NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 11th January 2021

(DUE TO THE IMPACT OF THE ONGOING COVID-19 NATIONAL & LOCAL EMERGENCY RESTRICTIONS, THE MEETING WAS NOT HELD IN A PUBLIC SETTING)

11/21 Board of Directors' (Public) Meetings

The Board noted that in response to the ongoing COVID-19 National Emergency and the UK Governments' social distancing requirements currently in place, meetings of the Trust's Board of Directors and Council of Governors had not been held in a public setting since mid-March 2020. It was further noted that all meetings with Group Non-Executive Directors and Governors were being conducted remotely via 'Electronic Communication' *(Microsoft Teams)* in keeping with the MFT Constitution – October 2017 *(Annex 7 – Standing Orders – Section 4.20 - Meetings – Electronic Communication – Page 108)* with scrutiny undertaken and assurance provided on the Trust's ongoing response to the pandemic during weekly 'virtual' Briefing Sessions with Group NEDs, regular Group Chairman / Governor 'virtual' Surgeries, and, 'virtual' Council of Governors and selected Board Sub-Board Committee meetings.

The Board also noted that whilst today's meeting (11/01/2021) was not held in a public setting, the agenda and supporting documents were posted on the MFT Public Website (https://mft.nhs.uk/board-meetings/board-of-directors-meeting) and members of the public invited to submit any questions and/or observations on the content of the reports and documents presented / discussed to Trust.Secretary@mft.nhs.uk.

12/21 Apologies for Absence

There were no apologies.

13/21 Declarations of Interest

There were no declarations of interest received for this meeting.

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

14/21 Minutes of the 'virtual' Board of Directors' Meeting held on 9th November 2020

It was noted that the Minutes of the 'virtual' Board of Directors' meeting held on 9th November 2020 were approved at the Board meeting (not held in Public due to the ongoing COVID-19 National Emergency Restrictions).

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

15/21 Group Chairman & Group Chief Executive's Reports

(i) A huge **thank you** from the MFT Board or Directors **to all staff and volunteers** throughout the Trust for their amazing resilience and tremendous response to the latest peak in the ongoing COVID-19 pandemic.

(ii) Congratulations was extended to **Julie Cawthorne**, Assistant Chief Nurse for Infection Prevention & Control (IPC), who had been awarded an **MBE** in the New Years' Honours. The Honour recognised Ms Cawthorne's outstanding contribution to patient safety over a 40-year career in nursing, in addition to her vital role in responding to the COVID-19 National Emergency.

Congratulations was also extended to **Sarah Wallace**, Consultant Speech and Language Therapist, who had been awarded an **OBE**. The Honour recognised Ms Wallace's work as an internationally recognised leader and senior clinician within the field of dysphagia and critical care in speech and language therapy (SLT) as well as her essential role in responding to the COVID-19 National Emergency.

(iii) The Board noted that **Geraldine Thompson**, Head of Clinical Photography and Medical Illustration Services, had been elected as Lead Governor at MFT and would serve a 12-month term of until November 2021.

(iv) The **MFT Procurement Team** were recognised with five awards at the National Health Care Supply Association (HCSA) Awards for their incredible contributions to procurement in 2020. In addition to this, all procurement teams in the UK, including MFT received the 2020 President's Award**,** presented by Lord Philip Hunt for their vital contributions during the COVID-19 National Emergency.

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

16/21 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

The Group Chief Operating Officer (COO) presented an update report which described the Trust's ongoing response to the COVID-19 National Emergency. She explained that as previously reported to the Board of Directors since the Spring of 2020, the Trust Governance arrangements to oversee and manage the Group response to COVID-19, remained firmly in place along with regional command and control structures (NHSE/I) in which MFT continued to be recognised as a key partner linking into the wider system structure.

The COO particularly emphasised that in line with the increased escalation levels, MFT Strategic Command had made the decision to reduce routine elective activity from the start of November 2020, in order to release bed and staff capacity to support critical care. The Board recognised that as a result, this was likely to have an impact on the Trust's recovery workstreams and performance against national standards. The Coo went on to described the continued impact of the surge on MFT's Critical Care capacity, the current numbers of COVD-19 patients in General & Acute (G&A) beds throughout the organisation, and, the continued emphasis on preserving patient safety and maintaining a clear focus on clinical priorities and clear pathways over the coming weeks.

The Group Chief Nurse provided the latest update on the Nightingale NW Hospital and it was confirmed that the current 36 bed capacity was full. It was also reported that consideration was being given on whether the facility's capacity should be further extended by another 36 beds to meet continued heightened demand across the Region.

The COO also reminded the Board of Directors that due to the escalating COVID-19 demand and pressures witnessed in recent weeks, the number of patients waiting >52 weeks for treatment throughout the Trust had significantly increased with continued focus on the longest waits and ensuring patients were appropriately prioritised along with the most clinically urgent patients. The Board also noted the Trust's latest performance data (within the report presented) against each of the remaining key headlines, namely, 'Urgent Care', 'Planned Care' (inc. previously referenced 52 wks & RTT), and 'Cancer'.

In response to questions and observations from Mr Barry Clare & Dr Ivan Benett, the COO confirmed that the current heightened COVID-19 demand experienced across all sites did not adversely impact on the continued delivery of Urgent & Emergency Care services with increased trauma activity witnessed in recent weeks in response to a range of incidents across the conurbation. It was also confirmed that unlike some other centres in England, the ECMO (Extracorporeal Membrane Oxygenation) Service had continued uninterrupted at Wythenshawe Hospital.

The Board's attention was drawn to the heightened 'forensic focus' on managing both admissions and discharges with examples cited of patient-by-patient discharge planning and dialogue between Hospitals/MCSs, the LCO, Local Commissioners, Directors of Social Care (M/c and Trafford). The importance of continued focus by both the Manchester and Trafford Community Cells was outlined including the extensive reviews underway of all patients with a length of stay (LoS) > 7 days and support from Local Commissioners in facilitating timely placements of patients.

The COO confirmed that the MFT Recovery and Resilience Board (RRB) had continued to drive the ongoing Recovery programme with a much greater focus on operational delivery. The Board was reminded that transformation activities associated with the elective, cancer, outpatient, urgent care and long term conditions programmes reported to the RRB alongside updates of EPRR activities and key enablers such workforce, estates and informatics. Details of the Programme were noted as presented in the report.

The Group Executive Director of Workforce & Corporate Business provided an overview of the current Workforce position (as at 11/01/21) and it was noted that the number of COVID-19 related staff absences was currently 1,057 (871 clinical staff) with the overall total of staff absences being 2,529. Of note, and whilst around 130-150 new staff absences were being reported each day, a similar number of staff were also returning to work each day with the overall sickness absence rate currently running at a consistently high level.

The Board noted that the 'Staff COVID-19 Risk Assessment' completion rate continued to be sustained at around 96%-97% and further work was to be undertaken, going forward, in relation to staff retention and resilience initiatives which would be required to counteract potential issues related to staff leaving, retirement, post-traumatic anxiety etc. The Group Executive Director of Workforce & Corporate Business particularly wished to acknowledge and thank Staff Side Representatives throughout the organisation for their continued support and close co-operation with many of the workforce-related initiatives outlined.

The Board noted that following the UK's exit from the EU on the 31st December 2020 and is now in a transition period that ends on the 31st December 2020, the Trust, alongside the national team, continued to focus on key areas of focus including HR, Pharmacy, Procurement, R&I, business continuity, and, reciprocal healthcare. The COO also reminded the Board that EU Exit planning continued to be overseen through the MFT Strategic Command (and EPRR) framework and the organisation's EU Exit Contingencies Group was being 'stood-up', with key leads from the above areas of focus to provide expertise as required.

In conclusion, the Board received and noted the report presented by the COO and supporting Group Executive Director colleagues.

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

Update on the COVID-19 Vaccination Programme

The Group Chief Nurse reminded the Board of Directors that whilst the vaccination programme was being managed at the national level, Regions had been given operational responsibility for ensuring delivery (Public Health Functions agreement for 2020/21) and this had been delegated to Greater Manchester Health and Social Care Partnership (GMHSCP) through the Section 7a agreement.

The Group Chief Nurse also confirmed that MFT's vaccination programme had successfully commenced on the Oxford Road Campus (ORC) on 16th December 2020 with dedicated vaccination clinics in place 7 days a week (8am to 8pm) at the MRI Out-patient Department (1,000 vaccines by Day 4 of operating). It was noted that the vaccination was offered, under a Patient Group Direction, to four main cohorts, consistent with the Joint Committee on Vaccination and Immunisation (JCVI).

The Board of Directors was advised that to date (11/01/21) 11,000 individuals had received their first vaccination jab (with 2,850 vaccinated over the previous single weekend). Discussion also centred on the interval between receipt of the 1st and 2nd vaccine and it was confirmed that MFT was adhering to the JCVI national recommendations and guidance (11 weeks between vaccinations).

In response to questions from Professor Luke Georgiou, the Group Chief Nurse confirmed that a Trust Communications and Engagement Plan was in place, ensuring alignment with Greater Manchester Health & Social Care Partnership, to encourage uptake and evidence the safety and efficacy of the vaccine(s). It was also noted in the report presented that in partnership with Staff Side, a series of Frequently Asked Questions had been developed for the MFT workforce.

In conclusion, the Board of Directors noted that the COVID-19 Vaccination leadership team were continuing to work in a responsive environment. It was also noted that key actions were identified within the Vaccination Programme plan that had supported vaccination of patients over 80 who had attended outpatients' appointments, or, at the point of hospital discharge, care home workers and clinically extremely vulnerable staff and those vaccinating in the identified cohorts. It was also acknowledged that plans were in place to expand the vaccination programme to all staff as directed by JCVI and from additional sites across the Group.

The Board of Directors noted the content of this report and the ongoing work to vaccinate all MFT health and social care staff and affiliate organisations.

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

Update on Nosocomial Infections

The Group Chief Nurse provided an overview of the Trust's response to nosocomial infections and especially the actions required for heightened prevention and management of infections throughout the Group in response to the NHSE's published document entitled: Key actions: Infection Prevention and Control and Testing.

The Board of Directors noted that continuous surveillance of all COVID-19 positive cases was undertaken by the Infection, Prevention & Control (IPC) surveillance team with daily COVID-19 data circulated at all levels across the Group. It was also noted that each identified case was reviewed by the IPC nursing team to ensure that all aspects of infection prevention control standards were being followed and any further actions required were in place. The Board was advised that the number of COVID-19 outbreaks across MRI, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from 1st September – 17th December 2020. It was further noted that the escalation in numbers in October and November 2020 could be attributed in part to the rising local community prevalence rate.

The Group Chief Nurse confirmed that as at 11/01/21, there were 70 beds currently closed throughout the organisation due to local outbreaks – 5 in the MRI; 1 Wythenshawe; and, 1 at NMGH. It was also confirmed that there were 1,000 staff absent due to COVID-19 (70% of which were clinical staff). It was also noted that several purpose-built isolation PODS had been ordered and would be installed in selected areas throughout the organisation to assist with 'patient flow' and additional 'isolation' requirements.

The Board of Directors also noted in the report presented NHSE's request for the Trust to review the implementation measures to reduce spread of nosocomial spread of COVID-19 in hip fracture patients in December 2020. The report highlighted that the review concluded that MFT was currently at a similar level of compliance with measures to reduce spread of nosocomial spread of COVID-19 in hip fracture patients as the other 23 hospitals who participated in the survey within the North West Region. The key findings of the review along with supporting actions were noted in the report presented.

The Group Chief Nurse confirmed that the IPC Board Assurance Framework (BAF) was regularly updated and presented to assurance and MFT scrutiny committees. She also confirmed that there was a regular review of national and local guidance at fortnightly meetings of the Expert IPC Group and at the Clinical Sub-group to the COVID-19 Strategic Group.

In conclusion, the Board of Directors noted that scrutiny was undertaken by commissioners and regulatory bodies and the Group IPC Team continued to liaise with Regional NHSE/I team regarding outbreaks of COVID-19 infection and shared practice across GM and the NW region. It was also reported there were regular meetings held with the regional and national team at Executive level.

The Board of Directors noted the Trust's activity and progress to date in the management of nosocomial transmission of COVID-19.

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

17/21 Group Chief Finance Officer's Report

The Chief Finance Officer (CFO) introduced the 'Chief Finance Officer's Report' and drew attention to MFT's financial performance to the end of Month 8 (November) 2020. It was also confirmed that information and key messages highlighted within the report had also been discussed in detail at the most recent meeting of the *MFT Finance Scrutiny Committee* (FSC) held a few weeks earlier on 22nd December 2020.

The Board noted in the report presented that in response to the COVID-19 National Emergency, the NHS financial framework had been amended and all Trusts had been placed on a 'block contract', with an adjusting 'top-up' made retrospectively to bring Trusts to a breakeven position. The Board also recalled that the aim was to provide stability in the short-term as Trusts responded to the pandemic and as they began to restore services during the recovery phase.

The CFO had explained in the FSC that the financial regime for the second half of the year maintained the block payments to Trusts broadly unchanged from the first half of the year. She had also explained that in addition, a system-wide (i.e. Greater Manchester) funding pot had been allocated by the national team and this had now been apportioned to each organisation within GM. The Board recalled that each organisation was expected to manage local costs, including COVID-19 costs, within this. THE CFO had also confirmed that for MFT, the exception to this was that any Nightingale costs would be supported nationally.

The Board was also reminded that the Trust had agreed a financial plan for the second half of the year which required the Trust to achieve a breakeven position. The CFO had explained at the FSC that this was phased differently across months 7 to 12, and whilst the Trust had achieved the target for November 2020 and there continued to be significant risks to delivery as the Trust entered a very challenging autumn / winter period, she was optimistic that the Trust would achieve and indeed exceed the year-end breakeven position.

The Board noted in the report presented that as the Trust continued into the latter half of the year, strong financial governance and control was essential, particularly in the face of an extraordinary and challenging operating environment. The CFO had explained to the FSC that Hospitals continued to report in-month against their projected forecasts, alongside reporting their forecast year end position against the respective Control Totals which had now been formally issued to each Chief Executive. She had also confirmed that as the financial regime had now become clearer for the remainder of the financial year, specific targets had been implemented at Hospital level, to reflect the constraint at Trust level.

The Board noted as presented in the report that as at 30th November 2020, the Trust had a cash balance of £295.4m and this remained higher than plan due to the "double-payment" of the block contract in April 2020, which it was expected would be recovered late in the financial year. It was also noted that the MFT capital plan reflected the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. The CFO had explained in late December (2020) that up to November 2020, £55.1m of capital spend was incurred which was lower than had been planned, however, the forecast was still to deliver the plan.

The CFO had reminded the FSC that in line with national planning requirements, the Trust had submitted a revised financial plan for the second half of the year, and that at the time of submission, the nationally set planning assumptions were predicated on activity recovery in line with the Phase 3 letter (previously reported at the FSC) and no second wave of COVID-19. The Board was also reminded that the Trust had submitted a plan demonstrating a breakeven position and that NHSI had adopted the first six months of actual income/expenditure and MFT's submitted plan for the second six months as the basis of monitoring returns and it was noted that this combined position was shown as the planned YTD values in the I & E Account data enclosed in the report presented.

The FSC had recognised that whilst the clinical / operational position within the Trust was substantively different from the planning assumptions, in the main, the underspends associated with the reduced levels of activity were compensating for the additional costs of responding to COVID-19 demands and the Trust was currently ahead of the planned trajectory at the end of November 2020.

The CFO had advised the FSC in December that within the respective Control Totals there was an implied Waste Reduction target, which aligned to the WRP targets set previously and the progress to date in achieving those savings were noted by the Committee in the schedules presented in the report. The CFO explained that Hospitals/MCSs were forecasting £19.4m achievement against schemes that had progressed to L3 on WAVE. She pointed out that this was an improvement of £2.1m from the figure presented the previous month. It was also noted that a further £1.2m was forecast against schemes that were below L3, suggesting that these schemes required further development and were at a higher risk of non-delivery.

The Board recognised, as anticipated, there had been a reduction in the level of expenditure in the first half of 2020/21 due to reduced activity and the redeployment of clinical staff. It was also noted that Agency spend rose sharply in October 2020, to the levels of early 2019/20, as departments grappled with high sickness rates and trying to deliver recovery actions as COVID-19 demand rose. However, the CFO had explained to the FSC that spend had reduced in Month 8, reverting to the spend levels incurred in previous months. Agency spend remained an area of scrutiny and was one of the key finance indicators in the AOF.

In conclusion, the Finance Scrutiny Committee had noted on 22nd December 2020 that:

- Strong financial governance and control is essential as the Trust moves through the second half of the year;

- Hospital/MCS/LCO Leadership Teams are working within their agreed Control Total and their accountability for delivery of these is resulting in a strengthening of the discipline on forecasting.

- 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 remains a key focus for the Finance Team

Decision:	The Group CFO's Report was Noted	**Action by:** n/a	**Date:** n/a

18/21 Update on Strategic Developments

The Group Director of Strategy presented a report in relation to strategic issues of relevance to MFT.

Particular attention was drawn to the future of Integrated Care Systems (ICS) at a national level and it was confirmed that at its November (2020) meeting, the Board of NHS England and NHS Improvement (NHSE/I) had approved a major policy paper which set out next steps for ICSs and proposals for legislative reform. It was explained that the document served to build on the vision set out in the NHS Long Term Plan for joining up health and care locally.

The Board noted (in the report presented), the proposals for how systems and their constituent organisations would work collaboratively in the future and build on progress achieved to date along with ICSs' key elements, and, two possible options for enshrining ICSs into legislation going forward; with the second option identified as the preferred way forward, namely, the creation of a statutory corporate NHS body model that additionally brought CCG functions into the ICS (ICSs would be established by re-purposing CCGs and would take on the commissioning functions of CCGs. The ICS would have its own Chair, Chief Executive and Chief Finance Officer). The Board was advised that the intention was to open up a discussion with the NHS and partners about integrating care and the options for embedding ICSs in legislation.

The Board was also advised of the timetable for producing Annual Plans for 2021-22 / Phase 4 COVID recovery plans and the specific details were noted as set out in the report presented. It was explained that further guidance on the priorities for 2021-22 from NHS EI was expected in January / February 2021.

The Group Director of Strategy also reported that the North West had recently bid to be designated as a Genomic Medicine Service Alliance (GMSA). Alliances are part of the next stage of the NHSE led Genomics strategy in England. It was also explained that it was intended there would be seven alliances across the NHS and MFT would host the alliance for the North West. The Board noted that we have now received confirmation that the North West bid was successful, and we will be working on developing its role and operating model with David Levy, Medical Director NHS NW.

In conclusion, the Board of Directors noted the updates in relation to strategic developments nationally and regionally.

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

19/21 Update on NMGH including the management agreement, the transaction process and the redevelopment plans

The Group Executive Director of Workforce & Corporate Business provided an update on key issues in respect of North Manchester General Hospital (NMGH) which included a description of the plans and processes to deliver a formal transaction to bring NMGH into MFT on the 1st April 2021, together with information on the NMGH Health Infrastructure Programme (HIP).

The Board of Directors was reminded, and noted, that HIP is the formal title of the capital development programme but the Department of Health and Social Care and NHS England / Improvement were increasingly referring to HIP as the 'New Hospitals Programme'.

The Group Executive Director of Workforce & Corporate Business explained that in keeping with MFT's Constitution (October 2017), the Transaction Business Case was considered and approved by an Extraordinary Meeting of the Board of Directors held 'virtually' and in private on the 14th December 2020.

It was further explained that prior to formal consideration of the Business Case by the Board of Directors, an engagement session had taken place with the MFT Council of Governors on 9th December 2020 to present the key issues contained within the document and to explain the process the Board of Directors had adopted to consider the Business Case.

The Group Executive Director of Workforce & Corporate Business confirmed that as planned, work was continuing to ensure due diligence information on key areas (including finance, workforce and clinical services) informed the final transaction plan. He also explained that in tandem, all legal documentation would be completed to ensure compliance with NHS Improvement Transaction Guidance so that the formal acquisition of NMGH could take place as a statutory process under Schedule 4 of the NHS Act 2006.

The Group Executive Director of Workforce & Corporate Business went on to report that the first iteration of the NMGH Post Transaction Integration Plan (PTIP) had also been finalised and approved by the NMGH Scrutiny Committee on 1st December 2020. The Board noted the document provided the detail of the work needed to safely deliver 'Day 1' and the progress that was being made towards this objective. It was confirmed that work had now started to develop the second iteration of this document which was scheduled for completion in March 2021. It was explained this document would focus on Day 1 preparations, service continuity for patients and support for staff; it would also set out plans into 2021/22 and explain the role of the NMGH Leadership Team.

The Board recalled that Pennine Acute NHS Hospitals Trust (PAHT) had led work to develop 'Safe Transfer Plans' (STPs), which served to set out the detail of the services that would transfer to either MFT or Salford Royal NHS Foundation Trust (SRFT). It was confirmed that MFT had been fully engaged with this work with all the STP documents for corporate (non-clinical) services developed and approved along with well over 90% of the clinical STP documents; with the remainder expected to be finalised by the end of January 2021.

The Group Executive Director of Workforce & Corporate Business recalled that the NMGH transaction was being undertaken on an 'as-is' basis with a commitment to minimise the change experienced by patients and staff on Day 1. It was also confirmed that both MFT and SRFT had agreed that existing patient pathways, across the North East Sector of the PAHT, should be maintained on 1st April 2021, despite the service disaggregation that would have taken place. The Board was advised that in order to deliver this commitment, a series of Service Level Agreement (SLA) documents would be required between MFT and SRFT; these documents would articulate the service that was being provided by one organisation to the other. It was further confirmed that a dedicated tripartite work stream, involving PAHT,SRFT and MFT, had been established to oversee the development of these SLA documents.

The Group Executive Director of Workforce & Corporate Business confirmed that MFT continued to actively contribute to the PAHT-led transaction communications and engagement group, engaged with staff at NMGH through presentations by the Single Hospital Service Team at monthly 'Team Talk Extra' meetings, and, worked with NMGH's dedicated communications manager to ensure messages across MFT were shared throughout the NMGH internal communication channels.

The Board of Directors noted the Health Infrastructure Programme (HIP) update as presented in the report. The Group Chief Finance Officer reminded everyone present at the meeting that both the Redevelopment of NMGH, and, the Digital Case in Support of the Redevelopment of NMGH OBCs had been presented in detail to the Board of Directors over many months during 2020 accompanied by extensive documentation and supporting data. Particular attention was drawn to the heightened level of scrutiny and discussion held at the Extraordinary Meeting of the Board of Directors held on 14th December 2020 and again at a bespoke session with MFT's Group Non-Executive Directors on 4th January 2021. It was also noted that MFT's Council of Governors had also received several briefings and presentations in relation to the redevelopment of NMGH and for the Digital Case with opportunities to seek further clarity and understanding, and, contribution to the development of the OBCs.

The Group Chief Finance Officer explained that in October 2020, £54m was awarded for enabling works on the NMGH site including construction of a multi-storey car park, provision of temporary accommodation for administrative staff and other site preparation activities. It was noted that as a result, a planning application for the car park had now been submitted and the installation of decant accommodation had commenced.

The Group Executive Director of Workforce & Corporate Business also confirmed that a public consultation process, regarding the North Manchester Strategic Regeneration Framework, had started in December 2020 and was being led by Manchester City Council; it was expected this process would conclude in February 2021.

The Board noted that feedback from early consultation activities had been overwhelmingly positive and that MFT would continue to play an active part in this process and would lead a number of digital engagement sessions with staff, voluntary group and the general public. It was also confirmed the MFT website would provide the focus for feedback via the specific 'Transforming the Future at North Manchester General Hospital'.

In conclusion, and in recognition that both OBCs had been presented in great detail to the Board of Directors in various settings over many months and especially at the Extraordinary Meeting of the Board of Directors held on 14th December 2020 and again at a bespoke session with MFT's Group Non-Executive Directors on 4th January 2021, it was noted the MFT Board of Directors had approved both the NMGH Redevelopment Outline Business Case and the NMGH Digital Outline Business Case at the 'Private Meeting' of the Board held immediately prior to the 'Public Agenda Meeting' on 11th January 2021.

In conclusion, the Board noted progress being made to complete the acquisition of NMGH and deliver the NMGH Redevelopment Programme.

Decision:	Report Noted along with the MFT Board of Directors decision to approve both the NMGH Redevelopment Outline Business Case, and, the NMGH Digital Outline Business Case.	**Action by:** n/a	**Date:** n/a

20/21 Ockenden Review of Maternity Services

The Group Chief Nurse presented a summary of a report on Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (published on 11th December 2020).

The Board of Directors noted the background to the Independent Review, which commenced in the summer of 2017, and that the investigation to date had looked at maternal and neonatal harm between the years 2000 and 2019, including cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies. It was further noted that whilst the total number of families to be included in the final review and report was 1,862, the first report now considered focused on the 250 cases reviewed to date (the number of cases considered so far included the original cohort of 23 cases).

The Group Chief Nurse explained that the key findings of the report centred around poor governance across a range of areas, especially board oversight and learning from incidents; lack of compassion and kindness by staff; poor assessment of risk and management of complex women; failure to escalate; poor fetal monitoring practice and management of labour; suggestion of reluctance to perform LSCS - women's choices not respected; poor bereavement care; obstetric anaesthetic provision; and, neonatal care documentation and care in the right place.

The Board was advised of the immediate and essential actions identified by the review panel as important themes which must be shared across all maternity services, as a matter of urgency, with the aim of forming *'Local Actions for Learning'* and make seven early recommendations for the wider NHS, labelled 'Immediate and Essential Actions'. The details of the 7 IEAs were noted by the Board of Directors in the report presented.

The Group Chief Nurse went on to describe the next steps for the Trust (Saint Mary's Hospital Managed Clinical Service – SMH) and it was confirmed that each Trust had been mandated to proceed to implement the full set of the Ockenden Immediate and Essential Actions (IEAs), and to confirm that the 12 urgent clinical priorities from the IEAs had been implemented by 5pm on 21st December 2020.

The Board of Directors particularly noted that the next step was for the Trust to complete the assurance assessment tool which would be reported through the GM&EC LMS and shared with the regional office by 15th February 2021. It was recognised this would demonstrate the level of compliance with all 7 IEAs of the Ockenden Report, NICE guidance relating to maternity, compliance against the CNST safety actions and a current workforce gap analysis.

It was confirmed that SMH and North Manchester General Hospital had assessed their current positions and could confirm compliance as set out in the table presented, and noted, in the report. The Group Chief Nurse also confirmed that work was already in progress on a number of those areas assessed as partially compliant and plans were being developed to commence addressing outstanding actions. It was recognised that some of the plans to report full compliance would be effective from 1st April 2021 due to the acquisition of NMGH. In the meantime, it was noted that support was provided to NMGH to enable them to fully meet the standards and provide assurance to Pennine Acute Hospitals NHS Trust Board.

The Group Chief Nurse confirmed that detailed analysis of each of the Immediate and Essential Actions developed and associated data would be tabled in a number of governance and scrutiny committees within SMH and MFT. It was also noted that SMH was working collaboratively with the GM&EC LMS on several actions which required system leadership and implementation (several examples cited in the report were noted).

In responding to the immediate and essential actions on 21st December 2020, the Group Chief Nurse also confirmed that SMH's maternity services had not identified any high-level patient safety risks and did not anticipate this being on the Trust risk register at a level over 15. The Board also noted several associated workstreams including continued close working arrangements with other Hospitals / MCS to ensure the ongoing development of IT systems required to demonstrate compliance with nationally reported MSDS; plans to work with both internal MFT comms leads and the GMEC in respect of access to information for families; a robust approach to monitoring compliance against the CNST standards and escalating any potential risk of full compliance; completion of the assurance assessment tool which would be reported through the GM&EC LMS and shared with the regional office in line with the more recently received deadline of the 15th February 2021. It was noted that a further workstream would involve SMH working with the Group Director of Clinical Governance to create a maternity infrastructure aligned with new patient safety and quality initiatives.

In conclusion, the Board of Directors noted that the CEs of both SMH and NMGH had reviewed the seven immediate and essential actions highlighted in the Ockenden Report and the initial reporting was against the 12 urgent clinical priorities and was confirmed by 21st December 2020. It was also noted this was overseen by the Group Executive Director and Board Safety Champions.

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

21/21 Ratify the CQC Statement of Purpose – Part 2

The Board of Directors was reminded by the Group Chief Nurse that MFT was required to register all new locations with the Care Quality Commission (CQC) as per the CQC regulations. She explained that the purpose of the report now presented was to inform the Board of four new locations that would be added to MFT's CQC registration as of 1st April 2021, namely

- **North Manchester General Hospital**
- **Fairfield General Hospital**
- **Rochdale Infirmary**
- **Royal Oldham Hospital**

It was noted that MFT was required to update its' statement of purpose document to reflect the additional locations, and, that whilst there were no changes to function or purpose, the new locations had been added to the statement of purpose.

In conclusion, the Board of Directors received and noted the amended statement of purpose (included as an Appendix to the report presented) and the additional locations as described.

Decision:	CQC Statement of Purpose Received and Noted	**Action by:** n/a	**Date:** n/a

22/21 Committee Meetings

The Board of Directors noted the following Board Sub-Committee 'virtual' meetings which had taken place during November and December 2020:

- Group Risk Oversight Committee held on 2nd November 2020
- NMGH Scrutiny Committee held on 1st December 2020
- Finance Scrutiny Committee held on 22nd December 2020
- Local Care Organisation Committee held on 11th November 2020
- EPR Committee held on 17th November 2020
- Audit Committee held on 4th November 2020

The following meetings had been stood down due to the ongoing COVID-19 National Emergency:

- Charitable Funds Committee scheduled for 23rd November 2020 (re-designated a 'virtual' workshop session)
- Quality & Performance Scrutiny Committee scheduled for 7th December 2020
- HR Scrutiny Committee scheduled for 15th December 2020

23/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday 8th March 2021** at **2pm**.

N.B. This meeting will not be held in a Public setting due to the COVID-19 National Emergency and the UK Governments ongoing local 'Lock-Down' restrictions in GM and 'Social Distancing' directives.

24/21 Any Other Business

There was no other business and no items for recording on an Action Tracker.

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

*(v) Attendance via 'Electronic Communication' (Microsoft Teams) in keeping with the **MFT Constitution – October 2017** (Annex 7 – Standing Orders – Section 4.20 - Meetings – Electronic Communication – Page 108)*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Chief Operating Officer
Paper prepared by:	Chief Operating Officer team
Date of paper:	March 2021
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: Julia Bridgewater, Chief Operating Officer Tel: 0161 701 5641

COVID – UPDATE ON THE TRUST ONGOING RESPONSE

1. PURPOSE

The purpose of this briefing is to provide the Board of Directors with an overview of the MFT response to the Covid19 pandemic ("Covid"), including ongoing planning and impact on long waits, staff testing, performance against national NHS constitutional standards and further development of Recovery Planning.

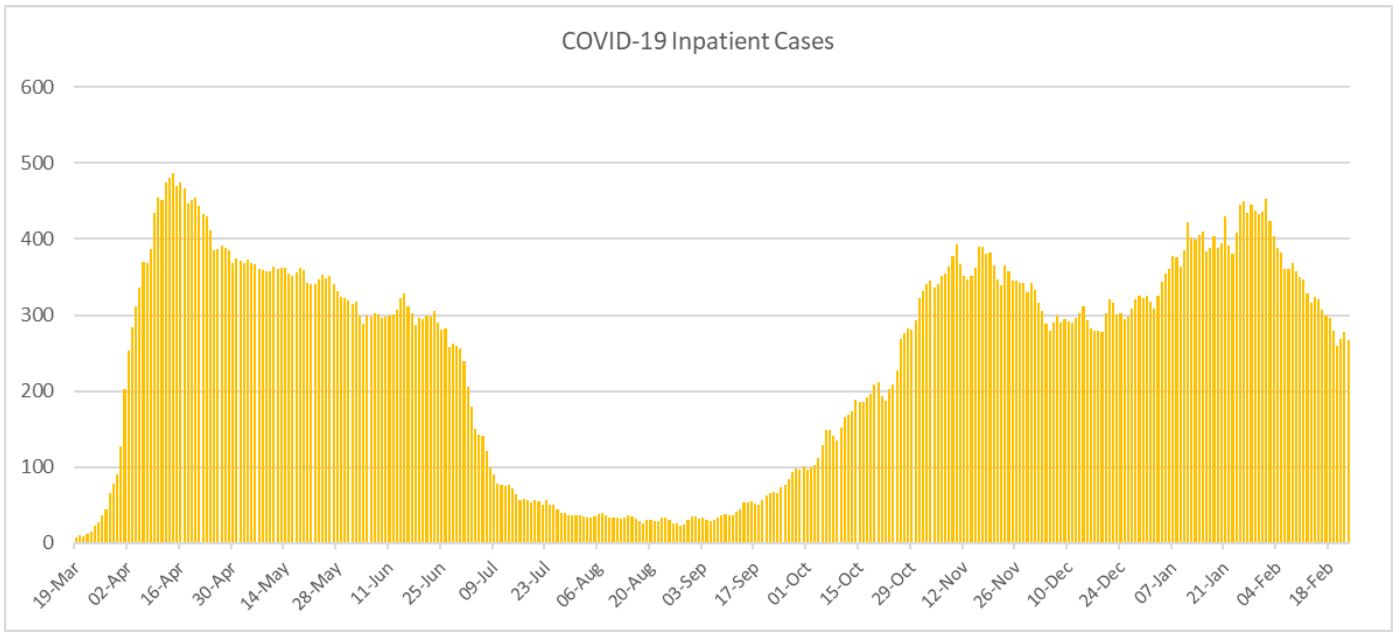
2. COVID POSITION

- A 3rd wave of Covid in January 2021 necessitated a further period of national lock down, that remains in place in February.
- MFT had two peaks of Covid attendances during January and early February.
    - The first peak occurred in the second week of January and saw 423 covid attendances.
    - A second rise in Covid attendances at the end of January resulted in a peak of 453 Covid patients occupying in-patient beds.
- Inpatient Covid numbers of 453 represented 93% of the wave 1 Covid peak – which occurred on the 14th April 2020 with 487 inpatients.
- On 4th February, MFT had a total of 64 Covid inpatients in Critical care (level 2/3 beds), 62% of the wave 1 peak (104 critical care patients).
- As at 23rd February 2021 the Trust had 267 inpatient Covid cases. The current Covid inpatient numbers are primarily concentrated within:
    - MRI – 123
    - Wythenshawe - 89
    - NMGH – 26
    - Trafford - 23

A key difference between the first and second/third waves of Covid (November 2020 and January 2021) is the number of non-Covid patients that have required treatment at the same time as Covid attendances have remained high.

In line with the increased escalation levels, MFT Strategic Group made the decision to reduce routine elective activity from the start of November, in order to release bed and staff capacity to support critical care. This has continued in January and into February, and as a result, has impacted on the Trust's recovery workstreams and performance against national standards.

Table 1. MFT Covid inpatient cases (March 2020 to February 2021)



3. CONTINUED COVID PLANNING

In response to the increased Covid position in the 3rd Quarter of the year, the MFT Strategic Group prepared plans for future waves, which aligned with national and regional guidance. The decision-making process to support Group escalation and its associated consequences, continues to be led by the Chief Operating Officer (and AEO); Medical Directors; Chief Nurse and the Group Executive Directors.

Individual Hospital / MCS escalation plans were approved via the MFT Strategic Group in October, supported by a Group Escalation Decision Making Framework. MFT took a tiered approach to the escalation process, to balance the impact on all activity programmes, as set out below. These priorities have remained appropriate throughout the period November to date.

Ongoing consideration of reductions in the Trust's elective and outpatient activities during the 3rd wave of Covid has been undertaken through the MFT Strategic Group. Agreement to reduce activity has been taken in order to meet Trust and hospital / MCS site demand on critical care and ward beds. Key priorities remain:

1. Protection of Specialist Hospital and Service activity
2. Mutual aid and equalisation of Covid / elective activity across all MFT Sites
3. Reduction / cessation of non-essential activities i.e. meetings
4. Reduction of Outpatient Activity to release clinical staffing – phased approach to minimise reductions
5. Reduction of Elective Activity to release clinical staffing. NB: this must be preceded by a request for mutual aid to GM Gold as part of a phased approach to minimise reductions.

In mid-January the Trust was asked by Greater Manchester Gold Command (GM Gold) to support delivery of a super surge plan for adult critical care capacity to OPEL Level 3, stage 3. This meant that Trust's across Greater Manchester would need to extend Covid care into enhanced care and non-critical care areas.

A further difference with previous waves of Covid is that during January and February 2021 the Trust has also been required by national teams to extend mutual aid across both Greater Manchester and inter-regionally to the Midlands. Without this approach these regions may not have been able to meet the health demands of their populations.

During the first Covid peak, normal on call arrangements were suspended and for a period of time and additional on call arrangements at a hospital level were established along with Group Tactical arrangements to coordinate the overall day to day incident management as well as responding to external partners. These were stood up again in respect of the 2nd Covid wave and have remained in place during the 3rd Covid wave to support management of the pandemic and to respond to external partners.

4. IMPACT OF COVID 3RD WAVE ON LONG WAITS

The continued incidence of Covid, and the need to stand down elective activity for significant periods of time since March 2020 has had a profound impact on the shape and size of the waiting list at MFT. Activity cessation and changes in patient behaviour, means that the NHS as a whole is now facing a large backlog of non-Covid care.

In addition, MFT has seen a significant rise in the volume of >52-week waiters. Based on data at the start of February showing patient breach dates from now until end of March, a worse-case do nothing scenario projects that there could be c.25,0000 patients which will have breached 52 weeks by the end of March. This is split c.20,600 at MFT and c.4,400 at North Manchester General Hospital (NMGH). Both MFT and NMGH continue with ongoing performance management of hospital / MCS delivery and clinical validation / priority work to ensure that the number of long waiters is minimised where possible.

5. RECOVERY PROGRAMME

The Recovery and Resilience Board (RRB) has been driving the ongoing Recovery programme with a much greater focus on operational delivery. Transformation activities associated with the elective, cancer, outpatient, urgent care and long-term conditions programmes report to the RRB alongside updates of EPRR activities and key enablers such workforce, estates and informatics.

It is clear however from the ongoing incidence of Covid from March 2020, and specifically the extended impact of the 2nd and 3rd Waves, that recovery will be both challenging and complex. Previous recovery plans focussed on the operational workstreams required to maintain and reshape services to respond to the immediate pandemic situation.

There now requires a permanent shift in operating models across MFT and the wider GM system to respond and recover from Covid. This will entail significant demands in terms of staff engagement and leadership capacity. The following key principles have been developed to underpin our Recovery whilst maintaining patient safety, minimising potential harm associated with long waits, and continuing to acknowledge the role that staff have played through the pandemic so far and support them through Recovery.

- How we operate – Reshaping the MFT operating model and working collaboratively with GM, regional and national partners to develop our planning;
- Minimising patient harm and maximising patient safety – allocating available capacity based on clinical need and ensuring equity of access using GM resources;
- Supporting and developing staff – prioritising staff wellbeing, recruitment and retention;
- Maintaining a safe environment – focus on Infection Prevention and Control and minimising transmission of Covid; and
- Maximising available capacity – effective use of key resources and accelerating discharge work to ensure where possible patients are treated in the community and in their homes.

Staff at all levels have had to manage significant change in the last year. Robust organisational development and Transformational support will be required to engage and support teams to develop and embed new ways of working.

6. PROGRESS ON RECOVERY WORKSTREAMS

In terms of current priority areas for Transformation work and the RRB these continue to be Urgent Care and Flow, Elective Surgery and Outpatients. A performance dashboard continues to be used to monitor outturn and inform the work of each RRB workstream. This section contains a summary of key areas of work.

6.1 URGENT CARE AND FLOW - DISCHARGE PLANNING

Given the extreme pressures on ED and inpatient, critical care bed base as a result of Covid the Trust has continued to work closely with system partners to provide additional focus on effective and timely discharge. Support to further improve processes across the Trust has been provided by the Trust Transformation team.

As a result of this work with system partners MFT has seen decreases in the number of long stay patients since 18th January, particularly in those with 21+ days length of stay as shown in the table below.

Table 3 . Analysis of movement in the number of long stay patients at MFT, and comaprison to GM average

	Number of patients		Level of decrease		
MFT	**18th January**	**8th February**	**MFT Patient numbers**	**MFT % Decrease**	**GM average % decrease**
Patients with 21+day LOS	301	267	-34	-11.3%	-1.90%

6.2 ELECTIVE CARE - CLINICAL PRIORITIATION / MESH

As a result of the challenging operational environment caused by Covid effective management of elective waiting lists at local level is required to ensure that MFT treats its most clinically urgent patients first, and will also play a critical role in delivering elective activity within the next phase of recovery.

MFT has developed a robust process to meet the objective of prioritising treatment of clinically urgent patients. Site based MESH (Manchester Emergency & Elective Surgical Hub) groups meet daily, one for WTWA and one for Oxford Road site. These groups are clinically led and oversee the validation and prioritisation of single pooled specialty Patient Treatment Lists. Outputs from these meetings come forward for Group MESH prioritisation of access to theatre capacity, to ensure the patients with highest clinical priority are operated on first and that there is equity of access across specialties and sites.

The Group MESH has been mobilised to ensure oversight and effective use of resources across MFT sites, including Independent Sector capacity already agreed for use of MFT. Chaired by one of the joint Group Medical Directors, it has wide clinical and operational representation from Group. It also oversees the process for referral of cancer patients to GM Cancer Hub, if required.

6.3 OUTPATIENTS

A re-basing exercise of Phase 3 activity projections was undertaken by hospitals at the end of December / early January. The prolonged impact of the 3rd wave of Covid in January has had an impact on delivery against outpatient activity plans across most of the MFT hospital sites.

The current proportion of activity that is virtual activity across MFT exceeded the internal target level of 35% for week ending 17th February, with 38% of consultations taking place virtually. Over 6% of consultations were undertaken via video. These delivery values are in line with Shelford Group median levels.

Hospitals continue to work on delivery of actions plans aimed at delivering further improvements, and are being held accountable by Group. Cross-cutting actions plans have ben identified that are led by Group. In respect of these transformational activities, roll out plans for Virtual triage are in development. These will integrate the Advice and Guidance function for GP's. Patient Initiated Follow-up (PIFU) plans will enable patients with suitable conditions to manage their condition better without the need to attend routine follow-up where this is not required. This will also help prepare the organisation and patient groups for the introduction of the patient portal available within Hive.

7. STAFF TESTING

A second programme of asymptomatic staff testing commenced on 23rd November, requiring staff to test and report on a twice weekly basis using a lateral flow method of testing across a twelve week period. The programme has aimed to support our understanding of how Covid is being transmitted, and to help to reduce the level of community transmission in the region as well as nosocomial infection rates within MFT. This programme has run alongside focused outbreak testing of symptomatic staff.

As at 18th February test kits had been distributed to over 24,000 staff and a cumulative total of 163,792 tests had been undertaken and reported by staff. The number of staff who have reported a positive lateral flow test is 643 (0.41% of tests reported).

As this programme is entirely voluntary, MFT has worked on actions to encourage participation and recording, including the development of an app and email reminders to ensure that Staff regularly record their test results.

The initial programme of staff testing will come to an end later this month. A further 12 weeks of testing will commence in March 2021.

8. PERFORMANCE

Urgent Care:

MFT

- Safety remains a key priority.
- Activity reduced during the 2nd lockdown period. At the end of January they remain below end November 2020 levels and are currently at 70% of 19/20 attendances.
- During January, normal winter pressures have remained, and non Covid-attendances remained high.
- Acuity of patients presenting, limitations on bed capacity due to Covid outbreaks and some flow restrictions at times of attendance have all impacted performance.
- MFT ended Q3 ranked 3rd in GM for 4-hour performance, and the position remains the same for January and Q4 to date.

NMGH

- Q3 attendances were 75% of Q3 2019, and January performance was 71.0%.
- Similar to MFT, operational pressures have been evident across Q3 and into Q4 due to flow restrictions, social distancing requirements, Covid outbreaks on wards and staffing sickness absence.
- Trolley waits experienced in November reduced in December to 3 and further in January to 0.

4 Hour Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Q4 to date
MFT 20/21 %	90.18	93.4	91.6	91.8	88.2	86.3	81.07	77.4	76.1	75.95	77.5
MFT GM Rank	3	3	2	2	3	3	2	2	3	3	3
NMGH 20/21%	88.1	87.9	81	82.4	79.4	75.8	68.2	69.2	70.0	71.0	
GM %	89.8	93.3	90.5	89.5	86.2	82.4	76.5	74.4	74.3	79.3	76.7
National %	90.4	93.5	92.8	92.1	89.3	87.3	84.4	83.8	80.3	78.5	

Planned Care:

RTT & 52 Weeks:

MFT

- The number of patients waiting >52 weeks has increased due to the factors listed within sections 3 and 4 of this paper.
- Along with treating the most clinically urgent patients, MFT continues to ensure that the longest waiters are also prioritised for treatment.
- Further focus has been undertaken in Q3 and January to convert face to face appointments to telephone and virtual.

NMGH

- Similar to MFT, the 52-week wait position has seen significant growth and at the end of January is c~3,000 patients.
- Activity has been supported mitigated by use of virtual attendances where possible.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
MFT	Wait List	98,785	102,318	101,203	102,381	104,150	106,272	106,438	106,706	109,452	111,006
	RTT %	67.2%	59.3%	47.0%	38.4%	42.7%	48.7%	52.4%	54.1%	53.7%	54.1%
	52 Weeks	369	1,042	1,959	3,245	4,260	4,846	5,946	7,100	8,443	10,602
	% of W/L >52 weeks	0.4%	1.0%	1.9%	3.2%	4.1%	4.6%	5.6%	6.7%	7.7%	9.6%
NMGH	Wait List	14,767	14,790	14,250	14,806	14,745	14,375	14,862	15,443	14,992	15,505
	RTT %	63.2%	56.5%	53.4%	37.5%	42.6%	45.5%	50.6%	51.7%	52.5%	51.8%
	52 Weeks	46	99	210	391	583	855	1,269	1,877	2,148	2,798
	% of W/L >52 weeks	0.3%	0.7%	1.5%	2.6%	4.0%	6.0%	8.5%	12.2%	14.3%	18.1%
National position	Wait list *Million	3.94	3.83	3.86	4.05	4.22	4.35	4.44	4.21	4.28	Not Available
	RTT %	71.3	62.2	52	46.8	53.6	60.6	65.5	62.6	67.6	
	52 Weeks	11,042	26,029	50,536	83,203	111,026	139,545	162,888	186,310	215,641	
	% of W/L >52 weeks	0.3%	0.7%	1.3%	2.1%	2.6%	3.2%	3.7%	4.4%	5.0%	

Diagnostics:

MFT

- The waiting list size for diagnostic tests at MFT (exc NMGH) has improved with a reduction of 878 patients between December and January as activity levels continue to improve.
- However, whilst the size of the diagnostic wait list reduced, the MFT breach rate of the 6 week standard increased from 26.3% to 27.10% resulting in patients waiting marginally longer for their diagnostic.

NMGH

- The NMGH breach rate of 6 week standard has improved significantly to 16.6% at the end of January, primarily as a result of focussed work in Audiology in January.

Breach rate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
MFT	46.90%	64.90%	59.90%	48.80%	46.90%	38.70%	32.70%	27.80%	26.30%	27.10%
NMGH	54.10%	51.30%	45.20%	40.60%	47.10%	43.30%	34.00%	27.80%	31.30%	16.60%
National	55.70%	58.50%	47.80%	39.60%	38%	33%	Not Available			

Cancer:

MFT and NMGH

- At the end of January, referrals for suspected cancer had returned pre-Covid levels across MFT sites.
- Performance against the 62-day standard has been variable between December and January.
- In respect of 2 week waits, WTWA see a considerable number of suspected breast and skin cancer which, by their nature require face to face appointments. A revised Breast trajectory remains on target for recovery during Q1 of the new financial year.

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
MFT	2WW	93%	83.21	87.65	76.73	63.23	67.89	64.03	68.9	70.76	73.3	69.2
	31 Day	96%	93.17	88.12	90.87	94.47	91.96	91.61	92.1	90.85	89.74	
	62 Day	85%	64.17	51.28	64.4	69.26	71.76	57.72	55.4	61.08	64.96	58.6*

* Unvalidated

		Target	Apr-20	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
NMGH	2WW	93%	87.6	99.6	98.1	95.5	96.4	93.8	95.8	82.8	58.4	55.4
	31 Day	96%	100	97	98.4	97.8	94.7	98.3	96.9	100	98.9	
	62 Day	85%	77.7	59.1	64.6	55.2	71.2	70.3	80	63.3	79.7	59.6

MFT and NMGH >104 day cancer waits

		Jan
MFT Total	**Trajectory**	**40**
	Actual	**65 (25)**
NMGH Total	**Trajectory**	**6**
	Actual	**24 (18)**

- MFT has made improvements in reducing the lengthier of the long cancer waits with prioritisation efforts through the Trust MESH process.
- At the end of January, MFT had 65 patients waiting past day 104 (5 over the pre COVID levels, 25 above trajectory).
- Of the 24 actual > 104 day waits, NMGH had 19 of within Urology.
- However, a high proportion of MFT and NMGH patients could not be progressed due to patient choice, patient unfit, and late referral.

9. RECOMMENDATION

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Alison Lynch, Corporate Director of Nursing
Date of paper:	March 2021
Subject:	COVID-19 Vaccination Programme
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:	• Improve patient safety, quality and outcomes • Improve the experience of patients, carers and their families
Recommendations:	The Board of Directors are asked to note: • The information provided in the report in relation to the COVID-19 Vaccination Programme
Contact:	Name: Alison Lynch, Corporate Director of Nursing Tel: 0161 276 5655

1. Background

1.1. The aim of the COVID-19 vaccination programme is to protect those who are at most risk from serious illness or death from COVID-19 or at risk of transmitting infection to multiple vulnerable persons or other staff in a healthcare environment.[1]
1.2. The MFT vaccination programme commenced on 16th December 2020.
1.3. The SRO for the vaccination programme is Professor Cheryl Lenney, Chief Nurse. The programme is being led by the Corporate Director of Nursing and the Chief Pharmacist, who provide support and guidance to the Workstream Leads.
1.4. An MFT staff vaccination programme is in place which is estimated to be completed by the end of May 2021, to date c.18,000[2] staff have been vaccinated and circa 12,500 affiliates[3]/associates[4]. 77% of MFT staff have booked or received the first vaccine.
1.5. Affiliates/Associates of MFT add approximately an additional third to the overall staff numbers giving MFT an overall staff population of circa 38,000 to vaccinate.
1.6. Vaccinations are delivered across MFT (NMGH, MRI, Wythenshawe & Trafford) in clinics to those who meet the JCVI eligibility criteria in cohorts 1 – 4 in collaboration with Manchester Health and Care Commissioning and Trafford Care Commissioning Group.

2. Strategic Context

2.1. There is a national expectation that all people in cohorts 1-4 of the JCVI priority areas will have been offered a Covid-19 vaccination by February 22nd. MFT have ensured that all staff and affiliates have been offered the vaccine within those cohorts and achieved that target. MFT have also offered the vaccine in partnership with MHCC and TCCG colleagues for care home workers and the independent health and social care sector, where eligible.
2.2. Vaccine supply has been constrained during end of February and anticipated to be the case up to early March but there is confidence nationally that enough vaccine will be available for all 2nd doses. MFT are managing supply and demand through rigorous management of the clinic activity
2.3. Changes to the vaccine provision with 2 new vaccines coming on line from April (Moderna and Novavax) alongside the success of the programme to date, has meant that the DHSC are looking to bring forward the vaccination time frame for cohorts 5-9 and hoping to achieve all adults having been offered the vaccine by summer 21. It is anticipated that will be no constraints on supply from April onwards.
2.4. There is a national group looking at the longer-term programme for the continuing provision of the vaccine in a business as usual model from 2021.
2.5. GMHSCP have commenced modelling the longer-term GM offer for citizens.
2.6. Hospital hubs are expected to provide a full vaccine offer to staff and affiliates including health and social care students on placement.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960977/COVID-19_vaccination_programme_guidance_for_healthcare_workers_11_February_2021_v3.3.pdf

[2] Data accurate at 17th February 2021

[3] Affiliates e.g. working at MFT but not employed by the Trust such as Sodexo, NHSP, G4S and agency staff

[4] Associates e.g. junior doctors, North Manchester General Hospital staff, academic staff and those on honorary contracts.

3. Vaccine Delivery

3.1. A programme team led by the Corporate Director of Nursing and Chief Pharmacist supported by Employee Health and Well-being and Informatics have defined and delivered the vaccination programme for MFT.

3.2. Around 45,5000 people identified through JCVI priority lists have received their first vaccine[5], including staff, patients, care home staff, MFT Affiliates and Associates, NHS Staff (Non-MFT) and Non-NHS Health and Social Care staff.

3.3. 100% of staff have been offered the vaccination; 77% have now booked or received their first vaccine[6]. An extensive communication plan is in place to increase staff uptake of the vaccine targeting those you have yet to take up the offer of a vaccination or who have declined.

3.4. 64% of staff who identify as BAME have taken up the vaccination offer.

3.5. It should be noted that the number of affiliates or associates add a third more staff numbers to the number of MFT directly employed staff.

3.6. Patient cohorts have been expanded in line with JCVI guidance. This includes:

- Inpatients
- Identified outpatient paediatrics
- Pregnant women
- Cystic fibrosis patient
- Transplant patients
- Renal dialysis patients, and
- Those with severe allergies

3.7. To support MFT staff, an initiative called 'Your Household' has been established, which allows eligible household and support bubble members of MFT staff to be vaccinated if they meet the JCVI cohorts 1 – 5 criteria.

3.8. 45,000[7] people are booked in to have their second vaccine by end of May 2021.

3.9. Work is ongoing to support staff who are vaccine hesitant with key groups identified, as: young women because of fertility or pregnancy and breast-feeding concerns, black British and staff in the lower AFC bands 2-4. These groups mirror community groups being targeted by MHCC to encourage vaccine uptake.

4. Policies, procedures and guidelines

4.1. To ensure the safe delivery of the vaccine, frameworks, policies and a series of standard operating procedures are in place to support safe delivery of the vaccination programme.

4.2. Processes are in place to respond to changes in national guidance, including PHE's Green Book[8] which describes the JCVI cohorts.

4.3. A document control process has been created for standard operating procedures and any supporting documentation.

4.4. Workstream Leads are responsible for the development and submission of standard operating procedures to ensure the safe delivery of the vaccination programme.

[5] Data accurate at 17th February 2021
[6] Data accurate at 17th February 2021
[7] Data accurate at 17th February 2021
[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/961287/Greenbook_chapter_14a_v7_12Feb2021.pdf

4.5. The COVID-19 Vaccination Strategic Group provides final approval of the standard operating procedures and any supporting documentation.

5. Data and reporting

5.1. Situation reports (Sitreps) are submitted regionally and nationally regularly in line with requests received, providing a range of information including vaccination uptake in:
- Frontline Healthcare staff
- Health and Social Care Workers
- Black, Asian and Minority Ethnic (BAME) staff
- Clinically extremely vulnerable staff; and
- Associate projections of vaccine requirements

5.2. A Reporting Working Group is in place to ensure that consistent and timely returns are made and to monitor and improve data quality.

5.3. A vaccination dashboard which summarises progress to date is issued daily.

5.4. Staff COVID-19 vaccination reports are distributed weekly and communicated with line managers in order to facilitate targeted wellbeing conversations.

6. Communications and Engagement

6.1. A coordinated and creative engagement plan has been implemented to ensure that all people offered the vaccine have the information required to make an informed decision.

6.2. A staff engagement group including representation from groups who are hesitant to take up the offer, is in place to increase the staff uptake of the vaccine.

6.3. An information pack is in place to support managers in holding wellbeing discussions with staff who have not accepted or have declined the offer of vaccination.

6.4. A vaccination inbox was set up to handle enquiries from staff, patients and the general public.

7. Governance

7.1. Vaccination Programme Meetings are held twice a week, focusing on the strategic planning of the vaccine programme, including the transition to business as usual.

7.2. The governance team provide a weekly summary of all incidents related to the vaccination clinics. No level 3 or 4 incidents have been recorded to date.

8. Next Steps

8.1. A sustainable long-term plan is under development to transition to business as usual. this will include dialogue with stakeholders including MHCC, TCCG and GMHSCP.

8.2. The current focus is to administer as many vaccines as possible, in line with JCVI guidance, by continuing to provide first and second dose vaccinations to staff groups, whilst offering the vaccine to new patient cohorts and eligible family members of MFT staff.

8.3. The focus will consider vaccine availability, clinic capacity, workforce requirements, and response to national directives that may be released.

8.4. MFT provides a leadership role to the GM Hospital Hub network and will continue to share knowledge to support effective vaccination delivery.

9. Summary

9.1. The COVID-19 vaccination leadership team are running an effective vaccination programme in a rapidly changing environment.
9.2. The programme has delivered 45,446 vaccines as of 17th February 2021 based on JCVI guidance and cohort requirements.
9.3. Further targeted support identified for those staff who are hesitant to take up the vaccination offer.
9.4. MFT will continue vaccinating members of the Manchester and Trafford population based on national guidance and as required by partners.
9.5. MFT will work with GM colleagues to define the future operating models for the COVID-19 vaccination programme.

10. Recommendation

10.1. The Board of Directors are asked to note the content of this report and progress of the vaccination programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse/Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC Dr Rajesh Rajendran, Associate Medical Director, Infection Prevention and Control
Date of paper:	February 2021
Subject:	To provide assurance to the Board of Directors on the Management of Nosocomial Infections
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:	For Patient safety & patient experience
Recommendations:	To note the contents of this report
Contact:	Name: Julie Cawthorne Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC Tel: 0161 276 4042

1. Introduction

1.1 The Trust is committed to the prevention and management of Nosocomial Infections as demonstrated in the continuing actions and improvement programmes set out in the IPC Board Assurance framework (BAF) Appendix A.

1.2 Prevention and management of nosocomial infections is multifaceted; actions not covered in this paper are covered in separate papers to the Board of Directors such as the Covid-19 Vaccination programme and staff testing.

1.3 This paper provides an update on Nosocomial Transmissions of COVID-19, progress on the Nosocomial Infection Dashboard and the deployment of temporary isolation facilities.

2. IPC BAF

2.1. The NHSE Infection Prevention Control Board Assurance Framework (IPC BAF) has been updated in February 2021 to include 43 new indicators. The IPC BAF is included at Appendix A where the new indicators are included. Examples of new indicators include

- monitoring of IPC practices
- testing and isolation strategies
- cleaning standards and ventilation
- communication of PHE hands, face, space campaign
- Face masks, including fit testing
- Screening
- Board oversight

2.2. Board oversight is demonstrated as follows; the IPC Board Assurance Framework has been reviewed at the following meetings of the Board of Directors and sub-committees since its publication in June 2020.

- 13th July 2020. Board of Directors
- 14th September 2020. Board of Directors
- 14th October 2020. Group Infection Prevention and Control Committee, a Sub-Committee of the Board of Directors
- 9th November 2020. Board of Directors (amalgamated into the Board Assurance Framework).
- 11th December 2020. Extraordinary Board of Directors
- 11th January 2021 Board of Directors

3. Current Position

3.1 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 18th February 2021 indicate the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West is 0.7 to 0.9. This compares to an R rate of 0.7 to 1 for the previous week.

3.2. There is a direct relationship between the transmission of the virus in the community with the transmission within health care settings.

3.3 The number of newly confirmed cases and COVID-19 in-patient burden for MFT can be found in Charts 1 and 2 below.

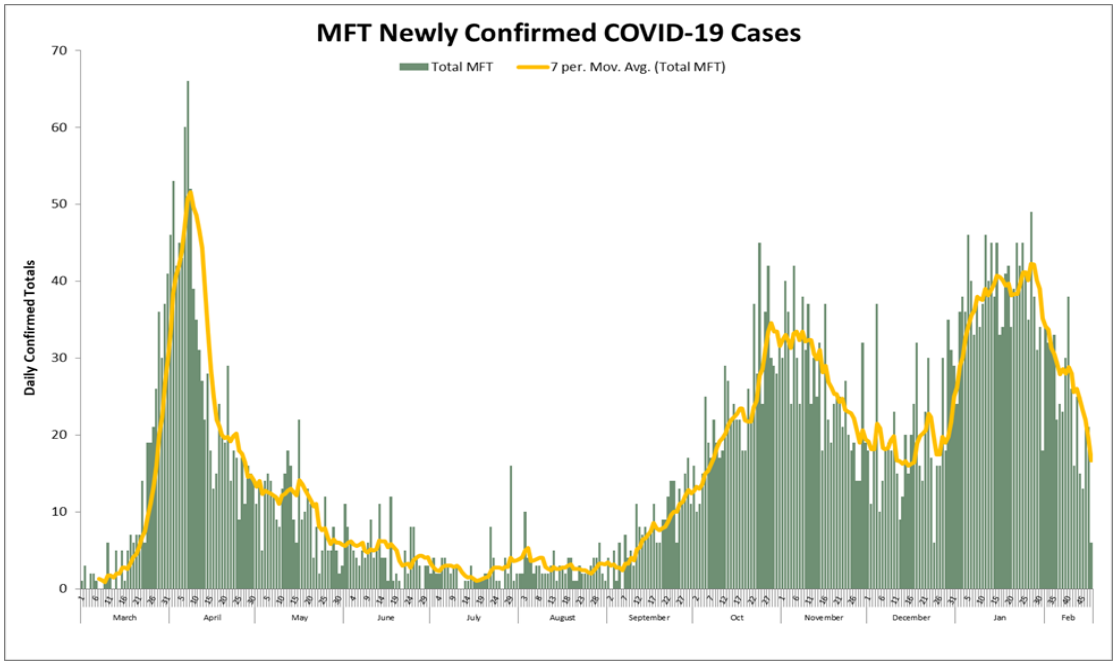


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – February 2021.

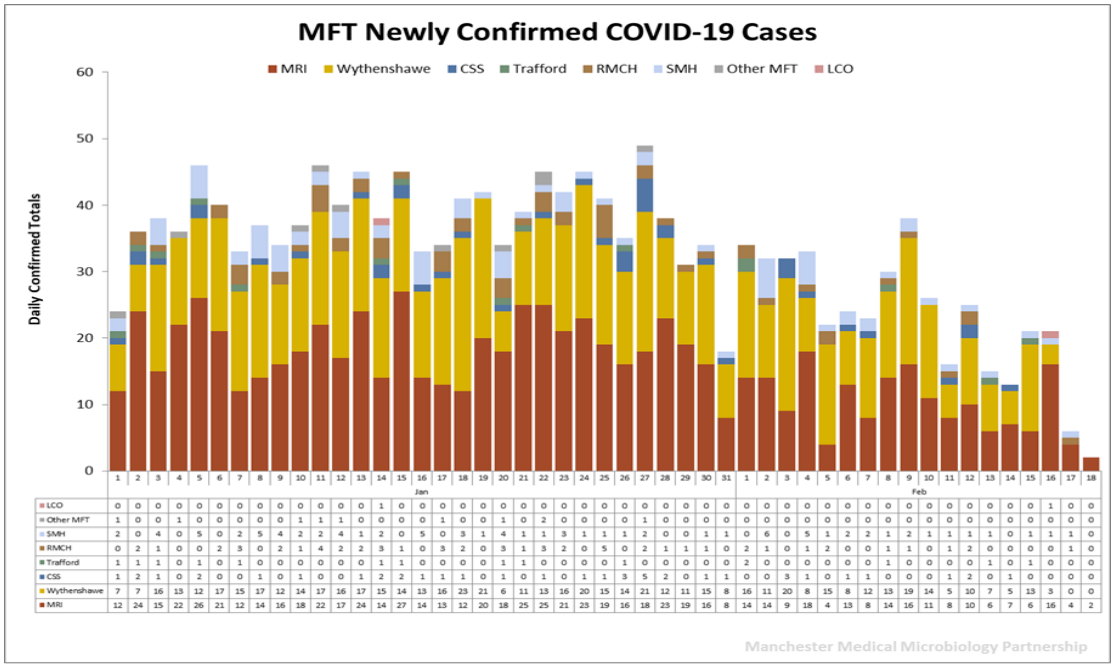


Chart 2 – Daily MFT inpatient burden of COVID-19 cases (laboratory-confirmed cases)

3.4. If a case forms part of an outbreak[1], an outbreak is declared, and control measures are implemented. Daily updates on outbreaks are circulated across the Trust. Each outbreak is reported to NHSE/I and monitored daily for 28 days.

3.5. Table 1 below shows the number of COVID-19 outbreaks across MRI, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from September – to date (18th February 2021).

Table 1: MFT COVID-19 Outbreaks	
September 2020	7
October 2020	21
November 2020	19
December 2020	17
January 2021	22
February 2021	9 to date (18th February 2021)

4. Implementation of Actions from COVID Outbreak Reviews

4.1 The Trust continues with an unrelenting focus on IPC measures including but not exclusive to hand hygiene, correct use of PPE, social distancing and strict adherence to IPC practice for interventional procedures.

4.2. Screening of inpatients as per national screening recommendation done on day 1,3,5-7 and weekly thereafter. There is an audit underway looking at the compliance with screening that will form part of the dashboard that is under development by Informatics (see section 5 below).

4.3. Improved virology turnaround times of samples with samples being processed within 17 hours of receipt in the laboratory.

4.4. Enhanced compliance with both staff and patient screening on declaration of an outbreak. IPC team monitors compliance as part of outbreak meetings.

4.5. COVID positive patients do not get tested within 90 days if they are immunosuppressed, and positive patients are stepped down to green wards on completion of 14 days and are asymptomatic for 72 hours.

4.6. There is a senior IPC Team member on-call to provide advice and support to the on-site Management teams regarding patient flow.

[1] for the purposes of HOCI, the definition of an outbreak is for two or more cases to occur within the same ward environment within 14 days

5. Outbreaks of COVID-19 Infection

5.1 Current Trust Policy, based on guidance form NHSE/I, is to close a ward when an outbreak is declared and implement control measures. The closure of wards has caused a significant impact to patient flow and may perversely increase the risk of cross transmission amongst patients where there is increased movement of patients across the hospital. In addition, there are potential consequences to care as patients who require specialist care are not able toto be admitted to a specialist ward due where there is an outbreak. Therefore, following consultation with the Trust IPC Expert Group the following changes were made to the Policy.

5.2 Change to Policy

1. Patients who are identified as COVID-19 positive at any stage of their in-patient stay will continue to be transferred to a COVID-19 ward.

2. All contacts of the positive patient(s) in the same bay(s) will be cohorted together for 14 days and cared for by dedicated staff with dedicated patient shared equipment/facilities.

3. Following a risk assessment with a senior member of the IPC Team, and the Director of Nursing/Deputy the remaining bays and side-rooms may remain open to receive new admissions.

4. Where there are indications or risk of continuing cross transmission of COVID-19 infection the IPC team will advise that the ward will be closed as an outbreak until the situation is resolved.

6. COVID Dashboard

6.1. The Trust Informatics Team (IT) have collaborated with the IPC team to produce COVID dashboard that will be launched within the coming weeks. Currently the dashboard is at the stage of data validation. The Dashboard in its first stage is designed to provide an overview of the overall COVID-19 inpatient numbers and HOCI numbers along with distribution of the cases across hospital sites and wards.

6.2. The dashboard when fully implemented (on completion of the 6 phases) would be able to provide ward level data on COVID patient placements, screening compliance, and bed days lost. The expectation is that the dashboard will provide both strategic and operational level data and will be used as we move forward to measure and manage all alert organisms.

7. Enhanced Isolation Facilities

7.1 A risk assessment is undertaken in all clinical areas to maintain 2m distancing. In wards where there is a high risk of transmission of COVID-19 that is; the COVID-19 status of the patients is indeterminate (amber areas), the Trust is implementing the use of 20 Clinell Redirooms to provide additional isolation capacity.

7.2 The room includes a canopy with integral foot operated door, windows with privacy curtains, a High Efficiency Particulate Air (HEPA) filter delivering 12 air exchanges per hour and at the entrance a dispenser for gloves, aprons, wipes and alcohol hand gel.

7.3. A risk assessment for where best to place the Redirooms has been undertaken by the Directors of Nursing for MRI, Wythenshawe, North Manchester and The Children's Hospitals with the Assistant Chief Nurse, IPC.

7.4. A standard Operating Procedure (SOP) has been developed for the use of Redirooms which will include; a risk assessment process to identify suitable patients, decontamination between each patient use and when to change the canopy.

8. Clinical Outcomes

8.1. The Group Medical Directors are leading a programme of work with Medical Director colleagues across GM to assess the clinical outcomes of patients who have acquired Covid infections whilst in hospital.

8.2. Discussions are underway to formalise the duty of candour to ensure patients are kept informed of their infection status whilst in our care.

9. Summary

9.1 The prevention and management of Covid-19 nosocomial infections is multifaceted and has been evolving throughout the pandemic as we learn more about the Covid-19 virus and how it is transmitted.

9.2. Prevention of transmission is the role of all staff and starts with adherence to good IPC practice.

9.3. Safety of our patients is paramount and there is a continuing focus and investment in practice and the environment of care to prevent the transmission of the virus.

9.3. There is evidence that the number of new cases of COVID-19 amongst in-patients is declining however, there is no room for complacency as outbreaks of infection continue to occur.

10. Recommendation

10.1. The Board of Directors are asked to note the actions and progress to reduce the transmission of Covid-19 across all our services.

APPENDIX A

Infection Prevention and Control Board Assurance Framework V7 February 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• Clinical Sub-Groups / Clinical Advisory Groups are in place to oversee adjusted or adapted systems and processes approved within hospital settings. • Patient streaming at access points. Emergency Department is zoned to provide designated areas • Screening of non-elective admissions recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place.	• Some COVID-19 positive individuals present at hospitals as asymptomatic patients • Audit of community required to ensure SOPs being utilised	• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily • All women admitted to Delivery Unit are screened for COVID-19. This is repeated at day 3 and day 7. • All women who attend for an

	• Development of EMIS template to record patients who are COVID-19 positive or self isolating and associated SOP • Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE;MDROs) • Guidance for ambulance trusts in place to support safe pre-alert to hospital trusts https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • Monthly point prevalence audit of screening swabs) • MFT Guidelines and SOPs available at: https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus including: • Joint Pathways and Protocols (01.04.20) • Managing patients who meet criteria for COVID testing (12.3.20)		elective maternity admission (Induction of labour or elective Caesarean section) have COVID-19 screening 72-48 hours prior to admission • On arrival for all maternity appointments women and partners are screened using symptom checker • All neonates transferred from other units swabbed on arrival • PHE/NHSE/I guidance in place • Revised guidance on '10 point plan' assessed with mitigating actions described

	• https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection updated 31 July 20 • Risk assessments in place for OPD appointments (Wythenshawe) • Risk Assessments for Interventional Radiology • Risk assessments in place for Maternity and neonatal services		https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus/safe-working-environment https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus
• patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	• Patient blue/yellow/green pathways in progress. Patients allocated according to risk category • Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place • Community inpatient facilities are designated green areas. • Community in-patient facilities have single rooms • MFT Guidelines and SOPs available at:	• Hospitals/MCS have progressed zoning plans, define zones including support services and communal access areas (e.g. corridors/lifts)	• Plans in place to address gaps in assurance based on national guidance as available • Revised screening regime introduced 30th November – Day 1.3.7 • Monthly point prevalence audit in place

	https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus including: • **Hospital Outbreak Control Procedure in place** • **Policy for Isolation of Infectious Patients** • **Data collection that is reported externally to the Trust is validated and checked for accuracy by an Executive and the DIPC.** • **New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).** • **Assessment of "social distance" of beds in all in-patient areas completed. Risk assessment in place for reduction of social distance and bed numbers**		• **RMCH/MCS have a covid19 pathway document that outlines where in the Hospital/MCS the various paediatric patient groups are managed (positive, negative and undetermined) in support of flow and ensuring right patient in right place.**

	monitored in 3 times daily capacity meeting		
• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	• Screening protocols in place for patients discharged or transferred to another health care or residential setting in place based on PHE Guidance and incorporated in to Staff and Inpatient Testing Guidelines • Monthly point prevalence audit		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance patients and staff are protected with PPE, as per the PHE national guidance	• Appropriate PPE defined by procedures in accordance with national guidance, including: • Face Masks and Covering Guidance • Communication with procurement/materials management • Education/training sessions for use of PPE to staff • Staff encouraged to raise concerns with line manager and complete incident forms if they consider a shortage of PPE	• Issue with supplies of PPE • Occasional conflict between national guidance from NHSE/PHE and guidance from Royal Colleges	• Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution • Estates/environment review has progressed with permanent structures to entrances arriving on site by

	• Escalation plans in place as per trust gold command and GM Gold command • Signage is in place in clinical/non clinical areas. Access to signs that can be adapted for individual areas, and those that must not be adapted are available to print on the Trust intranet • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required • IPC Safety Officer Audit		November 20. Temporary structures are in place currently and are sufficient.
• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Guidance cascaded through Strategic Oversight group • Daily communications email sent to all staff • IPC Team daily visit to clinical areas. have Attendance in wards/departments • Weekend IPC team provision • IPC team have developed reference posters for staff, with all guidance available on the staff intranet		• The Trust intranet provides a full range of information that is regularly updated and cascaded to all staff via daily communication. Links to the MFT Staff COVID-19 Resource Area are provided https://intranet.mft.nhs.uk/content/imp

	https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus • The following groups review new guidance/updates and recommend implementation: ❖ High level IPC meeting chaired alternate weeks by DIPC ❖ Clinical subgroup chaired by joint medical director bi-weekly ❖ Clinical Advisory Group weekly chaired by Hospital Medical Director ❖ IPC Operational Group bi-weekly chaired by Hospital Deputy Director of Nursing		ortant-information-about-covid-19-coronavirus • Regular and up to date information is published in this Resource Area, including the following key topics: ❖ Emergency Planning, Resilience and Response ❖ Employee Health & Well Being ❖ Research and Innovation for COVID-19 ❖ Infection Prevention & Control ❖ Hospital/MCS COVID-19 Resources
• changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• 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	• New risks to be identified as guidance changes	• Risks identified on Trust risk register and locally on Hospital/MCS risk

	Directors, sub board committees including: ○ Risk oversight committee ○ Group Infection Control Committee ○ Group Infection control committee • Risk register updated • Risk assessments in place, risk assessment documentation available via the Trust Intranet	• New risks may be identified through review of guidance published 20 August 2020 (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations).	registers/regularly updated. • The Trust Board Assurance Framework is continuously updated and submitted to Board of Directors November 2020. • Weekly meetings with NEDs to keep informed of issues arising through EPRR led by COO • Twice weekly meetings with executive directors provides opportunity to raise issues
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• There is an over-arching Group IPC risk for COVID-19. Hospitals/MCS/LCO have identified local risks and added them to local risk registers. • Risks managed through Strategic COVID-19 group	• Disruption to assurance framework by Suspension of Sub-board Committees due to COVID-19	• Sub committees re-instated • Risks reviewed formally at substantive groups and weekly through EPRR response due

	• Links made to the main Trust BAF, were reviewed at the Board of Directors meeting in November 2020		to the need to be responsive and adjust in real time • Subgroups have been re-instated in accordance with Trust governance and recovery programme
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Daily alert notifications continued and actioned • Monitoring of incidents of infection • Investigation of MRSA bacteraemia and CDIRCA completion • Accountability meetings with clinical leads re-instated • Hospital/MCS/LCO Infection control committees in place • Extraordinary meetings of COVID expert Group in place • Risk assessments in place address wider HCAI issues for: ❖ 2m social distancing ❖ Contact tracing ❖ Outbreak management ❖ Isolation ❖ Testing	• Three week period of non-toxin testing for CDI due to Aerosol generating procedures (resolved)	• All CDI patients clinically reviewed & PCR tested. • Alternative method for toxin testing implemented • Risk assessment and reports escalated • Investment in environmental mitigation: ❖ A number of Clinell Ready Rooms have been purchased and will be put in place in designated/agreed areas

	• Visibility of Executives and Directors. Frequent observation and review by DIPC, AMD and IPC team to address environmental issues as well as clinical practice		❖ Enhanced cleaning ❖ Partitions & physical barriers
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice.	• Resources that support staff to comply with IPC practices are in place: ❖ Effective systems in place to support control of HCAI's ❖ Policies are in place for the prevention and management of HCAI's ❖ Systems are in place to ensure that resources are allocated to effectively protect people, including staff ❖ PPE is readily available ❖ Education & Training is in place ❖ Facilities are in place to support good hand hygiene: these include	• Policies are in place to support managers in addressing specific concerns that relate to adherence to IPC measures	• Escalation process in place to local senior management team

	hand sanitization stations, sufficient hand wash facilities, sufficient supplies ❖ Signage is clear ❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including ❖ Hand hygiene ❖ PPE audit ❖ Increase in frequency of audits on outbreak wards • Data is collected monthly and Feedback to Directors of Nursing to address areas of concern		
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• IPC nursing champions are in place in all hospitals /MCS/MLCO; specifically, their work includes: ❖ role modelling best practice ❖ monitoring compliance ❖ sharing good practice, and		

	❖ challenging non-compliance.		
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Staff testing and isolation strategies are in place as part of the Trust Staff and Inpatient Testing Guidelines. • Staff PCR testing is routinely undertaken in identified high risk areas (where highly vulnerable patients receive treatment) and in areas where an outbreak occurs • Lateral Flow Testing is in place across the Trust, with clear guidance in place to ensure isolation and PCR testing follows a positive LFT test. • Staff with positive results advised to follow national guidance	• Access to external test results • Compliance with staff reporting LFT results	• Staff asked to report external test results to absence manager • Communication strategy in place to remind staff to report LFT results • Improvements planned to the way in which LFT test results are reported by staff to improve compliance with reporting
• Training in IPC Standard Infection Control and transmission-based precautions are provided to all staff.	• A series of IPC training packages are included in staff training profiles. • Practical training packages for donning and doffing (both for aerosol generating procedures (AGP's) and non AGP's) are in place via E learning.	•	• Compliance with training is monitored

	• An Infection Prevention & Control Development Pathway is newly developed and in place to assist staff development from fundamental awareness of IPC to specialist understanding. The IPCDP is available to registered and non-registered clinical staff.		
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training.	• The Trust learning hub includes a series of COVID-19 Training Resources. Examples include a series of 'essential skills' training. • Trust wide local induction include COVID-19 IPC measures • Specific COVID-19 training is in place in identified areas, for example the Emergency Department, Respiratory,		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work.	• The PHE campaign 'Hands Face Space' is visible across the Trust • There is clear signage at all access egress points as well as in all clinical areas • Regular reminders are distributed via trust-wide daily communications		

• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Staff attend the Trust mandatory training programme at the commencement of employment. • Practical competency training is in place which includes Hand Hygiene, use of PPE, donning and doffing • PPE Stocks are regularly monitored across all areas and there is an escalation procedure for areas where there has been increased demand • The Trust procurement team work closely with the IPC teams to ensure stock levels are maintained		
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• The Chief Nurse/DIPC is responsible for all data submissions	• Easily accessible information in one place to support sign off requires development.	• A COVID-19 infection dashboard is under development. Once implemented this will provide Trust, hospital and ward overview of nosocomial infections. The purpose is to provide further clarity of a range of

			information in order to support nosocomial infection prevention and management.
• Ensure Trust Board has oversight of ongoing outbreaks and action plans	• The Trust Board receive regular information from the Chief Nurse/DIPC on nosocomial transmission of COVID-19 • Nosocomial infection reports are presented and discussed at the following meetings: ❖ COVID-19 Strategy Group ❖ High Level Infection Prevention & Control Group ❖ Group Infection Control Committee (a sub-committee of the Trust Board) ❖ Council of Governors meetings	• See above	• See above

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training to care for and treat patients in COVID-19 isolation or cohort areas	• Programme of training for redeployed staff including use of PPE, maintaining a safe environment • Bespoke training programme for Clinical leaders to become PPE expert trainers • IPCT undertake regular reviews/ and provide visible presence in cohort areas • Staffing levels increased	• Redeployed staff may not be confident in an alternative care environment.	• Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Microbiologist and ICD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Liaison between Trust/PFI partners and partnership working • Domestic staff are fit tested and trained in donning and doffing PPE • Use of posters/videos FAQ's • Staff training records and roster allocations available as evidence of this for all areas.	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • (see access to environmental investment)

	• Hospital Estates & Facilities Matron provides oversight of training and standards of practice (NMGH)		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance • Group Estates and Facilities Decontamination Policy is in place and available via the Trust intranet • E and F/PFI partners and IPC Team met to review cleaning frequencies in line with updated guidance	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams.
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance is deployed in high flow areas such as ED • Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative		• Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased demand and that the service provision includes all clinical and non-clinical areas.

	• Cleaning twice daily and providing additional enhanced cleaning in high risk/outbreak areas		
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• additional frequency of cleaning schedules in place • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas.		• Domestic cleaning in ED and assessment areas 12 hours a day after every patient use of facilities
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine,as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution. • Used in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy Requires updating (pending new national guidance on cleaning standards)	• Cleaning policy to be updated once National Standards agreed. Current policy is appropriate and in use.

• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• See above		
• 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE	• Enhanced cleaning specifications in place for clinical and non-clinical areas • Trust Policy for working safely based on PHE guidance is in place • Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have ben put in place across all sites to meet PHE guidance. • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas		

removal by groups of staff (at least twice daily)			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	• Linen managed according to national guidance for foul/infected linen, Trust Policy in place – updated July 2020 • Staff in COVID-19 areas are wearing 'scrubs' – laundered through Trust laundry • Guidance on how to care for uniform published on Trust intranet		
• single use items are used where possible and according to Single Use Policy	• Single use items used according to local policy based on national guidance.	• Policy due for review in January 2021 pending review of National Cleaning Standards	• Policy will be updated by IPC Team
• reusable equipment is appropriately decontaminated in line with local and PHE national policy	• Re-useable equipment decontaminated in line with national guidance • Decontamination group is sub-group of Group ICC		• Decontamination group meeting re-instated from May 2020

• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• No mechanical ventilation system in waiting areas, use of electronic fans discouraged	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate
• Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Air filtration units (filtrex and Dentair unit) deployed in areas following AGP's in ENT and dental • Windows opened where possible	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate
• There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants.	• E&F continue to clean all surfaces (excluding flooring) using Chlor Clean disinfectant as per IPC advice. • Should IPC review the low risk pathway E&F would work with the cleaning management team to re-introduce GP detergents in appropriate location		• Continued the use of Chlor-clean across all areas of the adult Trust due to high community prevalence and risk of outbreaks

• **Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.**	• **Non-clinical areas are regularly inspected, and any issues are responded to in liaison with the cleaning management teams.** • **E&F team respond to any reporting incidents or concerns raised to resolve issues effectively.**	• **Site inspections are undertaken using checklists in clinical areas**	• **Trust wide incident reporting effectively used to escalate concerns.**

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lnes of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Appropriate policies reviewed and approved by the AMC • Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. • Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) • Monthly antimicrobial stewardship (AMS) audits on all ward areas • Microbiology support available 24 hours a day. • Antimicrobial prescribing advice available from pharmacy 24 hours a day • ICU ward rounds • Increased AMS support to COVID-19 cohort areas • Ad-hoc reporting to Clinical Subgroup identifying areas of	• Monthly AMS audits are being redeveloped to better inform prescribing practices. New audit proforma was introduced in June 2020 and is subject to ongoing review. • Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones. Previously these audits would be done by AMS pharmacists who now must not cross over zones.	• Plans in place to introduce virtual AMS ward rounds to COVID-19 cohort areas. This needs Trust wide support which is being reviewed in terms of: ○ Clinical engagement ○ IT infrastructure ○ Staffing and resources

	concern in terms of antimicrobial prescribing.		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• Policies/guidance in Acute sector updated to reflect pandemic • End of Life Policy adapted for current need • Controlled entrance & exits to Trust to minimise risk of cross infection • Policy reviewed following further guidance and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission • NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic'		• Guidance regularly updated in line with NHSE/I • Risk assessments in place for Maternity and neonatal services • Specific work plan addressing access for maternity partners – key areas are early pregnancy and 12 weeks scans • Guidance in place for visitors

	and the subsequent North West Good Practice Guide have been assessed • Visiting Policy available via Trust Intranet and information published on the Website		• Significant flexibility in guidance to allow for compassionate visiting • Additional technology (tablets and phones) issued to all in-patient areas to facilitate communication with loved ones / advocates.
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	• Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas • Dedicated entrances for blue/yellow/green patients where possible • Signage on entrances, signs are available to download and print via Trust Intranet • Screens in place at reception areas • Available guidance:	• Plans need to be flexible as situation changes	• Hospitals to re-assess as situation evolves. • Learning from outbreaks includes: ❖ Quick isolation and lock down of identified areas ❖ Testing and tracing of staff – Lateral Flow Testing in place for a time limited period

	○ Coronavirus Restricted Access Measures Guidance May 2020		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Dedicated website for all COVID related information/policies	• Risk that information may be out of date	• Website regularly updated by Comms/EPPR Team
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Preadmission Screening processes in place for elective patients • Screening processes in place for NEL (see previous) • Compliant with PHE guidance on screening patients being transferred to residential care • Where possible patients transferred in from referring hospitals are isolated until negative screen. When single rooms not available alternative models are used, such as cohorting • NMGH: Transfer documentation updated to include COVID status and individualized swabbing schedule (including for contact patients)	• Insufficient single rooms and isolation facilities	• Risk assessments in place • Environments investment (see previous pods/curtains/2m space) • SOP in place for maternity to use single and cohorting bays when required. Space in bays has been assessed by IPC to maximise distance between women.

• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned stations to guide and challenge visitors /staff if appropriate	• Lack of concordance amongst some patients/visitors	• Local escalation process in place

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Systems and processes are in place to ensure: • **front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance**	• **Patient streaming at access points in place at all ED access areas** • **See previous on streaming**	• **See environmental issues and age of estate**	• **Patient placement guidance in place** • **Keeping Safe - Protecting You – Protecting Others Document approved and in place** • **All patients admitted via ED are screened for COVID-19, data is reviewed daily** **https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus/safe-working-environment**

			https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus
• mask usage is emphasized for suspected individuals	• All patients encouraged to wear masks where clinically appropriate • Policy in place for wearing of facemasks in all areas • IPC Safety Officer Audits of in-patient areas		
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Trust review of working practices including working environment • Screens in place • PPE such as visors in place		• See previous
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• Covid and non-Covid clinical areas defined across the Trust. • All Non- elective admissions tested and elective admissions as per guidance in Hospital SOPs • 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.		• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • See previous

	• Recently updated and revised screening in place at 1,3,7 days from 30th November 2020 • Trust has an internal test and trace policy • Outbreak policy in line with NHSE guidance • Outbreaks contained and reported to NHSE/I using IIMARCH (Information, Intent, Method, Administration, Risk Assessment, Communication, Humanitarian issues) documentation and daily sitrep reports • NMGH: Outbreak / Surveillance meeting 3 times weekly chaired by DoN to oversee correct management of outbreaks and contact tracing of patients and staff		
• patients with suspected COVID-19 are tested promptly	• Screening of non-elective patients in place • Hospitals/MCS have put in place pre 48hour testing for elective admissions • Screening of patients prior to admission to community in-patient facilities and recorded in	• Turnaround time of tests and supply of testing reagents • Limited access to rapid (Cepheid) PCR testing	• Prioritisation of rapid testing for most high risk patients • Patients with suspected COVID-19 are assessed and cohorted

	patients notes – SOP in place/being developed • MFT site of PHE host laboratory and has capacity for extensive screening • DnaNudge in place at MRI and in process at Wythenshawe		according to clinical evaluation • Lack of Testing reagents escalated nationally • Pathway being developed for elective pathway patients who have been previously covid positive
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• patients are cohorted according to clinical presentation • Outbreak policy implemented		
• patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	• OPD services and community clinic services are using technology to undertake consultations where possible • Signage on entrances advising pathway for symptomatic patients. • Message on MFT phone services • Trust policy on managing patients who present with symptoms in place • All patients screened for symptoms on arrival (NMGH)		• New guidance has been reviewed and pathways (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).

• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	• Guidelines are in place to ensure that all patients are screened in accordance with national guidance i.e. prior to admission for elective treatment and on admission for non-elective patients. All patients screened on day 3, 5-7, and every 7 days thereafter	• Manual monitoring in place at present	• Automated monitoring process being developed for Dashboard
• Staff are aware of agreed template for triage questions to ask.	• Staff are aware of and are use agreed triage questions, all patients screened for COVID-19 symptoms on admission • All patients streamed through a respiratory/non-respiratory pathway in ED's.		•
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Staff are trained in the use of triage questions		
• Face coverings are used by all outpatients and visitors	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages.	• Not all patients/visitors are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place

	• Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		
• Face masks are available for patients with respiratory symptoms.	• FRSM available for all patients and visitors	• Not all patients are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care.	• All patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise	• As above	• As above
• For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative.	• All patients with new onset symptoms are tested and isolated. Risk assessment undertaken of all potential contacts		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	• All patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure:
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe
	• Programme of training for all staff and those who are redeployed including use of PPE, maintaining a safe environment in accordance with PHE guidance.
	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS
	• Bespoke training for Clinical leaders to become PPE expert trainers
	  • Mandatory training in place
	  • (See previous re PPE and fit testing)
		• Staff anxiety about risks of exposure to COVID -19	• Increase of IPC support to COVID -19 Wards
			• Prompt response to clusters/outbreaks of COVID-19
			• Plans for staff testing in high risk situations.
			• Use of posters/videos FAQ's
			• Multiple communication channels – daily briefing/dedicated website
			• Increased Microbiologist and AMD support
			• Expert Virology support
			• 7 day working from IPC/Health and Wellbeing

			• **New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).**
• **all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it**	• **Local information and guidance in place for COVID areas and non-COVID areas** • **PPE Infection Control Policy in place** • **PHE guidance in place** • **Donning and doffing videos available on the Trust intranet based on national guidance** • **Designated donning and doffing areas have relevant guidance and instruction displayed**		

	• Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required • See previous on fit testing		
• a record of staff training is maintained	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment • Standard Operating Procedures developed for decontamination of visors • Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline	• Escalation in shortages of PPE	• Staff asked to complete an incident form and escalate to their manager
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Staff advised to complete an incident form and report to their manager • Daily review of incidents submitted by risk management team		
• adherence to PHE national guidance on the use of PPE is regularly audited	• Audit of compliance undertaken		

• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand dryers are not used in accordance with trust policy • Guidance in public areas		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• posters and guidance in place https://intranet.mft.nhs.uk/content/hospitals-mcs/clinical-scientific-services/infection-control/hand-hygiene		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Monthly audits of hand hygiene compliance • Increase of audits on increased activity areas • Mandatory ANTT assessments annually • Hand Hygiene Policy in place • ANTT Policy in place • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required		

• staff understand the requirements for uniform laundering where this is not provided for on site	• Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Temporary staff changing facilities identified on COVID-19 wards • Staff on COVID-19 areas wearing scrubs laundered through hospital laundry		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• HR policies in place for staff to report on absence manager system if they are symptomatic • Trust complies with national guidance • EHWB service provides staff support • Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8	• Staff shortages due to COVID - 19	• Escalation to Strategic oversight group of low staffing numbers. • Activity to be titrated by staffing levels • Escalation processes in place and monitored through EPRR including reducing elective programme as required

• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	• There is separation of patient pathways at Emergency access points. • Use of one-way flow systems and restricted access /egress points in place in all diagnostic centers • Staff communal areas have clear signage and there are staggered breaks to facilitate reduced contact • Footfall reduced where possible	• Not always possible to maintain 2m distance in all areas because of building design constraints	• Local Risk assessment undertaken, and partitions used where appropriate.

• Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
  • hand hygiene facilities including instructional posters
  • good respiratory hygiene measures
  • maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care.
	• Additional Hand hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas.
	• All seating facilities in communal areas are marked to encourage 2m distancing
	• Corridor floors signed to say keep left
	• There is signage across all areas of the hospitals, including PHE campaign ‘hands face space’ messages.		

• Frequent decontamination of equipment and environment in both clinical and non-clinical areas.	• Enhanced cleaning in place for high risk vicinities such as amber areas (COVID-19 Indeterminate areas) where there is rapid turnover of patients with an unknown COVID-19 diagnosis. • Enhanced cleaning in place for wards where there is an outbreak • Disposable wipes available in communal toilet facilities		
• Clear advice on use of face coverings and facemasks by patients /individuals, visitors and by staff in non-patient facing areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• The Trust is able to access PHE support directly through its on-site PHE laboratory • Local population, regional and national surveillance intelligence is presented by Trust expert virology team (linking with the on-site PHE lab as above)	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

	• A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at: ❖ High Level Infection Control Meeting ❖ Clinical Sub-Group /Advisory Groups ❖ Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner • Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC and clinical teams		

• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation	• Investigations completed and IIMARCH forms submitted for 2 or more cases of HOCI. • All incidents of HOCI are reported on Ulysses/Datix for review and completion • Outbreaks are reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing		
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection	• Outbreak Policy is in place • Outbreaks reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing • The Procedure for Managing an outbreak is provided to the relevant ward/department manager for completion at onset of outbreak.	• Closure of beds due to outbreaks impacts on patient flow	• Senior IPC cover available out with working hours available to undertake a risk assessment with senior on-site team • Updated guidance for closure of wards based on risk assessment

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • **patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate**	• **patients are cohorted according to clinical presentation** • **Community inpatient facilities have single rooms** • **risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission** • **Isolation of Infectious Patients Policy in place** • **See previous on environment**	• **Lack of side rooms for isolation and also number of toilet facilities per ward** • **Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients)**	• **Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical location** • **Review of footprint of services across all hospitals to reduce risk of cross infection** • **Risk assessment undertaken based on symptoms (e.g. isolation of patients with diarrhea)**
• **areas used to cohort patients with or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance**	• **programme of review of air flow and ventilation undertaken throughout the pandemic**	• **Lack of side rooms for isolation and also number of toilet facilities per ward**	• **Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment**

		• Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) • some areas of estate particularly old and in poor condition	and geographical location • Review of footprint of services across all hospitals to reduce risk patient occupancy, flow and activity adjusted to align to the environment • Good IPC practice implemented in all areas of cross infection
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff.	• In COVID-Wards and Outbreak wards, measures have been put in place to restrict footfall • A Visiting Policy is in place which restricts access	• Staff need to leave the ward for rest/refreshment	• Food for staff delivered to high risk areas. • Breaks in Communal restrooms are staggered • Volunteers to support way finding

• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas.	• Clear sign posting in place • Restricted access using keypad where appropriate	• Regular re-configuration of wards due to changing demand for Blue/green areas	• Estates and facilities have regular meetings with hospitals to review signage

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individual	• UKAS accredited PHE laboratory conducting testing for NW of England • Posters to support training for staff on how to take a swab		• Frequency of testing ensures staff competence
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Screening of non-elective patients in place • Hospitals/MCS putting in place pre 48 hour testing for elective admissions • Policy for staff screening developed • MFT site of PHE host laboratory and has capacity for extensive screening • See previous on testing	• Lab capacity	• New equipment on line for full functionality December 2020 .

• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		
• Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening • DNA Nudge used for rapid assessment in agreed emergency department locations		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available.	• Turnaround times measured - planned programme of monitoring.	• Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	• Testing is undertaken through PHE laboratory in accordance with PHE guidance	• Trust Testing Strategy Group to receive regular reports to monitor compliance – under development	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • **staff are supported in adhering to all IPC policies, including those for other alert organisms**	• **Programme of training for redeployed staff including use of PPE, maintaining a safe environment in accordance with PHE guidance.** • **Bespoke training for Clinical leaders to become PPE expert trainers** • **Mandatory training in place** • **Plans for staff testing in high risk situations.** • **Use of posters/videos FAQ's** • **Multiple communication channels – daily briefing/dedicated website** • **Increased Mircrobiolgist and AMD support** • **Expert Virology support** • **7 day working from IPC/Health and Wellbeing**	• **Staff anxiety about risks of exposure to COVID -19**	• **Increase of IPC support to COVID -19 Wards** • **Prompt response to clusters/outbreaks of COVID-19**

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Any changes are received and discussed at key strategic meetings: ❖ High Level IPC meeting ❖ Clinical Sub-Group • This review can be weekly and at times daily • Guidance updated on intranet and communicated daily via email • Cascade system in place across the Group		
• all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All waste associated with suspected or positive COVID-19 cases is treated as normal infectious waste (orange waste stream sent for alternative treatment to render safe before incineration or landfill) • Staff follow Trust waste management policy • Healthcare waste e-learning module is mandatory for all clinical staff, based on waste management policy. • All bins are labelled to indicate which streams they have been designated for.	• Since the outbreak of COVID-19 there have been changes to advice from government regards waste (in particular initial categorisation of COVID-19 waste as Category A (similar to Ebola), a national Standard Operating Procedure and numerous Regulatory Position Statements from the Environment Agency) – the changing guidance	• New refreshed waste guidance and communication document currently in production (for healthcare staff, porters and cleaners)and will be circulated Trust-wide • Guidance will be regularly assessed as the situation evolves and national guidance is updated. • Temporary approach to waste audits being developed

		has been challenging to communicate clearly with staff. • Queries around disposal routes for visitor PPE – options for disposal which are both legal and practical are not currently clear. • COVID-19 precautions have meant Waste Team are no longer able to visit all wards to carry out waste pre-acceptance audits and establish that staff are following waste management policy. • There have been some waste related incidents whereby clinical waste (potentially infectious waste, associated with	• Fortnightly meeting of all relevant staff involved in waste management at each site to share emerging risks and issues associated with waste. • Weekly conference call between Trust and its main clinical waste collection provider (SRCL) • Trust also has access to "national cell" (Environment Agency, Cabinet office, etc) who are managing waste nationally at a strategic level through COVID, as well as national NPAG group. • Regards community waste, draft options paper prepared to inform future policy and process – further

		• COVID-19 cases) has been disposed of by staff as general domestic waste. • Gaps have been identified in relation to clear policy and process in relation to waste generated by COVID-19 cases and non-COVID-19 cases in the community	scoping details still required and options will then be taken forward through the appropriate channels
• PPE stock is appropriately stored and accessible to staff who require it	• Materials management team asses local stock levels and replenish every 2- 3 days • Update on stock levels circulated to DIPC/IPCT	• Shortages in supply	• Escalation process in place • Re-useable respirators provided for staff working in high risk areas place
10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and	• EHWB Policy in place • Employee Health and Well Being Service COVID-19 Guidance and Support available at:		

psychological wellbeing is supported	**https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8** • **All staff complete a COVID-19 self-risk assessment, electronically stored** • **Staff have access to a wide range of physical and psychological support services provided by the Employee Health and Wellbeing Service.** • **Staff who are working remotely can also access support.** • **Details of all EHW Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely.** • **EHW/OH advice and support is availabe to managers and staff 7 days a week.**		
• **staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained**	• **Training records held**		

• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staff not moved from COVID areas • Strict adherence to PPE guidance and practice • Staff testing policy in place	• Limited by access to reagents	• Prioritisation based on clinical and staff need
• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Trust policy in place		• Instructions in place not to travel to and from work in uniform
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Workplace guidance in place		• Adaptation of space to increase opportunity of break staggering
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• HR policies in place for symptomatic staff to report on absence manager system. Positive results are fedback via the EHW Clinical Team - ensuring advice and support • HR policies in place for staff to report on sickness absence via the Absence Manager system.		• Absence monitoring • Follow up and contact by line manager

	• All Trust protocols comply with National guidance and are kept under constant review. HR advice and support is provided to managers. • Regular comms and briefings ensure that staff are aware of policies and procedures as well as the support available to them. • Trust policy align with national guidance		
• staff who test positive have adequate information and support to aid their recovery and return to work	• EHWB service provides staff support • Staff receiving positive results are supported by an EHW Clinician to obtain advice and receive information regarding next steps, recovery and return to work.	• Some staff may choose to access alternative community test centres which means the results will not be known by the line manager and may be received via text message.	• Staff can contact Silver Command, Workforce Bronze, their line manager or the HR Team to seek advice on next steps having received their result via text. • Coronavirus (Covid-19) – Line Manager FAQ (fact sheet)
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority	• Risk assessments are in place and monitored through HR		

Ethnic (BAME) and pregnant staff.			
• **Staff who carry out fit test training are trained and competent to do so.**	• **Staff are locally trained by staff who are trained and assessed as competent to do so.**		
• **All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used.**	• **Staff are fit tested for FFP3 respirators**	• **Change in availability of make and model of FF3 respirators can cause anxiety and disruption**	• **The trust has procured additional fit testing machines to facilitate easy access to testing for FFP3** • **Procurement alert the trust in advance of changes to make and model of FFP3 available**
• **A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.**	• **There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly**		
• **For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods.**	• **As above** • **Staff are fit tested for alternate FFP3 masks**	• **Centralised system to be developed to allow regular review by the Board**	

• If member of staff fails to be adequately fit tested a discussion should be had regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. A documented record of this discussion should be available for the staff member and held centrally within the organization.as part of employment record including Occupational health.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		

• Boards need to have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO	• Centralised system to be developed to allow regular review by the Board	
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• Risk assessments are undertaken locally and mitigating actions undertaken		
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Karen Brown, Programme Finance Director Rachel McIlwraith, Operational Finance Director
Date of paper:	February 2021
Subject:	Financial Performance for Month 10 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 as the Trust moves through the final quarter of the year and the financial framework introduces significant financial constraint. • Hospital/MCS/LCO Control Totals have now been formally issued to Chief Executives and their accountability for delivery of these will result in a strengthening of the discipline on forecasting. In particular to ensure that the financial implications of decisions on service changes are understood and taken into account in the decision-making process. • It is of paramount importance that decisions are not made that commit the Trust to recurrent new expenditure without the appropriate level of scrutiny. • Aged debt remains a key focus for the Finance Team.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Financial Performance

1.1	**Delivery of financial Control Total**	In the first half of the year, as a response to the COVID-19 pandemic, the NHS financial framework was amended. All Trusts were put on a block contract, with an adjusting 'top-up' made retrospectively to bring the Trust to breakeven. This provided stability in the short-term as the Trust responded to the first wave of the pandemic and as it began to restore services during the recovery phase. The financial regime for the second half of the year maintains the block payments to Trusts broadly unchanged from the first half of the year. In addition, a system-wide (i.e. Greater Manchester) funding pot has been allocated by the national team and this has now been apportioned to each organisation within GM. Each organisation is expected to manage local costs, including Covid costs, within this. For MFT, the exception to this is that any Nightingale costs will be supported nationally. The Trust has agreed a financial plan for the second half of the year which requires the Trust to achieve a breakeven position. The Trust has exceeded the target for December and on a Year to Date basis has delivered a surplus of £9.4m which is £10.4m ahead of the plan. This is as a result of lower than planned elective activity due to the ongoing impact of Covid on the Trust; the underspend is increasing on a monthly basis.
1.2	**Run Rate**	Now that the Trust is in the final quarter of the year, strong financial governance and control remains essential, particularly in the face of an extraordinary and challenging operating environment. Hospitals continue to report each month against their projected forecasts, alongside reporting their forecast year end position against the Control Totals which have been formally issued to each Chief Executive. These Control Totals form part of the monthly accountability discussions held with each Hospital leadership team. A preliminary piece of work has been undertaken to identify the Trust and Hospital underlying run-rates, as a key step in developing financial plans for 2021/22. This work will be refined as the Trust develops high level budgets and as the national picture becomes more certain.
1.3	**Remedial action to manage risk**	The "expenditure led" financial regime that was in place in Months 1-6 of this financial year 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. Formal notification has been received that the current financial regime will remain in place at least for Q1 of 2021/22. The Control Totals implemented at Hospital level will be reviewed and refined in light of this guidance, to reflect the constraint at Trust level.
1.4	**Cash & Liquidity**	As at 31st January 2021, the Trust had a cash balance of £310.9m. This remains higher than plan due to the "double-payment" of the block contract in April 2020 (which will be recovered in March 2021) and also due to the level of accruals and provisions.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. Up to January 2021, £70.3m of capital spend was incurred which is lower than had been planned, however the forecast remains to deliver the plan.

Income & Expenditure Account for the period ending 31st January 2021

	NHSI Revised Plan - Oct 20	Year to date Actual - M10	Year to date Variance
INCOME	**£'000**	**£'000**	**£'000**
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	1,228,638	1,225,044	-3,594
National Top Up Funding 1-6	141,509	141,507	-2
National Top Up Funding 7-12 Covid - £32.465m	21,643	21,643	0
National Top Up Funding 7-12 - Nightingale	6,808	5,603	-1,205
NHSE - Cost passthrough drugs (increase above threshold)	13,893	15,841	1,948
Cost passthrough - Independent Sector	9,527	7,214	-2,313
GM System Funding 7-12 £51.985m	31,191	31,191	0
Wales	4,213	3,965	-248
Additional Funding outside financial envelope		797	797
Lateral flow funding £200k		137	137
Other (Other devolved / IOM / NORs)	1,998	2,927	929
Public Health England	318	316	-2
Local authorities	31,826	32,032	206
Sub -total Income from Patient Care Activities	**1,491,564**	**1,488,217**	**-3,347**
Private Patients/RTA/Overseas(NCP)	5,657	5,875	218
Total Income from Patient Care Activities	**1,497,221**	**1,494,092**	**-3,129**
Training & Education	53,823	54,638	815
Research & Development	52,491	53,127	636
Misc. Other Operating Income	55,239	62,106	6,867
Other Income	**161,553**	**169,871**	**8,318**
Total Income	**1,658,774**	**1,663,963**	**5,189**
EXPENDITURE			
Pay	-959,171	-961,508	-2,337
Non pay	-643,457	-636,156	7,301
Total Expenditure	**-1,602,628**	**-1,597,664**	**4,964**
EBITDA Margin (excluding PSF)	**56,146**	**66,299**	**10,153**
Interest, Dividends and Depreciation			
Depreciation	-22,982	-22,667	315
Interest Receivable	50	30	-21
Interest Payable	-34,201	-34,213	-12
Dividend	0	0	0
Surplus/(Deficit) Adjusted performance re system achievement	**-987**	**9,449**	**10,436**
Surplus/(Deficit) as % of turnover		**0.6%**	**201.1%**
PSF / MRET Income		**0**	**0**
Transfers by Absorption		**3,185**	**3,185**
Impairment	**-53,778**	**-50,820**	**2,958**
Non operating Income	**3,856**	**3,504**	**-352**
Depreciation - donated / granted assets	**-656**	**-629**	**27**
	-51,565	**-35,312**	**16,254**

In line with national planning requirements the Trust submitted a revised financial plan for the second half of the year, at the time of submission the nationally set planning assumptions were predicated on activity recovery in line with the Phase 3 letter and no second wave of Covid19. The Trust submitted a plan demonstrating a breakeven position.

NHSI have therefore adopted the first six months of actual income/expenditure and the submitted plan for the second six months as the basis of monitoring returns and this combined position is shown as the planned YTD values in the I & E Account table above.

Clearly the clinical / operational position is substantively different from the planning assumptions, however in the main the underspends associated with the non delivery of activity are more than compensating for the additional costs of responding to Covid demands and the Trust is currently significantly ahead of the planned financial trajectory at the end of January.

January is the fourth month of the revised financial regime. The in-month surplus is £8.3m (£4.9m in December) which is ahead of the planned in month surplus of £0.9m. The year to date position is now £10.4m better than plan. The planned position has been phased differently across months 7 to 12, reflecting the phasing of some of the system and CPT income across 5 months not 6.

The total Patient Care income received is now showing as under recovered by £3.3m however this primarily relates to a change in payment route of Clinical Excellence awards where the actual income is now shown under “Misc other operating income”. The position includes under performance against Nightingale of £1.2m which is matched by underspends primarily in non-pay – this change is due to the payment of some large invoices directly i.e. not via MFT which reduces spend and associated income. There is a £2.3m under-recovery of anticipated income against Use of Independent Sector and an over-recovery of CPT drugs of £1.9m; again these are matched by variances within non-pay spend. There is a small over-achievement against Private patients/RTA and Overseas patients’ income of £0.2m YTD, which is an improvement from December which was at £0.3m underachieved.

All other income is showing overperformance and this is largely matched by increased expenditure in particular regarding Education & Training and R & D income. An element of Education and Training income has been deferred to 2021/22 reducing the apparent over performance.

Pay costs are showing a minor overspend in month of £0.15m a continuation of the December position (£0.7m) – the year to date position continues to show an underspend against planned substantive pay with overspends on bank and agency across nursing, medical and other clinical staff groups.

The underspend on Non-Pay has increased to £7.3m in January: an increase from £2.7m underspend in December however this is directly linked to income under-recovery (see above) and the ongoing lower activity.

Key Run Rate Areas

1. Waste Reduction Programme

Within the Hospital Control Totals is an implied Waste Reduction target, which aligns to the WRP targets set previously and the tables below outline the progress to date in achieiving those savings. Hospitals/MCSs are forecasting £22.3m achievement against schemes that have progressed to L3 or higher on WAVE. This is an improvement of £2.97m from the figure presented last month. It should be noted that the 21/22 forecast value is £15.5m suggesting that circa £6.8m is non recurrent. The Turnaround team are now working with Hospitals/MCS/LCOs on plans for 21/22 and making sure that the recurrent run-rate as we move into the new financial year is managed carefully.

MFT Summary

Workstream	Savings to Date				Forecast 20/21 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Plan (20/21) £'000	Act/F'cast (20/21) £'000	Variance (20/21) £'000	Financial BRAG
Hospital Initiative	2,648	3,047	400	115%	3,397	4,157	760	122%
Contracting & income	931	868	-63	93%	1,184	1,059	-125	89%
Procurement	4,666	3,903	-763	84%	6,251	5,158	-1,093	83%
Pharmacy and medicines management	655	503	-152	77%	765	573	-192	75%
Length of stay	-	-	-		-	-	-	
Outpatients	121	121	-	100%	153	153	-	100%
Theatres	175	275	100	157%	175	375	200	214%
Workforce - medical	2,113	2,287	174	108%	2,782	2,926	144	105%
Workforce - nursing	2,566	2,537	-29	99%	3,029	2,973	-55	98%
Admin and clerical	1,020	889	-131	87%	1,232	1,071	-161	87%
Workforce - other	2,377	2,380	3	100%	2,897	2,914	17	101%
Blood Management	9	8	-2	83%	13	11	-3	81%
Budget Review	713	556	-157	78%	1,128	952	-176	84%
Total (L3 or above)	**17,993**	**17,374**	**-619**	**97%**	**23,006**	**22,322**	**-683**	**97%**

Summary against Target M1-11	YTD
Target	19,733
Actuals (L3 or above)	17,374
Variance to Target	-2,359
Lost opportunity (value of schemes below L3)	2,621
Variance to target if all schemes delivered as plan	262

Summary against Target 20/21	Act/F'cast (20/21)
Target	23,679
Actuals/Forecast (L3 or above)	22,322
Variance to Target	-1,357
Value of schemes below L3 (M11-12)	635
Variance to target	-722

Financial BRAG

The BRAG Rating in the table above is the overall financial risk rating based on the criteria defined below. There are many individual schemes within each main savings theme, and at a detailed level there will be a range of ratings within each theme. An example is Divisional Non Pay where Corporate is risk rated green where as the overall scheme is risk rated Red.

- Financial Delivery less than 90%
- Financial Delivery greater than 90% but less than 97%
- Financial Delivery greater than 97%
- Schemes fully delivered with no risk of future slippage

Hospital / MCS / Division targets and forecast for schemes at L3

Hospital / Division	20/21 Target	20/21 Actual/Forecast	20/21 Variance	% Variance
MRI	7,005	6,930	-75	-1%
RMCH	2,375	2,299	-76	-3%
St Mary's	2,339	1,789	-550	-24%
EYE & DENTAL	857	678	-179	-21%
WTWA	4,454	4,020	-434	-10%
CSS	3,259	2,874	-385	-12%
Corporate	2,525	1,052	-1,473	-58%
LCO	865	2,680	1,815	210%
Grand Total	**23,679**	**22,322**	**-1,357**	**-6%**

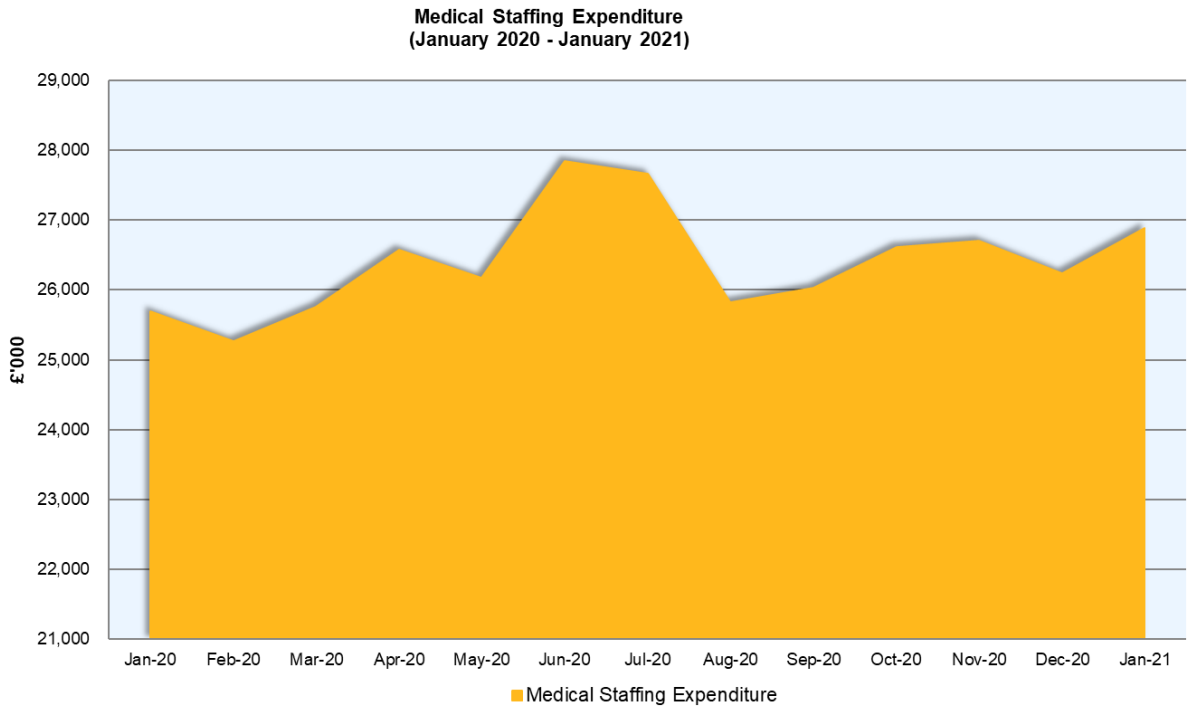
2. Agency spend by Staff Group and Hospital / MCS

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	Average M4-6 (20/21) £000's	Mth 7 (20/21) £000's	Mth 8 (20/21) £000's	Mth 9 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's
Consultant	-284	-268	-302	-275	-333	-261	-427	-196	-108	-244	-187
Career Grade Doctor	-89	-29	-36	-103	-35	-29	-73	-35	-39	-49	-20
Trainee Grade Doctors	-247	-253	-125	-84	-72	-104	-239	-163	46	-119	-188
Registered Nursing Midwifery	-574	-530	-511	-531	-303	-266	-326	-263	-343	-311	-173
Support to Nursing	-48	-45	-18	-41	-15	-34	-22	-38	-77	-46	-98
Allied Health Professionals	-83	-72	-109	-72	-64	-172	-245	-156	-176	-192	-199
Other Scientific and Theraputic	-141	-105	-20	27	-72	-14	-54	-52	-30	-45	-39
Healthcare Scientists	-8	-73	-118	-55	-62	-72	-161	-27	-143	-110	-41
Support to STT / HCS	-32	-39	-58	-39	-17	-16	-1	3	-21	-6	28
Infrastructure Support	-101	-40	-165	-98	-117	-104	-61	-29	-140	-77	-83
Grand Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**	**-1,071**	**-1,609**	**-956**	**-1,029**	**-1,198**	**-999**

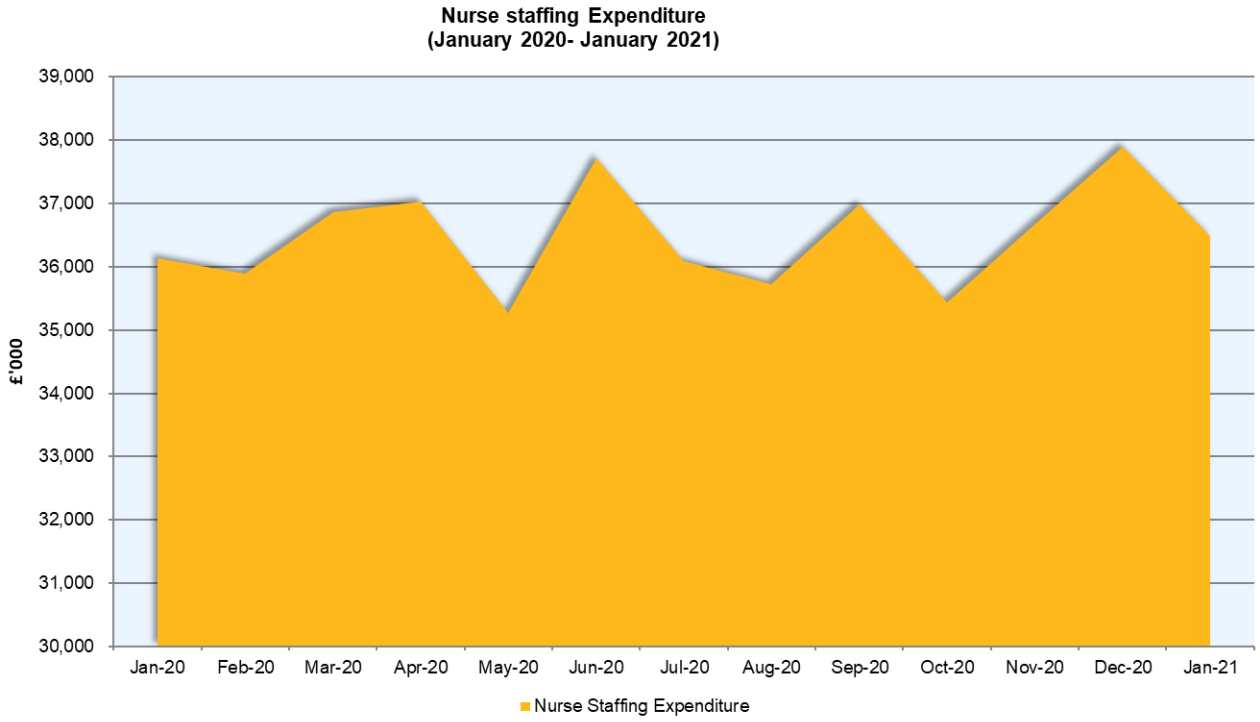
Hospitals	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's	Average M10-12 (19/20) £000's	Average M1-3 (20/21) £000's	Average M4-6 (20/21) £000's	Mth 7 (20/21) £000's	Mth 8 (20/21) £000's	Mth 9 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's
Clinical & Scientific Support	-191	-218	-156	73	-101	-219	-421	-179	-313	-304	-202
Manchester LCO	-44	-43	-110	-156	-152	-94	-83	-96	-54	-77	-45
MRI	-680	-534	-226	-534	-286	-223	-496	-342	-273	-370	-262
REH / UDH	-82	-91	-82	-73	-23	-11	-51	-55	-43	-50	-26
RMCH	-78	-94	-156	-109	-130	-101	-135	-55	-91	-94	-69
Saint Mary's Hospital	-24	-36	-33	-33	-18	-34	-57	-39	-64	-53	-60
WTWA	-412	-390	-532	-372	-199	-265	-292	-192	-166	-217	-245
Corporate	-99	-40	-162	-66	-182	-116	-5	8	-25	-7	-85
Research	2	-8	-5	0	1	-8	-70	-5	0	-25	-5
Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**	**-1,071**	**-1,609**	**-956**	**-1,029**	**-1,198**	**-999**

As would be anticipated, there was a reduction in the level of spend in the first half of 2020/21 due to reduced activity and the redeployment of clinical staff. Agency spend rose sharply in October, to the levels of early 2019/20, as departments grappled with high sickness rates and COVID isolation requirements, trying to deliver recovery actions as Covid related activity increased again. However spend has continued at a reduced level in Months 8 to 10 reverting to the spend levels incurred in previous months. Agency spend remains an area of scrutiny and is one of the key finance indicators in the AOF.

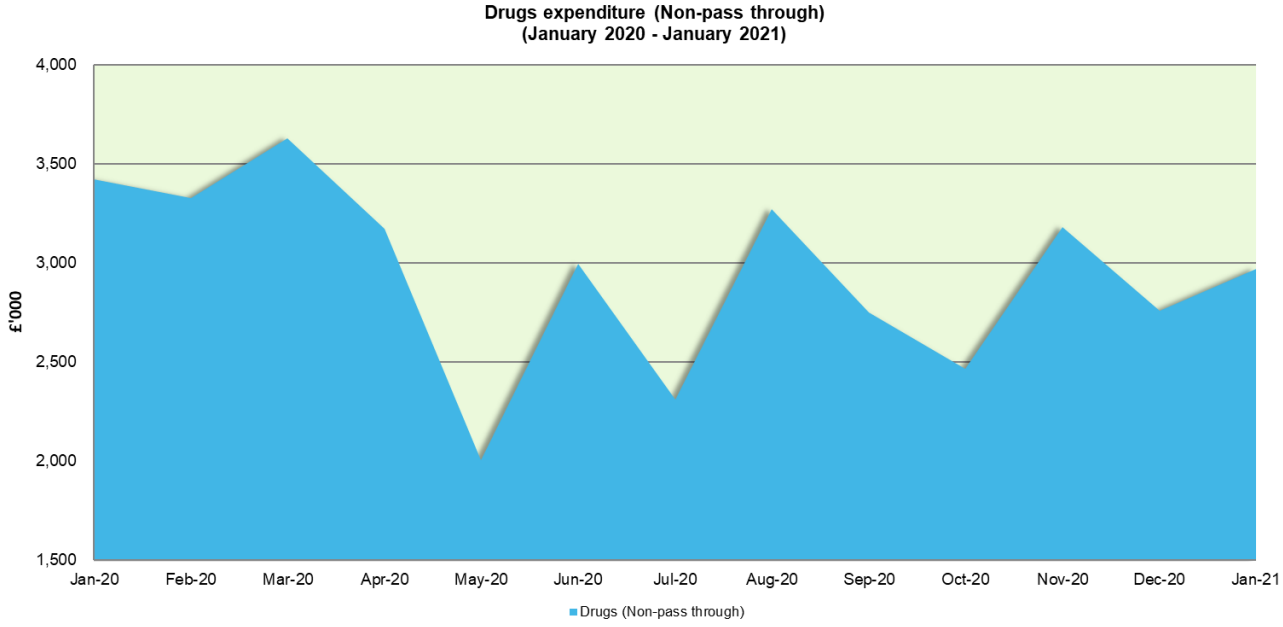
3. Medical Staffing:



4. Nurse staffing:



5. Prescribing:



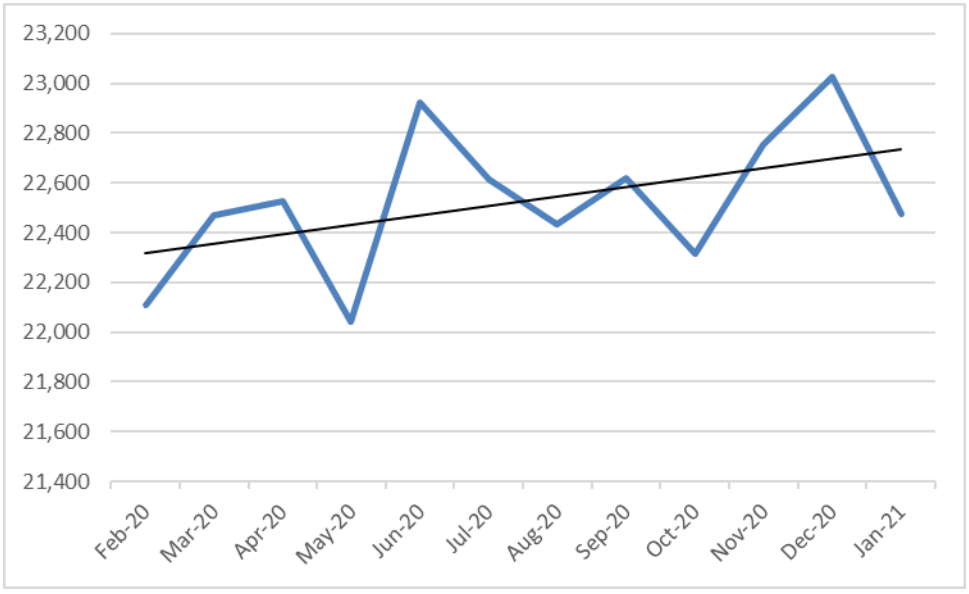
6. Staffing numbers

Staffing numbers have decreased in January primarily re Registered nursing and support to nursing linked to reduced overtime and increased bank usage. However the position of an overall increase over the last 12 months has been maintained at 2%.

	Whole Time Equivalent (WTE)											
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Allied Health Professionals	1,266	1,302	1,304	1,288	1,272	1,296	1,279	1,283	1,271	1,287	1,298	1,276
Career Grade Doctor	342	331	333	328	317	311	333	339	355	363	373	361
Consultant	1,171	1,189	1,201	1,171	1,206	1,190	1,218	1,222	1,242	1,252	1,217	1,222
Healthcare Scientists	945	953	939	950	944	945	932	944	958	965	978	950
Infrastructure Support	2,250	2,255	2,294	2,339	2,352	2,328	2,369	2,366	2,381	2,439	2,475	2,533
Other Scientific and Theraputic	863	872	862	861	903	925	929	947	948	953	970	938
Registered Nursing Midwifery	7,299	7,422	7,606	7,302	7,399	7,241	7,080	7,350	7,274	7,586	7,742	7,380
Support to AHPs	144	145	147	144	144	141	131	131	131	129	128	126
Support to Clinical	2,737	2,732	2,716	2,672	2,676	2,682	2,698	2,695	2,692	2,692	2,710	2,642
Support to Nursing	3,210	3,314	3,186	3,078	3,533	3,518	3,522	3,293	3,101	3,108	3,190	3,085
Support to STT HCS	713	737	724	712	841	762	730	734	735	739	757	742
Trainee Grade Doctors	1,170	1,215	1,215	1,196	1,335	1,275	1,209	1,314	1,226	1,242	1,191	1,222
Grand Total	**22,110**	**22,468**	**22,527**	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**

	Whole Time Equivalent (WTE)											
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
RMCH	2,145	2,207	2,258	2,209	2,305	2,327	2,268	2,231	2,211	2,259	2,321	2,214
CSS	3,741	3,803	3,846	3,774	3,808	3,753	3,778	3,863	3,896	3,947	3,992	3,880
Corporate Services	1,286	1,290	1,302	1,316	1,542	1,344	1,330	1,365	1,371	1,457	1,469	1,517
UDHM	270	263	263	255	257	248	252	253	260	253	244	244
Facilities	290	296	296	299	302	303	302	301	313	313	316	318
MLCO / TLCO	2,517	2,508	2,534	2,510	2,557	2,541	2,512	2,528	2,497	2,527	2,516	2,524
MRI	3,813	4,007	3,946	3,786	3,964	3,956	3,942	3,995	3,902	3,981	4,039	3,909
R&I	544	525	526	534	539	540	532	534	534	536	535	544
MREH	541	536	536	524	537	536	534	567	558	542	557	527
SMH	2,118	2,144	2,161	2,177	2,246	2,263	2,213	2,181	2,133	2,196	2,210	2,124
WTWA	4,845	4,889	4,860	4,656	4,865	4,803	4,767	4,799	4,639	4,743	4,830	4,676
Total WTE	**22,110**	**22,468**	**22,527**	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**

The above values are drawn from the ledger as opposed to the ESR system and reflect paid WTEs.

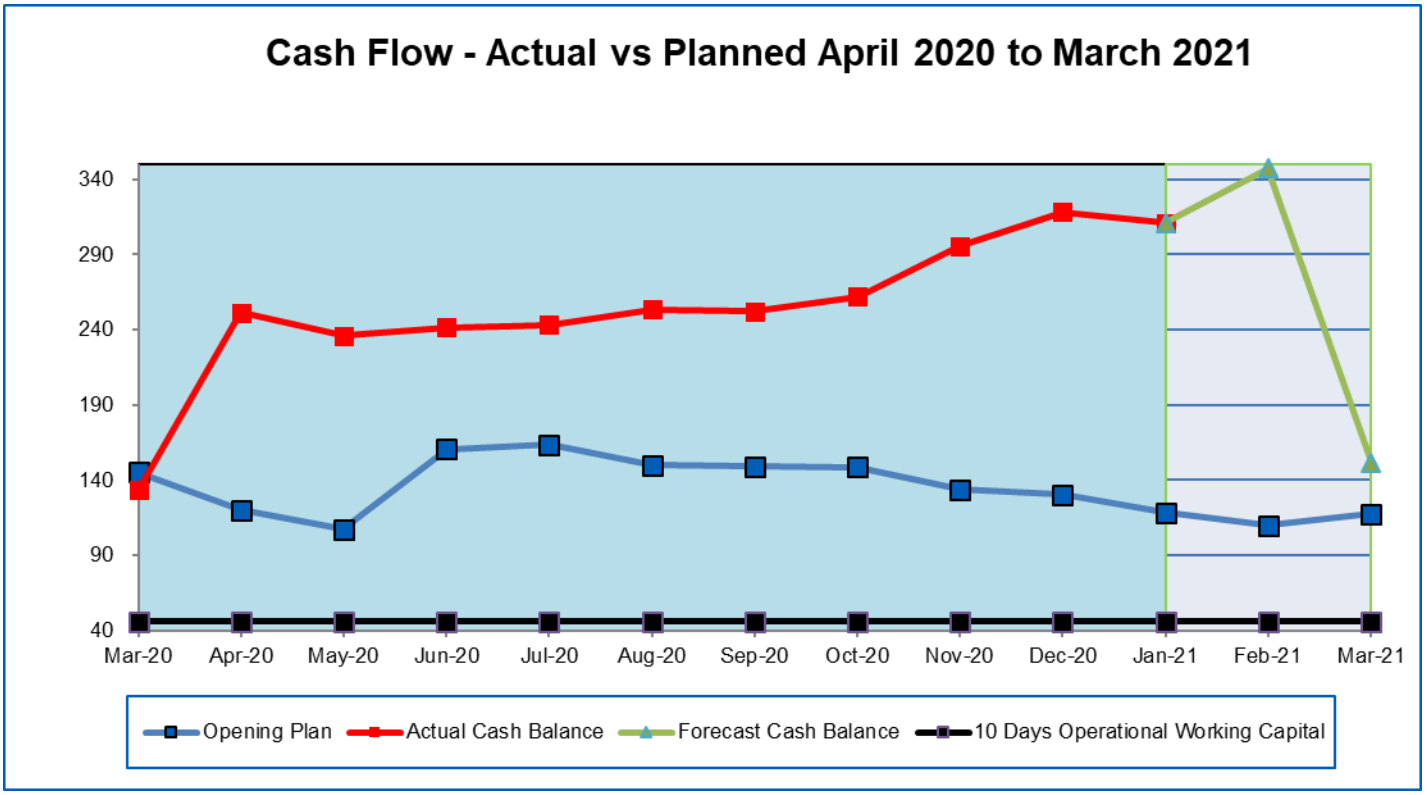


Statement of Financial Position

	Opening Balance 01/04/2020 £000	Actual Year to Date 31/01/2021 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,006	3,297	(709)
Property, Plant and Equipment	608,068	606,955	(1,113)
Investments	1,592	1,592	0
Trade and Other Receivables	6,329	4,503	(1,826)
Total Non-Current Assets	**619,995**	**616,347**	**(3,648)**
Current Assets			
Inventories	18,618	18,651	33
NHS Trade and Other Receivables	79,356	97,515	18,159
Non-NHS Trade and Other Receivables	37,302	33,157	(4,145)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	133,281	310,858	177,577
Total Current Assets	**268,767**	**460,391**	**191,624**
Current Liabilities			
Trade and Other Payables: Capital	(12,844)	(13,022)	(178)
Trade and Other Payables: Non-capital	(175,409)	(232,931)	(57,522)
Borrowings	(20,173)	(19,797)	376
Provisions	(13,417)	(14,012)	(595)
Other liabilities: Deferred Income	(18,435)	(183,310)	(164,875)
Total Current Liabilities	**(240,278)**	**(463,072)**	**(222,794)**
Net Current Assets	**28,489**	**(2,681)**	**(31,170)**
Total Assets Less Current Liabilities	**648,484**	**613,666**	**(34,818)**
Non-Current Liabilities			
Trade and Other Payables	(2,599)	(2,610)	(11)
Borrowings	(391,455)	(378,000)	13,455
Provisions	(14,635)	(14,161)	474
Other Liabilities: Deferred Income	(3,442)	(3,485)	(43)
Total Non-Current Liabilities	**(412,131)**	**(398,256)**	**13,875**
Total Assets Employed	**236,353**	**215,410**	**(20,943)**
Taxpayers' Equity			
Public Dividend Capital	208,994	224,579	15,585
Revaluation Reserve	49,424	49,504	80
Income and Expenditure Reserve	(22,065)	(58,673)	(36,608)
Total Taxpayers' Equity	**236,353**	**215,410**	**(20,943)**

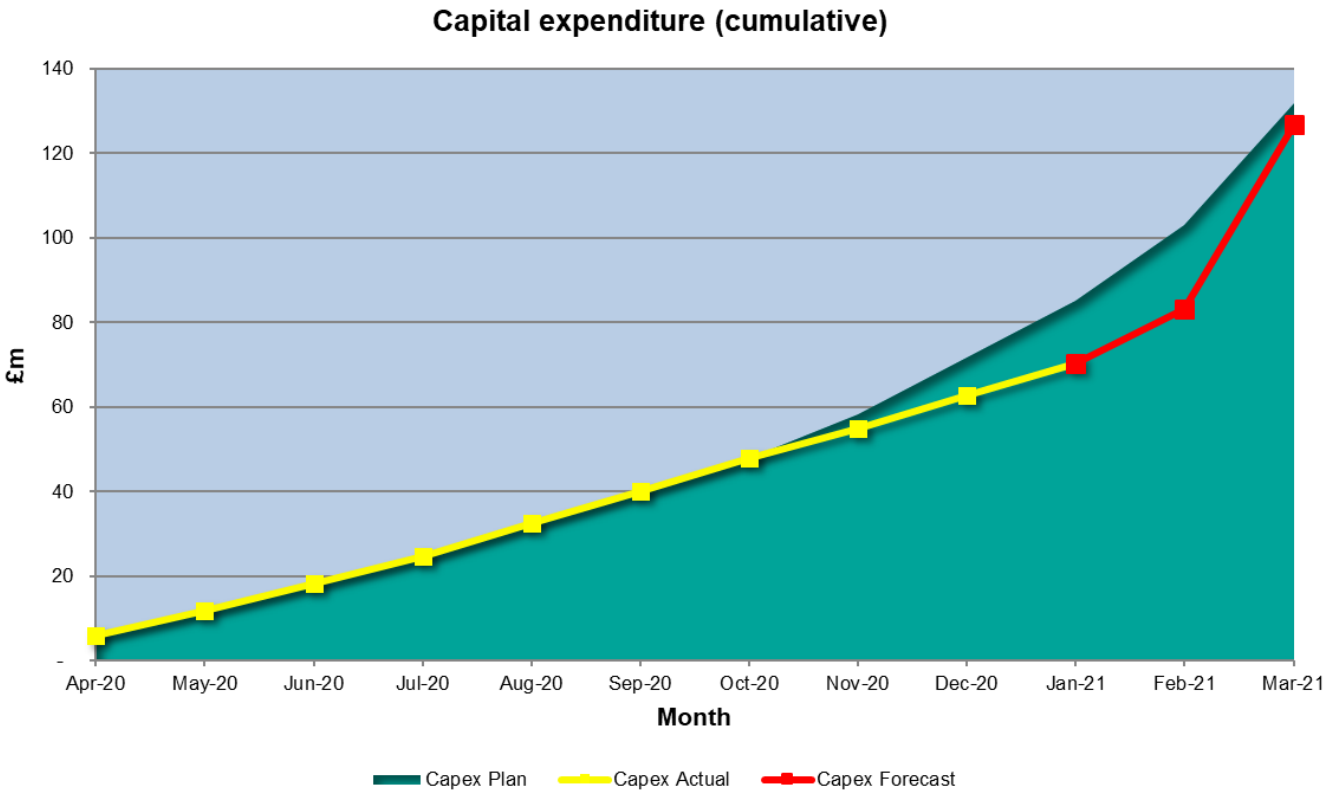
The most significant change on the SoFP in month 10 is the increase in NHS and non NHS Receivables which included the January VAT reclaim of £4.5m, which has now been received. PDC of £2.0m has also been received within the Taxpayers Equity relating to Winter Pressures funding and Critical Infrastructure.

Cash flow



The Trust has now been notified that the double-payment in April 2020 will be recouped in March 2021. Work on the forecast cash position continues as the Trust reviews the detail of the year end position and the revised outturn position and level of accruals and balance sheet provisions including regarding capital creditors.

Capital Expenditure



The chart above sets out the capital plan as it currently stands, with no further amendments since the Month 8 report at £131.9m. The Trust's capital plan and forecast expenditure for 2020/21 reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope.

The Capital Programme Managers for each of the three programmes are now required to re-forecast their expenditure on a monthly basis for the remainder of the financial year. The Trust has brought forward elements of spend from 2021/22 to compensate for anticipated slippage in order to make full use of the approved level of spend within the capital envelope.

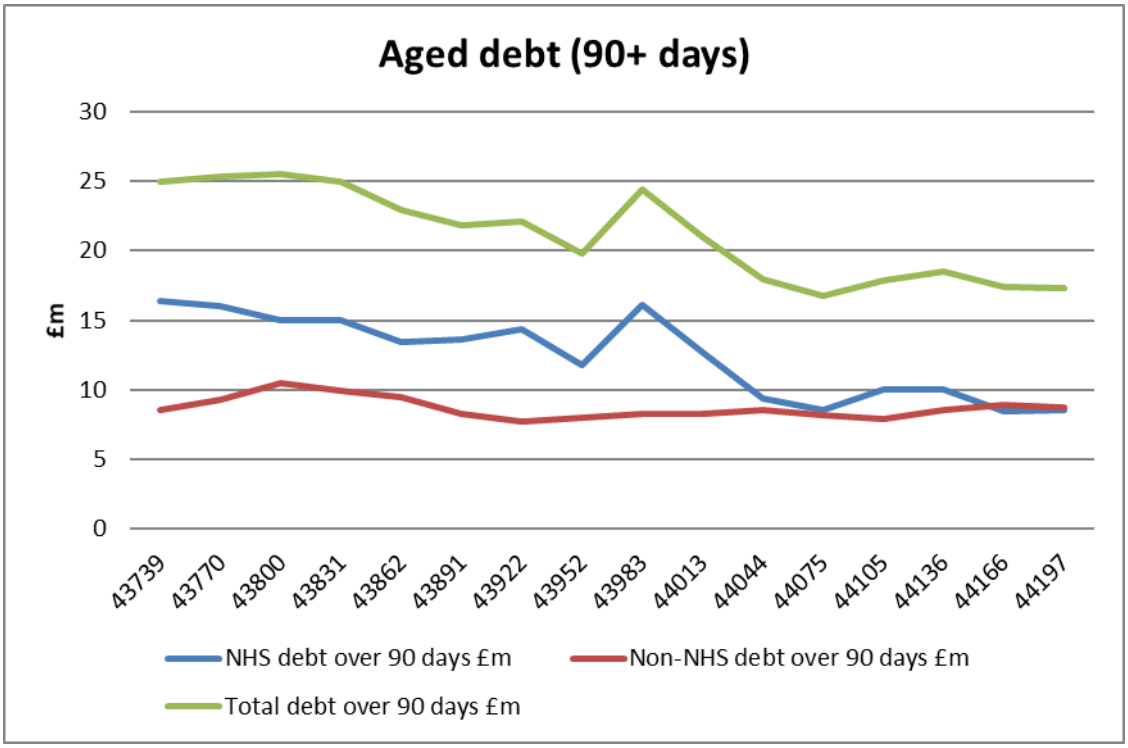
Aged debt

Aged Debt is a focus of the Finance Workplan during 20/21 as the level of outstanding debt continues to be subject to close scrutiny.

Total invoices raised that remain unpaid at the end of January 2021 stands at £38.1m, a decrease from the December figure of £38.5m and a reduction of £5.6m from April 2020. Of that balance, 45.5% of the invoiced value was raised over 90 days ago, a slight worsening from 45.1% in December however the value of the outstanding balances at 90+ Days shows a small decrease. A significant value has shifted from the 30-60 Days to the 60-90 Days.

	0-30 days (£)	30-60 days (£)	60-90 days (£)	90 DAYS + (£)	Grand Total (£)	% 90 DAYS +
Dec	8,883,653	9,970,854	2,281,917	17,379,215	38,515,638	45.1%
Jan	8,085,106	3,566,752	9,112,254	17,302,137	38,066,248	45.5%
Movement	- 798,547	- 6,404,102	6,830,337	- 77,078	- 449,390	

It is crucial that the benefits of the work undertaken across Greater Manchester to manage inter-provider debt more closely and to reduce transaction costs for these intra-NHS charges is not lost.



MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	February 2021
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

Government White Paper - Integration and Innovation: working together to improve health and social care for all'

The Government published its white paper 'Integration and Innovation: working together to improve health and social care for all' on 11 February 2021. It sets out proposals for a Health and Care Bill that will enable the NHS to build back better following COVID by:

- Removing the barriers that stop the system being truly integrated
- Removing transactional bureaucracy that has made sensible decision making harder
- Ensure that the system is more accountable and responsive to the people that use it and work in it.

The proposals have been grouped under the following four headings:

Working together to support integration

It is proposed that a two-part integrated care system is created comprising:

- An ICS Health and Care Partnership bringing together NHS, local government and partners – this will be statutory but much of the detail left for local determination
- An ICS NHS body responsible for the day to day running of the ICS and for making allocative decisions (it will take on the commissioning functions of CCGs and some of those of NHS E) – this will be more highly specified in the legislation.

The ICS NHS body will not have the power to direct providers; NHS Trusts and FTs will remain separate statutory bodies with functions and duties broadly as they are now.

NHS and local authorities will be under a new duty to collaborate with each other and there will be a 'triple aim duty' on health bodies to support:

1. Better health and wellbeing for everyone
2. Better quality of health services for all
3. Sustainable use of NHS resources

The ICS NHS Body will be required to meet system financial objectives and deliver financial balance. NHS providers will retain their current financial statutory duties and will be under a new duty to have regard for the system financial objectives.

The legislation will not cover the governance of place-based integration, this will be left to local determination. The legislation will create provisions for the establishment of joint committees, collaborative commissioning and pooling of budgets and joint appointments across and between NHS bodies and local authorities.

Proposals allow the NHS ICS body to delegate significantly to place level and to provider collaboratives. Further guidance from NHS E is expected on provider collaboratives.

Stripping out needless bureaucracy

These proposals are intended to address some of the bureaucracy that has grown up over a number of years and in particular some of the requirements in the 2012 legislation in relation to the procurement and provision of health services. They include for example removing the powers of the CMA and NHS I's competition functions and replacing the current arrangements with a new health services provider selection regime.

Enhancing public confidence and accountability

These proposals focus on ensuring that there is an appropriate level of accountability whilst also enabling systems to get on with doing their jobs. They include for example bringing NHS E and NHS I together into a single statutory organisation and giving SoS the power to dissolve and to transfer functions between Arm's Lengths Bodies (ALBs). They also give ministers the power to determine reconfigurations earlier in the process than is presently possible.

Additional proposals to support social care, public health and quality and safety

The additional proposals are not intended to form a coherent package but represent a set of proposals where change to primary legislation is required and include changes for social care, public health and quality and safety. Those particularly relevant to NHS Trusts include

- Legal framework for a discharge to assess model so that eg NHS continuing healthcare and funded nursing care assessments can take place after discharge from hospital.
- Placing Health Services Safety Investigations Body on a statutory footing.
- Establishing a statutory medical examiners system within the NHS for scrutinising deaths that do not involve the coroner.
- Putting hospital food standards on a statutory footing.
- Enable the SoS to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way and that professionals are regulated in the most appropriate and cost-effective manner.

On current timeframes and subject to parliamentary business the legislative proposals will begin to be implemented in 2022 and will form a critical part of recovery from the pandemic.

Phase 4 Planning

The timetable for producing 21/22 Annual Plans / Phase 4 COVID recovery plans reported in January was withdrawn in view of the COVID-related pressures that the system was under. The process is not expected to resume before April.

3. North West Region Issues

Genomics

The North West recently bid to be designated as a Genomic Medicine Service Alliance (GMSA). Alliances are part of the next stage of the NHSE led Genomics strategy in the NHS in England and it is intended there will be seven across the NHS. We have now been notified that the bid was successful, and we will be working with the NW Regional Medical Director to develop the Alliance. The Alliance will be hosted by MFT.

4. Actions / Recommendations

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce & Corporate Business
Date of paper:	March 2021
Subject:	Update on the NMGH transaction and redevelopment plans
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.
Recommendations:	The Board of Directors is asked to: • Note the content of the updates provided in this report including the revised transaction mechanism. • Endorse the technical adjustment to the previously agreed self-certification.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce & Corporate Business Tel: 0161 701 0190

1.0 Background and Purpose

1.1 NHS England / Improvement (NHS E/I) established a process to dissolve Pennine Acute NHS Hospitals Trust (PAHT) in such a way that MFT acquires North Manchester General Hospital (NMGH) and the remaining PAHT sites transfer to Salford Royal NHS Foundation Trust (SRFT).

1.2 MFT is committed to the acquisition of NMGH and work to deliver this objective, in collaboration with SRFT and PAHT, is progressing well. As part of the transaction process a Business Case for the proposed acquisition was considered and approved by the Board of Directors at the Extraordinary Meeting on 14th December 2020.

2.0 SRFT Proposed Transaction of Bury, Oldham and Rochdale

2.1 SRFT has written to NHS E/I requesting a deferral of the acquisition of the Bury, Oldham and Rochdale sites and services, so this transaction will not now proceed on 1st April 2021. SRFT's intention is to resubmit the business case and to seek to complete the transaction by 1st October 2021.

2.2 MFT's acquisition of NMGH will proceed as planned at 1st April 2021 but the legal mechanism will be slightly different – a prior commercial transaction rather than statutory transaction. A briefing and communications process was rolled out to staff and key stakeholders at the end of February.

2.3 As Bury, Oldham and Rochdale sites and services are not being acquired at 1st April 2021, PAHT will continue to exist as a legal entity, and the PAHT Board will need to remain in place. It is understood that the Bury, Oldham and Rochdale sites and services will continue to be operated under a management agreement between PAHT Board and SRFT.

3.0 NHS England /NHS Improvement (NHS E/I) processes

3.1 Following approval of the Acquisition Business Case in December 2020, the Board agreed the content of its self-certification at the January meeting, this was subsequently submitted to the NHS E/I Regional Team for review. A minor amendment has been made to this documentation to account for the revised legal mechanism, and a positive response letter has now been received from NHS E/I.

4.0 Due Diligence

4.1 The decision the Board took in approving the Acquisition Business Case was supported by the extensive Due Diligence exercise that had previously been undertaken. However, it was recognised that the original Due Diligence work had become dated, and so refresh exercises were undertaken in the areas of Clinical, Financial and Workforce Due Diligence. These reviews have demonstrated that the risk profile overall has not changed materially.

5.0 Prior Commercial Transfer

5.1 To complete the NMGH acquisition as a commercial transaction, a Business Transfer Agreement (BTA) has been developed. The signatories to the BTA are PAHT, MFT and NHS E/I. The development of this document has not been problematic, as many of its provisions were specified in the Transactions Agreement that had already been negotiated. The BTA requires a number of key schedules which specify the services, staff, estate, equipment, contracts, etc that will transfer. However, all of this information was already required for the Transactions Agreement, and the disaggregation processes have been set up to ensure that the schedules are developed.

5.2 NMGH will continue to have close joint working arrangements with other PAHT services after the acquisition, and an important element of the post transaction arrangements is the Service Level Agreement (SLA) that defines these arrangements. The intention previously was that the SLA would be between MFT and SRFT (PAHT having ceased to exist). The arrangement will now be between MFT and PAHT (recognising that some of the PAHT services will be managed through a Management Agreement with SRFT).

5.3 All of the legal documentation will be signed by the Chairman/Chief Executive on behalf of the Board to ensure that the transfer of NMGH to MFT can be completed on 1st April 2021.

6.0 Transaction activities

Brief updates can be provided on a number of key activities, as below. All of these activities are still required for the purposes of the commercial transfer, and none of them is adversely affected.

- **Disaggregation**: The Disaggregation processes are almost complete, with Safe Transfer Plan documents having been agreed for all clinical and corporate services.

- **Patient Pathways**: There are several patient pathways which cross between different sites within PAHT, and this will continue to be the case after 1st April 2021. Plans are currently being finalised for how these interactions can most effectively be managed.

- **Staff alignment:** Following the decisions made on disaggregation and service alignment, discussions have been proceeding with all PAHT staff to agree where their employment aligns in the transactions. The majority of these discussions happened prior to Christmas and have now been concluded. Lists of staff that will transfer to MFT have been provided, and validated, and arrangements to move these staff onto MFT's Electronic Staff Record (ESR) on 1st April are underway.

- **Service Level Agreement** (SLA): An SLA needs to be put in place to support the operation of services after 1st April 2021. The text of the overarching SLA document has been agreed, and work to develop service specific schedules is nearing completion.

- **Post Transaction Integration Plan** (PTIP): The second iteration of the PTIP, which sets out progress against plans to safely deliver 'Day 1' is being developed. It provides assurance that clinical and corporate teams are on track to deliver against their Day 1 milestones and that work to further integrate NMGH into MFT, after 1 April 20201, is also well underway.

7.0 Management Agreement

7.1 For 2020/21 MFT has operated NMGH on behalf of PAHT, under the terms of a Management Agreement, and this arrangement will come to a conclusion on 31st March 2021. Quarterly performance review sessions have been held with the PAHT Executive Team. NMGH has benefitted both from the strong local leadership team that was put in place, and from functioning as part of the MFT Group, and the arrangement is deemed to have worked effectively overall.

8.0 NMGH Health Infrastructure Programme Business Case Update

8.1 Redevelopment Outline Business Case The MFT Board endorsed both the Redevelopment and Digital Outline Business Cases at its meeting on the 11th January 2021 and that the OBCs were submitted to the NSH E/I and DSHC on the 29th January 2021.

8.2 **New Hospitals Programme and Final Business Case** The Trust has been formally notified that the NMGH redevelopment is one of eight Health Infrastructure Programme (HIP) schemes that will be taken forward as 'frontrunners' within this current spending review, with the other HIP schemes being eligible for funding from 2025 onwards only. As part of the national HIP Programme now referred to as New Hospitals Programme, the Trust has signed a Collaboration Agreement which sets out how the Trust will work with the new national team. The NHS E/I and DHSC central team and their technical advisors will now review each of the eight frontrunner schemes against the emerging central priorities such as design standardisation and modern methods of construction.

8.3 Strategic Regeneration Framework Update

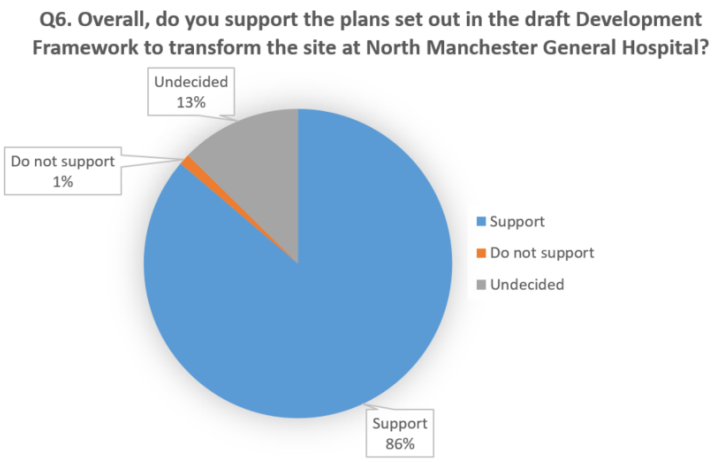
The public consultation period for the Strategic Regeneration Framework formally closed on 29th January 2021. During the consultation period, MFT led the engagement strategy which included:

- 7,000 leaflets posted to local residents/businesses
- 3 community events held – 15, 17 December and 6 January
- Councillor/Executive briefing
- 2 *Team Talks* staff engagement events held on 9 and 16 December
- Staff engagement information stand at NMGH
- Specific stakeholder briefings for Healthwatch, VSCE Assurance Group, CCGs, Union representatives, Our Manchester Disability Forum, Patient & Public Assurance Group.
- Local engagement through neighbourhoods, delivered in partnership with the LCO and Manchester Health and Care Commissioning

In terms of engagement capture, the MFT website provided the focus for information and feedback, backed up and promoted via press and social media coverage summarised as:

- Over 5,500 page views of the project website
- Wide-press coverage in MEN/BBC/PNW/Industry titles
- Over 75,000 social media impressions (Twitter, Facebook, Linkedin)
- 100s of staff /patient engagements
- 90 feedback forms (fully/partially completed) via MFT website
- 96 votes on the social media polls

Feedback has been overwhelming positive with 86% of respondents indicating their support for the proposals. The team are now reviewing the Strategic Regeneration Framework in light of the specific comments received and will work with the City Council to bring forward the final version of the document for full approval the City's Executive Committee in March.



8.4 Enabling Works

The following areas of activity continue to progress funded by the approved enabling works packages:

- The proposed multi-storey car park planning application was submitted in December 2020 with consideration expected at the planning committee in February 2021. Procurement for the contractor to construct this car park and deliver the required external works has also commenced.

- The decant accommodation required to provide ongoing office space for those affected by the commencement of enabling works will be located by the current Estates building. This four-storey modular block has been procured and planning permission granted.

- A Decant Strategy Team has been established to ensure that plans are communicated with relevant internal groups including PAHT colleagues.

- The Trust is working closely with Greater Manchester Mental Health NHS Foundation Trust to prepare to commence the enabling works on the PAHT Trust HQ site subject to written confirmation of funding.

9.0 Conclusions

Despite the changed transaction mechanism, all of the necessary processes to ensure an effective acquisition of NMGH on 1st April are in place and operating well.

All activities relating to the redevelopment programme are proceeding satisfactorily, pending feedback from the national team on the OBC.

10.0 Recommendations

The Board of Directors is asked to:

10.1 Note the content of the updates provided in this report, including the revised transaction mechanism.

10.2 Endorse the technical adjustment to the previously agreed self-certification.

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 (Patient Experience) Claire Horsefield, Head of Customer Services
Date of paper:	January 2021
Subject:	Quarter 3 Complaints 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:	Patient and Staff Experience
Recommendations:	The Board of Directors is asked to receive this report and note the: • Complaints and PALS service activity during Q3 2020/21 • Brief analysis of identified themes
Contact:	Name: Lynne Birchall, Head of Nursing (Patient Experience) Tel: 0161 701 7679

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st October 2020 – 31st December 2020

1. Executive Summary

1.1 This report relates to complaints and PALS activity across MFT in Q3 2020/21. The report provides:

- A brief summary of activity: Complaints and Patient Advice & Liaison Service (PALS)
- Q3 in context: Increase in Covid-19 related complaints, Monitoring of Complaints Process, The Parliamentary and Health Service Ombudsman (PHSO) and Christmas Virtual Visiting
- Overview of Complaints and PALS contacts including a brief analysis of themes
- Care Opinion and NHS Website feedback
- Improvements made and planned to ensure learning from complaints is embedded in practice, and
- Appendix 1: Supporting information presented in tables and graphs.

2. A brief summary of activity Q3 2020/21

- 1,401 PALS concerns were received compared to 1,272 in the previous quarter
- 275 new complaints were received compared to 298 in the previous quarter
- 100% of complaints were acknowledged within 3 working days; the position was maintained compared with previous quarters of 2020/21
- 342 complaints were closed compared to 246 in the previous quarter
- 95.3% of complaints were closed within the agreed timescale compared to 90.7% in the previous quarter. This is the second quarter that the Trust has achieved or exceeded the 90% target
- 77 (22.5%) complaints investigated were not upheld and 193 (56.4%) were partially upheld
- 9 cases were being investigated by the Parliamentary Health Service Ombudsman (PHSO), the same number that were reported in Q2, 2020/21
- The number of complaints relating to outpatients in WTWA and MRI has reduced by 56.9% compared to Q3 0f 2019/20; notably this reduction corresponds with the introduction of virtual clinics.
- North Manchester General Hospital (NMGH) Complaints and PALS activity continues to be reported separately through the NMGH quality assurance process and will be included in the MFT report from 1st April 2021.

3. Q3 2020/21 in context

During Q3, 2020/21 the Covid-19 pandemic affected the type and number of complaints the Trust received, with a rise in coronavirus-related concerns and complaints being received across the Trust.

Given the unprecedented situation, the PHSO advised service users that they were likely to experience delays of several months and asked that the PHSO office did not receive complaints relating to: delays with complaint responses, matters which are likely to resolve themselves in the next few weeks/months, and delays in service delivery, which were non-critical and as a result of an organisation coping with the pandemic.

As a result of the approach taken by the PHSO, during this quarter the PHSO did not close any cases and the same 9 cases from the previous quarter remained under investigation. Detail of the on-going PHSO investigations is set out in **Table 1**, Appendix 1.

Following the recommencement of the KO41a secondary care data collection that had been paused in response to the Covid-19 pandemic, NHS Digital confirmed that they aim to publish Q1 and Q2 data in January 2021. A timetable for the collection of Q3 2020/21 data is currently awaited. Further information regarding the KO41a is detailed in Section 4 of this report.

Following the commencement of the new PALS Volunteer role in the previous quarter, and the continuous positive impact on patient experience, a **Christmas Virtual Visiting Service** was developed this quarter. This additional provision offerered further support to patients to stay in touch with their families over the festive period. Further details of the service are set out in Section 6.

3.1. During Q3 the PALS and Complaints team have continued to:

- Maintain existing PALS and Complaints provisions.
- Support the PALS Volunteer role enabling patients and families to communicate during the on-going Covid-19 pandemic.
- Support Hospital/MCS/LCOs to continue to investigate and respond to complaints.
- Support Hospital/MCS/LCOs to continue to hold local complaint resolution meetings, either virtually or face to face, during the on-going Covid-19 pandemic.

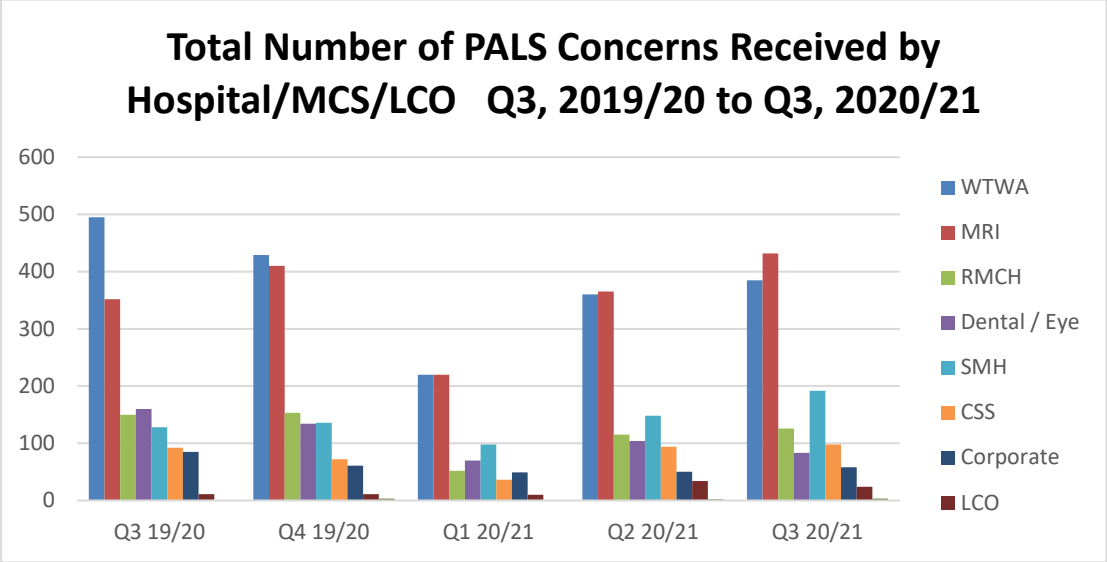
3.2 The Complaints Review and Scrutiny Group, chaired by a Non-Executive Director met once during Q3, 2020/21. The Management Teams from WTWA and CSS each presented a case in October 2020. The learning identified from these cases is detailed in Section 6 of this report.

4. Overview of Quarter 3, 2020/21

Patient Advice and Liaison Service (PALS) activity

4.1 During Q3, the PALS team responded to 1,401 concerns. This is a slight increase in comparison to the previous quarter. **Graph 1** below shows the number of PALS concerns received by each Hospital/MCS/LCO over the previous 5 quarters. Further detail is provided in **Table 2**, Appendix 1 of this report.

Graph 1: Total number of PALS Concerns Received by Hospital/MCS/LCO

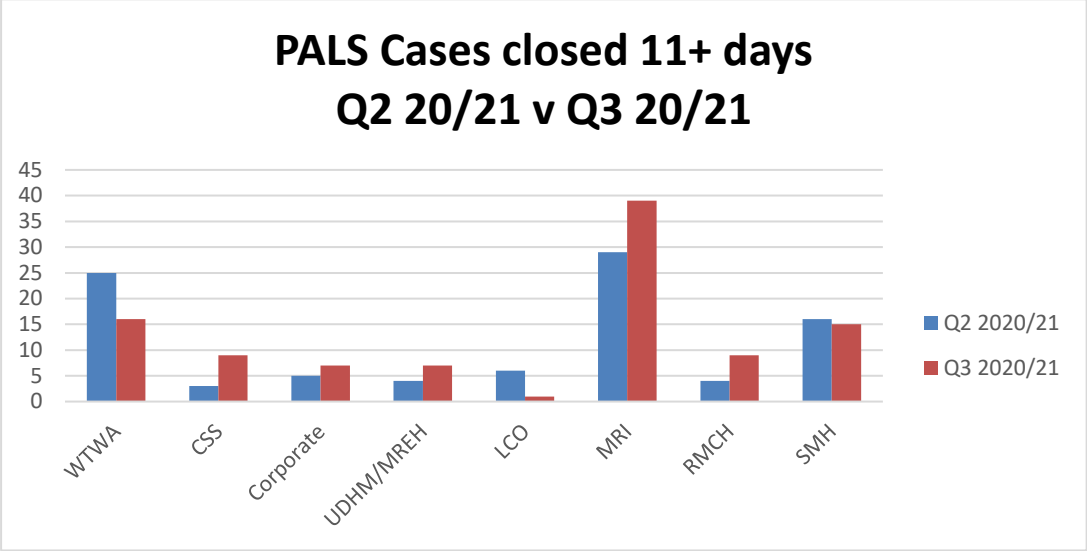


4.2 The Trust aims to quickly resolve PALS concerns. During this quarter, 93% of PALS concerns were resolved within 10 working days, which is a slight increase from the previous quarter. **Table 3**, Appendix 1 shows the timeframes in which PALS concerns have been resolved during the last five quarters. This data shows that resolution of PALS concerns within 10 days has remained above 90% for the past 3 quarters.

4.3 Delays in resolving PALS concerns are monitored by the Corporate PALS team and are reported to the relevant Hospital/MCS/LCO senior management teams via weekly reports detailing unresolved PALS concerns. PALS cases, which remain open at 8 days are escalated to the PALS Manager. **Graph 2** shows that with the highest number of PALS concerns overall, MRI also had the highest number of PALS concerns open longer than 10 days.

4.4 At the request of the WTWA and MRI senior management teams, monthly and quarterly reports continue to be produced by the PALS team. These reports identify the specific areas where the delays are encountered and drive ongoing improvement.

Graph 2: Number of PALS concerns taking longer than 10 days to close by Hospital / MCS/ LCO, Quarter 2, 2020/21 to Quarter 3, 2020/21



4.5 The number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Quarter 3, 2019/20 to Quarter 3, 2020/21 can be found in **Table 4** (Appendix 1).

4.6 There are occasions when in agreement with the complainant, PALS concerns are escalated to complaints. During Q3, five PALS cases were escalated to formal investigation. This represents a decrease from the previous quarter. **Table 5**, Appendix 1 shows the number of PALS cases escalated to formal investigation during the last five quarters. These data show that the number of PALS cases requiring escalation to a formal complaint investigation have reduced by 45% during this period.

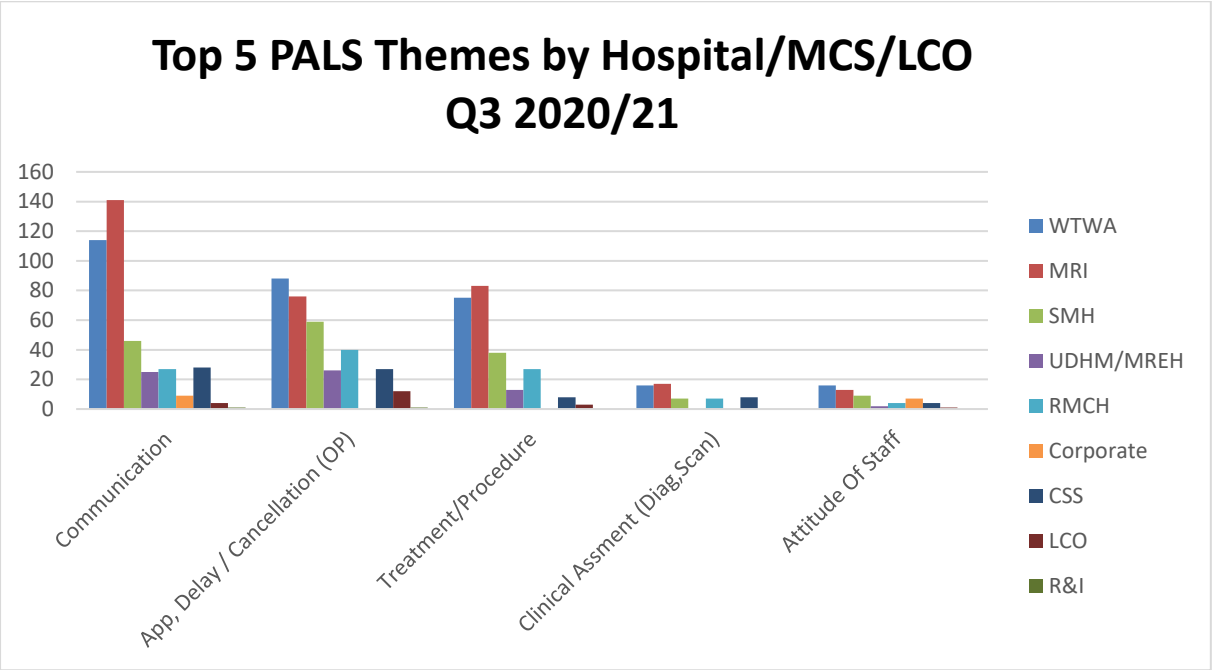
Themes from PALS concerns

4.7 Of the 1,401 PALS concerns received in Q3, 1,024 (73%) related to Outpatient areas, compared to 955 (75%) in the previous quarter. Trust-wide, the top 3 category themes for PALS concerns from this quarter remain unchanged and are:

- Communication
- Treatment/Procedure
- Appointment, Delay / Cancellation (OP)

Key themes are shown at hospital/MCS/LCO-level in **Graph 3,** below.

Graph 3: Number of Top PALS themes by Hospital/ MCS / LCO, Quarter 3, 2020/21



4.8 Examples of PALS concerns include:

- poor communication regarding a patient's clinic appointment
- delay in a patient receiving an appointment for a scan
- a patient requesting support in gaining an outpatient appointment

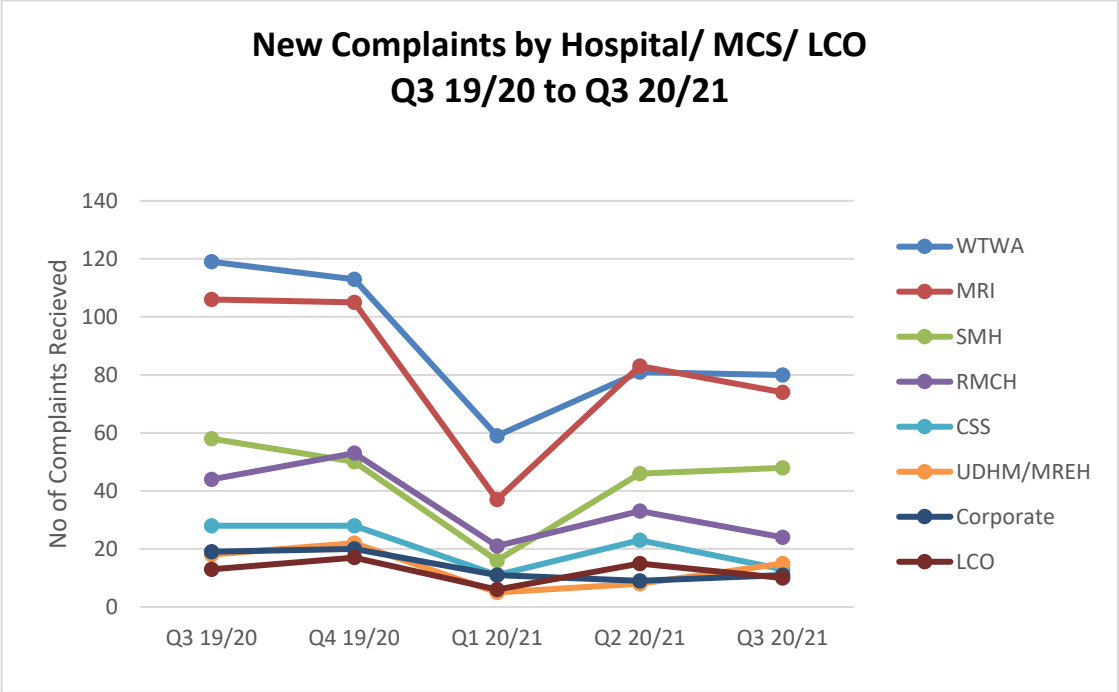
Complaints activity

4.9 Effective complaints handling is a cornerstone of patient experience. At all times the Trust aims to provide local resolutions to complaints; taking all complaints seriously. By listening and responding to complaints the Trust aims to remedy the situation as quickly as possible and to ensure that the individual is satisfied with the response they receive. The learning acquired from complaints is used to improve services for the people who use them, as well as for the staff working in them.

New Complaints received in Q3

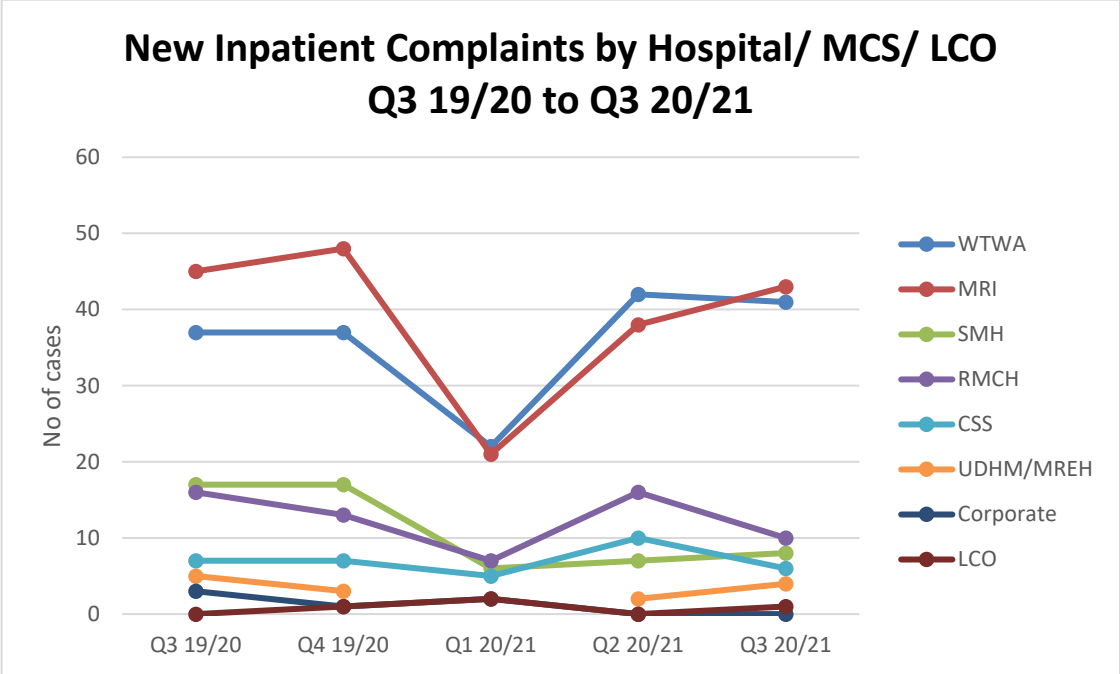
4.10 The Trust received 275 new complaints this quarter, which is a slight decrease compared to the last quarter. **Graph 4** shows the number of complaints received by each Hospital/MCS/LOC each quarter. Due to their size, it is expected that MRI and WTWA receive the greatest number of complaints. Further detail is provided in **Table 6**, **Appendix 1**.

Graph 4: Total number of New Complaints Received by Hospital/MCS/LCO

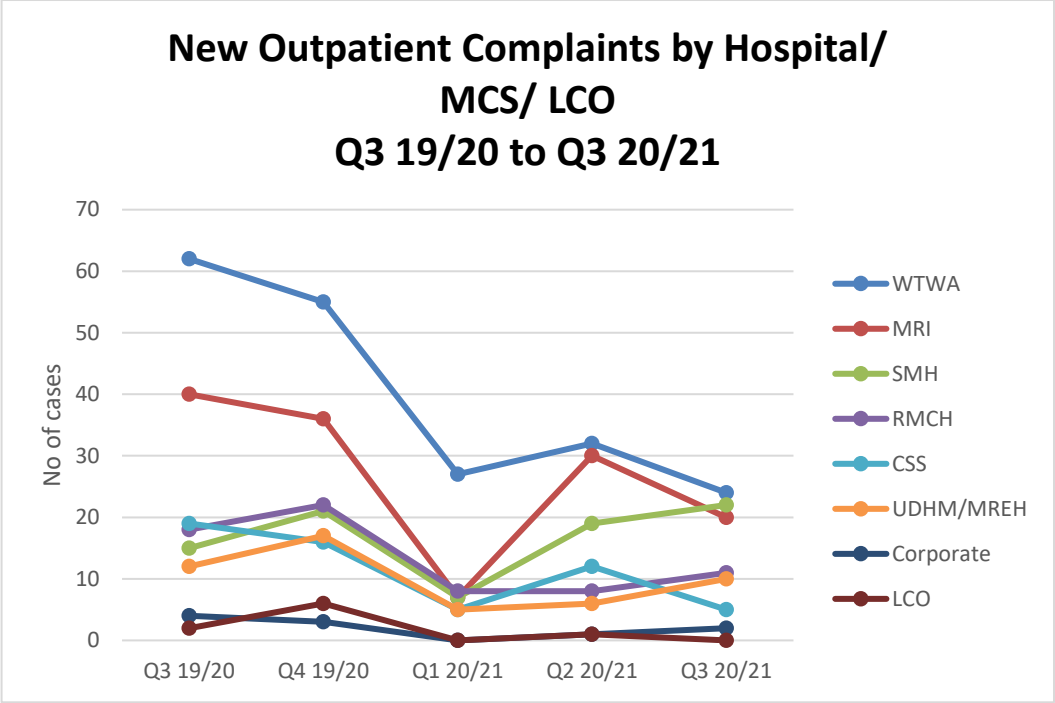


4.11 **Graphs 5 and 6** below illustrate the number of new complaints relating to inpatient and outpatient services for Quarter 3, 2019/20 to Quarter 3, 2020/21. Overall, the greatest increase in complaints relates to inpatients. It is notable that the reduction in complaints relating to outpatient coincides with a move to virtual clinics.

Graph 5: Number of new complaints relating to inpatient services by Hospital/ MCS/ LCO



Graph 6: Number of new complaints relating to outpatient services by Hospital/ MCS/LCO



4.12 Under the NHS Complaints Regulations (2009) all new complaints are required to be acknowledged within 3 working days of receipt of the complaint. The Trust has a performance indicator that all complaints are to be acknowledged within 3 working days in 100% of cases. This quarter, as in all previous quarters, the Trust met this indicator. **Table 7**, Appendix 1 demonstrates the complaints acknowledgment performance.

Resolved Complaints

4.13 During Q3, 95.3% of complaints were closed within the agreed timescale, which is a 4.3% increase (positive) compared to the previous quarter. This is the second quarter that the Trust has achieved above its 90% target, demonstrating the work undertaken within hospitals/MCS/LCOs to improve complaints management processes. **Table 8**, Appendix 1, provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

4.14 The oldest complaint case closed during Q3 was registered within the Local Care Organisation on 12th February 2020 and was 201 days old when closed on 26th November 2020. Delays in receiving comments from three external NHS organisations unfortunately resulted in the exceptional delay and the Trust not being able to provide a timely response. The complainant was kept updated and was fully supported throughout this process.

Outcomes from Complaint Investigations

4.15 Whilst all complaints provide an opportunity to review and improve services, the NHS Complaints Regulations (2009) require the Trust to report the volume of complaints which are well-founded. This information is provided on a quarterly basis through the KO41a submission to NHS Digital and the information obtained from the KO41a collection monitors written hospital and community health service complaints received by the NHS. It also supports the NHS commitment to improve the patient's experience by listening to the public voice.

4.16 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating team, the Complaints Case Managers review each of the issues raised to determine what happened. If failings are found in all the issues complained about, and substantive evidence is identified to support the complaint, then the complaint is recorded as **fully upheld**. If failings are found in one or more of the issues, but not all, the complaint is recorded as **partially upheld**. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as **not upheld.** It is important to note that there will not be outcomes for all registered complaints, for example where complaints have been withdrawn, or consent has not been received.

4.17 During Q3, 54 (15.78%) of the complaints investigated were fully upheld (well-founded), whilst 193 (56.43%) were partially upheld. **Table 9,** Appendix 1 demonstrates the outcome status.

Further Complaint Correspondence

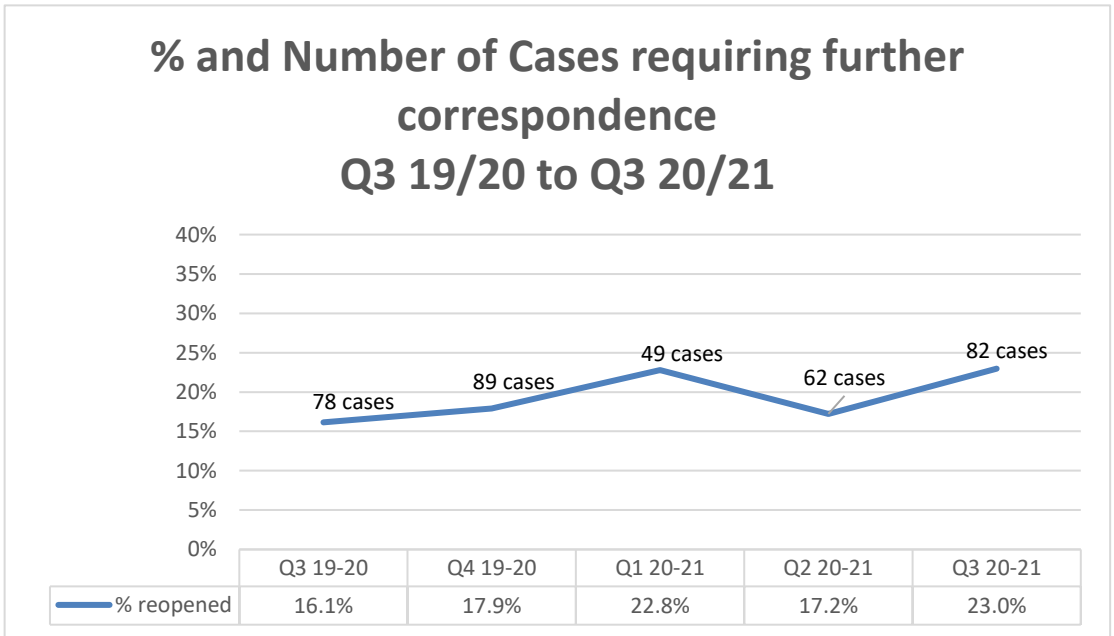
4.18 Further complaint correspondence is used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the MFT Chief Nurse. The Trust received further correspondence for 82 complaint cases during this quarter;representing a 23% further correspondence rate.

4.19 The Trust categorises further complaint correspondence from the complainant as:

- Request for a local resolution meeting
- New questions raised as a result of the information provided
- Response did not address all issues
- Dissatisfied with response

4.20 **Graph 7** demonstrates the numbers of further complaint correspondence received from Q3, 2019/20 to Q3, 2020/21.

Graph 7: Total further complaint correspondence received Quarter 3, 2019/20 to Quarter 3, 2020/21



4.21 Further complaint correspondence was received for 23% of complaints this quarter compared to 17.2% in Q2 and 22.8% in Q1, 2020/21. However, the increase in the number of further correspondence received aligns to an increase in the number of complaint responses delivered this quarter compared to Q2, 2020/21. **Table 10**, **Appendix 1** provides an overview of the predominant reasons for the further correspondence by Hospital/MCS/LCO during Q3.

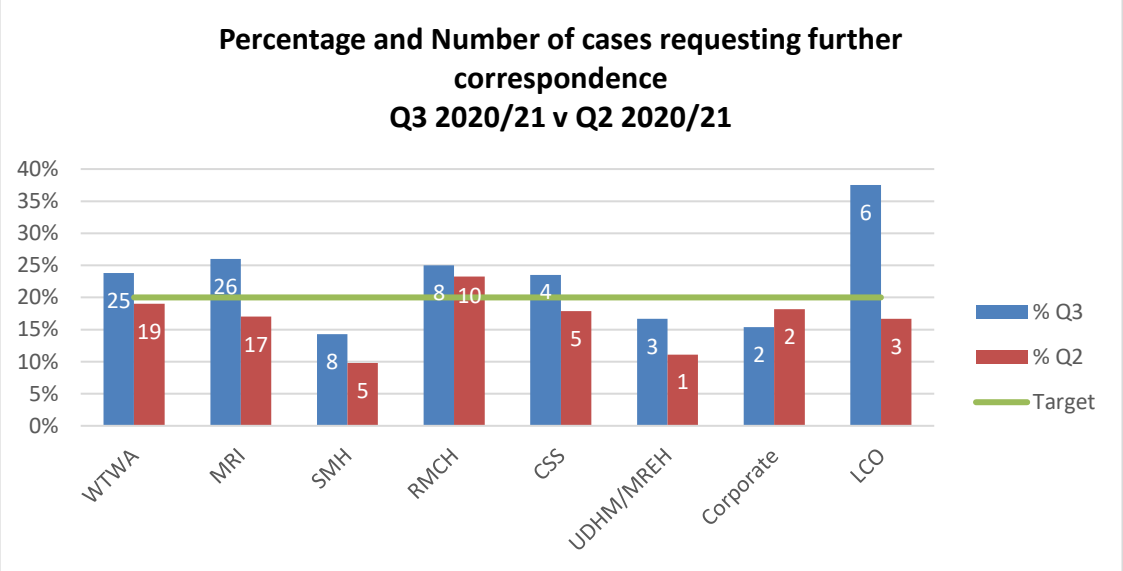
4.22 In 70 cases (85.3%) the predominant reason for further correspondence was due to the complainant being 'dissatisfied with the response', with WTWA and MRI receiving the greatest number.

4.23 Hospital/MCS/LCO performance against the 20% further correspondence threshold in Q3, where the threshold was exceeded is as follows:

- LCO (37.5%)
- MRI (26.0%)
- RMCH (25.0%)
- WTWA (23.8%)
- CSS (23.5%)

4.24 Further complaint correspondence received by MREH, UDHM and St Mary's Hospital fell below the 20% threshold. This position is demonstrated in **Graph 8** below. 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. The Corporate Complaints Team letter writing training programme continues to support improvements in the content and quality of responses as part of the educational sessions detailed in Section 9.1 of this report.

Graph 8: Percentage of further correspondence Complaints, Quarter 3, 2020/21



Themes from Complaints

4.25 Complaints are viewed as a learning opportunity to support the Hospital/MCS/LCOs to improve patient care and experience. By applying categorisation and theming to the complaints received, the Trust works to improve the quality of care where themes emerge, or practice is identified as requiring improvement.

4.26 During Q3 the top category was 'Treatment/ Procedure'. As in the previous quarter, 'Access' remains in the top 5 categories, and reflects the challenges in the provision of services during the NHS's response to the Covid-19 pandemic. The top themes in Q3 from complaints are shown in **Table 11** below. Also included are themes from previous quarters to enable comparison.

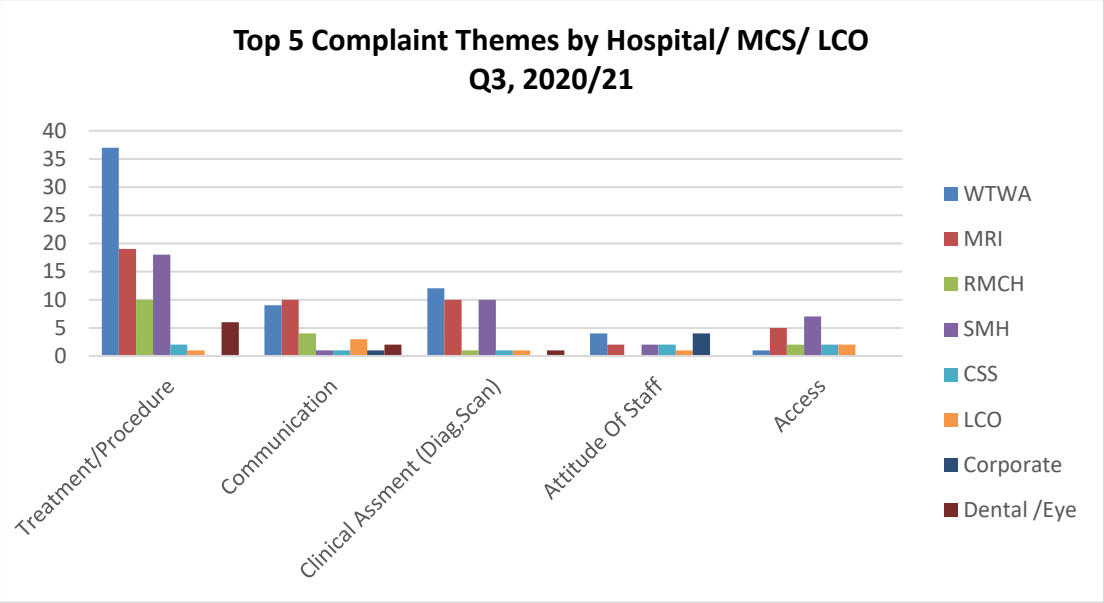
Table 11: Top Complaint Themes Quarter 3, 2019/20 to Quarter3, 2020/21

	Q3,19/20	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21
1	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure
2	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)
3	Communication	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Communication
4	App, Delay / Cancellation (OP)	Attitude Of Staff	Attitude Of Staff	Attitude Of Staff	Access
5	Access	App, Delay / Cancellation (OP)	App, Delay / Cancellation (OP)	Access	Attitude Of Staff

4.27 **Graph 9** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q3, 2020/21. As in the previous quarter, WTWA received the most complaints relating to 'treatment/procedure'. The majority of new complaints relate to inpatient and outpatient services. Some examples include:

- a patient experiencing delays in receiving pain relief and antibiotic treatment.
- a patient experiencing a delay in receiving a date for their Gynaecology surgery.

Graph 9: Total number of Top 5 Complaint Themes by Hospital/MCO/LCO, Q3, 2020/21



4.28 Work continued during this quarter to theme the concerns raised in complaints against the MFT *What Matters to Me* (WMTM) categories.

4.29 The themes identified from Q3, 2019/20 to Q3, 2020/21 are shown in **Table 12** below, with Professional Excellence and Positive Communication being illustrated as the top 2 WMTM themes. Examples of complaints received relating to Positive Communication and Professional Excellence are: a patient raised concerns about their blood results being reported incorrectly, and a complaint was received regarding inefficiencies and poor communication demonstrated by staff in a clinic.

Table 12: Theming of complaints to MFT WMTM cateogories, Q3, 2019/20 to Q3, 2020/21

WMTM themes	Q3,19/20	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21
Environment	1	3	27	5	2
Leadership	0	0	37	8	4
Organisational Culture	0	7	75	78	13
Positive Communication	2	10	77	104	22
Professional Excellence	10	17	45	61	73
Grand Total	**13**	**37**	**261**	**256**	**114**

5. Care Opinion and NHS Website feedback

5.1. 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.

5.2. This quarter a total of 26 comments were received, of which 69.2% (18) of the overall total number received were positive. Negative comments equated to 19.2% (5) of the overall total received this quarter. The number of Care Opinion and NHS Website comments by category; positive, negative and mixed, are detailed in **Table 13**, Appendix 1.

5.3. All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO. Responses are required for publication within 5 working days. Within each Hospital/MCS/LCO designated staff support the provision of a response to the PET. The PET ensures that responses are quality assured prior to on-line posting. **Table 14** below provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q3.

Table 14: Examples Care Opinion/ NHS Website Postings and Reponses Quarter 3, 2020/21

Quarter 3, 2020/21
Saint Mary's Hospital
Amazing staff, caring and so supportive. I had my second baby at Saint Mary's and both times I was so greatly looked after. All midwives were so lovely and helpful, they made me feel safe and cared for throughout the birth and when I stayed for a 48-hour observation with my son. They helped with all aspects, their reaction when my son had a slight breathing problem was swift. They know their job is saving lives, caring and supporting and they do it with their entire hearts and souls. Thank you so so much to all of you for what you do!

Response
Thank you for your positive comments posted on the NHS Choices / Patient Opinion website regarding your care in the Maternity Services 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 behavioural framework within which all members of the midwifery practice, so it was reassuring to read that you found the midwifery staff caring, supportive and professional and that your experience throughout the delivery of your son has been a positive one. I can assure you that we have passed on your feedback to the Clinical Head of Division for Obstetrics, the Divisional Director for Obstetrics and the Head of Midwifery who will be delighted to share your feedback with the staff involved. We would like to take this opportunity to wish you well for the future.
Manchester Royal Eye Hospital
Excellent I was very fortunate to be seen shortly before National Covid lockdown, for a repair to a previous procedure at a different hospital some 15-18 months earlier. I was apprehensive as the first operation had been painful and resulted in extensive facial bruising and did not work. The experience at RMEH could not have been more different. I had a very lengthy wait, due to an emergency procedure for another patient, obviously unforeseen. Despite a long day, the staff, perhaps picking up on my anxiety, went ahead with my operation instead of rescheduling. That in it-self was much appreciated. The procedure, whilst not pleasant, was carried out with what seemed great skill and care. All staff could not have been more pleasant (barring one receptionist whose manner was `interesting' fortunately, she had no clinical role!), thoughtful and caring. The lovely female surgeon who carried out my procedure has done a superb job; far less bruising than before, and no sign of the condition returning. I would want to return here if I ever require ophthalmology services again, an excellent unit. So glad it was done before Covid.
Response
Thank you for your positive comments posted on the NHS website regarding your care at Manchester Royal Eye 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. We were sorry to hear that your positive experience did not extend to the receptionist staff. Please be assured that we have passed your comments to the appropriate line manager. If you would like to discuss your feedback in more detail, please contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

6. Learning from Complaints: Service Improvements

6.1 The Trust is committed to continuous learning from complaints, which is reflected in service improvements. This section of the report provides examples of improvements made in response to feedback via complaints.

6.2 **The Complaints Scrutiny Group**, which is chaired by a Non-Executive Director, met once during Q3, 2020/21. The management teams from WTWA and CSS presented a case at a supplementary meeting in October 2020. Meetings that were missed due to the first wave of the Covid-19 pandemic had been rescheduled for November 2020, however as a result of the 2nd wave a decision was made to stand down November's supplementary meetings in order to release time to support the pandemic response.

The learning identified from the two cases that were presented in October 2020 along with the actions discussed and agreed at the meetings is outlined in **Table 15**. Transferable learning from complaints is identified and shared through this group.

Table 15: Actions identified at the Trust Complaints Scrutiny Group during Q3, 2020/21.

Hospital/MCS /LCO	Learning	Actions
WTWA	Communication breakdown with the family whilst the patient was on the ward	• Embed virtual visiting • Develop/enhance process of offering families time to meet with the clinical team caring for the patient should they have any concerns they wish to discuss in person
	Poor quality and minimal information provided within the patient's electronic discharge	• Discuss at Directorate meetings – Explore pursuing electronic discharges via voice recorder • Undertaking of an audit to define best standards & criteria
	Consultant's offer to meet with the family not shared within the two written complaint responses	• All staff involved/providing comment/s to the complaint investigation to review the written response prior to final Divisional QA
	MDT input not sought as part of the complaint investigation - Ineffective scoping of complaint upon receipt in the Division	• Lead Investigator for each complaint to have delegated authority to take ownership and responsibility for the complaint, including establishing and confirming the relevant staff/teams required to comment
	Brusque words used in final paragraph of written complaint responses	• Ensure wording is softened when appropriate • With the support of the Corporate Complaints team undertake audits using the Complaint Quality Standards Checklist
CSS	Poor communication in relation to: - Patient's feelings not listened to - MDT discharge plans and Discharge to Assess referral	• Staff member to undertake Communication Training • Discuss complaint anonymously at local team meeting • Discuss the importance of verbal and written discharge communication with the Therapy team

		• Therapy Discharge/Flow Champions identified to link with LCO therapist to work on Discharge Pathway – Explore how this can be implemented for the whole group
	Tone and content in written complaint response fell short of expected standard	• Share written response and audit outcome with the Allied Healthcare Professionals team, discuss expected standards • With the support of the Corporate Complaints team embed, and increase frequency of the undertaking of the Complaint Quality Standards Checklist audits • Staff to undertake Complaints Training • Improve cross reference of response with original complaint ensuring each question is responded to
	Nursing input not sought as part of the complaint investigation - Ineffective scoping of complaint upon receipt in the MCS/Division	• Lead Investigator for each complaint to have delegated authority to take ownership and responsibility for the complaint, including establishing and confirming the relevant staff/teams/departments required to comment.

6.3 Detailed below, in **Table 16** are some examples of how learning from complaints has led to changes and been applied in practice.

Table 16: Examples of the application of learning from complaints to improve services, Q3, 2020/21

Hospital/ MCS/LCO	Reason for complaint	Action Taken
WTWA	Care, Communication and End of Life Care	Monthly Matron Assurance Audits implemented to check personal care is being provided. Nursing staff supported in reflecting on dressing care provided. Ward Environment and Cleanliness Audits undertaken.

		Pressure Care Documentation Audits undertaken. Ward Contact Information Leaflet created and displayed on the ward. Complaint shared anonymously and discussed at safety huddles. Expected standards of attitudes and behaviours discussed with staff at the ward meeting. Completion of 'Respect' Form Education with staff. Pressure relieving mattress documentation developed and implemented on the ward. All staff reminded of the process of ordering/obtaining pillows. All staff reminded of the importance of documenting staff/patient communications in the patient's health records. Staff received communications training. Provision of Palliative Care team on weekly nursing ward rounds. Appointment of an End of Life Care Service Improvement Nurse.
CSS **(Critical Care)**	Patient's wellbeing affected due to noise on the ward	Patients' headphone requirements discussed with the nursing team and importance of patients being offered/provided with headphones at beginning of all shifts reiterated to all staff. Concern shared at the Trust's Quality and Patient Experience Forum in November 2020. Headphones stock in Critical Care increased to mitigate any supply challenges. Nurse caring for the patient supported in reflecting on events leading to the complaint.

		In order to enhance Patient experience a review of existing ear plugs within the unit is being undertaken.
CSS **(CTCCU)**	Patient's lost property.	A revised 'Admission' document has been developed enabling staff to record patient valuables within the unit. Concern shared anonymously and discussed at local team meetings. Trust Patient Property Policy and process shared in the Department's weekly bulletin. Development of a management of Patient Property and Valuables: Staff information poster being produced to be displayed prominently within the unit. Review to be undertaken of existing local Patient Property Handling Standard Operational Procedure and amendments implemented accordingly regarding 'patients and their property being transferred between units'.
RMCH (CAMHS)	Impact on patient's psychology assessment during the Covid-19 pandemic relating to: - Clinic spaces being refined in compliance with Covid-19 pandemic restrictions	Urgent review of seating arrangements undertaken and ensuring the requirements of Covid-19 Social Distancing measures, chairs removed and alternative chairs made available. Additional adjustable assessment tables made available in assessment rooms.
LCO **North Manchester Locality**	Concerns regarding end of life care by the District Nurses and the Palliative Care Team	Introduction of Electronic Scheduling Appointment System enabling all patients to be provided with bi-monthly face to face review appointments. Concerns shared with nursing team emphasising the importance of: - Arranging a face to face visit to reassess a patient's care needs when a relative raises concern. - Fully explaining the signs and symptoms to relatives when their

		family member is approaching end of life and what to expect after death. -Offering/providing supporting written material to families. -Encouraging relatives to write in the patient's 'Communication diary'. -Health Care Professionals to ensure review of the patients 'Communication Diary' at every visit. -Clear communication with patients and relatives at all times during the patient's journey.
MRI **(Theatres & Elective In-Reach)**	Patient's surgery cancelled due to a delay in the patient's Covid-19 swab test being reported by the laboratory.	A revised process has been implemented enabling patients to attend for Covid-19 swab testing 48 hours prior to surgery. Provision to check for specimens being processed developed and implemented enabling daily inspection and escalation to be carried out by the pre-operative administration staff.
MRI **(Outpatient Clinical Services)**	Due to Covid-19 Government Guidance on face coverings, a patient was challenged on their refusal to wear a face mask in the centre.	The importance of documenting a patient's exemption from wearing a face mask in their medical records discussed with all staff. Additional signage displayed in the centre detailing 'No admission to the centre without a face covering or a valid exemption'.
MRI **Head & Neck Specialties**	Due to Covid-19 patient's Micro Ear Suctioning Clinic appointment cancelled.	Meeting the requirements of Covid-19 a revised Nurse-Led Micro Ear Suctioning Clinic implemented at Trafford and Altrincham Hospitals. Patient's appointment rescheduled.
MREH	Patient not asked to change their personal face mask for a surgical face mask upon entering the hospital. Poor Communication regarding the waiting time in clinic.	The importance of all patients, visitors and staff adhering to Covid-19 Infection prevention controls reiterated to staff. Additional staff placed on the MREH main entrance to support the Security team. Concerns shared and discussed at team meeting emphasising the importance of communicating clinic running times to patients.

UDHM	Patient's clinic appointment cancelled while sat in clinic waiting room. Poor communication in consultant to consultant interactions.	Review of the Oral and Maxillo-facial Surgeons Appointment Scheduling undertaken by the team. A review of the standards of communication with clinicians at different NHS Trusts undertaken.
SMH	Impact on communication and access to services during the Covid pandemic relating to: -Gynaecology outpatient appointments -Gynaecology elective surgery	Implementation of a Recovery plan with all cases prioritised in line with Royal College guidelines. Action plan implemented to address shortfalls in administrative team, which contributed to poor patient communication. Gynaecology management team ensuring effective communication being maintained with patients regarding changes to appointments and surgery.

Quality Improvements

6.4 Improvement activities during Q3, 2020/21 included:

- **Launch of remote In-house Complaints Letter Writing Training Package/ Educational Sessions:**

  The Complaints team delivered its first remote training session for staff via the Bigblue Button on the Trust's Learning Hub during November.

  Three training sessions are provided per month; further detail can be found using the following link: https://learninghub.mft.nhs.uk/course/view.php?id=2389

- **In-house E-Learning Customer Service – PALS and Complaints package:**

  Progress is underway working with an external IT production company (Dynamic) to finalise Module 1 of the Customer Service, PALS and Complaints e-learning package.

  During this quarter the script for Module 1 has been ratified, patients videos have been agreed and staff have been identified to be filmed discussing their perspectives on customer service.

  Digital content is currently being developed aligned to the learning objectives and will be delivered using a range of media, such as text, graphics, audio and video. Examples of screens from the script are shown below.

  Completion of Module 1 is planned for Q4, 2020/21, and following quality assurance checks, technical tests and ratification, it is anticipated the package will be launched on the Trust's learning platform during Q1, 2021/22.

- **Virtual Visiting Service**

  Supported by the PALS and the Patient Experience Teams, a new PALS and Volunteer role has continued to provide virtual visiting during the on-going period of restricted visiting during Q3.

  In addition to virtual visiting activity being provided within clinical areas, during Q3, 197 virtual visits were provided by the PALS and Patient Experience teams.

  In order to offer further support to patients staying in touch with their families over the festive period a **Christmas Virtual Visiting Service** was developed and provided for 12 days by the Corporate Patient Experience Team.

Feedback from patients, families and volunteers about the Virtual Visiting Service included the following:

"The virtual visiting service has been very good and very helpful especially with the pandemic going on. Patients have been able to have video calls with their loved ones and at least when relatives that have not seen their loved ones for a while it has given them some reassurance".

"Just being able to see my mum in real time makes such a difference to me and provides me with reassurance that she is recovering. Thank you for providing this service for both us."

"I am so appreciative of the Volunteers; this is a fantastic service".

"As a volunteer this is a brilliant service and being able to support patients by simply talking to them and introducing them to a virtual video call makes such a difference. Some of the patients, particularly the older ones, have never had the opportunity to have interactions in this manner before and it helps reassure their families too. What I particularly enjoy is seeing the patient's recovery and progress in between the different visits and this is what has made such a difference to my experience as a Volunteer".

- **Listening to complainant feedback: Enhancing how MFT demonstrates learning across the Hospitals/MCS/LCO:**

  A focus on themes from complaints and showcasing changes in practice was planned to be shared at the Trust's Bee Brilliant event: 'Professional Excellence' during Q3, 2020/21, however in order to support the Trust's response to Covid-19 pandemic the virtual event was postponed until the beginning of Q4.

- **Internal Audit 2020/21: Complaints Handling**

  In order to provide assurance that the Trust's policies and processes for responding to patient complaints are appropriately designed during this quarter an internal audit was undertaken. This audit included assessment of the design of the local complaints process within each Hospital/MCS/LCO including how these align to the overall Trust Complaints Policy. The audit report will be presented to the Audit Committee in Q3 and to the Quality and Safety Committee in Q4. The audit findings will be included in the Q4, 2020/21 Complaints Report.

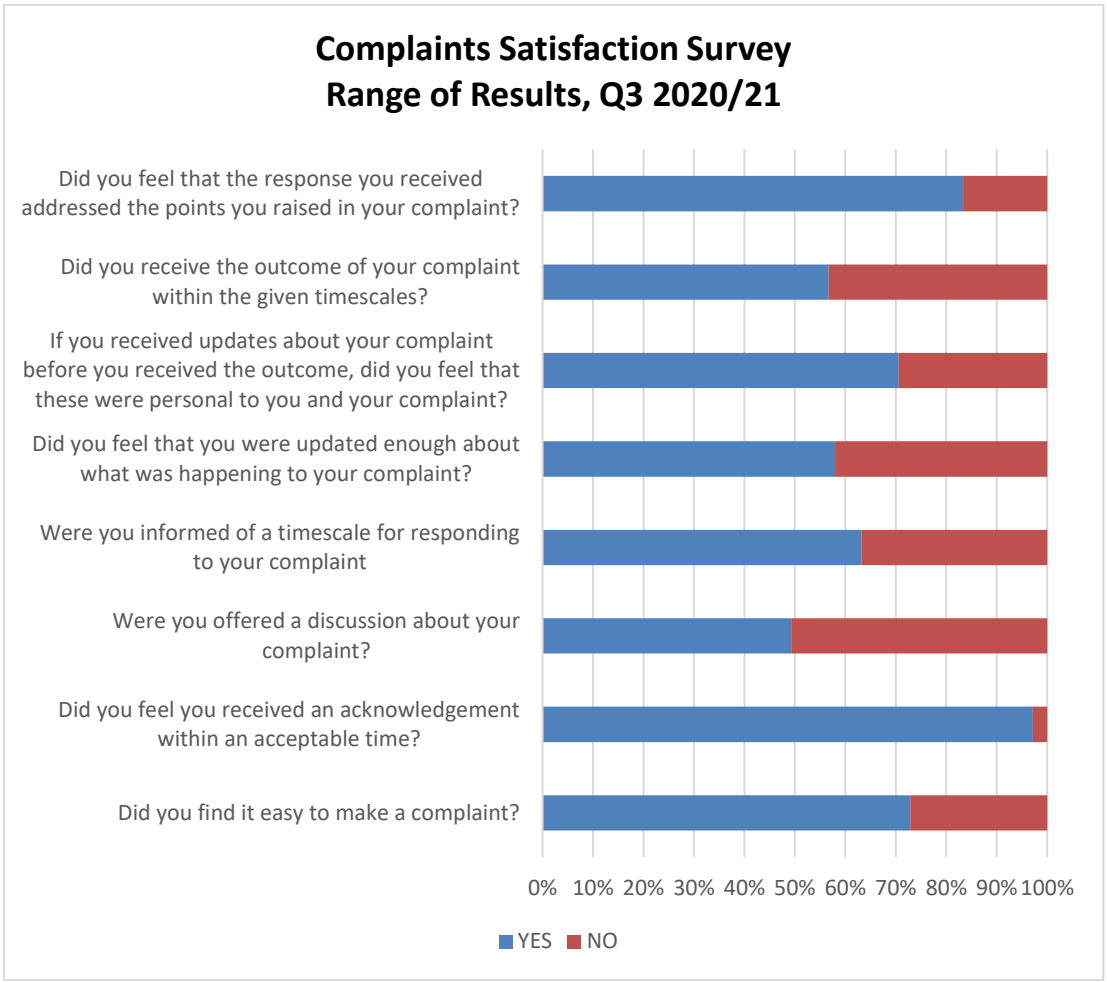
- **Standard Operating Procedures (SOPs):**

  In response to the Covid-19 pandemic a Standard Operating Procedure was developed and implemented during Q3 to support the Virtual Visiting.

Complainant's Satisfaction Survey

6.5 Based on the ***'My Expectations'***[1] paper, the Trust complaint's satisfaction survey has been developed by the Picker Institute. It is sent to complainants across all MFT Hospitals/MCS/LCOs. During this quarter 373 surveys were sent to complainants. 70 questionnaires were completed this quarter and the range of results from completed questionnaires in Q3, 2020/21 is shown in **Graph 10.** These results identify a slight reduction in complainants receiving the outcome of their complaint within the given timescales; however, this finding is likely to be associated with the continued operational pressures related to the on-going pandemic.

Graph 10: Range of complaints satisfaction survey results for Q3, 2020/21



[1] Available from: https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf

6.6 Listening to complainant feedback allows MFT staff to use the feedback to improve the standard of care and service provided. As detailed above in Section 6.2, a focus on complainant feedback and learning will be integral to planned improvements over the coming year. Comments received during Quarter 3, 2020/21 include the following:

Planned Improvements

6.7 Improvement priorities for Q4 include the following activities:

- Preparation for implementation of the new Corporate Complaints and PALS structure and patterns of working due to be implemented in Q1, 2020/21 to deliver an enhanced, responsive and compliant PALS and Complaints Service across MFT.
- Delivery of a Corporate PALS and Complaints Integration plan for North Manchester General Hospital.
- Implementation of Quality Control of the complaint 'acknowledgement' process; including development of complaint questions and the outcomes sought by the complainant.
- Equality and Diversity data checklist developed and made available to staff in PALS and Complaints teams.

- Development of Module 2 of the specifically tailored e-learning Customer Service package and finalisation of Module 1.
- Continue to encourage all Hospitals/MCS/LCOs to participate in the Complaint Response Letter Quality Standards Audit.
- Clearly displayed and easily accessible complaints information (NHSI Patient Experience Improvement Framework, 2018): To improve the accessibility of the Trust's website for PALS and Complaints a review of the resources will be undertaken throughout 2020/21.
- Standard Operational Procedures (SOPs): On-going development and review of SOPs.

7. Equality and Diversity Monitoring Information

7.1 The collection of equality and diversity data is shown in **Table 17,** Appendix 1. During this quarter the collection of the data continued to present the previously identified challenges. In view of this issue, an audit to evaluate the collection of this data was undertaken during this quarter.

The audit involved a review of a sample of 40 PALS and 40 complaint cases and for each case in the sample it was assessed whether equality and diversity data for ethnicity, religion, disability and gender had been collected or not. The results detailed below are a summary of the 80 cases included.

Of the 40 PALS cases included:

- 39 cases identified the complainant's ethnicity
- 4 cases identified the complainant's religion
- 0 cases identified the complainant's disability status
- 40 cases identified the complainant's gender

Of the 40 complaint cases included:

- 33 cases identified the complainant's ethnicity
- 13 cases identified the complainant's religion
- 13 cases identified the complainant's disability status
- 39 cases identified the complainant's gender

Whilst good compliance was found with regard to 'gender' data (98.75%) and 'ethnicity' data (90%); the audit found that 'religion' data was collected in only 21.25% (n=17) of the PALS and Complaint cases and 'disability' data was collected in 16.25% (n=13) of the cases.

All complainants should be informed of their right to support with their 'religion' and/or 'disability' status; however, the audit findings have identified a lack of consistency in the collection of this data.

The audit findings have identified that the current controls in place for collecting equality and diversity data for 'religion' and 'disability' status require improvement and urgent attention to address this is underway with the development of a departmental Equality and Diversity Checklist. Implementation of the checklist is planned for Q4, 2020/21 and a further audit to measure the outcome of the checklist will be undertaken during Q1, 2021/22.

8. Conclusion and recommendations

8.1 This report provides a concise review of matters relating to Complaints and PALS during Q3. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place.

8.2 In conclusion, the Trust will:

- Continue to monitor complaint response timescales against expected response timescales, providing support to Hospitals/MCS/LCOs when required.
- Continue to review and embed recommendations from National Guidance within MFT's policies.
- Continue to learn from complaints and concerns raised.
- Continue to progress the improvements outlined in this report.

8.3 Members of the Board of Directors are asked to note the content of this Q3 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.

Appendix 1 – Supporting information

Table 1: Overview of PHSO Cases open as at 31st December 2020

Hospital/ MCS/ LCO	Cases/s	PHSO Investigation Progress
CSS (1)	1	Awaiting Provisional Report
MRI (3)		
Cardio Vascular Specialty	1	Awaiting Final Report
Cardio Vascular Specialty	1	Awaiting Provisional Report
GI Medicine & Surgical Specialty	1	Awaiting Provisional Report
WTWA (5)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung	1	Awaiting Provisional Report
Heart & Lung	1	Awaiting Provisional Report
Surgery	1	Awaiting Provisional Report
TOTAL	9	

Table 2: Number of PALS concerns received by Hospital/ MCS/ LCO Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3,19/20	**Q4,19/20**	**Q1,20/21**	**Q2,20/21**	**Q3,20/21**
WTWA	495	429	221	360	385
MRI	352	410	219	365	432
RMCH	150	153	52	115	126
UDHM/MREH	160	134	70	104	83
SMH	128	136	98	148	192
CSS	92	72	37	94	98
Corporate	85	61	48	50	58
LCO	11	11	10	34	24
R&I	0	3	0	2	3
Grand Total	**1473**	**1409**	**755**	**1272**	**1401**

Table 3: Closure of PALS concerns within timeframe Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3,19/20	**Q4,19/20**	**Q1,20/21**	**Q2,20/21**	**Q3,20/21**
Resolved in 0-10 days	1332	1227	697	1098	1372
Resolved in 11+ days	156	198	49	92	103
% Resolved in 10 working days	**89.5%**	**86.1%**	**93.4%**	**92.3%**	**93.0%**

Table 4: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3,19/20	Q4, 19/20	Q1,20/21	Q2,20/21	Q3,20/21
WTWA	61	53	18	25	16
MRI	30	53	15	29	39
RMCH	16	26	0	4	9
UDHM/MREH	12	15	2	4	7
SMH	21	23	9	16	15
CSS	5	6	3	3	9
Corporate	11	21	2	5	7
LCO	0	1	0	6	1
R&I	0	0	0	0	0
Grand Total	**156**	**198**	**49**	**92**	**103**

Table 5: Number of PALS concerns escalated to formal investigation Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3,19/20	Q4,19/20	Q1,19/20	Q2,20/21	Q3,20/21
No of cases escalated	11	11	3	8	5

Table 6: Number of Complaints received by Hospital/ MCS / LCO Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3, 19/20	Q4,19/20	Q1,19/20	Q2,20/21	Q3,20/21
WTWA	119	113	59	81	80
MRI	106	105	37	83	74
SMH	58	50	16	46	48
RMCH	44	53	21	33	24
CSS	28	28	11	23	13
UDHM/MREH	18	22	5	8	15
Corporate	19	20	11	9	11
LCO	13	17	6	15	10
Grand Total	**405**	**408**	**166**	**298**	**275**

Table 7: Complaints Acknowledgement Performance

3 Day Target	Q3,19/20	Q4, 19/20	Q1, 20/21	Q2, 20/21	Q3, 20/21
100% acknowledgement	100%	100%	100%	100%	100%

Table 8: Comparison of complaints resolved by timeframe: Quarter 3, 2019/20 to Quarter 3, 2020/21

	Q3,19/20	Q4, 19/20	Q1,20/21	Q2,20/21	Q3,20/21
Resolved in 0-25 days	283	294	121	175	270
Resolved in 26-40 days	67	56	49	20	21
Resolved in 41+ days	97	77	77	50	51
Total resolved	**447**	**427**	**247**	**245**	**342**
Total resolved in timescale	342	362	172	223	326
% Resolved in agreed timescale	**76.5%**	**84.8%**	**69.6%**	**91.0%**	**95.3%**

Table 9: Outcome of Complaints, Quarter 3, 2019/20 to Quarter 3, 2020/21

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q3,20/21	342	54	193	77	7	8	1	2
Q2,20/21	246	37	144	55	6	3	1	0
Q1,20/21	247	26	158	55	8	0	0	0
Q4,19/20	426	79	245	86	16	0	0	0
Q3,19/20	446	76	263	98	9	0	0	0

Table 10: Further Complaint Correspondence by Hospital/MCS/LCO Quarter 3, 2020/21

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Dissatisfied with response	TOTAL
WTWA	0	1	1	23	25
MRI	1	1	1	23	26
SMH	0	1	0	7	8
CSS	0	0	0	4	4
RMCH	0	1	3	4	8
UDHM/MREH	0	1	0	2	3
Corporate	0	0	0	2	2
LCO	1	0	0	5	6
Grand Total	**2**	**5**	**5**	**70**	**82**

Table 13: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q3, 2020/21

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q3 20/21			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**2**	**3**	**2**
Wythenshawe, Trafford, Withington and Altrincham Hospitals	**7**	**1**	**0**
Clinical Scientific Services	**0**	**0**	**0**
Corporate Services	**0**	**0**	**0**
Manchester Royal Eye Hospital/ University Dental Hospital of Manchester	**2**	**0**	**1**
Manchester & Trafford Local Care Organisation	**0**	**0**	**0**
Royal Manchester Children's Hospital	**1**	**0**	**0**
Saint Mary's Hospital	**6**	**1**	**0**
Grand Total	**18 (69.2%)**	**5 (19.2%)**	**3 (11.6%)**

Table 17: Equality and Diversity Monitoring Information

	Q3,19/20	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21
Disability					
Yes	39	33	11	21	9
No	66	52	18	6	5
Not Disclosed	300	323	137	271	261
Total	**405**	**408**	**166**	**298**	**275**
Disability Type					
Learning Difficulty/Disability	0	3	0	1	0
Long-Standing Illness Or Health Condition	24	17	6	10	4
Mental Health Condition	5	2	0	0	0
No Disability	0	0	0	0	0
Other Disability	2	1	0	2	1
Physical Disability	4	9	3	4	1
Sensory Impairment	4	1	1	1	3
Not Disclosed	366	375	156	280	266
Total	**405**	**408**	**166**	**298**	**275**
Gender					
Man (Inc Trans Man)	173	180	73	123	110
Woman (Inc Trans Woman)	227	225	90	171	156
Non Binary	0	0	0	0	0
Other Gender	0	0	0	0	1
Not Specified	4	2	3	4	8
Not Disclosed	1	1	0	0	0
Total	**405**	**408**	**166**	**298**	**275**

Sexual Orientation					
Heterosexual	100	82	28	65	40
Lesbian / Gay/Bi-sexual	2	4	0	2	1
Other	0	2	0	0	0
Do not wish to answer	0	0	0	2	0
Not disclosed	303	320	138	229	234
Total	**405**	**408**	**166**	**298**	**275**
Religion/Belief					
Buddhist	1	0	0	0	0
Christianity (All Denominations)	53	52	17	39	24
Do Not Wish To Answer	0	0	0	3	1
Muslim	10	5	1	1	2
No Religion	30	24	10	24	9
Other	6	7	2	1	2
Sikh	0	1	0	1	0
Jewish	0	0	1	0	1
Hindu	2	0	0	0	1
Not disclosed	303	319	135	227	234
Humanism	0	0	0	1	1
Paganism	0	0	0	1	0
Total	**405**	**408**	**166**	**298**	**275**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	0	0	1
Asian Or Asian British - Indian	6	4	1	4	4
Asian Or Asian British - Other Asian	3	2	1	2	2
Asian Or Asian British - Pakistani	12	9	3	9	5
Black or Black British – Black African	10	7	6	2	4
Black or Black British – Black Caribbean	2	7	3	5	3
Black or Black British – other Black	2	0	1	0	1
Chinese Or Other Ethnic Group - Chinese	1	1	0	1	
Mixed - Other Mixed	0	0	0		5
Mixed - White & Asian	3	2	1	1	2
Mixed - White and Black African	2	0	0	1	0
Mixed - White and Black Caribbean	0	1	2	2	1
Not Stated	81	101	28	48	53
Other Ethnic Category - Other Ethnic	4	3	1	2	1
White - British	197	181	74	120	104
White - Irish	5	4	4	3	5
White - Other White	6	9	4	11	6
Not disclosed	70	76	37	87	78
Total	**405**	**408**	**166**	**298**	**275**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Acting Corporate Director of Nursing Lisa Murray, Workforce Matron
Date of paper:	February 2021
Subject:	Safer Staffing – To provide the Board of Directors with the bi-annual Nursing and Midwifery Safer Staffing 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:	Impact of report on key priorities and risks to give assurance to the Board that's its decisions are effectively delivering the Trust's strategy in a risk aware manner. 1. Patient Safety 2. Patient Experience 3. Productivity
Recommendations:	The Board of Directors are asked to note the contents of this paper.
Contact:	Name: Anne-Marie Varney, Acting Corporate Director of Nursing Tel: 0161 276 8862

1. Executive Summary

1.1 This paper provides the bi-annual comprehensive report to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[2]. The Guidance recommends that the Board of Directors receive a biannual report on staffing in order to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework[3]

1.2 The Board of Directors received a report in September 2020 outlining the Trusts position against the NQB standards. This paper will provide analysis of the Trust nursing and midwifery workforce position at the end of **December 2020** and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce. The report will also include a summary of the Allied Health Professions (AHP) workforce as per the NHSI guidance.

1.3 The Covid-19 pandemic has resulted in the nursing, midwifery and AHP workforce working in new ways, sometimes in unfamiliar settings and outside their usual scope of practice. These changes have often happened rapidly in order to meet increased demand whilst ensuring the care provided continues to be of high quality. NHSE/I principles and the NMC regulatory guidance have been utilised by the Trust to support a response and maintain safe staffing measures. Coordinated approaches to training, staffing huddles, staff shielding and collaboration between the hospital sites has also supported flexibility within the workforce.

1.4 Nursing and midwifery workforce supply continues to be a challenge nationally with the shortfall in registered nurses being well-documented across all NHS organisations. Additionally, the pressure of Covid-19 and the new ways of working have highlighted implications that could exacerbate the current national staffing problem.

1.5 At the end of December 2020 there was a total of **351.4 (4.6%)** qualified nursing and midwifery vacancies across the Group compared to **537.5wte (7.1%)** at the same period in the previous year (December 2019). This is a reduction of **186wte** vacancies, reducing the vacancy rate by **2.5%** over the last 12 months.

1.6 The majority vacancies are within the nursing and midwifery (band 5) workforce. At the end of December 2020 there were **235.6wte (5.8%)** compared to **368wte (9.2%)** at the same period in the previous year (December 2019). This is a reduction of **132.4wte** vacancies, reducing the vacancy rate by **3.4%** over the last 12 months. Due to the pandemic, the Trust has implemented alternative recruitment strategies with a focus on virtual recruitment and a guaranteed job offer to 'home grown' student nurses and midwives that are due to qualify in September 2021.

[1] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[2] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[3] https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led

1.7 At the end of December 2020, the 12-month rolling turnover rate for the registered nursing and midwifery staff group was **10.9%** and **13.0%** within the band 5 workforce. This is an improved position with a reduction **of 2%** in the overall turnover of nursing and midwifery staff and **3.5%** in the band 5 nursing and midwifery workforce.

1.8 There are currently **277** nurses and midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. They are due to commence in post before September 2021.

1.9 The Trusts International Recruitment Programme (IR) continues to provide an additional supply of Band 5 nurses to the workforce. Following the government's decision to lift travel restrictions in September 2020 **240** international nurses have arrived in the Trust. There is an additional **180** nurses due to arrive by the end of March 2021.The Trust will continue with an annual programme of overseas recruitment to supplement the domestic recruitment programme recruiting 360 nurses each year to address nursing turnover and workforce transformation plans. Recruitment will focus on hard to fill areas such as theatres, specialist medical services, care of the elderly and critical care.

1.10 There are currently **164** Nursing Associates (NARs) employed by the Trust working across general ward, community and theatre areas with an additional 44 trainees due to qualify in April 2021. There are **194** Trainee Nursing Associates (TNAs) in training across the Trust.

1.11 The sickness absence rate for nursing and midwifery was **3.3%** at the start of the pandemic in March 2020. Since this period absence has been reported daily due to significant registered staff unavailability and the prevalence of Covid asymptomatic and symptomatic absence. In December 2020 the absence rate for registered nursing and midwifery staff was **10.1%** and **6%** for AHPs. The staff vaccination programme will ultimately have a positive impact on staff absence as it is expected both symptomatic and asymptomatic absence to reduce as staff develop immunity.

1.12 There is currently no recognised national shortfall within generalist AHP therapists for adult services however there are shortfalls within the speciality posts such as adult acute Occupational Therapists (OT), Podiatrists and paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT).

1.13 Daily staffing levels continue to be assessed across each shift to ensure they are adequate to meet patient acuity and dependency needs on each ward and department. During the pandemic there has been a requirement to deploy staff to high dependency and adult critical care areas and at times resulting in a more dilute skill mix. Any changes to skill mix is risk assessed daily by a senior nurse to review the actions being taken to mitigate risk to patients safety.

1.14 The Board of Directors are asked to receive this paper and note progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.

2. Introduction

2.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery and Allied Health Professionals staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[4], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[5]. The Guidance recommends that the Board of Directors receive a biannual report on staffing in order to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework[6].

2.2 This report will provide analysis of the Trust nursing and midwifery workforce position at the end of **December 2020.** The report will describe the hospital/MCS workforce plans to support the pandemic response and workforce recovery plans. The report will also provide a summary of the Allied Health Professions (AHP) workforce as per the guidance.

2.3 The Hospital/MCS Directors of Nursing and the Director of Health Care Professionals (HCP) are required to present a quarterly Nursing and Midwifery workforce report to their Hospital/MCS/MLCO Boards. The December 2020 reports have been presented to the hospitals/MCS/MLCO Boards and inform this report.

3. National Context

3.1 The Covid-19 pandemic has placed severe strain on health systems worldwide, with large and rapid changes in demand for inpatient care. Caring for Covid-19 patients whilst maintaining treatment for patients with other conditions has been a complex planning challenge. Ensuring safe and timely care to both Covid-19 patients and those with other conditions has been and continues to be a crucial aspect of the NHS's response to the crisis. The NHS has created an exceptional level of surge capacity, including critical care, which has allowed staff to treat and care for a peak of more than 20,000 patients a day with confirmed Covid-19. The capacity to address this work is constrained by the need to focus on additional infection prevention and control measures, different working practices and social distancing rules. Trusts are required to develop robust covid-19 recovery plans that include adapted staffing process, drawing on the learning gained during the pandemic and considering new ways of working.

3.2 Nursing and midwifery workforce supply continues to be a challenge nationally with the shortfall in registered nurses being well documented across all NHS organisations. One in 10 nursing posts are vacant and absence rates has remained high throughout the pandemic. Additionally, the pressure of Covid-19 and the new ways of working have highlighted implications that could exacerbate the current national staffing problem due to:-

[4] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[5] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[6] https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led

- Increased staff sickness/absence - staff exposures, illness or need to care for family members at home.
- Shielding staff in high-risk categories - removed from front-line duties. Although this staff group have continued to carry out other important duties this has placed a burden on front line staff numbers.
- The donning and doffing of PPE adding additional time to routine activities.
- Increase in capacity and admissions to acute and critical care areas.

3.3 The NHS is in a situation where the number of people waiting for routine elective care exceeds 4 million and there is growing demand for mental health services. It has been recognised to fully recover from the pandemic, the government will need to exceed it's 50,000 new nurses target and put in place robust systems for recruiting and retaining a nursing workforce fit for the future[7].

3.4 The pandemic has reinforced the fact that nursing is a life changing career and has revealed just how valued healthcare frontline workers are. The expertise and flexibility of the nursing, midwifery and AHP staff has shown how safe, quality, compassionate care can still be delivered to patients even when under unprecedented pressure.

3.5 The government has pledged to train, recruit and retain an additional 50,000 nurses by 2024. To support this ambition, students study nursing, midwifery or allied health subjects can now access a non-repayable and non means tested annual grant in addition to existing mainstream student support[8].

3.6 International recruitment has been made a substantial part of the Covid response plan. NHS England (NHSE/I) and Health Education England (HEE) are working with the government to increase ethical international recruitment and build partnerships with new countries, making sure the supplying country is positively impacted, as well as the individual nurse and the NHS.

3.7 The Universities and Colleges Admissions Service (UCAS) have seen the number of applicants reach **58,550** in 2020. This follows a huge surge in interest in joining the NHS after the pandemic has shone a spotlight on the role of frontline healthcare workers. UCAS have found the pool of applicants interested in nursing degrees have been the most diverse with nursing having one of the highest proportions of course applicants from the black ethnic group **(20%).** Similar patterns have been observed when looking at mature students where **29%** of nursing students are aged over 30. The analysis has also shown that nursing recorded the second-best accessibility when looking at the socioeconomic status of applications, behind social work. Meanwhile, the number of men applying has grown by **8.5%.**

[7]The Health Foundation, 2020 Workforce pressure points - Building the NHS nursing workforce in England. The Health Foundation: London.
[8]The Health Foundation, 2020 Workforce pressure points - Building the NHS nursing workforce in England. The Health Foundation: London.

3.8 The professional regulators wrote to the retired healthcare workforce in March 2020 to encourage them to return to practice to support during the pandemic, with an overwhelming response. The NHS was able to manage demand during the peak and the additional staff have provided opportunity to boost the workforce with more experienced former nurses resulting in a 5% increase in the number of adult nurses.

3.9 In July 2020, NHSE/I published 'We are the NHS –People Plan 20/21 – action for all'[9]. NHSE/I intend to continue to work with all partners to develop a final People Plan which is scheduled for release later this year. The Plan outlines the actions organisations, employers and staff will need to take to transform the NHS workforce. Central to the plan is Our People Promise, which outlines behaviours and actions staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone and places and emphasis on tackling discrimination.

3.10 The detail contained within The Plan is being reviewed with the involvement of the Hospital/MCS/LCO Hospital Management Boards. A specific work programme will be developed to address nursing and midwifery and Allied Health Professions (AHPs) workforce recovery plans.

4. Greater Manchester (GM) Context

4.1 GM Provider organisations and Higher Education Institutions (HEIs) continue to work in collaboration in order to increase the pre–registration education pipeline. Due to the success of the collaboration in GM between the Chief Nurses and HEIs in September 2020 there was an increase of **17%** (161) in the number of adult nursing students; **18%** (49) increase in paediatric students and for the academic year in midwifery there is an expected **16%** (35) increase in students commencing a programme of education in comparison to September 2019. Training lead times however, results in these nurses and midwives not translating into the additional workforce supply until 2024.

4.2 The collaborative working of the GM Workforce PMO, HEIs and practice partners has enabled enough recovery of practice learning environments for all nursing & midwifery students that required a learning environment between September 2020 and January 2021 to be accommodated within the system. Innovative delivery of new and existing learning environments has been developed to help maintain or increase capacity e.g. MFT Educator Team Hub learning environment. Community settings remain a challenge, due to the need to maintain social distancing, and protecting vulnerable groups from too many people entering their homes. The pre-registration education teams continue to work closely will community colleagues to address any issues and maintain existing capacity.

[9] NHSE/I 2020 We are the NHS –People Plan 20/21 – Action for All

4.3 In March 2020 HEE introduced the Student Extended Placement Programme in response to the workforce challenges during the peak of the pandemic. Student nurses, midwives and AHPs were offered the opportunity to support the workforce response employing them into fixed terms contract of employment whist paying them to complete their training. Feedback from Aspirant Nurses who were deployed during this period has been largely positive, including comments of feeling 'an integral *part of the workforce'; 'development of autonomy as a practitioner'* and *'a feeling of increased confidence and better prepared for their role '*. HEI's are presently confident that the impact of the pandemic on students qualifying as planned is minimal but due to the disruption of programmes over the past 10 months it is considered that adapted/modified preceptorship programmes may be required to support the transition especially for 2nd year student who have moved into their 3rd year.

4.4 The recent NMC statement (14th January 2021) offers systems the opportunity to reinstate the emergency standards to facilitate final year nursing students supporting the health and social care workforce due to the continued challenges relating to the pandemic. The emergency standards will enable all final year nursing students to choose to undertake extended clinical placements for up to 100 per cent of their programme. There is also an agreement for the removal of the requirements for final year students covered by the emergency standards to be supernumerary. These changes will not apply to midwifery students. The NMC have made clear that the emergency standards are optional for HEI's and 3rd year students who may or may not want to undertake paid placements. The NMC have set out guidance of measures that must be in place to support student learning and welfare and patient safety. The emergency standard also allows first year nursing and midwifery students to focus on academic and online learning rather than participating in clinical placements while the system is under pressure. The GM System is considering these options in partnership with the HEI's.

4.5 There is an estimated 31 Return to Practice students due to commence programme in February 2021, a 250% increase on the 2020 intake. Appropriate learning environments have been identified to support the students to complete their practice hours.

4.6 GM have been successful in obtaining funding for year 2 of the Enabling Effective Learning Environments (EELE) project from HEE. This will allow the actions outlined in the GM Health and Care Learning Environment Strategy to be implemented focusing on increasing innovative learning environments via the creation of a GM Practice Education Centre of Excellence group (practice led and HEI informed); development of the educator workforce with clear standards of the requirements of a GM Educator and career development. The project will be looking to increase capacity through the development of Care Homes and private voluntary organisations as quality learning environments increasing the students experience of health and care in the wider system.

5. MFT Nursing and Midwifery Workforce COVID-19 Response

5.1 The Covid-19 pandemic has resulted in the nursing and midwifery workforce working in new ways, sometimes in unfamiliar settings and outside their usual scope of practice. These changes have often happened rapidly in order to meet increased demand whilst ensuring the care provided continues to be of high quality. NHSE/I principles and the NMC regulatory guidance have been utilised by the Trust to support a response and maintain safe staffing measures. Coordinated approaches to training, staffing huddles, staff shielding and collaboration between the hospital sites has also supported flexibility within the workforce.

5.2 A range of interventions have been implemented across the trust to increase capacity in response to the pandemic, including the establishment of additional acute/critcal care capacity, the upskilling and redeployment of staff and other resources and the procurement of equipment to support virtual or social distanced training/upskilling. The requirement to free up bed capacity was the cancellation of elective surgery and services has led to a backlog of patients now requiring care. The capacity to address this work in the following months is constrained by the need to focus on additional infection prevention and control measures, different working practices and social distancing rules which will require a workforce solution.

5.3 The pandemic has tested many components of service resilience over a sustained period. The trust has noted the importance of learning from the response to support longer term winter and major incident planning. The introduction of a systematic approach to deployment and redeployment has helped to support flexibility and resilience in the workforce but has also enhanced the response to other predictable challenges. The value of supporting workforce flexibility, understanding the need for and availability of clinical skills will continue to be important beyond the pandemic and need to be considered in future workforce and training plans.

5.4 As part of the Governments call out for nurses, midwives and other health professionals to return to practice and assist during the pandemic, the Trust employed 12 registered nurses who volunteered through the NHSI/E call to action to return to clinical practice. A fast track recruitment process was introduced within the Trust for registered nurses who had previously retired from the Trust and wished to return on short term contracts. There have been 20 previous employees who have returned through this route to support within ward areas and the staff vaccination programme.

5.5 Following the introduction of the Student Extended Placement Programme (HEE March 2020) student nurses, midwives and AHPs who selected to work at MFT were employed through fixed term employment contracts to undertake a paid placement. MFT saw the highest number of applications from students across the North West with **699** students requesting to work at the Trust during this period. Student nurses and midwives in their final 6 months of training (**306**) received guaranteed job offers from the Trust following their graduation of which **229** accepted offers of employment and started in the trust as Staff Nurses in September 2020. An additional **393** students were deployed into Band 3 Pre-Registration Nursing/Midwifery/AHP Assistant posts.

These students transitioned back into supernumerary placements in September 2020 to progress with their education programmes. These students will receive a guaranteed job offer of employment for when they graduate in 2021.

5.6 Following the NMCs decision to reinstate the emergency standards in January 2021, HEE reintroduced the student paid placement programme for 3rd year student nurses who are due to complete their programme within the next 6-8 months. The Trust has received expressions of interest from **92** third year students wishing to take up a fixed term paid placement. These students have all receive a guaranteed job offer of employment for when they graduate.

5.7 As part of a national programme, MFT started twice weekly asymptomatic lateral flow testing for all staff for 12 weeks from December 2020. The uptake of testing has enabled a rapid response to reduce the risk of transmission amongst across the trust.

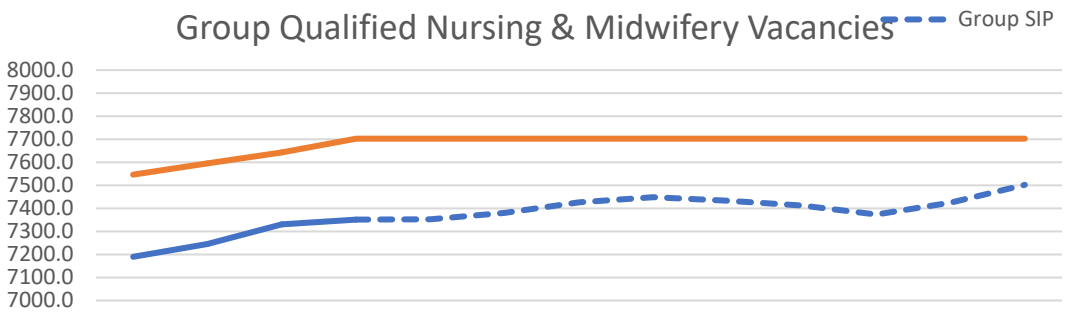
5.8 The Covid-19 staff vaccination programme was introduced in December when the Pfizer-BioNTech vaccine was approved for use. The clinics are based on the Oxford Road, Wythenshawe, Trafford General Hospital and North Manchester General Hospital sites. There are 75% of Trust staff who have received their first dose of the vaccine. Nursing, midwifery and AHP students and temporary staff have also been invited to have the vaccine at the Trust. The Hospitals/MCS are continuing to support nursing, midwifery and AHP staff who are extremely vulnerable and unable to work in front line services. Staff will be supported to return to work once it is deemed safe to do so.

6 MFT Workforce Position

6.1 At the end of December 2020 there was a total of **351.4 (4.6%)** qualified nursing and midwifery vacancies across the Group compared to **537.5wte (7.1%)** at the same period in the previous year (December 2019). This is a reduction of **186wte** vacancies, reducing the vacancy rate by **2.5%** over the last 12 months.

6.2 **Graph 1** provides the overall nursing and midwifery vacancy trajectory until the end of Q2 2021. Recent workforce modelling predicts an improved trajectory throughout 2021 when the nursing and midwifery vacancies are predicted to be **200.4wte (2.6%)** at the end of September 2021. This will be a reduction of **156.4wte (2.1%)** vacancies compared to the same period in September 2020 (**356.8wte).** The vacancy position is expected to improve in Q3 following the graduation of newly qualified nurses and midwives.

Graph 1

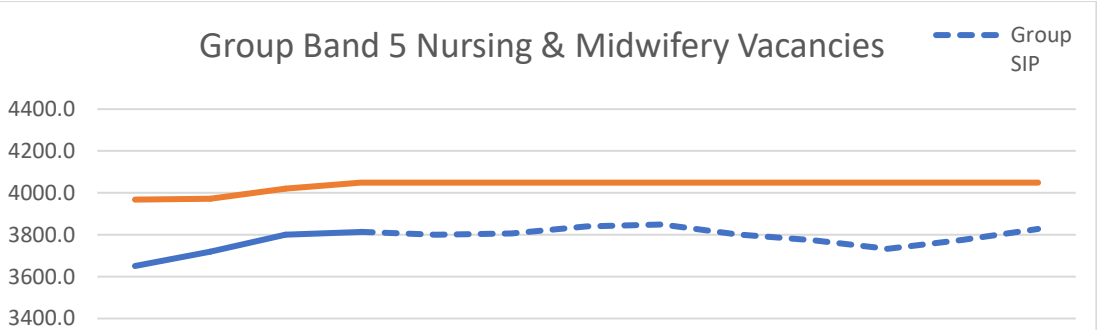


	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Group SIP	7189.5	7245.2	7330.4	7351.0	7352.4	7380.9	7426.6	7447.8	7432.9	7412.2	7372.6	7424.0	7502.0
Group Est	7546.3	7595.2	7642.7	7702.4	7702.4	7702.4	7702.4	7702.4	7702.4	7702.4	7702.4	7702.4	7702.4
Group Vac	356.8	350.0	312.3	351.4	350.0	321.5	275.8	254.6	269.5	290.2	329.8	278.4	200.4

6.3 The majority of vacancies are within the nursing and midwifery (band 5) workforce. At the end of December 2020 there were **235.6wte (5.8%)** compared to **368wte (9.2%)** at the same period in the previous year (December 2019). This is a reduction of **132.4wte** vacancies, reducing the vacancy rate by **3.4%** over the last 12 months.

6.4 **Graph 2** illustrates the Group Band 5 workforce position until the end of Q2 (2021). The workforce modelling predicts there will be **220.8wte (5.4%)** band 5 nursing and midwifery vacancies at the end of September 2021 which will be a reduction of **96.3wte (2.5%)** vacancies compared to the same period in 2020. The vacancy position is expected improve following the graduation and appointment of newly qualified nurses and midwives in Q3.

Graph 2



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Group SIP	3650.8	3719.2	3800.4	3813.3	3799.6	3805.8	3840.5	3849.0	3801.4	3774.4	3733.6	3774.9	3828.1
Group Est	3967.9	3972.0	4020.3	4048.9	4048.9	4048.9	4048.9	4048.9	4048.9	4048.9	4048.9	4048.9	4048.9
Group Vac	317.1	252.8	219.9	235.6	249.3	243.1	208.4	199.9	247.5	274.5	315.3	274.0	220.8

Nursing and Midwifery Turnover

6.5 At the end of December 2020, the 12-month rolling turnover rate for the registered nursing and midwifery staff group was **10.9%** and **13.0%** within the band 5 workforce (the national turnover rate for band 5 nursing and midwifery is **17.5%**). This is an improving position over the last 12 months when registered annual turnover was **13%** and band 5 turnover was **15.0%.**

Sickness Absence

6.6 The sickness absence rate for nursing and midwifery was **3.3%** at the start of the pandemic in March 2020. Since this period absence has been reported daily due to significant registered staff unavailability with the absence rate peak of **13%** in April 2020. In December 2020 the absence rate for registered nursing and midwifery was **10.1%** and **15.8%** for unregistered staff. Due to the nature of absences it is anticipated that this absence level will continue to remain significantly above 'normal' levels for the foreseeable future. The main reasons for this increase being the prevalence of Covid asymptomatic and symptomatic absence and an increase observed in mental health related sickness.

6.7 The staff vaccination programme will ultimately have a positive impact on staff absence as we would expect both symptomatic and asymptomatic absence to reduce as staff develop immunity. Given the delay in achieving immunity following receiving both doses, it is unlikely that a significant reduction will occur before the end of May 2021. Current modelling suggests there could be a small short-term increase in absence as staff may experience post vaccine symptoms after being vaccinated.

6.8 MFT have undertaken wider discussions with GM colleagues regarding agreeing some modelling assumptions for staff absence. Consensus is that absence in the nursing and midwifery workforce in the 2021/22 year will continue to be above 'normal' levels. This is due to the likelihood of persistent Covid absence particularly anticipated in the early part of the year and likely underlying increase in the mental health related absence. Trusts are exploring modelling an assumption of an additional 0.5–1% absence for increased prevalence of mental health conditions.

7. Recruitment

Domestic Recruitment

7.1 Due to the pandemic the Trust has been unable to deliver face to face recruitment open days to attract both experienced and newly qualified nurses and midwives. Alternative recruitment strategies have been implemented with a focus on virtual recruitment events. These events enable essential networking to support the ongoing domestic recruitment pipeline.

7.2 A guaranteed job offer for 'home grown' student nurses and midwives as they enter their final year of training has been introduced with a total of **229** graduate nurses and midwives recruited in Q3. The guaranteed job offer will now include nurses and midwives who are in their second year of training and complete most of their placements at MFT.

7.3 There are currently **277** domestic Nurses and Midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. Many of these applicants are students nurse and midwives who will graduate in the next 8 months.

International Recruitment

7.4 The Trusts International Recruitment Programme (IR) continues to provide an additional supply of Band 5 nurses to the workforce. Following the government's decision to lift travel restrictions in September 2020 **240** international nurses have arrived in the Trust. There is an additional **180** nurses due to arrive by the end of March 2021.

7.5 On arrival into the UK, the nurses are required to isolate for 10 days. They are provided with accommodation and pastoral support is provided during the 10-day quarantine period.

7.6 International Nurses who have arrive during the pandemic have been invited to join the NMC Temporary register and practice as registered nurses whilst waiting to complete their OSCE exam. The trust has supported **240** nurses to join the temporary register. These nurses have been deployed across the wards and to support the vaccination clinics and critical care areas following training.

7.7 The Trust will continue with an annual programme of overseas recruitment to supplement the domestic recruitment programme recruiting **360** nurses each year to address nursing turnover and workforce transformation plans. Recruitment will focus on hard to fill areas such as theatres, specialist medical services, care of the elderly and critical care.

8. Nursing Associates

8.1 There has been **175** Nursing Associates (NARs) who have completed their training at the Trust since the programme was first launched in 2017 of which **164** are still employed by the Trust working across general ward, community and theatre areas. The turnover rate in this staff group is low **(0.5%**). The hospitals are continuing to review ward/team establishments and skill mix as the NAR workforce continues to grow with a plan to introduce the role and a competency training framework into some of the more specialised areas.

8.2 There are **194** Trainee Nursing Associates (TNAs) in placements across the Trust of which **44** are due to qualify in April 2021. A further 35 TNAs have recently been recruited and will commence their training in March 2021. The Trust will continue to train TNAs through an apprenticeship model working in partnership with both the University of Salford and the University of Bolton. The Trust have introduced a guaranteed job offer for TNAs in their second year of training to secure a position following graduation.

8.3 In September 2021 the Trust started working with Manchester Metropolitan University and the University of Bolton to offer placements for 52 TNA on a self-funded foundation degree programme.

8.4 There are 5 Nursing Associates who have commenced a shortened pre-registration student nurse training. The NARs will graduate in 12 months-time and intend to return to the Trust as registered nurses.

9. Nursing Assistants/Midwifery Support Workers (NA/MSW)

9.1 It is recognised that NAs and MSWs play a vital role and are key to the delivery of care in clinical areas and have played a pivotal role in supporting the nursing and midwifery workforce throughout the pandemic. As registered nurses have been deployed into critical care areas to support the surge of critically ill patients, registered staffing ratios reduced due to staff sickness absence and the requirement to support patients in the absence of family and cares visiting the unregistered workforce has been required to take on new support roles. It has been recognised that the clinical skills they perform and the additional roles they champion are fundamental to the safe delivery of care and as such a skill mix review has been commissioned by the Directors of Nursing to consider the clinical skill requirements for wards and departments.

10. Safe Staffing

10.1 The recommendations set out in the Developing Workforce Safeguards Report (NHSI 2018) focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance supports a triangulated approach to staffing decisions, combining evidence-based tools such as the Safer Nursing Care Tool (SNCT) and Birth-rate Plus, professional judgement and outcomes that are based on patient needs, acuity, dependency and risks.

10.2 The pandemic has required the hospitals/MCSs to manage and deploy their workforce differently in response to the ever changing flexing bed capacity, patient acuity and dependency and to ensure the safeguarding of staff; keeping them safe and preventing the spread of infection, applying and removing PPE and adhering to additional infection prevention and control practices.

10.3 Daily staffing levels continue to be assessed across each shift to ensure they are adequate to meet patient acuity and dependency needs on each ward and department. The Allocate SafeCare tool is used to inform the daily ward/department staffing levels and the acuity and dependency of patients. This has supported senior nurses in making informed safe staffing decisions regarding the redeployment of staff across wards/departments, taking into consideration patient demand and staff availability. A rag rated 'situation on the ward' spreadsheet has been developed to align with SafeCare, allowing senior nurses to quickly identify staffing hotspots, assess risk and document actions to address any potential staffing issues. During the pandemic there has been a requirement to deploy staff to critical care areas at times resulting in a more dilute skill mix. Any changes to skill mix is risk assessed daily by a senior nurse to review the actions being taken to mitigate risk to patients safety.

10.4 A Safer Staffing Guidance Policy has been developed to provide clarity on the management of nurse staffing levels across wards and departments during a pandemic. The guidance outlines the process for monitoring safe staffing levels; assessing and recording shortfalls, risks and actions required; and reporting daily staffing escalation trigger levels to the Group Tactical Command. The guidance policy includes the actions and escalation to be enacted in the event of extremely high-risk staffing shortfalls following a surge or super surge of Covid infected patients.

10.5 The monthly NHSE/I Safe Staffing report which details the planned and actual staffing levels and care hours per patient day (CHPPD) was suspended in March 2020. The planned daily staffing levels have changed as services have altered to adapt to the patient needs during the pandemic. Therefore, the data available is not considered accurate with the risk of providing false assurances internally and externally and potentially leading to misguided decision making if used. Reporting is expected to recommence later this year.

11. Nursing and Midwifery Establishment Reviews

Safer Nursing Care Tool (SNCT)

11.1 The SNCT is an evidence-based tool used to calculate the recommended staffing establishments across inpatient wards by collecting patient acuity and dependency data on each ward over a 3-week period. A data census collection was undertaken in October 2020 to provide a baseline for recommended staffing, following the reconfiguration of wards/departments. Unfortunately, due to the continued ward changes throughout the census period, the data was not valid or reliable to support workforce establishment reviews. Future census collection periods will be re-scheduled in 2021 when the ward/departments are well established as part of the pandemic recovery plans.

Safe Staffing in Maternity Services – Birth Rate Plus

11.2 In 2018 the NQB published an evidence-based improvement resource to support safe staffing of maternity services. The guidance endorses Birth-Rate Plus (BR+) Midwifery Workforce Planning Tool which is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women with a higher clinical need. A BR+ study assesses the midwifery workforce based upon the needs of women and records data for a minimum of 3 months on all aspects of care provided by midwives from pregnancy through to postnatal care.

11.3 In December 2020, the Department of Health published the findings from Donna Ockenden's first report: *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals*[10]*.* The report sets out a set of immediate and essential actions including aligning workforce plans to the needs of local communities. Trust Boards are required to confirm that they have a plan in place to implement the Birthrate Plus standard and undertake a full review of midwifery staffing using the BR+ tool.

11.4 Saint Mary's Hospital MCS has worked alongside the Greater Manchester and East Cheshire Maternity Services to support funding to undertake a full review of midwifery staffing using the BR+ tool on both maternity sites. The data has been collected and submitted to the BR+ team and the analysis was delayed due to the Covid-19 pandemic. The results are expected to be shared in March 2021. A BR+ assessment will now be commissioned to review the midwifery establishment across North Manchester General Hospital. This information will be provided to inform the Trusts position against the Ockenden Review.

12. Hospitals and Managed Clinical Services Workforce

12.1 The Hospitals/MCS Directors of Nursing are required to present a quarterly nursing and midwifery workforce report to their hospital Boards. A summary from these reports follows, together with an updated workforce position.

13. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

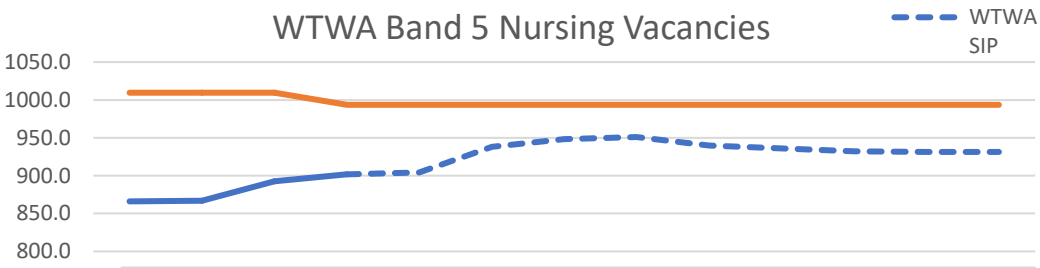
Workforce Position

13.1 At the end of December 2020, there was a total of **130.6 (7.1%)** qualified nursing vacancies across WTWA compared to **154.1wte (8.2%)** at the same period in the previous year (December 2019). This is a reduction of **23.5wte** nursing vacancies. The Hospitals vacancy position is expected to improve in Q1-2 when the number of vacancies is predicted to be **101wte (5.5%)** by September 2021.

[10] DH 2020 Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals

13.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce. At the end of December 2020 there were **91.8wte (9.2%)** band 5 vacancies compared to **117.4wte (11.6%)** in December 2019. This is a reduction of **25.6wte** band 5 vacancies during the last 12-month period. **Graph 3** illustrates the WTWA band 5 vacancy position until the end of Q2 (2020/21). The workforce modelling predicts the vacancy position will continue to improve in Q1&2 with the number of band 5 vacancies predicted to be **62.2wte (6.5%)** by September 2021.

Graph 3



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
WTWA SIP	866.1	866.9	892.6	901.8	904.1	938.2	948.4	951.0	939.7	935.8	932.0	931.5	931.4
WTWA Est	1009.6	1009.6	1009.6	993.6	993.6	993.6	993.6	993.6	993.6	993.6	993.6	993.6	993.6
WTWA Vac	143.5	142.7	117.0	91.8	89.5	55.4	45.2	42.6	53.9	57.8	61.6	62.1	62.2

13.3 There are **61** Band 5 Staff Nurses currently in the domestic recruitment pipeline for WTWA, **21** with confirmed start dates by February 2021. There are an additional **51** International Recruitment (IR) nurses planned to arrive before the end of March 2021.

13.4 The rolling 12-month turnover for nursing has improved over the previous 12 months reducing to **12.2%** from **13.3%.** The turnover for band 5 Staff Nurses is currently **13.3%** which is a significant reduction when compared to the same time last year when it was **17.2%.**

13.5 Sickness absence (including Covid related absence) within the registered nursing and staff group at WTWA was **10.8**% for registered nurses and **17.9%** for unregistered staff in December 2020.

13.6 Staff wellbeing and development has had renewed focus in 2020, particularly during the pandemic. A Health and Wellbeing Matron role has been introduced to work closely with the Nursing leadership team, Human Resources and Employee Health and Wellbeing in the development of a framework to support colleagues during the third peak of the pandemic. Team Time Schwartz Rounds are now established at WTWA, with colleagues currently undergoing the training for the Mental Health First Aider model.

WTWA Safe Staffing

13.7 The WTWA Nursing workforce continues to work flexibly to meet the changing demands arising from the Covid-19 pandemic. This has included supporting CSS with **54wte** redeployed to work in Critical Care and working with the Patient Experience Team with the allocation of volunteers to support patient dining. The hospital is also providing staff to support the Wythenshawe and Trafford vaccination clinics.

13.8 There has been significant reconfiguration of ward areas to support the response to the pandemic. A Senior Nurse Safe Staffing meeting is carried out twice a day to assess staffing levels and deploy staff as needed.

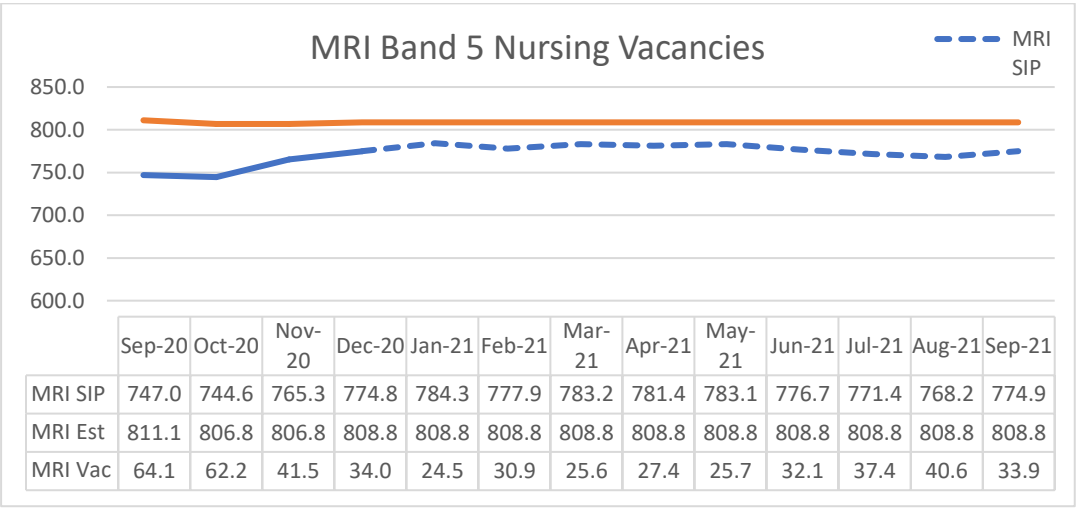
14. Manchester Royal Infirmary (MRI)

MRI Workforce Position

14.1 At the end of December 2020, there were a total of **64.6wte (4.3%)** qualified nursing vacancies across MRI compared to **148.9wte (9.9%)** at the same period in the previous year. This is a reduction of **84.3wte** nursing vacancies**.** The hospital vacancy position is expected to improve with **39wte (2.6%)** predicted by September 2021**.**

14.2 The number of staff nurse vacancies has also reduced. At the end of December there were **34wte (4.2%)** vacant staff nurse posts compared to **85.5wte (10.7%)** in December 2019. The band 5 vacancy position is expected to reduce further with the number of band 5 vacancies reducing to **33.9wte (4.2%)** by September 2021 **(graph 4).**

Graph 4



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
MRI SIP	747.0	744.6	765.3	774.8	784.3	777.9	783.2	781.4	783.1	776.7	771.4	768.2	774.9
MRI Est	811.1	806.8	806.8	808.8	808.8	808.8	808.8	808.8	808.8	808.8	808.8	808.8	808.8
MRI Vac	64.1	62.2	41.5	34.0	24.5	30.9	25.6	27.4	25.7	32.1	37.4	40.6	33.9

14.3 There are **46 Band 5** staff nurses currently in the domestic recruitment pipeline to commence in post over the next 3-6 months. The hospital will continue to supplement their domestic recruitment plans with IR recruitment, with **50** nurses arriving before the end of March 2021.

14.4 The rolling 12-month turnover for nursing is **10.3%** within MRI which is an improvement from December 2019 when it was **12.3%.** The turnover within the band 5 staff nurse workforce is **12.8%** which is an improvement from December 2019 when it was **15.9%**.

14.5 Sickness absence (including Covid related absence) within the registered nursing staff group at MRI was **12.43**% for registered nurses and **19.38%** for unregistered staff in December 2020. It is acknowledged that collaborative working between the Senior Nursing Team and Human Resource Team members will influence an improvement in nurse sickness absence by delivering some focused staff engagement sessions in areas with the highest sickness percentages in order to identify any issues and provide support and direction as needed to drive a reduction in non-attendance. The impact of Covid-19 related absence continues to be monitored and reported, alongside those staff absent from work due to shielding or self-isolation. Several workstreams have been implemented to focus on staff health and wellbeing in response to the pandemic.

MRI Safe Staffing

14.6 Ward/Department establishments have been reviewed with the DON and CSU Lead Nurses as part of the recovery plans to align the establishments to the new ward configurations, 'MRI Back to Better Plan'. The review has been undertaken in line with the MFT principles for reviewing establishments, considering that previous Safer Nursing Care (SNCT) data could not be used due to the significant change in ward configurations and therefore professional judgement has been utilised.

14.7 Daily staffing levels continue to be assessed across each shift to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. A dynamic response has been used by senior nurses during the pandemic with planned staffing levels changing on a day by day basis as the complexity and need changes. The hospital has supported the critical care escalation plans and redeployed staff to work in Critical Care and MRI vaccination clinic.

15. Royal Manchester Children's Hospital (RMCH)

RMCH Workforce Position

15.1 At the end of December 2020 there was an over establishment of registered nurses in RMCH following recruitment of a high number graduate nurses in Q3 (60wte). The hospital establishment is expected to move to a balanced position over the next 6 months.

15.2 There are **40** staff nurses currently in the domestic recruitment pipeline, with the majority due to start in September 2021 upon qualifying. RMCH continues to participate with all Group Recruitment campaigns which still includes, guaranteed job offers to Year 3 student nurses up to September 2021. A further **13** IR nurses are predicted to join RMCH before the end of March 2021.

15.3 The 12-month rolling turnover for nursing across RMCH is below the Trust target level at **8.5%.**

15.4 Sickness absence (including Covid related absence) within the registered nursing staff group at RMCH was **8.2**% for registered nurses and **16.2%** for unregistered staff in December 2020.

RMCH Safe Staffing

15.5 Current designated Covid-19 areas are Paediatric Critical Care, Ward 85 and Starlight Unit, prevalence of Covid-19 in babies, children and young people remains low. The impact of any increase in positive patients on acuity and dependency, in these areas is monitored closely to ensure enough support to manage any increase.

15.6 Paediatric Critical Care staff are providing support into Adult Critical Care during the recent pandemic surge. This support will continue if it is required and as long as Paediatric Critical Care activity is at a level that the staff can be released.

15.7 A daily staffing huddle is completed to assess the staffing levels for each clinical area, this is in line with the recently ratified Pandemic Safe Staffing Guidelines. Clinical areas are RAG rated according to their staffing levels and appropriate escalation / steps are taken to resolve staffing issues either at individual department level, at CSU level or as an overall hospital response.

Child and Adolescent Mental Health Service

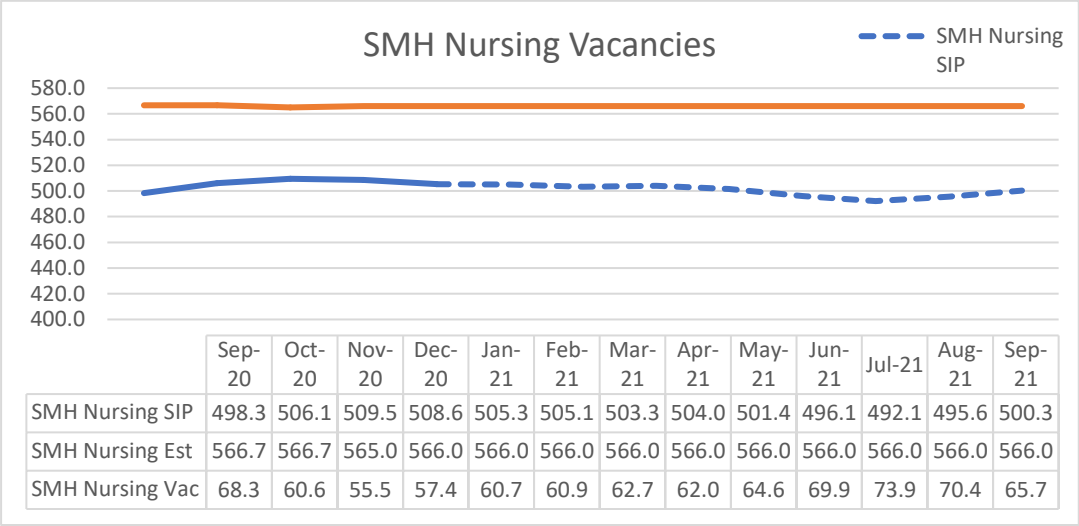
15.8 The numbers of young people being admitted with acute mental health illness into acute wards, either waiting for a Tier 4 bed, or with clinical/behavioural conditions not appropriate for a Tier 4 bed has increased in 2020. The pathway into RMCH/MCS for young people with acute mental health illness, had been reviewed with a plan for some young people to be transferred to Starlight Unit, however the same increase in numbers has been seen on both sites resulting in an average of 8 young people on inpatient wards across the two sites. Recruitment for a response team to support wards in the care planning and therapy of patients with mental health conditions is now underway to ensure staff are supported with the right skills to deliver care confidently to achieve the best outcome for this group of patients.

16. St Mary's Hospital MCS

SMH Nursing Workforce Position

16.1 At the end of December 2020 there was an overall nursing vacancy position of **57.4wte (10.1%)** of which **27.8wte** were within the band 5 nursing group. Most nursing vacancies are within Newborn Services with the remaining in gynaecology. **Graph 6** indicates that the vacancy position is expected to remain static in Q1-2.

Graph 6



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
SMH Nursing SIP	498.3	506.1	509.5	508.6	505.3	505.1	503.3	504.0	501.4	496.1	492.1	495.6	500.3
SMH Nursing Est	566.7	566.7	565.0	566.0	566.0	566.0	566.0	566.0	566.0	566.0	566.0	566.0	566.0
SMH Nursing Vac	68.3	60.6	55.5	57.4	60.7	60.9	62.7	62.0	64.6	69.9	73.9	70.4	65.7

16.2 There are 18 Band 5 Staff Nurses currently in the domestic pipeline appointed to work within Newborn Services and gynaecology before the end of September 2021. SMH will continue to recruit International Nurses focusing on a specific recruitment campaign to attract experienced international nurses for Newborn Services.

Newborn Services – Safe Staffing

16.3 In recognition of the national shortage of neonatal nurses the Newborn Services Division continues to review alternative roles and strategies to support the nursing cohort. All new band 5 starters to Newborn Services are supported to rotate between the level 3 and level 2 sites during the induction period. Moving forward the recruitment strategy is to have a responsive neonatal workforce that can work across the MCS depending on where the shortages in staffing lie. The service has seen this in action during the pandemic, where mutual aid across sites has supported the delivery of quality care. In order to support this staff will be recruited to the MCS as a rotation across MCS rather than to a base site.

16.4 Joint working has begun with Newborn Services at NMGH to look at an effective staffing model. Current national work is in progress to establish a national tariff for neonatal care around the neonatal critical care review. This will increase the nursing establishment across the MCS of which NMGH neonatal unit will be part of. These initiatives would see a significant increase in staffing at NMGH.

SMH Gynaecology

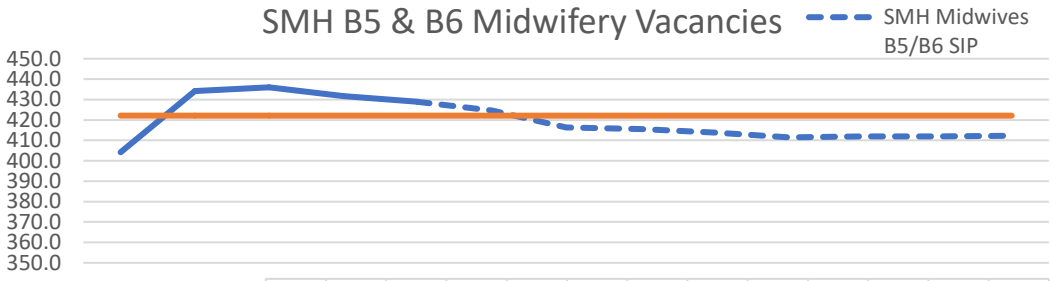
16.5 Due to the impact of the pandemic there was a requirement for the Gynaecology Division to implement a single service model for Gynaecology services across MFT, with the outcome being that the ORC would provide elective surgery and Wythenshawe hospital the non-elective which enabled the Division to facilitate green, yellow and blue areas. Staffing levels in these areas are reviewed daily at a senior nurse staffing huddle.

16.6 During the pandemic nursing staff have been redeployed to support critcal care areas, North West Nightingale Hospital and the staff vaccination programme.

SMH Midwifery Workforce Position

16.7 At the end of December 2020, there was an over establishment of bands 5 and 6 registered midwives in SMH. The vacancy position is expected to increase slightly by September 2021 due to turnover before newly qualified midwives commence in post (graph 7).

Graph 7



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
SMH Midwives B5/B6 SIP	404.2	434.1	436.0	431.7	428.9	424.7	416.3	415.6	413.9	411.5	411.9	412.0	412.2
SMH Midwives B5/B6 Est	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1	422.1
SMH Midwives B5/B6 Vac	18.0	-12.0	-13.9	-9.6	-6.8	-2.6	5.8	6.5	8.2	10.6	10.2	10.1	9.9

16.8 The Registered Nursing and Midwifery rolling 12-month turnover at SMH MCS has improved for both nursing and midwifery staff groups. The rolling 12-month turnover is **11.5% (**reduced from **13%)** for nursing and **11%** (reduced from **14.1%)** for the midwifery workforce.

16.9 Sickness absence (including Covid related absence) within the registered nursing and midwifery staff groups at SMH MCS was **9.1**% for registered nurses and **13.2%** for unregistered staff in December 2020.

17. Clinical Support Services MCS (CSS)

CSS MCS Workforce Position

17.1 At the end of December 2020 there were a total of **43.5wte (5.2%)** nursing vacancies across CSS MCS with most vacancies being within the band 5 staff nurse workforce. Following the recent expansion plan to increase the number of critical care beds across the Trust the nursing establishment has increased which impacts on vacancies.

17.2 Although the usual recruitment plans were affected due to Covid-19, CSS have continued to make progress with regards to recruitment mainly with the acceleration of International Recruitment and the guaranteed job offer to students nurses allocated to paid placements in Critical Care to support the Covid-19 pandemic. Consequently, significant impact has been made on the registered nurse vacancies that were identified as being necessary arising from the Greater Manchester modelling of Critical Care services that took place in May 2020. This identified a best-case scenario requirement of 37 adult critical care beds and worst-case scenario of 67 beds and a corresponding need to increase the registered nurse workforce by between 197.6wte and 359.1wte.

17.3 Within CSS the rolling 12-month turnover for all qualified nurses in December 2020 was **11.8%.** This is a decrease when compared to December 2019 when it was **15%.** The 12-month rolling turnover for band 5 staff for the same period is **14.4%** which is a reduction from **18.2%** in the previous year.

17.4 Sickness absence (including Covid related absence) within the registered nursing staff group at SMH MCS was **9.3**% for registered nurses and **12.5%** for unregistered staff in December 2020.

17.5 Work is ongoing to continue to address staff well-being which is a priority and especially during the pandemic. Initiatives such as Time To Listen, Take A Break, End of Shift Debriefs and ensuring staff have regular breaks from their PPE and are given opportunity to be a 'clean runner'. Introduction of weekly 'Reflective Round' led by both nursing and consultant medical staff to provide staff with an opportunity to share how they feel, to reflect on challenging situations, focus on the emotional impact.

CSS Workforce Transformation

17.6 During the first wave of the Covid-19 pandemic the provision of Adult Critical Care Services was tested in unprecedented circumstances and conditions. Between March and May 2020, the services were mobilised to concentrate efforts on the response to the pandemic. This included the provision of additional critical care bed capacity to support the predicted surge of critically ill Covid-19 patients anticipated by the NHS. There was a need to increase the nurse staffing and deploy and train noncritical care trained staff from other areas of the Trust. The release of the staff was facilitated due to the stepping down of activity in line with national incident and pandemic plans.

17.7 Over a period of 4 weeks a structured 2-day training and education programme was delivered to non-critical care trained staff and nurses with recent or previous critical care experience working in wards and departments and theatre areas across the Trust. The staff were then deployed to support the increased critical care capacity in line with national NHSEI & Covid 19 emergency clinical workforce staffing models adapted to integrate new staff into critical care teams safely and effectively. In total at the height of the pandemic there were **460wte** nursing staff and ODPs supporting the provision of Critical Care capacity. Across the sites over 50 additional critical care beds were provided including the expansion of ECMO provision from 3 to 14 beds.

17.8 Following the first wave of Covid-19 the MCS embarked on a recovery programme. Services are being redeveloped as part of the overall Trust reconfiguration of services in terms of estate and processes and pathways to support new ways of working with Covid-19 including Greater Manchester modelling to support critical care service provision, all of which have implications for the CSS nursing workforce.

CSS Safe Staffing

17.9 Professional standards have and continue to be the main reference throughout the pandemic in terms of CSS nursing workforce are Guidelines for the Provision of Intensive Care Services (GPICS 2019) and include the ratios of nurses to patients per shift, coordinators and support nurses per shift, numbers of clinical education nurses and use of agency staff. The units are compliant with all GPICS nurse staffing standards.

17.10 The provision of nurse staffing in Interventional Radiology Services in relation to national guidelines (RADU 2017) is entirely compliant on the Oxford Road Campus. This is now being addressed at Wythenshawe Hospital where a consultation has been concluded to replace a voluntary out of hours arrangement by a formal out of hours arrangement once the staff who have been recruited have completed the appropriate competency training (aiming for Feb 2021).

18. Manchester Royal Eye Hospital (MREH)

MREH Workforce Position

18.1 At the end of December 2020, there were a total of **9wte (5%)** qualified nursing vacancies across MREH. Vacancies are low with most established posts recruited into and awaiting start dates. Due to the low number of vacancies the hospital continues to recruit to turnover to maintain a static workforce position. The 12-month rolling turnover rate has reduced to **12.9%** for qualified staff (from **14.9%**).

18.2 Sickness absence (including Covid related absence) within the registered nursing staff group at MREH was **13.1**% and **22.2%** for unregistered staff in December 2020. Sickness absence continues to be a focus to support staff returning to work, and some staff have recently returned from long term sickness absence. All staff risk assessments have been completed and where a blended approach of home working has been possible, this has been facilitated.

18.3 New ways of working within a Covid-19 safe environment has increased the number of support staff required to provide patient support at the entrance of MREH, oversight of new waiting spaces within MREH and new cleaning regimes, plus additional staff have been required to operate Covid-19 swabbing clinics. Most areas have extended their working day and have a degree of weekend working to support patient waiting lists.

18.4 The hospital has recruited several new registered nurses and nurse associates over the last 12 months through both domestic and international recruitment campaigns. A in-house Ophthalmology course and theatre programme has been develop to support training of specialist skills within the newly recruited workforce.

MREH Safe staffing

18.5 Safe Staffing levels have been maintained throughout the pandemic, even with high numbers of staff deployed to other areas within MFT and NW Nightingale. Staffing across all MREH open areas have been reviewed daily by the Matrons and staff have been deployed internally across MREH sites where required to maintain safe staffing levels.

19. University Dental Hospital (UDHM)

UDHM Workforce Position (Dental Nurses)

19.1 At the end of December 2020, there were **2wte** qualified dental nursing vacancies which have been appointed to across the UDHM with the establishment currently at **83.37wte**. The UDHM does not experience any issues in recruiting dental nurses at all bands, therefore the Hospital will continue to recruit to turnover.

19.2 The Dental Nursing team is continuing to experience staffing pressures as a result of high levels of sickness absence and maternity leave. The UDHM sickness absence rate is currently **8.9%,** in addition to maternity leave which is currently at **14.9%** within the hospital. There are also **4wte** Dental Nurses currently redeployed to the NW Nightingale Hospital supporting the second wave of the pandemic.

UDHM Safe Staffing

19.3 The UDHM is looking at new ways of working post Covid-19 to fully utilize the skills of the workforce, including those staff that cannot be patient facing. Although the clinical activity within the hospital is significantly reduced in comparison to the pre-Covid activity plans, the pressures faced by the nursing workforce are significant. This is due to the way in which dentistry is supported by 1:1 nursing per clinical session in all specialties, even though we are seeing significantly less patients on each session.

19.4 Nursing assistants are providing support to the dental nursing teams, assisting the donning and doffing process for Aerosol Generating Procedures (AGPs) and acting as runners during clinics to enable the smooth running and flow of the clinics. The UDHM has also introduced the role of a housekeeper to one of the clinics as a trial. This will support the nursing team with the additional clean down requirements of the department due to the high volumes of AGPs being performed within Dentistry.

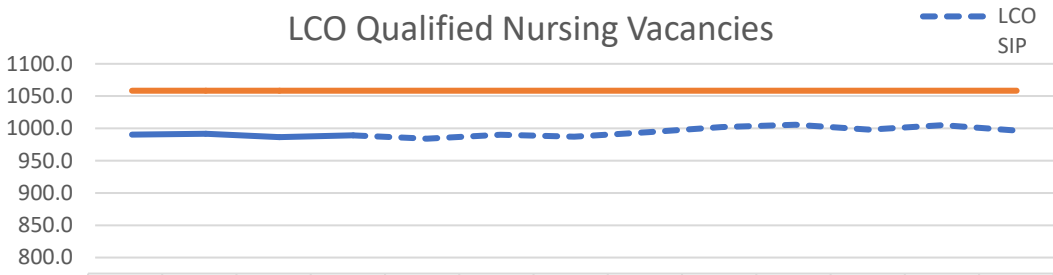
19.5 The hospital have recently recruited 7 student dental nurse apprentices who will undertake a 18 month apprenticeship rotational training course delivered by the School of Dental care Professionals (DCP's) based within the UDHM. This will provide additional support to the Nursing team within the UDHM.

20. Manchester Local Care Organisation/Trafford Local Care Organisation (M&TLCO)

M&TLCO Workforce Position

20.1 At the end of December 2020 there was a total of **69wte (6.5%)** qualified nurse vacancies across the M&TLCO compared to **91.7wte (8.5%)** at the same period the previous year (**Graph 8)**.

Graph 8



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
LCO SIP	990.4	991.7	986.5	989.3	984.1	990.0	987.0	994.2	1002.1	1005.6	997.8	1004.9	996.5
LCO Est	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3	1058.3
LCOVac	68.0	66.6	71.9	69.0	74.2	68.3	71.4	64.1	56.2	52.7	60.5	53.4	61.8

20.2 There are 2**4** Band 5 Staff Nurses currently in the domestic and international recruitment pipeline to start in the M&TLCO before the end of April 2021. In addition, there are 4 NARs planned to start in April 2021. The international recruitment pipeline will increase in 2021 and will focus on recruiting international nurses for intermediate care facilities and community led clinics.

20.3 The rolling 12-month turnover for nursing is **10.5%** which is a reduction of 1% over the last 12-month period when it was **11.5%** in December 2019.

20.4 Sickness absence (including Covid related absence) within the registered nursing staff group at M&TLCO was **9.1**% for registered nurses and **11.9%** for unregistered staff in December 2020. Programmes of work led by the Lead Nurses and HR Business Partners are in place to ensure that there are robust processes for monitoring and managing absence. This is supported by programmes of well-being and self-care both for physical and mental health. The implementation of the Absence Manager System has supported a more robust process for managing sickness.

M&TLCO Safe Staffing

20.5 The response to the pandemic has required an unprecedented increase in the number of M&TLCO front-line staff working differently to support essential services. A M&TLCO Recovery Programme Board established to oversee the reintroduction of stopped or partially stopped services based on localities and specialist teams. Due to high levels of staff absence in some teams' service recovery has been dependant on safe staffing levels.

20.6 The M&TLCO have been required to respond to requests to support the whole system and as such have deployed staff to support a number of programmes; antigen and antibody testing, 7-day covid swabbing service, GM vaccination programme, NW Nightingale, discharge to assess, crisis response service and virtual clinic support to primary care services and residential homes. The requirement to maintain social distancing in clinics and health centres has resulted in an increase in the number of patients requiring home visits.

20.7 The M&TLCO have established a task and finish group to benchmark current establishments within the District Nursing teams across Manchester and Trafford. The group will consider total nursing establishments, skill mix, roles, responsibilities and competencies at each band as well as consider the appropriateness of the provision of city-wide rather than locality-based services to improve efficiency and patient safety.

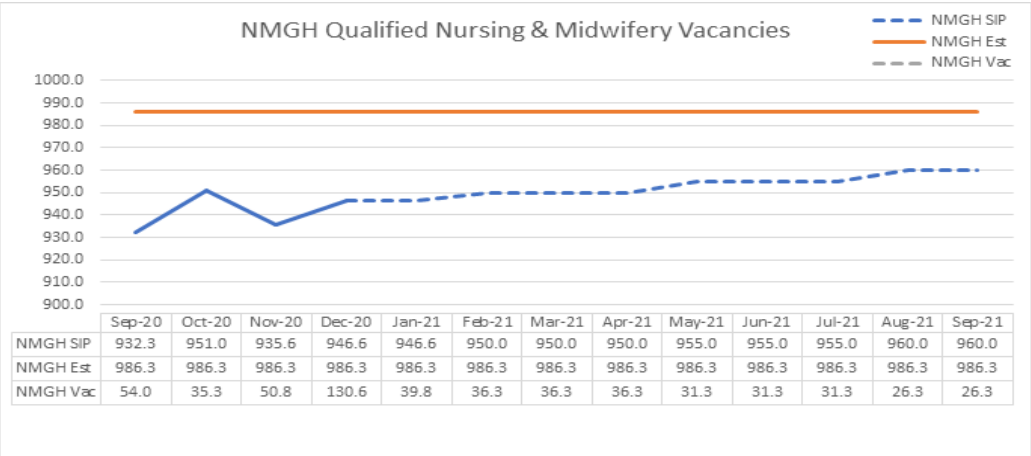
20.8 In order to ensure safe staffing levels there are several mechanisms in place across services to monitor and manage caseloads. A daily situation report has been introduced to manage caseloads and share resources where required. The situation report is based upon the scheduling element of the EMIS IT system and has proved useful when making decisions regarding temporarily relocating staff from either neighbourhoods or localities. The system has been further expanded during the pandemic to introduce action cards to support safe clinical decision making.

21. North Manchester General Hospital (NMGH)
NMGH Workforce Position

21.1 At the end of December 2020, there were a total of **39.7wte (4.1%)** qualified nursing and midwifery vacancies across North Manchester General Hospital (NMGH).

21.2 The nursing and midwifery vacancy position is much improved from the previous year. **Graph 9** indicates there will be **31.33wte** nursing and midwifery vacancies in April 2021 when the hospital transitions to MFT.

Graph 9



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
NMGH SIP	932.3	951.0	935.6	946.6	946.6	950.0	950.0	950.0	955.0	955.0	955.0	960.0	960.0
NMGH Est	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3	986.3
NMGH Vac	54.0	35.3	50.8	130.6	39.8	36.3	36.3	36.3	31.3	31.3	31.3	26.3	26.3

21.3 There are currently **22wte** qualified staff in the NMGH pipeline, undergoing pre-employment checks and expected to commence in post before the end of September 2021. The International Recruitment Programme workforce recruitment plans will include NMGH from April 2021.

21.4 NMGH turnover has followed a downwards trajectory. Over the last 6 months, this trend has continued. The turnover for November 2020 was at a reduced rate of **9.83%** in comparison the same period last year when it was **13.70%**.

21.5 Nursing and Midwifery Sickness absence levels peaked to **11.71%** during the height of the Covid-19 pandemic. In December 2020 the sickness absence rate was **8.22%.**

NMGH Safe Staffing

21.6 Prior to the Covid-19 pandemic establishments and staffing at NMGH have been determined using clinical professional judgement, with general wards aiming for Registered Nurse to patent ratio of 1:8, with a supervisory coordinator at a minimum on the early shift. Specialist services have a different nurse to patient ratio dependent on acuity/ clinical requirements. NMGH has not previously used the SNCT to inform establishment reviews.

21.7 The first SNCT census was undertaken in October 2020 to provide a baseline of data for all inpatient wards/departments. A NMGH-wide establishment review will be undertaken within each adult inpatient ward department in May 2021. The timing of the review will also align with the Covid-19 Recovery Programme, as the specialty ward requirements and infection prevention requirements will have been developed and embedded by January 2021.

NMGH Workforce Transformation

21.8 The flexibility of NMGH staff has supported service delivery from the start of the pandemic. Skill mixes introduced on wards and departments now encompass a wider range of specialist skills for each area. Professional judgement has been applied to determine appropriate staffing levels.

21.9 Allied Health Professionals (AHPs) staff have supported services by working differently and undertaking responsibilities that would traditionally have not been a routine part of their job, including supporting the proning team in critical care.

21.10 Steps are being taken to retain improved ways of working and lessons learnt over the previous 4 months. Work is underway on NMGH's redevelopment and service transformation. There are separate project groups in place to ensure staff are involved and engaged in the hospital's future workforce plans. A Clinical Lead will be appointed to support this work.

21.11 There is acknowledgement the current profile of staff requires diversity and there are plans to address this by working on the 'Removing Barriers Programme'. With the levels of changes planned for NMGH, there are plans to provide training and tools for staff on resilience and conflict resolution.

22. Allied Health Professions Workforce

22.1 There is currently no recognised national shortfall within generalist AHP therapists for adult services however there are shortfalls within the speciality posts such as adult acute Occupational Therapists (OT); Podiatrists; and paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT) due to reduced numbers attending training and the subsequent reduction in the number of universities delivering these programmes.

CSS MCS AHP Workforce Position

22.2 At the end of November 2020 there were a total of **49.4wte (7.4%)** registered AHP staff vacancies within CSS. The AHP vacancy rate is currently higher than the national vacancy comparison, however the Trust provides Paediatrics and other specialist tertiary care which prove the most challenging to recruit.

22.3 The rolling 12-month turnover rate for registered AHPs within CSS is **10.6%** and slightly less than the national AHP benchmark of **14.8%.**

22.4 The sickness absence rate in December 2020 within the AHP workforce was **5%.**

WTWA AHP Workforce Position

22.5 At the end of June 2020 there were **8wte (9%)** AHP vacancies within WTWA against an establishment of **78.4wte** and includes new posts to support a successful business case to enhance the Older Persons Assessment and Liaison (OPAL) service.

22.6 The rolling 12-month turnover for AHPs at WTWA is **7.2%** and there are no reports of difficulty recruiting to vacant positions.

22.7 Sickness absence within the registered AHP group at WTWA is **5.8%** in December 2020.

22.8 The AHPs at WTWA have continued to offer support to AHP services in CSS during the Covid-19 pandemic by redeploying staff to acute respiratory areas. There has also been support offered between services within WTWA and the M&TLCO to manage the backlog of referrals from the first wave of the pandemic.

22.9 AHPs at WTWA have been invited to join a recently formed steering group on 'Post Covid Syndrome' which is a collaboration between Greater Manchester Health & Care Partnership and Manchester Health & Care Commissioning Group.

M&TLCO AHP Workforce Position

22.10 There are **28wte (4.69%)** AHP vacancies in the M&LCO in December 2020 with the majority of vacancies in podiatry and occupational therapy. The AHP 12 month rolling turnover position is **9.6%** which is a reduction of 3% in the last 12 months.

22.11 The sickness absence rate within the M&LCO AHP workforce was **6.3%** in December 2020. This has been across a range of services and localities and is directly related to the impact of the pandemic.

MREH AHP Workforce

22.12 The Orthoptic department is fully established with no vacancies and does not experience any issues recruiting high calibre orthoptists at all bands. AHPs are required to implement job planning by 2021 and this is a current work stream of high quality and safe staffing for Orthoptists with the intention to implement early at MREH. Nationally Orthoptics is recognised as one of the four vulnerable AHP professions.

AHP Safe Staffing CSS

22.13 The AHP Division is working in collaboration with NHSE/I and the Shelford AHP Group to develop an evidence-based tool (AHPOST) to determine optimal AHP staffing requirements to deliver safe high-quality patient care in line with levels of dependency and acuity of the patient cohort.

22.14 In Oct 2020 NHSE/I in conjunction with the Shelford AHP leads decided to stand down the original AHPOST Tool development preferring to adopt a new approach which will use patient pathways to determine AHP safe staffing levels. The first pathway to be developed will be AHP staffing for Total Hip replacement. This work has been paused due to the pandemic but the Trust will be working closely with NHSE/I and Shelford AHPs to support the development of these tools

22.15 During the pandemic the AHP workforce have responded positively to a variety of situations including the redeployment of AHPs into critical care areas. Essential services have been sustained by rapidly changing practice including the implementation of virtual consultations and the use of digital platforms and Apps to support rehabilitation at home.

22.16 Workforce availability is captured every day via a strep process and reported through to the hospitals command teams to identify staffing risks and support measures. Risk assessments continue to be undertaken across all services and a range of mitigation actions have been agreed in response.

AHP Service Transformation

22.17 A Learning Needs Analysis has been undertaken to identify competency and training requirements to facilitate a workforce development plan for future resilience. This includes training and Accreditation support for AHP Advanced Clinical Practitioners (ACP) and First Contact MSK Practitioners (FCP): the introduction of a Musculoskeletal (MSK) Clinical Lead to support harmonisation and improve governance to support advanced practice Inc: Injection Therapy; non-medical prescribing and imaging request. An AHP Clinical Academic has been appointed role to support and increase the AHP research and audit agenda and support new researchers to complete successful bids and funding requests.

22.18 Digital innovation and transformation will also increase significantly across MFT this year and the AHP division is developing a robust structure to ensure AHPs are pro-actively involved in the development of the Trusts new EPR - EPIC. Increasing AHP Digital literacy is a priority and has been incorporated into every PDR from June 2020.

22.19 The opportunity to strengthen and raise the profile of AHPs in leadership will be enhanced with the delivery of a bespoke in house AHP leadership training programme across MFT. Several senior leads have recently completed the NW Workforce Health leadership programme and NHSE leadership training e.g. Mary Seacole.

22.20 The AHP Recruitment Task and Finish Group is continuing to explore opportunities for improving recruitment and retention and has introduced AHP Recruitment Ambassadors to promote AHP careers, working with local school and widening participation. AHP services are working collaboratively across hospitals/MCS to support cross site recruitment and development of rotational posts with the LCO's for posts in hard to fill specialties.

23. Summary

23.1 This paper outlines the continuing challenges in relation to nursing and midwifery and AHP staffing. Since presenting the previous bi-annual safe staffing report to the Board of Directors in September 2020 the Trust have been in escalation to support the national emergency pandemic response; as such the majority of previously set actions have been stood down or adapted to meet the ever-changing workforce demands.

- During this time and in summary, teams have been required to consider:
- Creation of new covid and non-covid wards/departments within their existing hospital footprint
- Large scale staff deployment across all sites and services
- Upskilling staff to support critical care areas or return to clinical front line
- Higher proportion of staff absence due to sickness, shielding and isolating
- Safe working practices for clinical and non-clinical staff and consideration for those most at risk
- Step down elective surgery and non-clinical treatments and services
- Restrictions on patient visiting requiring staff to support patients access virtual contact with family and carers
- Development of new staffing escalation and de-escalation plans

- Need for staff to work in a more agile way
- Release staff to support antibody testing, 7-day swabbing service, staff vaccination programme and NW Nightingale

23.2 The Trust has seen an improved nursing and midwifery workforce position over the last 12 months however it is acknowledged that this improvement has been achieved primarily due to the increase in international recruitment. There has been a reduction **of 2%** in the overall turnover of nursing and midwifery staff and **3.5%** in the band 5 nursing and midwifery workforce during the pandemic and therefore the number of staff leaving the Trust has reduced during this period.

23.3 Whilst the improved position supports the hospitals/MCS to achieve their workforce plans, learning from the work undertaken at the height of the pandemic response will be taken to inform the future. The emergency response and transferability of skills during this period has presented opportunities to consider how we retain staff and create new opportunities for existing staff to develop.

23.4 Across the Trust each Hospital/MCS has established a workforce recovery plan outlining plans to support remerging services and SHS transformation plans whilst ensuring the safety of patients and staff. Progress on these work streams will be reported to the Hospitals/MCS Management Boards by the Directors of Nursing, Midwifery, HCP and HR. The following work streams have been identified as the key priorities to support nursing, midwifery and AHP workforce plans:

23.5 **Support the health and well-being of staff**

- Continue to focus on initiates to support the health and mental well-being of staff as the workforce recovers from the pandemic
- Support staff who have been shielding back into the workplace when it is safe to do so

23.6 **Strategy to support safe staffing**

- Complete SNCT census (May, September) across all in patient areas and Emergency Departments (ED) and undertake establishment reviews.
- To complete BirthRate Plus assessment across all midwifery sites to inform future midwifery workforce requirements.
- To undertake local risk assessment of AHP services in the absence of a national evidence-based tool

23.7 **Recruitment**

- Continue to develop and update a responsive recruitment strategy to include both domestic and international recruitment to support growth of the nursing and midwifery workforce and focus on hard to recruit to areas.
- To provide a guaranteed job offer to all MFT trained nursing and midwifery students from the 2nd year on programme.
- Develop a platform to support virtual recruitment

23.8 **Retention**

- Develop flexible speciality rotations providing opportunities for staff to train and work across multiple specialities building on the skills gained during the pandemic.
- Establish a band 5 internal transfer scheme to support band 5 staff in transferring seamlessly when considering a sideward move to other specialities

23.9 **Developing the Unregistered Workforce**

- Undertake a skill mix review of the unregistered workforce to align service needs with band 2 and 3 nursing assistant job roles skill requirements
- Develop knowledge and skills frameworks to support vocational (apprenticeship) training and access to career opportunities.

23.10 Progress on these work streams will be monitored through the NMAHP professional Board. An update will be provided the HR Scrutiny Committee in May 2021.

24. Conclusion

The Board of Directors are asked to receive this paper and note progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Mrs Karen Connolly CEO Saint Mary's Hospital Managed Clinical Service (SMH MCS) Mrs Kathryn Murphy Director of Nursing and Midwifery SMH MCS Dr Sarah Vause Medical Director SMH MCS
Date of paper:	March 2021
Subject:	To update the Board of Directors of the response for maternity services arising out of the Ockenden Report 11th Dec 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:	Excels in quality, safety, patient experience, research, innovation and teaching To improve patient safety, clinical quality and outcomes To improve the experience of patients, carers and their families
Recommendations:	To receive a detailed update of the Assurance Framework narrative for the partial compliance of Saint Mary's Hospital Managed Clinical Service and North Manchester General Hospital against the 7 immediate and essential actions relating to maternity services and the actions required to deliver full compliance
Contact:	Name: Karen Connolly, CEO, St Mary's Hospital Tel: 0161 276 6124

1. Background and Key Actions

1.1. In January 2021 the Board of Directors received an update of the response to the seven immediate and essential actions for maternity services arising out of the Ockenden Report.

1.2. In responding to the immediate and essential actions, the maternity services have not identified any high-level patient safety risks and do not anticipate this being on the Trust risk register at a level over 15. Where there are lower level risks it is expected these will be mitigated through agreed actions and monitored as set out in section 2.3

1.3 The Trust, as requested, completed the National Assurance Assessment Tool which was reported through the Greater Manchester and East Cheshire Local Maternity Service (GM&EC LMS) to the NW Regional Office on the 15th January 2021. This provided a greater level of detail not only as to the level of compliance with all 7 IEAs of the Ockenden Report but also NICE guidance relating to maternity, compliance against the CNST safety actions and a current workforce gap analysis. The Maternity Divisions across the MCS and NMGH have developed a comprehensive action plan to deliver full compliance against each of the workstreams referenced. It is anticipated there will be a national reporting portal developed for the future submission of evidence together with assurance visits.

2 The Immediate and Essential Actions (IEAs), NICE guidance relating to maternity, compliance against the CNST safety actions and workforce: The Current position

2.1 Saint Mary's Hospital Managed Clinical Service and North Manchester General Hospital have assessed their current positions and can confirm compliance as set out in the table below. This has been **updated as of 18th February 21**.

Immediate and Essential Action	**Assured**	**Update as at 18th February 2021**
1: Enhanced Safety	Compliant: Full/Partial	
a) Perinatal Clinical Quality Surveillance Model	Partial	The Trust has seen the draft Perinatal Clinical Quality Surveillance Model (PCQM) through the LMS. In addition, the Maternity Transformation Board was asked to support the GMEC Quality Surveillance Model and Tool and support with implementation and adoption. This was agreed.
b) SI's shared with Boards/LMS/HSIB	Full	StEIS reported incidents are shared with the Maternity Safety Lead for GM&EC SCN. Additional steps will be taken to increase the detail in the SI's reports to Board of Directors to increase scrutiny, oversight and transparency.

		The Trust is participating in the LMS Special Interest Group to share learning and support the development of actions to improve care across the region. The first meeting was held in February 21. The Board Safety Champions and the NED booked with Aqua to co- design the safety programme
Link to Maternity Safety actions: Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 2: Are you submitting data to the Maternity Services Dataset to the required standard? Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Full	There is an action plan to support full compliance with Information Standard Notice MSDS v2.0 ECB1513 and 10/218 The Trust will agree a process with the LMS whereby the small number of term babies who do not meet the criteria for HSIB will be referred to the LMS for external opinion.
Nice Guidance: To provide assurance that NICE guidelines in maternity are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	Full	
Letter from Minister of State for Patient Safety Nadine Dorries MP. re Group B Streptococcus. 1st February 2021	Partial	A full report is attached as **Appendix A**
2: Listening to Women and their Families	Overall; Yes	
a) Robust service feedback mechanisms	Full	The role of the Senior Independent Advocate (SIA) is a national model with associated job description and funding. This role will be appointed to once agreed by NHSE The MVP chair role sits within the GMEC Transformation Board and will ensure that the voices of women from BAME backgrounds and those living in areas of high deprivation are heard. This role will work closely with the SIA
b) Exec/Non-Exec directors in place	Full	The Executive Director with specific responsibilities for Maternity Services is Professor

		Cheryl Lenney Chief Nurse & Non-Executive Director is Mrs Chris McLoughlin
Link to Maternity Safety actions: Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Full	Additional feedback is obtained from women through Debrief Clinics supported by the Consultant Midwife and Intrapartum Matron for women
3: Staff training and working together	Overall; Partial	
a) Consultant led ward rounds twice daily	Full	In place across all three sites
b) MDT training scheduled	Full	In place across all three sites
c) CNST funding ringfenced for maternity	Partial[1]	The resources allocated for maternity staff training are ring fenced. For NMGH there is currently a management contract in place with MFT pending the dissolution of the Pennine Acute Hospital Trust in April 21. At this point any refund monies will come to MFT and we will then be fully compliant.
Link to Maternity Safety actions: Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Full	Birthrate Plus (Midwifery staffing tool) has been completed for each of the maternity units and has been submitted to the NW Regional Midwifery Office as requested. A bi-annual staffing paper is submitted to the BoD as part of the chief Nurse Safer Staffing Report Review of the Clinician workforce has taken place in the last 12 months with an associated increase in consultant and junior obstetricians New training standards are awaited from NHSR which indicates additional training will

[1] pending disaggregation and dissolution of Pennine Acute Hospitals NHS Trust from April 1st 2021

		be required. This may alter the level of compliance and the resource required to deliver this
4: Managing complex pregnancy	Overall; Yes	
a) Named consultant lead/audit	Full	Audited in January
b) Development of Maternal Medicine Centres	Full	Saint Mary's Hospital Oxford Road is Maternal Medicine Centre for MFT and is currently working in partnership with GMEC LMS and the wider North West region to lead the development of the North West Maternal Medicine Network
Link to Maternity Safety Actions: Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Full	Saving Babies' Lives care bundle has been implemented and compliance is monitored as per Maternity Incentive Scheme CNST standards. An example of good practice the SMH Rainbow Clinic was developed to support bereaved families in subsequent pregnancies and improve outcomes. This model of care is well evaluated by families and has improved outcomes. The learning has been shared and the model has been implemented by other maternity units.
5: Risk assessment throughout pregnancy	Overall; Partial	
a) Risk assessment recorded at every contact and audited	Partial	Risk Assessment is undertaken at every visit. Regular audits commenced in January 21 National standardised risk assessment tool to be developed and implemented into local handheld records A Personalised Care and Support Plan (PCSP) document developed by GMEC LMS is provided at booking. Women are encouraged to complete their own personal care plans in partnership with their midwives and doctors. The PCSP is kept and maintained by the woman.

6: Monitoring Fetal Wellbeing	Overall; Yes	
a) Second lead identified	Full	This is fully compliant across MFT
7: Informed Consent	Overall; Partial	
a) Pathways of care clearly described, on website	Partial	Work has commenced to update the MFT website for maternity services to improve access and information for women. This will be undertaken in conjunction with the MVPs and will contain links to the LMS 'My birth My choice' website

2.2 The detailed analysis and associated data will be tabled in the following committees for the next year:

- Obstetric Divisional Quality and Safety Committees
- Saint Mary's Hospital Quality and Safety Committee
- Saint Mary's Hospital Management Board
- Group Quality and Safety Committee
- Group Board Quality and Performance Scrutiny Committee

2.3 SMH are working collaboratively with the GM&EC LMS on several actions which require system leadership and implementation such as

- Perinatal Clinical Quality Surveillance Model
- External review of incidents across the system, to optimise learning which can be shared across the system to prevent harm, for example the Safety Special Interest Group (SIG).
- Development of audit tools and process to support ongoing annual audit cycles across providers
- Standardisation of ward rounds
- Documentation of risk assessments
- Commissioning and establishment of the Maternal Medicine Network
- Building on the current work of the SCN maternity dashboard into a GMEC Quality Surveillance dashboard developed on Tableau. Each provider would have a dedicated page, covering various metrics which are updated on a regular basis. Having the data in one place which is easily accessible to all stakeholders would allow immediate identification of any patterns or issues arising and flag earlier any concerns. This could also be exported for reporting mechanisms as required for the new process of quality surveillance. Transparency is important and additionally the Maternity Voices Partnership (MVP) would be able to view this quality surveillance dashboard to gain knowledge and understanding in order to feedback to women regarding a trust's safety status.

2.4 In line with the letter received into the Group on the 11th January the Trust will await the NHSE/I Co-produced framework including the standard job description and training package for 'Advocates'; and principles for establishing a network to support Listening to Women and Families and support them to contact Advocates. This will also include mechanisms for contracting/ funding Advocates to ensure they remain independent. The delay with this is not considered a patient critical issue and mitigating plans are in place to work with the MVP and GMEC LMS until the new coproduced framework is available for implementation.

2.5 The Maternity Service teams have developed an action plan and to address those areas where there is partial compliance and to strengthen some of the areas where there is full compliance, but where it has been recognised that further improvements can be made. The ongoing reporting and monitoring will be via the committees identified in 2.2 of this report.

3 Recommendation

3.1 The Board of Directors is asked to note that the CEOs of Saint Mary's Hospital and North Manchester General Hospital have reviewed the seven Immediate and Essential Actions highlighted in the Ockenden Report and completed the Assurance Assessment Tool. This was overseen by the Executive Director, Non-Executive Director and Board Safety Champions and submitted on the 15th February 2021.

Appendix A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

MFT Compliance with RCOG Group B Streptococcal Disease, Early Onset; Green-Top Guideline No.36. Sept 2017

1. Background

1.1. Group B Streptococcus (GBS) is recognised as the most frequent cause of severe early-onset infection (less than 7 days) in neonates. GBS is a naturally occurring bacterium which can be dangerous for babies during labour and immediately after birth. Giving antibiotics to the mother during labour reduces the risk of GBS infection passing on to the baby (National Institute for Health and Care Excellence, 2012)

1.2. The Royal College of Obstetricians and Gynaecologists (RCOG) produced guidance on the treatment of mothers who are found to be carrying GBS (RCOG Group B Streptococcal Disease, Early Onset; Green-Top Guideline No.36. Sept 2017). On the 1st February 2021, the Department of Health & Social Care sought assurance from the Chief Executives of Trusts that this Green-Top Guidance is being followed with specific reference to the use of Enriched Culture Medium (ECM) for bacteriological testing if GBS carriage is indicated in pregnancy. This guidance is based on the UK Standards for Microbiology Investigations for GBS published by Public Health England.

1.3. PHE made the recommendations regarding screening processes and mediums for culture in 2016 and when the RCOG referred to culture media in their guidelines in 2017 this was discussed at the Obstetric Consultants' meeting supported by a presentation from Microbiology. There was an understanding from a SMH perspective that the process used within the MFT laboratory at this time was proficient and posed a minimum risk to pregnant women and babies.

2 Current position

2.1 Saint Mary's Hospital MCS and NMGH have a guideline in place that reflects the RCOG Guideline and this has been implemented at all sites. The following table demonstrates MFT and NMGH compliance with the RCOG Guidelines see Table 1.

Table 1

RCOG Guideline Recommendations	MFT and NMGH Guideline Compliance
All pregnant women should be provided with an appropriate information leaflet	Women booking for care at Saint Mary's Hospital Managed Clinical Service (MCS) and NMGH are provided with written information and/or sign posted to the online resources which includes GBS Information. A hard copy of the leaflet is provided to women who test positive for GBS which includes information about GBS, intrapartum antibiotic prophylaxis (IAP) and signs and symptoms of early onset infection. This leaflet is only available in English

Universal bacteriological screening is not recommended	MFT and NMGH guideline and practice reflect this recommendation
Clinicians should be aware of the clinical risk factors that place women at increased risk of having a baby with early-onset GBS (EOGBS) disease	Women that have had GBS infection in a previous pregnancy are counselled with respect to the risks in their current pregnancy and offered intrapartum antibiotic prophylaxis (IAP) or bacteriological testing at 35 to 37 weeks gestation (or 32 to 34 weeks for twins); women who are positive are offered IAP and monitoring of their baby in the immediate postnatal period
Explain to women that the likelihood of maternal GBS carriage in this pregnancy is 50%. Discuss the options of IAP, or bacteriological testing in late pregnancy and then offer of IAP if still positive	
If performed, bacteriological testing should ideally be carried out at 35–37 weeks of gestation or 3–5 weeks prior to the anticipated delivery date, e.g. 32–34 weeks of gestation for women with twins	
IAP should be offered to women with a previous baby with early- or late-onset GBS disease	
Clinicians should offer IAP to women with GBS bacteriuria identified during the current pregnancy.	Women who are identified as having GBS on low vaginal/ anorectal swab are counselled with respect to the need for IAP and monitoring of their baby in the immediate postnatal period. Both Saint Mary's Hospital and NMGH guidelines recommend antibiotic treatment for all positive urine cultures. There is a process for the follow up of all results, for informing the woman of the result and the need for antibiotic treatment. Women are informed of the need for antibiotics in labour and a GBS sticker is applied to the handheld notes with consent.
Women with GBS urinary tract infection (growth of greater than 105cfu/ml) during pregnancy should receive appropriate treatment at the time of diagnosis as well as IAP	
Where GBS carriage is detected incidentally or by intentional testing, women should be offered IAP	
Antenatal treatment is not recommended for GBS cultured from a vaginal or rectal swab	Both Saint Mary's Hospital and NMGH guidelines recommend that women should be informed that no antenatal antibiotic treatment is required if asymptomatic. Since 20-40% of antenatal women are carrying GBS at any time isolation is usually incidental – treatment does not alter the chances of being a carrier at the time of delivery
Antibiotic prophylaxis specific for GBS is not required for women undergoing planned caesarean section in the absence of labour and with intact membranes	Both Saint Mary's Hospital and NMGH guidelines recommend that antibiotics are not required prior to elective LSCS for women with intact membranes. Both Saint Mary's Hospital and NMGH guideline recommend commencing antibiotics as soon as possible after the onset of labour
Women who are known GBS carriers should be offered immediate IAP and induction of labour as soon as reasonably possible	The MFT and NMGH guideline for Pre-labour Spontaneous Rupture of Membranes >37 weeks recommend immediate IV antibiotics and augmentation of labour as soon as workload permits
In women where the carrier status is negative or unknown, offer induction of labour immediately or expectant management up to 24 hours. Beyond 24 hours, induction of labour is appropriate	Both Saint Mary's Hospital and NMGH guidelines recommend for low all low risk women a provisional time and date for IOL, at or before 24 hours post SROM. There is an escalation process to a senior midwife where care at the onset of labour cannot be given in a timely manner to identify additional resources and prevent delays. There is a review process whereby the delivery unit coordinator reviews all admissions

	within 30 minutes to ensure appropriate care and support is in place
Women who are pyrexial (38°C or greater) in labour should be offered a broad-spectrum antibiotic regimen which should cover GBS in line with local microbiology sensitivities	Both Saint Mary's Hospital and NMGH guidelines recommend that any women displaying signs of sepsis requiring broad-spectrum intrapartum antibiotic prophylaxis (includes reasonable GBS cover).
IAP is recommended for women in confirmed preterm labour	Both Saint Mary's Hospital and NMGH guidelines recommend IAP is indicated for all women in confirmed preterm labour regardless of GBS carriage
For those with evidence of colonisation in the current pregnancy or in previous pregnancies, the perinatal risks associated with preterm delivery at less than 34+0weeks of gestation are likely to outweigh the risk of perinatal infection. For those at more than 34+0weeks of gestation it may be beneficial to expedite delivery if a woman is a known GBS carrier	Both Saint Mary's Hospital and NMGH guidelines acknowledge the perinatal risks associated with preterm birth and perinatal infection in line with RCOG guidance
Enriched culture medium tests are recommended. The clinician should indicate that the swab is being taken for GBS	MFT do not use enriched culture medium. NMGH do use enriched culture medium
Women with known GBS colonisation who decline IAP should be advised that the baby should be very closely monitored for 12 hours after birth, and discouraged from seeking very early discharge from the maternity hospital	SMH and NMGH guidelines recommend well babies whose mothers did not receive adequate IAP in labour should be evaluated at birth for clinical indicators of neonatal infection and have observations checked at 0, 1 and 2 hours, and then 2-hourly until 12 hours. A Neonatal early warning score chart is in use, which was developed in conjunction with the neonatal team and education is provided to staff on its use.
Well babies should be evaluated at birth for clinical indicators of neonatal infection and have their vital signs checked at 0, 1 and 2 hours, and then 2-hourly until 12 hours	
Babies with clinical signs of EOGBS disease should be treated with penicillin and gentamicin within an hour of the decision to treat	Both SMH and NMGH guidelines recommend babies with clinical signs of EOGBS disease should be treated with benzylpenicillin and gentamicin within an hour of the decision to treat

3. Recommendation Division of Laboratory Medicine, CSS, MFT

3.1 On 3rd February 2021, Dr Kirsty Dodgson, Clinical Lead, Consultant Clinical Scientist, Microbiology Dept, ORC, Manchester Medical Microbiology Partnership confirmed that MFT laboratory processes are not compliant with the use of the Enriched Culture medium (ECM) as recommended by the Department of Health and Social Care and the UK Standards for Microbiology Investigations for GBS.

3.2 Within MFT, Chromogenic agar is used for vaginal swabs used in the antenatal period, with the availability for a rapid GBS swab result using Cepheid PCR technology for women in labour (2-hour turnaround time).

3.3 Comparison of the performance of these tests shows that the methods used within MFT higher sensitivity than ECM, and a high specificity.

Table 2

	Sensitivity	Specificity	Comment
ECM	93.5%	100%	Labour intensive – automation not possible in MFT >48 hours turnaround time Error prone as manual process
Chromogenic Agar	98.4%	99.6%	Automated process
PCR Cepheid	98.4%	99.6%	2-hour turnaround time

Church 2017

3.4 ECM testing for GBS is in place at NMGH.

4 Clinical Pathways and Assurance

4.1 In the last three years there have been no neonatal deaths across SMH MCS where GBS was a causative factor. All perinatal deaths are reviewed in detail to provide assurance that care was appropriate.

4.2 Across Saint Mary's Hospital MCS in 2020; 7 babies were confirmed as testing positive for GBS. This equates to 0.05% of the babies born in MFT in 2020. On analysis of these 7 cases all of which were from the ORC campus and born between 24-40 weeks gestation all care was appropriate in line with RCOG and MFT GBS guidelines.

4.3 Of these 7neonatal cases only one woman was known to be GBS Positive in pregnancy and as she gave birth following a precipitate labour at 34 weeks gestation, she didn't receive antibiotics in labour.

4.4 The care of all term babies who are admitted to the neonatal unit is reviewed as part of the ATAIN program (Avoiding Term Admissions to the Neonatal Unit). Maternal GBS is a risk factor that is identified as part of the review to ensure care is in line with guidelines.

4.5 In line with guidance not all women are routinely screened for GBS in the antenatal period, therefore GBS may be detected once the baby is admitted to the neonatal unit through routine blood cultures. In such cases the neonate would be treated, and the woman advised about GBS for any future pregnancies.

4.6 An audit of the care of the neonate in the immediate postnatal period was undertaken in 2012/13. This included the care of babies where there was known GBS present in either the mother or the baby. This audit demonstrated significant assurance. A re-audit of the guideline Prevention of early onset Group B streptococcus disease in the neonate will be undertaken across Saint Mary's Hospital MCS in March 2021.

4.7 Regarding the culture medium, there have been no reported clinical incidents where a neonate has developed GBS sepsis and the mother's GBS test result was negative (false negative).

5 Research

5.1 Clinical Research Network midwives assessed whether MFT could participate in the impending NIHR funded clinical trial relating to testing for GBS (GBS3 trial). However, the Trust was unable to become a centre for the trial as the MSDS dataset was incomplete for 3 of 5 required tables at the time, and Laboratory Medicine were unable to support with ECM testing. There was also significant COVID testing pressure on the laboratory.

6 Recommendation

6.1 The Board of Directors is asked to note that Saint Mary's Hospital MCS and North Manchester General Hospital have guidelines in place that reflect the RCOG guideline and this has been implemented at all sites.

6.2 The Maternity Service teams acknowledge there is a need to identify leaflets or electronic access in languages other than English.

6.3 The evidence for the various culture media will again be reviewed by Clinical Scientific Services MCS and Saint Mary's Hospital MCS within the Obstetric Governance meeting as MFT are not currently compliant with the use of the ECM.

6.4 A re-audit of compliance with the guideline has been added to the Obstetric annual audit forward plan.

References

RCOG Group B Streptococcal Disease, Early Onset; Green-Top Guideline No.36. Sept 2017

Church DL, Baxter H, Lloyd T, Larios O, Gregson DB. Evaluation of StrepBSelect Chromogenic Medium and the Fast-Track Diagnostics Group B Streptococcus (GBS) Real-Time PCR Assay Compared to Routine Culture for Detection of GBS during Antepartum Screening. J Clin Microbiol 2017;55:2137-42.

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:	February 2021
Subject:	Reviewed MFT Constitution – February 2021 (and supporting Annexes)
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:	Failure to produce an up-to-date (reviewed) NHS Foundation Trust Constitution in accordance with Schedule 7 of the National Health Service Act 2006 (the 2006 Act) as amended by the Health and Social Care Act 2012 (the 2012 Act) would not satisfy NHSI's (Monitor) authorisation criteria.
Recommendations:	The Board of Directors is asked to approve the reviewed MFT Constitution (including all supporting Annexes) presented to, and, approved by the MFT Council of Governors on the 10th February 2021 in keeping with *Section 44* - 'Amendments of the Constitution' - Sub Sections 44.1.1 & 44.1.2 - pages 22 & 23 (MFT Constitution 2017).
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

MFT CONSTITUTION – February 2021
(including Supporting Annexes)

1. **Purpose**

This paper asks the Board of Directors to receive and approve the reviewed MFT Constitution (including all supporting Annexes) presented to, and, approved by the MFT Council of Governors on the 10th February 2021 in keeping with *Section 44* - 'Amendments of the Constitution' - Sub Sections 44.1.1 & 44.1.2 - pages 22 & 23 (MFT Constitution 2017).

2. Context

In order to meet statutory and legislative requirements, a new Constitution for the new *Manchester University NHS Foundation Trust* (MFT) was ratified by the *Interim Board of Directors* on the 5th September 2017 and approved by the former *Central Manchester University Hospitals NHS Foundation Trust* on the 11th September 2017, and, former *University Hospital of South Manchester NHS Foundation Trust* on 14th September 2017.

The Constitution (including supporting Annexes), which is based on Monitor's *NHS Foundation Trusts: Model Core Constitution*, best practice from the Constitutions of the former two NHS Foundation Trusts, and, a number of agreed proposals from a joint-Governor 'Task & Finish Group' of the former CMFT & UHSM Councils of Governors (2017), became a 'living document' with effect from 1st October 2017.

3. Review and Update

In keeping with best practice, and with support from the Trust's Independent Legal Advisers, the MFT Constitution (ref. **Appendix A**) has been reviewed and updated during January & February 2021 with the following key information noted:

- The 2017 MFT Constitution was originally developed and approved with the potential North Manchester General Hospital (NMGH) Transaction in mind; and,

- The now updated 2021 MFT Constitution incorporates NMGH alongside minor housekeeping amendments/updates (e.g. references to re-named National Bodies) in addition to the removal of *Interim Directors* and *Transitional Governors* information (which are no longer applicable).

4. Recommendations

The Board of Directors is now asked to approve the reviewed MFT Constitution (including all supporting Annexes) presented to, and, approved by the MFT Council of Governors on the 10th February 2021 in keeping with *Section 44* - 'Amendments of the Constitution' - Sub Sections 44.1.1 & 44.1.2 - pages 22 & 23 (MFT Constitution 2017).

Manchester University NHS Foundation Trust (MFT)

Constitution

- FEBRUARY 2021 -

Table of Contents

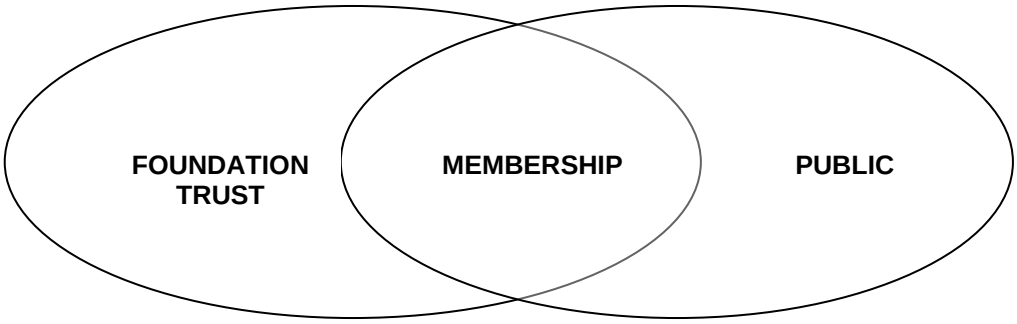
Introduction

An NHS Foundation Trust has more financial and operational freedoms than conventional NHS Trusts. However, Foundation Trusts are still firmly part of the NHS and subject to NHS standards, performance ratings and systems of inspection with their primary purpose being to provide NHS care to NHS patients according to NHS quality standards and principles i.e. free care based on need, not ability to pay.

Foundation Trusts were first introduced in April 2004 and are based upon the mutual organisation model in that those living in communities served by the Foundation Trust can become members. From these members, Governors are elected to represent members' interests in the running of the organisation. Members are therefore given a bigger say in the management and provision of services. By this method, Foundation Trusts provide greater accountability to patients, service users, local people and NHS staff with the overriding principle being that members have a sense of ownership over the services that a Foundation Trust provides. Foundation Trusts therefore have a duty to engage with their local communities and encourage local people to become members of their organisation.

Foundation Trusts are regulated by NHS Improvement and are subject to inspections by the Care Quality Commission.

The diagram below highlights the relationship between a Foundation Trust and the communities it serves: -



1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

1.3 Definitions in this Constitution:

'2006 Act'	National Health Service Act 2006
'2012 Act'	Health and Social Care Act 2012
'Accounting Officer'	is the Group Chief Executive, who from time to time discharges the functions as Accounting Officer of the Trust for the purposes of Government accounting as specified in paragraph 25(5) of Schedule 7 to the 2006 Act
'Annual Members Meeting'	is defined in paragraph 11 of the Constitution
'Appointed Governor'	is a Governor who has been appointed by stakeholder organisations to represent the interests of their organisations in the local community
'Board of Directors or **Board'**	is the Board of Directors of the Trust as constituted pursuant to this Constitution and the 2006 Act
'Consecutive Years'	are one year followed by another year unless there is a period not less than 12 months between them
'Constitution'	this Constitution that has effect in accordance with Section 56(11) of the 2006 Act and the Annexes to it
'Council of Governors'	is the Council of Governors of the Trust as constituted pursuant to this Constitution
'Directors'	are the Group Chairman, the Group Executive Directors and the Group Non-Executive Directors
'Elected Governor'	is a Governor who has been elected in accordance with this Constitution

'Governor'	is an individual who is a member of the Council of Governors
'Group Chairman' or 'Group Chair'	is the individual appointed as Group Chairman of the Board of Directors (and Chair of the Council of Governors) in accordance with paragraph 26.1 of this Constitution
'Group Chief Executive'	is the individual appointed as Group Chief Executive of the Trust in accordance with paragraph 17(3) of Schedule 7 to the 2006 Act and paragraph 28.1 of this Constitution
'Group Deputy Chair' or 'Group Deputy Chairman'	is the Group Non-Executive Director appointed as Group Deputy Chairman in accordance with paragraph 27 of this Constitution
'**Group Executive Director**'	is the Group Chief Executive or an individual appointed as a Group Executive Director of the Trust in accordance with paragraph 28.3 of this Constitution
'Group Non-Executive Director'	is an individual appointed as a Group Non-Executive Director of the Trust in accordance with paragraph 25 of this Constitution
'Licence'	means the Trust's provider licence number **130164** issued by Monitor on **1st October 2017**
'Local Authority Governor'	is a Governor appointed by a Local Authority (which for the avoidance of doubt is not to mean a Councillor of a Local Authority)
'Member'	is an individual registered as a member of one of the constituencies described at paragraph 5 and at Annex 1 and Annex 2 of this Constitution
'Monitor' or 'Trust Regulator'	is the body corporate known as Monitor, referred to in Section 61 of the 2012 Act
'NHS England/NHS Improvement'	are NHS England and NHS Improvement which operate together as a single organisation
'NHS England'	is the operational name of the NHS Commissioning Board
'NHS Improvement'	is the operational name for the organisation that brings together Monitor and the NHS Trust Development Authority

'Officer'	is an employee of the Trust or any person holding a paid appointment of office with the Trust
'Register of Members'	is a register of members which the Trust is required to have and maintain under Paragraph 20 of Schedule 7 of the 2006 Act
'Secretary'	is the individual appointed by the Group Chairman and Group Chief Executive as the Secretary
'Significant Transaction'	is defined in paragraph 45.3 of this Constitution
'Statutory Transaction'	is a merger under s56 of the 2006 Act or an acquisition under s56A of the 2006 Act or a separation under s56B of the 2006 Act or a dissolution under s57A of the 2006 Act
'Trust'	Manchester University NHS Foundation Trust

1.4 Save as otherwise permitted by law, the Group Chairman shall be the final authority for all purposes on the interpretation of this Constitution (on which he/she should be advised by the Group Chief Executive and/or Secretary).

2. Name

2.1 The name of the Trust is:

Manchester University NHS Foundation Trust (MFT)

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the Health Service in England.

3.2 The Trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a Committee of Directors or to a Group Executive Director.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency

5.1.2 the staff constituency.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust in accordance with this Constitution subject to paragraph 7, 8 and 9.

6.2 Where an individual applies to become a member of the Trust, once received and accepted by the Trust, the applicant's details will be entered into the Trust's Register of Members.

7. Public Constituency

7.1 An individual who lives in the area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The Public Constituency shall be divided into five descriptions of residents who are eligible for membership of the Public Constituency:

7.3.1 Manchester
7.3.2 Trafford
7.3.3 Rest of Greater Manchester
7.3.4 Eastern Cheshire
7.3.5 Rest of England & Wales.

7.4 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt this does not include individuals who assist or provide services to the Trust on a voluntary basis.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency:

8.4.1 Medical and Dental
8.4.2 Nursing and Midwifery
8.4.3 Other Clinical
8.4.4 Non-Clinical and Support.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default (Staff)

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency; and
9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10. Restriction on Membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 11 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8 (Further Provisions).

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 (Annual Members' Meeting).

12. Council of Governors (Composition)

12.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Elected Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13. Council of Governors (Election of Governors)

13.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules on the basis of [single transferable vote (STV) polling and the Model Election Rules shall be construed accordingly.

13.2 The Model Election Rules as published by NHS Providers form part of this Constitution. The Model Election Rules current at the date of their adoption under this Constitution are attached at Annex 4.

13.3 A subsequent variation of the Model Election Rules by NHS Providers or the Department of Health and Social Services shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution (amendment of the Constitution).

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors (Tenure)

14.1 An Elected Governor may hold office for a period of up to three years. The period of office shall be known as the term.

14.2 An Elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An Elected Governor shall be eligible for re-election at the end of his term.

14.4 An Elected Governor may not hold office for more than three terms or a maximum of nine Consecutive Years, whichever is the shorter in duration, and shall not be eligible for re-election if he has already held office for more than six Consecutive Years.

14.5 An Appointed Governor may hold office for a period of up to three years.

14.6 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him (terminates the appointment). An Appointed Governor shall be eligible for re-appointment at the end of his term.

14.7 An Appointed Governor may not hold office for more than three terms or nine Consecutive Years, whichever is the shorter in duration, and shall not be eligible for re-appointment if he has already held office for more than six Consecutive Years.

14.8 Further provisions as to the tenure for Governors, is set out at Annex 5.

15. Council of Governors (Disqualification and Removal)

15.1 The following may not become or continue as a Governor:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor and for the removal of Governors are set out in Annex 5.

16. Council of Governors (Duties of Governors)

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the Group Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

16.3 Further provisions about the duties of Governors are set out in Annex 8.

17. Council of Governors (Meetings of Governors)

17.1 The Group Chairman or, in his absence the Group Deputy Chair or, in his absence, one of the Group Non-Executive Directors, shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor of the Council of Governors will chair the meeting.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from all or part of a meeting for special reasons (in accordance with the Council of Governors Standing Orders – Annex 6).

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

17.4 Further provisions about Council of Governors' Meetings are set out in Annex 6.

18. Council of Governors (Standing Orders)

18.1 The Standing Orders for the practice and procedure of the Council of Governors are attached at Annex 6.

19. Council of Governors (Referral to the Panel)

19.1 In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

19.1.1 to act in accordance with its Constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors (Conflicts of Interest of Governors)

20.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors (Annex 6) shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors (Travel Expenses)

21.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Council of Governors (Further Provisions)

22.1 Further provisions with respect to the Council of Governors are set out in Annex 5.

23. Board of Directors (Composition)

23.1 The Trust is to have a Board of Directors, which shall comprise both Group Executive and Group Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 the Group Chairman.

23.2.2 a minimum of five other Group Non-Executive Directors; and

23.2.3 a minimum of five Group Executive Directors

23.3 One of the Group Executive Directors shall be the Group Chief Executive.

23.4 The Group Chief Executive shall be the Accounting Officer.

23.5 One of the Group Executive Directors shall be the Group Chief Finance Officer.

23.6 One of the Group Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Group Executive Directors is to be a Registered Nurse or a Registered Midwife.

23.8 The number of the Directors may be increased provided always that at least half of the Board, excluding the Group Chairman, comprises Group Non-Executive Directors.

24. Board of Directors (General Duty)

24.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors (Qualification for Appointment as a Group Non-Executive Director)

25.1 A person may be appointed as a Group Non-Executive Director only if:

25.1.1 he is a member of a Public Constituency, or

25.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

25.1.3 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors (Appointment and Removal of Group Chairman and other Group Non-Executive Directors)

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Group Chairman of the Trust and the other Group Non-Executive Directors.

26.2 Removal of the Group Chairman or another Group Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

26.3 The Council of Governors shall adopt a procedure for appointing/removing the Group Chairman and/or other Group Non-Executive Director in accordance with any guidance issued by the Trust Regulator.

26.4 Further provisions as to the appointment and removal of the Group Chairman and other Group Non-Executive Directors are set out at Annex 7.

27. Board of Directors (Appointment of Group Deputy Chair and Group Senior Independent Director)

27.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Group Non-Executive Directors as Group Deputy Chair.

27.2 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as a Group Senior Independent Director to act in accordance with Monitor's NHS Foundation Trust Code of Governance (as may be amended and replaced from time to time); and the Trust's Standing Orders.

28. Board of Directors (Appointment and Removal of the Group Chief Executive and other Group Executive Directors)

28.1 The Group Non-Executive Directors shall appoint or remove the Group Chief Executive.

28.2 The appointment of the Group Chief Executive shall require the approval of a majority of the Council of Governors.

28.3 A committee consisting of the Group Chairman, the Group Chief Executive and the other Group Non-Executive Directors shall appoint or remove the other Group Executive Directors.

29. Board of Directors (Disqualification)

29.1 The following may not become or continue as a member of the Board of Directors:

29.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

29.1.4 A person where disclosures revealed by a Disclosure and Barring Service check against such a person are such that it would be inappropriate for him to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

29.1.5 A person who is a Governor.

29.1.6 A person who is the spouse, partner, parent or child of an existing member of the Board of Directors of the Trust.

29.1.7 A person who is not a fit and proper person for the purposes of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or Condition G4 of the Trust's License.

29.1.8 A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986.

29.1.9 A person whose tenure of office as Group Chair or a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest.

29.1.10 A person who has within the preceding two years been dismissed, otherwise than by reason of redundancy or for ill health, from any paid employment with a health service body or a local authority

29.1.11 A person who is the subject of an order under the Sexual Offences Act 2003.

29.1.12 A person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list.

29.1.13 A person who is a Director or Governor or Governing Body member or equivalent of another NHS body except with the approval of the Board of Directors for Group Executive Directors or the Council of Governors for Group Non-Executive Directors.

29.1.14 In the case of Group Non-Executive Directors, a person who is no longer a member of one of the public constituencies.

29.1.15 In the case of the Group Non-Executive Directors, a person who has refused without any reasonable cause to fulfill any training requirement established by the Board of Directors.

29.1.16 A person who is a member of a Local Authority's Overview and Scrutiny Committee or Health and Wellbeing Board covering health matters.

30. Board of Directors (Meetings)

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors will send a copy of the minutes of the meeting to the Council of Governors.

30.3 Further provisions as to Board of Directors' Meetings are set out at Annex 7.

31. Board of Directors (Standing Orders)

31.1 The Standing Orders for the practice and procedure of the Board of Directors are attached at Annex 7.

31.2 The Board of Directors Standing Orders do not form part of this Constitution and any amendment of the Standing Orders shall not constitute an amendment of the terms of this Constitution for the purposes of paragraph 44 of this Constitution.

31.3 The Board of Directors Standing Orders may be amended in accordance with the procedure set out in Board of Directors Standing Order Annex 7. If there is any conflict between the Board of Directors Standing Orders and the Constitution, the Constitution shall prevail.

32. Board of Director (Conflicts of Interest of Directors)

32.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

32.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if:

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, "third party" means a person other than:

32.4.1 The Trust, or

32.4.2 A person acting on its behalf.

32.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest:

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the Directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

32.10 The Standing Orders for the Practice and Procedure of the Board of Directors (Annex 7) make further provisions for the disclosure of interests.

33. Board of Directors (Remuneration and Terms of Office)

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chairman and the other Group Non-Executive Directors.

33.2 The Trust shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chief Executive and other Group Executive Directors.

34. Registers

34.1 The Trust shall have:

34.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of Governors;

34.1.4 a register of Directors; and

34.1.5 a register of interests of the Directors.

34.1.6 The information to be included in the above registers shall be such as will comply with the requirements of the 2006 Act, and any subordinate legislation made under it and the provisions of this Constitution.

35. Admission to and Removal from the Registers

35.1 The Secretary shall be responsible for the maintenance of, admission to and removal from the registers under the provisions of this Constitution.

35.2 Each Director and Governor shall advise the Secretary as soon as practicable of anything which comes to his attention or which he is aware of which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 34.

35.3 Members will be removed from the Register of Members if:

35.3.1 the Member is no longer eligible or is disqualified; or

35.3.2 the Member dies.

36. Registers (Inspection and Copies)

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations made under the 2006 Act.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if he so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37. Documents Available for Public Inspection

37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current Constitution,

37.1.2 a copy of the current authorisation,

37.1.3 a copy of the latest Annual Accounts and of any report of the auditor on them, and

37.1.4 a copy of the latest Annual Report

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

37.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

37.2.8 a copy of any final report published under section 65I (administrator's final report).

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

37.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

37.4 If the person requesting a copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an Auditor.

38.2 A person may only be appointed Auditor if he (or in the case of a firm each of its members) is a member of one or more of the bodies referred to in Paragraph 23(4) of Schedule 7 to the 2006 Act.

38.3 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors in accordance with paragraph 23 of Schedule 7 to the 2006 Act.

38.4 The Auditor shall carry out its duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS Improvement on standards, procedures and techniques to be adopted.

39. Audit Committee

39.1 The Trust shall establish a Committee of Group Non-Executive Directors (at least one of whom that has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 NHS Improvement may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Trust's Auditor.

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement may with the approval of the Secretary of State direct.

40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.6 Further provisions as to the accounts are set out at Annex 8.

41. Annual Report, Forward Plans and Non-NHS Work

41.1 The Trust shall prepare an Annual Report and send it to the Trust Regulator.

41.2 The Trust shall give information as to its forward planning in respect of each financial year to the Trust Regulator.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

41.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about:

41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.5.1 the Council of Governors must:

41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

41.6.2 notify the Directors of the Trust of its determination.

41.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

41.8 Further provisions as to Annual Reports is outlined in Annex 8.

42. Presentation of the Annual Accounts and Reports to the Governors and Members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

42.1.1 the annual accounts

42.1.2 any report of the auditor on them

42.1.3 the annual report.

42.2 The documents shall also be presented to the Members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

43. Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44. Amendment of the Constitution

44.1 The Trust may make amendments of its Constitution only if:

44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1 At least one Governor must attend the next Annual Members' Meeting and present the amendment, and

44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.4 Amendments by the Trust of its Constitution are to be notified to NHS England/Improvement. For the avoidance of doubt, NHS England/Improvement's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and Significant Transactions

45.1 The Trust may only apply for a Statutory Transaction with the approval of more than half of the members of the Council of Governors.

45.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3 'Significant Transaction' is defined as:

45.3.1 The acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

45.3.2 The disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

45.3.3 A transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more that 25% of the value of the Trust's gross assets before the transaction.

45.4 For the purpose of this paragraph 45:

45.4.1 'Gross assets' means the total of fixed assets and current assets;

45.4.2 In assessing the value of any contingent liability for the purposes of sub-paragraph 45.3.3, the Directors:

45.4.2.1 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

45.4.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

45.4.2.3 may take account of the likelihood of the contingency occurring; and

45.4.3 A Statutory Transaction is not a Significant Transaction.

45.5 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed a threshold of 10% for any of the criteria set out in paragraph 45.3 above.

46. Indemnity

46.1 Governors and Directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the Trust.

46.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, the Council of Governors, the Board of Directors, and the Board Secretary.

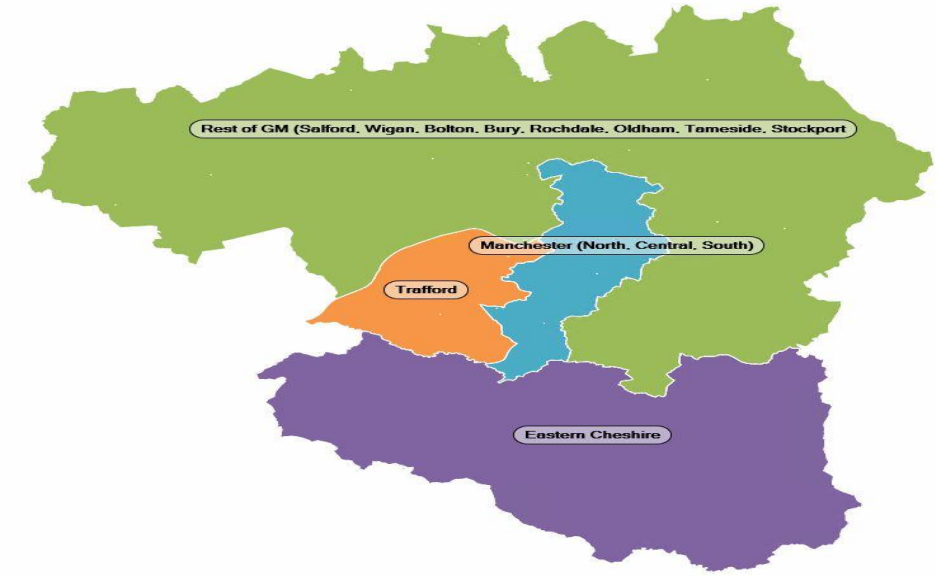
ANNEX 1

The Public Constituencies

(Paragraphs 7.1 and 7.3)

Name of Public Membership Constituency	Electoral wards within the following Local Authority boundaries	Minimum Number of Public Members
Manchester	Manchester City Council	4
Trafford	Trafford MBC	4
Eastern Cheshire	Cheshire East Council Electoral Wards as follows: Alderley Edge Bollington Broken Cross and Upton Chelford Disley Gawsworth Handforth High Legh Knutsford Macclesfield Central Macclesfield East Macclesfield Hurdsfield Macclesfield South Macclesfield Tytherington Macclesfield West and Ivy Mobberley Poynton East & Pott Shrigley Poynton West & Adlington Prestbury Sutton Wilmslow Dean Row Wilmslow East Wilmslow Lacey Green Wilmslow West & Chorley	4
Rest of Greater Manchester	Bolton MBC Bury MBC Oldham MBC Rochdale MBC Salford City Council Stockport MBC Tameside MBC Wigan MBC	4
Rest of England and Wales	All electoral areas in England and Wales not listed above	4

The map below illustrates the Public Member Constituencies for Manchester, Trafford, Eastern Cheshire and Rest of Greater Manchester areas. Areas that fall outside these Constituencies are captured in the Rest of England and Wales Constituency



ANNEX 2

The Staff Constituency

(Paragraphs 8.4 and 8.5)

Name of Staff Constituency	Minimum Number of Staff
Medical and Dental	4
Nursing and Midwifery	4
Other Clinical	4
Non-Clinical and Support	4

ANNEX 3

Composition of the Council of Governors

(Paragraphs 12.2 and 12.3)

1. The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

2. The Trust, subject to the 2006 Act, shall seek to ensure that:

   2.1 the composition of the Council of Governors reflects the composition of the membership

   2.2 the level of representation of the Public Constituencies, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs;
   and to this end, the Council of Governors:

   2.3 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the composition of the membership, the membership strategy, and shall from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

   2.4 when appropriate shall propose amendments to this Constitution.

3. The Council of Governors, subject to the 2006 Act, shall seek to ensure that the interests of the members as a whole and the public and communities served by the Trust are appropriately represented;

4. The Council of Governors of the Trust is to comprise:

Public Governors	**17**
Manchester	7
Trafford	2
Eastern Cheshire	1
Greater Manchester	5
Rest of England and Wales	2

Staff Governors	**7**
Medical and Dental	1
Nursing and Midwifery	2
Other Clinical	2
Non-Clinical and Support	2

Appointed Governors	**8**
Local Authority (Manchester City Council and Trafford Council)	2
Manchester University	1
Manchester Health Commissioning Group	1
Trust Volunteer	1
Trust Youth Forum	1
Manchester Council for Community Relations or Manchester BME Network	1
Umbrella third section organisation	1
Council of Governors Total	**32**

ANNEX 4

MODEL ELECTION RULES (2014)

(Paragraph 13.2)

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires: "*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution; "*council of governors*" means the council of governors of the corporation; "*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message; "*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b) "*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2; "*telephone voting record*" has the meaning set out in rule 26.5 (d); "*text message voting facility*" has the meaning set out in rule 26.3; "*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if

the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a Governor by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as

given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e- voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e- voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,
("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e- mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (URL) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope; ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer, ("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual, who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the URL of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X", "*non-*

transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter

ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub- paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records, and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued, the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5

Additional Provisions – Council of Governors

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless during the voting process they sign a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant area of the Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

2. A member of the Staff Constituency may not vote at an election for a Staff Governor unless during the voting process they sign a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant class of the Staff Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

3. The Appointed Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

Tenure for Elected and Appointed Governors

4. A Governor shall normally hold office for a period of three years commencing immediately after the Annual Members' Meeting or Special Members' Meeting at which his election or appointment is announced.

5. For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after the conclusion of the Annual Members' Meeting or Special Members' Meeting and ending at the conclusion of the next Annual Members' Meeting or Special Members' Meeting, but in any event shall not exceed a period of 12 calendar months.

6. A Governor may not stand again for re-election or re-appointment as a Governor until three years has elapsed since he resigned, or he completed the maximum three terms or nine Consecutive Years as a Governor.

6A A Governor may resign from office at any time during the term of office by giving notice in writing to the Trust Secretary save that if in the opinion of the Trust Secretary the Governor's conduct and tenure are or may become subject to review or investigation which may lead to his or her removal under paragraph 10 below, then any such notice of resignation will not be effective without the agreement of the Chairman or (if the Chairman is conflicted) the Deputy Chairman.

6B The Chairman or (if the Chairman is conflicted) the Deputy Chairman may suspend a Governor whose conduct and tenure are subject to review or investigation if in the opinion of the Chairman or the Deputy Chairman such review or investigation may lead to the Governor's removal under paragraph 10 below.

Appointment of Lead Governor of the Council of Governors

7. The Council of Governors shall elect one of the Governors to be Lead Governor of the Council of Governors.

7.1 Lead Governor elections will usually be held following the Annual Members' Meeting or Special Members' Meeting.

7.2 Candidates from all Governor constituencies (Public, Staff and Appointed) are eligible to stand for election as Lead Governor.

7.3 Governors must have a minimum of 12 months previous experience as a Governor in an NHS Foundation Trust in order to be eligible to stand for election as the Lead Governor for Manchester University NHS Foundation Trust.

7.4 Results of Lead Governor elections shall be announced at the next general meeting of the Council of Governors.

7.5 The Lead Governor serves a term of office of 12 months commencing immediately at the general meeting of the Council of Governors at which his election is announced.

7.6 An elected Lead Governor shall be eligible for re-election at the end of his term.

7.7 The Lead Governor shall cease to hold office if he ceases to be a member of the Council of Governors.

7.8 The Secretary shall inform NHS England/Improvement of the Lead Governor's name upon election.

7.9 Where a vacancy arises for the elected Lead Governor, the Council of Governors shall be at liberty either:

7.9.1 to call an election within three months to elect a Lead Governor for the remainder of the previous Lead Governor's term of office; or

7.9.2 to invite the next highest polling candidate at the most recent election for Lead Governor, who is willing to take office, to undertake the role of Lead Governor until the next annual election, at which time the role will fall vacant; or

7.9.3 to leave the seat vacant until the next Lead Governor elections are held and nominate a Governor to act as Acting Lead Governor until an election takes place

Further Provisions as to Eligibility to be a Governor

8. A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

8.1 they are a Director of the Foundation Trust or a Governor or Director of an NHS body (unless they are appointed by an appointing organisation which is an NHS body);

8.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

8.3 they are a member of a local authority's Scrutiny Committee covering health matters;

8.4 they have been previously removed as a Governor pursuant to paragraph 9 of this 6 or they are otherwise a person whose tenure as a governor of another foundation trust has been terminated for cause

8.5 being a member of the Public Constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

8.6 they are subject to an order under the Sexual Offences Act 2003;

8.7 they have, within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

8.8 they are a person whose tenure of office as the Chairman or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

8.9 they are a person who is not a fit and proper person as defined by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and / or condition G4 of the Trust's License.

8.10 they are a person who refuses to undertake a Disclosure & Barring Service (DBS) check and/or other fit and proper person checks including insolvency, bankruptcy and disqualified directors' registrations alongside health questionnaire/checks;

8.10.1 a Governor will be disqualified if on the basis of disclosure(s) (convictions/cautions) obtained through a DBS and or/other fit and proper person checks, he is not considered suitable by the Trust:

8.10.1.1 such a person is such that it would be inappropriate for him to become or as a Governor or

8.10.1.2 would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

8.11 they are a person who does not adhere to the Governors' Code of Conduct.

9. A person holding office as a Governor shall immediately cease to do so if:

9.1 they resign by notice in writing to the Secretary;

9.2 they fail to attend three consecutive meetings of the Council of Governors, unless the other Governors are satisfied that:

9.2.1 the absences were due to reasonable causes; and

9.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable;

9.3 they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

9.4 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the Governors' Code of Conduct;

9.5 they are removed from the Council of Governors under paragraph 10 below or any other provisions set out in this Constitution.

10. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting on the grounds that:

10.1 they have committed a serious breach of the Governors' Code of Conduct; or

10.2 they have acted in a manner detrimental to the interests of the Trust; and

10.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

Vacancies amongst Governors

11. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

12. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement or to leave the seat vacant until the next annual round of Governor appointments (nominations) are held.

13. Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

13.1 to call an election within three months to fill the seat for the remainder of the previous Governor's term of office; or

13.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office,; or

13.3 to leave the seat vacant until the next elections are held.

Further Provisions as to Meetings of Governors

14. The Council of Governors is to meet at least four times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least seven days written notice of the date and place of every meeting of the Council of Governors together with an agenda and any supporting papers to all Governors. Notice will also be published on the Trust's website.

15. Meetings of the Council of Governors may be called by the Secretary, or by the Chairman, or by ten Governors (including at least two Elected Governors and two Appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least seven but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or ten Governors, whichever is the case, shall call such a meeting.

16. Eleven Governors including not less than four Public Governors, not less than one Staff Governor and not less than one Appointed Governors shall form a quorum.

17. The Council of Governors may invite the Group Chief Executive or any other member or members of the Council of Directors, or a representative of the auditor or other advisors to attend a meeting of the Council of Governors.

18. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link and/or by viewing pre-recorded meeting information such as film-clips. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

19. Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

    19.1 In case of an equality of votes the person presiding at or chairing the meeting shall have a second and casting vote.

    19.2 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

20. The Council of Governors may not delegate any of its powers to a group, committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

21. All decisions taken in good faith at a meeting of the Council of Governors or of any group or committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

Further Provisions on the Relationship between the Council of Governors and the Board of Directors

22. The Council will agree with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

23 If the Council does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council had taken a different position.

Declaration

24. An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a Governor. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Elected Governors

ANNEX 6

Standing Orders for the Practice and Procedure of the Council of Governors

1 INTERPRETATION

In these Standing Orders:

(a) unless the context otherwise requires, the following expressions have the following meanings:

"the Board of Directors"	means the Board of Directors of the Foundation Trust from time to time;
"the Chairman"	means the Group Chairman of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, such person;
"the Constitution"	means the Constitution of the Foundation Trust as amended from time to time;
"the Council of Governors"	means the Council of Governors of the Foundation Trust from time to time;
"the Foundation Trust"	means Manchester University NHS Foundation Trust (MFT);
"Meeting"	means a duly convened meeting of the Council of Governors;
"Motion"	means a formal proposition (either with or without notice pursuant to Standing Orders 10 and 11) to be discussed and voted on during the course of a Meeting about a matter for which the Council of Governors has responsibility or which affects the services provided by the Foundation Trust;
"Question on Notice"	means a question from a Governor or Governors (notice of which has been given pursuant to Standing Order 7) about a matter for which the Council of Governors has responsibility or which affects the services provided by the Foundation Trust;
"the Secretary"	means the Secretary appointed under the Constitution;

(b) other terms defined in the Constitution shall have the same meaning in these Standing Orders.

2 THESE STANDING ORDERS

These Standing Orders for the Practice and Procedures of the Council of Governors are the standing orders referred to in paragraph 20 of the Constitution. They may be amended in accordance with the procedure set out in Standing Order 20 below. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

3 MEETINGS

Meetings of the Council of Governors shall be open to members of the public unless the presiding Chair decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds.

Meetings of the Council of Governors shall be held at regular intervals at such times and places as the Group Chairman may determine from time to time. The Secretary will publish the dates, times and locations of meetings of the Council of Governors for the year 6 months in advance. Other, or emergency, meetings of the Council of Governors may be called in accordance with the Constitution.

4 AGENDAS AND PAPERS

An agenda, copies of any Questions on Notice and/or motions on notice to be considered at the relevant Meeting and any supporting papers shall be sent to each Governor so as to arrive with each Governor normally no later than 7 days in advance of each Meeting. Minutes of the previous Meeting will be circulated with these papers for approval and this will be a specific agenda item.

5 REPORTS FROM THE GROUP EXECUTIVE DIRECTORS

At any Meeting a Governor may ask any question through the Group Chairman without notice on any report by an Group Executive Director, or other officer of the Trust, after that report has been received by or while such report is under consideration by the Council of Governors at the Meeting. Unless the Group Chairman decides otherwise no statements will be made other than those which are strictly necessary to define any question posed and in any event no statements will be allowed to last longer than 3 minutes each. A Governor who has put such a question may also put one supplementary question if the supplementary question arises directly out of the reply given to the initial question. The Group Chairman may, in its absolute discretion, reject any question from any Governor if in the opinion of the Group Chairman the question is substantially the same and relates to the same subject matter as a question which has already been put to that Meeting or a previous Meeting. At the absolute discretion of the Chairman, questions may, at any Meeting which is held in public, be asked of the group executive directors present by members of the Trust or any other members of the public present at the Meeting.

6 QUESTIONS ON NOTICE AT MEETINGS

Subject to the provisions of Standing Order 7, a Governor may ask a Question on Notice of:

(a) the Group Chairman;

(b) another Governor;

(c) a Group Executive Director of the Trust;

(d) the Chairman of any sub-group of the Council of Governors.

7 NOTICE OF QUESTIONS

Notice of a Question on Notice must be given in writing to the Secretary at least 14 days prior to the relevant Meeting. For the purposes of this Standing Order 7, receipt of any such Questions on Notice via electronic means is acceptable.

8 RESPONSE TO A QUESTION ON NOTICE

An answer to a Question on Notice may take the form of:

(a) a direct oral answer at the relevant Meeting (which may, where the desired information is in a publication of the Trust or other published work, take the form of a reference to that publication);

(b) where the reply cannot conveniently be given orally at the relevant Meeting, a written answer which will be circulated as soon as reasonably practicable to the questioner and to the other Governors or with the agenda for the next Meeting; or

(c) a brief oral answer at the relevant Meeting supplemented by a written answer circulated as soon as reasonably practicable to the questioner and to the other Governors and/or information will be provided as an agenda item for the next Meeting.

9 SUPPLEMENTARY QUESTIONS IN RESPECT OF A QUESTION ON NOTICE

Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Chairman.

10 MOTIONS ON NOTICE

(a) Notice

Subject to Standing Order 11, a motion may only be submitted by Governors and must be received by the Secretary in writing at least 14 days prior to the Meeting at which it is proposed to be considered, together with any relevant supporting papers. Except for motions which can be moved without notice under Standing Order 11, the notice of every motion must be signed or transmitted by at least two Governors. For the purposes of this Standing Order 10, receipt of any such motions via electronic means is acceptable. All motions received by the Secretary will be acknowledged by the Secretary in writing to the Governors who have signed or transmitted the same.

(b) Scope

Motions may only be about matters for which the Council of Governors has a responsibility.

11 MOTIONS WITHOUT NOTICE

The following motions may be moved at any Meeting without notice:

(a) in relation to the accuracy of the minutes of the previous Meeting;

(b) to change the order of business in the agenda for the Meeting;

(c) to refer a matter discussed at a Meeting to an appropriate body or individual;

(d) to appoint a group arising from an item on the agenda for the Meeting;

(e) to receive reports or adopt recommendations made by the Board of Directors;

(f) to withdraw a motion;

(g) to amend a motion;

(h) to proceed to the next business on the agenda;

(i) that the question be now put;

(j) to adjourn a debate;

(k) to adjourn a Meeting;

(l) to suspend a particular Standing Order contained within these Standing Orders (provided that any Standing Order may only be suspended if at least one half of the aggregate number of Governors are present at the Meeting in question and provided also that the Standing Order in question may only be suspended for the duration of the Meeting in question);

(m) to exclude the public and press from the Meeting in question (the motion shall be "To exclude the press and public from the remainder of the Meeting, owing to the confidential nature of the business to be transacted.");

(n) to not hear further from a Governor, or to exclude them from the Meeting in question (if a Governor persistently disregards the ruling of the Chairman or behaves improperly or offensively or deliberately obstructs business, the Chairman, in its absolute discretion, may move that the Governor in question be not heard further at the Meeting in question. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chairman may move that either the Governor leaves the meeting room or that the Meeting in question is adjourned for a specified period. If seconded, the motion will be voted on without discussion);

(o) to give the consent of the Council of Governors to any matter where its consent is required pursuant to the Constitution.

12 URGENT MOTIONS OR QUESTIONS

Urgent motions or questions may only be submitted by a Governor and must be received by the Secretary in writing before the commencement of the Meeting in question. The Chairman shall decide whether the motion or question in question should be tabled.

13 SPEAKING

This Standing Order applies to all forms of speech/debate by Governors or members of the Trust and the public in relation to the motion or question under discussion at a Meeting.

(a) Content and Length of Speeches

Any approval to speak must be given by the Chairman. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Chairman it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature complexity or importance, no proposal, speech, nor any reply, may exceed three minutes. In the interests of time the Chairman may, in its absolute discretion, limit the number replies questions or speeches which are heard at any one Meeting.

(b) When a person may speak again

A person who has already spoken on a matter at a Meeting may not speak again at that Meeting in respect of the same matter, except:

(i) in exercise of a right of reply;

(ii) on a point of order.

(c) Identification

All speakers must state their name and role before starting to speak to ensure the accuracy of the minutes.

14 VOTING

All questions put to the vote shall, at the discretion of the Chairman, be decided by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels. A paper ballot may be used if a majority of the Governors present so request.

15 ATTENDANCE

Governors who are unable to attend a Meeting shall notify the Secretary in writing in advance of the Meeting in question so that their apologies may be submitted.

16 QUORUM

The quorum for a Meeting will be as set out in paragraph 16 of Annex 5 to the Constitution.

17 CHAIRMAN

The arrangements for presiding at or chairing meetings of the Council of Governors are set out in the Constitution.

18 FURTHER PROVISIONS IN RESPECT OF THE COUNCIL OF GOVERNORS CONFLICTS OF INTEREST OF GOVERNORS

18.1 A material interest is:

a. any directorship of a company;
b. any interest or position in any firm, company, business, or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust;
c. any interest in an organisation providing health and social care services to the National Health Service;
d. a position of authority in a charity or voluntary organisation in the field of health and social care;
e. any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

19 DECLARATION OF INTERESTS

19.1 Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business, or organisation [including any charitable or voluntary organisation] in which the Governor or his spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:

a. shall withdraw from the meeting and play no part in the relevant discussion or decision; and

b. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

19.2 Details of any such interest shall be recorded in the register of interests of Governors.

19.3 Any Governor who fails to disclose any interest or material interests required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

20 AMENDMENTS TO STANDING ORDERS

These Standing Orders may only be amended at a Meeting. A motion to change the Standing Orders must be signed by five Governors and submitted to the Secretary in writing at least 21 days before the Meeting at which the motion is intended to be proposed.

21 DISPUTES BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

Dispute Resolution Procedure:

1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances when they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective.

2 The Council of Governors elects a Lead Governor who is the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Group Chairman on Governor matters.

3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Group Chairman (or Group Senior Independent Director or Group Deputy Chairman if the dispute involves the Group Chairman) will endeavour to resolve the dispute informally, through discussions with the Council of Governors.

4 If Governors have concerns and when approaches through normal channels (Lead Governor and/or Group Chairman and/or Group Deputy Chairman) have failed to resolve or for which such approaches are inappropriate, the Group Senior Independent Director (SID) acts as the point of contact for Governors with the Board of Directors.

5 The Group SID also acts as the point of contact for Governors with the Board of Directors during the Group Chairman's annual performance appraisal process (includes remuneration and other allowances).

The Council of Governors should only exercise its power to remove the Group Chairman, or any other Group Non-Executive Director, after exhausting all means of engagement with the Board.

ANNEX 7

Standing Orders for the Practice and Procedure of the Board of Directors

5	Arrangements for the Exercise of Functions by Delegation	
	Emergency Powers	
	Delegation to Committees	
	Delegation to Officers	
	Non-compliance with Standing Orders	
6	Committees	
7	Confidentiality	
8	Declaration of Interests and Register of Interests	
	Declaration of Interests	
	Register of Interests	
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9	Disability of Directors in Proceedings on Account of Pecuniary Interest	
10	Standards of Business Conduct Policy	
	Policy	
	Interests of Directors, Officers, all staff, Consultants, Contractors and Governors	
	Legislation Governing Public Procurement	
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	Contracts	
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	Legally Binding Contracts for the Provisions of Healthcare	
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	Determination of Contracts for Failure to Deliver Goods or Material	
11	Disposals	
12	In-House Services	
13	Custody of Seal and Sealing of Documents	
	Requirements to seal	
	Custody of seal	
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14	Signature of Documents	
15	Miscellaneous	
	Standing Orders to be given to Board Members and Officers	
	Documents having the standing of Standing Orders	
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1. Introduction

Statutory Framework

The Manchester University NHS Foundation Trust (the Trust) is a public benefit corporation which came into existence on 1st October 2017 following the grant of an application by Monitor (now NHS England/Improvement) pursuant to section 56 of the National Health Service Act 2006.

The functions of the Trust are conferred by the National Health Service Act 2006 and the Trust will exercise its functions in accordance with the terms of its provider license (no: **130164**) and all relevant legislation and guidance.

- The principal places of business of the Trust are:
- Manchester Royal Infirmary
- Manchester Royal Eye Hospital
- Royal Manchester Children's Hospital
- Saint Mary's Hospital
- Trafford General Hospital
- University Dental Hospital of Manchester
- Wythenshawe Hospital
- Altrincham Hospital
- Withington Hospital
- North Manchester General Hospital
- Manchester and Trafford Local Care Organisations

The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. Nothing in these standing orders shall override the Trust's Constitution, the National Health Service Act 2006 and the Health and Social Care Act 2012.

As a public benefit corporation, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property on behalf of patients.

2. Purpose

2.1 Delegation of Power

All the powers of the Trust are exercisable by the Board of Directors. The Constitution may provide for any of those powers to be delegated to a committee of Directors or to a Group Executive Director. Delegated powers are covered in a separate Scheme of Delegation. The Scheme of Delegation has effect as if incorporated into the Standing Orders.

2.2 Interpretation

2.2.1 Save as otherwise permitted by law, at any meeting the Group Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Group Chief Executive and/or Secretary to the Board of Directors).

2.2.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and vice-versa.

2.2.3 Any expression to which a meaning is given in the Constitution, the 2006 Act or the 2012 Act shall have the same meaning in this interpretation and in addition:

"2006 Act" the National Health Service Act 2006

"2012 Act" the Health and Social Care Act 2012

"Accounting Officer" is the Group Chief Executive, who from time to time discharges the functions as Accounting Officer of the Trust for the purposes of Government accounting as specified in paragraph 25(5) of Schedule 7 of the 2006 Act.

"Board of Directors or Board" is the Board formally constituted in accordance with the Trust's Constitution and the 2006 Act. It consists of a Group Chairman, Group Executive and Group Non-Executive Directors.

"Budget" is a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chair of the Board (or Trust)" is the person appointed by the Council of Governors to lead the Board of Directors and the Council of Governors to ensure that they successfully discharge their overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Group Deputy Chairman of the Trust if the Group Chairman is absent from the meeting or is otherwise unavailable.

''**Committee of the Board of Directors''** is a committee formed by the Board with specific Terms of Reference, Chair and membership.

"Constitution" means the Constitution of the Trust.

"Contracting and procuring" is the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Council of Governors" is the Council of Governors of the Trust formally constituted in accordance with the Trust's Constitution.

"Group Executive Director of Finance" is the Group Chief Financial Officer of the Trust who will ensure compliance with Standing Financial Instructions.

"Group Deputy Chairman" is the Group Non-Executive Director appointed by the Council of Governors to carry out the duties if the Group Chairman is absent for any reason.

"Director of the Board" is a Group Executive or Group Non-Executive Director appointed to the Board.

"Group Executive Director" means the Group Chief Executive and persons appointed in accordance with paragraph 28 of the Constitution to be a member of the Board of Directors.

“Governor” is an individual who is elected or appointed to the Council of Governors.

"Group Chief Executive" is the individual appointed as Group Chief Executive of the Trust in accordance with paragraph 17(3) of Schedule 7 to the 2006 Act and paragraph 29.1 of the Constitution.

“Licence” means the Trust’s provider licence number **130164** issued by Monitor (NHS England/Improvement) on 1st October 2017.

“Local Authority Governor” is a Governor appointed by a Local Authority (which for the avoidance of doubt is not to mean a Councilor of a Local Authority)

‘’Member’’ is a person registered as a member of one of the constituencies of the Trust as outlined in the Trust’s Constitution.

‘’Monitor’’ is the body corporate known as Monitor, referred to in Section 61 of the 2012 Act which operates now as NHS England/Improvement (as Foundation Trust Regulator).

‘’Motion’’ is a formal proposition to be discussed and voted on during the course of a meeting.

“NHS Standard Contract” the NHS standard contract mandated by NHS England/Improvement for use by commissioners for all contracts for healthcare services other than primary care.

“NHS Standard Terms and Conditions” the NHS terms and conditions for procuring goods and services published by the Department of Health.

“Nominated Officer” is an officer charged with the responsibility for discharging specific tasks within Standing Order in line with the 2006 Act.

“Group **Non-Executive Director"** is a person appointed by the Council of Governors to be a member of the Board of Directors in accordance with paragraph 26.1 of the Constitution. This includes the Group Chairman of the Trust.

"Officer" is an employee of the Trust or any person holding a paid appointment of office with the Trust.

“Regulators” means NHS England/Improvement (Monitor), the Care Quality Commission and any other public authority which regulates NHS foundation Trusts;

“Remuneration Committee” is a Committee of the Board of Directors consisting of the Group Non-Executive Directors which determines the remuneration and allowances for the Group Chief Executive and Group Executive Directors.

"Secretary" is the individual appointed by the Group Chairman and Group Chief Executive to act independently of the Board to provide independent advice to the Board and monitor the Trust's compliance with its License and Constitution.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"the Trust" is the Manchester University NHS Foundation Trust.

"Trust Hospital" is all or any hospital or other patient care facilities administered by the trust from time to time and designated by the Trust as falling within this definition.

3. BOARD OF DIRECTORS

3.1.1 All business shall be conducted in the name of the Trust.

3.1.2 All the powers of the Trust are exercisable by the Board of Directors, a committee of the Board of Directors or a Group Executive Director.

3.1.3 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Decisions and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3.1.4 The Board of Directors will function as a unitary Board. The Board is collectively responsible for discharging the powers and for the performance of the Trust. Group Executive and Non-executive Directors will have joint responsibility for every decision of the Board regardless of their individual skills or status.

3.2 Composition of the Board of Directors

3.2.1 In accordance with paragraph 23 of the Trust's Constitution the composition of the Board of Directors shall be:

3.2.1.1 a Non-Executive Director Group Chairman;

3.2.1.2 a minimum of five Group Non-Executive Directors;

3.2.1.3 a minimum of five Group Executive Directors

- One of the Group Executive Directors shall be the Group Chief Executive.
- The Group Chief Executive shall be the Accounting Officer.
- One of the Group Executive Directors shall be the Group Executive Director of Finance (Group Chief Finance Officer).
- One of the Group Executive Directors is to be a registered medical practitioner, or, a registered dentist (within the meaning of the Dentists Act 1984).
- One of the Group Executive Directors is to be a registered nurse, or, a registered midwife.

3.2.2 The number of Group Directors may be increased provided always that at least half of the Board, excluding the Group Chairman, comprises of Group Non-Executive Directors.

3.2.3 The Trust Secretary (or nominated deputy) will be in attendance at all meetings of the Board.

3.3 Appointment and Removal of the Group Chairman and Group Non-Executive Directors

3.3.1 In accordance with paragraph 26 of the Constitution and guidance issued by NHS England/Improvement, the Group Chairman and Group Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting of the Council of Governors.

3.3.2 The Group Chairman and Group Non-Executive Directors shall be appointed for a term of office of up to three years.

3.3.3 The Group Chairman and Group Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

3.3.4 The Group Chairman and Group Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to annual re-appointment and subject to external competition if recommended by the Board and approved by the Council of Governors. In establishing that the Group Non-Executive Director continues to be independent, the Group Chairman will take account of NHS England/Improvement's (formerly Monitor) guidance and conduct an evidence-based evaluation.

3.3.5 Any re-appointment after the second term of office (irrespective of tenure duration), for the Group Chairman and Group Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence.

3.4 Appointment and Powers of Group Deputy Chairman

3.4.1 The Council of Governors at a general meeting shall appoint one of the Group Non-Executive Directors as Group Deputy Chairman in accordance with 27.1 of the Constitution and, in similar manner, shall remove any person appointed from that position and appoint another Group Non-Executive Director in his place.

3.4.2 Before a resolution for any such appointment is passed, the Board may decide which of the Group Non-Executive Directors it recommends for that appointment; the Group Chairman shall advise the Council of Governors of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision.

3.4.3 In the absence of the Group Chairman, the Group Deputy Chairman shall be acting Group Chairman of the Trust.

3.4.4 Any Group Non-Executive Director may at any time resign from the office of Group Deputy Chairman by giving notice in writing to the Group Chairman. The Council of Governors upon the recommendation of the Board may then appoint another Group Deputy Chairman in accordance with paragraph 27.1 of the Constitution.

3.4.5 Where the Group Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Group Chairman owing to illness or any other cause, the Group Deputy Chairman shall act as Group Chairman until a new Group Chairman is appointed or the existing Group Chairman resumes his/her duties, as the case may be; and references to the Group Chairman in these Standing Orders shall, so long as there is no Group Chairman able to perform his/her duties, be taken to include references to the Group Deputy Chairman.

3.4.6 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as a Group Senior Independent Director to act in accordance with NHS England/Improvement's (formerly Monitor) NHS Foundation Trust Code of Governance (as may be amended and replaced from time to time); and the Trust's Standing Orders.

3.5 **Appointment and Role of the Group Senior Independent Director**

3.5.1 The Group Senior Independent Director (SID) is a role that is undertaken by one of the Trust's Independent Group Non-Executive Directors. The Group SID should be available to all stakeholders, particularly Governors and members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Group Chairman or Group Chief Executive, or in circumstances in which such contact would be inappropriate.

3.5.2 The Board shall (following consultation with the Council of Governors) appoint one of the Group Non-Executive Directors as the Group Senior Independent Director in accordance with paragraph 27.2 of the Constitution, for such a period not exceeding the remainder of the individual's term of office as a Group Non-Executive Director.

3.5.3 The Group Senior Independent Director shall meet with the Group Chairman at least annually to evaluate his/her performance, as part of a process, which should be agreed with the Council of Governors, for appraising the Group Chairman and on such occasions as are deemed appropriate.

3.6 **Terms of Office of the** Group **Chair and Group Non-Executive Directors** - The Group Chairman and Group Non-Executive Directors shall be appointed with terms and conditions of office as decided by the Council of Governors at a general meeting taking account of NHS England/Improvement's (formerly Monitor) governance guidance.

3.7 **Appointment and Removal of the Group Chief Executive**

3.7.1 In accordance with the Trust's Constitution paragraph 28, the Group Non-Executive Directors shall appoint or remove the Group Chief Executive.

3.7.2 The appointment of the Group Chief Executive requires the approval of the majority of the Council of Governors at a meeting in accordance with paragraph 28.2 of the Trust's Constitution.

3.8 **Appointment and Removal of Group Executive Directors**
In accordance with the Constitution, paragraph 28.3, all Group Executive Directors (excluding the Group Chief Executive) are to be appointed (and removed) by a Committee consisting of the Group Chairman, the Group Chief Executive and the other Group Non-Executive Directors.

3.9 **Joint Directors**

3.9.1 Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for group executive directorship or in relation to which a Group Executive Director is to be appointed, those persons shall count for the purpose of SO4. (composition of Board) as one person (save that the Group Executive positions of registered Medical Practitioner or registered Dental and registered Nurse or registered Midwife cannot be shared between the two professions).

3.9.2 Where such an arrangement is in force, both individuals shall be able to attend a meeting of the Board provided that at any meeting of the Board they may only count as one individual for the purposes of the quorum and may only exercise one vote between them.

3.9.3 Where the two individuals disagree as to how to vote at a Board meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both.

3.9.4 The presence of either or both persons shall count as the presence of one person for the purposes of quorum.

3.10 **Trust Secretary**

The Group Chairman and Group Chief Executive shall appoint a Trust Secretary to act independently of the Board, to provide advice on corporate governance issues to the Group Chairman and Board, and to monitor the Trust's compliance with its regulatory framework, the Trust's Constitution and SOs.

3.11 **Role of Group Chief Executive**

3.11.1 The Group Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business.

3.11.2 The Group Chief Executive reports to the Group Chairman of the Board.

3.11.3 The Group Chief Executive is the Accounting Officer and shall be responsible for ensuring the discharge of obligations under all relevant financial directions and guidance issued by NHS Foundation Trust Regulators or any other relevant body.

3.12 **Role of Group Chief Finance Officer**

3.12.1 The Group Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its Group Directors and for the supervision of financial control and accounting systems.

3.12.2 The individual shall be responsible, along with the Group Chief Executive, to ensure the discharge of obligations under all relevant financial requirements, conditions or notices issued by any Regulators or other relevant body.

3.13 **Role of Group Executive Directors**

Group Executive Directors shall exercise their authority within these SOs, SFIs and SoRD.

3.14 **Role of the Group Chairman**

The Group Chairman shall be responsible for the leadership of the Board (and Council of Governors) and chair all Board (and Council) meetings when present.

3.14.1 The Group Chairman must ensure effectiveness in all aspects of the Board's role and lead on setting the agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues.

3.14.2 The Group Chairman is responsible for ensuring that the Board and Council of Governors work effectively together.

3.15 **Role of Group Non-Executive Directors**

The Group Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

3.16 **The Board as a Trustee**

3.16.1 All funds received in trust shall be held in the name of the Trust as corporate trustee.

3.16.2 In relation to funds held in trust, powers exercised by the Board of Directors as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust.

3.16.3 The Trust has the functions conferred on it by the 2006 Act. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to NHS England/Improvement .

3.17 **Relationship between the Board of Directors and Council of Governors**

3.17.1 The Council of Governors has a statutory duty to hold the Group Non-Executive Directors individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its License. It remains the responsibility of the Board to design and implement agreed priorities, objectives and the overall strategy of the Trust. The Council is responsible for representing the interests of the Trust members and the public and staff in the governance of the Trust. Governors must act in the best interests of the Trust and should adhere to its values and Governors' Code of Conduct. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Trust should ensure that Governors have appropriate support to help them to discharge this duty.

3.17.2 The Board is to present to the Council of Governors, at a general meeting, the annual accounts, any report of the auditor on them, and the annual report.

3.17.3 The annual report should describe the process followed by the Council of Governors in relation to the appointments of the Group Chairman and Group Non-Executive Directors.

3.17.4 The Council of Governors will agree with the Audit Committee the criteria for appointing, re-appointing and removing External Auditors.

3.17.5 If the Council of Governors does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council had taken a different position.

4. MEETINGS OF THE BOARD OF DIRECTORS

4.1 Admission of the Public and Press

Meetings of the Board of Directors shall be open to members of the public and press in accordance with paragraph 30.1 of the Constitution.

4.1.1 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Board will resolve that:

'*In accordance with paragraph 30.1 of the Constitution and paragraph 18E of Schedule 7 of the 2006 Act, the Board of Directors resolves that there are special reasons to exclude members of the public from this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed*'.

4.1.2 Nothing within these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without prior agreement of the Board.

4.1.3 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Board and shall not be disclosed by any person attending the meeting without the consent of the Group Chairman of the meeting.

4.2 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine, with a minimum number of five meetings held each year.

4.2.1 Meetings of the Board of Directors may be called by the Secretary, or by the Group Chairman or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request.

4.2.2 The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Group Chairman or four Directors, whichever is the case, shall call such a meeting.

4.3 **Notice of Meetings**

Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Group Chairman or by an officer of the Trust authorised by the Group Chairman to sign on his/her behalf shall be delivered to every Director by hand or via e-mail, sent by post to the usual place of residence of such Director, and advertised on the Trust's website so as to be available to him/her at least three clear days before the meeting. Lack of service of the notice on any Director shall not affect the validity of a meeting.

4.3.1 Notwithstanding the above requirement for notice, the Group Chairman may waive notice in the case of emergencies or in the case of the need to conduct urgent business or on written receipt of the agreement of at least two-thirds of Directors (Group Executive and Group Non-Executive Directors taken together) but to include a minimum of two Group Executive Directors and two Group Non-Executive Directors.

4.3.2 In the case of a meeting called by Directors in default of the Group Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.3.3 Agendas and any supporting papers will, normally, be sent to Directors so to arrive no later than five days before the meeting, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. Subject to paragraph 4.3.1, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.4 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

4.4 **Notice of Extraordinary Meetings**

At the request of the Group Chairman or by at least one-third of the whole number of members of the Board, the Trust Secretary shall send a written notice to all Directors within 14 (fourteen) days of receipt of such a request specifying the date and place to discuss the specified business.

4.4.1 If the Trust Secretary fails to call such a meeting, then the Group Chair or at last one-third of the whole number of members of the Board, whichever is the case, shall call such a meeting.

4.5 **Setting the Agenda** – The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

4.5.1 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Group Chair at least 10 clear days before the meeting. The request should state whether the item of business should be taken in a closed session i.e. not open to the public, press or staff be transacted in the presence of the public.

4.5.2 Clear rationale and any appropriate supporting information should be provided in support of the request. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Group Chairman.

4.5.3 Before holding a meeting, the Trust Secretary must send a copy of the agenda of the Board meeting to the Council of Governors.

4.6 **Petitions** - Where a petition has been received by the Trust, the Group Chairman of the Board of Directors shall include the petition as an item for the agenda of the next Board of Directors meeting.

4.7 **Chair of Meeting**
At any meeting of the Board of Directors, the Group Chairman, if present, shall preside. If the Group Chairman is absent from the meeting or absent temporarily on the grounds of a declared conflict of interest the Group Deputy Chairman, if present, shall preside. If the Group Chairman and Group Deputy Chairman are absent, or are disqualified from participating, another Group Non-Executive Director, as the Directors determine shall choose who shall preside.

4.8 **Annual Members' Meeting**
The Trust will publicise and hold an Annual Members' Meeting, in accordance with paragraph 11 of the Constitution.

4.9 **Notices of Motion** - A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Group Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to paragraph 4.5 above.

4.10 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Group Chairman.

4.11 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the Group Chairman to propose a motion to the same effect within six months; however the Group Chairman may do so if he/she considers it appropriate.

4.12 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.12.1 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business(*)

- the appointment of an ad hoc committee to deal with a specific item of business.
- that the motion be now put. (*)
- a motion under paragraph 4.1.1.

*In the case of sub-paragraphs denoted by (*) above to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

4.12.2 No amendment to the motion shall be admitted if, in the opinion of the Group Chairman of the meeting, the amendment negates the substance of the motion.

4.13 **Group Chairman's Ruling**

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Group Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.14 **Voting**

Every question/decision put to a vote at a meeting shall be determined by a majority of the votes of the Group Chairman of the meeting and members present/participating and voting on the decision and, in the case of the number of votes for and against a motion being equal, the Group Chairman of the meeting shall have a second or casting vote. No resolution of the Board of Directors shall be passed if it is opposed by all of the Group Non-Executive Directors present or by all of the Group Executive Directors present.

4.14.1 All questions/decisions put to the vote shall, at the discretion of the Group Chairman of the meeting, be determined or by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels . A paper ballot may also be used if a majority of the Directors present/participating so request.

4.14.2 If at least one-third of the Directors present/participating so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.14.3 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.14.4 The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting and thus entitled to vote.

4.14.5 An officer who has been appointed formally by the Board of Directors to act up for a Group Executive Director during a period of incapacity or temporarily to fill an Group Executive Director vacancy, shall be entitled to exercise the voting rights of the Group Executive Director. An officer attending the Board of Directors to represent a Group Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Group Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

4.14.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.15 **Minutes**

The Minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next ensuing meeting where they will be signed by the Group Chairman presiding at it.

4.15.1 No discussion shall take place upon the minutes except upon their accuracy or where the Group Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.15.2 Minutes shall be circulated in accordance with the Directors' wishes.
The minutes shall be made available to the Council of Governors and to the public except for minutes relating to business conducted when members of the public are excluded under these Standing Orders (required by Code of Practice on Openness in the NHS).

4.16 **Waiver/Suspension of Standing Orders**

4.16.1 Except where this would contravene any provision of the Constitution or any direction made by NHS England/Improvement, any one or more of the Standing Orders may be suspended at any meeting, provided that at least 50% of the Board of Directors are present, including two Group Executive Directors and two Group Non-Executive Directors, and that a majority of those present vote in favour of suspension.

4.16.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.16.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Group Chairman and Board of Directors.

4.16.4 No formal business may be transacted while Standing Orders are suspended.

4.16.5 The Audit Committee shall review every decision to suspend Standing Orders.

4.17 **Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- the variation proposed does not contravene a statutory provision
- at least two-thirds of the Directors are present; and
- no fewer than half the total of the Trust's Group Non-Executive Directors vote in favour of amendment.

4.18 **Record of Attendance**

4.18.1 The names of the Group Chairman and Directors and all others present at the meeting (other than members of the public and media) who are present at the meeting shall be recorded in the minutes.

4.18.2 A meeting of the Board refers to officers being physically present and officers being present via the use of technology.

4.19 **Quorum**

4.19.1 No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of voting Directors are present including at least three Group Executive Directors and three Group Non-Executive Directors.

4.19.2 An officer in attendance for a Group Executive Director but without formal acting up status may not count towards the quorum.

4.19.3 If the Group Chairman or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he/she shall no longer count towards the quorum.

4.19.4 If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.19.5 Board Directors may participate (and vote) in its meetings by telephone teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute present in person at the meeting.

4.20 **Meetings – Electronic Communication**

4.20.1 Within these SOs, communication and electronic communication shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

4.20.2 A Director in electronic communication with the Group Chairman and all other parties to a meeting of the Board or of a standing Committee of the Board shall be regarded for all purposes as being present and personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other arties attending the meeting including all persons attending by way of electronic communication.

4.20.3 For meetings to be held in accordance with these SO for such a meeting to be quorate, quorum must be present and maintained throughout a meeting.

4.20.4 Minutes of a meeting held in this way must state that it was held by electronic communication.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 The 2006 Act provides for all powers of the Trust to be exercised by the Board on its behalf. It also states that the Board may delegate any of its powers to a committee of Directors or to a Group Executive Director, in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

5.2 Emergency Powers

5.2.1 The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 3) may in emergency be exercised by the Group Chief Executive and the Group Chairman after having consulted at least two Group Non-Executive Directors.

5.2.2 The exercise of such powers by the Group Chief Executive and Group Chairman shall be reported to the next formal meeting of the Board of Directors held in public for ratification.

5.3 Delegation to Committees

The Board of Directors:

- May appoint committees with a membership wholly of Directors to exercise any of its powers
- May appoint working groups consisting wholly or partly of members who are not directors for any purpose which is calculated or likely to contribute to or assist it in the exercise of its powers but it may not delegate the exercise of any of its powers to such a group. The power to appoint groups under this SO is delegated to the Group Chief Executive.
- shall agree from time to time to the delegation of executive powers to be exercised by committees, sub-committees or joint-committees, which it has formally constituted in accordance with its powers of delegation. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee, sub-committee or joint-committee shall be exercised on behalf of the Board of Directors by the Group Chief Executive. The Group Chief Executive shall determine which functions he/she will perform personally and shall nominate Executive Directors / Officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

5.4.2 The Group Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Group Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board of Directors as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Directors to provide information and advise the Board of Directors in accordance with the Constitution, Terms of the License or any statutory requirements or provisions required by NHS England/Improvement. Outside these statutory requirements the roles of the Group Chief Finance Officer shall be accountable to the Group Chief Executive for operational matters.

5.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.5 **Non-compliance with Standing Orders**

5.5.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification.

5.5.2 All staff have a duty to disclose any potential or impending non-compliance to their Group Executive Director who in turn has a duty to report to the Group Chief Executive and Group Chairman as soon as possible.

6. COMMITTEES

6.1 The 2006 Act states that:

6.2 The Board shall appoint an Audit Committee of Group Non-Executive Directors to perform such monitoring, reviewing and other functions as appropriate in accordance with these SOs and the constitution at paragraph 39.

6.3 The Board shall appoint a Committee of Group Non-Executive Directors to decide the remuneration and allowances, and other terms and conditions of office, of the Group Executive Directors in accordance with these SOs and the Constitution paragraph 33.

6.4 Subject to the 2006 Act and any such regulatory framework or guidance issued by NHS England/Improvement , the Board may appoint standing committees of the Board.

6.5 There are no requirements to hold meetings of committees in public.

6.6 The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors. In which case the term “Chair” is to be read as a reference to the Group Chairman of the committee as the context permits.

6.7 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation or direction issued by NHS England/Improvement. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.8 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

6.9 The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither officers nor Directors, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors.

The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.10 The Board of Directors may establish other committees, sub committees and joint committees which will work as working groups, including ad hoc committees, sub committees and joint committees at its discretion without requirement to amend these SOs.

7. CONFIDENTIALITY

7.1 A Director or appointee of a committee, sub-committee or joint committee or working group shall not disclose a matter dealt with, by, or brought before, the relevant committee without its permission until the committee sub-committee or joint committee or working group has reported to the Board of Directors or shall otherwise have concluded on that matter.

7.2 A Director or an appointee of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors otherwise dealt with by the relevant committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

8. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Declaration of Interests

8.1.1 All Board members, all Directors, Governors and Officers have a duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with interests of the Trust. Any Director who has an interest in a matter that he/she is required to declare in accordance with paragraph 32 of the Trust's Constitution shall declare such interest to the Board and:

- shall withdraw from the meeting and play no part in the relevant discussion or decision; and
- shall not vote on the issue (and if inadvertence they do remain and vote, their vote shall not be counted).

8.1.2 Details of any such interest shall be recorded in the Register of Interests of Board members. At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes. Any changes in interests shall be declared in accordance with the requirements of the Trust's constitution, these SOs and the Trust associated Policy.

8.1.3 Any Board member who fails to disclose any interest required to be disclosed under the preceding clause must permanently vacate their office if required to do so by a majority of the remaining Board members and, in the case of a Group Non-Executive Director, by the requisite majority of the Council of Governors.

8.1.4 Board members' directorships of companies which may conflict with their management responsibilities shall be published or referenced in the Trust's annual report. As the Trust maintains a Register of Interests which is open to the public, the disclosure included or reference within the annual report at the discretion of the Board, be limited to a comment on how access to the information in that Register may be obtained.

8.1.5 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

8.1.6 If Board members have any doubt about the relevance of an interest, this should be discussed with the Group Chairman or Trust Secretary.

8.2 **Register of Interests**

8.2.1 The Group Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other interests which have been declared by both Group Executive and Group Non-Executive Board members, in accordance with paragraphs 32 and 36 of the Trust's Constitution.

8.2.2 The Trust Secretary will keep these details up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated. It is the responsibility of each Board member to provide an update to the Trust Secretary of their register entry if their interest changes.

8.2.3 The Register will be available to the public and the Group Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

8.3 **Register of Gifts and Hospitality**

8.3.1 A Register of Gifts and Hospitality will be maintained by the Trust Secretary for the Board members, staff, all prospective employees – who are part-way through recruitment, Contractors and sub-contractors, Agency staff; and Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation).

8.3.2 The Register will be published on the Trust's website in line with regulatory requirements.

9. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 Subject to the following provisions of this Standing Order, if the Group Chairman or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Board of Directors may exclude the Group Chairman or a Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

9.3 The Board, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board that, in the interests of the Trust, the disability shall be removed.

9.4 Such action shall have the support of at 50% of the Directors present at the meeting (including two Group Executive and two Group Non-Executive Directors).

9.5 Any remuneration, compensation or allowances payable to the Group Chairman or a Director by the Trust shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9.6 For the purpose of this SO the Group Chairman and Director shall be treated, subject to these SOs as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

9.6.1 he/she, or a nominee of his/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

9.6.2 he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and

9.6.3 In the case of family, or, close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of these SOs to be also an interest of the other.

9.7 The Group Chairman or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

9.7.1 of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

9.7.2 of an interest in any company, body or person with which he/she is connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.8 Where the Group Chairman or Director:

9.8.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

9.8.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less; and

9.8.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

9.9 These SOs applies to a committee or sub-committee and to a joint committee as it applies to the Board of Directors and applies to an appointee of any such committee or sub-committee (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

10. STANDARDS OF BUSINESS CONDUCT POLICY

10.1 **Policy**

Staff should comply with the Trust's Constitution and the National Guidance Standards of Business Conduct for NHS Staff – "managing conflicts of interest in the NHS", which came into force on 1 June 2017. This guidance supersedes and extinguishes HSG (93)5 Standards of Business Conduct for NHS Staff. This guidance requires all NHS organisations to meet strict ethical standards in the conduct of any NHS business.

10.2 **Interests of Directors, Officers, all staff, Consultants, Contractors and Governors**

If it comes to the knowledge of a Director or Officer (the term officer in this instance includes all staff, consultants, contractors and Governors) of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Group Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.2.1 A Director should also declare to the Group Chief Executive any other employment or business or other relationship of his/her, or of a spouse/partner/other family member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust comply with the SOs, SFI, the financial limits specified in the SoRD, and the Trust's Tendering and Quotation Policy and Procedure.

10.3 **Legislation Governing Public Procurement**

10.3.1 The Trust shall comply with the Public Contracts Regulations 2015 (the 'Regulations') as applicable and any European Union (EU) Directives relating to EU procurement law having direct effect in England (the 'Directives') and any other duties derived from EU Treaty ('Treaty Obligations') and any other duties derived from the UK common law ('Common Law Duties') . The Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in these SOs as 'Procurement Legislation'.

10.3.2 The Trust should consider obtaining support from the NHS Supply chain and/or Cabinet Office where relevant and/or any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures).

10.3.3 When procuring services, the Trust should have regard to the requirements of the Public Services (Social Value) Act 2012 and its supporting regulations and guidance, as amended.

10.4 **Guidance on Procurement and Commissioning**

The Trust should have due regard to all relevant guidance issued in relation to the conduct of procurement practice.

10.5 **Formal Competitive Tendering**

10.5.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services: for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any Procurement Legislation or as otherwise set out in the Trust's Tendering and quotation Policy and Procedure and/or the SoRD.

10.5.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Group Chief Executive in accordance with the Trust's Policy and Procedure. All such waivers should be reported to the next available meeting of the Audit Committee.

10.6. **Contracts**

10.6.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

- These SOs;
- The Trust's SFIs;
- EU Directives and other statutory provisions;

10.6.2 Any relevant and mandatory directions including NHS England/Improvement's (formerly Monitor) guidance Supporting NHS providers: guidance on transactions for NHS foundation trusts, the Department of Health's Estate Code; and the NHS Standard Contract as applicable.

10.6.3 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.6.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Group Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

10.7 **Personal and Agency or Temporary Staff Contracts**

10.7.1 The Group Chief Executive shall nominate officers with delegated authority to enter into contacts of employment, regarding staff, agency staff or temporary staff service contracts.

10.8 **Legally Binding Contracts for the Provisions of Healthcare**
Legally binding contracts for the supply of healthcare services shall be drawn up in accordance with legal advice, best practice and where possible use the NHS Standard Contract. These legally binding contracts will be administered by the Trust.

10.9 **Cancellation of Contracts**

10.9.1 Except where specific provision is made in the NHS Standard Terms and Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

10.9.1.1 if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or foreseeing to show favour or disfavor to any person in relation to the contracts or any other contract with the Trust; or

10.9.1.2 if any relation to any contract with the Trust the contractor or any person employed by them or action on their behalf shall have committed any offence under the Bribery Act 2010 and any other appropriate legislation.

10.10 **Determination of Contracts for Failure to Deliver Goods or Materials**

10.10.1 There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereon within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

- such default; or
- in the event of the contract being wholly determined the goods or materials remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or material exceeds the amount which would have been payable to the contract in respect of the goods or materials shall be recoverable from the contractor.

11. DISPOSALS

11.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

11.1.1 Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in reserve) by the Group Chief Executive or his nominated officer.

11.1.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust.

11.1.3 Items to be disposed of with an estimated sale value of less than £(n) this figure to be reviewed annually.

11.1.4 Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with relevant contract.

12. IN-HOUSE SERVICES

12.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

12.2 Specification group, comprising the Group Chief Executive or nominated officer(s) and specialist(s).

12.3 In-house tender group, comprising representatives of the in-house team, a nominee of the Group Chief Executive and technical support.

12.4 Evaluation team comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £(n), a non-officer member should be a member of the evaluation team.

12.5 All groups should work independently of each other, but individual officers may be a member of more than one group. No member of the in-house tender group may participate in the evaluation of tenders.

12.6 The evaluation group shall made recommendations to a Committee of the Board of Directors and/or Board.

13. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

13.1 **Requirements to seal**

It is a legal requirement to place any property transactions e.g. purchase, sale, and lease, under seal.

13.1.1 Other contracts/documentation should be approved by an authorised signatory 'under hand' i.e. signed.

13.2 **Custody of Seal**

13.2.1 The Common Seal of the Trust shall be kept by the Trust Secretary on behalf of the Group Chief Executive in a secure place.

13.3 **Sealing of Document**

13.3.1 The Board delegates authority to the Group Chairman (or a Group Non-Executive Director) and the Group Chief Executive (or another Group Executive Director, but excluding the Group Chief Finance Officer) to apply the seal on behalf of the Trust to any document required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee or sub-committee to which the Board has delegated appropriate authority

13.3.2 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

13.4 **Register of Sealing**

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. The report shall contain details of the seal number, the description of the document, date of sealing and the names of persons who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

14. SIGNATURE OF DOCUMENTS

14.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Group Chief Executive or an officer acting on his/her behalf, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

14.2 The Group Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee or sub-committee to which the Board has delegated appropriate authority.

15. MISCELLANEOUS

15.1 **Standing Orders to be given to Board Members and Officers**
It is the duty of the Group Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Group Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of the Standing Orders.

15.2 **Documents having the standing of Standing Orders**
Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have effect as if incorporated into Standing Orders.

15.3 **Review of Standing Orders**
Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

15.4 **Dispute Resolution**

15.4.1 Where there is a dispute between the Board of Directors and the Council of Governors in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Group Chairman (or Group Senior Independent Director or Group Deputy Chairman if the dispute involves the Group Chairman) will endeavour to resolve the dispute informally, through discussions with the Council of Governors.

15.4.2 Where a dispute arises that involves the Group Chairman, the dispute shall be referred to the Group Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

15.4.3 The Group SID also acts as the point of contact for Governors with the Board of Directors during the Group Chairman's annual performance appraisal process (includes remuneration and other allowances).

15.4.4 The Council of Governors should only exercise its power to remove the Group Chair, or any other Group Non-Executive Director, after exhausting all means of engagement with the Board.

15.4.5 In the event of any unresolved dispute between the Board of Directors and the Council of Governors, the Group Chairman or the Secretary may arrange for independent professional advice to be obtained for the Foundation Trust. The Group Chairman may also initiate an independent review to investigate and make recommendations in respect of how the dispute may be resolved.

15.4.6 For avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first instance including any voting or legislation issues and shall otherwise follow up process of resolving such matters in accordance with any procedures agreed by the Board.

ANNEX 8

Further Provisions

1. DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become a member of the Trust if:

1.1.1 they are under 11 years of age; or

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against any registered volunteer.

2. TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this Constitution;

2.1.4 they cease to be entitled under this Constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Foundation Trust.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this Constitution;

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Group Chairman of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a General Meeting.

REPRESENTATIVE MEMBERSHIP

2.5 The Foundation Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

2.5.1 the Foundation Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

2.5.2 the Council of Governors shall present to each Annual Members' Meeting a report on:

2.5.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

2.5.2.2 the progress of the membership strategy;

2.5.2.3 any changes to the membership strategy.

COMMITMENTS

2.6 The Foundation Trust shall exercise its functions effectively, efficiently and economically.

Co-operation with NHS Bodies and Local Authorities

2.7 In exercising its functions, the Foundation Trust shall co-operate with NHS bodies and local authorities.

Openness

2.8 In conducting its affairs, the Foundation Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting Distribution

2.9 The profits or surpluses of the Foundation Trust are not to be distributed either directly or indirectly in any way at all among members of the Foundation Trust.

3. FRAMEWORK

3.1 The affairs of the Foundation Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this Constitution and the Foundation Trust's licence. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this Constitution.

Members

3.2 Members may attend and participate at members' meetings, vote in elections to, and if eligible, stand for election to, the Council of Governors, and take such other part in the affairs of the Foundation Trust as is provided in this Constitution.

Council of Governors

3.3 The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this constitution and the Trust's License, are outlined in 16.1, 26.1, 28.2, 33.1, 38.3, 44.1.1 and 45.1 of the Constitution.

3.4 Additional roles and responsibilities include:

3.4.1 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

3.4.2 to undertake such functions as the Board of Directors shall from time to time request;

3.4.3 to prepare and from time to time review the Trust's membership strategy and its policy for the composition of the Council of Governors and of the Group Non-Executive Directors and when appropriate to make recommendations for the revision of this Constitution.

Board of Directors

3.5 The business of the Foundation Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Foundation Trust, subject to any contrary provisions of the 2006 Act as given effect by this Constitution.

4. Secretary

4.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Group Chief Executive or the Finance Director. The Secretary's functions shall include:

4.1.1 acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

4.1.2 summoning and attending all Members' meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

4.1.3 keeping the register of members and other registers and books required by this Constitution to be kept;

4.1.4 having charge of the Trust's seal;

4.1.5 publishing to members in an appropriate form information which they should have about the Trust's affairs;

4.1.6 preparing and sending to NHS England/Improvement and any other statutory body all returns which are required to be made.

4.1.7 the Secretary shall make the final decision about the staff class of which an individual is eligible to be a member.

4.2 Minutes of every Members' meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of the Council of Governors' and Board of Directors' meetings will be read at the next meeting and signed by the Group Chairman of that meeting. The Council of Governors will approve the minutes of Members' meeting. The signed or approved minutes will be conclusive evidence of the events of the meeting.

4.3 The Secretary is to be appointed and removed by the Board of Directors.

5. FURTHER PROVISIONS AS TO ACCOUNTS

5.1 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

5.1.1 the accounts;

5.1.2 any records relating to them; and

5.1.3 any report of the auditor on them.

5.2 In preparing its annual accounts, the Accounting Officer shall cause the Trust to keep proper accounts and proper records in relation to the accounts that comply with any directions given by Monitor with the approval of the Secretary of State as to:

5.2.1 the methods and principles according to which the accounts are to be prepared;

5.2.2 the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

5.3 The Accounting Officer shall cause the Foundation Trust to:

5.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

5.3.2 once it has done so, send copies of those documents to NHS England/Improvement.

6. FURTHER PROVISIONS AS TO ANNUAL REPORTS

6.1 The annual reports are to give:

6.1.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership; and

6.1.2 any other information NHS England/Improvement requires.

6.2 The Foundation Trust is to comply with any decision NHS England/Improvement makes as to:

6.2.1 the form of the reports;

6.2.2 when the reports are to be sent to it;

6.2.3 the periods to which the reports are to relate.

7. DISPUTE RESOLUTION PROCEDURES (Non-Council of Governors related)

7.1 Every unresolved dispute which arises out of this Constitution between the Foundation Trust and:

7.1.1 a member; or

7.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

7.1.3 any person bringing a claim under this Constitution; or

7.1.4 an office-holder of the Foundation Trust

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by ACAS. The arbitrator's decision will be binding and conclusive on all parties.

7.2 Any person bringing a dispute must, if required to do so, deposit with the Foundation Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

8. DISSOLUTION

The Foundation Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

9. HEAD OFFICE

The Foundation Trust's head office is at Cobbett House, Oxford Road, Manchester or such other place as the Board of Directors shall decide.

10. NOTICES

10.1 Any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

10.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

ANNEX 9

Annual Members' Meeting

(Paragraph 11)

1. The Group Chairman shall be the final authority on the interpretation of these Standing Orders for the purpose of the Annual Members' Meeting (on which he shall be advised by the Group Chief Executive and the Secretary)**.**

2. Attendance

2.1 Each member shall be entitled to attend an Annual Members' Meeting.

3. Meetings in Public

3.1 Annual Members' Meetings are open to all members of the Trust, Governors and Directors, representatives of the External Auditor, and to members of the public subject to the provisions in paragraph 3.2 below:

3.2 The Group Chairman may exclude any member of the public from an Annual Members' Meeting if he is interfering with or preventing the reasonable conduct of the meeting.

3.3. Annual Members' Meetings shall be held annually at such times and places or in a format as the Group Chairman may determine.

3.4 All Members' Meetings other than Annual Members' Meetings are called Special Members' Meetings.

4. Notice of Meetings

4.1. All Members' Meetings are to be convened by the Secretary by order of the Council of Governors.

4.2 A notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Group Chairman, or by an officer of the Trust authorised by the Group Chairman to sign on his behalf, shall be served upon every Member, the Board of Directors, Council of Governors and to the External Auditor at least 14 clear days before the meeting and posted on the Trust's website and displayed at its headquarters.

4.3 The notice shall state whether the meeting is:

4.3.1 an annual or special members' meeting;

4.3.2 give the time, date, place and/or format of the meeting; and

4.3.3 indicate the business to be dealt with at the meeting.

4.4. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the Secretary and shall be available for inspection by a member free of charge at the place of the meeting and/or in electronic format, via the Trust's website

5. Setting the Agenda

5.1. The Group Chairman shall determine the agenda for Annual Members' Meetings which must include the business required by the 2006 Act.

6. Chair of Annual Members' Meetings

6.1 The Group Chairman of the Foundation Trust, or in their absence the Group Deputy Chairman of the Board of Directors, shall act as Chair. If neither the Group Chairman or the Group Deputy Chair of the Board of Directors is present/participating, the members of the Council of Governors present/participating shall elect one of their number to be Chair and if there is only one Governor present/participating and willing to act, they shall be Chair of the Annual Members' Meeting.

7. Chair's Ruling

7.1. Statements of members made at Annual Members' Meetings shall be relevant to the matter under discussion at that time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

8. Voting

8.1. Decisions at meetings shall be determined by a majority of the votes of the members present/participating and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

8.2 Where appropriate, the Trust may make arrangements for members to vote by post, or (except with regard to elections to the Council of Governors, which are subject to Annex 4) by using electronic communications.

8.3 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels.

8.4. In such circumstances when a member is absent member proxy voting will not be allowed at any time.

8.5. Every member present/participating and every member who has voted by post or using electronic communications is to have one vote.

9. Suspension of Standing Orders

9.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of their suspension.

9.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting.

9.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members.

9.4. No formal business may be transacted while the standing orders are suspended.

9.5. The Trust's Audit Committee shall review every decision to suspend the standing orders.

10. Minutes

10.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted to the Council of Governors for agreement.

10.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

10.3 The result of any vote will be declared by the Group Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

10.4. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website.

11. Quorum

11.1. Before a Members' Meeting can do business there must be a quorum present/participating. Except where this Constitution says otherwise, a quorum is 20 members present.

11.2 If no quorum is present within half an hour of the time fixed for the start of the meeting (if meeting is being held face-to-face), the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting (if meeting is being held face-to-face), the number of members present during the meeting is to be a quorum.

11.3 A resolution put to the vote at a Members' Meeting shall be decided upon by an oral expression or by show of hands unless a poll is requested by the Chair of the meeting.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Jane Abdulla, Assistant Director, Equality, Diversity and Inclusion Amy McCawley, Advice, Governance and Information Manager Equality and Diversity
Date of paper:	March 2021
Subject:	2020 Equality, Diversity and Inclusion Report Public Sector Equality Duty.
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 has a Public Sector Equality Duty to produce an annual report outlining progress against its equality objectives. This report meets that legal duty. It describes the work that has been carried out in year one of *Diversity Matters*, the Trust's equality, diversity and inclusion strategy 2019-2023.
Recommendations:	The Board is asked to acknowledge the report and endorse publication on the Trust's website by 31st March 2021 in line with statutory and legal requirements.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 8573

2020 Equality, Diversity and Inclusion Annual Report

1. Purpose

This paper introduces the 2020 Equality, Diversity and Inclusion Report (the Annual Report) which is attached an **Annex A**.

2. Background

2.1. The Annual Report is a legal requirement under the Equality Act 2010 Public Sector Equality Duty, which requires public sector organisations to publish progress on their equality objectives by March each year. It is aimed at providing stakeholders with an overview of the Trust's work and achievements on *Diversity Matters*, the Trust's equality, diversity and inclusion strategy 2019-2023.

2.2. Given the impact of the COVID-19 Pandemic on services, staff and patients, the report provides information on the significant work undertaken to maintain a supported workforce.

2.3. The Annual Report has been produced by the Group Equality, Diversity and Inclusion Team drawing on contributions from across the Trust.

3. MFT 2020 Equality, Diversity and Inclusion Report

3.1. The Annual Report provides:

- An overview of *Diversity Matters*, MFTs Equality, Diversity, and Inclusion Strategy 2019-2023.

- Examples of work carried out over the year to meet the Trust's equality aims of:
  - Improved patient access, safety and experience.
  - A representative and supported workforce.
  - Inclusive leadership.

- An overview of Trust governance structures for equality, diversity and inclusion.

- Annex 1: Diversity of our patients.

- Annex 2: Diversity of our staff.

- Annex 3: Additional Resources

3.2 The key headlines of the Report was presented and discussed at a weekly *Group NED COVID-19 Briefing Session* held on 15th February 2021 with minor amendments included following feedback and now reflected in the final version presented for publication.

4. Recommendations

The Board is asked to acknowledge the Annual Report and endorse publication on the Trusts website by the 31st March 2021.

NHS
Manchester University
NHS Foundation Trust

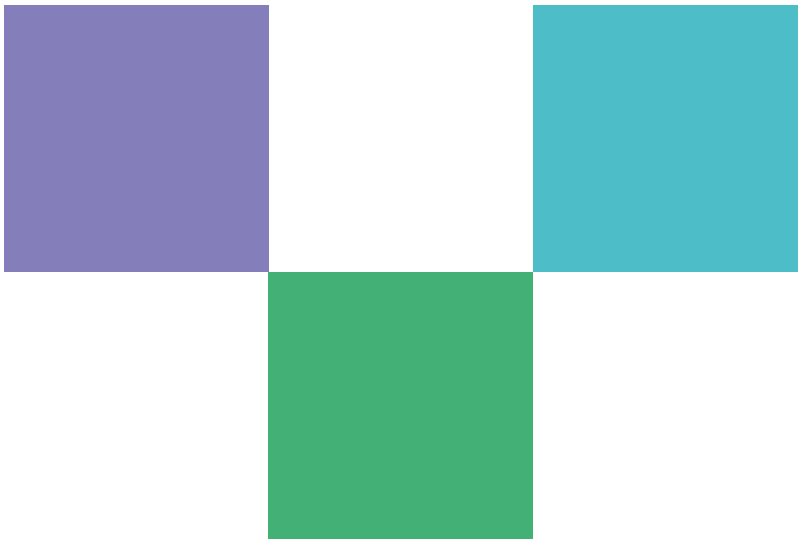
Diversity Matters

Equality, Diversity and Inclusion Annual Report

2020

disability confident EMPLOYER

Content



Foreword

One year on from the launch of *Diversity Matters*, the Trust's equality, diversity and inclusion strategy 2019-2023, the Trust has made progress against its strategic aims and objectives to:

- Improve patient access, safety and experience.
- Achieve a representative and supported workforce.
- Foster inclusive leadership.

Delivering *Diversity Matters* has happened in an unprecedented year in which the NHS has been challenged by COVID-19 on a scale and at a pace not previously seen. The Pandemic has certainly shone new light on the existing health inequalities experienced by our diverse communities.

Working together to meet the needs of patients, their families and our staff has never been more important. Staff have gone above and beyond to ensure the safety of patients, and I am proud of what they have done. All told an outstanding contribution for the people of Manchester, Trafford and Greater Manchester.

To have been able to continue to build on our commitment to equality, diversity and inclusion despite the challenges of the year is an achievement very much down to the ability, aptitude and ambition of Team MFT. The engagement and sense of responsibility displayed by staff has been nothing short of outstanding.

We know that creating services that are truly inclusive, where everyone matters is the only way to achieve the highest quality of personalised care. The Trust also recognises the importance of creating an inclusive workplace, where all staff feel that they belong, can flourish and achieve their fullest potential. By working together to achieve the aims of *Diversity Matters*, we will continue to contribute to the best experience possible for our service users and staff.

As we come together to celebrate the progress made this year, I would like to thank everyone for their contributions and look forward to work yet to be done.

Peter Blythin

Group Executive Director Workforce & Corporate Business

Introduction

Manchester University NHS Foundation Trust (the Trust) is the largest NHS Foundation Trust in England, employing over 23,000 staff. It was formed on 1st October 2017 and since then has been responsible for running a family of nine hospitals and community services across Manchester and Trafford across six separate sites.

It provides a wide range of services from comprehensive local general hospital care through to highly specialised regional and national services. From 1st April 2020, a tenth hospital, North Manchester General Hospital, joined the Trust through a Management Agreement pending formal acquisition in April 2021.

We are the primary provider of hospital care to approximately 750,000 people in Manchester and Trafford, and the single biggest provider of specialised services in the North West of England. The Trust is also the lead provider for a significant number of specialised services. These specialist services include Breast Care, Vascular, Cardiac, Respiratory, Urology Cancer, Paediatrics, Women's Services, Ophthalmology and Genomic Medicine.

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

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

This report details our performance during 2020 against the objectives of *Diversity Matters*, the Trust's equality, diversity and inclusion strategy 2019-2023. It contains examples of practice from across the Trust's hospitals, managed clinical services, local care organisation and corporate services. The report meets the Trust's statutory duty under the Equality Act 2010 to report on performance against equality objectives annually. It details the diversity of our patients, staff, leadership and governance for equality, diversity and inclusion.

Jane Abdulla

Assistant Director
Equality, Diversity and Inclusion

Our Hospital Sites

Manchester Royal Infirmary

Saint Mary's Hospital

Royal Manchester Children's Hospital

Manchester Royal Eye Hospital

University Dental Hospital of Manchester

Wythenshawe Hospital

Trafford General Hospital

Withington Community Hosptial

Altrincham Hospital

Manchester Local Care Organisation

Trafford Local Care Organisation

This report is reflective of our third full year as a single hospital service. The report details our performance during 2020 and contains examples of practice from across the Trust's Hopsitals, Managed Clinical Services (MCS), the Local Care Organisations (LCOs) and Corporate Services. It details the diversity of our patients, staff, leadership and governance for equality, diversity and inclusion.

If you require this information in an alternative format or would like to enquire about further details on information presented in this report please contact the Equality, Diversity and Inclusion Team: equality@mft.nhs.uk

Section One

Diversity Matters

In 2019, the Trust published *Diversity Matters*, its four year equality, diversity and inclusion strategy for 2019-2023. *Diversity Matters* outlines the Trust's ambition to be the best place for patient quality and experience and the best place to work. *Diversity Matters* is central to the Trust achieving its vision of 'improving health and well-being for our diverse population'. If you would like to access the complete *Diversity Matters* Strategy you can do so by clicking here.

Diversity Matters provides a framework for action focussing on three aims:

- Improved patient access, safety and experience.
- A representative and supported workforce.
- Inclusive leadership.

These aims are underpinned by a set of objectives for focus of activity over the four years. The aims and underpinning objectives are outlined in the table below.

Improved patient access, safety and experience	A representative and supported workforce	Inclusive leadership
We will: • Consider how our decisions will affect equality and reduce unfavourable effects. • Know who uses our services by equality and their experiences and reduce any differences that we find. • Carry on working towards the Accessible Information Standard. • Make sure that people with learning disabilities and autism get treatment, care and support. • Be the first Trust in the country to deliver Pride in Practice. This is recognition from the LGBT Foundation. • Make our way-finding and signage easier.	**We will:** • Consider how our decisions will affect equality and reduce unfavourable effects. • Know who our staff are by equality and their experiences and reduce any differences that we find. • Take a zero tolerance approach to bullying, abuse and harassment. • Work towards being a Disability Confident Lead employer. • Increase ethnic diversity at Board and senior management levels.	**We will:** • Board members and senior leaders will champion equality and diversity. Some examples include: > Talk about equality, diversity and inclusion > Engage their staff > Understanding how our decisions will affect equality and reduce unfavourable effects > Have equality, diversity and inclusion objectives in their local delivery plans > Use inclusive leadership competencies in recruitment and appraisal.
The results we are aiming for: • Everyone who needs to can use Trust services. • Individual people's health and care needs are met. • When people use Trust services they are free from harm. • People report positive experiences of Trust services.	**The results we are aiming for:** • Staff are free from harassment, bullying and physical violence. • Staff believe that the Trust provides equal opportunities. • Staff recommend the Trust as a place to work and receive treatment.	**The results we are aiming for:** • Board members and senior leaders demonstrate their commitment to equality, diversity and inclusion. • Board and Committee papers will identify equality-related impacts and how unfavourable effect will be reduced.

Section Two

Our Patients

One of our strategic aims is, 'improved patient access, safety and experience'. We want to continue to create a culture of care based on positive attitudes, towards welcoming the diversity of patients, their families, carers and service users and meeting their diverse needs. As a Trust we will continually look to improve by embedding inclusion into every day practice and at the heart of policy and planning.

This section provides examples of the progress that we have made on each of the patient objectives.

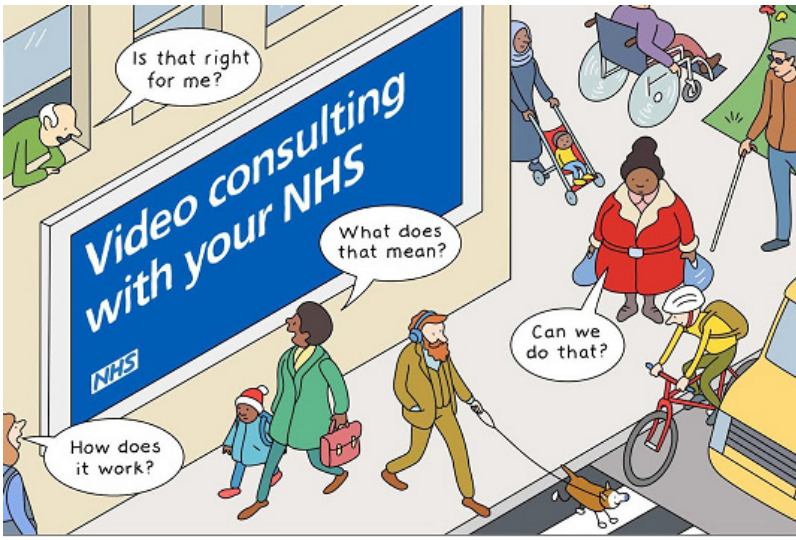
Consider how our decisions will affect equality and reduce unfavourable effects.

Our response to the COVID-19 Pandemic included the roll out of Attend Anywhere, a secure web-based platform which allows patients to access video consultations. Supported by NHS England, Attend Anywhere was rapidly implemented across the Trust services from April 2020 onwards, ensuring patients were seen in the safest way possible during the pandemic whilst also limiting their (and staff) exposure to the virus.

Between May and December 2020, the Trust has held just over 20,000 video consultations with hugely positive feedback from patients, who appreciate being able to have their appointment within the comfort and convenience of their home and reducing the need to take time off work and travel to a Trust site.

The Interpreting and Translation service has been able to support video consultations since the start of the roll out, and services such as Audiology have developed solutions to support D/deaf and hearing-impaired patients in using the platform.

The Trust undertook an equality impact assessment (EQIA) of Attend Anywhere in October 2020 to understand the effect on different groups of patients. As one of the first work streams to have an EQIA completed, the team held two comprehensive workshops for stakeholders to discuss further actions necessary. This has also led to the development of an Outpatients Inequalities Strategy to address the cross-cutting themes from the Outpatient Transformation Programme.



To support the outpatients recovery work the Trust has also introduced two new systems for patient letters: Doctor Doctor and Synertec. These new systems mean that patients who wish can receive their letters digitally through a text message link, and those who would prefer a printed letter can receive it in easy read, braille, or large print.

The Equality Impact Assessment of the systems showed that disabled patients needed to be consulted with to ensure positive impacts were maximised and negative impacts were appropriately mitigated. The team therefore decided to consult with the Disabled People's User Forum, an MFT patient forum that aims to improve the access to, experience of, and quality of health care for disabled people within our hospitals.

Consultation with the Disabled People's User Forum involved members feeding back on their experiences of patient letters at the Trust, the wording of text messages and letters, and testing new digital systems, all with the aim of ensuring the Trust's patient letters are accessible to all. As a result of this consultation with disabled patients the project team could confirm that the system will be accessible to people using screen reading software, adapt the wording of text messages to make them easier to read, and ensure that the system will automatically adjust letters to known accessible information requirements.

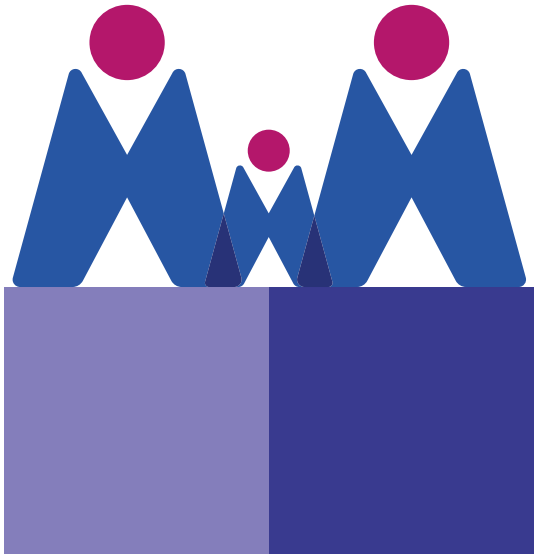
Know who uses our services by equality and their experiences and reduce any differences that we find.

In June 2020, in response to emerging evidence from UK Obstetric Surveillance System (UKOSS), the Chief Midwife for NHS England asked all maternity units to increase their support for Black, Asian and Minority Ethnic pregnant people during the COVID-19 Pandemic.

The evidence indicated that Asian women are four times more likely than White women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely. Maternity units were asked to take the following four actions:

- Increasing support of at-risk pregnant people – making sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in those from a Black, Asian and Minority Ethnic background.
- Reaching out and reassuring pregnant Black, Asian and Minority Ethnic people with tailored communications.
- Ensuring hospitals discuss vitamins, supplements and nutrition in pregnancy with all pregnant patients.
- Ensuring all providers record on maternity information systems the ethnicity of every person, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.

Saint Mary's cares for over 14,000 people each year of which 35% are from Black, Asian and Minority Ethnic backgrounds. A task and finish group was set up led by a Consultant Midwife and a Professor of Obstetrics. Training around the increased risk for pregnant Black, Asian and Minority Ethnic people has been made mandatory for all maternity staff. The task and finish group have ensured co-production of bespoke resources which have been widely shared. Data systems are already in place to capture ethnicity and co-morbidities and this will be further supported with the recruitment of a Digital Champion.



Carry on working towards the Accessible Information Standard.

The Accessible Information Standard (AIS) directs and defines a specific, consistent approach to Identifying, Recording, Flagging, Sharing and Meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a permanent or temporary disability, impairment or sensory loss. The Standard applies to service providers across the NHS and adult social care system, and it aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in decision-making about their health, care and wellbeing.

The Accessible Information Standard Steering Group which is made up of staff from across the Trust, have launched the Trust's AIS Guidelines this year. These Guidelines will help our staff to meet the communication needs of our patients. In addition, a bespoke e-learning module has been created to support staff understanding of the AIS; in October 2020 over 1,250 staff had completed this training.

The Trust provides all the accessible communication professionals that the AIS defines, and the Accessible Information Standard Steering Group have also been working to ensure that the Trust can provide information in accessible formats.

What Matters to Me: Sign Language Spelling Bee

Wythenshawe Hospital's Cystic Fibrosis Inpatient Unit created a 'Sign Language Spelling Bee' - a new staff initiative to improve patient communication and patient experience. The ward has a group of deaf and hearing-impaired patients who communicate via lip-reading or an interpreter. Staff wanted to do more to aid communication with patients, as wearing face masks was hindering their ability to lip read. Ward staff learnt the sign language alphabet and created a fantastic Spelling Bee to encourage one another. The whole of the Cystic Fibrosis and Multi-Disciplinary Team are now involved. You can follow the team on Twitter @PearceWard MFT.

The initiative has improved patient experience through using the sign language alphabet when communicating with patients to ensure patients feel valued, improve patient wellbeing and that the culture of the ward is to listen and respond to feedback.

Make sure that people with learning disabilities and autism receive treatment, care and support.

A case for change to increase the specialist learning disability nursing resource across the Trust has been successful, and Matron reviews take place with patients with learning disabilities and/or autism admitted to hospital. Resources have been identified to support and enable people with learning disabilities and/or autism to access community health services. An e-Learning module on learning disabilities and /or autism has been updated and all staff are expected to complete it. A mental health gateway pathway is in place to improve assessment of patients with learning disabilities for mental health services supported by monthly meetings with representatives from Greater Manchester Mental Health NHS Foundation Trust (GMMH).

The Trust encourages the use of the patient passport for patients with learning disabilities and/or autism and is working to establish consistent systems, processes and documentation. These include flagging for patients with learning disabilities and/or autism in Electronic Patient Records (EPR) and electronic Boards used on wards, supporting reasonable adjustments and best interests' meetings and consideration of capacity.

The Trust has planned a joint Learning Disability Conference with Cheshire and Wirral Partnership at Wythenshawe Education and Research Centre. This was postponed in June 2020 due to COVID-19 but, we are pleased to report, has been rescheduled to June 2021.

Be the first Trust in the country to deliver Pride in Practice. This is recognition from the LGBT Foundation.

The Trust partnered with the LGBT Foundation to deliver a Pride in Practice programme pilot for the first time in an acute Trust. Eight services participated and have now received training and an accreditation of Gold, Silver or Bronze from the LGBT Foundation to show their commitment to providing inclusive services to LGBT patients.

Pride in Practice is a quality assurance programme developed and delivered by LGBT Foundation. The programme was originally designed to support primary care services to strengthen and build their relationships with LGBT patients. The delivery of the Pride in Practice programme pilot at the Trust comprised training, a supported assessment and the accreditation of each department taking part. The pilot was successful in its aim to adapt the existing Primary care model to meet the needs of acute services, Pride in Care. In the coming year the Trust will continue to work together with the LGBT Foundation to further use the findings of the pilot to deliver the Pride in Care Programme across the Trust.

Make our way-finding and signage easier.

AccessAble
Your Accessibility Guide

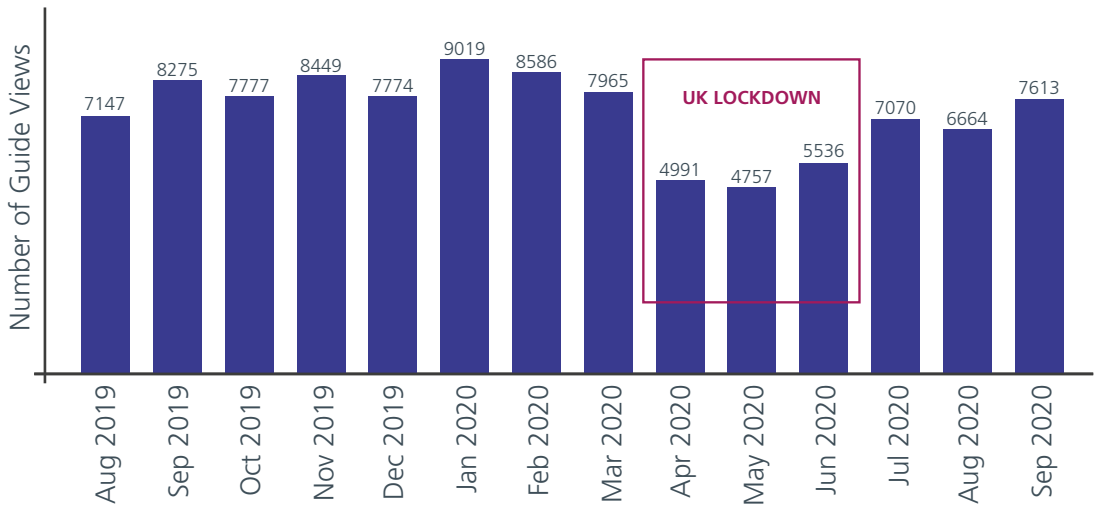
There are 13.3 million disabled people and 4.5 million carers in the UK. In a healthcare context a large proportion of patients and visitors will have accessibility requirements, either on a permanent or temporary basis; and many of our staff have access needs.

A lack of information on accessibility that is easy to understand, may mean people do not try to access a service at all or that they have poorer experiences of services when they do. For example, if a disabled service user knew in advance that a doorway was too narrow for their wheelchair, that a toilet had a transfer space on the wrong side for them, or that there was no assistive listening, then they could have a conversation before they attend to agree how the service could reasonably be adjusted. However, if there is no information accessible beforehand, it is not possible to make these arrangements before the service user attends.

In 2018, the Trust launched 404 online access guides that provide information about access in and around services to support our disabled patients to access those services. The guides include measurements, facts and photographs. Each guide is created and updated through an in-person assessment by a trained AccessAble surveyor. All the data included in the guides is useful to disabled people with all different needs and perspectives.

Since August 2019 we have been monitoring the use of the AccessAble online guides and the table below shows the total number of access guide views for all nine Trust sites from August 2019 to September 2020. On average, over the past 14 months, The Trusts access guides were viewed 7259 times a month. To make sure that the guides are up to date and show all the right information, they are checked each year and any small changes can then be made to update them.

Total Number of MFT Access Guide Views (ORC/WTWA)



Section Three

Our Staff

One of our strategic aims is, 'a representative and supported workforce'. The Trust will be an employer of choice that recruits and develops staff fairly, taking appropriate action whenever necessary, so that talented people choose to join, remain and develop within the Trust. Strong equality, diversity and inclusion at all levels will underpin consistently good patient care across all services.

This section provides examples of the progress that has been made on each of the staff objectives. As may be expected, the focus has been on supporting staff during the pandemic.

Consider how our decisions will affect equality and reduce unfavourable effects.

In response to the evidence published regarding the disproportionate impact of COVID-19 on people from Black, Asian and Minority Ethnic backgrounds, the Trust took swift action to review its risk assessment approach that was already in place for supporting other vulnerable groups. The review involved staff from Black, Asian and Minority Ethnic backgrounds and the approach was revised to include Black, Asian and Minority ethnicity to be considered 'at-risk' and 'vulnerable' to COVID-19.

A self-assessment was produced to enable staff to consider their risk factors and open up conversations with managers. The self-assessment is also included in on-boarding new staff. As part of the long-term digital solution to recording risk assessments, the Trust used the Empactis System to review and support staff on an on-going basis and to help to continue those important conversations.

A COVID-19 Black, Asian and Minority Ethnic Engagement Group was established of staff from across the Trust, in different roles and bands, to inform and shape the support to staff during the pandemic. The Group developed a communications campaign including letters to all staff, vlogs, posters and other resources to encourage uptake of self-assessment and risk assessment, about the importance of risk assessment, addressing myths as well as how Personal Protective Equipment can be used to feel safe in work. The result is that the uptake of risk assessment is consistently above 97%.

The Trust is building on the success of the COVID-19 Black, Asian and Minority Ethnic Engagement Group and is establishing a COVID-19 Disability Engagement Group and a COVID-19 LGBT Engagement Group to understand the issues for diverse staff groups and put in place approaches to safeguard their health and wellbeing. The purpose of the engagement groups is to ensure that workforce initiatives aimed at protecting and supporting staff during COVID-19 are informed by and co-produced with staff.

The groups provide a way of rapid design when needed, working with diverse staff groups as an equal expert. They provide a way of understanding the concerns of diverse staff groups, a way of escalating issues and act as advocates to disseminate communications. The engagement groups report through to the Trust's Strategic Group/Executive Leadership Team as illustrated in the diagram below.

Know who our staff are by equality and their experiences and reduce any differences that we find.

The Trust conducted a COVID-19 Staff Survey to further understand staff experience during the pandemic. The Survey asked about:

- Risk Assessments.
- Personal Protective Equipment.
- Staff testing.
- Employee Health and Wellbeing.
- Freedom to Speak Up Campaign.
- What has done well and what could be improved.

3,122 (13%) staff completed the survey. The survey indicated that some staff:

- Had not noticed or understood the letter about risk assessment.
- Had questions about impact on career of having a risk assessment.
- Had questions about the level of clinical knowledge needed to complete a risk assessment.
- Had questions about storage of records.
- Had questions about Personal Protective Equipment for different areas.
- Had questions about how to speak up about work environment.

The results of the Survey informed the communications campaign that was co-produced with the COVID-19 Black, Asian and Minority Ethnic Engagement Group as follows:

- Follow up letter sent directly to staff from Black, Asian and Minority Ethnic backgrounds.
- Posters raising awareness about risk assessments.
- Executive Blogs about risk assessments and Freedom to Speak Up Campaign.
- Email cascade from Medical Directors and Nursing.
- A video; simple training video on risk assessment for managers.
- Monitoring of the up-take of risk assessment.

The COVID-19 Black, Asian and Minority Ethnic Engagement Group continues to provide the lived experiences of staff that informs priorities and shapes responses to them.

Take a zero tolerance approach to bullying, abuse and harassment.

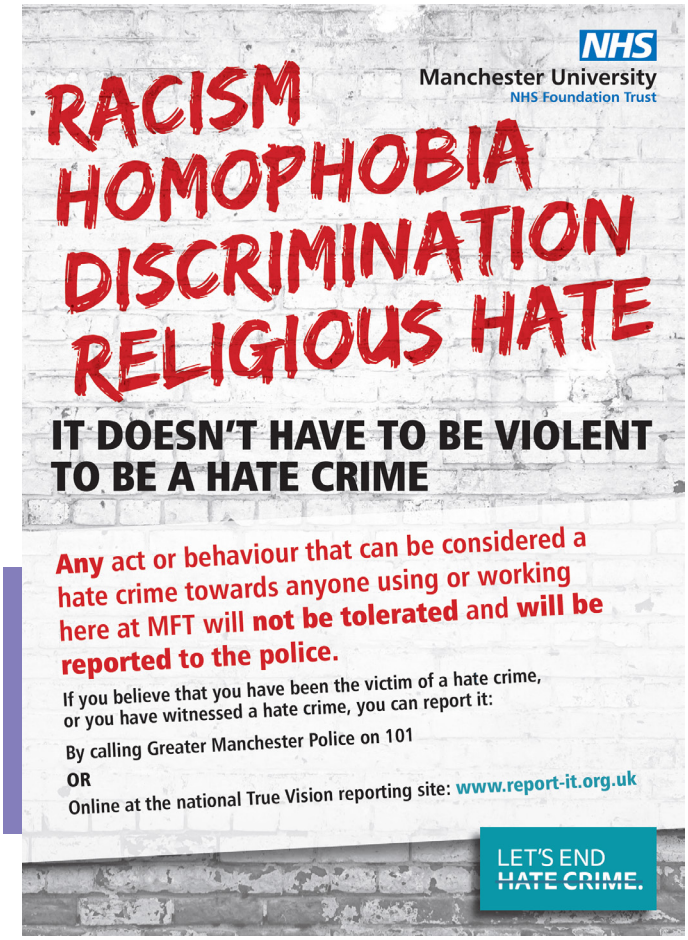
The Trust is part of a Greater Manchester Partnership hate crime reporting centre. The Hate Crime Reporting programme has been launched and hate crime reporting procedures rolled out across the Trust supported by training on recognising hate crime and what to do if staff witness hate crime.

The Trust's diversity networks are engaged to examine potential for leading on providing support for duty of care procedures for staff involved in reporting or who are victims of hate crime.

The Safeguarding Team are developing hate crime reporting awareness training to Safeguarding Champions and meeting Trust safeguarding requirements for patients and staff.

The Risk Management Team are looking at how existing reporting mechanisms may be amended to allow data collection of any recorded incidents of hate crime on the Trust site, and added to the new Incident reporting form to allow recording of possible hate crime.

The Trust security provider partners, Sodexo, are examining options for how hate crime reporting methodology links to current practice around dealing with criminality on site.



Work towards being a Disability Confident Lead employer.

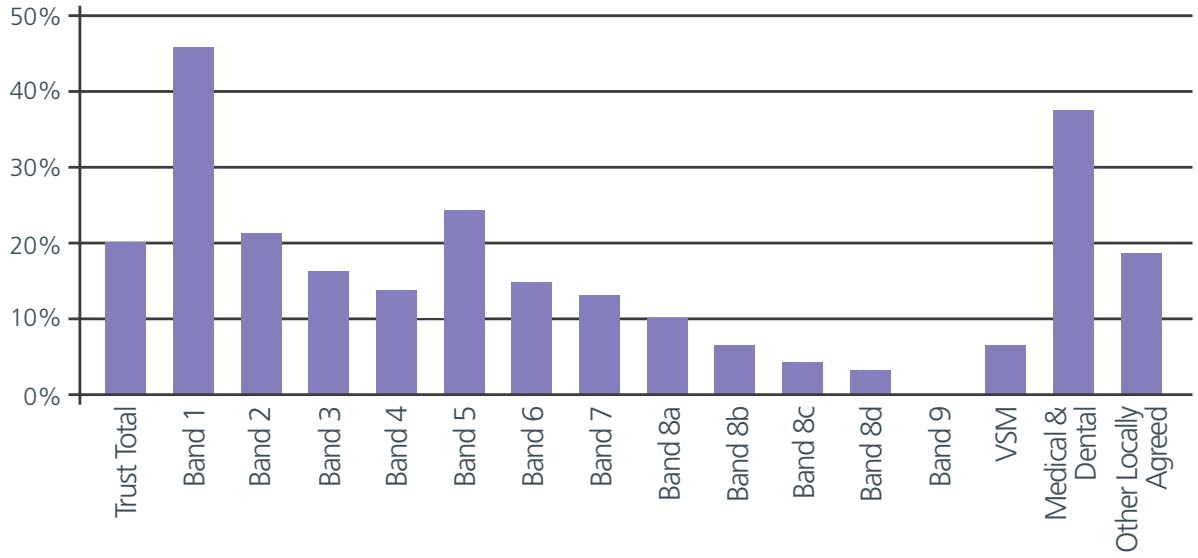
The Trust is a Disability Confident Employer. This means that the Trust actively looks to attract and recruit disabled people, through an inclusive and accessible recruitment process, offers interviews to disabled people who meet the minimum criteria for the job, is flexible when assessing disabled job applicants in order that they can demonstrate their ability to fulfil the role, proactively offers and makes reasonable adjustments as required and provides work experience to disabled people.

However our Workforce Disability Equality Standard has shown there is more that we need to do. That is why this year we have partnered with Manchester Health and Care Commissioning and Manchester City Council to develop a system wide approach to reasonable adjustment. The organisations attended workshops delivered by the Business Disability Forum where we explored the key issues to workplace reasonable adjustments. The next step over the next 12 months is to develop a reasonable adjustment policy that will be led by the COVID-19 Disability Engagement Group with support from the Business Disability Forum.

Increase ethnic diversity at Board and senior management levels.

The Trust's Workforce Race Equality Standard (WRES) Report highlights that the overall ethnic diversity of the Trust is increasing year on year and reflects the Greater Manchester population. However, the Trust is significantly less diverse at Agenda for Change (AfC) bands 8a and above as illustrated in the chart below. These results are reinforced by Staff Survey data, in which staff from Black, Asian and Minority Ethnic backgrounds are less likely to say that the Trust provides equal opportunities for career progression or promotion.

MFT Black, Asian and Minority Ethnic Workforce Profile by Band



The Trust has developed the Removing the Barriers Programme (the Programme) to increase the ethnicity diversity of the workforce at bands 8a and above in consultation with the, then, Black, Asian and Minority Ethnic Network.

The Programme is comprised of action in four areas across the employee life cycle as follows:

- Workforce planning and culture.
- Attraction and recruitment.
- In-role leadership development.
- Talent Management.

The progress made on the Removing the Barriers Programme to date includes:

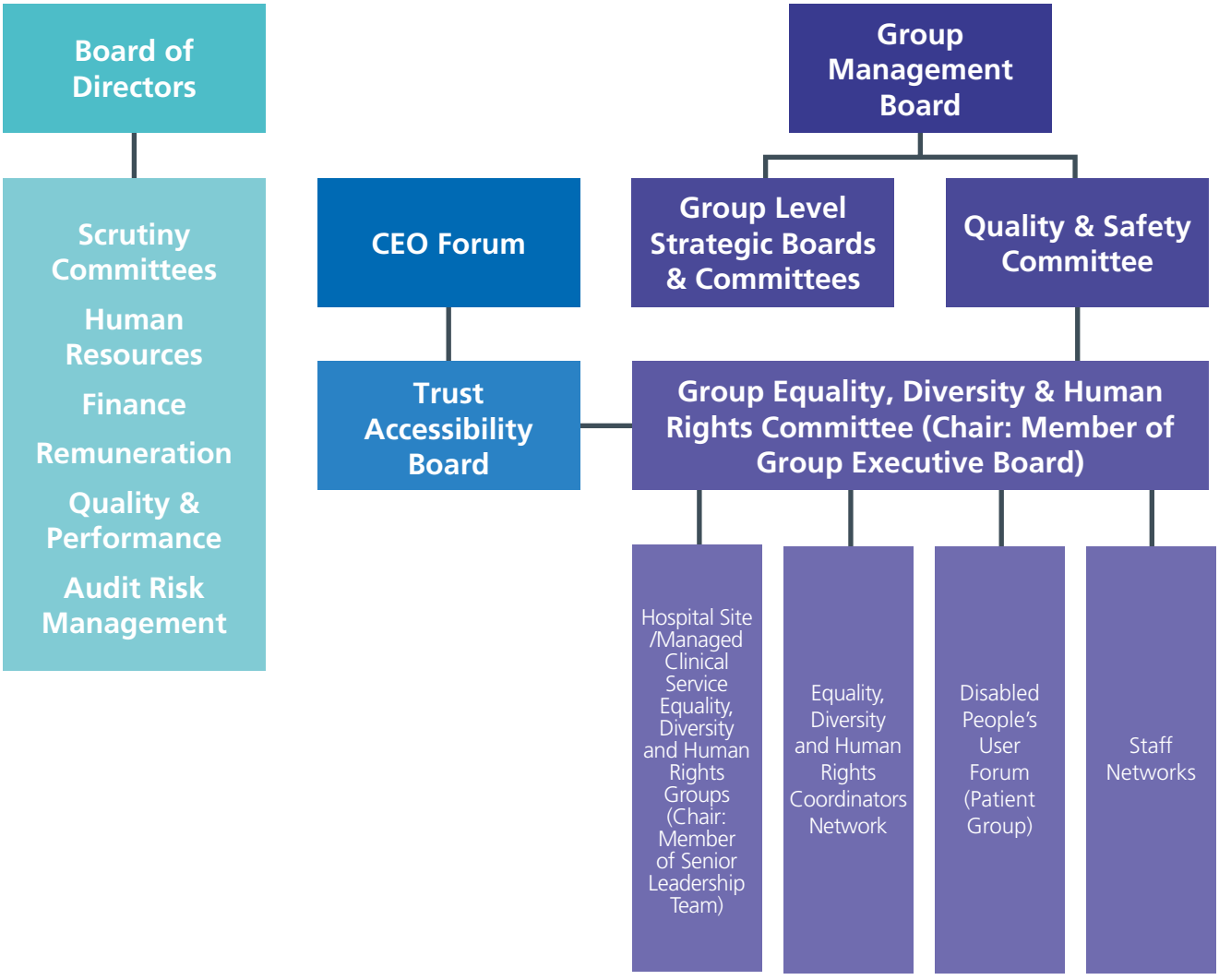
- The Trust's Attraction Strategy, 'All Here For You' has equality, diversity and inclusion embedded in it to enure that the campaign reflects the diversity of the communities the Trust serves.
- A Diverse Recruitment Panel's Scheme has been successfully piloted and implemented as a mandatory requirement for recruitment to roles at band 8a and above. To date over 20 interviews at band 8a and above have been supported since becoming a requirement in September 2020.
- A Reverse Mentoring Scheme has been piloted and is now transitioning into business as usual. Over 30 members of the Trust's senior leadership have signed up to the Scheme.
- Five staff members are on a bespoke development scheme at roles band 8a and above.
- Engagement targets are set with senior leadership and a collaboration hub is established to engage colleagues on developments.

Section Four

Inclusive Leadership

One of our strategic aims is 'inclusive leadership". The Trust will be recognised as a vanguard for equality, diversity and inclusion creating organisational and system wide changes to improve equality outcomes for patients their families and carers, service users and staff.

The Trust's equality, diversity and human rights governance structure shown below is built on the principle of leadership and inclusion. It includes a Group Equality, Diversity and Human Rights Committee (GEDHRC) that reports to the Group Quality and Safety Committee. The GEDHRC receives reports from the Hospital/Managed Clinical Service and Local Care Organisation Equality, Diversity and Inclusion Groups, the Equality and Diversity Coordinators, Staff Diversity Networks as well as the Disabled People's User Forum (patient group).



Diverse Representation in Command and Control

The Trust was committed to ensuring diverse representation in its COVID-19 command and control governance structure. Expressions of interest were sought from staff from Black, Asian and Minority Ethnic backgrounds and 70 staff came forward to contribute to the leadership of the Trust in managing the Pandemic response. As a result, opportunities were opened to join recovery work streams as well as command and control enabling the Trust to benefit from their skills and experiences. The experiences of some of the staff are illustrated in the quotes below.

I am a Senior Cardiac Radiographer in Clinical Scientific Services (CSS). I am a member of the CSS Operational Excellence Group. The Group provides scrutiny of operational matters in order to raise concerns to the Board. Ensures corrective action has been initiated and managed regarding to COVID 19. It provides assurance in operational performance and activity planning. I feel honoured being a member of the Group. It enables me to pass on information to my colleagues from Black, Asian and Minority Ethnic backgrounds. To raise concerns. And to support our the Group to understand the issues that colleagues from Black, Asian and Minority Ethnic backgrounds may face.

So far it's been a great insight into what the Trust finance team do "behind the scenes". Ample opportunities to ask questions and detailed responses are given.

Inclusive Leadership Training

The Trust has partnered with Pearn Kandola (PK) to deliver inclusive leadership training to senior leaders from across the Trust. The sessions will introduce the competencies and behaviours that inclusive individuals demonstrate on a daily basis, provide participants the opportunity to reflect on their own strengths and risks, and give leaders an opportunity to plan what changes they wish to make to their own leadership style. Leaders will be invited to:

- Commit to continuing own learning on equality, look for opportunities to increase own awareness and understanding.
- Make time to talk to diverse staff groups to understand their diverse experiences and engage diversity about what needs to change.
- Secure diverse representation on decision making structures.
- Be open to diverse views and role model that open culture.
- Develop rationale for work on and commitment to equality and communicate it consistently and regularly.
- Create opportunities for discussing equality within their hospital, managed clinical service, community services and corporate services.
- Proactively look for opportunities to visibly lead on equality for example by celebrating successes.
- Visibly lead on behaviours and challenge inappropriate behaviours.
- Take positive action to recruit a diverse leadership.

North West Equality, Diversity and Inclusion Leads' Network

The Trust recognises the importance of working in partnership to deliver the best quality care for patients and staff. One of our partnerships is as part of the North West Equality, Diversity and Inclusion Leads' Network co-chaired by the Trust's Assistant Director of Equality, Diversity and Inclusion. The Trust was instrumental in championing the Better Together initiative to create capacity within the North West NHS Equality and Diversity community.

The Trust led on an initiative to produce a compendium of key performance indicators and guidance on using them. The Compendium brings together NHS workforce equality reporting requirements into one place and includes Network members' learning from producing and using the reports. The compendium has been rolled out and well received by Network members, particularly those newer to the NHS and/or leading on equality, diversity and inclusion.

Section Five

Celebrating Diversity

The Trust recognises that it is important to share and celebrate the diversity of our communities. It is this diversity that makes us stronger. We are all unique and individual and by celebrating diversity we seek to understand and celebrate each other's differences. It means creating an environment where we can all be ourselves, and creates a culture where we are able to embrace and benefit from the rich knowledge, experience and skills of our diverse population.

Virtual Pride 2020

This year saw Pride Festivals across the country moved to virtual Prides. Our Trust also took part. The Group Equality and Diversity Team, alongside the Trust's LGBTQ+ Staff Network organised various events to mark and celebrate the month. The LGBTQ+ Staff Network launched a new virtual zone for members on the Learning Hub. This virtual space offers a place where members can meet virtually to connect and access up to date resources from a range of organisations. Staff added a virtual Pride Flag to their email signatures. The Pride Flag was raised on the flagpole outside Manchester Royal Infirmary. Pride flags were also distributed around the Trust to be displayed to visibly support LGBTQ+ inclusion, as can be seen in these photographs and articles from LGBT colleagues and allies were also published in the Trust's weekly newsletter, MFTiNews sharing what Pride means to them.

South Asian Heritage Month

South Asian Heritage Month was launched for the first time at the Trust in 2020 and runs annually between July 18th and August 17th. It aims to raise the profile of South Asian heritage and history in the UK through education, arts, culture and commemoration. The Trust celebrated with online blogs and vlogs from staff of South Asian origin. Dr Binita Kane, a Consultant at the Trust and co-founder of the month said, "MFT have a huge number of staff from the eight countries of South Asia, from doctors and nurses, to porters, pharmacists, domestic staff and more. It is estimated that up to 30% of the NHS workforce is of South Asian origin and many of us have parents and grandparents who helped to build the NHS from its inception. The month is about reclaiming British-South Asian identity, getting our stories heard but also provides a space to discuss issues that affect South Asian communities".

Black History Month

Black History Month each October, gives recognition to the contributions of black people in all aspects of life in the UK and joyously celebrates African, Caribbean and black British culture. The Trust celebrated with a month long programme of events and resources including:

- A Black History Month-Resource Pack.
- Books donated by Amazon and WHSmith available in the Trust's libraries.
- Equality Talks; a series of virtual workshops on the subjects of, 'What it means to be non-racist and to be anti-racist', 'The Impact of COVID-19 on people of African and Caribbean backgrounds' and 'Workforce race inequalities and inclusion in NHS providers'.
- Movers and Shakers; A series of vlogs showcasing the outstanding contributions of Black, Asian and Minority Ethnic staff, their experiences of career development, hopes and aspirations.
- Events were closed by a choir, who delivered an amazing and uplifting virtual performance as the Trust ended the month on a high note.

Making Histories e-book

2020 has been an unprecedented year in which the NHS has been challenged by COVID-19 on a scale and at a pace not previously seen. The Trust serves amongst the most diverse communities in the country, which is reflected in the Trust's workforce. Coming out of South Asian Heritage Month and Black History Month, staff from Black, Asian and Minority Ethnic backgrounds have shared their personal stories the Making Histories e-book. It is a celebration of the contributions of our Black, Asian and Minority Ethnic staff, which speaks of passion and commitment to caring for patients, to the Trust and to the NHS.

[You can view the Making Histories e-book by clicking here.]

Disability History Month

The 18th November to the 20th December 2020, was Disability History Month (DHM) and this year's national theme was, 'Access'. The month opened with a video of patients and staff talking about why Access Matters:

https://vimeo.com/264582281/05aadea234

This year, staff took the opportunity to share what the month means to them. If you would like to view the vlogs please use the links below:

https://vimeo.com/488127975/759469d17e

https://vimeo.com/488128277/b196e1387a

Other activities included:

- Disability e-learning.
- Guidance on hearing loops.
- Guidance on Access to Work.
- Access Guides.

The Trust is committed to creating a disability-inclusive environment for our people and our patients. We subscribe to the social model of disability. The social model focuses on the social and institutional barriers which restrict disabled people's opportunities. The social model sees the person first and argues that the barriers they face, and not their impairments, are what cause them to be disabled.

Barriers can make it impossible or very difficult to access jobs, buildings or services. Still, one of the biggest barriers is attitudes to disability. The social model says removing the barriers is the best way to include millions of disabled people in our society. Someone with mobility impairment, for example, becomes disabled when they encounter a building or service that's inaccessible to them due to the way it's been designed.

Section Six

Governance

The Trust's equality, diversity and human rights governance includes a Group Equality, Diversity and Human Rights Committee that reports to the Group Quality and Safety Committee, the Workforce and Education Committee and to the Human Resources Scrutiny Committee. The chair of the Human Resources Scrutiny Committee is the Board Diversity Champion, John Amaechi OBE.

The Board Diversity Champion

John Amaechi OBE

John not only brings a passion for equality, diversity and inclusion, but a wealth of experience to help challenge the organisation to think creatively about inclusion. As well as being one of our non-executive directors, John is an organisational psychologist and a high performance executive coach. He is also a New York Times best-selling author and a former NBA basketball player. John is also sought-after for his contribution to helping brands understand how to energise and use cause marketing and corporate social responsibility as a client and personnel engagement tool. In the UK, John has his own charitable sports and community centre with more than 2,500 young people per week going through its doors receiving schooling in sport, leadership and life skills.

Group Executive Director Workforce and Corporate Business Group Executive Lead for Equality, Diversity and Inclusion

Peter Blythin

I am passionate about the Trust's equality, diversity and inclusion agenda, which we can achieve by working together to deliver *Diversity Matters*. Promoting equality, diversity and inclusion are at the heart of our Trust values. They are all about bringing people together, to focus our efforts on creating an inclusive culture, to advance workplace equality and to deliver person-centred care. Our attention to *Diversity Matters* has been strengthened this year in part because of the Covid-19 Pandemic. The implementation of robust risk assessment processes and the establishment of the COVID-19 Black, Asian and Minority Ethnic Reference and Engagement Groups has helped to inform and shape the support for staff during the Pandemic. In this context the Trust has built on the success of these groups by establishing LGBTQ and Disability Engagement Groups.

This year's Black History Month celebrations, which, despite the Pandemic. was a month long celebration. It included weekly staff vlogs about their lived experiences and contributions from allies about what Black History Month means to them. Weekly virtual Equality Talks, books donated by Amazon and WH Smith that are in our libraries, a Resource Pack to facilitate conversations about race equality, and culminating in a closing event launching our Black, Asian and Minority Ethnic Staff Network were also included. All brought to a close by a Trust choir, who were truly outstanding.

Removing the Barriers, our programme for increasing diversity at senior levels, including our hospitals, managed clinical services, community and corporate services setting targets has progressed this year. Plans have moved into practice as we continue to foster a culture where colleagues from all backgrounds can flourish. I am committed to continuing to lead the advancement of an inclusive culture at the Trust based on positive attitudes towards welcoming the diversity of patients, theirfamilies, carers and meeting diverse needs, where all staff feel that they belong and are valued.

I look forward to working with staff across the Trust especially our Staff Networks to *Diversity Matters* so MFT is one of the best places to work and receive care.

Joint Group Medical Director
Chair Group Equality, Diversity and Human Rights Committee

Toli Onon

It is a great privilege for me to chair our Group Equality, Diversity and Human Rights Committee (GEDHRC) at the Trust. This is a committee working to promote the best environment across the Trust in which our passion for equality, diversity and human rights can flourish. We want to make a critical contribution to our Trust, such that the care we provide to all our service users is of the highest quality and safety – and the workplace for our dedicated staff assures their safety and personal development, too. Therefore our GEDHRC is a sub-committee of the Group Quality and Safety Committee, and through that route we provide assurance to our Board of Directors.

We want our committee to truly make a difference – to patient outcomes, access and experience; to staff working lives; and to support the organisation in delivering ever-better care to our local population and those who travel far to use our services. This great city-region of Manchester and its surrounding counties, is one of the most diverse parts of the country. What an honour for the Trust to serve such a population! There is so wide a variety of characteristics, beliefs and experience amongst our patients and staff – a diversity that deserves respect and from which much can be learned. As the GEDHRC, we have a duty to harness our authority and influence to drive change through application of the Trust's Equality, Diversity and Inclusion Strategy; to oversee new Group-wide initiatives aligned to the strategic aims of the Trust; and to ensure we have the right processes and organisational structures in which all can perform at their best.

Most important of all, we want a culture in which the full spectrum of diversity is valued – a culture in which all patients are treated with respect and personalised care, all staff are supported to reach their potential; and we are not afraid to challenge those who denigrate our values. Diversity comes in many forms – diversity of faith, of physical and intellectual ability, of sexuality and gender, of race and culture, of age and language – and every one of us, should be valued for our characteristics and positive choices.

The genuine delivery of 'equality, diversity and human rights' really matters to me, because I personally have gained so much through others' respect for those values. I am the child of refugees from a war zone – my parents escaped from repressive revolution to democracy. Thanks to the great nations who gave them citizenship, liberty and residence, I was born into an environment where I could flourish. I encountered so many people who believed in equality, celebrated diversity and respected human rights; and I thank them for what they did for me. Everyone has the right to celebrate their diversity, everyone deserves equal access to opportunity, and in the community of the Trust we all have an obligation to support each other.

We have seen in 2020 how there are still too many inequalities in our society, and how much work is still to be done to alleviate disproportionate impacts on the health and wellbeing of so many. The relevance of our committee is beyond dispute; the challenge for us, is making the most of our opportunity to contribute to the Trust's wider effort to reduce healthcare inequality and drive up standards of care to our most vulnerable patients.

We are a great organisation in a great city – that's not to say we can't do better – of course we can! But we can take pride in all that has been achieved in these challenging times, and commit ourselves with humility to taking the next steps. This report describes what has already been done, and demonstrates our platform for the next stage in the journey to a fairer, more equitable and proudly-diverse organisation.

Group Equality, Diversity and Human Rights Committee (GEDHRC)

The Group Equality, Diversity and Human Rights Committee (GEDHRC) is a sub-committee to the Group Quality and Safety Committee.

The GEDHRC has a strategic role rather than an operational function. In this context it will work to promote the culture and positive conditions for equality, diversity and human rights to flourish within MFT. The Committee will identify and share good practice from within and out with the Trust. It is also expected to oversee the development and implementation of approaches that require group wide consistency.

The Committee will provide assurance to the Group Quality and Safety Committee and through that Committee to the Board of Directors.

The scope of the GEDHRC includes patient outcomes, access and experience and include responsibility for all relevant workforce matters. The specific duties are:

- Advise on strategy development and oversee the continuous improvement of standards of quality and safety for the diversity of the Trust's patients and staff.
- Shape the strategic direction and priorities for equality and diversity and drive change through application of the Trust's ED&I Strategy.
- Oversee the development and implementation of group wide initiatives aligned to the high-level strategic aims of the Trust.
- Manage and report on the equality and diversity risk register.
- Take account in driving strategic change of specific equality and diversity statutory and contractual duties including;
  - » Equality impact assessment
  - » Equality monitoring
  - » Equality Delivery System 2
  - » Accessible Information Standard
  - » Workforce equality and diversity including Workforce Race Equality Standard and Workforce Disability Equality Standard
  - » Links to CQC
  - » Learning and development.

Hospital, Managed Clinical Service, Local Care Organisation and Corporate Services Equality Diversity and Inclusion Groups

Our hospitals, managed clinical service, local care organisation and corporate services each have an equality, diversity and inclusion group. The Groups promote inclusive cultures across their services to improve access to and experiences of services and working at the Trust. The Groups lead on development and oversight of improvement plan drawn from the annual Equality Delivery System assessment. The Groups also oversee:

- Equality impact assessment
- Equality monitoring
- Accessible Information Standard
- Access Able Access Guides
- Workforce equality and diversity plans
- Equality and Diversity Week.

The Groups make recommendations and escalate issues to the Group Committee and their Executive.

Equality and Diversity Coordinators

The Trust has a network of talented and dedicated Equality and Diversity Coordinators within our hospitals, managed clinical services, community services and corporate services. Our Coordinators:

- Actively promote, celebrate and raise awareness of equality, diversity and inclusion (EDI) issues.
- Support and encourage engagement in all equality and diversity initiatives.
- Share and promote best practice.
- Engage and communicate regularly with staff at a local level on matters concerning EDI.
- Act as a local resource / point of information on EDI.
- Co-ordinate the Equality Delivery System (EDS) self-assessment at local level.

Disabled Patients' User Forum

The purpose of the Disabled People's User Forum is to listen to the views and experiences of disabled patients and enables them to influence decision making within the Trust's hospitals. This influence aims to improve the access to, experience of, and quality of health care for disabled people within our hospitals.

The Disabled People's User Forum has a pan-disability membership that meets four times a year to discuss projects and initiatives at the Trust. This year the Forum has consulted on:

- Outpatient letter standardisation and digitalisation.
- Text message appointment reminders.
- Outpatients Recovery.
- Implementing the Accessible Information Standard.
- Way finding.
- Midwifery Disability Advocates.
- Changing Places Facilities.

LGBT+ Staff Network

The Trust's LGBT+ Staff Network was formed in 2019 and has continued to grow with over 500 members including allies. This year the Network supported the distribution of over 5000 rainbow badges across the Trust. This means that over 5000 staff accessed learning resources and made a pledge to support LGBT+ inclusivity to earn their Rainbow Badge.

With the restrictions of COVID-19, the Network quickly adapted to ensure it could continue to support and engage its members by introducing a virtual meeting area on the MFT Learning Hub. The offer of virtual meeting spaces meant that members have been able to continue to access peer support.

NHS
Manchester University
NHS Foundation Trust

LGBT+ Staff Network

Black, Asian and Minority Ethnic Staff Network

The Trust's Staff Network Black, Asian and Minority Ethnic Staff Network launched on 29th October 2020. Over 260 staff had signed up to membership with 24 colleagues on the Network Committee to run the activities and progress the development of the Network.

The Network will create a community for staff to connect with each other, share their lived experience, knowledge and diverse ideas to help drive change to support the Trust to be the best place to work. The key aims of the Network are:

- Build a sense of community across geographical boundaries.
- Provide opportunity where members may share experiences.
- Provide support, guidance and signposting where appropriate.
- Enable staff to feel that they are part of and have a vital role to play in the Trust.
- Assist the Trust in formulating new and reviewing existing policies and procedures.
- Disseminate best practice and ideas to Network members and beyond as appropriate.

Meet the Equality, Diversity and Inclusion Team

The Equality, Diversity and Inclusion Team is responsible for leading on developing and delivering and reviewing *Diversity Matters*, the Trust's equality, diversity and inclusion strategy 2019-2023 in order to promote the culture and positive conditions for equality, diversity and inclusion to flourish within the Trust.

The Team:

- Translates national advice, guidance, standards and legislation into Trust policy and practice.
- Provides advice and assistance on practice, contact equality@mft.mhs.uk
- Provides advice, assistance and quality assurance on equality impact assessment, contact equality@mft.nhs.uk
- Creates and runs programmes of work with hospitals, managed clinical services and community services.
- Creates resources, you will find these on the equality page of the staff intranet site.
- Creates learning resources that you will find on the Learning Hub, search equality.
- Runs communication campaigns.
- Analyses the Trust's performance on service and workplace equality, diversity and inclusion and translates this into continuous improvement actions.
- Benchmarks with other Trusts and organisations to bring the best pf practice into the Trust and to share Trust practice.
- Produces the Trust's statutory reports. You will find these reports on the Trust's website.
- Runs a Disabled Patients' User Forum, contact equality@mft.nhs.uk
- Supports staff networks, you will find information about these on the equality page of the staff intranet site.
- Supports Equality, Diversity and Inclusion Groups in hospitals, managed clinical services and community services.
- Partners with organisations in Manchester. Greater Manchester and the North West and beyond to work in systems.

The Team includes:

- Assistant Director, Equality, Diversity and Inclusion
- Equality and Diversity Lead
- Inclusion Programme Manager
- Community Partnership Manager
- Advice, Governance and Information Manager
- Equality and Diversity Advisor
- Equality and Diversity Project Support Office

Conclusion

To deliver the Trust's equality, diversity and inclusion ambition, a four-year road-map was developed as part of *Diversity Matters*. The road-map is intended to identify the implications of the Strategy for the Trust's hospital and managed clinical services, community and corporate services. The Trust is on track to achieving its first year's actions outlined in the road-map. The actions that the Trust needs to focus on where more progress is needed over the coming year includes an approach to reducing the incidence and impact of bullying, harassment and abuse in addition to the second year's actions of the road-map outlined in *Diversity Matters*.

Annex 1

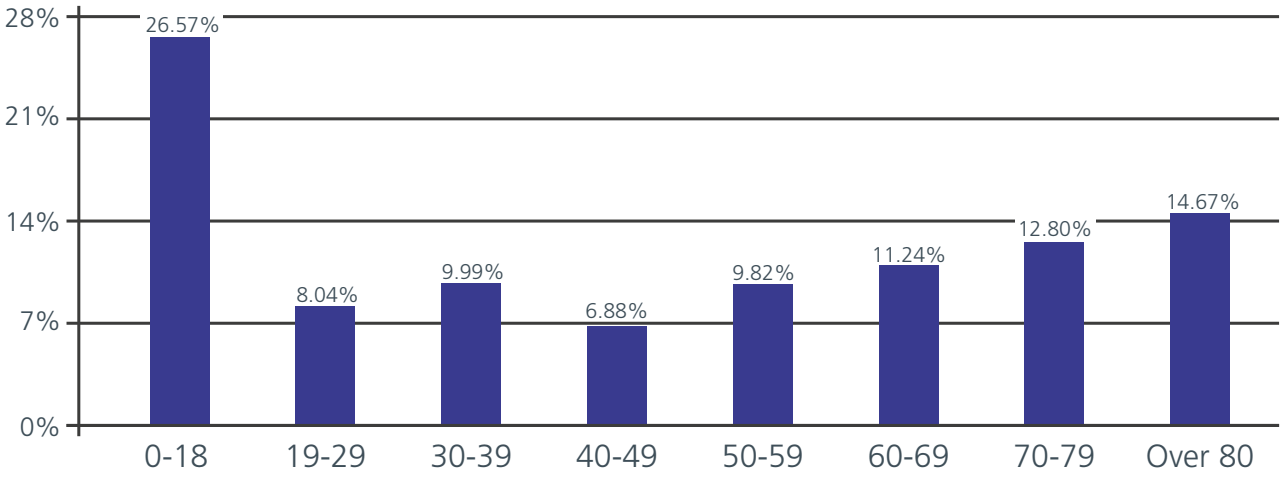
The Diversity of Our Patients

The Trust recognises that the diverse communities we serve and each individual who uses our services has different needs and that in order to provide safe and effective care, it is important to create an inclusive and accessible environment. It is our responsibility to meet those needs and ensure each service user receives fair care and treatment which is person-centred.

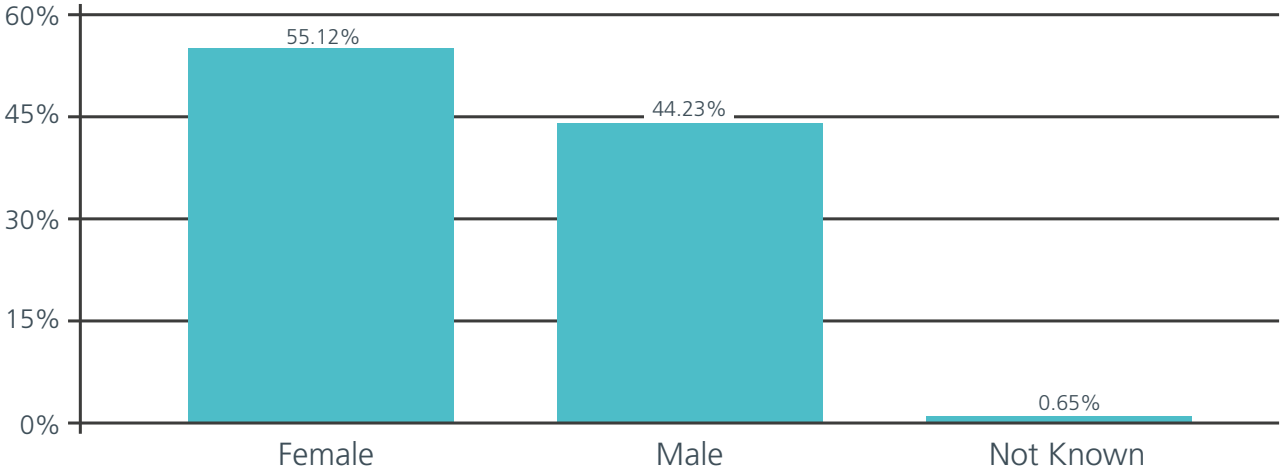
For the purpose of this report some categories have been grouped under the title of 'Not Known', this includes unassigned, NULL and no data categories. The introduction of the Hive EPR Programme will ensure that service equality monitoring and the categories for monitoring are consistent and reportable across all services. The implementation of the Hive EPR Programme will be followed by training and resources to improve staff confidence with equality monitoring.

The following charts provide information detailing the diversity of our service users in 2020 by the protected characteristics currently collected across each of our sites.

Age


28%
21%
14%
7%
0%
26.57%
8.04%
9.99%
6.88%
9.82%
11.24%
12.80%
14.67%
0-18
19-29
30-39
40-49
50-59
60-69
70-79
Over 80

Sex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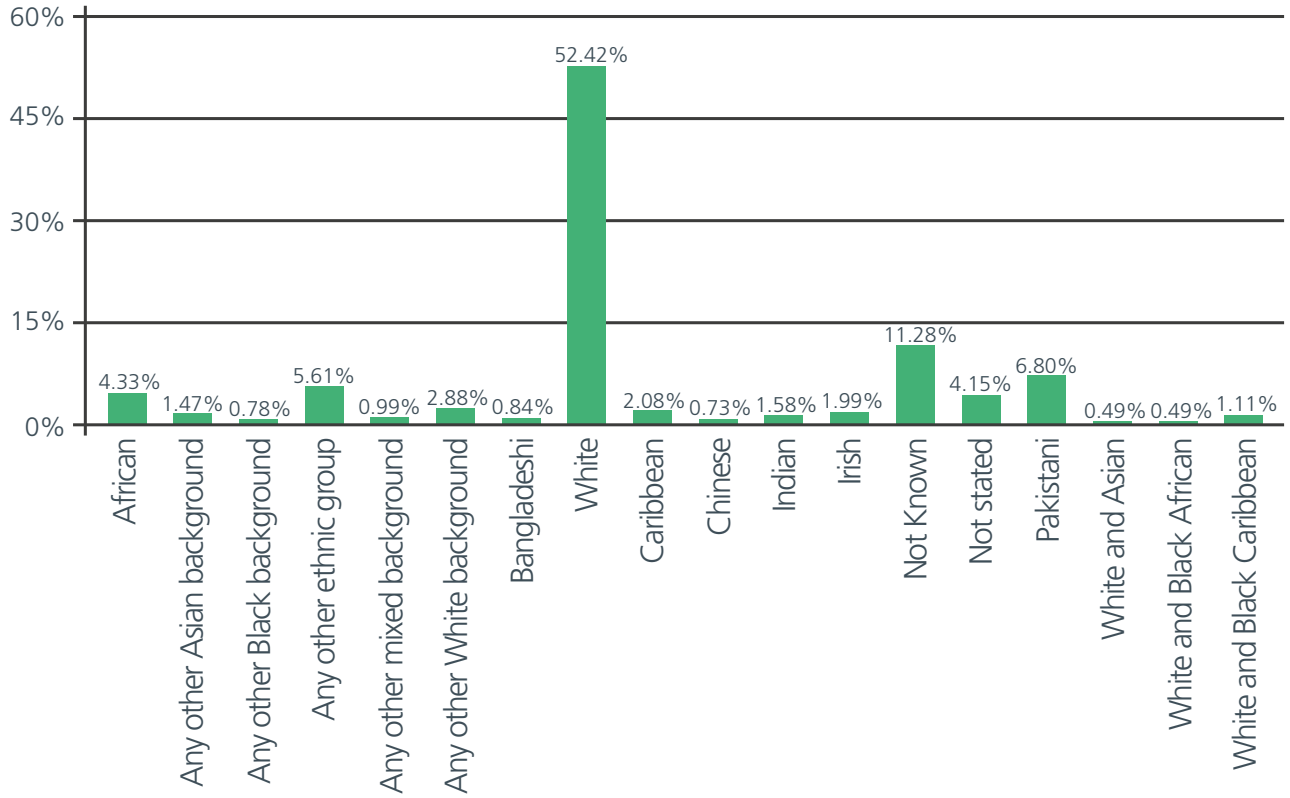
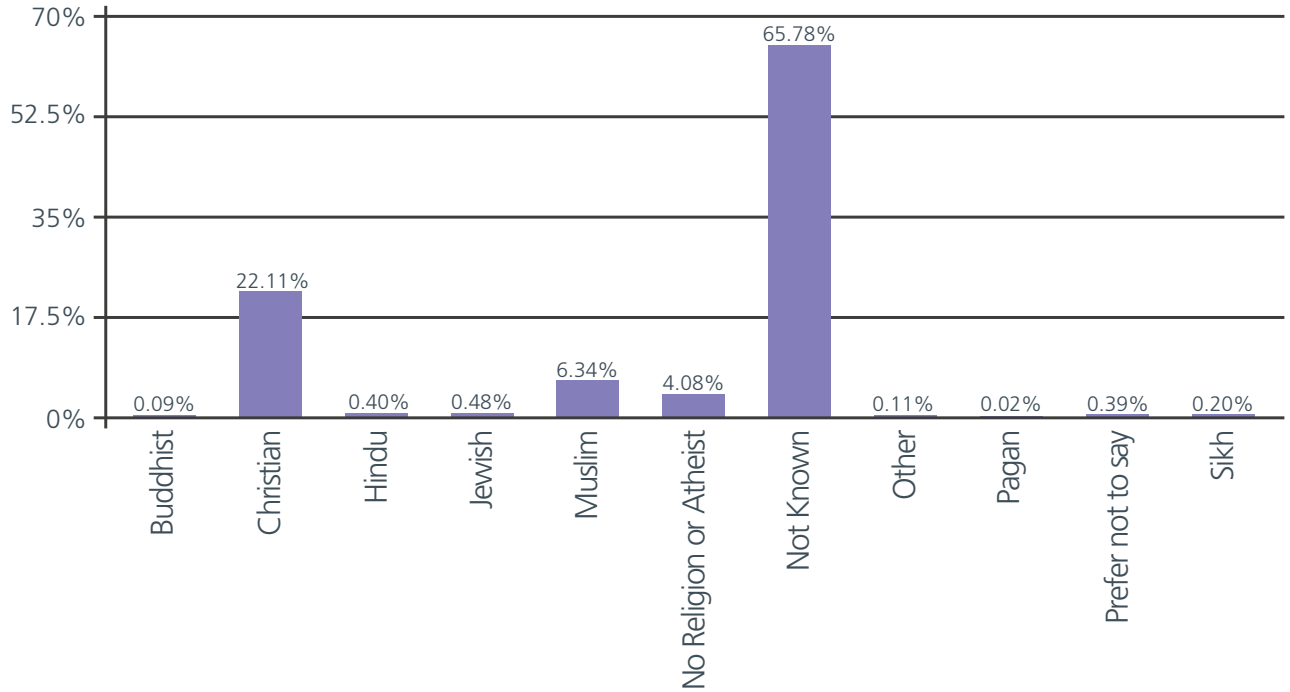
45%
30%
15%
0%
55.12%
44.23%
0.65%
Female
Male
Not Known

Ethnicity



Religion or Belief



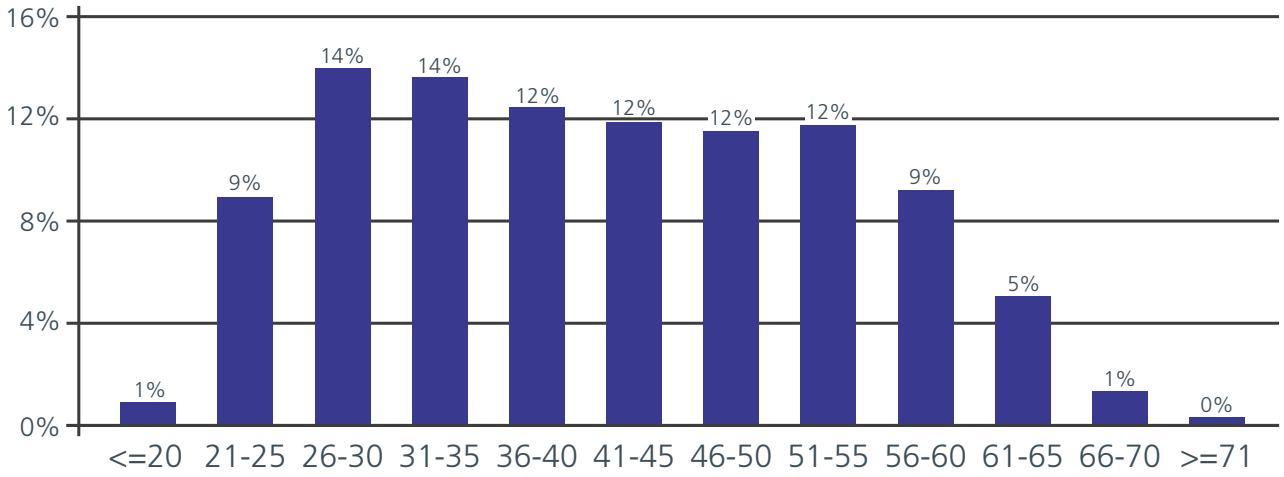
Annex 2

The Diversity of Our Staff

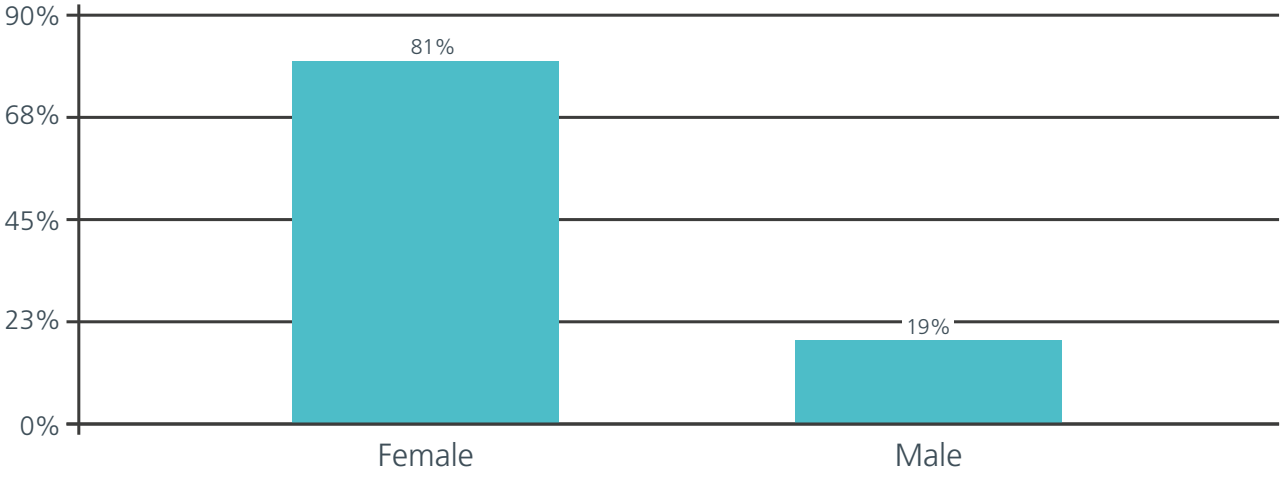
The Trust recognises the importance and benefits of a diverse workforce, and is committed to creating an inclusive, accessible and fair workplace for all employees. The Trust values the contribution of all employees and recognises that it is diversity of experience, skills and knowledge which support the delivery of the best possible services.

The following tables provide information about the Trust workforce by protected characteristic from 2020.

Age


16%
12%
8%
4%
0%
1%
9%
14%
14%
12%
12%
12%
12%
9%
5%
1%
0%
<=20
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71

Sex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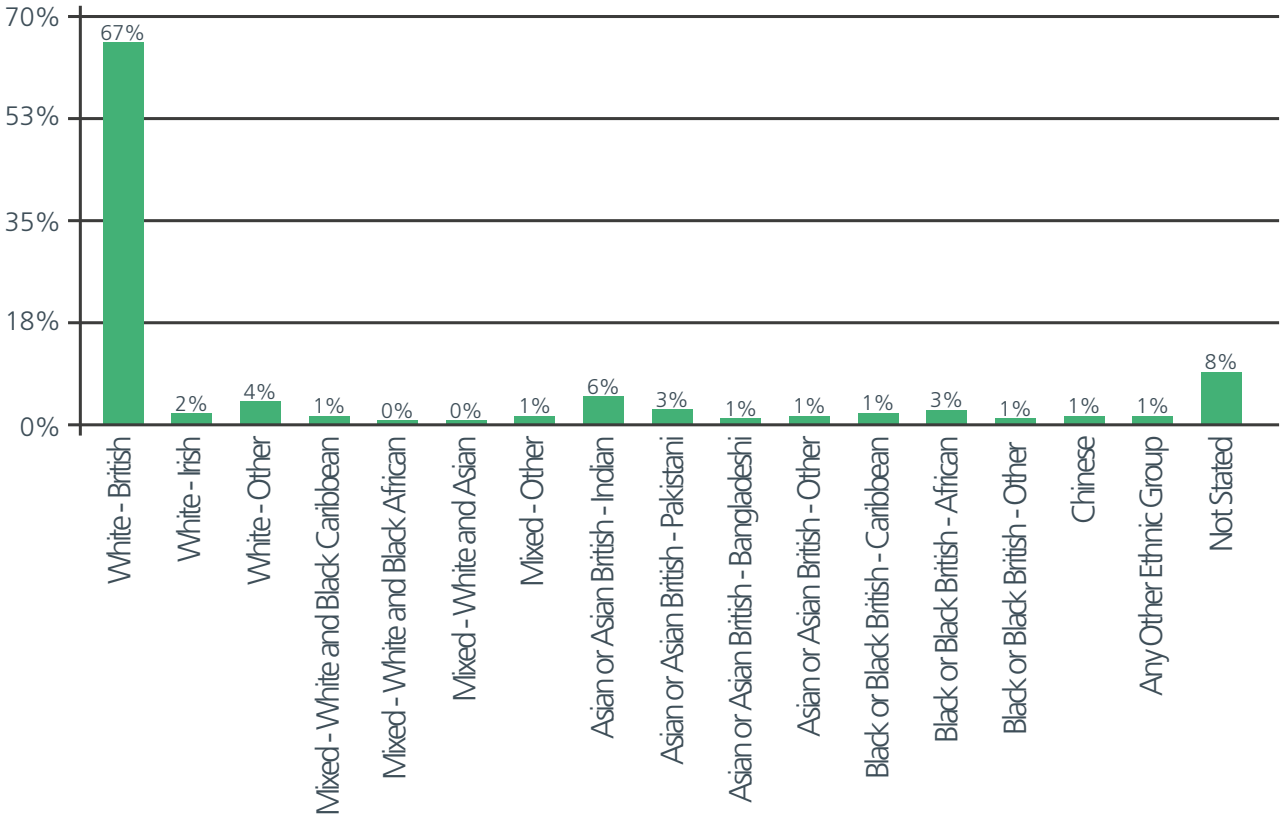
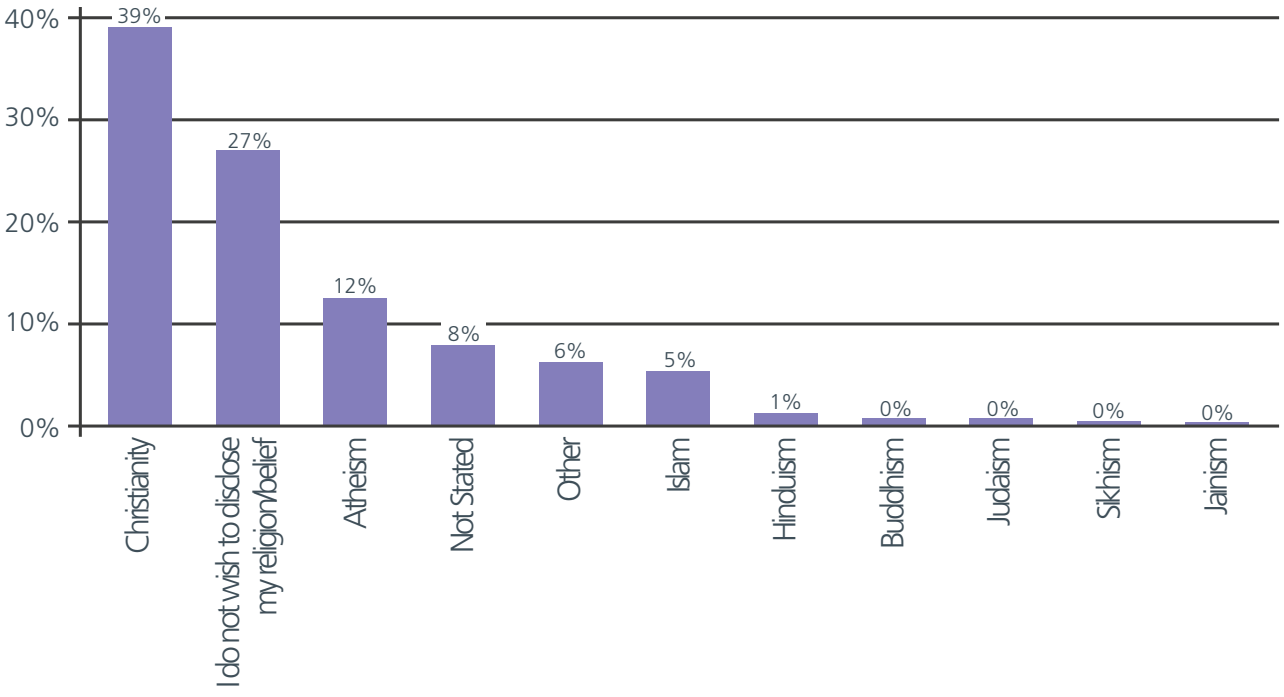
68%
45%
23%
0%
81%
19%
Female
Male

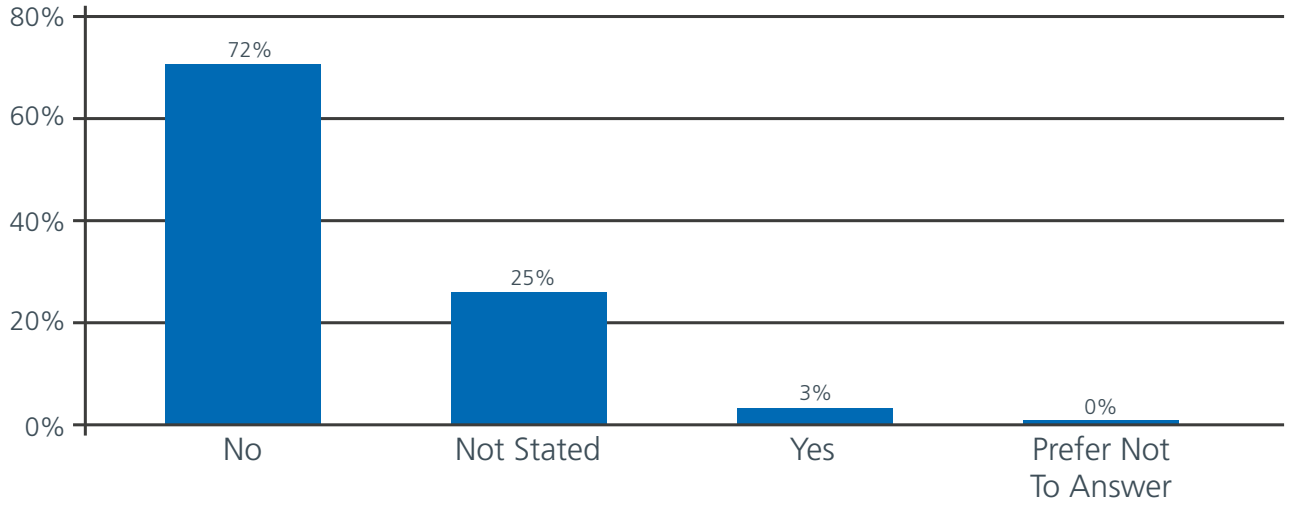
Ethnicity



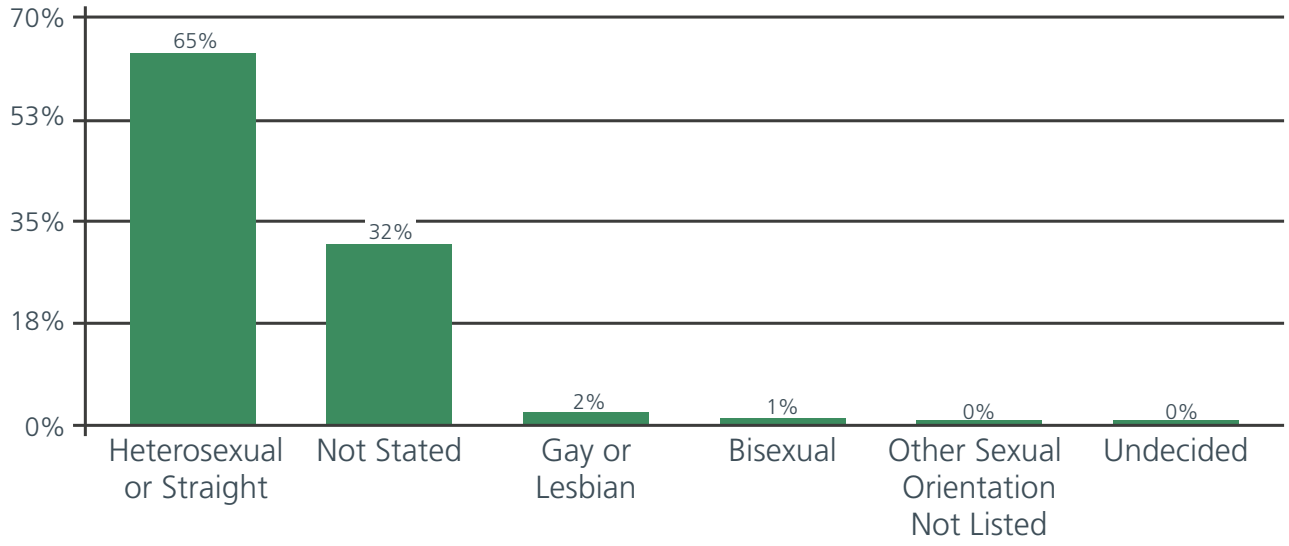
Religion or Belief



Disability



Sexual Orientation



Annex 3

Additional Resources

Equality, Diversity & Inclusion at MFT
www.mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Healthwatch Trafford
www.healthwatchtrafford.co.uk

Healthwatch Manchester
www.healthwatchmanchester.co.uk

Equality and Human Rights Commission
www.equalityhumanrights.com

Government Equalities Office
www.gov.uk/government/organisations/government-equalities-office

NHS Employers Diversity and Inclusion
www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce

Manchester Health & Care Commissioning Equality Information
www.mhcc.nhs.uk/about-us/equality-diversity

Greater Manchester Health and Social Care Partnership
www.gmhsc.org.uk

NHS England Equality Hub
www.england.nhs.uk/about/equality/equality-hub

Gender Pay Gap

Each year the Trust continues to review its pay by gender to see if there is any difference in pay between men and women. The Trust's latest Gender Pay Gap Report can be found at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Work Race Equality Standard (WRES)

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS healthcare providers, through the NHS standard contract. The Trust publishes a WRES Report each year and use the data within the report to inform actions to advance the equality of opportunity for Black, Asian and Minority Ethnic staff at the Trust. You can view the latest WRES Report at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Work Disability Equality Standard (WDES)

Implementation of the Workforce Disability Equality Standard (WDES) is a requirement of public sector organisation to report against a set of ten metrics to identify variation in the experience of Disabled employees. The Trust publishes its WDES Report each year and uses the data to inform a set of actions to improve inclusivity and accessibility. You can view the latest WDES Report at: https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/

Please contact the Trust's Equality and Diversity Team with any enquiries about the *Diversity Matters* Strategy. Email: Equality@mft.nhs.uk

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:	March 2021
Subject:	Board Assurance Framework (March 2021)
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 (March 2021) which is aligned to the MFT Strategic Aims and also highlights the continued 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 (March 2021)

1. Introduction

Performance against the Board Assurance Framework (BAF) is routinely reviewed at formal Board of Directors meetings 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 March 2021 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 (March 2021) which is aligned to the MFT Strategic Aims (2020/21) and also highlights the continued impact of the ongoing COVID-19 National Emergency.

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(March 2021)

Introduction

The Board Assurance Framework (BAF) is one of several tools the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the BAF each financial year, the potential risks to achieving the Strategic Aims are regularly assessed for inclusion on the framework. As such, all principal risks on the BAF are set out under each of the organisation's Strategic Aims.

The construct of the Trust's BAF is based on several key elements as follows:

- **Strategic Aims**
- **Principal Risk** & **Risk Consequence** – *'What is the cause of the risk?'*, and, *'What might happen if the risk materialises?'*
- **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'*
- **Progress**
- **Target Risk Rating** – Impact & Likelihood (*'Based on successful impact of Controls to mitigate the risk')*

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

	Likelihood				
Severity	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 Slight	2 Very Low	4 Very Low	6 Low	8 Low	10 Medium
3 Moderate	3 Very Low	6 Low	9 Low	12 Medium	15 High
4 Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5 Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

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

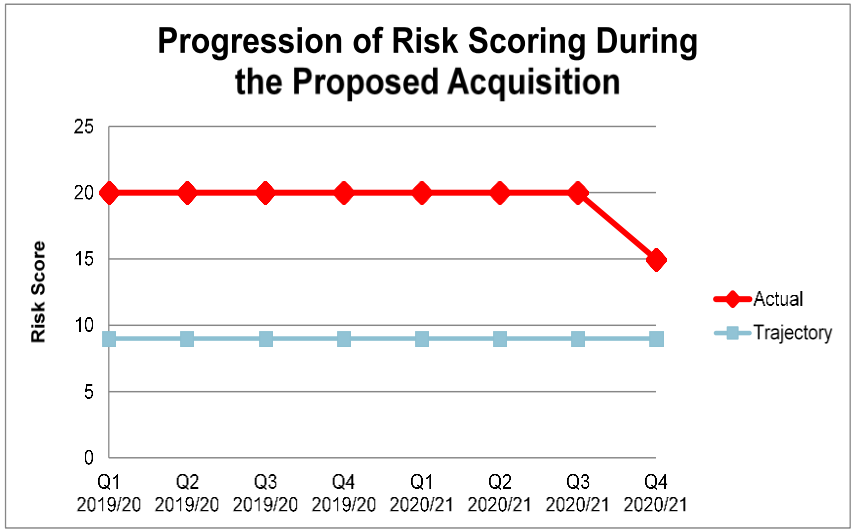
RISK CONSEQUENCES (What might happen if the risk materialises?):

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 NHS E/I 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:
NMGH PROGRAMME 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. A.2 Comprehensive Due Diligence work undertaken and financial effects reflected in discussions with NHS E/I. A.3 Establishment of an expanded and strengthened leadership team at NMGH has created stability, given staff confidence about the future, and allowed MFT to understand the operation of the NMGH site and services. 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 Disaggregation completed, including agreement of Safe Transfer Plans A.6 Transaction Business Case completed (including financial modelling) and approved by Board. A.7 Transaction Heads of Terms finalised and agreed. A.8 Post Transaction Integration Plan (v1) finalised and agreed. A.9 Inclusion of NMGH in the New Hospitals Programme, and submission of robust Outline Business Cases for the redevelopment of the NMGH site and Digital investment (Jan 2021).	B.1 Staff alignment and SLA development processes not yet complete. B.2 Legal documentation not yet signed off. B.3 PTIP needs to be kept up to date. B.4 Continued rapid progress of New Hospitals Programme not guaranteed – approval of OBC could be delayed.	C.1 Due Diligence reports reviewed by Board Committees and signed off by Board. C.2 NMGH leadership team established and joint working arrangements with Managed Clinical Services agreed. C.3 NMGH operating for 11 months under MFT management and governance processes C.4 Independent PAHT Board continuing to operate till 31 March 2021. C.5 Post Transaction Implementation Plan (v1) developed and approved. C.6 Collaborative Post Transaction Governance arrangements agreed. C.7 Council of Governors engagement completed. C.8 SOC for site redevelopment and Digital investment approved, and £54m of enabling monies released. OBCs for site redevelopment and	D.1 Original Due Diligence now 12-18 months old and may have become out of date. D.2 Complexity of operational and strategic agenda increased due to Covid-19.	15 (5x3)	E.1 Complete Due Diligence Refresh exercise for Clinical, Finance and Workforce risk. E.2 Complete staff alignment and development of SLAs. E.3 Complete development of Schedules to Transactions Agreement and sign off all legal documentation. E.4 Develop NMGH Post Transaction Integration Plan (v2). E.5 Implement Post Transaction Governance arrangements. E.6 Manage Covid agenda for NMGH as part of MFT and GM Hospital Cell management arrangements. E.7 Continue site enabling works and other appropriate preparations including on-going design development, consistent with availability of New Hospital Programme monies.	Executive Director of Workforce and Corporate Business, Chief Finance Officer	April 2021	Board of Directors	F.1 Weekly meetings of PAHT-led Transaction and Disaggregation Committee with support from specialist external advisers. F.2 Due Diligence refresh nearing completion F.3 Staff alignment and SLA processes nearing completion. F.4 Legal documentation largely agreed. F.5 PTIP (v2) in development. F.6 Site enabling works progressing. Appropriate capital planning activities continuing.	**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:

NORTH MANCHESTER PROGRAMME BOARD

NORTH MANCHESTER SCRUTINY COMMITTEE

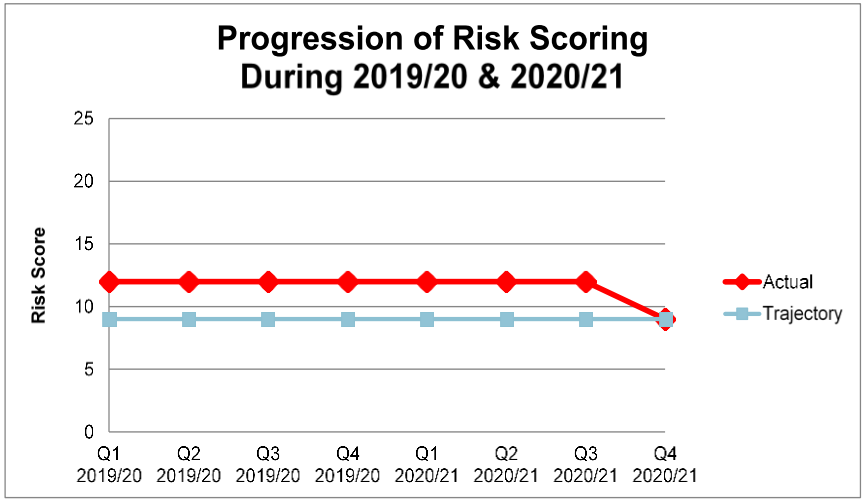
GROUP MANAGEMENT BOARD

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 North Manchester Programme Board brings together oversight of the Transaction and the HIP capital development programme.	B.1 Complexity of disaggregation process continues to require input from some Corporate Directors.	C.1 GM Transformation Funding in place to enable the infrastructure required to deliver the transaction. C.2 Revised and strengthened NMGH Leadership Team in place to provide a focus for decision-making in respect of NMGH. C.3 Additional resources made available to MCS and Corporate teams to manage transition processes. C.4. MFT internal governance arrangements working effectively including the sustained input of the SHS Team to support core leadership teams. C.5 Post Transaction Implementation Plan approved by North Manchester Scrutiny Committee. C.6 Early approval given for appointments to key roles in Corporate teams to ensure continuity of support at 1 April 2021.		**9 (3x3)**	E.1 Work of the North Manchester 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. E.4 NMGH as an integrated part of MFT Post Pandemic Recovery Plan.	Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	F.1 North Manchester Programme Board, Corporate Integration Steering Group and other supporting structures continue to function 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**

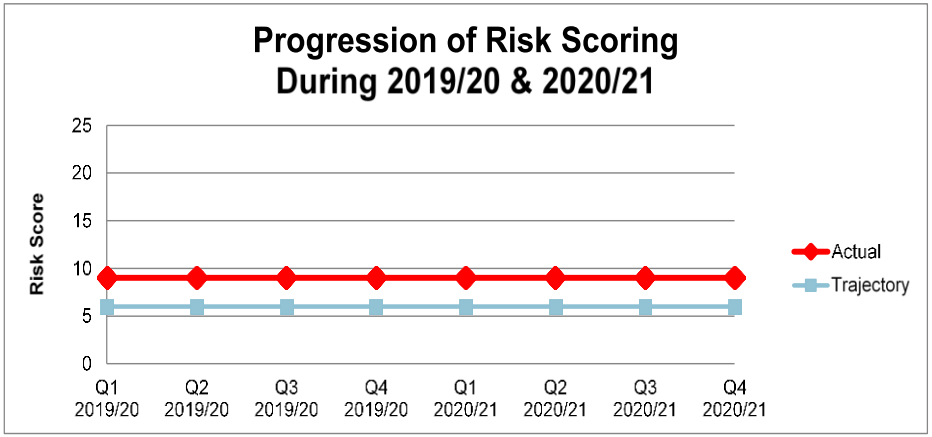
Associated Committee:
QUALITY AND SAFETY COMMITTEE

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.

*Please note change to score of current risk rating – score increased to reflect increased likelihood of safety issues arising as a result of the pandemic.



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 Now including the Tactical and Strategic response structures e.g. MESH, Clinical Sub Group and associated command structures A.4 AOF monitoring A.5 Patient Safety Training Programme – e.g. Infection Control, Human Factors and clinical mandatory training A.6 Review of incident investigation tools in line with the new Patient Safety Incident response Framework 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 A10 Responsive Review Process	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 National decision to defer the new framework to 2022 due to pandemic response 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	**12 (4x3)**	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 C2 Internal audit findings in response to clinical audit and learning from harm indicate some actions required to strengthen response to learning from clinical audit and harm – to be agreed	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 the other is the Trust Patient Safety Specialist Interim Assistant Chief Nurse post now agreed to strengthen the Quality and Patient Safety response 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) now completed and registered with the National Team 6. Trust wide visible Patient Safety Champions now appointed 7. Inclusion of patient safety in mandatory training under discussion as part of the mandatory training review 8. Circulated the new National Patient Safety Strategy and aligned with MFT Q&S Strategy 9. Completed the development of the Group Quality and Safety Recovery Plan 10. Clear information now available on legal costs (clinical negligence claims) 11. Deep dive exercises completed on Never Events and harm arising out of the management of diagnostic and screening test results 12. Human Factor Academy now progressing with membership agreed 13. Committee review now in progress 14. Development of SPC reporting and review of specific safety metrics progressing	**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**

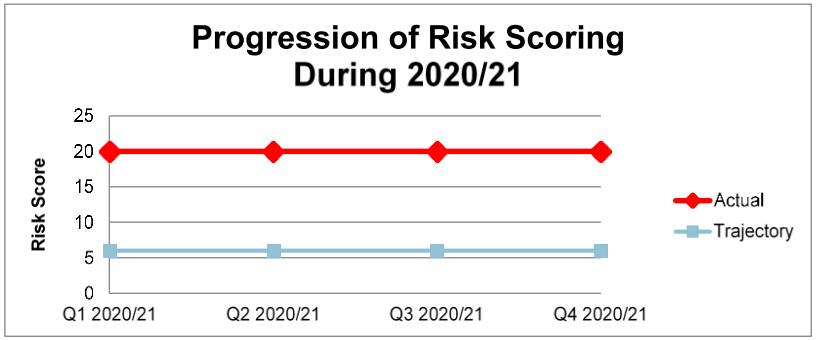
RISK CONSEQUENCES (What might happen if the risk materialises?):

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)	**A1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users** – All non-elective patients are screened upon admission – Preadmission screening implemented for elective admission – Screening protocols for patients discharged or transferred to another health care or residential setting in place – Joint Protocols are in place – Good infection prevention and control education and practice throughout the Group – Escalation plans in place as per trust gold command and GM Gold command - 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: o Risk oversight committee o Quality & Performance Scrutiny Committee o Group Infection Control Committee o COVID-19 Expert Group established - Microbiology and Virology support in place – Use of HPV/UVC in addition to PHE guidance – Covid and non-Covid clinical areas defined across the Trust. All Non- elective admissions tested and elective admissions as per guidance – Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced – Trust policy on managing patients who present with symptoms in place – Good infection prevention and control education and practice throughout the Group – PPE assessments in place o Use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment o Standard Operating Procedures developed for decontamination of visors o Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline o Fit testing databases are in place in hospitals/MCS - The training hub includes a series of COVID-19 training resources, local induction includes IPC measures.	B1. Some COVID-19 positive individuals present at hospitals as asymptomatic patients B2. Redeployed staff may not be confident in an alternative care environment. Anxiety of staff working in COVID-19 Wards. B2 Cleaning Policy Requires updating (pending new national guidance on cleaning standards) B3. Monthly AMS audits are being redeveloped to better inform prescribing practices. New audit proforma was introduced in June 2020 and is subject to ongoing review. B4. Plans need to be flexible as situation changes	C1. Patient streaming at access points. Emergency Department is zoned to provide designated areas. C1. Screening of non-elective admissions recorded on ED systems C1. Plans in place to screen elective patients 48 hours prior to admission, SOP's developed screening of elective patients in place screen results available via MFT systems C1. Joint Protocols are in place C1. Keeping Safe Policy in place focusing on the 'Four pillars of working safely' C1. Hospitals have identified green, yellow and blue areas and are currently presenting plans of flow throughout the patient journey. C1.Development of surveillance tool to highlight hotspot areas incorporating NHS guidance on probable/definite hospital acquisition C1. Audit tool developed so individual wards and departments can audit compliance to the guidance. C1. Cleaning audits developed C1. Hand hygiene audits in place C1. Clinical Sub-Group in place to oversee adjusted or adapted systems and processes approved within hospital settings	For All Existing Controls, plans need to be flexible as situation changes Hospitals to re-assess as situation evolve	20 (4X5)	E1. Hospitals have identified green, yellow and blue areas and are currently presenting plans of flow throughout the patient journey. E1. Patient placement guidance in place E1. Keeping Safe - Protecting You – Protecting Others Document approved and in place E1. All patients admitted via ED are screened for COVID-19, data is reviewed daily E1. Areas such as ICU, radiology and other areas which have a transient patient population are identifying flow throughout the departments to ensure risk level to patient minimized. E2. Increase of IPC support to COVID -19 Wards E2. Use of posters/videos FAQ's E2. Multiple communication channels – daily briefing/dedicated website E2. Microbiologist support E2. Virology support E2. 7 day working from IPC/Health and Wellbeing	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	NHSE Infection Prevention and Control Board Assurance Framework re-issued on 23 October, assurance and controls have been assessed, a further update in February has been provided - an additional 43 indicators have been included Plans in place to address gaps in assurance based on national guidance as available Patient placement guidance in place Keeping Safe - Protecting You – Protecting Others Document approved and in place All patients admitted via ED are screened for COVID-19, data is reviewed daily Covid 19 Outbreak policy written, and ratified Developed guidance around the use of alternate PPE as required, monitoring of compliance with IPC practices is in place. Introduction of masks and face coverings week commenced 15th June 2021 Sitrep reporting for nosocomial outbreaks in place. A COVID infection dashboard is in development. Estates/environment review has progressed with permanent structures to entrances arriving on site by November Temporary structures are in place currently and are sufficient	**6 (3X2)**

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

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)

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)	**A2. The Trust provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** – Estates and Facilities /PFI partners and IPC Team meeting to review cleaning frequencies in line with updated guidance – creased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative – Enhanced cleaning specifications in place for clinical and non-clinical areas – Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken – Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place – Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas – Dedicated entrances for blue/yellow/green patients where possible – Signage on entrances – Screens in place at reception areas – Signage on entrances advising pathway for symptomatic patients – Hygiene Programme of review of air flow and ventilation undertaken throughout the pandemic – All clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance **A3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** – Specific antimicrobial policies related to COVID-19 available on the Trust's Microguide platform. – Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) – Monthly antimicrobial stewardship (AMS) audits on all ward areas – Microbiology support available 24 hours a day. – Antimicrobial prescribing advice available from pharmacy 24 hours a day – IPC ICU ward rounds – Increased AMS support to COVID-19 cohort areas – Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing	B5. patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital B5. Policy in place for wearing of facemasks in all areas B5. Point of care testing at implementation stage B7. Avalilability of some PPE B7. Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) B7. Some areas of estate particularly old and in poor condition	C1. Recording of staff concerns raised C1. Incident reporting system C2. Programme of training for redeployed staff including use of PPE, maintaining a safe environment C2. Bespoke training programme for Clinical leaders to become PPE expert trainers C2. IPCT undertake regular reviews/ and provide visible presence in cohort areas Staffing levels increased C3. Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC C3. Appropriate policies reviewed and approved by the AMC C3. Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. C3. Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) C3. Monthly antimicrobial stewardship (AMS) audits on all ward areas C3. Microbiology support available 24 hours a day. C3. Antimicrobial prescribing advice available from pharmacy 24 hours a day C3. ICU ward rounds C3. Increased AMS support to COVID-19 cohort areas C3. Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing. C4. Policies/guidance in Acute sector updated to reflect pandemic C4. End of Life Policy adapted for current need C4. Controlled entrance & exits to Trust to minimise risk of cross infection		20 (4X5)	E2. Domestic staff have access to EHWB services E2. Increase of IPC support to COVID -19 Wards E2. Domestic staff have access to EHWB services E2. Increase of IPC support to COVID -19 Wards E2. Use of posters/videos FAQ's Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams and using site management checklists. E2. Use of window and other air filtration systems are being considered in older estate. E3. Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones. E4. Website regularly to be updated by Comms/EPPR Team	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	Regular and up to date information is published in this Resource Area, including the following key topics: – Emergency Planning, Resilience and Response – Employee Health & Well Being – Research and Innovation for COVID-19 – Infection Prevention & Control Hospital/MCS COVID-19 Resources – Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. Increase in IPC team on call/availability out of hours rota Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased demand and that the service provision includes all clinical and non-clinical areas Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital Point of Care Testing has been implemented in ED's Continue to cohort patients as per policies	**6 (3X2)**

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

PRINCIPAL RISK (MFT/004513):

Under delivery of activity / capacity which will impact on achievement of national operational standards for urgent and elective care, including cancer and diagnostics, due to long standing issues of: demand pressures, capacity, workforce and estate constraints, and the ongoing Covid19 pandemic.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284)

Enabling Strategy:
- Quality & Safety Strategy
- Transforming Care For The Future Strategy

Group Executive Lead:

Group Chief Operating Officer

RISK CONSEQUENCES

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

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		
	Oct	Nov	Dec
A&E 4 hour	81%	77%	76 %
RTT	52%	54%	54%
52 weeks	5,946	7,100	8,443
Waiting list	106,438	106,706	106,452
Diagnostics	33%	28%	26%
Cancer 2ww	69%	71%	73%
Cancer 31 Days	91%	91%	90%
Cancer 62 Days	55%	61%	65%

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"*
20 (4x5)	1.1 MFT Covid Governance Framework established including: • Strategic Command Group - chaired by COO • Tactical response - run by Corporate Directors • Operational Response - Hospital Management 1.2 Regional Covid Governance Structure, which MFT is represented at including: • GM Gold • Hospital / Community Cells • NW EPRR Single Point of Contact 1.3 Hospital and Group escalation plans and decision making frameworks: revised in October 2020 to prepare for future waves of the pandemic and approved via the MFT Strategic Command Group. 1.4 On call Structures have been revised and adapted to support the hospital/MCS response to the pandemic, in addition to business as usual operational running. Further supported by the strategic and tactical incident management arrangements. 1.5 Phase 3 activity planning, including performance trajectories for managing the longest waits and cancer, undertaken and submitted on 10th September, to meet the expectations set out in the national guidance: Implementing phase 3 of the NHS response to the Covid-19 pandemic. 1.6 Reporting in place to track activity levels against the phase 3 planning expectations and associated performance trajectories. *(Continued Next Page - below)*	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 Workforce availability to deliver activity levels: sickness Covid19, shielding, usual sickness levels and vacancies.	3.1 Reporting to the Executive Board and Committees in relation to the Covid Pandemic, Recovery programme and performance. 3.2 MFT Covid19 Recovery Programme 3.3 Minutes and papers relating to the MFT Covid19 Governance Structure. 3.4 Minutes and papers relating to Trust Committees. 3.5 Hospital Activity, capacity and annual plans. 3.6 Internal/external audits of data quality. 3.7 Annual Review and NHSI sign off Trust Access Policy.	None	20 (4x5)	Key actions are outlined in the Risk Report to the Group Risk Committee. Overarching MFT recovery programme in response to the Covid19 pandemic, incorporating 17 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 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 2021/22	Quality and Performance Scrutiny	Progress against the workstreams is being reported into the Strategic Covid Group, The Board of Directors, and Group Risk Management Committee. The performance position against national standards is reported via the Covid Recovery and Performance report to the Board of Directors.	16 (4X4)

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

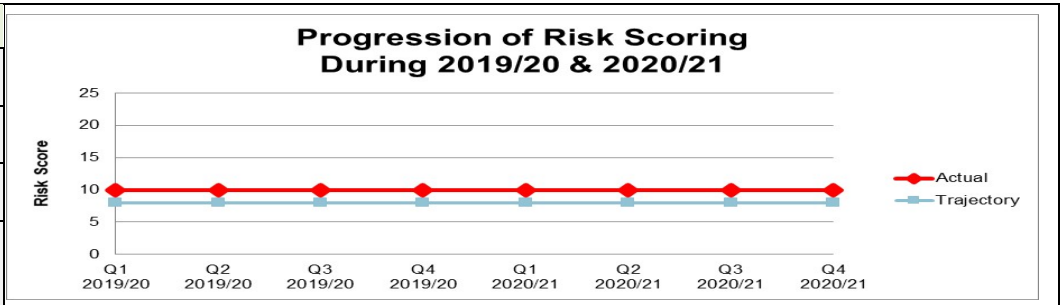
PRINCIPAL RISK (MFT/004513):

Under delivery of activity / capacity which will impact on achievement of national operational standards for urgent and elective care, including cancer and diagnostics, due to long standing issues of demand pressures, capacity, workforce and estate constraints, and the ongoing Covid19 pandemic.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111,

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**EXISTING CONTROLS** *"What controls/systems are currently in place to mitigate the risk?"*
20 (4x5)	**CONTINUED** 1.7 MFT Recovery programme established following wave one of the pandemic, underpinned by several workstreams several which focus on recovery of activity levels and associated performance against national operational standards related to: Outpatients, Elective Access, Cancer, Urgent Care. 1.8 Governance and reporting structure in place to support the Recovery Programme, with a Recovery and Resilience Board established, and routine reporting into the MFT Strategic Covid Group. 1.9 MFT Board and Committee activity and performance reporting in place 1.10 MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.11 Patient Access Policy 1.12 MFT EPRR Policies and Plans to support organisational response to Major Incident and Business Continuity incidents 1.13 MFT EPRR Governance Framework including: • MFT EPRR Committee • Hospital Site Forums • MFT EPRR annual assurance statement, against the national core standards for EPRR which underpin the Trust compliance with the Civil Contingencies Act. Associated action plans in place, and reporting / assurance against these has been provided to the Trust Quality and Performance Scrutiny Committee, with delivery of action monitored through the MFT EPR Committee. 1.14 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.

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)**



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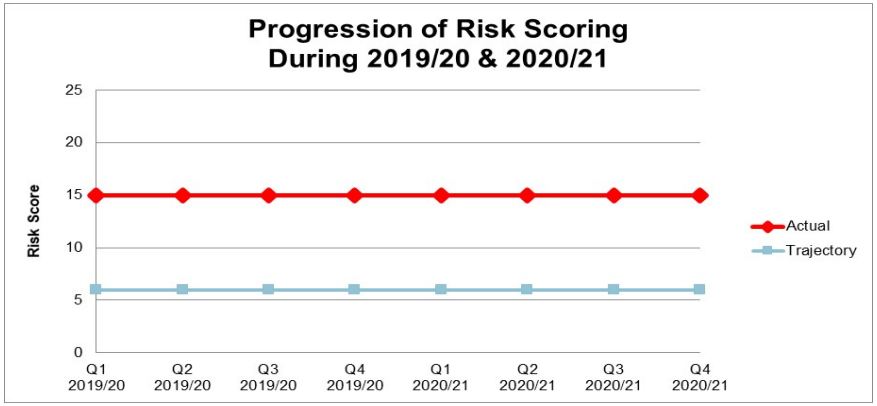
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/ LCO. A5. Named Doctors and Named Nurses 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	Assistant Chief Nurse (Safeguarding)	March 2020	Safeguarding Committee	A11. The installation of CP-IS within SMH maternity services has been slightly delayed due to pressures within the IT department particularly so during the COVID 19 pandemic response. Full implementation is expected by the end of Q4 2020/21. As part of the health service response to vulnerable children during the Covid-19 pandemic NHSE/I requested NHS Digital to roll out CP-IS within all 0-19 years' services. In Manchester and Trafford community health services CP- IS information is shared by Child Health with the Manchester and Trafford 0-19 services to ensure Practitioners are aware of children on their caseload who are Looked After or on a Child Protection Plan. CP-IS is fully implemented in Manchester community services and is currently being implemented in Trafford community services. B1. DoLS re audits were undertaken in 2020 and actions have been identified to improve the quality and compliance with DoLS criteria. Training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) is delivered as part of the Adult Safeguarding Level 3 training (compliance is shown at B3 below). B2. The number of DoLS applications across MFT continues to be high however there continues to be low levels of assessments authorised by the LA. Of 541 DoLS applications made by MFT in Q3 of 2020/21, only 5 were authorised, 32 were declined and the remainder either await assessment or are no longer inpatients. The Safeguarding Mental Health Matron is leading work with Manchester LA and Trafford LA DoLS leads to address this issue. B3. Competencies have been matched to roles in accordance with revised Intercollegiate Guidance. Improvement plans were developed and implemented by Directors of Nursing to improve compliance. **Overall safeguarding training compliance** at 31st December 2020 was 90.72%, which meets the Trust target of 90% and exceeds the CQC target of 85%, demonstrating continued improvement across all training levels. However, whilst level 1 and 2 adults and children's training exceeded 90% at the end of Q3, level 3 children's training has remained consistent at 76.03% and level 3 adult training has increased to 75%. An online safeguarding training programme of has continued to be delivered during the Covid-19 response and a review of Safeguarding level 3 training continued and work with ODT has resulted in all safeguarding training being booked via the learning hub. B4. Face to face level 3 safeguarding children and adults training remains paused due to Covid-19 however the online safeguarding training programme with the requirement to complete a 'workbook' to evidence learning continues and has received positive feedback and evaluation. B5. Following a successful business case to expand LD Specialist Nurse capacity, 2xband 7 and 1xband 6 posts have been recruited to with recruitment to 1xband 6 post currently being finalised. A "roadshow" to formally introduce the new team and to raise their profiles within the Hospitals/MCS is planned for Q4 when the final staff member has joined the team. B6 The LCO Chief Nurse continues to lead the MFT LD Steering Group. The Director of Adult Social Services (DASS) is 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. System leadership includes MHCC, MFT, Primary Care, GMMH and MLCO. The Directors of Nursing continue to lead local improvements within hospitals/MCS. B6. The updated LD work programme informed by self-assessment against NHS I learning disability improvement standards for NHS trusts continues. Regular updates are provided to the Safeguarding Committee. D1 Prevent training is delivered by e-learning via the MFT learning hub. Current compliance is 89.5%: this performance exceeds the national NHSE/I requirement of 85%for Level 3 Prevent.	**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 C3. Authorising Engineers in place for all life-critical services that provide external independent assurance reports on a periodic basis	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 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 2020 whilst areas of the Main Hospital Building on ORC were empty due to Covid. Significant work ongoing with ProjectCo; Sodexo and Engie to enhance record keeping and Trust access to records as required. Workstream in place with Sodexo & Project Co at Wythenshawe to improve Trust access to maintenance records	**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

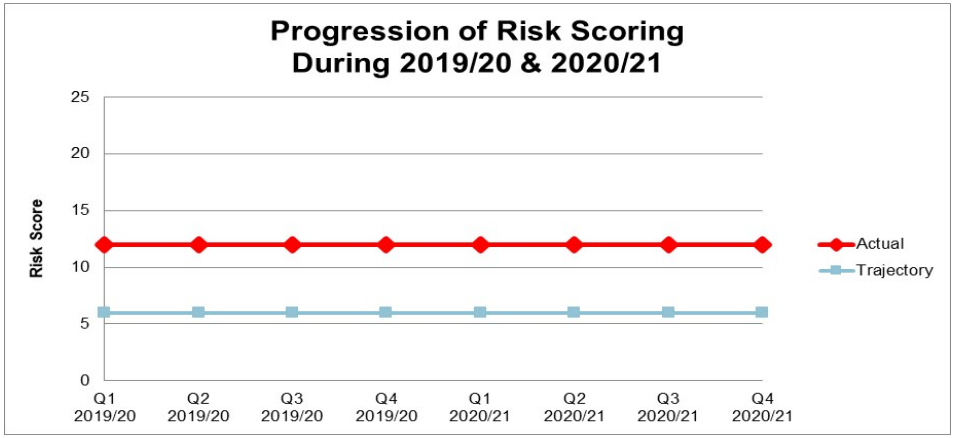
Group Executive Lead:
CHIEF NURSE

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:
DIRECTOR OF NURSING (WORKFORCE & EDUCATION)

Material Additional Supporting Commentary (as required):



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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 reporting 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. Corporate retention work schemes A12. Pandemic workforce recovery programme A13. Hospital/MCS and Group level pandemic escalation metrics and plans to manage workforce supply A14 NHSP professionals temporary staffing bank and agency workforce model	B1 National shortage of nurses for the pipeline with no increase in trainees graduating until 2021 B2 Uncertainty due to the impact of CV19 on graduate workforce supply in 2021 B3 Uncertainty due to the Impact of CV19 on international recruitment pipeline in 20/21	C1 Programme of domestic and international virtual recruitment events C2 Monthly NHSI safe staffing reporting C3 E Rostering - Roster confirm and challenge meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff C4 Absence manager - monitoring absence and trends to inform workforce requirements C5 Nursing Associates role provides additionality and support to registered nursing workforce C6 Bi-annual Safer Staffing reports to Board of Directors Group Management Board, HR Scrutiny Committee, NMAHP Professional Board, Risk Management Committee. C7 Monthly Nursing and Midwifery workforce dashboards, recruitment pipeline and vacancy trajectories C8 Hospital/MCS AOF KPI's C9 Safer Nursing Care Tool (SNCT) introduced to support annual inpatient workforce 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 Domestic and international recruitment campaigns resulting in substantive appointments of both nurses and midwives E2 Continue with the International recruitment programme with focus on supporting the pandemic workforce requirements, hard to fill areas (theatres, renal dialysis) and service expansion (CSS) E3 Nursing and midwifery workforce supply to address workforce requirement and capacity demand. E4 Reduce Nursing and Midwifery vacancies E5 Reduce turnover and improve retention rate in band 5 roles. E6 Review all in-patient ward areas' staffing establishments following reconfiguration of hospital/MCS service models E7 Manage staff absence as per policy; monitoring absence trends to inform workforce requirements during pandemic. E8 Implement upskilling programme to support redeployment of nursing workforce as required during the pandemic response. .	Chief Nurse' s Team	November 2020	NMAHP Professional Board	E1 Programme of virtual recruitment events planned for the next 6 months. E2 The Trust is to recruit 400 international nurses before the end of March 2021. The Trust will continue to source nurses from overseas and agreed to establish an ongoing recruitment pipeline of 300 nurses during 2021/22 focussing on areas such as CSS, NMGH and theatres. E3 The registered nurse and midwifery vacancy rate has reduced by 240wte (2.2%) in Q3 following the graduation of newly qualified nurses and international recruitment programme E4 A Guaranteed job offer has been introduced for 3rd year student nurses and midwives who undertake their final year placements at the Trust. E5 Annual rolling turnover rate for nursing and midwifery has reduced to 10.9% (from 12%). E6 The Safer Nursing Care Tool is now in place across all ward areas including NMGH. Ward staffing establishment reviews have been postponed until the pandemic surge has reduced and the clinical workforce stabilises. E7 Nursing and midwifery managers are working closely with NHS Professionals to ensure adequate bank and agency supply to cover sickness absence. Nursing and Midwifery absence rate has reduced to 9.6% in Q3 (12.9% in Q2) E8 An upskilling programme was established to support the deployment of nursing staff to adult critical care areas at the start of the pandemic. The programme has been established to provide additional training to support critical care escalation plans and staff redeployment.	**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**

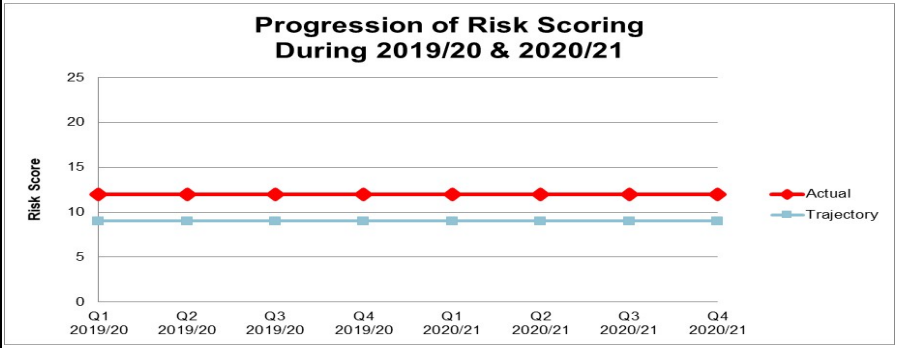
RISK CONSEQUENCES (What might happen if the risk materialises?):

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. Business case for new bank supplier **approved,** procurement **completed** & Go Live went smoothly in Nov 2020. MFT Tier 5 GMC sponsorship continues to progress. MSC in leadership **now launched** with MMU – recruitment initiatives. New single contract for locally employed junior doctors **agreed & launched** for new starters B2. MFT Job Planning Policy approved in January 2020. Roll out delayed by Covid-19. New 'Covid recovery' job planning principles **agreed** at July JLNCC. Job planning recommenced B2. Job plan training guide to support roll out **developed** & refined for Covid recovery Monthly reports sent to hospitals/MCS on job plan status and bi-weekly 'heat maps' **now sent** Project team now in place for roll out of Allocate Medical Workforce systems -completion by **March 21** B5. 7DS standard included in Patientrack & formal testing in MRI **delayed** due to COVID-19 D1. Complete - Updated dashboards rolled & will be replicated when new supplier embedded D2. New GOSW **recruited** & in post 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?):

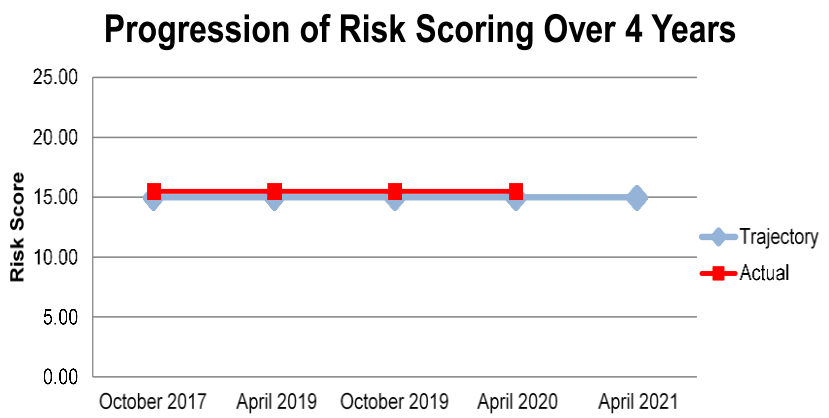
1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.**
2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.**
3. **Financial damage.**
4. **Reputational damage.**
5. **Staff 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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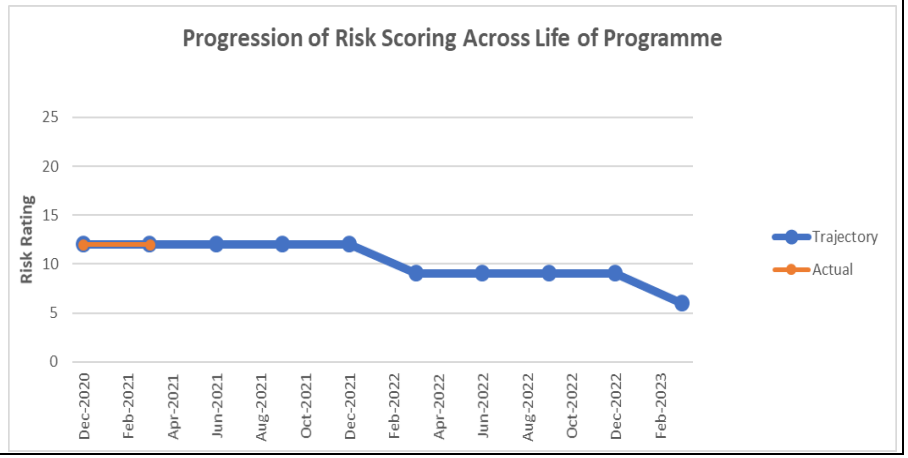
15 (5x3)	A.1 Appropriate Controls are in place to manage the threat of Cyber attack and other IT vulnerabilities and security threats.	B.1 Regular reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	C.1 Independent assurance scheduled at regular intervals to ensure best 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)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): **The Trust fails to effectively deliver the Hive EPR transformation programme and realise the clinical and operational benefits across the organisation.**	Enabling Strategy: **MFT CLINICAL SERVICES STRATEGY** Group Executive Lead: **GROUP CHIEF OPERATING OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. High unwarranted variation in clinical and administrative management and operational processes; 2. Poor patient experience, patient safety, quality of care and low staff morale; 3. Failure to meet the Trust objective of achieving financial stability by failure to realise the benefits case; 4. The Trust would remain at a low and worsening level of digital maturity.	Associated Committee: **EPR SCRUTINY COMMITTEE and EPR PROGRAMME BOARD** Operational Lead: **HIVE EPR PROGRAMME DIRECTOR** The programme is minimising the impact on COVID-19 wave 3 response through: 1. Delivery team virtual training programme and onboarding process. 2. Rapid Design Group virtual Epic EPR workflow walkthrough in late March designed to minimise individual time requirement This is actively being monitored.	

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 EPR Task and Finish Committee approved the Full Business Case on the 18th May 2020. A.2 Robust contractual and commercial arrangements in place with the contract signed on the 19th May 2020. A.3 EPR Governance Framework defined and approved by Trust Board EPR Task and Finish Committee. A.4 Terms of Reference defined and approved for EPR Implementation and Benefits Realisation Board. A.5 Introduction of a digital competency framework to support rapid adoption of the solution. A.6 Implementation of a data quality and migration strategy.	B.1 Changes in the external landscape	C.1 Extensive engagement with key stakeholders and subject matter experts representing all areas of the Trust and patient community C.2 Financial monitoring and effective governance against Group Informatics Capital Plan to ensure focus on EPR Programme and associated Technical Scheme. C.3 EPR Implementation and Benefits Realisation Board, chaired by the COO, with executive directors and Hospital/Managed Clinical Services leadership oversees the delivery of the programme C.4 EPR Scrutiny Committee, chaired by BoD deputy chair, provides BoD oversight. C.5 Internal Audit commissioned to carry out Hive Programme Risk Assurance and provide reports to the Audit Committee	D.1 External assurance gateway reports on the EPR Programme.	**6 (3x2)**	D.1 Procure service to provide external assurance consistent with public sector best practices. C.5 Review Internal Audit terms of reference for EPR Programme Risk Assurance and update to ensure they are complimentary to external assurance service.	Group Chief Operations Officer	Ongoing	EPR Scrutiny Committee	• Procurement commenced for an external assurance partner.	**4 (2x2)**

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**

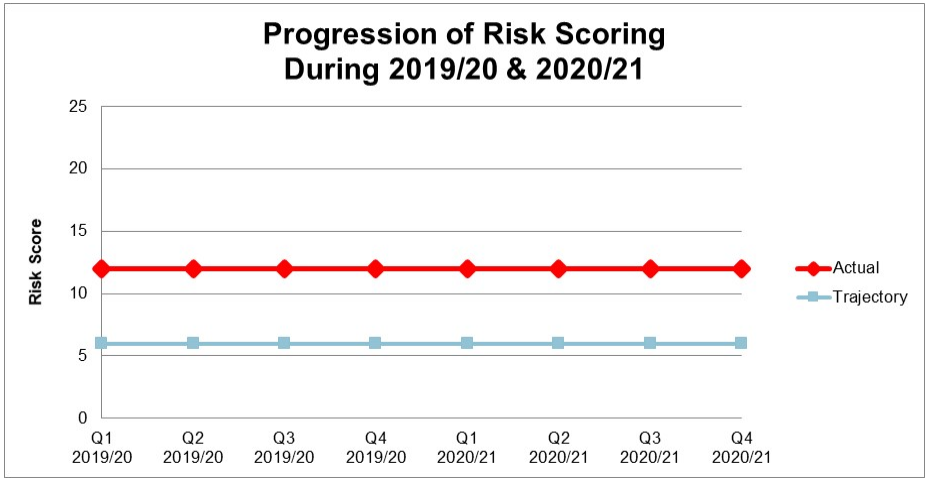
Associated Committee:

QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Operational Lead:

DEPUTY CHIEF NURSEHEAD OF NURSING(PATIENT EXPERIENCE)/HEAD OF NURSING (QUALITY)

Material Additional Supporting Commentary (as required):



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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 B7. Patient Environment of Care stood down during Q3, 2020/21 due to Covid-19 pandemic response	C1. Internal quality assurance processes (Clinical Accreditation programme – replaced by Assurance process during Covid-19 pandemic response, 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	C1. Senior Leadership Walkrounds paused in March 2020 and again in September 2020 to minimise COVID-19 transmission and not yet re-commenced. A10/C1. Accreditation process paused during COVID-19 response. A7/C2 AOF metric reporting limited during COVID-19 response. C5. Gaps in WMTM survey data collection during Covid-19 pandemic response. C8. FFT stood down nationally during Covid-19 pandemic response.	**12** **4X3**	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. Embed Patient Experience & Involvement Strategy B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO C1. Roster Matrons onto clinical shifts to support quality standards	Chief Nurse' s Team	March 2021	Quality and Performance Scrutiny Committee	A4. Full Complaints processes re-introduced in May 2020 and maintained. Virtual and limited face to face Local Resolution Meetings introduced to support communication with complainants. B1/B2. Following a pause in the roll out of training cohorts to support Hospital/MCS teams to embed WMTM and IQP, a new programme was launched in Q2, 2020/21 as part of the Covid-19 recovery plan and has been maintained. The programme includes NMGH. B1. Following a pause of the Always Events^{R} Programme, a revised project plan will recommence in Q4, 2020/21. B3. Hospital/MCS/LCO/E&F nutrition and hydration updates are monitored at Patient Environment of Care and Quality and Patient Experience Forum B.4 Patient Experience & Involvement Strategy 2020-2023 launched in Q2, 2020/21.	**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) revised in October 2020 sets out actions to maintain a positive patient experience.	(see above)	(see above)	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 PALS, Patient Experience & Volunteers Service to develop and embed virtual visiting service. C2 Develop revised patient experience AOF metrics to monitor progress during the Covid-19 recovery period. C1 Implement alternate temporary assurance process agreed by Professional Board whilst Accreditation programme paused C1 Review process and re-introduce Senior Leadership Walkrounds in defined areas from April 2021. C4,5&8. Re-establish QCR, WMTM and FFT data collection processes. D1. Review and deliver Patient Environment of Care work programme. D2. Develop and deliver Hospital/MCS/LCO action plans to drive improvement supported by 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	D1. Significant improvement in quality of food reported in national patient survey 2019. All other scores within average range. D2 Hospital/MCS/LCO action plan exception reports monitored on an ongoing basis. D3. 'Food Safety in the Clinical Environment Policy' was ratified at the ICP Committee on 13/1/21. A 'Policy on a Page' document is being developed to provide a summary of the key aspects of the policy. Mandatory food handling e-learning training is being developed by Dynamic. It is intended that staff will complete the food handling training prior to the launch of the policy. B5 Food task and finish group established with E&F and nursing membership focused on compliance with the regulatory requirements. 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 Virtual visiting service established in August 2020. B6. MFT and St John Ambulance volunteers recruited to provide assisted patient dining service. C1. Alternate temporary assurance process implemented whilst full accreditation programme not possible, which includes observation of clinical areas, assessment of all quality and safety data and assurance meeting of Director of Nursing with Chief Nurse/Deputy Chief Nurse. Clinical observation visits are on-going and assurance meetings conducted for MREH/UDHM and RMCH in Q3. C1. Senior Leadership Walkround schedule to be reconsidered in April 2021 and alternative arrangements by MS Teams to be considered for Covid-19 areas. C2 AOF patient experience metrics revised and monitoring continued. C4,5&8 QCR data collection re-established in May 2020. WMTM survey re-established from July 2020 and National FFT to reporting to recommenced in December 2020. C6 National Inpatient, Urgent & Emergency Care and Children & Young People's Surveys field work commenced. Maternity survey cancelled nationally but MFT have continued this survey with Picker.	**6** **3x2**

4	Strategic Aim: To Achieve Financial Sustainability											
PRINCIPAL RISK (What is the cause of the risk?): Risk that revised funding arrangements in place from October 2020, existing cost pressures and operational pressures as result of COVID-19 prevent the Trust from delivering its financial target and long-term sustainability.			Enabling Strategy: MFT CONSTITUTION & LICENCE REQUIREMENTS Group Executive Lead: CHIEF FINANCE OFFICER									
RISK CONSEQUENCES (What might happen if the risk materialises?): Failure to deliver the £25m gap to surplus identified in the October 2020 financial plan will potentially put the Trust in breach of its license and prevent the Trust from delivering the cash surplus to underpin MFT's capital plan in future years.			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 A6 Hospital/MCS/LCO control totals (including Waste Reduction Targets) set in advance of M7 2020/21 reporting – these are being used to hold these areas to account.		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, but during COVID AOF reviews have been replaced by monthly forecast submission and reviews with Hospital/MCS CEO/FD's and Group COO and CFO	None	20 (5x4)	None	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	Finance Scrutiny Committee	As at February 2021, MFT is forecasting to achieve an increased surplus against the plan submitted to NHSE/I in October 2020. However, the improvement against plan primarily reflects the reduction in activity (and hence costs required to deliver activity levels) as a result of WAVE 2 and 3 of COVID which were not reflected in the October 2020 plan.	**16 (4x4)**

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

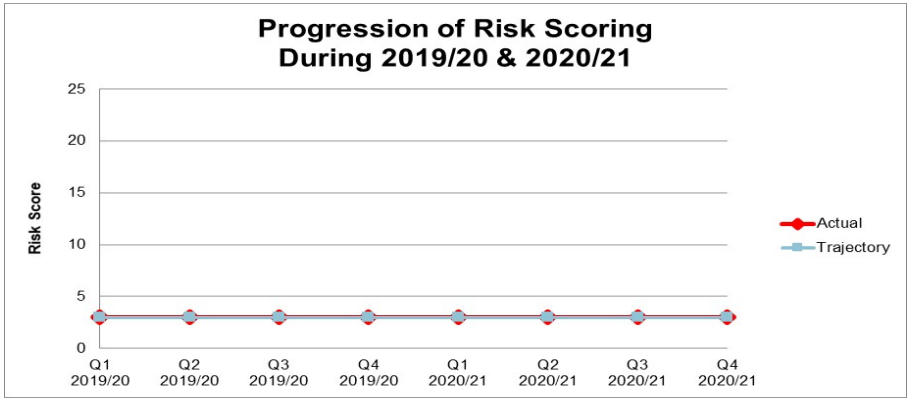
RISK CONSEQUENCES (What might happen if the risk materialises?):

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 Governanc	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 (paused during 20/21). 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 21/22	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**

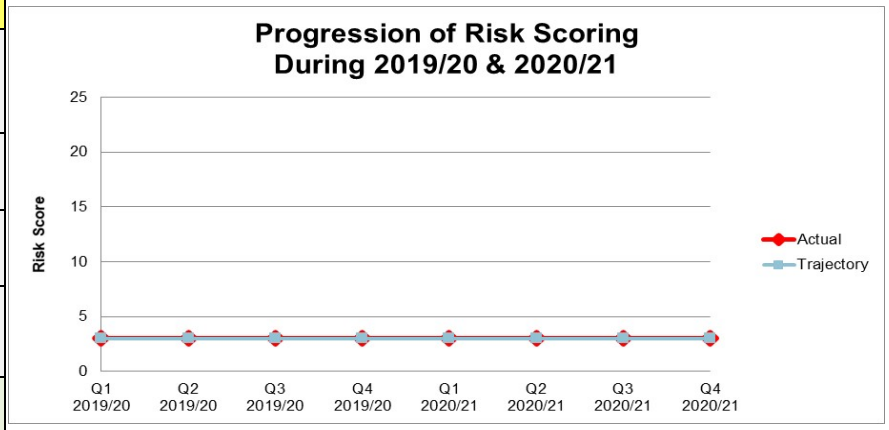
RISK CONSEQUENCES (What might happen if the risk materialises?):

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

Associated Committee: **GROUP SERVICE STRATEGY COMMITTEE**

Operational Lead: **DIRECTORS OF STRATEGY**

Material Additional Supporting Commentary (as required):



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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	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	D.1 Outcome of GM decisions in respect of 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.	

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

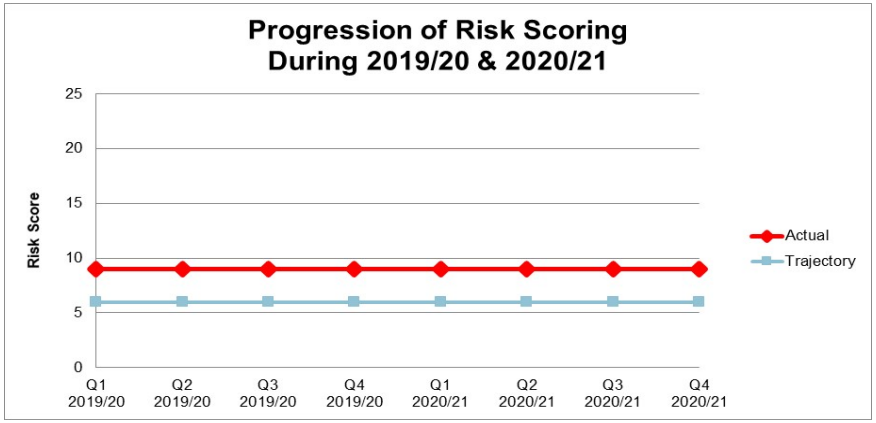
RISK CONSEQUENCES

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
HR SCRUTINY COMMITTEE

Operational Leads:
Group Director of HR

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 The Covid-19 recovery programme established to support Trust wide recovery	B.1 Policy development programme progressing B.2 Mandatory Training Programme needs embedding B.3 Workforce systems programme being implemented B.4 Inadequate funding in learning and education 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 A.5 Real time, establishment control not in place A.10 Vacancies impact upon service delivery, staff wellbeing and development opportunities	C.1 Workforce matters are an integral feature of the Trust's response to COVID-19 and recovery planning. The MFT People plan is under development and taken account of the context of the COVID-19 response and recovery, clinical service strategies and local, regional and national initiatives. 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 Implementation of Employee Health and Wellbeing Service Delivery Model C.15 Group Executive Director of Workforce &	D.1 Limited interoperability of Workforce systems D.2 Competing priorities impacting on engagement in workforce agenda D.3 Workforce metrics are limited and are not triangulated with other data sets e.g. finance, clinical D.4 Resource and funding pressures in workforce teams 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 MFT People Plan. 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 Progress data warehousing approach to workforce data to enable data triangulation 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 A.5 In conjunction with Informatics and Finance, explore data warehousing to enable real time, establishment control	Workforce Team	March 2022	Human Resources Scrutiny Committee	***B.2 Majority of the 41 recommendations in the Mandatory Training Review have been implemented*** ***B.3 Absence Manager has been implemented in full across the organisation and the system information on absence has been instrumental in the workforce modelling exercise to understand the impact of continued absence on delivery of services and workforce recovery*** ***B.3 The Attendance Policy is live on Case Manager supporting managers in the management of long term and frequent absence*** ***B.3 The flu programme is managed entirely through the Empactis Health Manager platform, improving reporting timeliness and quality. This has also provided an infrastructure for capturing staff vaccination information and supporting well-being discussions*** ***C.14 Manager Wellbeing discussions implemented to support Covid-19 risk assessments and engagement with the flu and Covid-19 vaccination programmes. Targeted health and wellbeing support services & programmes being delivered in key areas and based on staff needs. The EHW service achieved a successful SEQOHS re-accreditation*** ***D.3 Workforce metrics are in place for AOF, BAF and local reporting. In conjunction with Informatics, data warehousing is currently being developed to support sickness absence information allowing triangulation with other data sets*** ***A.9 Employee engagement and***	**6 (3x2)**