MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA ITEMS)

(DUE TO THE IMPACT OF THE ONGOING COVID-19 NATIONAL EMERGENCY RESTRICTIONS, THE MEETING WILL NOT BE HELD IN PUBLIC)

MONDAY, 13th JULY 2020

A G E N D A

1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Minutes of the Board of Directors' meeting held on 9th March 2020 were approved at the Board meeting (not held in Public due to the COVID-19 National Emergency Restrictions) on 11th May 2020.	*(Enclosed for information)*
4.	To Receive the MFT Board Assurance Report (May 2020)	*(All)*
5.	To Receive an Update Report on the Trust's ongoing response to the COVID-19 National Emergency	*(Report of the Group Chief Operating Officer Enclosed)*
6.	To Receive the Group Chief Finance Officer's Report	*(Report of the Group Chief Finance Officer Enclosed)*
7.	To Receive a Progress Report on the NMGH Management Agreement between Pennine Acute Hospitals NHS Trust and Manchester University NHS Foundation Trust and associated plans for a statutory acquisition of North Manchester General Hospital by MFT	*(Report of the Group Executive Director of Workforce & Corporate Business Enclosed)*
8.	To Receive an Update Report on the CQC Action Plan	*(Report of the Group Chief Nurse Enclosed)*
9.	To Receive the CRN: GM Annual Report (2019/20)	*(Report of the Joint Group Medical Director)*
10.	To Receive the 2020/21 Board Assurance Framework	*(Report of the Group Executive Director of Workforce & Corporate Business Enclosed)*
11.	To Receive the Following Annual Reports for 2019/20:	
	11.1 Complaints Annual Report (2019/20)	*(Enclosed)*
	11.2 Annual Infection Prevention Control Report (2019/20)	*(Enclosed)*
	11.3 Annual Nurse & Midwifery Revalidation Report (2019/20)	*(Enclosed)*
	11.4 Annual Accreditation Report (2019/20)	*(Enclosed)*
	11.5 Annual Safeguarding Report (2019/20)	*(Enclosed)*
	11.6 Q4 (2019/20) Complaint Report	*(Enclosed)*

12. To note the following Committees held:

12.1 Group Risk Oversight Committee held on 4th May 2020
12.2 Audit Committee held on 26th May 2020
12.3 Quality & Performance Scrutiny Committee on 2nd June 2020
12.4 HR Scrutiny Committee held on 16th June 2020
12.5 NMGH Scrutiny Committee held on 22nd June 2020

13. Date and Time of Next Meeting

The next meeting **Monday, 14th September 2020**

14. Any Other Business

NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 9th March 2020

(Held in Public)

36/20 Apologies for Absence

Apologies were received from Mr D Banks; Mrs J Bridgewater; Professor L Georghiou, and, Mr A Roberts.

37/20 Declarations of Interest

There were no declarations of interest received for this meeting.

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

38/20 Patient Story

The Group Chief Nurse introduced a DVD Story in the form of a DVD clip.

The Board did not debate or discuss the clip, preferring to use the story and the imaging to keep the business of the Board focused on the patient experience.

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

39/20 Minutes of the Board of Directors Meeting held on 13th January 2020

The minutes of the meeting held on the 13th January 2020 were agreed as a correct record.

40/20 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 13th January 2020 and noted progress.

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

41/20 Group Chairman's Report

(i) The Chairman reported that the pace of change and response to the management of the COVID-19 virus across the country and within the NHS was rapidly evolving with a further details highlighted under Agenda Item 43/20.

The Chairman also confirmed that the organisation had taken a decision the previous week to postpone the MFT Excellence Awards event scheduled for early March in response to the emerging response to the COCID-19 outbreak. It was confirmed that plans were being developed to re-schedule the event later in the year.

(ii) The Chairman reported that in January 2020, she visited the Genomics Hub at Saint Mary's Hospital with the High Sheriff of Greater Manchester, Mark Isaac Adlestone Esq OBE DL. The Board noted that the High Sheriff was deeply impressed with the range of services provided by the Hub.

(iii) The Board noted that the annual MFT Sustainability Awards had been successfully held in January 2020 and served to celebrate all the hard work being undertaken to ensure MFT was a greener and more energy efficient organisation.

(iv) The Chairman was pleased to report that MFT had been shortlisted for two BMJ Awards, namely, one team from Wythenshawe in the *Anaesthesia & Perioperative Medicine* category, and, a second team from Wythenshawe in the *Women's Health Team* category. It was noted that winners would be announced on 22nd April 2020.

(v) The Board noted that a new clinical space on the Newborn Intensive Care Unit (NICU) at Saint Mary's Hospital had been recently opened which created a welcoming environment for babies at all levels of dependency and their families, with state of the art equipment and space for up to eight cots.

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

42/20 Group Chief Executive's Report

(i) The Group Chief Executive reported that despite the additional pressures now presented by the emerging COVID-19 pandemic, he wished to highlight and acknowledge the huge efforts of the MFT workforce in continuing to rise to the challenge.

Both the Group Chairman and Group Chief Executive, on behalf of the Board of Directors and Council of Governors, expressed their gratitude and appreciation to all MFT staff for their continued efforts, energy and unstinting commitment to maintaining patient safety and experience.

(ii) The Board noted MFT's continued research efforts and collaboration across GM with news expected following a recent interview with an International Panel on GM's bid for re-designation as an Academic Health Science Centre (AHSC). It was noted that one particular area drawn-out by the Panel related to the Nursing, Midwifery & AHP research activity in Manchester (led by the MFT Group Chief Nurse) which distinguished Manchester from other comparable centres.

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

43/20 Operational Performance

Board Assurance Report

The Joint Group Medical Director provided an update under several key areas under the main heading of Safety. It was noted that that since the last Board of Directors in January 2020, a further three NEs had been reported. It was confirmed that whilst no serious harm to the patients concerned had been reported, it was, nevertheless concerning that there was a common theme of 'wrong site surgery' (one at the MREH and two at Wythenshawe). It noted that further investigations were underway into the latest NEs with a more detailed analysis and areas of learning to be presented to the next meeting of the Quality & Performance Scrutiny Committee in April 2020. It was emphasised by the Joint Group Medical Directors and Professor Dame Sue Bailey (as Chair of the Quality & Performance Scrutiny Committee) that focus continued on improving systems and processes and especially a review of culture and the impact of 'human factors' on performance and safety.

The Board also noted that High Level Incident Reporting within the Trust was 'good' with no untoward areas of concern. Similarly, Mortality Reviews were undertaken in all Hospitals/MCSs utilising the 'Standard Judgement Tool' to grade deaths with no reported Level 3 cases (or above) being reported (i.e. no avoidable features identified). It was also reported that there had been a rise in the Wythenshawe Hospital Crude Mortality data in December 2019 and January 2020 with a report presented to the Group Quality & Safety Committee (reviewing seasonal mortality on the site over recent years). However, it was noted that MFT's overall mortality indices were significantly below the expected range (taking into account the epidemiology of the population served by MFT Hospitals/MSCs).

The Group Director of Estates & Facilities (on behalf of the Group Chief Operating Officer) provided an overview of activity under three main headings, namely, A&E and Urgent Care (despite ongoing challenges, MFT was performing at 3% higher than the GMB average); Referral to Treatment & 18wks Pathways (with one 52wks breach in Ophthalmology due to an administrative error with no harm to the patient reported and learning shared across the Group. The overall MFT Waiting List size has grown by 5%); and, Cancer performance (positive 2wks wait time which has stabilised and is now within the required target coupled with the positive impact of the Trust's Cancer Excellence Programme). In response to questions and observations from Mr Nic Gower, discussion centred on the future benefit of more refined EPR data systems, validation and analysis.

The Group Executive Director of Workforce & Corporate Business highlighted key areas of performance, namely, Attendance (requiring further improvement with the role of the Absence Management System and next phase of implementation attracting scrutiny and attention via AOF); Mandatory Training (doing well on Core Mandatory Training but further focus required on Level 2 & 3 Mandatory Training). It was noted that further focus and scrutiny on key areas of performance would continue to be applied at the HR Scrutiny Committee.

The Board Assurance Report was noted.

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

<u>Update Report on the Trust preparedness for the management and treatment of patients with COVID-19</u>

The Group Chief Nurse provided an update on the Trust's progress to manage suspected cases of COVID-19. The Board noted the background to the pandemic and the reported national position (as 24/02/2020) which was 6,536 people tested for the virus in the UK of which 9 were tested positive.

The Board noted that the Group Chief Operating Officer was leading the Trust's response to the pandemic as Designated Lead for EPPR (supported by several Group Executive Director Subject Experts).

In response to questions and observations from Mrs Chris McLoughlin and Mr Barry Clare, particular attention was drawn to the details of the Trust's preparedness to managing patients who presented with suspected COVID-19 including escalation plans for additional capacity to manage patients to be tested (at hospital and community settings); review of potential isolation facilities in Critical Care Units; and, extending the programme for training staff to use enhanced PPE. It was also reported that the Trust had been actively engaged in following the patient pathway under the leadership of the Group Chief Nurse/Director of Infection Prevention and Control (DIPC) and Joint Group Medical Directors. It was also confirmed that daily Strategic and Tactical Meetings had been established in keeping with the Trust's EPPR Protocols and national guidelines.

In conclusion, the Board recognised that since the outbreak of the virus was a rapidly evolving situation, the focus across the UK currently remained at containment level with the Trust working closely with NHS England and GMHSCP on a daily basis to achieve this goal.

The Board noted and supported the Trust's plans and performance to date to manage patients who presented with suspected COVID-19.

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

Group Chief Finance Officer's Report

The Deputy Group Chief Finance Officer explained that whilst financial performance in February continued to fall short of Control Total requirements across Hospitals/MCSs collectively, the rate of deterioration had slowed due to a positive and encouraging response from Hospitals/MCSs to the 'Q4 Challenge'. However, it was recognised that significant challenges to stabilise the month-on-month run-rate remained with visible and sustained improvements needed to be delivered across all areas over the remainder of the year in order to provide greater assurance of the Trust's continuing financial sustainability. It was emphasised that improved delivery remained critical to the Board's ability to commit strategic investment decisions over the months ahead.

It was reported that ongoing follow-up discussions would continue to be held regularly between the Group CFO, Group COO and Hospital/MCS CEOs and leadership teams to ensure that progress was maximised and any delay factors were systematically tackled and removed moving into 2020/21. It was also reported that further in-depth analysis and assurance would be provided at the next meeting of the Trust's Finance Scrutiny Committee on 18th March 2020.

The Chief Finance Officer's Report was noted.

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

44/20 Strategic Review

Update on Key Strategic Developments

The Group Director of Strategy provided an update to the Board of Directors in relation to strategic issues of relevance to MFT. Particular attention was drawn to the national 'Anchor Programme' where large public sector institutions / organisations, which are unlikely to relocate and have a significant stake in a geographical area, have key roles around employment and procurement along with the use of land and estates and environmental sustainability throughout the country. It was noted that on the 22nd January 2020 MFT had hosted a visit from NHS England and NHS Improvement (NHSE/I) and the Health Foundation to present the organisation's track record in this area, which included discussions on the workforce strategy, procurement and commissioning for social value, use of capital and estates, environmental sustainability, and partnership working.

Attention was also drawn to several current strategic issues with the Greater Manchester conurbation including the Improving Specialist Care (ISC) Programme, and, progress with the Rapid Diagnostics Centres (RDC).

On a more local level, the Board was advised that MFT was continuing to develop its Clinical Service Strategy Programme with a focus on 'Engagement'. It was reported that there was a particular focus on the overarching Equality Impact Assessment (EQIA) on twelve key themes which emerged from the service strategies. The Group Director of Strategy explained that as part of this process, MFT was holding two workshops to understand the impact of these themes on patients, particularly those with protected characteristics.

In conclusion, the Board noted the updates in relation to the national, GM and local MFT strategic issues.

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

Progress Report on the NMGH Management Agreement between Pennine Acute Hospitals NHS Trust and Manchester University NHS Foundation Trust and associated plans for a statutory acquisition of North Manchester General Hospital by MFT

The Group Executive Director of Workforce & Corporate Business provided a summary overview of progress made since the last meeting of the Board of Directors in early January 2020 with the proposed acquisition of North Manchester General Hospital (NMGH) and the associated re-development of the NMGH site.

The Board was reminded that the new Management Agreement would need to be put into place by the end of March 2020 and that NHS E/I were progressing this work with the full support of all partner organisations who were committed to the delivery of safe, quality services for the local communities. It was also re-confirmed that formal transactions to make these arrangements permanent would be completed by April 2021 at the latest.

The Group Executive Director of Workforce & Corporate Business described the proposed governance arrangements under the new Management Agreement which were being put into place to ensure the safe transition of services from 'Day One' (1st April 2020). It was noted that an independent Board was being re-established for PAHT, to oversee the functioning of the management agreements in place with MFT and SRFT. It was also noted that the Board would also oversee the disaggregation of corporate and clinical services and support the completion of the two transactions. It was reported that membership of the Board would be consistent with statutory requirements and would include an independent chair and non-executive directors (Board profile noted).

The Board was advised that a North Manchester Implementation Plan (NMIP) had been developed which served to outline the proposed leadership and governance arrangements, programme risk management and monitoring, a process for required partnership working with SRFT, and formulation of an approach to 'Day One' planning. The Group Executive Director of Workforce & Corporate Business explained that as part of this work, MFT was in the process of establishing a NMGH leadership team that would take responsibility for the operation of the site and the management of the clinical services. It was noted that the team would participate in all the normal MFT governance arrangements and the North Manchester Chief Executive had recently been announced as Ms Dena Marshall, formerly Chief Executive of the Royal Manchester Children's Hospital.

The Board was also reminded of the North Manchester Proposition which had been shared previously and presented an opportunity for a broader integration health offer i.e. health as the basis for major urban change. The Board was advised that this programme of work had commenced and planning for the site was underway in line with the ambitions of the proposition. The outline of the re-development plans were noted along with the focus on progressing the masterplan and design of the site which would be completed with the input of clinical and corporate services. The Board noted that collaborative working arrangements were also being put into place to ensure that the design remained faithful to the proposition, GM programmes, MHCC commissioning intentions and MFT strategies.

In response to questions and observations from Mr Trevor Rees, it was confirmed that governance arrangements were in place to guide the process along with the establishment of a Task and Finish Group which reported to the North Manchester Transaction Board chaired by the Group Executive Director of Workforce and Corporate Business. It was confirmed that this Board would provide assurance on the overall transaction to the recently formed MFT North Manchester Scrutiny Committee (and would include regular updates on progress in completing a thorough due diligence exercise, alongside NHSE/I, on NMGH's underlying financial deficit).

In conclusion, the Board was advised that negotiations would continue to finalise the management agreement ready for Board consideration in late March 2020 along with the continued development of plans for taking on responsibility for NMGH, with the objective of ensuring a safe and effective transfer of responsibilities on 'Day One' of a management agreement, with minimal disruption to staff or patients.

In conclusion, the Board noted the progress being made with the transaction process and supported the strategic direction of the programme.

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

Update Report on the Local Care Organisation (LCO)

The Chief Executive of the LCO presented an update on the progress the LCO had made in delivering against its urgent care and system resilience plans; Trafford Community Services; and, Integrated neighbourhood working.

The Board noted that as in previous updates, the LCO continued to work closely with MFT and its principal hospital sites to support the alleviation of current and ongoing acute flow pressures. Particular attention was drawn to the support provided to the operational delivery of the discharge programme, with the LCO establishing a robust programme infrastructure that looked to continue oversight of the implementation and development of the MRI Integrated Discharge Team; support the wider deployment of system improvement across the North and South Integrated Discharge Teams; support flow changes across the wards to support timely discharges; establishment of a fully established Control Room for the LCO; and, the integration of Mental Health services across the discharge pathway.

In response to questions and observations from Mr Barry Clare regarding DTOCs, the Chief Executive of the LCO described the short term plan in response to the continued and escalating pressures within the health and care system in Manchester. Particular attention was drawn to the five key areas which included standing up the control room function including care brokerage; increasing deflection activity through MCR and avoiding admissions; IDT implementation (MRI focus and city wide) and improving D2A; Market stabilization; and, Data to drive care decisions, targeting and assurance.

The Chief Executive of the LCO provided an update on the Trafford LCO and explained that there were three layers to how health and social care service developments took place in Trafford, namely, a plan for Trafford as a locality; an alliance to help develop and oversee many parts of this plan; and, a partnership organisation to be the building block for integrated management and delivery of care. The Board also noted that the approach to the first six months of the Trafford LCO was characterised by two distinct phases which included the overseeing of the safe and effective transfer of services, and, the a comprehensive review of services and developing an operational plan for 2020/21.

It was confirmed that progress in regards to delivering the TLCO PTIP had been positive, with detailed work being undertaken on the model of governance to ensure that the services transferring over were appropriately aligned to existing MLCO arrangements. It was noted that this had included a comprehensive review of the risk register which was now overseen through the MLCO Risk Management Committee. It was further confirmed that in addition, a full review of community health services was in the process of being undertaken following a regulatory inspection framework. The Chief Executive of the LCO confirmed that the final part of phase 2 was working with commissioners to agree the transformation programme for 2020/21 and further.

The Board received an overview of the work to develop integrated neighbourhood teams in 2019/20 which was to build on and optimise the foundations that had been built, and previously reported, during 2018/19. It was also confirmed that the LCO would continue to optimise and develop the neighbourhood model in partnership with the health and social care teams, partners, stakeholders and residents during 2020/21 with the Operating Plan for the next 12 months developed through and from community health and social care services working with the neighbourhood partnerships and will be published in March 2020.

The Chief Executive of the LCO also confirmed that a COVID-19 testing service had been established on 6th March 2020.

In conclusion, the Board noted the contents of the update report.

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

45/20 Governance

Q3 Complaints Report (2019/20)

The Group Chief Nurse presented an overview and key highlights from the Quarter 3 Complaints Report (2019/20).

The Board noted that a total of 1,482 PALS concerns were received in Q3 compared to 1,404 in the previous quarter; representing a 5.6% increase. It was also noted that a total of 413 new complaints were received compared to 438 new complaints received in the previous quarter, which is a 5.7% decrease.

The Group Chief Nurse confirmed that the total number of complaints closed during the period was 472, which was an increase of 67 cases compared to the previous quarter; the number of complaints closed within 25 days increased, with 289 closed compared to 251 in the previous quarter; however there was a decrease in the number of complaints closed in 26-40 days.

The Board was advised that in accordance with the agreed schedule, the Complaints Scrutiny Group, which was chaired by a Group Non-Executive Director, met once during Q3 with the Management Team from Manchester Royal Infirmary (Renal Transplant Service) presenting a case at the November 2019 meeting; the learning identified from the case presented was detailed in Section 5 of the report presented.

The Board also noted improvements in the Complaint and PALS management processes as described in the report along with future quality improvements identified.

The Group Chairman and Dr Ivan Benett (NED Chair of the Complaints Scrutiny Group) acknowledged that the information within the report demonstrated an increase in PALS concerns and a decrease in formal complaints with evidence of previous improvements in the timeliness of closing complaints clearly continuing during the quarter.

Discussion also centred on the benefit of analysing and scrutinising Complaint themes against the Trust's Core Values and it was agreed that this would be explored and considered by the Trust's Quality & Performance Scrutiny Committee.

In conclusion, the Board noted the continued monitoring of the complaint response timescales against expected response timescales; the offer of Corporate Nursing Support to Hospitals/ MCSs/ LCO where performance was deteriorating; continued review and embedding of recommendations from National Guidance within MFT's policies; continued learning from complaints and listening to concerns; and, continued progress with the improvements as outlined in this report presented.

Decision:	Update Report Noted Analyse and scrutinise Complaint themes against the Trust's Core Values at the QPSC	**Action by:** Group Chief Nurse	**Date:** June 2020

MFT 'Safer Staffing' Bi-Annual Report

The Group Chief Nurse provided an overview of the bi-annual comprehensive report on Nursing and Midwifery staffing. It was noted that the report detailed the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016, and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018.

The Group Chief Nurse explained that the report provided detailed analysis of the Trust nursing and midwifery workforce position at the end of December 2019 and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce. It was also noted that the report included the first summary of the Allied Health Professions (AHP) workforce as per the NHSI guidance.

The Board was advised that nationally, nursing and midwifery workforce supply remained challenging with the shortfall in registered nurses being well-documented across all NHS providers.

The Group Chief Nurse pointed out that NHS Trusts were reporting a shortage of almost 145,000 staff, representing 1 in 11 posts with forecasts suggesting this gap could reach almost 250,000 by 2030 if current trends continued without significant action. The Board also noted that there were 41,000 vacancies nationally in nursing which equated to 1 in 8 posts with approximately 80% of the vacant shifts currently filled by bank and agency staff. It was further noted that within maternity services, the Royal College of Midwifery (RCM) reported a shortage of approximately 3,500 midwives.

Particular attention was drawn to the local position in MFT and it was noted that at the end of December 2019, there was a total of 537.5wte (7.1%) qualified nursing and midwifery vacancies across the Group compared to 820.3wte (11.6%) at the end of June 2019. It was reported that this was a reduction in the overall nursing and midwifery vacancies of 282.8wte (4.5%) since June 2019. The Group Chief Nurse confirmed that the majority of vacancies were within the Staff Nurse (band 5) workforce and that at the end of December 2019 there were 368.0wte (9.2%) compared to 567.1wte (14.2%) at the end of June 2019 (a reduction of 199.1wte 5%).

The Board was reminded of the ongoing Trust wide recruitment campaign to attract experienced nurses as well as newly qualified nurses and midwives due to qualify in September 2020. It was noted that there were currently 224 nurses and midwives with conditional job offers whose appointments were being processed through the Trust recruitment process; with 90 candidates due to commence in post over the next 3 months with 134 due to graduate in September 2020.

The Board also noted that a total of 233 international nurses had commenced in post since April 2019 with a further 148 nurses expected to arrive before the end of March 2020 bringing the total to 381 for 2019/20. The Group Chief Nurse emphasised that this was a significant increase on the number of nurses recruited in previous years and congratulated the MFT Nurse & HR recruitment teams for their efforts. She also explained that the first cohort of 67 Nursing Associates had been working within the Trust since January 2019, across general ward and community-based areas with a further 70 trainees due to qualify in June 2020.

It was reported that the sickness absence rate for the registered nursing and midwifery staff group was reported at 5.30% in December 2019 which was above the Trust target of 3.60%, and was a slight increase to the previous year (5.22%). The Group Chief Nurse confirmed that managing sickness absence continued to be a key priority within each individual Hospital/MCS/LCO.

The Board also noted that the annual programme to review inpatient ward nursing establishments had commenced across the Hospitals/MCS and would be undertaken by each Heads of Nursing using an evidence based approach and applying the Safer Nursing Care Tool (SNCT) to ensure staffing levels meet the acuity and dependency of patients within each ward environment.

The Group Chief Nurse explained that whilst there was currently no recognised national shortfall within generalist AHP therapists for adult services, there were some challenges in speciality posts such as acute Occupational Therapists (OT), paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT) due to lack of paediatric training in pre-registration courses. She confirmed that there were **69wte (4.2%)** vacancies across the AHP workforce with most vacancies in the MLCO/TLCO. It was noted that there were several Trust wide initiatives in place to support the development of the AHP workforce and creating new opportunities and roles.

The Group Chairman and Group CEO welcomed the latest bi-annual comprehensive report on Nursing and Midwifery staffing (inc AHPs) and acknowledged that the Trust had seen a continuous and positive improvement in the overarching position over the previous 12 months.

The Board received the paper and noted progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.

Decision:	Bi-annual Report Noted	**Action by:** n/a	**Date:** n/a

Update Report on the Outcome of the Staff Survey 2019

The Group Executive Director of Workforce & Corporate Business provided an update on the outcome of the 2019 Staff Survey under the key headlines of 'Background & Context'; 'Response Rate'; 'National Reporting of the Staff Survey Results'; 'Group Results: Summary – overall staff engagement'; 'Hospital / MCS / LCO / Corporate summary'; and, 'Survey free text comments'.

Particular attention was drawn to the Group Results and it was noted that there were 11 key themes in the staff survey. The Board noted the key themes results for 2019 in the accompanying documentation which compared the local sector average and with the equivalent scores for 2018. The Group Executive Director of Workforce & Corporate Business explained that the SCC report offered two statistically significant changes to the MFT key theme scores in the 2019 survey, namely, a statistically significant improvement for *Quality of Appraisal; and,* a statistically significant decline for *Safe Environment – Violence* (although, due to rounding and sample size, this score was summarily reported as unchanged).

The Group Executive Director of Workforce & Corporate described the next Steps and key actions for 2020/21 and explained that the detail provided by the NHS staff survey would be used to inform actions required to improve the experience of staff working at MFT. He also explained that this would include consideration of how best to build on the positive feedback provided by staff and that priority areas for improvement would focus on the key themes where the Trust had either deteriorated or where it was below the benchmark group as outlined in the report.

The Board noted that at Group Level, priority areas and actions would be progressed and monitored through the Staff Engagement Task & Finish Group, the membership of which included Hospital/MCS/LCO and representatives from staff side. It was explained that specific focus would be given to delivery of the MFT Leadership and Culture and Equality and Diversity Strategies both of which were aimed at making improvements to the working life of all MFT staff.

The Group Executive Director of Workforce & Corporate Business reported that in tandem with the Group level work, each Hospital /MCS would include specific actions in the annual plans to satisfy local circumstances, and, Corporate areas and the LCO would undertake similar activities. He also explained that feedback on staff experience and staff engagement would continue to be measured though the 'Staff Friends and Family Test', the Trust 'Pulse Checks', and, the 'Culture of Care' surveys. The Board noted that performance would be reported and monitored through the Accountability Oversight Framework (AOF) and to the Board of Directors through the monthly Board Assurance Reports.

The Group Executive Director of Workforce & Corporate Business confirmed that a comprehensive report on the survey results together with a detailed action plan would be submitted to the HR Scrutiny Committee (2020/21).

In conclusion, the Board noted the strengths, improvements and areas for development captured within the latest 2019 Staff Survey and the priority areas for action in 2020/21 as set out in the report presented.

Decision:	2019 Staff Survey Noted Comprehensive report on the 2019 staff survey results together with a detailed action plan to be presented to the HRSC.	**Action by:** The Group Executive Director of Workforce & Corporate Business	**Date:** June 2020

Report on the proposed changes to the Group risk management arrangements

The Joint Group Medical Director described proposed changes to the MFT Group risk management arrangements. It was particularly noted that there was strong evidence to indicate that the MFT Group model supported the local management of risk at Hospital/MCS/LCO level and that the Group Risk Management Committee could now, 24 months into the new structure, refocus on oversight of the risk management *process* rather than every risk at ≥15.

The Board also noted that in order to ensure that safe systems and good governance processes were in place to support the change, the Group Risk Management Committee commissioned an audit of the process in all Hospitals/MCS/LCO. The Joint Group Medical Director explained that the audit considered a number of factors including the design and operating effectiveness of the risk management arrangements within each Hospital/MCS/LCO as well as their processes for reporting and escalating risks up to Group level. She also pointed out that each Hospital/MCS/LCO was given a maturity rating and all of these were given as mature or developing from basic to mature as new processes embed.

The Board was advised that the Group as a whole was given 'significant assurance with two medium actions and five minor'. It was also noted that all of these were accepted as recommendations and were being acted upon.

The Board was advised that following a presentation to the Group Risk Management Committee on the new approach, the committee recommended the new approach, revised Terms of Reference, revised Risk Management Strategy and reporting schedule to the Board of Directors for approval.

In conclusion, the Board approved the key recommendations set out in the report along with the revised Terms of Reference for the Group Risk Oversight Committee. Associated revisions to the Trust Risk Management Strategy (presented within the report) were also approved.

Decision:	Approval of the key recommendations (as outlined); GROC ToRs, and, revisions to the Trust Risk Management Committee	**Action by:** n/a	**Date:** n/a

2019/20 MFT Board Assurance Framework (BAF)

The Board received the Board Assurance Framework (March 2020) and noted that the Trust Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

Decision:	BAF (March 2020) received by the Board of Directors	**Action by:** n/a	**Date:** n/a

Committee meetings which had taken place:

- Group Risk Management Committee held on 27th January 2020
- Audit Committee held on 5th February 2020
- Finance Scrutiny Committee held on 4th February 2020
- Quality & Performance Scrutiny Committee held on 4th February 2020
- Charitable Funds Committee held on 13th January 2020
- MLCO Scrutiny Committee held on 15th January 2020
- NMGH Scrutiny Committee held on 10th February 2020
- HR Scrutiny Committee held on 18th February 2020

46/20 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday 11th May 2020** at **1pm**.

N.B. This will be a 'Private' meeting only due to the COVID-19 National Emergency and the UK Governments 'Lock-Down' restrictions and 'Social Distancing' directives.

47/20 Any Other Business

There was no other business.

Present:	Mr J Amaechi	-	Group Non-Executive Director
	Professor Dame S Bailey	-	Group Non-Executive Director
	Dr I Benett	-	Group Non-Executive Director
	Mr P Blythin	-	Group Director of Workforce & Corporate Business
	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
	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
In attendance:	Mr D Cain	-	Deputy Chairman Fundraising Board
	Ms J Ehrhardt	-	Deputy Group Chief Finance Officer
	Mr D Furnival	-	Group Director of Estates & Facilities
	Mr A W Hughes	-	Director of Corporate Services / Trust Board Secretary
	Professor M McCourt	-	Chief Executive, M&TLCOs
	Mr J Wareing	-	Group Director of Strategy
Apologies:	Mr D Banks	-	Group Director of Strategy
	Mrs J Bridgewater	-	Group Non-Executive Director
	Professor L Georghiou	-	Group Chief Operating Officer
	Mr A Roberts	-	Group Chief Finance Officer

ACTION TRACKER

Board Meeting Date: 13th January 2020			
Action	Responsibility	Timescale	Comments
EPRR Action Plans to be presented to the *Quality & Performance Scrutiny Committee* for further review and scrutiny	Group Chief Operating Officer	April 2020	Deferred due to COVID-19 National Emergency

Board Meeting Date: 9th March 2020			
Action	Responsibility	Timescale	Comments
Comprehensive report on the 2019 staff survey results together with a detailed action plan to be presented to the HRSC	The Group Executive Director of Workforce & Corporate Business	June 2020	Subject to the impact of the COVID-19 National Emergency
Analyse and scrutinise Complaint themes against the Trust's Core Values at the QPSC	Group Chief Nurse	June 2020	Subject to the impact of the COVID-19 National Emergency

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:	June 2020
Subject:	Board Assurance Report – May 2020
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commenting 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, Information Management Tel: 0161 276 4768

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(May 2020)

1. Introduction

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.

2. Overview

The Board Assurance Report provides further evidence of compliance, non-compliance and/or risks to the achievement of the required thresholds within individual indicators. The report also highlights key actions and progress in addressing any shortfalls.

3. Key Priority Areas

The report is divided into the following five key priority areas:

- **Safety**
- **Patient Experience**
- **Operational Excellence**
- **Workforce & Leadership**
- **Finance**

Headline narratives provide context to the above key priority areas, stating current issues, identifying where progress is 'good', identifying future challenges and risks, and commenting on the latest developments around performance of the various indicators.

The narrative is provided by the person(s) accountable for the individual priority areas.

'Guidance Notes' are also included to support the interpretation of the data presented each month.

> 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 of five distinct domains as follows: Safety, Patient Experience, Operational Excellence, Workforce & Leadership, and Finance. 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

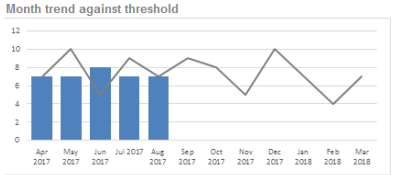
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

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.

> Board Assurance

May 2020

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	3	0	3	0

Headline Narrative

There are three core priorities which are not currently being met.

The Group has had 8 Never Events reported since May 2019.

A number of actions are underway and local assessment is being undertaken of further work required in those Hospitals / MCS with more than one reported event in the last 2 years (RMCH, WTWA, MREH and CSS). 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.

There have been two avoidable deaths reported and these have been investigated and action implemented to avoid further harm.

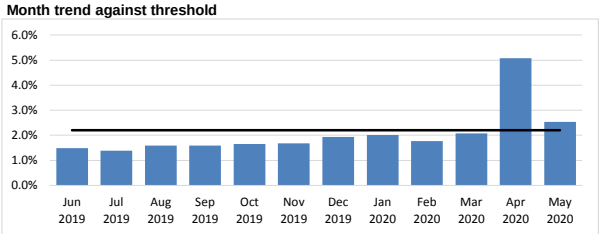
Safety - Core Priorities

Crude Mortality

Actual 3.74% YTD (Apr 20 to May 20) **Accountability** J.Eddleston\T.Onon

Threshold 2.20% (Lower value represents better performance) **Committee** Audit 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
✕	✕	✓	✓	✓	✓	✕
31.7%	5.7%	0.2%	0.3%	0.0%	0.0%	5.6%

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.

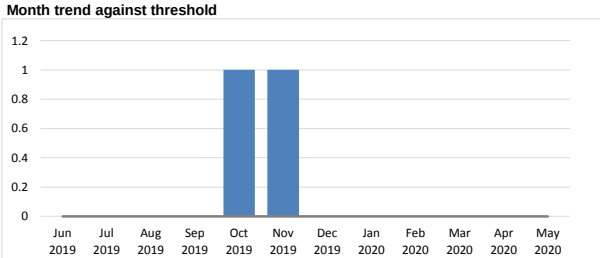
The crude mortality for March / April 2020 hasbeen impacted upon by the pandemic. Work is underway to fully understand the impact - this work includes detailed reviews of deaths, focussed reviews e.g. in Critical Care, triangulation of informaiton including covd-19 and non-covid-19 deaths.

Mortality Reviews - Grade 3+ (Review Date)

Actual 2 YTD (Apr 20 to Feb 20) **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
✕	✓	✓	✓	✓	✓	✓
2	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. The Chief Medical Examiner and a supporting team have now been appointed.

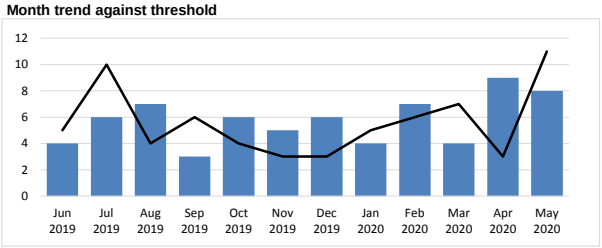
Actions

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.

Hospital Incidents level 4-5

Actual	17	YTD (Apr 20 to May 20)	**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
✓	✗	✓	✓	✓	✓	✓
1	8	2	1	0	0	5

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, 54.10 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. Of note however since the emergence of Covid-19 a decrease in reported incidents has been observed.

The overall number of serious harm incidents YTD compared to the same period last year is slightly higher. 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. These figures include a number of Hospital Acquired Covid-19 incidents. During the pandemic there have been a number of changes to ward functions which may impact on comparisons with previous year figures.

Actions

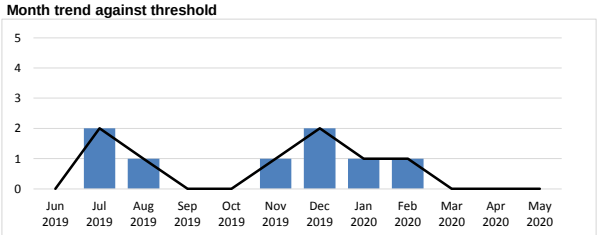
Communication of test results, delayed diagnosis and access to treatment remain a focus across the Group and work is underway to further develop the clinical risk plan in respect of communication and response to clinical tests. Detailed analysis of investigations relating to delayed diagnosis and / or delayed treatment is currently underway.

Thematic reports are reviewed at a number of forums and will inform the 2020/21 work plans.

Never Events

Actual	0	YTD (Apr 20 to May 20)	**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.

In the last 12 months there have been 8 Never Events: 1 misplaced NG Tube, 5 wrong site surgery/wrong site block and 2 retained items. Investigations for all of these are complete or underway 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.

Following these events a number of immediate actions were implemented including issuing of Trust-wide alerts. Investigations have been undertaken or are underway to identify learning with associated action plans in place.

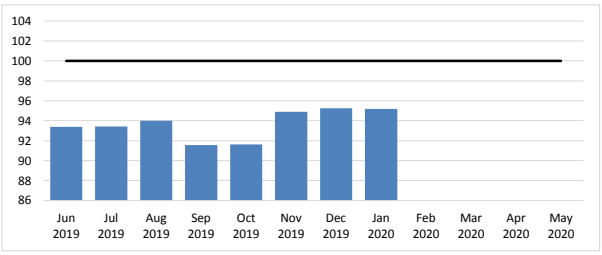
A new MFT Safe Procedure Policy is now in place. Further work is now being undertaken Group-wide on safer surgery/procedure checklist and item counts, with a focused pilot in MRI now completed which is subsequently being implemented across MFT. This work will be reported to the Quality & Safety Committee.

> Board Assurance

May 2020

SHMI (Rolling 12m)

Actual	95.2	R12m (Feb 19 to Jan 20)	**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	100.0	185.7	136.4	NA	NA	93.8

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.

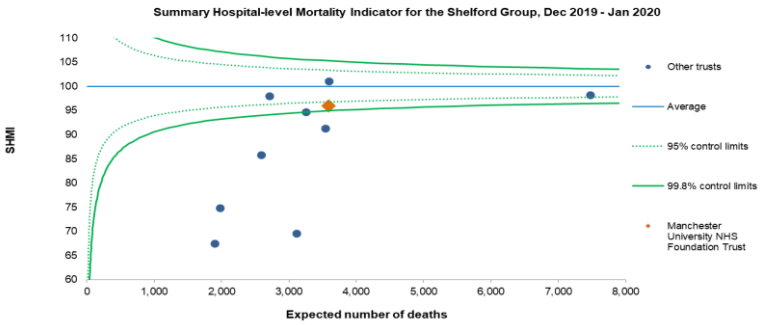
Progress

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.

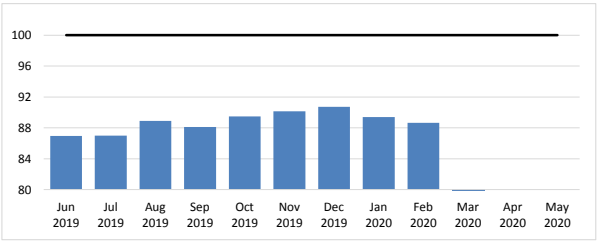
All child deaths and adults with a Learning Disability undergo a detailed mortality review.

Performance is well within the expected range.



HSMR (Rolling 12m)

Actual	88.6	R12m (Mar 19 to Feb 20)	**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	81.3	NA	NA	NA	NA	92.7

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.

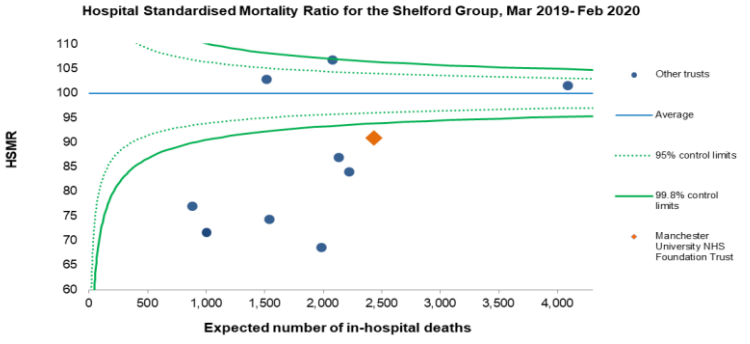
HSMR is a metric designed for adult practice.

HSMR is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.



Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	5	1	1	2

Headline Narrative

There was an increase in the number of complaints received in May 2020 and a slight improvment in the overall year to date performance for responses within timescale. The number of new formal complaints received across the Trust during May 2020 was 47, which is an increase compared to 31 in April 2020. An ongoing increase is expected to coincide with the re-establishment of planned activity following the response to the Coronavirus pandemic.
In response to the pandemic and in line with NHS Guidance in March 2020, the Trust's complaints process was temporarily paused. During May 2020 the pause was lifted for the majority of complaints. Performance is monitored and managed through the Accountability Oversight Framework (AOF). The number of over 41 day complaint cases at the end May 2020 (52) increased in number by 4 compared to April 2020 (48). The closure of complaints resolved within the agreed timescales across MFT in May 2020 was 71.4%.

The Friends and Family Test (FFT) is currenlty 'paused' nationally in order to release capacity to support the NHS's response to the COVID-19 pandemic.

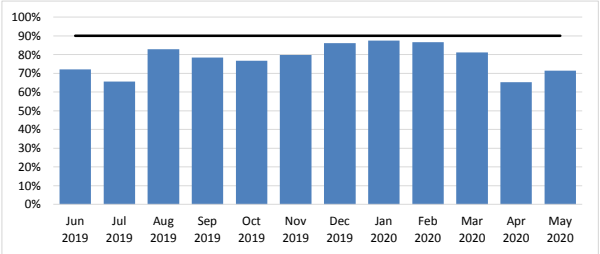
Infection prevention and control remains a priority for the Trust. CDI thresholds are currently being determined. Trust performance for the current financial year is above trajectory for MRSA due to one case being reported in April (against a threshold of zero).

Percentage of complaints resolved within the agreed timeframe

✕

Actual	67.4%	YTD (Apr 20 to May 20)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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
✓	✓	✕	✕	◇	✓	◇
91.7%	93.8%	48.3%	57.1%	75.0%	100.0%	77.4%

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.

There was an improvement in the number of complaints resolved within the agreed timeframe, with 71.4% in May 2020 compared with 65.3% in April 2020.
This slight increase was expected and coincides with the Trust lifting the temporary pause, which was previously put in place to support the Covid-19 response for the majority of complaints.

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

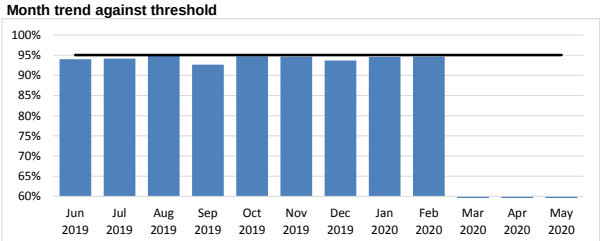
Performance is monitored and managed through the Accountability Oversight Framework (AOF).

FFT: All Areas: % Extremely Likely and Likely

◇

Actual	94.2%	YTD (Apr 19 to Feb 20)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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
✓	◇	◇	✓	◇	✓	◇
97.2%	92.5%	90.3%	97.6%	94.8%	97.5%	94.2%

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.

Progress

In response to the Coronavirus pandemic and in line with NHS England Guidance issued in March 2020, the FFT process continues to be temporarily paused.

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.

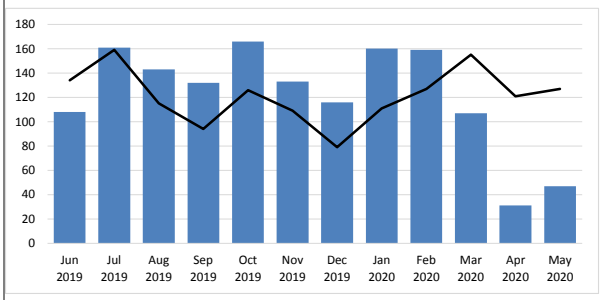
> Board Assurance

May 2020

Complaint Volumes

Actual	78	YTD (Apr 20 to May 20)	**Accountability**	C.Lenney
Threshold	127	(Lower value represents better performance)	**Committee**	Quality & Safety 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
✓	✓	✓	✓	✓	✓	✓
6	15	10	7	3	0	37

The KPI shows total number of complaints received. Complaint volumes 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 2020 was 47, which is an increase compared to 31 in April 2020. The numbers remain low in comparison to March 2020 (104) due to effects of the Coronavirus Pandemic.
WTWA received the highest number of complaints in May 2020; receiving 26 complaints (55% of the Trust total). This is an increase of 15 complaint for WTWA compared to the previous month (11). Of the 26 complaints received for WTWA the specific themes were 'Treatment/procedure' and 'clinical assessment'. No specific areas were identifed in the complaints relating to these themes.

At the end of May 2020 the total number of over 41 days old complaint cases increased slightly to 52, this represents an increase of 4 when compared to the previous month. The Hospital/MCS/LCO with the highest number of cases over 41 days at the end of May 2020 was WTWA with 19 (36.5%) of the total cases over 41 days old. This number is higher than the number of WTWA cases over 41 days old at the end of April 2020 (16).

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).

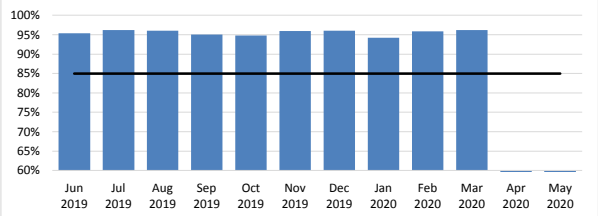
Progress

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.

Food and Nutrition

Actual	95.6%	YTD (Apr 19 to Mar 20)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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
✓	✓	✓	✓	✓	✗	✓
97.1%	95.8%	91.1%	96.7%	98.5%	77.3%	96.1%

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 in response to the low score achieved by the Trust within the National Impatient Survey. Patient Dining Forums are established for ORC and WTWA.

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 related to delivering the commitments withing the Nutrition and Hydration Strategy is monitored through the Trust Patient Experience and Quality Forum.

In recognition of the need to further improve the quality of food, a designated work programme, established in collaboration between Nursing, Estates and Facilities, was initiated in December of 2019 with the intention of identifying a number of high impact changes. A key work stream is the concept of a 'Model Ward'.The aim of the 'Model Ward' is to develop an exemplar ward with regard to the catering provision and the dining experience for patients, which will identify the changes that deliver the highest impact and which can be replicated across the wider Trust. Work on the Model Ward is temporarily paused due to the COVID-19 pandemic.

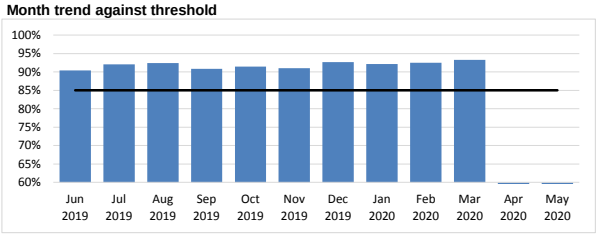
> Board Assurance

May 2020

Pain Management

Actual	91.8%	YTD (Apr 19 to Mar 20)	**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
✓	✓	✓	✓	✓	✓	✓
96.5%	86.9%	88.7%	94.3%	97.3%	97.7%	93.8%

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

Progress

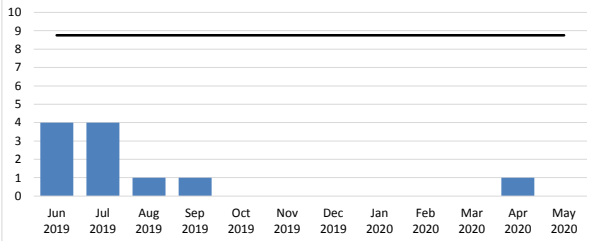
Work continues across the Trust to drive improvements in pain assessment and management.

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.

Clostridium Difficile – Lapse of Care

Actual	1	YTD (Apr 20 to May 20)	**Accountability**	C.Lenney
Threshold	18	(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 during 2019/2020 was 173 lapses in care. The KPI shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient.

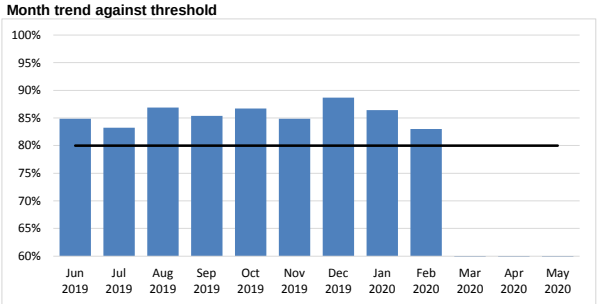
Progress

A total of 194 CDI cases were reported during 2019/2020: 145 (74.7%) of which were trust-attributable against a trajectory of 173. Following monthly external case reviews, there were 24 lapses in care identified. There remain 70 cases pending CCG review (delayed due to the COVID-19 pandemic). There were 9 trust-attributable CDI cases reported for May 2020

Nursing Workforce – Plan v Actual Compliance for RN

Actual	83.0%	(February 2020)	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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	80.3%	78.6%	87.1%	85.1%	NA	85.6%

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

The planned and actual safe staffing data is not avialable due to the reconfiguration of ward areas during the covid pandemic and whilst the hopistals/MCSs implement their workforce recovery plans.

A safe staffing daily risk assessment is undertaken by the Director of Nursing for each hopistal/MCS and the esculation level reported to the Trust Tactical Commander. Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels that meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals.

> Board Assurance

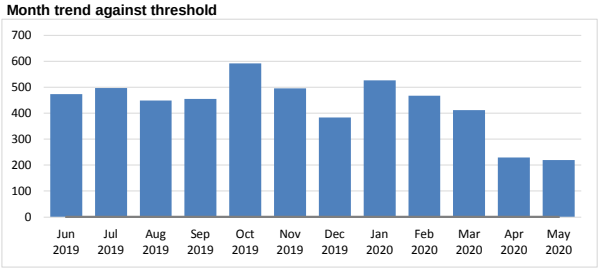
May 2020

PALS – Concerns

Actual 449 YTD (Apr 20 to May 20) **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
-	-	-	-	-	-	-
16	129	25	59	39	10	127

There was a slight decrease in the number of PALS concerns received by the Trust in May 2020.

Key Issues

A total of 220 PALS concerns was received by MFT during May 2020 compared to 229 PALS concerns in April 2020. This reduction coincides with the reduction in elective activity across the Trust to enable the continued response to the COVID-19 pandemic.

MRI and WTWA received the highest number of PALS concerns in May 2020; both receiving 68 (31%) of the total. This is an increase of 9 for WTWA compared to the previous month (59) and an increase of 7 for MRI compared to the previous month (61). The specific themes for WTWA related to Clinical Assessment, Treatment/Procedure and Discharge/Transfer'. The specific themes identified for MRI related to Treatment/Procedure, Discharge/Transfer and communication. Specific areas identified in the PALS concerns included 'Appointment cancellations across all Sites,' commmunication' for Trafford and Wythenshawe and 'Security' (predominently car parking).

Actions

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

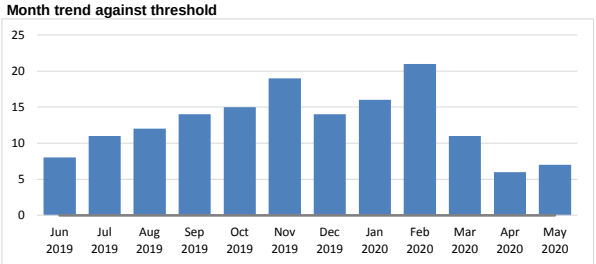
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

Actual 13 YTD (Apr 20 to May 20) **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
-	-	-	-	-	-	-
5	5	2	0	0	0	1

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 were 591 incidents of E.coli bacteraemia reported to PHE during 2019/2020. Of these, 158 cases (26.7%) were determined to be hospital-onset. There were 6 trust-attributed E. coli cases reported during May 2020.

There were 8 trust-attributable MRSA bacteraemia cases reported to PHE during 2019/2020, and 6 community-attributable cases reported. This represents a reduction from 10 attributable bacteraemia cases reported for 2018/2019. There was one trust-attributable case reported in May 2020.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	×	No Threshold
	2	1	8	0

Headline Narrative

The Covid19 pandemic has had a detrimental impact on MFT performance against constitutional standards, particularly those related to elective access. In line with national guidance relating to the Covid19 pandemic, on Tuesday 17th March MFT made the decision to suspend the elective programme with immediate effect, with the exception of life, limb or sight threatening procedures. Furthermore, outpatient activity had been suspended from the 26th March. The Trust continues to receive elective and cancer referrals as usual although these have reduced, which mirrors the position seen across the country as individuals self-isolate / shield. Following receipt, referrals are clinically triaged and either added to the waiting list, provided with an appointment (virtually or face to face where required) and or, discharged to GP if it is not an appropriate referral. However, the pandemic has resulted in some unexpected positive performance results relating to improved timeliness of access in A&E and improved discharge, due to less demand and the actions taken to manage the Covid19 response.

MFT has a governance framework in place to oversee and manage the Covid19 response, which also feeds into the GM Covid governance structure which is overseeing the system response. In addition, MFT has a recovery programme in place which incorporates a number of workstreams, a number of which specifically relate to constitutional standards: Outpatients, Elective Care, Urgent Care and Cancer. Each workstream has a designated Group Executive or Hospital Chief Executive lead to oversee the programme of work. The aim of the workstreams is to plan for the recommencement of activity, but in addition ensure best practice and improvements to pathways are implemented, some of which were already in progress prior to Covid19 to respond to demand and performance pressures. There is a weekly recovery workstreams meeting overseen by the Chief Transformation Officer to gain assurance that workstreams are making progress in line with agreed timescales. The recovery programme reports into the Trust Strategic Covid19 Incident Response meetings chaired by the Chief Operating Officer. In addition, a combined risk relating to the impact of covid 19 on national constitutional standards has been included on the risk register and will be reported to the Group Risk Committee.

Greater Manchester system has established a Governance Framework to oversee the response to the Covid 19 incident, providing a system wide view and facilitating mutual aid across providers, including the use of the independent sector. MFT links into the daily GM gold conference calls, with MFT representatives on the In Hospital and Community Cells. The command and control structure will be in place until year end to mitigate the impact of further Covid19 waves, and to coordinate system recovery planning.

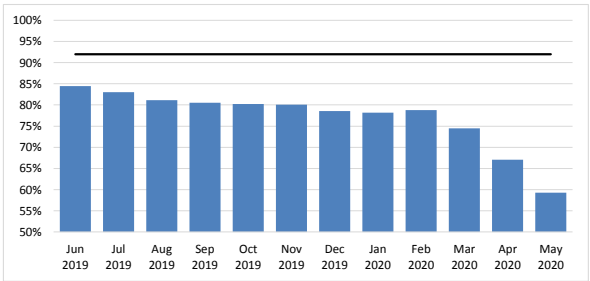
The Covid19 pandemic has had a detrimental impact on performance since March, exacerbating delivery against those operational standards which the Trust had previously been underachieving in 2019/20, mainly Cancer and RTT. However, the pandemic has resulted in some unexpected positive performance results relating to improved timeliness of access in A&E and improved discharge, due to less demand and the actions taken to manage the Covid19 response.

Operational Excellence - Core Priorities

RTT - 18 Weeks (Incomplete Pathways)

Actual	59.3%	(May 2020)	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



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

- Suspension of the elective programme as a result of Covid19.
- On-going programme of work to upgrade the PAS and to data quality assure the waiting list.

Actions

- Two key recovery workstreams are in place to support the RTT standards focused on Outpatients and Electives.
- Outpatient workstream is focused on: clinical triage of the waiting list, determining the activity which needs to be seen virtually or face to face, determine clinical urgency as capacity comes on line, establish protocols for use of virtual consultations, to establish demand management protocols, roll out of virtual consultations, ERS advice and guidance and electronic triage.
- Elective workstream is focused on: clinical review of the elective waiting list, identify current theatre capacity, consideration of pre-assessment pathways, workforce implications and impact on capacity, identify and maximise the use of the Independent Sector, confirm the critical care de-escalation plan and the associated implications for theatre staffing, determine any financial implications.
- Governance processes remain in place in relation to the longest waits to ensure harms is assessed.

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
×	×	×	×	×	×	×
65.6%	61.8%	60.4%	59.1%	62.3%	48.5%	59.1%

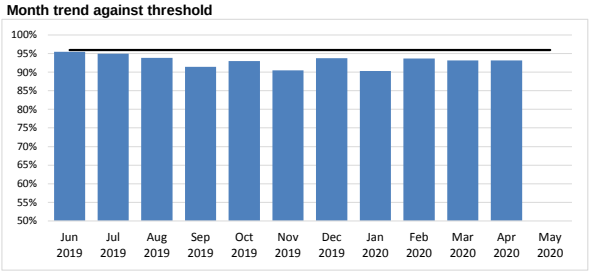
Progress

- As expected, the Impact of Covid19 and the suspension of the elective programme has had a detrimental impact on both the long wait and the RTT position since April.
- The waiting list size has increase from April to May by c.3500 patients, with the total waiting list at 102,318 patients .
- RTT performance has been reducing by 7% in April and May, with May at 59.3%.
- The number of patients waiting longer than 52 weeks increased from 44 in March to 369 in April, and 1042 in May. There is an equal spread of breaches across all hospitals with the exception of MRI which is the highest.

Cancer 31 Days First Treatment

Actual	93.2%	Q4 19/20 (Apr 20 to Apr 20)	**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	98.3%	100.0%	93.5%	NA	NA	91.4%

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

Key Issues

• Cancer Demand, 3 key challenged pathways: Lung, Urology and Gynaecology, Covid19 impact.

Actions

• Cancer treatments are being prioritised during the Covid19 pandemic, in line with national urgency criteria.
• The most urgent are discussed via a clinical panel to determine: alternative treatment options and risk of surgery.
• Capacity is assessed weekly by Cancer Managers, Hospital and Clinical Leads.
• Mutual aid for capacity is being coordinated via a GM Cancer Surgical Hub
• Cancer Recovery Workstream in place, details under the 62 day standard.
• Use of the Independent Sector throughout the Covid19 pandemic for thoracic and breast surgery.

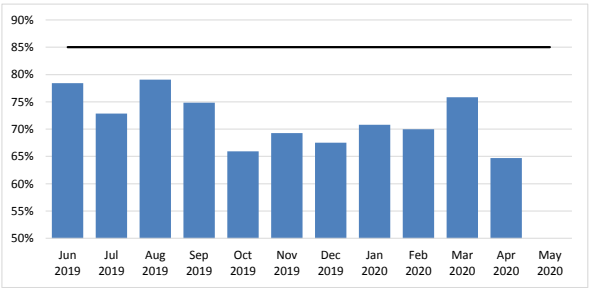
Progress

• The performance has been static for the last 3 months and is marginally below the standard by 2%.

Cancer 62 Days RTT

Actual	64.7%	Q4 19/20 (Apr 20 to Apr 20)	**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	65.1%	NA	63.3%	NA	NA	64.4%

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

• Historical underperformance against the standard due to demand pressures, 12% increase in 2 week wait referrals in 2019/20, and capacity constraints particularly relating to radiology and pathology reporting.
• The impact of covid19 has resulted in capacity constraints and affected the ability of cancer systems across the UK to deliver planned cancer treatment for all its cancer patients.

Actions

• A number of immediate actions were undertaken to support the continuation of the most urgent cancer activity during the Covid19 pandemic, with the cancer patient tracking lists clinically triaged in line with a national urgency criteria. The most urgent are discussed via a clinical panel to determine: alternative treatment options and risk of surgery. Each Hospital has a clinical MDT supported by a Cancer Manager to review waiting lists twice weekly. effective governance and a standardised operating procedure has been put in place across MFT to support these processes. New referrals continue to be received and clinically triaged, with telephone assessments and progress to diagnostics as appropriate.
• The wider GM system has put a number of action in place to coordinate system capacity, including mutual aid for capacity coordinated via a GM Cancer Surgical Hub. In addition, GM wide work is taking place on the introduction of a single queue for 4 specialist diagnostic tests (EBUS, CPEX, EUS and CT guided biopsy. MRI has been selected to lead on CPEX and Wythenshawe will lead the work around EBUS and CT guided biopsy).
• The MFT Cancer recovery workstream is focused on:
- Re-establishment of screening programmes,
- Rapid implementation of the rapid diagnostic centre programme over the next 2-3 months, with phase one specialities of Haematology, Gynaecology, Oesophago-gastric and HPB. Phase 2 will be towards the latter part of the year and will incorporate Lung, Sarcoma and expansion of the vague symptoms pathway.
- increasing capacity to undertake the lower risk stratified activity, although this is dependent on workforce, and availability of Covid screening.
- The cancer workstream interlinks, and will benefit from the actions being undertaken in the both the outpatient and elective workstreams.
- A key element of the workstream is to continue to progress the Cancer Excellence Programme that MFT had implemented through 2019/20, with phase one actions complete and reported to the Q&PSC in January. Implementation of best practice pathways underpins this programme of work.

Progress

• Referral demand remains lower than usual levels.
• MFT continues to have capacity for all cancer surgery, and during the pandemic has undertaken more cancer activity than the whole of GM.
• As expected performance has reduced in April by 11% compared to March, with performance at 64.7%. Patients have been clinically risk stratified in line with national guidance, during the Covid peak only the highest risk cases have been treated, with all other patients deferred, although these remain under clinician review.

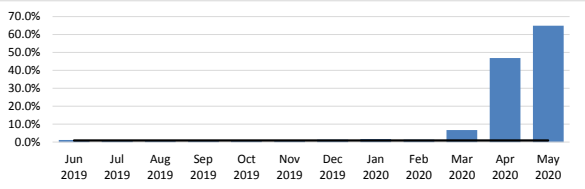
> Board Assurance

May 2020

Diagnostic Performance

Actual	64.9%	(May 2020)	**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	✗
63.2%	72.4%	77.7%	86.7%	NA	NA	64.5%

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
- Cancellation of diagnostics in March inline with National directive to cancel elective and OPD activity.
- Prioritisation of cancer scanning/reporting.

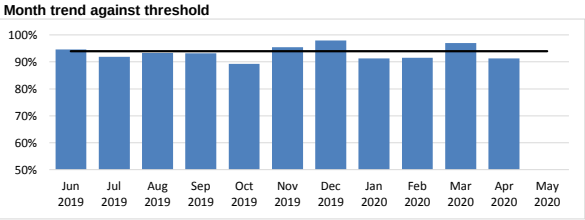
Actions
- Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog have been achieved as a result of less demand during the pandemic.

Progress
- Due to Covid pressures the performance since March has significantly deteriorated, with only a quarter of the usual level of diagnostic activity being undertaken therefore, a significant volume of patients remained on the waiting list which have rolled over into the +6 week category.
- performance in May was 65%, a 18% increase compared to the previous month.

Cancer 31 Days Sub Surgical Treatment

Actual	91.3%	Q4 19/20 (Apr 20 to Apr 20)	**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	100.0%	NA	50.0%	NA	NA	95.0%

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

Key Issues
- Cancer Demand increasing
- Smaller volume of treatments on this pathway

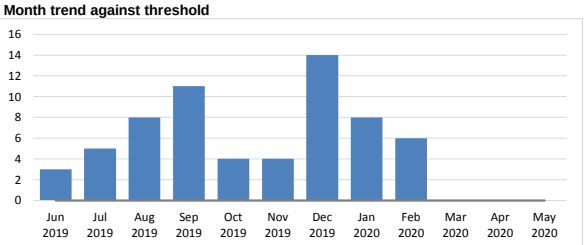
Actions
Actions noted under the above cancer standards.

Progress
- Performance in April was only marginally lower than the standard by 3%.

Cancelled operations - rescheduled <= 28 days

Actual	67	YTD (Apr 19 to Feb 20)	**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
✗	✗	✓	✓	✓	✓	✗
10	32	0	0	0	0	25

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
- National guidance to suspend the elective programme due to Covid19.

Actions
- See actions under the RTT standard, Elective recovery workstream.

Progress
•Please note that due to suspensions in data submissions as a result of Covid 19 the cancelled operations KPI has not been reported since March.

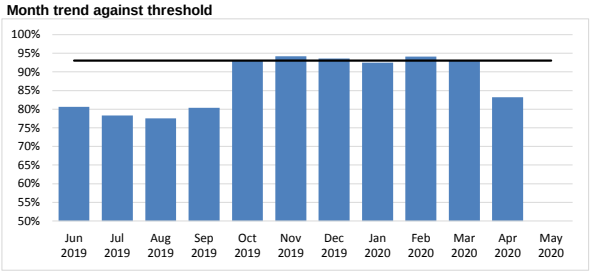
> Board Assurance

May 2020

Cancer Urgent 2 Week Wait Referrals

Actual	83.2%	Q4 19/20 (Apr 20 to Apr 20)	**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	13.7%	100.0%	87.8%	NA	NA	82.9%

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
- Demand, 13% increase in 2ww referrals in 2019/20
- Significant reduction in demand due to Covid19.

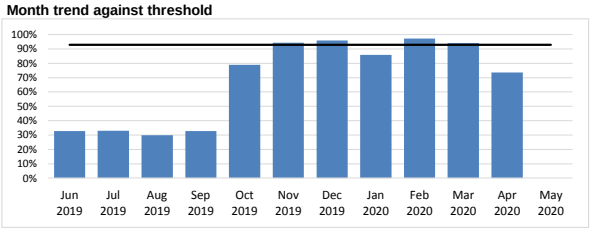
Actions
- Actions are noted under the above cancer standards, in addition the actions being undertaken as part of the outpatient recovery workstream will support resilience of this standard.

Progress
- As expected the 2WW standard performance reduced in April, this has been due to higher numbers of patients deferring appointment. In addition a new telephone triage service had to be established in April to replace traditional face to face appointments, this is now in place to ensure timely clinical review of all referrals and patient discussions.

Cancer 2 Week Wait - Breast

Actual	73.6%	Q4 19/20 (Apr 20 to Apr 20)	**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	73.6%

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

Key Issues
Demand pressures, support to other providers in GM, Impact of Covid19.

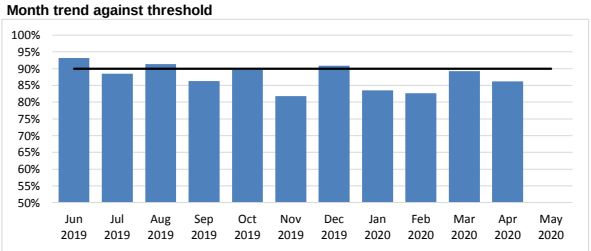
Actions
- All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
- Clinics are running at reduced numbers to maintain social distancing precautions and reduce Covid19 risk
- Cancer Recovery Workstream in place, details under the 62 day standard.

Progress
See the 2ww measure.

Cancer 62 Days Screening

Actual	86.2%	Q4 19/20 (Apr 20 to Apr 20)	**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	◇
NA	33.3%	NA	NA	NA	NA	89.1%

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
- Prior to Covid there was risk to the bowel screening programme due to the national introduction of a less invasive and more sensitive screening test. This led to an increase in uptake by participants, over and above the original planning assumptions which led to a temporary suspension of the programme as agreed with the regional hub.
- Nursing workforce capacity constraints have been a factor impacting on capacity.
- Covid19 impact.

Actions
- The Actions listed under Cancer 62 Days are applicable to this standard.

Progress
- Performance in May only reduced by 3% compared to the previous month.
- There is significant interest from GM and NHSI regarding the recommencement of screening programmes, Approval has been given by the MFT strategic group to restart the Bowel screening programme, along with high risk breast patients, and consideration is currently being given to restarting lung health checks although this is reliant on available imaging capacity.

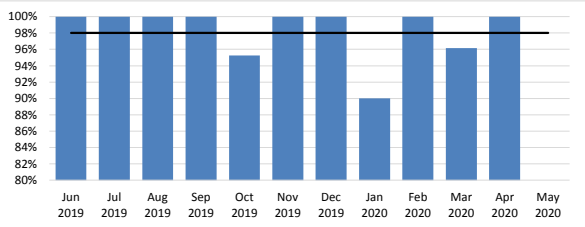
> Board Assurance

May 2020

Cancer 31 Days Sub Chemo Treatment

Actual	100.0%	Q4 19/20 (Apr 20 to Apr 20)	**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%	NA	100.0%	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.

Key Issues

• Small numbers of breaches requiring increased local surveillance.

Actions

• Actions are outlined under the cancer 62 day standard.

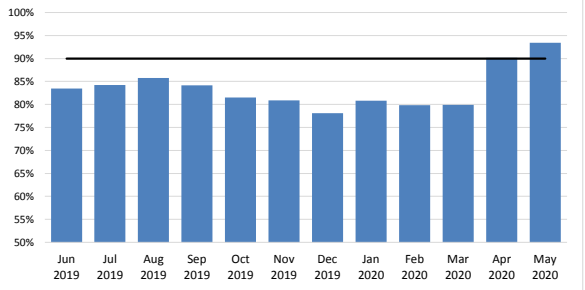
Progress

•Standard achieved in month.

A&E - 4 Hours Arrival to Departure

Actual	92.02%	Q1 20/21 (Apr to May 20)	**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	✓
NA	89.5%	99.0%	99.3%	99.8%	NA	90.5%

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

• Historical underperformance against this standard throughout 2019/20: due to demand pressures, higher acuity of presentations, flow constraints due to high long length of stay and delayed transfers of care.
• The Covid pandemic has had an unexpected positive impact on performance against the standard with significant less referrals against the standard in March - May, although towards the end of May this is starting to increase again across the GM system.

Actions

• GM have established a programme of work to support urgent care recovery, which is focused on implementation of the requirements set out in the long term plan, which were in progress prior to Covid including: increasing Streaming in ED, maximising Same Day Emergency Care, supporting flow out of hospital and reducing long length of stay. The lead for the MFT Urgent Care workstream is linking with GM partners with regards to this work. MFT Urgent Care Recover Workstream has similarities with the wider GM work and is focused on: Streaming, Same Day Emergency Care, Implementation of the new Urgent Care Treatment Centre model, review of workforce skill mix and maximising use of extended roles, fully embed and implement SAFER principles effectively at ward level and Discharge to Assess pathways, split of activity into Covid and non-Covid pathways. in addition, GM have collectively agree to implement over the next 6 months an appointments based system in ED.

Progress

• Due to Covid19 there has been a significant reduction in attendances, which are still c. 40% lower than usual levels.
• However demand is starting to increase month on month, with average daily attendances: 472 in April, 605 in May and currently 702 in June (at 20th).
• Whilst demand still remains low, acuity is starting to increase with a rise in the number of trauma cases at MRI.
• Performance remains exceptional at 93.4% for the month of May. and the national standard of 95% was achieved on 10 days in the month.
• Flow – improvements in long length of stay remain with:
o 7 day LoS remains -292 better than target
o 21 day LoS is - 209 better than target
o The DtoC standard has been achieved for the last three months, with all MFT sites better than target, and June performance is at an all time low.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	5	1	5	3

Headline Narrative

May was dominated by activity focused on the COVID-19 pandemic. Workforce mobilised at pace under challenging circumstances to provide services to patients, increasing critical care skill sets and redeployment in areas across MFT addressing service needs. Therefore some metrics have decreased in month, eg. appraisal/mandatory training which will be a focus to improve as part of our recovery plans.

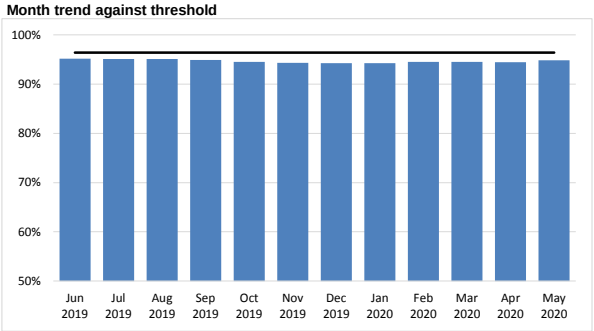
Workforce and Leadership - Core Priorities

Attendance

Actual 94.8% (May 2020) **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
✕	✕	✕	◇	✕	✕	✕
96.1%	92.7%	95.7%	96.2%	90.4%	93.7%	94.4%

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 attendance rate for May was 94.8% which is an increase on the previous month's figure (94.5%). The attendance rate was higher at the same point last year (May 2019) at 95.3%. Meanwhile the latest figures released by NHS Digital show that for January 2020 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.6% (these figures include all provider organisations and commissioners). MFT's performance for the same period was 5.7%.

The attendance rate does not include COVID-19 related absences. A COVID-19 absence dashboard has been created by Human Resources and all absences are reported on twice a day into the Strategic Group. During April as COVID-19 related absence increased (2700 staff at peak April). general absence has decreased,however post COVID-19 Peak, as COVID-19 absence reduces, other absence rates are steadily increasing.

Actions

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) / LCO also features prominently in the actions to improve performance. Corporate performance is addressed though the Corporate Directors' Group.

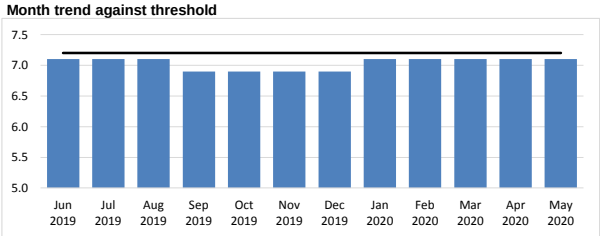
A programme to implement Absence Manager System across all sites and manged services was launched last year and is sponsored by Group Deputy Chief Executive to oversee implementation. Due to the COVID-19 pandemic the timetable to launch Absence Manager was expedited across all sites and managed clinical services not using the system. Currently only certain areas within the LCO are not using Absence Manager and a plan is in place to roll out the system in these areas this year. The LCO has implemented a daily sitrep return for all sickness and COVID-19 absence so that this information can be amalgamated into the COVID-19 absence dashboard so the Trust is able to report on all managed services and sites.

Engagement Score (quarterly)

Actual 7.10 Q1 20/21 **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
✕	✕	✓	✕	✕	✓	✕
7.0	7.0	7.2	6.9	7.1	7.6	7.1

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 Q3 staff engagement score for the MFT Group taken from the 2019 NHS Staff Survey is 7.1. This is unchanged from 2018.

The 2019-20 Quarter 4 Pulse Survey was replaced with a Leadership Behaviours Survey, which was conducted as part of the Culture Diagnostic work, due to conclude in March 2020. Recommendations for the use of Pulse Surveys in 2020-21 will be considered initially by the Group Executive Team.

Actions

The first stage of the MFT culture diagnostic, which included Board interviews, focus groups and marketplace events, as well as the Leadership Behaviours Survey, has now concluded, with analysis of the results now taking place.

Staff Survey plans and improvement trajectories are in place across all Hospitals / MCS / LCO, in response to the 2019 results, and have been presented to HR Scrutiny Committee. These will be updated for the 2019 results and presented to the Group Board and to the HR Scrutiny Committee.

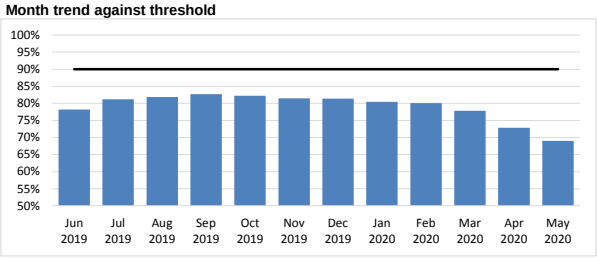
> Board Assurance

May 2020

Appraisal- non-medical

Actual	69.0%	(May 2020)	**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
✗	✗	✗	✗	✗	✗	✗
75.3%	52.5%	73.1%	83.7%	72.6%	81.6%	78.9%

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 April 2020 decreased by 4.9% to 72.9%. Compliance for all Hospitals and MCS position declined in month. The Appraisal (non-medical) rate was higher at this point last year at 82.8%. This is not unexpected due to the height of focused activity during the pandemic.

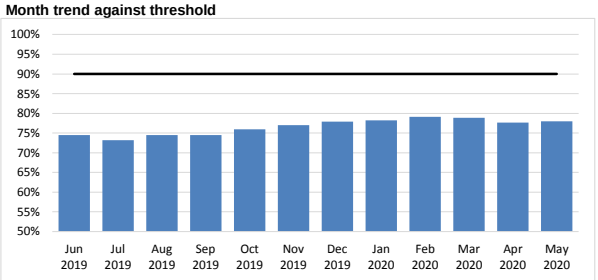
Actions

Work is now progressing so that current plans will be reviewed and refocussed to ensure demonstrable improvements in compliance. Hospitals / MCS / LCO and Corporate teams will be held to account through the AOF and Corporate Directors' Group.

Level 2 & 3 CSTF Mandatory Training

Actual	77.9%	(May 2020)	**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
✗	✗	✗	✗	✗	✗	✗
78.8%	73.2%	75.2%	84.1%	77.1%	81.5%	78.8%

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 by the Executive Team that all Hospitals / MCS / LCO ensure 90% compliance by October 2019 and the trend has been reset to April 2020. Plans are now in place and improvements are monitored through the AOF. The aggregate compliance for May 2020 increased by 0.3% to 77.9%.

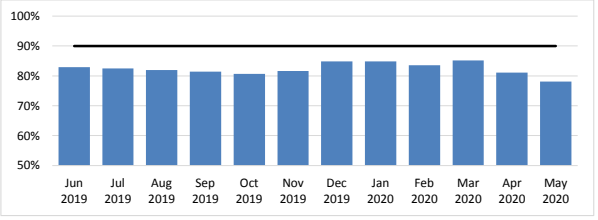
Actions

Due to the COVID-19 pandemic, the Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, which was established in January to meet every 2 weeks was suspended. The 5 key Mandatory Training work streams, chaired at CEO / Director level, which were established and have developed detailed action plans will be re-established and progress against these action plans will be reported at each Steering Group meeting. The group and work has now been reactivated.

Appraisal- medical

Actual	78.1%	(May 2020)	**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
✗	✗	✗	◇	◇	✗	✗
82.8%	72.5%	75.7%	86.0%	85.3%	79.7%	81.0%

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

Key Issues

Compliance decreased by 3.0% in May to 78.1%. This is expected due to redirected activity focused on COVID clinical care.

Actions

Current plans will be reviewed and refocussed to ensure demonstrable improvements in compliance. Hospitals / MCS / LCO and Corporate teams will be held to account through the AOF and Corporate Directors' Group.

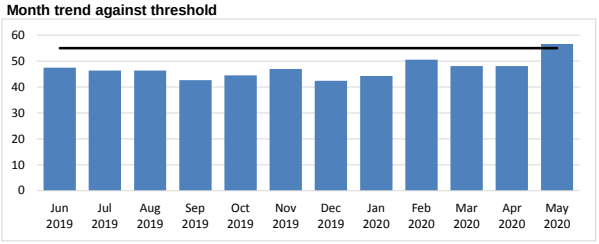
> Board Assurance

May 2020

Time to Fill Vacancy

Actual	56.7	(May 2020)	**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
◇	✗	✗	✗	✓	✓	✓
55.9	60.8	58.9	58.3	53.0	13.0	44.0

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 increased from 48.1 days to 56.7 days in May.

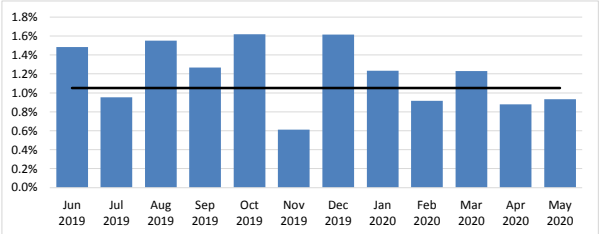
Actions

The Group's 'Time to Hire' for May 2020 has increased the previous month and now stands at 56.7 days. This is slightly above the group target of 55 by 1.7 days. The 'Time to Hire' figure for medical staff has decreased significantly on March's figures and has moved from 54.3 days to 61.5 days . The Medical and Dental staff group have a longer 'Time to Hire' due to the Medical Training Initiatives (MTI) where the Trust / College sponsors their GMC registration and Tier 5 (Temporary Worker) visa application and this can on average take between 2 -4 weeks.

B5 Nursing and Midwifery Turnover (in month)

Actual	0.93%	(May 2020)	**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	✓
0.82%	1.36%	1.04%	1.21%	0.00%	NA	0.78%

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 May 2020 is 0.93% against a monthly target of 1.05%. This is a increase from April 2020 at which the turnover was 0.88%.

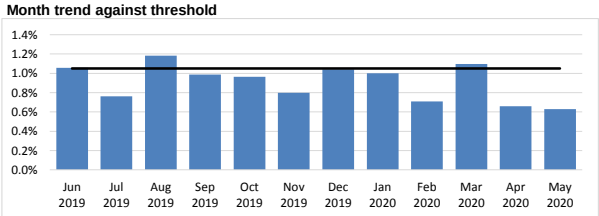
Actions

Retention of Nurses and Midwives remains a key focus for the Trust. Post COVID, work will continue to look at staff engagement career opportunitites and pastoral support for new students.

Turnover (in month)

Actual	0.63%	(May 2020)	**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
✓	✓	✓	✓	✓	✓	✓
0.64%	0.71%	0.54%	0.84%	0.00%	0.00%	0.73%

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 decreased and now stands at 0.63% compared to 0.66% for the previous month.

The turnover rate was slightly higher at the same point last year (May 2020) at 0.75%.

Actions

All Hospitals / MCS / LCO continue to focus on staff turnover with regular staff engagement sessions, facilitating internal moves to mitigate staff leaving the organisation.

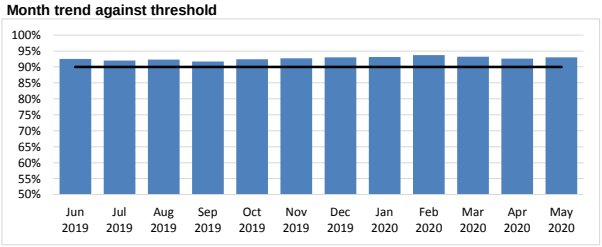
> Board Assurance

May 2020

Level 1 CSTF Mandatory Training

Actual	93.0%	(May 2020)	**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
✓	✓	✓	✓	✓	✓	✓
92.2%	91.1%	92.7%	96.5%	94.3%	96.4%	92.9%

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

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In May 2020 the aggregate compliance increased by 0.4% to 93.0%.

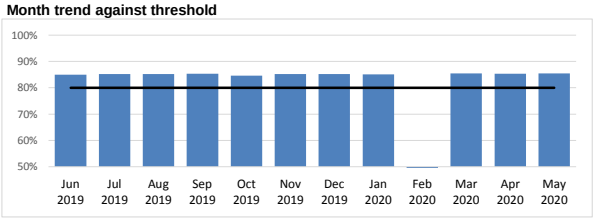
Actions

Due to the COVID-19 pandemic, the Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, which was established in January to meet every 2 weeks was suspended. The 5 key Mandatory Training work streams, chaired at CEO / Director level, which were established and have developed detailed action plans will be re-established and progress against these action plans will be reported at each Steering Group meeting. The group has now been reactivated.

Nurse Retention

Actual	85.4%	(April 2020)	**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
✓	✓	✓	✓	✓	✓	✓
86.2%	84.4%	87.2%	86.8%	85.3%	89.8%	84.7%

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 May 2020, Nursing and Midwifery retention stands at 85.4% which continues to be above the threshold of 80%.

Actions

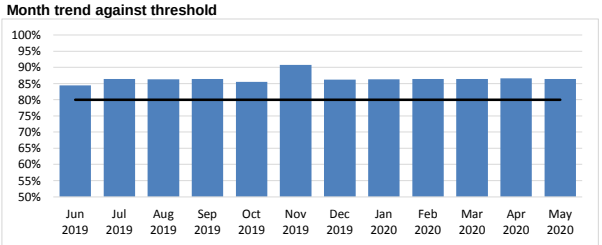
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 85.4%.

The Trust will continue with the NHSI Nurse Retention Improvement Programme. An action plan has been developed to progress and will be monitored by the NMAHP Professional Board led by the Corporate Director of Nursing.

BME Staff Retention

Actual	86.4%	(May 2020)	**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
✓	✓	✓	✓	✓	✓	✓
87.1%	86.1%	87.9%	86.2%	85.6%	93.5%	87.0%

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 Helen's & Knowsley Trust. The rate is shown as a rolling 12 month position.

Key Issues

In May 2020, the BME retention rate is significantly above the Trust's threshold of 80% month on month at 86.4%.

Action

All Hospitals / MCS / LCO are tracking this KPI within their AOF and developing plans to address where negative gaps are being identified.

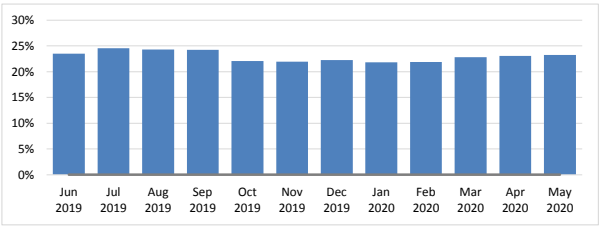
> Board Assurance

May 2020

% BME Appointments of Total Appointments

Actual	23.2%	(May 2020)	**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
-	-	-	-	-	-	-
25.5%	31.5%	22.1%	18.6%	51.5%	23.3%	25.7%

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

Almost one in four appointments is of black and minority ethnic origin (23.2%), which is consistent month on month.

Hospital / MCS / LCO below the Group average are SMH (18.6%) and RMCH (22.1%), and both hospitals have improved in this KPI since the start of the calendar year.

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%.

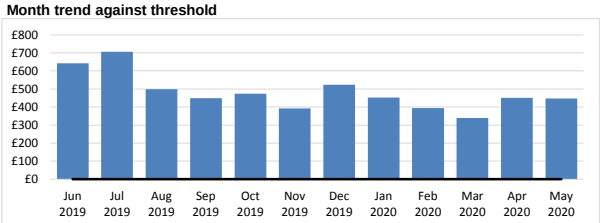
The Trust has launched the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of four interlinked components and associated priorities:

- Leadership and cultural transformation.
- Positive action and practical support, including diverse panels and talent management.
- Accountability and assurance.
- Monitoring progress and benchmarking.

Medical Agency Spend

Actual	£447	(May 2020)	**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
-	-	-	-	-	-	-
£0.0	£177.7	£143.8	£0.0	£3.8	£0.0	£121.9

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 2020 the total value of Medical and Dental agency staffing was £447k compared to £451k in April 2020.

Actions

Weekly and monthly spend meetings take place at each Hospital, to ensure all options have been considered prior to the approval of temporary staffing use.

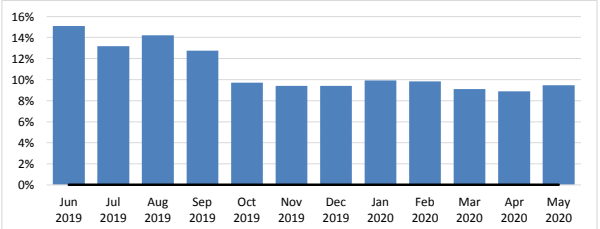
Work has begun to undertake targeted recruitment campaigns for those areas with hard to recruit to posts, to reduce the number of vacancies.

Review meetings with the Trust's Agency partners continue to take place to ensure, that when agency workers have to be engaged, efficient rates are paid.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	9.5%	(May 2020)	**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
-	-	-	-	-	-	-
5.7%	9.3%	2.8%	11.8%	11.1%	NA	11.7%

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 within Nursing and Midwifery are within the staff nurse (band 5) role. At the end of May 2020 there were 379.5 wte (9.5%) staff nurse / midwife / ODP (band 5) vacancies across the Trust Group. This is a slight increase in vacancies from April 2020 when there were 357.9 wte (8.9%). There is an additional 186.9 wte band 5 staff nurses compared to the same time last year.

Actions

A Group Resourcing Plan has been developed including a schedule of recruitment events to support the recruitment strategies implemented across all sites and managed services.

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	0	0	0	0

Headline Narrative

Financial data for 20/21 unavailable at time of publication.

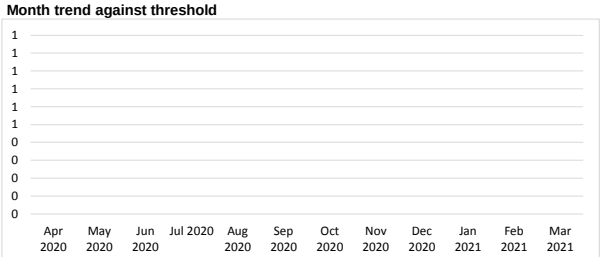
Finance - Core Priorities

Operational Financial Performance

Actual | **Accountability** A.Roberts

Threshold | **Committee** TMB and Board Finance 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

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.

Regulatory Finance Rating

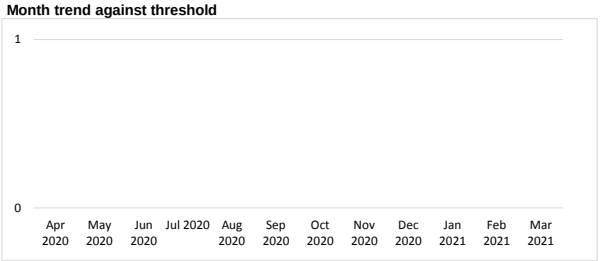
Actual

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:	Chief Operating Officer
Paper prepared by:	Rachel Bayley, Director of Performance and EPRR
Date of paper:	June 2020
Subject:	Trust Response to the COVID-19 National Emergency
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Delivery of high quality care and safety for patients, including timely access to Trust services.
Recommendations:	The Board of Directors are asked to note the information set out in this paper.
Contact:	Name: Rachel Bayley, Director of Performance and EPRR Tel: 0161 276 6718

TRUST RESPONSE TO THE COVID-19 NATIONAL EMERGENCY

1. PURPOSE

The purpose of this briefing is to provide the Board of Directors with an update on the Trust's response to the Covid-19 pandemic. The report will cover the impact on operational delivery, infection prevention and control (IPC), Test and Trace, and the implications of workforce and finance on the operational position.

2. INTRODUCTION

The report to the Private Board of Directors in May outlined the Trust Governance arrangements that have been established to oversee and manage the Group response to the Covid-19 incident, which will continue to remain in place for the foreseeable future. Key risks that have been considered through the governance arrangements include:

- Mutual aid across the GM system relating to PPE, and medical equipment i.e. ventilators.
- Mutual aid relating to ventilated bed capacity across all GM critical care facilities to ensure that this is equally dispersed to prevent a single organisation becoming overwhelmed.
- Temporary movement of services / activity, and maximising the use of all capacity including the independent sector.
- Patient and staff testing capacity, including initial constraints related to availability of equipment and consumables.
- HR / Employment Practices

Now the NHS has moved through the peak of the Covid activity, planning has shifted towards resilience and where possible some return to business as usual. Recognising that this may look different to pre-Covid arrangements and that for some time the NHS will need to plan for the management of Covid and non-Covid activity.

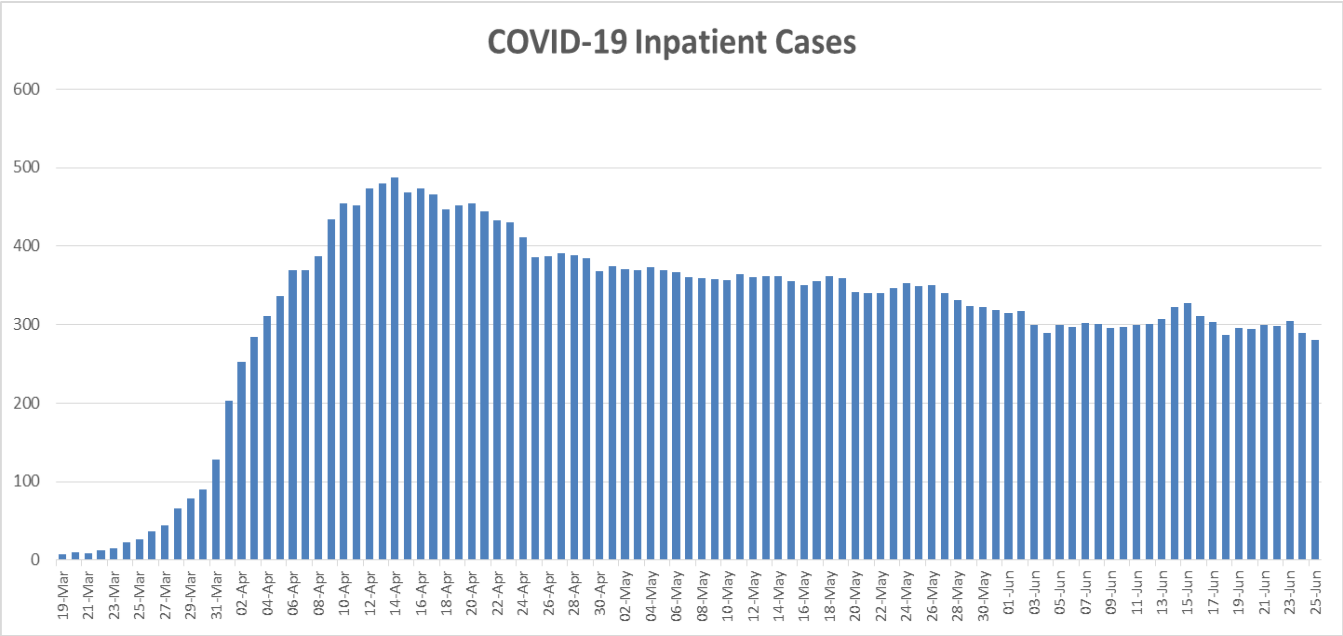
The Trust has established a Recovery programme, which is underpinned by 16 workstreams with each having an assigned Senior Responsible Officer of a Group Executive or Hospital Chief Executive. Progress against this programme of work, including consideration and approval of the recommencement of services / activity, is reported into the Group Covid-19 governance arrangements.

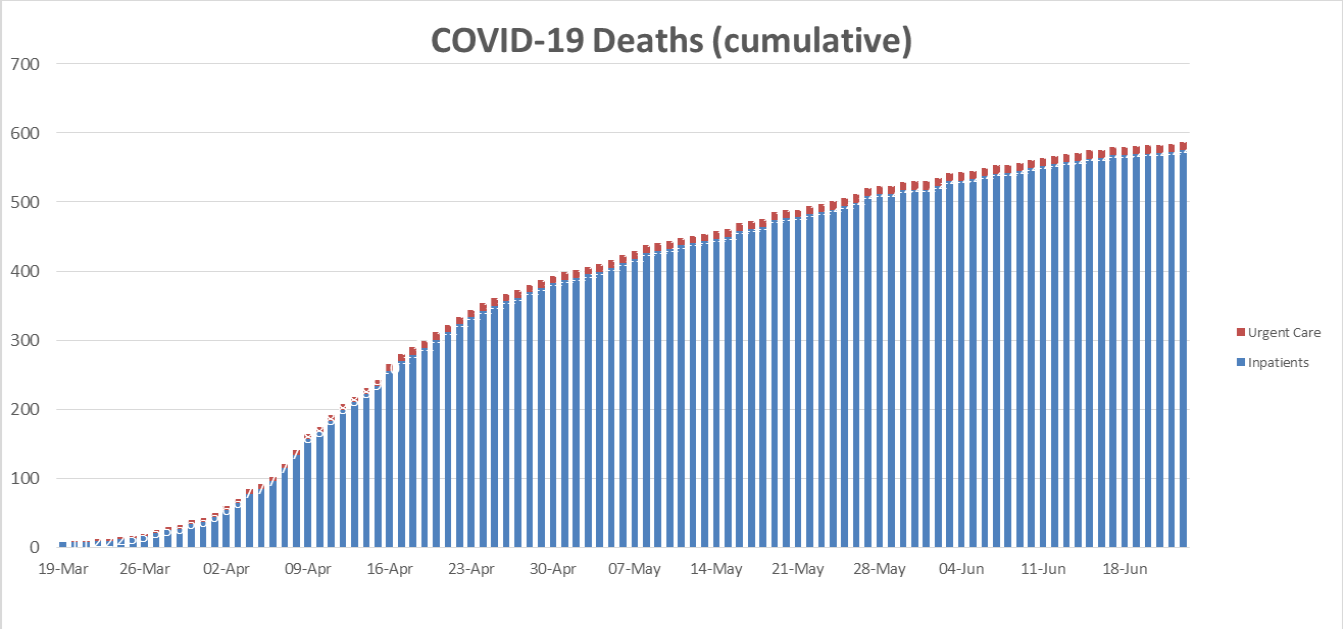
3. IMPACT ON OPERATIONAL DELIVERY

Capacity / Covid19

- Capacity escalation plans and trigger levels were developed for each hospital to manage the expected surge of Covid activity. Whilst these were high throughout the peak of the pandemic they have since de-escalated to lower levels, with less need for surge capacity.

- As at 25th June the Trust (including NMGH) had 281 Covid positive inpatients, of which 15 were in critical care level 3 beds and 6 in level 2 beds (HDU). To date there have been 590 Covid related deaths.





Operational Performance

The Board Assurance Report for May outlines the detailed impact of the pandemic on the Group performance against national constitutional standards, key points:

In line with national guidance on Tuesday 17th March MFT Strategic Command made the decision to suspend the elective programme with immediate effect, with the exception of life, limb or sight threatening procedures. Furthermore, outpatient activity was suspended from the 26th March for a period of 3 months. As a direct result the performance since March has been exacerbated against those elective access standards where the Trust had already experienced challenges in delivery during 2019/20.

The pandemic resulted in some unexpected positive performance results relating to improved timeliness of access in A&E and improved discharge, due to less demand and the actions taken to manage the Covid19 response.

MFT performance in the last two months against constitutional standards aligns to that of the national position, which has seen elective and diagnostic waiting lists grow, deterioration in elective, diagnostic and cancer performance, but an improvement in urgent care delivery.

Demand levels across both urgent and elective care and cancer pathways continue to be reduced compared to usual levels. Although, urgent care is starting to see an increasing trend, and acuity and trauma activity has been a challenge through June.

MFT performance management through the Accountability Oversight Framework (AOF) process were maintained throughout the pandemic with the continued production of the AOF dashboard, although the review meetings were suspended for Mar – June. The review meetings between the Group Executive Directors and Hospital / MCS/ MLCO Executive Teams have recommenced from the 1st July and a revised dashboard, supporting the focus on recovery, will be in place from August.

The NHSE *Clinically-Led Review of NHS Access Standards*, commenced in May 2019, and was expected to inform the planning round and contract for 2020 with potential changes to the long standing constitutional standards. This has now been deferred to later in the year, with monitoring and reporting of the current standards remaining in place.

Delivery of improvement against operational performance standards for 2020/21 will be aligned with the recovery programme, and any changes in national priorities and the *Clinically-led review of NHS Access Standards* when this is published. In addition, recognising that MFT will have a significantly more challenged baseline and that improvement is likely to be phased over a longer period of time.

4. **INFECTION PREVENTION AND CONTROL (IPC)**

The IPC team are central to the pandemic response including providing advice, support and education across the Trust on Personal Protective Equipment (PPE), isolation and cohorting of COVID and non COVID patients whilst maintaining a clean safe environment. The team are supporting the hospitals/MCS as part of the trust phase 2 (recovery) responses as the Trust begins to admit more patients both through elective and non-elective streams with and without COVID infection. Due to the infectious nature of COVID it is important that the systems and processes in place protect patients from each other and from our staff, in the transmission of the virus.

Pivotal to the next phase is managing the risks associated with reducing the incidents of nosocomial (disease pertaining to, or acquired in, a hospital) transmission of COVID. The IPC Team have developed an outbreak policy with a clear process of escalation based on guidance from North West NHSE/I which complements the Trust policy for the Management and Control of Outbreaks. To date there have been a number of outbreaks based on the NHSE/I definition. All have been reported through the daily sitrep.

Clinical Area	**No: patients affected**	**No: staff affected**	**Current position**
F4 WTWA	19	3	Ongoing ward closed to admissions no new cases since closure
AM1/2 MRI	42	26	Outbreak Closed
F1 (NMGH)/Crumpsall vale	18	32	Outbreak Closed
E1 NMGH	2	0	Patients in cohort area – no new admissions
F5 NMGH	2	1	Ward closed to admissions

Learning from the outbreaks is informing the streaming and management of patients during their stay in our healthcare facilities. A staff and patient screening strategy has been developed and circulated to the hospitals/MC to assess the number of tests required which will inform the prioritisation of staff and patient screening.

The IPC team have worked in partnership with colleagues in other departments to develop guidance on a range of prevention and control measures in both the clinical and non-clinical environment including; hygiene factors, distancing, testing and tracing and PPE. These four areas of practice are being drawn together to provide a strategic overview document. The aim of this document will be to provide staff with a quick reference guide to the key prevention and control activities with sign posts to the underpinning Trust policies. It will be communicated out through the Trust Communications Te am and regularly reviewed and updated in line with national changes to policy. It will be available on the trust Covid -19 and IPC website.

The stock levels of Personal Protective Equipment (PPE) are monitored daily and any escalation reported up to Gold Command.

WORKFORCE & TEST & TRACE

Absence rates relating to COVID-19 peaked at circa 2700 during the early stages of the pandemic and are now showing a downward trend towards 1350, 700 or so of the 1350 are staff shielding under the guidance issued by NHSE/I and will remain absent from work until the end of July at the earliest. The remaining staff numbers consist of newly diagnosed staff, those residing with a family member tested positive for COVID-19, or staff who are taking longer than 7 days from confirmation of a positive test to be fit to return to work.

Over recent weeks in response to Government Test and Trace planning the Trust has activated internal contact tracing following the identification of a positive COVID-19 index cases. The system is also influenced by notifications received from Public Health England Test and Trace Programme (MFT is not required to social trace).

Active management of staff affected by COVID-19 is embedded in the operational management systems, which includes a full 7-day monitoring arrangement. This enables active workforce planning and the identification of support for staff.

Workforce data modelling is in place which tracks trends to inform forward planning.

Staff testing has been in place for almost three months and at the time of producing this report 2744 staff have been tested, of which 1793 have been advised to return to work.

In tandem with the transactional and planning work, Employee Health and Wellbeing Services have been involved with the provision of advice to staff and managers including interpretation of national guidance. This has included a dedicated work stream devoted to risk assessments for vulnerable groups.

FINANCE

A separate report from the Chief Finance Office has been provided to the Board of Directors.

RESEARCH & INNOVATION

MFT is at the cutting-edge of Research and Innovation (R&I) and we are utilising this expertise to address the urgent priorities for research as part of a global, coordinated effort to enhance understanding of COVID-19 (Coronavirus).

Dr Tim Felton, Honorary Consultant at Wythenshawe Hospital and Senior Lecturer in the Division of Infection, Immunity and Respiratory Medicine at The University of Manchester, is the Clinical Lead for all MFT COVID-19 related research studies. These studies are being supported and coordinated from R&I by a newly assembled COVID-19 Research Team and delivered across MFT, including the NIHR Clinical Research Facility presences at the Oxford Road and Wythenshawe Hospital sites.

The research is focussed on four key areas:

1. Treatments (interventional)
2. Data
3. Diagnostics
4. Observational

As at 26/6/2020 MFT have:

- Recruited 3,809 participants into MFT COVID-19 research projects
- 18 studies currently open to recruitment across MFT
- 5 new studies setting up
- 4 studies now closed to recruitment ("in follow-up").

As well as delivering the new portfolio of COVID-19 studies and maintaining studies providing essential treatment to patients' life or limb, many Research Nurses were redeployed to Critical Care and other frontline COVID-19 treatment areas, including nurses from the Greater Manchester NIHR Clinical Research Network (CRN) to the Nightingale North West Hospital.

MFT is a significant contributor to the Greater Manchester wide efforts in R&I, which are brought together under the COVID-19 Research Rapid Response Group (R3G) chaired by Professor Ian Bruce, Health Innovation Manchester (HInM) Academic Director and Manchester NIHR Biomedical Research Centre (BRC) Director. The group brings together academic researchers and activity from The University of Manchester with GM NHS Trusts and has received 163 projects across 10 priority areas:

Public Health, Epidemiology & Mental Health; Emerging themes; Mechanisms of disease; Global health; New diagnostics; Organisational development; Clinical trials; Prevention & vaccination; Patients with chronic illnesses; and Data analysis.

HInM have also been supporting efforts in estates and equipment, such as 3D printing for personal protective equipment (PPE). HInM, BRC and CRN are wider Manchester organisations hosted at MFT through R&I.

RECOMMENDATIONS

The Board of Directors are asked to note the contents of the report

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	James Bradley, Finance Director Rachel McIlwraith, Operational Finance Director
Date of paper:	July 2020
Subject:	Financial Performance for Month 2, 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	• Strong financial governance and control is essential during this extremely unusual finance regime. • Working Day 1 reporting has now been delivered which will allow much earlier consideration and response to financial results. • Stronger discipline on forecasting has recently been introduced to ensure that the financial implications of decisions on service changes are understood and taken into account in the decision-making process. • Whilst Waste Reduction is not required under the existing finance regime, the Trust continues to place a strong focus on delivering high quality patient care efficiently. • It is of paramount importance that decisions are not made that commit to the Trust to recurrent new expenditure without the appropriate level of scrutiny. • Aged debt is a key focus for the Finance Team.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	As a response to the COVID-19 pandemic, the NHS financial framework has been amended. Currently all Trusts are on a block contract, with an adjusting 'top-up' made retrospectively to bring the Trust to breakeven. This provides stability in the short-term as the Trust responds to the pandemic and as it begins to restore services during the recovery phase. This arrangement is in place until the end of July 2020, and therefore the Trust does not currently have an agreed Control Total for 2020/21. Whilst full details have not yet been shared nationally, it is expected that the financial regime which is anticipated to come into place on 1st August 2020 will maintain the block payments to Trusts, but that the costs in excess of this will be financed from a system-wide (ie Greater Manchester) funding pot. This has not been quantified as yet, however financial constraints are expected to increase. The Trust has worked with partners across GM to set up a structure to lead and manage this GM-wide funding mechanism. Until the quantum is known, it is difficult to be explicit as to the level of risk within the system.
1.2	**Run Rate**	Despite the assurance of a breakeven position in the short term, strong financial governance and control is essential. In June, the overall expenditure of the Trust has remained consistent with the expenditure in May, which is a positive outcome. There has been a reduction in income as the new financial regime has been fully understood and embedded. Hospitals began to forecast their future monthly financial positions based on Month 2 and in the main have returned results within a relatively small margin. At the end of Month 2 it was anticipated that further discussion and learning on improving the forecasting methodology would be required, and this has proved to be the case. This is part of the accountability discussions held with each Hospital leadership team. Waste reduction schemes continue to be developed. As the financial framework for the remainder of the year becomes clearer, additional waste reduction schemes will need to be identified and delivered by all parts of the organisation.
1.3	**Remedial action to manage risk**	The current "expenditure led" financial regime presents significant risk to the Trust, through the changed behaviours which it drives. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic. As the financial regime becomes clearer for the remainder of the financial year, pecific targets will be implemented at Hospital level, to reflect the constraint at Trust level.
1.4	**Cash & Liquidity**	As at 30th June 2020, the Trust had a cash balance of £241.6m. This remains higher than plan due to the "double-payment" of the block contract in April, which it is expected will be recovered during the financial year.
1.5	**Capital Expenditure**	The internal capital plan is now the subject of negotiations across Greater Manchester to bring the total planned spend into line with the new capital envelope. Up to June 2020, £18.2m of capital spend was incurred. Any future capital expenditure relating to Covid requires approval at a national level and the process has been widely communicated across the Trust.

Financial Performance

Income & Expenditure Account for the period ending 30th June 2020

	Baseline run-rate	Year to date Actual - M3
INCOME	**£'000**	**£'000**
Income from Patient Care Activities		
NHSE Block		369,682
Wales		340
Wales Specialised		923
NORs / blood and transplant accrual		447
Other (eg. Devolved administrations) and IOM		108
SARC accrual		402
PHE Breast screening accrual		95
Councils		9,079
Sub -total Income from Patient Care Activities	**375,437**	**381,076**
Private Patients/RTA/Overseas(NCP)	2,217	1,474
Total Income from Patient Care Activities	**377,654**	**382,550**
Training & Education	17,301	17,386
Research & Development	15,080	13,728
Misc. Other Operating Income	27,419	12,746
Other Income	**59,800**	**43,860**
Total Income	**437,454**	**426,410**
EXPENDITURE		
Pay	-274,186	-267,811
Pay (COVID)		-18,135
Non pay	-155,731	-152,944
Non pay (COVID)		-48,406
Total Expenditure	**-429,917**	**-487,296**
EBITDA Margin (excluding PSF)	**7,537**	**-60,886**
Interest, Dividends and Depreciation		
Depreciation	-6,456	-6,336
Interest Receivable	271	30
Interest Payable	-10,216	-10,201
Dividend	-145	-351
Surplus/(Deficit) excluding MRET and national top-up	**-9,010**	**-77,744**
Surplus/(Deficit) as % of turnover		**-18.2%**
PSF / MRET Income		**0**
National top up funding		**77,744**
Impairment		**-8,718**
Non operating Income		**686**
Depreciation - donated / granted assets		**-186**
		-8,218

It can be seen that the total income is c£11m lower than the baseline. This reduction includes for example car parking income and income from other providers for specific activity. Whilst underlying expenditure for the quarter has reduced by £9m, the increase in expenditure relating to Covid amounts to £66.5m. There are two non-material but system-generated negative impacts on Interest Receivable (no longer paid on the Government Banking Service balances) and Dividend (increased due to the increased cash balance).

Specific focus is being placed on spend on Agency and Bank staff in discussions with Hospitals, with an expectation that these will be minimised wherever appropriate.

Hospital / MCS Financial Performance

Hospital / MCS	Category	Baseline run-rate	Year to date (M3)	- of which COVID	Year to date (M3) excl. COVID	Year to date forecast (M3)	Difference to TYD forecast (M3)
		£'000	£'000	£'000	£'000	£'000	£'000
Clinical & Scientific Support	Income	5,529	4,690	0	4,690	4,867	-177
	Pay	-51,387	-53,299	-2,981	-50,318	-52,429	-870
	Non pay	-16,338	-16,442	-2,332	-14,110	-17,350	908
	Total	**-62,196**	**-65,051**	**-5,313**	**-59,738**	**-64,912**	**-139**
Manchester LCO / Trafford LCO	Income	3,693	645	0	645	683	-38
	Pay	-26,370	-27,154	-1,830	-25,324	-27,039	-115
	Non pay	-5,967	-5,367	-184	-5,183	-5,360	-7
	Total	**-28,644**	**-31,876**	**-2,014**	**-29,862**	**-31,716**	**-160**
MRI	Income	1,848	1,442	0	1,442	1,641	-199
	Pay	-45,921	-48,269	-3,415	-44,854	-48,854	585
	Non pay	-33,846	-27,995	-447	-27,548	-27,974	-21
	Total	**-77,919**	**-74,822**	**-3,862**	**-70,960**	**-75,187**	**365**
REH / UDH	Income	804	182	0	182	255	-73
	Pay	-10,314	-10,039	-127	-9,912	-10,052	13
	Non pay	-5,886	-3,152	-56	-3,096	-3,153	1
	Total	**-15,396**	**-13,009**	**-183**	**-12,826**	**-12,950**	**-59**
RMCH	Income	846	1,412	0	1,412	1,237	175
	Pay	-30,354	-31,611	-1,908	-29,703	-31,447	-164
	Non pay	-17,046	-18,694	-251	-18,443	-17,799	-895
	Total	**-46,554**	**-48,893**	**-2,159**	**-46,734**	**-48,009**	**-884**
Saint Mary's Hospital	Income	3,735	1,307	0	1,307	1,537	-230
	Pay	-26,358	-28,247	-1,953	-26,294	-27,967	-280
	Non pay	-6,138	-4,913	-391	-4,522	-4,808	-105
	Total	**-28,761**	**-31,853**	**-2,344**	**-29,509**	**-31,238**	**-615**
WTWA	Income	4,227	2,420	0	2,420	2,424	-4
	Pay	-58,743	-58,228	-1,998	-56,230	-57,822	-406
	Non pay	-34,302	-22,189	-242	-21,947	-24,610	2,421
	Total	**-88,818**	**-77,997**	**-2,240**	**-75,757**	**-80,008**	**2,011**
TOTAL		**-348,288**	**-343,501**	**-18,115**	**-325,386**	**-344,020**	**519**

This is the first month that monthly performance can be compared to forecasts. Accountability meetings now focus on the performance against forecasts, to develop the financial understanding of our services and to ensure that the financial impact of decisions is fully understood. Whilst there are currently no targets for the Hospitals to achieve when the new financial regime is implemented in August, targets will be flowed to Hospitals and performance will be reported against these. Each Hospital/MCS is now meeting on a monthly basis with the Group CFO and Group COO to explain both their historic performance and the assumptions underpinning their forecasts.

The baseline run rate has been calculated using performance from 2019/20 Months 7-11, and adjusted for known changes coming into 20/21 such as inflation and reducing recharges between Hospitals/MCSs.

Key Run Rate Areas

1. Waste Reduction Programme

In April 2020, the Hospital finance teams were asked to review the identified waste reduction schemes and quantify the potential impact of COVID-19 on those plans. A summary of the estimated impact at that time is shown in the table below. Of the £52.3m previously identified, **£28.2m** was then considered deliverable.

Hospital/MCS	Pre Covid Plans	Covid Impact	Post Covid Plan	% Write down
MRI				
- Income	7,110	-4,510	2,600	-63%
- Pay	3,604	-404	3,201	-11%
- Non Pay	3,184	-405	2,779	-13%
Eye & Dental				
- Income	1,925	-1,909	16	-99%
- Pay	177	-50	127	-28%
- Non Pay	253	0	253	0%
CSS				
- Income	3,777	-3,405	372	-90%
- Pay	1,729	-640	1,089	-37%
- Non Pay	2,172	-297	1,875	-14%
WTWA				
- Income	3,627	-895	2,732	-25%
- Pay	1,090	-206	884	-19%
- Non Pay	2,777	-440	2,337	-16%
RMCH				
- Income	15,711	-8,170	7,541	-52%
- Pay	2,462	-2,462	-0	-100%
- Non Pay	789	0	789	0%
St Mary's				
- Income	1,435	-141	1,294	-10%
- Pay	17	0	17	0%
- Non Pay	455	-145	309	-32%
	52,292	-24,079	28,213	-46%

It is now expected that many of the income schemes that were still considered viable in April are at risk, putting the realistic figure of deliverable schemes closer to **£18.6m**.

The Group Turnaround Team have begun to reinstate their usual processes to support Hospitals/MCSs to consider efficiency in particular identifying new more efficient ways of working which have been precipitated by the Covid situation.

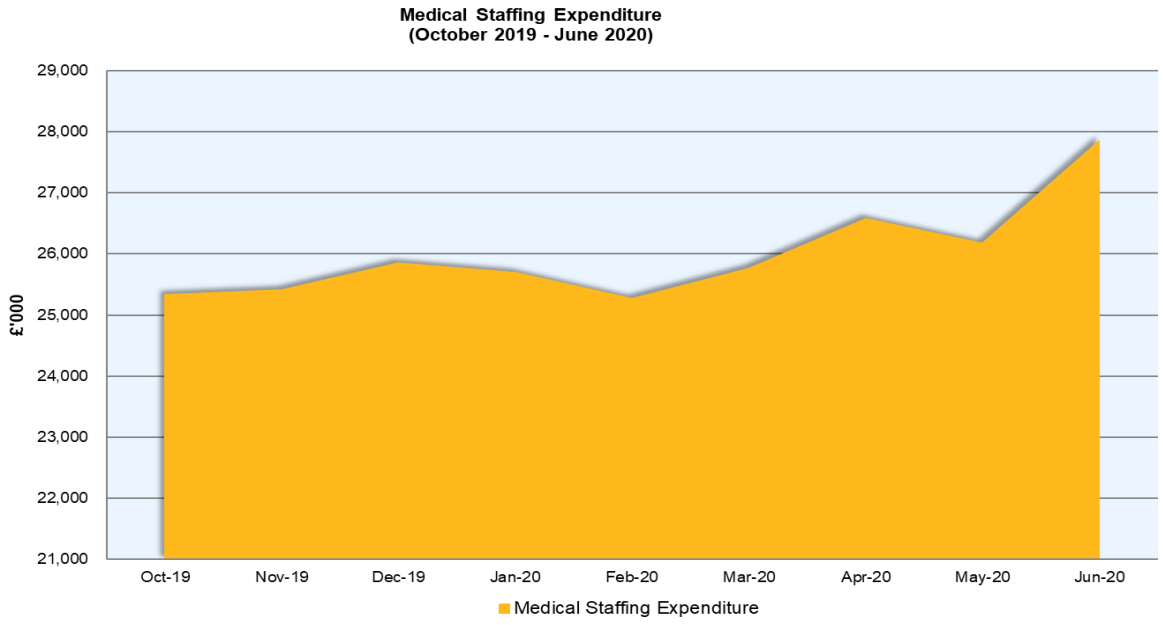
2. Agency spend by Staff Group and Hospital / MCS

Staff Group	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's	Average M10-12 (19/20) £000's	Average M1-3 (20/21) £000's
Consultant	-284	-268	-302	-275	-333
Career Grade Doctor	-89	-29	-36	-103	-35
Trainee Grade Doctors	-247	-253	-125	-84	-72
Registered Nursing Midwifery	-574	-530	-511	-531	-303
Support to Nursing	-48	-45	-18	-41	-15
Allied Health Professionals	-83	-72	-109	-72	-64
Other Scientific and Theraputic	-141	-105	-20	27	-72
Healthcare Scientists	-8	-73	-118	-55	-62
Support to STT / HCS	-32	-39	-58	-39	-17
Infrastructure Support	-101	-40	-165	-98	-117
Grand Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**

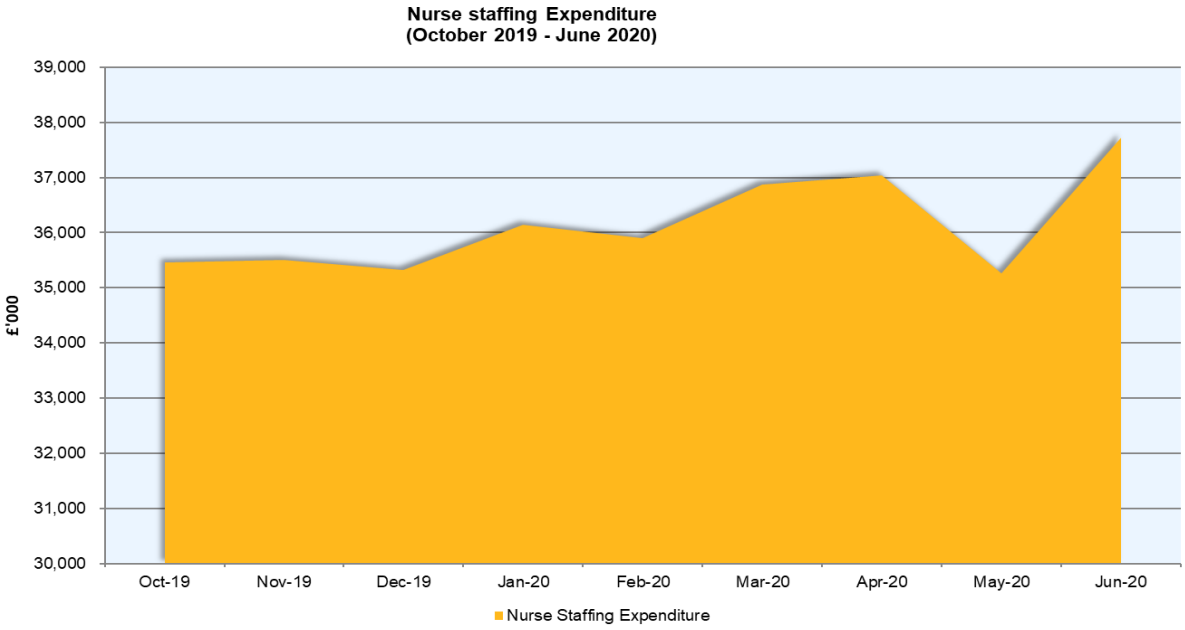
Hospitals	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's	Average M10-12 (19/20) £000's	Average M1-3 (20/21) £000's
Clinical & Scientific Support	-191	-218	-156	73	-101
Manchester LCO	-44	-43	-110	-156	-152
MRI	-680	-534	-226	-534	-286
REH / UDH	-82	-91	-82	-73	-23
RMCH	-78	-94	-156	-109	-130
Saint Mary's Hospital	-24	-36	-33	-33	-18
WTWA	-412	-390	-532	-372	-199
Corporate	-99	-40	-162	-66	-182
Research	2	-8	-5	0	1
Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**

As would be anticipated, there has been a reduction in the level of spend in 20/21 due to reduction in activity and the redeployment of clinical staff. Further scrutiny is being placed on agency spend given the current circumstances, and it remains one of the key finance indicators in the AOF.

3. Medical Staffing: June 2020

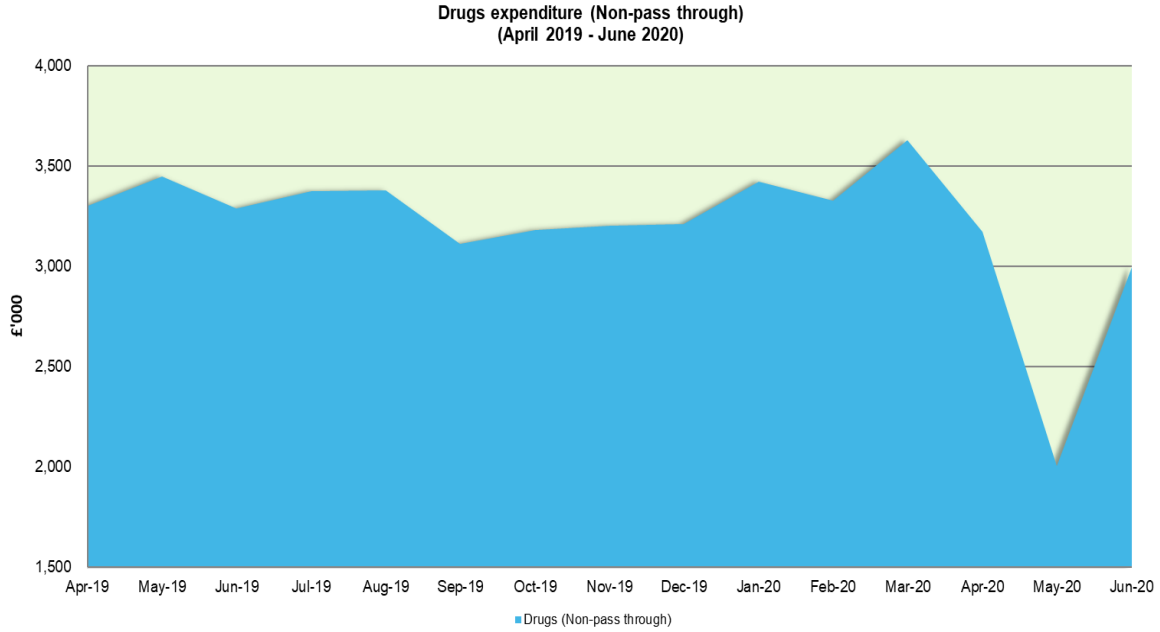


Nurse staffing: June 2020



The significant reduction in expenditure in May is due to the correction of an over-estimate in April.

4. Prescribing: June 2020



Through WD1 Reporting, the Trust has changed the methodology by which drug expenditure is recorded in Month 2. This change in recording is the reason for the significant drop in expenditure in month 2. The level reported at Month 3 is considered a more realistic on-going level.

5. Staffing numbers

Staffing numbers have shown a significant increase in June, with increases in clinical support posts and medical staffing.

	Whole Time Equivalent (WTE)								
	Oct-19	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**
Allied Health Professionals	1,261.84	1,263.31	1,266.93	1,260.65	1,265.99	1,301.87	1,303.58	1,288.33	1,271.72
Career Grade Doctor	297.87	285.84	287.55	337.58	342.19	331.05	332.81	327.52	317.06
Consultant	1,175.66	1,161.67	1,159.27	1,152.41	1,171.39	1,189.14	1,201.36	1,170.64	1,206.07
Healthcare Scientists	935.21	951.78	940.70	943.77	944.84	953.14	939.28	950.26	944.19
Infrastructure Support	2,202.81	2,228.50	2,225.12	2,219.11	2,249.52	2,254.97	2,294.16	2,338.67	2,351.79
Other Scientific and Theraputic	846.08	858.31	841.02	848.47	863.02	872.39	861.92	861.44	902.64
Registered Nursing Midwifery	7,081.78	7,187.17	7,145.76	7,209.98	7,299.20	7,422.10	7,605.55	7,302.18	7,399.14
Support to AHPs	144.53	140.55	138.86	143.32	144.31	145.39	146.76	143.60	144.21
Support to Clinical	2,707.31	2,674.86	2,674.66	2,698.29	2,737.44	2,732.40	2,716.26	2,671.57	2,675.53
Support to Nursing	3,265.12	3,241.72	3,225.48	3,239.96	3,209.55	3,314.23	3,186.18	3,078.18	3,533.29
Support to STT HCS	737.59	730.75	731.66	721.03	712.86	736.50	724.40	712.10	841.43
Trainee Grade Doctors	1,236.60	1,225.16	1,228.60	1,170.79	1,170.11	1,214.82	1,214.57	1,195.87	1,334.92
Grand Total	**21,892.40**	**21,949.62**	**21,865.61**	**21,945.36**	**22,110.42**	**22,468.00**	**22,526.83**	**22,040.36**	**22,921.99**

	Whole Time Equivalent (WTE)								
	Oct-19	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**
RMCH	2,105.42	2,123.63	2,124.04	2,126.54	2,145.20	2,206.93	2,258.22	2,209.06	2,305.04
CSS	3,692.18	3,722.39	3,684.52	3,715.38	3,741.01	3,802.95	3,845.52	3,773.63	3,807.95
Corporate Services	1,300.70	1,268.54	1,268.66	1,269.95	1,286.20	1,289.55	1,302.15	1,315.89	1,541.72
UDHM	258.65	259.90	262.21	254.40	269.74	262.77	262.65	254.81	257.46
Facilities	294.41	285.05	288.37	293.42	290.25	295.87	295.82	299.09	301.67
MLCO / TLCO	2,440.88	2,466.37	2,468.11	2,466.11	2,517.37	2,508.24	2,534.08	2,510.32	2,556.51
MRI	3,839.46	3,809.72	3,779.12	3,799.22	3,813.36	4,007.40	3,946.14	3,785.86	3,964.00
R&I	532.44	542.06	532.79	529.65	543.55	525.16	525.63	534.35	539.46
MREH	546.15	550.17	540.89	539.39	541.24	536.10	535.91	523.87	537.35
SMH	2,108.57	2,134.95	2,105.99	2,109.36	2,117.76	2,144.40	2,160.79	2,177.27	2,246.25
WTWA	4,773.54	4,786.84	4,810.91	4,841.94	4,844.74	4,888.63	4,859.92	4,656.21	4,864.58
Grand Total	**21,892.40**	**21,949.62**	**21,865.61**	**21,945.36**	**22,110.42**	**22,468.00**	**22,526.83**	**22,040.36**	**22,921.99**

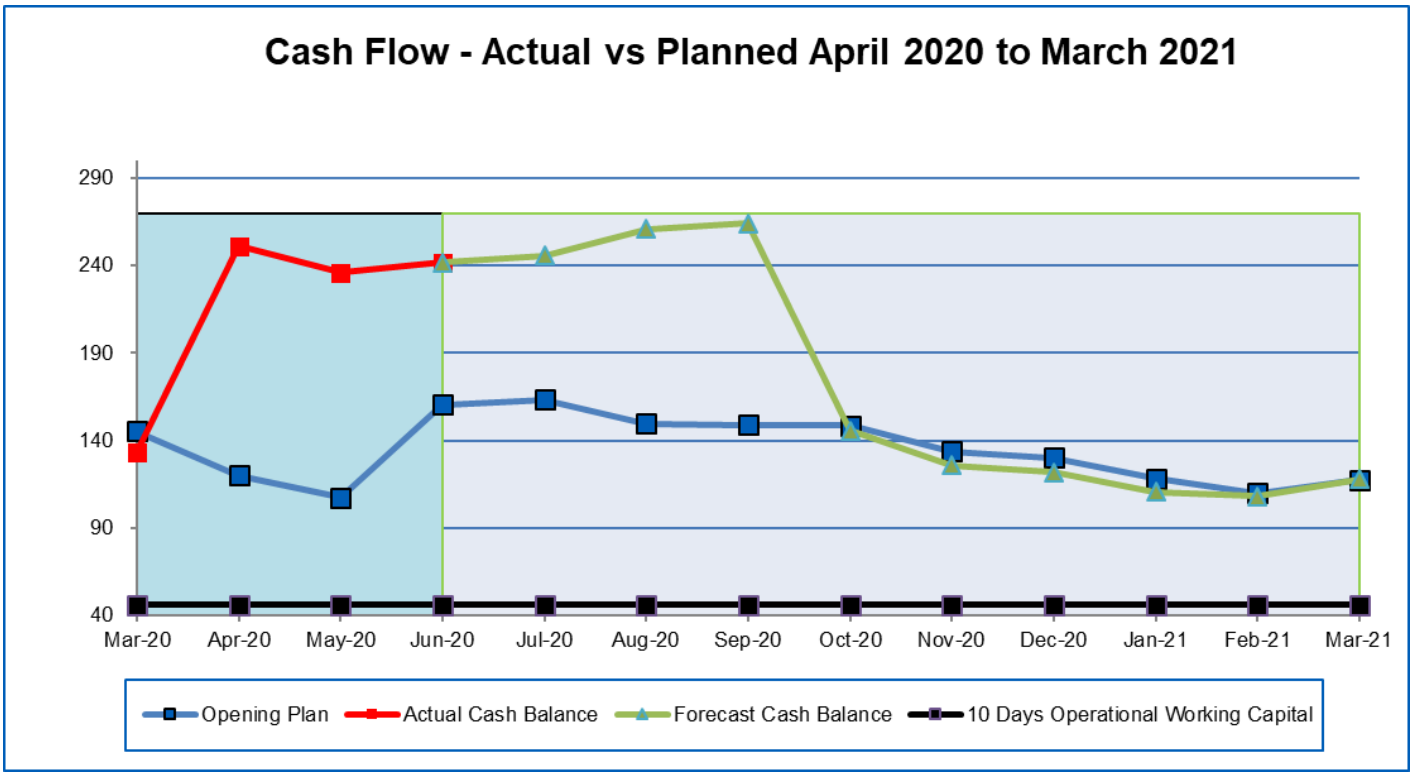
Statement of Financial Position

	Opening Balance 01/04/2020 £000	Actual Year to Date 30/06/2020 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,006	3,719	(287)
Property, Plant and Equipment	608,068	611,288	3,220
Investments	1,592	1,592	0
Trade and Other Receivables	6,329	6,011	(318)
Total Non-Current Assets	**619,995**	**622,610**	**2,615**
Current Assets			
Inventories	18,618	18,838	220
NHS Trade and Other Receivables	79,356	90,999	11,643
Non-NHS Trade and Other Receivables	37,302	35,173	(2,129)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	133,281	241,629	108,348
Total Current Assets	**268,767**	**386,849**	**118,082**
Current Liabilities			
Trade and Other Payables: Capital	(12,844)	(8,762)	4,082
Trade and Other Payables: Non-capital	(175,409)	(181,447)	(6,038)
Borrowings	(20,173)	(19,986)	187
Provisions	(13,417)	(13,452)	(35)
Other liabilities: Deferred Income	(18,435)	(143,761)	(125,326)
Total Current Liabilities	**(240,278)**	**(367,408)**	**(127,130)**
Net Current Assets	**28,489**	**19,441**	**(9,048)**
Total Assets Less Current Liabilities	**648,484**	**642,051**	**(6,433)**
Non-Current Liabilities			
Trade and Other Payables	(2,599)	(2,706)	(107)
Borrowings	(391,455)	(388,704)	2,751
Provisions	(14,635)	(14,348)	287
Other Liabilities: Deferred Income	(3,442)	(3,462)	(20)
Total Non-Current Liabilities	**(412,131)**	**(409,220)**	**2,911**
Total Assets Employed	**236,353**	**232,831**	**(3,522)**
Taxpayers' Equity			
Public Dividend Capital	208,994	213,691	4,697
Revaluation Reserve	49,424	49,424	0
Income and Expenditure Reserve	(22,065)	(30,284)	(8,219)
Total Taxpayers' Equity	**236,353**	**232,831**	**(3,522)**
Total Funds Employed	**236,353**	**232,831**	**(3,522)**

The most significant change on the SoFP is the increase in Cash and offsetting increase in Deferred Income. This reflects the double-payment of the block contract income in April, which was done to ensure all NHS providers were in funds to prevent any cash-related issues impacting on the response to Covid.

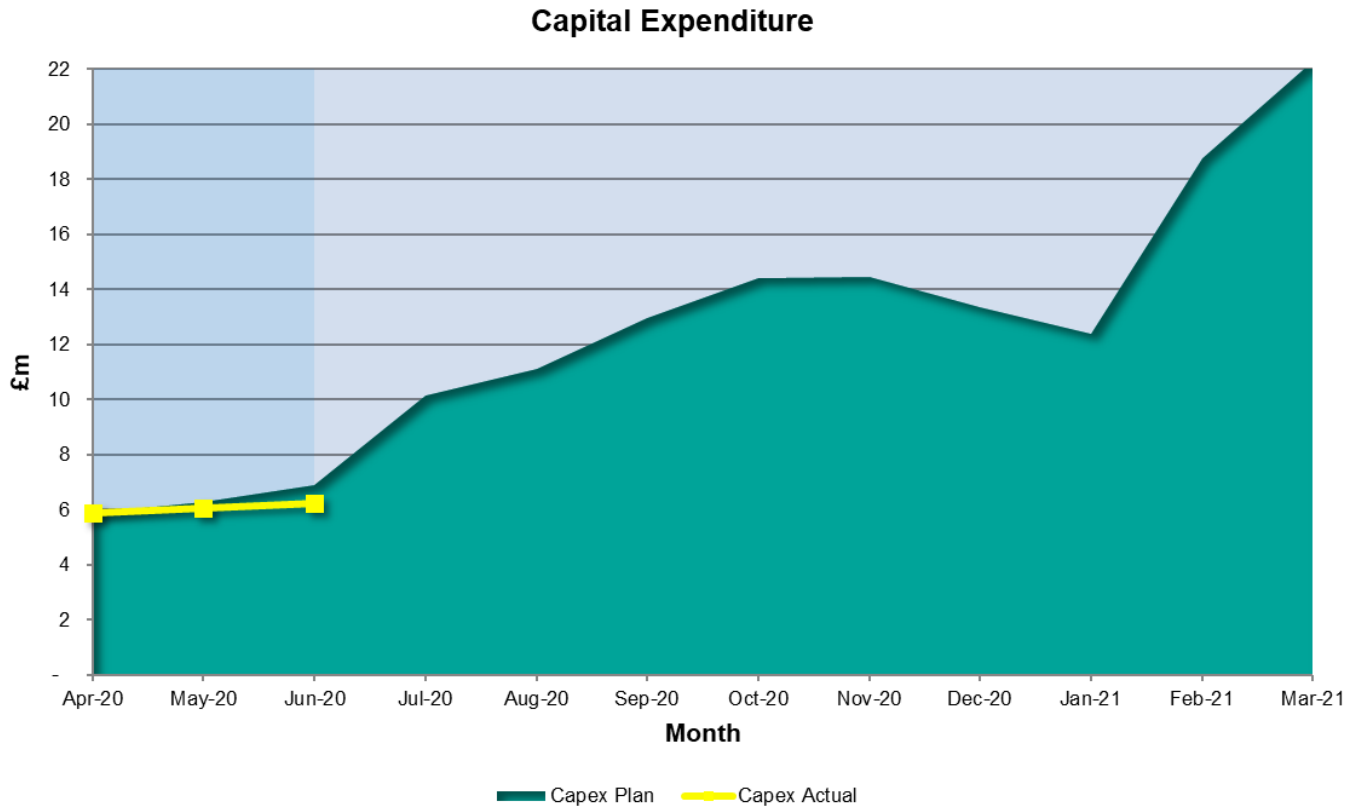
The rise in NHS Trade receivables is due to accrual of the top-up income.

Cash flow



It is anticipated that the double-payment in April will be recouped in October, however this is not yet confirmed.

Capital Expenditure



The chart above sets out the capital plan as approved by Finance Scrutiny Committee in February 2020. However, as the Board is aware, new guidance was published in early April 2020 which sets a capital envelope at Greater Manchester level and requires that providers work together to ensure that capital expenditure is contained within that envelope. This process is ongoing, and the Trust has agreed to reduce its capital plan due to slippage of the EPR from 1st April 2020 as originally planned.

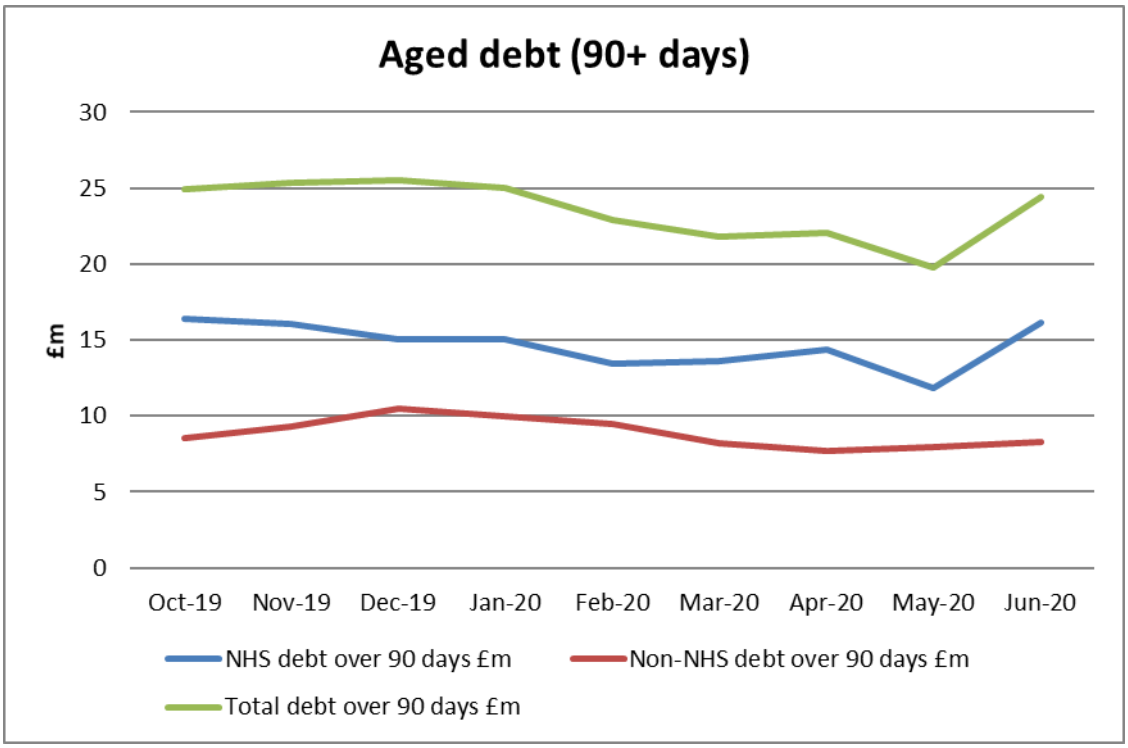
The Capital Programme Managers for each of the three programmes are now also being expected to forecast their expenditure in the coming months. This chart will be updated with the forecast expenditure at an appropriate time.

Aged debt

Aged Debt is a focus of the Finance Workplan during 20/21 as the level of outstanding debt is significant and needs close scrutiny.

Total invoices raised that remain unpaid at the end of June 2020 stands at £38.9m, a reduction of £4.8m from April 2020. Of that balance, 63% of the invoices were raised over 90 days ago, increasing the risk that those balances will not be received. Despite steady decreases in recent months, the proportion of outstanding debtors over 90 days has risen markedly in June, principally with balances due from NHS partners.

A piece of work is being undertaken across Greater Manchester to manage inter-provider debt more closely and to reduce transaction costs for these intra-NHS charges. It is expected that this could have a significant impact on the Trust's aged debt, releasing time for management of non-NHS debt.



Hospital / MCS	0-30 days (£)	30-60 days (£)	60-90 days (£)	90 DAYS + (£)	Grand Total (£)
Royal Manchester Children's Hospital	174,674	156,467	103,644	994,575	1,429,360
Clinical & Scientific Services	165,350	65,145	398,339	4,268,192	4,897,026
Corporate Services	185,916	136,419	202,200	817,019	1,341,554
Dental Hospital	21,425	8,887	13,106	33,435	76,852
Facilities	1,140,217	73,338	65,963	720,707	2,000,225
Manchester & Trafford LCOs	71,393	8,249	133,516	555,351	768,509
Manchester Royal Infirmary	141,705	66,226	33,935	2,461,697	2,703,563
Group transactions	3,397,315	812,853	259,712	5,884,522	10,354,402
Research & Innovation	1,249,284	2,551,536	237,517	1,102,140	5,140,477
Royal Eye Hospital	10,366	2,136	2,298	85,987	100,787
Saint Marys Hospital	565,788	312,067	464,929	4,429,447	5,772,231
WTWA	915,376	214,416	132,111	3,067,079	4,328,982
Grand Total	**8,038,809**	**4,407,740**	**2,047,270**	**24,420,149**	**38,913,968**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce and Corporate Business.
Date of paper:	July 2020
Subject:	Progress Report on the NMGH Management Agreement between Pennine Acute Hospitals NHS Trust and Manchester University NHS Foundation Trust, arrangements for a statutory acquisition of North Manchester General Hospital by MFT and plans for the redevelopment of the NMGH site.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against the Trust's Vision and Values and Key Strategic Aims:	Failure to deliver the Manchester Single Hospital Service Programme effectively will potentially present risks to the Trust priority – '*to deliver the merger of the two organisations with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.'*
Recommendations:	The Board of Directors is asked to: • Receive this report and note progress being made with the transaction process. • Support the strategic direction of the programme.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

1. Purpose

1.1. The purpose of this paper is to provide an update on the North Manchester General Hospital (NMGH) management agreement, the proposed acquisition of NMGH and the associated re-development of the site.

2. Background

2.1. NHS England / Improvement (NHS E/I) set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve Pennine Acute Hospitals NHS Trust (PAHT) and formally transfer the remaining hospital sites at Bury, Rochdale and Oldham to Salford Royal NHS Foundation Trust (SRFT). The intention for MFT to acquire NMGH is consistent with the Manchester Locality Plan.

2.2. NHS E/I also implemented changes to the management of PAHT that saw, from 1st April 2020, the re-introduction of a PAHT Board and the establishment of revised management agreements for PAHT services. This means that NMGH is now managed by MFT and the remaining PAHT sites by SRFT.

3. Management Agreement

3.1. On 1st April 2020, the management of NMGH transferred to MFT. Under the terms of the management agreement, it was decided that MFT would oversee delivery of the entire complement of services that previously fell within the 'North Manchester Care Organisation', as managed under the previous management agreement with SRFT. This arrangement accounts for the majority of clinical services delivered on the NMGH site but excludes a number of corporate services that, during this period of transition, continue to be managed by SRFT. A more comprehensive alignment of services with MFT will take place as part of the formal transaction (see section 4.2).

3.2. The new leadership team at NMGH, led by Dena Marshall (NMGH Chief Executive) is now fully established and has quickly become embedded on site. MFT has been able to support NMGH in a number of areas over the previous three months, particularly in relation to the response to the COVID-19 Pandemic.

3.3. A North Manchester Implementation Plan (NMIP) document was prepared to support delivery of the new management agreement. This document has recently been updated to review progress over the last three months and to provide assurance on the implementation of key activities. The NMIP was approved by the NMGH Scrutiny Committee on the 22nd June.

3.4. A formal quarterly review of the management contract between MFT and PAHT is planned for July 2020. This meeting will review performance over the first three months of the management agreement, identify and consider any emerging risks/concerns and ascertain whether any further oversight is required before the next quarterly review session. MFT will comply fully with the review process.

4. Transaction Process

4.1. MFT is working to achieve a formal acquisition of NMGH on 1st April 2021. A timeline to achieve this objective has been developed and a series of key milestones, that form the 'critical path' have been identified. MFT intends to develop a transaction business case and the first iteration of a 'Post Transaction Integration Plan' (PTIP) in the autumn on 2020 and is working with NHS E / I to identify the appropriate assurance mechanism for this work.

4.2. The transactions will require clear arrangements that outline the PAHT services, staff, equipment, contracts, etc. that will transfer to either MFT or SRFT. Many existing services within PAHT, especially those in corporate areas, are constructed on a Trust wide basis and so the process to identify which elements of service 'belong' to NMGH, or other PAHT hospital sites, is complex and multifaceted. This 'disaggregation' work is being led by the PAHT Executive Team and a robust governance structure has been established to oversee delivery.

4.3. A weekly 'PAHT Transaction and Disaggregation Committee', chaired by the PAHT Chief Executive is in place and this group oversees the work of eleven work stream areas. These include: Clinical Services, Corporate Services, Finance, Staff Transfer, IMT and Statutory Responsibilities. MFT is supporting the work undertaken across all areas of the disaggregation process and is working collaboratively with colleagues at both PAHT and SRFT to ensure that key objectives are met and milestones delivered.

4.4. MFT has also started to scope and plan the activities that will be required to integrate NMGH formally into the MFT Group at the point of acquisition. Activities critical for 'Day 1' (1st April 2021) are being identified and plans for their delivery established. The online project management WAVE tool, utilised effectively to manage merger-related integration activities within MFT, will be employed to ensure plans are progressing on track and that any risks/issues can be mitigated. A comprehensive description of the NMGH integration plans will be produced in the Post Transaction Implementation Plan which is due to be submitted to the MFT Board of Directors in the autumn of 2020.

4.5. To help maintain sound transaction business and governance there is a need to establish a Heads of Terms document in advance of the proposed transactions. This will be signed by all parties (NHS E/I, PAHT, MFT and SRFT) and will set out a shared view of how the transactions will be structured. The deadline for agreeing the Heads of Terms is end July 2020.

5. The North Manchester Proposition and the redevelopment of the NMGH site

5.1 The scope of the business case looks to deliver the aims set out in the North Manchester Proposition document which was developed and approved by MFT and partners in 2019. The vision is to work with, and empower, North Manchester's communities in order to level-up health outcomes, productivity and sustainability in the area. This will be done by using a healthcare-led investment programme on the North Manchester site, along with a new approach to public-service delivery and appropriate private-sector involvement, as an anchor and enabler for wider renewal. In this plan, much needed reinvestment to renew facilities for hospital and mental health services will act as a catalyst for the transformation of health and

care services in their broadest sense.

5.2 While the key messages of the Proposition remain unchanged, circumstances have changed since it was originally developed, not least because of the Covid-19 Pandemic and the associated socioeconomic changes. Further work is underway to refresh the Proposition messaging to ensure it remains relevant to the current situation, and can continue to support the development of plans for the redevelopment of the site.

5.3 North Manchester is now identified for significant capital investment through the Government's Health Infrastructure Plan (HIP) Programme. Initially part of the second tranche of investment, North Manchester is now recognised as a frontrunner in terms of the progress made by the MFT HIP Team as follows:

- Strategic Outline Case submitted on 31st January 2020
- Enabling Plan submitted 30th March 2020

The national Joint Investment Committee met on 30 April 2020 to consider the NMGH Strategic Outline Case and Enabling Plan. The Committee recommended that the Strategic Outline Case be endorsed with approval to proceed to Outline Business Case (OBC) stage**.**

5.4 Stage 1 design reports for the various elements (acute, wellbeing hub, education) have now been signed off through the relevant governance and the next steps are to agree a coherent Stage 2 Brief which responds to the Joint Investment Committee feedback. To maintain the OBC programme, this brief will need to be agreed in June to allow the design team to progress engagement and the iterative design and costing process required to complete the next stage.

5.5 HIP Seed Funding was secured for the delivery of the Strategic Outline Case (SOC) and the first stage of OBC. The second tranche of seed funding is now required for ongoing delivery of the OBC and we anticipated this to be confirmed in June. HIP seed funding will support a wide range of activity which delivers the OBC through the work streams.

5.6 The development of a Strategic Regeneration Framework is in progress, led by MFT in liaison with MCC. It is intended to achieve an endorsed Strategic Regeneration Framework this calendar year and this will fit in with the expected statutory planning submissions and considerations for both the HIP scheme and the Greater Manchester Mental Health NHS Foundation Trust (GMMH) new Park House project.

5.7 The following priority activities have been identified as next steps:

- Develop a Stage 2 design brief which responds to the SOC feedback.
- Liaison with Department of Health and Social Care (DHSC) and NHS E / I colleagues to agree OBC timescales and Enabling Plan support.
- Prepare a draft Strategic Regeneration Framework for consultation with internal stakeholders.

- Develop and deliver a comprehensive Communications and Engagement Strategy for the redevelopment programme.

6. Recommendations

6.1. The Board of Directors is asked to:

- Receive this report and note progress being made with the transaction process.
- Support the strategic direction of the overall Programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Mrs Sarah Corcoran, Director of Clinical Governance
Date of paper:	June 2020
Subject:	CQC Action Plan 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient safety and clinical quality
Recommendations:	The Board of Directors are asked to note progress.
Contact:	Name: Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Introduction

1.1. Following completion of the comprehensive inspection and submission of the trust action plan in 2018/19 the CQC continued with its programme of oversight of the Manchester University NHS FT. This oversight consisted of:

- Comprehensive inspection action plan oversight
- Routine Engagement Meetings
- Unannounced inspection programme
- Regular enquiries in respect of outlier reports and notifications to the CQC

1.2. This paper sets out progress and next steps which were approved at the Quality and Performance Scrutiny Committee on June 2nd, 2020.

2. Comprehensive Action Plan Progress

2.1. An action plan in response to the report was submitted on the 22nd April 2019 and was overseen by the time limited CQC Inspection Response Group (CIRG). This group was chaired by the Chief Nurse, reported to the Group Quality and Safety Committee remedial action being undertaken and provided assurance to the Quality and Performance Scrutiny Committee. This structure held Corporate Services/Hospitals/MCS to account on completion of actions which were risk assessed and prioritised accordingly.

2.2. In addition quarterly Performance Assurance Meetings were chaired by the Chief Nurse who will oversaw an in-depth review with Hospital / MCS / MLCO and Corporate Teams on progress against the plan and assurance evidence on outcomes. Reports were provided to the Quality and Safety Committee and any issues escalated if necessary. These took place in September and March and were the mechanism for sign off and closure of completed action.

2.3. The CQC Relationship Team were due to be in attendance at these meetings unfortunately, due to the pandemic response, the CQC were not able to attend the March meeting and alternative arrangements were made.

The arrangements made were that an updated action plan and supporting evidence was submitted from each of the hospitals, MCS and the M&TLCO. The trust submitted a narrative that described the progress of each of the hospitals, managed clinical services and community services and each of these went with a supporting presentation. A number of pdf narrative reports on the trust wide actions that have been overseen corporately and supporting evidence portfolio were also submitted. In most cases the portfolio comprised a list of evidence, rather than the evidence itself, to illustrate that the trust had it and where it could be found.

2.4. The trust submitted that all actions, except two, had now been completed. The two remaining actions are the establishment of the electronic patient record (EPR) and the paediatric anaesthetic dental waiting list. The CQC are aware of progress on the EPR and accepting of the timescales and that the paediatric dental list has made significant progress but that the demand issue is largely out with the trust control.

2.5. On April 9th 2020 the trust received a letter from the CQC that detailed that they had signed off the plan and noted that it was evident that a huge amount of work had gone into this from all staff at the trust to improve quality and safety for patients. They also noted that they had seen evidence of this when they visited the hospitals/MCS and that staff had told them about the improvements that they had made. They confirmed that from their perspective the action plan is now closed and that they will monitor the two outstanding actions as part of their routine engagement process.

3. Nightingale North West Hospital Registration

3.1. The decision was taken to place the Nightingale Hospital North West on standby from the end of June. The Hospital may need to be stood back up at a later date if a further surge requires it.

Advice was sought from the CQC on the arrangements for registration and it has been jointly decided that the Hospital will remain on the MFT Statement of Purpose and be registered as part of the organisation in the short term. This will negate the need to repeat the registration process if the Hospital is stood back up.

The situation will be reviewed on a month to month basis and de-registration undertaken when appropriate. When this occurs a revised Statement of Purpose will be submitted to the Board of Directors for approval.

4. Next Steps

4.1. The CQC have indicated that they will visit any of the trust sites in the near future if they are aware of any specific indicator of high risk that requires them to do so.

4.2. Discussions are now underway as to how the evidence submitted informs the ratings and how the trust can demonstrate improvement as appropriate without the process of onsite inspection. These discussions are being led by Professor Lenney.

4.3. The two remaining actions continue to be addressed and are now subsumed into business as usual.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Debbie Visun, Chief Operating Officer, CRN, Greater Manchester
Date of paper:	June 2020
Subject:	CRN Greater Manchester Annual Report 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Report demonstrates that CRN:GM's performance is in line with Trust's vision and key strategic aims regarding development of research portfolio and patient participation, and has been delivered with the behaviours required by the Trust values.
Recommendations:	Accept the annual report.
Contact:	Name: Sarah Fallon, Deputy Chief Operating Officer, CRN Greater Manchester Tel: 07557804526

CRN Greater Manchester
2019/20 Annual Report

A. Three highlights from 2019/20

CRN:GM Impact Report illustrates key highlights throughout the year and has been summarised across three areas:

1. *Delivery of Performance*: A key objective in 19/20 across GM was to improve HLO2b by a minimum of 5%. CRN:GM far exceeded this target, celebrating a 17% increase through embracing digital innovations. GM are proud to have maintained performance for HLO2a for the 5th consecutive year. Technology and process reviews also enabled CRN:GM to considerably improve the study support service compliance metrics. In addition, 18 significant "patients firsts" were recruited at GM sites, including 3 global, and 1 European, as well as improving performance in 14 specialty areas.

2. *Engagement and Events:* In 19/20 CRN:GM organised and contributed to a number of events, including strengthening the Northern offer, as a region for research delivery. A selection of events are detailed in the following links: International Clinical Trials Day 2019; IQVIA Northern Prime Site; Primary Care challenge; Primary Care Collaboration; Christie Oncology Outreach; Christmas event; Digital Her; International Women's Day 2020; 'Bite Sized' events; CRN:GM Research Awards It was a successful year of media coverage with 92 pieces on local and national TV, radio and press.

3. *Digital Transformation:* Web-based automation of the site identification and site intelligence services began in 19/20, using Google Script. The system is ready to launch and involves automatically sending feasibility to sites. To monitor the effectiveness, a Data Studio dashboard was created to track the number of feasibility responses. The new feasibility process allows sites and PI's to be identified, and automatically sends pre populated forms for them to review. CRN:GM anticipates this will provide a broader range of studies across GM, enabling an increase in the number of studies offered to under-served populations.

B. High Level Objectives (HLO) Performance

2019/20 CRN:GM Successes:

In 19/20 HLO1a and 1b targets were both met, thanks to the work of both CRN:GM and GM partner organisations. Respiratory, Surgery, and Reproductive Health and Childbirth were among the specialties surpassing their recruitment from 18/19. HL02a exceeded previous years performance at 87.9%, and remains the top performing region nationally. HL02b surpassed its target, and was a considerable improvement compared with last year's performance. This has been enhanced by GM's integrated study support service and sharing best practice across commercial and non-commercial studies. HLO6a and 6b were delivered through strategic working relationships between CRN:GM and local Partner Organisations, who share ambitions to continue building Industry relationships. CRN:GM produced a suite of marketing materials to support the PRES in HLO8 activity. Newsletters and social media channels carried regular messages and progress updates. GM Partner organisations were given PRES targets, and monthly feedback. This all supported GM's significant contribution to the national target and greatly surpassed 18/19's contribution. The CRN:GM regularly shares strategies between Trusts and Sponsors to streamline set-up processes and facilitate delivery of HLO9a and 9b. It is widely recognised across GM that the reduced study setup provides increased recruitment periods, which ultimately enhances participant access to research.

HLO	Goal	Actual	%	Pass
HLO 1A:	48,522	50,888	105%	Y
HLO 1B:	3,729	3,192	86%	Y
HLO 2A:	80%		88%	Y
HLO 2B:	80%		88%	Y
HLO 3A:	63	60	95%	Y
HLO 6A:	99%	14	100%	Y
HLO 6B:	70%	11	79%	Y
HLO 6C:	45%	119	25%	N
HLO 7:	2000	1421	71%	N
HLO 8:	650	2296	353%	Y
HLO 9A:	80	44		Y
HLO 9B:	60	41		Y

2019/20 CRN:GM Challenges:

The target for GP engagement was not met in 19/20, and whilst this remains a disappointment, a review of previous activities and cross-network collaboratives are already providing new approaches, which will deliver an improved performance in 20/21.

Unfortunately, GM did not meet the HLO7 target. This was an ongoing challenge due to significant paucity of local dementia specific PIs. However CRN:GM hosted an early career researcher training event, led by a National specialty lead to encourage new PIs.

Despite the challenges with HLO7, Join Dementia Research continues to successfully aid recruitment in GM, and volunteer sign-ups are increasing monthly via ERICA pilots and strategies occurring across the region.

C. Response to COVID-19

CRN:GM were the lead for the first activated urgent public health study ISARIC CCP-UK. Urgent Public Health Plans were activated simultaneously across the network to facilitate the re-opening of the study across the UK. This rapid set up delivered the first patient into the study within a number of weeks.

GM Study Support Service has reacted efficiently to COVID-19 providing a 7 day service, with the team covering the SPOC evenings, weekends and bank holidays to ensure expedited set up of urgent public health priority studies. An example of this being Gilead studies CPMS 45459/45460 which had costing templates validated within an hour. The RDMs established regular contact with the Partner Organisations, and the team have developed accessible infographics to support communication with all stakeholders, examples include UPH process and Covid-19 local workflow process**.**

The CRN:GM Core Delivery Team has been solely supporting Covid-19 studies since March 2020, and providing research leadership in the NHS Nightingale Hospital North West. The GM Research Nurse Manager blog described the experience and shared lessons learnt across the NIHR CRN.

The CRN:GM Comms team has taken to social media to both engage GPs in taking part in research, and to thank our patients for taking part in research studies. These videos have been viewed collectively, nearly 5000 times. A further video thanking local R&D teams, delivery staff and support services will be released to mark ICTD 2020.

D. Targeting Health Needs

CRN:GM successfully set aside 2% of the 19/20 budget to support key activities targeting health needs. This was a long term programme to embed and build better outcomes for our local communities. Cancer recruitment increased by over 1700 participants from 18/19, and progress was made with the Christie Oncology Outreach programme. In 19/20 there was an increase in overall number of recruits and number of research active Trusts, including primary care, for the cardiovascular specialty. Recruitment to heart failure studies was a focus and GM saw a 21% recruitment increase in this area. The harmonised objective for the specialty also exceeded its ambition of increasing the number of cardiothoracic surgeons (to 3) as PI's on studies (CPMS- 41872, 39765, 37464). From a respiratory perspective, the appointment of a new specialty lead has made a significant impact engaging well with investigators across GM, overall recruitment has increased with asthma showing a rise in recruitment to 267 participants from 89 participants in 18/19. Research for the Future, the consent for approach initiative in GM to facilitate recruitment research, has continued to grow over the last year. A report detailing how it has supported research in heart, kidney, respiratory and diabetes disorders can be found here.

CRN:GM provided leadership for the ENRICH project with the team establishing a collaborative 'ENRICH & Care Home Research Interest Group' which includes Academic and Clinical Leads. There has been an increased number of research ready care homes signed up to the ENRICH project, now at 81. Two of the GM care homes who previously participated in the Namaste study (36458) still utilise the intervention they used within this project to benefit their residents.

E. Partner Engagement

The CRN:GM scores for satisfaction in the Partnership Survey were significantly higher than the median across all LCRNs. There is evidence of a strong and effective Partnership Board in GM, which includes representation from Medical Directors and community representatives. This group, in collaboration with the Operational Management Group, provided a visible, effective and accessible leadership team. Together in 19-20, they agreed a new Domain approach, providing a new clinical structure for specialty management and leadership. Engagement continued to be important across the Partnership Group. During 19-20, CRN:GM held joint ventures with RDM/SL/WL&D and the clinical training Deanery teams for specialities such respiratory, ENT, surgery and Primary Care.

This generated engagement opportunities resulting in wider-workforce research delivery; an increase in trainee collaborative involvement; participation in Associate PI programme; and a GM-led portfolio respiratory study. CRN:GM appointed senior lecturers in both Dentistry and Social Care (SC) into CRN Champion roles. CRN:GMs Health Visitor Champions have formed a local collaborative of iHV members who range from those developing a research interest to those acting as PI or CI.

Future improvements include a focus on stronger partnerships with Primary Care, Mental Health and Community leaders in GM. Developments in these areas have already begun through the Primary Care challenge and the GM Social Care strategy.

F. Patient and Public Involvement and Engagement (PPIE)

Two GM Champions attended the national conference which involved sharing experiences, and ideas to shape strategies. Three GM Champions have spoken about their successes at the CRN induction day, and to date two have contributed to the GM Partnership Board meeting. Two champions workshops were held in GM designed to give updates on national strategies, and gather input from them to advise and inform our local activities. As part of our Primary Care strategy CRN:GM targeted Patient Participation Groups. GM Champions attended four meetings in GP's surgeries and two events with exhibition stands.

Throughout the year CRN:GM have provided opportunities for Champions to attend workshops and courses to improve their knowledge and abilities. Two Case studies were produced and featured on our website and newsletters. CRN:GM connected with two young people who will be working with the network in the future with our host Trust's Young Voices initiative. CRN:GM collaborated with Dementia Research Champion on PPIE initiatives including a Dementia week twitter campaign, writing an article for GMMH Dementia newsletter and co-producing workshops to discuss what information patients and carers need to know before taking part in research.

G. Social Care Pump Priming Pilot, including confirmation of any underspend

GM have undertaken considerable consideration to supporting research within social care, this has particularly gathered momentum in the latter half of 19/20. CRN:GM welcomed the opportunity to embrace key partners and stakeholders from non-traditional settings across social care, and recently gathered opinions from the Specialty group at CRN regional annual meeting. To provide crucial leadership CRN:GM appointed a Social Care Champion. CRN:GM have pledged to support a national project to create bitesize information to increase awareness amongst the social care community and share videos with social care colleagues, communication teams and NIHR channels. The Northern CRN Social Care leads successfully facilitated a Supranetwork meeting for Early Career Researchers in Social Care.

Summary

Greater Manchester CRN continues to look for every opportunity to provide new and innovative solutions to the health and social care of its local population. We are proud of our teamwork and engagement; 19/20 has been another great year. The team has continued to go above and beyond this year, with their inspirational ideas. The message though, is the same; the Greater Manchester Clinical Research Network is here first and foremost to serve the local population, support Partner Organisations, and enable access to research for all.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	June 2020
Subject:	Board Assurance Framework (June 2020)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to accept the latest BAF (June 2020) which is aligned to the MFT Strategic Aims and especially highlights the impact of the ongoing COVID-19 National Emergency.
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (June 2020)

1. Introduction

Performance against the Board Assurance Framework (BAF) is reviewed at every formal Board of Directors via the Intelligent Board metrics (Board Assurance Report). Significant risks to achieving the Trust's key strategic aims are reviewed and reported on at the Group Risk Oversight Committee (GROC) and across other corporate Executive committees, where necessary, dependent on the risk rating.

The Trust's Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The BAF is received and noted at least twice a year by the full Board of Directors. The updated BAF for June 2020 is attached (**APPENDIX A**) and has been updated to especially highlight the impact of the ongoing COVID-19 National Emergency.

2. MFT Strategic Aims (2020/21)

Key Risks associated with the following Strategic Aims will be regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee (as required):

- *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 achieve financial sustainability*
- *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.*

3. Recommendation

The Board of Directors is asked to accept the latest BAF (June 2020) which is aligned to the MFT Strategic Aims (2020/21) and which especially highlights the impact of the ongoing COVID-19 National Emergency.

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(June 2020)

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

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that MFT may not be able to access sufficient resources to address the finance, clinical, estates and IM&T issues identified at NMGH through the finance counterfactual and due diligence processes.

Enabling Strategy:

SINGLE HOSPITAL SERVICE

Group Executive Lead:

EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Negative and potentially destabilising impact on MFT.**
2. **Inability to deliver services at NMGH to the standard MFT would expect.**
3. **If funding is not secured other options would need to be considered by NHSI /E and Commissioners for delivering care at NMGH.**
4. **Existing difficulties with staff recruitment and retention compounding due to uncertainty about the transaction prompting further de-stabilisation of NMGH.**
5. **If service delivery at NMGH is compromised by uncertainty about the transaction, significant unplanned shifts in clinical activity might occur.**
6. **Support contingent on demonstrating multi-agency commitment and delivery of a wider set of objectives.**

Associated Committees:

MFT TRANSACTION MANAGEMENT BOARD

NMGH SCRUTINY COMMITTEE

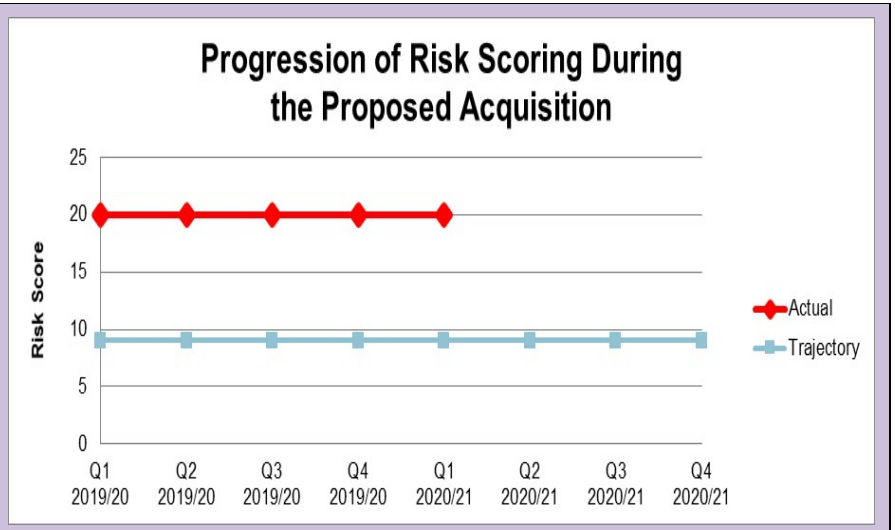
GROUP MANAGEMENT BOARD

GROUP BOARD OF DIRECTORS

Operational Lead:

DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required):



INHERENT RISK RATING Impact / Likelihood *"Without Controls"*	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 "With Controls"*	ACTIONS REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	TARGET RISK RATING Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	A.1 Strengthened transaction governance processes, with more effective leadership from NHS E/I and the re-established independent PAHT Board, and on-going senior level discussions at national and local level on access to financial support. A.2 Comprehensive Due Diligence work undertaken and aggregated through Exec-led Finance Star Chamber sessions. Financial requirements to address Due Diligence challenges communicated to NHS E/I. A.3 Establishment of an expanded and strengthened leadership team at NMGH to create stability, give staff confidence about the future, and to start developing appropriate control and influence. A.4 Negotiation and implementation of an appropriate Management Agreement to ensure a fair balance between the responsibilities transferring to MFT and the support being provided by other parties. A.5 Development of the North Manchester Implementation Plan (NMIP v1 and 2) to capture and communicate the Trust's planned approach to managing NMGH, including the role of the Managed Clinical Services, the Day One plans of Corporate teams, and the Partnership Working Arrangements with PAHT/SRFT. A.6 Development of the North Manchester Proposition, inclusion of NMGH in the national HIP2 programme for investment in health infrastructure, and submission of an appropriate Strategic Outline Case for the redevelopment of the NMGH site.	B.1 Discussions on financial support inconclusive to date. B.2 Heads of Terms for PAHT Transaction still in negotiation – essential to confirming the transaction arrangement. B.3 Uncertainty about timescales for other part of the transaction (ie Bury/Oldham/ Rochdale) B.4 Continued rapid progress of HIP2 capital planning work not guaranteed.	C.1 Due Diligence reports reviewed by Board Committees and signed off by Board. C.2 NMGH leadership team established. C.3 Independent PAHT Board re-established. C.3 North Manchester Implementation Plan approved by North Manchester Scrutiny Committee. C.4 NMGH SOC submitted, seed funding released, and MFT advised to continue (and accelerate) capital planning processes.	D.1 Challenges at NMGH remain (finances, performance, estate, informatics, etc) D.2 Complexity of operational and strategic agenda increased due to Covid-19. D.3 Uncertainty on timescale for Bury/Oldham/ Rochdale transaction.	20 (5x4)	E.1 Continue discussions with NHS E/I and local Commissioners about a financial plan to enable the safe transfer of NMGH to MFT. E.2 Complete negotiation of Heads of Terms to confirm the transaction arrangements. E.3 Manage Covid agenda for NMGH as part of MFT and GM Hospital Cell management arrangements. E.4 Develop NMGH Transaction Business Case to support Board decision-making. E.5 Develop NMGH Post Transaction Integration Plan (PTIP). E.6 Maintain rapid design development process for next phase of HIP Capital Programme work.	CEO, Chief Finance Officer, Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	F.1 Weekly meetings of PAHT-led Transaction and Disaggregation Committee with support from specialist external advisers. F.2 Heads of Terms in negotiation. F.3 Disaggregation processes progressing satisfactorily. F.4 Capital Planning activities all in place, targeting OBC submission in January 2021.	**9 (3x3)**

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

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that the acquisition of North Manchester General Hospital (NMGH) could have a negative impact on the rest of MFT's services.

Enabling Strategy:

SINGLE HOSPITAL SERVICE

Group Executive Lead:

EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Demands on senior leaders to deliver the transfer of NMGH to MFT could mean a reduced focus on MFT including integration benefit delivery.**

Associated Committee:

MFT TRANSACTION MANAGEMENT BOARD

NORTH MANCHESTER SCRUTINY COMMITTEE

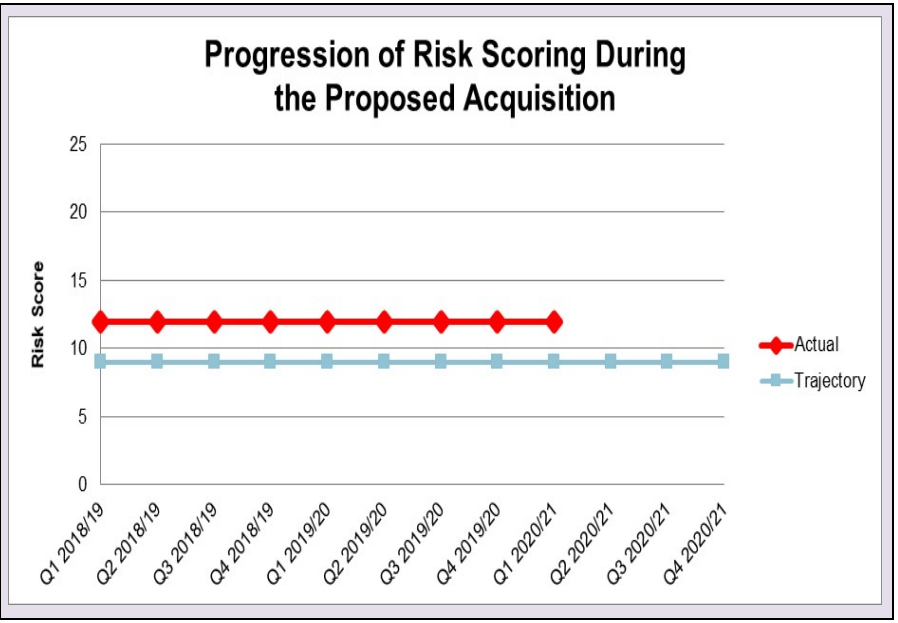
GROUP MANAGEMENT BOARD

GROUP BOARD OF DIRECTORS

Operational Lead

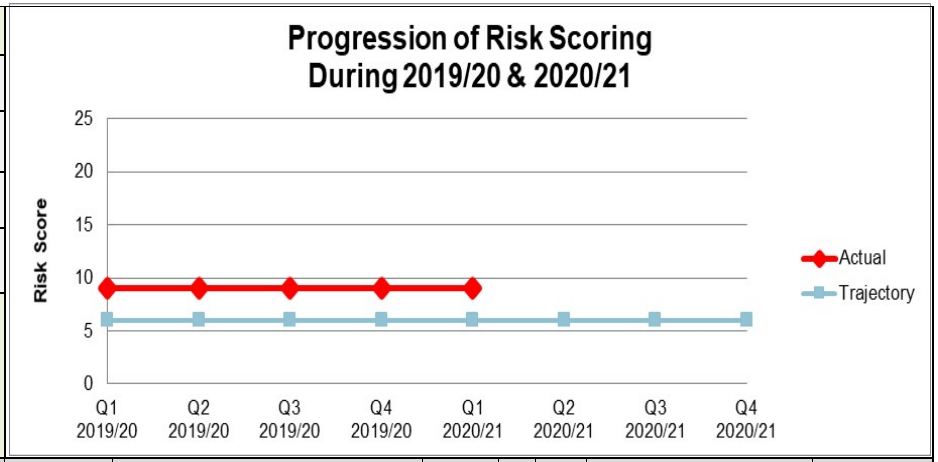
DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required)



INHERENT RISK RATING Impact / Likelihood *"Without Controls"*	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 "With Controls"*	ACTIONS REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	TARGET RISK RATING Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Project funding secured through the Greater Manchester Transformation Fund (GMTF) to minimise demand on existing MFT resources during management agreement/transaction. A.2 Experienced team appointed to SHS PMO function to manage the transaction and provide targeted support to core MFT teams. A.3 Establishment of an expanded and strengthened leadership team at NMGH, (with additional senior capacity for Covid agenda) to reduce the input required from Group Executive and Corporate Directors. A.4 Clearly defined clinical and corporate disaggregation processes being implemented to enable senior MFT staff to understand the services being acquired. A.5 PAHT "BAU" Group established (building on previous Pennine Transaction Operational Group) to ensure MFT is aware of current and forthcoming operational changes in PAHT. A.8 NMGH Programme Board brings together oversight of the Transaction and the HIP capital development programme.	B.1 Complexity of disaggregation process will require detailed input from some Corporate Directors.	C.1 GM Transformation Funding in place to enable the infrastructure required to deliver the transaction. C.2 Revised NMGH Leadership Team in place to provide a focus for decision-making in respect of NMGH C.3. MFT internal governance arrangements working effectively including the sustained input of the SHS Team to support core leadership teams. C.4 North Manchester Implementation Plan approved by North Manchester Scrutiny Committee.	D.1 Heads of Terms document needs to be negotiated and agreed to confirm the transaction arrangement and timescales.	**12 (4x3)**	E.1 Work of the NMGH Programme Board to continue alongside focussed discussion at EDT. E.2 Maintain input of SHS programme team to support Corporate Directors. E.3 Utilise Corporate Integration Steering Group to support Corporate Teams in planning for integration of NMGH services.	Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	F.1 Corporate Services Integration Group established and functioning effectively..	**9 (3x3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes
PRINCIPAL RISK (What is the cause of the risk?): If the Quality and Safety Strategy is not delivered then harm may occur to patients	Enabling Strategy: **QUALITY AND SAFETY STRATEGY** Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Increase in serious harm to patients** 2. **Poor safety culture (including leadership) undermines Trust performance** 3. **Failure to eradicate 'Never Events'** 4. **Reputational damage because of safety concerns** 5. **Poor staff experience** 6. **Regulatory consequence**	Associated Committee: **QUALITY AND SAFETY COMMITTEE** Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE** Material Additional Supporting Commentary (as required): The patient safety commentary detailed here covers all aspects of patient safety including but not limited to, clinical outcomes, infection control, clinical incidents (including never events), mortality review and harm free care.



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Freedom to Speak Up (F2SU) programme and personnel A.2 Quality and Safety Strategy and related policies A.3 Trust Governance structure – including Quality and Performance Scrutiny Committee, Infection Control Committee and other specialist groups A.4 AOF monitoring A.5 Patient Safety Training Programme – e.g. Infection Control, Human Factors and clinical mandatory training A.6 Root Cause Analysis (RCA) Training Programme A.7 Trust alert circulation process A.8 Trust incident investigation process – to include focussed investigations such as IPC and Falls A9 Trust Recovery Plan – Quality and Safety Work Stream	B.1 Policy controls weak B.2 F2SU not fully embedded B.3 Governance structure still in development B.4 PST Training not mandatory for all staff B.5 No capacity to deliver this to all staff B5 Restrictions on face to face training B.6 No current evaluation of impact of PST or RCA training B.7 General Patient Safety training not included in mandatory training packages – including induction B.8 Lack of links with University and Training Schools on PST B.9 Lack of patient involvement in investigation and feedback to staff B.10 Mechanistic circulation and response to alerts without follow up and audit programme B.11 Lack of Trust wide visible Patient Safety Champions B.12 Patient safety commitment not fully embedded into recruitment practice B. 13 Variation in compliance with clinical policies and guidelines	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information) C.2 Trust clinical and internal audit systems C.3 Staff survey C.4 Regulatory inspection processes C.5 Internal quality assurance processes (Internal Audit, Ward accreditation, Quality Review) C.6 AOF and leading and lagging patient safety metrics reporting – including harm free care, infection control and never events now agreed	D.1 Incident reporting system may not capture all harm – can be a cumbersome process D.1 Incident reporting for less serious incidents decreased during pandemic period D.2 Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels D.3 Staff survey does not adequately capture full understanding of patient safety culture D.6 Patient safety metrics not yet fully reported on D.5 Actions following harm not always evaluated or reviewed D.6 Lack of full understanding of finance and performance cost of harm in relation to claims, lost bed days etc	**9 (3x3)**	A.8 Implement and embed the National Patient Safety Incident Response Framework (PSIRF) A.2 Align the Quality and Safety Recovery work stream fully with the Quality and Safety Strategy B.6 Define processes for on-going evaluation of safety culture C.5 Develop patient information leaflet on 'When things go wrong' B.4 Review all training post COVID-19 to ensure social distancing measures met D.4 Develop an in-house Patient Safety Champion qualification – PST / RCA + Patient Safety Project D.5 Implement revised process following 'Never Event' to include a panel review similar to the Emergency Bleep Meeting concept – consider NED lead for this process D.3 Undertake Trust wide patient safety training needs analysis D.3 Develop Human Factors faculty B.7 Build the requirements of a patient safety training needs analysis into the mandatory training framework B.13 Include statement on commitment to patient safety in all Trust contracts D.2 Develop post-investigation feedback questionnaire for staff and patients D.4 Set 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 B.3 Define CSG/CAC/CGC and relationship with Recovery Plan in standardisation of clinical practice	Medical Director's / Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business	June 2021 – revised completion date updated following launch of PSIRF	Quality and Performance Scrutiny Committee	1. Patient Safety/Clinical Governance Team now strengthened with additional posts recruited to – one of these posts to have an early focus on NMGH arrangements 2. Development workshops completed with GMB on NHS Patient Safety Strategy and safety culture now completed 3. MFT Quality & Safety Strategy has now been reviewed to ensure it is fully aligned with new National Patient Safety Strategy 4. Plan in place to revise investigation procedures 5. Identification of Trust Patient Safety Specialist as per National Guidance (Associate Director of Clinical Governance) 6. Inclusion of patient safety in mandatory training under discussion as part of the mandatory training review 7. Circulated the new National Patient Safety Strategy and aligned with MFT Q&S Strategy 8. Commenced the development of the Group Quality and Safety Recovery Plan 9. Clear information now available on legal costs (clinical negligence claims)	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients.

(Revised risk previous component of MFT/003111)

Enabling Strategy:
INFECTION PREVENTION AND CONTROL STRATEGY

Group Executive Lead:
GROUP CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Increase in serious harm to patients**
2. **Increase in nosocomial infections**
3. **Increase in staff outbreaks**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee:
INFECTION CONTROL COMMITTEE

Operational Lead:
ASSISTANT CHIEF NURSE IPC/TV
CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL

Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	1. Widespread implementation of PHE Personal Protective Equipment (PPE) guidance in all areas of the organisation including both Aerosol Generating Procedures (AGP) and non AGP procedures 2. Communication with procurement/materials management 3. Implementation of type 1 and type 2 face masks for staff, patients and visitors to the organisation as per recent PHE guidance 4. Provision of PPE education to senior members of staff to support local implementation of PPE policy 5. Working with Employee Health & Wellbeing and Equality and Diversity to ensure staff who have risk assessments and alternate provision to PPE as required 6. Test and trace implemented nationally 7. All non-elective patients are screened upon admission 8. Preadmission screening implemented for elective admissions 9. Screening protocols for patients discharged or transferred to another health care or residential setting in place 10. Notification of any hospital outbreaks to NHSE 11. Staff outbreak informed by the test and trace national policy 12. Good infection prevention and control education and practice throughout the Group 13. Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place 14. Escalation plans in place as per trust gold command and GM Gold command 15. Communication: 16. -Guidance cascaded through Strategic Oversight group 17. -Daily communications email sent to all staff 18. -IPC Team daily visit to clinical areas 19. -Attendance in wards/departments 20. -Weekend IPC team provision 21. -IPC team have developed reference posters for staff 22. -Guidance on staff intranet 23. Oversight: 24. Response to COVID outbreak managed by Exec leads for EPPR and DIPC through Strategic Gold Command and escalated through this route to the Board of Directors, sub board committees including: 25. Risk oversight committee 26. Quality & Performance Scrutiny Committee 27. Group Infection Control Committee 28. COVID-19 Expert Group established - Microbiology and Virology support in place 29. Programme of training for redeployed staff including use of PPE, maintaining a safe environment 30. Bespoke training programme for Clinical leaders to become PPE expert trainers 31. Increase to staffing levels and re-deployment programme 32. Use of HPV/UVC in addition to PHE guidance 33. Estates and Facilities /PFI partners and IPC Team meeting to review cleaning frequencies in line with updated guidance 34. Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative	1. Some potential issues with availability 2. Potential issues with compliance 3. Potential issues with compliance 4. Potential for screening not to pick up COVID-19 5. Potential for nosocomial infection 6. Potential for screening not to pick up Covid-19 7. Potential for nosocomial infection 8. Consistency in knowledge and practice 9. Potential non-compliance 10. In times of pressure not all staff may be able to access training 11. In times of high demand staff may not be available 34-40 Potential for non-compliance 12. Patients may be asymptomatic 13. Potential non-compliance	- Monthly audits of hand hygiene compliance - Increase of audits on increased activity areas - Mandatory ANTT assessments annually - Audit of screening protocol - Record of staff concerns raised - Incident reporting system - Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC		20 (4X5)	1. Departments reviewing ability to reintroduce services to patients in non-urgent capacity 2. Development of a document for workforce safety is in draft, the document will focus upon the 'Four pillars of working safely' 3. Development of surveillance tool to highlight hotspot areas incorporating NHS guidance on probable/definite hospital acquisition 4. Further audit tools to be developed to encompass COVID-19 guidance	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	Covid 19 Outbreak policy written, now requires ratification Developed guidance around the use of alternate PPE as required Introduction of masks and face coverings week commencing 15th June 2020. Sitrep reporting for nosocomial outbreaks in place Hospitals zoning green, yellow and blue areas and are currently presenting plans of flow throughout the patient journey. Staff Testing Policy ratified Areas such as ICU, radiology and other areas which have a transient patient population have identified flow throughout the departments to ensure risk level to patient minimized. Audit tool developed so individual wards and departments can audit compliance to the guidance. Piloting tool week commencing 29th June 2020 Cleaning audits developed Hand hygiene audits in place	**6 (3X2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes - CONTINUED								
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**EXISTING CONTROLS** *"What controls/systems are currently in place to mitigate the risk?"*		**Current Risk Rating Impact / Likelihood** *"With Controls"*	**ACTION(S) REQUIRED** *"Additional actions required to bridge gaps in Controls & Assurance"*	**RESPONSIBILITY**	**COMPLETION TIMESCALE**	**MONITORING COMMITTEE**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	1. Enhanced cleaning specifications in place for clinical and non-clinical areas 2. Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken 3. Specific antimicrobial policies related to COVID-19 available on the Trust's Microguide platform. 4. Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) 5. Monthly antimicrobial stewardship (AMS) audits on all ward areas 6. Microbiology support available 24 hours a day. 7. Antimicrobial prescribing advice available from pharmacy 24 hours a day 8. IPC ICU ward rounds 9. Increased AMS support to COVID-19 cohort areas 10. Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing. 11. Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas 12. Dedicated entrances for blue/yellow/green patients where possible 13. Signage on entrances 14. Screens in place at reception areas 15. Dedicated website for all COVID-19 related information 16. Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical face mask when moving around the hospital 17. Trust has Policy in place for wearing of face masks in all areas 18. For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible. 19. Covid and non-Covid clinical areas defined across the Trust. All Non- elective admissions tested and elective admissions as per guidance 20. Patients who develop symptoms are tested again and the trust has PHE guidance in place on the testing of patients at 5-7 days and every 7 days thereafter. 21. Trust has an internal test and trace policy 22. Outbreak policy in line with NHSE guidance 23. Outbreaks contained and reported to NHSE/I 24. Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced 25. Patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	26. Patients are cohorted according to clinical presentation 27. Outbreak policy implemented 28. OPD services are using technology to undertake consultations where possible 29. Signage on entrances advising pathway for symptomatic patients. 30. Message on MFT phone services 31. Trust policy on managing patients who present with symptoms in place 32. Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS 33. PPE Supply: 34. Re-use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment 35. Standard Operating Procedures developed for decontamination of visors 36. Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline 37. Hygiene Programme of review of air flow and ventilation undertaken throughout the pandemic 38. All clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance 39. Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing 40. Staff on COVID-19 areas wearing scrubs laundered through hospital laundry 41. Temporary staff changing facilities identified on COVID-19 wards 42. Staff advised on how to decontaminate uniforms in accordance with NHSE guidance	20 (4X5)	(see above)	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	(see above)	**6 (3X2)**

2	**Strategic Aim:** **To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?):
Under achievement of national constitutional standards for urgent and elective care, including cancer and diagnostics, due to long standing issues of:

1. demand pressures, capacity, workforce and estate constraints, and
2. exacerbated by the Covid19 pandemic.

This risk replaces previous individual risks related to national standards including: 001493, 001701, 001707, 001708

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Increase risk of serious harm to patients
2. Poor patient experience
3. Reputational damage to Trust
4. Low system confidence – increased scrutiny from regulators

Enabling Strategy:
QUALITY & SAFETY STRATEGY
TRANSFORMING CARE FOR THE FUTURE STRATEGY

Group Executive Lead:
GROUP CHIEF OPERATING OFFICER

Associated Committee:
QUALITY & SAFETY COMMITTEE
PERFORMANCE AND QUALITY SCRUTINY COMMITTEE
GROUP RISK MANAGEMENT COMMITTEE
Board of Directors

Operational Lead:
HOSPITAL / MCS CHIEF EXECUTIVES

Standard	Performance		
	Mar	April	May
A&E 4 hour	79.91%	90.18%	93.4%
RTT	74.4%	67.17%	59.3%
52 weeks	44	369	1042
Waiting list	98,732	98,785	102,318
Diagnostics	6.79%	46.96%	64.9%
Cancer 2ww	93.2% (Q4)	83.2%	Not available
Cancer 31 Days	92.5% (Q4)	91.3%	Not available
Cancer 62 Days	72.9% (Q4)	64.7%	Not available

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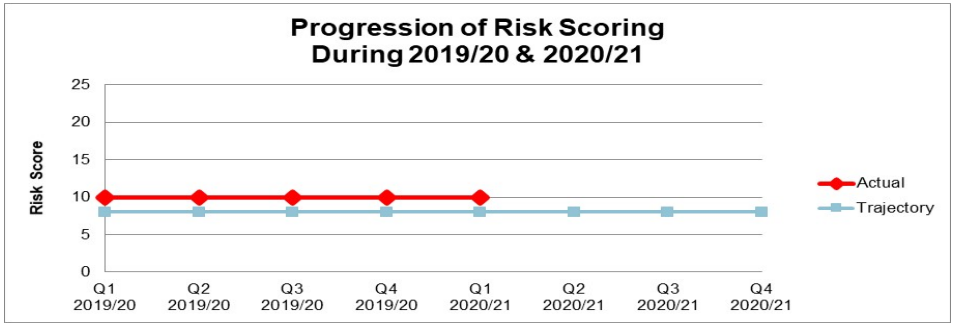
20 (5x4)	1.1 MFT Accountability Oversight Framework 1.2 MFT Board and Committee performance reporting in place 1.3 MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.4 MFT Covid19 governance framework and structure 1.5 MFT Recovery programme and underpinning workstreams, a number of which are focused on national constitutional standards. The programme reports into the MFT Covid19 governance structures. 1.6 GM Covid19 governance structures to support system working and mutual aid, MFT feeds into the wider GM structure. 1.7 MFT Patient Access and Policy 1.8 Audits are routinely undertaken, by internal and external audit, around the national constitutional standards to provide assurance of performance reporting to the Board of Directors. 1.9 GM Governance Framework to oversee the response to the Covid 19 incident, providing a system wide view and facilitating mutual aid across providers, including the use of the independent sector. MFT links into the daily GM gold conference calls, with MFT representatives on the In Hospital and Community Cells. The command and control structure will be in place until year end to mitigate the impact of further Covid19 waves, and to coordinate system recovery planning.	2.1 Capacity shortfalls requiring reliance on private sector. 2.2 Surge of demand to pre-Covid levels. 2.3 Primary care demand management. 2.4 Standardisation of Pathways and processes across MFT and the Greater Manchester System to support equitable patient access. 2.5 Workforce availability to deliver activity levels: sickness Covid19, shielding, usual sickness levels and vacancies.	3.1 Reporting to the Executive Board and Committees. 3.2 Monthly AOF Group Executive oversight of Hospitals. 3.3 MFT Covid19 Recovery Programme 3.4 Minutes and papers relating to the MFT Covid19 Governance Structure. 3.5 Minutes and papers relating to Trust Committees where national performance standards are discussed. 3.6 Hospital Activity, capacity and annual plans. 3.7 Internal/external audits of data quality. 3.8 Annual Review and NHSI sign off Trust Access Policy.	None	20 (5x4)	Key actions are outlined in the Risk Report to the Group Risk Committee. Overarching MFT recovery programme in response to the Covid19 pandemic, incorporating 16 workstreams, of which the outpatient, elective, urgent care and cancer workstreams align to national constitutional standards. GM Hospital Cell / GM Gold is overseeing system recovery planning and capacity, facilitating standardisation and implementation of best practice, equity of access for patients, and facilitating the use of independent sector capacity. Outpatient workstream focus: waiting list clinical triage, implementation virtual consultations, prioritisation capacity, demand management protocols, establish advice and guidance Elective workstream focus: clinical review of the elective waiting list, theatre capacity, pre-assessment pathways, workforce implications, use of the Independent Sector, confirm the critical care de-escalation plan, financial implications Cancer Workstream focus: Endoscopy capacity, implementation of rapid diagnostic centres, implementation of best practice pathways, continued roll out of the Living With and Beyond Cancer programme and the Cancer Excellence Programme both of which were in place prior to covid, linking in with GM Cancer and GM Surgical Cancer Hub. Diagnostics: is incorporated within a number of recovery workstreams, in order to understand the wider implications a weekly task and finish group is in place. In addition, the Trust is linking in to GM structures for Diagnostics. Workforce is a key element to all recovery workstreams, with HR representatives on these groups to ensure the workforce implications are considered and addressed.	Julia Bridgewater	Ongoing throughout 2020/21	Quality and Performance Scrutiny	Progress against the workstreams is being reported into the Strategic Covid Group, and to the Board of Directors. The performance position against national standards is reported via the Board Assurance report to the Board of Directors.	**12 (3x4)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm	Enabling Strategy: **QUALITY & SAFETY STRATEGY**
	Group Executive Lead: **CHIEF NURSE**
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Adults and children at risk of abuse or neglect may come to harm** **2. Failure to comply with statutory and regulatory safeguarding standards**	Associated Committee: **SAFEGUARDING COMMITTEE** Operational Lead: **DEPUTY CHIEF NURSE /ASSISTANT CHIEF NURSE (SAFEGUARDING)** Material Additional Supporting Commentary (as required):



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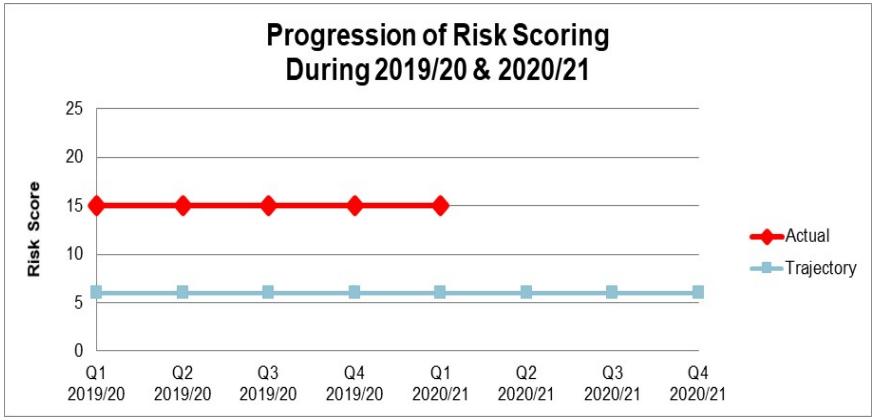
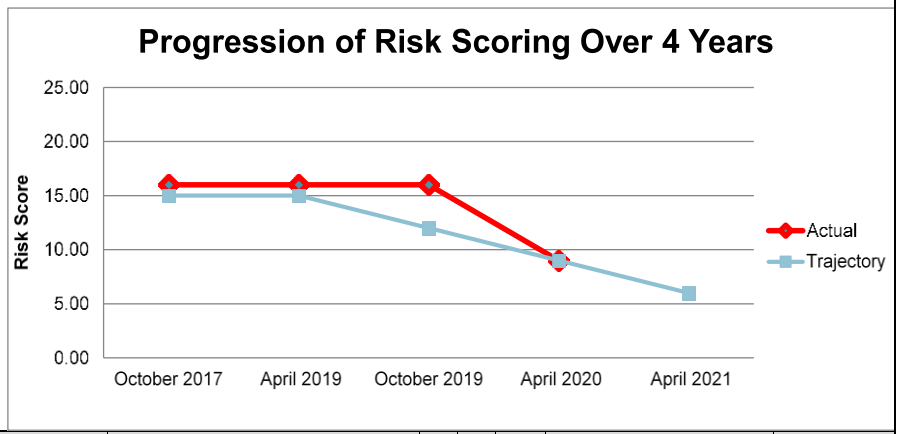
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/ LCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at all levels of the safeguarding Partnership Arrangements to support statutory duty to cooperate. A7. Safeguarding adults and children's training programme in place as per Intercollegiate guidance underpinned by learning from SCRs/SARs/ DHRs. A8. Safeguarding Supervision process in place. A9. Learning Disability flag to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend. A11. Child Protection Information Sharing System (CP-IS) in place in all relevant areas except SMH maternity services. A12 AOF monitoring (MLCO)	B1. Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) are of inconsistent quality B2. DoLS applications are often not authorised by Local Authority due to lack of capacity B3. Level 3 Safeguarding training compliance is below the required threshold of 90% B4. The Trust is not yet compliant with the changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult safeguarding training B5. LD Specialist Nurse Capacity is very limited B6. LD and/or Autism Strategy not finalised	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/LCO annual Safeguarding Work Programme, monitored by Safeguarding Team. C3. Annual Hospital/MCS/ LCO safeguarding assurance processes, observed by NED, to assess compliance with CQC and statutory requirements. C4. Completion of SCR actions - reported to the Safeguarding Committee. C5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. C6.Submission of safeguarding adults Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data C10. Annual safeguarding audit programme C11. Safeguarding supervision data	D1. Prevent training compliance below threshold	**10 (5x2)**	B1. Deliver MCA and DoLS training to relevant staff through Level 3 Adult Safeguarding Training B1. Audit the quality of MCA assessments and DoLS applications B2. Submit DoLS applications in accordance with statutory requirements B3. Deliver targeted safeguarding training to meet Intercollegiate requirements B4. Hospitals/MCS/LCO to deliver agreed trajectories B5. Develop Business Case to increase capacity to meet patient needs B6. Finalise and launch a System-wide LD and/or autism Strategy B6. Deliver the Trust's LD work plan D1. Target Prevent training to non-complaint areas D2. Work with the Local Authority to agree a process for invitations to strategy meetings	Assistant Chief Nurse (Safeguarding)	March 2020	Safeguarding Committee	A11. Work is underway to implement the Child Protection Information Sharing System (CP-IS) within SMH maternity services with full implementation expected by the end of Q2 2020/21 CPIS now implemented in Children's Community Services in Manchester B1. Increased provision of DoLS training ongoing. B1. DoLS audits undertaken in 2019 and actions delivered to improve quality and compliance with DoLS criteria. MCA/DoLS re-audit completed in Q4 and will be presented at the Group Safeguarding Committee in August 2020. B2. The number of DoLS applications across MFT continues to be high with 1838 applications being made in 2019/2020. There continues to be low levels of assessments/authorisation by the LA with only 4% being assessed in 2019/2020. B3. Competencies matched to roles in accordance with revised Intercollegiate Guidance and staff groups prioritised to receive training in year 1, 2 and 3. Improvement plans developed by Directors of Nursing to improve compliance. Overall raining compliance at 31st May was 88.2%, which is slightly below Trust target of 90% but exceeds the CQC target of 85% and shows improvement across all training levels. B3. On-going online programme of safeguarding training has continued to be delivered during the Covid-19 response. Work commenced to review delivery options through Mandatory Training Scrutiny Committee. Work on safeguarding level 3 training continued during pause of the committee for COVID-19 response. There has been significant improvement in training compliance at all levels with level 1 and 2 adults and children's training exceeding 85%, level 3 children's training at 76.03% and level 3 adult (year 1 cohort) at 71.73%. See B4 for recent changes to the training delivery model. B4. Increased level 3 adult safeguarding training capacity established but face to face training currently paused to prevent Covid transmission. An online Level 3 training package which includes a work book to demonstrate learning has been developed and has evaluated very well. B5. Case to expand LD Specialist Nurse capacity agreed and recruitment process initiated. B6 LCO Chief Nurse is now leading the MFT LD Steering Group. Director of Adult Social Services (DASS) is now the Executive lead for the system-wide LD Strategy with the LCO Chief Operating Officer as the operational lead and the Assistant DASS is the Programme Director with PMO support. A refreshed Programme accountability group is being designed, which includes system leadership including MHCC, MFT, Primary Care, GMMH and MLCO. B6. The revised LD governance structure that was presented to Safeguarding Committee in April 2019 is now in place. B6. Self-assessment against NHS I learning disability improvement standards for NHS trusts refreshed and LD work programme updated. Regular updates provided to Safeguarding Committee. D1. As of 1 June 2020, MFT were at 93.2% compliant for basic level and 84.1% compliant for higher level Prevent training against a target of 85% for both levels. This is a significant improvement from the same period last year. D2. Work with the Local Authority to agree a process for invitations to strategy meetings is now complete.	**8 (4x2)**

2	**Strategic Aim:** To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): **If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public**	Enabling Strategy: **QUALITY & SAFETY STRATEGY** **ESTATES STRATEGY**
	Group Executive Lead: **CHIEF OPERATING OFFICER**
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Inability to use public, staff or clinical areas as intended, leading to inability to provide treatment as planned** **2. Potential impact for harm to staff, patient of public**	Associated Committee: **CEO FORUM**
	Operational Lead: **GROUP DIRECTOR OF ESTATES AND FACILITIES**
	Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure is maintained to the required level A.4 Internal & external reviews of systems and processes to highlight gaps and required actions	B.1 Not all maintenance regimes have been adhered B.2 Not all infrastructure schematics accurately represent the 'as built' estate B.3 Given above points redundancy systems may not operate as planned B.5 Some controls are reactionary, based on minimising impact should an issue occur	C.1 Ongoing certification (internal or external as required) of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects. C.2 Schematics are being updated on a periodic basis to reflect the as built environment	D.1 Survey and remedial works take a significant period to complete & until complete full assurance cannot be gained. D.2 Some schematics remain outdated in the review period and the update process will take several years to complete D.3 The new CAFM system will need to run for 12 months to give full assurance as some tasks are yearly D.4 The external audits highlighted areas of further work which is being carried out but full assurance cannot be gained until works are complete	15 (3x5)	D.1 Complete surveys and agree programme of remedial works by site and infrastructure system D.2 Infrastructure schematics updated in line with the survey and remedial work	Chief Operating Officer	Assurance task complete Remedial actions will run for a prolonged period (circa 24 months)	CEO Forum	Survey and remediation work ongoing Schematics being updated on an as needed basis Fire compliance risk now being shared at a Hospital level Significant progress on Fire Compartmentation remediation during May & June 2020 whilst areas of the Main Hospital Building on ORC were empty due to Covid	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): Inability to access the patient health record at the point of care, or poorly maintained health records may cause patient harm and poor patient experience.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF FINANCE OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Increase in serious harm to patients** 2. **Poor patient experience** 3. **Poor safety culture (including leadership) undermines Trust performance** 4. **Reputational damage because of safety concerns** 5. **Lower staff morale** 6. **Regulatory and Information Governance consequences** 7. **Financial penalty and damage**	Associated Committee: **GROUP INFORMATION GOVERNANCE BOARD** Operational Lead: **GROUP CHIEF INFORMATICS OFFICER** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	A.1 Oxford Road Campus (ORC): Best Practice Standards for Records Management in place & achievement of the standard monitored through a suite of KPIs which improve availability at point of need. A.2 Improve visibility of electronically captured patient information by providing access through one system. A.3 Creation of Case Notes reduced to 5 areas and the PAS district number has replaced the manually allocated case note number for ORC, to become the unique identifier in the system. A.4 Clinic preparation for ORC has moved to ORC Health Records Hub 3rd Floor RMCH. A.5 New sets of case notes now labelled with barcodes to facilitate tracking. A.6 Obstetric notes will be retained in the Health Records Hub (3rd Floor RMCH) from Sep 2018. A.7 Commencement of Terminal Digit Filing within the Gorton Library. A.8 Performance Indicators now being presented to the Group Information Governance Board.	B.1 Best practice Records Management standards are not followed. B.2 Full KPI suite not yet embedded into operational practice. B.3 Full EPR not in place. B.4 Movement of case-notes between clinical services, where the case-note is already in support at one clinical setting.	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information). C.2 Internal quality assurance processes (Health Records KPI suite). C.3 Gorton Library has maintained a consistent pulling rate of 95% for case-notes tracked to Gorton.	D.1 Accurate tracking of the location of the case note, particularly once delivered to Hospitals.	16 (4x4)	B.1 Best Practice Standards for Records Management implemented through Health Records Improvement Programme. Best Practice Standards for Records Management implemented through Health Records Improvement Programme . D.1 To support the Hospitals in ensuring that case note is in the appropriate location to support patient care. B.3 Tactical EPR Roadmap identified to support journey to full EPR implementation. D.1 It has been established that the notes now missing are already out supporting Clinical care so need to address how to improve the movement of notes in clinical settings.	Director of Digital Delivery	April 2021	Group Informatics Strategy Board (Performance Metrics are reported to Group Information Governance Board)	• Significant progress made on a range of Actions completed 2018/19. • Continued tactical development of EPR in place to for 2018 -2020 and procurement and full implementation of new EPR solution. • Ongoing implementation of best practice standards for records management implemented through Health Records Improvement Programme. Further Business Case approved to facilitate the turning of the whole library to Terminal Digit Filing. • Patient Records campaign on what is a patient record and promoting the use of the electronic systems has concluded. • Deployment of scanners to improve tracking of case notes completed. • Concluded review of the impact to patient experience when the case note is missing and evidence of harm. • Patient Records Group Terms of Reference approved and level of attendees under review. • Gorton's pulling rate for case-notes has been assured at 95% and managed service requests are cleared. • Informatics are supporting MRI's current transformation project in raising awareness with administration staff of their role within case-note flow. • Paper to be drafted for GIGB, GISB and Hospital Boards to migrate the ownership and control to the individual hospitals to manage	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?):
If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised

Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

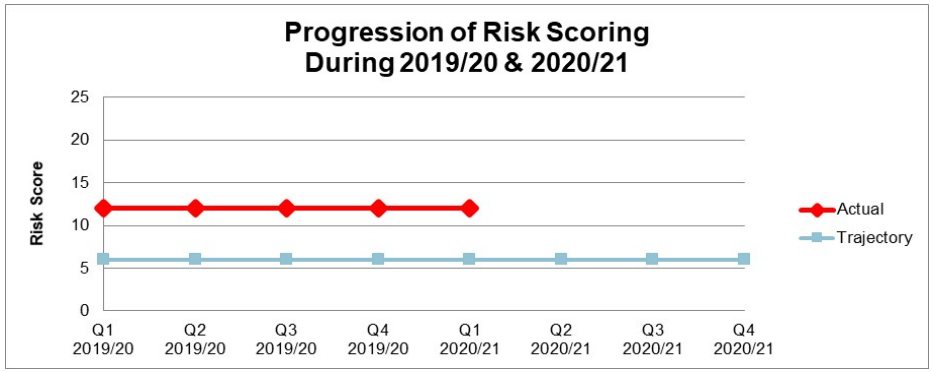
Group Executive Lead:
CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):
1. **Compromised patient care**
2. **Adverse patient experience**
3. **Increased complaints**
4. **Failure to comply with NHSI regulatory standards**
5. **Inability to recruit well trained nursing and midwifery staff further compounding the staffing issue**
6. **Inability to offer a quality training experience to students**

Associated Committee:
NMAHP PROFESSIONAL BOARD
HR SCRUTINY COMMITTEE

Operational Lead:
ASSISTANT CHIEF NURSE (WORKFORCE)

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A1. Reports on controls to- NMAHP Professional Board, Clinical Risk Management Committee and HR Scrutiny Committee, Board of Directors and Group Management Board A2. Domestic and International recruitment campaigns A3. Hospital/MCS workforce dashboards A4.Hospital/MCS Nursing and Midwifery retention strategies A5. e roster KPIs and dashboard A6. Daily safe staffing huddles and staff deployment based on acuity and dependency A7. Temporary staffing reporting processes aligned with finance and workforce planning data A8. Triangulation of workforce establishment data with clinical quality metrics A9. Developing and embedding new roles within the Nursing workforce. A10. Establishments reviews undertaken utilising SNCT A11. Trust have joined NHSI Retention programme - Corporate retention work schemes A12. Covid 19 workforce recovery programme	B1 Embedding use of E roster and safe care in real time within all clinical areas. B2 National shortage of nurses for the pipeline with no increase in trainees graduating until 2021 B3 Uncertainty due to the impact of CV19 on graduate workforce supply in 20/21 B4 Uncertainty due to the Impact of CV19 on international recruitment pipeline in 20/21	C1. Programme of domestic and international recruitment events C2. NHSI safe staffing report C3. Reduced turnover and improved retention rate C4 E Rostering C5. Programme of work to reduce nursing and midwifery absence rates and improve retention of staff C6 Nursing Associates embedded within the established workforce. C7. Bi annual Safer Staffing reports to Board of Directors Group Management Board, HR Scrutiny Committee, NMAHP Professional Board, Risk Management Committee. C8 Nursing and Midwifery vacancies and turnover reported against Hospital/MCS AOF KPI's C9 Safer Nursing Care Tool (SNCT) introduced to support annual inpatient establishment reviews. C10 Workforce Programme Board established to monitor CV19 workforce recovery programmes	D1. Variation in staffing levels and workforce supply within the hospitals MCS/ MLCO. D2 Hospitals/ MCS/LCO CV19 workforce recovery required to meet policy guidance D3 Workforce supply potentially impacted by CV19 response.	**12** **4x3**	E1. Recruitment campaigns resulting in substantive appointments of both nurses and midwives E2 Apply social distancing rules when planning recruitment events, introducing virtual events E3. NHSI safe staffing report taken from Health Roster to ensure accuracy of planned and actual staffing data E4. Reduced turnover and improved retention rate in band 5 roles. E5 Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) E6. Continue with the International recruitment programme with focus on hard to fill areas, service expansion (CSS) and increased activity (theatres) E7. Roster confirm and challenge meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff E8. Programmes of work in partnership with HR to reduce nursing and midwifery absence rates and improve retention of staff E9. Evidence based approach to establishment reviews E10. Embed the Nursing Associates within the workforce establishments .	Chief Nurse` s Team	March 2020	NMAHP Professional Board	E1 Recruitment and retention schemes have resulted in reduction in vacancy rate for band 5 roles E1 Guaranteed job offer introduced for 3rd year student nurses and midwives. To be introduced for all MFT trained 2nd year N&M students from September Programme of recruitment events planned for the next 12 months E4 Annual rolling turnover rate for nursing and midwifery has reduced to 12.2% (from 12.8%). E5 Nursing and midwifery vacancies reduced by 289 wte (4.2%) over previous 12 month period E5 Predicted vacancy rates will reduce in Q3 and Q4 following graduation of newly qualified nurses E6 MFT continues to recruit International nurses. 32 IR nurses recruited into theatre areas in Q4. Recruitment campaign to support additional workforce supply for CSS expansion E8 Hospital/MCS/MLCO sickness/absence reduction trajectories are established E9 The Safer Nursing Care Tool has been introduced across all inpatient ward areas to support safe staffing establishment reviews. E10 There are 134 Nursing Associates employed in the Trust with an additional 40 due to graduate in Q2 of 2020/21. There are 200 Trainee Nursing Associates in training due to graduate in the next 18 months.	**6** **3x2**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): Failure to deliver medical workforce workstreams (consolidated risk)

Enabling Strategy: **WORKFORCE STRATEGY**

Group Executive Lead: **JOINT GROUP MEDICAL DIRECTORS**

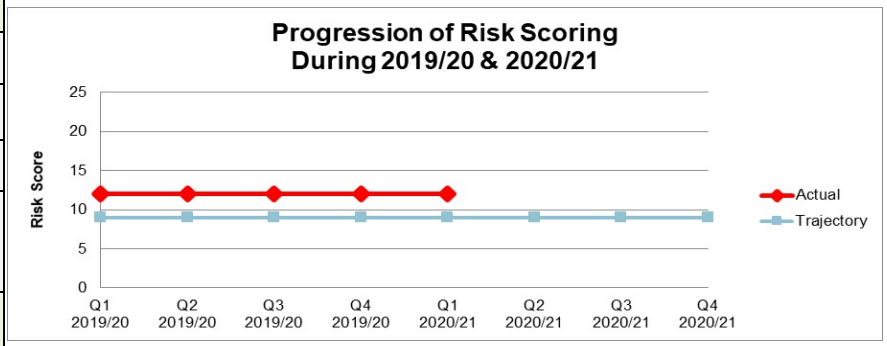
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Patient safety & quality of care risk if unable to fill medical shifts/vacancies**
2. **Inequity of care delivered at weekends v weekday**
3. **Loss of control on medical agency & internal bank spend**

Associated Committee: **WORKFORCE & EDUCATION COMMITTEE**

Operational Lead: **CHIEF OF STAFF / GROUP ASSOCIATE DIRERCTOR OF WORKFORCE**

Material Additional Supporting Commentary (as required):



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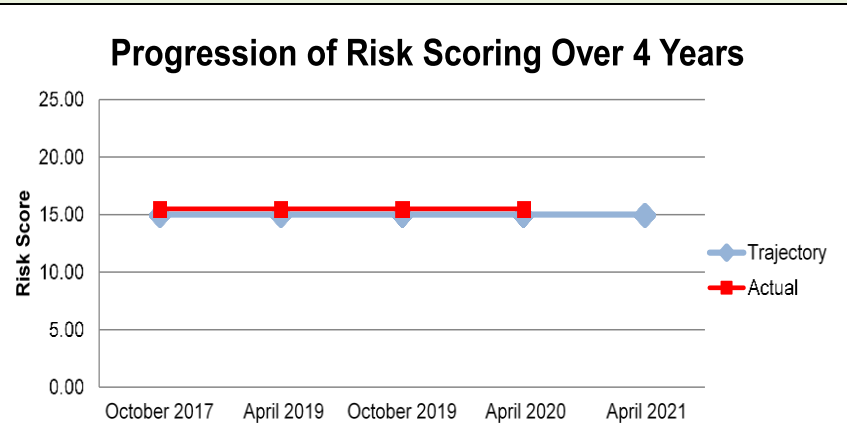
12 (4X3)	A1. Group Executive Sponsors of Medical Workforce Workstreams A2. Hospital/MCS Executive teams A3. HR Scrutiny Committee oversight A4. Finance scrutiny committee oversight A5. Hospital Review meetings A6. Accountability Oversight Framework (AOF) A7. Medical Directors' Workforce Board A8. Workforce Systems Programme board A9. LNC Liaison A10.Job Planning & Medical Leave Policy A11.Medical Workforce Electronic systems (job planning, rotas etc) A12.Internal Turnaround governance programme including WAVE A13.Management of Direct Engagement supplier A14. 7DS Joint Assurance Group A15. 7DS action plan A16. Locum and agency dashboards A17. Guardian of Safe working (GOSW)	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Key medical workforce processes (job planning, leave etc)require alignment across Group) B3. Medical Workforce systems not fully rolled out across Group B4. Medical workforce dashboards not fully in place and information not shared between systems B5. No electronic means of recording the 7DS standards.	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**12 (3X4)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Roll out new MFT job plan policy and leave policy B2. Develop job plan training guide for clinical leaders B2. Provide regular reports on job plan status to Hospitals/MCS B3. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. (and D1) Develop and roll out new dashboards for Medical temporary staffing B5. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment D2. Develop GOSW reports to include non training grade vacancies	Group Medical Directors Team & Group HR Directors Team	March 2021	Human Resources Scrutiny Committee	B1. Temporary staffing manager appointed. Formal options appraisal/procurement completed for medical bank. MFT Tier 5 GMC sponsorship progressing well which has improved international recruitment New single contract for locally employed junior doctors to be agreed in Q2 and rolled out B2. New MFT Job Planning Policy approved in January 2020. Rolled out delayed by Covid-19. New 'Covid recovery' job planning principles to be agreed at July JLNCC B2. Job plan training guide to support roll out developed and will be refined for Covid recovery Monthly reports sent to hospitals/MCS on job plan status Project team now in place for roll out of Allocate Medical Workforce systems B5. 7DS standard included in Patientrack scoped and formal testing to commence in MRI in July 2020 D1. Complete - Updated dashboards rolled out across Hospital/MCS D2. GOSW reports updated and full link to vacancies will be available when Allocate rotas fully rolled out	**9 (3X3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF FINANCE OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.** 2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.** 3. **Financial damage.** 4. **Reputational damage.** 5. **Staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Operational Lead: **GROUP CHIEF INFORMATICS OFFICER** Material Additional Supporting Commentary (as required): Please note there is a national mandate that Cyber risk scoring remains at 15, despite work being undertaken to reduce severity.	

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15 (5x3)	A.1 Appropriate Controls are in place to manage the threat of Cyber attack and other IT vulnerabilities and security threats.	B.1 Regular reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	C.1 Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	D.1 Emerging Cyber Risk may mean gap in assurance through non-availability of specialist knowledge at point of risk.	15 (5x3)	A.1 Implementation of the Group Informatics Cyber Security Action Plan, which will track and monitor all ongoing Actions at a detailed level. This will ensure continuous monitoring in line with ongoing and emerging risks at a national and global level.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. Additional improvements have been carried out and Cyber Essentials Plus Action Plan updates submitted to NHS Digital for ratification.	**6 (3x2)**

3	Strategic Aim: To improve the experience of patients, carers and their families

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation

Enabling Strategy:

QUALITY AND SAFETY STRATEGY;

PATIENT EXPERIENCE AND INVOLVEMENT STRATEGY

NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:

CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Adverse patient experience**
2. **Increased complaints**
3. **Failure to comply with regulatory standards**
4. **Damage to Trust reputation**

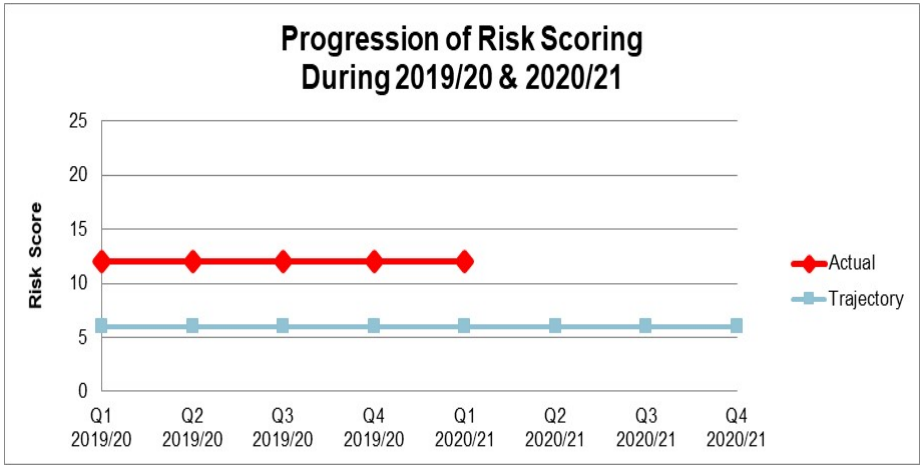
Associated Committee:

QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Operational Lead:

DEPUTY CHIEF NURSE

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A1. Corporate and hospital/MCS/ LCO Quality governance and delivery structures. A2. Patient Environment of Care Group oversees delivery of work programme and monitors impact. A3. Contract monitoring focused on patient experience outcomes. A4. Monitoring and reporting systems in place for complaints, concerns and compliments. A5. MFT Compliments, Complaints and Concerns Policy A6. Complaints management guidance provided to Hospitals/Managed Clinical Services/LCOs. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation programme. A11. Nutrition and Hydration Strategy A12. Quality and Patient Experience Forum	B1. WMTM patient experience programme not fully embedded in all areas. B2. IQP not fully embedded in all areas. B3. Nutrition and Hydration Strategy not fully embedded in all areas. B4. Patient Experience Involvement Strategy not yet embedded. B5 Food handling training not yet fully rolled out to comply with the EHO recommendations B6 Visiting restricted since March 2020 to reduce Covid-19 transmission	C1. Internal quality assurance processes (Clinical Accreditation programme, Quality Reviews, Senior Leadership Walkrounds, Unannounced CQC action walkrounds) with annual Accreditation report to BoD C2. AOF metrics reporting C3. Quarterly and annual complaints reports C4. Quality of Care Round (QCR) data C5. WMTM patient experience survey data C6. National patient survey data/reports C7. Regulatory inspection processes C8. Friends and Family Test data C9. Joint compliance audits with Sodexo	A4. Complaints programme paused during Covid-19 response (March -1April) to release clinical capacity C1. Senior Leadership Walkrounds paused in March 2020 to minimise Covid-19 transmission. C1. Accreditation process paused during COVID-19 response. C2 AOF metric reporting limited during Covi-19 response.	**12** **4X3**	A4 Continue to triage complaints and respond to urgent issues during Covid -19 response. Re-establish normal complaints processes as a priority within the recovery programme. B1. Patient Experience Matron to support areas where WMTM is not yet embedded B2. Quality Improvement Team to roll out IQP training to support areas where IQP is not yet embedded B3. WTWA, MRI and RMCH to establish local nutrition groups B3. SMH, MREH and CSS to establish nutrition as a standing agenda item within quality and safety meetings B3. Hospitals/MCS/LCOs to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met B4. Launch and embed Patient Experience & Involvement Strategy B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO	Chief Nurse' s Team	March 2021	Quality and Performance Scrutiny Committee	A4. Complaints processes maintained for urgent issues during Covid-19 response and full process re-introduced in May 2020. Virtual Local Resolution Meetings introduced to support communication with complainants. B1/B2Following a pause of the roll out of cohorts to Hospital/MCS teams to embed WMTM and IQP, a new programme has been developed and will be launched in Q2, 2020/21 as part of the Covid-19 recovery plan. The programme will include NMGH. B1. Always Events^{R} Programme paused in response to the Covid-19 pandemic. Revised project plan developed as part of recovery plan following Covid-19 pandemic, project will recommence in Q2, 2020/21. B3. Hospital/MCS/LCO/E&F nutrition and hydration updates are agenda'd at Patient Environment of Care and Quality and Patient Experience Forum B.4 Patient Experience & Involvement Strategy 2020-2023 approved at Group Quality & Safety Committee, and will be launched in Q2, 2020/21. C6 National patient survey delayed due to Covid -19 pandemic. Maternity survey cancelled nationally but MFT has continued this survey with Picker.	**6** **3x2**

3	Strategic Aim: To improve the experience of patients, carers and their families - CONTINUED										
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**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** *"With Controls"*	**ACTION(S) REQUIRED** *"Additional actions required to bridge gaps in Controls & Assurance"*	**RESPONSIBILITY**	**COMPLETION TIMESCALE**	**MONITORING COMMITTEE**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A14 Environmental Health Officer (EHO) inspections A15 Interim Covid-19 Visiting Policy implemented in March 2020 sets out actions to maintain a positive patient experience.	(see above)	(see above)	D1. Below average scores in national patient surveys for quality of food, discharge, experience, knowing how to complain and being ask about the quality of care D2. Variation in AOF patient experience scores across the Trust D3 Limited evidence that all staff involved in food handling processes comply with relevant level of food hygiene training	**12** **4X3**	B6 Temporary Family Liaison team in place to support virtual visiting across the Trust C2 Develop revised patient experience AOF metrics to monitor progress during the Covid-19 recovery period. C1 Alternate temporary assurance process agreed by Professional Board whilst Accreditation programme paused. C4,5&8. Re-establish QCR, WMTM and FFT data collection processes. D1. Deliver Patient Environment of Care work programme. D2. Develop and deliver Hospital/MCS/LCO action plans to drive improvement supported corporate services as required. D3. Develop and deliver food handling training to relevant staff, including level 2 training as indicated.	Chief Nurse' s Team	March 2021	Quality and Performance Scrutiny Committee	D2 Hospital/MCS/LCO action plan exception reports monitored at AOF meetings. B5 Food task and finish group with E&F and nursing to comply with the regulatory requirements established. Food Safety in the Clinical Environment Policy developed. Patient food fridge monitoring booklet drafted. Food safety training sub-group established to enable compliance with the EHO recommendations. Patient visitor food safety sub-group established. B6 Temporary Family Liaison team in place to support virtual visiting across the Trust C2 AOF patient experience metrics revised and monitoring continued. C4,5&8 QCR data collection re-established in May 2020. WMTM survey and FFT currently being re-established.	**6** **3x2**

4	Strategic Aim: To Achieve Financial Sustainability

PRINCIPAL RISK (What is the cause of the risk?):
Risk paused following temporary suspension of NHS Finance regime until end July 2020 due to COVID pandemic. In the short term the revised funding arrangements mitigates the immediate risk to financial sustainability.

Enabling Strategy:
MFT CONSTITUTION & LICENCSING REQUIREMENTS

Group Executive Lead:
CHIEF FINANCE OFFICER

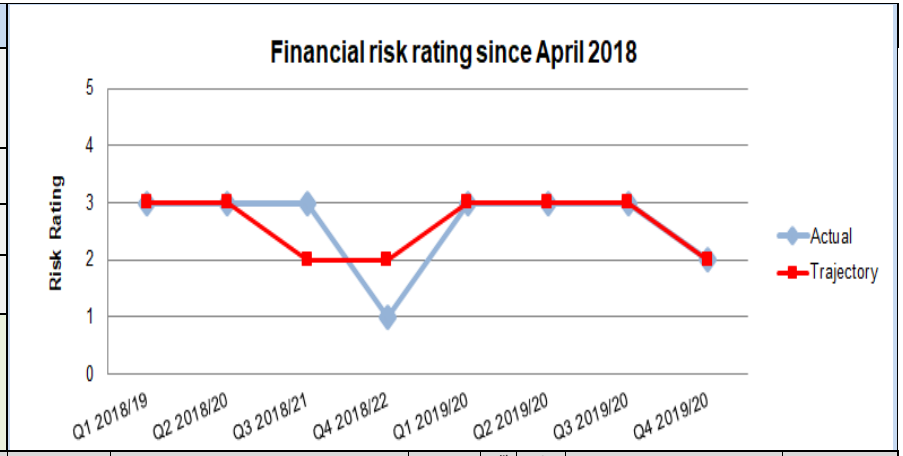
RISK CONSEQUENCES (What might happen if the risk materialises?):

The post COVID financial regime is yet to be confirmed. This risk will be reassessed once it is understood

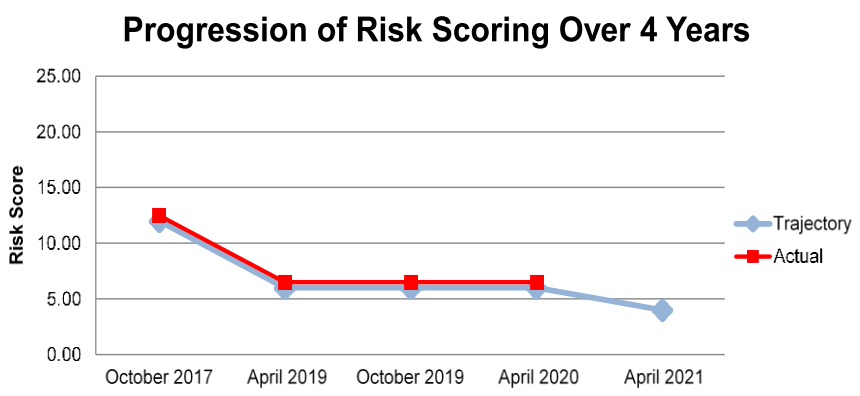
Associated Committee:
FINANCE SCRUTINY COMMITTEE

Operational Leads:
HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the A.arisk?"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	During the COVID pandemic the following has been in operation: A.1 The budget framework has been maintained linked to BAU processes to retain hospital level financial targets and requirements for improvement A.2 Ongoing financial assessment and oversight into all elements of COVID 19 recovery programme A.3 Progressing implementation of EPR system to support and drive changes and appropriate standardisation of clinical care and operational support processes A.4 Maintained monthly review of financial performance against expenditure trajectories etc to reflect revised financial regime A5 Implemented new forecasting regime for Hospitals/MCS/LCO to ensure recovery plans are developed with financial sustainability as a key part of the planning		C.1 An extensive framework of review, challenge and escalation is fully embedded within the organisation C.2 Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, which determines the level of progress recognised, intervention and support required	None	20 (5x4)	None	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	Finance Scrutiny Committee		**16 (4x4)**

4	Strategic Aim: To Achieve Financial Sustainability	
PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity than its ambition.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF INFORMATICS OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Inability to deliver against Trust strategies.** 2. **Inability to deliver benefits associated with transformational programmes of work.** 3. **Poor patient care and or experience.** 4. **Reputational damage.** 5. **Financial loss.** 6. **Low staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Operational Lead: **Group CIO, Corporate Directors, and Hospital CEOs.** Material Additional Supporting Commentary (as required): • Following Covid-19 Informatics are under resourcing pressures due to increase demand on services; • North Manchester aquisition • HIVE EPR, • Existing capital plan 20/ 21 • Business as usual service plan • Increased demand on Information services to support modelling work • Support of the recovery workstream which has a heavy reliance on digital solutions	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Monitoring of: • Delivery of Informatics Plan. • Benefits Realisation - Qualitative and Quantitative. • Digital Maturity Index for Trust. • Integration Steering Group monitoring of Informatics PTIP Plan. • Strategic and Outline EPR Business Case approved. • EPR Governance Framework defined and approved by Trust Board EPR Task & Finish Committee. • EPR Scrutiny Committee Terms of Reference defined. • EPR Implementation & Benefits Realisation Programme Board Terms of Reference defined. • EPR Task and Finish	B.1 Changes in the external landscape.	C.1 Introduction of SHS Informatics Governance in 2018/19 C.2 Group Management Board approval made in January 2018 to go to Open Procurement for the strategic EPR solution. C.3 Monitoring against HIMSS digital maturity Index. C.4 Regular updates to Hospitals and Group C.5 Informatics Membership on Boards. C.6 Informatics PTIP Reporting C.7 EPR Task & Finish Committee, Aug 2018 approval for EPR OBC; commencement of OJEU Competitive Dialogue; and Procurement Gateways C.8 EPR Task & Finish Committee, Apr 2019 approval to commence EPR Procurement dialogue phase, and approval of the EPR Benefits Approach C.8 Review of Informatics governance framework completed and revised	D.1 The significant workload to understand the landscape of the MFT organisation and the planned programmes of work.	**6 (3x2)**	C.2 Procure and implement strategic EPR solution for MFT organisation C.2 Cross section of staff to participate in Innovation Council. A.1 Appropriate engagement with Workforce Committee and wider Trust,, to ensure staff are skilled to meet the needs of our digital organisation. A.1 Operational readiness work programme is in progress to support the cultural change. A.1 Continued monitoring of the delivery roadmap for the EPR tactical work until the strategic solution is implemented. C.10 Recruitment of programme and technical resources to support implementation and delivery has commenced and will continue through the summer 2020	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Robust Monthly Monitoring against plans. • Good development work with both EPR Tactical Business cases going through the approval process. • EPR Innovation Council implemented. • HCCIOs appointed. • New MFT Informatics Strategy Approved by GISB. • Concluded the Group Informatics Management of Change process. • EPR Governance Framework defined and approved by EPR Task & Finish Committee. • EPR Scrutiny Committee Terms of Reference defined. • EPR Implementation &	4 (2x2)

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development), GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

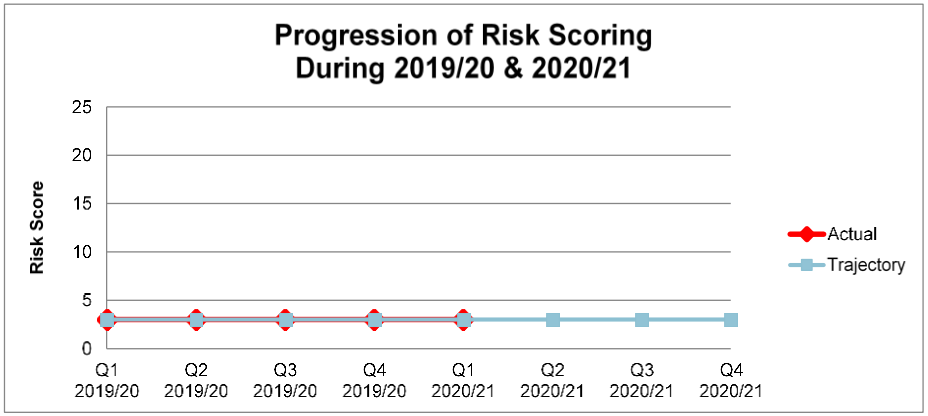
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of Service**
2. **Reduction in a range of services (offered within GM)**
3. **Damage to reputation**
4. **Loss of staff**
5. **Reduction in research opportunities**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING OMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
6 (2X3)	A.1 Internal process for service reconfiguration to strengthen key specialised services A.2 Involvement in strategic clinical networks A.3 Regular discussions with NHS England and foundation trust colleagues through the Shelford group A.4 Active involvement in Operational Delivery Networks A.5 Regular meetings with NHSE North A.7 Early notification of consolidation through national representation on clinical reference groups A.8 Partnership groups not meeting however in regular dialog with NHSEI regarding service changes related to COVID	B.1 Management capacity within corporate hospital and MCS teams to identify ongoing risks and issues against each of our specialised services (as flagged through quality surveillance reviews and other national and local reviews) B.2 Lack of Group wide review of compliance against service specifications	Award of: C.1 National tender for Auditory Brainstem Implantation - one of only two providers in the country. C.2 CAR-T designation for adults and children C.3 Northern Paediatric MS service (MFT lead with Alder Hey and Newcastle), Genomics Lab Hub C.4 Outcome of 19/20 quality surveillance reviews. 87 services achieved 100%, 53 services achieved 80-99% compliance. C.5 Outcome of Peer Reviews C.6 AOF Domain provides assurance that services are consistently delivering against milestones providing a view of strategic progress/ maturity	D.1 No Gaps in Assurance	**3 (3X1)**	B.2 Annual surveillance reviews are unlikely to go ahead this year. The annual Trust wide review will recommence 21/22.	Group Governance Team	October 2021	GSSC	Ongoing	**3 (3x1)**
						B.2 Plans to address areas of non-compliance continue to be included in Hospital/ MCS plans for 20/21. Delivery of this may be affected and therefore residual issues will be included in 21/22 plans.	Hospitals / MCS	Ongoing 20/21	GSSC	Ongoing	
						B.2 National specialised services under review by NHSE to be analysed and individually risk rated by the strategy team as part of the corporate team's regular risk management process. This will identify specialised services viewed as being most vulnerable to consolidation away from MFT. Planned outcome – Risk rated list of specialised services under NHSE review for prioritisation and further action.	Group Strategy Team	Q1 21/22	GSSC	Ongoing	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews. Planned outcome – Strategy team to remain informed regarding NHSE clinical service review priorities and timescales. Monthly meetings with NHSE specialised services arranged as part of structured intelligence gathering. Meetings with the NHS England team continue but are more focussed on service recovery planning.	Group Strategy Team	Ongoing 20/21	GSSC	Ongoing	
						A.1 Continued review of single service progress across MFT e.g. single governance, single clinical teams through COVID reviews.	Hospitals / MCS	Q2 020/21	MFT Strategic	Underway	

5	**Strategic Aim: To develop single services that build on the best from across all our hospitals**

PRINCIPAL RISK (What is the cause of the risk?): There is a mismatch between MFT and Greater Manchester Health & Social Care Partnership plans for the development of services

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

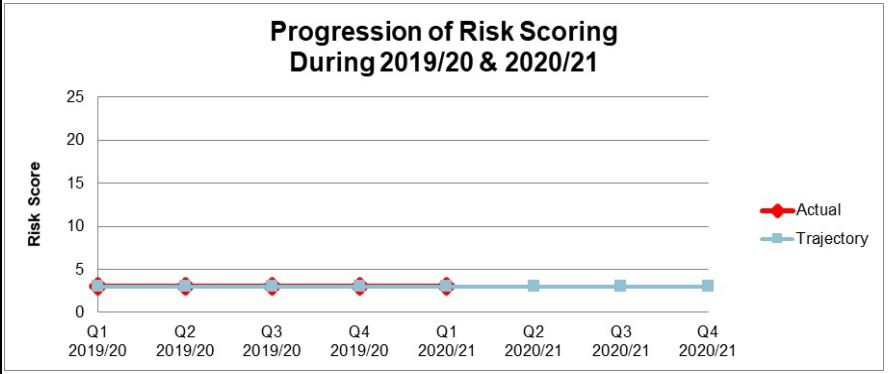
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of united voice for GM**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
8 (4X2)	A.1 MFT representatives on GM boards inc Health and Care Board, Partnership Executive Board, Provider Federation Board, Chairs' group, HR, Directors of Finance, Directors of Strategy, Directors of Ops, JCB Executive Group etc. A.2 MFT representatives on Improving Specialist Care (ISC) Board, ISC Executive, ISC Clinical Reference Group A.3 Strengthened role of PFB enables providers to engage as a group within GM A.4 Process in place for GM decision making which involves and recognises the Trust's decision making requirements A.5 Development of MFT group and individual clinical service strategy, takes GM decisions into account to form coherent strategies for the Trust that align with GM decisions. A.6 Involvement of key GM stakeholders in development of Group and Clinical Service Strategies A.7 New governance for COVID level 4 incident. MFT representation on GM Gold and GM COVID Recovery groups.	B.1 Complete MFT Group and Clinical Service Strategies	C.1 MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) C.2 MFT (Wythenshawe) designated lead provider for urology cancer surgery (ISC) C.3 MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM C.4 GM PACS procurement in alignment with MFT aims C.5 Positive response to outcome of MFT Group service strategy and waves 1-3 of our clinical service strategies from key GM stakeholders C.6 The Joint Commissioning Board has agreed, subject to consultation, GM Models of care for breast, vascular and respiratory services.	D.1 Outcome of GM decisions in respect to paediatric medicine and cardiology models of care. D.2 Response from GM stakeholders to the MCS clinical strategies.	3 (3X1)	A.1 Maintenance of control - Ensure regular MFT representation at all GM meetings	MFT Strategy team	On-going	GSSC	Mapping of all meetings and MFT coverage underway	3 (3X1)
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1 19/20	GSSC	Completed. Group Clinical Service Strategy approved by BoD (July 2019)	
						D.2 Complete underpinning clinical service level strategies engaging with GM stakeholders in development.	MFT Strategy team	Q1 19/20	GSSC	Completed. Clinical services strategies completed and approved by BoD. GM stakeholders engaged and communications plan developed.	
						D.2 Complete service strategies for CSS, engaging with GM stakeholders in development.	MFT Strategy team	Q3 20/21	GSSC	Commenced but paused for COVID.	

7	**Strategic Aim:** To develop our workforce enabling each member of staff to reach their full potential.

PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT.

Group Executive Lead:
GROUP EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

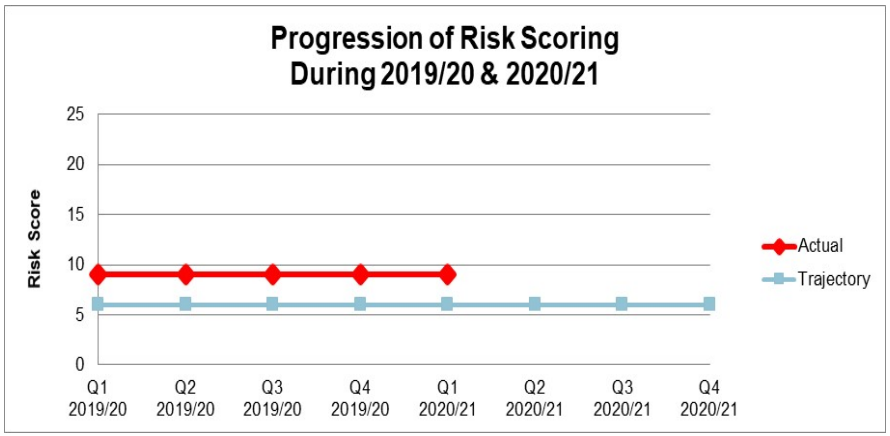
RISK CONSEQUENSES

1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**

Associated Committee:
WORKFORCE & EDUCATION COMMITTEE

Operational Leads:
Group Director of HR
Associate Director of Inclusion, Community & EHWB

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	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 *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Emergent People and related policies A.2 Trust Governance structure – including Human Resources Scrutiny Committee & Workforce Education Committee A.3 AOF monitoring A.4 Mandatory Training programme A.5 Workforce Plans A.6 MFT Operational Plan A.7 Equality, Diversity and Human Rights Strategy agreed & Group and Hospital / MCS Committees in place A.8 Workforce Technology Framework A.9 Leadership and Culture Strategy A.10 COVID-19 workforce recovery programme established (Workforce Recovery Board) which will become the People Strategy delivery plan in due course	B.1 Policy development programme progressing due for completion in October 2020 B.2 Mandatory Training Programme still needs embedding B.3 Workforce systems programme in early stages of implementation. B.4 Inadequate funding in training and development to match current and forecast demand B.5 Apprenticeship delivery programme to be embedded B.6 Limited intelligence informing workforce plans relating to global influences B.7 Ensuring the basics are delivered B.8 Limited investment to increase capacity to deliver COVID-19 recovery programme and enhanced technology	C.1 Realignment of Workforce related strategies providing one People strategy aligned to Trust service clinical strategy C.2 Trust Workforce systems and reporting e.g. eWIP C.3 Trust external and internal audit systems C.4 Staff survey and pulse checks C.5 Regulatory and statutory inspection processes and standards C.6 Internal quality assurance processes (Ward accreditation, Quality Review) C.7 AOF C.8 External accreditations C.9 Hospital / MCS reviews C.10 ISG Board reviews PTIP progress C.11 Agreed objectives for the Executive Director of Workforce and Corporate Business C.12 Review of HR Scrutiny committee arrangements completed and revised assurance process agreed C.13 Increased Executive presence at various key committees e.g.: TJNCC, HRD group, Workforce technology / Informatics Board C.14 Employee Health and Wellbeing Service Framework Approved C.15 Workforce Recovery Board C.16 Programme of work to support vulnerable at risk groups (pregnancy, over 70 etc.) including BAME staff	D.1 Limited interoperability of Workforce systems D.2 Competing priorities impacting on engagement in workforce agenda D.3 Workforce metrics not yet fully developed or reported on D.4 Resource and funding pressures in workforce teams D 5 Currently no formal outputs from Shelford HRD Forum D.6 Partial and time limited investment which may impact on delivery of People Strategy D.7 Capacity to deliver and competing large scale strategic change D.8 Workforce services and programmes under review as part of COVID-19 recovery D.9 Work to complete a Risk Assessment for all staff in an at risk group is still ongoing including accurate and detailed reporting	**9 (3x3)**	A.10 Approval of recovery workstream to enable actions to inform People Strategy delivery plans D.1 Review of and implementation of Workforce Technology Framework to be incorporated into Informatics Strategy D.2 Clear terms of Reference and membership to ensure attendance and commitment at relevant committees ensuring engagement D.3 Develop full range of workforce metrics as part of balanced scorecard D.4 Resourcing plan for corporate Workforce Teams to reflect priorities and delivery of BAU alongside COVID-19 recovery B.1 Complete policy reviews B.8 Scope and research global partnerships/organisations with exemplary workforce initiatives for shared learning and insights C.13 Review the Workforce, Education Committee refresh of membership and terms of reference in light of COVID-19 recovery boards	Workforce Team	March 2020	Human Resources Scrutiny Committee	***B.2 Workforce Recovery Board now in place and requires approval and supported resourcing plan.*** ***B.3 New governance and programme management arrangements in place to embed Mandatory Training*** ***B.6 Post Ofsted Inspection and ESFA audit plans in place and new Apprenticeship governance arrangements established.*** ***D.1 Delivery of key programme activities ongoing aligned to project delivery plans. Absence Manager programme implemented (roll out occurred quicker than expected due to COVID-19), moving into Phase 2 to embed and benefits realisation. Absence Manager has provided increased reporting functionality during COVID-19 requiring exploration as to how it is best used to capitalise on this strong position.*** ***D.2 All current committees Terms of Reference have been reviewed. Workforce Education Committee to be reviewed in September 2020.*** ***D.3.Workforce metrics reviewed and agreed for AOF and the BAF + report in place. Further development in line with People Strategy.*** ***D.4 Continue to review and finalise establishment with Finance to determine resource plan.*** ***B.1 Policies reviewed in line with implementation plan.*** ***C14 Wellbeing Assessments undertaken by Hospital / MCS, Terms of Reference agreed for oversight committee. Successful SEQOHS accreditation.***	**6 (3x2)**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Lynne Birchall, Head of Nursing, Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	June 2020
Subject:	Annual Complaints Report 2019/20 for MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations	The Board of Directors is asked to note the content of this report, the work undertaken during 2019/20 and, in line with statutory requirements, provide the approval for the report to be published on the Trust website.
Contact:	Name: Lynne Birchall, Head of Nursing, Quality & Patient Experience Tel: 0161 701 7679

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 2019 and 31st March 2020.

1.2 This report celebrates achievements and improvements, whilst acknowledging continuous improvement is always fundamental in an ongoing effort to improve processes and services across the Trust.

1.3 Throughout the report the term **Complaints** is used to describe 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 / Managed Clinical Services (MCS's) and Local Care Organisations (LCO) 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 and Trafford LCO (LCO), and Wythenshawe Hospital, Trafford General Hospital, Withington Hospital and Altrincham Hospital (WTWA).

2. Summary of Activity

2.1 As in 2018/19, the quality of complaints data reporting continued to improve during 2019/20, as did the overall year performance of the timeliness of the closing of complaints.

2.2 In response to the Coronavirus pandemic (COVID-19), and in line with the NHS Guidance in March 2020 the Trust's complaints process was temporarily paused. All complainants were notified of the situation, however Hospital / MCS / LCO's continued to investigate and respond wherever possible, particularly where immediate action was required to resolve the concern and prevent a recurrence.

2.3 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.

2.4 The total number of PALS concerns received in 2019/20 at MFT was 5,897. This represents a decrease of 8 compared with 5,905 received in 2018/19; a 0.14% decrease in the number of PALS concerns received during the last year.

2.5 The total number of complaints received in 2019/20 at MFT was 1,628. This represents an increase of 55 compared to 1573 complaints received, in 2018/19, a 3.37% increase 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

2.6 As a measure of performance against organisational activity, the number of complaints should be considered in the context of organisational activity. The following table (**Table 1**) shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2018/19 compared to 2019/20. These data show a slight reduction in complaints per inpatient episode, a similar position regarding outpatient complaints and slight increase in complaints per A&E attendance.

Table 1: Complaints received in context of activity

		2018/19	2019/20
Inpatient	Complaints Received	574	523
	Finished Consultant Episodes (FCE)	438,411	431,667
	Rate of FCs per 1000 FCEs	1.31	1.21
Outpatient	Complaints Received	714	711
	Number of Appointments	2,482,635	2,541,377
	Rate of complaints per 1000 Appointments	0.29	0.28
A&E	Complaints Received	138	191
	Number of Attendances	410,916	413,741
	Rate of complaints per 1000 attendances	0.34	0.46

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 2020 22.91% of cases were over 41 days, compared to 18% at the end of March 2019. This represents a 4.91% increase in unresolved cases over 41 days old. All cases over 41 working days old continue to be escalated within the relevant Hospital/ MCS / LCO and assurances are provided via the Accountability Outcomes Framework (AOF).

2.8 The average response rate for patients and carers raising a concern through PALS was 4.5 days during 2019/20, compared with 4.9 days during 2018/19.

2.9 The national statutory requirement for the acknowledgement of complaints, according to the NHS Complaints Regulations (2009) is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. Throughout 2019/20, 100% was achieved.

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 17 cases pertaining to the Trust between 1st April 2019 and 31st March 2020; of these; 1 complaint was upheld, 7 were partly upheld and 9 were not upheld. The details of each PHSO case are set out in this report (as detailed in Section 12). This compares to 34 cases closed in 2018/19 when 1 complaint was upheld, 15 cases were partly upheld and 18 cases were not upheld. It should be noted that at 31st March 2020, at the time of the evolving COVID-19 pandemic, the PHSO made the decision to stop accepting new health service complaints or progressing existing ones that required contact with the NHS. MFT had 7 cases under investigation by the PHSO at the end of March 2020, compared to 13 at the end of March 2019.

2.12 WTWA is the Hospital/MCS with the highest level of activity within the MFT Group and received the highest number of complaints in 2019/20, with 31.6% (515 out of a total of 1,628). This represents an increase of 73 complaints received when compared to 442 in 2018/19. Reduction in complaint volumes is a high priority for the WTWA Director of Nursing's programme of continuous improvement.

2.13 WTWA also received the highest number of PALS concerns with 32.6% (1,920 out of a total of 5,897). This compares to 1,901 (32.19%) PALS Concerns received in 2018/19, which is an increase of 19 cases.

2.14 The oldest complaint case recorded as closed during 2019/20 was received by WTWA. The case was opened on 13th December 2017 and the case was 410 days old when it was closed on 31st July 2019. The complaint involved a senior independent review and arrangement of several local resolution meetings with the patient's family and Executive Directors of the Trust. The complainant was kept updated and fully supported throughout the process.

2.15 A significant focus and a considerable amount of work to deliver improvements in 2019/20, has specifically demonstrated:

- The average response rate of complaints responded to within the agreed timescale with the complainant has improved from 72.6% in March 2019 compared to 86.6% in March 2020.

- The number of re-opened complaints during 2019/20 was 285 cases (17.5%). This represents an improvement when compared to 353 (22.4%) re-opened in 2018/19.

3 Complaints Scrutiny Group

3.1 The Complaints Scrutiny Group demonstrates Board level engagement and assurance regarding complaints handling through the Non-Executive Director Chair. This role is complimented by other core group members, which includes a Trust Governor, an Associate Medical Director, the Head of Nursing (Quality and Patient Experience) and the Trust's Head of Customer Services. The group met five times in total during 2019/20 and reviewed nine cases involving five Hospitals / MCSs across MFT. For each participating Hospital/ MCS and presented case, an evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion was undertaken.

4 Complaints Improvement Programme

4.1 The Trust is committed to the delivery of continuous improvement in all aspects of the complaints process. The Head of Nursing (Quality and Patient Experience) continues to work with the Head of Customer Services, the PALS and Complaints Team and Hospital/ MCS /LCO Teams to continue to identify and deliver improvements to the management of PALS and Complaints within the Trust.

4.2 Significant improvements delivered in 2019/20 include:

- Relocation of PALS office at Wythenshawe Hospital
- Development of an in-house Complaints Letter Writing Training Package

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 2019/20 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.

6.2 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.

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 2019 and 31st March 2020.

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 Executives/Group 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 quality of complaints data reporting has continued to improve throughout 2019/20 and comparative data is provided within the report.

2.4 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.

2.5 It should be noted that due to the need to ensure that Trust resources were focused on responding to the on-going Coronavirus pandemic (COVID-19) and, in line with National Guidance, the Trust's complaints process was temporarily placed on "pause" on 27th March 2020. This decision accorded with a national system-wide "pause" of the NHS Complaints Process. All complainants were notified of the situation, however Hospital / MCS / LCOs continued to investigate and respond wherever possible, particularly where immediate action was required to resolve the concern and prevent a recurrence.

3. Overview of Activity

3.1 The number of PALS contacts received for 2019/20 was 5,897, which is 8 less than the number received in 2018/19 (5,905). This demonstrates a 0.14% decrease in the number of PALS concerns received during the last year. It is important to note however, that expected volumes of PALS concerns in March are typically lower, however the reduction identified in March 2020, 415 compared to 469 in February 2020 also coincides with the COVID-19 pandemic response. **Graph 1** provides the number of PALS contacts received by month for the financial year 2019/20.

Graph 1: Number of PALS contacts (by month) for 2019/20, MFT

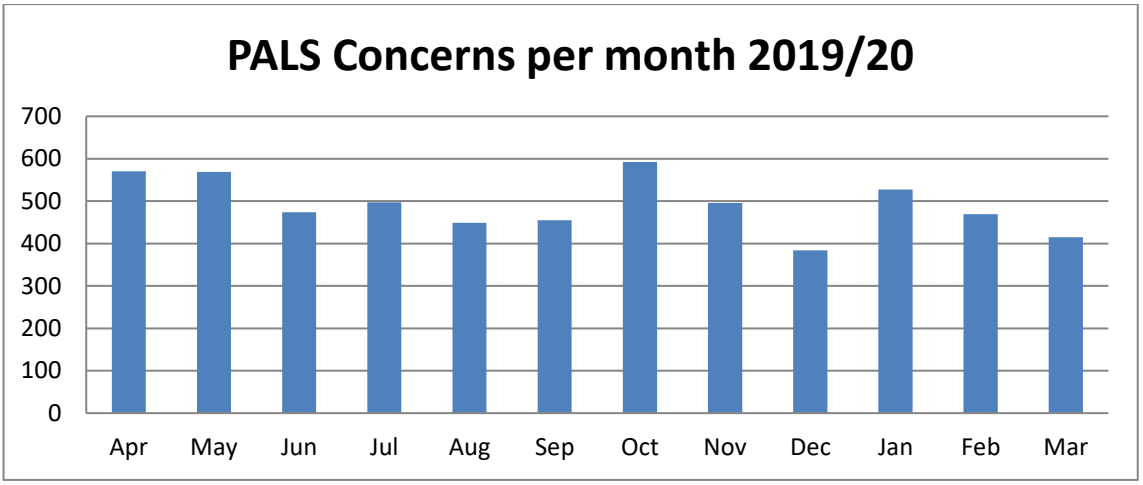


Table 2: Number of PALS contacts by Hospital/ MCS/LCO

Hospital / MCS / LCO	2018/19	2019/20
Clinical Scientific Services (CSS)	277	335
Corporate Services	214	298
Manchester & Trafford Local Care Organisation (LCO)	25	52
Manchester Royal Infirmary (MRI)	1,671	1,531
Research & Innovation (R&I)	18	15
Royal Manchester Children's Hospital (RMCH)	561	621
Saint Mary's Hospital (SMH)	467	526
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	528	447
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	1,901	1,920
Not Stated / General Enquiry / Non-MFT	243	19
MFT Total	**5,905**	**5,897**

3.2 WTWA received the highest number of PALS concerns with 32.6% (1,920 out of a total of 5,897). This compares to 1,901 (32.19%) received in 2018/19, which is an increase of 19 cases. MRI received the second largest number of PALS concerns with 26.0% (1,531 out of a total of 5897). This compares to 1671 (28.2%) in 2018/19 which is a decrease of 140 cases. As the Trust's largest services, it is expected that these two areas receive the greatest proportion of PALS concerns.

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. 2019/20 has seen a significant increase in the number of PALS concerns rated red and amber. Of the 2 PALS concerns rated red in 2019/20; 1 related to treatment/procedure and 1 related to communication. Of the 68 PALS concerns rated as amber; 39 related to treatment/procedure. This position compares to 11 PALS concerns rated as amber in 2018/19. Analysis of these data has classified the 39 cases relating to treatment and procedure as being distributed across many services of the Hospitals, with no specific area being identified.

Table 3: 2019/20 PALS contacts by risk grading, MFT

Category	2018/19	2019/20
Green	4,808	4,420
Yellow	819	933
Amber	30	68
Red	0	2
Not graded, escalated or enquiry	248	474
MFT Total	**5,905**	**5,897**

3.5 The 2019/20 total of PALS concerns includes 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 2,094 in 2018/19 to 2,454 in 2019/20. This represents an increase of 17.5%. 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 express dissatisfaction with services than older people and women more likely to express dissatisfaction with services than other sexes.

3.9 The percentage of people who did not state their ethnicity for PALS Concerns has decreased from 62.2% in 2018/19 to 48.1% in 2019/20. Work will continue in 2020/21 to improve the quality of these data.

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 2019/20, MFT

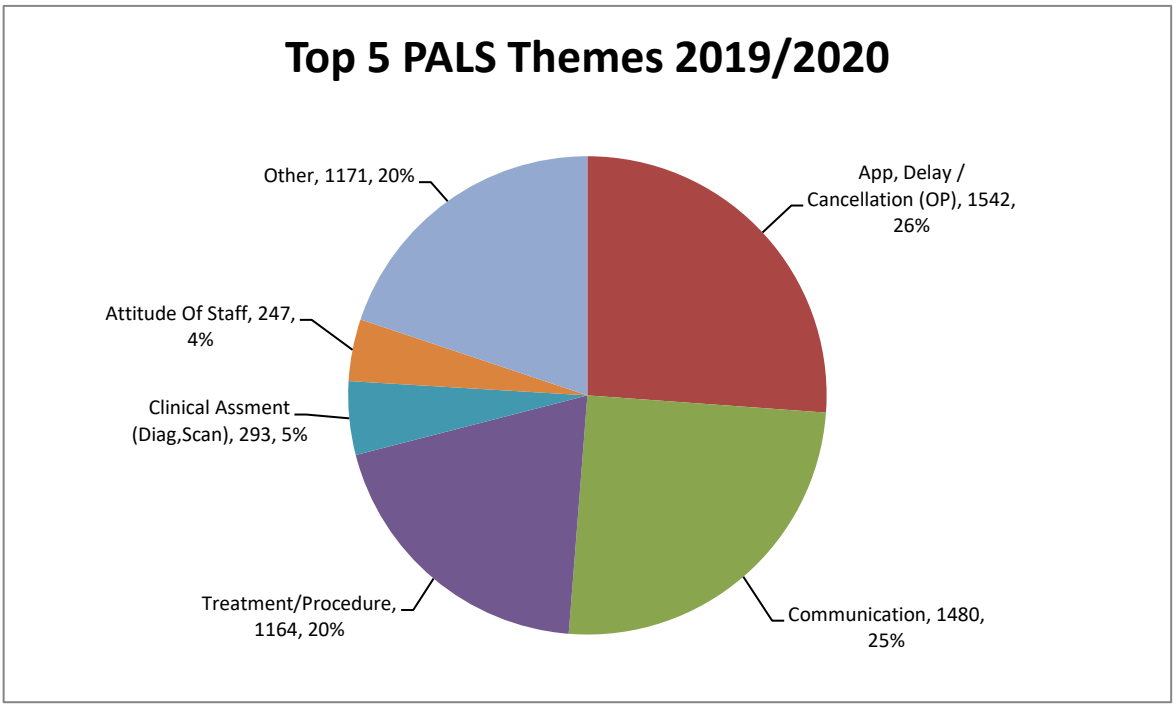


Table 8: Comparison of Top 5 PALS Themes**,** MFT

	2018/19	2019/20
1.	Appointment Delay / Cancellation	Communication
2.	Communication	Appointment Delay / Cancellation
3.	Treatment / Procedure	Treatment / Procedure
4.	Attitude of Staff	Clinical Assessment (Diagnosis, Scan)
5.	Enquiry	Attitude of Staff

3.11 The average response rate for patients and carers raising a concern through PALS at MFT was 4.5 days during 2019/20, compared with 4.9 days during 2018/19.

4. Complaints Activity

4.1 The number of complaints has increased in 2019/20 compared to 2018/19, with a total of 1,628 complaints received, compared to 1,573 in 2018/19, representing a 3.5% increase during the last year. In response to COVID-19 the Trust's complaints process was temporarily placed on pause on 27th March 2020.

Table 9: Number of Complaints, MFT

Year	2018/19	2019/20
Complaints Received	1,573	1,628

4.2 **Table 10** details the 2 year trend for complaints at Hospital/ MCS and LCO level. WTWA received the most complaints during 2019/20 with 515 complaints received; this represents an increase of 16.5% compared to 442 received in 2018/19. Themes identified for WTWA were 'Treatment and Procedure, 'Communication' and 'Clinical Assessment'. The Director of Nursing, will lead detailed work to identify and address the underlying causes of the increase in complaint volumes will be a key focus for WTWA during 2020/21. The Corporate Services achieved a reduction in the number of complaints received during 2019/20 with 68 complaints received; representing a reduction of 25.3% complaints compared to 91 received in 2018/19. Worthy of note, however, is that where services are dealing with a smaller number of complaints this can appear to have a larger impact when these figures are presented as percentages.

Table 10: Number of complaints by Hospital/ MCS and LCO

Hospital / MCS / LCO	2018/19	2019/20
Clinical Scientific Services (CSS)	82	103
Corporate Services	91	68
Manchester & Trafford Local Care Organisation (LCO)	27	44
Manchester Royal Infirmary (MRI)	452	419
Research & Innovation (R&I)	2	0
Royal Manchester Children's Hospital (RMCH)	167	189
Saint Mary's Hospital (SMH)	190	194
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	115	96
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	442	515
Not Stated / General Enquiry / Non-MFT	5	0
MFT Total	**1,573**	**1,628**

4.3 Complaints are risk rated using a matrix aligned to that used within the Trust to assess the severity of incidents. This matrix assigns a level of Red, Amber, Yellow or Green dependent upon the risk score. When compared to 2018/19, the numbers of Red, Amber and Green complaint cases received in 2019/20 have decreased. Yellow cases received have seen an increase from 807 in 2018/19 to 903 in 2019/20, representing an increase of 11%. Of the 6 complaints rated as Red in 2019/20, 3 relate to Treatment or Procedure, 2 relate to Clinical Assessment, and 1 relates to Communication.

4.4 Table 11, presented in Appendix 2, provides the breakdown of the risk rating of complaints for 2019/20 compared to 2018/19.

4.5 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 2018/19 and 2019/20 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.

4.6 The demographic data for complaints presented within Appendix 2, also supports the findings[2] that younger people (or their parents) are more likely to express dissatisfaction with services than older people, and women are more likely to express dissatisfaction with services than other sexes.

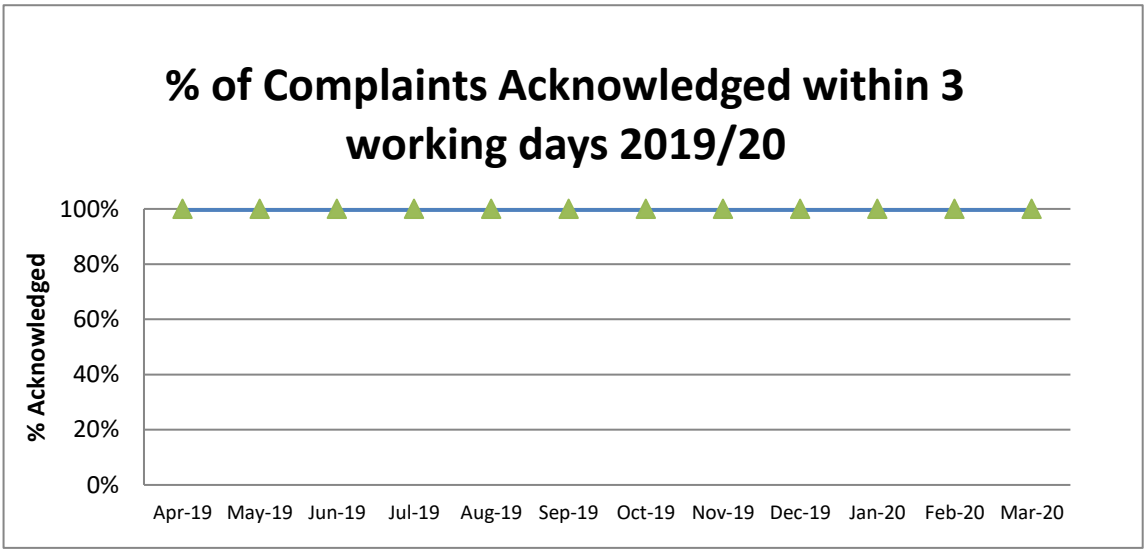
4.7 For complaints the percentage of people who did not declare their ethnicity has improved from 64.0% in 2018/19 to 21.3% in 2019/20.

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 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 2019/20, 100% performance was achieved in all 12 months of the fiscal year. This compares to an overall 99.8% performance during 2018/19.

Graph 3: Percentage of complaints acknowledged ≤ 3 working days during 2019/20, 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 2019/20.

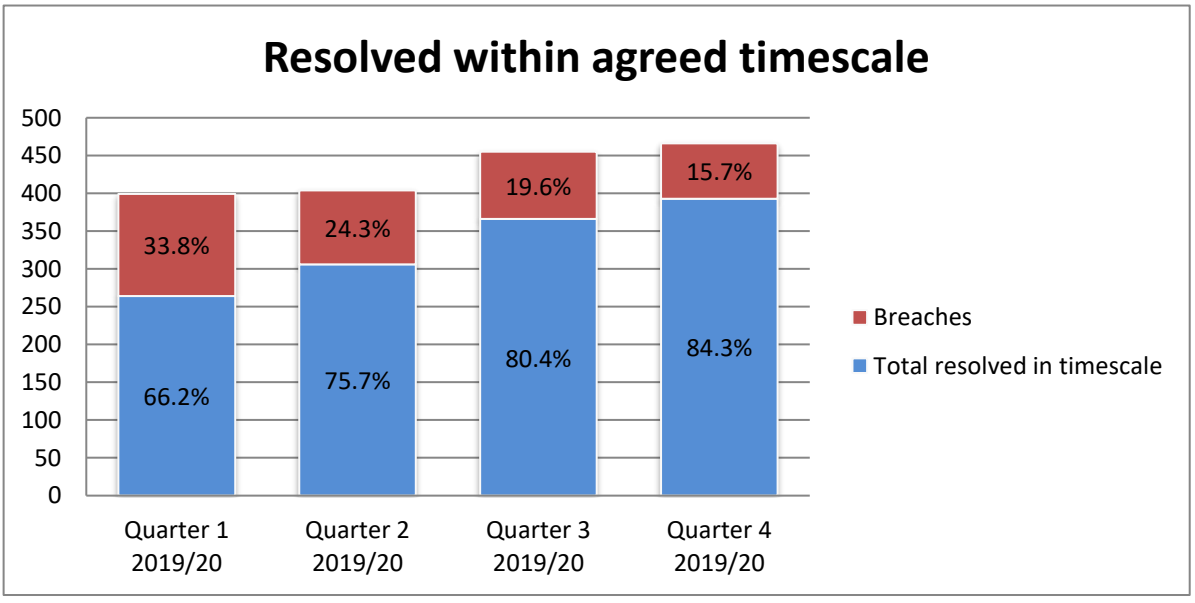
6.2 The MFT performance in response times (**Table 15**) has been variable throughout the year with 1065 (61.78%) complaints responded to in 0-25 working days, 310 (17.98%) of complaints being resolved in 26-40 days and 349 (20.24%) of complaints responded to in 41+ days.

6.3 Over the course of the year there has been a significant focus to deliver improvements in response times. In March 2020, 84.3% of complaints were responded to within the agreed timescale, compared to 72.6% in April 2019 (**Graph 4**). The focus and work on improvements has resulted in an improving trend, therefore the current strategy for improvement will continue into 2020/21.

Table 15: Comparison of complaints resolved by timeframes, 2019/20, MFT

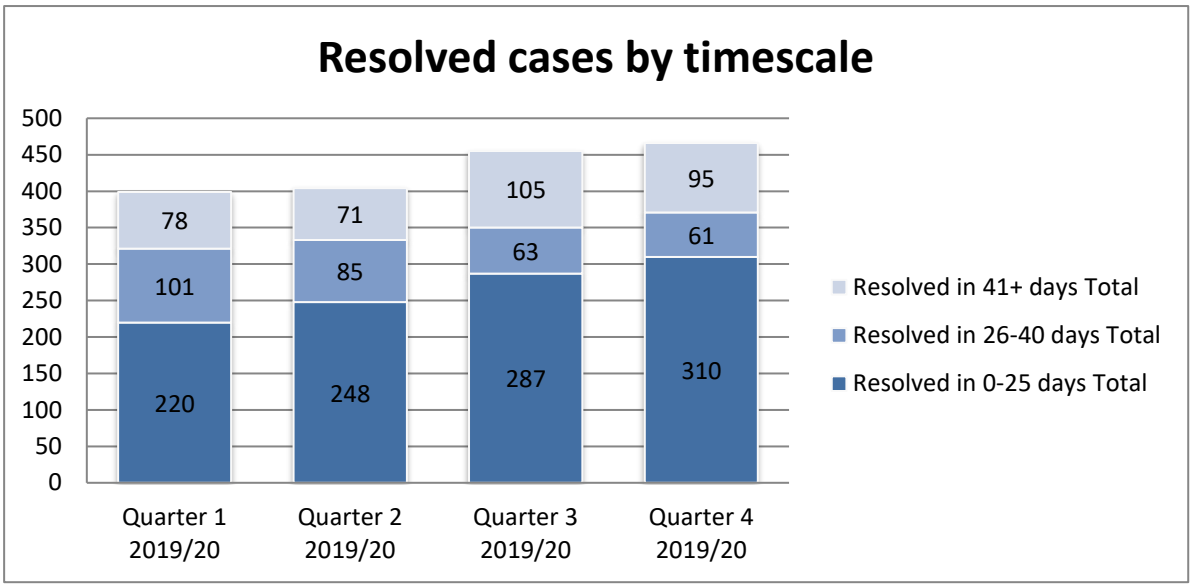
		2019/20
Complaints resolved	New Reopened Total	1439 285 1724
Resolved in 0-25 days	New Reopened Total	907 158 1065
Resolved in 26-40 days	New Reopened Total	249 61 310
Resolved in 41+ days	New Reopened Total	283 66 349
Total resolved in timescale		1329
Breaches		395
Total resolved		1724

Graph 4: Breakdown of complaints closed within agreed timescales 2019/20, MFT

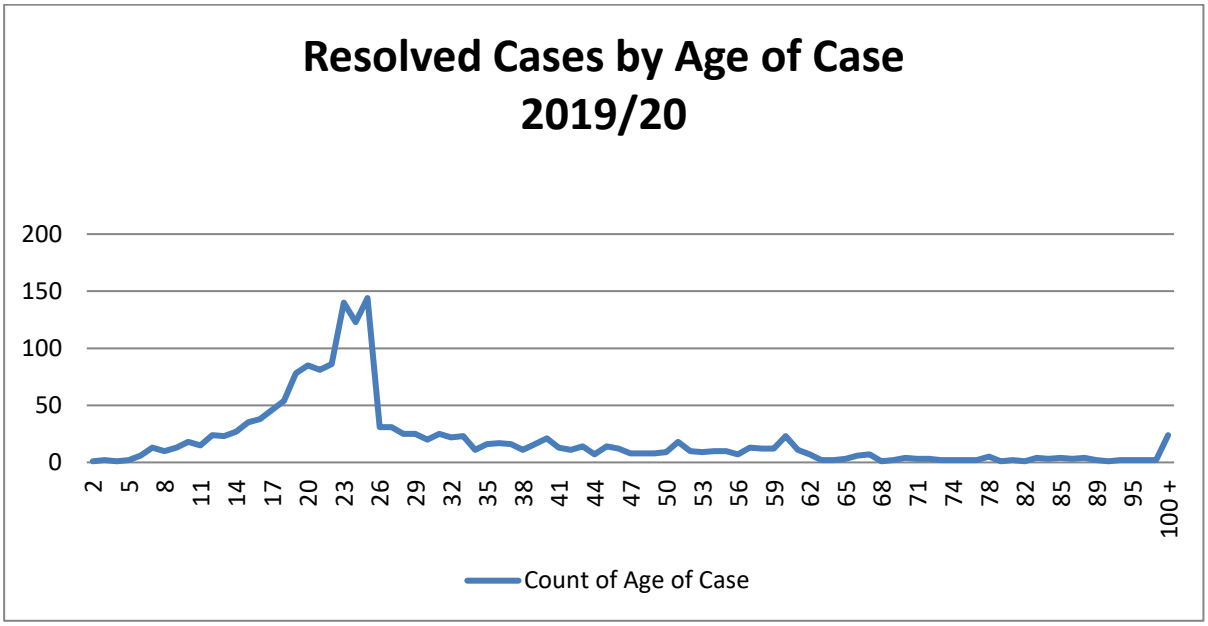


6.4 **Graph 5** shows the overall performance in relation to response times for complaints closed during 2019/20, for MFT. **Graph 6** then presents a granular level breakdown of the data shown in Graph 5.

Graph 5: Complaints closed within timeframes during 2019/20, MFT



Graph 6: Breakdown of closed complaints 2019/20 (24 extremely long cases (100+ days) not included as these are small in number)

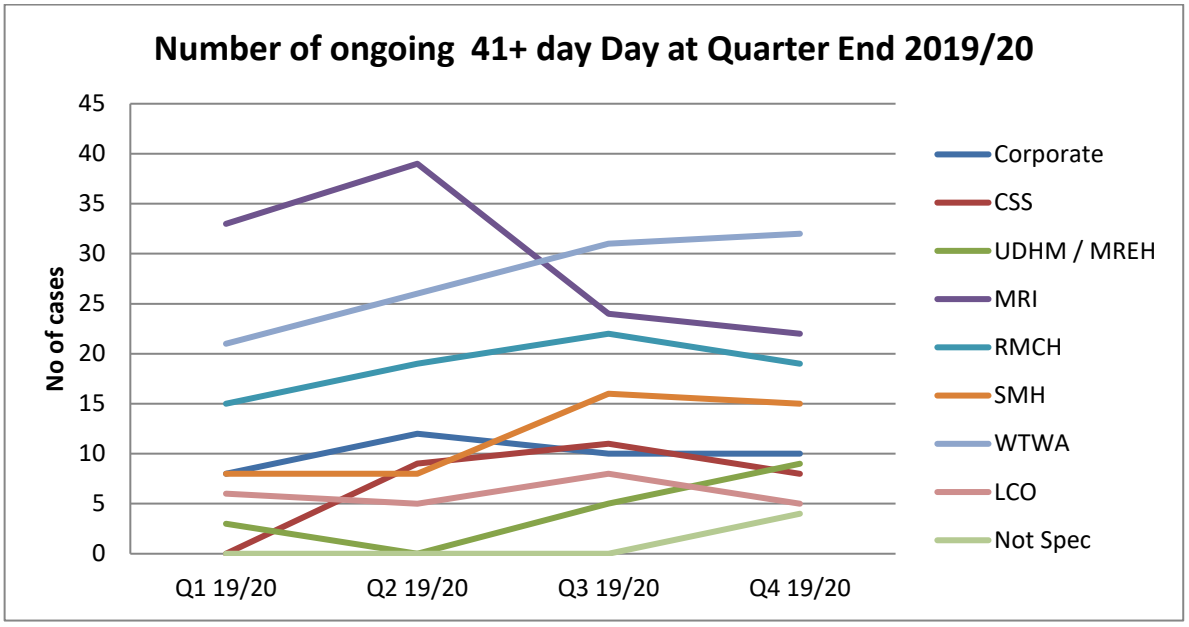


On-going Complaints

6.5 There has been a continued focus during 2019/20 on managing the number of open complaints that were over 41 working days old. At the beginning of April 2019, there were 31 cases (18% of open cases [172]) Trust-wide that were unresolved over 41 days. However, this figure did fluctuate throughout the year, ranging from 30 open cases at the end of June 2019, 54 at the end of October 2019, and 55 (22.91% of open cases [240]) at the end of March 2020.

6.6 **Graph 7** shows the number of open complaints, by Hospital/ MCS and LCO unresolved after 41 days at the end of each quarter of 2019/20 and demonstrates a continuing increase in unresolved complaints after 41 days in Quarter 2 and 3, 2019/20, with a slight reduction being seen in Q4, 2019/20.

Graph 7: Open complaints by Hospital/ MCS and LCO unresolved after 41 days at the end of each quarter of 2019/20



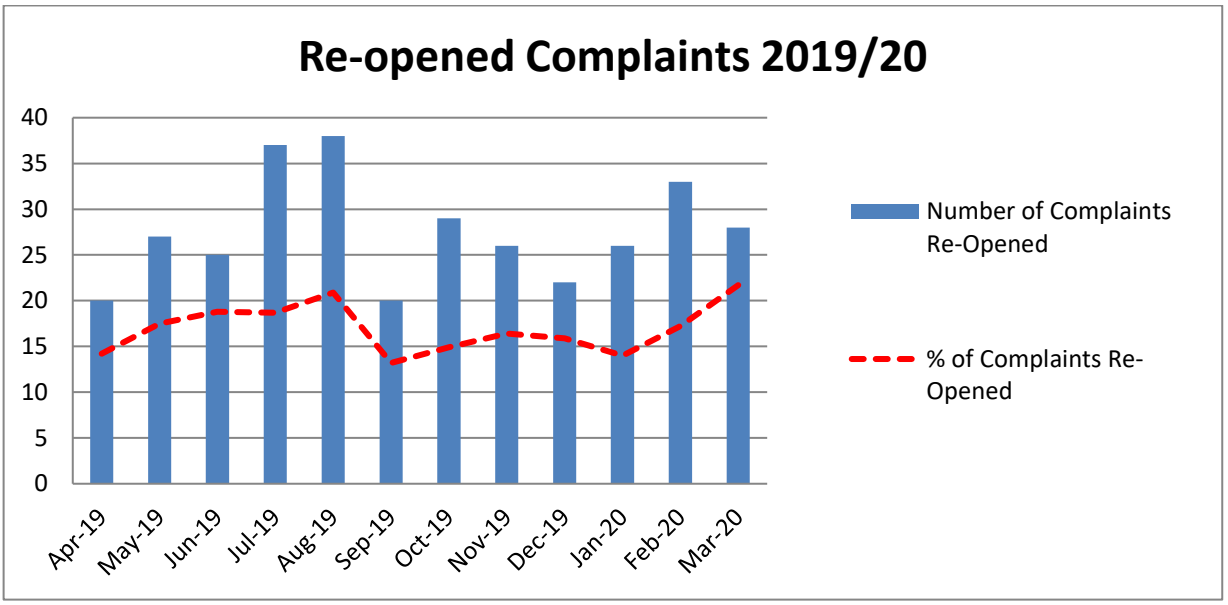
	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
Corporate	8	12	10	10
CSS	0	9	11	8
UDHM / MREH	3	0	5	9
MRI	33	39	24	22
RMCH	15	19	22	19
SMH	8	8	16	15
WTWA	21	26	31	32
LCO	6	5	8	5
Not Spec	0	0	0	4
MFT Total	**94**	**118**	**127**	**124**

6.7 All cases over 41 working days are monitored at Group level via the AOF, which informs the decision-making rights of Hospital/ MCS and LCO Chief Executives and their teams.

6.8 The oldest case closed during 2019/20 was received by WTWA. The case was opened in December 2017 and the case was 410 days old when it was closed in July 2019. The complaint involved a senior independent review and arrangement of several local resolution meetings with the patient's family and Executive Directors of the Trust. The complainant was kept updated and fully supported throughout the process.

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 2019/20 there was a wide variation in the number of re-opened complaints received across the Trust with a total of re-opened cases during 2019/20 equating to 331 (16.9%). This compares to 353 (22.4%) re-opened in 2018/19.

6.10 **Graph 8** details the number of re-opened complaints by month during 2019/20, MFT

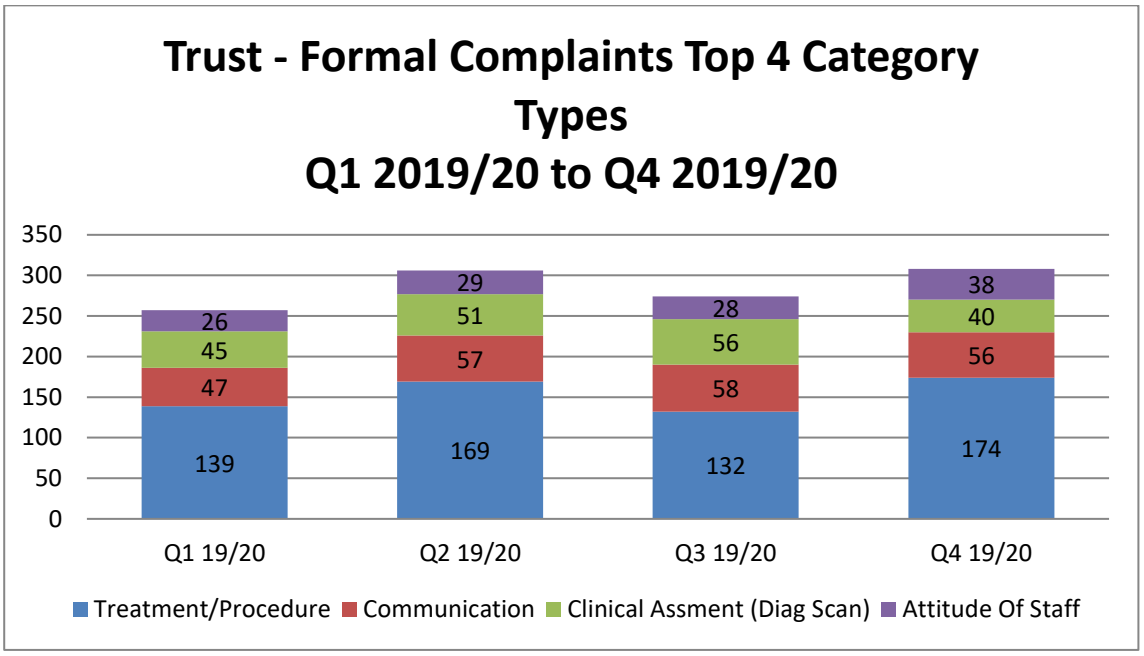


7. Themes

7.1 The themes and trends from complaints are reviewed at a number of levels across MFT. Each Hospital/ MCS and LCO 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 is provided in quarterly complaints reports to the Board of Directors.

7.2 **Graph 9** demonstrates the 4 most prevalent categories of issues raised in complaints in 2019/20.

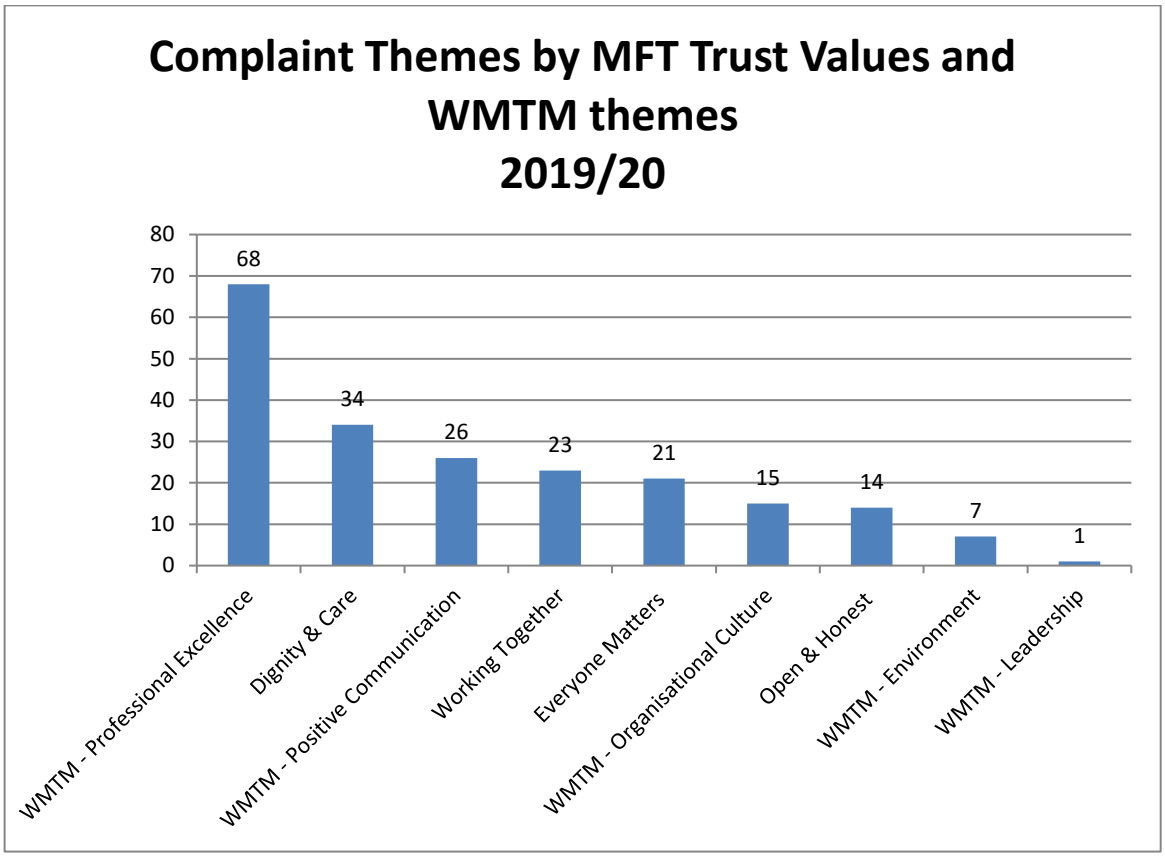
Graph 9: Top 4 Complaint Themes, MFT



7.3 Theming of complaints to the MFT Trust Values: **Everyone Matters, Working Together, Dignity & Care, Open and Honest** continued during 2019/20.

The Trust-wide themes from the concerns identified in complaints compared to the MFT Trust Values and What Matters to Me patient experience themes, 2019/20 are shown in **Graph 10**. The collection of this data has been challenging, and a review of the system has identified that the design of the current database is ineffective in capturing this data. In order to support improvement work, the Customer Services Manager will review opportunities to improve the data base and carry out audits of closed cases during 2020/21. This focused approach is expected to provide a more meaningful means to identify trends within complaints that relate to Trust values.

Graph 10: Complaints – Theming of complaints to MFT Trust Values and WMTM themes, 2019/20



7.4 The mapping and tracking of complaints to specific topic areas has also continued during 2019/20. Complaints relating to dementia, pain relief, end of life care and nutrition and hydration continue to be captured and used for monitoring and for targeting improvement activity. To enable future monitoring of complaints related to Covid-19, this category was added to the database in March 2020 and will be reported in Quarter 1 of 2020/21.

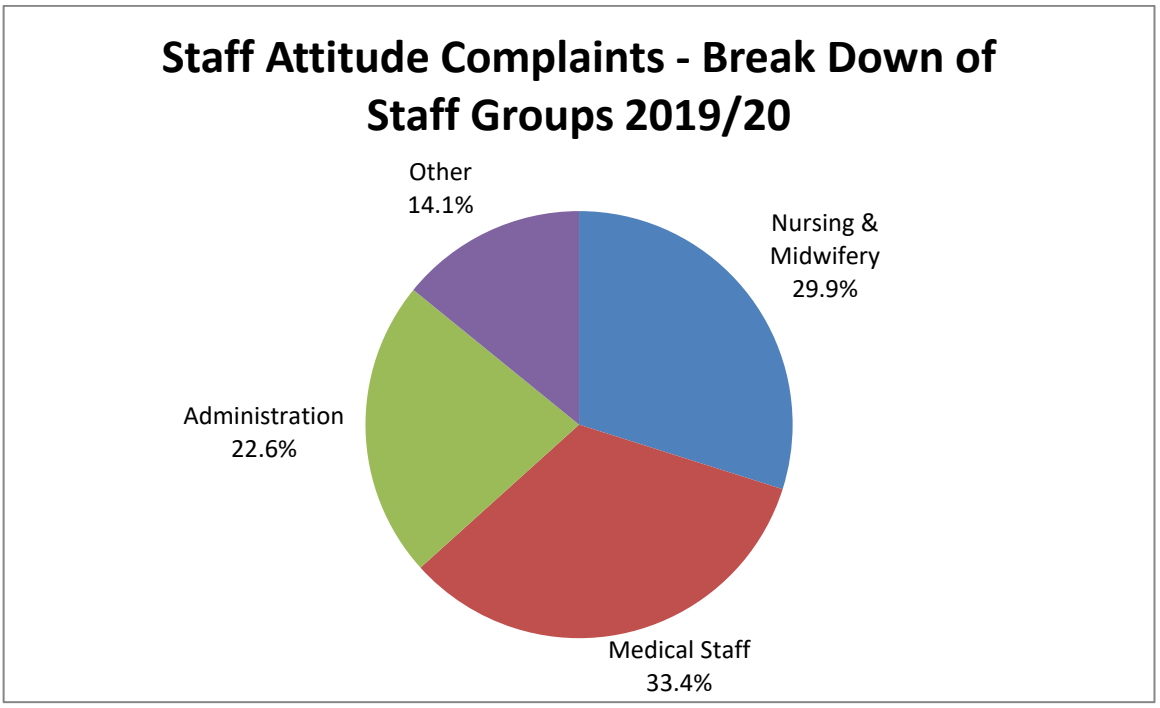
8. Our People

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	2018/19	2019/20
PALS Concerns	304	247
Complaints	350	121
Total	**654**	**368**

Graph 11: Percentage of complaints and PALS concerns relating to staff attitude by staff group, MFT

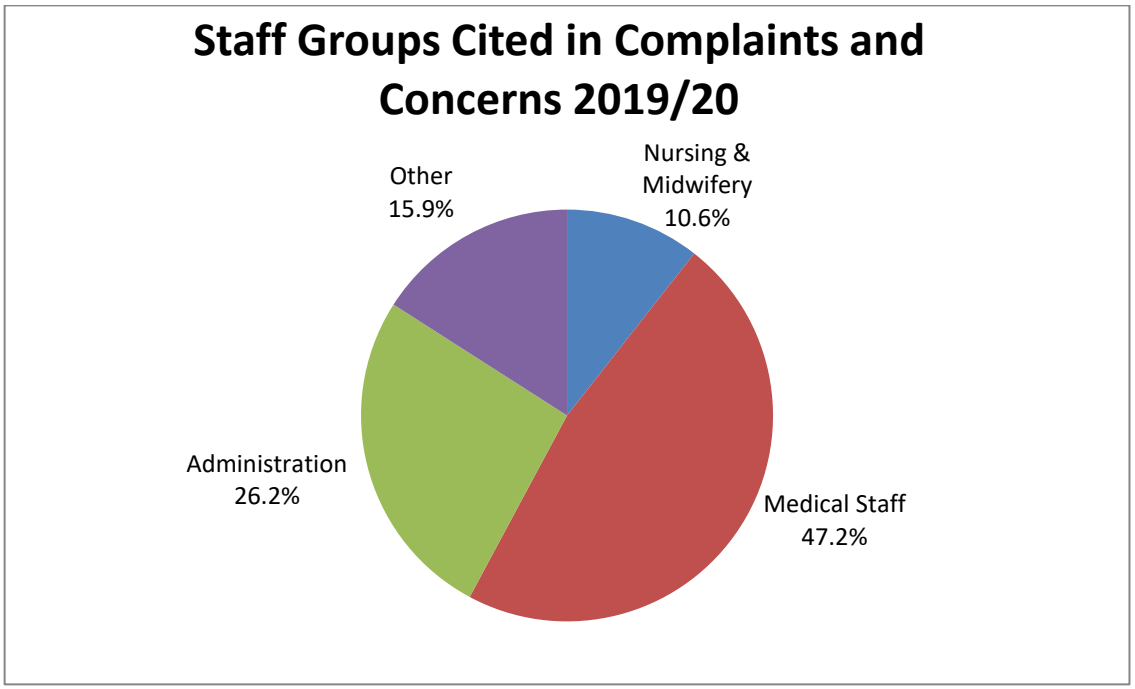


8.2 During 2019/20, the number of complaints and PALS Concerns received (7,525) which cited staff attitude decreased to 368 (4.9% out of total 7,525) compared to 654 during 2018/19. This is a very notable change and represents a positive reduction of 43.7%. This improvement evidences the positive impact of the Trust's What Matters to Me Patient Experience and Improving Quality programmes as well as the embedding of the MFT Values and Behaviours. The attitude of the medical staffing group was cited in more complaints (33.4%) than any other staffing group. Of note it is recognised that medical staff, as the lead practitioner for episodes of care, it is not unusual for them to be cited by patients who wish to make a complaint.

8.3 **Graph 12** highlights the top 3 professions referenced in complaints and PALS concerns. Medical Staff are the highest group referenced with a total of 3,555 complaints, followed by Administration and Clerical (A&C) staff that are referenced in 1,973 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.

8.4 The importance of Positive Communication is one of the six key themes 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 a 'First Impressions Training Programme' has been developed in partnership with A&C staff and is now delivered across the Trust.

Graph 12 Top 3 most referred to professions in Complaints and PALS concerns, MFT



9. Overview and Scrutiny

9.1 The Trust Complaints Scrutiny Committee 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 five times during 2019/20 and reviewed 9 presented cases involving five Hospitals/ MCSs across MFT. A further meeting had been planned for March 2020, however as a result of the evolving COVID-19 pandemic this meeting was stood down to release clinical and managerial capacity to support the pandemic response. The meetings are planned to commence again in July 2020.

9.4 The actions agreed at each of the Scrutiny Committee meetings are recorded and provided to the respective Hospital/ MCS / LCO 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 2019/20 are outlined in **Table 17**. All Hospitals/ MCS/ LCO 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 2019/20

	Hospital/MCS/ LCO	Learning	Actions
Quarter 1	**MRI (Medicine)**	No joint (Respiratory & Haematology) MDT clinic	• Joint Respiratory & Haematology Multi-Disciplinary Team (MDT) clinic to be set up & all patients with Pulmonary Embolism to be invited to attend.
		The CT scans identified in this complaint were not reported adequately No formal recording of reason why radiology investigation was put on hold or not processed	• Utilise complaint as a case study for teaching. • Discuss case at the next Divisional Clinical Governance meeting. • Approach CSS to explore the possibility of this information being shared with a view to utilising this information for learning. • Explore the possibility of an audit of radiology request forms.
Quarter 1	**MRI (Surgery)**	Substandard quality of some of the theatre equipment	• Equipment management is being addressed at Group level and through the MRI Theatre Improvement Group.
		Lack of calming environment for patients in theatre	• Patients not to arrive in theatre before the environment is prepared and ready. • Review of theatre set-up process to ensure the environment is prepared before the patient is brought in to the theatre

			anaesthetic room.
		Lack of appropriate assistance and advice to some complex patients post-surgery	• Transplant Co-ordinators are to provide teaching and training to all new nursing staff regarding pre and post-operative care of renal transplant patients and living donor. • Nursing staff to be provided with training to assist and advise complex patients post-operatively.
Quarter 2	**WTWA (Medicine)**	Provision of adequate nutrition and hydration	• Training and education undertaken around monitoring of fluid balance.
Quarter 2	**WTWA (Heart & Lung)**	Breakdown in communication	• Importance of communication / briefings prior to meeting with a family to be disseminated at A&E, Medical staff, End of Life care and Ward Managers meetings. • Staff involved in the incident to attend communication LEAD training.
		Protected Mealtimes	• Reinforcement of the Protected Mealtime Policy to all staff.
		Consistency of adhering to safe infection prevention practice in maintaining and cleaning equipment	• In line with Trust Policy; patient bedside boards to be updated at all times and checklist put in place to ensure cleaning of equipment.
Quarter 2	**RMCH**	Percutaneous Nephrolithotomy (PCNL) service not commissioned by RMCH	• Development of full business case to provide a PCNL service at RMCH.
		Quality of complaint response	• With the support of the Complaint's team, RMCH to undertake the Complaints Response Audit.
Quarter 2	**SMH**	Scanning capacity	• Increase staffing capacity through training.
		Understanding of maternal viewpoint and needs • Use of individualised care plan	• Continuation of roll out of What Matters to Me (WMTM).
Quarter 3	**MRI (Renal Transplant)**	Delay in escalation/delay in implementation of Zero Tolerance Policy/Behavioural Contract	• The required actions will be embedded within on-going Complex Patient Pathway improvement work.

		Limited recognition/ understanding of how best to manage inappropriate behaviours and needs of complex patients Consideration to be given to develop a process for dedicated named consultant for long term in-patient management	
Quarter 4	**UDHM**	Paediatric Dentistry waiting list in excess of 12 months – lack of provision in the North of England	• Review and improve the process regarding listing patients on a Saturday. • Continue to work with Commissioners to review capacity across Greater Manchester with a view to reducing variance in paediatric waiting times by transferring patients to Hospitals with shorter waiting times. • Families, to be invited, via the Commissioners, to attend the Paediatric Managed Clinical Network. • Liaison with National Getting It Right First Time (GIRFT) lead for Dentistry.
Quarter 4	**MREH**	Limited recognition / communication of how best to manage needs of complex patients Delay in referring complex patients for second opinions	• Explore the possibility of additional Eye Clinic Liaison Officer. • Allocate longer time slots for clinic appointments. • Consideration to be given for improved counselling services. • Create a Standard Operating Procedure (SOP). • Patient story to be shared at MREH's next ACE day.

9.6 In addition to the scrutiny described above, complaints are also reviewed within the Accreditation process to assess if teams are aware of complaints specific to their area and to examine what actions have been taken and changes embedded 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 Trust's real time **What Matters to Me** Patient Experience surveys in order to identify any trends.

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 26.9% decrease in the number of postings made on these websites during 2019/20 (from 275 postings in 2018/19 to 201 postings in 2019/20). The number of posts on these websites by category; positive, negative and mixed negative and positive comments, are recorded as detailed in **Table 18.** These data demonstrate that the majority of comments received in 2019/20 were again positive (64.7% 2019/20 compared to 56% in 2018/19). 25.4% of the comments related to a negative experience of the Trust's services, however, this is a positive decrease of 7.3% compared to 2018/19 when 32.7% of comments were categorised as negative.

Table 18 Number of Care Opinion postings by Hospital/MCS and LCO 2019/20

Number of Patient Opinion Postings received by Hospital/MCS/LCO 2019/20			
Hospital/MCS/LCO	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	1	1	1
Corporate Services	1	1	3
Manchester & Trafford Local Care Organisation (LCO)	0	0	0
Manchester Royal Infirmary (MRI)	16	16	7
Research & Innovation (R&I)	0	0	0
Royal Manchester Children's Hospital (RMCH)	7	3	1
Saint Mary's Hospital (SMH)	24	12	0
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	15	2	3
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	66	16	5
Total	**130 (64.7%)**	**51 (25.4%)**	**20 (9.9%)**

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 2019/20

Cardiothoracic Surgery – Wythenshawe Hospital
I had lung surgery and can genuinely say that I have been overwhelmed by the level of care provided by the medical team on Ward F2. All the nursing staff were exceptional. All were absolute gems and were fully involved in my health care and I would like to thank them for their intervention and words of encouragement, because this contributed to my speedy recovery.
Response:

[3] https://www.cqc.org.uk/what-we-do/how-we-use-information/how-we-use-information

Thank you for your positive comments posted on the Care Opinion website regarding your care on Ward F2 at 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 you thought all the nursing staff were exceptional and that their involvement in your healthcare and words of encouragement aided your recovery. I can assure you that we have passed on your thoughts to the Head of Nursing who will share your kind feedback with all the staff involved.

Maternity Services, Saint Mary's Hospital

Excellent in an emergency.

My delivery experience was very positive, all the midwives and doctors were very good. The birth was a bit tricky and I spent time on Ward 66 where the staff were really nice. There I had a postpartum haemorrhage and was quickly assessed and taken to theatre. The team were excellent and I am very grateful to them for saving me. Lots of informed consent etc even in an emergency. The midwife and critical care nurse who helped me afterwards were lovely. They also helped with the baby so my partner could rest. I moved to Ward 47B which was fully booked but the staff still found time to look after my baby at night when I was too unwell to get out of bed. There were lots of other nice little touches like when one midwife got an anaesthetist to put a drip in for me as I was terrified and my veins were shrivelled up due to losing lots of blood. The triage area is often very, very busy and you do have to wait a while there. You get the impression triage needs more staff, but then this is the case for the whole NHS given skills shortages and funding cuts… Overall I felt lucky to have delivered at Saint Mary's as when things went wrong I felt in safe hands.

Response:

Thank you for your positive comments posted on the NHS website regarding your care on the Maternity Unit, Wards 66 and 47B at Saint Mary's 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 the hard work and dedication of our staff.

The Trust has introduced a behaviour framework called 'Together Care Matters' within which all members of the midwifery and medical teams practice so it was reassuring to read that the medical team and midwives providing care were able to make you and your partner feel supported and cared for. I can assure you that we have passed on your thoughts to the Clinical Head of Division for Obstetrics and Head of Midwifery who will be pleased to share your feedback with the extended Midwifery team.

We appreciate your understanding regarding the waiting times in the Obstetric Triage Department and would like to assure you that the Obstetric management team are undertaking a range of service improvement options to minimise patient waiting times.

May I take this opportunity to wish you and your family well for the future.

Phlebotomy, Altrincham General Hospital

I recently went for my annual blood tests. Due to the new appointment service I literally waited ten minutes before I was seen, however the phlebotomist that took my blood left me with horrific bruising on my arm. It was also very uncomfortable whilst the phlebotomist took the blood. I had had blood work done the day before at Wythenshawe Hospital and never felt a thing and no bruising. I have been having bloods done for 30 years and have never had such bruising.

Response:

Thank you for your feedback. We are sorry to learn that your experience was not as positive as we would hope on your attendance at Altrincham Hospital Phlebotomy Department. It is important to us that comments are shared with staff and seen as an opportunity to make changes and improvements wherever possible to services at the hospital.

The Medical Day Unit Ward Manager explains that bruising can occur due to the nature of the procedure and reactions occur on an individual basis dependent upon many contributing factors which may lead to a person experiencing bruising who has never bruised previously. The Ward Manager has discussed your experience with the phlebotomy staff and reiterated the need to be more understanding of how a patient is feeling when they are having their bloods taken, offer an explanation of what to expect regarding bruising and discomfort, especially if the extraction has been particularly difficult.

11 Meetings with Complainants

11.1 A total of 113 Local Resolution Meetings (LRMs) are recorded as taking place during 2019/20 of which 33 related to WTWA, 31 related to MRI, 10 related to SMH with the remainder being spread relatively evenly across RMCH, CSS, UDHM and MREH. This compares to 96 LRM's held in 2018/19 and represents an increase of 17.7%.

11.2 Meetings are facilitated by the identified Complaints Case Manager and high level summary letters are provided to the complainant with an audio recording of the discussion. This enables the complainant to listen to the recording outside of the meeting so that they can review specific responses or consider any further questions they may wish to raise.

12 Parliamentary and Health Service Ombudsman (PHSO)

12.1 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.

12.2 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.

12.3 The PHSO informed the Trust of the outcome of their investigation of 17 complaints during 2019/20. **Table 20** shows the financial year in which the Trust initially received the complaints which have been closed in 2019/20 following PHSO investigation.

Table 20: Financial year in which the Trust, including legacy organisations, initially received the complaints closed in 2019/20 following PHSO investigation

Year	Number Received
2015/16	0
2016/17	4
2017/18	7
2018/19	6
2019/20	0

12.4 **Table 21** shows the outcome of the PHSO investigation for complaints resolved in 2018/19 and 2019/20.

Table 21: Outcome of PHSO investigations 2018/19 and 2019/20, MFT

	2018/19	2019/20
Fully up-held	1 (2.94%)	1 (5.89%)
Partially up-held	15 (44.11%)	7 (41.17%)
Not up-held or withdrawn	18 (52.95%)	9 (52.94%)

12.5 In summary, 9 cases were not upheld or were withdrawn, 7 cases were partially upheld and 1 case was fully upheld.

12.6 Payment of compensation was advised by the PHSO in 3 of the 17 cases totalling a sum of £1,950. This compares to the payment of £3,000 to 7 complainants in 2018/19 and £850 to complainants in 2017/18.

Table 22 is presented in Appendix 3 and provides details of the PHSO cases resolved in 2019/20 and shows the distribution of PHSO cases across the Hospitals /MCS's and LCO's.

12.7 The Trust had 7 cases under the review of the PHSO at the end of Quarter 4 in 2019/20, however on 31st March 2020, at the time of the evolving COVID-19 pandemic the PHSO made the decision to pause existing complaints that required contact with the NHS. The PHSO is keeping the situation under close review and plans to resume consideration of health service complaints as soon as possible.

13. Complaint Data Analysis and Implementing Learning to Improve Services

13.1 All Hospitals /MCSs and LCO's receive their complaint data via automated reports produced by the Ulysses Customer Services Module. Hospitals/ MCSs and LCO's 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 /MCSs and LCO's 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 2019/20. All of these examples have been published in the quarterly Board of Directors Complaints Reports during 2019/20.

13.2 Manchester Royal Infirmary

Manchester Royal Infirmary (MRI)	2018 / 19	2019 / 20
Number of Complaints	452	419
Number of PALS Concerns	1671	1531
Number of Re-Opened	117	99
Number Closed in 25 days	70	261
Number Closed Over 41 Days	292	103
Number of Meetings Held	49	31
Top 3 Themes		
Treatment / Procedure – 800		
Communication – 710		
Appointment Delay / Cancellation (Outpatient) – 435		

Division	Complaint and Lessons Learnt
Medicine Q1	Clinical Diagnosis: A complaint was received from a patient raising concerns about the failure to assess and diagnose a spinal fracture in MRI Emergency Department. The patient was discharged from the ED and after review of the CT scans the next day, had a confirmed fracture to the spine and was transferred to Salford Royal Hospital to the specialists in spinal fractures. Findings: There is a clear protocol in place for the assessment and imaging of potential spinal fractures and this was not followed. This is an unusual occurrence and the individuals concerned will be educated about their responsibilities to follow the protocol. Actions: ▪ On-going education of Emergency Department and Radiology staff related to the protocol for spinal imaging.

Outpatient Services Q2	Patient Experience: A patient was transitioned from one drug to a biosimilar drug but felt that after 6 months of using the biosimilar it was not as effective in managing their symptoms. The patient also found there to be delays in arranging their clinic appointment, delay in ordering an ultrasound, and were frustrated in the delay in their telephone messages being returned. They recognised that the service information was out of date on the Trust website. Actions: ▪ The referral management procedure was reviewed to ensure that tests requested are not missed and are acted upon accordingly ▪ The nursing helpline provision and rota was reviewed to ensure that the appropriate staffing levels were in place to provide appropriate care to patients ▪ The rheumatology service details on the Trust website were reviewed and updated to ensure that patients are able to contact the right department regarding their care
MRI (GI Medicine & Surgical Specialties) Q3	Communication: The mother of a deceased patient raised a formal complaint regarding communication. The patient had mild learning disabilities and the patient's mother questioned if, following the patient's death, a Learning Disability Mortality Review (LeDer) been carried out. The patient's mother asked for a copy of the review and the actions taken as a result. As a result of the complaint the following actions were agreed: ▪ A retrospective LeDer review to take place and to include a review of why the patient's learning disability was not originally flagged on the hospital system (which would be the usual process). ▪ Once completed a copy detailing the key findings and planned improvement actions will be shared with the patient's mother.

13.3 Royal Manchester Children's Hospital

Royal Manchester Children's Hospital (RMCH)	2018 / 19	2019 / 2020
Number of Complaints	167	189
Number of PALS Concerns	561	621
Number of Re-Opened	18	22
Number Closed in 25 days	35	81
Number Closed Over 41 Days	78	56
Number of Meetings Held	5	10
Top 3 Themes		
Communication – 304		
Treatment / Procedure – 287		
Appointment Delay / Cancellation (Outpatient) – 234		

Division	Complaint and Lessons Learnt
RMCH Q2	Lack of Care & Patient Dignity: A complaint was received from a patient's mother raising concerns that her son had developed a pressure ulcer during an inpatient admission and that there was a lack of patient dignity whilst he was on the ward. During the child's surgery he had an epidural catheter inserted and on return to the ward he was unable to move his legs normally especially his left leg. To ensure this inability to move his legs was related to his epidural and not any complications, his epidural was stopped and then restarted later once movement had returned. During this time the patient was unable to move himself to relieve any pressure and the patient's increase risk of developing a pressure ulcer should have been recognised on his admission to the ward The patient's mother also complained that on a number of occasions, nursing staff and cleaning staff entered the patient's bed space without announcing themselves and requesting permission to enter. As a result of the complaint and to avoid a similar incident happening in the future the following actions were agreed: ▪ Pressure ulcer risk assessments are reviewed in a timely manner by a senior nurse on each shift checking all risk assessments are completed. ▪ Nursing Staff have received additional education around pressure risk assessments, body maps, care plan and the importance of reassessment with documentation. ▪ Nursing Staff have received additional education on the implications of epidural infusions on the child's skin integrity and the information that is given to both the child and family. ▪ This case has been discussed at the Harm Free Care meeting and any other learning identified. ▪ Ward Manager has shared complainant's privacy and dignity concerns with ward team, at the staff huddle, so that they can realise how their behaviour affects patients and their families.

13.4 Wythenshawe, Trafford, Withington and Altrincham (WTWA)

Wythenshawe, Trafford, Withington and Altrincham (WTWA)	2018 / 19	2019 / 2020
Number of Complaints	442	515
Number of PALS Concerns	1901	1920
Number of Re-Opened	112	104
Number Closed in 25 days	148	377
Number Closed Over 41 Days	257	94
Number of Meetings Held	18	33
Top 3 Themes		
Communication – 959		
Treatment / Procedure – 947		
Appointment Delay / Cancellation (Outpatient) – 649		

Division	Complaint and Lessons Learnt
WTWA (Heart & Lung) Q1	Poor nursing care in relation to pain management : A patient complained following admission for surgery. Although, the patient's surgery was performed successfully the patient raised concerns regarding the general nursing care he received. The patient explained that he had found a member of staff to be rude and unhelpful, alongside displaying a general lack of knowledge regarding various analgesics. Despite being given the standard analgesia of paracetamol and codeine his pain had not resolved. The patient was told that he could not be prescribed strong analgesia as this would prevent him from being discharged the following morning. However, on discharge he noted that he had been prescribed such analgesia as part of his take home medications. Findings ▪ Poor communication from nursing staff. ▪ Unprofessional and uncaring attitude of nursing staff ▪ Lack of knowledge of the Trust's Medication Policy Actions ▪ The anonymised complaint and the patient experience were shared with the member of staff the complaint related to for reflection. ▪ Education regarding pain assessment, reviewing patient responses to analgesia and the correct escalation process to be delivered to all nursing staff on the Ward. ▪ Nursing staff to be familiar with the Trust's Medication Policy and ensure that all medication charts are reviewed for each patient during medication rounds.

WTWA (Surgery) Q2	Communication, Capacity: A patient's daughter raised concerns about the care her father received on one of the surgical wards. The patient lacked mental capacity to make decisions about his care and treatment and often did not verbally communicate. The patient regularly declined care, food and fluids The patient's daughter was concerned that staff did not interact with her sufficiently to understand her father's needs. Concerns were also raised about her father experiencing incontinence during his admission. Actions: As a direct result of the complaint investigation, the following actions were identified: ▪ The Ward Manager used the themes from the complaint at ward meetings to raise the importance of effective communication with families, and the importance of recording conversations and care delivered or declined by the patient with family members and ensure staff are up to date with mental capacity assessments and communication with patients who lack capacity ▪ The Ward Manager will undertake 'Reach Out to Me' compliance audits and raise awareness amongst staff of the benefits of using the document.
WTWA (Medicine) Q3	Patient Experience: The patient's wife raised concerns regarding her husband's nutritional needs not being met during his stay in hospital and staff not following Speech and Language Therapy (SALT) guidelines. As a result of the complaint the following actions were agreed: ▪ Food ordering process changed in line with Hospital's process. ▪ Raising awareness of new food order process. ▪ SALT training provided to all nursing staff. ▪ Chef employed to ensure continuity of service within the kitchen team.

13.5 Saint Mary's Hospital (SMH)

Saint Mary's Hospital (SMH)	2018 / 19	2019 / 2020
Number of Complaints	190	194
Number of PALS Concerns	467	526
Number of Re-Opened	45	49
Number Closed in 25 days	51	149
Number Closed Over 41 Days	95	35
Number of Meetings Held	11	10
Top 3 Themes		
Treatment / Procedure – 294		
Communication – 254		
Appointment Delay / Cancellation (Outpatient) - 155		

Division	Complaint and Lessons Learnt
SMH **(Gynae)** **Q4**	Importance of honest and open communication: A range of complaints received during this quarter have demonstrated the need for clear, honest communication. A patient raised concern regarding delayed communication with the Outpatient Administration team causing upset and frustration. The patient was concerned regarding the lengthy wait, poor communication, and lack of transparency and openness experienced, which resulted in the patient opting to have the procedure undertaken privately. A further patient reported staff were not answering the phones and raised concern about the lack of communication. An additional patient raised concern as to why she had not been provided during the consultation with a realistic waiting time. The waiting time was reported to be 8 to 10 weeks'; however a delay of a further 4/6 weeks was experienced resulting in a 14 week waiting time. As a result of the complaint the following actions were agreed: ▪ A Gynaecology Special Measures Oversight group has been established, which will meet weekly to scrutinise and review data analysis of Referral to Treatment (RTT) times and Cancer performance. ▪ An experienced Gynaecology Service Manager has been seconded to provide support to the Administration and Clerical teams in a series of changes to work streams. This will allow improvement in the efficiency and effectiveness of patient appointment organisation and introduce changes to the management of telephone lines and timely responses in returning of calls.

13.6 Clinical & Scientific Services (CSS)

Clinical & Scientific Services (CSS)	2018 / 19	2019 / 2020
Number of Complaints	82	103
Number of PALS Concerns	277	335
Number of Re-Opened	2	22
Number Closed in 25 days	27	79
Number Closed Over 41 Days	32	18
Number of Meetings Held	5	6
Top 3 Themes		
Clinical Assessment (Diagnosis / Scan) – 237		
Communication – 196		
Treatment / Procedure – 164		

Division	Complaint and Lessons Learnt
CSS (Radiology) Q2	Dignity and Care, Open and Honest: A patient complained that the radiology service had failed to x-ray them on two occasions on the same day, delaying their care, and failing to consider their welfare throughout. Actions: ▪ The patient's experience was shared with the ward manager for the Acute Medical Assessment Unit so that both radiology and the Acute Medical Assessment Unit staff understand why an initial physiotherapy assessment is important and why directly referring patients to radiology is not appropriate for patients who are attending for more complex imaging. ▪ A pro-forma has been developed and introduced which will be completed prior to all patients requiring plain film x-rays in the standing position being sent to radiology. This will ensure that both the referring ward and radiology are happy that the physiotherapy assessment has been undertaken where relevant and that there are sufficient experienced staff available to support the patient on arrival. ▪ Dedicated appointment slots will be identified in radiology so that patients arriving for plain film x-rays in the standing position can attend when the Radiology Department is quieter and when there are sufficient staff on duty to ensure that the patient is well supported prior to, during and after the x-ray examination.

CSS (Anaesthetics) Q4	Patient Experience: Two patients separately raised concern regarding the change in the booking of appointments in the Pain Clinic. They complained that the Pain Clinic Nurses were no longer able to schedule each of their treatments manually, every four weeks, and that as a result of the introduction of the new electronic system, a number of appointments had been inadvertently cancelled. It was reported that the patients felt the transferring of the appointments on to an electronic booking system to streamline the process brought more harm than good and their "preferences" were no longer being considered. As a result of the complaint the following actions were agreed: ▪ The electronic booking system remains in use in the Pain Clinic; however this is now managed by the Pain Clinic Nurses who are fully aware when the patient's next treatments are due. This will allow patients' preferences to be accommodated and fit in around their social and work life. ▪ Patients receive appointment notifications/reminders via telephone and text message.

13.7 University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)

University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)	2018 / 19	2019 / 2020
Number of Complaints	115	96
Number of PALS Concerns	528	581
Number of Re-Opened	22	13
Number Closed in 25 days	51	78
Number Closed Over 41 Days	33	6
Number of Meetings Held	6	5
Top 3 Themes		
Appointment Delay / Cancellation (Outpatient) - 291		
Communication - 200		
Treatment / Procedure - 182		

Division	Complaint and Lessons Learnt
UDHM Q3	Patient Experience: The patient's daughter complained regarding her mother's regular attendances in the Oral Maxillofacial Surgical Department. She raised concerns as each appointment attended with her mother was between 2- 3 hours behind the given appointment times and no consideration was given to patients for their discomfort, pain or inconvenience during these waits. She was also concerned that patients were asked to attend 15 minutes before their appointment time which also added to the waiting time. As a result of the complaint the following actions were agreed: ▪ Assign a Waiting Times Champion who will ensure that patients and the reception staff are always aware of any delays ▪ Provide feedback from the patient to the Outpatient Letter Improvement Board ▪ Explore options for drinking water to be available to patients at all times during clinics
MREH Q1	Outpatient Appointment Waiting Time, cursory examination and staff attitude A parent of a patient wrote to complaint about his attendance in clinic when he came to a hospital appointment to support his son who suffers from the eye condition Keratoconus. Specifically the parent complained about: 1. They experienced a three hour wait in clinic 2. The patient was tested for a comparison eye test following his last appointment, and was back from the test within a few minutes. The patient's parent felt this was a cursory eye test at best. The patient was then tested for any degeneration against his previous visit, and then was seen by the Consultant. The patient was told there was no further degeneration, and asked the Consultant if there was anything that could be done to improve his vision. The consultant replied 'No, nothing really'. The patient's father complained about the general apathy and lack of interest which he found disturbing. Findings ▪ The consultant had perceived to show a lack of interest in the patient's condition

	▪ The patient had attended at 3:00pm for a 3:15pm outpatient appointment, and eventually left the hospital at 5:50pm. Actions ▪ An Outpatient Improvement Board has now been established to review existing processes and consider improvements that can be made to provide a more effective support to patients ▪ The doctor who saw the patient apologised that he did not show an interest in the patient's condition. ▪ Staff are to be reminded to offer pagers to patients to enable patients to leave the clinic for refreshments, if their appointments are delayed ▪ In response to the complaint response letter the patient's parent wrote to thank the Outpatients team for all their efforts.

13.8 Research & Innovation (R&I)

Research & Innovation (R&I)	2018 / 19	2019 / 2020
Number of Complaints	2	0
Number of PALS Concerns	18	15
Number of Re-Opened	0	0
Number Closed in 25 days	1	0
Number Closed Over 41 Days	0	0
Number of Meetings Held	0	0
Top 3 Themes		
Treatment / Procedure - 4		
Communication - 4		
Appointment Delay / Cancellation (Outpatient) - 4		

13.9 Corporate Services

Corporate Services	2018 / 19	2019 / 20
Number of Complaints	91	68
Number of PALS Concerns	214	298
Number of Re-Opened	15	13
Number Closed in 25 days	39	25
Number Closed Over 41 Days	24	23
Number of Meetings Held	2	2
Top 3 Themes		
Infrastructure (Staffing & Environment) - 165		
Communication – 131		
Documentation (Records / Identification) - 51		
Facilities - 51		

13.10 Manchester and Trafford Local Care Organisation (LCO)

LCO	2018 / 19	2019 / 2020
Number of Complaints	27	44
Number of PALS Concerns	25	52
Number of Re-Opened	3	9
Number Closed in 25 days	3	15
Number Closed Over 41 Days	9	14
Number of Meetings Held	0	3
Top 3 Themes		
Communication – 38		
Treatment / Procedure – 30		
Appointment Delay / Cancellation (Outpatient) - 21		

Division	Complaint and Lessons Learnt
MLCO (Central) Q3	**Patient Experience** A patient was referred to the Macmillan Team for advanced care planning by their GP who advised the patient that the Macmillan Team would undertake their blood tests. The GP was not aware that members of the Macmillan Team did not have venepuncture training/skills and were unable to take blood. This led to frustration for the patient and resulted in the patient's son making a formal complaint. The patient's son also felt that the seriousness of the patient's diagnosis was not explained properly to him whilst attending hospital appointments. As a result of the complaint the following actions were agreed: ▪ All clinical members of the Macmillan Team to undertake venepuncture training. ▪ A daily huddle has been introduced with representation from the District Nursing Team, Macmillan Team and medical consultant input to discuss individual patient care. An invite is extended to GPs. ▪ Weekly Specialist Palliative Care Multidisciplinary Team meetings are held with the Hospital Palliative Care Team which increases awareness of admission/discharge planning issues for patients and their families. ▪ Continuing Healthcare training is in place for all Community Macmillan Nurses.

13.11 Non-MFT

Non-MFT	2018 / 19	2019 / 2020
Number of Complaints	5	0
Number of PALS Concerns	243	18
Number of Re-Opened	2	0
Number Closed in 25 days	1	0
Number Closed Over 41 Days	4	0
Number of Meetings Held	N/A	N/A
Top 3 Themes		
Treatment / Procedure – 69		
Communication – 50		
Clinical Assessment (Diagnosis / Scan) - 41		

14. Complaint Satisfaction Survey

14.1 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 1,560 MFT complainants following closure of their complaints during 2019/20, with a response rate of 11.15%.

14.2 Whilst 82.4% of complainant survey respondents indicated they were aware of their single point of contact at the Trust if they had any questions during the complaint process, only 61.90% of respondents felt the main points of their complaint were summarised correctly.

14.3 Additionally, only 42.86% of complainants felt confident that their future care would not be negatively affected by making a complaint and only 26.32% of complainants were satisfied with the outcome of their complaint, with a further 36.84% of complainants being satisfied, to some extent.

14.4 These results indicate a need to make further improvements to complaint handling, including more personalised acknowledgement of new complaints as well as continuing to improve the quality of investigations and responses.

Comments received from complainant include the following:

- PALS is an exceptional service. They take your complaint very seriously and investigate and address all your concerns. They are professional at all times. I was truly grateful for all their help.
- Initial response deadlines were not met, although I did receive apologies regarding this.
- I have answered this form in terms of the formal complaint I raised. Had these been addressed earlier, the timely and costly (for NHS) process of formal complaint would have been avoided.
- Some responsibility for my experience was acknowledged and accepted in part by the individual. I was pleased some recommendations were made and I hope what I experienced is not repeated.
- Had conflicting information, didn't feel like their senior people responding had communicated.
- The doctor looking after me at my next appointment properly explained things instead of brushing things and rushing the appointment.
- I felt the response was quite defensive and not appreciate of the emotional impact.
- The improvements that were to be made showed that there was a genuine care for mistakes or negligence could be prevented. This was really reassuring and most satisfactory solution.
- Failings were identified, agreed upon and action taken.
- It felt as if my complaint was undermined. Felt as if the same reasons were given and my points not addressed correctly.
- I felt subsequent visits were more keenly observed.
- This was the second attempt and it worked well, this time round, compared to the first.

[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

15. Work Programme 2019/20 - Update

15.1 In 2019/20 the Patient Services Team committed to a number of work-streams, a progress update on each of the work-streams is detailed below:

- **Relocation of PALS office at Wythenshawe Hospital**

  During Quarter 1, 2019/20 work started on the design phase to relocate the PALS office to a new, central more visible location within Wythenshawe Hospital. Work commenced in March 2019 and hand over of the new facility took place at the end of June 2019.

  The new PALS facility will enable members of the public to make enquiries and book appointments to see a PALS Case Worker or Case Manager.

  Picture 1: Newly built PALS Reception and Office at Wythenshawe Hospital, Entrance 5, opened July 2019

- **Education**

  During Quarter 1 and Quarter 3 of 2019/20 educational sessions were facilitated by The Parliamentary and Health Service Ombudsman (PHSO) to support staff members' understanding of their role and development work. The PHSO also provided an educational session to the Matrons participating in the Trust's Making Matrons Matter Leadership Programme.

Image 1: Trust Flyer promoting PHSO Educational Sessions

During Quarter 2, 2019/20 the Head of Customer Services facilitated educational sessions for the Trust's transplant middle-grade doctors and Safeguarding Team.

During Quarter 4, 2019/20 the PALS Manager also facilitated an educational session as part of the Band 7 Development Programme at Wythenshawe Hospital.

- **In-house Complaints Letter Writing Training Package**

  In order to support and develop skills in staff who manage complaints, this year the introduction to Complaint Response Writing training package was developed. Full roll out of this newly developed training package was planned for Q4, 2019/20 with the first training course to take place at Wythenshawe Hospital in March 2020; however, as a result of the COVID-19 pandemic and in order to reduce transmission of Coronavirus the training courses were temporarily paused.

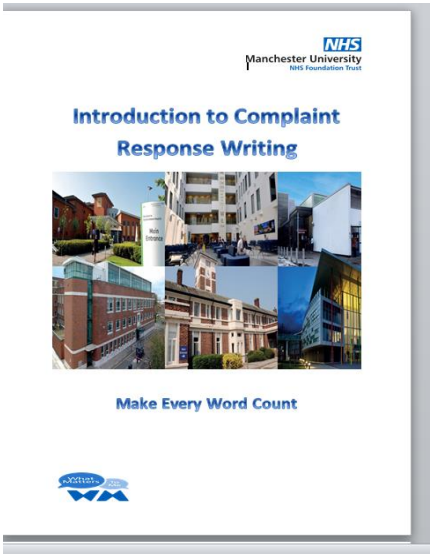


Image 2: Trust's In-house Complaints Letter Writing Training Package

- **In-house Customer Service e-learning package**

  During 2019/20 work commenced on the development of an e-learning Customer Service package tailored specifically to meet the needs of the Trust. Completion of the newly developed e-learning package had been planned for Q1, 2020/21; however due to the COVID-19 pandemic the development has been temporarily paused and will now be completed in Q2 of 2020/21.

- **'Tell us Today' Audit**

  '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.

  'Tell us Today' is aligned with the 'What Matters to Me' Patient Experience Programme. Only 6 calls were recorded on the system in 2019/20, compared to 3 in 2018/19. The low number of recorded calls does not reflect of the frequency with which clinical staff report that they respond to concerns from patients, relatives and carers at departmental level; therefore suggesting that this is a recording issue.

  In view of the continued exceptionally low numbers recorded, an audit to evaluate the 'Tell us Today' service was undertaken during Quarter 1, 2019/20. The results detailed below are a summary of 70 responses from a mixture of staff and service users:

  Staff Results:
  - 6 staff at Trafford General Hospital (TGH) were aware of the 'Tell us Today' Service and were aware what it is used for and where they could find information about the service.
  - 0 staff at MRI and Wythenshawe were aware of the 'Tell us Today' Service.

  Service User Results:

- 3 service users (patients, carers, relatives) at Wythenshawe were aware of and understood the function of the 'Tell us Today' Service.
- 0 of the service users at MRI and TGH were aware of the 'Tell us Today' Service, and did not understand the function of the 'Tell us Today' service or where to find information about the service.
- None of the service users had used the 'Tell us Today' Service.

It was clear from the audit there was a necessity to communicate the 'Tell us Today' service to staff and service users, therefore during 2019/20 the 'Tell us Today' Service was promoted by the PALS Manager engaging with the senior nursing/midwifery teams in the Hospitals/ MCS / LCOs.

The process for handling and recording of ward and department level concerns will be reviewed during 2020/21.

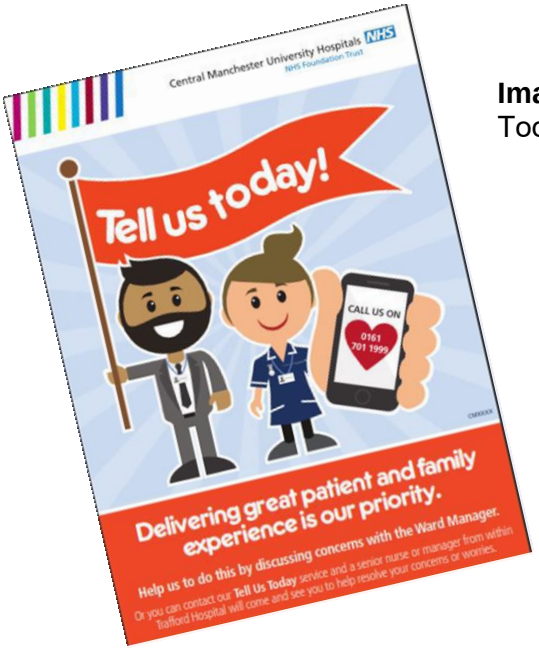


Image 3: Trust's poster promoting 'Tell us Today'

- **MFT Compliments, Concerns and Complaints Policy (2019)**

The MFT Compliments, Concerns and Complaints 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 3, 2019/20 a revision to the Policy was made with the inclusion of new Guidance for the Management of Concerns and Complaints by Children and Young People.

- **PHSO Research – Frontline Complaint Handling – 'Complaints Standards Framework'**

  During Q1, 2019/20 the PHSO commenced their research to inform an insight publication on Frontline Complaint Handling in the NHS and Government Departments and plan for their research to directly support their work in their development of a 'Complaints Standards Framework'. The aim of the Framework is to set out a unified vision of best practice in complaint handling for the NHS and social care.

  In support of this work, the Trust accepted the PHSO's request to participate in their research and during Q2, 2019/20 participated specifically in research interviews, exploring the common themes identified in complaint handling.

  Picture 2: (L to R): PALS Case Manager, pictured with a staff member from the Parliamentary and Health Service Ombudsman

- **National Customer Service Week**

  During Quarter 3, 2019/20 the PALS and Complaints team celebrated the importance of customer service and that of the staff who care and support its patients, relatives and carers on a daily basis.

  Promotional stands were set up across Hospital sites raising awareness of customer service and the vital role it plays in delivery a good patient experience.

Picture 3: Complaints Case Manager promoting National Customer Service Week

- **Complaint Quality Audit and Analysis Tool**

  Following the sharing of the Complaint Quality Audit and Analysis Tool to all Hospitals/ MCSs and LCO the Corporate Complaints team supported CSS colleagues to undertake an audit of 20 complaint cases. CSS subsequently used the learning from the audit to improve the investigation and response to complaints.

- **Staff Support**

  During Quarter 1, 2019/20 Helplines Partnership facilitated sessions to the PALS and Complaints team. Helplines Partnership is the membership body for organisations that provide information, support or advice via telephone, email or online and supports organisations that provide non-face to face advice and support.

  The sessions focused on 'Understanding Vicarious Trauma (VT) and provided the PALS and Complaints staff with the knowledge and skills to identify the impact of VT, self-reflection in relation to practice and self-care techniques, along with an understanding of what support is available.

Image 4: Helplines Partnership Logo

  In order to continue to provide health and wellbeing support to the PALS and Complaints team, during Quarter 4, 2019/20 consideration to the provision of bespoke psychological training sessions was underway with the Trust's Employee Health and Wellbeing Service; however again, as a result of the COVID-19 pandemic and its impact on NHS work, this work was temporarily paused in March 2020. The planning of these bespoke sessions will be kept under close review and will resume as soon as it is feasible to do so.

- **Communications – External and Internal**

  In view of the NHS Improvement (NHSI) Patient Experience Improvement Framework (2018) recommendation of complaints information being clearly displayed on Trust websites and available in two clicks; during Quarter 3, 2019/20 a full review of the PALS and Complaints resources available on the Trust's website was undertaken. Whilst it is recognised there are good levels of accessibility on the website, continuous improvement is always fundamental and modifications are planned to the 'PALS and Complaints' section throughout 2020/21.

  In addition to the Trust's continued approach to make MFT's website more accessible the Head of Customer Services will be working closely with the Trust's Inclusion Programme Manager throughout 2020/21 creating a short British Sign Language video replicating the 'PALS and Complaints' section.

  Furthermore as part of the Trust's on-going work migrating departmental information further updates to the 'PALS and Complaints' section on the Trust's recently developed intranet site will continue during 2020/21.

- **Equality Delivery System (EDS)**

  The EDS is designed to help local NHS Organisations in reviewing and improving performance for patients, communities and staff in respect to all characteristics protected by the Equality Act 2010.

  This year the focus for the EDS was 'Improved patient access, safety and experience'

with a specific focus on ‘when people use Trust services, they are free from harm’.

Below is a summary of some of the excellent work undertaken by the PALS and Complaints team during 2019/20, which contributed to the Trust’s rating of green for the EDS, which reflects, a benchmark of ‘achieving’.

- Completion of Safeguarding training
- Lessons learnt patient stories from complaints/compliments
- Recruitment process, e.g. Disclosure and Barring Service (DBS)
- Content in Quarterly and Annual Reports

- **Standard Operating Procedures**

In order to ensure the Trust maintains compliance with the NHS Complaints Regulations (2009) review of the PALS and Complaints Standard Operating Procedures (SOPs) continued throughout 2019/20. SOPs which have been updated this year include:

- Process for handling Red complaints
- Process for requesting extension to response timescale

16. Work Programme 2020/21

16.1 The PALS and Complaints team key priorities for 2019/20 include:

- **Complaints Process:**
  Continue to work with the Hospitals/ MCS and LCO teams to improve responsiveness to complaints and the processes by which they are managed, making the necessary changes, in line with national recommendations.

- **Complaints Training:**
  Continue to offer training to staff and implement a programme of training sessions on complaints management. This will include the implementation of the evolving Customer Service e-learning package and delivery of the newly developed in-house Complaints Response Writing training package.

- **Improved Reporting**
  Continuing to improve the quality and accuracy of the equality monitoring data, and complaint themes throughout 2020/21, with on-going emphasis on the importance of reporting consistent and accurate information.

- **Supporting Staff**
  Continue to support PALS and Complaints Case Managers through the development and implementation of bespoke supervisory sessions.

- **Communication enhancement**
  Continue to improve and enhance the Trust's PALS and Complaints information available on the Trust's external and internal websites.

- **Learning from the COVID-19 pandemic**
  - Digital Access/Technology – MFT is committed to continually providing its service users with new solutions and will implement in early 2020/21 the use of a virtual platform in which complaint local resolution meetings can be offered and held.

  - Connecting hospital patients with their families – The launch of the Trust's temporary Family Liaison Team during the national pandemic played a vital role by providing companionship and connecting hospital patients with their families virtually. Work is planned to commence exploring the long-term accessibility of this model within the PALS along with different ways in which patients could be supported virtually.

  - 'Paper light'- Increase and maintain the 'paper-light' system of working using electronic systems and capabilities of the Trust's Customer Services database Ulysses.

17. Conclusion and Recommendation

17.1 During this year a great deal of work has taken place to improve the timeliness of complaint responses and reduce the number of re-opened complaints; there has been an overall improvement as a result, however, there remains opportunity for further improvement.

17.2 Complaint timeframes, progress of the number of all cases over 41 working days and re-opened complaints will continue to be closely monitored, always seeking positive performance and improvement, with performance continuing to be monitored at a Group level via the Accountability Oversight Framework (AOF).

17.3 The three primary themes of dissatisfaction remain largely the same as 2018/19, with the most common being Treatment/Procedure, Communication, and Clinical Assessment. However, the actions outlined in this report demonstrate that complaints received by the Trust are acted upon and are used to inform pieces of work aimed at improving the patient's experience. Analysis of the complaint themes and trends will continue to be closely monitored at a Group Level via local Governance Forums.

17.4 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 In-house Complaints Letter Writing Training and e-learning Package will be utilised to inform the delivery of education and training to enhance the Trust's customer service and support continual improvement to the quality of complaint responses during 2020/21. Bespoke complaints and PALS training will continue to be delivered across the Trust improving outcome and understanding.

17.5 The Trust is grateful to those patients and families who have taken the time to raise their concerns and complaints and acknowledges their contribution to improving services, patient experience and patient safety.

17.6 The Board of Directors is asked to note the content of this report, the work undertaken by the Corporate and Hospitals/MCS and LCO 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	2018/19	2019/20
Email	2087	2462
Face to Face	583	472
Complaints	2	0
Family Support	1	0
PALS	4	1
Letter	68	55
MP	2	0
Other	6	9
Telephone	3144	2892
Tell us Today	8	6
Totals	**5905**	**5897**

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	2018/19	2019/20
0 – 18	1118	1092
19 – 29	583	578
30 - 39	752	767
40 - 49	668	640
50 – 59	884	826
60 – 69	687	753
70 – 79	724	737
80 – 89	394	413
90 – 99	92	87
100+	3	4
Totals	**5905**	**5897**

Table 6 details the number of contacts by sex; again the sex relates to the people who were the focus of the PALS concern.

	2018 / 19		2019/20	
Sex	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	3257	55.15%	3309	56.11%
Male	2571	43.53%	2546	43.17%
Not Specified	1	0.04%	3	0.05%
Other	76	1.28%	39	0.67%
Total	**5905**		**5897**	

Table 7 describes the ethnicity of the patients who were the focus of the PALS enquiry.

Category	**2018/19**	**2019/20**
Any Other Ethnic Group	44	58
Asian or Asian British - Bangladeshi	7	9
Asian or Asian British - Indian	33	44
Asian or Asian British - Other Asian	31	34
Asian or Asian British - Pakistani	65	106
Black or Black British - African	32	62
Black or Black British - Caribbean	27	46
Black or Black British - Other Black	14	22
Chinese Or Other Ethnic Group - Chinese	8	12
Mixed - Other Mixed	15	15
Mixed - White & Asian	4	15
Mixed - White & Black African	4	11
Mixed - White & Black Caribbean	47	56
White - British	1871	2053
White - Irish	50	64
White - Other White	58	86
Do Not Wish to Answer	437	376
Not Stated	3158	2828
Totals	**5905**	**5897**

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	2018/19	2019/20
Not Stated / Other	1	0
White	0	0
Green	60	49
Yellow	807	903
Amber	691	670
Red	14	6
Totals	**1573**	**1628**

Table 12: Age range of person who was the subject of the complaint

Age Range	2018/19	2019/20
0 - 18	471	384
19 - 29	138	159
30 - 39	187	222
40 - 49	165	172
50 - 59	159	186
60 - 69	154	184
70 - 79	176	178
80 - 89	96	109
90 - 99	26	34
100+	1	0
Totals	**1573**	**1628**

Table 13: Sex of person who was the subject of the complaint

	2018 / 19		2019/20	
Sex	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	880	55.9%	907	55.7%
Male	642	40.8%	706	43.4%
Not Specified	50	3.2%	13	0.8%
Other	1	0.1%	2	0.1%
Total	**1573**		**1628**	

Table 14: Ethnicity of the person who was the subject of the complaint

Category	2018/19	2019/20
Any Other Ethnic Group	12	13
Asian or Asian British - Bangladeshi	1	8
Asian or Asian British - Indian	7	16
Asian or Asian British - Other Asian	6	15
Asian or Asian British - Pakistani	29	38
Black or Black British - African	8	31
Black or Black British - Caribbean	10	14
Black or Black British - Other Black	7	8
Chinese Or Other Ethnic Group - Chinese	0	4
Mixed - Other Mixed	3	1
Mixed - White & Asian	6	9
Mixed - White & Black African	2	5
Mixed - White & Black Caribbean	11	14
White - British	445	712
White - Irish	10	25
White - Other White	9	42
Do Not Wish to Answer	0	327
Not Stated	1007	346
Totals	**1573**	**1628**

Appendix 3

Table 22: Complaints closed between 1st April 2019 and 31st March 2020 following PHSO investigation

Hospitals/MCS /LCO	Outcome	Date complaint initially received by the Trust	PHSO Rationale/Decision	Recommendations
Quarter 1				
MRI (Medicine)	Partly Upheld	August 2019	Failings in incident reporting	Retrospective completion of incident report. Written formal apology and explanation of what actions have been taken to address the failings identified in the report.
WTWA (Surgery)	Upheld	July 2017	Failings in care, treatment and communication	Conduct a thorough investigation into the reasons why the serious failings identified in the report occurred. Explain what actions have been taken to address the failings identified in the report. Financial remedy to be explored via NHS Resolution. Provide evidence of the root cause analysis and action plan.
MRI (Surgery)	Partly Upheld	December 2018	Failings in discharge process	Develop an action plan outlining lessons learnt. Explain what actions have been taken to address the failings identified in the report.
Quarter 2				
WTWA (Medicine)	Partly Upheld	July 2018	Failing in commencing treatment	Provide a full acknowledgement and apology for the distress and failings identified in the report.

				Explain what actions have been taken to address the failing identified in the report. Financial redress of £700 to be awarded.
RMCH	Not Upheld	22/11/18	No failings found	None
RMCH	Partly Upheld	12/03/19	Failings in a joint approach resulting in failings in communication	Financial redress of £500 to be awarded.
SMH + CSS	Not Upheld	29/01/19	No failings found	None
WTWA (Heart & Lung)	Partly Upheld	29/08/19	Failure to arrange treatment within a timely manner	Provide an apology for the failing identified in the report.
MRI (Medicine)	Not Upheld	14/02/19	No failings found	None
CSS	Not Upheld	14/02/19	No failings found	None
WTWA (Medicine) + WTWA (Surgery) + CSS	Not Upheld	07/03/19	No failings found	None
WTWA (Medicine)	Not Upheld	27/06/19	No failings found	None
Quarter 3				
WTWA (Medicine)	Not Upheld	16/04/18	No failings found	None
Quarter 4				
WTWA (Heart & Lung)	Partly Upheld	11/11/16	Failing to provide appropriate care needs Failure to be open and honest	Provide a full acknowledgement and an apology for the impact and failings identified in the report. Provide assurance of lessons learnt. Explain what actions have been taken to address the failing identified in the report.
WTWA (Surgery)	Partly Upheld	05/10/17	Failure to diagnose within a timely manner	Provide a full acknowledgement of the failings identified in the report.

				Financial redress of £750 to be rewarded.
WTWA (Surgery)	Not Upheld	01/02/18	No failings found	None
SMH	Not Upheld	13/03/18	No failings found	None

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse and Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse and Clinical Director of Infection Prevention and Control
Date of paper:	June 2020
Subject:	Annual Infection Prevention and Control Report 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Experience Staff and Patient Safety
Recommendations:	The Board of Directors are asked to receive the Annual Report for April 2019 to March 2020 and approve for publication
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse and Clinical Director of Infection Prevention and Control Tel: 0161 276 4042

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control (IPC) Annual Report 2019/2020

1. Executive Summary

1.1 The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details Infection Prevention and Control activity from April 2019 to March 2020 outlining our key achievements and an assessment of performance against national targets for the year.

1.2 This year has been one of exceptional challenges beginning with a national outbreak of *Listeria monocytogenes* that occurred in April 2019 involving nine in-patients in total across several hospitals in England including two people who were cared for at the Manchester Royal Infirmary. In the final quarter of 2020, the Trust united in action to respond to the COVID-19 pandemic. In both instances the trust has demonstrated a timely and unified response to protect patients and staff.

1.3 The Trust has maintained the standards of Infection Prevention and Control and a zero tolerance to Healthcare Associated Infections (HCAI) as confirmed in the contents of this report.

1.4 Professor Cheryl Lenney, Chief Nurse, is the designated to the post of Director of Infection Prevention and Control (DIPC) for MFT and Chaired the Group Infection Control Committee (GICC).

2. Key Achievements and Challenges

2.1 The Wythenshawe Hospital Microbiology Laboratory was transferred and integrated to the Oxford Road Campus (ORC) in August 2019 and the Clinical Microbiology Teams are in the process of integration at the time of writing this report.

2.2 The Infection Prevention and Control/Tissue Viability (IPC/TV) Nursing Team was integrated in April 2019. In January 2020 the Team expanded to welcome the IPC and TV Teams from Trafford Local Care Organisation (TLCO).

2.3 The Trust IPC/TV Nursing Team provided IPC advice and Guidance to St Ann's Hospice across the three North West Hospice sites: The Neil Cliffe Centre (based at Wythenshawe Hospital), Heald Green, and Little Hulton through a Service Level Agreement (SLA).

2.4 There were eight Trust-attributable Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases (four in MRI, two in CSS and two in Wythenshawe Hospital), reported to Public Health England (PHE) during 2019/2020, and six community-attributable cases reported. This was a reduction from 2018/19 when there were 10 Trust-attributable bacteraemia reported. All incidents of MRSA bacteraemia were investigated, reviewed locally and actioned as appropriate supported by the IPC Team.

2.5 A total of 194 *Clostridium difficile* infection (CDI) cases were reported during 2019/2020: 145 (74.7%) of which were trust-attributable against a trajectory of 173. Following monthly external case reviews, there were 24 lapses in care identified. Due to the pandemic 47 cases between January and March 2020 were not reviewed by the Clinical Commissioning Group (CCG). Advice from PHE was that these cases be recorded as unknown.

2.6 In November 2016, the Department of Health announced ambitions to halve the number of GNBSI by 2020/21. This objective was amended in January 2019 to a 25% reduction by April 2022 and a 50% reduction by April 2024. The threshold for GNBSI was set at 228 for 2019/2020 which was based on a 15% reduction to achieve the national reduction objective. The Trust exceeded the threshold by 20%.

2.7 All incidents of Catheter Associated Urinary Tract Infection **(**CAUTI) that occurred in patients across MFT were monitored, investigated and reviewed at Hospital/MCS Harm Free Care meetings. Lessons learned and actions were incorporated into local Infection Control work plans. Actions to reduce incidents of CAUTI included; a review of the Adult Urinary Catheterisation and Catheter Care Policy, Urinary Catheter Care Integrated Care Pathway (ICP) and catheter Passport and standardising catheter fixation devices and catheter bags supported by ward based training on appropriate usage.

2.8 A total of 30 Vancomycin-resistant Enterococci VRE bacteraemia were reported during 2019/2020. This compares to 27 reported during the previous year: an 11% increase. The majority of incidents were spread in time and location across the organisation. Individual incidents of VRE bacteraemia were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings.

2.9 The Healthcare Associated Infection (HCAI) objectives compared to the Shelford Group demonstrated that the Trust performance was rated; seventh for MRSA bacteraemia; third for CDI, second for GNBSI and seventh for Meticillin-sensitive *Staphylococcus aureus* (MSSA)

2.10 The Trust has experienced an on-going Carbapenemase producing Enterobacteriaceae (CPE) outbreak since 2009 with *Klebsiella pneumonia* as the most frequently isolated organism.The mean number of monthly CPE acquisitions during 2019/2020 was 27**,** compared to an average of 31 cases per month in 2018/2019. This represents a 12% reduction.

2.11 The Trust is at the forefront of developing the evidence base for the management and control of patients with CPE. This is reflected in the research published over the past 12 months by members of the IPC team (Professor Cheryl Lenney, Chief Nurse/DIPC; Dr Andrew Dodgson, Consultant Microbiologist, Infection Control Doctor (ORC) and Head of Service; Mrs Julie Cawthorne, Assistant Chief Nurse, IPC/TV /Clinical DIPC; Dr Ryan George, Senior Surveillance Officer, IPC/TV).

2.12 The Trust Surgical Site Infection **(**SSI) programme was led by the Trust Clinical Lead for SSI Professor Ferdinand Serracino-Inglot and reported to the Trust GICC. The IPC/ TV team seconded a nurse to support the programme. As a result of the secondment of the Trust was able to extend SSI surveillance to include two additional surgical specialities in the national Surgical Site Infection Surveillance Service. In addition, the SSI nurse reviewed the data collection submitted for Orthopaedic and Cardiac surgery. Findings identified under reporting of data in both specialities. This issue will be addressed prior to the resumption of the SSI programme which was suspended due to the pandemic

2.13 The Trust participated in the National Getting it Right First Time (GIRFT) audit between May 2019 and October 2019, led by Professor Ferdinand Serracino-Inglot, 12 out of the 13 assigned specialities took part. The denominator data was submitted in December 2019. The Trust's results have been received and are currently being reviewed.

2.14 A national outbreak of *Listeria monocytogenes* occurred in April 2019 involving nine in-patients in total across several hospitals in England. Two of these were treated at the MRI. In accordance with national reporting the Trust notified the Greater Manchester Health Protection Unit (GMHPU) of these cases and co-operated fully with the investigation.

2.15 There was confirmed microbiological evidence linking all nine cases to sandwiches produced by one company and its meat products supplier who supplied sandwiches to 43 NHS organisations in England. The supply of sandwiches from the Company was withdrawn across the Trust on the 25th May 2019 following advice from PHE as a precautionary measure and an alternative supplier was identified.

2.16 As a proactive measure the Chief Nurse/DIPC requested a trust-wide unannounced audit against the standards included in the Trust Policy for Food Safety and Hygiene in the Clinical Environment (2018). The results of the audit demonstrated that there is variance in practice regarding the management of food brought in for patients by their relatives/visitors to in-patient areas. The recommendations of the audit were addressed through a Task and Finish Group.

2.17 The Environmental Health Officer (EHO) from Manchester City Council (MCC) made an unannounced visit to the Sodexo Catering Preparation Facilities at The Oxford Road Campus ORC on 15th May 2019. The food service retained its five star rating and no major issues were raised. There were no actions for the Trust following this visit. The EHO returned to the Trust five days later and focused on food service by clinical ward staff. Seven recommendations were subsequently made to the Trust of which three were notified as a requirement. The requirement included, additional training for staff and the registration of the Trust as a food provider.

2.18 The Trust invited the EHO to work in partnership to develop an extended food handling policy for food handlers in the clinical environment that included appropriate legislative actions and training needs for Level 1 and Level 2 food handlers. A subject matter expert from the Food Standards Agency (FSA) was engaged to advise and support on the written policy.

2.19 The Trust has registered as a Food provider with the EHO and is awaiting the final report from PHE for the national outbreak.

2.20 The timing, extent and severity of 'seasonal' influenza activity can vary. It occurs mainly during an eight to ten week period during the winter and usually peaks between December and March, although activity can persist as late as May. This year 2019/20 Influenza season was associated with reduced activity in comparison to the preceding 2018/19 season in terms of cases in the community and admissions to the Trust.

2.21 In anticipation of the 2019/20 flu season the Trust policy for The Management of Patients with Influenza was updated to reflect changes in anti-viral therapy and advice on offering vaccination to long-stay in-patients who may not have had the opportunity to be vaccinated through their General Practitioner.

2.22 Contingency plans were made for escalation including; Identification of dedicated cohort areas/wards if there are high numbers of patients admitted with flu and plans to extend laboratory hours to enable rapid turnaround of results.

2.23 The Department of Health (DH) set a national uptake target for vaccination of all frontline Healthcare Workers (HCWs) at 80% for the 2019-20 season. Achieving the 80% target was also expected in relation to the National Health and Wellbeing Flu Vaccination CQUIN target.

2.24 The Chief Nurse/DIPC, was the board champion for the flu campaign and also a flu champion and launched the campaign by vaccinating board colleagues' members on the 30th September 2019. Photographs of the event were published across MFT.

2.25 The Campaign to vaccinate frontline HCW's built on the successes from last year and incorporated lessons learned. A range of activities were implemented to make it easier for staff to gain access to the vaccine this included starting early with advanced communication in July 2019, an increased pool of Flu Champions, (280 compared to 170 for the previous year; and an enhanced engagement plan called 'Spot the Dot' – vaccinated staff were given a yellow sticker to be placed on their identity card making it fun and easy to see who has had their vaccine and to encourage conversations with staff who have not had their vaccines yet.

2.26 The Campaign was a great success; the Trust achieved a 79.4% uptake of flu vaccination amongst frontline healthcare workers.

2.27 During the containment phase of the COVID-19 pandemic (January 2020 to February 2020) the Consultant Virologists and IPC Team liaised with clinical colleagues in all emergency access areas to advise and support on: The identification of potential isolation facilities across all emergency access areas (for adults and children), to manage cases of suspected COVID-19 who needed to be assessed; The installation and management of Assessment POD's for testing members of the public who were suspected to have COVID-19; Isolation rooms for patients who needed to remain hospitalised whilst awaiting test results; Guidelines and training for staff on the use of Personal Protective Equipment (PPE).

2.28 A number of specific actions were undertaken by the IPC Team during the March 2020 phase of the COVID-19 pandemic, these are summarised below:

- The IPC Team interpreted frequently changing national guidance to produce local policies for clinical staff including; guidance on isolation/cohorting/collection and transport of high consequence infectious diseases (HCID) samples
- The Team consistently updated advice on PPE undertaking risk assessments and developing standard operating procedures to rise to the challenges of shortages in the national provision of PPE including; decontamination of face visors/fit checking of single use FFP3 respirators/use of coveralls instead of gowns
- Provision of expert advice and support at strategic and operational meetings and engaging with Clinical Teams from a wide range of specialities throughout each stage of the pandemic
- Training and education on the use of PPE for a range of staff in the acute and community setting and training to upskill staff that were deployed to clinical areas
- The IPC Nursing Team provided training for senior leaders to enable them to role model and cascade on the spot advice for staff working in clinical settings. Feedback from these sessions indicated that they were well received. This information will be used to inform practice in the future

- A wide range of educational materials were developed to support staff including videos, posters and frequently asked questions. These resources were available on the Trust COVID-19 Intranet page and the IPC intranet page
- During the period of national shortages of PPE, the IPC Team provided advice on procurement of PPE from alternative suppliers and liaised with local partnerships for example, the University of Manchester to design and provide face visors using 3D printers. Further work was also undertaken with local companies to source supplementary PPE
- The Manchester Partnership PHE Laboratory based at ORC Trust was the first centre outside of London to test for COVID-19. The Laboratory capacity was increased to provide testing for the trust and the North West region. 24 hour working was introduced to cope with capacity and reduce the turnaround time of results
- The IPC Team worked in conjunction with colleagues from Information Technology to provide real time surveillance data regarding COVID-19 in-patients. This information was used to inform internal and external reports
- The IPC Nursing Service was extended to provide additional on-site support to the Trust across 7 days

2.29 The IPC/TV Team provided support to the Nightingale Hospital North West including advice on planning and training on the principles of IPC, based on the Trust existing policies and procedures. The team has continued to maintain a service since the facility was opened.

2.30 This year the IPC nursing team provided quarterly study days for the Infection Prevention Link Workers, who acted as Champions in their wards and departments raising awareness on current infection prevention and control practices and supporting the implementation of policies, guidelines and best practice. The study days included practical sessions and lectures delivered by microbiologists, guest speakers and members of the IPC Team.

2.31 Over the last 12 months the IPC Team supported the participation in two national initiatives focusing on infection prevention and control. These included the World Health Organisation (WHO) clean care for all– it's in your hands: raising awareness that hand hygiene, along with IPC principles is critical to achieve quality of care and patient safety across all levels of the health sector.

2.32 During International Infection Control week in October 2019 the IPC Team and Education teams produced a mobile roadshow which visited all the Wards and Departments across the sites raising awareness of local Infection Control issues, hand hygiene and use of (PPE) to all members of the Multidisciplinary Team.

2.33 The programme of works to upgrade the Trust's Endoscope Decontamination Suites (EDS) continued, the Children's Hospital theatres, MRI Outpatients Department, Elective Treatment Centre, Main Endoscopy, and Withington and Trafford Hospital Suites have all been completed. At the time of writing the Wythenshawe EDS is overdue a major upgrade and this is being progressed by a Task and Finish group alongside the Endoscopy Unit upgrade.

2.34 A set of risk-mitigation work streams were established to address ongoing issues these included: Replacement and life cycling of existing facilities, additional equipment to cope with demand for decontamination of nasendoscopes at Trafford Hospital, replacement of the Steris contract servicing both at Wythenshawe and Trafford Hospitals and the appointment of a Trust Decontamination Lead.

2.35 The Patient Led Assessment of the Care Environment (PLACE) assessments, were undertaken across all Trust sites and four Manchester Local Care Organisation (MLCO) sites. The assessments were the first to be conducted under the updated standards, and the first co-ordinated as MFT. The scores were equal to or above the national average on the acute sites except for six out of 28 areas (the greatest difference was less than 3% against the national average). The scores for the MLCO sites identified one site as consistently below the national average.

2.36 The Trust wide Antimicrobial Stewardship Committee (AMC) was a subgroup of the GICC and was responsible for developing, implementing and monitoring the Antimicrobial Stewardship Programme and reporting progress to the GICC. This year the AMC became affiliated with the Greater Manchester Antimicrobial Resistance (AMR) strategy group and the Antimicrobial Stewardship (AMS) groups and continues to work with these groups to ensure there is a coordinated approach to the AMR strategy across Manchester healthcare services.

2.37 A point prevalence audit was undertaken in March 2020. This audit was designed to determine the level of compliance with the Trust wide Antimicrobial prescribing guidelines (on Microguide) and determine actions required to address non-compliance. 518 patients prescribed antimicrobials across MFT were audited against a defined set of Antimicrobial Stewardship standards. Overall compliance with was 94%. A Trust wide action plan has been implemented and individual hospitals received a breakdown of their results.

2.38 The Director of Infection Prevention and Control acknowledges the breadth and depth of work undertaken by the wider IPC Team, members of the Infection Control Committees as well as the day to day contribution of all our staff and clinical leaders working together to reduce the incidence of HCAIs and to keep patients and our staff safe.

Recommendation

The Board of Directors are asked to receive the Infection Prevention and Control Annual Report for 2019/20 and approve for publication.

SECTION 3: INFECTION PREVENTION and CONTROL ARRANGEMENTS

3.1 The Director of Infection Prevention and Control (DIPC)

Professor Cheryl Lenney, Chief Nurse was designated as the DIPC from September 2017

Professor Cheryl Lenney,
Chief Nurse, DIPC

3.2 Members of the IPC Team

The senior members of the IPC team can be found below:

***Dr Andrew Dodgson**,*
Infection Prevention & Control Doctor (IPCD), Oxford Road(ORC)/Trafford Campus

***Mrs Julie Cawthorne**,*
Assistant Chief Nurse/Clinical DIPC, MFT

***Dr Moira Taylor**,*
Infection Prevention & Control Doctor (IPCD) Wythenshawe and Withington Hospitals

Microbiology and Virology Services are provided by the Manchester Medical Microbiology Partnership, collaboration between the Trust and Public Health England (PHE).

3.3 Microbiology Services

The Wythenshawe Hospital Microbiology Laboratory was transferred and integrated to the Oxford Road Campus in August 2019. The Clinical Microbiology Teams are in the process of continuing to integrate at the time of writing this report.

3.4 Virology Services

There were four Clinical Virologists based at the Oxford Road Campus who provided a service across the Trust and a regional service.

3.5 The Infection Prevention and Control (IPC) Nursing Team

The Infection Prevention and Control/Tissue Viability (IPC/TV) Nursing Team was integrated in April 2019 and provided a service to the Oxford Road Campus (ORC), Wythenshawe, Trafford, Withington and Altrincham Hospitals, (WTWA) and the Manchester Location

Community Services (MLCO). In January 2020 the Team expanded to welcome the IPC and TV Teams from Trafford Local Care Organisation (TLCO).

A diagram demonstrating the updated structure of the combined IPC/TV Nursing Team can be found in Appendix 1.

3.6 Antimicrobial Stewardship Pharmacists

There were 2.6 Whole Time Equivalent (WTE) Antimicrobial Stewardship Pharmacists working across the Trust

3.7 Provision of IPC Team Services

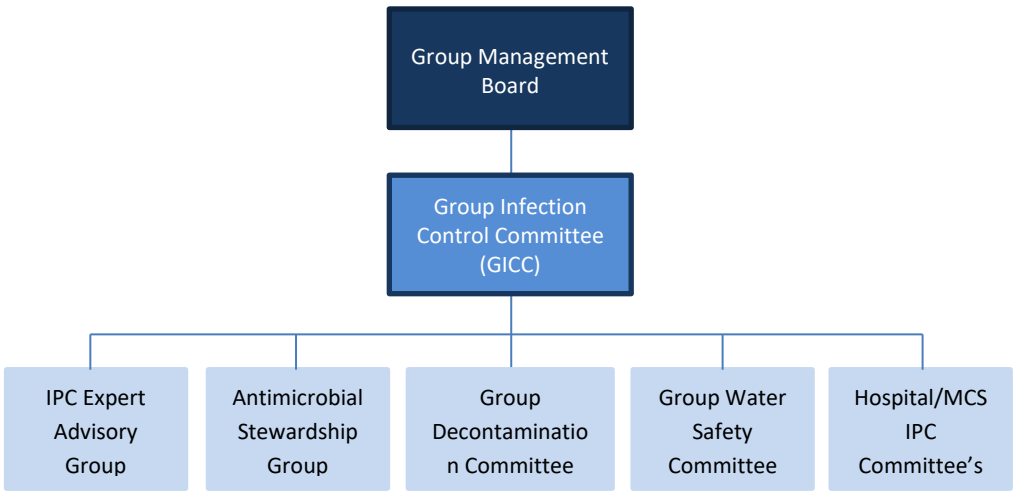
The IPC teams provided 24-hour advice and support on IPC issues to the staff and patients of the Trust across all sites. At the Oxford Road/Trafford Campus this included an out of hour's telephone on-call service by the IPC nursing team and microbiology. At Wythenshawe Hospital out of hours IPC advice was provided by the Microbiologist on call.

3.8 The Group Infection Control Committee (GICC)

The Group Infection Control Committee had corporate responsibility for overseeing the implementation of infection prevention and control activities. The GICC met four times during the year and was chaired by the DIPC. The Group Infection Control Committee reported to the Group Management Board. The GICC Terms of Reference can be found in Appendix 2.

3.9 Framework for IPC

The IPC governance framework can be seen below;



3.10 Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)

An Infection Control Committee was established within each Hospital/MCS and MLCO. The portfolio for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS and the MLCO appointed a Clinical Lead to support IPC policy and practice across professional groups and represent their Hospitals/MCS and MLCO at the GICC.

The minutes from the Hospital/MCS IPC Committees were presented at the GICC.

3.11 Service Level Agreement (SLA) with St Ann's Hospice

The Trust IPC/TV Team provided IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and; Little Hulton through a Service Level Agreement. This included:

- The provision of policies and procedures relevant to the prevention and control of infections
- Attendance at the quarterly Infection Prevention and Control Committee hosted by St Ann's Hospice
- Review of the annual audit report by the Head of Nursing for Infection Prevention and Control produced by St Ann's Hospice for the Little Hulton and Heald Green sites
- The provision of *ad hoc* advice and guidance as sought by senior clinicians and managers at St Ann's Hospice e.g. following an outbreak or incident, or in response to a Care Quality Commission (CQC) report

3.12 Funding for Infection Prevention and Control Services

The IPC/Tissue Viability nursing teams provided a service to the organisations. Funding for the IPC/TV nursing services was provided by the Trust within the Clinical and Scientific Managed Clinical Services.

3.13 Microbiology Laboratory Services

Funding for Microbiology services was covered by the SLA between the Trust and Public Health England (PHE). Financial support for outbreaks of infection (excluding laboratory costs) was sourced locally by the Hospitals/MCS.

3.14 Electronic Surveillance System

Recurrent funding for ICNet (electronic Infection Prevention & Control surveillance database) was from the Clinical and Scientific Managed Clinical Services.

SECTION 4: HEALTHCARE ASSOSCIATED INFECTIONS (HCAI)

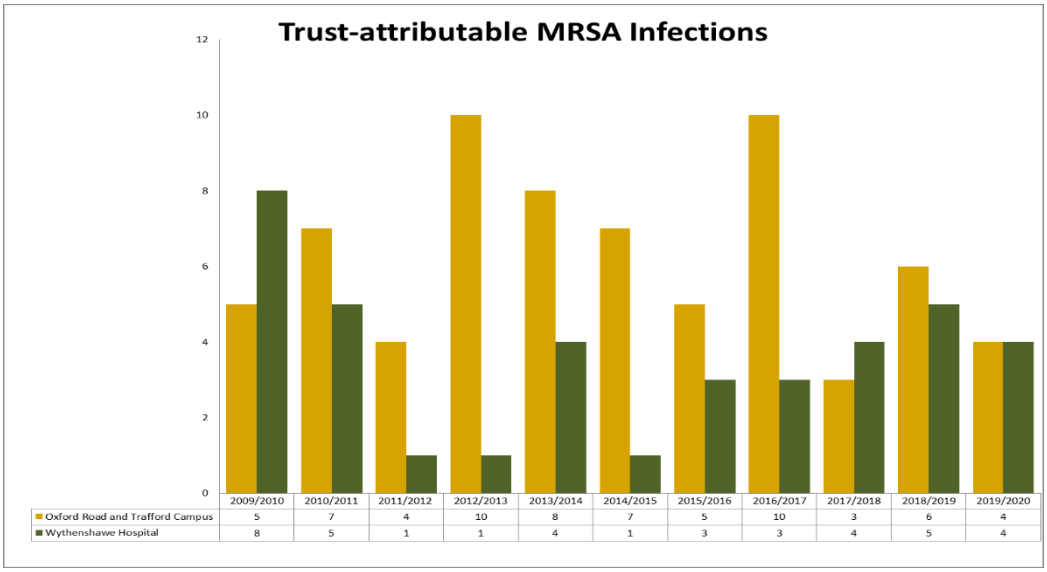
4.1 HCAI Performance Targets

The prevention and control of infection is a high priority for the Trust and there is a strong commitment to prevention of all HCAI Infections.

4.2 Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

There were eight Trust-attributable MRSA bacteraemia cases (four in MRI; two in CSS and two in Wythenshawe Hospital), reported to PHE during 2019/2020, and six community-attributable cases reported. This was a reduction from 2018/19 when there were 10 Trust-attributable bacteraemia reported. Chart 1 below compares the number of cases of attributable MRSA bacteraemia at ORC/Trafford Hospital and Wythenshawe Hospital from 2007/8 -2019/20.

Chart 1 Trust – Attributable MRSA bacteraemia (2007/8 – 2019/20)



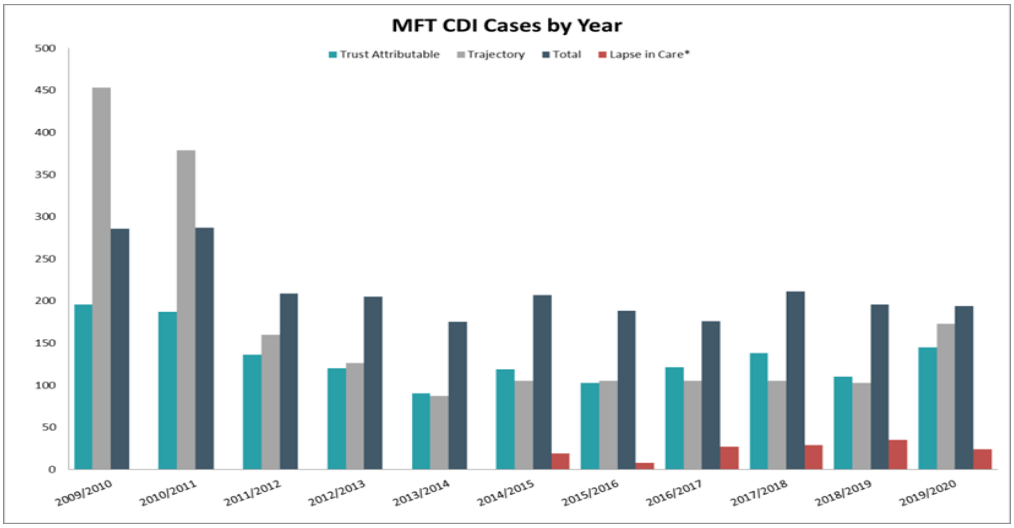
A Route Cause Analysis (RCA) was used to investigate each incident of MRSA bacteraemia the findings indicated that two were found to be avoidable and six unavoidable. All incidents were reviewed by the responsible Hospital/MCS. Lessons learned were identified and disseminated through the local accountability meetings.

4.3 *Clostridium difficile* infection (CDI)

Chart 2 below shows the number of Trust attributable CDI and lapses in care numbers for 2009/10 – 2019/20. A total of 194 CDI cases were reported during 2019/2020: 145 (74.7%) of which were trust-attributable against a trajectory of 173.

Changes to the national apportioning algorithm for 2019/2020 meant that trust-attributable cases also included community cases that had been an inpatient at the reporting trust within the prior 28 days (now referred to as healthcare-associated).

Chart 2 Trust Attributable CDI and Lapses in Care 2009/10 – 2019/20



Following monthly external case reviews, there were 24 lapses in care identified. Due to the pandemic 47 cases between January and March 2020 were not reviewed by the Clinical

Commissioning Group (CCG). Advice from PHE was that these cases be recorded as unknown

4.3 Gram Negative Bloodstream Infections (GNBSI)

In November 2016, the Department of Health announced ambitions to halve the number of GNBSI by 2020/21. This objective was amended in January 2019 to a 25% reduction by April 2022 and a 50% reduction by April 2024. The threshold for GNBSI was set at 228 for 2019/2020 which was based on a 15% reduction to achieve the national reduction objective. The Trust exceeded the threshold by 20%.

The main cause of GNBSI is *E.coli*. There were 591 incidents of *E. coli* bacteraemia reported to PHE during 2019/2020 of these, 158 cases (26.7%) were determined to be hospital-onset.

4.4 Case Review of Incidents of GNBSI April 2019 – December 2019.

A review of the incidents of all GNBSI was presented to the Group Infection Control Committee (GICC) in January 2020.

Investigation into MFT-attributable cases at Wythenshawe Hospital revealed diverse reasons for bacteraemia development including a severe burn, gastrointestinal complications, biliary malignancy/biliary sepsis and urinary tract infections. Of the 29 cases reviewed, 21 (73%) indicated urosepsis as the primary cause. Of these 21 cases, 11 were determined to be associated with a urinary catheter (see section 4.5 for management of Catheter Associated Urinary Tract Infection).

Root Cause Analysis (RCA) of cases at MRI indicate that 23% of GNBSI were associated with a urinary focus (50% of which were in catheterised or recently catheterised patients), 29% were respiratory focused and 33% were associated with an intravascular device. However, this may have represented bias in terms of RCA completion and required further analysis of infection and clinical speciality. A further update on the investigation to the GICC in March was delayed due to the onset of the pandemic.

Utilising the location of specimen collection as an indication of underlying focus, 21 cases (23%) of GNBSI reported by MRI (96) indicated possible hepatobiliary involvement. This has resulted in the instigation of a weekly ward round between the Microbiologist and the Clinical Team to review infection management of hepatobiliary patients.

Analysis of age indicated that 5% of all MFT GNBSI were under one year of age with 51% of cases being reported in patients over the age of 65.

4.5 Catheter Associated Urinary Tract Infection (CAUTI)

CAUTI surveillance has been in place at ORC/TGH since 2014, and was adopted at Wythenshawe Hospital in October 2018. A total of 252 CAUTI were reported during 2019/2020, a monthly average of 21 cases. Changes to reporting criteria/methodology precludes comparison to previous reporting years.

Actions to reduce the number of incidents of CAUTI

- All incidents of CAUTI that occurred in patients across MFT were monitored, investigated and reviewed at Hospital/MCS Harm Free Care meetings. Lessons learned and actions were incorporated into local Infection Control work plans.

- The Trust continued to participate in the GNBSI Reduction Ambition Group in collaboration with colleagues from the CCG, MLCO and Neighbouring trusts.
- The Adult Urinary Catheterisation and Catheter Care Policy, Urinary Catheter Care Integrated Care Pathway (ICP) and Catheter Passport were revised and updated and were to be ratified at the GICC meeting in March 2020. This has been postponed to July 2020 due to the pandemic.
- Work was completed on streamlining catheter fixation devices and catheter bags supported by ward based training on the appropriate usage.
- General ward based training was undertaken out following an audit of catheter usage at ORC. This training focused on positioning of catheter to support drainage, early removal of catheters and changing the practice of dip sticking urine to identify a CAUTI.
- The Bladder and Bowel team have evaluated bladder scanners which have been made available within the Trust

4.6 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Mandatory reporting of all MSSA bacteraemia began in January 2011. A total of 209 MSSA bacteraemia cases were reported to PHE during 2019/2020. Of these, 80 cases (38.2%) were trust-apportioned (i.e. occurred 48 hours or more after admission). There is currently no target associated with MSSA bacteraemia incidence.

4.7 Vancomycin-resistant Enterococci (VRE) bacteraemia cases

A total of 30 VRE bacteraemia were reported during 2019/2020 (see Table 1 below for distribution of cases of VRE bacteraemia across MFT). This compares to 27 reported during the previous year: an 11% increase.

Table 1 Distribution of Cases of VRE Bacteraemia

Individual incidents of VRE bacteraemia were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings. The majority of incidents were spread in time and location across the organisation with the exception of an outbreak on the Cardiothoracic Critical Care Unit (CTCCU) at Wythenshawe (see section 4.8).

Hospital /MCS	Number of Cases
MRI	13
CSS	11
RMCH	1
Wythenshawe Hospital	4
Trafford General Hospital	1

4.8 Outbreak of VRE on CTCCU Wythenshawe Hospital

Between June and September 2019 there were seven patients identified as VRE positive, three of these patients had a VRE bacteraemia. Typing of four isolates demonstrated two were the same type and two were unique. The Unit remained open during the outbreak with strict monitoring of control measures implemented. In response to the outbreak the CTCCU Team and IPC Team developed a charter that was distributed to all staff to support IPC practice.

4.9 Summary of Outbreaks of Infection 2019 – 2020

A summary of clusters/outbreaks of infection requiring additional IPC control measures are shown below in Table 2.

Table 2 Outbreaks April 2019 – March 2020

Dates	Ward	Cause	No. Patients affected	Bed closures
WTWA				
16/05/19 – 24/05/19	F14	Norovirus	6 4 staff	8 beds x4 days 4 bed x4
31/05/19 – 06/06/19	F4	Norovirus	12	0
17/06/19- 15/08/19	Burns	MRSA	4	0
22/08/19-10/09/19	CTCCU	VRE	7	0
07/07/19- 28/07/19	A7	CDI	4	0
15/08/19 – 12/09/20	F14	MRSA	3	4beds x2 days
10/09/19- 01/10/19	A4	CDI	3	0 PII*
25/010/19 – 29/10/19	A7	Norovirus	8	12 beds x4 days
14/11/19- 18/11/19	TGH -Ward 6	D+V- no organism isolated	13 4 staff	12 beds x 4 days
03/12/19 – 24/12/19	F4	CDI	2	0
19/01/20- 26/02/20	A9	CPE	16	28 beds x6 days beds closed during cleaning process.
March 2020	SCBU	Klebsiella oxycoctoca	4	PII*
ORC				
24/04/19 – 02/05/19	Ward 85	Norovirus	16 2 staff	28 beds x7 days
31/07/19- /08/19	Ward 36 and 37	CPE	12	0
16/08/19 – 14/10/19	Ward 32	CDI	4	0
	AM4	CPE VIM	4	0 PII*
03/12/19 – 11/12/19	NICU	MRSA	5	0
31/12/19- 09/01/20	Ward 85	Norovirus	9 11 staff	28 beds x 9 days

*PII = Period of increased incidence

4.10 Peripheral Blood Culture Trends

There is no national UK standard for contamination rates, but rates should be below 3%, aiming for zero. The most recent contamination rates in adults (>16 yrs) was 2.14% and 2.9% for children (<16 yrs).

4.11 Shelford Group Comparison

MFT's performance compared to other members of the Shelford Group can be found in Charts 3 to 6**.** The charts detail the 2019/2020 HCAI rates using KH03 occupied overnight beds data (per 100,000).

Chart 3 Shelford Group Hospital-onset MRSA bacteraemia rates (per 100,000 overnight beds)

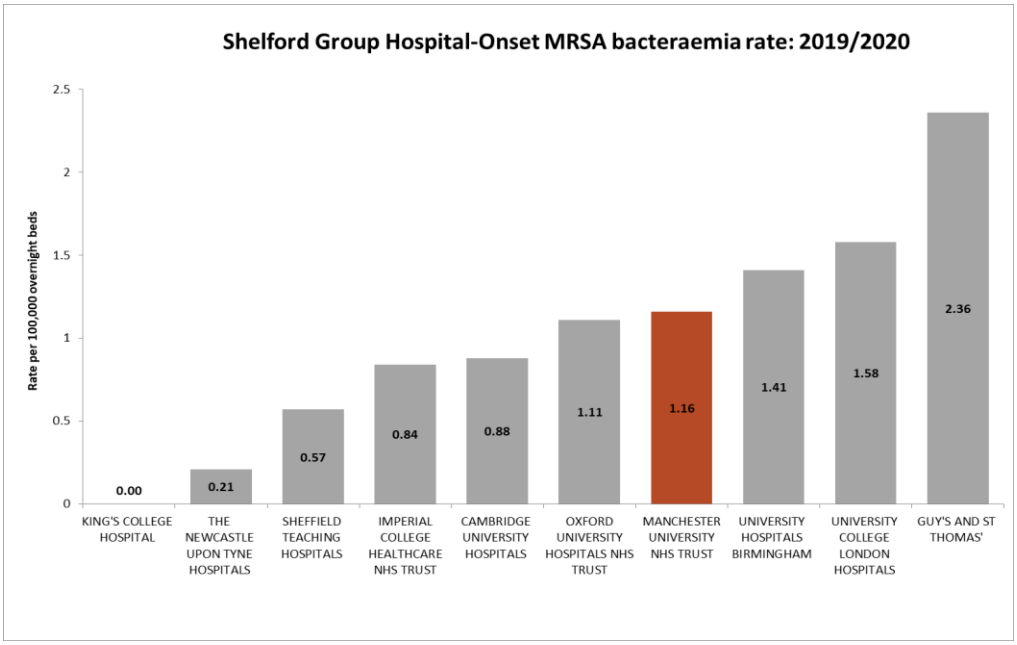


Chart 4 Shelford Group Healthcare-Associated CDI rates (per 100,000 overnight beds)

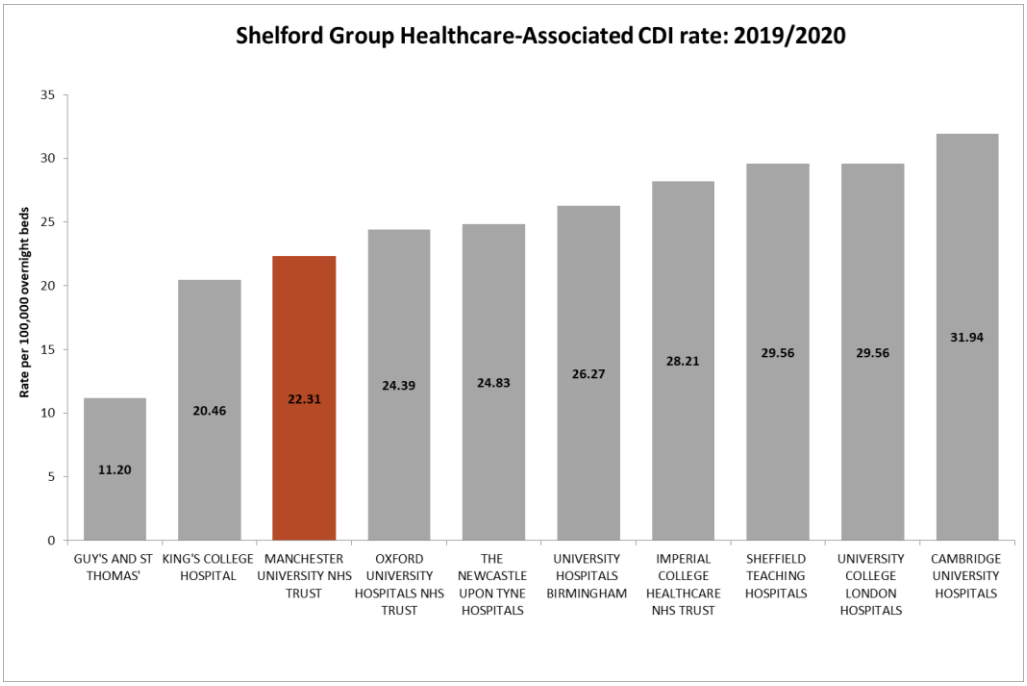


Chart 5 Shelford Group Hospital-onset *E. coli* bacteraemia rates (per 100,000 overnight beds)

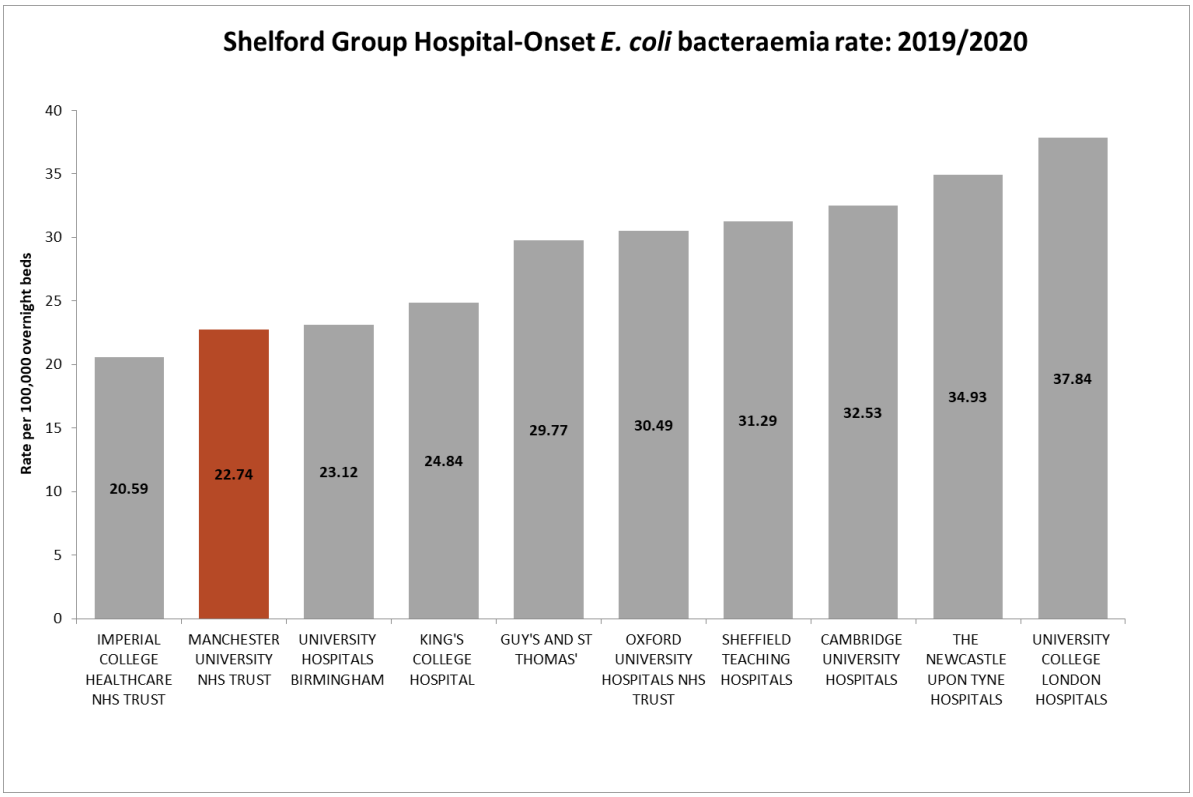
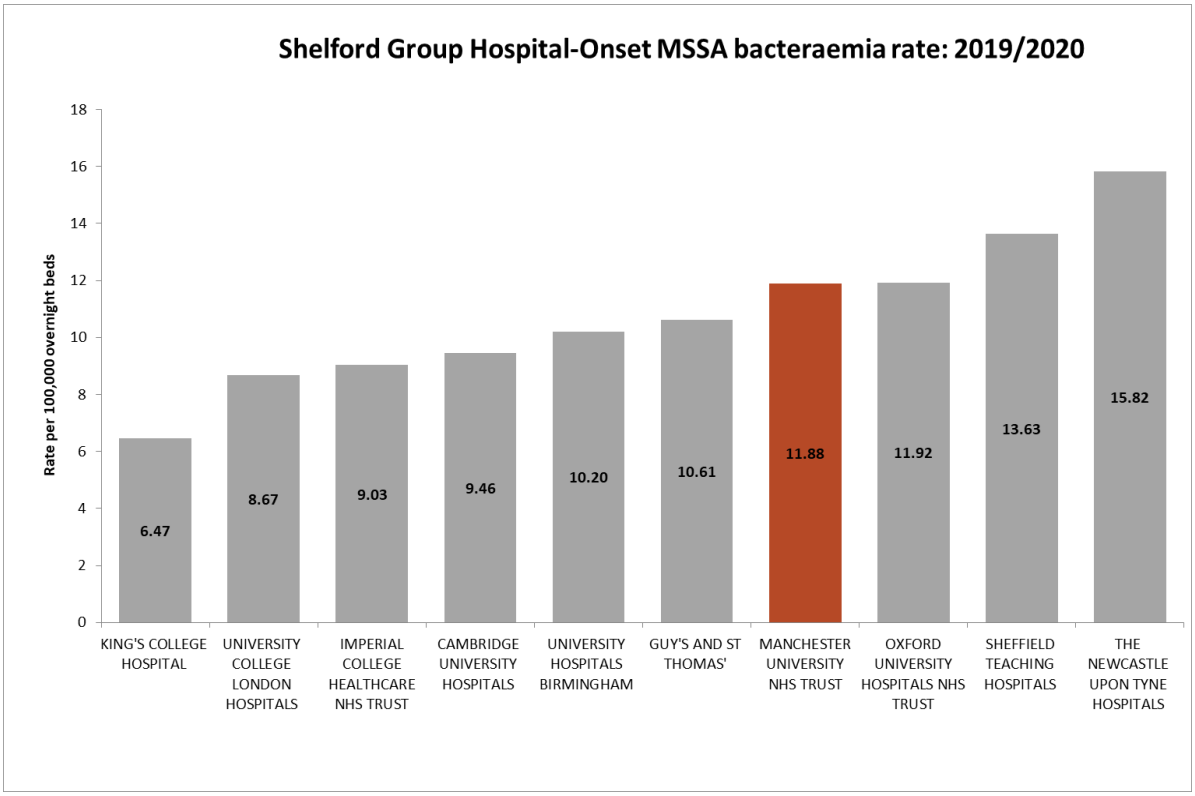


Chart 6 Shelford Group Hospital-onset MSSA bacteraemia rates (per 100,000 overnight beds)



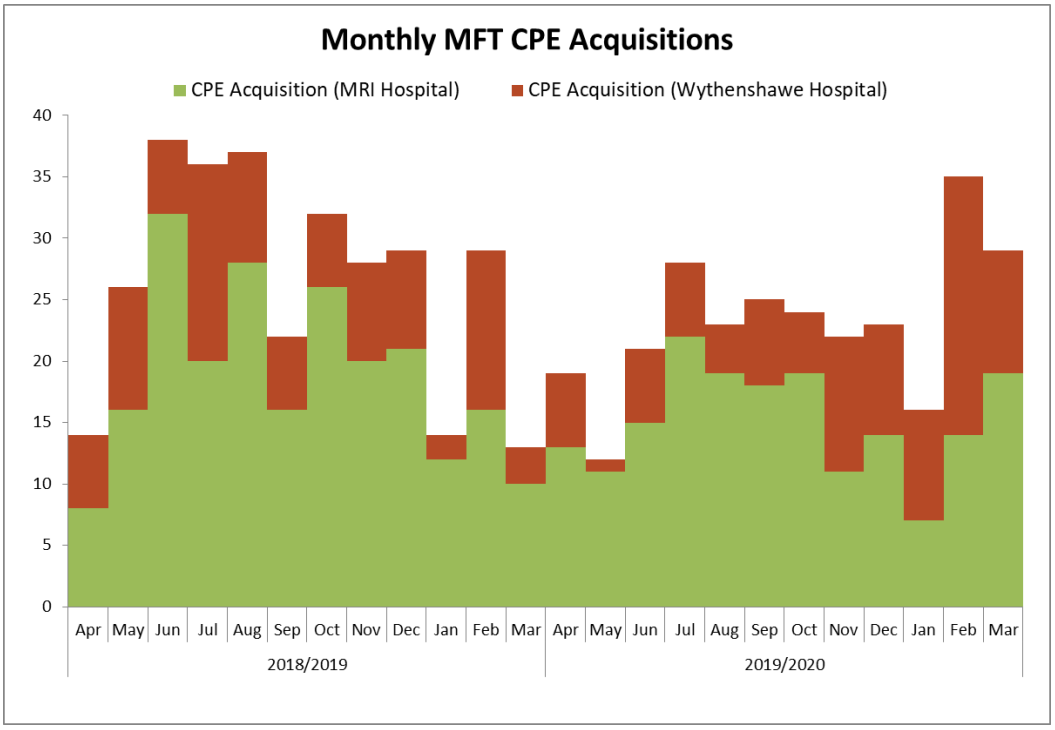
SECTION 5: CARBAPENEMASE-PRODUCING ENTEROBACTERIACEAE (CPE)

5.1 Carbapenemase-producing Enterobacteriaceae (CPE)

The Trust has experienced an on-going CPE outbreak since 2009 with *Klebsiella pneumonia* as the most frequently isolated organism. Intensive local IPC measures in line with national and international recommendations have been implemented in response.

The mean number of monthly CPE acquisitions during 2019/2020 was 27**,** compared to an average of 31 cases per month in 2018/2019. This represents a 12% reduction. Monthly peformance can be seen in Chart 7 which presents CPE acquistion data for Wythenshawe and MRI Hospitals. There were eight CPE bacteraemias reported during 2019/2020 compared to 12 in 2018/2019.

Chart 7 Monthly MFT CPE Acquisitions



5.2. Research Studies

Building on the success of the TRACE project published in January 2017; The Trust has continued to be at the forefront of developing the evidence base for the management and control of patients with CPE. This is reflected in the research published over the past 12 months by members of the IPC team (Professor Cheryl Lenney, Chief Nurse/DIPC; Dr Andrew Dodgson, Consultant Microbiologist, Infection Control Doctor (ORC) and Head of Service; Mrs Julie Cawthorne, Assistant Chief Nurse, IPC/TV /Clinical DIPC; Dr Ryan George, Senior Surveillance Officer, IPC/TV), these are summarised below;

5.3 Genomic Epidemiology of Complex, Multispecies, Plasmid-borne *bla* $_{KPC}$ Carbapenemase in *Enterobacterales* in the United Kingdom from 2009 to 2014.

GStoesser N, Phan HTT, Seale AC, Aiken Z, Thomas S, Smith M, Wyllie D, **George R,** Sebra R, Mathers AJ, Vaughan A, Peto TEA, Ellington MJ, Hopkins KL, Crook DW, Orlek A, Welfare W, **Cawthorne J**, **Lenney C, Dodgson A**, Woodford N, Walker AS; TRACE Investigators' Group.Antimicrob Agents Chemother. 2020 Apr 21;64(5):e02244-19. doi: 10.1128/AAC.02244-19. Print 2020 Apr 21.PMID: 32094139.

The study was a result of the TRACE collaboration between MFT, the University of Oxford and PHE. By using whole genome sequencing of a large number of CPE organisms, the study described the way that the genes responsible for Carbapenemase production are able to spread between different species and strains of bacteria. The work has potential implications for future surveillance and strategies to control CPE and other antibiotic resistant bacteria.

5.4 Carbapenem-resistant Enterobacteriaceae dispersal from sinks is linked to drain position and drainage rates in a laboratory model system.

Aranega-Bou P, **George RP**, Verlander NQ, Paton S, Bennett A, Moore G; TRACE Investigators' Group.J Hosp Infect. 2019 May;102 (1):63-69. doi: 10.1016/j.jhin.2018.12.007. E pub 2018 Dec 18.PMID: 30571992

A further study resulting from the previously reporting TRACE collaboration used a series of sinks built into a laboratory at PHE's Porton Down site to simulate a hospital ward situation. This study examined how CPE could be dispersed from contaminated sink drains back in to the environment. The position of the tap and drain outlet and the rate of drainage exerted a profound effect on the amount of organism dispersed into the environment. The study has implications for both hospital design and maintenance and their role in the control of infection and outbreak investigation.

5.5 Screening for carbapenemase-producing Enterobacteriaceae in previous carriers readmitted to hospital: evaluation of a change in screening policy.

Tucker A, **George R,** Welfare W, Cleary P, **Cawthorne J, Dodgson A.**J Hosp Infect. 2019 Oct;103(2):156-159. doi: 10.1016/j.jhin.2019.04.012. Epub 2019 Apr 27.PMID: 31039383

From April 2016, the Trust implemented a new risk based approach to KPC-CPE screening policy at MRI, all patients previously identified as KPC-CPE positive were admitted to a side room on readmission and offered screening for CPE using a highly sensitive and reliable molecular method.

Patients with an initial negative screen were classified as 'CPE not detected' and a risk assessment was undertaken to establish the presence of factors that may increase the risk of transmission If low risk, the patient was transferred to a general ward where they were monitored, screened and risk –assessed every 72 hours.

This study evaluated the Trust screening policy for patients with a history of CPE. The results showed that most (76.5%) patients with a history of CPE did not have detectable KPC-CPE on re-admission or during their subsequent hospital stay but that repeat screening after an initial negative result is required. The findings of this study support the Trust decision to develop a risk based approach to the management of patients with KPC-CPE from April 2016 onwards.

5.6 Patient experience of hospital screening for carbapenemase producing Enterobacteriaceae: A qualitative study

Caroline King BSc Hons, MSc, PhD, Research Fellow| Tracyanne Grandison BN, Senior Research Nurse **Julie Cawthorne** BSc Hons, MSc, Assistant Chief Nurse/Clinical Director Infection Prevention and Control Kay Currie BSc, MSc, PhD, RN, Professor of Nursing Journal of Clinical Nursing (2019). 00:1–11.J Wiley
(*This study was funded by NHS Health Protection Scotland and the Scottish Infection Research Network).*

The aim of this study was to explore patients' accounts of screening and being managed for colonisation with the antimicrobial resistant organism,carbapenemase-producing *Enterobacteriaceae* (CPE), when in hospital. Two main themes were identified: “I can't make sense of CPE,” illustrating limitations in patients' understandings of CPE; and, “I feel as if they are saying it is my fault,” indicating the feelings of responsibility and blame which patients experienced. This paper contributed original evidence to the limited literature on patients' experiences of being colonised with CPE. The findings suggest that support and information provided for patients by healthcare professionals needs to be based on current evidence-based guidance on the nature of CPE and its implications for patient care, as well as being responsive to patients' emotional needs

SECTION 6: SURGICAL SITE INFECTION SURVEILLANCE (SSIS)

6.1 Surgical Site Infection Surveillance

The Trust SSI programme was led by the Trust Clinical Lead for SSI Professor Ferdinand Serracino-Inglot and reported to the Trust GICC. The IPC/ TV team seconded a nurse for a year into the role of Surgical Site Infection (SSI) Nurse Band 6.

6.2 MFT Participation in the National Getting it Right First Time (GIRFT) Audit

The Trust participated in the national GIRFT audit between May and October 2019, led by Professor Ferdinand Serracino-Inglot, 12 out of the 13 assigned specialities took part. The denominator data was submitted in December 2019. The Trust’s results have been received and are currently being reviewed.

6.3 Participation in the National Surgical Site Infection Surveillance Service (SSISS)

As a result of the secondment of the SSI Nurse the IPC/TV team were able to extend the programme for SSI surveillance to include two additional surgical specialities this year, (Hepatobiliary and Breast surgery). In addition, the SSI nurse reviewed the data collection submitted for Orthopaedic and Cardiac surgery. Findings identified under reporting of data in

both specialities. This issue will be addressed prior to the resumption of the SSISS programme which was suspended due to the pandemic

6.4 Mandatory Orthopaedic Joint Replacement Surgery (Hip and Knee) SSI Surveillance

The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for orthopaedic implant surgery. See table 1 below which shows the results for participation over the three-year period 2018 – 2020 against the national rate for the previous five years.

The denominator should be taken into consideration when comparing local rates of Infection to the national rate.

Table 3 Trust-wide SSI results for hip and knee replacement 2018 -2020

Oxford Road Campus									
	2018			**2019**			**2020**		
	Ops	**SSI**	**SSI%***	**Ops**	**SSI**	**SSI%***	**Ops**	**SSI**	**SSI%***
Hip replacement				26	2	7.69%			
Knee replacement				12	0	0			
Wythenshawe Hospital									
Hip replacement	110	0	0	126	1	0.79%	45	1	2.22%
Knee replacement				100	0	0	`35	0	0
Trafford Hospital									
Hip replacement	383	0	0	370	0	0	39	0	0
Knee replacement									

*National rate for previous five years = 0.9% hip replacement and 1.2% knee replacement

6.5 Participation in the Voluntary PHE SSI Surveillance Programme

In addition to the PHE mandatory SSI programme the Trust has also participated in the voluntary SSI programme for four other categories of surgery.

6.6 Breast Surgery Wythenshawe Hospital

The IPC/TV Team met with the Breast specialist to agree participation in SSI surveillance for all categories of Breast Surgery from 1st October 2019 for 3 months. SSI rates for breast surgery are shown in table 4

Table 4 Results for Breast Surgery SSI Surveillance

Wythenshawe Hospital									
	2018			**2019**			**2020**		
	Ops	**SSI**	**SSI%***	**Ops**	**SSI**	**SSI%***	**Ops**	**SSI**	**SSI%***
Breast surgery				381	5	1.31%			

*National rate for previous five years = 3.1%

6.7 Voluntary Participation in Hepatobiliary (HPB) SSI Surveillance

For the first time the Trust was able to participate in the PHE voluntary SSI surveillance for HPB, 93 operations were undertaken in Q4 2019 and 87 operations were undertaken in Q1 2020. A local review was undertaken of the data submitted. Fifteen organ space SSI's were identified within the three-month period. A local in depth RCA tool was developed and completed on a sample of five identified SSI's. Of the five investigations four were identified

as SSIs and one was incorrectly reported. Further action was suspended due to the onset of the pandemic. See Table 5 below for results)

Table 5 Results for Hepatobiliary SSI Surveillance

Oxford Road Campus									
	2018			2019			2020		
	Ops	SSI	SSI%*	Ops	SSI	SSI%*	Ops	SSI	SSI%*
Hepatobiliary Surgery				93	15	16%	87	6	6.9

*National rate for previous five years = 9.4%

6.8 Voluntary Participation in Cardiac Surgery SSI Surveillance

The Trust also continued to participate in the voluntary PHE data collection for Cardiac surgery. Analysis of the data identified seven surgeries where patients were re-admitted with deep incision or organ space infection. The SSI Nurse completed an in-depth root cause analysis on all the seven cases. Several themes were identified following the investigation see Table 6 below.

Table 6 Themes identified following investigation

Findings	Action
Inadequate post-operative wound care	An incisional wound assessment tool was developed
Inappropriate swabbing	A Standard Operating Procedure for how and when to take a wound swab was developed
Insufficient documentation of key perioperative care elements e.g. pre-operative showering, type of drape used, hair removal method and irrigation practices	To be actioned at resumption of Surgical Programme in phase 2 of pandemic

Table 7 Results for Cardiac Surgery SSI Surveillance

Oxford Road Campus									
	2018			2019			2020		
	Ops	SSI	SSI%*	Ops	SSI	SSI%*	Ops	SSI	SSI%*
Coronary artery bypass graft (CABG)	95	1	1%	355	12	3.38%			
Cardiac surgery (other than CABG)							1		0
Wythenshawe Hospital									
Coronary artery bypass graft				133	1	0.75%	113	1	0.88%
Cardiac surgery (non-CABG)				105	-	0%	59		0%

*National rate for previous five years = 5.8% for CABG surgery and 2.2% for non-CABG surgery

6.9 Trust- wide Audit of Practice against NICE Guidelines for SSI Prevention 2019

The SSI Nurse undertook a pilot audit of practice against the NICE guidelines for SSI prevention. 17 theatres were audited. The findings were presented at the Group Infection Control Committee in October 2019 with a plan to refine the tool and re-audit in 12 months.

SECTION 7: NATIONAL OUTBREAK OF LISTERIOSIS

7.1 Background of National outbreak of Listeriosis

A national outbreak of *Listeria monocytogenes* occurred in April 2019 involving nine in-patients in total across several hospitals in England. Two of these were treated at the Manchester Royal Infirmary (MRI). In accordance with national reporting the Trust notified the Greater Manchester Health Protection Unit (GMHPU) of these cases and co-operated fully with the investigation.

PHE lead a multi-agency investigation into the outbreak which found the nine confirmed cases were linked by whole genome sequencing, six of whom died. There was a Trust response lead by the Chief Nurse/DIPC supported by key stakeholders.

Listeria was isolated from the blood cultures of the two patients receiving care in MRI. Both patients received the appropriate care and treatment however both died, and Listeria was recorded as a contributory factor to the cause of death. Both of the patients had underlying health conditions. An internal review of both cases was undertaken, and the incident was STEIS reported and the CQC were informed.

7.2 Actions taken to reduce the risk of further cases by the Trust

All cases identified as part of the national outbreak had potential exposure within healthcare settings before 25th May 2019. There was also confirmed microbiological evidence linking all nine cases to sandwiches produced by one company and its meat products supplier who supplied sandwiches to 43 NHS organisations in England. The supply of sandwiches from the Company was withdrawn across the Trust on the 25th May 2019 following advice from PHE as a precautionary measure and an alternative supplier was identified.

As a proactive measure the Chief Nurse/DIPC requested a trust-wide unannounced audit against the standards included in the Trust Policy for Food Safety and Hygiene in the Clinical Environment (2018). The results of the audit demonstrated that there is variance in practice regarding the management of food brought in for patients by their relatives/visitors to in-patient areas.

A separate audit of all-day care and residential services within the MLCO that provide catering services for patients was also undertaken the results of which also demonstrated variance in practice and facilities.

The recommendations of the audits were addressed through a task and finish group commissioned by the Chief Nurse/DIPC.

Information for staff on frequently asked questions, including further information for pregnant women, vulnerable patients and advice for clinicians concerned that a patient may have suspected Listeriosis was provided by the Infection Prevention and Control (IPC) team and circulated to all staff through the Directors of Nursing.

7.3 External Review of Catering Services

The Environmental Health Officer (EHO) from Manchester City Council (MCC) made an unannounced visit to the Sodexo Catering Preparation Facilities at The Oxford Road Campus on 15th May 2019. The food service retained its five-star rating and no major issues were raised. There were no actions for the Trust following this visit.

The EHO returned to the Trust five days later and focussed on food service by clinical ward staff. Seven recommendations were subsequently made to the Trust of which three were notified as a requirement. The requirement included: additional training for staff and the registration of the Trust as a food provider.

7.4 Action

The Trust invited the EHO to work in partnership to develop an extended food handling policy for food handlers in the clinical environment that included appropriate legislative actions and training needs for level 1 and level 2 food handlers. The Trust employed a subject matter expert from the Food Standards Agency (FSA) to advise and support on the written policy.

The policy was reviewed internally in January 2020 before being forwarded to the EHO for final comment in February 2020.

7.5 Summary of Outstanding Matters

- The incubation period for this outbreak of *Listeria monocytogenes* concluded at the end of July 2019 when the national investigation closed.
- The Trust continued to offer support to the families of both patients who died whilst in our care.
- The Trust has registered as a Food provider with the EHO
- The ratification of the food handling Policy was delayed due to the pandemic and will be ratified in quarter 2
- The final report from PHE for the national outbreak has not yet been circulated

SECTION 8: MANAGING THE RISK OF INFLUENZA

8.1 Managing the Risks of Influenza

The timing, extent and severity of 'seasonal' influenza activity can vary. It occurs mainly during an eight to ten-week period during the winter and usually peaks between December and March, although activity can persist as late as May. This year 2019/20 Influenza season was associated with reduced activity in comparison to the preceding 2018/19 season in terms of cases in the community and admissions to the Trust.

8.2 Management of Patients with Influenza 2019/2020 Season

In preparation for the 2019/20 flu season, building on experience and lessons learned from previous years the IPC Team collaborated with Clinical Colleagues across the Trust to develop a plan of action summarised below.

- The Trust policy for The Management of Patients with Influenza was updated to reflect changes in anti-viral therapy and advice on offering vaccination to long-stay in-patients

who may not have had the opportunity to be vaccinated through their General Practitioner.

- The IPC Team liaised with the Senior Management Teams from Wythenshawe Hospital and the MRI to advise on preparation of an escalation policy with additional actions that would be implemented if activity reaches a threshold that impacted on service delivery this included:
    - Identification of dedicated cohort areas/wards if there are high numbers of patients admitted with flu.
    - Extend laboratory hours to enable rapid turnaround of results.

Preparations were also made to provide data on inpatient Influenza positive cases and participate in the national surveillance schemes.

8.3 Front-line staff influenza vaccination programme 2019/20

The Department of Health (DH) set a national uptake target for vaccination of all frontline Healthcare Workers (HCWs) at 80% for the 2019-20 season. Achieving the 80% target was also expected in relation to the National Health and Wellbeing Flu Vaccination CQUIN target.

The staff flu vaccination planning group which includes stakeholders from across the Trust was established in July 2019 and included focus groups with staff to gain insight into what went well/could do better. The plan for this year built on the successes from last year and incorporated lessons learned please see summary below;

- The Chief Nurse/DIPC, was the board champion for the flu campaign is a flu champion and launched the campaign by vaccinating board colleagues on the 30th September. Photographs of the event were published across MFT.
- The campaign was supported by Senior Medical, Nursing and Management staff across the organisation with a variety of local events to promote uptake of vaccination and incentives for staff to be vaccinated.
- Communication of the programme began in July 2019 to prepare staff for the flu campaign and address any issues or concerns that they might have to help dispel myths and provide key facts.
- Vaccinated staff were given a yellow sticker to be placed on their identity card as part of an enhanced engagement plan called **'Spot the Dot'** – making it fun and easy to see who has had their vaccine and to encourage conversations with staff who have not had their vaccines yet.
- Staff who were approached to be vaccinated and decline were asked to complete the consent form stating the reason why they had declined.
- This year there was an Increased pool of Flu Champions, approximately 280 trained Flu champions (compared to 170 for the previous year), who provided vaccination clinics across all areas of the Trust and covering all shifts.
- Daily open access clinics at the Employee Health and Wellbeing (EHW) service.
- Information regarding opportunities for staff to access flu vaccination are locally promoted.
- There were specific plans to support community services to increase their uptake rate including more Flu Champions to make the vaccine accessible to all staff, regular bespoke communications and a higher level of senior leadership support.

Data collection recording/capture for this year was enhanced to enable the Trust to monitor uptake. Hospital Management Teams received weekly reports from the end of October 2019 to enable them to focus on 'hot spot' areas and improve engagement. In addition, consent was requested to enable managers to be provided with the names of their staff who declined vaccination.

The Campaign was a great success; the Trust achieved a 79.4% uptake of flu vaccination amongst frontline Healthcare Workers (HCW).

SECTION 9: COVID-19

9.1 COVID-19 Pandemic Background

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). COVID-19 is a novel corona virus first identified in Wuhan China in late 2019.

The severity of infection caused by COVID-19 ranges from mild symptoms of upper respiratory tract infection (with or without fever) to more severe symptoms including; fulminant pneumonia requiring hospitalisation and advanced respiratory support.

9.2 Containment Phase January 2020 - February 2020

The national response to COVID-19 has been led by NHSE/I and PHE. The Trust was actively engaged from the beginning under the leadership of the Chief Nurse/DIPC, an Incident Management Team was established that included stakeholders from both the acute and community settings.

The Consultant Virologists and IPC Team liaised with clinical colleagues in all emergency access areas to support and advise on:

- The identification of potential isolation facilities across all emergency access areas (for adults and children), to manage cases of suspected COVID-19 who needed to be assessed.
- The installation and management of assessment POD's for testing members of the public who were suspected to have COVID-19
- Isolation rooms for patients who needed to remain hospitalised whilst awaiting test results.
- Guidelines and training for staff on the use of Personal Protective Equipment (PPE) that were made available on the Trust IPC website

9.3 Pandemic Phase March 2020

As the situation moved into the pandemic phase the response was expanded and led by the MFT Accountability Emergency Officer (AEO) / Group Chief Operating Officer, Julia Bridgewater supported by the Chief Nurse / DPIC, Professor Cheryl Lenney and other Group Executives.

The Trust contingency plans included; escalation plans for additional capacity to manage patients who presented to be tested, review of potential isolation facilities and extending the programme for training staff to use enhanced PPE.

9.4 Actions undertaken by the IPC Team

Several specific actions in response to the pandemic were undertaken by the IPC team, these are summarised below.

9.5 Implementation of National Guidance

As the pandemic rapidly evolved there was rapidly changing national guidance from PHE supplemented by additional guidance from professional bodies. The IPC Team interpreted national guidance to produce local policies for clinical staff including; guidance on isolation/co-horting/collection and transport of high consequence infectious diseases (HCID) samples

The Team Consistently updated advice on PPE undertaking risk assessments and developing standard operating procedures to rise to the challenges of shortages in the national provision of PPE including; decontamination of face visors/fit checking of single use FFP3 respirators/use of coveralls instead of gowns.

9.6 Expert Advice

The Consultant Virologists and IPC Team provided advice and support at strategic and operational meetings that was incorporated into policies and daily communications. In addition, they also engaged with Clinical Teams from a wide range of specialities throughout each stage of the pandemic.

9.7. Training and Education for COVID-19

The IPC Nursing Team developed and delivered bespoke presentations on the emerging coronavirus and use of PPE, based on national guidelines for a range of staff in the acute and community setting throughout both phases furthermore they provided training to upskilled staff that were deployed into clinical areas.

In addition, the IPC Nursing Team provided training for senior leaders to enable them to role model and cascade on the spot advice for staff working in clinical settings. There were nine sessions attended by a total of 93 staff. The sessions included; the mode of transmission of COVID -19 and national guidance regarding use of PPE.

Feedback from these sessions indicated that they were well received (see Table 8 PPE Expert Training Attendees Follow up Survey Results). This information will be used to inform practice in the future.

The IPC Team used a wide range of educational materials to support staff including videos, posters and frequently asked questions. These resources were available on the Trust COVID-19 Intranet page and the IPC intranet page. (See examples below)

NHS
Manchester University
NHS Foundation Trust

Coronavirus (COVID-19)
Infection Prevention & Control

Personal Protective Equipment (PPE)

For suspected and positive COVID-19 patients you will require the following PPE:

PPE differs for aerosol generating procedures – see guidance.

Disposable Gloves

Disposable Apron

Surgical Mask

Risk assess if required:

Possibility of bodily fluid splash

Disposable Eye Protection

NHS
Manchester University
NHS Foundation Trust

Coronavirus (COVID-19)
Infection Prevention & Control

Sampling

Blood Sampling

- Blood cultures and routine/urgent bloods – double bag in biohazard bag

Category B Samples

Virology COVID-19

- Nose and throat swab
- Send sputum sample if possible
- Send samples in a high consequence infectious disease transport box
- Complete COVID-19 screening request form

To obtain Category B sampling kit:
Mon-Fri, 9-5pm – Contact Virology on **68788 / 68854**
Out of hours – Contact porters **64850**

Microbiology

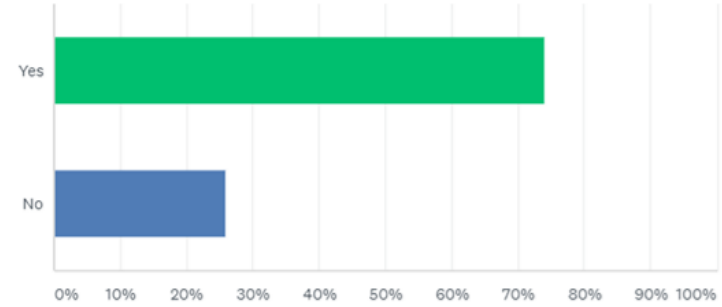
- Urine, sputum and faeces samples for SUSPECTED and CONFIRMED COVID-19 patients must be sent in high consequence infectious disease transport box
- Send samples in a high consequence infectious disease transport box

To obtain Category B sampling kit:
Mon-Fri, 9-5pm – Contact Microbiology on **68788**
Out of hours – Contact porters **64850**

NO SAMPLES SHOULD BE SENT USING THE POD

Within patient contact areas do you think that PPE usage is compliant with current policy?

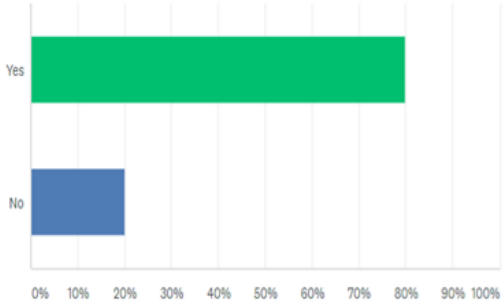
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	74.00%	37
No	26.00%	13
TOTAL		50

Have you personally challenged anyone who appears to be using PPE incorrectly?

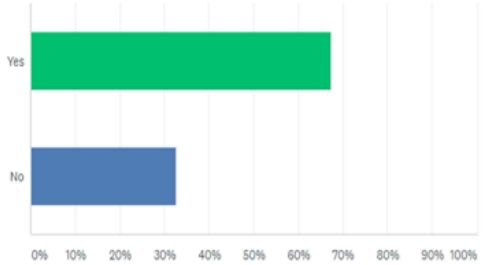
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	80.00%	40
No	20.00%	10
TOTAL		50

Do you feel that staff are confident in their understanding of appropriate PPE use?

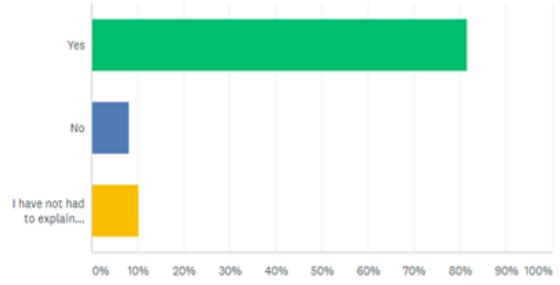
Answered: 49 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	67.35%	33
No	32.65%	16
TOTAL		49

Do you feel that the PPE expert training has helped you explain concerns relating to PPE to staff?

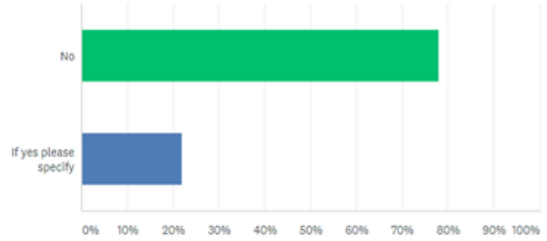
Answered: 49 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	81.63%	40
No	8.16%	4
I have not had to explain anything	10.20%	5
TOTAL		49

Do you feel there was anything missing from the PPE expert training?

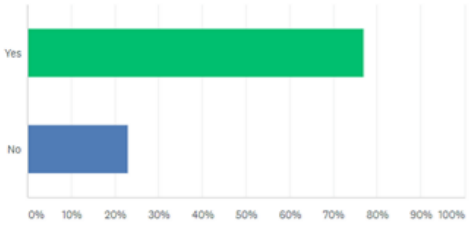
Answered: 50 Skipped: 0



ANSWER CHOICES		RESPONSES	
No		78.00%	39
If yes please specify	Responses	22.00%	11
TOTAL			50

Do you feel that there is currently enough PPE in the trust to comply with current policy?

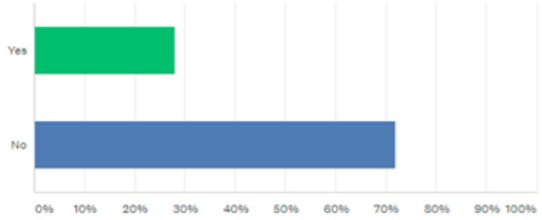
Answered: 48 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	77.08%	37
No	22.92%	11
TOTAL		48

Do you think that knowledge of PPE use prior to the pandemic was sufficient for safe practice with regards to PPE?

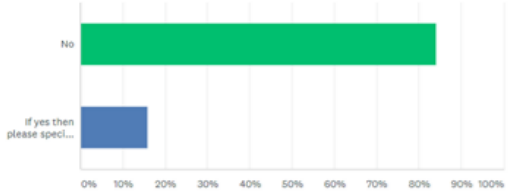
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	28.00%	14
No	72.00%	36
TOTAL		

On being challenged have any members of staff refused to change their use of PPE?

Answered: 50 Skipped: 0



This question had a free text element which was completed by 8 (16%) of respondents. There were too few respondents for a meaningful analysis of themes. Notably however, 38% (n=3) of respondents identified medical staff as having refused to change their PPE on being challenged

What would you say is the most common issue you encounter relating to PPE in the clinical areas?

This question had a free text response. Overall this question was completed by 47/50 respondents. Four clear themes were noted from the responses:

Theme	Mentions in free text response	Proportion of overall responses
Incorrect use of masks	20	43%
Knowing what PPE to wear	14	30%
Fear and anxiety	5	11%
Incorrect donning/doffing	5	11%

Other responses included incorrect handwashing practice, availability of PPE and understanding of COVID -19 transmission.

9.8 Procurement of Personal Protective Equipment (PPE)

During the period of national shortages of PPE, the IPC Team provided advice on procurement of PPE from alternative suppliers and liaised with local partnerships for example, the University of Manchester to design and provide face visors using 3D printers. Further work was also undertaken with local companies to source supplementary PPE.

9.9 National Screening Programme

The Manchester Partnership PHE Laboratory based at ORC Trust was the first centre outside of London to test for COVID-19. The Laboratory capacity was increased to provide testing for the Trust and the North West region. 24-hour working was introduced to cope with capacity and reduce the turnaround time of results.

9.10 Surveillance

The IPC Team worked in conjunction with colleagues from Information Technology to provide real time surveillance data regarding COVID in-patients. This information was used to inform internal and external reports

9.11 Extension of IPCT Services

The IPC Nursing Service was extended to provide additional on-site support to the Trust across 7 days

9.12 Nightingale Hospital North West

The team have provided IPC advice and support for the Nightingale Hospital this including; during the construction phase, induction training for staff on the use of PPE/general IPC principles. In addition, the team have provided ongoing advice and support whilst the facility has been open.

SECTION 10: TRAINING and EDUCATION

10.1 Training and Education

The IPC Nursing Team updated the e-learning package which is undertaken by all new staff on Induction to the Trust and delivered face-to-face training on the management of Healthcare associated infections to all new starters in Clinical induction.

10.2 Aseptic Non-Touch Technique (ANTT) theory sessions

The IPC Team supported the development of an e-learning package on the ANTT theory component and key principals of infection prevention and control to be undertaken by all staff across the trust who undertaken ANTT procedures.

Following the theoretical training session all members of staff whose practice included ANTT were competency assessed in the clinical environment. Thereafter staff must complete an annual re-assessment of competency to practice.

10.3 Bespoke learning activities

The IPC nursing teams continued to deliver learning activities bespoke to the individual sites of WTWA and ORC.

This year the IPC nursing team provided quarterly study days for the Infection Prevention Link Workers, who acted as Champions in their wards and departments raising awareness on current infection prevention and control practices and supporting the implementation of policies, guidelines and best practice. The study days included practical sessions and lectures delivered by microbiologists, guest speakers and members of the IPC Team.

The IPC team also continued to support the Local Universities with the delivery the ANTT theory component and basic Infection Control principles to both Nursing and Medical students.

In addition, the IPC Team delivered a range of training /education sessions to the following staff groups:

- International Nurses recruited to MFT
- Medical Team Induction
- Hospital Volunteers
- Work experience Students
- New Healthcare Support Workers
- Internship across sites
- Annual Young Peoples Open Day
- Porter Staff
- Staff working in areas when there was an increase/outbreak of infection
- Bespoke training on Ward/Departments

10.4 Hand Hygiene – Focus on practice

It is universally agreed that performing hand hygiene correctly and at the right time is the most effective measure in reducing Healthcare Associated Infections (HCAI). The Trust always expects all staff to comply with good hand hygiene practice.

This year the Infection Prevention and Control team has led the Trust participation in the Royal College of Nursing (RCN) accredited Gojo Hand hygiene training with sessions being undertaken in both the Acute and Community settings. These received very positive feedback from those who attended.

Also, in the last 12 months the Infection Prevention and Control team supported the participation in two national initiatives focusing on infection prevention and control. These included the World Health Organisation (WHO) clean care for all– it's in your hands: raising awareness that hand hygiene, along with Infection Control is critical to achieve quality of care and patient safety across all levels of the health sector.

The second initiative was International Infection Control week in October 2019. During this week the Infection Prevention and Control/Tissue Viability and

Education teams produced a mobile roadshow which visited all the Wards and Departments across the sites raising awareness of local Infection Control issues, hand hygiene and use of personal protective equipment to all members of the Multidisciplinary team members.

SECTION 11: MAINTAINING a CLEAN ENVIRONEMT

11.1 Governance Arrangements

Decontamination, Ventilation and Water services were governed by policies along with local operational plans. Each topic had local safety groups reporting into a group level committee that met quarterly and reported into the Group Infection Control Committee (GICC). All appropriate professional appointments, including Authorising Engineers, were in place and monitored through the Estates and Facilities Group Management Board (EFGMB). The services were assured by a programme of independent annual audits.

11.2 Decontamination Services

Sterilisation of re-useable surgical devices were undertaken centrally on site at the Oxford Road Campus in the Decontamination Services Department. The Department was accredited to ISO 13485:2016 and was also assessed and certified as meeting the requirements of Directive 93/42/EEC on medical devices, Annex V.

Wythenshawe, Trafford and Withington Hospitals continued in partnership with Christies and North Cheshire to receive sterile services from Steris. This was monitored by the WTWA Estates & Facilities Decontamination Group through Positional Reports provided by the Contract Manager.

Decontamination of flexible endoscopes was undertaken on the Oxford Road Campus in satellite units within associated clinical areas and at Trafford, Wythenshawe and Withington in centralised units. The Endoscopy Departments at Manchester Royal Infirmary (MRI) Endoscopy Unit, Trafford and Wythenshawe Hospitals were accredited by the Joint Advisory Group (JAG) with some actions noted (see below).

11.2.1 Achievements

The programme of works to upgrade the Trust's Endoscope Decontamination Suites (EDS) continued; the Children's Hospital theatres, MRI Outpatients Department, Elective Treatment Centre and Main Endoscopy, and Withington and Trafford Hospital Suites have all been completed. At the time of writing the Wythenshawe EDS is overdue a major upgrade and this is being progressed by a Task and Finish group alongside the Endoscopy Unit upgrade.

11.2.2 Required Developments

A set of seven risk-mitigation workstreams has been established (see below) to address ongoing issues as well as those highlighted by Audits and JAG Inspections.

- Replacement of Wythenshawe endoscopy facilities
- Lifecycle upgrade of DSD facilities at ORC
- Introduction of a fourth Automated Endoscope Reprocessor (AER) at Trafford

- Review of DSD & endoscopy facilities across MFT
- Introduction of electronic Track & Trace at ORC & Trafford
- Replacement of the Steris contract servicing both Wythenshawe & Trafford
- Appointment of a Trust Decontamination Lead.

Decontamination of Nasendoscopes at Trafford Hospital Nasendoscopes used in the Ear Nose and Throat (ENT) Department at Trafford and Altrincham are currently decontaminated by a manual wash followed by use of the Tristel Wipe System, (this meets the Essential Quality Requirements (EQR) in HTM01-06 but is not considered Good Practice). Spot audits were carried out on the process to maintain a minimum standard. As the Trafford Decontamination Suite has been upgraded it was intended to move the Trafford ENT scopes into the upgraded unit but the lack of a fourth Automated Endoscope Reprocessor has generated concerns for capacity and throughput.

There is an ongoing concern relating to Scopes, Blades and Probes which require either Decontamination or Sterilisation but cannot be reprocessed through the equipment the Trust currently has available. This is being reviewed with Procurement and the IPC & TV team for a resolution.

11.3 WATER SAFETY

11.3.1 Management of Risk for *Legionella*

Water sampling for *Legionella* was undertaken in accordance with L8 and Health Technical Memoranda (HTM-04). Remedial action was successfully undertaken on outlets that did not meet the required standard. All building and engineering projects were required to provide additional testing if they included modification or connection to the existing water system including the need to undertake Water Risk Assessments in line with the HTM.

11.3.2 Management of *Pseudomonas aeruginosa* from Water Outlets in High Risk Clinical Areas

Pseudomonas risk assessments for all augmented care areas were in place. Sampling for *Pseudomonas* continued in accordance with the addendum to HTM 04 with appropriate follow up on positive results. A Trust Wide review of the range of areas included within the Augmented Care Units definition has been ongoing but as of the date of this report has not reached a conclusion.

11.3.3 Achievements

Comprehensive maintenance programme and water testing regime for WTWA which now includes an in-house Pseudomonas water testing facility (IDEXX Pseudalert) which identifies positive results within 24 hours rather than 3 days. A Healthy Water Project that monitored water temperature and flow was undertaken at ORC. This identified areas of concern and timely resolution for low or no use outlets utilising new technology.

11.3.4 Required Developments

As well as the Augmented Care definitions review described above work has been ongoing between the Estates and Facilities Teams and IPC&TV relating to rise and fall baths (often referred to as Arjo Baths). This project is ongoing.

11.4 VENTILATION

The management of Ventilation Systems was based upon monitoring the legal and mandatory requirements of ventilation systems in healthcare premises; this includes the design, maintenance and the operation of ventilation systems:

Annual performance and verification checks were undertaken on all critical ventilation systems, including Ultra Clean Theatres, for assurance purposes. A 2019 Theatre PPM planner was issued for all theatres and critical ventilation plant.

Critical Ventilation systems are currently under review across MFT to establish where investment is required to improve existing facilities in Theatre areas.

11.5 CLEANING SERVICES

11.5.1 Contracting Arrangements

The Trust cleaning services were provided by both internal and external contractors/teams.

- Sodexo Healthcare was the main contractor for the provision of cleaning services across the Oxford Road Campus, including the Dental Hospital and Old Saint Mary's building and Wythenshawe Hospital.
- Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had services provided by in-house teams.

11.5.2 Monitoring Arrangements

As part of the contracts Sodexo were required to self-monitor the performance of cleaning services against key performance indicators. These were reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Estates and Facilities Team.

The services at Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.

In addition, the standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, the Ward Accreditation Process and the Patient Experience Tracker, (Oxford Road Campus/Trafford Hospital). These results informed areas of best practice and areas where additional focus was required.

11.5.3 The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo and internal providers to ensure cleaning standards were met across the Trust.

11.5.4 Cleaning Schedules

Cleaning schedules were publicly displayed in all clinical areas and processes were in place to report and escalate cleaning problems. These included: an agreed process which provided users with information on what services should be delivered and how to escalate non-compliance; and, a cleaning matters/logbook process which required clinical and cleaning staff to record the completion of tasks and log additional or amended requirements.

11.5.5 Infection Prevention and Control Training for Domestic Staff

All new employees attended a generic induction which included the principles of Infection Prevention and Control.

11.5.6 Patient Led Assessment of the Care Environment (PLACE)

The PLACE assessments were undertaken across the MFT sites and four MLCO sites. The assessments are the first to be conducted under the updated standards, and the first co-ordinated as MFT. The overall timeframe for the PLACE Assessments, including preparation, re-fresher training and data entry spanned from 14th August 2019 to 14th November 2019. (See Table 9 and 10)

Table 9: MFT PLACE Score Summary

Category	National Average %	ORC %	Wythenshawe %	Trafford including Altrincham %	Overall MFT, including MLCO %
Cleanliness	**98.60**	98.38	98.82	99.10	98.63
Food	**92.19**	93.70	94.54	92.59	93.97
Organisational Food	**91.92**	100	88.89	94.07	95.50
Ward Food	**92.62**	92.23	95.92	91.67	93.66
Privacy, Dignity & Wellbeing	**86.09**	86.33	88.85	93.16	87.88
Condition, Appearance & Maintenance	**96.44**	97.68	96.81	98.18	97.44
Dementia	**80.70**	79.68	87.34	88.08	83.20
Disability	**82.52**	79.78	84.84	87.18	82.30

Table 10: MLCO Score Summary

Category	National Average %	Buccleuch Lodge %	Dermott Murphy %	Gorton Parks %	Average MLCO %
Cleanliness	**98.60**	100	100	100	100
Food	**92.19**	91.77	97.53	98.33	95.88
Organisational Food	**91.92**	85.19	95.56	97.04	92.60
Ward Food	**92.62**	100	100	100	100
Privacy, Dignity & Wellbeing	**86.09**	85.71	88.10	91.53	88.45
Condition, Appearance & Maintenance	**96.44**	95.19	100	98.44	97.88
Dementia	**80.70**	73.13	88.24	87.50	82.96
Disability	**82.52**	69.64	80.36	92.59	80.86

Score above national average
Score just below national average
Score below national average

The scores for Buccleuch Lodge were influenced by work being undertaken to upgrade the environment at the time of the assessment. This work has now been completed. The full report on this has been presented to Patient Environment of Care Steering Group.

SECTION 12: ANTIMICROBIAL STEWARDSHIP

12.1 Antimicrobial Stewardship Committee

The trust- wide antimicrobial stewardship committee (AMC) was a subgroup of the GICC and was responsible for developing, implementing and monitoring the antimicrobial stewardship programme and reporting progress to the GICC. This year the AMC became affiliated with the Greater Manchester Antimicrobial Resistance (AMR) strategy group and the Antimicrobial Stewardship (AMS) groups and continues to work with these groups to ensure there is a coordinated approach to the AMR strategy across Manchester healthcare services.

Manchester Biomedical Research Centre (BRC) was one of ten leading research centres across the country to receive funding to explore innovative new ways to inform prescribing and identify patterns of resistance. The investment will result in expansion of the National institute for Health Research (NIHR) Manchester BRC's respiratory research.

12.2 Health Education England AMR innovation grant - AMS Change

In 2019 key members of the AMS team together with two health psychologists from the University of Manchester were awarded a HEE AMR innovation grant. In January 2020, 25 healthcare professionals from across MFT and Manchester Health and Care Commissioning (MHCC) were trained as "master trainers" that is, trainers in behaviour change techniques

with regards to AMS. Evaluation of this project and the interventions will be done as part of the follow-up for the grant.

12.3 Antimicrobial guidelines

The AMC had a continuous programme of development and review of the trust- wide antimicrobial formulary, ensuring that the guidelines were up to date; evidence based and in accordance with best practice and trends in surveillance. The guidelines were hosted on the MicroGuide platform which is accessible via an app and a web browser.

12.4 COVID-19 guidance

In March 2020 the 1st guidelines for the management of patients with Covid-19 (SARS-CoV) infection were published on MicroGuide. These guidelines are under constant review by the key members of the committee in line with the emerging evidence/ national guidance.

12.5 Point prevalence Audit March 2020

This audit was designed to determine the level of compliance with the Trust-wide antimicrobial prescribing guidelines (on Microguide) and determine actions required to address non-compliance. 518 patients prescribed antimicrobials across MFT were audited against a defined set of antimicrobial stewardship standards (see **Table 11** below).

Overall compliance with the trust-wide antimicrobial guideline was 94%. A Trust wide action plan has been implemented and individual hospitals received a breakdown of their results.

12.6 World Antibiotic Awareness Week 2019

In November 2019 the Antimicrobial stewardship team supported by the IPC team undertook a range of activities across the Trust to promote awareness of antimicrobial resistance. This was done in collaboration with our colleagues at The University of Manchester and Manchester Metropolitan University.

Table 11 Results of Point Prevalence Audit March 2020

Standard	Compliance (%)
1. Standard one Antibiotic treatment should be prescribed as per MFT antibiotic guidelines, unless specific micro advice, Culture and Sensitivity are available (or specific clinical indications prevent this)	94%
2. Standard two The indication for antibiotic treatment should be documented in the medical notes and on the drug chart	Notes: 92% Chart: 91%
3. Standard three The duration for antibiotic treatment should be documented in A) The medical notes B) the drug chart	Notes: 64% Chart: 77%
4. Standard four Doses and dose frequency should be appropriate for age, weight, renal and hepatic function	99%

5. Standard five IV antibiotic treatment should be appropriate for the patient's clinical status/match the guidelines	96%

SECTION 13: CONCLUSION

The content of this report establishes the broad spectrum of activity associated with infection prevention and control across the Group. The outcomes of the practice and process described are evidence of the hard work and commitment of staff working across the organisation.

The Group has maintained its reputation for strong and effective prevention and management of Infection Prevention and Control despite the challenges of the national outbreak of *Listeria monocytogenes* and the COVID-19 pandemic. In both situations staff across the organisation have shown their commitment to care for patients and each other under extreme circumstances.

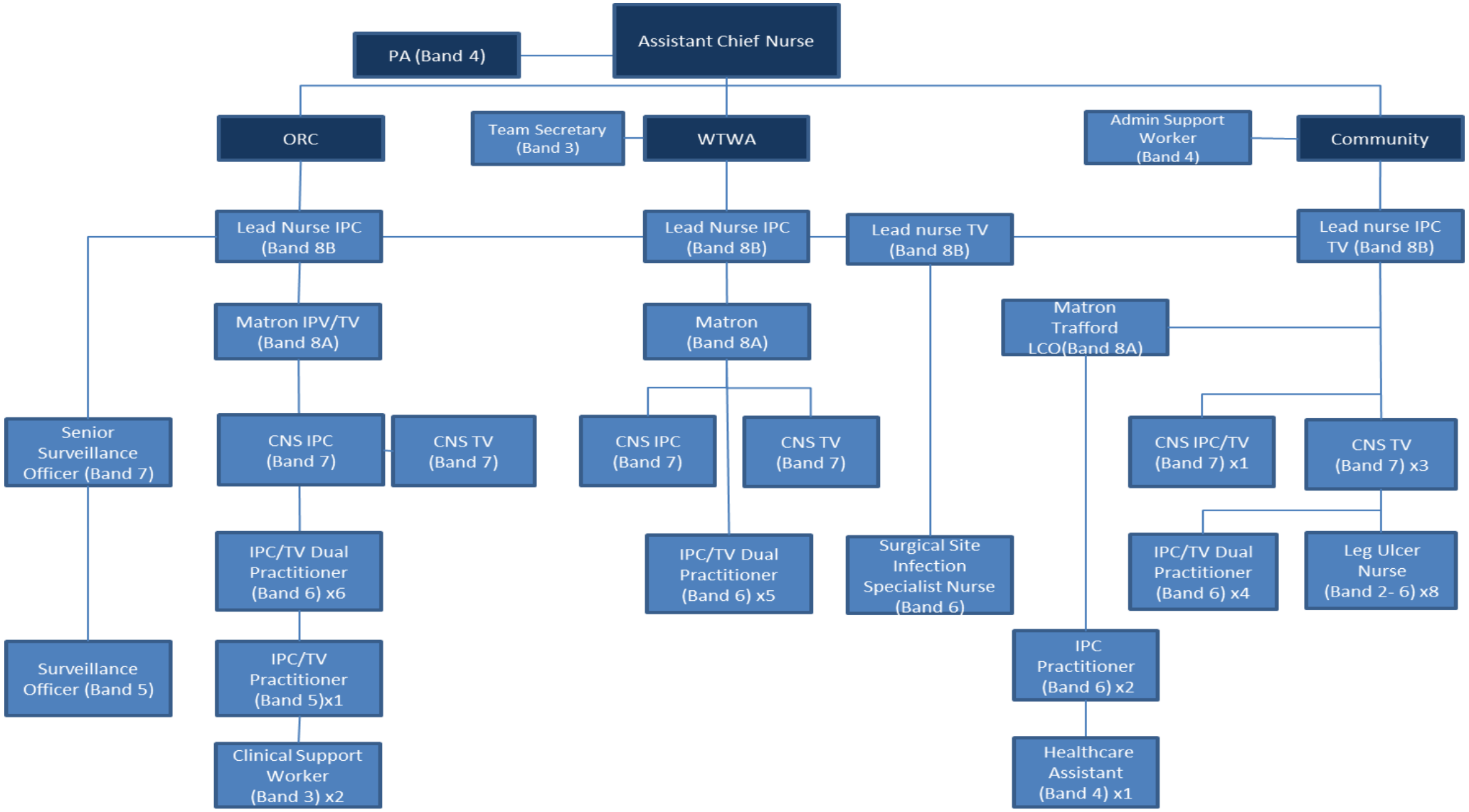
The content of this report reflects the breadth of activity and the enthusiasm to constantly improve and to develop new and innovative means of improving patient care. Moreover, this report demonstrates a culture of openness and transparency in regards to the internal and external review processes for key infections.

The Board of Directors are asked to receive this report for April 2019 to March 2020 and approve for publication.

Julie Cawthorne
Assistant Chief Nurse/Clinical Director of Infection Prevention and Control
June 2020

Appendix 1

MFT IPC/TV Nursing Team Structure 2019/20



Appendix 2

GROUP INFECTION CONTROL COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Group Management Board has established a Committee to be known as the Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Infection Control Committee is chaired by the Chief Nurse/ Director of Infection Prevention and Control.

2. MEMBERSHIP

2.1 Membership shall consist of:

Chief Nurse/DIPC (CHAIR)
Consultant Microbiologist/Infection Control Doctors (Vice-Chair)
Deputy Infection Control Doctor
Directors of Nursing
Assistant Chief Nurse Clinical DIPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
Consultant in Communicable Disease (Public Health England)
MHCC Infection Control Lead
Antimicrobial Pharmacist
Director of Estates and Facilities
Associate Director of Clinical Governance
Director of Clinical Governance
LCO representative
Assistant Director, Employee Health & Wellbeing
Chair of Antimicrobial Committee

All group executives have an open invitation to and may attend committee meetings

2.2 No business should be transacted at the meeting unless a minimum of ten members are present, which must include the Chair or Deputy Chair, four Hospital Clinical Leads, and either the Director of Nursing (Corporate) or the Assistant Chief Nurse/Clinical DIPC

3. ATTENDANCE AT MEETINGS

3.1 The Infection Control Committee may require the attendance of any Trust employee (or agent of the Trust)

4. FREQUENCY OF MEETING

4.1 The Committee will meet every three months (four times a year), but may be convened at other times as deemed necessary.

5. OVERVIEW

5.1 The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

5.2 The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence based practice and standards.

6. SCOPE AND DUTIES

6.1 Provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets.

6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites.

6.3 Approve the programme of work of the Trust Clinical Infection Control committee.

6.4 Receive Hospital/MCS ICC performance and exception reports

6.5 Receive, review and ratify group policies, clinical pathways and reports, including the Annual Infection Control Report.

6.6 Approve the annual audit calendar to provide assurance that standards are met and any required changes to practice, systems and processes are delivered.

6.7 To report to the Group Management Board on performance against infection control indicators and audits, including actions taken to address any areas for improvement.

6.8 To determine and commission programmes of work required to deliver the work programme of the Infection Control Committee

6.9 Oversee the Trust's involvement in and response to, internal and external assessments and inspections.

6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

6.11 Approve the Trust's Annual Infection Control Report.

6.12 To describe, review and monitor the principle and significant risks related to infection control on behalf of the Trust and present these with the plan of controls to the Group Management Board and Risk Management Committee.

6.13 The Infection Control Committee will receive exception reports from the Hospital/MCS Infection Control leads where performance is out with the standards set out in the IPC strategy

6.14. The Infection Control Committee will receive at each meeting a report from the Trust Infection Control Group to include:

1. Policy and pathway development
2. Infection Control Group activity
3. Changes to national or local strategy
4. Trust wide themes identified from adverse events

7. AUTHORITY

7.1 The Infection Control Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

8.1 The Committee will report to the Group Management Board.

8.2 The Committee will work closely with relevant Group Committees and the Clinical Advisory Committee and will provide assurance to the Board of Directors in relation to infection prevention and control

8.3 The minutes and exception report (as required) will be considered at the next Risk Management Committee and Quality and Performance Scrutiny Committee

9. REVIEW

9.1 These terms of reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

1. 75% attendance of all listed members or nominated deputy
2. Presentation of the Annual Infection Control Report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Helen Rogers, Assistant Chief Nurse (Education) Michael McNamee, Matron Post Registration Education Sherine Campbell, Professional Education and Development Team Co-ordinator
Date of paper:	June 2020
Subject:	Nursing and Midwifery Revalidation Annual Report 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff Experience/Patient Safety
Recommendations:	To note the actions taken and on-going plans in place to support nurses, midwives and nursing associates across the Trust to meet the Nursing & Midwifery Council Statutory Revalidation requirement.
Contact:	Name: Helen Rogers, Assistant Chief Nurse (Education) Tel: 0161 701 8569

BOARD OF DIRECTORS

1. Introduction

1.1 This is the third annual report for Manchester University NHS Foundation Trust (MFT) to provide assurance on Nursing and Midwifery Revalidation to the Board of Directors. Within the report, the data is reported from1st April 2019 to 31st March 2020 for MFT.

2. Background

2.1 Since April 2016, Nurses and Midwives have been required to undergo a triannual process of revalidation to demonstrate that their practice is in line with the Code (Nursing and Midwifery Council (NMC) (2018). Revalidation replaced the previous post-registration education and practice (PREP) standards.

2.2 The NMC opened the Nursing Associate part of the professional register on 28th January 2019. Nursing Associates registered with the NMC are now in employment throughout MFT and will be subject to the same regulation and revalidation criteria as all other registered nurses and midwives. The first Nursing Associates who qualified and registered in January 2019 will be subject to revalidation in January 2022. Revalidation reports from January 2022 will therefore also need to provide assurance of Nursing Associate revalidation to the Board of Directors.

2.3 The requirements for revalidation are as follows:

- 450 practice hours, or 900 if renewing as both a nurse and midwife
- 35 hours of Continuing Professional Development including 20 hours of participatory learning
- Five pieces of practice-related feedback
- Five written reflective accounts
- A reflective discussion with an appropriate “Confirmer”
- Health and character declaration
- Professional indemnity arrangement
- Confirmation that the requirements have been met

2.4 Registrants are required to maintain a portfolio of evidence, which demonstrates they have met the requirements for revalidation.

2.5 It is the individual Nurse, Midwife and Nursing Associate’s professional responsibility to ensure that they meet the revalidation standards. However, as a supportive employer, the Trust has a responsibility to support Registrants in meeting the requirements in order to demonstrate that practice is safe and effective.

3. National Process

3.1 All registrants will receive direct communication from the NMC to provide a reminder of their pending revalidation and the time to prepare their evidence for completion of the process.

3.2 Registrants can be granted an extension; this does require an application to be made to the NMC which looks at any exceptional circumstances causing delay in the process.

3.3 For quality assurance purposes, each year, the NMC will select a sample of Nurses, Midwives and Nursing Associates to provide further information about their revalidation application. This process is known as verification.

4. Implementation of Revalidation

4.1 The Chief Nurse remains 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.

4.2 The Directors of Nursing have oversight of the process and compliance position for individual registrants in their hospital/MCS/MLCO. They link closely with the Professional Education & Development Team to maintain scrutiny and oversee the process for their areas.

4.3 The process for revalidation is supported through the Trust's annual appraisal process, In preparation for revalidation, nurses, midwives and nursing associates are asked about their revalidation date, and are required to produce two pieces of reflective evidence and two pieces of practice related feedback to discuss at their appraisal each year. This evidence will then allow the registrant to submit the five required reflective accounts and feedback at the three-year renewal point.

4.4 From an organisational perspective, ongoing support is provided through resources online and local revalidation champions.

4.5 The MFT Nursing and Midwifery Revalidation Policy and the Verification of Professional Registration Policy have been updated in 2019 to include the monitoring and recording of Nursing Associate revalidation.

5. Revalidation figures 1st April 2019 - 31st March 2020

5.1 From 1st April 2019 to 31st March 2020, 2,235 nursing and midwifery staff were due to revalidate; 2,229 revalidated. Six nurses did not revalidate, one does not require NMC registration for their employed role in the Sexual and Reproductive Health Team, four nurses allowed their NMC registration to lapse due to retirement and one nurse resigned from her post.

6. 2020/21 Revalidation work programme

6.1 A significant factor in the successful implementation of Nursing and Midwifery Revalidation has been the integration of revalidation within everyday practice through continuing professional development. To ensure continued success within MFT the following actions are in progress:

- The MFT Nursing and Midwifery Revalidation Policy and the Verification of Professional Registration Policy have been updated to include the monitoring and recording of Nursing Associate revalidation.
- Updated resources, support and advice are available to staff through the revalidation page on the Intranet.
- The MFT Nursing and Midwifery Revalidation data collection process has been reviewed and ratified, and monthly monitoring is in place to ensure all registrants whore required to revalidate, have done so.
- Annual Nursing and Midwifery Revalidation portfolio audit.

7. Conclusion and Recommendation

7.1 Revalidation for Nurses and Midwives has been a mandatory requirement since April 2016. The initial wave of registrants who revalidated in 2016 will be repeating this process in 2020.

7.2 The Trust has developed and delivered a range of mechanisms to prepare Nurses, Midwives, Nursing Associates and their managers for the requirements of revalidation. Nursing and Midwifery Revalidation is now embedded across MFT. The continued support of registrants to ensure that they successfully revalidate remains a core patient safety objective for the Trust.

7.3 The report is provided to assure the Board of Directors that nurses and midwives employed by MFT as appropriately registered and revalidated with the NMC.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Tracy Shawcross, Matron for Quality & Patient Experience Lynne Birchall, Head of Nursing Quality & Patient Experience
Date of paper:	June 2020
Subject:	Annual Accreditation Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's vision & values and Key Strategic Aims:	Patient and Staff Experience Patient Safety
Recommendations:	To note the content of the report and the progress and outcomes of the Trust Accreditation Programme in 2019/2020
Contact:	Name: Lynne Birchall Head of Nursing for Quality & Patient Experience Tel: 0161 276 5061

Manchester University NHS Foundation Trust (MFT) Accreditation Report

01st April 2019 – 31st March 2020

1. Executive Summary

1.1 Members of the Group Board of Directors are asked to note the Accreditation Report (2019/20) for Manchester University NHS Foundation Trust (MFT).

1.2 The accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high quality care and the best patient experience.

1.3 The MFT Accreditation Programme commenced on April 1st 2018. Prior to this date, accreditation processes were well established within legacy trusts. Accreditation assessment models and standards are in place for wards, day case areas, emergency departments, theatres, treatment centres, outpatient departments and community services across the Trust. The process for each of the accreditations is designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

1.4 In total 156, areas were accredited in 2019/20 utilising the MFT Accreditation assessment, which is 3 more areas than were accredited in 2018/19

1.5 The accreditation process involves assessment against agreed standards for a number of key domains and is scored as Gold, Silver or Bronze. The collated result across all domains provides an overall result for the area. Areas that cannot demonstrate they are achieving minimum accreditation standards are described as 'White', indicating the requirement for an intensive support package.

1.6 This report highlights the on-going correlation between effective leadership and high performing teams.

1.7 In 2019/20, 36% (56) of areas attained Gold, 53 % (83) attained Silver and 11% (17) attained Bronze status. 3 areas were initially classified as White and following a bespoke support package were reaccredited 6 months later, in accordance with the MFT Accreditation Standard Operating Procedure (SOP), and achieved Bronze status.

1.8 Of the 56 Gold areas, 55% (31) achieved Gold in both 2018/19 and 2019/20, and 19% of these areas (6) achieved Gold in every domain of the accreditation for 2019/20.

1.9 To celebrate these achievements, an Excellence in Care award, has been developed, which recognises areas that have attained Gold for two or more consecutive years and have achieved Gold in all domains. Clinical areas are able to apply to the Chief Nurse for this new award if the criteria have been met and there has been no change in leadership in the 12 months prior to the application.

1.10 Areas attaining Gold are presented with their certificates by the Hospital/Managed Clinical Service/LCO Director of Nursing/Midwifery/LCO Chief Nurse and/or the relevant Chief Executive and representatives from the area and usually invited to the MFT Excellence Awards in recognition of their achievements. Alternative arrangements will be made in 2020 due to the impact of the Coronavirus pandemic.
Illustration 1: Gold Certificate presentation, Forum and Baguley Health Visiting Team LCO

1.11 The planned MFT Accreditation Programme for 2020/21 will be temporarily replaced by an alternative assurance process to take account of the impact of the pandemic response. The alternative process has been designed to provide on-going assurance regarding care standards and the quality of patient experience.

1.12 The Group Board of Directors is asked to note the content of the report and the plans to maintain an assurance process during 2020/21.

2.0 Background

2.1 The Accreditation Programme is a process that assesses the quality of care and aims to raise the overall standard of care provided to patients. The accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high quality care and the best patient experience. The process is underpinned by the Improving Quality Programme and supported by, the Trust Values, the 'What Matters to Me' patient experience programme and the Nursing, Midwifery and AHP Strategy.

2.2 Data is used extensively to inform the accreditation process; including Quality of Care Round (QCR), WMTM patient survey data and Friends and Family (FFT) data along with local incident and complaints/PALS data and staff and learner feedback in order to provide a 360 degree assessment of the area.

2.3 Areas that undergo accreditation include inpatient wards, day-case and treatment areas, critical care areas, theatres, emergency departments, dialysis units, community services and outpatient departments. The accreditation assessment process includes the review of a series of defined standards and metrics within wards and departments across hospitals and Managed Clinical Services. During an accreditation the following domains are assessed: Leadership and culture of continuous improvement, communication about and with patients and staff, record keeping, environment along with a range of nursing and administrative processes depending upon the area being assessed. Each area is required to undertake continuous improvement activities, driven by local data, and to display details of their performance and their improvement programme on their local Improving Quality Programme board in order to ensure visibility to patients, families and staff.

2.4 The process for each of the accreditations has been designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

2.5 The accreditation involves assessment against agreed standards within each domain, which are scored as Gold, Silver or Bronze. The collated result across all domains provides an overall result for the area. All areas accredited in 2019/20 have been awarded an overall result of Bronze, Silver or Gold. The criteria for each of the scores are as follows:

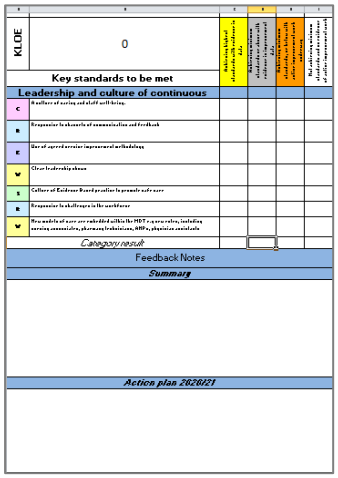
- Gold: Excellent, achieving highest standards with evidence in the data that success sustained for at least six months
- Silver: Very good, achieving minimum standards or above with evidence of improvement in relevant data
- Bronze: Good, achieving minimum standards or below but with evidence of active improvement work
- White: Not achieving minimum standards and no evidence of active improvement.

2.6 Within the accreditation domains, standards are mapped to the appropriate CQC Key Line of Enquiry (KLOE), to support teams to identify if areas are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-Led

2.7 In 2019/20 an additional 2 standards were included into the leadership domain aligned to Responsive and Well Led. The purpose of this addition was to ensure leaders within clinical areas are actively addressing workforce issues and that new models of care are being developed and embedded within individual teams in response to patient needs.

Illustration 2: KLOE Leadership Standard



Leadership and culture of continuous improvement	
C	A culture of caring and staff well-being.
R	Responsive to channels of communication and feedback
E	Use of agreed service improvement methodology
W	Clear leadership shown
S	Culture of Evidence Based practice to promote safe care
R	Responsive to challenges in the workforce
W	New models of care are embedded within the MDT e.g new roles, including nursing assosciates, pharmacy technicians, ANPs, physician assistants

2.8 The accreditation process is described in detail in an Accreditation Standard Operating Procedure (SOP). The SOP is reviewed annually to ensure the assessment standards and processes remain current, relevant an evidence-based.

3.0 2019/20 Accreditation Programme

The Improving Quality Programme (IQP)

3.1 IQP is the Trust's methodology for continuous improvement which supports staff to review their data, identify areas of concern, research best practice based on current evidence, implement changes, follow a structured approach using a Model for Improvement and Plan-Do-Study-Act (PDSA) cycles and to ensure that changes are evidence based, measurable, embedded and sustained in practice. IQP enables teams to improve their ward environment and processes, which is intended to 'release time', that can be reinvested in improving quality, safety and the patient experience.

3.2 As a part of the MFT Accreditation process, teams are assessed on their continuous improvement journey to ensure the best patient and staff experience.

3.3 IQP is a well-established methodology within services based on the Oxford Road Campus and at Trafford Hospital. In order to ensure consistency across all the Trust's services, roll-out of IQP commenced in 2018/19 for Wythenshawe Hospital through delivery of an intensive training and support programme. Rollout was temporarily suspended during Q4 2019/20 to release capacity to support the pandemic response. This pause provided an opportunity to review and revise the training programme, which will be relaunched in 2020/21 across all MFT hospitals/MCS/LCOs using a new, collaborative approach.

4.0 Champion Handbooks

4.1 A series of Improving Quality Champion Handbooks have been developed during 2019/20 and are now available on the MFT Intranet to support teams to implement the Improving Quality Programme and deliver continuous improvements.

Illustration 3: Improving Quality Programme – Shift Handover Champion Handbook

5.0 Accreditation Results 2019/20

Illustration 4: Gold Certificate presentation, Eye J Day Case MREH

5.1 In 2019/20 156 accreditations were undertaken utilising the MFT Accreditation process between May 2019 and February 2020; the overall results are detailed below in Table 1. Detailed results by area can be found at **Appendix 1**.

Table 1: MFT Accreditation Results (2018/19 -2019/20)

MFT– Accreditation Results	2018/19		2019/20	
	No	**%**	**No**	**%**
Gold	54	35	56	36
Silver	70	46	83	53
Bronze	29	19	17	11
White	0	0	3*	0
Total	**153**	100	**156**	100

- See section 5.2 below

5.2 Three areas were initially assessed as 'White' in 2019/20. Two areas were within Manchester Royal Infirmary (Head and Neck Surgical Unit and Ward 46) and one within RMCH (Paediatric Emergency Department). Compliance with medication standards was a key factor in all three areas. Compliance with the Trust's standards for meals processes in one of the areas and compliance with environment standards in another of these areas also contributed to the "White" outcome. All three areas were provided with a bespoke support package based on their individual needs. Delivered by the Hospital/MCS management team and the Quality Improvement Team, the package included one to one quality improvement support focused on ensuring safe practice and on establishing systems and processes in the aspects of the accreditation that were assessed as below Trust standard. All three areas were re-accredited during 2019/20 in accordance with the MFT Accreditation Standard Operating Procedure

(SOP), and demonstrated improvement within all areas that had been previously assessed as 'White' enabling them to be awarded 'Bronze' accreditation status.

5.3 All areas attaining Gold status were presented with their certificates by the Hospital/ Managed Clinical Service/LCO Director of Nursing and/or the Chief Executive. Representatives of Gold areas are usually invited to the MFT Excellence Awards to celebrate their achievements. As a result of the impact of the pandemic response, alternative arrangements will be made during 2020.

5.4.1 During 2019/20 there was a slight increase of 1% (2) in Gold areas, a 7% (13) (positive) increase in Silver areas and an 8% (12) (positive) decrease in Bronze areas. Three areas were initially accredited as 'White'; indicating a need for a bespoke support package. All three areas were re-accredited within six months, in accordance with the MFT Accreditation SOP, and were subsequently awarded Bronze status after demonstrating improvement. The 2019/20 results show that 89% of areas are now accredited as Gold or Silver; this is a significant improvement of 8% when compared to the 2018/19 position.

6.0 Leadership

6.1 Frontline Clinical Leadership, particularly compassionate inclusive leadership is considered key to enabling cultural change so that NHS organisations can deliver high quality care[1]. The MFT Culture and Leadership Strategy recognises that this means every interaction by every member of staff, every day, influences the extent to which the Trust develops a culture of high quality, continually improving and compassionate care[2].

6.2 Inclusion of an assessment of leadership, in the context of the journey of continuous improvement, is a key domain that is assessed as part of the accreditation.

6.3 In the last MFT Accreditation Annual Report, analysis was presented, which demonstrated a correlation between the outcome of the assessment of the leadership domain and the overall accreditation result. The data presented in Table 2, below, demonstrate that this correlation has continued in 2019/20, with 93% of areas that were awarded Gold overall also achieving Gold in the Leadership Domain, however, for areas that achieved Bronze overall, only 6% achieved Gold in the Leadership Domain.

[1] NHSI and The Kings Find (2017) Culture and Leadership Toolkit; Phase2.
Available from:https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/01-NHS104 Phase_2_Toolkit_060717_FINAL.pdf

[2] MFT Culture and Leadership Strategy (2017)

Table 2: MFT Accreditation: Overall Result compared to Leadership Domain Result

MFT 2019/2020		
	Overall Result (Number of areas)	**Leadership Domain Result (Number of areas)**
Gold	56	Gold – 52 Silver – 4 Bronze – 0
Silver	83	Gold – 33 Silver – 45 Bronze –5
Bronze	17	Gold – 1 Silver –7 Bronze – 9
White	0	N/A
Total		100

6.4 These data demonstrate that strong clinical leadership drives high performance against quality standards and emphasise the importance of the Trust's commitment to the development of clinical leaders at every level of the organisation in order to ensure a high quality patient experience and safe care.

7.0 Impact of Workforce Factors on Accreditation Results

7.1 Concern that the quality of patient care can be compromised if there are insufficient nurses and midwives available, is well-publicised[3].

7.2 The Trust's workforce indicators including turnover, sickness and qualified nurse vacancies have triangulated against accreditation outcomes for 2019/20 to determine if there is a correlation.

7.3 **Turnover:** Areas that were accredited as Gold overall had turnover rates ranging from 0.0% to 34.5%, with 29 of the 57 (51%) areas awarded Gold exceeding the Trust target turnover rate of 12.6%. Areas that were accredited as Bronze overall had turnover rates ranging from 2.49% to 32.8% with 11 of the 17 (65%) Bronze areas exceeding the Trust target turnover rate of 12.6%.

7.4 **Sickness Absence:** Areas that were accredited as Gold had sickness rates ranging from 1.2% to 17.1%. For areas that were accredited as Bronze, sickness rates ranged from 3.5% to 12.6%.

7.5 **Vacancies**: Areas that were accredited Gold had a 6 month rolling average of Registered Nurse/Midwife vacancy rate ranging from 0.0% to 35.8% and those accredited as Bronze had a vacancy rate ranging from 0% to 31.2%. Caution should be applied when considering the percentage vacancy rates, as in a small team fewer vacancies have a greater impact of the vacancy percentage.

7.6 Overall, as was also the case in 2018/19, triangulation of accreditation results with workforce indicators shows no correlation between turnover, sickness or vacancy rates and accreditation outcome. The data presented above do however, highlight the value of clinical leadership in maintaining the delivery of a high quality service to patients; sometimes despite pressures that may result from vacancies and sickness absence.

[3] Francis, R. (2013) The Mid Staffordshire NHS Foundation Trust: Public Enquiry. Available from: http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report

Throughout 2019/20, the Trust has continued to provide leadership development opportunities for Ward/Department Managers and Matrons.

8.0 Accreditation 2020/21

8.1 156 areas were scheduled to undergo accreditation in 2020/21, however, in order to release clinical and managerial capacity to support the pandemic response and recovery, and to minimise footfall and the risk of transmission of Coronavirus within clinical areas, the Accreditation programme has been paused during 2020/21. In order to maintain assurance regarding the quality of care and patient experience during this time, an alternative process is being developed.

8.2 In the temporary assurance process, assurance meetings will be undertaken, led by the Chief Nurse or Deputy Chief Nurse, with each Director of Nursing/Midwifery/LCO Chief Nurse and their teams to review key indicators across each of their clinical areas. This process will be supported by the Quality Improvement Team who will populate an agreed template with relevant quality data prior to the assurance meeting. Directors of Nursing/Midwifery/LCO Chief Nurse will be required to provide specific information relating to the performance of their clinical areas.

8.3 Leadership analysis will focus on evidence of progress against a local IQP recovery plan and evidence that actions implemented as part of the Trust's CQC action plan have been sustained.

8.4 The process will be underpinned by a walk round of each clinical area by one member of the Quality Improvement Team in order to assess the environment of care, including safe and secure storage of medicines, and to observe an agreed nursing process, which will be defined through analysis of local data. The findings of the walk round will be captured on the assurance template in advance of the assurance meeting.

8.5 Clinical areas will maintain their current accreditation status during 2020/21 and the outcome of the assurance process will inform local improvement activity. The full accreditation programme will be recommenced in April 2021.

9.0 Recommendation

9.1 The Group Board of Directors is asked to note the content of the Annual Accreditation Report 2019/20 and the plans to implement a temporary assurance process during 2020/21 to maintain oversight of the quality of care that is provided to MFT patients during the pandemic recovery period, pending recommencement of the full accreditation programme in April 2021.

Illustration 5: MFT Excellence Award presentation

Appendix 1: Validated Results 2019/20

Manchester Royal Infirmary (MRI):

Manchester Royal Infirmary	
Emergency Assessment & Access	
Name	**2019/20 Validated Result**
Ward 1 & 2 (Previously ESTU)	**08.10.19**
Ambulatory Care Unit (ACU)	**01.10.19**
Acute Medical Unit(AMU)	**25.06.19**
MRI Emergency Department	**27.08.19**
Surgical Admission Unit SAU (Ward 15)	**10.12.19**

Cardio- Vascular Specialties	
Name	**2019/20 Validated Result**
Acute Cardiac Centre (ACC - Ward 35)	**02.07.19**
Manchester Heart Centre OPD	**30.07.19**
Ward 3	**23.07.19**
Manchester Vascular Ward (MVC)	**09.07.19**
Ward 5 MRI	**07.01.2020**
Ward 4	**16.07.19**

GI Medicine & Surgical Specialities	
Name	**2019/20 Validated Result**
AM3	**02.07.19**
AM4	**11.06.19**
Ward 8	**25.06.19**
Endoscopy MRI	**24.12.19**

Ward 11 & 12	25.06.19

In Patients Medical Specialities	
Name	2019/20 Validated Result
AM1	04.06.19
AM2	01.11.19
Ward 6	01.10.19
Ward 30	24.09.19
Ward 31	06.08.19
Ward 32	27.08.19
Ward 44	11.06.19
Ward 45	23.07.19
Ward 46	14.01.2020
Manchester Ward	15.11.19
Haematology Day case	01.10.19

Urology, Renal & Transplant Specialities	
Name	2019/20 Validated Result
Acute Kidney Unit (Ward 37a)	01.10.19
Altrincham Renal Dialysis Unit	07.01.2020
Tameside Renal Dialysis Unit	19.11.19
ETC: Urology	23.07.19
Ward 9 & 10	09.07.19
Ward 36	02.07.19
Ward 37	04.02.2020
NMGH Renal Dialysis Unit(Hexagon)	25.02.2020

MRI Renal Dialysis Unit	27.08.19

Head & Neck Specialities	
Name	2019/20 Validated Result
Head and Neck Surgical Unit	25.02.2020
Peter Mount OPD	12.11.19

Outpatients Clinical Services	
Name	2019/20 Validated Result
Diabetes OPD	12.12.19
Rheumatology OPD	01.10.19
Main OPD including Fracture Clinic	15.10.19

Theatres & Elective In-Reach	
Name	2019/20 Validated Result
ETC Day case + Surgical Admissions Lounge (SAL)	30.07.19
MRI Theatres	12.12.19

Clinical and Scientific Services (CSS):

Clinical & Scientific Services Managed Clinical Service	
Name	2019/20 Validated Result
Acute Intensive Care Unit (AICU, based Wythenshawe Hospital)	03.12.19
Cardiac Intensive Care Unit (CICU previously CSITU, based MRI)	15.10.19
Cardiothoracic Critical Care Unit (CTCCU, based Wythenshawe Hospital)	04.06.19
CSS OPD (Physiotherapy 1)	18.02.2020
Intensive Care Unit (ICU MRI)	28.05.19
High Dependency Unit (HDU MRI)	18.06.19

High Care Unit (HCU TGH)	**13.08.19**
Radiology Intervention Unit (RADU)	**12.12.19**

Research and Innovation (R&I):

Research & Innovation	
Name	**2019/20 Validated Result**
Adults Clinical Research	**25.09.19**
Children's Clinical Research	**09.07.19**

Manchester Royal Eye Hospital (MREH) and University Dental Hospital Manchester (UDHM):

Manchester Royal Eye Hospital	
Name	**2019/20 Validated Result**
Ward 55	**02.07.19**
Day Case Unit (Eye J)	**23.07.19**
MREH Theatres and Dental Sedation Unit	**18.06.19**
Emergency Eye Department	**11.06.19**
MREH OPD	**05.11.19**
Macular Treatment Centre's	**15.11.19**
University Dental Hospital of Manchester	
Name	**2019/20 Validated Result**
Dental OPD	**11.02.2020**

St Mary's Hospital (SMH):

Saint Mary's Hospital	
Name	**2019/20 Validated Result**
Ward 47a (MLU)	CLOSED
Ward 47b (MLU)	02.07.19
Ward 62	10.09.19
Ward 63 EGU	02.07.19
Ward 64 (CDU and Triage)	10.12.19
Ward 65	04.06.19
Ward 66	31.12.19
Ward 68 - Neonatal Intensive Care Unit (NICU) (Based at St Marys Hospital)	09.07.19
Antenatal OPD	25.06.19
Enhanced Recovery Programme (ERP)	26.11.19
SMH Gynaecology OPD	14.01.2020
Reproductive Treatment Centre (Ward 90)	26.11.19
SMH Theatres	17.12.19
Birth Centre (Based at Wythenshawe Hospital)	22.10.19
Ward C2	23.07.19
Ward C3	23.07.19
Delivery Suite (Based at Wythenshawe)	19.11.19
Ward F16	01.10.19
Neonates (NNU) (Based at Wythenshawe Hospital)	01.10.19

Royal Manchester Children's Hospital:

Royal Manchester Children's Hospital	
Name	**2019/20 Validated Result**
Starlight Inpatients (based at Wythenshawe Hospital)	18.02.2020
Starlight Day case & OPD (based at Wythenshawe Hospital)	18.02.2020
BMTU and Stem Cell Unit (Ward 84a & 84c)	01.11.19
Children's Resource Centre (based at TGH)	03.12.19
Galaxy House	28.01.2020
Oncology/Haematology Day case (Ward 84b)	26.11.019
RMCH ED	18.02.2020
RMCH OPD	15.10.19
RMCH Theatres	17.12.19
Ward 75	29.10.19
Ward 76 (Short Stay/Day Case)	13.08.19
Ward 77	26.11.19
Ward 78	03.06.19
Ward 80 (Paediatric Intensive Care Unit)	12.11.19
Ward 81 (Burns Unit)	12.11.19
Ward 82 (Paediatric High Dependency Unit)	03.09.19
Ward 83 (TCU)	03.12.19
Ward 84 (Inpatients)	11.06.19
Ward 85	17.09.19

Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA):

WTWA	
Wythenshawe Hospital	
Medicine	
Name	**2019/20 Validated Result**
Acute Medical Unit (AMU)	**05.11.19**
Clinical Decision Unit (CDU)	**07.02.2020**
F4	**26.11.19**
F7	**01.10.19**
Ward A9	**23.07.19**
Ward F12	**22.10.19**
Ward F14	**28.05.19**
Ward F15	**19.11.19**
OPAL House	**28.01.2020**
Wythenshawe ED	**18.02.2020**
Heart and Lung	
Name	**2019/20 Validated Result**
Acute Coronary Care unit (ACCU)	**19.11.19**
Doyle Ward	**15.11.19**
Jim Quick Ward	**06.08.19**
North West Ventilation Unit (NWVU)	**30.07.19**
Pearce Ward	**04.02.2020**
Ward A7	**25.06.19**
Ward F11: Planned Investigation and Treatment Unit (PITU)	**09.07.19**
Ward F2 Lung Surgery	**29.10.19**

Pulmonary Oncology Unit (POU)	24.09.19
Ward F5 + F2 Day Case	25.09.19
Ward F6	30.07.19
Wilson Ward	13.08.19
Surgery	
Name	**2019/20 Validated Result**
Acute Theatres (A Block)	03.09.19
Burns Unit	17.12.19
Theatres (F Block)	14.01.2020
Treatment and Diagnostic Centre Theatre (TDC)	14.01.2020
Ward A1 - Vascular	02.07.19
Ward A2	10.12.19
Ward A3 - Orthopaedics	29.10.19
Ward A4	06.08.19
Ward A5	31.12.19
Ward A6	11.02.2020
Ward F1	03.12.19
Ward F3 - Urology	26.11.19
Ward F9	28.05.19
Trafford General Hospital	
Name	**2019/20 Validated Result**
Ward 2	09.07.19
Ward 3 INRU	22.10.19
Ward 4	25.06.19
Ward 6	25.02.2020

Ward 11 (Previously Ward 1 Stroke)	10.09.19
Ward 12 MOC and DC	10.09.19
Altrincham Minor Injuries Unit	15.11.19
Altrincham OPD & MREH OPD	05.11.19
Acute Medical Unit (AMU TGH)	08.09.19
Medical Day Unit TGH	12.11.19
Trafford OPD	03.09.19
Trafford Theatres	04.02.2020
Trafford Urgent Care	22.10.19

Manchester Local Care Organisation (MLCO):

Manchester Local Care Organisation	
Name	2019/20 Validated Result
District Nursing Service - Patch 1	22.10.19
District Nursing Service - Patch 2	21.01.2020
District Nursing Service - Patch 3	29.10.19
District Nursing Service - Patch 4	07.01.2020
Gorton & Levenshulme District Nursing Team	30.07.19
Stancliffe Road, Northenden & Chorlton Park	26.11.19
Forum & Baguley Health Visiting Team	11.02.2020
Chorlton, Fallowfield and Whalley Range Community Services	19.07.19
School Nursing Team North	18.02.2020
Dermot Murphy House	04.02.2020
Buccleugh Lodge	04.06.19

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Deputy Chief Nurse Barbara Mitchell, Assistant Chief Nurse – Safeguarding Ruth Speight, Head of Nursing – Safeguarding
Date of paper:	June 2020
Subject:	Safeguarding Children and Adults and Looked After Children Annual Report (2019/20)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Trust is required to comply with Care Quality Commission Regulation 13 and safeguarding statute. However, with safeguarding recognised as a key priority, the Trust aims to achieve beyond its statutory and regulatory requirements. The 2019/2020 annual report reflects the safeguarding work undertaken throughout the Trust and outlines some of the key safeguarding priorities across the city of Manchester.
Recommendations:	To approve the content of the report,its publication on the Trust's website and sharing with Manchester Safeguarding Partnership to provide information and assurance with regard to the Trust's safeguarding activity.
Contact:	Name: Barbara Mitchell, Assistant Chief Nurse – Safeguarding Tel: 0161 274 4981

Safeguarding
Children and Adults
and
Looked After Children
Annual Report
2019/2020

Authors:

Ruth Speight, Head of Nursing - Safeguarding

Barbara Mitchell, Assistant Chief Nurse - Safeguarding

In collaboration with the MFT Safeguarding Teams

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Key Documents

SECTION A

Purpose of the Report

1. Purpose of the Report

1.1. The Safeguarding Annual Report for 2019-2020 provides assurance to the Board of Directors that Manchester University NHS Foundation Trust (MFT) is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004[1] and in the Care Act 2014[2]. This report provides assurance that systems are in place to support MFT staff to keep our service users safe and protect them from neglect or harm whilst they are in the care of our Hospitals, Managed Clinical Services (MCS) and both the Manchester and Trafford Local Care Organisations (MLCO, TLCO). The report also identifies how patients, service users and their loved ones have a voice, by ensuring that they are actively involved in any decision-making regarding their safety and protection and that they feel safe.

1.2. The report informs the Board of Directors of the internal and external safeguarding activity undertaken in 2019-2020 and outlines the key priority areas for 2020-2021.

1.3. Safeguarding activity is underpinned by standard and statutory guidance outlined in **Figure 1**. 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.

1.4. Key Documents

Figure 1: 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)
- The Serious Crime Act (2015)
- The Care Act (2014)
- Mental Capacity Act (2005)
- Mental Capacity Amendment Act (2019)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)

[1] https://www.legislation.gov.uk/ukpga/2004/31/contents
[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/en

SECTION B

Executive Summary

2. Executive Summary

2.1 This 2019-20 annual report reflects the safeguarding work undertaken throughout the Trust and outlines some of the key safeguarding priorities across the city of Manchester and the borough of Trafford.

2.2 The MFT safeguarding teams work with other health organisations and our multi-agency partners to ensure a cohesive and consistent approach to safeguarding children and adults at risk across the MFT footprint.

2.3 2019-2020 has been an extremely busy year for safeguarding with challenges, changes and opportunities within the Trust and across Manchester and Greater Manchester. Changes to legislation, national policy and guidance continue to influence the safeguarding agenda. This year the MFT footprint has extended following the aquisition of Trafford Local Care Organosation (TLCO) in October 2019. Safeguarding has continued to be operated 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'.***

2.4 Supporting staff to ensure that all patients and service users are protected is crucial to ensuring safe and effective safeguarding of all age groups regardless of ethnicity, religion, gender or background. Central to this message is listening and hearing the voice of children, young people, adults at risk and their families and ensuring that we always make safeguarding personal.

2.5 The safeguarding service is delivered as a single corporate service Trust wide. The service offers a resilient, robust, visible and accessible safeguarding offer across all of our hospitals/MCS/LCO.

2.6 Throughout this annual report year the safeguarding service has continued to review models of working to further future-proof safeguarding in MFT. The year has seen significantly strengthened partnership working across the three Manchester localities and in Trafford. In 2020/21 work will be undertaken with North Manchester General Hospital (NMGH) and the North Adult Community Service in preparation for the Manchester single hospital system. Although challenging, this is also an exciting time for us to ensure that patients and services are central to service design and that safeguarding continues to have a high profile across the Trust.

2.7 Key drivers have shaped safeguarding services during 2019-2020, some of which have challenged our teams to think and work differently; **Figure 2** provides an overview of some of the drivers that have informed our safeguarding priorities;

Figure 2: Key Drivers

Key Driver	Key Change
Working Together to Safeguard Children (2018)	Implementation of the Manchester and Trafford 'Multi-agency Safeguarding Partnership arrangements. Introduction of the Child Safeguarding Practice Reviews arrangements to replace the Serious Case Reviews.
Mental Capacity Amendment Act (2019)	Implementation of the Liberty Protection Safeguards to replace the Deprivation of Liberty Safeguards
Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)	Three year implementation plan to deliver mandatory Level 3 Safeguarding Adult Training
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)	Review of the mapping, content and delivery of the Safeguarding Children Training.
Coronavirus Act (2020)	New arrangements in response to the impact of Covid 19 in respect of the Mental Capacity Act, the Deprivation of Liberty Safeguards, the Mental Health Act and Public Protection.

2.8 Hearing the voice of patients and service users is vitally important to the Trust: for this reason through 2019-2020 'Making Safeguarding Personal' (MSP) and capturing the voice of the child has been embedded throughout the Trust's work plans. This has required the Hospitals, MCS and 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.

2.9 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 the required staff have completed their mandatory safeguarding training. This was a key priority for the safeguarding service working with the Hospitals, MCS and MLCO in 2019/2020 with substantial improvements recorded in mandatory safeguarding training compliance this year, significantly in compliance of Level 3 Adult Safeguarding Training.

2.10 Safeguarding training is a mandatory requirement across the Trust. During this annual report year the Trust's safeguarding training content has continued to be revised and updated in line with the National 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018)[3] and the 'Safeguarding Children and Young People: Roles and competencies for healthcare staff (2019)[4] Intercollegiate Guidance'.

[3] Adult Safeguarding: Roles and Competencies for Health Care Staff(2018) 1st edition

[4] Safeguarding Children and Young People: Roles and competencies for healthcare staff 4th edition (2019)

2.11 National information sharing systems were strengthened within the Trust this year with the successful implementation of the Female Genital Mutilation (FGM) Information Sharing System in maternity services. This system enables electronic information regarding the risk of FGM in new-born female babies to be shared from the acute Trust to primary and community systems to promote the safeguarding of girls at risk of FGM.

2.12 Throughout 2019-2020, 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.

2.13 The Trust has actively supported the work of the Manchester and Trafford Safeguarding Partnerships (MSP and TSP). The Trust consulted with partner agencies on the development of the new Multi-Agency Safeguarding Arrangements (MASA) in Manchester which were published in June 2019 and launched by September 2019, following the changes set out in new 'Working Together to Safeguard Children' (2018) guidance. The safeguarding service has worked to ensure representation at all the Manchester and Trafford Safeguarding Partnership boards, sub-groups and work streams.

2.14 This year has seen 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 children's safeguarding teams leading on this agenda. In June 2019 the Manchester City Council (MCC) Children's Services Multi Agency Safeguarding Hub was transformed to three localities Advice and Guidance Service (AGS). The Manchester safeguarding work plan has increasingly focussed on developing local partnership arrangements to ensure that safeguarding practice is at the heart of communities.

2.15 In respect of adult safeguarding there has been continued development of a consistent and unified approach across the Trust with the implementation of the Ulysses system for reporting and recording safeguarding concerns, the delivery of a consistent training package and the safeguarding mental health team providing support and expertise across all of the Trust sites. This annual report year has seen the implementation of the self-neglect strategy and toolkit which supports services to recognise and respond to adults from vulnerable groups who neglect their personal health and wellbeing.

2.16 Deprivation of Liberty Safeguards (DoLS) remains a challenge nationally and to the Trust. In 2019 the Mental Capacity (Amendment) Act set out proposed changes to legislation, which reformed 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

Liberty Protection Safeguards (LPS) process, which will streamline the process for the deprivation of an individual's liberty where appropriate.

2.17 In 2019 the new legislation was given royal assent with the expected implementation of changes being in place by October 2020, although this may be delayed with the impact of Covid-19. The current challenges with the DoLS process are associated with limited capacity within Local Authority (LA) DoLS teams to undertake timely assessments to enable authorisation of the deprivation of liberty. 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 to the Trust.

2.18 In this annual report year the Trust completed a self-assessment 'Section 11' of the Children Act 2004 audit and the Greater Manchester Safeguarding Contractual Standards 2019-20 Audit Tool to measure NHS Provider compliance with the NHS Assurance and Accountability Framework for Safeguarding (Safeguarding Vulnerable People in the NHS 2015)[5]. The outcome of both has demonstrated that MFT is compliant with the statutory requirements.

2.19 In quarter 4 of this report year the safeguarding service, in line with all other NHS services, reviewed the delivery, support and response to vulnerable citizens, their families and MFT services due to the impact of Covid-19. Throughout the pandemic safeguarding has remained a key priority for the Trust and the safeguarding service has continued to work with frontline services to respond to changes in legislation, policy and practice affected by Covid-19 in order to prioritise safeguarding vulnerable children, young people, adults at risk and their families.

2.20 In summary, during 2019-2020 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 best outcomes for vulnerable people.

[5] Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework

SECTION C

National Overview and Reflections on Manchester City-wide and Trafford Safeguarding

3. Manchester and Trafford Overview

3.1 The city of Manchester is a culturally diverse metropolitan borough of Greater Manchester. Manchester is the 5th most deprived borough in the country[6] and consists of 12 local neighbourhoods each with their own unique culture and demography.

3.2 Trafford is classified as 191st out of 317 in index of deprivation (1 is the most deprived); it is comprised of 21 local wards. Trafford's Black and ethnic minority population (14.5%) is similar to England as a whole (14.6%)[7]

3.3 Acute and community safeguarding provision across MFT spans the diversity and specific needs of all these neighbourhoods and wards.

3.4 Keeping Adults Safe in Manchester and Trafford

3.4.1 The Manchester Safeguarding Partnership vision for vulnerable adults is:

> "Living a life that is free from harm and abuse is a fundamental human right of every person. When abuse does take place, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the issues. In addition, the person at risk, at the centre of any safeguarding concern, must stay as much in control of decision-making as possible. The right of the individual to be central throughout the process is a critical element in the drive to ensuring personalised care and support."

3.4.2 The Trafford Safeguarding partnership vision is

> "• Co-produce with children, young people and families using their strengths and assets to develop services to meet their individual needs.
> • Provide robust independent scrutiny and assurance to the partnership in relation to safeguarding and the welfare of children and young people in Trafford.
> • Make safeguarding personal.
> • Identifying and sharing approaches and practices that will support the safeguarding arrangements"

[6] Manchester City Council Key Deprivation Statistics
[7] Trafford Joint Strategic Needs Assessment

3.4.3 As a committed partner, MFT embraces these visions and has put robust systems in place to ensure that adults at risk who access MFT services are protected from abuse and neglect.

3.4.4 The Manchester Safeguarding Board Annual Report (2019[8]) identified that compared with other major English cities Manchester has a;

- higher than average proportion of younger working age adults.
- a smaller, but more vulnerable, population of older people.

The population growth in Manchester has outstripped that of other major cities; between the 2001 and 2011 Census Manchester experienced the highest rate of population growth of any local authority in England.

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 2015/17, life expectancy at age 65 in Manchester was the lowest in England and Wales for both men and women. In Manchester there are some significant variations in health outcomes between different parts of the city and the communities living in it. For example, life expectancy is 8.1 years lower for men and 7.0 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

3.4.5 The Trafford Safeguarding Partnership Annual Report (2018)[9] identified that the health and wellbeing of people in Trafford is generally better than the England average.

In Manchester and Trafford, all agencies, both statutory and voluntary, work together to ensure people are safe from abuse and neglect.

3.5 Safeguarding Adults National Context

3.5.1 The Care Act (2014) outlines the following categories of abuse for adults:

Figure 3: Categories of Abuse

[8] Manchester Safeguarding Adult Board 2018/19 Annual Report
[9] Trafford Strategic Partnership Annual Report (2018)

3.5.2 All MFT staff regardless of their role 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 practice which may put a patient or service user at risk.

3.5.3 The latest National Data for Safeguarding Adults in England identifies key themes (**Figure 4** below)[10].

Figure 4: Key themes identified by National Data for Safeguarding Adults in England (based on the most recent national data)

- 415,050 concerns of abuse were raised during 2018-19, an increase of 5.2% on the previous year
- The number of Section 42 enquiries (into adult safeguarding concerns led by the LA) that commenced during the year increased by 8.7% to 143,390 and involved 116,230 individuals
- The most common type of risk in Section 42 enquiries that concluded in the year was Neglect and Acts of Omission, which accounted for 31.4% of risks
- The most common location of the risk was the person's own home at 44.8%.

3.5.4 **Figure 5** identifies the number of Section 42 enquiries by risk in England, Manchester and Trafford in 2018/19.

Figure 5: Section 42 Enquiries

Area	Physical Abuse	Sexual Abuse	Psychological Abuse	Finical Abuse	Discriminatory Abuse	Organisational Abuse	Neglect Act of Omission	Domestic Abuse	Sexual Exploitation	Modern Slavery	Self-Neglect
England	37,630	6,920	23,480	24,625	980	7,040	54,450	7,990	1,060	340	7,790
Manchester	255	80	235	275		40	425	330	5		40

[10] Safeguarding Adults in England (This is the most recent national data set).

Trafford	110	15	45	30		25	250				15

3.5.5 Neglect and omission in care followed by physical abuse remain the most recognised forms of adult abuse in England, Manchester and Trafford in 2018/19.

3.5.6 **Figures 6** and **7** below identify the safeguarding enquiries according to types of abuse completed in Manchester and Trafford

Figure 6: Safeguarding enquiries (according to types of abuse) completed in Manchester

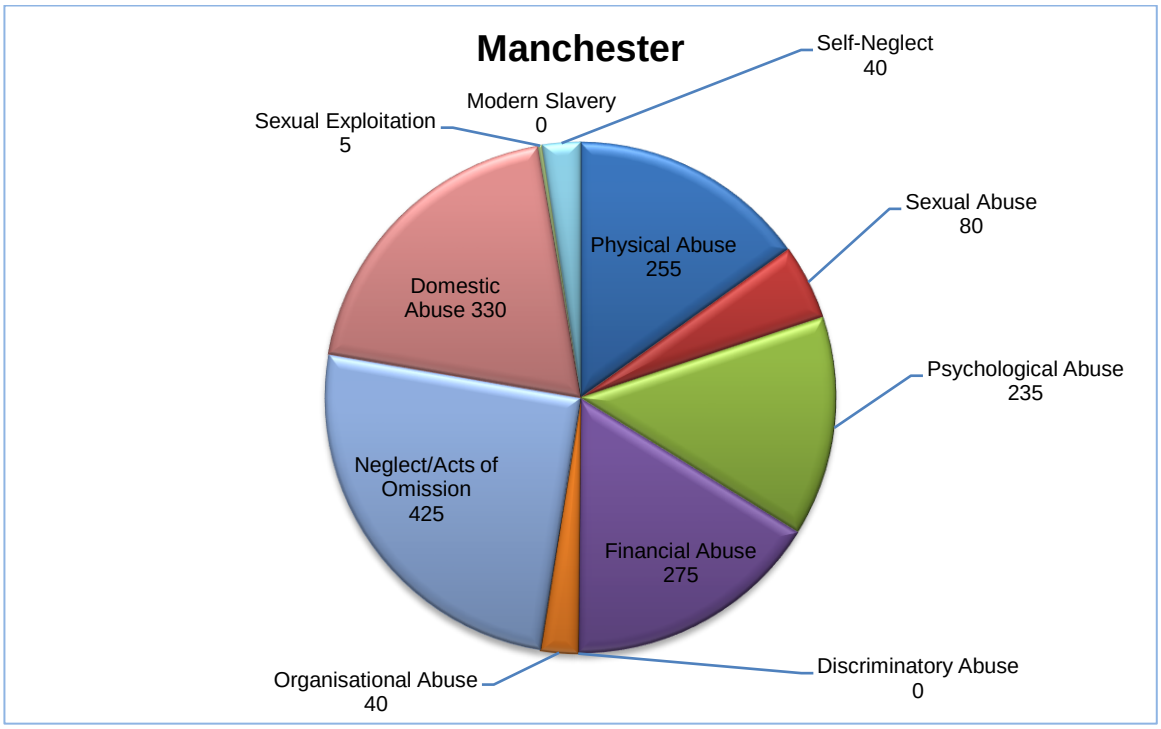
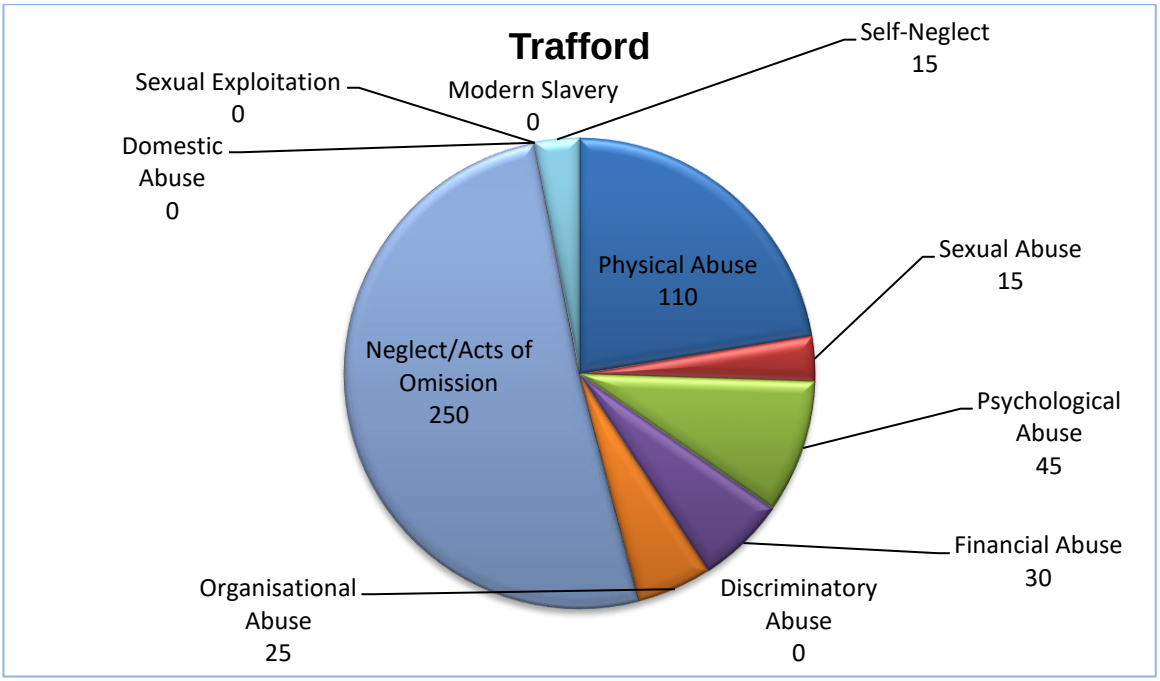


Figure 7: Safeguarding enquiries (according to types of abuse) completed in Trafford



3.5.7 A key part of adult safeguarding for the Trust is ensuring that all patients in MFT hospitals, who lack capacity to consent to care and treatment and who are not free to leave, have been assessed and a Deprivation of Liberty Safeguards (DoLS) application has been submitted to ensure their best interests have been considered in their care arrangements.

3.5.8 National data regarding Deprivation of Liberty Safeguards (DoLS) identifies that in England in 2018/19;

- There were 240,455 applications for DoLS received during 2018-19, relating to 200,225 people. The number of applications has increased by an average of 15% each year since 2014-15.
- The number of applications completed (authorised by the LA) in 2018-19 was 216,005. The number of completed applications has also increased each year, by an average of 36.3% each year since 2014-15.
- The reported number of cases that were not completed as at year end was 131,350. This is higher than in previous years; however the gap between the volume of applications and those completed within each year has narrowed from 54.5% in 2014-15 to 10.2% in 2018-19.
- The proportion of completed applications in 2018-19 that were not granted was 45.9%. The main reason given was change in circumstances, at 58.1% of all not granted cases.
- The proportion of standard applications completed within the statutory timeframe of 21 days was 22.0% in 2018-19. The average length of time for all completed applications was 147 days.

3.5.9 The Manchester Safeguarding Adult Board 2019 annual report identified that during 2018/19 there were:

- 8884 safeguarding adult concerns raised, 1751 of which progressed to enquiry (Section 42 or other)
- 2972 DoLS were requested, 1112 of those were granted.

From the national safeguarding data in Trafford in 2018/19 there were;

- 3685 safeguarding adult concerns with 585 progressing to a safeguarding or other enquiry
- 1905 DoLS applications were requested and 1145 were authorised.

3.5.10 Established processes are in place across MFT to identify categories of abuse and neglect. Clear procedures are also embedded across the Trust to support staff when completing referrals for safeguarding concerns or enquiries and for making DoLS Applications.

3.5.11 The annual report section on performance identifies the significant numbers of DoLS applications made by the Trust that are not authorised within the statutory time scales during the patient stay in hospital.

3.6 Keeping Children Safe in Manchester and Trafford

3.6.1 The Office of National Statistics 2020 has completed a comprehensive overview of child abuse in England and Wales.

Figure 8 summarises the key messages from this report;

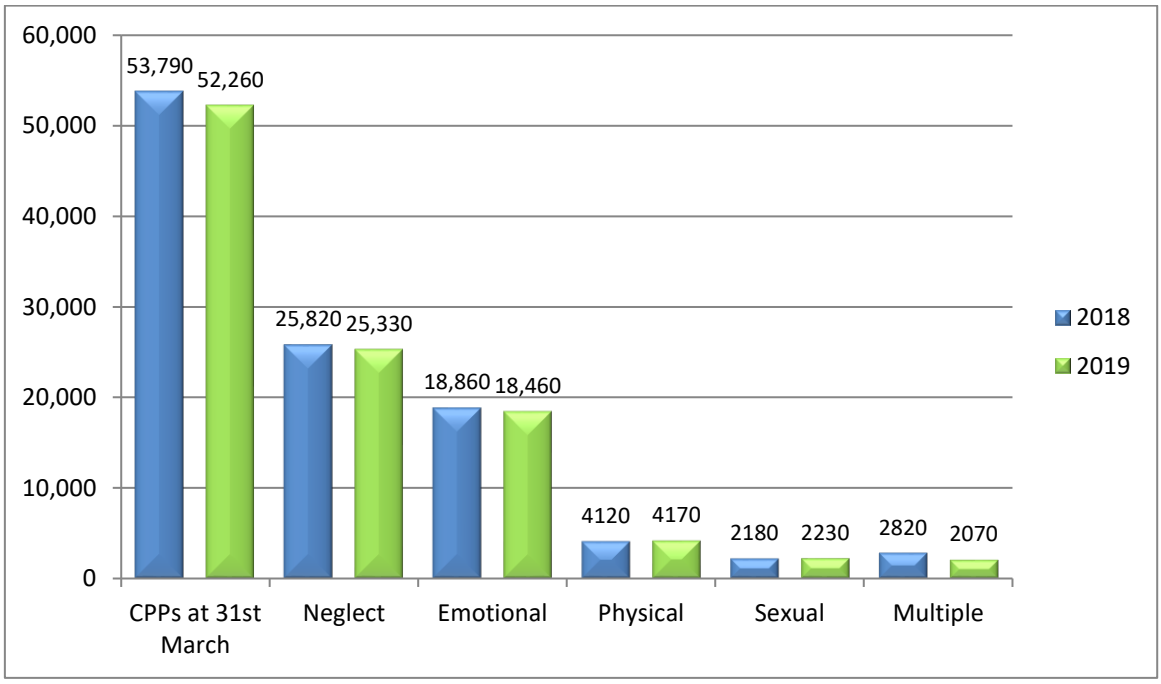
Figure 8: Office of National Statistics 2020

- One in five adults aged 18 to 74 years experienced at least one form of child abuse, whether emotional abuse, physical abuse, sexual abuse, or witnessing domestic violence or abuse, before the age of 16 years (8.5 million people).
- 1 in 100 adults aged 18 to 74 years experienced physical neglect before the age of 16 years (481,000 people).
- An estimated 3.1 million adults aged 18 to 74 years were victims of sexual abuse before the age of 16 years; this includes abuse by both adult and child perpetrators.
- Witnessing domestic violence or abuse and emotional abuse were the most commonly experienced types of child abuse.
- Just under half of victims experienced more than one type of abuse.
- Women are more likely than men to have experienced abuse before the age of 16 years.
- Many cases of child abuse remain hidden and do not enter the criminal justice system.
- What is often a hidden crime can have an impact later in life.
- Around half of adults (52%) who experienced abuse before the age of 16 years also experienced domestic abuse later in life, compared with 13% of those who did not experience abuse before the age of 16 years.

3.6.2 At 31st March 2019, 52,260 children in England were the subject of a child protection plan (CPP) due to experiencing or being at risk of abuse or neglect; neglect was the most common category. This is a small decrease from the previous year (3%) however the number has increased by 21% since the year ending March 2013.

3.6.3 **Figure 9** identifies the number of children subject to child protection plans in each category of abuse and neglect in England in the last 2 years.

Figure 9: Number of children subject to CPP in each category of abuse and neglect in England in the last 2 years



3.6.4 There were 399,500 'Children in Need' (CIN) at 31st March 2019[11]. A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired without the provision of services, or the child is disabled.

[11] Department of Education Characteristics of Children in Need (2019)

3.6.5 During this annual report year there has been a slight decrease of 1% from 2018. The rate of 'CIN' per 10,000 of the population also decreased slightly, down to 334.2 in 2019 from 341.0 last year. Both the number and rate of 'CIN' at 31st March 2019 have fluctuated over the last seven years, with no long term increasing or decreasing trend.

3.6.6 At 31st March 2019, 49,570 children in England and 4,810 children in Wales were 'looked after' by their LA due to experiencing or being at risk of abuse or neglect: this is an increase of 4% in England.

3.6.7 The dataset reviewed in the Manchester Population health plan 2018-2027[12] provides a clear overview of the vulnerability of the child and young person population in Manchester.

- Manchester has one of the highest rates of child poverty with 35.6% of children under 16 years living in poverty; this equates to roughly 36,255 children.
- Children and young people under the age of 15 make up 20.1% of the population of Manchester.
- Manchester has a major challenge in dealing with the impact of homelessness in families.
- The infant mortality rate is significantly greater than the England average.
- More babies in Manchester have low birth weights than in the rest of England.
- The levels of school readiness in Manchester remain lower than those across England as a whole, however local figures have been improving.
- Manchester has a high number of 'looked after children' compared to the national average and the average for other core cities.
- Manchester has more young people not in education and employment than the England average.
- There are more children aged 10-11 years with excess weight than the England average.
- Children's dental health is worse than the rest of England.

[12] Manchester Population Health Plan 2018-2027

3.6.8 The Trafford Strategic Partnership (2018) annual report identifies the health and wellbeing of children in Trafford is generally better than the England average. It is estimated that there are 60,302 people aged 0-19 years (25.6% of the total population) with the under-5 population in Trafford estimated at 14,853 (6.3% of the total). On these measures, Trafford is similar to England in age structure.

3.6.9 The Manchester Safeguarding Partnership vision for children and young people is for:

> "Every child in Manchester to be safe, happy, Healthy and successful. To achieve this, we will be child-centred; we will listen to and respond to children and young people, focus on strengths, resilience and take early action."

3.6.10 The Trafford Safeguarding partnership vision is:

> "Co-produce with children, young people and families using their strengths and assets to develop services to meet their individual needs.
> Provide robust independent scrutiny and assurance to the partnership in relation to safeguarding and the welfare of children and young people in Trafford.
> Make safeguarding personal.
> Identifying and sharing approaches and practices that will support the safeguarding arrangements"

3.6.11 As a committed partner, MFT embraces the vision and has systems in place to ensure that all children in our care are protected from abuse and neglect.

3.6.12 Manchester and Trafford have a significant number of children and young people who require services under the Children Act (1989) framework to keep them safe, at either a Child in Need (Section 17) or Child Protection (Section 47) of the Children Act (1989)

3.6.13 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.

3.6.14 The most recent data (**Figures 10a and 10b**) outlines how Manchester and Trafford compares statistically in relation to the National, North West and its

statistical neighbours in respect of the numbers of children who are categorised as CIN or Children on a CPP.

Figure 10a: CIN Statistical Comparison[13]

Area	CIN on 31st March 2018	CIN on 31st March 2019	Rate of CIN at 31 March 2019 per 10,000 children
England	**404,710**	**644,730**	**539.3**
North West	**58500**	**98,470**	**634**
Manchester	**5634**	**10,387**	**851.7**
Liverpool (Statistical Neighbours)	**3817**	**7,510**	**791.3**
Trafford		**1,409**	**251.2**
Bury (statistical neighbour)		**2,934**	**680.1**

3.6.15 The CIN statistics identify an increasing number in Manchester: with a statistically higher rate in Manchester than the England average and a lower than average rate in Trafford.

Figure 10b: Children Subject to a CPP Statistical Comparison

Area	Children on a CPP on 31st March 2018	Children on a CPP on 31st March 2019	Rate of CPP at any point 2018-19 per 10,000 children
England	**119,720**	**52,260**	**43.7**
North West	**19,010**	***8,780***	***56.5***
Manchester	**1,112**	***787***	***64.5***
Liverpool (Statistical Neighbour)	**540**	***554***	***58.4***
Trafford		**193**	**34.4**
Bury (statistical neighbour)		**203**	**47.1**

3.6.16 The number of children subject to a CPP has decreased this year in Manchester, however the rate is higher than the National average in Manchester and lower in Trafford

3.6.17 The decrease in the number of children subject to a CPP in Manchester may be related to the increased work across the partnership in promoting Early Help for Children and families.

[13] Characteristics of Children in Need 2018-2019

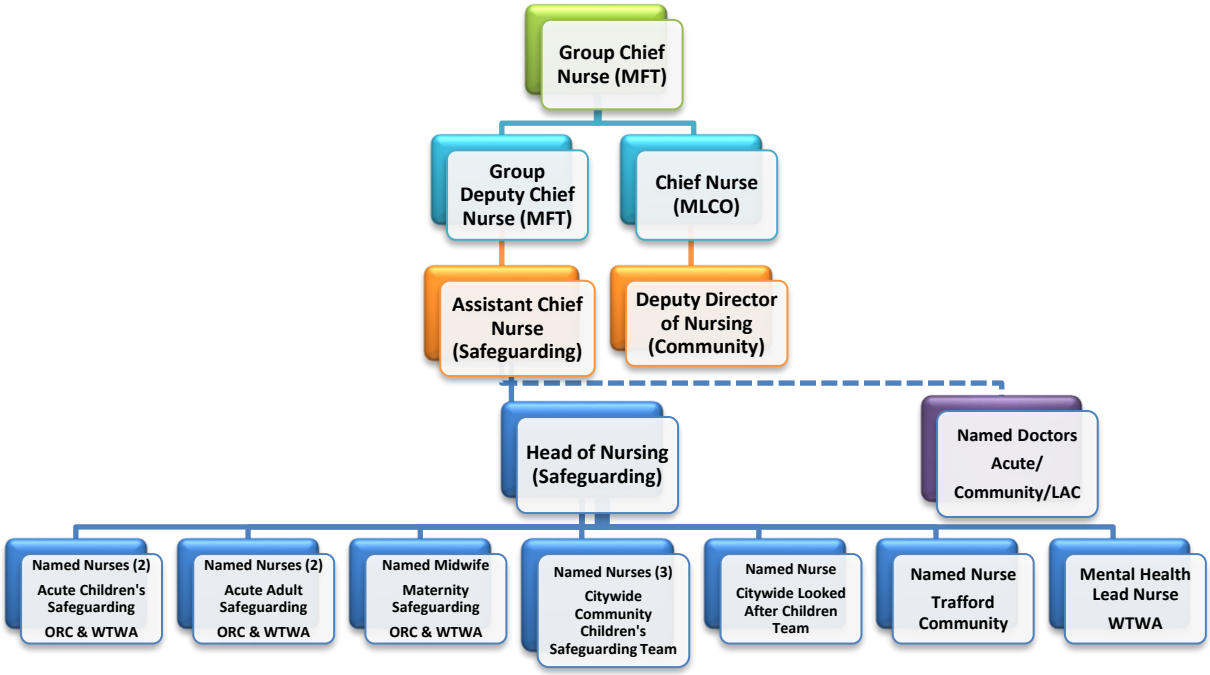
SECTION D

Safeguarding Governance and Accountability

4. Safeguarding Governance and Accountability

4.1 The MFT Group 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 11**). The Assistant Chief Nurse - Safeguarding provides expert leadership across the Trust and supports the Group Deputy Chief Nurse strategically across the partnerships. 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 partnerships.

Figure 11: MFT Safeguarding Structure



4.2 Effective safeguarding communication and information sharing across MFT is essential to support the Hospitals, MCS and LCOs in the Trust's Group structure, whilst aligning to both Manchester and Greater Manchester governance requirements.

4.3 In order to effectively address the breadth of safeguarding practice, the governance structure set out in **Figure 12** has been established. This ensures that there is a clear line of sight from multi-agency work-streams into the Hospitals, MCS and the Local Care Organisations (LCO).

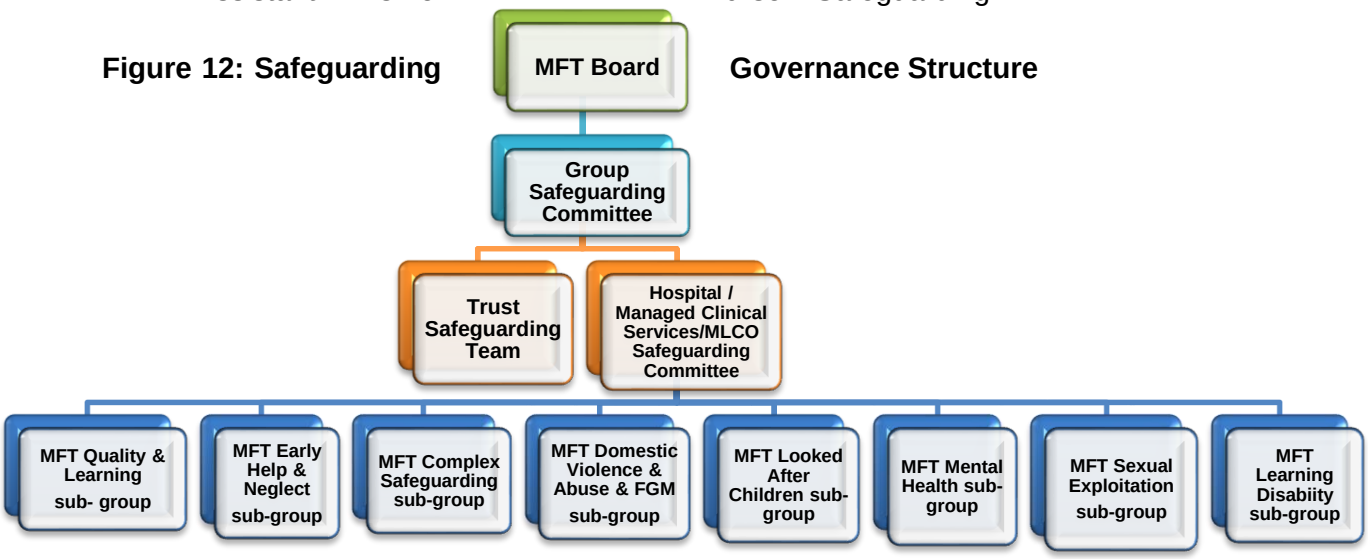
4.4 Each Hospital/MCS/LCO has a site safeguarding committee chaired by the Director of Nursing or agreed senior lead. The Group Safeguarding Committee thematic sub-

groups are chaired/supported by a senior member of the safeguarding team and all of the Hospitals, MCS and LCOs are represented.

The sub-groups and the Hospital/MCS/LCO safeguarding committees are accountable to the Group Safeguarding Committee, which is chaired by the MFT Chief Nurse. The Group Safeguarding Committee reports, through the Trust's governance structure, to the MFT Board of Directors.

4.5 The Trust's Named Nurses and Doctors are statutory roles and are responsible for supporting all the activities necessary to ensure that the Trust meets its responsibilities. Named Doctors for Safeguarding Children and Looked After Children provide leadership, training and advice to medical colleagues to support the clinical assessment and care of children and young people where there are safeguarding/child protection concerns. Alongside the Named Nurses in the safeguarding team the Named Doctors ensure that the Trust has robust safeguarding policies and procedures in line with legislation, national guidance, and the guidance of the Manchester Safeguarding Partnership (MSP). The Named Doctors are core members of the Group Safeguarding Committee alongside the Assistant Chief Nurse – Safeguarding.

Figure 12: Safeguarding Governance Structure



4.6 The following section provides an overview of the MFT Safeguarding Committee sub-group activity and the work completed in these thematic work streams during 2019-20.

4.6.1 **MFT Quality and Learning Sub-group**

i) **Purpose of the Group**

The Safeguarding Quality and Learning Sub-group aims to ensure that national and local safeguarding messages influence and inform policy development, safeguarding practice, safeguarding training programmes and sharing of learning to frontline practice across the Trust. The group has oversight of single and multi-agency audits, reviews and work plans that are completed by the Trust by monitoring the implementation and progress of action plans.

ii) **Group Work Streams and Relationships With Multi-Agency Groups**

Figure 13: Quality and Learning Sub-group Reporting Structure

iii) **Key Achievements**

- ✓ Compliance with mandatory safeguarding training is now at the CQC expected compliance levels for Level 1 and 2 safeguarding training. There has been significant improvements in the compliance with Level 3 Adult Safeguarding training.
- ✓ Significant work has been completed with the Learning and Development team to review the mapping and recording of training for Level 3 Adult Safeguarding Training.
- ✓ Learning from Serious Case Reviews (SCRs) and Safeguarding Adult Reviews (SARs) has been shared across the Trust through safeguarding training, briefings and monthly Safeguarding Newsletters.
- ✓ The MFT Quality and Learning Sub-group has an established membership and attendance.

- ✓ Key messages and priorities from the Safeguarding Partnerships have been shared and have influenced safeguarding practice in the Trust including the development of Mental Health Awareness training, implementation of the Graded Care Profile (to identify child neglect) and review of the Complex Safeguarding risk indicator checklist.

- ✓ Messages from SCRs and SARs (Manchester SCR P1, Q1 Trafford SAR John and SAR Ruth Trafford SCR Baby X, Bury SCR B19, Stockport Single Agency Review IJ, and Domestic Homicide Reviews [DHRs]) have been shared with the group to cascade learning to the Hospitals/MCS/MLCO.
- ✓ Learning about how the messages from SCRs are embedded into practice have been identified. For example the ICON programme aimed at supporting parents to cope with crying babies has been implemented by maternity and health visiting services following SCRs that identified the vulnerability of babies from abusive head injuries.
- ✓ Safeguarding policies have been consulted upon and progressed through the group (including Managing Allegations Policy, Safeguarding MFT Apprentices Standard Operating Procedure, Safeguarding Children and Young People Policy and the Deprivation of Liberty Safeguarding Policy).
- ✓ Key messages from audits have been shared including Mental Capacity Act (MCA) Staff Awareness and the MCA Case Note Review, EMIS Electronic Patient Record Audit, Strategy Meeting audit, Children's Social Care Referrals review and the Manchester Safeguarding Board Neglect Audit.
- ✓ Sharing of Safeguarding Work Plan achievements has influenced practice development across the Hospitals/MCS/MLCO. For example CSS shared learning about raising awareness to radiographers in respect of the identification of Female Genital Mutilation (FGM).

iv) **Areas for Development and Priorities for 2020-2021**

- The Trust has contributed to a number of multi-agency safeguarding partnership adult and children reviews this year: next year the learning and implementation of the action plans for these reviews will be coordinated through this group.
- Mandatory safeguarding training is being reviewed across the Trust: this group will ensure the key messages regarding the training from the hospitals/MCS/LCO inform the training programme.
- To further strengthen the group's reporting to and from the site safeguarding groups and frontline practice.

4.6.2 **Our Children (Looked after Children) Sub-group**

i) **Purpose of the Group**

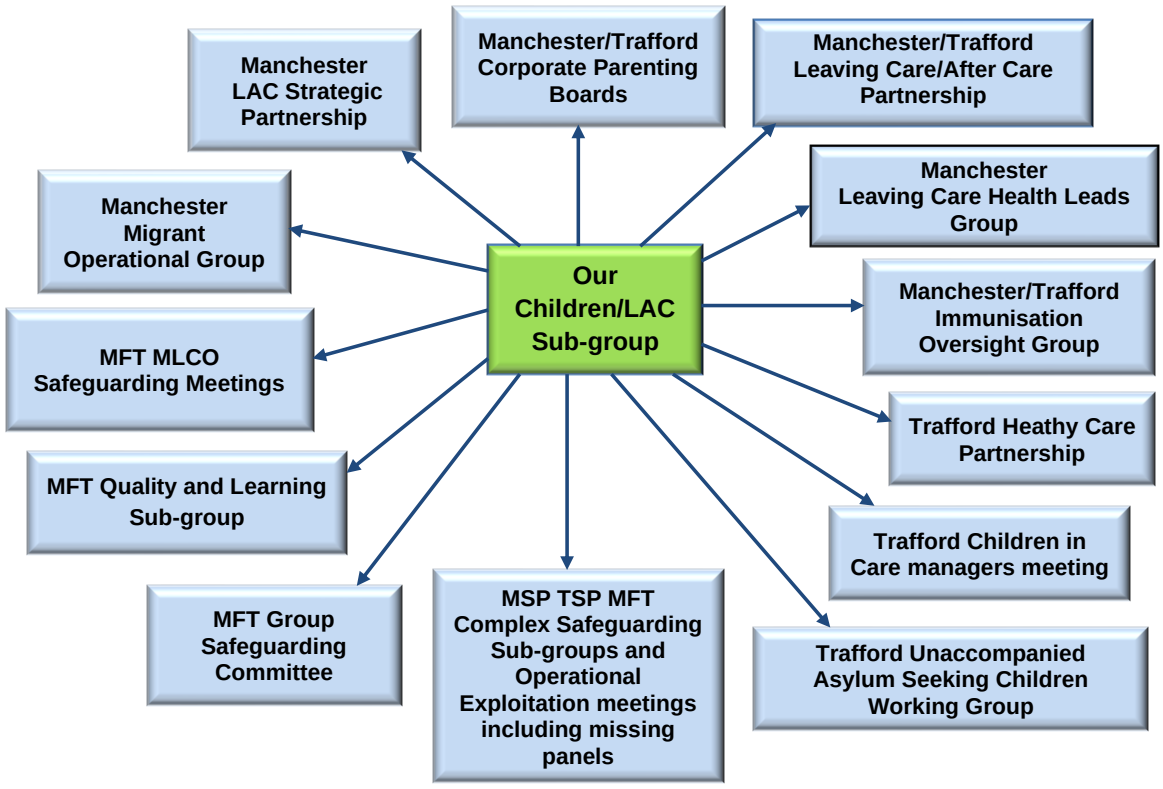
Children and young people who are cared for by the LA are known as Looked after Children (LAC). In Manchester the children looked after by Manchester LA have asked to be known as "Our Children".

The remit of the Our Children sub-group is to ensure that the key areas of the Our Children agenda are embedded within adult and children services across the Hospitals/MCS/LCO.
These include:

- Our Children service delivery and practice development ensuring Our Children policy, strategy and guidance is developed and disseminated across all of the Hospitals/ MCS/MLCO.
- The review of health outcomes for 'Our Children' including statutory performance indicators.
- The quality of the statutory health assessments.
- The voice and influence of 'Our Children'.
- Partnership work and key messages from Manchester and Trafford's Corporate Parent Panels, LAC Strategic Board and Multi-agency subgroups.
- To develop and implement training and briefings for the Hospitals/MCS/MLCO in line with Our Children requirements.
- To seek assurance that the Our Children priorities are known and understood including the statutory requirements across the Hospitals/MCS/MLCO.

ii) **Group Work Streams and Relationships with Multi Agency Groups**

iii) **Figure 14: 'Our Children' Sub-group Reporting Structure**



iv) **Key Achievements**

- ✓ The Our Children Sub-group has seen improved representation from services and divisions which provides robust oversight into the services that Our Children receive through individual service feedback.

- ✓ There is improved awareness of the Our Children Specialist Nursing Team amongst the MFT workforce.
- ✓ There is a robust quality assurance pathway ensuring that the voice of the child is heard throughout the health assessment process.
- ✓ Commencement of a Trust wide audit to benchmark staff awareness of Our Children requirements in practice.

v) **Areas for Development and Priorities for 2020-2021**

- Full implementation of the revised Manchester Our Children Service Specification to include the development of a dashboard for the sub-group to present key performance and quality assurance outcomes in a meaningful way.
- Development of a comprehensive training package for professionals including health (community and acute) and social care to inform of the health needs of Our Children, their journey through the LAC process and the professionals roles and responsibilities in order to achieve the best outcomes for Our Children. This will be in line with the Looked after Children: Knowledge, skills and competencies of health care staff - Intercollegiate Role Framework (2015)[14].
- Implementation of revised health assessment documentation to support health practitioners to undertake a holistic assessment for Our Children which incorporates the child/young persons voice.
- Development of an MFT 'Our Children' Policy.

4.6.3 MFT Early Help and Neglect Sub-group

i) **Purpose of the Group**

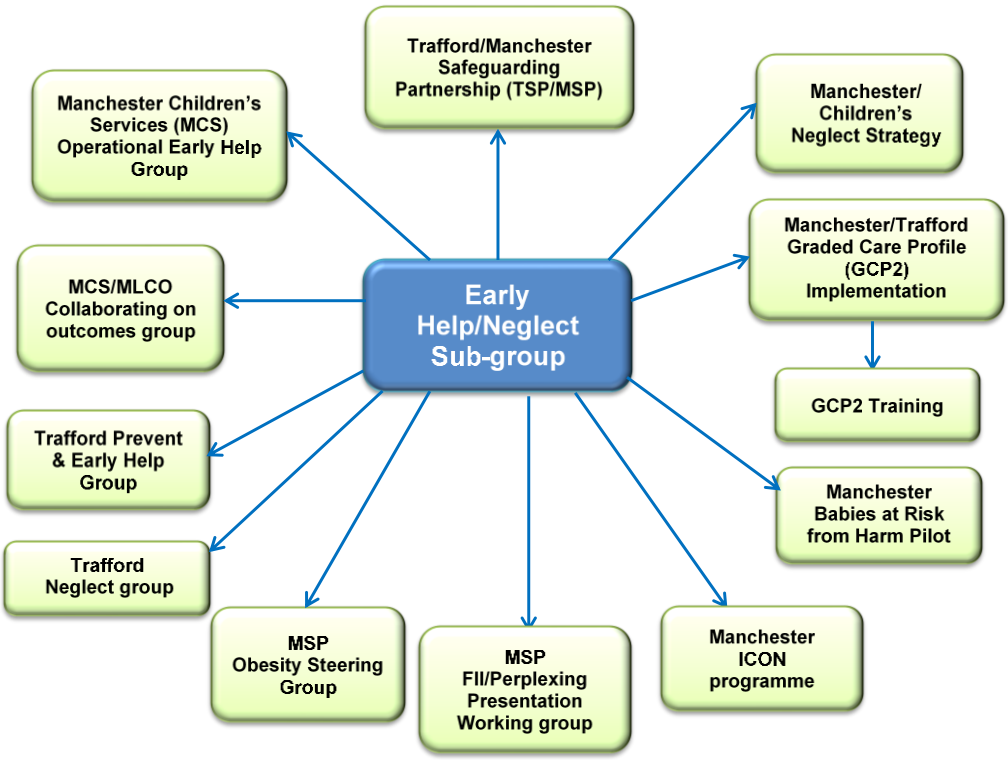
The remit of the Early Help and Neglect Sub-group is to ensure that the key areas of the Early Help and Neglect agenda are embedded across children's/young people and adult services/departments/wards/teams across Hospitals/MCS/MLCO and to ensure quality assessments/information is in line with multi-agency standards.

This group's remit is to;

- Ensure local practice and procedures are reflective of the National messages, Manchester and Trafford Safeguarding Partnerships strategic and operational groups and learning from safeguarding reviews.
- Develop and implement training and briefings for Hospitals/MCS/MLCO in line with Early Help and Neglect requirements.
- Ensure that health care professionals have the tools and support to work sensitively to undertake the assessments and plans in partnership with children, parents, adults and other professionals.
- Ensure that Early Help support and help are accessible to all service users.
- Seek assurance on the Hospital/MCS/MLCO compliance with safeguarding legislation and regulation in relation to the safeguarding specialist area.

[14] Looked after Children: Knowledge, skills and competencies of health care staff - Intercollegiate Role Framework (2015).

ii) **Figure 15: Group Work Streams and Relationships with Multi-Agency Groups Early Help And Neglect Sub-Group.**



iii) **Key Achievements**

- ✓ Development of the Early Help and Neglect Implementation Plan which highlights the progress on how Early Help and Neglect is being embedded across the hospitals/MCS and MLCO. The plan has been well received, promoted and recognised as good evidence of partner progress within the Manchester City Council's Early Help Operational Group.
- ✓ Manchester Safeguarding Partnership have adopted the NSPCC 'Graded Care Profile 2' (GCP2) screening tool to assist in the early identification and multi-agency planning process to address child neglect. In this annual report year the MFT safeguarding team has trained 188 staff, including school nurses, health visitors, AHPs and acute hospital based nurses, to use the tool.
- ✓ The group has contributed to the development of the Manchester Adult Self-Neglect and Hoarding Strategy which was launched in September 2019. The Strategy and Toolkit was circulated and disseminated in the Trust by the sub-group. The group acknowledged the value and contribution of the Strategy and the Toolkit in working with both adults and children which links with a

previous SCR in Manchester for which repeated hoarding was a factor (Child I1).

- ✓ Learning has been incorporated within the group from SCRs, SARs and audits with learning that highlights how early help/intervention could have been effective in safeguarding vulnerable people. In 2019/2020 this has included:
  - Patient stories are provided at meetings and evidence of how this is incorporated into work within the Hospitals/MCS/MLCO. This aids both understanding of the support available as well as ensuring that the sub-group remain focussed on this work
  - SCR I1 identified both child neglect and repeated parental hoarding, the learning from this review has supported development of the hoarding assessment tool
  - SCR F1 child neglect /obesity which identified a coordinated Early Help approach is key to reducing the risk of significant harm from neglect
  - SCR P1 which identified the long term impact of domestic abuse linked with physical neglect of children and babies
  - Adult Reviews – the need for recognition of the risks of silo working and the need to 'think family'
  - An audit of the quality and outcomes of referrals to Manchester Children's Services has been able to highlight how the Hospitals/MCS/MLCO are able to support children and families earlier and more effectively
- ✓ Representation at the group by St Mary's Hospital has been a significant addition in 2020; this has provided an opportunity to work together on more appropriate early help provision for children and families to avoid escalation for social work support. The specialist midwives, the Newborn Intensive Care Unit (NICU) and community midwifery teams have shared their Early Help activity with the group. Manchester's Early Help hubs have provided bespoke Early Help training to St Mary's services.
- ✓ Over 160 health professionals have completed the e-learning from the Manchester Early Help hubs.
- ✓ There has been a contribution from the Child and Adolescent Mental Health Service (CAMHS) regarding the 3 year implementation plan of the 'Thrive' model across Manchester known as MThrive (Manchester Thrive).
- ✓ The group has contributed to the Manchester Safeguarding Partnership Neglect Strategy.
- ✓ MLCO and St Marys have been involved in a range of Early Help work including the 'babies at risk of harm pilot.

iv) **Areas for Development and Priorities for 2020/21**

- To strengthen and streamline the work plan to achieve a better understanding of the range of Early Help activity across MFT.
- To increase the contribution from adult services to this sub-group in order to ensure the safeguarding needs of, and risks to, adults at risk are considered.

- To refresh the terms of reference of the group.
- To promote representation from all hospitals at this group.
- To ensure messages from the group are clearly disseminated across the Trust.

4.6.4 MFT Complex Safeguarding Sub-Group

i) **Purpose of the Group**

Complex Safeguarding is a term used to describe Criminal Activity (often organised), or behaviour associated with criminality, involving children and adults where there is exploitation and/or a clear or implied safeguarding concern.
The remit of the Complex Safeguarding Subgroup is to communicate information and share best practice in relation to the Complex Safeguarding Agenda. This includes but is not exhaustive of:

- Exploitation (Sexual/Criminal /Adult/Child)
- Modern Slavery/Trafficking
- Vulnerability and Organised Crime
- Preventing Violent Extremism
- Honour based abuse/Forced Marriage
- Female Genital Mutilation

Complex Safeguarding remains a key priority for the Manchester Safeguarding Partnership (MSP) Learning and Improvement Business Plan 2019-20. MFT is represented on the MSP Complex Safeguarding sub-group and has contributed to the new Manchester's Complex Safeguarding Strategy for 2020-2023.

ii) **Figure 16: Group Work Streams and Relationships with Multi-Agency Groups Complex Safeguarding**

iii) **Key Achievements**

- ✓ A patient story presented at each meeting enables members to understand some of the issues surrounding complex safeguarding and helps members to better understand their responsibilities, the transition period from child to adult and the importance of effective multi-agency working.
- ✓ MFT continues to have representation at the Manchester Modern Day Slavery and Human Trafficking Strategy Partnership, which aims to ensure the strategy is embedded across statutory and third sector key partners within the City of Manchester. The Trust has ensured that Health is recognised as a major contributory partner in the continuing development of the strategy and the safeguarding agenda.
- ✓ A Complex Safeguarding Risk Assessment Checklist has been developed for patients presenting to hospital settings with injuries relating to knife or gun crime or serious assault and is being piloted across the Trust.
- ✓ The Child Sexual Exploitation (CSE) Specialist Nurse has updated the group on the developments of the Complex Safeguarding Hub.
- ✓ CSE and Child Criminal Exploitation (CCE) 7 minute briefings were developed by the CSE Specialist Nurse and cascaded through the membership of the group with a request for members to disseminate during the 'exploitation week of action' during March 2020.
- ✓ The Child Exploitation Risk Indicator Checklist and Referral Pathway was developed though the Sexual Exploitation sub-group and cascaded accros the Trust via the membership of the sub-group.

- ✓ A ‘Prevent’ training needs analysis has been undertaken to ensure the appropriate level of training is aligned to each role in line with the National Health Service England (NHSE) competenancy framework.

iv) **Areas for Development and Priorities for 2020/21**

- The Sexual Exploitation Sub-group and Complex Safeguarding Sub-group are to merge from June 2020 in line with MSP arrangements to merge the Sexual Exploitation Delivery Group with the Multi-agency Complex Safeguarding Sub-group. The reason for this is that increasingly it is now more widely understood that the different forms of exploitation cannot be seen as separate with many cases overlapping sexual and criminal exploitation.The Named Nurse Safegaurding who will chair the MFT internal sub-group is a member of MSP Complex Safeguarding Sub-group: this will allow two way sharing of information and learning.
- The MSP Complex Safeguarding Strategy is to be a platform for developing the work of the sub-group.
- Further exploration is needed regarding how the Sexual Exploitation Risk Indicator Checklist can be developed and applied within adult services.
- Further consideration is to be given as to how MFT adult services link in with the wider partnership around complex safeguarding and how they support/link with the Manchester Complex Safeguarding Hub.

4.6.5 **MFT Sexual Exploitation Sub-Group**

i) **Purpose of the Group**

The remit of the Sexual Exploitation (SE) Sub-group is to ensure that all practitioners understand their individual and corporate responsibility and accountability in respect of safeguarding adults and children from sexual exploitation. The group has continued to develop and deliver the Hospital’s/MCS contribution to the Trust’s annual safeguarding programme.

The SE sub-group met for the last time in March 2020 in the present format and will merge with the Complex Safeguarding sub-group which next meets in June 2020.

Key Achievements

- ✓ Consistent membership from some key areas.
- ✓ Training is a standing agenda item and has continued to be promoted across the Trust. A further 118 staff were trained in this annual report year.
- ✓ A Child Exploitation Risk Indicator (RIC) has been developed to support staff in identifying all forms of exploitation to replace the CSE RIC which was previously in use. There have been examples of good practice when staff in the Paediatric Emergency Department (PED) have used the RIC to evidence their concerns in a referral that have resulted in cases being opened to the Complex Safeguarding Hub for a multi-agency safeguarding response.

- ✓ A standing agenda item is CSE themes: members are invited to share any known intelligence about emerging hotspots for SE in Manchester.
- ✓ The Adult and Children stories at the beginning of the meetings have helped members to focus on what are the aims of the subgroup are. In January 2020 the Adult Social worker, in the Complex Safeguarding Hub, attended the subgroup to share some of her ongoing work around transition and she encouraged staff to use her as a resource for advice.
- ✓ In May 2019 a number of the sub-group members, including School Health, Sexual Health and PED contributed to a health focus group as part of the Local Government Association (LGA) CSE Peer Challenge. Feedback from the reviewers was that of those people they met, **'there was energy, commitment, pride and passion to work together and improve lives'**.
- ✓ Subgroup members contributed to the CSE weeks of action in October 2019 and March 2020. In the earlier week of action members supported the Safeguarding Team and the CSE Specialist Nurse in visiting areas of Royal Manchester Children's Hospital (RMCH) to promote the updated Child Exploitation RIC. The second week of Action in March coincided with the COVID-19 restrictions on face to face contact therefore members took the opportunity to promote across the Trust, the two new 7 minute briefings on CSE and child criminal exploitation (CCE). In addition posters were also disseminated for display.

ii) **Areas for Development 2020/21**

- Continue to promote and embed the Child Exploitation RIC into practice across the Trust.
- Continue to raise awareness of CSE and CCE through the 7 minute briefings which have been disseminated widely across the Trust.
- There is still a need to consider how the RIC can be developed for use with adults.
- The adult agenda is starting to emerge and will link in with the Manchester Partnership Safeguarding subgroup.
- The group need to develop adult pathways taking into consideration transition.
- Need to develop the MFT CSE guidance to include Complex Safeguarding guidance incorporating all forms of exploitation and to include the risk to adults.

4.6.6 **MFT Domestic Violence and Abuse (DVA) and Female Genital Mutilation (FGM) Sub-group**

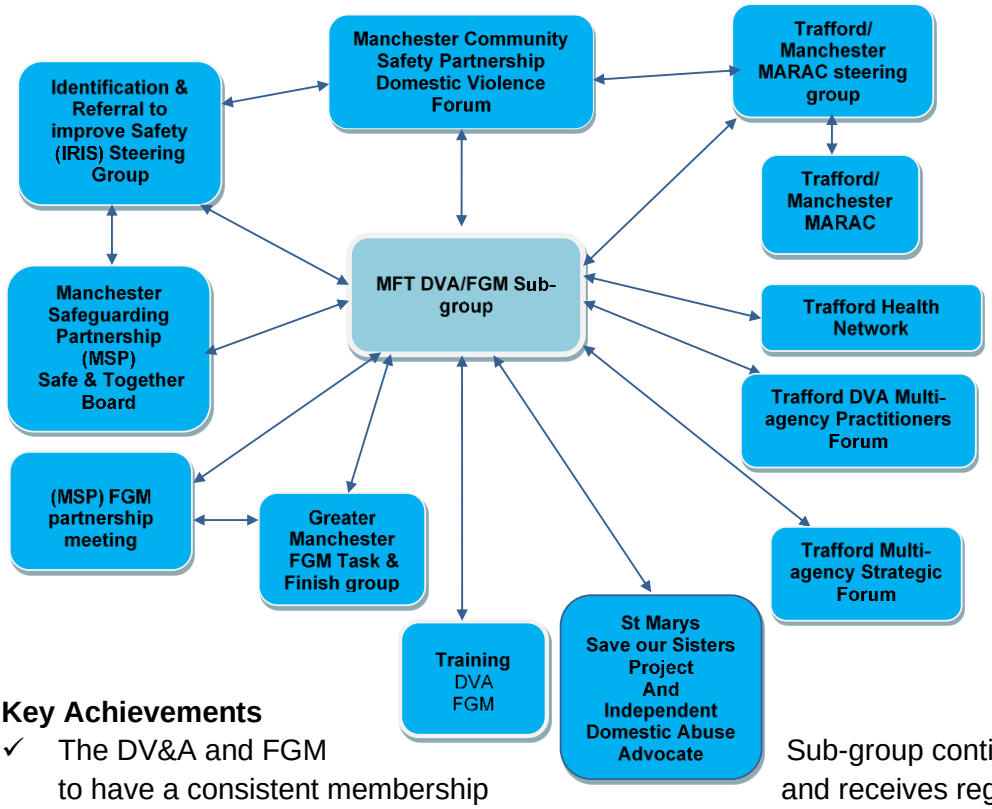
i) **Purpose of the Group**

The DVA and FGM Sub-group develop policy, practice, training and cascade key messages and learning from local and national reviews and messages to improve the response in recognition, risk assessment and safeguarding victims and survivors of DVA and FGM. The membership of the group ensure that messages from operational and strategic domestic

violence and FGM groups in Manchester, Trafford and Greater Manchester inform and influence practice across the Trust.

ii) **Group Work streams and relationships with multi agency groups**

Figure 17: DVA/FGM Sub-group Reporting Structure



iii) **Key Achievements**

- ✓ The DV&A and FGM Sub-group continues to have a consistent membership and receives regular reports from the clinical areas to assure the group and subsequently the MFT Group Safeguarding Committee on how MFT is responding to DV&A and FGM. There is an ongoing training programme within MFT that incorporates national and local data and key messages with the training plan identifying priority groups for training
- ✓ Key messages from local strategic groups, to which MFT actively contribute, are shared across the MFT Group via the sub-group:

FGM

- ✓ The safeguarding service continues to network with professionals and voluntary organisations across Greater Manchester (GM) involved in providing services to, and supporting the national FGM agenda. A member of the team attends the GM FGM Forum. This informs the work of the sub group.
- ✓ The group membership includes representation from NESTAC who work with the Trust. This year the NESTAC (New Step for African Community) “Save our Sisters” model of addressing issues for women and girls who have experienced FGM by providing psychosocial interventions for the victims has been evaluated along with “The Guardian project” (children and young people’s service) and research published. The MFT contribution and partnership working has been acknowledged in the research.

- ✓ The safeguarding newsletter continues to provide updates and training dates for FGM.

Domestic Violence and Abuse

- ✓ A Trust wide domestic abuse audit of referrals to the Multi-Agency Risk Assessment Conference (MARAC) has been completed.
- ✓ Messages from Domestic Homicide Reviews/Serious Case Reviews and Adult Safeguarding Reviews where domestic abuse is a feature have been shared with the group for dissemination across the Hospitals. LCO's and MCS.
- ✓ The Trafford safeguarding team were welcomed to the sub-group and gave an overview of the learning from a recent serious case review (Baby X) where DVA was a significant factor.
- ✓ Partnership working continues with the Manchester Safeguarding Partnership (MSP) as the safeguarding team contribute to DVA training delivered by the MSP.
- ✓ MFT continue to make a significant contribution to the MARAC meetings across the city and play a key role in the MARAC steering group.
- ✓ MFT continue to attend and contribute to the Identification & Referral to improve Safety (IRIS) steering group who have recently produced their annual report.
- ✓ DVA training continues to be delivered across the Trust. Further specialist training on the 'Safe &Together' model is being developed and preparation is underway to deliver this training across the Trust.

- ✓ The community safeguarding team is supporting and attending the 'Safe & Together' workshops in partnership with children's social care. The aim of the workshops is to look at how the model has been applied to real scenarios in social work practice and is a learning opportunity for social workers and health practitioners involved.
- ✓ The MARAC risk indicator checklist DVA audit report has been completed.

iv) **Areas for Development**

FGM

- The group will need to contribute to the GM FGM training package which is being developed. This will inform FGM training to be delivered to key priority areas within MFT as identified by the safeguarding team in conjunction with the Hospitals/LCO's and MCS.
- Previous partnership working with the 'Guardian' project needs to continue through the various pathways such as St Marys Ante-natal clinic, the Sexual Assault and Referral Centre (SARC) and through wider safeguarding work.

DVA

- To continue to contribute to the review being undertaken by the MSP DVA group.
- To continue to contribute to the review of MARAC process led by Greater Manchester Police (GMP).

- To continue to develop ‘Safe & Together’ training and attend the MSP workshops.
- MFT Domestic Abuse Training to continue to be rolled out across the Trust and the DV Trainer to ensure the package meets the requirements set out by MSSP and TSSP.
- To continue to raise awareness of DVA across the Trust in order that service users and staff are safeguarded from domestic violence and abuse. This will include the implementation of the revised policy to support staff affected by DVA.
- To report on the findings of the Trust DVA audit.
- To support staff in the challenging work of supporting families in the community from April 2020 during Covid-19 crisis when domestic Abuse cases are expected to increase due to the impact of family stress during lock down.

4.6.7 **Mental Health Safeguarding Group (MHSG)**

i) **Purpose of Group**

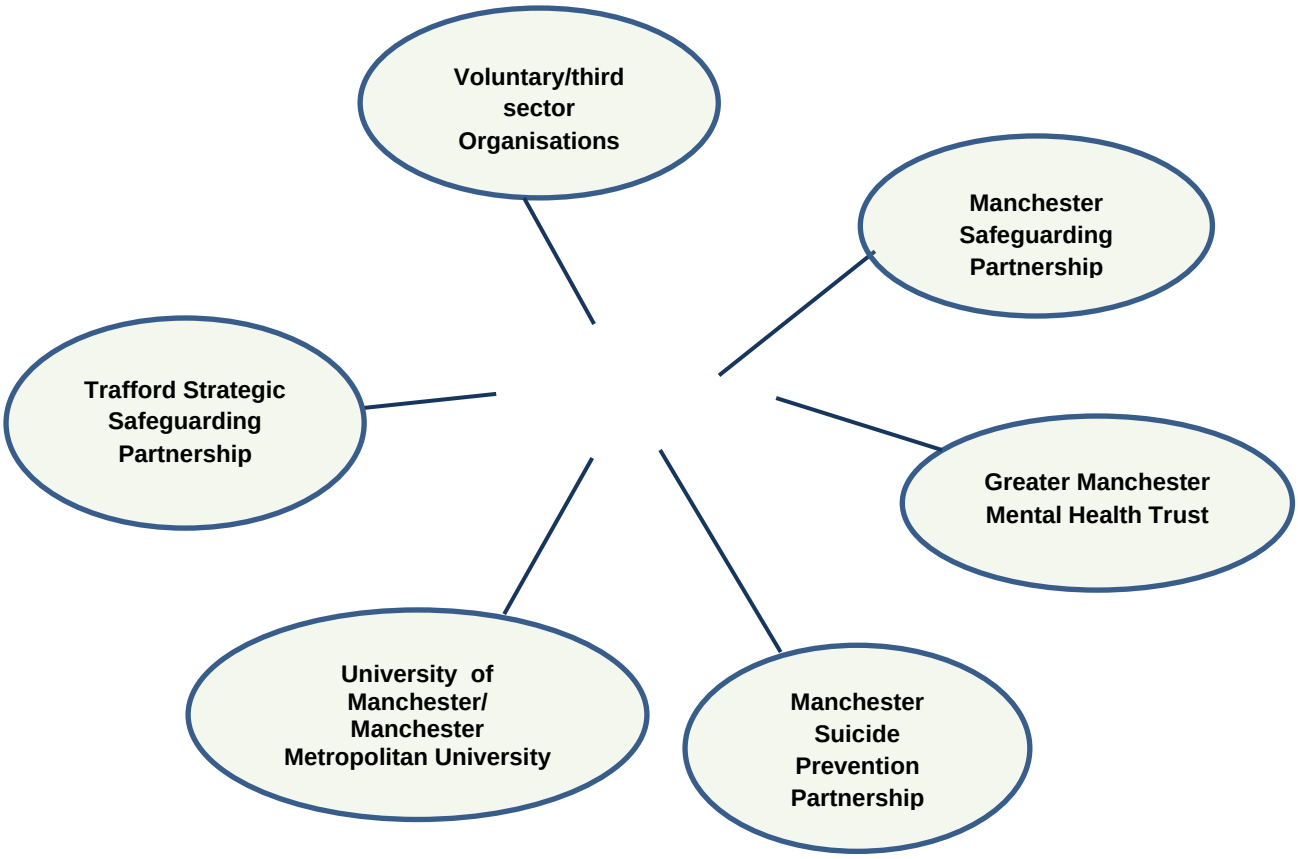
The purpose of the MHSG is to provide corporate oversight across the Trust relating to the quality standards for mental health care.

This includes:

- Leading on the development of an overarching mental health policy, in collaboration with commissioned liaison mental health service managers and clinicians.
- Working with workforce development to ensure that all staff receive targeted education and training to deliver best care including mental health care for all patients.
- Develop and monitor action plans for tracking progress to meet the quality standards and to mitigate the mental health related risks, including risks on the corporate/local risk register.
- Audit and monitoring of key performance targets, particularly as this relates to risk management, e.g.
  - Self-harm/suicidal behaviour
  - Risk associated with patients who abscond from care
  - Management of interventions for behavioural disturbance
  - Use of mental health legislation/ safeguards to protect the patients rights
  - Evidence to demonstrate reduced need for restrictive interventions
  - Performance issues related to the contract for liaison mental health service.
- To report on the patients experience of care, with additional evaluation and showcasing of good practice across the Trust, including learning from the seven minute briefings to cascade key actions to share or highlight to colleagues.

ii) **Group Work Streams and Relationships with Multi Agency Groups**

Figure 18: Mental Health Sub-group Reporting Structure



iii) **Key achievements**

- ✓ Establishment of the Trust wide Mental Health Sub-group. Prior to the Trust merger there were mental health operational groups that represented the work at the former University Hospital South Manchester NHS Foundation Trust and the former Central Manchester University Hospitals NHS Foundation Trust. This year the Trust wide Mental Health safeguarding group has been established to provide assurance for mental health related activity on all sites covered by MFT. This year the legacy actions from the operational groups have all been completed.
- ✓ The action plan for Prev from self-harm & suicide prevention has been ap
- ✓ The following safeguard icies and procedures have been harmonised across the Trust:
  - Suicide prevention
  - Mental Health Act
  - Care for adult patients who experience behavioural disturbance due to mental health conditions
  - Prevention and management of missing & absconding patients
  - Prevention and management of restrictive interventions for adult patients
  - Rapid tranquilisation guidance for use of medication to manage behavioural disturbance in adult patients
- ✓ The group now considers the patient experience of mental health care.

- ✓ The group has contributed to the development of an e-learning package to ensure that all staff are compliant with the mandatory key skills framework for mental health. This was launched Trust wide in October 2019, with over **15,000 staff** receiving the training in the first 6 months of its introduction. In addition the group has increased awareness of the high risk groups for self-harm and suicide through promotional events such as Mental Health week and World Mental Health day.
- ✓ The MHSG provide specialist mental health oversight across all areas of activity, with a positive relationship with the Liaison Mental Health Team (LMHT), the psychology team, CAMHS, and employee health wellbeing. This has enabled the group to offer specialist input to MH developments, including inter-organisational development of the MH transfer document that improves the pathway for patients who require ongoing medical care once transferred to a mental health facility.
- ✓ The MHSG has also provided oversight to the development of Core 24 services for LMHT across all sites, monitoring the progression towards an all age liaison service.

iv) **Areas of development and Priorities for 2020-2021**

- The group chair has successfully formed the group identity over the year: further work is planned for 2020/2021 to ensure that the site representatives are able to attend regularly and that they are of sufficient seniority to progress actions at local sites.

- Supporting the preparation for the Mental Capacity Act Amendment, Liberty Protection Safeguards to replace DoLS. This will include changes to policy, systems, education and training which will be delivered through an implementation plan incorporating impact assessment, and transitional arrangements.
- Development of a best practice model to demonstrate a reduction in the need to use restrictive interventions.
- Development of additional evaluative research in conjunction with the University of Manchester regarding the patients experience of the mental health crisis care pathway.
- Supporting the provision of the Safeguarding Conference for National Safeguarding Adults Week (19/11/20).
- Build on successful implementation for the integrated care pathway for self-harm & suicide across all sites, with a particular focus on urgent care.
- Establishment of a high level case monitoring group, that will advise on matters related to frequent attenders, serious case reviews/ RCA's/near miss events associated with missing and absconding patients/self-harm or suicide incidents as necessary.
- Developing a focus on "Making Safeguarding Personal" to support the work of MSP through inter- agency collaboration.

SECTION E

Partnership Working

5. Partnership Working

5.1 MFT Contribution to Manchester and Trafford Safeguarding Partnerships (MSP) (TSP)

This year the implementation of the new Working Together to Safeguard Children (2018)[15] guidence has seen the introduction of the new Manchester and Trafford multi-agency safeguarding partnership arrangements. MFT is fully committed to multi-agency working for both adult and child safeguarding and our staff are committed to playing an active role in the safeguarding partnership activity at all levels and to contributing to the wider work of the Partnerships in ensuring feedback from multi-agency sub-groups and lessons from Serious Case Reviews/Child Safeguarding Practice Reviews (SCR/CSPR) and Safeguarding Adult Reviews (SAR) are embedded into practice.

5.2 MFT Progress against Manchester Safeguarding Board Priorities and Strategic Objectives 2019-2020

In the 2018-2019 MFT Safeguarding Annual Report, the Trust committed to ensuring that the strategic objectives of the MSP were clearly embedded in the safeguarding agenda across MFT. In 2019 Trafford community services joined the Trust, which means that MFT now provide acute and community health services to Trafford and work towards Trafford's Safeguarding Partnership objectives.

Figure 19: below provides information on how this was achieved in 2019-2020.

Figure 19: MFT Achievements against Manchester and Safeguarding Partnership Objectives

Safeguarding Priority	Board	MFT achievements to address priorities

[15] Working Together to Safeguard Children (2018)

Adverse Childhood Experiences (ACE)	**MSP**	The Safeguarding Team and the Children's Community Health Services have contributed to the ACE work in North Manchester. The safeguarding children training package has been updated to include ACE
Neglect Child Neglect, Wilful Neglect and Self Neglect	**MSP**	MFT has an Early Help and Neglect Safeguarding Sub-group with Trust wide representation which oversees practice in relation to neglect. The Trust has implemented key messages from the Child Neglect Strategy including an implementation plan for the Graded Care Profile 2 (GCP2) to assist services to identify and respond to childhood neglect. GCP2 training has been delivered across the Trust with188 staff being trained to deliver GCP2 with families where children are living in the context of neglect. The Named Nurse Safeguarding Adults has contributed to the development, launch and implementation of the Adult Self Neglect and Hoarding Toolkit.
Mental Health	**MSP**	MFT has a Trust wide Mental Health Safeguarding Sub-group. The Safeguarding Mental Health Service has supported the hospitals/MCS with safeguarding where there are vulnerabilities associated with mental health. The Team have delivered events to raise awareness of Mental Health and Suicide Prevention throughout Mental Health Awareness week.
Transitions	**MSP/TSP**	The 'Our Children' (LAC) team have developed and delivered the Care Leaver passport to enable young people to understand their health needs as they transition to adult hood. The "think family" approach of the safeguarding team ensures a holistic all age response at transition.
Domestic Violence and Abuse	**TSP**	MFT has a Domestic Abuse Safeguarding Sub-group with Trust wide representation which oversees and ensures domestic abuse training policy and practice. There is a domestic abuse training programme and plan targeted at priority groups as identified in the National Institute for Health and Care Excellence (NICE) Domestic Violence and Abuse Guidance. The Trust has a Domestic Abuse Policy. Staff are supported in their roles and responsibilities around domestic abuse. The MFT policy for supporting staff who are affected by domestic violence and abuse has been reviewed. The safeguarding team deliver Domestic Violence and Abuse training and have attended the multi-agency 'train the trainer' Safe and Together training. An implementation

		plan has been developed to deliver the model into front line practice in children's services
Exploitation	**TSP**	The Trust has Complex Safeguarding and Sexual Exploitation Sub-groups with Trust wide representation which has implemented training, policies and risk assessments around CSE. The Complex Safeguarding Sub-group is raising awareness of complex safeguarding across the Trust. A Children and Young Person Risk Indicator Checklist in the context of exploitation has been developed.

5.3 MFT contribution to the Multi-agency Safeguarding Hub (MASH) and Manchester Advice and Guidance Service/ Children's MASH

5.3.1 Manchester Locality Advice and Guidance Service

This year the central children's Multi Agency Safeguarding Hub (MASH) ceased to operate and was replaced by three multi-agency locality based hubs called the Advice and Guidance Service (AGS) which are located in the North, Central and South of the city. Each hub has a Social Care Team Manager overseeing the day to day running of the hub, with the Locality Service Managers having overall responsibility for the effective delivery of the service.

MFT currently provide a Health Visitor (HV) and administrative support to the AGS based in the Central Hub; they also have a physical and virtual link with the North and South Hubs to provide a citywide service. The HV in the AGS supports the multi-agency function of the Children's Services front door process by gathering and sharing health information which contributes to assessing the level of risk to child/ren.

A Named Nurse from the MFT Safeguarding Service has continued to provide professional support and leadership to the HV in the AGS as well as supporting the development of policies, procedures and guidance to ensure the role of health is understood in the hubs. The Named Nurse also maintains a strategic link between the management teams in the AGS and the wider health economy. She also continues to provide safeguarding supervision for the HV as well as supporting the management of difficult cases or complex decision making whilst ensuring that the escalation process is fully understood and utilised when required. The HV within the AGS gains support through peer supervision with her safeguarding colleagues.

i) **Key Achievements 2019/20**

- ✓ In this annual report year the AGS health team have completed **2,717** enquiries regarding children, young people and their families that have been referred into Children's Social Care. In **2568** of these enquiries the health information has influenced the multi agency response and outcome for the child or young person.
- ✓ In the last annual year AGS health have provided health information on 51 cases for strategy meetings to support health practitioners where information is urgently required to influence child protection enquiries.
- ✓ In March 2019 the referral process to Manchester's Children's Social Care was changed to the 'David Thorpe' model. This model requires practitioners who are making a referral to Children's Social Care to have a meaningful telephone

conversation with a social worker rather than submitting a written referral. The primary aim of the conversations is to reduce the number of 'inappropriate' referrals and to reduce the number of referrals that provide limited information to Children's Services. Through these conversations the practitioners are able to explore the concerns and agree a plan of support for families and their children. The new referral process has required a significant change for practitioners: the AGS health practitioner has supported health staff to understand and recognise the benefits of this process. The health practitioner has also been able to support staff with some of the more complex cases and has been able to negotiate with Children's Social Care when practitioners have not been satisfied with the outcome of their conversation with a social worker.

- ✓ The new referral process has introduced challenges for the out of hours hospital services however the AGS health practitioner has been involved in developing an out of hours pathway which has been successfully piloted and is now being embedded into practice.
- ✓ The health processes have been updated and included as an appendix to the AGS Memorandum of Understanding (MoU) to enable partners to have a better understanding of the health role and to know how to engage with health services if the health practitioner is not available.
- ✓ The AGS health practitioner has been completing monthly reviews of referrals that have been submitted from the Trust to review whether the referrals are at the right threshold of need for Social Care assessment.

ii) **Next Year's Priorities Development Plans for 2020/21**

- To ensure the Out of Hours Referral Pathway is promoted and fully embedded across the Trust
- To promote the AGS health role in gathering information for strategy meetings in all 3 of the hubs
- To continue to strengthen multi agency working relationships
- To complete regular review and audit of health referrals and the response from the AGS to ensure children and young people have been effectively safeguarded and to explore any themes/changes which may be required.

5.3.2 **Adult MASH**

i) Throughout this annual report year the Adult MASH has continued to be located centrally in the city with the health team being commissioned directly from the Clinical Commissioning Group (CCG). MFT have a seconded safeguarding nurse into the Adult MASH who is supported by the Manchester City Council Health researcher posts.The safeguarding nurse is professionally accountable to MFT, reporting to the Head of Nursing – Safeguarding and is operationally managed by Manchester City Council (MCC).

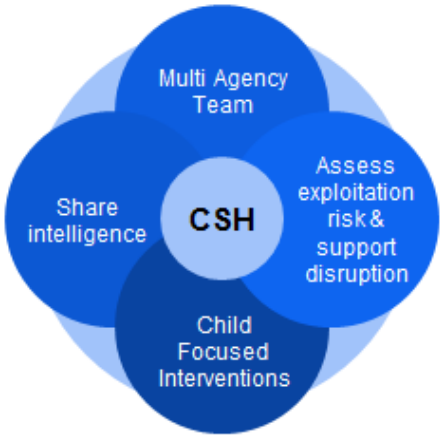
ii) The MFT adult safeguarding team work closely with the MASH to ensure appropriate information sharing and good working relationships are in place.

5.3.3 **Manchester Complex Safeguarding Hub**

i) A Senior Specialist Nurse Child Sexual Exploitation (SSN CSE) is based within the Manchester Multi-agency Complex Safeguarding Hub. **Figure 20** illustrates the role

of the multi-agency LA, Police, Health, Youth Justice and Third Sector services in the Complex Safeguarding Hub.

Figure 20: Manchester Complex Safeguarding Hub role and function;



The SSN CSE provides specialist health advice to the Hub, is the conduit for information sharing between health and the multi-agency teams. She offers an advice and consultation service to health professionals in respect of CSE and provides training and briefing sessions for MFT staff, including input into the multi-agency MSP Complex Safeguarding training. The SSN CSE has a small clinical caseload of young people who are 16-18, hard to reach and do not have access to a school nurse for support.

This annual report year has been a very busy year for the SSN CSE who has been involved in the embedding of practice within the newly developed Complex Safeguarding Hub.

ii) **Key Achievements 2019/20**

Across MFT

- ✓ Over the year the SSN CSE has continued to support MFT staff in the recognition and response to CSE: she has provided advice, consultation and support in collaboration with the acute and community safeguarding teams.
- ✓ The CSE Risk Indicator Checklist (RIC) was reviewed and a new Child Exploitation RIC has been developed covering both child sexual and criminal exploitation and a referral pathway to support staff has been developed. This supports the Trust's frontline staff to recognise and respond to children and young people who are at risk of exploitation.
- ✓ Training and Development opportunities have been provided through:
  - 7 minute briefings to support staff in recognising Child Sexual Exploitation and Child Criminal Exploitation.
  - Half day CSE training sessions have grown in attendance and a number of 30-60 minute briefings have been completed for a variety of audiences. 135 staff have attended training.
  - Integration of CSE into the revision of the level 3 safeguarding children training.

- ✓ Supervision has been provided for the Northern Integrated Sexual Health Service across Manchester, Tameside, Trafford and Stockport.
- ✓ Awareness raising work was completed across MFT, during the Complex Safeguarding Week of Action in October. This included a walk-about session around the Central Hospital site to raise awareness of exploitation and to promote the use of the new Child Exploitation RIC. Members of the SE sub-group used the opportunity to promote the RIC and to raise awareness across the Trust.
- ✓ A second week of action that was planned for March was not able to be fully progressed due to social distancing difficulties during the Covid – 19 pandemic. However the 7 minute briefings were promoted by members of the SE sub-group and posters were displayed in patient areas.

Multi-Agency work

- ✓ SSN CSE has represented MFT in Silver Meetings for five complex Police operations.
- ✓ SSN CSE is involved in monthly dip-sampling of cases open to the Complex Safeguarding Hub to audit the efficacy of each agency's work.
- ✓ SSN CSE has co-delivered on the MSP 'Understanding Exploitation' training and will support the review of the package in the nect report year.
- ✓ SSN CSE has been a member of the multi-agency CSE delivery group and the Phoenix operational group.
- ✓ SSN CSE has contributed to the development of the Complex Safeguarding Strategy for Manchester (due to be published in the coming financial year).
- ✓ SSN CSE was interviewed as part of the Local Government Association (LGA) peer review of CSE in Manchester which received positive feedback in respect of effective multi-agency working.
- ✓ SSN CSE contributed to the Greater Manchester Phoenix review.

5.4 **Next Year's Priorities Development Plans for 2020/21**

5.4.1 To review the data collection in the hub to develop a multi-agency integrated dashboard of the complex safeguarding hub activity.

5.4.2 To work with the clinical commissioning group on the findings of their desktop review completed in March 2020 on complex safeguarding.

5.5 **Serious Case Reviews (SCR)/Child Safeguarding Practice Reviews, Safeguarding Adult Reviews (SAR), Domestic Homicide Reviews (DHR)**

5.5.1 SCR's, SAR's and DHR's are commissioned through the multi-agency partnership arrangements in accordance with the statutory guidance following the death of 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 to improve multi-agency practice to safeguard children, young people, adults at risk and their families.

5.5.2 In June 2019 the implementation of the new Working Together (2018) guidance has resulted in all new children's reviews being known as child safeguarding

practice reviews (CSPR). This year has seen the completion of all of the legacy SCR's and the commencement of the new CSPR arrangements.

5.5.3 2019-2020 has been another busy year in terms of SCR/SAR/DHR activity. MFT has contributed to the range of methodologies used to undertake reviews in Manchester, Trafford and out of area (**Figures 21a, 21b and 21c** below).

Figure 21a: SCR/SAR/DHR Contribution by the Safeguarding Team in 2019-2020

2019/20	Q1	Q2	Q3	Q4	Total to date
Serious Case Reviews (child)	**5**	**5**	**10**	**1**	**21**
Safeguarding Adult Reviews	**1**	**2**	**5**	**4**	**12**
Domestic Homicide Reviews	**0**	**0**	**1**	**1**	**2**

Figure 21b: SCR/SAR/DHR Contribution by the Safeguarding Team in 2019-2020

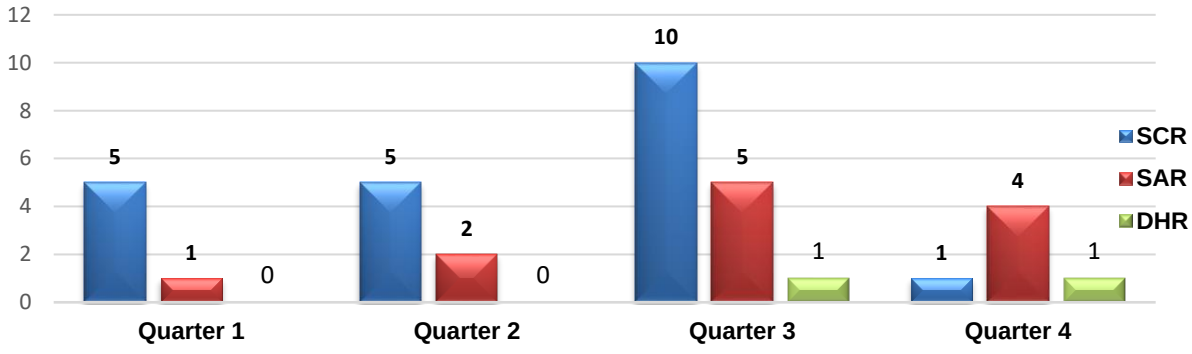
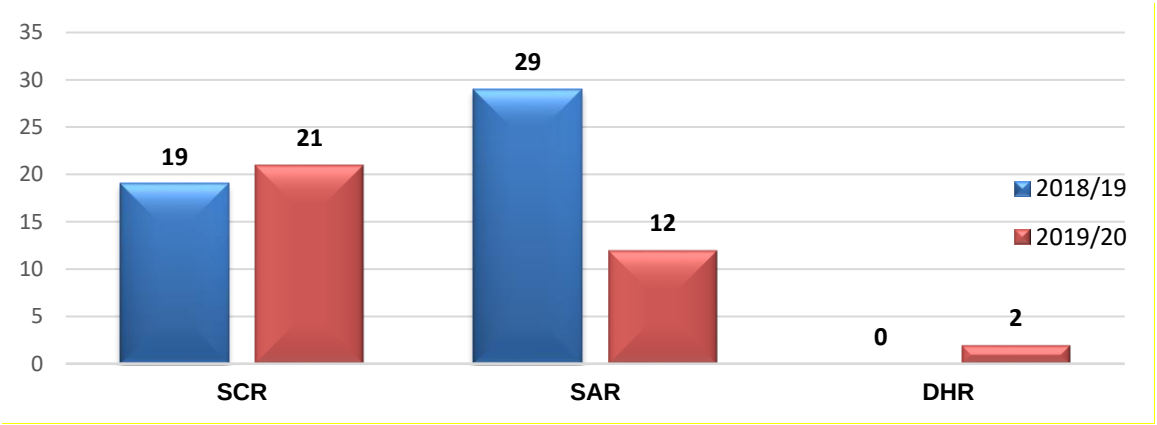


Figure 21c: Comparison with 2018/19



5.5.4 Activity around safeguarding adult reviews has decreased this year however children's reviews have increased slightly.

5.5.5 Currently the Trust is working with a number of ongoing reviews that have not been finalised as well as new and emerging concerns indicating that in 2020/21 there will be ongoing involvement from the Trust in legacy and new reviews.

5.5.6 At the end of quarter 4, there were;

- 7 serious case reviews ongoing in Manchester and 2 out of area involving MFT services.
- 10 children's local learning reviews ongoing in Manchester.
- 7 Safeguarding Adult Reviews ongoing in Manchester.
- 11 adult local learning reviews ongoing in Manchester.
- 2 adult cases progressing to thematic review in Manchester.
- 1 domestic homicide ongoing out of area.

5.5.7 In 2019/20 the Trust contributed to five published Serious Case Reviews (from Salford, Trafford, Stockport, Bury and Tameside) and two published Safeguarding Adult Reviews from Trafford. Manchester published one Domestic Homicide Review. MFT provides tertiary services for both children and adults, therefore the Safeguarding Teams are involved in SCRs, SARs and DHRs both within and outside the Manchester area.

5.5.8 Named Nurses from across the Safeguarding Teams represent MFT on review panels. MFT's Named Nurses lead on ensuring key messages and lessons learned from reviews are shared across the Trust through safeguarding training, the safeguarding newsletter, briefings to safeguarding governance groups and specific hospital/MCS/MLCO action plans.

5.5.9 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 practitioners.

5.5.10 **Appendix 1** identifies in depth key learning for the Trust from the reviews that have been published in 2019/20.

5.5.11 Key messages from SCRs this year include the vulnerability of babies, the importance of sharing information across agencies, and local borders, and the importance of professional curiosity and clear documentation.

5.5.12 Learning from DHRs is reviewed by the Trust Domestic Violence and Abuse Sub-group. Key messages include the important part health professionals play in recognising and responding to domestic abuse, the importance of robust risk assessment and raising awareness of domestic abuse through quality training.

5.5.13 Learning from SARs includes the importance of making safeguarding personal, professional curiosity, assessment and documentation of mental capacity/best interest assessments and the importance of completing a safeguarding referral.

5.5.14 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 F

Safeguarding Activity and Performance

6. MFT Safeguarding Activity and Performance from 1st April 2019 to 31st March 2020

6.1. Introduction

6.1.1 This section of the report provides an overview of MFT safeguarding activity and performance from 1st April 2019 to 31st March 2020. It provides assurance that MFT has 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.

6.1.2 MFT Safeguarding Services are comprised of the following teams:

- Acute Children's Safeguarding
- Acute Adult Safeguarding
- Maternity Safeguarding Services
- Community Safeguarding Children and Looked after Children teams providing Manchester citywide and Trafford safeguarding services.
- Safeguarding Mental Health

6.1.3 Trafford Local Care Organisation joined the Trust in October 2019 and the corporate safeguarding service has operationally managed the Trafford community safeguarding team since January 2020. The safeguarding activity in the Trafford report reflects Trafford's previous data collection, however in the next annual report 2020/21 data will be harmonised across all services.

6.1.4 The safeguarding services are based on the Oxford Road Campus (ORC) and Wythenshawe sites and in the community at Rusholme Health Centre and Trafford

Town Hall. Although they are centrally based, the teams work throughout the hospitals/MCS/LCOs and aim to be visible and accessible to all Trust services.

6.1.5 There has been significant progress this year in ensuring consistent ways of working across the safeguarding service, however in 2020/21 further work will be completed to strengthen consistency in safeguarding activity across the Trust.

6.2 Safeguarding Referrals for Adults and Children

6.2.1 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 LA children's or adult services. The role of the MFT safeguarding team is to support practitioners in their decision making to ensure that each referral to child or adult protection services is at the correct threshold for statutory intervention.

6.2.2 Collectively during this reporting period MFT safeguarding teams excluding (Trafford community) dealt with **23,800** 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. This level is slightly higher than last year's reporting's when **23,162** referrals were completed.

6.2.3 **Figure 22** (below) provides a breakdown of referrals across the safeguarding teams for this annual report year.

Figure 22: MFT Safeguarding Referrals to each Safeguarding Team 2019/20

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	**2652**	**1933**	**4585**	• Sexual Abuse • Child and Young Person mental health including self-harm • Domestic Abuse
Adult Safeguarding team	**1878**	**2299**	**4177**	• Mental Health • Domestic Abuse • Neglect
Maternity Team	**7139**	**1000**	**8139**	• Mental Health • Domestic Abuse • FGM
Children's Community Safeguarding	**6899**		**6899**	• Neglect • Mental Health • Domestic Abuse
Combined Total			**23800**	

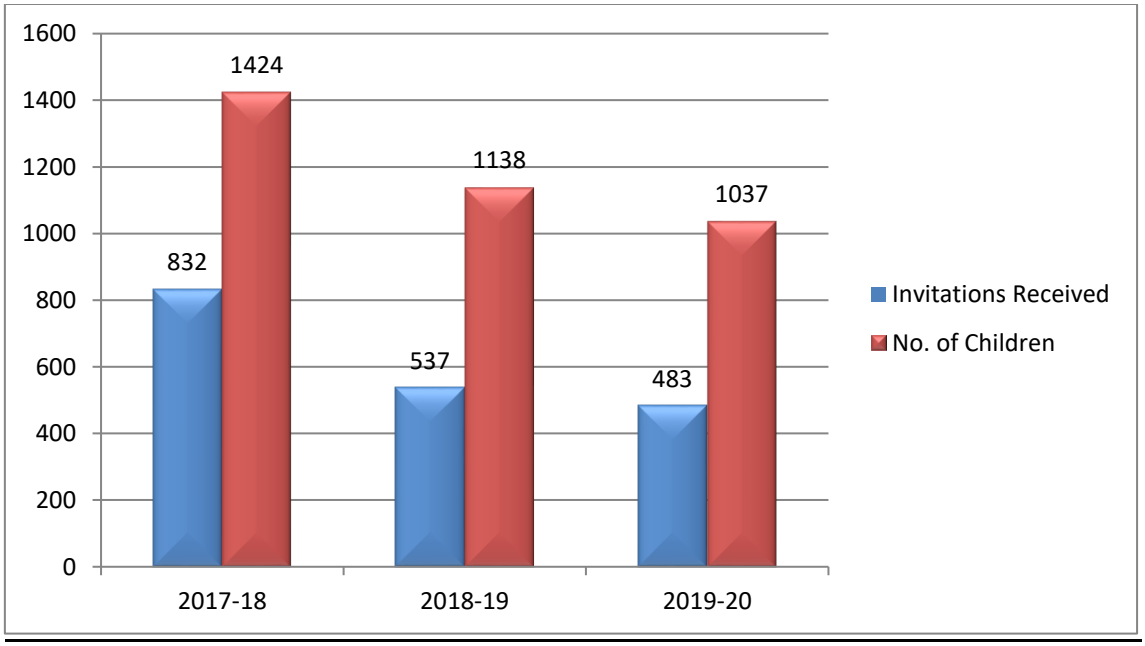
6.2.4 Detailed analysis of the referral data is provided later in this report in the context of the activity of each MFT safeguarding team.

6.3 MFT Contribution to Manchester Child Protection Plans (CPP)

6.3.1 When children are identified as being at risk of, or suffering significant harm, abuse and/or neglect health professionals contribute to the multi-agency child protection planning process. At the beginning of 2019/2020 Manchester LA identified that **798** children were subject to CPP in Manchester. The safeguarding team support the health professionals to safeguard these children and to effectively contribute to child protection planning.

6.3.2 **Figure 23** shows the numbers of families where MFT health professionals were invited to attend Manchester child protection case conferences to ascertain if the child/ren were subject to or at risk of significant harm and required child protection planning. Manchester is consistent with the national data identified in Section B whereby numbers of children and young people subject to a CPP is slightly decreasing. This is in response to considerable work across the partnership to strengthen the Early Help and Child in Need process.

Figure 23: Initial Child Protection Conferences Invitations Manchester 2017-2020



6.4 Manchester Community Children's Safeguarding Activity

6.4.1 The community safeguarding children team provide a citywide safeguarding service to all community staff working with children. Support for the community children's workforce is vitally important as health visitors and school nurses hold and manage high levels of complex child protection caseloads.

6.4.2 The complexity of safeguarding is changing: this year, as can be seen in **Figures 24a to 24d** below, notifications include categories such as child sexual and criminal exploitation (CSE CCE), Female Genital Mutilation (FGM), Forced Marriage and so called Honour Based Violence and radicalisation, all of which pose significant challenges to both the safeguarding team and the clinical staff in terms of developing and maintaining skills to support recognition and response.

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

Figure 24a: Community children's safeguarding notifications 2019-2020 by category

Category of referral	Number of notifications
Adult Mental Health	0
Adult (and Child) Substance Misuse	337
Allegations against staff	2
Child Criminal Exploitation	149
Child Mental Health (Inc. Self-harm)	855
CSE	184
Domestic Violence & Abuse	687
Emotional	371
External Agency Referral	433
FGM	21
FII / Perplexing Presentation	64
Forced Marriage	28
Homelessness	0
Learning Disability	0
Looked After Children (LAC)	125
Missed Appointments	155
Neglect (Inc. parenting capacity)	1813
Physical	253
Radicalisation	16

Sexual	155
Trafficking/Modern slavery	0
Other	1251
Total	**6899**

Figure 24b: Children's Community Safeguarding referrals by category 2018-2020

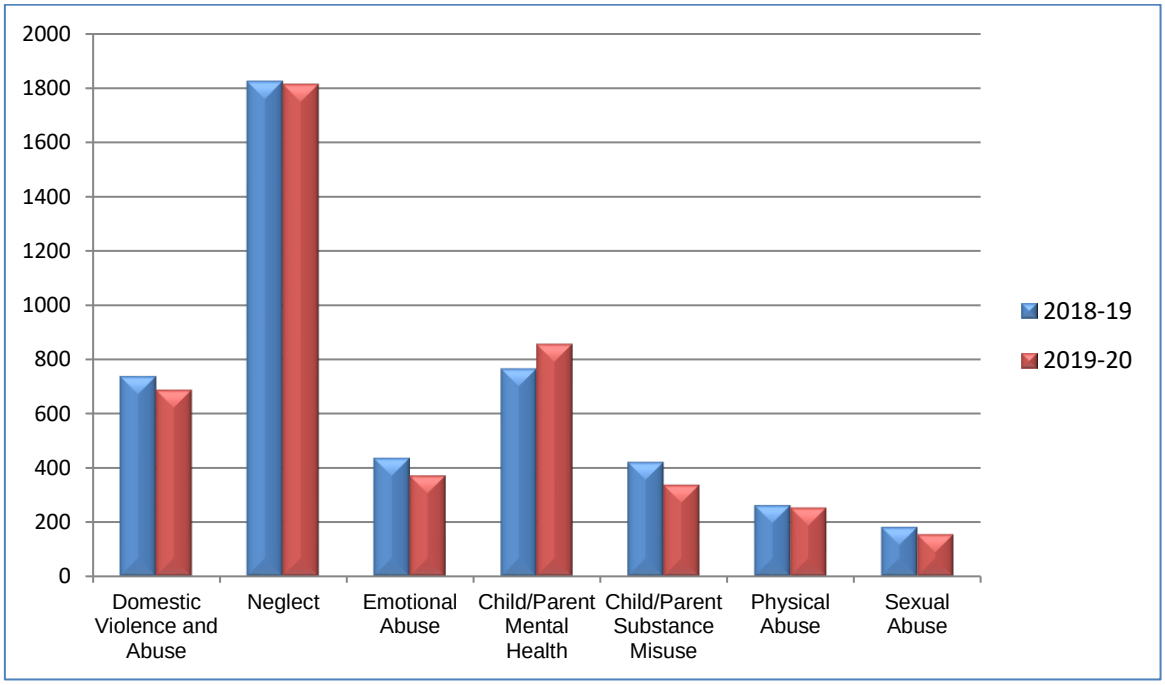


Figure 24c: 2018-19 and 2019-20 Comparison of Referral Categories

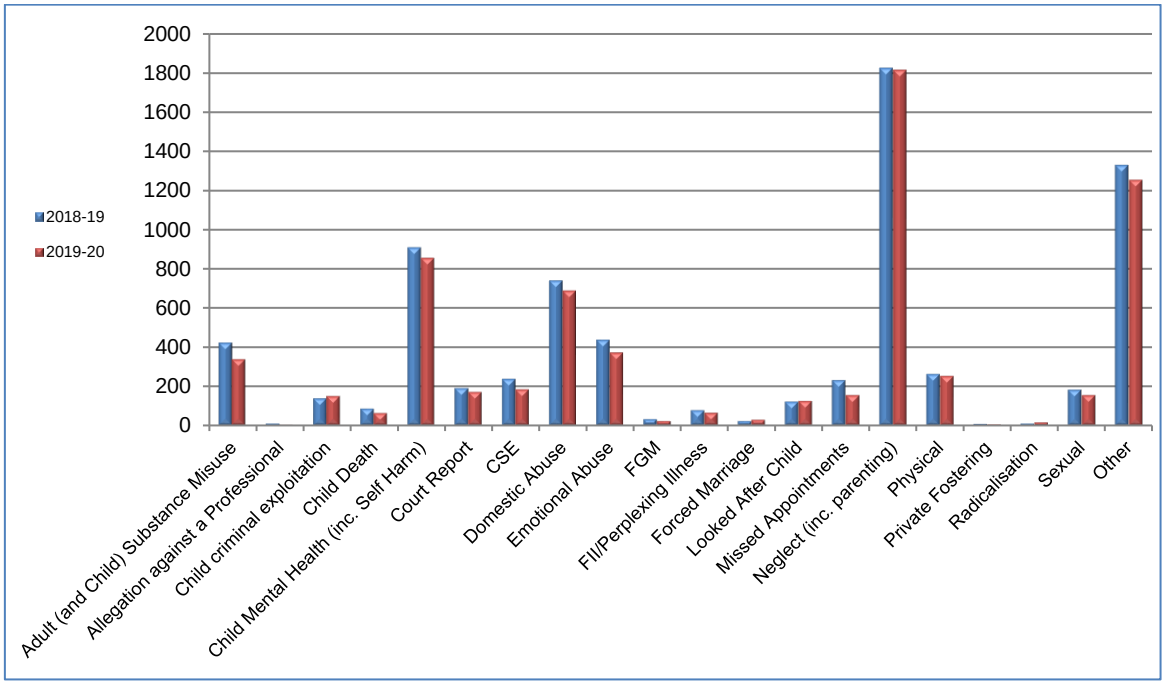


Figure 24d: MFT safeguarding notifications - 3 year comparison

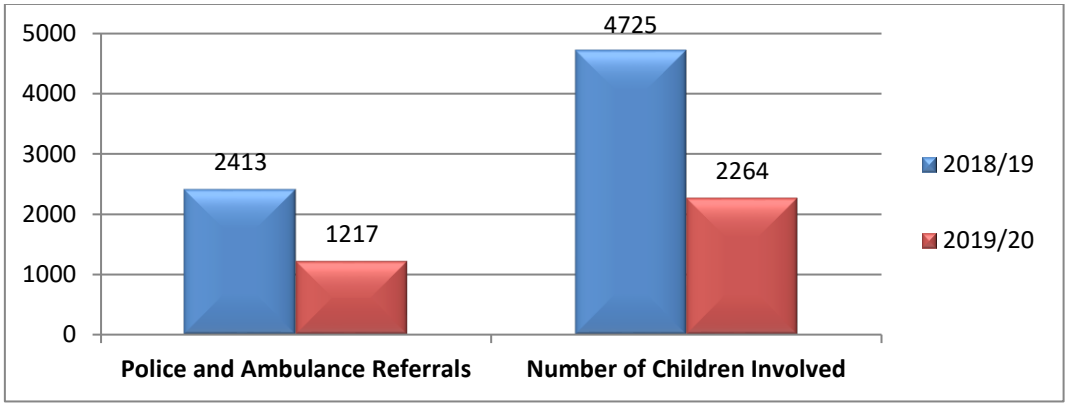
Year	Number of Notifications
April 2017- March 2018	3,449
April 2018- March 2019	3,992
April 2019- March 2020	3,853

6.4.3 The data above shows a consistent level of reporting in all categories of referral over a three year period. This Manchester picture aligns with national messages that neglect is the most common cause of safeguarding concern for children and young people followed by emotional harm and that a significant number are impacted by domestic violence abuse in their homes.

6.4.4 **Police and Ambulance Safeguarding Referrals**

i. 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 as appropraite. Many of the referrals from the police are cases where they 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 notify community health services to ensure the child's community health caseload holder (health visitor or school nurse) can review the incident to ensure the child or young person's health needs are being met and to assess if there ar any additional vulnerability or risk factors for the child and family. This also allows the health practitioner to build a chronology around a child's daily lived experience.

Figure 25: Police and Ambulance Referral to MFT Safeguarding Services Data



ii. The number of referrals has decreased this year. This may be due to the three Manchester Locality Advice and Guidance Services having the police physically located in the hub so risk assessments are being completed at the locality domestic abuse triage meetings. Additionally through the police operation 'Encompass' schools are now being updated daily about domestic abuse cases in a pupil's households and as school nurses are physically based in schools for allocated sessions each week there are evolving information sharing pathways In the next annual report year (2020/21) the community safeguarding team, in

collaboration with MLCO children's community services, are reviewing with police and Children's Services the most effective and proportionate way to share information regarding police domestic abuse incidents.

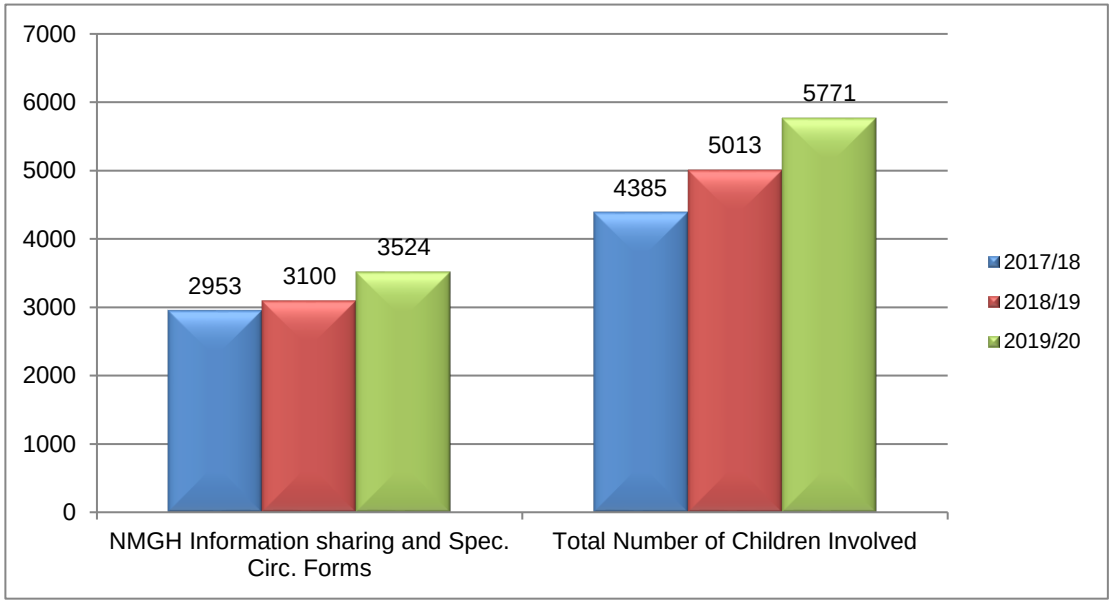
6.4.5 Referrals from North Manchester General Hospital

i. Lord Laming's recommendations following the Victoria Climbie inquiry in 2003[16] required all emergency departments to notify the health visitor or school nurse when a child has attended. These notifications are well established across all Manchester hospitals and are shared by the MFT emergency departments directly to children's community services. The information from North Manchester General Hospital (NMGH) is processed via the MFT community safeguarding team.

ii. The community safeguarding team ensures that these notifications are disseminated to the health visiting and school nursing teams for information and case management. In 2019/20 there was an increase in the number of children attending NMGH with safeguarding concerns. This aligns with the demographic data seen in the north of the city, which has the highest levels of child safeguarding concerns within Manchester.

iii. **Figure 26** shows that there has been an increase in notifications year on year, suggesting raised awareness and recognition of safeguarding concerns. Moving forward with the MFT single hospital service across Manchester there will be an opportunity to review and strengthen information sharing from North Manchester General Hospital to community services.

Figure 26: North Manchester General Hospital Information sharing and Special Circumstances Forms 3 year comparison

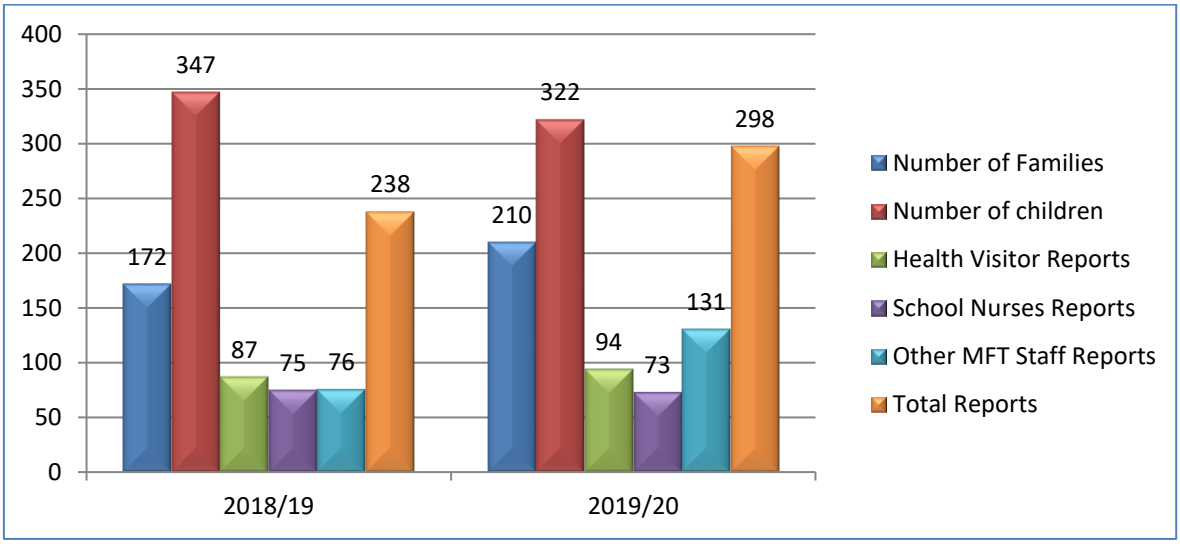


6.4.6 Court Report Activity for Child Care Proceedings

[16] The Victoria Climbie Inquiry

i. Court reports are requested by the Manchester City Council (MCC) legal team and are completed within defined timescales by community practitioners. Robust quality assurance by the MFT safeguarding team prior to submission of the reports ensures that very few frontline practitioners are called to give evidence in court. **Figure 27**, below outlines the numbers of court reports undertaken by community services in 2019-20.

Figure 27: Court reports quality assured by the Safeguarding Team



ii. The community safeguarding team has developed good working relationship with MCC Legal Services.

iii. Child care proceedings are commenced when the multi-agency safeguarding concerns have reached the threshold for legal intervention. Feedback from legal services identifies that the court report quality by MFT community staff continues to be very high.

iv. This year there has been reduced numbers of reports requested with 210 requests relating to 322 children, compared to 2018/2019 – 238 reports relating to 347 children and 2017/2018 - 309 report relating to 566 children. This reduction is mainly due to a strengthening of the Manchester safeguarding procedures and a more robust process in MCC, who work on all pre-child care proceedings cases, with the aim of only the most appropriate cases being taken to Family Court and that those cases are 'court ready' to be processed in a timely way through care proceedings to avoid any further delay for children.

v. MFT has contributed to child care proceedings through the submission of court reports from a range of professionals including those from specialist services including Allied Health Professionals comprising of physiotherapy, occupational therapy, CAMHS, Continence Services, Children's Community Nurses, Epilepsy nurse specialists, health visitors and school nurses.

vi. This year the community safeguarding team, in collaboration with MCC Legal Services, has undertaken work to provide more focussed, quality reports from

CAMHS and School Health. The renewed court report template is more focused on the health needs of the child/young person, safeguarding risks and the impact on their health and wellbeing. The new reports keep the child central, ensuring the health needs are clearly evidenced and identifying to the court how health needs are met.

The top 5 areas for referral in Maternity are:

- Mental Health
- Domestic Abuse
- Female Genital Mutilation (FGM)
- Substance Misuse
- Neglect

vii. The safeguarding team has delivered multi-disciplinary training and bespoke court report writing training quarterly which has been positively evaluated.
Of the reports produced over this annual report year there have been no community health staff required to give evidence in court. This illustrates that the quality of the reports submitted appears to meet the needs of the Family Court.

viii. The safeguarding team provides advice and guidance in providing police statements in criminal proceedings if there are ongoing safeguarding children concerns.

ix. In collaboration with medical legal services the safeguarding team provides safeguarding advice and support to staff when approached to provide reports in child care private law proceedings. Commonly this takes place when there are parental decisions made around child contact arrangements (previously custody).

6.5 Maternity Safeguarding Activity

6.5.1 Maternity safeguarding services are based at the Oxford Road Campus (ORC) and Wythenshawe Hospital and provide support to hospital and community-based services across MFT.

6.5.2 The safeguarding maternity team continue to receive all referrals for vulnerable pregnant women, newly delivered women, new-born babies and their siblings. The safeguarding midwives ensure direct support and visibility is achieved by undertaking daily ward rounds across both of the MFT maternity inpatient sites.

6.5.3 **Figure 28** below shows the number of safeguarding referrals made to the Safeguarding Team at each site.

Figure 28: Maternity Safeguarding Referrals

Unborn baby/Children's Referrals	Maternity ORC	Maternity WTWA	Total
Adult/Child Mental Health	2097	484	2581
Adult (and child) substance misuse	178	50	228
Allegations against staff	0	0	0
Child Mental health (Inc. self-harm)	0	2	2
Criminality	9	0	9
CSE	6	2	8
Domestic Violence & Abuse	438	115	553
Emotional	3	3	6
External Agency Referral	0	1	1
FGM	389	11	400
FII/Perplexing presentation	0	0	0
Forced Marriage	9	1	10
Homelessness	120	31	151
Learning Disability	31	10	41
Looked After Child	53	17	70
Missed appointments	0	42	42
Neglect (including parenting)	55	42	97
Physical	20	5	25
Radicalisation	0	0	0
Sexual	20	20	40
Trafficking/Modern Slavery	12	0	12
Other	3,698	164	3,862
Sub-Total	**7,138**	**1000**	
Total Referrals			**8,138**

6.5.4 Safeguarding midwives across both sites continue to receive a high volume of referrals; the most common category being maternal mental health. The second highest category of concern is domestic violence and abuse.

6.5.5 At St Mary's Hospital (ORC) there is a MCC employed Independent Domestic Violence Advisor (IDVA) and at Wythenshawe a Women's Aid IDVA who work closely with the safeguarding team to risk assess victims/survivors of domestic abuse and formulate safety plans for victims/survivors, their unborn babies and families.

6.5.6 Maternity services at ORC identified 389 service users impacted by Female Genital Mutilation (FGM) compared to lower levels (11) identified at Wythenshawe Hospital. This is reflective of the local population in Manchester and the increased vulnerabilities of women and girls living in FGM traditional practicing communities. Considerable work has been undertaken to raise awareness of the harmful impact of FGM to women and girls in Manchester. In recognition of this St Mary's Hospital (SMH) hosts a 'New Steps' to African Communities psycho-social clinic to ensure service users are offered a holistic response to the identification of FGM.

6.5.7 The FGM-IS was introduced at MFT in April 2019 and is now firmly embedded within practice. This year, 169 new-born girls (2 at Wythenshawe site and 167 at

ORC) have been born into families where a history of FGM has been identified. For each of these female babies, a safeguarding risk assessment is completed and information sharing, including a safeguarding marker has been placed on the NHS Spine (a national NHS information system). This enables safeguarding through the girl's childhood by alerting health partners to the risk of FGM. The named midwife/matron for safeguarding has been involved in national work with NHS England to enhance the visibility of the marker within the child's record on the NHS Spine to strengthen the safeguarding response.

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

6.5.8 **Maternity Court Report Activity**

i. 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 2019/20 the ORC safeguarding team completed 52 court reports for local authorities. This has decreased from 62 (2018/19), again reflecting the reduction across the city in requests for court statements

ii. Safeguarding midwives across both sites continue to work closely with social workers completing pre-birth assessment work. Over the course of the year the safeguarding midwives have contributed to a total of 67 assessments where the outcome has been negative and the baby is removed from parents care at birth (51 at ORC and 16 at Wythenshawe). The safeguarding midwives have been working with Manchester Children's Services Central locality team and multi-agency partners on the 'Babies at Risk of Harm' pathway to pilot the pre-birth assessment which involves early intervention and help to review the interventions offered to families in the antenatal period to enable the best outcomes postnatally. The outcome of this pilot is expected in 2020/21.

6.6 **Children's Acute Safeguarding Activity**

6.6.1 **Children's Acute Referrals**

i. The acute safeguarding children's service is delivered from ORC and Wythenshawe Hospital. The teams have promoted their availability and visibility across the acute footprint this year.

ii. **Figure 29** shows the number of referrals or alerts to the acute children's safeguarding team in 2019/20 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 4,312 in 2018-2019 to 4585 in 2019-2020. This is reflective of an increased awareness of safeguarding due to training and visibility leading to higher numbers of referrals.

Fig 29: Referrals to the Acute Safeguarding Children Teams

Category of Referral	Total
Adult Mental Health	726
Adult (and Child) Substance Misuse	278
Allegations against staff	4
Child (and Adult) Criminality	35
Child Mental Health (Inc. Self-harm)	548
CSE	121
Domestic Violence & Abuse	505
Emotional	50
External Agency Referral	90
FGM	13
FII / Perplexing Presentation	26
Forced Marriage	9
Homelessness	0
Learning Disability	16
Looked After Children (LAC)	118
Missed Appointments	60
Neglect (Inc. parenting capacity)	362
Physical	286
Radicalisation	7
Sexual	915
Trafficking/Modern slavery	24
Other	392
Total	**4585**

iii. In contrast to community and maternity services, the main referral category seen in the acute children's safeguarding referrals is sexual abuse/exploitation. The service covers sexual health services for young people along with the Greater Manchester and Merseyside Sexual Assault Referral Centre (SARC) as well as both RMCH and the wider Trust, which accounts for the high volume of referrals for sexual abuse.

iv. The acute referrals reflect the national messages of safeguarding children concerns with mental health and childhood neglect remaining a significant reason for referral in acute services: this is consistent with 2018-2019 activity.

v. The Wythenshawe, Trafford, Withington and Altrincham (WTWA) acute children's team identify that 609 (or 31.5%) of the referrals received into the team have come from the adult Emergency Department (ED) where parental mental health has been the reason for attendance. In 2020/21 the safeguarding team in partnership with the Manchester Safeguarding Partnership complex safeguarding executive will review the child safeguarding and parental/child mental health service journey following arrival at the emergency department.

The top 5 areas for referral in Acute Adults are:

- Neglect and Self Neglect
- Mental Health
- Domestic Abuse
- Sexual Abuse

6.6.2 **Section 47 Child Protection Medicals**

i. Child protection medicals are provided by acute and community paediatricians to contribute to Section 47 child protection enquiries. These are provided both in the community and in the hospitals for children less than 18 months of age or where an acute or urgent out of hour's medical is required.

ii. **Community Child Protection Medicals Coral Suite**
During this annual report year there were a total of 676 referrals. This number includes referrals for section 47 medicals and Looked after Children medicals. 320 Child Protection Section 47 medicals were completed and 357 'looked after children' medicals. The total number of referrals shows little change from the figure for 2018/19 [662]. The total number of Child Protection Section 47 medicals was lower than the previous year's figure [416]. The school closures and 'Stay at Home' restrictions connected with Covid-19 came into force in mid-March 2020 and would not have had a substantial impact on these figures.

iii. **Wythenshawe Child Protection Medicals**
The Wythenshawe paediatric team continue to provide child protection/S47 medicals for South Manchester and Trafford Children's Social Care for children aged under 18 months and for older children when medicals are not available in the community clinics, as well as for patients seen acutely at the hospital where safeguarding concerns have been raised 46 medicals completed over the last year).

6.7 **Adult Acute Safeguarding Activity**

i. The safeguarding adult teams are based at ORC and at WTWA and support MFT hospital and community services.

6.7.1 **Acute Adult Referrals**

i. The total number of referrals to the adult acute safeguarding team in 2019/2020 was 4177 compared to 2,254 in 2018/19. The increase in referrals reflects the increased awareness of adult safeguarding concerns as well as improvements in the team's methodology of recording the referrals through the implementation of the Ulysses incident and safeguarding reporting system across the Trust. **Figure 30** shows the breakdown of referrals by site and category.

Fig 30: Referrals to the Adult Safeguarding Teams

Category	ORC	WTWA	Total
Allegations Against Staff	1	0	1
Discrimination	0	0	0
Domestic Violence & Abuse	410	239	649
Emotional/Psychological Abuse	173	31	204
External Agency Referral	0	70	70
Female Genital Mutilation	1	2	3
Financial Abuse	75	46	121
Homelessness	46	25	71
Forced Marriage/Honour Based Violence	3	3	6
Institutional/Organisational Abuse	0	2	2
Learning Disability	59	12	71
Mental Health	192	514	706
Modern Slavery/Trafficking	16	6	22
Neglect	126	277	403
Self-Neglect	98	130	228
Physical Abuse	191	133	324
Radicalisation	0	5	5
Sexual Abuse	393	23	416
Substance Misuse	72	0	72
Other	22	781	803
Total	**1878**	**2299**	**4177**

i. 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 at ORC relates to SARC, which is a Greater Manchester and Merseyside service.

ii. In response to the identification of high levels of safeguarding concerns around neglect and self-neglect in adults, the MFT named nurses for adults have supported the implementation of the Manchester Safeguarding Board Self Neglect Strategy and Toolkit which was launched in the Trust in 2019/20.

6.7.2 Deprivation of Liberty Safeguards (DoLS) activity

i. 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 who is deemed to not have mental capacity to consent to care and treatment 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) where the patient is a usual resident.

ii. 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.

iii. In this annual report year 1,838 DoLS applications were made by the Trust. This is a decrease from 2067 reported in last year's MFT Annual Safeguarding Report. The small decrease may be impacted by Covid-19 and the changing nature of patients in the acute wards at the end of quarter 4 as well as the ongoing requirement to raise awareness to frontline staff of the importance of completing DoLS applications for patients.

iv. There has been considerable activity through level 3 adult safeguarding training and the use of informatics systems (DoLS portal at ORC and Ulysses at WTWA) to promote, streamline and ensure DoLS are put into place appropriately. The data provided in **Figure 31** identifies theTrust activity regarding DoLS.

Figure 31: 2019/20 Deprivation of Liberty Applications and Outcomes

	ORC				WTWA				Totals
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Number of DoLS applications	224	148	128	132	325	348	254	279	**1838**
Number granted/authorised				2	17	10	36	12	**75**
Number waiting assessment				120	130	123	134	253	**760**
Number RIP/discharged prior to assessment				19	297	315	199	175	**1005**
Number withdrawn/regained capacity				1	14	13	7	9	**44**
Number declined by LA				13	7	1	3	2	**26**
Number notified to CQC	9	16	19	17	17	10	36	12	**136**

v. In this annual report year 1838 DoLS Urgent Authorisations/standard applications were made to the LA of which only 75 were granted. There have continued to be significant delays in the processing and assessment of DoLS applications by Manchester and Trafford City Council. **Figure 31** outlines the numbers of DoLS applications assessed and granted by the LA compared to those submitted. The low number is due to the application of the ADASS Screening tool[17], which is a

[17] Adass Priority Tool

nationally recognised tool used to prioritise the allocation of requests to authorise a deprivation of liberty. The delays and the associated low numbers authorised have been recognised as an organisational risk and are recorded on the Trust Risk Register. The issue has been raised at Manchester Safeguarding Adult Board as the majority of DoLS applications are to Manchester City Council.

vi. The challenges to the current DoLS process are recognised in the Mental Capacity Amendment Act, which was granted Royal Assent in May 2019 which introduces the new Liberty Protection Safeguards process. (LPS). LPS aims to streamline the current process but will place increased duty on acute settings for the authorisation of the deprivation of liberty. In 2020/2021 the safeguarding team will work with hospitals/MCS/LCO to implement LPS across the Trust which is currently scheduled to be implemented in October 2020. In preparation for LPS a significant number of the safeguarding nurses have completed the Best Interest Assessor course at Manchester Metropolitan University.

6.8 **Domestic Violence and Abuse**

6.8.1 Domestic violence and abuse (DVA) training is in place across the Trust. The aim of this training is to prepare staff to be able to Recognise, Respond and Refer when DVA is a safeguarding concern.

6.8.2 Manchester as a partnership have launched the 'Safe and Together' model in order to work together to support families where there is domestic abuse. The model supports practitioners to partner with the victim and also engage with perpetrators so that the safety and well-being of children and young people in the family is maximised. The model focuses on the patterns of behaviour of the perpetrator, whilst adopting a non-blaming, partnering approach with the victim. The model is based on the belief that children are best protected and nurtured when kept "safe and together with the non-offending parent". Safe and Together has been highlighted in the Trust's regular domestic abuse awareness training since January 2019.

6.8.3 The model is now a significant priority within the Manchester Domestic Abuse strategy, it will from April 2020 also be highlighted in the mandatory level 3 children's safeguarding package and targeted workshops are planned for those practitioners working directly with families.

6.8.4 **Multi-agency Risk Assessment Conference (MARAC) Activity**

i. The Safeguarding Service continues to support the Trust's contribution to MARAC. MARAC is the process where all agencies including health staff identify and risk assess victims of domestic abuse referring the highest risk victims for a multi-agency risk assessment to facilitate safety planning in order to reduce the risk of harm and domestic violence homicide.

ii. The Trust makes a significant contribution to the Manchester and Trafford MARAC process for which good quality referrals are essential in line with the Trust's safeguarding policies, guidance, practice and training. All MARAC referrals are quality assured through the safeguarding teams to ensure the MARAC has the required information to appropriately safeguard victims.

iii. In this report year the Trust completed 483 referrals to MARAC.

iv. The safeguarding team contribute to MARAC by facilitating information sharing, risk assessment and safety planning information. Relevant and proportionate health information is shared from both acute and community health services.

v. In 2019/2020 there were 2,039 referrals to Manchester MARAC, an increase from 1,680 referrals in 2018/2019. These referrals involved 2,130 children and young people living in the household an increase from 1,742 children/young people in 2018/2019. Information was shared with the community caseload holders (health visitors and school nurses) for all of these children and information shared to MARAC from community in 1,517 cases.

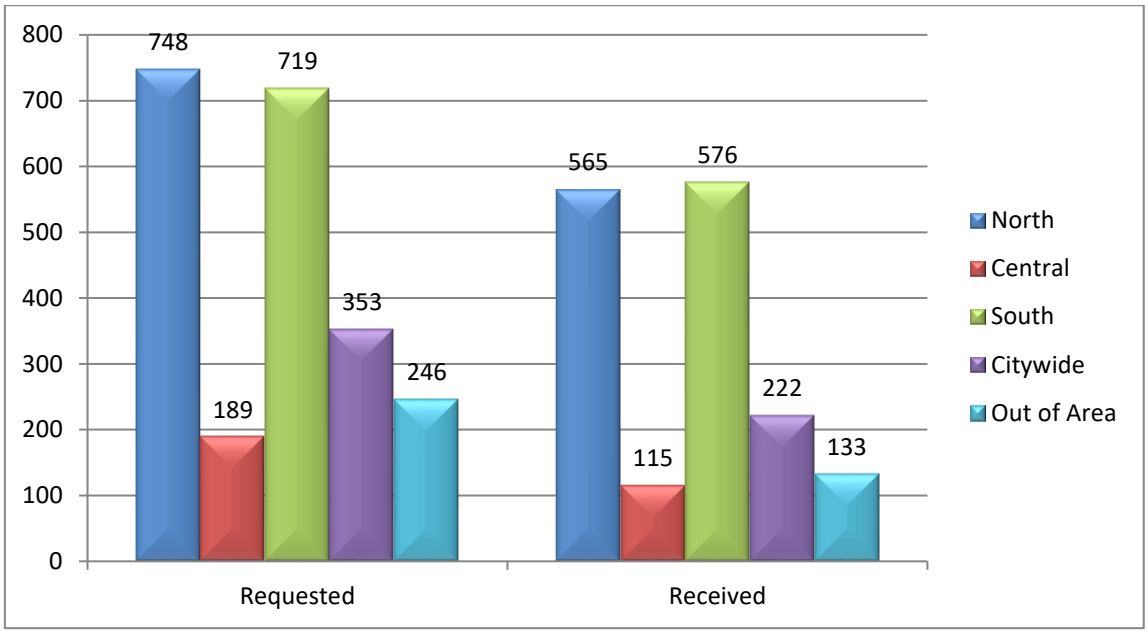
Figure 32: Health contribution to Manchester MARAC children's risk assessment

Manchester MARAC		
	Quarter 4 (Q3 data)	**Year to date**
Total Number of MARAC referrals	**531 (519)**	**2,039**
Number of requests for health information (children)	**646 (400)**	**2,130**
Number of requests for health information received (children)	**474 (272)**	**1,517**

vi. **Figure 32** shows the volume of requests and returns for MARAC information sharing and illustrates the significant numbers of children living in 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.

vii. **Figure 33** below, illustrates the breakdown of MARAC information requests across the region and the number of responses received.

Figure 33: MARAC health information sharing



6.9 **Female Genital Mutilation**

6.9.1 Mandatory reporting and the FGM Data Collection Tool

There are three information systems/situations where information about women and girls affected by FGM must be shared[18] by health professionals;

I. FGM Information Sharing System (FGM IS). Information is uploaded at birth to a female 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.
II. FGM mandatory reporting to the police when a girl under 18 years old discloses or is observed to have had FGM. Safeguarding referrals to children's social care must also be completed.
III. FGM enhanced data set is completed through the FGM reporting tool when a contact is made with a service user who has had FGM. This enables patient population statistics to be collected.

6.9.2 Mandatory dataset reporting continues within the Trust: this data is shared with NHS Digital in accordance with mandatory reporting requirements.

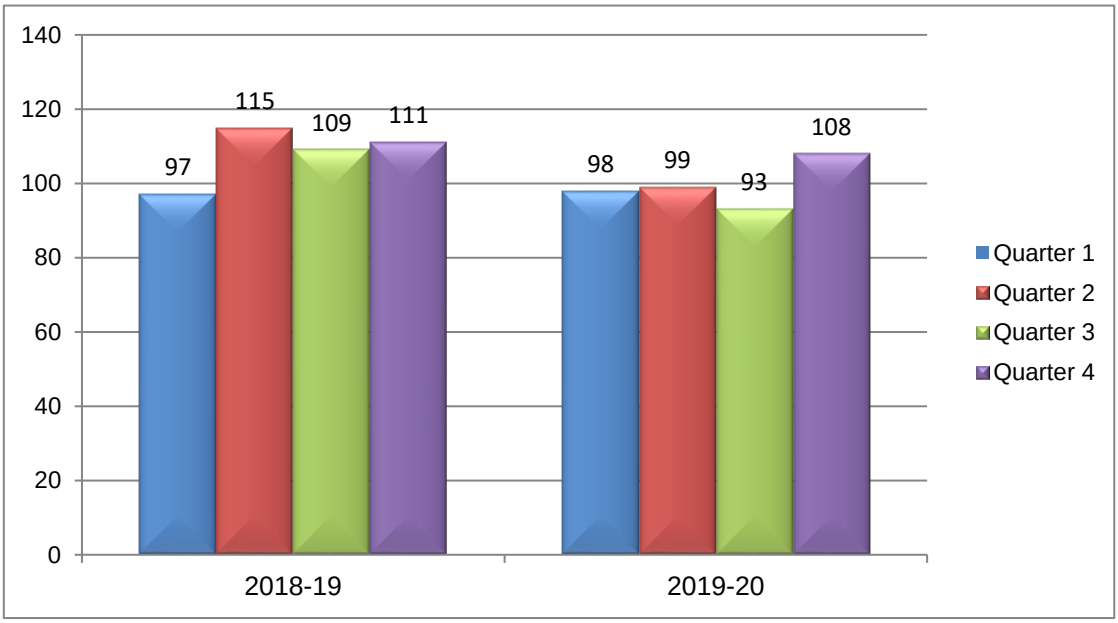
6.9.3 The mandatory reporting data identifies a slight decrease in the number of observations and disclosures of service users who have had FGM with 398 reports this year compared to 432 in 2018/19. In comparison with the NHS national dataset, MFT has been identified in the top ten of highest prevalence 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 34: FGM Reports

[18] FGM Risk Indication System

2019/20	FGM Type 1	FGM Type 2	FGM Type 3	FGM Type 3 - Re-infibulation Identified	FGM Type 4	History of FGM Type 3	Unknown	Grand Total
Quarter 1	16	8	9	0	0	0	65	98
Quarter 2	24	10	14	0	2	2	47	99
Quarter 3	14	11	5	0	0	3	60	93
Quarter 4	4	15	7	1	0	2	79	108
Grand Total	**58**	**44**	**35**	**1**	**2**	**7**	**251**	**398**

Figure 35: FGM Mandatory Reporting Data



6.9.4 As requested by NHS Digital, MFT implemented the FGM IS by the end of March 2019 and this is now embedded within practice in St Marys.

6.10 Safeguarding Mental Health Service

6.10.1 The safeguarding mental health service delivers advice, support and training to safeguard vulnerable people where there are risks and/or needs in relation to mental health. The safeguarding mental health team work alongside the safeguarding adult and children's safeguarding teams at MFT, to offer their specialist support whilst also providing assurance in respect of:

- Suicide prevention.
- Care for patients with behavioural disturbance and reducing the need for restrictive interventions.
- The Mental Health Act (MHA) and the associated MHA code of practice.

Annual statistics show a full year for WTWA related activity and an increasing provision of cover for ORC sites.

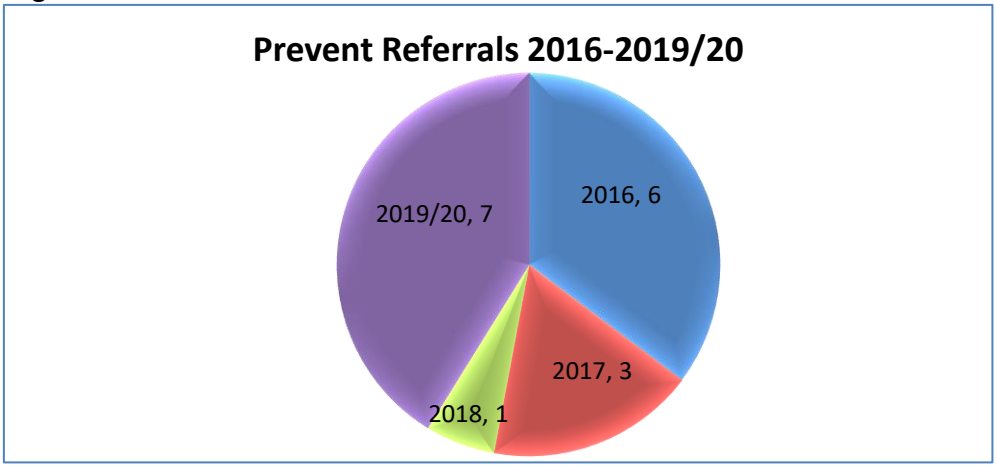
Figure 36: Safeguarding Mental Health Service Activity

Activity	WTWA Sites	ORC Sites	Total
Ward Support	252	130	382
Education	60	45	105
Other Including meetings	95	104	199
Total activity by site	407	279	686

6.11 **Prevent Activity**

The safeguarding team provides advice and guidance where there are concerns around radicalisation. The team also 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. In 2019/20 there were 61 information sharing requests completed for Channel and 7 referrals were made by MFT. This 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 has established information sharing processes with the Adult MASH and the Children's Advice and Guidance Service health teams to ensure proportionate and appropriate information sharing takes place with Channel about all referrals to the programme.

Figure 37: Prevent Referrals

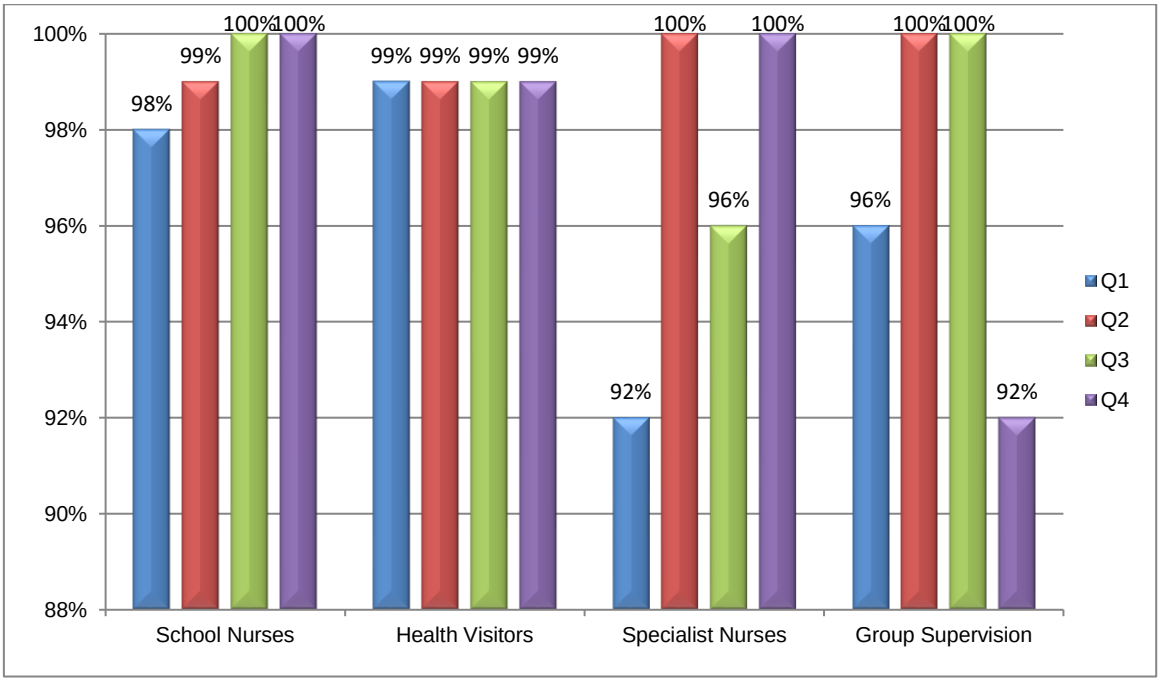


6.12 **Safeguarding Supervision Performance**

6.12.1 Safeguarding supervision is mandatory for all children's services community staff who are caseload holders. Local and national learning highlights the importance of staff receiving safeguarding supervision to support reflective and critical analysis in complex safeguarding cases.

6.12.2 **Figure 38** below shows the excellent compliance maintained this annual report year for the delivery and attendance of safeguarding supervision within Children's Community Services: school nurses consistently achieve 100% and health visitors above 98%. Staff also have access to group supervision, this has remained above 95%.

Figure 38: Safeguarding supervision compliance 2019-20



6.12.3 This year, in response to the recommendations made following a Care Quality Commission (CQC) Safeguarding and Looked after Children inspection across Manchester in 2017, the Trust's acute services have strengthened the safeguarding supervision offer. Formal safeguarding supervision sessions are provided for identified practitioners working within RMCH Managed Clinical Service, including CAMHS; these have been positively received by staff.

6.12.4 Safeguarding children's supervision has also been developed across the WTWA hospitals. The focus for safeguarding supervision has been to continue to embed this provision within the:

- specialist nursing team
- two trafford community teams
- Trafford Early Devlopment Service
- Children's Learning Disability Team

In addition, the WTWA based safeguarding team has developed safeguarding children supervision within the Adult Neurological Rehabilitation 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 enables a "Think Family" approach.

6.12.5 At ORC the monthly safeguarding supervision group continues to be facilitated by the 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 increase learning and development within this group.

i. At Wythenshawe Hospital safeguarding supervision is provided to all midwives. Community midwives receive quarterly supervision whilst all other midwives receive annual supervision.

Figure 39: Safeguarding supervision across MFT 2019-20

	RMCH	St. Marys	WTWA	MLCO	Corporate	MRI	Total
Group Supervision Sessions	17	13	13	48	0	8	99
Number of staff who have received group supervision	155	281	32	493	0	103	1064
1:1 Supervision Sessions	0	24	0	747	74	5	850
Total number of staff who have received 1:1/group supervision	155	305	32	1240	74	108	1914

ii. All of the safeguarding nurses have had the opportunity to attend either the NHS England safeguarding supervision course or a bespoke commissioned safeguarding supervision training course that has been provided in 2019/20 and 2020/21.

6.13 Safeguarding Training

6.13.1 Mandatory Training

i. 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[19].

ii. All staff in the Trust are mapped on the Trusts 'Learning Hub' to the relevant, appropriate level of adult and children's safeguarding training. It is the responsibility of the staff member and their service manager to ensure that they complete their safeguarding training.

iii. The adults safeguarding intercollegiate guidance published in 2018 identified that a much wider staff group (all practitioners who have regular contact with patients, their families or carers, or the public) are required to complete level 2 safeguarding adult training, with a new expectation for all registered health care staff working with adults who engage in the assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns are required to complete level 3 safeguarding training.

[19] Adult Safeguarding: Roles and for Health Care Staff (2018) 1st edition
[19] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

iv. In 2018, 7,618 staff were mapped to the level 3 competency, therefore a risk-based, phased roll out of training over a 3 year period was agreed by the Group Safeguarding Committee, in order to train the appropriate staff to the Level 3 competency. This year sees the end of the first year of the three year adult safeguarding training roll out.

v. This annual report year a consistent Trust wide safeguarding training package has been developed, with all services completing the same level 1, 2 and 3 adults and children safeguarding package. Level 1 and 2 training are delivered by e-learning with level 3 being face to face learning. At the end of the year however due to the Covid-19 pandemic understandably face to face safeguarding training was suspended with a new virtual training package being developed for 2020/21.

vi. All booking and reporting on safeguarding training is through the learning hub. All of the hospitals/MCS/LCO can access the data on the hub to review individual and service training compliance data.

vii. The Trust compliance target for safeguarding children training is 90%, the Clinical Commissioning Group (CCG) require 85% compliance 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 impact of Covid-19 at the end of quarter 4, compliance is not at the expected levels.

viii. **Figure 40** below shows the training compliance data: the RAG rating aligns to the Trust/CCG/CQC requirements.

Figure 40: Mandatory Training Compliance (2019/20)

	Q1	Q2	Q3	Q4
Level 1 Adult e-Learning as part of corporate mandatory training	92%↑	91% ↓	91% ⇔	91%⇔
Level 1 Children e-Learning as part of corporate mandatory training	94%⇔	92% ↓	92%⇔	92%⇔
Level 2 Adult e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	77%↑	81%↑	85%↑	87%↑
Level 2 Children e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	81%↑	83%↑	86%↑	87%↑
Level 3 Adults This is a full day face to face training delivered by the safeguarding team	31%↑	45%↑	64%↑	73%↑
Level 3 Children Full day face to face training delivered by the safeguarding team	74%↑	74%⇔	77%↑	78%↑

ix. There has been a significant and sustained improvement in safeguarding training compliance across the Trust this year.

x. Level 1 safeguarding training is meeting all the expected compliance levels.

xi. Level 2 training is at the CCG and CQC expected compliance levels.

xii. There has been an increase in level 3 safeguarding training compliance this year.

xiii. Safeguarding training capacity has been reviewed and extended this year to meet the expected training requirements.

xiv. There has been significant work completed by the adult safeguarding team to deliver the level 3 adult safeguarding training to 1,249 staff over this last year to achieve the current level of compliance.

xv. This year, level 3 safeguarding children training has been reviewed by a task and finish group, working with the wider safeguarding team to adapt training to the needs of the ever expanding organisation and the increasing numbers of staff needing to be trained. The task and finish group has explored how the safeguarding team can facilitate the training across the Trust whilst utilising the safeguarding team resource more effectively. The group has considered at how training can be provided to a larger audience and a small working group has been updating the package.

xvi. In the next annual report year level 3 safeguarding training will again be reviewed due to the impact of Covid-19 on face to face learning and as part of the Trust's wider review of mandatory training.

xvii. Below is some of the feedback gathered from frontline staff in response to questions within the training evaluations from the sessions delivered by the safeguarding community team:


"Safeguarding supervision really good as did not have this is my previous role" (School Nurse)
"Easy contact when needed. Expert Knowledge and advice"
"very accessible by phone. Regular supervision offered" Clinical Psychologist
"I find it useful when advice given over the phone is followed up by email and then safeguarding contact us at a later date to follow up" (Adult Service Community Nurse)
"Help available by phone. Supervision" (Paediatric Speech and Language Therapist)
"1:1s are helpful and training" (Health Visitor)
"Have always found Rusholme very supportive and helpful when ringing for information" (Sexual Health Service nurse)
"It is reassuring to know I can phone the team with any queries or concerns" (Adult Service Community Nurse)
"Having the safeguarding team available for additional support, to facilitate thought processes & review action plans. Fresh set of eyes." (Health Visitor)
"Group supervision and the duty support is very useful" (Health Visitor)
"I have always found the team extremely helpful. I ring you a lot!!!!" (Clinical Psychologist)
"Direct contact and supervision. Always responsive" (Epilepsy Specialist nurse)
"You are doing a great job. Thanks for your support and help" (Doctor in Sexual Health Services)
"I find supervision very helpful in advising (on) and supporting (with) any concerns I may have" (School Nurse)
"Knowing that the Team are there for support/ advice when needed. The training provided is excellent and give opportunities to rethink" (Paediatric Physiotherapist)
"Value current level of support from Community SG team. Excellent service" (Sexual Health Service Nurse)
"Court Report advice - 2 members of my team have been supported and were very grateful for the support they received" (Orthoptist)
"Supervision is fantastic and the team are always supportive with your concerns/ queries" (School Nurse)
"the safeguarding team are always a helpful port of call and have a fount of knowledge. Thank you for your ongoing help" (Paediatric Speech and Language
"Access by phone is very helpful" Psychologist, CAMHS (Health Visitor)
"I find the safeguarding (team and essential resource and support for safeguarding concerns. It provides support to plan how to ensure a child is adequately safeguarded" (Health Visitor)

6.13.2 **Additional Safeguarding Training**

i. In addition to statutory safeguarding training, MFT offer staff a range of 'bespoke' safeguarding courses which include:

- Domestic Violence and Abuse.
- Human Trafficking & Modern Day Slavery Awareness.
- Child Sexual Exploitation.
- Recognition & Response to Women & Girls at Risk of FGM.
- Aspects of Safeguarding Documentation.
- Court report writing for child care proceedings.
- Graded Care Profile 2 training.
- Mental Capacity Assessment and completion of DoLS application.
- Safeguarding Investigation and Referral process.

ii. **Figure 41** identifies the numbers of staff who have attended additional training in 2019/2020. The data demonstrates the breadth of safeguarding training activity taking place across the Trust. The number of sessions and the broad range of safeguarding courses have increased this year as well as the number of staff who have attended the training.

Figure 41: Numbers of staff attending additional training

Years	Level 1 Safeguarding (NEDs)	Safeguarding Basic Information	DoLS Training	Mental Capacity Act	Referral Process Training	Forced Marriage & Honour Based Violence	Aspects of Documentation and Court Reports for Child Care Proceedings	Child Sexual Exploitation (CSE)	Domestic Violence and Abuse (DV&A) Abuse	Prevention, Recognition and Safeguarding Women and Girls from FGM	Neglect in Children Graded Care Profile 2 Training:	Human Trafficking/Modern Day Slavery
2018/19								272	545	58		96
2019/20	8	60	70	42	26	156	47	126	707	163	188	135

iii. **Appendix 2** identifies the breadth of training delivered across the Trust, the aims and objectives of the training and the feedback received from staff who have attended training this annual report year.

6.13.3 **Multi Agency Training**

In addition to the 'in house' safeguarding training MFT staff are invited to attend the Manchester Safeguarding Partnership (MSP) training which is both face to face and e-learning. 111 staff have attended the MSP training this annual report year. The safeguarding team facilitate multi-agency safeguarding courses in neglect, domestic violence and abuse and signs of safety with partner agencies.

6.13.4 **Prevent training**

i. All health staff, according to their 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). A training needs analysis review has taken place, to ensure the level of training is appropriate for each role in line with the NHS England competency framework.

ii. All prevent training within MFT is by e-learning. As of 31 March 2020, MFT were 91% compliant with level 1-2 training and 83% compliant with 3-5 prevent training, a significant improvement from the same period last year. The target set by Manchester Health Care Commissioners (MHCC) is 85% for all levels of training.

iii. Prevent training has been added as a metric to the Accountability and Oversight Framework which is used to hold each Hospital/MCS to account by the Group Executive each month. The Group Medical Director, as the executive lead for prevent, is responsible for holding Hospitals/MCS to account for compliance with prevent training.

iv. Monthly compliance reports for all levels of mandatory training are now available online for managers, allowing them to monitor compliance and identify individual staff and groups who requiring training.

6.13.5 **Mental Health Safeguarding Training**

This year has seen the development of a mental health e-learning package to level 2 as part of the mandatory training provision for compliance with the key skills framework for mental health. The workforce development team have reported that since its inception on World Mental Health Day (10th October 2019) to current (6 months) 15,208 staff has completed this e-learning package.

6.14 **Safeguarding Newsletter**

The safeguarding newsletter continues to be published monthly across the Trust with additional newsletters provided to share new and evolving information due to the impact of Covid-19.

6.15 **Incident Reporting**

6.15.1 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 42c**. All safeguarding incidents are reviewed by the safeguarding team to enable expert support and advice to be provided to the hospitals/MCS/MLCO in respect of the investigation process and safeguarding response if required.

6.15.2 In this report year 1,454 safeguarding incidents were reported compared to 1,076 in 2018-2019: this evidences increasing identification and reporting of safeguarding

concerns. There were 2 StEIS (Strategic Executive Information System) reportable safeguarding incidents reported this year.

6.15.3 A thematic review of safeguarding incidents is undertaken quarterly and reported to the Trust Group Safeguarding Committee. **Figure 42a** provides a summary of the annual incident themes reported by category and **Figure 42b** provides a breakdown of reporting by Hospital/MCS/MLCO. **Figure 42c** identifies out of all the incidents reported how many included a safeguarding vulnerability.

Figure 42a: Incident Reporting by Category

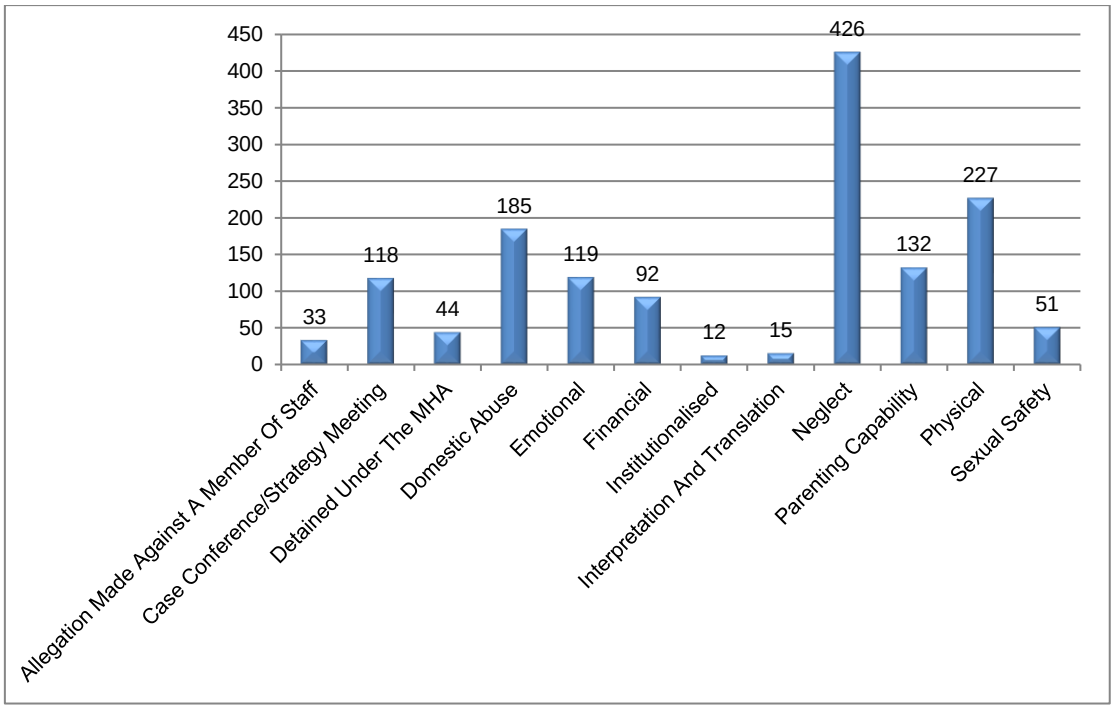


Figure 42b: Incident Reporting by Reporting Hospital/MCS/MLCO

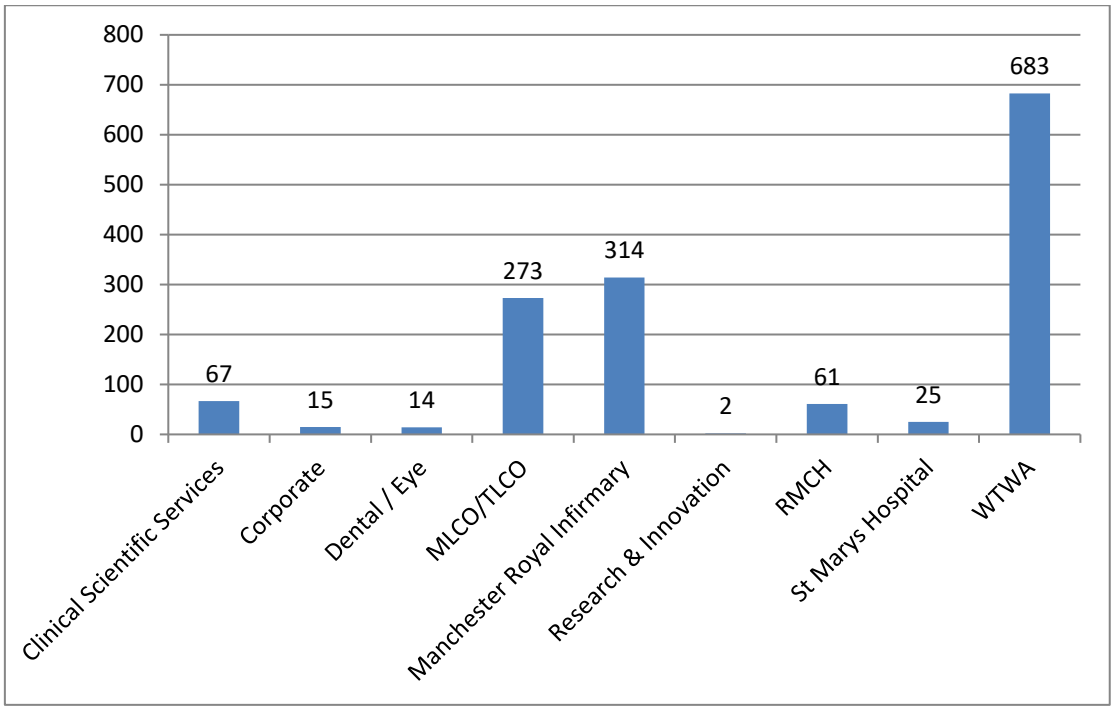


Figure 42c: Vulnerability of Service User in Incident Reporting

Question	2018/19	2019/20
Is patient a vulnerable adult?	1694	1996
Is there a safeguarding children concern?	683	643

6.15.4 **Analysis of Incident Data**

i. 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. Safeguarding children incidents are reported where the safeguarding process has not worked as expected therefore it is positive to note a decrease in safeguarding children incident reporting.

ii. As identified earlier in this report neglect, domestic abuse, and physical abuse are the most common cause of safeguarding concern across the Trust.

iii. The data identifies that the Trust recognises and responds to all allegations against staff in order to safeguard individuals. This is supported through the Trust-wide 'Managing Safeguarding Allegations against Staff Policy'.

iv. The Trust has a statutory obligation to contribute to child protection case conferences and strategy meetings: 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 that this places on services, mainly health visiting and school nurses, who are often expected to attend up to 6 case conferences daily.

v. The highest number of incidents reported is WTWA, MRI and MLCO. This would be expected as it is through the emergency departments, medical areas and community services that most safeguarding concerns are recognised and actions are required/taken to appropriately safeguard.

vi. Data from incident reporting identifies increased incident reporting involving vulnerable adults this year. In safeguarding adults the notification of an incident is part of documentation of the safeguarding response. Therefore increased incidents indicates increased recognition and response of safeguarding concerns.

vii. In Safeguarding children the incident reporting is completed when there is a concern that the safeguarding response is outside of expected practice so it is positive there has been a decrease in safeguarding children's incident reporting this year.

6.16 **Assurance Visits and Meetings**

6.16.1 This year has seen the introduction of unannounced safeguarding assurance visits by the safeguarding team to the Hospitals/MCS/LCO to review frontline operational safeguarding. To date visits have been completed to MRI, RMCH, Manchester Royal Eye Hospital (MREH), St Mary's Hospital and Wythenshawe Hospital. The outcomes of the visits are shared at ward level to formulate safeguarding ward development plans and to each hospital safeguarding group to share key themes across the site.

6.16.2 The annual assurance meetings have also again been completed across the Trust with senior leaders in each Hospital/MCS/LCO attending a panel chaired by the Deputy Chief Nurse and scrutinised by the Non-Executive Director Safeguarding lead. A report containing thematic learning will be shared at the Group Safeguarding Committee in quarter 2 of the 2020/21 report year.

6.17 **Risk Register**

6.17.1 At the end of this reporting period the following five risks relating to corporate 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 LA.

✓ **Mental Capacity Act (MCA)**
This risk relates to implementation of the MCA 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 (LAC) 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 below the expected standard 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 children team base location**

This risk was identified in a Serious Case Review, relating to the safeguarding team not being physically located in RMCH. The safeguarding team this year were highly visible within RMCH through regular walk rounds and hot desking.

The risk register is reviewed quarterly.

6.18 **Safeguarding Audit**

6.18.1 Following learning and recommendations from safeguarding reviews the following audits were commenced in this annual report year:

- Audit to benchmark staff awareness of LAC requirements in practice.
- Quality Assurance of Referrals to Children's Services.
- Mental Capacity Act (MCA) Staff Awareness and MCA Case Note Review.
- Making Safeguarding Personal.
- Safeguarding Supervision Review.
- Domestic Violence Re-audit of Multi-Agency Risk Assessment Conference.
- Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist.
- Review of Safeguarding Record Keeping in Community Child Health Records.
- Strategy Meeting Audit.

6.18.2 All audits planned for this year have been commenced or completed with the exception of the Making Safeguarding Personal audit which has been delayed due a delay by the MSP who are awaiting the outcome of the making safeguarding personal task and finish group. In quarter 1 (2020/21) there will be a review of the quality of adult safeguarding referrals which will include a focus on the voice of the adult.

6.18.3 The audits and reviews of practice completed both as part of the MFT safeguarding audit plan and the MSP audit programme; details are provided in **Appendix 3**.

6.19 **Trafford Community Safeguarding Activity**

6.19.1 **Trafford Community Safeguarding Team**

i. Trafford Local Care Organisation (TLCO) joined MFT in October 2019 with operational management of the safeguarding provision by the MFT safeguarding service commencing in January 2020.

The top 4 areas for referral in the Trafford Community Children's are:

- Domestic violence and abuse
- Sexual abuse
- Child Neglect
- Fabricated and Induced Illness

ii. In this year's annual report the data report is based on the Trafford data set of recordings: from the start of the 2020-2021 annual report year the MFT data set will be utilised.

iii. The role of the Trafford Safeguarding Families Team promotes good professional practice, provides advice, support and expertise to practitioners and ensures that training and supervision is in place in relation to safeguarding. The team has been integrated into the MFT Corporate safeguarding service, but will continue to work from Trafford Town Hall.

6.19.2 Trafford Community Children's Service

i. The Trafford community safeguarding children team provide a borough wide 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.

ii. The data on referrals and consultations to the team has only been collected since transfer of the service to the MFT safeguarding team and can be found in **Figure 43** below.

Figure 43: Referrals to Trafford Community Safeguarding Team (since transfer to MFT)

6.19.3 Police and Ambulance Safeguarding Referrals

i. The community safeguarding children team process safeguarding referrals from police, ensuring that this information is disseminated to frontline health visitors and school nurses. Many of the referrals from police are cases where they 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, they will notify community health services to ensure the child's community health caseload holder (health visitor or school nurse) can review the incident in order that the child or young person's health needs are being met and they can assess if there are any additional vulnerability or risk factors for the child and family. This also allows the health practitioner to build a chronology around a child's daily lived experience.

Category of referral	Number of notifications
Adult Mental Health	1
Child Mental Health (Inc. Self-harm)	6
CSE	2
Domestic Violence & Abuse	12
FGM	1
FII / Perplexing Presentation	5
Neglect (Inc. parenting capacity)	5
Sexual	8
Other	5
Total	**45**

ii. In this annual report year 2,456 police child protection notifications were received compared to 2,663 in the previous year.

iii. The safeguarding team share information with the community health practitioners in order to inform their safeguarding risks assessments when referrals are shared from North West Ambulance Service of which there were 299 referrals this annual report year. The team also share information with the community health practitioners regarding referrals from the SARC of which there were 30 referrals this annual report year.

6.19.4 Court Report Activity for child care proceedings

The top 3 areas for referral in the Trafford Safeguarding Adults are

- Neglect
- Self-Neglect
- Domestic violence and abuse

i. Court Reports are requested by Trafford City Council legal team and are completed within defined timescales by community practitioners. Robust quality assurance of these reports by the MFT safeguarding team prior to submission ensures that very few frontline practitioners are called to give evidence in court. In 2019/20 113 requests for court statements were received.

6.19.5 Trafford Community Section 47 Child Protection Medicals

The Trafford community paediatric service provide section 47 child protection medicals for Trafford children and young people requiring a medical In the community setting. **Figure 44** identifies the Trafford Section 47 activity 2019-2020. In total there were 90 calls to the service which resulted in 53 children and young people requiring a child protection medical.

Figure 44: Referrals to Trafford Community Child Protection Clinic

	Total
Total No of S47 medicals completed	**53**
Number deferred	**5**
Advice only	**1**
DNA's	**0**
SW did not ring back	**0**
Cancelled by Social Worker	**9**
Medical not required	**13**
Number sent to Wythenshawe	**10**
Number referred to SARC	**4**
Total calls	**90**

6.19.6 Adult Safeguarding

The data for the number of advice and consultations for adult safeguarding concerns has not been collected until Q4 this year therefore the data presented in **Figure 45 below** reflects this position.

Figure 45: Trafford Community Safeguarding Team Adult Safeguarding Concerns (Q4)

Category of referral	Number of notifications
Adult Mental Health	2
Emotional/Psychological Abuse	1
Domestic Violence & Abuse	7
Neglect	16
Self Neglect	9
Institutional/Organisational Abuse	1
Other	56
Total	**93**

6.19.7 Police Referrals and Information Sharing

The Trafford team received 85 notifications from the police regarding vulnerable adult referrals; these have significantly increased (21) in 2018/2019 due to information received via the new Daily Risk Management Process meetings. These referrals are shared with community practitioners where relevant.

Figure 46: Trafford Community Safeguarding Team Adult Safeguarding Concerns (Q4)

Activity Performance Indicators	Q1	Q2	Q3	Q4
Number of vulnerable adult referrals from police received known to MFT Trafford	3	9	0	**73****

6.19.8 Domestic Abuse

The Trafford safeguarding adult team represent MFT at the Trafford MARAC contributing to the multi-agency risk assessment and safety planning. Information is shared by the Trafford safeguarding team with community practitioners to inform the MARAC risk assessment and the ongoing clinical assessment by health visitors and school nurses. The team processed 578 MARAC referrals this year that included 355 with children.

Figure 47: Trafford Community Safeguarding Team MARAC Referrals

MARAC data	Q1	Q2	Q3	Q4
Number of MARAC cases	145	119	155	**159**

Number of MARAC cases featuring children	96	71	93	**95**

6.19.9 **Mandatory Female Genital Mutilation reporting**
There have been 3 cases of FGM were reported this year.

6.19.10 **Safeguarding Supervision**
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.

6.19.11 **Figure 48** below shows the good compliance maintained this year for delivery and attendance of safeguarding supervision within Children's Community Services. Individual safeguarding supervision compliance has been above 80% for 2019/20: staff have also accessed group supervision.

In addition, the Trafford safeguarding team provide safeguarding supervision for community adult practitioners. By working closely with the adult health teams and their managers, the team has successfully promoted adult safeguarding supervision following a previous decline in attendance

Figure 48: Trafford Community Safeguarding Team MARAC Referrals

Safeguarding Supervision Performance	Q1	Q2	Q3	Q4
Children's health practitioner compliance with safeguardingsupervision (HV teams, school health and CCNT)	98%	80%	88%	**91%***
Children's AHP attendance at group safeguarding supervision sessions (figure = number of attendees)	25	22	20	**20**
CAMHS attendance at group safeguarding supervision sessions (figure = number of attendees)	17	11	23	**6**
Adult health practitioners attendance at safeguarding supervision sessions (figure = number of attendees)	88	51	41	**73**

6.19.12 **Safeguarding Training**
Safeguarding training is well established in Trafford **(see Figure 49).** The CQC expected rate of compliance is being achieved in all areas except for adult level 3 safeguarding training. There is a low level of compliance with Level 3 adult safeguarding training, this is attributed to a difference in the mapping process between MFT and Pennine Care for roles and competencies requiring Level 3. In line with Intercollegiate guidance a mapping of the frontline staff who need to complete level 3 adults was completed on joining MFT and identified a much wider cohort of staff required training than previously mapped. There is a clear plan and training offer in place for TLCO staff to complete the MFT safeguarding adult training in 2020/21.

Figure 49: Trafford Safeguarding Training Compliance (Quarter 4, 2019/20)

Competence	Required	Achieved	Non-compliant	Compliance %
Safeguarding Adults - Level 1 - 3 Years	645	607	38	**94.11%**

Safeguarding Adults - Level 2 - 3 Years	514	483	31	**93.97%**
Safeguarding Children - Level 1 - 3 Years	645	589	56	**91.32%**
Safeguarding Children - Level 2 - 3 Years	514	458	56	**89.11%**
Safeguarding Children - Level 3 - 3 Years	122	100	22	**81.97%**
Safeguarding Adults Level 3 - 3 Years	108	36	72	**33.33%**
Grand Total	**2548**	**2273**	**275**	**89.21%**

The Trafford Safeguarding Team has contributed to the Trafford Safeguarding Partnership training, as illustrated in **Figure 50.**

Figure 50: Trafford Safeguarding PartnershipTraining (contribute to by the Trafford Safeguarding Team

Training Course	Number of Courses delivered	Number of Participants attending
L3 Multiagency Domestic Abuse Training	7 full day	210
Multiagency GCP2	2	60

SECTION G

Safeguarding Team Achievements 2019/2020

7. Safeguarding Team Achievements 2019/20

7.1. **Named Doctors Child Safeguarding, Community Child Health**

The Coral Suite provides a service for Section 47 Medical Examinations with daily clinics on weekday afternoons, five days per week, based at Moss Side Health Centre. The service is provided by a team of Consultant Paediatricians and experienced Specialist Trainees in Paediatrics. The clinic is supported by administrative staff plus a Community Nursery Nurse and Clinic Support Worker. Referrals are received by the administrative staff on a dedicated telephone line, and the Doctor on call for the day responds to the referrer by telephone. Appointments are offered in the next available clinic slot.

Name of Team	Coral Suite Child Protection Team, Community Paediatrics
Has the team delivered on actions within safeguarding work plan	• Work has been undertaken to develop pathways and lines of communication in relation to Fabricated and Induced Illness during the period of this report. Support and guidance is provided by the Named Doctor Safeguarding and a regular meeting with the Named Nurses - Safeguarding takes place approximately eight times per year.
Key Achievements 2019/20	• During 2019/20 a new Clinic support worker was recruited and trained to provide age appropriate support to children attending clinics at the Coral Suite. • During the year, clinic furniture and equipment was reviewed and updated and some new tables and child friendly seating was provided. A range of toys is provided to support children and families accessing the clinic: For older children an IPad with appropriate games and activities is available. • There was a review of the security arrangements within the clinic to respond to instances of violence and aggression. • Because of the high prevalence of dental disease in Manchester Children generally, and particularly amongst children attending the clinic, a referral pathway has been set up to obtain a community dentistry appointment for all children attending the Coral Suite if this is required. This is important as many children attending the clinic are found to be not registered with a dentist, or not to have had a dental examination in a long time. • In response to the Covid-19 epidemic, the Strategy Telephone Call process for booking appointments at the clinic was adapted to include screening questions designed to identify persons at risk of having Covid 19, in order to risk assess their attendance at the clinic. Personal Protective Equipment has been provided for the clinic in order that if children have Covid 19 or are suspected to have the infection their medical examination can still be completed. There is also the facility to access interpretation remotely via telephone interpretation, to help maintain appropriate social distancing. • There is the facility for Section 47 Medicals to be carried out at Specialist Schools rather than at the Coral Suite, if appropriate and suitable facilities are available. • There is ongoing Peer Review of Child Protection cases, and for Paediatricians, twice yearly dedicated Child Protection Continuing Professional Development.

7.1.1. **Named Doctor, Wythenshawe Hospital**

Name of Team	Named Doctor, Wythenshawe Hospital

Has the team delivered on actions within safeguarding work plan?	• Wythenshawe Paediatric team continue to provide child protection/S47 medicals for South Manchester and Trafford Children's Social Care for children aged under 18 months and for older children when medicals are not available in the community clinics, as well as for patients seen acutely at the hospital where safeguarding concerns have been raised (46 medicals completed over the last year).
Key Achievements 2019/20	• In addition support has been given to other professionals when concerns have been raised around fabricated or induced illness or perplexing presentations. • All Child Protection Medicals are reviewed at Safeguarding Peer review by medical staff and the safeguarding specialist nurses. • Additional Safeguarding induction and training is provided for doctors who start in paediatrics and the emergency department. • Staff provide information for serious case reviews if the child or family are known to MFT services. • A number of audits have been completed including Child Protection Medical documentation and Strategy Meeting audit.

7.1.2. **Safeguarding Children Community Team**

Name of Team	Community Safeguarding Team
Has the team delivered on actions within safeguarding work plan	• Review all Level 3 safeguarding training packages, incorporating learning from Serious Case Reviews. Named Nurse Safeguarding Children has facilitated a Level 3 Children Training Task and Finish Group, working with wider safeguarding team to adapt training to the needs of the expanding organisation and numbers of staff needing to be trained. The Task Group has looked at how the safeguarding team can facilitate the training across the Trust and utilize the safeguarding team resource more effectively. The group has been looking at how training can be provided to a larger audience and a small working group has been updating the package. • Review of safeguarding processes for MARAC processes has been completed • Graded Care Profile2, MFT and MSCB training programme to ensure dissemination to priority groups across the Trust. • Specialist Nurses Safeguarding Children have attended the NSPCC GCP2 (Graded care profile 2 Neglect assessment) train the trainer's multiagency course. Following on from this an implementation plan was devised which involved training acute and community staff who had contact with children and young people (children and adult health services have attended the training) to be licensed to use the GCP2 neglect assessment tool. A training package was developed utilising the information and case study from the licensed NSPCC training pack. Neglect is a key priority on the Manchester Safeguarding Partnership business plan 2019/20. • MFT Exploitation Risk Indicator Checklist has been updated to include all forms of exploitation, • The continued use a young person/adult sexual exploitation story at each Child Sexual Exploitation sub group meeting, has keep the subgroup focused on what it is the Trust wants to achieve for young people and adults. • The Managing Allegations training has been updated in line with the updated policy.

Key Achievements 2019/20	**Training** • Specialist Nurse Safeguarding Children has contributed to Manchester Safeguarding Partnership Forced Marriage and Honour Based Abuse training which is always well received and over-subscribed. • Specialist Nurse Safeguarding Children has been involved in delivering Forced Marriage and Honour Based Abuse training to Manchester University social work students, North Manchester social workers and to school health team in a special school in acknowledgement that these children were at a great risk of forced marriage. • Named and Specialist Nurses Safeguarding Children were involved in providing an awareness session to newly qualified Social Workers across the City to support them in understanding health services in community and hospital across Manchester and how to make contact with health practitioners. • Specialist Nurses Safeguarding Children are involved in the working group and training pool to develop the Manchester Safeguarding Partnership training for – Recognising and Responding to child Neglect. **Safeguarding Champion Meetings** • Safeguarding Champion Meetings have been held quarterly within the community to support implementation of key safeguarding messages. This year guest speakers have included- Healthy weight management service, Complex Safeguarding Social Worker update on contextual safeguarding, Domestic Abuse Lead on safe and together and Vulnerable Baby Service-safe sleep. Briefings have been given on-serious case reviews, domestic homicide reviews, safeguarding assurance visits, completing health chronologies, FGM, and child on parent violence. **Police Operations** • Specialist and Named Nurses Safeguarding Children have been involved in sharing health information and contributing to the risk plans for a number of police operations running from the multi-agency Complex Safeguarding Hub **Multi-agency meetings** • A Specialist Nurse and Named Nurse are involved in the Core Group Task and Finish Group looking at the effectiveness of Core Groups and how they can be improved. A multi-agency standard is in development to streamline the process and to ensure that the contribution of agencies is effective in safeguarding children. This has led to a bigger piece of work to include review of the Strategy Meeting process and documentation. • Named and Specialist Nurses Safeguarding Children are involved in partnership meetings across the city which were developed following the Locality Leadership 2 day residential programme in January 2019 to Ghyll Head in the Lake District. Over the two days, participants undertook a range of activities aimed at developing relationships and leadership skills across the partnership. • Named Nurses Safeguarding Children remain chairs for the locality Fora meetings although there has only been one meeting during the last year due to changes to the Manchester Safeguarding Partnership arrangements. The Fora are due to take place again from September 2020.

	Serious Case Reviews • Named Nurses Safeguarding Children have been involved in 8 ongoing Serious Case Reviews (SCR) panels (7 Manchester and 1 out of area – Bury). Two cases received high media attention because the children were murder victims. Specialist Nurses Safeguarding Children have been involved in the rapid reviews of cases and involved in multi-agency learning activities, of which there were 3, where the threshold for SCRS has not been met. **Signs of Safety** • Specialist Nurse Safeguarding Children continues to deliver the MFT implementation in the signs of safety (SOS) safeguarding model adopted by Manchester Children's Services. This has involved co-delivering the Manchester Safeguarding Partnership training, MFT training and liaison with social care practice lead around how partner agencies are implementing the model. • Named Nurse and Specialist Nurse have provided guidance on the experience of implementation of Signs of Safety together with recording templates to Safeguarding Teams elsewhere in the country. **Fabricated and Induced Illness** • A working draft pathway for managing cases where there are concerns of FII has been developed and training was provided for the school nurses to raise their awareness in recognising fabricated and induced illness and for them to understand the process for referrals. **Obesity** • Specialist Nurse Safeguarding Children has supported the development of a 7 minute briefing on safeguarding children in the context of obesity with the support of the Health Weight Team for the Manchester Safeguarding Partnership • Named Nurse Safeguarding children has supported health staff in the escalation of a challenging obesity safeguarding case which has resulted in a successful outcome – joint funding from Health Education and Social Care resulting in a therapeutic placement being secured for a young person. **Learning Disability** • Specialist Nurse Safeguarding Children has provided information regarding learning disability to include in the training packages delivered by the team. There has been liaison with a speech therapist and a visual tool is being developed for the Coral Suite where the community child protection medicals are carried out. This will help explain the process to children who are visual learners. Specialist Nurse Safeguarding Children has contributed to the Learning Disability Steering Group - exploring the 'Sunflower Lanyard' scheme for the Trust (contact made with Guy's and St Thomas's Trust who have introduced the scheme). • There is a plan to consider re-starting 'Safeguarding Children with a Disability' study day with Manchester Safeguarding Partnership. **CSE - Local Government Association (LGA) Peer review of CSE in Manchester** • Named Nurse Safeguarding Children was involved in coordinating MFT involvement for the focus group which included representation from Paediatric Emergency Department, School Nursing, CAMHS, and Sexual Health. The outcome was very positive and the review team commented on the energy, commitment, pride and passion of the people they met to work together and improve the lives, experiences and outcomes of our children.

7.2. Safeguarding Children Oxford Road Campus (ORC) and Wythenshawe, Trafford, Withington and Altrincham (WTWA) Team

Name of Team	WTWA and ORC Safeguarding Children Team
Has the team delivered on actions within safeguarding work plan	• Ongoing development of the Safeguarding Team, including further joint working across hospital sites – There has been increased visibility in MRI to promote the safeguarding children agenda for 16-17 year olds, including opportunistic ward walks and established connections with the Adult Major Trauma Team. • Ongoing development of safeguarding practice in alignment with Manchester Safeguarding Partnership work streams – The team have supported the implementation of the Child Exploitation Risk Indicator Checklist in RMCH and PED with the CSE Specialist Nurse. • Review of Safeguarding Documentation and Case File Audits- The safeguarding children team have designed and piloted Safeguarding Assessment/Care Plans within RMCH – this will need auditing prior to being rolled out across RMCH. • Further development of links with ward areas to promote and develop safeguarding practice- Established Safeguarding Link Nurse meetings frequency has been was changed from monthly for an hour to bi-monthly for 1.5 hours in order to increase participation and attendance. • Links with the airport have been developing on a case by case basis and requires further progress over the coming year. • The WTWA safeguarding team ensure that appropriate health information sharing is completed with Trafford Sexual exploitation and missing panel • Level 3 Safeguarding Children training has been supported at WTWA, with the role out of both the Domestic Abuse training and CSE trains within WTWA site.
Key Achievements 2019/20	• Safeguarding Children team continued to undertake regular ward walks and provide safeguarding support across the Oxford Road Campus footprint this has been particularly beneficial in Paediatric Emergency Department This Promoted and participated in Patient safety Week by undertaking ward walks promoting safeguarding, utilising safeguarding quizzes, providing and updating posters and packs for Paediatric area's for their folders, safeguarding boards • Supported the implementation of RIC (CSE/CCE) during CSE awareness week which included visiting wards with the CSE Specialist Nurse • Safeguarding Children team contributed to the development of the revised Out of Hours referral process within Health to Manchester Children's Social Care following Manchester changing their referral process to telephone referrals. This work stream developed and supported building good working relationships between RMCH PED and Wythenshawe's Emergency Department (ED) and Manchester Children's Social Care. • Named Nurses Safeguarding Children has contributed and been involved in rapid review scoping and SCRs • Continued to support the Tertiary Consultant Paediatricians in managing complex safeguarding cases and support to

	Consultant Paediatricians in managing complex Fabricated and Induced Illness cases • Facilitated Link Nurse meetings which have - delivered safeguarding children updates and training - enabled discussions on what is working well and what we are worried about in respect of safeguarding with staff in-order to support them in their responsibilities to safeguard patients • Contributed to the development of the new single Level 3 Safeguarding Children Training package for MFT and continued to deliver the Level 3 Safeguarding Children • Delivered regular referral workshops and drop in sessions in RMCH and WTWA ED to support and improve the identification and response to safeguarding concerns and to also embed the signs of safety model • Developed fortnightly meetings with Wythenshawe ED Safeguarding Link Nurse to discuss both what is working well and what we are worried about in respect of safeguarding to support ED in their responsibilities to safeguard patients. • Delivered safeguarding children updates within the NIPPA training • Contributed to the new discharge policy to ensure safeguarding is embedded in the policy • Named Nurse Safeguarding Children has provided Named Nurse leadership and support to Trafford Safeguarding Families team October –December following the merge to MFT and whilst their Named Nurse completed her maternity leave. • Co worked cases with the Adult Safeguarding Team to support patient transition from Children's services to Adult services and the Think Family approach, this was demonstrated through a co worked honour based violence case with adult safeguarding which incorporated partner agencies from across different borders within the country along with interdisciplinary health professionals within the organisation to ensure the patient was safeguarded, the children associated were safeguarded and the patient was discharged safely with the appropriate support package whilst ensuring the safety of staff within the hospital.

7.3. Acute Safeguarding Adults

Name of Team	Adult Safeguarding Team, Oxford Road Campus (ORC) and Wythenshawe Trafford Withington and Altrincham (WTWA) Teams
Has the team delivered on actions within safeguarding work plan	• ORC and WTWA teams have worked together to align services. Both services now using the Ulysses system for recording safeguarding team case work and reporting safeguarding concerns. The reporting forms have also been updated to better capture the voice of the individual, and ensure that initial protection plans are documented. • The Ulysses system links and collates the incident reporting framework with safeguarding notifications, actions and outcomes. The system allows clearer data collection and enables more detailed reporting. • The Ulysses reporting system is also used at WTWA for making DoLS applications. This has streamlined the

	process significantly and allowed for better monitoring of the numbers and locations of patients detained under DoLS. • Awareness and compliance with the Mental Capacity Act is being addressed via the updated Adult Safeguarding Level 3 training now aligned across the Trust. This now also covers mental capacity act and DoLS. During the Covid-19 pandemic, this training has been adapted to be delivered virtually with learning assessed via a workbook. So far, very positive feedback has been received in relation to this. • Mental Capacity Assessment Audit has been completed and the results and action plan developed.
Key Achievements 2019/20	**The 6 principles of the Care Act 2014 along with CQC Regulation 13 requirements, Empowerment, Prevention, Proportionality, Protection, Partnership, and Accountability underpin the work of the Adult Safeguarding Team and this is evident within their key achievements.** • The MFT Adult Safeguarding Team delivered a presentation at the launch of the 'Self-Neglect and Hoarding Strategy and tool kit' in September 2019 at the Christie Hospital in collaboration with Manchester Safeguarding Partnership (MSP) and Manchester City Council (MCC). The presentation was well received by the NHS England Safeguarding Lead (key speaker at the launch) who delivered the introduction to the launch. The key note speaker acknowledged the work which was being undertaken by MSP and partner agencies. • The Adult Safeguarding Team is represented at both the Self-neglect and Homeless Deaths thematic review. This has allowed information and learning to be shared, not just within MFT, but also with our partners and commissioners. • The Team has also worked to embed within all areas a clear understanding and oversight of Deprivation of Liberty Safeguards. This has been achieved through ward walks, training and latterly virtual ward walks, with closer monitoring of the DoLS portal at ORC and communication with the wards. • The team streamlined the DoLS reporting system at WTWA, receiving very positive feedback from staff. • Throughout the year the Team has continued to emphasise to all relevant members of staff, the importance of understanding and applying the principles of the Mental Capacity Act 2005 in all areas of care. • The team now ensure MFT adult safeguarding contribute to the MARAC review process. • The team has developed online level 3 training which has received very positive feedback.

7.4. Midwifery Safeguarding Oxford Road Campus (ORC and WTWA)

Name of Team	Safeguarding Maternity (ORC and WTWA)
Has the team delivered on actions within safeguarding work plan	• The objectives from the safeguarding work plan for maternity have mainly been achieved successfully. The Safeguarding Maternity team continue to receive all referrals for vulnerable pregnant women, newly delivered women, new-born babies

	and their siblings. The safeguarding midwives ensure direct support and visibility is achieved by undertaking daily ward rounds across both MFT maternity inpatient sites. • Named Midwife for Safeguarding/Modern Matron supports Saint Mary's Hospital with the safeguarding agenda by contributing to the bi-monthly Hospital Safeguarding Group meeting and by the team providing leadership in group supervision sessions for Community Midwives and safeguarding case load holders across Oxford Road site. This will be developed to the same standard at Wythenshawe site within the next financial year. • Safeguarding Maternity has been involved with supporting maternity management and Human Resources with cases referred by the Designated Officer. • Face to face training on 'Managing Allegations' for maternity managers within Saint Mary's has not been completed due to the policy review in 2019 and review of training presentation; and also due to there being a significant change in the post holders of senior management. This will be prioritised in the next financial year. • Safeguarding maternity team has represented MFT at Serious case Reviews and Safeguarding Adult Reviews during the last financial year. The learning will be shared following publication, through formal learning sessions and planned briefings. • The safeguarding maternity team continues to support community and hospital based midwives with their attendance at Initial Child Protection case Conferences; strategy meeting; core groups and Child in Need meetings.
Key Achievements 2019/20	• In April 2019 Marie Zsigmond, Named Midwife/Matron for Safeguarding, was asked to deliver a presentation regarding the maternity team success in supporting victims of Human Trafficking and Modern Day Slavery, for NHS England Annual Safeguarding Conference, at Old Trafford Football club; this presentation was also replicated at the Maternity Public Health Networking meeting in Leeds later the same month. Marie was honoured to be awarded the Gold Award for Services to Midwifery, by the Chief Midwifery Officer UK, during the NHS England event. • The Named Midwife/Matron for Safeguarding continues to represent the team on the Reproductive Medicine Ethics Committee, which ensures all patients requesting IVF treatment are considered fairly, whilst taking into account previous or ongoing safeguarding concerns. • The ICON programme, developed to reduce the risk of abusive head trauma, has been successfully rolled out across Central and South Manchester following the initial pilot scheme. The programme has more recently been developed and commenced in Trafford. • Harmonisation of safeguarding maternity teams across the Oxford Road and Wythenshawe site has enhanced the delivery of safeguarding support that is offered for all maternity patients across MFT. • FGM-iS was introduced at MFT in April 2019 and is now firmly embedded within practice. This year, 169 new-born

	girls (2 at Wythenshawe site and 167 at Oxford Road) have been born into families where a history of FGM has been identified. For each of them, a safeguarding marker has been placed on the NHS Spine. The Named Midwife / Matron for Safeguarding have been involved in work with NHS England to enhance the visibility of the marker within the child's record on the NHS Spine. • MFT continues to have representation by the Named Midwife for Safeguarding at the Manchester Modern Day Slavery and Human Trafficking Strategy Partnership, which meets bi-monthly to ensure the strategy is embedded across all key partners within the City of Manchester. Working together with Manchester City Council, Children's and Adults Social Care, the Police, ICTG service, AFRUCA, housing and other multi-agency groups , Manchester Foundation Trust ensure that Health is recognised as a major contributory partner in the continuing development of the strategy and safeguarding agenda.

7.5. Mental Health Safeguarding Service

Name of Team	Safeguarding & Mental Health Team (SMHT)
Has the team delivered on actions within safeguarding work plan	• Continued development of preventing future deaths action plan across all MFT sites. This provides safe, effective, consistent clinical practices that demonstrate evidence for assurance related to the associated risk action plan on the risk register. Risk has been lowered on WTWA site by Head of risk and governance to 9, with aspiration this year to achieve rating of 4. • Recruitment of additional band 6 mental health nurse resource to support role out of strategy across all MFT sites. • Establishment of SMHT inbox for monitoring/ reviewing all mental health cause groups. This has enabled to team to respond proactively to address concerns or support teams across the Trust, increasing visibility and offer real –time support for ongoing care management. • Establishment of twitter account for increased communications related to mental health care at MFT. • Improved bespoke education & training delivered directly to clinical areas to meet key requirement for suicide prevention at MFT. • Approved overarching mental health policy related to: - Suicide Prevention - Prevention & Management of missing and absconding patients - Care of adult patients who experience behavioural disturbance due to mental health conditions • Establishment of MFT mental health subgroup membership, completing legacy action plans. The team has worked closely with colleagues in different sites/ liaison mental health teams to improve quality and patient safety for mental health. This has included shared learning from incidents and promotion of mental health through learning events across the Trust.
Key Achievements 2019/20	• Development of a mental health e-learning package to level 2 as part of the mandatory training provision for compliance with the key skills framework for mental health. The workforce development team have reported that since inception on World Mental Health Day 10/10/19 to current (6 months) **15,208** staff has completed the e-learning for mental health. This figure is not

	included in the education stats reported on a quarterly basis, although hopefully this can be reflected in 2020/ 2021 quarterly reporting figures. • Significant progress in the development of an all age approach to mental health, with development of policy work streams that will enable further collaborative work on this agenda this year. • Learning from experience has demonstrated that staff in clinical areas have imbedded learning related to the integrated care pathway for self-harm & suicide preventions. On two occasions patients were prevented from experiencing serious harm due to prompt intervention by clinical staff in the removal of ligatures. • SMHT have increased awareness and visibility of the service at Oxford Road Campus. This has required significant cross site working and the development of new relationships with key staff. SMHT has also responded to serious clinical incidents, with a rapid provision of bespoke training as required. • Improved level 3 mental health study day offer that covers all key performance targets for high risk areas with respect to overarching mental health policy. • Development of Level 4 mental health training for complex case management. 1st cohort is recruited to and will proceed later in 2020 once current Covid -19 restrictions are lifted. • Completion of the final component for the prevention and management of behavioural disturbance approach, namely the procedure for use of rapid tranquilisation (RT). Whilst this is an option of last report, MFT did not have access to a Trust wide procedure to guide prescribers in line with NICE recommended guidance for RT. This has been published in conjunction with senior pharmacy colleagues and oversight by the medicines management committee. • Development and delivery of additional suicide prevention training designed for MFT school nurses and community staff from within the MLCO.

7.6. Trafford Community Service

Name of Team	Trafford Safeguarding Families Team (Community)

Has the team delivered on actions within safeguarding work plan	• The Trafford Safeguarding Families Team were part of Pennine Care NHS Foundation Trust (PCFT) until October 2019 when TLCO joined with MFT.
	• The team made a positive contribution towards the priority areas identified in the PCFT Safeguarding Annual Report for 2018 in the following areas;
	  • Delivery of a comprehensive package of all-age safeguarding supervision in line with local needs, including the development of supervision within CAMHS.
	  • Contribution to revision of the Trust safeguarding training packages and role requirements in line with revised Intercollegiate Frameworks for both children and adults.
	  • Promotion of adult safeguarding within Trafford including developing understanding around the Mental Capacity Act and ensuring that staff adhere to guidelines and understand their roles and responsibilities in relation to MCA.

	• The sharing of lessons learnt from case reviews with frontline staff.
Key Achievements 2019/20	• The team has remained visible and accessible to community health practitioners for supervision and support. • The team has continued to enhance working relationships with multiagency partners. • There has been successful recruitment of a Social Worker into the Specialist Practitioner (adult) post, which brings valuable skill-mix to the team. • The Specialist Practitioners have developed their skills and experience in relation to both child and adult safeguarding delivering PCFT's all-age family safeguarding model. • The team has made a positive contribution to the local safeguarding partnership. • The team has maintained a presence on the Learning and Improvement Committee of the TSSP and contributed to reviews and identifying lessons learnt to inform practice. • The team has promoted the roll-out of the Graded Care Profile 2 in Trafford, including contribution to the training pool. • The team has contributed to the development of a multi-agency strategy for safeguarding when obesity is an issue and promotion of learning in this area has led to positive developments in the recognition and response to these challenging cases by the health workforce. • The team has also contributed to the development of a multi-agency strategy for self-neglect. • Whilst the team continued to promote the wider safeguarding agenda, the Specialist Practitioners undertook a particular focus on using their knowledge, skills and experience to promote a 'think family' approach to domestic abuse. The team have worked with the Safeguarding Partnership to develop practice, including driving forward a review of local MARAC processes and leading on the design and delivery of a multiagency domestic abuse training package. • The team has promoted the need to capture the voice of the child and wishes and feelings of children and adults at risk in all safeguarding activity. • Both additional and mandatory training has been delivered to a high standard by the team and highly positive feedback has been received.

SECTION H

Safeguarding Forward Plan for 2020/2021

8 MFT Safeguarding Team Development Plans for 2019/2020

8.1 During 2020/21 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:

8.1.1 Coral Suite Child Protection Team, Community Paediatrics

- Ongoing work is focussing on the Covid-19 recovery plan as an increase in referral numbers is expected once restrictions are lifted and children begin to return to school and nursery settings. There is likely to be the need for increasing capacity in the clinics, whilst at the same time maintaining social distancing.
- There is ongoing work to address the needs of children and young people affected by fabricated and induced Illness. This work will need to take in to account new national guidance which is expected to be published in 2020.
- The need to feed into virtual meetings with partner agencies so as to maintain social distancing to prevent the transmission of Covid-19 is likely to be a further area of development over 2020/21.

8.1.2 Manchester Safeguarding Children Community Team

i. Domestic Violence and Abuse

- To continue to support the Safe & Together implementation programme.
- To contribute to the development of new multi-agency risk indicator checklist for domestic abuse being developed by Manchester IDVA service which is scheduled to be completed towards the end of 2020.
- To scrutinise the Trust's contribution to the MARAC process which is formally being evaluated by Greater Manchester Police – this work will be complete in late 2020 and brought to MARAC steering group. Any new processes will need to be fed back through the training, supervision and newsletters delivered by the safeguarding team.
- To continue to support the administration team to further develop their skills in supporting the safeguarding service in relation domestic violence and abuse.

ii. Obesity

- Named Nurse Safeguarding Children to be a member on the reformed multi-agency Obesity Steering Group to develop further work on safeguarding obese children and young people.

iii. Neglect

- To plan and review how to embed the Graded Profile 2 into practice as there is limited evidence that the tool is being used.

iv. **Audit**

- The supervision audit planned for quarter 2 has been postponed due to COVID-19
- Re – audit Electronic Patient Record EMIS documentation in respect of the effectiveness of safeguarding record keeping.

8.1.3 **Safeguarding Children ORC and WTWA Teams**

- Review and standardise safeguarding children processes across the MFT footprint.
- To contribute to the multi-agency referral process to the LA where mental health is the precipitating factor (whether that be child mental health or adult mental health).
- To develop safeguarding champion meetings at WTWA in conjunction with the adult safeguarding team.
- To support the MFT CSE trainer in delivering the CSE training within MFT.
- Review and embed safeguarding supervision within the acute services in order to standardise the process across the MFT footprint
- Review and audit of the safeguarding assessment/care plans currently being piloted in RMCH
- Continue to embed the safeguarding children agenda for 16-17 year olds within MRI.

8.1.4 **Adult Safeguarding ORC and WTWA Teams**

- Develop an adult safeguarding link nurse network and/or peer supervision group for adult practioners especially in the MLCO.
- To support the implementation of LPS.
- To contribute to the safeguarding conference scheduled to take place in November 2020.
- To implement Ulysses as the process for frontline staff to apply for a DoLS.
- To provide further support for staff to ensure that Making Safeguarding Personnel is embedded within MFT.
- To ensure that ‘Managing Allegations’ training is available.
- To deliver the lessons learned from the thematic reviews and SARS from the year 2019-2020.
- Alignment of the adult safeguarding service to include TLCO..
- Develop the level 3 adult safeguarding training for community staff.
- To increase visibility and support at Trafford General Hospital.

8.1.5 **Midwifery Safeguarding ORC and WTWA**

- To establish across site working process for safeguarding maternity teams.
- To align the offer of safeguarding supervision for community and specialist midwives at Wythenshawe maternity site with the offer at Oxford Road Campus.
- To support and assist SMH maternity management in embedding the safeguarding agenda.

- Continue to establish and deliver robust safeguarding training, which is appropriate and effective for all staff.
- Disseminate learning from recent SCRs and SARs once published.
- Managing Allegations Training for SMH managers to be facilitated.

8.1.6 **Safeguarding & Mental Health Team (SMHT)**

- Preparation for the amendment to the Mental Capacity Act, changing from DoLS to LPS.
- Develop plans for the implementation of Approved Mental Capacity Professionals (AMCP's).
- Preparation for sharing good practice in respect of mental health safeguarding with colleagues from North Manchester.
- Development of service evaluation with academic partners, with particular emphasis on patient experience of crisis care pathways for mental health at MFT.
- Sharing best practice across other areas within regional networks/conferences.
- Working with AQuA and workforce development to design a model of best practice for reducing the need for restrictive interventions.
- Contribution to the National Safeguarding Adults Conference being planned for November 2020.

8.1.7 **Trafford Safeguarding Families Team (Community)**

- To work with MFT safeguarding colleagues to continue to harmonise processes and policies, sharing good practice across teams and to ensure that services across Trafford are updated.
- To ensure that data collection tools are adequate in line with MFT reporting requirements.
- To adapt local procedures for court statements for care proceedings in line with the model used by MFT community services in Manchester to ensure a more analytical and concise approach. This will include supporting the workforce to adapt to this change and working with CAMHS to strengthen existing quality assurance processes.
- To develop local administrative and specialist practitioner procedures for operating on a day-to-day basis.
- To continue to drive forward local domestic abuse practice via specialist practitioner contribution to the local MARAC Task and Finish Group and Strategic Domestic Abuse Forum. To work with the school nurse service to develop consistent practice in response to domestic abuse.
- To support the workforce to safeguard vulnerable families and manage additional complexities and risks during the Covid-19 pandemic and respond to the anticipated increase in safeguarding activity as during the 'recovery' phase.
- Whilst continuing to promote the wider safeguarding agenda, the team has identified the multi-agency response to child sexual abuse concerns as an area for development and plan to work on this with the Safeguarding Partnership.
- The team has also identified the need for a greater emphasis on safeguarding within the local new starter induction package and plan to support with developing this further.

- To continue to promote safeguarding supervision compliance to ensure it remains above 90% for all relevant staff and work with services to ensure robust reporting processes.

8.2 **Safeguarding Audit Plan 2018/19**

In line with key priorities of the Safeguarding Partnerships and messages from previous MFT audits the following audit plan is proposed for 2020/2021:

- Mental Capacity Act (MCA) Staff Awareness and Mental Capacity Assessment Case Note Review.
- Deprivation of Liberty Safeguards benchmark review in preparation for Liberty Protection Safeguards implementation plan.
- Review of the Quality of Referrals to Social Care for adult safeguarding concerns including a review of how the referral considers Making Safeguarding Personal.
- Review of the Quality of Referrals to Children's Social Care.
- Review of Recording and Documentation of Child Safeguarding Concerns.
- Review of the implementation of Female Genital Mutilation Information Sharing System in Clinical practice.

In addition outstanding audits not fully completed will be finished and reported on:

- Safeguarding Supervision review.
- Review of the quality of Multi Agency Risk Assessment referral (MARAC/ DASH) process.
- Looked After Children Benchmark Audit.

8.2.1 These audits will span all services and give MFT a clearer picture of the gaps and areas for development as well as areas of good practice. It will allow alignment with Manchester and Trafford Safeguarding Partnership key priority areas.

8.2.2 MFT will also continue to take part in Manchester and Trafford multi-agency audits.

8.3 **Delivery of Safeguarding Work Plan 2019-2020 and Priority Setting for 2020-2021**

8.3.1 **Figure 51** summarises the outcomes achieved through the delivery of the MFT safeguarding work plan in 2019/2020 **(Appendix 4)** and sets out the priority areas that will inform the 2020/2021 MFT safeguarding work plan**.**

Figure 51: Progress against 2019-2020 Trust Safeguarding Work Plan and Priorities for 2020-2021

Key Priority	Key outcome	Achieved	2020-2021 Priority
Audit	All Audits completed, with action plans in place Plan for re-audit if assurance not given. Plan for audit in 2020/21 with rationale where audit not completed in 2019/20s 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 consolidate 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 has 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 workforce survey in key priority areas**
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** **To review the level 3 safeguarding training in line with the Trust's review of mandatory training**

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 strengthen the sharing of key safeguarding messages through site and thematic safeguarding groups.** **To ensure key messages from local and partnership groups are shared with the Trust through safeguarding governance groups.** **To embed learning from Serious Case Reviews and Safeguarding Adult Reviews into practice.**
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 ensure Making Safeguarding Personal/ Voice of the child/young person and embed in 'What Matters to me' is embedded in all safeguarding operational and strategic practice.**
Mental Capacity Act (MCA)	Staffs have an increased understanding of MCA/DoLS across the Trust.		**To further develop understanding of MCA/DoLS/LPS across all services.**
Deprivation of Liberty Safeguards DoLS	Staff understand their role and responsibility, and are following guidelines.		**To work with hospitals/MCS/LCO on the implementation of LPS**
Liberty Protection Safeguards	Hospitals/MCS/MLCO monitor their DoLS activity		
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 disseminated to all areas from SCRs SARs and DHR.**
To ensure the Trust meets statutory safeguarding obligations across the Trust footprint	Trafford community safeguarding team have joined MFT safeguarding team. TLCO contribute to Trust safeguarding governance group and safeguarding work plan		**To work with North Manchester General Hospital safeguarding service to prepare for transition to MFT in April 2021**

8.4 Conclusion and Recommendations

8.4.1 This year the profile of MFT changed as Trafford Community Services joined the Manchester Local Care Organisation. Manchester continues to have one of the country's highest rates of deprivation, bringing with it a range of challenges for safeguarding. Trafford borough is a diverse area with areas of affluence and deprivation and with localised safeguarding needs and vulnerabilities.

8.4.2 The 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 and the amendment to the Mental Capacity Act regarding introduction of Liberty Protection Safeguards. Challenges continue to emerge and require a robust response with the further embedding of the Complex Safeguarding agenda and the need to prepare for future challenges within the evolving health and social care landscape.

8.4.3 In addition, in 2020 at the end of this reporting period, the Trust safeguarding service worked closely with Trust services to review the operational response to safeguarding concerns due to the impact of Covid-19 pandemic. The service supported the hospitals/MCS/LCOs to implement new ways of working to continue to prioritise frontline and essential safeguarding activity. This included the provision of the safeguarding support to the Nightingale Hospital North West.

8.4.4 This annual report demonstrates the complexity of the safeguarding work undertaken within the Trust by the safeguarding team and the wider workforce to ensure that patients and staff are safe.

8.4.5 Safeguarding is a key priority for the Trust, and this report provides assurance that the safeguarding team continue to deliver high volume and high quality support, to enable the Trust to meet its statutory requirements.

8.4.6 The increasing complexity of safeguarding is evident in this report. The activity has been extensive across the Trust during this 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 still required to increase compliance, the impact of this training is evidenced by the increase in referrals to the Trust safeguarding team.

8.4.7 In the coming year, the safeguarding team will consolidate the delivery of safeguarding services under the Single Hospital Service and will prepare for the transfer of North Manchester General Hospital's (NMGH) safeguarding function to MFT in April 2021. This will include working closely NMGH to understand safeguarding in the hospital and the North adults community services to ensure systems and processes are in place to safeguard citizens and ensure the protection of patients remain central in all organisational change.

8.4.8 The safeguarding team will continue to support the Trust 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.

8.4.9 The safeguarding team will continue to respond and support service delivery through the surges and recovery work streams in response to Covid-19 which is expected to include a safeguarding surge in response to nation's recovery from "Lock Down".

8.4.10 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.

SECTION I

Manchester Looked after Children and Trafford Children in Care Annual Report 2019/20

Contributors to the report:
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MFT Our Children/ Children in Care Health Teams

9 Manchester Looked after Children and Trafford Children in Care

9.1 Introduction

9.1.1 Health and wellbeing of looked after children

i. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers[20].

ii. The Royal College of Paediatrics and Child Health (2015) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems[21]. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy, unhealthy lives as adults.

9.1.2 Definition of a looked after child

i. Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she is:

- provided with accommodation (by the Local Authority) for a continuous period of more than 24 hours
- subject to a care order; or
- subject to a placement order

ii. A child that is being looked after by the Local Authority might be living with

- foster parents
- at home with their parents under the supervision of Children's Social Care
- in residential children's units
- other residential settings like schools or secure units

They might have been placed in care voluntarily by parents struggling to cope or Children's Social Care may have intervened because a child was at significant risk of harm.

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20 Promoting the health and well-being of looked after children (2015) Department for Education and Department of Health.

21 Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework (2015) Royal College of Paediatrics and Child Health

iii. A looked after child ceases to be looked after when he or she turns 18 years old. On reaching his or her 18th birthday, the status of the child changes from being looked after to being a young adult eligible for help and assistance from the local authority, known as a Care Leaver. Such help and assistance is usually provided in accordance with the various aftercare provisions of The Children and Social Work Act (2017).

9.2 **Purpose of the Report**

9.2.1 The purpose of this report is to provide an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of Our Children/Looked after Children/Children in Care in Manchester and Trafford. This includes all cohorts of Our Children/Looked after Children who Manchester City Council and Trafford City Council are responsible for, no matter where they are residing.

This report covers the period 1st April 2019 to 31st March 2020. It will summarise key improvements, service performance, along with setting out the objectives and priorities for the next financial year (2020/2021).

9.2.2 Within all national and local policies and guidance, the service is known as looked after children. 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)."*

9.2.3 In Trafford Looked after Children are known as "Children in Care".

Trafford's commitment to Children in Care is to;

> *"To work with children, families and carers to find solutions together. This starts with our relationships with each other, listening and taking account of children's wishes and feelings. We will recognise and build on strengths to help our children, families, carers, staff and services grow. We will provide high support along with a high level of challenge".*

National Policies and Legislation relevant to Our Children/Looked after Children
The statutory guidance focused around looked after children is in abundance; the key documents and legislation are outlined as follows:

- **Children Act (1989, 2004)**
  Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours.

  There are four main groups:
  - **Section 20** children who are accommodated under a voluntary agreement with their parents
  - **Section 31 and 38** children who are subject to an interim care order or care order
  - **Section 44 and 46** children who are subject to emergency orders
    Section 21 children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence

- **Adoption and Children Act (2002)**
  This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

- **Care Matters: Time for Change (2007)**
  This document sets out the steps to take to improve the outcomes of children and young people in care.

- **Children and Young People's Act (2008)**
  The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care services which are focused on and tailored to their needs.

- **Children and Families Act (2014)**
  This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs.

- **Promoting the Health and Wellbeing of Looked After Children (2015)**
  This guidance was issued by the Department of Health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

- **Looked After Children: Knowledge, skills and competencies of health care staff, Intercollegiate Framework (2015)**
  This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children.

- **The Children and Social Work Act (2017)**
  The Act is intended to improve support for looked after children and care leavers, promote the welfare and safeguarding of children and make provisions about the regulation of social workers.

9.3 Care Leavers

9.3.1 A Care Leaver is an adult who has spent time in care as a child, such as foster care, living with family or in a residential care setting. Their time in care could have lasted for a few months or from birth until their 18th birthday. All young people who leave care at 16, 17 or 18 years of age are statutorily provided with some support from the local authority in the area in which they live. This includes being assigned a Personal Advisor to help them in the transition to living independently.

9.3.2 Statutory Guidance on Promoting the Health and Well-Being of Looked After Children (2015) requires local authorities, Clinical Commissioning Groups and NHS England to ensure that there are effective plans in place to enable looked after children aged 16-17 years to make a smooth transition to adulthood.

9.4 National and Local Context

9.4.1 Nationally the number of looked after children has increased steadily over the past 8 years. There were 78,150 looked after children on 31st March 2019, an increase of 4% compared to 31st March 2018[22]. The most up to date national figures for 2019/2020 are not yet available from the Department for Education, the usual publication date being December 2020.

Figure 52a: Number of children looked after in England at 31st March 2015 to 31st March 2019

Year	Number	Rate per 10,000 child population
2015	69,470	60
2016	70,410	60
2017	72,610	62
2018	75,370	64
2019	78,150	65

[22] Data Collection Statistics Looked after Children.

Figure 52b: Number of children looked after in North West England, Manchester and Trafford at 31st March 2015 to 31st March 2020

Year	North West		Manchester		Trafford	
	Number	Rate per 10,000 child population	Number	Rate per 10,000 child population	Number	Rate per 10,000 child population
2015	12,490	82	1,310	114	334	62
2016	12,550	82	1,252	107	331	61
2017	13,220	86	1,169	97	384	70
2018	14,050	91	1,258	104	383	69
2019	14,660	94	1,290	106	417	74
2020			1,431			

9.5 Commissioning Arrangements

9.5.1 A set of complex commissioning arrangements within the 'Responsible Commissioner' guidance (2013) underpin access to health services for children in care. The guidance states that the child's registered GP at the point of placement determines the responsible Clinical Commissioning Group (CCG) for the cost of any health services in addition to universal services. This includes services provided through its commissioned services such as CAMHS or community paediatrics as well as for routine health assessments.
Currently there is an agreement within the Greater Manchester health economies that there is no cross charging for health assessments.[23]

9.5.2 Manchester Health and Care Commissioning currently commission the Manchester University NHS Foundation Trust (MFT) Our Children (LAC) health team to ensure the health needs of Manchester's looked after children, young people and care leavers are met in line with national guidance and local service specification. Manchester Local Care Organisation are commissioned to meet the health needs of Our Children within the Health Visiting and School Health services which includes undertaking Review Health Assessments and liaising with all relevant agencies to support and promote their health and wellbeing. The completion of Initial Health Assessments is included within this commissioning arrangement.

9.5.3 Prior to October 2019 NHS Trafford Clinical Commissioning Group commissioned Pennine Care NHS Foundation Trust to provide a looked after children's health service within Trafford. This service is now commissioned to be provided by MFT.

[23] Who pays? Determining responsibility for payments for providers: Rules and Guidance for CCG's: NHS Commissioning Board (2013)

9.6 **Governance**

The Trust response to Our Children/Children in Care is overseen by the Our Children (LAC) Sub Group which reports to Group Safeguarding Committee.

9.6.1 **Our Children (LAC) Sub Group**

i. **Purpose of the Group**

The remit of the subgroup is to ensure that the key areas of the Our Children/Children in Care agenda is embedded across adult and children services across Hospitals/MCS/LCO, These include –

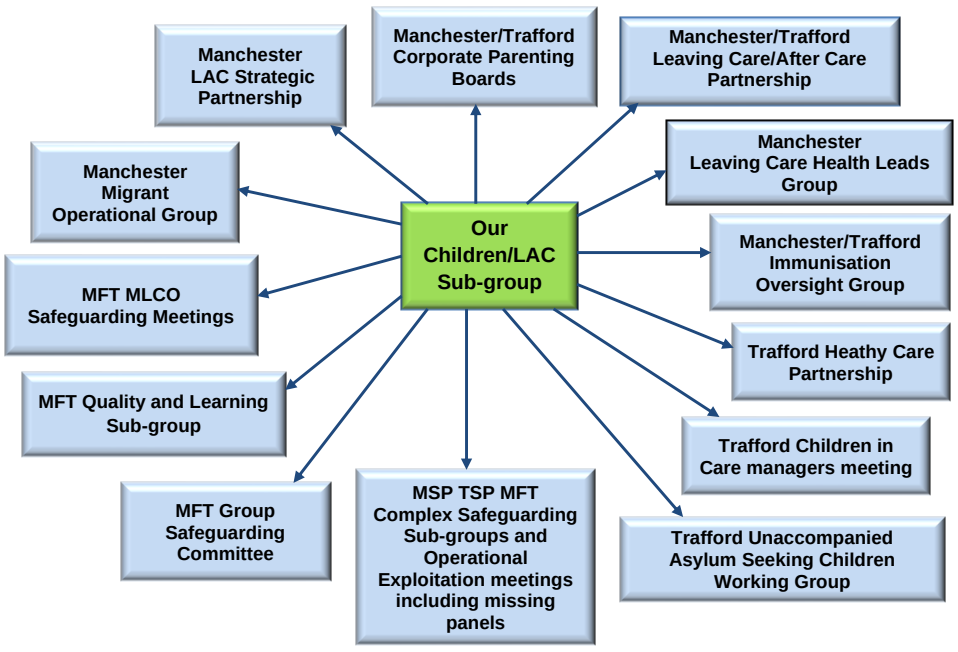
- LAC service delivery and practice development
- Health Outcomes for 'Our Children/Children in Care' / Statutory KPI performance
- Quality of Statutory health assessments
- Voice and Influence of 'Our Children/Children in Care'
- Partnership work and key messages from Corporate Parent Panel, LAC Strategic Board and Multi-agency subgroups.

ii. **Key Terms of Reference**

- Ensure LAC policy, strategy and guidance is disseminated across all Hospitals/MCS/LCO
- Develop and implement training and briefings for Hospitals/MCS/LCO in line with Looked After Children requirements
- Develop policies and guidelines
- Seek assurance that Our Children/Children in Care priorities are known and understood including statutory requirements across Hospitals/MCS/LCO

iii. **'Our Children' (LAC) Sub-group Reporting Structure**

Figure 53: 'Our Children' (LAC) Sub-group Reporting Structure



iv. **Areas for Development during 2019-2020**

- Trust wide audit to benchmark staff awareness of LAC requirements in practice.
- Develop a work plan for the sub group.
- Develop a dashboard for the sub group to present in a meaningful way, the key performance outcomes for Our Children/Children in Care and the quality assurance outcomes of statutory health assessments completed by MFT practitioners.
- Development of the Our Children (LAC) sub-group with membership from the services that Our Children access, to 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/Children in Care 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 competencies of health care staff - Intercollegiate Role Framework (2015).
- Demonstration that we have sought the views of Our Children/Children in Care on what needs to be done to improve the services they use.

v. **Key Achievements**

- ✓ The Our Children (LAC) sub group has seen improved representation from services and divisions which provide a robust oversight into the services that Our Children receive through individual service feedback.
- ✓ Improved awareness of the Our Children (LAC) health team amongst the MFT workforce.
- ✓ Robust quality assurance pathway ensuring that the voice of the child is heard throughout the health assessment process.
- ✓ Completion of trust wide audit to benchmark staff awareness of LAC requirements in practice.

vi. **Priorities for 2020-2021**

- Full implementation of the revised Manchester Our Children Service Specification to include the development of a dashboard for the sub group to present key performance and quality assurance outcomes in a meaningful way.
- Development of a comprehensive training package for professionals including health (community and acute) and social care to inform of the health needs of Our Children/Children in Care, their journey throughout the looked after process and the professionals roles and responsibilities in achieving the best outcomes for Our Children.
- Implementation of revised health assessment documentation to support health practitioners to undertake a holistic assessment for Our Children/Children in Care which incorporates their voice.
- Development of a MFT ‘Our Children’ (LAC) Policy.

9.6.2 **Audit**

i. In early 2020 a Trust wide audit was undertaken to identify staff awareness of the requirements in relation to LAC in practice in order to influence training development. Unfortunately the survey was launched as the Covid-19 pandemic commenced, resulting in a poor response rate which was unable to provide an accurate reflection of staff awareness across the Trust. The survey will be redeveloped and relaunched at a more appropriate time.

9.7 **Manchester Our Children/Looked After Children**

The figures identified in section 9.4 have indicated the numbers of Our Children continues to increase year on year for Manchester. Over the last financial year there has been an 11% increase. These figures are higher than the previous national average increase of 4%. Manchester also has higher rates of looked after children per 10,000 child population than national figures. The reasons for this are complex and to some extent unknown, however there may be a link potentially to the austerity of the local area, increase in Social Care cases overall and the complexities of children/young people due to their adverse childhood experience.

The following **figures (54a and 54b)** identify the profile of Our Children in Manchester by gender and age.

Figure 54a: Gender of current LAC

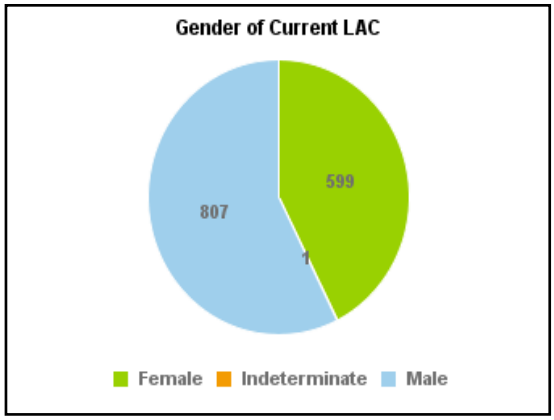
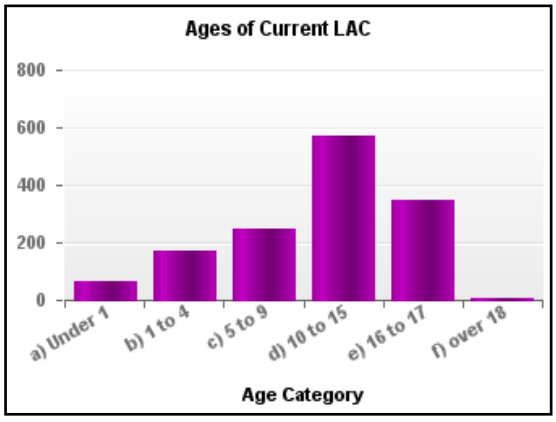


Figure 54b: Age of current LAC



9.8 Key Performance Indicators

9.8.1 The work undertaken by the Our Children (LAC) health team is underpinned by statutory requirements against which performance is monitored by the Trust and reported to Manchester Health and Care Commissioning.

9.8.2 Statutory guidance set out in Care Planning, Placement and Case Review (England) Regulations (2010) 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 looked after (Regulation33(1))
- A health review should be undertaken at least once in every period of 6 months before the child's fifth birthday and at least once in every period of 12 months after the child's fifth birthday.

9.8.3 In September 2019, Manchester Health and Care Commissioning revised the Service Specification for Specialist Looked After Children Health Services and introduced updated Key Performance Indicators (KPI) which will take full effect from April 2020.

Figure 55: Our Children Key Performance Indicators (KPIs)

Our Children	KPI
% of Initial Health Assessments within Statutory Timescales	90%
% of Review Health Assessments within Statutory Timescales	95%
% Immunisation Status	90%
% Dental Attendance	95%
% SDQ's available to inform Review Health Assessment	85%
% of young people leaving care in receipt of a Care Leaver Health Summary	80%
% up to date Health Surveillance Check	95%
% BMI's recorded	95%

9.9 Manchester Our Children's (LAC) Service

9.9.1 The MFT Our Children (LAC) health 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.

9.9.2 Manchester has higher numbers of Our Children and LAC compared with national and North West figures. This places significant pressures on the Our Children (LAC) health team, but also on paediatricians, health visitors and school nurses in ensuring the statutory health needs of Our Children are met.

9.9.3 MFT is commissioned to provide IHA and Review Health Assessments (RHA), including Our Manchester Children placed in Manchester and children from other LA areas placed in Manchester.

9.9.4 **Unaccompanied Asylum Seeking Children (UASC)**

i. UASC are under 18 years and are likely to become looked after because they are without accommodation, separated from both parents and are not being cared for by an adult who by law has responsibility to do so. Under Section 20 of the Children Act 1989, local authorities are under statutory obligation to provide accommodation for unaccompanied asylum seeking children who present in their area. This means that they become looked after and should be safeguarded and have their welfare promoted in the same way as any other looked after child/young person.

ii. The Our Children (LAC) health team has a dedicated UASC Nurse Specialist who supports the health needs of the UASC population in Manchester to ensure the best possible health outcomes for this cohort of young people.

iii. The numbers of UASC in Manchester has increased during the reporting period with the UASC Nurse Specialist currently overseeing a caseload of approximately 140 young people. This is a combination of Manchester UASC Manchester placed and UASC from other local authorities placed in Manchester. To ensure that these young people receive the best possible service to support their health needs, additional specialist nursing capacity has been recruited to.

9.9.5 **Care Leavers**

i. Statutory Guidance on Promoting the Health and Well-Being of Looked After Children (2015) requires local authorities, Clinical Commissioning Groups and NHS England to ensure that there are effective plans in place to enable looked after children aged 16-17 years to make a smooth transition to adulthood. This includes providing them with as much detail as possible on their health history including birth details. Care leavers should expect the same level of care and support that other young people get from their parent. Young people looked after by Manchester City Council will be provided with a summary of their health history prior to their 18th birthday.

ii. The introduction of the Children and Social Work Act 2017 ensures that all local authorities provide a local offer for care leavers including the provision of a personal advisor up to the age of 25 years. This has been reflected in the revised Service Specification whereby the Our Children (LAC) health team will support care leavers through advice and consultation during their transition into adulthood.

9.9.6 Our Children (LAC) Nursing Team

i. Objectives from 2018/2019

- 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 special educational needs and disability (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.
- 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 needs.

ii. Key Achievements

- ✓ Improved awareness of the Our Children (LAC) health team across the trust in both community and acute settings
- ✓ A review of the Our Children (LAC) health team which has improved service delivery
- ✓ An increase in nursing capacity within the Our Children (LAC) health team to provide more comprehensive support for Our Children
- ✓ Improved partnership working with the MCC Leaving Care Team to develop services for Our Children leaving care
- ✓ Partnership working with Children's Social Care with regards to their new system Liquid Logic whereby notifications and initial health assessment requests are received
- ✓ Improved quality assurance process to ensure that the voice of the child is reflected within the health assessment

iii. Challenges

- The Our Children (LAC) health team has been functioning on reduced nursing capacity which has impacted the levels of service delivery and development.
- The introduction of the Children's Social Care Liquid Logic system has increased the length of time taken to process notifications and IHA requests.
- The revision of the Service Specification is to improve outcomes for Our Children, however the electronic systems required to support the data collection is not in place to reflect the work undertaken.
- The Covid-19 pandemic in the latter part of the report period has provided challenges in providing the assurance that Our Children are safe and that their health needs are being met in addition to ensuring that the Trust is meeting its statutory obligations. It has, however, enabled alternative ways of working and communicating to be explored.

9.9.7 **Paediatric Looked After Children Service**

Name of Team	Paediatric Looked After Children Service 2019-2020
Priorities identified in Safeguarding plan 2018-2019	1. To continue to work with the Local Authority to streamline the request process for health assessments. 2. To work with Manchester Health Care Commissioning to review service specification of Looked After Children's team with a focus on improving outcomes for "Our Children"
Has the team delivered on actions within safeguarding work plan	1. Maintained high rate of offer of Initial Health Assessment (IHA) within statutory time scales. 2. Maintained a high percentage of children aged under 5 and looked after for 12 months or more with an up to date developmental review. 3. On-going support from a Nursery Nurse or Clinic Worker at the Coral suite when completing initial health assessments. Continued positive feedback received.
Key Achievements 2019/20	1. Developed close working relationships with the Trafford named team to ensure sharing of good practice. 2. Developed close working relationships with CAMHS-LAC team to enable appropriate referral for prompt emotional health support when required. 3. Development of regular case based discussion meetings to standardise excellent care for children and young people and ensure support for health care professionals. 4. Developed pathways in conjunction with the LAC nursing team to offer young people who are reluctant to attend an appointment at the Coral suite an option of an assessment by a Specialist Nurse in placement or other venue according to young person's preference.
Main barriers	1. Delay in receiving notification of child becoming looked after. 2. Delay in receiving consent for health assessment which has the potential to lead to a delay in an appointment; under on-going review due to starting to use liquid logic. 3. Difficulties with arranging face to face interpretation when required; either due to interpreters cancelling or not being available which can lead to delay in completing assessment. 4. Difficulties caused by the Covid-19 pandemic leading to initial health assessments being completed via telephone rather than face to face.
Development Plans for 2020/21	1. Explore methods for ensuring prompt administration of immunisations to Looked after children. 2. Develop pathway to ensure links with the Education department to enable sharing of information about children who are looked after and have education health care plans. 3. Continue to seek feedback from children and young people about health assessments, and incorporate feedback in future service developments.

	4. Recognise that due to the Covid-19 pandemic, there may be a short-term increase in the number of children becoming looked after and ensure preparation for this. 5. Consider that our growing expertise in using technology to reach children and young people remotely due to the restrictions caused by Covid-19 may be of value in the future and could be usefully utilised to carry out health assessments of looked after children who may not be able to attend or who are reluctant to attend a face to face appointment.

9.9.8 **Performance**

i. The performance data below shows the information which is currently being collated to benchmark against the KPI's. It is not currently possible to report on some of the data required for the KPI's, however this work is being undertaken and it is envisaged that a reporting mechanism will be available for the next quarter's report.

Fig 56: LAC Performance Data (against KPIs) 2019/20

Our Children	KPI	Q1	Q2	Q3	Q4
% of Initial Health Assessments within Statutory Timescales	90%	65%	47%	39%	52%
% of Review Health Assessments within Statutory Timescales	95%	88%	83%	79%	71%
% Immunisation Status	90%	82%	80%	78%	80%
% Dental Attendance	95%	48%	51%	47%	47%
% SDQ's available to inform Review Health Assessment	85%	Not yet recorded	Not yet recorded	Not recorded	Not yet recorded
% of young people leaving care in receipt of a Care Leaver Health Summary	80%	Not yet recorded	Not yet recorded	Not yet recorded	Not yet recorded
% up to date Health Surveillance Check	95%	100%	99%	85%	100%
% BMI's recorded	95%	Not yet recorded	Not yet recorded	Not yet recorded	Not yet recorded

ii. **Initial Health Assessments (IHA)**

It has been a challenging year for IHA compliance with Children's Social Care implementing their new electronic system Liquid Logic in July 2019. This caused delays in notifications and IHA requests being received. However, during quarter 4, there has been a significant improvement in the numbers of children and young people seen for their IHA within the statutory timeframes of 20 working days. At the end of January, the MFT Our Children (LAC) health team gained access to Manchester City Council's electronic recording system, Liquid Logic. This has enabled notifications of children entering care and requests for initial health assessments from social workers to be forwarded in a timely manner which has resulted in the improvements. As the administration team become more confident in its use and there is improved awareness amongst social workers, it is anticipated that compliance will further improve.

iii. **Review Health Assessments (RHA)**

Fig 57: Review Health Assessments (Quarter 4 2019/20)

	Mcr LAC – Mcr Placed	Mcr LAC – OOA Placed	Mcr LAC – Placed Anywhere	Total MFT Performance
Review Health Assessments	83%	66%	73%	71%

Compliance has continued to decrease during the reporting period mainly attributed to the lack of health assessments for Our Children being completed for those who are placed outside of the Manchester area. On review, there is a continued delay in receiving the appropriate consent from social workers to enable the assessment to be undertaken. This has been raised with the local authority, who has been provided with a list of the consents required. In addition, there had been reduced capacity within the health administration team in the latter part of the quarter 4 due to the Covid-19 pandemic which has caused a delay in the health assessments being uploaded onto the electronic patient record therefore affecting the reporting data.

iv. **Immunisations**

Immunisation uptake has been a concern throughout the reporting period. There is currently a process of validation being undertaken to identify the reasons behind the poor compliance. Preliminary findings are identifying that the information on the electronic patient record is not necessarily the most up to date information in that the immunisation may have been outstanding at the RHA but has since been administered and this has not been updated onto the record for reporting. Further exploration will be undertaken to determine how this can be more efficiently recorded but in the interim, quarterly validation of the outstanding immunisation reports is being undertaken.

v. **Dental Attendance**

Dental attendance remains poor and has done so throughout the reporting period, therefore an in-depth review is required as to why there is such a low compliance. This information is recorded at the RHA which for most children and young people is undertaken annually, therefore if a child or young person attends the dentist in the interim period before the next assessment, this information is not added to the child/young person's record which could then show that they haven't been seen by a dentist for a long period of time. Dental attendance should be recorded by the Independent Reviewing Officers (IRO) at each statutory looked after review which takes place 6 monthly therefore consideration needs to be given as to how this more up to date information can be captured within health records.

vi. **Health Surveillance Check**

There are currently no concerns regarding the completion of health surveillance checks, these are being undertaken at the relevant stage which is reflected in the performance.

9.9.9 **Partnership Working**

i. A partnership approach is key to ensuring best outcomes for Our Children and the Our Children (LAC) health team work closely with Manchester City Council 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.

9.9.10 **Engagement**

i. The Our Children (LAC) health team contributed to the development of the LAC Strategy devised by Manchester City Council to ensure that the physical and emotional health needs of Our Children were heard throughout the document.

ii. A Trust wide audit has been undertaken to identify staff awareness of LAC requirements in practice in order to influence training development. Unfortunately the survey was launched as the Covid-19 pandemic commenced therefore there was a poor response rate which was unable to provide an accurate reflection of staff awareness across the Trust. The survey will be redeveloped and relaunched at a more appropriate time.

iii. The Our Children (LAC) health team consulted with Manchester Local Care Organisation (MLCO) Health Visiting and School Health colleagues in relation to the development of more concise review health assessment documentation which better reflects the voice of the child. The new documentation has been devised and its use agreed within the Trust: however, its implementation has been delayed due to the Covid-19 pandemic.

iv. Providing support for Care Leavers during their transition into adulthood has required further development by the Our Children (LAC) health team to identify the most appropriate support for young people at this time. A period of consultation with the MCC Leaving Care Team, Personal Advisors and Care Leavers had commenced but has been postponed due to the Covid-19 pandemic.

9.9.11 **Objectives and Priorities for 2020/2021**

- Continue to raise awareness of the specialist nursing service for ‘Our Children’ across the Trust to develop pathways for coordinated care.
- Full implementation of the revised Our Children Service Specification to include the development of a dashboard for the sub group to present key performance and quality assurance outcomes in a meaningful way.
- 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 needs.
- Implementation of revised health assessment documentation to support health practitioners to undertake a holistic assessment for Our Children which incorporates their voice.
- Immunisation coverage for Our Children is lower than acceptable which requires further review.

- Further work is needed to ensure the Strengths and Difficulties Questionnaire (SDQ) completed with Our Children informs their health assessment.
- Increase the focus more on outcomes and provide evidence of the impact services have for Our Children.
- Development of a comprehensive training package for professionals including health (community and acute) and social care to inform of the health needs of Our Children, their journey throughout the looked after process and the professionals roles and responsibilities in achieving the best outcomes for Our Children.
- Development of a MFT 'Our Children' Policy.

9.9.12 **Manchester "Our Children" report Conclusion**

i. 2019/2020 has seen a rise in the numbers of children and young people entering care in Manchester including the rise in UASC also entering the region. This has had an impact on the service delivery within the Our Children's (LAC) nursing team, subsequently leading to a full review of the service which also incorporated the revised service specification. The commencement of a new Named Nurse for Our Children during the report period provided an optimum time for this review to be undertaken.

ii. The latter part of the report period introduced unprecedented times for Manchester as well as Great Britain as a whole in the form of the Covid-19 pandemic. This has provided a significant challenge for both health and social care colleagues in respect of ensuring that the physical and emotional health needs of Our Children continue to be supported and managed as effectively as possible.

9.10 **Trafford Children in Care (Looked After Children)**

9.10.1 On 31st March 2019 the number of children looked after by Trafford council was 417, which represents a 64% increase since 2011. This increase is not specific to Trafford and is represented across the whole of England and Trafford's ten nearest statistical neighbours. However, the rate per population of 74 per 10,000 is higher than the average for Trafford's ten nearest statistical neighbours (57 per 10,000) and England as a whole (65 per 10,000). This has placed an increased demand on all services which safeguard and promote the health and wellbeing of Trafford's children in care.[24]

9.10.2 The MFT Children in Care (CIC) Health Team ensure that the health needs of Trafford's CIC and care leavers are met in line with national guidance and the local service specification. Trafford Local Care Organisation (TLCO) is commissioned to meet the health needs of CIC within the Health Visiting and School Health services which includes the completion of Review Health Assessments (RHA) for under 5's and school-age children of other Local Authorities (LA) placed in borough. TLCO is commissioned for completion of Initial Health Assessments (IHA) by the paediatric team.

[24] Trafford 2020 – 2021 Joint Strategic Needs Assessment.

9.10.3 The service specification for the CIC Health Team incorporates responsibility for:

- Children and young people (aged 0-18) who are looked after by Trafford and placed in borough
- Children and young people (aged 0-18) who are looked after by another LA, but reside in borough
- Trafford LA children (aged 0-18) placed out of borough
- Open access to care leavers from 16 up to age 21 who are living within the borough.

9.11 Performance

9.11.1 The work undertaken by the Trafford CIC Health Team is underpinned by the statutory requirements for Looked after Children. In May 2019 an Ofsted inspection of Trafford's Children's Services identified that the experience and progress of children in care required improvement to be good[25]. This has resulted in increased scrutiny and review of services to Trafford children in care. The Trafford CIC team now report on a monthly basis on the timeliness of statutory health assessments to the Trafford Director of Children's Services' meeting following review at the TLCO Quality Sub Group. Further performance measures in relation to the health needs of CIC were reported within the quarterly Quality, Assurance and Governance Report for Safeguarding in Trafford, which has been shared with the CCG following review by the TLCO.

Figure 58: Key Performance Indicators

Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach
% of under 5s with up to date Children in Care health assessments	95%	**Numerator:** number of under 5s who have 2 health assessments in a 12 month period **Denominator:** total number of under 5s eligible for 2 health assessments in same 12 month period	Action plan with commissioners
% of over 5s with up to date Children in Care health assessments	95%	**Numerator:** number of over 5s who have 1 health assessment in a 12 month period **Denominator:** total number of over 5s eligible for a health assessment in same 12 month period	Action plan with commissioners

9.11.2 Statutory guidance set out in Care Planning, Placement and Case Review (England)
Regulations (2010) states:

- LA's must arrange for all LAC to have a health assessment.
- The IHA must be undertaken by a registered medical practitioner.

[25] Trafford Metropolitan Borough Council Inspection of Childrens Social Services

- 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 looked after (Regulation33 (1)).
- A health review should be undertaken at least once in every period of 6 months before the child's fifth birthday and at least once in every period of 12 months after the child's fifth birthday.

9.12 **MFT Trafford's Children in Care Service**

9.12.1 Overview of the Service

- The Trafford Children in Care Health Team comprises of;
  - Named Nurse Children in Care
  - Named Doctor Children in Care
  - Specialist Nurse Children in Care
  - Children in Care Nurse
  - Business Support Officer

- The team is part of the wider CIC multi agency service within Trafford. Health and social care colleagues are co-located which strengthens multiagency working. The team work alongside the Clinical Psychologist for CIC to facilitate prompt mental health support when required. The Specialist Nurse for the Youth Offending Service makes a significant contribution to promoting the health and wellbeing of CIC in Trafford.

- The team work closely with the Designated Nurse for Safeguarding /CIC within Trafford CCG who provides strategic oversight of the service.

9.13 **Statutory Health Assessments for Children in Care**

9.13.1 Initial Health Assessments (IHA) are undertaken by the Trafford Community Paediatric Team.

9.13.2 Review Health Assessments (RHA) for children who are under 5 years of age are undertaken by the Trafford Health Visitors (HV). The CIC Nurses complete the RHA for school age children and those young people who are aged 16 years and over. This has resulted in a more co-ordinated approach for the children and young people regarding their health care provision, particularly as the multi-agency CIC team is integrated.

9.13.3 As Trafford has a large number of looked after children resident in the borough from other local authorities, requests from out of area LA for RHA for school aged children placed in Trafford are completed by the CIC nurse or the child's School Nurse (SN) dependant on the child's current need.

9.13.4 Many of Trafford's children who are placed out of borough are placed in neighbouring authorities and continue to attend a Trafford school. These children and young people continue to receive a service from the children in care team to address health needs.

9.13.5 The CIC Nurses quality assure all the review health assessments for Trafford Children in Care.

9.14 Strengths and Difficulties Questionnaire (SDQ)

9.14.1 The strengths and difficulties questionnaire (SDQ) is a tool used to help professionals assess the emotional health and well-being of children and young people. Statutory guidance states that it is the responsibility of the LA to ensure that the SDQ is completed; in Trafford the children in care service specification states that an SDQ is offered at the time of the RHA.

9.14.2 When a RHA is requested for Trafford CIC placed out of borough, the SDQ documentation is also requested to be completed. However, not all out of area boroughs provide the SDQ at the time of the RHA. This leaves data collection for SDQs incomplete.

9.15 Immunisations

9.15.1 The CIC Nurses work closely with the Social Worker (SW), the School nursing team and the Specialist Nurse situated within the youth offending service to promote the uptake of immunisations for the 'hard to reach' young people. Children and young people can be seen at their GP, school, or at home for their immunisation. This flexible approach supports the uptake of immunisations for children in care.

9.15.2 Additionally the children in care asseses and proactively supports individual children to receive immunisations for example there are a number of children/young people who are needle phobic and time is spent preparing them to receive their immunisations.

9.16 Training

9.16.1 As part of the Pennine Care NHS Foundation Trust training programme the CIC nurses delivered Level 3 Looked after Children training in line with the Intercollegiate Roles Framework (2015)[26].

9.17 Performance

9.17.1 **Figure 59** below identifies performance measures for the MFT Trafford CIC health service for 2019/2020.

[26] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

Figure 59: Performance measures for the MFT Trafford Children in Care health service for 2019/2020.

Performance Measures	KPI	Q1	Q2	Q3	Q4
% Initial Assessments within statutory timescales	95%	49%	15%	40%	90%
% Review Assessments within statutory timescales under 5 years old	95%	97.2%	75%	78%	91%
% Review Assessments within statutory timescales over 5 years old	95%	96%	90%	88%	87%
% Immunisation Status	N/A	82%	79%	85%	86%
% Dental Assessments	N/A	67%	60%	83%	78%

9.17.2 The initial health assessment compliance with statutory timescales significantly increased in quarter 4. Review health assessments have continued to be delivered within the statutory timescales in the majority of cases. It should also be noted that there are many compounding factors that impact on the completion of timely health assessments including provider capacity, communication between the LA and health services including the timely completion of consent for assessment and the engagement of the carer and/or child or young person.

9.17.3 Dental assessments are recorded at the RHA, which for most children and young people is undertaken annually, therefore if a child or young person attends the dentist in the interim period before the next assessment, this information is not added to the child/young person's record providing a false negative in the data.

9.18 **Key Achievements 2019/2020 and Delivery of priorities outlined in the Annual Report 2018/2019**

9.18.1 The CIC team has made a positive contribution on both a strategic and operational level to child and young people in care;

- ✓ Work has been undertaken to address the communication with other LA's regarding out of area children placed in Trafford and ensuring that their health needs are addressed. This has resulted in improvement to the current system to manage notification of placement changes or children ceasing to be looked after by a placing LA.
- ✓ As part of the Healthy Care Partnership the CIC health team have contributed by providing data regarding the profile of CIC for inclusion in the Trafford 2020-2021 Joint Strategic Needs Assessment (JSNA). Trafford is one of the few boroughs in Greater Manchester that has incorporated CIC within the JSNA.
- ✓ The Specialist Nurse for CIC has developed up-to-date guidelines for the transportation of maternal breast milk to be considered when babies are looked after.

- ✓ The Specialist Nurse for CIC supported work raising awareness of Hepatitis B with foster carers to promote the uptake of immunisations for children in care.
- ✓ The CIC Nurses have supported new staff within community health services in respect of completion of high quality RHA.

9.18.2 **Challenges**

There has been a 64% increase of children and young people in care in Trafford since 2011. During this period the capacity of the service has not increased to meet the health needs of the increased numbers of children in care. Therefore the service has been challenged to complete all review health assessments, address the health needs of children in care and develop the service to focus on improving health outcomes for children in care. Due to concerns about the team's capacity to meet the health needs of children in care according to statutory guidance and the service specification an options paper and business case has been submitted in 2019 to the clinical commissioning group to increase capacity in the CIC health team to enable flexibility and specialist input for complex cases, particularly in respect of a high level of support for unaccompanied asylum seekers (UASC) and care leavers.

- The model of service delivery used in Trafford is different to that provided in other areas such as Manchester, as the CIC Nurses complete all the RHA for children/young people over 5 years who are looked after by Trafford LA. This results in high caseloads numbers and reduced capacity to focus on complex cases.
- The scrutiny of children in care services through the performance data sets across the partnership has presented challenges in data collection for the CiC team due to use of different methodologies and limitations in data collection across the partnership.
- A significant number of children in care have been affected by criminal and sexual exploitation. Currently there is no commissoned health worker based within the Trafford Complex Safeguarding Team to lead on the health response to exploited young people.
- The impact of the Covid-19 pandemic towards the end of the reporting period has presented challenges in service delivery to children in care. The service has responded by reviewing their service offer to include the provision of virtual health assessments, communication and support.

9.19 **Paediatric Children in Care Service**

Name of Team	Paediatric Children in Care Service
Key Achievements 2019/20	1. Work has been undertaken with the MFT team for CIC in Manchester to develop a pro forma for IHA for Unaccompanied Asylum Seeking Children (UASC). 2. Monthly meetings have been initiated between the Named Doctor, Paediatric Service Manager and the CIC Nursing team. These will be supported by the Named Nurse going forward into 2020/2021.

	3. Following an audit, the practice of using recent Section 47 Medical Assessments in place of the IHA has now stopped. This improves the quality of the assessment by ensuring the focus is on general wellbeing and emotional health needs rather than acute physical assessment. 4. Data collection has been completed for a local audit on the quality of IHAs and record keeping. The final report is outstanding due to redeployment of the lead auditor as part of the response to the Covid-19 pandemic.
Development Plans for 2020/21	1. To ensure a robust management system for incoming requests for an IHA by way of a generic email inbox to avoid delays due to sickness and absence of individual staff members. 2. To work with colleagues in the Manchester CIC Health Service to improve communication particularly when children move out of the area or are no longer looked after. 3. To continue to respond to the Covid-19 pandemic and remain committed to completing high quality and timely IHAs. The service has adopted joint video assessments involving children and young people and foster carers as well as social care. Procedures will continue to be updated in line with national guidance and restrictions in place.

9.20 **Unaccompanied Asylum Seeking Children (UASC)**

9.20.1 Across England there has been a growing population of UASC. UASC are likely to become looked after because they are without accommodation, separated from both parents and are not being cared for by an adult who by law has responsibility to do so. Under section 20 of the Children Act 1989, LA's have a statutory obligation to provide accommodation for UASC who present in their area. These children should be safeguarded and have their welfare promoted in the same way as any other looked after child/young person and often present with a variety of complex needs. Many of these children will have lived through trauma and profoundly stressful circumstances, which means that they are more likely to require specialist care. They may also have other specific physical and emotional health needs that need addressing by services.

9.20.2 In 2019 the published data identified nine UASC that were looked after by Trafford Council.

9.20.3 The CIC health team review the health needs of Trafford and out of area UASC placed in Trafford. These young people are increasingly likely to have complex health needs and require the CiC team to promote effective provision and oversight of health services and support.

9.20.4 The CIC Nurse has participated in the UASC Working Group meetings within Trafford.

9.20.5 The CIC Health Team plan to review their offer of support to meet the health needs of UASC.

9.21 **Care Leavers**

9.21.1 A 'care leaver' is an adult who has spent time in care as a child, either in foster care, living with family or in a residential care setting. The introduction of the Children and Social Work Act 2017 states that all LA's must provide a local offer for care leavers including the provision of a personal advisor up to the age of 25 years. The team will work with commissioners to ensure that changes to this legislation are reflected when the CIC health team service specification is reviewed.

9.21.2 The Greater Manchester Grant Thornton Review completed in November 2019 identified 186 care leavers up to the age of 25 residing in Trafford.

9.21.3 The CIC health team currently provide support to care leavers, through consultation with their 'personal advisor' in respect of complex health issues. The team plan to update the health summary document for care leavers in 2020/2021 and to further review the offer of support to this group of young people.

9.22 **Clinical Effectiveness**

9.22.1 **Complex Safeguarding Peer Review**

i. Following on from *Operation Augusta* (the enquiry into historic service provision for young people who have experienced sexual exploitation), the CIC health team contributed to a review of Trafford's complex safeguarding arrangements. The review identified that when health services were involved, multiagency working was 'visibly enhanced'.

9.22.2 **Grant Thornton Review**

i. The Grant Thornton Review was commissioned by Greater Manchester Health and Social Care Partnership (GMHSCP) with participation from all ten boroughs. The review was undertaken with a view to reducing the level of variation that LAC and Care Leavers experience in and across Greater Manchester; the CIC health team contributed to this review. An over-arching finding highlighted the importance of a "consistent and stable workforce that has sufficient capacity" as being fundamental to effective care.

9.22.3 **Client Engagement**

i. **Children in Care Council**
The CIC Council in Trafford is well-established. During 2019/2020 the CIC health team delivered sessions to the group to discuss their physical and mental health needs and to obtain user feedback on their experience of health assessments.

This included using a 'worry bag' which allowed the children/ young people to write down their concerns rather than being required to speak out. The nurses also discussed the risks of smoking tobacco and gave support and advice around healthy eating. The team will continue to consult with CIC and Care Leavers on "what we want from our CIC Nurse" and collate service feedback.

ii. **Foster Carer Training**

The CIC health team deliver training to foster carers twice a year. During 2019/2020 the training included topics such as; improving health outcomes for CIC and care leavers, adverse childhood experiences (ACEs), health inequalities for CIC in comparison with the rest of the population, barriers to addressing the health needs of CIC, protective factors, the risk of exposure to blood-borne viruses including hepatitis B, statutory health assessments, multiagency working, and the role of the CIC health team. The team will continue to consult with carers and the LA 'family placement team' to identify ongoing training needs in relation to health.

iii. **Healthy Care Partnership**

The Specialist Nurse for CIC has made a significant contribution to Trafford's Healthy Care Partnership which supports a coherent and collaborative approach to meeting the health needs of children in care across the health economy and with partner agency. The partnership is accountable to Trafford Corporate Parenting Board. The Named Nurse for Safeguarding and CIC will maintain oversight of the team's contribution to this group during 2020/2021.

iv. **Children in Care Team Objectives and Priorities for 2020/2021**

- Ensure that a robust plan is in place in order to ensure that statutory timescales are met and that the health needs of children in care can be responded to effectively whilst awaiting the outcome of the options paper and business plan from the clinical commmissioning group.
- Continue to work with Trafford Council to ensure that reporting of data in relation to performance and demographics of children in care is consistent across agencies.
- Update the electronic recording systems to improve the standard and timeliness of performance information and the quality of information sharing, in order to create more time to spend on supporting the CIC/ young people.
- Continue to raise awareness of the health needs of CIC and develop pathways for coordinated care.
- Development of a comprehensive training package for staff, including health colleagues and Social Workers to inform of the health needs of children in care, their journey throughout the looked after process and the professional's roles and responsibilities in achieving the best outcomes for children and young people.
- Development of a MFT Looked After Children Policy.
- The CIC health team have identified a number of priority areas in their work plan for development for the year ahead including; weight management, review of response to UASC, care leavers and young people impacted by complex safeguarding concerns.

9.23 **Trafford Children in Care Conclusion**

9.23.1 There has been a continued rise in the numbers of children and young people entering care in Trafford, which has had an impact on the service delivery within the CIC health team.

9.23.2 Children in care in Trafford continue to receive a service from a dedicated team of health professionals working to ensure their health needs are met to a high standard. This includes delivering a 'needs led' service to all children in care regardless of the placing LA.

9.23.3 2019-2020 has seen a continued commitment to the CIC health agenda across the Trafford health system at both operational and strategic levels.

9.23.4 The MFT Trafford CIC service will continue to work with relevant providers and commissioners in borough and across Greater Manchester in order to strengthen existing systems and pathways and strive to develop a service which makes a positive difference to children in care in Trafford.

9.23.5 The children in care health services in Trafford are under review in terms of capacity and demand. All partners will be updated with progress.

9.23.6 The latter part of the reporting period introduced unprecedented times for Trafford due to the Covid-19 pandemic. This has provided a significant challenge for both health and social care in ensuring that the physical and emotional health needs of children in care continue to be supported and managed as effectively as possible.

Appendix 1: Key Learning from Safeguarding Adult Reviews, Serious Case Reviews and Domestic Homicide Reviews published 2019/20 (Pseudonyms are used in the published reviews to protects the individual identity)

Local Authority	Type of Review Name	Context	Key Learning for the safeguarding partnership	Key Learning relevant to the Trust
Trafford				
Trafford	SAR Ruth	Ruth was 91 years old and lived with her son. She had a diagnosis of Dementia and had reduced mobility. Ruth died after developing a severe pressure ulcer and osteomyelitis. Ruth had been receiving care from her GP, District Nursing service and Domiciliary care. Shortly before her death Ruth was assessed by a Tissue Viability Nurse who arranged for urgent hospital admission and made an adult safeguarding referral due to concerns about her care, vulnerability and isolation. Following treatment Ruth was discharged from hospital with palliative care. Ruth died days later at home.	• Look at how to effectively identify and support vulnerable people in emergency situations alongside Resilience Forum. • Sharing of good practice in the recording of mental capacity assessments across partnership. • Need to consider more frequent multiagency/best interest meetings particularly when needs change. • There was an absence of escalation within multiagency partnership. • Ruth and her needs were not always central to multi-agency decision making.	• Need to better coordinate and review Pressure Ulcer services between agencies and ensure they are responsive to client need. • Staff trained and competent in management of pressure ulcers. Improved accountability process in tissue viability management. • Improved referral processes which combine incident reporting and safeguarding referrals which are shared timely with Adult Social Care where a patient is known to them. • Processes developed to ensure effective monitoring and review of outsourced medical equipment. • Improved safeguarding alert on electronic patient records and consideration of safeguarding with CHC fast track discharges. • Improvement in accuracy and completeness in record keeping through management led monthly and annual audits. • Improve communication within the multiagency team particularly where patient needs have changed.
Trafford	SAR John	"John" has a diagnosis of learning disability and schizophrenia and had been residing in supported living accommodation with on-site 24 hour support for many years when a series of falls led to a number of hospital admissions across the North West during 2017. Following discharges from hospital to his supported living accommodation, John had further falls leading to re-admissions to hospital. John suffered serious injuries as a result of this series of falls	• Clarity is needed around the commissioning arrangements for in-hospital support by the patient's provider of care and support within the community. • Assurance is needed in respect of recognition when advocacy support is required and the availability of such advocacy support. • Patient passports should be initiated and maintained in respect of all adults with learning disabilities.	• Discharge planning was not well completed for the majority of John's hospital admissions across the North West. Risks were not fully assessed and so he was discharged without any appropriate management plans. • Consideration should be given to the impact of medication on falls risks. It is known that people with learning disabilities are at risk of over medication and so regular reviews should be carried out. • Action is required to improve the application of the Mental Capacity Act.

			• Agencies must ensure that reasonable adjustments are made for people with learning disabilities.	• Deprivation of Liberty Safeguards must be appropriately applied within hospital trusts. • Good practice was noted in the care received whilst in Trafford Hospital, both around the joint working with John's community support workers and in the discharge planning.
Trafford	Baby X Serious Case Review	The Baby X Serious Case Review (SCR) is a review of the life of a 17 week old baby, who died of as a result of multiple location subdural haemorrhage and significant widespread brain damage. With no history of trauma, the injuries were consistent with Baby X being shaken. A criminal investigation was conducted and charges were brought against Father of Baby X (FX) in respect of these injuries. FX pleaded guilty to Manslaughter for which he received a 17 year custodial sentence with 2 year sentence to run consecutively for Coercive and Controlling Behaviour. There was a history of domestic abuse in the family, both prior to and following the birth of Baby X.	• That the Partnership prioritises a refresh and update of the multi-agency Domestic Abuse Policy and Guidance. • That the Partnership, in consultation with Community Safety Partnership undertake a sufficiency review of domestic abuse services including a focus on early help services. • That the Partnership, along with Public Health, undertake a joint strategy to raise an awareness and reduce risk from Abusive Head Trauma. • That the Partnership give consideration to upskilling professionals with critical thinking skills.	• To review the effectiveness of the approach to routine questioning about domestic abuse and how the approach can be strengthened to connect better with victims and perpetrators of domestic abuse. • To review how effectively risks of abusive head trauma are shared with parents. An invigorated approach to the education of professionals and the public should be taken to reduce risk of fatal and non-fatal injuries
Stockport				
Stockport	SCR Child M	Child M had been known to St Mary's neonatal unit before being discharged home to the community. Child M sadly died in the community and the review was commenced due to concerns around maternal neglect.	• Front line practitioners to consider the impact of the experience on babies and parents/carers of a newborn being a patient in Neonatal Care • Importance of timely information sharing and relevant knowledge of family history across and within health care services to inform understanding of risk • Agencies to consider using the Early Help Assessment as a means of supporting families who present with a child who has complex health care needs	• Neonatal units to be consider the impact on the family from babies being discharged from a Neonatal Unit who have complex needs and/or social care need. • To ensure that the current safe sleep advice is appropriate and includes the impact of alcohol consumption and smoking when caring for a young baby; and is effectively communicated to families.
Salford				
Salford	SCR	Baby MD's was the 5th child born to family with a context of parental mental ill health, parental substance misuse and domestic violence and abuse.	• To support the development of trauma informed practice. • To support safeguarding practice for complex families with multiple risk factors.	• To share multi agency learning.

		Baby MD died, aged 5 weeks, after being placed to sleep in parents' bed. Parents had consumed a significant amount of alcohol and there had been a domestic abuse incident prior to Baby MD's death.	• To ensure effective information sharing where families move across local authority boundaries.	
Tameside				
Tameside – Child Y	Multi-Agency Critical Review	• Child Y was 4 years old, removed from her mother's care and placed with father on a Care Order. • Safeguarding concerns from birth experiencing neglect, significant instability and loss and exposed to adults taking drugs and to violence. • Child Y lived with father and partner and several step siblings. • During father's partner pregnancy, Child Y returned to live with mother despite no assessments/approval taking place. • School reported safeguarding concerns during this time including bruises and scratches, foraging for food, falling asleep in class and absences. • Subsequent child protection medical identified 18 bruises to her face and body with the opinion that the majority were likely to be non-accidental.	• There was a lack of multi-agency working or co-ordinated plan that addressed the vulnerabilities of the placement or Child Y's emotional needs. • Partners did not understand the changing circumstances for Child Y and the impact that they were having. • Placement with parents must be better monitored and receive multi-agency support. • Pre-birth assessment work needs to be improved and involve partner agencies. • Professionals should understand the impact that parental substance misuse and neglect can have on children.	• Professionals need to be made aware of Our Children living at home to understand their role with respect to safeguarding, professional curiosity and the need to work in a co-ordinated way with multi-agency teams. • Professionals need to be aware of the Specialist Team for Our Children so that they know how to seek advice and guidance particularly when working with cross border agencies. • Professionals need to be aware of Our Children's journey through the looked after process in respect of assessments, statutory reviews and contacts to include their individual roles and responsibilities within the multi-agency partnership.
Bury				
Bury	SCR	Dina died in early 2019, aged 16 after taking her own life. The note Dina left indicated Dina had been troubled for several years, had a desire to end her life, had low self-esteem, concerns about academic achievements, relationships, body image and she referred to a relationship with a male person. Dina had 'been seeing an older man' in London with whom she had a sexual relationship with and she had taken drugs with him. Dina had been referred by the family to a local faith based counselling service and was seeing a private therapist. Safeguarding processes were initiated and followed including a police investigation.	Mental Health screening, cross border referral processes, clarity in documentation recording and plans. Suicide risks – contagion strategy, identification and response Child Sexual Exploitation and Complex Safeguarding. • Culturally appropriate practice and resources • Cross boundary working – health, education, police – local and national • Daily lived experience/child's views • Barriers to engagement and management of young people /parents/professionals.	• Record Keeping – multi-agency safeguarding process/documents, Strategy Meetings, Child in Need Meetings, chronologies, transfer of record process • Mental health need, assessments, plans and associated complex safeguarding needs • Cross Boundary communication, referral process, records • Training and supervision package updated – learning, escalation, step up and down plan re actions incomplete work • Clarity and timing of health assessments

				• A Chronology of Significant Events should be included in both the safeguarding and general record keeping audits.

Appendix 2: Safeguarding Training Delivered in 2019/20

Training Course	Learning Objectives	Number of Courses delivered	Number of Participants attending	Examples of feedback received following course completion demonstrating impact of course
Safeguarding				
Basic Information				
Volunteers induction	Safeguarding basic information	6	30	Feedback collected by volunteer coordinator so not held within SG.
Healthcare Support Workers	Face to face training overview of Safeguarding	1	10	Numerous questions through the presentation, good verbal feedback at the end of the session.
Bespoke safeguarding training to the University of Bolton Associate nurse students	To have an appreciation of adult safeguarding in context of their role	1	20	
Level 1				
NEDS – Board level safeguarding adults & children training	Safeguarding adults and children level 1 plus MFT specific themes and targets	1	8	"I thought your presentation was brilliant. You brought the subject to life and engaged in a way that involved us all. I hope you appreciated from our questions and interest that this is a subject close to all our hearts."
Domestic Abuse				
Domestic Abuse	• Understand how to identify domestic violence abuse and how to assess risk • Understand the impact of domestic violence and abuse on victims and their children. • Understand your role in relation to domestic abuse	52 DVA course aimed at all employees as a multi-disciplinary session. 3.5 hour session with additional sessions	707	• Course was the best I have been on, very informative and helpful • It was good to use the Risk Assessment • The course was really well presented and utilised a varied use of resources, learning methods which made it even more interesting. • Clearer understanding of effects and support available for victims • The Safe & Together information is really useful • Emphasis of non-blaming victims

	and know how to respond and refer in order to support victims and survivors	provided as requested to include: • A&E doctors on induction • Dentists on induction • Healthy Schools attendees (full day session provided) • Sexual Health Ace days • Emergency Nurse practitioners course • Safe & Together introduction for safeguarding staff and community team leaders. • New starters in A&E in Wythenshawe		• Will allow me to work more effectively with DV cases and support them. • Useful information about MARAC • Things to look out for with children • I was unaware of the term “ACES” and will research into this and share with colleagues • The role of the employer in supporting victims
Female Genital Mutilation (FGM)				
FGM	• To raise awareness and understanding about what is FGM • To enable staff to assess and manage health care needs • To ensure staff are aware of legal requirements	4	127+ bespoke session for School nurses 36 attended	• Greater understanding of FGM and how widespread it is, the importance of being able to identify and refer to appropriate agencies • Has highlighted my awareness of the group of patients at risk of FGM • I now know about different types of FGM • What to look out for when speaking to a child, who may be at risk of being taken abroad for FGM • Legal obligation to report a child who has had FGM

	around mandatory reporting and recording of FGM • To safeguard women and girls at risk of FGM. **Audience** Training open to all staff but is particularly relevant to midwives, health visitors, school nurses, paediatric staff, staff working in urology, sexual health and GUM, gynaecology.			• How to find a risk assessment • Following the policy and using pathways • Knowing who and where the correct people are to report to and knowing help and support is available from safeguarding • I feel more confident discussing with patients and supporting families • I will share this with my team • Gives an insight into cultural issues. • I don't think any changes need to be made, brilliant course.
Forced Marriage and Honour Based Violence				
Forced Marriage and Honour Based Violence (delivered to University, MSP and MFT staff, also to SW North Manchester)	• To have an understanding of the issues related to forced marriages& honour based violence • To recognise the triggers relating to FM/HBV • Be clear about your role and responsibilities of those requiring safeguarding • Understand what to do when you have concerns about a person at risk of forced marriage or honour based violence • Understanding the policy and procedures in place and agencies available to support professionals and potential victims/victims of forced marriage and honour based violence.	4	156	• I thought the whole course was excellent. It was very emotional; however, the trainer delivered the training in a fantastic way. I felt as though I came away from the training with a better understanding of forced marriage, and honour based violence, I then spent the entire weekend watching documentaries and researching about it, as it had really touched me. • There was a range of discussions, video's, group work, and lecturing, which I thought was a fantastic way to keep us all engaged. I could also tell that the trainer was passionate about the subject, and appeared very knowledgeable about the subject. • Really found interesting the indicators but also the real life stories that brought the training to life. The trainer was extremely knowledgeable about the topic. • I absolutely loved this course and have highly recommended to other colleagues to sign up for it next time it is on offer. • Although I have a lot of knowledge and am very familiar with this subject, I attended to see if there were any changes, we worked in line with MCC standards etc. and learn and share best practice. I found the course very informative, it was interactive and there were

				some really good case studies. I thought that the facilitators were great especially as they work in this field rather than generic trainers.
Complex Safeguarding				
Child Sexual Exploitation				
Child Sexual Exploitation	• To clearly define Child Sexual Exploitation • To consider the prevalence of CSE and who is at risk • To gain an understanding of different models of CSE and the grooming process • To consider who perpetrates CSE • To consider possible indicators of CSE • To gain an understanding of how to respond to possible CSE and how to work with victims • To consider the work of partner agencies around CSE.	8 (Including 1 briefing session)	126	• It was an interactive session which kept everyone engaged. Also it was practical so could easily be applied in practice • Instructor was very knowledgeable and interactive • I felt very well informed after the course. It was clear the teacher had a lot of knowledge on this subject and the stories that were told helped to put it into context • Great group work • Videos were very good • Would recommend to others
Modern Slavery and Human Trafficking				
Modern Slavery and Human Trafficking	• Raising awareness of HT and MDS. • Providing updates on the relevant legislations • Health professional's role if they suspect or encounter HT or MDS. • Know who to contact and how to make a referral to	12	135	• Fantastic insight in to this topic. • Highlighted gaps in my knowledge and made my think about my practice. • Trainers had a sound knowledge of the topic and this session has given me a better understanding of this complex topic. • More staff need to attend this training. • This training made me more empathetic. • This training was well thought out and the trainers kept the large attending engaged for the whole session.

	support a victim of HT or MDS			
Adults Safeguarding				
Referral Process Training				
Safeguarding investigation and referral process/recognising changes in behaviour and management strategies	• Recognising changes in behaviour and management strategies	2 Workshop/ discussion Format at ward level ACE day	26	• Good interaction & feedback on the day. • Good feedback – they requested that we return to provide further training
Deprivation of Liberty Safeguards Training				
Safeguarding and DoLS new referral process training	How to make safeguarding and DoLS referrals via the Ulysses Incident Reporting System – training for key staff in each area for dissemination to their teams.	38	60	Positive feedback received around new process. “I feel I need to tell you that the new way of submitting DOLS has changed my life! Your hard work has paid off.”
DoLS portal training	To be able to use the DoLS portal to apply for a DoLS	8	10	Good feedback on the day. Obvious increase of DoLS from their area of work
Mental Capacity Act				
Mental Capacity Assessments Documentation	Recording capacity assessments on EPR Awareness Training	2	42	Positive feedback received around new process
Safeguarding Children’s Training				
Aspects of Documentation				

Aspects of Documentation	• To enable health professionals to complete analytical holistic child focused reports to contribute to multi-agency safeguarding children procedures.	2	18	New package was developed for 19-20 following previous feedback. The session was adjusted to a half-day session with a case study running through the training to allow for completing paperwork from an early help level through the whole child protection process up to court report. This also includes electronic records and health and impact chronologies.
	• To have a basic understanding of the signs of safety model. • To have an understanding of the process around effective, analytical record and report writing. • To know where to access resources and support.			It was a great session; I think the mix of group work and slides worked well. 10 of the feedback forms commented on the case study aspect working well. It was noted to make it feel like a real family staff work with every day. The training gave knowledge and advice, giving real life experience of cases.
Neglect in Children - Graded Care Profile 2 (GCP2)				

Graded Care Profile 2	This training is aimed at children's community and acute health staff to support their practice in assessing levels of Neglect in families and assess what level of support is required to improve children and young people lived experiences. What is Neglect? Child development and how it can be affected by Neglect. Graded care profile 2 assessments and its completion. Resources and support available. To become licensed to be a lead professional in completing the assessment tool.	13 Completed a number of awareness sessions as well with VSCT, SALT, acute, LAC and adult community	188 Awareness session participants not included in the numbers	• All participants had increased their knowledge of the tool and felt more confident to use it. • Some small groups were done and those participants liked that as felt they were more confident to ask questions. • Felt trainers had very good knowledge of the subject. • Adult services who attended felt it was beneficial to see how their information could feed into the assessment. • Liked the case study and that the trainers gave examples from different age groups from practice,
Family Court Statement				
Family court statement	• Discuss how the legal provision is implemented • Provide developments in court statement writing • Share good practice in statement / report writing • Promote confidence in the process of completion of report writing • Extend the principles • Provide an update on legal provision with regards to children	2	29	• Clear concise training. • This training is a must for my colleagues in health visiting. • Very good content which almost made me look forward to completing a court report. • This training was worth taking the time out of my busy to attend. My many questions were answered and I now feel confident in completing a report for legal services.

APPENDIX 3 – 2019-2020 Safeguarding Audit Calendar

Safeguarding Audit Calendar 2019/2020							
Title	**Lead**	**Time Frame**	**Strategic Links**	**Assurance**	**Progress with audit**	**Assurance**	**RAG**

Audit to benchmark staff awareness of LAC requirements in practice.	LAC Team	Quarter 1	• LAC Statutory Guidance • Section 11 Audit • Trust policy • Trust Safeguarding and Record keeping policy • MSP procedures • Corporate Parenting Board	Trust Safeguarding Committee Quality and Learning Sub Group Looked After Children Sub Group	Review has been commenced by Looked After Children Team. The survey monkey has been completed –the responses are currently being reviewed and analysed with a full report being completed in Q1.		
Quality Assurance of Referrals to Children's Services	Community/Acute Safeguarding Children teams	Quarter 1	• Statutory Guidance • Trust policy • MSP procedures • Section 11 Audit	Trust Safeguarding Committee Quality and Learning Sub Group	Dip sampling of health referrals into the locality Advice and Guidance Service is now completed monthly by the Specialist Health Visitor in the Advice and Guidance Service with key messages shared to MFT services.	The regular reviews identify that staff are making referrals to Manchester Children's Services although they are not consistently using the telephone advice service recommended by Children's Social Care with 40% of referrals being written referrals Analysis of referrals made identify health professionals are responding to children and families who requiring additional support but 40% of the referrals reviewed could have been directed to early help as they did not meet threshold of statutory social work intervention.	
Title	**Lead**	**Time Frame**	**Strategic Links**	**Assurance**	**Progress with audit**	**Assurance**	**RAG**

Mental Capacity Act (MCA) Staff Awareness and MCA Case Note Review	Safeguarding Adult/Mental Health Teams	Quarter 1	• Statutory Guidance • MSAB Assurance • Trust policy • Trust Safeguarding and Record keeping policy • MSAB procedures	Trust Safeguarding Group Safeguarding Committee Quality and Learning Sub Group	Audit of Mental Capacity Assessments completed in Wythenshawe, Trafford, Withington and Altrincham sites and outcome reported to WTWA Patient Safety Committee and Quality and Learning Committee. Audit of quality of documentation of Mental Capacity Assessments completed at Oxford site in Quarter 4 and reported to Quality and Learning Committee in March 2020	WTWA The audit indicated that the documentation available does not provide assurance that care decisions are made in line with the requirements of Mental Capacity Act, recommendations from the audit include attendance by appropriately mapped staff to Level 3 Adult Safeguarding Training and re audit in 12 months. ORC audit did not provide assurance on the quality of documentation of mental capacity assessments and further work is required through the audit action plan The action plan will increase the knowledge and skills of MFT staff to ensure that patients are safeguarded with specific regard to the application of their Human Rights (Article 5 Right to Liberty) and the decision making processes in respect of all aspects of care and treatment. It will provide assurance to the commissioner's that as an organisation MFT is compliant with The Mental Capacity Act (2005) and the application of a Deprivation of Liberty Safeguards.	
Title	**Lead**	**Time Frame**	**Strategic Links**	**Assurance**	**Progress with audit**	**Assurance**	**RAG**

Making Safeguarding Personal	Community/Acute Safeguarding teams	Quarter 2	• Statutory Guidance • MSAB Assurance • Trust policy • MSAB procedures	Trust Safeguarding Committee Quality and Learning Sub Group	This Audit has been delayed due to the Safeguarding Team awaiting an update and progress from the Manchester Safeguarding Board Making Safeguarding Personal Task and Finish Group. This audit will be reviewed in 2020/21 and the voice of the adult will be considered in the context of safeguarding adult referrals.		
Strategy Meeting Audit	Wythenshawe Hospital	Quarter 1 and 2	• Statutory Guidance • MSP Assurance • Trust policy • Trust Safeguarding and Record keeping policy • MSP procedures	Trust Safeguarding Committee Quality and Learning Sub Group	In response to an action plan from a root cause analysis an audit has been completed of the contribution of Trust staff at child protection strategy meetings at Wythenshawe Hospital.	The audit identified good representation of paediatric consultants, safeguarding nurses and ward staff to strategy meetings with limited contribution from community health staff based off site.	

Title	Lead	Time Frame	Strategic Links	Assurance	Progress with audit	Assurance	RAG
EMIS Electronic Patient Record Keeping Review of Child Protection Case Conference information on Manchester Community Child Health Records	Children's Community Safeguarding Team	Quarter 3	• Statutory Guidance • MSP Assurance • Trust policy • Trust Safeguarding and Record keeping policy • MSP procedures	Quality and Learning Group Children's EPR steering Group	The electronic patient record (EPR) was implemented to health visiting and school health practice within Manchester University Hospitals Foundation Trust in January 2018. This is the third safeguarding children record keeping reviews undertaken to review impact of implementation of EPR on recording child protection case conference activity in child health records.	The audit identified that in the majority of records the health professional saved the child protection documentation, updated the child's chronology of significant events and saved their case conference report indicating their contribution to conference. Further development is required to ensure health professionals file copies of the final minutes from child protection conferences. The record keeping audit needs to be reviewed in 2020 to ensure that health professional's contribution to child protection conferences is clearly documented.	
Safeguarding Supervision Review	Community/Acute Safeguarding Children teams	Quarter 4	• Statutory Guidance • Trust policy • Section 11 Audit • MSCB procedures	Trust Safeguarding Committee Quality and Learning Sub Group	The audit has been agreed by the audit team who are supporting with the design and report. The survey tool has been developed and will be commenced in Q1 2020/21		
Re-Audit MARAC/ DASH process	Community / Acute Safeguarding teams		• Statutory Guidance • Section 11 Audit • Trust policy • Trust Safeguarding and Record keeping policy • MSP procedures		The audit has been commenced, documentation reviewed against expected standards with a plan for the audit to be reported in Q1 2020/21		

Title	Lead	Time Frame	Strategic Links	Assurance	Progress with audit	Assurance	RAG
Review of Child protection medicals at Wythenshawe Hospital	Named Doctor Wythenshawe	Quarter 4	• Statutory Guidance • Section 11 Audit • Trust policy • MSP procedures	Trust Safeguarding Committee Quality and Learning Sub Group	The audit reviewed child protection medicals in 2018-19.	There was an increase in the number of medicals (54) completed. The majority were children less than 18 month's old living in Manchester and Trafford. 52% were completed out of hours. There was an increase in the number of children not discharged home but to an alternative care indicating the level of safeguarding concern. The audit identified that child protection medicals were being completed as per expected practice	
Child Protection documentation Audit	Named Doctor Wythenshawe	Quarter 3	• Statutory Guidance • Section 11 Audit • Trust policy • MSP procedures	Trust Safeguarding Committee Quality and Learning Sub Group	There was a retrospective review of the case notes of the identified cases for the year 1st April 2018-31st March 2019 to audit the information documented on the child protection proformas.	The audit identified that the child protection proforma is used and is completed well. The documentation is of a high standard. Action: a) To ensure a 'time slot' for the Named Doctor at SpR induction to discuss child protection procedures and issues raised in this audit, especially about need to copy report to health visitor/school nurse and the expected time scale to get reports completed by. b) Following a serious incident, part of the action plan was to have the same Child Protection Medical Pro forma throughout MFT. Since September 2019 the RMCH pro forma has been adopted, with local Wythenshawe adaptations (see attachment). The pro forma includes a form to complete for an Immediate Summary for CSC. The pack continues to include Guidance on Report Writing. c) To re audit in a year.	

There will also be a requirement to undertake audit throughout the year in response to Serious Case Reviews (SCRs)/Domestic Homicide Reviews (DHRs) and High Level Investigations (HLIs) therefore there will be flexibility and capacity within the calendar to achieve this.

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 MSP	MFT lead	Complete
Joint MSCB / MSAB theme: **Mental Capacity Act Assessment**	23 October 2019	8th November 2019	Audits have been completed and returned to MSP but the Trust is awaiting the partnership review of the completed audit.	tbc	Named Nurses and Midwives	
Joint MSCB / MSAB theme: **Transition – CAMHS to Adult Services** **Audit not yet commenced by MSP**	21 June 2019	19th July 2019	11 September 2019 tbc	tbc	Named Nurses	
MSCB theme: **Looked After Children (placed at home)** **Audit not yet commenced by MSP**	20 September 2019	18 October 2019	11 December 2019 tbc	tbc	Named Nurse Looked After Children	

APPENDIX 4 – 2019/2020 Safeguarding Work Plan

Safeguarding Work Plan 2019/20

Name of Hospital/MCS/MLCO	Corporate Safeguarding Work plan
Director of Nursing	Completed by R Speight Head of Nursing Safeguarding in collaboration with Named Nurses Safeguarding

Hospitals/MCS Responsibilities

This is your Hospital/MCS/MLCO Safeguarding Work plan, the Assurance and examples of evidence are a guide. If you have different or additional evidence that is specific to your Hospital/MCS/MLCO, please add this and include the related actions in your work plan.

Hospitals/MCS/MLCO are required to provide evidence and assurance that they comply with or are working towards compliance in the areas highlighted below. It is important to be able to demonstrate that processes for safeguarding adults and children are in place across the Hospitals/MCS/MLCO and there is a clear line of accountability from senior managers and clinicians to frontline staff. Evidence should provide assurance that all staff are aware of their role and responsibility relating to safeguarding.

Adult Safeguarding								
Underpinned by the 6 principles of the Care Act 2014 along with CQC Regulation 13 requirements. Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability								
Objective 1	**Keeping people safe** There are systems and processes in place to enable staff to recognise and respond to the needs of adults at risk adults to safeguard them from abuse and neglect.							
Assurance						**Examples of Evidence**		
• Staff can Identify, assess and provide support and onward referral of any concerns. • Categories of abuse are understood and applied. • Staff know who to contact to seek support internally and externally. • Safeguarding information, policies and procedures are disseminated to all frontline staff. • Documentation of safeguarding risk assessment and actions taken is evident in nursing and medical records. • All staff understand the referral processes to adult social care and these are easily accessed by frontline staff. • Staff understand and recognise vulnerability in adults for example; radicalisation, mental health, early help.						• Number of safeguarding referrals. • Number of incident reports. • Evidence of processes in place to share safeguarding information within the Hospitals/MCS. • Evidence of sharing of information with frontline staff. • Monitoring of record keeping.		
Actions /Evidence								
Q1	**RAG**	**Q2**	**RAG**	**Q3**	**RAG**	**Q4**	**RAG**	
There are robust processes in places for trust wide staff to report concerns to the safeguarding team for advice and guidance. There is a Safeguarding Adult at Risk Policy. Named Nurse Adult Safeguarding has contributed to the development of Self Neglect and Hoarding Strategy and toolkit.		In Quarter 2 Named Nurse Safeguarding Adult was involved in the Manchester Safeguarding Adult Board launch of the Self Neglect and Hoarding Strategy		There are robust processes in places for trust wide staff to report concerns to the safeguarding team for advice and guidance. There is a Safeguarding Adult at Risk Policy. All Safeguarding incidents continue to be reviewed by the safeguarding team on a daily basis.		There are robust processes in places for trust wide staff to report concerns to the safeguarding team for advice and guidance. There is a Safeguarding Adult at Risk Policy. All Safeguarding incidents continue to be reviewed by the safeguarding team on a daily basis. All policies have been reviewed within timescales.		
Ulysses system is being used at WTWA to report safeguarding incidents, complete DoLS applications and is being introduced to support safeguarding referrals to the Local Authority.		The Ulysses system rolls out has progressed across WTWA in Quarter 2 and will be launched across Oxford Road in Quarter 3.		The Ulysses system has been implemented for referrals to the safeguarding team and to support referrals to the LA		The Ulysses system has been implemented for referrals to the safeguarding team and to support referrals to the LA		

There is an ongoing plan to roll out this system of reporting across the trust in 2019/20							

Objective 2	**Training** Training is accessed by all staff in accordance with their role and competency requirement as per Intercollegiate Guidance requirements (2018) and the Care Act 2014.

Assurance	Examples of Evidence
• All staff have received level 1 safeguarding training as part of induction. • Staff have been aligned to appropriate training for their role and responsibility. • Process in place for monitoring compliance at Hospitals/MCS level. • Evidence of up to date training records for the Hospitals/MCS including compliance. • The 6 principles outlined in the Care Act are understood. • Hospitals/MCSs keep and monitor their own training records and this is monitored through Hospitals/MCS safeguarding meetings.	• Training compliance figures. • Competency requirements have been assessed. • Evidence of management oversight of attendance at training.

Actions/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
The level 1 and 2 Adult Safeguarding e learning was updated prior to roll out in April 2020. The Safeguarding team continue to support the hospital safeguarding governance groups. Safeguarding team continue to have capacity in Safeguarding Training to support Training requirements offering 270 training places monthly. The safeguarding team review monthly and report quarterly on safeguarding training compliance		The Adult Safeguarding team continue to prioritise the delivery of safeguarding training, In Quarter 2 834 places were available for Adult Safeguarding Level 3 training and 578 staff attended. 2,166 staff have been targeted to attend the training in Year one and the Safeguarding team had capacity in the training places this quarter to achieve compliance.		Safeguarding Training continues to be delivered by e learning for Level 1 and 2 and by face to face training for Level 3. Level 1 Safeguarding training compliance for Adult Safeguarding training is at expected levels for Level 1 (91.18%) Level 2 Safeguarding Adult training is at 84.68% compliance Level 3 Face to face safeguarding adult training has now increased significantly to 64.3% compliance. The safeguarding team continue to ensure there is enough capacity in training places to meet demand to achieve compliance.		Safeguarding Training continues to be delivered by e learning for Level 1 and 2 and by face to face training for Level 3. Level 1 Safeguarding training compliance for Adult Safeguarding training is at expected levels for Level 1 (91.1%) Level 2 Safeguarding Adult training is at 86.77% compliance Level 3 Face to face safeguarding adult training has now increased significantly to 73.22% compliance. The safeguarding team continue to ensure there is enough capacity in training places to meet demand to achieve compliance.	

Objective 3	**Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)** All relevant members of staff understand and apply principles of the Mental Capacity Act 2005 in all areas of care. There is clear understanding and oversight of Deprivation of Liberty Safeguards.

Assurance	Examples of Evidence
• Staff attend adult safeguarding training as applicable to their role and responsibility. • Best interest process is followed when a person lacks mental capacity to consent to their care or treatment, including the use of Deprivation of Liberty Safeguards, where appropriate. • Monitoring and management of DoLS applications. • Local records kept. • Incident report generated when a DoLS application is submitted to the Local Authority • Process to monitor the quality of MCA assessments and documentation as per requirements **(CQC inspection action).**	• Local training records. • Use of DoLS portal or evidence of DoLS application • Incident reporting. • Audits. • Risk register.

Action/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
MCA and DOLS training is provided as part of the Level 3 Safeguarding Adult Training package delivered monthly at Wythenshawe and Oxford Road sites and quarterly at Trafford.		MCA and DOLS training is provided as part of the Level 3 Safeguarding Adult Training package delivered monthly at Wythenshawe and Oxford Road sites and quarterly at Trafford.		MCA and DOLS training is provided as part of the Level 3 Safeguarding Adult Training package delivered monthly at Wythenshawe and Oxford Road sites and quarterly at Trafford. All Adult Safeguarding and Mental Health Safeguarding Nurses have been allocated a place on the Metropolitan University of Manchester Best Interests Assessors Course Commencing in January 2020.		MCA and DOLS training is provided as part of the Level 3 Safeguarding Adult Training package delivered monthly at Wythenshawe and Oxford Road sites and quarterly at Trafford. Adult and Children's Safeguarding Nurses and Midwives and Mental Health Safeguarding Nurses have attended the Metropolitan University of Manchester Best Interests Assessors Course This has increased the teams knowledge in application of the Mental Capacity Act and DoLs process	

MCA audit has been completed at WTWA and is being completed at Oxford Road Sites in Q2. There is still continued training and awareness required across the trust to ensure that frontline staff document all mental capacity assessments.		MCA audit has been carried out in the Oxford Road Site in Q2 and a report of the audit is expected in Q3. The Safeguarding Team as part of the Manchester Safeguarding Partnership Joint Quality Assurance Sub Group have contributed to a Multi-Agency MCA audit tool which will be used for a multi-agency audit in Q3.		The safeguarding team have ensured the Trust has contributed appropriately to the Manchester multi-agency mental capacity audit. An internal mental capacity audit is being completed and will be reported on in Q4.		MCA audit of the documentation of the quality of mental capacity assessments completed at the Oxford Road Campus for a sample of patients subject to deprivation of liberty safeguards has been completed. The audit identified the requirement for further action plan to improve the quality of documentation of mental capacity assessments	
The new amendments bill for the Mental Capacity Act (MCA) 2005 in respect of replacing Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS) was agreed in parliament and a report prepared for Group Safeguarding Committee.		The Safeguarding Team have scoped and accessed initial training required in order to prepare the Trust for implementation of Liberty Protection Safeguards in 2020.		The Safeguarding Mental Health Lead Nurse will lead the implementation plan on Liberty Protection Safeguards across the Trust. National statutory guidance is awaited to inform the implementation plan, the current implementation date is October 2020		The Safeguarding Mental Health Lead Nurse will lead the implementation plan on Liberty Protection Safeguards across the Trust. National statutory guidance is awaited to inform the implementation plan, the current implementation date is October 2020 The safeguarding team are cognisant and up to date with training and guidance provided to date regarding LPS.	
The Ulysses system is being used to report Deprivation of Liberty Safeguards (DoLS) at WTWA site and will be implemented across MFT this year to report on DoLS and support Safeguarding Referrals		The Ulysses system is being used to report DoLS at WTWA site and the DoLS portal is used at ORC. The Ulysses system will be implemented this year as a harmonised method to report Deprivation of Liberty Safeguards.		The Ulysses system is being used to report Deprivation of Liberty Safeguards at WTWA site and the DoLS portal is used at ORC. The roll out of Ulysses in ORC is supporting safeguarding referrals and the DoLS portal remains in use		The Ulysses system is being used to report DoLS at WTWA site and the DoLS portal is used at ORC. The roll out of Ulysses in ORC is supporting safeguarding referrals and the DoLS portal remains in use. The safeguarding team have oversight of the DoLs applications made by the Trust	

Generic Safeguarding Responsibilities	
Objective 4	**Raising Concerns/Managing Allegations** There is a culture whereby patients and relatives can raise concerns and they will be listened to and safeguarding is made personal If an allegation is made against a member of staff, all staff involved are aware of the processes to be followed.

Assurance	Examples of Evidence
• Process in place for managing an allegation or concern. • If an allegation is substantiated, there is a process to ensure the abuse is not repeated. • Procedures to follow if the victim is a child including the role of the Designated Officer in the local authority • Processes in place to ensure safeguarding adults allegations are shared with the Local Authority Person's in Position of Trust process • Policies in line with the Manchester Safeguarding Multi Agency Arrangements for dealing with allegations against people who work with children. • Policies disseminated and understood by all staff. • Key staff in the Hospitals/MCS have attended Managing Allegations training.	• Attendance at training. • Internal processes. • Incident reporting. • Notifications/consultations with safeguarding team • Lessons learnt embedded in practice.

Action /Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
The safeguarding Team support all hospital and community staff with regard to concerns around Managing Safeguarding Allegations. The Managing Allegations Against MFT Staff who work with children and adults at risk has been updated. Safeguarding Named Nurses have attended Manchester Safeguarding Board Managing Allegations Training. The Safeguarding Managing Allegations policy has been reviewed and the new policy uploaded to the intranet.		The Safeguarding Team have updated the Managing Safeguarding Allegations Training in line with the updated policy. Trust wide Managing Safeguarding Allegations Training will be available booked via the Learning Hub. The Support for Staff in relation to Domestic Abuse has been reviewed and updated by the Safeguarding Team and Human Resources.		The Managing Safeguarding Allegations policy is available on the intranet. Trust wide Managing Safeguarding Allegations Training is available and can be booked via the Learning Hub. The support for staff in relation to Domestic Abuse has been reviewed and updated by the Safeguarding Team and Human Resources.		There was a date set on 26.03.2020 to complete Managing Allegations training but unfortunately this was cancelled due to Covid-19. The plan is to book a quarterly training session in September, December and March 2021 The support for staff in relation to Domestic Abuse has been reviewed and updated by the Safeguarding Team and Human Resources.	

Objective 5	**Accountability/Accessing information /Documentation** Management oversight and ownership of safeguarding in the Hospitals/MCS. Frontline staff aware of their role responsibility and accountability and where to access appropriate information Staff adhere to Trust, legal and Professional Body documentation requirements.

Assurance	Examples of Evidence
• Information is shared across the Trust and disseminated across Hospitals/MCSs. • Managers understand their individual responsibilities for safeguarding. • Evidence that information from the Trust Safeguarding Group on any national and local changes to safeguarding arrangements is disseminated via the Hospitals/MCS Safeguarding meeting to frontline staff. • Evidence of management support to ensure that all staff are aware of their statutory requirement to participate in Safeguarding Adult Reviews, Serious Case Reviews and Domestic Homicide Reviews. • Staff know where to access relevant information and support around recognising and reporting abuse and the choices available to them to ensure their own safety. • There is evidence that risks, concerns, actions and outcomes are documented in clinical records when a child or adult at risk is identified, in line with Trust and professional body requirements.	• Safeguarding newsletter. • Minutes of meetings. • Staff participation in reviews. • Any changes to practice and/or recommendations relating to SCRs or SARs are implemented and a Hospitals/MCS process in place for sharing learning. • Hospitals/MCS assurance processes regarding documentation including audit.

Action/ Evidence							
Q1	**RAG**	**Q2**	**RAG**	**Q3**	**RAG**	**Q4**	**RAG**
The Safeguarding team support the safeguarding governance groups across the trust. The Safeguarding team produce the Safeguarding Newsletter, support the Link Nurse/Champion Meetings and deliver Safeguarding Training to ensure frontline staff are aware of safeguarding roles and responsibilities across the trust.		The Safeguarding team support the safeguarding governance groups across the trust. The Safeguarding team produce the Safeguarding Newsletter, support the Link Nurse/Champion Meetings and deliver Safeguarding Training to ensure frontline staff are aware of safeguarding roles and responsibilities across the trust. In Quarter 2 the Safeguarding Services have reviewed the Information Sharing Confidentiality Agreement with Adult MASH to ensure safe and effective sharing of Trust information in the Adult MASH.		The Safeguarding team support the safeguarding governance groups across the trust. The Safeguarding team produce the Safeguarding Newsletter, coordinate and support the Link Nurse/Champion Meetings and deliver Safeguarding Training to ensure frontline staff are aware of safeguarding roles and responsibilities across the trust.		The Safeguarding team support the safeguarding governance groups across the trust. The Safeguarding team produce the Safeguarding Newsletter, coordinate and support the Link Nurse/Champion Meetings and deliver Safeguarding Training to ensure frontline staff are aware of safeguarding roles and responsibilities across the trust. There is a process in place to ensure that the Safeguarding Champion meeting key points are disseminated shared within the MLCO and those messages are copied to the Lead Nurse/ Managers In Q4 the safeguarding website has been reviewed and updated to provide a single safeguarding website across the Trust footprint.	

						Due to the impact of COVID 19 and the importance of maintaining essential safeguarding at a time of operational and organisational change the safeguarding team have been producing COVID 19 safeguarding newsletters to update services on the impact of the pandemic on safeguarding legislation, arrangements, policy and practice. In the MLCO a document has been provided to update staff of key contact information and messages from Serious Case and Learning Reviews. This has been circulated via MLCO safeguarding meetings and the Link Nurses/Champion meeting	
The Safeguarding Team have developed a CQC preparation safeguarding assurance tool to be piloted across the Trust. ORC Safeguarding Children Team have piloted the Safeguarding Assurance questionnaire with Ward Managers and the Safeguarding Specialist Nurse allocated to the area to benchmark current safeguarding practice and inform further development.		The Safeguarding team have piloted the tool in the Trust and this will be used across the Trust commencing in Quarter 3 as part of the CQC action plan.		Assurance visit process to frontline areas was established and implemented with assurance visits being completed to MRI and WTWA. Feedback has been shared with ward areas and the safeguarding governance groups in each area		A number of Assurance visits completed including RMCH, RMEH and St Mary's Hospital	

Objective 6	**Partnership / Information Sharing** Staff work with other agencies to ensure the safety and protection of adults and children at risk.

Assurance	Examples of Evidence
• Evidence of partnership with other agencies to contribute to safeguarding assessments and plans for adults and children at risk. • Information is shared with other agencies and frontline staff are aware of these processes and their role and responsibility. • Information is shared appropriately and timely on a need to know basis and there is a process via handover to ensure all staff are kept up to date of actions taken to safeguard vulnerable adults and children.	• Contribution to multi-agency safeguarding investigations. • Examples of good working practices and liaison. • Examples of information sharing that contributed to good outcomes of adults and children at risk or who are vulnerable.

Action/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
The Safeguarding team ensure that there is representation at all appropriate Manchester and Trafford Strategic Safeguarding Groups, Domestic Abuse Strategic groups and Looked After Children partnership groups. Key messages from these partnership groups are shared with Trust wide safeguarding governance groups The Safeguarding Team ensure representation at multi-agency Missing from home, Domestic Abuse MARAC, CSE and FII meetings.		The Safeguarding team ensure that there is representation at all appropriate Manchester and Trafford Strategic Safeguarding Groups, Domestic Abuse Strategic groups and Looked After Children partnership groups. The Assistant Chief Nurse Safeguarding is contributing to the Strategic Group to implement the new Manchester Safeguarding Partnership, Manchester Multi Agency Safeguarding Arrangements. Key messages from these partnership groups are shared with Trust wide safeguarding governance groups		The Safeguarding team ensure that there is representation at all appropriate Manchester and Trafford Strategic Safeguarding Groups, Domestic Abuse Strategic groups and Looked After Children partnership groups. The Assistant Chief Nurse and Head of Nursing Safeguarding are ensuring that the Trust is represented across all the groups in the newly developing Manchester and Trafford Strategic partnership arrangements.		The Safeguarding team ensure that there is representation at all appropriate Manchester and Trafford Strategic Safeguarding Groups, Domestic Abuse Strategic groups and Looked After Children partnership groups. Manchester locality partnership work includes: Babies at Risk of Harm group, Early Help/ Early Years Task and Finish Group focusing on Tobacco Free Families which links with the learning from Serious Case Reviews and Learning Reviews The safeguarding team are currently supporting to the Child Safeguarding Practice review process in reviews being completed in Manchester, Salford and Bury, as well as Safeguarding Adult Reviews in Manchester and Trafford.	

The Safeguarding team are currently supporting Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR) in Manchester Trafford, Tameside, Bury, Salford, Stockport and Wigan Safeguarding Information and learning from the partnership is disseminated to staff via the Hospital Safeguarding Groups, The Safeguarding Newsletter, Link Nurse/Champion Meetings and Safeguarding Training. The Safeguarding Nurses attend SCR and SAR Learning Events and disseminate learning via the Hospital Safeguarding Groups,		The Safeguarding Team ensure representation at multi-agency Missing from home, Domestic Abuse MARAC, CSE and FII meetings. The Safeguarding team are currently supporting Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR) in Manchester Trafford, Tameside, Bury, Salford, Stockport and Wigan Safeguarding Information and learning from the partnership is disseminated to staff via the Hospital Safeguarding Groups, The Safeguarding Newsletter, Link Nurse/Champion Meetings and Safeguarding Training. The Community Children's Safeguarding Team have worked with Children's Services to maintain partnership working across the three Manchester Localities with the implementation of the three Manchester Advice and Guidance Hubs (AGS). There is actual and virtual presence of a Specialist Health Visitor in the AGS hubs.		The safeguarding team are currently supporting to the Child Safeguarding Practice review process in reviews being completed in Manchester, Salford, Tameside, Bury, Stockport and Trafford, as well as Safeguarding Adult Reviews in Manchester and Trafford. Key messages from these partnership groups are shared with Trust wide safeguarding governance groups Safeguarding Information and learning from the partnership is disseminated to staff via the Hospital Safeguarding Groups, The Safeguarding Newsletter, Link Nurse/Champion Meetings and Safeguarding Training. The Community Children's Safeguarding Team have worked with Children's Services to maintain partnership working across the three Manchester Localities with the implementation of the three Manchester Advice and Guidance Hubs (AGS). There is actual and virtual presence of a Specialist Health Visitor in the AGS hubs.		Since mid- March meetings if they are held are virtual due to covid-19 Safeguarding Information and learning from the partnership is disseminated to staff via the Hospital Safeguarding Groups, The Safeguarding Newsletter, Link Nurse/Champion Meetings and Safeguarding Training. The Community Children's Safeguarding Team have worked with Children's Services to maintain partnership working across the three Manchester Localities with the implementation of the three Manchester Advice and Guidance Hubs (AGS). There is actual and virtual presence of a Specialist Health Visitor in the AGS hubs.	

Objective 7	**Complex and wider Safeguarding Agenda** Staff contribute to the wider safeguarding agenda and are aware of how to escalate concerns responding to the needs of vulnerable groups this includes – • Domestic Violence and Abuse (DV&A) • Child Sexual Exploitation (CSE) and Criminal Exploitation • Learning Disability • Safeguarding in response to Neglect/Self Neglect • Mental Health and Safeguarding • Forced Marriage & Honour Based Violence (FM & HBV) • Female Genital Mutilation (FGM) • Human Trafficking & Modern Slavery • Our Children (Looked After Children)

Assurance	Examples of Evidence
• Staff are supported to attend additional training to enhance understanding and practice. • Information is shared with frontline staff. • Mandatory reporting requirements are understood and followed (FGM, Human Trafficking). • The Hospitals/MCS has suitable representation on the Trust Safeguarding groups. • All Hospitals/MCS reps attend and feedback via the Hospitals/MCS safeguarding meetings. **Safeguarding Groups are as follows –** • Safeguarding Committee • Quality and Learning Group • Complex Safeguarding Group • Domestic Abuse and FGM sub-groups (combined) • Child Sexual Exploitation • Early Help and Neglect • Looked After Children Sub Group • Mental Health • Adults & Children's Acute and Community Safeguarding Champions meetings	• Engagement with Trust Safeguarding Groups and sub-groups. • Examples of dissemination of information. • Practice related evidence/case studies. • Champions in place. • Representative sat on Trust Sub-groups. • Evidence of information shared to frontline.

Action/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
The Safeguarding team continue to chair and lead the thematic safeguarding sub groups across the trust driving policy, training and practice across the trust.		The Safeguarding team continue to chair and lead the thematic safeguarding sub groups across the trust driving policy, training and practice across the trust.		The Safeguarding team continue to chair and lead the thematic safeguarding sub groups across the trust driving policy, training and practice across the trust.		The Safeguarding team continue to chair and lead the thematic safeguarding sub groups across the trust driving policy, training and practice across the trust.	

The Safeguarding team ensure representation across the partnership at thematic safeguarding strategic and operational safeguarding groups, including Complex Safeguarding Partnership and Operational Groups, Domestic Abuse and FGM Forums, MARAC and Missing from Home operational and strategic groups. The safeguarding team deliver bespoke thematic safeguarding training in DVA, CSE, Modern Slavery, Mental Health and FGM.		The Safeguarding team ensure representation across the partnership at thematic safeguarding strategic and operational safeguarding groups, including Complex Safeguarding Partnership and Operational Groups, Domestic Abuse and FGM Forums, MARAC and Missing from Home operational and strategic groups. The safeguarding team deliver bespoke thematic safeguarding training in DVA, CSE, Modern Slavery, Mental Health and FGM.		The Safeguarding team ensure representation across the partnership at thematic safeguarding strategic and operational safeguarding groups, including Complex Safeguarding Partnership and Operational Groups, Domestic Abuse and FGM Forums, MARAC and Missing from Home operational and strategic groups. The safeguarding team deliver bespoke thematic safeguarding training in DVA, CSE, Modern Slavery, Mental Health and FGM.		The Safeguarding team ensure representation across the partnership at thematic safeguarding strategic and operational safeguarding groups, including Complex Safeguarding Partnership and Operational Groups, Domestic Abuse and FGM Forums, MARAC and Missing from Home operational and strategic groups. The safeguarding team deliver bespoke thematic safeguarding training in DVA, CSE, Modern Slavery, Mental Health and FGM. The last partnership Complex Safeguarding subgroup was held as a virtual meeting due to covid-19 A Specialist Safeguarding Nurse has been identified to lead on safeguarding children with disabilities and contributing to the Trust Learning Disability sub-group. The plan is to devise a work plan in relation to children with disabilities and safeguarding	
CSE Specialist Nurse working within Complex Safeguarding Hub. The new Child Exploitation Risk Indicator Checklist has been agreed and included in the Child Sexual Exploitation Guidance		CSE nurse and wider Safeguarding Team contribute to multi-agency police lead operations regarding CSE and Child Criminal Exploitation (CCE) in Manchester		CSE nurse and wider Safeguarding Team contribute to multi-agency police lead operations regarding CSE and Child Criminal Exploitation (CCE) in Manchester		CSE nurse and wider Safeguarding Team contribute to multi-agency police led operations regarding CSE and Child Criminal Exploitation (CCE) in Manchester. The CSE senior specialist nurse has developed 7 minute briefings for CSE and CCE which have been distributed widely across the Trust	

Safeguarding team supported trust to contribute to Local Government Association Peer Review of CSE where there was noted to be good evidence of partnership working		CSE Nurse as part of the Complex Safeguarding Hub has contributed to the Greater Manchester CSE review. Safeguarding team at WTWA site have delivered CSE awareness sessions across WTWA		CSE Specialist Nurse working in Complex Safeguarding Hub and Named Nurse Safeguarding Children have updated regarding CSE Operation ongoing in Manchester in response to GM Mayors Report into CSE Manchester due to be published in January 2020		There was a press release on the 14.01.20 of the 'Independent assurance review of the effectiveness of multi-agency responses to child sexual exploitation in Greater Manchester Part One – An assurance review of Operation Augusta. A summary report was produced by named nurse safeguarding Children supported by CSE senior specialist nurse of the key messages from the report and implications for the Trust.	
Named Nurse Safeguarding Children has contributed to the Manchester Safeguarding Board Neglect Strategy.		Community Safeguarding Team have trained 117 staff to be licenced to use the Graded Care Profile 2 Tool which was devised to assist practitioners in early identification and work on neglect.		Community Safeguarding Team have trained 174 staff to be licenced to use the Graded Care Profile 2 Tool which was devised to assist practitioners in early identification and work on neglect.		There is an is an implementation plan focusing on Graded Care Profile 2 tool training attendance, reviewing how training is then progressing to completed Graded Care Profile tools. The implementation plan reviews if the tool is used if escalation is required and if a request for a social work assessment is required the tool must be completed (with an awareness to not delay referral where children and young people are at risk of significant harm)	

Objective 8	**Making Safeguarding Personal (Voice of the Adult at Risk)** **Voice of the Child** A culture of listening and hearing the voice of children and adults at risk and their families, taking account of their wishes and feelings both in individual decisions and development of services

Assurance	Examples of Evidence
• Adults are listened to and their views regarding decisions about their treatment and care are listened to and documented • Ensure that the voice of vulnerable patients at risk informs service development. • Ensuring there are mechanisms in place to listen to and involve children in decisions. • Ensure family members have an opportunity to be involved in decision making as appropriate.	• Hospitals/MCS specific work in relation to the client group seen. • Innovative practice. • Link to patient feedback. • Link to complaints, raising concerns and incidents.

Action/Evidence							
Q1	**RAG**	**Q2**	**RAG**	**Q3**	**RAG**	**Q4**	**RAG**
ORC Safeguarding Children Team has evidence of considering the Voice of the Child is evident in the Quarterly Safeguarding Team Case File Audits. Documentation of the voice of the child is an area being reviewed in the RMCH documentation review which the Safeguarding Team are supporting. Community Safeguarding team consider voice of child in quality assurance of case conference reports		Documentation of the voice of the child is evidenced within safeguarding documentation and patient records.		In October EMIS community health record keeping safeguarding review it was identified that there is some evidence of the child's lived experience/voice recorded by the health practitioner in the majority of cases in community practitioners child health records		The learning from the health record keeping review has been widely circulated. Community safeguarding team have worked with community services in strengthening the child's voice in a greater quality and numbers in record keeping.	
Making Safeguarding Personal multi-agency task and finish group has been implemented by the Manchester Safeguarding Partnership. MFT Adult Safeguarding Named Nurse will contribute to this group and ensure recommendations are shared with MFT.		Making Safeguarding Personal multi-agency task and finish group is being developed and learning from the group to inform Making Safeguarding Personal Audit.		Making Safeguarding Personal multi-agency task and finish group is being developed and learning from the group to inform Making Safeguarding Personal Audit.		The named nurse safeguarding children is a representative on the Manchester Safeguarding Partnership, Making Safeguarding Personal multi-agency task. An audit tool has been developed for Q1 2020/21 to review the voice of the adult in safeguarding referrals.	

Children Specific Requirements As outlined in Section 11 of the Children Act 2004 and CQC Regulation 13	
Objective 9	**Keeping children safe** There are processes in place to ensure the needs of the child are prioritised and the Trust and Hospitals/MCSs are committed to prioritising the protection of children in all work streams.

Assurance	Examples of Evidence
• Staff are aware of procedures to be followed both internally and externally to keep children safe. • Processes in place to identify and escalate as appropriate the needs of – - Children at risk (Section 47 child protection) - Children in need (Section 17 Child in Need) - Children in need of Early Help - Looked After Children (LAC) - Child Sexual Exploitation - Children missing from home and/or education. • Staff are aware of policies and procedures and legislation relating to safeguarding children and receive updates via Hospitals/MCS safeguarding meetings. • Identification of LAC and understanding of the legal frameworks including consent and parental responsibility. • The Hospitals/MCS has suitable representation on the Trust Safeguarding groups for Early Help and Neglect and Looked after Children.	• Meeting minutes. • Liaison with other services. • Access to additional training. • Examples of cases. • Evidence of dissemination and application of policies and procedures. • Contribution to Early Help Assessments. • Referrals to social care.

Action/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
Referral process to Manchester Children's Social Care was changed in March 2019 to a telephone referral for a strengths based conversation approach during office hours. MFT Safeguarding Teams are reviewing the impact of this referral process on services and regularly review the Record of Referral forms submitted to the Safeguarding teams and feedback key themes and messages to monthly Children's Services Referral meetings.		The Safeguarding Service convened a multi-agency Out of Hours Referral Workshop to review how Urgent Care Staff can complete referrals out of Children's Services Monday to Friday 8.30am to 4.30pm timescales. Oxford Road and WTWA Safeguarding Children Teams have established task and finish groups to review this issue.		In Quarter 3 The Safeguarding team in collaboration with the Emergency Department have worked with Children's Services Advice and Guidance Hubs to establish a referral pathway to Children's Social Care out of Monday to Friday day time hours. This pathway has been piloted within Wythenshawe ED		The Out of Hours referral to children's services has been agreed with Children's Services and cascaded out to urgent care settings in the Trust. The Health Practitioner in AGS completes a monthly dip sample of 5 referrals into Children's Social Care by MFT practitioners to ascertain whether the referral threshold is being met. The outcome of the dip sampling is included in the quarterly dashboard.	

There is the ongoing concern that out of hours urgent care settings are having difficulty making referrals out of hours to Manchester Social Care resulting in planned task and finish group approach in quarter 2 to address this.		Referral workshops have been delivered with Emergency Department staff at WTWA regarding the new Manchester Referral process and embedding the signs of safety model. The Safeguarding Teams continue to review the Record of Referral forms and attend the monthly Children's Services Referral meetings to highlight any issues. Task and Finish Group Meeting has been arranged at WTWA with Children's Social Care to address the out of hours referrals WTWA Named nurse Safeguarding Children and Named Doctor Safeguarding children hold regular meetings with ED to support with addressing any safeguarding issues and embedding key messages into practice.		The Safeguarding Teams continue to review the Record of Referral forms and attend the monthly Children's Services Referral meetings to highlight any issues.		The Safeguarding Teams continue to review the Record of Referral forms and attend the monthly Children's Services Referral meetings to highlight any issues.	
Children's Safeguarding team continue to be visible across all sites Maternity Safeguarding team continue to provide daily ward rounds within Saint Mary's Hospital – both sites – to ensure safeguarding visibility and to support with complex issues.		Safeguarding team at WTWA site continue to be visible across the WTWA sites. Visibility at Trafford General still needs to be increased but is progressing.		Children's Safeguarding team continue to be visible across all sites Safeguarding Assurance walk rounds now established across the trust Safeguarding Children and Young People Policy has been reviewed and shared with the Trust Quality and Safeguarding Group in preparation for Safeguarding Committee in January 2020.		Children's Safeguarding team continue to be visible across all sites The community Safeguarding Children Team ensure where possible to work within clinic bases to promote visibility and access to the team as well as have an opportunity to be able to observe some safeguarding child practice	

Evidence within patient's records and ward round diary Safeguarding Maternity team continue to be hospital based within the antenatal clinic ensuring access for support by all staff can be achieved. The Acute Oxford Road Safeguarding team each have link areas they visit regularly and provide additional support/training Updates etc. as appropriate. The Safeguarding Team visit RMCH PED daily to support staff and increase safeguarding awareness. RMCH Lead Nurse and Named Nurse Safeguarding Children meet weekly to review any current safeguarding concerns and support safeguarding practice. **Evidence in meeting documentation.** Children's Community Specialist Nurses are visible across community bases		During Patient Safety Week in RMCH all wards were visited by the Oxford Road Children's Safeguarding Team and given a pack of leaflets, posters, information cards, contact numbers and directions to create either a safeguarding notice board or a safeguarding file with an allocated nurse in each area taking responsibility for creating the boards/files. The outcome of this event will be reviewed in December 2019.				Safeguarding Assurance walk rounds now established across the trust Safeguarding Children and Young People Policy has been ratified by Group Safeguarding Committee in January 2020.	
Section 11 multi-agency audit is expected to be completed by all agencies by Manchester Safeguarding Partnership.		Safeguarding Team is contributing to the Manchester Safeguarding Partnership Joint Quality Assurance Group which is developing a Workforce Survey to complete the Section 11 audit in early 2020.		Safeguarding Team is contributing to the Manchester Safeguarding Partnership Joint Quality Assurance Group which is developing a Workforce Survey to complete the Section 11 audit in early 2020.		Section 11 Audit completed and submitted to Manchester Safeguarding Partnership for 2019/20.	

Objective 10	**Supervision and support** To ensure staff are supported to seek support when dealing with difficult and complex safeguarding cases.

Assurance	Examples of Evidence
• Staff have access to advice, support and supervision as required and are supported by the Hospitals/MCS to meet this. • Managers support staff when they deal with difficult cases and decision making. **Community Children Services** • Staff are supported to attend safeguarding 1:1 supervision as per statutory requirements. **RMCH Children Services** Staff are supported to attend safeguarding supervision	• Supervision stats. • Support mechanisms for staff. • Utilising safeguarding champions for support. • Mechanisms in place for de-briefing.

Action/Evidence

Q1	RAG	Q2	RAG	Q3	RAG	Q4	RAG
Safeguarding Maternity team provide safeguarding group supervision and learning to community midwives and to specialist midwives with a safeguarding case load. **Evidence within minutes of meetings and attendance sheets.**		Safeguarding Maternity team provide safeguarding group supervision and learning to community midwives and to specialist midwives with a safeguarding case load. **Evidence within minutes of meetings and attendance sheets.**		Safeguarding Maternity team provide safeguarding group supervision and learning to community midwives and to specialist midwives with a safeguarding case load. **Evidence within minutes of meetings and attendance sheets.**		Safeguarding Maternity team provide safeguarding group supervision and learning to community midwives and to specialist midwives with a safeguarding case load. **Evidence within minutes of meetings and attendance sheets**	
1:1 case supervision is provided to all community midwives; hospital based midwives; and medical staff with regard to maternity safeguarding. **Evidence within patient records.**		1:1 case supervision is provided to all community midwives; hospital based midwives; and medical staff with regard to maternity safeguarding. **Evidence within patient records.**		1:1 case supervision is provided to all community midwives; hospital based midwives; and medical staff with regard to maternity safeguarding. **Evidence within patient records.**		**The safeguarding team are currently finalising a safeguarding supervision audit tool to be distributed across the Trust to evaluate the effectiveness of supervision provided**	

1:1 safeguarding supervision to be offered to all Community Midwife team leaders; and specialist midwives across both sites. Not yet achieved due to staffing levels; however dates will be sent during quarter 2 to all relevant staff to ensure compliance		1:1 safeguarding supervision to be offered to all Community Midwife team leaders; and specialist midwives across both sites. Not yet achieved due to staffing levels; however dates were sent during quarter 2 to all relevant staff to ensure compliance		1:1 safeguarding supervision to be offered to all Community Midwife team leaders; and specialist midwives across both sites.		1:1 safeguarding supervision to be offered to all Community Midwife team leaders; and specialist midwives across both sites. **The safeguarding midwives are visible and available in oxford road and Wythenshawe to provide one to one support and advice.**	
Safeguarding supervision is delivered on a quarterly basis within WTWA Safeguarding team offer advice and guidance to staff within the organisation.		Safeguarding supervision is delivered on a quarterly basis within WTWA Safeguarding team offer advice and guidance to staff within the organisation.		Safeguarding supervision is delivered on a quarterly basis within WTWA Safeguarding team offer advice and guidance to staff within the organisation.		Safeguarding supervision is delivered on a quarterly basis within WTWA Safeguarding team offer advice and guidance to staff within the organisation.	
ORC Safeguarding Children Team Safeguarding Supervision is provided for all staff on an individual ad hoc basis. Monthly Group Safeguarding Supervision Sessions are provided for identified staff (as per Trust Safeguarding Supervision Policy) and RMCH attendance is monitored via the RMCH Safeguarding Meeting. De-briefing sessions in relation to difficult/challenging cases are provided/attended by the Safeguarding Team as required. **Evidence is available from meeting minutes.**		ORC Safeguarding Children Team Safeguarding Supervision is provided for all staff on an individual ad hoc basis. Monthly Group Safeguarding Supervision Sessions are provided for identified staff (as per Trust Safeguarding Supervision Policy) and RMCH attendance is monitored via the RMCH Safeguarding Meeting.		ORC Safeguarding Children Team Safeguarding Supervision is provided for all staff on an individual ad hoc basis. Monthly Group Safeguarding Supervision Sessions are provided for identified staff (as per Trust Safeguarding Supervision Policy) and RMCH attendance is monitored via the RMCH Safeguarding Meeting.		ORC Safeguarding Children Team Safeguarding Supervision is provided for all staff on an individual ad hoc basis. Monthly Group Safeguarding Supervision Sessions are provided for identified staff (as per Trust Safeguarding Supervision Policy	

Community Children's team The Community Safeguarding team deliver group and 1.1 safeguarding children supervision Compliance is within expected trust wide expectations		Community Children's team The Community Safeguarding team deliver group and 1.1 safeguarding children supervision Compliance is within expected trust wide expectations		Community Children's team The Community Safeguarding team deliver group and 1.1 safeguarding children supervision Compliance is within expected trust wide expectations		Community Children's team The Community Safeguarding team deliver group and 1.1 safeguarding children supervision Compliance is within expected trust wide expectations **Currently finalising a safeguarding supervision audit tool to be distributed across the Trust to evaluate the effectiveness of supervision provided**	
A training needs analysis was completed that identified 17 of 43 nurses in the team had completed a Safeguarding Supervision Training with only 4 staff completing this training in the last 3 years.		Safeguarding Supervision course has been commissioned and all clinical staff allocated a place in Quarter 3 and 4.		Safeguarding Supervision course has been commissioned for the Trust's Safeguarding Nurses and all safeguarding team clinical staff has been allocated a place in Quarter 4 and 1 2020/21.		Safeguarding Supervision course has been commissioned for the Trust's Safeguarding Nurses and all safeguarding team clinical staff has been allocated a place in Quarter 4 and 1 2020/21.	

Objective 11	**Training** To ensure we meet our statutory requirements as outlined in Section 11 of the Children Act 2004, and statutory guidance in Working Together 2018. Training is also compliant with Intercollegiate Guidance (2019) Trust Compliance 90%

Assurance	Examples of Evidence
• Evidence that staff have undertaken the correct level of safeguarding children training for their role and responsibility. • Evidence of local oversight and management of safeguarding training requirements, including monitoring and management of local training records for safeguarding. • Training aligned to MSCB requirements	• Local training records monitored. • Knowledge and understanding of local needs and compliance. • Evidence of governance oversight of training requirements via Hospitals/MCS safeguarding meetings. • Risk to achieving compliance identified and actions in place.

Action/Evidence							
Q1	**RAG**	**Q2**	**RAG**	**Q3**	**RAG**	**Q4**	**RAG**
The level 1 and 2 Children's Safeguarding e learning was updated prior to roll out in April 2020 Safeguarding team continue to have capacity in Safeguarding Training to support Training requirements. The safeguarding team review monthly and report quarterly on safeguarding training compliance		Safeguarding Children Team continue to deliver Level 3 Safeguarding Children Training across the organisation to ensure there is capacity to meet the organisational requirements. Reporting continues quarterly into the Hospitals and the safeguarding team continue to support the governance within each of the Hospitals/ MCS. In Quarter 2 428 places were available for Level 3 Safeguarding Children Training with 322 places being utilised. At the end of Quarter 4 934 staff were identified to require Level 3 Safeguarding Training. There are 1,701 training places available in Quarter 3 to support to achieve the compliance required.		Level 1 Safeguarding training is now at **91.99% compliance so at trust wide expected level** Level 2 Safeguarding training is at **86.15% so at CCG expected compliance levels** **Level 3 Safeguarding training remains below expected compliance levels at 76.88%** Safeguarding Children Team continue to deliver Level 3 Safeguarding Children Training across the organisation to ensure there is capacity to meet the organisational requirements. Reporting continues quarterly into the Hospitals and the safeguarding team continue to support the governance within each of the Hospitals/ MCS.		Level 1 Safeguarding training is now at **91.71% compliance so at trust wide expected level** Level 2 Safeguarding training is at **86.51% so at CCG expected compliance levels** **Level 3 Safeguarding training remains below expected compliance levels at 78.05%** Safeguarding Children Team continue to deliver Level 3 Safeguarding Children Training across the organisation to ensure there is capacity to meet the organisational requirements. Face to face level 3 training has been updated to provide across MFT with trainers co-working across the Team with an aim of providing more training in bigger venues	
All Safeguarding Nurses are supported to attend trust wide safeguarding children training		90% compliance across the Safeguarding team with Safeguarding training		98% compliance across the safeguarding team with safeguarding training		All Safeguarding Nurses are supported to attend trust wide safeguarding children training and external courses	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Lynne Birchall, Head of Nursing – Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	June 2020
Subject:	Quarter 4 Complaints Report 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations:	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	Name: Lynne Birchall, Head of Nursing Quality & Patient Experience Tel: 0161 701 7679

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st January 2020 – 31st March 2020

1. Executive Summary

1.1. Members of the Board of Directors are asked to note the Quarter 4, 2019/20 Complaints Report for Manchester University NHS Foundation Trust (MFT), covering the period 1st January 2020 to 31st March 2020 (Q4).

1.2 The report provides an overview of the Complaints and PALS performance for Q4. Due to new reporting capabilities to refresh and cleanse previous data, the data provided in this report for the periods prior to this quarter differ slightly to the data presented in previous reports.

1.3 A total of 1,412 PALS concerns were received in Quarter 4 compared to 1,472 in the previous quarter; representing a 4.1% decrease.

1.4 A total of 420 new complaints were received compared to 415 new complaints received in the previous quarter, which is a 1.2% increase.

1.5 The total number of complaints closed this quarter was 466; representing an increase of 11 cases compared to Quarter 3.

1.6 The number of complaints closed within 25 days increased this quarter, with 310 cases closed compared to 287 in the previous quarter; however there was a very slight decrease in the number of complaints closed in 26-40 days.

1.7 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days following receipt of the complaint. The Trust achieved 100% compliance with this Key Performance Indicator during Quarter 4.

1.8 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Quarter 4. The Management Team from University Dental Hospital of Manchester and Manchester Royal Eye Hospital (UDHM/MREH) presented two cases at the January 2020 meeting. The learning identified from the cases presented is detailed in Section 5 of this report.

1.9 Improvements in the Complaint and PALS management processes are described in the report with future quality improvements identified in section 9.

1.10 The Board of Directors is asked to note that due to the need to ensure that Trust resources were focused on responding to the on-going Coronavirus pandemic (COVID-19) and, in line with NHSE guidance, in the latter part of Quarter 4, the Trust's complaints process was temporarily paused. This decision accorded with a national system-wide "pause" of the NHS complaints process. During this period any urgent complaints, which required an immediate response were actioned.

2. Overview of Quarter 4, 2019/20 Performance: PALS

2.1 There was a decrease in the number of PALS concerns received with 1,412 PALS concerns being received, compared to 1,472 in the previous quarter. This represents a 4.1% decrease compared to the previous quarter and is a numerical decrease of 60 PALS concerns.

2.2 As appropriate and in agreement with the complainant, PALS concerns can be escalated to complaints or complaints de-escalated to PALS concerns. Ten PALS cases were escalated to formal investigation during Quarter 4, which is a decrease when compared to the 11 PALS cases escalated during the previous quarter. Cases are predominantly escalated due to the complexity of the concern and following discussion and agreement with the complainant. Conversely, 4 complaint cases were de-escalated during this quarter, which is the same number of cases that were de-escalated during the previous quarter.

2.3 As in previous reports, the Hospital/MCS/LCO with the highest number of PALS concerns received was Wythenshawe, Trafford, Withington and Altrincham (WTWA) with 425 cases, followed by Manchester Royal Infirmary (MRI) with 406 cases, representing 30.1% and 28.8% respectively of the total number of PALS concerns received. Numerically, this is a decrease of 70 cases for WTWA and an increase of 54 cases for MRI when compared to Quarter 3. It should be noted that these hospitals undertake the greatest volume of activity across the Trust. To support the Hospital senior management teams to understand the reasons for PALS concerns, the Corporate PALS team continue to provide quarterly thematic PALS reports to WTWA and MRI. Analysis against broad, nationally applied themes has identified 'Outpatient Appointment Delay/Cancellation' 'Treatment/Procedure' and 'Communication' as the most common themes from PALS concerns received at both WTWA and MRI. This information enables Hospital teams to undertake further interrogation at hospital level in order to identify focussed areas for improvement.

2.4 The majority of PALS concerns received in Quarter 4 related to Outpatient areas, which accounted for 1,120 (79.3%) of the 1,412 contacts received. This compares to 1,143 (77.6%) of concerns relating to Outpatient areas in the previous quarter.

2.5 The Trust aims to quickly rectify the cause of informal PALS concerns, with the majority of issues being addressed with 7 days. **Table 1** shows the timeframes in which PALS concerns have been resolved during the last four quarters. These data show a slight improvement in resolution within 7 days in Quarter 4 (68.7%) compared to Quarter 1 (66.8%).

Table 1: Closure of PALS concerns within timeframes.

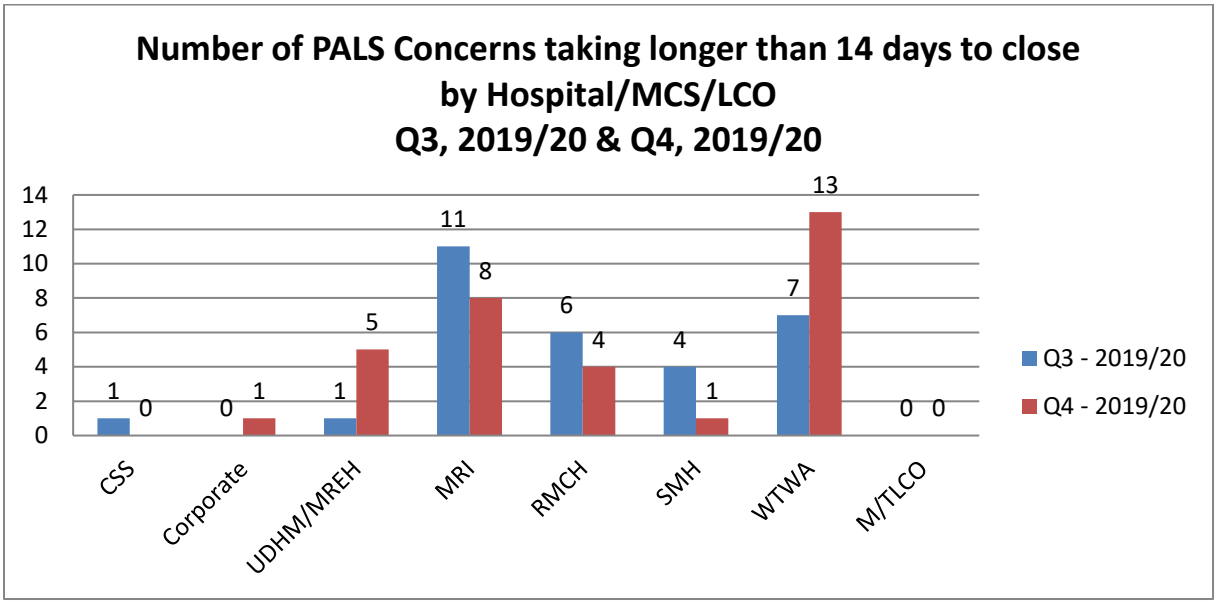
	Quarter 1, 2019/20		Quarter 2, 2019/20		Quarter 3, 2019/20		Quarter 4, 2019/20	
Days to Close	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe
0-7	1109	66.8%	1005	71.0%	1083	71.8%	994	68.7%
8-14	515	31.0%	383	27.0%	395	26.2%	421	29.1%
15+	36	2.2%	29	2.0%	30	2.0%	32	2.2%

2.6 All PALS cases that are still open at 12 days continue to be escalated to the PALS Manager. This process continues to be successful in reducing the time taken to resolve PALS

concerns. Across MFT, resolution within 14 days or under was 97.7% in Q4, which is in line with timeframes achieved in each of the previous quarters shown in Table 1.

2.7 Delays in resolving PALS concerns are monitored by the Corporate PALS team who escalate delays to the relevant Hospital/MCS/LCO Senior Leadership Teams and provide them with weekly reports detailing their unresolved PALS concerns. Graph 1 shows that WTWA had the highest number of PALS cases that took longer than 14 days to resolve in Quarter 4. Of the 32 cases that exceeded this timeframe, themes were identified as 'Appointment – Delay' 'Outpatients', 'Communication Failure' and 'Appointment - Cancellation' 'Outpatients'. This information is used by the management team to inform specific improvements, such as work undertaken to improve the outpatient experience.

Graph 1: Number of PALS concerns taking longer than 14 days to close by Hospital/MCS/LCO Quarter 3, 2019/20 and Quarter 4, 2019/20.

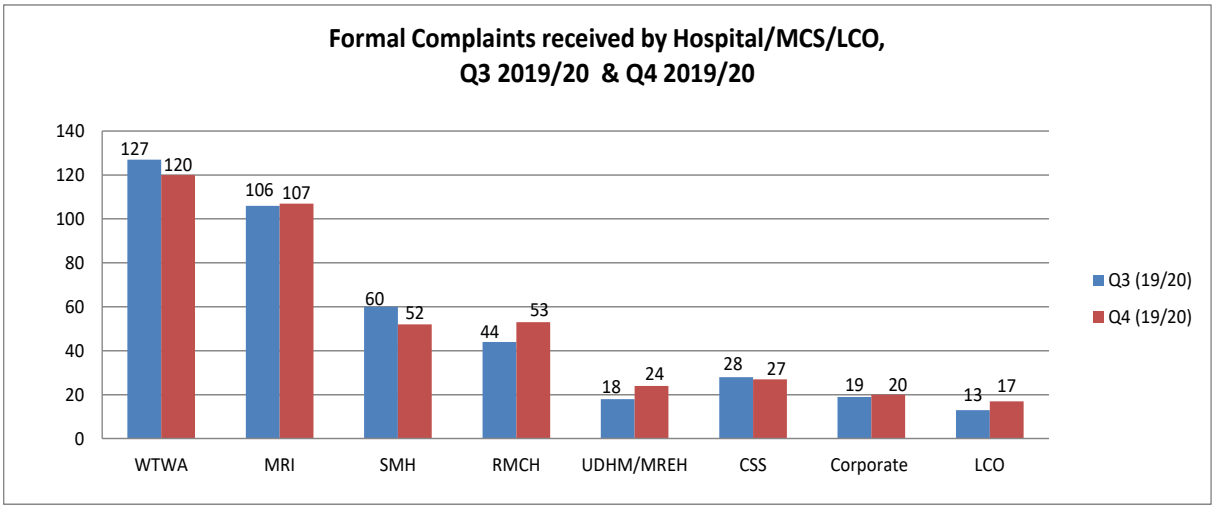


New Complaints

2.8 A total of 420 new formal complaints were acknowledged this quarter. This compares to 415 in Quarter 3, 2019/20, 437 in Quarter 2, 2019/20 and 356 in Quarter 1, 2019/20. This represents a 1.2% increase in formal complaints (increase of 5 in number) when compared to the previous quarter. On a monthly basis there continues to be a variation within normal limits of new and re-opened complaints received with 186 in January 2020, 192 in February 2020 and 130 in March 2020, totalling 508.

2.9 **Graph 2**, below, compares the total number of new complaints acknowledged by Hospital/ MCS/LCOs in Quarter 3, 2019/20 and Quarter 4, 2019/20.

Graph 2: Total number of New Complaints Acknowledged by Hospital/MCS/LCO



2.10 Whilst the highest number of new complaints was received by WTWA (120), this quarter, University Dental Hospital of Manchester/Manchester Royal Eye Hospital (UDHM/MREH) received the highest percentage increase with 24 new complaints compared to 18 last quarter, representing a 33.3% increase. Although, it should be noted that smaller numbers result in higher percentages. The largest decrease in the number of new complaints in this quarter compared to the previous quarter was for Saint Mary's Hospital (SMH), which had a reduction of 8 cases (13.3%).

2.11 Trust-wide, out of the total of 420 complaints, 130 new complaints related to inpatient services and 183 related to outpatient services. This represents a decrease of 5 cases (3.7%) for inpatient services, and an increase of 7 cases (4.0%) for outpatient services. The area with the highest number of outpatient complaints was WTWA with a total of 57 of the 183 complaints (31.0%). Themes identified for outpatient services were 'Treatment/Procedure', 'Communication' and 'Appointment - Delay/Cancellation, 'Outpatient'. Themes for inpatient services were 'Treatment/Procedure', 'Communication' and 'Discharge/Transfer'.

2.12 The national statutory requirement for the acknowledgement of formal complaints, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. As per the previous quarters throughout 2019/20, the Trust achieved **100%** compliance with this key performance indicator (KPI) during this quarter.

Current Complaints

2.13 In accordance with the NHS Complaint Regulations (2009) the Trust has set complaint response timescales as; 25 working days, 26-40 working days and 41 days and above.

2.14 As stipulated in the Trust's Complaint Triage process, timescales are discussed and agreed with the complainant in three broad timeframes, as follows:

- 25 working days, normal response timeframe
- 40 working days, highly complex case response timeframe
- 60 workings days, highly complex case involving multiple organisations, High Level Investigations (HLIs), Independent/External reviews and HR investigations response timeframe

2.15 The accountability for complaints management and monitoring is fully devolved to the Hospital/MCS/LCO Chief Executives and performance is monitored at a Group level via the Accountability Oversight Framework (AOF).

2.16 There were 224 complaints open at the end of Quarter 4, compared to 210 at the end of the previous quarter. This is a 6.7% increase equating to a numerical increase of 14 complaints. The 224 ongoing complaints comprised of 139 which had been assigned a 25 working day timescale, 64 which had been assigned a 40 working day timescale and 21 which had been assigned a 60 working day timescale. At the end of this quarter, 81.7% of ongoing cases were being managed within the planned timescales, agreed with the complainant. The worst performance related to complaints with a 60 day timeframe, reflecting the complexity of this group of complaints, which often require multi-agency involvement. **Table 2** shows a breakdown by the agreed working day timescales.

Table 2: Details of ongoing cases at 31st March 2020 by agreed timescale.

	Number of ongoing cases	In timescale	Number not responded to in assigned timescale
25 working day timescale	139	111 (79.9%)	28 (20.1%)
40 working day timescale	64	57 (89.1%)	7 (10.9%)
60 working day timescale	21	15 (71.4%)	6 (28.6%)
Total	**224**	**183 (81.7%)**	**41 (18.3%)**

2.17 WTWA had the highest number of open cases in Quarter 4 with 68 cases (63 of which were in the agreed timescale with the complainant). This compared to 70 open cases in Quarter 3 and 61 open cases in Quarter 2. Of the open cases 36 were within 0-25 days, 4 were within 26-40 days, and 28 were over 41 days.

Resolved Complaints

2.18 The oldest complaint case closed during this quarter was registered within the Royal Manchester Children's Hospital (RMCH) on 1st May 2019 and was 212 days old when closed on 2nd March 2020. The complaint involved a Level 5 High Level Investigation within RMCH. The complainant was kept updated and fully supported throughout this process.

2.19 **Table 3** provides a comparison of complaints resolved within each timeframe from Quarter 1, 2019/20 to Quarter 4, 2019/20. These data show an improved position, whereby 84.3% of complaints closed in Quarter 4 were resolved within the agreed timeframe compared to 80.4% in the previous quarter.

2.20 In Quarter 4, there was a (positive) increase of 23 cases resolved within 0-25 working days and a decrease of 2 cases resolved between 26-40 days, however, the number of cases resolved at 41+ days decreased by 10 cases compared to the previous quarter. Overall, in Quarter 4 of 2019/20, the number of complaints resolved within timescale increased by 3.9% compared to Quarter 3 of 2019/20 and by 18.1% compared to Quarter 1 of 2019/20, representing a positive improvement.

Table 3: Comparison of complaints resolved by timeframe: Quarter 1 to Quarter 4, 2019/2020.

		Quarter 1 2019/20	Quarter 2 2019/20	Quarter 3 2019/20	Quarter 4 2019/20
Resolved in 0-25 days	New	190	206	242	269
	Reopened	30	42	45	41
Resolved in 26-40 days	New	84	66	46	53
	Reopened	17	19	17	8
Resolved in 41+ days	New	67	53	83	80
	Reopened	11	18	22	15
Total Resolved	New	341	325	371	402
	Reopened	58	79	84	64
Total resolved		399	404	455	466
Total resolved in timescale		264	306	366	393
% Resolved in agreed timescale		66.2%	75.7%	80.4%	84.3%

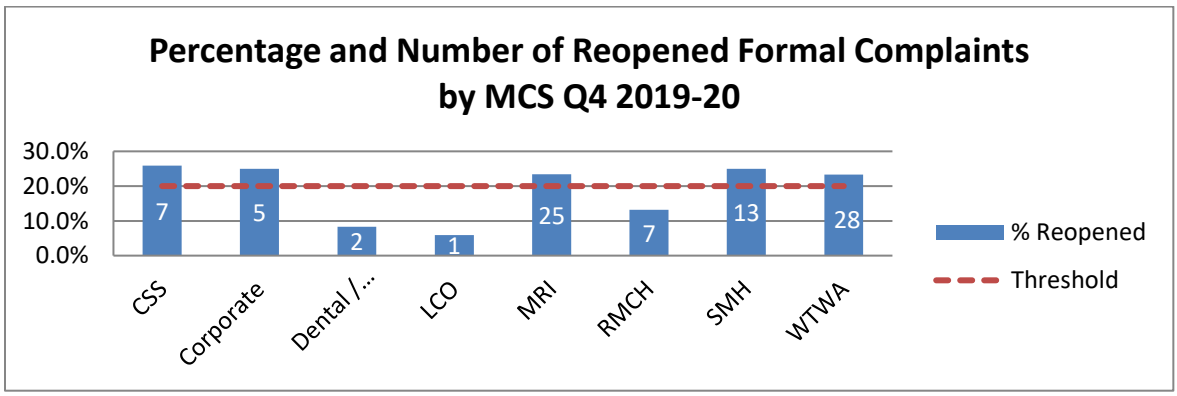
Re-opened Complaints

2.21 Re-opened complaints are used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the Group Chief Nurse. There were 88 complaints re-opened in Quarter 4 compared to 79 in the previous quarter. This deterioration represents a 10.2% increase in re-opened complaints. Overall re-opened cases accounted for 21.0% of all complaints received compared to 19.0% in the previous quarter.

2.22 The highest number of re-opened cases was received by WTWA (28 cases), compared to 25 in the last quarter. Of the 28 re-opened complaints received by WTWA the predominant reason was due to unresolved issues, a request for a local resolution meeting or the complainant did not accept the information provided. The letter writing training programme provided by the Corporate Complaints team will continue to support improvements in the content and quality of responses as part of the educational sessions detailed in Section 9.5 of this report.

2.23 **Graph 3** illustrates Hospital/MCS/LCO performance against the 20% re-opened threshold in Quarter 4 with; Clinical Scientific Services (CSS) 25.9% (7 re-opened cases), SMH 25.0% (13 re-opened cases), Corporate 25.0% (5 re-opened cases), MRI 23.4% (25 re-opened cases), and WTWA 23.3% (28 re-opened cases), exceeding the 20% threshold during Quarter 4; with all the other Hospital/ MCS/ LCO's recording re-opened cases below the threshold. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS/LCO or Corporate Service can result in large percentage changes for those areas where the overall number of complaints is low.

Graph 3: Percentage of re-opened Complaints, Quarter 4, 2019/20.



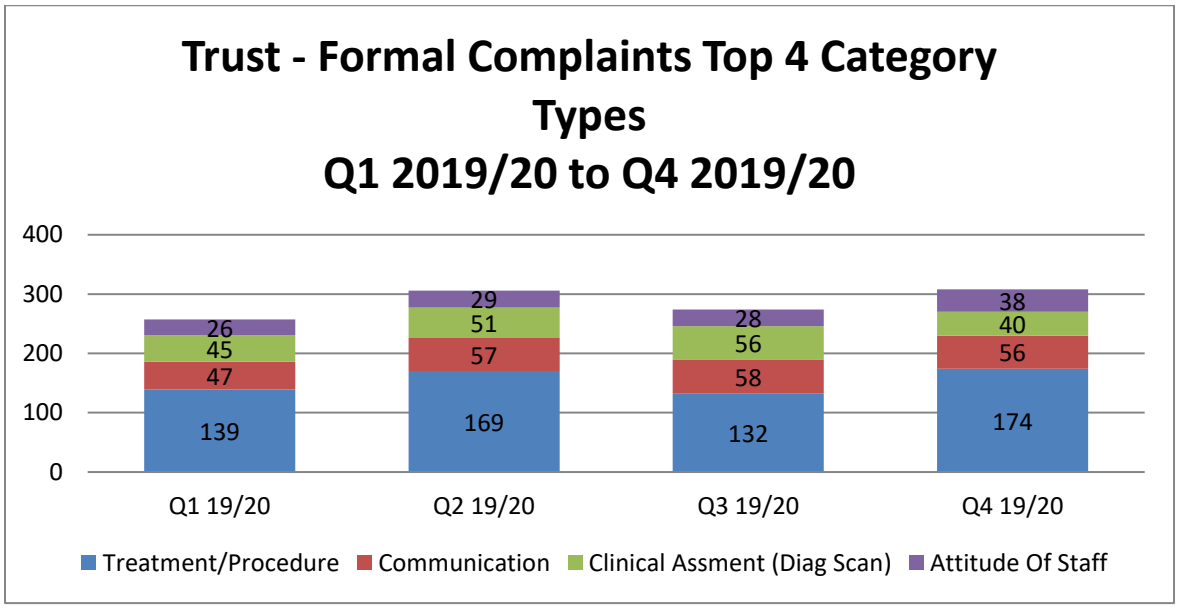
3. Themes from Complaints and PALS concerns

3.1 In Quarter 4, the medical staffing group was cited in 44.6% of all PALS concerns and 63.1% of all complaints, compared to 39.5% and 60.0% respectively in the previous quarter. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff, it is recognised that it is not unusual for medical staff, as the lead practitioner for many episodes of care, to be cited by patients who wish to make a complaint. Actions in relation to this trend are undertaken on a case by case basis by the relevant Hospital/MCS/LCO.

3.2 The top category types for formal complaints from Quarter 1, 2019/20 to Quarter 4, 2019/20 are shown in **Graph 4.**

3.3 'Treatment/Procedure', 'Clinical Assessment' and 'Communication' remain in the top three categories in Quarter 4, 2019/20.

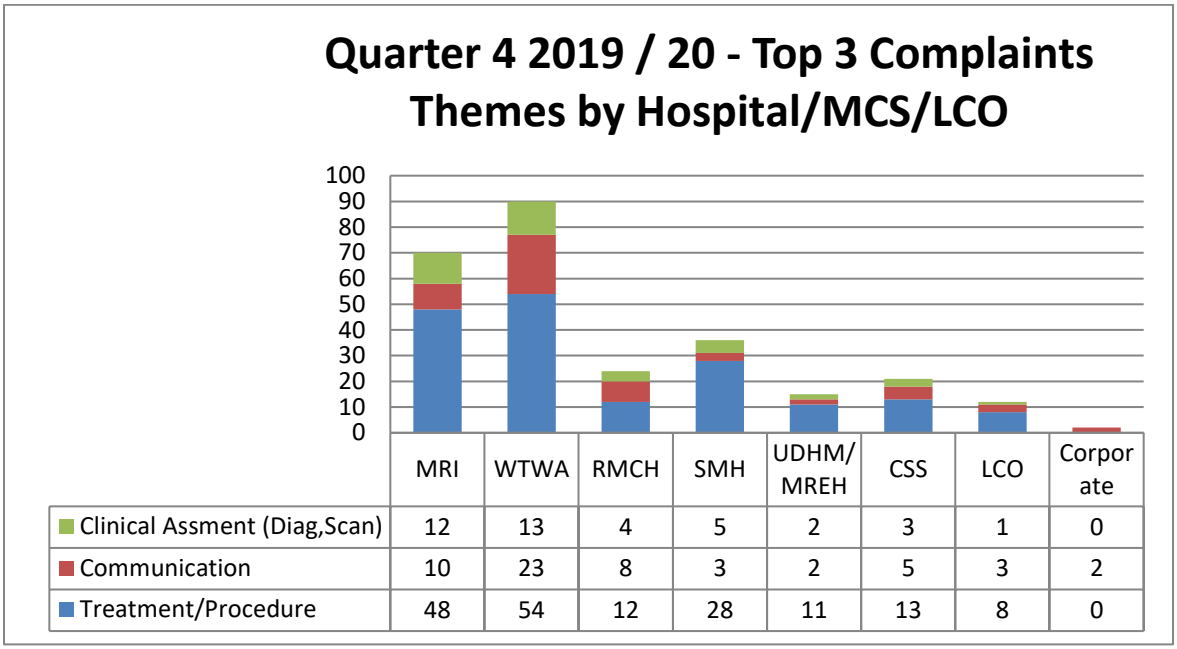
Graph 4: Formal Complaints – Top Categories Quarter 1, 2019/20 to Quarter 4, 2019/20



3.4 **Graph 5** illustrates the total number of top 3 categories by Hospital/ MCS/LCO in Quarter 4 2019/20.

3.5 In Quarter 4 the top category, 'Treatment/Procedure' (174) was cited in 45.0% of WTWA's complaints, 44.8% of MRI's complaints, 22.6% of RMCH's complaints, 53.8% of SMH's complaints, 45.8% of UDHM and MREH, 48.1% of CSS's complaints and 47.0% of the Local Care Organisations' (LCO) complaints.

Graph 5: Total number of Top 3 Complaint Categories by Hospital/MCS/LCO, Quarter 4, 2019/20



	MRI	WTWA	RMCH	SMH	UDHM/ MREH	CSS	LCO	Corporate
Clinical Assment (Diag,Scan)	12	13	4	5	2	3	1	0
Communication	10	23	8	3	2	5	3	2
Treatment/Procedure	48	54	12	28	11	13	8	0

4. Care Opinion and NHS Website feedback

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

4.2 The number of Care Opinion and NHS Website comments by category; positive, negative and mixed, are detailed in **Table 4.**

4.3 This quarter, 64.3% of the NHS Website and Care Opinion feedback comments received were positive. This represents a decrease of 5.3% compared to Quarter 3 when the overall positive comments represented 69.6% of the total. Negative comments equated to 21.4% of the overall total received this quarter, which equates to an unchanged position when compared to 21.7% during Quarter 3.

4.4 This quarter a total of 18 positive comments were received; this is a decrease of 14 compared to the last quarter but is consistent with the overall reduction in the number of comments received in Quarter 4.

4.5 All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO; with a request for a response for publication with 5 working days. Within each Hospital/MCS/LCO designated staff support the provision of a response to the PET. The PET ensures responses are quality assured prior to posting online.

4.6 All responses to negative and mixed comments include a Ulysses reference number and offer the person posting the comment the opportunity to make contact with PALS should they require further support.

Table 4: Number of Care Opinion/ NHS website postings by Hospital/ MCS/ LCO in Q4, 2019/20.

Number of Postings received by Hospital/MCS/LCO/Corporate Service Quarter 4, 2019/20			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**1**	**1**	**1**
Wythenshawe, Trafford, Withington and Altrincham Hospitals	**10**	**4**	**0**
Clinical Scientific Services	**0**	**0**	**0**
Corporate Services	**0**	**0**	**0**
Manchester Royal Eye Hospital/ University Dental Hospital of Manchester	**3**	**0**	**2**
Manchester & Trafford Local Care Organisation	**0**	**0**	**0**
Royal Manchester Children's Hospital	**0**	**1**	**1**
Saint Mary's Hospital	**4**	**0**	**0**
Overall MFT Total	**18 (64.3%)**	**6 (21.4%)**	**4 (14.3%)**

4.7 **Table 5** provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during this quarter.

Table 5: Examples Care Opinion/ NHS Website Postings and Reponses Quarter 4, 2019/20.

Quarter 4 , 2019/2020
University Dental Hospital Manchester
Patient gave the dental students at the Dental Hospital a rating of 5 stars. *"After not visiting a dentist for 52 years due to terrible experience I visited the Dental Hospital very scared. I have now been on numerous occasions and have been treated superbly by the students and teaching staff. I have had roots extracted, teeth extracted, fillings and numerous other treatments. Everyone understood how I felt and treated me with great respect and care. I cannot thank your students enough."* Posted on 09 January 2020
Response
Thank you for your comments posted on the NHS Website regarding the care you received at the University Dental Hospital Manchester. It was very kind of you to write and compliment the staff as it is always good to receive positive feedback that reflects the hard work and dedication of our staff. It was reassuring to hear that you felt understood and were treated with care and respect. I can assure you that we have passed on your thoughts to the Matron who will share your comments with the staff involved.

Manchester Royal Infirmary
Patient gave the Integrated Sexual Health Service online booking service a rating of 3 stars. *"Booking online is a nightmare. Had a number of occasions when it wouldn't allow me past the data entry screen. Today, I made 3 attempts on picking available appointments - All 3 of which then came up as unavailable due to a very slow system - Despite the fact I had selected it when green. Last time I was in the centre (think around November). All appointments were running late (mine at least 2 hours). No one communicated anything to us, and when I asked a nurse for an update, she seemed put out I 'dared' to ask. Once seen the Doctors, they do tend to be nice and helpful."* Posted on 10 January 2020
Response
Thank you for your feedback. We were sorry to learn that your experience was not as positive as we would hope when accessing the services offered by the Integrated Sexual Health Team. 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 Matron for The Northern Contraception, Sexual Health & HIV Service would like to apologise for any inconvenience you were caused by a delay in being seen in clinic and for the difficulties you experienced when trying to book your appointment via the online system. After receiving your comment the Matron has discussed the concern you raised about staff attitude and patients not being informed of clinical delays, during the team brief to ensure that going forward patients are appropriately updated when clinics are running behind. It is difficult to respond to all posts in a full way often because of a lack of detailed information, therefore if you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk Posted on 10 January 2020

5. Complaints Scrutiny Group

5.1 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Quarter 4 2019/20. UDHM/MREH presented two cases at the January 2020 meeting.

5.2 Transferable learning from complaints is identified and shared through this group. The learning identified from the case presented and the actions discussed and agreed at the meeting are outlined in **Table 6**.

Table 6: Actions identified at the Trust Complaints Scrutiny Group during Quarter 4, 2019/20.

Hospital/ MCS	Learning	Actions
UDHM	Paediatric Dentistry waiting list in excess of 12 months – lack of provision in the North	• Review & improve the process regarding listing patients on a Saturday • Continue to work with Commissioners to review capacity across Greater Manchester with a view to reducing variance in paediatric waiting times by transferring patients to Hospitals with shorter

		waiting times • Families, to be invited, via the Commissioners, to attend the Paediatric Managed Clinical Network • Liaison with National Getting It Right First Time (GIRFT) lead for Dentistry
MREH	Limited recognition/communication of how best to manage needs of complex patients	• Explore the possibility of additional Eye Clinic Liaison Officer • Allocate longer time slots for clinic appointments • Consideration to be given for improved counselling services • Create a Standard Operating Procedure (SOP) • Patient story to be shared at MREH's next ACE day
	Delay in referring complex patients for second opinions	

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The PHSO makes the final decisions on complaints that have not been resolved by the NHS in England, United Kingdom Government Departments and other public organisations.

At the end of March 2020, at the time of the evolving COVID-19 pandemic, the PHSO made a decision that in order not to place additional burdens on the NHS, they would not be accepting new health service complaints or progressing existing ones that required contact with the NHS.

6.2 The Trust had 7 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Quarter 4 compared to 9 under review at the end of Quarter 3.

Table 7 provides details of the progress of each PHSO case, specifically the number of reports that are awaited and shows the distribution of PHSO cases across Hospital/ MCS. These data show that investigations are on-going for 2 of the 7 cases, with the remainder awaiting the PHSO final report.

Table 7: Overview of PHSO Cases open as at 31st March 2020

Hospital/ MCS	Case/s	PHSO Investigation Progress
CSS (1)	1	Investigation on-going
MRI (2)		
GI Medicine & Surgical Specialties	1	Awaiting draft report
Cardio-Vascular Specialties	1	Awaiting final report
WTWA (3)		
Surgery (Orthopaedics)	1	Investigation on-going
Heart & Lung (Respiratory)	1	Awaiting draft report
Heart & Lung (Cardiology)	1	Awaiting draft report
RMCH (1)	1	Awaiting final report
Total	**7**	

6.3 The PHSO closed 4 cases in this quarter; of these cases 2 were partly upheld and 2 were not upheld. The Trust was asked to pay £750.00 financial redress in this quarter. This compares to no financial redress in the previous quarter and £1200.00 in Quarter 2.

Table 8: PHSO closed cases in Quarter 4, 2019/20 presented by outcome.

Hospital/ MCS	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
WTWA (Heart & Lung (Cardiology))	Partly upheld	10/11/16	Failing to provide appropriate care needs Failure to be open and honest	Provide a full acknowledgement and an apology for the impact and failings identified in the report. Provide reassurances of lessons learnt. Explain what actions have been taken to address the failing identified in the report.
WTWA (Surgery)	Partly upheld	05/10/17	Failure to diagnose within a timely manner	Provide a full acknowledgement of the failings identified in the report. Award compensation of £750
WTWA (Surgery)	Not upheld	01/02/18	No failings found	None
SMH	Not upheld	13/03/18	No failings found	None

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Hospital/MCS/LCOs regularly receive their complaint data and review the outcomes of complaint investigations at the Hospital/MCS/LCO governance meetings. **Table 9** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the Hospital/MCS/LCOs.

Table 9: Examples of the application of learning from complaints to improve services, Quarter 4, 2019/20

Hospital/ MCS	Learning & Improvements
WTWA (Heart & Lung)	**Patient Experience:** A patient's granddaughter raised concerns about the care and treatment her grandparent received on the Coronary Care Unit.

	The patient's granddaughter was concerned that staff had not escalated, in a timely manner, concerns from the family and patient regarding the patient's condition. Nursing care was reported to be inadequate with delays being experienced in obtaining specialist medical opinions. Concerns were also raised regarding the clinical decisions being made and ineffective communication between the family and the medical team. **As a result of the complaint and following a local resolution meeting the following actions were agreed:** • Early Warning Scores (EWS) standards were reviewed and appropriately reset by the Matron for Cardiology and staff received additional training. • Nursing staff received additional education around Sepsis awareness. • The Matron for Cardiology reminded nursing staff of the importance of accurate nursing documentation and the complaint was shared with staff to support their learning. • The Heart and Lung Clinical Standards Group Lead, in conjunction with MRI is reviewing ways of strengthening the Renal Input Service with a plan to establish an improved service within six to twelve months.
MRI (Head & Neck)	**Patient Experience:** A patient asked their MP to raise a formal complaint because the Audiology Department at Altrincham Hospital was requesting that patients provide the department with a stamped addressed envelope to enable them to post out their replacement hearing aid batteries. **As a result of the complaint the following actions were agreed:** • The Policy was reviewed and amended to ensure that all hearing aid batteries are posted to patients at no cost.
RMCH	**Lack of Care:** A patient's father raised concerns that his child was not cared for appropriately following major surgery, resulting in her developing pressure ulcers. The family attended a Local Resolution Meeting where it was acknowledged that measures should have been in place to lessen the risk of the child developing pressure ulcers, and these did not happen. An incident report had alerted senior members of the team to investigate. The incident investigation set out the timeline of the child's care and identified where lapses and omissions of care had occurred which all contributed to the outcome. It was noted that the investigation and learning were triggered by the incident investigation and not as a result of receiving the complaint. **Lessons Learned:** • Presentation arranged at RMCH Harm-Free Care Meeting to discuss learning from the incident and share best practice • One to one training for each member of staff involved in the child's care who omitted to complete tissue viability assessments • Ward Manager to ensure that each bay on Ward 77 has information posters for families to encourage them to help children mobilise and

	how to seek help if they are not sure how to do this safely. • The incident was discussed with the RMCH Lead Nurse for Patient Safety and it has been agreed that pressure relieving mattresses will be provided for patients in advance of undergoing complex or lengthy surgery.
SMH	**Importance of honest and open communication in Gynaecology:** A range of complaints received during this quarter have demonstrated the need for clear, honest communication. A patient raised concern regarding delayed communication with the Outpatient Administration team causing upset and frustration. The patient was concerned regarding the lengthy wait, poor communication, and lack of transparency and openness experienced, which resulted in the patient opting to have a procedure undertaken privately. A further patient reported staff were not answering the phones and raised concern about the lack of communication. An additional patient raised concern as to why she had not been provided, during the consultation, with a realistic waiting time. The waiting time was reported to be 8 to 10 weeks; however a delay of a further 4 weeks was experienced resulting in a 14 week waiting time. **As a result of the complaint the following actions were agreed:** • A Gynaecology Special Measures Oversight Group has been established, which will meet weekly to scrutinise and review data analysis of Referral to Treatment (RTT) times and Cancer performance. • An experienced Gynaecology Service Manager has been seconded to provide support to the Administration and Clerical teams in a series of changes to work streams. This will allow improvement in the efficiency and effectiveness of patient appointment organisation and introduce changes to the management of telephone lines and timely responses in returning of calls.
UDHM	**Patient Experience:** A patient's mother raised concerns regarding the difficulties experienced in making contact with the Appointments Reception Desk at the UDHM. She complained of being disconnected on making contact and provided suggestions on the improvement of the telephone answering system. **As a result of the complaint the following actions were agreed:** • Increase in the availability of telephone lines
CSS	**Patient Experience:** Two patients separately raised concern regarding the change in the appointment booking process for the Pain Clinic. They complained that the Pain Clinic Nurses were no longer able to schedule each of their treatments manually, every four weeks, and that as a result of

	the introduction of the new electronic system, a number of appointments had been inadvertently cancelled. It was reported that the patients felt the transferring of the appointments onto an electronic booking system to streamline the process brought more harm than good and their "preferences" were no longer being considered. **As a result of the complaint the following actions were agreed:** • The electronic booking system remains in use in the Pain Clinic; however this is now managed by the Pain Clinic Nurses who are fully aware when the patient's next treatments are due. This allows patients' preferences to be accommodated around their social and work life. • Patients receive appointment notifications/reminders via telephone and text message.

8. Equality and Diversity Monitoring Information

8.1 **Table 10** provides Equality and Diversity information gathered from complainants for this quarter. During this quarter, in accordance with the Equality Act 2010 and Service Equality Monitoring, and in addition to the use of the Equality Monitoring Form, a process has been introduced to extract this information from the patient's electronic records if available. However, the table demonstrates that collection of this data remains inconsistent and in order to support improvement during Quarter 1, 2020/21 the Head of Customer Services will undertake an audit of closed cases to understand the challenges.

Table 10: Quarter 4, 2019/20 Equality and Diversity Monitoring Information

Disability	**No.**
Yes	29
No	51
Not Disclosed	338
Total	**418**
Disability Type	
Long-Standing Illness Or Health Condition	2
Learning Difficulty/Disability	15
Mental Health Condition	2
No Disability	0
Other Disability	1
Physical Impairment	8
Sensory Impairment	1
Not Disclosed	389
Total	**418**
Gender	
Man (Inc. Trans Man)	180
Woman (Inc. Trans Woman)	234
Non Binary	0
Other Gender	0
Not Specified	4
Total	**418**
Sexual Orientation	
Heterosexual	78
Lesbian/Gay/Bi-sexual	4

Do not wish to answer	0
Other	2
Not disclosed	334
Total	**418**
Religion/Belief	
Buddhist	0
Christianity (All Denominations)	49
Do Not Wish To Answer	0
Muslim	5
No Religion	22
Other	6
Sikh	1
Jewish	1
Hindu	0
Not disclosed	334
Total	**418**
Ethnic Group	
Asian Or Asian British - Bangladeshi	1
Asian Or Asian British - Indian	4
Asian Or Asian British - Other Asian	2
Asian Or Asian British - Pakistani	9
Black or Black British - Black African	7
Black or Black British - Black Caribbean	7
Black or Black British - other Black	0
Chinese Or Other Ethnic Group - Chinese	1
Mixed - Other Mixed	0
Mixed - White & Asian	2
Mixed - White and Black African	0
Mixed - White and Black Caribbean	1
Other Ethnic Category - Other Ethnic	3
White - British	175
White - Irish	4
White - Other White	8
Not Stated	189
Total	**418**

9. Quality Improvements

Improvements Quarter 4, 2019/2020

9.1 In-house Complaints Letter Writing Training Package

Roll out of the newly developed In-house Complaint Response Writing training package was planned during Quarter 4, with the first training course taking place at Wythenshawe Hospital in March 2020.

As a result of the COVID-19 outbreak and in order to reduce transmission of Coronavirus and create the safest possible environment for all staff, the training course was temporarily paused, therefore preventng the planned roll out. This decision will be reviewed in Quarter 1, 2020/21.

9.2 PHSO Research

Frontline Complaint Handling – 'Complaints Standards Framework for NHS Staff'

The PHSO has been working with the NHS, members of the public and advocacy organisations to prepare a draft Complaints Standards Framework, which was planned to be ready for public consultation from 25th March 2020.

However, as a result of the Coronavirus pandemic, the PHSO postponed the start of the public consultation.

Image 1: PHSO Complaints Standards Framework Logo

9.3 Educational Sessions

Following the previous successful educational sessions across the Trust, as part of the Band 7 Development Programme, the PALS Manager facilitated an education session at Wythenshawe Hospital. A further educational session planned for Quarter 1, 2020/21, has been temporarily suspended as a result of the Coronavirus pandemic response.

9.4 Complainant's Satisfaction Survey

The Complaint's Satisfaction Survey is based upon ***'My Expectations'***[1] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/ MCSs/LCOs and during this quarter, 44 responses to the survey were received compared to 56 responses in the previous quarter.

Survey results for Quarter 4, 2019/20 indicate:

- 69.05% of complainants felt that they received acknowledgement of their complaint within an acceptable timeframe.
- 62.79% of complainants felt they had a single point of contact at the Trust who they could approach if they had any questions.
- 61.90% of complainants felt the Trust summarised the main points of the complaint correctly.
- 54.76% of complainants found it easy to make a complaint.
- 50% of complainants felt they were informed of a timescale for the Trust to respond to their complaint and were satisfied with this, with a further 11.90% being informed of a timescale, but were not satisfied with this.
- 42.86% of complainants felt confident that future care would not be negatively affected by making a complaint, with a further 23.81% feeling confident, to some extent.
- 41.86% of complainants felt that they were taken seriously when they first raised their complaint, with a further 16.28% feeling they were taken seriously to some extent.
- 26.19% of complainants were completely satisfied with the outcome of their complaint, with a further 30.95% satisfied to some extent.

[1] Available from:
https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf

These results demonstrate the need for continuous improvement of the complaints process, particularly to increase complainant satisfaction with the outcome. The on-going education sessions and planned letter writing training package aim to improve complainant satisfaction with the outcome of their complaint

Comments received during Quarter 4, 2019/20 include the following:

- Failings were identified, agreed upon and action taken.
- I could not be reassured this problem I had would not happen again until systems were put in place.
- I explained to the nurse that the doctor treated me like a conveyor belt not a person.
- I felt subsequent visits were more keenly observed.
- I had spoken to the ward sister and subsequently the ward manager a number of times without satisfaction.
- I wanted to talk to someone to explain but that wasn't possible.

Future Planned Improvements

9.5 Education and Training

In-house Customer Service e-learning package

Completion of the development of a specifically tailored e-learning Customer Service package is planned to continue during Quarter 1, 2020/21.

The Trust's Head of Customer Services is leading work to make e-learning packages to be available to all staff within the Trust in Quarter 2, 2020/21.

9.6 Communications – External and Internal

Clearly displayed and easily accessible complaints information
(NHSI Patient Experience Improvement Framework, 2018)

Following a full review of the resources available on the Trust's website for PALS and complaints during the previous quarter, the Corporate Complaints team will be working throughout 2020/21 making modifications to improve the levels of accessibility on the website.

9.7 Standard Operational Procedures (SOPs)

Review of the Complaints and PALS SOPs will be undertaken throughout 2020/21.

10. Conclusion and recommendation

The Board of Directors is asked to note the content of this Complaints Report and the on-going work of the corporate and Hospital/MCS/LCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience. In conclusion, the Trust will:

- Continue to monitor complaint response timescales against expected response timescales.
- Offer Corporate Nursing support to Hospitals/MCS/LCO where performance is deteriorating.

- Continue to review and embed recommendations from National Guidance within MFT's policies.
- Continue to learn from complaints and listen to concerns.
- Continue to progress the improvements as outlined in this report.
- Continue to monitor the national system-wide "pause" of the NHS complaints process.
- Address quality issues that arise from complaints during the pandemic response without delay.