oct 23	81.0
Nov 23	84.0
Dec 23	82.0
Jan 24	75.0
Feb 24	87.0
Mar 24	85.0
Apr 24	81.0
May 24	88.0
Jun 24	87.0
Jul 24	88.0
Aug 24	84.0
Sep 24	85.0
Oct 24	88.0
Nov 24	86.0
Dec 24	82.0
Jan 25	84.0
Feb 25	88.0
Mar 25	89.0

Updates since previous month

No significant variation in performance observed, but the Trust is above the plan for the month of 85.0%.

Current issues

Surgical capacity for treatment in high volume treatment areas – although through the recovery actions some areas (lung) have brought their booking windows down to under 2 weeks.

Key dependencies

Surgeon core capacity
Theatre productivity
Anaesthetic cover
Recovery plan success

Future actions

Continue monitoring weekly surgical numbers and waits, focus on LGI, Lung and Urology
Mutual aid lists in place with the Christie

Page 114

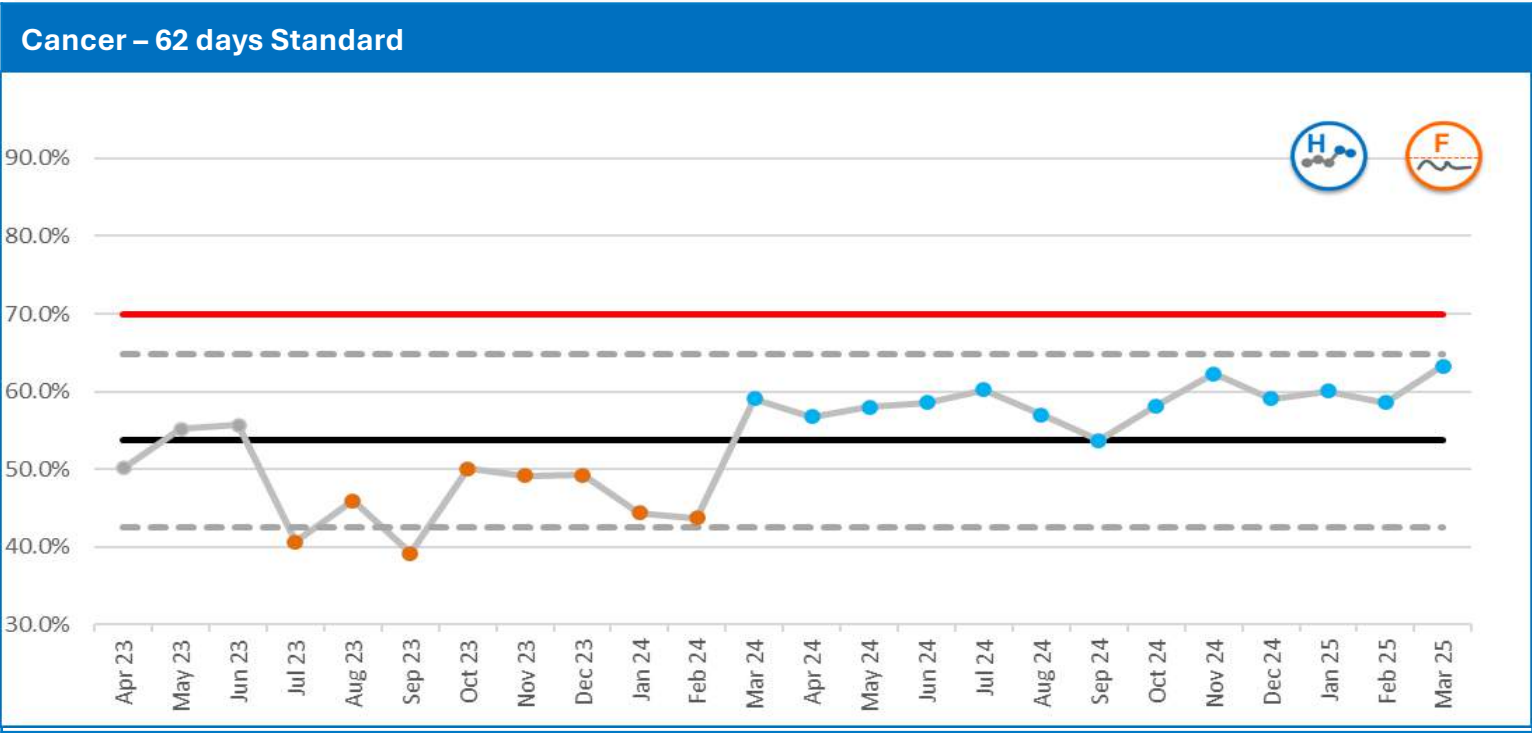
Cancer 62-day Standard (1 of 2)

Advise	SOF3 metric

Mar-25	Plan
63.3%	70.0%

Compliance	Variance	Assurance	Actions

Clinical Group Overview			
MRI	54.23%		70.0%
WTWA	61.30%		70.0%
North	47.06%		70.0%
Specialist	57.14%		70.0%



Updates since previous month

Cancer 62d performance shows improving variation, but has consistently been below the standard throughout 24/25. In the latest period, performance was 6.7% worse than plan (63.3% vs 70.0%).

Current issues

The increase in backlog following the bank holiday periods is being closely monitored. April and May performance is currently projected to be an improvement on the March position.

Key dependencies

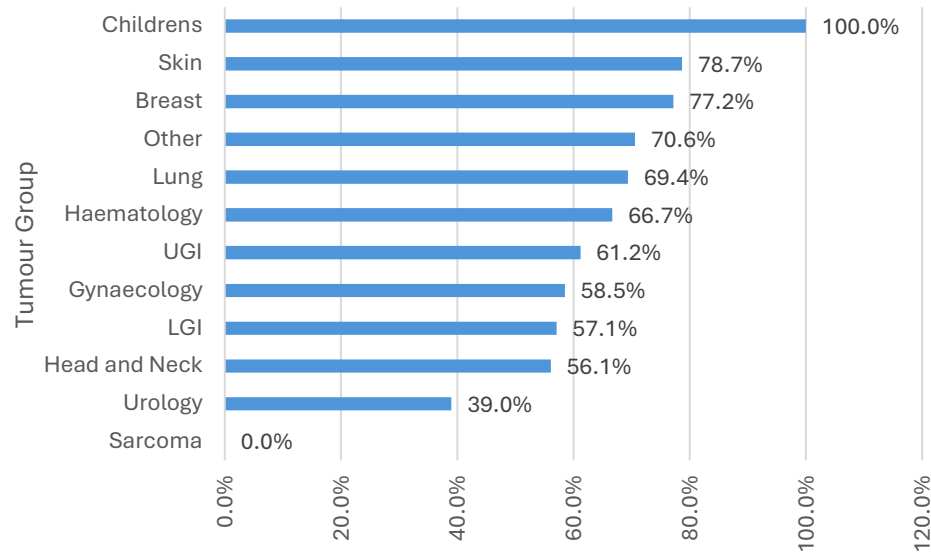
Continue to progress actions agreed in Collaborative Improvement groups covering all tumour groups. Utilisation of weekly post breach report to bring forward patients and reduce breach volumes

Future actions

2025/26 plans through Cancer Collaborative to be focussed on performance improvements required.

Cancer 62 day Performance by Tumour Group (2 of 2)

62 day performance by Tumour Group - March



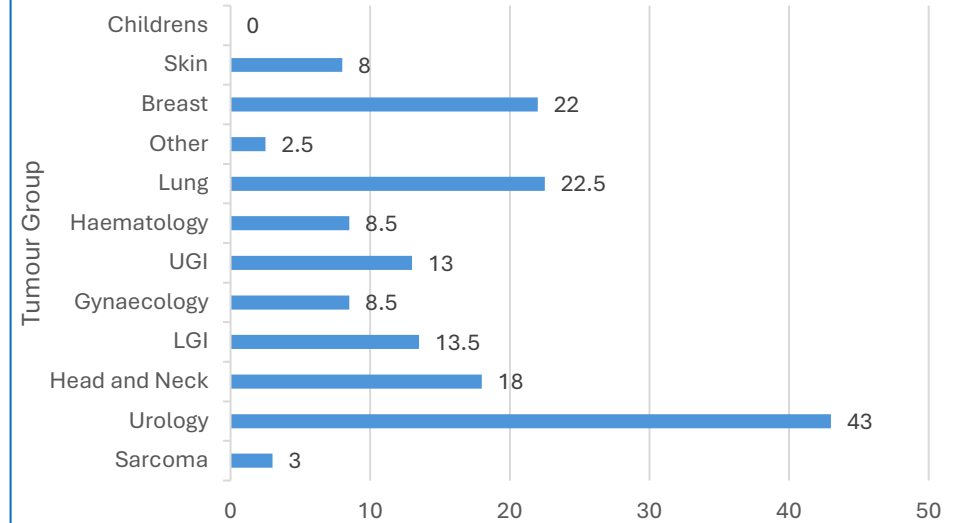
Updates since previous month

Significant improvement observed in lung tumour group performance over 2024/25 following increases in surgical capacity

Key dependencies

Continue to progress actions agreed in Collaborative Improvement groups covering all tumour groups. Utilisation of weekly post breach report to bring forward patients and reduce breach volumes

62 day Breaches by Tumour Group - March



Current issues

Urology performance and breach volumes have increased and the pathway requires further improvement action and capacity improvement. Additional diagnostic capacity is being provided in May/June

Future actions

Focus remains on LGI, Head and Neck, Lung, Urology, Gynaecology and CSS. Schemes run across the entire pathway to include diagnostics and treatments.

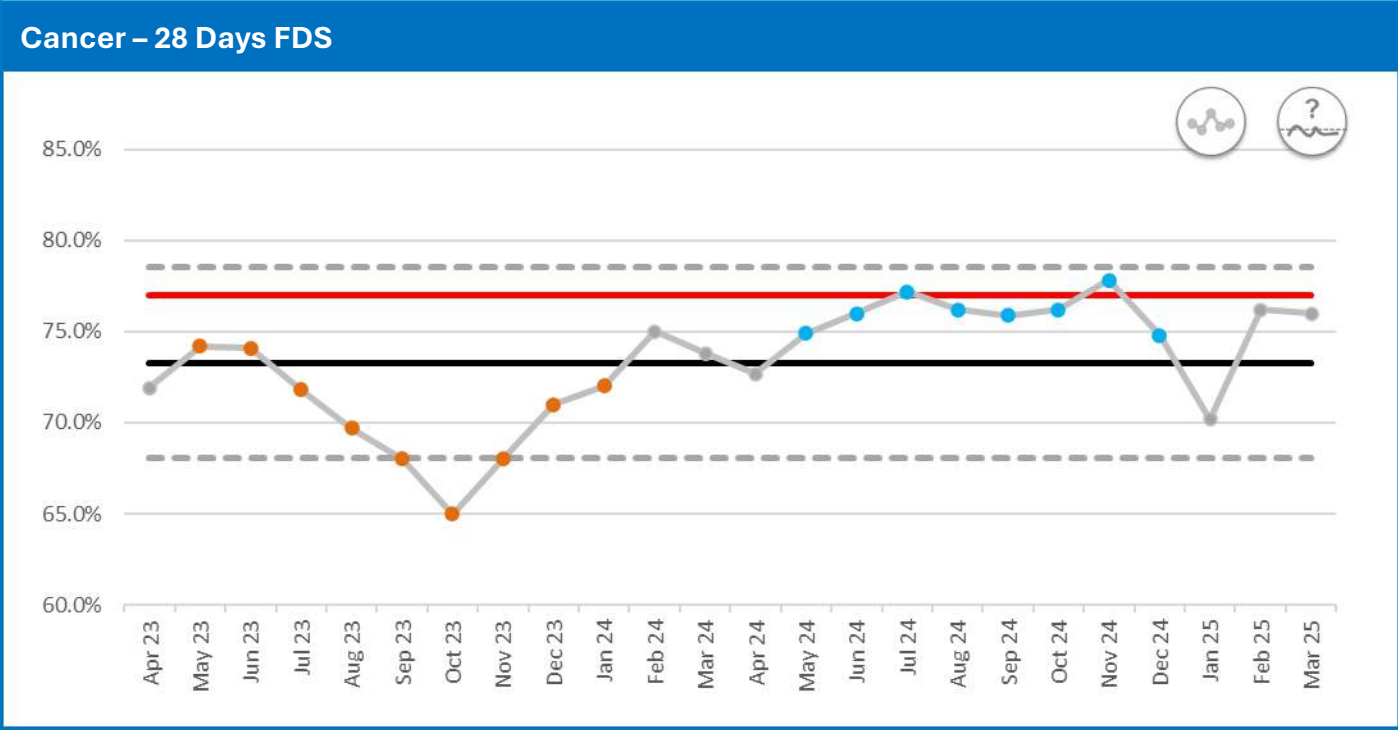
Cancer 28 day Faster Diagnosis Standard

Advise SOF3 metric

Mar 25	Plan
76.0%	77.0%

Compliance	Variance	Assurance	Actions

Clinical Group Overview			
MRI	73.1%		77.0%
WTWA	82.2%		77.0%
North	69.9%		77.0%
Specialist	53.1%		77.0%



Updates since previous month
FDS performance in March was 76.0%, above the national target of 75% and marginally below the MFT planned trajectory of 77.0%. Performance continues to show normal variation, with recovery from January's reduced position.
Key dependencies
Continue to progress actions agreed in Collaborative Improvement groups covering all tumour groups.

Current issues
Future performance is at risk reduced following high referral rates in some areas and diagnostic capacity issues; actions are in place to address during May
Future actions
Mutual aid for gynaecology pathology being progressed, alongside GM assistance for lung CT guided biopsies. CSS are working on improvements to the CT colon pathway.

RTT PTL Waiting list size

Assure

SOF3 metric

Apr-25

Plan

193,114

198,819

Compliance

Variance

Assurance

Actions

Clinical Group Overview

MRI	44,326	42,151
WTWA	42,619	41,452
CSS	4...	3,279
North	28,360	30,123
Specialist	58,429	59,428
LCO Dental	15,83	15,276
Unallocated	5,142	1,405

RTT PTL

Month	Actual (Black)	Plan (Red)
Apr 23	206,000	198,819
May 23	204,000	198,819
Jun 23	201,000	198,819
Jul 23	201,000	198,819
Aug 23	193,000	198,819
Sep 23	185,000	198,819
Oct 23	179,000	198,819
Nov 23	178,000	198,819
Dec 23	185,000	198,819
Jan 24	186,000	198,819
Feb 24	188,000	198,819
Mar 24	188,000	198,819
Apr 24	190,000	198,819
May 24	190,000	198,819
Jun 24	189,000	198,819
Jul 24	192,000	198,819
Aug 24	194,000	198,819
Sep 24	196,000	198,819
Oct 24	198,000	198,819
Nov 24	201,000	198,819
Dec 24	201,000	198,819
Jan 25	199,000	198,819
Feb 25	198,000	198,819
Mar 25	194,000	198,819
Apr 25	193,114	198,819

Updates since previous month

The overall PTL size returned to normal variation and is below April planned levels. An automated waiting list validation Chatbot programme commenced April which will further help with identifying those who no longer require treatment

Current issues

To sustain performance improvements in long waits, further waiting list reduction are required through 2025/26, with the aim to deliver a maximum list size of 175,000 by March 2026.

Key dependencies

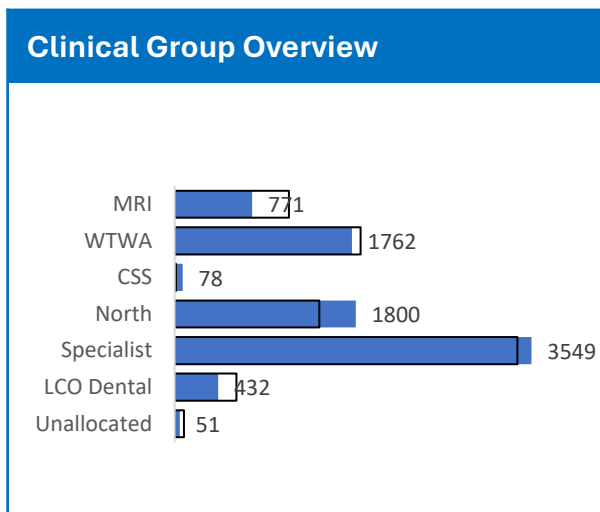
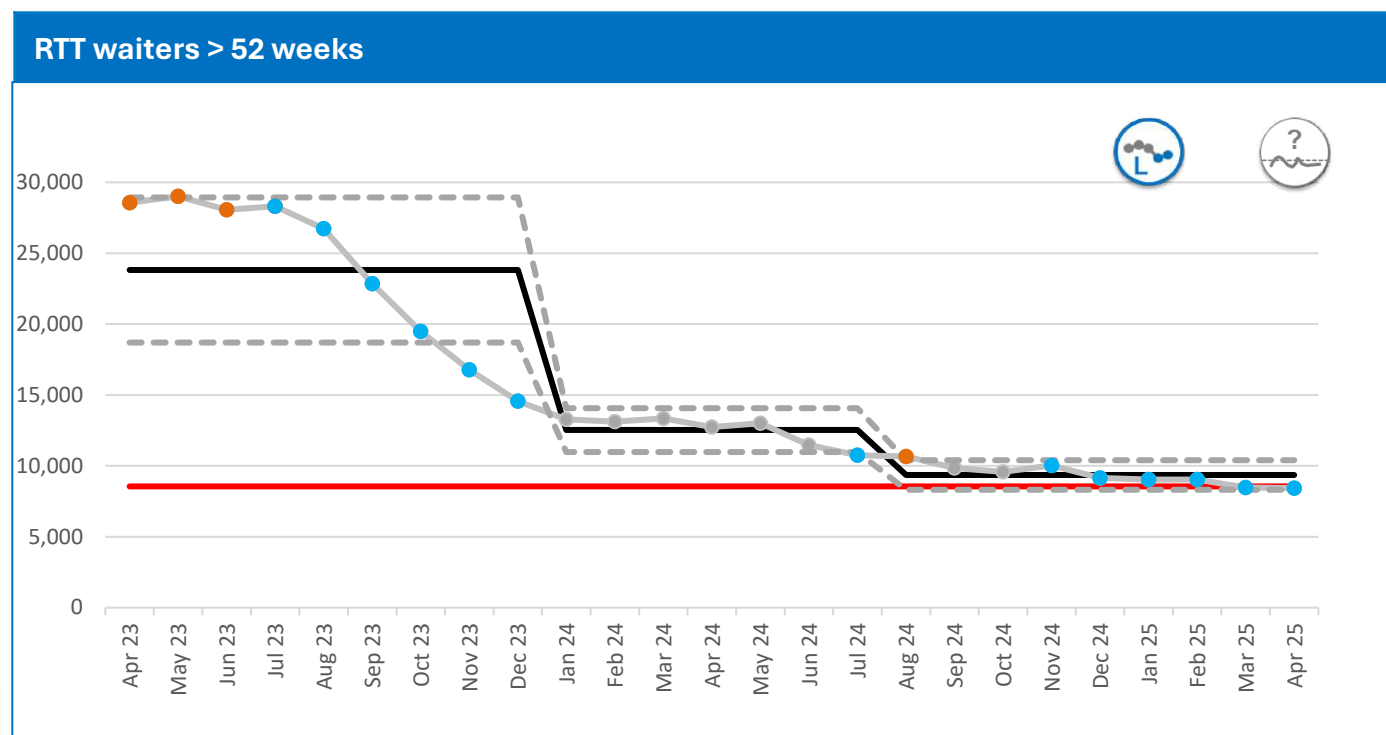
Ensuring capacity is maximised and bookings are made timely to reduce long waiters, outcoming is timely and accurate.

Future actions

Elective recovery programme went live in April 2025 to further drive pathway transformation and waiting times improvement.

RTT > 52 Week waiters

Assure		SOF3 metric	
Apr-25		Plan	
8,433		8,554	
Compliance	Variance	Assurance	Actions



Updates since previous month

Reduction of the overall 52 week wait cohort continues with in month performance 121 below the plan. The elective delivery programme is continuing to work with operational leads to maximise capacity.

Key dependencies

Outpatient capacity
Theatre capacity for complex cases

Current issues

Largest volumes of 52WW patients are in gynaecology, T&O, ENT and gastroenterology.

Future actions

Plans for 2025/26 focus on 52W delivery as the key long-wait metric, with the expectation that long waits will continue to reduce.

RTT > 65 Week waiters

Advise	SOF3 metric

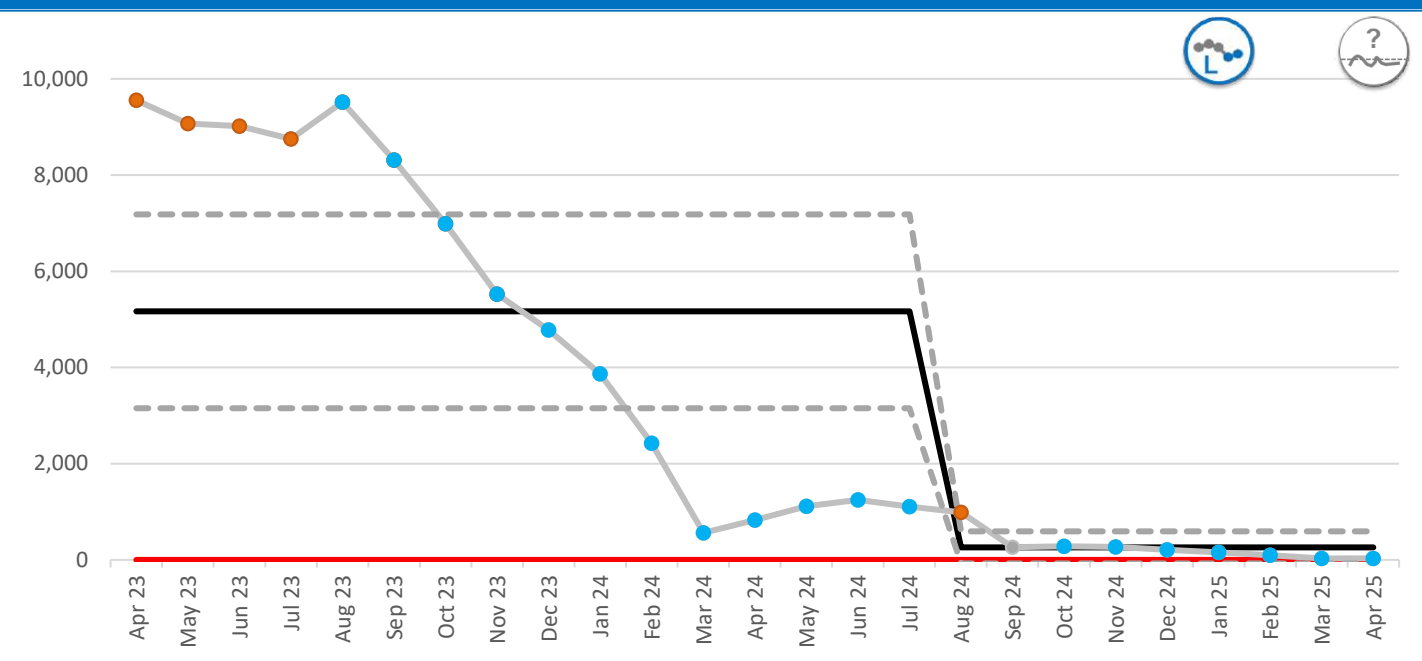
Apr-25	Plan
32	0

Compliance	Variance	Assurance	Actions

Clinical Group Overview

MRI	0
WTWA	
CSS	0
North	5
Specialist	27
LCO Dental	0

RTT waiters > 65 weeks



Updates since previous month

Final validated data for April is 32 >65-week waits vs a plan of 0, which compares to 98 in February. 23 of these patients were waiting for corneal grafts.

Current issues

Remaining risks in this cohort relate to residual long waiting corneal graft patients and long pathways for complex elective pathways in T&O, gynaecology and some paediatric specialties.

Key dependencies

Dedicated recovery programmes for gynaecology and T&O
Tissue availability for grafts

Future actions

Continue weekly oversight, ensuring delivery of actions.
Prioritisation of corneal graft patients in place nationally.

RTT 18-week performance

Assure	SOF3 metric

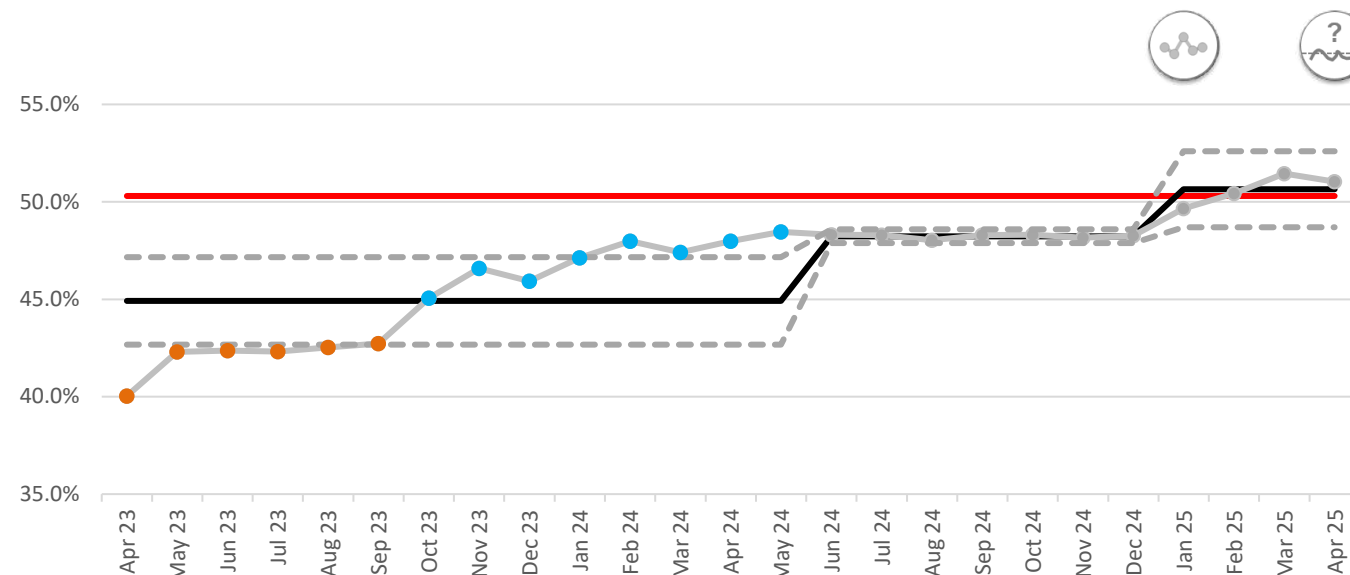
Apr-25	Plan
51.04%	50.26%

Compliance	Variance	Assurance	Actions

Clinical Group Overview

MRI	55.30%
WTWA	55.20%
CSS	47.24%
North	46.44%
Specialist	48.67%
LCO Dental	45.10%

RTT 18 week performance %



Updates since previous month

Continued improvement in MFT's 18-week performance, with an improvement to 51.04% in April from 49.7% in January.

Current issues

MFT PTL needs to be 100,000 patients to sustainably deliver 18 weeks but is currently almost double this size; first milestone is MFT plan to achieve list size of 175,000 patients by March 2026.

Key dependencies

Sustainable PTL size
Sufficient activity levels
Prioritisation and operational focus

Future actions

Elective improvement programme has a range of workstreams aiming to deliver 18-week performance, including programmes of work on operational management, technical support and engagement and training

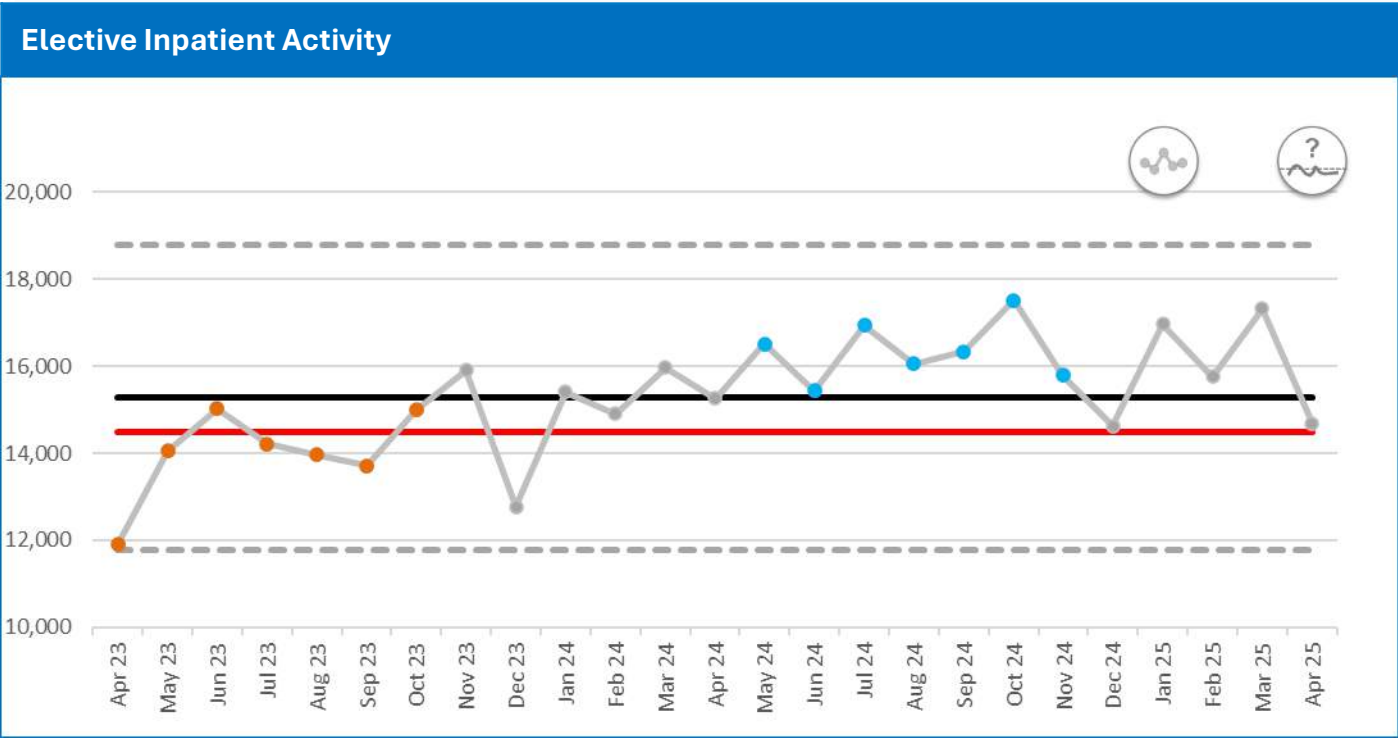
Elective Inpatient Activity

Assure

Apr-25	Plan
14,682	14,499

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
MRI	6,081	6056
WTWA	3,179	3056
CSS	397	
North	1,131	1227
Specialist	3,602	3407
LCO Dental	356	



Updates since previous month

Elective activity currently showing positive variance to plan (+183). Contract plans and activity allocations are still being finalised through the planning round and so are subject to change.

Key dependencies

Theatre productivity programmes

Page 122

Current issues

Optimising capacity to increase activity levels further e.g. through theatres whilst increasing utilisation

Future actions

Delivering volumes required to maintain performance and achieve this year's performance goals. Ensuring reporting is finalised and allocations agreed

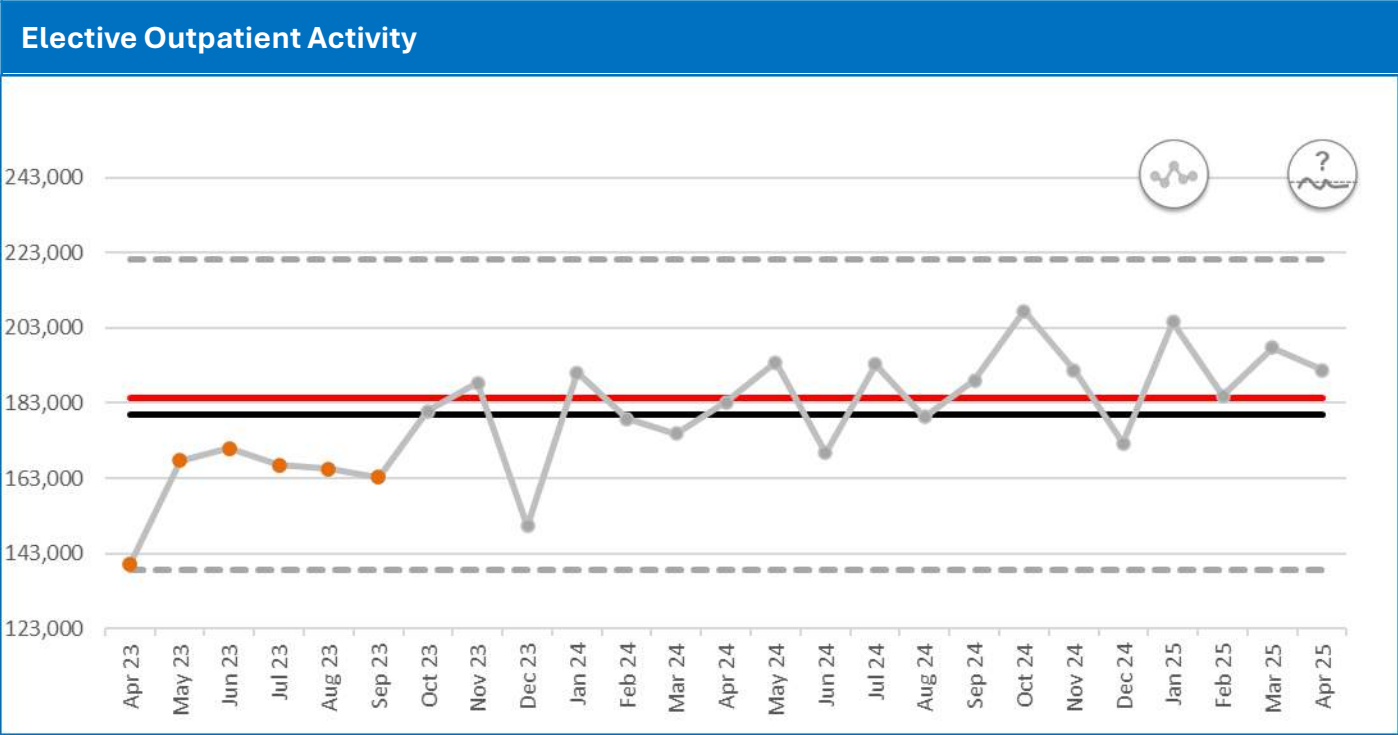
Elective Outpatient Activity

Assure

Apr-25	Plan
191,827	184,447

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
MRI	33872	29884
WTWA	39876	41403
CSS	19368	18164
North	18404	19235
Specialist	75,078	69706
LCO Dental	5229	6055



Updates since previous month
Elective activity currently showing positive variance to plan (+7,380). Contract plans and activity allocations are still being finalised through the planning round and so are subject to change.
Key dependencies
Outpatient improvement programme and outcoming are key workstreams to support delivery.

Current issues
Activity is currently reported above planned levels.
Future actions
Working group to reflect on allocations and counting methodology to ensure consistent and accurate reporting.

Diagnostics – DM01 Total Waiting List Size

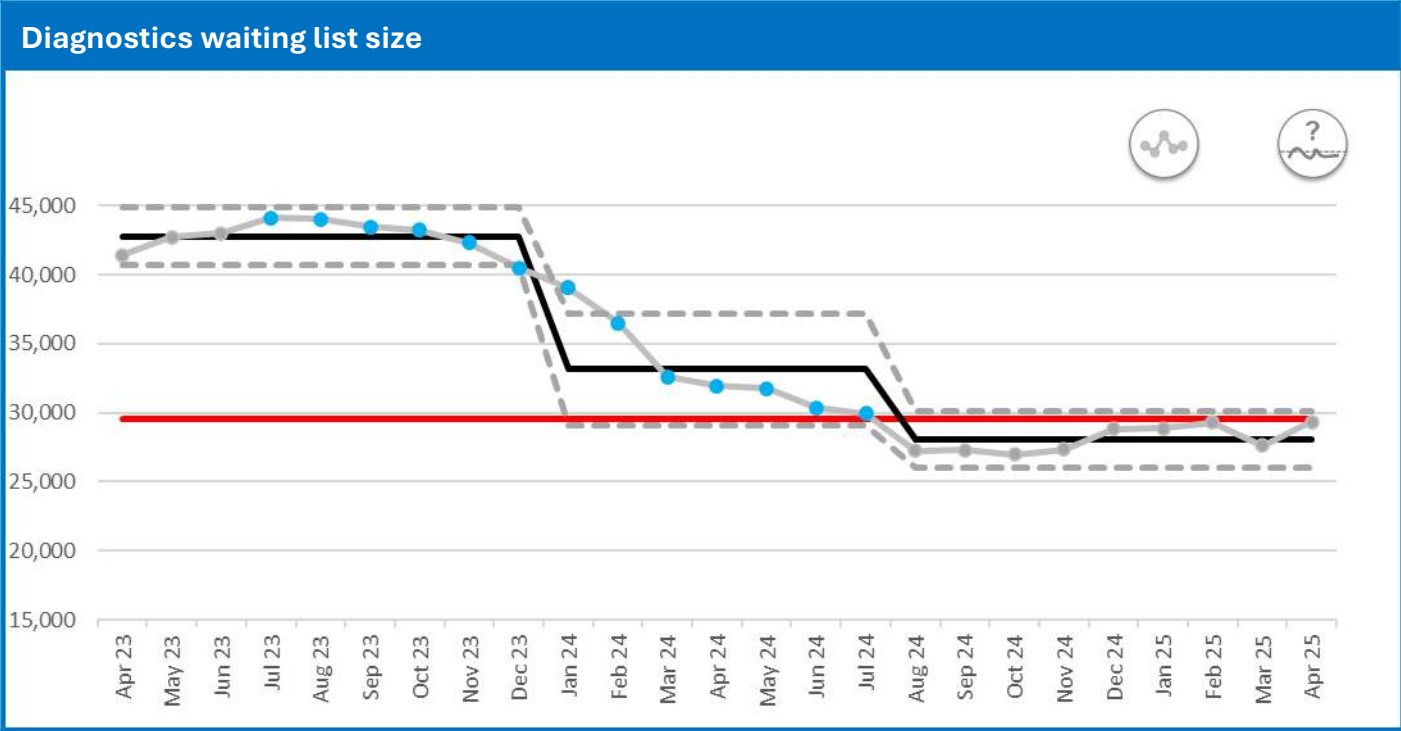
Advise

SOF3 metric

Apr-25	Plan
29,331	29,527

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
MRI	2,664	2636
WTWA	6,825	6289
CSS	18,792	19499
North	264	231
Special...	771	436
LCO...	0	0



Updates since previous month

Overall waiting list has continued to decrease into April from March, and is marginally ahead of plan (196) at month end

Key dependencies

Modality level tracking and recovery plans
Additionality provision
Utilisation of CDC

Current issues

Continuing demand observed across planned and Elective activity within MRI, CT and NOUS, activity levels are within normal range of variation.

Future actions

Weekly oversight meetings at modality level tracking performance and waiting list size

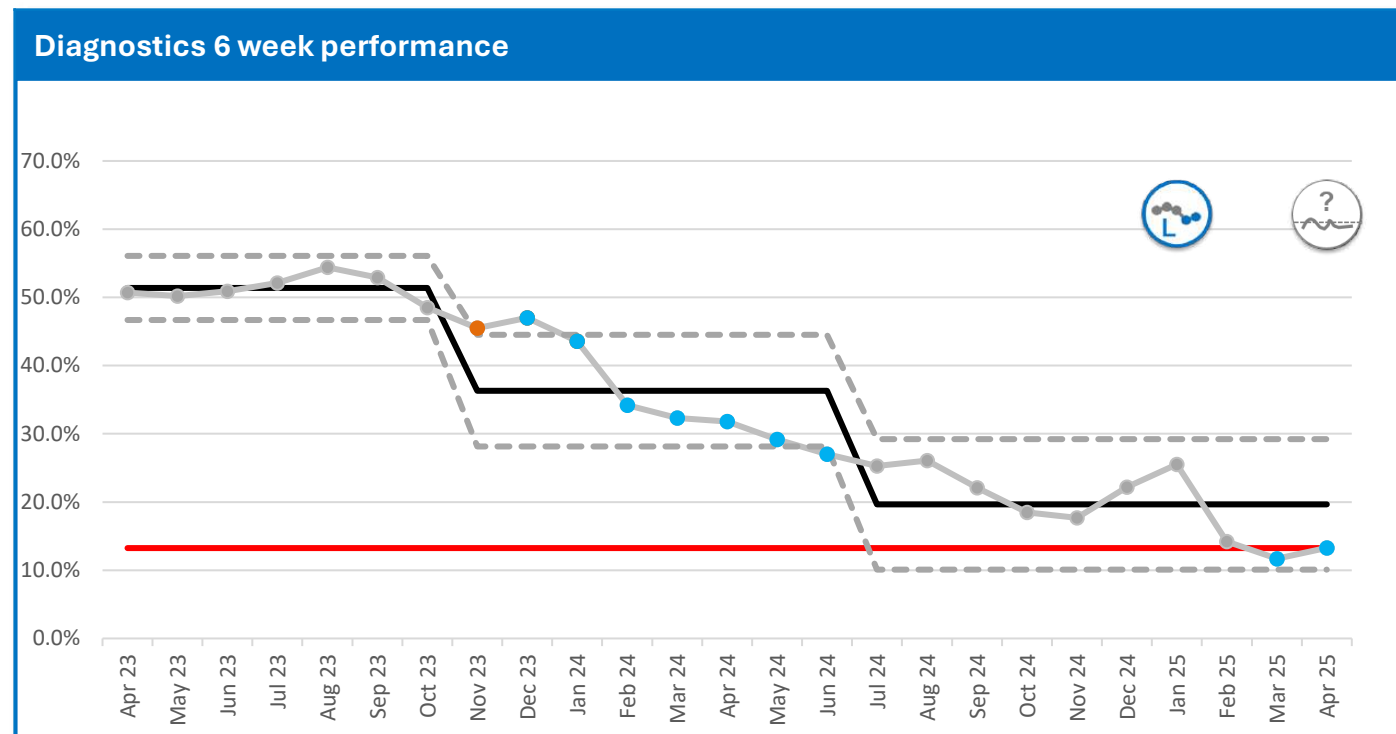
Diagnostics – DM01 6 week performance

Assure	SOF3 metric

Apr-25	Plan
13.2%	13.2%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
MRI	6.5%	5.8%
WTWA	29.5%	31.2%
CSS	6.1%	6.0%
North	3.4%	9.1%
Specialist	69.8%	70.2%
LCO...	0.0%	0.0%



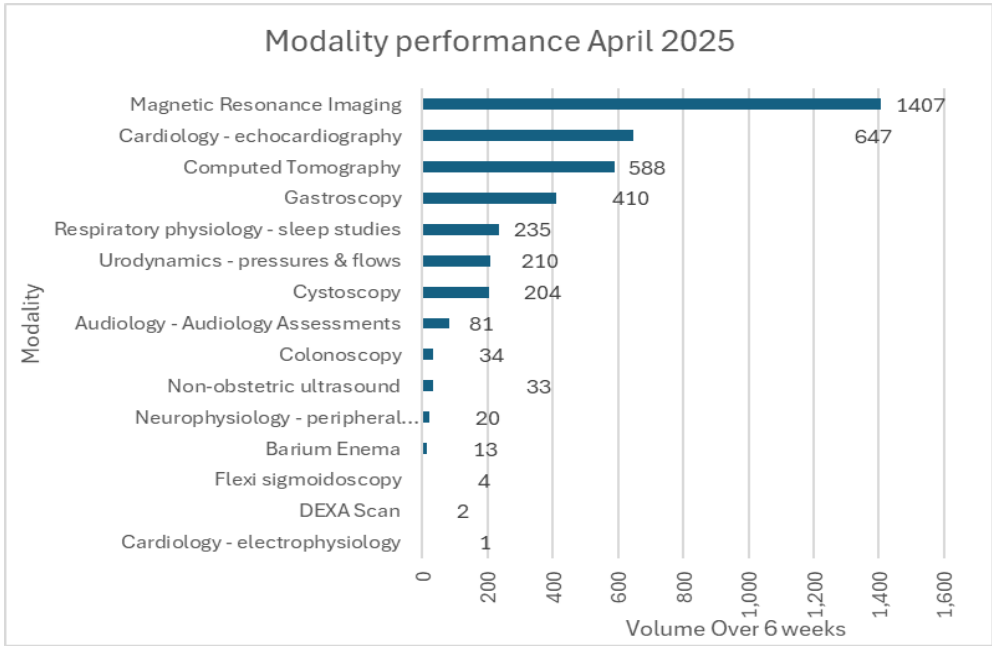
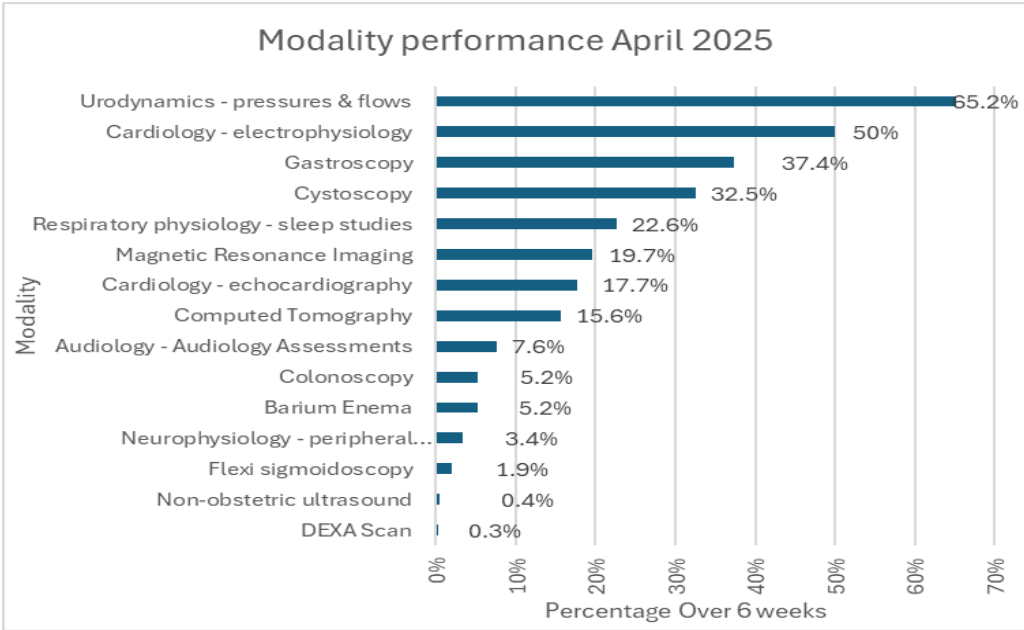
Updates since previous month
Performance improvements observed earlier in the year have continued into April, performance was on plan with at 13.2%

Current issues
Increased demand across CT/ MRI and NOUS continuing, unscheduled demand reducing to normal variation

Key dependencies
Increase bookings < 3 weeks Modality level tracking and recovery plans Additionality provision Utilisation of CDC

Future actions
Monitoring of challenged modalities (MRI, CT, NOUS) driving performance Demand management programme to streamline demand and deliver performance improvements

Diagnostics – DM01 6 week performance



Updates since previous month

Performance challenges continue within MRI, CT, Sleep, echocardiography, cystoscopy and urodynamics with all at variance to plan in month. Modality level recovery plans are being tracked weekly to improve performance through breach reduction.

Key dependencies

Success of modality level performance improvement programmes and activity increases in echo, sleep and imaging.

Current issues

Despite increasing demand in quarter 4 across MRI/CT and NOUS specifically performance continued to improve in this key metric. Planned and Elective levels of activity currently tracking to plan and unscheduled reducing to normal variation.

Future actions

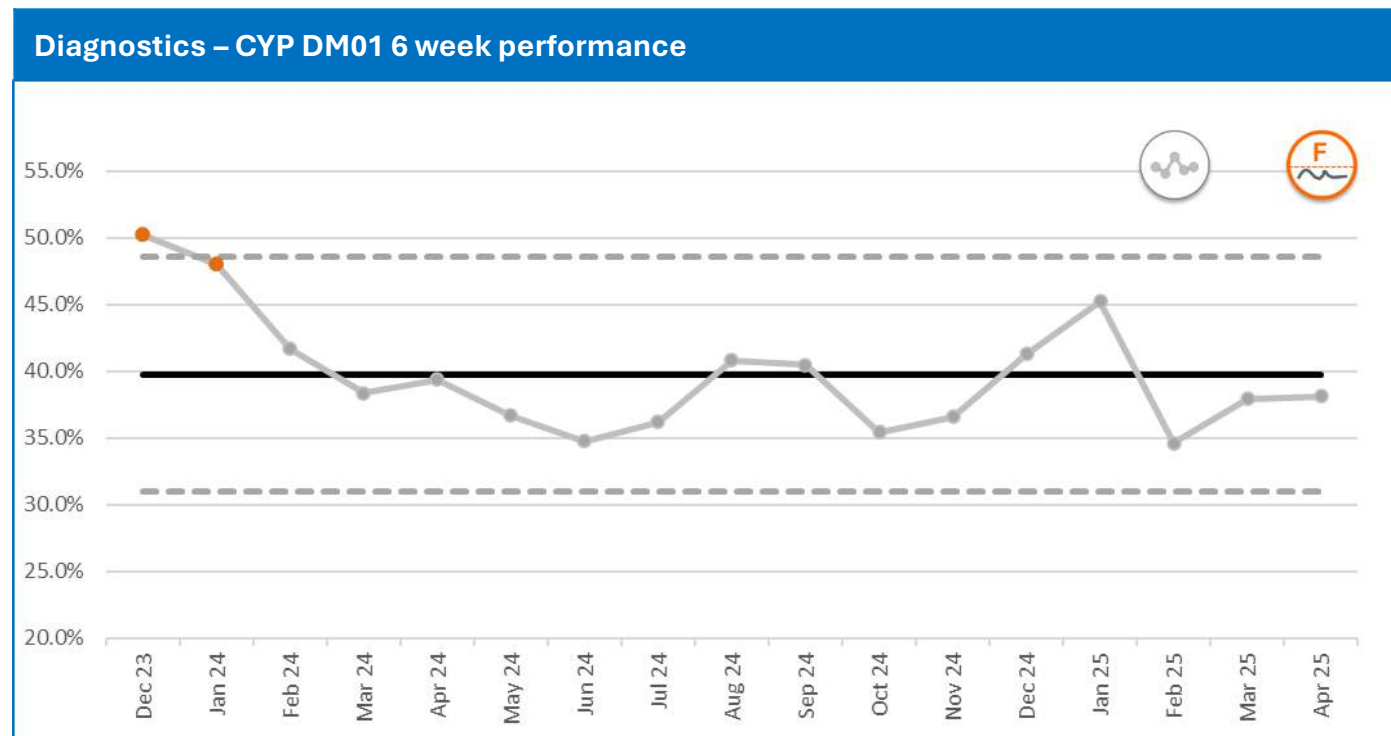
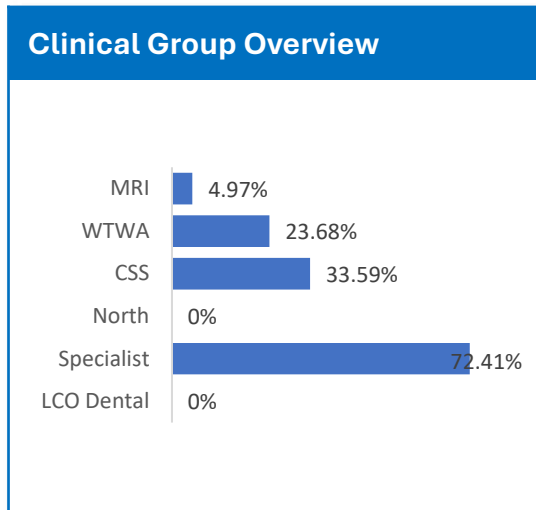
Continue modality level recovery plans with weekly oversight – sustaining improvements into April
Plans in place to reduce extended waits in MRI and echocardiography

Diagnostics – CYP DM01 6 week performance

Advise SOF3 metric

Apr-25 Plan
38.1%

Compliance	Variance	Assurance	Actions
			



Updates since previous month

MRI, endoscopy, NOUS and sleep continue to be the key drivers of reduced paediatric DM01 performance with MR and Endoscopy contributing the largest by volume

Key dependencies

Prioritising DM01 performance vs P2/long waits in theatre
Adults to paed capacity conversion for NOUS
Additionality for sedation MRI

Current issues

Insufficient capacity for sedation lists for MRI scans
Access to theatres for endoscopy procedures requiring sedation

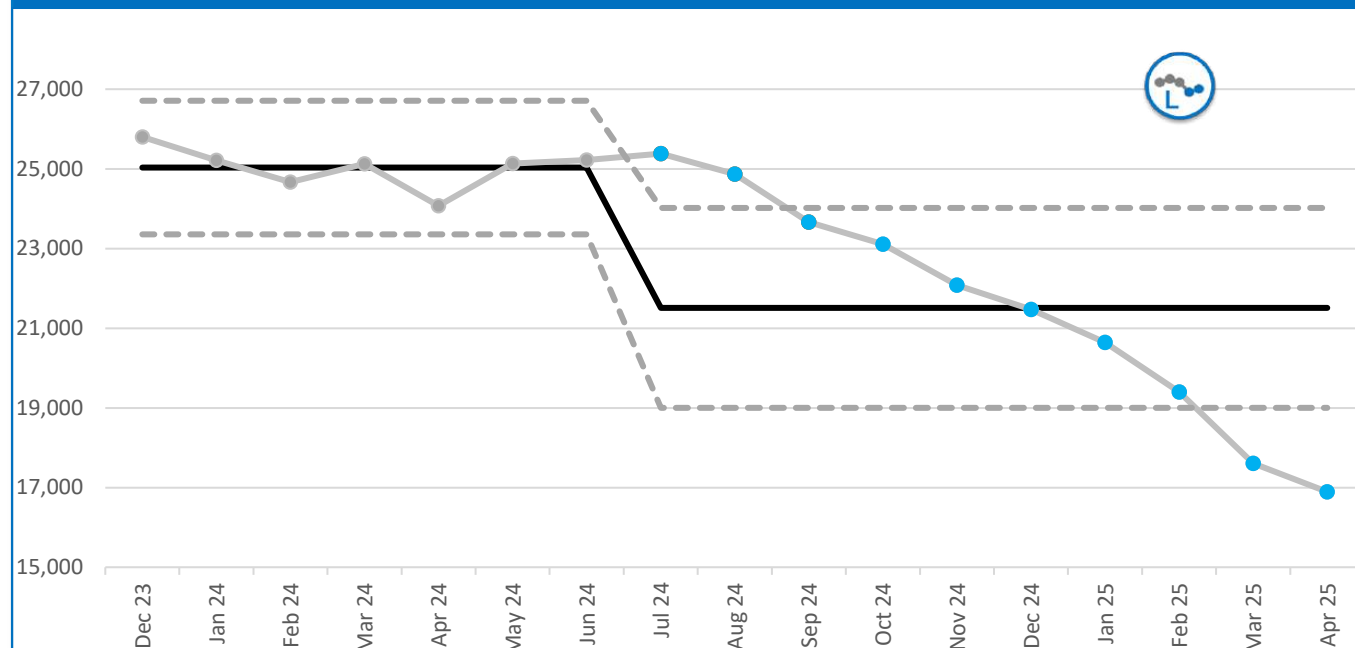
Future actions

New CT scanner at Wythenshawe dedicated to reducing CYP waits

Community Performance – Community Total Waiting List

Assure		SOF3 metric	
Apr-25		Plan	
16,893		24,711	
Compliance	Variance	Assurance	Actions

Community Total Waiting List



Updates since previous month

Total waiting list size continues to significantly decrease since the high in July. This has been driven by reductions in the number of waiters in MSK and Podiatry across both Manchester and Trafford localities.

Current issues

Long waiters in Trafford Occupational Therapy Assessment Team and are being actively monitored. Increased referrals particularly for paediatrics are being monitored.

Key dependencies

Non-standardised implementation of the community EPR (EMIS) means waiting list reporting carries DQ risk, with oversight in place.

Future actions

We anticipate an increase in the waiting list of approximately 1,500 from June 2025, as the local definition of the waiting list report is improved – performance to be monitored closely.

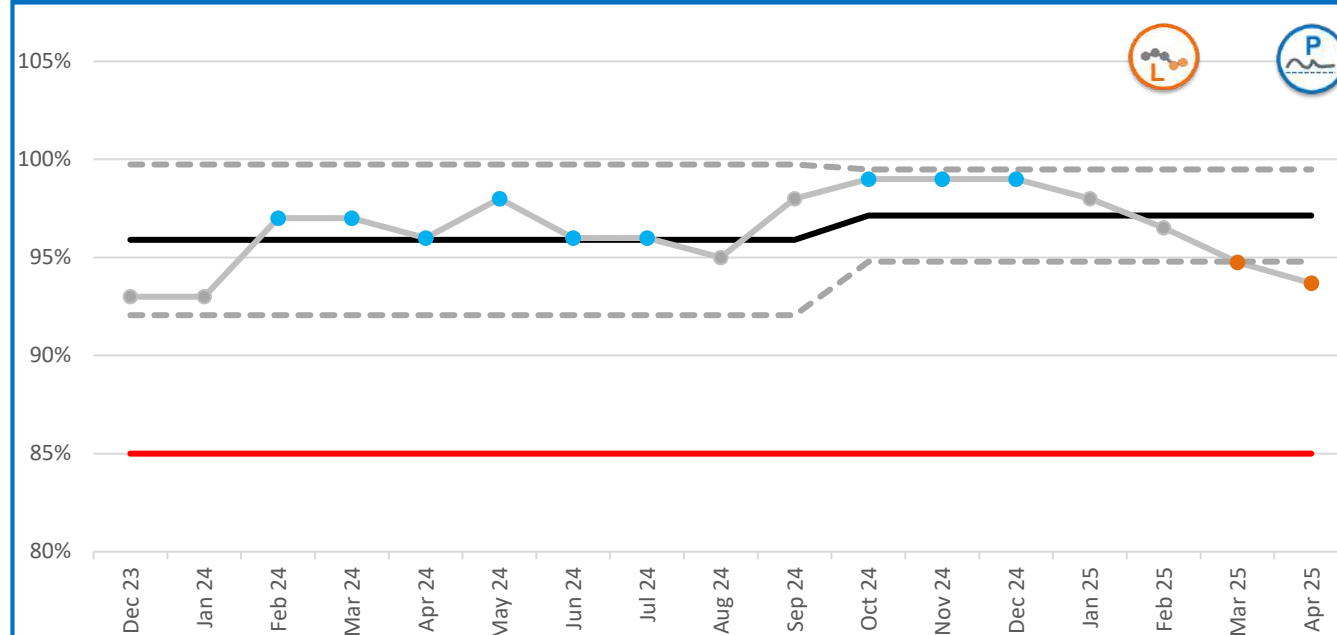
Community Performance – Crisis Response

Advise		SOF3 metric	
Apr-25		Plan	
93.7%		85%	
Compliance	Variance	Assurance	Actions

Locality Overview

TCR Crisis Trafford	85%	97.27%
MCR Crisis South	85%	93.90%
MCR Crisis Central	85%	90.43%
MCR Crisis North	85%	93.38%

Community Performance – Crisis Response



Updates since previous month

Similar to the previous month the proportion of referrals seen in two hours remains well above the standard, but is showing a decline in performance.

Current issues

The proportion of referrals seen in two hours is 97.3% within Trafford and 90.4%% at the Central locality – a variance of 6.84% in performance.

Key dependencies

ACP vacancies across the city leading to increased service closures but performance expected to be maintained above national target

Future actions

Ongoing ACP recruitment
Community Urgent Care Front door review (including H@H)

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



Trust IPR Metric Assurance Summary

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Workforce capacity	W1					Establishment WTE	Local / GM
	W2					Staff in Post WTE	Local / GM
	W3					Vacancy WTE	Local / GM
	W4					Vacancy %	Local
	W5					Temporary Staffing WTE	Local / GM
	W6					Temporary Staffing Cost	Local / GM
	W7					Bank % of Pay bill YTD	Local / GM
	W8					Agency % of Pay bill YTD	Local / GM
	W9					Price Cap Compliance	Local / GM
	W10					Off Framework	Local / GM
Looking after our people	W11					Single Month Sickness Absence %	Local
	W12					Rolling 12 Month Sickness Absence %	Local / GM
	W13					Call Back & Return to Work Compliance %	Local

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Belonging	W14					Level 1 Mandatory Compliance %	Local / GM
	W15					Level 2 & 3 Mandatory Compliance %	Local / GM
	W16					Appraisal – Non Medical Compliance %	Local
	W17					Appraisal – Medical Compliance %	Local
	W18					Oliver McGowan compliance %	Local
	W19					Staff Engagement Score	Local
	W20					Friends and Family Recommend to Work	Local
	W21					Friends and Family Recommend to receive Care / Treatment	Local
	W22					% of BME in Medical and Dental pay scales	Local
	W23					% BME in band 8a and above roles	Local
	W24					% BME in band 7 and below	Local
	W25					% Disability in Medical and Dental pay scales	Local
	W26					% Disability in band 8a and above roles	Local

Measuring our performance

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.

Trust IPR Metric Assurance Summary

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Workforce capacity	W1					Establishment WTE	Local / GM
	W2					Staff in Post WTE	Local / GM
	W3					Vacancy WTE	Local / GM
	W4					Vacancy %	Local
	W5					Temporary Staffing WTE	Local / GM
	W6					Temporary Staffing Cost	Local / GM
	W7					Bank % of Pay bill YTD	Local / GM
	W8					Agency % of Pay bill YTD	Local / GM
	W9					Price Cap Compliance	Local / GM
	W10					Off Framework	Local / GM
Looking after our people	W11					Single Month Sickness Absence %	Local
	W12					Rolling 12 Month Sickness Absence %	Local / GM
	W13					Call Back & Return to Work Compliance %	Local

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Belonging	W14					Level 1 Mandatory Compliance %	Local / GM
	W15					Level 2 & 3 Mandatory Compliance %	Local / GM
	W16					Appraisal – Non Medical Compliance %	Local
	W17					Appraisal – Medical Compliance %	Local
	W18					Oliver McGowan compliance %	Local
	W19					Staff Engagement Score	Local
	W20					Friends and Family Recommend to Work	Local
	W21					Friends and Family Recommend to receive Care / Treatment	Local
	W22					% of BME in Medical and Dental pay scales	Local
	W23					% BME in band 8a and above roles	Local
	W24					% BME in band 7 and below	Local
	W25					% Disability in Medical and Dental pay scales	Local
	W26					% Disability in band 8a and above roles	Local

Trust IPR Metric Assurance Summary

Key Oversight Performance Metrics							
Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Belonging Future Focus	W27					% Disability in Band 7 and below	Local
	W28					Turnover %	Local / GM
	W29					Retention / Stability %	Local
	W30					Time to Hire	Local / GM

Executive summary

Assurance		
 Achieving Target	 Inconsistently Achieving Target	 Not Achieving Target
Off Framework Level 1 Compliance % Appraisal Medical Compliance % % BME in Medical & Dental Payscales % BME in band 7 and below roles Turnover % Retention % Agency % of Pay bill YTD	SM Sickness % R12m Sickness %	Level 2 & 3 Compliance % % BME in band 8a and above roles Oliver McGowan Compliance %
		Appraisal – Non medical Compliance %
		Temporary Staffing WTE Price Cap Compliance Call Back & Return to Work Compliance %

Mandatory training compliance levels are showing a general improvement over the last 12 months. Level 1 Mandatory compliance for May achieved against target at 95.0%. However, ongoing attention is needed in relation to levels 2 & 3 compliance which remain below target at 88.2%, 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.

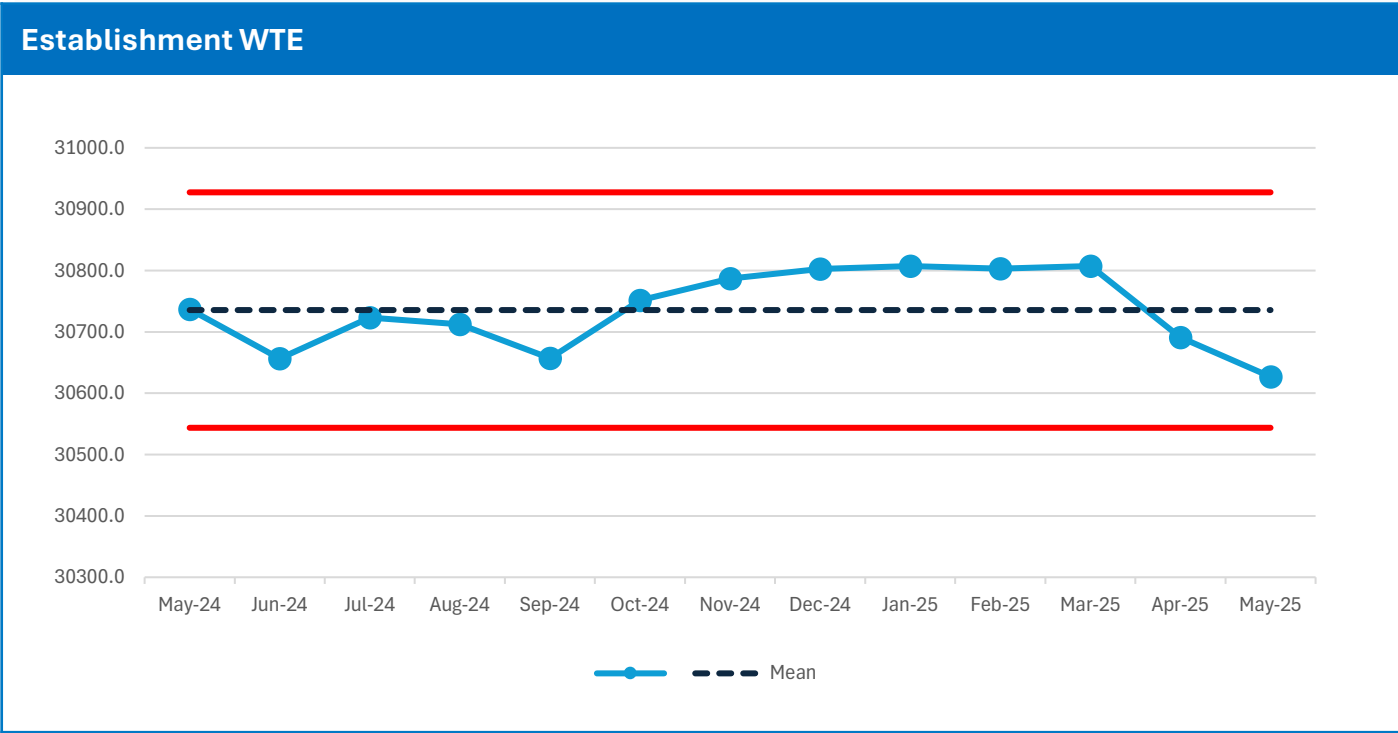
As of May 2025, the Trust R12m sickness rate was 6.1%. Levels of absence remain high, above pre-pandemic levels and are reflective of a challenging operational context. Our 25/26 operating plan is predicated on a reduction of sickness absence to 5.8% by end of financial year. A comprehensive programme 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.

Advise W1 metric

May-25	Target
30,626.9	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	881.6
Research	762.5
Corporate	2041.0
LCO & UDH	3069.8
Specialist	6647.5
CSS	5153.7
NMGH	2582.7
WTWA	5248.5
MRI	4239.5



Source
General Ledger (Trial Balance Report)

Updates since previous month

At the start of the 2025/26 financial year, the establishment was reduced in line with a budget reset, to align staffing and resources with revised financial priorities and operational goals.

Current issues

The establishment is at its lowest level in the past rolling year and currently stands 110.6 WTE below the same reporting period last year.

Key dependencies

Establishment levels are influenced by several key dependencies, including budget availability, workforce planning strategies, service demand, and organisational restructuring.

Future actions

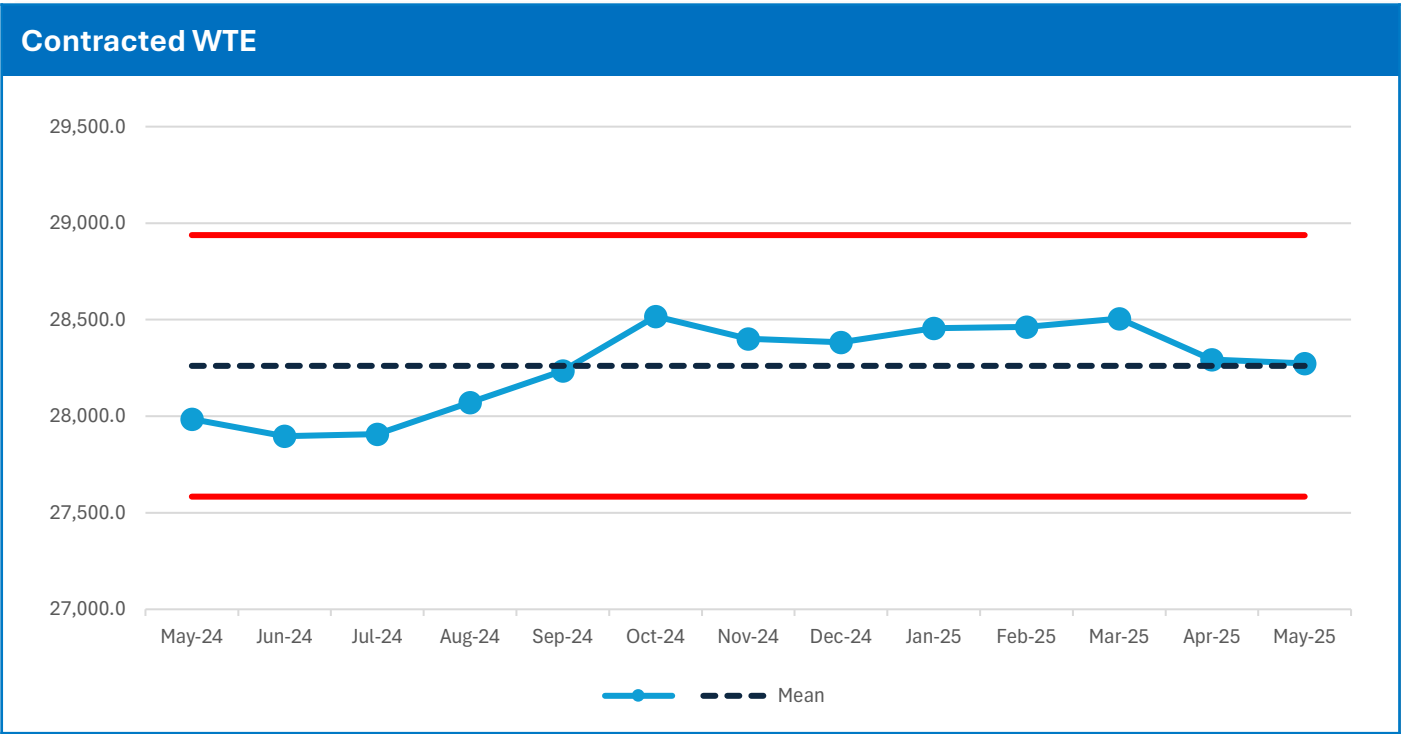
The establishment is regularly reviewed throughout the financial year to ensure efficiency, compliance, and continuous improvement.

Contracted (Staff in Post) WTE

Advise	W2 metric
May-25	Target
28,274.3	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	799.9
Research	700.4
Corporate	1735.7
LCO & UDH	2880.4
Specialist	6138.2
CSS	5003.4
NMGH	2257.1
WTWA	4750.9
MRI	4008.4



Source
General Ledger (Trial Balance Report)

Updates since previous month

Contracted WTE has reduced this financial year by 231.9 WTE which aligns with the reduction in establishment.

Current issues

The Workforce Annual Plan for 2025/26 is predicated on a reduction of 324.8 WTE by the end of the financial year.

Key dependencies

Delivery of the new organisation model and vacancy control restrictions will have an impact on contracted WTE.

Future actions

Contracted WTE will be monitored monthly in collaboration with the ICB through the Provider Workforce Return.

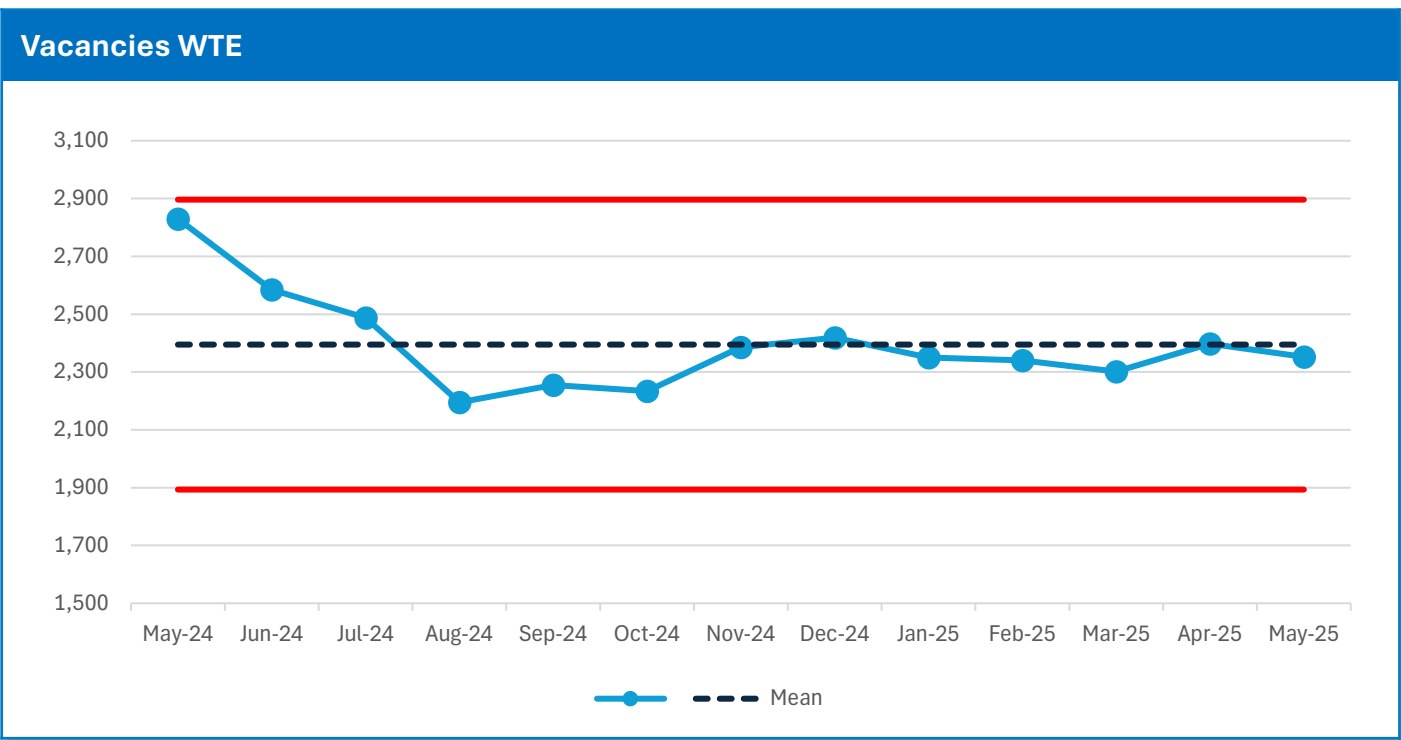
Vacancies WTE

Advise	W3 metric

May-25	Target
2,352.6	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	81.68
Research	62.17
Corporate	305.33
LCO & UDH	189.4
Specialist	509.3
CSS	150.3
NMGH	325.6
WTWA	497.7
MRI	231.1



Source
General Ledger (Trial Balance Report)

Updates since previous month

The reported number of vacancies at the Trust has been relatively stable for the last 7 months even though there has been fluctuating staffing and establishment changes.

Current issues

Enhanced scrutiny and assurance will be implemented via vacancy control panels to rigorously oversee and manage staffing vacancies.

Key dependencies

Anticipating a vacancy adjustment as part of VfP once savings work has been transacted.

Future actions

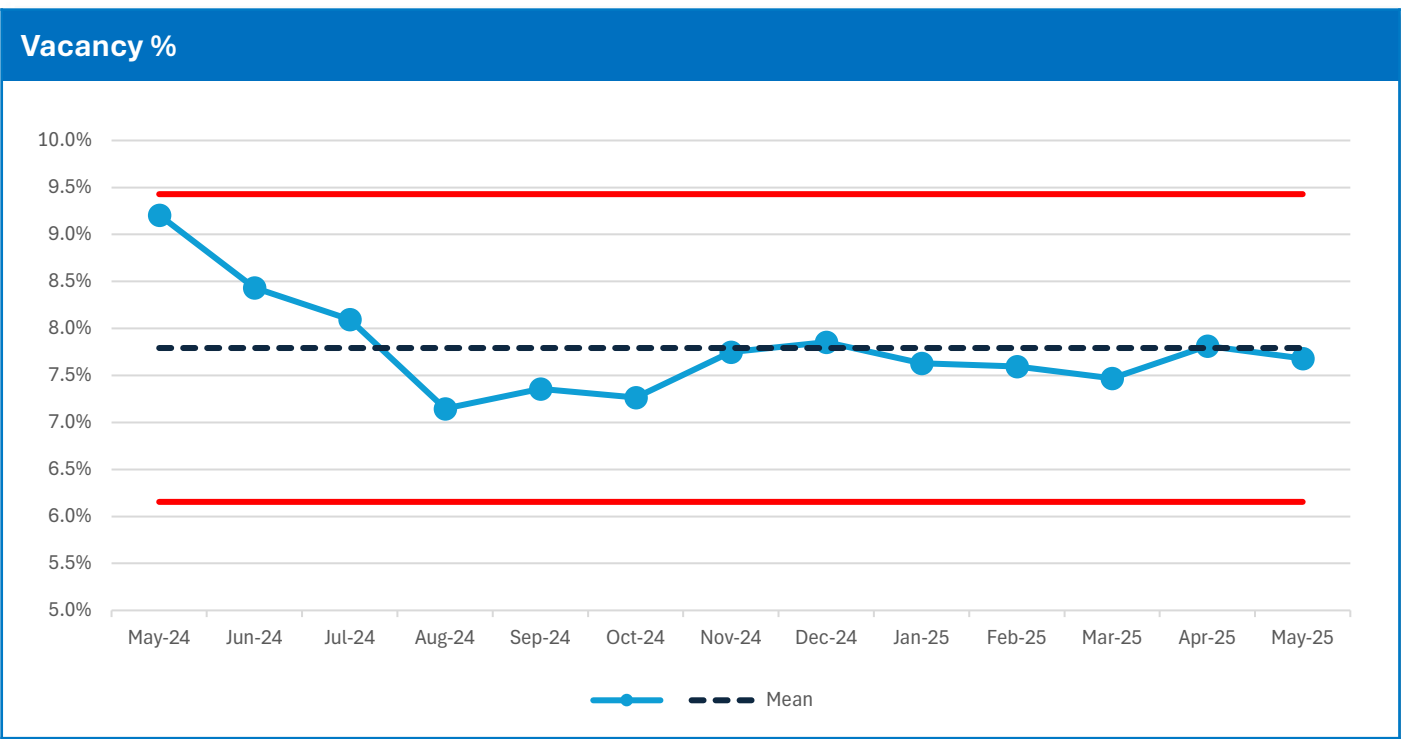
The Trust vacancy control panel will directly impact time to hire and the number of vacancies in the system.

Vacancy %

Advise	W4 metric
May-25	Target
7.7%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	9.3%
Research	8.2%
Corporate	15.0%
LCO & UDH	6.2%
Specialist	7.7%
CSS	2.9%
NMGH	12.6%
WTWA	9.5%
MRI	5.5%



Source
General Ledger (Trial Balance Report)

Updates since previous month

The vacancy percentage has decreased by 1.5% over the rolling 12-month period, primarily due to reductions in establishment and an increase in contracted WTE.

Key dependencies

Anticipating a vacancy % adjustment as part of VfP once savings work has been transacted.

Current issues

Corporate is showing to have the largest percentage of vacancies followed by NMGH.

Future actions

The Trust vacancy control panel will directly impact time to hire and the number of vacancies in the system.

Temporary Staffing WTE

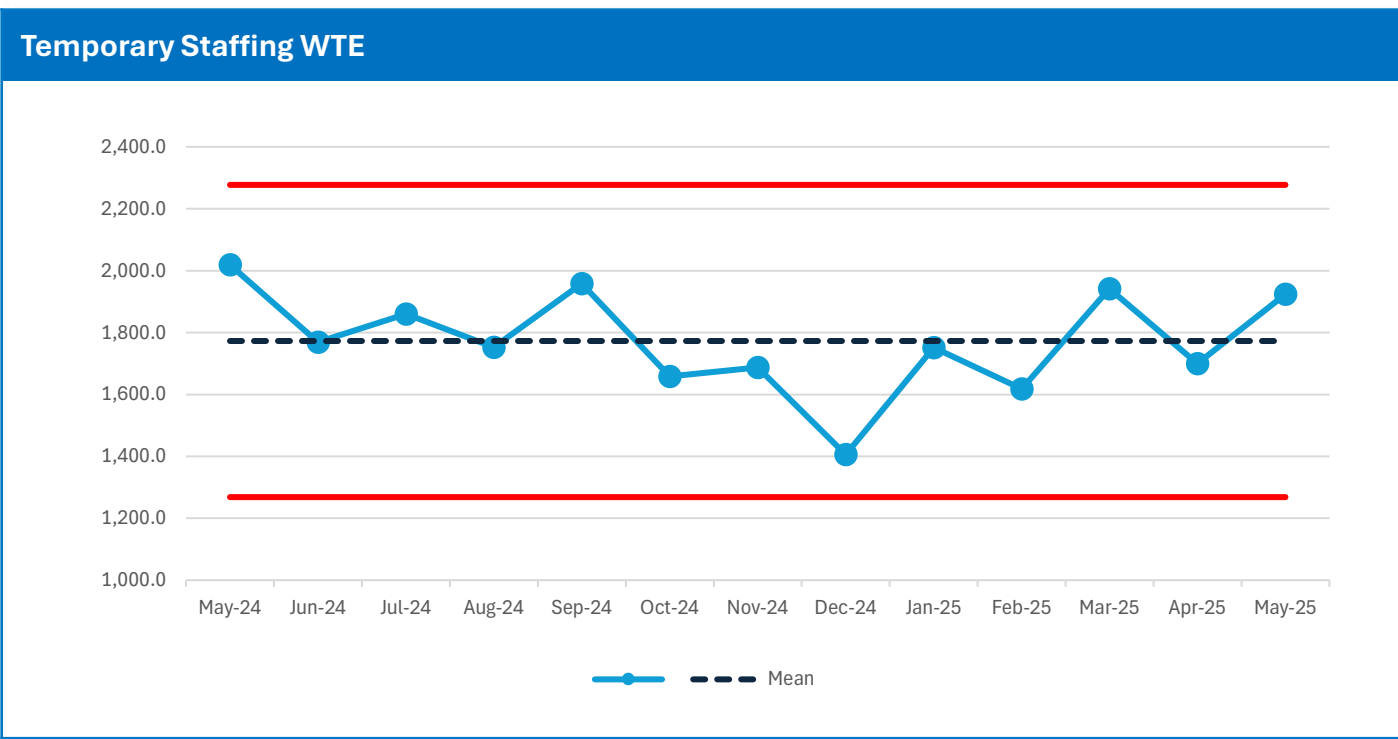
Alert

W5 metric

May-25	Target
1,924.6	1,608.8

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	58.5
Research	2.5
Corporate	49.3
LCO & UDH	71.8
Specialist	399.4
CSS	183.1
NMGH	385.1
WTWA	332.1
MRI	442.9



Source

General Ledger (Trial Balance Report)

Updates since previous month

Temporary Staffing WTE continues to show less variation month on month compared to the previous years. For M02 2025/26 Temporary Staffing increased by 225 WTE.

Current issues

The Temporary Staffing WTE shows the bank and agency usage in the month. For M2 2025/26 this was higher than the planned bank and agency WTE submitted as part of the Workforce Annual Plan.

Key dependencies

Attendance, Roster Efficiencies , Job Planning and Off Platform Activity all impact Temporary Staffing.

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Future actions

Continued work on initiatives to reduce the reliance on bank and agency across 2025/26 and progression of initiatives to control pay growth.

Temporary Staffing Cost

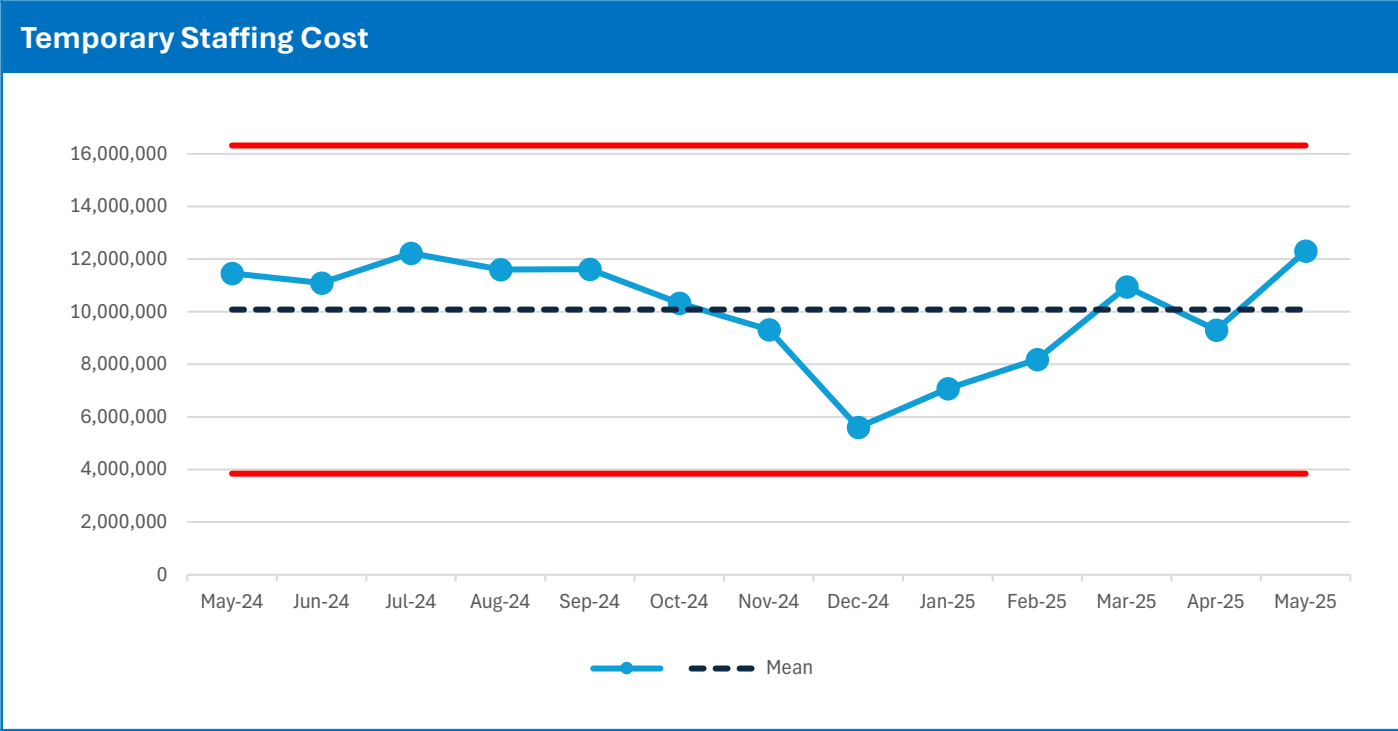
Advise

W6 metric

May-25	Target
£12,306,724	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	£248,683
Research	£17,228
Corporate	£210,570
LCO & UDH	£348,276
Specialist	£2,786,179
CSS	£1,670,253
NMGH	£2,477,378
WTWA	£2,141,823
MRI	£2,402,168



Source

General Ledger (Trial Balance Report) & Global Monitoring Sheet

Updates since previous month

Temporary staffing costs in month M02 of 2025/26 were the highest in the past year, highlighting continued workforce challenges and an ongoing reliance on temporary staff.

Key dependencies

Attendance, Roster Efficiencies , Job Planning and Off Platform Activity all impact Temporary Staffing.

Current issues

Temporary Staffing expenditure was slightly higher than in the same reporting period last year, which may reflect the increases in average staff costs between financial years.

Future actions

Pay controls implemented and continue to be monitored, this includes agency/bank protocols.

Bank % of Pay bill YTD

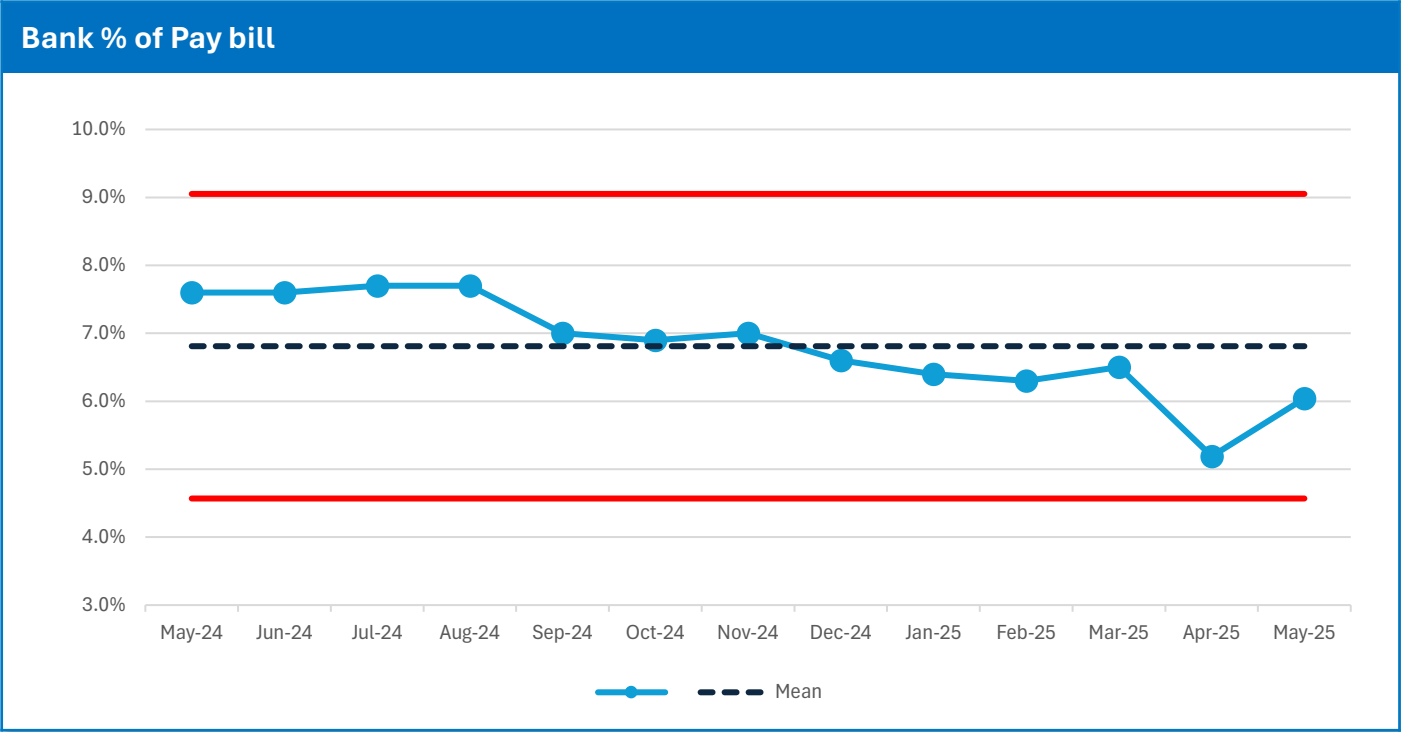
Advise	W7 metric
May-25	Target
6.0%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview

LCO & UDH
Specialist
CSS
NMGH
WTWA
MRI

IN
DEVELOPMENT



Source

General Ledger (Trial Balance Report) & Global Monitoring Sheet

Updates since previous month

The Bank % of Paybill YTD has increased by 0.8% in M02 2025/26.

Current issues

Currently, no target is set for the Year-to-Date Bank % of the Pay Bill in the Provider Finance Return (PFR), unlike the target established for Agency spend.

Key dependencies

Attendance, Roster Efficiencies , Job Planning and Off Platform Activity all impact Temporary Staffing.

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Future actions

As part of the Annual Planning round there will be expected further reductions to the usage of Bank staff in 2025/26.

Agency % of Pay bill YTD

Assure

W8 metric

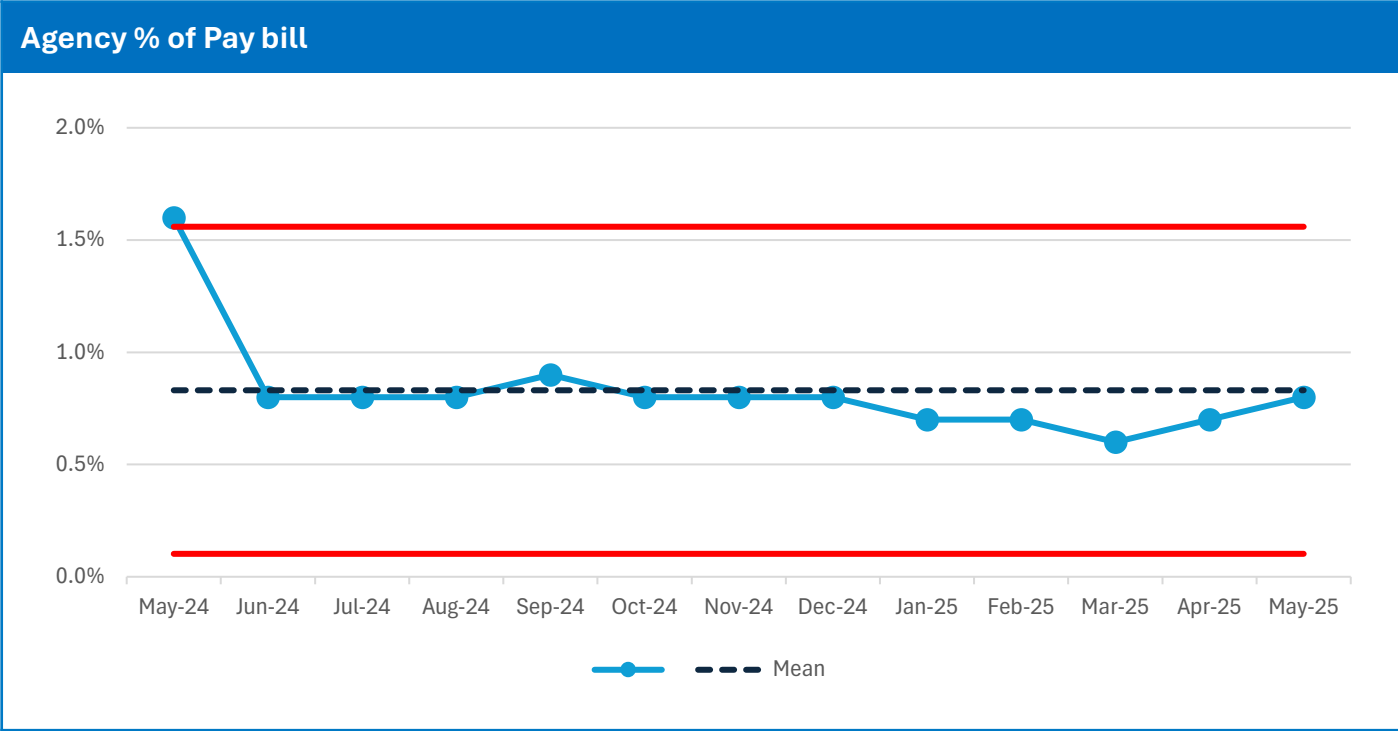
May-25	Target
0.8%	1.6%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview

LCO & UDH
Specialist
CSS
NMGH
WTWA
MRI

IN
DEVELOPMENT



Source

General Ledger (Trial Balance Report) & Global Monitoring Sheet

Updates since previous month

The Trust continues to outperform the 1.6% target month on month as set in the Provider Finance Return (PFR).

Current issues

This metric exceeds the current target but there will still be further reductions expected in the Annual Plan WTE this financial year.

Key dependencies

Attendance, Roster Efficiencies , Job Planning and Off Platform Activity all impact Temporary Staffing.

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Future actions

Price Cap Compliance

Alert

W9 metric

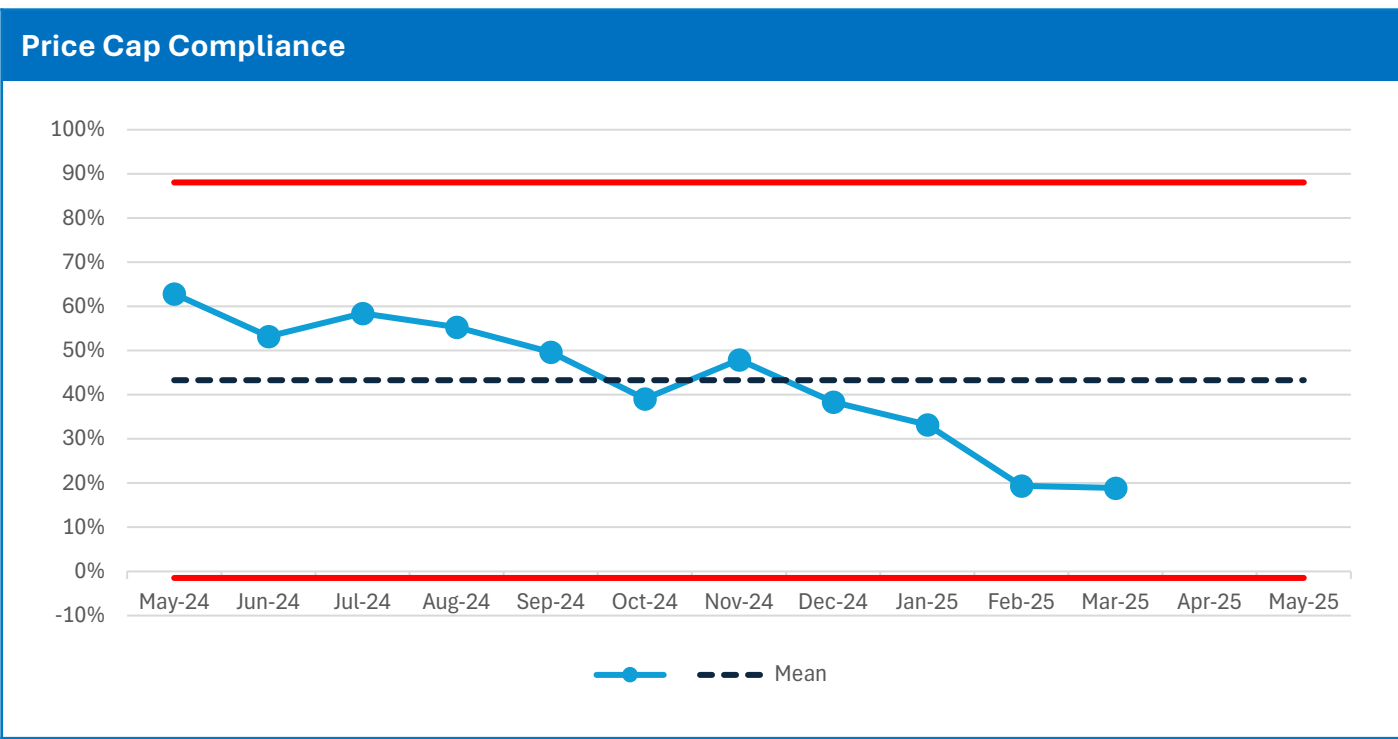
Mar-25	Target
18.9%	60.0%

Compliance	Variance	Assurance	Actions

Clinical Group Overview

LCO & UDH
Specialist
CSS
NMGH
WTWA
MRI

IN DEVELOPMENT



Source

GM Temporary Staffing Dashboard

Updates since previous month

The Trust has consistently fallen short of the 60% target for Price Cap Compliance, achieving it only once in the rolling year.

Current issues

The most recent data available for this metric is from month M12 of the 2024/25 financial year.

Key dependencies

With the Trust reducing its Agency spend this year it has been left with hard to fill roles which have a premium cost to them and has led to a lower price cap compliance score.

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Future actions

Focus on enhancing monitoring mechanisms, improving cost efficiency, and aligning with updated regulatory guidelines within the NHS.

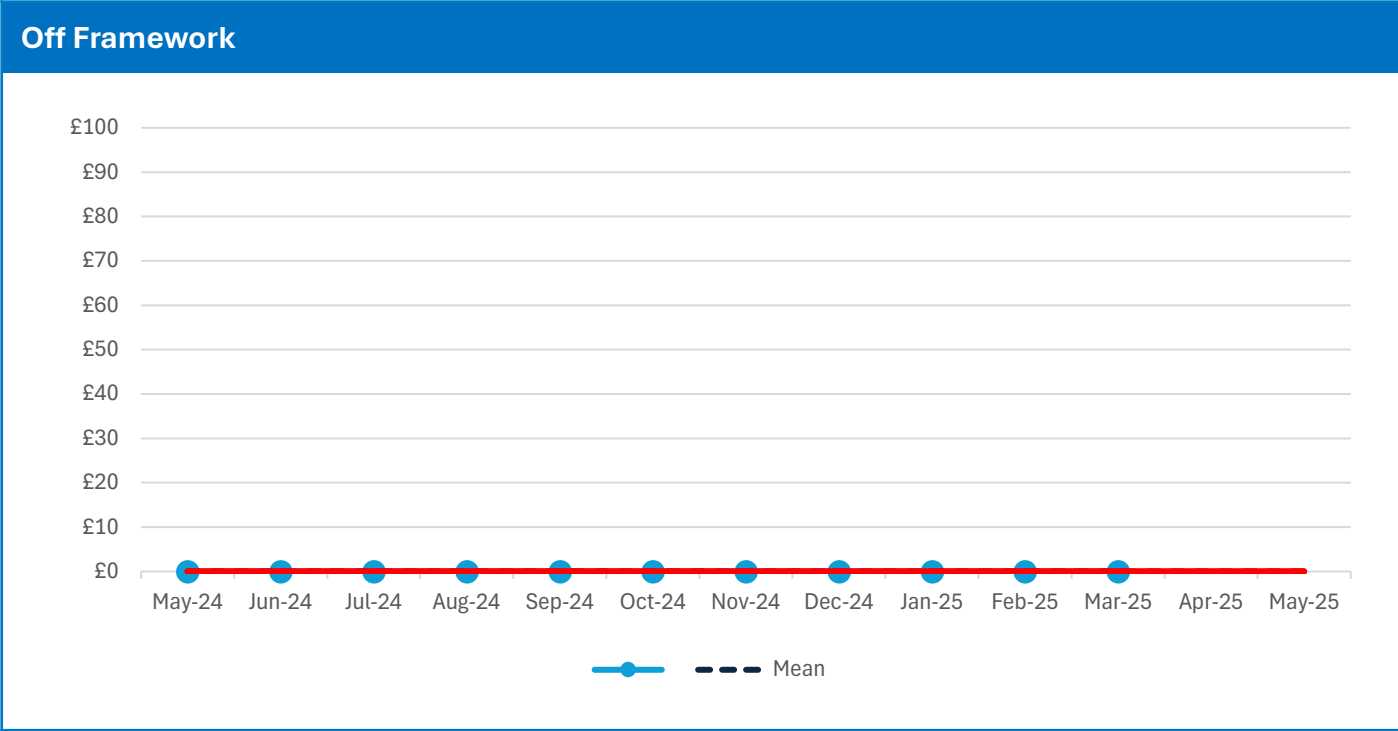
Off Framework

Assure	W10 metric

Mar-25	Target
£0	£0

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
LCO & UDH	£0
Specialist	£0
CSS	£0
NMGH	£0
WTWA	£0
MRI	£0



Source
GM Temporary Staffing Dashboard

Updates since previous month

MFT has 'zero' Off Framework spend since January 2024.

Current issues

The most recent data available for this metric is from month M12 of the 2024/25 financial year.

Key dependencies

There should be zero off framework agency use from July 2024 following The Chancellor's announcement in the Spring Budget 2024.

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Future actions

The Trust will continue to monitor Off Framework spend to be compliant with the 'zero' spend target.

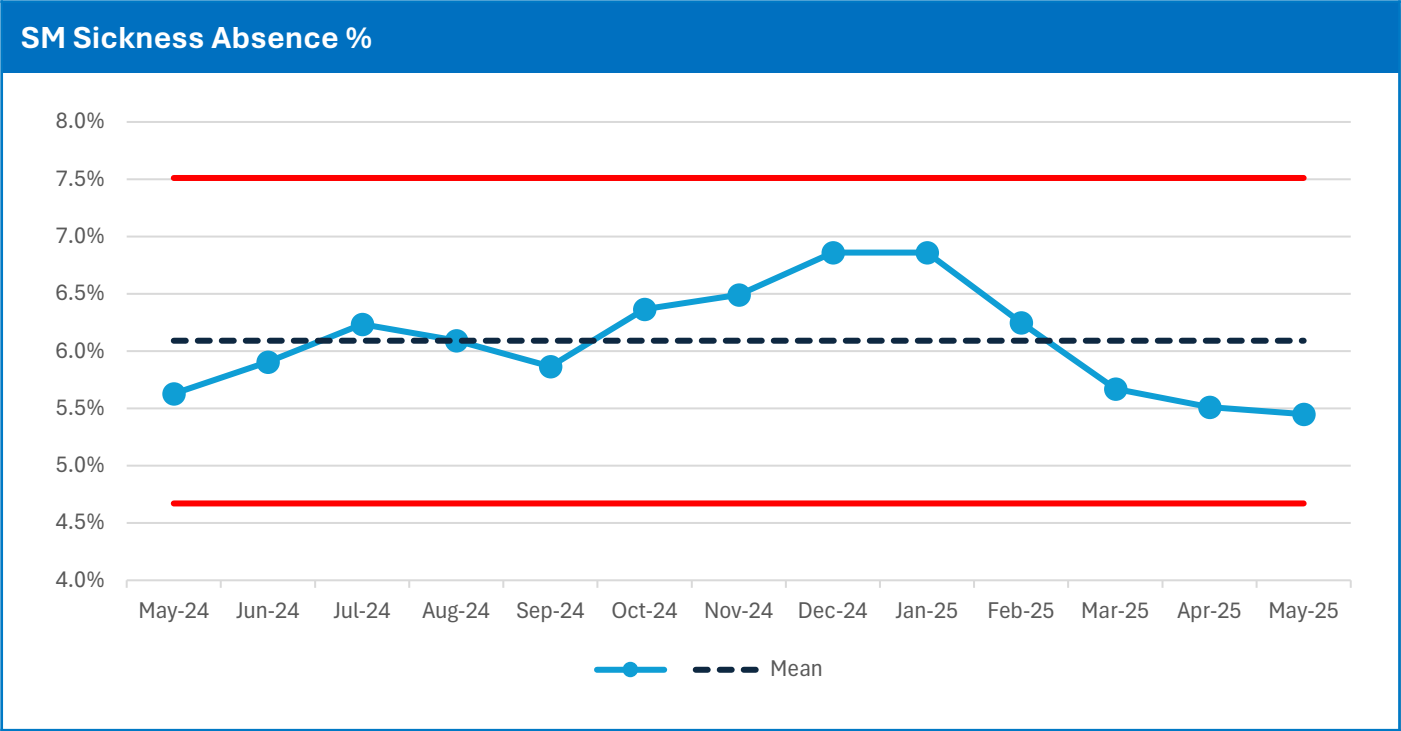
Single Month Sickness Absence %

Assure	W11 metric

May-25	Target
5.5%	5.8%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	5.6%
Research	4.5%
Corporate	4.0%
LCO & UDH	6.1%
Specialist	5.1%
CSS	4.6%
NMGH	5.7%
WTWA	5.8%
MRI	6.9%



Source
ESR (Electronic Staff Records)

Updates since previous month
A comprehensive programme approach to absence prevention and attendance management is underway. Each Clinical Group has a bespoke target and plan to drive local actions.

Current issues

Key dependencies
The 2025/26 Workforce Annual Plan is predicated on a targeted reduction in sickness absence, recognizing its critical impact on staff wellbeing, operational efficiency, and overall service delivery. Page 146

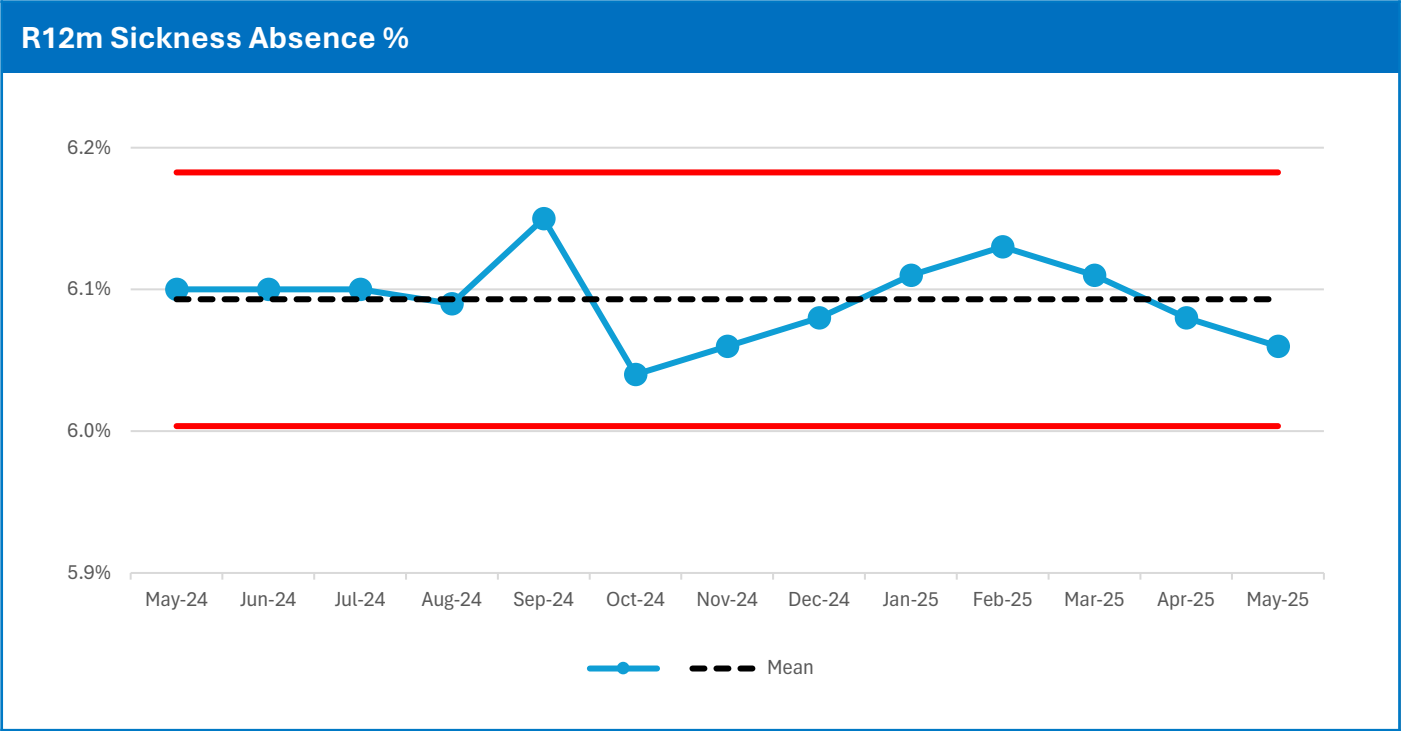
Future actions
Integrating operational sickness reports with case management data to enhance insights and drive targeted interventions for improved employee health outcomes.

Rolling 12 Month Sickness Absence %

Assure	W12 metric
May-25	Target
6.1%	6.1%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	7.5%
Research	5.2%
Corporate	4.3%
LCO & UDH	6.6%
Specialist	5.8%
CSS	5.4%
NMGH	6.2%
WTWA	6.6%
MRI	6.9%



Source
ESR (Electronic Staff Records)

Updates since previous month
A revised sickness absence plan has been developed through stakeholder engagement as presented to the PBC in April. Each Clinical Group has a bespoke target and plan to drive local actions which will be reviewed.
Key dependencies
The 2024/25 Workforce Annual Plan is predicated on a reduction of sickness absence with incremental improvements to 5.8% by the end of the financial year.

Current issues
Ongoing efforts are being made to improve attendance, aiming to achieve a 5.8% target for rolling 12-month sickness by the end of the financial year, as outlined in the Workforce Annual Plan.
Future actions
Integrating operational sickness reports with case management data to enhance insights and drive targeted interventions for improved employee health outcomes.

Callback & Return to Work Compliance %

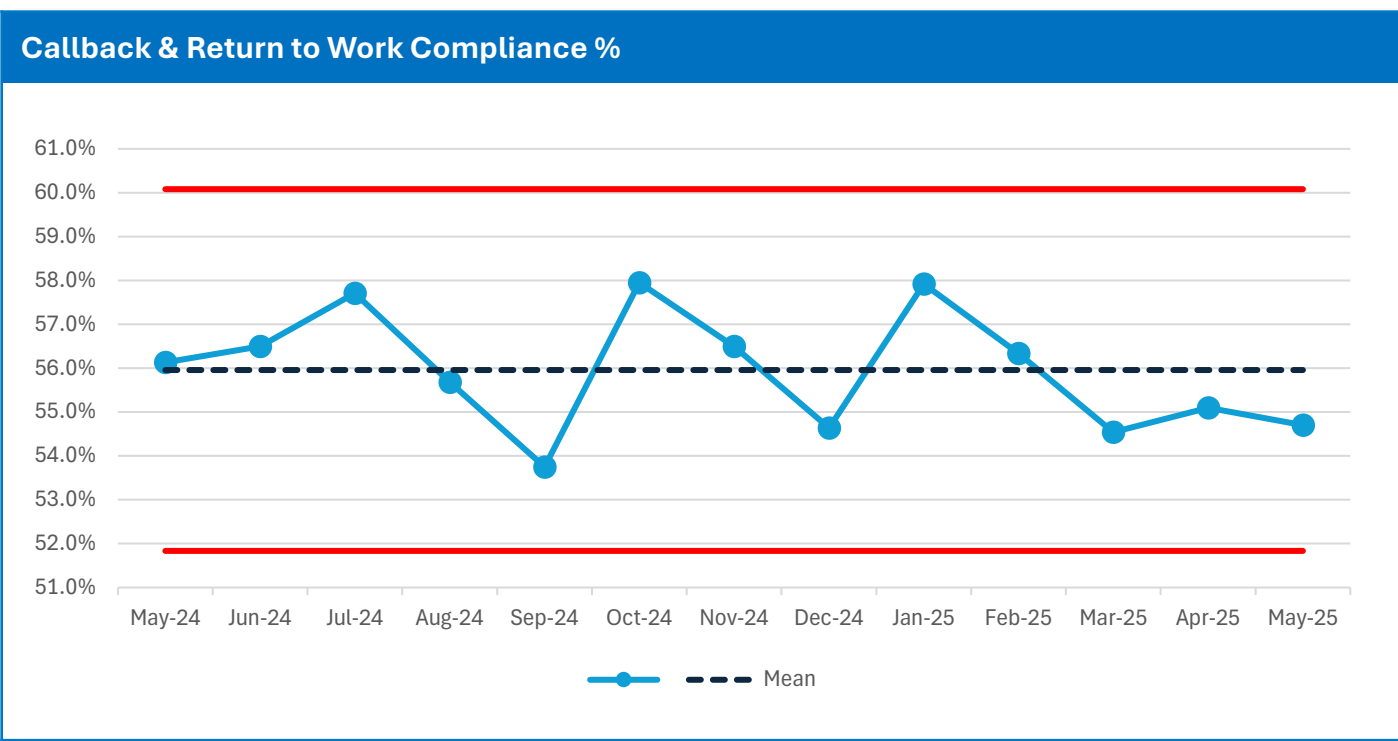
Alert

W13 metric

May-25	Target
54.7%	80.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	74.1%
Research	59.7%
Corporate	50.0%
LCO & UDH	
- UDH	68.6%
- LCO	61.9%
Specialist	
- REH	52.3%
- SMH	52.6%
- RMCH	52.8%
CSS	50.5%
NMGH	30.9%
WTWA	69.2%
MRI	51.7%



Source

Absence Manager, Empactis

Updates since previous month

Call back & Return to Work compliance has remained stable between 54 to 58%.

Current issues

Since the full rollout of Absence Manager in MFT, the Trust has consistently not reached the 80% target.

Key dependencies

Training and management tools are provided to managers to support with call back and return to work compliance.

Page 148

Future actions

Work to include the new Clinical group structure in Absence Manager for ease of reporting at this level.

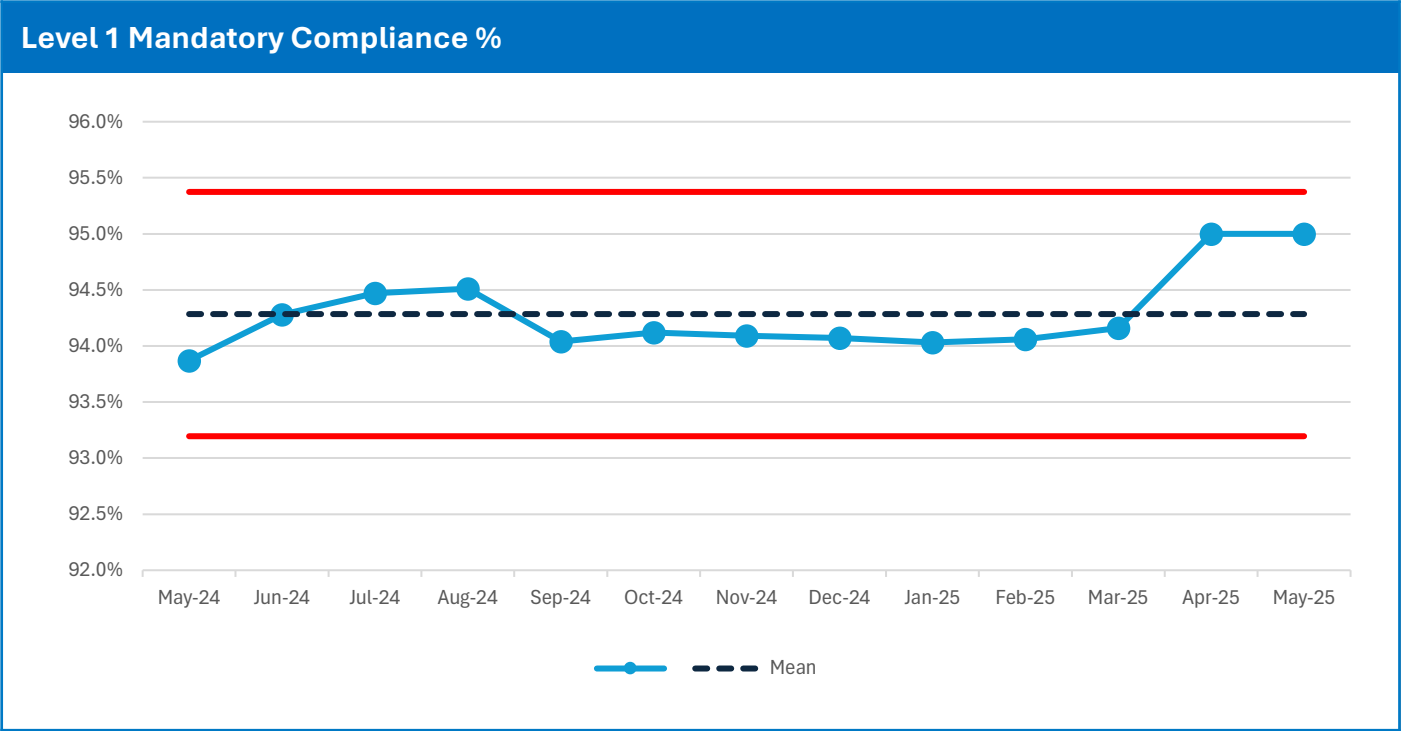
Level 1 Mandatory Compliance %

Assure	W14 metric

May-25	Target
95.0%	90.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	96.4%
Research	93.9%
Corporate	96.4%
LCO & UDH	95.8%
Specialist	95.2%
CSS	94.7%
NMGH	95.2%
WTWA	93.7%
MRI	95.2%



Source
ESR (Electronic Staff Records)

Updates since previous month
All Clinical Groups are meeting the 90% target and the Trust continually meets this target. Compliance is currently 5% above the target.

Current issues
Undertaking a review of mandatory training in line with new national guidance in terms of frequency and allocation to staff groups.

Key dependencies
Adherence to national guidelines and legal requirements, such as those set by the Care Quality Commission (CQC) and Health and Safety Executive (HSE).

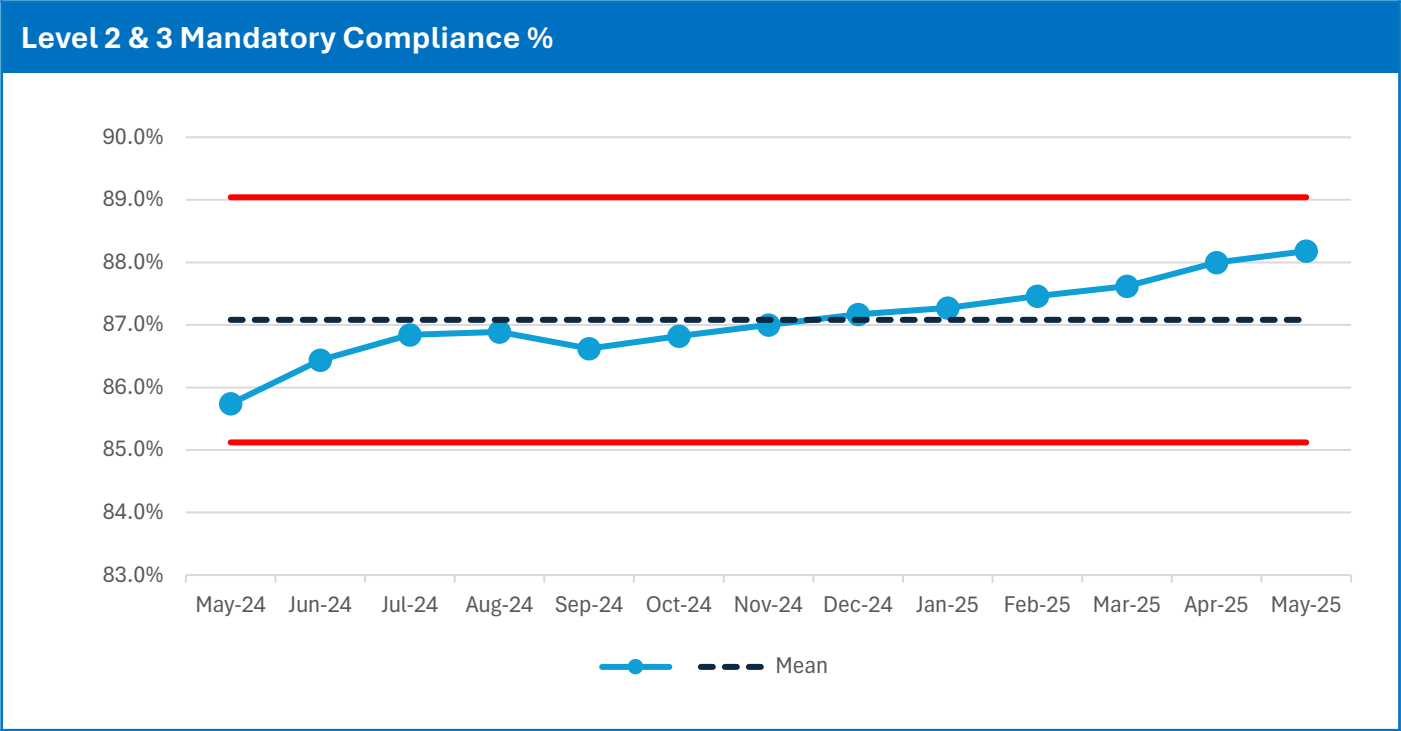
Future actions
Compliance driven locally, with assurance via the IPR process. Directors of Workforce & OD leading local compliance improvement plans.

Level 2 & 3 Mandatory Compliance %

Advise	W15 metric
May-25	Target
88.2%	90.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	92.9%
Research	90.4%
Corporate	81.0%
LCO & UDH	90.7%
Specialist	89.5%
CSS	86.9%
NMGH	88.2%
WTWA	85.7%
MRI	88.8%



Source
ESR (Electronic Staff Records)

Updates since previous month
There has been a steady improvement in Level 2 & 3 Mandatory training compliance in the rolling 12 month period. The Trust is close to reaching the 90% target.
Key dependencies
Adherence to national guidelines and legal requirements, such as those set by the Care Quality Commission (CQC) and Health and Safety Executive (HSE).

Current issues
Future actions
Compliance driven locally, with assurance via the IPR process. Directors of Workforce & OD leading local compliance improvement plans.

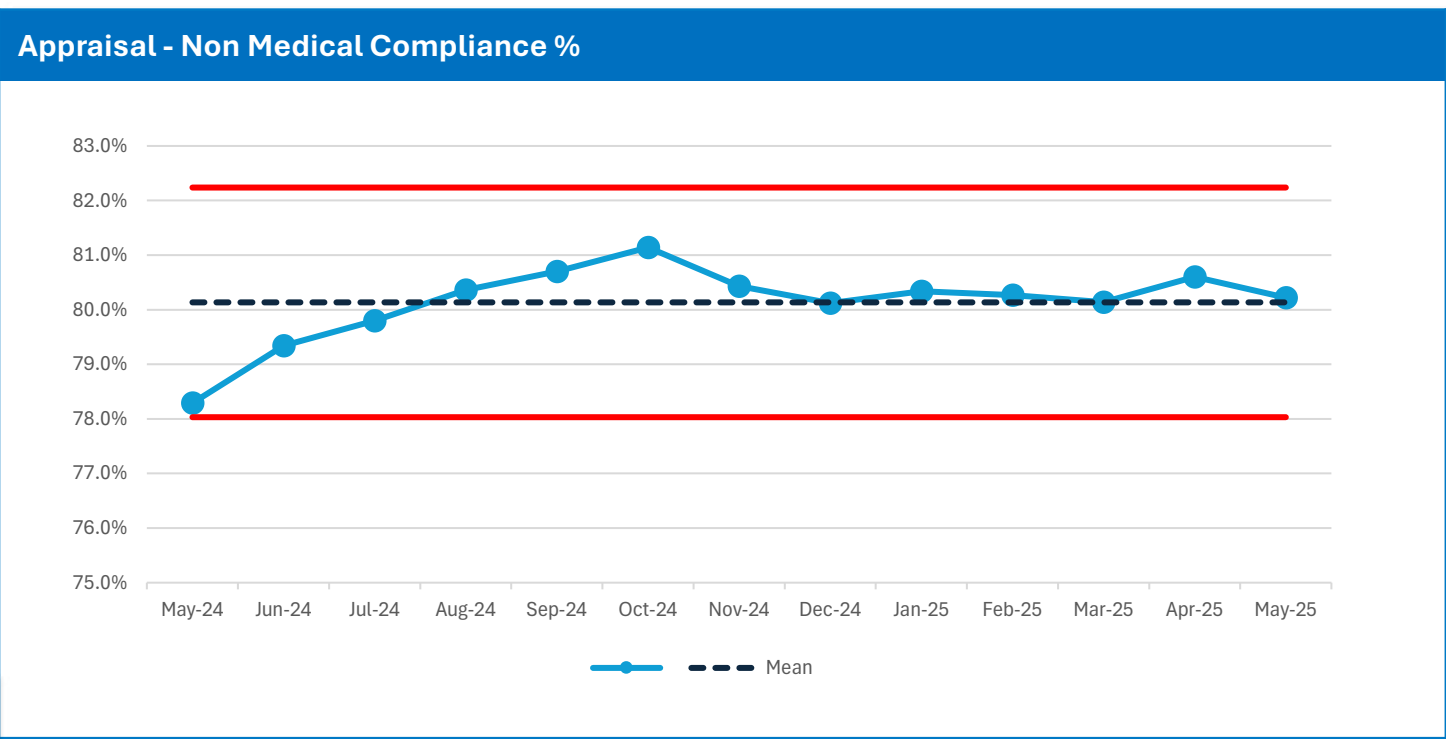
Appraisal – Non Medical Compliance %

Alert W16 metric

May-25	Target
80.2%	90.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	78.3%
Research	66.8%
Corporate	59.5%
LCO & UDH	86.5%
Specialist	82.0%
CSS	79.0%
NMGH	84.2%
WTWA	81.2%
MRI	84.6%



Source
ESR (Electronic Staff Records)

Updates since previous month

Currently none of the Clinical Groups are meeting the 90%.

Current issues

The overall Trust compliance has shown no real improvement in the proceeding last 7 months where prior to this there was an incremental improvement.

Key dependencies

Sufficient time set aside for both appraisers and employees to prepare for and conduct appraisals without disrupting service delivery.

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Future actions

Compliance driven locally, with assurance via the IPR process. Directors of Workforce & OD leading local compliance improvement plans.

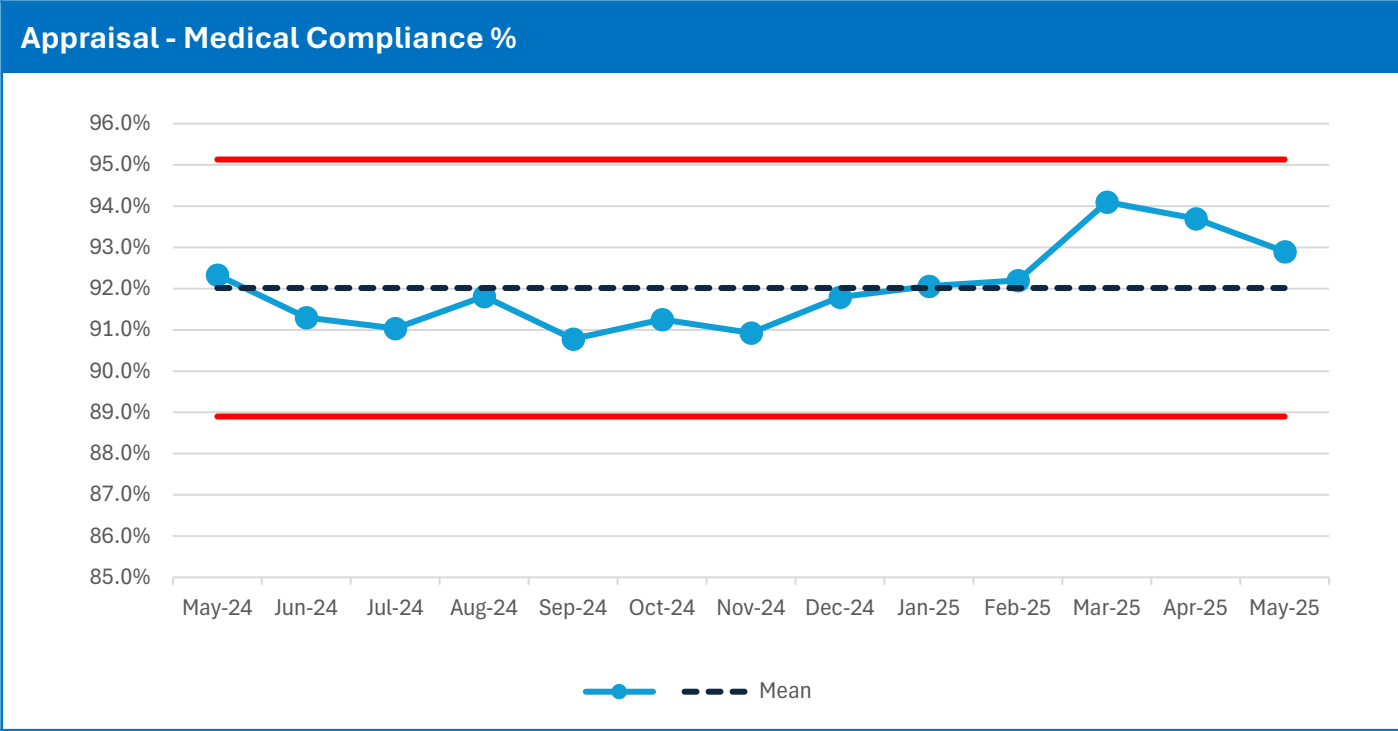
Appraisal – Medical Compliance %

Assure	W17 metric

May-25	Target
92.9%	90.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	
Research	100.0%
Corporate	100.0%
LCO & UDH	93.0%
Specialist	93.8%
CSS	92.2%
NMGH	92.9%
WTWA	92.3%
MRI	92.5%



Source
ESR (Electronic Staff Records)

Updates since previous month
All Clinical Groups have met the 90% target and the Trust continues to be above the target for this metric.

Current issues

Key dependencies
Sufficient time set aside for both appraisers and employees to prepare for and conduct appraisals without disrupting service delivery.
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Future actions
Compliance driven locally, with assurance via the IPR process. Directors of Workforce & OD leading local compliance improvement plans.

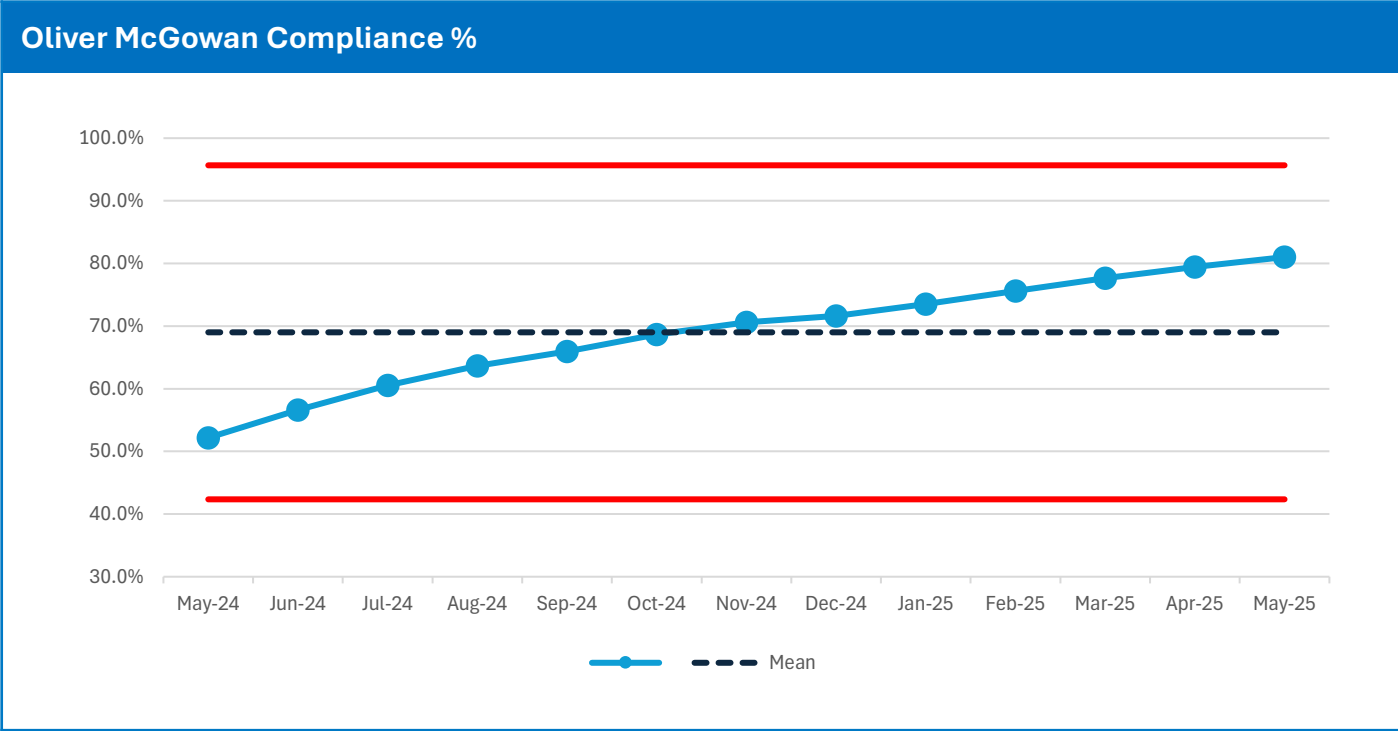
Oliver McGowan Compliance % - Part 1 (eLearning)

Advise W18 metric

May-25	Target
81.0%	90.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	89.7%
Research	94.6%
Corporate	73.9%
LCO & UDH	85.8%
Specialist	81.4%
CSS	71.7%
NMGH	88.7%
WTWA	81.4%
MRI	82.5%



Source
ESR (Electronic Staff Records)

May-25 Spotlight areas
Saint Marys – 86.2%
Children's Services – 74.1%
CAMHs – 84.6%

Updates since previous month

The Trust compliance score has improved throughout the financial year but is still 9% below target.

Key dependencies

Adherence to national guidelines and legal requirements, such as those set by the Care Quality Commission (CQC) and Health and Safety Executive (HSE).

Current issues

Future actions

Compliance driven locally, with assurance via the IPR process. Directors of Workforce & OD leading local compliance improvement plans.

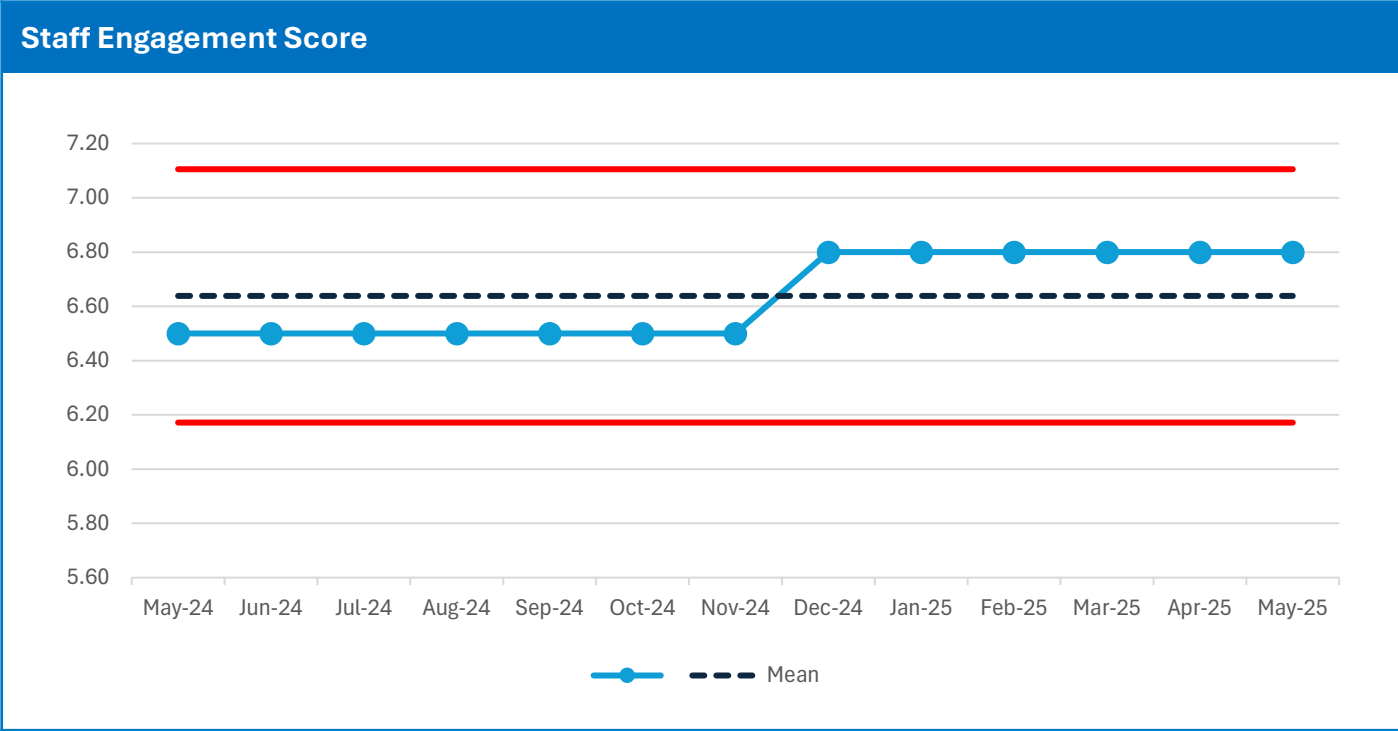
Staff Engagement Score

Assure	W19 metric

May-25	Target
6.8	6.8

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
LCO & UDH	
- UDH	6.6
- LCO	7.1
Specialist	
- REH	6.8
- SMH	6.7
- RMCH	6.8
CSS	6.6
NMGH	6.9
WTWA	6.8
MRI	6.9



Source
Staff Survey / Pulse Check

Updates since previous month

The Staff Engagement score is a quarterly score. The Trust has met the 6.8 staff engagement target.

Current issues

Data for the Staff Survey was taken before the change to Clinical Groups which may hinder reporting in the new format for future months.

Key dependencies

Staff participation in the Staff Survey remains critical with the Trust encouraging high responses through incentives and clear communication.

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Future actions

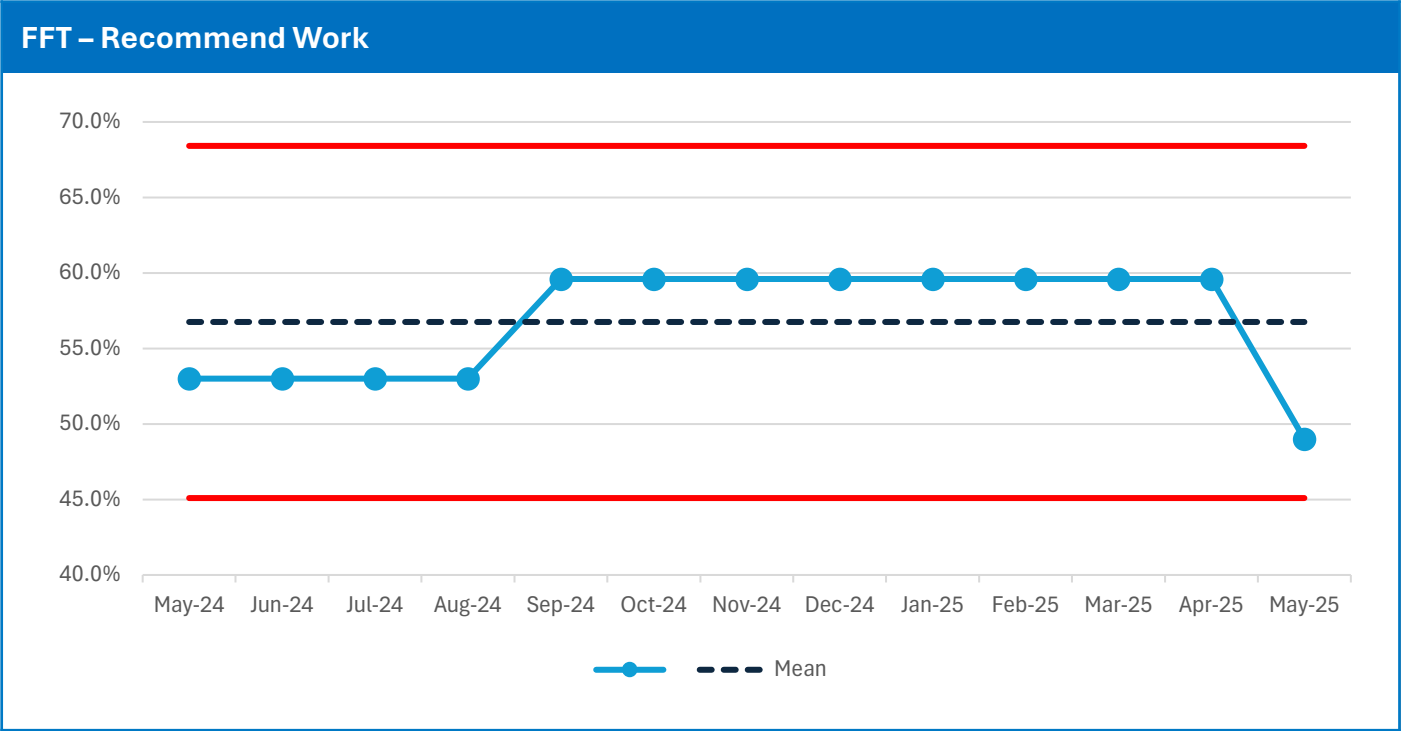
Active backing from leadership to promote the survey/pulse check and emphasize its importance to staff.

Friends and Family Test – Recommend Work

Advise	W20 metric
May-25	Target
49%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
LCO & UDH	
- UDH	48%
- LCO	55%
Specialist	
- REH	44%
- SMH	49%
- RMCH	49%
CSS	46%
NMGH	49%
WTWA	48%
MRI	44%



Source
Staff Survey / Pulse Check

Updates since previous month

The FFT 'Recommend as a Place to Work' score for month M02 2024/25 was 49%, marking the lowest point in the past rolling 12-month period.

Current issues

This information is to be used with other data to create a cultural dashboard to help drive improvement.

Key dependencies

The FFT is most useful when it's part of a broader continuous improvement cycle where feedback is regularly reviewed, analysed, and acted upon.

Future actions

Using FFT alongside other surveys or quality improvement systems to create a fuller picture of performance and satisfaction.

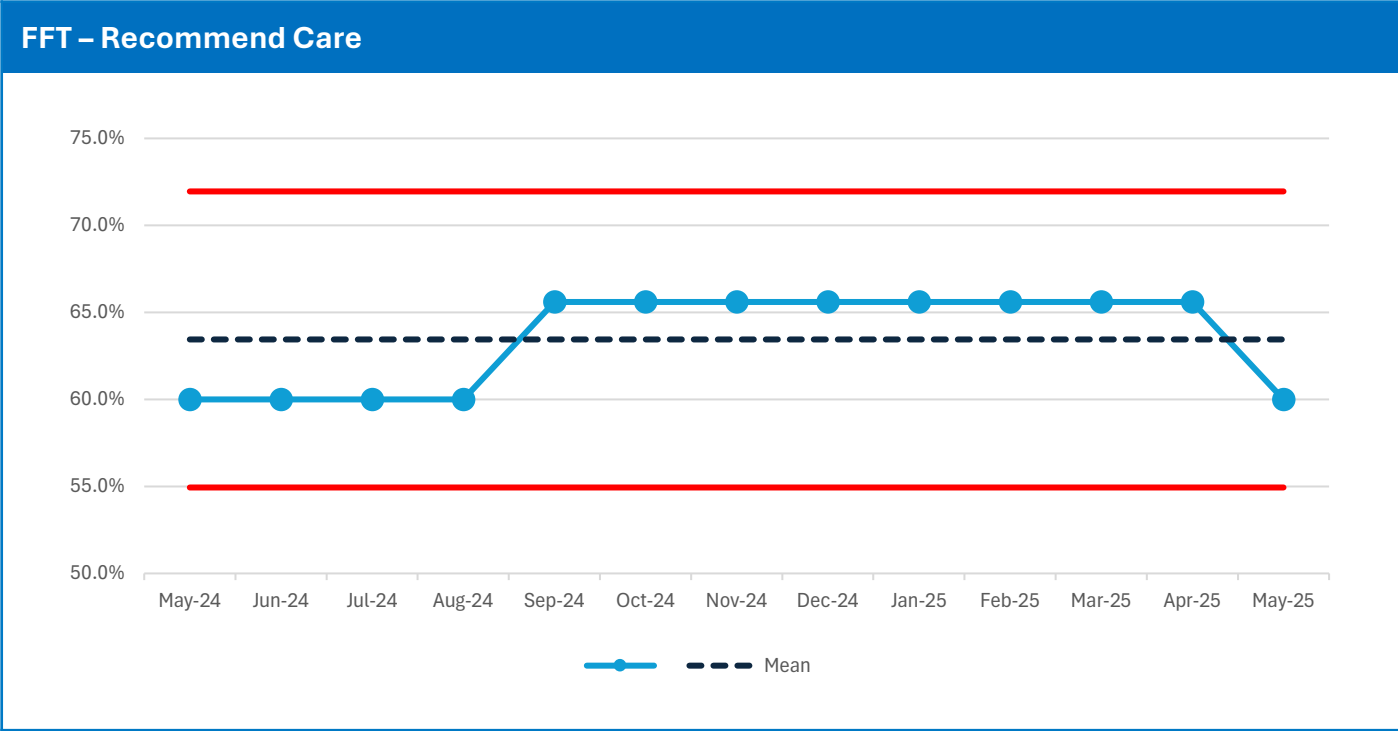
Friends and Family Test – Recommend Care

Advise W21 metric

May-25	Target
60%	-

Compliance	Variance	Assurance	Actions
			

Clinical & Corporate Group Overview	
LCO & UDH	
- UDH	68%
- LCO	67%
Specialist	
- REH	64%
- SMH	65%
- RMCH	63%
CSS	53%
NMGH	60%
WTWA	58%
MRI	55%



Source
Staff Survey / Pulse Check

Updates since previous month

The FFT 'Recommend as a Place for Care' score for month M02 2024/25 was 60%, marking the joint lowest point in the past rolling 12-month period.

Current issues

This information is to be used with other data to create a cultural dashboard to help drive improvement.

Key dependencies

The FFT is most useful when it's part of a broader continuous improvement cycle where feedback is regularly reviewed, analysed, and acted upon.

Future actions

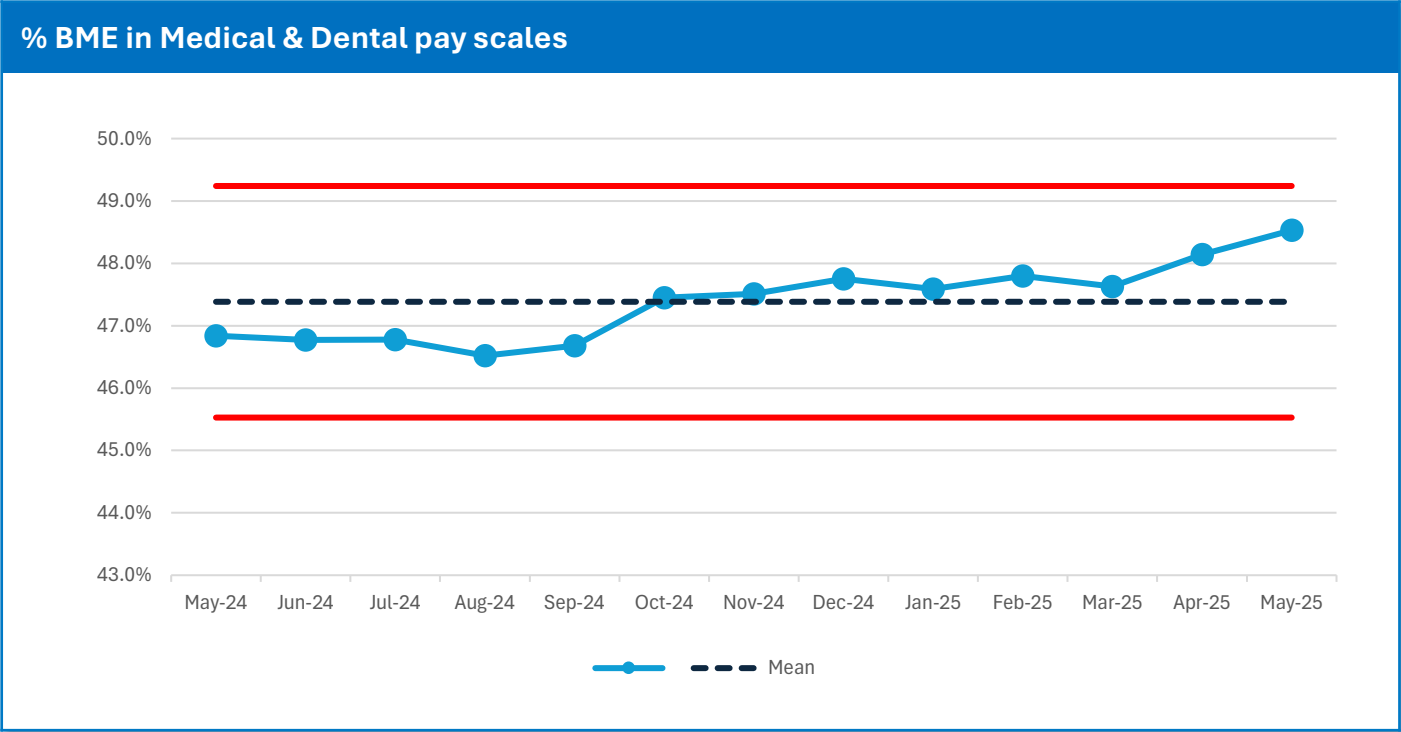
Using FFT alongside other surveys or quality improvement systems to create a fuller picture of performance and satisfaction.

% BME in Medical & Dental pay scales

Assure	W22 metric
May-25	Target
48.5%	23.6%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	
Research	60.0%
Corporate	38.2%
LCO & UDH	39.1%
Specialist	48.2%
CSS	47.7%
NMGH	52.8%
WTWA	48.0%
MRI	49.8%



Source
ESR (Electronic Staff Records)

Updates since previous month
The Trust continues to have high representation of BME staff in Medical and Dental roles and this is shown within all of the Clinical Groups.

Current issues

Key dependencies
Well-defined policies regarding visa sponsorship and the employment of international staff, including compliance with UK immigration laws.

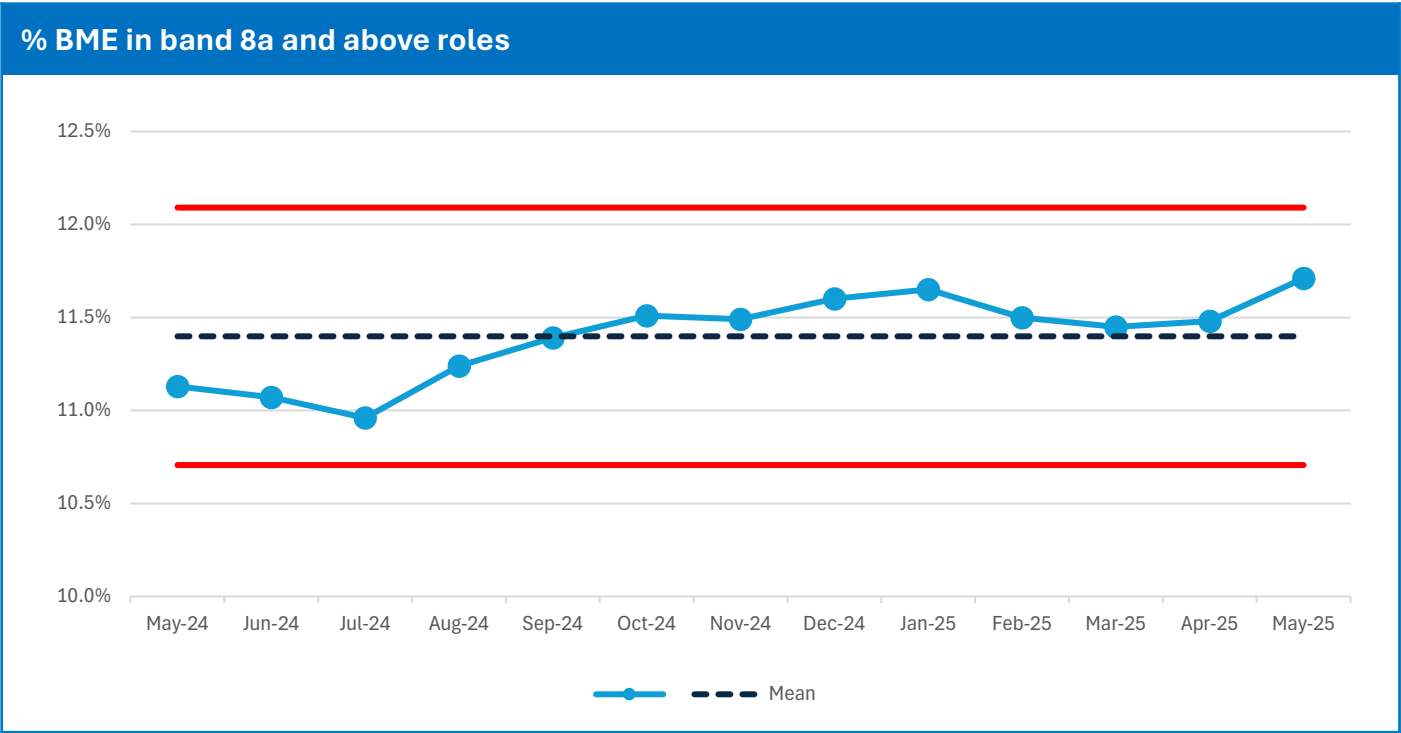
Future actions
This metric currently only needs monitoring as part of the Clinical Group IPR process and no interventions.

% BME in band 8a and above roles

Advise	W23 metric
May-25	Target
11.7%	23.6%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	3.0%
Research	13.1%
Corporate	11.1%
LCO & UDH	12.5%
Specialist	9.2%
CSS	14.7%
NMGH	8.6%
WTWA	9.9%
MRI	15.3%



Source
ESR (Electronic Staff Records)

Updates since previous month
None of the Clinical Groups are meeting the internal target of 23.6% which is based on the BME Greater Manchester representation.

Current issues
Although the Trust is making gains/improvements in this metric, it is not yet close to the target.

Key dependencies
Well-defined policies regarding visa sponsorship and the employment of international staff, including compliance with UK immigration laws.

Future actions
Develop retention initiatives that address the specific needs and concerns of BME staff, including supportive networks and career progression pathways in these payscales.

% BME in band 7 and below roles

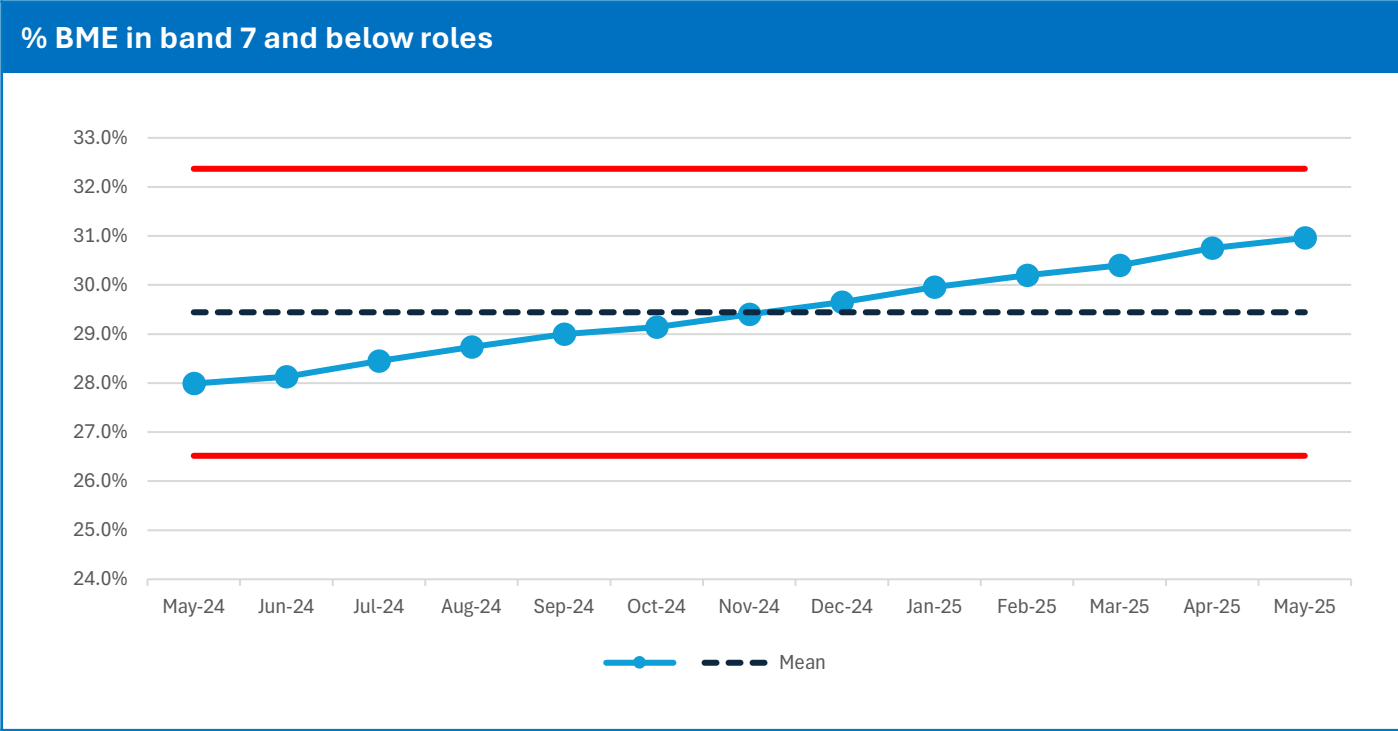
Assure

W24 metric

May-25	Target
31.0%	23.6%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	25.4%
Research	37.2%
Corporate	24.4%
LCO & UDH	21.4%
Specialist	23.8%
CSS	35.2%
NMGH	38.4%
WTWA	32.0%
MRI	43.3%



Source

ESR (Electronic Staff Records)

Updates since previous month

The % of BME staff in these paycales has increased month on month and is currently meeting the Trust target of 23.6%.

Current issues

Not all Clinical Groups are currently meeting the 23.6% target for this metric.

Key dependencies

Well-defined policies regarding visa sponsorship and the employment of international staff, including compliance with UK immigration laws.

Future actions

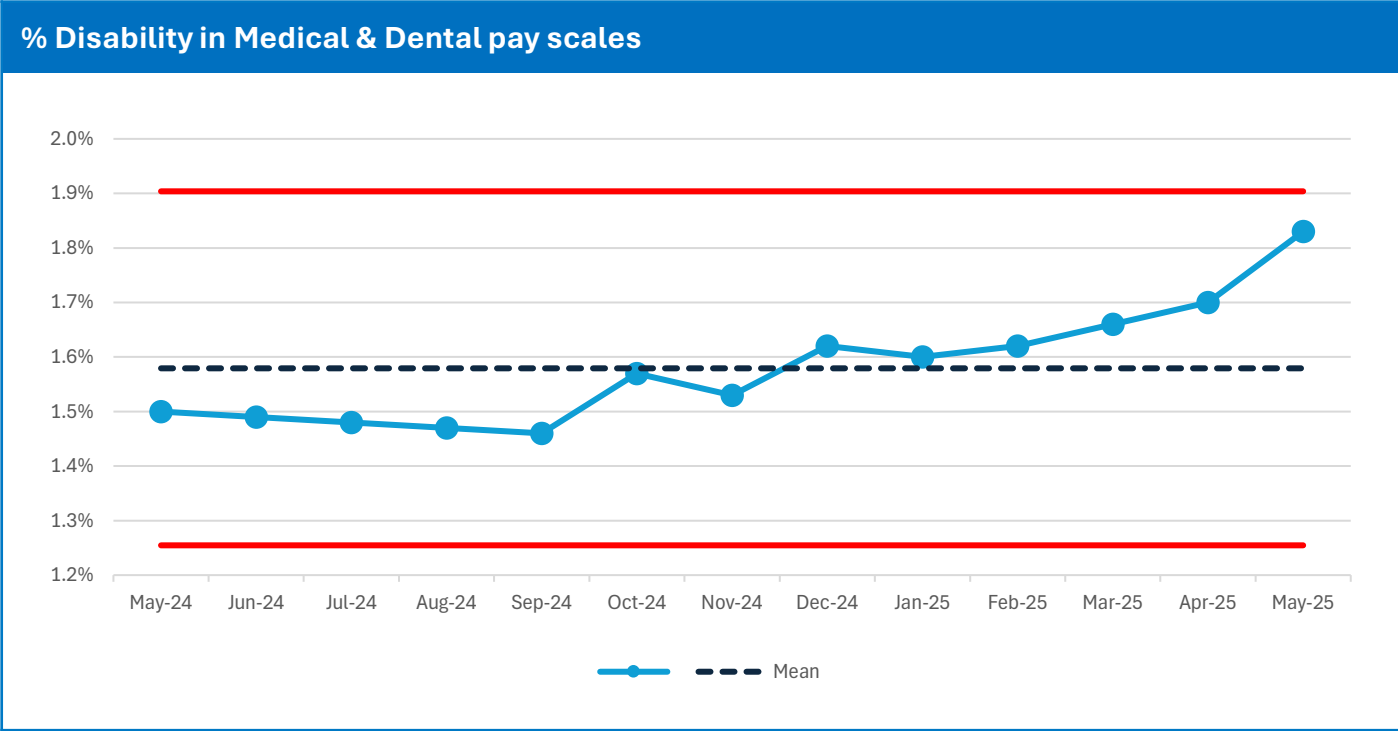
This metric currently only needs monitoring as part of the Clinical Group IPR process and no interventions.

% Disability in Medical & Dental pay scales

Advise	W25 metric
May-25	Target
1.8%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	
Research	
Corporate	0.0%
LCO & UDH	2.3%
Specialist	2.4%
CSS	1.6%
NMGH	1.6%
WTWA	1.3%
MRI	1.9%



Source
ESR (Electronic Staff Records)

Updates since previous month

The Disability % in this staff group is currently at 1.8% and has improved in the rolling 12 month period.

Current issues

Currently underreporting on this metric due to nearly 30% of staff not having declared their disability status on ESR in the Medical and Dental workforce.

Key dependencies

Develop and implement recruitment policies that prioritise the inclusion of disabled candidates, ensuring job postings reach diverse communities.

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Future actions

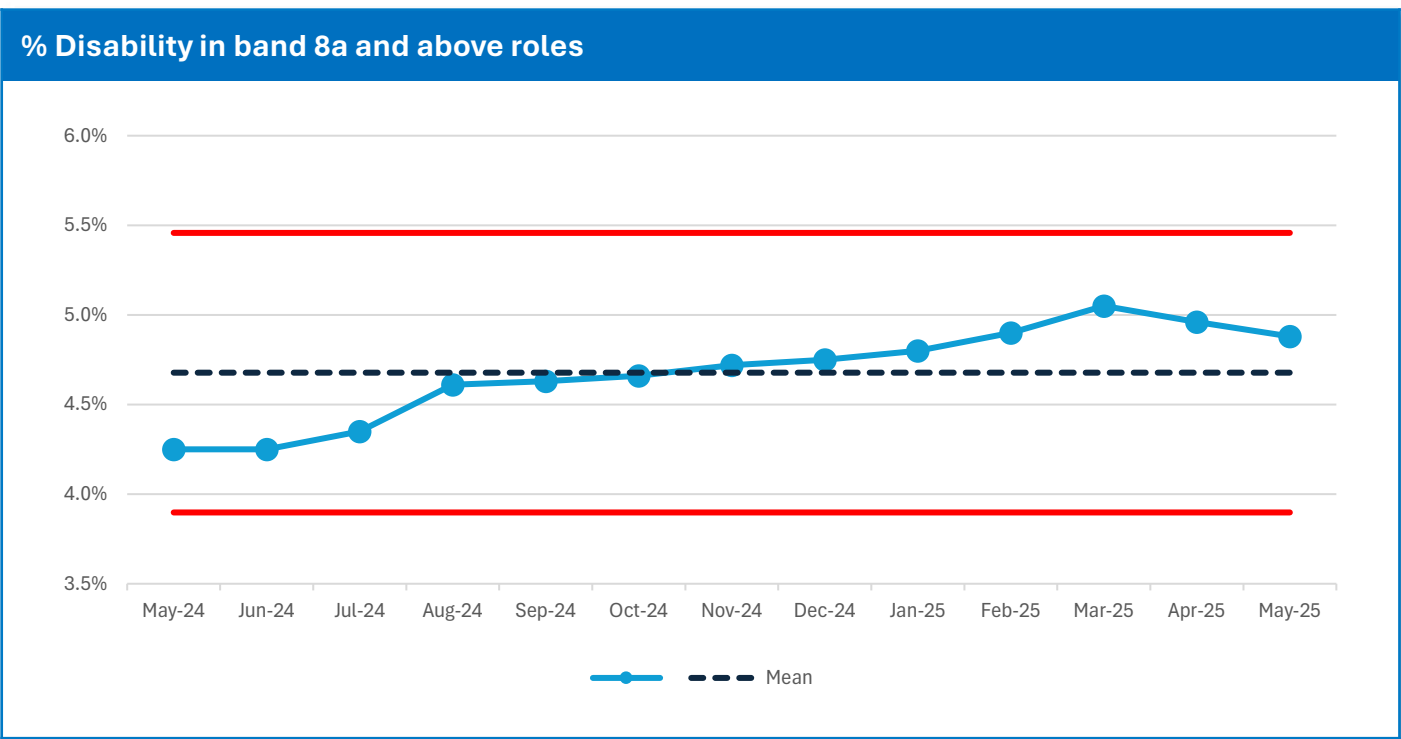
Work undertaken by the ED&I team to improve the data collection of Disability status through Employee Self Service on ESR.

% Disability in band 8a and above roles

Advise	W26 metric
Mar-25	Target
4.9%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	3.0%
Research	8.8%
Corporate	8.4%
LCO & UDH	5.4%
Specialist	4.1%
CSS	3.0%
NMGH	7.6%
WTWA	4.2%
MRI	2.2%



Source
ESR (Electronic Staff Records)

Updates since previous month

The Disability % in this staff group is currently at 4.9% and has improved in the rolling 12 month period.

Current issues

Currently underreporting on this metric due to nearly 13% of staff not having declared their disability status on ESR in the Band 8a and above workforce.

Key dependencies

Develop and implement recruitment policies that prioritise the inclusion of disabled candidates, ensuring job postings reach diverse communities.

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Future actions

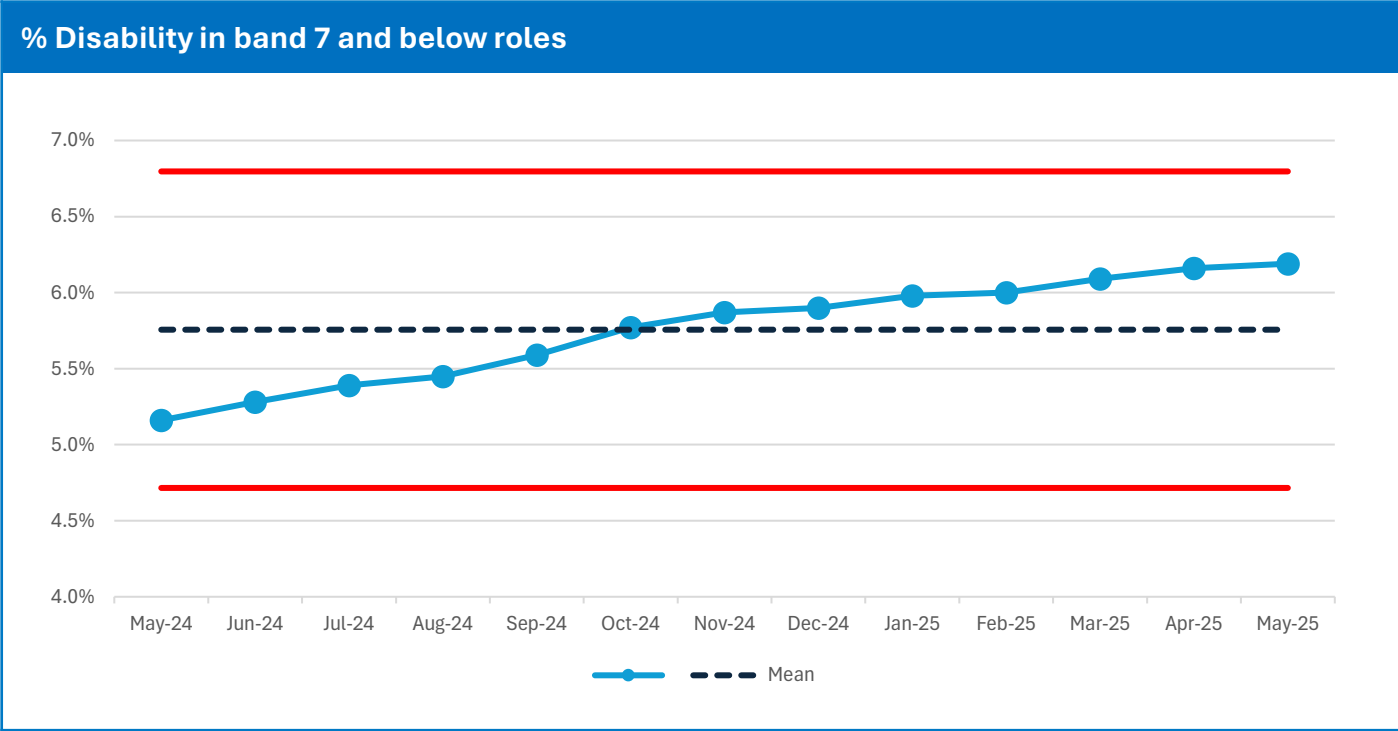
Work undertaken by the ED&I team to improve the data collection of Disability status through Employee Self Service on ESR.

% Disability in band 7 and below roles

Advise	W27 metric
Mar-25	Target
6.2%	-

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	6.6%
Research	6.0%
Corporate	8.1%
LCO & UDH	7.8%
Specialist	7.2%
CSS	6.4%
NMGH	5.5%
WTWA	4.5%
MRI	4.6%



Source
ESR (Electronic Staff Records)

Updates since previous month
The Trust is seeing an improvement in this metric month on month.

Current issues
Currently underreporting on this metric due to nearly 20% of staff not having declared their disability status on ESR in the Band 7 and below workforce.

Key dependencies
Develop and implement recruitment policies that prioritise the inclusion of disabled candidates, ensuring job postings reach diverse communities.
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Future actions
Work undertaken by the ED&I team to improve the data collection of Disability status through Employee Self Service on ESR.

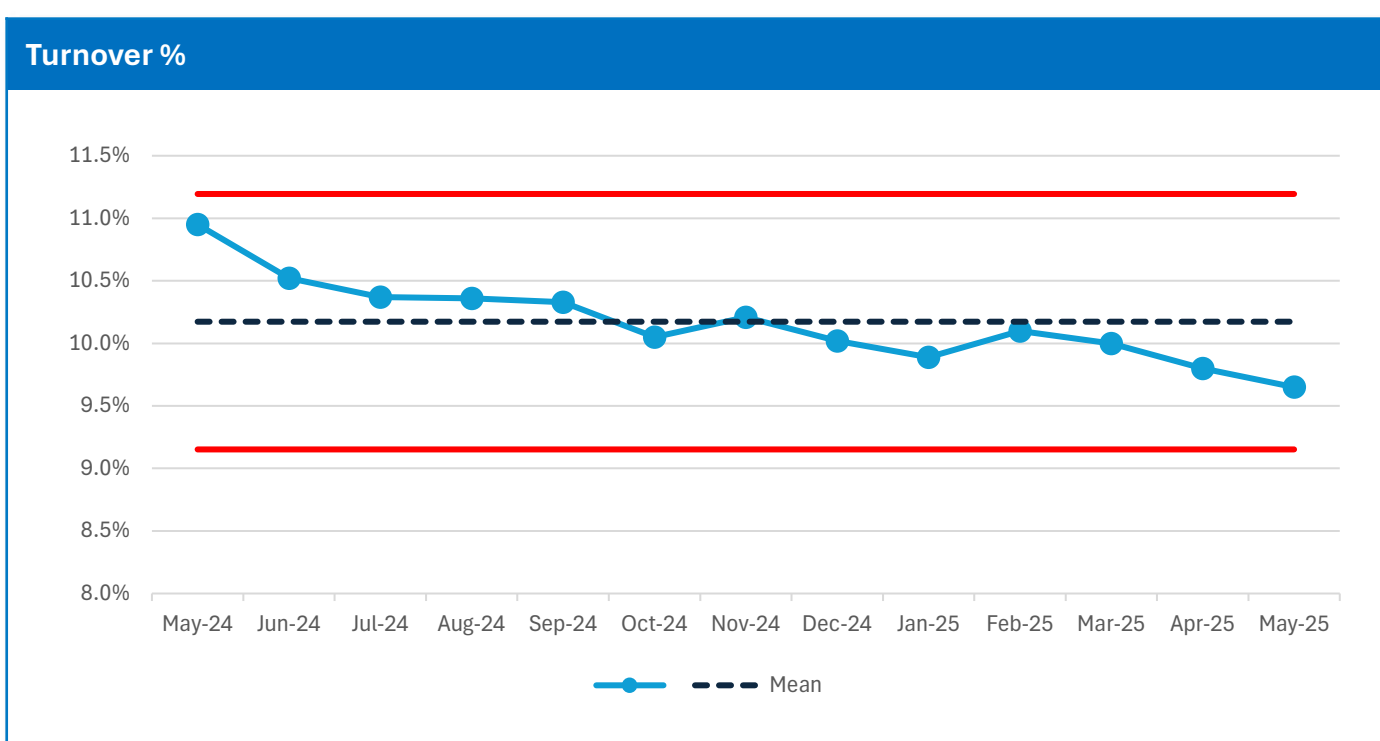
Turnover %

Assure	W28 metric

May-25	Target
9.7%	11.0%

Compliance	Variance	Assurance	Actions
			

Clinical & Corporate Group Overview	
Facilities	11.2%
Research	6.1%
Corporate	10.1%
LCO & UDH	10.9%
Specialist	9.1%
CSS	10.0%
NMGH	9.0%
WTWA	9.6%
MRI	9.4%



Source
ESR (Electronic Staff Records)

Updates since previous month
All Clinical Groups are meeting the 11.0% target for this metric.

Current issues

Key dependencies
High levels of engagement and job satisfaction among staff are crucial for reducing turnover.

Future actions
The Trust has set a target of keeping below 11% Turnover as part of the Workforce Plan to the NHSE/ which it has done.

Retention / Stability %

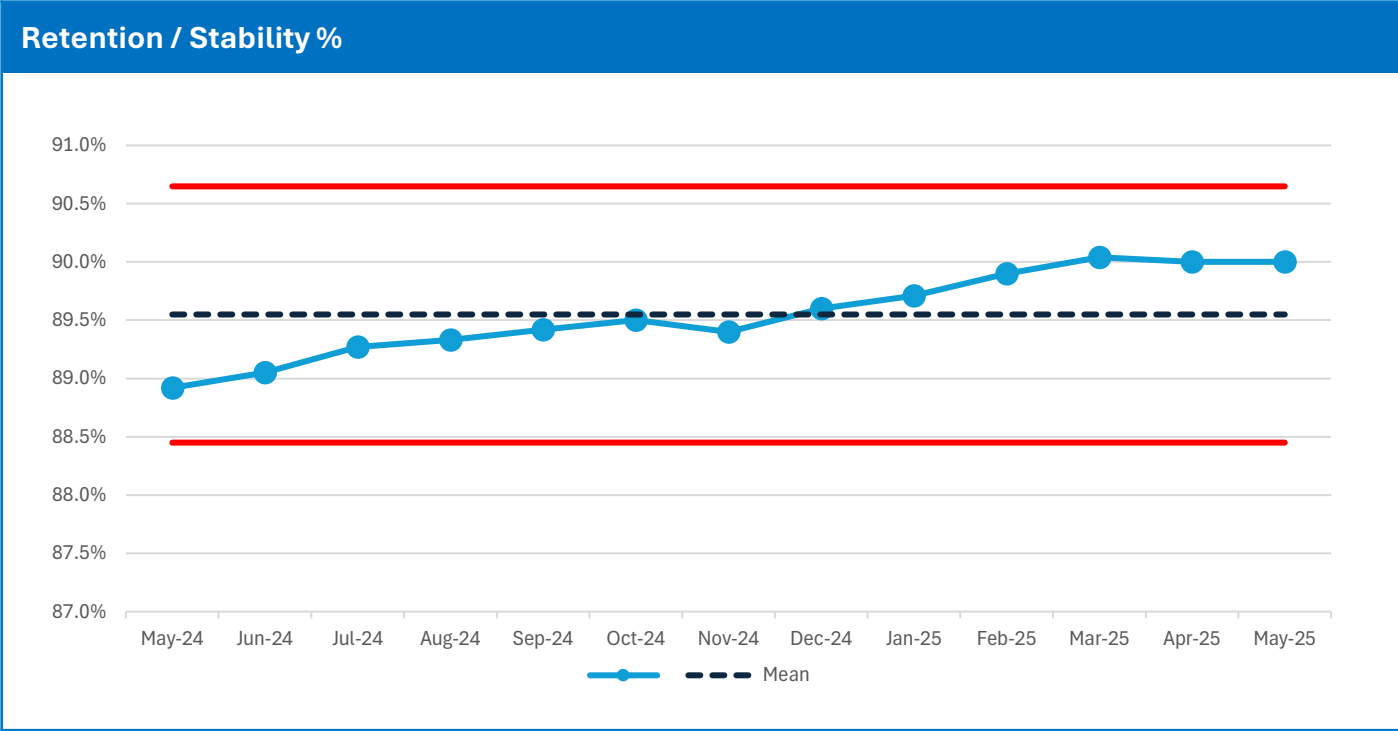
Assure

W29 metric

May-25	Target
90.0%	89.0%

Compliance	Variance	Assurance	Actions

Clinical & Corporate Group Overview	
Facilities	87.8%
Research	91.1%
Corporate	88.2%
LCO & UDH	87.8%
Specialist	88.0%
CSS	88.5%
NMGH	87.8%
WTWA	85.5%
MRI	86.5%



Source

ESR (Electronic Staff Records)

Updates since previous month

The Trust is currently exceeding the 89% target for this metric.

Current issues

Key dependencies

A high stability metric can indicate a positive work environment, effective management, and employee satisfaction.

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Future actions

MFT People Plan will be reviewed in 2025/26 and will include a range of new measures under the people promise including retention.

Time to Hire

Advise

W30 metric

Mar-25

Target

62.4

-

Compliance

Variance

Assurance

Actions



Clinical & Corporate Group Overview

LCO & UDH

- UDH 78.0

- LCO 63.2

Specialist

- REH 64.4

- SMH 72.9

- RMCH 55.9

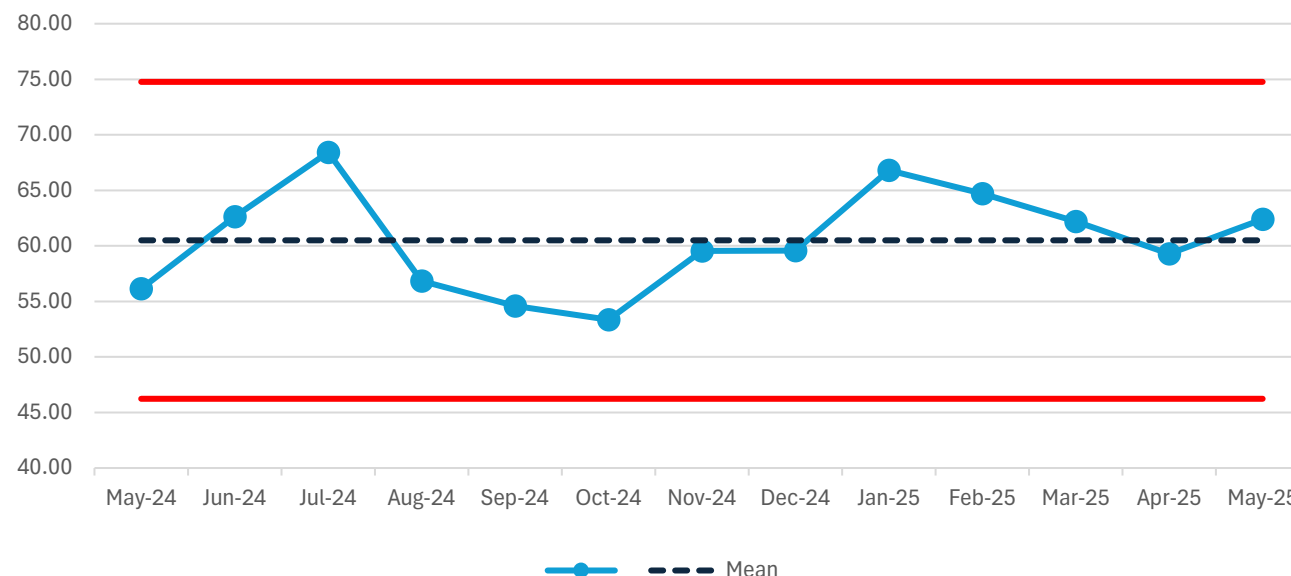
CSS 67.6

NMGH 53.6

WTWA 60.6

MRI 52.7

Time to Hire



Source

TRAC e-recruitment system

Updates since previous month

The Trust has recently started reporting the Time to Hire through the Provider Workforce Return (PWR).

Current issues

Key dependencies

The VCP process will have an impact on the time to hire metric.

Future actions

The ICB are pulling together a reporting platform for all GM Trusts so we can benchmark this metric across different Trusts and Staff Groups.

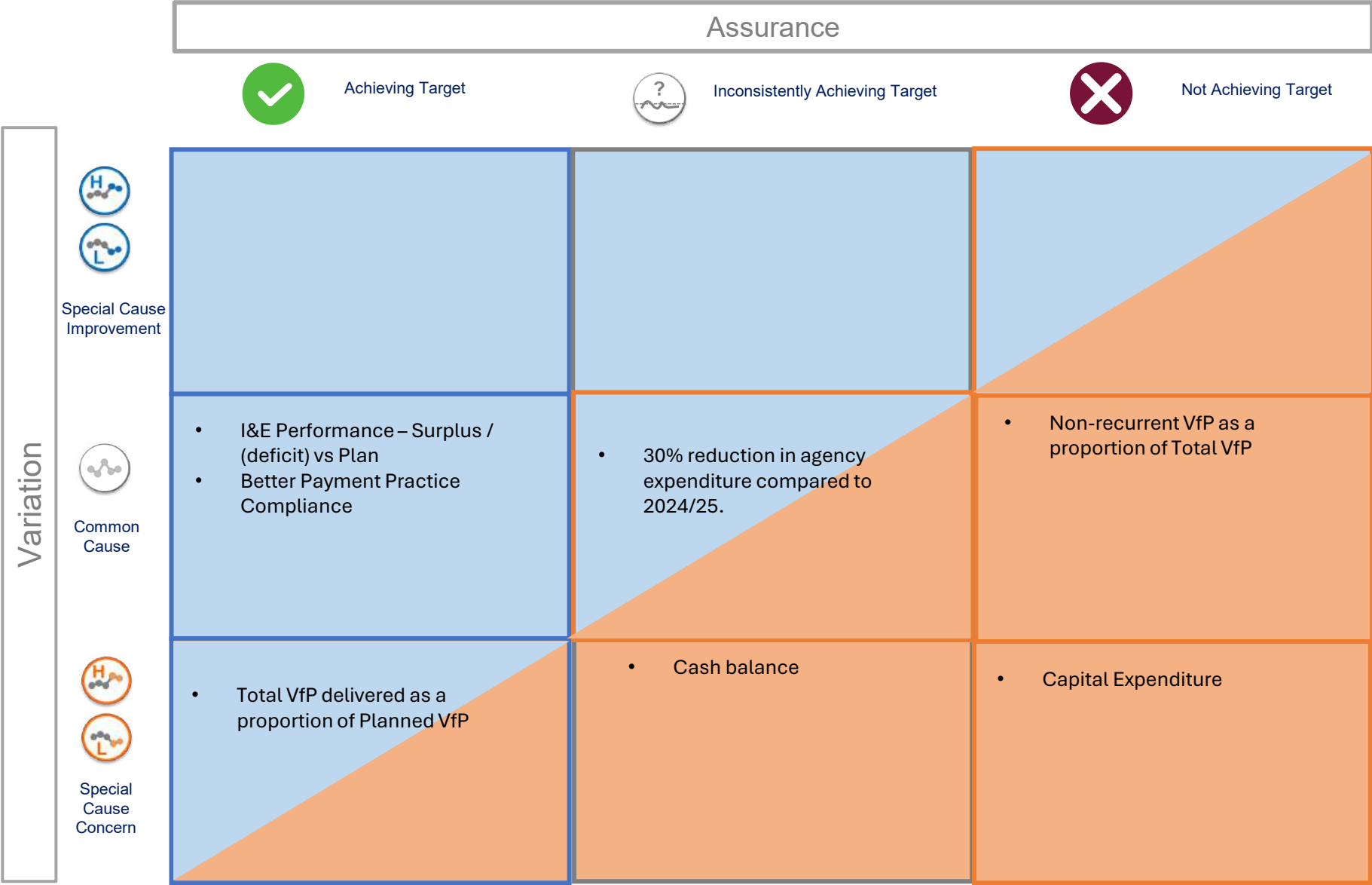
**Ensure value for our
patients and communities
by making the best use of
our resources**



Trust IPR Metric Assurance Summary

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

Executive summary



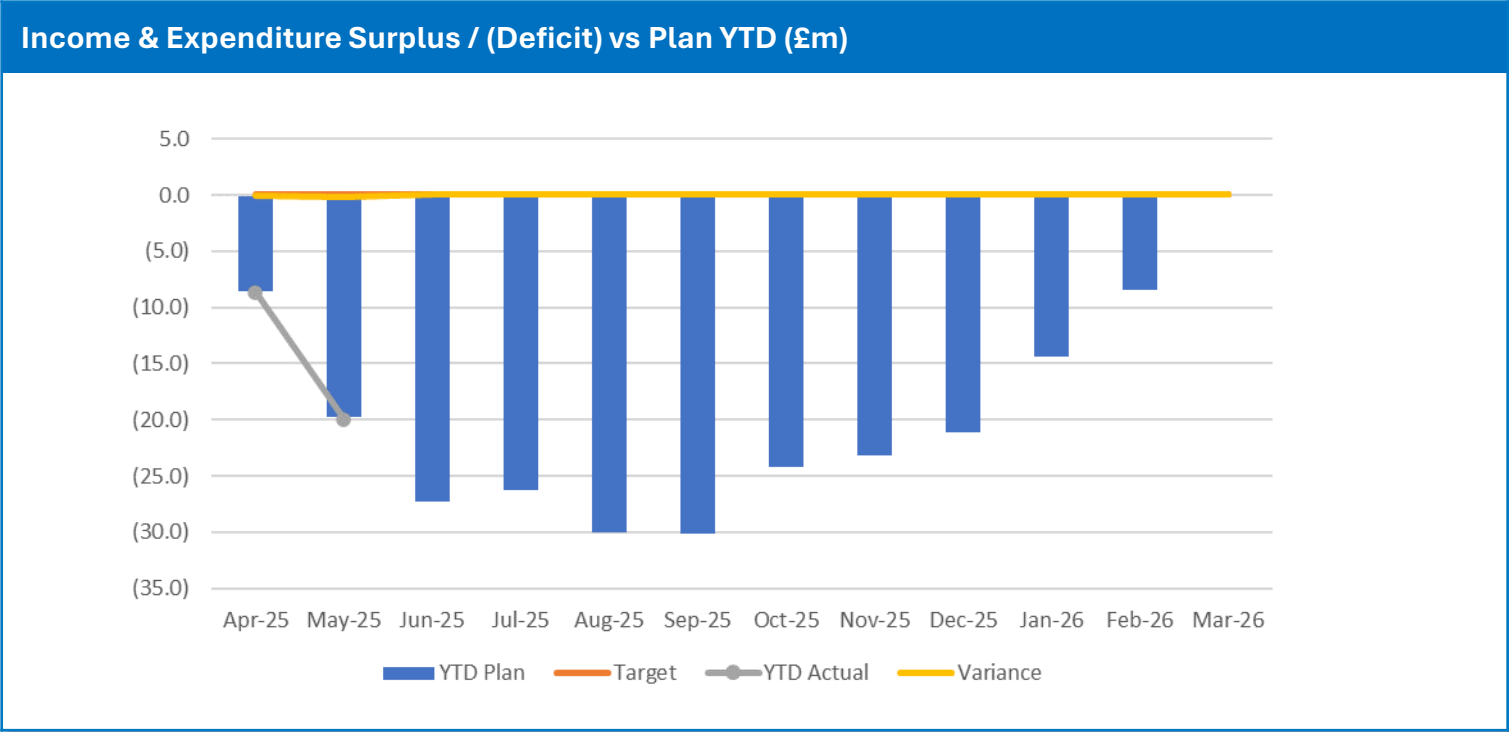
- Consistent assurance can be provided on:
- YTD I&E performance
 - BPPC compliance for invoices paid by value consistently above the 95% target
 - YTD delivery of VfP
- Cash balances at the end are c. £12.7m lower than plan. This is predominantly due to delivery of the financial position by non cash releasing means.
- Alerts for:
- Cash balance, £12.7m lower than plan
 - Delivery of VfP through non recurrent schemes
 - Capital spend which is marginally behind plan in M2
 - Reduction in agency expenditure compared to 2024/25 (although note MFT's expenditure as a % of overall pay expenditure is one of the lowest in the country)

Assure

May-25	Target
£0.0	£0m

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
Rank	Clinical Group	YTD Value £m
1	WTWA	1.2
2	Spec. Hospitals	0.6
3	CSS	(0.1)
4	LCO & Dental	(0.7)
5	MRI	(1.7)
6	NMGH	(2.8)



Updates since previous month

Surplus delivered YTD is in line with plan.

Key dependencies

VfP programme
Cash

Current issues

Identification of plans to deliver the full VfP target across all areas, in line with plan and 75% recurrent.
Inflationary pressures on non-pay expenditure.
Premium pay (primarily bank costs and ECLs).

Future actions

25/26 performance against CG plans will be closely monitored.
A high level of scrutiny will be on VfP plans to ensure delivery

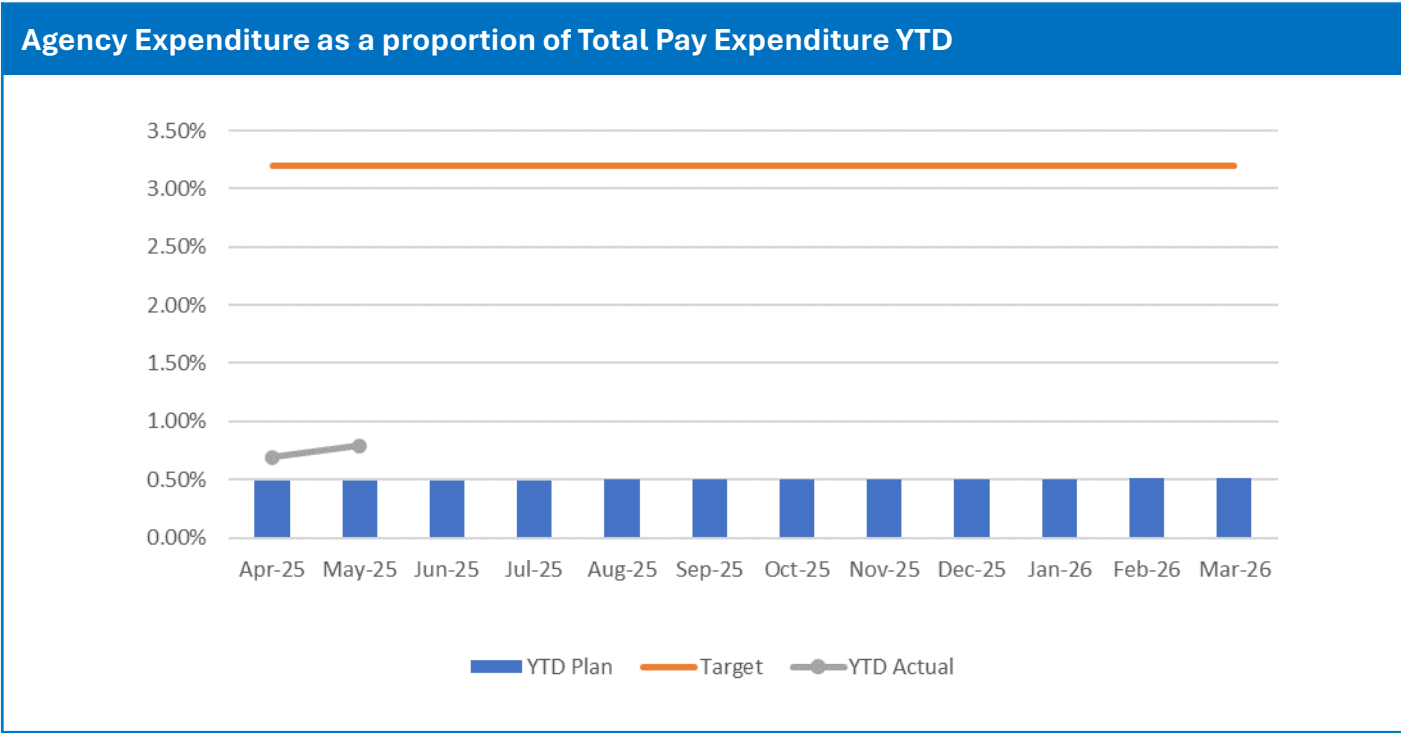
Agency - % of total staffing costs

Advise

May-25	Target
0.8%	0.5%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
Rank	Clinical Group	YTD Value %
1	LCO & Dental	0.1%
2	Spec. Hospitals	0.3%
3	WTWA	0.5%
4	MRI	0.8%
5	CSS	1.3%
6	NMGH	2.6%



Updates since previous month

National guidance requires a reduction of 30% of agency costs in 2025/26.
MFT has one of the lowest agency usage nationally in proportion to total staffing costs

Key dependencies

Total pay costs

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Current issues

There are still some challenges to resolve relating to a reduction in the use of off-platform agency for difficult to recruit posts.

Future actions

Identification of alternatives to off-platform agency.

Value for Patients delivered YTD

Advise

May-25

Target

115%

100%

Compliance

Variance

Assurance

Actions



Clinical Group Overview

Rank	Clinical Group	YTD Value %
1	WTWA	110%
2	NMGH	97%
3	LCO & Dental	90%
4	CSS	88%
5	Spec. Hospitals	61%
6	MRI	51%

Total VfP delivered YTD (from Wave)

Year to Date	Recurrent			Non Recurrent			Total			Actual v Target %	Delivered NR %
	Target £'000	Actual £'000	Variance to target £'000	Target £'000	Actual £'000	Variance to target £'000	Target £'000	Actual £'000	Variance to target £'000		
CSS	965	788	(177)	322	346	24	1,287	1,134	(153)	88%	31%
LCO & Dental	386	139	(247)	129	323	194	514	461	(53)	90%	70%
MRI	866	586	(279)	289	0	(289)	1,154	586	(568)	51%	0%
NMGH	384	370	(14)	128	126	(2)	512	496	(16)	97%	25%
Specialist Hospitals	1,233	245	(987)	411	765	354	1,644	1,010	(633)	61%	76%
WTWA	862	457	(405)	287	807	520	1,149	1,264	115	110%	64%
Total - Clinical Sites	4,695	2,585	(2,110)	1,565	2,367	802	6,260	4,952	(1,307)	79%	48%
Corporate exc Informatics	234	88	(146)	78	0	(78)	312	88	(225)	28%	0%
Informatics	210	267	56	70	0	(70)	280	267	(14)	95%	0%
Estates & Facilities	293	10	(283)	98	167	69	391	176	(214)	45%	95%
Total - Support Services	738	364	(373)	246	167	(79)	983	531	(453)	54%	31%
Trust	379	0	(379)	126	3,400	3,274	505	3,400	2,895	674%	100%
Grand Total	5,811	2,949	(2,862)	1,937	5,934	3,997	7,748	8,883	1,135	115%	67%

Updates since previous month

The £8.8m YTD VfP performance is £1.1m above the M2 YTD target but has been delivered through predominantly non recurrent schemes, with Central flexibilities brought forward to support.

Key dependencies

I&E performance
Impact on cash

Current issues

The level of non-recurrent delivery in 24/25 has impacted on the underlying financial position coming into 25/26. Close scrutiny of the programme will be required in the 25/26 financial year to avoid slippage.

Future actions

External support commissioned to support continued identification and development of the schemes for 25/26 by all areas
Executive focus through fortnightly Trust Recovery Board

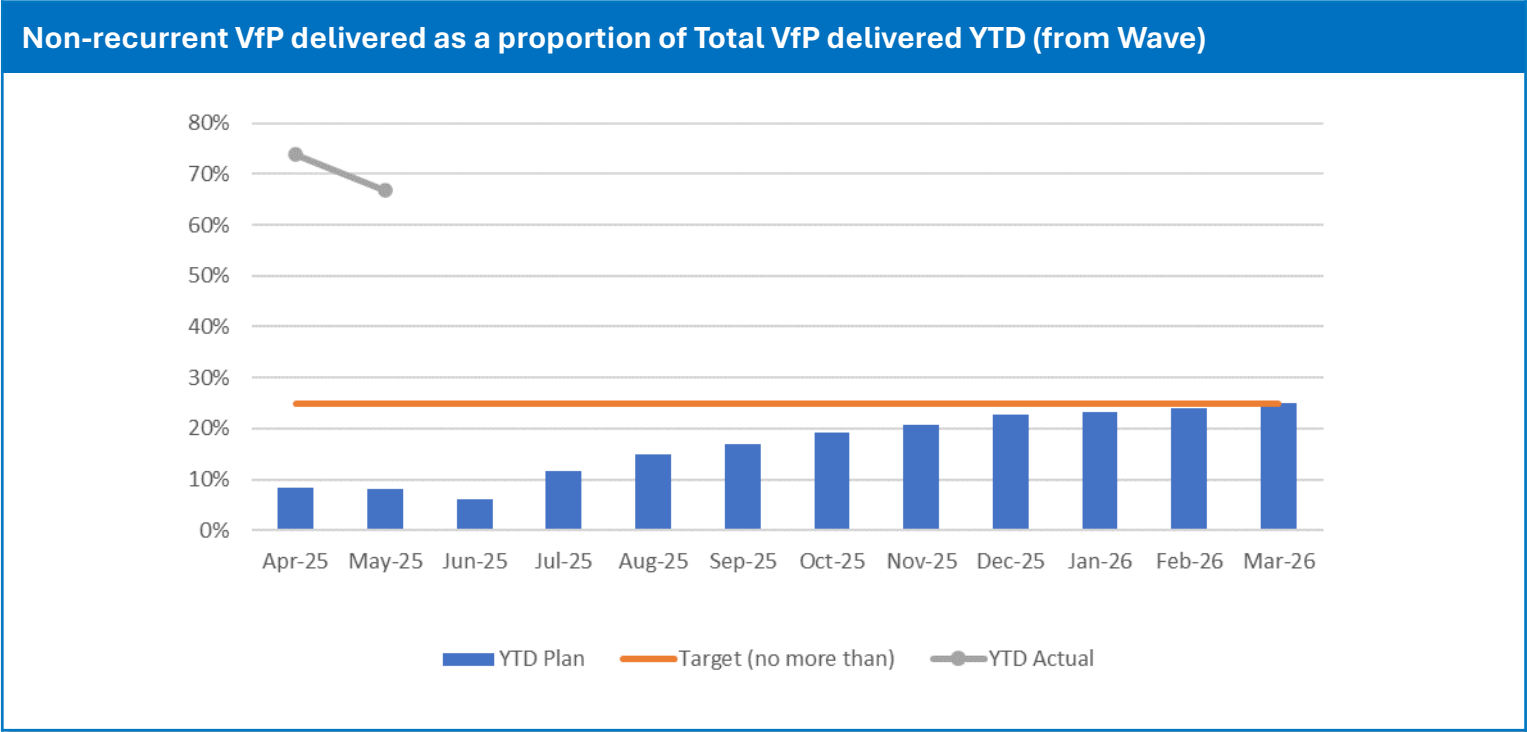
Non -recurrent Value for Patients delivered YTD

Alert

May-25	Target
67%	25%

Compliance	Variance	Assurance	Actions

Clinical Group Overview		
Rank	Clinical Group	YTD Value %
1	MRI	0%
2	NMGH	25%
3	CSS	31%
4	WTWA	64%
5	LCO & Dental	70%
6	Spec. Hospitals	76%



Updates since previous month

The Non recurrent delivery of VfP is higher than planned due to central VfP schemes being brought forward to offset under-delivery in the Clinical Groups

Current issues

Any non recurrent delivery will impact on the Trust’s underlying financial position.

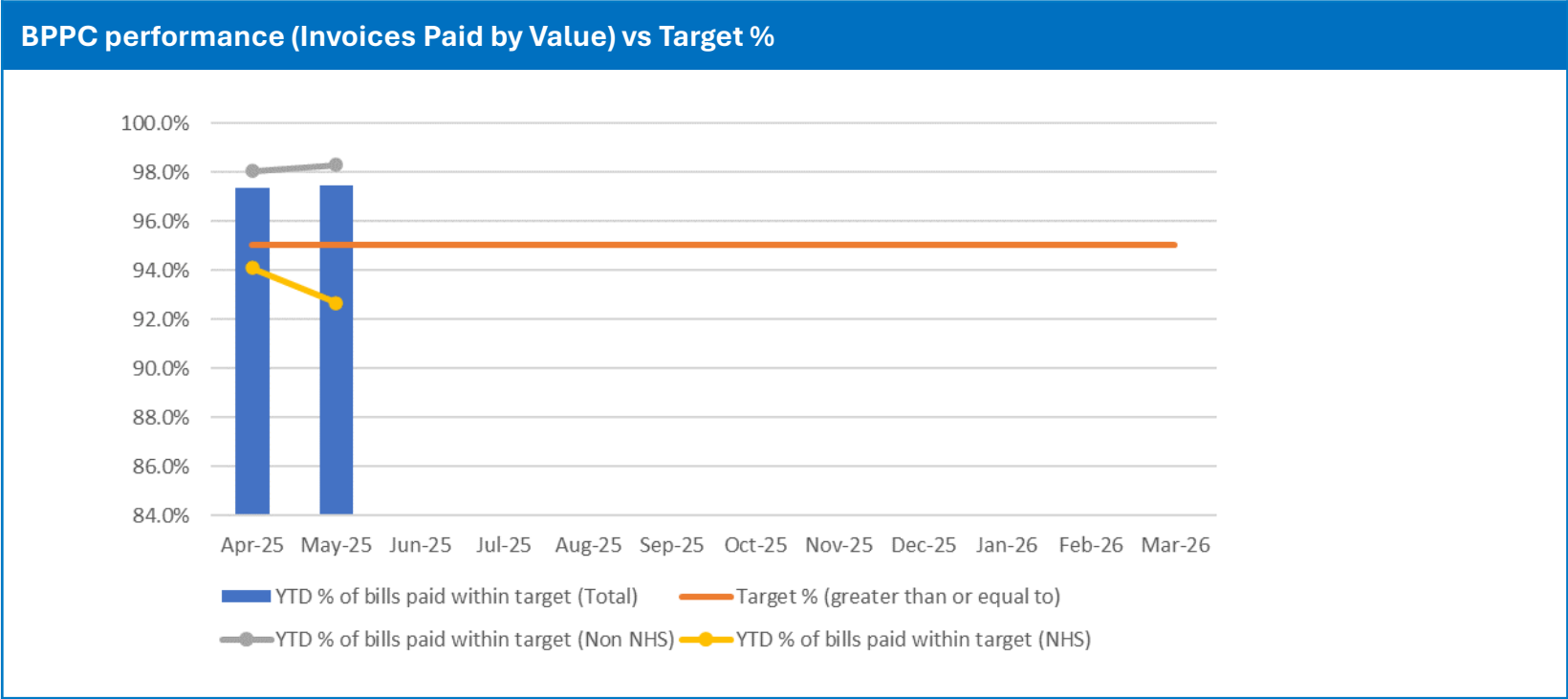
Key dependencies

I&E performance
Impact on cash

Future actions

Development at pace of schemes to deliver the full the 25/26 programme with a focus on recurrency.

Assure			
May-25		Target	
97%		95%	
Compliance	Variance	Assurance	Actions



Updates since previous month

A consistent level of c97% of all bills paid within target.

Current issues

The Trust is falling short on NHS invoices paid within target at 92.7%. Performance against invoices paid by number (not shown) is 94.4% with NHS invoices just 67.0%.

Key dependencies

BPPC performance vs target for invoices paid by number (not shown on the chart).
Impact on cash

Page 173

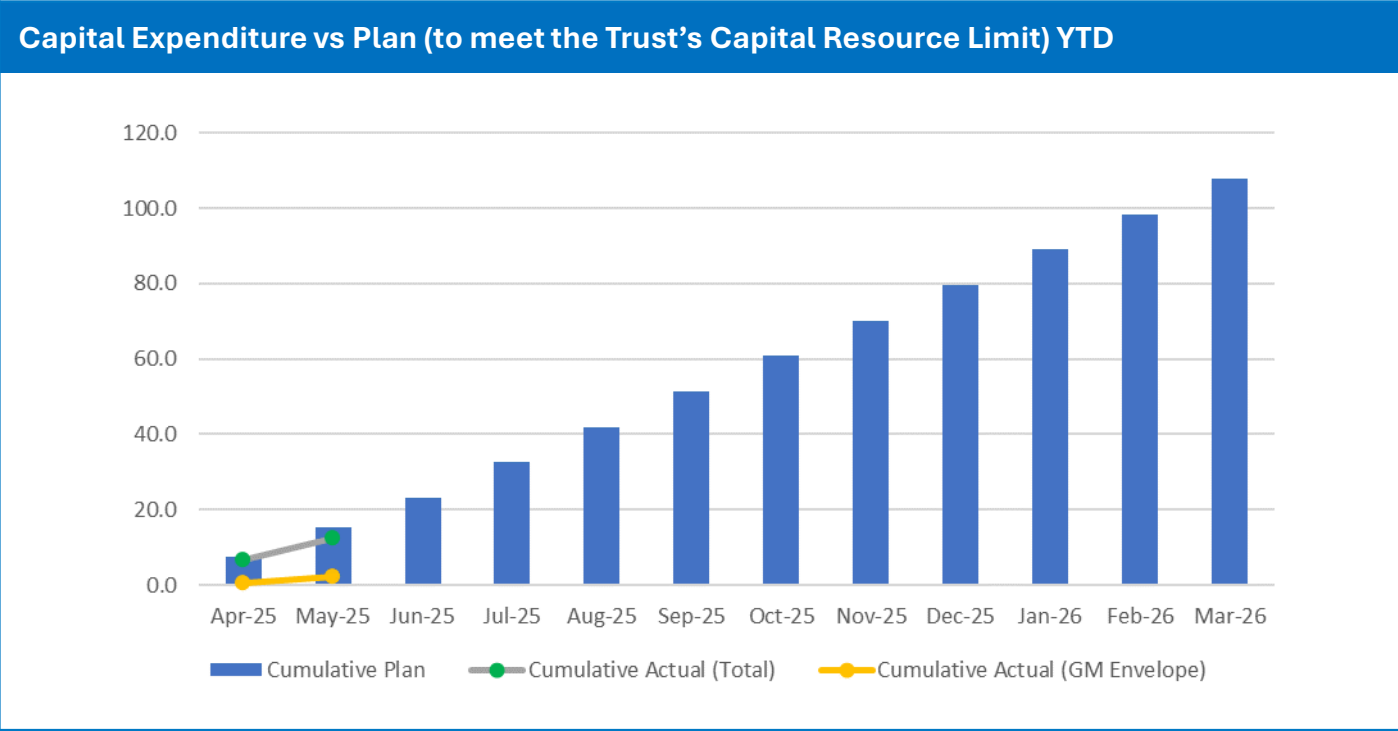
Future actions

Although the overall target is being met for the primary driver of invoices paid by value there is further to do to pay NHS invoices in a timely manner and to increase the number of invoices paid to target. However, this will need to be managed in line with maximising the organisations cash.

Advise

May-25	YTD Target
£11.2m	£10.1m

Compliance	Variance	Assurance	Actions



Updates since previous month

Overspent against plan due to a timing difference of an anticipated CDEL credit as a result of securing more favourable lease terms but anticipating to be back on plan by the middle of Q2.

Key dependencies

Cash

Current issues

Trust capital requirements exceed CDEL limit. If the cash position falls to a level where revenue cash support is required, this will impact on the affordability of the capital programme and it would need to be slowed down/reduced.

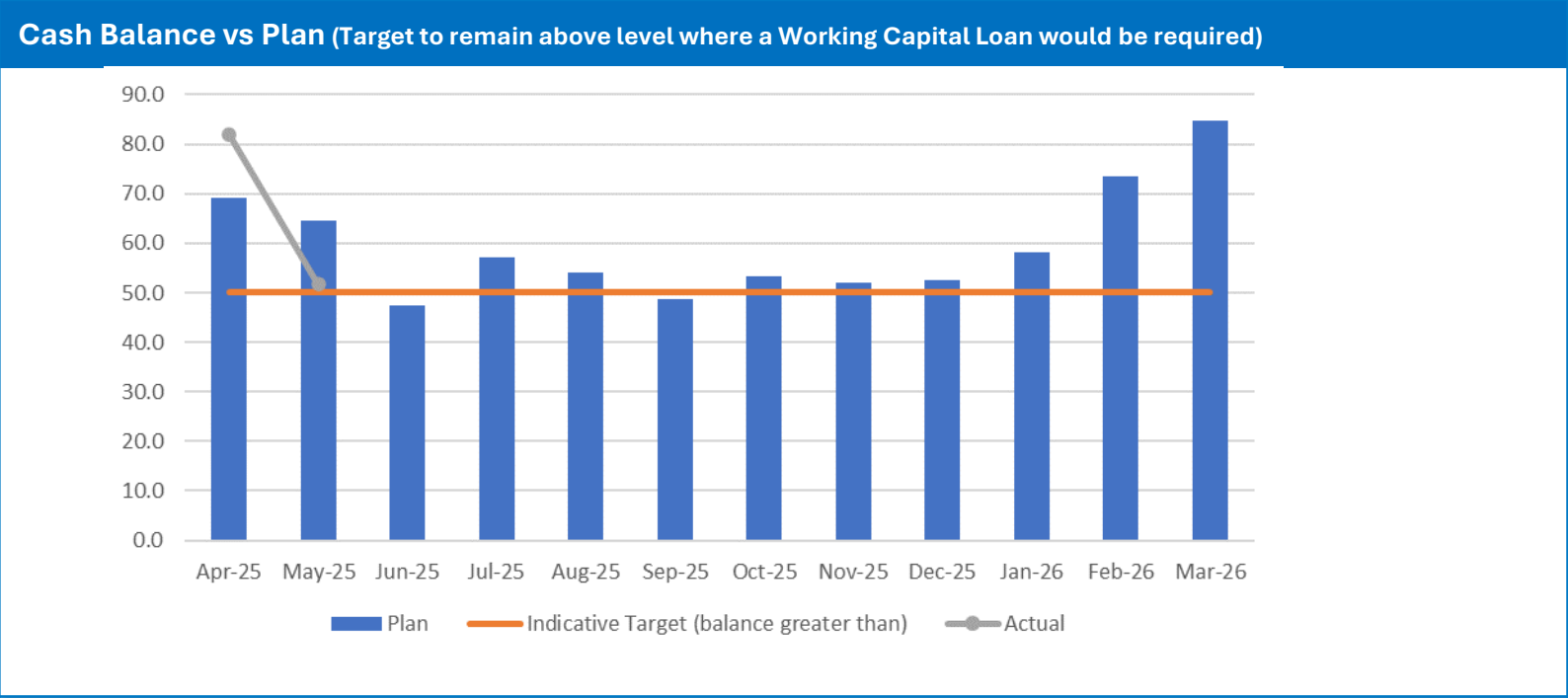
Future actions

Application for any national funding made available for capital schemes
Work ongoing to identify alternative funding mechanisms for capital requirements

Alert

May-25	Target
£51.8m	£64.5m

Compliance	Variance	Assurance	Actions



Updates since previous month

The cash position continues to be challenged due to delivery of the financial position by non cash releasing means and planned deficit for the first quarter of the year.

Key dependencies

I&E deficit.
Capital underspends

Current issues

Risk of requiring national revenue cash support if monthly expenditure is not reduced in line with the profiled plan.

Future actions

Weekly cash meetings to monitor and maximise Trust cash position
Senior sign off for all supplier payment runs
Focus on development and implementation of cash releasing VfP schemes.

**Deliver world-class research &
innovation that improves
peoples lives**



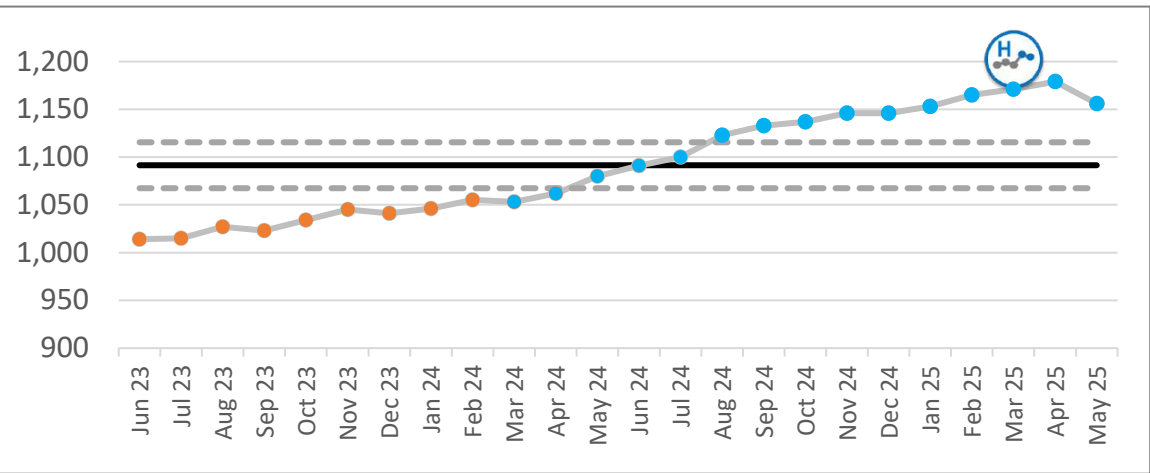
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
All research studies Open to Recruitment or in Follow- Up	May 25	1156				1091	1067	1116
Percentage of all research studies approved within 40 day target	May 25	60%	80%			74%	27%	100%
Monthly participants recruited to NIHR Portfolio-adopted research studies	May 25	1272	1584			1615	1034	2196
MFT-sponsored, NIHR Portfolio-adopted research studies on track for recruitment to time and target	May 25	49%	80%			51%	39%	63%
UKCRD Commercial Metric 1 Under Construction	May 25	457	60			380	70	689
UKCRD Commercial Metric 2 Under Construction	May 25	132	30			200	-131	531

Metric Summary

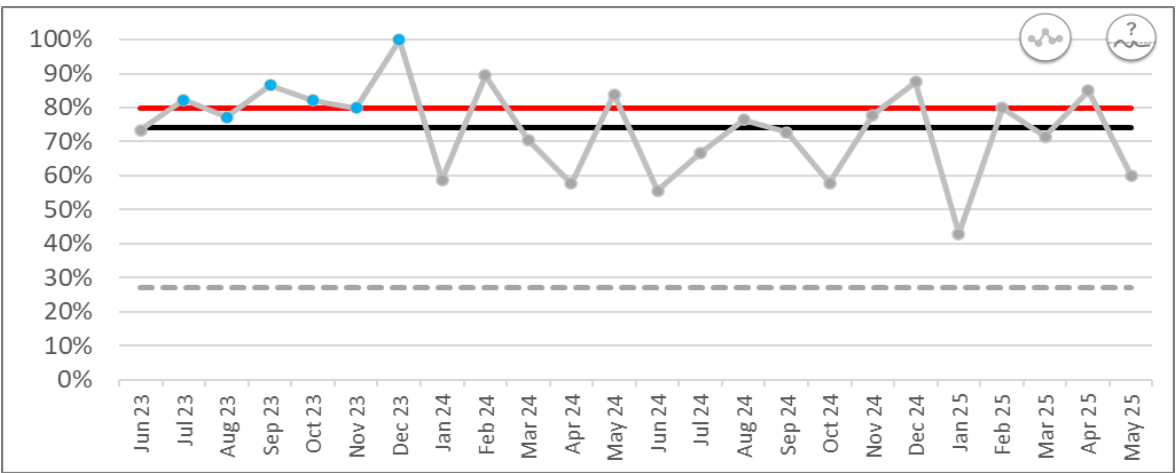


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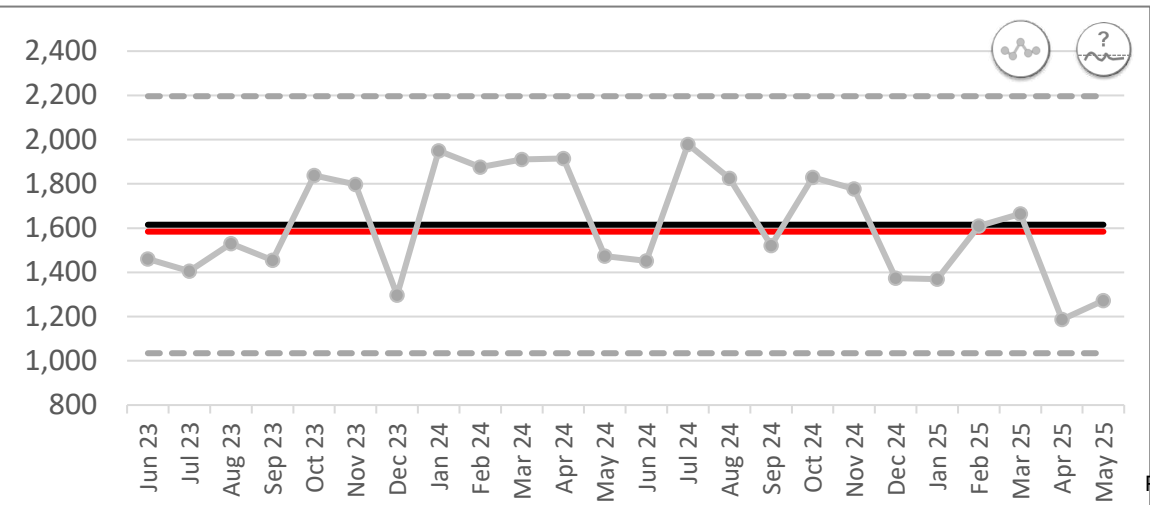
All research studies Open to Recruitment or in Follow- Up



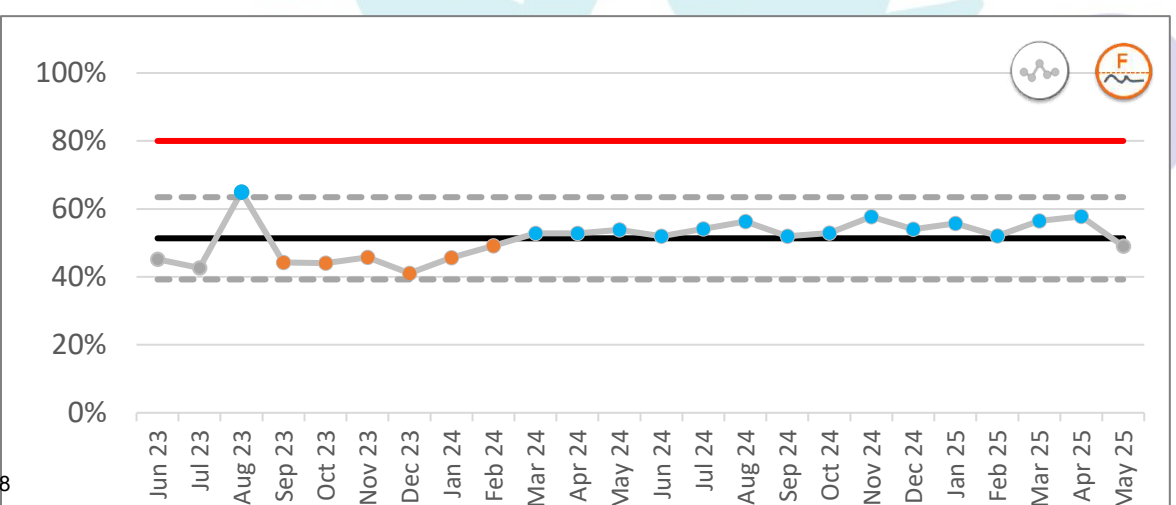
Percentage of all research studies approved within 40 day target



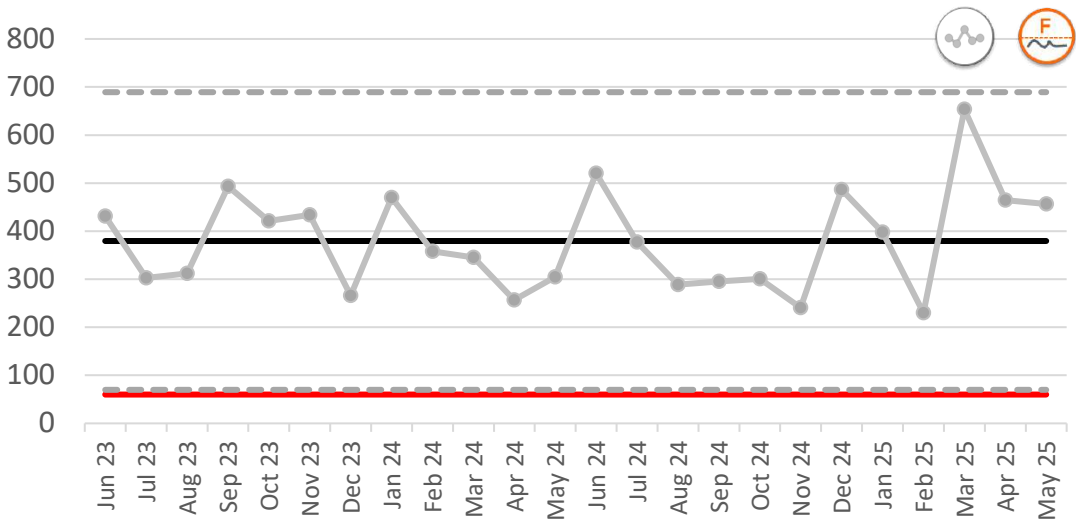
Monthly participants recruited to NIHR Portfolio-adopted studies



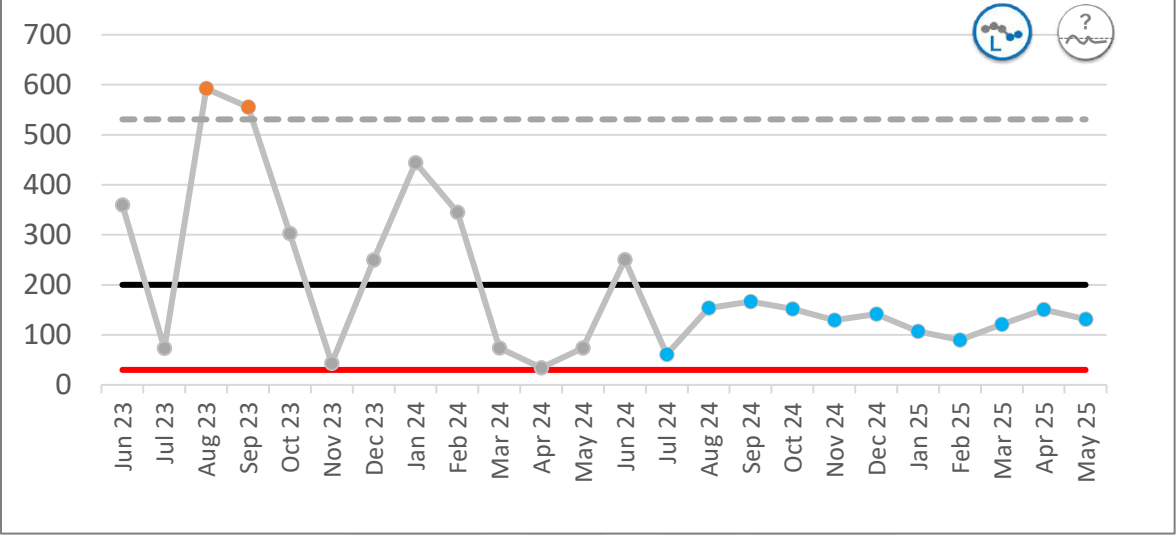
MFT-sponsored, RDN Portfolio studies on target



UKCRD Commercial Metric 1 Under Construction



UKCRD Commercial Metric 2 Under Construction



All Active Studies Number



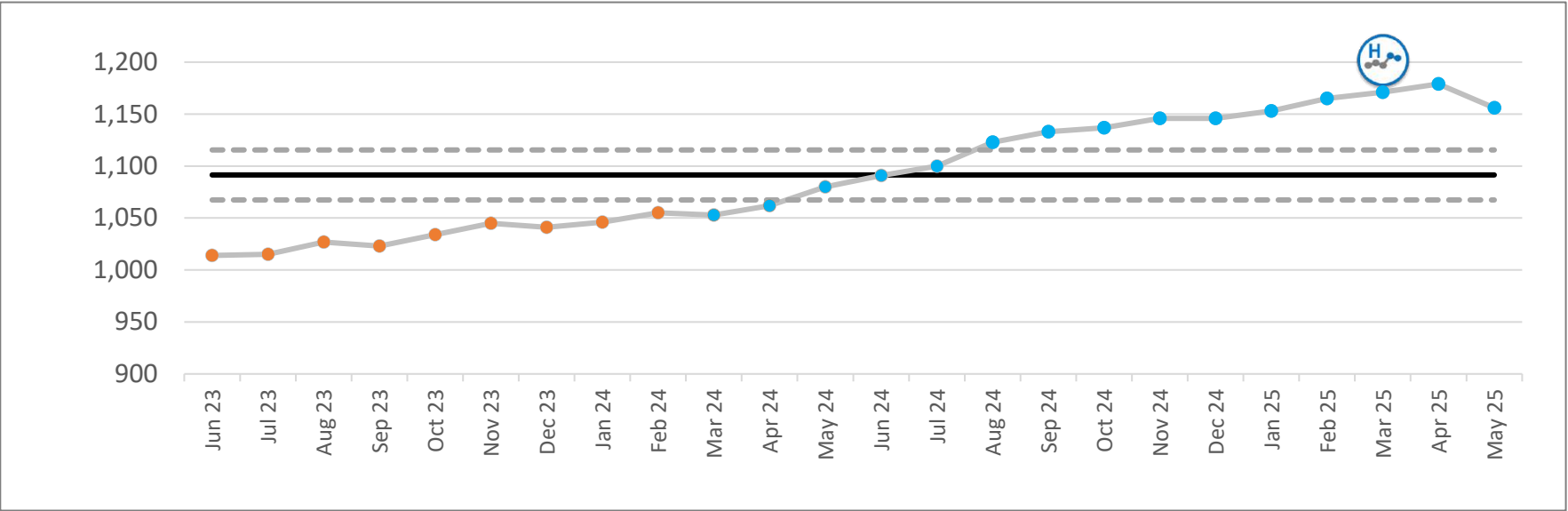
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May-25	Target
1179	-

Compliance	Variance	Assurance	Actions

Status
Assure

All research studies Open to Recruitment or in Follow- Up



Updates since previous month

N/A - First report

Current issues

Growth in all research studies especially driven by growth in non-commercially sponsored studies. Especially evident since proportionate review introduced for lower risk/complexity studies enabling faster set up.

Key dependencies

Indicator of overall capacity to support research

Future actions

None required

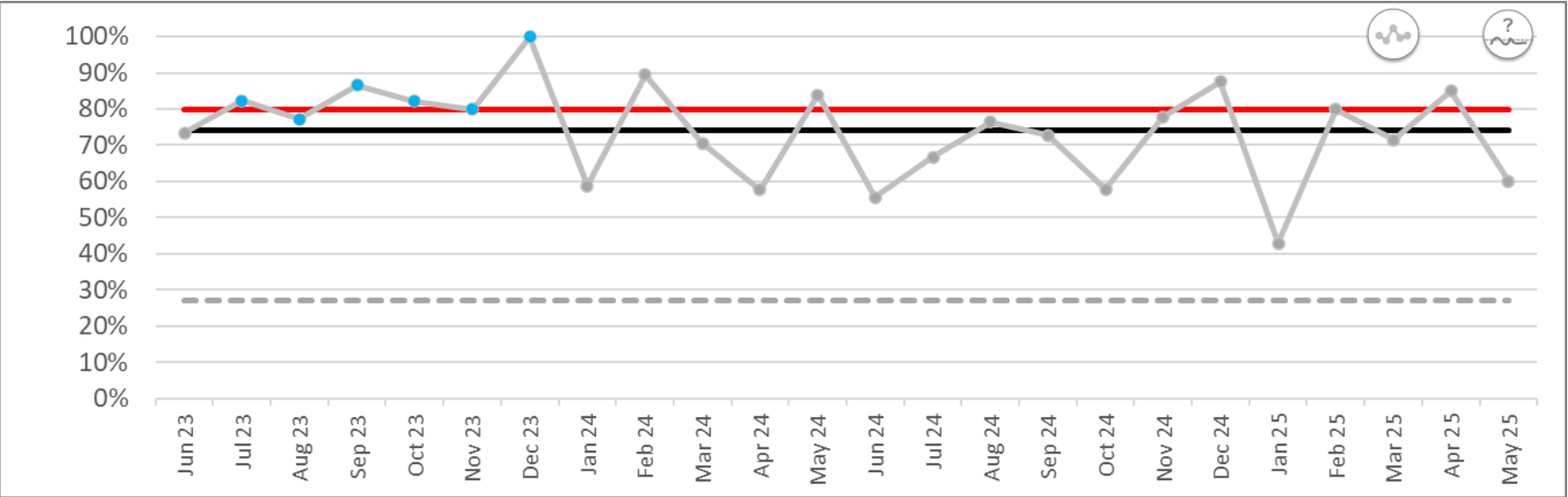
All Studies Approval Time

May-25	Target
60%	80%

Compliance	Variance	Assurance	Actions
			

Status
Advise

Percentage of all research studies approved within 40 day target



Updates since previous month

N/A - First report

Current issues

Research Office staffing levels have been impacted by turnover and extended vacancy periods, although being addressed and set to improve across second half of 2025. Imaging capacity remains a long-term issue on which CSS and R&I are focussed.

Key dependencies

Full staffing of key and relatively small Research Office team supporting approvals essential. Also indicates capacity of Clinical Trial Pharmacy team and Imaging teams in CSS to support new studies.

Future actions

Maintain Research Office and research critical service staffing levels. Continue efforts to addressing staffing arrangements for paediatric MR scanning for research studies and overall MR capacity for research.

Portfolio Studies Recruitment Number



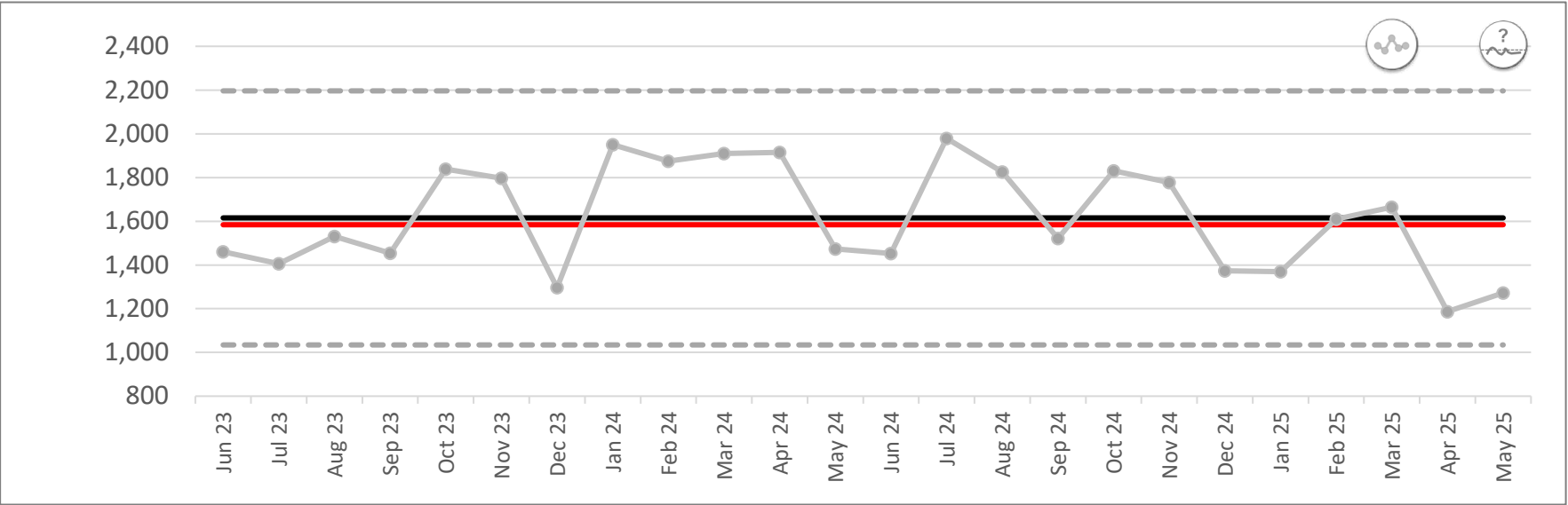
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May-25	Target
1272	1584

Compliance	Variance	Assurance	Actions

Status
Advise

Monthly participants recruited to NIHR Portfolio-adopted research studies



Updates since previous month

N/A - First report

Current issues

Recruitment lower in 2024/25 due to large number of vacancies and extended times to recruit reducing delivery staff capacity. Note that whilst overall increase in number of participants is important, a great deal of early phase experimental medicine studies involve very small numbers of patients.

Key dependencies

Related to number of research studies and recruitment targets of those studies. Impacted by staff availability to recruit, especially Clinical Research Nurse capacity.

Future actions

Maintain full staffing of research delivery staff to enable recruitment of eligible patients.

Sponsored studies recruitment performance



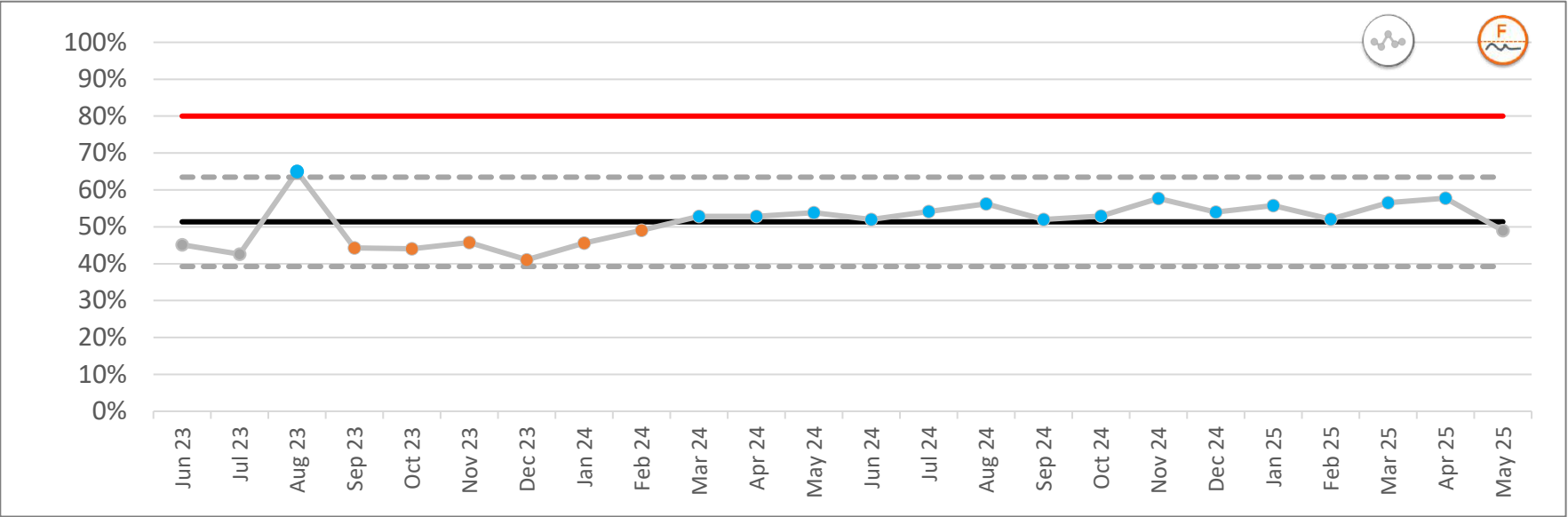
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May-25	Target
86%	80%

Compliance	Variance	Assurance	Actions

Status
Assure

MFT-sponsored, NIHR Portfolio-adopted research studies on track for recruitment to time and target



Updates since previous month

N/A - First report

Current issues

Data presented here is currently incomplete and actual performance is at 86%. This is work in progress involving external data provider to be completed by end August.

Key dependencies

This is a nationally set target by the NIHR which MFT must meet to ensure infrastructure awards (e.g., BRC, CRF) are paid in full. Failing the target will reduce such award income.

Future actions

Maintain focus on realistic research study methodologies, recruitment strategies and staff capacity to quickly identify and consent participants, and monitoring performance at senior levels in R&I.

Commercial Studies Approval Time



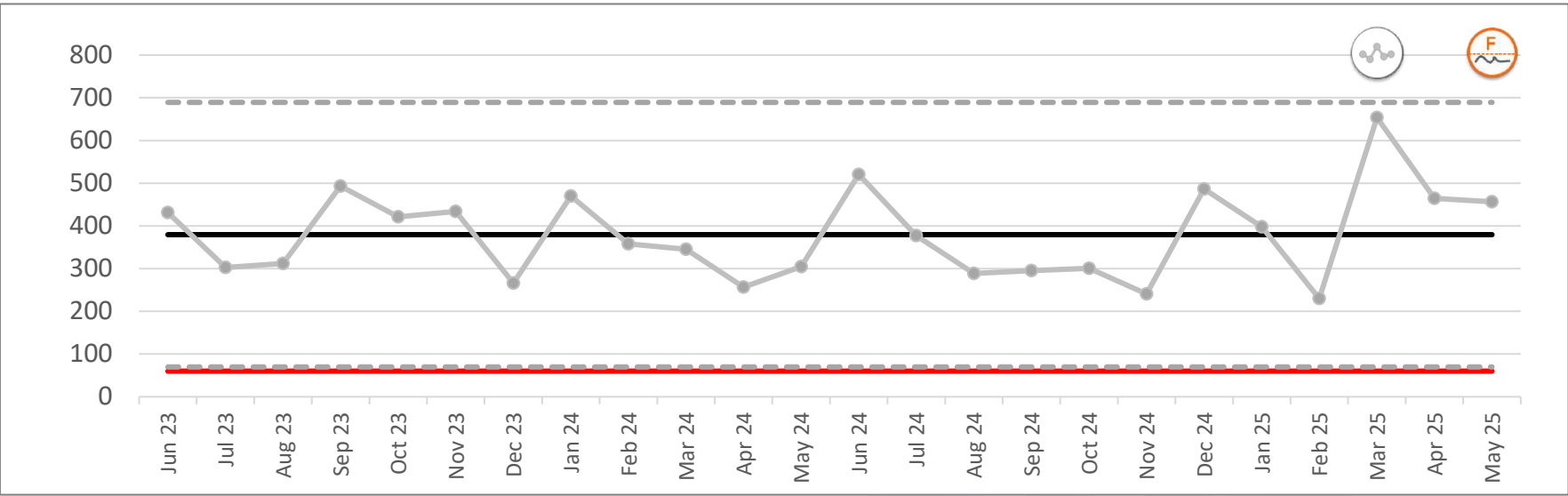
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May-25	Target
457	60

Compliance	Variance	Assurance	Actions

Status
Alert

UKCRD Commercial Metric 1 Under Construction



Updates since previous month

N/A - First report

Key dependencies

This metric is about approval speed for commercially sponsored clinical trials approved at MFT each month.

Current issues

This is a nationally set metric by NIHR which is publicly available for use by commercial sponsors and contract research organisations so they can see how sites perform. It has only started this year and with only three months of reports (one month in arrears) there is insufficient actual data for an SPC chart.

Future actions

For this report: identifying and extracting accurate data from national reporting website and constructing a hypothesized SPC chart until sufficient months of data in place. To speed up approval: external review of set up processes took place in May. Awaiting report recommendations to inform revisions.

Commercial Studies First Patient Recruitment



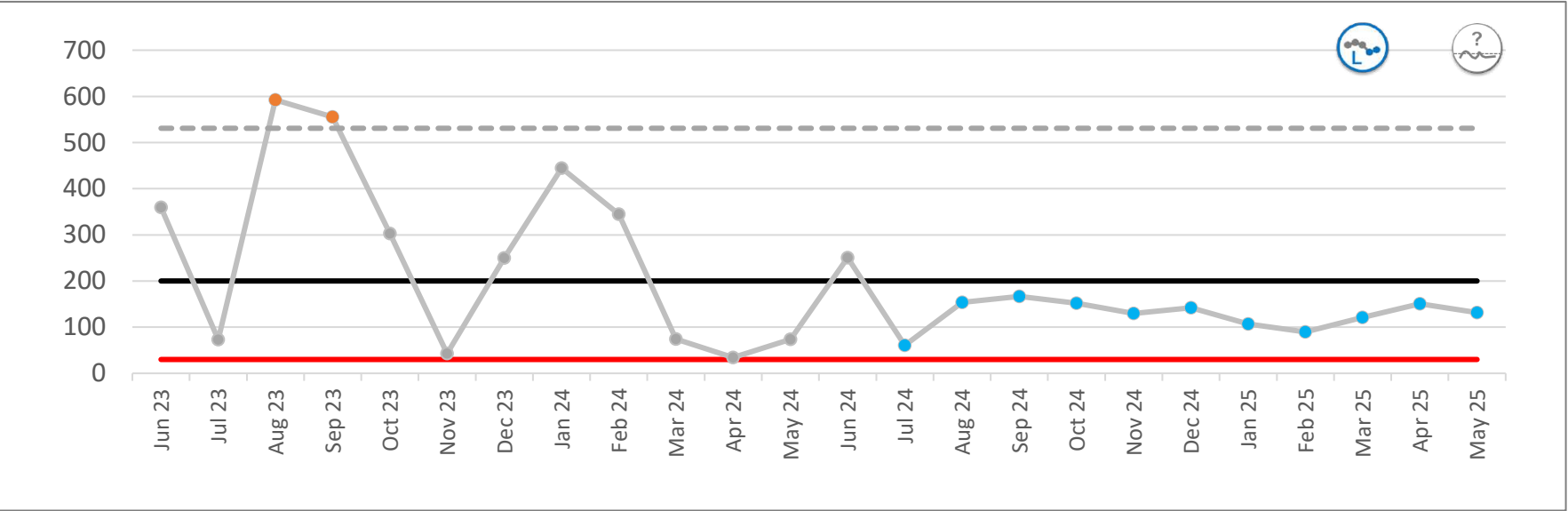
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May-25	Target
132	30

Compliance	Variance	Assurance	Actions

Status
Assure

UKCRD Commercial Metric 2 Under Construction



Updates since previous month

N/A - First report

Current issues

This is a nationally set metric by NIHR which is publicly available for use by commercial sponsors and contract research organisations so they can see how sites perform. It has only started this year and with only three months of reports (one month in arrears) there is insufficient actual data for an SPC chart.

Key dependencies

This metric is about speed of recruitment of first participant to commercially sponsored clinical trials at MFT.

Future actions

For this report: identifying and extracting accurate data from national reporting website and constructing a hypothesized SPC chart until sufficient months of data in place. To speed up recruitment: external review of set up processes took place in May. Awaiting report recommendations to inform revisions.



Manchester University
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Escalation and Assurance Report

Research Innovation and Population Health Board Committee (RIPHBC)

Report to: Board of Directors

Report from: Kathy Cowell, Trust Chair

Date of meeting: 22/05/2025

Key escalation and discussion points from the meeting

Alert

Advise:

The Committee received an update on the suite of metrics being identified to enable monitoring of the work related to Strategic Aim 1 of the MFT strategy. These will feature in the IPR moving forward. It was proposed to have a Board The Committee emphasised the need to need to ensure that data regarding children and young people isn't lost within analysis of broader data.

The GM Live Well programme is creating Live Well hubs in each locality. GMCA have put forward a proposal to the government to become a 'Prevention Demonstrator'.

The Committee received an update on the work to adopt a socio-economic duty at the Trust following approval by The Board of Director in November 2024. A programme of work, with six themes, has been developed and progress in its delivery will be overseen by the Population Health Management Committee. The Committee stressed the need to ensure that there is a focus on outcomes throughout the programme.

The Committee received an update on the revised Green Plan which was approved at the Board meeting on 21/5/25. The plan has the capacity to be flexed to meet any changes of requirements from national policy and any new technologies or innovations. The Committee discussed the importance of staff engagement to support delivery of the programme.

The Committee discussed the current R & I infrastructure within the Trust and how the different bodies work together across the whole research to treatment spectrum. The Committee discussed the importance of ensuring that R & I work was underpinning delivery of the Trust's strategic objectives and the opportunities to leverage more support from commercial organisations.

The Committee received a presentation on the work of the Research Delivery Network. The potential of further opportunities with commercial organisations and life sciences was highlighted along with the need to compress the time it takes to get studies up and running.

Assure:

The Committee discussed the sections of the Board Assurance Framework relevant to the Committee. Nearly 200 staff have now been trained in health literacy and the positive impact of the training is being seen in clinical practice. The Citizens Advice service has realised £1m of benefit entitlement or debt management over the last 12 months. This is greater than Citizens Advice see from other locations where their service is provided. The Committee discussed further opportunities to connect our patients to other services which address the wider determinants of health. The Committee also considered the R & I risks and actions and discussed some recent changes to R & I governance which should streamline structures and enable more transparent reporting.

Report approved by: Kathy Cowell, Trust Chair

Agenda



Manchester University
NHS Foundation Trust

Research, Innovation and Population Health Board Committee

Date: 22nd May 2025

Time: 9:30-11:30

Location: Main 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.	Minutes of the previous meeting (27 th February 2025) (Verbal)	Meeting admin	Chair	
4.	Action Log	Discussion	Chair	
5.	Matters Arising	Discussion	Chair	
6.	Assurance Reporting			
6.1	Board Assurance Framework	Discussion	SM	
7.1	Strategic aim 1: Work with partners to help people live longer, healthier lives			
7.1	Population Health metrics	Discussion	SM	

7.2	Population Health annual planning 2025/26 Connection with Live well Programme	Discussion (Verbal)	SM	
7.3	Socioeconomic Duty	Discussion	SM	
7.4	MFT Green Plan 2025-28 updates	Discussion	RJ	
8.	Strategic aim 5: Deliver world class research and innovation that improves people's lives			
8.1	NIHR infrastructure organogram	Discussion	IM	
8.2	NIHR North West Regional Research Delivery 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: Wednesday 10th September 2025 at 02:00pm				

Public Board of Directors Wednesday 30th July 2025

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

Executive summary / key messages for the meeting to consider

This paper outlines the following strategic developments:

- At a national level:
 - Fit for the Future - 10 Year Plan
 - NHS Oversight Framework – arrangements for assessing integrated care boards (ICBs) and NHS trusts and foundation trusts in 2025/26
 - NHS Urgent and Emergency Care (UEC) Plan – plan for significantly improving Urgent and Emergency Care services this winter
 - NHS Quality Impact Assessment Framework – a revised framework that recognises the need for QIAs to be carried out in a wider range of circumstances, not just those focused on making financial savings
 - Review of patient safety across the health and care landscape – findings and recommendation of the review undertaken by Dr P Dash into whether the current organisations associated with patient safety oversight and regulation deliver effective leadership, listening and learning
- At a regional and local level:
 - NHS ICB Blueprint – a revised operating model for ICBs
 - Major Trauma Centre Provision within GM – review the potential options to develop major trauma services across GM
 - Cardiac & Vascular service change assurance process.
- At MFT:
 - Integrated Neighbourhood Teams
 - Diabetes Pathfinder
 - Single Services Programme
 - Genomic Medicine Service Tender
 - Lab Medicine – partnership working with Northern Care Alliance
 - North Manchester General Hospital – New Hospitals Programme
 - R&I - Annual Planning

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:

-

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 Fit for the Future - 10 Year Plan

The 10-Year Plan, Fit for the Future, was launched on Thursday 3 July 2025. It sets out a comprehensive vision for how the service will develop over the next decade. It describes three radical shifts – from treatment to prevention, from hospital to community, and from analogue to digital. It also describes changes to how we work that will support the scale of change required and deliver the three shifts at pace.

Our MFT strategy aligns well with the 10-Year Plan. Our aims and objectives reflect many of the plan's key themes, in particular the importance of neighbourhood services, the expansion of genomic testing and its adoption into clinical practice, the growth in digital technology and data capabilities, and the expansion of research and innovation in life sciences.

The plan also signals considerable changes, particularly the scale of transformation in outpatient services and a reduction in hospital-based appointments, a renewed focus on patient experience and outcomes with greater transparency of care quality at a provider level, and the renewal of the foundation trust (FT) model with a re-authorisation process and a return of freedoms for the new wave of FTs. A new operating model and financial framework are outlined, along with a forthcoming 10 Year People Plan.

The 10 Year Plan offers considerable opportunities for MFT to build on some of our strengths, and also to transform the way that we deliver services. Given the change outlined in the plan, we are considering its implications in detail and plan to refresh our MFT strategy over the coming months accordingly. With the annual planning round expected to be brought forward this year, the aim is to complete this work by the autumn so that it can inform our priorities and plans for the coming year, ensuring that we can play our part in delivering the vision set out in the 10 Year Plan.

2.2 NHS Oversight Framework

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS providers. This is a 1-year framework which will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

Organisations will be assessed against a set of national priorities alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes. The contextual metrics will not constitute part of the score.

NHS England will place every provider into a segment from 1 (high performing) to 5 (low performing). Segment 5 is for the most challenged organisations that require the most support to improve. The NHS priorities and operational planning guidance 2025/26 will

require all ICBs and providers to deliver a balanced net system financial position. Unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

The segmentation score and consideration of the organisation's leadership and governance (provider capability) will then be used to determine the organisation's support or intervention needs. The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHS England will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead them to use regulatory powers to step in and secure improvement.

NHS England will not be segmenting ICBs in 2025/6, as this will be a year of significant change. ICB performance will be reported against the full suite of oversight metrics, but they will not get a comparative rating. A segmentation approach for ICBs will be introduced in 2026/27.

2.3 Urgent and Emergency Care Plan

The Urgent and Emergency Care Plan 2025/26 sets out a national framework to improve the quality, timeliness, and integration of urgent and emergency care services across the NHS. The plan outlines seven priorities including improvements in patient flow, discharge, and emergency department performance. The following are priorities within the plan:

- Reducing ambulance handover delays to a maximum of 45 minutes. This is expected to release significant ambulance capacity and reduce congestion at hospital front doors.
- Achieving a national target for 78% of patients attending A&E to be admitted, transferred, or discharged within four hours. This is supported by an investment of £250 million in capital for expansion of Same Day Emergency Care and Urgent Treatment Centres.
- Addressing 12-hour waits in corridors. Trusts are to publish site-level data on long waits and implement clinical models that ensure patients are seen by the most appropriate clinician without delay.
- Mental health provision in emergency departments, particularly for children and young people. The plan supports the development of crisis assessment centres and community-based alternatives to A&E. Systems are expected to ensure timely access to specialist support and reduce reliance on emergency departments for mental health crises.
- Improving discharge processes. Trusts are required to set stretching targets for daily discharges across all care pathways and eliminate internal delays over 48 hours. Collaboration with local authorities and ICBs is essential to ensure timely transfers to community or home-based care, supported by the Better Care Fund.
- Leadership and data-driven improvement. Trusts are expected to use real-time data tools to manage demand and optimise patient flow. Executive teams are encouraged to maintain visible leadership in emergency departments and to drive cultural and operational change to meet performance standards ahead of winter 2025/26.

The aim is for the plan to significantly improve urgent and emergency care services this winter compared to recent years. Work on winter planning across MFT is well underway, with a copy of our winter plan for 25/26 being presented to the Board of Directors later on the agenda.

2.4 Review of patient safety across the health and care landscape

Dr Penny Dash, Chair of NHS England, undertook a review of the operational effectiveness of the Care Quality Commission in 2024. A successor review was commissioned by the Secretary of State for Health and Social Care to assess whether the current organisations associated with patient safety oversight and regulation deliver effective leadership, listening and learning. The report outlining the findings and recommendations was published on 7 July 2025.

The review found that there has been a shift towards safety compared to other areas of quality of care over the last 5 to 10 years, with considerable resources deployed, but relatively small improvements seen and that there has been limited strategic thinking and planning with regard to improving quality of care.

The recommendations of the review are:

- Revitalise and significantly enhance the role of the National Quality Board
- Continue to rebuild the CQC with a clear remit and responsibility
- Continue HSSIB's role as a centre of excellence for investigations, clarify the remit of any future investigation (including for HSSIB's functions to be transferred into CQC)
- Transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare products Regulatory Agency, and broader patient safety work to a new directorate for patient experience within NHSE, transferring to the new proposed structure within DHSC
- Bring together the work of Local Healthwatch with the engagement functions of ICBs and providers. These should work together to ensure patient and wider community input into the planning and design of services.
- Streamline functions relating to staff voice - staff should be supported and encouraged to share concerns with a clear role for Freedom to Speak Up Guardians in commissioner and provider organisations. The responsibilities of the National Guardian for Freedom to Speak Up in the NHS and the National Guardian's Office should be incorporated into providers.
- Reinforce responsibility and accountability of commissioners and providers for delivering and assuring high-quality care - far greater emphasis and attention should be given to how providers deliver high quality care and how commissioners hold them to account,
- Technology, data and analytics should play a far more significant role in supporting quality of health and social care.
- There should be a national strategy for quality in adult social care, underpinned by clear evidence

A number of the reports findings, such as governance structures for providers and commissioners and the use of technology and data, were highlighted in the 10 Year Health Plan. Some areas that are outside of the plan have been raised such as the reconfiguration of professional bodies and the role of statutory organisations. Further work will be required to develop these areas and enact the changes. It is acknowledged that this may require changes to primary and secondary legislation.

3. Regional and Local

3.1 ICB operating model

The publication of the Model ICB Blueprint was the first step in a joint programme of work to reshape the focus, role and functions of ICBs, aligned with the 10 Year Health Plan and in response to the Darzi Review. ICBs are expected in future to focus on strategic commissioning and to move to the same level of efficiency in their administrative costs which, on average, means reducing costs by approximately 50%.

The Blueprint outlines the purpose, core functions of ICBs and what needs to be in place to ensure success. Key features are:

- ICBs will continue to play a vital leadership role, focused on understanding population health needs, planning for the long term, reducing health inequalities and ensuring access to consistently high quality and efficient care
- ICB functions will be more focused, with some responsibilities moving to providers or regional/national teams over time.

Not all the changes can be made this year as some require legislative changes, and some functional changes will need time to be done safely.

NHS GM has been engaging with partners and established a programme framework to develop its response to the Blueprint, including a revised model for the 10 Place Based Partnerships (localities) in Greater Manchester. Changes are being proposed with the aim of providing clearer accountability, enhance efficiency, partnership competence and rigour, and will align NHS planning levels with local government.

3.2 Cardiac and Vascular Commissioner Assurance Process

Commissioner-led service change assurance process around Cardiac and Vascular services is progressing. The Cardiac Pre-Consultation Business Case (PCBC) has been drafted and is being shared with stakeholders for support. Work continues to develop the options for Vascular services that will feed into the PCBC.

3.3 Major Trauma Centre Provision within Greater Manchester

Work continues with GM Integrated Care Board (ICB) and Northern Care Alliance NHS Foundation Trust (NCA) colleagues to review the potential options to develop major trauma services across GM. A key part of this work is considering the potential costs and safety considerations of the options under consideration, including the potential implications for co-dependent services. The ICB intend to make a decision at their Board meeting in September 2025.

4. Key Strategic Developments

4.1 Integrated Neighbourhood Teams

The development of Integrated Neighbourhood teams is an area in which Greater Manchester has historically led nationally, and a key part of the 10 Year Plan. Integrated Neighbourhood Teams have been established across Manchester and Trafford, but in different ways. MFT is currently working with partners across the health and care system, including local authority colleagues, to develop the next phase of delivery for

neighbourhood services. Areas of potential opportunity include further alignment with mental health, alignment of primary care, The Live Well programme and accelerating the shift of care from hospital into the community.

4.2. Diabetes Pathfinder

The Diabetes Pathfinder Programme aims to redesign the support for people living with Diabetes across Manchester and Trafford so that they receive the right care, at the right place and time. All providers and patient representatives will be involved in co-producing a new community-based pathway from primary care through to secondary services. A programme board has been established to oversee the project, initially looking at capacity and demand across the system. This is an example of how we are working on the 'shift' towards the community and prevention.

4.3. Single Services Programme

A single service across MFT for Oral-Maxillofacial Surgery (OMFS), led by the North Manchester General Hospital (NMGH) Clinical Group, was implemented on the 1 April. The new single service also took on the provision of the Tameside OMFS service on 1 July 2025.

MFT has been asked by GM ICB to assess the impact of becoming GM Lead provider for OMFS. Work is underway to review capacity and demand across Greater Manchester which the OMFS MSS Board will review to inform a decision about the feasibility of creating a single GM OMFS service led by MFT.

4.4. Genomic Medicine Service Tender

The national model for genomic services has been under review and there is to be a re-tendering of the genomics contracts nationally to create Regional Genomic Medicine Services. MFT is bidding to provide the regional service for the North West. The development of genomic testing is one of the transformative technologies (or big bets) identified in the 10 Year Plan that will personalise care, improve outcomes, increase productivity and boost economic growth areas.

4.5. Lab Medicine – partnership working with Northern Care Alliance

The combined pathology services across NCA and MFT deliver over 60 million tests annually. Both services are facing challenges in relation to rising demand, workforce shortages and requirements for infrastructure updates. A collaborative approach to pathology services has been identified as a priority within the Greater Manchester Trust Provider Collaborative. Together with colleagues from NCA we are developing a proposal setting out how by working more closely together we can improve laboratory services, enhance efficiency and quality and achieve greater financial and workforce sustainability across the service.

4.6. North Manchester General Hospital – New Hospitals Programme

The national NHP team have confirmed support for the outpatient building, however the Trust awaits confirmation of support for the design approach. A review of governance and the redevelopment team is being undertaken to prepare for the Outline Business Case. A Demand and Capacity Roundtable took place with the national NHP team earlier in July.

4.7. Research and Innovation - Annual Planning

The annual planning process for 2026/27 is being brought forward and preparation for the planning round has commenced. As a new development for 26/27 the Research and Innovation (R&I) team are undertaking a capacity and demand analysis to feed into the overall MFT activity plans. The aim is to ensure that we can put the necessary capacity in place to deliver our plans for growth in R&I. Although we have not yet received a formal timeline from NHSE, we are planning to launch the internal planning process in late September.

5. Recommendations

The Board of Directors is asked to note the updates in relation to strategic developments nationally and regionally and the key MFT strategic programmes of work.

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

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: 25/6/25

Key escalation and discussion points from the meeting

Alert

The Committee discussed the process of Board assurance and risk appetite consideration where decisions were taken to depart from national guidance when local circumstances demand a different approach. Executive Directors are considering how to ensure Board awareness on such occasions.

Manual data submission has been maintained for 53 out of 54 national clinical audits, although some are partial submissions. Work is underway to enhance Hive functionality to enable automated data submission. A process is in place to determine local clinical audits' prioritisation. The Committee sought further assurance on this matter including with regard to the current planned completion date for full automation. A further report will be presented to the Committee in 6 months' time.

Advise:

There has been a reduction in the MREH waiting list in as number of high risk areas. A £2m business case has been approved to further improve performance. Trajectories will continue to be monitored by the Committee within an additional metrics added to the IPR to aid oversight.

The GM ICB work to review Adult and Paediatric Major Trauma across the system, and the concerns with regard to the potential impact on patient care due to existing clinical interdependencies, were discussed. The need for an accurate financial analysis was also emphasised. The ICB plan to make a final decision in September. A strategic risk regarding this issue has been raised and is included in the Board assurance Framework.

The Committee received the Bi-Annual Legal Services Activities Report. In Q3 and Q4 for 2024/25, the Trust has had 283 inquests opened and 195 inquest hearings. 109 of those hearings were on complex cases with 9 requiring external legal representation and 100 being handled by the in-house legal team. The Trust received no Prevention of Future Death Reports in the reporting period and two informal letters from Coroners with no key themes identified. The Trust has complied with the GIRFT Litigation Data Pack 2025 requirements. Clinical Groups have been asked to review their claims that have not been through a complaints or incident process to consider whether additional improvement work can be done.

Significant progress has been made against the 20 recommendations included in the external PSIRF review discussed at a previous committee meeting. Two of the five workstreams (training and safety actions) have completed their actions and have been stood down, with oversight reverting to business-as-usual arrangements. Activities that remain include finalising the revised PSIRF and Duty of Candour policies, launch of use of national tools, and development of a Patient Safety Academy. A Patient Safety education session, which is a BoD training requirement, will be held at the Board Seminar in October 2025.

The Complaints Annual Report showed that the Trust received 8,517 contacts into the Patient Advice and Liaison Service (PALS) in 2024/25, a 5% decrease from 2023/24. 1,975 complaints were received during 2024/25; a 6% decrease from the 2,107 received in 2023/24. 100% of the complaints were acknowledged within three working days. 89% of complaints were responded to within the agreed timescale and 94% of PALS cases were resolved within 10 working days. The Complaints Review Scrutiny Group has been reviewed to enable additional scrutiny and oversight of the shared learning in particular. The internal audit of MFT complaints handling found there was significant assurance, with minor improvement opportunities, and was assured by the controls in place.

The Committee discussed the Quality & Patient Experience Annual Report 2024/25 noting the service improvements which have taken place over the year. The important role of the 416 volunteers across the Trust was recognised. A report on volunteers will be shared at a future People Board Committee meeting. A discussion took place with regards the current challenges being considered and the remedies in action.

The Annual Safeguarding Report for 2024/25 was discussed. A total of 42,702 referrals to the safeguarding team were completed, an increase from 38,181 in 2023/24. The most frequent categories of safeguarding concerns were neglect and self-neglect, safeguarding people with a mental health condition and domestic violence and abuse. Oliver McGowan training compliance has increased across the Trust and there is a focus for 2025/26 on ensuring level 3 safeguarding training rates for the medical and dental workforce are improved. A discussion took place regarding the increase in support and referrals for patients suffering mental health conditions in the acute and UEC settings.

The PLACE assessment results for 2024 show an improvement in the Trust score for the Ward & Food and Privacy and Dignity domains and a decline in the Cleanliness, Environment Condition/maintenance, Dementia, and Disability domains. Variation exists across the different Trust sites. Results from the Place audit have been discussed and escalated via existing governance forums. Targeted follow-up inspections are planned as a follow up (June 2025) to assess progress on action plans and identify emerging risks.

Recommendations from the Mersey Care Mental Health Peer Review, completed in January 2024, continue to be implemented and have been integrated into the Trust's Mental Health Improvement Plan. Two recommendations were identified as high risk: the use of security staff for supervising mental health patients requiring enhanced supervision and the oversight and care of young people admitted to adult wards with mental health illnesses. Progress continues in both areas, with improved visibility of data through Hive and security data systems, daily escalation to senior teams for oversight, the development of operating procedures to ensure senior input, and an audit plan to review ongoing improvements. In total, 31 of the 62 recommendations have been completed, 30 remains on the action plan with improvement work underway, and one recommendation is no longer applicable. The Trust's Mental Health Subgroup and Learning Disability Steering Group monitor delivery of the work programme.

Progress has been made to improve the patient experience of the outpatient pharmacy dispensing service across the Trust following the new contract introduced in December 2024. Further work is required to improve achievement of the target 30 minute waiting time at the MREH and Wythenshawe sites. Further improvement work includes increased use of FP10 prescriptions, pre-labelled pre-packs, transfer of prescriptions to another site and implementation of the new collection and delivery model.

The Committee discussed the annual Never Events update for 2024/25. Three Never Events were reported during the year, a reduction from 11 in 2023/24. In all cases, action plans have been developed to address any recommendations and a wider MDT approach is being considered.

The Committee discussed the process for learning from deaths at the Trust and supported the development of a comprehensive mortality review portal.

The Trust has a strategy in place for the implementation of LocSSIPs/NatSSIPs and improving compliance with them. The establishment of an Optimising Surgical and Invasive Procedure Safety Steering Group has been accelerated due to the incidence of Never Events relevant to the checklists since April 2025.

A Standard Operating Procedure for ambulance handovers was discussed and supported by the Committee. Clinical Groups Clinical Governances and MDT clinical teams will review any patients where the handover takes more than 45 minutes and the incident profile will be monitored.

The Trust's new Waiting Safely framework was discussed. Risk assessment tools using demographic and health data are being piloted. The framework will be rolled out across the whole Trust and the Trust communications team are involved to ensure that communication with patients is clear and comprehensive.

The first draft of the Trust's Winter Plan for 2025/26 was discussed. Plans are in place for a national stress test of the plans in addition to a local exercise planned for September. The Committee emphasised the need for close oversight for delivery due to the new leadership within Clinical Groups following implementation of Phase 3 of the One MFT programme.

An update on current service developments across MFT was presented to the Committee by the Interim Director of Strategy.

The Committee discussed the 2024/25 Quality Account and proposed some changes to aid clarity for those reading the document.

Assure:

The Committee discussed the Operational Performance and Quality Safety sections of the Integrated Performance Report (IPR):

- Positive progress has been made against cancer metrics and the metrics regarding patients who have been waiting a long time..
- There has been a reduction in performance against the Hospital at Home standard being addressed by an increase to step-up and step-down referrals.
- There had been a further Never Event since the report presented to the Committee was produced meaning that there have been a total of five in 2025/26. Actions to address the themes were discussed within the substantive item on Never Events on the agenda of the meeting. A further paper is being presented to TLTC to describe the work and action to date and next steps.
- The medicines safety metrics are presenting as off-target and work is being undertaken to ensure the data and trajectories are correct and accurate.
- There has been progress made with safeguarding levels 2 and 3 training and further work is required to meet the standards.

The Trust's Director of Nursing and Midwifery presented the maternity-related metrics within the IPR, the Maternity Safety Report and the PMRT Q4 report to the Committee:

- Performance is improving against the maternity triage target following the redesign work carried out in 2024.
- Obstetric haemorrhage figures are showing as higher than the Greater Manchester average and remain within normal variation.
- There was one Opel Level 4 full maternity service divert instigated in April 2025.
- There were two cases validated as moderate harm, or above, in March and none in April 2025 compared to seven reported during January and February 2025.
- MIS year 6 has now been completed and the service is working to MIS year 7.
- National maternity early warning score (MEWS) was not adopted by the service as it was felt not to be sensitive enough and the local MEWS parameters adopted instead are more stringent than the national ones. Any incidents are reviewed closely and there have been none related to the non-compliance of national MEWS. The Committee discussed working outside national guidance (see item in the Alert section of this report). A further report was requested to a future Committee meeting to show the evidence that the local MEWS is more sensitive than the national one.
- The spike in perinatal deaths for women of Black African heritage was noted by the Committee and monitoring is in place to identify whether a trend is emerging or not.

Risks discussed at the meeting

The section of the Board Assurance Framework relevant to the scope of the Committee was discussed. The Committee discussed the achievability of the target rating and scores for the corporate risk on diagnostics demand and capacity, the constitutional standards strategic risk, and the vascular services strategic risk. The nature of the Cryostorage corporate risk was also discussed.

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



Manchester University
NHS Foundation Trust

Quality, Safety and Performance Board Committee

Date: Wednesday 25th June 2025

Time: 10:00am – 1:00pm

Location: Nowgen Boardroom, 1st Floor, Nowgen

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 (23 rd April 2025)	Meeting admin	Chair	10:00am
4.	Action Log	Discussion	Chair	10:00am
5.	Matters Arising	Discussion	Chair	10:00am
6.	Assurance Reporting			
6.1	Board Assurance Framework	Discussion	Executive Directors	10:10am

6.2	Integrated Performance Report	Discussion	Executive Directors	10:15am
6.3	Maternity safety reporting, including Q4 PMRT and Maternity Early Warning Score (EWS)	Discussion	Director of Nursing and Midwifery	10:25am
7.	Strategic aim 2: Provide high quality, safe care with excellent outcomes and experience			
7.1	Update on MREH Overdue Backlog for non RTT follow up Risk	Discussion	Chief Delivery Officer	10:35am
7.2	Report of the Major Trauma Quality and Safety Board	Discussion	Joint Chief Medical Officer	10:45am
7.3	Update on Completion of National Audits	Discussion	Director of Clinical Governance	10:55am
7.4	Legal Services Activity Report	Discussion	Director of Clinical Governance	11:00am
7.5	PSIRF Update	Discussion	Director of Clinical Governance / Interim Deputy Chief Executive -Chief Nursing Officer	11:05am
7.6	Annual Infection Prevention and Control (IPC) Report	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	11:10am
7.7	Annual Complaints Report	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	11:20am
7.8	Annual Patient Experience Report	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	11:25am
7.9	Annual Safeguarding Report	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	11:35am
7.10				11:45am

	Update on the Patient-Led Assessment of the Care Environment (PLACE)	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	
7.11	Update on the Mental Health Review	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	11:50am
7.12	Update on Outpatient Pharmacy Dispensing Services	Discussion	Chief Pharmacist	12:00pm
7.13	Never Events Update	Discussion	Joint Chief Medical Officer	12:10pm
7.14	Update on Learning from Deaths	Discussion	Joint Chief Medical Officer	12:15pm
7.15	Update on surgical checklist improvement work	Discussion	Joint Chief Medical Officer	12:20pm
7.16	Ambulance handover Standard Operating Procedure	Discussion	Chief Delivery Officer	12:30pm
7.17	Clinical Harm Review including update on development of the Waiting Safely Framework	Discussion	Director of Clinical Governance	12:35pm
7.18	25/26 Winter Planning	Discussion	Chief Delivery Officer	12:40pm
7.19	Update report on service developments (strategic objectives 4 and 5)	Discussion	Acting Chief Strategy Officer	12:45pm
Committee business				
8.	Quality Account	For noting	Director of Clinical Governance	12:50pm
9.	Escalation report	Approval	Chair	12:55pm
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 3 rd September 2025 at 10:00am, Medical Boardroom				

Public Board of Directors Wednesday 30th July 2025

Paper title:	Safeguarding Annual Report 2024-2025	Agenda Item 11.2
Presented by:	Kimberley Salmon Jamieson, Interim Trust Deputy Chief Executive & Chief Nursing Officer	
Prepared by:	Ruth Speight, Assistant Chief Nurse, Safeguarding	
Meetings where content has been discussed previously	Trust Safeguarding Group (reported quarterly 2024-25). Quality, Safety and Performance Board Committee – June 2025.	
Purpose of the paper Please check one box only:	☒ For approval ☐ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider

Executive Summary

This report provides an overview of safeguarding governance, activities, and assurance within Manchester University NHS Foundation Trust (MFT) for the year 2024-2025. It details how MFT has successfully met its statutory and regulatory responsibilities, highlighting key governance structures, significant safeguarding activities undertaken, and the assurance mechanisms in place to ensure compliance and effectiveness.

Key Points:

1. Governance and Oversight:

- **The MFT governance and reporting arrangements have been strengthened to provide the Board of Directors (BOD) with oversight and assurance of safeguarding activities.**
- The Interim Trust Deputy Chief Executive & Chief Nursing Officer is the Board Executive lead for safeguarding.
- There is a Board Non-Executive Director for safeguarding.
- There is a robust senior leadership and operational structure to deliver safeguarding responsibilities in the Trust.
- The Trust Safeguarding Group provides strategic leadership and oversight, reporting to the Trust's Quality and Safety Management Committee.
- Monthly Integrated Performance Reports, annual reports, and exception reports are provided to the Quality Safety and Performance Board Committee (QSPBC). An Annual Safeguarding report is provided to the BOD.
- The Interim Trust Deputy Chief Executive & Chief Nursing Officer commissioned a Safeguarding Review in December 2024 and the findings from this are currently being reviewed.

2. Audit and Assurance:

- **Internal and external NHS England (NHSE) and Integrated Care Board (ICB) assurance reporting mechanisms have been conducted to evidence safeguarding practice aligned to regulatory and statutory requirements.**

- The Trust was compliant with the NHS England (NHSE) Provider Safeguarding Commissioning Assurance Toolkit **28** standards and **33** of the 38 Greater Manchester ICB Contractual Standards with improvement plans in place reporting to Trust Safeguarding Group to address 5 areas of partial compliance.
- In 2024-25, **31** safeguarding audits with an action plan of continuous improvement were completed including **4** Manchester and Trafford multi-agency audits.

3. **Safeguarding Activities:**

- **There has been an increase in the number of safeguarding concerns identified by MFT colleagues, resulting in an increase in the number of patients having a safeguarding assessment and care plan.** A total of **42,702** referrals to the safeguarding team were completed, an increase from 38,181 in 2023-24.
- The most frequent categories of safeguarding concerns were neglect and self-neglect, safeguarding people with a mental health condition and domestic violence and abuse. **1099** high risk victims of domestic abuse were referred for multi-agency risk assessment and safety planning to prevent domestic homicide at multi agency risk assessment conferences.
- The Trust has implemented a suite of **24** policies and guidance and mandatory and continuous professional development (CPD) training programmes to support the workforce address these concerns.

4. **Training and Supervision:**

- **There is an increasing number of colleagues across the workforce who have completed safeguarding training and supervision.**
- MFT has implemented comprehensive training programmes for the workforce, achieving over 90% compliance in level 1 and 2 safeguarding training.
- Improvements are required to increase the training compliance in safeguarding level 3 adults and children training to the 90% standard (level 3 training was at **85%** compliance Trust wide at end of Q4 2024-25 compared to **80%** at end of Q4 2023-24). A medical and dental safeguarding training improvement plan is being overseen by the Joint Chief Medical Officer's Forum reporting to the Quality and Safety Management Committee (QSMC) to increase training compliance in the medical and dental workforce (at end of Q4 compliance was **66%** compared to **56.5%** at end of Q1 2024-25).
- **4270** colleagues completed CPD safeguarding training (**3261** in 2023-24).
- Safeguarding supervision has been provided to **3285** colleagues, (**2879** in 2023-24) with **95%** compliance rates of attendance at supervision in areas of high safeguarding risk and need.

5. **Partnership Working:**

- **MFT has worked with multi-agency partners to deliver safeguarding priority workstreams in Greater Manchester, Manchester, and Trafford.** This has included completion of **42** safeguarding reviews with learning reported and delivered through the Trust's Safeguarding Quality and Learning Subgroup.
- Engagement in all Safeguarding Boards, Executives, Sub Boards, and Groups in Manchester and Trafford (**26** groups delivering **6** priorities).

6. **Key Priorities for 2025-26:**

The safeguarding work programme is informed by the aims, pillars and commitments of the Trust Strategy 2024-29 "Where excellence Meets Compassion" and the Nursing Midwifery and Allied Health Professional Strategy "Professional Excellence Where Excellence Meets Compassion". Safeguarding in MFT aims to provide high quality, safe care with excellent outcomes and experience.

In 2025- 26 working collaboratively with Clinical Groups and our safeguarding partnerships, we will.

- Deliver a safeguarding service, governance arrangements and work programme that incorporates the recommendations of the Safeguarding Review commissioned by the Interim Trust Deputy Chief Executive & Chief Nursing Officer in December 2025.

The safeguarding work programme will be underpinned by the NMAHP strategy pillar that we value the provision of high quality, patient centred care that prioritises the wellbeing and satisfaction of our patients, their families and carers.

- Lead in delivering joined-up physical and mental health services for families, children and young people, working with partners to develop and deliver integrated plans. This will consider the legislative changes of the Mental Health Act reforms to equip our workforce to deliver our Mental Health Strategy and Mental Health Improvement plan in line with regulatory guidance.
- Invest in continuing education, learning and development, to support our workforce. We will ensure MFT colleagues have completed mandatory safeguarding level 3, mental health, Oliver McGowan and Positive Behavior Support least restrictive and restraint training to expected Trust standards.

This will include delivery of the safeguarding training improvement plan focusing on medical and dental workforce completing level 3 safeguarding training to achieve 90% training compliance.

We will deliver a programme of learning and improvement in response to safeguarding reviews, incidents and audit.

- Work with partners to help people live longer, healthier lives and further develop engagement and communication opportunities, to work collaboratively across our local communities to safeguard people. Priority workstreams for our system wide workstreams will include.
 - Support and challenge with the Local Authority to complete Deprivation of Liberty Safeguards (DoLS) authorizations within required statutory timeframes.
 - Partnership working to deliver statutory responsibilities to meet the health and wellbeing of Looked After Children (LAC) with multi-agency partners.
 - Working in partnership with Local Authority colleagues to deliver the system wide implications of Children's Social Care Reforms including engagement in the delivery of the Families First Programme (FFP)¹ in Manchester and Trafford.
 - Delivering the Manchester Safeguarding Partnership priority to tackle neglect through a training and improvement programme reported to Trust Safeguarding Group.
- We will continue to develop our digital skills across the workforce to support data confidence and new emerging technologies. We will review our digital reporting systems to optimise data collection and reporting of safeguarding priorities focusing on the MFT response to tackle neglect and implementation of the NHSE led Child Protection Information Sharing Phase 2 project.
- Make safeguarding personal and ensure we hear the voice of the person, who will be central to safeguarding practice in the Trust. We will communicate listen and provide patient centred care, safeguarding our families and communities with dignity and respect.

Recommendation(s)

The Board of Directors is asked to:

- Note the assurance provided in the report that Trust is meeting expected statutory and regulatory standards.
- Acknowledge the continuous improvement work of the Safeguarding team and Clinical Groups to ensure the Trust recognises and responds effectively to safeguarding concerns.
- Support the safeguarding work programme to continuously deliver a person-centred high-quality safeguarding response to people at risk of or experiencing abuse and neglect.

¹ Families First Programme accessed at <https://www.gov.uk/government/publications/families-first-partnership-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	☒	VfPs objective 1	☒
VfPs objective 2	☒	R&I objective 1	☐
R&I objective 2	☐	Good Governance	☒

Links to Trust Risks

Care Quality Commission domains.

Please check **all** that apply

☐ Safe

☒ Effective

☒ Responsive

☒ Caring

☒ Well-Led

Compliance & regulatory implications

The Trust is required to meet the following legislative and regulatory requirements.

CQC registration standards, Health and Social Care Act 2008
The Children Act (1989)
The Children Act (2004)
<u>Children and Social Work Act (2017)</u>
<u>Domestic Abuse Act (2021)</u>
<u>Female Genital Mutilation Act (2003)</u>
<u>Health and Care Act 2008 and 2022</u>
<u>Health and Social Care Act 2008 (Regulated Activities)</u>
The Sexual Offences Act (2003)
The Serious Crime Act (2015)
The Care Act (2014)
Mental Capacity Act (2005)
<u>Mental Capacity Amendment Act (2019)</u>
<u>Mental Health Act (1983 updated 2007)</u>
<u>Prevent Duty Guidance (2023)</u>
<u>Serious Violence Duty 2022</u>
Safeguarding Children and Young People: Roles and
<u>Working Together to Safeguard Children (2023)</u>

1. Introduction

This 2024-2025 Safeguarding Annual Report provides assurance to the Board of Directors (BOD) that Manchester University NHS Foundation Trust (MFT) is fulfilling its statutory and regulatory responsibilities to safeguard people from abuse and neglect.

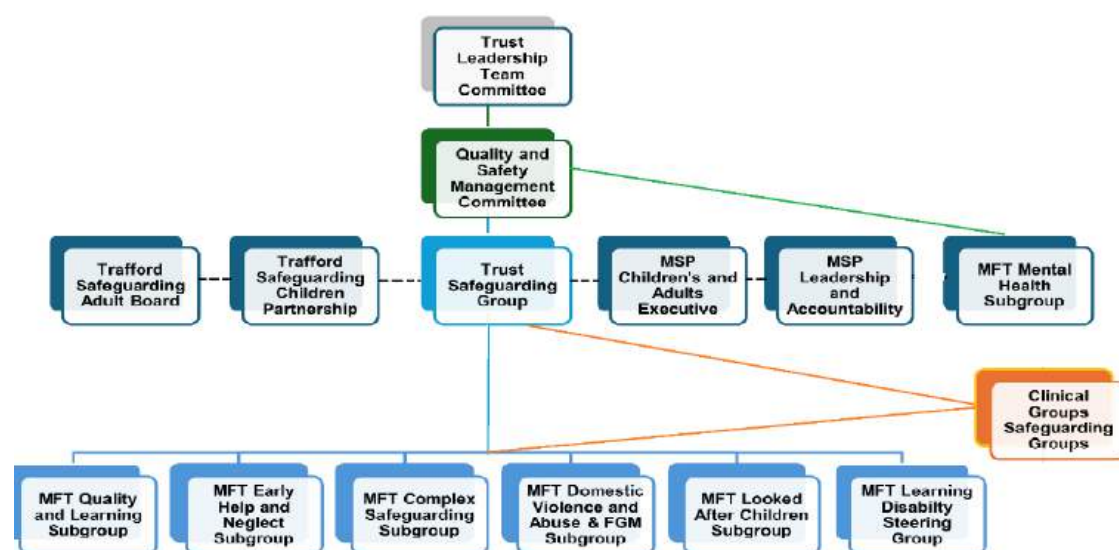
The report provides assurance of MFT performance in relation to the following areas.

- Safeguarding People as outlined in Section 11 of the Children Act² and in the Care Act 2014³.
- Promoting the health and wellbeing of Looked after Children in line with statutory guidance⁴.
- Providing person centred care to ensure that people experiencing acute or chronic mental health conditions are safely supported when accessing MFT services in line with the Mental Health and Mental Capacity Act delivering the aims of the MFT Mental Health Strategy.
- Providing high quality, safe person-centred care to people with a learning disability and/or autism, in line with the MFT Our Plan for people with learning disabilities and/or autism, their families and carers.

2. Governance

Figure 1 identifies the MFT safeguarding governance arrangements.

Figure 1: MFT Safeguarding Governance Arrangements



Arrangements are in place for Trust Board executive leadership to be provided by the Interim Trust Deputy Chief Executive & Chief Nursing Officer in collaboration with a Non-Executive Director who is the lead for safeguarding. They are supported by a robust senior leadership, and operational structure that ensures safeguarding services are aligned in terms of governance and accountability.

The Trust Safeguarding Group (TSG) provides strategic leadership and oversight of assurance and direction of safeguarding across MFT. The group reports to the Trust's Quality and Safety Management Committee (QSMC). Monthly Integrated Performance Reports, an annual report and exception reports have been provided to the Quality, Safety and: Performance Board Committee on safeguarding priorities in the Trust, with an annual report provided to the BOD.

The Clinical Group Safeguarding Groups have reported to TSG through quarterly alert, advise and assurance (AAA) reports evidencing delivery of the safeguarding workplan (included in appendix A), oversight, monitoring, and assurance of safeguarding activity at each site.

² The Children Act (2004)

³ The Care Act (2014)

⁴ Promoting Health and Wellbeing of Looked after Children

The Clinical Groups have all completed an annual safeguarding self-assessment aligned to the Care Quality Commission regulatory standard 13, “safeguarding service users from abuse and improper treatment”⁵ and legislative standards of the Children Act (1989 and 2004) and Care Act (2014) and the NHS England (NHSE) NHS Safeguarding accountability and assurance framework⁶ standards.

The self-assessments are scrutinised at an annual safeguarding assurance meeting, with the Clinical Group Directors of Nursing, Medical Directors, Deputy Chief Nursing Officer and Assistant Chief Nurse Safeguarding. All Clinical Groups self-assessments in 2024-25 identified expected statutory and regulatory safeguarding standards were met.

The areas of improvement identified in the self-assessment were aligned to the MFT Safeguarding Risk Register, Safeguarding Workplan and Safeguarding Audit Calendar.

The safeguarding governance arrangements are aligned to deliver the 6 safeguarding priorities and workstreams of the Manchester and Trafford Safeguarding and Community Safety Partnerships (MSP, TSP and CSP).

- MSP Leadership and Accountability board, Children’s and Adult’s Executives, CSP Board and the Trafford Safeguarding Adults Board and Safeguarding Children’s Partnership align to TSG.
- TSP, MSP, CSP strategic and operational groups align to the Trust’s seven thematic safeguarding subgroups to operationally deliver the strategic workstreams.

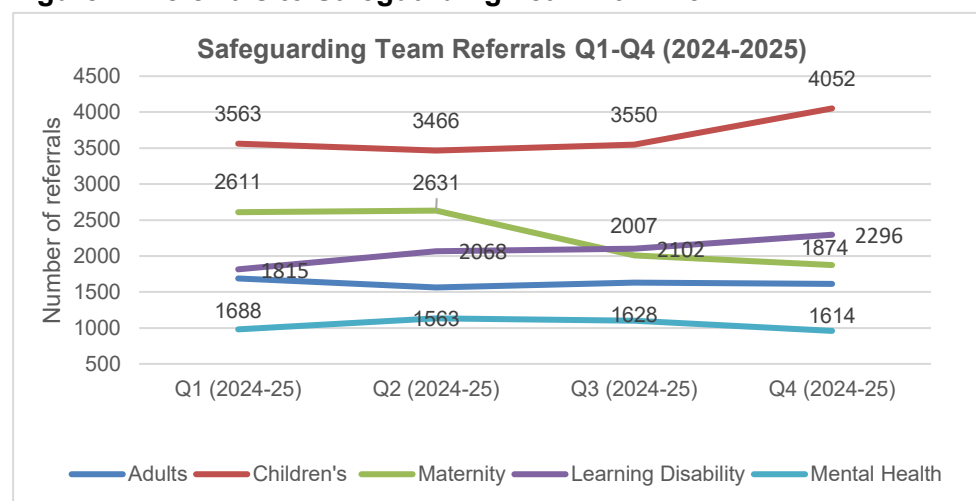
The Trust’s safeguarding team consists of the head of safeguarding, lead nurses, named and specialist safeguarding, looked after children (LAC) mental health and learning disability practitioners, who have delegated responsibility reporting to the Assistant Chief Nurse Safeguarding to, promote and deliver safe safeguarding systems and practice, in line with the Royal College Intercollegiate guidance competencies⁷ regulatory and legislative standards.

3. Safeguarding Activity

3.1 Safeguarding Referrals

Figure 2 indicates referrals made to the safeguarding team.

Figure 2: Referrals to Safeguarding Team 2024-25

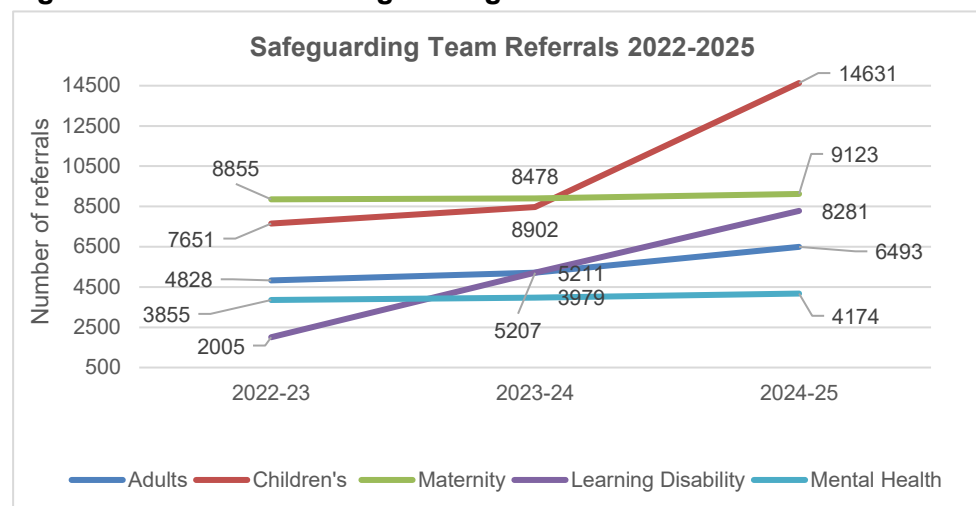


⁵ Regulation 13 Safeguarding service users from abuse and improper treatment

⁶ NHS England Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework

⁷ Adult Safeguarding: Roles and Competencies for Health Care Staff
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff

Figure 3: Referrals to Safeguarding Team 2022-25



42,702 referrals to the safeguarding team were completed in 2024-25, an increase from 38,181 in 2023-24, equating to **120** referrals every day (105 2023-2024). The high level of referrals to the MFT safeguarding team identifies that the workforce is increasingly recognising and responding to indicators of safeguarding concerns and there are increasing requests for support to apply reasonable adjustment care for people with a mental health condition, learning disability and or autism. The increase in referrals and contacts is attributed to.

- An approachable and available “Think Whole Family” safeguarding team based across the Trust.
- An increase in the numbers of staff completing safeguarding training and supervision.
- Safeguarding visibility and accessibility in digital systems through Hive and EMIS electronic patient records (EPR).

All referrals are risk assessed and a safeguarding plan instigated by the safeguarding team in collaboration with Trust colleagues and multi-agency safeguarding partners.

In 2024-25, **282** serious safeguarding incidents with system wide learning were escalated to the Chief Nursing Officer, Clinical Group Directors of Nursing and the ICB Designated Safeguarding Team

42 safeguarding concerns met the criteria for safeguarding adult, child or domestic homicide reviews.

3.2 Safeguarding Activity in line with Manchester and Trafford Safeguarding Partnership Priorities

Figures 4 to 7 identify the number of safeguarding referrals to the Trust safeguarding teams with categories of safeguarding concern that align to the safeguarding partnership priorities.

Figure 4: Adult Safeguarding Referrals Categories of Safeguarding Concern 2024-25

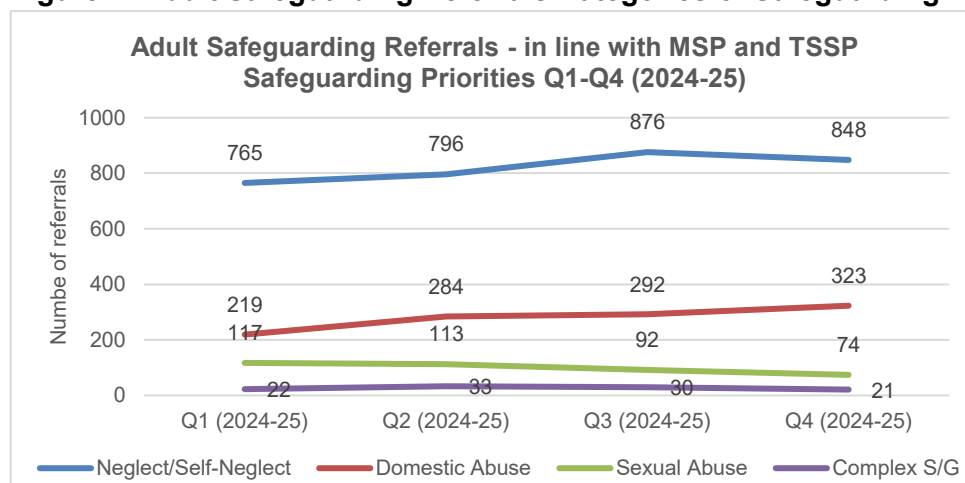


Figure 5: Adult Safeguarding Referrals Categories of Safeguarding Concern 2022-25

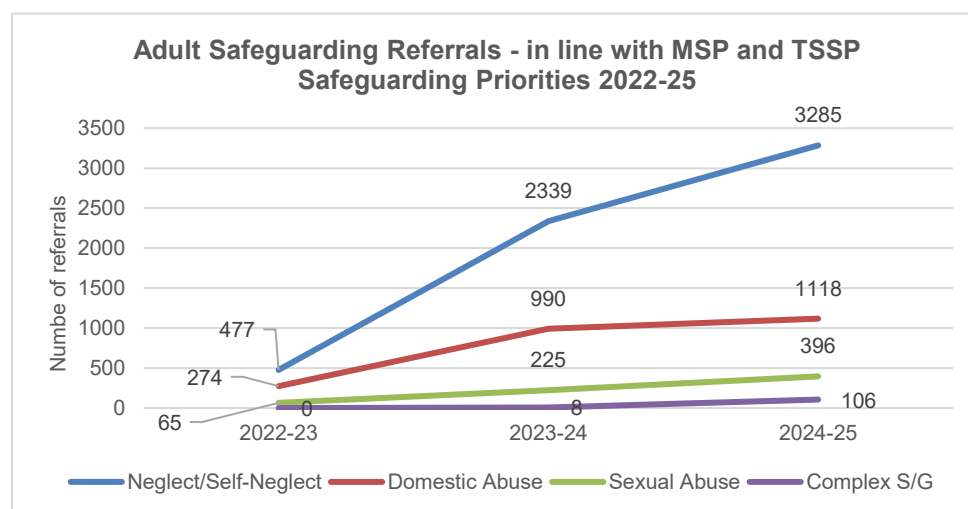


Figure 6: Safeguarding Children and the Unborn Referrals Categories of Safeguarding Concern 2024-25

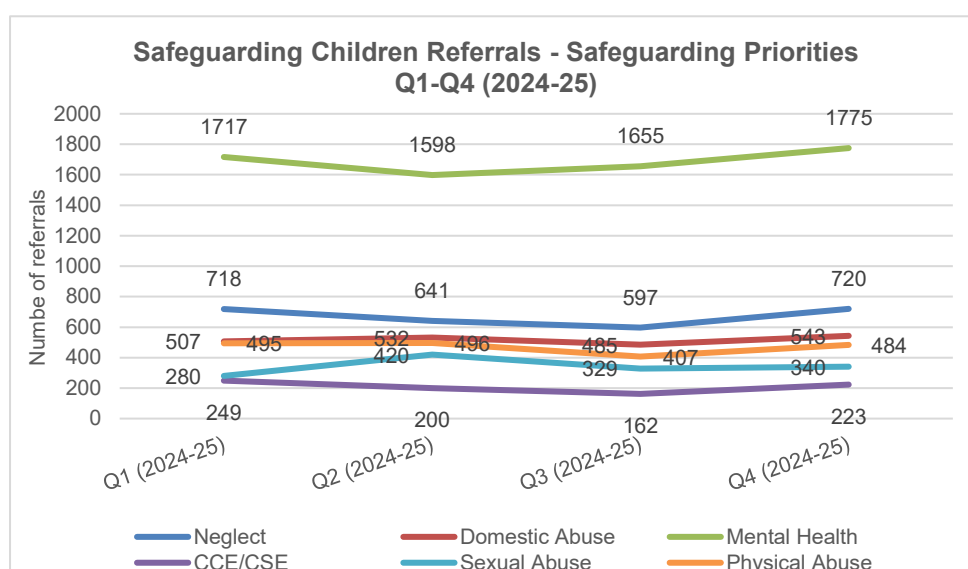
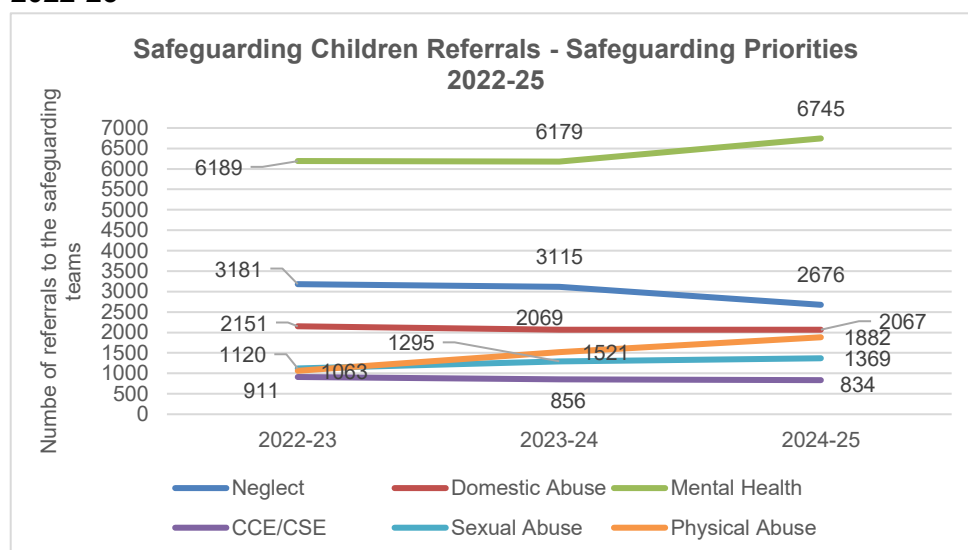


Figure 7: Safeguarding Children and the Unborn Referrals Categories of Safeguarding Concern 2022-25



Figures 4 to 7 indicate the category of safeguarding concerns identified in the referrals to the adults and children's safeguarding team. Neglect, domestic violence and abuse, and safeguarding people in the context of mental ill health have remained the most frequent categories of safeguarding concern reported, and this has aligned with the safeguarding partnership priorities reported in sections 4, 5 and 12.

4. Recognition and Response to Neglect and Self Neglect in Adults

In line with national⁸ reporting and MSP and TSP priorities, **Figures 4 to 7** identifies neglect (in adult and child safeguarding), and self-neglect (in adult safeguarding) are the most frequent category of safeguarding concern in safeguarding adults and the second most frequent category in safeguarding the unborn and children in MFT. **Figures 4 to 7** indicate that from 2022 until 2025 there is an increase in safeguarding adult neglect/self-neglect referrals and sustained high levels of safeguarding children/unborn neglect referrals.

The MFT Early Help and Neglect Subgroup has supported colleagues across the Trust to recognise and respond to neglect through.

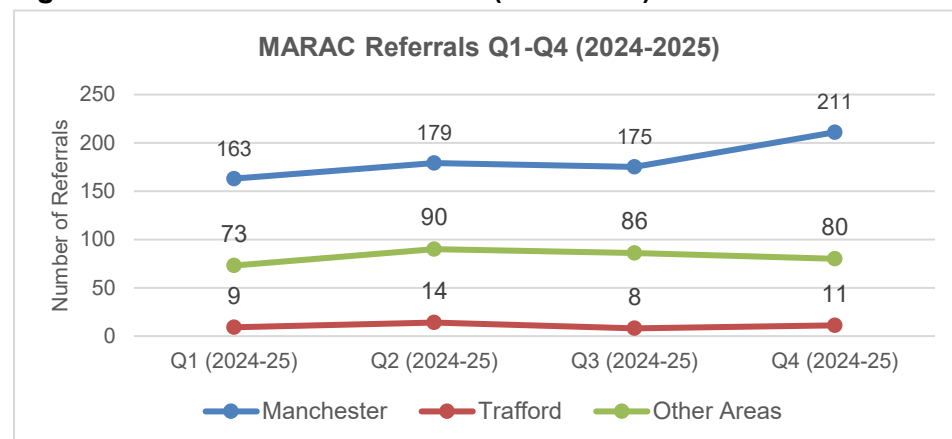
- Supporting the MSP and TSP implementation of their neglect strategies including the MSP Self Neglect and Hoarding Guidance and development of the MSP All Age Neglect Screening Tool.
- Training **6** colleagues to become licenced NSPCC Graded Care Profile 2 (GCP2) trainers (the preferred MSP and TSP tool to identify neglect in children), who in turn supported **130** MFT colleagues to be trained in completing the Graded Care Profiles to identify and safeguard children and young people experiencing neglect. A digital solution to document completion of GCP on Hive and EMIS EPR is in development overseen by the Digital Safeguarding Group. This will provide data to evaluate the impact of training in completion of GCP2 in 2025-26.
- Identification of **15** neglect champions who have attended **2** MSP Neglect Champion events and promoted implementation of the MSP Neglect strategies.
- Completing the TSP multi-agency neglect audit that evidenced the voice of the child was heard using a child centred approach in MFT safeguarding practice.
- Development of MFT child, adolescent, and adult neglect/self-neglect and hoarding e-learning training packages.

5. Domestic Violence and Abuse

Figures 4 to 7 identify domestic violence and abuse (DVA) is the 2nd most frequently reported category of concern for safeguarding adults and 3rd most frequently reported category in safeguarding children and the unborn. There were **3185** safeguarding referrals with DVA being the category of concern in 2024-25, compared to 3083 in 2023-24.

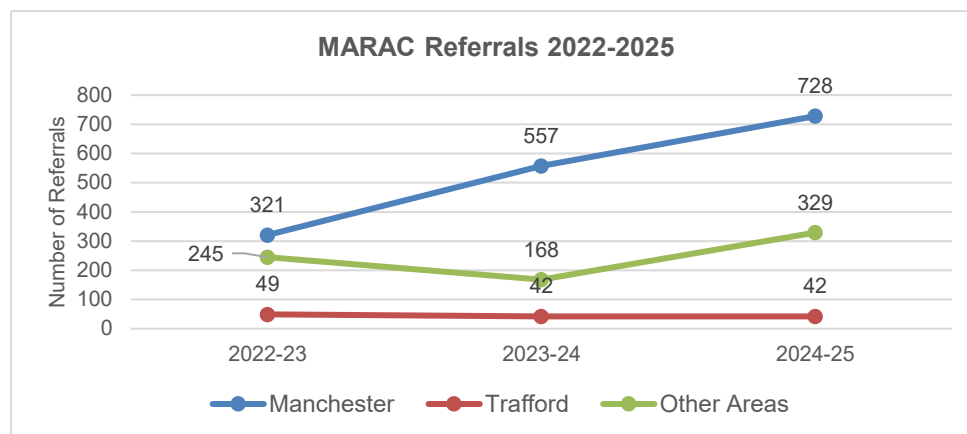
Figures 8 and 9 identify **1099** people experiencing high-risk domestic violence and abuse were identified by Trust colleagues and referred to the Multi Agency Risk Assessment Conference (MARAC).

Figure 8: MARAC Referrals Q1-Q4 (2024-2025)



⁸ [Safeguarding Adults - NHS England Digital Children in Need national statistics](#)

Figure 9: MARAC Referrals 2022-25



Referrals to MARAC are completed by all multi-agency safeguarding partners. MFT completed 25% of the total multi-agency referrals to Manchester MARAC and 3% of the total referrals to Trafford MARAC. Nationally acute and secondary care health providers complete 2.6% of referrals to MARAC⁹, this identifies that the MFT workforce are identifying people at high-risk of DVA above the national average for health providers

Figures 10 and 11 identify **458** mandatory reports were completed to the NHS national FGM dataset¹⁰ when FGM was observed in clinical practice, (all reports were for women over 18 years).

Figure 10: Women identified to have experienced FGM reported to the National Database – Q1-Q4 (2024-25)

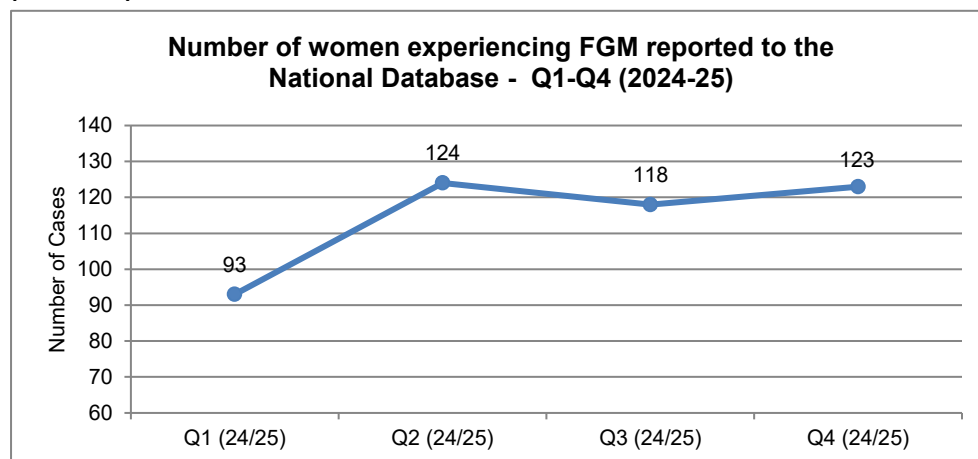
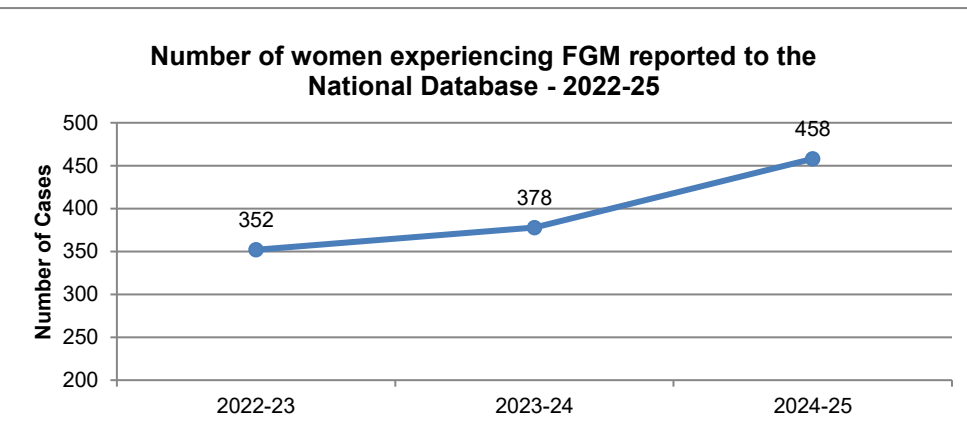


Figure 11: Women identified to have experienced FGM reported to the National Database – 2022-25



⁹ [MARAC data – Key findings January 2024 - December 2024](#)

¹⁰ [Female Genital Mutilation national dataset](#)

MFT reported the 7th highest number of FGM cases out of all NHS provider Trusts in England. This reflects the communities living in Manchester identified by the World Health Organisation to be at high-risk of traditional FGM practice¹¹ and the knowledge and skill of the MFT workforce in recognition and response to FGM.

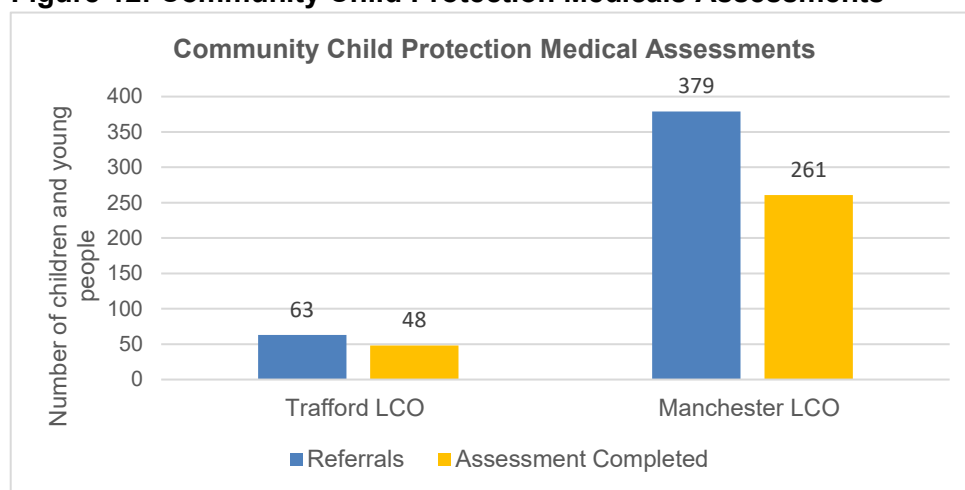
The Domestic Violence and Abuse Subgroup have overseen the Trust's response to DVA and FGM.

- The Trust has implemented revised policies on Domestic Violence and Abuse, Supporting Staff Affected by Domestic Abuse, and Safeguarding Women and Girls at Risk of FGM, ensuring alignment with national legislation and learning from safeguarding partnerships.
- A deep dive into the Trust's response to DVA was conducted, resulting in an action plan to improve frontline staff's knowledge and awareness. This followed thematic learning from 12 of 21 unannounced assurance visits in 2023–24, which identified gaps in staff confidence and skills to recognise DVA.
- An audit programme was completed on the quality of DVA MARAC referrals which identified that colleagues were confident in recognising DVA. The audit action plan included, a training programme being delivered to promote continuous improvement in the quality of the DVA risk assessment and referrals, through mandatory safeguarding training and **185** colleagues completing CPD DVA training.
- MFT continues to support the delivery of specialist domestic abuse services in the Trust through the provision of the Independent Domestic Violence Advocates (IDVAs) within the Sexual Assault and Referral Centre (SARC) and partnership working with the ICB commissioned Assessing for Domestic Violence in Sexual Health Environments (ADVISE) project in sexual health services and the Local Authority Midwifery and Domestic Abuse Support Service (MIDASS) project based in maternity services.
- The safeguarding teams contributed to risk assessments and multi-agency safety planning for victims and survivors discussed at the Manchester and Trafford MARACs. In 2024–25, there were **2,909** referrals to Manchester MARAC (up from 2,774 in 2023–24) and **1,068** referrals to Trafford MARAC (up from 861 the previous year), reflecting a continued rise in high-risk cases requiring multi-agency intervention.

6. Child Protection Medicals

Figure 12 reports on child protection medicals completed to contribute to Children Act Section 47 child protection enquiries. Local Care Organisation (LCO) children's community services (CCS) complete the child protection medicals with the exception of children aged less than 18 months of age, or for children who need to be seen acutely in a Trust hospital.

Figure 12: Community Child Protection Medicals Assessments



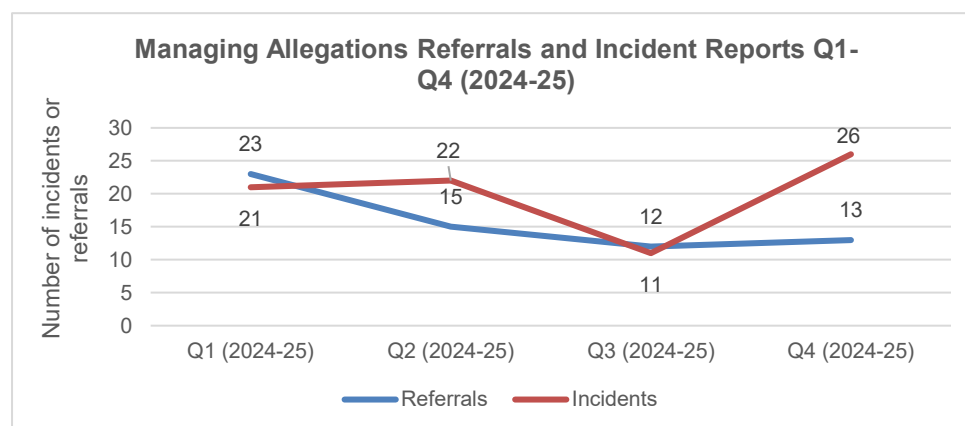
¹¹ [FGM -the facts.](#)

- 6.1 In Wythenshawe, Trafford, Withington and Altrincham (WTWA) 56 medicals were completed over the last year (an increase from 47 medicals last year), 23 of which were requested by Children's Social Care (CSC). The number of referrals for child protection medicals has continued to increase this year, following all referrals the paediatrician and children's social worker agree if a medical is indicated in line with Trust and multi-agency policy to safeguard the child (as indicated in **Figure 12**, 133 referrals resulted consultation and advice from the child protection consultant or diversion to the hospital service and not a community medical.
- 6.2 Named Doctors for Safeguarding Children have overseen developments in the child protection service including.
- Developing a ratified guideline on 'How to arrange Child Protection medicals in MFT'.
 - Developed a ratified local guideline for 'Standards for Child Protection medicals' based on RCPCH¹² standards. Safeguarding peer review in Trafford has been reviewed and updated to ensure compliance with RCPCH standards.
 - Worked with CSC to improve the arrangements for child protection medicals.
 - Continuing to work closely with the Hive team to develop an electronic version of the Child Protection Proforma which is planned for implementation by Q2 2025-26.
 - The development of an escalation procedure to ensure there are agreed procedures for managing periods of increased referrals, in Q1 2024-25 to provide assurance that all child protection medicals are delivered within the child protection enquiry timescale.

7. Managing Safeguarding Allegations against MFT Colleagues

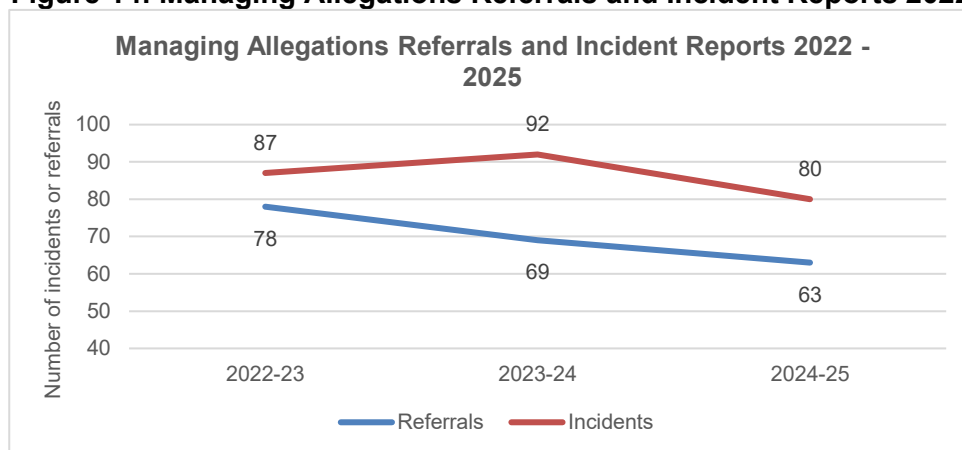
Figures 13 and 14 indicate **80** managing allegations incidents were reported this year, a slight decrease from 2023-24.

Figure 13: Managing Allegations Referrals and Incident Reports Q1 – Q4 (2024-25)



¹² Child protection service delivery standards accessed at <https://childprotection.rcpch.ac.uk/resources/service-delivery-standards/>.

Figure 14: Managing Allegations Referrals and Incident Reports 2022-25



The delivery, assurance and oversight of the response to Trust Policy Managing Allegations against MFT colleagues who work with children, young people and adults at risk has been strengthened through the following activities.

- A review and implementation of revised Trust policy designed to be more accessible to colleagues.
- Development of an e-learning training package and bespoke training provision to **150** management colleagues.
- Establishment of an oversight mechanism to review all incidents on a 6 weekly basis reporting to the Deputy Chief Nursing Officer.

8. Patient Experience and Person-Centred Care

8.1 Making Safeguarding Personal, providing a person-centred safeguarding service

Making Safeguarding Personal and hearing and listening to the voice of the person is the first objective of the MFT safeguarding workplan, included in Appendix A, which is completed by all Clinical Groups and the safeguarding teams and reported to Clinical Group Safeguarding Groups and the MFT Quality and Learning Subgroup. Exceptions from the workplans include.

- Patient stories presented to safeguarding governance groups.
- RMCH patient and Public Involvement Strategy and action plan.
- Patient experience surveys completed in the looked after children (LAC) and safeguarding learning disabilities teams informing quality improvement work in LAC health assessments and provision of enhanced observations of care.
- Feedback from the Navigator Service of young people's experience of serious youth violence to inform the work programme of the Complex Safeguarding group through the Greater Manchester Violence Reduction Unit Hospital Navigator Pilot - Implementation Evaluation¹³. The Navigator Service provides a youth service to children and young people attending MFT hospitals who have experienced serious violence.

8.2 Children's Rights

In Manchester there is an ambition to become a UNICEF Child Friendly City¹⁴, a city which implements the United Nations Convention on the Rights of the Child in everything it does. This informs safeguarding practice in Manchester, for example, the MSP has delivered a Safeguarding Children Champion Programme with safeguarding partnership senior leads collaborating with schools to deliver a child led safeguarding project.

¹³ Greater Manchester Violence Reduction Unit Hospital Navigator Pilot - Implementation Evaluation Manchester Metropolitan University (2024).

¹⁴ [Our Child friendly Manchester Putting Children's Rights into Practice](#)

The MFT Head of Safeguarding supported Oswald Road School children in creating a comic featuring 'Bubble Boy' and their school mascot, an owl, to promote personal boundaries, an initiative that will be shared across Manchester schools.

8.3 Advocacy

In 2024-25 advocacy audits were completed in WTTA, Manchester Royal Infirmary (MRI) and North Manchester General Hospital (NMGH) which identified an improvement in the workforce's understanding of provision of advocacy under the Mental Capacity Act (MCA). The audit action was to raise awareness of the role of advocacy services in line with the Mental Health Act, and was delivered through focussed awareness raising events at the safeguarding champions network meetings and in ward walk rounds in Safeguarding Adult Week (November 2024) and through provision of advocacy service information forward and department safeguarding notice boards.

In Royal Manchester Children's Hospital (RMCH), a risk has been identified that there is no local authority (LA) commissioned independent mental health advocacy service in accordance with the Mental Health Act (MHA) Code of Practice¹⁵ for children under 16 years. In 2024 9 patients detained under the MHA required this service. To mitigate the risk for these children advocacy was provided by the RMCH Galaxy House commissioned service. The risk is included on the MSP safeguarding risk register and has been escalated to LA Commissioners, the Manchester LA commissioned Advocacy provider, ICB Quality and Safety team in Manchester and the GM Mental Health Strategic Commissioning team. The provision of advocacy services for this group of young people is a priority for the Mental Health Improvement plan 2025-26 with a meeting arranged with ICB and LA commissioners in Q1 2024-25.

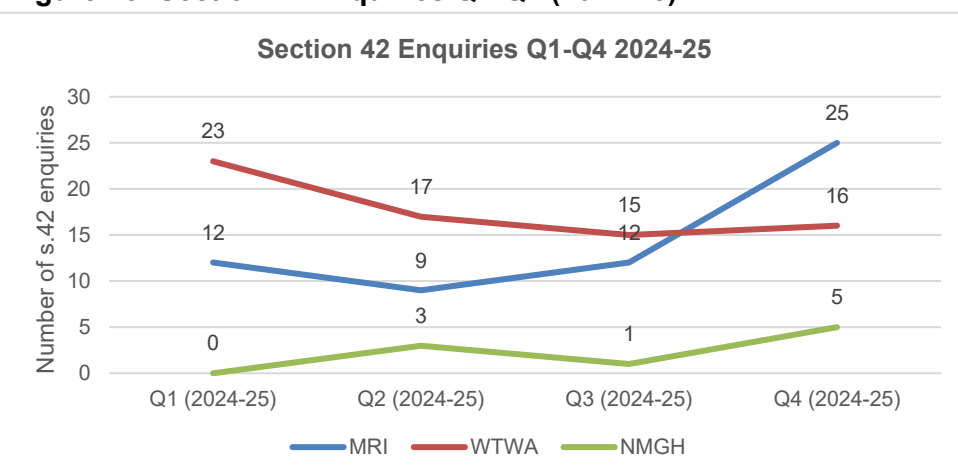
8.4 Patient Experience

Patient experience in safeguarding is heard through patient stories presented at Clinical Group and thematic safeguarding governance groups and through review and reporting to Clinical Group safeguarding groups and TSG on all complaints where safeguarding is identified as an area of concern and learning from adult safeguarding section 42 (s.42) Enquires.

8.5 Section 42 Enquiries

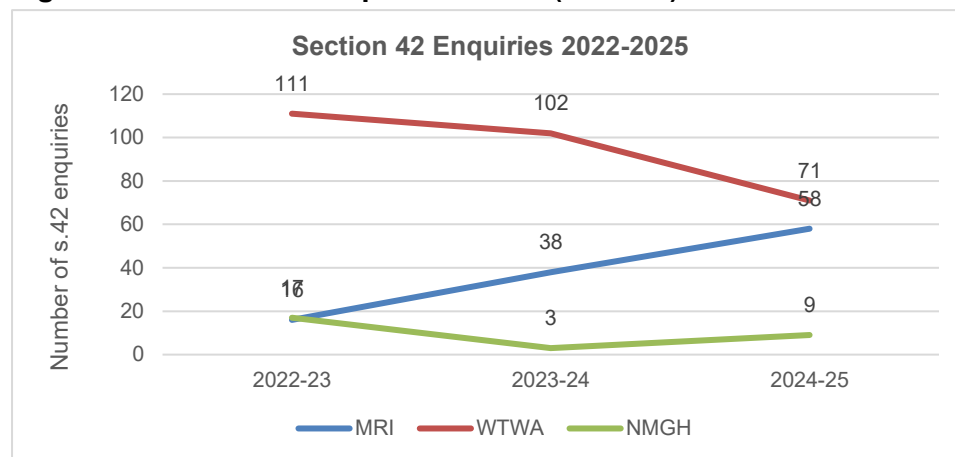
Figures 15 and 16 identify that in 2024-25 138 (144 2023-24) Care Act Adult Safeguarding Section 42 (s.42) enquiries were completed by the LA where there were safeguarding concerns about care and treatment provided in MFT. The most frequent themes of the s.42 enquiries were unsafe discharge, managing allegations of abuse against staff, medication errors, skin damage and falls with harm.

Figure 15: Section 42 Enquiries Q1-Q4 (2024-25)



¹⁵ [Mental Health Act 1983](#)

Figure 16: Section 42 Enquiries Q1-Q4 (2024-25)



In 2024-25 **138** (144 2023-24) Care Act Adult Safeguarding Section 42 (s.42) enquiries were completed where there were safeguarding concerns about care and treatment provided in MFT. The most frequent themes of the s.42 enquiries were unsafe discharge, managing allegations of abuse against staff, medication errors, skin damage and falls with harm.

Delivery of an effective response to s.42 enquiries was supported by.

- Clinical Group senior leadership teams, safeguarding team and risk and governance teams providing oversight and a coordinated response to each enquiry to ensure a person-centred response with an individual action plan for the ward or department overseen by Clinical Group Safeguarding Groups.
- The statutory timescale of response to the LA is 20 working days, **95% (141)** of MFT s.42 enquiries were responded to within this timescale, with all LA receiving a response from the Trust to all s.42 enquiries in 2024-25.
- Thematic review of learning from s.42s in NMGH and WTWA Clinical Groups has been completed following safeguarding concerns identified in the discharge process, these actions will inform a Trust wide thematic review of s.42 learning from discharges to inform Trust wide discharge processes in Q1 2025-26.
- Piloting and implementation of a revised standard operating procedure (SOP) to respond to s.42 enquiries in MRI and NMGH, which will be implemented in WTWA in Q1, 2025-26. This SOP has strengthened the delivery of immediate actions to safeguard patients in MFT care and identification of learning and actions plans within 7 days of the enquiry being initiated. Application of the SOP within Trust timescales will be reported upon in the 2025-26 safeguarding reports.

8.6 Safeguarding Complaints

Figures 17 and 18 indicate that there were **136** complaints identified to involve a safeguarding concern.

Figure 17: Safeguarding Concerns/Complaints by Site Q1-Q4 (2024-25)

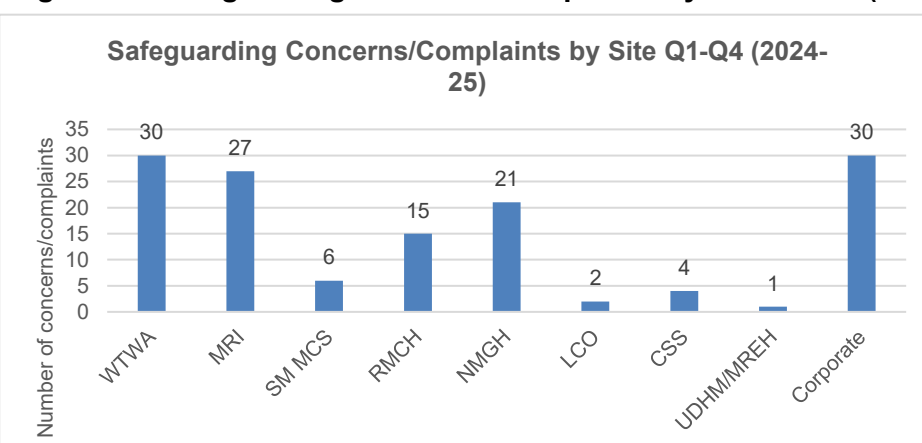
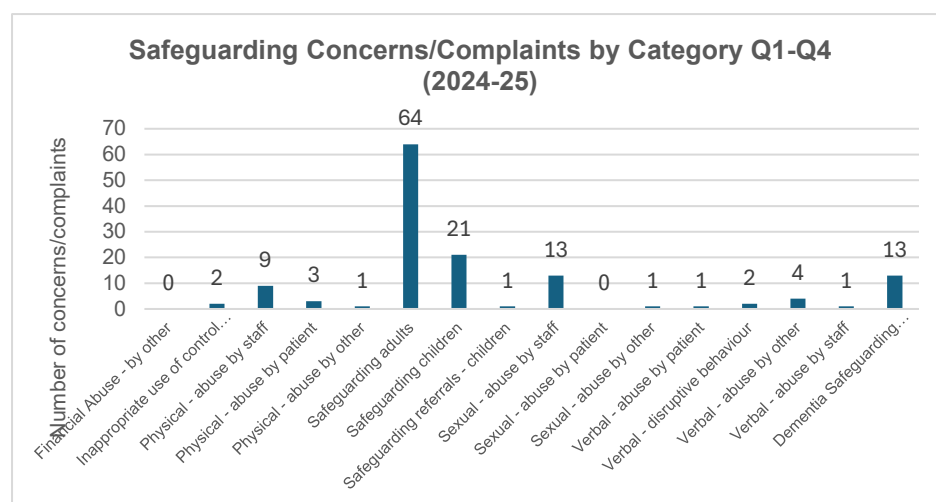


Figure 18: Safeguarding Concerns/Complaints by Category Q1-Q4 (2024-25)



136 complaints involving a safeguarding concern were identified, in response the following was actioned.

- Reporting arrangements were in place to ensure that all complaints categorised to include a safeguarding concern were referred to the safeguarding team to address immediate safeguarding risks in line with Trust safeguarding policy as well as to contribute to the complaint response overseen by the Trust complaints team and Clinical Group senior leadership team.
- Reporting arrangements were established in 2024-25 to monitor learning from complaints that identified a safeguarding concern in quarterly safeguarding reports, contributing to the safeguarding workplan. In the majority of safeguarding complaints, the Trust safeguarding policies had been applied, with immediate actions taken when policy was not applied. An immediate senior escalation process was established to ensure all serious allegations arising from complaints had a timely senior safeguarding oversight response within the same working day.
- A deep dive was completed to explore the increasing number of sexual safety complaints between 2021 and 2024 (**18** in total). In 67% of the complaints a referral was made to the safeguarding team which resulted in application of the Managing Allegations against Staff policy. An immediate action has been instigated to alert the complaints team that all sexual safety complaints must be referred to the Trust's safeguarding team. A revised complaints response to sexual safety complaints was introduced in 2024-25 to ensure the response to sexual safety complaints included a referral to the safeguarding team to deliver Trust safeguarding policies and the new Sexual Safety policy implemented as part of the Trust response to implementation of the NHSE Sexual Safety Charter.¹⁶

9. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Thematic learning themes from **22** multi-agency safeguarding adult scoping reviews completed in the Trust triangulated with MSP, TSAB and national SAR learning¹⁷, **39** LeDeR and the **3** MFT mental capacity audits completed have identified that improvement work is required to increase the workforce's knowledge and skills in application of the MCA and DoLS. This is included in 2 risks on the Trust's risk register, included in the GM ICB MFT safeguarding contractual standards improvement plan reported quarterly to TSG and has been exception reported to TSG in February 2025.

There has been considerable activity in the provision of training, learning resources, review, and audit of practice to address this risk.

- **85%** (80% 2023/24) of the mapped workforce have been trained in the application of the MCA and DoLS.

¹⁶ [NHSE Sexual Safety Charter](#)

¹⁷ [Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023](#)

- **306** (341 2023/24) staff have attended additional localised bespoke training. The KPMG external audit that identified significant assurance of the operational application of the MFT MCA Policy action plan has been completed to address the minor improvement opportunities. These actions focused on strengthening quality assurance processes and improving the tracking of DoLS applications and have been reported to Trust audit committee.
- The Trust contributed to the Manchester Safeguarding Partnership (MSP) task and finish group, which reviewed training and resources to promote consistent application of the MCA, with a focus on assessing executive functioning in mental capacity assessments.
- The MCA policy was reviewed to streamline guidance to adopt a user-friendly approach.

Figures 19 and 20 identify the significant risk to the Trust that **4749** DoLS applications were completed which resulted in only **93** authorisations from Local Authority Best Interest Assessment (LA BIA).

Figure 19: DoLS Applications and Authorisations Q1-Q4 (2024-25)

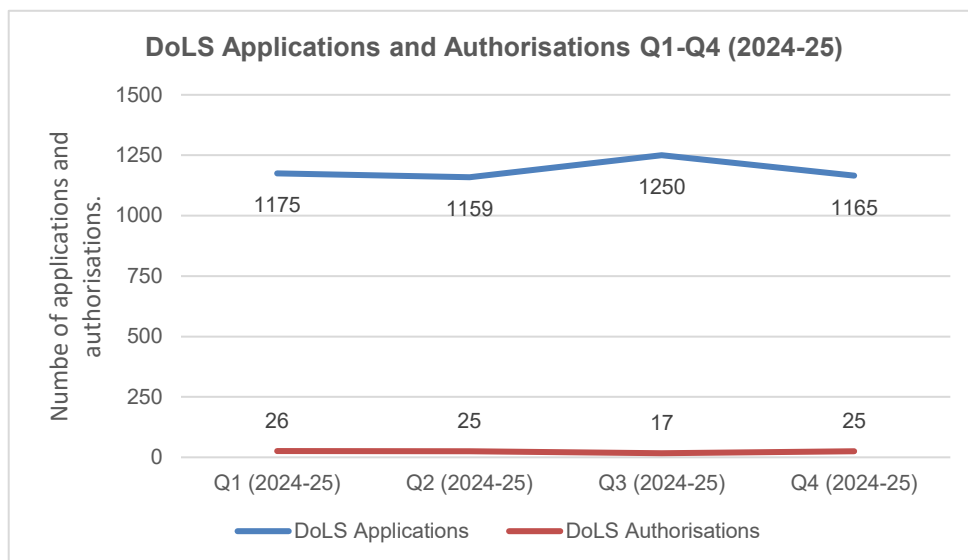
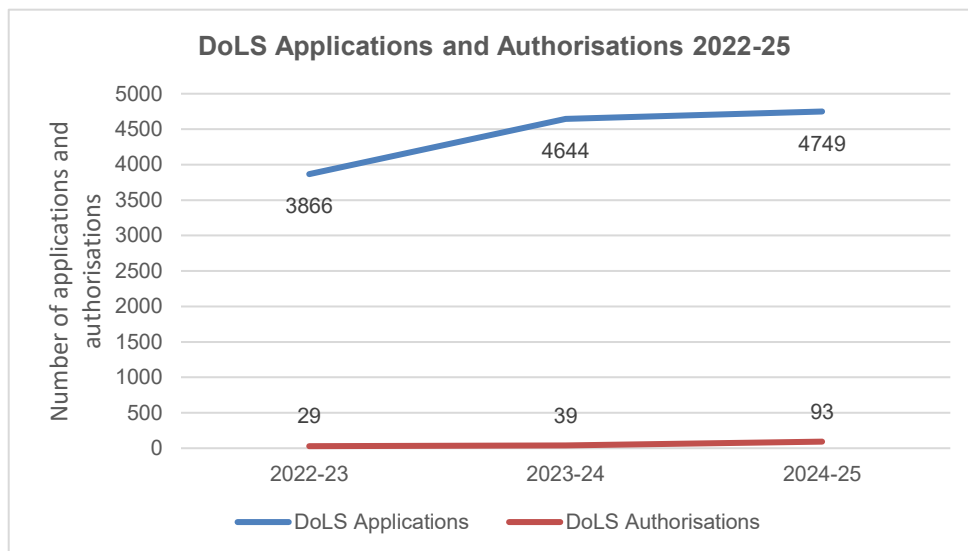


Figure 20: DoLS Applications and Authorisations 2022-25



The Care Quality Commission (CQC) has acknowledged the ongoing national challenges within the DoLS system, which continue to place individuals at risk of being deprived of their liberty without the necessary legal safeguards or protections¹⁸. Nationally, **19%** of standard DoLS applications were authorised within the statutory 21-day timeframe.

In Manchester acute hospitals, **8.6%** of applications were authorised within this period, while Trafford acute hospitals report a rate of **5.4%**¹⁹. The majority of MFT DoLS authorisations are submitted to Manchester Local Authority.

The number of DoLS authorisations has increased this year; however, the low authorisation rate leaves the Trust at risk of unlawfully detaining patients after the expiry of standard DoLS authorisations.

Progress to address this risk is reported monthly in the IPR to the QSPBC and quarterly to TSG. A deep dive of the DoLS process was completed in the Trust in 2024 with the following actions to mitigate the risk.

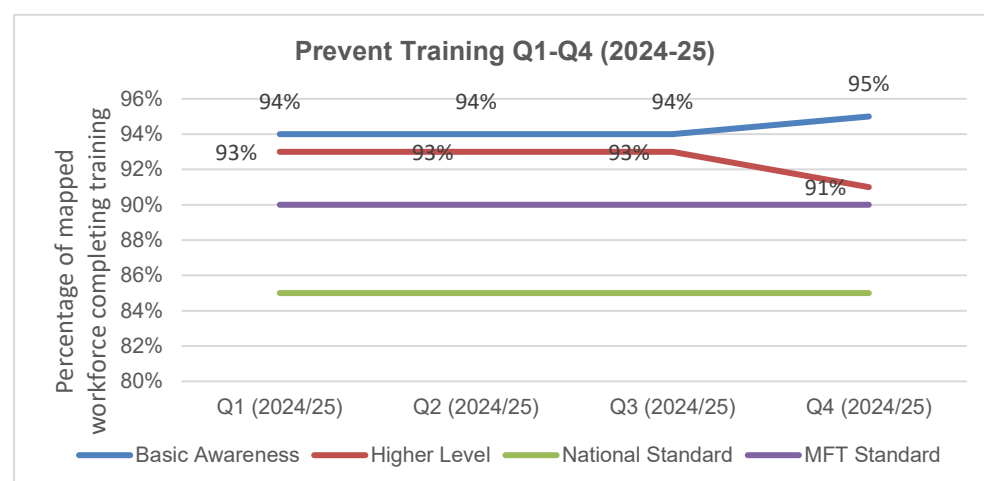
- Implementation in January 2025 of the DoLS application process through Hive electronic patient record, this has delivered a streamlined process and improved the quality of applications.
- A review of Trust DoLS process with LA BIA teams, internal and external legal teams to inform a revised DoLS policy to be consulted upon in the Trust in Q1 2025-26.
- A weekly review of DoLS applications with Manchester LA BIA to prioritise the patients who are subject to most restriction for best interest assessments. In 2025-25 Q1, the review meetings will be commenced with Trafford LA.
- A deep dive into the Manchester LA BIA teams challenges to authorisations of MFT applications expected to be completed in Q1 2025-26.

10. Prevent

In 2024 executive leadership for the Prevent responsibilities was transferred to the Chief Nursing Officer with the Prevent Duty allocated to Assistant Chief Nurse Safeguarding with the delegated Prevent Lead being the Lead Nurse Safeguarding.

Figures 21 and 22 identify that compliance with Prevent e- learning by Trust colleagues is achieving the expected 90% Trust compliance standard.

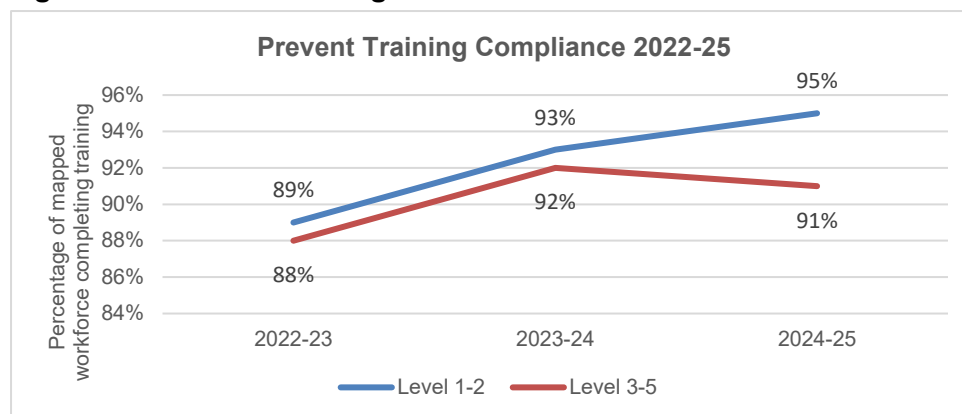
Figure 21: Prevent Training Q1-Q4 (2024-25)



¹⁸ [CQC 2022 State of Care 2023/24](#)

¹⁹ [Deprivation of Liberty Safeguards](#)

Figure 22: Prevent Training 2022-25



The Trust has reported quarterly to the National Safeguarding Steering Group (NSSG)²⁰ that the Trust is compliant in expected standards of Prevent training.

The Trust has continued to contribute to Manchester and Trafford Channel Panels completing **21** information sharing requests and has completed **2** Prevent referrals. The Trust's Prevent policy has been reviewed and ratified at TSG.

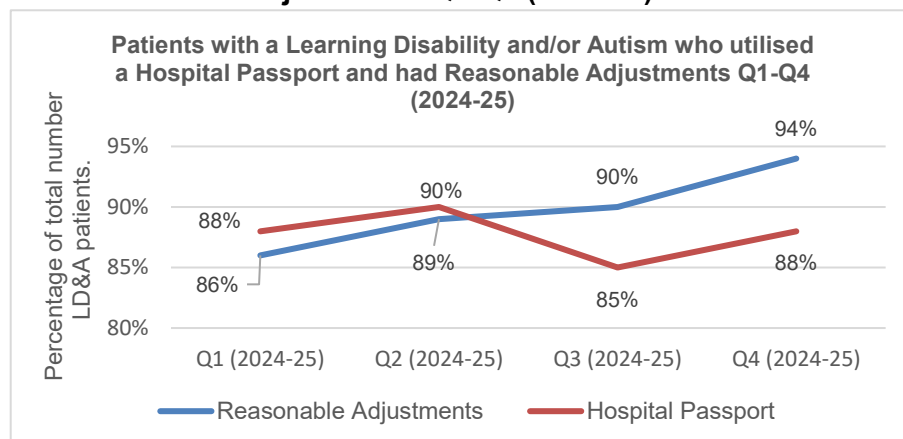
11. Providing high quality reasonable adjustment care to people with a learning disability and autism. Our plan for people with learning disabilities and/or autism, their families, and carers.

The progress to the strategic aims of the MFT strategy "Our plan for people with learning disabilities and/or autism, their families, and carers 2022–2025" has been reported to the MFT Learning Disability Steering Group, which has led and driven the delivery of strategy commitments and monitored assurance of the strategy delivery.

A team of 7 learning disability specialist nurses support the workforce in Trust hospitals in the delivery of high-quality reasonable adjustment care to people with a learning disability and/or autism.

All adult patients admitted with a diagnosis of learning disability and autism (LD&A) are flagged with an equalities monitoring LD&A flag on their Hive EPR, within 48 hours of admission all flagged LD&A patients receive a Quality Care Check (QCC) completed by the specialist LD&A nursing team²¹. The QCC reviews if the patient is receiving appropriate reasonable adjustment care in line with their individualised needs documented in their hospital passport. The outcome of the QCC is reported in **Figure 23**.

Figure 23: Patients with a Learning Disability and/or Autism who utilised a Hospital Passport and had Reasonable Adjustments Q1-Q4 (2024-25)



²⁰ National Safeguarding Steering Group (NSSG) NHS Safeguarding Integrated Dashboard

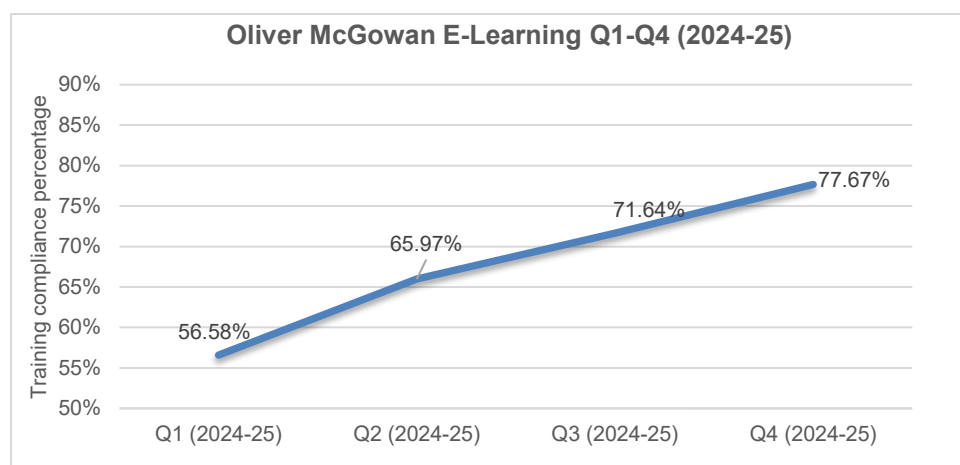
²¹ Quality Care Checklists are provided in line with the MFT Care of patients with Learning Disabilities and/or Autism in acute hospital setting policy.

- **1708** (1206 in 2023-24) QCCs (including reviews) have been completed in 2023-24.
- **87.5%** patients with an LD/A had a Hospital Passport uploaded to their EPR, noting an increase from (48%) in 2023-24.
- **90%** reasonable adjustment assessments had been completed compared to (53%) in 2023-24.
- When the passport or reasonable adjustment assessment was not completed, an immediate escalation was completed with the ward or department to support frontline staff to apply the MFT Care of Patients with Learning Disabilities and/or Autism in Acute Hospital Setting Policy by obtaining or completing a passport and reasonable adjustment assessment. An escalation procedure was triggered if this action was not completed within 1 working day.

The flagging and completion of reasonable adjustment care in RMCH has been under review, identifying a significant number of RMCH patients have a learning disability, however these children are not consistently flagged on the EPR, often due to a diagnosis not yet being made. A point prevalence review and a mapping of children's needs against service provision is being completed in Q1 2025-26 to inform guidance to support the workforce to consistently evidence reasonable adjustment care.

All Trust colleagues are expected to complete the nationally mandated Oliver McGowan Training and this is documented in **Figure 24**.

Figure 24: Oliver McGowan E-Learning Q1-Q4 (2024-25)



Key priorities delivered in the Learning Disability Workplan reported to the LD&A steering group and TSG have included.

- **77.68%** of colleagues had completed Oliver McGowan e-learning, not meeting the Trust standard set for 90% of colleagues to complete by December 2024. Improvement plans are in place across Clinical Groups and the expected trajectory to meet expected Trust standard has been reported to the LD&A steering group and TSG.
- Training has commenced for Tier 2 Oliver McGowan Training with **2** Lead Trainers and **24** Facilitators trained. A plan to deliver the Tier 2 training is being led by the Chief People Officer in 2025-26 aiming to train 30% of the workforce in 2025-26 according to GM ICB training trajectory standards.
- **39** Best Practice Reviews have been completed to contribute to **39** LeDeR reviews following the death of a person with a learning disability. Findings from the LeDeR have included.
 - Identification of good practice in communication and multi-disciplinary working.
 - Areas of learning addressed included promoting the consistent application of MCA and to improve documentation of family involvement in the process delivered to agree 'do not attempt cardiopulmonary resuscitation' decisions. This was completed as an immediate action if identified in the QCC or as an immediate response in the provision of training and in reports to the LD&A steering group.

- An audit of flagging and awareness of reasonable adjustment tools on the Hive EPR provided limited assurance that the workforce was consistently applying the flagging correctly and an action plan has been initiated which is a priority for review in Q1 2025-26. The safeguarding LD&A nursing team complete daily reviews of LD&A flagged patients immediately addressing any inaccurate flagging identified.
- The Trust has implemented the NHS England's 'Ask, Listen, do' framework to enhance how we manage concerns, complaints, and co-production processes.
- Patient experience and co-production have been completed through the MFT Learning Disability and Autism patient Carer Forum which has contributed to modification of hospital passports and contribution to review of discharge arrangements.
- The Trust wide improvement work on Enhanced Therapeutic Observations of Care aligned NHS England (NHSE), ETOC Improvement Collaborative has been informed by our patients with a learning disability voices, with their views on what they require from the workforce to deliver ETOC identified in **Figure 25**.

Figure 25: Patient's Views on what they require from the workforce to deliver ETOC



12. Mental Health Improvement Plan

A priority focus for the safeguarding work programme has been the Mental Health Improvement Plan to review, deliver, support, and provide assurance that the Trust is safeguarding and providing high quality care for people with a mental health condition in line with the Trust's Mental Health Strategy. **Figures 26 to 32** identify Trust performance in mandatory mental health training and application of Mental Health Act (MHA) standards.

The safeguarding mental health team is a team of 6 nurses, an MHA manager and coordinator who support the Trust in delivery of the mental health improvement work, including quality assurance of application of the MHA.

12.1 Mental Health Training

Figure 26: Mental Health Training Compliance 1 Q1-Q4 (2024-25)

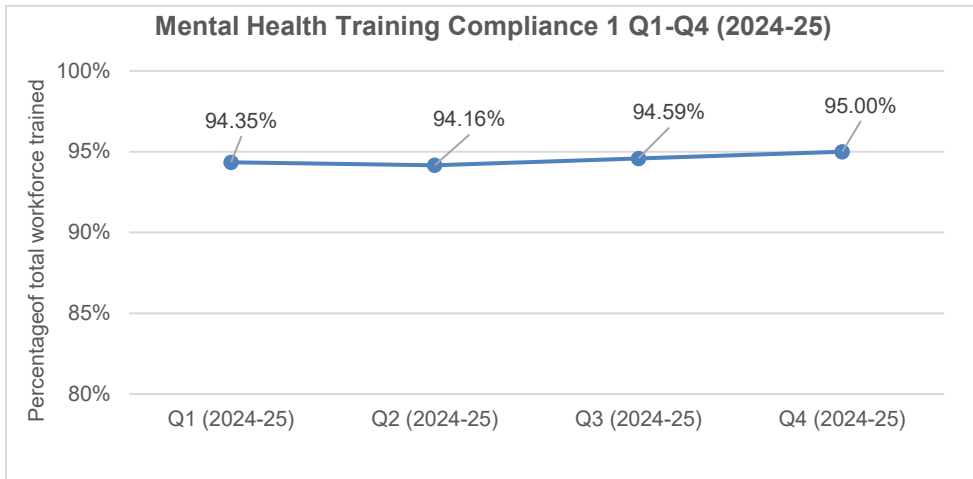


Figure 27: Mental Health Training Compliance 2 Q1-Q4 (2024-25)

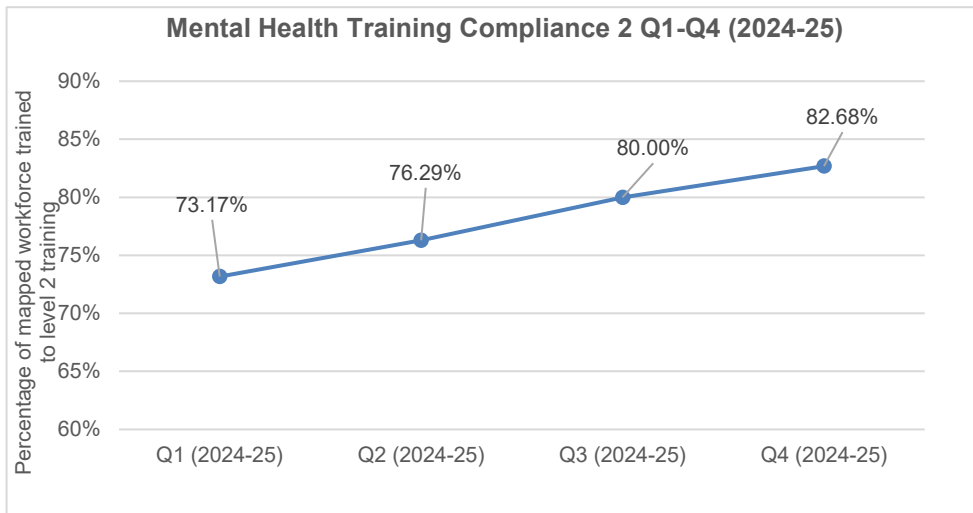


Figure 28: Patients detained under MHA Section Missing from Hospital Care Q1-Q4 (2024-25)

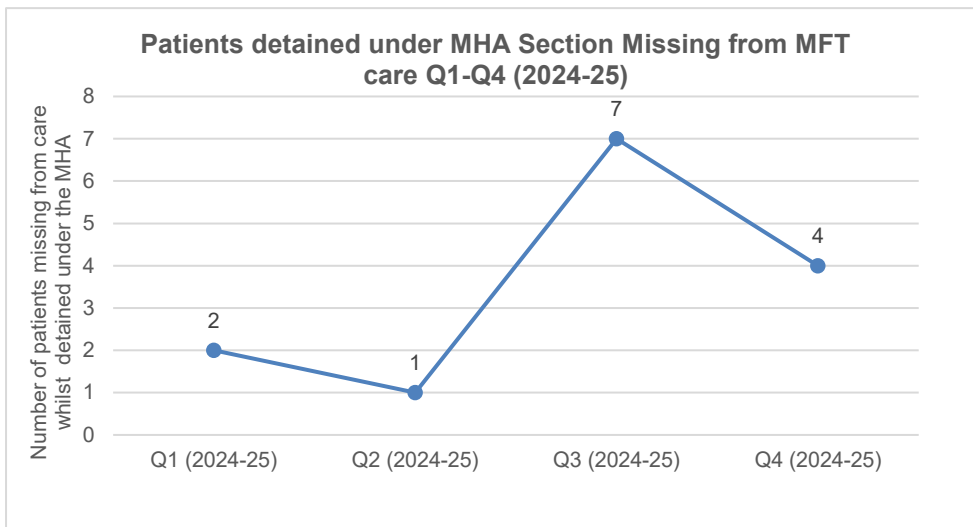


Figure 29: Percentage of Rights Read to Patients Detained on a Mental Health Section Q1-Q4 (2024-25)

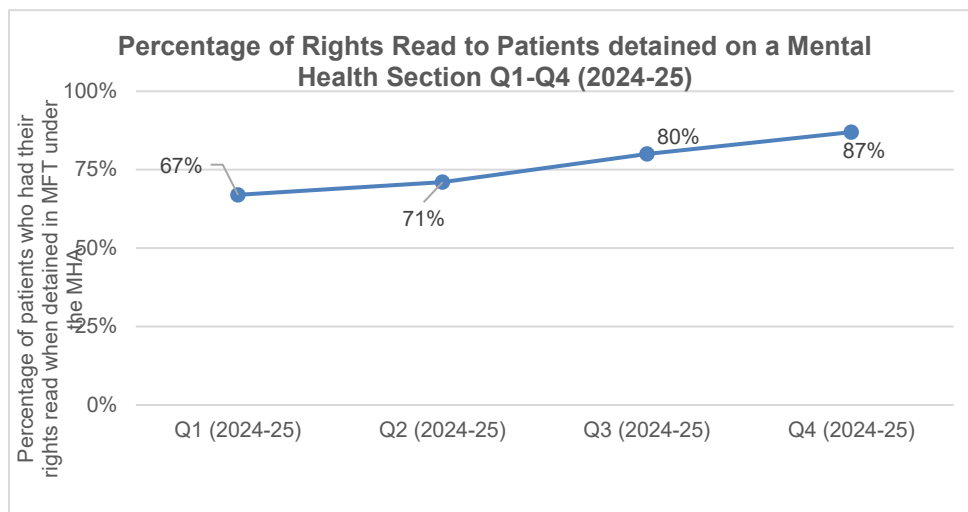


Figure 30: Percentage of Rights Read to Patients detained under the MHA (2024-25)

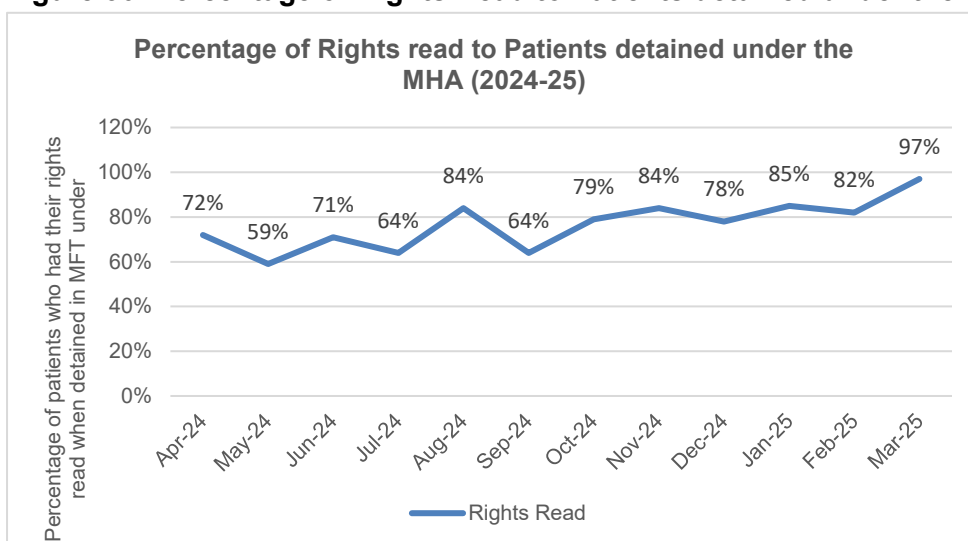


Figure 31: Total Number of Patients detained under a Mental Health Section and Number of MHA Appeals Q1-Q4 (2024-25)

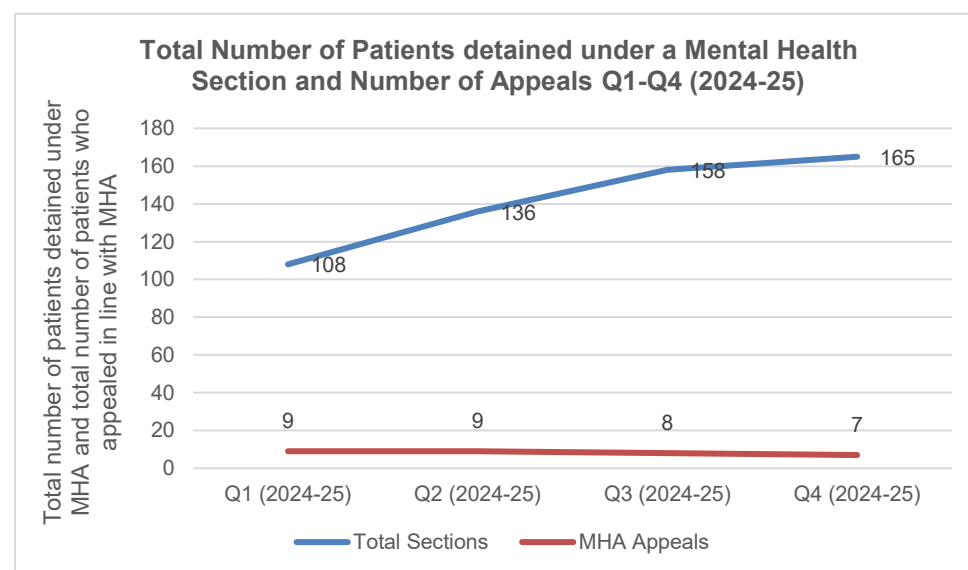
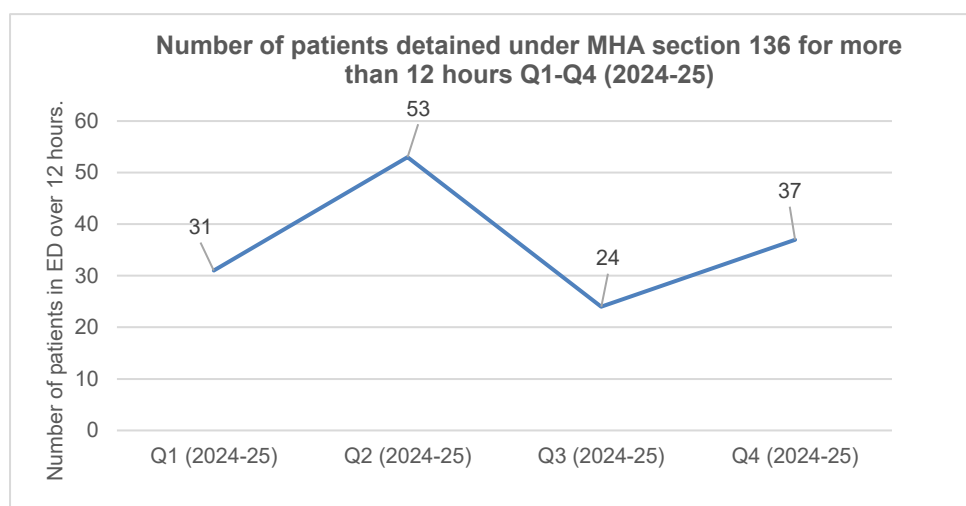


Figure 32: Number of Patients detained Section 136 for more than 12 hours Q1-Q4 (2024-25)



In the safeguarding annual assessments, 78% of Clinical Groups reported an increase in both the volume and complexity of individuals accessing MFT services with mental health conditions. This aligns with data indicating a broader trend of rising mental health needs among the population served.

- **4174** referrals were completed to the Trust's safeguarding mental health team (3,979 2023/24).
- A **52%** increase in the number of patients detained to the Trust under the Mental Health Act (MHA) to **567** patients in 2024-25.

The Mental Health Subgroup has overseen the delivery of the Mental Health Improvement Plan, addressed the five strategic aims of the Mental Health Strategy and implemented the 62 recommendations from the Mersey Care Mental Health Peer Review. Progress has been reported quarterly to QSPBC, with the following key developments achieved.

- **31** recommendations from the Mental Health Peer Review have been completed, with a mental health audit plan and reporting arrangements in place to ensure continued assurance and compliance. **30** recommendations remain active within the action plan. **1** action related to Liberty Protection Safeguards is not currently applicable due to a national pause on this workstream.
- The Delegation of Statutory Functions for MFT regarding patients detained under the MHA has been developed and was approved by the QSPBC and the BOD in December 2024. The Trust MHA policy is currently being reviewed, and a programme of MHA training has been commissioned to strengthen the training delivered by the safeguarding mental health team in 2024-25 to **280** colleagues, prioritising training the Clinical Groups Senior Leadership teams in Q4 (2024-25). Application of the MHA has been scrutinised by the safeguarding mental health team quality assurance programme of audit (3 audits) and daily review of all MHA detention documentation in the Trust. There has been a significant increase in patients' rights being read with 1 working day of detention to **97%** in March 2025.
- The restraint reduction programme has been reviewed including a strengthened strategic risk, revised physical, chemical and mechanical restraint policies and the delivery of Positive Behaviour Support (PBS) training in least restrictive interventions and restraint training programme to **658** colleagues at level 1 to 3 (level 1 345, level 2 199, level 3 114). All clinical groups have completed a training needs analysis and training plan, reporting to the Mental Health subgroup, to progress completion of PBS training.
- The **8** Trust wide mental health risks, (7 included on the safeguarding risk register), have been reviewed and clinical group risks and incident profiles are overseen by the Mental Health Subgroup.
- Mental health mandatory training compliance at level 1 and 2 has improved. As level 2 training is currently at **82%** compliance, not achieving Trust 90% standard, all clinical groups are reporting their improvement plans to the Mental Health Subgroup.

- **2,312** colleagues completed additional bespoke mental health training.
- A MFT response to the Greater Manchester Police (GMP) Right Care Right Person (RCRP) system wide programme, to refocus the police response to their core roles in prevention and detection of crime, has been delivered in partnership with Manchester and Trafford RCRP oversight and GM ICB readiness groups. A revised response to missing patients and the safe care and treatment of people detained under a Section 136 in Trust emergency departments (EDs) in line with legislative and regulatory requirements has been delivered through, policy, guidance, training, digital documentation and reporting on Hive EPR and weekly assurance reports on the implementation of Phase 1 (September 2024) and 2 (April 2025).
- In response to serious incidents and learning, **9** Trust policies (Mental Health Act, Suicide Prevention, Caring for persons of all ages who are experiencing distressed behaviours, Prevention and Management of Missing Patients and Least Restrictive Interventions, Rapid Tranquilisation, MCA, DoLS and Enhanced Security Supervision Observations) were reviewed. In addition, new escalation and MHA Section 136 guidance were developed for the E.Ds. All policies have incorporated the use of digital documentation and reporting on Hive EPR to ensure regulatory and legislative standards are monitored and reported on.
- Daily, weekly and quarterly reports have been developed to ensure clinical group senior leadership teams have oversight of mental health activity.

The Mental Health Improvement Plan aims to implement the majority of the Mersey Care Peer Review recommendations (**30**) in 2025-26, noting that 5 recommendations involving the physical environment and workforce models are longer term recommendations to achieve.

13. Safeguarding Training

Figures 33 to 36 report on compliance of the Trust's workforce to meeting expected mandatory safeguarding training standards.

Figure 33: Mandatory Safeguarding Training Compliance Level 1 to 3 Q1-Q4 (2024-25).

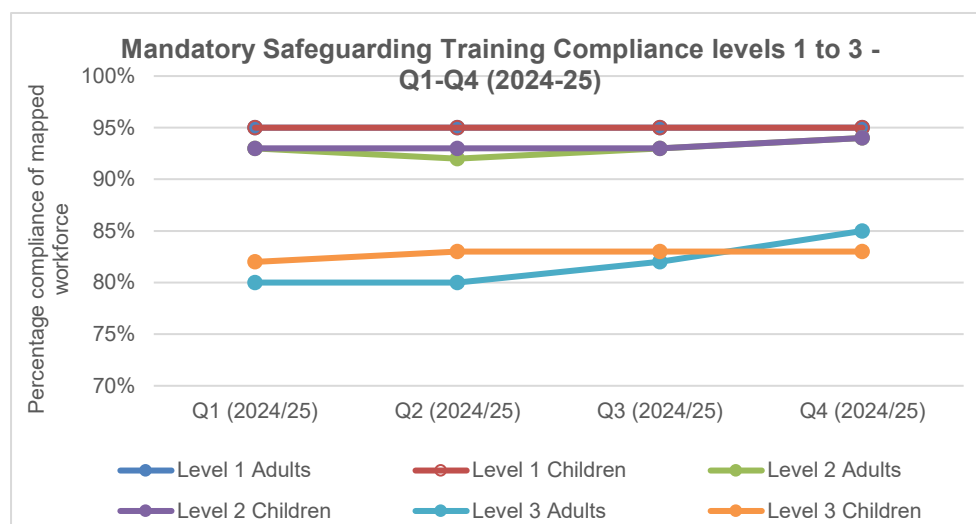


Figure 34: Mandatory Safeguarding Training Compliance Levels 1 to 3 2022-25

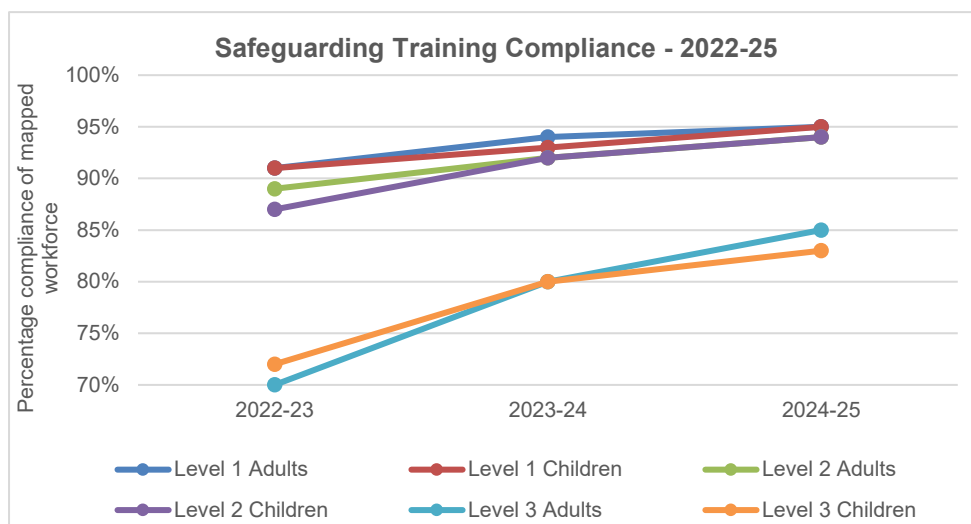


Figure 35: Safeguarding Children Level 3 Training Compliance – AHPs, Medical and Dental, Nursing and Midwifery Q1-Q4 (2024-25)

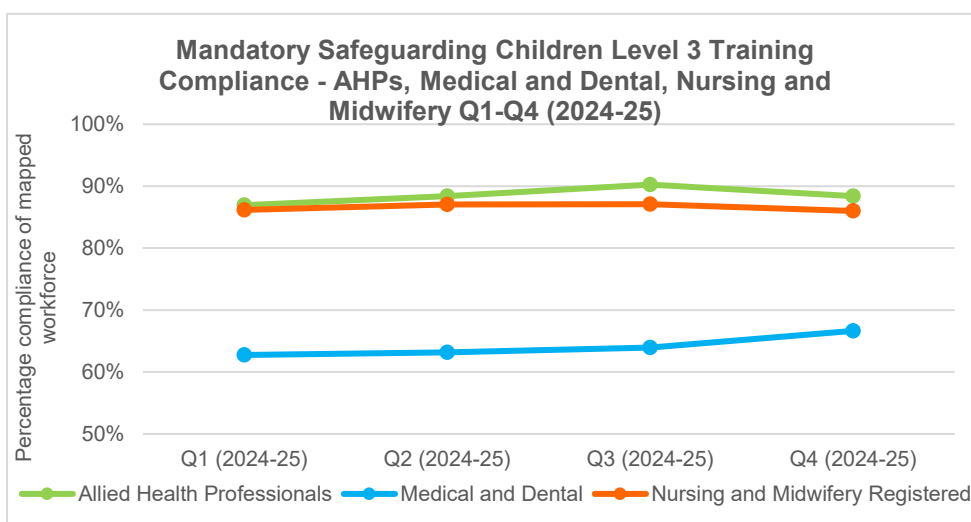
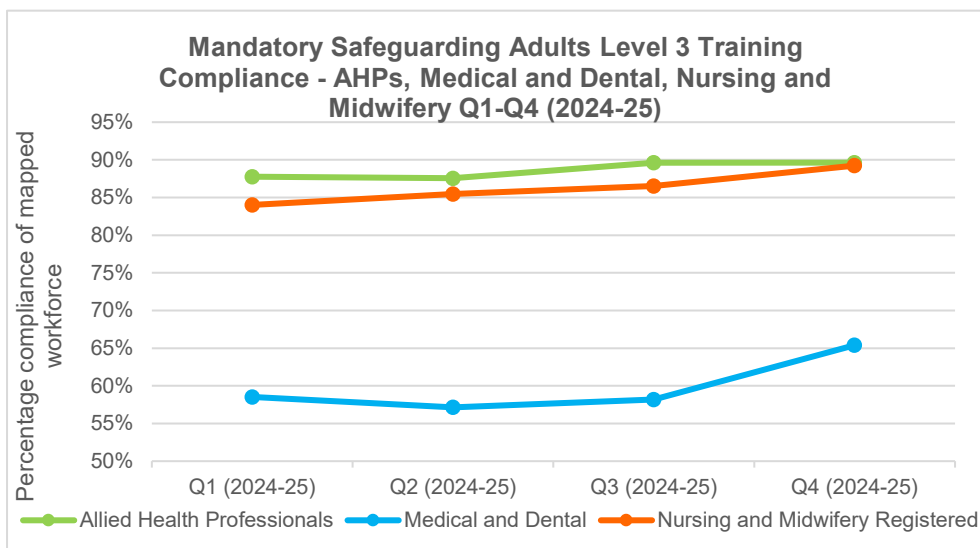


Figure 36: Safeguarding Adults Level 3 Training Compliance – AHPs, Medical and Dental, Nursing and Midwifery Q1-Q4 (2024-25)



A “Think Family” mandatory safeguarding training programme has been delivered in line with competencies recommended by the Royal College Intercollegiate Guidance²² which was updated in 2024 for adult safeguarding and is expected to be updated for children’s safeguarding in 2025. The Safeguarding Training Strategy Group oversees the delivery of safeguarding training reporting to the Safeguarding Quality and Learning Subgroup.

- Expected compliance levels of over 90% have been consistently achieved in level 1 and 2 safeguarding training.
- Small improvements in level 3 safeguarding training compliance of 1-4% in nursing, midwifery and allied health professionals will achieve expected compliance standard of 90% of colleagues mapped, achieving the standard.
- Significant improvements are required in compliance in level 3 training for medical and dental workforce.
- A risk is included on the Trust safeguarding risk register regarding level 3 adult and children’s training not meeting expected 90% compliance standard. There is a Clinical Group, Medical and Dental Workforce and overarching Trust Safeguarding Training Improvement Plan with training compliance reported monthly to QPSBC in the IPR, quarterly to Clinical Groups Safeguarding Groups and TSG and monthly to the Safeguarding Training Strategy Group. The improvement plans include detailed oversight, improvement plans and expected trajectories for all colleagues not compliant with training, Trust wide review of the delivery and documentation of training programme and system wide working to acknowledge training delivered in other NHS organisations according to the nationally agreed Memorandum of Understanding (MOU) between NHS Bodies²³.

4270 colleagues received bespoke safeguarding training according to local safeguarding risk and need.

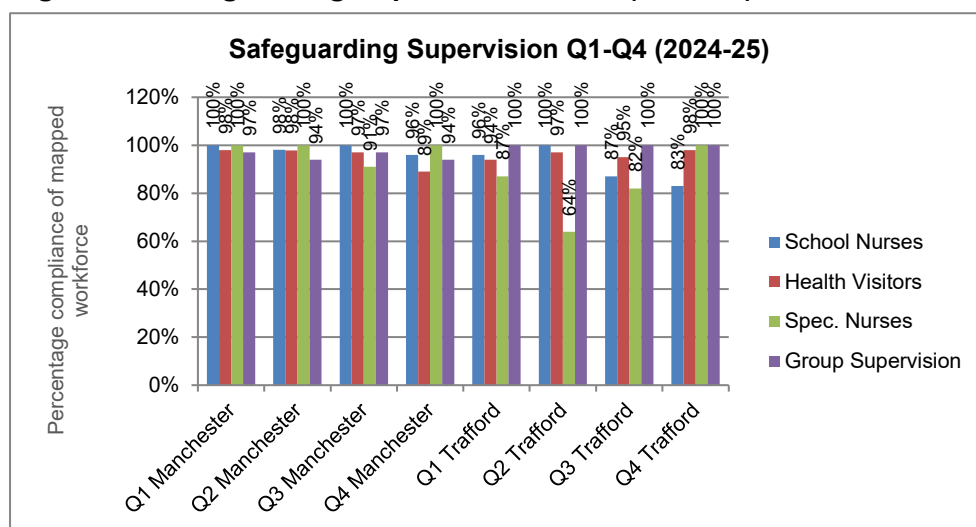
A Safeguarding Newsletter was cascaded monthly across the Trust to share key safeguarding messages, the content and presentation has been revised to focus on delivery of key safeguarding messages.

14. Safeguarding Supervision is provided and attended by the workforce in areas of high safeguarding risk and need.

3285 colleagues have received safeguarding supervision across acute and community services, in line with the Trust’s Think Family Approach to Safeguarding Supervision Policy.

Figures 37 and 38 indicate the compliance of completion of mandatory safeguarding supervision.

Figure 37: Safeguarding Supervision Q1-Q4 (2024-25)

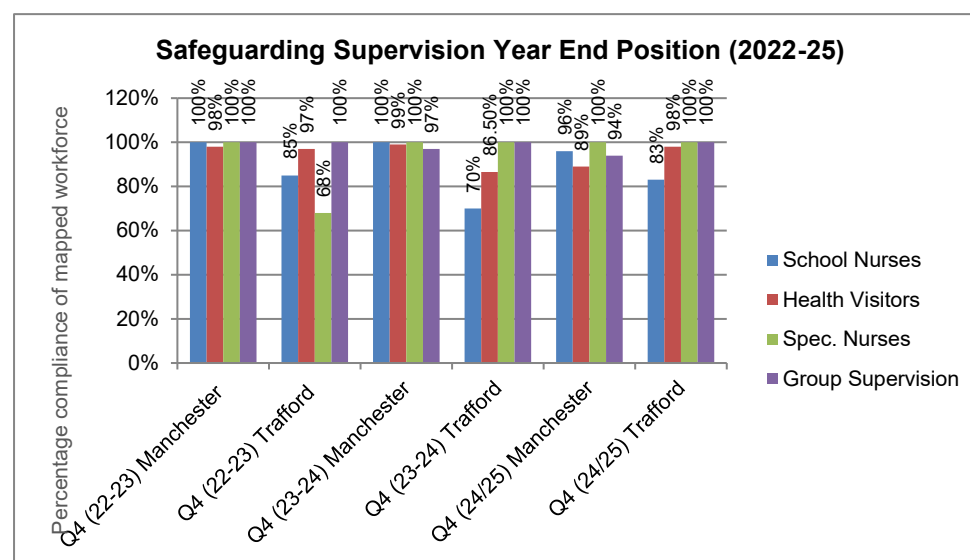


²² Adult Safeguarding: Roles and for Health Care Staff (2024) 2nd edition

²² Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

²³ NHS England statutory and mandatory learning (StatMan) training letter to all Chief People Officers 2025

Figure 38: Safeguarding Supervision 2022-25



The Safeguarding Team has continued to provide supervision across maternity, children, and adult services. Supervision remains mandatory for all community children's services staff with safeguarding caseloads, safeguarding nurses, and CAMHS teams. A successful business case has secured the recruitment of a Named Nurse for Safeguarding in CAMHS, who will start in Q2 2025–26. A key priority for this role is to develop and implement an effective and equitable safeguarding supervision model within CAMHS, as reflected in the Trust Safeguarding Risk Register.

A network of Safeguarding Champions has been established across the Trust, supported by the Trust Safeguarding Team through quarterly Champions meetings. The effectiveness of this programme will be evaluated and reported to the Quality and Learning Safeguarding Subgroup in Q1 2025–26.

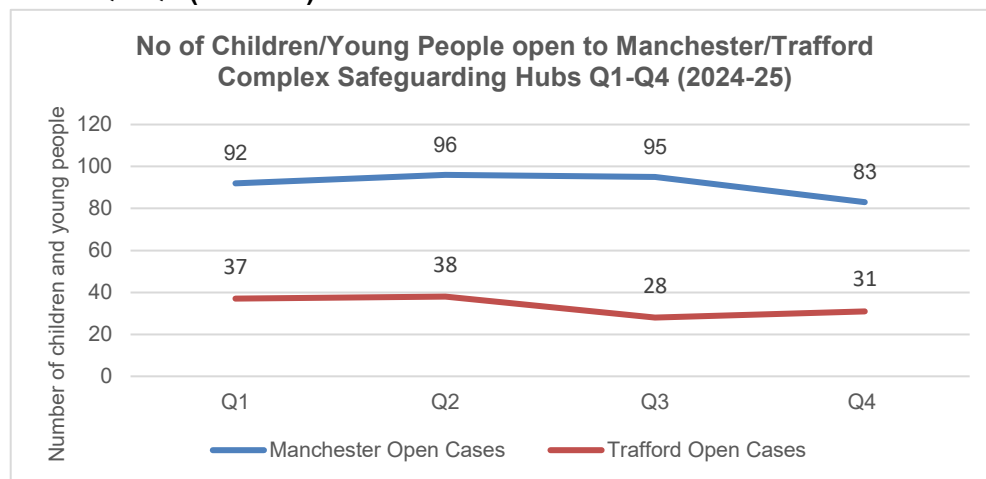
15. Partnership Working

MFT has worked closely with multi-agency partners to strategically and operationally deliver safeguarding priority workstreams across Greater Manchester, Manchester, and Trafford. Key areas of contribution include.

- Active Participation in Governance Structures:**
MFT has engaged in all safeguarding boards, executive groups, sub-boards, and working groups across Manchester (9 groups) and Trafford (17 groups in 2024–25, currently under review). This includes contributing to the revised consultation and board structures following the disaggregation of the Children's Partnership and Safeguarding Adults Board, in line with *Working Together to Safeguard Children* statutory guidance.
- Delivery of Partnership Priorities:**
The Trust has supported the implementation of two MSP and six TSSP priorities, both across the partnership and internally within the Trust.
- Multi-Agency Learning from Harm Reviews:**
MFT contributed to **42** multi-agency scoping reviews relating to incidents where individuals died or experienced serious harm due to abuse or neglect, enabling shared learning and service improvement across safeguarding systems.
- Collaboration with NHS Greater Manchester Provider Collaboratives:**
MFT remains an active partner in provider collaboratives across Manchester, Trafford, and Salford, contributing to strategic alignment of safeguarding practices.

- Implementation of the Child Protection Information System (CPIS):**
 The nationally mandated CP-IS has been implemented across all urgent and emergency care settings, including maternity triage. However, assurance reviews have identified inconsistent application across services. A Trust-wide audit provided limited assurance that current guidance standards are met, with 50% of Clinical Group Annual Self-Assessments identifying the need for improvement. This remains a key priority for 2025–26 and is recorded on the Trust Safeguarding Risk Register, with ongoing review of action plans and mitigations in Q1.
- Complex Safeguarding Nurse Provision:**
 MFT provides a Complex Safeguarding Nurse within the Manchester and Trafford Complex Safeguarding Teams. These nurses play a critical role in assessing health needs and supporting children and young people receiving services from the hubs (see Figure 39). Their contributions have been highlighted in the Greater Manchester Mayor’s Review of Complex Safeguarding Hubs, which recognised the essential role of health input and recommended the ICB review commissioned nurse capacity. This has been escalated to the Safeguarding Risk Register, and discussions have taken place between the ICB, safeguarding, quality, and commissioning leads and MFT’s safeguarding senior leadership to manage associated risks.
- Response to Serious Violence:**
 In November 2024 the Multi-agency responses to serious youth violence: working together to support and protect children - GOV.UK²⁴ was published. The report identified. “Children received a high standard of coordinated care when attending the Manchester Royal Infirmary ED. The hospital had good processes in place to provide a prompt multi-agency approach to managing risk and planning longer-term support. For example, ED staff made referrals to children’s social care. They also worked with the police to manage children’s safety while they were in the ED, including through an internal security system. This meant, for example, that if children from different groups who could cause harm to each other might be attending at the same time, staff could identify this and ensure an appropriate multi-agency response to keep children safe. Inspectors were impressed generally with the ED’s response.”

Figure 39: Number of Children/Young People open to Manchester/Trafford Complex Safeguarding Hubs Q1-Q4 (2024-25)



- Multi Agency Safeguarding Children Hubs**
 The Trust provides a specialist nurse and administration co-ordinator in Manchester and Trafford front door multi-agency safeguarding teams. The nurses lead the Trust’s safeguarding response in the co-ordination and timely information sharing to enable risk management and response to child safeguarding referrals to CSC. **Figures 40-42** identify the volume of health referrals the specialist nurses have reviewed in the teams to strengthen the multi-agency response.

²⁴ [Multi-agency responses to serious youth violence: working together to support and protect children - GOV.UK](https://www.gov.uk/government/publications/multi-agency-responses-to-serious-youth-violence-working-together-to-support-and-protect-children)

Figure 40: Manchester Multi Agency Safeguarding Hub (MASH) Enquiries by Area Q1-Q4 (2024-25)

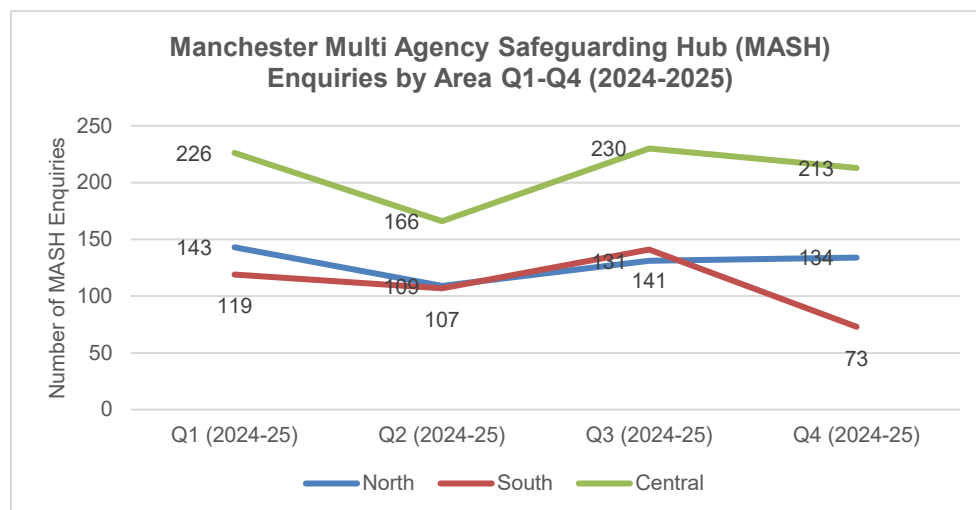


Figure 41: Manchester MASH Enquiries by Area Q1-Q4 (2024-25)

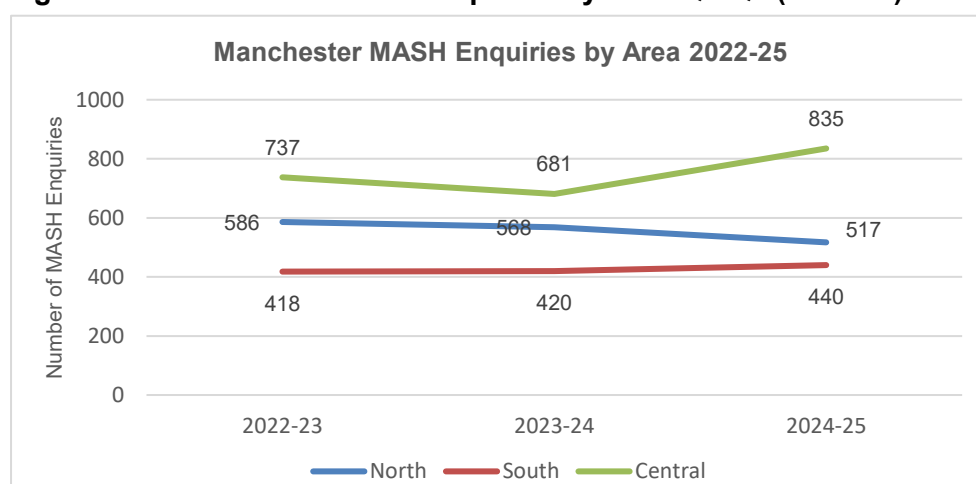
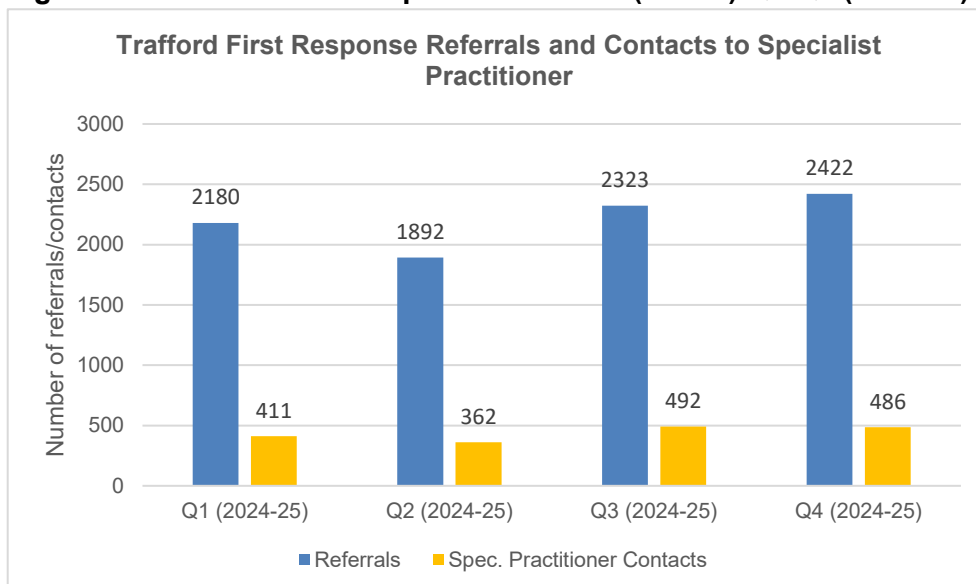


Figure 42: Trafford First Response Referrals (MASH) Q1-Q4 (2024-25)



16. Multi Agency Safeguarding Reviews

Figure 43 indicated that MFT has contributed to **42** scoping reviews and in **Figure 44**, all commissioned child safeguarding practice reviews (CSPR), safeguarding adult reviews (SAR) and domestic homicide reviews (DHR) where MFT provided care and treatment to the person involved or their family.

Figure 43: Scoping Activity Q1-Q4 (2024-25)

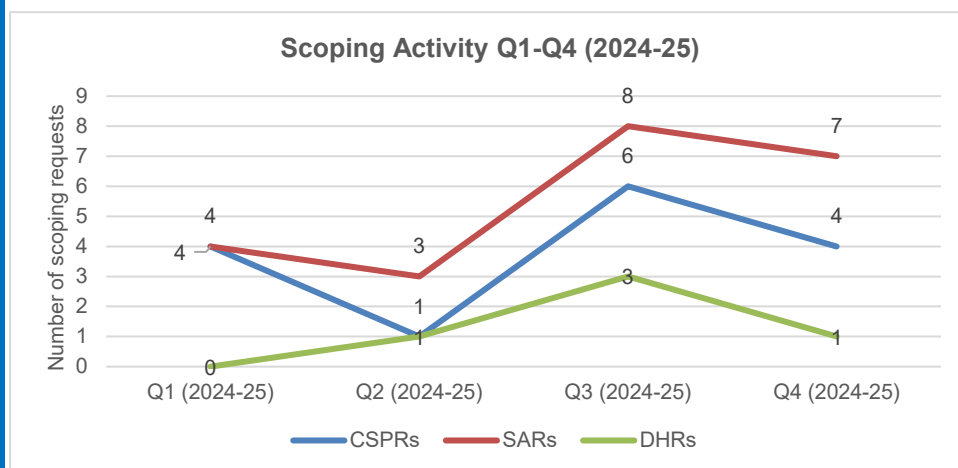


Figure 44 indicates the reviews that have been published by MSP and TSP this year. Learning from each review is implemented in the Trust and partnership and reported to the Safeguarding Quality and Learning Subgroup, Clinical Groups and in the Trust newsletter with a thematic report provided annually to TSG.

Figure 44: Publications Q1-Q4 (2024-25)

Quarter (2024-25)	Publications
Q1	Trafford CSPR Child 17 Trafford CSPR 20
Q2	Trafford Safeguarding Adult Review R Trafford Safeguarding Adult Review W
Q3	Trafford Safeguarding Adult Review Mike
Q4	Manchester CSPR Kyle

Figure 45 provides a summary of the most frequent learning from safeguarding reviews completed and the Trust response.

Figure 45: Learning from completed Safeguarding Reviews and Trust Response

Learning from SAR, CSPR and DHR	
Thematic Learning	MFT response
Promote Professional Curiosity into safeguarding concerns	Safeguarding Quality and Learning group has overseen the delivery of - Professional curiosity training delivered to 70 colleagues. - Professional curiosity guidance shared via the group and in safeguarding newsletter. - Professional curiosity supported in safeguarding training and supervision.
Multi Agency Risk Management include pathways for information sharing and escalation	Safeguarding team have supported application of MSP TSP and MFT escalation pathways. Safeguarding adults at risk and children and young people's policies have been reviewed.
To support workforce to apply Mental Capacity Act	Safeguarding Quality and Learning group has overseen the delivery of - MCA policy review, which provided accessible and clear guidance on legal application of MCA. 306 colleagues attended bespoke MCA training. 85% mapped workforce have completed MCA training. - Suite of Trust and multi-agency resources developed and available on Trust intranet to guide colleagues.
Consider safeguarding when appointments are missed	Early Help and Neglect group has overseen. - Implementation of Prevention and Management of Missed Appointments policy. - Development of Bespoke Neglect Level 3 Training module

	Mandatory safeguarding training and supervision has included application of Prevention and Management of Missed Appointments policy.
Think Family approach to safeguarding	Safeguarding Training programme is a Think Family training package. Safeguarding supervision includes a whole family response

17. Looked After Children (LAC)

Under the Children Act 2004 and in line with Statutory Guidance on Promoting the Health and Well-Being of Looked after Children²⁵, health professionals have a legal responsibility to promote the health and wellbeing of children and young people. Evidence shows that Looked after Children (LAC) and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter the care system with a worse level of health than their peers, in part, due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect.

In Manchester at the end of Q4 there were **1346** looked after children (LAC) and **367** in Trafford.

Figures 46-48, identify the performance of the MFT looked after children's services and local care organisation community children's services in meeting statutory looked after children's health requirements in partnership with the local authority CSC.

Figure 46: Manchester LAC Statutory Health KPIs Q1-Q4 (2024-25)

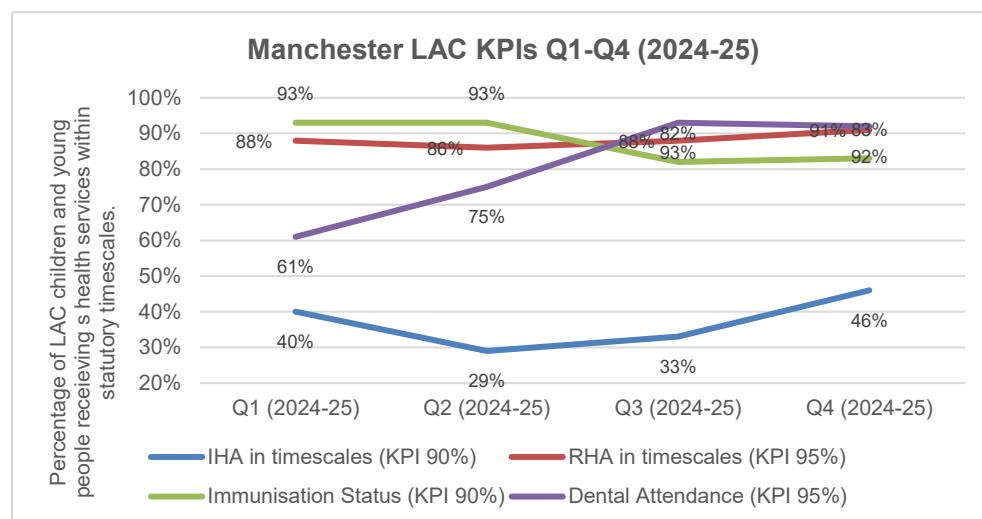
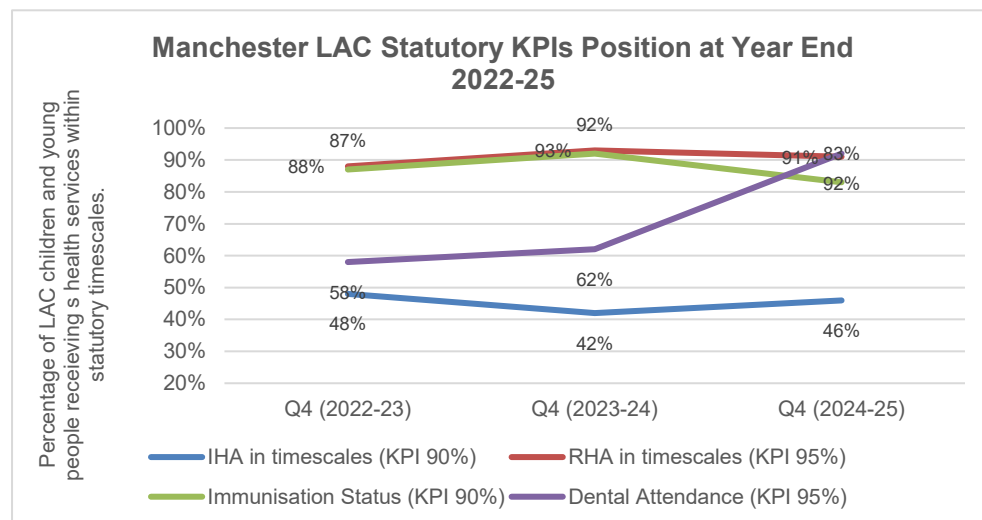
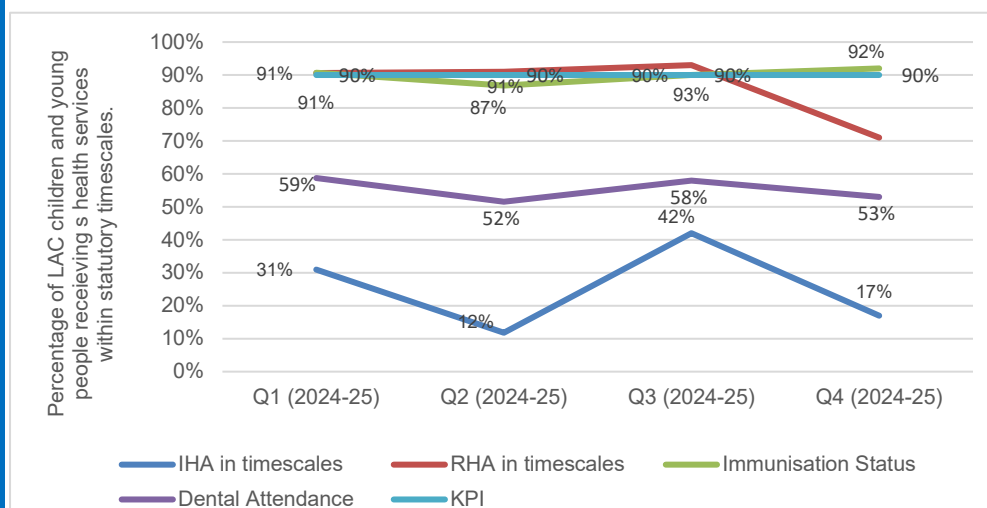


Figure 47: Manchester LAC Statutory KPIs Position at Year End 2022-25



²⁵ Statutory Guidance on Promoting the Health and Well-Being of Looked after Children 2015 accessed at <https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2>.

Figure 48: Trafford LAC Statutory KPIs Q1-Q4 (2024-25)



Performance in Manchester for meeting statutory health requirements is currently over 90% in all areas apart from initial health assessment (IHA), whilst in Trafford continued improvement is required to improve review health assessment, dental and review health assessment performance.

The LAC Subgroup has overseen the LAC improvement plan to increase the number of IHA completed within statutory timescales, this has involved extensive partnership working with CSC in Manchester and Trafford to overcome the primary barrier of achieving information and consent for the IHAs from CSC in time to complete the IHA in 20 working days. This risk is included on the safeguarding risk register. The trajectory of improvement is inconsistent in both Trafford and Manchester due to fluctuating numbers of children entering LA care and inconsistent timely information sharing from CSC. However, the LCO children's community services have made improvements to ensure there is capacity for paediatric consultants to complete IHAs within the 20-day timescales following a child entering LA care.

In addition, the following has been achieved for LAC.

- Care Leavers have consistently received a health summary prior to their 18th birthday. The LAC team have worked closely with multi-agency and MFT partners to implement learning from the MSP Care Leavers thematic review, which will be presented to TSG in Q1 2025-26.
- At the end of Q4 there were **251** unaccompanied asylum-seeking children (UASC) in Manchester and **62** in Trafford. UASC often present with complex health needs including trauma related symptoms. A specialist response to UASC is provided by MFT which includes targeted specialist IHA, RHA, health plans and care leaver summaries which are trauma informed and culturally sensitive. In December 2024, a conference was delivered by the Trust's LAC team on; 'Working together to support UASC in Manchester/Greater Manchester'. The event was attended by **77** health colleagues from across Greater Manchester.
- The LCO children's community services and LAC teams have prioritised hearing the voice of children and young people, this is documented in over **97%** of LAC health assessments in 2024-25. A newly developed patient experience questionnaire is being implemented in 2025-26. Co production with care leavers informed development of revised care leaver summaries.

18. Risk Register

There are **17** risks, being actively managed by the safeguarding team on the Trust Safeguarding Risk Register including **2** strategic risks, 9 corporate risks and 6 operational risks. The risk controls and actions are reviewed monthly by the Assistant Chief Nurse Safeguarding and are reported quarterly in the safeguarding quarterly report to TSG. All risk scores are 12 or below. Risks are related to.

- Provision of services for people with a mental health condition (7).

- MCA and DoLS application (2).
- Delivery of statutory responsibilities for LAC (3).
- Safeguarding training.
- Safeguarding supervision.
- CP-IS.
- Workforce capacity of acute safeguarding team and complex safeguarding team (2).

Clinical group safeguarding risks are included in AAA quarterly reports to TSG with mental health risks reported to the Mental Health subgroup who receive a quarterly risk profile for review and analysis.

19. Safeguarding Assurance and Accountability

19.1 External Assurance Mechanisms National Safeguarding Steering Group NHS Safeguarding Integrated Data Dashboard

From September 2024 the National Safeguarding Steering Group mandated NHS provider Trusts to complete the NHS Safeguarding Integrated Data Dashboard Data Quality Improvement dashboard²⁶ as part of the NHS Safeguarding accountability and assurance framework²⁷ (SAAF). This has been updated quarterly by the safeguarding team following reports to TSG, which inform on how MFT has been compliant in meeting the Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) and Prevent standards. To be fully compliance MFT was required to provide evidence for.

- **7** standards on MFT Prevent training compliance, with MFT meeting expected compliance in all standards.
- **28** Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT) standards of MFT having a policy, training and governance framework in the following 7 thematic areas, safeguarding leadership, training, recruitment and human resources, interagency working, implementation of Shared Learning, patient engagement and supervision. MFT met all required standards.

19.2 External Assurance Mechanisms Schedule 2.K NHS Greater Manchester Safeguarding Children, Young People and Adults at Risk Contractual Standards 2024-2025.

As part of the NHSE SAAF, MFT is required to complete an annual self-assessment of the Greater Manchester Safeguarding Children, Young People and Adults at Risk Contractual Standards and update this quarterly at contractual standards compliance meetings with the Manchester and Trafford's ICB designated safeguarding team.

- The Trust was fully compliant in **33** of 38 standards, noting that there was continuous improvement work in place to maintain compliance with all the standards.
- There were **0** standards rated as non-compliant.
- There are **5** areas of partial compliance requiring an improvement plan, these are indicated in **Figure 49** with progress to meet standard articulated in sections 8, 9, 12, 13 and 17 of this report.

Figure 49: Areas of Partial Compliance requiring an Improvement Plan

Safeguarding Training

- Standard 17 There is a training framework, which identifies safeguarding training levels for the workforce (both paid and voluntary staff) in line with the Intercollegiate Document for Safeguarding Children, Looked After Children, Adults at Risk, NHS Prevent Training and Competency Framework and Safer Recruitment training. The training framework must include how the provider will monitor effectiveness of safeguarding training and impact to staff and service users.

²⁶ National Safeguarding Steering Group NHS Safeguarding Integrated Data Dashboard Data Quality Improvement Plan (draft)

²⁷ [Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework](#)

Current position Safeguarding Training Framework in place and delivering expected standard in all areas except for safeguarding training at level 3, expected compliance rate of 90% not met 90-Improvement plan in place to increase compliance currently at 84% (section 13 of report).

- II. Standard 18 Staff who work with Adults and Children have completed MCA/DoLS training.

Current position Training Framework in place 85% of mapped workforce trained a delivering Improvement plan in place (section 9 and 13 of report).

- III. Standard 19 The provider must identify staff who may be required to use restrictive physical interventions with children or adults and ensure they have received specialist training which is compliant with Restraint Reduction Network (RRN) training standard 219.

Current position 658 colleagues have completed RRN training- Mental Health Improvement plan in place to have training needs analysis and improve compliance with training (section 12 of report).

- IV. Standard 27 There is a discharge policy, with accompanying pathways (including failed discharges). The discharge policy should be in line with the requirements set out within the MCA (2005).

Current position S.42 adult safeguarding enquires thematic learning need to review discharges from safeguarding perspective- Improvement plan in place (section 8 of report).

- V. Standard 29 There are systems in place for completing IHAs and Review Health Assessments (RHAs) for Looked After Children, to enable the organisation to demonstrate levels of compliance for the completion of IHAs and RHAs within statutory timescales.

Current position Performance for initial health assessments not meeting statutory timescales. Multi-agency improvement plan in place (section 17 of report).

19.3 Safeguarding Audit Programme

31 MFT safeguarding audits including 4 multi-agency audits were reported to the MFT Quality and Learning Subgroup and relevant safeguarding subgroup to ensure learning from the audit is shared across the Trust and action plans implemented.

Figure 50: Safeguarding Audit Completion

Audits	Audits completed	Key messages	Area for improvement
Safeguarding Children and the unborn Actions overseen by Quality and Learning Group and reported to Clinical Group Safeguarding Groups.	9 audits completed focused on: Child Protection Medical Examination and Documentation against RCPCH standards Attendance at Section 47 Strategy Meetings. Case Review Audit. Review of Safe discharge of children and young people where there is child protection concerns/ looked after. Safeguarding supervision audit Safeguarding Risk Assessment on Hive. ICON pathway within maternity services	Good evidence of close and effective working between the Paediatric Doctors, Safeguarding Children Nurses and community teams. High standard of safeguarding documentation noted. Good assurance of timely child protection strategy meetings and attendance from the Safeguarding Nursing Team and Paediatric Consultants. Evidence of good practice in caring for young people aged 16 and 17 years with complex mental health presentations with reviewing safeguarding risk and concerns Good assurance that the ICON pathway is embedded within maternity services in the acute and community settings. There is significant assurance that at the pink dot is present on HIVE when safeguarding assessments are completed on Hive.	Training to be completed with Paediatric team regarding RCPCH standards for Child Protection Medical. To promote consistent application of the Safeguarding Children and Young People Policy in the Unscheduled Care Departments. To support completion of actions following safeguarding supervision and uploading of supervision forms to EPR.
Looked after children Actions overseen by Quality and Learning Group and reported to LCO Safeguarding and LAC Group.	2 audits focusing on Dental Health of LAC LAC with a raised body mass index	Partial compliance of a child's BMI being reflected within their care plan- good range of advice was evidenced within the care plans relating to their BMI. Good evidence that cared for children under Trafford Local Authority are registered with a dentist. Limited assurance documented that a child was being seen by the dentist within the six-months of the recommended time.	To support completion of follow up of health actions between review health assessments. LAC Team to continue delivering training to Health Visitors and School Nurses within to highlight the importance of documenting the last dental check date.

Mental Health Actions overseen by Quality and Learning Group and reported to, Mental Health and Clinical Group Safeguarding Groups.	5 audits in Restrictive Interventions – colleagues understanding of MFT Policy. Audit of data from security on restrictive interventions and physical restraint MHA s.132 patients' rights MHA – Review of documentation. RCRP – Readiness check for implementation	90% of colleagues could articulate what may contribute to a patient's distress. Significant assurance that prevention and management of restrictive interventions policy applied. Monthly review of data identifies significant assurance rights applied in majority of detentions. Limited assurance (70%) on quality check that documentation completed in line with IHA. Initial audit limited assurance of workforce knowledge of RCRP but good assurance knowledge of what constitutes a high-risk missing patient.	Action to increase colleague's knowledge and confidence using the Brosset Violence Checklist in line with Trust policy through bespoke training and PBS training. Immediate escalation and action pathway in place to address inaccurate MHA documentation. MHA training is being delivered. Targeted training package and weekly missing patient incident review indicated significant improvement in workforces' application of Prevention and Management of missing patient incidents.
Safeguarding Adults Actions overseen by Quality and Learning Group and reported to Clinical Group Safeguarding Groups.	5 audits 3 audits Mental Capacity Act and DoLS application of policy. Domestic Violence and Abuse (DVA) – Quality of completion of Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklists DASH/RIC audit. Advocacy Audit	Limited assurance on workforces understanding on application of DoLS. Good assurance in relation to quality of DASH/RIC completion. Good assurance in relation to the role of the Independent Mental Capacity Advocate (IMCA) Colleagues awareness of Independent Mental Health Advocate (IMHA) required improvement	DoLS training programme and revised application process implemented. Revised DoLS guidance and policy being developed. Promotion of implementation of policy and guidance on advocacy arrangements in line with MHA
Learning Disability and Autism (LD&A) Actions overseen by Quality and Learning Group and reported to Clinical Group Safeguarding and LD&A Groups.	2 audits Workforces' knowledge and confidence in caring for patients with an LD/A. Review of flagging and documentation of reasonable adjustments on Hive.	Workforce had limited of what a learning disability is and how to document reasonable adjustments on Hive.	LD&A training programme including • Oliver McGowan training in place. • Bespoke training sessions to all wards, with limited assurance in audit Safeguarding LD&A continued support to inpatient areas with ward visits when completing Quality Care Checklists
Multi agency Actions overseen by Quality and Learning Group and reported to Clinical Group Safeguarding Groups.	MSP Core Group Audit MSP Children who have disabilities audit MSP Safeguarding Threshold Audit	MSP Core Group Audit found. • Effective collaboration from midwives and family teams. • Positive contribution attendance and recognition from midwives, • In 96% of cases colleagues were aware of their roles and responsibilities. MSP Children who have disabilities audit highlighted • Effective multiagency collaboration to safeguard children • Professional engagement in planning and decision making, • Evidence of family and child engagement.	Requirement to promote family involvement in core group meetings. Improvement work will focus on training professionals to understand and address the unique challenges faced by children with disabilities; ensuring a comprehensive package of support for families underpinned by Education and Health Care Plan that informs the multiagency plan. MSP Safeguarding Threshold Audit highlighted that further focused audit within Children's Social Care was required to monitor the distribution of strategy meeting minutes to ensure partner agencies are receiving them; to ensure the appropriate professionals are invited to Section 47 Child

	TSSP Neglect Audit	TSSP Neglect Audit evidenced voice of the child in all cases and all cases were child centred whilst still ensuring a Think Family Approach.	Protection multiagency strategy meetings. TSSP Neglect audit raised concerns about families understanding of safeguarding concerns and responsibilities- learning focused on embedding Graded Profile.

A total of 26 safeguarding audits are planned for 2025–26, including 12 focused on safeguarding children and unborn babies, 2 related to Looked After Children (LAC), and 12 safeguarding adult audits.

19.4 Clinical Group Annual Regulation 13 Self-Assessment

As part of oversight and governance, all Clinical Groups and the Research and Innovation team completed an annual self-assessment and scrutiny process, which they reported to the Deputy Chief Nursing Officer and the Assistant Chief Nurse for Safeguarding during an annual assurance meeting.

The self-assessment measures compliance against CQC Regulation 13 requirements²⁸, the NHS England Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework²⁹, legislation outlined in Section 11 of the Children Act 2004³⁰ and the Care Act Principles³¹ delivered through application of statutory guidance Working Together to Safeguard Children³² and Care and Support Statutory Guidance³³

Figure 51 indicates a summary of the headline findings of the self-assessment.

Figure 51: Safeguarding Audit Completion

Regulation 13 Self Assessments completed in all Clinical Groups Outcome		
What's Working Well	What Are We Worried About	Areas Requiring Safeguarding Support
Safeguarding governance meetings delivered in all Clinical Groups (CG), and all had assurance and oversight mechanisms of safeguarding activity.	Safeguarding training at level 3 requires improvement to meet 90% compliance standard.	Safeguarding team to continue to be available to support the frontline workforce.
The Trust wide safeguarding work programmes were evidenced to be delivered at the frontline.	78% CG identified increasing volume and complexity of safeguarding and mental health concerns.	Safeguarding supervision and safeguarding champions network to support frontline services.
Detailed self-assessments evidence CG were. - Responding to safeguarding concerns. - Working in partnership to safeguard people. - Making safeguarding personal.	34% identified thematic safeguarding concern around unsafe discharges.	Safeguarding bespoke training to continue to be delivered at the frontline line.

20. Conclusion

The annual report has evidenced that every day the workforce recognises and responds on average of **120** safeguarding concerns totalling **42,702** referrals to the safeguarding team in 2024-25.

²⁸ [CQC Regulation 13 requirements](#)

²⁹ [Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework](#)

³⁰ [Section 11 of the Children Act 2004](#)

³¹ [Care Act Principles](#)

³² [Working Together to Safeguard Children](#)

³³ [Care and Support Statutory Guidance](#)

The report has evidenced that through reporting arrangements, external and internal assurance mechanisms, the Trust has delivered statutory and regulatory safeguarding standards. There are action plans reported to TSG in all areas where improvement is required to continuously strengthen the Trust's safeguarding response in collaboration with system wide partners.

The delivery of the Trust's statutory and regulatory safeguarding responsibilities has been achieved through.

- **Governance and Oversight:** MFT has established robust governance structures, including safeguarding groups and reporting structures to the QSPBC and BOD to oversee MFT safeguarding activities and performance. In line with national guidance senior and named safeguarding leads have continued to promote, support and ensure compliance with statutory and regulatory requirements.
- **Training Programs:** MFT has implemented comprehensive training and supervision programmes for the workforce to enhance their understanding and skills in safeguarding, looked after children and caring for people with a LD&A or mental health condition. These programmes ensure that all staff members are well-equipped to identify and respond to safeguarding concerns. Safeguarding training compliance at level 3 requires improvement particularly in the medical and dental workforce. There are plans in place to improve compliance with safeguarding training in 2025-26.
- **Audits, internal and external assurance programmes:** 31 audits and internal and external NHS England and ICB assurance reporting mechanisms have been conducted to monitor, evaluate and provide assurance that safeguarding standards are met. These activities have identified areas for improvement to ensure continuous adherence and provide assurance that high standards of care and protection are delivered.
- **Interventions and Support:** MFT has undertaken various interventions to support individuals at risk through application of continuously reviewed suite of Trust 24 policies and guidance in safeguarding, mental health and learning disabilities. This includes providing timely and appropriate support to those in need, ensuring their safety and well-being.
- **Working in Partnership:** MFT has worked in partnership with Manchester and Trafford Safeguarding Partnerships to deliver national and local safeguarding messages and deliver local 6 safeguarding priorities, this has been coordinated through 26 partnership groups and the MFT 7 thematic safeguarding groups.
- **Feedback Systems:** MFT has established feedback systems through safeguarding governance structures and reporting to gather input from the workforce, patients, and other stakeholders. This feedback is used to improve safeguarding practices and address any concerns promptly.
- **Proactive Measures:** MFT has implemented strategic and operational proactive measures to prevent safeguarding issues through the safeguarding and LD&A work plans and the mental health improvement plan completing 31 of the 62 recommendations from the Mersey Care Peer Review in the Mental Health Improvement groups.

These key activities demonstrate MFT's commitment to maintaining high standards of care and protection, providing assurance and ensuring compliance with statutory and regulatory responsibilities.

In December 2024 the Chief Nursing Officer commissioned a Trust wide Safeguarding Review and the recommendations from this have been received and are being reviewed.

Priority areas for the safeguarding workplan are included in appendix A which has 13 objectives in 2025-26.

20.1 Key Priorities for 2025-26:

The safeguarding work programme is informed by the aims, pillars and commitments of the Trust Strategy 2024-29 “Where excellence Meets Compassion” and the Nursing Midwifery and Allied Health Professional Strategy “Professional Excellence Where Excellence Meets Compassion”. Safeguarding in MFT aims to provide high quality, safe care with excellent outcomes and experience.

In 2025- 26 working collaboratively with Clinical Groups and our safeguarding partnerships, we will.

- Deliver a safeguarding service, governance arrangements and work programme that incorporates the recommendations of the Safeguarding Review commissioned by the Interim Trust Deputy Chief Executive & Chief Nursing Officer in February 2025. The safeguarding work programme will be underpinned by the NMAHP strategy pillar that we value the provision of high quality, patient centred care that prioritises the wellbeing and satisfaction of our patients, their families and carers.
- Lead in delivering joined-up physical and mental health services for families, children and young people, working with partners to develop and deliver integrated plans. This will consider the legislative changes of the Mental Health Act reforms to equip our workforce to deliver our Mental Health Strategy and Mental Health Improvement plan in line with regulatory guidance.
- Invest in continuing education, learning and development, to support our workforce. We will ensure MFT colleagues have completed mandatory safeguarding level 3, mental health, Oliver McGowan and Positive Behavior Support least restrictive and restraint training to expected Trust standards.
- This will include delivery of the safeguarding training improvement plan focusing on medical and dental workforce completing level 3 safeguarding training to achieve 90% training compliance.
- We will deliver a programme of learning and improvement in response to safeguarding reviews, incidents and audit.
- Work with partners to help people live longer, healthier lives and further develop engagement and communication opportunities, to work collaboratively across our local communities to safeguard people. Priority workstreams for our system wide workstreams will include.
 - Support and challenge with the Local Authority to complete Deprivation of Liberty Safeguards (DoLS) authorizations within required statutory timeframes.
 - Partnership working to deliver statutory responsibilities to meet the health and wellbeing of Looked After Children (LAC) with multi-agency partners.
 - Working in partnership with Local Authority colleagues to deliver the system wide implications of Children’s Social Care Reforms including engagement in the delivery of the Families First Programme (FFP)³⁴ in Manchester and Trafford.
 - Delivering the Manchester Safeguarding Partnership priority to tackle neglect through a training and improvement programme reported to Trust Safeguarding Group.
- We will continue to develop our digital skills across the workforce to support data confidence and new emerging technologies. We will review our digital reporting systems to optimise data collection and reporting of safeguarding priorities focusing on the MFT response to tackle neglect and implementation of the NHSE led Child Protection Information Sharing Phase 2 project.
- Make safeguarding personal and ensure we hear the voice of the person, who will be central to safeguarding practice in the Trust. We will communicate listen and provide patient centred care, safeguarding our families and communities with dignity and respect.

³⁴ Families First Programme accessed at <https://www.gov.uk/government/publications/families-first-partnership-programme>.

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 specialized 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	Strengthening 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 – Safeguarding Work Plan Objectives

1. Making Safeguarding Personal	
Objective	Making Safeguarding Personal (Voice of the Adult at Risk) Voice of the Child A culture of listening and hearing the voice of children and adults at risk and their families, taking account of their wishes and feelings both in individual decisions and the development of services. Professional curiosity – talking to patients/citizens.
2. Adult Safeguarding	
Underpinned by the 6 principles of the Care Act 2014 along with CQC Regulation 13 requirements. Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability	
Objective	Keeping people safe There are systems and processes in place to enable staff to recognise and respond to the needs of adults at risk adults to safeguard them from abuse and neglect.
3. Safeguarding Children	
As outlined in Section 11 of the Children Act 2004 and CQC Regulation 13	
Objective	Keeping children safe There are processes in place to ensure the needs of the child are prioritised and that the Trust and the Clinical Groups are committed to prioritising the protection of children in all work streams. Safeguarding children practice is in line with Working Together to Safeguard Children Statutory (2023) guidance.
4. Staff have access to supervision and support to safeguard people	
Objective	Supervision and support To ensure staff are supported when dealing with difficult and complex safeguarding cases.
5. Mandatory Adult and Children's Safeguarding Training	
Objective	Safeguarding training should achieve Trust Compliance levels of 90% To ensure we meet our statutory requirements for children's safeguarding training as outlined in Section 11 of the Children Act 2004, and statutory guidance in Working Together 2023 and the Care Act 2014.
6. Looked after Children (Our Children/Children in Care and Care Leavers)	
Objective	To safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people and care leavers as outlined in Looked After Children: roles and responsibilities of healthcare staff (2020) and statutory guidance in promoting the health and wellbeing of Looked After Children (2015). Nice guidelines on Looked-after children and young people 2021.
7. Application of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is appropriate and proportionate across the Trust	
Objective	Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) All relevant members of staff understand and apply the principles of the Mental Capacity Act 2005 in all areas of care. There is clear understanding and oversight of Deprivation of Liberty Safeguards.

8. Raising Concerns/Managing Allegations for People in Positions of Trust working with unborn, children and families and adults at risk

Objective	Raising Concerns/Managing Allegations There is a culture whereby patients and relatives can raise concerns. Evidence of making safeguarding personal in all responses to concerns raised. If an allegation is made against a member of staff, all staff involved are aware of the processes to be followed.

9. Complex and Wider Safeguarding

Objective	Complex and wider Safeguarding Agenda Staff contribute to the wider safeguarding agenda, and they know how to escalate concerns in respect of responding to the needs of vulnerable groups. This includes – • Domestic Violence and Abuse (DV&A) • Child Sexual Exploitation (CSE) and Criminal Exploitation (CCE) including serious violence. • Neglect/Self Neglect • Forced Marriage & Honour Based Violence (FM & HBV) • Female Genital Mutilation (FGM) • Human Trafficking & Modern Slavery • Mental Health

10. Safeguarding in the Context of a Citizen with Mental Health needs

Underpinned by the 6 principles of the Care Act 2014 Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability, Children Act 1989 and 2004, CQC Regulation 13 requirements. The Mental health Act (1983) and the Mental Capacity Act (2005)

Objective	Caring for people with a mental health condition There are systems and processes in place to enable staff to recognise and respond to the needs of people with. a mental health condition. This includes delivery of Mental Health Strategy Plan, Mersey Care Mental Health Peer Review Recommendations, Mental Health Act reforms, Right Care Right Person through the Mental Health Improvement Plan,

11. Safeguarding in the Context of a Citizen living with a Learning Disability and or Autism

Underpinned by the 6 principles of the Care Act 2014 Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability, Children Act 1989 and 2004, CQC Regulation 13 requirements. The Mental health Act (1983) and the Mental Capacity Act (2005)

Objective	Caring for people living with a learning disability/Autism There are systems and processes in place to enable staff to recognise and respond to the needs of people with a learning disability and/or autism. Delivery of Learning Disability and Autism Strategy- Our plan for people with learning disabilities and/or autism, their families, and carers 2022–2025.

12. Documentation

As outlined in Section 11 of the Children Act 2004 and CQC Regulation 13

Objective	Accountability/Accessing information /Documentation. Management oversight and ownership of safeguarding in the clinical groups. Frontline staff are aware of their role responsibility and accountability and where to access appropriate information. Staff adhere to Trust, legal and Professional Body documentation requirements. Digital systems support application of safeguarding policy.

13. Working Together

Objective	Partnership Working/ Information Sharing Staff work with other agencies to ensure the safety and protection of adults and children at risk. Talking Together is a safeguarding priority. Delivery of Children's Services Reforms including Families First Programme and phase 2 of Child Protection Information Sharing Programme.

Public Board of Directors

Wednesday 30th July 2025

Paper title:	MFT Annual Complaints Report 2024/25	Agenda Item 11.3
Presented by:	Kimberley Salmon-Jamieson, Interim Deputy Chief Executive & Chief Nursing Officer	
Prepared by:	Niall Bancroft, Customer Services Manager Deborah Carter, Director of Safety and Quality	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee Professional Board	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

- During 2024/25, the Trust received 8,517 contacts into the Patient Advice and Liaison Service (PALS); this represents a 5% decrease from the 8,964 received in 2023/24.
- The Trust received 1,975 complaints during 2024/25; a 6% decrease from the 2,107 received in 2023/24.
- 23% (452) of complaints were '*upheld*', 55% (1071) were '*partially upheld*' and 22% (424) were '*not upheld*' based on the Parliamentary Health Service Ombudsman (PHSO) classification).
- 100% of the complaints were acknowledged within three working days. 89% of complaints were responded to within the agreed timescale and 94% of PALS cases were resolved within 10 working days. All of these represent a significant improvement when compared to these performance metrics in last year's report.
- During 2024/25, the PHSO confirmed they had opened new investigations into 15 MFT complaints. The PHSO also confirmed they had completed 10 investigations into MFT complaints, of which 1 was '*upheld*', 7 were '*partially upheld*', 2 were '*not upheld*'.
- Improvement work has continued throughout the year, with a focus on optimising learning from complaints.
- Complaints Review Scrutiny Group is now under the leadership of the Chief Nursing Officer, for additional scrutiny and oversight and the leadership team has implemented a rapid review process for complaints received by the Chief Executive, to ensure immediate attention and action.
- PALS and Complaints management strengthened the data collection of Equality and Diversity Information and implemented changes to improve the accessibility of service, to best meet the needs of patients and families.
- Improvement work and process changes shared with Governors and Members as part of their oversight programme.
- KPMG audit of MFT complaints handling found there was significant assurance, with minor improvement opportunities, and was assured by the appropriately designed controls in place.

Recommendations

The Board of Directors is asked to:

- Understand the performance achieved via the PALS and Complaints processes.
- Recognise the continuous improvement work of the Central PALS and Complaints Department and Clinical Group teams, to ensure that MFT is responsive to concerns and complaints to meet regulatory compliance.
- Support the approach to promote MFT wide learning from complaints and PALS.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

☒ **Yes**
☐ **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/001664 – to ensure timely and appropriate acknowledgement and response to complaints

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 16: Receiving and acting on complaints
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- PHSO NHS Complaint Standards

Main report

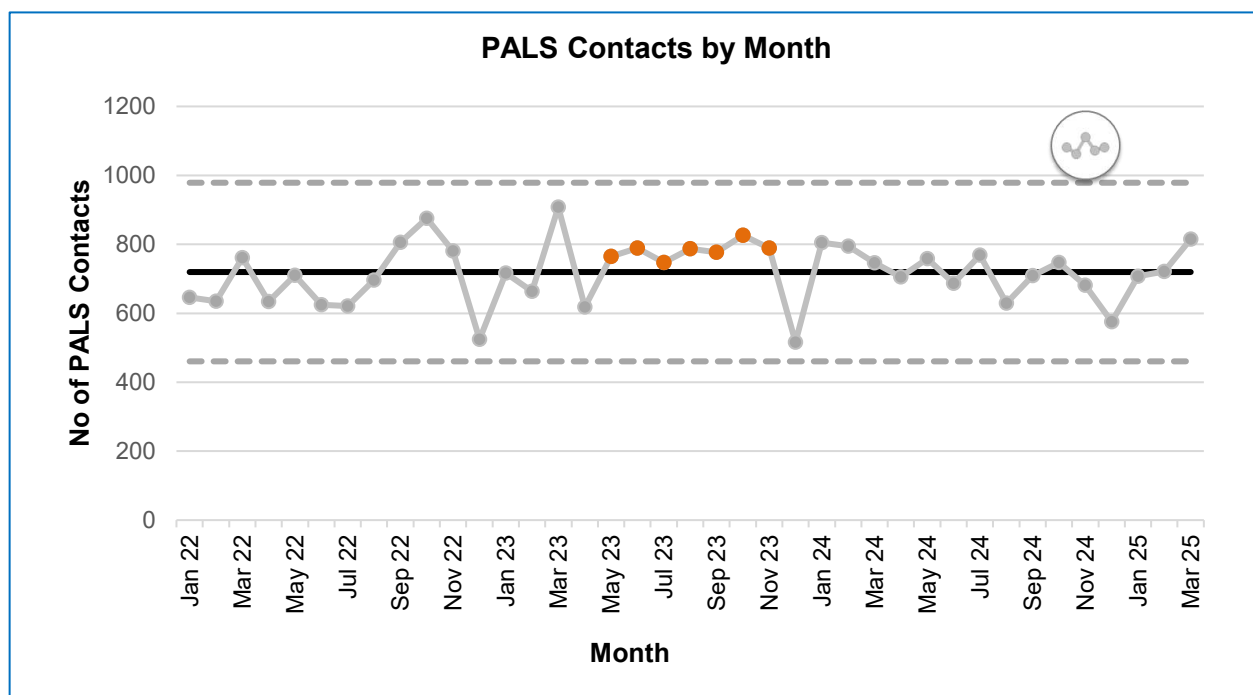
1. Introduction

1.1 Manchester University NHS Foundation Trust's (MFT) Patient Advice and Liaison Service (PALS) and Complaints Team ensure effective complaints handling and monitoring to meet the national regulatory requirements. The team support the operational teams to ensure that learning from

complaints and PALS is used to triangulate with data from other sources in order to improve services for the people who use them, as well as for colleagues working in them.

2. An overview and thematic analysis of PALS contacts

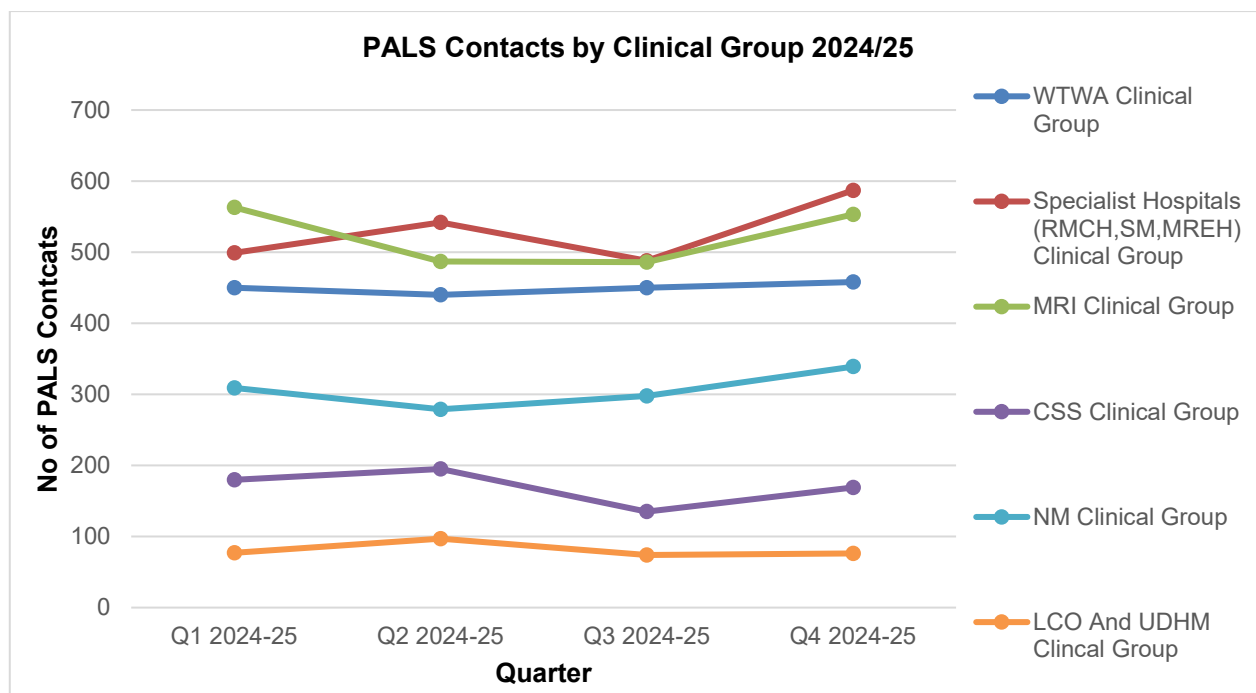
2.1 There was a 5% decrease in PALS contacts in 2024/25, with 8,517 received compared to the 8,964 received in 2023/24. **Graph 1** shows the number of PALS contacts by month, with the most months in 2024/25 receiving fewer than the historic average of contacts in PALS. This marks an improvement from 2023/24, when most months experienced a higher number of contacts than average (highlighted on the graph).



Graph 1: PALS Contacts by Month

2.2 The decrease in PALS contacts throughout the year is partially attributable to a reduction in the number of contacts relating to delays in reporting scans. This is a positive outcome from the actions put in place within the Clinical Scientific Services (CSS) Clinical Group to improve the timeliness in reporting of radiology examinations.

2.3 The PALS Team has also engaged with colleagues from across the Trust with early/local resolution training sessions. These sessions empower and support clinical and operational individuals and teams to resolve concerns locally, to the patient's/family's satisfaction. An element of this training focuses on reducing the practice of signposting people directly to PALS, through staff taking the opportunity to first actively listen and compassionately engage with patients, relatives and carers.

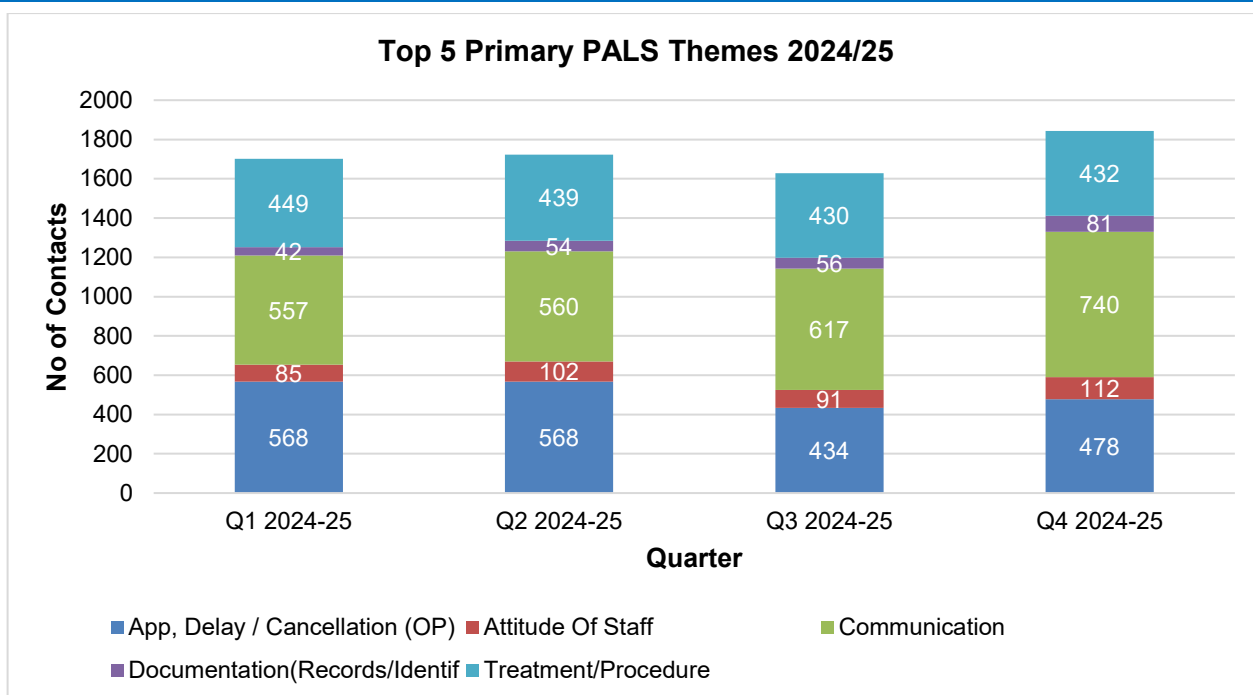


Graph 2: PALS Contacts Received by Clinical Group 2024/25

2.4 **Graph 2** shows the number of PALS contacts received by each Clinical Group per quarter. The Specialist Hospitals Clinical Group, received the greatest number of PALS contacts, receiving 2116, followed by Manchester Royal Infirmary (MRI) Clinical Group with 2089.

2.5 **Graph 3** shows the distribution of the top five PALS themes (more than one theme is recorded for each contact where appropriate), with the greatest proportion of PALS concerns in 2024/25 relating to 'Communication', particularly regarding 'Staff Communication with Patients and Relatives'. The largest proportion of concerns and complaints were regarding communication between administrative staff and patients and relatives relating to outpatient appointments.

2.6 Work is already underway to improve communications to patients regarding appointments, with the 'MFT Digital First Appointment Details for All Project', with concerns and complaints included as a monitoring tool to assess the impact of this, throughout 2025/26. The Trust has also implemented a Waiting Safely improvement project, which proactively support patients on waiting lists by providing wellbeing resources and focuses on improving communication with patients.



Graph 3: Top 5 Primary PALS Themes 2024/25

3. PALS responsiveness and key performance indicators (KPI)

3.1 The PALS Team deliver a timely service to patients and their representatives, with 94% of PALS cases resolved within 10 working days during 2024/25. This a continuance of PALS consistently achieving >90% compliance with the Trust response deadlines for the past two years.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total
Total resolved	2191	2118	2063	2150	8522
% resolved within 10 working days	94%	94%	93%	93%	94%

Table 1: Percentage of PALS cases resolved within 10 working days 2024/25

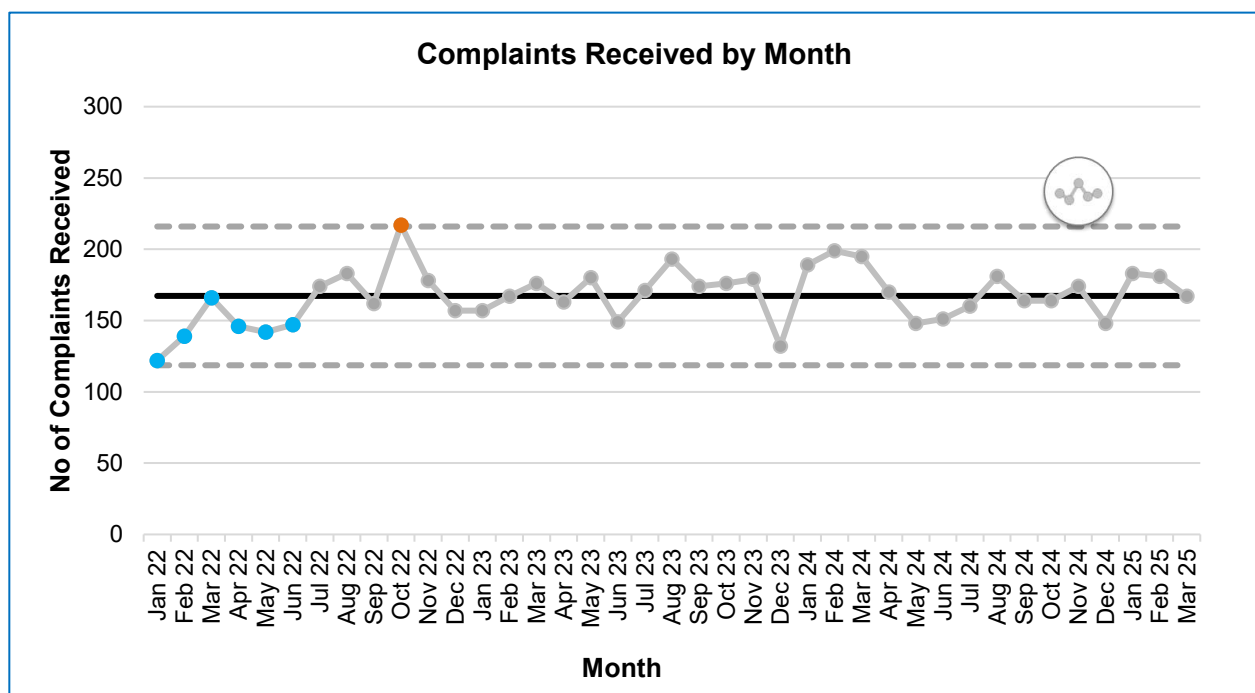
3.2 **Table 2** shows the number of PALS cases that were escalated to formal complaints and vice-versa. There has been a continued focus on achieving early resolution of concerns to improve the process and satisfaction outcomes for both patients and staff. The data evidences a reduction in the number of cases escalated from PALS to complaints compared to 2023/24 and demonstrates a sustained higher proportion of cases managed successfully through PALS, to support a real or near time response to concerns raised and positive outcome for patients.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total
Number of PALS cases escalated to complaints	23	51	41	34	149
Number of complaints de-escalated to PALS	114	104	124	110	452

Table 2: Number of PALS cases escalated to complaints and complaints de-escalated to PALS concerns 2024/25

4. An overview and thematic analysis of complaints

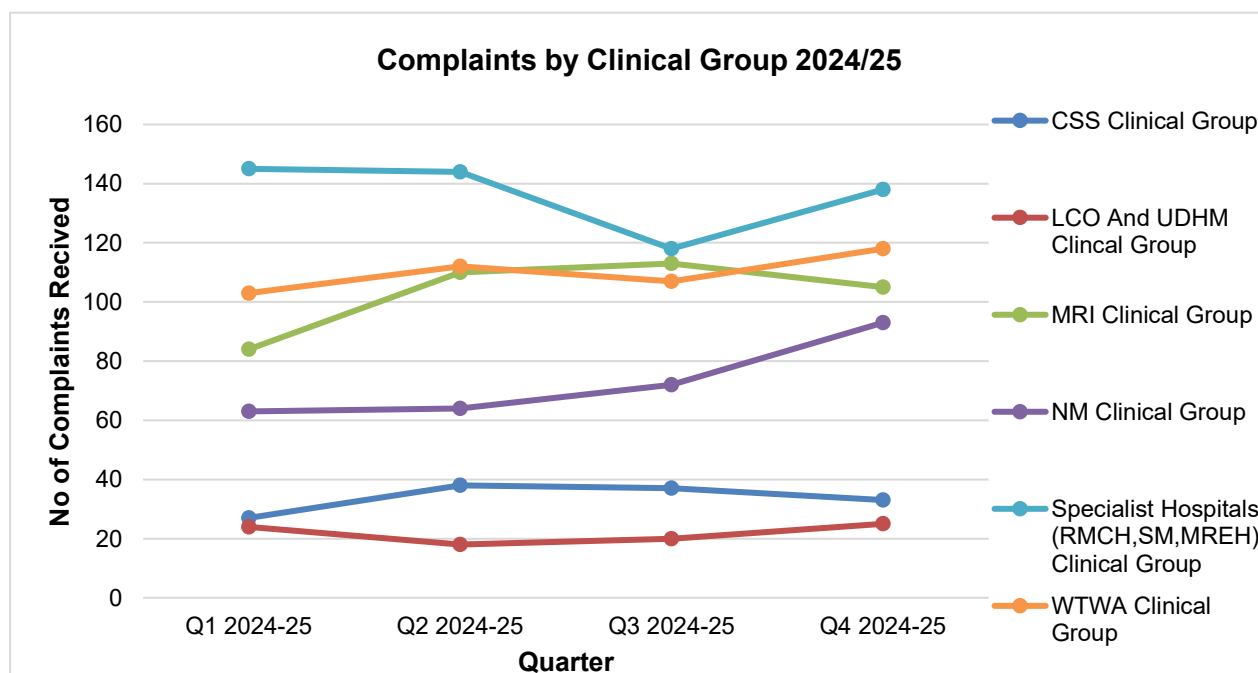
4.1 There was a 6% decrease in complaints received during 2024/25, with 1,975 new complaints received compared to the 2,107 received during 2023/24. **Graph 4** shows the number of complaints received per month.



Graph 4: Complaints Received by Month

4.2 The reduction in complaints is very positive as it is mainly driven by a decrease in concerns related to 'Appointment Delays/Cancellations', which correlates with the work that has been done as part of the Trust's updated Elective Access Policy.

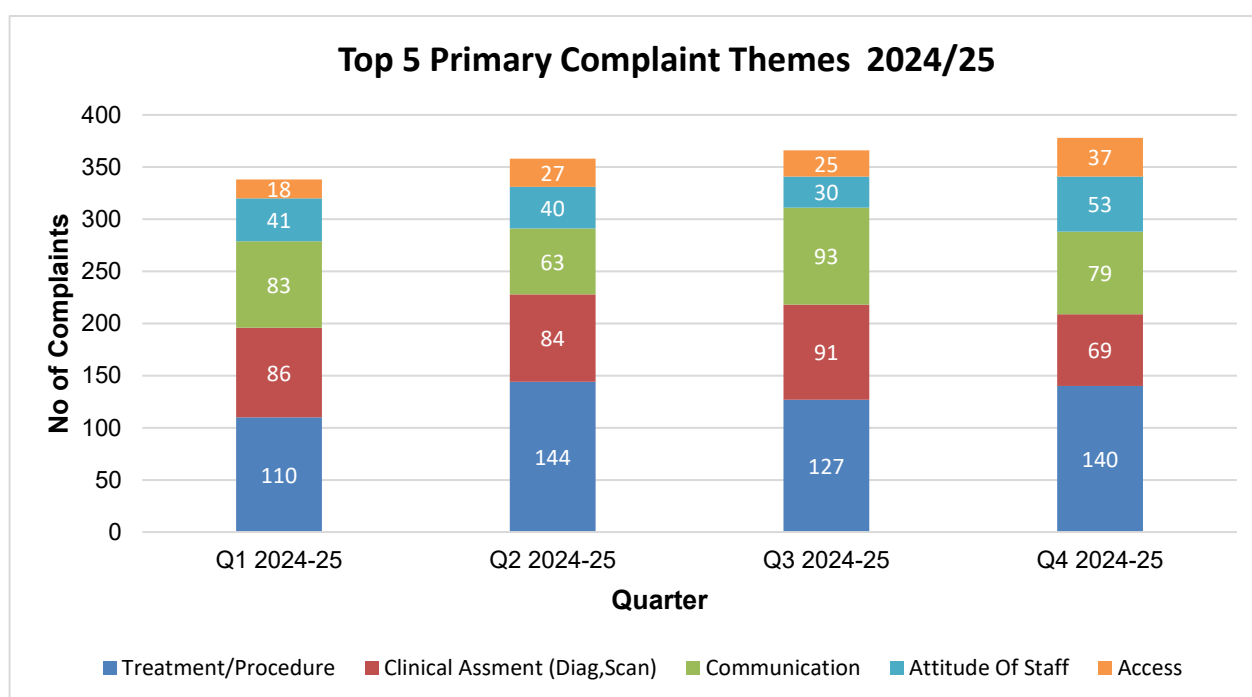
4.3 **Graph 5** shows the number of complaints received by each Clinical Group. The Specialist Services Clinical Group received the greatest number of complaints (545), followed by WTWA Clinical Group (440).



Graph 5: New Complaints Received by Clinical Group 2024/25

4.4 'Treatment/Procedure' was the top theme of complaints in 2024/25, followed by 'Clinical Assessment (Diagnostics/Scans)' and 'Communication'. **Graph 6** shows that these were consistently the top three complaint themes, throughout the year at MFT and noting the alignment with the top three national complaint categories.

4.5 As noted above, there has been a marked reduction in complaints relating to 'Appointments Delays/Cancellations', with that theme no longer being in the top 5 for MFT. There was an increase in the number of complaints related to 'Attitude of Staff'. To support this, the Trust is encouraging colleagues to attend the Civility Saves Lives training and the 'Sage and Thyme' customer service and communication skills training sessions. PALS and Complaints Management are also collaborating with the Corporate Lead Nurses for Workforce, to deliver PALS and customer service training at NMAHP leadership and development days and at ward and departmental level. This training focuses on compassionate engagement with patients and families, as well as de-escalation of challenging situations. Further training and engagement work is planned, throughout 2025/26, with a focus on supporting clinical and administrative staff in this area.



Graph 6: Top Primary Complaint Themes 2024/25

4.6 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 3** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2024/25 compared to previous years.

4.7 The Trust has seen a decrease in complaints across both inpatient and outpatient services, and its Emergency (ED) Departments. This is despite the number of inpatient episodes and ED attendances increasing.

		2021/22	2022/23	2023/24	2024/25
Inpatient	Formal Complaints Received (FC)	531	624	632	623
	Episodes of Care	455,841	450,081	415,093	438,949
	Rate of FCs per 1000 Episodes of Care	1.16	1.39	1.52	1.42
Outpatient	Formal Complaints Received (FC)	665	919	1062	861
	Number of Appointments	1,470,442	1,854,418	2,644,348	2,316,684

	Rate of FCs per 1000 Appointments	0.45	0.50	0.40	0.37
ED	Formal Complaints Received (FC)	270	314	315	311
	Number of Attendances	482,908	483,880	515,260	524,396
	Rate of FCs per 1000 attendances	0.55	0.65	0.61	0.59

Table 3: Number of complaints received by patient activity 2021/22 – 2024/25

5. Complaint responsiveness and key performance indicators (KPI)

5.1 Under the NHS Complaints Regulations (2009), there is a requirement that all new complaints are acknowledged within three working days of receipt of the complaint; MFT is committed to achieving this in 100% of cases. This indicator was met during 2024/25, with all complaints acknowledged on time.

5.2 Against the Trust's standard of 90%, the Trust achieved closure of 89% of complaints within the agreed timescale during 2024/25. A number of changes were embedded during Q1 and sustained improvement has been achieved throughout the rest of the year, as seen in **Table 4**. The aim is to continue to see an increase in compliance with further improvements being achieved throughout 2025/26.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Total resolved	500	482	474	491
Total resolved in timescale	403	431	431	458
% resolved in agreed timescale	81%	89 %	91%	93%

Table 4: Number and percentage of complaints resolved by timeframe 2024/25

5.3 **Table 5** details the breakdown of complaints closed within the agreed timescale by Clinical Group. Good and sustained improvement has been achieved in MRI. To address the lower compliance achieved within Specialist Hospitals Clinical Group, the Clinical Governance Teams are providing additional bespoke support to the Divisions of Paediatric Surgery and Gynaecology, with escalations to the Clinical Group Senior Leadership Team (SLT) including additional KPI meetings with areas as required. Further work in the coming months will focus on early interventions and escalation where any challenges are anticipated.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
CSS	97%	100%	100%	97%
LCO and UDHM	88%	96%	96%	100%
MRI	66%	83%	97%	96%
NM	98%	97%	95%	97%
Specialist Hospitals	62%	80%	74%	81%
WTWA	100%	100%	100%	99%

Table 5: Comparison of complaints resolved by timeframe by Clinical Group 2024/25

6. Complaint outcomes

6.1 Complaints often relate to more than one issue. In line with the expectations of the NHS complaints standards, if concerns are identified in all the issues raised and substantive evidence is identified to support the complaint then it is recorded as 'upheld'. If concerns are found in one or more of the issues, and not all, the complaint is recorded as 'partially upheld'. Where there is no evidence to support any aspects of the complaint made, it is recorded as 'not upheld'.

6.2 During 2024/25, 23% (452) of complaints were 'upheld', 55% (1071) were 'partially upheld' and 22% (424) were 'not upheld'. This represents a large increase in the number of complaints 'upheld', from the previous year (12% in 2023/24).

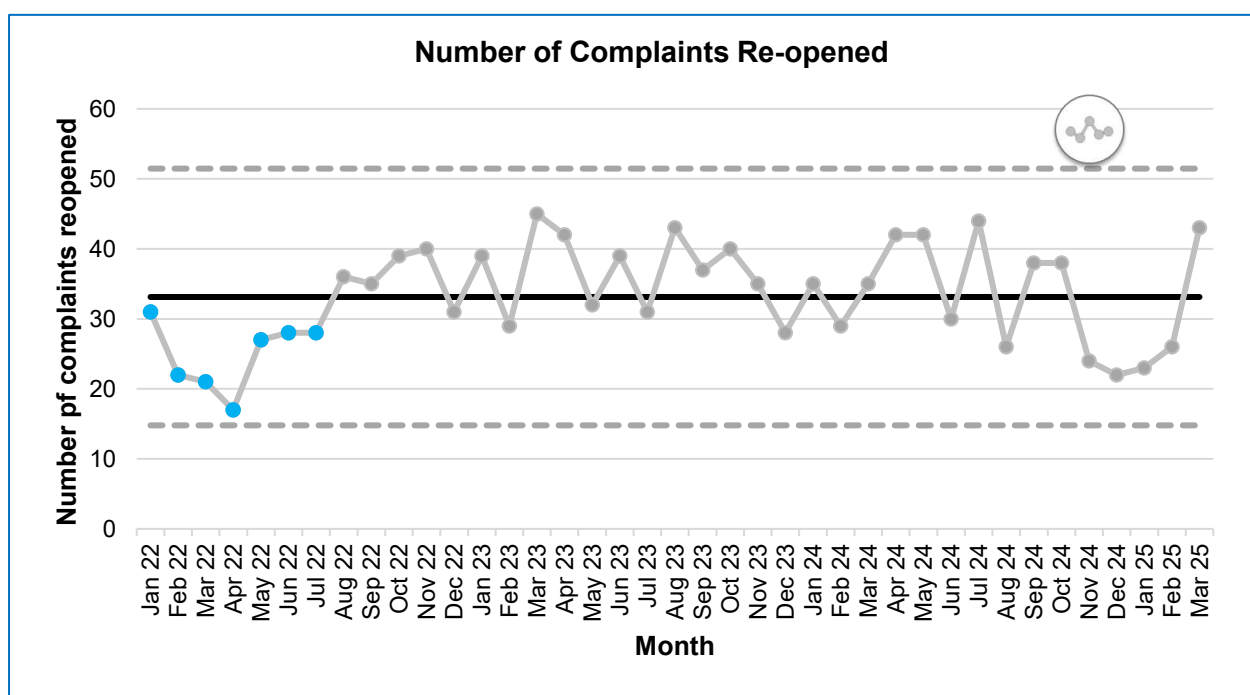
7. Re-opened Complaints

7.1 **Graph 7** demonstrates the number of complaints which were re-opened (which currently includes the request for a meeting). The number of re-opened complaints is used as an indicator to measure the quality of the initial response.

7.2 During 2024/25, 17% of complaints were reopened, against the Trust tolerance threshold of 20%, which is the same proportion as the previous year. The main reason for complaints being re-opened, however, was due to new questions being raised which is not a direct reflection on the quality of the initial response. This marks a positive change from 2023/24, when the majority of complaints were re-opened due to the response letter not addressing all issues raised. Further focus will be applied to this area in the coming year.

7.3 Improvements have been supported through the complaint investigation and response writing training sessions, delivered by the Complaints Team management to hundreds of staff across the Trust. These sessions aim to equip staff, who investigate complaints, with the skills and knowledge required to conduct thorough investigations and write clear and easy to understand complaint responses in a compassionate manner, to ensure complaints are resolved first time.

7.4 There is a continued drive to offer more local resolution meetings when complaints are first received. These meetings enable staff to meet with patients, relatives and carers, to hear and discuss their concerns offer apologies and share the findings and learnings from the investigations either in person or virtually.



Graph 7: Number of Re-opened Complaints

8. Lessons learned from complaints

8.1 Patient complaints offer opportunities for both learning and improvement that can be used to change practice and improve patient experience and outcomes. Each Clinical Group holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. In addition to this, the Complaints Review Scrutiny Group (CRSG), chaired by the Assistant Chief Nurse, Quality and Patient Experience and supported by a nominated Non-Executive Director and Governor, met on 12 occasions during 2024/25 reviewing 20 complaints in total. The extract below * provides examples of learning from complaints and the changes applied to practice.

8.2 The terms of reference for CRSG have been refreshed and strengthened, in collaboration with the Chief Nursing Officer and Non-Executive Director, to refocus the purpose of the meeting to increase learning from complaints across MFT and to provide more senior leadership scrutiny. During 2025/26 CRSG will include representation from members of the Clinical Group SLTs. This will focus on the Clinical Group Complaints and PALS dashboards which scrutinise the number of complaints and PALS, compliance with response times, re-opened complaints and PHSO escalations and the quality of complaint responses with a focus on identifying organisational learning through the triangulation of complaints data and themes. The CRSG will be reviewed in six months, to assess effectiveness and share learning.

*Examples of Learning from Complaints

You said...	We did...
Concerns regarding poor discharge process and patient discharged with another patient's medication.	Medical ward round in the morning to include specific instructions to prepare patients for discharge appropriately, including the removal of any invasive lines, and completing medical discharge notes. The senior nursing team in the clinical area utilised huddles and team meetings to engage staff in discussion in relation to the need for bed space cleaning and emptying of medicine boxes post discharge/transfer of patients. Quality improvement project to ensure a robust system is in place for patient transfer and discharge from the ward. Checklist produced to ensure all tasks are completed prior to transfer/discharge from the ward. Daily audits and spot check audits to ensure safe storage of medicines.
There was a delay on the day of discharge, due to waiting for take home medication	Pharmacist and coordinating nurse to ensure early escalation for TTO (medications to take out for discharge), to allow for adequate medication preparation time and to prevent discharging without TTOs. Discharge and medication process discussed at ward meetings and daily safety huddles, with ward staff and Pharmacist also in attendance. There is currently a Trustwide workstream looking at how systems and processes can be improved to facilitate safe and effective discharge home, including that of TTOs.

Staff were unsympathetic when a patient with disabilities attended their scheduled appointment but rescheduled due to illness, Staff also marked the patient as a "Did Not Attend".	Refresher training on the Trust's Access Policy, in particular about the appropriate coding of appointments, was arranged for all department administration staff. Staff were engaged in understanding the importance of supporting reasonable adjustments and respecting patient choice.
Concerns regarding end-of-life care, and lack of face-to-face palliative care provision.	The Palliative Care team, supported by the Head of Nursing for Palliative and End of Life Care, are delivering a programme of education to enhance the knowledge and skills of staff in delivering end-of-life care. This end-of-life care 'champion' programme began in September 2024 and will provide essential training in relation to end-of-life care and provide the necessary training materials for the champions to cascade information back in their clinical area. The department will complete a quality improvement programme to ensure that all staff are compliant with acute illness management training and the mandatory training acute care management module. All ward areas to identify a member of the team to become an End-of-Life Champion to share education and provide support to team members, patients and relatives. Topic of effective, caring, compassionate communication and clear and concise documentation shared with all members of the team through "Themes of the Week" programme delivered to staff at twice daily patient safety huddles and handovers. To reduce health inequalities the senior nursing team educated the staff in relation to providing patients with appropriate interpretation services to support informed decision making and discussion.
A patient's nutrition and hydration needs were not met, whilst they were an inpatient on a ward.	The Ward Manager undertakes regular audits of the MUST (Malnutrition Universal Screening Tool) to ensure patients' usual weight is captured to ensure the correct MUST score is calculated. The audit also ensures patients with a MUST score of 2 or more are referred to the Dietician. A Trustwide nutrition and hydration and food improvement group is in place to identify and implement improvements across the Trust and improve patient experience of care.
There was a complication from a Ferinject infusion.	A new patient information leaflet, on iron infusions, was co-produced in collaboration with the Maternity and Neonatal Voice Partnership, with all patients to receive a leaflet, prior to administration of Ferinject. Lead consultant has provided feedback to the Obstetric Team to ensure communication and information is provided to patients requiring Ferinject and confirmation of patient understanding is clearly documented at the point of consenting to the infusion.
Patient pain management and onward referrals were not managed effectively.	Department to ensure that patients' referral to treatment time (RTT) pathway is not stopped, when they are referred to the pain team for optimisation, to prevent any delays to their surgery date. Direct instructions, with regards to additional pain

	management, to be clearly provided in clinic outcome letters to GPs.
A patient had to wait for four hours for a neck strap whilst in triage and had to lay down on the bed.	A review was commissioned of the training needs for all Paediatric Emergency Department nursing staff, in relation to triage. Additional triage audits have been undertaken, and one-to-one educational support has been provided, as required.
There was a delay in treatment for a patient experiencing urinary retention, due to the lack of bladder scanners.	12 new bladder scanners have been purchased and there is a supporting training programme to ensure that staff are competent and able to use the new machines.
There were long waits for results from colonoscopies.	The Histopathology Department is recruiting to vacancies within the Consultant Histopathologist Team to support a reduction in the number of cases that need to be sent to external services. This feedback provided an opportunity to review current cover arrangements between teams and work together to overcome challenges to service delivery. As a result of this an office staff contingency plan between the two Histopathology offices has been created. This will allow the department to utilise the wider administrative and clerical staffing to support when one office experiences staff shortages. This resilience plan will ensure timely upload of externally reported cases and prevent the delays experienced.
Care plans were stored in more than one location and were not accurately shared with the patient's school.	A Standard Operating Procedure has been developed, so that all members of the team can follow the correct process, including communication to parents. The process of storing care plans on shared drives will be stopped and all information contained in the shared drives will be reviewed. An audit will then take place, to ensure this is maintained. Care plans and training needs were added as a standing item for team meetings to ensure that all staff are aware of the correct processes and individual training needs identified for staff have been addressed, with all staff now aware of the correct processes
There was a lack of information provided regarding eligibility for IVF funding.	A fertility information leaflet is to be given to patients attending their initial investigations, which will include a link to the Greater Manchester Integrated Care Board (ICB) Assisted Conception Policy.

9. Parliamentary Health Service Ombudsman (PHSO)

9.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK Government departments. The PHSO considers and reviews complaints, when someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

9.2 During 2024/25, the PHSO opened new investigations into 15 MFT complaints. The PHSO informed the Trust of 10 completed investigations into MFT complaints, of which 1 was 'upheld', 7 were 'partially upheld', 2 were 'not upheld'.

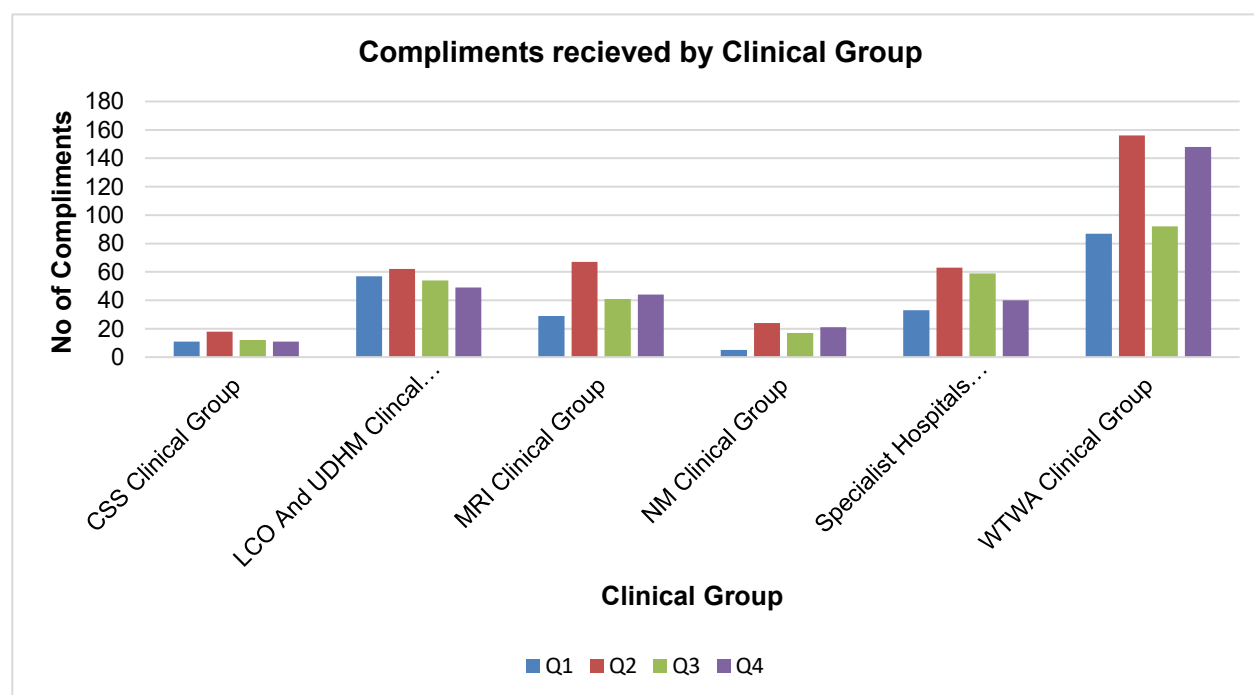
9.3 In addition to the completed investigations, the Trust successfully liaised with the PHSO and patients/families to resolve cases through early resolution and the PHSO determined that no further investigations were required for many of the cases it initially reviewed, as it was assured that MFT had handled the complaints appropriately in line with the regulations and standards.

10. Compliments

10.1 Compliments received from members of the public provide valuable feedback and the opportunity to learn from positive experiences. The Customer Services Manager and Patient Experience Manager review compliments, alongside positive patient experience feedback, and are making improvements to how compliments are recorded. This will enable thematic analysis of positive feedback, which will provide greater opportunities to identify wider learning from good practice to drive Trustwide quality improvement initiatives.

10.2 **Graph 9** shows the number of compliments, received from members of the public about MFT Clinical Groups, recorded on the Trust's Customer Services Database during 2024/25. WTWA Clinical Group recorded the most compliments (483).

10.3 To make it easier for people to share compliments and positive experiences with staff, the Customer Services Manager has worked with the Communications Team to develop an online compliments form, which will enable people to submit compliments directly through the MFT website.



Graph 8: MFT compliments received by Clinical Group 2024/25

11. Equality and Diversity Monitoring Information

11.1 The Trust is committed to collecting data from complaints relating to Equality Diversity and Inclusion (EDI) to ensure all patients and representatives are supported and have equal access to providing feedback on services, which is shown in the table in **Appendix 1**. Fundamental to this is the provision of an accessible PALS and Complaints service.

11.2 The PALS and Complaints Department made 'Health Inequalities' the theme of their Customer Service Week, in 2024. This focussed on improving access to provide feedback for people with disabilities or in different languages. PALS are also exploring options to increase the ways children and young people can raise concerns about their own care and experience.

11.3 PALS and Complaints colleagues have worked with patient, families and carers through established Trust groups and focus group sessions in the community, to coproduce new PALS and Complaints posters and leaflets. The new literature is available in different and more accessible formats, as well as multiple languages, and is being distributed to all wards, departments and services across the Trust.

11.4 A new British Sign Language (BSL) PALS information video has also been developed, which will be played on patient-facing screens in MFT hospitals and will be available on the MFT website. In addition to this, PALS and Complaints colleagues work closely with the Interpretation and Translation Service (ITS), to ensure that interpreters are available to support patients, relatives and carers, to raise concerns in languages other than English.

12. Conclusion and recommendations

12.1 In October 2024, KPMG, an audit and professional services company, shared the outcome of its internal audit of MFT's Complaints Handling. KPMG found there was significant assurance with minor improvement opportunities. KPMG was assured by the appropriately designed controls in place for complaints handling at the Trust, including adherence to national regulations and PHSO standards and the utilisation of KPIs and monitoring tools to achieve high compliance with response timescales.

12.2 The recommendations from the audit have been fully implemented, which include an updated MFT Complaints, Concerns and Compliments Policy and MFT complaints framework, to standardise the process of managing complaints across the Trust and to embed a culture of learning from complaints and seek continuous improvement

12.3 The Board of Directors is asked to note the content of this 2024/25 Complaints Report and the ongoing work of the Corporate and Clinical teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to seek continuous improvement.

12.4 The Board of Directors is asked to support a proposal to receive reports relating to complaints handling and performance on a six-monthly basis.

12.5 The Board of Directors is asked to note that, in line with the MFT Management of Change, the Complaints and PALS teams will move to the leadership of the Director of Clinical Governance in September 2025.

Appendix 1

Complaints Equality Diversity and Inclusion Monitoring Data 2024/25

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	2024/25
Disability					
Yes	50	57	54	61	222
No	65	66	57	82	270
Chose Not To Disclose	354	382	368	379	1483
Total	469	505	479	522	1975
Disability Type					
Learning Disability	0	2	3	3	8

Long-Standing Illness Or Health Condition	16	14	16	18	64
Mental Health Condition	6	7	4	10	27
Other - Please State In Details Box	2	2	3	2	9
Physical Disability	11	15	7	11	44
Sensory Impairment	3	3	6	4	16
Chose Not To Disclose	426	454	430	465	1775
Autism	5	8	10	9	32
Total	469	505	479	522	1975
Gender					
Man (Inc Trans Man)	189	196	189	212	786
Woman (Inc Trans Woman)	272	308	282	299	1161
Non Binary	0	0	0	0	0
Other Gender	1	1	0	3	5
Chose Not To Disclose	7	0	8	8	23
Total	469	505	479	522	1975
Sexual Orientation					
Chose Not To Disclose	363	398	380	411	1552
Bisexual	0	0	4	3	7
Gay Or Lesbian	4	7	6	6	23
Heterosexual Or Straight	95	96	88	96	375
Not Known	6	4	1	6	17
Something Else	1	0	0	0	1
Total	469	505	479	522	1975
Religion/Belief					
Christian: Church Of England	35	45	35	33	148
Christian: Roman Catholic	27	14	11	18	70
Christianity (All Denominations)	1	2	1	1	5
Christian: Free Church	1	2	1	0	4
Christian: Orthodox	1	1	0	1	3
Islam	13	12	16	21	62
Judaism	0	1	2	3	6
None	31	35	31	46	143
Other	1	4	0	3	8
Prefer Not To Answer	10	8	4	12	34
Chose Not To Disclose	346	376	372	379	1473
Paganism	0	0	1	0	1
Buddhism	0	0	0	1	1
Hinduism	0	2	2	0	4
Humanism	1	0	0	0	1
Atheism	2	3	3	4	12
Total	469	505	479	522	1975
Ethnic Group					
Asian Or Asian British - Bangladeshi	0	0	0	3	3

Asian Or Asian British - Indian	2	10	8	8	28
Asian Or Asian British - Other Asian	6	3	2	5	16
Asian Or Asian British - Pakistani	16	14	23	14	67
Black Or Black British - Black African	4	6	5	11	26
Black Or Black British - Black Caribbean	5	6	4	4	19
Black Or Black British - Other Black	5	4	2	5	16
Chinese Or Other Ethnic Group - Chinese	1	0	3	3	7
Mixed - Other Mixed	4	4	3	6	17
Not Stated	119	139	143	142	543
Other Ethnic Category - Other Ethnic	3	5	4	10	22
White - British	208	210	182	196	796
White - Irish	4	1	6	5	16
White - Other White	10	7	6	8	31
Chose Not To Disclose	73	86	76	91	326
Prefer Not To Answer	2	4	2	6	14
Mixed - White And Asian	1	0	3	4	8
Mixed - White And Black African	2	3	4	0	9
Mixed - White And Black Caribbean	4	3	3	1	11
Total	469	505	479	522	1975

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

Public Board of Directors Wednesday 30th July 2025

Paper title:	Quality & Patient Experience Annual Report 2024/25	Agenda Item 11.4
Presented by:	Kimberley Salmon-Jamieson, Interim Deputy Trust Chief Executive & Chief Nursing Officer	
Prepared by:	Deborah Carter, Director Quality and Safety. Gail Meers, Director of Nursing, Patient Experience & Engagement.	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee: 25 June 2025 Quality and Safety Management Committee: 07 July 2025	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

This paper presents the 2024/25 Patient Experience Report for Manchester University NHS Foundation Trust (MFT), providing a comprehensive overview of the feedback received from patients, carers, and families between 1st April 2024 and 31st March 2025.

The report demonstrates how insight from those we serve has not only shaped improvements but contributed directly to delivering on Strategic Objective 2 'ensuring care is safe, high quality, and person-centred with excellent outcomes and experiences'.

Following review at the Quality, Safety and Performance Board Committee and the Quality and Safety Management Committee, the report was updated to include specific examples of actions taken in response to survey findings, and the Executive Summary was strengthened to reflect a clearer focus on outcomes and impact.

Over the past year, MFT has strengthened its approach to experience of care. Key outcomes and their strategic impact include:

- A 33% increase in completion rates for the 'What Matters to Me' survey
This reflects improved patient engagement in care planning. More importantly, this engagement has enabled personalised care delivery, supporting safer, more responsive services aligned to individual need.
- Expansion of the Bee Involved programme
Patient and public involvement in service design and transformation has grown, embedding co-production into Trust-wide improvements and ensuring services are better shaped by those who use them.

- Focus on personalised care through Bee Brilliant
Bee Brilliant has focused education sessions on the fundamentals of care, ensuring care is not only safe but meaningful, directly contributing to improved experience for patients and carers.
- Continued use of the Accreditation process
This has maintained oversight and driven improvements across clinical areas, ensuring quality and productivity are continually enhanced based on insight and standards.
- Deployment of real-time feedback tools
These tools have enabled timely and responsive changes at the point of care. Growing opportunities for data analysis have allowed more focused improvements and development of innovative, patient-informed solutions.
- Over 144,000 interpretation interactions
These supported inclusive and equitable access to services, helping remove language barriers and improve safety and experience for patients from diverse backgrounds.
- Over 24,000 chaplaincy pastoral care contacts
This has enhanced support for faith and religious needs, improving cultural awareness and contributing to a more respectful and holistic care experience.
- Recognition of 416 volunteers contributing over 33,000 hours
Volunteers played a vital role in enhancing patient care across MFT sites, improving the emotional and social aspects of care for patients and families.
- Implementation of patient-facing improvements in communication, pathways, and service accessibility
These changes have supported more seamless, informed, and accessible care experiences, addressing areas of previous concern and aligning directly with feedback themes.

These actions and improvements have contributed directly to delivering Strategic Objective 2 by:

- Improving personalisation and safety of care
- Strengthening co-production and responsiveness
- Enhancing equity and inclusion
- Embedding insight-led quality improvement

This represents a shift from activity to meaningful outcome, a tangible improvement in how care is experienced by our patients, and how that experience continues to shape Trust-wide transformation.

To continue delivering against Strategic Objective 2, MFT will focus on:

- A measurable increase in patient satisfaction across key domains
- A reduction in inequalities in experience
- Full implementation of co-production in major transformation initiatives
- Introduction of advanced analytics to enhance feedback-to-action cycles

Recommendation(s)

The Public Board of Directors is asked to:

- Formally acknowledge the 2024/25 Patient Experience Report, recognising the significant work undertaken and the progress made in strengthening MFT's approach to experience of care.
- Approve the priorities for 2025/26, which are designed to further embed patient experience insight into care quality improvement and strategic delivery.

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: • Patient Experience		
Care Quality Commission domains Please check <u>all</u> 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: • Nil		

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

Public Board of Directors

Wednesday 30th July 2025

Paper title:	Infection Prevention and Control Annual Report 2024/25	Agenda Item 11.5
Presented by:	Kimberley Salmon-Jamieson, Interim Deputy Chief Executive, Chief Nursing Officer/ Director of Infection Prevention and Control	
Prepared by:	Michelle Worsley, Assistant Chief Nurse, Infection Prevention and Control.	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee Wednesday 25 th June 2025	
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 Annual Report outlines the progress and achievements over the past year, with a dedicated focus on Infection Prevention and Control (IPC), a core priority under the NHS Standard Contract. Our commitment to delivering safe, high-quality care is reflected in significant advances in reducing healthcare-associated infections and strengthening IPC practices across all services.

Position

Throughout the year, MFT has maintained rigorous infection prevention and control standards, ensuring compliance with national frameworks and contractual obligations. Despite ongoing challenges posed by emerging infectious threats, including seasonal pressures and variants, we continue to prioritise, safeguarding both patients and colleagues. Our IPC governance structures have been reinforced to ensure continuous monitoring, risk mitigation, and rapid response to outbreaks.

Improvements

In line with the NHS Standard Contract's quality and safety objectives, we have implemented targeted interventions to enhance IPC across the Trust. These improvements include:

- Continual monitoring of hand hygiene compliance programs
- Updating cleaning and environmental decontamination protocols
- Deploying advanced surveillance and reporting systems for real-time infection monitoring.
- Expanding staff training initiatives on IPC best practices, ensuring all clinical and non-clinical colleagues meet mandatory competencies.
- Strengthening antimicrobial stewardship efforts to minimise the impact of antimicrobial resistance.

Highlights

Key IPC achievements this year include:

- Achieving a 55% reduction in Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections in comparison to 2023/34
- Successful management of seasonal virus control measures and outbreak containment.
- Effective collaboration with regional health partners to align IPC standards and share best practices.

The report reflects the Trust's commitment to improving infection control measures and reducing HCAs. While there have been notable improvements, ongoing challenges necessitate sustained efforts and strategic planning going forward MFT will continue to invest in IPC innovation, workforce development, and patient engagement to further reduce infection risks and uphold the highest standards of safety and quality.

Recommendation(s)

The Board of Directors is asked to:

- Note the information provided in the Executive Summary, and
- Accept the Infection Prevention and Control Annual Report for 2024/25

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:

- Relevant risks are noted within the report

Care Quality Commission domains

- ☒ Safe
- ☒ Effective
- ☐ Caring
- ☒ Well-Led

Please check all that apply	☐ Responsive	
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Health and Social Care Act 2008	

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

The Infection Prevention and Control Annual Report 2024/2025

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Infection Prevention and Control (IPC) Annual Report 2024/2025

1. Executive Summary

The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 Department of Health, 2014)¹. Under this Act, the Board of Directors must receive an Annual Report from the Director of Infection Prevention and Control (IPC).

The purpose of the Annual Report is to inform the Board of Directors how the Trust's Infection Prevention and Control team (IPCT) has engaged in Health Care Associated Infection (HCAI) Prevention and Control during the period 2024/2025.

2. Purpose

The Annual Report details Infection Prevention and Control activity from April 2024 to March 2025, outlining key achievements, and seeks to provide assurance on our progress against the annual programme which is set against the 10 criteria of the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections. The Code was updated in December 2022 to reflect changes to the Act itself and the role of IPC including cleanliness in optimizing antimicrobial use and reducing antimicrobial resistance and considering changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic.

3. Financial Implications

It is widely accepted that healthcare acquired infections carry both a human and financial cost including the increased cost of environmental decontamination and bed losses during ward outbreaks and extended length of patient stay.

4. Risk

The Trust Infection Prevention and Control Committee (TICC) provides executive oversight of the Trust's IPC programme, reporting to the Quality and Safety Management Committee with infection prevention and control matters that have been reviewed during 2024/2025 and monitored at Hospital/MCS/LCO level. Risks are managed through the Trust Corporate Risk Register and a continued focus is required on the controls in place to mitigate the risks associated with healthcare acquired infections.

5. Communication and Involvement

The Annual Report has been developed by the Infection Prevention and Control Team in conjunction with the Clinical Groups. Review, assurance and actions where agreed are undertaken at Clinical Group/Hospital/MCS levels where required and monitored through Trust level Committees.

6. Summary of Infection Prevention & Control Activity

The following sections provide a summary of activity and performance during 2024/2025 that are detailed in full in the Trust Annual Report.

6.1 Governance

6.1.1 The Trust Infection Prevention & Control Committee (TICC) has responsibility for

¹ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Health and Social Care Act 2008: code of practice on the development and control of infections and related guidance. Updated December 2022

monitoring Infection Prevention and Control activities, as laid out in the key 10 commitments. During 2024/2025 the TIPCC met five times during the year and is chaired by the Deputy Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control. The TICC Terms of Reference are provided at Appendix 2.

- 6.1.2 The Deputy Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control (DIPC) review are held with each Director of Nursing supported by their Senior Leadership team including medical colleagues who have delegated responsibility for IPC in the Hospitals/MCS/LCOs, regularly throughout the year.
- 6.1.3 The review meetings provided an opportunity to focus on activity and performance, risks posed and mitigation in place to support ongoing patient safety.
- 6.1.4 The Trust Integrated Performance Review (IPR) monitors a range of healthcare related infections attributed to the Trust which are reported externally to the UK Health Security Agency Mandatory Data Capture System (UKHSA DCS) and is reported to the Quality and Safety Management Committee for oversight and assurance.
- 6.1.5 Risks associated with Infection Prevention & Control are monitored through Hospital/MCS/LCO IPC meetings and TICC and where escalation occurs, through the Quality and Safety Management Committee.

6.2 COVID-19

On the 1st of April 2023 changes were made to existing national COVID-19 testing policy² and MFT policy towards an overall theme of moving to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as Influenza and Respiratory Syncytial virus (RSV) with an emphasis on local decision making around patient pathways and risk management. A Respiratory Risk Assessment (RRA) was produced to support ward and departmental managers in understanding the wider risks associated with seasonal respiratory viral infections, by integrating IPC measures into the risk assessment process to enhance patient and staff safety.

6.3 Healthcare Associated Infections (HCAI)

HCAI figures are considered against nationally calculated thresholds which are set by NHS England except for Carbapenemase-producing Enterobacterales where no threshold is applied.

Organism	2023/24	2024/25	Threshold	Trend
Meticillin Resistant Staphylococcus aureus (MRSA)	20	9	0	↓
Clostridioides difficile	275	292	266	↑
Gram-negative Bloodstream Infections (GNBSI)	490	551	479	↑

² COVID-19: testing from 1 April 2023 - GOV.UK (www.gov.uk)

	Vancomycin-resistant Enterococci (VRE)	34	34	0	
6.4	Carbapenemase-producing Enterobacterales (CPE) acquisition	572	489	N/A	
	Carbapenemase-producing Enterobacterales (CPE) bacteremia	17	10	N/A	

6.4 Antimicrobial Stewardship

- 6.4.1 The Antimicrobial Stewardship Committee (AMC) oversees the stewardship of antimicrobials in line with the MFT AMS vision, reporting to the Medicines optimisation Board and TICC.
- 6.4.2 The AMC met each quarter during 2024/2025, in April, July, December and March. In June 2023 the AMS-operational group was convened to operationalise the objectives and priorities of the AMC, Dr Katherine Ajdukiewicz was appointed as Chair and the group meets every two months. The Guideline Development Group (GDG), Education and Training and Quality Improvement and Research groups became subgroups of AMS- operational group.
- 6.4.3 In terms of national ranking, MFT ranks 112 out of 132 Trusts in England for total antibiotic use, measured in Defined Daily Doses (DDD) per 1000 admissions.
- 6.4.5 48% of antibiotic prescriptions at MFT are from the World Health Organisation (WHO) access category (narrow spectrum), MFT rank 84 out of 132 Trusts.
- 6.4.6 Co-amoxiclav remains the most prescribed antibiotic, exceeding twice that of any other antibiotic. Co-amoxiclav is associated with a higher incidence of C. difficile cases. A retrospective review of C. difficile cases at MRI and NMGH (April-November 2023), carried out in May 24 identified that 57% of patients had received at least one course of co-amoxiclav.
- 6.4.7 The annual Point Prevalence Survey (PPS), conducted in April 2024, showed a decline in compliance with antimicrobial prescribing standards across most areas. However, a noted improvement in prompt intravenous to oral switch with the Trust achieving the target of < 15% patients remaining on IV antibiotics when meeting the switch criteria.
- 6.4.7 Antimicrobial Stewardship remains a priority within MFT requiring a dashboard to inform clinicians of prescribing habits and areas of improvement. The implementation timeline is currently awaited from Hive analysts and data engineering.

6.5 Surgical Site Infection Surveillance (SSI)

- 6.5.1 The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for Orthopaedic implant surgery. Data was submitted for both hip and knee replacement surgery for routine surgery performed at Trafford

Campus.

- 6.5.2 Across MFT **316** knee replacement procedures and **234** hip replacement procedures were conducted during the previous four quarters in which surveillance was undertaken, with **3** patients readmitted due to or reporting an SSI.

6.6 **Cleanliness**

- 6.6.1 The Trust cleaning services were provided by internal and external contractors/teams. The services at North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were delivered through internal in-house arrangements with the service managers and domestic staff, services at Wythenshawe and Oxford Road Campus were delivered through PFI arrangements.

- 6.6.2 The standards of cleanliness were monitored and reported for all sites through the National Standards of Cleaning (NSoC) monitoring, monthly Quality of Care Rounds, the Ward Accreditation Process and the What Matters to Me (WMTM) Tracker. These results informed areas of best practice and areas where additional focus was required.

- 6.6.3 As required by the (NSoC) Commitment to Cleanliness Charters were publicly displayed in all clinical areas, replacing cleaning schedules, and Star Ratings to demonstrate the standard of cleaning delivered on each Ward/department. Results have been displayed in accordance with the NSoC.

- 6.6.4 An external review of cleaning and cleaning services was conducted by PJT Solutions during July and August 2024, as requested by the Chief Nursing Officer/DIPC. Feedback was given to all Clinical groups, Estates, and Facilities teams, and action plans were developed. These plans are monitored at the Cleaning Improvement Meeting and TICC. A further external review is expected in July 2025.

- 6.6.5 Environmental cleanliness remains a critical component of infection prevention and control within, recent audits/IPC walkrounds/clinical accreditations have identified areas where standards are below expectations, posing a risk for healthcare-associated infections. To address this, a comprehensive improvement plan has been implemented, focusing on enhancing cleaning protocols, increasing the frequency and thoroughness of high-touch surface disinfection, and ensuring strict adherence to cleaning schedules. Colleague training including PFI partners has been intensified to reinforce best practices, supported by regular competency assessments. Additionally, the introduction of more robust monitoring systems, including real-time audits and feedback mechanisms, will help sustain accountability and drive continuous improvement. Collaboration with PFI partners and clinical teams continues to be strengthened to ensure cleaning practices align with clinical needs, ultimately creating a safer, cleaner environment for patients and colleagues alike.

6.7 **Outbreak Management – MFT Outbreak Policy Implementation**

The management of outbreaks of diarrhoea and vomiting requires swift, coordinated action to contain the spread and protect patients and staff. Upon identification of any outbreaks, immediate isolation or cohorting of affected patients was essential to prevent transmission and, in some cases, either patient bays or entire wards required closure. Enhanced infection prevention measures, including strict hand hygiene, use of appropriate personal protective equipment (PPE), and intensified environmental cleaning with effective disinfectants, were implemented throughout the affected areas. Staff education and communication were crucial to ensure early recognition of symptoms and adherence to control protocols. Surveillance was heightened to monitor any new cases, and visitor restrictions/notifications were applied if necessary. The outbreaks were managed in collaboration with the Infection Prevention and

Control team, microbiology/virology to identify the causative agent, implement targeted interventions to seek a safe and timely resolution.

- 6.7.1 In 2024/25 there were ward or bay closures due to outbreaks of diarrhoea and vomiting (D&V) where either Norovirus or Rotavirus or no confirmed organism was found. There were 8 full ward closures, with a total of 26 ward/bays closed or partially closed. The total numbers of bed days lost are detailed below. There were 26 bed days lost more in 2024/25 than in 2023/24 (1673 days)

Clinical Group	Organism	Lost bed days
WTWA	Norovirus/Rotavirus/Diarrhoea & Vomiting	1040
ORC	Norovirus/Rotavirus/Diarrhoea & Vomiting	417
NMGH	Norovirus/Rotavirus/Diarrhoea & Vomiting	242
TOTAL		1699

- 6.7.2 There were also outbreaks of CPE (4), and Influenza A (17) between April 2024 and March 2025. There were also outbreaks of MRSA (4), as well as a period of increased incidence of Group A Streptococcus (1).

- 6.7.3 There were some periods of increased incidence (PII) of Clostridioides difficile, but no outbreaks during 2024/2025. There were no outbreaks of (ESBL) outbreaks during 2024/2025

6.8 Water Safety

- 6.8.1 Site Water Safety Groups (WSGs) meet quarterly to monitor any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works. Emerging risks and issues that required escalation were taken to the site Technical Boards and the E&F Compliance, Risk and Governance (CRaG) Oversight Committee to determine further actions and/or escalations as required. Water Safety Plans are in place for ORC, NMGH and WTWA and will be reviewed and revised as required in 2025/26.

- 6.8.2 The review of areas classified as Augmented Care for sampling for Pseudomonas took place across the ORC, WTWA and NMGH sites and were agreed by the Water Safety Groups. Sampling continued in accordance with HTM04-01 Part C.

6.9 Ventilation Systems

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. Where other non-specialised ventilation systems are installed, they are maintained in accordance with manufacturers recommendations and any required standards.

6.10 Decontamination

The decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the STERIS facility based in Wythenshawe in July 2021, for the DSD at ORC to undergo a life cycling refurbishment program which is being undertaken through the Trust's PFI partner Equans. The new Decontamination Services Department reopened in 2023 on the ORC site.

6.11 **External Service Level Agreements (SLA)**

The (SLA) provision of IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites through a Service Level agreement (SLA)

The Neil Cliffe Centre (based at Wythenshawe Hospital);
Heald Green; and,
Little Hulton

6.12 **Professional Development**

6.12.1 The Infection Prevention and Control Development Pathway (IPCDP) was commissioned in 2020 by Greater Manchester IPC Leads The pathway is available to healthcare staff across the Northwest region including MFT colleagues. The pathway is delivered at three levels Foundation, Intermediate and Advanced, and focuses on knowledge, skills and behaviour with an emphasis on changing behaviour in relation to IPC and assisting others to do this. It is an interactive e-learning package with personal and professional development activities throughout the programme.

6.12.3 The Infection Prevention and Control nursing team have focused on providing Respiratory Protective Equipment training (RPE) within the Trust throughout 2024/2025. The IPC team have also celebrated eventful days within the year such as 'World Hand Hygiene Day', 'Leg Matters' week and 'Stop the Pressure' week. These are in addition to bespoke training sessions for wards as required.

6.13 **Digital Implementation**

6.13.1 In September 2022, the EPIC Electronic patient record (EPR) system Hive, was implemented The IPC team have continued to develop functionality to improve practice and communication between IPC and clinical teams to facilitate patient care.

6.13.2 During 2024-2025 HIVE was utilised to undertake a Trust wide CAUTI audit and a dashboard created for CQUIN 12 Pressure Ulcer Risk Assessment. The CAUTI audit was distributed to the Clinical Groups and an oversight group chaired by the ACN IPC was established. The action plans are included in the Clinical Group reports to TICC.

6.14 **Vaccination Program**

6.14.1 This year seasonal influenza vaccine programmes were delivered in accordance with national guidance. Vaccination rollout commenced in September 2024.

6.14.2 Final administration rates for seasonal influenza vaccine programme:
42% (12,849 vaccines) of MFT staff received the vaccination

6.14.3 As with the previous year vaccine hesitancy has had an impact on uptake rates in 24/25 and this is reflected in regional and national uptake rates, as well as at MFT.

7. **Recommendations**

7.1 The Quality Safety and Performance Board Committee are asked to:

- Note the information provided in the Executive Summary
- Review and accept as ongoing assurance the Infection Prevention and Control Annual Report for 2024/25

8. Infection Prevention and Control Arrangements

The Director of Infection Prevention and Control (DIPC)



Kimberley Salmon-Jamieson was appointed as the Chief Nursing Officer and designated DIPC for MFT in April 2024 and has been employed as Chief Nursing Officer and DIPC at a former NHS Trust since 2017.

The Infection Prevention and Control Team (IPCT)



Dr Rajesh Rajendran Associate Medical Director/Deputy DIPC for IPC. Rajesh was appointed as Regional IPC Doctor and Medical Microbiologist from July 2021 and in November 2021 became Clinical Director of the Division of Laboratory.



Mrs Michelle Worsley is the Assistant Chief Nurse. Michelle started working at the Trust in 1990 and has substantial experience in both adult, neonatal nursing, Michelle was appointed as an IP&C specialist nurse in 2007 and was appointed to the lead Nurse position IPC team in 2020 following her clinical leadership experience before becoming Assistant Chief Nurse in May 2022.



Dr Nicholas Machin Consultant Virologist, Clinical Lead for Virology maintained his role as an Infection Control Doctor (ICD). Consultant Virologist, Clinical Lead for Virology and Deputy Head of Service for Manchester Medical Microbiology Partnership. Dr Machin is also an Infection Control Doctor for MFT and currently leads on IPC for RMCH, St Mary's and the Eye and Dental hospital.



Dr Shazaad Ahmad Consultant Virologist continued his role as an Infection Control Doctor. Shazaad helped to set up the Data Science Unit at MFT in the field of infection data which has been used to inform regional and national decision making regarding COVID-19.



Dr Eamonn Trainor, Consultant Medical Microbiologist, joined MFT in February 2023 and is Infection Control Doctor for North Manchester General Hospital. Dr Trainor has worked as a consultant with an interest in infection prevention and control for almost a decade. Recently he has worked with the Healthcare Infection Society to produce national guidelines for the management of norovirus outbreaks in acute and community health and social care settings



Mrs Lorraine Durham was appointed as Head of Nursing for IPC in February 2023. Lorraine has substantial experience in Intensive Care Nursing, prior to moving to Infection control and Tissue Viability over 20 years ago, having worked across GM hospitals for 31 years.



Dr Tristan Banks, Consultant in Infectious Diseases & Microbiology, Joined the MFT as a consultant in December 2024 following completion of training in the Northwest. He is an IPC doctor for Wythenshawe Hospital. Tristan also undertakes clinical infectious diseases work in the Specialist Regional Infectious Diseases Centre (NMGH), supports the inpatient infection consults service (Oxford Road Campus), and undertakes specialist clinics in HIV, viral hepatitis and chronic pulmonary aspergillosis.



Dr Prasun Chakravorty Consultant in Medical Microbiology and Infectious Diseases, joined MFT in December 2024, and is an Infection Control Doctor for Wythenshawe Hospital. Prasun has an interest in Diabetic Foot Infections, and undertakes specialist clinics involving patients with HIV, Chronic Hepatitis B and Chronic Pulmonary Aspergillosis.

8.1 **Microbiology and Virology Laboratory Services**

Microbiology and Virology Laboratory services were provided on-site at the Oxford Road Campus (ORC) by the Manchester Medical Microbiology Partnership (MMMP). Virology services were provided across the region as well to the Trust.

8.2 **The Infection Prevention and Control (IPC)/Tissue Viability (TV) Team**

All IPC services are managed within the Clinical and Scientific Services (CSS). The Medical members of the IPC Team are in the Division of Laboratory Medicine. The Nursing Team is in the CSS Clinical Group. Recruitment and succession plans are in place for both the medical and nursing team, to ensure that the IPC team develops its workforce.

An organogram demonstrating an overview of the structure of the IPC/TV Nursing Team can be found in Appendix 1.

8.3 **The Trust Infection Prevention and Control Committee (TICC)**

The Trust Infection Prevention and Control Committee has corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. The TIPCC met five times during the year chaired by the Deputy Chief Executive Officer/Chief Nursing Officer/DIPC. The TICC reported to the Group Management Board, and to the Board of Directors via the Quality and Performance Scrutiny Committee. The TICC, terms of reference (TOR) can be found in Appendix 2.

8.4 **Framework for IPC**

The IPC governance framework can be seen below.



8.5 Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)/Local Care Organisation (LCO)

8.5.1 Infection Control Committees are in place within each Hospital/MCS and LCO. The day-to-day management for IPC was delegated to the Directors of Nursing by the Deputy Chief Executive Officer/Chief Nursing Officer/DIPC. Each Hospital/MCS/LCOs appointed a Clinical Medical Lead to support IPC policy and practice across professional groups and represent the Hospitals/MCS/LCO at the Trust Infection Control Committee (TICC).

8.5.2 Each Hospital/MCS/LCO present their Infection Control Assurance reports including any escalated issues or concerns. Attendance at the hospital/MCS/LCO meetings includes designated IPC nurses and Infection Control Medical colleagues.

8.6 Service Level Agreement (SLA) with St Ann's Hospice

The Trust IPC/TV Team were once again asked to renew the Service Level Agreement (SLA) provision for IPC advice and guidance to St Ann's Hospice and include Tissue Viability across the Northwest Hospice sites:

- The Neil Cliffe Centre (based at Wythenshawe Hospital);
- Heald Green
- Little Hulton

9. COVID-19

9.1 COVID-19 Testing

On the 1st of April 2023 changes were made to existing national COVID-19 testing policy towards an overall theme of moving to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as Influenza and Respiratory Syncytial virus (RSV).

9.1.1 The emphasis is now based on local decision making around patient pathways and

management of risk; therefore a Respiratory Risk Assessment (RRA) remains in place to support ward and departmental managers in understanding the wider risks associated with seasonal respiratory viral infections, including COVID-19, to staff and patients.

9.2 Respiratory Risk Assessment

9.2.1 Implementation of Respiratory Risk Assessment (RRA)

The RRA was introduced to ward and departmental managers in May 2023 for implementation across the organisation. The Director of Nursing have oversight of the risk assessments which are monitored at the hospital/MCS Infection Control Committees (ICC) and reported to TIPCC by exception. Information posters were circulated with the RRA so wards and departments can display the requirement to wear FRSM within the area if required. The RRA are to be regularly reviewed including at ward level during respiratory outbreaks.

9.2.2 Fluid Resistant Surgical Masks (FRSM)

The National Infection Control manual (NIPCM) recommendations are followed regarding the application of Standard IPC precautions and Transmission based precautions depending upon the organism and route of transmission.

10. Health Care Associated Infections (HCAI)

All charts are included in Appendix 3. Over the past year, our hospitals have made notable progress in reducing the overall incidence of healthcare-associated infections (HCAIs) including MRSA, MSSA, and CPE bacteremia, demonstrating the positive impact of ongoing infection prevention and control (IPC) initiatives. Enhanced staff training, improved hand hygiene compliance, and strengthened environmental cleaning protocols have contributed to a downward trend in several key HCAI indicators.

However, despite these achievements, we have observed an increase in infections caused by certain organisms, including *Clostridioides difficile* and multi-drug resistant Gram-negative bacteria. These rises emphasise the continuing challenges posed by evolving microbial threats and highlight areas where targeted efforts must be intensified.

Moving forward, our focus will be on deepening surveillance, refining antimicrobial stewardship, and reinforcing multidisciplinary collaboration to address these emerging risks. By building on our successes and addressing current gaps, we remain committed to improving patient safety and minimizing the burden of HCAIs across the hospital.

10.1 Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia. There have been 9 hospital-onset MRSA bacteraemia reported for the 2024/2025 which represents a decrease based on the previous year's performance of 20 cases. There have been 271 MRSA acquisitions for the 2024/2025 financial year which is a reduction of 11 from the previous year position (282). Actions to reduce occurrence include.

- Implementation of decolonisation protocol within Hive
- Senior Nurse reviews of all complex patients
- Targeted colleague education and training in high-risk groups i.e. Neonatal patients, renal patients
- Colleague screening pilot in high-risk areas (NICU)
- Updated screening policy in line with national recommendations
- Colleague education in the use of decolonisation therapy

- 10.2 **Clostridium difficile Infection (CDI)** There has been a total of 292 healthcare associated CDI cases reported for 2024/25, against a trajectory of 266. This represented an increase from 276 cases reported for the previous year. Lapse in care data is being determined retrospectively upon review: there are currently 57 lapses in care recorded for 2024/2025. Actions to reduce occurrence include.
- Antimicrobial stewardship
 - Risk assessment updates within Hive
 - Targeted education around timely sampling techniques
 - In depth review of all CDI cases
 - Implementation of Patient Safety Framework to understand learning themes
 - Ribotyping of cases in periods of increased incidence
 - Education and training in environmental hygiene standards
- 10.3 **Gram Negative Blood Stream Infections (GNBSI)** There was a total of 551 healthcare associated Gram-Negative Bloodstream Infections reported for the last financial year, which is over the NHSEI trajectory of 479 and represents a 12.7% increase on last year's position (489) for the same period. Actions to reduce occurrence include.
- MFT wide vascular access device and urinary catheter audit undertaken Dec 2024, results shared with Clinical Groups and action plans for improvement developed.
 - MFT wide Urinary Catheter Care audit in January 2025 results shared with Clinical Groups and action plans for improvement developed.
 - Risk factor proforma developed and added to the Ulysses incident reporting system to provide themes and further areas for action.
- 10.4 **Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia** A total of 97 hospital onset MSSA bacteraemia cases have been reported for 2024/2025, compared to 108 cases for 2023/2024. There is currently no target associated with MSSA bacteraemia incidence. Actions to reduce occurrence- please see 10.1
- 10.5 **Carbapenemase-producing Enterobacterales (CPE)** There is a total of 489 CPE acquisitions recorded for 2024/2025, compared to 572 cases for 2023/2024. There have been 10 hospital-onset CPE bacteraemia recorded for 2024/2025, compared to 17 cases recorded during 2023/2024. Actions to reduce occurrence include.
- Increased screening protocol to support identification and placement of patients
 - Outbreak and control management within clinical areas
 - Review of environmental decontamination and use of advanced technologies to reduce bio burden
 - Education and training in environmental hygiene standards
- 10.6 **Vancomycin-resistant Enterococci (VRE)** A total of 34 hospital-onset cases have been reported for 2024/2025, with a total of 600 acquisitions. Based on last year's performance (34 bacteraemia, 405 acquisitions), the total number of VRE bacteraemia has not changed but we have seen an increase of 48.1% in total VRE acquisitions.
- Increased screening protocol to support identification and placement of patients which highlighted the increase in acquisitions specifically in vascular and haematology/oncology patient cohorts.
 - Outbreak and control management within clinical areas
 - Review of environmental decontamination and use of advanced technologies to reduce bio burden

- Education and training in environmental hygiene standards
- An in-depth review of VRE cases began in April 2025 and will be presented to the TICC in July 2025

10.7 **Catheter Associated Urinary Tract Infections (CAUTI)** surveillance continues to be on hold there are plans to monitor utilising HIVE in the future. An MFT wide CAUTI audit was undertaken in January 2025 utilising the Hive system. The audit reviewed the care of 288 patients in total. Audit findings and recommendations will inform development of Hospital /MCS/LCO actions plans and help to target and measure specific improvements and a review of workforce education and training programmes. It is expected that each Hospital /MCS develop an action plan to address the areas of non-compliance which is managed and monitored via local Infection Prevention Committee Meetings. CAUTI audits from previous years have reported variance in methodology and sample size making direct comparison of year-on-year results unreliable measures of improvement. However, a review of the audit percentage compliance results undertaken since 2021 did not identify any significant change in compliance with the standards related to:

- Documented indication for the catheter.
- Documentation of daily care.
- Use of catheter fixation device

There is a plan to reaudit CAUTI in July 2025 to understand where improvements have been made.

10.8 **Peripheral blood culture trends**, the monthly rates for ages under 16 years are 2.0% overall for latest 12 months and those 16 and over 2.6% overall for latest 12 months. Both are set against a trajectory/threshold of <3%. Aggregated rate for the Trust for the latest 12 months is 2.4%. Management and monitoring of Aseptic Non-Touch Technique (ANTT) compliance is imperative to maintaining this standard. The IPC team updated the MFT ANTT policy including education, training and compliance recording components and continue to monitor Trust wide ANTT compliance.

10.9 **Shelford Group Comparison** for financial year 2024/2025 MFT have finished with the 5th highest healthcare associated CDI rate with a rate of 38.70, slightly up from the 2023/2024 position of 36.85. For MRSA, MFT have finished with the 7th highest MRSA bacteraemia rate with a final position 1.21, a much-improved rate from 2023/2024 which was a rate of 2.68.

10.10 **Seasonal Viral infections**
Healthcare management of seasonal viral infections, including Influenza and COVID-19, involves a multi-layered approach aimed at reducing transmission, minimizing illness severity, and protecting vulnerable populations. Key strategies include vaccination programs to provide immunity and reduce disease burden, rigorous infection prevention and control measures such as effective hand hygiene, use of personal protective equipment (PPE), and respiratory etiquette. Early identification and isolation of symptomatic patients are critical to preventing outbreaks within healthcare settings. Clinical management focuses on supportive care, antiviral treatments where appropriate, and careful monitoring for complications. Additionally, the implementation of surveillance and reporting protocols to track infection trends and inform responses. Staff education and collaboration between multidisciplinary teams ensured preparedness and resilience during seasonal peaks of these viral infections.

Influenza the Acute Respiratory Infection (ARI) report was circulated throughout the winter months and will be reinstated for the next Influenza season, A chart showing

MFT overnight inpatient population vs patients with the active 'Influenza' tag on their patient chart is provided for an overview of impact on service. Healthcare worker vaccination strategy and outcomes are detailed in section 11.

In total there were 59 outbreaks of Influenza A during 2024/25 resulting in the loss of 1027 bed days in total.

SARS-CoV-2 data is no longer required to be submitted via the national database however any individual cases are managed in line with local policy and periods of increased incidence or outbreaks are managed in line with the outbreak policy. In total there were 133 outbreaks of COVID-19 during 2024/25 with no loss of any bed days due to bed closures.

10.12 **IPC Risks**

There are currently seven risks on the MFT Risk Register relating to Infection Prevention and Control the risks are monitored monthly and are reported to the TICC bi-monthly and include any updated actions and mitigations currently applied. The risks include.

- MFT/000987 Outbreak of HCAI scoring 10
- MFT/000988 Isolation of patients with a known/potential HCAI scoring 9
- MFT/000989 Compliance with IPC policies and procedures scoring 12
- MFT/0001122 Infection Control targets scoring 12
- MFT/001123 Control of carbapenemase producing Enterobacteriaceae scoring 12
- MFT/004292 COVID-19 acquisition scoring 9
- MFT/007792 Condemned mattress replacement programme scoring 9

11. **Employee Health and Wellbeing Service: IPC and Vaccination Programmes**

- 11.1 The key objectives of Employee Health and Wellbeing (EHW) Service IPC Programmes, encompassing seasonal influenza vaccination, occupational pertussis, Mpox, MRSA Swabbing, and outbreak management, are to safeguard employees from debilitating illnesses, mitigate the operational impact caused by increased sickness absence and its associated costs, and minimise the infection risks to staff & patients.
- 11.2 The MFT Seasonal Influenza Programme rollout began in September 2024, while the Occupational Pertussis Programme commenced in December 2025. Both programmes were delivered by Peer-to-peer Champions from each of the Hospitals/MCS. However, the Employee Health & Wellbeing service was responsible for the implementation, training, and oversight.
- 11.3 During the 2024-2025 influenza season, MFT administered flu vaccines to 42% of their frontline care workers (12,849 vaccines). This percentage represents an increase from the previous year's total uptake of 37%, but it remains significantly below the pre-COVID levels of 70-80%
- 11.4 Vaccine hesitancy, health inequalities, operational challenges, lack of dedicated resources, and communication barriers have all had an impact on uptake rates at MFT in 2024-2025. Nationally, concerns about disease, confidence in vaccine safety, healthcare provider recommendations, and longstanding immunisation inequities have also influenced vaccine uptake rates. These factors collectively contributed to the overall vaccination rates observed during this period.
- 11.5 In addition to routine business-as-usual (BAU) vaccination programs, the EHW Service has responded to additional vaccine recommendations from the Green Book,

and UKHSA national guidance, including the provision of Pertussis vaccines to high-risk groups and the scoping and planning for Pre-Exposure Mpox vaccines. These efforts have required operational adjustments and resource allocation beyond routine activities, to ensure high-risk populations received timely immunisation in line with evolving public health guidance.

- 11.6 To support vaccination efforts, the EHW service trained and supported peer-to-peer vaccinators across all hospitals/MCS, enabling broader immunisation coverage. However, following clarification from the Specialist Pharmacist Service (SPS), the peer-to-peer delivery of pertussis vaccines by champions had to be discontinued, as peer-to-peer Written Instructions are only acceptable for influenza and COVID-19 vaccines. Consequently, peer-to-peer vaccinators can no longer operate under this framework for the Pertussis vaccination programme. The EHW Service is therefore seeking additional support to enable ongoing delivery of the programme.
- 11.7 The increase in contact tracing exercises for staff exposed to infectious diseases has placed significant strain on existing EHW resources. In 2023, EHW recorded 5 contact tracing exercises, this figure escalated to 91 in 2024, and as of May 2025, there have already been 40+ cases. The EHW Service is not resourced to provide services to meet this level of demand. This upward trend highlights the growing need for timely local risk management, including use of PPE and education and training. The EHW Team are collaborating with IPC and local management teams to maintain operational efficiency while ensuring staff safety.
- 11.8 The EHW Service has supported the MRSA colleague screening programme having processed 376 results between 20th March 2025 and mid-May 2025. To date there have been 11 positive results, who were provided with telephone triage, decolonisation treatment, and follow up swabs.
- 11.9 Ensuring compliance with vaccination and immunisation programs, whether at pre-employment screening or through required periodic reviews, is essential for maintaining a safe healthcare environment. However, current compliance levels could be improved, highlighting the need for clear guidance and greater accountability from both candidates, colleagues and managers. By embedding vaccination compliance into organisational culture and policy frameworks, the Trust can safeguard patient and healthcare worker well-being while ensuring alignment with national health directives.

12. **Antimicrobial Stewardship** **Annual Report for Trust Antimicrobial Stewardship Group (AMG)**

Financial Year: 2024-2025

- 12.1 **Executive Summary**
The Antimicrobial Stewardship Group (AMG) has continued to oversee the stewardship of antimicrobials in line with the MFT AMS vision. In 2024/25, the AMG met three times, advancing key initiatives related to antimicrobial resistance (AMR) and optimising antimicrobial prescribing across the Trust. This report summarises the progress, challenges, and strategic directions of the AMG during this period, highlighting significant actions taken, changes in governance, and key performance indicators (KPIs) for the year ahead.
- 12.2 **Governance and Organisational Changes**
Currently the AMG report to the Trust Quality and Safety Management Committee while maintaining connections with the Medicines Optimisation and Oversight Group

(MOOG) and Trust Infection Control Committee (TICC). This restructuring reflects an evolving approach to enhancing safety and quality in the stewardship of antimicrobials.

The AMG met three times in 2024/25: June, September, and January, maintaining a multi-disciplinary representation from clinical leaders, infection specialists, and senior pharmacy leadership. The group's primary goal continues to be improving engagement across the Trust to optimise antimicrobial use. Meeting frequency will be increased in 25/26 to bimonthly.

Several changes were made to the subgroups reporting to the AMG. Following a review of activity and workstreams, the Quality Improvement and Research Group, along with the Education and Training Group, were disbanded. The responsibilities were reassigned to the AMS-operational group and the Adult and Paediatric Guideline Development Groups, streamlining operations and enhancing focus on critical priorities.

In January 2025, the resignation of the Consultant Pharmacist for AMS led to a decision to not reinstate the role. Instead, development of a new position for a Trust Clinical Director for AMS/AMR is in progress, pending funding approval.

12.3 **UK 5-Year Action Plan for Antimicrobial Resistance (2024-2029)**

In May 2024, the Department of Health released the UK's second 5-year national action plan for AMR, outlining ambitions and actions for reducing antimicrobial usage, optimising treatment, investing in innovation, and addressing global AMR challenges. The Greater Manchester AMR board has aligned its AMR/IPC improvement plan with this national framework.

The AMG is committed to assessing these priorities and formulating a local action plan that incorporates AMS, AMR, and IPC initiatives. Additionally, the group has emphasised the need for clear accountability through MFT's reporting systems, with a focus on leadership at all levels — including medical and nursing leadership — to ensure a comprehensive and coordinated response to AMR.

12.4 **MFT Performance in 2024/25**

12.4.1 Antibiotic Consumption Tracking antibiotic use continues to be a challenge. Data from pharmacy systems, such as ward stock and dispensing data, is utilised to report consumption nationally, but these figures reflect only the volume of medicines issued rather than actual usage or administration. This limits the ability to provide feedback at the specialty or prescriber level.

In terms of national ranking, MFT ranks 112th out of 132 Trusts in England for total antibiotic use, measured in DDDs per 1000 admissions. Just 48% of antibiotic prescriptions at MFT are from the WHO Access category (narrow spectrum), placing the Trust in 84th position out of 132 Trusts. Co-amoxiclav remains the most prescribed antibiotic, with its usage exceeding twice that of any other antibiotic. A retrospective review of *C. difficile* cases at MRI and NMGH (April-November 2023), carried out in May 24 identified that 57% of patients had received at least one course of co-amoxiclav.

12.4.2 Antimicrobial Prescribing Audit Regular audits continue to assess the quality of antibiotic prescribing at MFT. The annual Point Prevalence Survey (PPS), conducted in April 2024, showed a decline in compliance with antimicrobial prescribing standards across most areas. Over 400 patients on antimicrobials were audited across NMG, WTW, MRI, SMH and RMCH. The results were disseminated to clinical leads and associate medical directors to develop local action plans. To ensure continued monitoring, a rolling PPS audit program was established for 2025, ensuring all ward areas are audited at least once during the year.



AMG continued to monitor prompt IV to oral switch as part of the NHSE CQUIN-like quality indicator. 300 patients were audited across the MRI, WTA and NMGH and the Trust met the target of 15% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.

- 12.4.3 **Antimicrobial Resistance** The 2023-2024 English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report highlighted concerning trends in AMR, including rising infection rates and increasing drug resistance. The Northwest has the highest rates outside of London, and MFT continues to report the highest number of Carbapenemase-producing Enterobacteriaceae (CPE) acquisitions in the region. Additionally, resistance to daptomycin and linezolid in vancomycin-resistant enterococci has been detected in high-risk patient groups such as critical care and haematology.

The AMG is particularly concerned with the link between AMR and social deprivation. Between 2019 and 2023, the gap in AMR burden between the most and least deprived groups increased significantly. This highlights the need for targeted interventions to address the growing disparities in AMR burden.

- 12.5 **AMS Reporting in Hive**
 Efforts to improve AMS surveillance have been a key priority for AMG in 2024/25 and are ongoing. The proposal to implement live dashboards in Hive is being developed to provide real-time information on patients receiving antibiotics for infection alongside performance dashboards, to provide Clinical Groups with antimicrobial usage data to inform annual plans, measure performance and evaluate effectiveness of their AMS activities. These dashboards will help prioritise patient reviews and improve overall AMS performance. The implementation timeline is currently awaited from Hive analysts and data engineering.

- 12.6 **Antibiotic Prescribing Priorities and KPIs**
 Reflecting on current performance and national priorities, the AMG has identified the following key areas for improving antibiotic use:
- **Reduction in Routine Antibiotic Course Length:** Efforts will be made to ensure shorter, more targeted courses of antibiotics.

- **Reduction in Broad Spectrum Antibiotic Use (Watch and Reserve):** There will be a focus on minimising the use of broad-spectrum antibiotics to reduce the potential for AMR.
- **Improvement in Timely IV to Oral Switch:** Ensuring that patients are switched from intravenous to oral antibiotics promptly will be a key focus.
- **Reduction in Omitted Doses of Antibiotics:** Efforts to minimise missed doses will be prioritised.

Key Performance Indicators (KPIs) have been established to guide progress, including:

- **By April 2026:** Achieve a 1% reduction in total antibiotic use.
- **By April 2026:** Achieve 90% compliance with the appropriate duration of antibiotic prescriptions.
- **By April 2026:** Increase the proportion of narrow-spectrum antibiotic use (Access category) by 5%.
- **By April 2026:** Ensure that ≤15% of patients remain on IV antibiotics past the point at which they meet switching criteria.
- **By April 2026:** Reduce the percentage of omitted critical medicines, particularly antimicrobials, to 1%.

Priorities and KPIs were shared with medical leaders at the Chief Medical Officers Forum in January 25 and MFT leadership at Quality, Safety and Performance Board Committee in February 25 with the request for further dissemination to Clinical Groups and specialities and acknowledging that improving antimicrobial prescribing and stewardship is dependent on strong clinical leadership. Consultants and other senior members of the healthcare team should be supported to embed AMS within clinical practices, promoting responsible antibiotic use and optimising patient care.

12.7
12.7.1

AMS Operational Group Overview

The AMS Operational Group continues to enhance patient safety and optimise antimicrobial prescribing through several key workstreams:

1. **Gentamicin Prescribing Optimisation:** Ongoing efforts focus on improving gentamicin prescribing, including modifications in HIVE and additional educational initiatives. The development of a Safety Improvement Plan, in collaboration with the Medicines Safety Committee, aims to reduce broad-spectrum antibiotic use through increased gentamicin use.
2. **Antimicrobial Duration and Expiry Management:** The group has conducted a large-scale audit and developed an action plan to minimise incidents related to expired antimicrobials. The plan supports prompt review of IV antimicrobials to reduce associated risks.
3. **Penicillin Allergy De-labelling:** A protocol for penicillin allergy de-labelling has been developed, with the HIVE build in progress to support implementation.
4. **Decision Support Tools:** The group is facilitating the use of infection order sets in HIVE to enhance adherence to antimicrobial prescribing guidelines.
5. **Fluoroquinolone MHRA Alert Response:** Following the January 2024 MHRA alert, the group has supported actions including guideline reviews, laboratory reporting adjustments, and HIVE optimisation. This has led to a steady decline in fluoroquinolone usage.

12.8

Guideline Development Group Overview

1. **Transition to Eolas Platform:** In September 2024, the Trust transitioned antimicrobial guidelines from Microguide to Eolas, a new digital platform. This transition, led by the AMS pharmacy team with support from IT and other

departments, included a risk assessment, guideline review, and a communications campaign. Since launch, Eolas has been accessed nearly 14,000 times per month and offers improved analytics and document control.

2. **Guideline Updates:** The adult and paediatric guideline development groups have made ongoing updates, including:
3. **Adult Updates:** Updates cover areas such as infective endocarditis, skin infections, pelvic inflammatory disease, and new guidelines for Faecal Microbiota Transplant and infections in cystic fibrosis.
4. **New Drug Additions:** New drugs added to the formulary include ampicillin/sulbactam, aztreonam/avibactam, rezafungin, extended use of dalbavancin, generic liposomal amphotericin B.
5. **Paediatric Guidelines:** Updates have been delayed due to staffing vacancies, with plans to accelerate updates in 2025/26.
6. **Forward Plan:** The Trust Procedural Documents Group has requested that by the end of 2025, all guidelines hosted on Eolas will be reviewed to ensure they are up to date. A significant number of adult and paediatric guidelines are scheduled for review, and clinical specialties will be engaged to support this process.

12.9

Conclusion

The Trust Antimicrobial Stewardship Group has prioritised the stewardship and optimisation of antimicrobial use across MFT. While challenges remain, particularly in the areas of antibiotic consumption data, AMR surveillance, and ensuring appropriate prescribing practices, the group is committed to addressing these issues through collaboration, focused leadership, and the implementation of key performance measures. The coming year will be critical in building on the progress made and ensuring that MFT continues to meet the national AMR objectives, working with partners in primary care, contributing to the global effort to combat antimicrobial resistance. A comprehensive action plan of 2025/26 priorities which includes but is not limited to the creation of an AMS performance dashboard within Hive, a review of adult antimicrobial guidelines prioritising guidelines containing Co-Amoxiclav, a review of all MFT adult antimicrobial guidelines. Ongoing management of the action plan will be provided to the Quality, Safety and Performance Board Committee via the Antimicrobial Management Group.

13.

Maintaining a Clean Environment

13.1

The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team have worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo and internal providers to ensure cleaning standards are met across the Trust and any changes required following the pandemic were consistently implemented.

13.2

Contracting Arrangements:

The Trust cleaning services were provided by both internal and external contractors/teams.

13.2.1

Sodexo Healthcare are the main contractor for domestic cleaning services across the Oxford Road Campus (ORC), including the Dental Hospital, and at Wythenshawe Hospital. In addition to the core domestic service Sodexo provide HPV and UVC decontamination services at both sites.

13.2.2

North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had domestic services provided by in-house teams. The inhouse teams provide HPV decontamination services at North Manchester and Trafford.

13.3 **National Standards of Healthcare Cleanliness 2025**

13.3.1 The Estates and Facilities Team in collaboration with PFI partners continues to work to the National Standards Healthcare Cleanliness and has carried out a comprehensive review of the revised 2025 standards to ensure compliance. The NSoC provides a consistent approach to cleaning across the NHS and aims to deliver improvements in cleanliness standards and reporting of these.

13.3.2 The Trust Cleaning Policy has undergone a multi-disciplinary review to ensure it not only reflects the National Standards of Healthcare Cleanliness but also reflects the Trust approach to ensuring cleanliness across the Trust.

13.3.3 To promote an ethos where cleanliness is everybody's responsibility. Education sessions relating to the National Standards of Healthcare cleanliness have been delivered to colleagues across the Trust.

13.4 **Monitoring Arrangements:**

13.4.1 The National Standards of Healthcare Cleanliness 2025 audit regime includes 3 levels of audit:

- Technical audits, which check and score cleanliness outcome against the safe standard
- Efficacy audits which check the effectiveness of the cleaning at the point of delivery.
- External audit provides quality assurance and checks both the technical audit and the efficacy audit.

13.4.2 The Trust have a monitoring schedule in place across all the Clinical Groups. Monitoring is undertaken by trained monitoring officers, employed by the Estates and Facilities department and Sodexo. Nursing colleagues join NSoC audits as they are conducted to ensure a multi-disciplinary approach.

13.4.3 Technical audits have been carried out in line with the frequencies set out in the NSoC and the efficacy audits were carried out as multi-disciplinary management audit on an annual basis.

13.4.4 The Deputy Chief Executive Officer/Chief Nursing Officer/Director of Infection Prevention Control commissioned an independent expert to complete an external audit of the processes and procedures that the Trust has in place in relation to cleaning. The findings of this audit were presented in a report with Trust and Clinical Group specific actions. Task and finish groups were formed to address findings of this audit.

13.4.5 Updates on progress in relation to Clinical Group action plans were reported through Clinical Group Infection Prevention Committees with escalations being reported at the Trust Infection Prevention and Control Committee. Clinical Group Infection Prevention Committees receive a monthly report outlining the domestic performance across the group. This report highlights any areas that have not achieved 4* or above ratings and the issues that have been identified through the escalation planner.

13.5 **Commitment to Cleanliness Charters and Star Ratings**

13.5.1 As required by the new NSoC Commitment to Cleanliness Charters are publicly displayed in all clinical and public facing circulation areas, these have replaced the cleaning schedules. Star ratings are displayed in all patient facing wards, departments

and circulation areas to demonstrate the standard of cleaning delivered in these areas.

- 13.5.2 The Trust Infection Control Committee receives any escalations from the Clinical groups in relation to cleaning standards

13.6 **Infection Prevention and Control Training for Domestic Staff:**

- 13.6.1 All new employees attended a generic induction which included the principles of Infection Prevention and Control.

13.7 **Patient Led Assessment of the Care Environment (PLACE):**

- 13.7.1 The PLACE assessments were completed across October and November 2024 across all qualifying sites. These assessments were led by patient assessors and representatives from other Trusts as per the national guidance. The Trust achieved a score of 95.90% across the cleanliness domain.

- 13.7.2 The PLACE assessments results and actions are reported through to the Patient Experience Forum in the first instance providing assurance around progress against action plans. This is then reported to the Quality, Safety and Performance Board Committee

14. **Water Safety Overview**

There continues to be a single independent Authorising Engineer (AE) for water across the Trust. This role ensured that water safety was managed as consistently as possible across the Trust sites. The AE attends the quarterly site Water Safety Group meetings which also included attendance from the Appointed/Responsible Persons and representation from IPC. Monthly meetings between Estates and Facilities, the Associate Medical Director – Infection Control/Microbiology, and Assistant Chief Nurse IPC/TV continued to be held in 2024/25 year to discuss water safety items outside of TICC and site water safety groups.

In addition, the AE continues to support the Authorising Persons (APs) across the acute sites with mentoring and training, along with supporting additional operational water safety meetings to specifically look at any day-to-day challenges, and work through audit actions.

Annual water safety audits were completed by the Authorising Engineer (Water) in the 2024/2025 year for ORC; WTWA; NMGH sites. Actions from audits are reviewed and monitored through the quarterly site water safety groups. The Estates Operational teams continue to work to complete actions identified, with all actions requiring sign off by the AE before closing.

The Authorising engineer also completed a review of water risk assessments for community based Macular Treatment Centres in 2024/25 year, to review and ensure compliance with water safety guidance is being adhered to. Actions identified in the review were reported to the centres facilities management company and monitored via the Trust E&F Compliance Manager for Off Campus/Community Premises.

Water Safety Planned Preventative Maintenance (PPM) information continued to be provided to the Group Infection Control Committee in 24/25 and will continue to be provided going forward as part of the Water Safety AAA report.

Trust Water Safety Policy is in date, supported by site Water Safety Plans which are in place for ORC (ratified September 2024); NMGH (ratified April 2025). There is a

working draft in place for WTWA which is being reviewed by the newly appointed RP before being submitted for ratification in Q1 2025/26.

At WTWA the Sodexo RP (water) expressed concerns regarding the Wythenshawe Allied Health Professionals (AHP) Adult and Paediatric Hydrotherapy Procedural Document. The draft policy was not presented to the Estates safety groups for an opportunity to comment, and indicates *Cryptosporidium* sampling is required. However, this is not currently carried out by Sodexo. The Chair of the WSG has requested a meeting with the authors of the document, IPC, Sodexo and AE Water for further consultation.

NHS Estates Technical Bulletin NETB No. 2024/3 Designing safe spaces for patients at high risk of infection from nontuberculous mycobacteria and other waterborne pathogens was issued by NHSE on 27th August 2024. The objective of the document is:

1. To enhance existing guidance set out in HTM 04-01 safe water in Healthcare premises, to address risks from nontuberculous mycobacteria (NTM) and other waterborne pathogens, and
2. To identify specific measures required for new hospital premises and major refurbishments for those patients at greatest risk of healthcare-associated infections.

The Trust AE Water provided a detailed synopsis of the publication. It was recommended that a risk assessment should be conducted and uploaded to the risk register, even if the risk is low. This will require input from clinical teams and IPC.

The E&F Compliance Managers have sought advice on the guidance from the AE (Water), who advised that Risk Assessments should be undertaken for individual patients / wards and where required 0.2-micron sterilising point of use filters should be installed on showers. Further discussions regarding undertaking these risk assessments are required at site water safety groups and TICC as required.

14.1 Water Safety Risks

The following risks are owned on the Trust risk register under Estates and Facilities relating to water safety.

E&F Division

MFT/002980 Augmented Areas – identification and review of areas. Risk score 8.

ORC

MFT/002980 – infection to patients in augmented care areas (via water outlets) from *Pseudomonas aeruginosa*. Score 8

MFT/002979-Potential for *Legionella* bacteria to develop within water systems on site (accepted/monitoring only). Score 10.

WTWA

MFT/001456 - Opportunist pathogens – *Legionella*, *Pseudomonas*. Score 9

MFT/004822 - Never event: scalding. Score 3

MFT/006962 - Loss of water supplies. Score 9

NMGH

MFT/006397 NMGH Water systems - Actions discussed around ring main drawings

being required, especially with the uptick in enabling works for the re-development taking place-Score 6

In addition to the above, the following 'extreme' risks relating to water safety are reported onto the risk register system and monitored through Water Safety Groups; Estates and Facilities Management Group and relevant Clinical Group Management Board/risk meetings.

MFT/007838 UDHM dental hospital water tanks. Risk register assessment was developed between the hospital and estates colleagues. Risk score of 16. A number of actions were implemented in the year to mitigate the risk, until the tanks can be replaced. These actions are documented on the risk assessment and being monitored through ORC water safety group, estates and facilities Management Group and UDHM/LCO Clinical Group management/risk meetings.

MFT/002390-OSM Cold Water Storage Tanks (and general building condition risk). Ongoing discussions relating to building use with OSM SLT and Estates and Facilities. New facet survey commissioned to review condition.

14.2 Management of Risk for Legionella:

Water sampling for Legionella and Control of Legionnaires' disease continues to be undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites.

All positive legionella samples are discussed through the relevant site safety meetings and followed up with re-sampling and remedial actions (such as POU filters fitted) as appropriate.

To support legionella testing at NMGH at the beginning of 2024 appointments were made for estates technical service staff to bring the service in-house for 24/25 year. This has allowed for a more flexible testing regime to be implemented with more consistency in sampling procedure.

14.3 Management of Pseudomonas aeruginosa from Water Outlets in Higher-Risk Clinical Areas:

The review of areas classified as Augmented Care for the purpose of sampling for Pseudomonas took place across the ORC, WTWA and NMGH sites and were agreed by the Water Safety Groups. Sampling continued in accordance with HTM04-01 Part C.

Routine water sampling for the presence of Pseudomonas Aeruginosa resumed in Quarter 1 2024/25 across ORC. The number of samples taken increased due to returning to taking hot and cold samples separately (per HTM 04-01 recommendations).

NMGH introduced the use of the IDEXX Pseudalert system for the detection of Pseudomonas aeruginosa in 24hours in 24/25 year. Feedback from the Water Responsible Persons and IPC colleagues has been positive, and on two 2 occasions the estates team were able to turn around testing in 24 hours to show negative water samples in the ICU.

Pseudalert has been in use for the rapid testing of pseudomonas, at WTWA for approximately 3 years and has been approved by the Water Safety Group and AE Water. The product provides definitive results in 24 hours and allows a quicker

response to positive samples. Samples continue to be sent to the laboratory alongside using Pseudalert.

Off Campus/Community Premises - In addition to the identified Augmented Care areas within the Acute hospitals, Pseudomonas sampling was undertaken quarterly at the Community Macular Treatment Centres at outlets associated with intravitreal injections. This quarterly testing continues into 2025/26.

A procedure which outlines the procedures to be implemented at all MFT Augmented Care Units (ACU) following a positive Pseudomonas or Legionella water sample has been drafted by Head of Compliance, Risk and Governance – E&F, and shared with WSG members. It is currently awaiting approval by IPC.

14.4 2025/26 Water Safety Management

A piece of work led by Estates & Facilities, working with clinical teams, to identify Arjo baths in situ across and risk assess those which are no longer required, is underway and will continue to be monitored through the Trust Infection Control Committee. The aim is to remove those baths which have been risk assessed by clinical teams as no longer required. It is noted that removal will require works to be carried out by Trust Estates Team and the level of work will need to be determined on a room by room basis and consider other factors in change of use from bathrooms such as fire safety compartmentation.

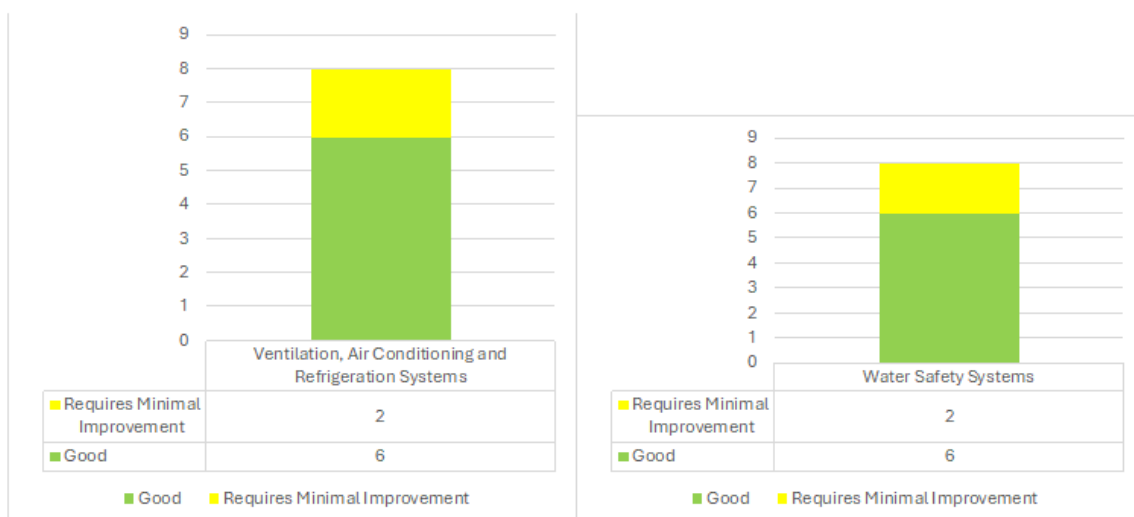
Cleaning of sinks and wash hand basins:

Estates and facilities Matron reported to the WTWA Water Safety Group that the MFT draft SOP for the cleaning of WHB is near completion. IPC has been consulted, together with AE(Water). The original draft has been revised to align with the requirements of the revised National Standards of Healthcare Cleanliness 2025. The safety groups await the final SOP, which is expected in Q1 2025/26 for issue and dissemination.

14.5 Assurance Reporting

Assurance of all Estates technical services/disciplines under HTM guidance (including water safety and ventilation) is recorded through the Estates and Facilities Assurance Module (via Concerto Platform). The questions within the E&F module are a duplicate to the questions within the NHSE Premises Assurance Model to allow external annual reporting.

As of end April 2025 the assurance scores for water safety and ventilation are shown in the following graphs and diagrams. Water Safety assurance questions are reviewed and monitored through the water and ventilation safety site meetings and also in assurance review meetings through the E&F Compliance, Risk and Governance Team.



SAQ Title	List Of Qs	Question	Trust NHS PAM Score
Water Safety Systems	SH08-1	Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Requires Minimal Improvement
	SH08-2	Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Good
	SH08-3	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	Good
	SH08-4	Are assets, equipment and plant adequately maintained? (Note 1)	Good
	SH08-5	Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Good
	SH08-6	Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Requires Minimal Improvement
	SH08-7	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Good
	SH08-8	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Good

SAQ Title	List Of Qs	Question	Trust NHS PAM Score
Ventilation, Air Conditioning and Refrigeration Systems	SH11-1	Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Requires Minimal Improvement
	SH11-2	Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Good
	SH11-3	Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Good
	SH11-4	Are assets, equipment and plant adequately maintained?	Good
	SH11-5	Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Good
	SH11-6	Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Requires Minimal Improvement
	SH11-7	Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Good
	SH11-8	If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Good

15. Ventilation Overview

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. Where other non-specialised ventilation systems are installed, they are maintained in accordance with manufacturers recommendations and any required standards.

All new and refurbishment schemes continue to be required to provide verification reports, inclusive of commissioning information and any derogations where new systems were introduced or were being connecting to existing plant.

The AE engineer continues to attend quarterly site Ventilation Safety Groups (VSG), alongside Appointed/Responsible Persons and representation from IPC. The safety groups continued to monitor risks, issues, failed verifications, remedial works, reactive works, derogations, and lifecycle works. Issues that required escalation were taken to the site Technical Boards and Estates and Facilities Management Group to determine further actions and/or escalations as required. Monthly meetings between Estates and Facilities, the Associate Medical Director – Infection Control and Microbiology, and Assistant Chief Nurse IPC/TV continued to be held in 2024/25 year to discuss ventilation outside of TICC and site water safety groups.

Annual ventilation HTM audits were completed by the Authorising Engineer (Ventilation) in 2024/2025 for ORC; WTWA; NMGH sites. Actions from audits are reviewed and monitored through the quarterly site water safety groups. The Estates Operational teams continue to work to complete actions identified, with all actions requiring sign off by the AE before closing.

Ventilation Safety Planned Preventative Maintenance (PPM) information continued to be provided to the Group Infection Control Committee in 24/25 and will continue to be provided going forward as part of the Ventilation Safety AAA report.

Trust Ventilation Policy has been reviewed and is due to be ratified at Estates and Facilities Management Group in May 2025. Ventilation Safety Policy is supported by site Ventilation Safety Plans which are in place for ORC, NMGH (ratified January 2025). There is a working draft in place for WTWA and ORC plan is under development, both for ratification in Q1 2025/26.

15.1 Ventilation Safety Risks

The following risks are currently owned under Estates and Facilities on the risk register relating to ventilation. These are monitored through Ventilation site safety groups and items for escalation raised through Estates and Facilities Management Group, decontamination committee (as relevant) and TICC.

ORC

MFT/002067 - Potential failure of critical ventilation systems, 2 open actions for systems lifecycle & ductwork cleaning.

MFT/002656 - Potential failure or Theatre 1-12 due to delayed lifecycle, 2 open actions for frost coil replacements & AHU lifecycle.

MFT/002746 - Excessive temperatures, 1 open action for chiller replacement scheme.

MFT/008093 - Endoscopy Decontamination Suite, low pressure differential and flow

rates. This risk was closed with all actions completed at the ORC Ventilation Safety Group (January 2025), with approval of closure at the Decontamination Committee (April 2025).

WTWA

MFT/001840 - Critical Ventilation – Aged Infrastructure - Score 9

NMGH

MFT/006394 - NMGH Critical Ventilation- relating to condition and life-cycling of critical ventilation systems and LEV systems on NMGH site - Score 12

MFT/007450 - NMGH ICU ventilation-Risk around the upgrade of the ICU Ventilation system - Score 12

MFT/007889 - NMGH Fire dampers risk-restricted of access has led to a lack of testing and maintenance of fire dampers in some areas. Capital funding will be required to complete remedial works - Score 12

MFT/008206-NMGH HSDU AHU upgrade - Upgrade of the current AHU serving the clean room in the HSDU service

Risk relating to 'cleaning of ventilation grilles in patient areas' identified during the external cleaning review was further reviewed by the Head of Compliance, Risk and Governance, Estates and Facilities in 2024/25. This paper will be taken to Estates and Facilities Management Group for approval, then noting at a future TICC. A key action identified is to develop a Task and Finish/Steering Group will commence in 2025/26 year with key stakeholders (including facilities and IPC) to address gaps identified in cleaning and develop and action plan. This will require a consistent approach across the Trust with clinical group support.

Emerging risks continue to be identified across NMGH site in relation to ventilation plant due to the age of the ventilation plant. Limited life cycling of ventilation plant, under the previous Trust, means that now AHU's in Phase 1 and 2 are now over 20 years old. A draft risk assessment is in development at the time of writing this report to identify actions required, including upgrades to the ventilation systems across several theatres at NMGH in the future.

15.2 Ventilation Safety Guidance Update

Guidance relating to cleaning requirements for UCV theatre perforated screens was discussed by the Ventilation Authorising Engineer at the site Ventilation Safety Groups. A review on actions required by MFT Estates is underway, with a likely addition to PPM (planned preventative maintenance) tasks required.

16. Decontamination

16.1 Sterile Services

All MFT Sterile Service departments are Certified to ISO 13485:2016 Medical Devices Quality Management Systems and UK Medical Device Directive. All PPMs, machine validation, environmental monitoring and ISO quality compliance for the two internal Sterile Services departments have been suitably managed and compliant for 2024/25.

16.1.1

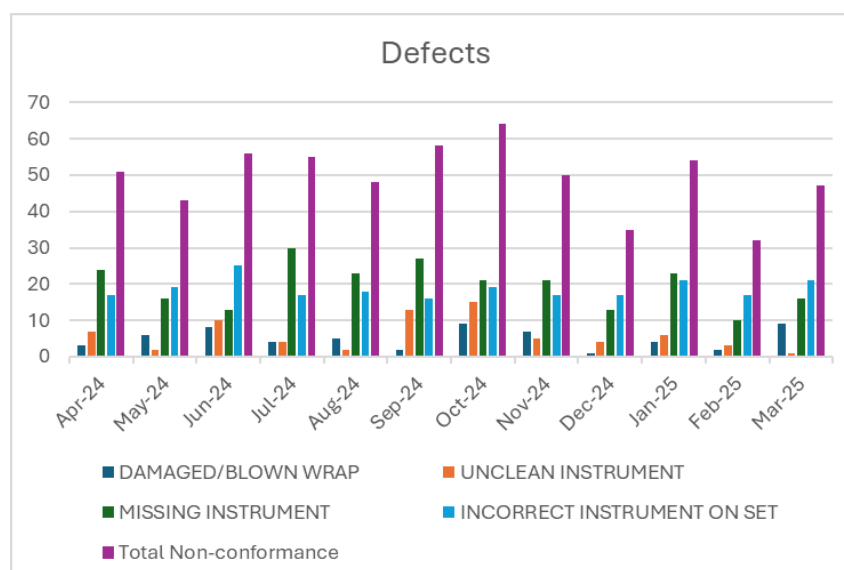
Oxford Road Campus (ORC) Decontamination Services Department (DSD)

The ORC DSD continued to provide satisfactory, compliant, and accredited levels of service to all sites. All DSD staff are fully trained and competent with all systems and equipment within the unit. DSD's overall production figures increased by 3% with 382,743 trays and supplementary items processed. The average turnaround time was 29-hours. DSD met the turnaround time for 75% of the reported months. DSD have identified an 8% shortfall for production entering the department that has not been customer issued within the same period. Overall WTE establishment for production staff has remained at 32.61 with no increase to meet the additional demand of 7-day surgery across the Trust.



DSD has maintained a defect rate below the 0.2% target for 2024/25 with the exception of September 2024 averaging 0.15%.

DSD had a V2 Surveillance Audit in October 2024 and passed with only 1 minor corrective action and passed with only 1 minor corrective action.



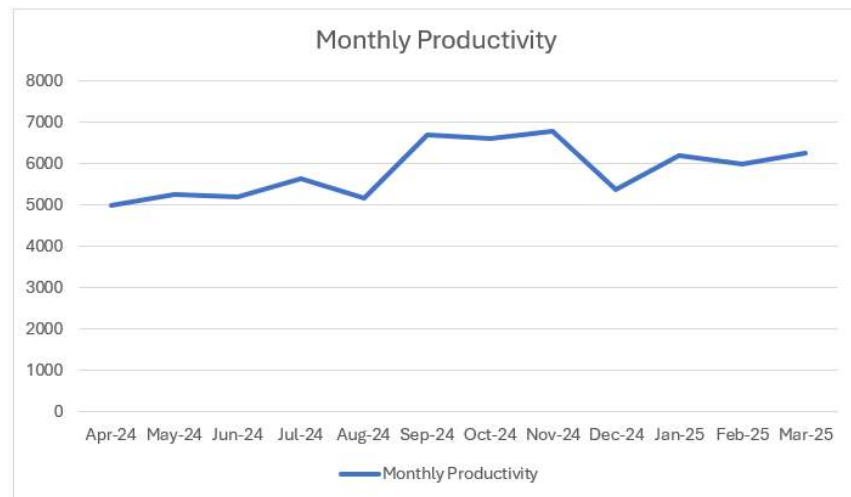
16.1.2

North Manchester General Hospital (NMG) Hospital Sterilisation & Disinfection Unit (HSDU).

The Hospital Sterilisation and Disinfection Unit (HSDU) at North Manchester General

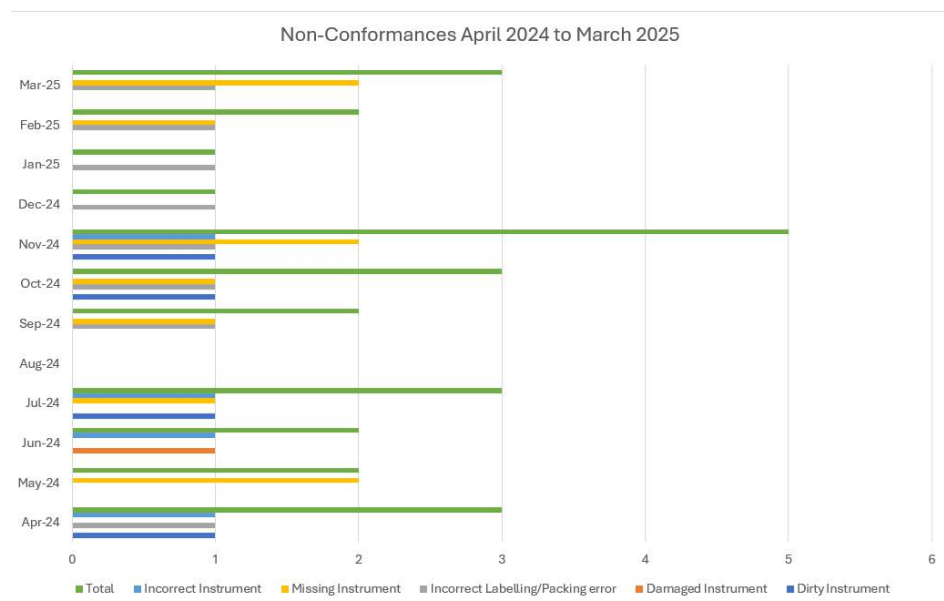
Hospital (NMGH) continues to operate well within its capacity and remains able to accommodate increased volumes if required.

An annual review of plant equipment, including analysis of breakdowns and maintenance reports, has confirmed that while the current equipment is approaching the end of its expected lifecycle, it has been exceptionally well maintained. Risk assessments indicate that the existing equipment remains fit for purpose and could continue to operate effectively for at least another five years.



Throughout 2024/25, the HSDU consistently maintained a defect rate below the 0.1% target, averaging an impressive 0.04%.

In late November 2024, the unit underwent a full recertification audit, which it passed successfully with only one minor corrective action. Following this, SGS—an MHRA-approved notified body—issued updated ISO 13485 and UK MDD certificates, confirming the unit's continued regulatory compliance.



- 16.1.3 **Wythenshawe, Trafford and Withington (WTWA) Sterile Services (Steris)**
 WTWA Hospitals continued in the Northwest Sterile Service partnership (NWSSP) with the Christie and Warrington hospitals to receive their sterile services provision from Steris, the independent decontamination services provider, from their facility in Wythenshawe. There was a change to reporting structures in 2024, where the Contract Manager role transferred to Estates and Facilities from Wythenshawe Theatres. The contract was re-awarded to Steris in March 2025. This contract is expected to run for at least 7 years with the options for three annual extensions.
- Steris defect rate is slightly over target for 2023/24, this is addressed monthly via the contract service review meetings. Refurbishment of the decontamination machines is planned for mid-2024, expected to support improving defect figures.
- 16.2 **Endoscope Decontamination Units (EDUs)**
 The EDUs across the Trust continued to provide satisfactory, compliant, and accredited levels of service to all sites. All Endoscope Decontamination Staff are fully trained and competent with all new systems and processes (verified as part of the JAG Audit and the Independent Authorising Engineer (Decontamination) (AE(D) Institute of Healthcare Engineering and Estates Management (IHEEM) Annual Compliance Audit process). Certification remains in place with the Joint Advisory Group (JAG).
- 16.2.1 **ORC EDUs (MRI, OPD, ETC & Endoscopy)**
 The washers, driers and Reverse Osmosis systems for these units are supplied on a lease and maintained by Getinge and Envirogen, the two machine manufacturers. Getinge also provides validation and water sample testing for these services. This has been a successful contract with all machines maintained and regular timely water sample reports.
- 16.2.2 **WTWA EDUs (Withington, Wythenshawe & Trafford)**
 Wythenshawe was deemed a centre of excellence for Endoscope decontamination in January 2024. Withington EDU is the only EDU with different washers and RO system than the rest of MFT, the water system has again been challenging during 2024. The WCH management team have addressed concerns with the supplier.
- 16.2.3 **NMGH EDU**
 The unit came under MRI management in 2024 which has been a positive step to unifying services across MFT. In 2024 the unit also adopted responsibility for TOE probe decontamination. As with many Areas this is still conducted via a 3 step disinfection wipe process while SLTs move to automated UV decontamination.
- 16.3 **Pathology & Laboratories**
 The laboratory Sterilisers for ORC and Wythenshawe hospital were regularly tested and validated accordingly. However, the new AMR lab steriliser has been out of use for all of 2024 due to insufficient commissioning tests from the supplier, the Trust Decontamination Lead and AE(D) cannot accept this device into operation until the necessary validations have been completed. SLT are working with the supplier to resolve this issue.
- 16.4 **Domestics & Room Decontamination**
 MFT operates two methods of room decontamination supplied by Inivos a commercial provider. These methods are Vaporised Hydrogen peroxide (HPV) and Ultra Violate light (UVc). In March 2024 a project group was formed to standardize processes across all sites and agree criteria for the methods employed to combat the different

bacterial and viral infections. Post infection cleans are always followed by room decontamination using one of the chosen methods.



16.5 Local Decontamination (TV/TOE Probes & In-situ decontamination)

16.5.1 Trans Oesophageal Echo (TOE) cardiac probes continue to be decontaminated using an automated UVc system at Wythenshawe CTCCU. However, the process at MRI Echo Hub, MRI Theatres and NMG Cardiology is to use a wipe system. The recommendation for automated process has been communicated Cardiology SLT who are exploring options to acquire an automated process.

16.5.2 Ultrasound and Gynaecology TV Probes moved from using a foam and wipe system early 2025 for a more robust 3 step disinfection wipe. This is the minimum accepted process for decontamination of these devices and has been approved as it is considered an improvement to the subjective foam system, while the SLT procure an automated UVc cabinet for TV probes.

16.5.3 ENT Nasendoscope. Following the success of the three UVc decontamination cabinets at NMG last year, ENT has procured a further six units to roll out this process to all ENT Nasendoscope departments.

16.6 Laundries

16.6.1 MFT has two external Linen services providers Ellis and Synergy Linen Management Services (LMS). Ellis supplies ORC and Wythenshawe. Synergy LMS supply NMG, TGH, WCH and Altrincham.

16.6.2 Both services have maintained compliance to HTM01-04 Decontamination of linen for health and social care and BS EN 14065:2016 microbiological quality of processed textiles. MFT receives monthly reports from both providers, these are reviewed by the trust Facilities management team with Microbiological reports being reviewed by the Decontamination Lead.

16.7 LCO Dental Practices

- 16.7.1 Decontamination is confined to community dental practices; instruments are processed through benchtop washer Disinfectors & Sterilisers. 2024 has been a difficult year for this service due to aging equipment and lack of capital investment. All sites have been reduced to hand washing instruments prior to sterilisation and steriliser are struggling to pass validation tests. This service is now at critical mass, the equipment needs to be urgently replaced. Business cases have been submitted, risk currently sits at 20. No funds have been allocated to date.

16.8 Training & Competency

- 16.8.1 In May 2024 NHSE released the technical Bulletin as an addendum to HTM01-01. This highlighted the recommendations from the 2022 HSSIB report for Decontamination professionals to be registered with the Academy for Healthcare Science, and for all decontamination staff to have formal, levelled qualification for the science of decontamination. A TNA was conducted which identified gaps with the underpinning knowledge and qualifications for MFT decontamination staff. E&F quickly responded by allocating an annual budget for Training and CPD for the Sterile Services departments. In January 2025 with the support of the DIPC and MRI DoN, funding was allocated from the Education department for training and CPD of Endoscope Decontamination staff.

16.9 Regulation Compliance

- 16.9.1 As a result of the release of the technical Bulletin to HTM01-01, a compliance tracker was created to monitor progress with the actions outlined to obtain compliance. This is reviewed at each Trust Decontamination Committee. The document sets out several recommendations relating to Board visibility of decontamination quality, professional registration of senior decontamination staff and standardized job profiles and qualification for decontamination staff. Organisations have been given 5 years to comply.
- 16.9.2 Following the appointment of the new DIPC in 2024 a subcommittee of TICC for Decontamination was formed, The Trust Decontamination Committee (TDC). This committee was granted the authority to review high level risks and ratify policies related to Decontamination on behalf of TICC. The committee is a strategic level group to govern Decontamination compliance and processes across MFT, it is well represented by all DoNs, is chaired by the Trust Decontamination Lead and supported by the Deputy DIPC and Associate Medical Director and ACN, IPC/TV.

16.10 Risks

- 16.10.1 The Risk for Decontamination MFT/002842, has been reviewed by TDC throughout the year. The risk currently sits at 12. There are only two ongoing actions open on this risk, after which it can be reduced to 8.
- 16.10.2 The Risk for Tracking and Traceability of Surgical Instruments to Patients MFT/007404, was identified in October 2023 and originally scored at 20. After a working group was established to close the gaps in controls the risk was reduced to 8 in 2024. The compliance is now regularly monitored at TDC.
- 16.10.3 SMH Newborn services risk for Video laryngoscope obsolescence for managing difficult airway situations in NICU MFT005887 and Connect Northwest MFT007048, identified June 2023 initially scored 9. This was increased to 16 following an IPC and Decontamination review of the replacement devices in January 2024. A low temperature Steriliser was installed in March 2025 to mitigate the issues. This risk will be reviewed at the July Trust Decontamination Committee and if the new process is deemed successful, the risk will look to be closed.

- 16.10.4 TOE Probe decontamination, MFT/006680, this relates to not all areas having an automated process for TOE Decontamination as Wythenshawe CTCCU and Cardiac Theatres have. Through the TDC DoNs and SLT are seeking to procure additional automated processes to have uniformity across the organisation. Current score 12.
- 16.10.5 US Probe Decontamination MFT/007856, following audits from the Trust Decontamination Lead, it was identified that the manual process using a foam spray was insufficient decontamination for the risk level of these devices. In January 2025 all Ultrasound departments transferred away from the subjective foam process to a more robust 3 step disinfection wipe system. This was accepted by the Trust Decontamination lead and IPC as the minimum standard and a short-term solution until an automated decontamination system can be procured. Currently the business case is in draft, and the risk remains at 12.
- 16.10.6 DSD Checking instruments into Wash, MFT//007893, this risk was identified following a HILA for a patient harm incident. E&F have a plan to redeploy additional staffing from another unit to DSD to allow for additional resource to be allocated to conduct this work. Risk Currently 16.
- 16.10.7 Obsolete Dental Decontamination equipment LCO, MFT/006251, At the TDC in January 2025 it was agreed to increase this risk to 20. This was to reflect the reduction in capability to maintain the washers resulting in medical devices having to be hand washed and that several lists had to be rescheduled due to failing Sterilisers. The Dental Practices are now at the stage where they could need to cease services due to in ability to decontaminated devices between patients.

17. The Infection Prevention and Control Development Pathway (IPCDP)

- 17.1 The Infection Prevention and Control Development Pathway (IPCDP) was commissioned in 2020 by Greater Manchester IPC Leads. The pathway is delivered at three levels Foundation, Intermediate and Advanced, and focuses on knowledge, skills and behaviour with an emphasis on changing behaviour and assisting others to do this. It is an interactive e-learning package with personal and professional development activities throughout the programme.
- 17.1.3 Additionally, the pathway is aligned with a knowledge, skills and behaviours framework, allowing individuals to assess and plan their professional development linked to IPC. This is aligned to NHS Knowledge and Skills framework (KSF), Infection Prevention Society (IPS) and World health Organisation (WHO) competencies.
- 17.1.4 The Foundation level of the pathway is available to IPC practitioners and healthcare workers across the Northwest, including MFT.
- 17.1.5 The table below details total numbers of participants enrolled and their progression with each of the pathways to date:

GM Cares	Completed	In-progress	Totals
Foundation	277	256	533
Intermediate	135	50	185
Advanced	49	126	175

MFT Learning Hub	Completed	In-progress	Totals
Foundation	107	145	252
Intermediate	46	71	117
Advanced	7	16	23

17.2 Training and Education

17.2.1 Respiratory Protective Equipment (RPE) Training

In accordance with the requirements of the IPC Board Assurance Framework (BAF) local Hospitals/MCS fit testing records are maintained on the central learning hub. Fit testing competencies are uploaded on the Kallidus Learning hub.

17.2.2 The IPC team have helped in facilitating quarterly fit test 'trainer' sessions during 2024/25. External accredited companies have provided training for staff at all MFT hospital sites. Each directorate pays a fee that reimburses the IPC team for the external company training sessions provided.

17.2.3 There is an ongoing national requirement for all healthcare staff who must use FFP3 within their role to be fit tested every two years to at least two different masks to ensure there is no over-reliance on a particular brand of mask.

17.3 Focus on practice

17.3.1 The IPC/TV team participated in the World Health Organisation's hand hygiene day on 5th May and visited clinical areas across the Organisation during that week with the lightbox encouraging both staff and visitors to participate. The focus was on correct hand hygiene practices including reinforcing the 5 moments of Hand hygiene with staff promoting the "Save lives: clean hands" motto. They conducted challenges and identified hand hygiene champions

17.3.2 International Infection Prevention Week ran from 13th-19th October 2024, where general IPC practices were the focus including – Gloves off campaign updates, Information on healthcare associated infections and quizzes. The key theme of the week was 'Moving the needle on Infection Control'. Feedback for both events was good from both staff and visitors across the organisation.

17.3.4 The Gloves Off campaign, launched in 2022 to reduce inappropriate overuse of disposable gloves and improve compliance with hand hygiene, reduce the level of skin complaints in healthcare workers and reduce plastic waste within the environment, was reinvigorated throughout 2024/25. From 2022 to 2024 the reduction in MFT spend on disposable gloves was £58,602. Nonsterile disposable gloves are often used when they are not needed and can impact patient experience, they are often not changed at critical points and as a result are associated with a significant potential for cross infection and transmission of HCAI. The IPC team held monthly meetings with nominated Gloves Off champions from wards and departments across MFT and supported them to

- Promote the campaign
 - Act as roles models and visible advocates
 - Act as a resource for ward/departmental colleagues
 - Lead and participate in Quality Improvement projects relating to the campaign
- Meetings will continue throughout 2025/26 to support the clinical teams to reduce

inappropriate use of gloves and promote best practice regarding hand hygiene and infection prevention.

17.4 **Legs Matter Week**

17.4.1 Legs matter week was held in June and formed part of a campaign promoting the national wound strategy. This was a joint venture with Tissue Viability, Podiatry and the vascular teams where the focus was to raise awareness of the importance of looking after legs and lower limb issues.

17.5 **Stop the pressure week**

17.5.1 The IPC/TV team celebrated Stop the Pressure week 18 -22 November 2024, where the focus was the fundamentals of pressure ulcer care and prevention, answering queries and hosting 'Cake and Conversation Events' which were open to all clinical staff. There were quizzes, games, interactive learning and competitions with prizes for the winners. Videos are available on the TV Resources page on the staff intranet site. The Tissue Viability Academy focussed on pressure ulcers in November to support the campaign.

17.6 **Additional Training and Education**

17.6.1 The IPC/TV team provided induction training to new starters across the organisation and provides e-learning annual updates developed in line with national standards. In addition to these, bespoke sessions in both IPC and TV were also delivered to individuals as required and the following groups:

Internship programme students

Student nurses

Spoke days for student nurses

Bespoke sessions in response to increased incidence of HCAI's, outbreaks or as required

TV academy study days

Planned IPC updates arranged locally

Care home staff

Practice nurses and GP's

Age UK staff

Activity camp children

General public within a library setting

Away days for several teams

17.6.2 Delivery of the MFT IPC and TV education strategy is assisted by representatives from companies whose products are used across the Community and Acute MFT settings. Their support is integral to MFT delivering local and national strategies for IPC and TV through both Induction of new staff to the organisation or ongoing support of existing MFT employees.

17.6.3 In the past year over 550 colleagues have received training in the use of Chlorclean to ensure both safety of staff and correct use of product to ensure the environment is cleaned appropriately, this training was provided by the company with further training planned for 2025/26.

17.6.4 In 2024/25 1068 colleagues received training in the correct use of Octenisan MRSA decolonisation therapy to ensure patients are receiving the correct dose and application methods to reduce the burden of MRSA and subsequent risk of MRSA bacteraemia. Further training will be continued throughout 2025/26.

17.7 **Infection Prevention and Control and Tissue Viability Team Development**

17.7.1 In addition to the training and education that the IPC/TV team provide across MFT,

we also recognise the importance that we invest within our own team. By strengthening our own knowledge and skills we can ensure our education and training delivery across the organisation aligns with national standards thereby supporting the organisation to deliver safe and effective care to our patients and their families.

- 17.7.2 Examples of types of education and training undertaken by the team include a wide range of wound care and infection prevention conferences and study days, leadership and management courses and Masters modules and pathways. These have been delivered by both internal and external providers across the community, acute and higher education establishments.

17.8 **HIVE Update**

- 17.8.1 Digital systems play a crucial role in supporting IPC across the organisation. Hive is integral to service delivery and our focus is on continually developing functionality to help clinical teams deliver quality care, including IPC Dashboards, SSI monitoring tools, internal messaging systems direct to clinical teams and HCAI surveillance.

17.9 **Clinical Group Review**

The Hospital/MCS/LCO have prepared and submitted an overview of Infection prevention activities undertaken within each of the clinical groups this year, the review is included in Appendix 3

17.10 **Conclusion**

- 17.10.1 In summary, this year's Infection Prevention and Control activities have demonstrated sustained progress in safeguarding patients, maintaining compliance with national standards, and supporting a culture of continuous improvement. Key performance indicators show consistent alignment with best practices, and the robust response to both routine and emerging infection risks reflects the commitment of our staff and leadership to high-quality care.

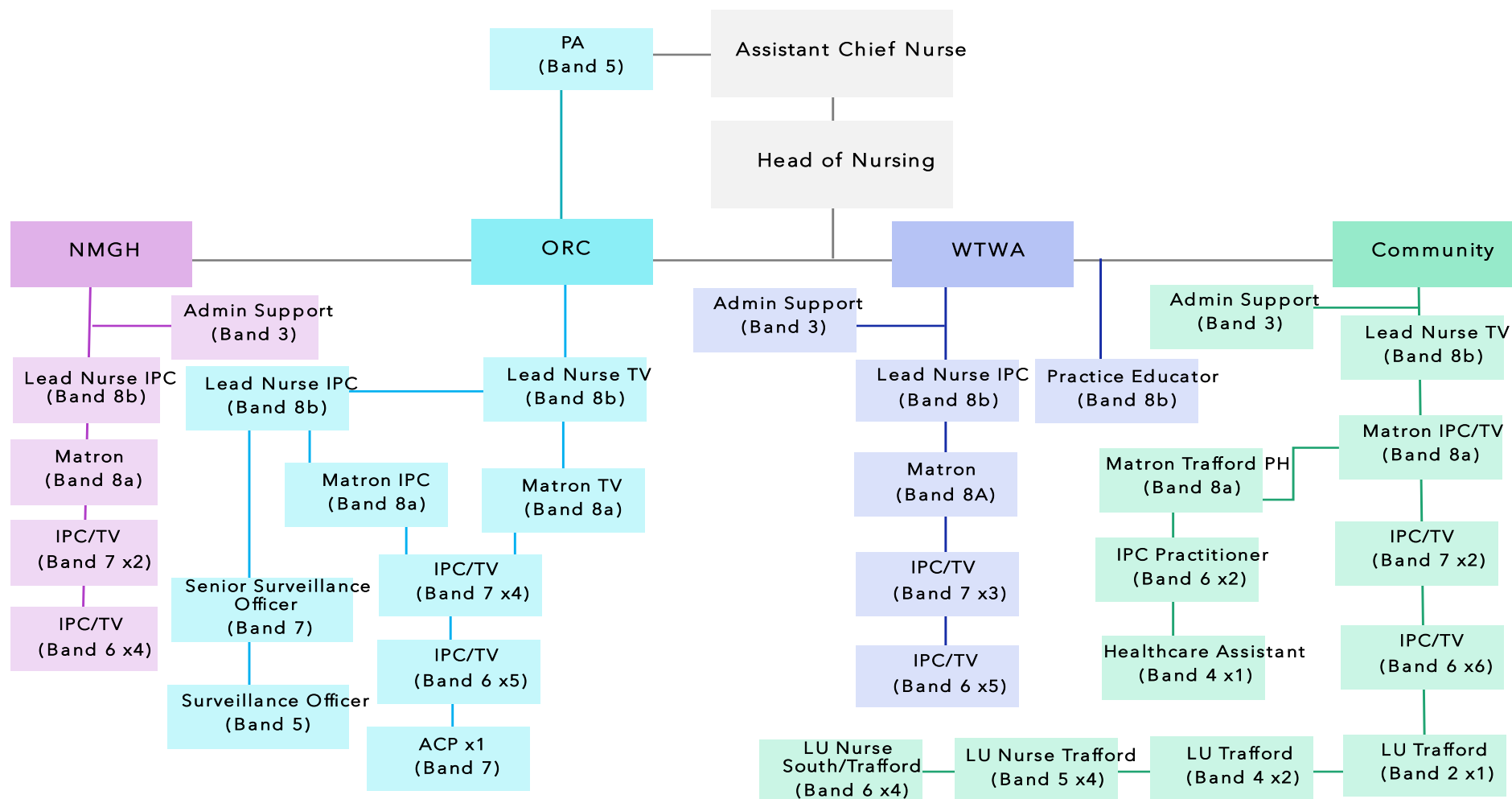
As we look ahead, our focus will remain on proactive risk management, enhancing data-driven surveillance, and embedding learning from incidents and audits into everyday practice. Strategic priorities for the coming year include strengthening antimicrobial stewardship, increasing staff education and engagement, optimizing environmental hygiene standards, and further integrating IPC into organizational resilience planning.

The QSPBC can be assured that infection prevention remains a top priority, supported by clear governance, evidence-based interventions, and a forward-thinking agenda designed to respond to evolving challenges while continuously improving patient and staff safety.

17.11 **Recommendations**

- 17.11.1 The QSPBC are asked to:
Note the information provided in the Executive Summary and
Accept the Infection Prevention and Control Annual Report for 2024/2025.

Appendix 1 MFT IPC/TV Nursing Team Structure 2024/25



Appendix 2 **TRUST INFECTION PREVENTION & CONTROL COMMITTEE** **TERMS OF REFERENCE**

1 CONSTITUTION

The Quality, Safety and Performance Board Committee has established a committee to be known as the Trust Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Trust Infection Control Committee is chaired by the Deputy Chief Executive/Chief Nursing Officer/Director of Infection Prevention and Control.

2. Membership

2.1 Membership of Trust Infection Control Committee shall consist of:

Deputy Chief Executive Officer/Chief Nursing Officer/DIPC (CHAIR)
Associate Medical Director Infection Control/Deputy DIPC (Deputy Chair)
Deputy Chief Nursing Officer
Assistant Chief Nurse, IPC & TV
Consultant Virologists/Consultant Microbiologists (IPC medics)
Clinical Group Directors of Nursing
Head of Nursing IPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
Consultant in Communicable Disease (Public Health England)
Lead Antimicrobial Pharmacist
Director of Estates and Facilities
Assistant Director, Employee Health & Wellbeing
Chair of Antimicrobial Stewardship Committee

2.2 The Committee may require the attendance of any Trust employee (or agent of the Trust) as required.

2.3 A quorum shall consist of a minimum of ten members including the Chair or Deputy Chair, four Clinical Group Leads and either the Deputy Chief Nursing Officer or Assistant Chief Nurse (IPC/TV)

3. ATTENDANCE AT MEETINGS

Members are expected to attend at least five meetings per year.

4. FREQUENCY OF MEETING

The Committee will meet every two months (six times a year) but may be convened at other times as deemed necessary. With prior agreement from the chair, well briefed deputies may attend by exception.

5. OVERVIEW

The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence-based practice and standards.

6. SCOPE AND DUTIES

The scope and duties of the Committee are

- 6.1 To provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets
- 6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites
- 6.3 Approve the programme of work of the Trust Infection Prevention and Control committee
- 6.4 Receive Clinical Group/MCS IPC escalation and assurance reports
- 6.5 Receive, review and ratify Trust policies, clinical pathways and reports including the Annual Infection Control report
- 6.6 Approve the annual audit calendar to provide assurance that standards are met and any changes to practice, systems and processes are delivered.
- 6.7 To report to the Quality, Safety and Performance Board Committee on performance against infection control indicators and audits, including any actions taken to address areas of improvement.
- 6.8 To determine and commission programmes of work required to deliver the work programme of the committee
- 6.9 Oversee the Trusts involvement in and response to internal and external assessments and inspections
- 6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with the infection prevention and control standards
- 6.11 Approve the Trusts annual Infection prevention and Control annual report
- 6.12 To describe, review and monitor the principle significant risks related to Infection control on behalf of the Trust and present these with a plan to the Quality, Safety and Performance Board Committee and Quality and Safety Management Committee.
- 6.13 The Committee will receive escalation and assurance reports from the Clinical Groups/MCS Infection Control leads.
- 6.14 The Committee will receive at each meeting a report including
 - Policy and pathway development
 - Infection Control group activity
 - Any changes to national/local strategy
 - Any Trust wide themes from adverse incidents or events

7. **AUTHORITY**

The committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. **REPORTING**

The committee will report to the Quality, Safety and Performance Board Committee and will provide assurance to the Board of Directors in relation to infection prevention and control. Minutes and escalation reports will be provided as requested.

9. **REVIEW**

These Terms of Reference will be reviewed annually

10. **Key Performance Indicators**

These Terms of Reference will be considered against the following key performance indicators

- 75% attendance of all listed members or nominated deputies
- Presentation of the Infection prevention and Control Annual Report

Appendix 3 Health Care Associated Infections Positional Charts

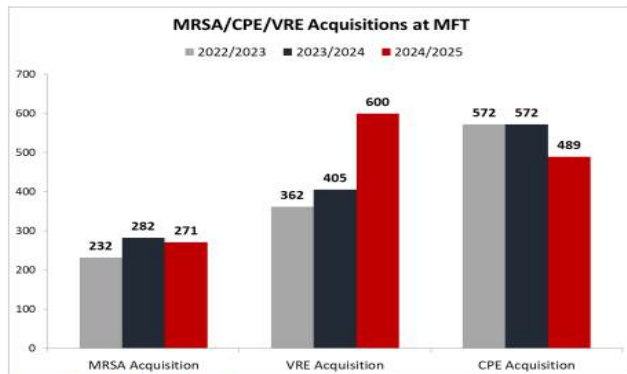


Chart 1: MRSA/CPE/VRE Acquisitions

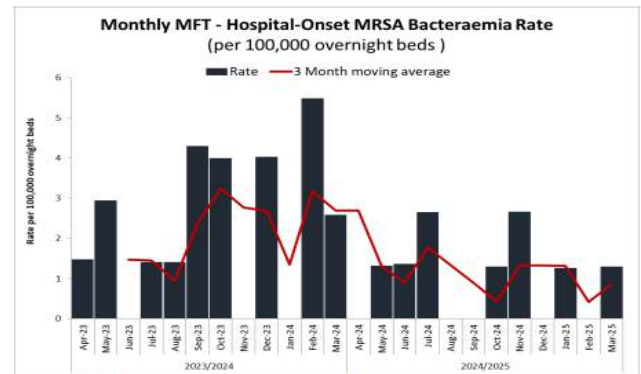


Chart 3: MFT hospital-onset MRSA bacteraemia rate

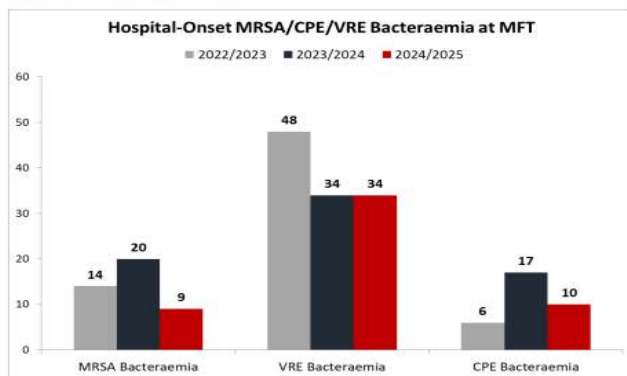


Chart 2: MRSA/CPE/VRE Bacteraemia cases

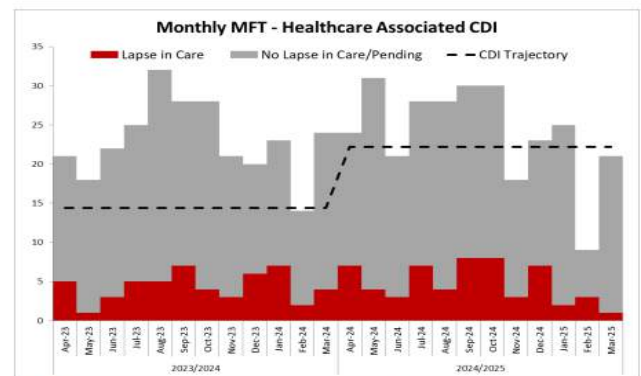


Chart 4: Monthly healthcare-associated CDI with Lapse in Care status and trajectory

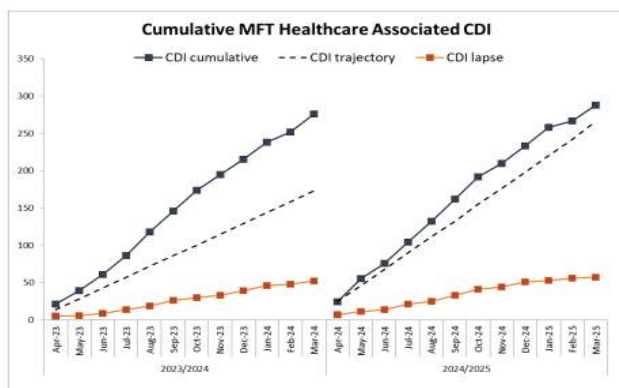


Chart 5: Cumulative healthcare associated CDI with lapse in care and trajectory

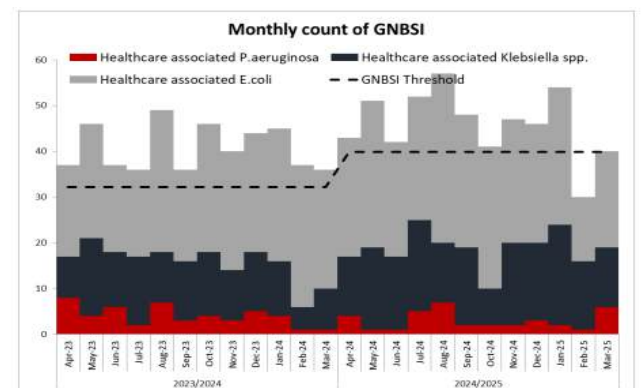


Chart 7: Monthly healthcare associated GNBSI cases

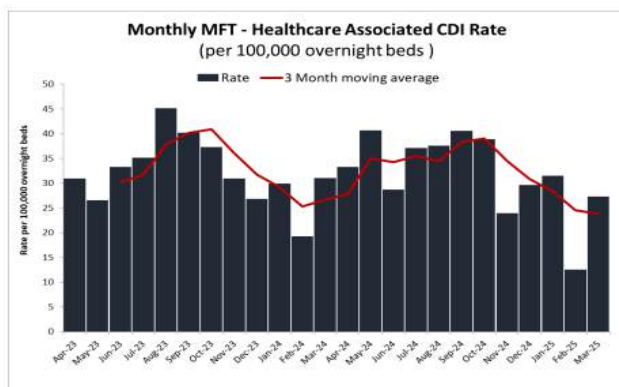


Chart 6: MFT healthcare-associated CDI rates

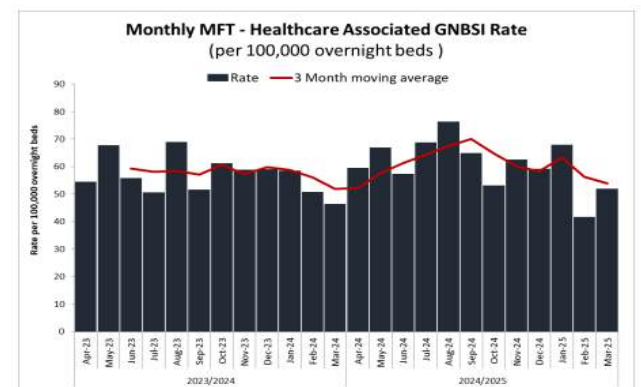


Chart 8: MFT healthcare associated GNBSI bacteraemia rates

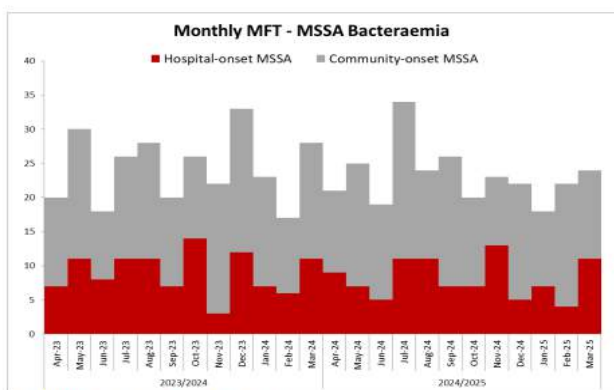


Chart 9: Monthly MSSA cases by onset

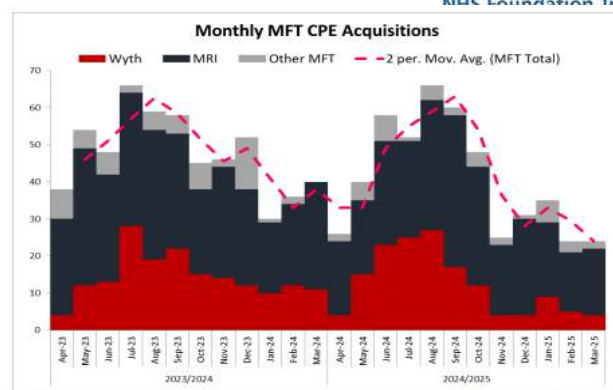


Chart 11: Monthly CPE acquisitions for MRI, Wythenshawe Hospital and other MFT

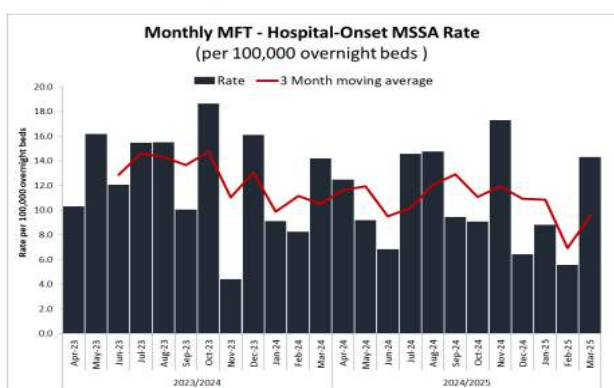


Chart 10: MFT hospital-onset MSSA bacteraemia rate

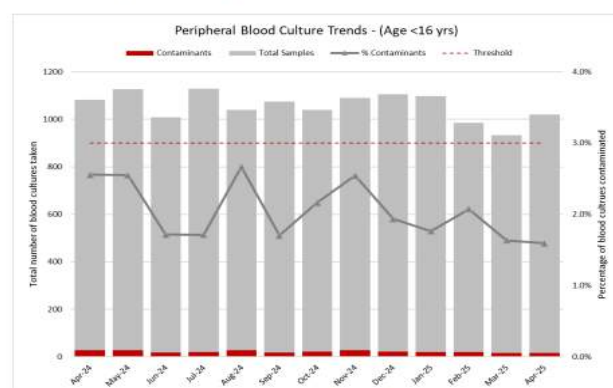


Chart 12: MFT-wide peripheral blood culture trends (<16 yrs)

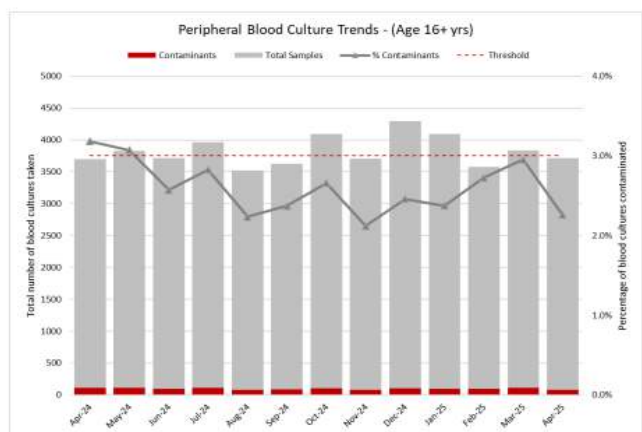


Chart 13: MFT-wide peripheral blood culture trends (>16 yrs)

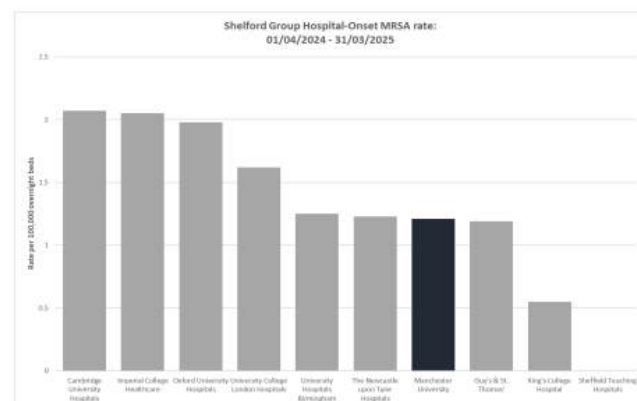


Chart 15 - Sheffield Group hospital-onset MRSA bacteraemia rates (per 100,000 overnight beds)

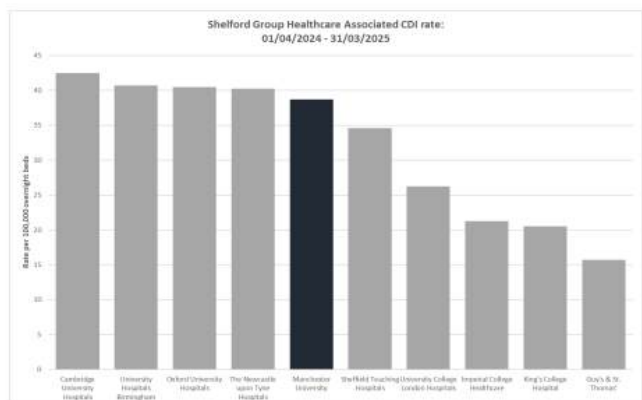


Chart 14 - Sheffield Group healthcare associated CDI rates (per 100,000 overnight beds)

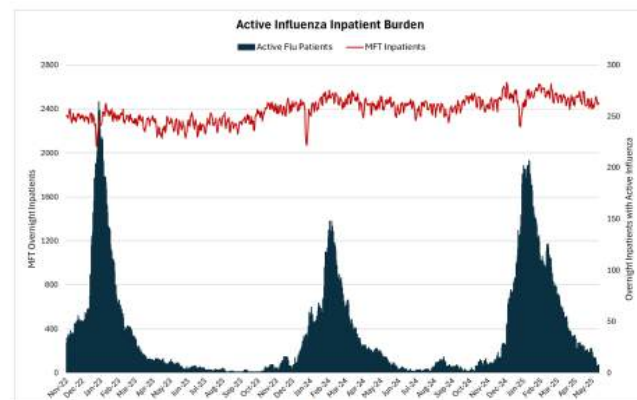


Chart 16 - MFT Population vs Active Flu Patients

Public Board of Directors

Wednesday 30th July 2025

Paper title:	MFT’s Winter Plan 2025-26	Agenda Item 11.6
Presented by:	Vanessa Gardener, Chief Delivery Officer	
Prepared by:	Dan Lythgoe, Director of Urgent and Emergency Care	
Meetings where content has been discussed previously	Quality, Safety and Performance Board Committee	
Purpose of the paper Please check <u>one</u> box only:	☒ For approval ☐ For support ☐ For discussion	

Executive summary / key messages for the meeting to consider

- Winter pressures continue to affect the quality and performance of the services we provide.
- Whilst Winter 2024-25 demonstrates areas of improvement across the Trust, further improvement is required to achieve our planned UEC key performance indicators.
- The Trust's Winter Plan serves to provide a strategic oversight of the delivery of care during winter pressures.
- In addition, NHS England and Department of Health launched their UEC Plan for 25-26 on 6th June 2025. This document has been reviewed to ensure that the prescribed actions and focus areas are contained within the Winter Plan.
- Subject to Board approval, the trust winter plan will be subject to rigorous scenario-based stress testing during September 2025 with system partners.

Recommendation(s)

The Board of Directors is asked to:

- Approve the Trust winter plan

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/006469

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

Main report appended

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 Winter Plan 2025/26



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Winter Plan Overview



The Winter Plan outlines Manchester Foundation Trust's (MFT) preparations and operational approach for the winter period. It forms a key component of the broader Manchester & Trafford Locality Plan.

The plan is built on the recognition that:

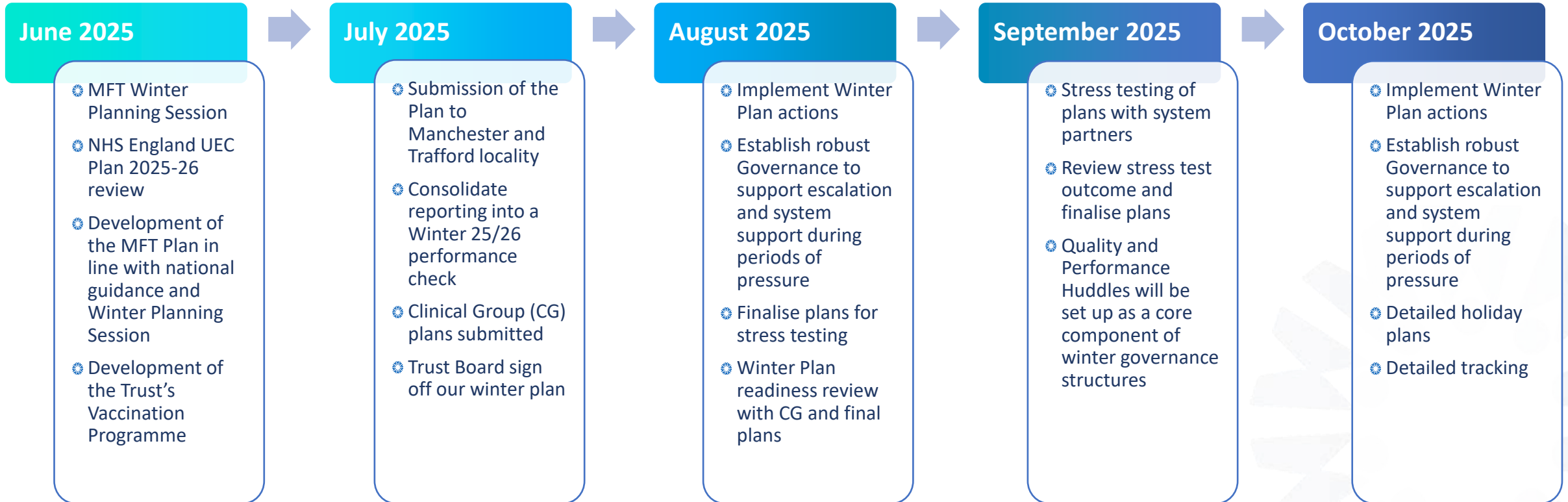
- ❁ Winter presents significant challenges for health and social care services.
- ❁ It is not considered an emergency or an exceptional event. Winter is to be seen as a time of heightened pressure due to clinical acuity and greater demand on resources.
- ❁ The season often brings a rise in infectious diseases such as Norovirus, Influenza, and Respiratory Syncytial Virus (RSV), along with the potential emergence of more severe threats like pandemic flu or COVID-19.

Key Success Factors for Winter Readiness

A successful winter response will depend on:

- ✓ Robust operational planning to ensure delivery of both elective and non-elective care.
- ✓ Strong performance management, with rapid identification of variances and effective corrective actions.
- ✓ Collaborative system-wide working, engaging with partners to coordinate winter preparedness and develop contingency responses.
- ✓ Achievement of the Trust's stretch targets as outlined in the annual plan.

Enacting the MFT plan

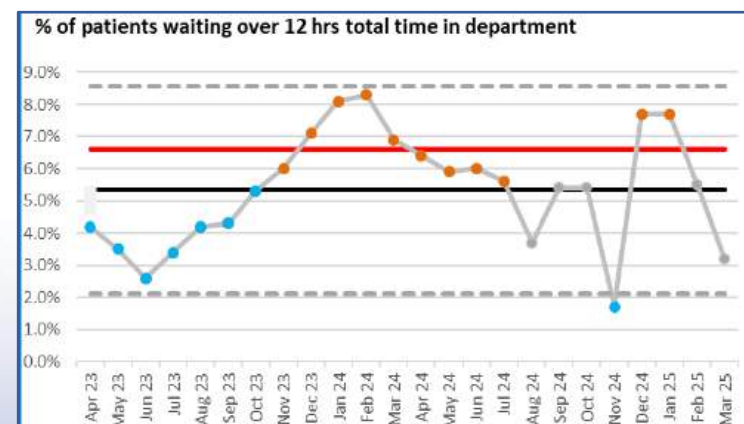
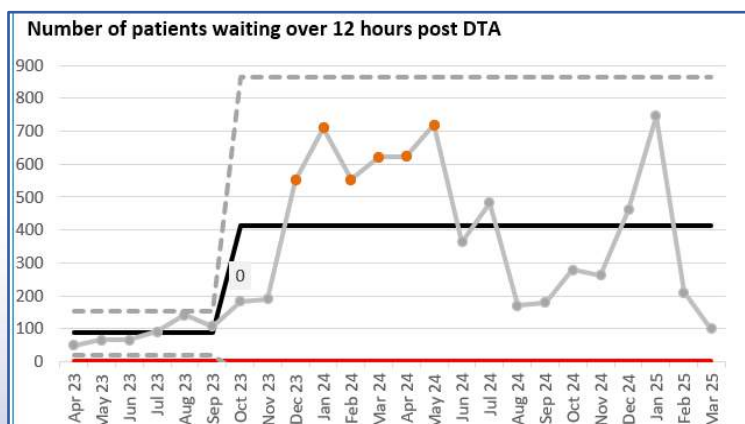
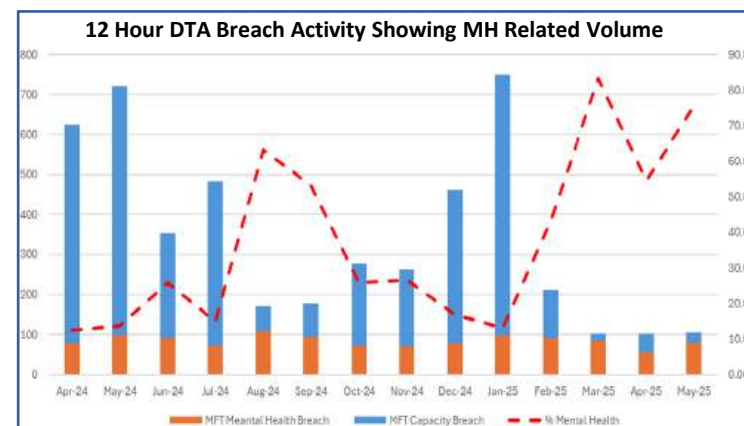
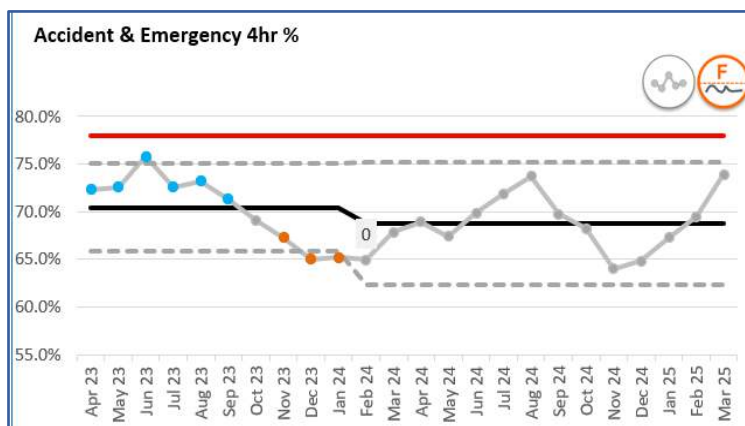


Review of Winter 2024/25



Winter 2024/25 ED performance

4-hour performance as a barometer for safety and system pressure is at its worst during November to January, improving from February. 12-hour Trolley waits peaked in January at appx 750 before returning to below 200 patients. March dropped further to 100 patient with the majority of these being Mental Health patients. Winter 24/25 must focus on delivering these two standards whilst managing increased acuity.



24/25 Winter Plan Evaluation Headlines

- ❁ MFT performance, which we know is a marker for safety, for March 25 was 73.9% vs 67.8% in March 2024. This is a 6.1% improvement and equates to nearly 3000 more patients seen within 4 hours.
- ❁ MFT achieved a 6% improvement in patients not referred/not admitted than March 24 improving patient experience.
- ❁ UTC performance improved by 3% to 95.6% compared to March 24, of which 97% of patients were not admitted.
- ❁ Patients waited 20 fewer minutes to be seen than they did in 2024 and 30 mins fewer minutes from being seen to discharged.
- ❁ There was an 84% reduction in 12-hour trolley waits – 566 fewer patients waiting over 12 hours on trolleys March 25 compared with last March 24
- ❁ During March, our LCO and Social care colleagues have halved the patients with no criteria to reside in our intermediate care beds, supporting flow from our acute sites into rehabilitation community beds.
- ❁ During April reporting G&A beds has improved since April 25 and live bed positions are now used, along with monitoring of use of Temporary Escalation Spaces



The Winter Evaluation 24/25 defined the following actions to be undertaken as part of Winter 25/26 planning

VACCINATION

- Consider the communication plan for delivering improvement to staff vaccination programme
- Review processes for ensuring those that can be vaccinated are.

REPORTING PROCESSES

- 12-hour reporting to be added to the overview with associated escalation
- 12-hour performance to be reviewed within clinical groups and added to reporting processes

MENTAL HEALTH

- Co-ordination centre to continue to support clinical groups in the escalation and management of Mental Health DTA wait reduction
- MFT Co-ordination centre to establish a weekly PTL review with GMMH and ad hoc escalation review at peak periods of pressure
- Escalation through to GM SCC of MH (or Acute) patients waiting over 48 hours for admission

FUTURE INVESTIGATIONS

- Deep dive into reduction in the sickness rate
- Deep dive into the spike of complaints received in January 25 to take actions into Clinical Group improvement plans.
- Investigate opportunities to reduce Disruptive, Aggressive Behaviour Infection/Sepsis management and Safeguarding
- Winter plan to include a review of attendances and have associated plans to manage periods of surge
- UEC Improvement board to lead response to respiratory presentations in paediatrics

Winter Plan 2025/26



Roles and Responsibilities for NHS Trusts

Responsibility	Response
Demonstrate plans to improve vaccination rates in health and care workers	MFT will develop a comprehensive vaccination awareness and engagement plan involving MFT communications, Health and Wellbeing Services, Clinical Groups and Infection Prevention Control Consultants.
Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments	HWB team developing the Vaccination Plan for 25/26.
Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target	MFT performs well and has agreed an improvement trajectory with NHS GM.
To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards	Paediatric Winter Plan with focus on RMCH MCS sites.
Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week	Site owned and managed. Profiled and supported through NC2R PTL approach, particular response to Housing requirements.
Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients	Local performance targets in place in line National Benchmarking. Care Closer to Home managing against. Agreed by partners and Clinical Groups. LCO SLT leadership.
Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so.	Care Closer to Home programme in place with Winter plans to deliver managing surge capacity and IPC cohorting.

DHSE Urgent and Emergency Care Plan 2025/26 (2)

Target
Develop / test plans

From <<https://www.england.nhs.uk/long-read/urgent-and-emergency-care-plan-2025-26/>>

Category	Actions	MFT 2024/25	MFT 2025/26 Aspiration
Ambulance wait times	- Establish defined trajectory towards achieving 15-minute handover target △ Meet 45-minute maximum handover standard	MFT handover for the full year was approximately 17 mins.	The Trust continues to perform well with agreed target of 20 mins. As of June 25, the Trust is performing at 17.2 mins and ahead of the target. The Trust has an agreed trajectory to reach < 15 min handovers to March
A&E attendances	- Ensure a minimum of 78% admit, transfer or discharge within 4 hours - waiting for admission or discharge over 12 hours occurs less than 10% of the time △ Develop and test plans to improve flow / eliminate corridor care - Make progress on eliminating corridor care	- For the full 2024/25 524181 attends of which 361841 patients were discharged or transferred within 4 hours. This equates to 69.0% 30488 patients were in ED longer than 12 hours equating to 94.2% performance - TES spaces were reported	Annual plan established to achieve 78.0% by March 2026 with a 2.7% increase in attendances profiled. If MFT achieves this there would be 31,000 more patients are treated within 4 hours.
Vaccination	- Improve staff vaccination uptake by minimum 5% △ Develop and test plan to achieve significant increase △ Actionable IPC strategy	- EHW trained 169 Flu Champions across the Trust who delivered the programme. - Flu vaccine uptake achieved 41.4%	In line with the UEC Plan the Trust would be required to achieve 46.4%; 1,500 more staff being vaccinated
Mental Health	Reduce number of MH patients awaiting admission over 24 hrs	During the year 1244 patients with a MH Consult were awaiting admission for more than 24 hours.	Working with GMMH, MFT is working hard to support quicker transfer of these patients into MH beds. Focused work on this during Q2 of 25/26
Discharge & NCTR	- Tackle delays in discharge △ Improve discharge times - Eliminate internal discharge delays of more than 48 hrs	Discharge programme through 24/25 but continued with challenges	Sites to have discharge improvement plans and manage them to improve discharge times
Paediatric	Increase number of children seen within 4 hours	Across 24/25 paediatrics 83.9% of children were discharged or admitted within 4 hours rising to 88.3% in March 2025.	Annual plan to achieve 78% for the Trust defines RMCH to achieve 83.7%. RMCH will have to redefine their target to support this action
Community	△ Plan to increase number of UEC patients seen in primary, community, MH settings (including urgent community response & virtual wards)	- Acute Respiratory Hubs - Manchester Acute Respiratory Infection Service (MARIS) –20,200 appointments delivered Impact – 33% of all appointments for children. At least 50% of these appointments would be seen in A&E. - UCR – Winter 24/25 Occupancy was consistently 98% occupied. - Hospital at Home	- UCR leadership is being reconfigured in October 25 with OneMFT approach. Co-ordinated Flow into UCR and Hospital at Home will improve through SPOA programme (Call before Convey) - Acute Respiratory Hubs will be reviewed through the Manchester and Trafford Urgent Care Board should Capacity funding be made available
LoS	△ Reduce by 0.4 days LoS for Patients with overnight emergency admission	During 2024/25 the average LOS for overnight admitted patients is 24 hours longer than those who are admitted during the day.	UEC and Flow Improvement programmes across Clinical Groups and MFT looking to address LOS with care Closer to Home programme supporting improvement

The MFT Winter Plan is presented in the four areas identified below:

System and MFT Co-ordination throughout winter

- Working together across the locality and GM with the Transfer of Care Hubs for Manchester & Trafford and ICS System coordination Centre
- Establish Quality & Performance Huddles from October 2025
- Start further reporting and escalation of pressures
- Establish Manchester / Trafford UEC huddle
- Forsee period of increased demand and ensure clear visualisation of plans
- Support the escalation and management of Mental Health in UEC and Ambulance handovers

Looking after our patients & our staff

- Support the health and wellbeing for our people with MFT having a range of programmes in place to support staff.
- The MFT vaccination programme to be developed and implemented in September 2025
- Robust workforce plans in place to deal with surges in demand and management of leave over peak holiday times.

Creating the capacity to meet the demand

- Extend hospital front-door that sees ambulatory pathways materially reduce admission rates SDEC and Hospital at Home including Virtual Ward and Urgent Crisis Response.
- Making sure that people are only in hospital when they need to be and ensuring discharges are planned well with our partners
- Maintaining emergency surgery and ensuring as little disruption as possible to routine operations through protecting our elective capacity and optimising Trafford as our Elective Hub
- Making sure that people who come to the ED are seen quickly and by a specialist in a timely way
- Work with partners across the system to keep patients well at home and avoid attendance to Emergency Departments driven through the Hospital at Home programme.

Communication Plan

- Preparing our people and communities ensuring communication is succinct and wide reaching
- Supporting our patients to understand when and what services to access and when to self-care

System and MFT Co-ordination Throughout Winter



Role of the MFT Co-ordination Centre into 2025/26 onwards

Responsibility for

- Responsibility for developing further forecasting of demand pressures across our system. Attendances, discharges and Infection Prevention Control
- Responsibility for reducing MH patients in Acute Hospital Care, right bed right time
- Responsibility for the escalation and drive to reduce those patients awaiting discharge who are out of area
- Responsible for the co-ordination of Repatriation and Tertiary referral escalations. In the main, Clinical Groups manage this, but MFT CC have oversight on delays and escalations.
- Responsible for oversight and escalation of 4-hour Crit Care step down breaches and mixed sex accommodation breaches
- Responsible for the representation of MFT into GM ICB, GM SCC and other health and social care partners
- Responsibility for the co-ordination of Quality and Performance engagement with Trust and Clinical Group teams

Leadership of

- Reporting to support and inform MFT Co-ordination centre and Clinical Group management team
- Responsible for the leadership on Trust wide initiatives that reduce ambulance hand over times of 45 mins and use of TES spaces
- Leading the implementation of Trust wide initiative for holiday periods or forecasted variation in expected performance breaches

Delivery of the interventions will be measured through the 4-hour A&E performance and No Reason to Reside numbers. Trajectories have been developed underpinned by Clinical Group plans. The UEC Improvement Workstream will be responsible for overseeing delivery of the plans. The plans aim to exceed the 78% by March 26. The NR2R plan will support a reduction in occupancy levels through Winter.

A&E 4hr

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
MFT	71.95%	72.22%	73.85%	74.59%	75.09%	72.64%	73.04%	71.22%	70.11%	70.10%	73.21%	78.08%
MRI	67.98%	68.18%	70.36%	70.70%	70.68%	69.51%	70.54%	69.36%	66.79%	66.06%	70.83%	75.16%
NMGH	65.49%	66.05%	69.57%	71.11%	71.61%	69.34%	69.44%	68.84%	67.40%	66.18%	68.97%	75.77%
WTWA	69.39%	69.26%	69.53%	70.50%	71.00%	68.40%	69.01%	68.75%	65.55%	67.25%	71.80%	75.44%

No Reason to Reside

No Reason to Reside

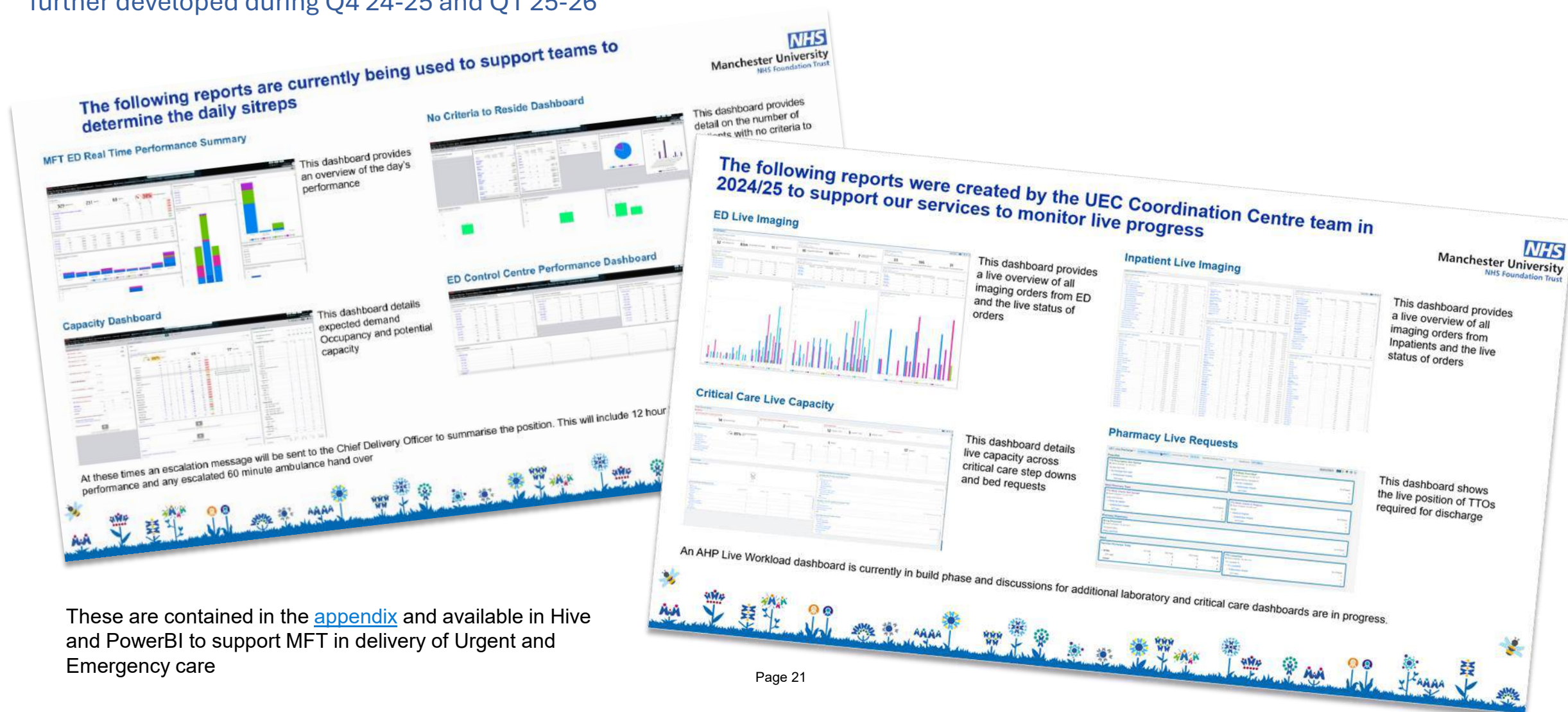
		Trajectory								
		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Overall	North Manchester General Hospital	87	83	77	76	75	75	75	75	75
	Manchester Royal Infirmary	87	83	77	76	75	75	75	75	75
	Trafford Hospital	39	37	35	34	34	34	34	34	34
	Wythenshawe Hospital	87	83	77	76	75	75	75	75	75
		300	285	267	262	259	259	259	259	259

Trajectory to demonstrate ambition to reduce NC2R to 259 by November 2025 by Clinical Group

- ✓ Established / Complete
- In Progress
- ❖ Planned
- Delayed

	Q1 2025/26	Q2 2025-26	Q3 2025/26	Q4 2025/26
Formal establishment of MFT Co-ordination Centre	➤ CC Systems / Processes SOPs ➤ Programme Plan / schedules ➤ Room setup review & information ❖ SharePoint setup ❖ Digital Support Plan	❖ Finalise recruitment ❖ Process review / imp (Appendix F) ❖ Programme development ❖ Site Relationship plan ❖ Review of CC: Site communication ❖ CC facility improvement Plan	❖ Winter Plan Go Live ❖ Establish Q&P Huddles ❖ Increase Daily Reporting ❖ Establish Manchester / Trafford UEC huddle ❖ Feedback & team assessment	❖ Start Winter Plan Evaluation ❖ Expand CC against appendix F ❖ Role development
Technical	❖ Hive Dashboard Review ❖ Dashboard Plan ➤ Daily Reporting Dashboard Design ❖ Daily Reporting Dashboard Build	❖ CSS Dashboard Consolidation ❖ Site Data & Reporting Review ❖ Report validation (criteria & linking)	❖ Site dashboard builds ❖ Data improvement as per site requirements ❖ In Hive reporting improvements	❖ Maintenance & Improvement data & dashboards
Information	➤ Review documents ❖ Information management plan ❖ Dashboard Information Report	❖ Resource System development ❖ System flow mapping	❖ Information review / gaps ❖ Information updates	❖ Begin consolidation of Winter information
Intelligence	❖ Data overview ❖ Review NHS-wide / literature ❖ Improvement (JDI) Review ➤ Easter / BH Plans	❖ Site review / visits ❖ Data gathering & analysis ❖ Improvement (JDI) Plan	❖ Site review report ❖ Activities from site report / data ❖ Implement JDI plan ❖ BAU & reducing pressure	❖ Activities from site report / data analysis ❖ BAU & reducing pressure
Programmes & Planning	➤ LOS Delivery Plan development ❖ Action Cards revised / reissued ✓ MFT and System Winter Review ❖ Winter Plan V1.0 dev / approved ❖ Bed Reduction Oversight	❖ Winter Plan V2.0 dev /approved ❖ Site Process review ❖ EDD Project ❖ LOS Delivery Plan in place ❖ Review of Call Before Convey	❖ Winter Holiday Resilience Plan ❖ 2026-27 Planning ❖ GMO Project start	❖ March Focus – 78% ❖ Deliver a Starting Well in January linked to Winter Holiday Plan

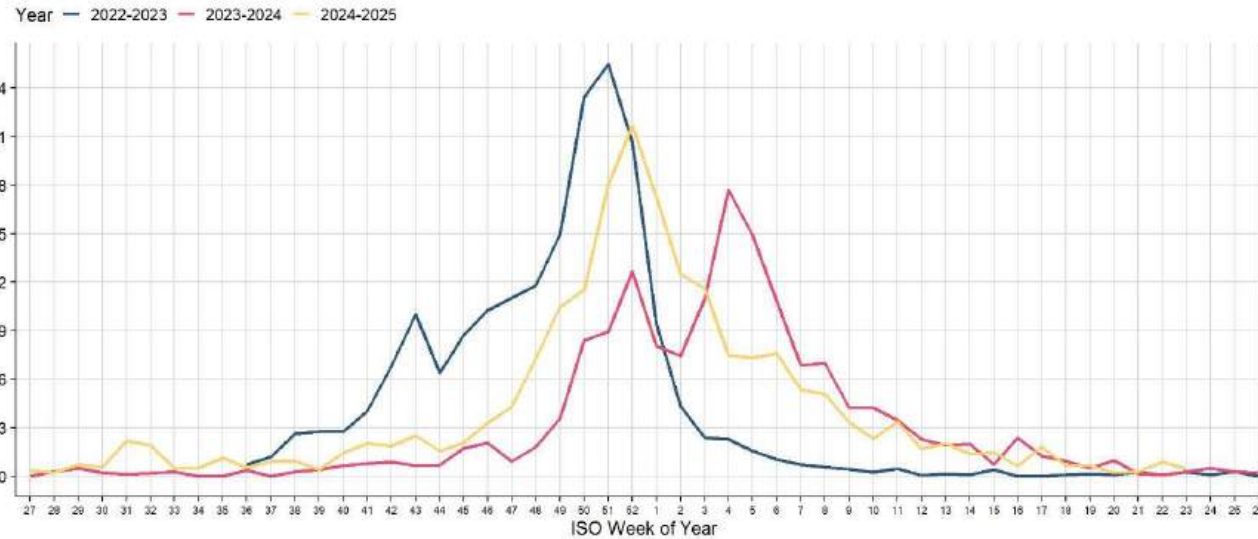
Reports and Dashboards will be used to track and measure the success of the Winter Plan. These reports have been reviewed and further developed during Q4 24-25 and Q1 25-26



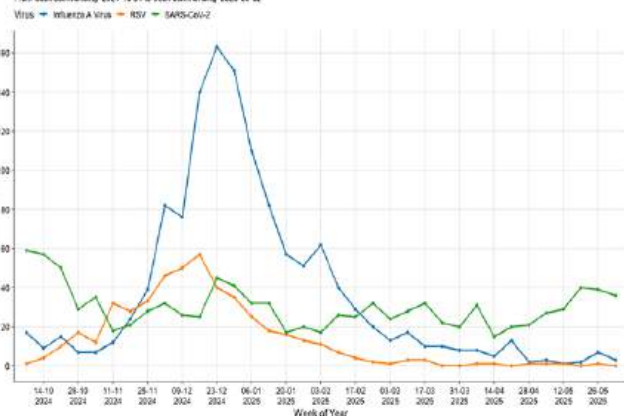
Presence of Influenza, RSV and Covid on MFT wards

– Prediction for Winter 2025-26

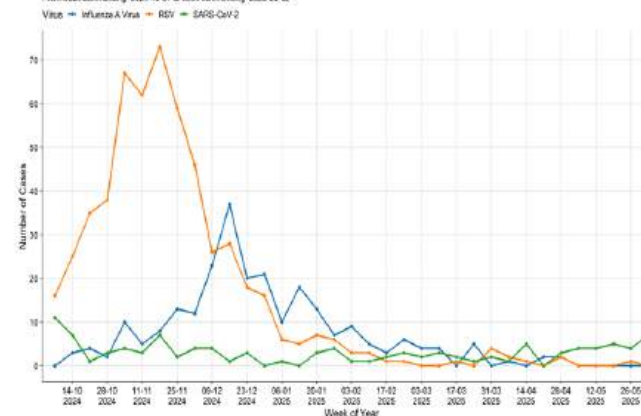
Percentage of Tests Positive for Influenza A Virus in Adults by Year



Weekly Adult Admissions Testing Positive for Influenza A, RSV, and SARS-CoV-2



Weekly Number of Children Admitted with a Positive Test for Influenza A, RSV, and SARS-CoV-2



- For Adults, Influenza and Covid peaked in December 24 and for Children RSV peaked in November.
- Covid rates fluctuated through winter of all admitted patients but saw a peak in December 24 and in late May 25.
- Comprehensive data from the Southern Hemisphere will be available by the end of August beginning of September which can aid in prediction for Northern Hemisphere data.
- It is too soon to predict what winter 25/26 might bring but we have resources that the IPC team are using in informing expectations :
 - FluNet (WHO) <https://www.who.int/tools/flunet>
 - Australian Respiratory Surveillance Reports (Australian CDC) <https://www.health.gov.au/resources/collections/arsr?language=en#reports>
 - National flu and covid reports (UKHSA) <https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2024-to-2025-season>
 - Northwest Winter Situational Awareness report - (UKHSA NW Field Service, emailed out) – checking to see if this will be regularly produced over winter 25/26
 - Direct contact with UKHSA lead epidemiologists for Influenza, SARS-CoV-2 and RSV
 - All Hazards Winter Planning report – produced Sept 2025 but not circulated till Nov 2025. I'll check if it's being produced again this season.

Acute Respiratory Infection (ARI) Pathway Planning and Optimisation

Pre-Season

- Encourage Vaccination for patients & staff
- Baloxavir in stock
- Use of CMDUs

Pre-Hospital

- Engage with call before convey
- Preventing ED attendances (respiratory hubs, referral to H@H, virtual ward)
- Link with community COPD team
- Explore remote testing
- Patient information sheets for flu, COVID and RSV

Admission / Discharge Criteria

- NEWS 2 + oxygenation + age + frailty score + co-morbidities
- CURB-65
- Share admission criteria to reduce referrals
- Work with ED and trainees to devise admission and discharge criteria

ED

- Identify ARI at triage
- POC/Rapid test
- ED criteria
- Facilitate referral to H@H at night
- Antiviral prescribing
- Early post take
- Use of procalcitonin to stop antibiotics?
- Flu kits available in ED

Admitted Patients

- Criteria for admission to respiratory ward
- Criteria referral to critical care
- Treatment guidance
- Infection control guidance (isolation & cohorting)
- Discharge criteria (early discharge via H@H, virtual ward, COPD teams)
- Optimise discharge planning
- Positives list for discharge

Data

- Understand impact of ARI on the Trust
- Make timely organisational decisions (escalation beds / cohorting)
- Identify triggers for action/escalation/de-escalation
- Identify actions (cohorting)
- ARI flag to identify patients to review for discharge and escalation
- Improve the ARI report with a forecasting element and a weekend report for situational awareness.
- Build order sets in Hive

Staff

- Monitor staff absence due to ARI
- Fit testing
- Staff vaccination plan

Respiratory Virus Testing

- Most tests in ED should be rapid/POC tests
- Develop new front end to optimise test ordering
- Demand manage respiratory virus testing

Sound escalation processes in place with roles and responsibilities clearly defined, working across group and in partnership with the System Co-ordination Centre (SCC)

- In 2024, NHS England released revised OPEL framework and associated action cards. MFT implemented these associated with reporting requirements
- To support Winter surge the MFT Co-ordination centre is developing a detailed range of Scenario Action Cards. These will be developed with Clinical Groups and will direct actions to 10 main focal areas:
 - Ambulance Handover
 - 12 Hour acute DTA
 - Mental Health pressures
 - Bed capacity (Full capacity Protocol)
 - Limited number of Expected Discharges
 - High number of No Criteria to Reside
 - High number of attendances
 - Long wait to be seen time
 - Pressure on Respiratory response across Emergency Care
 - Bed closures due to Infection Prevention Control and Estates issue
- For winter 25/26 it will be a successful winter to maintain an OPEL level 2 or low level 3 position
- As part of the Stress Testing of Winter plans, MFT and System partners will undertake an OPEL exercise. This is to ensure system levers are defined and support the reduction in UEC pressure through Winter 25-26 and beyond

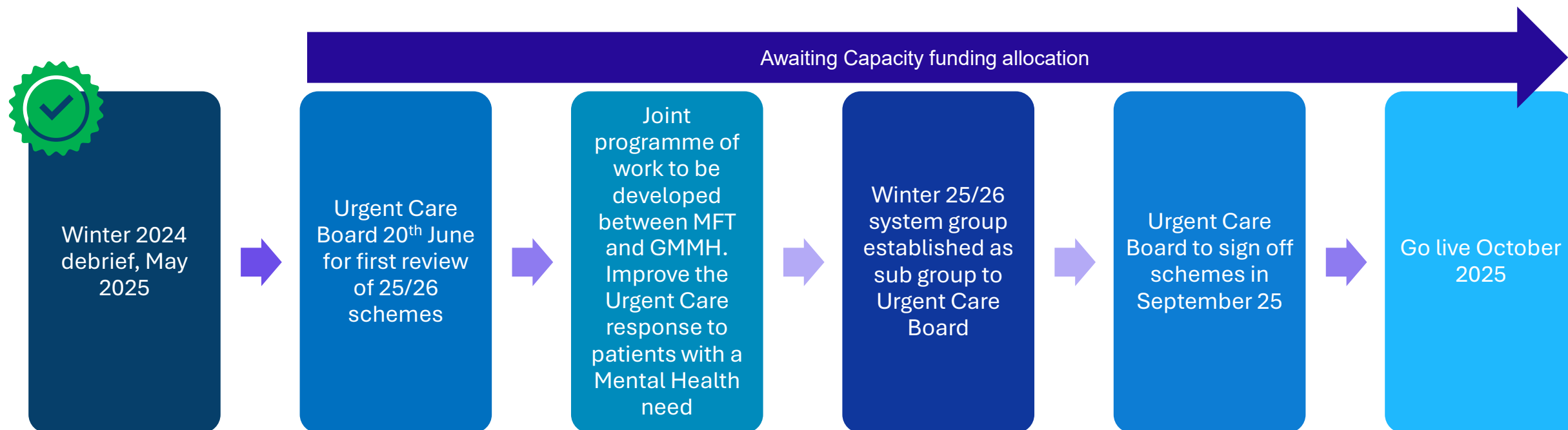
OPEL Parameter	Score			
	0 points	1 point	2 points	3 points
Ambulance Handover (minutes)	<15 min	15-60	>60-90	>90
ED 4-hour performance	>95%	78-95%	60-78%	≤60%
ED Majors and Resus Occupancy	≤80%	>80-90%	>90-100%	>100%
Median Time to Treatment (minutes)	≤60	>60-120	>120-240	>240
Patients in ED > 12 Hours	≤2%	>2-5%	>5-10%	>10%
Decision to Admit	≤2%	>2-5%	>5-10%	>10%
Bed occupancy	≤85%	>85-95%	95-98%	>98%
No Longer Meeting Criteria to Reside	≤5%	>5-10%	>10-15%	>15%
Patients Discharged	>10%	>5-10%	>2-5%	≤2%
Infection Prevention Control	≤0.5%	>0.5-1.5%	>1.5-3%	>3%

Aggregated OPEL Score	OPEL	Clinical Risk	Response
0-7	OPEL1	Low	See OPEL Action Card (and MFT policy/protocols)
8-15	OPEL2	Medium	
16-22	OPEL3	High	
23-30	OPEL4	Very High	

Reporting System

[NHS GM Integrated OPEL Framework | GM ADSP](#)

Manchester and Trafford locality expect to support the Urgent Care system through the allocation of Capacity funding allocated through NHS England. This is not yet known. Manchester and Trafford Urgent Care Board are working to the following activities and timeframes

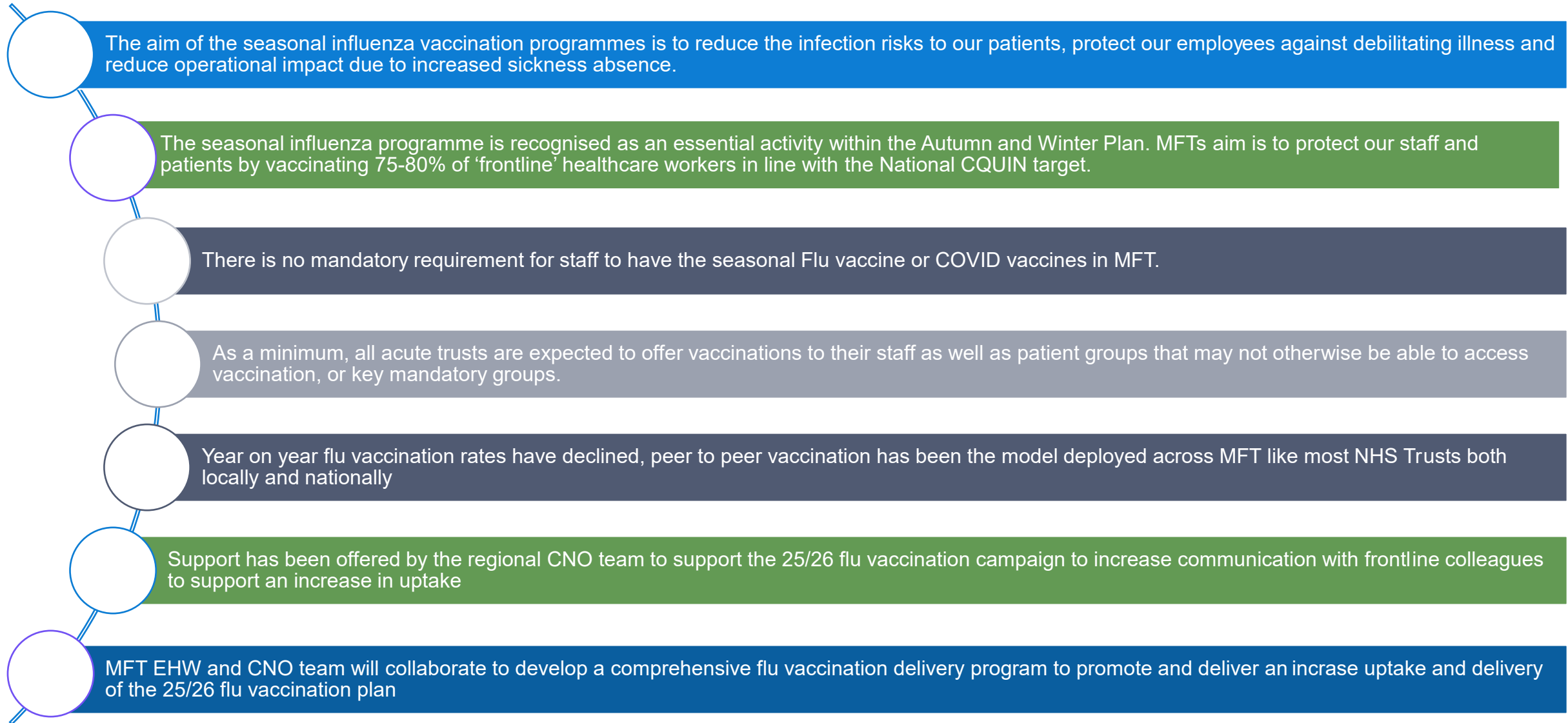


Looking After our Patients & our Staff

Having robust workforce plans in place to support the health and wellbeing of our staff

All Hospitals have Workforce escalation plans in place for tracking absence levels and triangulating with OPEL status to maintain safe staffing levels. Our staff matter to us and our people plan provides regular communication to support us all to look after each other. It is important to us that our staff have access to the right support and are vaccinated to protect both themselves and the population we serve. Below outlines what is on offer for staff.

Programme	Plan	Programme	Plan
System	System Co-ordination Centre – On behalf of Wider GM System to oversee pressure points and support all systems with a co-ordinated response to escalation pressures	Vaccinations – Flu	- The programme is expected to began in September 2025. (JCVI guidance is expected during Summer 2025) - Details of the plan can be found on the next slide
Violence Prevention	Violence Prevention policy Violence Prevention Charter – commitments to support staff Violence Prevention training – de-escalation, release Body Worn Camera pilot in Emergency Departments Security Team support	Psychological Wellbeing and Mental Health Service	- The Psychological Wellbeing Service provides a range of psychological wellbeing support to all Manchester Foundation Trust (MFT) employees. Please Click Here for further information. - This includes Critical Incident and Trauma Support Pathway.
Peer support	Staff Networks to support colleagues with protected characteristics. Wellbeing Champions Rewards and Benefits – Social activities – Hobby Health	Physiotherapy Treatment Service	The Physiotherapy Team are highly skilled individuals that aim to support employees to access assessment, treatment and advice to help back to better physical health. For more information please Click Here.
Staff Screening	Cervical Screening offer for staff Support Answer Cancer - screening	Health & Well Being	- Menopause Support - Stop Smoking - Physical Activity and much more - Mental health First Aiders Access the monthly updates, newsletters and information to support lifestyle behavior change click HERE - Training Offers Please click here to see all of our training
National Support programmes	- All staff access to the National Health and Wellbeing platform ‘Supporting Our NHS People’ - NHS Practitioner Health - NHSPH 85258 for 24/7 support in a crisis - Text Support Service SHOUT to 85258 – free 24/7 confidential mental health support service	Employee Assistance	- A 24 hour helpline from Health Assured to support your through any of life's issues or problems 0800 028 2047 - Where required, EAP provides immediate access to qualified and experienced counsellors, either face to face or over the phone, as well as online psychological support.



Creating the Capacity to Meet the Demand

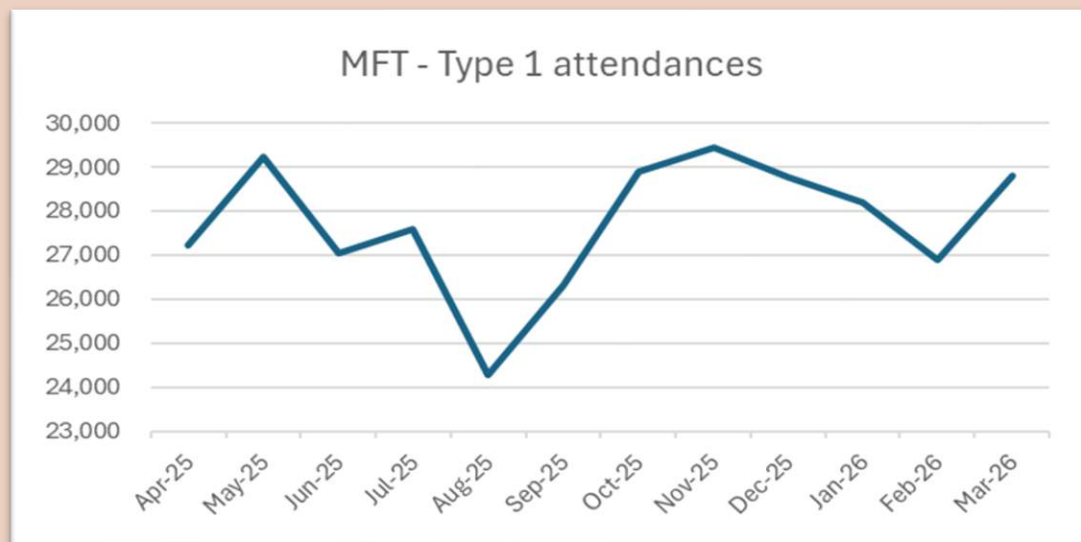


Developing the Winter Plan at Clinical Group

The below provides the Improvement ambitions for each Clinical Group to support ensuring right sized capacity during Winter

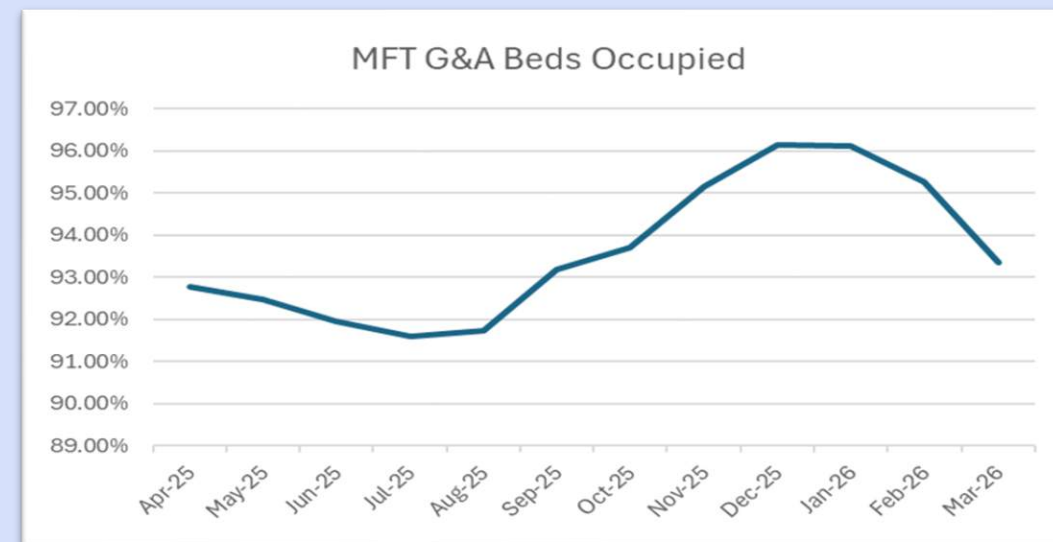
	MRI	NMG	WTWA	Specialist	LCO
Start	Develop acute service pathways	Return to care home processes	Flow improvement group established	Improved complex paediatric discharges	Single point of access
	Staff fit testing in line with ARI plan	New ways to monitor inpatient KPIs	UTC capacity & demand modelling	Criterion led discharge expansion to Koala / POAU	Address dual EPR systems
	Pharmacy stock plans	Improving processes : Radiology, Pharmacy and Therapies to reduce delays	Respiratory provision for managing influenza in the community	Golden review / discharge identification	Reablement 7-day offer
	Ward plans	for nurse assessment to reduce delays	6-12 LoS review	Medical workforce rota redesign at NMGH	Navigator roles
	SDEC admissions reviewed and improved	Site matron team review and redesign		High flow patient's standardisation of ward level care	Weekend core triage
	Monitoring discharge processes to increase	Working closely with RMCH to improve response to children in ED or Starlight		Hive list for golden review patient & golden discharge patient	Review hot days, review rota arrangement
		Development of an osteoporosis frailty service		CYP actions to be embedded within North and WTWA Winter plans	Clear data from control rooms
				Establish a PAMU and WIWO respiratory hub	Comms on clear process for fast tracks
Continue and/or Change	streaming CCDU & staffing	7-day LOS focus	Demand surge planning - divisional offers	Hospital - divisional - ward level LoS meetings	Data led and improve visibility
	respiratory ED	Frailty service at the front door	Escalation ward F11 criteria / staffing model	Review & change the elective profile over high peak winter months	Utilise voluntary services more (Age UK, RVS, CAB etc.)
	H@H flu streaming	Whole hospital approach	Temperature check on staff feedback of winter progress	plan for surge beds across RMCH / Starlight wards	IMC focus on delays
	UTC over night streaming	Friday senior walk around	Improve the response to Staff vaccination & health checks	Robust MDT developed winter plan	Integration of community urgent care offer
	Flu cohort / pathways	Weekend discharge pathway BAU rota		Surgical SDEC model to improve flow from PED	Integration with GMMH
	Staffing plans for high pressure	Support from partners to Out of Area Flow		Pharmacy on wheels - further expansion	better proactive management plan to avoid readmission
				surge capacity in POAU & Koala	7-day a week approach

UEC Attendances



- MFT expects to see between 42,000 patients in February of 2026 and 46,641 in October 2025. This level of variation can also be seen in Type 1, where we see the greatest pressure on bed demand and ED acuity.
- Type 1 is expected to vary September 25 26,300 attends through to November 25 with 29,400. Managing this demand places pressure on our bed capacity and achieving the 4-hour standard.
- To support this, Clinical Groups have for example the following key actions:
 - Further improvements in streaming to UTC (Type 3) activity
 - Call before convey (Single Point of Access) to maximise the use of Hospital at Home and Community Crisis Response as an alternative to conveyance

Bed Occupancy



	Nov-25	Dec-25	Jan-26	Feb-26
Of total G&A beds open, number occupied	2080	2090	2078	2030
Total G&A Beds Open	2186	2174	2162	2131
Percentage Occupied	95.15%	96.14%	96.11%	95.26%
Beds occupied to achieve 94%	2055	2044	2032	2003
Differential to be addressed	-25	-46	-46	-27

- Aligned to the increase in acuity expected during Winter 25/26 the chart above describes the bed occupancy rising to 96% during December and January.
- Reducing our bed occupancy to 94% this will require additional targeted actions to affect November 25 to February 26 with a peak deficit of -46 beds. Actions to address will include:
 - Reduction in demand through increased use of Hospital at Home
 - Targeted use of Community Crisis Response
 - Reduction in Length of Stay programmes in Clinical Groups
 - Achieving the No Criteria to Reside trajectory with system partners

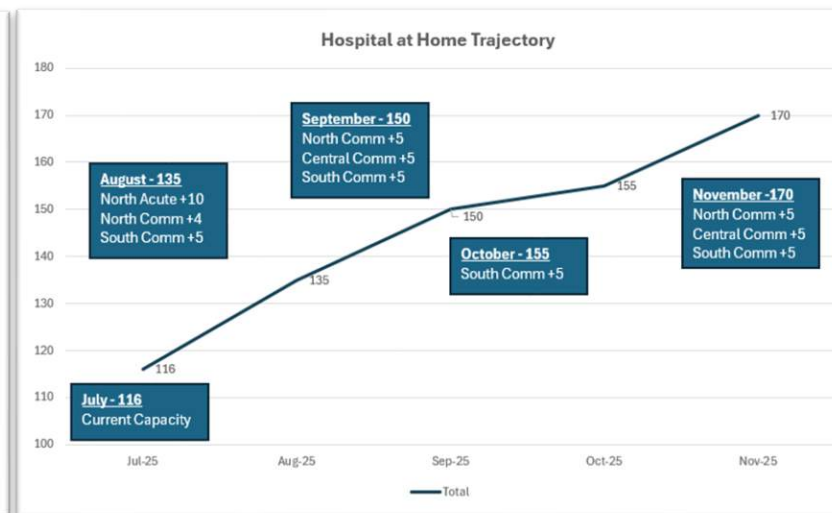
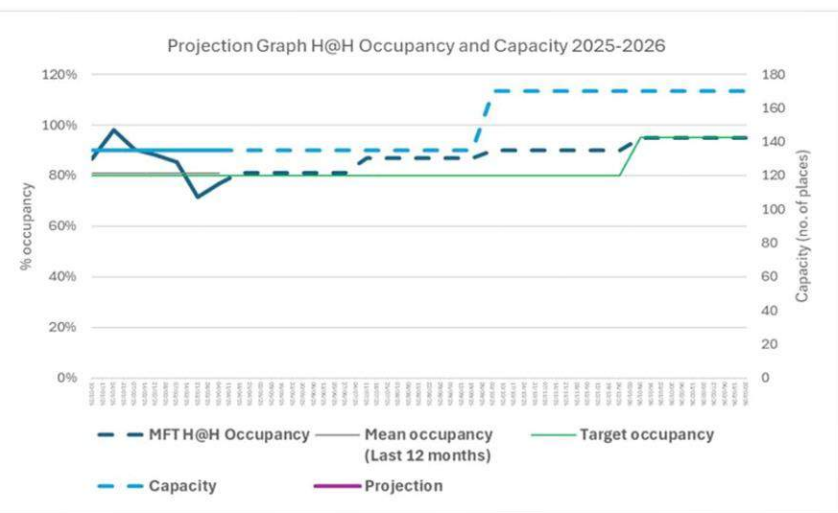
MFT and System Partners agreed No Criteria to Reside trajectories

MFT, NHS GM Manchester and Trafford and GMMH have agreed a trajectory of performance improvement against achieve a plan of No Criteria to Reside reduction. The ambition is to have no more than 259 patients with No Criteria to Reside by November 2025. April and May performance validated actuals.

No Criteria to Reside		Percentage of NCTR target	Apr-25	May-25	System Partner Trajectory									
					Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Acute	Integrated Discharge Team/Site	23%			74	69	66	62	61	60	60	60	60	60
	Therapies	15%			49	46	44	41	40	40	40	40	40	40
Local Authority	Control Room Manchester	27%			88	83	80	73	71	70	70	70	70	70
	Control Room Trafford	12%			35	33	30	30	30	30	30	30	30	30
	Out of Area - (GM Manchester & Trafford Locality to lead)	12%			37	35	33	31	30	30	30	30	30	30
Mental Health	MH Assessment	10%			31	29	28	26	25	25	25	25	25	25
	MH Awaiting bed	2%			5	5	4	4	4	4	4	4	4	4
Total		100%	351	359	320	300	285	267	262	259	259	259	259	259
Combined Manchester and Trafford					123	116	110	103	101	100	100	100	100	100

Out of Hospital Capacity Response

There are agreed operational plans to create 170 beds of capacity per day by November 2025 and we will focus on delivering this trajectory



There are key actions between April 2025 to March 2026 to increase H@H capacity to 170 with 95% occupancy consistency. The LCO plan also maintains Crisis capacity whilst developing the model through OneMFT and innovative pilots to support admission avoidance.

April-June 25 - Focus on stabilising the capacity at 135 and occupancy at 81% given the workforce risks and mitigations. Call before convey pilot in June will test a Crisis and Hospital at Home community step up offer. Workforce review to support staffing resilience.

Winter 2025-26

October 25 – LCO Urgent Care established which will begin the integration of Crisis, H@H and IV into a single operating model.

(October-December 25) – uplift in capacity to 170 beds and occupancy to 90% - following the formal workforce review and improvements embedded as part of BAU.

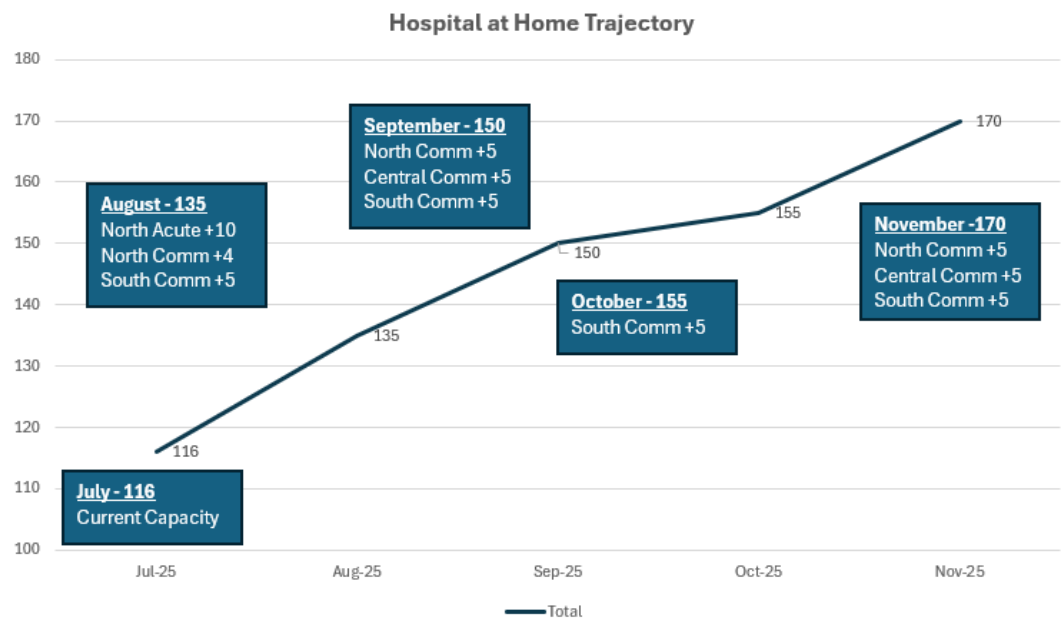
(January-March 26) – occupancy increase to 95% following stabilisation of combined urgent care front door offer linked to Single Point of Access (SPoA).

Hospital at Home Capacity Trajectory

	North Acute	North Community	Central Acute	Central Community	South Acute	South Community	Total
Jul-25	15	16	25	20	30	10	116
Aug-25	25	20	25	20	30	15	135
Sep-25	25	25	25	25	30	20	150
Oct-25	25	25	25	25	30	25	155
Nov-25	25	30	25	30	30	30	170

Hospital at Home Capacity Trajectory for Winter 2025/26

To achive LCO to update this



Hopsital at Home Capacity Trajectory

	North Acute	North Community	Central Acute	Central Community	South Acute	South Community	Total
Jul-25	15	16	25	20	30	10	116
Aug-25	25	20	25	20	30	15	135
Sep-25	25	25	25	25	30	20	150
Oct-25	25	25	25	25	30	25	155
Nov-25	25	30	25	30	30	30	170

The System ambition is to reduce MFT NR2R to 259 for November 2025

We will focus on maintaining patient safety and flow by establishing a robust operational grip with all system partners.

We will apply a Home first ethos and three principles will guide our approach:

1. The system's plan will be data led, so that plans are realistic and we focus on high impact activity
2. The system's response will be co-ordinated
3. Lessons learnt from Winter 2024-25 focus on recovery eg IMC, reablement and equipment support
4. Period of planning will continue to run across Winter with specific focus on known periods of surge of capacity challenges, such as the Christmas period.

Discharge - The hospital sites will...	Discharge - The LCO will...	System risks to mitigate in advance
• Submit referrals for complex supported discharge at agreed timeframes • Secure extra transport • Ensure resilience of discharge staffing – and the 6/7 day offer • Ensure validation of NCTR for Data Quality • Ensure all equipment an crisis clean/ VCSE requests are coordinated by therapy and IDT teams in advance.	• Focus on increasing discharge churn as part of readiness – weekly 165 target. • Ensure that sites have visibility of community service capacity for discharge. • Make sure that all capacity in the system is appropriately utilised to maximise flow. • Ensure equipment teams are present on planning PTLs • Increase P1 and P2 referrals	• Ascot House flow – Trafford • Housing Assessment delays – Manchester Council • Fast Track • Care Home capacity • High cost placements/packages – delays • Staffing – what is the commitment and realistic staffing proposal for the bank holiday staffing • GMMH & Out of Area

Operational plans are in place to maintain elective activity during periods of high pressure, supported through our Elective Recovery Programme ‘Care on Time’.

- Activity plans have been modelled using seasonal capacity assumptions to forecast demand surges and enable responsive adjustments to elective delivery.
- Elective activity is front-loaded into Q1 and Q2 to create headroom for anticipated winter pressures.
- We are maximising utilisation of the Trafford Surgical Hub, prioritising high-volume, low-complexity (HVLC) procedures to maintain throughput during peak demand.
- An elective scheduling huddle established to enable dynamic reallocation and prioritisation of patients in response to operational pressures

Elective Programme Ambitions to support the delivery of the elective care plan and front-loading activity and improvement into Q1 and Q2 2025/26 to protect managing against the elective plan during Winter.

The programme aims to deliver high quality, timely, and patient centred elective care for all accessing our services. It will ensure care is provided in the right place and patients are informed and in control of their own health needs.

Objectives

Reduced waiting times and improved access

Delivering the right care in the Right Place

Enhanced efficiency, productivity and streamlined services

Empowered and motivated staff

Financial sustainability

Delivered through the following workstreams:

Digital by Default

Key Deliverables

expansion of MyMFT, digitising letters, use of AI, fastpass

Pathway Redesign

Key Deliverables

Sustainable new models of care, adopting GIRFT best practice and systemising A&G, expanding community based care, eg TIER2

Use of Resources

Key Deliverables

Expanding and Optimising surgical hub capacity, 6 day working delivered in core capacity and straight to hub referral

Faster Diagnostics

Key Deliverables

Expanding CDC straight to test pathways, optimising capacity and implementing iRefer

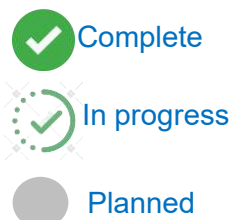
Waiting Safely

Key deliverables

Framework for Proactive review and risk stratification of patients, communication whilst waiting

Access & Care coordination Hub

Standardise referral management, booking & scheduling and waiting list management



Tumour Group	Q1	Q2	Q3/4
Urology	 FDS Short term additional capacity to reduce waits. Insourcing support for cystoscopy and Prostate biopsy's  62/31 Day Additional theatre capacity in place with Christie  FDS PIRADs pathway tested at WTWA site	 Full Pathway Additional and dedicated short term support to oversee cancer pathway, ensure timely clinical management, and progress patient pathways whilst longer term improvement work is undertaken  Full Pathway GM Cancer support with full capacity and demand modelling  FDS rollout of MRI prostate pathway across sites	 Service Review GIRFT commission – initial sessions to start in June, with on site visits in September. Terms of reference will include nursing workforce opportunities, national benchmarking and practice and benchmarking workforce  FDS Haematuria pathway task and finish group in progress.
Lung	 Full Pathway Rapid Hub Tracking Board standardised across all sites  Safety To implement a new work queue and robust booking and monitoring processes within HIVE for the nurse led nodular and surveillance pathways.	 62/31 Day Efficiency and productivity review underway in Thoracic Surgery to ensure maximum usage of all available capacity and reduce wastage.  Full Pathway Delivery of estate, workforce and all capacity requirements within the Targeted Lung Health Checks expansion business case	 62/31 Day Develop enhanced care beds on lung surgery ward to reduce HDU reliance and reduce cancelled procedures on the day, whilst ensuring quality specialist care  Quality Increased access to the Thoracic Surgery Robot

-  Complete
-  In progress
-  Planned

Tumour Group	Q1	Q2	Q3/4
Breast	 FDS Increase provision of patient Navigators to tackle DNAs and ensure correct streaming into clinics  62/31 Day Review pre op capacity at NMGH. Possible move of gender pre op to Trafford site	 Safety Standardise resection turnaround times to 10 days. Recruitment ongoing.  FDS Capacity shortfall for 1st OPA appointment across the MSS. Currently 1st OPA shortfall is 150 OPA slots per. Capacity & Demand paper written to highlight issue to SLT. Currently using evening & weekend ECL to manage core capacity.	 Quality Options for clinic space for NMGH patients due to closure of Oldham unit Quality Review provision of screening service to NMGH site to allow equity of access
Head and Neck	 FDS Implementation of EU TIRADS classification system for H&N  31/62 Day Review theatre access across sites particularly to enable treatment within 24 days of IPT	 FDS Test a new dysphagia pathway which could standardise practice across MFT and allow patients to receive more timely investigations.  31/62 Day Straight to biopsy pathway from Tier 2 Service (NMGH)	 Quality GIRFT Feedback – Implement a resolution for the split ENT and OMFS pathway at Bolton, with a view to bring activity to MFT.

-  Complete
-  In progress
-  Planned

Tumour Group	Q1	Q2	Q3/4
Lower GI	 FDS Increase BCSP endoscopy capacity. Additional capacity in place at weekends to reduce wait.  FDS Review use of negative FIT SOP	 FDS Implement Single Point of Access with single expanded nurse triage team. Business case signed off. Recruitment and training required.  FDS Standardise bowel prep clinics with change in prep used FDS Standardise points per Endoscopy list across MFT Sites and increase productivity/List utilisation	 31/62 Day Expand robotic surgery to use CMR robot. Training commenced.  FDS Implement Face to Face triage nurse appointment to lessen demand on consultant appointments
Gynaecology	 FDS Implementation of straight to radiology provision  FDS Additional short term capacity through CEC and Hysteroscopy clinics  62/31 Day Additional theatre capacity/Mutual aid from the Christie	 FDS Additional capacity via regional mutual aid for histopathology.  Full Pathway New Gynae-Oncology Consultant commences in post, supporting sustainable delivery and widen scope for additionality within the service	 31/62 Day Implement straight to pre-op from CEC clinics to reduce delays and repeat visits as part of routine practice  31/62 Day Robotic surgery to have been fully implemented following training period commencing Q1

Communication Plan

MFT will enact their communication plan working with locality partners and through the System Coordination Centres to ensure messages reach staff and the wider community.

Trigger	Internal messaging – all channels	External messaging/actions – all channels
OPEL 4	- Pressures awareness - Actions to take /actions taken - Wellbeing /support	- Patients with minor ailments who attend EDs may be waiting for much longer than normal. - Highlighting Keep Well This Winter/Choose the Right Care messaging - Active media and stakeholder management potentially required. - Communications activity managed in conjunction with NHS GM and NHSE NW communications teams. - Led via SCC who will co-ordinate/share messaging with system partners
OPEL 3	- Pressures awareness - Actions to take /actions taken - Wellbeing /support - WhatsApp messages for more frequent site meetings, actions to be taken	- Patients with minor ailments who attend EDs may be waiting for much longer than normal. - Highlighting Keep Well This Winter/Choose the Right Care messaging - Active media and stakeholder management potentially required. - Communications activity managed in conjunction with NHS Gmand NHSE NW communications teams.
IPC alerts, e.g., Covid / Norovirus	- Criticality of observing the basics - Contextual messaging	- Responsible visiting - Ward and visiting restrictions
Cold weather alerts	Staff actions/advice	- Keep Well This Winter / Choose the Right Care - Use of MFT social media channels/provision of case studies to support national and regional public information campaigns
Autumn /winter BAU	- Staff vaccinations campaign (Vaccination communication plan to be developed, end of Q1) - Wellbeing / support - System Transfer of Care Hub – embedded virtual network to support communication on discharge and flow	- Support delivery of the NHS Greater Manchester Winter communications and engagement plan, with social media, digital and media activity. - Support delivery of staff/regional/national vaccination programmes campaigns with internal, social media, digital and media activity.
Informed by NHS Winter Plan and NHS GM Winter Plan	- Local staff briefings/bulletins - MFT Time - Mark's Weekly Message - Intranet stories - MFTV 12 days of Christmas 2025 campaign supporting discharge developed by LCO Communications Team.	- Social media content - Media releases/case studies – for example, normalising use of H@H to manage patient/family expectations. - MFTV - Social media - Website messages - Stakeholder bulletin

Risks and Issues



Risks	Impact	Mitigations
Sustained high attendances and high acuity to ED over predicted demand	Overcrowded A&E departments leading to potential safety risk, poor patient experience, negative media coverage and stakeholder involvement.	- Escalation Plans, Site winter plans - Virtual ward capacity to avoid admissions - Reduction in no reason to reside to ensure flow in maintained to 259 - Media and stakeholder management in line with an expected NHS GM Winter Communications and Engagement Plan
Mental Health demand, and mental health bed availability	- Loss of A&E cubicle capacity - Poor patient experience - Safety risk - Negative media coverage - Stakeholder interest	- Collaborative working with MH Teams, proactive management @Transfer of Care hubs / System Coordination Centre (SCC) - Managing MH in ED action cards - GMMH Winter plan escalation and media / stakeholder management plan - GM System Control Centre support
Infection, flu and Covid-19 outbreaks in the community. Risk of cross infection of Covid, flu, pneumonia, RSV following admission to hospital	- Increased staff absence - Risk of safe staffing levels - Loss of flow within acute bed base leading to longer length of stay and discharge delays	- IPC team working with Manchester University to develop a prediction tool that will be this winter to predict the expected demand over the coming weeks, providing greater opportunity for capacity planning - Vaccination programme, opportunistic vaccination programme - Surge plans enacted - COVID/IPC plans - MFT People Plan, HR, Workforce plans, Health & Wellbeing support teams
Patient transfer of care delays due to capacity pressures across system and 154 planned bed closures during 25-26.	- Longer length of stay and delays to discharge leading to increased no reason to reside numbers - Risk to elective recovery programme - Tertiary referrals delayed	- Transfer of Care Hub - Use of SCC to support escalation and adherence to GM Policies - Protected Capacity at Trafford - Use of the Independent Sector - Mutual aid - VFP schemes with associated Clinical Group level mitigation plans - Care Closer to Home programme for MRI with learning for other Clinical Groups
Industrial action	- Reduced non-elective staffing risking patient safety - Cumulative fatigue and stress in medical staff leading to increased sickness - Further elective cancellations	- Well being initiatives - Enhanced payments to boost rotas in line with GM pay rates - WLI
Staff being transferred to support other areas within group	- Low morale leading to increased sickness - Safe staffing levels	- Workforce plan 'Buddy system' in place - Well being initiatives - Ward handover booklets
Theatre recovery being converted into a critical care area	- Risk to elective recovery programme - Increased elective cancellations	- CC Surge plan enacted - Protected Capacity at Trafford
Timely access to diagnostics due to winter pressures on diagnostics teams alongside recovery	- Risk to elective recovery programme - Staff fatigue leading to increased absence levels - Longer length of stay	- Diagnostic Recovery plans - Additional radiology staffing - Use of Community Diagnostic Centres
If the Trust is unable to maintain complex discharge flow and therefore have increased numbers of patients with No Criteria to Reside then clinical groups will have increased occupancy which impacts on ED flow.	- Risk to patient to safety - ED performance - Site occupancy - Wider system pressures	- LCO winter plan - Increase in admission avoidance - Care Closer to Home programme - Oversight of No Criteria to Reside through daily PTL - Integrated Discharge Team – a consistent offer across MFT

Appendix



Requirement	Indicator	Performance	Reflections and actions for 25/26
To support staff to be well thus minimising the impact on patient care	Influenza vaccination to achieve 75% of workforce	A total of 26% (8,040) vaccinations occurred as at 16th January 2025, 49% under performance and 13% less than 2023/24	- Consider the communication plan - Review processes for ensuring those that can be vaccinated are.
To support staff to be well to minimise impact on patient care	Sickness rate to reduce to 5.1% from 6% April 2024	- Summer 2024 average of appx 6% rose to a winter average of 6.5% - Peaks during December 2024 and January 2025 in line with national rise in respiratory infection prevalence - MFT sickness levels are in line with North West regional NHS organisations but North West remains high by comparison to other regions	- Deep Dive to take place across the Trust led by CPO - Following Deep Dive implement best practice and support challenging areas
Management of Incidents	UEC incidents recorded	- Incident reporting remained in line this winter with 23/24 and whilst there is slightly fewer recorded incidents in Summer, all months remain within normal variation - A review by site does not indicate any special cause variation - Winter has shown an increase in the following incident categories: - Disruptive, Aggressive Behaviour - Infection/Sepsis management - Safeguarding	- Continue working with Clinical Groups as directed by Clinical Governance - Investigate opportunities to reduce Disruptive, Aggressive Behaviour Infection/Sepsis management and Safeguarding
Management of Complaints	Complaints received in an ED setting	- Incidents reported remained in normal variation during Winter with appx. 20 reported complaints per month - Complaint type remained in normal variation with only one Special Cause Variation (SCV) in Privacy, Dignity and Wellbeing complaints in February. 13 received against an average of 4 per month - The three adult EDs show special cause variation in January 25 for complaints, this was not seen in paediatric departments.	- Deep dive into the spike of complaints received in January 25. - Learning and improvements to be carried out by Clinical Groups
To maintain UEC and Flow performance	Attendances expected to rise by 3.5% in Winter	- Comparing Urgent and Emergency Care attendances, Oct 24 - March 25 against July 24 – Oct 24 there were in fact 0.5% fewer attendances this winter than there were in the summer months. - MFT did not realise a 3.5% increase in attendances as the Winter Plan predicted.	Activity Plan to be reviewed in response to 2024/25 attendances realised

Requirement	Indicator	Performance	Reflections and actions for 25/26
To maintain UEC and Flow performance	4-Hour performance to achieve 78% by March 2025	- Special Cause Variation can be seen between February and the end of March 25. - The end of March position finished at 73.9%, 4.1% lower than plan but is the Trusts best performing month since 2022	Clinical Groups enact annual plans
To maintain UEC and Flow performance	No patient should be in the department more than 12-Hours	In line with 4-hour performance, 12-hour performance also significantly improved February and March and peaked at 97% following Low SCV in December through till February at 93%.	12-hour reporting to be added to the Co-ordination centre overview 12-hour performance to be reviewed within clinical groups and added to reporting processes
To maintain UEC and Flow performance	No patient should wait for admission more than 12-Hours following Decision to Admit (DTA)	- November to February, in line with 4- and 12-hour low performance also shows (Appendix C) an increase. Performance significantly improved during the later part of February and March 25 - Mental Health patients remain consistently appx 100 DTA breaches per month	- Co-ordination centre to continue to support clinical groups in the escalation and management of Mental Health DTA wait reduction - From April 25, MFT Co-ordination centre to establish a weekly PTL review with GMMH and ad hoc escalation review at peak periods of pressure - Escalation through to GM SCC of MH (or Acute) patients waiting over 48 hours for admission

MFT has committed to delivering elective care through Winter. The following demonstrates the trusts commitment to RTT, Cancer and DM01 profiled and accounts for Winter pressures

Elective Care - Annual Plan

Cancer 31 days

KPI metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Compliance	408	488	430	492	490	485	537	570	525	491	505	515
Compliance R	86.44%	87.77%	89.03%	89.78%	89.74%	90.99%	89.65%	90.48%	87.06%	88.79%	88.60%	90.67%
Treats	472	556	483	548	546	533	599	630	603	553	570	568

Cancer 62 days

KPI metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
compliance	296	315	300	324	318	323	372	345	305	325	298	333
Compliance R	62.45%	63.77%	66.08%	67.22%	68.68%	68.43%	71.81%	69.56%	66.89%	66.33%	70.95%	75.34%
Treats	474	494	454	482	463	472	518	496	456	490	420	442

Cancer 28s FDS

KPI metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Compliance	4129	4180	3958	4501	4115	4242	4715	4320	4125	4100	4023	4443
Compliance R	76.28%	76.71%	76.72%	77.05%	75.78%	77.42%	78.31%	79.28%	75.37%	75.20%	78.90%	80.65%
Total	5413	5449	5159	5842	5430	5479	6021	5449	5473	5452	5099	5509

RTT

Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
<18 Weeks	99,920	98,933	98,909	99,848	100,752	101,619	102,449	103,244	104,002	104,724	105,409	106,058
>52 Weeks	8,554	7,964	7,371	6,754	6,138	5,521	4,900	4,280	3,659	3,035	2,412	1,785
Total PTL	198,819	195,053	191,281	189,504	187,727	185,961	184,167	182,389	180,621	178,846	177,067	175,297
% > 52w	4.30%	4.08%	3.85%	3.56%	3.27%	2.97%	2.66%	2.35%	2.03%	1.70%	1.36%	1.02%
% <18w	50.26%	50.72%	51.71%	52.69%	53.67%	54.65%	55.63%	56.61%	57.58%	58.56%	59.53%	60.50%

RTT Starts

Group	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Clinical & Scie	836	836	796	873	790	829	873	761	829	836	761	836
Manchester Rc	3,046	3,047	2,908	3,194	2,888	3,021	3,194	2,774	3,021	3,047	2,774	3,046
Manchester Rc	8,525	8,525	8,146	8,913	8,070	8,453	8,913	7,750	8,453	8,525	7,750	8,525
North Manches	4,498	4,498	4,294	4,701	4,260	4,462	4,701	4,091	4,462	4,498	4,091	4,498
Royal Manches	3,147	3,147	3,002	3,290	2,979	3,122	3,290	2,863	3,123	3,147	2,863	3,147
Saint Mary's H	3,943	3,943	3,764	4,121	3,732	3,910	4,121	3,583	3,910	3,943	3,583	3,943
University Den	1,952	1,952	1,863	2,040	1,847	1,936	2,040	1,773	1,936	1,952	1,773	1,952
Wythenshawe,	10,313	10,313	9,839	10,776	9,757	10,224	10,776	9,369	10,224	10,313	9,369	10,313
	36,260	36,265	34,616	37,912	34,327	35,961	37,912	32,968	35,962	36,265	32,968	36,264

DM01

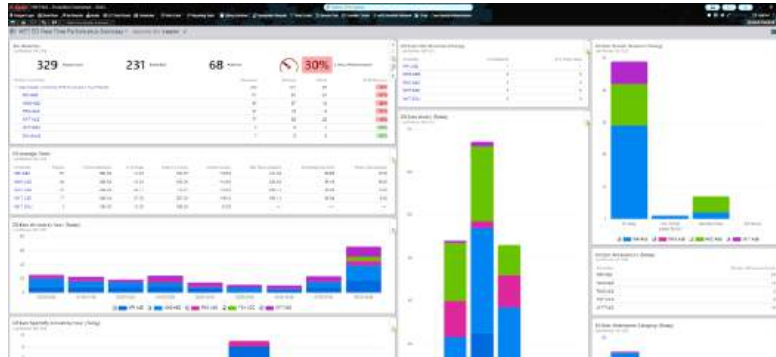
KPI metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
DM01 - % Perf	13.25%	12.53%	11.87%	12.90%	13.25%	11.88%	11.88%	10.34%	11.50%	13.17%	7.28%	5.49%
DM01 - PTL Siz	29527	30296	29152	29545	29774	28901	28779	28068	28384	30049	26724	26670
DM01 > 6 week	3911	3795	3461	3811	3946	3438	3420	2903	3263	3956	1945	1464

Supporting Documents

Document title	Embedded Document
Full Capacity Protocol	 Full Capacity Protocol - Dec 24
OPEL - Acute	 OPEL Acute 24  OPEL MFT rdination Centre D
OPEL - Community	 OPEL Community  OPEL Community onse to Acute pre:
OPEL – ICS and 111 action cards (NHS England Document) (<u>For reference</u>)	 OPEL ICS  OPEL Mental Health  OPEL 111
Mental Health – NHS England’s Winter 24/25 action cards	 Mental Health NHS Action Cards
Countdown to Christmas (Winter Holiday Plan)	 Countdown to Christmas
Mental Health Emergency Department escalations	 Adobe Acrobat Document

The following reports are currently being used to support teams to determine the daily sitreps

MFT ED Real Time Performance Summary



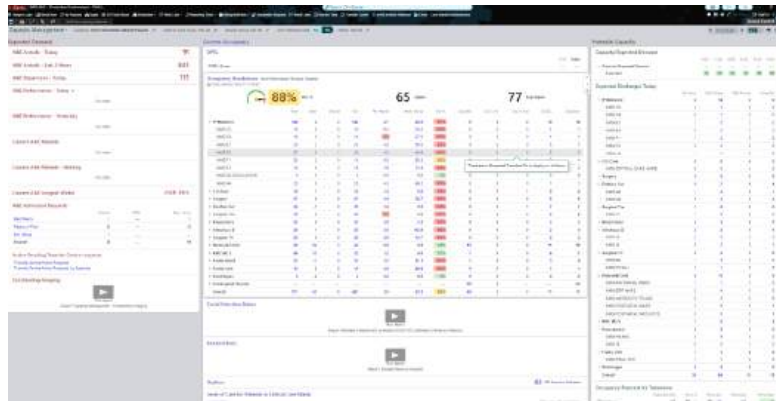
This dashboard provides an overview of the day's performance

No Criteria to Reside Dashboard



This dashboard provides detail on the number of patients with no criteria to reside

Capacity Dashboard



This dashboard details expected demand Occupancy and potential capacity

ED Control Centre Performance Dashboard

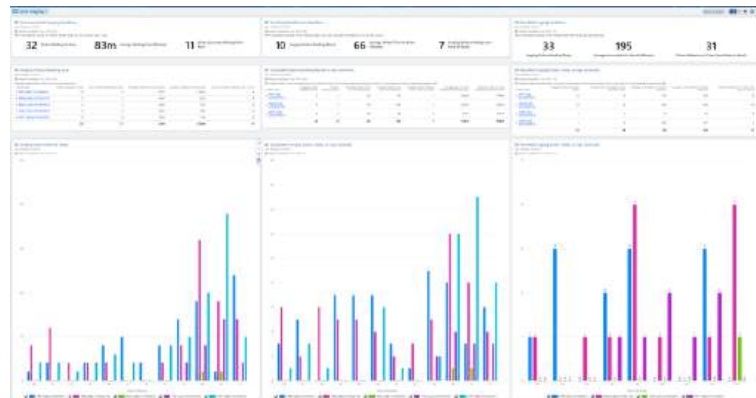


This dashboard summaries 4hr and 12hr performance by those left the department and those still in the dept

At these times an escalation message will be sent to the Chief Delivery Officer to summarise the position. This will include 12 hour breaches, 4 hour performance and any escalated 60 minute ambulance hand over

The following reports were created by the UEC Coordination Centre team in 2024/25 to support our services to monitor live progress

ED Live Imaging



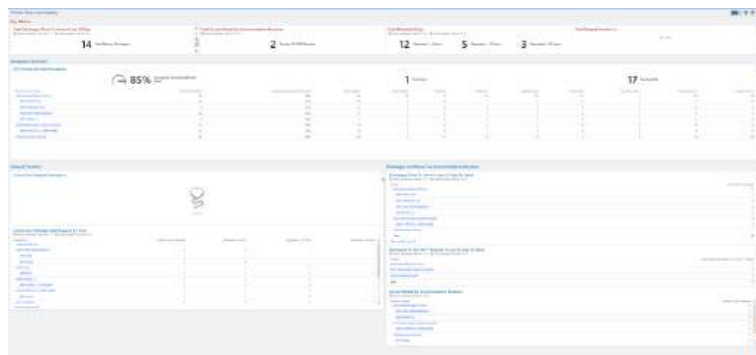
This dashboard provides a live overview of all imaging orders from ED and the live status of orders

Inpatient Live Imaging



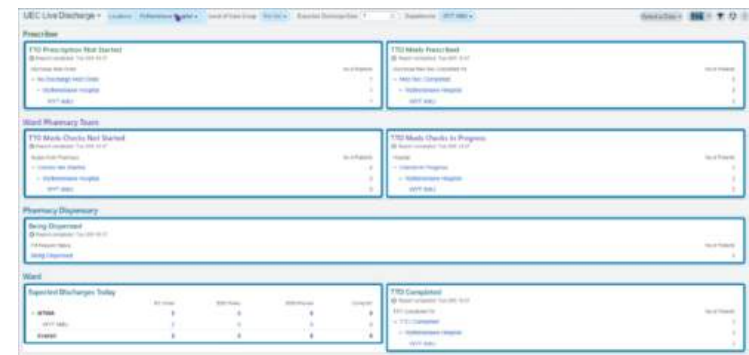
This dashboard provides a live overview of all imaging orders from Inpatients and the live status of orders

Critical Care Live Capacity



This dashboard details live capacity across critical care step downs and bed requests

Pharmacy Live Requests



This dashboard shows the live position of TTOs required for discharge

An AHP Live Workload dashboard is currently in build phase and discussions for additional laboratory and critical care dashboards are in progress.

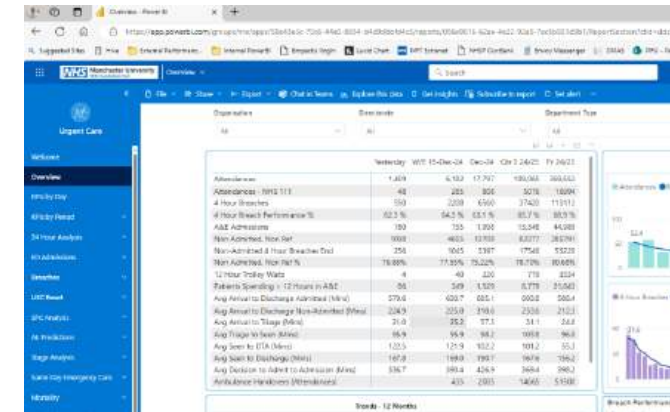
The following reports are currently being used to support teams to determine the daily sitreps

NWAS HAS screen

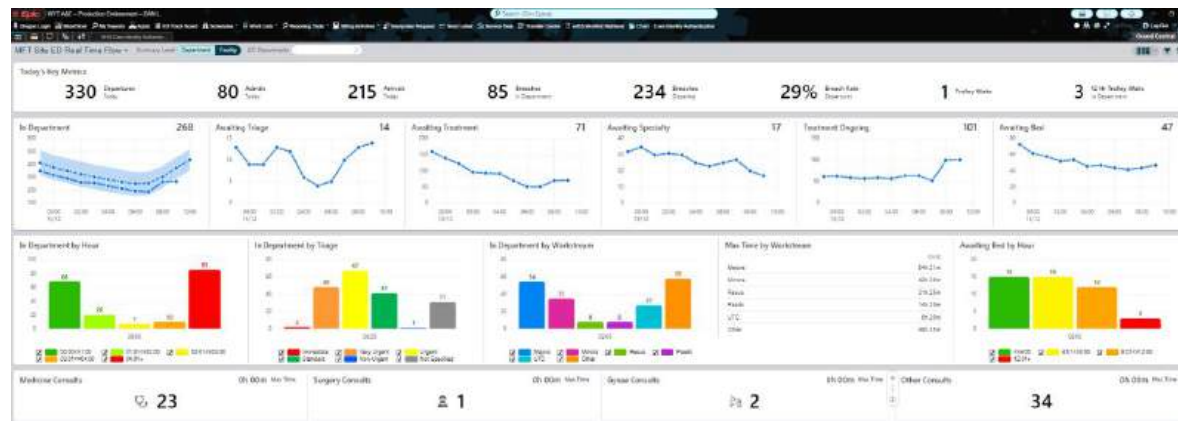


This screen identifies by site the ambulances Arrived, Inbound and Expected.

PowerBI



This Urgent Care PowerBI site enables performance assessment over time including SPC charting for assessment of variation

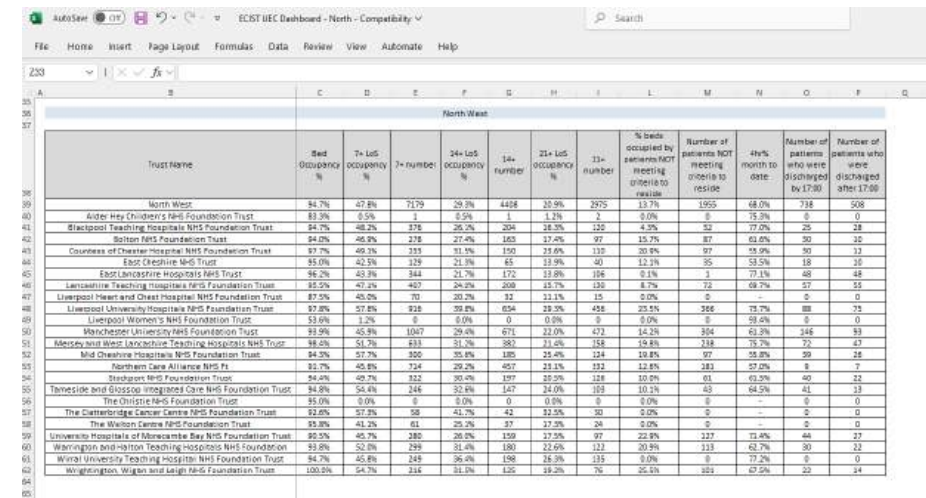


This dashboard identifies by site the performance over time during the day

MFT Site Real Time ED Flow

Manchester University
NHS Foundation Trust

ECIST UEC Dashboard



GM Tableau – finger on the pulse



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: 25/06/25

Key escalation and discussion points from the meeting

Alert

Advise:

The Committee discussed progress in delivery of the Workforce Digital Strategy with updates on the work on workforce system implementation, digital ID checking, automation and establishment control, service improvements, and support to Clinical Groups.

The Establishment Control project has completed a first phase review of all Clinical Group Ledger and ESR data and transacted the required cleansing within either the ledger or ESR.

The Committee discussed progress in finalising an EDI Delivery Plan and the MFT Diversity Matters Strategy which are due later this year and will respond to the NHS England EDI Improvement Plan and its six high impact actions. Engagement continues with senior leaders, the staff networks, staff-side representatives, cultural change agents as well as members of the workforce team to ensure that it addresses areas that are of concern.

The Committee received the Employee Health and Wellbeing Service 2024-25 Annual Report. The service's SEQOHS accreditation was successfully renewed and feedback from the NHS Staff Survey highlighted the highest ratings in four years for organisational action on wellbeing and managerial support. The Occupational Health aspect of the service is being reviewed.

Delivery of the Trust's Culture programme continues informed by the staff engagement work which has already taken place. Alignment with the Medical Engagement Programme and other relevant programmes across the Trust is underway to enhance the Change Agent approach which has been used. A Culture Dashboard is being developed to monitor, and provide an overview of, cultural trends.

Following a refresh of NHSE's Violence Prevention and Reduction Standard, the Trust has identified key actions for 2025/26 to reduce incidents of violence and abuse and ensure staff feel safe, supported and empowered to report concerns. A Violence Prevention Reduction Working Group is being established to finalise the Improvement Plan and outline the Trust's strategy for meeting compliance standards.

The Committee received the Quarter 4 Freedom to Speak Up report. The team continue to recruit FTSU Champions, with 139 active Champions and 24 currently onboarding. 103 concerns had been raised during the period and this remains less than the national average when compared to staff numbers. Worker Safety & Wellbeing was the most reported theme raised this quarter, with several recurring themes that impacted

staff wellbeing shared. Work is underway to consider how to enable issues to be raised confidentially to the team.

The Guardian of Safe Working Q4 report showed 220 exception reports submitted by 93 doctors in Q4, which is 32 fewer ERs than the number reported in Q3 (252). In Quarter 4, 89% of ERs were reviewed within 28 days. Reporting to the Committee will be more detailed in future reports.

Assure:

The Committee discussed the IPR section relevant to the committee's scope:

- There has been improvement in sickness absence figures over the last 3 months but it is too early to be certain that this is as a result of the improvement work undertaken.
- Non-medical appraisals remain below target. The need for corporate services to improve their performance was noted.
- There has been a drop in the staff engagement score within the last Pulse survey results, when compared to the NHS Staff survey, potentially due to difference between the different nature of the two surveys but also potentially due to the impact of current organisational change. This will continue to be closely monitored.

The Trust remains compliant with national guidance in relation to safer staffing for nursing and for midwifery. Maternity Services are also compliant with the nationally recommended establishments from Birthrate Plus (BR+) calculations and in line with MIS Year 71 requirement to repeat this establishment review every three years with a review due to take place in 2025.

Risks discussed at the meeting

The Committee discussed the strategic and corporate risks included in the Board Assurance Framework presented to the Committee. These have been recently reviewed with changes approved by the Trust risk Oversight Committee.

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

Agenda

People Board Committee

Date: Wednesday, 25th June 2025

Time: 2:00pm – 4:00pm

Location: Main Boardroom, Cobbett House, ORC

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 (23 rd April 2025)	Meeting admin	Chair	2:00pm
4.	Action Log	Discussion	Chair	2:05pm
5.	Matters Arising	Discussion	Chair	2:10pm
6.	Staff story (film)	Discussion	Chief People Officer	2:15pm
7.	Assurance Reporting			
7.1	Integrated Performance Report	Discussion	Deputy Chief People Officer	2:25pm
7.2	Board Assurance Framework	Discussion	Chief People Officer	2:35pm
Strategic aim 3: Be the place where people enjoy working, learning and building a career				
8.1	Chief People Officer report	Discussion	Chief People Officer	2:45pm
8.2	Diversity Matters Progress Report	Discussion	Chief People Officer	2:55pm
8.3	Medical and Non-Medical Staff Appraisals	Discussion	Chief People Officer	3:00pm

8.4	Employee Health and Wellbeing Service Annual Report	Discussion	Director of Learning and Development	3:05pm
8.5	Collective Leadership Programme	Discussion	Interim Director of OD inclusion	3:10pm
8.6	Workforce Digital Strategy Progress Report / Digital ID check demonstration	Discussion	Deputy Chief People Officer	3:15pm
8.7	Violence Prevention Reduction Standards Update	Discussion	Director of corporate Workforce	3:20pm
8.8	Freedom to Speak Up Quarterly Report (Q4)	Discussion	Freedom to Speak Up Guardian	3:25pm
8.9	Guardian of Safe Working Quarterly Report (Q4)	Discussion	Joint Chief Medical Officer	3:30pm
8.10	Safer Staffing Report (nursing) - Strategic Nurse Staffing Review Report - Theatre Recruitment	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	3:35pm
8.11	Safer Staffing Report (midwifery and newborn services)	Discussion	Interim Deputy Chief Executive / Chief Nursing Officer	3:45pm
Committee business				
9.	Escalation report	Approval	Chair	3:50pm
10.	Workplan Review	Meeting admin	Chair	3:55pm
11.	Any Other Business (verbal)	Discussion	All	3:55pm
12.	Meeting Evaluation (verbal)	Meeting admin	Chair	4:00pm
Date of next meeting: Wednesday, 3rd September 2025 at 2.00pm in the Main Boardroom, near Cobbett House				

Public Board of Directors Wednesday 30th July 2025

Paper title:	Bi-monthly Safe Staffing Report (Nursing) – including bi-annual Safe Nurse Staffing Establishment Review	Agenda Item 12.2
Presented by:	Mark Keegan, Corporate Director of Nursing for Workforce and Education	
Prepared by:	Mark Keegan, Corporate Director of Nursing for Workforce and Education; Darren Dunleavy, NMAHP Workforce Programme Lead; Marie Matthew, NMAHP Workforce Lead Nurse	
Meetings where content has been discussed previously	Workforce and Education Management Committee, 4 th June 2025 People Board Committee, 25 th June 2025	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

1. This safe staffing report provides assurance that the Trust remains compliant with the national guidance in relation to safer staffing for nursing. A midwifery safe staffing report is provided separately.
2. The Board of Directors will receive an annual strategic staffing review in June followed with a comprehensive staffing report after six months to ensure workforce plans are still appropriate in accordance with National Quality Board (NQB) Safer Staffing Guidance (2016), and the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018).
3. During May and June several webinars will be provided to the Senior Leadership Teams (SLT) across all Clinical Groups by Ann Casey, Deputy Director, England's Chief Nursing Officer's Safer Staffing Faculty and Course Director for the MSc in Healthcare workforce planning, delivery and assurance run jointly by NHSE and Birmingham City University. The interactive sessions provide an overview of the national approach to Safe Staffing for Nursing and Midwifery and provide an opportunity for SLT colleagues to gain a greater understanding of their delegated responsibility as outlined in section 2 of this report.
4. In the last two months finance accelerator schemes have been maintained and monitored by the NMAHP Corporate Workforce team in collaboration with the NMAHP Workforce leads for each Clinical Group and new schemes have been identified including Enhanced Financial Oversight Framework for wards/departments and utilisation of shorter bank shifts for Care Support Workers.
5. MFT has maintained licences for all the Safer Nursing Care Tool (SNCT) evidence-based tools, which are developed by the Shelford Group and endorsed by the National Institute

for Health and Care Excellence (NICE) to support nursing establishment and skill mix assessments. The revised Community Nursing Safer Staffing Tool will be implemented during 2025 and the revised Emergency Department and Children's and Young People's tools are expected in the coming months.

6. The funded establishment in March 2025 was 9,079wte for registered nursing roles (band 5 and above) and 3,658wte for unregistered staff. There are 8,888wte registered nurses and 3,218wte unregistered nursing support colleagues in post with a vacancies of 210.8wte and 238.8wte respectively.
7. Between January 2025 and April 2025 MFT recruited 151 nursing graduates from local HEIs and there will be c1000 student nurses graduating in September 2025. Unregistered nursing recruitment is being supported by several initiatives such as the widening participation programme, supporting 16–18-year-olds into employment through the T Level programme and expanding the apprenticeship offer.
8. The Theatre workforce forum will be reinstated during April 2025 to oversee the NMAHP workforce plan for Theatres which will report into the NMAHP Workforce Forum. The priorities for the forum include securing a consistent pipeline of Operating Department Practitioners from training through to recruitment and retaining skilled practitioners across the three Theatre disciplines of Scrub, Anaesthetics and Recovery.
9. Turnover for registered nurses has reduced over the past 12 months and as of March 2025 is 8.1% against a national rate of 7.2%. Sickness rate has seen no significant variation in recent months with current rates just above 5.9% for registered nurses. There has been improvement in unregistered nursing support colleague sickness rates down to 10% following a seasonal winter peak of 12.5% in December 2024. There is currently an unbudgeted pressure on nursing workforce due to maternity leave of 4.3%.
10. There is currently less than 2wte specialist community agency workers in placement, and NMAHP corporate team are working closely with colleagues from LCOD clinical group to finalise exit strategies for the remaining agency workers by the end of quarter 4 of 2024/25. The community agency cascade was closed on Friday 14th March 2025. This is the final area of nursing agency usage across Trust.
11. The NHSP enhanced pay rates were reduced on 4th November 2024 in Emergency Departments, Critical Care Units and Theatres. Following an initial reduction in fill rates from a mean average of 95% to 68% in the first week the fill rate has increased gradually since to a current level of 88% during February 2025. On 20th March 2025 the Trust Leadership Team Committee approved plans to progress with phase 2 of enhanced rate reduction which is set to be implemented from 12th May 2025. Based on the current demand and fill profile the assumed projected annual savings have been calculated at circa £4.3 million through 2025/2026.
12. MFT has joined a national improvement collaborative sponsored by NHSE with a focus on Enhanced Therapeutic Observations of Care. MFT has successfully completed the 90-day national collaboration programme sponsored by NHSE and has submitted a comprehensive improvement plan aligned with national expectations. MFT has been recognised for its contribution to supporting other organisations in the collaborative specifically related to the development of a national ETOC data guide. NHSE have invited MFT to lead the development of a national ETOC risk assessment tool that would be validated for application across the NHS. This is being progressed through collaboration with Manchester Catalysts and Manchester Metropolitan University (MMU).

13. The overall shift fill rate across MFT on average has been maintained above the organisation's target of 95% up until the last two months where there has been two consecutive months just below 95% standard. In March 2025 the fill rate was 94.6%.
14. The MFT wide average Care Hours Per Patient Day (CHPPD) level is at 9.4 hours per patient against a Shelford Group average of 9.7 hours, indicating that the Trust staffing levels result in a CHPPD level aligned with the Shelford average.
15. During the period February 2025 to April 2025, a total of 766 incidents related directly to staffing levels were reported. Most of the incidents were recorded as no harm and the appropriate actions were taken at the time (when investigations were successfully closed). Of the 6 incidents recorded as moderate, 4 related to corporate services and had no direct impact on patient care, one related to delayed care resulting in potentially avoidable hospital admission to WTWA ED and one related to low staffing levels on a respiratory ward in MRI. The most frequently reported staffing related issue were low staffing levels.
16. There were one category 3 or 4 attributable pressure ulcers at WTWA Clinical Group in March 2025 and Special Cause Variation Noted for Falls per 10,000 in March 2025. 7 out of 8 incidents were reported within the WTWA Clinical Group within the complex health directorate in various locations. A Falls Academy (MRI) and Dementia and Falls Operational Group (WTWA) have been established to capture and Implement learning, which included completion of falls risk assessments, recognition of lying and standing blood pressure and mental capacity assessments.
17. Nursing establishments are set using a triangulated approach including an evidence-based acuity and dependency tool, professional judgement and assessment of nursing sensitive outcomes. The suite of Safer Nursing Care Tool (SNCT) applications, developed by the Shelford Group and endorsed by the National Institute for Health and Care Excellence (NICE) are used to support nursing establishment and skill mix assessments.
18. The biannual ward SNCT census collection undertaken in February 2025 included a total of 90 inpatient areas completing the census using the revised SNCT descriptors. This informed the review of nurse staffing establishments across adult and children and young people in-patient areas across MFT.
19. The census demonstrated that the highest proportion of patients are stable, and dependent on nursing care (41.83%) with a similar proportion of the patients (38.25%) patients with low dependency/acuity who require hospitalisation but whose needs are met by normal ward care. There was a small increase in the proportion of patients who are stable but have increased dependency on nursing care to meet most or all of their daily living activities (3.48%). This can be attributed to more accurate scoring and effective use of risk assessments in caring for patients requiring enhanced observations and care.
20. The census identified 30 clinical areas (33%) to have a funded establishment 10% or more below the SNCT recommenced establishment and 28 areas (31%) to have a funded establishment 10% or more above the SNCT recommenced establishment. The "Professional Judgement Framework" was used by all Clinical Groups to review and act on the census findings.

21.WTWA, NMGH and MRI Clinical Groups have developed plans to re-distribute establishments to ensure safe staffing levels across all areas. Specialist Hospitals are undertaking a detailed professional judgement review of the findings to confirm the nursing establishment requirement which reflects the needs of the patient cohorts.

22. Recommendation(s)

The Board of Directors is asked to:

- Receive this report and note that MFT remains compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer nurse staffing.
- Support presentation of this report at the Board of Directors in July 2025.
- Note the plan to receive an update report on the annual strategic nurse staffing review in November 2025.

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:

- National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)
- CQC's fundamental standards – staffing; safety; good governance

- Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing; NHSE; 2018

Main report

1. Introduction

This bi-monthly Safe Staffing report provides the Board of Directors with assurance that MFT remains compliant with the national guidance in relation to safer staffing for nursing. A midwifery safe staffing report is provided separately.

2. Background

The National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), states 3 expectations of the Trust Board of Directors. These are endorsed by the NHS Improvement (NHSI) Developing Workforce Safeguards (DWS) Guidance (2018).

Expectation 1: Right staff

Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Expectation 2: Right skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Expectation 3: Right place and time

Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

The Board of Directors will receive an annual strategic staffing review in June followed with a comprehensive staffing report after six months to ensure workforce plans are still appropriate.

In between these reports, the Board of Directors will receive a bi-monthly safe staffing report to provide assurance that the Trust remains compliant with the national guidance in relation to safer staffing for nursing.

3. Nursing Workforce Productivity

In the last two months the NMAHP Corporate Workforce team have continues to support Clinical Groups with several financial control schemes in collaboration with the NMAHP Workforce leads

for each Clinical Group and Clinical Group Directors of Finance to ensure the financial impact is accurately reported.

The schemes are as follows:

- Maintain roster and establishment alignment.
- Reduce access to and use of premium overtime and agency.
- Standardised supernumerary periods for new starters.
- Maintain bank payment mechanisms, e.g. pay to shift rather than pay to band.

New financial control schemes have also been established:

Enhanced Financial Oversight Framework:

Trial of an Enhanced Financial Oversight Framework for nurse staffing expenditure at ward / department level has commenced at MRI Clinical Group and WTWA Clinical Group during April 2025. The framework identifies wards / departments that are exceeding the established budget by 5% or more, and analyses workforce metrics and roster performance to tailor interventions that target the specific causes of overspend. Use of the framework will be implemented across all Clinical Groups during May and June 2025.

Short bank shifts for Care Support Worker:

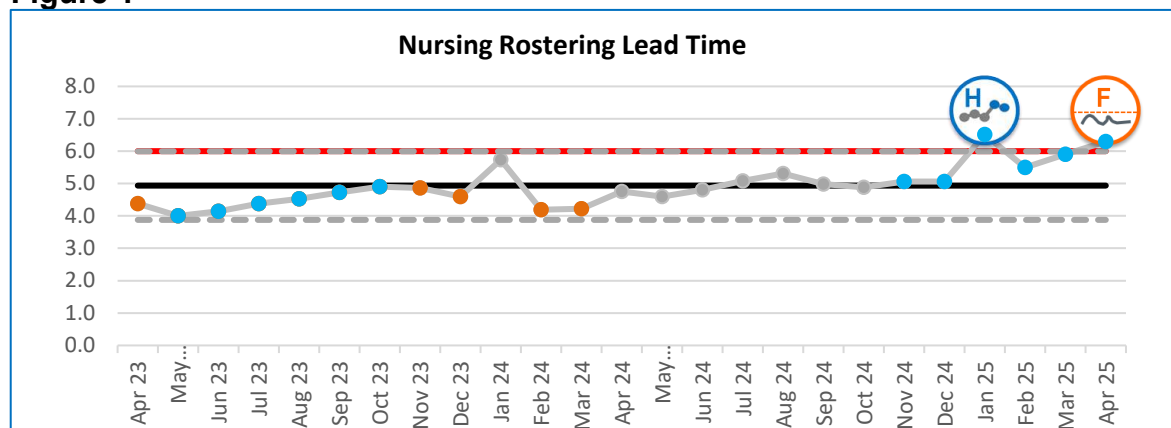
MRI Clinical Group trialled the substitution of standard 8.5 hour bank shifts for Care Support Workers (CSW) with a shorter 6 hour shift. The ward / department areas with the highest conversion to short days demonstrated the intended reduction in filled hours and cost compared to the areas with low utilisation of short days. The 8 hour shift remains the standard shift length of choice across MFT and the Clinical Groups are completing quality impact assessments with a view to converting to shorter 6 hour bank shifts for CSWs.

Since March 2025, the NMAHP Corporate Workforce team have continued to focus on the workforce planning improvement programme, with the current priorities as:

- Increase roster approval lead time
- Reduce access to and use of agency
- SafeCare System update and training refresh

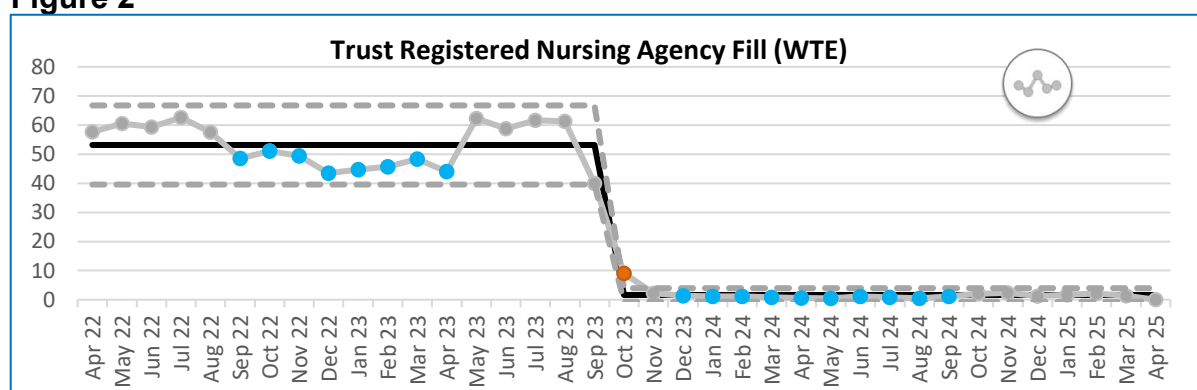
The Chief Nursing Officer set a standard for all Clinical Groups to ensure all nursing rosters were set and approved at least 6 weeks in advance. This has a positive impact on staff experience and demonstrates effective management of rosters. Through proactive reporting and escalation of non-compliance, the current overall Trust roster lead time has met the 6-week approval lead time. From the 277 areas reported during the April 2025 roster period, 224 (80.9%) were compliant which is an improvement to previous two roster periods in February and March 2025 and mirrors the improvement in overall average lead time shown in **figure 1**. Further improvement in compliance will be monitored at the monthly NMAHP Workforce and Education Forum.

Figure 1



Use of agency nursing staff reduced in October 2023 with the exception of 1-2 wte usage per month in specialised community roles (figure 2). The Corporate NMAHP Workforce team supported the LCO Clinical Group's Director of Nursing with the removal of agency usage, primarily with by migrating agency colleagues to bank or substantive contracts.

Figure 2

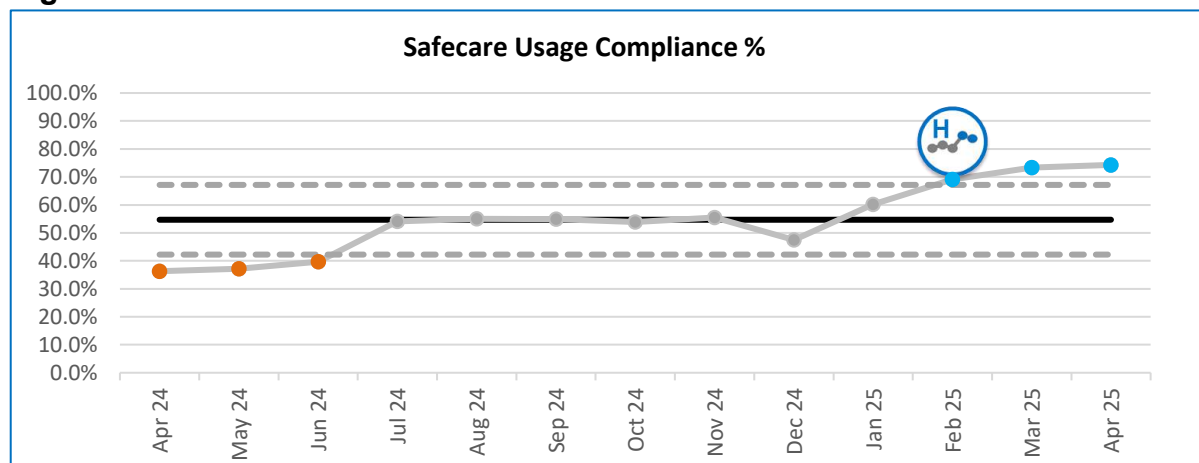


Safecare is a system that facilitates the measurement of acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the bed. In November 2024, SafeCare was upgraded by the supplier (Allocate) and refresher training was delivered to over 400 Ward/Team Managers, Matrons, Lead Nurses and Heads of Nursing across the Clinical Groups.

Strengthening the understanding and use of Safe Care helps teams to proactively highlight and address risks before they lead to patient safety incidents. In the longer term, this is expected to reduce the number of staffing-related incident, whilst also improving the early identification and management of staffing pressures and facilitate effective workforce deployment.

Compliance with use of SafeCare has increased from 56% in December 2024 to 74% in April 2025 (figure 13), with compliance levels ranging from 65% to 95% across all Clinical Groups. Improvement in compliance is now being monitored through the NMAHP Workforce and Education Forum.

Figure 13



In 2022 a team from Institute for Fiscal Studies, Imperial College Healthcare NHS Trust and the Health Foundation published a research study which investigated nurse staffing and inpatient mortality ^(a). It concluded that Registered Nurse (RN) staffing and seniority levels were associated with patient mortality, and the lack of association for Care Support Workers indicated they are not effective substitutes for RNs who regularly work on the ward. MFT are part of a multi-site study, led by The Institute for Fiscal Studies and Shelford Group, which aims to build on the evidence by using data for a more recent period.

(a) “Nurse staffing and inpatient mortality in the English National Health Service: a retrospective longitudinal study” in BMJ Quality and Safety (September 2022).

4. Safe Nurse Staffing Establishment

The Safer Nursing Care Tool (SNCT) is an evidence-based tool and methodology developed by the Shelford Group and endorsed by the National Institute for Health and Care Excellence (NICE) to support nursing establishment and skill mix assessments. The tool provides a framework for incorporating professional judgement and assessment of nursing sensitive outcomes as part of a triangulated approach to ensure nursing establishments reflect patient needs in terms of acuity and dependency.

During May and June several webinars will be provided to the Senior Leadership Teams (SLT) across all Clinical Groups by Ann Casey, Deputy Director, England’s Chief Nursing Officer’s Safer Staffing Faculty and Course Director for the MSc in Healthcare workforce planning, delivery and assurance run jointly by NHSE and Birmingham City University. The interactive sessions provide an overview of the national approach to Safe Staffing for Nursing and Midwifery and provide an opportunity for SLT colleagues to gain a greater understanding of their delegated responsibility as outlined in section 2 of this report.

Adult and Children and Young Persons Inpatient Ward Safer Nursing Care Tool (A&CYP IPW SNCT)

The latest census was conducted from 1st February 2025 to 30th February 2025 across all Clinical Groups and the findings will support the re-assessment of the nursing establishment and skill mix. The recommendations and actions from this census are presented in section 10. A review and refresh of the CYP SNCT by the Shelford Group Safer Staffing Faculty is currently underway and expected to conclude in early 2025.

Community Nursing Safer Staffing Tool (CNSST)

The tool sets out safety standards for district nursing workforce and will provide a recommended nursing workforce model for each district nursing team based on patient acuity and caseload. The CNSST has been revised and relaunched by NHSE during January 2025 following its testing stage, which involved a pilot at MFT in 2023. The license for the revised tool has been renewed for use at MFT and the Corporate NMAHP Workforce Team are supporting the LCO Clinical Group with plan to implement the tool in during 2025.

Emergency Department Safer Nursing Care Tool (ED SNCT)

Additional work has recently been undertaken Shelford Group Safer Staffing Faculty to incorporate a new algorithm for patients spending longer than 12 hours in the department. Application of the tool at MFT has been paused following initial census in 2023 pending the outcome of this work.

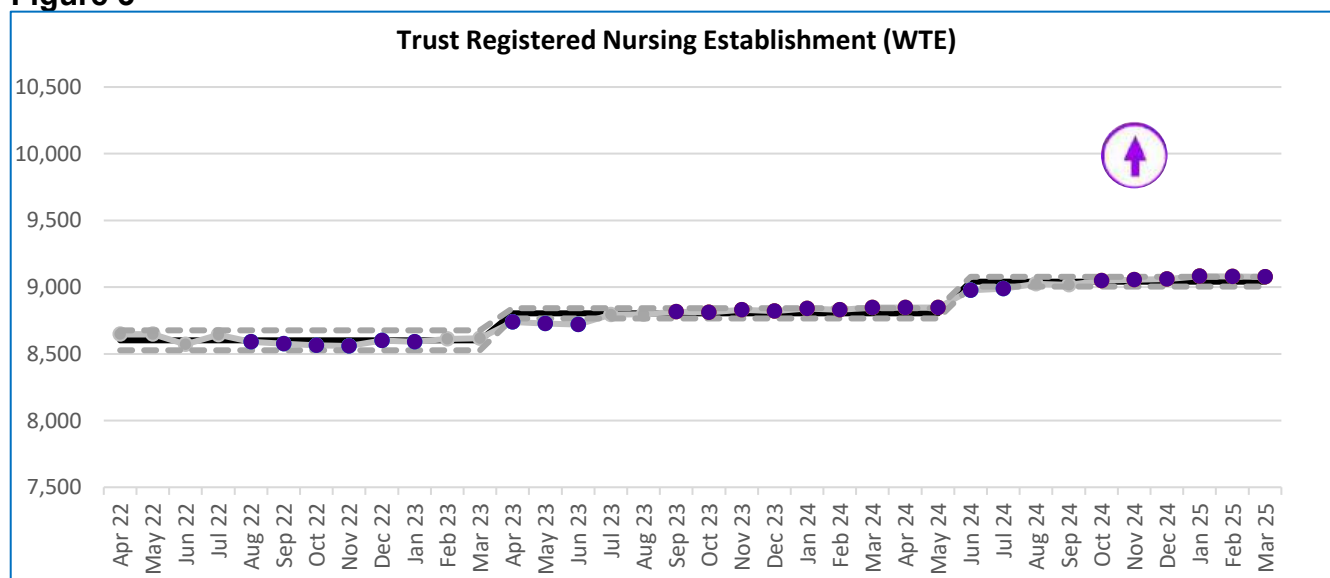
Mental Health Optimal Staffing Tool (MHOST)

The MHOST tool is a multi-disciplinary, evidence-based all age acuity and dependency tool used for inpatient mental health settings to identify workforce requirements has also been developed by the Shelford Group in response to the DWS Guidance. MHOST was adopted for use in the Children and Young People Mental Health (CAMHS) inpatient unit (Galaxy House), in 2024, with the first census being completed in November 2024. The second census has been completed in April 2025 and a third census is planned for later in the year, and results from the three consecutive census periods will be summarised in the next safer staffing report.

Registered Nursing

The current registered nursing establishment for roles band 5 and above in March 2025 was 9,079wte.

Figure 3



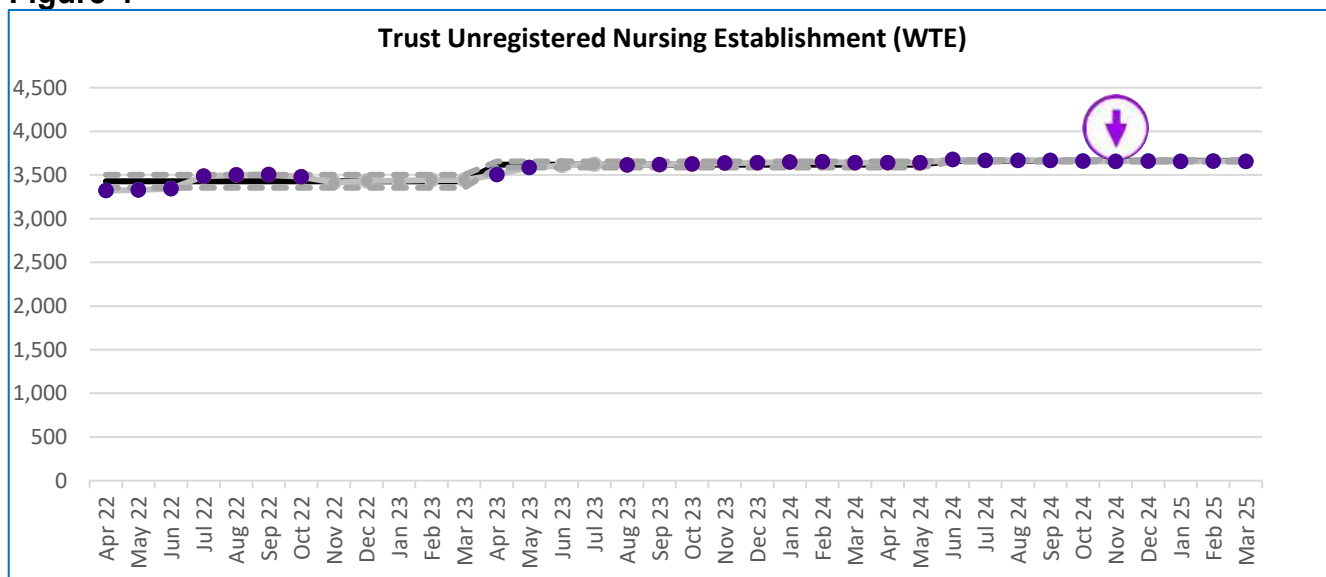
There have been no significant changes to establishment in the last two months.

A new process has been approved at NMAHP Professional Board on 25th March 2025 to ensure all proposed increases in nursing establishment are reviewed by the Chief Nursing Officer prior to approval.

Unregistered Nursing

The current unregistered nursing establishment in February 2025 was 3,658wte, with no change in the previous two months.

Figure 4

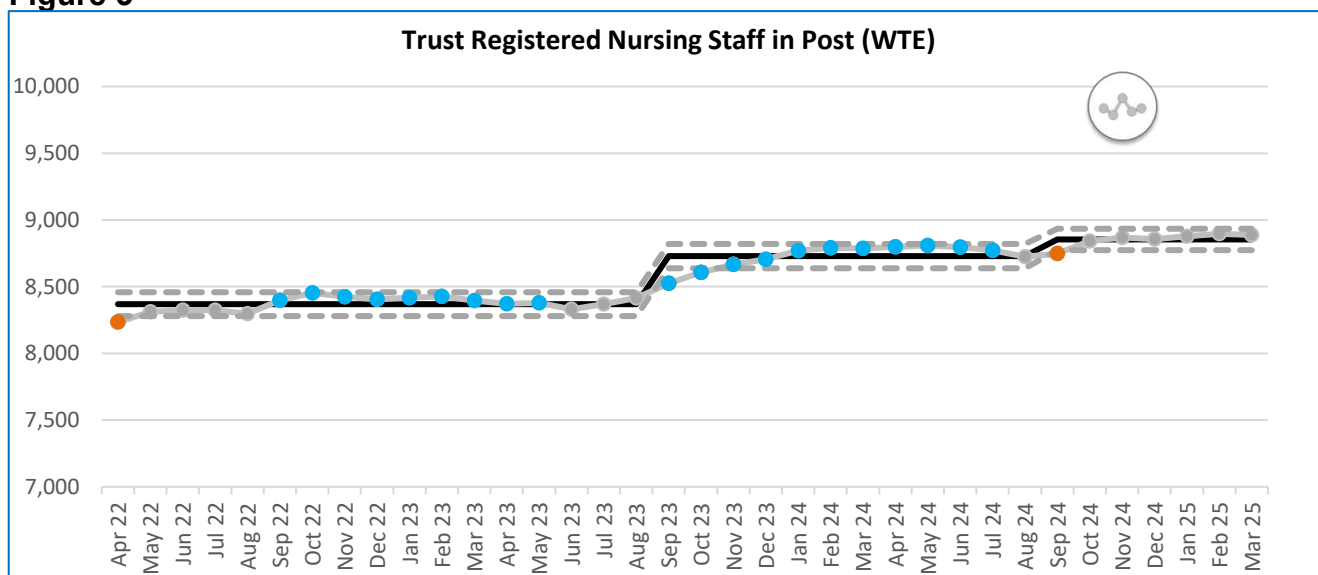


5. Achieving the set establishment

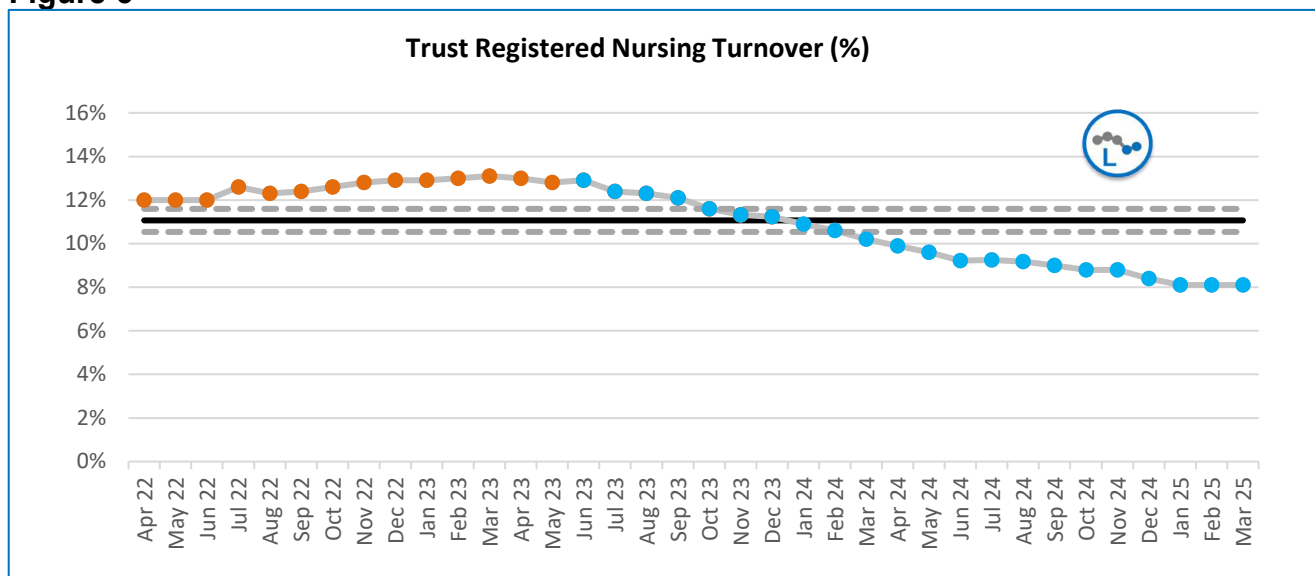
Registered Nursing

The number of staff in post has continued to increase in the last two months following continued successful recruitment across Clinical Groups, up to 8,888wte (**Figure 5**). Recruitment planning and maximising domestic candidate attraction is fundamental to maintain or further increase staff in post position.

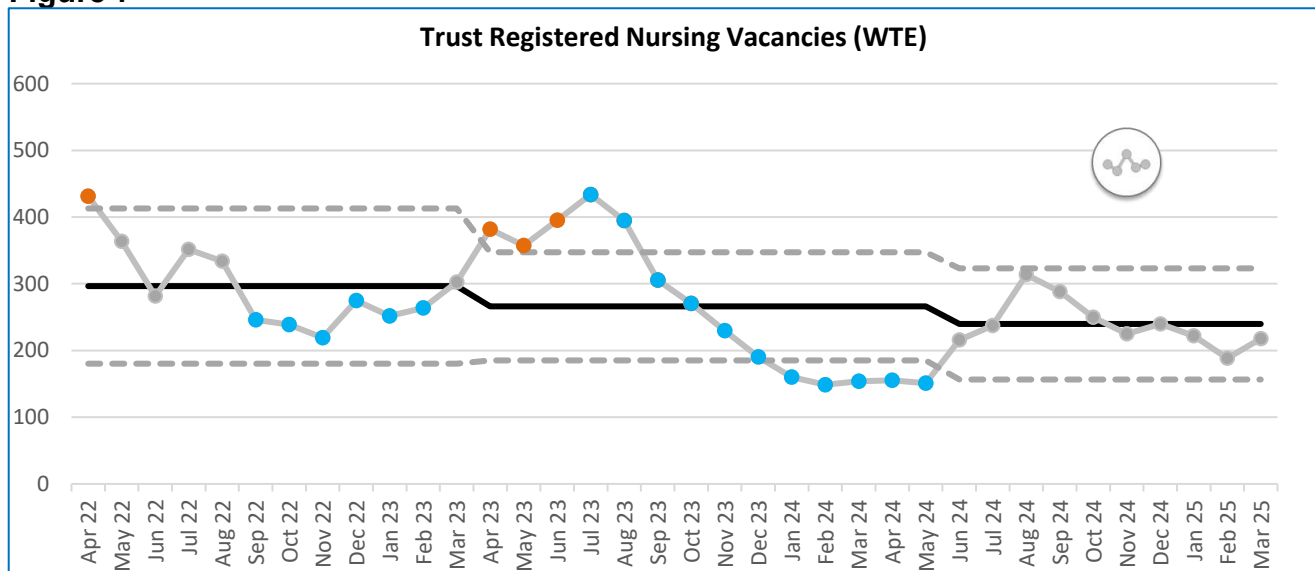
Figure 5



Following continued improvement since April 2023, registered nursing turnover has remained static at 8.1% from January to March 2025 (**Figure 6**). This has followed the national trend with a turnover rate currently reported at 7.2%.

Figure 6

Decreased turnover rates have balanced the potential impact on the registered nursing vacancy position, following the conclusion of the international recruitment programme in 2024. The trend of registered nursing vacancies has followed an annual cycle with the regular influx of graduate starters in Autumn each year (**Figure 7**). There are currently 210.8wte (2.1%) registered nursing vacancies, significantly less than the current national vacancy rate at 6.4%. A detailed breakdown of current registered nursing vacancies by Clinical Group and speciality can be found in Appendix A.

Figure 7

MFT wide recruitment initiatives continue to attract student nurses and operating department practitioner on placement at MFT from the University of Bolton (UoB), University of Salford (UoS), Manchester Metropolitan University (MMU) and Edgehill University who graduate from their programme in March/April 2025.

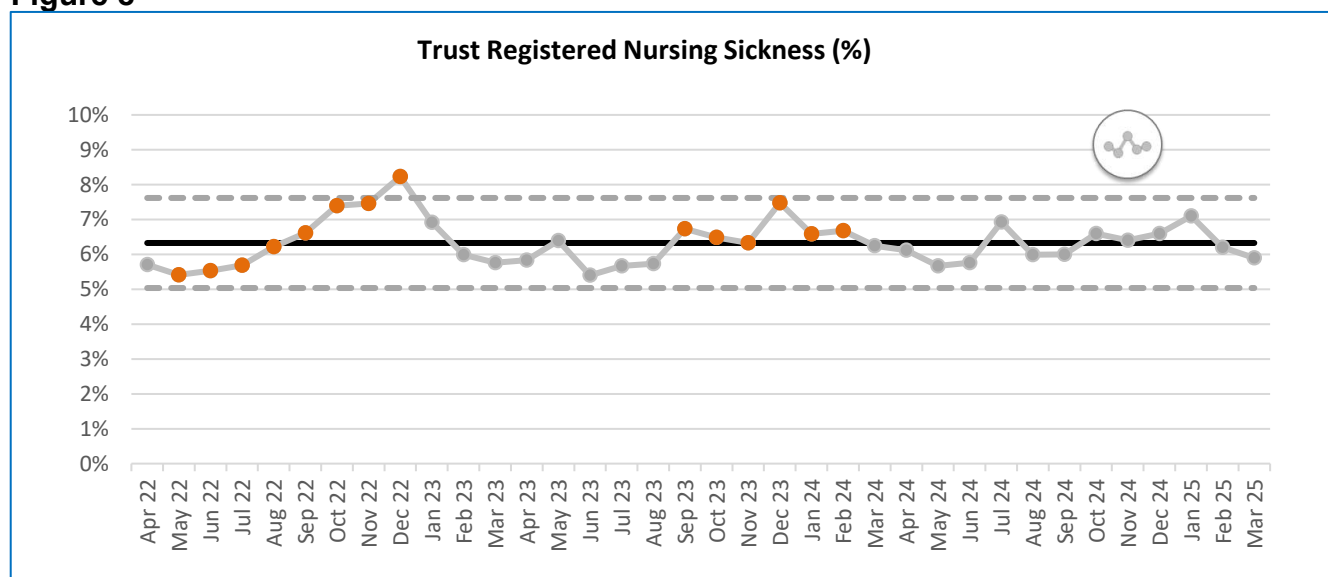
Between January 2025 and April 2025 MFT recruited 151 nursing graduates from local HEIs from an available pool of 180. MFT's projected Band RN vacancy position in September will be c305wte, based on the previous 6 month's turnover rate and a similar rate of regular domestic recruitment compared to the same period last year. The pool of available graduates in September 2025 (c1100) will be more than available vacancies, based on those students who

have had a 3rd year placement at MFT during the 12 months from September 2024 to September 2025. The Corporate NMAHP Workforce and Education teams are working closely with the Greater Manchester NMAHP Workforce Office, Higher Education Institutions (HEI) and NHS England (NHSE) to put plans in place to support recruitment of new graduates into employment.

The Theatre workforce forum was reinstated in April 2025 to oversee the NMAHP workforce plan for Theatres which will report into the NMAHP Workforce Forum. This will support the elective surgery programme and non-elective surgery capacity including training the future workforce, recruitment and retention initiatives and professional development. The priorities for the forum include securing a consistent pipeline of Operating Department Practitioners from training through to recruitment and retaining skilled practitioners across the three Theatre disciplines of Scrub, Anaesthetics and Recovery.

Additional factors impacting the availability of registered nurses are sickness and maternity leave require continuous management and monitoring. The registered nursing sickness rate has seen no significant variation in recent months with current rates down to 5.9% (**Figure 8**). There is currently an unbudgeted pressure on nursing workforce due to maternity leave of 396.0wte (4.5%). Further details and breakdown of registered nursing workforce metrics by Clinical Group can be found in Appendix A.

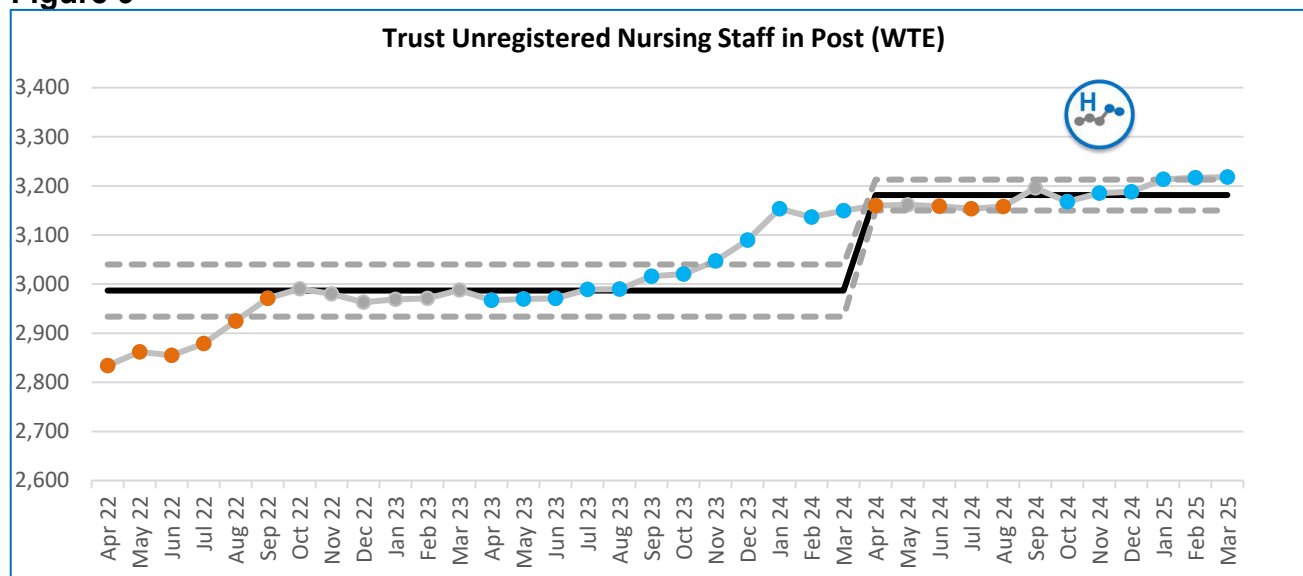
Figure 8



Unregistered Nursing Support

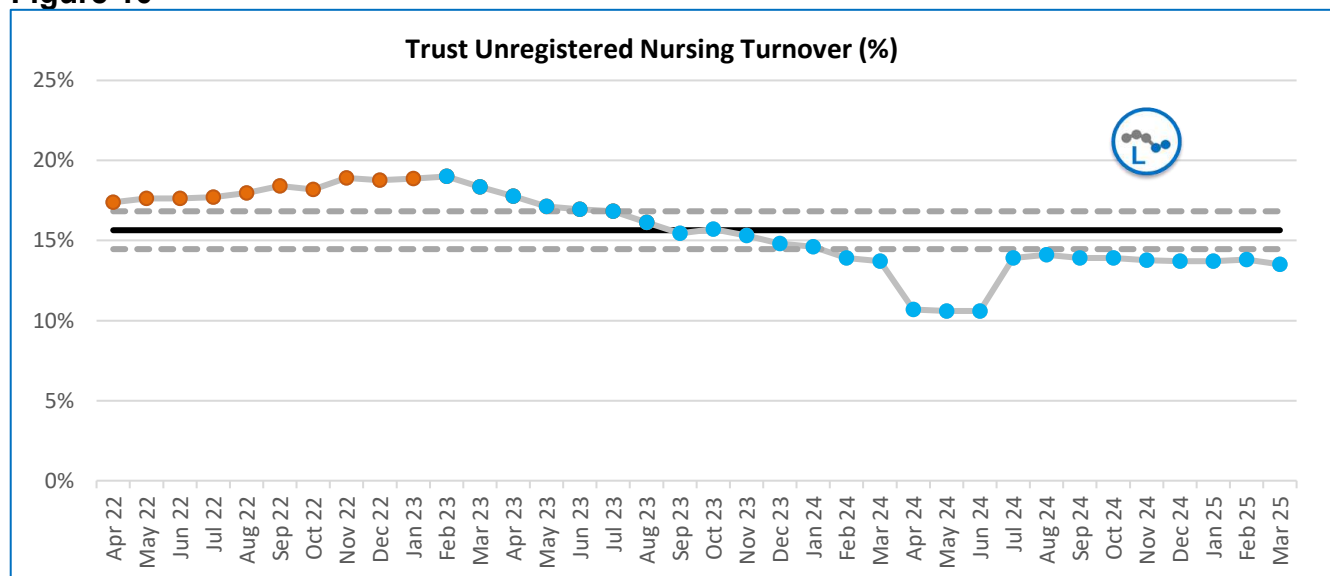
The number of unregistered nursing support colleagues in post has continued to increase in the last two months, up to 32,18wte in March 2025. The current recruitment pipeline for unregistered nursing represents a narrowly improved picture. Clinical Groups are actively using a range of approaches to attract and recruit applicants, including regular recruitment events, working with the widening participation team to support the pre-employment initiative and the T-level programme with Manchester, Trafford and Stockport colleges.

Figure 9



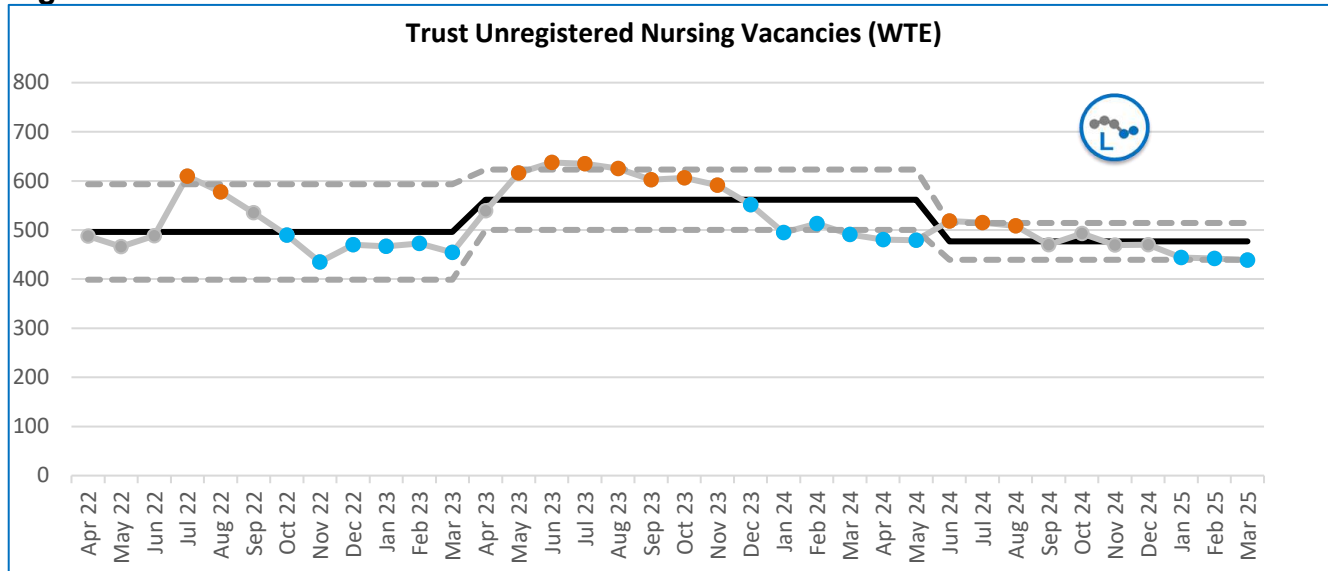
Continued improvement has also been noted in unregistered nursing support turnover rates, since February 2023 (Figure 10), with a current rate of 13.5%. The national turnover rate for unregistered nursing support has seen a similar trend since April 2023, and currently is reported at 11.7%.

Figure 10



Increases to staff in post have driven a recent decrease in unregistered nursing support vacancies down to 438.8wte in March 2025 (**Figure 11**). An increased pipeline is required to reduce vacancies in the short and long term and this is being supported by a number of initiatives such as the widening participation programmes, supporting 16-18 year olds into employment through the T Level programme and expanding the apprenticeship offer. Detailed breakdown of current unregistered nursing vacancies by clinical group and speciality can be found in **Appendix A**.

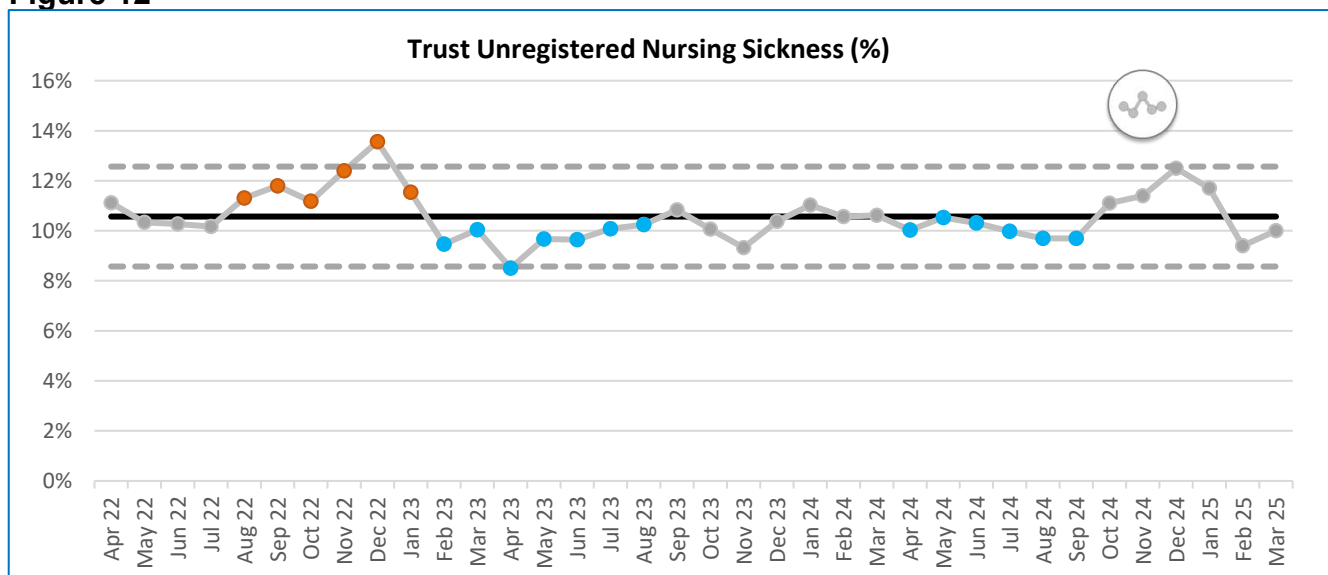
Figure 11



The unregistered nursing support sickness rate in March 2025 is 10.0% (Figure 12). A comprehensive programme approach to absence prevention and attendance management is underway through the MFT Absence Management Accelerator Plan including, 1:1 conversations with ward/team managers, work trial pre-recruitment and career pathways.

There is currently an unbudgeted pressure on unregistered nursing support workforce due to maternity leave of 70.6wte (2.2%). Further details and breakdown of unregistered nursing workforce metrics by clinical group can be found in appendix A.

Figure 12



6. Managing Staff Shortfalls

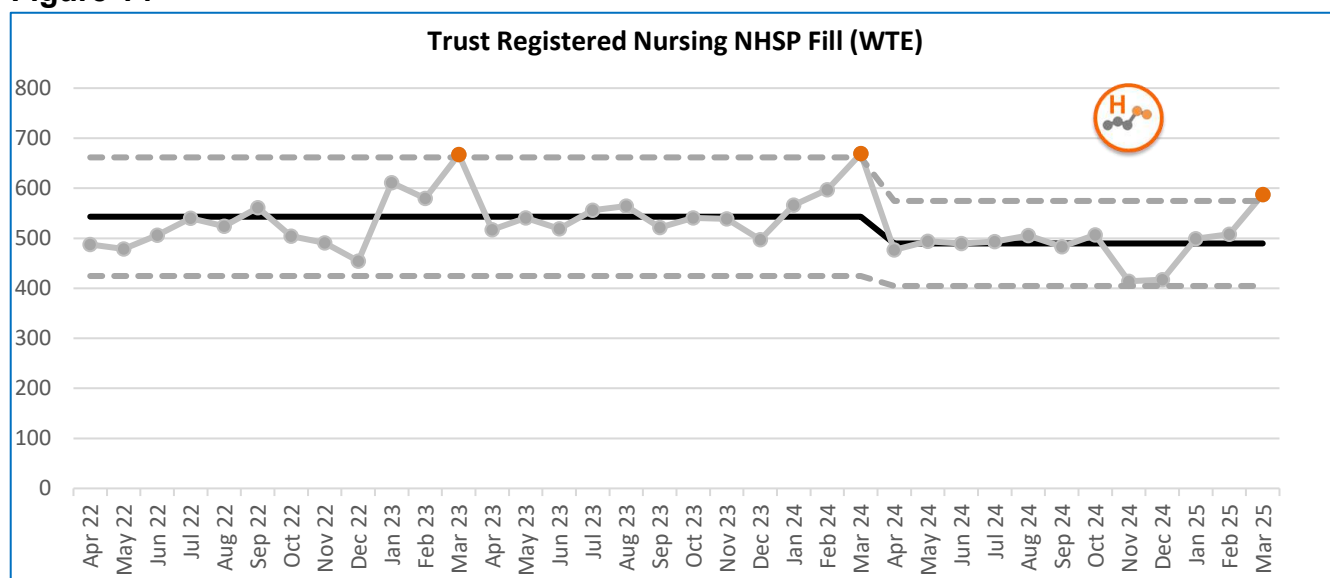
Temporary Staffing

MFT has a contract with NHS Professionals (NHSP) for the provision of temporary staff to cover shortfalls in the nursing workforce. Systems are in place to monitor usage and key lines of enquiry are established through NMAHP 'check and challenge' financial workstreams to control bank and agency usage.

The nursing bank at MFT is well established, primarily by a large proportion of substantive staff who are registered with NHSP to undertake bank additional hours. During February and March 2025, a total of 470,982 hours were requested through NHSP, and 382,634 hours were filled (81.2%). A further detailed overview of nursing NHSP bank fill can be found in Appendix B.

Fill rates returned to the mean average of 490wte per month in January and February 2025 following a drop in fill rates due to the reduction to enhanced rates of pay in November 2024. The peak in March each year is attributed to a commensurate increase in annual leave during the last month of the financial year. Effective rostering and distribution of annual leave throughout 2025/26 will be monitored through the monthly Temporary Staffing Check and Challenge meetings held by the NMAHP Workforce team and Clinical Group Directors' of Nursing/Midwifery, Finance and Workforce during. (Figure 14),

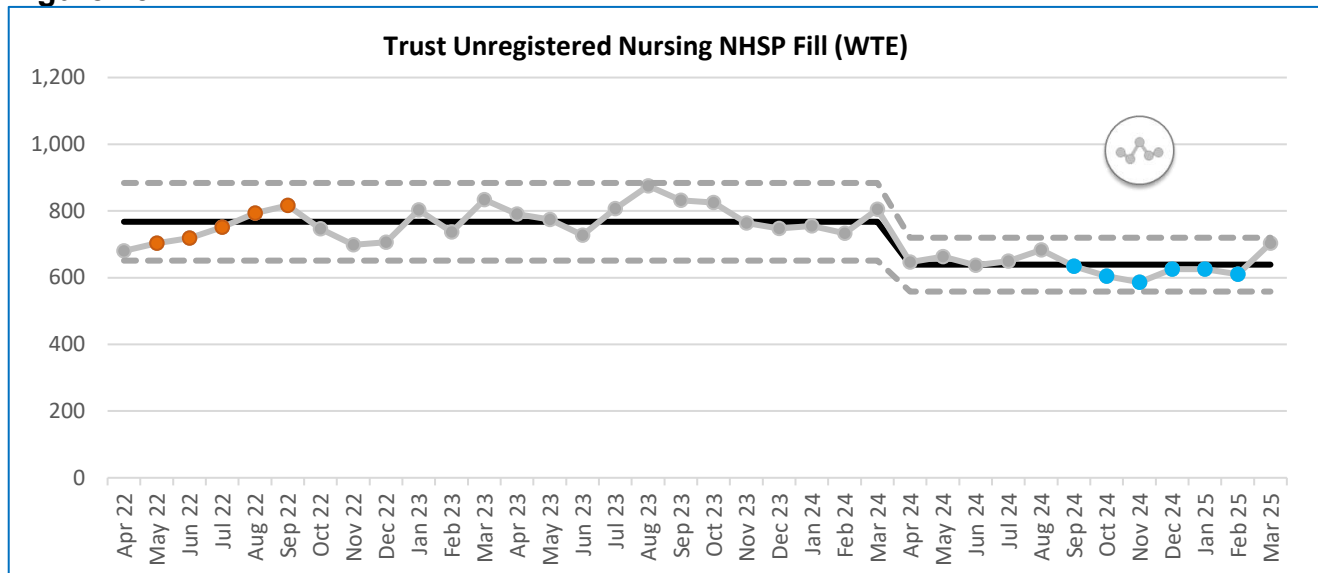
Figure 14



The reduction in unregistered nursing support bank usage in April 2024 has been maintained throughout the financial year overall. In March 2025 there has been a slight increase above the mean average to 719.2wte (Figure 15). 25.8% of unregistered bank usage during this period was to support enhanced therapeutic observations of care across the clinical groups. The remaining filled shifts are to support gaps associated with vacancies, sickness and maternity leave.

Fill rates for each individual Clinical Group are provided in appendix C.

Figure 15

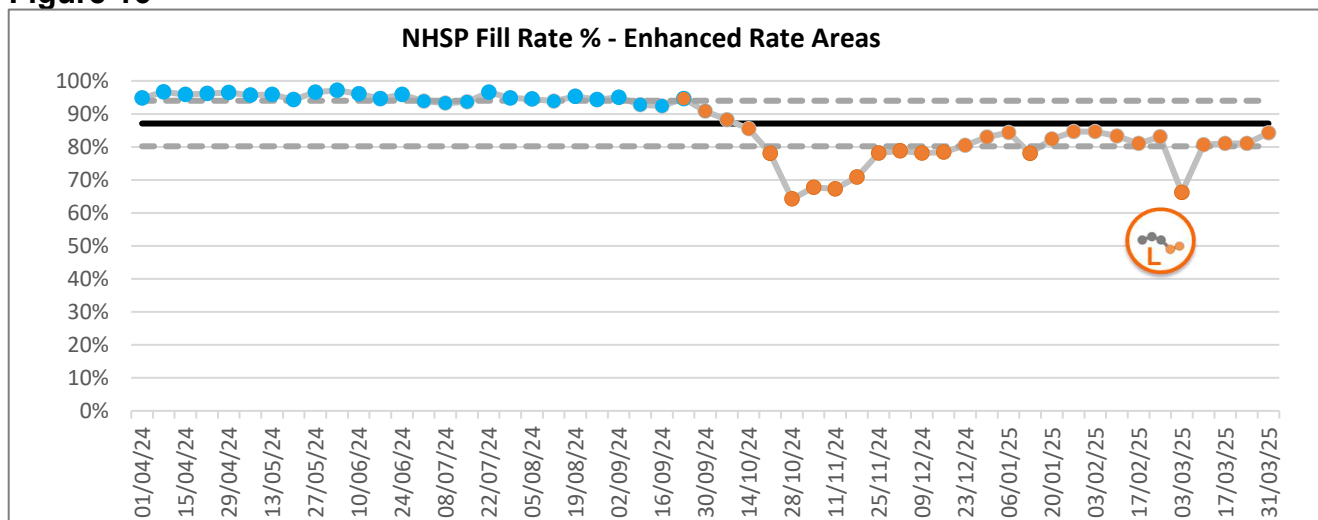


Reduction of enhanced pay rates

An enhanced rate of pay for NHSP bank shifts was introduced approximately 10 years ago by many acute providers in several designated clinical areas where there was competition from Nurse Staffing Agencies and to support recruitment into critical areas. The increment pays band 5 and 6 shifts at a rate equivalent to the top increment of band 7 and 8a respectively. The use of agency staff has gradually reduced over recent years, and the NHSP cascade to agencies was discontinued in October 2023 at MFT.

The Chief Nursing Office and the Corporate Director of Nursing for Workforce developed a plan to reduce the NHSP enhanced pay rates alongside Northern Care Alliance NHS Foundation Trust on 4th November 2024. Fill rates across all affected areas collectively reduced from a mean average of 95% to 68% in the first week since the pay rate reduced on 1st November 2025. This resulted in a one-off financial benefit of c.£300k during the 6-8 weeks following the reduction in rates. The fill rate has increased gradually since to a current level of 81.7% during March 2025 (Figure 16).

Figure 16



All Clinical Groups have mitigation plans are in place, including regular monitoring of demand and fill rates with support from the NMAHP Corporate Workforce team. On 20th March 2025 the

Trust Leadership Team Committee approved plans to progress with phase 2 of enhanced rate reduction which is set to be implemented from 12th May 2025. Based on the current demand and fill profile the assumed projected annual savings have been calculated at circa £4.3 million through 2025/2026.

Enhanced Therapeutic Observations and Care

Demand for enhanced therapeutic observations and care (ETOC), often referred to as enhanced care, 1:1 care, cohorting or specialling, has been increasing, predominantly due to an aging population and greater health complexities. It is vital that staff positively engage with patients to reduce identified risk of harm to self and others and ensuring ETOC requirements are clinically assessed and commenced, evaluated and discontinued appropriately.

The Trust has joined a national improvement collaborative sponsored by NHSE with a focus on Enhanced Therapeutic Observations of Care. A Steering Group has been established, and an improvement plan has been developed to focus on clinical assessment and decision making, data, workforce deployment models, temporary staffing escalations and staff training. The overall aim of the programme is to ensure ETOC is least restrictive, thereby reducing the reliance on 1to1 observation and the use of temporary staffing.

MFT has successfully completed the 90-day national collaboration programme sponsored by NHSE and has submitted a comprehensive improvement plan aligned with national expectations. MFT has been recognised for its contribution to supporting other organisations in the collaborative specifically related to the development of a national ETOC data guide. NHSE have invited MFT to lead the development of a national ETOC risk assessment tool that would be validated for application across the NHS. This is being progressed through collaboration with Manchester Catalys and Manchester Metropolitan University (MMU) with the support from a research fellow for 18 months to conduct the research study.

Staffing Escalation and Daily Review.

Recommendations set out in DWS focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance states organisations must demonstrate compliance with the key principles of safe staffing, supporting a triangulated approach to decide staffing requirements.

Nursing staffing levels within the Clinical Groups are reviewed daily in real time and monitored through the safer 'staffing huddles' to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. The daily staffing levels are viewed along with reported outcome measures to provide safe and effective patient care. Professional judgment in managing unplanned absences or increased demand, alongside the skill mix and competences is paramount to provide the safest care possible across the organization.

Temporary staffing requirements are approved by the Matron and are reviewed on a weekly basis by the Heads of Nursing / Midwifery. The Corporate Director of Nursing for Workforce chairs monthly 'Temporary Staffing Check and Challenge' sessions with each Clinical Group represented by the respective Director of Nursing/Midwifery, Director of Finance and Director of Workforce.

The daily staffing review process informs identification of the staffing escalation position and the identification of any red flag staffing events. A risk rating is calculated for each area. Staffing escalation above level 3 initiates a Director of Nursing workforce escalation meeting chaired by the Chief/Deputy Chief Nursing Officer to review staffing and identify mitigating actions such as

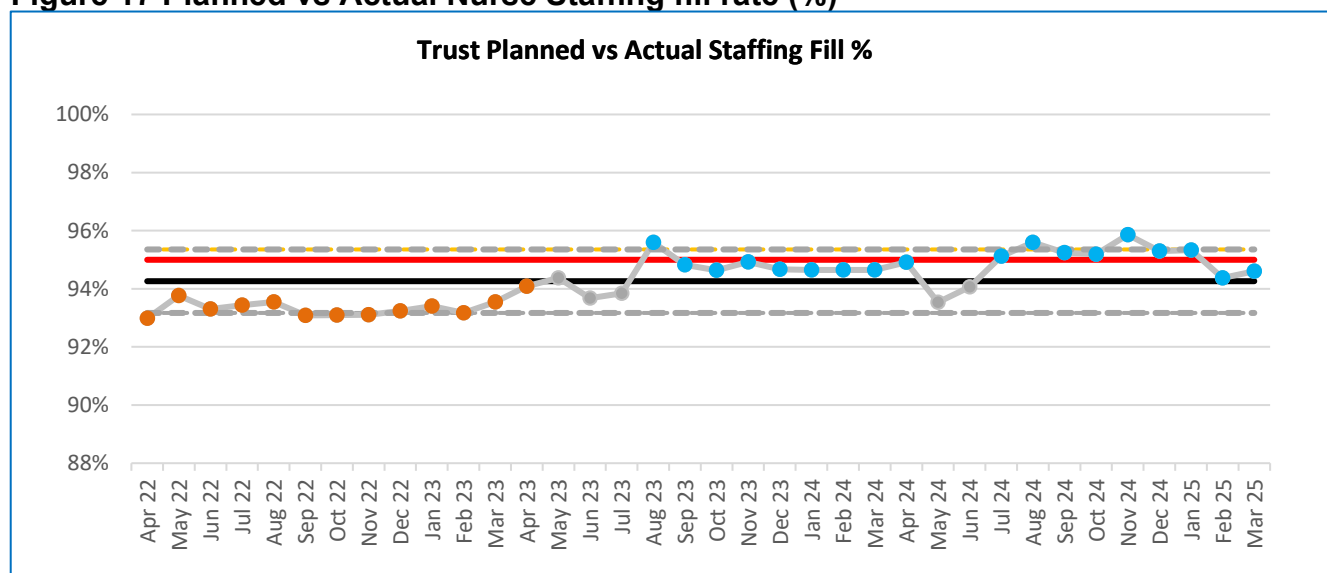
mutual aid between Clinical Groups. Director of Nursing daily staffing escalation meetings are undertaken during periods of escalation and in response to the trusts EPRR process.

The Nursing Dashboards shared with the Hospital Directors of Nursing provide a comparison of Nursing workforce and safe staffing data against quality outcomes.

7. Fill rate

MFT is required to submit a monthly Safe Staffing Unify Report to NHSI detailing actual registered nurse staffing levels as a percentage against those that were planned. On average the MFT level fill rate has been maintained above the organisation's target of 95% up until the last two months where we have seen two consecutive months just below 95% standard. In March 2025 the fill rate was 94.6%. It is important to note that these fill rates are based on the budgeted bed base of each area and do not take account of any additional beds that are open. Additionally, it should be noted, actual fill rates are inclusive of additional staff sourced through NHSP bank or additional substantive hours. 55 areas from a reported 120 met the trust fill rate target of 95.0% or above in March 2025. This metric features in the workforce IPR.

Figure 17 Planned vs Actual Nurse Staffing fill rate (%)



8. Care Hours Per Patient Bed Days (CHPPD)

Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward-based settings since April 2016. CHPPD is a metric to reflect care hours per patient bed day and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight.

CHPPD is not indicative of the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive, therefore must be considered in conjunction with measures of safety and quality and using professional judgement. CHPPD relates to hospital inpatient wards only where patients stay overnight.

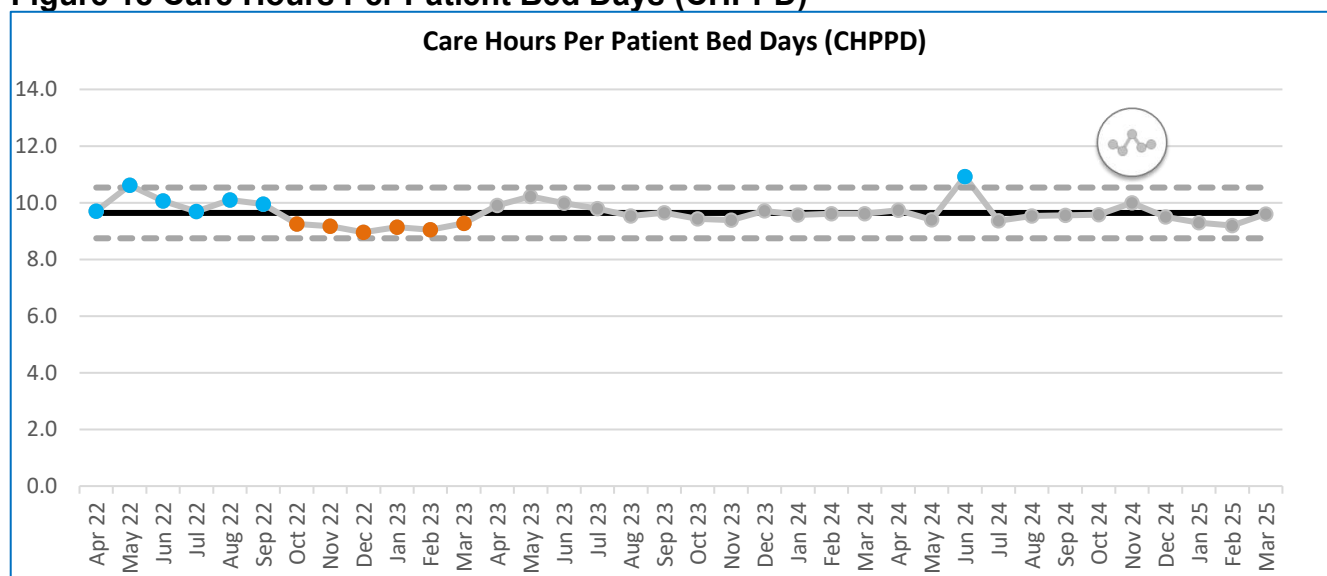
CHPPD can be viewed for each professional group that deliver care in a ward-based setting or as a combined total for benchmarking productivity against regional providers or national peers. This ensures skill-mix is well-described and the nurse-to-patient ratio is considered when

deploying the clinical professionals to provide the planned care, reflected alongside an aggregated overall actual CHPPD.

There is no national target for CHPPD, however NHSE publish the data on the NHSE Model Hospital portal for Trusts to benchmark the data against other organisations. Figure 18 illustrates CHPPD data trend which has remained stable over the last 24 months demonstrating the workforce is being deployed to meet patient activity and patient needs.

The MFT wide average CHPPD in February and March 2025 was 9.4 against a Shelford Group rolling average of 9.7 hours.

Figure 18 Care Hours Per Patient Bed Days (CHPPD)



9. Safe Staffing Incidents

MFT has an established staffing escalation system through the incident reporting process, managed through the patient safety management system (Ulysses).

During the period February 2025 to April 2025, a total of 766 incidents related directly to staffing levels were reported. The majority of the incidents were recorded as no harm and the appropriate actions were taken at the time (when investigations were successfully closed).

Of the 6 incidents recorded as moderate, 4 related to corporate services and had no direct impact on patient care, one related to delayed care resulting in potentially avoidable hospital admission to WTWA ED and one related to low staffing levels on a respiratory ward in MRI. The most frequently reported staffing related issue were low staffing levels.

Table 1 Incidents

Incident Actual Impact	Incident Period February – April 2025
Level 1 – No harm	653
Level 2 –Slight	107
Level 3 – Moderate	6
Level 4 -Severe	0
Overall	766

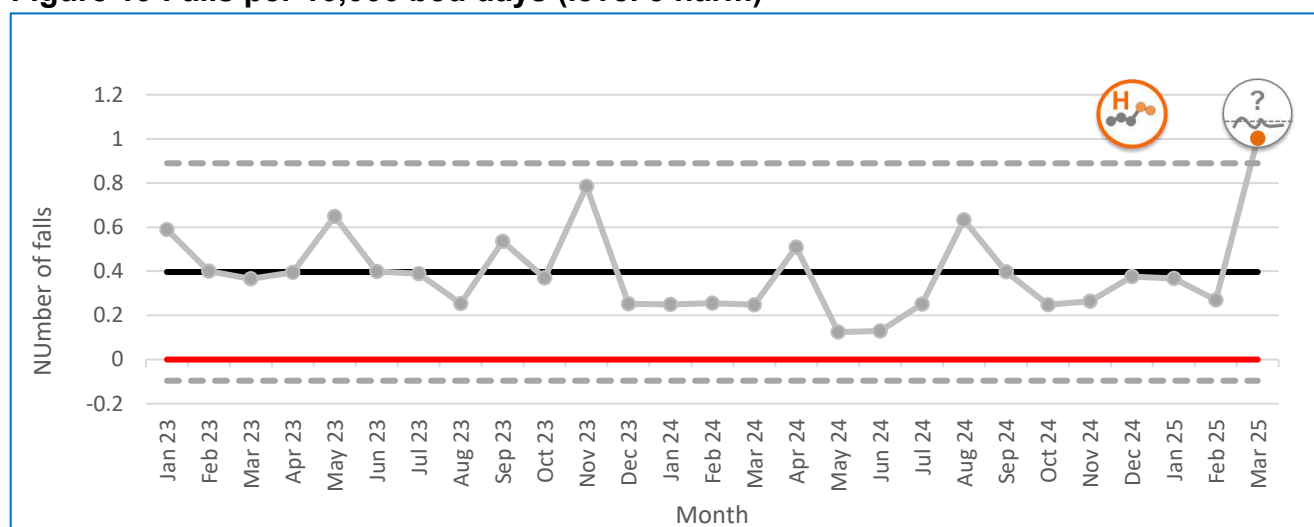
Pressure Ulcers

There was 1 category 3 attributable pressure ulcer in an in-patient areas March 2025, which occurred in WTWA.

Falls

Special Cause Variation Noted for Falls per 10,000 in March 2025. 7 out of 8 incidents were reported within the WTWA Clinical Group within the complex health directorate in various locations. A Falls Academy (MRI) and Dementia and Falls Operational Group (WTWA) have been established to capture and implement learning, which included completion of falls risk assessments, recognition of lying and standing blood pressure and mental capacity assessments.

Figure 19 Falls per 10,000 bed days (level 5 harm)



10. Annual Establishment Review

The Trust utilises the Safer Nursing Care Tool (SNCT) to determine the acuity and dependency of patients. SNCT is an evidence-based tool and methodology developed by the Shelford Group and endorsed by the National Institute for Health and Care Excellence and provides a framework for incorporating professional judgement and assessment of sensitive outcomes as part of a triangulated approach to ensure nursing establishments reflect patient needs in terms of acuity and dependency. Originating in 2006, the tool was updated in 2013 and further refreshed in 2023.

The revised version of the tool published in October 2023 incorporates updated patient levels of care descriptors with two additional levels of care (1c and 1d) for one-to-one care and two-to-one care, aligned to refreshed nursing resource multipliers. There are 7 levels of care with associated descriptors to determine the level of care a patient requires. The tool also provides for traditional ward layout with a separate section for wards with side rooms. The decision matrix allows staff to measure the acuity (how ill a patient is) and dependency (how dependent a patient is on the nursing staff to have their normal needs met) on a ward.

The bi-annual nurse staffing establishment reviews are informed by the collection of the SNCT census. SNCT has specific criteria that must be evidenced: a license, minimum data collection for 30 days including weekends, census collected by no more than 3 senior staff trained for each ward, established external validation of the data, interrater reliability assessment and data available showing the daily acuity and dependency levels for the previous 24 hours.

Three ward census collections have been undertaken in January 2024, July 2024 and February 2025 utilising the revised tool. The Lead Nurse from the Corporate NMAHP Workforce team is responsible for quality control of the data collection, process, and outputs. External data validation is undertaken weekly by a trained senior nurse outside the ward's budgetary control.

The census provides a clear depiction of the progressive impact of using the revised SNCT and opportunities for the triangulation of data and professional judgement to support evidenced-based decision making, thus supporting the principles of safer staffing, and achieving optimal nurse staffing levels.

SNCT Analysis

The biannual ward SNCT census collection undertaken in February 2025 included a total of 90 inpatient areas completing the census using the revised SNCT descriptors. The SNCT census does not include Intensive Care Units who align to their respective guidelines for staffing recommendations such as the Guidelines for the Provision of Intensive Care Services (GPICS). This census also does not include Emergency Departments (ED) pending review of the ED specific tool.

SNCT guidance requires review of data from a minimum of two census periods before implementing changes to establishments/budgets and the most recent census in February 2025 was the third consecutive census since the tools were revised at the end of 2023.

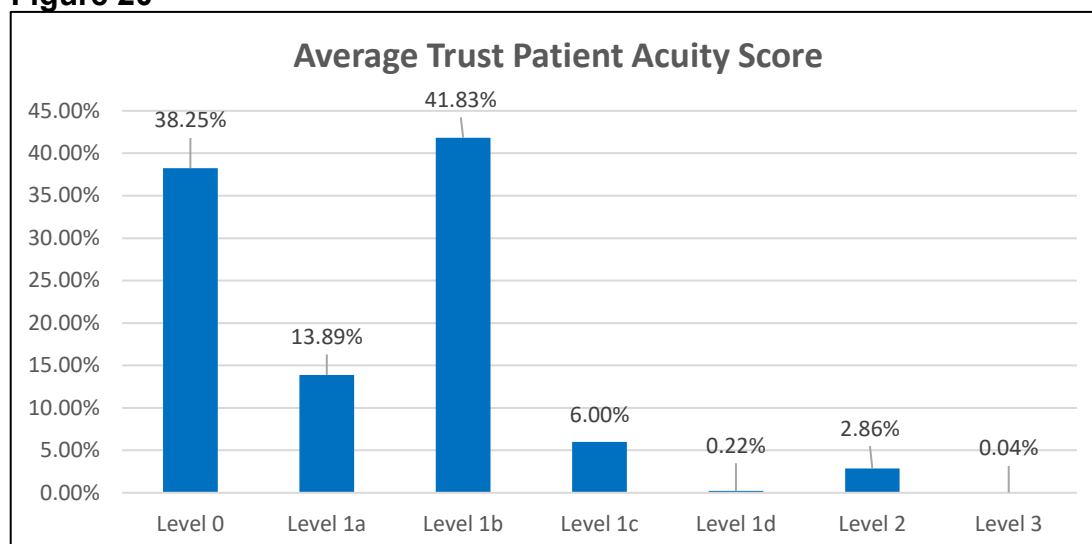
The Professional Judgement Framework (2023), based on the results of research funded by the National Institute for Health Research in England, and developed alongside several safe nurse staffing professional experts, has been used to guide the review of the census results.

This process allows for more targeted staffing adjustments, leading to improved operational efficiency and patient care outcomes. Aligning staffing levels more closely with demand, can achieve better cost efficiency without compromising care quality.

It is acknowledged that ward reconfigurations, changing patient demographics, variation in patient flow and seasonal variation are potential factors impacting the acuity and dependency scores for areas reported to be above or below the SNCT recommended establishment.

The overall average percentage of data for adult ward acuity demonstrates that the highest proportion of patients are stable, but dependent on nursing care with 41.83% of level 1b patients. This level indicates that a patient is requiring an elevated level of nursing time and support. There is a similar proportion (38.25%) of the patients classified at level 0 (Figure 1). As expected, there are a small number of level 3 patients.

The recent census shows a decrease of 1.1% in patients classified as level 1c and 1.92% in patients classified as level 2 from the previous census. However, there is a small increase in the proportion of patients classified as Level 1b (3.48%) and Level 0 (3.0%). This can be attributed to more accurate scoring and effective use of risk assessments in caring for patients requiring enhanced therapeutic observations and care (ETOC).

Figure 20

The February census has identified 30 clinical areas (33%) to have a funded establishment 10% or more below the SNCT recommended establishment. 13 of these areas are within MRI, 2 areas at NMGH, 4 areas at RMCH and 11 areas at WTWA. This is a decrease of 7 areas identified as under-established in comparison to the July 2024 census.

The acuity and dependency of patients arising from enhanced therapeutic observations and care (ETOC) requirements are higher in the majority of these areas with increased number of patients classified at level 1c and 1d. Due to the fluctuating nature of demand for ETOC daily at an individual ward level, this does not automatically indicate the need for an uplift in establishment for each individual ward and should be considered in the context of staffing resource requirements across a group of wards.

Conversely, the census has identified 28 areas (31%) to have a funded establishment 10% or more above the SNCT recommended establishment. This includes 13 areas at MRI, 7 areas at NMGH, 1 area at RMCH, 2 areas at SMH and 6 areas at WTWA. The overall number of areas above the SNCT recommended establishment remains unchanged from the previous census, though there is a reduction in the number of areas reported from NMGH as over established.

Review of the findings for the last 3 census have identified 15 areas to consistently have a funded establishment 10% or more below the SNCT recommended establishment and 14 areas to have consistently have a funded establishment 10% or more above the SNCT recommended establishment (**Table 2**).

Table 2

Clinical Group	Number of participating areas	Areas within SNCT recommended threshold	Areas 10% or more below SNCT recommended establishment	Areas 10% or more above SNCT recommended establishment
MRI	29	2	6	4
NMGH	21	4	1	8
REH	1	1	0	0
RMCH	8	4	4	0
SMH	2	0	0	1
WTWA	29	1	4	1
TOTAL	90	12	15	14

to carefully assess the specific needs of these wards, ensuring staffing levels are appropriate to the demand and acuity of patients.

A full establishment review triangulating the SNCT recommendations, patient outcomes and using the “Professional Judgement Framework”, has been undertaken by the Clinical Groups as summarised below. A full breakdown of ward area by Clinical Group is shown in appendices E to H.

MRI Clinical Group

Wards 1, 6, 9, 31, 37 and Acute Medical Unit 2 are identified as areas 10% or more below the SNCT recommended establishment.

Ward 6 configuration and patient cohort has changed between census periods and this area is now Care of the Elderly ward. CSU continues to review and monitor staffing requirements to ensure safe staffing to meet patient cohort needs.

Ward 9 complexity and acuity of patient cohort has increased over the last 12 months specifically in relation to the care of mental patients, who are often fit for discharge or awaiting mental health placement. Ward has high usage of enhanced therapeutic observations of care and security through temporary staffing. Ward is currently part of Care Closer to Home programme with aspiration that this should reduce complexity of patients.

Ward 1 complexity and acuity of patient cohort has increased over the last 12 months specifically in relation to the care of mental patients, who are often fit for discharge or awaiting mental health placement. Ward has high usage of enhanced therapeutic observations of care and security through temporary staffing. Ward is currently part of Care Closer to Home programme with aspiration that this should reduce complexity of patients.

AM2 complexity of respiratory patients’ needs has seen increase in patient requiring non-invasive ventilation or with complex respiratory needs such as tracheostomy. The CSU is undertaking review of service demand to understand future demand and align workforce requirements to service needs. This review will include AM1, which is the other Respiratory ward within the MRI.

Ward 31 is the MRI Stroke unit and the complexity and acuity of the patient cohort is variable, as the unit provides care for acute stroke patients and those requiring rehabilitation following stroke. The SNCT tool does not capture the MDT workforce contribution the care delivery by physiotherapists, Occupational therapist and other MDT staff which mitigates the SCNT recommended nursing establishment.

Ward 37 Renal Medicine clinical area has high demand for dialysis care which required 1to1 nursing input for the period that patients are undergoing dialysis. The CSU is reviewing the workforce configuration along with the establishment on ward 36 which is the other renal medicine ward area in the MRI.

Wards 11, Acute Cardiac unit, ETC Surgery and Surgical Assessment Unit are identified as areas 10% or more above the SNCT recommended establishment. Patient complexity deems a higher registered nurse workforce within these areas and a triangulated approach using data, patient outcomes and professional judgement is recommended to aligning staffing levels more closely with demand, can achieve better cost efficiency without compromising care quality.

NMGH Clinical Group

The 3 censuses undertaken by NMGH Clinical Group has identified H4 as a clinical area that consistently has indicated a funded establishment 10% or more below the SNCT recommended establishment. Ward H4 has been identified as the area 10% or more below the SNCT recommended establishment, although the configuration of the ward changed in December 2024 and therefore it will need a further 2 census' to inform a review of establishment.

Wards F1, F4, C3, C5, C6, D5, D6 and F2 STU are identified as areas 10% or more above the SNCT recommended establishment. Escalation beds, ward reconfigurations and fire evacuation assessments indicate the requirement for a higher establishment within these areas.

Specialist Hospitals Clinical Group

RMCH:

The 3 censuses have identified four clinical areas (50%) to consistently have a funded establishment 10% or more below the SNCT recommended establishment (Appendix C).

Ward 76 is the Elective Treatment Centre for RMCH and consists of 17 inpatient beds, a day case unit including trolley and chair spaces and a medical investigation unit consisting of treatment rooms and treatment spaces. The SNCT census is only completed for the inpatient beds. Professional feedback from the Ward Manager and Matron is that there has been an increase in acuity of patients on Ward 76, with more complex patients being admitted who would have previously attended the tertiary wards, and at least one patient admitted who is at risk of harm to self and often requires an increased level of monitoring and care.

Ward 78 is a 32 bed Neurosciences, Trauma, Orthopaedics, Spinal Surgery and ENT ward. The SNCT data indicates up to 13.92wte establishment shortfall, (24%), this is predominantly in unregistered workforce. Professional feedback is that Ward 78 is consistently at 100% capacity with high demand for beds, flow of patients from PCC is high, patients are increasingly complex with care needs/observation that requires arms-length to 1:1 visibility to maintain safety when parents or carers are unavailable.

Ward 85 is a 28 bed Specialist Medicine ward which includes, respiratory, cystic fibrosis, metabolic, cardiology and rheumatology specialities. The SNCT data indicates up to 9.36wte establishment shortfall, (18%), this is a mix of registered and unregistered workforce. Professional feedback from the ward team describes increasing acuity and dependency due to the complexity of patients and their families, which includes the support requirements of parents and managing the relationships when length of stay is extensive, and a yearly increase in the number of patients they are required to care for on ventilatory support which was traditionally managed in Paediatric Critical Care.

NMGH Inpatients unit is 20 bed plus High Dependency Unit, general paediatric ward, co-located with and Observation and Assessment Unit (KOALA), Day Case beds and Outpatients Department. The SNCT census is completed for the inpatient beds only. The SNCT data indicates there is up to 9.85wte shortfall in establishment, (31%) which is predominantly registered workforce. Professional feedback identifies complexity in social backgrounds of the patient cohort and a continuous flow of young people with mental health illness, dysregulated behaviours or in crisis impacting upon overall dependency requirements in the unit.

A detailed establishment review of these areas is underway, applying the Professional Judgement Framework, (2023), to confirm the nursing establishment requirement which reflects the needs of the patient cohort.

The 3 census periods have identified no clinical areas to consistently have a funded establishment 10% or more above the SNCT recommended establishment.

St Mary's Hospital – Gynaecology:

Of the two in-patient Gynaecology wards at St Mary's, Ward F16 has been identified as the area 10% or more above the SNCT recommended establishment. Plans are in place to undertake a regular review of activity to ensure establishment reflects acuity and implement a reduction in establishment through natural turnover.

WTWA Clinical Group

The 3 censuses have identified 4 clinical areas (14%) to consistently have a funded establishment 10% or more below the SNCT recommended establishment and 1 clinical area (3%) is identified to consistently have a funded establishment 10% or more above the SNCT recommended establishment.

Medicine and Outpatients - Across the division, SNCT recommendations were consistently above 10% of the budgeted establishment for wards F14 and Wilson.

Enhanced Therapeutic Observations of Care (ETOC) requirements are high across the Division with a total of 38.6 wte recommended to support ETOC for level 1c or 1d patients. Senior oversight and support and effective strategies are in place to care for patients requiring ETOC and budgeted establishments are considered appropriate for most areas. The Divisional senior nursing team consider the increased establishment recommendation on Wilson to be appropriate given the consistently high ETOC requirements. Currently, 1 Care Support Worker per shift (accounting for 5wte) is assigned to Doyle ward budget to support ETOC across both Doyle and Wilson; it is recommended that this is extended to ensure 1 Care Support Worker available on each ward and the senior nursing team are exploring options to fund the required 5wte posts.

Cardiac - Across the division, SNCT recommendations were consistently above 10% of the budgeted establishment for Jim Quick.

Since 2022, Jim Quick has reported a 300% increase in level 2 patients and a significant increase in occupancy. A full establishment review has been undertaken triangulating the SNCT recommendations, patient outcomes and quality metrics, and professional judgement. A proposal to increase the establishment using part of the F5 budget has been submitted to the WTWA Senior Leadership Team.

Respiratory - Across the division no ward was consistently highlighted as having a funded establishment above or below 10% above the SNCT recommendations.

Surgery and Trauma & Orthopaedics, Burns & Plastics - Across the division, SNCT recommendations were consistently above 10% of the budgeted establishment for ward A5.

Ward A5 have 2 Care Support Workers per shift to support ETOC within the budgeted establishment. Whilst the SNCT recommendations remain above the budgeted establishment, work is ongoing to reduce the requirement for ETOC and the Divisional senior nursing team

consider the budgeted establishment to be appropriate. F7 had a lower recommended establishment over the last 2 census collections, however the patient group of altered airways and plastic surgery flap reconstructions require a nursing ratio of 1:4 which is not captured within the SNCT.

Emergency Care Village - SNCT recommendations were above 10% of the budgeted establishment on AMU over the last 2 census collections. It is however acknowledged that the applied Acute Assessment Unit multipliers, are recommended where patient turnover exceeds 2 patients per day. During the census collection an average of 30 patients were admitted per day on a 56 bedded unit. In consideration of this and utilising professional judgement of the Divisional senior nursing team, the establishment is considered to be appropriate.

Manchester and Trafford Local Care Organisation (LCO) and University Dental Hospital Manchester (UDHM) Clinical Group

As reported in section 4 of this report the CNSST has been revised and relaunched by NHSE during January 2025 following its testing stage, which involved a pilot at MFT in 2023. The license for the revised tool has been renewed for use at MFT and a census period is planned for July 2025. the Corporate NMAHP Workforce Team are supporting the LCO Clinical Group with plan to implement the tool in during 2025.

Clinical and Scientific Services Clinical Group

The staffing establishments within the Critical Care unit are determined by the number and level of commissioned level 2 and 3 beds within each unit, taking into account the standards outlined in GPICS v2.1 (2022) and as such, annual review of these is not routinely undertaken, except under the circumstances where beds are reconfigured due changes within the service.

The most recent of these changes has been the transfer of management responsibility of the Burns Intensive Care Unit beds from WTWA Clinical Group to CSS Clinical Group. Current staffing establishments within Critical Care have moved toward compliance with GPICS standards (both 2019 and 2022) following the inception of MFT and the subsequent acquisition of NMGH Critical Care from Northern Care Alliance NHS Foundation Trust.

A full and external review of nursing critical care establishments is planned for Q2/3 2025/26 which will be reported on separately once ToR have been completed and the review has been commissioned.

11. Conclusion

The Board of Directors is asked to:

- Receive this report and note that MFT remains compliant with the national guidance (NQB 2026; DWS 2018) in relation to safer nurse staffing.
- Support presentation of this report at the Board of Directors in June 2025.
- Note the plan to receive an update report on the annual strategic nurse staffing review report in November 2025.

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

References

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time Safe sustainable and productive staffing; National Quality Board; July 2016.

Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing; NHS Improvement; October 2018.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing; 3 June 2024

Saville C, Griffiths P, Casey A, Chable R, Chapman H, Radford M, and Watts N (2023) Professional Judgement Framework, doi: 10.5258/SOTON/P1102 University of Southampton
(<https://doi.org/10.5258/SOTON/P1102>)

Appendix A

Registered Nursing - Workforce Metrics by Clinical Group (March 2025)

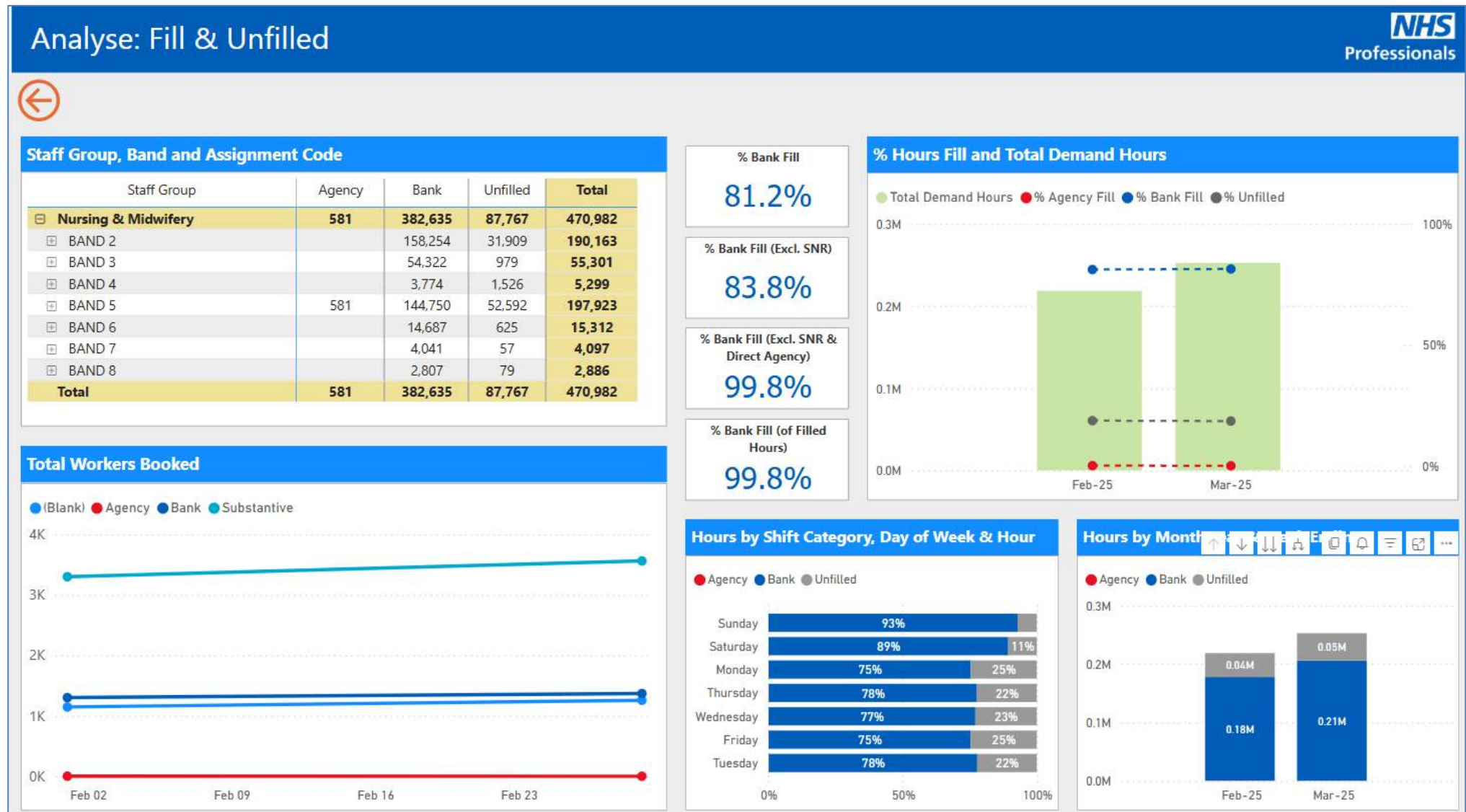
Clinical Group	Establishment (WTE)	Staff in Post (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	1005.3	966.0	393.3	3.9%	9.2%	5.0%	4.1%
LCOD	1071.3	1040.8	30.5	2.9%	9.2%	3.4%	6.2%
MRI	1765.9	1699.7	66.2	3.7%	8.6%	4.2%	6.5%
NMGH	872.7	879.1	0.0	0%	6.2%	4.5%	5.8%
SPEC – REH	171.5	167.0	4.5	2.6%	4.3%	4.4%	4.0%
SPEC – RMCH	1119.4	1122.5	0.0	0%	7.9%	5.0%	7.2%
SPEC – SMH	652.1	616.4	35.7	5.5%	9.5%	6.4%	4.5%
WTWA	2037.2	2004.5	32.7	1.6%	7.9%	4.5%	5.0%

Unregistered Nursing - Workforce Metrics by Clinical Group (March 2025)

Clinical Group	Establishment (WTE)	Staff in Post (WTE)	Vacancies (WTE)	Vacancy Rate %	Turnover %	Maternity Leave %	Sickness %
CSS	93.2	125.0	0.0	0%	5.3%	0.0%	7.1%
LCOD	468.9	362.9	106.0	22.6%	15.4%	2.1%	8.7%
MRI	896.3	825.0	71.3	8.0%	12.6%	2.7%	10.4%
NMGH	565.9	503.5	62.3	11.0%	13.8%	2.6%	9.9%
SPEC – REH	69.0	59.8	9.2	13.3%	14.4%	1.7%	9.3%
SPEC – RMCH	338.5	296.6	41.9	12.4%	16.2%	1.7%	6.5%
SPEC – SMH	114.8	94.8	20.0	17.4%	5.3%	1.0%	7.7%
WTWA	1053.6	945.6	108.0	10.3%	13.5%	2.2%	10.3%

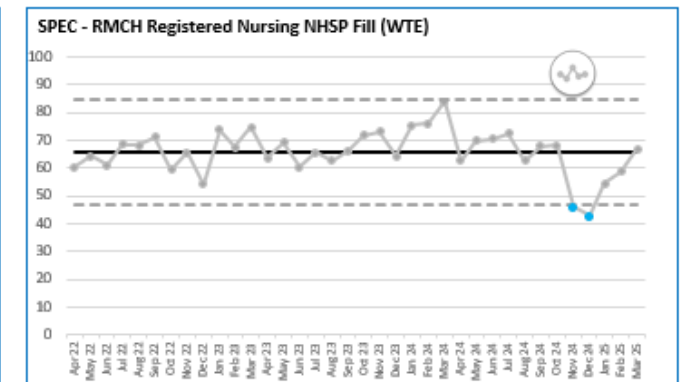
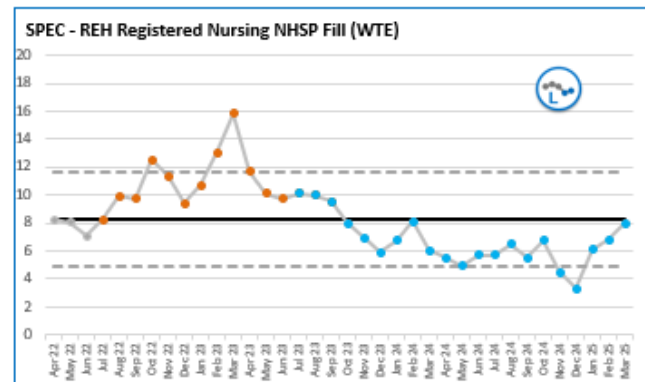
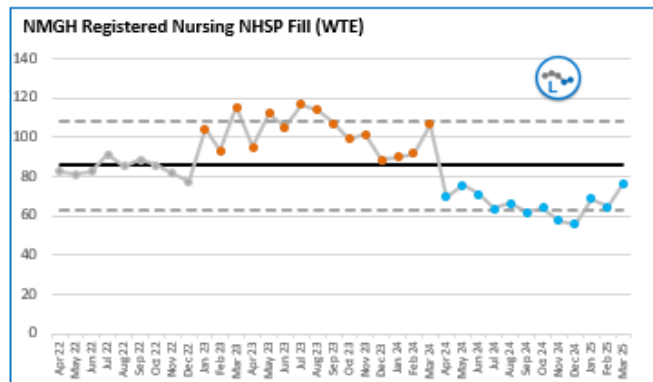
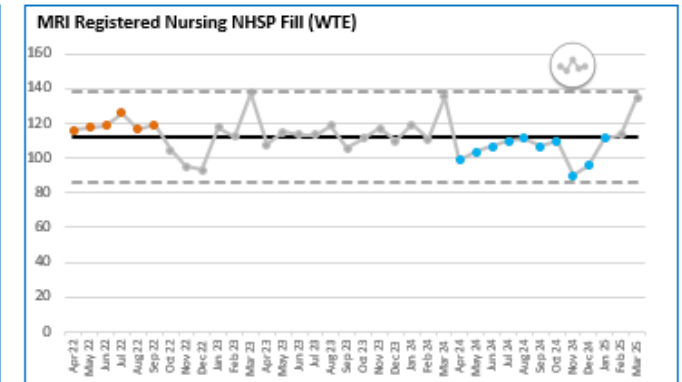
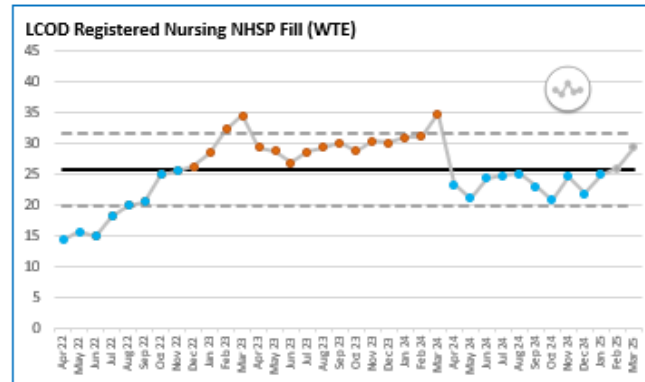
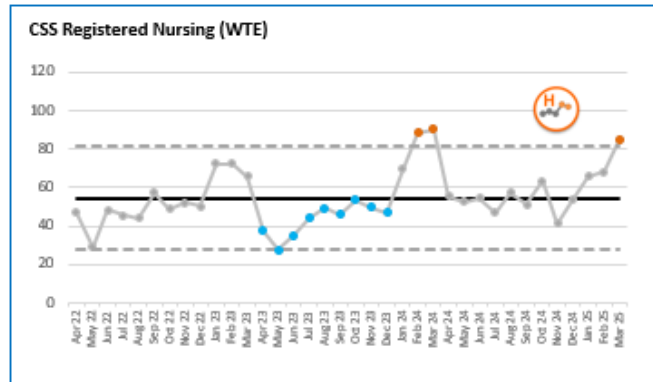
Appendix B

NHSP Fill Overview – Nursing

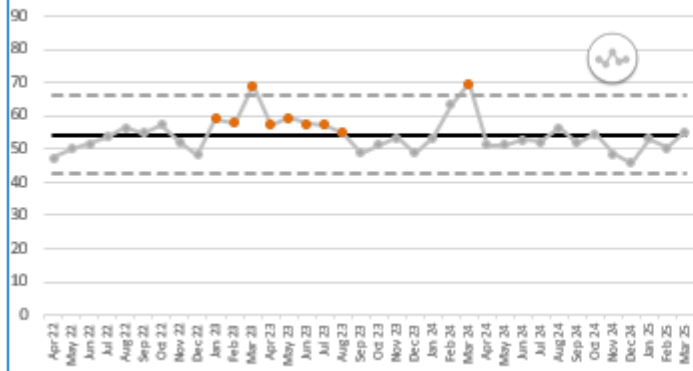


Appendix C

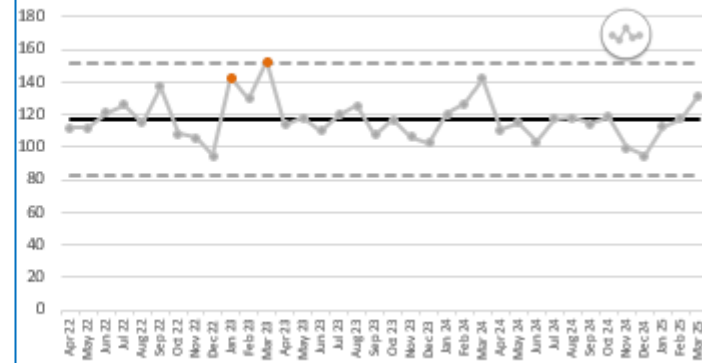
NHSP registered nursing fill rate by clinical group



SPEC - SMH Nursing Registered NHSP Fill (WTE)

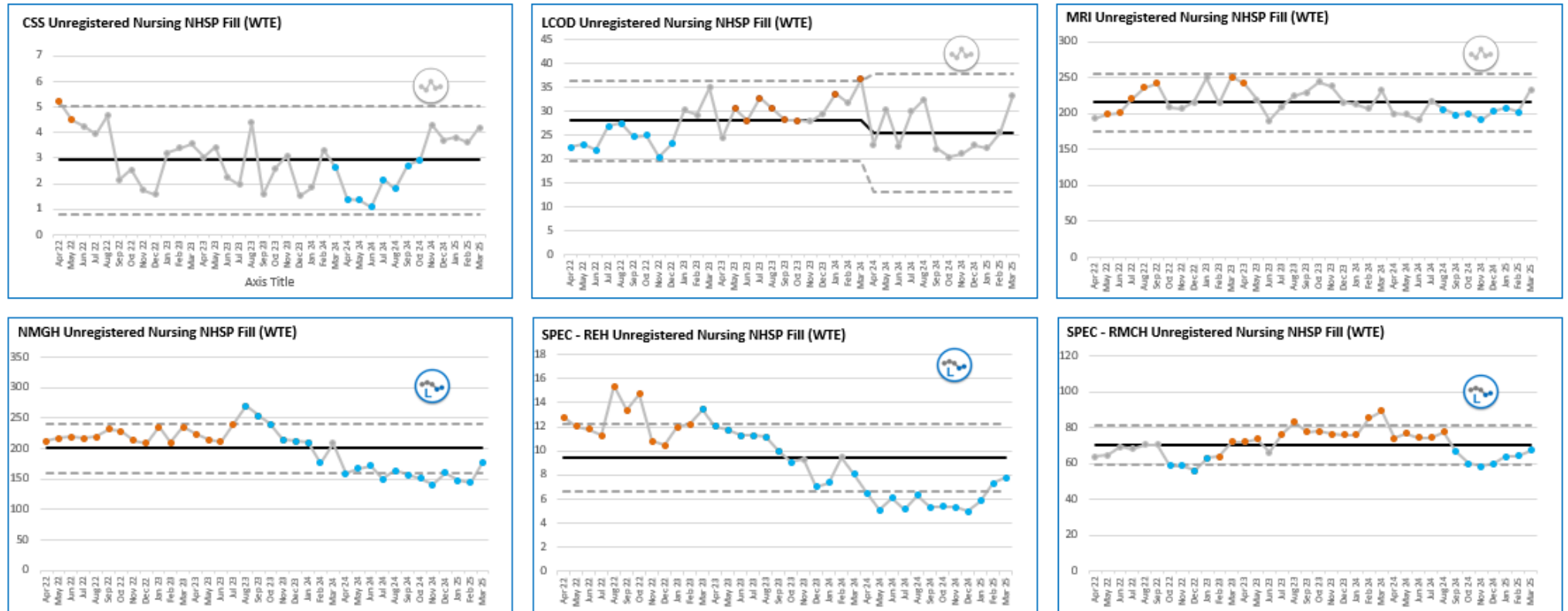


WTWA Registered Nursing NHSP Fill (WTE)

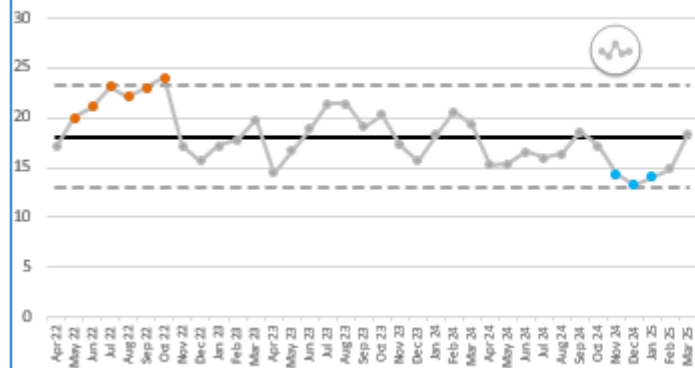


Appendix D

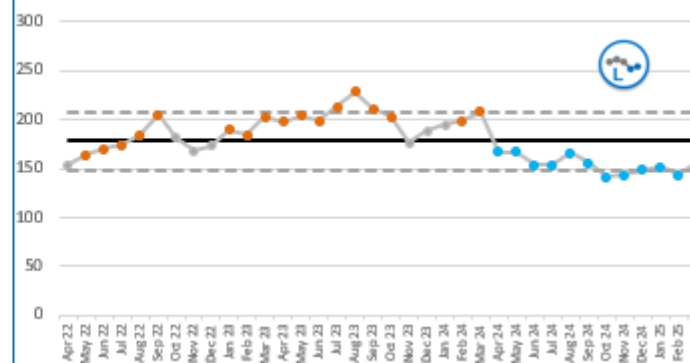
NHSP unregistered nursing fill rate by clinical group



SPEC - SMH Nursing Unregistered NHSP Fill (WTE)



WTWA Unregistered Nursing NHSP Fill (WTE)



Appendix – E

Proposed changes to establishment (MRI)

Division/CSU	Ward/Department	Current Funded Establishment			SNCT Recommended Establishment (Jan 24)	Variance (Jan 24)		SNCT Recommended Establishment (Jul 24)	Variance (Jul 24)		SNCT Recommended Establishment (Feb 25)	Variance (Feb 25)		Comments
		Total WTE	Skill Mix % Reg	Skill Mix % Unreg	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	
Cardio-Vascular	ACC	43.04	76%	24%	36.60	6.44	15%	37.91	5.13	12%	28.36	14.68	34%	Increased acuity requiring 2 patient to 1 RN ratio ,
Cardio-Vascular	Manchester Vascular Ward	76.44	55%	45%	84.00	-5.56	-7%	49.20	27.24	36%	50.03	26.41	35%	No change recommended
Cardio-Vascular	EVC							41.09	35.35	46%	38.57	37.87	50%	No change recommended
Cardio-Vascular	Ward 3	44.70	61%	39%	37.16	4.99	12%	44.23	0.47	1%	43.44	1.27	3%	No change recommended
Cardio-Vascular	Ward 4	29.45	60%	40%	35.97	10.73	23%	46.54	-17.09	-58%	37.41	-7.96	-27%	No change recommended
Emergency Assessment & Access	AM3	48.78	63%	37%	41.67	0.11	0%	45.22	3.56	7%	44.88	3.90	8%	No change recommended
Emergency Assessment & Access	AM4	48.03	49%	51%	51.86	-4.83	-10%	39.36	8.67	18%	41.01	7.02	15%	No change recommended
Emergency Assessment & Access	AMU - MRI (Ward 18&19)	84.28	57%	43%	109.02	-24.74	-29%	108.54	-24.26	-29%	91.88	-7.60	-9%	No change recommended
Emergency Assessment & Access	Ward 6	38.77	57%	43%	79.94	-41.21	-106%	81.16	-42.39	-109%	66.43	-27.66	-71%	Ward configuration and patient cohort has changed between census periods, continues to review and monitor staffing requirements
In Patient Medical Specialties	Ward 5	38.60	53%	47%	37.22	2.38	6%	60.29	-21.69	-56%	50.14	-11.54	-30%	No change recommended
In Patient Medical Specialties	Ward 10	31.99	66%	34%	41.56	-12.87	-45%	47.04	-15.05	-47%	30.22	1.77	6%	No change recommended
In Patient Medical Specialties	Ward 9	42.50	55%	45%	51.90	-9.40	-22%	62.68	-20.18	-47%	55.16	-12.66	-30%	Increased acuity of MH patients, ward is currently part of Care Closer to Home programme with potential to reduce complexity of patients.

GI Medicine & Surgery	Ward 11	43.92	49%	51%	32.35	14.57	31%	35.26	8.66	20%	34.08	9.84	22%	Review staffing in conjunction with ward 12
GI Medicine & Surgery	Ward 12	38.10	54%	46%	40.91	-0.51	-1%	40.05	-1.65	-4%	40.52	-2.42	-6%	As above
GI Medicine & Surgery	Ward 46 Gastro	43.70	50%	50%	42.34	3.36	7%	37.28	6.42	15%	38.88	4.83	11%	No change recommended
Theatres & Elective in Reach	ETC Sal & DC	30.22	59%	41%	30.69	0.92	3%	30.69	-0.47	-2%	33.50	-3.28	-11%	No change recommended
Head & Neck	ETC Surgery	47.36	57%	43%	44.52	5.85	12%	37.82	9.54	20%	30.69	16.67	35%	Increased acuity requiring 2 patient to 1 RN ratio ,
In Patient Medical Specialties	AM1	40.91	54%	46%	52.45	-10.54	-25%	44.98	-4.07	-10%	55.62	-14.71	-36%	Review workforce demands and configuration for respiratory wards
In Patient Medical Specialties	AM2	39.92	50%	50%	49.02	-6.10	-14%	47.77	-7.85	-20%	48.00	-8.08	-20%	Review workforce demands and configuration for respiratory wards
In Patient Medical Specialties	Ward 1	41.56	53%	47%	47.60	-4.50	-10%	47.52	-5.96	-14%	46.00	-4.44	-11%	Increased acuity of MH patients, ward is currently part of Care Closer to Home programme with potential to reduce complexity of patients.
In Patient Medical Specialties	Ward 2	41.56	53%	47%	42.08	0.48	1%	53.34	-11.78	-28%	55.76	-14.20	-34%	No change recommended
In Patient Medical Specialties	SAU	67.43	53%	47%	46.94	9.71	17%	42.92	24.52	36%	39.85	27.58	41%	SNCT tool does not capture the requirement for supernumerary shift coordinator role in assessment areas
In Patient Medical Specialties	Ward 30	35.73	45%	55%	35.25	1.49	4%	40.57	-4.84	-14%	24.04	11.69	33%	No change
In Patient Medical Specialties	Ward 31	39.10	49%	51%	53.29	-14.19	-36%	48.77	-9.67	-25%	59.87	-20.77	-53%	The SNCT tool does not capture the MDT workforce contribution which mitigates the SCNT recommended nursing establishment.
In Patient Medical Specialties	Ward 32	36.73	47%	53%	37.21	0.52	1%	45.90	-9.17	-25%	46.24	-9.51	-26%	No change recommended
In Patient Medical Specialties	Ward 44	84.62	77%	23%	69.07	15.55	18%	80.59	4.03	5%	78.60	6.02	7%	No change recommended
In Patient Medical Specialties	Ward 45	38.09	60%	40%	45.03	-5.30	-13%	41.04	-14.11	-52%	35.71	2.38	6%	No change recommended
Urology, Renal & Transplant	Ward 36 Transplant	30.17	58%	42%	25.35	2.58	9%	41.23	-3.50	-9%	37.68	-7.51	-25%	Review workforce demands and configuration for renal wards
Urology, Renal & Transplant	Ward 37	30.35	58%	42%	52.91	-15.80	-43%	53.55	-18.44	-53%	34.69	-4.34	-14%	Review workforce demands and configuration for renal wards

Appendix – F

Proposed changes to establishment (NMGH)

Hospital	Division/CSU	Ward/Department	Current Funded Establishment			SNCT Recommended Establishment (Jan 24)	Variance (Jan 24)		SNCT Recommended Establishment (Jul 24)	Variance (Jul 24)		SNCT Recommended Establishment (Feb 25)	Variance (Feb 25)		Comments
			Total WTE	Skill Mix % Registered	Skill Mix % Unregistered	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	
NMGH	Division of Integrated Medicine	CCU	19.19	70%	30%	18.39	1.44	7%	17.77	1.42	7%	19.69	-0.50	-3%	
NMGH	Division of Integrated Medicine	E1	53.05	35%	65%	52.47	-5.96	-13%	54.39	-7.88	-17%	57.29	-4.24	-8%	
NMGH	Division of Integrated Medicine	E3	53.05	35%	65%	41.71	4.81	10%	58.58	-12.07	-26%	47.51	5.54	10%	use of escalation beds
NMGH	Division of Integrated Medicine	F1	41.13	36%	64%	31.57	5.43	15%	31.45	5.55	15%	23.61	17.52	43%	this ward is also now a gastroenterology ward
NMGH	Division of Integrated Medicine	F4	39.41	34%	66%	27.13	8.15	23%	22.15	13.13	37%	27.12	12.29	31%	Establishment felt to be appropriate increase in unregistered establishment in 2025 supporting ETOC
NMGH	Division of Integrated Medicine	Frailty Unit	37.13	42%	58%	33.75	3.38	9%	37.42	-0.29	-1%	33.67	3.46	9%	
NMGH	Division of Integrated Medicine	H4	39.86	51%	49%	48.34	-8.48	-21%	46.94	-7.08	-18%	56.99	-17.13	-43%	Further review as had only had 1 census in current form.
NMGH	Division of Integrated Medicine	I6	39.76	51%	49%	48.99	-8.23	-20%	43.51	-3.75	-9%	36.43	3.33	8%	
NMGH	Division of Integrated Medicine	J3/J4	56.54	52%	48%	50.77	5.77	10%	42.19	14.35	25%	51.64	4.90	9%	
NMGH	Division of Integrated Medicine	C3	35.28	38%	62%	27.49	7.79	22%	31.01	4.27	12%	27.99	7.29	21%	
NMGH	Division of Integrated Medicine	C4	35.28	38%	62%	41.35	-6.07	-17%	24.51	10.78	31%	41.20	-5.92	-17%	Review of establishment as is now working as a Gastroenterology ward as of Jan 25 - increase in acuity.
NMGH	Urgent Care & Patient Flow	H3/J6	106.49	52%	48%	120.65	-10.47	-10%	123.72	-17.23	-16%	107.18	-0.69	-1%	
NMGH	Division of Surgery	C5	24.36	55%	45%	13.96	10.40	43%	13.86	10.50	43%	15.32	9.04	37%	Day case unit need to have 2 RN's at all time
NMGH	Division of Surgery	C6	24.36	55%	45%	13.87	10.49	43%	11.88	12.48	51%	12.88	11.48	47%	Day case unit need to have 2 RN's at all time
NMGH	Division of Surgery	D5	34.35	51%	49%	23.23	11.13	32%	18.16	16.19	47%	22.32	12.03	35%	
NMGH	Division of Surgery	D6	34.76	51%	49%	21.92	12.84	37%	22.83	12.93	36%	22.96	11.80	34%	
NMGH	Division of Surgery	E2	31.34	54%	46%	29.21	3.13	10%	30.07	1.27	4%	32.09	-0.75	-2%	
NMGH	Division of Surgery	F2 STU	40.52	58%	42%	22.60	17.92	44%	20.51	20.01	49%	24.01	16.51	41%	Receiving unit and management of a Surgical hot clinic/ Surgical SDEC.
NMGH	Division of Surgery	F3	35.58	53%	47%	34.40	1.18	3%	29.56	6.02	17%	21.17	14.41	40%	Increase in ETOC - medical outliers
NMGH	Division of Surgery	F6	34.29	51%	49%	33.06	1.23	4%	33.15	1.14	3%	29.22	5.07	15%	
NMGH	Division of Surgery	I5	48.09	50%	50%	49.09	0.00	0%	51.88	-2.79	-6%	48.25	-0.16	0%	

Appendix – G

Proposed changes to establishment (RMCH & SMH)

Division/CSU	Ward/Department	Current Funded Establishment			SNCT Recomm ended Establish ment (Jan 24)	Variance (Jan 24)		SNCT Recomm ended Establish ment (Jul 24)	Variance (Jul 24)		SNCT Recomm ended Establish ment (Feb 25)	Variance (Feb 25)		Comments
		Total WTE	Skill Mix % Reg	Skill Mix % Unreg	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	
Children's Surgery and Theatre	Ward 76	23.19	72%	28%	32.42	-9.23	-40%	32.69	-9.50	-41%	33.45	-10.26	-44%	Increased acuity, Establishment review using Professional Judgment Framework
Children's Surgery and Theatre	Ward 77	63.29	73%	27%	66.03	-2.74	-4%	65.86	-2.57	-4%	67.09	-3.80	-6%	No establishment change
Children's Surgery and Theatre	Ward 78	58.59	71%	29%	72.02	-13.43	-23%	69.85	-11.26	-19%	72.51	-13.92	-24%	Increased acuity, high requirements for arm's length observation, Establishment review using Professional Judgment Framework
Children's Medicine Unit	Ward 84 Inpatient s	60.60	64%	36%	60.75	-0.15	0%	61.57	-0.97	-2%	54.79	5.81	10%	No establishment change
Children's Medicine Unit	Ward 85	52.14	78%	22%	61.54	-9.40	-18%	60.29	-8.15	-16%	61.50	-9.36	-18%	Increased acuity , increased patients on ventilatory support, Establishment review using Professional Judgement Framework
Children's Medicine Unit	Ward 86	54.51	81%	19%	65.69	-11.18	-21%	55.05	-0.54	-1%	55.89	-1.38	-3%	No establishment change
Children's MCS	F8 Children's ward	32.90	69%	31%	32.24	0.66	2%	33.80	-0.90	-3%	32.69	0.21	1%	No establishment change
Paediatrics NMGH	NMGH inpatient ward	31.90	79%	21%	42.08	-10.18	-32%	42.52	-10.62	-33%	41.75	-9.85	-31%	Increased acuity in patients with mental illness, Establishment review using Professional Judgement Framework
SMH Gynae	F16	27.96	65%	34%	18.05	11.95	40%	16.07	13.89	46%	14.87	13.09	47%	Over established, implement reduction in establishment as per turnover

Appendix – H

Proposed changes to establishment (WTWA)

Division	Ward	Jan 25 Current Funded Establishment			SNCT Recommended Establishment (Jan 24)	Variance (Jan 24)		SNCT Recommended Establishment (Jul 24)	Variance (Jul 24)		SNCT Recommended Establishment (Jan 25)	Variance (Jan 25)		Professional Judgement	Comments
		Total WTE	RN est	unreg est	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff	Total WTE	WTE diff	% diff		
Respiratory	A1	54.38	31.45	22.93	91.07 (incl A3)	-3.78	-4%	53.44	0.94	2%	47.29	7.09	13%	No establishment change recommended	Level 2 patients reduced from 370 in July to 290 in Jan. Need further census to identify if there is an over-establishment since change to patient acuity following the A3 move
Medicine	A2	36.71	18.08	18.63	39.10	-2.39	-7%	42.54	-5.83	-16%	38.93	-2.22	-6%	No establishment change recommended	High number of MH ETOC patients in Jul 24- this is variable
Respiratory	A3	42.93	19.89	23.04							43.96	-1.03	-2%	No establishment change recommended	New silver trauma ward established July 2024, no previous SNCT data
Surgery & Theatres	A4	40.20	22.00	18.20	43.51	-3.31	-8%	43.10	-5.50	-15%	38.74	1.46	4%	No establishment change recommended	Ward speciality has changed over the last 12 months due to pressure on medical beds and reconfiguration within the Division. Now specialises in general surgery (elective/ emergency) and establishment is appropriate for this patient group.
T& O, B&P	A5	47.80	19.68	28.12	62.87	-13.31	-27%	59.02	-13.93	-31%	53.45	-5.65	-12%	No establishment change recommended	High ETOC requirements across 3 data sets but ongoing work to manage and reduce this
Surgery & Theatres	A6	46.00	27.80	18.20	50.70	-4.70	-10%	50.34	-9.54	-23%	45.46	0.54	1%	No establishment change recommended	Average of 8 admissions/ day. For reference, recommendation of 33.3wte based on ward multipliers
Medicine	A7	37.87	17.98	19.89	38.52	-0.80	-2%	46.97	-9.10	-24%	47.65	-9.78	-26%	No establishment change recommended	High number of ETOC patients in Jul 24 and Jan 25- this is variable
Medicine	A9 / OAU	57.37	30.78	26.59	55.57	0.80	1%	56.46	-5.56	-11%	55.49	1.88	3%	No establishment change recommended	Average of 5 admissions/ day. For reference, recommendation of 44.8wte based on ward multipliers
Emergency Care Village	AMU	92.61	53.65	38.96	98.25	-5.64	-6%	111.53	-19.92	-22%	104.33	-11.72	-13%	No establishment change recommended	Average of 29 admissions/ day. For reference, recommendation of 82.76wte based on ward multipliers
Medicine	Doyle	32.07	13.81	18.26	38.81	-6.74	-21%	33.58	-1.51	-5%	37.11	-5.04	-16%	No establishment change recommended	High number of ETOC patients in Jul 24 and Jan 25- 1 NA within the establishment to cover ETOC across both Doyle and Wilson. Proposal to increase Wilson establishment to allow for 1 additional NA on each ward 24/7
Medicine	ELM Unit	48.99	21.89	27.10	56.19	-7.53	-15%	60.50	-11.51	-23%	52.45	-3.46	-7%	No establishment change recommended	
Medicine	F12	38.54	17.37	21.17	41.69	-3.15	-8%	64.69	-26.15	-68%	46.34	-7.80	-20%	No establishment change recommended	High number of ETOC patients in Jul 24 and Jan 25- this is variable and managed well across the ward and work is ongoing to reduce ETOC requirements
Medicine	F14	38.65	17.15	21.50	49.85	-11.71	-31%	51.77	-13.12	-34%	47.50	-8.85	-23%	No establishment change recommended	High number of ETOC patients however this is managed well across the ward and work is ongoing to reduce ETOC requirements
Medicine	F15	39.25	20.24	19.01	42.49	-7.20	-20%	44.25	-5.00	-13%	35.39	3.86	10%	Potential over-establishment	Similar staffing model to f12 and F14 despite 6 less beds. May have some scope to reduce establishment to support increase on Wilson
Cardiac	F2N	28.11	19.64	8.47				17.81	10.30	37%	18.89	9.22	33%	No establishment change recommended	Budget split in May 2024 allowing for separate SNCT recommendations from F5. High acuity which is not always reflected in SNCT

Respiratory	F3 Lung Surgery	41.74	29.64	12.10	24.49	-2.29	-10%	19.56	2.88	13%	39.80	1.94	5%	No establishment change recommended	Ward increased from 16 to 32 beds in July 2024 and establishment updated at this point
T& O, B&P	F4	23.20	13.04	10.16							22.94	0.26	1%	No establishment change recommended	A3 (28 beds) moved to F4 (16 beds) in July 2024 and establishment updated at this point
Cardiac	F5	51.50	35.20	16.30	41.30	33.27	45%	43.05	8.45	16%	37.38	14.12	27%	Potential over-establishment	Establishment review in progress to reduce establishment to support increase required on Jim Quick
Cardiac	F6	46.17	31.73	14.44	46.87	-0.51	-1%	42.44	3.73	8%	38.56	7.62	16%	No establishment change recommended	High acuity which is not always reflected in SNCT
Surgery & Theatres	F7	50.88	30.55	20.33				35.61	8.81	20%	37.39	13.49	27%	No establishment change recommended	Establishment based on 1:4 nursing for 4 altered airways and 1:4 nursing for DIEP/Flap for 4 patients. This is not captured within SNCT
Cardiac	Jim Quick Ward	21.55	17.70	3.85	26.88	-5.33	-25%	28.45	-6.90	-32%	32.56	-11.01	-51%	Under- established	due to high acuity of patients (50% level 2)
Respiratory	NWVU	35.98	23.11	12.87	32.14	4.43	12%	32.57	4.00	11%	34.06	1.92	5%	No establishment change recommended	Patients LT Trach- ventilated- require 1:1 RN care particularly when nursed in isolation- not always reflected in SNCT
Medicine	Opal House	55.49	22.00	33.49	49.34	7.15	13%	70.89	-15.40	-28%	61.35	-5.86	-11%	No establishment change recommended	increase in 1b patients during this census. Single room multipliers used, however during the day most patients are cared for in a communal day room therefore reducing the staffing requirements
Respiratory	Pearce	28.92	18.76	10.16	28.36	0.56	2%	32.93	-4.01	-14%	32.57	-3.65	-13%	No establishment change recommended	increase in acuity over the last 2 census collections. Single room multipliers but acknowledged that most patients are young, self-caring and have family present most of the time- may consider moving establishment from A1 after next census
Respiratory	POU	23.31	13.14	10.17	23.34	3.11	12%	22.05	3.69	14%	23.13	0.18	1%	No establishment change recommended	
Medicine	Ward 11	49.81	25.64	24.17	53.46	-2.85	-6%	48.76	-1.75	-4%	48.61	1.20	2%	No establishment change recommended	
Medicine	Ward 2 OAK	67.08	29.01	38.07	61.29	-16.97	-38%	66.24	1.84	3%	74.00	-6.92	-10%	No establishment change recommended	
Medicine	Ward 3	78.69	30.77	47.92	69.45	10.77	13%	72.51	6.18	8%	60.87	17.82	23%	No establishment change recommended	Note that 5 beds closed since the fire at TGH- Est correct for fully opened beds
Medicine	Wilson	31.40	15.45	15.95	43.74	-12.34	-39%	37.73	-6.33	-20%	37.99	-6.59	-21%	Under- established	mostly due to ETOC requirements and this is consistent across 3 data sets. 1 x NA to support ETOC within Doyle budget to work across Doyle and Wilson. Additional NA required so each ward has 1 per shift

Public Board of Directors Wednesday 30th July 2025

Paper title:	Saint Mary’s Managed Clinical Services (SM MCS) Midwifery and Newborn Services bi-monthly Safe Staffing Reporting period March 2025	Agenda Item 12.3
Presented by:	Kimberley Salmon-Jamieson, Interim Deputy Chief Executive & Chief Nursing Officer	
Prepared by:	Kathy Murphy Director of Nursing and Midwifery, Specialist Hospitals Clinical Group (SHCG)	
Meetings where content has been discussed previously	Peoples Board (July 2025) Workforce and Education Committee (June 2025) Specialist Hospital Clinical Group (SHCG) Management Board SHCG Workforce and Education Committee 20 th May 2025	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

The Maternity and Newborn Services Divisions bi-monthly safe staffing report provides assurance that the Trust remains compliant with the national guidance in relation to safer staffing.

Safer Staffing report covers March - April 2025 regarding:

- National professional staffing standards
- National nursing and midwifery challenges
- Maternity Incentive Scheme (MIS) Safety Action requirements¹

Maternity Services are compliant with the nationally recommended establishments in accordance with Birthrate Plus (BR+) calculations² and in line with MIS Year 7¹ requirement to repeat this establishment review 3 yearly, have planned a further BR+ exercise for 2025. BR+ safe staffing toolkit has been endorsed by the Royal College of Midwives (RCM) as the recommended midwifery workforce planning tool to support review of midwifery staffing levels against NICE Guideline Safe Staffing for maternity setting (NG4, 27/02/2015)³

Up to 31st March 2025, there has been a sustained reduction in overall Red Flag midwifery staffing incidents.

Turnover continues to reduce within maternity services with a slight rise on 0.44 WTE in Newborn Services. Newborn Services had hoped to be at full establishment by March 2025, however, there has been a 19% withdrawal rate from candidate's pipeline. Newborn Services have proactively recruited into vacant post, replacing the withdrawals.

¹ [MIS-Year-7-guidance.pdf](#)

² <https://birthrateplus.co.uk/workforce/>

³ <https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637>

As informed previously, Qualified in Specialty (QIS) compliance within the newborn service division remains non-compliant and remains risk score 12. To improve compliance Newborn services division support up to 40 nurses to attend QIS course annually.

SM MCS midwifery students qualifying in autumn 2025 are being offered guaranteed job interviews. The interviews are planned for June and July 2025. It is noted that there may be more students than available band 5 midwifery positions; as a result, if this occurs, all successful candidates may be offered substantive contracts at less than whole time equivalent (WTE).

Recommendation(s)

The Board of Directors is asked to:

- Accept the report and note the progress undertaken to support midwifery staffing in the Division of Maternity Services and nurse staffing in the Division of Newborn Services
- Note SM MCS maternity division remains compliant with the national guidance in relation to safer staffing
- Note the sustained reduction in midwifery red flag incidents reported
- Note the risk related to Qualified in Specialty (QIS) and support the recommendation to continue to support 40 nurses per year access QIS training.

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:
The work contained with this report links to the following strategic, corporate or operational risks:

- MFT/005896: Midwifery staffing Risk score 10
- MFT/004452: Insufficient neonatal nursing workforce qualified in specialty to meet national service specification. Risk score 12

Care Quality Commission domains Please check <u>all</u> 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: • Maternity Incentive Scheme Year 7¹ • NHS England 3 Year Delivery Plan for Maternity and Neonatal services⁴ • CQC	

Main report

1. Background

- 1.1. This report will detail the reporting period March to April 2025, to report the position of Saint Mary's Managed Clinical Services (SM MCS) Maternity and Newborn Services (NBS) Divisions, in relation to:
 - National professional staffing standards
 - National nursing and midwifery challenges.
 - Maternity Incentive Scheme (MIS) Safety Action requirements
- 1.2. The paper sets out the midwifery and nursing staffing position of the SM MCS maternity and newborn services divisions and provides:
 - Nationally Recommended Establishments
 - Current Midwifery Establishment.
 - Current Nursing Establishment in line with British Association of Perinatal Medicine (BAPM) nurse staffing standards.
 - Evidence of supernumerary midwifery workforce compliance with oversight of birth activity within the service and the escalation process
 - Evidence of compliance the service requirement to support 1:1 care in labour.
 - Evidence of compliance to Qualification in Speciality (QIS) in line with the national BAPM standard of 70%.
 - Health Roster benchmarking against KPI standards
- 1.3. Further to the March 2023 Care Quality Commission (CQC) inspection of maternity services safe staffing remains a focused workstream. Progress on the workstream continues to be managed through the division and reported through the approved Governance framework.
- 1.4. SM MCS continues to attract and recruit staff across all three sites, recruiting nurses and midwives both newly qualified and experienced. June to October historically demonstrate the highest number of vacancies in the calendar year as newly qualified midwives and nurses graduate in September and take up their first posts throughout September to January.

2. Nursing and Midwifery workforce productivity

- 2.1. As reported in the Nursing Safer Staffing Paper In the last two months finance accelerator schemes have been maintained and monitored by the NMAHP Corporate

⁴ [NHS England » Three year delivery plan for maternity and neonatal services](#)

Workforce team in collaboration with the NMAHP Workforce leads for each Clinical Group and have been supported by a designated Clinical Group Director of Finance to ensure the financial impact is accurately reported.

The schemes are as follows:

- Confirm roster and establishment alignment.
- Reduce access to and use of premium overtime and agency.
- Establish the optimal supernumerary period considering professional and regulatory standards / guidelines. Standardise across MFT where appropriate.
- Establish bank payment mechanisms, e.g. pay to shift rather than pay to grade.
- Establish plan for the removal of overtime.

2.2. Since January 2025, the NMAHP Corporate Workforce team have continued to focus on the workforce planning improvement programme, with the current priorities as:

- Increase roster approval lead time
- Quarterly roster template alignment to ledger establishments review completed Jan/Feb 2025 with HoMs and NMAHP Workforce Programme Lead
- SafeCare System update and training refresh completed in Feb 2025

2.3. The roster KPI's are monitored by the CNO and reported per roster period, see Table 1 for the last two months reported KPI's specific to Maternity and NBS

Table 1 Roster KPI's for Maternity and NBS

Clinical Group	Annual Leave Registered		Annual Leave Unregistered		Roster Approval (weeks)	
	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr
Spec - SMH	15.9%	15.3%	17.1%	12.9%	6.5	6.4

Clinical Group	Additional Duties		Safecare Compliance		Sickness	
	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr
Spec - SMH	0.8%	1.1%			6.4%	6.4%

Clinical Group	Under Hours/ Hours Owed By Staff		Over Hours/Time Owing		NHSP Shifts	
	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr	17 Feb - 16 Mar	17 Mar - 13 Apr
Spec - SMH	4.8%	4.2%	5.3%	3.9%	95.8%	97.6%

2.4. The Chief Nursing Officer set a standard for all Clinical Groups to ensure all nursing rosters were set and approved at least 6 weeks in advance. This has a positive impact on staff experience and demonstrates effective management of rosters. Through proactive reporting and escalation of non-compliance, areas with non-compliance are reported to the Chief Nursing Officer and relevant Directors of Nursing/Midwifery

2.5. All areas across Maternity and NBS met the required 6 week target throughout this reporting period.

3. Safer Staffing Standards and calculation of Establishments using recognised staffing models

3.1. NICE Guideline Safe Staffing for maternity setting (NG4, 27/02/2015)³ covers safe midwifery staffing in all maternity settings, including at home, the community, day assessment units, obstetric units, and midwifery led units. It aims to improve maternity care by advising on staffing levels and actions to take if there are insufficient midwives to meet the needs of women and babies in the service.

3.2. Maternity provider Trusts undertake a systematic process to calculate the midwifery staffing establishment using a NICE endorsed toolkit; Birthrate Plus (BR+) safe

staffing toolkit also endorsed by the Royal College of Midwives (RCM) as the recommended midwifery workforce planning tool to support review of midwifery staffing levels against NICE guideline NG4.

- 3.3. The use of BR+ every 3 years is also incorporated within NHS Resolution Maternity Incentive Scheme year 7¹ standards.
- 3.4. The NHS England Three-Year Delivery Plan for Maternity and Neonatal Services, March 2023⁴, outlines that Trusts will meet establishment set by staffing tools and achieve fill rates by March 2027. The most recent BR+ review was completed in May 2023, the recommendations from this review were implemented with support from SM SLT by April 2024.
- 3.5. The next review is due to take place in 2025 and is required to be commissioned by MFT at a cost of £21,600. This was supported by SM SLT in August 2024 and a date for completion has been agreed with the BR+ team to be October 2025.

Table 2 Current Funded Midwifery Establishment (WTE)

	ORC	Wythenshawe	North Manchester	Grand Total
Current Midwifery Establishment	376.09	226.87	189.11	792.07

- 3.6. BAPM recommend minimum standards for neonatal nurse staffing levels for each category of neonatal care. Neonatal Intensive Care: 1:1 nursing for all babies, Neonatal High Dependency Care: 2:1 nursing for all babies, Neonatal Special Care: 4:1 nursing for all babies. All intensive care and high dependency care should be provided by QIS staff, so where a unit has a high proportion of critical care activity, the percentage of QIS staff required is required to be above 70%. BAPM standards require all units to have a supernumerary shift coordinator to meet the care needs of the babies on the unit during each shift.

Table 3 Current Funded Neonatal Nursing Establishment (WTE)

Site	Current Establishment (WTE)
Oxford Road	247.17
Wythenshawe	48.28
North Manchester	40.59
Total	336.04

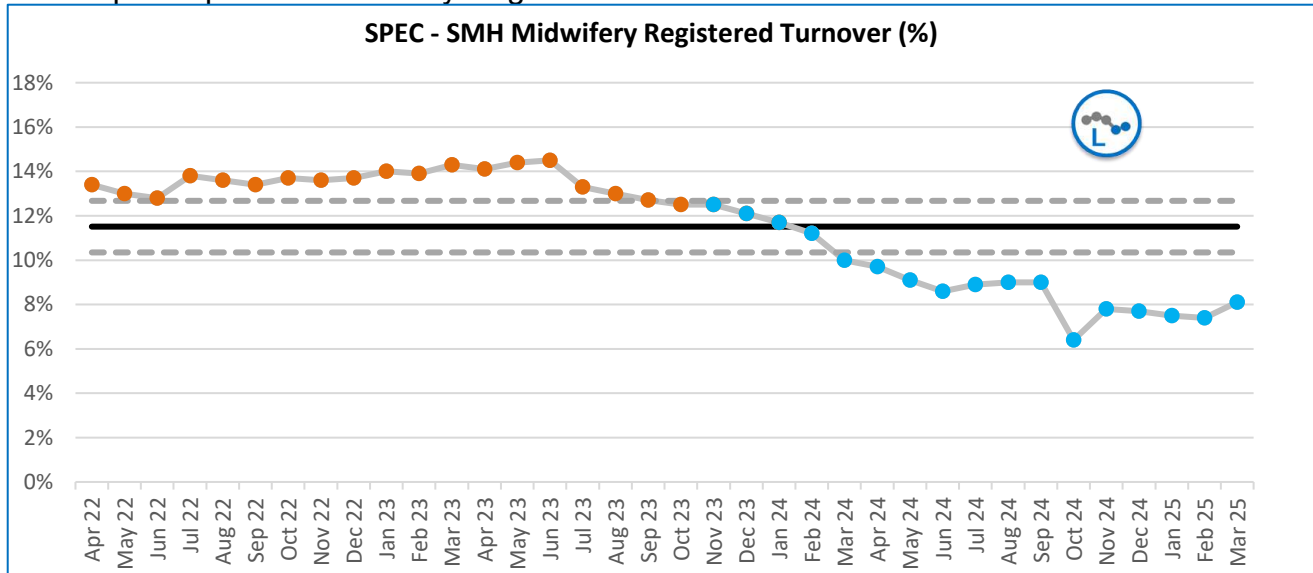
4. Recruitment and Retention March - April 2025

- 4.1. The turnover has continued to reduce for midwifery services, and slight increase in newborn services. Current SMH registered staffing turnovers reflected in Table 4 and trends demonstrated through SPC charts in Graphs 1 & 2.

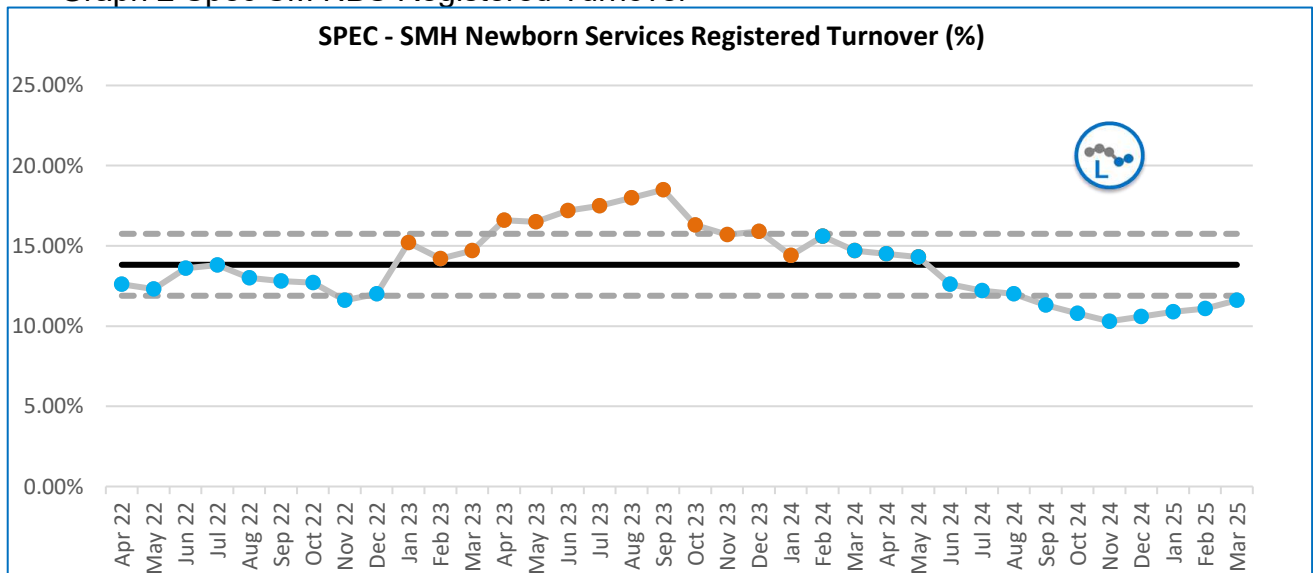
Table 4 Demonstrates SMH Spec Registered Staffing Turnover

		Maternity Services Turnover p/m	Newborn Services Turnover p/m
January 2025	-	6.0 WTE	2.88 WTE
February 2025			
March 2025	-	5.66 WTE	2.98 WTE
April 2025			
Variation		0.34 WTE reduction	0.10 WTE increase

Graph 1 Spec SM Midwifery Registered Turnover



Graph 2 Spec SM NBS Registered Turnover



- 4.2. Midwifery recruitment between September 2024 and Feb 2025 equated to 141.41 WTE midwives. 56.31 WTE were Manchester University NHS Foundation Trust Learners who were supported with guaranteed job offers (GJO). 73.98 WTE were external band 5 midwives. 11.12 WTE were band 6 recruits.
- 4.3. There are a further 4.6 WTE midwives who have commenced in post between March and April 2025.

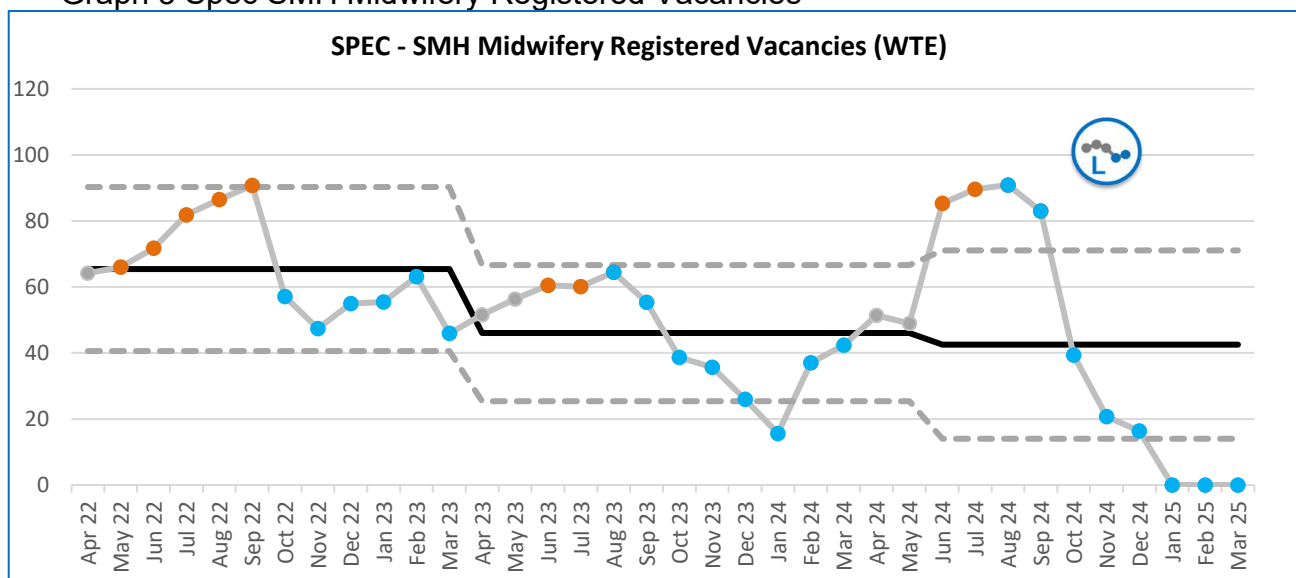
- 4.4. SM MCS midwifery students who are expected to qualify in autumn 2025 are being offered guaranteed job interviews. The interviews are planned for June and July 2025. It is noted that there may be more students than available band 5 midwifery positions; as a result, if this occurs, all successful candidates may be offered substantive contracts at less than WTE.
- 4.5. The division of Maternity is reporting a positive position in overall midwifery establishment for the first time in over 7 years, breakdown of the midwifery vacancy at close of Month 12 is demonstrated in Table 5

Table 5 Current Midwifery nursing vacancy

Site	Month 12 Vacancy (WTE)
Oxford road	+1.49
Wythenshawe	+6.33
North Manchester	3.44
TOTAL	+4.38

- 4.6. Current trend in midwifery vacancy demonstrated through SPC chart in Graph 3.

Graph 3 Spec SMH Midwifery Registered Vacancies



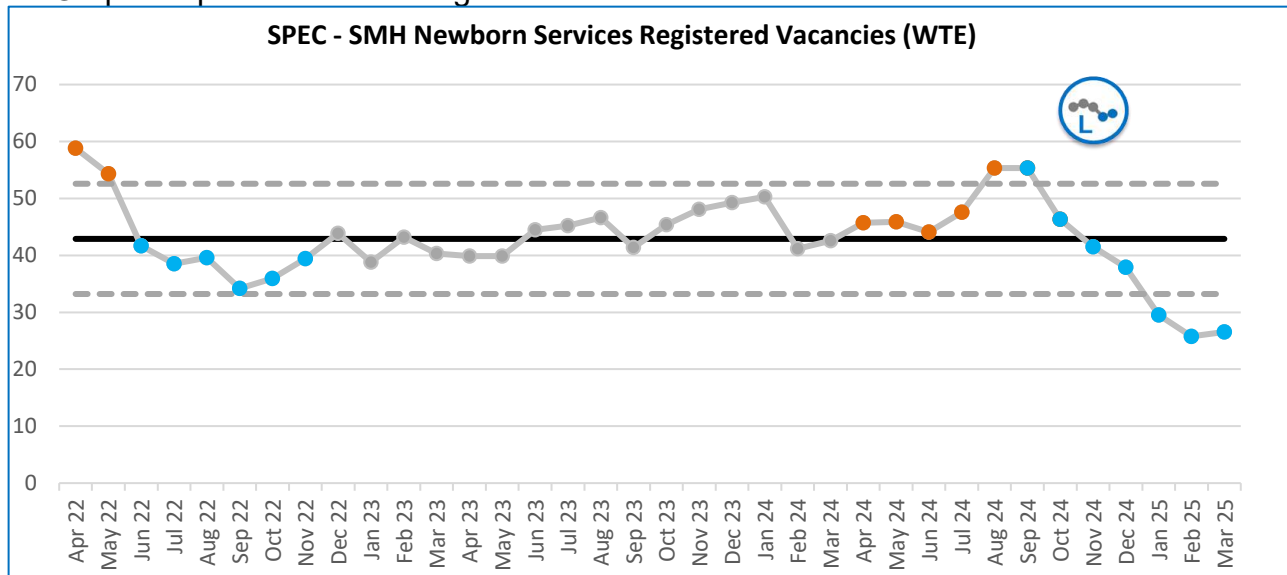
- 4.7. The neonatal nursing vacancy at the end of April 2025 is 22.31 WTE, there are 25 WTE Band 5 nurses in the pipeline recruited against this gap leaving a residual vacancy factor of 0 WTE across all bands of staff at the end of this reporting period. The Division are being supported to recruit to turnover into Band 5 post. 8 WTE of the Band 5 nurses in pipeline are not due to commence until August and September 2025. The Division is aiming to be fully recruited in all bands by September 2025 but will closely monitor band 5 pipeline dropout rate to ensure proactive recruitment to turnover.
- 4.8. Current Neonatal Nursing vacancies reflected in Table 6 and vacancy trend demonstrated through SPC chart in Graph 4.

Table 6 Current Neonatal nursing vacancies and pipeline

Site		Vacancies April 2025	Current Pipeline April

	Vacancies February 2025		2025 (Including turnover)
Oxford road	17.65	14.1	22
Wythenshawe	6.4	6.43	3
North Manchester	2.84	1.78	Band 6 posts at recruitment stage
TOTAL	26.89	22.31	25

Graph 4 Spec SMH NBS Registered Vacancies



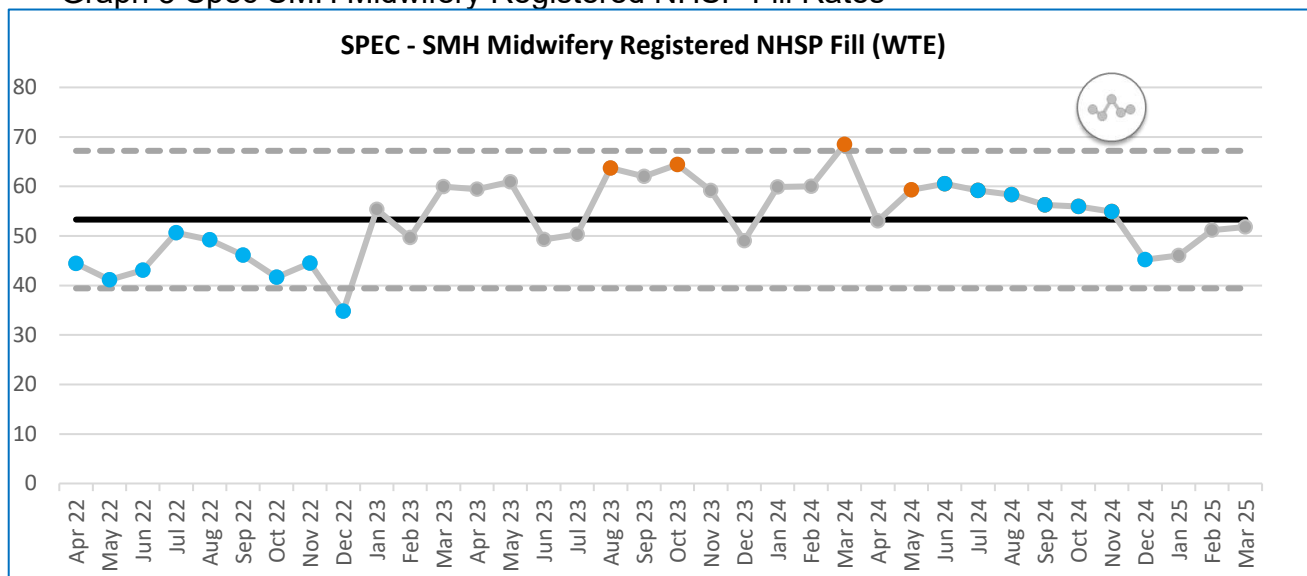
- 4.9. The midwifery retention team 'keep in touch' with all staff in the pipeline to maintain engagement through coffee mornings, email updates and virtual calls. Any candidates who withdraw, are contacted to better understand the reasons why.
- 4.10. SM Maternity Division are able to report a positive impact of recruiting to turnover reflected in:
- Reduced short term sickness
 - Reduced NHSP spend
 - Recruitment from internal Guaranteed Job Offer's (GJO's)
 - Increased ability to positively impact Maternity Triage and IOL pathways
- 4.11. A Workforce recruitment strategy for Sept 2026 have been developed to progress Guaranteed Job Interview's (GJI's) rather than GJO's.

5. Managing staffing shortfalls

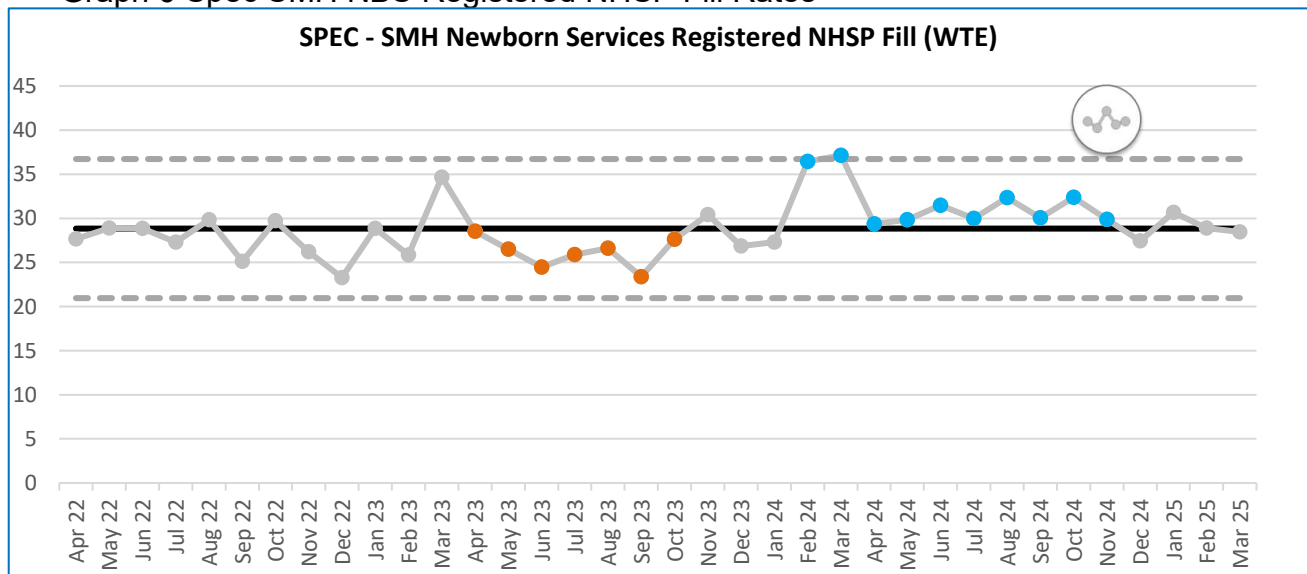
- 5.1. Temporary staffing is utilised to support staffing levels throughout the Trust. Weekly NHSP temporary staffing huddles continue to ensure maximisation of engagement between SM MCS and NHSP.
- 5.2. The Heads of Midwifery and Head of Nursing attend a monthly meeting with the NHSP Managers to review NHSP fill rates, incidents and workforce applications.

- 5.3. NHSP fill rates are monitored on a weekly basis by the Heads of Midwifery and Head of Nursing using the Ward Establishment Review Model (WERM Tool). Both Nursing and Midwifery are compliant with zero spend linked to premium overtime payments. Trends in NHSP fill rates demonstrated through SPC charts in Graphs 5 & 6, with further data available in Appendix 1 & 2.
- 5.4. As neonatal units provide an emergency driven service and admissions are not always planned, staffing requirements can vary from shift to shift and depart from those rostered, therefore NHSP is utilised to maintain safer staffing. Newborn Services only use NHSP to backfill shortfalls in staffing numbers, such as nursing vacancies and unexpected staff sickness and occasionally due to high patient acuity/workload increase to support improved skill mix. In Q4 the neonatal division completed a Quality Impact Assessment (QIA) and Risk Assessment in relation to the impact of removal of enhanced NHSP and in line with the organisational plan which was agreed at Trust Leadership Team Committee (TLTC) on 20th March 2025. In line with phase 2 of the enhanced rate reduction Newborn services will move to a staged reduction in rates from 12th May 2025.

Graph 5 Spec SMH Midwifery Registered NHSP Fill Rates



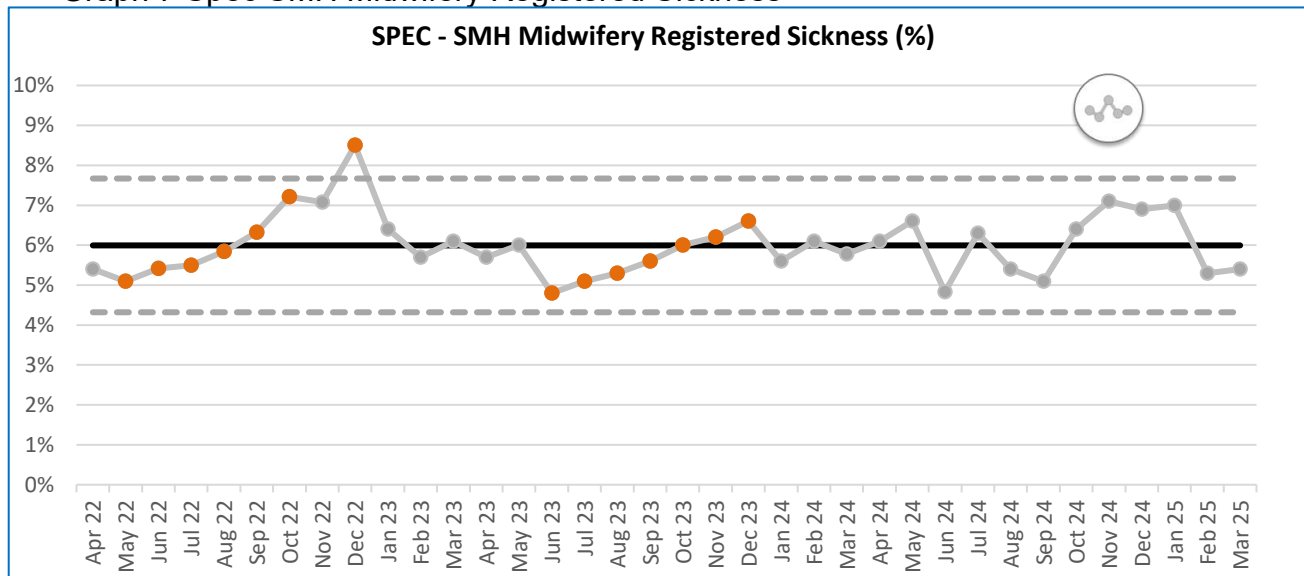
Graph 6 Spec SMH NBS Registered NHSP Fill Rates



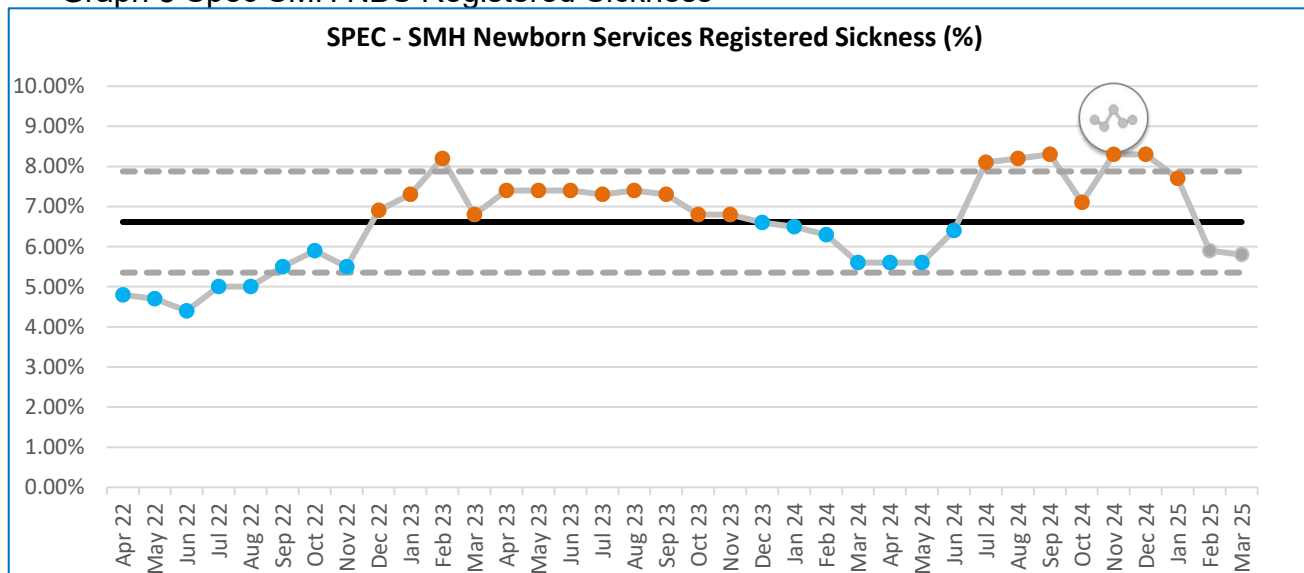
6. Sickness Absence

- 6.1. Short term absence continues to be the main driver for overall sickness across both Maternity and Newborn Services. Overall sickness remains static at 5.07% (maternity) and 7.12% (Newborn Services) over the reporting period, which remains over the Trust target of 3.6% and above the divisional trajectory of 5%. The main reasons for staff absence are anxiety/stress and cold/flu. Both divisions have fortnightly sickness meetings to review position and have in place action plans to address absence which is tracked at the twice weekly staffing meetings. Both divisions are monitored via the established workforce check and challenge process. Trends demonstrated through SPC charts in Graphs 7 & 8.

Graph 7 Spec SMH Midwifery Registered Sickness



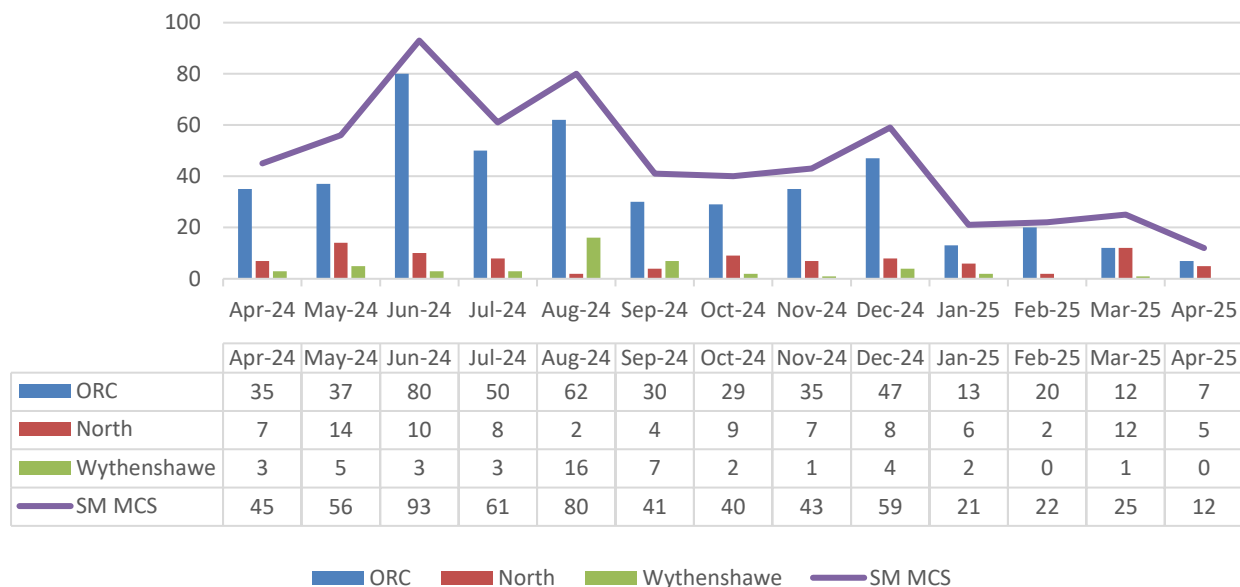
Graph 8 Spec SMH NBS Registered Sickness



7. Maternity 'Red Flags Events', Escalation and monitoring of staffing MIS Safety Action 5

- 7.1. NICE guidance NG4 Safe Staffing for Maternity Settings (2015) recommends that the maternity service has procedures in place for monitoring and responding to unexpected changes in midwifery staffing requirements, and report 'red flags' if there is a reduction in required staffing.
- 7.2. Red flag events are signs that there may not be enough midwives available and include:
- Activities that need to be done on time are delayed or cancelled.
 - After giving birth, a woman waits for 60 minutes or more before she is washed or given stitches, if she needs them.
 - A woman does not get the medicines she needs when she's been admitted to a hospital or a midwifery-led maternity unit.
 - A woman waits 30 minutes or more to get pain relief when she's been admitted to a hospital maternity unit or a midwifery-led maternity unit.
 - A woman who is in labour or who has a problem needing midwife care waits 30 minutes or more for assessment after the midwife has been alerted.
 - A woman is not given a full examination when she reports she is in labour.
 - There is a delay of 2 hours or more between coming in for an induction and the induction being started.
 - Delays in spotting and acting on signs that the woman may have a serious health problem.
- 7.3. On analysis of Red Flag incidents reported in March 2025 of the 25 reported across SM MCS:
- 11 related to delays in access to maternity theatre – on review all were due to 2 theatres being open and all women/babies remained clinically safe whilst waiting
 - 12 related clinical incidents – all related to clinical acuity, and not midwifery staffing
 - 2 related directly to midwifery staffing – both involved delay in commencing induction of labour for more than 2 hours (4 and 6 hour delays experienced and there was no negative impact on outcomes for either woman)
- 7.4. Throughout the first 3 months of 2025, there has been a sustained reduction in overall Red Flag incidents, when compared to previous months as shown in Graph 9. For comparison, the latest data for April 2025 has been provided to demonstrate a marked reduction when compared to April 2024.
- 7.5. There is clear correlation of a reduction in Red Flag incidents and a reduction in the midwifery vacancy rate.
- 7.6. Further work, supported by Trust Governance Team, has commenced to support appropriate categorisation when delays occur that are not related to midwifery staffing. It is expected that this will result in further reductions in Red Flag reportable incidents going forwards.

Red Flag Incidents Reported April 2024 to April 2025



Graph 9 Saint Mary's MCS Midwifery Red Flag Reportable Incidents

Supernumerary status of labour ward coordinator

7.7. The Maternity Division has continued to report and monitor compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour. The maternity division have achieved 100% compliance with maintaining a supernumerary labour ward coordinator at all times across the 3 maternity sites.

Provision of 1:1 care in labour

7.8. During March 2025, the maternity division provided one-to-one care in labour to 99.78% of women. As reported previously, the maternity division have in place a detailed action plan for occasions where with provision of one-to-one care has not been achieved, which is monitored through the maternity quality and safety committee.

8. Qualification in Speciality

8.1. The Qualification in Speciality (QIS) staffing levels across newborn services continues to be a pressure, which affects the skill mix particularly in the intensive care rooms. As the service has not achieved the national standard of 70% QIS trained, a risk assessment has been undertaken and is on the risk register scoring 12 (MFT/004452). Table 7 shows the current percentage compliance against national standards across all units. The ORC position has improved since the last reporting period due to new graduates at ORC. North Manchester's position has decreased due to 3 newly qualified staff commencing in post.

Table 7 Demonstrates Qualification in Speciality % Compliance (April 2025).

	ORC	North	Wythenshawe
8	100%	100%	100%

7	100%	100%	100%
6	100%	100%	100%
5	29%	27%	54%
Total	54%	56%	72%

- 8.2. As informed previously, Qualified in Specialty (QIS) compliance within the newborn service division remains non-compliant and remains risk score 12. To improve compliance Newborn services division, support up to 40 nurses to attend QIS course annually.

9. Recommendation

The Board of Directors is asked to:

- Accept the report and note the progress undertaken to support midwifery staffing in the Division of Maternity Services and nurse staffing in the Division of Newborn Services
- Note SM MCS maternity division remains compliant with the national guidance in relation to safer staffing
- Note the sustained reduction in midwifery red flag incidents reported
- Note the risk related to Qualified in Specialty (QIS) and support the recommendation to continue to support 40 nurses per year access QIS training.

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

Analyse: Fill & Unfilled



Staff Group, Band and Assignment Code

Staff Group	Bank	Unfilled	Total
Nursing & Midwifery	52,270	29,620	81,891
BAND 5	20,830	12,029	32,859
BAND 6	25,717	16,868	42,586
BAND 7	5,723	723	6,446
Total	52,270	29,620	81,891

% Bank Fill

63.8%

% Bank Fill (Excl. SNR)

66.8%

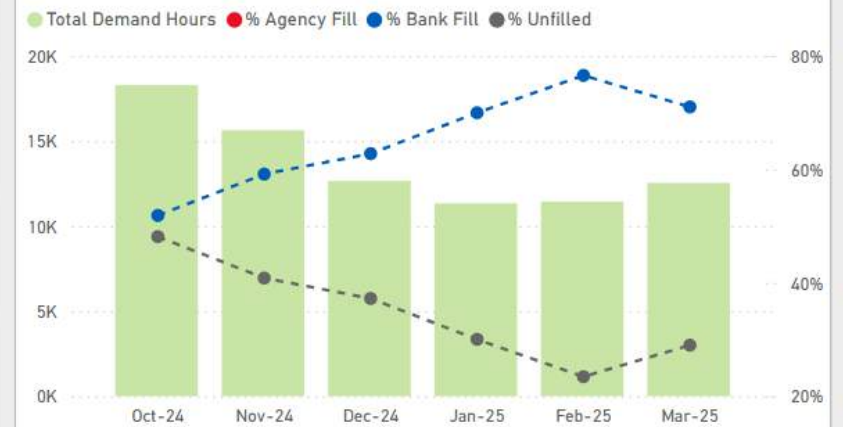
% Bank Fill (Excl. SNR & Direct Agency)

100.0%

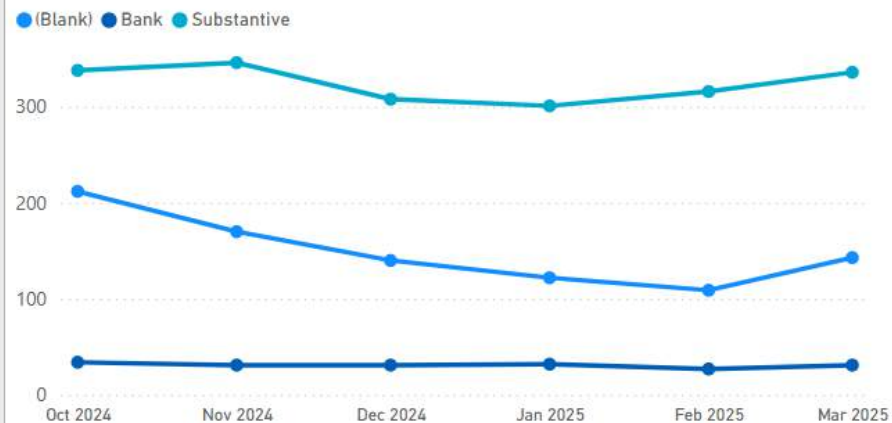
% Bank Fill (of Filled Hours)

100.0%

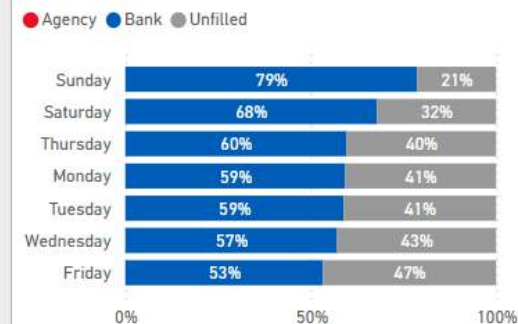
% Hours Fill and Total Demand Hours



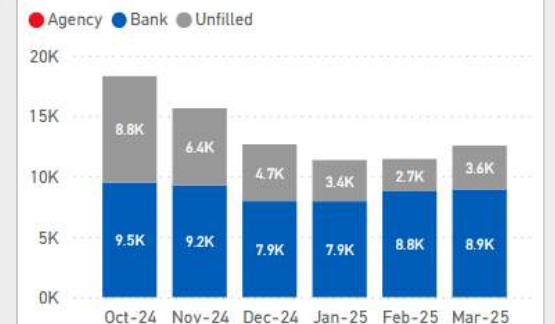
Total Workers Booked



Hours by Shift Category, Day of Week & Hour



Hours by Month Year & Week Ending



Analyse: Fill & Unfilled



Staff Group, Band and Assignment Code

Staff Group	Bank	Unfilled	Total
Nursing & Midwifery	28,319	712	29,031
BAND 4	222		222
BAND 5	24,060	614	24,673
BAND 6	2,131	41	2,172
BAND 7	747	11	758
BAND 8	1,159	46	1,205
Total	28,319	712	29,031

% Bank Fill

97.5%

% Bank Fill (Excl. SNR)

98.2%

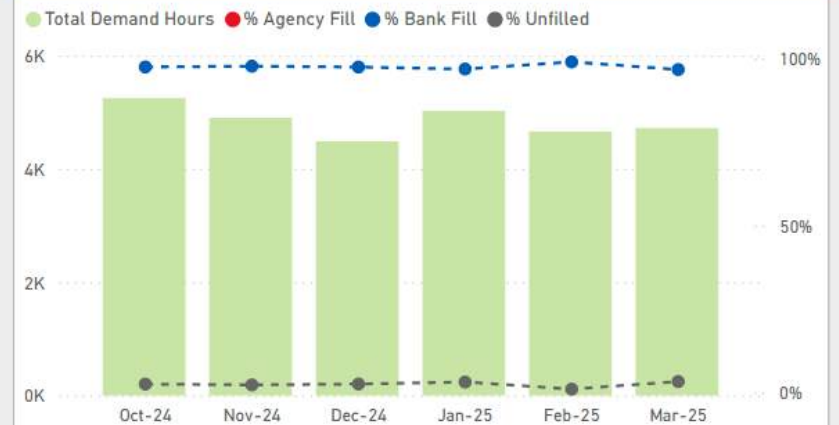
% Bank Fill (Excl. SNR & Direct Agency)

100.0%

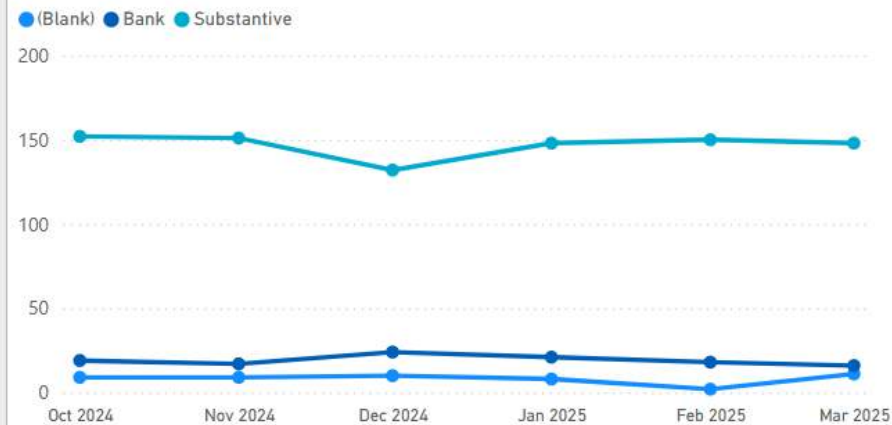
% Bank Fill (of Filled Hours)

100.0%

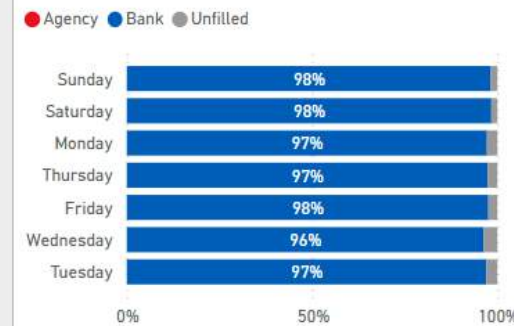
% Hours Fill and Total Demand Hours



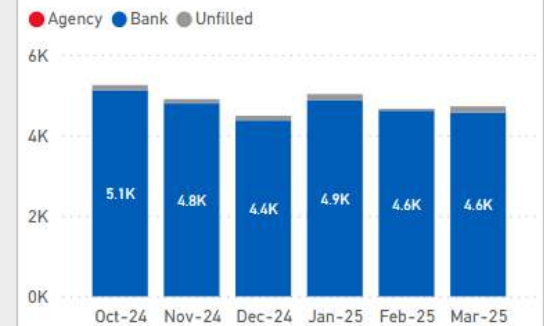
Total Workers Booked



Hours by Shift Category, Day of Week & Hour



Hours by Month Year & Week Ending





Manchester University
NHS Foundation Trust

Escalation and Assurance Report

Audit and Risk Committee

Report to: Board of Directors

Report from: Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee

Date of meeting: 24th June 2025

Key escalation and discussion points from the meeting

Alert

Following delegation from the Board of Directors to the Audit and Risk Committee, the Committee approved the Trust's Annual Report and Annual Accounts for 2024/25.

Advise

The Committee received and discussed the Internal Auditor's reports on Special Leave, which received a rating of 'Partial Assurance with improvements required', and their review of follow-up actions from previous partial assurance rated audits, which was not subject to a rating due to its scope. The Committee heard that actions are in place to address recommendations in both cases and the Special Leave audit had been identified by management as it had been identified an area where improvement work was required.

The Committee discussed the June 2025 Counter Fraud Progress Report which included details of action being taken on referrals received by the service, as well as the proactive work being undertaken, including a new staff communications and engagement programme.

The Committee received the report detailing the tenders waived for the period 1/3/25 to 1/5/25, each has been reviewed in accordance with Trust policy.

The Committee received the annual Losses and Special Payments report and a report covering the period 1/4/25 to 31.5.25.

Assure

The Head of Internal Audit opinion for 2024/25 is that 'Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.' They concluded this on the basis of 'The range of individual assurances arising from contemporary core reviews of financial systems, governance, risk management and data quality).

The External Auditors concluded there was not a significant weakness in the Trust's arrangements in 2024/25, though delivery of savings clearly remains a key risk to achieving value for money. They noted that the Trust is fully aware that any under-delivery of the £165m savings programme in 2025/26 presents a risk both to short-term liquidity and longer-term recovery. No significant weaknesses were found in their

assessment or arrangements for financial sustainability, governance, and improving economy, efficiency and effectiveness. Some opportunities for improvement were identified.

An internal audit benchmarking of strategic risks indicated that the Trust is broadly in line with peers in relation to the nature of the risks being managed.

Report approved by: Nic Gower, Non-Executive Director and Chair of Audit and Risk Committee

Agenda



Audit and Risk Committee

Date: Tuesday 24th June 2025

Time: 10:00am – 12:00pm

Location: Main Boardroom, Cobbett House, Oxford Road Campus

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence & confirmation of quoracy (verbal)	Meeting admin	Chair	10am
2.	Declaration of interest (verbal)	Meeting admin	Chair	10am
3.	Minutes of the previous meetings (9 th April 2025)	Meeting admin	Chair	10.05am
4.	Action Log	Discussion	Chair	10.10am
5.	Matters Arising	Discussion	Chair	10.15am
6.	Internal Audit Annual Report and Head of Internal Audit Opinion (2024/25)	Discussion	Internal Audit (KPMG)	10.20am
7.	External Audit 2024/25 Reports	Discussion	External Audit (Grant Thornton)	10.30am
8.	To review and approve MFT's:			
8.1	Annual Report 2024/25	Approval	Interim Deputy Trust Chief Executive	10.40am

8.2	Preparation of Annual Accounts for the period 1 st April 2024 to 31 st March 2025	Approval	Chief Finance Officer	10.50am
9.	Internal Audit:			
9.1	Internal Audit Progress Report	Discussion	Internal Audit (KPMG)	11.00am
10.	Local Counter Fraud:			
10.1.	Counter Fraud Progress Report	Discussion	Local Counter Fraud (KPMG)	11.10am
11.	Items for Noting and / or Information			
11.1	Tenders Waived for the period 1 st March to 31 st May 2025 above £50,000	Noting	Procurement Director	11.20am
11.2	Losses and Special Payments for the period 1 st April 2024 to 31 st March 2025 and 1 st April 2025 – 31 st May 2025	Noting	Operational Finance Director	11.30am
Good governance				
12.	Escalation reports from Board committees and Trust Risk Oversight Committee	Noting	Trust Board Secretary	11.50am
Committee business				
13.	Escalation report	Approval	Chair	11.55am
14.	Workplan Review	Meeting admin	Chair	11.55am
15.	Any Other Business (verbal)	Discussion	Committee Members	11.55am
16.	Meeting Evaluation (verbal)	Meeting admin	Chair	11.55am
Date of next meeting: Wednesday 10 th September at 10:00am – 12:00pm in the Medical Boardroom, Cobbett House, ORC				



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: 24/06/25

Key escalation and discussion points from the meeting

Alert

The Trust's cash position will be challenging during 2025/26. At the end of May 2025, the cash position is £51.8m against a plan of £64.5m, an adverse variance of £12.7m. Measures are being planned to mitigate the risk and full delivery of the Value for Patients programme, with the majority of schemes cash releasing, will be necessary. A restricted cash position could have an impact on all Trust spending including capital spending and therefore on achievement of the Trust's Annual Plan. The Cash Management Committee will now be chaired by the CFO to strengthen oversight of the issue.

The Committee supported the development of an Outline Business Case for a Pathology Service Collaboration between MFT and the NCA. This has been an ambition for a number of years and is supported by the Greater Manchester Trust Provider Collaborative. Reassurance was provided that there is clinical support for the case for change and the emerging proposal.

Advise:

The Committee received the Chief Finance Officer's M2 report and the finance elements of the Integrated Performance Report, and discussed in detail the current financial position. The in-month position is an £11.3m deficit against an £11.2m deficit plan. Discussions are ongoing with commissioners to agree a 25/26 contract value and this may result in the management of activity later in the year to deliver within the commissioner affordability envelope. Clinical Groups are now provided with their own Income and Expenditure reports to empower them to better manage their financial position.

The Committee discussed the 2025/26 financial plan which forecasts a breakeven position in line with year 2 of the 3-year financial plan. The plan includes a Value for Patients programme of £165.8m (5.8% of 'influenceable operating expenditure'). The total capital plan for 2025/26 is for £115.5m. Internal prioritisation of capital schemes is currently ongoing through a risk based assessment process. The Committee discussed in detail the risks to delivery of plan.

The Committee received an update on delivery of the 2025/26 Value for Patients programme, including a presentation from the external organisation working with the operational and clinical teams to develop and deliver the VfP programme at pace. A series of 'sprints' are being undertaken within Clinical Groups to identify opportunities and move them to level 3 schemes as soon as possible. Committee members emphasised the need to ensure that learning and good practice is shared and implemented across all Clinical Groups to increase in house capability.

The 3-year financial recovery plan has been reviewed in light of the 2024/25 outturn position and will be developed further following the publication of the '10 Year Health Plan for England' and discussed at the next Committee meeting.

Assure:

The Committee considered the section of the BAF relevant to the scope of the committee and noted the progress made in delivering actions in place to deliver the Trust's strategic objectives.

Risks discussed at the meeting

The Committee discussed the strategic risks and corporate risks aligned to the finance element of the strategic aim of which the committee has responsibility for oversight. The achievability of the target rating for the strategic risk regarding capital will be reviewed.

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

Agenda:

Manchester University
NHS Foundation Trust

Finance Board Committee

Date: Tuesday 24th June 2025

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	2:00pm
2.	Declaration of interest (verbal)	Meeting admin	Chair	2:00pm
3.	Minutes of the previous meeting (22 nd April 2025)	Meeting admin	Chair	2:00pm
4.	Action Log	Discussion	Chair	
5.	Matters Arising	Discussion	Chair	
6.	Assurance Reporting			
6.1	Board Assurance Framework	Discussion	Chief Finance Officer	2:05pm
6.2	Integrated Performance Report	Discussion	Chief Finance Officer	2:20pm

7. Strategic aim 4: Ensure value for our patients and communities by making best use of resources				
7.1	Chief Finance Officer's report	Discussion	Chief Finance Officer	2:35pm
7.2	2025/26 Financial Plan – Final NHSE Submission	Noting	Chief Finance Officer	2:45pm
7.3	Value for Patients programme update Including update on VfP Acceleration Programme	Discussion	Chief Delivery Officer	2:55pm
7.4	Pathology Service Collaboration Strategic Outline Case	Discussion	Chief Delivery Officer / Chief Executive of CSS	3:05pm
Committee business				
8.	Escalation report	Approval	Chair	3:20pm
9.	Workplan Review	Meeting admin	Chair	
10.	Any Other Business (verbal)	Discussion		
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	
Date of next meeting: Tuesday 2 nd September 2025				



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: 19/6/25

Key escalation and discussion points from the meeting

Alert

Advise:

There is potential to pursue national funding to address network improvements and current gaps in Hive features. This will be explored to ensure the necessary resources are available for these critical projects.

Trafford and Altrincham have been retrofitted to net zero, making them national exemplars. The committee will explore how to better communicate these achievements and their impact.

The Trust's Estates Optimisation Group will work on the findings from the recent estate review, focusing on strategic opportunities for better utilization of space and cost savings.

The alignment process for North Manchester Hospital 2.0 is underway, with the goal of completing the outline business case by March 2026. This includes a focus on demand and capacity modeling, new schedule of accommodation, and compliance with the 2.0 design.

Creative funding solutions are being sought for the redevelopment of the dental hospital, which is a critical project given the current state of the facility.

Assure:

The Integrated Performance Report for both digital and estates provided valuable insights and assurance. The detailed presentation of metrics and RAG ratings for digital services projects was particularly appreciated. A report explaining estates metrics will be presented at the next meeting, focusing on safety scores and the actions being taken to address areas needing improvement.

The Data Security and Protection Toolkit (DSPT) submission for cybersecurity and information governance is on track to meet standards by the end of the month. This is a significant assurance for the committee.

Risks discussed at the meeting

The Committee discussed the strategic risks within the Board Assurance Framework and noted the planned amendments to the cyber security and asbestos management risks.

A new strategic risk related to network infrastructure has been identified. This risk will be discussed at the Trust Risk Oversight Committee (TROC) and subsequently brought to the appropriate governance mechanisms, including this committee.

Report approved by: Sam Liscio, Non-Executive Director and Chair of the DEBC.

Agenda:



Manchester University
NHS Foundation Trust

Digital and Estates Board Committee

Date: Thursday 19th June 2025

Time: 12:00pm – 2:30pm

Location: MS Teams

Agenda

	Item	Purpose	Lead	Time
1.	Apologies for absence & confirmation of quoracy (verbal)	Meeting admin	Chair	12:00pm
2.	Declaration of interest (verbal)	Meeting admin	Chair	12:00pm
3.	Minutes of the Previous Meeting (4 th March 2025)	Meeting admin	Chair	12:00pm
4.	Action Log	Discussion	Chair	12:05pm
5.	Matters Arising	Discussion	Chair	12:05pm
6.	Assurance Reporting			
6.1	Board Assurance Framework	Discussion	Chair	12:10pm
6.2	Integrated Performance Report	Discussion	DW / RJ	12:20pm
Strategic aim 4: Ensure value for our patients and communities by making best use of resources				
7.1	Chief Digital and Information Officer's report (including operational and BI performance and vertical KPIs)	Discussion	DW	12:30pm
7.2	Update on Hive programme	Discussion	DW	12:45pm
7.3	Cyber Assessment Framework Final Position (Cyber and IG)	Discussion	DW	12:55pm
7.4	Update on Medicinema	Discussion	DW	1:00pm
7.5	Director of Estates and Facilities' report	Discussion	RJ	1:10pm

7.6	Update on Estates and Facilities' priorities	Discussion	RJ	1:25pm
7.7	Output from the Space Utilisation work plan External Review	Discussion	RJ	1:35pm
7.8	Update on NMGH development programme	Discussion	MH	1:55pm
7.9	Update on Project RED	Discussion	RJ	2:05pm
7.10	Update on University Dental Hospital	Discussion	TRa	2:15pm
Committee business				
8.	Escalation report	Approval	Chair	2:25pm
9.	Workplan Review	Meeting admin	Chair	2:25pm
10.	Any Other Business (verbal)	Discussion		2:25pm
11.	Meeting Evaluation (verbal)	Meeting admin	Chair	2:25pm
Date of next meeting: Tuesday 9 th September 2025 at 10:00am				

Public Board of Directors Wednesday 30th July 2025

Paper title:	Chief Finance Officer's Report – Month 2	Agenda Item 13.4
Presented by:	Claire Wilson, Chief Finance Officer	
Prepared by:	Ann Bracegirdle, Deputy Chief Finance Officer Paul Fantini, Deputy Director of Planning and reporting	
Meetings where content has been discussed previously	Finance Board Committee	
Purpose of the paper Please check <u>one</u> box only:	☐ For approval ☐ For support ☒ For discussion	

Executive summary / key messages for the meeting to consider

- The financial position against control total (CT) for M2, May 2025 in month is an £11.29m deficit against an £11.22m plan. The year to date position is a £19.91m deficit against a £19.80m deficit plan, broadly in line with plan.
- After non-operating adjustments, the month 2 position is an £16.22m deficit against a plan of a £5.04m deficit, a £1.1m adverse variance. The year to date position is a £28.07m deficit against a £27.42m deficit plan, £0.64m adverse to plan.
- The month 2 year to date VfP performance was £8.9m, £1.1m above the target of was delivered in full although included £3.4m of central VfP brought forward to achieve this.
- The cash position is becoming challenged and there is significant focus on maximising the Trust's cash balance.

Recommendation(s)

The Board of Directors is asked to:

- Note the contents of the 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:

-

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

See 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 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

Month 2 2025/26 Financial Position Update

Where

Excellence

Meets

Compassion



**Manchester University NHS
Foundation Trust**

June 2025



Summary – M2 Position – May 2025

Summary

- In month 2, for NHSE reporting purposes, the Trust delivered a **deficit of £11.3m** against a planned deficit of £11.2m – **adverse to plan by £0.1m**. YTD this is a £19.9m deficit vs a planned deficit of £19.8m, adverse £0.1m
- After non-operating adjustments in the month 2 the Trust delivered a **deficit of £16.2m** against a planned deficit of £15.0m – **adverse to plan by £1.2m**. The YTD deficit of £28.1m is adverse to the planned £27.4m deficit by £0.6m.
- The adverse income variance in month of £3.8m is driven by CPT Drugs which is aligned with CPT expenditure at £6.1m below plan, offset by overperformance against ERF income.
- Adverse expenditure variances primarily reflect under performance against the VfP across Clinical Groups/Corporate and costs of delivering activity above the plan.

The month 2 position includes £2.0m of brought forward central Value for Patients delivery with the YTD value at £3.4m.

Current Month Variance to Plan

Income **£3.8m** adverse

Staffing Costs **£1.4m** adverse

Non Pay Costs **£5.2m**
favourable

YTD Variance to Plan

Income **£1.6m** adverse

Staffing Costs **£3.1m** adverse

Non Pay Costs **£4.7m**
favourable

M2 Financial Position – May 2025

In month 2 Trust delivered a deficit of £11.3m, £0.1m adverse to plan. YTD shows a £19.9m deficit, £0.1m adverse to plan

Income

The YTD **£1.6m** adverse variance to plan (£3.8m adverse in month) is largely driven by:

- Under-performance against CPT Drugs and Devices of **£6.1m** – offset by underspends in non-pay.
- Over-performance against ERF income by **£4.1m**.

Pay Variance (£0.4m of b/f NR Central VfP supporting the position at M2)

The YTD **£3.1m** adverse variance to plan is driven by:

- Under-performance against the YTD budget reducing VfP target across Clinical Groups.
- Premium pay use across all CGs covering vacancies, enhanced care nursing and medical staffing gaps.
- Costs associated with delivering the ERF over-activity.

Non-pay Variance (£3.0m of b/f NR Central VfP supporting the position at M2)

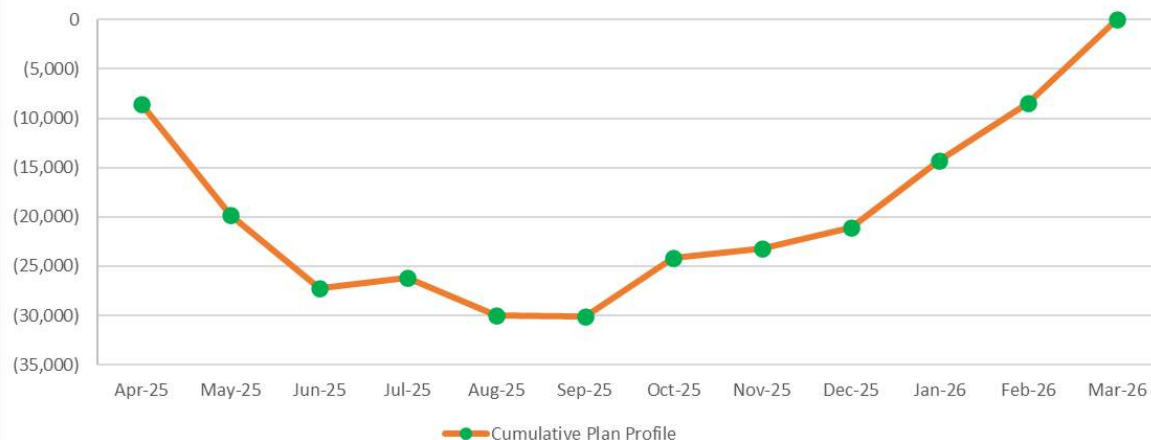
The YTD **£4.7m** favourable variance to plan is predominantly driven by:

- Underspends on CPT Drugs and Devices (offset by income)
- Central VfP support brought forward of £3.0m.
- Offset by under-performance against the budget reducing YTD VfP target across Clinical Groups.
- Insourcing/Outsourcing (adverse £1.6m) relating to over-performance on ERF.

I&E Category	2025/26	Current Month - M2			YTD		
	Original Plan £'000	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Actual £'000	Variance £'000
NHS England	436,957	36,334	29,471	(6,863)	72,668	66,520	(6,148)
ICBs	2,203,788	181,824	184,613	2,789	363,648	367,936	4,288
NHS Trust and Foundation Trusts	2,744	229	229	0	458	458	0
Local Authorities	43,162	3,597	3,597	0	7,194	7,194	0
Non-NHS: private patients, overseas patients & RTA	11,765	981	884	(97)	1,962	1,781	(181)
Non NHS: other	11,898	992	992	(0)	1,984	2,483	499
Income from Patient Care Activities	2,710,314	223,957	219,786	(4,171)	447,914	446,371	(1,543)
Research & Development	107,091	8,924	8,921	(3)	17,848	17,839	(9)
Education & Training	105,603	8,800	9,350	550	17,600	18,114	514
Misc. Other Operating Income	101,090	8,424	8,202	(222)	16,848	16,267	(581)
Other Operating Income	313,784	26,148	26,473	325	52,296	52,219	(77)
Total Income	3,024,098	250,105	246,259	(3,846)	500,210	498,590	(1,620)
Staffing Costs	(1,817,452)	(157,106)	(158,465)	(1,359)	(313,369)	(316,438)	(3,069)
Drugs	(315,512)	(26,426)	(22,542)	3,884	(52,852)	(48,815)	4,037
Supplies and Services - Clinical	(294,450)	(24,201)	(23,189)	1,012	(49,834)	(50,225)	(391)
Insourcing & Outsourcing Costs	(35,748)	(2,979)	(3,587)	(608)	(5,958)	(7,561)	(1,603)
Premises & Establishment Costs	(81,955)	(7,084)	(8,892)	(1,808)	(14,168)	(15,674)	(1,506)
Supplies and Services - General	(15,600)	(1,300)	(3,519)	(2,219)	(2,600)	(4,356)	(1,756)
PFI Charges	(81,514)	(6,616)	(7,400)	(784)	(12,985)	(13,825)	(840)
Lease Expenditure	(7,730)	(883)	(629)	254	(1,784)	(1,612)	172
Depreciation & Amortisation	(71,583)	(5,673)	(5,638)	34	(11,426)	(10,886)	540
Other	(229,665)	(23,040)	(17,577)	5,463	(43,021)	(36,993)	6,028
Non Pay Costs	(1,133,757)	(98,201)	(92,973)	5,228	(194,628)	(189,948)	4,680
Total Operating Expenditure	(2,951,209)	(255,307)	(251,438)	3,869	(507,997)	(506,385)	1,612
EBIT Margin	72,889	(5,202)	(5,179)	23	(7,787)	(7,795)	(8)
Interest & Dividends	(52,322)	(2,711)	(2,747)	(36)	(23,860)	(23,851)	9
Surplus / (Deficit) before adjustments	20,567	(7,913)	(7,926)	(13)	(31,647)	(31,647)	0
Adjust PFI revenue costs to UK GAAP basis	(20,567)	(3,308)	(3,367)	(59)	11,852	11,732	(120)
Surplus / (Deficit) for CT purposes	0	(11,221)	(11,293)	(72)	(19,795)	(19,914)	(119)
I&E Excluded from CT	(62,291)	(3,821)	(4,931)	(1,110)	(7,629)	(8,159)	(530)
Surplus / (Deficit) after CT excluded items	(62,291)	(15,042)	(16,224)	(1,182)	(27,424)	(28,073)	(649)

2025-26 Plan Profiles (£000s)

Cumulative I&E Plan Profile 2025-26



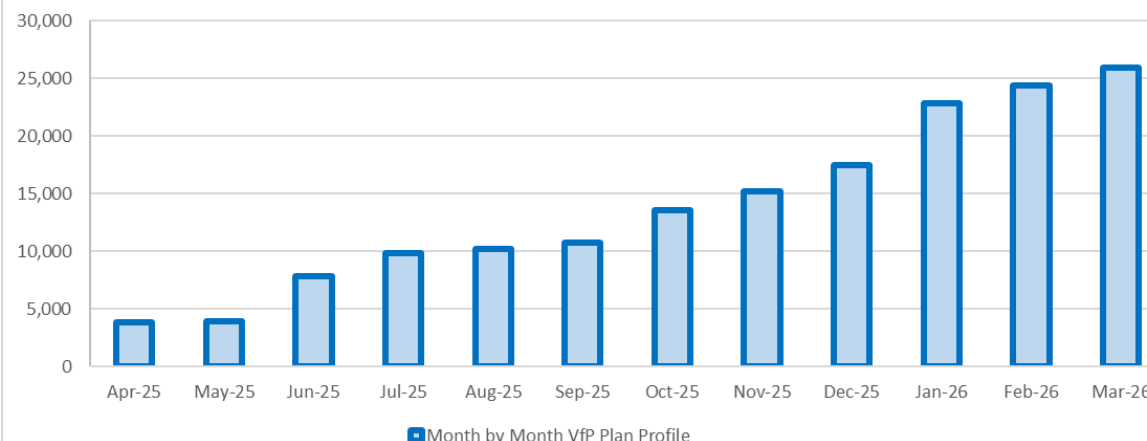
Value for Patients Plan

- The Value for Patients (VfP) profile has been phased to deliver increasingly higher reductions in expenditure month on month as plans are further developed and implemented.
- Q1 planned delivery is 9.4%, with Q2 at 18.6%, Q3 at 27.9% and Q4 the remaining 44.1% of the full £165.8m target

I&E Plan

- The 2025-26 plan assumes that deficits are delivered over the first half of the financial year with surpluses delivered in H2.
- This profile is driven on the income side by working days and calendar days for activity types, as appropriate, and on the expenditure side primarily by the Value for Savings delivery profile.

Month by Month VfP Plan Profile 2025-26



M2 Financial Position by Area

YTD at Month2	CSS	LCOD	MRI	NMGH	SPEC	WTWA	CORP	E&F	R&I	TRUST	TOTAL
	Variance	Variance	Variance	Variance	Variance	Variance	Variance	Variance	Variance	Variance	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Devolved Clinical Income	505	(148)	924	26	2,169	372	0	0	0	(5,210)	(1,361)
Other Income	(332)	(96)	51	144	3	(328)	132	(506)	(10)	308	(633)
Total Income	173	(244)	975	170	2,172	44	132	(506)	(10)	(4,902)	(1,994)
Staffing Costs	(450)	(443)	(1,085)	(1,751)	503	644	944	(300)	9	141	(1,789)
Non Pay Costs	178	(9)	(1,591)	(1,202)	(2,101)	476	(906)	694	(4)	8,241	3,776
Financing Costs	0	0	0	0	0	0	0	(0)	0	(110)	(110)
Total Expenditure	(273)	(452)	(2,677)	(2,953)	(1,598)	1,120	38	394	5	8,271	1,876
Contribution	(99)	(695)	(1,702)	(2,783)	574	1,164	170	(112)	(5)	3,369	(119)

- Note that internal budgets differ to the original plan against the income, pay and non-pay categories so although the overall variance is the same, at £0.1m adverse to plan, the make up is different due to reallocation of budgets internally, as required.

- Underperformance across CSS, LCO and Dental, MRI and NMGH largely is driven by under-delivery against the budget reducing VfP targets and premium costs to cover vacancies/specialling costs
- Significant focussed work is underway by all Clinical Groups and Corporate teams to develop and implement VfP schemes at pace.

Month 2 - ERF Income

ERF Income by Clinical Group - May YTD												
Site / MCS	Elective (£000s)			Outpatients First Attendance (£000s)			Outpatients Procedures (£000s)			Total (£000s)		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Clinical & Scientific	1,736	1,943	207	903	1,049	146	710	862	153	3,349	3,854	505
Manchester Royal Eye Hospital	2,454	2,798	344	492	508	15	2,234	2,418	184	5,179	5,723	544
Manchester Royal Infirmary	13,685	14,094	409	3,007	3,280	273	617	859	242	17,309	18,233	924
North Manchester General Hospital	6,017	5,882	(135)	2,111	2,298	188	579	552	(27)	8,707	8,733	26
Royal Manchester Children's Hospital	8,913	10,186	1,273	1,739	1,830	91	235	327	92	10,887	12,343	1,456
Saint Mary's Hospital	2,782	3,110	328	1,972	1,974	2	1,019	858	(160)	5,773	5,942	170
University Dental Hospital	601	530	(71)	450	428	(22)	869	814	(55)	1,920	1,772	(148)
Wythenshawe, Trafford, Withington	16,874	16,709	(165)	4,509	4,855	346	2,826	3,017	191	24,209	24,581	372
Trust	0	0	0	2,247	2,922	675	24	-400	(423)	2,271	2,523	252
Total	53,062	55,253	2,191	17,431	19,144	1,713	9,111	9,308	197	79,604	83,705	4,101

ERF Income to M2

- Actuals will be refreshed to exclude the elective top up values as these now form part of the fixed element of the API contract
- Commissioner plan discussions are progressing but there remains a material affordability gap with Specialised Commissioning, consequently the reported variance is an **additional** pressure in regard to realising both future income and cashflow.
- ERF dynamics continue to be used to calculate the variance, but subject to finalising agreement this is likely to broaden so that all elective 1st OP and all OPPROC (with the exception of Maternity & CAMHs) are treated as variable along with Imaging and Chemotherapy.

Month 2 - ERF Activity

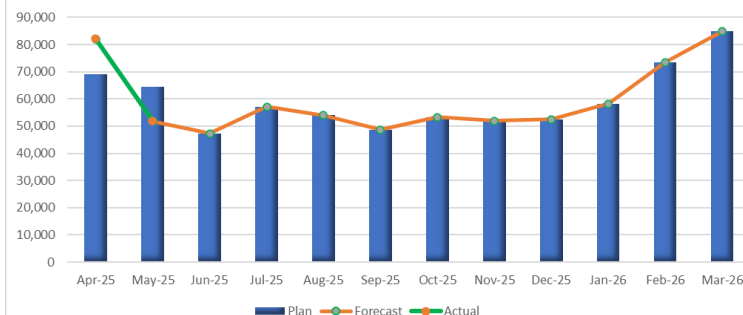
ERF Activity by Clinical Group - May YTD												
Site / MCS	Elective			Outpatients First Attendance			Outpatients Procedures			Total		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
Clinical & Scientific	793	779	(14)	10,192	11,267	1,075	2,946	3,493	547	13,931	15,539	1,608
Manchester Royal Eye Hospital	1,586	1,725	140	2,938	3,031	93	16,746	18,152	1,407	21,269	22,908	1,640
Manchester Royal Infirmary	12,110	12,698	588	15,641	16,341	700	3,531	5,000	1,469	31,283	34,039	2,756
North Manchester General Hospital	2,454	2,377	(78)	9,790	10,538	748	3,192	2,996	(196)	15,437	15,911	474
Royal Manchester Children's Hospit	4,280	4,561	281	8,723	8,988	266	1,287	1,814	527	14,291	15,364	1,073
Saint Mary's Hospital	947	1,130	183	6,482	6,751	269	3,497	2,728	(770)	10,926	10,609	(317)
University Dental Hospital	714	668	(45)	2,333	2,301	(33)	4,964	4,587	(377)	8,011	7,556	(454)
Wythenshawe, Trafford, Withington	6,097	6,524	427	21,463	25,735	4,272	15,822	17,578	1,756	43,382	49,837	6,455
Trust	0	0	0	0	0	0	0	4	4	0	4	4
Total	28,982	30,463	1,481	77,561	84,952	7,391	51,986	56,352	4,367	158,529	171,768	13,239

ERF Activity to M2

- The plan is based on data supplied by the BI/Performance team and agreed with each Clinical Group.

Month 2 – Cash and Capital

Cash Flow



Cash Plan vs Actuals - M2		£m
Plan Cash Balance		64.5
Actual Cash Balance		51.8
Variance - Higher/(Lower) than plan		-12.7
Revenue Operating Cash Days		6.5
Monthly Low		51.6
Monthly High		228.8

Cash

- At month 2 the cash position was £51.8m against the plan of £64.5m, adverse by £12.7m.

Favourable variances include:

- Capital payments are lower than plan by £5.9m

Adverse variances include:

- Payments to suppliers were £14.2m higher than planned – reflecting timing issues, overspends and underperformance against VfP in the I&E position
- Net VAT receipts/payments are £2.5m adverse to plan YTD reflecting timing issues and will unwind in future months.
- Settlement of 24/25 commissioner funding lower than expected by £1.9m

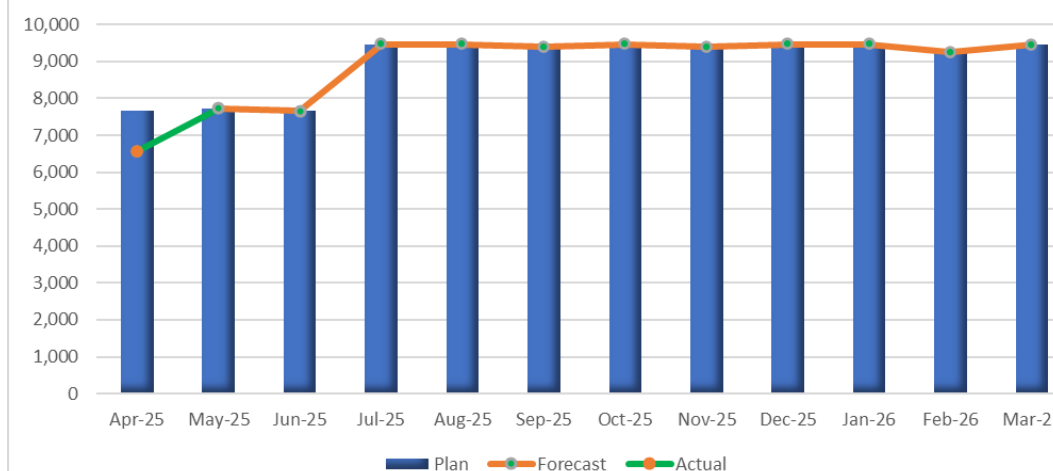
- The Trust was holding 6.5 days of revenue operating cash days at month end. The NHSE Treasury Team will follow up with any Trust reporting below 4 days of Revenue cash operating expenditure in 25/26.

- There are now weekly Cash management meetings to monitor and maximise the Trust's cash position, and every BACS payment runs is paid following senior review and sign off.

Capital

- MFT's 2025/26 capital plan is a total of £101.7m including IFRS 16 leases, PDC, grant and charity capital and the capital expenditure associated with the Trust's PFIs.
- The M2 position is £12.6m against a plan of £15.4m, £2.8m behind plan. This is related to delays to schemes within the GM envelope of £1.6m, an underspend against the NHP of £1.4m offset by above planned spend on Decarbonisation and RAAC schemes YTD. It is anticipated these schemes will return to plan over quarter one.

Total Capital



Risks and Mitigations

- In month 2, £2.0m (YTD £3.4m) of central VfP delivery was brought forward to mitigate VfP under-performance across Clinical Groups and Corporate teams. This reduces the availability of central delivery later in the year.

Risk	Mitigation/Action Being Taken	Risk Value	Timescale	Owner
ERF Income – assumption of c.£17m above contract value currently in the plan to deliver the performance requirements	- Working with Commissioners to agree a contract value that delivers performance requirements. - Any additional costs required to deliver activity are approved through Trust Governance processes. - Activity plans broken down by Clinical Group based on agreed contracts so any requirement in activity reduction can be aligned to reduction of capacity and therefore cost.	£17.0m	Ongoing	Chief Delivery Officer Vanessa Gardener Chief Finance Officer Claire Wilson
ERF Income – ICB contract reduced by c.£8m for delivery of activity demand management schemes to support delivery of performance requirements	- Monitoring of demand management schemes, working in conjunction with the ICB. - Expectation that income will be received if demand management schemes are unsuccessful.	£8.0m	Ongoing	Chief Delivery Officer Vanessa Gardener Chief Finance Officer Claire Wilson
Different ICB approaches and general commissioning changes resulting in income reductions, currently extremely high risk. There are various funding streams which are at risk.	Discussions with the GM ICB and Specialist Commissioners and therefore NHSE continue to ensure all funding anticipated is received, or costs can be reduced in alignment with income reduction.	£15.0m	31 st March 2026	Chief Finance Officer Claire Wilson
Expenditure run rate doesn't reduce to deliver 25/26 financial plan	- 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. - Carnall Farrar are providing support to develop the Value for Patients programme at pace.	£50.0m	Ongoing	All Executive Directors
NHSE requirement to reduce Corporate cost growth by 50% compared to 18/19	- Indicative requirements by area circulated to Executive Directors. - Work ongoing to develop corporate services to operate within the funding available.		Ongoing	All Executive Directors
Non recurrent delivery of Value for Patients and mitigations to offset pressures will increase the Trust's underlying deficit financial position	- Review all non recurrent schemes to determine if they can be delivered recurrently. - Focussed work by Carnall Farrar to fast track development of recurrent schemes.		Ongoing	All Executive Directors
If the financial plan is not delivered in line with cash flow assumptions the Trust will potentially need to access revenue support funding by Q2 and/or have to slow down/reduce capital expenditure plans.	- Weekly Cash management group established to support maximisation of Trust cash balances. - Enhanced cash flow monitoring and reporting - Senior review and approval of all BACs payment runs - Focus on the management of debtors. - Working with the GM ICB to maximise the Trust's cash position on a monthly basis		Ongoing	Chief Finance Officer Claire Wilson