The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 3rd December 2020

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
3rd December 2020
Virtual Meeting
WCFT
09:30 – 11.40pm

V = verbal, d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.30	Minutes and actions of meeting held on 3rd November	J Rosser	Decision (d)
4	09.35	Patient Story – Jen Makin (Patient Experience Team)	L Vlasman	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update - Verbal	J Rosser/ H Citrine	Information (v)
PERFORMANCE				
6	10.20	Integrated Performance Report	CEO/Execs	Assurance (d)
BREAK – 10 MINS				
QUALITY				
7	10.50	Infection Prevention & Control Assurance Framework	L Vlasman	Assurance (d)
GOVERANCE				
8	11.05	Modern Slavery Act Statement	L Vlasman	Decision (d)
9	11.10	Emergency Preparedness & Readiness Response Self-assessment	J Ross	Decision (d)
10	11.15	Quality Committee Chair's Report	S Crofts	Assurance (d)
11	11.20	Business Performance Committee Chair's Report	J Rosser	Assurance (d)
12	11.25	Charity Committee Chair's Report	S Rai	Assurance (d)
13	11.30	Neuroscience Programme Board Chair's Report	M Burns	Assurance (d)
CONCLUDING BUSINESS				
14	11.35	Items for inclusion in the BAF	J Rosser	(v)
15	11.40	Reflections on the meeting	J Rosser	(v)
		AOB CQC Visit - L Vlasman	J Rosser	Information

Date and Time of Next Meeting:
4th February 2021

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

5th November 2020

Present:

Ms J Rosser	Chair
Ms K Bentley	Non-Executive Director
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Vlasman	Acting Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation
Ms J Hindle	Corporate Secretary

In attendance:

Mr J Baxter	Executive Assistant
Ms S Greenwood-Davies	Specialist Speech and Language Therapist (item TB78-20/21 only)

Observing:

Mr C Cheeseman	Public Governor – Cheshire
Mr J Desmond	Public Governor – Merseyside
Ms M Worthington	Partnership Governor – Cheshire and Merseyside Neurological Alliance

Trust Board Attendance 2020-21

Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Mar
Ms J Rosser	✓	✓	✓	✓	✓		✓		
Mr S Crofts	✓	✓	✓	✓	✓		✓		
Ms S Samuels	✓	✓	✓	✓					
Ms B Spicer	✓	✓	✓	✓	Apols				
Ms S Rai	✓	✓	✓	✓	✓		✓		
Prof N Thakkar	✓	✓	✓	✓	✓		✓		
Mr D Topliffe							✓		
Ms K Bentley							✓		
Ms H Citrine	✓	✓	✓	✓	✓		✓		
Mr M Burns	✓	✓	✓	✓	✓		✓		
Mr M Gibney	✓	✓	✓	✓	✓		✓		
Dr A Nicolson	✓	✓	✓	✓	✓		✓		
Ms J Ross	✓	✓	✓	✓	✓		✓		
Ms L Salter	✓	✓	✓	✓	Apols		Apols		
Ms L Vlasman					✓		✓		

TB75-20/21 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams. It was noted that two new Non-Executive Directors had joined the Trust along with a new Governor and introductions were made.

Apologies were received from Ms L Salter.

TB76-20/21 Declarations of interest

There were no declarations of interest in relation to the agenda.

TB77-20/21 Minutes of the meeting held on the 24th September

It was clarified that Ms Rosser presented item TB72-20/21 and not Ms Spicer. Following completion of this amendment the minutes were agreed as a true account.

TB78-20/21 Patient Story

Ms Greenwood-Davies shared a story from a patient who had been admitted to the Complex Rehab Unit .An overview of the patients diagnosis was provided along with the speech and language therapy diagnosis which concluded that the patient had difficulties in understanding complex auditory information and had limited ability to use expressive language effectively however had good use of gesture and facial expression. The patient had a fall -it was unknown if the patients communication difficulties had played a part in their fall. Information regarding how to support a patient's communication needs was available but not readily accessed by staff. Post fall actions were reviewed and it was highlighted that the patient had felt frustrated by staff hypothesising about why they had fallen and was resistant to falls prevention measures. The Speech and Language Therapists (SLTs) reviewed the patients key communication guidelines and these were placed above the patient's bed and handed over to the ward sister. The SLTs also worked jointly with psychology colleagues to establish the patients understanding of falls prevention methods and the reasons why these were important. The patients outcomes were highlighted and it was noted that the patient had no more falls. An overview of actions to be undertaken moving forward to assist with falls prevention for patients with communication difficulties was provided.

In response to a query from Ms Rai, Ms Vlasman stated that there were few falls with harm in any one year however there were a number of falls with low harm, no harm and assisted falls. Post falls questionnaires were completed with patients following each fall however some patients were unable to complete these which highlighted the importance of this work. Ms Ross confirmed that data relating to falls was contained in the Governance Report.

Professor Thakkar highlighted that evidence that improving communications with patients is beneficial in many areas including patient falls. Ms Rai queried if assessments of which patients were more likely to be at risk of falls were undertaken and Ms Vlasman confirmed that risk assessments of all patients were completed on admission and then revisited on a weekly basis in case anything had changed.

Ms Bentley stated she would contact Ms Greenwood-Davies regarding information sharing.

The Chair thanked Ms Greenwood-Davis for sharing the patient story and noted that important lessons had been made with good improvements made.

TB79-20/21 Chair & Chief Executive Report

Ms Citrine reported the appointment of an additional consultant Interventional Radiologist to strengthen the team . Hayleys Huddle meeting went ahead virtually. They are drop in sessions open to all staff to ask any questions and a short presentation was provided at each session detailing current updates across the Trust. Trust walkabouts were still taking place and an email inbox titled Ask Hayley had also been launched. It was noted that there had been two virtual Hayleys Huddle meetings this year and both had been well attended.

Ms Rosser updated members stating that the Trust had 11 governor vacancies. It was clarified that this would not affect quoracy at meetings however it was recognised that the governor body was depleted with partnership governors most affected.

The national Freedom to Speak Up Guardian office had issued a memo regarding Freedom to Speak Up training for all staff This training is not currently mandated but is available to staff.

The Board:

- **noted the report.**

TB80-20/21 Covid-19 Update

Ms Citrine presented an update regarding COVID-19 informing that the NHS incident level had been raised to level 4 -national command and control structure had been reintroduced 7 days per week and was already in place within the Trust. Daily COVID-19 meetings were held and it was reported that 99% of Trusts across the North west were reporting that they were at the same occupancy levels as the peak reached in April with 6 Trusts reporting to be substantially above the previous peak. All core critical care beds were in use across the region with some patients utilising surge beds however there were some surge beds still available.

It was reported that the sustained survival rate was 85% in critical care patients during the second wave due to a better understanding of the virus however this had an impact on the patient length of stay. Numbers of positive cases were increasing and although the region was in tier 3 prior to the national lockdown it would take a couple of weeks for any improvements to be recorded.

Some Trusts were standing down elective work along with some urgent work. The Trust would be taking head and neck cancer patients as part of mutual aid and the need to continue cancer surgeries across the region had been recognised. A reduced threshold for accepting patient transfers was introduced during the first wave however the Trust was not currently accepting COVID positive patients during this wave in line with the in-hospital cell escalation levels.

Ms Citrine reported that she was part of the in-hospital cell for the region and also the Lead for nosocomial infections across Cheshire and Merseyside.

It was noted that North West Ambulance Service (NWAS) had declared a major incident over the weekend due to the pressures on the service.

Mr Crofts reported that the trajectory of the second wave felt different with hospital capacity threatened very early in the wave and queried what the impact would be

and what plans were in place. Ms Ross stated that the biggest impact on phase 3 plans was staffing- some Trusts had trialled COVID testing of all staff which had led to some asymptomatic staff testing positive and having to isolate. The Trust would be affected by the regional mass testing pilot and it was recognised that staff members who were previously shielding would likely need to do so again. Some elective work may need to be reduced to accommodate mutual aid and there would be an overlap with flu plans and regular winter planning.

Ms Ross reported that debriefing sessions had been held with staff groups after the first wave to understand what support was most needed. It was noted that Project Wingman had received the largest volume of positive feedback from the first wave and the Board Room had been temporarily converted to a staff rest area. A request for charitable funds had also been made to convert external areas into internal areas for additional staff break out areas. Mr Topliffe queried the figure of 27% for the staff survey return rate, Ms Citrine clarified that this was the national staff survey and the return rate was currently 27% with response numbers reduced across the region. The survey had been mainly conducted online this year and the deadline remained open however this was recognised as an early warning to encourage completion.

Ms Rai queried how lowering the threshold for admissions would work and it was clarified that thresholds were lowered each winter but would be lowered further this year however only patients that our clinicians felt confident in treating would be accepted to enable bed space in other Trusts to be freed up.

It was noted that the Trust had introduced mental health first aid training and there had been 40 applicants which equated to approximately a third of line managers. If any further applications were received the trust would look into funding possibilities for these. Training sessions were due to begin in November.

Professor Thakkar stated that occupancy modelling that had been used across Manchester had been very useful and it was confirmed that this was also being used in the Cheshire and Mersey hospital cell. It was noted that the Nightingale hospital in Manchester had reopened and was taking non-COVID patients.

The Board:

- **noted the report.**

TB81-20/21 Transformation Strategy

Ms Ross presented the transformation strategy and noted that this had previously been presented to Business Performance Committee (BPC). Some minor amendments were requested at BPC and these had been taken on board, following this BPC had recommended the strategy for Board approval. An overview of the key points was provided and it was recognised that the Outpatient Review had progressed much quicker due to the impact of COVID-19. Partnerships across Cheshire and Merseyside were reflected within the plan and most actions had timelines assigned with underpinning plans in place. It was confirmed that this strategy would be monitored by BPC.

The Board:

- **approved the strategy subject to inclusion of amendments requested by BPC.**

TB82-20/21 Integrated Performance Report

Ms Citrine provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at both Quality Committee and Business Performance Committee as noted within the chairs reports. The effect of COVID19 on several areas was noted which had created some key challenges around activity and waiting times. It was highlighted that recovery was being noted in some areas and work was underway to sustain this during the second wave. Operational activity was on target for phase 3 plans apart from elective activity and it was noted that diagnostic recovery plans were on track. Cancer waiting times were being maintained and clinicians were reviewing all patients that were not on track. It was recognised that not all activity would be completed due to the second wave however as much as possible would be completed. It was noted that activity recovery plans would not normally be shared at Board but these had been added for clarity.

Quality

Ms Vlasman provided an update on hospital acquired infections and noted that deep dives following the entire patient journey were undertaken for all of the reported MSSA cases. An increase in venous thromboembolisms (VTEs) had been reported however it was clarified that COVID positive patients were susceptible to pulmonary embolisms (PEs) and this accounted for the majority of reported VTEs with only one non- COVID patient VTE recorded.

Performance

Ms Ross commented that recovery within Diagnostics had been much improved however it was recognised that this would likely be affected by mutual aid and deteriorate again during the second wave.

Workforce

Mr Gibney advised members that agency and overtime usage had reduced however bank staff usage had increased. Staff absence rates were reported to be 8.5% with a number of these staff members isolating.

Ms Bentley queried what plans were in place if a number of asymptomatic staff had to isolate following the mass testing pilot within the city region. Mr Gibney clarified that business continuity plans were in place across all areas of the Trust and these would be initiated if required. Ms Citrine noted that asymptomatic staff testing positive across the Cheshire and Mersey region accounted for between 1% and 4% of absences, the biggest issue would likely be due to isolation and child care.

Finance

Mr Burns provided a high-level summary of the financial position at month 6 with a reported deficit before adjustment of 760K. A top up was required due to increased activity and the corresponding increase in costs incurred to deliver this. It was noted that this was the last month that a top-up was available so the Trust was likely to be in a deficit position going forward. The top-up plan was based on an R number of 1 and the North West had been much harder hit. It was stated that

finances would change in months 7 to 12.

Ms Rai queried if the Trust had considered what savings regarding CIP could be materialised. It was recognised that this would be difficult to do at short notice – options had been considered however a long lead time would be required to achieve any savings.

The Board:

- **noted the report.**

TB83-20/21 Winter Plan 2020

Ms Ross presented the winter plan for 2020 and stated that this plan tried to reflect COVID-19 as the biggest pressure. The Trust normally relaxed admission thresholds and offered mutual aid where possible during winter months. It was noted that the plan had not been shared outside the Trust due to meetings where it would normally be shared being cancelled. It was noted that the main winter pressure for the Trust would normally be trauma patients and the Trust had learnt lessons from previous winters. It was recognised that there would be difficulty in managing this along with COVID pressures and the increased terrorism threat. It was clarified that the capacity plan took into account a reduced number of beds due to distancing measures implemented between each bed space.

Ms Rai queried if the flu jab was available for staff working from home, and it was clarified that the flu jab had only been offered to clinical staff so far.

The Board:

- **approved the plan.**

TB84-20/21 Nosocomial Infections

Ms Vlasman provided an update on work to reduce and minimise the transmission of nosocomial infections within the Trust and gave an overview of the key themes. It was highlighted that the use of appropriate PPE had been reviewed and the Trust was working with Liverpool Clinical Laboratories (LCL) to deliver a robust testing plan. Action plans were put in place for each outbreak and bed spaces had been reviewed with some beds being removed to ensure two metre distancing between each bed. All patients were required to wear face masks when mobilising and a programme of regular deep cleaning was in place which had been extended further in areas with COVID positive patients. Visiting has been suspended and work had been undertaken to remove furniture from day rooms and ensure distancing measures were in place. The Same Day Admission area in Theatres had been utilised as an additional day room to provide additional space and the Board Room had been converted into a staff break out area.

A COVID outbreak had been identified within Theatres with two members of staff tested positive. Following this a full screening programme was undertaken with all Theatres staff, including those who were asymptomatic, and patients swabbed and tested. A further 11 positive cases were identified and this outbreak was closed after 28 days.

A further outbreak was identified on Cairns ward following a patient testing positive. All other patients on the ward and ward staff were tested and three further patients and 7 staff members were confirmed as positive. The ward was closed for a deep clean and patients moved to the red pathway.

For each outbreak Public Health England (PHE), the CQC and NHSE were informed. A meeting was held with PHE who reported that they were pleased with the work undertaken by the Trust and had no recommendations to make.

Ms Rai queried whether changes had been made to the Do Not Attempt Resuscitation (DNAR) policy. It was clarified that changes had recently been agreed however these were not related to COVID-19.
Ms Rai queried if there was a timescale for when visiting might be reintroduced. It was noted that there was no date as yet but this was constantly under review. The Trust was working collaboratively with all other Trusts across the region to ensure a consistent approach however it was noted that there were some exceptions for visiting such as long term patients and end of life care. It was highlighted that a team of staff were assisting with daily telephone calls to update patients families.

The Board:

- **noted the update report.**

TB85-20/21 Nurses Revalidation Annual Report

Ms Vlasman presented the annual Nurse revalidation report and noted that staff had to register with the NMC annually and revalidate every 3 years. The Trust had recorded 100% compliance every year since the revalidation process was introduced.

The Board:

- **noted the report.**

TB86-20/21 Q2 Governance, Risk and Patient Experience Report

Ms Vlasman presented the Q2 governance, risk and patient experience report and informed all that this had been previously discussed by Quality Committee. There had been two serious incidents recorded in Q2-one was an unexpected cardiac arrest due to a dislodged tracheotomy and the second was an unstageable pressure ulcer. An increase in incidents of violence and aggression towards staff was noted and it was clarified that the majority involved patients who lacked capacity and there were 3 patients who had been responsible for 26 of these incidents. There had been one incident that required reporting to RIDDOR and this was in relation to a staff injury that resulted in a 7 day absence from work. There were 3 new risks on the COVID risk register and an overview of these was provided. Ms Citrine noted that this was a key report that provided assurance that the appropriate actions were being taken.

Ms Rai queried if feedback was received from the relevant bodies that serious incidents were reported to. It was clarified that feedback is received once the process is completed, in relation to the patients with a dislodged tracheotomy this had been shared with commissioners and a deep dive was underway. This had been discussed at the closed Board session last month prior to this work being undertaken and it had also been openly discussed with the family under duty of candour.

A large increase in communication issues had been noted, it was highlighted that this was a combination of all communication issues and work was underway to

break this data down to see the detail clearly.

Ms Rai queried if the outcome of the deep dive into increased MSSA rates was available. It was clarified that this was not yet available however a full review of every step of the journey had been undertaken by the Infection Prevention and Control Team with the Clinical Director for Neurosurgery and the results would then be compiled onto an A3 presentation which was likely to be reported back to Quality Committee in January and then fed back to Board.

Mr Topliffe noted that the number of incidents in Q2 for 2020/21 was higher than any other time and queried if this was due to an increase in reporting or an increase in actual incidents. It was confirmed that there had been an increase in reporting around medication discrepancies and an increase in Deprivation of Liberty Safeguards (DoLS) issues due to delays in local authority attendance. An increase in violence and aggression incidents was always a concern however it was recognised that this figure can fluctuate due to the patient cohort who are prone to this as part of their condition or treatment and the trend analysis would show more detailed information and reasoning.

Mr Crofts queried if data relating to how many incidents were due to one particular patient could be provided, Ms Vlasman would review this and provide a response.

The Board:

- **noted the report.**

TB87-20/21 Mortality and Morbidity Quarterly Report Q1 and Q2

Dr Nicolson presented the mortality and morbidity report for Q1 and Q2 and noted that this had previously been discussed in detail at Quality Committee. An increase in the crude number of deaths was recorded during Q1 due to the change in patient type such as stroke patients being treated at the Trust however this had reduced again during Q2. All deaths were reviewed at mortality and morbidity meetings. Fluctuations in the RAMI (Risk Adjusted Mortality Index) score were highlighted and it was noted that additional work was required around this. It was reported that fluctuations were related to co-morbidities and how these were coded, the length of stay of the patient etc. An increase in the crude numbers had been recorded over the previous 12 months however this was related to the differing patient mix, such as thrombectomy patients.

Mr Topliffe queried why the readmission data appeared to be lower than average and it was clarified that patients from the Trust were likely to be readmitted to another Trust.

The Board:

- **noted the report.**

TB88-20/21 Strategic BAME Advisory Committee Terms of Reference

Ms Citrine presented the terms of reference for the Strategic BAME Advisory Committee for ratification and highlighted that this committee had been set up as a more senior level group to oversee issues in BAME staff and patient inequalities.

The first meeting had taken place and had been well attended. An overview of key areas of discussion was provided.

The Board

- **ratified the terms of reference.**

TB89-20/21 Audit Committee Chair Report

Ms Rai provided an update from the Audit Committee meeting held on 20th October focusing in particular on the annual review of Standing Financial Instructions (SFI) and the Scheme of Reservation and Delegation (SoRD). A benchmarking paper on regional SoRD limits and proposed revised limits was presented and recommended for Board approval. Three tender waivers were presented for consideration and it was agreed to explore the possibility of transferring two of these to purchase orders going forward.

The Board

- **noted the update from the Audit Committee.**

TB90-20/21 Quality Committee chair report

Mr Crofts provided an update from the meeting of the Quality Committee held on 22nd October and highlighted that COVID debriefing sessions were in place for staff.

The Board:

- **noted the update from the Quality Committee**

TB91-20/21 Business Performance Committee chair report

Ms Rosser provided an update from the meeting of the Business Performance Committee held on 27th October focusing on a detailed review of the financial framework and planning submission. A presentation had been received by the committee detailing the ongoing transformation programme work which had been well received.

The Board:

noted the update from the Business Performance Committee

TB92-20/21 Research, Development & Innovation Committee chair report

Mr Crofts provided an update from the meeting of the Research, Development & Innovation Committee noting the challenges in progressing people through studies due to the impact of COVID-19, it was also highlighted that predicted income from research studies was £300k lower than expected due to this. A large amount of activity was underway regarding COVID studies which were off plan. A report had been received from Health Education England in relation to medical education which provided a lot of recognition of the Trusts successes and the need to consider job planning for Consultants involved was highlighted.

The Board:

- **noted the update from the Research, Development & Innovation Committee**

TB92-20/21 Education and Training Self-Assessment Report

Dr Nicolson presented an Executive summary of the education and training self-assessment report which highlighted the multidisciplinary approach to training across the Trust. It was noted that the undergraduate education curriculum was changing to provide greater scrutiny on what funding was spent on. It was recognised that medical education was a strength of the Trust and the feedback from the first batch of students during COVID times was positive.

The Board:

- **approved the self-assessment return**

TB93-20/21 Standing Financial Instructions / Scheme of Reservation and Delegation

Ms Hindle presented a report highlighting key changes in Standing Financial Instructions and the Scheme of Reservation and Delegation. It was noted that approval limits had been updated however these would not take effect until the current emergency powers ended. The updated limits were recommended for approval.

The Board:

- **approved the change of limits**

TB95-20/21 AOB

The Trust had received a letter from NHSEI requesting that the Trust step up Brexit preparations via the emergency planning route. It was noted that EPRR Leads were managing this through the same route as COVID for business continuity. The potential for traffic disruption in Liverpool was noted as Liverpool could be utilised as a back-up port. Professor Thakkar queried if any clinical trials would be impacted and it was clarified that had been reviewed as part of the early planning phase and no concerns had been identified however this would be revisited.

TB96-20/21 Reflections on the Meeting

Mr Cheeseman informed that he was interested to see the shape of the agenda and overall was impressed by the way things had changed and business had been put together. It was felt that the balance was correct and papers were accessible which led to good discussions. Good analysis was provided along with clear position statements and Mr Cheeseman felt that there was a very strong Board in place.

Ms Bentley wished to echo the comments made by Mr Cheeseman noting that there were a lot of papers but they had been well prepared and presented. The level of debate was felt to be good and proportionate and Ms Bentley informed that

she would link in with Ms Greenwood-Davies regarding disability communications.

Mr Topliffe confirmed that as a new board member he was on a steep learning curve with a lot of acronyms and jargon to learn however the papers were very good.

Ms Rai stated that there had been a good balance between COVID and non-COVID issues and noted that the key points within the executive summary could be bullet pointed to steer the Board to the pertinent points.

Mr Crofts stated that the new Non-Executive Directors made the Board stronger and this would bring different aspects and good challenge to the Board.

Ms Citrine noted that it was good to have a full recruitment of Non-Executive Directors and also wished to commend Ms Vlasman who has provided the Board with a high standard of papers and dealt with challenge well.

There being no further business the meeting closed at 12.45pm

TRUST BOARD
Matters arising Action Log
December 2020

	Complete & for removal
	In progress
	Overdue

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
05.11.20	**TB78-20/21**	**Patient Story** Ms Bentley to contact Ms Greenwood-Davies regarding information sharing.	K Bentley		December 2020	
05.11.20	**TB87-20/21**	**Q2 Governance, Risk and Patient Experience Report** Acting Director of Nursing and Governance to review how many incidents of violence and aggression were attributed to one particular patient	L Vlasman		December 2020	
22.05.20	**TB16/20-21**	**COVID 19 Update** Director of Workforce to provide an update on the national and local position in relation to annual leave of staff.	M Gibney	**June 2020** There had been no national update on the matter and it was not expected until the end of the financial year.	~~June 2020~~ February 2021	
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **May 2020** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ March 2021	

REPORT TO TRUST BOARD

Date 03/12/2020

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Deputy Chief Executive
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence
Previously considered by:	• Committee – None • Group - None • Other - None

Executive Summary

This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee. Measures have been grouped into three categories to highlight high performing measures, measures with opportunity for improvement and those measures currently under performing. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking.

The ongoing COVID-19 situation has impacted the performance of a number of measures. Changes to Outpatient and Elective services in response has led to increased waiting times for overall RTT Pathways and for our 6 week wait diagnostic tests due to the reduction in elective and outpatient activity. Activity has now increased and is planned to continue to throughout the remainder of the year. Cancer Performance has remained above targets as the Trust has continued to prioritise this activity. Healthcare Acquired Infections and Harms have remained within expected low levels.

Key Performance Indicators – Caring **Opportunity for Improvement Measures** Complaints – Due to covid19 all complainants were written to and advised there may be a delay in response. The divisions and patient experience team are now working closely together to respond to complaints. **Key Performance Indicators – Well Led** **High Performing Measures** Agency Spend Staff Friends & Family Test **Opportunity for Improvement Measures** Vacancy Levels Nursing Turnover Sickness/Absence	**Key Performance Indicators – Responsive** **High Performing Measures** Cancer Standards – Two Week Wait Cancer Standards – 31 Day First Definitive Treatment Cancer Standards – 31 Day Subsequent Treatment Cancer Standards – 28 Day Faster Diagnosis **Opportunity for Improvement Measures** 6 Week Diagnostic Waits – A recovery plan was produced and performance against this standard has improved over last five months and has moved closer to target. Due to infection prevention and controls measure resulting in activity being limited to 90% of normal levels in Radiology performance remains a risk. **Key Performance Indicators – Effective** **Underperforming Measures** Referral to Treatment – Wales as described in the paper the trust has only seen and treated urgent patients **Key Performance Indicators – Safe** **Opportunity for Improvement Measures** Infection Control – local performance is on plan with the exception of MSSA and the Trust is generally in line with national benchmark average, also with the exception of MSSA in which incidences have increased in 20/21.
Related Trust Ambitions	Delete as appropriate: • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	
Related Assurance Framework entries	

Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____
Action required by the Board	Delete as Appropriate • To consider and note

NHS
The Walton Centre
NHS Foundation Trust

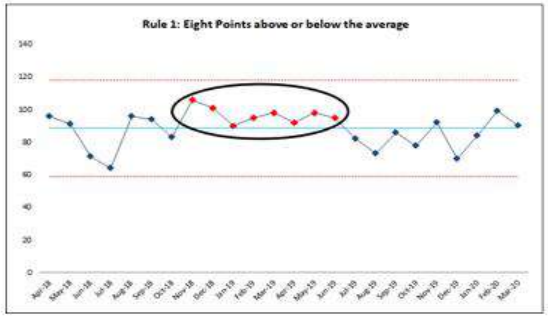
Board KPI Report
November 2020

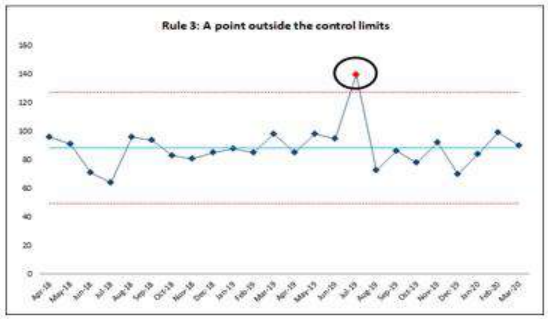
Data for October 2020 unless indicated

SPC Charts Rules

The Walton Centre NHS Foundation Trust

When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in seperating normal variation (exepcted performance) from special cause variation (unexpected performance).





All SPC charts will follow the below Key unless indicated

Actual — UCL — Average — LCL — National Average — Target

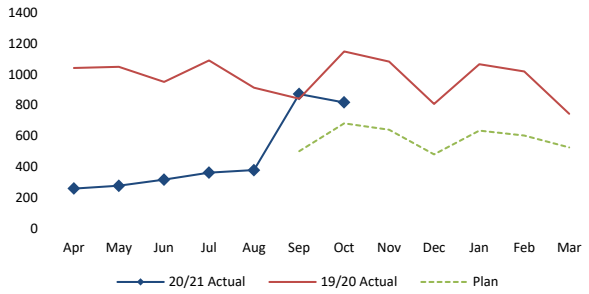
Excellence in Neuroscience

Operational

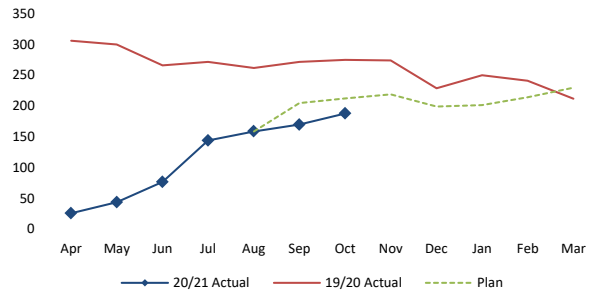
Effective - Activity Recovery Plan

The Walton Centre
NHS Foundation Trust

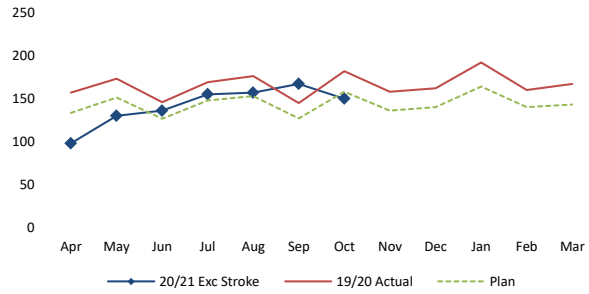
Daycase Activity v Plan



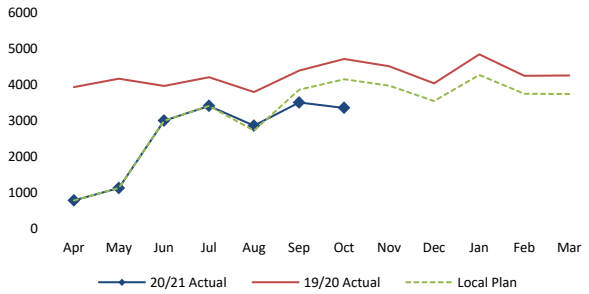
Elective Activity v Plan



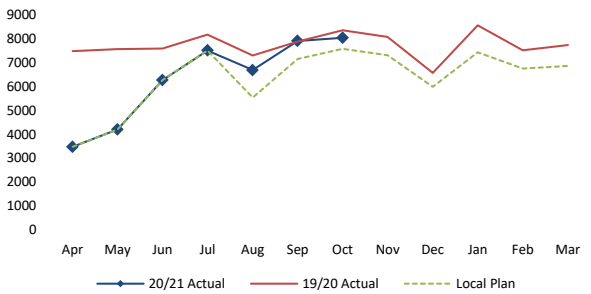
Non Elective Activity v Plan



New Outpatients Activity v Plan



Follow Up Outpatients Activity v Plan



October 20 Activity Performance

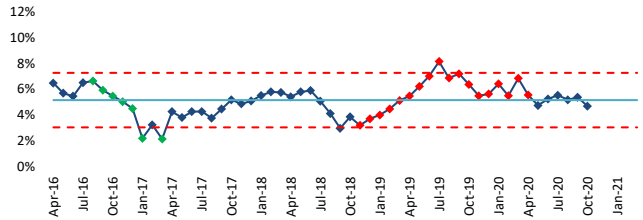
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	71.19%	59.29%
Elective	68.36%	77.29%
Non Elective	94.94%	85%
New Outpatients	71.08%	87.95%
Follow Up Outpatients	96.22%	90.69%

Quality of Care

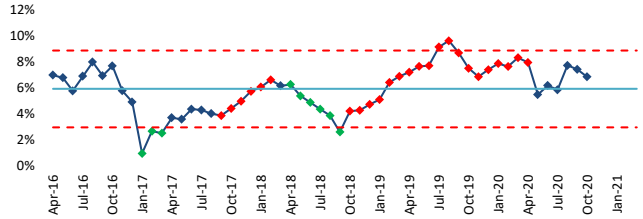
Well Led - Workforce KPIs

NHS
The Walton Centre
NHS Foundation Trust

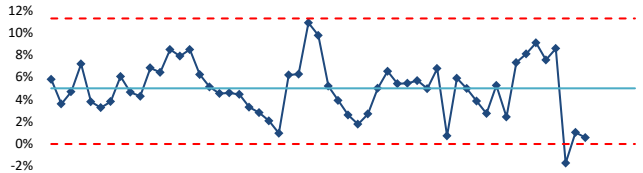
Overall Vacancy Level %



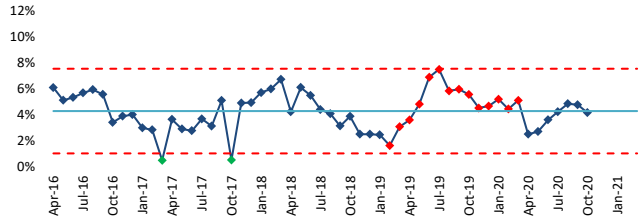
Nursing Vacancy Level %



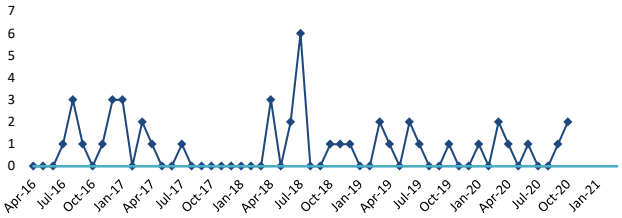
Medical Vacancy Level %



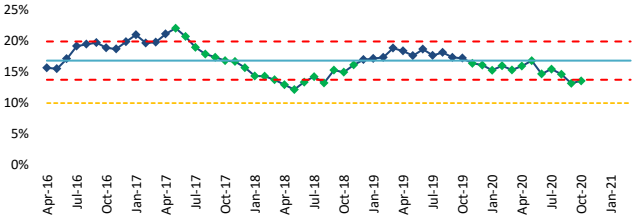
Other Staff Vacancy Level %



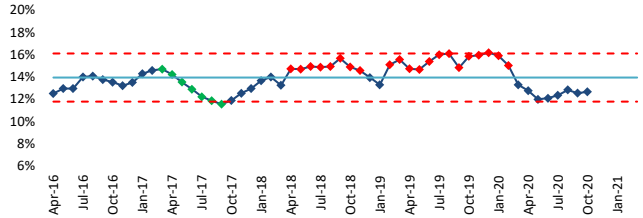
Medical Leavers



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Vacancy Levels

After a period of special cause variation Overall vacancy levels are within normalvariation. This is also the case when broken down to staff group for nursing and other staff. Medical vacancies are inside expected limits.

Nursing Turnover

Nursing turnover has significantly improved over the last 11 months and is within special cause variation. At division level, the target is also outside of the control limit for neurology and neurosurgery, however Neurosurgery experienced special cause variation in Oct 20 and is below the target.

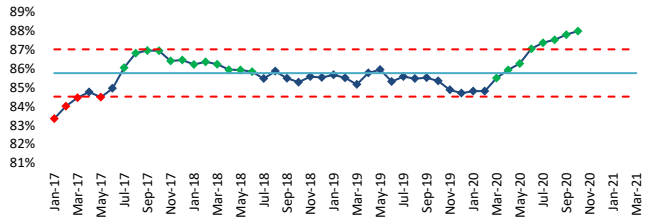
Sickness/Absence

Sickness/Absence is within expected levels for all types, however long term sickness has significantly increased over the last year.

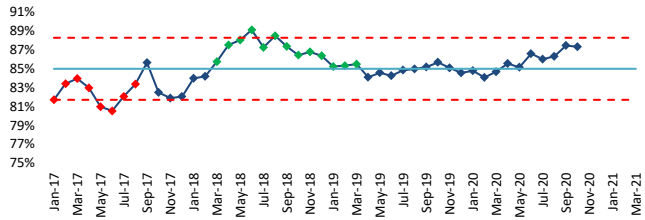
Staff Stability

Staff stability index for all staff has significant improved since March 20, this looks driven by more nursing staff remaining in post for 12 months.

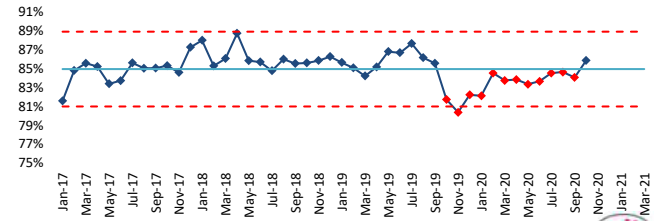
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

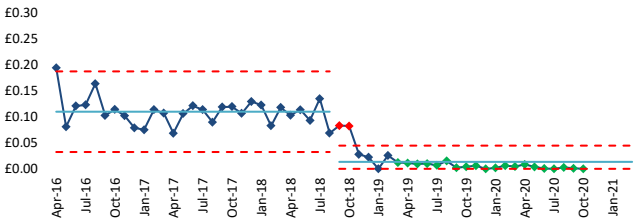


Quality of Care

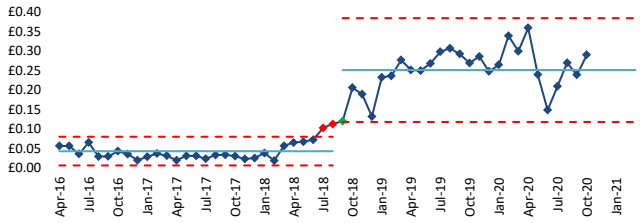
Well Led - Workforce KPIs

NHS
The Walton Centre
NHS Foundation Trust

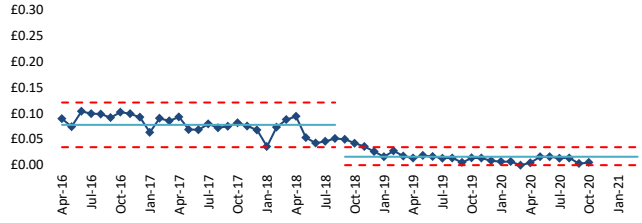
Nursing & HCA Agency Spend (£m)



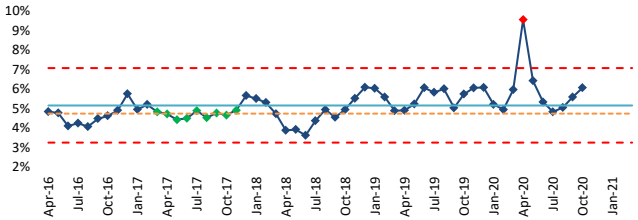
Nursing & HCA Bank Spend (£m)



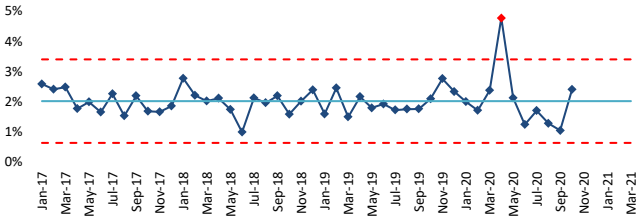
Nursing & HCA Overtime Spend (£m)



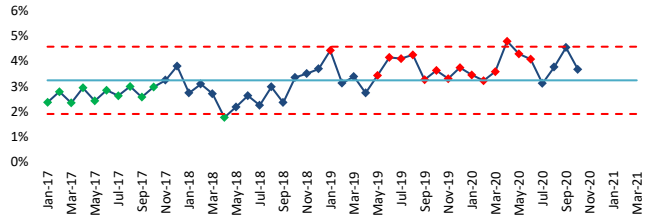
Sickness/Absence (Monthly)



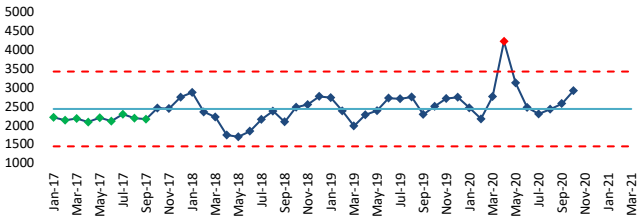
Short Term Sickness/Absence (Monthly)



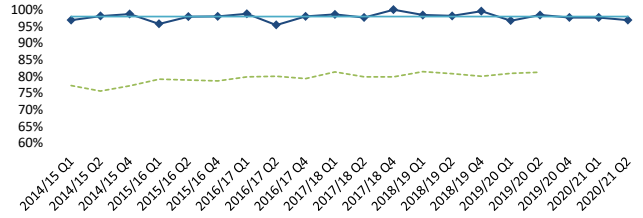
Long Term Sickness/Absence (Monthly)



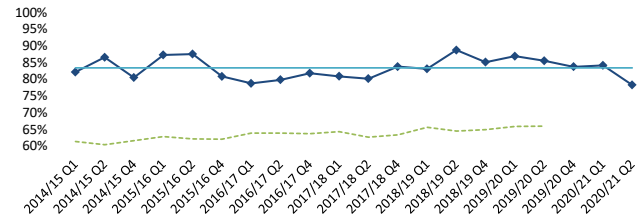
Lost Days due to Sickness/Absense (Monthly)



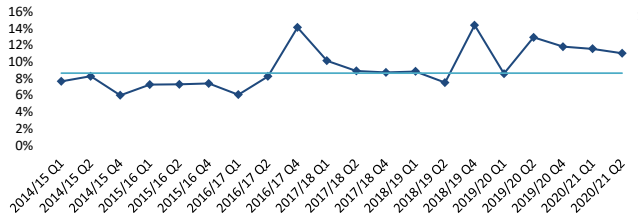
Staff FFT - % Recommend as Place of Care



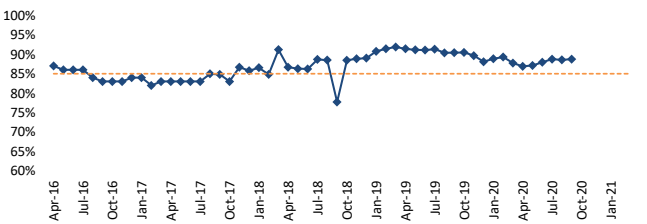
Staff FFT - % Recommend as Place of Work



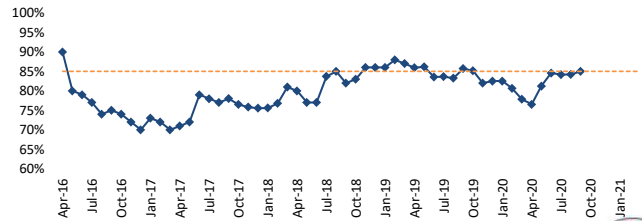
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)

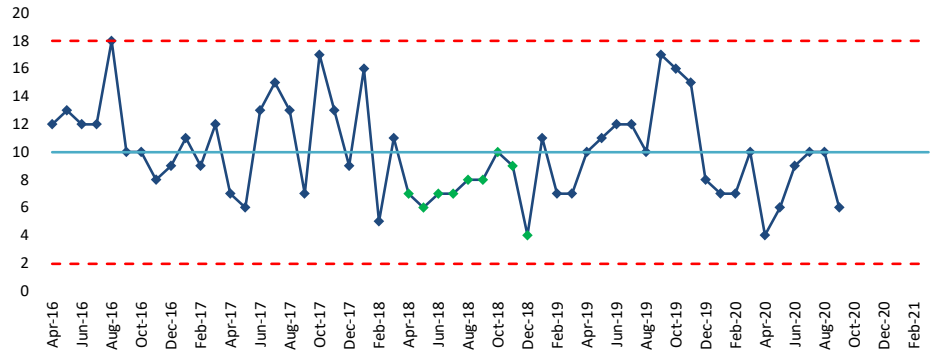


Quality of Care

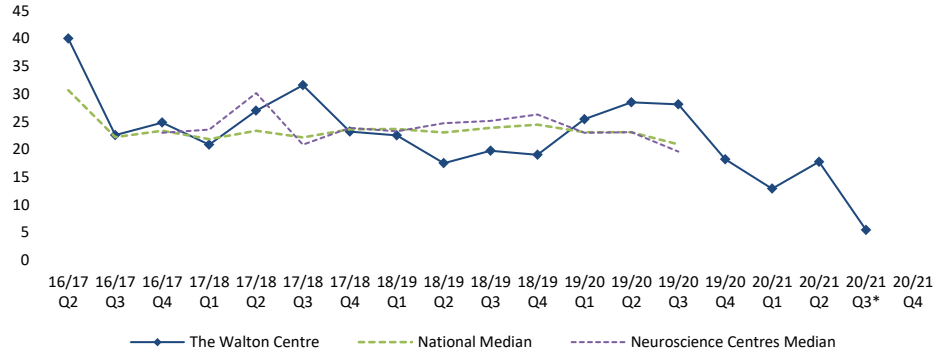
Caring - Complaints

The Walton Centre NHS Foundation Trust

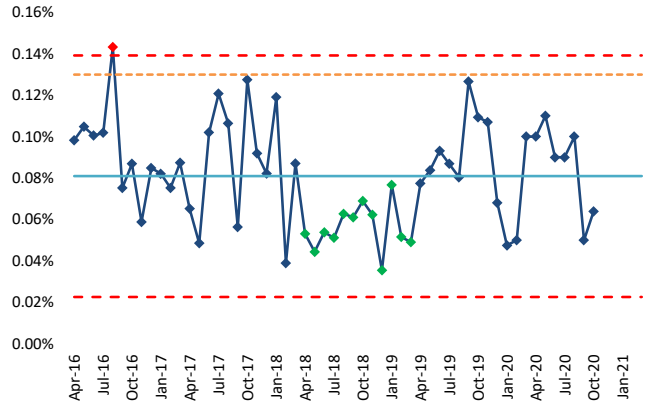
Total Complaints Received in month



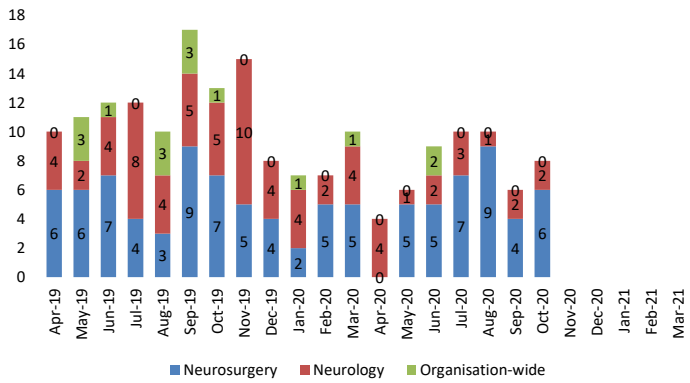
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In October 2020 the Trust received 8 complaints. 2 Neurology and 6 Surgery.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received per 1000 WTE is above both the national average and other Organisations with a large neurosciences service. Local data shows a reduction in Q4 and Q1. Publication of national data has been suspended due to COVID-19.

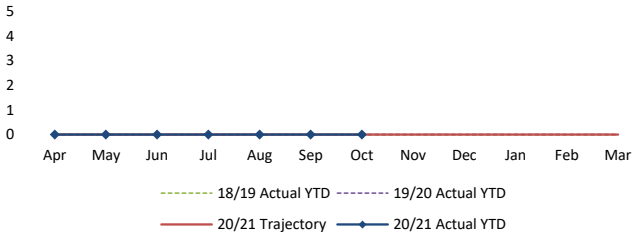
Excellence in Neuroscience

Quality of Care

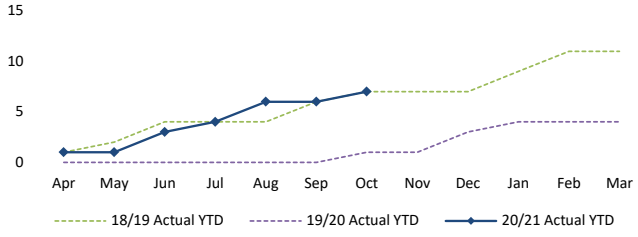
Safe - Infection Control

The Walton Centre NHS Foundation Trust

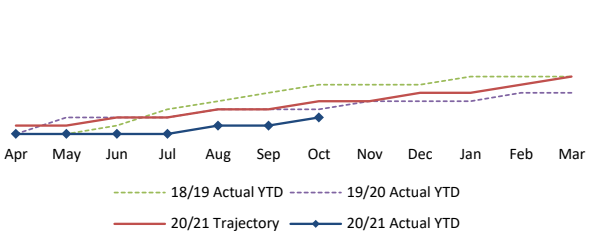
MRSA Bacteraemia



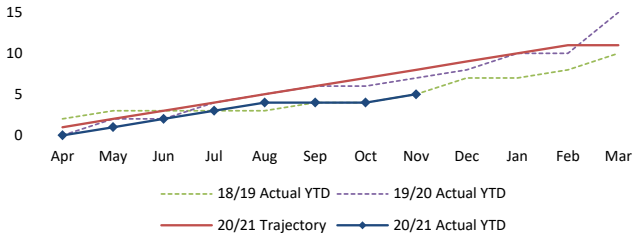
CPE



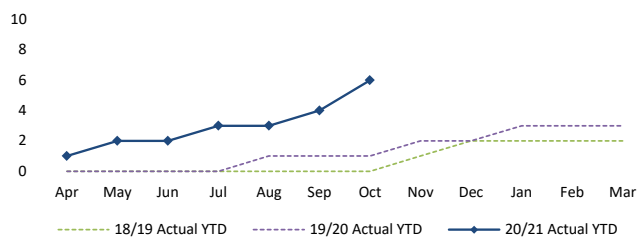
C.Diff



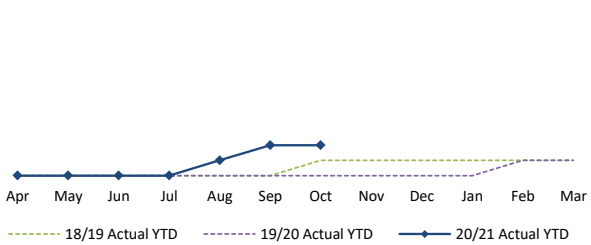
E.Coli



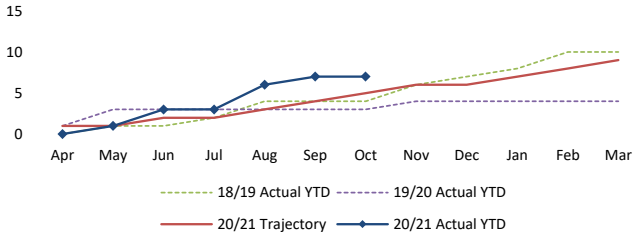
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		2	1				1	**4**
Caton		1					2	**3**
Chavasse				1		1		**2**
CRU					1			**1**
Dott		3		1	2		1	**7**
Horsley		1	1	2	2	1	3	**10**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**7**	**2**	**5**	**6**	**2**	**7**	**29**

October Breakdown

1x C.Diff- Horsley
1x CPE - Cairns
2x KB - Dott, Horsley
1x E.Coli - Horsley

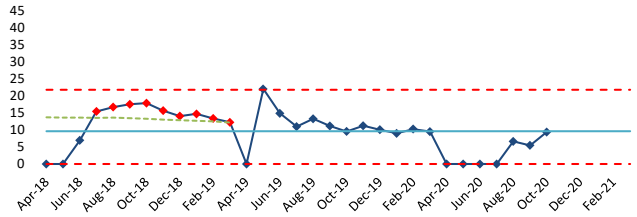
Excellence in Neuroscience

Quality of Care

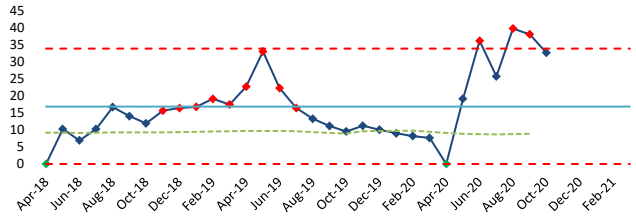
Safe - Infection Control

The Walton Centre NHS Foundation Trust

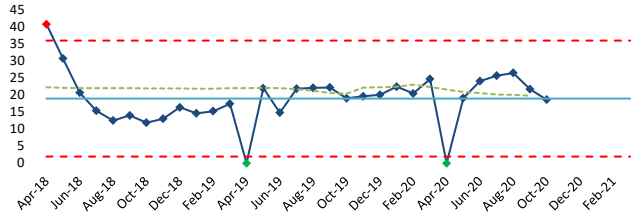
C.Diff Rate per 100,000 Bed Days YTD



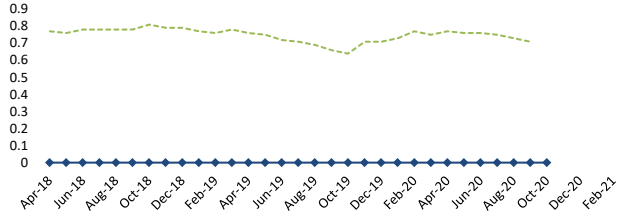
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

All infection types are within their YTD trajectory level for 20/21 during October 20 with the exception of MSSA in which there has been seven recorded instances against a YTD trajectory of five.

MSSA rates per 100,000 bed days had typically been above the national average since July 18 and after reducing have increased again in 20/21.

E.Coli rates have been better or inline with the average, while MRSA has been consistently better.

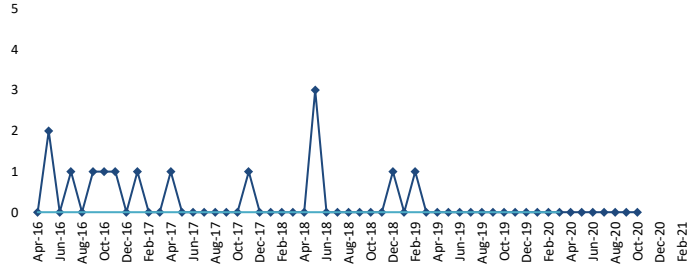
As of March 19 the C.Diff hospital acquired rate is no longer published.

Quality of Care

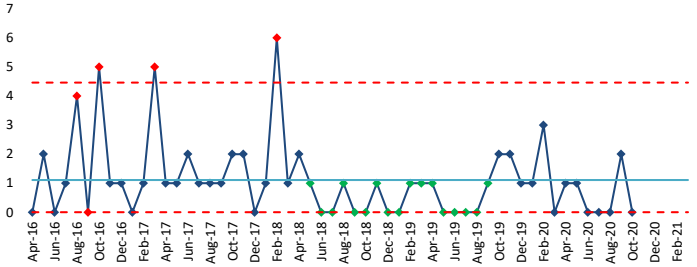
Safe - Harm Free Care

The Walton Centre NHS Foundation Trust

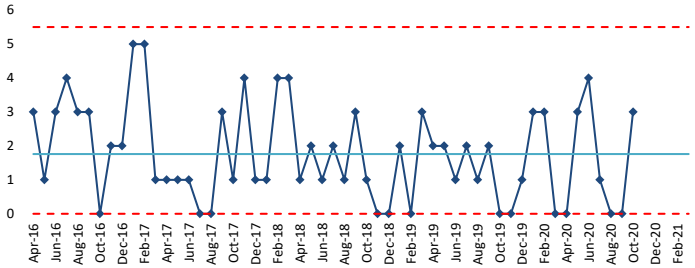
Total Moderate or Above Harm Patient Falls



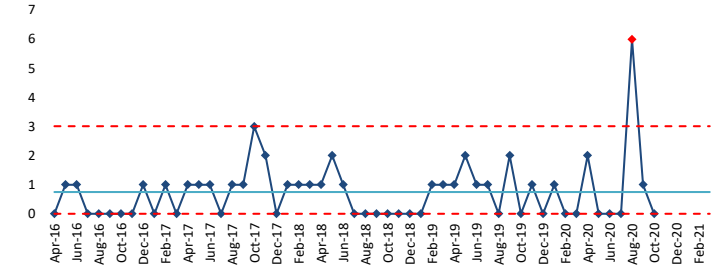
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no falls which resulted in moderate or above harm in October 20.

There were no Hospital Acquired Pressure Ulcers in October 20

There were three CAUTI incidences in October 20

There were no VTE incidence in October 20.

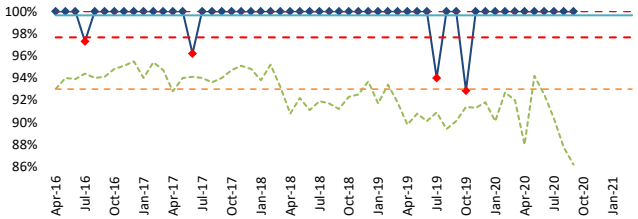
All harm measures are within normal variation.

Operational

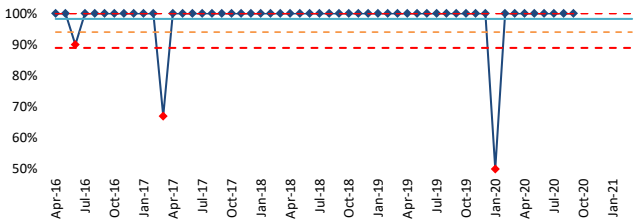
Responsive - Cancer

The Walton Centre NHS Foundation Trust

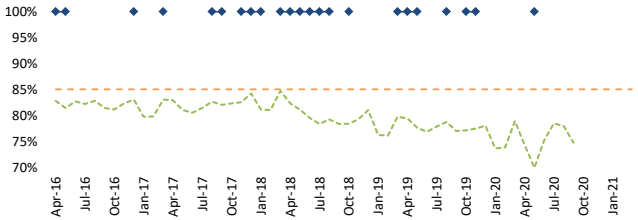
14 Day Performance



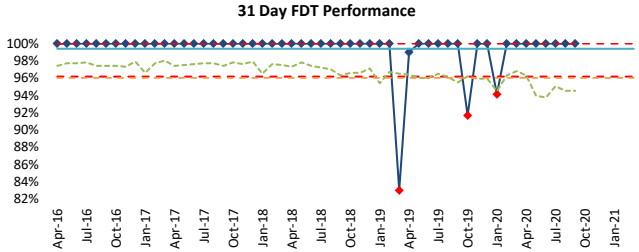
31 Day Subsequent Performance



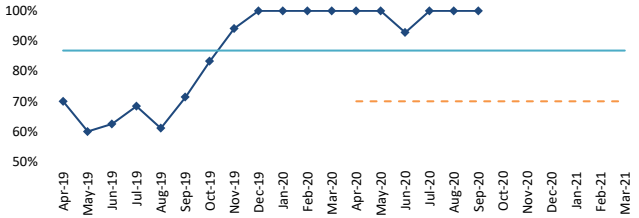
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

All Cancer Access Standards have been met in the latest reporting period of September 2020.

The Trust has continued to see and treat all cancer patients throughout April as these patients were urgent, therefore the impact of covid-19 is minimal.

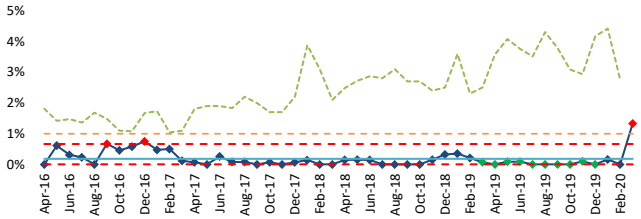
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has consistently met this target since its introduction.

Operational

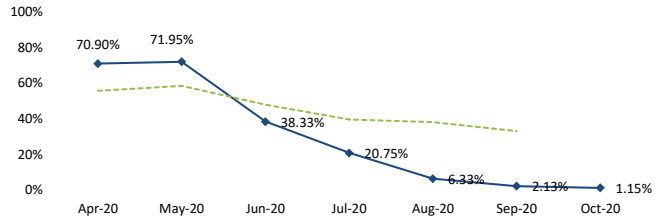
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

6 Week Diagnostic Performance (16/17 - 19/20)



6 Week Diagnostic Performance (20/21)

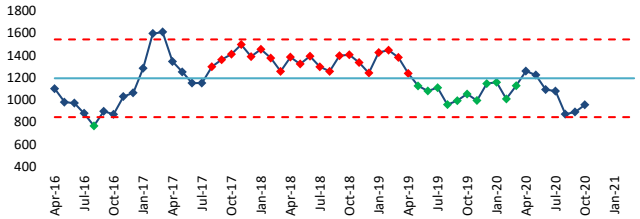


Narrative

Diagnostic performance in October 20 was 1.15%. This is an improvement from 2.13% in September 20.

Performance has improved since May, however due to Infection Prevention and Control measures Radiology will be running at 90% capacity which remains a risk to performance.

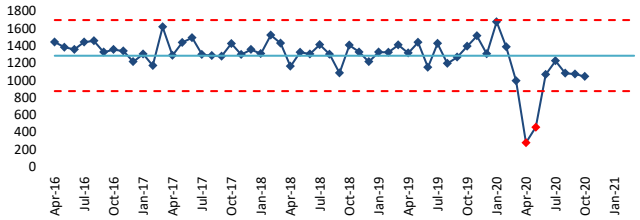
Total Diagnostic Waits at Month End



There were 11 six week diagnostic breaches in month.

MR - 11

Total Diagnostic Activity in Month



WELL LED

Finance

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	9,054	9,183	129	60,059	60,188	129	105,022	105,580	558
Exclusions	1,786	1,786	0	12,499	12,499	0	21,427	21,427	0
Private Patient	1	11	10	24	34	10	29	39	10
Other Operating	428	534	106	3,169	3,275	106	5,402	5,560	158
Total Operating Income	**11,269**	**11,514**	**245**	**75,751**	**75,996**	**245**	**131,880**	**132,606**	**726**
Pay	(6,066)	(6,082)	(16)	(42,010)	(42,025)	(15)	(72,565)	(72,607)	(42)
Non-Pay	(2,437)	(2,639)	(202)	(16,920)	(17,124)	(204)	(29,168)	(29,704)	(536)
Exclusions	(1,785)	(1,554)	231	(9,808)	(9,577)	231	(18,736)	(18,504)	232
COVID / Reserves	(509)	(402)	107	(3,138)	(3,029)	109	(6,353)	(6,347)	6
Total Operating Expenditure	**(10,797)**	**(10,677)**	**120**	**(71,876)**	**(71,755)**	**121**	**(126,822)**	**(127,162)**	**(340)**
EBITDA	**472**	**837**	**365**	**3,875**	**4,241**	**366**	**5,058**	**5,444**	**386**
Depreciation	(403)	(404)	(1)	(2,820)	(2,822)	(2)	(4,834)	(4,837)	(3)
Profit / Loss On Disp Of Asset	0	1	1	2	3	1	2	3	1
Interest Receivable	0	0	0	5	5	0	5	9	4
Financing Costs	(52)	(52)	0	(361)	(362)	(1)	(620)	(620)	0
Dividends on PDC	(95)	(95)	0	(881)	(882)	(1)	(1,357)	(1,362)	(5)
I & E Surplus / (Deficit)	**(78)**	**287**	**365**	**(180)**	**183**	**363**	**(1,746)**	**(1,363)**	**383**
Capital donations I&E impact	**19**	**(91)**	**(110)**	**121**	**11**	**(110)**	**216**	**106**	**(110)**
I & E Surplus / (Deficit)	**(59)**	**196**	**255**	**(59)**	**194**	**253**	**(1,530)**	**(1,257)**	**273**

In response to the COVID-19 pandemic, the financial regime has now moved into the next phase, with the trust now being monitored against the year-end forecast of £1.5m deficit submitted in October (a revised forecast was submitted on 16th November with a planned year end deficit of £1.3m). Although this plan is currently being assumed by NHSI/E, it has not been finalised / agreed.

From October (Month 7), the key changes from reporting in April – September (Month 1-6) are:
- 'Block' funding received for COVID related costs & growth (based on fair share of sector funding) for M7-12 rather than being reimbursed via retrospective top-up;
- No retrospective monthly top-up funding will be received to bring Trust to breakeven;

At month 7, the Trust reported a £194k surplus position. This is a £253k improvement against the planned deficit position of £59k. The improvement primarily driven by underspends on excluded drugs and devices.

The in-month position includes £0.2m spend incurred as a result of COVID-19.

The Trust is forecasting a year end deficit position of £1.3m (after the impact of donations), which is in line with the planned year end position.

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Oct-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	38	(11)
Tangible Assets	82,591	80,956	(1,635)
TOTAL NON CURRENT ASSETS	**82,640**	**80,994**	**(1,646)**
Inventories	1,232	1,322	90
Receivables	9,287	6,974	(2,313)
Cash at bank and in hand	26,673	40,238	13,565
TOTAL CURRENT ASSETS	**37,192**	**48,534**	**11,342**
Payables	(18,088)	(28,200)	(10,112)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(29,874)**	**(10,112)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,660**	**1,230**
Provisions	(639)	(621)	18
Finance Lease	(115)	(90)	25
Loans	(25,031)	(24,333)	698
TOTAL ASSETS EMPLOYED	**74,285**	**74,610**	**325**
Public Dividend Capital	27,554	27,696	142
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,370	183
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,610**	**325**

STATEMENT OF CASH FLOW - 2019/20	October-20 Plan	October-20 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(181)**	**183**	**364**
Non-Cash Flows In Operating Surplus/(Deficit)	4,055	4,062	7
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**3,874**	**4,245**	**371**
Increase/(Decrease) In Working Capital	14,117	13,644	(473)
Increase/(Decrease) In Non-Current Provisions	(11)	(18)	(7)
Net Cash Inflow/(Outflow) From Investing Activities	(5,383)	(3,415)	1,968
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**12,597**	**14,456**	**1,859**
Net Cash Inflow/(Outflow) From Financing Activities	(462)	(891)	(429)
NET INCREASE/(DECREASE) IN CASH	**12,135**	**13,565**	**1,430**
OPENING CASH	**26,673**	**26,673**	**0**
CLOSING CASH *	**38,808**	**40,238**	**1,430**

*Cash flow inclusive of an additional month of commissioner payments due to providers having to deal swiftly with the Covid-19 outbreak.

COVID-19 expenditure:

YTD £2.0m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

In month (October) spend was £222k.

COVID-19 costs are subject to independent audit if requested through NHS Improvement.

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	Jul-20 Actual £'000	Aug-20 Actual £'000	Sep-20 Actual £'000	Oct-20 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	49	91	898
Annual leave provision	287	(287)	52	0	0	0	0	52
PPE	62	148	259	63	10	94	0	636
Decontamination	9	8	(2)	6	(3)	9	4	31
Agile working	21	(19)	1	92	0	3	97	195
ITU	5	2	(3)	0	2	0	(2)	4
Other	37	24	18	23	18	33	32	185
TOTAL	**520**	**130**	**516**	**302**	**123**	**188**	**222**	**2,001**

Other spend includes providing free car parking for staff, increasing the number of staff uniforms for staff and a contribution towards storage costs at the Liverpool arena for PPE.

Capital

In month plan - £1,342k

In month actual - £261k

In month variance - £1,081k below plan.

Year to date - £2,002k below plan

The full year plan includes additional non-recurrent funding of £0.5m allocated by NHSI for critical infrastructure costs.

Despite this increase there is still a forecast over commitment against annual plan of approx. £0.7m.

The Trust has been allocated £0.5m from the C&M Adapt and Adopt scheme for an additional CT scanner which will be utilised by the Trust and to provide additional diagnostic capacity for the local system.

The detailed capital forecast is being monitored and reviewed regularly by Director of Finance and Director of Ops and Strategy.

CAPITAL

	Annual Plan £'000	In month Plan £'000	In month Actual £'000	In month Var £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Var £'000
Division							
Heating & Pipework	1,482	196	97	99	831	395	436
Estates	368	31	21	10	215	117	98
IM&T	1,283	107	27	80	748	204	544
Neurology	2,122	1,435	(12)	1,447	1,695	6	1,689
Neurosurgery	1,702	142	128	14	993	215	778
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,603)	(569)	0	(569)	(1,304)	0	(1,304)
TOTAL (excl. COVID-19)	**4,504**	**1,342**	**261**	**1,081**	**3,178**	**937**	**2,241**
COVID-19	0	0	0	0	0	239	(239)
TOTAL	**4,504**	**1,342**	**261**	**1,081**	**3,178**	**1,176**	**2,002**

Capital spend in month is £261k.

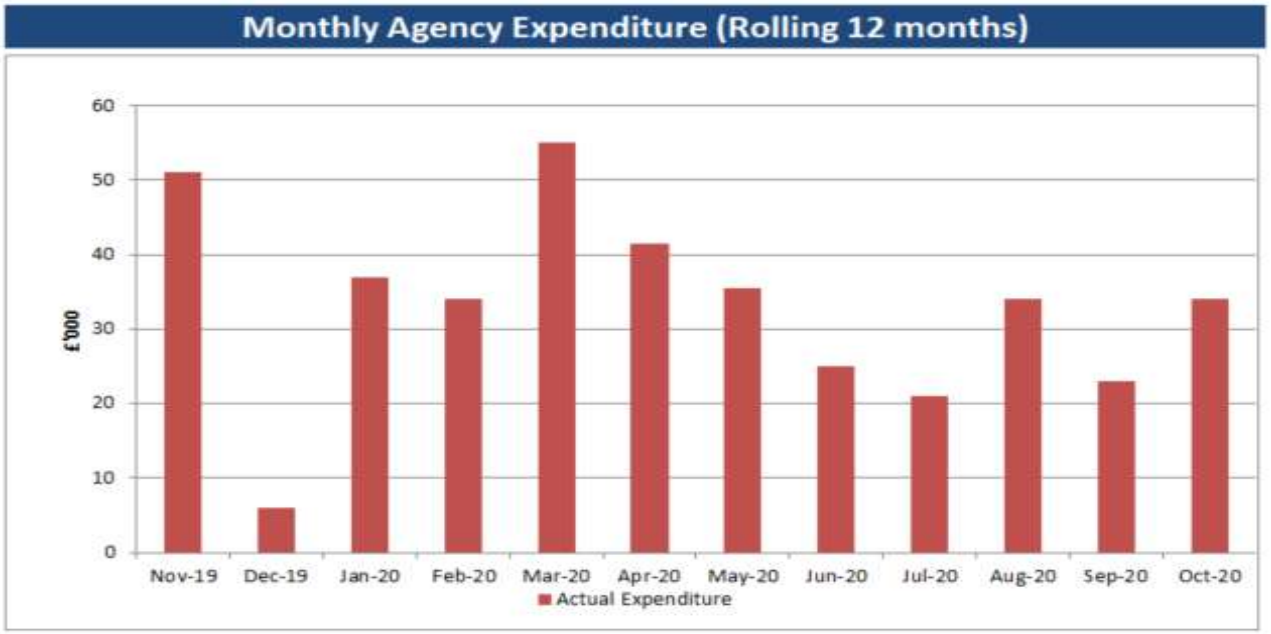
There is £97k capital spend on phase 3 heating/pipework scheme. This is below budgeted spend in month but plans are still in place to meet YTD final budgeted spend. A further £21k has been spent on other Estates schemes.
There has been £27k of IMT spend on staffing for projects and Capital expenditure of £128k on neurosurgery equipment (Spinal endoscopy £110k) – funded by the charity.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 20/21 phase 3 planning process.

NHS I/E are in regular contact to monitor spending.

Although year to date spend is below plan, it is anticipated that it will be higher than plan by the end of the year due to the number of schemes planned at the end of the financial year (e.g. bi-plane replacement, pipework replacement).

As of the end of October: Actual Cash Balance: £40.2m Number of days operating expenses = 118 days		The Trust cash balance at the end of October was £40.2m. This is a decrease of £1.4m from the end of September. The cash position includes an additional month block payment received in October relating to November for the new financial arrangements to cover the COVID-19 pandemic.

Agency Expenditure: In month Actual: £34k YTD Actual: £214k		Agency spend incurred in October was £34k, an increase of £11k compared to September. There was no additional agency expenditure in month relating to the COVID-19 response. At the end of October, £41k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions for 2020/21

As a result of the COVID-19 pandemic financial regulations have changed for 2020/21, with the main changes being:

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the year and income being based on block values determined nationally (based on 2019/20 expenditure between November and January 2019). To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable COVID-19 and other known cost increases from 2019/20 (e.g. CNST contributions). This was the position for M1-6 with a block element of funding being allocated for COVID-19 and growth to C&M HCP for M7-12 which is to be distributed to all organisations;
- The trust is currently being monitored against the year-end forecast of £1.5m deficit submitted to NHS I/E and C&M HCP in October. A revised 20/21 year end forecast is being submitted on 18th November with a planned year end deficit of £1,3m (compared to the current planned year end deficit of £1,5m). Although this plan is currently being assumed by NHSI/E, it has not been finalised / agreed;
- An Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M6-M12). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then will receive a retrospective financial penalty. This has yet to be applied as we are awaiting further guidance;
- 2020/21 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this allocation does not include any phase 2 COVID-19 capital requirements or additional PDC allocated for specialist capital projects;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 20/21 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	Block payments for English commissioners planned income are based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. Assumed income for Welsh commissioners is consistent with this approach (as instructed by NHSI/E for month 7). It is currently not known what the approach for Welsh commissioners will be for M7-12, and national negotiations are on-going around this. However there could be a material reduction to the Trusts income if WHSSC agree only to pay for activity that is undertaken (or if excluded drugs and devices are removed from any block agreement in line with English funding flows). IOM are only paying for actual activity that has been delivered (which is reflected within the financial position), again resulting in an under payment compared to centrally assumed levels of income in line with 19/20 outturn. Although there was an increase in activity in M7, this is not expected to continue following the 2nd national lockdown that has been imposed in England.
Current/ Future NHS Financial Framework	Currently guidance has been issued for NHS financial framework until September 2020; for the remainder of the year block funding will remain in place but COVID-19 will not be retrospectively reimbursed, with central funding allocated to the HCP for the rest of the year. C&M HCP is expected to achieve a breakeven position by the end of the financial year but work is still ongoing on what this means for WCFT. STP's were required to submit phase 3 recovery plans for activity (and associated financial implications) on 1st September with final plans being submitted on 21st September. As part of this process the Trust has been completing phase 3 forecasts based on anticipated levels of activity to understand the financial implications for the Trust which have been submitted to the C&M Healthcare Partnership with final submissions

	submitted in late October. The trust is now being monitored against the year-end forecast of £1.5m deficit within this submission. Although this plan is currently being assumed by NHSI/E, it has not been finalised / agreed. The Trust submitted a further return in early November with a planned year end deficit of £1.3m – this has not been assumed in the M7 financial returns. Further updates will be provided once available.
Elective Incentive Scheme	The Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity. The Trust under-performed against this target in M6 and M7 (mainly in relation to the levels of elective activity) and as such should receive a retrospective financial penalty. This is currently outside the reported financial position and if applied will impact on the Trust's ability to break even. This has the potential to have a significant impact on the Trust as the % levels of activity have increased in M7 for the remainder of the year during which the region is entering a second wave of the pandemic limiting further the capacity required to deliver elective activity.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult.
Changes to 2020/21 capital limits	2020/21 capital targets have been set at a Health and Care Partnership (HCP) level across the C&M area. The planned expenditure for C&M providers was higher than the HCP allocation therefore the Trusts' submission had to be reduced back to its initial plan. Given the increase in capital requirements by the Trust, there is a risk that the Trust will overspend against its CRL (which would impact on other C&M providers) unless there is an underspend within the HCP in year. The Trust has re-prioritised its schemes to mitigate this risk and will work with the HCP should it be at risk of overspending its CRL allocation;
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to

	deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as fewer patients will be able to be seen given the additional PPE/ social distancing requirements).

The Walton Centre
NHS Foundation Trust

REPORT TO THE TRUST BOARD
3rd December 2020

Title	**COVID Board Assurance Framework**	
Sponsoring Director	Name: Lindsey Vlasman Title: Acting Director of Nursing and Governance/DIPC	
Author (s)	Name: Helen Oulton Title: Lead Nurse Infection Prevention & Control/Tissue Viability	
Previously Considered by	N/A	
Executive Summary:- The COVID-19 Board Assurance Framework has been developed by NHSE/I to assist the Trust in the development of robust organisational processes to manage the risk of COVID-19. The framework provides the assurance that quality standards are being maintained, and identifies areas of risk to enable corrective action. The framework was updated nationally in October 2020 and is subject to ongoing internal review to enable the Trust to maintain optimum standards of safety for our patients and staff. Additional staffing has been approved by the executive team to support infection control and the management of COVID 19.		
Related Trust Strategic objectives/goals	Goals □ Always Caring	Strategic Objectives □ Quality of Care
Risk and Assurance	There is a risk to patients/staff and business continuity if the prevention and control of COVID-19 is sub-optimal. A comprehensive delivery plan is in place to mitigate potential risk.	
Related Assurance Framework entries	Risk associated with non delivery of the programme will be recorded on divisional and Trust risk registers. These will be monitored via the Emergency Resilience Group and Infection Prevention and Control Committee	
Are there any associated legal implications / regulatory requirements?	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 CQC Fundamental Standards	
Equality Impact Assessment completed?	N/A	
Action required by the Committee	The Board is requested to: • Take assurance that the Trust has effective systems and processes in place to manage the risk of COVID-19.	

Infection prevention and control board assurance framework

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

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	• Transfer handover • Admission risk assessment form • Positive results stored on PAS system • HITU admission risk assessment	• Not filed in patients case notes	• Discussion with Divisions to ensure documentation is filed in patient notes. Request for ep2 version (completed)
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Trust RAG rating system for the placement of patients. • Movement of patients goes through bed managers and IPCT • COVID-19 patient pathway • De-escalation protocol • Trust COVID-19 policy	• Decisions being made outside of the IPC Ward RAG rating (evenings/weekends) • Non compliance with PHE /Trust guidance	• COVID-19 Dashboard updated in real time • Escalation to bronze or silver on call if required (completed)
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Trust COVID-19 policy in line with PHE guidance	• Non compliance with guidance	• Continued staff support and education • IPCT staff support and education (completed)
• monitoring of IPC practices, ensuring	• Register of staff training for fit testing	• Ad hoc communication to staff groups	• PPE discussed at daily Trust wide safety

resources are in place to enable compliance with IPC practice • monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety	and donning and doffing • Visual aids of PPE guidance • IPC team communicates any changes noted within national guidance in a timely manner. This is managed through command and control (dependent on level) and communications	• Staff may not engage • Conflicting guidance for PPE	huddle • Ongoing education and support (completed) • IPC Walk about`s • Engagement with clinical teams, Ongoing education and support (completed)
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Staff screening guidance • Outbreak screening guidance • Electronic notification of staff results	• Non identified	
• training in IPC standard infection control and transmission-based precautions are provided to all staff	• Mandatory training • Bitesize sessions • Area specific as required	• Non identified	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• As above	• Non identified	
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Daily safety huddle • Communications bulletins • Posters	• Staff rest areas and social distancing	• Estates team placing signage within the areas and removing furniture IPC spot checks (completed)

• 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	• Mandatory training • Bitesize sessions • Area specific as required • Posters	• Non identified	
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Daily Gov.uk COVID-19 update • Communication bulletin • Command and control	• Non identified	
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Daily emails circulated Trust wide • Tactical meetings • Direct escalation to executive team • Operational risk on Datix which informs the Trust BAF • COVID-19 BAF • IPC quarterly reports • HCAI surveillance within the Trust reported via Datix • Mandatory HCAI reporting • Training records • Care pathways • Patient placement guidance • Minutes of Quality Committee • compliance with the national	• Non identified	

• risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • 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 • ensure Trust Board has oversight of ongoing outbreaks and action plans.	• guidance around discharge or transfer of COVID-19 positive patients • As above	• Non identified	

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 are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Each clinical area has allocated domestic teams. • Register of staff training and monitored by Divisional Managers and reported through to Heads of Departments	• Movement of staff due to sickness/holidays	• Staffing only to be moved when absolutely necessary (completed)
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• As above • Fit testing for FFP3 masks where needed, logged on database (as above) • ISS domestic services management guidance compliant with PHE guidance • COVID-19 policy • Cleaning policy • ISS/facilities operational group minutes	• Poor communication • Staff anxieties • Non adherence to policy	• Continued staff support and education/visual aids • ISS/Facilities Operational Group (completed)
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency, at least twice daily, of cleaning in areas that have	• COVID-19 Policy • Decontamination Policy • Isolation Policy • Monitoring and discussion at Trust safety huddle • Facilities Manager audits • COVID-19 Policy • Isolation Policy • Decontamination Policy • Cleaning schedules amended during	• Non adherence to policy / schedule	• Refer to appropriate policy during education sessions, signpost to intranet page • Education/training sessions • Refer to appropriate policy during education sessions, signpost to intranet page

higher environmental contamination rates as set out in the PHE and other national guidance	COVID-19 • Facilities/ISS audit programme • Housekeeper check list • Terminal clean check list • Cleaning of frequent touch areas agreed and increased	• Non adherence to policy / schedule	(completed)
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at minimum strength of 1,00ppm 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.	• Procurement ordering system • COVID-19 policy • Decontamination policy • ISS Service Level Agreement • Decontamination policy • ISS Training records • COVID-19 policy • ISS cleaning schedule	• Non adherence to policy / schedule	• Policies on intranet and regular comms
• Manufactures' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	• COVID-19 policy • ISS schedule • ISS/Facilities group minutes • Outbreak meeting minutes	• Non adherence to policy	• Polices on intranet and regular comms
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed	• COVID-19 policy • House keeper duties	• Non adherence to policy	• IPC Walkabouts

rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or bodily fluids.			
• electronic equipment, eg mobile phones, desk phones, tablets, desktops and key boards should be cleaned at twice daily.	• Desk space cleaning record	• Non adherence to policy	• Refer to appropriate policy during education sessions, signpost to intranet page (completed)
• rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Decontamination policy	• Non adherence to policy	• IPC Walkabouts
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Laundry contract • Standard precautions policy • Decontamination policy	• Non adherence to policy	• IPC Walkabouts
• single use items are used where possible and according to Single Use Policy	• Standard precautions policy • Mandatory training lesson plans	• The trust does not have a single use policy	• IPC Walkabouts
• reusable equipment is appropriately	• Range of single use items • Mandatory training/Induction	• Non identified	• Staff support and education

decontaminated in line with local and PHE and other national guidance	• Clean trace • Infection Prevention and Control Policy • SOP for cleaning of visors/goggles and hoods • COVID -19 policy • Infection Prevention and Control Policy		• COVID-19 policy
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Facilities audit outcomes	• Non identified	
• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Natural ventilation in Ward/OPD Areas	• Non identified	
• 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	• Not applicable at this time		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Antimicrobial ward round – virtual if required. • Microbiology advice available 24/7	• Inconsistency in ward rounds • Medical input variable	• Clinical engagement • Clinical Director review • Review of processes (completed)
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• IPC surveillance • Minutes of Antimicrobial stewardship meetings • HCAI surveillance reporting through PHE monitoring system. • IPC quarterly and annual report taken through Quality Committee and Trust board. • Serious incidents managed via SI meeting and report to Quality Committee and Trust Board	• Non identified	
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**
• implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage	• Visitors guidance • Patient information leaflets • Social media page • Signage at ward entrance • Transfer form • Posters at entrances and in departments/wards	• Non identified	

and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organization or department when a possible or confirmed COVID-19 patient needs to be moved • there is clearly displayed and written information available to prompt patients' visitors and staff to comply with	• Pre-operative patient letter		

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • 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	• Assessment undertaken via telephone pre visit • Face to face Clinics currently reduced • Signage clear at the entrance / reception area and on the Trust website • Temperature/PPE stations at entrance/exits • Screens in place in reception areas • Allocation beds – Chavasse	• Information taken during assessment not being highlighted clearly in the documentation or on PAS.	• Review with Divisional Nurse Directors (completed)

	• Bed Managers risk assessment		
• 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	• COVID-19 policy • Staff testing SOP • Liverpool Clinical Laboratories SOP for patient testing. • COVID-19 policy • Protocol for rapid COVID 19 testing • OPD SOP • Patients attending with symptoms will be assessed and confirmed whether they need to go home to self-isolate or be admitted, depending on their condition	• Transfer time to Chavasse can be delayed due to capacity	• Escalated to Director of Operations/acting DIPC for review, 3 red side rooms have now been ring fenced for COVID patient sonly and there is an escalation process that has been undertaken (completed)
• staff are aware of agreed template for triage questions to ask • 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	• In all areas	• Non identified	
• face masks are available for patients with respiratory symptoms	• In all areas	• Non identified	
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk	• Screens in place	• Non identified	

pathways if this can be tolerated and does not compromise their clinical care			
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• All staff using surgical mask	• Non identified	
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Testing available 24/7 7 days a week • De-escalation protocol • Dashboard • Patient pathway document	• Delay in results from LCL due to increased numbers being tested • Incorrectly labelled samples, potential delay in results due to sample not processed	
• 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	• Amber / red pathway in place	• Non identified	
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Swabbing process in place	• Non identified	

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: • 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 • all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation	• Patient pathway Guidance • Floor signage • Back entrance restricted to Staff only • Maximum occupancy notices in break areas • Additional break area provided • Agile working policy • Education and training • Training records • Signage • IPC walkabouts • Posters • IPC walkabouts • Leaflets • Decontamination policy • COVID-19 policy • No hand dryers in Trust • Staff screening protocol • Outbreak protocol • SBAR • IMARCH	• Additional public signage required in some areas e.g. lifts	• Communications Team are reviewing and additional signage/sites agreed (completed)

and on how to Don and Doff it safely • a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • 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 metres wherever possible unless wearing PPE as			

part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by • patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand infection control precautions • the use of hand air dryers should be avoided in all clinical areas. 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 • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas			

• staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms • 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) • 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 and are reported. • robust policies and			

procedures are in place for the identification of and management of outbreaks of infection			

7. 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	• Trust guidance on the visiting of patients, as per national guidance and local assessment	• Non adherence of policy	• Senior managers to meet with visitors if required SOP now implemented (completed)
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Ward RAG rating for patient placement • COVID-19 policy	• Non identified	
• information and guidance	• Intranet COVID-19 site		

on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Log is maintained within command and control of any changes to documents and reports decisions made. • Protocol for admission and discharge. • Nursing transfer letter • COVID-19 dashboard	• Non identified • Potential for transfer letter not being completed	• Discussions with receiving organisation prior to patient leaving the ward (completed)
8. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • patients with suspected or confirmed COVID-19 are isolated in appropriate	• Ward RAG rating for placement of patients • All side rooms have en-suite facilities • All positive patients nursed within the same area • COVID-19 Dashboard • Minutes of divisional group meetings • Command and control log • IPC walkabouts • Management of multi drug resistant organism policy • Isolation policy • SOP for side room allocation • IPC daily escalation email / ward visits	• Non identified • Non identified • Limited side rooms • Non identified	• IPCT have daily communication with bed manager/matrons

facilities or designated areas where appropriate • areas used to cohort • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Decontamination policy • Daily infection list/review		

9. 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: • ensure screens taken on admission given priority and reported within 24hrs	• SOP for testing • LCL guidance on testing and packaging of samples • SOP for staff testing • COVID-19 policy	• Turnaround time may fluctuate	

• regular monitoring and reporting of the testing turnaround times • with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• MDRO policy • Quarterly audits undertaken • MRSA policy • BSC • HCAI surveillance • CPE policy • Outbreak screening guidance • Pre-op screening	• SBAR identified admission/5day screening not robust	• Daily email for day 5 screens (completed)

10. 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	• Mandatory health and safety training • Induction training • Ward manager meetings / IPC Committee / PNF	• Non adherence to policy	• Refer to appropriate policy during education sessions, signpost to intranet page

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• COVID-19 policy • PPE posters • COVID 19 intranet page • Twice daily Communications from Command and Control	• Non adherence to policy	• Discussion at Trust safety huddle • Staff support and education • Mandatory Health and Safety
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance PPE stock is appropriately stored and accessible to staff who require it	• COVID-19 policy • Waste audits • Health and safety committee minute • Fallow storage space, stock levels managed by procurement / Command and Control • Command and Control/Tactical Meeting/Safety huddle daily	• Non compliance to correct waste segregation • Non identified	• Discussion at Trust safety huddle • Staff support and education • Mandatory Health and Safety
11. 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 psychological wellbeing is supported	• Staff COVID-19 risk assessment • COVID–19 staff support helpline • Shiny minds • Numerous emails sent to staff highlighting health and wellbeing initiatives • Occupational health	• Staff do not wish to engage with support	• Managers advised to support staff and encourage interaction
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or	• Staff risk assessment Proforma	• Non identified	

shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff			
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• Fit testing is being delivered as per protocol and recorded centrally in database	• Non identified	
• staff who carry out fit test training are trained and competent to do so	• Accredited fit tester training		
• 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	• As previous sections		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organization	• Inputted on database • SOP for staff testing • COVID-19 staff support helpline • Return to work assessment • Occupational health • HR COVID-19 policy • Hoods/reusable (personal issue) respirators provided	• Ad hoc communication	• Robust records held by the governance team (completed)
• 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 • for members of staff who fail 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 organisation, as part of employment record including Occupational health • 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 • boards 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 • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any	• Communication bulletins • Minutes of safety huddle • IPC Walkabouts • Implementation of regional directive for all staff to wear masks	• Staff noncompliance with rest areas • Ongoing assessment of COVID-19 secure areas	• Daily bed/staff escalation • Estates department reviewing scope for additional areas • Desk dividers • Managers to ensure communication is shared with all members of their teams

workplace risk(s) are mitigated maximally for everyone • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff testing positive have adequate information to aid their recovery and return to work	• ESR records • Testing provided 7 days per week • Information available to all staff who test positive		• Managers and teams and occupational health available to support staff. FTSUG in place (completed)

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date 3rd December 2020

Title	**Modern Slavery Act Statement**
Sponsoring Director	Name: Lindsey Vlasman Title: Acting Director of Nursing & Governance
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary The statement constitutes the Walton Centre's annual response to the requirements of the Modern Slavery Act 2015 to be published online in accordance with the public sector duties under that Act.	
Related Trust Ambitions	• Be recognised as excellent in all we do
Risks associated with this paper	There are no risks identified that are associated with this paper, as the actions undertaken by the Trust which are mentioned in the paper have already been undertaken and those actions, taken alongside the Board considering the paper and the Trust publishing the paper online, constitute full compliance with the Trusts duties in respect of the Modern Slavery Act 2015.
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• N/A
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	The Board is requested to: • Approve the Modern Slavery Act Statement • Note that it will be published via the Trust's Website

The Walton Centre's Response to the Requirements of the Modern Slavery Act 2015

This Act was brought about to make provision about slavery, servitude and forced or compulsory labour and about human trafficking; including provision for the protection of victims; to make provision for an Independent Anti-Slavery Commissioner; and for connected purposes.

Slavery is not an issue confined to history or an issue that only exists in certain countries – it is something that is still happening today. It is a global problem and the UK is no exception.

Modern slavery is part of the safeguarding agenda for children and adults.

All staff at the Walton Centre, be they in clinical or non-clinical roles, have a responsibility to consider issues regarding modern slavery, and incorporate their understanding of these issues into their day to day practice. Front line NHS staff are well placed to be able to identify and report any concerns they may have about individual patients who present for treatment.

Modern slavery is a real issue.

It is also a serious concern for public services.

As a Trust we are committed to working in partnership with local authorities to identify cases of modern day slavery and to intervene to protect vulnerable adults and children when they are identified.

Who is affected?

Victims found in the United Kingdom come from many different countries, including Romania, Albania, Nigeria, Vietnam and the United Kingdom itself.

Social and economic deprivation, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are some of the key drivers that contribute to the trafficking of victims.

Victims can also face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

The Walton Centre is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain and has taken steps to ensure that all staff are aware of the issue of Modern Slavery and what they can do to prevent it by including information in the Safeguarding Adult and Children Policies.. Any concerns are raised with the Safeguarding Matron who will escalate accordingly.

Modern Slavery

Starting in 1 November 2015, specified public authorities have been given a duty to notify the Home Office of any individual encountered in England and Wales who they believe is a suspected victim of slavery or human trafficking.

The 'duty to notify' provision is set out in the Modern Slavery Act 2015 and applies to all police forces and local authorities in England and Wales, the Gang masters Licensing Authority and the National Crime Agency.

Procurement arrangements:

All contracts established by The Walton Centre use the NHS Terms and Conditions for Supply of Goods, which contains Anti-Slavery clauses that require providers/contractors to comply with Law and Guidance, use Industry Good Practice and to notify the authorities if they become aware of any actual or suspected incident of slavery or human trafficking. The Walton Centre Procurement team has issued Modern Slavery Act 2015 compliance letters to our supply chain and keeps a database of responses. Also, the Trust's purchase orders to suppliers now set out the Trusts expectations in terms of compliance with the Act.

In addition to the above The Walton Centre will investigate any concern raised with the service. This could be by national or local media publicity, through supply chain contacts or by individuals.

Employment arrangements: As an NHS Employer we are required to comply with the NHS employment check standard for all directly recruited staff.

The six checks which make up the NHS Employment Check Standards are:

1. Verification of identity checks

2. Right to work checks

3. Professional registration and qualification checks

4. Employment history and reference checks 5. Criminal record checks

6. Occupational health checks

No individual is permitted to commence employment with the Trust without these checks having been completed. The checks are carried out centrally by the recruitment team and recorded on the Trust workforce information system (ESR). These measures ensure that the Trust does not unwittingly employ people subjected to modern slavery.

If staff have concerns about the supply chain or any other suspicions related to modern slavery they will be encouraged to raise these concerns through line management and report the issues to appropriate agencies. This will be raised particularly with clinical staff that may be in contact with vulnerable people.

Date approved: 3 December 2020

The Walton Centre NHS Foundation Trust

REPORT
TRUST BOARD MEETING

Date 3rd December 2020

Title	**Emergency Planning Resilience & Response (EPRR) self-assessment against NHS England Core Standard**
Sponsoring Director	Jan Ross Director of Operations & Strategy
Author (s)	Patrick McEvoy Deputy Head of Risk
Previously considered by:	• Resilience Planning Group • Business Performance Committee 24th November 2020 and agreed

Executive Summary

This report highlights the Emergency Preparedness, Resilience & Response (EPRR) annual assurance self-assessment outcome and onward reporting process. Due to the impact of Covid-19 the 2019-2020 core standards are to be carried over to provide assurance for 2020 – 2021. The Trust is compliant with the applicable standards and no actions were required following the self-assessment process.

In line with the NHS England Guidance organisations are required to formally report and receive approval of the assessment by the organisation's Board, in a public meeting and also publish it within the annual report.

Related Trust Ambitions	Delete as appropriate: • Be recognised as excellent in all we do
Risks associated with this paper	None
Related Assurance Framework entries	NA
Equality Impact Assessment completed	• No – (please specify) Not applicable
Any associated legal implications / regulatory requirements?	• Yes – Civil Contingencies Act 2004
Action required by the Board	• To approve the statement of compliance

1. Emergency Preparedness, Resilience & Response (EPRR) Annual assurance self-assessment process

Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

Core standards

Due to the impact of Covid-19 the 2019-2020 core standards are to be carried over to provide assurance for 2020 - 2021. There are 55 Core standards applicable to Specialist providers of which 51 are applicable to the Trust. The 4 standards which are not applicable relate to the management of Hazardous Materials (HAZMAT) and Chemical Biological Radiological Nuclear (CBRN) decontamination.

Trusts that identified further actions in the 2019-2020 core standards are required to provide an update towards completion of outstanding actions.

The Trust is compliant with the applicable standards and no actions were required following the self-assessment process.

Deep dive

The Trust is also compliant with these standards.

Statement of compliance

Organisations are required to complete a Statement of Compliance and report this via the relevant group/committee to a public Board meeting.

The statement of compliance (see appendix) has been approved at the Resilience Planning Group on the 19th October 2020 and then submitted to the December Board.

This report, along with the Core Standards assurance ratings are submitted to the CCG and Local Health Resilience Partnership (LHRP) which in turn reports to NHS England.

2. Conclusion

There have been significant improvements within our internal and external EPRR arrangements within the past 6 months due to the arrangements put in place for the Covid-19 Level 4 national incident response. We continue to utilise the learning from local, regional and national incidents to strengthen response arrangements.

For the remainder of this year there will be on going testing and updating business continuity management arrangements in line with the Resilience Planning Groups work plan.

3. Recommendation

The Board is requested to:

- approve the statement of compliance

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2020-2021

STATEMENT OF COMPLIANCE

The Walton Centre NHS Foundation NHS Trust (RET) has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR
Following assessment, the organisation has been self-assessed as demonstrating the Full compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
51 **	xx	xx	51
Specialist providers: **55**			

** *Includes 7 HAZMAT/CBRN standards.*

NB: 4 of these standards are not applicable as the Trust is a Specialist Tertiary Unit with no A&E or walk in facility.
Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.
I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Sign Name

Jan Ross
Print Name
The organisation's Accountable Emergency Officer

03/12/2020
Date of board

06/10/2020
Date signed

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
03/12/20

Report Title	**Chair's Assurance Report – Quality Committee 19 November 2020**
Sponsoring Director	Seth Crofts, Non-Executive Director
Author (s)	Lindsey Vlasman Acting Director of Nursing
Purpose of Paper:	
The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Quality Committee held on Thursday 19 November 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Positive feedback received from the Peer Review of the Major Trauma Network, GMC Trainer/Trainee Survey and from Liverpool University Neurology placement students
- KPI's that do not feed into the Quality Committee IPR but have an impact of patients i.e. patient waiting times and 52 week breaches
- Following discussion around the patient's story, provision for patients with visual and other impairments to be noted
- The Quality Presentation by the Spinal Team
- Quality Accounts achieved for 2020/21 and requests for 2021/22
- End of Life Care update
- The support and team work shown by Outpatient's department during the covid pandemic

2.0 Items for the Board's information and assurance

The Committee received the following updates:-

a) Medical Director's update

Dr. Nicolson noted that the clinical teams were continuing to manage issues relating to the covid pandemic and that liaison meetings across the region are on-going.

Dr. Nicolson advised that a Peer Review for the Major Trauma Network had been completed. The report highlighted high standards of care for major trauma patients at the Walton Centre which were also maintained throughout the covid pandemic.

The results from the GMC trainer/trainee survey undertaken in July 2020 had been received. Dr. Nicolson highlighted key points from the conclusion of the report which included:-

- the learning and working environment was reported as being fair and inclusive
- opportunities for education and training at the Walton Centre remained viable despite the significant clinical pressures of the covid pandemic
- positive feedback was received from students with the Trust rated as good or very good for the support offered.

Dr. Nicolson also drew attention to the report received from the University of Liverpool following a change to their curriculum for medical students, which altered neurology placements. The Walton Centre scored higher than other trusts across all domains. Dr. Nicolson conveyed his thanks to the training teams for an excellent job during a very difficult period. Again feedback from students was very positive, acknowledging the high standard of teaching at the Walton Centre.

b) Quality Presentation – Spinal Team

Ms Smallwood, Spinal ANP presented the Quality Presentation to the Committee on behalf of the Spinal Team. The presentation noted how the team has grown and developed and how the team has supported the reduction in junior doctor hours. Attention was drawn to issues around education for the ANPs as courses fall between nursing and medical courses. The team aim to provide an MSc Spinal Module with a view to this commencing in September 2020 and also envisage showing casing their work in medical journals.

c) Integrated Performance Report (IPR)

An overview of the IPR was provided. It was noted that there have been 7 cases of MSSA with a trajectory of 8 year to date, for which there is an improvement group working on reducing further cases. An increase in the number of VTE incidents was noted, which were attributed to a consequence of the covid pandemic. The risk assessments remain in the red but teams are aware of this and are working to rectify. Further work is being undertaken with regards to pressure ulcers and falls prevention. Attention was also drawn to waiting times for patients and 52 week breaches with it being noted that teams are doing all that is possible to bring patients in as soon as possible. It was felt this KPI should be added to the IPR for Quality Committee.

d) Visibility & Walkabout Update

An overview of the Visibility and Walkabout report was presented. It was noted that walkabouts are currently reduced due to the covid pandemic but the senior leadership team continue to meet with staff to gather feedback and concerns. Covid de-brief sessions for staff have been undertaken to obtain further feedback from staff. The daily safety huddle, Hayley's Huddle and the regular covid tactical command meetings provided further opportunities for raising concerns. Daily communications are circulated by the Communications team to keep staff fully up to date.

e) Quality Accounts

Ms Kane delivered an update with regards to the Quality Accounts. 9 priorities had been achieved for 2020/21 and planning is commencing for 2021/22.

f) In-Patient Survey Update

Ms Gurrell provided a short update on progress to date with actions all on target. The 2020 In-patient survey will capture patients who are in the hospital during November 2020 for which posters have been displayed around the Trust and notifications shared on social media.

g) End of Life Care (EoLC) Update

An update was provided by Ms Crofton who noted that it has been a difficult year for the EoLC and Palliative Care teams. Ms Crofton advised that some systems have been streamlined and clarified for staff which included the use of the universal DNA CPR form. End of Life Care plans have been introduced in paper format with the view of moving to eP2. Initial feedback for the EoLC care plans is positive. Memory boxes for bereaved families have also recently been delivered to wards but as yet have not been used. The operational group is in place with Aintree and there has been an increase in the number of palliative care interventions and referrals.

h) Clinical Audit Progress Report

Dr. Nicolson provided an update on progress to date with regards to clinical audits. The clinical audit department are managing a number of audits and working through the action plans.

i) Quarterly Trust Risk Register Report

Ms Vlasman gave an overview of the Trust Risk Register and noted the two new risks with a score of 16 that have been added i. e. Risk 807 with regards to staff rest areas to allow for 2 metres social

distancing, if suitable rooms are not found there is a risk of staff contracting Covid-19. Risk 812 with regard to decreasing staffing levels affecting staff health & well-being and work/life balance

j) AOB

- Ms Vlasman provided an update on forth-coming Covid projects that of Lateral Flow Asymptomatic staff testing, Covid vaccination programme and Lamp Testing. An internal project manager has been assigned to oversee all of the above projects.

- Ms Vlasman highlighted the 75% uptake of the flu vaccine by patient facing clinical staff.

- A Quality Committee meeting has been added for December 2020.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
3 December 2020

Report Title	**Chair's Assurance Report – BPC 24 November 2020**
Sponsoring Director	Janet Rosser – Chair of Board of Directors
Author (s)	Jan Ross, Director of Strategy and Operations
Purpose of Paper:	
The Business Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Business Performance Committee held on 24 November 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Approval of Intelligence Strategy.
- Approval of Guide XT Agreement.
- Approval of the EPRR core standards self-assessment

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Cost Improvement Programme – Update Paper

The Committee were given a high level overview on the CIP position and how efficiency targets have been applied nationally for this financial year. Whilst it was not clear what the CIP ask would be for 2021-22 the Trust would be looking at what could be introduced and implemented for the coming financial year. Discussions took place around efficiency improvements and cost improvements and it was acknowledged that efficiency schemes were not necessarily cash releasing. Updates were provided on innovations and the repurposing beds scheme that was due to be implemented. The situation remained unclear as to how C&M HCP would bridge the gap to ensure a break even position but it was updated that a range of negotiations had been taking place. The Committee noted the contents of the paper.

Integrated Performance Report

Operations – The IPR continued to focus on activity. The Committee were referred to the summary of KPIs. Key concerns were around waiting times except for cancer patients. Average wait overall was 14.85 weeks with 'Other' at 23 weeks (Pain patients). Waiting times were moving in the right direction but some patients had waited 52 weeks breaching the standard. Measures were being taken to bring these back on trajectory. Diagnostic waiting times were improving week by week following a robust improvement plan however infection control principles remain a challenge. Discussions took place around Covid positive staff numbers and impact on service delivery; introduction of lateral flow testing for front line staff; update on the measures to improve those patients waiting 52 weeks; cancelled operations and DNA rates in Outpatients.

Finance – The Committee were asked to note that the financial regime changed in Month 7 meaning that retrospective top up payments would no longer be applied to bring trusts back to breakeven and no monthly payments would be made for Covid costs (as block funding had been received for Months 7-12). At M7 the Trust reported £196k surplus against a planned deficit of £59k (which was £255k better than plan) and the Committee were briefed on how this figure was achieved. Discussions took place around a second CT scanner; the possible elective penalty to be included in the forecast; capital plan; cash position and increase in agency costs in M7.

Workforce – The Committee were updated on the current workforce position including sickness rates (including a break-down of sickness absence figures) and nursing turnover. Discussion took place around long term sickness and whether it was higher in specific areas.

b) Estates and Facilities Q2 Report

The Committee were presented with a quarterly update on the performance and progress within the Trust's Estates and Facilities services for Q2 2020-21. The report covered updates on agile working; hotel services contract; water quality scheme; heating replacement scheme; fire compartmentation works; theatre ventilation refurbishment works; clinical waste and waste management service. Main discussion took place around the impact on theatres if there was a chance they were not compliant in having appropriate ventilation. It was agreed that this was a risk but assurance given that theatres were clean with very low infection rates so were workable. The contents of the report were noted by the Committee.

c) Transformation Programme Update

The Committee received the update on the work that had been conducted within the 3 main focus areas for Service Improvement and Transformation which were Outpatients; Theatres and Patient Flow together with an update on Agile working. It was requested that going forward KPIs be added to the report in order to see the benefits and measures of the transformation programme. The Committee were interested to see how the £200k of financial savings referred to through agile working had been identified - this would be picked up with Mr Davies and Mr Burns outside the meeting.

d) Terms of Reference

To be updated to include new reporting arrangements and would be presented for approval at the meeting in January 21.

e) Update against Agile Working Policy

The report covered how work on implementing a full agile system within the Trust had been ongoing since June 2020 following the initial impact of Covid 19 and how new ways of working were required to be put in place quickly. The report covered the background to the schemes and the current position. The Agile Working Policy had been produced and signed off and was located on the intranet for staff to access. Discussion took place around how the schemes worked e.g booking pods to work in; staff rotas for being on site etc. The situation had also provided an opportunity to review governance arrangements and meeting structures and how meetings would take place in the future.

f) EPRR Annual Assurance Self-Assessment Process

The annual report highlighted the EPRR assurance self-assessment outcome and onward reporting process. It was updated that due to the impact of Covid 19 the 2019-20 core standards were to be carried over to provide assurance for 2020-21. The Trust was compliant with the applicable standards and no actions were required following the self-assessment process.

g) Cycle of Business

Noted by the Committee.

h) Patient Initiated Follow Up (PIFU) Project

A presentation was given on the PIFU Project which the Trust had been an early adopter site for. The proposal was to implement an enhanced general referral triage process delivering many benefits including a reduction in the number of inappropriate referrals that result in an appointment, reduction in the waiting time for general neurology new appointments and a reduction in the number of patients on the new patient waiting list. The presentation covered actions taken to date and an overview of progress with the key areas of focus in the first 90 days being Epilepsy, MS and Headache. The benefits realisation were identified and the need to ensure good communication around the Project. Discussions took place around how the project would work in practice and whether the current 7,000 patients waiting for a first appointment would be part of a separate project.

i) Intelligence Strategy

The Strategy set out the Intelligence plan for the coming years and was aligned to the Trust's 2019-2023 strategy. The aim of the strategy was to put data and analytics at the heart of every decision across the Trust with the aim of supporting and improving the care and experience of all service users. The Committee noted the vision, values and goals together with priorities and delivery and also the risks to delivering the strategy. The biggest risk was considered to be the cultural adoption of the plan and willingness to change around the organisation. The Committee approved the Strategy

j) AOB – Guide XT Agreement

The Committee were asked to approve an agreement. Boston Scientific have offered the Trust a Guide XT licence and software package in support of Implantable Pulse Generators purchased via the High Cost Tariff Excluded Devices scheme. The package comes at no financial cost and is offered based on a market share of at least 50% in this area achieved in the last financial year and a commitment to do so in the next 12 months. Admittedly the Committee were confused about what they were asked to agree to which was basically committing to purchasing Boston devices via the central model for a 12 month period. At the moment these devices are paid directly by NHSE/I under the zero cost model however in the coming months the Trust will move into the visible cost model which will mean the Trust will pay for the devices and then reclaim the monies from NHSE/I. The spend on the devices (covered by NHSE/I) is in excess of £500k per annum so the agreement was sought by the Head of Procurement for transparency purposes. Following a lengthy debate the Committee agreed to approve the agreement but it would be reviewed in 6 month's time.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
3 December 2020

Report Title	**Chair's Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Mike Burns, Director of Finance and IT
Purpose of Paper:	
The Walton Centre Charity Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Walton Centre Charity Committee held on 12 November 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention
The Committee noted that the item relating to solicitors being on site was still under review.

2.0 Items for the Board's information and assurance

The Committee received the following updates. Items listed in order of discussion.

a) Update on Investment Position
The CCLA portfolio was valued at £545,554 at 30 June 2020 and £559,791 at 30 September 2020 an increase of £14,237. Positive contributions came from holdings in some consumer facing sectors and health-related industries, in particular equipment providers.

The Ruffer portfolio was valued at £510,917 at 30 June 2020 and £511,672 at 30 September 2020 a rise of £755. The Ruffer portfolio has remained protectively positioned throughout this quarter and has continued to deliver positive returns which were driven primarily by the gold mining stocks and the US inflation linked bonds (TIPS).

Summary Reports from:

CCLA July – September
CCLA provided a detailed report on the performance of the investments between 1 July and 30 September 2020. The report included market information, fund holdings and transactions and Ethical and Responsible Investment Report.

Ruffer as at 5 November
Ruffer provided a summary of the current position of the portfolio as at 5 November which outlined that that the fund had reduced to £504,124 from £511,672 at 30 September.

b) Jagger and Associates Performance Report
Jagger & Associates are an independent investment advisor who monitor and review the performance of both investors over the period 30th June 2019 to 30th June 2020. The report was noted. Some suggestions were offered as to where Jagger & Associates could add some valute to the Trust in future requirements.

c) Finance Report as at 31 October 2020
This report detailed the financial performance of the charity as at 31 October 2020 and showed that the fund had reduced by £92,825k from 1 April 2020. The report also detailed the closing balances of the individual funds to enable the committee members to review the performance of these funds.

d) Fundraising Activity Report

The Committee received the report and noted the contents. The Head of Fundraising highlighted the following sections from the report:

- Despite cancelled events due to the pandemic, and the subsequent impact on community fundraising, many patients/families have continued to do what they can in an individual capacity to help raise funds and awareness for the Charity.
- The Jan Fairclough Ladies Lunch was held virtually over the summer – supporters were given a three course menu recipe in return for a donation. Lunches held in own homes. £2,000 was raised.
- A donation of £10,000 had been received for the Home from Home via the Construction Impact Framework.
- The current focus is the Christmas Campaign and implementation of the Lottery scheme.

Second Wave Grant

The Charity has received a further £50,000 from NHS Charities Together to help support staff as they care for patients through the second wave of the pandemic. Total grants received from this national campaign to date is £145,500.

The funds have been spent, or allocated to be spent, as outlined below:

£27,000	Miscellaneous during first wave including staff breakfast/snack bags; volunteer wellbeing packs; dietician snack trolley for patients; new seating/shading for courtyards.
£50,000	Allocated to the refurbishment of the junior doctors' mess.
£18,500	Allocated staff rest/break area improvements.
£50,000	Second wave grant allocated to support staff through winter months by providing extra facility for breaks to help ensure social distancing and health & wellbeing.

Total £145,500

Covid 19 Landscape Report

A report from external fundraising consultant to provide the Committee with observations and context on the impact of the pandemic on fundraising income in the charity sector as a whole. Sources included Institute of Fundraising, Charity Times and National Lotteries Heritage Fund. Impact is severe, with UK charities facing a £12 billion funding gap. The Walton Centre Charity's position is much more positive as we have benefitted from the national campaign and only have a small team structure to sustain.

e) Applications for funding from T&D Department

All 19 applications for T&D funding were approved. However attention was drawn to an application received from PMP for an MSc qualification for which the applicant was not contributing to the cost of the course which is usual procedure. Concerns were raised that this could set a precedent for the future. It was agreed that the application would be approved but that further information would be obtained by T&D as to why nil contributions had been agreed. It was also noted that the education budget is include as part of the review of Charitable Projects Budgeting Process.

f) Application for Specialist Arm Board

Dr. Chandran presented the application for £7,201 for the purchase of a Specialist Arm Board which is used to support a patient's arm in the correct position to allow radial puncture for day case angiography. This piece of equipment has been in use, free of charge for a trial period which is now

at an end. It was noted that patients are able to mobilise sooner following their procedure and that there are fewer complications. Feedback from patients is positive. The Committee approved this application.

g) Application for Long Service Awards

The application for £8,400 for long term staff awards was approved by the Committee. It was noted that due to the covid pandemic, there would be no formal event. The value of the vouchers remains the same as last year.

h) Application for Staff reward and recognition platform Highfive

The application for funding to support a staff reward and recognition platform called Highfive was approved. Following discussion with regards to how the platform works, it was agreed that funding would be approved for a trial period of one year. The initial application is for £5,400 but it was noted that all of this may not be required as funding may possibly be available from Health and Wellbeing budgets.

i) Review of Charitable Projects Process

A sub-group consisting of Dr Moore, Dr Niven, Mr Buxton, M. Burns and M. Fletcher had met to discuss the process and following some further discussions still to be held will present an updated plan at the next Charity Committee meeting in January.

j) Report on longer term commitments to the Charity

The report was received by the Committee and clarified by Ms. Lang. It was noted that £371,000 has been committed to spend but movement is slow due to the covid pandemic. Dr. Moore requested further information with regards to the timescale of the commitments as some could be long term. Ms Lang advised she would add a timescale column to future reports in order to provide this information.

k) Risks associated with the Charity

It was agreed that a Risk Management Policy with associated risk register should be developed for the Charity in order for the Committee to monitor and manage risks in more detail. M. Fletcher will draft to be discussed at meeting in January.

l) RDI Annual Report (update on funding used for excess treatment costs)

Ms Williams provided an explanation of excess treatment costs and an update on the position to date. It was confirmed that none of the £30,000 allocated had been used as many clinical research trials had been suspended due to the covid pandemic. It was highlighted that reserving funds for excess treatment costs was limiting and discussion ensued as to whether this funding could be extended to other research projects. Ms Williams advised she would add this to the agenda for the next R, D & I meeting with a view to provide an update in January 2021.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
3 December 2020

Report Title	**Chair's Assurance Report – Neuroscience Programme Board Meeting held 8th October 2020**
Sponsoring Director	Mike Burns Director of Finance and IM&T
Author (s)	Mike Burns
Purpose of Paper:	
The paper provides an update on the main points discussed at the meeting held on 8th October 2020	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

No matters were raised which require the Board's attention.

2.0 Items for the Board's information and assurance

The Programme Board received the following updates:

a) C&M Collaboration Headache Pathway
Inconsistencies in the Headache Pathway had been identified. This will be raised with the Clinical Commissioning Group Accountable Officers to ensure a consistent approach is adopted.

b) Pain Services:
Work to improve delivery of pain services has been put on hold indefinitely due to the previous lead no longer working on the project; a position statement is being sought for the Programme Board. A community foundation bid to help those with neurological conditions with emotional and psychological support was unsuccessful; however this will be further explored by the Programme Board.

c) C&M Collaboration update Parkinson's Disease (PD) pathway
A region-wide pathway has been agreed to support General and Acute Physicians treating patients with PD that are admitted to hospital for unrelated reasons. This will be in place alongside WCFT pathways to provide guidance.

d) Response to GIRFT (Getting it Right First Time)
With the exception of Arrowe Park Hospital, deep dive visits had been delayed due to COVID-19. It is anticipated that the main issues to arise will relate to acute neurology not delivered directly by the WCFT. Deep dive visits will help shape how acute neurology can be delivered more effectively.

e) Presentation on Movement Analysis Laboratory (MAL)
The MAL presentation was delivered to the Programme Board. A wide range of questions were raised which will be further explored in clinical and patient research. The presentation was well received and Dr Rose was invited to present to the Neurological Alliance.

f) Lessons learned from COVID-19.
Dr Wilson and Dr Lakhani shared views on the positive/ less positive aspects of working differently throughout the outbreak. Positives included virtual consultations/ telephone clinics, the willingness of staff to take on different roles, adherence of PPE guidance and collaborative working across the region.

Less positive views included: communication of PPE rules to staff due to changing national guidance, impact on waiting lists, time taken to agree a system that worked well for fit testing and that the level of emotional support for staff had been underestimated.

Positive comments were received from stakeholders on how the Trust responded during the First Wave.

g) Neurology GIRFT - next steps

Dr Nicolson is establishing a group to look at GIRFT (Getting it Right First Time) from all Trusts once visits have concluded. The group will look at neurology services regionally, particularly to improve acute services and chronic disease management.

h) Hot Topics from other hospitals

Dr Buchannan, Arrowe Park Hospital advised that significant progress has been made on the Status Epilepticus Pathway.

Dr Francis, Liverpool University Hospitals Foundation Trust shared that LUFT are exploring a back pain pathway which might potentially be adopted to manage patients consistently wherever they present. Key to this is ready access to MRI to enable more accurate assessments. GIRFT are also pushing for a 7 day 08:00-20:00 MRI service for every Trust.

Dr Nicolson updated on the current position relating to spinal services; agreement on a region-wide spinal service pathway would be a way forward to progress.

M Burns
Director of Finance and IM&T
November 2020