NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 13th May 2019

(Held in Public)

70/19 Apologies for Absence

Apologies were received from

71/19 Declarations of Interest

There were no declarations of interest received for this meeting.

Decision:	Noted	**Action by:** n/a	**Date:** n/a

72/19 Patient Story – 'What Matters to Me'

The Board viewed a DVD on the *'Reablement following Major Trauma - the Manchester Institute of Health and Performance Project'.*

The Group Chairman commended the film clip which provided an excellent example of a service which had provided invaluable specialised support and expertise to the victims of the Manchester Arena Bomb since May 2017. A truly inspiring story.

Decision:	Patient Story Received and Noted	**Action by:** n/a	**Date:** n/a

73/19 Minutes of the Board of Directors Meeting held on 11th March 2019

The minutes of the meeting held on the 11th March 2019 were agreed as a correct record.

74/19 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 14th January 2019 and noted progress.

Decision:	Noted	**Action by:** n/a	**Date:** n/a

75/19 Group Chairman's Report

i). The Group Chairman reported that since the last meeting of the Board, the CQC had published its ratings for MFT on Tuesday, 19th March 2019. It was noted that MFT had been rated as '**Good'**, with the Manchester Royal Eye Hospital and the University Dental Hospital Manchester, as well as Adult Critical Care and CAMHS services, receiving an overall rating of '**Outstanding'**. It was noted that a more detailed report would be presented by the Group Chief Nurse under Agenda Item 79/19.

ii). The Group Chairman reported that she was pleased to report that the organisation had over 650 Team MFT colleagues signed-up to join the 'NHS Blue Wave' at the Great Manchester Run on Sunday, 19th May.

iii). The Board noted that the annual Nursing, Midwifery & Allied Health Professional (NMAHP) research conference had successfully taken place on Friday, 3rd May 2019 at Wythenshawe Hospital. The Group Chairman reported that this year, the annual MFT event focussed on 'Embedding Research to Improve Care' and enjoyed high levels of attendance from colleagues across the Trust.

iv). The Group Chairman reported that the Saint Mary's Sexual Assault Referral Centre (SARC) had held its 17th annual two day conference at the Midland Hotel, putting the spotlight on accessibility for victims of rape and sexual assault. It was noted that very positive feedback had been received on how the event provided valuable insight and discussion for over 200 delegates working in the field of rape and sexual violence.

v). The Group Chairman congratulated the Manchester Lung Health Check Programme team who had been recently named as the Cancer Care Team of the year at the BMJ Awards.

vi). The Group Chairman was pleased to report that the Lord Mayor of Manchester, Councillor June Hitchen, had visited the Royal Manchester Children's Hospital's Theatres & Wards on Wednesday, 17th April 2019, to join staff in celebrating their recent CQC 'Outstanding' rating for theatres, surgery and anaesthetics.

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

76/19 Group Chief Executive's Report

i). The Group Chief Executive was pleased to report that Mrs Vanessa Gardener had recently commenced in post as the new Chief Executive of the Manchester Royal Infirmary.

ii). The Group Chief Executive provided a summary overview of the current challenges and pressures facing the NHS; both nationally and locally. It was noted that further details would be shared with the Board of Directors later on the agenda.

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

77/19 Operational Performance

Board Assurance Report

The Joint Group Medical Director reported that MFT had experienced a fifth 'Never Event' (NE) at the end of March 2019. Details of the NE were shared with the Board which focused on the mistaken connection of a patient in RMCH to Air instead of Oxygen. The Joint Group Medical Director confirmed that the child concerned had not experienced harm as a result of the error. She also described the investigation which had taken place following the incident and the mitigation plans which were immediately introduced in RMCH to prevent reoccurrence (along with the 'learning' which would be shared with Hospitals/MCSs throughout the organisation). It was agreed that a further update on the Management of NE's would be presented to the Board of Directors in July 2019.

The Joint Group Medical Director pleased to report that MFT's Mortality Indices (SHMI & HSMR) continued to be below the national mid-point (100).

The Group Chief Nurse reported that an update on Complaints would be presented later on the agenda.

The Group Chief Operating Officer reported that MFT's Q4 (2018/19) cumulative emergency access 4-hour wait performance was 84% compared to GM's position of 80% (MFT 2nd in GM). It was noted that the current position (April 2019) was 84.7% with twice weekly operational performance scrutiny meetings ongoing along with close dialogue and partnership with the Manchester Local Care Organisation (MLCO) around key mobilisation workstreams such as 'Stranded Patients'.

The Group Chief Operating Officer was pleased to report that only six (Deep Inferior Epigastric Artery Perforator - DIEP) patients were waiting more than 52 weeks for treatment in MFT at the end of March and that this number had further reduced to '0' patients by the end of April 2019. The Group Chief Operating Officer particularly commended Wythenshawe Hospital for the heightened focus and commitment to commencing treatment for all DIEP patients waiting more than 52 weeks by the end of April.

The Board also noted MFT's 6 weeks Diagnostics performance (1.18%) at the end of March 2019, and, Cancer performance in Q3 (2018/19) which was 80.85%. However, it was anticipated that the Trust's Cancer performance in Q4 (2018/19) would be 77.38%. The Chief Operating Officer explained that whilst the Diagnostics performance was good, an operational decision to prioritise Cancer patients (and associated diagnostics) was likely to impact on the sustainability of this overall position going forward.

In response to questions from Mr Gower, the Group Chief Operating Officer described some of the anticipated pressures on the Trust's RTT trajectory over the coming 12 months. Attention was also drawn to the new national monitoring arrangements with a focus on the overall size of Waiting Lists in NHS Provider Organisations; comparing the positions of individual Trusts in March 2020 and their previous positions in March 2019.

The Group Chairman welcomed Mr Peter Blythin to his first formal Board of Directors as Group Executive Director of Workforce & Corporate Business and invited him to given an overview (by exception) on the key Workforce indicators highlighted within the Board Assurance Report. The Board noted the Trust's overarching Attendance, Turnover & Mandatory Training positions which were 'plateauing'. It was also noted that a recent HR Scrutiny Committee Stocktake Meeting had taken place with the aim of reviewing current Workforce metrics and identifying key areas of future scrutiny and assurance going forward. Particular attention was also drawn to the ongoing challenges with Recruitment & Retention (which was also a challenge nationally) along with the implementation of MFT's range of mitigating action plans to improve the position in key 'hot spots'.

In response to questions from Mr Rees regarding Turnover and trends over recent months, the Group Executive Director of Workforce & Corporate Business and Group Chief Nurse described some of the initiatives within the Trust to mitigate these trends going forward. It was also noted that the MFT Staff Survey would be presented to the HR Scrutiny Committee in June 2019.

The Group Chief Finance Officer reported that an update on the Trust's financial position would be presented later on the agenda.

The Group Executive Director of Strategy describe why the format of the Board Assurance Report did not necessarily work well for the strategy domain and that a proposal was being developed which highlighted an alternative way to assure the Board of Directors in relation to progress against the strategic agenda.

The Board Assurance Report was noted.

Decision:	Report Noted Further update on the Management of Never Event's to be presented to the next Board of Directors MFT Staff Survey to be presented to the HR Scrutiny Committee	**Action by:** Joint Group Medical Director Group Executive Director of Workforce & Corporate Business	**Date:** July 2019 June 2019

Transforming Care For the Future 2019/20 Annual Plan and Transforming Care For the Future Q4 (2018/19) Report

The Chief Operating Officer provided an overview of the 2019/20 'Transforming Care for the Future' Annual Plan and Commitments along with a summary of the Q4 (2018/19) Transformation Report. She was also pleased to report that Ms Veronica Devlin had been appointed as the Trust's new Chief Transformation Officer and would be starring in post on 2nd June 2019.

The Chief Operating Officer reminded the Board of Directors that the 'Transforming Care for the Future' Strategy was approved back in September 2017 and that 2019/20 was described as the year when the new, merged organisation moved from 'Good' to 'Great'. She explained that the focus would be on drawing-out the integration benefits (pathways) with 'quantifiable' plans implemented over the 12 months. The Board noted that key workstreams would concentrate on 'Operational Excellence', 'Pathways', and, 'Capacity & Capability'.

The Group Board of Directors approved the 2019/20 'Transforming Care for the Future' Annual Plan and Commitments and noted the Q4 (2018/19) Transformation Report.

Decision:	2019/20 'Transforming Care for the Future' Annual Plan approved Q4 (2018/19) Transformation Report Noted	**Action by:** n/a	**Date:** n/a

Progress Report on the Single Hospital Service

The Group Executive Director of Workforce & Corporate Business provided an updated on the Single Hospital Service (SHS) Programme.

The Board was reminded that the Programme was being delivered through two linked projects, namely, 'Project One' (creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), was completed on 1st October 2017); and, 'Project Two' (proposal for North Manchester General Hospital (NMGH) to transfer from Pennine Acute Hospital NHS Trust (PAHT) to MFT).

The Group Executive Director of Workforce & Corporate Business outlined the details of the progress to date under the main headings of 'Governance Arrangements for Delivery'; 'Assurance on the Approach to Benefits Management'; 'Ongoing Development of the Benefits Management Approach'; and, the proposed acquisition of North Manchester General Hospital (including the Strategic Case and Due Diligence & Disaggregation).

The Board noted that the integration work was progressing well aimed at realising patient benefits and creating new efficiencies. The Group Executive Director of Workforce & Corporate Business explained that the work of the Integration Steering Group (ISG) continued to oversee the robust tracking and delivery of a number of organisational and patient benefits associated with the merger.

The Board also noted the importance of post-merger integration notwithstanding, MFT remained committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, it was reported that MFT would continue to engage with all key stakeholders and in particular, work with Greater Manchester Health and Social Care Partnership in its role in overseeing the plan to dissolve Pennine Acute Hospitals NHS Trust.

The Board of Directors noted the progress of the Single Hospital Service Programme.

Decision:	Progress Report Noted	**Action by:** n/a	**Date:** n/a

Group Chief Finance Officer's Report

The Group Chief Finance Officer presented a summary overview of his Month 12 (2018/19) report. He confirmed that the financial performance for the year was a bottom line surplus (on a control total basis excluding Provider Sustainability Fund) of £7.5m (0.5% of operating income).

It was noted that whilst there had been sustained improvement at Hospital/MCS level in some areas, such as agency expenditure, during the second half of 2018/19, run-rate financial performance continued to fall short of plans with very limited aggregate improvement delivered across the fourth quarter overall. The Group Chief Finance Officer explained that this level of underlying financial performance meant that the Trust was taking a deficit run rate of £50m into 2019/20. He pointed out that whilst all hospitals had evidenced strong delivery plans towards fully addressing this deficit run rate in 2019/20, robust delivery needed to be demonstrated from the beginning of April 2019, to adequately assure the Trust's continuing financial sustainability.

The Board was advised that the Trust over achieved by £19.6m against its overall 2018/19 Control Total set by NHS Improvement, through a substantial number of non-recurrent benefits which had arisen in-year. It was noted that this had enabled significant further access to the PSF incentive fund (£32.5m coming to Manchester), which provided critical additional financing capacity towards funding the existing, prioritised 2019/20 capital programme.

The Group Chief Finance Officer provided a brief overview of the cumulative strain on capital affordability nationally and highlighted that the forecast spending far outstripped available resources in 2019/20. It was noted that NHSI's new Chief Finance Officer was currently inviting all Provider Boards and National Budget Holders to provide a re-forecast of expenditure in 2019/20 with the aim of mitigating the risk.

Mr Rees explained that the Finance Scrutiny Committee would be closely scrutinising delivery of plans across Hospitals towards fully addressing the previously reported run rate deficit in 2019/20.

The Group Chairman concluded by stating that whilst the Trust had ended 2018/19 in a good position, it was critical that focus was now on addressing the deficit run rate of £50m going into 2019/20.

The Chief Finance Officer's Month 12 Report (2018/19) was noted.

Decision:	Month 12 (2018/19) Report Noted	**Action by:** n/a	**Date:** n/a

78/19 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update to the Board of Directors in relation to strategic issues of relevance to MFT. Attention was drawn to the NHS Long Term Plan published in 2019 and it was confirmed that local health systems were tasked with developing their own strategies for taking forward the ambitions set out in the Long-Term Plan. The Group Executive Director of Strategy confirmed that the Greater Manchester Health and Social Care Partnership had now developed and submitted its Operational Plan for turning the Long-Term Plan into local action across Greater Manchester.

The Board was advised that further to the appointment of Mr Bill McCarthy as the North West Regional Director for NHSI, he was now appointing his senior leadership team. It was also noted that under the new arrangements, Mr Jon Rouse, Chief Officer of the GMH&SC Partnership, would report directly to the NW Regional Director.

The Group Executive Director of Strategy confirmed that the final version of the MFT 2019/20 Operational Plan had been successfully submitted to NHS I/E on 3rd April 2019 prior to the deadline of 4th April 2019. He also explained that the MFT internal business planning round had been completed and each MFT Hospital/MCS had developed their plans for 2019/20 with an over-arching MFT Annual Plan currently being developed.

The Board noted progress within Greater Manchester in relation to GM Cancer and the Improving Specialist Care programme.

The Board was reminded that the overarching Group Service Strategy had been approved by the Board of Directors in November 2018 and the document had been circulated to the MFT Council of Governors and key external stakeholders for comment. It was also recognised that this document would remain a 'live' document until completion of Waves 2 and 3, and the Managed Clinical Services (MCS) strategies. The Group Executive Director of Strategy confirmed that it would be updated in May to reflect any feedback received and to capture the outputs from the whole programme and re-presented to the Board in July 2019.

The Group Executive Director of Strategy also confirmed that Waves 1, 2 and 3 covered the services spanning Wythenshawe, Trafford, Withington & Trafford (WTWA) and the Manchester Royal Infirmary (MRI). He also explained that Waves 1 and 2 service strategies had now been approved by the Board and Wave 3 had commenced (which included Orthopaedics, Infectious Diseases, Burns and Plastics' Breast and Rehabilitation).

The Board was advised that the development of the Managed Clinical Services (Children's, Saint Mary's, Eye and Dental) strategies was on-going and were planned to be completed by mid-April and to be presented to the Board in May and July 2019. It was noted that the proposals outlined in all of the strategies were at a formative stage and MFT was now about to engage with commissioners on the next steps.

The Group Executive Director of Strategy reported that following confirmation that MFT had been chosen as the preferred provider for Trafford Community Services, the Trust was in discussion with Trafford CCG and Pennine Care NHS Foundation Trust about the due diligence process.

The Board noted the updates under each of the key headlines as presented.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

Update Report on the Manchester Local Care Organisation (MLCO)

The Chief Executive of the MLCO presented a summary overview of a report which provided a more detailed update from the MLCO under the key headlines of system resilience and escalation; new care models (Integrated Neighbourhood Teams / Manchester Community Response / Crisis Response / Discharge to Asses / High Impact Primary Care); development at neighbourhood level; communication & engagement; adult social care improvement programme; CQC regulatory inspection; Roadmap and Phase 2 update; and, the MLCO business plan and phase 2.

Particular attention was drawn to 'System Resilience' and partnership activities and workstreams between the MLCO, MFT and the wider system in GM in preparation for the challenges anticipated next Winter.

The Chief Executive of the MLCO was pleased to report that the MLCO, following a regulatory inspection in October 2018, received a report which offered an overall rating of 'Good' across all five of the domains: Well-led; Caring, Safe, Effective, and Responsive. He explained that out of 30 assessed domains, the MLCO was assessed as being 'Good' in 29, with only one domain being assed as 'requires improvement'; responsiveness in community health services for children and young people. The Group Chairman commended the MLCO for an excellent outcome; especially after only being in operation for 6 months at the time of the regulatory inspection.

The Chief Executive of the MLCO confirmed that significant progress had been made through the continued discussions with partners on the MLCO roadmaps for 2019/20 and the Board was reminded that the roadmaps set out how MLCO would develop in 2019/20. The Board was advised that in April 2019, the MLCO Partnership Board supported the phasing proposals that were put forward, through 2019/20 and become responsible for the delivery of c£287m of services. It was noted that whilst MFT would still need to undertake appropriate due diligence in regards to the budgets and contracts that would transfer, it was agreed that at the point of transfer, the operational management of these services would be through MLCO. It was acknowledged that this was a huge step forward and supported Manchester to deliver on the ambitions of the locality plan.

The Board was advised that work on the Business Plan had been ongoing during the and as previously reported, the MLCO had 12 neighbourhood business plans, business plans from the 3 localities, social care and children's services which were all being finalised. It was further noted that a corporate overarching business plan would also be produced alongside these, which would be available to all Partner organisations (summary content noted as presented).

The Chief Executive of the MLCO confirmed that given the above, it was agreed by the MLCO Partnership Board that an overarching high level Business Plan for the MLCO would be presented at its next meeting (scheduled for May 2019) and would include the full set of overarching neighbourhood, community service, social care and children's community service plans.

The Group Chief Executive and Mr Clare commended the MLCO for its significant achievements and progress during its first 12 months of operation. In response to a question from Mr Rees, the Chief Executive of the MLCO also confirmed that there was good engagement and dialogue with Primary Care and individual Practices throughout he various localities.

The Board noted the content of the MLCO update report.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

79/19 Governance

Delegated Authority to Sign-off the MFT Annual Report & Accounts for 2018/19 to the Audit Committee

The Chief Finance Officer requested that the Board delegated authority, as in previous years, to the Audit Committee for the formal sign-off of the MFT Annual Report & Accounts 2018/19 (which included the 2018/19 Annual Quality Account, and, Annual Governance Statement) to the MFT Audit Committee.

Decision:	The Board delegated authority to the MFT Audit Committee for the formal sign-off of the MFT Annual Report & Accounts (inc. the Annual Quality Account and Annual Governance Statement) for 2018/19.	**Action by** The Chief Finance Officer. and, Chair of the Audit Committee	**Date:** 22nd May 2019

Report on the Outcome of the CQC Comprehensive Assessment and Next Steps

The Group Chief Nurse reminded the Board that a briefing paper had been submitted to the Board of Directors in early March 2019 detailing the progress of the CQC comprehensive inspection of the Manchester University NHS Foundation Trust (MFT) and that the Trust was awaiting the final results at the time of the meeting.

The Board noted that on the 19th March 2019, the CQC had published their final report which confirmed that MFT had received an overall rating of 'Good'.

The Group Chief Nurse went on to describe the Summary Findings of the final CQC report and was pleased to confirm that the report narrative included very positive commentary about MFT services and also detailed areas where improvement was required. It was particularly noted that the main areas identified as 'requiring improvement' were identified as risks as part of MFT's pre-inspection submission to the CQC and the majority of those areas were also detailed on the Trust's Risk Register.

The Board of Directors particularly noted the following outcomes:

- For MFT overall, the ratings for the key lines of enquiry (the way in which they measure services) were extremely positive. The Trust was assessed in 5 areas; Caring was rated as 'Outstanding' and Safe, Effective, Responsive and Well-led were rated as 'Good'

- Two hospitals were rated as Outstanding: Manchester Royal Eye Hospital and the University Dental Hospital of Manchester.

- Two MFT-wide services, Adult Critical Care and Child and Adolescent Mental Health Services, were rated as Outstanding

- There were 24 individual indicators rated as outstanding for individual key lines of enquiry across the Group.

The Group Chief Nurse also confirmed that the Manchester Local Care Organisation (MLCO) had been rated as 'Good' which was viewed as a significant achievement as the MLCO had only been established for six months at the time of inspection. Attention was also drawn to the Manchester Royal Infirmary which was rated as 'Requires Improvement'. However, it was also noted that within the MRI, Critical Care was rated as 'Outstanding', End of Life Care and Medicine were rated as 'Good' and. Caring was also rated as 'Good' reflecting the way in which staff demonstrated kindness and compassion when caring for patients.

The Board acknowledged that the rating for the Trust provided patients and families with significant assurance about the quality of care they could expect to receive from MFT, whether that was in one of the organisation's hospitals, the community, or, in their home.

The Group Chief Nurse explained that the CQC had provided detailed commentary on areas of outstanding practice and areas for improvement and the Group-wide headlines were noted as presented in the report. The Board noted the 'Next Steps' which included a detailed internal and external communications plan along with an action plan in response to the report which was submitted on the 22nd April 2019 and would be overseen by a time limited MFT CQC Inspection Response Group (Terms of Reference noted as presented in the report).

It was also confirmed that in addition, Performance Assurance Meetings would be chaired by the Group Chief Nurse who would oversee an in-depth review with Hospital / MCS / MLCO and Corporate Teams on progress against the plan and assurance evidence on outcomes. The Group Chief Nurse explained that a report would be provided to the Quality and Safety Committee and any issues escalated if necessary. It was confirmed that a number of actions had already been undertaken in response to feedback at the time of inspection and the draft report, for example, a focus on mandatory training and improvements to equipment maintenance rates.

It was confirmed that the Chair of the Quality & Performance Scrutiny Committee, or, any of the Group Non-executive Directors, could request specific areas of scrutiny were presented through the Board of Directors scrutiny committees.

Mrs McLoughlin commented that it was a credit to all of staff that one year after the largest merger in the NHS, the Trust had received an overall 'Good' rating with many 'Outstanding' features. She noted that it was a significant achievement and provided the Trust with a solid foundation on which to move to 'Outstanding' in the future.

The Group Chief Nurse explained that core services rated as 'requiring improvement' would develop an additional plan to prepare for their unannounced inspection within the following 2 years.

The Board of Directors noted the CQC Report and approved the 'Next Steps' as set-out in the report presented.

Decision:	Report Noted and 'Next Steps' Approved	**Action by:** n/a	**Date:** n/a

Quarter 4 Complaints Report (2018/19)

The Group Chief Nurse presented an overview of the Quarter 4, 2018/19 complaints report for Manchester University NHS Foundation Trust (MFT), covering the period 1st January 2019 – 31st March 2019.

The Board noted that the report provided an overview of the Complaints and PALS performance for Quarter 4, 2018/19 and that due to new reporting capabilities to refresh and cleanse previous data, the data provided in the report for the periods prior to the current quarter (Quarter 4) would differ slightly to the data presented in previous reports.

The Group Chief Nurse explained that during Quarter 4, 2018/19, work continued to integrate the Trust's complaints functions and develop a single set of performance metrics. She pointed out that this had enabled comparisons to be made between the Hospitals/MCS and MLCO across the Group and that a fundamental part of the integration had involved the reporting alignment of formal complaints and PALS concerns to Hospitals/MCS and the MLCO.

The Board noted the content of the report and that during Quarter 4, 2018/19 there had been a total of 1,753 PALS concerns received. The Group Chief Nurse explained that this compared to 1,494 concerns received in Quarter 3; which was a 17.3% increase in concerns compared to Quarter 3, 2018/19 (numerically this was an increase of 259 PALS concerns). She went on to explain that during Quarter 4, 2018/19, there was a total of 409 new formal complaints received and this compared to 333 new formal complaints received in Quarter 3, 2018/19; which was a 22.8% increase in formal complaints compared to Quarter 3, 2018/19 (numerically this was an increase of 76 formal complaints).

In response to observations from Mr Clare, it was noted that natural seasonal variation of complaint numbers received on a monthly basis had continued which had ranged from 78 (December) to 165 (March) complaints received in 2018/19 at Group level.

The Board noted the finer details of the data presented in the report (numerical increases and decreases across MFT) and it was reported that in accordance with the agreed schedule, the Complaints Scrutiny Group, which was chaired by a Group Non-Executive Director, had met twice during Quarter 4, 2018/19. Dr Benett confirmed that CSS and WTWA (Medicine) had each presented a case at the January 2019 meeting and the University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH) each presented a case at the March 2019 meeting. The Board noted the learning identified from the cases presented in Section 5 of the report presented.

In conclusion, the Board of Directors noted the content of the Quarter 4, 2018/19 Complaints Report and the on-going work of the corporate teams and the Hospital/ MCS and MLCO teams to ensure that the Trust is responsive to concerns raised and learnt from patient feedback in order to continuously improve the patient's experience.

It was also noted that the Trust would continue to monitor complaint response timescales against expected response timescales; offer Corporate Nursing Support to Hospitals/ MCSs/ MLCO where performance was deteriorating; continue to review and embed recommendations within MFT's policies from National Guidance, including the recently published *'The roles of the Parliamentary and Health Service Ombudsman and NHS Resolution: Information for NHS Trusts'*; and, continue to progress the improvements as outlined in the report as presented by the Group Chief Nurse.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Annual Infection Prevention Control Report (2018/19)

The Group Chief Nurse provided an overview of the Annual Infection Prevention Control Report for 2018/19. The Board was reminded that the Trust had a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010) and that a requirement of this Act was for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. It was also noted that the report detailed Infection Prevention and Control activity from April 2018 to March 2019, outlining MFT's key achievements and an assessment of performance against national targets for the year.

The Group Chief Nurse confirmed that the prevention and control of infection was a high priority for the Trust and there was a strong commitment to preventing all Healthcare Acquired Infections (HCAI) and a zero tolerance to all avoidable infections. She explained that there had been an 80% reduction in the number of cases of *Clostridium difficile* infection (CDI) reported (from 540 Trust-attributable cases in 2007/2008, to 110 cases reported in 2018/2019). It was further reported that the Trust also observed a 67% reduction in the number of Trust attributable Meticillin resistant *Staphylococcus aureus* (MRSA) blood cultures (from 33 to 11 cases during the same period).

The Board noted that there was a national ambition to reduce healthcare associated Gram-negative blood stream infections (GNBSIs) by 50% by March 2021 by providers and commissioners working together across the whole healthcare economy. The Group Chief Nurse explained that members of the MFT Infection Prevention and control (IPC) team represented the Trust in a collaborative group including partners from across the whole healthcare economy to focus on reducing the incidence of Urinary Tract Infection (UTI), catheter associated UTI and appropriate antibiotic stewardship, which are the main risk factors for GNBSI, (Public Health England (PHE), 2018).

The Board noted the full range of key achievements, challenges along with the MFT IPC governance framework outlined in the report presented.

The Group Chief Nurse reported that in preparation for the 2018/2019 flu season the MFT Group Infection Control Committee (GICC) had approved a number of actions and these included widespread communication of updated guidance and a rapid testing service with extended laboratory hours/ additional support from the IPC Team during the weeks of peak activity. She explained that these were developed in response to lessons learned from the 2017/2018 flu season which demonstrated higher levels of activity than seen over the previous two seasons.

The Board noted that the Healthcare Workers Flu Vaccination Programme was launched on the 1st October 2018 and had Executive leadership provided by both the Group Chief Nurse/DIPC and Group Executive Director of Workforce. It was further noted that across MFT, a total of 13,890 staff (64.12%) received the vaccine, of which 11,339 staff (76%) were Frontline Healthcare Workers. It was confirmed that this exceeded the Department of Health target of 75% and the success of this year's programme received National recognition as the Trust was shortlisted for the NHS Employers Flu Fighter Award in the 'Most Improved' Category.

In conclusion, the Board of Directors received the Infection Prevention and Control Annual Report for 2018/19 and approve for publication.

Decision:	Annual Report Received and Approved for Publication	**Action by:** n/a	**Date:** n/a

Annual Nursing & Midwifery Revalidation Report (2018/19)

The Group Chief Nurse presented the second annual report for Manchester University NHS Foundation Trust (MFT) to provide assurance on Nursing and Midwifery Revalidation to the Board of Directors. She explained that within the report, the data was reported from 1st April 2018 to 31st March 2019.

The Board was reminded of the background and details of the requirements (since April 2016) for all Nurses and Midwives to undergo a three yearly process of revalidation to demonstrate that their practice was in line with the Code (Nursing and Midwifery Council (NMC) (2015). The Board also noted the National process and the implementation process and especially that the Group Chief Nurse remained the responsible officer for all nursing, midwifery and nursing associate revalidation, supported by the Deputy Chief Nurse and the Hospital/MCS/MLCO Directors of Nursing/Midwives.

The Group Chief Nurse confirmed that for the period 1st April 2018 to 31st March 2019, 1,967 nursing and midwifery staff were due to revalidate with 1,965 successfully completing revalidated. She explained that two nurses did not revalidate during the period; explaining that one did not require NMC registration for their employed role in the Assault Centre, and, the other nurse allowed their NMC registration to lapse due to family circumstances (and this was following communication with the Director of Nursing/Midwifery and the NMC). It was noted the NMC register showed that this nurse had now completed the revalidation process following a period when she was not on the NMC register.

The Group Chief Nurse explained that the Trust had developed and delivered a range of mechanisms to prepare its Nurses, Midwives, Nursing Associates and their managers for the requirements of revalidation. Nursing and Midwifery Revalidation was now embedded across MFT. It was noted that there was continued support of registrants to ensure that they successfully revalidate remained a core patient safety objective for the Trust.

The Board of Directors receive the report for assurance regarding the NMC revalidation process.

Decision:	Report Received for Assurance	**Action by:** n/a	**Date:** n/a

Annual Accreditation Report (2018/19)

The Group Chief Nurse reported that the MFT Accreditation process was part of the Trust's assurance mechanisms for ensuring the provision of high quality care and the best patient experience. She explained that following the establishment of the Trust in October 2017, the MFT Accreditation Programme was developed and commenced on April 1st 2018. The Board was reminded that the Accreditation assessment models and criteria were developed for wards, day case areas, emergency departments, theatres, treatment centres, outpatient departments and community services. It was also explained that the process for each of the accreditations was designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

The Group Chief Nurse confirmed that in total 153, had been accredited during 2018/19 utilising the newly designed MFT Accreditation assessment, establishing a baseline position for MFT. She explained that the Accreditation involved assessment against agreed criteria for each standard and was scored as 'Gold', 'Silver' or 'Bronze'. The Board noted that the collated result across all categories provided an overall result for the area.

It was also noted that the areas that could not demonstrate they were achieving minimum accreditation standards were described as 'White', indicating the requirement for an intensive support package.

The Group Chief Nurse explained that in 2018/19, 35% of areas attained 'Gold', 46% attained 'Silver' and 19% attained 'Bronze' status and she was pleased to confirm that no area had been classified as 'White'.

The Board was advised that areas attaining Gold were presented with their certificates by the Hospital/ Managed Clinical Service Director of Nursing and/or the Chief Executive and representatives were invited to the 'MFT Excellence Awards' in March 2019 in recognition of and to celebrate, their achievement.

The Board noted the content of the report which provided analyses of the specific leadership assessment within the Accreditation process compared to the overall Accreditation result; demonstrating the correlation between effective leadership and high performing teams. It was particularly noted that the correlation between human resource metrics and the overall Accreditation result had been explored and that the overall Accreditation results included human resource indicators which demonstrated no direct correlation between turnover, sickness or vacancy rate and the Accreditation outcome.

The Group Chairman commended the report and invited the Group Non-Executive Directors to triangulate the key findings of the report during their 2019/20 programme of Senior Leadership Walkabouts.

The Group Board of Directors noted the content of the report and the plans for the MFT Accreditation Programme 2019/20 (as presented).

Decision:	Report Noted	**Action by:** n/a	**Date**: n/a

Report on the 2019/20 NHSI FT Self-Certification

The Group Executive Director of Workforce & Corporate Business reminded the Board of Monitor's healthcare licensing regime and that all NHS Foundation Trusts were required to self-certify whether or not they had complied with the conditions of the NHS provider licence, had the required resources available if providing commissioner requested services, and, had complied with governance requirements.

The Board was also reminded that MFT had an NHS Provider Licence (No. 130164) and the guidance issued by NHSI in April 2017 required NHS Providers to self-certify only three Licence Conditions after each financial year-end, namely, Condition G6(3); Condition G6(4); Condition FT4(8); and, Condition CoS7(3).

The Group Executive Director of Workforce & Corporate Business provided an overview of the evidence presented for each condition and following a short discussion it was agreed that based on the evidence highlighted in the supporting documentation, Condition G6(3) & Condition G6(4) Self-Certification would be formally signed-off as 'Confirmed'. Similarly, and based on the evidence highlighted, the Board agreed that declaration 'B' within the Condition CoS7(3) Self-Certification would be formally signed-off as 'Confirmed'.

With regards to Condition FT4(8), it was noted that the Board had already received an electronic copy of the *draft* summary set of evidence to support this Condition with the aim of identifying any risks with compliance and any action taken, or, being taken to maintain future compliance.

It was agreed that the Board would review and comment (via the Board Secretary) on the draft governance statements during May and early June 2019 and that the Group Chairman & Chief Executive would be given delegated authority to 'sign-off' the Self-Certification ('Condition FT4(8)') in order to meet the self-certification deadline of 30th June 2019; which was prior to the next Board of Directors meeting on 8th July 2019.

The Board approved Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) as 'Confirmed' and agreed that the Group Chairman & Chief Executive would be given delegated authority to 'sign-off' the Self-Certification ('Condition FT4(8)') in order to meet the self-certification deadline of 30th June 2019.

Decision:	Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) approved as 'Confirmed' Delegated authority agreed for the Group Chairman & CEO to sign-off Condition FT4(8) before 30.06.19	**Action by:** Trust Board Secretary Trust Board Secretary	**Date:** 31st May 2019 30th June 2019

Board of Directors Declaration of Interests (April 2019)

The Board received and noted the Board of Directors Declaration of Interests (April 2019). It was noted that the document would be published on the MFT Public Website.

Decision:	Board of Directors Declarations of Interests (April 2019) received and noted.	**Action by:** n/a	**Date:** n/a

Board Assurance Framework (April 2019)

The Board of Directors received the new version of the Board Assurance Framework (April 2019) and noted the updated Strategic Aims and associated Key Priorities for 2019/20.

The Group Executive Director of Workforce & Corporate Business explained that the new 2019/20 BAF had now been further developed and refined following a developmental review of Leadership & Governance arrangements using the 'Well Led' framework during the Summer 2018, an Internal Audit review of the BAF in October 2018 followed by key recommendations from a Task & Finish Group (consisting of Group Non-Executive Directors and Group Corporate Directors) during Q3 and early Q4 2018/19. The Board was reminded that the refinements now included in the new 2019/20 BAF were presented to, and, approved by the Audit Committee in February 2019 and ratified by the Board of Directors in March 2019.

Mr Gower (Chairman of the MFT Audit Committee) welcomed the new BAF and explained that any further refinements, adopting a formative approach, would be overseen and monitored by the Audit Committee (on behalf of the Board of Directors) going forward.

Decision:	New version of the MFT BAF (2019/20) received by the Board	**Action by:** n/a	**Date:** n/a

Committee meetings which had taken place:

- Group Risk Management Committee held on 4th March 2019
- Audit Committee held on 3rd April 2019
- Finance Scrutiny Committee on 13th March 2019
- Quality & Performance Scrutiny Committee on 2nd April 2019
- Charitable Funds Committee held on 11th March 2019
- MLCO Scrutiny Committee held on 6th March 2019
- HR Scrutiny Committee Stock Take held on 16th April 2019

80/19 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 8th July 2019** at **2pm** in the **Main Boardroom**

81/19 Any Other Business

There was no other business.

Present:	Professor Dame S Bailey	- Group Non-Executive Director
	Mr D Banks	- Group Director of Strategy
	Dr I Benett	- Group Non-Executive Director
	Mr P Blythin	- Group Director of Workforce & Corporate Business
	Mrs J Bridgewater	- Group Chief Operating Officer
	Mrs K Cowell (Chair)	- Group Chairman
	Mr B Clare	- Group Deputy Chairman
	Sir M Deegan	- Group Chief Executive
	Professor J Eddleston	- Joint Group Medical Director
	Mr N Gower	- Group Non-Executive Director
	Mrs G Heaton	- Group Deputy CEO
	Mrs M Johnson	- Group Director of Workforce & OD
	Professor C Lenney	- Group Chief Nurse
	Mrs C McLoughlin	- Group Non-Executive Director
	Miss T Onon	- Joint Group Medical Director
	Mr T Rees	- Group Non-Executive Director
	Mr A Roberts	- Group Chief Finance Officer
In attendance:	Mr D Cain	- Deputy Chairman Fundraising Board
	Mr M McCourt	- Chief Executive, MLCO
	Mr A W Hughes	- Director of Corporate Services/Trust Board Secretary
Apologies:	Mr J Amaechi	- Group Non-Executive Director
	Professor L Georghiou	- Group Non-Executive Director

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 14th January 2019			
Action	Responsibility	Timescale	Comments
Follow-up report on the Gosport Improvement Programme to be provided in the Summer 2019,.	Joint Group Medical Director	July 2019	*On the Agenda*
Update Report on progress with Never Events actions	Joint Group Medical Director	July 2019	*On the Agenda*

Board Meeting Date: 11th March 2019			
Action	Responsibility	Timescale	Comments
Refinements to the cancelled operations dataset to be presented to the QPSC	Group Chief Operating Officer	June 2019	*Completed*
Progress Report on the Nursing & Midwifery Retention Programme Work Streams to be presented to the HR Scrutiny Committee and the Board of Directors	Group Chief Nurse	September 2019	*Scheduled for September 2019*
Priority areas for action from the 2018 National Staff Survey to receive a mid-year review of progress against agreed actions by the HR Scrutiny Committee.	Group Executive Director of Workforce & Corporate Business	October 2019	*Scheduled for October 2019*

Board Meeting Date: 13th May 2019			
Action	Responsibility	Timescale	Comments
Further update on the Management of Never Event's to be presented to the next Board of Directors	Joint Group Medical Director	July 2019	*On the Agenda*
MFT Staff Survey to be presented to the HR Scrutiny Committee	Group Executive Director of Workforce & Corporate Business	June 2019	*Completed*
The Board delegated authority to the MFT Audit Committee for the formal sign-off of the MFT Annual Report & Accounts (inc. the Annual Quality Account and Annual Governance Statement) for 2018/19.	The Chief Finance Officer. and, Chair of the Audit Committee	22nd May 2019	*Completed*
Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) approved as 'Confirmed'	Trust Board Secretary	31st May 2019	*Completed*
Delegated authority agreed for the Group Chairman & CEO to sign-off Condition FT4(8) before 30.06.19	Trust Board Secretary	30th June 2019	*Completed*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Gareth Summerfield, Head of Information Information Management, MFT
Date of paper:	May 2019
Subject:	Board Assurance Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Gareth Summerfield, Head of Information Tel: 0161 276 4768

> Board Assurance Narrative Report – Guidance Notes

The purpose of this document is to assist with the navigation and interpretation of the Board Assurance Report, taking into account Trust performance, indicator statuses, desired performance thresholds as well as who is accountable for the indicator. The report is made up six distinct domains as follows: Safety, Patient, Operational Excellence, Workforce & Leadership, Finance, and Strategy. Each domain is structured as follows:

Summary Bar (Example –Safety Domain)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

- 3 indicators are flagged as achieving the Core Priorities desired threshold
- 1 indicator is flagged as a warning. A warning may relate to the indicator approaching a threshold or exceeding the threshold by a set margin.
- 1 indicator is flagged as failing the desired threshold
- 0 indicators have no threshold attributed. In some cases, indicators will not have a national of local target/threshold in which to measure against.

Headline Narrative

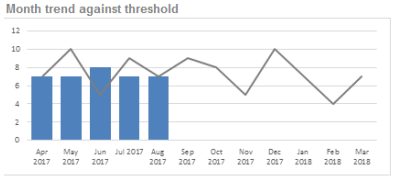
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities

Hospital Incidents level 4-5
MFT

Actual	36	Year To Date	Accountability	R.Pearson\T.Onon
Threshold	38	(Lower value represents better performance)	Committee	Clinical Effectiveness

Month trend against threshold



12 month trend (Sep 2016 to Aug 2017)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Manchester Royal Eye Hospital	Royal Manchester Children's Hospital	St Mary's Hospital	Trafford General Hospital	University Dental Hospital of Manchester	Wythenshawe Hospital
✓	✓	✓	✓	✓	✓	✓	×

This is a broad, all embracing category covering incidents at a high level e.g. falls, pressure ulcers, medication errors etc.

Key Issues
Serious harm (level 4 & 5 actual harm incidents). The organisation continues to report high numbers of patient safety incidents per 1000 bed days, 57.69 in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents. The CQC described a culture of reporting and learning from incidents.

Key issues are a plateau in the level of actual serious harm over the last year against a planned 5% reduction and small cohorts of staff describing dissatisfaction with the reporting and investigation process. A small decrease has been observed in the first 3 months of this year which if sustained would result in achievement of 5% reduction.

Actions
The thematic reports detailed in the last narrative are reviewed at a number of forums and have informed the 2016/17 work plans.

Communication of test results remains a focus and work is underway to further develop the clincal risk plan in respect of communication and response to clinical tests.

Each of the individual core priorities are set out as above. Firstly with an individual summary bar detailing:

- **Actual** – The actual performance of the reporting period
- **Threshold** – The desired performance threshold to achieve for the reporting period. This may be based on a national, local, or internal target, or corresponding period year prior.
- **Accountability** - Executive lead
- **Committee** – Responsible committee for this indicator
- **Threshold score measurement** – This illustrates whether or not the indicator has achieved the threshold, categorised into three classifications: Meeting threshold (green tick), approaching threshold (amber diamond) and exceeding threshold (red cross). Amber thresholds are indicator specific.

Below the summary box detail on the left hand side of the page are 3 graphics, as follows:

- **Bar Chart** – detailing the monthly trend (bar) against the threshold for this particular indicator (line)
- **12 month trend chart** – Performance of this indicator over the previous 12 months.
- **Hospital Level Compliance –** This table details compliance of the indicator threshold by hospital

On the right hand side of these graphics is the executive narrative which details the key issues behind indicator compliance and the actions in place to mitigate this.

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

May 2019

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	5	0	1	0

Headline Narrative

Core priorities for patient safety are currently being met with one exception. The Group has had a number of Never Events reported over the last 12 months. Since June 2018 there have been four reported events.

In response to this the following actions are underway and will be included in a review of the group risk (Never Events - 3228).

- New MFT Policy in place for Safe procedures and being implemented
- Group wide work is being undertaken on Safe Surgery/Procedure Checklists
- Work is being undertaken with the National Health Safety Investigation Branch (HSIB) on learning
- Work is being undertaken with the Shelford Safety leads to ascertain if there is further learning and action that can be shared
- A further Safety Alert has been circulated to all Hospital sites with required actions

-All Hospital Sites / MCS are undertaking risk assessment for each Never Event typeincluding identifying controls in place and actions required and adding to the Risk Register
The Quality and Safety Committee will be overseeing this work and the aim continues to be to eradicate these events.

Serious harm incidents so far this year are just below the threshold compared with same period last year.

Mortality Metrics at Group level continue to be within accepted performance level and improving over time. Mortality Review procedures are under review and awaiting National guidance before finalising.

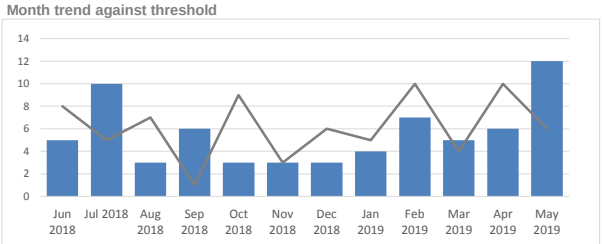
Safety - Core Priorities

Hospital Incidents level 4-5

✕

Actual 18 Year To Date **Accountability** J.Eddleston\T.Onon
Threshold 16 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✕	✓	✓	✕	✓	✕
0	8	0	1	1	0	8

This is a broad, all embracing category covering incidents at a high level e.g. falls, pressure ulcers, medication errors etc. (These figures include incidents that are unconfirmed so may decrease)

Key Issues

Serious harm (level 4 & 5 actual harm incidents). The organisation continues to report high numbers of patient safety incidents per 1000 bed days, 53.03 in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents.

The overall number of serious harm incidents ytd compared to the same period last year is slightly lower. In terms of hospital sites the threshold is based on the same period last year and it can be seen that a small increase has been observed in some sites, however these are small numbers and natural variation will occur and a number of these remain unconfirmed. In addition as services change / reconfigure this may impact on this method. Therefore alternative approaches to this are being considered.

Actions

Communication of test results remains a focus across the Group and work is underway to further develop the clinical risk plan in respect of communication and response to clinical tests.

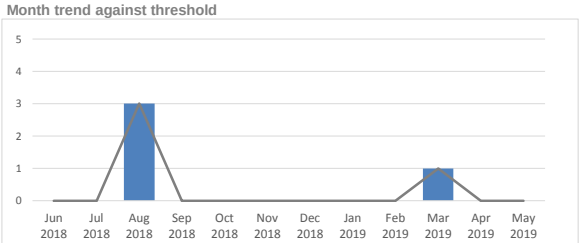
Thematic reports are reviewed at a number of forums and will inform the 19/20 work plans.

Never Events

✓

Actual 0 Year To Date **Accountability** J.Eddleston\T.Onon
Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
0	0	0	0	0	0	0

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally.

Since June 2018 there have been four Never Events 2 misplaced NG Tubes in critical care areas, 1 wrong site surgery and 1 wrong implant. Investigations for all of these are complete with a range of actions being implemented.

Actions

Working groups are reviewing local risks and implementing solutions to reduce harm with the ongoing implementation of Local Safety Standards for Invasive Procedures (LocSSIPs).
The never events risk is under review.

Progress

Following these events a number of immediate actions were implemented including issuing of Trust wide alerts. Investigations have been undertaken to identify learning with associated action plans in place. In addition we are working with the Healthcare Safety Investigation Branch on the wrong route medication Never Event to contribute to national learning and solution development.

A new MFT Safe Procedure Policy is now in place. Further work is now being undertaken Group wide on safer surgery/ procedure checklists and item counts, this work will be reported to the Quality and Safety Committee.

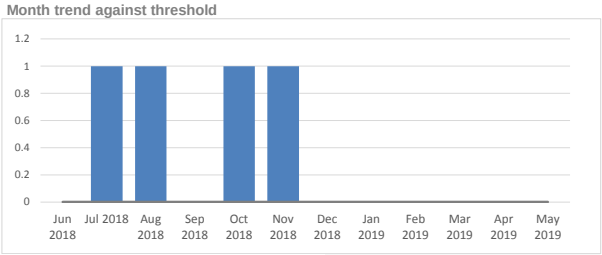
> Board Assurance

May 2019

Mortality Reviews - Grade 3+ (Review Date)

Actual	0	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
0	0	0	0	0	0	0

The number of mortality reviews completed where the probability of avoidability of death is assessed as definitely avoidable.

Key Issues

Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care.

The role of the Group Mortality Review Group in supporting dissemination of good practice, lessons and action plans is being developed. Mortality review processes are generally robust, but will be altered by the introduction of a Medical Examiner system. A deficiency in mortality review for patients with learning disability has been identified, and a new process commenced.

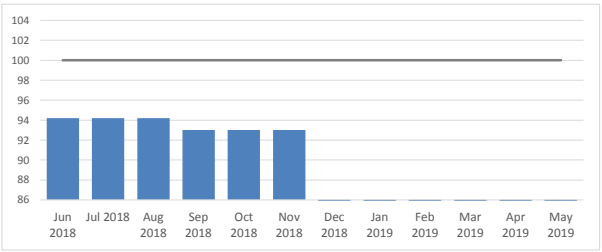
Overall, mortality metrics suggest that the work programs of 2017/2018 to address coding issues have been successful, but that co-morbidity coding requires further work.

Actions

The creation of MFT has provided an opportunity to re-evaluate the approaches to learning from deaths in both organisations, and to implement a new policy based on national guidance and best practice in both organisations. Going forward, the focus will be on learning from deaths, and dissemination of the resulting changes and developments in practice across the organisation.

SHMI (Rolling 12m)

Actual	93.0	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	96.0	NA	NA	NA	NA	92.4

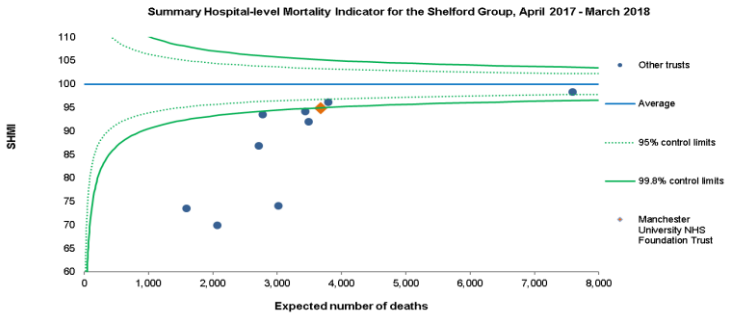
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline.

Progress

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

SHMI is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded). Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review.

Performance is well within the expected range.

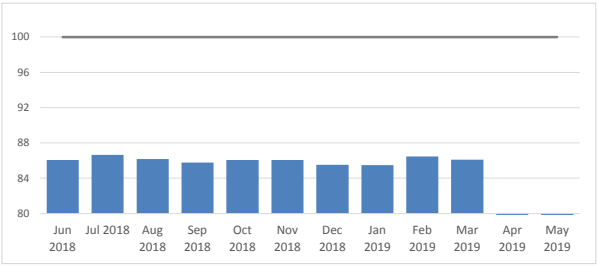


> Board Assurance

May 2019

HSMR (Rolling 12m)

Actual	86.1	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



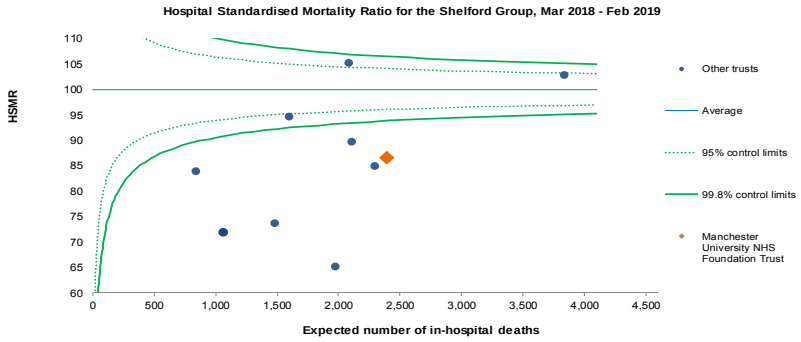
HSMR monitors a Trust's actual mortality rate when compared to the expected mortality rate. It specifically focuses on 56 diagnosis codes that represent 85% of national admissions.

HSMR is a metric designed for adult practice.
Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review
HSMR is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded)

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

Progress

The Group HSMR is within expected levels.



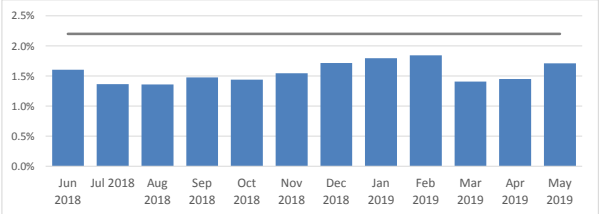
Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	80.8	NA	NA	NA	NA	86.0

Crude Mortality

Actual	1.55%	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period.

Key Issues

Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment.

For the Crude Mortality the latest figures are within acceptable range.

Progress

The Trust is currently reviewing Elective crude mortality which whilst still low has increased in the quarter.

There is currently consideration being given to mortality metrics in RMCH, deaths per 1000 bed days will now be reported to allow for additional benchmarking with other specialist children's hospitals.

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	✓	◇
NA	1.6%	0.1%	0.4%	0.0%	0.0%	2.4%

Patient Experience

C.Lenney

Core Priorities	✓	◇	×	No Threshold
	5	1	1	2

Headline Narrative

The number of new formal complaints received across the Trust during May 2019 was 130; compared to 121 in April 2019 and 165 in March 2019. Performance is monitored and managed through the Accountability Oversight Framework (AOF). At the end of May 2019 there was a total of 33 cases over 41 days, compared to 32 cases at the end of April 2019 and 37 cases at the end of March 2019, which refelcts a relatively static position in May 2019 when compared to April. The closure of complaints within the agreed timescales across MFT in May 2019 was 51.1%, compared to 57.7% in April 2019 and 72.6% in March 2019, which reflects a decrease in the number of complaints resolved within the timeframe agreed with the complainant.

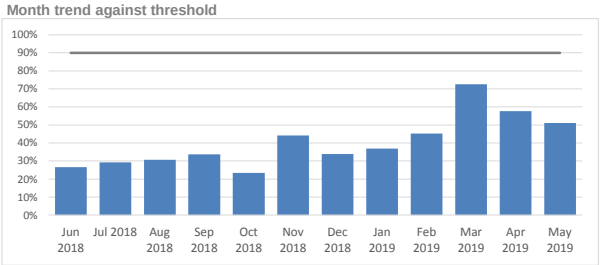
Infection prevention and control remains a priority for the Trust. Trust performance for the current financial year (until the end of May 2019) is below trajectory for CDI but above trajectory for MRSA due to one case being reported in May (against a threshold of zero).

Patient Experience - Core Priorities

Percentage of complaints resolved within the agreed timeframe ×

Actual	54.6%	Year To Date		**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)		**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
×	×	×	◇	◇	×	◇
46.2%	38.6%	45.7%	74.2%	72.7%	50.0%	75.0%

The Trust has a responsibility to resolve complaints within a timeframe agreed with the complainant. The timeframe assigned to a complaint is dependent upon the complexity of the complaint and is agreed with the complainant.

Progress

The percentage of complaints resolved within the timeframe agreed with the complainant is closely monitored and work is on-going with Hospital/MCS management teams to ensure timeframes are appropriate, agreed with complainants and achieved.

The overall MFT performance for May 2019 was 51.1% compared to 57.7% in April 2019 and 72.6% in March 2019.

In July 2018, the closure of complaints within the agreed timescales at Manchester Royal Infirmary (MRI) was 13.9%. The issue was identified and an improvement programme was developed with an agreed trajectory for improvement. Closure of cases within agreed timeframe at MRI was 46.9% in March 2019, 37.8% in April 2019 and 39.1% in May 2019 demonstrating an slight improvement in May 2019 compared with April 2019.

The Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. It should be noted that where Hospitals/MCS receive lower numbers of complaints, small numbers can result in high percentages.

Actions

Performance is monitored and managed through the Accountability Oversight Framework (AOF).
MRI is currently receiving additional supported from the Corporate Team to increase compliance with this indicator.

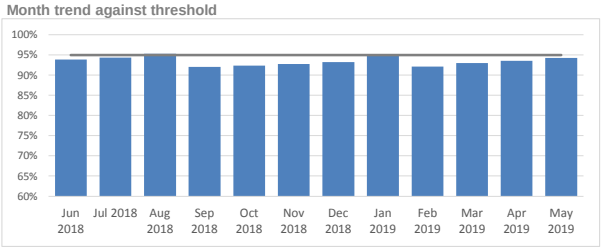
> Board Assurance

May 2019

FFT: All Areas: % Extremely Likely and Likely

Actual	93.9%	Year To Date	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	✓	◇	✓	◇
93.7%	92.4%	91.2%	97.3%	93.8%	96.8%	94.7%

The Friends and Family Test (FFT) is a survey assessing patient experience of NHS services. It uses a question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, a person is to recommend the service to a friend or family member if they needed similar treatment. This indicator measures the % of inpatients 'extremely likely' and "likely" to recommend the service.

Actions

Each Hospital/Managed Clinical Service reviews and monitors of FFT response rates and patient feedback to identify any areas for improvements in order to increase response rates and act upon the feedback received.

The Quality Improvement Team and Patient Experience Teams are working with our provider for patient experience and Hospitals / MCS to support consistent collection of FFT feedback and supporting training on the Meridian reporting system.

Progress

The Quality Improvement Team and Patient Experience Teams continue to work with Hospitals / MCS teams to support collection of FFT feedback.

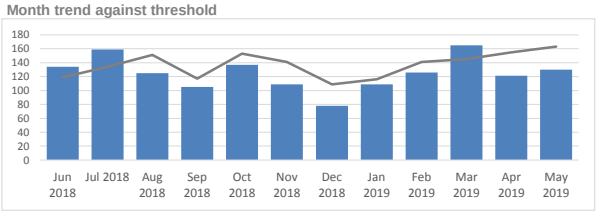
The overall response rate for Inpatients in May 2019 was 22.4%, this compares to 23.6% in April 2019 and 17.1% in March 2019.

For our Emergency Departments the response rates in May 2019 was 12.1%, this compares to 11.3% in April 2019 and 11.7% in March 2019.

Complaint Volumes

Actual	251	Year To Date	**Accountability**	C.Lenney
Threshold	318	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✗	✓	✓	✓	✓
13	68	30	29	11	5	86

The KPI shows total number of complaints received. Complaint volumes will allow the trust to monitor the number of complaints and consider any trends.

Key Issues

The number of new complaints received across the Trust in May 2019 was 130. This compares to 121 in April 2019 and 165 in March 2019.

WTWA received the highest number of formal complaints in May 2019 receiving 51 complaints. This number is higher than the number received by WTWA in April 2019 (35) and March 2019 (49).

At the end of May 2019, there was a total of 33 cases over 41 days old, this compares to 32 cases at the end of April 2019 and 37 at the end of March 2019. The Hospital/MCS with the highest number of cases over 41 days at the end of May 2019 was MRI with 15 (45% of total) cases at 41 days old.

Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart.

Actions

All Hospitals/MCS continue to prioritise closure of complaints older than 41 days. Chief Executives are held to account for the management of complaints cases that exceed 41 days through the Accountability Oversight Framework (AOF).

Progress

All Hospitals/ MCS have established their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying learning to inform future complaints prevention and management.

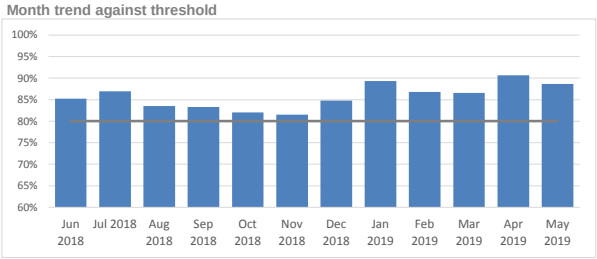
> Board Assurance

May 2019

Nursing Workforce – Plan v Actual Compliance for RN

Actual	88.7%	Latest Period	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	NA	✓
NA	84.9%	86.9%	91.2%	80.9%	NA	91.2%

As part of Safer Staffing Guidance the Trust monitors wards compliance with meeting their planned staffing levels during the day and night. This KPI provides the overall % compliance across all wards within the Trust with meeting the planned staffing levels. The actual staffing includes both substantive and temporary staff usage.

Progress

At the end of May 2019 there were 14 (15%) inpatient wards across the Group that had a registered nurse vacancy factor above 25%. The nurse fill rate continues to reach the 80% target with a fill rate of 88.7% this month. This is a slight reduction on the previous month when the fill rate was 90.6% .
Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels to meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals

Actions

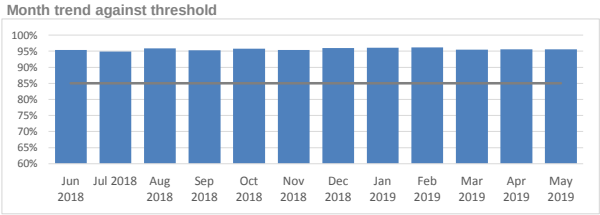
Where shortfalls in nurse staffing levels occur and this cannot be resolved, staff are redeployed from other areas following a risk assessment and professional judgement based on the acuity and dependency of patients in each area. Nursing assistant levels are increased in some areas to support such a shortfall and provide care and enhanced supervision for less acute but dependant patients. These processes are reviewed by the Directors of Nursing for each Hospital/MCS on a weekly basis.

Acuity and dependency data is captured through the Allocate SafeCare system which supports daily deployment of nursing staff. The Safer Care Nursing Tool (SNCT) has been introduced to support establishsment reviews. The hopitals are curently completing a 2nd data census to determine the acuity and dependancy of patients on their wards. This data will support annual establishment reviews to ensure wards are staff safely based on patients needs

Food and Nutrition

Actual	95.6%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✓
98.4%	95.6%	90.5%	97.7%	97.2%	75.0%	96.3%

The KPI shows the % of the total responses to food & nutrition questions within the Quality Care Round that indicate a positive experience.

Progress

Improvement work continues at both Ward and Trust-wide level across all aspects of food and nutrition. Patient Dining Forums are established for ORC and WTWA. The Oxford Road Campus Improvement Programme 'Good to Great' is now led by the Head of Nursing (Quality and Patient Expereince) the Improvement Programme has been rolled out to WTWA, led by the Deputy Director of Nursing.

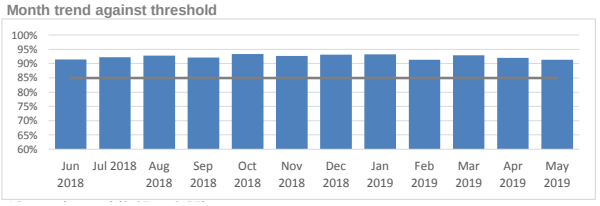
The MFT Nutrition and Hydration (food and drink) Strategy 2019-2022 was launched as part of Nutrition and Hydration Week in March 2019. The Strategy sets out our commitments to improve Nutrition and Hydration.

The Hospital/ MCS progress relatedto delivering the commitments withing the Nutrition and Hydration Strategy is monitored through the Trust Patient Experience and Quality Forum.

Pain Management

Actual	91.7%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
95.9%	86.5%	86.6%	95.7%	98.6%	100.0%	93.9%

The KPI shows the % of the total responses to pain management questions within the Quality Care Round that indicate a positive experience.

Progress

Work continues across the Trust to drive improvements in pain assessment and management.
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm Free Care structure.

> Board Assurance

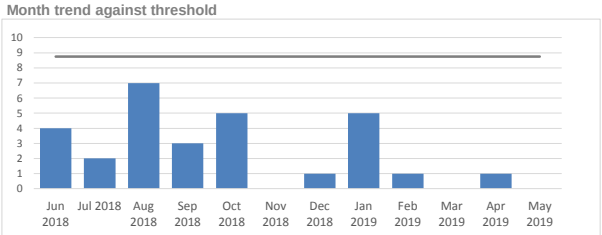
May 2019

Clostridium Difficile – Lapse of Care

✓

Actual	1	Year To Date	**Accountability**	C.Lenney
Threshold	114	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
0	1	0	0	0	0	0

Each Clostridium difficile infection (CDI) incident is investigated to determine whether the case was linked with a lapse in the quality of care provided to patient. The maximum threshold for the Group is 105 lapses in care. The contractual sanction applied to each CDI case in excess of the target is £10,000. The KPI shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient.

Progress

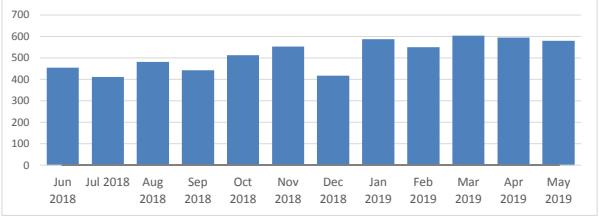
There have been a total of 32 cases of Clostridium difficile infection reported since April 2019, there have been no cases reported in the month of May: 18 of which were trust-attributable against a trajectory of 36. Following CCG review, there have been three lapses in care identified: one lapse in care identified at MRI (HPB) and two lapses in care identified at Wythenshawe Hospital (Ward A4 and Ward A1), with 9 cases pending review

PALS – Concerns

-

Actual	1174	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
64	302	118	100	72	35	369

The number of PALS enquires received by the Trust where a concern was raised.

Key Issues

A total of 580 PALS concerns were received by MFT during May 2019. This compares to 594 PALS concerns received in April 2019 and 604 in March 2019. This is within the limits of normal seasonal variation and is monitored closely.

The Hospital / MCS level performance against this indicator for year to date is detailed in the Hospital/ MCS Level Compliance Chart.

Actions

PALS concerns are formally monitored alongside complaints at weekly meetings within each Hospital / MCS.

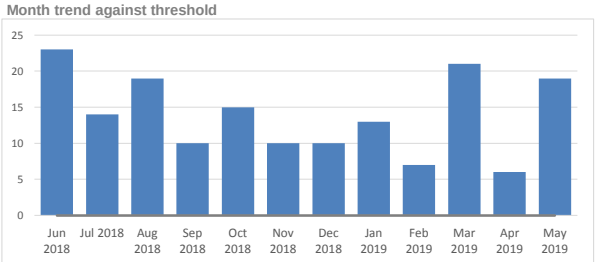
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

-

Actual	25	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
2	13	1	1	0	0	8

MRSA and E.coli. There is a zero tolerance approach to MRSA bacteraemia.
For healthcare associated Gram-negative blood stream infections (GNBSIS), trusts are required to achieve a 25% reduction in healthcare associated GNBSIs by April 2022, and a 50% reduction by April 2024. There are currently no sanctions applied to this objective

Progress

There have been 92 E. coli bacteraemias reported since April 2019: 24 of which were trust-attributable. There was one MRSA bacteraemia reported during May 2019 (Acute ICU: Wythenshawe).

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	6	1	4	0

Headline Narrative

• Diagnostic standard - MFT delivered a performance of 1.12% This is significantly better than the latest reported national picture of 2.1% March 2019. Key area of risk remains Adult Endoscopy with actions in place to address this. SMH have also experienced 7 breaches in Urodynamics with actions taken by the senior management team to review capacity. The priorirty to deliver access and turnaround of diagnostics in the Cancer Pathway places this standard at risk.

• A&E 4 hours - In May MFT had a performance of 84.5% and ranked 3rd across GM. Performance into June remains challenged, in line with the national and regional positions. Patient safety remains a key priority with strong performance for ambulance handover and no 12 hour trolley waits. Focus remains on improving overnight performance, flow within the hospitals and timely discharge, and working with system partners on reducing demand and long length of stay.

• RTT - May performnace is reported as 84.1% which is below the National profile, but in line with actions being taken via the Trust RTT Task Force. The Trust waiting list increased across 18/19 due to a combination of factors related to: growth, changes to the Trust PAS system, data quality and reporting and prioritisation of capacity to treat the longest wait patients. Progress updates have been provided to the Trust Quality and Safety and Quality and Performance Scuritny Committees outlining the factors and ongoing actions, with oversight maintained through the RTT Task Force and close working with Commissioners. The waiting list size trajectory has been delivered in both April and May, at -0.5% better than trajectory.

• +52 week Waits - The Trust delivered its committment to eliminate all 52 week waits with zero reported in May.

• Cancer 62 Day - As expected in line with action taken to treat a number of the longest wait patients and improve the size of the cancer patient tracking lists, Q4 performance reduced to 77.4%. Performance was challenged across the MRI, SMH and WTWA. Focused action is being taken to implement the actions identified from the January Cancer Committee. In Q1 there is emergence of improving performance at the MRI, however WTWA remains challenged due to capacity pressures within the Lung pathway and decdicated action is being taken to address this.

• Cancelled operations >28 days - There were 6 reportable breaches in April, which improved to 0 in May.

•The Board Assurance includes data aligned to Managed Clinical Sites, and whilst some sites will note a shift in performance, there has been no change to final submissions for the Trust.

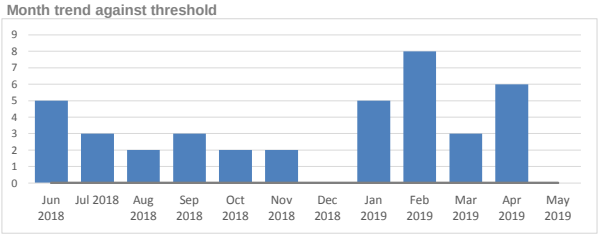
Operational Excellence - Core Priorities

Cancelled operations - rescheduled <= 28 days

✕

Actual	6	Year To Date	**Accountability**	J.Bridgewater
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✕	✓	✓	✓	✓	✕
0	1	0	0	0	0	5

Patients who have operations cancelled on or after the day of admission (for non clinical reasons) must be offered a binding date for their surgery to take place within 28 days.

Key Issues

Risk of non elective patient outliers in elective bed capacity.
System response to stranded patients > 7 and >21 days.
Urgent and emergency care pressures
Complex patients requiring specialist skills and beds

Actions

Cancelled operations are escalated and overseen through Hospital / MCS performance meetings, including risks to the 28 day standard.
Capacity and Demand plans are in place to support Trust bed requirements which is a factor in cancellations.

Progress

• Following 6 reported breaches in April and actions taken, there were no 28 day breaches reported in May.
• MFT continues to perform strongly against this target, and remain within the top three acute Trusts in GM.
• MFT typically performs better than the national position against this standard.

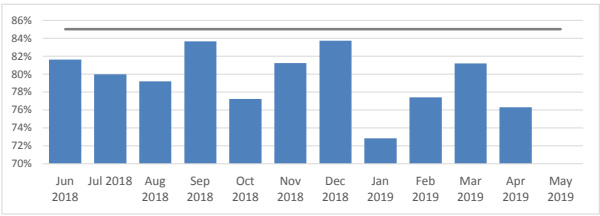
> Board Assurance

May 2019

Cancer 62 Days RTT

Actual	77.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✗
NA	69.8%	100.0%	62.5%	NA	NA	82.8%

The percentage of patients receiving first treatment for cancer following an urgent GP referral for suspected cancer that began treatment within 62 days of referral.

Key Issues

• The Trust continues to experience a significant increase in the demand for cancer services in excess of the national and regional profile, circa 20%.
• Capacity is affected in services where there are known national workforce shortages particularly radiology.

Actions

• Oversight and Monitoring by Hospital Cancer Boards.
• Assurance and challenge through AOF
• Senior Corporate monitoring and escalation of delays in patient pathway on cancer PTL
• Task force established with MRI, CSS and Corporate Performance team to support the review of cancer pathways across the sites.

Key Hospital/MCS Actions:
• Speciality level recruitment of workforce to match demand.
• Pathway developments i.e. Lung, LGI
• SMH increasing 2ww and diagnostic capacity
• CSS increasing diagnostic scan and reporting capacity
• A joint working group between the Performance Team and Hospital Director of Operations are progressing actions from the January Cancer Committee and will continue to report progress to Committee.
• Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity tools, strengthening training for teams.

Progress

•The Trust is underperforming against the 62 day standard,
• Q4 performance reduced to 77.4% in line with actions to improve the patient tracking list size and increase the number of treatments undertaken. .
• Across the quarter there was an improving trend in performance, with January and Febuary the most challenged months. MRI improved month on month shifting upwards from circa 70% to 80% in April. However, this has been off set by a deterioration in performance at WTWA, which traditionally delivers but has experienced pressures within the lung pathway.
• Gynaecology is a high risk area for SMH.
• There has been some improvement in Radiology reporting turnaround times, although capacity gaps remain in specialist tests. In addition, national best practice pathways are driving lower scan/reporting turnaround times than MFT is currently delivering presenting a further demand/capacity challenge.
• NHSI enhanced training attended by Cancer Manager to explore further improvement opportunities across networks.
• The GM region is also experiencing increased pressure with demand growth, which is impacting on performance across a number of providers and underperformance of the 62 day standard.
• National underperformance continues against the standard: Q1 80.9%, Q2 78.6% Q3 79.5%.

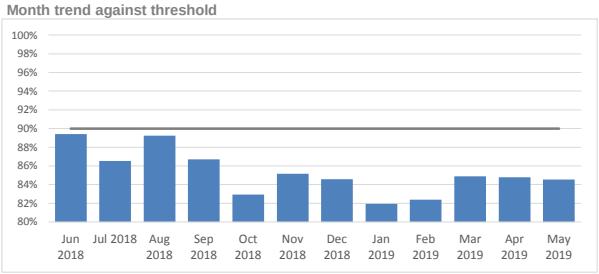
> Board Assurance

May 2019

A&E - 4 Hours Arrival to Departure

Actual	84.65%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.00%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✗	✓	✓	✓	✗
NA	77.7%	87.1%	97.1%	100.0%	99.5%	85.8%

The total time spent in A&E - measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department (by admission to hospital, transfer to another organisation or discharge). With a target that 95% of all patients wait no more than four hours in accident and emergency from arrival to admission, transfer or discharge.

Key Issues

- Mutual aid to other GM providers is a risk of increased pressure on A&E and out of area admissions.
- Increasing numbers of patients >21 days from postcodes outside Manchester in May.
- Greatest challenges by Hospital include: Wythenshawe workforce deficits, MRI capacity and flow, RMCH ED capacity.
- Increased demand seen in Q4 has continued into Q1.
- Community capacity as alternative to A&E, Primary care capacity to facilitate increased streaming.
- Reduction/changes in community/care home capacity across GM.
- Age profile of presentations to Wythenshawe weighted with older, frail patients.
- RMCH has seen a change in demand profile with an increase in acutity and patients requiring critical care.
- Mental Health workforce and bed capacity.

Actions

- Internal oversight arrangements are in place with twice weekly meetings between the Group COO and Hospital Chief Executives.
- Hospitals have a number of plans in place that are being progressed to support resilience including:
  - 2019/20 Capacity Plans
  - Transformation plans and patient flow improvement boards
- Working with system partners and the LCO to reduce long length of stay and improve discharge, with a trajectory in place for 19/20.
- Joint working with GM Mental Health, task force established, working to improve ambulatory pathways and timely assessment of patients.
- Capital upgrade to Wythenshawe, MRI, and PED.
- Treat and Transfer pathways RMCH
- Working with system partners to seek external expertise and assurance in relation to: long length of stay patients and corridor care.
- Supporting GM wider review of Same Day Emergency Care with MRI and Wythenshawe sites have underatken a deep dive of ambulatory care supported by NHS Elect.
- Additional interim actions are being taken to support improvement in performance during June / July, overseen by the Group COO, and supported by additional regional discussions.

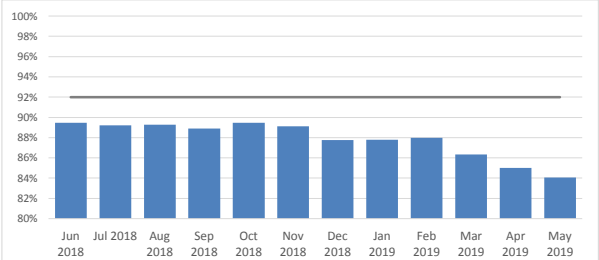
Progress

- MFT reported performance of 84.5% for May, which is a slight reduction compared to April.
- May performance has remained challenged, in line with the national and regional positions. GM perforamnce for May is 83.1%, with MFT rank 5th for the month.
- The Trust is engaging with ECIST to take additional improvement action as recommended.
- The National LLOS reporting tool and workshops are being progressed by the Trust to commence reporting of stranded patients >21days from July.

RTT - 18 Weeks (Incomplete Pathways)

Actual	84.0%	Latest Period	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✗	✗	✗	✗	✗
92.5%	84.3%	82.8%	80.4%	86.0%	83.3%	85.1%

The percentage of patients whose consultant-led treatment has begun within 18 weeks from the point of a GP referral. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.

Key Issues

- Demand for Trust services continues to grow, particularly for specialist services and cancer.
- Capacity and workforce pressures.
- Urgent Care pressures
- Work to upgrade the PAS and 18 week reporting systems is a key risk to growth of the waiting list.

Actions

RTT Taskforce in place, chaired by the Chief Operating Officer and Chief Information Officer

- RTT Recovery programme in place, with delivery across 6 workstreams including 52+ week waits, data quality, PAS upgrade, training and education and outpatient transformation.
- RTT PMO in place to ensure delivery and support to hospitals.
- Continued timely validation of PAS/waiting lists by Hospital sites, and data quality audits on-going.
- Additional resource to support validation and accuracy of data.
- Delivery of Hospital/MCS transformation and capacity plans.
- Development of middle manager elective care education programme, in conjunction with NHS Improvement
- Working with Commissioners in relation to demand management, particularly for specialist hospitals, to support stability of the waiting list.
- Additional independent sector capacity was undertaken in Q4 of 18/19, to support a reduction in the waiting lists
- Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity sustainability tools, strengthening training, knowledge and expertise for hospital teams.

Progress

- The Trust has had no 52 week breaches in April or May. High risk area is Gynaecology on the Oxford Road Campus.
- Trust RTT performance in May is 84.1% which is below the National profile of (86.7% latest March)
- Trust waiting list has increased across the year with a peak in March 19 due to a combination of factors related to growth, changes to the Trust PAS system, data quality and reporting and prioritisation of capacity to treat the longest wait patients.
- Actions outlined above will support stabilisation of the waiting list across 19/20.
- Waiting list performance is currently slightly better than the Trust Trajectory.

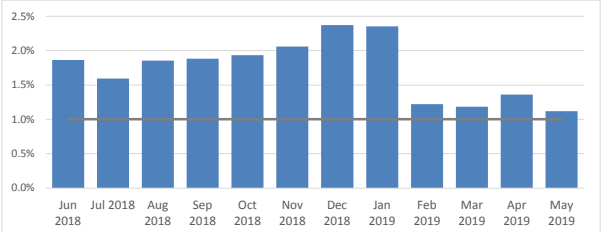
> Board Assurance

May 2019

Diagnostic Performance

Actual	1.1%	Latest Period	**Accountability**	J.Bridgewater
Threshold	1.0%	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	◇	✗	NA	NA	✓
1.0%	2.2%	1.3%	31.3%	NA	NA	0.5%

NB - the % at RMCH and SMH is high due to the small waiting list in this area, the volume of breaches in these areas are marginal

The number of patients waiting over 6 weeks for a range of 15 key diagnostic tests.

Key Issues

- Demand for Diagnostic tests continues to increase in line with urgent and elective care pressures.
- Capacity constraints within adult Endoscopy and paediatric MRI.
- Ability to secure ad hoc sessions and workforce to increase capacity.
- Prioritisation of cancer scanning/reporting, with is also increasing, is a risk to routine capacity.

Actions

- Recovery trajectory in place for the key under performing tests with monitoring through the Trust AOF process.
- Implemntation of Hospital and particularly CSS capacity plans.
- Implementation of the business case for the 3rd MRI scanner.
- Additional recurrent radiology sessions.
- Intensive actions being undertaken in adult endoscopy by MRI Director of Operations and include: Review of scheduling, utilisation of clinics, securing additional capacity through the private and community sector.
- Monthly forecasting in place, risks escalated to Hospital Directors.

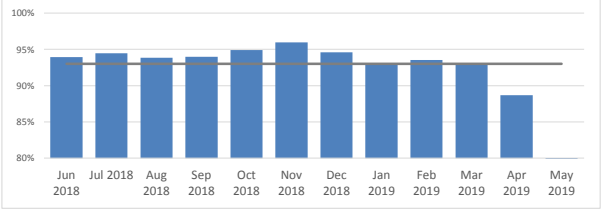
Progress

- Improved May Performance, reporting 1.12%. Latest reported National Picture is: 2.1% (March 2019)
- Significant progress in month, June forecast is predicting a static performance for the month, based on first draft Hospital assessment.
- Key area of risk remains adult and childrens Endoscopy, and Urodynamic SMH. Focused work is being undertaken in these areas to improve capacity and efficiency.

Cancer Urgent 2 Week Wait Referrals

Actual	93.1%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✓	✗	NA	NA	✓
NA	89.5%	100.0%	79.3%	NA	NA	96.8%

The percentage of patients urgently referred for suspected cancer by their GP that were seen by a specialist within 14 days of referral.

Key Issues

Increased demand in 2 week wait referrals continues to place pressure on MFT cancer services, creating capacity pressures.

Actions

Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
SMH have reviewed the Gynaecology pathway and have an action plan in place, although additional support is being put in place in Q1 / Q2 as this is currently the area of greatest riskto the standard.
GM have recognised the increase in demand is significant across the region and are reviewing the demand profile.
Actions being taken to support the 62 Day standard will also support 2ww delivery.

Progress

Q4 - the standard was achieved althought only marginally over the standard.
Q1 - achievement of the standard is currently a risk due to demand pressures in the breast pathway and Gynaecology pathway, with an action plan and additional interim support in place.

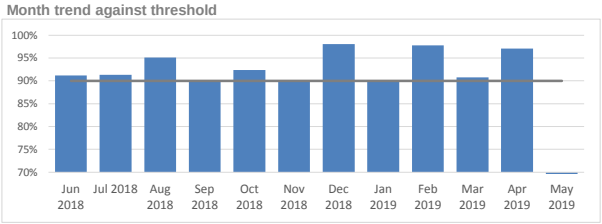
> Board Assurance

May 2019

Cancer 62 Days Screening

Actual	92.3%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✓	NA	NA	✓
NA	25.0%	NA	100.0%	NA	NA	97.4%

The percentage of patients receiving first definitive treatment for cancer following referral from an NHS cancer screening service that began treatment within 62 days of that referral.

Key Issues
The Trust has delivered performance against this standard.

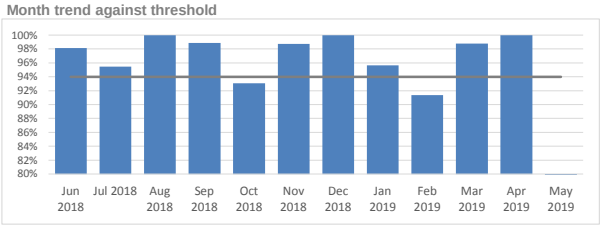
Actions
Actions to improve and refine current cancer pathways included in Divisional cancer plans submitted to Cancer Board.

Progress
The Trust achieved this target in Q4, performance is 92.4%.

Cancer 31 Days Sub Surgical Treatment

Actual	95.7%	Quarterly	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✓
NA	90.0%	100.0%	90.5%	NA	NA	97.4%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was surgery.

Key Issues
The Trust met the target for Q4.

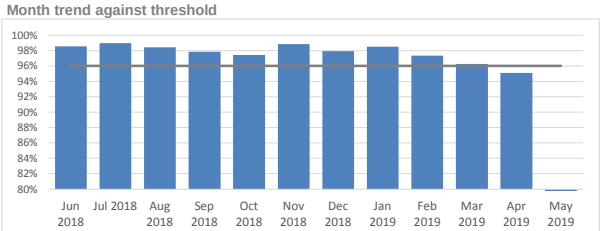
Actions
ORC currently have not met the standard for Q4 at 90 but this is due to 3 breaches only.

Progress
The Trust achieved the target in Q4, performance is 95.7%

Cancer 31 Days First Treatment

Actual	97.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✓	✗	NA	NA	✓
NA	95.6%	100.0%	91.1%	NA	NA	98.5%

The percentage of patients receiving their first definitive treatment for cancer that began that treatment within 31 days.

Key Issues
The Trust has achieved this standard.

Actions
MRI failed Q4 with a signifcant number of breaches in Urology. A back log was cleared within this time and some surgery has now moved to Christie and WTWA.

Progress
The Trust continues to achieve this standard

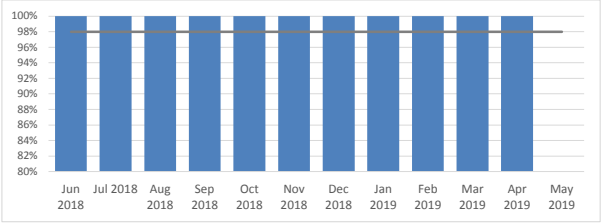
> Board Assurance

May 2019

Cancer 31 Days Sub Chemo Treatment

Actual	100.0%	Quarterly	**Accountability**	J.Bridgewater
Threshold	98.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	NA	NA	NA	✓
NA	100.0%	100.0%	NA	NA	NA	100.0%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was an anti-cancer drug regimen.

Progress

The Trust continued to achieve the standard.

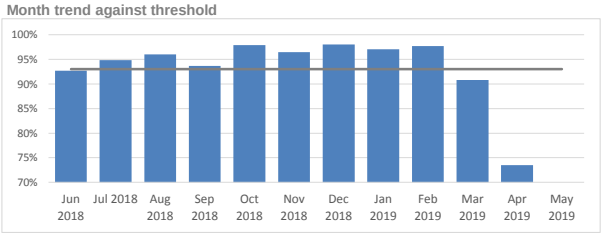
Actions

Actions taken as per the 62 day standard.

Cancer 2 Week Wait - Breast

Actual	94.9%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	NA	NA	NA	NA	NA	✓
NA	NA	NA	NA	NA	NA	94.9%

Any patient referred with breast symptoms would be seen within 2 weeks, whether cancer was suspected or not.

Key Issues

Specialist cancer services are provided by Wythenshawe Hospital. The Hospital continues to deliver strong performance against this standard.

Progress

The Trust achieved 94.9% in Q4 against National 88.1% (latest data)

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	5	2	4	3

Headline Narrative

The Leadership & Improvement Academy was introduced in May.

Absence Manager implementation programme launched to support attendance.

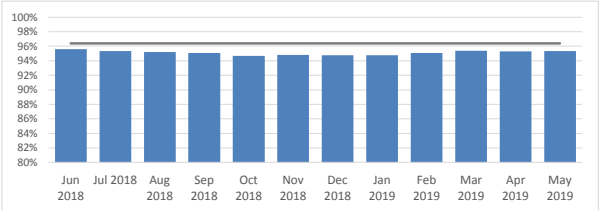
Workforce and Leadership - Core Priorities

Attendance

Actual 95.3% Latest Period **Accountability** P. Blythin

Threshold 96.4% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✕	✕	✕	✕	✕	✕
96.3%	95.4%	95.6%	95.3%	94.2%	95.3%	94.3%

This monitors staff attendance as a rate by comparing the total number of attendance days compared to the total number of available days in a single month.

Key Issues

The Group's attendance rate for May has remained the same at 95.3% compared to the previous month's figure (95.3%).

The attendance rate was slightly higher at the same point last year (May 2018) at 95.8%.

Meanwhile the latest figures released by NHS Digital show that for December 2018 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.3% (these figures include all provider organisations and commissioners). MFT's performance for the same period was 5.2%. Performance in the North West is significantly worse than any of the other sectors with the best being North West London at 3.5%.

Actions

Work is underway to ensure Health and Wellbeing initiatives are focussed in areas where the biggest improvements can be made. The MFT HWB Framework is currently in development and will be ready for application by November 2019. Attendance is one of the key metrics which is closely monitored through the Accountability Oversight Framework (AOF). Focussed discussion with the HR Directors of each Hospital/Managed Clinical Service (MCS) also features prominently in the actions to improve performance. Corporate performance is addressed though the Corporate Directors' Group.

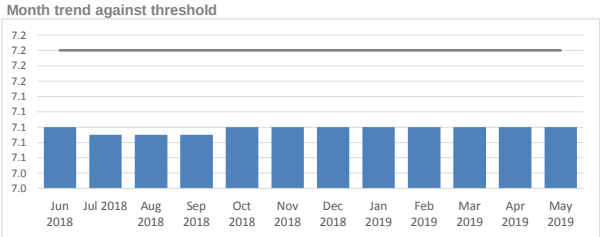
A programme to implement Absence Manager across all Hospitals/MCS sites has been launched and is sponsored by Group Deputy Chief Executive, Gill Heaton to oversee implementation. In parallel to this guidance and training for line managers supporting staff is one of the themes running through the programme. Each Hospital/MCS has developed a trajectory and action plan to increase attendance.

Engagement Score (quarterly)

Actual 7.10 Latest Period **Accountability** P. Blythin

Threshold 7.20 (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✓	✓	✕	✓	✓
7.10	7.00	7.30	7.20	7.00	7.30	7.20

This indicator measures the Staff Engagement score taken from the annual Staff Survey or quarterly Pulse Check. This score is made up of indicators for improvements in levels of motivation, involvement and the willingness to recommend the NHS as a place to work and be treated.

Key Issues

The most recent Group staff engagement score is 7.1. taken from the Q4 2018-19 Pulse Survey, which concluded in March 2019. This score is unchanged from the 2018 staff survey.

The Q1 2019-20 Pulse Survey runs from June 3rd to June 23rd and the Group staff engagement score will be available the first week in July. A detailed report on staff engagement is being presented to the HR Scrutiny Committee in June 2019, including a summary of Hospitals', MCS' and Corporate Services' staff engagement action plans, whilst an ongoing focus is maintained via the AOF meetings.

Actions

The 2019-20 Q1 Pulse Survey high level results will be disseminated to the Group by Friday 5th July. A Task and Finish Group for staff engagement, initially with a focus on improving access and response rates to the Pulse and Staff Surveys, has been established, with monthly meetings scheduled for June through to December 2019.

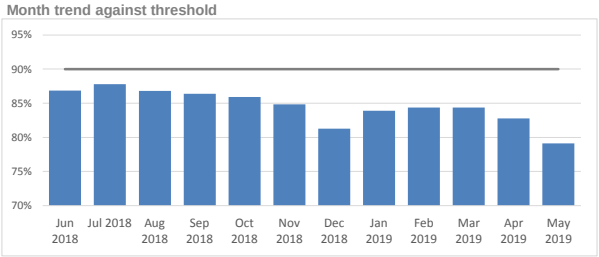
> Board Assurance

May 2019

Appraisal- non-medical

Actual	79.1%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	◇	✓	✗	✗
80.1%	68.3%	84.0%	88.7%	94.4%	84.6%	84.3%

These figures are based upon compliance for the previous 12 months, new starters are now included in these figures and will be given an appraisal date with a 3 month compliance end date, in line with the appraisal policy statement: 'new starters should have an initial appraisal meeting within three months of commencement in post'. These figures do not include Medical Staff because this data is captured in a separate metric aligned to the medical appraisal system.

Key Issues

Compliance in May has deteriorated by 3.7% on the previous month. This is due primarily to a 18% drop in compliance across MRI.

Actions

MRI introduced an April-June appraisal window in 2018 and the MRI Executive Team have issued a communication to all managers to complete all outstanding appraisals before the end of June to improve the position.

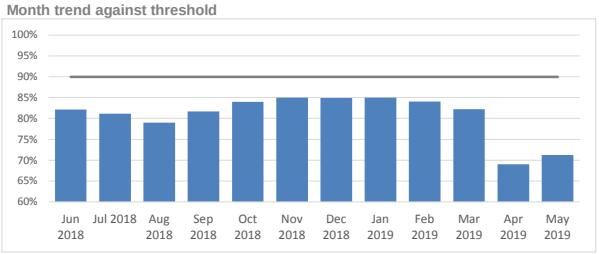
All Hospitals / MCSs / Corporate Directorates have plans in place to improve compliance. Progress against these plans will be reviewed as part of the month AOF process and adjustments will be made to ensure compliance improves.

HRD's also have regular ongoing discussions within their Hospital/MCS management teams to monitor progress and compliance against plans that are developed.

Level 2 & 3 CSTF Mandatory Training

Actual	71.2%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✗	✗	✗
71.9%	67.5%	62.4%	77.3%	75.7%	65.0%	80.0%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken Level 2 & 3 CSTF Mandatory training within the previous 12 months.

Key Issues

A new Clinical Mandatory Training Programme became effective across the Group from the start of the financial year. Some of these subjects have previously not been reported as part of mandatory training. In view of this it was agreed at EDT that Hospitals/MCS and Corporate Teams ensure 90% compliance by October 1st and the trend has been reset to April 2019. Plans are now in place and improvements are monitored through the AOF. The aggregate compliance against 6 of the Level 2 and Level 3 Core Clinical increased by 2.3% in May to 71.2%.

Actions

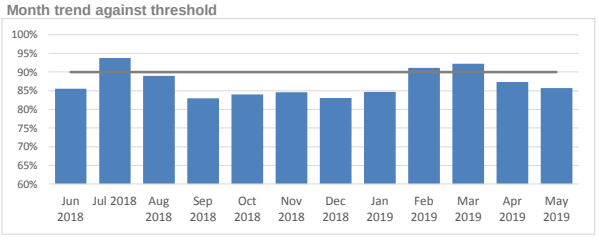
A widespread communication plan has been delivered to ensure that all staff understand the changes to the new programme.

The OD Team is supporting the Hospital/ MCS in the resolution of initial issues emerging as a result of the new programme implementation. Ongoing discussions at the AOF are a priority to ensure effective implementation, understanding and compliance against plan. Close scrutiny via the AOF will continue to monitor and mange any deviation from plan effectively.

Appraisal- medical

Actual	85.7%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	✗	◇	◇	✗	✗
89.9%	87.1%	82.0%	88.1%	85.3%	79.4%	83.6%

These figures are based upon compliance for the previous 12 months for Medical & Dental staff.

Key Issues

There has been a further increase in the numbers of medical staff starting, increasing the numbers of staff required to either complete an appraisal or provide evidence of a previous appraisal.. All new starters provide previous appraisal history so that this can be included within the reporting figures in line with NHS England guidance. The forms are provided in the medical recruitment packs but these are not being consistently returned to the appraisal team.

Actions

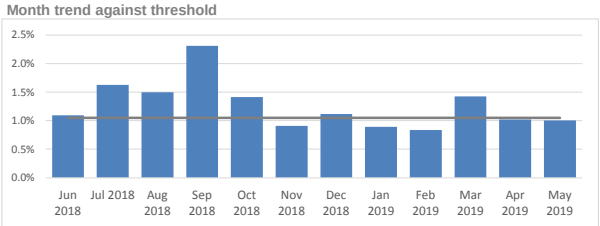
All Hospitals / MSCs / Corporate Directorates continue to deliver against plans that were developed to increase compliance. Monitoring also takes place through the monthly AOF reviews where Hospitals/MCS present the trajectories and action plans in place to achieve compliance.

In addition monitoring of progress against plans and issue escalation is reviewed at the Medical Professionals Oversight Committee chaired by the Group Medical Director. Hospital/MCS appraisal leads have been actioned to submit new starter forms. Support is provided by Group Associate Medical Directors and HR to address poor performance / doctors in difficulty.

B5 Nursing and Midwifery Turnover (in month)

Actual	1.01%	Latest Period	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✓	✓	NA	✗
0.80%	1.20%	0.84%	0.78%	0.00%	NA	1.57%

This indicator measures and monitors the turnover of Band 5 Qualified Nursing & Midwifery staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes Fixed Term Contract staff). The graph show the rate in a single month.

Key Issues

The turnover for April 2019 is 1.01% against a monthly target of 1.05%. This is a decrease in turnover from April 2019 at which the turnover (1.02%).

Actions

Retention Strategies developed by each Hospital/MCS continue to be monitored by the Directors of Nursing.

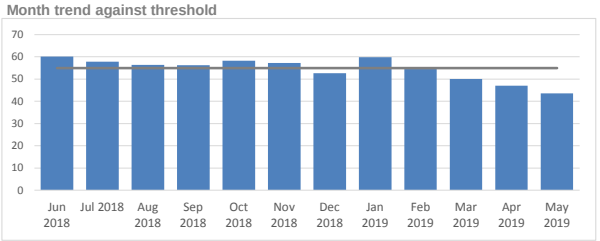
The strategies focus on the following work streams:-

- Divisional work streams focusing on wellbeing/staff focus groups/take a break
- Nursing and Midwifery extended induction for new starters
- Roll-out of 12 hour shifts for staff who wish to condense their hours over a shorter working week
- Identifying new roles within the unregistered workforce to support careers/skills escalator
- Band 5 rotation programmes have been introduced in RMCH, MRI and WTWA
- Focus on flexible working options
- Staff engagement and we're listening events within the hospitals/ MCS
- The development of an internal transfer scheme for Band 5 Registered Nurses

Time to Fill Vacancy

Actual	43.6	Latest Period	**Accountability**	P. Blythin
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✗	✓	✓
40.7	38.8	51.6	50.4	61.3	44.0	43.9

This indicator measures the average time it takes, in days, to fill a vacancy. It measures the time taken from the advertising date (on the TRAC Recruitment System), up to the day of unconditional offer. The graph shows an in month rate. The metric does not include Staff Nurses as there is a separate metric for this provision.

Key Issues

Group wide, the Time to Fill figure has reduced from 47 days and now stands at 43.6 days for May.

Actions

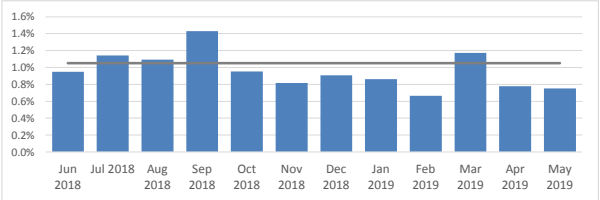
The Trust 'Time to Hire' for May 2019 (without Band 5 Nursing starts) is 43.6 working days, which has dropped by a further 4 days from April figures and 16 working days from January's figures. There will be an increase in the next 2-3 months as the Trust is waiting on exam results for September intakes of Nurses. There is further work to do around streamlining processes and there has been a strong emphasis on the medical workforce as their overall time to hire is higher at 79.8 working days which has improved by 6 working days since April, where more focused support has been directed to support medical recruitment.

An internal audit of the end to end recruitment process has commenced which is due to conclude in August 2019.

Turnover (in month)

Actual	0.75%	Latest Period	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✗
0.41%	0.90%	0.78%	0.77%	0.31%	0.00%	1.12%

This indicator measures and monitors the turnover of staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes the naturally rotating Foundation Year 1 and Year 2 junior medical staff and the Fixed Term Contract staff). The graphs shows a single month rate.

Key Issues

The single month turnover position for the Group has fallen and now stands at 0.75% compared to 0.78% for the previous month.

The turnover rate was higher at the same point last year (May 2018) at 0.82%.

Actions

The Hospitals/MCS/Corporate Services continue to focus on staff turnover with regular staff engagement sessions, facilitating internal moves to prevent staff leaving the organisation.

MRI has introduced 6 weeks after initial Trust induction a 'Welcome to MRI' meeting to introduce staff to MRI Directors and to support staff to see how they are settling into their roles and remind them about local induction requirements and mandatory training. MRI also has plans in development to schedule a further 6 month meeting to support retention.

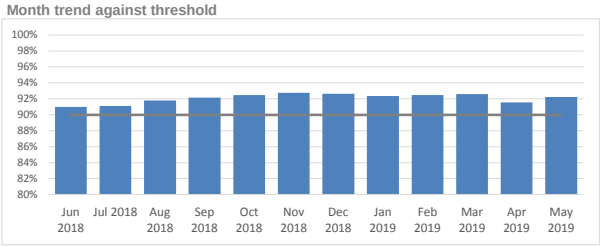
> Board Assurance

May 2019

Level 1 CSTF Mandatory Training

Actual	92.2%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✗	✓	✓	✗	✓
93.3%	89.6%	89.4%	96.5%	92.5%	89.7%	93.4%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken corporate mandatory training within the previous 12 months.

Key Issues

Following the successful integration of Core Level 1 training in the 2018/19 financial year, compliance is now being monitored against the aggregate of all 11 Core Level 1 subjects. In May the aggregate compliance increased by 0.7% to 92.2% .

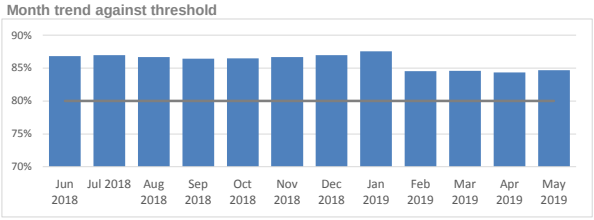
Actions

Monthly compliance reports continue to be made available via eWIP. Ongoing review of target compliance will continue with non compliant hospitals/MCS being monitored by the AOF process. Monthly review of target compliance for Corporate functions is monitored through the Corporate Directors' Group.

Nurse Retention

Actual	84.7%	Latest Period	**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	NA	✓
84.6%	82.7%	87.1%	85.3%	86.7%	NA	84.9%

This indicator measures the Nursing & Midwifery staff retention rate. It measures, by %, the Nursing & Midwifery registered staff in post for the Trust 12 months ago who are still employed in the organisation to date.

Key Issues

In April 2019, Nursing and Midwifery retention stands at 84.3% which is a slight increase from April 2019 at which the retention rate was 84.3%. This rate remains above the threshold of 80%.

Actions

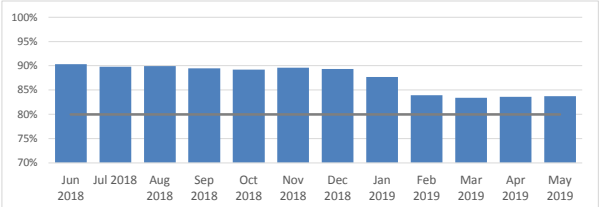
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 84.7%.

Actions are detailed in the above metric for Nursing and Midwifery Turnover and are a result of the retention plan developed in January 2019 which continues to progress and be monitored.

BME Staff Retention

Actual	83.7%	Latest Period	**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
85.2%	82.0%	85.2%	87.1%	85.5%	80.0%	82.5%

This indicator measures the Black Minority & Ethnic (BME) staff retention rate. It measures, by %, the BME staff in post for the Trust 12 months ago who are still employed in the organisation to date. The retention rate information excludes the naturally rotating Foundation Year 1 and Foundation Year 2 junior medical staff as they are employed by the lead employer St Helens & Knowsley Trust. The rate is shown as a rolling 12 month position.

Key Issues

In May 2019, there was no significant difference between the BME and White staff retention rates. The BME retention rate remains consistently above the Trust's threshold of 80% month on month.

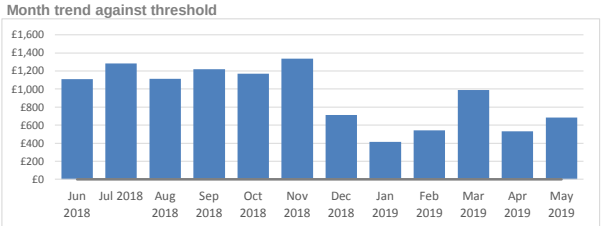
Action

Hospital Sites/MCSs are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified. The Trust is developing a removing the barriers Programme aimed at increasing the representation of BME colleagues in leadership roles across the Trust. This programme will embedded as part of the new ED&I Strategy due to be considered by the GMB for approval in September 2019

Medical Agency Spend

Actual	£684.4	Latest Period	**Accountability**	P. Blythin
Threshold	None	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
£8.1	£398.5	£20.9	£5.4	£72.6	£6.4	£172.5

The Medical and Dental Agency Spend figure represents the cost of supply/temporary M&D staff throughout the Trust. This may represent cover for long term absences either through vacancies, long term illnesses or for other specific staffing requirements. The value is in £000s and is the reported month cost.

Key Issues

For May 2019 the total value of Medical and Dental agency staffing was £684.4 compared to £531.9 in April 2019.

Actions

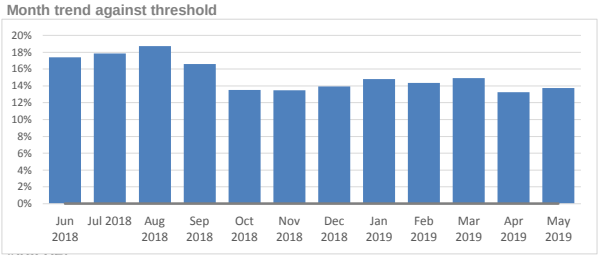
Hospital/MCS are continuing to make improvements to their agency spend position, with weekly review meetings taking place. The approval process for agency workers has been improved, to give the Hospital / MCS Management Teams greater grip and control on spend. Monitoring is ongoing via the Finance AOF dashboard.

Tiered framework for agency suppliers launched. Corporate teams are working closely with the tier 1 agencies to establish relationships and work on plans to increase fill rates and reduce rates of pay and agency commission.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	13.8%	Latest Period	**Accountability**	P. Blythin
Threshold	None	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
10.0%	14.6%	9.9%	11.7%	6.6%	NA	16.8%

The Qualified Nursing and Midwifery vacancy rate represents the total number of posts vacant within the Band 5 Nursing and Midwifery staff group, including Operating Department Practitioners.

Band 5 and 6 Midwifery vacancies are reported together as these posts are transitional posts for entry level (newly qualified) midwives who progress to band 6 on completion of preceptorship.

Key Issues

The majority of vacancies with Nursing and Midwifery are within the staff nurse (band 5) role. At the end of May 2019 there were 548.4 wte (13.8%) staff nurse/midwife/ODP (band 5) vacancies across the Trust Group. This is a decrease from April 2019 when there was 558.6 wte vacancies (14.0%).

Actions

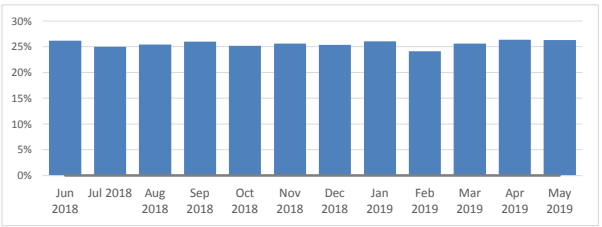
There are 129 nurses and midwives expected to start before the end of August 2019 with a further 208 nurses with conditional job offers and whose appointments are being processed through the Trust recruitment process. The trust continues to recruit nurses from overseas. There are 36 international nurses expected to start in July 2019 with cohorts of approximately 25 to 30 nurses expected to arrive every 6 weeks for the rest of the year.

A Group Resourcing Plan has been developed including a schedule of recruitment events to support the recruitment strategies implemented across the Hospitals and MCS.

% BME Appointments of Total Appointments

Actual	26.3%	Latest Period	**Accountability**	P. Blythin
Threshold	None	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
28.9%	37.2%	19.8%	18.9%	43.0%	36.4%	28.9%

This indicator measures the number of BME appointments as a percentage of all appointments. This is measured through the Trust's Recruitment System (TRAC). The graph shows an in month rate.

Key Issues

The data shows a slight reduction of 0.1% from 26.4% to 26.3% from the reporting figure of last month; one in four appointments is of black and minority ethnic origin. In May 2019, the MLCO, SMH, RMCH and Corporate Services appointed at percentages lower than the Trust average of 26.3%. However, at SMH the number of BME appointments as a percentage of all appointments increased significantly in May 2019 on previous months. In addition, at RMCH and Corporate Services the number of BME appointments as a percentage of all appointments is above the Greater Manchester BMEpopulation made.

Actions

The Group figure is higher than the Greater Manchester BME population of almost 17% but lower than the Manchester BME population of over 30%. Hospital Sites/MCSs are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified.

> Board Assurance

May 2019

Finance

A.Roberts

Core Priorities	✓	◇	×	No Threshold
	1	0	1	0

Headline Narrative

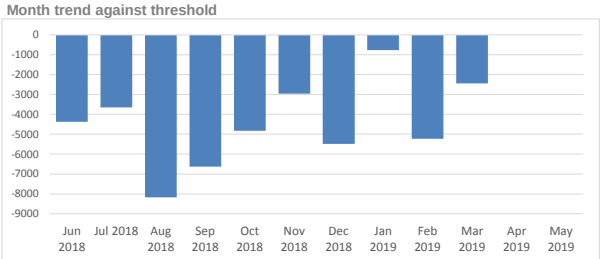
- Please see agenda item 5.2

Finance - Core Priorities

Operational Financial Performance

Actual -£55,440 Year To Date
Threshold
Accountability A.Roberts
Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



Comparing the financial actual expenditure against the agreed budget (£'000). A negative value represents an overspend. A positive value represents an underspend.

Please see the Chief Finance Officer's report for more detail.

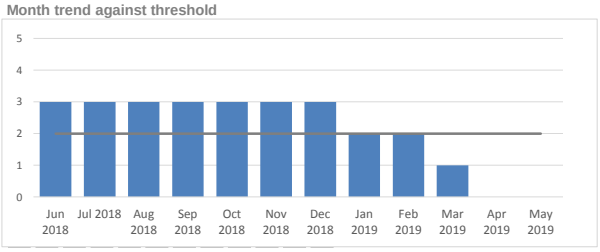
Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
×	×	×	×	×	×	×

Regulatory Finance Rating

Actual 1 Latest Period
Threshold (Lower value represents better performance)
Accountability A.Roberts
Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of NHSI's single oversight framework, incorporating five metrics:
- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Group Chief Operating Officer
Paper prepared by:	Lorraine Cliff, Deputy Director of Transformation
Date of paper:	June 2019
Subject:	TRANSFORMING CARE FOR THE FUTURE 19/20 Quarter 1 Progress Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	The report provides progress against the Transforming Care for the Future 19/20 plan and commitments to achieve the top decile for quality - clinical outcomes, safety, patient experience, staff engagement and operational efficiency measures
Recommendations:	The Board are asked to note and support the MFT Transforming Care for the Future Programme 19/20 Quarter 1 report.
Contact:	Name: Lorraine Cliff, Deputy Director of Transformation Tel: 0161 701 5115

Manchester University
NHS Foundation Trust

Transforming Care for the Future

2019/20 Quarter 1 Report

June 2019

Contents

Manchester University
NHS Foundation Trust

Overview

Manchester University NHS Foundation Trust

The MFT Transformation Strategy was approved by the Interim Board of Directors on 19 September 2017 pending the formation of MFT on the 1st October 2017. Our ambition is to lead healthcare in the NHS and therefore we need to be in the top decile for quality in its broadest sense not only on outcomes and safety but patient and staff experience and operational efficiency.

As a result we aspire to be recognised for excellence in patient and staff experience and use of technology, facilities and strong leadership are enablers for staff to change. This is the key driver for our transformation programme and in 3 years' time through a culture of clinically led change we want to achieve:

Operational excellence across all hospitals and community services, alongside being recognised for excellence in quality, patient and staff experience

Fully integrated single hospital services

Effective partnerships with our Local Care Organisation, Devolution Manchester, Shelford Group and other key stakeholders

The aim of our transformation strategy is to ensure we:

- ✓ Continue to build upon and strengthen the transformation work already in place
- ✓ Continue to build the capability of staff to ensure a culture of continuous improvement.
- ✓ Ensure we are making best use of existing resources and corporate teams to support improvement and support the clinical teams and divisions / hospitals in a coherent way.
- ✓ Continue to co-ordinate projects to ensure lessons are shared .

The Transforming Care for the Future Programme objectives for the next 3 years are:

	Culture for change	Continue to create the right culture across each Hospital and Division to deliver change through embedding the values and behaviours and leadership
	Build Capability	Continue to build staff capability in leadership and change using a single methodology to support continuous improvement
	Delivery	Through collaborative working achieve operational excellence and excellence in patient and staff experience which will continue to deliver efficiencies through transformational change, supporting the financial strategy
	Governance	Comply with the governance process / PMO to ensure rigour to the work and expectations to achieve top decile for quality

The Roadmap

The 3 year road map within the Transformation Strategy outlines year 3 as going from good to great with a continuation of delivering and building on the integration benefits delivered in 2018/19.

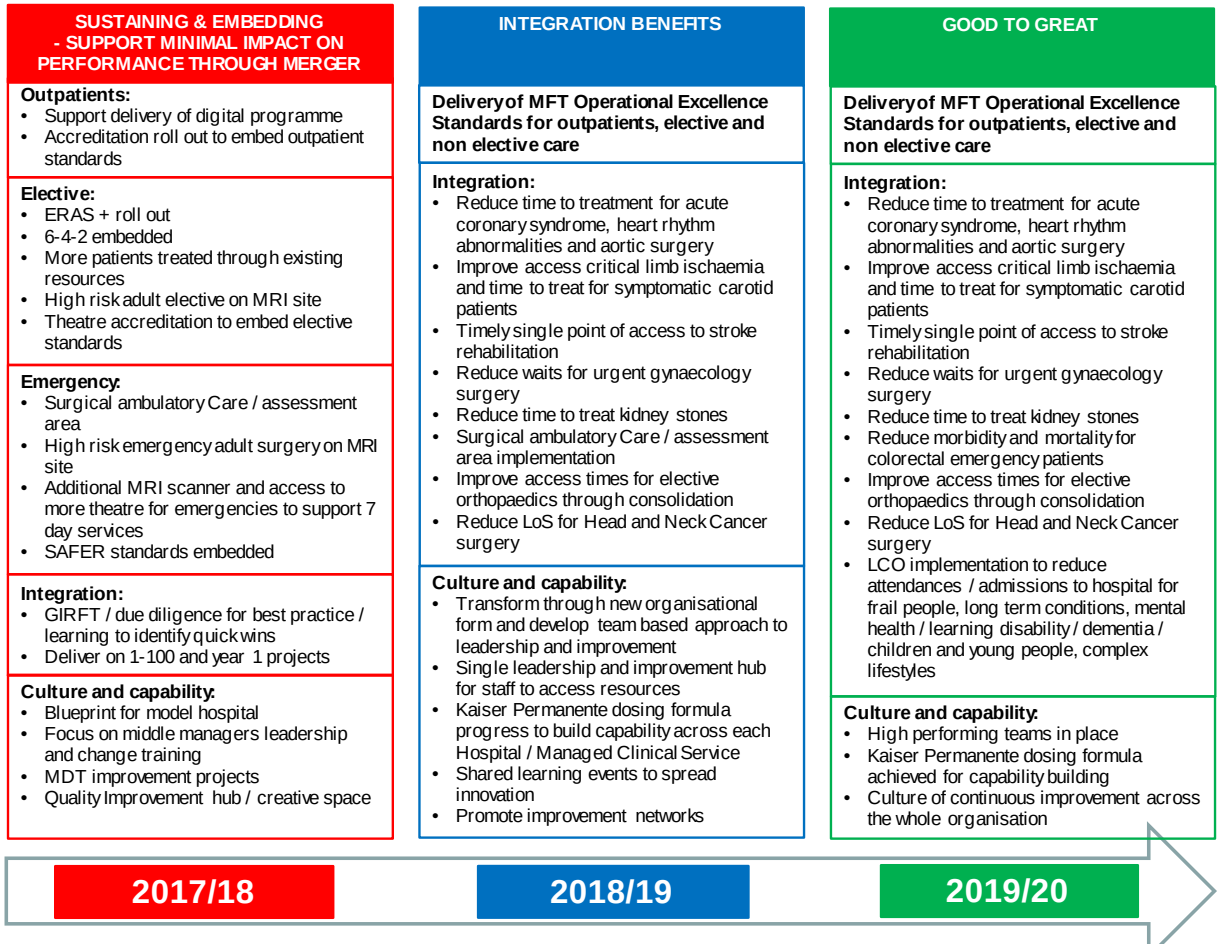
Following the creation of MFT in October 2017 the 2017/18 work programme focused on sustaining and embedding practices whilst ensuring minimal impact on performance through the merger.

During 2018/19 the focus was surrounding the delivery of the integration benefits agreed with commissioners through the Manchester Agreement, which consequently secured transformational funds. Under the decision rights it is the responsibility of Hospitals/MCSs to embed and sustain the MFT standards for outpatients, elective and non elective care, which has continued throughout the year but to varying degrees.

For 2019/20 The transformation resource will focus on the complex change work streams which will primarily be in the delivery of the integration benefits along with providing support across the Group to leverage and scale up good practice against delivery of the MFT Operational Excellence Standards.

This report outlines the timescales and commitments to deliver the 2019/20 transformation programme.

The next 3 year strategy is to be refreshed during the year to commence from 20/21 onwards.



Summary of Q1 Objectives

Delivery of MFT Operational Excellence Standards	Integration	Culture Change, Capability Building & Standardisation

• Support MRI Transformation programme of work including:-
  • Commence joint programme with LCO, MSCC and Hospitals on Complex Discharge Planning
  • Implement virtual ward and ambulatory care projects as part of the MRI patient flow programme
  • Complete RTT improvement programme in ENT at the MRI
  • Commence training on FourEyes ENT scheduling tool in ENT as pilot site
  • Support development of plans for centralised booking at the MRI
• Support St Mary's in developing a continuous improvement programme in Gynaecology across outpatients, theatres, ambulatory care, EGU
• Support MREH outpatient team to deliver service improvements, implementing trust outpatient standards
• Review of Trafford theatres and develop set of options for maximising capacity
	• Implement joint coronary rhythm management rota
	• Begin regular monitoring of cardiac KPIs
	• Develop proposal for consistent 5 day TIA service
	• Begin reporting of the Manchester Agreement metrics relating to the single point of access
	• Review the scope of the T&O programme board and launch new workstreams
	• Complete the phasing work associated with the wave 1 strategic moves and establish programme governance arrangements
	• Launch community and secondary integration projects relating to respiratory services
	• Urology programme to oversee the transfer of cystectomies from MRI to Wythenshawe
		• Share Learning through Transform Together Event, focusing on projects to scale up and publish case studies
		• Launch new curriculum for building capability
		• Support Hospitals in developing training plans
		• High Performing Team Coaching and accreditation
		• Implement Single Improvement Hub
		• Support 'tackling poor behaviours' initiative
		• Evaluate Transform Together projects and identify opportunities to scale up and spread
		• Facilitation of GIRFT visits: Renal, cardiology, breast surgery and update to Clinical Advisory Committee

Key Message

The Transformation Team have delivered against the objectives set out for Q1. Key deliverables during the quarter have been:-

- review of Trafford theatres
- support to the MRI in developing centralised booking
- sustained performance against the Manchester Agreement Metrics for Gynaecology and Lithotripsy services along with good performance on the Stroke KPIs which went live on the 1st April.
- launch of the 19/20 curriculum for building capability and implementation of a single improvement hub on the new intranet site
- well received GIRFT visits across Renal, breast surgery and Cardiology

Launch of community and secondary integration projects in respiratory has been deferred.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

OUR COMMITMENTS WE WILL:

Objective 1:

✓ ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work. We will continue to support standards becoming "business as usual" through Hospital / Managed Clinical Service Transformation Leads

Objective 2:

✓ ensure the outpatient, elective and SAFER standards are reviewed annual with clinical teams and patients and based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. Provide the expertise to hospitals/MCSs in developing new care models to deliver against the NHS Long Term Plan for outpatients and urgent care, with targeted support in these areas for the MRI

Objective 3:

✓ scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme

Objective 4:

✓ provide support working with informatics, OD&T and clinical services in preparing the organisation for a new electronic patient record (EPR) system

PROGRESS DURING QUARTER 1:

The MFT Transformation Team were commissioned in April 2019 by the WTWA Director Of Operations to undertake a **rapid review of utilisation in Trafford Theatres**. This was against a backdrop of a **shortage of theatres** identified through the capacity planning for WTWA. Trafford General Hospital has 9 operating theatres providing general adult and paediatric surgery for Hospitals and MCSs across the Group. Overall management of Trafford now resides with Wythenshawe with 57% of sessions used for Elective Orthopaedics and the remainder shared between MRI, St Mary's, CSS and RMCH. The review triangulated data, observed processes and gathered feedback from staff.

The findings from the review can be summarised into a number of key themes:-

Leadership & Culture – responsibility spanning multiple sites, no control or consistency
Scheduling – various systems and processes in place
Cancellations – high volumes of cancellations for an elective site
Equipment – availability of kit and transfer of equipment between sites
Clinical Criteria – restricting ability to fully maximise theatres
Productivity – fallow lists, poor utilisation, multiple systems leading to error/duplication

The review proposed a number of **efficiency recommendations** which were shared with Hospitals/MCSs. These included clarity on roles and responsibilities, review of clinical criteria and having a coordinated approach to scheduling.

It was agreed that a **set of principles** be developed for Trafford Theatres that will aim to hold Hospitals/MCSs to account in maximising their theatre sessions. This will be monitored by WTWA with the key principle being where sessions continue to be under-utilised these will be given up for other specialties to utilise.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

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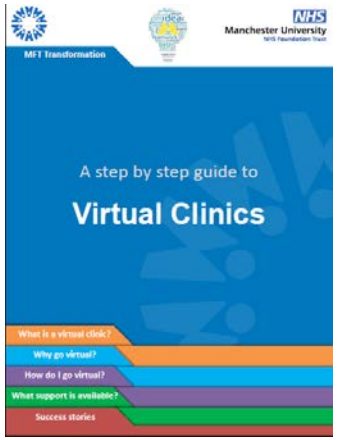

A step by step **guide to virtual clinics** has been produced that provides helpful information for Hospitals/MCSs on what needs to be considered when implementing a virtual clinic.

PROGRESS DURING QUARTER 1:

Across **outpatients** there has been a specific focus in the Manchester Royal Infirmary (MRI) to deliver **centralisation of systems and processes** . The Transformation team are providing on-site support to standardise the following areas

- Booking and Scheduling
- Appointment Reminder System Management
- Outpatient Appointment Letters

This is a **complex change management programme** which will be phased over a number of months to achieve full implementation. During Q1 a series of workshops with staff have been held to scope current booking and scheduling practices, understanding the variances and resources. The outputs of this have been developed into a proposal for the MRI Executive Leadership team to approve.

The existing appointment reminder service has been reviewed and the current supplier contract re-negotiated to **improve the management of text messaging and tracking of patient reminders**. In addition a scoping exercise has been carried out with regards to the production and sending of appointment letters with discussions underway with a third party provider for a single centralised solution. This programme of work is taking into consideration the findings from the CQC report and other on-going initiatives across outpatients, including self check in Kiosks.

The team are also working across MFT in developing a **clinic letter template and standards**. Guidance was published in September 2018 by the Academy of Medical Royal Colleges promoting clinic letters needing to be patient focused, well structured, informative, easy to read and engaging. A sample of our current letters have been reviewed which demonstrated there are large variations in layout and structure. A number of workshops have been held with clinicians to critique existing letters and have supported the development of standards and a letter template. This will be circulated for wider consultation with clinicians, patients and GPs prior to being presented to the Clinical Advisory Committee for approval.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

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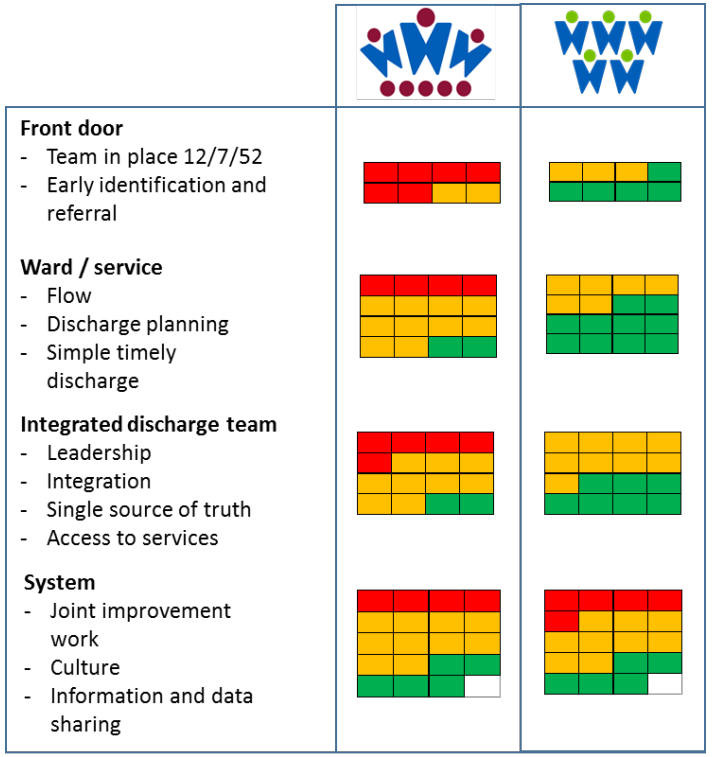
Objective 4:

✓ provide support working with informatics, OD&T and clinical services in preparing the organisation for a new electronic patient record (EPR) system

PROGRESS DURING QUARTER 1:

Continuing with the work across MRI & Wythenshawe on **patient flow** the Transformation Team have worked with the LCO in undertaking a **baseline assessment against Greater Manchester Discharge Standards**. The standards recently published by Greater Manchester Health & Social Care Partnership sets out 58 elements from community interface at the front door to across the whole system. The assessment clearly identified areas of focus which are consistent with earlier review findings. The MRI are now aligning this assessment to their existing patient flow programme.



S A F E R

The Transformation Team has continued to offer support to the **MRI Patient Flow programme** focusing on continuing to roll out and embed **SAFER standards**, further development of **ambulatory care** and development of a **virtual ward model** which will be piloted in Q2.

Integrated Care and Pathways to deliver Clinical Benefits

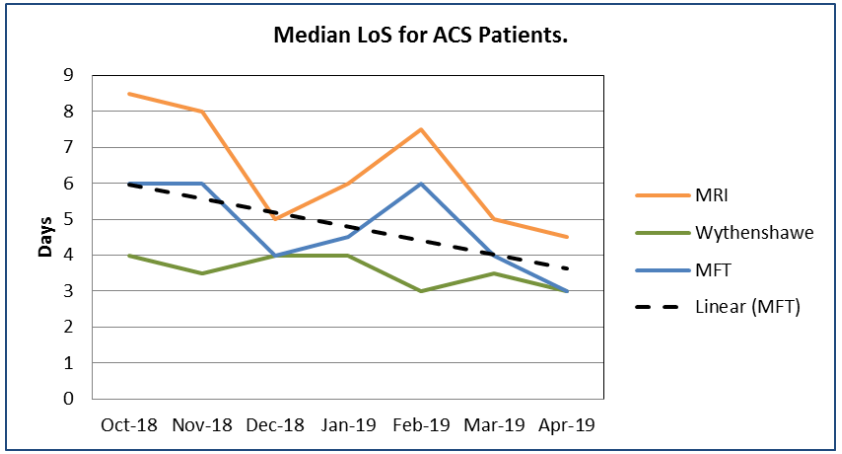
NHS Manchester University NHS Foundation Trust

OUR COMMITMENTS, WE WILL:

Objective 5:
- ✓ ensure the patient benefits for year 2 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement

Objective 6:
- ✓ work with Hospitals/MCSs in delivering the phased implementation plans against the clinical service strategies

Objective 7:
- ✓ work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and PTIP

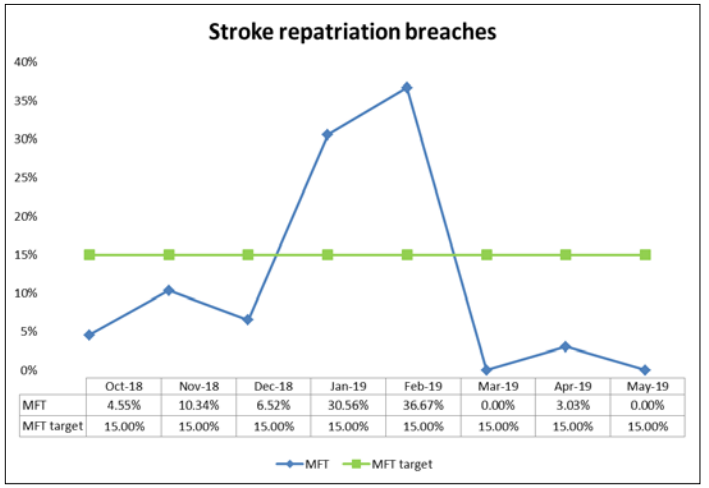


Supported by Transformation the **cardiac** integration programme continues to develop. A single weekend rota for urgent pacemaker implantation across MRI and Wythenshawe went live on 1st April and access and length of stay for patients requiring treatment for **acute coronary syndrome (ACS)** continues to improve.

PROGRESS DURING QUARTER 1:

The Transformation team has continued to make progress with the delivery of the **year 2 patient benefits** including those in the Manchester Investment Agreement where **good performance has been maintained** in lithotripsy and urgent gynae and significant improvements have been made in stroke repatriation.

In **stroke services** the Manchester Agreement KPI went live from 1st April and performance has significantly improved with 3% of repatriations breaching in April and no breaches in May. This is a result of **continuous improvement** of the single point of access model and improvements made to the bed management processes.



	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
MFT	4.55%	10.34%	6.52%	30.56%	36.67%	0.00%	3.03%	0.00%
MFT target	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%

Significant changes have been made with respect to the **governance** of the integration programme with the aim of accelerating some of the reconfiguration plans that will deliver major patient benefits. A **single MRI / WTWA portfolio board** has been established with the respective CEOs as joint chairs. It is anticipated that this will drive significant developments and some of the **'big ticket'** integration projects in 2019/20.

Creating the Culture and build capability for continuous improvement for Change

Manchester University NHS Foundation Trust

OUR OBJECTIVES, WE WILL:

Objective 8:
- ✓ work with OD to ensure the high performing team principles and values and behaviours underpin the integration programmes of work which in turn will support and improve staff experience

Objective 9:
- ✓ continue to commission leadership and improvement courses to meet the needs of staff, working with those organisations with a lead role in improvement and innovation, such as NHS Improvement, AQuA, Haelo and Health Innovation Manchester

Objective 10:
- ✓ work with the Clinical Standards Groups (CSG's) and clinical teams to continue to generate ideas and translate into practice through reviewing new care models nationally and internationally and through established networks

Objective 11:
- ✓ Embed GIRFT recommendations and delivery into CSG and integration work programmes, to avoid duplication and maximise the benefits of sharing knowledge and learning

- **AffinaOD team coaching** programme continues, and in Q1 7new teams have registered for support, there are 47 coaches still in the trust, with 9 being fully accredited through the programme.

- 114 people have completed **improvement training** through AQuA courses. 37 of these have been through face to face course attendance with 77 via e-learning programmes.

PROGRESS DURING QUARTER 1:

The Transformation team has worked with hospital transformation leads to focus attention towards improving outpatients by sharing learning about virtual clinics. The culmination of this preparatory work will be a **Transform Together – Virtual Clinics** event to be held on 2nd July.

Working with OD&T, attention has been focused towards identifying a robust baseline of **staff numbers trained in improvement and leadership** across the Trust. This knowledge, which aligns staff training to the four Kaiser Permanente levels, will enable hospital HR Directors to develop local training plans to work towards achieving a balanced departmental **spread of improvement and leadership competency**, and thereby maximising the impact of staff who are able to embrace , promote and deliver transformational change.

The team provided input into the **Trust 'tackling poor behaviours'** initiative. To drive positive leadership and inspire change and improvement, it is necessary that the right environment and conditions which are conducive to improvement are prevalent. This group will build on positive behavioural factors and will target and help to deliver the cultural focus of the transformation programme.

The **single improvement hub** has now been launched as part of the new Trust intranet. It aligns knowledge and support from Transformation, OD&T, Nursing & Quality and Innovation, to deliver a cohesive mechanism for staff, who may have previously been confused over which functions they need to engage with for education, support and guidance.

In conjunction with the intranet site, a **OD and transformation network** has been formed. This will bring together change agents across the organisation, ensuring staff requiring support can engage with experts to receive coaching and guidance, and in general to benefit from the learning of others. A summit of key clinicians and leaders took place in June to start to develop the network.

Getting it Right First Time (GIRFT) specialty visits by national clinical leads took place in Q1 for Cardiology, Renal and Breast Surgery. The result will be a set of recommendations that each specialty can consider in order to remove unwarranted variations in clinical practice.

Looking Ahead to Q2

NHS
Manchester University
NHS Foundation Trust

	Delivery of MFT Operational Excellence Standards	Integration	Culture Change, Capability Building & Standardisation
Quarter 2	• Implement initial phase of outpatient booking centralisation at the MRI • Roll out of first wave of virtual clinics at MRI • Roll out of RTT improvement programme to other MRI services • Outpatient clinic letter standards drafted for Clinical Advisory Group approval • Continue to support REH in delivering against outpatient standards • Support St Mary's in developing a continuous improvement programme in Gynaecology, undertaking a review of Out Patient Services	• Evaluate progress against Manchester Agreement • Audit of programme documentation to uphold process and reporting standards, and continuous improvement • Begin implementation of the wave 1 strategic moves • Implement first phase of the TIA improvement programme • Urology programme to oversee the transfer of nephrectomies from MRI to Wythenshawe	• Share Learning through Transform Together Event • Quarterly staff pulse check • Transformation team development session to deliver continuous improvement • Facilitation of GIRFT acute and general medicine specialty visits • Assessment of GIRFT actions, implementation and benefits report to Clinical Advisory Committee • Support implementation of clinical standards via CSG's: surgical consent, WHO checklist, cardiothoracic GIRFT recommendations, pulmonary embolism pathway • Collaborate with Hive implementation team to develop a standardised change management approach to support Hive implementation • Develop a plan for capacity and capability building in Transformation Team and wider team leading Hive, to support the organisational culture change required to drive continuous quality improvement and successful Hive adoption • Develop the Transformation and OD Network offer and begin linking up staff across the trust to drive continuous improvement

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts, Group Chief Finance Officer
Paper prepared by:	Ursula Denton, Group Director of Finance
Date of paper:	June 2019
Subject:	Financial Performance for 2019/20
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term.
Recommendations:	Operating financial position worsened in-month, with performance against operational income & expenditure budgets in May being more than £5.6m worse than the £4.7m deficit profile within the approved Hospital Control Totals. Robust delivery of signed off operational plans need to be demonstrated month-on-month to establish assurance the Trust's continuing financial sustainability.
Contact:	Name: Adrian Roberts, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for May was **a bottom line deficit** (on a control total basis excluding Provider Sustainability Fund) **of £8.8m** (3.2% of operating income). This deficit continues to be inconsistent with the delivery of the financial plans put into place across Hospitals. Successful delivery of the overall 2019/20 plan approved by the Board demands a sharp upturn in financial performance across Hospitals with immediate effect.
1.2	**Run Rate**	Operating financial performance has continued to worsen in-month, with performance against operational income & expenditure budgets in April and May now over £5.6m worse than the approved Hospital/MCS Control Totals. Robust delivery of the signed-off operational and financial plans needs to be demonstrated month-on-month to assure the Trust's continuing financial sustainability.
1.3	**Remedial action to manage risk**	Specific additional recovery and delivery actions have been agreed with each Hospitals/MCS leadership team during the second week of June, to secure stronger, more consistent delivery of the required operating financial performance through the immediate upcoming months. Follow up discussions will continue to be held fortnightly between the Group CFO, Group COO and Hospital CEOs and leadership teams to ensure that progress is maximised and any delay factors are systematically tackled and removed.
1.4	**Cash & Liquidity**	As at 31st May 2019 the Trust had a cash balance of £116m.
1.5	**Capital Expenditure**	The revised capital plan submitted to NHS Improvement for 2019/20 is £74.4m. Against a planned spend for May of £11m the actual spend was £9.5m.

Financial Performance

Income & Expenditure Account for the period ended 31st May 2019

	Year to date - Month 2					
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to month 1	Year to date Actual
	£'000	£'000	£'000	%	£'000	£'000
INCOME						
Income from Patient Care Activities						
A and E	53,712	9,039	-64		-19	8,975
Non-Elective (includes XBD's)	304,268	50,286	56		-473	50,342
Elective (includes Day Case & XBD's)	229,764	37,847	-1,875		-483	35,972
Out-Patients (includes First & Follow up)	188,113	30,815	-770		-686	30,045
Other NHS Clinical Income	448,019	74,433	-456		-266	73,977
Community Services (includes LCO)	106,822	17,804	0		0	17,804
Drugs (excludes Blood Products)	146,417	24,402	58		-367	24,460
Sub -total Income from Patient Care Activities	**1,477,115**	**244,626**	**-3,051**	**-1.2%**	**-2,295**	**241,575**
Private Patients/RTA/Overseas(NCP)	10,964	1,592	-482		-115	1,110
Total Income from Patient Care Activities	**1,488,079**	**246,218**	**-3,533**	**-1.4%**	**-2,410**	**242,685**
Training & Education	62,438	10,406	110		-28	10,516
Research & Development	58,061	9,677	-45		-35	9,632
Misc. Other Operating Income	110,272	18,360	-3,320		-1,469	15,040
Other Income	**230,771**	**38,443**	**-3,255**	**-8.5%**	**-1,532**	**35,188**
Total Income	**1,718,850**	**284,661**	**-6,787**	**-2.4%**	**-3,942**	**277,874**
EXPENDITURE						
Pay	-1,010,287	-171,309	2,253	1.3%	1,962	-169,056
Non pay	-650,218	-108,843	2,721	2.5%	1,802	-106,122
Total Expenditure	**-1,660,505**	**-280,152**	**4,974**	**1.8%**	**3,764**	**-275,178**
EBITDA Margin (excluding PSF)	**58,345**	**4,509**	**-1,813**	**1.0%**	**-178**	**2,696**
Interest, Dividends and Depreciation	0	0	0		0	0
Depreciation	-27,927	-4,714	314		159	-4,400
Interest Receivable	444	74	108		54	182
Interest Payable	-40,848	-6,819	-21		-2	-6,840
Dividend	-3,261	-544	80		0	-464
Surplus/(Deficit) on a control total basis	**-13,247**	**-7,494**	**-1,332**	**-17.8%**	**34**	**-8,826**
Surplus/(Deficit) as % of turnover	**0**					**-3.2%**
PSF Income	**27,020**					**2,950**
Non operating Income						**112**
Depreciation - donated / granted assets						**-124**
Impairment						**-4,565**
	13,773	**-4,544**	**0**	**0**	**0**	**-10,453**

Operating Unit Performance against breakeven measures

Income	Pay	Non Pay	Trading Gap	Hospital / MCS	Variance to breakeven budgets - (adverse) / positive		Prior months distance from Control Total	Variance to Control Total		I&E Annual Turnover
Year to date variance					Year to date (to month 2)			Control Total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
981	-941	590	-275	Clinical & Scientific Support	355	0.9%	-109	250	105	232,513
102	794	83	-408	Facilities, Research & Corporate	571	1.1%	55	0	572	301,156
-90	432	48	-179	Manchester LCO	212	1.2%	-19	233	-22	103,356
-1,553	-769	-757	-4,095	MRI	-7,174	-11.2%	-2,301	-3,867	-3,307	384,138
40	88	-3	-433	REH / UDH	-307	-2.2%	-84	-200	-107	83,311
168	-151	6	0	RMCH	23	0.1%	-199	49	-26	247,810
-779	-59	596	-589	Saint Mary's Hospital	-831	-2.9%	-115	-114	-717	174,002
-1,711	466	218	-2,109	WTWA	-3,137	-4.5%	-993	-1,017	-2,119	421,456
-2,842	**-139**	**782**	**-8,088**	**Trust position**	**-10,287**	**-3.2%**	**-3,765**	**-4,666**	**-5,621**	**1,947,742**

Key Run Rate Areas

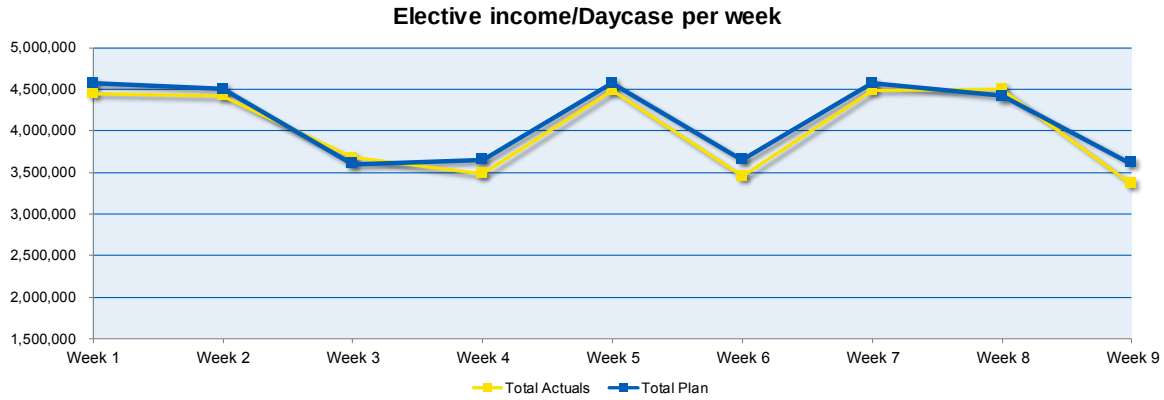
1. Agency spend by Staff Group and Hospital / MCS

Staff Group	Average M1-6 (18/19) £000's	Average M7-9 (18/19) £000's	Average M10-12 (18/19) £000's	M1 (19/20) £'000s	M2 (19/20) £'000s
Consultant	-452	-438	-258	-287	-281
Career Grade Doctor	-48	-52	-38	-54	-108
Trainee Grade Doctors	-685	-571	-352	-191	-296
Registered Nursing Midwifery	-772	-637	-601	-593	-596
Support to Nursing	-137	-150	-117	-39	-68
Allied Health Professionals	-177	-93	-103	-89	-86
Other Scientific and Theraputic	-177	-206	-135	-154	-158
Healthcare Scientists	-164	-81	-105	-58	-43
Support to STT / HCS	-89	-106	-41	-39	-26
Infrastructure Support	-85	-90	-113	-60	-63
Grand Total	**-2,786**	**-2,424**	**-1,863**	**-1,563**	**-1,725**

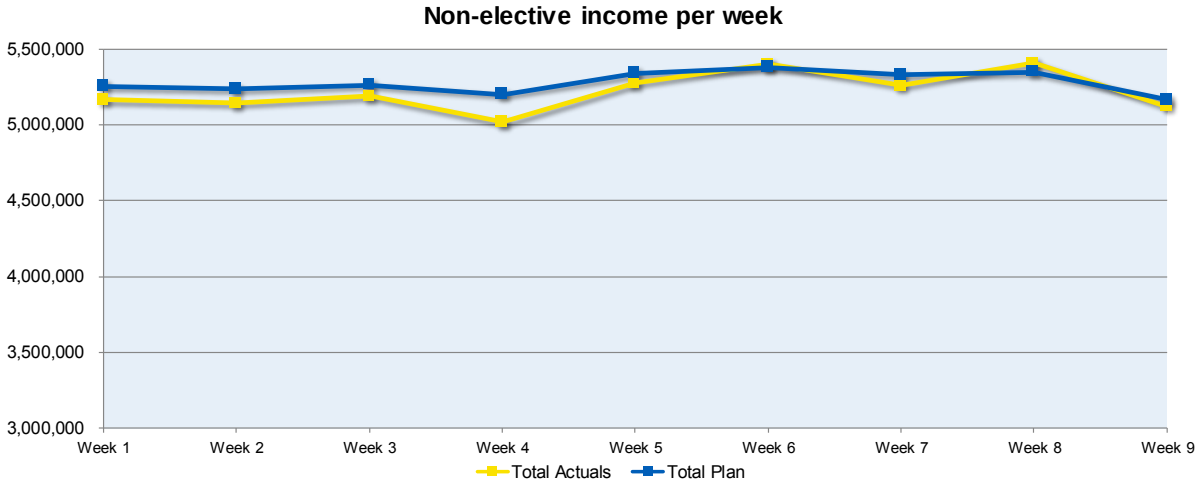
Hospitals	Average M1-6 (18/19) £000's	Average M7-9 (18/19) £000's	Average M10-12 (18/19) £000's	M1 (19/20) £'000s	M2 (19/20) £'000s
Clinical & Scientific Support	-444	-301	-271	-228	-228
Manchester LCO	-47	-44	-61	-47	-38
MRI	-924	-859	-524	-637	-766
REH / UDH	-111	-117	-89	-83	-85
RMCH	-144	-157	-142	-65	-81
Saint Mary's Hospital	-36	-30	-38	-13	-38
WTWA	-899	-697	-632	-387	-478
Corporate	-164	-179	-101	-118	-3
Research	-17	-40	-5	15	-8
Total	**-2,786**	**-2,424**	**-1,863**	**-1,563**	**-1,725**

Trust Total	Agency spend - YTD	Agency ceiling - YTD	Difference (£000)	% Above / (below) ceiling
	3,288	4,388	-1,100	(25.1%)

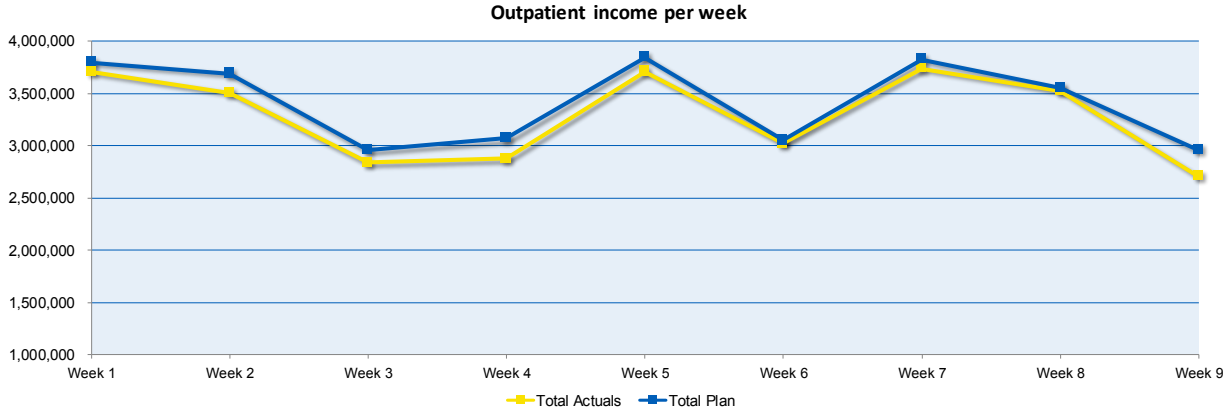
2. Elective / Daycase income: May 2019



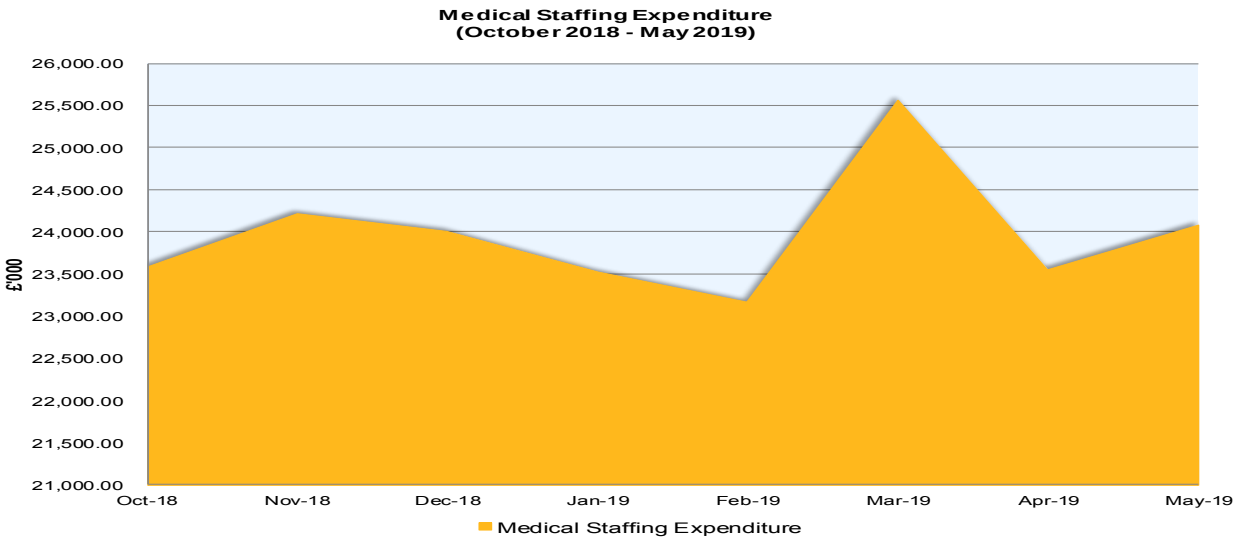
3. Non-Elective income: May 2019



4. Outpatient income: May 2019

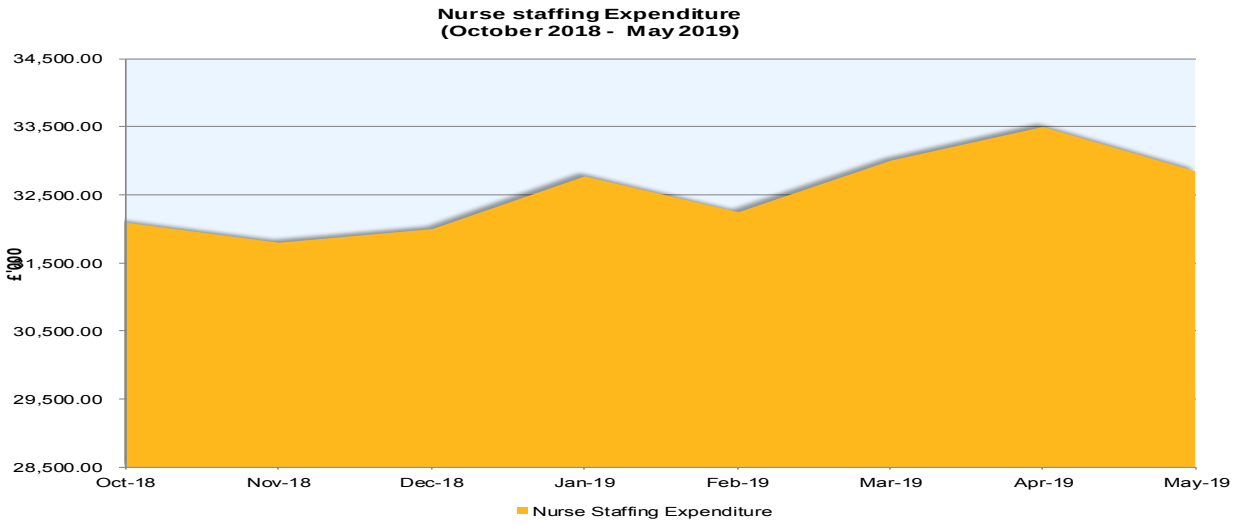


5. Medical Staffing: May 2019



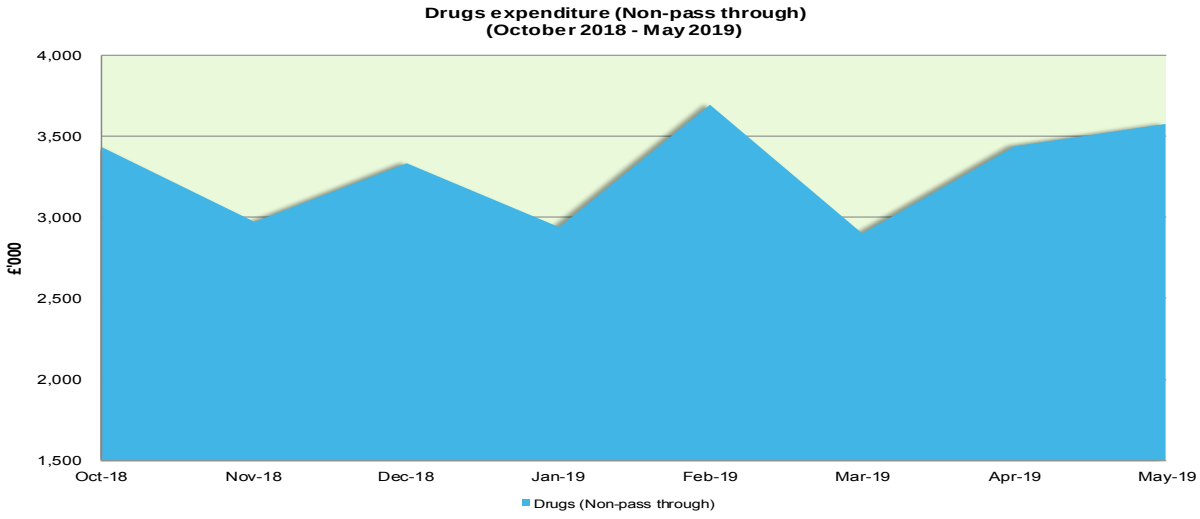
Please note that 18/19 figures have been increased for the 19/20 pay inflation to aid comparability.

6. Nurse staffing: May 2019



Please note that 18/19 figures have been increased for the 19/20 pay inflation to aid comparability.

7. Prescribing: May 2019



NHS Improvement's KPIs

	Plan YTD		Actual YTD	
	Metric	Level	Metric	Level
Liquidity ratio	2.4	1	8.0	1
Capital servicing capacity	0.6	4	0.5	4
I&E Margin	(1.6%)	4	(2.1%)	4
I&E margin: Distance to financial plan	0.0%	1	(0.5%)	2
Agency spend Metric - above / (below) the agency ceiling	(4.6%)	1	(25.1%)	1
Use of Resource (UOR) metrics - Level 1 being highest		**3**		**3**

	Annual Plan (full year)		Forecast 19/20	
	Metric	Level	Metric	Level
Liquidity ratio	(3.2)	2	(3.2)	2
Capital Servicing Capacity	1.4	3	1.4	3
I&E Margin	0.8%	2	0.8%	2
I&E margin: Distance to financial plan	0.0%	1	0.0%	1
Agency spend Metric - above / (below) the agency ceiling	(9.1%)	1	(9.1%)	1
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

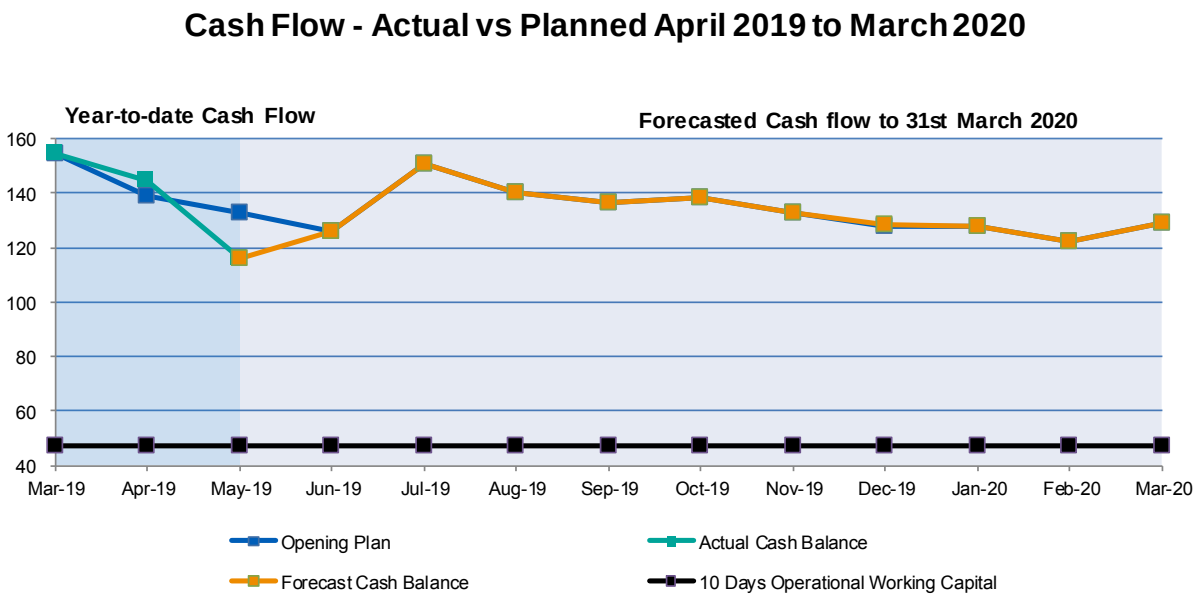
Narrative:

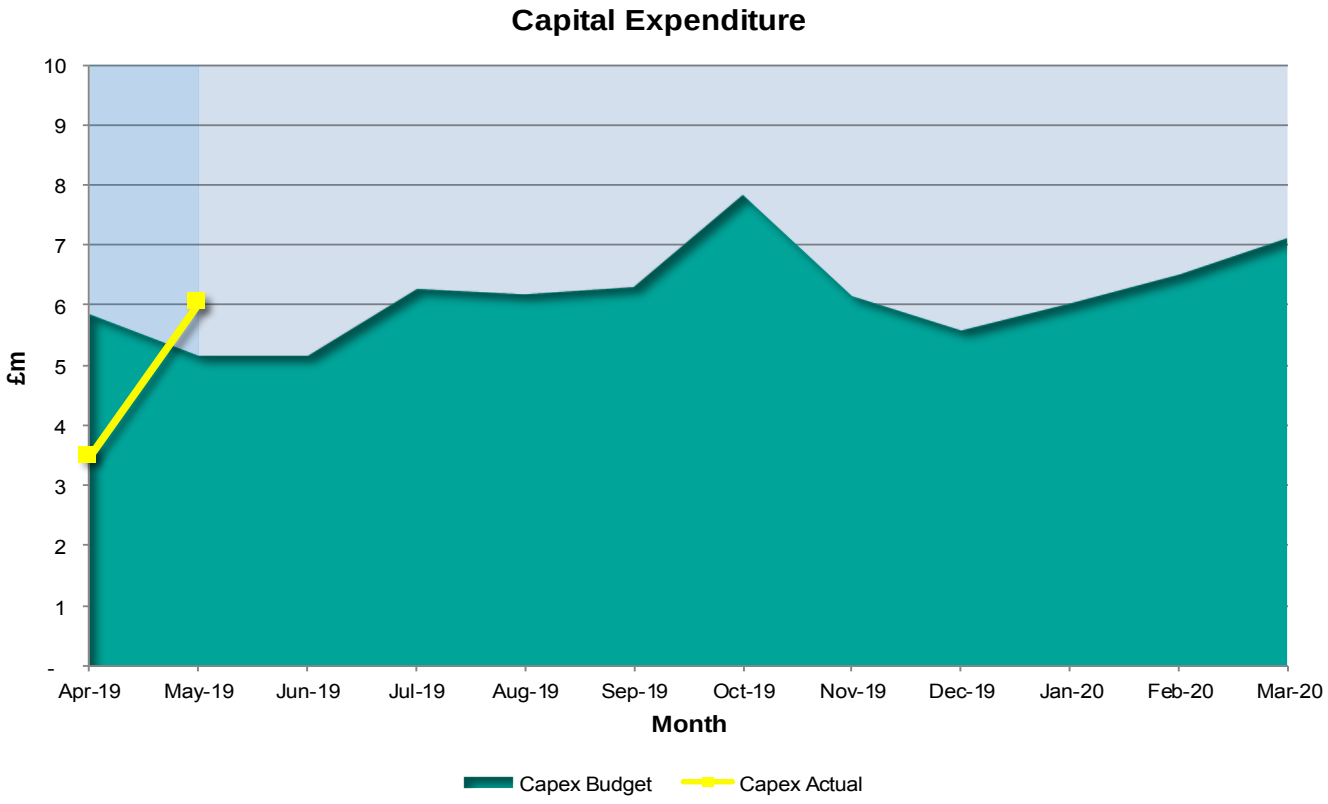
The Trust's financial performance to date is not in line with its Control Total. This is driving an adverse variance in the I&E Margin metrics.

Balance Sheet

	Opening Balance 01/04/2019 £000	Actual Year to Date 31/05/2019 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,120	3,965	(155)
Property, Plant and Equipment	594,723	595,325	602
Investments	2,513	2,513	0
Trade and Other Receivables	4,969	5,598	629
Total Non-Current Assets	**606,325**	**607,401**	**1,076**
Current Assets			
Inventories	16,462	17,292	830
NHS Trade and Other Receivables	83,118	115,487	32,369
Non-NHS Trade and Other Receivables	45,816	33,057	(12,759)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	154,563	115,919	(38,644)
Total Current Assets	**300,169**	**281,965**	**(18,204)**
Current Liabilities			
Trade and Other Payables: Capital	(4,242)	(5,217)	(975)
Trade and Other Payables: Non-capital	(171,403)	(167,868)	3,535
Borrowings	(19,780)	(18,542)	1,238
Provisions	(15,858)	(16,099)	(241)
Other liabilities: Deferred Income	(20,400)	(19,859)	541
Total Current Liabilities	**(231,683)**	**(227,585)**	**4,098**
Net Current Assets	**68,486**	**54,380**	**(14,106)**
Total Assets Less Current Liabilities	**674,811**	**661,781**	**(13,030)**
Non-Current Liabilities			
Trade and Other Payables	(2,600)	(5,047)	(2,447)
Borrowings	(407,793)	(404,231)	3,562
Provisions	(8,815)	(7,202)	1,613
Other Liabilities: Deferred Income	-	(151)	(151)
Total Non-Current Liabilities	**(419,208)**	**(416,631)**	**2,577**
Total Assets Employed	**255,603**	**245,150**	**(10,453)**
Taxpayers' Equity			
Public Dividend Capital	204,780	204,780	0
Revaluation Reserve	45,408	45,408	0
Income and Expenditure Reserve	5,415	(5,038)	(10,453)
Total Taxpayers' Equity	**255,603**	**245,150**	**(10,453)**
Total Funds Employed	**255,603**	**245,150**	**(10,453)**

Cash flow and capital expenditure





Scheme	Full Year Plan £'000	Plan YTD at 31st May 2019 £'000	Spend YTD at 31st May 2019 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes					
Cardiac MR Scanner	800	0	0	800	800
Diabetes Centre	1,649	0	27	1,622	1,649
Helipad	4,746	875	46	4,700	4,746
Other Charity Funded Projects	496	0	0	496	496
Property & Estates Schemes - backlog maintenance	22,479	3,002	2,667	19,812	22,479
MRI ED redevelopment	2,100	0	342	1,758	2,100
RMCH ED redevelopment	1,020	170	0	1,020	1,020
RMCH Atrium	200	0	2	198	200
3rd MRI scanner	1,692	800	590	1,102	1,692
BMT	3,287	0	227	3,060	3,287
Property & Estates - sub-total	**38,469**	**4,847**	**3,901**	**34,568**	**38,469**
IM&T schemes	**17,625**	**3,913**	**3,746**	**13,879**	**17,625**
Equipment rolling replacement programme	**6,734**	**646**	**320**	**6,414**	**6,734**
Healthier Together	**1,750**	**0**	**0**	**1,750**	**1,750**
PFI Lifecycle	**9,813**	**1,636**	**1,567**	**8,246**	**9,813**
Total expenditure	**74,391**	**11,042**	**9,534**	**64,857**	**74,391**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Darren Banks, Group Executive Director of Strategy
Date of paper:	June 2019
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to: National level ▪ NHS Long Term Plan ▪ Annual Planning 2019/20 ▪ Alignment of NHS England and NHS Improvement Greater Manchester level ▪ Improving Specialist Care Programme ▪ PET-CT Service Local level ▪ MFT Clinical Service Strategy Development ▪ Trafford Community Services
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

NHS Long Term Plan

The NHS Long Term Plan was published in January 2019. It set out proposals for:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems, and
- Supporting people to age well.

An implementation framework will be published shortly and will mandate the format and content of local implementation plans. GM will respond to this in the second five-year plan, due to be published in Autumn 2019.

Alignment of NHS England and NHS Improvement

Nationally Amanda Pritchard, Chief Executive of Guys and St Thomas NHS FT and a member of the Shelford Group has been appointed as the Chief Operating Officer for NHS E/I.

The North West Regional Director Bill McCarthy attended the GM Health & Social Care Board and set out what he saw as the role of the Regional Office:

- Coherence – bringing coherence to a system that this currently fragmented
- Follow through of decentralisation – making decisions more locally
- Improving health status and addressing inequalities
- Delivering NHS constitutional standards
- Ensuring the safety and quality of services
- Follow through of the implementation of the long term plan
- Working as a development partner and developing the social value agenda

Annual Planning 2019/20

The final version of the MFT 2019/20 Operational Plan was submitted to NHS I/E on 3 April 2019 prior to the deadline of 4 April 2019.

The MFT internal business planning round has completed. Each Hospital / MCS has developed their plan for 19/20 and an over-arching MFT Annual Plan has been developed – see agenda item 9.2.

3. Greater Manchester Issues

Improving Specialist Care Programme

It has been agreed that paediatric medicine will be an in-scope specialty for the Improving Specialist Care programme.

PET-CT Service

Having been named by NHS England as the preferred supplier through phase 2 of the national procurement of PET-CT, MFT and The Christie are finalising contractual arrangements for the delivery of the PET-CT service for Greater Manchester.

The aim is to have these arrangements finalised in July. In the short-term there will be an increase in the number of PET-CT scans currently delivered on the Oxford Road Campus, as well as scanners at The Christie and Wigan. In the coming years the service will see 3 additional scanners installed across Greater Manchester delivering a significant improvement in access for patients in some of the areas where the need is greatest, including Wythenshawe.

4. MFT Issues

MFT Clinical Service Strategy Development

Overarching Group Service Strategy
The overarching Group Service Strategy was approved by the Board of Directors in November 2018. The document has been circulated to the Council of Governors and key external stakeholders for comment. The document has been updated based on the feedback received and findings from the development of the individual clinical services and is being presented to the Board for approval this month.

Clinical Service Strategies
Waves 1, 2 and 3 cover the services spanning WTWA and MRI. The wave 1 and 2 service strategies have now been approved by the Board. Wave 3, which includes Orthopaedics, Infectious Diseases, Burns and Plastics' Breast and Rehabilitation and the Saint Mary's and RMCH Clinical Service Strategies are now complete and are also being presented to the Board this month for approval.

This will mark the end of the development phase of the programme. The next steps include wider engagement, business case development (for those proposals contained within the strategies that have resource implications) and implementation planning.

It is important to note that the proposals outlined in all of the strategies represent our preferred option at this point. However, they are at a formative stage only. We will not decide to make or implement any material service changes until after we and/or our commissioners have taken appropriate steps that may (as required) include public involvement, consultation with the relevant Health Overview Scrutiny Committee(s) and the completion of an equality impact assessment.

Trafford Community Services

Due diligence on the proposed transfer of community services from Pennine Care NHS FT to MFT is underway. A target date for transfer has been agreed as 1 October 2019.

5. Actions / Recommendations

The Board of Directors is asked to note the updates in relation to:

National level
- NHS Long Term Plan
- Annual Planning 2019/20
- Alignment of NHS England and NHS Improvement

Greater Manchester level
- Improving Specialist Care Programme
- PET-CT Service

Local level
- MFT Clinical Service Strategy Development
- Trafford Community Services.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	June 2019
Subject:	Annual Planning 2019/20
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	The Annual Plan sets out how we plan to deliver the Trust vision and strategic aims.
Recommendations:	The Board of Directors is asked to: - Approve the MFT Annual Plan 2019/20. - Note that further work will be brought back to the Board to show how progress will be monitored.
Contact:	Name: Caroline Davidson, Director of Strategy Tel: 0161 2768976

1. Introduction

The purpose of this paper is to seek approval from the Board of Directors for the MFT Annual Plan 2019/20.

2. Background

The purpose of an Annual Plan is to set out what the organisation intends to do in the coming year in order to achieve its short-term targets (such as performance and financial targets) as well as making progress towards its longer-term vision and strategic aims.

Each year Foundation Trusts are required to submit an Operational Plan to NHS E/I. The content of this is prescribed by NHS E/I. Last year, in line with many other Trusts, our MFT Group-level plan was the Operational Plan required by NHS E/I. However on reflection and based on feedback from CoG, it was felt that the content and format of this plan did not reflect what we would expect to see in an MFT annual plan and that for 2019/20 we would also produce a separate MFT Annual Plan. This document would explain the national and local context within which we are working and bring together the plans from across the Hospitals / MCSs and the corporate departments. It would illustrate how, as a large organisation made up of individual Hospitals / MCSs, we all work towards a common vision and aims.

For 2019/20 we have therefore produced an Operational Plan for NHS E/I and a MFT Annual Plan.

3. MFT Operational Plan 2019/20

The MFT Operational Plan was developed from January to March 2019. It was reviewed by the Council of Governors and approved by the Board prior to submission to NHE E/I on 3 April 2019. This was the subject of a Board paper in March 2019.

4. MFT Annual Plan 2019/20

The starting point for the annual planning cycle internally is to review the Trust vision and strategic aims and ensure that they remain relevant and valid for the coming year. The MFT vision and strategic aims were established as part of the Single Hospital Service Programme and, as such were designed to be relevant for the duration of the programme. As the SHS programme is still in train it was agreed that the existing vision and strategic aims would be retained for 2019/20. They are set out at attachment A for information.

Each Hospital / MCS within the Group develops their own business plan. As part of this, the Hospital / MCS decides what their priorities for the coming year should be. These reflect their own particular services and circumstances, as well as aligning to the Group level vision and strategic aims. Corporate departments also develop work plans for the coming year.

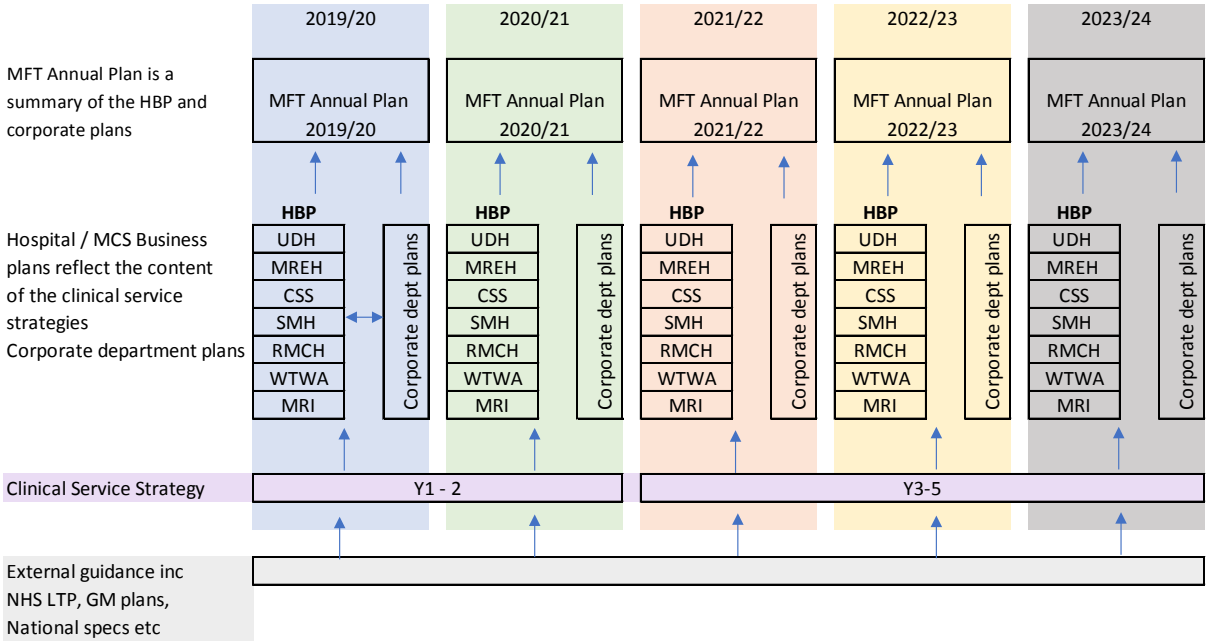
The MFT Annual Plan (attachment B) brings together, at a summary level, the Hospital / MCS business plans and the plans of the Group-wide departments such as HR, Transformation. It is formatted to show the contribution made by the individual Hospitals/ MCS and corporate departments to each of the Trust strategic aims.

Views of the Council of Governors

As a Foundation Trust, we must 'have regard to the views of the Council of Governors' who should in turn represent the views of their constituents. In order to facilitate this, the MFT Membership Team distributed a questionnaire to members and the public asking for their views on what our priorities for 2019/20 should be. The responses to this were analysed and the results were fed back to the Hospitals/MCSs so that they could be considered in their planning. Each Hospital / MCSs also presented their proposed key priorities and plans to the Council of Governors in December 2018 and members had the opportunity to comment and provide feedback on the proposals directly.

Links to the Clinical Service Strategy

As Board members are aware, work has been undertaken during 2018/19 and into quarter 1 of 2019/20 to develop our Clinical Service Strategy. This sets out our longer term (5 year) ambitions for the development of our services. The initiatives described in the strategy are grouped in to year 1-2 and year 3-5. We would expect to see the year 1-2 initiatives reflected in the annual plans for 19/20 and 20/21 as set out in the graphic below.



5. Monitoring Delivery

The objectives described in the Annual Plan will be monitored in various ways; some through the Board Assurance Report, others through less formal mechanisms. Further work is to be undertaken to map for each initiative how progress will be monitored and reported.

6. Recommendations

The Board of Directors is asked to:

- Approve the MFT Annual Plan 2019/20.
- Note that further work will be brought back to the Board to show how progress will be monitored.

Attachment A

The MFT vision and strategic aims are set out below:

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

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

This is underpinned by our strategic aims, which are:

- **To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner**
- **To improve patient safety, clinical quality and outcomes**
- **To improve the experience of patients, carers and their families**
- **To develop single services that build on the best from across all our hospitals**
- **To develop our research portfolio and deliver cutting edge care to patients**
- **To develop our workforce enabling each member of staff to reach their full potential**
- **To achieve financial sustainability**

Attachment B

Manchester University NHS Foundation Trust

Annual Plan 2019/20

CONTENTS

1. Introduction

The purpose of developing an Annual Plan is to set out our plans for the coming year for:

- Delivering services to NHS performance standards - how we are going to deliver the activity required to meet demand and meet the required NHS performance targets, and
- Progressing our strategic aims – what progress we are going to make towards the achievement of our long vision and strategic aims and how we are going to achieve this.

This document describes MFT and the context in which we are developing our plans; the challenges that we are facing and the opportunities open to us in both the coming year and in the longer-term. It sets out key plans for 2019/20 for both the group level teams and for each of the Hospitals and Managed Clinical Services, what they are aiming to achieve ultimately and what specifically will be achieved in 2019/20. It also describes how we manage the risks to delivery of the plan, and how we monitor delivery over the year.

Who we are

Manchester University NHS Foundation Trust (MFT) is one of the largest NHS trusts in England providing community, secondary, tertiary and quaternary services to the populations of Greater Manchester and beyond. We have a workforce of over 20,000 staff and are the main provider of hospital care to approximately 750,000 people in Manchester and Trafford and the single biggest provider of specialised services in the North West of England. We are a university teaching hospital with a strong focus on research and innovation.

The Trust is organized into seven operational units; five of these are described as Managed Clinical Services and two as Hospitals. Managed Clinical Services (MCS) are accountable for the delivery and management for a defined group of services wherever they are delivered across MFT. In addition to this they are also responsible for setting standards and developing strategy for those services. Our Managed Clinical Services are:

- Royal Manchester Children's Hospital (RMCH)/ Children's Services
- Saint Mary's Hospital (SMH) / women's services and genomics
- Manchester Royal Eye Hospital (MREH)/ eye services
- University Dental Hospital of Manchester (UDH) / dental services
- Clinical and Scientific Services (CSS)

The Hospitals are responsible for the services delivered on their sites. They work to MFT group standards and strategies. Our Hospitals are:

- Manchester Royal Infirmary (MRI)
- Wythenshawe, Trafford, Withington and Altrincham (WTWA)

MFT also hosts Manchester Local Care Organisation (MLCO). MLCO provides integrated out-of-hospital care for the city of Manchester. Services provided incorporate community nursing, community therapy services, intermediate care and enablement, and some community-facing general hospital services.

Our vision and values

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

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

Our work is underpinned by our values statement that Together Care Matters and a values and behaviours framework as shown in the graphic below. These values and associated behaviours will support the creation of a compassionate, inclusive and high quality care culture that enables excellence in quality and safety to flourish.

Our Vision

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

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

Our Values

Together Care Matters

Everyone Matters
Working Together
Dignity and Care
Open and Honest

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

2. Key Challenges and Opportunities

The following sets out the context in which we are operating, in particular the challenges and opportunities that we face. Many of these are longer-term issues and will not be resolved in one year, but the plans set out in section 3 describe what we will be doing and the progress that we expect to make in 2019/20.

Financial pressures
As for all NHS providers, we face financial challenges; funding growth is forecast to be slower than historic long-term trends and there is limited access to capital for investment and transformation. Spending pressure on Local Authorities also continues, impacting on the provision of social care and public health spending in Manchester and Trafford.

Workforce
Pressure on the NHS workforce generally is increasing, with demand for staff growing faster than the size and skill mix of the available population. Although MFT is able to attract and retain staff in many areas where other Trusts cannot, we do face challenges in specific areas. These include consultant staff (in particular within emergency medicine, paediatric specialties, acute medicine, dermatology and ophthalmology specialties), junior medical staff (in paediatrics, urology and emergency medicine), nurses (in emergency medicine, theatres, and paediatrics) and radiographers.

Growing demand
Across the NHS, patient volumes and overall workload are increasing faster than population growth. This is driven in large part by an ageing population. Our increasing ability to treat disease and extend life is leading to additional demand from the chronically ill, and patients with multiple morbidities.

Deprivation
The population of both Manchester and Greater Manchester are significantly more deprived than the England average. This impacts on the prevalence of long term conditions and ultimately on higher mortality rates. We also see an impact on child health and wellbeing; childhood obesity rates for Greater Manchester are above average and growing.

National policy
The NHS long term plan sets out the direction of travel for the NHS over the next 5 to 10 years. It focusses on prevention and the development of local out-of-hospital services. It sets an ambition to reduce face-to-face hospital-based outpatients by 30% and to change the way in which urgent care is provided.

Local policy
Devolution has placed Greater Manchester in charge of its own health spending and planning and enables the region to think differently about the delivery of care and improvement of health outcomes for its population. Working in closer partnership with all of the health and social care organisations across GM puts a responsibility on us to provide support to fragile services in the surrounding hospitals such as dental and breast services.

Estate and capacity
Some areas of the Trust face challenges in relation to the estate in terms of its quality or capacity. These include the University Dental Hospital, Wythenshawe Hospital, the emergency departments at MRI and RMCH and some of our community facilities.

Data and digital adoption
There is a national agenda to increase the use of electronic systems for recording data across the NHS. At MFT many of our systems and processes remain paper-based which presents challenges in relation to communications between staff and with patients and to our productivity and efficiency.

Opportunities

Personalised medicine
Developments in advanced diagnostic disciplines such as genomics, as well as a more data-driven approach to designing and delivering care, are creating increasing opportunities in the field of precision medicine. We are increasingly able to tailor treatment to the individual and their specific needs, improving the effectiveness and efficiency of the care we provide. As a Genomics Lab Hub we are in a position to be at the forefront in the development of personalised medicine.

Electronic Patient Record
MFT is in the process of procuring an electronic patient record system (EPR). An EPR will enable our patients and system partners, including primary care colleagues, to interact with us in a completely different way and will ultimately facilitate the transformation of our services and a significant improvement in our productivity and efficiency. This is however a 2-3 year programme. Implementation starts July 2020 and the planned go-live date is September 2022.

Single Hospital Service
The creation of the Single Hospital Service has provided the potential to deliver a range of benefits for patients and staff. These benefits were identified through the merger process and we have committed to the delivery of many of these benefits as part of the Benefits Case and the Manchester Agreement.

Capacity and space
The merger presented the Trust with an opportunity to better utilise space across our broadened estate. The potential acquisition of North Manchester General Hospital could offer further opportunities for us to rethink how we most effectively use our estate in future years.

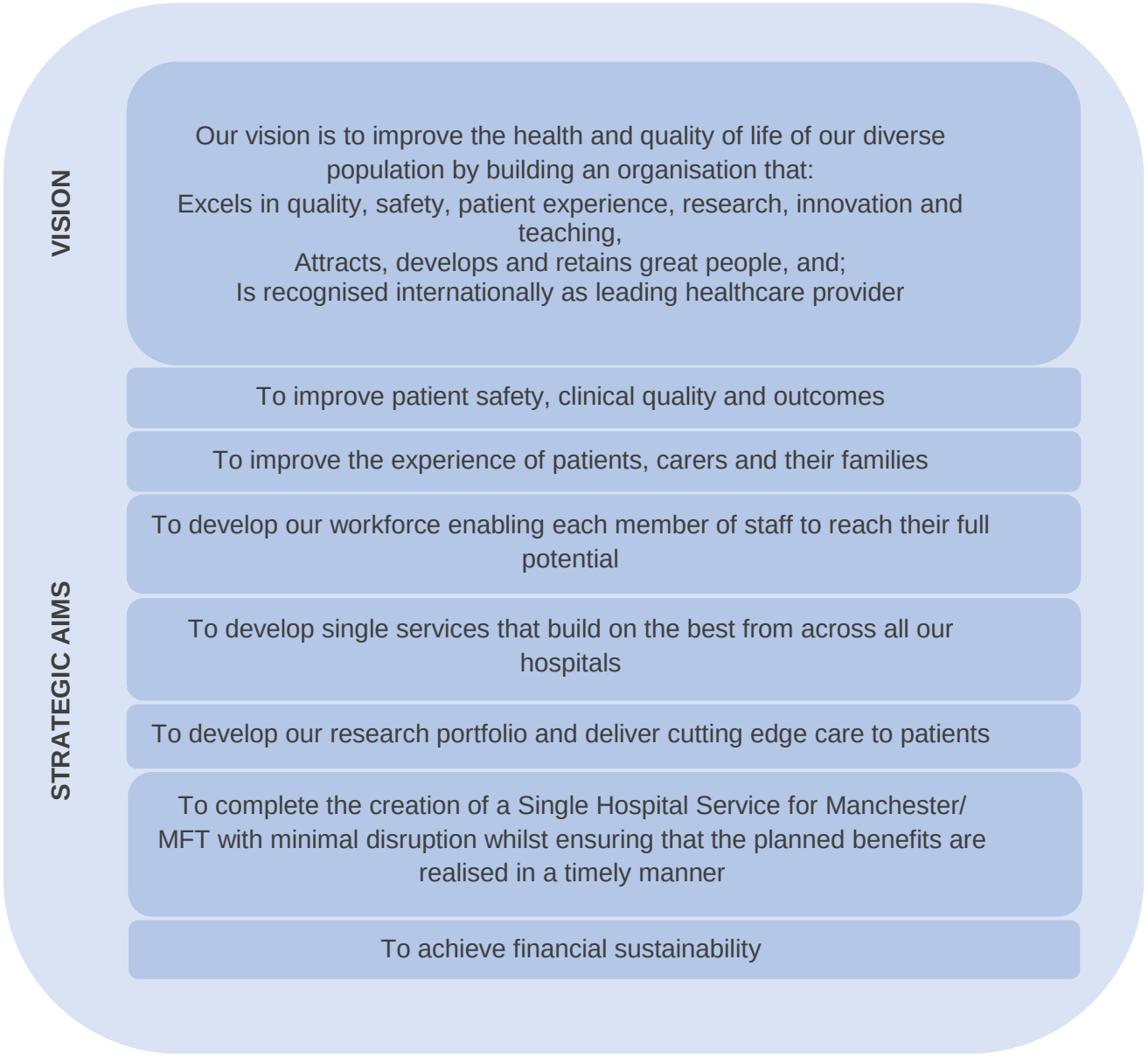
Unwarranted variation
Across the Trust, the type and quality of the service provided to patients can vary depending on the location at which the patient presents which can lead to sub-optimal care for patients and inefficiencies across our services. The merger has presented us with an opportunity to further tackle variation to improve the care we provide across all 9 of the MFT sites.

Wythenshawe estate
An ambitious scheme to re-develop the Wythenshawe site improving the quality of the estate and the clinical facilities has been developed. This is an innovative plan that leverages the close proximity of the Wythenshawe campus to the airport, the proposed HS2 development and new Metrolink station. The early phases of this ambitious 15 year programme, as well as enhancing the clinical facilities, will improve access to the site and connectivity to the community to support the HS2 and Metrolink developments.

Capital developments
Although capital funding is significantly limited, there are plans in train to invest in a number of key areas including the emergency departments in both MRI and RMCH.

3. MFT Vision and Strategic Aims

Our vision sets out what sort of organisation we want to become over the coming 5 to 10 years. It is underpinned by seven strategic aims that describe in more detail what we want to achieve over the same timeframe. Our vision and strategic aims are set at the MFT group level and ensure that the whole organisation is working to the same agenda.



Priorities and Plans for 2019/20

Based on our MFT vision and strategic aims, each Hospital / MCS and corporate team develops their own priorities and plans for the coming year. The following summarises key plans for 2019/20 for both the group level teams and for each of the Hospitals and Managed Clinical Services. The tables set out which corporate department or Hospital /MCS is responsible, what they are aiming to achieve and what specifically will be achieved in 2019/20 and by which quarter. These are in no way exhaustive but give a flavour of the priority areas for 2019/20. In some areas the balance is towards the Hospitals and MCS delivering the majority of the work and in others, such as the Single Hospital Service, it is towards the corporate teams.

To improve patient safety, clinical quality and outcomes

Quality is at the heart of what we do, our aim is to become the best in class; delivering high quality, safe and effective healthcare services that are informed by cutting edge research that enables us to be ambitious for the future health and wellbeing of the people of Manchester and surrounding areas.

We have made a commitment to everyone who uses our services, our staff and stakeholders; that quality and safety will always be our top priority and that we will continue to improve our services in the future. We are implementing a programme of sustained improvement supported by our values and behaviours and a safety culture where quality and safety are everybody's business, to ensure we deliver the best outcomes and experience every time.

Group level	What we are going to do	What will be achieved in 2019/20	By when
Clinical Governance	Revise and relaunch consent process	• New MFT wide policy launched • Standard speciality based risk consent information rolled out	Q1 Q2
Clinical Governance	Implement World Health Organisation (WHO) Safe Surgery Check List	• New MFT wide policy launched • New policy embedded and compliance improved	Q1 Q2
Clinical Governance	Deliver Care Quality Commission (CQC) action plan	All actions closed or transferred to business as usual	Q4
Corporate Nursing	Develop two key patient focused collaboratives for Falls and Wound Care to improve outcomes and align research to patient benefit	• Multi-agency collaboratives established. • Reduction in falls achieved • Reduction in variation in wound care practice achieved	Q4
Transformation	Discharging complex patients - joint programme with Manchester Health & Care Commissioning (MHCC)/MLCO	New ways of delivering care to patients at home (virtual ward) and ambulatory care implemented to improve patient flow	Q1
Transformation	Improve frailty care	Frailty service established at MRI for timely identification, access and management of frail patients	Q4
Estates	Redevelop paediatric Emergency Department so that capacity is broadly doubled	Design and development phase commenced (completed 2022)	Q4
Estates	Redevelop MRI Emergency Department to meet the needs of the Manchester population by 2021	Enabling works commenced on site	Q4
Estates	Provide integrated neurosurgical MRI scanning and theatre facilities within RMCH (iMRI) by 2022	Design and development phase commenced	Q4

Estates	Wythenshawe Site Masterplan Programme	RIBA stage I and further agreed programmes of work completed	Q4
IM&T	Implement electronic observation and monitoring	Patientrack implemented at Wythenshawe	Q4
		ViewPoint foetal monitoring solution at Oxford Road Campus (ORC) upgraded and implemented at Wythenshawe	Q3
IM&T	Implement electronic patient record systems	Electronic Patient Record (EPR) rolled out to Community Services	Q4
		Clinical client record system for use by the Sexual Assault Referral Centre (SARC) implemented	Q2
IM&T	Prepare for Electronic Patient Record (go live date Sept 2022)	• Strategic procurement of Hive EPR and business readiness for implementation achieved. • Implementation of tactical roadmap for business continuity and readying systems for decommissioning achieved	Q4
IM&T	Implement Blood Tracking to give full traceability and achieve compliance with national requirements.	Batch Blood Tracking module implemented at Wythenshawe	Q1

Hospital / MCS	What we are going to do	What will be achieved in 2019/20	By when
RMCH	Improve response to acutely ill and deteriorating child	New escalation policy implemented for acutely ill and deteriorating children	Q4
RMCH	Implement systems to support nurse staffing and longer-term workforce modelling	Safe Care embedded to support daily nurse staffing decisions and longer-term workforce modelling	Q2
SMH	Maintain low infection rates	Benchmarked levels achieved throughout the year.	Q4
SMH	Implement Postgraduate Medical Education action plan	Positive scoring achieved in the General Medical Council training survey	Q4
WTWA	Implement new Trust-wide Safe Surgery Policy	Reduction in never events achieved	Q4
WTWA	Embed safe Infection Prevention and Control (IPC) working practice	Reduction of IPC incidents in line with thresholds	Q1
WTWA	Deliver harm free care	Reduction of Hospital Acquired Pressure Ulcers (HAPU) and Catheter Associated Urinary Tract Infections (CAUTI) in line with agreed profile for 19/20	Q4 Q4
MRI	Institute a systematic hospital response to the CQC report	• Progress monitoring against comprehensive action plan implemented • Programme of culture change work within the hospital implemented • Litmus tests: safe surgery checklist, equipment cleanliness/management	Q4
MRI	Strengthen infection prevention and control	• Hand hygiene practice is universal • Plan achieved for level of infections	Q1-4
MRI	Ensure full compliance with national requirements for major trauma centres	• Successful peer review achieved	Q2
MREH	Increase medical capacity in the form of consultant posts	Eliminate use of agency locum cover to provide baseline contracted activity. Reduced medical agency locum costs	Q2
MREH	Decrease risk of 'lost to follow up'	• Risk Stratification Process developed • Failsafe Policy Implemented • Failsafe Dashboard developed	Q1
UDHM	Be national leader in relation to patient safety	Hosted national Association of Dental Hospitals patient safety event	Q3
UDHM	Continue to develop Mouth Care Matters across MFT	Training materials completed for use	Q4
CSS	Achieve 14 day turnaround for CT scans for patients on suspected cancer pathway at ORC	Additional radiographers appointed	Q3
		Cancer sessions increased	Q4
		RMCH CT scanner utilised in afternoons/evenings	Q4
CSS	Achieve 14 day turnaround for MRI for patients on suspected cancer pathway at ORC	Schemes for one stop clinics piloted	Q2
		• New MRI Scanner operational • Current staff structure reviewed and moved to a 7-day service	Q2 Q4
CSS	Achieve 7 day lab results turnaround for patients on suspected cancer pathway	Lab Key Performance Indicators (KPI) introduced	Q4

To improve the experience of patients, carers and their families

Patient experience, patient safety and clinical effectiveness are the three aspects of quality in health care. A high-quality health service exhibits all three. Our ambition is to provide the highest quality of care and the best patient experience, making Manchester University NHS Foundation Trust the place that people want to work and receive care.

We aim to be in the top decile in the NHS across all quality, safety, patient experience and staff satisfaction metrics and to be nationally and internationally renowned for excellence in providing every patient with a high quality, personalised experience at every contact.

Group level	What we are going to do	What will be achieved in 2019/20	By when
Corporate Nursing	Support consistent implementation of standards for patients with Learning Disabilities across the hospitals/MCS	Compliance with NHS I Learning Disability Improvement Standards for NHS Trusts	Q4
Corporate Nursing	Support hospitals/MCS/MLCO to improve the timeliness and quality of complaint responses	• Reduction in dissatisfied complainants. • Reduction in unresolved complaints exceeding 40 days	Q4
Corporate Nursing	Further develop the What Matters To Me (WMTM) patient experience programme across the Group, including the MLCO	• WMTM embedded in practice and strategy across the Trust • Continuous improvement in Friends and Family Test (FFT) and WMTM patient survey data	Q3
Corporate Nursing	Review and deliver a revised PALS service across MFT	Revised Patient Advice & Liaison Service (PALS) model implemented offering proactive early support to resolve concerns	Q4
Transformation	Implement Outpatient transformation programme	• Virtual models of care increased • Centralised booking/functions implemented in the MRI • Outpatient clinic letter standards developed	Q3
ED&I	Implement Trust wide Equality & Diversity Strategy - key focus on accessibility	Agreement of a new wayfinding strategy for the Oxford Road Site (ORS) site including improved site maps and signposting.	Q4
IM&T	Implement OPD self-service check-in kiosks	Self-Service Check in kiosks installed (phased roll-out)	Q4

Hospital / MCS	What we are going to do	What will be achieved in 2019/20	By when
RMCH	All wards to actively participate in a quality improvement journey Further embed the What Matters to Me WMTM process across RMCH MCS	8 wards rated as Gold as part of the Ward Accreditation Programme achieved	Q4
RMCH	Review of North West Operational Delivery Networks with commissioners, clinical leads, patients and families	New network strategies, governance, leadership and implementation plans in place to improve paediatric care access across the North West	Q4
SMH	Reduce waiting times within the Emergency Gynaecology Unit	Achieve Emergency Gynaecology Unit 4 hour waiting time trajectory each quarter.	Q4
SMH	Reduce inpatient waiting times	No 52 week breaches during the year	Q4
WTWA	Review Out Patient (OP) appointments to ensure care is delivered in the best setting	Improved feedback/reduced complaints	Q4
WTWA	Reduce last minute cancelled appointments	Recruitment programme completed for consultants, nurses and advanced care practitioners to improve the staffing of clinics	Q4
MRI	Improve handling and learning from complaints	• Fewer open complaints • Increase in complaints handled within timescale agreed with complainant • Demonstrate embedded learning from key complaint themes	Q4
MRI	Improve outpatient experience	• Standardised centralised management of outpatient booking • Reduction in patients not attending appointments (DNAs) • Improvement in Friends and Family Test score (FFT) • Overall open waiting list size maintained or reduced	Q4
MRI	Improve inpatient care pathways	• Reduction in patients waiting over the 4 hour target in A&E • Reduced length of stay through the Safer Better Together Patient Flow Programme • Fewer theatre delays and cancellations through the Theatre Improvement Programme	Q4
MREH	Implement Outpatient Improvement Programme to improve utilisation, increase efficiency and improve the patient experience	• Outpatient Improvement Board implemented • Work Programme identified and commenced • Performance Dashboard developed.	Q1
MREH	Develop Theatre Improvement Programme to improve utilisation, increase efficiency and improve the patent experience	• Theatre Improvement Board implemented • Work Programme identified and commenced • Performance Dashboard developed.	Q1
MREH	Promote leadership in the patient safety agenda • Embed Failsafe role • Promote widened participation at Audit & Clinical Effectiveness (ACE days)	• Failsafe Officer post embedded and leading on initiatives to reduce lost to follow up • Regular attendance at ACE Days from the wider Multi-disciplinary Team (MDT) with a range of presentations from all disciplines • Reduction in High Level Investigations • Increased staff awareness of the role	Q4

	• Participation in patient safety events and campaigns • Embed the Speak Up Safely Champion roles		
UDHM	Improve waiting time position in relation to Orthodontics and Paediatrics	Orthodontics waiting time position improved to compliance and reduction in numbers on Paediatric Dentistry Waiting List	Q3
UDHM	Maintain an 'Outstanding' Accreditation status across the entire hospital	Gold Accreditation maintained across the hospital	Q1
CSS	Resolve complaints within agreed timeframe	New staff training including Standard Operating Procedures implemented	Q1
CSS	Engagement with Patient Advice & Liaison Service (PALS) to actively manage the complaints process	Reduce the number of complaints	Q2

To develop our workforce enabling each member of staff to reach their full potential

With almost 20,000 paid staff and volunteers, our workforce is the driving force behind what we deliver as a Trust for one another, our patients and our community. It is vital that we develop our relationships and support our people in becoming the best at what they do.

When our staff perform at their best we deliver the highest quality of care and patient experience and this makes staff proud to work for our Trust and act as positive advocates for us as a provider of health and social care services and an employer of choice.

People performing at their best requires sustained effort and contribution on their part, together with a working environment that encourages and supports excellence all of the time.

Group level	What we are going to do	What will be achieved in 2019/20	By when
ED&I	Run a 'removing barriers' programme to increase the number of BME (Black & Minority Ethnic group) staff in leadership positions across the Trust	Removing barriers programme launched, implementation and monitoring (through Workforce Race Equality Standard) commenced	Q3
ED&I	Implement the Employee Health & Wellbeing Framework to improve the wellbeing of staff	80% take up of flu vaccination programme achieved	Q3 / Q4
ED&I	Deliver 'widening participation' programme to provide access to work experience for schools, colleges and community partners (runs to 2012)	Over 500 work experience placements in a 12 month period from Q4	Q4
Transformation	Share learning	'Transform together' events for staff to share and showcase change projects	Q4
Transformation / OD&T	Support learning and improvement	• Academy and E-learning module for improvement launched • Single improvement hub established via intranet	Q1
Workforce	Develop single MFT workforce policy suite in collaboration with staff side colleagues	All workforce policies reviewed to develop single MFT policy where appropriate in line with legislation and best practice	Q4
Workforce	Pilot internal transfer initiative to encourage staff development and progression and retain existing workforce	Pilot scheme implemented in nursing	Q3
Workforce	Embed new appraisal process - Values and Behaviours Programme	Improvements in appraisal compliance and quality of appraisal as measured by the pulse checks and staff survey	Q4

Workforce	Embed High Performing Team Framework (Affina Team Development Programme)	Increase in the numbers of accredited team coaches, teams undertaking Affina Programme and improvements in the team working indicators	Q4
Comms	Develop communications which enhance the profile of MFT	Bespoke Hospital/MCS communications plans implemented which will result in positive press coverage, proactive social media content, improved website content and improved staff communications through eg Hospital CE blogs	Q4
Governance	Drive continuous improvement in Leadership & Governance in keeping with the 'Well Led' Framework	• Annual Review of the MFT Organisational governance arrangements completed • Membership Recruitment Campaign completed	Q4
Corporate Nursing	Transform nursing, midwifery and AHP workforce	New roles developed and introduced with appropriate skills to meet patients' needs	Q4
Corporate Nursing	Lead a programme of work to upskill the nursing, midwifery and AHP workforce to meet revised professional regulatory standards	• Increase in extended and advanced roles. • Workforce with appropriate to meet service needs and professional regulatory standards	Q4
Corporate Nursing	Work in partnership with Higher Education Institutes (HEI) to develop a portfolio of training/education programmes to expand the Nursing, Midwifery and Allied Health Professionals (NMAHP) workforce pipeline	Increased number of students and apprentices	Q4

Hospital / MCS	What we are going to do	What will be achieved in 2019/20	By when
RMCH	Develop RMCH workforce strategy that is aligned with MFT Workforce, Leadership and Culture strategy for delivery over the next 5 years	RMCH workforce strategy developed and implementation commenced	Q4
RMCH	Improve team working, workplace experience and retention of staff over the next 5 years	Leadership and Culture plan developed and delivered that builds on staff survey and Pulse Check results	Q4
RMCH	Support continuous professional development across all staff groups over the next 5 years	Plans developed and implementation commenced to ensure compliance with appraisal, medical appraisal, mandatory training and education requirements for newly qualified clinical staff	Q4
SMH	Utilise Affina to facilitate leadership development programmes	Demonstrable evidence that Affina team journey has been undertaken in selected areas of the MCS	Q4
SMH	Present Saint Mary's MCS as an employer of choice	Attraction & Recruitment strategy developed and implemented	Q4
WTWA	Build leadership and management capability	• Leadership programme for senior Divisional Management teams developed and implemented • Affina OD team journey rolled out across Divisions, Directorates and Teams	Q3 Q2
WTWA	Improve recruitment and retention to key staff groups	• Offer for medical workforce in 'hard to recruit' specialities reviewed • WTWA Nursing Workforce Strategy implemented	Q4
MRI	Increase nurse staffing levels with improved retention	• Successful innovative recruitment (international and nursing associates) • Reduction in turnover rate • Reduction in vacancy rate	Q4
MRI	Improve staff engagement within the hospital	• Opportunity for all staff to be engaged in work on the hospital's future direction • Pulse Check engagement score	Q1 Q4
MREH	Increase staff engagement and promote a positive, proactive culture	Increased Staff Engagement Scores	Q1
MREH	Create extended roles able to support clinical activity previously undertaken by medical staff	Optometry and Orthoptic Professionals recruited	Q4
MREH	Develop a workforce strategy aligned to long-term clinical service model aspirations, including increasing non-consultant delivered activity	• Education and Workforce Group established • Education and Workforce Strategy developed and ratified at Hospital Management Board	Q2
UDHM	Maintain staff engagement and promoting a positive culture	Improved staff engagement scores on Staff Survey	Q1
UDHM	Develop a workforce strategy that takes advantage of the apprenticeship levy	Strategy to increase numbers of apprentices developed	Q4
CSS	Launch and champion new appraisal system	Appraisal (Non-medical) targets achieved	Q2
CSS	Continually improve the wellbeing of the CSS staff	Staff engagement plan refreshed including staff Health & Well-being campaign, CSS Stars and 'intention to stay' actions	Q1

To develop single services that build on the best from across all our hospitals

It is important that we keep pace with the changes in health care so that we to continue to provide the highest quality care to our patients. This can be by growing our services, providing new services or changing the way in which we provide existing services. It is of particular importance that, following the merger, we create single services across MFT that bring staff together into larger clinical teams that are required to deliver the SHS benefits.

Group level	What we are going to do	What will be achieved in 2019/20	By when
Transformation	Implement head and neck strategy	• Pathways mapped • Capacity & demand analysis completed • Plans for service change developed	Q4
Transformation	Transform Acute Coronary Syndrome & heart rhythm pathways	Joint coronary rhythm management rota implemented	Q4
Transformation	Transform Stroke and Transient Ischaemic Attack (TIA) service	• Proposal for 5-day TIA service developed • Rehabilitation access for Stroke patients improved	Q1
Strategy	Complete Clinical Service Strategy Programme to deliver 5 year plans for patient services	Strategies developed for all clinical services and implementation of year 1 initiatives commenced	Q2
Strategy	Develop Clinical and Scientific Services strategy	Strategy developed for clinical support services	Q4
Strategy	Support 'Improving Specialist Care' (ISC) across GM – vascular	Proposal for GM-wide vascular service developed in collaboration with GM partners	Q4
Strategy	Support 'Improving Specialist Care' (ISC) across GM	Proposal for GM pathways for chest pain, pacemakers, devices developed in collaboration with GM partners	Q4
		Proposal for GM wide pathways for respiratory services developed in collaboration with GM partners	Q4
		New model of care developed for paediatric medicine	Q4
Strategy	Support GM work on digital pathology	Scope of work and delivery timetable agreed	Q1
Strategy	Establish GM Haematological Cancer Diagnostic service with The Christie	Haematological Cancer Diagnostic service operational across GM	Q4
Strategy	Progress development of National Breast Imaging Academy	Business case developed and funding options explored	Q4
Strategy	Implement GM Gynaecological cancer service with The Christie	Single GM gynaecological cancer service implemented	Q4

Hospital / MCS	What we are going to do	What will be achieved in 2019/20	By when
RMCH	Expand the RMCH A&E department	Full business case approved by the Board of Directors	Q3
RMCH	Implement intra-operative MRI equipment	Full business case approved by the Board of Directors	Q3
RMCH	Develop care models for children across MFT	Optimum service models for children and young people's care developed for each site	Q4
SMH	Deliver service provider consolidation as part of the development of the North West Genomics Laboratory Hub	Transfer of Liverpool Women's Hospital Genomics Laboratory staff completed	Q2
SMH	Achieve Maternity Incentive Scheme standards	Maternity Incentive Scheme standards delivered	Q3
WTWA	Implement GM wide changes including Urology, Breast, Healthier Together, Orthoplastics and Lung Screening	Services implemented/progress achieved in accordance with programme timelines	Q4
WTWA/MRI	Establish revised governance arrangements for service integration between MRI & WTWA	Governance arrangements in place	Q1
WTWA/MRI	High level phasing plan agreed for Healthier Together, PTIP and Clinical Service Strategy moves	Phasing plan agreed	Q2
MRI	Effectively deliver the MRI capital programme	• Bone Marrow Transplant Unit phase 1 completion • A&E enabling works commenced • Diabetes centre in use • Helipad in use	Q3 Q4 Q3 Q3
MREH	Develop 5 year strategy to achieve the MREH vision	• Strategy approved • Strategy shared with all staff groups • Milestones Identified • Q1 Milestones achieved	Q1
		•	
MREH	Work in partnership with commissioners and peers in Greater Manchester	Priorities mapped and Local Eye Health Network (LEHN) implementation plan developed with colleagues from the LEHN.	Q2
UDHM	Document key long-term vision for UDHM and University of Manchester Division of Dentistry	UDHM & UoM strategy approved by Board and implementation commenced	Q4
UDHM	Develop business case for a new hospital and school, and interim measures to mitigate estate and equipment risks	RIBA stage 2 Outline Business Case developed	Q4
UDHM	Work in partnership with commissioners and peers in Greater Manchester and develop referral criteria for UDHM	Revised referral criteria and UDHM input into Managed Clinical Network work programmes	Q3
CSS	Introduce chimeric antigen receptor T-cell therapy (CAR-T) and gene therapy technologies	CAR-T service further developed and other gene therapy technologies introduced	Q4
CSS	Continue integration of services	Integration of lab medicine achieved	Q2

To develop our research portfolio and deliver cutting edge care to patients

Research and innovation (R&I) are core parts of what we do; they touch on all aspects of the organisation in some form. Undertaking research and innovation has a substantial impact on our ability to provide high quality clinical services through enabling us to:

- Adopt pioneering clinical practice
- Engage and empower patients by offering access to research programmes and studies
- Attract and retain leading clinicians and wider staff
- Embed our relationship with surrounding universities and the life sciences commercial sector;
- Create a reputation and brand associated with excellence.

Developing our research and innovation therefore goes hand in hand with delivering a high-quality care.

Group level	What we are going to do	What will be achieved in 2019/20	By when
R&I	Develop R&I strategy aligned with the UoM	R&I strategy produced that is aligned with the University of Manchester (UoM)	Q3
R&I	Communicate Biomedical Research Centre (BRC) annual report	Plan for communicating the BRC annual report developed and executed	Q2
R&I	Build grant funded laboratory infrastructure to deliver antimicrobial resistance research	Majority of building and refurbishment of the laboratory space completed as per agreed outputs and timelines for the grant funding	Q4
R&I	Develop data driven healthcare	Staff proposals for data driven projects funded	Q1
R&I	Increase external clinical research fellowships	3 external clinical research fellowship applications supported	Q1
R&I	Increase capacity for recruitment to breast cancer trials	Nightingale Unit reconfigured to provide clinical research clinic space	Q3
R&I	Develop research in pharmacy	Increase in clinical pharmacy staff funded for 2 years to increase clinical trials capacity	Q4
R&I	Develop stem cell research	Increase in stem cell lab staff funded for 2 years to increase capacity to take on research	Q4
R&I	Increase grant writing capacity and capability through grant writing workshops	Increase on last year in successful grant applications	Q4
R&I	Support bid for Next Generation Hospital at Trafford	Successful bid to develop a model 5 G hospital at Trafford	Q3
Corporate Nursing	Lead the implementation of the Nursing, Midwifery and AHP (NMAHP) Strategy (2018-2022)	• Increased number of NMAHP PhD applications • Increased number of clinical academic NMAHP roles • Increased in grants for NMAHP research • Evidence of translation of research findings into practice • Increased number of roles to support capacity building	Q4

Hospital / MCS	What we are going to do	What will be achieved in 2019/20	By when
RMCH	Develop RMCH / MCS Research and Innovation Strategy	Research capabilities across paediatric specialities assessed and support for high priority areas of national significance provided	Q2
RMCH		'Centre of excellence' developed for high performing research areas for Paediatrics	Q3
RMCH		RMCH children's research and innovation strategy produced and implementation commenced	Q4
SMH	Develop MCS Research Oversight Committee	MCS Research Oversight Committee Proposal for MCS approved by HMB MCS Research Oversight in operation	Q1 Q2
SMH	Develop MCS annual research plan	Key 2020/21 research ambitions, development priorities identified for MCS annual research plan	Q4
WTWA	Align with Group strategy and deliver key WTWA research priorities	• One or more major research grants awarded from MRC, Welcome, NIHR or CRUK • As a group, provide at least six 4* papers and twelve 3* papers to the upcoming Research Assessment • Recruitment of at least one young clinical researcher on at least Senior Lecturer level	Q4
WTWA	Implement Nursing, Midwifery and Allied Health Professions' (NMAHPs) Research Strategy	Strategy implemented	Q4
WTWA	Development of Manchester Cardiac MR Imaging Programme in partnership with UoM and British Heart Foundation	Cardiac MR scanner in opertion	Q4
MRI	Create an MRI research identity	Research and innovation embedded in the hospital's vision and plans	Q2
MRI	Establish an integrated approach to Informatics and service transformation within MRI	Service improvement plans reflect and optimise digital development	Q3
MREH	Develop a Research Oversight Committee for MREH	Committee established and key objectives identified	Q2
MREH	Identify wider opportunities for commercial partnerships.	Meetings to have taken place to scope opportunities and if appropriate schemes to be proposed.	Q4
UDH	Bring together oversight and co-ordination of research across the School and the Hospital	Joint Research Committee established	Q2
UDH	Agree a joint research plan, covering academic and commercial research	Plan Developed and approved by the Joint Research Committee	Q2

To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner

The proposal to establish a Single Hospital Service in Manchester forms an integral part of the Manchester Locality Plan and will ultimately enable us to provide much better, safer, more consistent hospital care that's fit for the future. Building on the work of the independent Single Hospital Service Review, led by Sir Jonathan Michael, the SHS Programme has been operational since August 2016. The Programme is being delivered through two linked projects. Project One, the creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), was completed on 1st October 2017. Project Two is the proposal for North Manchester General Hospital (NMGH) to transfer from Pennine Acute Hospital NHS Trust (PAHT) to MFT.

The proposed acquisition of NMGH is being overseen by a Transaction Board established at the end of November 2017. The Board, of which MFT is a member, is chaired by Jon Rouse, Chief Officer Greater Manchester Health & Social Care Partnership (GMH&SCP).

A Strategic Case for the proposed acquisition of NMGH has been developed, and this was approved by the Board of Directors at its meeting on 13th March 2019, and subsequently submitted to NHS I on 29th March 2019. Following the submission of the Strategic Case, NHS I has commenced its review of the document. Feedback will be provided by NHS I / E in the Summer.

The Trust has continued to progress its planning and exploratory work, including a comprehensive Due Diligence programme, and the outcomes of this work will be considered in full in the Business Case. Initial Due Diligence was undertaken in 18/19 and a financial model was developed that described the outlook for PAHT in the absence of the proposed transactions. These exercises identified significant issues that can only be mitigated through a multiagency approach.

MFT remains committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, MFT will continue to engage with all key stakeholders, in particular NHS Improvement and Greater Manchester Health and Social Care Partnership.

Group level	What we are going to do	What will be achieved in 2019/20	By when
Single Hospital Service	Strategic Case – work collaboratively with NHS I / E Review Team	NHS I / E review process completed, and next steps determined (approval to proceed to Business Case or alternative process). Refresh Programme Plan in light of Strategic Case outcomes	Q1
Single Hospital Service	Undertake Due Diligence on the proposed acquisition of NMGH	All risks associated with the proposed transaction identified and clearly understood.	Q4
Single Hospital Service	Undertake disaggregation planning with NMGH/PAHT teams	Clarity about those services transferring to MFT as part of NMGH, and plans in place for maintaining operational arrangements on Day 1.	Q4
Single Hospital Service	Develop Business Case for acquisition of NMGH	Develop Business Case, achieve Board sign off, and manage through NHS I review process (subject to outcome of Strategic Case process)	Q3
Single Hospital Service	Develop Post Transaction Integration Plan (PTIP) for acquisition of NMGH	Develop first draft of PTIP for NMGH acquisition, including identification of benefits and benefits realisation process (subject to outcome of Strategic Case process).	Q3
Single Hospital Service	Undertake approvals stage activities	Completion of legal processes, Reporting Accountant Reports, NHS I transaction risk rating, Board approval, Transaction Agreement, Statutory Instruments, etc.(subject to outcome of Strategic Case process)	Q1
Strategy	Develop service delivery models	Clinical Models for the delivery of medical, surgical, children's & women's services at NMGH developed	Q4

To achieve financial sustainability

The Trust continues to face a financial challenge in 2019/20, with underlying pressures carried forward from 2018/19 along with in-year inflation and funding challenges. We have accepted a Control Total for 2019/20 of a £13.8m surplus. To achieve this financial position, we need to make in-year efficiencies of £61.7m. This will entail continued reduction in run rate overspends, delivering new activity with minimal extra cost and delivery of new cost savings plans.

At a group level we continue to evolve and develop our approach to strategic procurement and clinical productivity gains together with generating further efficiencies from the merger. The Trust is also participating in GM wide efficiency programmes.

Hospitals and MCSs have developed delivery programmes for the additional productivity and cost savings. This work has been informed by national benchmarking tools; the NHS Getting It Right First Time (GIRFT) programme and the NHS Model Hospital. All savings plans undergo a robust Quality Impact Assessment process to ensure that they do not have any detrimental impact on quality of care.

Financial performance and achievement of these delivery programmes will be monitored on a regular basis at Hospital / MCS level, through the Trust's Accountability & Oversight Framework and at the Board Finance Scrutiny Committee (FSC). The FSC oversees and scrutinise the achievement of the overall Financial Plan and progress with delivery programmes across Hospitals/MCSs.

The Trust plans to spend £79m on capital projects in 2019/20, which includes schemes across Estates, IM&T and equipment. The programme is largely funded from internal resources with £10.2m coming from charity contributions to support projects including Cardiac MR Scanner at the Wythenshawe Hospital site, and the Diabetes Centre and the Helipad at the Oxford Road Campus.

Group level	What we are going to do	What will be achieved in 2019/20	By when
Procurement	Further roll out of managed inventory	Creation of Corporate Scan for Safety Team	Q1
		Completed roll out in SMH Theatres and additional MRI areas	Q4
Procurement	Pilot more autonomous procurement support model	Dedicated MRI Purchasing Team developed to become more autonomous within the Group Procurement structure	Q2
Workforce	Improve relationship with medical staffing agencies through development of tiered agency framework	Improved fill rates achieved	Q1
Medical Directors Team	Support with temporary staffing planning - booking/compliance	Dashboards developed to improve temporary staffing management	Q1
Medical Directors Team	Develop with MFT PGME department a long-term strategy to address medical gaps	• Overseas sponsorship capability explored • "Making medicine Brilliant" initiatives implemented • Post CCT trainees in fellowships created • FY3 posts created	Q4
Workforce	Increase attendance through absence management	Absence management system rolled out on ORS	Q4

Workforce	Deliver workforce technology plan to improve efficiency in use of workforce	E-rostering rolled out for medical staff in line with project plan	Q4
Workforce	Deliver attraction strategy to recruit in high risk areas	• Reduction in vacancies • Reduction in spend on temporary staff	Q4

4. Risk and Monitoring Arrangements

Risks to Delivery

Risks to delivering the plan are monitored and managed through the established Trust risk management arrangements. The Group Risk Management Committee oversees the management of all high level risks to the delivery of the organisational strategic aims and key priorities and these are mapped on the Board Assurance Framework.

Risks that present a significant threat to the Trust objectives or that score 15+ are reported bi-monthly to the Group Risk Management Committee. Detailed plans are in place to mitigate against these risks.

Monitoring Delivery

Delivery of the plans will be monitored throughout the year through the following mechanisms.

Board Assurance Report

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

Accountability Oversight Framework (AOF)

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

Hospital / MCS Review

A more in-depth review of delivery of the Hospitals / MCS plans takes place twice a year across the Executive Director Team and each Hospital / Managed Clinical Service.

Annual Review

A year-end review of the Annual Plan will be undertaken in December. Through this process progress to date will be used to project year end performance and RAG rate achievement. This will be presented to the Council of Governors at the Annual Planning development session.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Michael McCourt, Chief Executive, Manchester Local Care Organisation
Paper prepared by:	Tim Griffiths, Assistant Director, Corporate Affairs, Manchester Local Care Organisation
Date of paper:	June 2019
Subject:	Manchester Local Care Organisation Update
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The Board of Directors are asked to note the contents of this paper.
Contact:	Name: Tim Griffiths, Assistant Director – Corporate Affairs Manchester Local Care Organisation Tel: 07985448165

1. Introduction

1.1 This report provides an update from Manchester Local Care Organisation to Board of Directors. It covers the following:

- System resilience and escalation;
- Integrated neighbourhood working;
- Communications and engagement;
- Phase II and business case development;
- Business Plan and MLCO 2019/20 priorities;
- Adult social care improvement programme; and,
- Trafford.

2. System resilience and escalation

2.1 As per previous updates to Board, MLCO continues to work with Manchester University NHS Foundation Trust (MFT) and partners such as Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust to support the alleviation of current acute flow pressures. This work became one of MLCO's key delivery priorities for 2018/19 and has been identified as one of MLCO's key priorities for 2019/20.

2.2 Alongside its partners, MLCO has now commenced winter planning for 2019/20 and the MLCO response to supporting the alleviation of winter pressures and wider system flow has been identified as one of our five key priorities for 2019/20.

3. Integrated neighbourhood working and 2018/19

3.1 'Putting integrated neighbourhood teams into action' has been identified as one of the MLCO key priorities for 2019/20.

3.2 As per previous updates MLCO has been actively progressing the recruitment to the 12 INT Lead posts. It is now expected that 11 of the 12 will have taken up post by the end of June; the final staff member will take up post in July 2019. In recognition I have written to elected members across the city to introduce the INT Leads to members to facilitate the development of close and positive working relationships between the INTs and elected members in the neighbourhoods.

3.3 The 12 neighbourhoods are the principal building blocks of MLCO and underpin our strategic planning. As part of this, and as part of the business planning process, we have developed 12 neighbourhood plans. These will be subject to further refinement over the coming weeks with the intention of producing 12 detailed plans as well as plans on a page. The MLCO business plan will be discussed in more detail through the substantive agenda.

3.4 The Nesta 100-day challenge which launched across four neighbourhoods in April 2019 is now reaching its conclusion. In getting to this stage, two planning and design workshops were held with leaders from across the Manchester system in January and March 2019. In addition, coaching development for the seven local coaches took place in March.

3.5 The four neighbourhoods are outlined below and will focus on tackling a key issue in their area ranging from social isolation to mental health in over 50's:

- Miles Platting, Newton Heath, Moston and City Centre;
- Cheetham and Crumpsall;
- Chorlton, Whalley Range and Fallowfield; and,
- Wythenshawe, Bagueley, Sharston and Woodhouse Park

3.6 To mark the end of wave one there will be a series of feedback and learning events in July. It is anticipated the second wave will commence in September.

3.7 The second wave of neighbourhoods have now been selected:

- Ancoats, Bradford, and Clayton;
- Gorton and Levenshulme;
- Didsbury East and West, Burnage, and Chorlton Park; and,
- Wythenshawe (Brooklands), and Northenden.

3.8 Whilst the substantive report focusses on neighbourhood working, the Board are aware MLCO assumed responsibility for delivering a broad range of services in April 2018. These included delivery of new care models including the delivery of integrated working at neighborhood level, High Impact Primary Care, and Manchester Community Response. MLCO also became responsible for delivering community health services across the city and a range of adult social care services.

3.2 An overview of the work of MLCO in 2018/19 is appended to the substantive report; 'Our first year' is MLCO's draft annual review (Appendix A).

4. Communication and engagement

4.1 MLCO is currently undertaking a significant amount of work to support the delivery of our adult social care improvement programme. This includes the development of a comprehensive communications strategy which started with the first adult social care forum taking place at the end of March. Almost 100 staff attended to hear about the improvement plan and updates on work around integration. Feedback has been positive. The second forum takes place at the end of June and developmental work is underway. The focus of the next forum from the MLCO perspective will be integration - showcasing how Integrated Neighbourhood Teams are working and how health and social care staff are working together to achieve better outcomes for people. MLCO is also working with partners in MCC to streamline the internal communications offer to ASC staff.

4.2 MLCO is currently mobilising a programme of work to develop the core communication activity for the INTs. A communications plan template has been developed that outlines the core offer we want for all INT's. This affords a degree of flexibility and allows for significant customisation to ensure the teams are able to respond to local needs – in addition to the 12 neighbourhood plans it is our intention to have 12 accompanying neighbourhood communication and engagement plans.

A pilot neighbourhood video is being developed to support INTs work in their neighbourhoods. A range of bespoke communications work has taken place with the four INTs who are undertaking the first Nesta 100 day challenges including social media to reach particular communities of interest, event support and wider communications and engagement activities.

4.3 As one of the many steps we need to take to further integrate our health and social care staff we have rolled the 'pulse survey' to all MLCO deployed staff. For the first time this will provide us with some key insights into how our workforce feel as an integrated workforce. It is expected that results for the first adult social care pulse check (which has been piloted as an in-house survey) will become available in late June 2019 and they will be correlated with results from the pulse check for health staff (run by MFT through an external provider).

4.4 Development has started on a new MLCO website with the aim of bringing core service information on community health and social care services across the city on to one platform. A delivery plan is being developed for this work with our partners in the MFT communications team (who will host the site) but it is hoped that development will be relatively quick for delivery in Q2/early Q3 2019/20.

5. Phase II and business case development

5.1 As the Board will be aware Manchester Health and Care Commissioning are responsible for the commissioning of the health and care system in Manchester; this includes MLCO.

5.2 In the latter part of 2018 it was agreed by commissioners that the commissioning and procurement of MLCO would be achieved through the production of a comprehensive joint business case. This business case will be required to offer assurances in multiple areas, and will be assessed against the ability of MLCO to deliver the requirements placed upon it. The production of the business is one of the key immediate priorities for MLCO in Quarter One and Two of 2019/20.

5.3 This business case will, as a minimum, offer an assurance against the following:

- There are clear transformational benefits envisaged for patients and populations;
- There is appropriate commissioning governance and management in place;
- The contracted services are financially sustainable for the local health economy;
- There is appropriate provider entity structure, financial capacity, governance and capability to transform and deliver;
- The contract documentation is appropriate; and,
- In the event of provider failure, there are contingency plans in place.

5.4 The business case also has to be compliant with NHS England's and NHS Improvement's Integrated Support Assurance Process (ISAP). The objectives of ISAP are aligned to the list of assurances set out above, as such it is appropriate that Manchester should be guided by this approach.

5.5 A key part of this process was to identify a lead health contractor – for MLCO this will be Manchester University NHS Foundation Trust.

5.6 In adopting the approach described above at the latter end of 2018 it is envisaged that the procurement process be concluded by October 2019.

5.7 The successful mobilisation of the services outlined within the business case will see MLCO grow significantly and as a result, through 2019/20, it will become responsible for the delivery of £287m of services. It should be noted that for those services that transfer to MFT a process of due diligence is being undertaken.

6. MLCO Business Plan and 2019/20 Priorities

6.1 In addition to producing the business case, MLCO is in the process of finalising its business plan. The process to produce a business for MLCO is a relatively complex one, with the plan being built from 12 neighbourhood plans, 3 locality community service plans, one adult social care plan and citywide children's service plan.

6.2 To date all 12 neighbourhoods have produced neighbourhood (health and care plans), and MLCO currently working on producing a 'plan on a page' from the neighbourhood plan which will include social care, mental and children's services. These are being developed and will be taken through the Neighbourhood Partnerships, with an expectation that these are finalised during July 2019

6.3 As the Board will be aware 2019/20 is the second year of our ten-year journey to deliver improved health and care outcomes for people in Manchester , and the 2019/20 business plan will set out the MLCO response to five overarching priority objectives in pursuit of delivering the ten year vision:

- Population health delivery;
- Achieving integrated working in neighbourhood teams;
- Building strong relationships with primary care;
- Delivering better system resilience; and
- Achieving Phase 2 for the MLCO.

6.4 More detailed planning is now underway to set out how MLCO will deliver against those priorities, and important what support is required from partners to ensure that they can be delivered.

7. Adult social care improvement programme

7.1 As per previous updates to the Board the adult social care improvement programme is a key programme of delivery for MLCO and the Manchester system in 2019/20.

7.2 The programme is focused on ensuring the basics are in place for adult social care to deliver high quality services for our residents and to successfully deliver health and social care reform and integration. There is a need to ensure the right foundations are in place by embedding streamlined processes, effective practice, and an enabled workforce with the right resources in place to manage demand.

7.3 Over the last few months a programme plan for this work has been developed, based on the outcomes of diagnostic work. The programme includes workstreams on:

- Assessment function including social work and primary assessment teams. This work is focused on putting the right processes in place to ensure efficient and effective delivery of Care Act assessments and reviews, alongside improvements to practice.
- Safeguarding and Quality Assurance functions. This work is focused on areas where specific pressure is felt (e.g. Deprivation of Liberty Safeguards) as well as reviewing our approach to quality assurance
- Provider services including our supported accommodation, reablement and supporting independence services. This work is focused on maximising our resources and strengthening the service, including use of technology
- Workforce skill and capacity. This work is focused on strengthening our workforce across adult social care including improving the social work career pathway and supporting staff to develop
- Adult social care commissioning. This work is in development and will focus on improving our approach to commissioning and contracting in adult social care as it pertains to our statutory duties
- Front door. This work is in development and includes focusing on the front door offer and Command Centre, improving use of information to support prevention and maximising independence of citizens.

7.4 As part of additional overall investment to meet increased need for adult social care, it was agreed by Manchester City Council in February that additional resources of £4.225m in 2019/20 rising to £4.8m for 2020/21 and 2021/22 be invested into services to support the delivery of the improvement programme through increased capacity in front-line roles.

7.5 The delivery of this programme will be overseen by MLCO Executive Team.

8. Trafford

8.1 As the Board are aware in January 2019, Manchester University NHS Foundation Trust (MFT) received confirmation that it had been chosen as the preferred provider for Trafford Community Healthcare Services following an external tender process.

8.2 It has previously been agreed that MLCO would assume a leadership role in mobilising these arrangements and provide the ongoing leadership for the delivery of services.

8.3 Work is now underway to undertake due diligence (supported by an agreed one off investment from Trafford CCG) in regards to the proposed transaction. Work is also being undertaken to deliver key activities to support the transition including the TUPE transfer of staff into MFT. First engagement sessions with Trafford staff began this week and were very positive.

9. Recommendations

9.1 The Board is asked to note the contents of this report.

Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

OUR FIRST YEAR

Manchester Local Care Organisation

2018-2019 year in review and key information

Powered by:

NHS Manchester University NHS Foundation Trust

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MANCHESTER CITY COUNCIL

Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

THE MANCHESTER PRIMARY CARE PARTNERSHIP

Michael McCourt
Chief executive
Manchester Local Care Organisation

"We are only 12 months in to a 10 year plus journey to improve outcomes for the people of Manchester. However, I believe we have made a great start. Things feel different and progress is being made."

Welcome

It gives me great pleasure to welcome you to our first annual review and speak about our first year as Manchester Local Care Organisation.

It's been an incredible year as we have started to build an organisation that will have a major impact on the health and wellbeing of people right across the city. Over the last 12 months I think we have built really solid foundation. We have been bedding in a new culture, new ways of working and how we want to do things as a Local Care Organisation.

In this review you can read about some of the things that we have done as we bring together health and social care services, the new initiatives that have been launched and what we want to do next.

It's easy to focus on all the new things that are happening, but it is important to remember that we run day to day health and social care services in the community that reach hundreds of people each day.

One of our key aims was to ensure that we made a safe start so those services came to the new organisation in a way that ensured continuity of services. Bringing 3,000 staff into a new organisation from different places is not a simple task.

We had a key test of our safe start goal when the Care Quality Commission inspected our **healthcare** services just six months into our year. We were delighted to receive a good rating from the CQC for our community health care services following their inspection. It is highly positive that those who use our services can be assured of the quality and safety of the care we provide.

It's been a pivotal year in **adult social care** as well. Our social care improvement plan includes significant investment in the workforce to increase capacity. At the same time we are looking at assistive technology and how we can better use that to support people in the community - empowering them where possible.

We still have a lot to do. We are only 12 months in to a 10 year plus journey to improve outcomes for the people of Manchester. However, I believe we have made a great start. Things feel different and progress is being made. I am incredibly proud to be chief executive of Manchester Local Care Organisation and of all that we have achieved in our first year. My thanks to everyone who has supported us and who works with us as part of the organisation or in a partnership role across the city.

Michael McCourt
June 2019

1. About MLCO

Manchester Local Care Organisation is a pioneering new type of public sector organisation that is bringing together NHS community health and mental health services, primary care and social care services in Manchester. We're here to improve the health of local people in the city, working as one team across traditional organisational boundaries.

MLCO was formed on 1 April 2018. We are part of the public sector and a partnership organisation powered by Manchester University NHS Foundation Trust, Greater Manchester Mental Health, Manchester City Council, Manchester Health & Care Commissioning and the Manchester Primary Care Partnership.

We have brought together the teams from these organisations that provide community-based care in the city in a new way.

Over 3,300 staff from Manchester's adult and children's NHS community teams and adult social care teams have now been deployed to MLCO.

They include social workers, nurses, health visitors, therapists, support staff and many other health and care professionals. These teams are now working together as part of one single organisation for the first time.

"In simple terms, we manage your community health and care services in the city, but we are here to do much more that by ensuring that we work in new ways and do things differently to improve the health of the people of Manchester."

What we do - our mission and vision

Our mission statement is **leading local care, improving lives in Manchester, with you**. We think that sums up what we want to do and how we want to do that by working with local people.

Our vision is that we believe that, by working together, we can help the people of Manchester to:

- Have equal access to health and social care services
- Receive safe, effective and compassionate care, closer to their homes
- Live healthy, independent, fulfilling lives
- Be part of dynamic, thriving and supportive communities
- Have the same opportunities and life chances - no matter where they're born or live.

So whilst we manage your community health and care services, we are here to do much more that by ensuring that we work in new ways and do things differently in the city.

Our year one aims were:

1. Ensuring a Safe Start and transfer of the teams to MLCO

2. Preparing for Integrated Neighbourhood Teams

3. Developing the Manchester Community Response model across the city

4. Implementing the High Impact Primary Care model

5. Escalation to support the hospitals

6. Building for future years.

3. Ensuring a safe start for MLCO

Ensuring a safe start was one of our key priorities for the year to ensure that there was continuation of services without disruption as we formed MLCO.

Over 2,200 health and social care staff were deployed to MLCO in April 2018 as the new partnership organisation came into being. They were joined by staff from North Manchester community health in July. At the end of 2018-2019, the deployed community health and social care workforce totalled nearly 3,000.

Our healthcare services were visited by **Care Quality Commission** inspectors in autumn 2018 as part of their wider planned inspection of Manchester University NHS Foundation Trust. Inspectors spent three days in our services talking to staff, services users and carers.

The report was published in March 2019 and the outcomes were:

- Community health services for adults, children & young people, end of life care, inpatient services and community dentistry were all individually rated good by the CQC in their report released in March
- MLCO also achieved overall good ratings across all five domains the CQC measure – safe, effective, caring, responsive and well led.

What the CQC said

- Adult community services - staff cared for patients with compassion, dignity and respect.
- Inpatient settings - staff had the appropriate skills and experience to provide effective care and treatment
- End of life care - the approach to end of life care was multi-disciplinary with all partners working together to support patients at the end of their lives
- Community dental services - there were arrangements for patients requiring emergency treatment both in and outside normal working hours
- Community children's services - teams across the city understood and met the needs of local people.

2019 CQC ratings for MLCO community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	**Good**
Community health services for children and young people	Good	Good	Good	Requires Improvement	Good	**Good**
Community health inpatient services	Good	Good	Good	Good	Good	**Good**
Community end of life care	Good	Good	Good	Good	Good	**Good**
Community dental services	Good	Good	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

4. Preparing for Integrated Neighbourhood Teams

A key part of our strategy for improving health and social care is a neighbourhood approach with integrated teams working together from hubs in the community. This is based on international evidence of the model and its outcomes.

Neighbourhood teams allow us to ensure that priorities are based on the needs of the people in that community - with staff working together to provide the best possible coordinated care.

During the year we have established our 12 Integrated Neighbourhood Teams (INTs). Each team has a neighbourhood leadership team of the neighbourhood team lead, GP lead, nurse lead, social care lead and mental health lead. They work alongside a Health Development Coordinator in each area and other partners.

An ambitious neighbourhood leadership development programme has commenced, focusing on projects that will make a real difference to health outcomes in the neighbourhood.

Early work from **Didsbury East & West, Burnage and Chorlton Park INT** early implementer has found:

+ improved communication between health and social care teams

+ better understanding of roles, speeding up of assessments and more joint visits

= **better coordinated care for local residents**

Did you know?

- The neighbourhood approach breaks Manchester into 12 neighbourhoods, each with a population of between 30,000 and 50,000 people
- Each neighbourhood has a hub that our INT staff work together from - usually a clinic or health centre in the heart of the community
- Each team will engage with its local community to identify priorities.

5. Developing Manchester Community Response

Manchester Community Response (MCR) is the umbrella term for a range of community services that aim to keep people at home rather than need hospital care.

During the year we've launched MCR crisis team services in central and south Manchester that prevent patients needing to be admitted to hospital by providing highly skilled crisis care in the community - based on a model already provided successfully in North Manchester.

Up to 72 hours of crisis care is delivered at home by advanced practitioners and a wider health & social care team before onward referral and support is arranged to prevene an issue escalating.

The central crisis team launched in November 2018 – accepting referrals from the ambulance service following 999 calls. The south crisis team launched in December – accepting referrals from hospital urgent care, GPs and social care. During 2019-2020 these teams will expand to provide the full range of services in each area of Manchester as recruitment is completed.

Central Community Crisis Response Nov-Feb

209 accepted amber referrals from NWAS

177 patients treated in community and avoided A&E/admission

South Community Crisis Response team Dec- Feb

108 referrals accepted from GPs/urgent care and treated in community

Did you know?
As well as the crisis service, the other core elements of MCR are:

- **Intermediate care** - providing care at home or in beds in the community for up to six weeks
- **Reablement** - getting people back to independence by supporting daily living tasks
- **Discharge to assess** - allowing discharge assessments to be carried out at home rather than waiting in hospital
- **Community IV** - providing intravenous drug therapies at home or community settings that have traditionally only been provided in hospital.

Case study

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How joint working through **Integrated Neighbourhood Teams** is better coordinating services for people

Manchester Local Care Organisation's Didsbury East and West, Burnage and Chorlton Park Integrated Neighbourhood Team (INT) has been an early implementer of our new model of neighbourhood working across Manchester. It's one of our 12 INTs in the city.

The neighbourhood's social work and district nursing teams have been working together from their hub at Withington Community Hospital in West Didsbury. Teams now work together and can immediately share information and take action. Joint visits are also undertaken between health and social care.

A great example was the district nurses going out to elderly service user who had a high level of dementia and mobility issues. They sadly found that their main carer and spouse, also elderly, had been diagnosed with cancer with a poor prognosis. The carer couldn't provide the care they previously had done and 24-hour care was going to be needed.

When a nursing needs assessment is requested by a social worker that process can traditionally take days, or even weeks. In this case, because the teams are now co-located, the nurses let the social work team know straight away of their concerns. The case was discussed in the district nurse huddle that day and the INT team was able to get the social care and nursing needs assessments completed in a day and the right care in place a couple of days later.

It's a simple example of an outcome of the teams being able to talk to each other on the spot about cases, but one that made a massive difference to the service user.

> "The biggest single difference is really the better exchange of information between health and social care staff on a daily basis. With that comes increased knowledge of what we all do day to day and the ability to get things done quicker and more efficiently for the people we are caring for."
>
> **Niikwae Kotey -** social care lead for the INT.



6. Implementing High Impact Primary Care

High Impact Primary Care (HIPC) is a service that provides care and support to people with complex health and care needs.

The HIPC teams are led by a GP, working alongside a nurse, social worker, wellbeing adviser and pharmacist.

A small percentage (2%) of Manchester people are very vulnerable and have complex physical health, mental health and social care needs. They often find it difficult to navigate and access the standard healthcare system due to the multiple difficulties they are facing and end up using hospital-based services such as A&E as a default.

HIPC is designed to support these people - wrapping a bundle of care around them so they are less reliant on hospital and other urgent care services.

High Impact Primary Care has been piloted in three neighbourhoods in the city in 2018-2019 - Cheetham and Crumpsall; Gorton and Levenshulme; and Wythenshawe - with positive early results.

High Impact Primary Care

3 neighbourhood pilots in the city

911 people enrolled in HIPC by April 2019

With outcomes including

14.3% lower secondary care costs for HIPC users who've needed hospital care

25.8% reduction in length of stay in hospital for those users

Did you know?

- The High Impact Primary Care pilots have been extended until March 2020 and are being extended to a further three neighbourhoods across the city
- HIPC staff work with primary care to proactively identify service users who will benefit from the approach - using data on access to services as well as personal approaches.

7. Escalation to support the city's hospitals

Since the summer of 2018 we worked closely with Manchester University NHS Foundation Trust to look at solutions to improve patient flow at the Manchester Royal Infirmary.

We worked to identify medically fit patients who had been waiting for discharge from hospital for the longest time - know as 'stranded' and 'super stranded' patients.

Using our integrated role across community health and social care we have been able to better coordinate discharge of these complex patients back to the community by mobilising services to meet their, often complex, discharge needs. This helps ensure they have the most suitable care and frees up capacity at the hospitals.

The work has had a significant impact on numbers of stranded individuals and also on overall length of stay at the hospitals. Further winter planning funding was also identified to support this work into 2019.

As at close of project on 15 March 2019

164 super stranded and stranded patients discharged

with a combined length of stay in hospital of

16,900 days

Contributing to a reduction of around five days in average inpatient length of stay at MRI .

Did you know?

- The work to identify stranded patients contributed to a fall of around five days in the overall average length of stay at the Manchester Royal Infirmary
- The escalation programme will become an ongoing piece of work in partnership between the hospitals and MLCO moving forward.

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High Impact Primary Care - wrapping care round the most vulnerable of our residents

A small percentage (2%) of Manchester people are very vulnerable and have complex physical health, mental health and social care needs. The High Impact Primary Care teams are led by a GP, working alongside a nurse, social worker, wellbeing adviser and pharmacist.

Mrs H is a service user with multiple issues including alcohol dependency, epilepsy, hearing and sight impairment, anxiety and depression and multiple long-term health conditions.

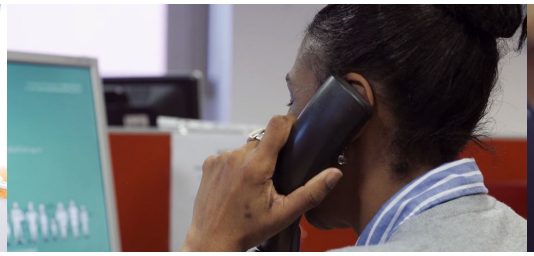
She had started detox several times but not completed the courses and had cancelled multiple social care packages – putting herself at risk of harm. She attended A&E almost every day. Alcoholism had created a strained relationship with her children and she had no contact with her grandchildren.

The HIPC team provided weekly support and developed a plan with Mrs H. They accompanied her to hearing and eye tests, arranged counselling and alcohol service support and organised attendance at social interaction groups.

With the support of the team, Mrs H's drinking significantly reduced and she agreed to go to residential detox. She now has a hearing aid that has greatly improved her communication and has had support from pharmacy to improve how she uses her inhaler to control breathlessness; and the HIPC GP to prescribe a nebuliser to reduce anxiety.

She is now much more willing to work with agencies and her attendance at A&E has reduced from once every day to around once every three weeks. Family relationships have improved greatly and her children and grandchildren now come to visit.

> "Each of our three pilot HIPC teams builds links with the local community and works in partnership with other local services. The HIPC service offer is tailored to the goals and aspirations of each individual person, joining up care and support to best meet their needs."
>
> **Emma Gilbey -** lead for High Impact Primary Care.


8. A health and wellbeing prevention approach

The work of MLCO is underpinned by new approaches to health and wellbeing prevention in the city.

We're delivering a programme across the city to change the way services work with people and communities, to prevent ill-health and promote wellbeing.

We are supporting **people** to identify and build on their strengths, address the things that can cause poor health and wellbeing, and access support in their in their community.

We are supporting **communities** to build on their strengths, develop ways of supporting people's health and wellbeing, and influence and work together with health and care services.

Our vision is that people in Manchester will feel more in control of their health, that communities will be empowered to improve health and wellbeing, and that health and care services will work in a person-centred and community-centred way.

Core elements of our prevention approach are:

- **Be Well** - offers free, confidential, one-to-one advice and support for people referred by primary care or other health and care services. Be Well workers support people to identify what will improve their health and wellbeing, access community support and services, and develop understanding and skills to manage their own health. You may hear this approach referred to as 'social prescribing'.
- **Health Development Coordinators** - bring health and social care services and staff together with voluntary and community sector groups and services, and other public sector and neighbourhood services. They support neighbourhoods to identify priorities and opportunities, develop and deliver plans, co-design local solutions, and access resources to build community capacity.
- **Buzz neighbourhood health workers** - use community development approaches 'on the ground' to improve health and wellbeing for people in their neighbourhood. Buzz also provides a knowledge and information service for communities to access health and wellbeing information and training.

These services work alongside Care Navigators, targeted prevention schemes, the voluntary, community and social enterprise sector (VCSE) and existing health and social care services.

9. Building for future years

2018-2019 was year one of our long term vision to improve health outcomes in the city.

We have been working with our staff, partners and community groups across neighbourhoods and localities to develop our plans for 2019-2020.

In terms of services, 2019/20 will be a year of embedding our new care models like Manchester Community Response, High Impact Primary Care and Integrated Neighbourhood Teams and continuing to work at pace on integrating services based on a population health model.

By the end of 2018-2019, each of the 12 integrated neighbourhood teams has a plan. There are also plans for adult social care, community health and children's community health services.

Our emerging priorities for 2019-2020 are:

- **A population health approach** - Supporting prevention programmes to improve health of the people of Manchester
- **Playing a lead role in system resilience** - Helping people get the right care in the right place with a community first ethos
- **Delivering MLCO Phase 2** - Growing MLCO as an integrated health and care organisation
- **Putting Integrated Neighbourhood Teams into action** - Supporting our 12 Integrated Neighbourhood Teams (INTs) to make an impact on their communities
- **Linking with Primary Care Networks** - Creating a formal board level connection to MLCO to ensure joint working with the new Primary Care Networks.

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BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin , Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Mags Bradbury, Associate Director Employee Wellbeing, Inclusion & Community. Jane Abdulla, Assistant Director for Equality and Diversity.
Date of paper:	July 2019
Subject:	MFT Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES).
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	This report aligns to the principal risk of failure to deliver high quality, safe care due to the inability to recruit, retain and engage the current and future workforce of MFT. In addition both the WRES and WDES are part of the NHS Standard Contract and a requirement of healthcare providers.
Recommendations:	The Board is asked to: (i) Approve the report as the basis for publication of the data and submission to NHS England by 31st July 2019. (ii) Note the key areas of focus and work underway to make improvements against both the WRES and WDES Standards (iii) Agree delegated responsibility to the HR Scrutiny Committee for monitoring overall performance of WRES and WDES actions.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business. Tel: 0161 701 8573

1. Purpose

1.1 The purpose of this paper is to present to the Board of Directors the 2018/2019 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

2. Background

2.1 The purpose of the Standards is to ensure NHS organisations review their data against the prescribed indicators and to produce an action plan to reduce the gaps in the workplace for Black and Minority Ethnic (BME) staff and disabled staff.

2.2 The WRES and the WDES are included in the NHS Standard Contract. The WRES has been a requirement of NHS commissioners and NHS healthcare providers including independent organisations since July 2015 and the WDES since April 2019. All NHS Trusts are required to produce and publish their WRES and WDES reports on an annual basis by the 31st July and 31st August respectively.

2.3 The requirements of this report for both WRES and WDES are set by NHS England. The indicators are different for each Standard and therefore the report sets out the two Standards separately.

2.4 All staff on MFT contracts have been captured in the analysis including Sodexo staff on Retention of Employment (RoE) contracts with MFT.

2.5 The data has been provided as a percentage and actual number where possible. It is not possible for the staff survey and for some of the indicators as the numbers are below 10 and individuals may be able to be identified which breaches the guidance and MFT's commitment when handling sensitive equality data.

3. WORKFORCE RACE EQUALITY STANDARD (WRES) 2018/19

3.1 The WRES data included in the this report has been obtained from the following sources:

- Electronic Staff Records.
- Human Resource Team records.
- Organisational Development records.
- Staff Survey.

3.2 **Indicator 1** - The workforce Profile is shown in figure 1.

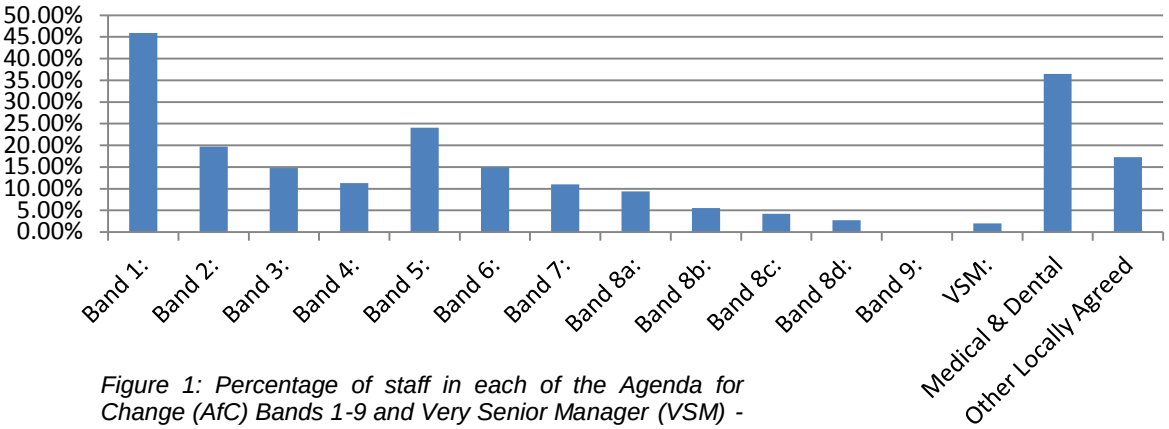


Figure 1: Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) - including Executive Board members, compared with the percentage of staff in the overall workforce.

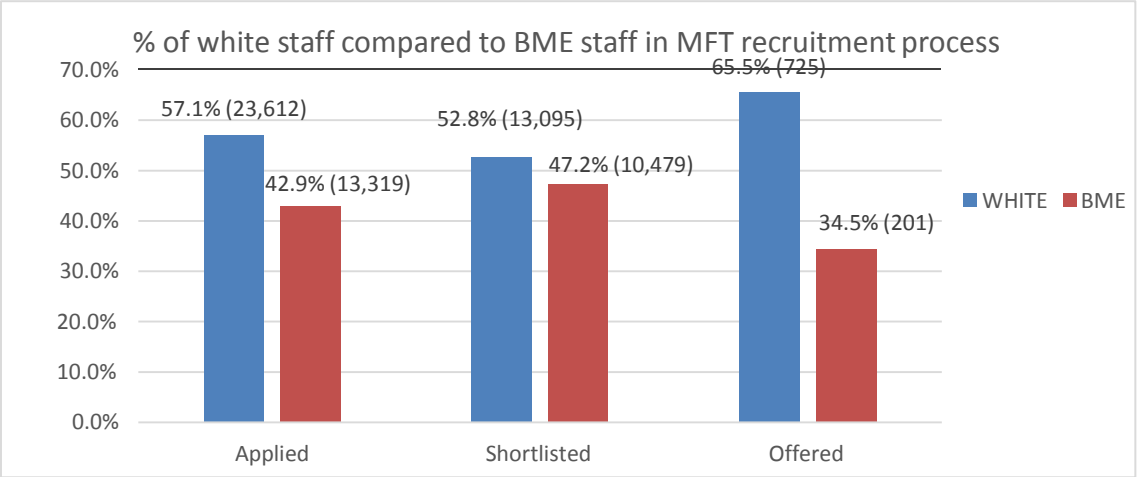
The first indicator in the WRES looks at representation across the workforce. The overall representation of BME staff who have declared on *the Electronic Staff Records* (ESR) system in the Trust is 19.18% (4209), which is representative of the Greater Manchester population at around 18%. Whilst data for Bands 2-7 and bands 8a – 8d show a slight increase overall, representation of BME staff decreases at higher pay bands. It is also noted that 8.3% (1812) of staff have not declared their ethnicity on the ESR System and therefore on this basis, the percentage of BME staff could be greater than the reported 19.18%.

3.3 **Indicator 2** – Recruitment

This indicator looks at the likelihood of recruitment for white staff compared to BME staff. This indicator is now in the Hospital/MCS / MLCO Accountability Framework (AOF) to track and improve the Trust's performance against this measure.

The table below shows the number of applications, shortlisted and offers to white and BME staff:

White/BME	Applied	Shortlisted	Offered
White	41,352	24,802	1,107
BME	31,046	22,202	582



3.4 **Indicator 3** – Disciplinary Process

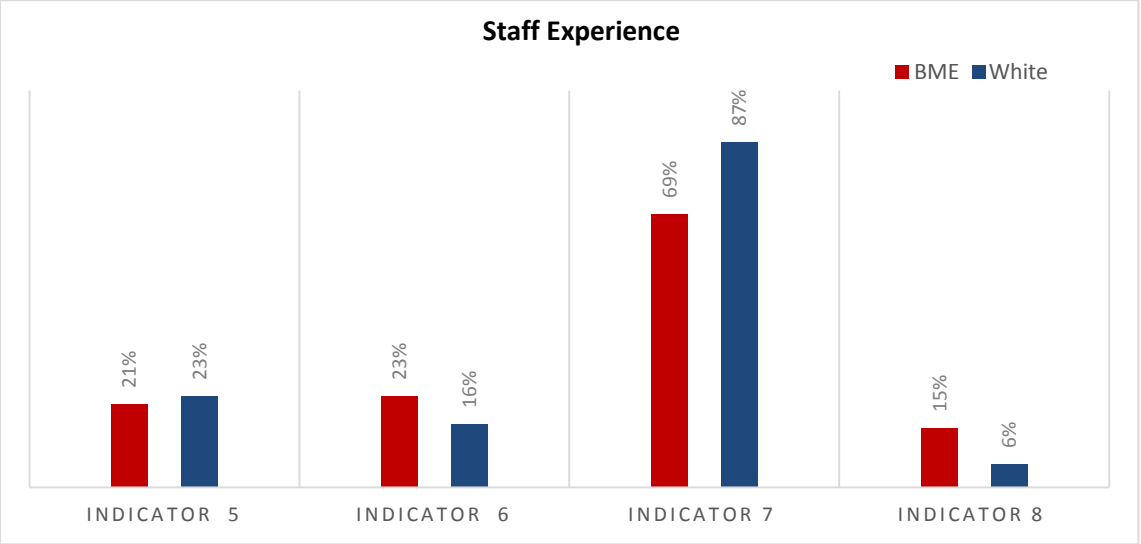
Indicator 3 is the relative likelihood of BME staff entering a formal disciplinary process compared with white staff (measured by entry into formal disciplinary investigation). This indicator is based on data from a two year rolling average of the current year and the previous year. The data for indicator 3 shows that BME staff are 1.27 times more likely than their white colleagues to enter formal disciplinary process. The national data shows that BME staff are 1.24 times more likely to enter the formal disciplinary process.

3.5 **Indicator 4** – Training

Indicator 4 looks at the relative likelihood of white staff accessing non-mandatory training and CPD compared with BME staff. MFT's data indicates white staff are 1.08 times more likely than BME to access this type of training compared to the national data of 1.5. This is an improvement in MFT over the previous 12 months when the likelihood was the same as the national position (1.5).

3.6 **Indicators 5 – 8** - Staff Experience

Indicators 5 to 8 are drawn from the national staff survey and compare the experience of white staff to BME staff.



Indicator 5 - compares the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. Over the last 12 months there has been a 2% decrease in reported experience of harassment from both white and BME staff in MFT. The national data for this indicator shows that 29% of BME staff have experienced this type of harassment, which is 8% higher than the Trust's position.

Indicator 6 - compares the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. Over the last 12 month the instance of staff experiencing harassment bullying or abuse from other staff has decreased overall for both white and BME staff by 7%. However, the data suggests that similar to last year BME staff are 7% more likely to experience harassment, bullying and abuse from other staff compared to their white colleagues. This is 5% less than the National average (which is 28%) the continued focus on the reduction of abuse experienced by all staff will continue to be a priority for the Trust.

Indicator 7 - compares the percentage of staff believing the Trust provides equal opportunities for career progression or promotion. The data presented indicates that more white staff, compared to BME staff, feel that the Trust provides equal opportunities for progression or promotion. There has been a 1% increase in BME staff believing that the Trust provides equal opportunities for promotion or progression over the last 12 months, compared to a 4% increase in white staff. This indicates that the gap between white and BME staff feeling that there is equal opportunity for progression or promotion has increased by 3% in the last year.

Indicator 8 - compares how many staff have personally experienced discrimination at work from a Manager/Team Leader or other colleagues in the last 12 months. The data for this indicator shows that there has been a 3% decrease for BME staff and 2% decrease for white staff compared to previous years. Whilst this is an encouraging trend, there was twice the number of BME staff (15%) who reported feeling they had experienced discrimination from a Manager/Team leader or other colleagues, compared to white staff (6%).

3.6 Indicator 9 - Board Representation

This indicator asks organisations to compare the percentage difference between the organisation's Board voting membership and its overall workforce. The Trust has 17.65% representation of BME staff on its Board, which has increased from 9.1% in the previous year.

4. Actions to WRES Priority Areas

4.1 The data analysis presented in this report identifies three key areas of priority for the Trust:

- Increasing the representation of BME staff within Senior Leadership Teams. The Trust is developing a 'Removing the Barriers' Programme focused on attracting, recruiting and progressing BME staff.
- Tackling poor behaviour and the experience of harassment, bullying and abuse. The Trust is revising and relaunching a Trust wide initiative to reduce the incidence and impact of poor behaviour which will encompass the Trust Values.
- Understanding the variation in disciplinary outcomes. The Trust will review a representative sample of 'disciplinary decisions' undertaken within the last year, focusing on where there is an overrepresentation of BME staff in the disciplinary procedures in comparison to their percentage in the AFC pay band.

4.2 In addition to these key areas of focus, the Trust will:

- Improve the monitoring of ethnicity in relation to Non-Mandatory Training over the coming year.
- Continue to promote ESR self-recording of protected characteristics, including ethnicity, by sharing information on how to access and use ESR.
- Celebrate the diversity of the Trust with events and activities such as Equality, Diversity and Human Rights Week and Black History Month.
- Continue to support and develop the BME Staff Network as part of the Trusts wider Staff Diversity Networks.
- Deliver an Equality, Diversity and Human Rights Strategy.

4.3 Monitoring Trust Wide Performance

The Trust will monitor progress on the delivery of the WRES action plan at the Trust Equality, Diversity and Human Rights Committee chaired by the Group Chief Finance Officer. In addition, Hospitals/MCSs/MLCO will be monitored via the AOF tracking recruitment outcomes for BME staff whilst Corporate Service Teams will be monitored via the Corporate Directors Group. Assurance on delivery of the various strands of work will be through the HR Scrutiny Committee (sub-committee of the Board of Directors).

5. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

5.1 The WDES data has been obtained from the following sources:

- Electronic Staff Records.
- Human Resource Team records.
- Staff Survey.

5.2 The WDES introduces a reporting category of, 'Other Locally Agreed' pay. These are staff who are not on Agenda for Change contracts and who are not Very Senior Managers, Medical or Dental staff. They include, for example, staff who remain on Whitley pay scales and Apprentices on specific pay points. There are 104 staff at the Trust on, 'Other Locally Agreed' pay.

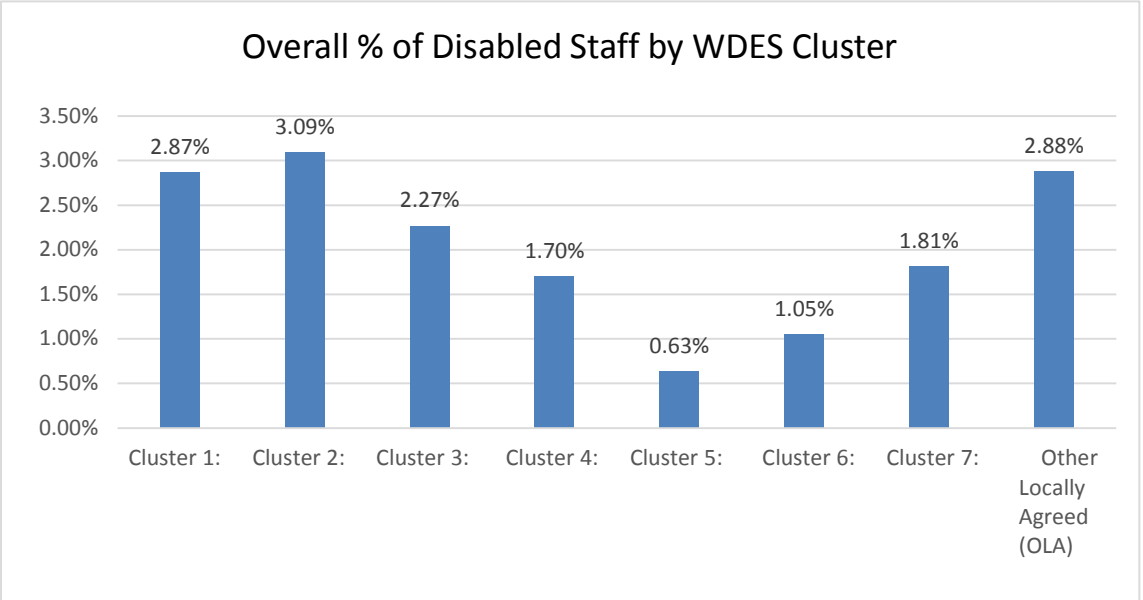
5.3 **Indicator 1**-Workforce Profile

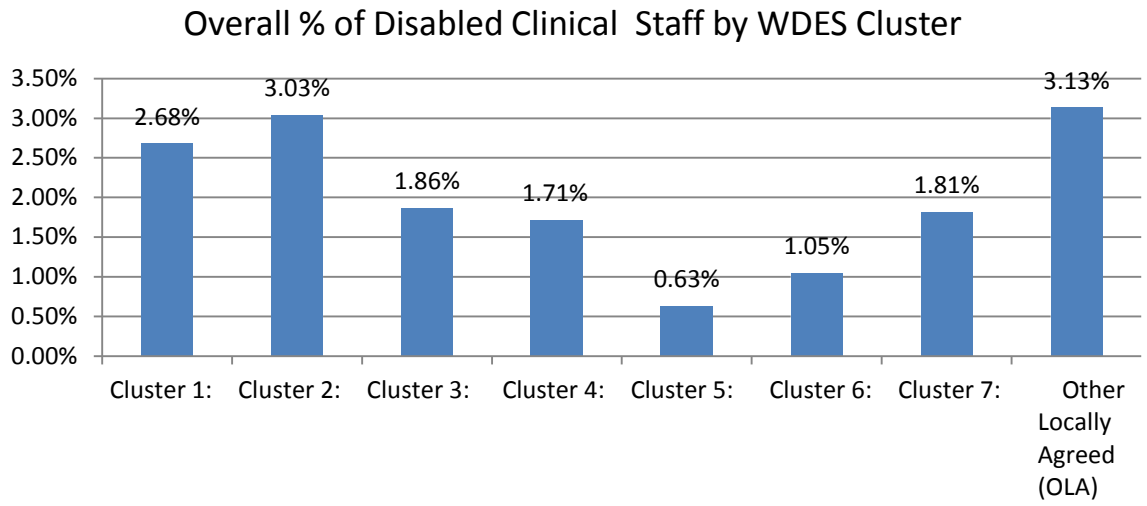
This indicator shows the percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data analysis is separate for non-clinical and for clinical staff. The WDES standards requires organisations to 'group' staff into 'clusters.' The clusters are as follows:

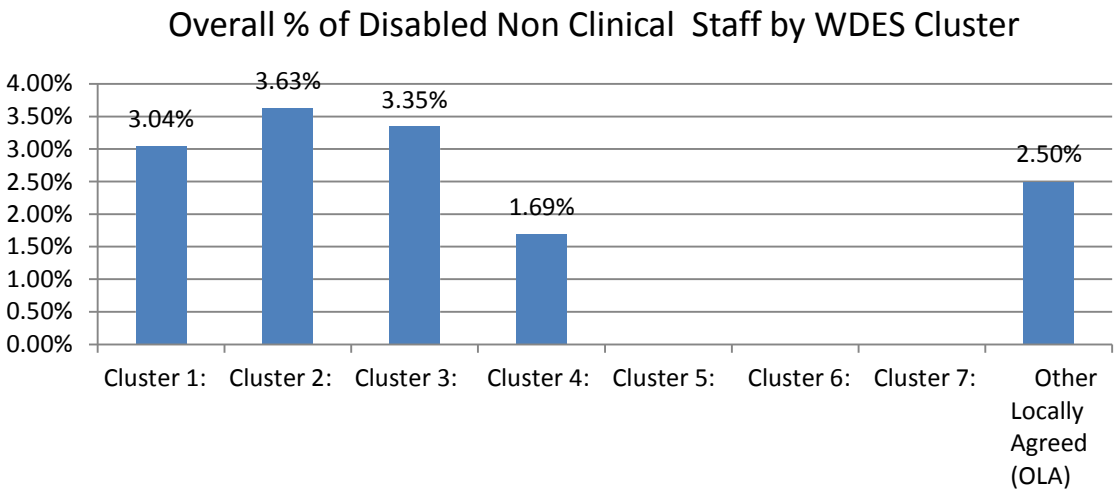
Cluster 1: AfC Band 1, 2, 3 and 4
Cluster 2: AfC Band 5, 6 and 7
Cluster 3: AfC Band 8a and 8b
Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)
Cluster 5: Medical and Dental staff, Consultants
Cluster 6: Medical and Dental staff, Non-consultant career grade
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

Overall, disabled staff make up 2.84% (615) of the workforce. At present, 28% (6,144) of the workforce has not declared their status on disability.





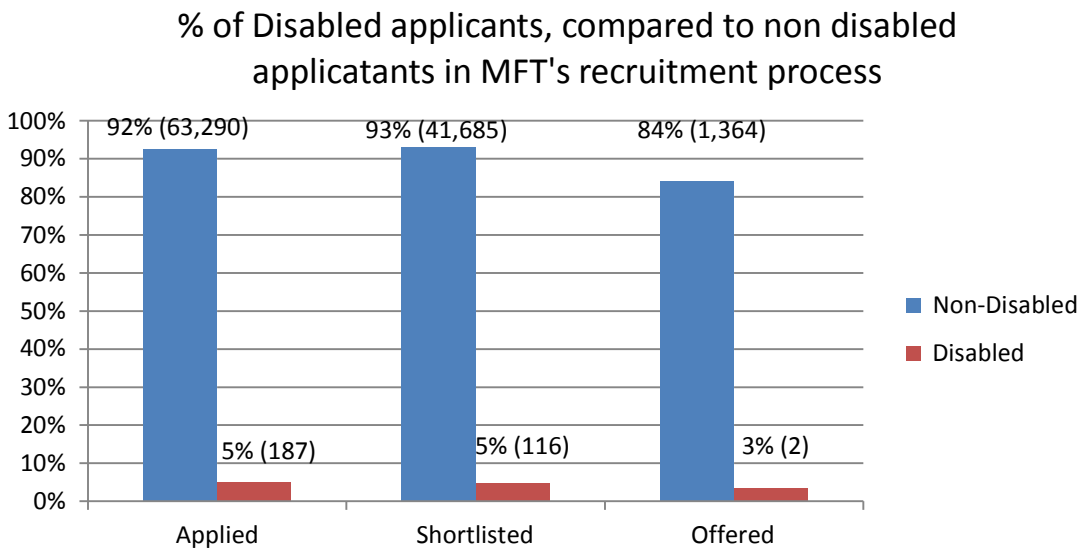


The data highlights that disabled staff are slightly more represented in non-clinical roles than in clinical roles (by 0.86%). The overall representation of disabled staff (2.8%) is low when compared to the 17.8% of Manchester's surveyed population. However, there has been an increase in representation of disabled staff compared to 2017/18, with the exception of cluster 2, which has seen a 1.1% decrease in the last year.

5.4 Indicator 2- Recruitment

Indicator 2 is the same as the WRES and looks at the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. The table below highlights the number of disabled people who apply for roles at MFT compared to non-disabled people:

Disability	Applied	Shortlisted	Offered
Non-Disabled	68,793	44823	1,624
Disabled	3,734	2316	66



The data presented refers to both external and internal posts. The Trust implements a Guaranteed Interview Scheme (GIS) which means that any disabled candidate who meets the essential criteria will be offered an interview. Disabled applicants are 1.43 times more likely to be appointed from shortlisting than non-disabled applicants. Disabled applicants have the option of requesting that their application is considered under the terms of the GIS on the basis that they meet the minimum criteria for the role. During 2019/20, the Trust has provided training to increase disability awareness with a Fast Track to Accessibility Programme training pilot.

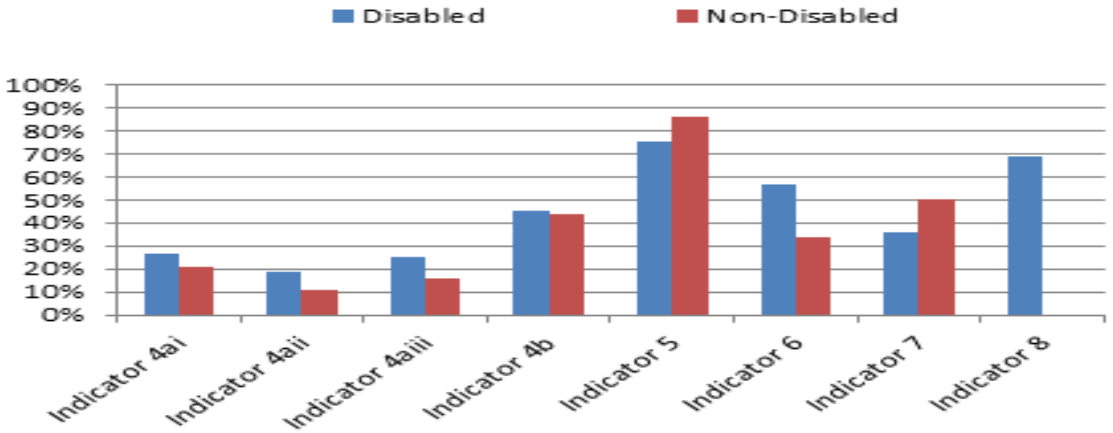
5.5 **Indicator 3**-Capability

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

This indicator is based on data from a two-year rolling average of the current year and the previous year. The data identifies that disabled staff are 1.9 times more likely to enter the formal capability procedure. The data provided is based on capability in relation to performance and this has remained the same for the last two years.

5.6 **Indicator 4-8** - Staff Experience

Indicators 4 to 8 look at the experience of disabled staff in the organisation. The table below compares staff experience for disabled staff and non-disabled staff:



Indicator 4 is broken down into two sections:

- Section a) looks at the percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

    i. Patients/service users, their relatives or other members of the public
    ii. Managers
    iii. Other colleagues

- Section b) looks at the percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

This data is taken from the national staff survey and shows that overall disabled staff are:

- more likely to experience bullying or abuse than their non-disabled colleagues.

- most likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public, and least likely to experience this from their Manager.

Compared to the previous reporting period, there has been a 20% increase in the reporting of bullying and abuse by disabled staff, and a 28% increase in reporting by non-disabled staff.

Indicator 5 compares the percentage of disabled staff to non-disabled staff who believe that the Trust provides equal opportunities for career progression or promotion. The data shows that 75% of disabled staff feel that the Trust provides equal opportunities for career progression or promotion. This is 11% less than their non-disabled colleagues.

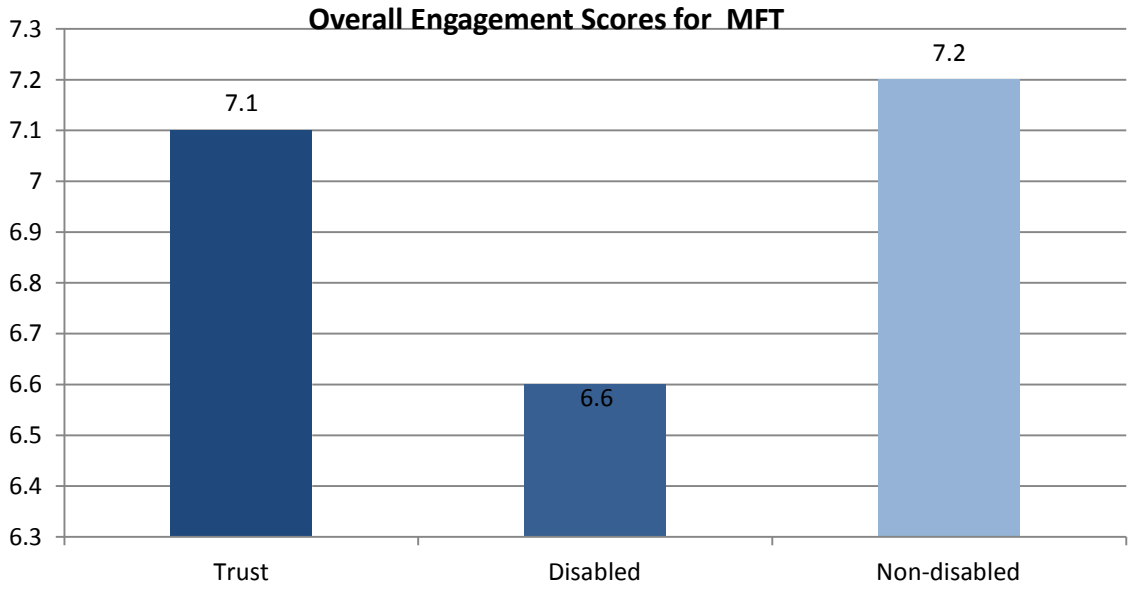
Indicator 6 compares the percentage of disabled staff to non-disabled staff who said that they have felt pressure from their Manager to come to work, despite not feeling well enough to perform their duties. The data shows that 57% of disabled staff have felt pressured to come to work despite not feeling well enough to perform their duties. This is 23% more than their non-disabled colleagues

Indicator 7 compares the percentage of disabled staff to non-disabled staff who said that they are satisfied with the extent to which their organisation values their work. The data indicates that 36% of disabled staff feel that their work is valued by the Trust. This is 14% less than their non-disabled colleagues.

Indicator 8 shows the percentage of disabled staff who said that they feel the Trust has made adequate adjustment(s) to enable them to carry out their work. 69% of disabled staff reported that they felt that adequate reasonable adjustment to enable them to carry out their work had been made.

5.7 Indicator 9-Engagement

Indicator 9 looks at disabled staff engagement including an analysis of the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. The indicator also asks NHS organisations to outline their engagement with disabled staff.



The data shows that non-disabled staff feel more engaged than disabled staff. The Trust has an active Disabled User Patient Forum, which disabled staff regularly attend. However , the focus of this forum is on the patient's experience rather than staff's experience. Whilst the Trust has successfully established a BME and LGBT staff network, a disabled staff network has not yet gained momentum. MFT is doing more work to engage with staff with disabilities and are working to establish a Disabled Staff Network. This network will facilitate a safe and supportive space for staff to share their concerns and experiences, and act as a platform to elevate the voices of disabled staff whilst helping the Trust to better understand the barriers faced by our disabled staff and service users.

5.8 Indicator 10-Board Representation

Indicator 10 compares the percentage difference between the organisation's Board voting membership and the overall workforce. 10.4% of the Trust Board self-reports to be disabled. The difference between the organisation's Board voting membership and the overall workforce is +3%, which indicates that the Trust Board is representative of the overall workforce.

6 Actions to Address WDES Key Priority Areas

6.1. Overall the Trust has seen an increase of representation of disabled staff rising from 2.6% to 2.84% between 2017-2018 and 2018-2019. However, disabled staff are under-represented in all clusters compared to the population of Manchester with a disability (17.8%). Disabled staff are also under-represented in bands 8a upwards in comparison to the overall Trust average of 2.84%. A key issue with the data is that at present 28% of disability status is not known.

6.2. The data in this report identifies key areas of priority for the Trust:

- Addressing variation in the under representation of the Trust's workforce to reflect the population. The Trust will work towards increasing self-reporting through the Electronic Staff Record system and through the recruitment and retention processes.

- Building on the recruitment and selection process at MFT to ensure the transparency and inclusiveness of applicants. The Trust will capitalise on the opportunities provided by the development of the new Attraction Strategy to ensure that MFT is an employer of choice for disabled people. MFT will continue its award winning Widening Participation Programme which creates opportunities for disabled people to work with the Trust.

- Understanding the variation in the outcomes of the capability process. The Trust will review capability formal process decisions in the previous year which relate to disabled staff.

- The Trust is introducing a new Absence Management policy, which will aim to increase the awareness of staff on how reasonable adjustments can be made to support people in work.

- The Trust's Employee Health and Wellbeing Service will continue to support new and existing staff and their managers to identify reasonable adjustment. This will be strengthened as the team develop its new delivery model for MFT.

- The Trust will develop an equality and diversity learning and development programme which will include disability employment training and unconscious bias training.

6.3. Monitoring Trust Wide Performance

The Trust will monitor progress of the WDES action plan at the Trust Equality, Diversity and Human Rights Committee chaired by the Group Executive Director of Finance. Since this is the first year of the WDES, further work is underway to support Hospitals/MCSs/MLCO/Corporate Teams to monitor their progress. Assurance on delivery of the various strands of work will be through the HR Scrutiny Committee (which is a Sub-Committee of the MFT Board of Directors).

7. Conclusion

MFT is committed to reducing the gap in representation and experience. The development of the Removing Barriers Programme aimed at increasing representation of BME staff is a key programme to delivering change. It is the first year of the WDES for the NHS and the data has identified gaps. MFT has already built a programme that support young people with disabilities, supported internships, and is the largest provider of this type of access to work schemes. However, more work is being undertaken to understand and address the areas for improvement identifies in the new disability standard.

8. Recommendations

The Board is asked to;

(i) Approve the report as the basis for publication of the data and submission to NHS England by 31st July 2019.

(ii) Note the key areas of focus and work underway to make improvements against both the WRES and WDES Standards

(iii) Agree delegated responsibility to the HR Scrutiny Committee for monitoring overall performance of WRES and WDES actions.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Toli Onon, Joint Group Medical Director
Paper prepared by:	Debbie Vinsun, Chief Operating Officer Clinical Research Network: Greater Manchester (CRN:GM)
Date of paper:	June 2019
Subject:	Clinical Research Network: Greater Manchester Annual Report (2018/19)
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	The 2018/19 CRN GM Annual Report provides a detailed assessment of the LCRN's delivery against the 2018/19 CRN GM Annual Plan which was approved by the MFT Board of Directors on the 14th May 2018. It offers the assurance that the LCRN and Host Organisation have been fully compliant in discharging the requirements of the Department of Health/LCRN contract and have delivered initiatives, activities and projects which have contributed to the National NIHR CRN High Level Objectives.
Recommendations:	The Board of Directors is asked to receive and approve the CRN GM Annual Report (2018/19).
Contact:	Name: Debbie Vinsun, Chief Operating Officer Tel: 0161 276 8008

NIHR | Clinical Research Network Greater Manchester

Annual Report 2018/19

Key Highlights

1. In 2018/19 CRN: GM has continued to rise to the challenge of significant poor health and poor health outcomes across the region when compared with other parts of England, delivering high quality clinical research to a record number of participants. Through true collaboration, partnership and innovation CRN: GM has contributed 9.5% of CRN total recruitment and when corrected for population has recruited over 27 participants per 1000, ranking GM 1st out of 15 networks. Heart disease and cancer present a significant burden of illness across GM and within these specialty areas we have ranked in the top 5 when compared across networks. There are multiple factors contributing to this success including stability, enthusiasm and drive within both the CRN: GM network management and clinical leadership teams underpinned by support from the Host Organisation and Partnership Board. Full engagement from all partner organisations and promotion of a flexible model of research delivery within these organisations ensures that the demands of the portfolio are being met. It is our collective ambition that everyone has a right to be included in research; this is our primary focus and can be clearly illustrated by Jackie's story. A patient on a clinical trial delivered by the Christie Outreach programme enabling her the opportunity to stay closer at home for her research treatment.
   https://www.youtube.com/watch?v=V2cGOY_YnHM&feature=youtu.be
   We continue to work together across GM towards this ambition.

2. Another significant success across CRN GM continues to be our commercial partnerships that contribute over 29 % of our NIHR CRN portfolio and which have enabled over 4000 participants access to new technologies and treatments within 2018/19. Recruitment to time and target (HLO 2A) remains at 86% and CRN GM is the only network that has surpassed the 80% goal within this financial year. This is testament to the close partnership working between the CRN GM Industry team and Research Teams across the region underpinned by the Business Development Team who link closely with all key Sponsors and CROs. Despite potential threats to the portfolio due to Brexit uncertainty, the volume of studies has remained consistent with 2017/18 and the breadth of study types demonstrates the emergence of health tech companies within this sector. Within 2018/19 25 out of 30 clinical specialties in GM delivered commercially funded research and 17 of those specialties ranked as one of the top 5 networks nationally. CRN GM are always ready to respond to the changing industry landscape as we aspire for exceptional healthcare for all and enhanced partnerships and effective study delivery with the health tech and pharmaceutical sector will continue as we move into 2019/20. Michele's story demonstrates the life changing effect that these studies can have.
   https://www.nihr.ac.uk/news/patient-says-life-has-been-changed-by-ground-breaking-research-at-manchester-royal-eye-hospital/10352

3. Developments across our GM Business Intelligence System have transformed the day to day activities of all our stakeholders within GM. The Local Project Management System (LPMS) RPEAK is now operational in all partner organisations and application developments and updates have taken place throughout the year responding to requirements. Connectivity to the Central Project Management System (CPMS) is planned in Q1 19/20 and the BI/ RPEAK

team working with the national team have been preparing for the go live date. RPEAK Training events for all partners and bespoke training days with individual organisations have occurred in 2018/19.

The GM ODP APP has also become an extremely powerful tool for CRN GM providing up to date GM focussed data which is used frequently in meetings, for presentations and for up to date study statistics. The app now produces instant reports for Trusts and for Specialty Leads providing recruitment data, tracks recruitment to target and also enables the ability to horizon scan. The CRN GM Senior Management team utilise the app to drill further in to the data and can look at Value for Money Reports, commercial activity and now includes the data from the Patient Research Experience Survey (PRES) which took place in 2018/19. We have begun working towards the establishment of a cohort of BI Champions from all GM organisations who will work closely with the CRN GM BI Team in ensuring that we are all maximising use of our Business Intelligence System.

4. In 2018/19 the CRN GM Communication and PPIE team focussed on making improvements to the Patient Research Experience Survey. CRN: GM are committed to ensuring that research is for all, that our participant's experience is the best it can be and therefore wanted to see an increase in response rate when compared with the previous year. The team reviewed the survey and included specific questions around age, gender, drivers for taking part and how participants found out about research. We worked closely with our partner organisations in ensuring that the survey was rolled out across all the Trusts consistently and also utilised the broad reach of both Join Dementia Research and Research for the Future. We had a staggering increase in response from 169 returns in 17/18 to 828 returns in 18/19 and we had active engagement from all secondary care and mental health trusts in GM compared with only 6 in 17/18. This is extremely powerful data and gives CRN GM an insight in to the demographics of participants, their concerns and their reasons for participation. As described the PRES data can now be viewed via the GM ODP APP and we will continue to build on this work throughout 2019/20.

5. One of the many strengths within the research community across CRN GM is the willingness and desire to deliver research to hard-to-reach participant populations to ensure a broad range of portfolio studies, enabling us to pose and answer questions that best serve these communities. In 2018/19 CRN GM have continued to support the delivery of these studies in a broad range of settings. The 'Be On the Team' meningitis study took place in a number of colleges and schools across Greater Manchester recruiting over 3800 students. The Presto study began recruitment in Q4 2018/19 which involves the North West Ambulance NHS Trust paramedics in Greater Manchester assessing whether future patients who call 999 with chest pain can be safely assessed and managed by paramedics, without having to go to hospital. There has been a large dental research programme working with reception aged children successfully delivered in GM. We have also seen a rise in the number of forensic research programmes taking place in prisons within and outwith GM. Research with our ageing population within community dwellings, nursing and care homes also continues to be an area of strength underpinned by the ENRICH programme. Finally we have successfully delivered a research programme in palliative /end of life care and together this demonstrates the ability of CRN GM to continue to support research delivery in these key areas as our portfolio continues to expand.

Performance against High Level and Specialty Objectives and Key Indicators

High Level Objectives

Overall CRN GM has performed exceptionally well against HLO 1 and 2A and recruitment to over 1000 studies in 2018/19 demonstrates the breadth and depth of our portfolio.

Non-commercial recruitment to time and target performance has dropped to 71%, however we have streamlined our systems throughout the year and closer performance monitoring of our portfolio will provide improvements. Study start up times have remained consistent year on year and we continue to provide support to partner organisations encouraging shared learnings across the GM R & I community.HLO5A and 5B performance remains challenging however is comparable with partner CRNs. Performance against HLO 6C highlights one of the key challenges we have identified across our region as we look to improve performance and research outputs from primary care. Although commercial performance within the primary care setting continues to do well supported by the creation of hybrid models of research delivery, from an academic perspective we lack CIs and PIs generating research and partnering with other academic groups nationally. As federations and conglomerates of practices have come together there are research initiatives being put in place to ring-fence GP time enabling support of portfolio studies and development of their academic careers. CRN GM have also identified a GP Champion and RSI processes have been reviewed during 2018/19. It is hoped that this will lead to improvements in performance over the coming year. Finally although the HLO7 target has not been reached, performance has remained satisfactory despite a number of challenges throughout the year which have included a decrease in the number of studies particularly commercial clinical trials taking place, and the loss of a key academic in CRN GM. Join Dementia Research still provides significant levels of recruitment to the GM portfolio.

Specialty Objectives

CRN GM have demonstrated strong performance and clinical leadership across all 30 specialties, offering a wide range of research opportunities to our GM community. Significant work has already begun in early career researcher development across a number of specialities including the encouragement of the trainee networks to deliver portfolio research. These learnings will be harnessed to move the ECR programme of work forward across all specialities in 19/20. The Speciality Leads have met together with the CRN Senior Leadership team on three occasions throughout 2018/19 and have met with their nominated RDM on a regular basis. They have all been active members of their national groups and although we have had 4 vacancies within 2018/19, these posts have now been filled. Several specialties have held regional forums where clinicians and teams have come together to discuss the current portfolio, highlight challenges, celebrate successes and review pipeline and this has proven successful. A number of specialty ‘Champions’ have supported our work throughout the year within key areas including sexual health, CAMHS, health visitors and cancer sub specialties.

LCRN Operating Framework Indicators

CRN GM are confident that the organisational requirements and operational systems and processes in order to ensure the effective discharge of duties and requirements for all our stakeholders are in place. This has been demonstrated aby the strong performance across all key areas within the network in 2018/19.

LCRN Partner Satisfaction Survey Indicators

In 2018/19 the Chair of the CRN GM Partnership Board has taken an active role in ensuring that partner organisations understand the importance of the survey and complete the survey within the required timelines.

This has been tabled as an agenda item at the Partnership Board which has then been followed up by direct communication to each of the Board representatives, followed up with communication to the R & I Manager /Director.

LCRN Customer Satisfaction Indicators

The communications team have circulated information about the customer satisfaction survey across the usual channels within CRN GM. We have also used social media to promote survey completion.

LCRN Patient Experience Indicators

The work focussed on the CRN GM Patient Experience Survey has been described in detail throughout this report. We have partnered closely with our Trusts in order to empower them to encourage completion of the survey at suitable points within the research participant's journey. We have ensured that the survey can be completed either online or on paper and response rates have been exceptional in 2018/19. Data is now live on the CRN GM ODP App.

Host Organisation

Manchester University NHS FT has continued to act in line with the requirements stated within the DHSC/LCRN host organisation agreement even during their period of transition. HR and Finance Support has been consistent throughout 2018/19. The COO meets regularly with the host Divisional Director of R & I, annual reports and annual plans are presented to the Host Trust Board for review and approval. Following completion of the first Contract Compliance Assurance Framework in Q3 2018/19, meetings with the host senior team have been instigated to ensure that this framework can be reviewed regularly in partnership with the CRN GM team

Governance and Management

Deputy COO and Deputy Clinical Director Posts have been filled in 2018/19. Partnership Board meetings have maintained significant levels of attendance from the majority of partners enabling close scrutiny of CRN GM performance. Operational Management meetings have been held on a monthly basis and now incorporate membership from both Clinical leaders and R & I leaders from across GM. Use of the CRN GM ODP app within these meetings enables interrogation of real time performance data.

Financial Management

In 2018/19 it is pleasing to report a break even position despite significant challenges during the year. These challenges have included managing the funding flow of the 18-19 pay award pressure i.e. the management of unallocated funds due to uncertainties around the pay award; the migration to a new finance ledger system (Integra), including the development of off-line systems in response to GDPR and changes to data collated in the NIHR Finance Tool, and the change management involved in Excess Treatment Cost flow and distribution. There was an internal audit with significant assurance level overall and we successfully managed the trial period of ETC payments and liaised with PO's regarding the process / thresholds.

CRN Specialties

Recruitment against all 30 clinical specialties has taken place in 2018/19 with 80% of specialities ranked in the top 10 networks nationally. CVD and cancer continue to be areas of strength and reflect the high disease burden in GM. Research within GM into areas such as common mental health disorders is low and needs to be addressed to reflect the need across the GM population. Developing areas including anaesthesia, genetics and surgery have registered strong performance in 2018/19. Clinical leadership within smaller specialties including ageing and public health is strong and through their networks and connections nationally they will begin to broaden the portfolio within these areas.

Research Delivery

A Cross Divisional Research Delivery Team which includes an IOM, BD Manager, RDMS and ARDMS has been in place to support all clinical specialities in 2018/19. The review and streamlining of the study support service offer, processes and systems has taken place and improvements made. A single point of contact is now operational for all studies both commercial and non-commercial. Use of the Kanbanchi dashboard application to manage workflow has ensured an effective and timely service for all.

Pennine Acute Hospitals NHS Trusts has recruited the highest number of participants nationally out of 494 Trusts with Manchester University NHS FT ranked 5th. Greater Manchester Mental Health NHS FT has ranked 11th out of 50 mental health trust providers.

Information and Knowledge

The LPMS system (RPEAK) is now operational across all partner organisations. The system has been working well supported by training delivered by the BI team. Significant development of the GM ODP App as described in detail within the report allows use of accurate data for reporting and analysis purposes. A cohort of BI Champions has begun to be established in GM and these will work closely with the BI team to ensure maximum uptake of the entire Business Intelligence System

Stakeholder Engagement and Communications

CRN GM has effectively promoted a number of research stories to news outlets within GM throughout 2018/19 which has led to both local and national tv and radio coverage. CRN GM continues to push activities out via the usual channels but have enhanced their presence on social media throughout the year. Analytics prove how effective this method of communication can be. Closer partnership working both with supra CRN network and wider NIHR colleagues has enabled greater visibility of work taking place. PRA Ambassadors number 40 across GM and we have established a programme of work which began in 2018/19 looking at how we can harness the power of their collective voice to support recruitment and retention to clinical research studies across the locality.

Workforce Learning and Organisational Development

CRN GM has delivered 55 face to face training courses to 812 individuals across the community within 2018/19 under the umbrella of safeguarding and regulation enabling delivery of network business. The profile of the training programme available across GM is continually raised with partner organisations. A number of bespoke courses have been created and delivered and this has included the training of 225 paramedics to support the delivery of the PRESTO trial.

A number of the prepared materials can be found here
https://www.youtube.com/watch?v=YJRiltBPTHM

The CRN GM Workforce plan was created and approved in 2018/19. A series of workshops brought together individuals from key partner organisations within GM in order to consider the priorities for the workforce as we move in to the next 2-5 years. This process highlighted the challenges facing the research delivery workforce and in order to address them, a GM workforce Steering Group has been established to oversee progress.

Business Development and Marketing

Key achievements in 2018/19 include the development of research-ready primary care centres with14 PRIME Research Sites conducting both academic and commercial studies. This has been helped by the establishment of three Federation Research Models . The development of oncology capability across the network as CRN GM has looked to increase awareness of centres at MFT/Stockport/East Cheshire and WWL to Pharma.

CRN GM has looked to develop the secondary care/primary care hybrid model to support research delivery and we have continued to support the ‘rising stars’ programme which encourages motivated investigators to take part in more challenging commercial research, in both primary and secondary care. Established investigators are providing mentorship and support to these new investigators to enable them to become more commercially research-ready.

National Contributions

CRN GM CD is the Clinical Director for Business Development and Marketing, the COO is co-lead on the National Industry Improvement programme and the DCOO is one of the Super GCP Facilitators for the Network. Members of the CRN GM have also been involved in the development of the Interactive Costing Tool to be launched in 2019/20.The CRN GM RDMs attend, chair and contribute regularly to national RDM meetings, and attend Specialty meetings when required . The industry team supports regular national and supra network meetings. In 2018/19, 3 members of the CRN GM Exec have held national specialty lead roles. The BI team contribute to the Business Intelligence community meetings and forums specifically in relation to LPMS.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli Onon, Joint Group Medical Director
Paper prepared by:	Mrs Sarah Corcoran, Director of Clinical Governance
Date of paper:	June 2019
Subject:	Update Report on the management of 'Never Events' – Safety Culture and the Need for Transformation
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	To improve patient safety, clinical quality and outcomes.
Recommendations:	The Board of Directors are asked to note the Update Report on the management of 'Never Events'
Contact:	Name: Mrs Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Introduction

1.1. In December 2018 the CQC published a paper entitled *Opening the door to change: NHS safety culture and the need for transformation*.[1] The same month NHS Improvement published its consultation document, *Developing a patient safety strategy for the NHS*[2].

1.2. In January 2019 the Board received a report on the number and type of never events occurring in the last 12 months and action in response.

1.3. This paper summarises the published documents, sets out recommendations in response to the possible changes ahead and presents detail on never events to date.

2. Developing a patient strategy for the NHS

2.1. In the forward NHS I set out the rationale for the development of this strategy following the Secretary of States announcement in September 2018 that "a new patient safety strategy will mean safety is cemented into our long term NHS". The consultation document sets out proposals for that strategy.

2.2. The document defines patient safety thus:
"Patient safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare. It is one of three core components of quality in healthcare alongside clinical effectiveness and patient experience."

2.3. It goes on to define the role of the National Patient Safety Team and their two statutory duties, collecting information about what goes wrong in healthcare and using information from incident reports and other sources to develop policy and provide advice and guidance.

2.4. The current challenges are set out and these include the capability and capacity of NHS organisations to undertake effective investigations and apply learning when harm occurs, the pressure of rising demand and increasingly complex health needs and a fear of blame by NHS staff.

2.5. NHS I then propose the overarching vision of the NHS being the safest care system in the world supported by three aims for the NHS:

- be world leading at drawing insight from multiple sources of patient safety information
- give staff at all levels the skills and support they need to help improve patient safety, so they can be the infrastructure for safety improvement, working with patients and partner organisations
- decrease harm in key areas by 50% by 2023/24 and beyond through specific patient safety initiatives

2.6. These aims and the supporting actions are set out in fig.1 over.

2.7. Delivery of the aims is then described and readers asked to respond on the detail which includes:

2.7.1. The new National Patient Safety Incident Management System – MFT is currently actively working with NHS I as a pilot site for this however the new system is not yet available for use.

[1] Opening the door to change. NHS Safety culture and the need for transformation. CQC. December 2018
[2] Developing a patient safety strategy for the NHS. Proposals for consultation. NHS Improvement. December 2018

2.7.2. A review of the National Serious Incident Management Framework

2.7.3. Delivery of the Learning from Deaths Policy to include the introduction of the Medical Examiner System

2.7.4. Clarification on how safety alerts are circulated and monitored for effectiveness

2.7.5. How data from National Clinical Audit and Clinical Outcome Review Programmes is used.

2.7.6. Review of patient safety training / human factors training curricula across the NHS.

2.7.7. Development of a network of senior Patient Safety Specialists.

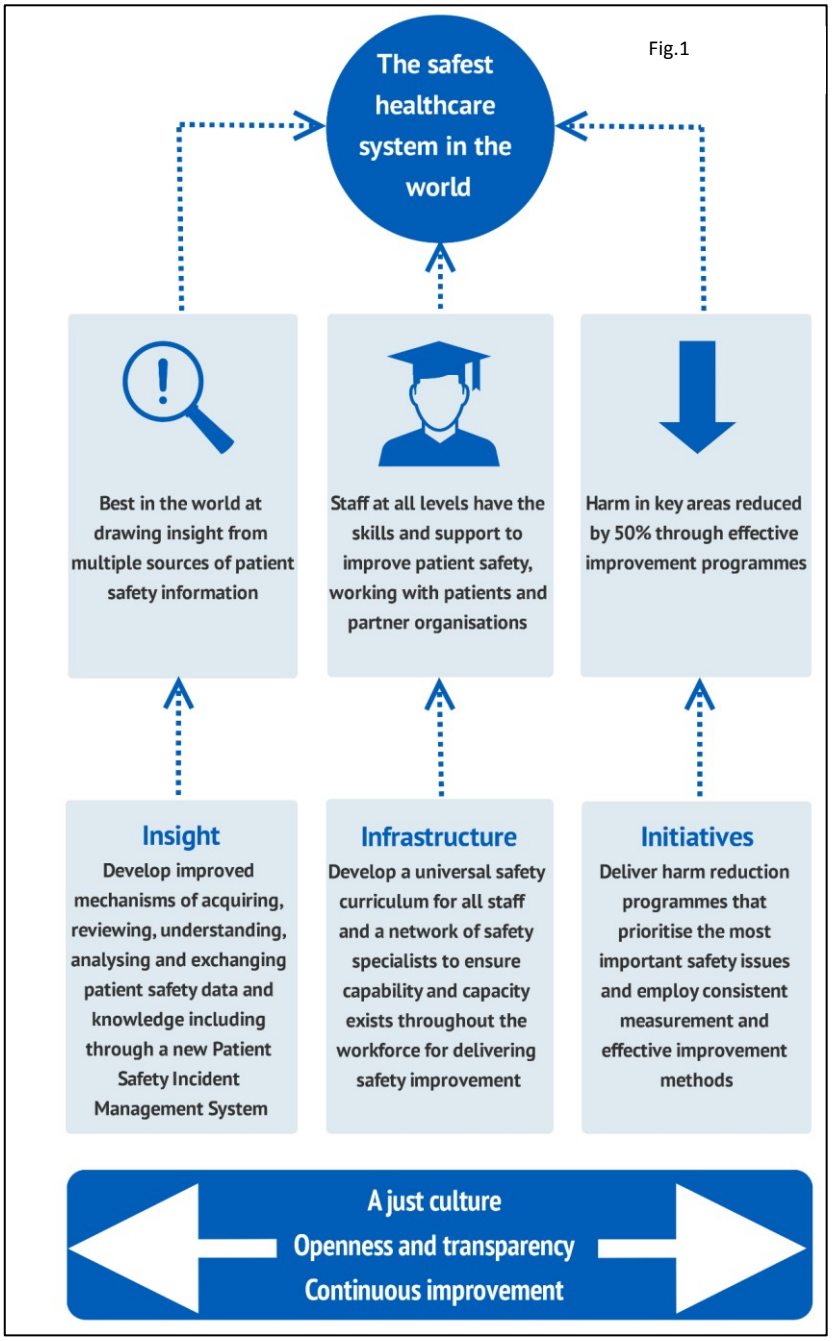
2.7.8. Development of patient advocates for safety.

2.7.9. Establishment of a dedicated Patient Safety Support Team to work with Trusts experiencing particular difficulties.

2.7.10. Review of litigation to understand significant harm and the development of initiatives in response.

2.7.11. A review of the Patient Safety Collaborative programme – recommending this continue but with a more structured approach.

Fig.1



2.7.12. Work on medication safety aligned with the World Health Organisation's *Medication Without Harm* challenge.

2.7.13. Specific safety projects aligned with frequently occurring harms such as infection, falls, pressure ulcers, nutrition and mental health.

2.7.14. Finally the strategy will align with the CQC proposals on safety culture as detailed below.

2.8. The consultation document is currently under review.

3. Opening the door to change: NHS safety culture and the need for transformation

3.1. In his introduction, Ted Baker, CQC Chief Inspector of Hospitals, reports that despite much work and a strong focus on safety in the NHS in recent years there remains a lack of understanding of human factors and patient safety in NHS organisations and that the failure of the NHS to eradicate 'Never Events'[3] tells us something fundamental about the safety culture of our health care.

3.2. This report details a study undertaken by the CQC in which they considered the following questions:

- How is the guidance to prevent Never Events, including patient safety alerts, regarded by trusts?
- How effectively do trusts implement the safety guidance?
- How do other system partners support trusts with the implementation of safety guidance?
- What can we learn from other industries?

3.3. They visited a number of Trusts and spoke to staff and patients across a wide variety of care settings.

3.4. They found that there were a number of challenges faced by trusts including:

3.4.1. Competing pressures on staff due to high workloads impacting on the ability to make the changes required following alerts

3.4.2. A need for greater standardisation

3.4.3. Different approaches to governance and leadership and lack of consistency in Board discussions about Never Events (some Board receiving no reports at all on same)

3.4.4. Different leadership styles and hierarchies impacting on safety culture

3.5. Across the NHS as a whole the CQC found that there exists a complex and often confusing approach to safety across a number of different bodies who all issued safety information to trusts, variation in support from CCGs and a lack of systems for learning at a National level.

3.6. Furthermore they identified poor patient involvement across the system – particularly in relation to investigations.

3.7. In respect to training the CQC found that without better understanding of safety systems and human factors Never Events are almost certain to continue to occur. Their report identified a lack of consistency, capacity and capability to deliver that training at the undergraduate, post graduate and clinical settings. There was a lack of inclusion of safety training in mandatory training schedules and that whilst recognised as important education in this area has not been effectively completed.

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[3] *Never Events are serious incidents that are considered to be wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. However, Never Events continue to happen: there were* ***468*** *incidents provisionally classified as Never Events between 1 April 2017 and 31 March 2018.* Opening the door to change. NHS Safety culture and the need for transformation. CQC. December 2018

3.8. The CQC conclude that never events continue to happen despite the best efforts of staff, different parts of the National, regional and local systems do not work together and there is a need for a top down recognition of patient safety as a top priority.

3.9. The CQC set out 7 recommendations – see fig.2

Fig.2

Our recommendations

1.	NHS Improvement should work in partnership with Health Education England and others to make sure that the entire NHS workforce has a common understanding of patient safety and the skills and behaviours and leadership culture necessary to make it a priority. NHS Improvement and Health Education England should also develop accessible, specialist training in patient safety that staff can study as part of their clinical education or as a separate discipline.
2.	The National Patient Safety Strategy must support the NHS to have safety as a top priority. Driven by the National Director of Patient Safety at NHS Improvement, it should set out a clear vision on patient safety, clarifying the roles and responsibilities of key players, including patients, with clear milestones for deliverables. It should ensure that an effective safety culture is embedded at every level, from senior leadership to the frontline.
3.	Leaders with a responsibility for patient safety must have the appropriate training, expertise and support to drive safety improvement in trusts. Their role is to make sure that the trust reviews its safety culture on an ongoing basis, so that it meets the highest possible standards and is centred on learning and improvement. They should have an active role in feeding this insight back to NHS Improvement so that other NHS organisations can learn from it, as is the case in other industries.
4.	NHS Improvement should work with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying where clinical processes and other elements, such as equipment and governance processes, can and should be standardised.
5.	The National Patient Safety Alert Committee (NaPSAC) should oversee a standardised patient safety alert system that aligns the processes and outputs of all bodies and teams that issue alerts, and make sure that they set out clear and effective actions that providers must take on safety-critical issues.
6.	NHS Improvement should work with professional regulators and royal colleges to review the Never Events framework, focusing on leadership and safety culture, and exploring the barriers to preventing errors such as human behaviours.
7.	CQC will use the findings of this report to improve the way we assess and regulate safety, to ensure that the entire NHS workforce has a common understanding of leadership and just culture, and the skills and behaviours necessary to make safety a priority.

4. Current Performance and Actions in Response to Never Events

4.1. At 14th June 2019 the Trust has had 5 never events in a 12 month period and the risk is currently rated at a 16

These were:

- 2 misplaced NG Tubes
- 1 incorrect site surgery
- 1 wrong implant
- 1 connection to air instead of O2

4.2. A range of actions have been implemented or are in progress as a result of incidents including a new MFT Safe Procedure Policy, updated training programmes for NG tube position checking, implementation of a time out before insertion of implants and review of covers on air outlets.

4.3. A clinical 'away session' was held to review practice in respect of safety checklists and this has informed an improvement project which is now underway within the MRI. The results of this will inform improvement work across the Group.

4.4. All Hospitals have undertaken work on assessing all invasive procedures and focusing on developing and implementing local safety standards for the highest risk areas.

5. Action to Date

5.1. The consultation document was reviewed and a response submitted overseen by the Group Joint Medical Director, Miss TS Onon on February 14th 2018.

5.2. A Group Management Board Seminar was undertaken on April 29th 2019 where a detailed discussion on culture was undertaken. This work is now being used to inform the Quality and safety Strategy and next steps.

5.3. The Clinical Governance Team has undertaken a gap analysis based on the report and likely outcome of the consultation and this is detailed at appendix 1.

6. Recommendations

6.1. The Board of Directors are asked to note the work to date

Appendix 1 - Gap Analysis

Inherent Risk Rating Impact / Likelihood *"Without*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *t*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"* "	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16	**1.** Freedom to Speak Up (F2SU) programme and personnel **2.** Quality and Safety Strategy and related policies **3.** Trust Governance structure – including Quality and Performance Scrutiny Committee **4.** AOF monitoring **5.** Patient Safety (Human Factors) Training Programme (PST) **6.** Root Cause Analysis (RCA) Training Programme **7.** Trust alert circulation process **8.** Trust incident investigation process **9.** Shelford Safety Leads forum for sharing learning	1. Policy controls weak 2. F2SU not fully embedded 3. Governance structure still in development 4. PST Training not mandatory for all staff 5. No capacity to deliver this to all staff 6. No current evaluation of impact of PST or RCA training 7. General Patient Safety training not included in mandatory training packages – including induction 8. Lack of links with University and Training Schools on PST 9. Lack of patient involvement in investigation and feedback to staff 10. Mechanistic circulation and response to alerts without follow up and audit programme 11. Lack of Trust wide visible Patient Safety Champions 12. Patient safety commitment not fully embedded into recruitment practice	1. Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information) 2. Trust clinical and internal audit systems 3. Staff survey 4. Regulatory inspection processes 5. Internal quality assurance processes (Ward accreditation, Quality Review) 6. AOF and leading and lagging patient safety metrics reporting	1. Incident reporting system may not capture all harm – can be a cumbersome process 2. Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels 3. Staff survey does not adequately capture full understanding of patient safety culture 4. Patient safety metrics not yet fully developed or reported on 5. Actions following harm not always evaluated or reviewed 6. Lack of full understanding of finance and performance cost of harm in relation to claims, lost bed days etc	**16**	1. Undertake Trust wide Patient safety Culture Survey 2. Define processes for on-going evaluation of safety culture 3. Develop patient information leaflet on 'When things go wrong' 4. Obtain accreditation for PST 5. Develop an in-house Patient Safety Champion qualification – PST / RCA + Patient Safety Project 6. Implement revised process following 'Never Event' to include a panel review similar to the Emergency Bleep Meeting concept – consider NED lead for this process 7. Undertake Trust wide patient safety training needs analysis 8. Build the requirements of this analysis into the mandatory training framework 9. Build the requirements of this analysis into appraisal and revalidation processes 10. Include statement on commitment to patient safety in all Trust contracts 11. Develop post-investigation feedback questionnaire for staff and patients 12. Develop further the clear aims in relation to reduction of harm aligned with NHS Patient Safety Strategy – Deterioration, Sepsis, NEWS, medication safety, IPC, maternity, falls pressure ulcers, nutrition and mental health 13. Appoint Trust Compliance Officer to oversee alert circulation, response, review and follow-up 14. Define CSG/CAC/CGC roles in standardisation of clinical practice	March 2020	Quality and Performance Scrutiny Committee	1. Trust Compliance Officer appointed	**5**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse Miss Toli Onon, Group Joint Medical Director
Paper prepared by:	Sarah Corcoran, Director of Clinical Governance
Date of paper:	June 2019
Subject:	Response to the Gosport Inquiry Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	To improve patient safety, clinical quality and outcomes
Recommendations:	The Board of Directors is asked to: • Note the progress • Note and approve sources of assurance • Approve the continuation of this work through business as usual processes
Contact:	Name: Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Overview

1.1. The Board of Directors last received an update report on the Trust response to the findings of the Gosport Independent Panel in January 2019. This paper details progress with actions agreed.

1.2. *Gosport War Memorial Hospital - The Report of the Gosport Independent Panel* was published in June 2018. The report detailed the findings of an independent panel set up to investigate concerns raised by families and nursing staff at the Gosport War Memorial Hospital from 1991 onwards.

1.3. The investigation at Gosport found that the pattern of opioid prescribing of concern occurred during the period between 1989 and 2000 at the Gosport War Memorial Hospital and that over the period the panel concluded that:

- There was a disregard for human life and a culture of shortening the lives of a large number of patients

- There was an institutionalised regime of prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.

- When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions

- The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved."

1.4. **Manchester University NHS FT Response Timeline**

June 2018	Publication of the Gosport War Memorial Hospital - The Report of the Gosport Independent Panel
August 2018	Presented to the Group Quality and Safety Committee in and a number of questions raised in response. It was agreed that the questions would be reviewed both by the hospitals and MCSs and by the corporate Medical and Nursing Teams.
September 2018	A report was presented to the Group Management Board setting out the main findings and an analysis of the position at Manchester University NHS Foundation Trust (MFT) in respect of the potential for this practice to have arisen in the past or in the future.
January 2019	Hospitals and MCS detailed review and response presented to Board of Directors A follow up report requested for Summer 2019 to provide assurance that there are no on-going areas of concern

2. Exception Report on Action in Response

2.1. **Manchester Royal Infirmary**

A key area of concern for the MRI was complaints management. MRI recognised the need to reduce the volume of open complaints and improve on the timeliness of completion. The hospital has seen a 50% decrease in the number of open complaints over the past 6 months, and continues to sustain this improvement. The hospital continues to address the need to improve timeliness of responses and has a trajectory to meet 90% of responses completed in time by Q2.

Mortality reviews have been undertaken for all patients with a recognised learning disability and the process for mortality review is currently under scrutiny for further development.

2.2. **Wythenshawe, Trafford, Withington and Altrincham**

WTWA Staff reported that feedback following incidents was not effective. An audit of incident feedback is undertaken by the Corporate Risk Management Team, findings are shared via monthly via WTWA Quality and Patient Safety Committee and overall the audit has provided positive assurance. Further actions identified to improve the quality of feedback provided. Actions identified to address quality of feedback provided: including sharing examples of what good feedback looks like to support managers to provide feedback which is valuable to the reporter, additional training for managers validating incidents on provision of feedback.

2.3. **Royal Manchester Children's Hospital**

The actions planned are largely complete with the exception of the introduction of the new mortality review system which has been delayed in order to ensure that the new process links with the regional death overview panel and the National Child Mortality database in response to the Department of Health's guidance for child death review published in October 2018.

RMCH/MCS now has 4 Freedom to Speak Up Champions who are working across the MCS to support staff in raising concerns.

2.4. **Saint Mary's Hospital**

Saint Mary's Hospital MCS report that all actions planned are complete.

2.5. **Clinical and Scientific Services**

Mortality and morbidity meetings now well established at Wythenshawe Critical Care units utilising the Oxford Road Campus ACCU model.

Work is ongoing to establish and embed a more robust Morbidity and Mortality review process for Cardiac Intensive Care at the MRI.

2.6. **Manchester Local Care Organisation**

Complaints improvement plan now embedded with a 100% on time response rate for complaints from April 2019. Further support agreed from corporate team for Lead Nurses in their role of quality assurance.

2.7. **Group wide Action**

Group wide actions are largely complete and the detail on progress is reported at Appendix 1.

Of particular note is the development of the Freedom to Speak Up Champions network which is now becoming embedded across all Hospitals and MCS. 'Freedom to Speak Up' Champions were recruited in September 2018 to support the Trusts Freedom to Speak Up Guardian. A number of champions are based in each Hospital / MCS however staff can contact any of the 18 champions' based at any site.

3. Assurance

4. Whilst it is not possible to be fully assured that an individual would not seek to harm patients it is essential that the Board is assured that the systems and processes in place would mitigate any such risk and protect patients from any systematic harm over time that was evident at the Gosport Memorial Hospital.
Existing Assurance sources are presented here against the four themes identified in the report.

Theme	Current Assurance Mechanisms
There was a disregard for human life and a culture of shortening the lives of a large number of patients	1. Mortality review reports – including assessment on avoidable deaths. This will be further strengthened with the introduction of the Medical Examiner. 2. Mortality review process includes prescribing 3. Hospital Standardised Mortality Ratio (HSMR) detailed at Hospital MCS level on AOF 4. Summary Hospital Mortality Indicator (SHMI) detailed at Hospital MCS level on AOF 5. Minutes and reports from the Group Learning From Deaths Committee 6. Hospital / MCS Mortality Scrutiny Meetings – chaired by a NED 7. Integrated governance reports for all Hospitals – thematic analysis and summary presentation at Quality and Safety Committee 8. Board scrutiny of performance through the Board Assurance Report
There was an institutionalised regime of prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.	
When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions	1. Complaints management reports on AOF 2. Complaints Scrutiny Meeting chaired by a NED 3. CQC and Ombudsman oversight of complaints
***The senior management of the hospital, healthcare organisations**, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved."*	1. AOF 2. Minutes of the Quality and Safety Scrutiny Committee 3. External review of leadership capacity and capability 4. Comparative analysis of harm, complaints and claims across groups such as Shelford

5. Next Steps

5.1. All outstanding actions have been reviewed and aligned with existing work plans and action plans**.** The Quality Strategy, Executive Work Plans and the CQC Action Plan all address any of the outstanding issues for completion. These actions relate to:

- Standardisation of mortality review processes
- Availability of site level data for some outcomes and specialty SHMI
- Improvements to Pharmacy audit process

6. Recommendations

6.1. The Board of Directors are asked to note progress
6.2. The Board of Directors are asked to note and approve sources of assurance
6.3. The Board of Director are asked to approve the continuation of this work through business as usual processes

Appendix 1 – Update against agreed Group wide action

Improvement Required	Oversight	Lead	Update	Position
Further alignment of the monitoring of NICE guidance and associated clinical audit programme	Quality and Safety Committee	Director of Clinical Governance	Clinical Audit processes now agreed and to be finalised with new Hospital / MCS clinical audit roles established from April 1st 2019. Clinical audit programme aligned with NICE guidance. Clinical audit programme monitored at the Group Clinical Governance Committee and reported to the Quality and Safety Committee. **Assurance: Clinical Audit monitoring reports to Clinical Governance Committee**	Complete
Improvements to the controlled drugs audit tool	Medicines Management Committee	Directors of Pharmacy	Controlled Drug audit harmonised and consistent across all sites Plan to audit the prescribing and administration of palliative care/anticipatory medicines across all sites against the standards identified in the relevant MFT guidelines. **Assurance**: **Audit outcomes and action plans will be reported to MFT Medicines Management Committees and Group Medicines Safety Committee.** Plan to audit palliative care/anticipatory medicines across all sites.	Work progressing
Improvements to the complaints management process and timeliness of response and alignment of systems across all sites	Quality and Safety Committee	Corporate Director of Nursing	Since the formation of MFT work has successfully been completed to align the complaints processes of the legacy Trusts to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints regulations (2009). **Assurance: Complaints reporting data**	Complete
Feedback to staff following reporting of serious incidents and themes identified	Quality and Safety Committee	Director of Clinical Governance	Improvements to feedback mechanisms built into Medical Director's work plan. Good mechanisms for Group feedback at a high level – MFT Safety Matters, intranet site in development, Group Governance structure.	Complete

Improvement Required	Oversight	Lead	Update	Position
			Systems for individual feedback and support being integrated into incident investigation processes – feedback monitored via Ulysses. **Assurance: Ulysses feedback data to Clinical Governance Committee in February**	
Pharmacy support – consistency across all sites	Medicines Management Committee	Directors of Pharmacy	Pharmacy CD meetings held every 2 months – CDAO and pharmacy staff representing all sites (including community) Monthly ADiOS reports produced for all sites Quarterly review of CD incidents undertaken for all sites Review of palliative care pharmacy services to be undertaken as inconsistencies across different sites. This will be undertaken as part of a wider review of Clinical Services starting April 2019. The Clinical Pharmacy Standards have been updated and will be rolled out across all of MFT. **Assurance: Meeting minutes, reports and audit outcomes will be reported to the Division of Pharmacy and Medicines Optimisation Quality and Safety Committee and ultimately any exceptions to the Group Medicines Safety Committee.**	Work progressing
Consistency and completeness of mortality reviews	Group Mortality Review Committee	Associate Medical Director - CE	Plan for introduction of Medical Examiner role to be led by Associate Medical Director for completion in 2019. Mortality review processes in place across Group – roll out of SJR underway for completion in 2019. **Assurance: Annual Mortality reports to BoD, Group mortality portal data, Group HSMR and SHMI at specialty level, outlier reports and responses,**	Work progressing
Availability of site level data for some outcomes and specialty SHMI	Group Mortality Review Committee	Director of Digital Delivery	The Group has the ability to load a record specialty level SHMI data set, and in future we plan to import and present in the KPI dashboard, aligned to MCS. This will be scheduled once phase 2 priority data sets are complete on the SHS work programme (RTT, incidents/harms, theatre, Cancer, CUR, VTE, waits, Critical care, bed days, Maternity, cancelled ops, CDS, readmissions, activity, and FFT) – approximately quarter 2 19/20. **Assurance: Hive, SHMI to be tested as an indicator as part of the audit process for the annual Quality Report**	Work progressing but may be delayed due to IT priorities

Improvement Required	Oversight	Lead	Update	Position
Storage and security of medicines	Medicines Management Committee	Directors of Pharmacy	Multidisciplinary Task and Finish group set up to review Schedule 3-5 CDs and make recommendations for consistent management of these medicines across all Trust sites to be adopted into revisions of the Trust Medicines Policy and Controlled Drugs Policy. **Assurance: Revised Medicines and Controlled Drugs Policies approved at MMCs.** Controlled Drug audit subsequently harmonised and consistent across all sites. Proposal presented to the Group Medicines Safety Committee April 2019. The option of utilising automated dispensing cabinets will be explored.	Work progressing
Completion of Freedom to Speak Up Champion appointments	HR Scrutiny Committee	Associate Director Inclusion & Community	18 Champions were recruited in August 2018 to support the Trusts Freedom to Speak Up Champions. A programme of communication and engagement has supported the roll out of the Champions. The Trust has established two KPI's for the programme, developed an online reporting concerns recording system and reviewed responsibilities across the Trust for Freedom to Speak Up programme. The Trust is already seeing a rise in number of people contacting the Guardian and Champions in Quarter 3. **Assurance: Freedom to Speak Up reporting data**	Complete

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli Onon, Group Joint Medical Director Professor Jane Eddleston, Group Joint Medical Director
Paper prepared by:	Dr Nicky Anders, Associated Medical Director Mrs Sarah Corcoran, Director of Clinical Governance
Date of paper:	June 2019
Subject:	Learning from Deaths
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	To improve patient safety, clinical quality and outcomes.
Recommendations:	The Board of Directors is asked to note this report and the actions undertaken
Contact:	Name: Mrs Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

Introduction

This paper aims to provide assurance to the Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Board's (NQB) National Guidance on Learning from Deaths (LFD) (March 2017), and Guidance on Working with Bereaved Families and Carers (July 2018).

Summary Information on Learning from Deaths

Conforming to national guidance, a summary of mortality review activity, and the number of deaths deemed potentially avoidable is available on the public MFT web-site, this information has also been included in the Quality Report 2018/19.

Group Level SHMI

Indicator	Outcomes	MFT 2018/19	National Average 2018/19	MFT 2017/18 Full year	Highest Performing Trust 2018/19	Lowest Performing Trust 2018/19
SHMI	To be less than 100	93.02%	100	*No data available	69.17	126.81

Mortality Review Information

	Deaths (excluding Patients with a Learning Disability)		
Quarter	Total	Reviewed	Avoidable (>50% likelihood)
Q1	765	183	3
Q2	696	97	1
Q3	765	157	0
Q4	761	61	0
Total	**2987**	**498**	**4**

The Trust aims to review around 10% of all deaths; in 2018/19 the organisation achieved 16%.

In addition to randomly selecting 10% there are a number of types of death that are subject to mandatory review, these include:

- Any patient with a recognised learning disability
- Any patient under 18 years
- Any maternal death
- Any death where a patient safety incident has been investigated

The Trust has a Learning from Deaths Strategy and Policy which contain further detail on the types of reviews undertaken and how they are utilised. All reviews inform improvement and it is not necessarily the case that a death is reviewed because there is an identified problem, experience suggests that there is much to learn from the care of patients overall.

In 2018/19 positive findings included:

- ✓ Very few deaths of the total reviews were defined as potentially avoidable
- ✓ Improvements to sepsis management

- ✓ Good end of life care
- ✓ Good management of complex surgery
- ✓ Good input from palliative care team
- ✓ Improvement in palliative care coding
- ✓ More rapid response to possibility of sepsis

The following improvement requirements were identified:

- × Poor communication – particularly record keeping
- × Medicines contraindication
- × Pre-operative assessment
- × Serious harm from falls
- × Improved capacity for urgent surgery
- × Detailed review of deaths for patients with a recognised learning disability

The Trust undertook the following action in response to learning:

- ✓ Increased consultant presence on orthopaedic wards and improved ortho-geriatric support
- ✓ Continuation of Human Factors training, focus on communication and non-technical skills
- ✓ Improvements to mentoring arrangements in cardiac surgery at the Manchester Heart Centre
- ✓ Falls Team review of all falls and sharing of learning
- ✓ Trust wide changes on nutrition support for patients who are nil-by-mouth
- ✓ Education for medical staff on the management of patients with Parkinson's Disease when nil-by-mouth
- ✓ Improvements to sepsis management
- ✓ Improvements on the management of hypokalaemia (low potassium levels)
- ✓ Improvements to the management of nutrition
- ✓ Review of pre-operative preparation processes
- ✓ Improvements made to the process of reviews of deaths of patients with an identified learning disability

Mortality Reviews

Mortality reviews are undertaken in cohorts of patients where a review is considered mandatory as defined in the Mortality Review Policy, and in addition in line with speciality best practice.

Across MFT, it is the intention that the Royal College of Physicians' Structured Judgement Review Tool will be used for all adult deaths, once the Informatics work program permits the alteration to the electronic Portal. This work is yet to be completed and in June 2019 the Group Mortality Review Committee set a proposed date of October 2019 to establish the SJR as the Group wide tool on the electronic portal. The committee has requested confirmation from the Informatics Team that the necessary changes can be made to the portal to achieve this date. The committee is of the view that this change is a key milestone in the achievement of standardised processes across the Group and essential for the establishment of the Medical Examiner role currently being recruited to.

For neonatal review, the internal process has been adjusted to take account of new National Recommendations. For children, all deaths are reviewed; the RMCH process is being re- evaluated to avoid duplication between the Paediatric Intensive Care Unit (PICU) and RMCH processes.

Hospitals and Managed Clinical Services (MCS) present a summary of their Mortality Review work to the Group Learning From Deaths Committee, in addition to their internal Mortality and Quality and Safety meeting. Correlation and dissemination of these cases is improving learning across the Group.

Patients with a Learning Disability

The Government and NHS England have committed to reducing health inequalities for people with learning disabilities and have established national programmes to improve treatment and outcomes. The Government's Mandate to the NHS 2018 set an objective for the NHS to close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole.

Additionally the National Learning Disability Mortality Review Programme (LeDer) seeks to review all deaths of people with a learning disability to provide learning and recommendations nationally for NHS services

The Board Assurance Framework report on mortality reviews notes the following *'Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care. The Learning from deaths group have taken an overview in supporting dissemination of good practice, lessons and action plans are being developed. A deficiency in mortality review for patients with learning disability has been identified, and a new process commenced'*

A consistent review process for all deaths of people with a Learning Disability on the Oxford Road Campus was established in January 2019. The informatics team provided a list of deaths which was identified using the PAS special register, diagnostic coding and Bedman. The parameters for identification were adults with a learning disability who had died in hospital. The information provided was for all deaths from 1.4.2018 – 30.12.2018.

A small team was established to undertake the reviews which comprised of a Consultant Physician, Consultant Geriatrician, Specialist Learning Disability Nurse and Trust Assurance Manager. A recurring weekly meeting was agreed to ensure that time was set aside to complete the reviews.

It was agreed that the review process should be an enhanced form from the normal mortality review process. Additionally, it was recognised that the current mortality review template would not adequately capture supplementary information that is necessary to specifically consider the needs of someone with a learning disability, which is often non-medical.

It was noted that Wythenshawe, Trafford, Withington and Altrincham (WTWA) had already developed a learning disability mortality review process utilising a checklist which considered additional issues relating to the care and treatment of someone with a learning disability. It was agreed that this may be helpful in supporting the Oxford Road Campus reviews and as such was used as a 'pilot'. The checklist included the following prompts:

- was a Learning Disability Passport in place
- was contact made with the learning disability liaison nurse for advice
- was there engagement with the community learning disability team
- did a mental capacity assessment take place
- was there a Best Interests decision as necessary
- was DoLs considered and where necessary appropriately administered

Learning disability mortality reviews have been in place at WTWA for some time. The reviews are undertaken by a consultant and a representative from the Adult Safeguarding Team who also have responsibility for completing the notifications of death to the national LeDer programme. The Adult Safeguarding Team produce an annual Learning Disability Mortality Review Report which collates the learning and findings from the cases reviewed, and is disseminated through the relevant WTWA governance systems.

All, but one of the ORC reviews, have been completed and no avoidable deaths have been identified.

The following are the areas of focus going forward based upon the key themes identified from the completed reviews when considering the learning disability aspects of care.

- Mental Capacity Assessments
- Best Interests Meetings
- Absence of Deprivation of Liberty safeguards (DoLs)
- Learning Disability Passport
- End of Life Care

Work is now continuing to continue and embed a consistent approach to the review of deaths of patients with an identified learning disability. A number of national reports have also been published on mortality review and their recommendations addressed as part of this work.[1]

Introducing the Medical Examiner System

It is the intention of NHS England to introduce a Medical Examiner system for reviewing all deaths from April 2019. This approach, using sessional Medical Examiners and Medical Examiners Officers, has been trialled in a number of organisations. All deaths have a rapid review of the last 24 hours of care, and after a conversation with the family, a decision is taken as to whether or not to refer for mortality review.

It is envisaged that the cost will be funded from cremation fees, with the only additional monies being for patients who are not cremated.

A working group, chaired by the Chief of Staff from the Medical Directors Office overseeing implementation. This will include any adjustment to the Mortality Review Strategy and Policy.

Involving Families

The learning from deaths process is now detailed in the Bereavement leaflet given to patients' families. A number of reviews have been requested in year and these have been undertaken and shared with families.

Mortality Indices Summary

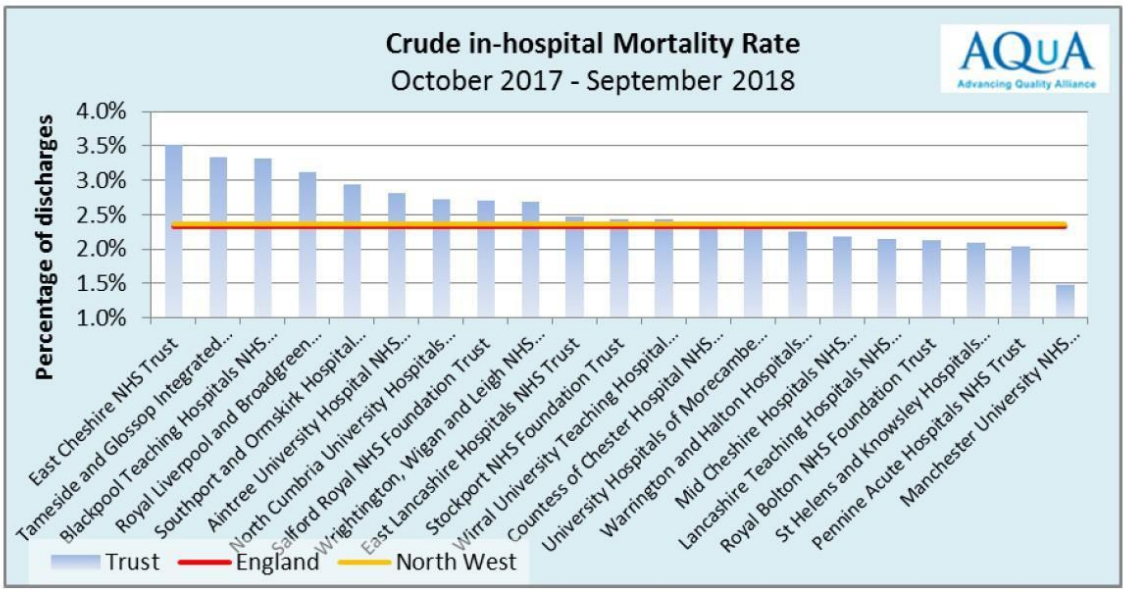
There are a number of mortality indices which are used in determining whether more information is required on death rates in particular specialties. It is important to note that no one indicator will give absolute assurance on mortality and they must be viewed in the context of other indices.

[1] The Learning Disability Mortality Review (LeDeR) Programme, Annual Report 2018, University of Bristol Norah Fry Centre for Disability Studies
Learning from Deaths. A review of the first year of NHS Trusts implementing the national guidance. Care Quality Commission, March 2019

The reported **SHMI** for 2018/19 is **93.02%**. This is just below the 100 and indicates less deaths occurring than expected.

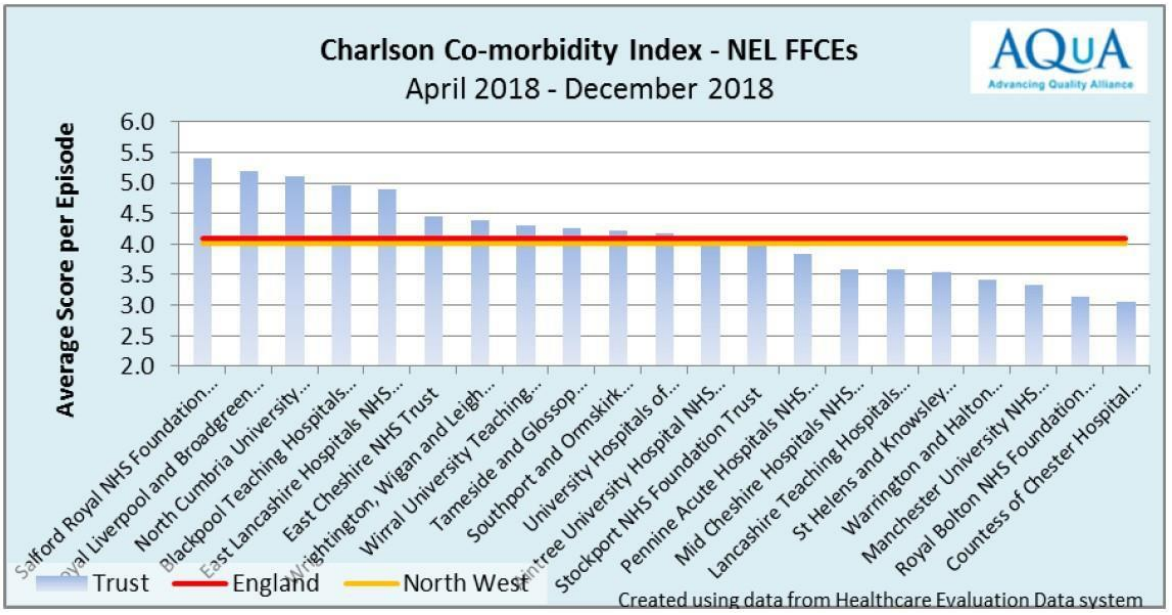
The crude mortality rate (see fig.1) is low in comparison to other North West Trusts, but this must be viewed in the context of having high levels of patient activity in specialties with very low numbers of deaths and direct comparisons between trusts should be treated with caution due to potential differences in case-mix and the age-profile of the patients treated.

Fig 1.



Overall, co-morbidity coding remains low (see fig 2) and this remains an issue for the Trust. Palliative care coding is now above peers, while the use of R codes (symptom coding on discharge) is now lower than peers and national value.

Fig.2



Learning from Deaths Scrutiny Meetings

The Learning from Deaths Scrutiny meetings are chaired by a Non-executive Director and provide a forum where the processes of mortality review in each Hospital/MCS are subject to regular scrutiny. In addition, an informative case is presented, and key themes, challenges and action plans and dissemination are reviewed. Immediate feedback is to the Hospital/MCS Quality and Safety Committee.

Issues that have been identified where action plans have been developed include;

- Failure to recognise deterioration
- Poor communication
- The need for consistent application of pathways

These meetings have proved extremely valuable in understanding the depth and extent of mortality review processes across the Group, and in highlighting differences in the issues identified in the quality of care that can be important across the organisation.

The schedule for these meetings in 2019/20 is being agreed.

Conclusions

Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care. There must now be some pace applied to the implementation of the structured judgement review as the tool for the review of all adult deaths.

The role of the Group Learning From Deaths Group in supporting dissemination of good practice, lessons and action plans is key to the future understanding of mortality indices across. Mortality review processes are generally robust, but need standardisation.

Overall, mortality metrics suggest that the work programs of 2018/2019 to address coding issues continue to deliver improvement, but that co-morbidity coding still requires further work.

Going forward, the focus will be less on process and more on the learning from deaths, and dissemination of the resulting changes and developments in practice across the organisation

Recommendations

The Board of Directors is asked to receive the report and note the actions taken.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Debra Armstrong, Assistant Chief Nurse, Quality and Professional Practice Karen Meadowcroft, Corporate Director of Nursing
Date of paper:	June 2019
Subject:	Annual Complaints Reports 2018/19 for MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities	Patient and Staff Experience
Recommendations	The Board of Directors is asked to note the content of this report, the work undertaken during 2018/19 and, in line with statutory requirements, provide the approval for the report to be published on the Trust website.
Contact:	Name: Debra Armstrong, Assistant Chief Nurse, Quality and Professional Practice Tel: 0161 276 5061

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

1. Executive Summary

1.1 The Trust adheres to the Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under the NHS Complaint Regulations (2009)[1]. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the current and legacy Trusts, received between 1st April 2018 and 31st March 2019.

1.2 Extensive work was undertaken during 2018/19 to develop the complaints systems and processes for the newly formed MFT. This report celebrates some of those achievements and improvements, whilst acknowledging there are further improvements still to be realised in the newly established Trust as Hospitals/ Managed Clinical Services (MCSs) and the Manchester Local Care Organisation (MLCO) develop and refine their processes for complaints handling.

1.3 Throughout the report the term **Complaints** is used to describe formal complaints requiring a response from the Chief Executive and the term **Concerns** is used to describe informal contacts with the Patient Advice and Liaison Service (PALS), which require a faster resolution to issues that may be resolved in real time.

1.4 The report refers to all Hospitals/ MCS and the MLCO across the MFT Group. These are Manchester Royal Infirmary (MRI), Manchester Royal Eye Hospital (MREH), Saint Mary's Hospital (SMH), Royal Manchester Children's Hospital (RMCH), University Dental Hospital of Manchester (UDHM),Clinical Scientific Services (CSS), Manchester Local Care Organisation (MLCO) and Wythenshawe Hospital, Trafford General Hospital, Withington Hospital and Altrincham Hospital (WTWA).

2. Summary of Activity

2.1 Comparative data is provided within the report compared to the previous year's performance. During 2018/19, the quality of complaints data reporting has continued to improve. Where data is provided that is pre-alignment of the Ulysses Customer Services Module, where possible data has been aggregated from the legacy Trust data systems to provide a direct comparison. However, some of the data of the legacy organisations is significantly different and would be normalised if aggregated and therefore the data has been displayed separately to prevent the aggregated figures disguising any areas of concern or high performance for either legacy Trust for 2017/18.

2.2 Due to the nature of complaints' processes and management, the data fluctuates from day to day as complaints progress through the process and this can influence the numbers reported within any one reporting period. Small variances within monthly, quarterly and annual reporting are therefore expected and accepted.

2.3 The total number of PALS concerns received in 2018/19 at MFT was 5,905. This represents an increase of 74 compared with 5,831 received in 2017/18. This demonstrates a 1.27% increase in the number of PALS concerns received during the last year.

2.4 The total number of formal complaints has been static in 2018/19 compared to 2017/18, with a total of 1,573 formal complaints received, compared to 1,572 in 2017/18. This represents a 0.06% increase in the number of formal complaints received during the last year.

[1] The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). Available from: http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

2.5 As a measure of performance against organisational activity, the number of formal complaints should be considered in context of organisational activity. The following table (**Table 1**) shows the number of formal complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2017/18 compared to 2018/19.

Table 1: Complaints received in context of activity

		2017/18	2018/19
Inpatient	Formal Complaints Received (FC)	603	574
	Finished Consultant Episodes (FCE)	423,559	438,411
	Rate of FCs per 1000 FCEs	1.42	1.31
Outpatient	Formal Complaints Received (FC)	691	714
	Number of Appointments	2,417,358	2,482,635
	Rate of FCs per 1000 Appointments	0.29	0.29
A&E	Formal Complaints Received (FC)	117	138
	Number of Attendances	406,512	410,916
	Rate of FCs per 1000 attendances	0.29	0.34

2.6 The average age of formal complaint cases for MFT at the 31st March 2019 was 25.8 working days. This compares to 27 working days as at 31st March 2018 at Oxford Road Campus and Trafford Hospitals (which include Trafford General Hospital and Altrincham Hospital) and 49 working days as at 31st March 2018 at Wythenshawe and Withington Hospitals which demonstrates positive progress on all sites with regard to the timeliness of investigations and responses to complainants.

2.7 The Trust has an internal target of no more than 20% of unresolved cases being over 41 days old at any one time. This allows the Trust to investigate complex complaints which may involve multiple organisations or the time to undertake High Level Investigations (HLI) where appropriate. At the end of March 2019 15.7% of cases were over 41 days. This compares to 31.0% for Oxford Road Campus and Trafford Hospitals and 78% of cases for Wythenshawe and Withington Hospitals at the end of March 2018. This demonstrates positive progress in the reduction of unresolved cases over 41 days old. All cases over 41 working days old continue to be escalated within the relevant Hospitals/ MCSs and MLCO and assurance is provided via the Accountability Outcomes Framework (AOF).

2.8 The average response rate for patients and carers raising a concern through PALS was 4.9 days during 2018/19, compared with 6.8 days for Oxford Road Campus and Trafford Hospitals and 8.5 days for Wythenshawe and Withington Hospitals during 2017/18. At the beginning of Quarter 2, 2018/19 a new process was implemented for the escalation of all PALS cases over 12 days. All cases are now escalated to the PALS Manager on day 12 and this earlier escalation process has been successful in reducing the time to resolve PALS concerns.

2.9 There has been an improvement in performance in relation to the statutory requirement to acknowledge complaints within 3 working days. Throughout 2018/19, 100% was achieved in 9 months of the fiscal year with 3 months achieving 99.4%, 99.3% and 99.2%. For each of the months that did not achieve the performance indicator this relates to 1 case in October, 2018, 1 case in November 2018 and 1 case in January 2019. This compares to 100% for Oxford Road Campus and Trafford Hospitals and 87.5% for Wythenshawe and Withington Hospitals during 2017/18. The alignment of the Complaints process across the new organisations has been successful in achieving improved performance in the acknowledgement of complaints within the 3 day target.

2.10 The Parliamentary and Health Service Ombudsman (PHSO) represents the second and final stage of the NHS complaints process and the Trust has worked with the PHSO to satisfactorily resolve the referrals to the PHSO throughout the year.

2.11 The PHSO closed 34 cases pertaining to the Trust between 1st April 2018 and 31st March 2019; of these; 1 complaint was upheld, 15 were partly upheld and 18 were not upheld. The details of each PHSO case are set out in this report (as detailed in Section 13). This compares to 15 cases closed in 2017/18 when 1 complaint was upheld, 4 cases were partly upheld and 10 cases were not upheld. At 31st March 2019 there were 13 cases under investigation by the PHSO.

2.12 MRI received the highest number of formal complaints with 28.73% (452 out of a total of 1,573). This compares to 435 (27.67%) formal complaints received in 2017/18, which is an increase (negative) of 17 cases.

WTWA received the highest number of PALS concerns with 32.2% (1,901 out of a total of 5,905). This compares to 2,101 (36.03%) PALS Concerns received in 2017/18, which is a reduction of 200 cases.

An integral part of the implementation of the new Trust Ulysses Customer Services Module was the reporting alignment of Formal Complaints and PALS Concerns to Hospitals/ MCS's and the MLCO for services they manage across all Hospitals. The changes in reporting have resulted in a reduction of PALS Concerns assigned to Wythenshawe Hospital, as whilst services continue to be delivered at Wythenshawe Hospital, PALS Concerns received are now aligned to the relevant MCS.

2.13 The oldest case recorded as closed during 2018/19 was received by WTWA. The case was opened on 27th December 2017 and the case was 223 days old when it was closed on 13th November 2018. Delays in receiving the clinician's comments and quality assurance unfortunately resulted in the exceptional delay and resulted in the Trust not being in a position to provide a timely response. The complainant was kept updated throughout the process.

2.14 A significant focus and a considerable amount of work to deliver improvements in 2018/19, has demonstrated an improvement in the timeliness of response to Formal Complaints and PALS Concerns and a reduction in the number of unresolved complaints over 41 day; specifically

- The average response rate of complaints responded to within the agreed timescale with the complainant has improved from 29.4% in April 2018 compared to 72.6% in March 2019.

- The average response rate for patients and carers raising a concern through the PALS at MFT was 4.9 days during 2018/19, compared with 6.8 days for Oxford Road Campus and Trafford Hospitals and 8.5 days for Wythenshawe and Withington Hospitals.

- The number of open complaints that were over 41 working days old. At the beginning of April 2018, there were 164 cases (59% of open cases [278]) Trust-wide that were unresolved over 41 days. This figure decreased to 38 (16.5% of open cases [230]) at the end of March 2019.

3 Complaints Scrutiny Group

3.1 The Complaints Scrutiny Group demonstrates Board level engagement and assurance regarding complaints handling through the Non-Executive Chair. This role is complimented by other core group members, which includes a Trust Governor, an Associate Medical Director, the Assistant Chief Nurse (Quality and Professional Practice), the Head of Nursing (Quality and Patient Experience) and the Trust's Head of Customer Services. The group met six times in total during 2018/19 and reviewed thirteen presented cases involving all Hospitals/ MCSs across MFT. At each meeting one complaint for each participating Hospital/ MCS was reviewed, including an evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion the division attended the meeting.

4 Complaints Improvement Programme

4.1 The Trust is committed to the delivery of continuous improvement in all aspects of the complaints process. The Assistant Chief Nurse (Quality and Professional Practice) and Head of Nursing (Quality and Patient Experience) continue to work with the Head of Customer Services, the PALS and Complaints Team and Hospital/ MCS and MLCO Teams to continue to identify and deliver improvements to the management of PALS and Complaints within the Trust.

4.2 Significant improvements delivered in 2018/19 include:

- **Single Hospital Service**
  Work continued during 2018/19 to align the complaints processes of the legacy trusts to ensure MFT maintained compliance with the NHS Complaints Regulations (2009) to ensure that complainant receive a timely and high quality response to the concerns they have raised. Aspects of the complaints management process were devolved from Corporate Services to the Hospitals/ MCSs and MLCO.

- **MFT Complaints, Concerns and Compliments Policy (2018)**
  The MFT Complaints, Concerns and Compliments Policy (2018) was developed and ratified by the Group Quality and Safety Committee, with the aim of providing a framework for MFT to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) and provides staff with support and assistance in dealing with complaints, concerns and compliments; specifically ensuring the concern or complaint are acknowledged in a timely manner, things are put right as quickly as possible, lessons are learnt and by identifying and implementing service improvements a recurrence is prevented.

- **New MFT Ulysses Customer Services Module**
  Following the introduction of the new single Ulysses Customer Services Module in Quarter 1, 2018/19 and the work undertaken to tailor and configure the module to meet the specific needs of the Hospitals/ MCSs and MLCO full alignment of the module was completed in Quarter 4, 2018/19. The alignment has enabled reporting at Hospital/ MCS level which supports the Hospital/ MCS teams to monitor and review performance and identify areas for improvement.

- **MFT Trust Values**: **Everyone Matters, Working Together, Dignity & Care, Open and Honest**
  Introduction in Quarter 3, 2018/19 of the theming of formal complaints aligned to the MFT Trust Values. It is anticipated that this will provide an opportunity to further understand the adoption and impact of Trust values at group, Hospital/ MCS and MLCO level.

- **Complaint Quality Audit and Analysis Tool**
  During Quarter 3, 2018/19 a Complaint Quality Audit and Analysis Tool was developed and piloted at WTWA 23 Complaint responses were reviewed and themes for improvement identified. The pilot identified themes for improvement set against a measurable quality framework for complaint responses to meet in order to comply with the Trust's expected quality standards for formal complaint response letter writing. Both the audit and analysis tools are now available for use for all Hospital/ MCS and MLCO teams.

5 Learning

5.1 This report details examples of learning and change as a direct result of feedback received through complaints and concerns. Examples of learning from complaints have been published in each Quarter during 2018/19 as part of the Board of Directors Quarterly Complaints Report.

6 People

6.1 The Trust is grateful to those patients and families who have taken the time to raise concerns and acknowledges their contribution to improving services, patient experience and patient safety.

7 Recommendation

7.1 The Board of Directors is asked to note the content of this report and in line with statutory requirements provide approval for it to be published on the Trust's website.

Picture 1: ‘Rockin’ Rehab’; Patient Choice Proud to Care on Camera winner

Contents

1. Statement

1.1 The Trust adheres to the Statutory Instruments No. 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public under the NHS Complaints Regulations (2009)[1]. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the Trust, received between 1st April 2018 and 31st March 2019.

2. Introduction

2.1 This report sets out the achievements and improvements of the Trust, whilst acknowledging there are further improvements to be achieved with the philosophy of continuous improvement.

2.2 Throughout this report the term ***Complaints*** is used to describe formal complaints requiring a response from the Chief Executive and the term ***Concerns*** is used to describe informal contact with PALS requiring a faster resolution to issues that may be resolved in real time.

2.3 The report refers to all Hospitals/ Managed Clinical Services (MCS) and the Manchester Local Care Organisation (MLCO) across the MFT Group. These are Manchester Royal Infirmary (MRI), Manchester Royal Eye Hospital (MREH), Saint Mary's Hospital (SMH), Royal Manchester Children's Hospital (RMCH), University Dental Hospital of Manchester (UDHM), Clinical Scientific Services (CSS), Manchester Local Care Organisation (MLCO) and Wythenshawe Hospital, Trafford General Hospital, Withington Hospital and Altrincham Hospital (WTWA).

2.4 Comparative data is provided within the report compared to 2017/18. During 2018/19, the quality of complaints data reporting has continued to improve with continued integration of reporting alignment enabling more detailed analysis at Hospital/ MCS and MLCO level from Quarter 3, 2018/19.

2.5 Where data is provided that is pre-alignment of the Ulysses Customer Services Module, where possible, data has been aggregated from the legacy Trust data systems to provide a direct comparison. However, some of the data of the legacy organisations is significantly different and would be normalised if aggregated and therefore the data has been displayed separately, to prevent the aggregated figures disguising any areas of concern or high performance for 2017/18.

2.6 Due to the nature of complaints' processes and management, the data fluctuates from day to day as complaints progress through the process and this can influence the accuracy of the numbers reported within any one reporting period. For example, once a complaint has been received and registered a complaint may be withdrawn, de-escalated, identified as being out of time, or consent not received. Small variances within monthly, quarterly and annual reporting are therefore expected and accepted.

2.7 Please note that the alignment means that some services will see an increase or decrease in complaints/PALS depending on which services are aligned but this does not affect the overall total.

3. Overview of Activity

3.1 The number of PALS contacts received for 2018/19 was 5,905, which is 74 more than the number received in 2017/18 (5,831). This demonstrates a 1.27% increase in the number of PALS concerns received during the last year. **Graph 1** provides the number of PALS contacts received by month for the financial year 2018/19.

Graph 1: Number of PALS contacts (by month) for 2018/19, MFT

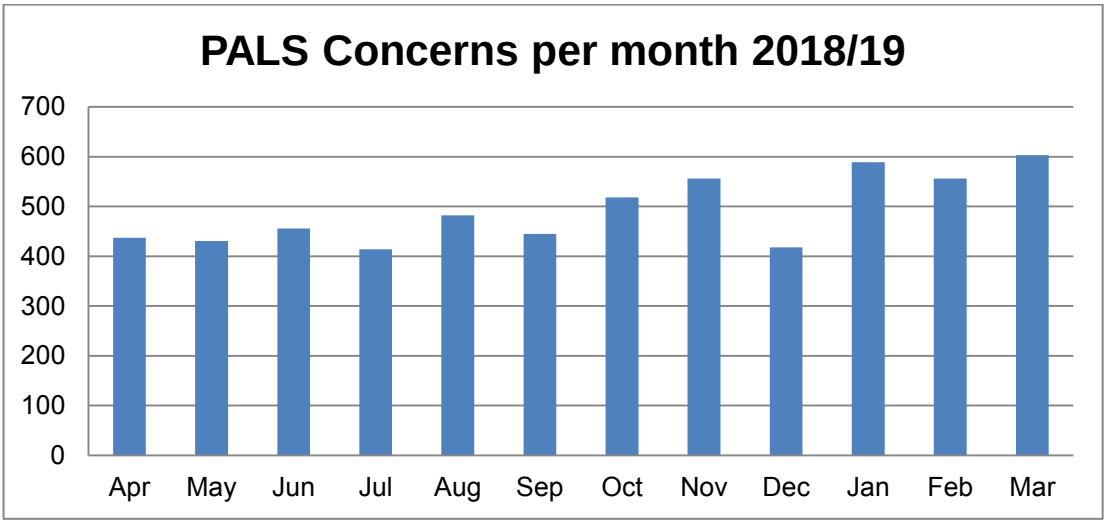


Table 2: Number of PALS contacts by Hospital/ MCS and MLCO

Hospital / MCS / MLCO	2017/18	2018/19
Clinical Scientific Services (CSS)	183	277
Corporate Services	208	214
Manchester Local Care Organisation (MLCO)	N/A	25
Manchester Royal Infirmary (MRI)	1,692	1,671
Research & Innovation (R&I)	1	18
Royal Manchester Children's Hospital (RMCH)	563	561
Saint Mary's Hospital (SMH)	357	467
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	610	528
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	2,101	1,901
Not Stated / General Enquiry / Non-MFT	116	243
MFT Total	**5,831**	**5,905**

3.2 WTWA received the highest number PALS concerns with 32.2% (1,901 out of a total of 5,905). This compares to 2,101 (36.03%) PALS concerns received in 2017/18, which is a reduction of 200 cases. Research & Innovation demonstrated the largest percentage increase receiving 1 concern in 2017/18 and 18 cases in 2018/19. Worthy of note is that where services are dealing with a small number of complaints this may appear to have a larger impact when these figures are presented as percentages. A thematic analysis of the 18 concerns identified 38.9% were in respect of appointment delay/ cancellation and 27.8% in regard communication. CSS demonstrated the second largest percentage increase with a 51.36% increase (183 concerns in 2017/18 compared to 277 concerns in 2018/19). The changes in reporting have resulted in an increase in the number of PALS concerns recorded by CSS, SMH and Corporate Services as they are now aligned by MCS/ MLCO.

3.3 All PALS concerns are RAG rated upon receipt based on the severity of the initial details of the concerns raised.

3.4 **Table 3** indicates the number of MFT contacts by risk rating grade.

Table 3: 2018/19 PALS contacts by risk grading, MFT

Category	2017/18	2018/19
Green	4,490	4,808
Yellow	830	819
Amber / Orange	140	30
Red	0	0
Not graded, escalated or enquiry	371	248
MFT Total	**5,831**	**5,905**

3.5 The 2018/19 total of PALS concerns include those cases that were escalated for formal investigation (these are reported in the formal complaints section, Section 4 of this report), were withdrawn by the complainant or were considered to be out of time according to the NHS Complaints Regulation (2009)[1] timescales.

3.6 Tables 4 to 7 are presented in Appendix 1. These tables indicate how people access the PALS service and provide information about their demographics. Table 4 shows that the number of concerns raised by email has increased from 1,610 in 2017/18 to 2,089 in 2018/19. This represents an increase of 29.75%. The number of concerns raised by telephone continues to be the most favoured route of contact.

3.7 Table 5 in Appendix 1 details the number of contacts by age; the age range relates to the people who were the focus of the PALS concern as opposed to the complainant. Table 6 in Appendix 1 details the number of contacts by gender; again the gender relates to the people who were the focus of the PALS concern. Table 7 in Appendix 1 describes the ethnicity of the patients who were the focus of the PALS enquiry.

3.8 The demographic data for PALS concerns presented within Appendix 1 supports the findings[2] that younger people (or their parents) are more likely to be dissatisfied with services than older people and women more likely to be dissatisfied with services than other sexes.

3.9 The percentage of people who did not state their ethnicity for PALS Concerns has increased from 54.5% in 2017/18 to 62.2% in 2018/19. This information supports the service to meet the specific needs of the population it serves and work will continue in 2019/20 to improve the quality of this data; specifically in 2019/ 20 the reasons why complainants opt out of providing this information will be explored in collaboration with the Equality, Diversity and Inclusion (EDI) Team.

3.10 **Graph 2** and **Table 8** provide a more detailed analysis of the principle PALS themes, indicating the main themes for PALS concerns relate to treatment and procedure, communication and appointment delays and cancellations.

[2] DeCourcy, West and Barron (2012) The National Adult Inpatient Survey conducted in the English National Health Service from 2002 to 2009: how have the data been used and what do we know as a result? BMC Health Services Research series: Open, Inclusive and Trusted 2012 12:71

Graph 2: Top 5 PALS Themes 2018/19, MFT

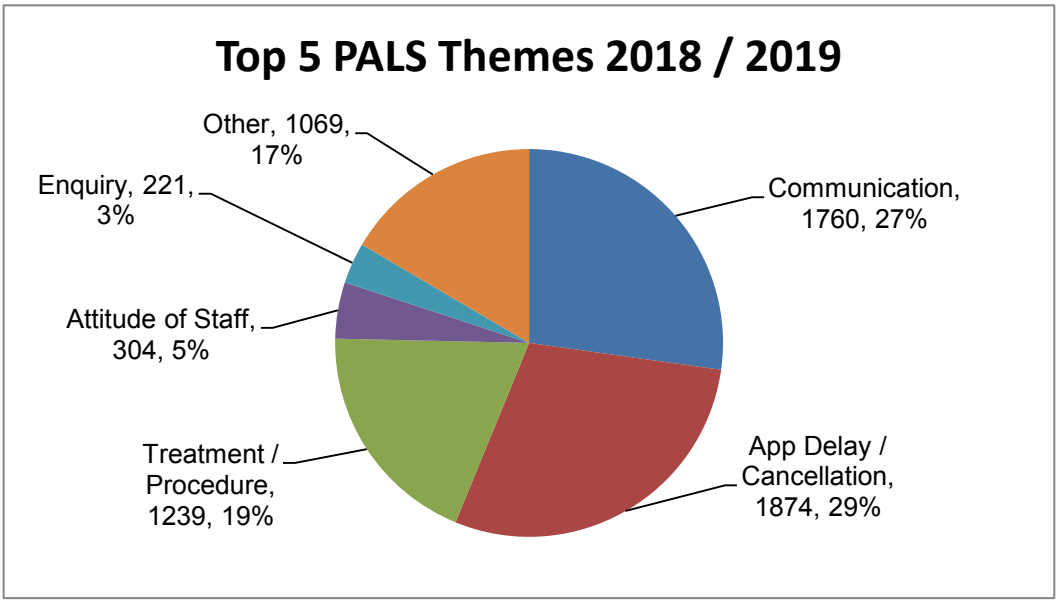


Table 8: Comparison of Top 5 PALS Themes**,** MFT

	2017/18	2018/19
1.	Communication	Appointment Delay / Cancellation
2.	Appointment Delay / Cancellation	Communication
3.	Treatment / Procedure	Treatment / Procedure
4.	Clinical Assessment (Diagnostics, Scan)	Attitude of Staff
5.	Infrastructure (Staffing / Environment)	Enquiry

3.11 The average response rate for patients and carers raising a concern through the PALS at MFT was 4.9 days during 2018/19, compared with 6.8 days for Oxford Road Campus and Trafford Hospitals and 8.5 days for Wythenshawe and Withington Hospitals. At the beginning of Quarter 2, 2018/19 a new process was implemented for the escalation of all PALS cases over 12 days. All cases are now escalated to the PALS Manager on day 12 and this earlier escalation process has been successful in reducing the time to resolve PALS concerns.

4. Complaints Activity

4.1 The number of complaints has been static in 2018/19 compared to 2017/18, with a total of 1,573 complaints received, compared to 1,572 in 2017/18. This represents a 0.06% increase in the number of complaints received during the last year.

Table 9: Number of Complaints, MFT

Year	2017/18	2018/19
Complaints Received	1,572	1,573

4.2 **Table 10** details the 2 year trend for complaints at Hospital/ MCS and MLCO level. MRI received the most complaints during 2018/19 with 452 complaints received; this represents an increase of 3.9% complaints received compared to 435 received in 2017/18. WTWA achieved a reduction in the number of formal complaints received during 2018/19 with 442 complaints received; this represents a reduction of 33.93% complaints compared to 669 received in 2017/18.

4.3 An integral part of the implementation of the new Trust Ulysses Customer Services Module was the reporting alignment of complaints to Hospitals/ MCS's and the MLCO for services they manage across all Hospitals. The changes in reporting have resulted in an increase in the number of complaints recorded by Clinical Scientific Services, Royal Manchester Children's Hospital, St Mary's Hospital and Corporate Services as complaints from all hospital sites are now aligned to these MCSs. This has conversely resulted in a reduction of complaints assigned to Wythenshawe Hospital, as whilst services continue to be delivered at Wythenshawe Hospital, complaints received are now aligned to the relevant MCS.

Table 10: Number of complaints by Hospital/ MCS and MLCO

Hospital / MCS / MLCO	2017/18	2018/19
Clinical Scientific Services (CSS)	34	82
Corporate Services	50	91
Manchester Local Care Organisation (MLCO)	n/a	27
Manchester Royal Infirmary (MRI)	435	452
Research & Innovation (R&I)	0	2
Royal Manchester Children's Hospital (RMCH)	143	167
Saint Mary's Hospital (SMH)	124	190
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	115	115
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	669	442
Not Stated / General Enquiry / Non-MFT	2	5
MFT Total	**1,572**	**1,573**

4.4 Complaints are risk rated using a matrix closely aligned to that used by the Risk Management Team when assessing the severity of incidents. When compared to 2017/18, the numbers of yellow cases and amber cases have increased by 7.7% and 1.3% respectively, whilst the numbers of green cases and red cases have decreased by 44.4% and 46.2% respectively. Of the 14 complaints rated as red in 2018/19, 7 relate to Treatment or Procedure, 4 related to Clinical Assessment, 2 related to Personal Accident/Incident and 1 related to Maternity/Neonatal Care.

4.5 Table 11, presented in Appendix 2, provides the breakdown of the risk rating of complaints for 2018/19 compared to 2017/18.

4.6 Equality monitoring data is collected in relationship to complainants' protected characteristics. In addition, complainants are requested to provide information regarding their protected characteristics when they receive a written acknowledgement in response to a complaint; this information is presented within Tables 12 to 14 in Appendix 2. The age and gender of the patients involved in complaints during 2017/18 and 2018/19 are highlighted in Tables 12 and 13 in Appendix 2. Table 14 describes the ethnicity of the patients represented in complaints for the past 2 fiscal years.

4.7 The demographic data for complaints presented within Appendix 2, also supports the findings[2] that younger people (or their parents) are more likely to be dissatisfied with services than older people and women are more likely to be dissatisfied with services than other sexes.

4.8 For complaints the percentage of people who did not declare their ethnicity has increased from 45.4% in 2017/18 to 64.0% in 2018/19. This information supports the service to meet the specific needs of the population it serves therefore work will continue in 2019/20 to improve the quality of this data and exploration as to the reasons why people opt out of stating their ethnicity; specifically in 2019/20 the reasons why complainants opt out of providing this information will be explored in collaboration with the Equality, Diversity and Inclusion (EDI) Team.

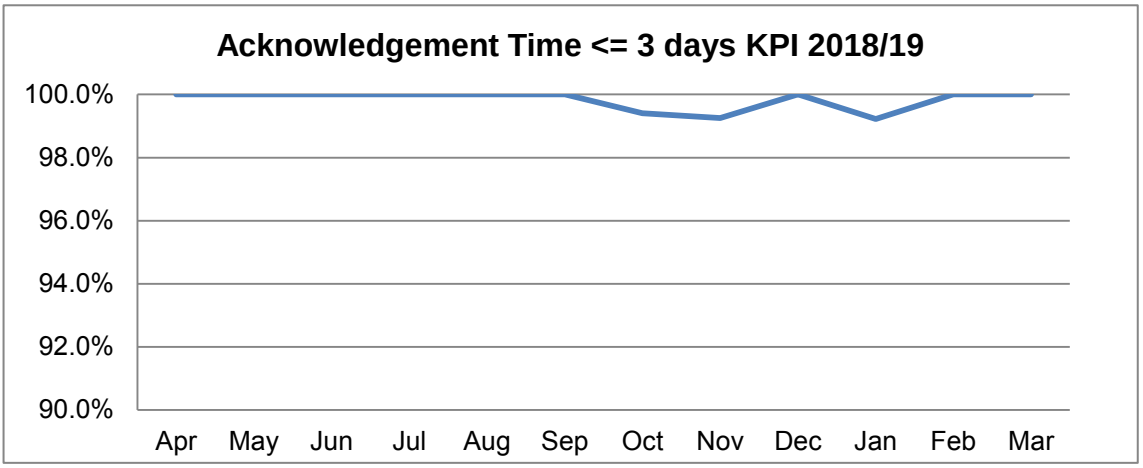
Picture 2: 'Meeting Gorgeous Dr Ben'; Proud to Care Runner Up.

5. Acknowledging Complaints

5.1 The NHS Complaints regulations (2009)[1] place a statutory duty upon the Trust to acknowledge 100% of complaints within 3 working days.

5.2 There has been an improvement in performance in relation to the acknowledgement of complaints within 3 working days in 2018/19. Complaints requiring acknowledgement also include those which are withdrawn, where consent or required information is not received, are de-escalated or are deemed 'out of time' under the 2009 NHS Complaints Regulations.[1] Throughout 2018/19, 100% performance was achieved in 9 months of the fiscal year with 3 months achieving 99.2%, 99.3% and 99.4%. For each of the months that did not achieve the performance indicator this relates to 1 case in October, 2018, 1 case in November 2018 and 1 case in January 2019. This compares to an overall 95.8% performance during 2017/18.

Graph 3: Percentage of complaints acknowledged ≤ 3 working days during 2018/19, MFT



6. Response Times

6.1 The Trust target of resolving 80% of complaints within 25 working days continues to be monitored closely. Based on the complexity of complaints and the Trust's Complaints Triage Process, in agreement with the complainant, all 'High and Medium' category complaints are given a 40 or 60 working day timeframes. **Table 15** and **Graph 4** provide a breakdown of performance in 2018/19.

6.2 The MFT performance in response times (**Table 15**) has been variable throughout the year with 25.1% of complaints responded to in 0-25 working days, 26.2% of complaints being resolved in 26-40 days and 48.6% of complaints responded to in 41+ days.

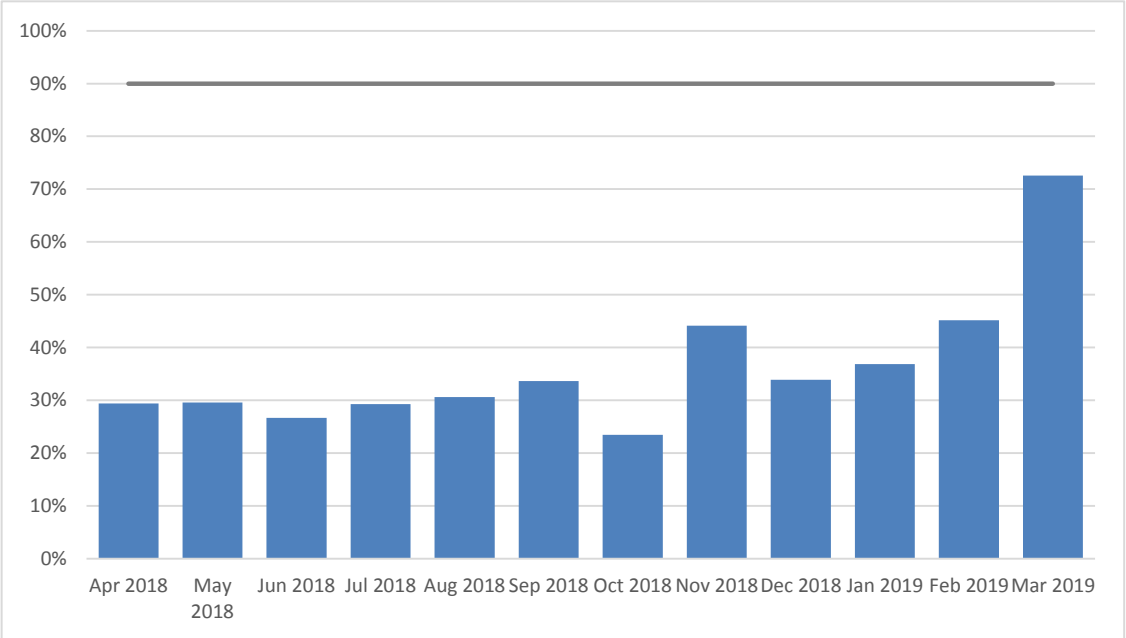
6.3 A significant focus and a considerable amount of work to deliver improvements, which is a key metric on the Hospitals / MCSs and MLCO Assurance Operating Framework (AOF) has demonstrated an improvement from 29.4% of complaints responded to within the agreed timescale (**Graph 4**) with the complainant in April 2018 compared to 72.6% in March 2019. The focus and work on improvements has resulted in an improving trend therefore the current strategy for improvement will continue into 2019/20.

Table 15: Monthly breakdown of complaints closed within timeframes 2018/19, MFT

Number and percentage of Complaints Closed within Timeframes 2018/19												
Days to Close	Apr	%	May	%	Jun	%	Jul	%	Aug	%	Sep	%
0-25	27	25.0%	32	17.9%	40	19.4%	32	25.8%	45	24.7%	28	23.1%
26-40	30	27.8%	40	22.3%	47	22.8%	30	24.2%	47	25.8%	34	28.1%
41+	51	47.2%	107	59.8%	119	57.8%	62	50.0%	90	49.5%	59	48.8%
Total	**108**		**179**		**206**		**124**		**182**		**121**	
Days to Close	Oct	%	Nov	%	Dec	%	Jan	%	Feb	%	Mar	%
0-25	30	18.6%	50	32.1%	30	25.2%	21	21.6%	40	29.4%	53	46.9%
26-40	42	26.1%	45	28.8%	41	34.5%	24	24.7%	33	24.3%	33	29.2%
41+	89	55.3%	61	39.1%	48	40.3%	52	53.6%	63	46.3%	27	23.9%
Total	**161**		**156**		**119**		**97**		**136**		**113**	

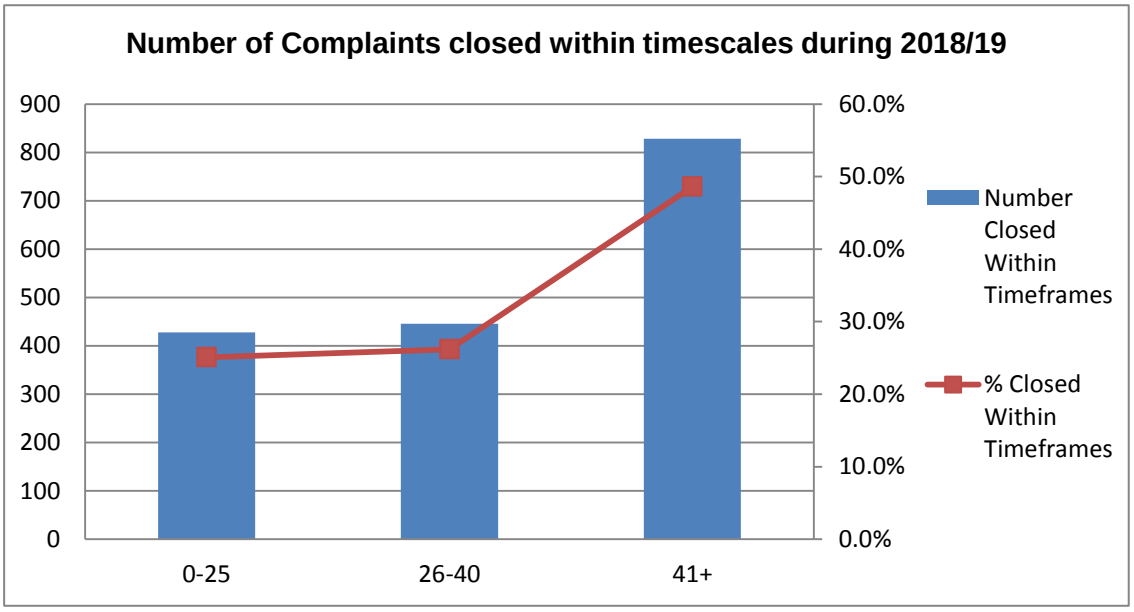
Days to Close	**Number**	**%**
0-25	428	25.1%
26-40	446	26.2%
41+	828	48.6%
Total	**1702**	

Graph 4: Monthly breakdown of complaints closed within agreed timescales 2018/19, MFT

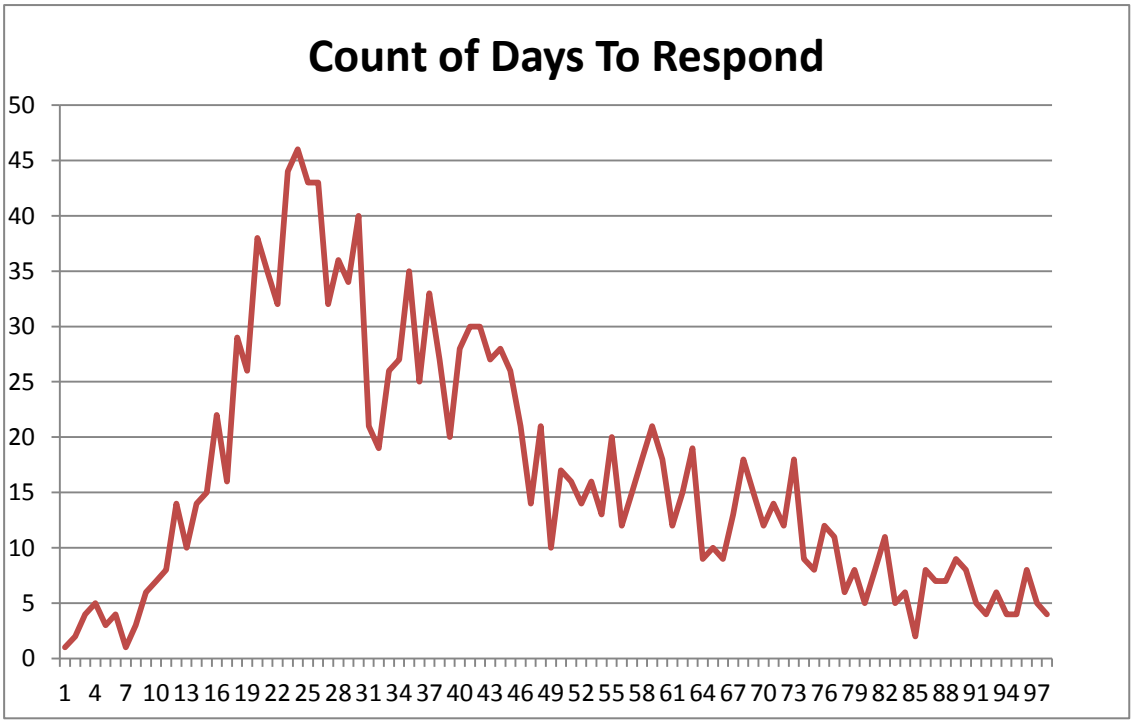


6.4 **Graph 5** shows the overall performance in relation to response times for complaints closed during 2018/19, for MFT. **Graph 6** then presents a granular level breakdown of the data shown in Graph 5.

Graph 5: Complaints closed within timeframes during 2018/19, MFT



Graph 6: Breakdown of closed complaints 2018/19 (95 extremely long cases (100+ days) not included as these are small in number)



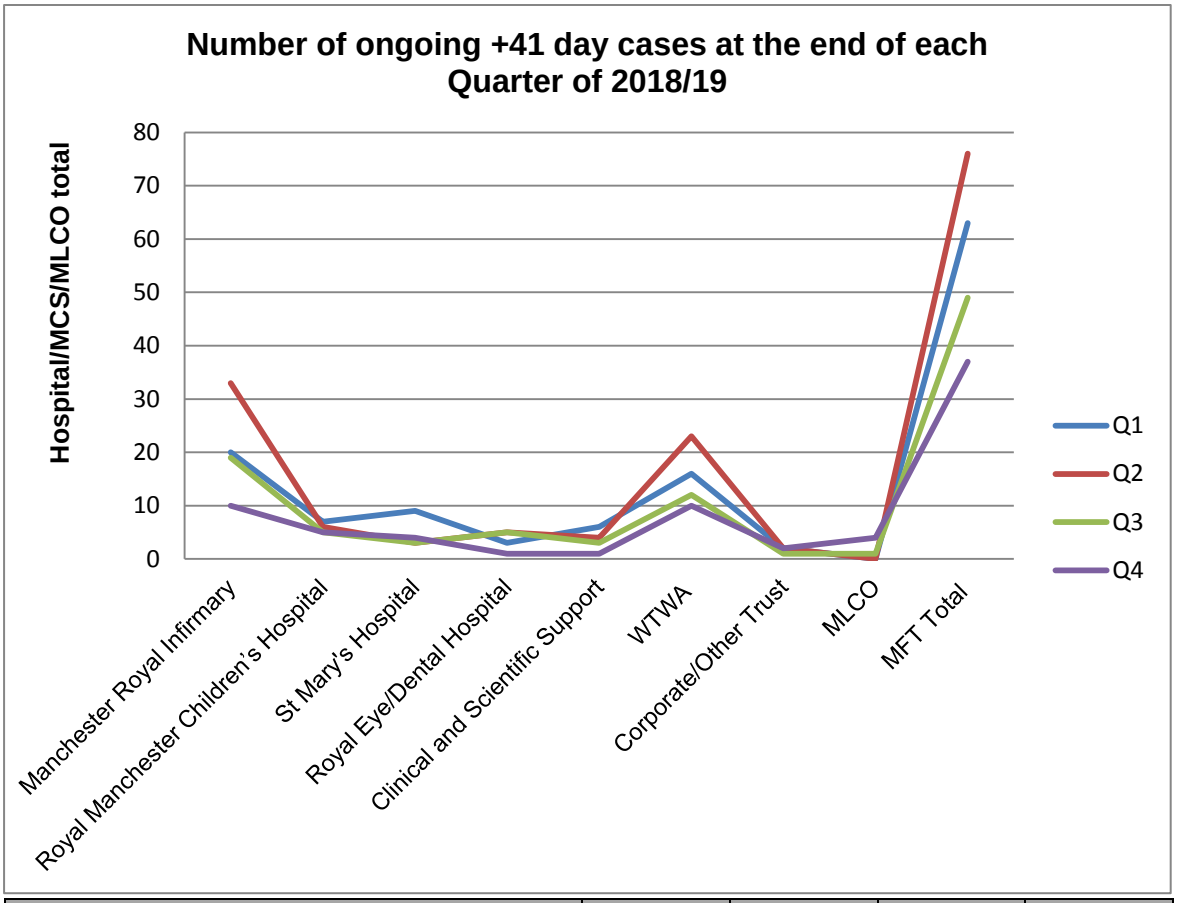
6.5 Ongoing Complaints

There has been a continued focus during 2018/19 on managing the number of open complaints that were over 41 working days old. At the beginning of April 2018, there were 164 cases (59% of open cases [278]) Trust-wide that were unresolved over 41 days. This figure decreased to 38 (16.5% of open cases [230]) at the end of March 2019.

As previously reported in the 2017/18 Annual Complaints Report, 101 of the cases at the end of March 2018 related to a backlog of complaints identified at Wythenshawe and Withington Hospitals. Once the issue was identified, immediate action was taken and an Improvement Programme developed and implemented by the Senior Leadership Team at WTWA. Significant progress was made at WTWA during Quarter 1, 2018/19 with the

closure of cases, with only 5 of the 101 cases remaining open at the end of the quarter.

Graph 7 shows the number of open complaints, by Hospital/ MCS and MLCO unresolved after 41 days at the end of each quarter of 2018/19 and demonstrates the continuous improvement in 2018/19 of the number of open complaints by Hospital/ MCS and the MCLO in unresolved complaints after 41 days.



	Q1	Q2	Q3	Q4
Manchester Royal Infirmary	20	33	19	10
Royal Manchester Children's Hospital	7	6	5	5
St Mary's Hospital	9	3	3	4
Royal Eye/Dental Hospital	3	5	5	1
Clinical and Scientific Support	6	4	3	1
WTWA	16	23	12	10
Corporate/Other Trust	2	2	1	2
MLCO	N/A	N/A	1	4
MFT Total	**63**	**76**	**49**	**37**

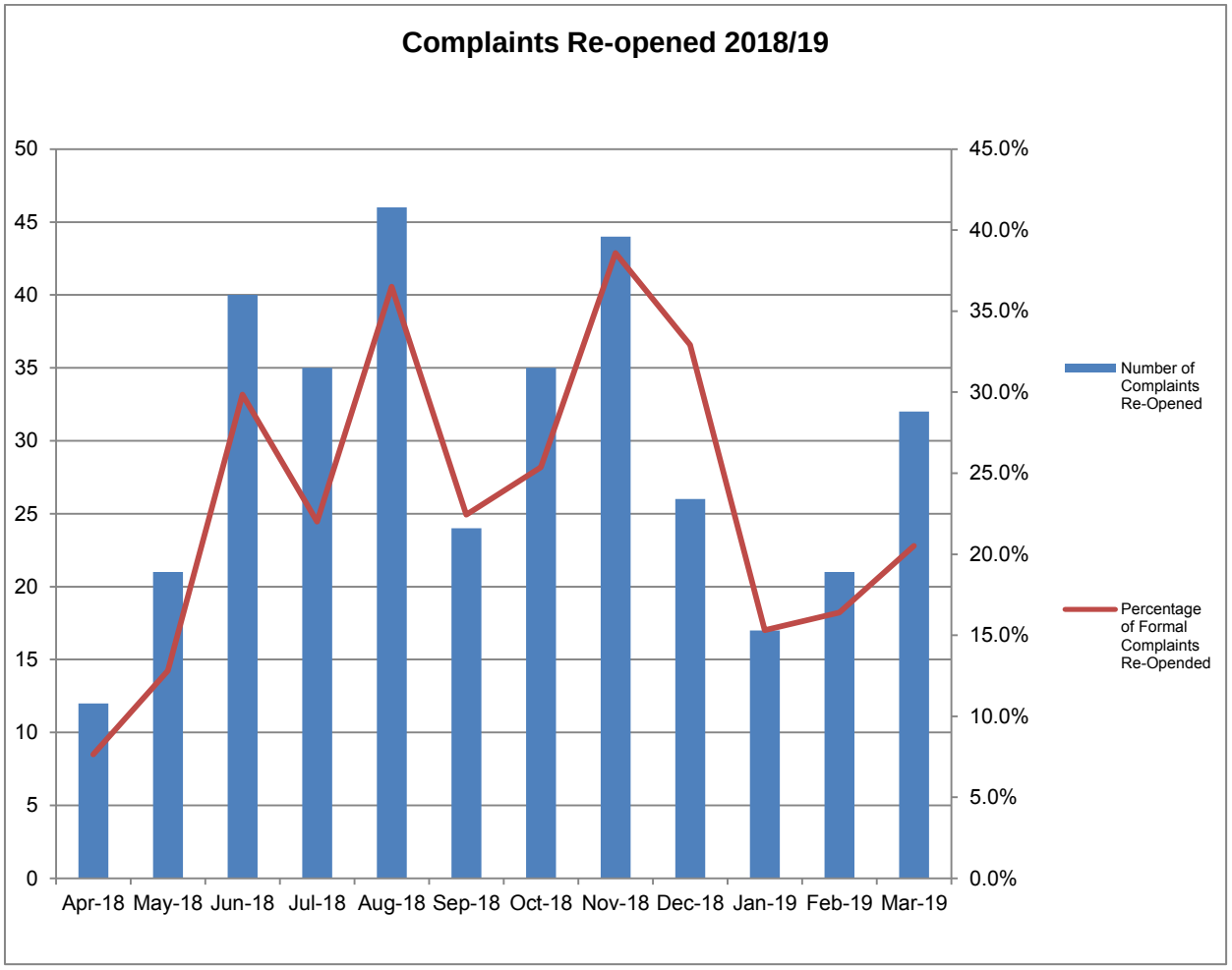
6.6 The accountability for the management and monitoring of complaints was fully devolved to the Hospital/ MCS and MLCO Chief Executives during Quarter 4, 2017/18. All cases over 41 working days are now monitored at Group level via the Accountability Oversight Framework (AOF), which informs the decision-making rights of Hospital/ MCSs and MLCO Chief Executives and their teams.

6.7 The oldest case closed during 2018/19 was received by WTWA. The case was opened in December 2017 and the case was 223 days old when it was closed in November 2018. Delays in receiving the clinician's comments and quality assurance unfortunately resulted in the exceptional delay and resulted in the Trust not being in a position to provide a timely response. The complainant was kept updated throughout the process.

6.8 Following the implementation in 2017/18 of the new system for triaging complaints based upon their complexity, all complaints continued to be triaged in line with this process during 2018/19.

6.9 Further contact from complainants after the receipt of the Trust written response to their complaint is recorded as being re-opened and provides an indication of the quality of the response. Throughout 2018/19 there was a wide variation in the number of re-opened complaints received across the Trust with a total of re-opened cases during 2018/19 equating to 353 (22.4%). This compares to 311 (20%) re-opened in 2017/18.

6.10 **Graph 8** details the number of re-opened complaints by month during 2018/19/ MFT.

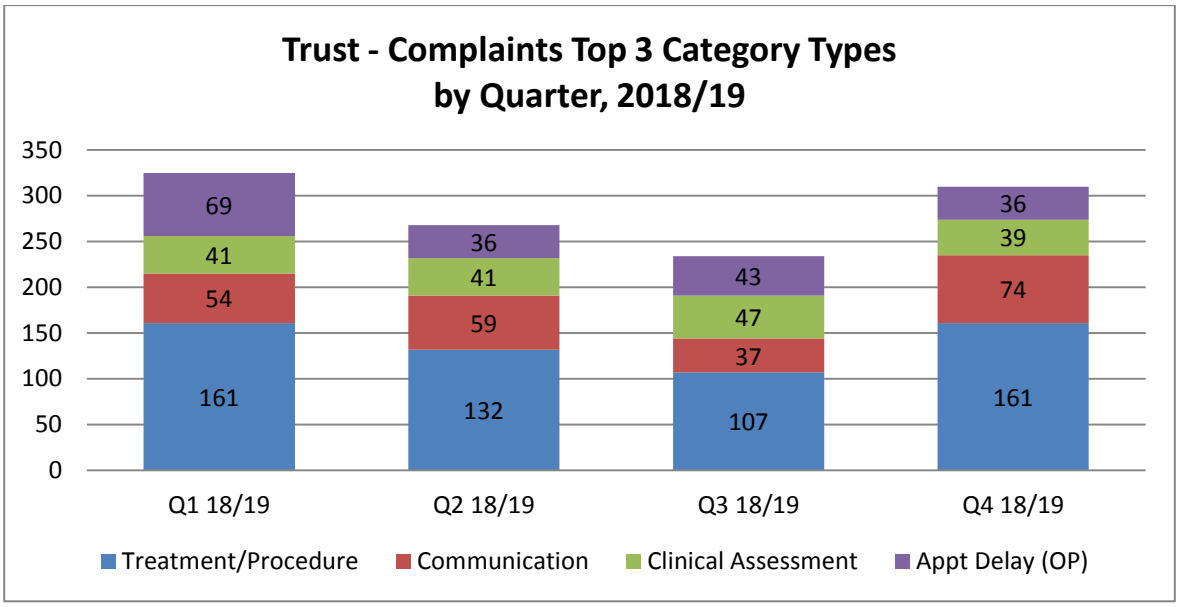


7. Themes

7.1 The themes and trends from complaints are reviewed at a number of levels across MFT. Each Hospital/ MCS and the MLCO consider local complaints on a regular basis as part of their weekly complaints review meetings and monthly Quality and Clinical Effectiveness Forums. Further analysis of complaint themes and trends are provided in quarterly complaints reports to the Board of Directors.

7.2 **Graph 9** demonstrates the 3 most prevalent categories of concerns raised in complaints in 2018/19.

Graph 9: Top 3 Complaint Themes, MFT

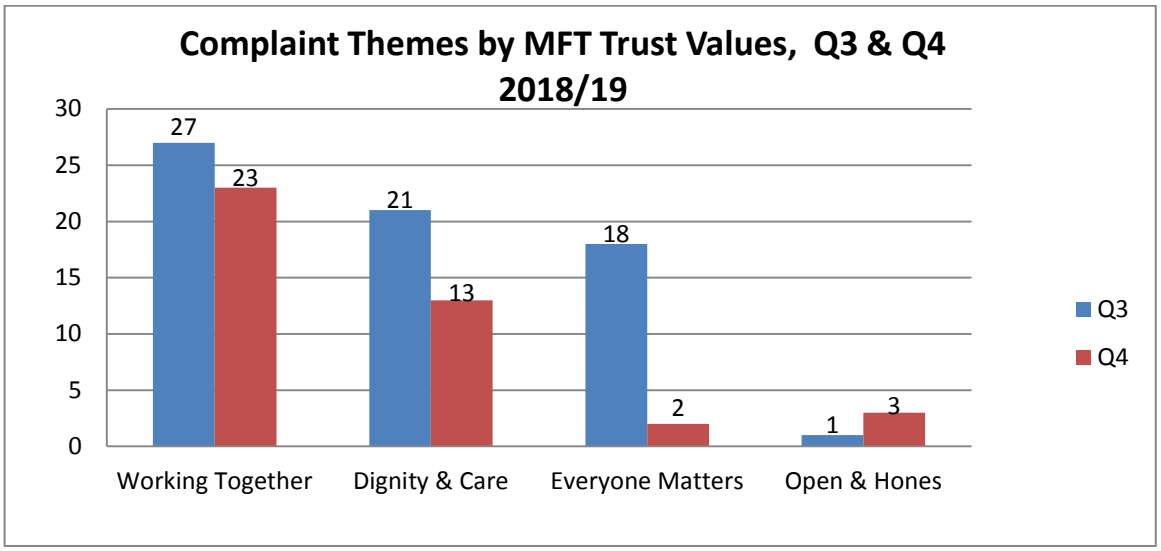


7.3 Theming of formal complaints to the new MFT Trust Values: **Everyone Matters, Working Together, Dignity & Care, Open and Honest** commenced during Quarter 3, 2018/19.

The Trust-wide themes from the concerns identified in complaints compared to the MFT Trust Values for Quarter 3 and Quarter 4, 2018/19 are shown in Graph 10. As more data becomes available the accuracy of the data will improve; this will provide an opportunity to further understand the adoption and impact of Trust values at both a group and Hospital/ MCS and MLCO level, with the expectation that the number of concerns raised aligned to the Trust values will reduce as a result of the values being embedded in the organisation.

7.4 Whilst complaints are themed to the MFT Trust Values the complaints performance using the established comparable metrics will continued to be utilised.

Graph 10: Complaints – Theming of complaints to MFT Trust Values for Quarter 3 and Quarter 4, 2018/19



7.5 Similarly, the mapping and tracking of complaints to specific topic areas has also continued during 2018/19. Complaints relating to dementia, pain relief, end of life care and nutrition and hydration are captured and are used for monitoring and for targeting improvement activity.

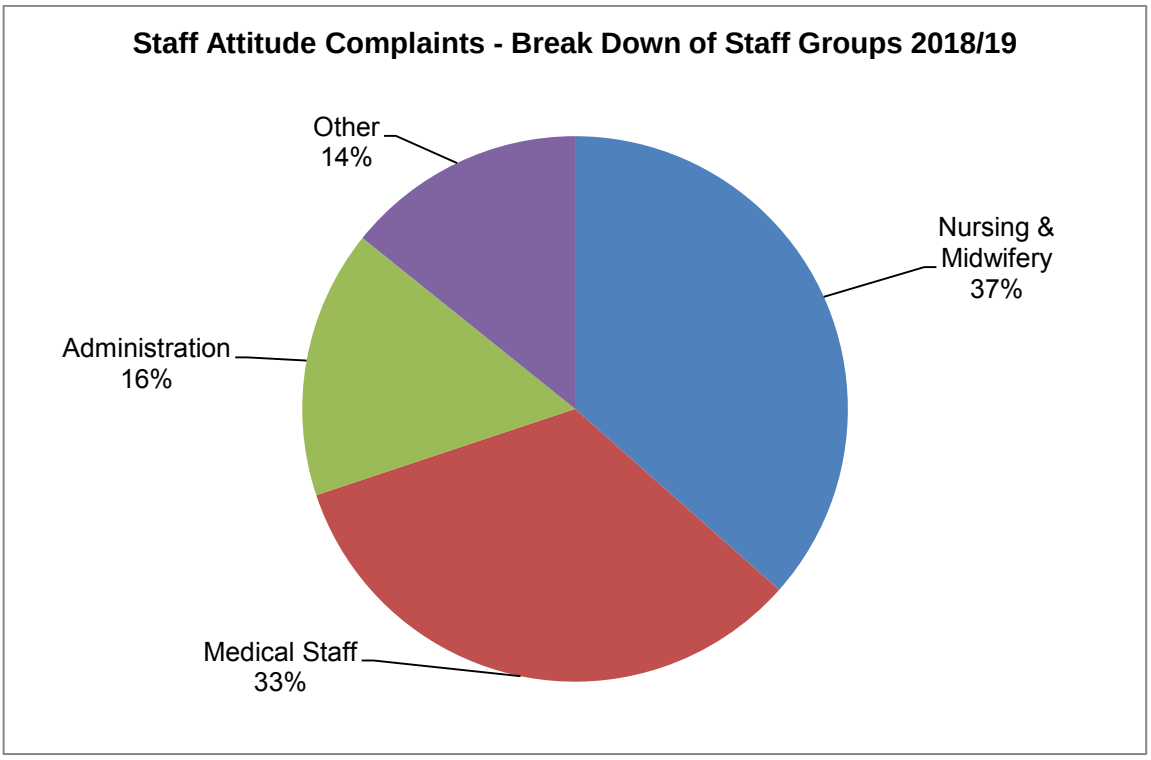
8. Our People

8.1 **Table 16** provides the number of complaints and PALS concerns that refer to 'staff attitude' and **Graph 11** breaks these down into the staff groups involved.

Table 16: Number of complaints and concerns that refer to staff attitude

Attitude of Staff	2017/18	2018/19
PALS Concerns	210	304
Complaints	296	350
Total	506	654

Graph 11: Percentage of complaints and PALS concerns relating to staff attitude by staff group, MFT



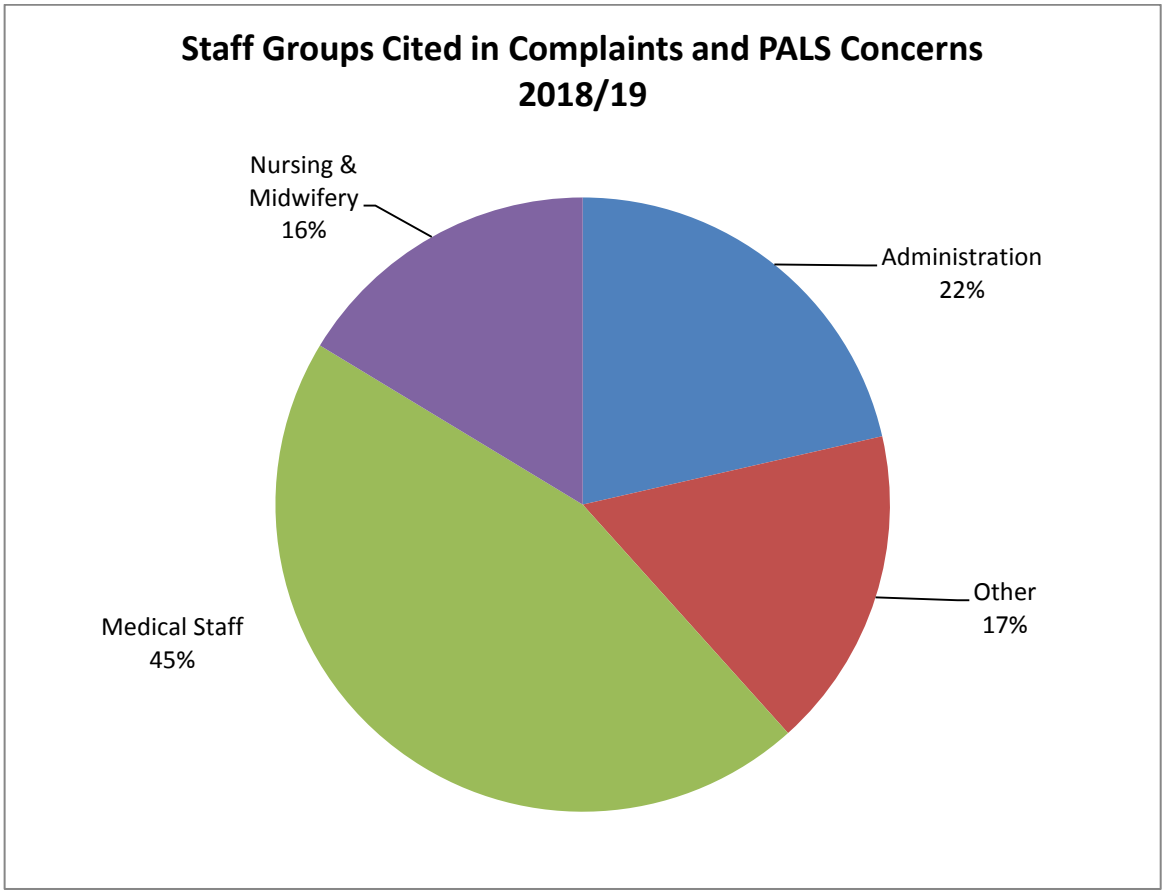
8.2 During 2018/19, the number of complaints and PALS Concerns received (7,478) which cited staff attitude increased to 654 (8.74% out of total 7,478) compared to 506 during 2017/18. This represents an increase of 29.25%. The attitude of nursing and midwifery staffing group were cited in more complaints (37%) than any other staffing group. Of note nursing and midwifery is the largest occupational group within the Trust.

8.3 The importance of Positive Communication is one of the 6 Key Themes identified as part of the ***What Matters to Me*** Patient Experience Programme. Often, the first interaction a patient has with the Trust's services is with a receptionist or another member of Administrative and Clerical (A&C) staff. In recognition of this key interface an integral element of the What Matters to Me work programme, in collaboration with the Organisational Development and Training Team and members of the Trust A&C Teams, was the co-design of the 'First Impressions Training Programme' for A&C Staff. The 'face-to-face' aspect of the programme was piloted in June 2018 and the finalised version rolled-out in September 2018 with approximately 220 A&C staff attending the course in 2018/19 at the regular sessions delivered across the hospital sites. The 'First Impressions' course has a unique visual identity (**Picture 3**).

Picture 3: First Impressions Course Visual Identity

8.4 **Graph 12** highlights the top 3 professions referenced in complaints or PALS concerns. Medical Staff are the highest group referenced with a total of 5,131 complaints, followed by A&C staff that are referenced in 2,426 complaints. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff/ certain A&C staff, it is recognised that medical staff as the lead practitioner for episodes of care and A&C staff who are often the first point of contact for patients, it is not unusual for these staff groups to be cited by patients who wish to make a complaint.

Graph 12 Top 3 most referred to professions in Complaints and PALS concerns, MFT



9. Overview and Scrutiny

9.1 The Trust Complaints Scrutiny Group is chaired by a Non-Executive Director and is a sub-group of the Group Quality and Safety Committee. Meetings are held every two months.

9.2 The main purpose of the Committee is to review the Trust's complaints processes in a systematic and detailed way through the analysis of actual cases, to ascertain learning that can be applied in order to continuously improve the overall quality of complaints management; with the ultimate aim of improving patient experience.

9.3 The Complaints Scrutiny Committee met in total six times during 2018/19 and reviewed thirteen presented cases involving all Hospitals/ MCSs across MFT. The MLCO have not yet been invited to the Scrutiny Group, this is scheduled for 2019/20.

9.4 The actions agreed at each of the Scrutiny Committee meetings are recorded and provided to the respective Hospitals/ MCS following the meeting in the form of an action log, with progress being monitored at subsequent meetings.

9.5 Examples of the learning identified from the cases presented and actions discussed and agreed at the meetings in 2018/19 are outlined in **Table 17**. All Hospitals/ MCS teams are asked to identify and share transferable learning from the scrutiny process within and across their services.

Table 17: Actions identified at the Complaints Scrutiny Committee during 2018/19

	Hospital/MCS/ MLCO	Learning	Actions
Quarter 1	**MRI (Medicine)**	Communication – • Disparity in complex discharge arrangements • Lack of standardisation • Complex discharge systems	• Standardisation of complex discharge Improvement Programme • Link in with MLCO
		Communication breakdown	• Implementation of buddying system/nominated communicator
Quarter 1	**MRI (Surgery)**	Capacity Issues – • Increasing number of patients waiting for ENT surgery • Closed waiting list RTT pathway	• Continue to review all closed waiting lists on regular basis • Undertake a clinical review/validation to understand size of problem & move, where appropriate, patients back onto open waiting list • Decision to be made by Chief Executive regarding referral to treatment (RTT) pathway
		Long waits	• Discussion with Chief Executive in relation to the management of referrals
Quarter 2	**SMH**	Scan not performed prior to discharge	• Implementation of additional screening tool • Guidelines strengthened

		Not all complaint documentation reviewed on Ulysses Customer Services Module	• Divisional Lead to review all documents upon notification of complaint
Quarter 2	**WTWA (Medicine)**	Call bell out of reach	• Regular audits to be undertaken • Matron rounds to be undertaken
		Lack of support & detection of mental health problem (Delirium)	• Look into what other areas across MFT offer to support patients with Delirium. • Consider and adopt good practice.
Quarter 2	**WTWA (Surgery)**	Issues identified with End of Life Care	• To continue with ongoing improvements to End of Life Care
		Copy of the lead Trust's complaint response not shared with MFT	• Copy of final response to be requested from lead Trust. Following the meeting the complaint response was requested, received and shared with the WTWA team.
Quarter 3	**MRI (Specialist Medical Services - SMS)**	Need for reasonable adjustment – 'open' visiting for vulnerable patients	• Policy reiterated to all staff in Manchester Heart Centre regards 'open' visiting & reasonable adjustments
		Ineffective communication	• Complaint shared with ward and medical staff highlighting the importance of accuracy and timeliness of communication
Quarter 3	**MRI (Surgery)**	Receipt of compliment not registered	• Compliment to be registered on Customer Services database
		Poor communication regarding waiting times	• Consideration to be given as to how correct waiting times for surgery can be provided to patients to ensure appropriate expectations are set and waiting times understood • Complaint to be shared at December 2018 ACE Day • Follow up process (following inpatient discharge) to be reviewed • Review of use of Stoma Nurse input
Quarter 3	**RMCH**	Actions not captured as part of the complaints process	• Share complaint with team to ensure learning • Establishment of RMCH quality assurance (QA) process • Re-establishment of Hospital/Clinical Service Unit weekly position report • Implementation of weekly KPI

			meeting • Complaints responses to clearly identify action points • Increased focus on learning from complaints rather than the process • Quarterly update to RMCH Safety & Quality Committee for learning
		Lead clinician to coordinate patient pathway	• Review Manchester Access Group in Children (MAGIC) service and hours of working • Looking into how can be linked in with Complex Care Project
Quarter 4	**CSS**	Patients with a disability may require help to change into a suitable gown and are not being offered assistance when attending for a scan	• All staff to be reminded of the importance of offering assistance when patients require help to change • Pictures of how gowns are worn to be placed on back of all changing room doors
		Lack of experience and confidence from junior staff dealing with patients with a disability	• Fully trained/senior CT radiographer/s with a significant number of years' experience to be placed in the department to supervise junior staff
		Lack of time to fully support patient throughout scan	• Certain scans to be performed on dedicated lists
		Female radiographer unavailable to chaperone female patient in the CT Scanning Department	• Female radiographer to always be available in the CT Scanning Department
Quarter 4	**WTWA (Medicine)**	Patients in the Phlebotomy Clinic are not being treated with respect or in line with the Trust Values and Behaviours	• Complaint shared with staff • Staff reflection taken place
		No voicemail facilities detailing alternative contact telephone numbers for patients to contact	• Explore introduction of patient communication via email • Introduction of new Call Centre in November 2018 • Introduction of new booking system at Trafford General Hospital • Introduction of new ticket option for waiting areas
		Lack of accessible Phlebotomy services across Trafford	• Explore other available options
Quarter 4	**UDHM**	Lack of clarity of NHS	• Engage with the Commissioners

		funded treatments for both General Dental Practitioner (GDP) and patients	to discuss communication with GDPs. • Review of information currently available on UDHM website and ensure criteria for implant funding is available to patients • Devise patient information leaflet detailing information on long term maintenance • Review the Newcastle Dental Hospital website • Explore the Referral Management Service (RMS) referral criteria
Quarter 4	**MREH**	Delays in clinic/length of wait to be seen in clinic	• Training in resolving concerns expressed by service users to be arranged for staff member • Staff to ensure patients concerns are escalated to the nurse in charge in clinic • When delays experienced in clinic staff to ensure: - Patients are kept informed of delay via the yellow boards - Patients have been offered a pager - Patients have been offered appropriate refreshments • Ensure clinic notice boards indicate if consultant present in clinic or not • Staff to be reminded of the importance of ensuring all clinic notice boards to be kept up to date at all time
		Outpatient appointment cancelled and rebooked on several occasions	• Review waiting lists and sub-speciality information to determine where there is increased acuity • Review processes and determine if fit for purpose

9.6 In addition to the scrutiny described above, complaints are also reviewed within the Accreditation process to assess if the teams are aware of complaints and to examine what actions have been taken to improve services.

9.7 Complaints are also triangulated with feedback received through a number of different processes including the Friends and Family Test (FFT), National Survey data, the Care Opinion and NHS Websites and the real time **What Matters to Me** Patient Experience surveys to identify any trends.

Picture 4: 'Father Matters too'; Proud to Care on Camera Winner.

10. Patient Experience Feedback

10.1 Care Opinion and NHS Website Feedback

Care Opinion is an independent healthcare feedback platform service whose objective is to promote honest conversations about patient experience between patients and health services. The NHS Website (formally NHS Choices) was launched in 2007 and is the official website of the NHS in England. It has over 43 million visits per month and visitors can leave their feedback relating to the NHS services they have received. The Care Quality Commission (CQC) utilises information from both these websites to help monitor the quality of services provided by the Trust[3].

10.2 There has been a 13.46% decrease in the number of postings made on these websites during 2018/19 (from 312 postings in 2017/18 to 275 postings in 2018/19). The number of posts on these websites by category; positive, negative and mixed negative and positive comments, are recorded as detailed in **Table 18.** The data demonstrates that the majority of comments received in 2018/19 were positive (56% compared to 55.8% in 2017/18), however, 32.7% of the comments related to a negative experience of the

[3] https://www.cqc.org.uk/what-we-do/how-we-use-information/how-we-use-information

Trust's services. This is an increase (negative) in negative postings of 3.2% compared to 2017/18 when 29.5% of comments were categorised as negative.

Table 18 Number of Care Opinion postings by Hospital/MCS and MLCO 2018/19

Number of Patient Opinion Postings received by Hospital/MCS/MLCO 2018/19			
Hospital/MCS/MLCO	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	7	1	3
Corporate Services	1	1	0
Manchester Local Care Organisation (MLCO)	0	0	0
Manchester Royal Infirmary (MRI)	31	25	13
Research & Innovation (R&I)	0	0	0
Royal Manchester Children's Hospital (RMCH)	9	3	0
Saint Mary's Hospital (SMH)	14	8	3
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	17	6	3
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	75	46	9
Total	**154**	**90**	**31**

10.3 **Table 19** provides three examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website that were published in 2018/19

Opal House, Wythenshawe Hospital
My grandfather was admitted into Opal House approx. 3 months ago. In the time he has been here the staff have provided an excellent standard of care, and have all treated him as if he were their family. They have gone above and beyond in every aspect and have made him feel at ease and comfortable, which is usually a difficult task for him as his dementia causes confusion and stress. I cannot express the gratitude I have for all the staff at Opal House. They have been amazing, and I'm sad to see him leave. Anyone who's wondering about their relatives being in here, you will not be disappointed. Everything was perfect.
Response:
Thank you for your positive comments posted on the NHS website regarding your grandfather's care at Opal House, Wythenshawe Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects their hard work and dedication. It was reassuring to read that your grandfather received excellent care and that the staff went above and beyond, making him feel comfortable and at ease. I can assure you that we have passed on your feedback to the Head of Nursing who will share this with all the team at Opal House who have made you grandfather's experience perfect during his 3 month stay.

Cardiology, MRI

Felt my dignity and concerns were addressed amazing staff!
I came into MRI after I was at stepping hill for a short time concerning my heart I'm 22 and on arrival in the cardiology wards the drs and nurses were quick to give me the treatment and tests needed, within 10-15 mins of having my echocardiogram the drs were quick to take me into theatre for a angiogram all while this was going on the nurses and drs were quick to put my mind at ease, within 30 mins after the angiogram I was told I had no blockages and was placed on the ward for obs overnight, the healthcare assistants were amazing. By the day after I was placed on that ward they told me on the rounds I'd be moved for further tests and obs. On that ward the nurses and healthcare assistants were great there as well. I left on the Saturday with a diagnosis and treatment plan. Can't thank them all enough as a support worker myself it's a great feeling to know I'm receiving quality care. Thanks to all the healthcare staff at MRI I'm now on the mend you do a cracking job!

Response:

Thank you for taking the time to post your positive comments on the NHS website following your recent attendance at the Cardiology Department of the Manchester Royal Infirmary. It was very kind of you to take the time to write and compliment the staff as it is good to receive feedback which reflects the hard work and dedication of our staff. It was reassuring to read that you received quality care.

We can assure you that we have passed on your thoughts to the Head of Nursing, Specialist Medical Services, Manchester Royal Infirmary.

Haematology, Trafford General Hospital

Can we please make appointments I went for a blood test last week. The Phlebotomy staff are always great and there is no complaint there but have to have a blood test every month and as I work full time it is becoming impossible to avoid it interfering with my job. The last few times I have queued for nearly 2hours. I've tried a variety of times to no avail. It used to be quiet in the afternoon but not for over a year now. Could we please have some kind of appointment/ booking system to avoid these incredibly long way times? Thank you.

Response:

Thank you for your comments posted on the NHS website. We are sorry to learn of the delay you experienced whilst waiting for a blood test at Trafford General Hospital and for the inconvenience and frustration this caused you. It is important to us that comments are heard and seen as an opportunity provided to the service to make changes and improvements wherever possible. In response to your comment, we are pleased to inform you that all blood tests in Trafford will be by appointment only from the 1st November 2018. It is hoped that introducing a booking system for our Trafford patients for blood tests will reduce the amount of waiting time in phlebotomy clinics and improve patient experience. Please be assured that we take all issues surrounding patient care very seriously. If you wish to discuss your concern regarding the phlebotomy services at Trafford General Hospital further please contact our Patient Advice and Liaison Service on 0161 276 8686 or email pals@mft.nhs.uk and they will be happy to discuss this with you.

11 Compliments

11.1 The registration of written compliments received by the Group Chief Executive is managed by the PALS Team and the Hospital/ MCSs and MLCO management teams manage registration of locally received compliments on the Ulysses Customer Services Module. All responses are managed locally by the Hospitals/ MCSs and MLCO. In 2018/19 there was recognition that there are many other methods that patients, families and carers utilise to provide feedback about the satisfaction and quality of care received, these include but are not exclusive to thank you cards, Tweets, Facebook postings and gifts. This feedback is not captured, formally recorded or reported. The indicator may actually perversely make departments look like services are deteriorating because formal compliments have not been logged even though informal compliments may have increased from other sources such as Twitter, Facebook, cards and gifts.

11.2 During Quarter 3, 2018/19 feedback from the Board of Directors indicated that reporting written compliments that are received formally did not adequately represent the number of compliments received by the organisation. In response the Chief Nurse took a proposal, which was approved, to the Quality and Safety Committee to support the recommendation that Hospitals /MCSs and the MLCO teams manage all compliments at a local level and compliments are removed as a group-level quality indicator.

11.3 All positive Patient Opinion and NHS Website postings continue to be shared with the relevant departments, with negative and mixed postings sent to Hospital/ MCS and MLCO teams for an individual response. In addition, weekly reports are circulated to Hospitals/ MCS and MLCO teams detailing compliments that are registered both corporately and locally. The reports include the number, detail and progress and are shared within Hospitals/ MCSs and the MLCO in order to celebrate and spread good practice.

12 Meetings with Complainants

12.1 A total of 96 Local Resolution Meetings (LRMs) are recorded as taking place during 2018/19 of which 49 related to MRI, 18 related to WTWA, 11 related to SMH with the remainder being spread relatively evenly across RMCH, CSS, UDHM and MREH and Corporate. This compares to 101 LRM's held in 2017/18. This represents a reduction of 4.95%.

12.2 Meetings are facilitated by the identified PALS Case Managers and summary letters are provided to the complainant with an audio recording of the discussion. This enables the complainant to listen to the recording outside the meeting so that they can review specific responses or consider any further questions they may wish to raise.

13. Parliamentary and Health Service Ombudsman (PHSO)

13.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. The PHSO is not part of government, the NHS in England, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

13.2 The PHSO is the final stage for complaints about the NHS in England and public services delivered by the UK Government. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and not put things right.

13.3 The PHSO informed the Trust of the outcome of their investigation of 34 complaints during 2018/19. **Table 20** shows the financial year in which the Trust initially received the complaints which have been closed in 20018/19 following PHSO investigation.

Table 20: Financial year in which the Trust/ legacy organisations initially received the complaints closed in 2018/19 following PHSO investigation

Year	Number
2013/14	1
2014/15	0
2015/16	3
2016/17	6
2017/18	17
2018/19	7

13.4 **Table 21** shows the outcome of the PHSO investigation for complaints resolved in 2017/18 and 2018/19.

Table 21: Outcome of PHSO investigations 2017/18 and 2018/19, MFT

	2017/18	2018/19
Fully up-held	1 (6.6%)	1 (2.94%)
Partially up-held	4 (26.6%)	15 (44.11 %)
Not up-held or withdrawn	10 (66.6%)	18 (52.95 %)

13.5 In summary, 18 cases were not upheld or were withdrawn, 15 cases were partially upheld and 1 case was fully upheld.

13.6 Payment of compensation was advised by the PHSO in 7 of the 34 cases totalling a sum of £3,000. This compares to the payment of £850 to 2 complainants in 2017/18 and £2,300 to complainants in 2016/17.

Table 22 is presented in Appendix 3 and provides details of the PHSO cases resolved in 2018/19 and shows the distribution of PHSO cases across the Hospitals /MCS's and MLCO.

13.7 The Trust had 13 cases under the review of the PHSO at the end of Quarter 4 in 2018/19.

14. Tell Us Today

14.1 **'Tell us Today'** is a service that enables inpatients and their families to escalate concerns in real time via a dedicated telephone number to a senior nurse/manager so that issues can be resolved, the patient's experience improved and potentially a complaint averted.

14.2 **'Tell us Today'** is aligned with the **'What Matters to Me'** Patient Experience Programme and was re-launched during Quarter 2, 2018/19. During 2018/19 the number of recorded calls on the Ulysses Customer Services Module has been exceptionally low. A total of only 3 calls were recorded on the system in 2018/19, compared to 5 in 2017/18. The low number of recorded calls is not reflective of the frequency which clinical staff respond to concerns from patients, relatives and carers at departmental level, but is anecdotally a recording issue. The intention in 2019/20 is to undertake an audit of staff knowledge to identify their understanding of the 'Tell us Today' Service and how they are promoting this to patients.

15 Complaint Data Analysis and Implementing Learning to Improve Services

15.1 All Hospitals /MCSs and the MLCO receive their complaint data via automated reports produced by the Ulysses Customer Services Module. Hospitals/ MCSs and the MLCO also review the outcomes of complaint investigations at their Quality or Clinical Effectiveness Committees. The following tables identify the complaint data for each of the Hospitals /MCS and MLCO mapped against a number of key performance indicators and a selection of complaints that demonstrate how learning from complaints has been applied in practice to contribute to continuous service improvement during 2018/19. All of these examples have been published in the quarterly Board of Directors Complaints Reports during 2018/19.

15.2 **Manchester Royal Infirmary**

Manchester Royal Infirmary (MRI)	2017 / 18	2018 / 19
Number of Formal Complaints	434	452
Number of PALS Concerns	1692	1671
Number of Re-Opened	120	117
Number Closed in 25 days	108	70
Number Closed Over 41 Days	195	292
Number of Meetings Held	46	49
Top 3 Themes		
Treatment / Procedure - 394		
Communication - 305		
Appointment Delay / Cancellation (Outpatient) - 232		

Division	Complaint and Lessons Learnt
SMS Q2	**Issues with ordering process** A complaint was received that outlines the frustration caused to a patient who tried to ring to order supplies from the Diabetes Centre. **Lessons Learnt:** The process at the Diabetes Centre for ordering supplies was complex, after calling the phone number given and opting for the 'ordering line' a patient was put through a series of automated messages, which eventually led to a voicemail where they were told they could leave a message, at that point the phone would cut out with no option to leave a message. The patient then opted for the 'appointments line' where she got through to a member of staff who took down her details. The staff member said she did not deal with orders so promised to pass the message on to a colleague who would call her back. This did not happen and the patient was left without supplies or any communication. The patient made a formal complaint about her experiences. **As a direct result of the complaint:** ▪ The Diabetic Centre's team have revised the process for ordering supplies and established a robust process for placing orders via email or phone, which are now recorded. ▪ The Diabetic Centre's team have introduced a process to confirm all orders with the patient, received from both emails and telephone calls. ▪ All administration staff have been reminded of the importance of recording messages and sharing these messages with appropriate staff at the team meeting. ▪ All administrative staff have been briefed and trained on the new ordering processes.

Surgery Q2	**Communication issues leading to late cancellation of surgery** A complaint was received from a patient who waited for 1½ hours for an outpatient appointment due to a reception administrative error. The investigation into the concerns raised, identified that the patient arrived for their outpatient appointment at 09.30 hours after fasting since 20.00 hours the night before. The receptionist did not put the patient's notes out for the nursing staff hence the nursing team did not realise that the patient had arrived. This led to the patient experiencing an extended delay in being seen by the doctor. The investigation into the concerns raised by the patient identified that this incident was a genuine human error. A full review of the booking-in process in the Outpatient Department has been undertaken by the Assistant Directorate Manager and the Matron. In addition the implementation of a computerised booking and patient call facility is underway for the Outpatient Department to minimise the risk of this type of incident recurring in the future.
Medicine Q4	**Pain Management** Failure to assess and manage pain is one of the most frequent causes of complaints from patients attending the MRI Emergency Department, highlighting that failure to provide adequate analgesia is a significant cause of poor patient experience. Whilst this has always been a common theme within the complaints received for the ED, a recent spike in complaint numbers led to a review and implementation of a targeted work programme. The complaints ranged from pain relief not being provided at triage, to pain relief provided at triage not providing adequate respite and not being followed up in a timely manner. The ED is the first point of contact for patients who have injured themselves and therefore it is expected that a significant proportion of these patients will be in pain. Pain assessments and the management of pain are key steps in the patient journey and the first opportunity to intervene is at triage with pain assessments being included within the Manchester Triage system. The Improvement project, led by a Senior Sister in ED commenced with a 4 day internal audit where pain management at triage for patients streaming into the Minor Injuries Department were reviewed. A total of 173 patient care episodes were reviewed. Following the audit, the ED team have introduced a process whereby at triage, and having received pain relief, patients are provided with a postcard to advise them about what steps to take if the pain relief has not been sufficient whilst the wait to be seen by the relevant healthcare practitioner. This includes directions on how to alert the ED team so that the relevant steps can then be taken if they continue to experience pain whilst they are waiting. To date the initial patient feedback on this process has been positive and the team plan to work with the Patient Experience Team to undertake a formal evaluation of this change with patients attending ED.

15.3 **Royal Manchester Children's Hospital**

Royal Manchester Children's Hospital (RMCH)	2017 / 18	2018 / 19
Number of Formal Complaints	143	167
Number of PALS Concerns	563	561
Number of Re-Opened	19	18
Number Closed in 25 days	35	35
Number Closed Over 41 Days	55	78
Number of Meetings Held	11	5
Top 3 Themes		
Treatment / Procedure - 155		
Communication - 143		
Appointment Delay / Cancellation (Outpatient) - 97		

Division	Complaint and Lessons Learnt
RMCH Q2	**Surgical and Nursing Care – Delayed Diagnosis** A complaint was received from a patient's mother concerned that her son's knee was dislocated following hip reconstruction surgery and no one realised for several days. She alleged there was insufficient padding on the cast resulting in her son suffering cuts and she was also concerned that the nursing care regarding pain management and cannula care was poor. On investigating the concerns it was identified that the child had corrective hip surgery on 3rd May 2018 and as a result a hip spica (orthopaedic cast used to immobilize the hip or thigh) was fitted to promote healing of the hip joints. The spica was well padded during theatre. The patient was admitted to the Paediatric High Dependency Unit post operatively so that he could be closely observed and receive sufficient analgesia. Spica casts may need trimming and additional padding added and this should be done within 24 hours of the spica being fitted. Unfortunately, the necessary adjustments were not made within 24 hours on this occasion. There were concerns raised about the patient's pain following surgery and the patient was reviewed daily by the orthopaedic team. X-rays had been taken which did not demonstrate any fracture or dislocation. Regular pain relief was administered throughout the patient's admission.

15.4 **Wythenshawe, Trafford, Withington and Altrincham (WTWA)**

Wythenshawe, Trafford, Withington and Altrincham (WTWA)	2017 / 18	2018 / 19
Number of Formal Complaints	383	442
Number of PALS Concerns	2101	1901
Number of Re-Opened	85	112
Number Closed in 25 days	132	148
Number Closed Over 41 Days	100	257
Number of Meetings Held	21	18
Top 3 Themes		
Treatment / Procedure - 354		
Communication - 250		
Appointment Delay / Cancellation (Outpatient) - 214		

Division	Complaint and Lessons Learnt
Medicine Q3	**Discharge Planning Communication** A gentleman's daughter made a complaint that her father had been discharged home from a medical ward without a package of care having been put in place. She felt the discharge was premature and also expressed concern that she was not informed of her father's discharge or given the opportunity to collect him from hospital. **Findings:** The patient was assessed as having mental capacity to make decisions about his own care and treatment Nursing staff completed a social work referral with the patients consent to identify additional support that might be available for the patient following discharge. The patient met with social services on the ward and despite encouragement to accept support, declined and wanted to go home to continue to live independently. The patient was discharged the following day, no contact with the patient's family was attempted and hospital transport was arranged. **Actions:** The ward staff reviewed the anonymised complaint together during a ward meeting to share learning. Acknowledgement that the patient should have been asked if they wished staff to contact family regarding transport home. The team agreed this will be actioned as part of the discharge checklist in future. Documentation regarding decision making and communication with family to be improved by ensuring correct utilisation of the discharge planning sheet in the nursing documentation.

WTWA - Heart & Lung Q4	**Follow up Care** A Patient raised concerns regarding follow up care in the Cardiology Department. The Patient was transferred from Trafford General Hospital for an angiogram, following an 11 day admission for a Non ST segment elevation myocardial infarction (NSTEMI). The discharge letter stated the patient was for cardiac rehabilitation and follow up in the Cardiology Clinic which the patient was led to believe would be provided at Wythenshawe Hospital. The patient has previously undergone cardiac rehabilitation at their local hospital, Trafford General Hospital as arranged by the cardiac nurses. The patient had not received notification of a follow up appointment 6 weeks after surgery and contacted the Cardiology secretary to follow this up. The patient was informed a follow up appointment had not been arranged and the secretary agreed to discuss this with the consultant. The Patient did not receive any further communication from the hospital and made a number of telephone calls attempting to gain feedback. The patient eventually managed to speak to the secretary to be told that the Consultant had been undertaking procedures for 3 days, and that their case had unfortunately not been discussed. The patient received a call the same day to be told they did not require review at Wythenshawe Hospital and would be referred back to Trafford General Hospital for further follow up. **Findings:** ▪ Ineffective communication between clinical teams and Hospital sites. ▪ Poor communication from secretarial staff to patient. ▪ Follow up care following discharge had not been adequately provided. ▪ Incorrect detail on patient discharge summary. **Actions:** ▪ The complaint will be anonymised and the patient experience will be shared with the secretarial team with the aim of demonstrating the impact of poor communication and promote timely communication and feedback to patients. ▪ The lack of follow up arrangements for the patient post NSTEMI to be discussed at the Cardiology Directorate Governance Board in April 2019, which has clinical and management representation across all Cardiology teams. This will provide the opportunity to share learning on the appropriate follow up arrangements for patients following NSTEMI, including ‘treat and return’ patients. ▪ The Consultant Cardiologist and Trust Speciality Trainee Lead will review the case with all Cardiology junior doctors. Junior doctors are often responsible for completing the ward discharge summary, which includes reference to any follow up including the requirement for an outpatient appointment.

WTWA – Trafford Q1	**ReSPECT** ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. A complaint was received raising concerns that attempts were made to resuscitate a patient when a ReSPECT form was in place. The form documented the patient's wishes in regards that they were not to be resuscitated. It was found that the patient had two large volumes of notes; with the older second volume being stored on a lower shelf of a ward trolley. The ReSPECT form was in the second volume of notes, and only the first set of notes were check by the attending CPR team. **Action & Learning identified:** The Ward Clerk now checks Patients' notes each morning to ensure that ReSPECT forms are in place and visible. Any discrepancies found by the Ward Clerk are escalated to the Ward Manager or Matron immediately. The Head of Nursing Trafford Hospital is overseeing the implementation of a daily review process across all medical wards to ensure that ReSPECT forms are in place and visible.
WTWA – Surgery Q4	**Poor Experience – on the day cancellation of surgery** A complaint was received from a patient raising concerns that he did not receive adequate after care following the cancellation of his day surgery. The patient had been cancelled by the surgical team following discussion with the anaesthetist and cardiologists. There were concerns that the patient had an irregular heart beat which needed further investigation, therefore based upon the clinical findings it was established that it was not appropriate for him to have surgery on that day. The irregular heart beat had not been identified during pre-operative assessments. The referral for a cardiology review/ opinion was not made by the orthopaedic team for 14 weeks, causing the patient unnecessary anxiety and his surgery to be unduly delayed. **Actions:** As a direct result of the complaint the following actions have been identified: ▪ A clinician to complete a discharge summary for any patient who has had an 'on the day' surgery cancellation, clearly stating what the plan is/offering a rescheduled date, with the aim of ensuring that any follow up care requirements are noted and actioned. ▪ A copy of the discharge summary to be given to the patient and a copy sent to the patients GP.

15.5 **Saint Mary's Hospital (SMH)**

Saint Mary's Hospital (SMH)	2017 / 18	2018 / 19
Number of Formal Complaints	124	190
Number of PALS Concerns	357	467
Number of Re-Opened	22	45
Number Closed in 25 days	22	51
Number Closed Over 41 Days	39	95
Number of Meetings Held	5	11
Top 3 Themes		
Treatment / Procedure - 143		
Communication - 118		
Appointment Delay / Cancellation (Outpatient) - 65		

Division	Complaint and Lessons Learnt
SMH Q2	**Positive Communication, Environment of Care, Leadership. Recognising Domestic Abuse** A patient attended the Emergency Gynaecology Unit (EGU) a number of times during her pregnancy in 2016, complaining of stomach ache, bleeding and sickness. The team examined the lady and undertook scans on every occasion, but no cause for her symptoms were found and there was no reported cause for concern. The lady attended with her partner who remained present at all times, speaking on her behalf, and asking questions for her. The lady did not disclose the fact that she was a victim of domestic abuse but in her complaint in 2018, advised that she felt that both the nursing and medical personnel had missed a lot of warning signs and she felt very let down. When reviewing the electronic patient records, the Ward Manager identified that on 3 occasions the nursing staff had indicated that the lady had been 'unable to answer' when asked if there was any domestic violence / abuse and on one occasion had answered no. The normal practice of the nursing staff, if they were concerned or identified unhealthy behaviours, would be to create a situation in which the lady can safely by separated from her partner and given an opportunity to voice any concerns. However, in an area like EGU, partners are very often concerned and involved in the care and share the women's worries and fears over the pregnancy, so the nursing and medical team did not identify this behaviour as significant. Actions: ▪ The Ward Manager has shared the lady's concerns with the team to raise their awareness and understanding that although when asked, women may still not disclose abuse that they should always consider the environment and behaviour of individuals at the time and consider the previous history. ▪ The Information Technology Department have been asked to change the options on the Electronic Patient Record, Domestic Abuse Section to 'unable to ask question safely' with a free text box to state the reason why. This will enable the next member of staff reviewing the patient in EGU to identify that the question has not been answered and highlight the need for follow up. ▪ The team in EGU follow the Trust policy for Domestic Violence and

	Abuse Policy and receive training about asking the question safely. All staff complete mandatory online safeguarding training and have a full day face to face safeguarding training every three years. The Ward Manager has ensured that all members of her team are up to date with their training.

15.6 **Clinical & Scientific Services (CSS)**

Clinical & Scientific Services (CSS)	2017 / 18	2018 / 19
Number of Formal Complaints	34	82
Number of PALS Concerns	183	277
Number of Re-Opened	14	2
Number Closed in 25 days	8	27
Number Closed Over 41 Days	14	32
Number of Meetings Held	5	5
Top 3 Themes		
Treatment / Procedure - 140		
Appointment Delay / Cancellation (Outpatient) - 139		
Communication - 73		

Division	Complaint and Lessons Learnt
CSS – Bereavement Wythenshawe **Q1**	Communication and Patient Experience (joint plan of action with Medicine) The relative of a patient contacted a member of the Bereavement Team about acquiring a death certificate for their relative. The relative had been informed by the ward that the Bereavement Centre would be able to provide him with the actual death certificate. However, the Bereavement Team informed the relative that they did not provide a death certificate but a cause of death certificate which had not been prepared as the patient's death had been referred to the coroner. The relative became extremely upset that he had been given conflicting information. The member of staff spoke to him in a courteous and professional manner, but unfortunately, during this difficult time, communication broke down due to the added distress caused by the miscommunication of information. As a result of the complaint, the Bereavement Team will be providing training dates to the wards so that all ward nursing staff complete a Trust approved competency checklist regarding their responsibilities to patients and families after a death and the support that is available for relatives and carers.

CSS – Radiology Q1	**Imaging : Communication** A female patient with Asperger's syndrome came to the Imaging Outpatient Department for a Computerised Tomography (CT) scan. One of her triggers related to her Asperger's syndrome for anxiety and panic, was sudden loud noises. Unfortunately, there were no flags in the electronic booking system that highlighted this and the lady did not disclose this when she on her arrival in the department. Once in the CT scanner she became very upset and her complaint centred on the lack of information provided about the loud noises, and she was concerned that staff were not trained in how to communicate with autistic people. As a direct result of the complaint the following actions were taken: ▪ Staff involved in this patients care undertook online autism training and a review is underway to identify other key staff within the department to undertake this training ▪ The complaint was shared anonymously with the team to promote awareness of the importance of explaining procedures to all patients ▪ A poster called 'behind the door' was put on the doors to the scan rooms which has images of the CT scanner, including the warning that for some patients, their care will involve machines that cause noises that may affect them Clinical and Scientific Services, is involved in improving compliance across all departments with the Accessible Information Standard to ensure that any information regarding special requirements for communication is flagged and shared with relevant health professionals and on relevant systems in the future.

15.7 **University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)**

University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)	2017 / 18	2018 / 19
Number of Formal Complaints	115	115
Number of PALS Concerns	610	528
Number of Re-Opened	29	22
Number Closed in 25 days	61	51
Number Closed Over 41 Days	25	33
Number of Meetings Held	10	6
Top 3 Themes		
Appointment Delay / Cancellation (Outpatient) - 64		
Treatment / Procedure - 57		
Communication - 52		

Division	Complaint and Lessons Learnt
MREH Q1	**Improving staff awareness, communication, access and services for Children and People with Learning Difficulties** A difficult and distressing situation occurred for a mother and her daughter when they attended the MREH outpatient service. The mother and daughter had been waiting for a significant period of time and during the wait the daughter had become restless and started to run around, including behind the reception desk. This raised a comment by a staff member which was upsetting for the mother to hear. Subsequently the mother wrote a formal complaint letter which highlighted the poor awareness, communication and support for children and young people with Learning Difficulties (LD). As a result of the investigation into the formal complaint the team at MREH are working with the mother to improve several areas of our services. Firstly to raise awareness and improve communication the team are developing with the mother an audio story for use by staff as an LD teaching resource and to cascade the learning via its presentation at the Hospital Clinical Effectiveness Board and other MREH training events as well as LD awareness session presented by the Optometry Lead for Children's Services in MREH. The team at MREH have also approached the Children's hospital in relation to part funding of a play therapist who would be able to provide play therapy sessions at the MREH outpatients, at present MREH is working with the Trust Charity team to source funding for this role.

UDHM Q3	**Implant Funding** A patient initially complained in May 2018. The main concern raised related to the patient not being able to access NHS funded dental implant treatment at UDHM. The patient had been informed by their consultant that they did not meet the criteria for such treatment under the guidance based upon current Clinical Commissioning Group (CCG) guidance. **Findings:** The patient had previously had implants fitted overseas, which had failed due to extensive periodontal disease. In view of this, the patient lacked enough bone to support the implants and was at higher risk of failed implants in the future. The patient was given alternative treatment options but still wanted to pursue funding for dental implants. The patient was dissatisfied with the formal response and a telephone meeting was held. A further CEO letter was sent following this meeting summarising the discussions at the meeting. A further letter was then received in December 2018 from the patient's MP in relation to the matter and a response detailing the assessment and outcome of the patient's condition and the reasons why the patient did not meet the criteria for funded dental implant treatment. The letter also explained the details of how this had been explained to the patients including a tele-conference meeting in an attempt to resolve the patients concerns. **Action:** To review the provision of information provided to patients regarding NHS dental implant treatment in order to improve future communication.

15.8 **Research & Innovation (R&I)**

Research & Innovation (R&I)	2017 / 18	2018 / 19
Number of Formal Complaints	0	2
Number of PALS Concerns	0	18
Number of Re-Opened	0	0
Number Closed in 25 days	0	1
Number Closed Over 41 Days	0	0
Number of Meetings Held	0	0
Top 3 Themes		
Treatment / Procedure - 4		
Communication - 2		
Discharge / Transfer - 1		

15.9 **Corporate Services**

Corporate Services	2017 / 18	2018 / 19
Number of Formal Complaints	50	91
Number of PALS Concerns	208	214
Number of Re-Opened	9	15
Number Closed in 25 days	22	39
Number Closed Over 41 Days	2	24
Number of Meetings Held	1	2
Top 3 Themes		
Communication - 71		
Infrastructure (Staffing & Environment) - 60		
Documentation (Records / Identification) - 36		

Division	Complaint and Lessons Learnt
E&F Q3	**Signage** A number of complaints have highlighted the difficulties that patients are experiencing with wayfinding from Oxford Road when arriving by bus, particularly since the 147 has stopped travelling through the site. **Actions :** ▪ In response the Facilities Management Team are reviewing signage at the site perimeter to improve wayfinding for patients and visitors.

15.9 **MLCO**

MLCO	2017 / 18	2018 / 19
Number of Formal Complaints	N/A	27
Number of PALS Concerns	N/A	25
Number of Re-Opened	N/A	3
Number Closed in 25 days	N/A	3
Number Closed Over 41 Days	N/A	9
Number of Meetings Held	N/A	0
Top 3 Themes		
Treatment / Procedure – 26		
Communication – 12		
Attitude of Staff - 6		

15.10 **Non-MFT**

Non-MFT	2017 / 18	2018 / 19
Number of Formal Complaints	2	5
Number of PALS Concerns	0	243
Number of Re-Opened	0	2
Number Closed in 25 days	N/A	1
Number Closed Over 41 Days	N/A	4
Number of Meetings Held	N/A	N/A
Top 3 Themes		
Treatment / Procedure - 91		
Communication - 56		
Appointment Delay / Cancellation (Outpatient) - 48		

16 Complaint Satisfaction Survey

The Complaint Satisfaction Survey was developed by the Picker Institute and is based upon the PHSO, the Local Government Ombudsman (LGO) and Healthwatch England's user-led 'vision' of the complaints system; **'My Expectations for Raising Concerns and Complaints'**[4]. The survey was sent to 1,253 complainants following closure of their complaints during 2018/19, with a 13.8% response rate.

Comments received include the following:

- The process went according as it said in the PALS leaflet
- Personal contact from my Case Manager was very professional, helpful and efficient. I was made to feel at ease when discussing my concerns.
- Perhaps the manager in charge could have simply picked up the phone and called me?
- The response was clearly set out and dealt with each point (complaint) individually. Each point stated what had gone wrong and measures that would be taken to ensure the issues raised would not reoccur.
- It felt too long after the event that I had feedback and they would not identify the nurse on the ward my complaint focussed on.
- It ensured that the future care was handled professionally and in a timely manner and has improved communication greatly.
- I worked clinically in the NHS for 37 years, so understand the process well, which may affect my perception. A clearer explanation of why it takes so long would be useful for those who have no knowledge/experience. The formal response should be checked for accuracy – both factual and grammatical.

Results for Complaint Satisfaction Survey for 2018/19:

- 94.0% of complainants felt they were made aware of their right to take their complaint further, if they were not completely satisfied with the outcome and/ or recommendations.
- 77.78% of complainants felt that they received acknowledgement of their complaint within an acceptable timeframe.
- 72.22% of complainants felt that they were taken seriously when they first raised a complaint.
- 61.54% of complainants said they received the outcome of their complaint within the

[4] PHSO, the Local Government Ombudsman (LGO) and Healthwatch (2014) My Expectations for Raising Concerns and Complaints. Available from: https;//www.ombudsman.org.uk/publications/my-expectations-raising- concerns-and-complaints

given timescales.

- 61.11% of complainants found it easy to make their complaint.
- 50% of complainants felt confident that future care would not be negatively affected by making a complaint.

Picture 5: ‘There is no place like home’; Proud to Care on Camera Runner-up.

17 Work Programme 2018/19 - Update

17.1 In 2018/19 the Patient Services Team committed to a number of work-streams, a progress update on each of the work-streams is detailed below:

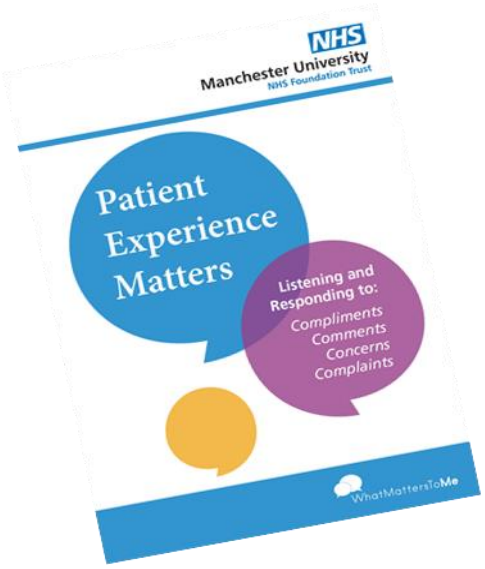
- **Single Hospital Service**

  During Quarter 1 and 2 of 2018/19 work continued to align the complaints processes of the legacy Trusts to ensure Manchester University NHS Foundation Trust maintained compliance with the NHS Complaints Regulations (2009).

  Following the devolvement of accountability for complaints management during Quarter 1, 2018/19 performance continued to be monitored at Group level with the Accountability Oversight Framework (AOF).

- **PALS Leaflet**

  In view of the Trust now providing services across six sites and community locations during Quarter 1, 2018/19 the PALS team developed a single point of access to the service via one telephone point, one email point and one postal point. In addition during Quarter 1, 2018/19 a MFT PALS leaflet was designed and is available for all teams to order and on the MFT website.



- **Benefits of the New MFT Ulysses System**

  Following the introduction of the new single Ulysses Customer Services Module in Quarter 1, 2018/19 and the work undertaken to tailor and configure the module to meet the specific needs of the Hospitals/ MCSs and MLCO full alignment of the module was completed in Quarter 4, 2018/19.

- **MFT Complaints, Concerns and Compliments Policy (2018)**

  The MFT Complaints, Concerns and Compliments Policy (2018) provides a framework for MFT to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) and provides staff with support and assistance in dealing with complaints, concerns and compliments.

  During Quarter 2, 2018/19 the policy was ratified at the Group Quality and Committee and circulated widely across the Trust.

- **Education**

  During Quarter 1 of 2018/19 the Corporate PALS team held a Ulysses Customer Service Module Master Class for staff at Wythenshawe Hospital to support the effective use of the electronic Customer Services database used to record and track Formal Complaints, PALS Concerns and Compliments.

  During Quarter 3, 2018/19 the Head of Customer Services facilitated an educational session at University of Manchester, School of Health Sciences, Faculty of Biology, Medicine and Health. The session was attended by clinical scientists undertaking their Higher Specialist Scientific Training (HSST) and focussed on handling complaints in an appropriate way.

  During 2018/19 the Corporate PALS team also held 13 Complaints Educational sessions for staff involved in responding to complaints at Estates and Facilities, WTWA, RMCH, MRI, and MLCO. The session delivered to the Estates and Facilities Team also included a sections related to writing complaint responses and quality assuring responses.

- **Staff Support**

  In order to support the health and wellbeing of the PALS team, formal staff support sessions were introduced during 2017/18. The sessions are facilitated by the Trust's Employee Health and Wellbeing Service and offer staff the opportunity to talk with trained counsellors and psychologists about some of the cases they found difficult or challenging to manage. Further sessions were held during 2018/19 and are planned to continue during 2019/20.

- **Relocation of PALS office at Wythenshawe Hospital**

  During Quarter 4, 2018/19 work commenced on the new PALS office and completion of the new office is scheduled for the end of Quarter 1, 2019/20. The new facility will provide a larger footprint for the service that is more accessible and includes a 4 person office, a welcoming reception for patients/ visitors and 2 interview/ quiet rooms.

  Picture 6: An artist impression of the planned PALS Reception, Wythenshawe Hospital

- **Complaint Quality Audit and Analysis Tool**

  During Quarter 3, 2018/19 a Complaint Quality Audit and Analysis Tool was developed and piloted.

  The intention of the tool is to provide a measurable quality framework for complaint responses to meet in order to comply with the Trust's expected quality standards for formal complaint response letter writing.

  The audit tool focuses on plain English, tone, formatting and content and during Quarter 4, 2018/19 analysis of the findings of the pilot at WTWA was undertaken. The results showed that the content of the response was the highest performing area, whilst the tone of response was identified as offering the greatest opportunity for improvement. To support improvement following these findings educational sessions were delivered as detailed above.

  Both the audit and analysis tools are now available for use for all Hospital/MCS's and MLCO teams.

- **Standard Operation Procedures**

  Work was established during 2018/19 and will continue in 2019/20, to review the Formal Complaints and PALS Standard Operating Procedures (SOPs) to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints Regulations (2009).

  The SOPs produced during 2018/19:

  - 'Red' Graded Formal Complaints
  - Media Escalation
  - Formal Complaint Triaging
  - Formal Complaint Extension Request
  - Handling of Serial and Unreasonable Complainants
  - Compliments

18 Work Programme 2019/20

18.1 The Patient Services Team will continue to work with the Hospitals/ MCSs and MLCO teams in order to improve responsiveness to complaints and to improve the processes by which they are managed.

18.2 The Educational Programme for staff who manage complaints will continue to be further developed during 2019/20. This will also include the roll out of the in-house Writing Complaints Responses course, which was piloted with the Estates and Facilities Team.

18.3 Following the development of the single point of access in Quarter 1, 2018/19 it became apparent during Quarter 4, 2018/19 that the volume of activity through the one email address for both PALS and Complaints was creating significant administrative burden. During Quarter 4, 2018/19 a new email account for formal complaints was developed and launched internally to the Trust. During 2019/20 the team will publically launch the two key email accounts, one for PALS and one for Complaints, with the Customer Services Team working closely together to ensure the service remains seamless for its users.

19 Conclusion and Recommendation

In accordance with the principles of continuous improvement, considerable work has been undertaken during 2018/19 to develop the Complaints and PALS services and processes and to integrate the services provided by the two former trusts following the establishment of MFT in October 2017.

This report details examples of learning and change as a direct result of feedback received through complaints and concerns. Examples of learning from complaints have been published in each Quarter during 2018/19 as part of the Board of Directors Quarterly Complaints Report.

This work has presented challenges however there has been an demonstrable improvement in the timeliness of complaint acknowledgement, more timely response to PALS concerns and formal complaints and a reduction in the number of unresolved complaints over 41 days.

The Complaints/ PALS processes will continue to be reviewed and developed in 2019/20 in order to ensure that the Trust continues to be responsive to feedback received in the form of complaints or PALS concerns. The Quality Audit Tool will be utilised to identify themes in order to inform the delivery of targeted educational and training to support improvement to the quality of complaint responses during 2019/20. It is anticipated that improvement of the complaint response will lead to a reduction in the number of re-opened cases.

The Trust is grateful to those patients and families who have taken the time to raise concerns and acknowledges their contribution to improving services, patient experience and patient safety.

The Board of Directors is asked to note the content of this report, the work undertaken by the corporate and Hospitals/ MCSs and MLCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provide approval for the report to be published on the Trust's website.

Appendix 1

Tables 4 to 7 provide information regarding how people access the PALS service and provides their demographical breakdown.

Table 4: Source of PALS Concerns by enquirer

Source	2017/18	2018/19
Email	1605	2094
Face to Face	514	584
Tell Us Today	5	3
Comment Box	4	0
Letter	47	67
Telephone	2635	3110
Website	0	0
Fax	0	0
From Complaints	6	2
From Family Support	0	1
From PALS	0	4
Complainant	638	16
Family Member / Friend	264	4
M.P	1	4
Commissioners	0	2
Member of Staff	0	3
Other	112	11
Totals	**5831**	**5905**

Table 5 details the number of contacts by age; the age range relates to the people who were the focus of the PALS concern as opposed to the person raising the concern

Age Range	2017/18	2018/19
0 - 18	1249	1137
19 - 29	593	594
30 - 39	742	749
40 - 49	585	668
50 - 59	758	856
60 - 69	745	688
70 - 79	697	725
80 - 89	375	395
90 - 99	80	90
100+	7	3
Totals	**5831**	**5905**

Table 6 details the number of contacts by sex; again the sex relates to the people who were the focus of the PALS concern.

	2017 / 18		2018 / 19	
Gender	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	3192	54.7%	3257	55.2%
Male	2542	43.6%	2564	43.4%
Other	0	0.0%	1	0.0%
Not Specified	97	1.7%	83	1.4%
Total	**5831**		**5905**	

Table 7 describes the ethnicity of the patients who were the focus of the PALS enquiry.

Category	**2017/18**	**2018/19**
Any Other Ethnic Group	30	46
Asian or Asian British - Bangladeshi	9	7
Asian or Asian British - Indian	30	33
Asian or Asian British - Other Asian	29	29
Asian or Asian British - Pakistani	80	62
Black or Black British - African	25	30
Black or Black British - Caribbean	40	28
Black or Black British - Other Black	15	14
Chinese Or Other Ethnic Group - Chinese	10	8
Mixed - Other Mixed	16	15
Mixed - White & Asian	8	5
Mixed - White & Black African	10	5
Mixed - White & Black Caribbean	19	52
White - British	2202	1791
White - Irish	52	53
White - Other White	73	54
Do Not Wish to Answer	5	0
Not Stated	3178	3673
Totals	**5831**	**5905**

Appendix 2

Tables 11 to 14 provide information regarding the risk rating of complaints and the demographic details of the person affected as a result of the complaint

Table 11: Complaint Risk Rating

Category	2017/18	2018/19
Not Stated / Other	7	1
White	0	0
Green	108	60
Yellow	749	807
Amber	682	691
Red	26	14
Totals	**1572**	**1573**

Table 12: Age range of person who was the subject of the complaint

Age Range	2017/18	2018/19
0 - 18	347	471
19 - 29	145	138
30 - 39	200	187
40 - 49	169	165
50 - 59	197	159
60 - 69	181	154
70 - 79	199	176
80 - 89	100	96
90 - 99	32	26
100+	2	1
Totals	**1572**	**1573**

Table 13: Sex of person who was the subject of the complaint

	2017 / 18		2018 / 19	
Sex	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	855	54.4%	880	55.9%
Male	686	43.6%	642	40.8%
Not Specified	31	2.0%	50	3.2%
Other	0	0.0%	1	0.1%
Total	**1572**		**1573**	

Table 14: Ethnicity of the person who was the subject of the complaint

Category	2017/18	2018/19
Any Other Ethnic Group	9	12
Asian or Asian British - Bangladeshi	2	1
Asian or Asian British - Indian	10	7
Asian or Asian British - Other Asian	12	6
Asian or Asian British - Pakistani	29	29
Black or Black British - African	8	8
Black or Black British - Caribbean	15	10
Black or Black British - Other Black	2	7
Chinese Or Other Ethnic Group - Chinese	5	0
Mixed - Other Mixed	10	3
Mixed - White & Asian	4	6
Mixed - White & Black African	3	2
Mixed - White & Black Caribbean	4	11
White - British	696	445
White - Irish	18	10
White - Other White	27	9
Do Not Wish to Answer	5	0
Not Stated	713	1007
Totals	**1572**	**1573**

Appendix 3

Table 22: Complaints closed between 1st April 2018 and 31st March 2019 following PHSO investigation

Hospitals/MCS /MLCO	Outcome	Date complaint initially received by the Trust	PHSO Rationale/Decision	Recommendations
Quarter 1				
RMCH	Partially Up-held	06/05/18	Failings in care and communication	Provide an acknowledgement and apology for the distress and failings identified in the report Explain what actions have been taken to address the failings in the report
WTWA	Partially Up-held	03/04/18	Failings in care	Provide a full acknowledgement and apology for the distress and failings identified in the report Award compensation of £100 Explain what actions have been taken to address the failings identified in the report
WTWA	Partially Up-held	20/06/17	Complaint handling not in line with Regulations or PHSO principles	Provide a full acknowledgement and apology for the distress and failings identified in the report Explain what actions have been taken to address the failings identified in the report
MRI (SMS)	Not Up-held	28/07/17	No failings found	None
MREH	Not Up-held	07/09/17	No failings found	None
CSS	Not Up-held	23/08/17	No failings found	None
Quarter 2				
WTWA	Not Up-held	10/04/17	No failings found	None

SMH	Not Up-held	21/12/17	No failings found	None
MRI (Surgery)	Partially Up-held	15/09/17	Failings in care, treatment and communication	Provide a full acknowledgement and apology for the impact of the failings identified in the report
MRI (DMACS) & WTWA	Not Up-held	11/05/18	No failings found	None
MRI (Surgery) & CSS	Not Up-held	02/03/18	No failings found	None
Quarter 3				
MRI (Surgery)	Up-held	13/02/17	Failings in care and treatment	Written formal apology and financial redress in the sum of £1,000
MRI (Surgery/DMACS /SMS) & CSS	Partially Up-held	15/07/16	Failings in care and treatment	Written formal apology and action plan outlining lessons learnt
MRI (Surgery) & CSS	Partially Up-held	10/12/15	Failings in care and treatment	Written formal apology and action plan outlining lessons learnt
MRI (DMACS) & CSS	Not Up-held	08/01/18	No failings found	None
MRI (DMACS) & CSS	Partially Up-held	21/04/17	Failings in care, treatment and communication	Written formal apology and action plan outlining lessons learnt
MRI (DMACS)	Not Up-held	23/11/17	No failings found	None
MRI (DMACS/SMS)	Partially Up-held	12/04/16	Failings in care, treatment and communication	Written formal apology and action plan outlining lessons learnt. Financial redress in the sum of £500
RMCH	Not Up-held	01/06/17	No failings found	None
SMH	Not Up-held	09/05/16	No failings found	None
SMH & CSS	Not Up-held	08/06/17	No failings found	None
UDHM	Not Up-held	15/12/16	No failings found	None
UDHM	Partially Up-held	20/10/17	Failing to arrange a scan which would have resulted in earlier treatment	Financial redress in the sum of £350
UDHM	Partially Up-held	26/10/17	Failings in care	Written formal apology and financial redress in the sum of £350

WTWA & CSS	Partially Up-held	28/12/13	Failings in care, treatment and communication	Financial redress in the sum of £250
WTWA	Not Up-held	22/07/15	No failings found	None
WTWA & MRI (SMS)	Partially Up-held	09/02/16	Drug error identified	Written formal apology
WTWA (Medicine)	Partially Up-held	31/01/17	Failure to observe during triage	Written formal apology
WTWA (Surgery)	Not Up-held	05/09/17	No failings found	None
Quarter 4				
WTWA (Trafford)	Not Up-held	14/08/18	No failings found	None
MRI (DMACS)	Partially Up-held	01/02/18	Failings in record keeping	Written formal apology and action plan outlining lessons learnt
WTWA	Not Up-held	25/09/18	No failings found	None
WTWA	Not Up-held	20/10/18	No failings found	None
UDHM	Partially Up-held	02/10/18	Delay in treatment leading to loss of tooth	Financial redress in the sum of £450

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Ruth Speight, Head of Nursing (Safeguarding)
Date of paper:	June 2019
Subject:	MFT Safeguarding Children and Adults and Looked After Children Annual Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Patient Safety
Recommendations:	The Board of Directors is asked to note the safeguarding activity undertaken during 2018-2019 to support MFT staff and services to be responsive to the safeguarding needs of patients and service users and to approve publication of this annual report.
Contact:	Name: Sue Ward, Group Deputy Chief Nurse Tel: 0161 701 0331

Safeguarding
Children and Adults
and
Looked After Children
Annual Report
2018-2019

Authors:

Ruth Speight, Head of Nursing (Safeguarding)

Sue Ward, Group Deputy Chief Nurse

In collaboration with the MFT Safeguarding Teams

Contents

SECTION A

Executive Summary

1. Executive Summary

1.1 This 2018-19 annual report reflects the safeguarding work undertaken throughout the Trust and outlines some of the key safeguarding priorities across the city of Manchester.

1.2 The MFT Safeguarding Service works with other health and multi-agency partners to ensure a cohesive and consistent approach to safeguarding children and adults at risk in the city of Manchester and across the MFT footprint.

1.3 2018-2019 has been an extremely busy year for safeguarding with challenges, changes and opportunities in safeguarding within the Trust and across Manchester and Greater Manchester. Changes to legislation, national policy and guidance continue to influence the safeguarding agenda. The establishment and embedding of MFT and the Manchester Local Care Organisation (MLCO) has enabled safeguarding to be considered at a whole system level across the organisation and beyond. Throughout these changes, the underpinning safeguarding principle has remained unchanged: ***'We listen, We believe, We act'.***

1.4 Supporting staff to ensure all patients and service users are protected, is crucial in ensuring safe and effective safeguarding for all age groups regardless of ethnicity, religion, gender or background. Central to this message is the Trust listening and hearing the voice of children, young people, adults at risk and their families and ensuring that we make safeguarding personal.

1.5 Following the merger of the Safeguarding Teams from the former Central Manchester Foundation Trust (CMFT) and University Hospital South Manchester Trust (UHSM) in 2017-2018, the new single safeguarding service within MFT was consolidated in 2018-2019. This year has seen the development and consolidation of the single safeguarding governance structure, policies, training and assurance processes. In 2019-2020 a case for change will be developed to ensure the Safeguarding Service is resilient and robust in readiness for for future opportunities and challenges.

1.6 A new model of working will be required to further future-proof safeguarding in MFT, in preparation for the changing health economy and partnership arrangements across Manchester. Although challenging, this is also an exciting time to ensure that patients and service are central to service design and to ensure that safeguarding continues to have a high profile across the Trust.

1.7 Key drivers have shaped safeguarding services during 2018-2019, some of which have challenged teams to think and work differently; **Figure 1** provides an overview of some of these drivers that have informed safeguarding priorities throughout 2018-2019.

Figure 1: Overview of Key Drivers

1.8 The voice of patients and service users is vitally important, and in 2018-2019 Making Safeguarding Personal (MSP) has been embedded through work plans across Manchester. This, along with capturing the voice of the child, will be a priority area for MFT's safeguarding work programme in 2019-2020. This will require the Hospitals, Managed Clinical Services (MCS) and Manchester Local Care Organisation (MLCO) to ensure that systems and processes are in place across all clinical areas that capture the wishes and feelings of all adults and children who are at risk of abuse or neglect, and that this information forms a vital part of their treatment and care choices.

1.9 MFT's Care Quality Commission (CQC) Inspection report, published in March 2019, recognised that effective systems were in place to safeguard patients in the

organisation, citing a number of examples of good practice. However, the inspection report also highlighted that the Trust should review its systems to provide assurance that staff have completed mandatory safeguarding training. This will be a key priority for the safeguarding service working with the Hospitals, Managed Clinical Services (MCS) and Manchester Local Care Organisation (MLCO) in 2019/2020.

1.10 Safeguarding training is mandatory requirement across the Trust. During this annual report year the Trust's safeguarding training content was revised and updated following the publication of the National 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018)[1] and the 'Safeguarding Children and Young People: Roles and competencies for healthcare staff (2019)[2] Intercollegiate Guidance'.

1.11 The Child Protection Information Sharing (CP-IS) system is a national information sharing systems that shares information regarding acute hospital attendances in respect of vulnerable children who are looked after by the Local Authority (LA) or who are subject to child protection plans, with their Children's Services. 2018-2019 saw the successful phase two roll-out of the CP-IS system across key areas of MFT including Trafford Hospital, the Eye and Dental Emergency Departments and the Gynaecology Emergency Department. The planning for phase 3 of the rollout across St Mary's Hospital is underway; however this is co-dependant on the alignment of IT systems across the Trust.

1.12 National information sharing systems were also strengthened within the Trust this year with the introduction of the Female Genital Mutilation (FGM) Information Sharing System in maternity services enabling electronic information about the risk of FGM in new-born babies to be shared from the Trust to primary and community systems to promote safeguarding of girls at risk of FGM.

1.13 Throughout 2018-2019, the importance of ensuring that the Complex Safeguarding agenda was embedded throughout the Trust, in line with partnership priorities, was identified as a priority work stream. This report highlights the work undertaken across the Trust aligned to the Complex Safeguarding agenda and focuses on areas of complexity in safeguarding across Manchester. This year has seen the implementation of Manchester's Complex Safeguarding Hub.

1.14 The Trust has actively supported the work of the Manchester Safeguarding Boards (MSB) for both adults and children. This has included supporting the health contribution of the Multi-Agency Safeguarding Hub (MASH), the review of the Early Help Strategy and, as a partner, consulted on the development of the new Multi-Agency Safeguarding Arrangements (MASA), which are due to be published in

[1] Adult Safeguarding: Roles and Competencies for Health Care Staff(2018) 1st edition accessed at https://www.rcn.org.uk/-/media/royal-college-of.../documents/.../pdf-007069.pdf

[2] Safeguarding Children and Young People: Roles and competencies for healthcare staff 4th edition (2019) accessed at https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies-healthcare-staff

June 2019 and launched in Manchester by September 2019, following the changes set out in new 'Working Together to Safeguard Children' (2018) guidance. The MFT contribution to the Manchester MASA will be a key safeguarding priority in 2019-2020.

1.15 In the last year there has been an increased emphasis on children's safeguarding multi-agency partnership working within the north, central and south localities across Manchester with the Trust's three community safeguarding teams leading on this agenda. In 2019-2020 Manchester City Council (MCC) Children's Services will form three locality MASHs and the safeguarding work plan will increasingly focus on developing local partnership arrangements to ensure that safeguarding practice is at the heart of communities.

1.16 Locality working was strengthened following the formation of the MLCO in April 2018. This brought the opportunity for the development of a single, cohesive safeguarding service across the city, designed to support hospital and community teams to recognise and respond to safeguarding needs.

1.17 In respect of adult safeguarding there has been a focus this year on the development of the self-neglect strategy and toolkit with the next year seeing the implementation of this strategy across the Trust.

1.18 'Deprivation of Liberty Safeguards' (DoLs) remain a challenge nationally. In 2018 the Mental Capacity (Amendment) Bill set out proposed changes to legislation, which will reform the process for authorising arrangements for people who lack capacity to consent to their care or treatment. The new legislation has recommended that DoLS are repealed and replaced by a new scheme called the Liberty Protection Safeguards, which would streamline the process for the deprivation of an individual's liberty where appropriate. In 2019 the new legislation will be given royal assent with the expected implementation of changes being in place by early 2020. The current challenges associated with the DoLS process are associated with limited capacity within Local Authority (LA) DoLS teams to undertake timely assessments. Across MFT this issue has been acknowledged and processes are in place to recognise and escalate the potential risk that this poses to any patient who is deprived of their liberty, and to the Trust itself.

1.19 In 2018 the Domestic Violence and Abuse Bill was published for consultation. MFT contributed to the consultation and in 2019-2020 the relevant recommendations of the Bill will be implemented.

1.20 In this annual report year the Trust completed a self-assessment Section 11 of the Children Act 2004 audit and an Adult Safeguarding Multi Agency Safeguarding Board Assessment to demonstrate compliance with its statutory requirements.

1.21 During 2018-2019 the MFT Safeguarding Team has continued to lead and develop arrangements across the Trust to meet local and national challenges whilst remaining focussed on ensuring that patients/service users are afforded safety and protection whilst in the care of the Trust, and that staff are supported to listen, recognise, respond and act to ensure the best outcome.

2. Purpose of the Report

2.1 The Safeguarding Annual Report for 2018-2019 provides assurance to the Board of Directors that the Trust is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004[3] and in the Care Act 2014[4]. The report provides assurance that systems are in place that support MFT service users to be kept safe whilst in the care of the Trust's Hospitals, Managed Clinical Services (MCS) and the Manchester Local Care Organisation (MLCO), and to ensure they are protected from neglect or harm. It also ensures that patients, service users and their loved ones have a voice, ensuring that they are actively involved in any decision-making regarding their safety and protection; that they feel safe and are protected from harm or neglect.

2.2 The report informs the Board of Directors of the internal and external safeguarding activity undertaken in 2018-2019 and outlines key the priority areas for 2019-2020.

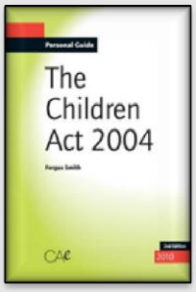
2.3 Safeguarding activity is underpinned by standard and statutory guidance outlined in **Figure 2**. This is not an exhaustive list but outlines the key legislation and statutory guidance that the Trust is required to follow to ensure statutory safeguarding compliance.

[3] https://www.legislation.gov.uk/ukpga/2004/31/contents
[4] http://www.legislation.gov.uk/ukpga/2014/23/contents/en

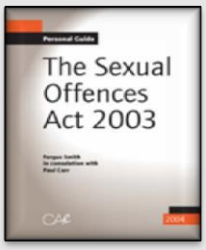
Figure 2: Standard and Statutory Guidance

CQC registration standards, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

The Children Act (1989)



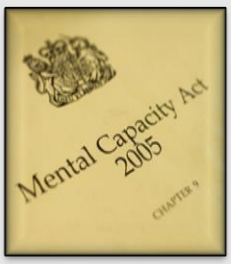
The Children Act (2004)



The Sexual Offences Act (2003).

Serious Crime Act (2015)

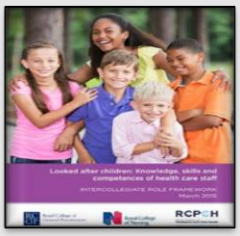
The Care Act (2014).



Mental Capacity Act (2005)

Working Together (2018)

Adult Safeguarding Roles and Competencies for Health care Staff



Intercollegiate Document (2014), Promoting the health and well-being of Looked After Children (2015)

SECTION B

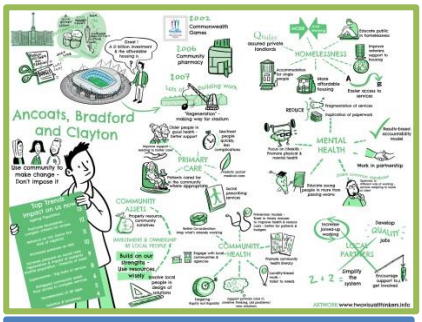
National Overview and Reflections on Manchester City-wide Safeguarding

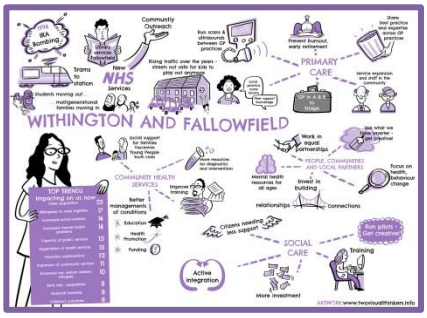
3. Manchester Overview

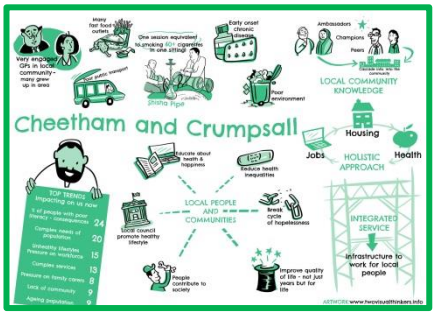
Manchester Neighbourhoods

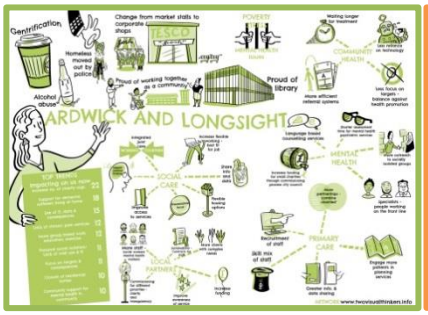
3.1 Manchester consists of 12 local neighbourhoods each with their own unique culture and demographic. The images below *(courtesy - Manchester City Council)* show the uniqueness of each of the neighbourhoods in the residents' own words.

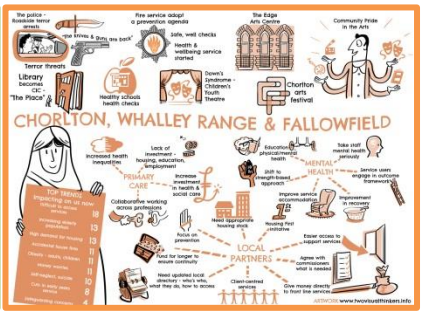
3.2 Acute and community safeguarding provision across MFT spans the diversity and specific needs of all these neighbourhoods.

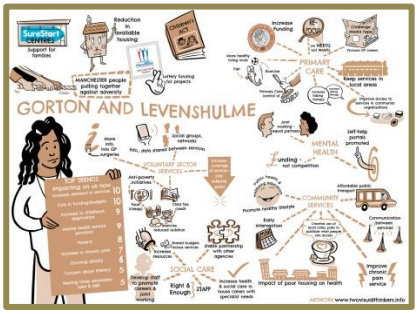


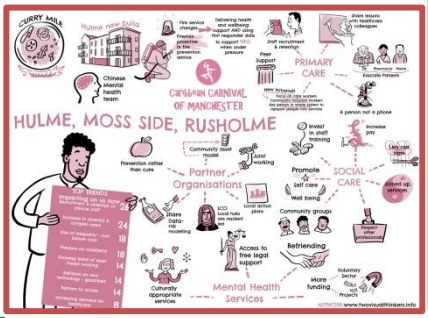


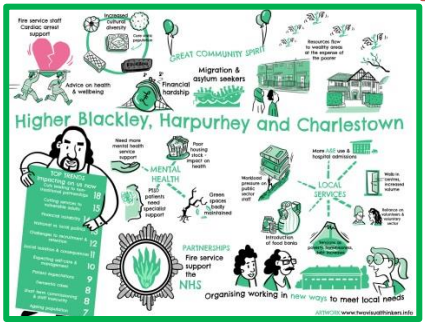


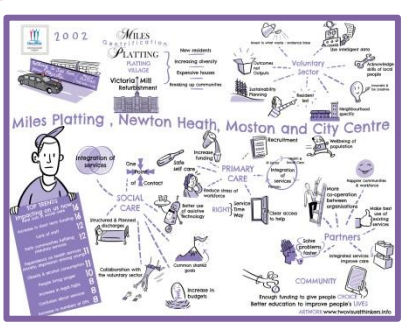












Keeping Adults Safe in Manchester

3.3 The Manchester Safeguarding Adult Board vision is to:

"Ensure every citizen in Manchester is able to live in safety, free from abuse and neglect. Everyone who lives or works in the city has a role to play".

3.4 As a committed Local Safeguarding Board partner, MFT embraces this vision and has put systems in place to ensure that adults at risk who access services are protected from abuse and neglect.

3.5 The Manchester Safeguarding Board Annual Report (2018) identified that 70.5% of Manchester's population is aged 16 - 64 years with 9.3% being above 65 years of age. The report identified that this section of the population gives rise to significant and wide-ranging safeguarding challenges.

3.6 Manchester remains behind much of the rest of the country in terms of health outcomes across the population; this is strongly linked to levels of deprivation. In Manchester, all agencies both statutory and voluntary, work together to ensure people are safe from abuse and neglect.

3.7 The Care Act (2014) outlines the following categories of abuse for adults:

Figure 3: Categories of Adult Abuse

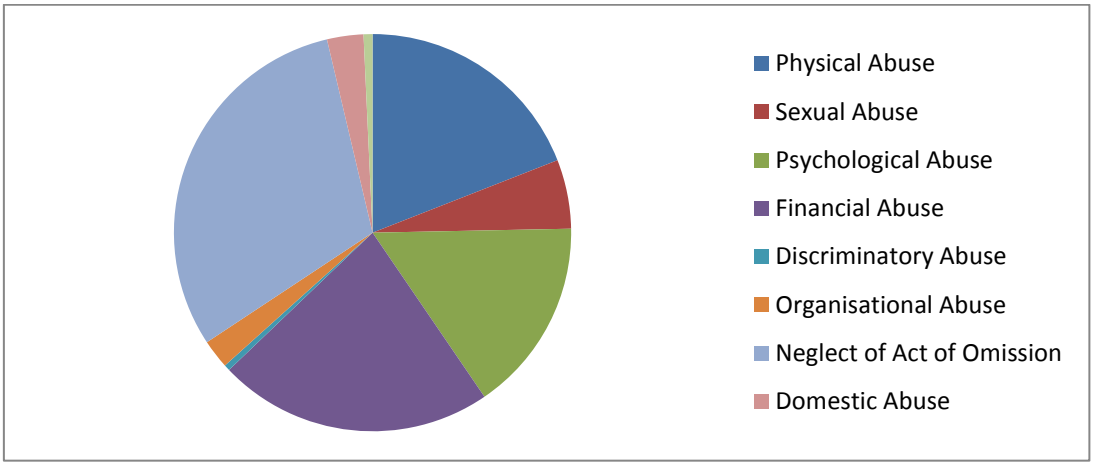
3.8 All MFT staff regardless of role and responsibility have a part to play in identifying and escalating safeguarding concerns, along with taking the necessary steps to prevent harm or abuse occurring. This includes the identification of poor professional practices which may put a patient or service user at risk.

3.9 The Manchester Safeguarding Adult Board 2018 annual report identified that there were:

- 7,693 adult concerns identified leading to 1,513 safeguarding enquiries.
- 2,796 Deprivation of Liberty Safeguards (DoLS) requested.

3.10 **Figure 4** shows the categories of concern identified in the safeguarding adult enquiries during 2018.

Figure 4: Categories of Concern in Manchester Safeguarding Enquiries



3.11 Established processes are already in place across MFT to identify these categories of abuse and neglect. Clear procedures are embedded across the Trust to support staff when completing referrals for safeguarding concerns or enquiries.

3.12 In addition to the categories of abuse set out above, **Figure 5** outlines some of the emerging issues from both local and national Safeguarding Adult Reviews (SARs). Recent learning from a number of SARs in Manchester identified themes that indicated a need for more focus on specific areas of adult vulnerability and enabled MFT to explore how emerging themes are managed in clinical practice both in hospital and community settings.

3.13 Themes such as self-neglect and safeguarding vulnerabilities in the homeless population however require more consideration and will be addressed in the Trust's 2019-2020 safeguarding work plan. Emerging themes from complex safeguarding are also cross-cutting across both adults and children: these are outlined later within this report.

Figure 5: **Emerging Issues for Manchester** [5]

Substance Misuse across Manchester

Estimated around **200,000** adults currently receiving treatment for substance misuse

1/3 are parents who have children living with them

May include experimental, recreational, poly-drug

Misuse of drugs and/or alcohol is strongly associated with significant harm to children

Mental Health across Manchester

16.3% of patients report moderate or extreme anxiety or depression. (National average 12%).

7.1% of patients report a long term mental health problem, (National average of 4.5%)

Between **1:8-10** Manchester adults are prescribed anti-depressant medication.

Hoarding

An emerging issue often identified by Community staff.

A debilitating psychological condition that is only just beginning to be recognised.

When hoarding interferes with everyday living or negatively affects the person's quality of life help needs to be sought.

Hoarding disorders are challenging to treat, because many people who hoard don't see it as a problem, or have little awareness of how it's impacting their life

Fraud, Scams & safety

UK estimated to lose around £3.5 billion every year – the equivalent of £70 for every adult in the country.

People are cheated out of their money by post, phone, email, online and sometimes by a knock on the door.

Many of our patients and clients can be vulnerable and have experienced this type of abuse.

Mate crime

Defined as the exploitation, abuse or theft from any person at risk from those they consider to be their friends. Those that commit such abuse or theft are often referred to as **'fake friends'.**

People with disabilities, particularly those with learning disabilities, are often the targets of this type of crime. In some cases victims of mate crime have been badly harmed or even killed.

[5] Greater Manchester Drug and Alcohol Strategy
https://www.gmcvo.org.uk/system/files/draft_drug_and_alcohol_strategy_for_listening_and_engagement_16th_jan_2018_0.pdf

Keeping Children Safe in Manchester

3.14 The 2018 NSPCC report 'How safe are our children'[6] provides a comprehensive overview of child protection in the UK. **Figure 6** summarises the key messages from this report for keeping children safe in the UK.

3.15 There has been a long-term upward trend in the UK of children subject to child protection plans and child in need plans in the UK. These trends are clearly reflected in Manchester in 2018 statistics; however local statistics in 2019 show signs of a decreasing number of children subject to child protection plans. Local figures are yet to be externally verified and therefore should be treated with caution. Nationally, the numbers of children who are 'looked after' due to abuse and neglect is the highest on record in England.

3.16 The NSPCC report identified that whilst neglect remains the common reason why children are subject to child protection plans; there is an overall upward trend in the proportion of children and young people who have been identified as suffering or likely to suffer emotional abuse in the UK.

3.17 The same NSPCC report identifies the increased recognition of children and young people exposed to complex safeguarding concerns with an increased number of referrals (65.7%) for child victims of modern slavery in the UK. Data from the Independent Child Trafficking Service identified that the service received 257 referrals for children and young people who had been victims of modern slavery or child trafficking nationally, and 24% of these were from Greater Manchester.

[6] How safe are our children? (2018) https://learning.nspcc.org.uk/research-resources/how-safe-are-our-children/

Figure 6: NSPCC National statistics 2018

- **Neglect remains the most common reason for being subject to a Child Protection Plan (CPP) in England**
- **In CPP due to Emotional Abuse**
- **In death rates for assault, neglect and undetermined intent in England**
- **Suicide rates among 15 to 19 year olds**
- **The rate of recorded sexual offences across the UK**
- **Increase in recorded offences of cruelty and neglect of children under 16 by a parent or carer**
- **There has been an increase in referrals to children's services in UK since 2016/17 by 4%**
- **There is an increase in children in need**
- **18.6% of 11 to 17-year olds have experienced some type of severe maltreatment**
- **5.6% o 10 to 15-year olds have been victims of violent crime**
- **30% of reviews by young people of the most popular social networking sites, apps and games, reported seeing violence and hatred.**
- **64% increase in number of police-recorded offences relating to indecent images in England**

3.18 The Manchester Safeguarding Children Board vision is that:

"Every Child in Manchester is safe, happy, healthy and successful. To achieve this we will: be child-centred; listen to and respond to children and young people; focus on strengths and resilience and; take early action".

3.19 As a committed Local Safeguarding Board partner, MFT embraces this vision and has systems in place to ensure that all children in our care are protected from abuse and neglect.

3.20 In 2017 the CQC considered the following dataset as part of their inspection of safeguarding and 'Looked after Children' health services across the City of Manchester. This dataset continues to provide a clear overview of the vulnerability of the child and young person population in Manchester.

- **Children and young people under the age of 20 make up 25.6% of the population of Manchester.**
- **60.9% of school age children from a minority ethnic group.**
- **Health of children in Manchester is not as good as the rest of England**
- **Family homelessness is significantly higher than the rest of England**
- **The proportion of children living in low income families is also significantly higher than the England average**
- **The number of children in care is significantly greater than England**
- **Infant mortality rate is greater than the England average**
- **More babies in Manchester have low birth weights than in the rest of England**
- **More children aged 4-5 years with obesity**
- **Children's dental health is significantly worse than the rest of England**
- **Under 18 conceptions are higher than average**
- **Hospital admissions for young people under 18 with alcohol related conditions are higher**
- **Hospital emergency department (ED) attendances for young children aged 0-4 years is worse than England.**

3.21 Manchester has a significant number of children and young people who require statutory intervention to keep them safe at both Child in Need (Section 17) and Child Protection (Section 47) of the Children Act (1989) levels.

3.22 A robust partnership approach is essential in identifying children and young people who are at risk of, or who are suffering harm, to ensure the best protection is afforded to them.

3.23 As of 31st March 2019, Manchester Local Authority identified that there were:

- *1,281 Looked after Children/Young People*
- *798 Children were on Child Protection Plans*
- *5,480 Children were identified as Children in Need*[7]

3.24 The most recent data (**Figures 7a, 7b and 7c**) outlines how Manchester compares statistically in relation to national, North West and its statistical neighbour in terms of numbers of children who are categorised as Children in Need, Children on Child Protection Plans (CPP) and Looked after Children/Young People.

3.25 Manchester aligns with the national statistics which identify that neglect is the highest category of abuse for children subject to CPP.

Figure 7a: Children in Need statistical comparison [8]

Area	Children In Need on 31st March 2017	Children In Need on 31st March 2018	Rate of children in need at 31 March 2018 per 10,000 children
England	**389,040**	**404,710**	**341**
North West	**114,770**	**58500**	***379***
Manchester	**9,925**	**5634**	***464.9***
Liverpool (Statistical Neighbours)	**9,563**	**3817**	**408**

[7] Data provided by Performance, Research and Intelligence (PRI) Manchester Local Authority, these are provisional figures pending data verification and submission processes for the DfE end of year statutory returns

[8] Characteristics of Children in Need 2017-2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757922/Children_looked_after_in_England_2018_Text_revised.pdf

Figure 7b: Children subject to a child protection plan statistical comparison

Area	Children on a Child Protection Plan on 31st March 2018	Rate of child protection plan at any point 2017-18 per 10,000 children
England	**119,720**	**100.9**
North West	**19,010**	***123.2***
Manchester	**1,112**	***173***
Liverpool (Statistical Neighbour)	**540**	***97.4***

Figure 7c: Children subject to a child protection plan in 2018 by category of concern

Breakdown of CPP category of concern - England				
Neglect	**Physical Abuse**	**Emotional Abuse**	**Sexual Abuse**	**Combined Categories**
48.0%	***7.7%***	**33.8%**	**4.4%**	**5.2%**

3.26 The number of Manchester children considered to be in need of care or protection is above the national and the North West average. The Child Protection figures also show Manchester has higher numbers of children subject to Child Protection Plans than national, North West and statistical neighbours' rate.

3.27 This figure has risen by 5.3% since 2017-2018. This suggests that early help may not yet be effectively preventing children from requiring statutory intervention to keep them safe. Early help is therefore a key priority for the partnership.

Looked After Children/Young People (LAC/YP) – "Our Children"

3.28 A child/young person is 'looked after' if they are in the care of the LA for more than 24 hours. Legally, this could be when they are:

- With foster carers.
- At home with their parents under the supervision of social care.
- In residential children's homes, schools or secure units.
- Placed in care voluntarily by parents struggling to cope.
- Where children's services have intervened because a child was at significant risk of harm and an interim or full care order is in place.

3.29 **Figure 8a** below, demonstrates the comparisons of LAC/YP in Manchester with national, North West and statistical neighbours and **Figure 8b** provides a comparison with the numbers of 'Unaccompanied Asylum-Seeking Children' (UASC), Care leavers, LAC/YP who go missing, and the numbers of children

adopted in Manchester with national, North West and statistical neighbours. The data shows that Manchester's numbers significantly exceed those of its statistical neighbour.

3.30 The numbers of children in LA care continues to increase both nationally and locally in Manchester.

Figure 8a: Looked after Children/Young People statistical comparison

Area	Looked After Children during the year on 31st March 2017	Looked After Children during the year on 31st March 2018
England	70,440	75,420 looked after children in England, up 4%
North West	13,220	14,070
Manchester	1,169	1,257
Liverpool (Statistical Neighbours)	1,120	1,191

Figure 8b: Additional LAC/YP statistical comparison

Additional categories as of 31st March 2018				
Area	Unaccompanied Asylum Seeking Children (UASC)	Care Leavers 17-21 years	LAC missing At least 1 episode in 12 months	Adoption
England	4,480	2,770	10,700	3,820
North West	290	200	1,820	620
Manchester	71	57	195	49
Liverpool (Statistical Neighbours)	49	19	140	40

3.31 MFT services contribute significantly to the care of Looked after Children/Young People across Manchester. This activity is described in section E of this report.

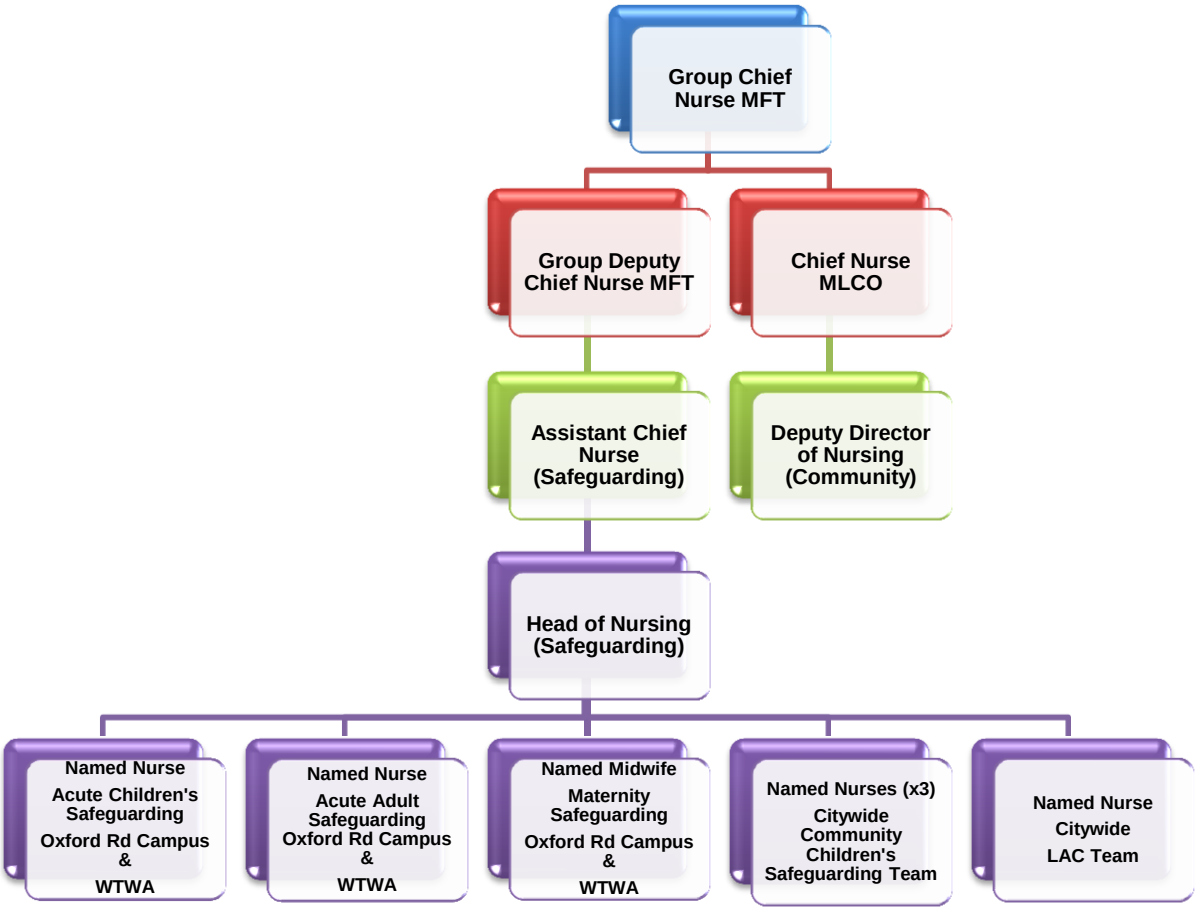
SECTION C

Safeguarding Governance and Accountability

4. Safeguarding Governance and Accountability

4.1 The MFT Chief Nurse is the Board Executive lead for Safeguarding and is accountable for safeguarding across MFT. The Chief Nurse is supported by a robust senior and operational structure that ensures both acute and community safeguarding services are aligned in terms of governance and accountability (see **Figure 9**). In recognition of the priority afforded to safety and safeguarding, an Assistant Chief Nurse (Safeguarding) was appointed during this annual report year. This post provides expert leadership across the Trust and supports the Deputy Chief Nurse strategically across the partnership. This appointment demonstrates the commitment of the Chief Nurse and the Board of Directors to safeguarding adults and children. The Head of Nursing (Safeguarding) provides operational leadership across the safeguarding service whilst also contributing to partnership activity in order to underpin the objectives of the local safeguarding boards.

Figure 9: MFT Safeguarding Structure



4.2 Further work will take place in 2019-2020 to review the structure of the safeguarding function across the city in order to ensure that it is designed in a way that meets the growing requirements and complexities of adult and children's

safeguarding and that it continues to support practitioners as new service models emerge.

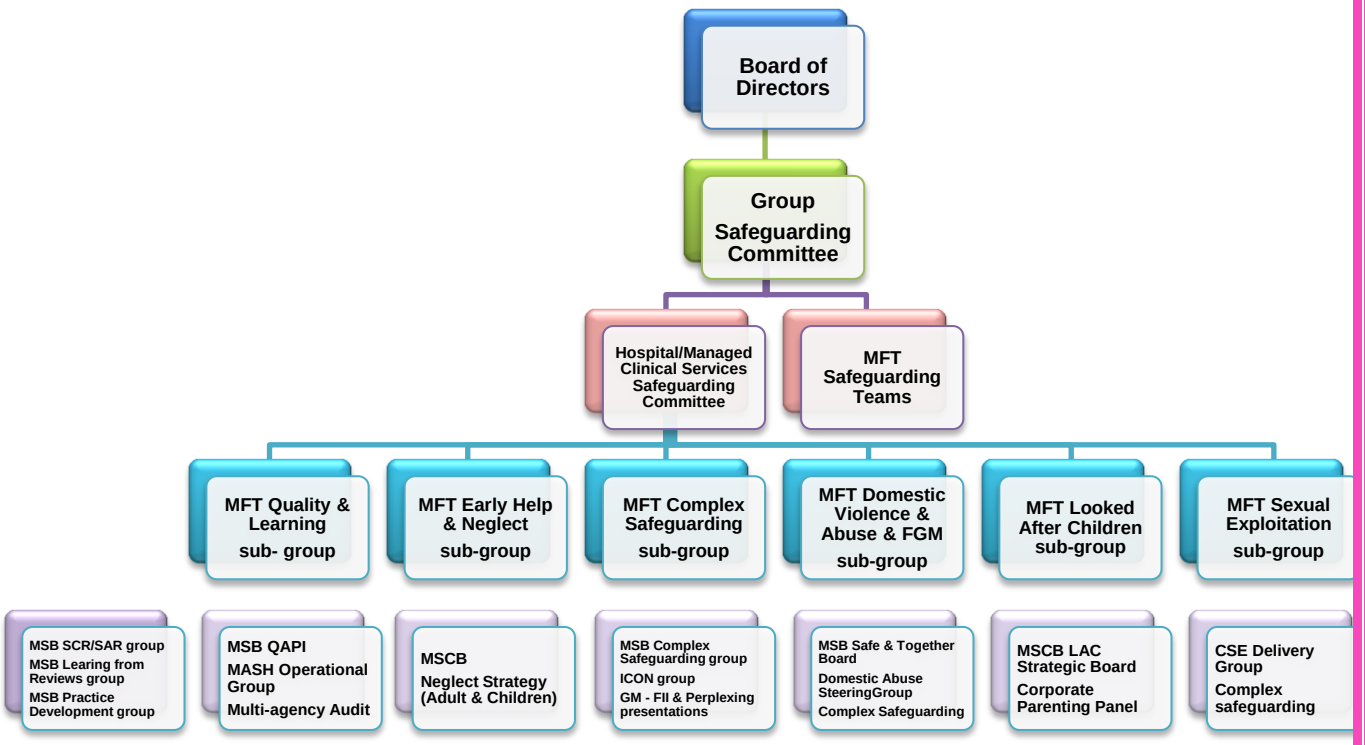
4.3 MFT has recognised the complexity of safeguarding and the importance of having robust governance arrangements in place, which incorporate both adults and children with a 'Think Family' approach.

4.4 Effective safeguarding communication and information sharing across MFT is essential to support Hospitals, Managed Clinical Services (MCS) and the MLCO in the Trust's Group structure, whilst aligning to both Manchester and Greater Manchester governance requirements.

4.5 In order to effectively address the breadth of safeguarding practice, the governance structure set out in **Figure 10** has been established. This ensures that there is a clear line of sight from multi-agency work-streams into Hospitals, Managed Clinical Services (MCS) and the MLCO.

4.6 The Safeguarding Committee sub-groups are chaired by a senior member of the safeguarding team and all Hospitals, MCS and the MLCO are represented. The sub-groups and the Hospital/MCS safeguarding committees are accountable to the Group Safeguarding Committee, which is chaired by the Chief Nurse and report, through the Trust's governance structure, to the MFT Board of Directors.

Figure 10: Safeguarding Governance Structure



4.7 The following section provides an overview of MFT Safeguarding Committee sub-group activity and work completed in these thematic work streams during 2018-19.

MFT Quality and Learning Sub-Group

4.8 The Safeguarding Quality and Learning sub group aims to ensure that national and local safeguarding messages influence policy, practice, training and learning in the Trust. The group also reviews the safeguarding assurance processes in the Trust

4.9 During this year the MFT Learning and Development group was combined with the Quality and Performance sub group in recognition of the cross cutting themes of these groups

4.10 The Quality and Learning group has the following work streams:

- Review of key messages for safeguarding practice from Manchester and Trafford Safeguarding Boards
- Review and implementation of Learning from Serious Case Reviews
- Review and development of Safeguarding Policies
- Learning from Audits and Reviews
- Review of Safeguarding Training
- Review and development of Hospitals/Manged Clinical Services (MCS)/Manchester Local Care Organisation (MLCO) safeguarding work plan.

4.11 **Key Achievements**

- ✓ The MFT Quality and Learning Group has established membership and attendance
- ✓ Messages from all published Serious Case Reviews and Safeguarding Adult Reviews have been shared with the group to share across Hospitals/MCS/MLCO
- ✓ Learning about how the messages from Serious Case Reviews are embedded into practice have been identified for example the establishment of the Obesity Steering group, Obesity pathways in school health and health visiting and development of Obesity Safeguarding Tool following the learning from Serious Case Review F1 a morbidly obese child where there were concerns around neglect.
- ✓ Safeguarding policies have been consulted upon and progressed through the group (including Domestic Abuse Policy, Child Sexual Exploitation Policy, Prevention Recognition and Safeguarding Women and Girls from FGM and Safeguarding Supervision Policy).
- ✓ Key messages from audits have been shared including Quality of risk assessments for Multi Agency Risk Assessment Conferences for Domestic Abuse, Voice of Young Person and Prevention of Missing and Absconded Patients.
- ✓ Sharing of Safeguarding Work Plans achievements has influenced practice developments across Hospitals/MCS/MLCO.

4.12 **Areas for development 2019-20**

- Compliance with mandatory safeguarding training remains below expected levels and is the key priority for safeguarding across the Trust.
- The volume of Serious Case Reviews and Safeguarding Adult Reviews the trust contributes to remains high (48 review scoping and full reviews last year) and impacts on the ability of the Trust to share learning effectively.

MFT Early Help and Neglect Sub-Group

4.13 Manchester Safeguarding Board's key priority is safeguarding children, young people and adults living in families from neglect and self-neglect. This year has seen the implementation of the Children's Neglect Strategy and the development of the Adult Safeguarding Self Neglect Strategy and Toolkit. MFT has contributed to the development of these strategies. Additionally the Trust has been involved in the Manchester Safeguarding Board Neglect and Self Neglect Audit.

4.14 Nationally, and locally in Manchester there is a drive to increase Early Help to provide services either at early age or at an early stage of concern to prevent risk and harm from Neglect. The MFT Early Help and Neglect subgroup now focuses on both children and adults, which reflects the 'think family approach'.

4.15 In Manchester an Early Help Assessment is completed when children and families have additional needs and require support from a multi-agency team around the child. This intervention is below the level of statutory social work intervention. In 2018-2019 3,164 Early Help Assessments were completed, with health services completing 784 Early Help Assessments according to Manchester Safeguarding Board Quality and Performance data.

4.16 The Trust's Early Help and Neglect subgroup leads and coordinates early help and neglect practice across the Trust.

4.17 **Key Achievements**

- ✓ The Early Help subgroup is established and has contribution from across the Hospitals, MLCO and Managed Clinical Services.
- ✓ Recognition that the range of services provided by MFT has differing knowledge, experience and contribution to Early Help activity. Early Help and Neglect work plan has been devised to assist in tracking progress, quality and impact.
- ✓ Improved links with Manchester City Council Early Help lead noting the benefit of the MFT Early Help work plan and advocated a similar plan be adopted by other multi-agency partners.
- ✓ Learning from the range of reviews (serious case reviews, adult reviews and learning reviews) as well as single or multi-agency audits has contributed to the promotion of Early Help work with the expectation that such examples is cascaded into representatives specialities.
- ✓ Strong contribution in the refreshed Neglect training package development and delivery both within MFT Safeguarding training as well as multiagency training.
- ✓ It was agreed at the MSCB in 2017-2018 following the development of the Neglect Strategy 2017-2019 that Manchester would initially undertake a pilot in the north of the city of the NSPCC Graded Care Profile 2 screening tool, which is used to assist in the identification and assessment of neglect. It was subsequently agreed that this tool should be adopted in Manchester. There has been a good contribution to the MSB Neglect Strategic Group and a training plan has been developed and delivered enabling MFT staff to be trained in the delivery of the Graded Care Profile 2 training.

4.18 **Areas for development 2019-2020**

- Evaluation of the effectiveness of the Graded Care Profile 2 training.
- Assess and report on the quality of the tool and review evidence of impact.
- Launch the Adult Hoarding and Self Neglect Strategy and associated tools.
- Increase train the trainer Graded Care Profile training within MFT.
- Review the training plan and promote the Graded Care Profile training within the acute hospital sites.

MFT Complex Safeguarding Sub-Group

4.19 The term "Complex Safeguarding" is used to describe criminal activity (often organised), or behaviour associated to criminality, involving vulnerable children/young people, adults who may/have care and support needs where there is exploitation and/or a clear or implied safeguarding concern.

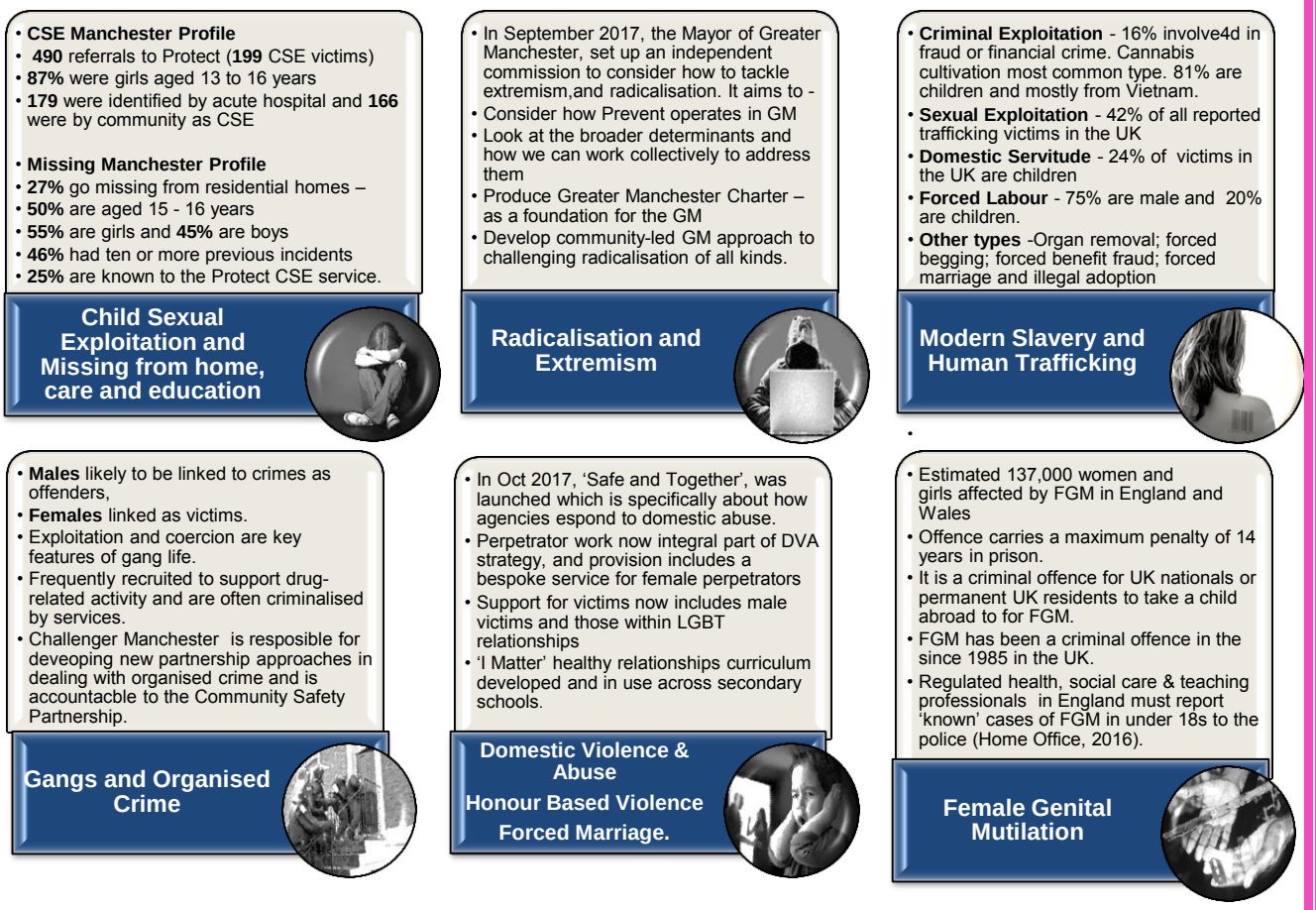
Types of exploitation include:

- Child/ Adult Sexual Exploitation
- Child /Adult Criminal Exploitation
- Modern Slavery/Trafficking
- Serious Organised Crime/Gangs/Threat to life
- Preventing Violent Extremism
- Honour based abuse/Forced Marriage
- Female Genital Mutilation (FGM)

4.20 Complex Safeguarding has been a key priority of the Manchester Children and Adults Safeguarding Boards this year and development of Manchester's response to this priority has been led through the Complex Safeguarding sub-group of both Manchester Safeguarding Boards. MFT is represented on the sub-group and has contributed to all aspects of Complex Safeguarding data collection and strategy development including the Modern Slavery and Human Trafficking Strategy, which was launched in April 2018.

4.21 There is increased complexity across both Adult and Children's Safeguarding services in managing cases and supporting health practitioners to identify complexities and escalate for support. Complex Safeguarding is a highly challenging and stressful part of safeguarding work. An overview of the complexities that are being experienced within the city, which inform the work of the Complex Safeguarding Sub-group is provided in **Figure 11**.

Figure 11: Overview of Complex Safeguarding



4.22 In October 2018 the Manchester Complex Safeguarding Hub went live. The hub is a multi-agency service that leads on safeguarding vulnerable children, young people and adults affected by complex safeguarding concerns. The functions of the multi-agency team are set out in **Figures 12 and 13.** MFT is represented in the Complex Safeguarding Hub by the Child Sexual Exploitation Specialist Nurse who provides health expertise.

Figure 12: Complex Safeguarding Hub (CSH) Functions

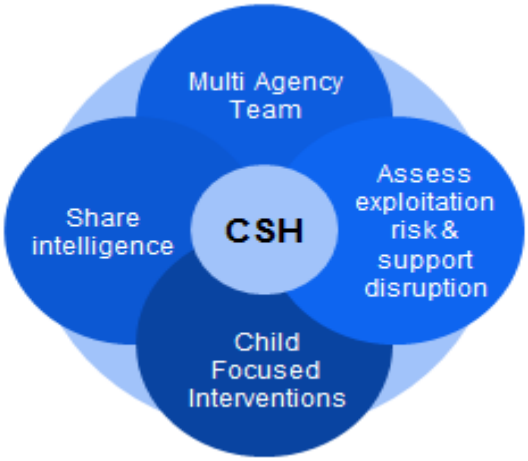
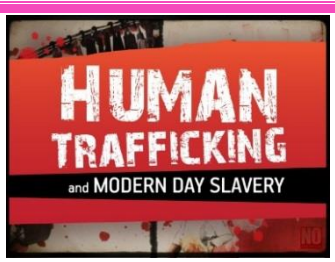


Figure 13: Complex Safeguarding Hub Multi-agency Compents

Strategic lead	**Xcallibre Police- Firearms & Gangs**	**Education**
Early Help Team parenting support	**Children Society MFH Team**	**Probation**
Missing from Home (MFH) Team and MFH Police	**Specialist** **CSE Nurse**	**Adult Social Worker**
Challenger Police- Organised Crime	**Social Work team**	**Trusted Relationships** **Child Psychology**
Youth Justice Officer	**Independent Child Trafficking Advocate (ICTA)**	**CSH Police**



Modern Slavery and Human Trafficking

4.23 The MFT Complex Safeguarding Sub-Group support the Trust's work on Modern Slavery and Human Trafficking. The Manchester Safeguarding Board Manchester Modern Slavery and Human Trafficking Strategy has been in place since April 2018. **Figure 14a** below provides further detail regarding what constitutes modern slavery and human trafficking and **Figure 14b** demonstrates the extent of this global issue.

Figure 14a: What is Modern Slavery/Human Trafficking?

What is Modern Slavery?

- **'Slavery'** is where ownership is exercised over a person
- **'Servitude'** involves the obligation to provide services imposed by coercion
- **'Forced or compulsory labour'** involves work or service extracted from any person under the menace of a penalty and for which the person has not offered himself voluntarily
- **'Human trafficking'** concerns arranging or facilitating the travel of another with a view to exploiting them.

Modern Slavery Act 2015

Figure 14b: Human Trafficking

Human Trafficking

- Recruitment, transportation, transfer, harbouring or receipt of persons.
- By means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person; (where a child is involved, the above means are irrelevant).
- For the purposes of exploitation, which includes (but is not exhaustive):
  - Prostitution
  - Other sexual exploitation
  - Forced labour
  - Slavery (or similar)
  - Servitude
  - Removal of organs

4.24 MFT actively participated in the development of the Manchester Safeguarding Board (MSB) 'Modern Slavery and Human Trafficking Strategy' in order to ensure that the roles and responsibilities of all front-line health staff were taken into account when creating support processes and pathways for professionals. MFT participation in the strategy development demonstrated the Trust's commitment to tackling the issue of modern slavery and the many forms including the trafficking of people, forced labour, servitude and slavery that the issue presents.

4.25 Through the internal MFT safeguarding governance structures, the launch of the MSB 'Manchester Modern Slavery and Human Trafficking Strategy' in April 2018 was cascaded to staff across all MFT hospital and community sites. Leading on from this the Trust's 'Complex Safeguarding Sub-group' is responsible for overseeing the sharing of key messages in relation to modern slavery and human trafficking and for ensuring that local policy and practice within the Trust is reflective of the principles and requirements of the strategy.

4.26 MFT has embedded modern slavery awareness-raising into mandatory Level 3 safeguarding children and adult training packages and all staff across the Trust have access on request to bespoke training provided by the MFT safeguarding team in respect of modern slavery and human trafficking.

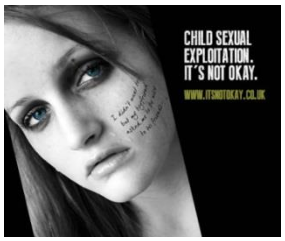
4.27 MFT has completed a revised Modern Slavery and Human Trafficking Statement which, will be published in the public domain in 2019-20.

4.28 **Key Achievements**

- ✓ The MFT Complex Safeguarding Subgroup commenced in August 2018 to ensure that policy, strategy and guidance in relation to the Safeguarding Board Complex Safeguarding Agenda is disseminated across the Trust and to ensure that complex safeguarding priorities are known, understood and embedded across MFT.
- ✓ There is MFT representation in the Multi Agency Complex Safeguarding Hub which went live in 2018 and a presentation on the work of the Hub was delivered to the Complex Safeguarding Subgroup in March 2019.
- ✓ There is MFT representation on the MSB Complex Safeguarding Subgroup and key information from this meeting is provided to the Group Safeguarding Committee and shared across the Trust via the MFT Complex Safeguarding Subgroup.
- ✓ Complex Safeguarding Cases are being identified and managed within MFT.

4.29 **Areas for development 2019-2020**

- Ongoing development of the Complex Safeguarding Agenda across MFT in response to emerging themes and priorities.
- Review of training needs.
- Development of adult Services within the Complex Safeguarding Hub.
- Continued involvement in the Complex Safeguarding Agenda to enable MFT staff to identify risk and appropriately respond to safeguard children and adults accessing MFT services.



MFT Sexual Exploitation Sub-Group

4.30 The Safeguarding Team has a Senior Specialist Children's Sexual Exploitation Nurse who is co-located within the Complex Safeguarding Hub. The nurse provides clinical expertise to children and young people where there are concerns around child sexual exploitation as well as advice and consultation to health and multi-agency professionals. A key role of the CSE Nurse is training and the CSE Nurse has trained 272 staff in 2018-2019.

4.31 The remit of the Sexual Exploitation Sub-group is to ensure that all practitioners understand their individual and corporate responsibility and accountability in regards to safeguarding adults and children from sexual exploitation. The group will develop and deliver the Hospital/MCS contribution to the Trust's annual safeguarding programme.

4.32 **Key Achievements**

- ✓ The Child Sexual Exploitation (CSE) subgroup has changed to the Sexual Exploitation subgroup to include adults in the agenda.
- ✓ A training plan has been developed and representatives have been responsible for promoting CSE training across the services during 2018-2019 and developing awareness of staff. CSE training has increased year on year since the subgroup was set up which has included bespoke training in some areas where CSE may be identified: Sexual Health, Adult Emergency Department, Paediatric Emergency Department, Child and Adolescent Mental Health Service (CAMHS), Midwifery and Gynaecology.
- ✓ Work has been undertaken to develop the CSE Risk Indicator Checklist (RIC) to include all forms of exploitation.
- ✓ The CSE trust policy guidance has been updated.
- ✓ Good representation from across the Trust and representatives are fully engaged in wanting to improve the outcomes for children and adults at risk of sexual exploitation.
- ✓ Development of the new Trust subgroups has enhanced the representation.
- ✓ At the beginning of each meeting there is a child/young person or adult sexual exploitation story which has increased the understanding of the representatives.
- ✓ The sub group enables up to date information to be disseminated across MFT and intelligence is regularly shared about local themes and hotspots.
- ✓ Representatives provided with updates in relation to the Complex Safeguarding Hub.
- ✓ The work of the subgroup linked in with the multi-agency SE subgroup and Trust and MSCB Complex Safeguarding Subgroups.

4.33 **Areas for development 2019-20**

- Pilot the updated child exploitation Risk Indicator Checklist (RIC) and promote the tool across the Trust.
- Consideration around transferability of RIC to adults.
- Need to develop the adult agenda and understanding.
- Develop Adult pathways and pay particular attention to transition from child to adult.

MFT Domestic Violence and Abuse and Female Genital Mutilation Sub-Group

4.34 Statistics on domestic violence and abuse indicate a significantly high prevalence across the city of Manchester.

- From September 2015 to September 2017: **10,525** crimes of domestic abuse were recorded by the police;
- In 2016-2017 MCC children's services received **5,312** contacts where there were safeguarding children concerns where domestic violence and abuse was a key issue;
- In 2018- 2019 there were **1,680** high risk victims of domestic abuse cases identified.

4.35 MFT has a training programme and multi-agency guidance to enable frontline professionals to be trained in the role and responsibilities in recognition, risk assessment and referrals to enable victims of domestic abuse to be safeguarded.

Multi-Agency Domestic Abuse Risk Assessment Conferences (MARAC)

4.36 Multi-Agency Domestic Abuse Risk Assessment Conferences (MARAC) are held throughout the country to enable multi-agency partners to risk assess and develop safety plans to protect high risk victims of domestic abuse. Referrals are completed for MARAC where there are concerns that a person (service user or staff member) is at high risk of harm or homicide from domestic abuse. The number of referrals to MARAC continues to increase this year reflecting increased awareness and recognition from staff of indicators of domestic abuse. This suggests that the work of the Domestic Violence and Abuse sub-group and refreshed Domestic Violence and Abuse training programme and plan have positively influenced practice.

4.37 **Figure 15a** below identifies the number of MARAC referrals completed by MFT staff to Manchester MARACs for service users living in Manchester. If the service user lives out of Manchester a referral is sent to the MARAC of the relevant local authority. **Figure 15b,** shows the increased number of referrals to MARAC in Manchester, demonstrating an increase in recognition and response. **Figure 15c** shows the staff groups making MARAC referrals. Currently MFT's safeguarding team attends 5 Manchester and 2 Trafford MARAC meetings each month to contribute to risk assessment and safety planning of high risk victims. In 2019-2020 MFT will contribute to multi-agency work through Manchester Safeguarding Board to review effective ways of working to respond to the high volume of MARAC referrals and to consider alternatives to current bimonthly meetings in the localities.

Figure 15a: MARAC referrals by MFT staff

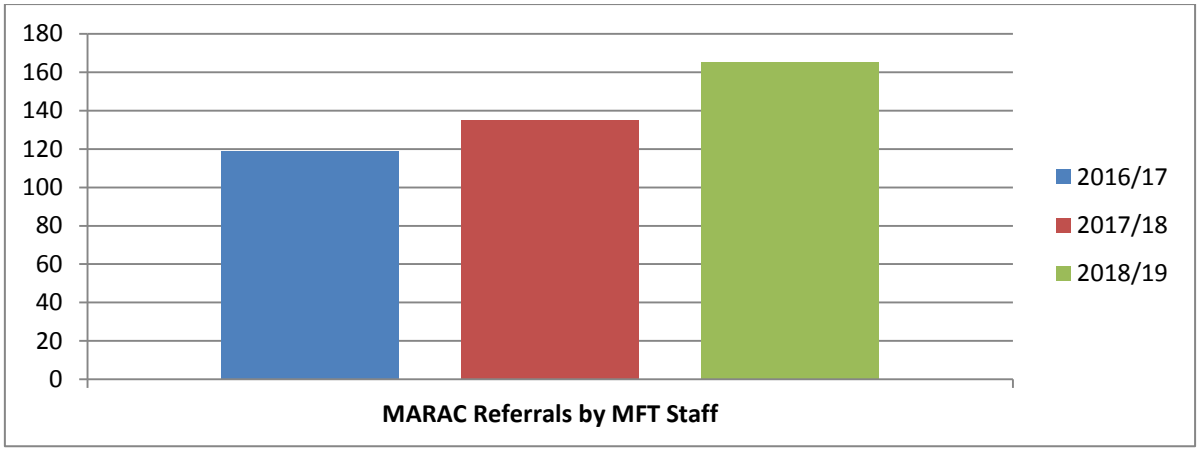


Figure 15b: Total Number of Referrals to MARAC

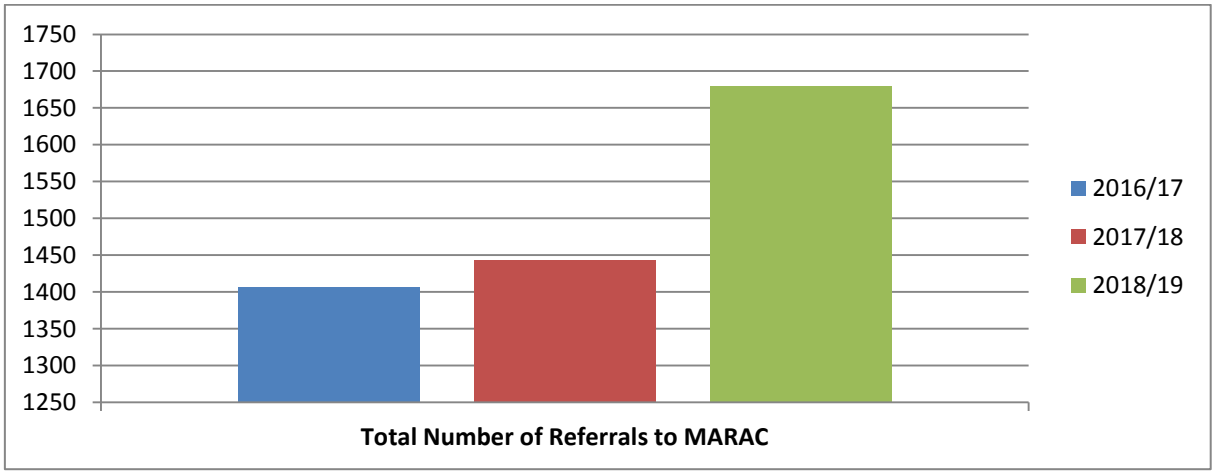
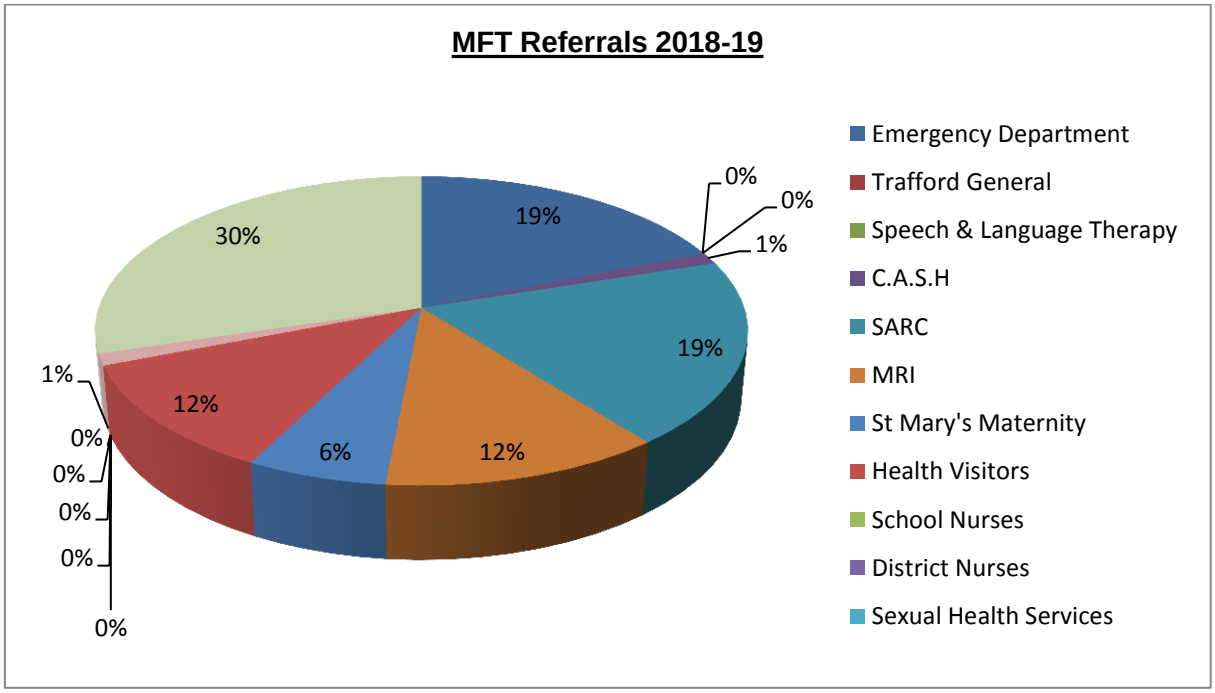


Figure 15c: MARAC referrals by staff groups



4.38 The majority of the MFT MARAC referrals are completed by health professionals in Emergency Departments, Sexual Assault Referral centre and community settings. This reflects the key priority areas identified in NICE Domestic Violence and abuse guidance[9] where victims of domestic abuse are most likely to present.

4.39 The Domestic Violence and Abuse and Female Genital Mutilation subgroup review the work plans for this agenda across the Trust. The group has Trust-wide representation and membership from partner agencies who deliver services across the Trust's sites to victims of domestic violence and abuse and FGM including:

- Independent Domestic Violence and Abuse Advocates (IDVA).
- Manchester Women's Aid.
- NESTAC (New Step for African Community) FGM service.

4.40 **Key Achievements**

- ✓ A Domestic Violence and Abuse (DV&A) and Female Genital Mutilation (FGM) group was established approximately four years ago in the former CMFT and has been reviewed and extended across MFT.
- ✓ This group is now established as a sub-group, has consistent membership and receives reports from clinical areas on how MFT services are responding locally to DV&A and FGM.
- ✓ The group has continued to meet quarterly and has led on the Trust's response to DV&A and FGM. The work plan ensures that national and local learning, policy and practice are reviewed and developed to influence frontline practice across the Trust.
- ✓ Key messages from the following local strategic groups, to which MFT actively contribute, are shared across the MFT Group via the sub-group:
  - Manchester Domestic Abuse Forum
  - Manchester and Greater Manchester FGM Forum
  - Manchester IRIS steering group (Identification and Referral to Improve Safety)
  - Manchester Safe and Together Board
- ✓ Messages from Domestic Homicide Reviews and Serious Case Reviews around DV&A shared
- ✓ Trust wide DVA and FGM policy have been reviewed.
- ✓ The DVA training programme has been reviewed and an ongoing training plan is in place identifying priority groups for training.

4.41 **Areas for development 2019-20**

- In response to a Trust wide audit of referrals to MARAC, the group will focus in improvement in the quality of MARAC referrals to enable effective response to victims.
- The Trust wide policy for staff affected by domestic abuse will be reviewed and updated.

[9] Overview | Domestic violence and abuse | Quality standards | NICE https://www.nice.org.uk/guidance/qs116

4.42 This year the partnership working between MFT and New Steps for African Community (NESTAC) to enable a holistic response to women and girls affected by, or at risk of, FGM was celebrated through a presentation at the MFT Nursing and Midwifery Conference in October 2018. A poster was subsequently developed (**Figure 16)** and was displayed at the Manchester National FGM Conference in December 2018.

Figure 16: MFT and NESTAC partnership working around FGM poster

Looked After Children (LAC) in Manchester "Our Children" Sub-Group

4.43 In Manchester the children and young people cared for by the local authority have been asked to be known as "Our Children" in recognition of Manchester's corporate parenting responsibilities of this cohort of children and young people. *Manchester's Promise to Our Children (Looked after Children) and Care Leavers says:*

"we will care for you and support you to stay healthy and make sure you get good health care when you need it (including physical, mental and sexual health)"

4.44 The MFT "Our Children" safeguarding subgroup has been established this year and is reviewing the response to looked after children across the Trust. The achievements and plans for development of this group going forward are highlighted below.

4.45 **Key Achievements**

- ✓ Our Children matter to MFT and are a priority. One way we have demonstrated how important 'Our Children' are and how we have respected the use of the new

words, is to name a newly established subgroup, specifically for the 'Looked after Children's agenda' as 'Our Children's 'Subgroup.

- ✓ The Subgroup for 'Our Children' is newly formed and the initial meetings were well attended, engaging and meaningful. Development of the sub-group, with membership from the services that Our Children access will support the Trust to focus on issues that matter to Our Children whilst driving compliance with statutory guidance.

4.46 **Areas for development 2019-20**

- Trust wide audit to benchmark staff awareness of LAC requirements in practice.
- Develop a work plan for the subgroup.
- Develop dashboard for the subgroup to present in a meaningful way the key performance outcomes for our children and the quality assurance outcomes of statutory health assessments completed by MFT practitioners.
- Development of the Our Children sub-group, with membership from the services that Our Children access will support the Trust to focus on issues that matter to Our Children whilst driving compliance with statutory guidance.
- Assurance that healthcare staff who come into contact with 'Our Children' have, as a minimum, an insight and know who to contact should they need further advice, support and guidance.
- Development of the training framework for our workforce in line with the Looked after Children: Knowledge, skills and competences of health care staff- Intercollegiate Role Framework (March 2015).
- Demonstration that we have sought the views of our children on what needs to be done to improve services they use.

SECTION D

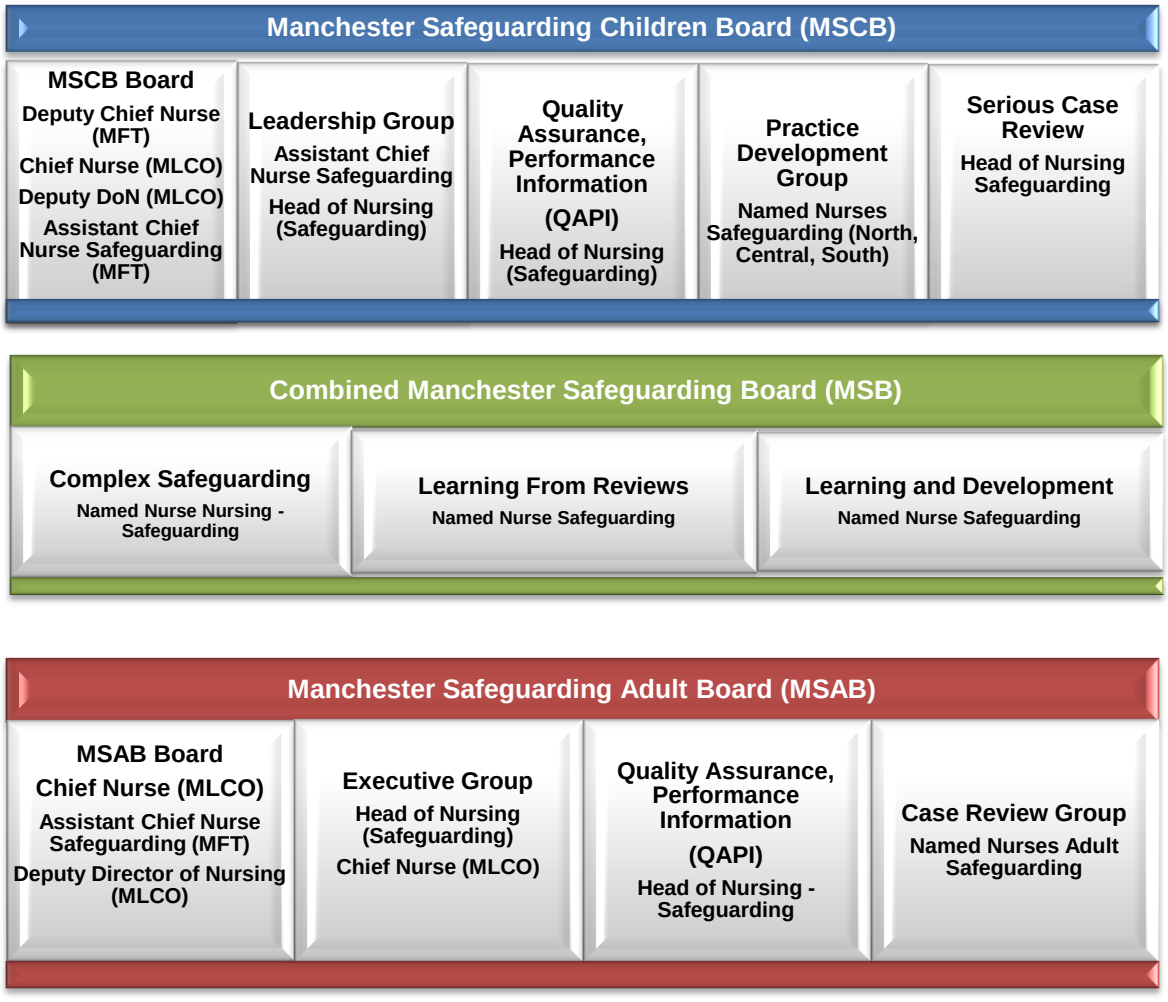
Partnership working

5. Partnership Working

MFT Contribution to Manchester Children and Adults Local Safeguarding Boards (MSAB) (MSCB)

5.1 MFT is fully committed to multi-agency working for both adult and child safeguarding. MFT staff play an active role in Local Safeguarding Board activity at all levels and contribute to the wider work of the Boards in ensuring feedback from multi-agency sub-groups and lessons from Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR) are embedded into practice. **Figure 17**, below outlines the commitment of MFT to the MSCB and MSAB.

Figure 17: MFT/MLCO Representation on the MSCB and MSAB



5.2 The implementation of Working Together to Safeguard Children (2018)[10] policy guidelines has informed the new Multi-Agency Safeguarding Arrangements (MASA) in Manchester. The MASA is to be published in June 2019 and implemented by September 2019. MFT will review and ensure safeguarding health contribution is clear within the new arrangements

MFT Progress against Manchester Safeguarding Board Priorities and Strategic Objectives 2018-2019

5.3 In the 2017-2018 Safeguarding Annual Report, the Trust committed to ensuring that the strategic objectives of the Manchester Safeguarding Adults and Children's Boards (MSAB and MSCB) were clearly embedded in the safeguarding agenda across MFT. **Figure18** below provides information on how this was achieved in 2018-2019.

[10] Working Together to Safeguard Children (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Figure 18: MFT Achievements against Manchester Safeguarding Board Objectives

MSCB | MSAB	2017-2018 What we achieved
Engagement and Involvement - Listening & learning; hearing the voice of children, young people and adults	• *The voice of the child and adult at risk is embedded in all Hospital/MCS/MLCO work plan.* • *A voice of the child audit was completed with 16 to 17 years in Wythenshawe Hospital with positive outcomes.* • *Patient Stories have been included in Safeguarding subgroups to hear messages from our service users.*
Complex Safeguarding - Domestic Violence & Abuse (DV&A), Female Genital Mutilation (FGM), Sexual Exploitation, Radicalisation, Organised Crime, Trafficking & Modern Slavery, So-called Honour Based Violence	• *The Safeguarding Board Complex Safeguarding subgroup is attended by Named Nurse Safeguarding Children who chairs the Trust wide Complex Safeguarding group.* • *The multi-agency DV&A Forum is attended by Named Nurse Safeguarding Children who chairs the Trust wide DVA Safeguarding group.* • *The Safeguarding Board Sexual Exploitation subgroup is attended by Named Nurse Safeguarding Children who chairs the Trust wide Sexual Exploitation group.* • *CSE, DVA and FGM Policies have been reviewed.* • *Bespoke training courses provided in DVA, CSE and Modern Slavery.*
Transitions - Moving from child to adulthood in a safe and positive way	• *Our Children/Looked After Children team have developed health passport for Care Leavers.* • *Think Family approach to embedded in safeguarding work plans.*
Neglect - Adults at risk of self-neglect, wilful neglect or neglect by omission are safeguarded and supported	• *Early Help and Neglect subgroup has reviewed implementation of Neglect strategy.* • *Safeguarding team have been trained in the Graded Care Profile 2 (Manchester's neglect risk assessment tool) and have developed training to roll out training to MFT staff.* • *Named Nurse Safeguarding Adults has led on the development of the multi-agency Self Neglect Strategy and tool.* • *MFT have contributed to Safeguarding Board neglect audits.*

MFT contribution to the Multi-agency Safeguarding Hub (MASH)

Children's MASH

5.4 The Children's MASH was established in 2014-2015 and has developed and evolved over the past 4 years. MFT has a specialist health visitor working in the MASH and a safeguarding administration post. Additionally, the Community Named Nurses continue to have oversight of MASH health activity and provide management and leadership to health practitioner in the MASH.

5.5 The MASH health team coordinate the health contribution to safeguarding children enquiries and decision making at the children's services "Front Door".

5.6 A Monthly MASH Health Dashboard has been developed to provide analysis of work undertaken and identification of improvements. To support development, the MFT Named Nurses are involved with regular multi-agency audits to look at the quality of referrals and ensure that they are reaching the correct threshold for MASH. In addition, the Community Safeguarding Team quality assures community referrals into the MASH. This process has demonstrated that referrals are of a high quality.

5.7 In 2019 the Central MASH will be relocated into North, Central and South localities. The new Locality MASHs will be co-located with Early Help and Children's Services Locality Teams. In 2019-2020 the MFT Safeguarding Team in collaboration with MLCO Children's Community Services will continue to review and evolve health partnership working to the 3 MASHs.

5.8 MFT and the MLCO are represented in MASH Operational and Strategic partnership boards to review the health contribution to MASH.

5.9 In March 2019 Children's Services introduced a new telephone referral process to refer to children and young people to Social Care following a MSCB-commissioned review of the MASH Front Door arrangements. MFT has worked in partnership with MCC Children's Services to ensure health professionals effectively and safely continue to complete referrals to children's social care. The impact of these changes will be reviewed by the MFT Safeguarding Team in 2019-2020.

Adult MASH

5.10 In 2017-2018 the Adult MASH was established with a commissioned health team from the Clinical Commissioning Group (CCG). The Adult MASH is co-located with the Children's MASH and currently exploring how to both improve working together to share relevant information and prevent duplication when the Children's MASH moves to the localities and the Adult MASH remains centrally located.

5.11 There are 2 MFT seconded clinical staff in the adult MASH as well as Manchester City Council Health Researcher posts. The health roles in Adult MASH are commissioned by the CCG and operationally managed by Manchester City Council (MCC). The clinical staff are professionally accountable to MFT reporting to the Head of Nursing (Safeguarding).

5.12 MFT Adult Safeguarding Team work closely with the MASH to ensure appropriate information sharing and good working relationships are in place.

Serious Case Reviews (SCR), Safeguarding Adult Reviews (SAR), Domestic Homicide Reviews (DHR)

5.13 SCR SAR and DHR are commissioned through multi-agency partnership arrangements in accordance with statutory guidance following a death or serious significant harm of a person through abuse, neglect or domestic homicide where there is concern that agencies have not worked together to protect the victim. The purpose of the review is to learn lessons from the review to improve multi-agency practice to safeguard children, young people, adults at risk and their families

5.14 2018-2019 has been again another busy year in terms of SCR/SAR/DHR activity. MFT has contributed to the range of methodologies used to undertaken reviews both in Manchester and out of area (**Figures 19a, 19b and 19c** below).

Figure 19a: SR/SAR/DHR Contribution by the Safeguarding Team in 2018-2019

2018/19	Q1	Q2	Q3	Q4	Total to date
Serious Case Reviews (child)	1	5	4	9	19
Safeguarding Adult Reviews	6	7	8	8	29
Domestic Homicide Reviews	0	0	0	0	0

Figure 19b: SCR/SAR/DHR Contribution by the Safeguarding Team in 2018-2019

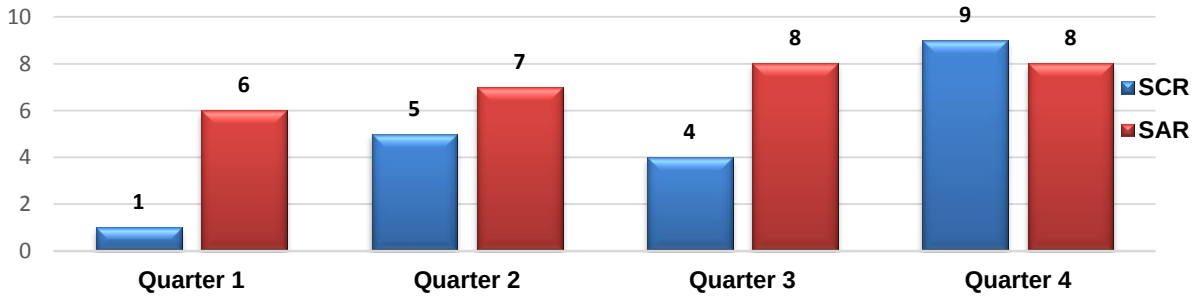
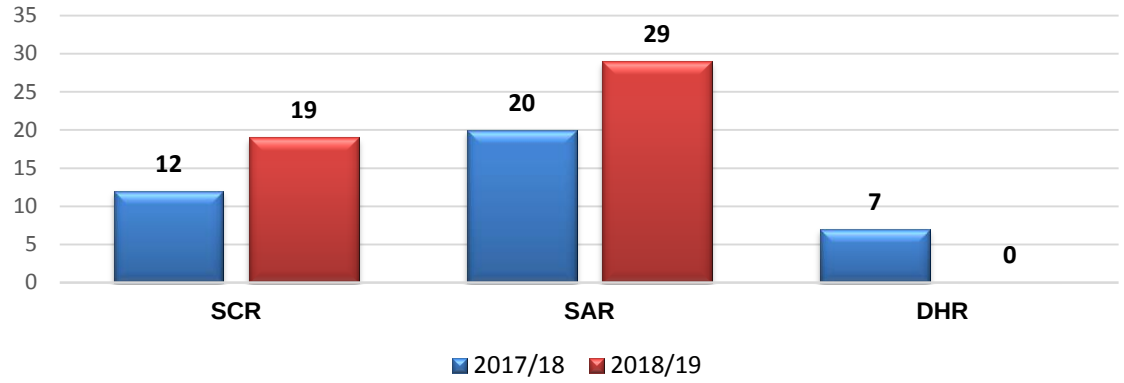


Figure 19c: Comparison with 2017/18



5.15 Data received from Manchester Serious Case Review Subgroup in April 2019 identified that at the end of 2018-2019 Quarter 4 there were;

- 8 serious case reviews ongoing
- 2 learning reviews ongoing
- 3 out of area serious case reviews involving Manchester services
- 8 Safeguarding Adult Reviews

5.16 In 2018-19 there were 5 published Serious Case Reviews, 1 published Safeguarding Adult Review and four Domestic Homicide Reviews

Analysis of SCR, SAR and DHR data

5.17 MFT provides tertiary services for both Children and Adults and therefore the Safeguarding Teams are involved in SCRs, SARs and DHRs both within and outside the Manchester area.

5.18 Named Nurses from across the Safeguarding Teams represent MFT on review panels. MFT's Named Nurses lead on ensuring key messages and lessons from reviews are shared across the Trust through safeguarding training, safeguarding newsletter, briefings to safeguarding governance groups and specific hospital/ MCS/MLCO action plans.

5.19 For each serious case review, a Trust action plan is developed to ensure the learning is embedded in the organisation. The themes from the reviews are collated through the Quality and Learning sub group to ensure learning is shared with Frontline practice.

5.20 Key messages from Serious Case Reviews this year include the vulnerability of babies, the importance of a clear escalation process for practitioners to follow when their safeguarding concerns are not heard, the importance of sharing information across agencies, hearing and listening to the voice of the child and review and analysis of when obesity is a safeguarding concern.

5.21 Learning from Serious Case Reviews had enabled developments in frontline practice for example the development of the Safeguarding Analysis Tool in the Context of Obesity in Children's Community Services following Serious Case Review F1 involving a child who died from cardiac failure whose treatment options were limited due to morbid obesity in the context of parental neglect.

5.22 Learning from Domestic Homicide Reviews is reviewed by the Trust Domestic Violence and Abuse group. Key messages include the importance of health professional who may be a key multi agency partner to recognise and respond to domestic abuse, importance of risk assessment and raising awareness of domestic abuse through training.

5.23 Learning from Safeguarding Adult Reviews include the importance of professional curiosity, consideration, assessment and documentation of capacity and importance of completing a safeguarding referral.

5.24 There has been an increase in the contribution of MFT to Serious Case Reviews and Safeguarding Adult Reviews this year however there have been no new requests for information for Domestic Homicide Reviews.

5.25 A key message from adults and children's reviews is hearing and listening to the voice of the child/vulnerable person. This has been embedded in safeguarding work plans across the Trust.

SECTION E

Safeguarding Activity and Performance

6. MFT Safeguarding Activity and Performance from 1st April 2018 to 31st March 2019

6.1 This section of the report provides an overview of MFT all safeguarding activity and performance from 1st April 2018 to 31st March 2019. The report provides assurance that MFT fulfilled its statutory and regulatory requirements for safeguarding children and adults as outlined in the Children Act 1989 and 2004 and the Care Act 2014, and CQC Regulation 13.

6.2 MFT Safeguarding Services is comprised of the following teams:

- Acute Children's Safeguarding
- Acute Adult Safeguarding
- Maternity Safeguarding Services
- Community Safeguarding Children and Looked After Children teams providing citywide safeguarding services.

6.3 The services are based on the Oxford Road Campus, Wythenshawe, Trafford, Withington and Altrincham site and in the community at Rusholme Health Centre. Although they are centrally based, the teams work throughout the hospitals/MCS/MLCO and aim to be visible and accessible to all Trust services.

6.4 Following on from the establishment of MFT in 2017, there has been considerable activity in 2018-2019 to merge children and adults safeguarding policies and to ensure statutory and legal requirements are aligned across the new Trust.

6.5 A Post Transaction Implementation Plan (PTIP) was devised and delivered to support a programme of work to align all underpinning safeguarding additional policies and procedures. A new senior structure was developed and implemented to lead safeguarding not only across MFT and the MLCO but across the partnership and provide focussed strategic working partnerships and planning for future safeguarding developments across the city, informed by commissioning plans.

6.6 2018-19 has seen completion of the safeguarding PTIP, development of Trust wide safeguarding work plans, assurance processes, data collection, training and audit.

6.7 There has been progress in ensuring consistent ways of working across the safeguarding service. In 2019-20 further work will be completed to ensure consistency in safeguarding activity across the Trust. This will require the support of the Informatics Service to align IT systems.

Safeguarding Referrals for Adults and Children

6.8 Safeguarding referrals/notifications relate to cases that have been notified to the Safeguarding Teams and for which the Teams have provided advice and case management support to practitioners. A small proportion of these cases will be referred to Local Authority Children's or Adult services. The role of the MFT

Safeguarding Team is to support practitioners in decision making to ensure that each referral to child or adult protection is at the correct threshold for statutory intervention.

6.9 **Figure 20** (below) provides a breakdown of referrals across the Safeguarding Teams for 2018-19.

6.10 Collectively during this reporting period MFT Safeguarding teams dealt with **23,162** referrals for children and adults with varying levels of need who were at risk of, or there were concerns that vulnerable people were suffering abuse and/or neglect.

Figure 20: MFT Quarter 1 and 2 Safeguarding Referrals to each Safeguarding Team

MFT Safeguarding Team	Number of referrals by site			Top 3 categories of referral
	Oxford Road Campus	Wythenshawe, Trafford, Withington and Altrincham	TOTAL	
Children's Acute Safeguarding	**2,456**	**1,856**	**4,312**	• Neglect • Sexual Abuse • Child and Young Person mental health including self-harm
Adult Safeguarding team	**2,464**	**1,990**	**4,454**	• Neglect including self-neglect • Domestic Abuse • Physical Abuse
Maternity Team	**6,395**	**738**	**7,133**	• Mental Health • Domestic Abuse • FGM
Children's Community Safeguarding	**7,263**			• Mental Health • Domestic Abuse • Neglect
Combined Total			**23,162**	

6.11 Detailed analysis of the referral data is provided later in this report in the context of the activity of each MFT Safeguarding Team.

MFT Contribution to Child Protection Plans

6.12 When children are identified as being at risk of, or suffering significant harm from, abuse and neglect health professionals contribute to the multi-agency child protection planning process. At the end of 2018-2019 Manchester Local Authority identified that **798** children were subject to child protection plans in Manchester. The safeguarding team support the health professionals to safeguard these children and effectively contribute to child protection planning.

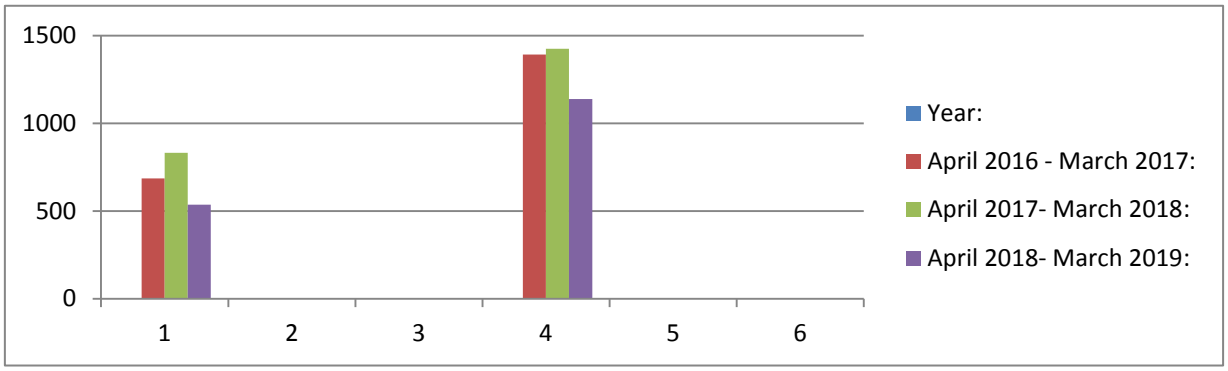
6.13 **Figures 21a and 21b** show the numbers of families where MFT health professionals were invited to attend case conferences to ascertain if the children were subject to significant harm and required child protection planning. Unlike the

national data identified in Section B where numbers of children and young people subject to child protection planning is increasing, in Manchester the number of children subject to initial case conferences decreased this year. This is in response to considerable work across the partnership to strengthen the Early Help and Child in Need process

Figure 21a Initial Child Protection Conferences Invitations Manchester 2018-2019

Year:	ICPC Invitations received:	Total Number of Children:
April 2016 - March 2017	685	1,391
April 2017- March 2018	832	1,424
April 2018- March 2019	537	1,138

Figure 21b Initial Child Protection Conferences Invitations Manchester 2016-2019



6.14 The data in the **Figure 21c** shows the number of children added or removed from a child protection plan. Children are removed from child protection plans when the risk of harm is no longer significantly impacting on their wellbeing.

Figure 21c Child Protection Conference Decisions:

Year:	Children added on Child Protection Plans:	Children Removed from Child Protection Plans:
April 2017- March 2018	1,163	1,110
April 2018- March 2019	938	1,103

6.15 It is important to note that this data applies to Manchester children and MFT services are also provided across Greater Manchester and the North West and staff contribute to child protection process for children living outside of Manchester.

Community Children's Safeguarding Activity

The top 5 areas for referral in the Community are:

- Domestic violence and abuse
- Neglect
- Emotional abuse
- Parental and child Mental Health
- Parental and child Substance misuse

6.16 The community safeguarding children team provide a citywide safeguarding service to all children's community staff. Support for the community children's workforce is vitally important as Health Visitors and School Nurses hold and manage child protection caseloads.

6.17 The complexity of safeguarding is changing with a shift to complex safeguarding, which incorporates domestic violence and abuse and Child Sexual Exploitation (CSE). This year, as can be seen in **Figures 22a to 22d** below, notifications include categories such as child criminal activity (child at risk of criminal exploitation), FGM, Forced Marriage and so called Honour Based Violence and radicalisation, all of which pose significant challenges to both the safeguarding team and clinical staff in terms of developing and maintaining skills to support recognition and response.

Figure 22a: Community children's safeguarding notifications 2018-2019 by category

Safeguarding Categories	Number of notifications
Physical	263
Sexual	182
Emotional	437
Neglect (including parenting)	1,824
FGM	32
CSE	238
FII/Perplexing presentation	77
Domestic Violence & Abuse	739
Adult/Child Mental Health	767
Adult (and child) substance misuse	422
Trafficking/Modern Slavery	0
Criminality	138
Missed appointments	231
Child Mental health (Inc. self-harm)	142
Allegations against staff	8
Radicalisation	8
Looked After Child	122
Other	1,633
External Agency Referral	0
Total	**7,263**

Figure 22b: Children's Community Safeguarding referrals by category 2017-2019

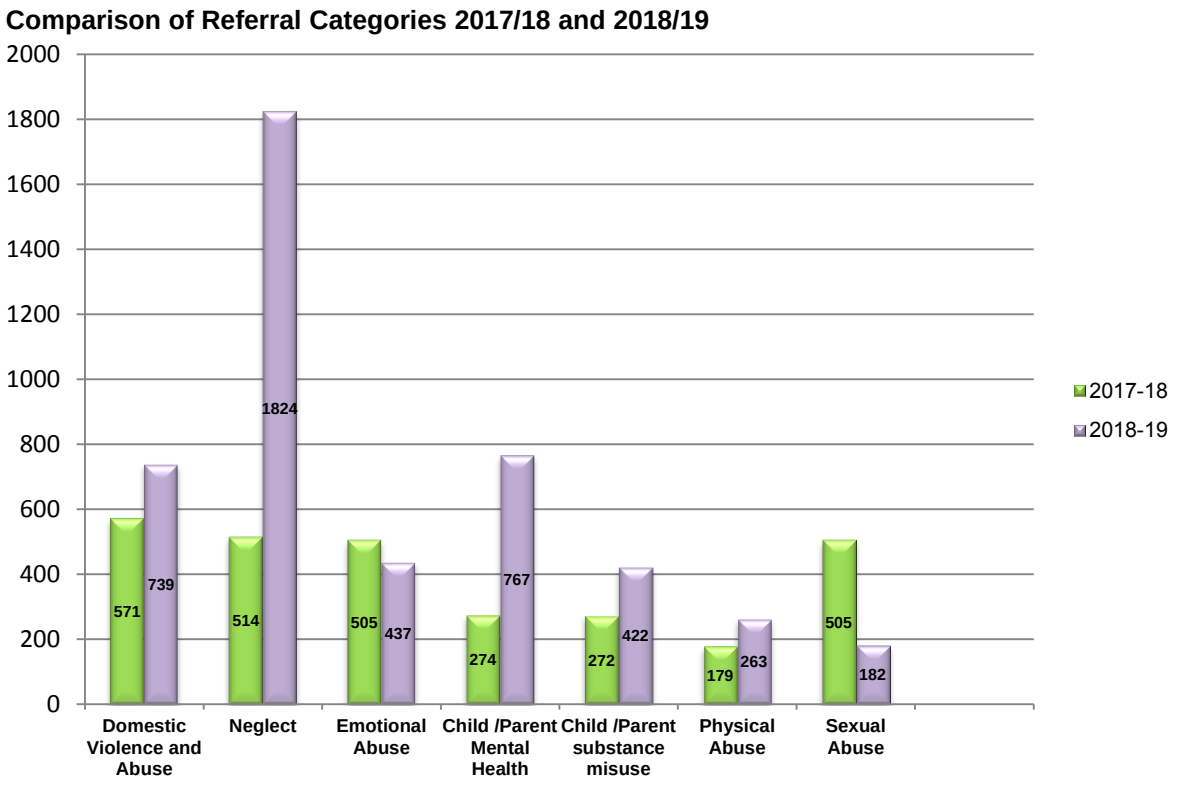


Figure 22c: 2017-18 and 2018-19 Comparison of Referral Categories

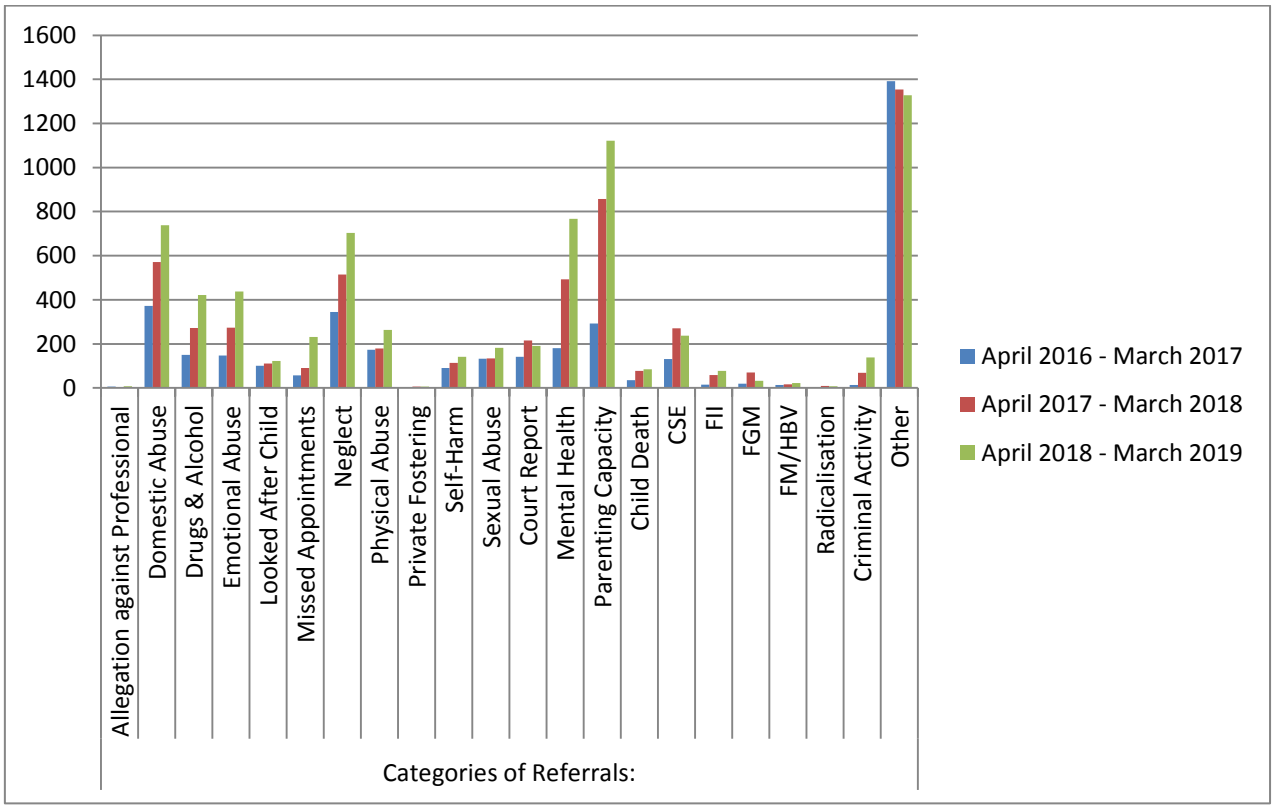


Figure 22d: MFT safeguarding notifications - 3 year comparison

Year	Number of Notifications
April 2016 - March 2017	2,974
April 2017- March 2018	3,449
April 2018- March 2019	3,992

6.18 The data above shows an increase in all categories of referral in 2018-19 compared to 2017-18 with the exception of emotional abuse and sexual abuse. This data reflects the increased activity in 2018-19. This picture aligns with national messages that neglect is the most common cause of safeguarding concern in children and young people in this country.

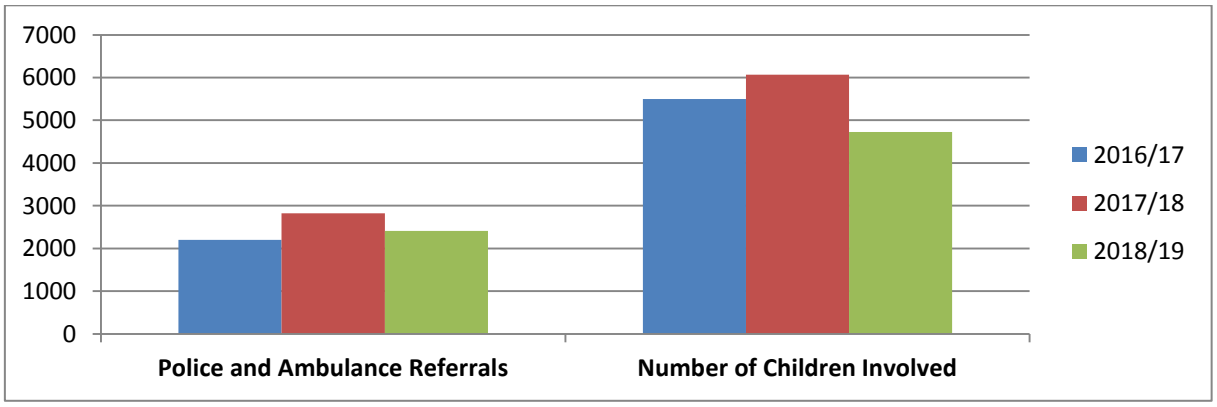
Police and Ambulance Safeguarding Referrals

6.19 The Citywide Community Safeguarding Children Team process safeguarding referrals from police and ambulance services, ensuring that this information is disseminated to frontline health visitors and school nurses. Many of the referrals from the police are cases where the police have been called to a domestic abuse incident. Some of these incidents will be categorised by the police as low level and will not require a referral to MARAC, however, the police always notify community health services to ensure the child's health needs are being met. This also allows the health practitioner to build a chronology around a child's daily lived experience.

Figure 23a: Police and Ambulance Referral to MFT Safeguarding Services Data

Year	Police & Ambulance Referrals:	Total number of children involved:
April 2016 - March 2017	2,202	5,498
April 2017- March 2018	2,820	6,068
April 2018- March 2019	2,413	4,725

Figure 23b: Police and Ambulance Referrals to MFT Safeguarding Services



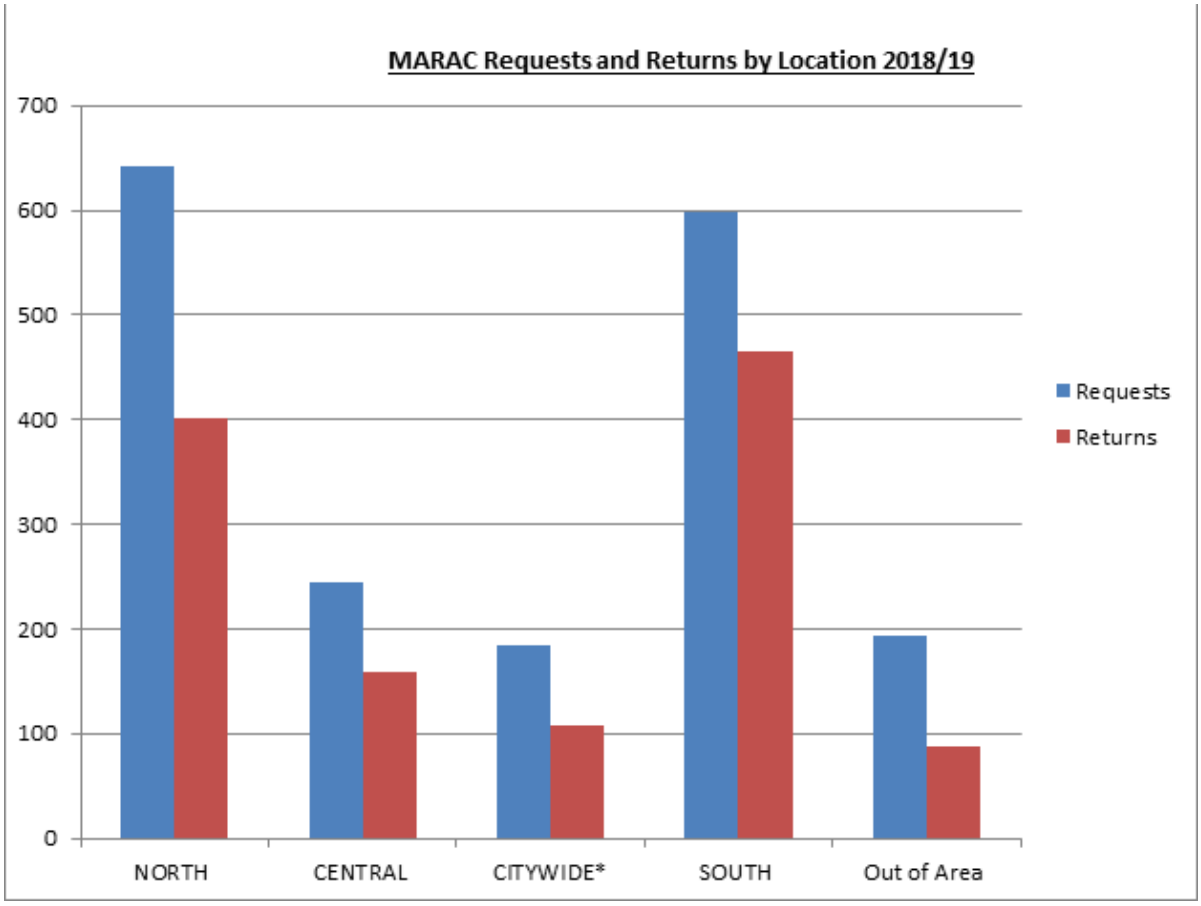
Community MARAC activity

6.20 The Trust makes a significant contribution to the Manchester MARAC process and good quality referrals are essential in line with the Trust's safeguarding policies, guidance, practice and training. The Community Safeguarding Team contribute to MARAC through facilitating information sharing, risk assessment and safety planning information from community health staff to and from MARAC.

6.21 In 2018-2019 there were 1,680 referrals to Manchester MARAC involving 1,742 children. Information was shared with the community caseload holders (health visitors and school nurses) for all these children and information shared to MARAC from community in 1,158 cases.

6.22 The community safeguarding team and MLCO community services are working to promote the information sharing at MARAC. **Figure 24** shows the volume of requests and returns for MARAC information sharing and illustrates the significant numbers of children in living households where there is high risk of harm from domestic violence and abuse. The MARAC information sharing process enables information sharing for community health professionals and safeguarding team to inform their decision making and actions to safeguard these children and young people.

Figure 24: MARAC health information sharing



Referrals from North Manchester General Hospital

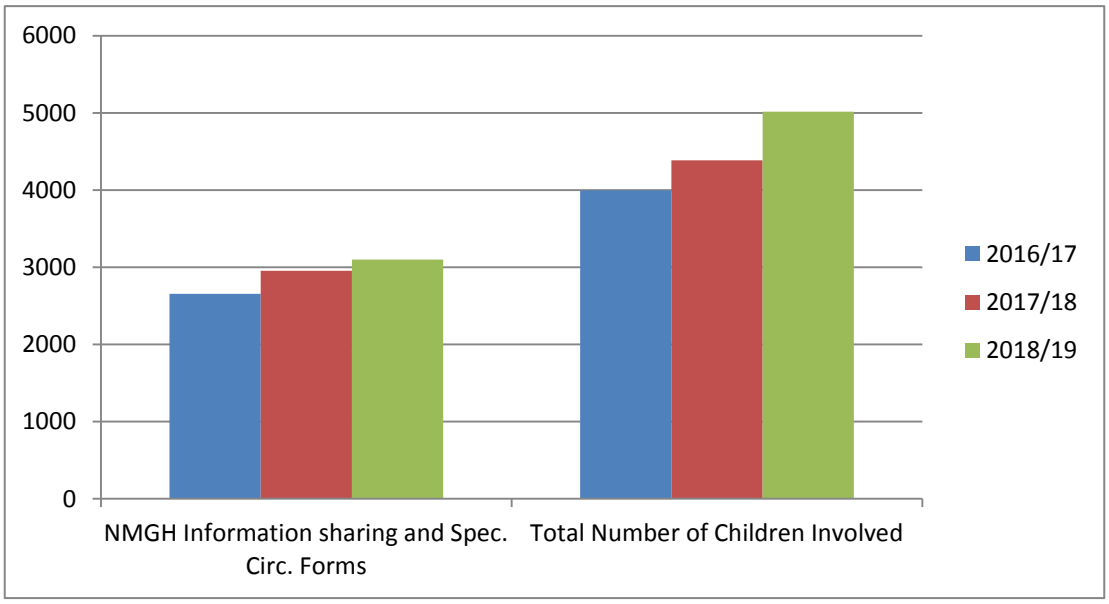
6.23 Lord Laming's recommendations following the Victoria Climbie inquiry in 2003[11] required all Emergency Departments to notify the health visitor or school nurse when a child attended. These notifications are well established across all Manchester hospitals and are processed via the MFT community safeguarding team.

6.24 The Community Safeguarding Team ensure that these notifications are disseminated to the Health Visiting and School Nursing Teams for information and case management. In 2018-19 there was an increase in the number of children attending North Manchester General Hospital with safeguarding concerns. This aligns with the demographic data seen in the north of the city, which has the highest levels of child protection within Manchester. **Figures 25a and 25b** show that there has been an increase in notifications year on year, suggesting raised awareness and recognition of safeguarding concerns.

Figure 25a: North Manchester General Hospital Information sharing and Special Circumstances Forms:

Year	NMGH Information sharing and Special Circumstances Forms	Total number of children involved
April 2016 - March 2017	2,655	3,995
April 2017- March 2018	2,953	4,385
April 2018- March 2019	3,100	5,013

Figure 25b: North Manchester General Hospital Information sharing and Special Circumstances Forms 3 year comparison.



[11] https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming

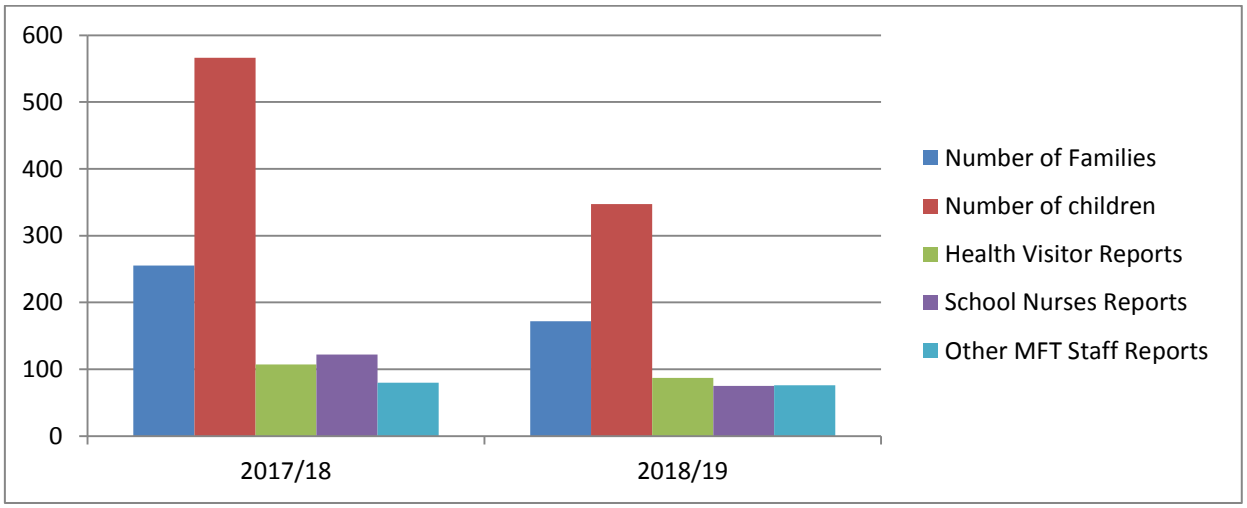
Court Report Activity for child care proceedings

6.25 Court Reports are requested by Manchester City Council legal team and are completed within defined timescales by community practitioners. Robust quality assurance by the MFT Safeguarding Team of these reports prior to submission ensures that very few frontline practitioners are called to give evidence in court. **Figure 26a and 26b**, below outlines the numbers of court reports undertaken by community services in 2018-19

Figure 26a: Court reports quality assured by the Safeguarding Team

Year	Number of Families involved	Number of Children involved	Health Visitors reports	School Nurses Reports	Other MFT Staff Reports	Total Reports
April 2017- March 2018	255	566	107	122	80	309
April 2018- March 2019	172	347	87	75	76	238

Figure 26b: Court reports quality assured by Safeguarding Team 2017/2019



6.26 The Community Safeguarding Team has developed a good working relationship with Manchester City Council Legal Services. Child Care Proceedings are commenced when the multi-agency safeguarding concerns have reached the threshold for legal intervention. In Manchester there has been an increasing number of care applications during this year (37%). In response to this increase Manchester City Council has appointed a lead to work on pre-child care proceedings process with the aim of only the most appropriate cases relating to high risk children and young people being taken to Public Law Proceedings (Family Court) and those cases are 'court ready' to avoid any further delay for children's permanence arrangements.

6.27 Manchester City Council Children's Services has established a robust pre-proceedings process for children and young people suffering significant harm where the multi-agency child protection processes have not had the expected positive impact on a child's care. The Local Authority's significant concerns and

plans are formally shared with parents with the aim of achieving a positive change. If change is not evidenced within the specific timescale the reports will be prepared for Family Court and the case put before a judge. Over the past year this approach has shown that 74 cases that would previously be heard at court have achieved the changes for children that were required. This analysis provides context to the reduced number of court reports completed this year.

6.28 MFT has contributed to child care proceedings process with reports submitted by a range of professionals including those from Specialist Services including CAMHS, Continence Service, Children's Community Nurse, Epilepsy nurse specialist and others, as well as Health Visitors and School Nurses.

Criminal Court activity

6.29 The Safeguarding Children Team support staff in producing witness statements for police investigations and preparing staff should they be required to give evidence in court regarding criminal investigations for abuse and neglect.

Maternity Safeguarding Activity

The top 5 areas for referral in Maternity are:

- Mental Health
- Domestic Abuse
- Female Genital Mutilation (FGM)
- Substance Misuse
- Neglect

6.30 Maternity Safeguarding Services are based at the Oxford Road Campus and Wythenshawe Hospital and provide support to hospital and community-based services across MFT.

6.31 As 2018-19 is the first year reporting as a whole MFT team there are limitations in reporting comparative data in relation to last year's report. However this year's report clearly identifies the safeguarding vulnerabilities around mental health and domestic violence and abuse identified by maternity services. **Figure 27,** below shows the number of safeguarding referrals to the Safeguarding Team at each site.

Figure 27: Maternity Safeguarding referrals

Unborn baby/Children's Referrals	Maternity ORC	Maternity WTWA	Total
Physical	34	8	42
Sexual	18	21	39
Emotional	12	6	18
Neglect (including parenting)	81	28	101
FGM	397	9	406
CSE	8	5	13
FII/Perplexing presentation	0	2	2
Domestic Violence & Abuse	511	114	625
Adult/Child Mental Health	2,102	364	2,466
Adult (and child) substance misuse	187	79	266
Trafficking/Modern Slavery	12	0	12
Criminality	51	0	51
Missed appointments	0	17	17
Child Mental health (Inc. self-harm)	0	0	0
Allegations against staff	0	0	0
Radicalisation	0	0	0
Looked After Child	55	0	55
Other	2,927	85	3,012
External Agency Referral	0	0	0
Sub-Total	**6,395**	**738**	
Total Referrals			**7,133**

6.32 Maternity Services at Oxford road identified 397 service users impacted by female genital mutilation compared to lower levels identified at Wythenshawe Hospital. This is reflective of the local population in Manchester and increased vulnerabilities of women and girls living in FGM traditional practicing communities. Considerable work has been undertaken to raise awareness of the harmful impact to women and girls from FGM in Manchester. In recognition of this St Marys Hospital hosts a New Steps to African Communities psycho-social clinic to ensure service users are offered a holistic response to identification of FGM.

Maternity Court Report Activity

6.33 The Trust's safeguarding midwives continue to support MFT in contributing to child care public law proceedings to ensure the safety and welfare of the unborn. In 2018-19 the Oxford Road Safeguarding Team completed **62** court reports for local authorities. For the St Mary's Hospital Oxford Road site the service supported professionals in safeguarding **56** new-born babies who were removed from parental care prior to leaving hospital.

Midwifery Safeguarding Supervision activity

6.34 At the Oxford Road Campus the monthly safeguarding supervision group continues to be facilitated by safeguarding midwives, with membership including all specialist midwives across a range of hospital and community midwifery specialities such as mental health; substance abuse; refugees; young parents; antenatal screening; NICU and HIV. Dissemination of key safeguarding activities

and priorities, legislation updates, learning from complex cases and bespoke safeguarding speakers has contributed to increased learning and development within this group.

6.35 At Wythenshawe Hospital safeguarding supervision is provided to all midwives; community midwives receive this quarterly and all other midwives receive annual supervision.

Children's Acute Safeguarding Activity

The top 5 areas for referral in Acute Children's safeguarding are:

- Sexual Abuse/Exploitation
- Child and parent mental health
- Neglect
- Physical Abuse
- Child and parent mental health Substance Misuse
- Physical Abuse

Children's Acute Referrals

6.36 The acute safeguarding children's service is delivered from the Oxford Road Campus and Wythenshawe Hospital. **Figure 28** shows the number of referrals or alerts to the acute children's safeguarding team in 2018-19 by category of abuse. The data shows an increase in the total number of referrals and alerts to the acute children's safeguarding team this year from 2,329 in 2017-18 to 4,312 in 2018-2019. Further analysis will be undertaken in 2019-20 to develop an understanding of this increase in reporting, which may relate to data recording methodology differences between the previous Trusts prior to the establishment of MFT, but may also be reflective of increased awareness leading to higher numbers of referrals.

Figure 28: Referrals to Acute Safeguarding Team in 2018-19

Children's Referrals to Acute Safeguarding Team			
Category of abuse	**Oxford Road Campus**	**Wythenshawe, Withington, Trafford and Altrincham**	**Total**
Physical	207	130	337
Sexual	793	24	817
Emotional	91	22	113
Neglect (including parenting)	440	138	578
FGM	2	4	6
CSE	68	2	66
FII/Perplexing presentation	0	14	14
Domestic Violence & Abuse	222	145	367
Adult/Child Mental Health	0	389	389
Adult (and child) substance misuse	177	86	263
Trafficking/Modern Slavery	8	2	10
Criminality	0	86	86
Missed appointments	26	31	57
Child Mental health (Inc. self-harm)	310	274	584
Allegations against staff	0	6	6
Radicalisation	0	1	1
Looked After Child	76	0	78
Other	36	502	538
External Agency Referral	0	0	0
Sub-Total	**2,456**	**1,856**	
Total			**4,312**

6.37 In contrast to Community and Maternity services, the main referral category seen in Acute Children's Safeguarding referrals is sexual abuse/exploitation. The service covers sexual health services for young people along with the SARC in addition to both RMCH and the wider Trust, which accounts for an increase in this category. Childhood neglect remains a significant reason for referral in Acute services, which is consistent with 217-2018 activity and national messages. Child and parental mental health vulnerabilities raising safeguarding concerns is a clear indicator of concern identified by Trust-wide services especially in children's and adults emergency departments and Royal Manchester Children's Hospital (RMCH)

Looked After Children – "Our Children" activity

6.38 The MFT Our Children (LAC) team provide a citywide health service for Our Children Manchester placed in Manchester and children Looked After from other local authority areas placed in Manchester. The work undertaken is underpinned by statutory requirements against which performance is monitored by the Trust and reported to Manchester Health and Care Commissioning.

6.39 Manchester has higher numbers of Our Children and LAC compared with national, North West and statistical neighbour figures. This places significant pressures on the Our Children (LAC) team, but also on paediatricians, health visitors and school nurses in ensuring the statutory health needs of Our Children are met.

Looked After Children Statutory Guidance and Responsibilities

6.40 Statutory guidance set out in Care Planning, Placement and Case Review (England) Regulations (2010)[12] states:

- Local Authorities (LA) must arrange for all Looked after Children to have a health assessment;
- The Initial Health Assessment (IHA) must be undertaken by a registered medical practitioner;
- The IHA should result in a health plan, which should be available in time for the first statutory review of the child's care plan by the Independent Reviewing Officer (IRO);
- The case review by the IRO must happen within 20 working days from when the child became LAC (Regulation 33(1).

6.41 Nationally LAs and Clinical Commissioning Groups (CCGs) adopt a standard for IHAs to be completed within 20 working days of a child entering care. Performance with regard to this standard is not nationally monitored and benchmarks are not available.

Looked After Children- Health Providers' Responsibility

6.42 Once notified by the LA of a child coming into care, MFT is responsible for making the arrangements for the IHA. MFT responsibility is as follows:

- IHA completion for Manchester children placed in Manchester.
- IHA completion for children from other LA placed in Manchester.
- Request sent to the relevant provider to complete the IHA for Manchester children placed out of Manchester,

6.43 Completion of IHAs within 20 working days is wholly dependent on the timeliness of the notification and request (including consent) from the Local Authority, without which an IHA cannot take place.

6.44 A partnership approach is key in ensuring best outcomes for Our Children and the Our Children (LAC) team work closely with Manchester City Council (MCC) colleagues to ensure they have the correct information in a timely manner to provide a robust health offer for Our Children. Escalation processes are also agreed and in place between MFT and MCC, to address issues as they arise to ensure a timely response and service provision for Our Children.

LAC Performance Data

6.45 MFT is commissioned to provide IHA and Review Health Assessments (RHA) for LAC, including Our Manchester Children placed in Manchester and children from other LA areas placed in Manchester.

- Children are required to have an Initial Health Assessment within 20 working days of becoming LAC.

[12] http://www.legislation.gov.uk/uksi/2010/959/contents/made

- Children under 5 years are required to have two Review Health Assessments per year.
- Children over 5 years are required to have yearly Review Health Assessments.

Figure 29a: LAC Key Performance Indicator (KPI) Data 1st April 2018 – 31st March 2019

KPI	Manchester Our Children -Manchester Placed	Manchester Our Children – Out of Area placed	Manchester Our Children and LAC placed in Total	Total MFT performance *
Review Health Assessment up to date	**98%**	**85%**	**91%**	**96%**
Immunisations up to date	**87%**	**87%**	**87%**	**85%**
Developmental Assessment up to date	**100%**	**100%**	**100%**	**90%**

* *Total Performance includes Manchester LAC placed in Manchester, Manchester LAC placed in other LA areas, other LA LAC placed in Manchester or attending a Manchester school.*

Figure 29b: Percentage of Initial Health Assessments completed within 20 working days of a child becoming 'looked after'

	Month	Manchester Our Children placed in Manchester	Manchester Our Children placed out of area
2018	**April**	87%	12%
	May	76%	56%
	June	96%	29%
	July	75 %	0%
	August	81%	16%
	September	71%	20%
	October	73%	43%
	November	50%	27%
	December	80%	9%
2019	**January**	87%	77%
	February	71%	31%
	March	53%	73%
2018-2019 overall performance		**75%**	**34%**

Analysis of Looked After Children data

6.46 Data from Manchester local authority identified that at the end of 2018-19 there were 1,281 Looked After Children. Initial Health Assessment (IHA) performance fluctuates on a monthly basis, with the overall performance of the number of completed initial health assessments within 20 days at 75% for children placed in area and 34% for those placed out of area in 2018-2019.

6.47 Performance for Our Children placed in Manchester is better than for Manchester Our Children placed out of area, which equates to more than half of Manchester's Our Children population. While MFT make a request for IHA to be undertaken by out of area providers, the Trust does not have influence over the timeliness of

these assessments. This impacts on the overall IHA performance and has been raised with the Designated Safeguarding Team within MHCC. The LAC service has worked closely with MCC to promote timely notification to MFT that children have been looked after and receipt of a request for health assessment from children's social care so that MFT can respond within expected timescales. A clear escalation process is now in place to identify and address the notification of requirement for health assessment within timescales.

6.48 Review Health Assessments (RHA) for Manchester children placed out of area also impacts the overall total performance (91% of Manchester LAC have had a health assessment). However, for MFT performance, 96% of children had a Review Health Assessment this year. An overall review of performance shows that Review Health Assessment performance for 2018-2019 is the highest to date at 98%. Additionally, from quality assurance, the assessments consistently reflect the voice of the child, are child centred and focus on emotional and mental wellbeing as well as physical health.

6.49 MFT performance for Our Children (LAC) Immunisations is 87%. It is also important to note that the Manchester population health statistics of vaccine uptake is 94.4%, which is lower than the average England 95.[13]The Our Children (LAC) team continue to explore actions to promote immunisation uptake but often the children coming into care already have a history of neglect and missed immunisations.

Adult Acute Safeguarding Activity

6.50 The Safeguarding Adult Teams are based on Oxford Road Campus and at Wythenshawe, Trafford, and Altrincham Hospitals and support MFT hospital and community services.

The top 5 areas for referral in Acute Adults are:

- Neglect and Self Neglect
- Mental Health
- Domestic Abuse
- Sexual Abuse
- Physical Abuse

Acute Adult Referrals

6.51 The total number of referrals to the Adult Acute Safeguarding Team in 2018-19 was 2,254 compared to 2,919 referrals in 2017-18. However, different data collection methodologies were in place in the two former trusts prior to establishment of MFT, therefore caution is required in considering different patterns of referral. **Figure 30** shows the breakdown of referrals by site and category.

[13] Manchester Population Health plan accessed at file://xcmmc.nhs.uk/UserData$/ReDir/ruth.speight/Downloads/Manchester_Population_Health_Plan_2018_2027.pdf

6.52 The key categories of concern identified by MFT staff in safeguarding referrals reflect the local Manchester picture (identified in Section B of this report); namely physical abuse, neglect/self-neglect, sexual abuse, domestic violence and abuse and mental health. The high referral/notification rate for sexual abuse on the Oxford Road Campus relates to the Sexual Assault Referral Centre, which is a Greater Manchester service.

6.53 In response to the identification of high levels of safeguarding concerns around neglect and self-neglect in adults, one of the MFT Named Nurses for adults has supported the development of a Manchester Safeguarding Board Self Neglect Strategy and Toolkit which will be launched in the Trust in 2019-20.

Deprivation of Liberty Safeguards (DoLS) activity

6.54 MFT is a managing authority under DoLS legislation and is required to apply to the relevant Local Authority (supervisory body) if it is identified that a patient is being deprived of their liberty. If a potential deprivation of liberty is identified, hospital/care home staff are required to complete the relevant documentation self-authorising the deprivation for 7 calendar days. This completed form is forwarded via secure email to the relevant Local Authority (LA). The relevant LA is identified by where the patient is a usual resident.

6.55 Once processed by the LA, the LA is required to commission a Best Interest Assessor and a Mental Health Assessor who will complete the six assessments required to authorise a standard application. This assessment process should occur prior to the expiry date of the urgent authorisation. On receiving the standard authorisation, the Trust must notify the Care Quality Commission of the Deprivation of Liberty; this process is completed by the safeguarding adult team.

6.56 In 2018-2019 2,067 DoLS applications were made by the Trust. Data from the former CMFT and UHSM relating to 2017-2018, prior to the establishment of MFT, suggests a continued trend in the increase in DoLS applications, which was reported in last year's MFT Annual Safeguarding Report. **Figure 31a** compares DoLS applications in the first quarter of this and last year.

Figure 31a: Quarter 1 Comparative Reporting on DoLS applications 2017/18 and 2018/19

	Number of DoLS Applications Submitted
CMFT and UHSM Q1 2017-18	220
MFT Q1 2018-19	287

6.57 There has been considerable activity through safeguarding training, the introduction of informatics systems (DoLS portal on the Oxford Road Campus and Ulysses at Wythenshawe, Withington, Trafford and Altrincham Hospitals) and DoLS point prevalence reviews to promote, streamline and ensure Deprivation of Liberty Safeguards are put in place appropriately. This data provided in **Figure 31b** suggests that there is increased awareness in relation to making Deprivation of Liberty Safeguards applications.

Figure 31b: 2018-19 Deprivation of Liberty Applications and Outcomes

	ORC				WTWA				Totals
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Number of DoLS applications	153	246	278	182	364	134	385	325	**2067**
Number granted/authorised	1	1	1	1	2	4	6	17	**33**
Number waiting assessment	146	205	146	115	20	77	158	147	**1014**
Number RIP/discharged prior to assessment	72	49	88	67	307	243	327	209	**1362**
Number withdrawn/regained capacity						8	26	15	**49**
Number declined by LA						0	1	1	**2**
Number notified to CQC	31	30	2	17	2	4	6	17	**109**

6.58 Although there is an increased rate in application rates for DoLS across the Trust, data from the DoLS point Prevalence review completed this year identified further work was required in enabling hospital/community bed services to identify eligible patients requiring a DoLS.

6.59 The point prevalence study was completed across all MFT sites. Inpatient wards at MRI, Wythenshawe Hospital, Trafford General Hospital, Community bed-bases within the MLCO, Saint Marys Hospital Gynaecology wards (Wythenshawe Hospital and Oxford Road Campus) and Ward 55 in the Eye Hospital were all subject to the study. An overview of the findings of the point prevalence study can be seen in **Figure 32.**

Figure 32: DoLS Point Prevalence Findings

Hospital Site	Total number of patients included in study	Number and (%) patients identified requiring a DoLS	Number and (%) of patients on a DoLS	Number and (%) identified as needing DoLS	% under reported	Improvement from previous study May 2018
MRI	*697*	136 (20%)	58 (8%)	78 (11%)	57%	3%
Wythenshawe	*631*	148 (23%)	109 (17%)	39 (6%)	26%	19%
Trafford	*159*	55 (35%)	35 (22%)	20 (13%)	36%	15%
St Marys	*45*	0	0	0	0	N/A
Eye	*9*	0	0	0	0	N/A
MLCO	*61*	19 (31%)	11 (18%)	8 (13%)	42%	N/A
Total	**1602**	**358 (22%)**	**213 (13%)**	**145 (9%)**	**40%**	

6.60 The data showed that across the Trust 145 individuals were identified as requiring assessment for DoLS but no application had been made. This indicates at that time of the point prevalence study, 9% of the total eligible patient population who should have been on a DoLS, had no application made to the LA.

6.61 Following the review, the safeguarding service worked with areas and hospitals noted to be under reporting to develop action plans to focus improvements.

Additionally, the roll out of Adult Safeguarding Level 3 training continues to raise awareness, support skills and knowledge development in mental capacity assessment and DoLS application.

6.62 In 2018-19 2,067 DoLS Urgent Authorisations/standard applications were made to the LA of which 33 were granted. There have continued to be significant delays in the processing and assessment of DoLS applications by Manchester City Council. **Figure 31b** outlines the numbers of DoLS applications assessed and granted by MCC compared to those submitted. The low number is due to the application of the ADASS Screening tool[14], which is a nationally recognised tool used to prioritise the allocation of requests to authorise a deprivation of liberty. The delays and the associated low numbers granted has been recognised as an organisational risk and is recorded on the Trust Risk Register with a process of incident reporting when DoLS applications have not been assessed after 14 days of application. The issue has been raised at Manchester Safeguarding Adult Board as the majority of DoLS applications are to Manchester City Council.

6.63 The challenges to the current DoLS process are recognised in the Mental Capacity Amendment Bill, which was granted Royal Assent in May 2019. The subsequent amendments to the Mental Capacity Act aim to streamline the DoLS process but will place increased duty on acute settings for authorisation. In 2019-2020 the Safeguarding Team will work with hospitals/MCS/MLCO to implement MFT's response to the revised Mental Capacity Act by spring 2020.

Female Genital Mutilation

Mandatory Reporting and the FGM Data Collection Tool

6.64 There are three information systems/situations where information about women and girls affected by female genital mutilation must be shared [15] by health professionals;

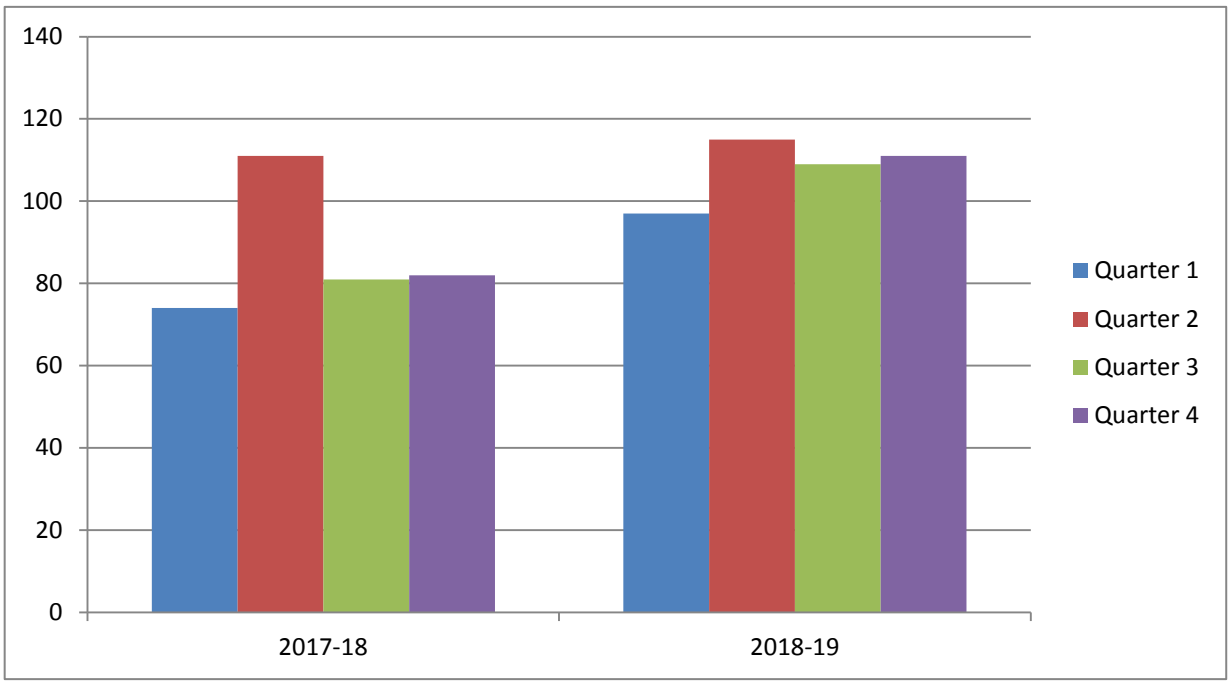
- Female Genital Mutilation Information Sharing System (FGM IS). Information is uploaded at birth to female's child's health record if they are born to a mother who has had FGM. This information is used to support safeguarding throughout her childhood
- FGM mandatory reporting to the police when a girl under 18 years old discloses or is observed to have had FGM. Safeguarding referrals to the social care must also be completed
- FGM enhanced data set completed through FGM reporting tool when a contact is made with a service user who has had FGM. This enables patient population statistics.

[14] https://www.adass.org.uk/adass-priority-tool-for-deprivation-of-liberty-requests/
[15] FGM Risk Indication System https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci2112-fgm-risk-indication-system-fgm-ris-local-system-integration
FGM Mandatory Reporting Duty
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf

6.65 Mandatory dataset reporting continues within the Trust and this data is shared with the NHS Digital in accordance with mandatory reporting requirements. Data is also shared with Manchester Safeguarding Boards' Quality Assurance Performance Information sub-group (QAPI).

6.66 The mandatory reporting data identifies an increase year on year of the number of observations and disclosures of service users who have had FGM with 432 reports this year compared to 358 last year. In comparison with the NHS national dataset, MFT has been identified in the top ten of highest prevalence of FGM reporting in the country. The data demonstrates an awareness of FGM across the Trust and a consistent and embedded approach to routine enquiry regarding FGM in health visiting and midwifery practice.

Figure 33: FGM Mandatory Reporting Data

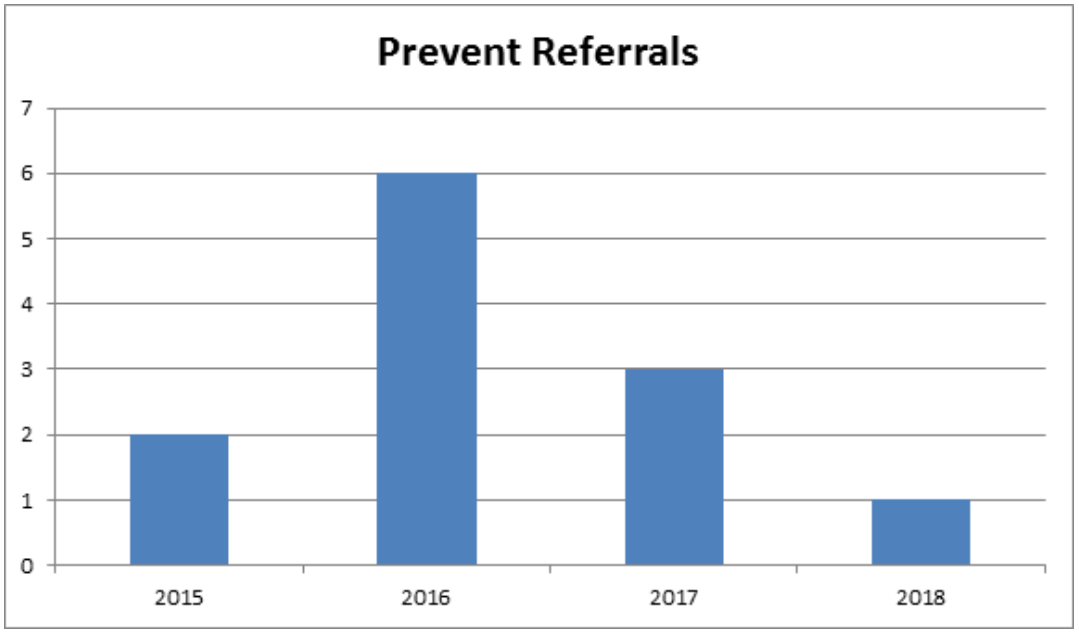


6.67 As requested by NHS digital, MFT implemented FGM IS by the end of March 2019. The FGM IS is an information sharing process where a risk indicator is added to a female child's summary care record following birth to a family where the mother has had FGM. Work has been completed with the Informatics Service, St Mary's Hospital/MCS, the MFT Safeguarding Team and NHS digital to implement the system. An agreed process to implement the information sharing is included as an appendix to the MFT Prevention Recognition and Safeguarding Women and Girls from Female Genital Mutilation policy.

Prevent activity

6.68 The Safeguarding Team provides advice and guidance where there are concerns around radicalisation and manages referrals to the Channel programme, which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. Referral data demonstrates that very few referrals are made to Channel by the Trust, despite mandatory training and raising of awareness at all levels across the Trust. In 2019-20 the Safeguarding Team will work with the Trust Prevent Lead to review referrals rates to Channel to develop an increased understanding of why the referral rates remain low.

Figure 34: Prevent Referrals



Safeguarding Supervision Performance

6.69 Safeguarding supervision is mandatory for all children's services community staff who are caseload holders. Local and national learning highlight the importance of staff receiving safeguarding supervision to support reflective and critical analysis in complex safeguarding cases. **Figure 35** below shows the good compliance maintained this year for delivery and attendance of safeguarding supervision within Children's Community Services.

Figure 35: Safeguarding supervision compliance 2018-19

2018-19	Q1	Q2	Q3	Q4
School Nurses	**89%**	**99%***	**100%**	**97%**
Health Visitors	**90%**	**99%**	**99%**	**99%**
Specialist Nurses	**96%**	**100%**	**94%**	**100%**
Group Supervision	**96%**	**100%**	**100%**	**100%**

6.70 This year, in response to recommendations made following a Care Quality Commission Safeguarding and Looked After Children inspection across Manchester in 2017, the Trust's acute services have also developed a safeguarding supervision model. Formal Safeguarding Supervision sessions have been implemented for identified practitioners working within Royal Manchester Children's Hospital (RMCH) Managed Clinical Service; these have been positively received by staff.

6.71 Safeguarding children's supervision has also been developed across the Wythenshawe, Withington, Trafford and Altrincham (WTWA) hospitals. In addition, the WTWA-based safeguarding team has developed Safeguarding Children supervision within the Adult Neuro Rehab Unit at Trafford Hospital in light of the complex nature of the patients receiving care on this unit. Staff have engaged well with supervision, which has enabled a "Think Family" approach.

7. Safeguarding Training

Mandatory Training

7.1 It is a statutory requirement that all staff regardless of role and responsibility undertake the appropriate level of safeguarding training on a 3 yearly basis. MFT safeguarding training is informed by the national "Royal College Intercollegiate Documents" for Adults and Children's safeguarding training. [16]

7.2 In 2018-19 the Intercollegiate document guidance for adults[i] (2018) was published and the document for children[ii] (2019) was updated. These publications identified the staff groups required to complete levels 1, 2 and 3 safeguarding training as well as specifying the content and the delivery of the safeguarding training programme.

7.3 In response to the new guidance, a Trust-wide mapping process was completed to map all staff to the relevant level of adult and children's safeguarding training. The new guidance for adults identified a much wider staff group (all practitioners who have regular contact with patients, their families or carers, or the public) being required to complete adult level 2 safeguarding training and a new expectation for that registered health care staff working with adults who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns are required to complete level 3 safeguarding training. As 7,618 staff were mapped to the level 3 competency, a risk-based, phased roll out of training over a 3 year period was agreed by the Safeguarding Committee, in order to train the appropriate staff to Level 3 competency.

7.4 This year a consistent Trust-wide safeguarding training package has been developed, with all services completing consistent level 1 and 2 adults and

[16] [16] Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) 1st edition

[16] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

children training and a level 3 adults course. Level 3 children's training is consistent across all acute and maternity services, with community services delivering a bespoke package for community staff.

7.5 Additionally this year has seen the development of a Trust-wide booking and reporting system for safeguarding training, increasing the accuracy and transparency of the data.

7.6 The Trust compliance target for safeguarding children training is 90% and the CQC target is 80%. This year there has been a significant focus on promoting compliance with safeguarding training. However due to the increased expectations regarding the number of staff required to attend training and the transparency of the learning hub reporting, compliance is not at expected levels. **Figure 36** shows training compliance levels. The RAG rating aligns to CQC requirements.

Figure 36: Mandatory Training Compliance

Mandatory Training				
	Q1	**Q2**	**Q3**	**Q4**
Level 1 Adult Training: e-Learning as part of corporate mandatory training,	**89%**	**90%**	**91%**	**90.52%**
Level 1 Children Training: e-Learning as part of corporate mandatory training,	**93%**	**93%**	**94%**	**93.60%**
Level 2 Adult Training: e-Learning as part of clinical mandatory training includes Level 2 adult and ,& MCA and DoLS training.	**81%**	**71%**	**71%**	**70.73%**
Level 2 Children Training: e-Learning as part of clinical mandatory training includes Level 2 adult and ,& MCA and DoLS training.	**81%**	**82%**	**81%**	**78.97%**
Level 3 Safeguarding Adults: This is a full day face to face training delivered by the safeguarding team.	**NA**	**NA**	**22%**	**21.97%**
Level 3 Training Children: Full day face to face training delivered by the safeguarding team	**93%**	**80%**	**63%**	**73.48%**

7.7 The level of compliance with level 3 adult training is reflective of the significantly increased denominator. The Safeguarding Team has worked closely with Hospitals/Managed Clinical Services and the Manchester Local Care Organisation to ensure plans are in place to achieve expected levels of compliance in 2019-2020. Safeguarding training capacity has been reviewed and extended to meet expected training requirements.

7.8 Compliance with mandatory safeguarding training was recognised as an area in which action was required in the Manchester University NHS Foundation Trust Care Quality Commission Inspection published in March 2019. The report identified effective systems were in place to safeguard patients in the organisation.

However, the Trust should review systems, so they are assured staff have completed safeguarding mandatory training. This will be a key priority for the safeguarding service working with Hospitals, Managed Clinical Services (MCS) and Manchester Local Care Organisation (MLCO) in 2019-2020.

Additional Safeguarding Training

7.9 In addition to statutory safeguarding training, MFT offers staff a range of safeguarding speciality courses which include:

- Domestic Violence and Abuse.
- Human Trafficking & Modern Day Slavery Awareness.
- Child Sexual Exploitation.
- Recognition & Response to Women & Girls at Risk of Female Genital Mutilation (FGM):
- Signs of Safety
- Court report writing and safeguarding documentation.
- Learning from Manchester Serious Case Reviews

7.10 **Figure 37** identifies the numbers of staff attending additional training in 2018-19 and demonstrates the breadth of safeguarding training activity taking place across the Trust.

Figure 37: Numbers of staff attending additional training

Year	Child Sexual Exploitation (CSE)			Domestic Violence and Abuse (DV&A) Awareness			Family Court Statement and Abuse Awareness			Human Trafficking & Modern Day Slavery Awareness			Learning from Manchester Serious Case Reviews			Recognition & Response to Women & Girls at Risk of Female Genital Mutilation (FGM)			Signs of Safety		
April 2018 – March 2019	Capacity	Attended	DNA's	Capacity	Attended	DNA's	Capacity	Attended	DNA's	Capacity	Attended	DNA's	Capacity	Attended	DNA's	Capacity	Attended	DNA's	Capacity	Attended	DNA's
	362	272	19	1021	545	70	60	30	8	140	96	6	104	51	0	117	58	22	25	21	0

Domestic Violence and Abuse (DV&A) Training

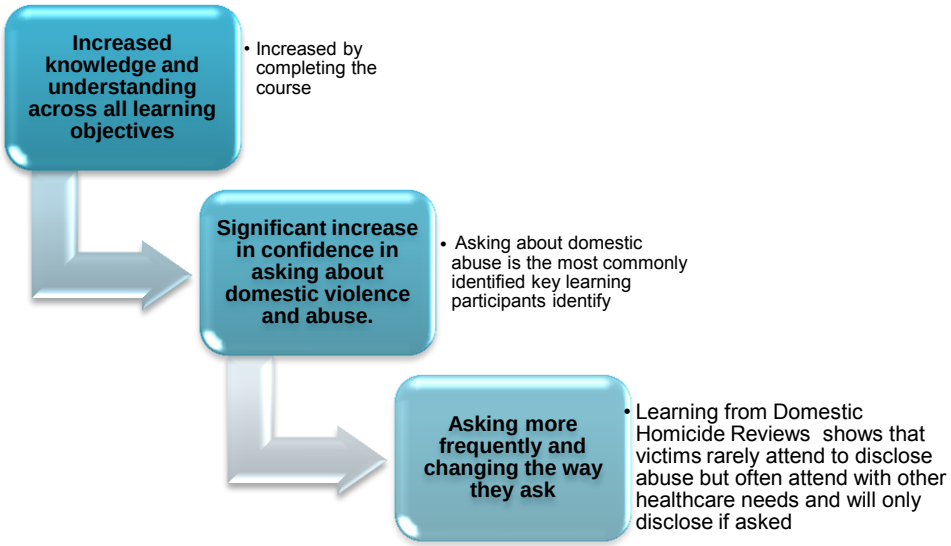
7.11 Provision of DV&A training supports frontline staff in implementing policy and ensuring that victims/survivors of domestic violence and abuse receive a timely and safe response in line with Manchester's Multi-Agency Domestic Violence and Abuse Strategy and Policy.

7.12 The Trust Domestic Abuse sub-group has developed a Training Plan identifying the priority areas and services that require training in domestic violence and abuse in line with NICE guidance. These areas are illustrated in **Figure 38.** 545 staff attended domestic abuse training this year. Following safeguarding training an impact evaluation is completed and **Figure 39** shows feedback on the impact of training.

Figure 38: Areas in which Domestic Violence and Abuse Training has been delivered

The Safeguarding Team has also contributed to the Healthy Schools *Behind the Behaviours* programme by designing the Domestic Violence and Abuse courses which focus on the impact of DVA on children.

Figure 39: Evaluation of DV&A training



Child Sexual Exploitation (CSE) Training

7.13 CSE training is delivered by a Senior Specialist CSE Nurse who works within the multi-agency Complex Safeguarding Hub. CSE training is delivered across the Trust but targeted to areas more likely to see CSE, for example Children's Acute and Community Services, Adult and Children's Emergency Care and Sexual Health Services. 272 staff were trained in CSE this year.

Recognition & Response to Women & Girls at Risk of Female Genital Mutilation (FGM):

7.14 FGM training is delivered in two ways across the Trust:

- Incorporated into generic safeguarding training at levels 1, 2 and 3
- Bespoke FGM training delivered for key areas that are more likely to see and treat women and children who are at risk.

7.15 In 2016-17 FGM training was developed to raise awareness about FGM and to ensure staff were aware of mandatory reporting requirements. This training has been further developed in line with the changing policy and updated following successful FGM perpetrator prosecution reported nationally.

7.16 In 2018-19, 58 staff attended FGM bespoke training. Additionally information regarding FGM has been shared widely within the Trust through the regular Safeguarding newsletter.

7.17 A Working in Partnership in Preventing, Recognising and Safeguarding Women and Girls affected by FGM presentation was delivered by the safeguarding team in collaboration with New Step for African Community (NESTAC) at this year's annual Nursing, Midwifery and AHP Conference. This provided a further forum through which to spread best practice and raise awareness.

Human Trafficking & Modern Day Slavery Awareness

7.18 In response to the Manchester Safeguarding Board MSB Manchester Modern Slavery and Human Trafficking Strategy the safeguarding team has developed a training course to raise awareness of Modern Slavery and Human Trafficking. 96 staff members have attended this training this year.

7.19 Safeguarding activity data shows that there were 34 notifications or requests from health professionals for support and advice to manage safeguarding concerns where the cause for concern was modern slavery this year, this indicates raised awareness. This is the first year that data has been recorded across the service in this category.

Signs of Safety training

7.20 Manchester Children's Services, in partnership with the Manchester Safeguarding Board, have introduced the "Signs of Safety" way of working with children and families. This is a strengths-based, safety-organised approach to child protection casework. To support implementation, MFT delivered a Signs of Safety course to enable health professionals to understand the principles. 21 staff attended prior to a decision to access MSB Signs of Safety training in order to promote multi-agency training.

Embedding Learning from Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)

7.21 5 SCRs, 2 SARs and 4 DHRs were published in 2018-19 in Manchester. Learning is embedded in MFT safeguarding training and also delivered through bespoke training courses. Additionally, presentations on lessons learned from SCRs and SARs have been shared at the Safeguarding Quality and Learning group each

quarter. The Domestic Violence and Abuse Group has shared presentations on DHRs and lessons learned from DHRs is a standing item on the subgroup agenda. The MFT Safeguarding Newsletter has also continued to share key messages from SCRs, SAR's and DHRs.

Report writing training

7.22 Court report training is provided for staff to enable health professionals to complete high quality reports for child care proceedings to enable the child's health needs to be considered in the future plan to safeguard the child or young person.

7.23 Aspects of Safeguarding Documentation training is provided to support staff to deliver high quality safeguarding referrals reports for multi-agency meetings to ensure the child's health needs are considered in the multi-agency context.

Prevent training

7.24 All health staff according to roles and responsibilities are mapped to receive Prevent training at either Level 1-2 (Basic Prevent Awareness) or Level 3-5 (Workshop Raising Awareness of Prevent)[17]. The training in MFT is by e learning. On 30th April 2019, MFT were 85% compliant with level 1-2 training and 78% compliant with 3-5 prevent training. The target set by Manchester Health Care Commissioners is 85% for all levels of training.

7.25 Work has commenced with the Organisational Development and Training team to ensure that the correct competencies are added to staff records on completion of training.

7.26 Monthly compliance reports are distributed to the Chief Executive, Medical Director and Director of Nursing of each Hospital to enable monitoring of compliance and identify individual staff and groups requiring training.

7.27 The Group Medical Director, as the Executive Lead for Prevent, is responsible for holding Hospitals/MCS to account for compliance with Prevent training. Non-compliant areas are required to provide localised action plans to improve compliance. It is anticipated that MFT will be compliant with the higher level training target by October 2019.

8 Incident Reporting

8.1 The Trust incident reporting system includes a facility for incidents to be categorised as safeguarding. Incident reports identify if the service user has a vulnerability, which is reflected in **Figure 40c**. All safeguarding incidents are reviewed by the Safeguarding Team to enable expert support to be provided to

[17] Prevent Training and Competencies Framework https://www.england.nhs.uk/wp-content/uploads/2017/10/prevent-training-competencies-framework-v3.pdf

hospitals/MCS/MLCO into the investigation process and safeguarding response. In 2018-2019 **1,076** safeguarding incidents were reported.

8.2 A thematic review of safeguarding incidents is undertaken quarterly and reported to the Trust Safeguarding Committee. **Figure 40a** provides a summary of the annual incident themes reported by category and **Figure 40b** provides a breakdown by reporting Hospital/MCS/MLCO.

Figure 40a: Incident Reporting by Category

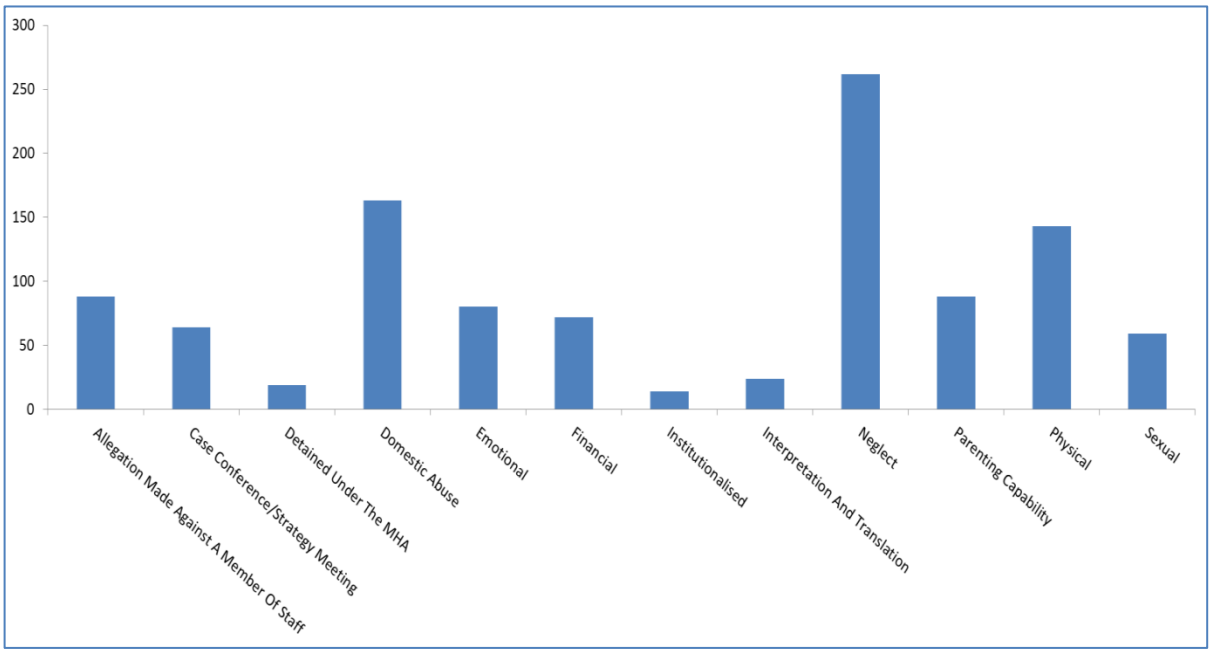


Figure 40b: Incident Reporting by Reporting Hospital/MCS/MLCO

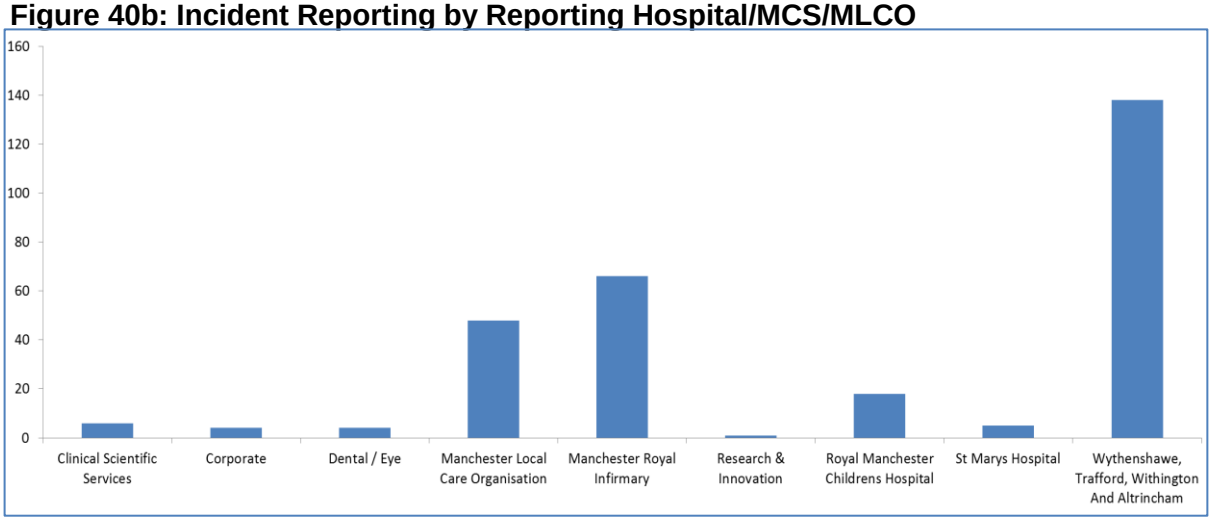


Figure 40c Vulnerability of Service User in Incident Reporting

Is patient a vulnerable adult?	1694
Is there a safeguarding children concern?	683
Has the patient a recognised learning disability?	763

Analysis of Incident Data

8.3 MFT has a culture of transparent incident reporting evidenced by the number of safeguarding incidents reported. The safeguarding adult reporting process is closely aligned to the incident reporting process, hence the higher number of safeguarding incidents in adult safeguarding.

8.4 Incident reporting in the Trust reflects the safeguarding concerns identified earlier in this report that neglect, domestic abuse, and physical abuse are the most common cause of safeguarding concern in the city.

8.5 The data show that the Trust recognises and responds to any allegations against staff in order to safeguard victims. This is supported through the Trust-wide Managing Safeguarding Allegations against Staff Policy.

8.6 The Trust has a statutory obligation to contribute to child protection case conferences and strategy meetings and incident reporting is completed when services are unable to meet this requirement. Non-attendance is related to the high numbers of children on child protection plans and the demand on services, mainly health visiting and school nurses, to attend up to 6 case conferences daily.

8.7 The highest number of incidents reported are from Wythenshawe, Trafford, Withington and Altrincham Hospitals, Manchester Royal Infirmary and Manchester Local Care Organisation. This would be expected as it is through the Emergency Departments, Medical areas and community services that most safeguarding concerns are recognised, and appropriate actions taken.

9 Risk Register

9.1 At the end of this reporting period the following six risks relating to safeguarding were recorded on the organisational risk register and mitigation was in place to reduce the risk:

- ✓ **Deprivation of Liberty Safeguards (DoLS)**

This is an accepted risk and relates to the process associated with the Local Authority. This continues to be a risk to the Trust as following the expiry of the urgent authorisation, the deprivation of liberty becomes illegal until a time the Local Authority have authorised the standard application. This legal responsibility sits with the Local Authority and is out of the control of the Trust.

- ✓ **Level 3 Safeguarding Children Training**

This risk relates to current compliance with the level 3 safeguarding children's training target. It is a mandatory requirement that all staff who have a primary role working with children and young people must attend level 3 training on a three-yearly basis.

✓ **Mental Capacity Act**

This risk relates to implementation of the Mental Capacity Act across the organisation and ensuring compliance with the statutory requirements of the legislation to empower and protect adults who lack capacity to make their own decisions.

✓ **Looked After Children Health Assessments**.

It is the responsibility of the Local Authority to provide consent and information to health providers to enable statutory health assessments within defined time scales. Performance from the local authority is poor in sharing information in a timely way, impacting on MFT and out of area performance in offering timely health assessments for children and young people. An escalation pathway has been agreed with the local authority to attempt to reduce this risk.

✓ **Use of Ligatures as a means of self-harm.**

The Mental Health Safeguarding Team has developed policy, training and practice in this area across the Trust in order to mitigate this risk.

✓ **Safeguarding Adult Referral Process at Wythenshawe Hospital**

The process of completion of referrals was formerly completed through the safeguarding team and work is ongoing to enable health staff to complete direct referrals to social care.

A review of the risk register will be completed in Quarter 1 of 2019-20.

10 Safeguarding Audit

10.1 In 2018-2019, audits and reviews of practice were completed both as part of the MFT safeguarding audit plan and the Manchester Safeguarding Board audit programme; details are provided in ***appendix 1.*** Audits were completed in the following areas:

- ✓ Review of Multi Agency Risk Assessments for Domestic Abuse by Trust wide health staff
- ✓ Review of Referrals to Children's Services by Community Staff
- ✓ Review of Safeguarding Record Keeping in the Community
- ✓ Review of 16 to 17-year-old experience in hospital care Wythenshawe, Withington, Trafford and Altrincham
- ✓ Prevention of Missing and Absconding Patients
- ✓ Manchester Safeguarding Board Self Neglect Audit
- ✓ Manchester Safeguarding Board Neglect with a focus on Children with Disabilities.

10.2 The outcomes and action plans of the audits are shared with hospitals/MCS/MLCO safeguarding groups and through the Safeguarding Quality and Learning sub group. The aspiration to complete a full audit programme as outlined in the 2018-19 audit plan ***(Appendix 1)*** was not achieved in full due to

additional pressures within the safeguarding team. Therefore, the following audits will be carried forward to 2019-20:

- Looked After Children. A Looked After Children audit for 2018-19 to benchmark staff awareness of Looked After Children requirements in practice was commenced in Quarter 4 of 2018-2019 and will be completed in Quarter 1 2019-2020.

- Mental Capacity Act Awareness. Information from the DoLS point prevalence review and learning from practice has identified the requirement to review awareness of the Mental Capacity Act. However due to the increased training offer and attendance of Level 3 Adult Safeguarding training it was agreed to complete this audit in 2019-2020 to review impact in practice of the training offer.

SECTION F

Manchester University NHS Foundation Trust (MFT)

Safeguarding Team Achievements 2018-2019

11 Safeguarding Team Achievements 2018/19

11.1 Named Doctors Child Safeguarding, Community Child Health

The Community Child Protection Clinic, known as the Coral Suite in order to provide a more child friendly feel, has been established for many years and takes referrals from Social Workers, mainly but not exclusively for children where physical abuse is suspected, and children are seen the same day or the next working day. The service also sees children where there has been suspected neglect and a specialist medical opinion is required.

- 416 children and young people attended the Coral Suite in 2018-2019
- Professional discussions took place about 719 children and young people referred to the Coral Suite

Key Achievements 2018-2019

- ✓ The move to all day clinic availability in the Coral Suite has made it possible to arrange planned appointments for certain vulnerable children where there are concerns about neglect or other types of abuse. The facilities available in the clinic and the possibility of a one-hour appointment meets their needs better than an appointment in a local health centre.
- ✓ The service has developed links with dentistry to allow easier referral of children seen in the clinic to specialist paediatric dental clinics.
- ✓ The Named Doctors have worked with the Designated Doctor for safeguarding to provide a service for children where there are concerns around Fabricated and Induced Illness/Perplexing Presentations of illness to collate information and provide advice to the Safeguarding team, including where appropriate identifying a Lead Paediatrician
- ✓ Coral Suite provides excellent experience for our Specialist Trainees in Paediatrics.
- ✓ Regular Peer Review of cases seen in the Coral Suite provides excellent in-service training for Paediatricians.

11.2 Paediatric Looked After Children Service

Key Achievements 2018-19

- ✓ Maintained high rate of offer of Initial Health Assessment (IHA) within statutory time scales.
- ✓ Continued pilot project with GP at Manchester Medical Practice (MMP) seeing young people age 14 years and over for IHA, including Unaccompanied Asylum Seeking Children – increasing awareness of GP services for young people, and giving option to register with MMP if do not have GP.
- ✓ Most children seen for IHA at Moss Side Health Centre (Coral Suite), enabling support to be provided by Nursery Nurse or Clinic Worker – especially helpful for children attending in sibling groups, positive feedback from children and carers.
- ✓ Very good working relations between MMP and MFT Paediatricians.

11.3 Nursing Looked After Children Service

Key Achievements 2018-2019

- ✓ At a health themed Corporate Parent Panel, MFT provided assurance about the Trust's services. Positive feedback about the quality, commitment and partnership working was received from the panel and elected members of the Council.
- ✓ Young people leaving care should be equipped to manage their own health needs wherever possible; a new care leavers' health summary has been developed with supporting care package for transition to adulthood.
- ✓ Review Health Assessment performance for 2018-2019 is the highest to date at 98%.
- ✓ There has been raised awareness of the Specialist Nursing service for 'Our Children' across the Trust in developing pathways for co-ordinated support.

11.4 Safeguarding Children Community Team

Key Achievements 2018-2019

- ✓ Contribution to the *Signs of Safety* implementation across Manchester, including the multi-agency training package design and delivery. There has been attendance at the Practitioner Updates for Signs of Safety. This means that MFT Safeguarding is well informed on the ongoing implementation of Signs of Safety. Community Safeguarding has been able to support other trusts in the implementation of Signs of Safety by sharing good practice. The benefits of the Signs of Safety Training have been evident in assessments, referral and reports, which have demonstrated the voice/ view of children. There has been very good evidence of this with children with disabilities when some very creative approaches have been used to illicit the child's view.
- ✓ Contribution to Manchester Safeguarding Children Board (MSCB) Neglect Training package (children) – this has been updated and will have a Senior Safeguarding Nurse involved in the delivery of training.
- ✓ Contribution to the MSCB Neglect Strategy Implementation Group and identified safeguarding team to be part of the delivery both within MFT and as part of the multi-agency training pool.
- ✓ Safeguarding Supervision – this has remained above 95% throughout 2018-2019 and has been prioritised to ensure that staff working directly with children and families receive high quality one to one or group supervision. Over the period of 2018-2019, 300 individuals or groups have had access to supervision as per MFT Safeguarding Supervision policy. Supervision has been extended on a group basis to the 3 Community CAMHS services as well as the Eating Disorder Service, Emerge and the Learning Disability CAMHS team.
- ✓ Modern Day Slavery and Human Trafficking training has been developed and delivered monthly across the Trust. This is extremely well evaluated. The learning from this training has contributed to the wider work in Complex Safeguarding.
- ✓ Learning from Serious Case Review (SCR) F1 - Manchester health data has contributed to the joint development of the Manchester Obesity Analysis Tool. Guidance has also been developed to support this work.

- ✓ SCR training provided to community staff to ensure they are aware of the learning and the implications for health.
- ✓ Impact Chronology Guidance has been developed to support staff in identifying health needs and the impact on children to contribute to multi-agency case planning.
- ✓ More robust process has been established for children where there are concerns around Fabricated and Induced Illness (FII) with Named Nurse oversight.
- ✓ Safeguarding Newsletter is produced monthly with a wider distribution developed, including North locality, to support staff with up to date safeguarding information on a monthly basis.
- ✓ Contributing to the MSB training on Forced Marriage (FM) and Honour Based Violence (HBV). There is a Health training package that is used to raise awareness to multiagency partners.
- ✓ Training to social work students at University of Manchester (once a year) on FM and HBV.
- ✓ Domestic Abuse training packages updated to incorporate Safe and Together. Package to emphasise recognition, response and referral process.
- ✓ Safeguarding Team contributed to the CQC Trust inspection which recognised good safeguarding practice in the Trust.

11.5 Safeguarding Children Wythenshawe, Trafford, Withington and Altrincham (WTWA) Team

Key Achievements 2018-2019

- ✓ More robust safeguarding documentation has been embedded within the team.
- ✓ A single agency Level 3 safeguarding children training package across the acute footprint has been developed and delivered. 16 sessions a year of Level 3 Safeguarding Children training is delivered within WTWA.
- ✓ Developed Safeguarding Children Supervision within the Adult Neuro Rehabilitation Unit at Trafford in light of the complex nature of the patients who receive care on the unit. Safeguarding Children Supervision is being established within the WTWA footprint.
- ✓ Ward Walks are occurring regularly in the key areas of the paediatric ward and Wythenshawe Emergency Department.
- ✓ Domestic Abuse training is now being delivered and offered to staff within WTWA.
- ✓ Named Nurse continues to attend Trafford Safeguarding Board sub groups and partakes in local Serious Case Reviews (SCRs).
- ✓ Named nurse has had monthly meetings with the Nursing Director WTWA to support embedding the safeguarding agenda in WTWA.
- ✓ Whilst the Safeguarding Team have undergone a period of reduced capacity there has been successful recruitment and further development of skills and experience within the Team.
- ✓ Worked alongside partner agencies form the airport managing trafficking cases.

11.6 Acute Safeguarding Children Oxford Road Campus

Key Achievements 2018-2019

- ✓ Level 3 full day Safeguarding Children training has been reviewed and updated and is receiving positive evaluation from staff.
- ✓ Level 1 and 2 e-learning safeguarding training has been updated.
- ✓ Whilst the Safeguarding Team have undergone a period of reduced capacity there has been successful recruitment and further development of skills and experience within the Team.
- ✓ There has been the introduction of formal Safeguarding Supervision sessions for identified practitioners in RMCH which have been positively received by staff.
- ✓ Good links have been maintained and further developed with specialist areas, including the Burns Service, PICU, CAMHS and the Trauma Team.
- ✓ Safeguarding processes are being developed in relation to Complex Safeguarding/ Contextual Safeguarding issues in line with multi-agency work streams. The Named Nurse attends the MSCB Complex Safeguarding Group and also chairs the MFT Complex Safeguarding sub-group whereby information is disseminated across all areas of the Trust.
- ✓ Bespoke safeguarding training/updates have been facilitated. For example the Multi-Agency Complex Safeguarding Hub have delivered presentations of their role/service to the MFT Complex Safeguarding Subgroup and to relevant areas within MFT.
- ✓ proactive in supporting MFT staff in relation to the new MSCB referral process and in providing constructive feedback to Local Authority partners.

11.7 Midwifery Safeguarding Oxford Road Campus (ORC)

Key Achievements 2018-2019

- ✓ Named Midwife/Modern Matron for Safeguarding has represented MFT with partnership agencies at the development and implementation of the Manchester Safeguarding Boards- “Staying Safe- Manchester’s Modern-Day Slavery and Human Trafficking Strategy 2018-2020.” This has included supporting the launch of the strategy across Manchester partnership agencies. Safeguarding Midwives have represented MFT by presenting at the annual public health conference in Birmingham (NEC) and at the Royal College of Midwives Annual Conference (Harrogate), to showcase our work supporting victims of human trafficking and the development of the strategy.
- ✓ As part of agency partnership development, Safeguarding Maternity have worked alongside social care, health visiting and Early Help, within the strategic group to support vulnerable women and their unborn babies, and those at risk of having babies removed from their care. This has resulted in a Central Manchester pilot scheme, offering joint support from Early Help, alongside a Named Social Worker to ensure the maximum support is given, for families to stay safe and together.
- ✓ The Named Midwife/Modern Matron for Safeguarding has continued to represent safeguarding at the IVF ethics committee, helping to ensure that safeguarding concerns are identified and addressed prior to the commencement of treatment from

reproductive medicine i.e. IVF conceptions. The IVF ethics committee was recently awarded Saint Mary's Hospital managed Clinical Service Recognition Award for Excellence in Equality, Diversity and Conclusion.

- ✓ Working in partnership with national IT systems, safeguarding midwives have helped to implement the FGM- Information System within Saint Mary's, which records all female babies born to women who have disclosed FGM, to the NHS National Spine. This will ensure that health visitors and GPs are aware of the risk to the female infant should the families move out of area.
- ✓ In order to ensure that safeguarding information is shared effectively within maternity and gynaecology, the Early Pregnancy Unit and Gynaecology wards now have full read only access to safeguarding referrals and safeguarding care plans electronic data. This will reduce the risk of harm to those babies who are unknown to midwifery when the mothers have failed to attend for routine antenatal care but have attended for early pregnancy dating scans.
- ✓ Continued to enhance partnership working with social care, the Police and partner agencies.
- ✓ Ensuring group supervision is given to all specialist midwives and those managing a safeguarding case load, on a monthly basis.
- ✓ Community Midwives receiving regular group supervision.
- ✓ Liaison and support between Oxford Road Safeguarding Midwives and Wythenshawe Safeguarding Midwives.
- ✓ Maintaining a visible ward presence by conducting daily ward rounds.
- ✓ Specialist Midwives now have the ability to upload their own safeguarding care plans to the database, ensuring that the information is accurate and up to date.
- ✓ Following the introduction of the request for GP's to share any safeguarding information when they receive the pregnancy notification.

11.8 Maternity Safeguarding Wythenshawe, Trafford, Withington and Altrincham

Key Achievements 2018-2019

- ✓ Attendance at child protection case conferences representing St Mary's at Wythenshawe Maternity.
- ✓ Provision of full and comprehensive reports for all child protection conferences.
- ✓ Completion of all requests for Court Reports and other legal documents.
- ✓ Facilitated discharge planning meetings when required.
- ✓ Remained accessible to Midwives and other members of staff for advice, guidance and support despite difficulties in staffing levels encountered.
- ✓ Co-delivered Level 3 Safeguarding Children training with the Safeguarding Children's Nurses.
- ✓ Provided additional training to Midwives on the Midwifery Study Day
- ✓ Provided safeguarding supervision to all Midwives.
- ✓ Co-delivered Female Genital Mutilation (FGM) training with other members of the wider Safeguarding Team.
- ✓ Contributed to FGM meetings across Manchester and Trafford to collaborate with the wider FGM team of professionals; Education, Police, Health.
- ✓ Provided support to staff in relation to substance misuse, FGM, surrogacy and domestic violence
- ✓ Continued to work closely with the Independent Domestic Violence Advisor (IDVA) who supports pregnant women with domestic abuse/violence

11.9 Adult Safeguarding Oxford Road Campus

Key Achievements 2018-2019

- ✓ Members of the Safeguarding Adult Team at ORC have led on the Self-Neglect Hoarding Strategy and Tool kit for Manchester Safeguarding Board (MSB). The Strategy will be launched in early autumn 2019 and the launch will be co-facilitated by the Safeguarding Adult Team (ORC) in partnership with the MSB and Manchester City Council (MCC).
- ✓ Adult Safeguarding notifications have risen by 14% (compared to the last financial year) reflecting the consistent training and advice given by the Adult Safeguarding Team.
- ✓ Safeguarding Adult Level 3 training is compliant with the Adult Intercollegiate document (Adult Safeguarding: Roles and Competencies for Health Care). Training is now being delivered to a wider audience on a monthly basis across MFT. The Manchester Local Care Organisation (MLCO) is also able to access the training.
- ✓ There has been a consistent increase in attendance at the new all-day Level 3 Adult Safeguarding training. Training evaluations have been positive and constructive.
- ✓ Regular attendance at Hospital/Managed Clinic Service (MCS) Safeguarding meetings.
- ✓ Quality assurance of the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Assessment Check list by the Safeguarding Adult Team assists with the quality of the research to be delivered at MARAC.
- ✓ The Safeguarding Adult Team is represented on the Sexual Exploitation Sub-group which assists in recognising the transition of individuals to adult services and supports in the sharing of relevant information.
- ✓ Representation by MFT on the Safeguarding Adult Review (SAR) Sub-group and SAR panels.
- ✓ Clinical staff attending practitioner learning events held by MSB.
- ✓ Attending Safeguarding conferences and outside training.
- ✓ Represented MFT on the MSB Making Safeguarding Personal (MSP) Task and Finish group.

11.10 Adult Safeguarding WTWA

Key Achievements 2018-2019

- ✓ DoLS point prevalence audits - completed in May and September 2018. The second audit showed an improvement across all sites from the baseline audit in compliance with DoLS legislation
- ✓ Level 3 Training – Training package reviewed and standardised across the MFT footprint to meet the requirements of the 2018 Intercollegiate Document. Delivery of the new package commenced in January 2019 and initial feedback has been very positive, with the vast majority of attendees reporting an increase in their knowledge following the training.
- ✓ Capacity/Best Interest documents established on Wythenshawe Electronic Patient Record (EPR) This allows the practitioner to be guided through the process as questions and prompts appear based on their previous responses. The system

went live in February 2018. The process is still becoming embedded in practice but an initial review of completed forms suggests that the quality of recording has improved.

- ✓ The Wythenshawe EPR system has been updated to include a safeguarding advice note. This has improved communication with the wards as telephone advice can be entered directly into the patient record.
- ✓ Making safeguarding personal – WTWA safeguarding referral form has been updated to prompt staff to discuss desired outcomes with the person in line with the MSP agenda.
- ✓ Falls/Safeguarding training – the team at WTWA collaborated with the Falls Specialist Nurse to develop a training package to develop understanding of the interaction between falls prevention and safeguarding. This has now been rolled out across WTWA sites and has been well received by staff.
- ✓ Trafford Hospital – Provision of Safeguarding support was transferred to the WTWA team in April 2018. Members of the team have worked closely with managers and staff at Trafford to develop good working relationships. Training has been delivered at Trafford to increase staff competence around safeguarding and MCA.
- ✓ Ulysses – In January 2019 the team moved on to the MFT joint Ulysses database from the previous UHSM system. This has improved joined up working with other corporate teams (e.g. PALS, Risk & Governance). The configuration of the system has also been amended to improve data accuracy for reporting purposes.
- ✓ Trafford MARAC – The geographical location of the WTWA sites means that patients using the service predominantly live in Manchester or Trafford Local Authorities. Previously, the team had been represented at Manchester South MARAC and in the past year, have extended this to cover attendance at Trafford MARAC also.
- ✓ LeDeR - Continued involvement in the learning disability mortality review process has ensured safeguarding specialist oversight and consideration specifically looking for reasonable adjustments and implementation of the Mental Capacity Act.

11.11 Mental Health Safeguarding Service

Key Achievements 2018-2019

- ✓ The service has been expanded to facilitate Trust wide provision.
- ✓ Preventing Future Deaths Action Plan (PFD) for mental health - further development of an action plan to provide assurance for the approved PFD action plan (legacy Wythenshawe) that applies across the Trust since merger. This has required further support to areas in the Trust that have not been notified of the requirements of the PFD previously. The primary focus has been to develop knowledge and skills in respect to:
    - Ligature risk assessment/ Incident response
    - Prevention & Management of Missing and Absconding patients
    - Mental Health Act requirements
    - Responding to incidents that involve behavioural disturbance
- ✓ Further work is on-going through the mental health sub –group to ensure that all areas identified as moderate/high risk of contact with the patient cohort for self-harm/

suicide risk are provided with approved training. The utilisation of an integrated care pathway for possible self-harm/ suicide presentations is fully imbedded at Wythenshawe, with work underway to ensure that this pathway is adopted across MFT. It is expected that this will be rolled out across urgent care by September 2019, with further rollout across MFT by the end of the year.

- ✓ Mental Health Policies - Overarching mental health policies related to have now been ratified across the MFT footprint. This includes:
    - Suicide Prevention Policy
    - Care for patients who experience behavioural disturbance due to mental health conditions
- ✓ Mental Health Training – training continues to be delivered regularly across the Trust with the addition of mandatory mental health awareness training for TNAs. A mental health education strategy working group has been commenced, with further training needs analysis to be completed across the Trust. The strategy will be reviewed by the Mental health sub –group, with an anticipated completion date of April 2020.
- ✓ All current training has been reviewed and updated to include content with respect to ratified policy and legal changes throughout the year. Work is ongoing with learning & development to review level 2 e-learning to ensure this is reflective of key performance actions for staff, linking in with Trust values for equity and parity of esteem for mental health care at MFT.
- ✓ MFT Mental Health subgroup – Decision made for mental health accountability at MFT for key work streams related to overarching mental health policies through a Trust wide group. A Mental Health subgroup has been formed to provide assurance to the Group Safeguarding Committee that actions related to quality and patient safety issues are being addressed and appropriate, timely progress monitoring is taking place.
- ✓ Making Mental Health Safeguarding personal -Work has commenced with local service user/ expert by experience groups to help the team to develop pathways/ service improvements that improve the experience of receiving mental health care with the Trust.

SECTION G

Manchester University NHS Foundation Trust (MFT)

Safeguarding Forward Plan for 2019-2020

12 MFT Safeguarding Team Development Plans for 2019-2020

During 2019-2020, the component teams that make up the MFT Safeguarding Service will continue to develop safeguarding practice and structures in order to continuously improve support to staff, multi-agency colleagues and service users. Key actions are summarised below:

12.1 Named Doctors Child Safeguarding, Community Child Health

- The service now receives referrals of children with Fabricated and Induced Illness and this work will be audited with a particular focus on the time taken to prepare and assess children.

12.2 Paediatric Doctors Looked After Children Service

- To offer a flexible approach for young people who are unsuitably supported or reluctant to attend for formal clinic attendance, with option for joint visit with Paediatrician and Specialist Nurse for Initial Health Assessment (IHA), in placement or other venue according to young person's preference.
- Continue project with Moss Side Medical Practice, review extending involvement of primary care (GP) and widening health offer for young people aged 14 years and over.
- Explore alternative ways to seek feedback from children and young people about health assessments, and incorporate feedback in future service developments.
- Develop pathway to ensure links between the Education Health Care plan process and the statutory health assessment process.

12.3 Nursing Looked After Children Team

- Raise awareness of the Specialist nursing service for 'Our Children' across the trust to develop pathways for coordinated care
- Recognise, celebrate and share our successes and good practice.
- Further development of the SEND agenda in relation to Our Children.
- Immunisation coverage for 'Our Children' is lower than aspired and will be reviewed
- Further work is needed to ensure the Strengths and Difficulties Questionnaire (SDQ) completed with Our Children" informs the health assessment.
- Our services need to focus more on outcomes and evidence the impact they have with Our Children. The commissioning review of the service specification is an opportunity to do so as it aims to develop outcomes focused specification.
- Seeking the views of Our Children on what needs to be done to improve the services we provide.
- Partnership work with Children's Social Care with regards to their new system Liquid Logic and what this means with respect to future processes for notifications and health assessment requests.
- Develop the service in line with the new service specification.
- Demonstrate how we engage our children at each stage of their care planning in order to help them be involved in, and take ownership of, their own health and care.

- A full review of the Looked after Children: Knowledge, skills and competences of health care staff- Intercollegiate Role Framework (March 2015) is required in order to propose and develop a LAC training package

12.4 Safeguarding Children Community Team

- Review all Level 3 safeguarding training packages, incorporating learning from Serious Case Reviews.
- Review safeguarding processes for multi-agency Missing from Home and MARAC processes
- Graded Care Profile2, MFT & MSCB training programme to ensure dissemination to priority groups across the Trust.
- To prioritise safeguarding training for MFT.
- To ensure staff's individual professional development.
- To review safeguarding processes around Prevent to ensure effective health contribution to the Channel process.
- To review and analyse data around the number of victims of human trafficking and modern day slavery being identified in health settings.
- To review and develop the processes to support dental MFT staff.
- Redesign court statement training package.
- To complete Safeguarding Supervision Audit.
- MFT Exploitation Risk Indicator Checklist is being updated to include all forms of exploitation,
- To continue to use a young person/adult sexual exploitation story at each Child Sexual Exploitation sub group meeting, keeping the subgroup focused on what it is the trust wants to achieve for our young people and adults.
- Update Managing Allegations training in line with the updated policy.

12.5 Acute Safeguarding Children

- Further review and alignment of Level 3 Training across all MFT Community/Acute areas.
- Safeguarding Link Nurse Meetings to be reviewed and learning and development shared across clinical teams.
- Further development of working relationships with multi-agency partners in Manchester and other local areas.
- Further review and alignment of Acute Safeguarding Children processes across all MFT sites.
- Ongoing development of safeguarding processes in relation to Complex Safeguarding issues and alignment with Local Authority multi-agency work streams.
- Involvement in MASA and dissemination of learning from SCR's across MFT.
- Further development of Fabricated Induced Illness (FII) and Perplexing Illness Presentation processes and guidance for staff on receipt of National Guidance and review of training.
- Ongoing development of the Safeguarding Team, including further joint working across hospital sites.

- Ongoing development of safeguarding practice in alignment with MSB work streams.
- Review of Safeguarding Documentation and Case File Audits
- Safeguarding Record Keeping audit in RMCH.
- Further development of links with ward areas to promote and develop safeguarding practice.

12.6 Midwifery Safeguarding

- Harmonising safeguarding processes across both maternity sites.
- Developing information sharing processes from safeguarding maternity to GPs.

12.7 Adult Safeguarding and Mental Health

- Further alignment of Adult services at Oxford Road Campus (ORC) and Wythenshawe, Trafford, Withington and Altrincham (WTWA). This will involve establishment of closer working relationships across the safeguarding teams
- The introduction of Ulysses as the main electronic source of reporting safeguarding adult notification and recording actions and outcomes. To develop system to streamline DoLS and safeguarding referral processes
- To promote awareness and compliance with the Mental Capacity Act. This is being addressed via the updated Safeguarding Level 3 training.
- Following the introduction of the new Mental Capacity Act (MCA) amendment bill a review of the MCA training delivered in Adult Safeguarding training is required.
- Further development of the new Liberty Protection Safeguards (DoLS) in collaboration with the responsible bodies in response to Mental Capacity Act Amendments
- Adult Supervision for frontline workers model to be developed with the Manchester Health and Care Commissioners (MHCC).
- Developing a pathway across the trust to ensure reporting and referring to the Safeguarding Team when harm has occurred within MFT
- Lessons learned from SARs to be embedded within clinical practice and effectiveness, quality performance e.g. documentation.
- Implementation and embedding of Making Safeguarding personal across MFT.
- Development of Self-Neglect Training with Manchester Safeguarding Board (MSB).
- Implementation of the MSB Self –Neglect and Hoarding Strategy and Toolkit across MFT.
- Streamlining of the safeguarding referral process with the introduction of Ulysses.
- Adult safeguarding to be embedded within all safeguarding sub groups in MFT
- MFT Adult Safeguarding to be represented in the review of the Manchester MARAC process.
- Ensuring safeguarding visibility and support across the MFT footprint.

13 Safeguarding Audit Plan 2018/19

13.1 In line with key priorities of the Safeguarding Adults and Children Boards and messages from previous MFT audits the following Audit Plan is proposed for 2019-2020:

- Review of the quality of Multi Agency Risk Assessment Risk Assessment referral (MARAC/ DASH) process
- Mental Capacity Act (MCA) Staff Awareness and Mental Capacity Act Case Note Review
- Making Safeguarding Personal (for adults and children including the voice of the child)
- Review of Referrals to social care
- Safeguarding Supervision review

13.2 These audits will span all services and give MFT a clearer picture on gaps and areas for development as well as areas of good practice. This will allow alignment with MSAB/MSCB key priority areas. MFT will also continue to take part in MSAB and MSCB multi- agency audits.

14 Delivery of Safeguarding Work Plan 2018-2019 and Priority Setting for 2019-2020

14.1 **Figure 41** summarises the outcomes achieved through the delivery of the MFT Safeguarding Work Plan in 2018-2019 and sets out the priority areas that will inform the 2019-2020 MFT Safeguarding Work Plan.

Figure 41: Progress against 2018-2019 Trust Safeguarding Work Plan 2018-2019 and Priorities for 2019-2020

Key Priority	Key outcome	Achieved	2019-2020 Priority
Audit	All Audits completed, with action plans in place Plan for re-audit if assurance not given. Plan for audit in 2019/20 with rationale where audit not completed in 2018/19 as planned	✓	**To complete audits in line with Safeguarding Audit plan.**
Supervision	All staff has access to supervision and support relevant to their area of work. Community Safeguarding Supervision compliance is above 90% for all relevant staff. Supervision developed in areas such as CAMHS, Royal Manchester Children's Hospital, St Marys and Sexual Health services	✓	**To cosolidate safeguarding supervision in acute services with establishment of robust reporting processes**
Policy /practice changes	Policies and practice is reviewed and updated within timescales and all divisions receive timely updates. Hospitals/MCS/MLCO have provided assurance that these have been embedded across all relevant staff groups.	✓	**All safeguarding policies are reviewed and updated within expected timescales**

Section 11 Audit	Section 11 audit is completed and action plan is completed or in progress.		**To complete new Section 11 audit**
Training	There is a safeguarding training package in place There is capacity to meet the safeguarding training requirements across the Trust. There is a system in place to report on attendance and compliance with safeguarding training.		**To work in partnership with hospitals/MCS/MLCO to improve training compliance to expected 90% compliance levels**
Safeguarding children/ Adults	Key messages regarding priority areas have been shared across all hospitals/MCS/MLCO. Domestic Abuse, Female Genital Mutilation, Complex Safeguarding, Child Sexual Exploitation, Early Help and Neglect sub-groups are established within MFT.		**To review implementation of the Neglect Strategy for children across the Trust.** **To embed the Self Neglect Strategy and Toolkit across the Trust.** **To embed learning from Serious Case Reviews and Safeguarding Adult Reviews into practice, including learning around safeguarding vulnerabilities of homeless population.**
LAC (Looked After Children)	Compliance against statutory requirements monitored and risks identified. Close working with multi-agency partners to achieve best outcomes for Looked After Children.		**To continue to work with the Local Authority to streamline the request process for health assessments.** **To work with Manchester Health Care Commissioning to review service specification of Looked After Childens team with a focus on improving outcomes for "Our Children"**
Voice of the Child Voice of the Vulnerable Adult	All hospitals/MCS/MLCO are aware of the need to include the child and vulnerable adult's wishes and views in all safeguarding decisions. The safeguarding work plans identify strengths and areas for development identified within hospitals/MCS/MLCO and there is evidence of plans to manage any gaps in practice areas. Safeguarding Adult and Children champions are in place across all frontline areas.		**To audit Making Safeguarding Personal and Voice of the child and embed in 'What Matters to me' agenda.**
Mental Capacity Act (MCA) Deprivation of Liberty Safeguards DoLS	Staffs have an increased understanding of MCA/DoLS across the Trust. Staff understand their role and responsibility, and are following guidelines. Hospitals/MCS/MLCO monitor their DoLS activity		**To further develop understanding of MCA/DoLS across all services.**
Serious Case Reviews/ Safeguarding Adult Reviews and Domestic Homicide Reviews	MFT contribute to All reviews Lessons learnt are shared across the Trust and inform practice.		**To ensure there are robust processes inplace and learning is dissenainated to all areas from SCRs SARs and DHR.**

15 Conclusion and Recommendations

15.1 Manchester continues to have one of the country's highest rates of deprivation, bringing with it a range of challenges for safeguarding and for all health services. The health profile is also changing across Manchester with the development of the Single Hospital service and the Manchester Local Care Organisation. In 2019-2020 the Trust footprint will increase with addition of North Manchester Hospital and Trafford Community Services.

15.2 Amidst all these changes MFT safeguarding service continues to ensure that the Trust remains sighted on legislative and practice changes that affect safeguarding. The key changes include the implementation of the new Working Together guidelines for safeguarding children arrangements across the partnership, the amendment to the Mental Capacity Act regarding introduction of Liberty Protection Safeguards and responding to new Domestic Abuse legislation. Challenges continue to emerge and require a robust response with the further embedding of the Complex Safeguarding agenda and the need to prepare safeguarding services for future challenges within the evolving health and social care landscape.

15.3 The 2018-2019 Annual Report demonstrates the complexity of the safeguarding work undertaken within the Trust by the Safeguarding Team and wider workforce whilst ensuring that patients and staff are safe. Safeguarding is a key priority for the Trust, and this report provides assurance that the Safeguarding team delivers high volume and high quality support, to enable the Trust to meet its statutory requirements.

15.4 The increasing complexity of safeguarding is evident in this report and activity has been extensive across the Trust during the reporting period to protect patients and service users and to support staff to effectively identify and manage safeguarding issues. A wide-reaching training programme has been delivered to support the development of knowledge and skills across the workforce and, although improvement is necessary to increase compliance, the impact of this training is evidenced by the increase in referrals to the Trust Safeguarding Team.

15.5 In the coming year, the Safeguarding Team will consolidate delivery of safeguarding services under the Single Hospital services and will ensure that the support of staff and the protection of patients remain central in any organisational change. The Trust will continue to embrace best practice, actively participate as a key multi-agency partner, but most importantly ensure that all patients and service users are afforded the best possible protection form abuse and neglect.

15.6 The Board of Directors is asked to note the activity undertaken within the Trust and across the multi-agency partnership to support MFT staff and services to be responsive to the safeguarding needs of patients and service users. The Trust's on-going focus on safety supports safeguarding to remain a key organisational priority.

APPENDIX 1 – 2018-2019 Safeguarding Audit Calendar

Safeguarding Audit Calendar 2018-2019

Community and LAC audits and reviews 2018

Community

Title	Lead	Time Frame	Strategic Links	Assurance	Evidence	Assurance	RAG
RE-AUDIT MARAC/ DASH process	Community / Acute Safeguarding teams	Completed 09/08/2018	Statutory Guidance Section 11 Audit Trust policy Trust Safeguarding and Record keeping policy MSCB procedures	Trust Safeguarding Committee	Report completed	Limited assurance Audit plan in place for review 2019/20	
Quality Assurance of Referrals to Children's Services April, May and June 2018	Community Safeguarding teams	Completed 09/08/2018	Statutory Guidance Trust policy MSCB procedures	Trust Safeguarding Committee	Report completed community safeguarding referrals to social care were high quality and at appropriate level of need		
Review of Safeguarding Record Keeping Community Electronic Patient Records	Community Safeguarding teams	Completed 24/09/2018 And reviewed 23.1.19	Statutory Guidance Trust policy	MLCO Safeguarding Committee	Reports completed	Limited assurance. Review plan in place with community children's services	

Looked After Children

Title	Lead	Time Frame	Strategic Links	Assurance	Evidence	Assurance	RAG
Audit to benchmark staff awareness of LAC requirements in practice	LAC team	March 2019	LAC Statutory Guidance Section 11 Audit Trust policy	Trust Safeguarding Committee	Audit plan commenced in quarter 4 and will be completed by quarter 1 2019-20		

			Trust Safeguarding and Record keeping policy MSCB procedures.				
Acute Children's Safeguarding							
Title	**Responsibility**	**Time Frame**	**Strategic Links**	**Assurance**	**Evidence**	**Assurance**	**RAG**
Repeat 16 & 17 year old audit – to identify if improvements have been made following initial audit completed November 2016.	Children's Safeguarding team WTWA	Completed April 2018	Statutory Guidance Section 11 Audit Trust policy Trust Safeguarding and Record keeping policy MSCB procedures	WTWA Safeguarding Committee	**Report completed**	Full assurance in relation to a young person's emotional needs being met however limited assurance that their care responsibility's at home had been considered whilst being cared for by the Trust.	
Adult Safeguarding and Mental Health							
Title	**Responsibility**	**Time Frame**	**Strategic Links**	**Assurance**	**Evidence**	**Assurance**	**RAG**
Mental Capacity Act (MCA) Staff Awareness and Mental Capacity Act Case Note Review	Safeguarding Adult Teams	2018/2019	Statutory Guidance MSAB Assurance Trust policy Trust Safeguarding and Record keeping policy MSAB procedures Statutory Guidance MSAB Assurance Trust policy Trust Safeguarding and Record keeping policy	Trust Safeguarding Group Safeguarding Committee	MCA Audit completed in Q2 2017/18. Very poor uptake from across the Trust with only 113 respondents. To be re-audited across both sites in 2018/19.	2017/2018 audit Very limited assurance. Needs Hospital support for next audit**.**	

			MSAB procedures		2019/20 Deprivation of Liberty Safeguarding point prevalence Point Prevalence completed across all MFT sites in 2018 identified 9% of total eligible patient population who should have been on a DoLS had no application made		
Prevention of Missing & Absconded Patients	February 2019	Report completed	Trust policy	Trust Mental Health Sub group and Quality and Learning Committee	Report to be presented to Quality and Learning Committee March 2019	Report and action plan completed	

There will also be a requirement to undertake audit throughout the ear in response to SCR/ DHR and HLIs therefore there will be a flexibility and capacity within the calendar to achieve this.

Manchester Safeguarding Board Multi-Agency Audit 2017/18

	Audit emailed out and briefing session if applicable	**Audits required back by**	**Overview report to QAPI**	**Report presented to MSCB**	**MFT lead**	**Complete**
MSAB Self Neglect Audit	Completed	Completed	Completed	Ongoing awaiting final report	**Safeguarding adult Named Nurses**	
MSCB Neglect with focus on Children With Disabilities	Completed	Completed	Completed	Ongoing awaiting final report	**Community Named Nurses**	
MSAB theme: Mental Capacity Act Tbc	29 March 2019	26 April 2019	16 May 2019 tbc	TBC	**Safeguarding Adult Named Nurses**	

Audit plan for 2019/20

In 2019/20, proposed audits and re-audits include:

1. MARAC/ DASH process
2. Mental Capacity Act (MCA) Staff Awareness and Mental Capacity Act Case Note Review
3. Making Safeguarding Personal (for adults and children including the voice of the child)
4. Review of Referrals to social care
5. Safeguarding Supervision review

The following contribution will be required to Manchester Safeguarding Board audits

Manchester Safeguarding Board Multi-Agency Audit 2019/2020

	Audit emailed out and briefing session if applicable	**Audits required back by**	**Overview report to QAPI**	**Report presented to MSCB**	**MFT lead**	**Complete**
Joint MSCB / MSAB theme: Transition – CAMHS to Adult Services	21 June 2019	19th July 2019	11 September 2019 tbc	tbc	**Named Nurses**	
MSCB theme: Looked After Children (placed at home)	20 September 2019	18 October 2019	11 December 2019 tbc	tbc	**Named Nurse Looked After Children**	

[i] Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) 1st edition

[ii] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition