The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 5th November

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
5th November 2020
Virtual Meeting
WCFT
09:30 – 13.10pm

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 24th September 2020	J Rosser	Decision (d)
4	09.35	Patient Story	L Vlasman	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update	J Rosser/ H Citrine	Information (d)
6	10.10	COVID-19 Update	H Citrine/ Execs	Information (d)
7	10.20	Transformation Strategy	J Ross	Decision (d)
PERFORMANCE				
8	10.35	Integrated Performance Report	CEO/NED Chairs	Assurance (d)
9	11.00	Winter Plan 2020	J Ross	Decision (d)
BREAK – 11.15				
QUALITY				
10	11.25	Nosocomial Infections	L Vlasman	Assurance (d)
11	11.40	Nurses Re-validation Annual Report	L Vlasman	Assurance (d)
12	11.50	Q2 Governance Report	L Vlasman	Assurance (d)
13	12.00	Mortality and Morbidity Quarterly Report Q1&2	A Nicolson	Assurance (d)
GOVERANCE				
14	12.20	Strategic BAME Advisory Committee Terms of Reference	H Citrine	Decision
15	12.25	Audit Committee Chair's Report	S Rai	Assurance (d)
16	12.30	Quality Committee Chair's Report	S Crofts	Assurance (d)
17	12.35	Business Performance Committee Chair's Report	J Rosser	Assurance (d)
18	12.40	RIME Committee Chair's Report	S Crofts	Verbal (v)
CONSENT AGENDA These items are provided for consideration by the Board . Members are asked to read the papers prior to the meeting and, unless the Chair / Trust Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with the process for Consent Items. The recommendations will then be recorded in the minutes of the meeting.				
19	12.45	Education and Training Self-Assessment Report	A Nicolson	Decision (d)
20	12.47	Standing Financial Instructions/ Scheme of Reservation and Delegation	M Burns J Hindle	Decision (d)
CONCLUDING BUSINESS				
21	12.50	AOB Brexit J Ross	J Rosser	Information
22	13.05	Reflections on the meeting: • Has the Board focussed enough time on the key agenda items? • Are there any item(s) that were not given enough	J Rosser	Discussion

Item	Time	Item	Owner	Purpose
		attention? • Do any matters need to be referred to a Committee? • Are Board members satisfied with the quality of papers: • Is the purpose and content clear? • Are papers clear on the Board action required?		

Exclusion of Press & Public
In accordance with the Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

Date and Time of Next Meetings:

Trust Board Meeting:
3rd December 2020

Board Development Session
14th December

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

24th September 2020

Present:

Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	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

In attendance:

Mr J Baxter	Executive Assistant
Mr A Moore	Communications and Engagement Officer (item TB61-20/21 only)
Mr A Rose	Head of Commercial Engagement and Marketing (item TB61-20/21 only)
Mr D Thornton	Assistant Clinical Director of Pharmacy (items TB64-20/21 and TB65-20/21 only)
Mr A Lynch	Equality and Inclusion Lead (items TB68-20/21 and TB69-20/21 only)

Observing:

Mr S Winstanley	Public Governor – North Wales
Ms D Brown	Public Governor – Merseyside

Trust Board Attendance 2020-21

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

TB55-20/21 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams.

Apologies were received from Ms B Spicer and Ms L Salter

TB56-20/21 Declarations of interest

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

TB57-20/21 Minutes of the meeting held on the 30th July

It was requested that the final sentence of the third paragraph under item TB44-20/21 was removed. Following completion of this amendment the minutes were agreed as a true account.

TB58-20/21 Patient Story

Ms Vlasman shared a story from a patient who had been under the care of the Trust for 11 years. The patient wished to share their story to ensure lessons were learned from their experience. The patient shared that they had a poor experience at the Trust five years ago when they had attended for revision of a spinal cord stimulator. The patient felt that pre-operatively any potential procedure complications had not been explained to them and post-operatively they had also felt that communication was poor. The patient had raised these concerns at the time and experiences since had been fine however the patient attended the Trust this year and again experienced poor communication resulting in them feeling unprepared and scared when attending theatre.

Ms Vlasman provided an overview of learning and changes in pre-assessment pathways that had been put into practice since the patient had shared their experiences. Ms Vlasman had since met with the patient and informed them of the work completed around lessons learned and the patient reported that they had been happy with changes implemented.

Ms Rai queried how the patient came to share their story, Ms Vlasman clarified that this came from a discussion between the patient and their Specialist Nurse and that the patient had not wished to raise a formal complaint.

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

Ms D Brown joined the meeting at 10:05.

TB59-20/21 Chair & Chief Executive Report

Ms Citrine updated members in relation to the ongoing COVID-19 situation and stated that hospital admissions were doubling every 8 days. It was stated that elective admissions would continue for as long as possible however this was under constant review. Relaxed visiting procedures had been reversed and the need to be mindful of the patient experience was recognised.

Ms Rosser updated members in relation to the ongoing Non-Executive Director recruitment process stating that there had been 41 applicants with 8 shortlisted. Focus groups would be held on 25th September with interviews to take place the following week.

The Board:

- **noted the report.**

TB60-20/21 Covid-19 Update

Ms Citrine presented an update regarding COVID-19 and stated that due to the ever evolving situation some of the information in the report had been superseded. The national alert level was 3 and this was reviewed regularly however the regional level felt higher than this. Phase 3 recovery plans had been submitted to NHSE & NHSI and activity levels from 2019/2020 had been utilised as a baseline, with the request that we

achieved 90% of this activity level.

It was noted that virtual appointments had been received well by patients and the Trust had received a lot of positive feedback around this. There was still a lot of work to do to ensure the patient pathway was as smooth as possible and it was recognised that virtual appointments worked well for follow up appointments however they were not optimal for assessing all patients.

It was agreed that due to the ever changing nature of the pandemic future reports would be delivered verbally to ensure the most up to date information was presented.

The Board:

- **noted the report.**

TB61-20/21 Communication and Engagement Strategy

Mr Rose and Mr Moore joined the meeting to present the communications and engagement strategy and provided an overview of the strategy. It was noted that this had previously been presented at Business Performance Committee and comments received at that committee had been taken welcomed and incorporated into the strategy.

Mr Moore stated that the strategy provided a lot of emphasis on evaluation of current processes to ensure that these best suited the requirements of the Trust. Timelines for operationalising the strategy had been amended in light of the COVID-19 pandemic and it was noted that there was some work to be completed regarding internal and external stakeholders.

Professor Thakkar noted that the Director of Public Health should be added to the list of external stakeholders.

The Chair noted that the strategy had been positively received at Business Performance Committee and had been endorsed for Board approval.

The Board:

- **approved the strategy.**

TB62-20/21 Integrated Performance Report

Ms Citrine provided an overview of performance noting the report had been discussed in detail at both Quality Committee and Business Performance Committee as the chairs reports noted. The effect of COVID19 on several areas was noted which had created some key challenges around activity and waiting times. There were however some positive areas in quality, finance and workforce areas.

Quality

Ms Vlasman updated on hospital acquired infections and noted that deep dives following the patient journey were undertaken for all of the reported MSSA cases. It was highlighted that Divisional Nurses were to meet with the Head of Information and Business Intelligence to discuss risk assessments.

Mr Crofts stated that incidences of MSSA had been discussed at length at Quality

Committee. It was also noted that in relation to the 7 day pharmacy service KPI, the service would continue in its current form with workarounds developed in the short term.

Performance

Ms Ross commented that the Trust continued to perform well seeing and treating cancer patients and had maintained that standard throughout COVID. In terms of diagnostic testing, Ms Ross advised members that this area continued to be a big issue both nationally and regionally, however it was noted that big improvements had been made during August but there was still work to complete. Progress towards the activity recovery plan was reviewed and it was noted that the plan had been based on activity during 2019/2020 and not the phase 3 plans submitted to NHSE and NHSI. The Chair requested that percentage figures were added to future graphs to ensure the data was meaningful.

Workforce

Mr Gibney advised members that Nursing turnover figures were stable for August and also noted that there were no concerns around vacancy levels. Sickness levels had returned to pre-COVID levels and a report would be prepared detailing rates of sickness, shielding and quarantine/self-isolation due to COVID-19.

Finance

Mr Burns provided a high-level summary of the financial position at month 5 with a reported deficit before adjustment of 307K. This top up was required due to increased activity and the corresponding increase in costs incurred to deliver this. An explanation was provided regarding the areas of underperformance in relation to Wales and Isle of Man finances. It was stated that as activity increased, the profit margin would start to reduce due to the Trust being in receipt of block funding and that the block funding arrangements may be in place for the remainder of the financial year.

Expenditure related to COVID-19 was highlighted and it was noted that any reasonable COVID-19 related costs would be reimbursed by NHSI/E if this was over and above block income levels.

Key financial risks and actions for 2020/2021 were highlighted.

The Board:

- **noted the report.**

TB63-20/21 The NHS People Plan

Mr Gibney provided an updated presentation regarding the Trust People Strategy and noted that COVID-19 had pushed health and wellbeing up the national agenda. The NHS People Plan contained much of what the Trust was already providing however it was noted that the national strategy was about raising standards across the system. Key headlines from the Trust People Strategy were provided along with key actions from the national People Strategy.

Mr Crofts noted the opportunity to link CPD with the career pathway aspirations of staff to ensure staff have a stake in staying at the Trust. Mr Crofts queried how the Trust manages the wellbeing of staff who are working from home and provide infrastructure support. Mr Gibney stated that home risk assessments were under review and work to finesse home working opportunities was ongoing.

Mr Thakkar recognised the need for a balance for the wellbeing of staff working from home with shared conversations required for staff working from home and staff working on site. Ms Ross noted the need to be mindful and recognise the huge culture shift regarding agile working.

Ms Rai queried the level of staff on staff violence within the Trust, Mr Gibney stated that the last staff survey recorded this at 4% of responses received but clarified that this had not been solved yet.

The Board:

- **noted the report.**

TB64-20/21 Accountable Officer for Controlled Drugs Annual Report

Mr Thornton joined the meeting to present the Accountable Officer for Controlled Drugs annual report and stated that the report ran from August 2019 to June 2020 to tie in with quarterly reporting timescales. Key issues were highlighted and it was noted that the handling of patients own controlled drugs had improved however it was recognised that further improvements were required. Fewer incident reports were recorded than the previous year and the majority were low risk with variances within the 5% tolerance range. There were two reportable high risk incidents and an overview of each was provided.

Ms Rai queried if a total of 87 incidents was deemed a reasonable level and Mr Thornton confirmed this was reasonable.

The Board:

- **noted the report.**

TB65-20/21 Pharmacy and Medicines Management Annual Report

Mr Thornton presented the Pharmacy and Medicines Management annual report stating that the pharmacy department continued to be run from LUFT as per the agreed SLA and noted the highlights from the last financial year. Mr Thornton informed the Board that the EPMA system, which was an upgrade from the JAC system, was still in the infancy of development. This was noted to be a brand new system and the project management team would incorporate the Trust into the system however it would be run from LUFT.

The need to ensure that all high cost drugs are recorded and approved on the BluTeq system was noted, Mr Thornton will clarify if drugs used within the Trust fall under this regulation.

Mr Thornton informed that the pharmacy department was following all instructions from Department of Health in regards to Brexit preparedness. It was unknown if there would be any problems when the transition period with the EU ended.

The Board:

- **noted the report.**

TB66-20/21 Guardian of Safe Working Quarterly Report

Dr Nicolson presented the Guardian of Safe Working quarterly report and noted that there were currently 52 Junior Doctors on the new contract at the Trust and no vacant posts. It was stated that positive feedback continued to be received from Junior Doctor.

Ms Citrine recognised that this was a positive report with very few exceptions all of which had been resolved quickly.

The Board:

- **noted the report.**

TB67-20/21 Senior Information Risk Owner Annual Report

Mr Burns introduced the Senior Information Risk Owner annual report and provided an overview of key messages. It was noted that while the number of Freedom of Information requests had reduced the time spent responding to these had increased. The Trust had met the target of 95% of staff completing Data Security training. The strategic direction for 2020/2021 was reviewed and it was recognised that the Trust was working collaboratively with the Cheshire and Mersey Information Governance meeting and the newly implemented Information Governance Strategy meeting.

The Board:

- **noted the report.**

TB68-20/21 Workforce Race Equality Standard Annual Report

Mr Lynch joined the meeting to present the Workforce Race Equality Standards (WRES) annual report for 2020 and provided an update for each of the indicators noting that the Trust had recorded a marked deterioration in five of the nine indictors and also recorded a smaller level of deterioration in one other. There were three indictors where the Trust recorded an improvement; this was a marked contrast to the previous year which saw the Trust progressing on eight of the indicators. It was recognised that this was very disappointing following the gains made in the previous year however the Trust was now in a stronger position which should make a big difference going forward.

Ms Rai queried if anything had been identified in particular for 2019 that had affected numbers as fewer BAME staff had completed the related survey. Mr Lynch stated that a lot of work to promote WRES had been completed which had sparked conversation and provided staff with the confirmed information. It was noted that indictors related to bullying and harassment from patients would fluctuate due to the patient cohort so the emphasis was more around support and prevention.

Ms Citrine stated that the results were very disappointing, however would be used as an opportunity to improve and the BAME Strategic Advisory Committee was essential to improving equality for BAME staff and patients and in turn this was expected to improve performance against these indicators. The need for consistent improvement was recognised and – the strategic committee would hear from those examining the granularity of the data.

The Board

- **noted the report and intended approach.**

TB69-20/21 Workforce Disability Equality Standard Annual Report

Mr Lynch presented the Workforce Disability Equality Standard (WDES) annual report for

2020 and noted that the situation had not changed much from the previous annual report. The Trust continued to have low numbers of staff who identified themselves as having a disability and the number had reduced slightly with overall numbers at 3%. It was noted that all Trusts experienced the same situation and although it was early days for the standard work to improve, this clearly indicated the need to continue. Mr Lynch summarised the key points of the report and gave an overview of the findings of each metric, however it was recognised that the numbers of respondents was so small that it could not be identified if the findings were statistically significant.

Mr Gibney noted that there was an element of staff members not wanting to identify or declare themselves as disabled and this required a broader conversation.

The Board

- **noted the report.**

TB70-20/21 Revalidation Annual Report (Medical)

Dr Nicolson presented the Medical Revalidation annual report and informed that the Trust had been on track to have no missed appraisals prior to COVID-19 and that appraisals for Doctors would restart during November 2020.

The Board

- **noted the report.**

TB71-20/21 Quality Committee chair report

Mr Crofts provided an update from the meeting of the Quality Committee held on 17th September focusing in particular on a presentation from the communications team, the integrated performance report, the quarterly pharmacy KPI reports and the pharmacy review that related to pharmacy provision within critical care. It had been noted that the infection control PLACE review would not be undertaken due to COVID-19.

The Committee also approved the updated DNA-CPR policy.

The Board:

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

TB72-20/21 Business Performance Committee chair report

Ms Spicer provided an update from the meeting of the Business Performance Committee held on 22nd September focusing on a detailed review of the integrated performance report and noting that the Trust recorded a break even financial position although this required a top-up due to the financial pressures related to COVID-19. It was highlighted that activity would be incorporated into performance reporting within the report.

The Committee

- received assurance around the phase 3 finance and activity plan.
- recommended that the Board approve the six month extension of the ISS Facilities Management contract and sign off the re-procurement timetable. This would be presented to the Board at the next meeting.

- recommended that the Board approve the Communications and Engagement strategy.

The Board:

noted the update from the Business Performance Committee

TB73-20/21 Research, Development & Innovation Committee chair report

Mr Crofts presented the report from the meeting of the Research, Development & Innovation Committee held on 2nd September 2020:

MHRA Corrective and Preventative action plan – The committee were informed that there were no outstanding actions from the action plan. A formal audit procedure had not been implemented by the Neuroscience Research Centre due to staffing constraints however this would be instigated in 2021.

Intellectual Property update – Mr A Rose was developing an Intellectual Property policy along with additional guidance to be adopted across the Trust.

Innovation Strategy Quarterly Update – The Committee received a comprehensive report detailing progress of implementing the Trust's Innovation Strategy which included an overview of the short term and medium term objectives. A review of all innovation pipeline projects and initiatives was due to be undertaken in Q3.

The Board:

- **Noted the update from the Committee**

TB74-20/21 AOB

Mr Crofts informed that he held discussions with the Divisional Nurses each month to discuss their experience and it had been noted that morale amongst staff was strong.

There being no further business the meeting closed at 13.05pm

TRUST BOARD
Matters arising Action Log
November 2020

	Complete & for removal
	In progress
	Overdue

Actions not yet due

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 THE TRUST BOARD
Date 5th November 2020

Title	**Chair and Chief Executives Report**
Sponsoring Director	Name: Janet Rosser – Chair Hayley Citrine – Chief Executive
Author (s)	Name: Jane Hindle Title: Corporate Secretary
Previously considered by:	N/A
Executive Summary The purpose of this report is to update the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.	
Related Trust Ambitions	• Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	None identified
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	N/A
Any associated legal implications / regulatory requirements?	None
Action required by the Board	The Board is requested to: • note the report

1.0 INTRODUCTION

1.1 The purpose of this report is to update the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

2.0 UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

2.1 Hospitals, mental health and community trusts in England are set to receive a multi million-pound boost to help recruit thousands more nurses.

With the NHS continuing to respond to the COVID-19 pandemic, bringing all routine services back online and preparing for winter, England's Chief Nursing Officer, Ruth May, has written to nurse leaders setting out support available to help accelerate recruitment.

The financial offer includes a £28 million fund to support international nurses and midwives who are waiting in the wings to join the NHS front line.

According to the latest NHS Digital data, there are now more than 300,000 nurses in England after more than 13,442 nurses joined the NHS. And this year there was a 22% increase in applications for nursing degrees.
https://www.england.nhs.uk/2020/09/nursing-boost-for-englands-nhs/

2.2 CQC's draft strategy for 2021 and beyond

The Care Quality Commission (CQC) has today published a draft strategy for 2021 and beyond for discussion ahead of the formal consultation period. In the draft, CQC sets out how it plans to develop its approach in line with a changing health and care landscape taking into account the context and learning from COVID-19, the development of system working and greater use of digital technologies. CQC has identified a need to transform and ensure its regulatory model is relevant and fit for purpose in an evolving system. draft strategy for 2021 and beyond

2.3 Evaluation of the well-led framework

The findings of the Alliance Manchester Business School evaluation of the health care services well led framework, in partnership with Deloitte has now been published. The review, commissioned by the NHS national improvement and leadership development board, examines the contribution made by the well-led framework (WLF) to assessing, supporting and improving NHS leadership, including CQC's well led inspection regime, developmental well-led reviews, and the use of the framework by organisations to support improvement. Alliance Manchester Business School evaluation of the health care services well led framework

3.0 INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

3.1 A verbal update will be provided at the meeting

4.0 INTERNAL MATTERS

4.1 Council of Governors

The Council of Governors met on 17th September. Items on the agenda included a regular performance update and highlights from the business of the committees of the board provided by the Non-Executive Directors and approval of Mr Crofts as Deputy Chair.

Following an interview process, the Council approved the appointment of two new Non-Executive Directors on 1st October 2020.

We would like to welcome Melanie Worthington as the new Partnership Governor representing Cheshire and Merseyside Neurological Alliance who replaces Ruth Austen-Vincent.

Melanie has recently been appointed co-chair for the Cheshire and Merseyside Neurological Alliance and hopes that she can bring her skills and experiences to the role as Partnership Governor at the Walton Centre.

The Walton Centre
NHS Foundation Trust

REPORT TO TRUST BOARD
Date 5th November 2020

Title	**COVID-19 Update Report**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Jan Ross, Director of Strategy and Operations, Mike Gibney, Director of Workforce and Innovation, Lisa Salter, Director of Nursing and Governance, Mike Burns Director of Finance.
Previously considered by:	None
Executive Summary The purpose of the report is to summarise the approach to COVID-19 to date; to inform the Board of new ways of working, emergency resilience and operational preparedness, recognising regional and national responses and directives.	
Action required by the Board	The Board is requested to: • note the updated position
Related Trust Ambitions	1. Deliver best practice care and treatments on our specialist field. 2. Provide more services closer to patient's homes, driven by the needs of our communities, extending partnership working. 3. Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff. 4. Lead research, education and innovation, pioneering new treatments nationally and internationally. 5. Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family centred care. 6. Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing
Risks associated with this paper	
Related Assurance Framework entries	BAF Risk ID001 COVID-19
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	Follows national and regional guidance related to Coronavirus

1.0 INTRODUCTION

The purpose of this report is to update the Trust Board on key developments in relation to COVID-19.

2.0 WORKFORCE

North West Staff Movement MOU
Cheshire and Merseyside Staff Partnership Forum have agreed to extend the existing MOU until March 2021. It is important to note that any staff relocating will be required to have a new risk assessment.

The national SPF statement on industrial relations is still proving problematic within certain trusts. North West Employers are leading an exercise to create a set of draft principles for conducting virtual hearings.

Sickness Absence – In response to the higher levels of sickness absence across the region, Liverpool Health Partners have been asked to undertake some research into better understanding of the causes and underlying factors. Clearly this will take quite some time (around 18 months) and is only for noting at this stage.

Walton Centre Workforce
The Trust continue to offer a number of local, regional and national support initiatives, an example of which can be seen below: .

All staff continue to be encouraged to complete a risk assessment, and for those who have completed them during wave 1 managers have been reminded of the importance of on-going risk assessments with staff as appropriate.

De-briefs are on-going and lessons learnt will be disseminated in the next few weeks. Converting the Boardroom to a rest area has come out of these discussions and this has now been implemented.

IIP assessment completed awaiting final report.

Staff survey only at 27% which is the lowest for an Acute Specialist Trust.

Mental Health First Aid training- 4 cohorts, which means we will have 40 staff trained by end of January 2021, 1st cohort commences in early November.

The Trust has signed up to the Zero Suicide Alliance on line training programme, which will be rolled out to all staff.

Supporting Medics
Following on from the facilitated session we ran with Jo Potier, Jeanette Chamberlain and Kerry Turner on the Staff Advice Liaison Service at Alder Hey, some discussion at that session focussed on how to engage medics in support available and how to ensure medical colleagues access support, and Jo has kindly shared the attached BMJ article Supporting Clinicians during Covid-19 and Beyond - Learning from Past Failures and Envisioning New Strategies.

The Walton Centre Charity
As previously reported, The Walton Centre Charity has received £95,500 from the national NHS Charities Together campaign (first stage emergency appeal funding). To date, £50,000 has been allocated to the refurbishment of the junior doctors' mess; and £27,000 has been spent on general support during the first wave including the breakfasts/snackbag initiative, and the Project Wingman lounge. There is still about £18,500 unspent which needs to be spent on staff health/wellbeing. A number of options have been explored to improve staff rest/break areas and a possible location has been identified in the main hospital building that could accommodate a new large staff rest area. If this turns out to be a feasible option, the remaining NHS Charities Together grant could be allocated to support this. There is also £16,500 received in donations through the emergency appeal that could be added to top up the £18,500 should it be needed.

A new shared staff rest/break area would be a great legacy of the NHS Charities Together support during this pandemic. Because of the second wave, the NHS Charities Together have also allocated a further £10 million to support charities with covid-specific requests (over and above NHS requirements) during this second wave. We are waiting to hear the detail of this allocation, but the Head of Fundraising has made some initial enquiries about funding to support a temporary staff rest/break area in the courtyard (marquee) to help with social distancing over the winter months – quotes are in the region of £36K - £50K (November to March), so depending on what our allocation might be from the 'second wave' funding this might be something we can apply for.

There is also a Stage 2 (community and social care pathways) and a Stage 3 (recovery) grants available – deadline 31 March 2021, and the Head of Fundraising is liaising with NHS Charities Together and colleagues from other NHS charities in the region to co-ordinate this process.

3.0 FINANCE AND PROCUREMENT

PPE

The trusts PPE stock continues to be delivered on a daily basis via the national PUSH system. Last week the managed inventory process went live which means future PUSH deliveries will take into account the trusts burn rates (taken from the information inputted by procurement each day in the foundry system) to ensure a 14 day stock level is available at the trust. This seemed to work well last week and the procurement team have not noted any issues with this process to date.

At the moment most PPE at the trust appears in a healthy position. The procurement team continue to work with colleagues to ensure the ongoing challenges around 3M FFP3 masks is addressed. The team have built up a stock of alternative brands of disposable FFP3's for fit testing as well as placed further orders for reusable masks and hoods to ensure a variety of options are available.

Procurement continue to deliver push PPE to the clinical areas around the organisation.

All national returns relating to PPE are responded to as and when required and any issues in relation to PPE are raised through the internal Command and Control meetings.

The National PPE strategy was published at the end of September and advised that there will be a four months stock pile of PPE available nationally by early November to ensure enough PPPE is available through the winter months.

Finance

A number of finance submissions and requests for information have been made to HCP and NHSI/E around forecast levels of spend for months 7-12 (often with very little turnaround time). For M7-12 the Trust will continue to be funded via a block (based on similar methodology used for M1-6) but there will not be any retrospective top-ups for COVID related spend or to bring the Trust back to breakeven.

C&M region have been funded for the anticipated levels of COVID spend and growth which has been allocated to individual organisations (although these allocations may change).

Overall the C&M HCP is expected to breakeven by the end of the year but this can be achieved through some organisations delivering a surplus and others a deficit.

A number of financial risks remain for the Trust (and across the region) around the level of funding that will be received from Wales for M7-12 (still to be agreed); IOM only paying on a PBR basis and reductions in other elements of income (R&D, car parking etc.) which NHSI/E assume will be returned to 2019/20 levels.

It is currently not clear on how the impact of the Elective Incentive Scheme (EIS) will be allocated across the HCP (from month 6).

At the present time it is not clear how financial planning for 2021/22 will be undertaken or what form the financial regime will take.

Title	**Transformation Strategy Paper**
Sponsoring Director	Jan Ross Deputy Chief Executive, Director of Operations and Strategy
Author (s)	Ben Davies, Head of Transformation
Previously considered by:	Business Performance Committee – October 2020

Executive Summary

This document sets out our strategic transformational plan for the coming five years as we embark upon our journey of service redesign and reform to enhance and improve health and wellbeing for our patients utilizing our services across Merseyside and beyond. The Transformation Programme plan will support and enable our Trust to deliver the over-arching strategy for the next five years.

Our Five Year Transformation Programme will drive and underpin the long term service change, and to support our staff, to continue to provide the outstanding treatment and care we have been recognized for by the CQC once again in 2019.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	See performance assurance framework (separate report) – N/A
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes/No – N/A
Any associated legal implications / regulatory requirements?	• No – (please specify) No legal implications. Regulatory implications (NHSI risk rating) covered in report
Action required by the Board	The Board is asked: a) To approve the Transformation Strategy

Transformation Strategy
2019 - 2024

Contents

Overview

Welcome to The Walton Centre's Five Year Transformation Programme. This document sets out our strategic transformational plan for the coming five years as we embark upon our journey of service redesign and reform to enhance and improve health and wellbeing for our patients utilizing our services across Merseyside and beyond. The Transformation Programme plan will support and enable our Trust to deliver the over-arching strategy for the next five years.

The NHS, much like other public sector organisations, is facing considerable resource and financial issues and we need to ensure we are best placed to respond to the new local and national priorities which underpin our improvement and transformation programmes. As such the context for making these transformational changes are even more challenging than ever.

Our Five Year Transformation Programme will drive and underpin the long term service change, and to support our staff, to continue to provide the outstanding treatment and care we have been recognized for by the CQC once again in 2019.

Introduction

"Change can be hard. It requires no extra effort to settle for the same old thing. Auto-pilot keeps us locked into past patterns. But transforming your life? That requires courage, commitment, and effort. It's tempting to stay camped in the zone of That's-Just-How-It-Is. But to get to the really good stuff in life, you have to be willing to become an explorer and adventurer." John Mark Green

Our Transformation Strategy covers the next 5 years and is aligned to the Trust Strategy goals and timescales. By doing this it will enable us to not only focus on our in-year priorities but also to coordinate our transformation programme to the Trusts long term goals. Transformation is an on-going journey and one that requires us, as a Trust, to review the ways in which we currently work and how we can adapt our services to meet the needs of our customers – our patients, their families and other NHS service providers.

As stated by the NHS Long Term Plan - As medicine advances, health needs change and society develops, the NHS has to continually move forward so that in 10 years' time we have a service fit for the future. It is with this in mind that we have endeavored to future proof our Transformation Strategy so that it can flex to the needs of the services and patients.

The Walton Centre is striving to achieve 'Excellence in Neuroscience' and believes that the strategies we have identified will enable this success. We will continue to cherish the standards we have achieved to date, whilst exploring how we can enhance this further, shaping neuroscience, treatments and care for the future.

The objectives of transformation are to define what our organization intends to achieve in order to improve upon its ability to pursue our values and purpose within the current ever-changing NHS environment. Our Transformation Strategy has been developed to support and deliver the Trust's six strategic priorities, Excellence in Neurosciences, which are listed below.

Vision, Values and Goals

DELIVER
best practice care

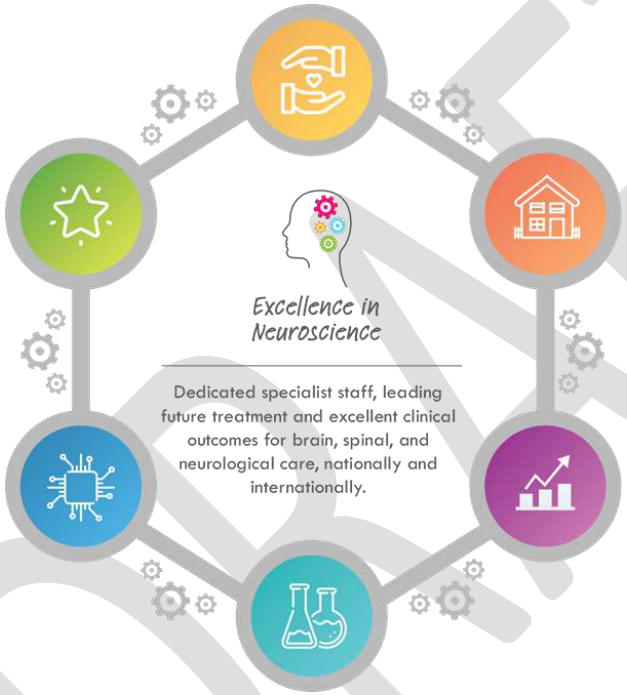
PROVIDE
more services closer to patients' homes

INVEST
be financially strong

LEAD
research, education and innovation

ADOPT
advanced technology and treatments

RECOGNISE
be recognised as excellent in all we do



Our Transformation Vision

To lead, drive and champion the application of transformation and improvement science at The Walton Centre supporting delivery of the Trusts strategic priorities and objectives.

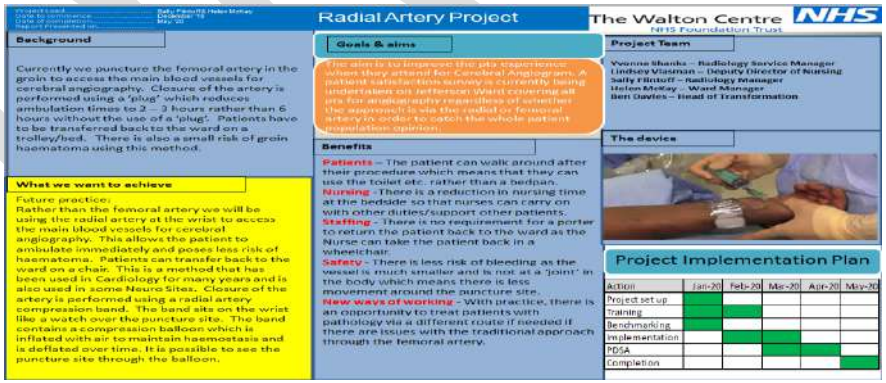
Establish a common purpose

The transformation strategy has been designed to support, enable and deliver the trust wide strategy and goals that we have set out. The reason for this is that there is a common purpose and goal that we all, as a Trust, are working towards. Often a strategy can be overly complex and set out to address and change so many different objects that they can fail to reach them by spreading themselves to thin. As such we have made sure that the transformation strategy has been built around the Trusts strategic priorities whilst complimenting and supporting each areas individual strategy.

A3 Methodology

A3 methodology is seen as a highly effective tool to aid and guide those implementing change and transformation. A3 thinking is the rigorous application of the Plan, Do, Study, Act approach which is presented on an A3 size page. This gives a high level overview of the project providing the background to the project, what the identified issue is and what the plan is in order to address the problem. By following a structure approach research has found that, when used properly, the chances of success improve dramatically.

This is an approach that has been used in the trust for a number of years now and continues to be utilised for suitable projects and initiatives. The use of A3 methodology is done with the teams who have identified a problem they want to address with the aim to impart shared learning and build upon the culture of continuous improvement we are striving for. It also allows the staff an opportunity to showcase the work they have done as the trust displays the final A3 reports and the project teams feedback to management on how the project went along with lessons learnt.



Transformation Priorities & Delivery

We face some significant challenges which can make it difficult to always deliver the high standard of patient care to which we aspire. As such we have agreed that rather than try to tackle a multitude of areas we will focus on the following 3 main pillars of transformation - Outpatients, Theatres and Patient Flow. By making these are primary aim it will allow us as a Trust to focus on the key areas that will improve out patients care and experience whilst also help to create flow and efficiency within the hospital. However we will also continue to support the Trusts overarching strategy and other tactical transformation programmes of work as and when the need arises.

We have devised a comprehensive programme to transform patient care and experience over the next 5 years in partnership with our staff, local partners and patients. Our transformation strategy will enable the changes that we need to improve patient care in the long term whilst driving continuous improvement on a daily basis. Below sets out what we are aiming to achieve with each of the 3 pillars and the work that will underpin how we can achieve those goals.

The Transformation strategy is leading transformative change on these and other areas to make sure patients needing planned care see the right person, in the right place, first and every time, and get the best possible outcomes, delivered in the most efficient way.

Outpatients

Our mission statement:

The aim of the programme is to ensure that patients are seen in the right place, at the right time, by the right healthcare professional, saving patients' time and ensuring clinical time is used effectively. The programme will transform outpatient services by improving the quality and efficiency of referrals**,** from the initial GP referral, to patients receiving the right on-going care**.** This would be achieved by harnessing digital solutions and removing unnecessary new and follow up appointments.

How we will achieve this?

Goal	How much by when?		
	2020-21	2021-22	2022-23
Redesigned service pathways to deliver patient programmes virtually	Implement	Embed	
Early adoption of patient initiated follow up giving patients greater control over their hospital follow up care	Pilot	Implement	
Improved out-patient clinic utilisation and how patients chose and book their appointments	Pilot	Implement	
Provide more accessible services to our patients based on their needs in line with the NHSI outpatient transformation priorities to reduce face to face follow ups	10%	20%	33%
To ensure we offer emotional and psychological support to our patients with long term neurological conditions	Baseline	Pilot	Implement
Move to a more automated patient communication method allowing more timely and accurate correspondence	Pilot	Implement	

Theatres

Our mission statement:

To ensure that we maximise the utilisation of our theatres and expertise of all the staff who work there thus allowing them to deliver outstanding patient treatment and care at a time when our patients put their lives in our hands

How will we achieve this?

Goal	How much by when?		
	2020-21	2021-22	2022-23
To have all of our morning elective theatre sessions start at the designated and agreed time	85%	90%	95%
Reduce the number of same day non-clinical theatre cancellations	10%	15%	20%
Develop a theatre performance dashboard to support awareness of current performance and overall aims/trajectories	Pilot	Implement	
Implement a track & trace solution for medical consumables allowing patient level costing and the ability to undertake safety recalls of products if required	Implement		
Offer an improved patient experience for those undergoing surgery, making them more aware of what can be expected and making them feel more at ease	Explore	Baseline	Pilot
Exploration of robotic treatment and how it can complement and enhance our patient services	Explore	Baseline	Pilot

Patient Flow

Our mission statement:

Optimisation of the patient's journey to remove any unnecessarily steps from the pathway thus allowing us to deliver care in the right place, at the right time and enabling patients to return to their usual place of care in a timely manner.

How we will achieve this?

Goals	How much by when?		
	2020-21	2021-22	2022-23
To increase the amount of same day admissions and discharges within the Trust	75%	85%	90%
More remotely delivered services for those with long term conditions			
Utilisation of estimated date of discharge and reduction of delayed transfers of care	Pilot	Implement	
Optimisation of our pain services to improve the functionality we offer to be more responsive and timely for our patients	Pilot	Implement	
Improve and expand the care offered to our patients closer to home	Explore	Baseline	Pilot

Tactical Transformation

Our mission statement:

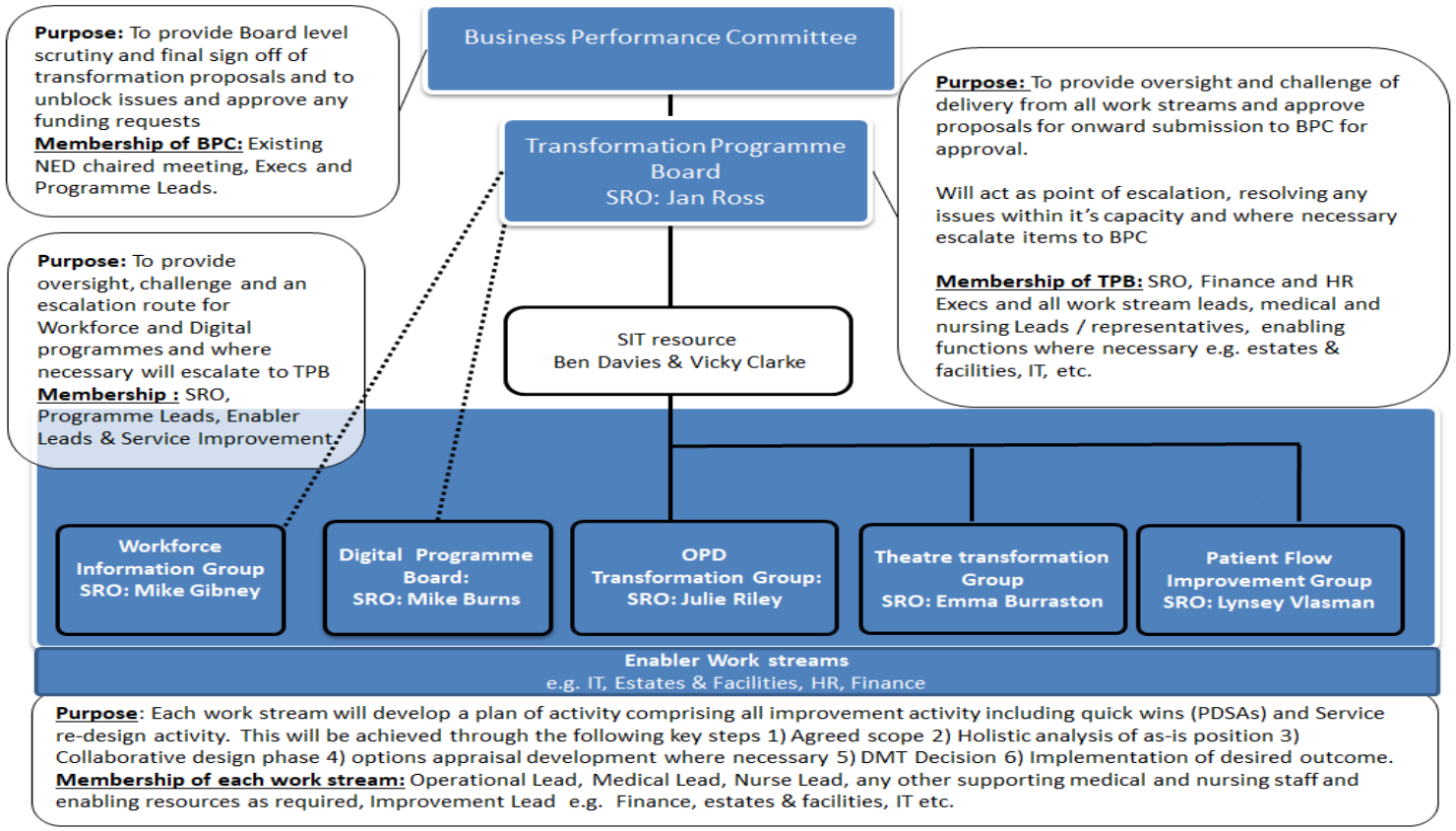
To support in the delivery of the Trusts overarching strategy along with being able to adapt to the needs of the trust and delivery of other tactical transformation work as required, to support the delivery of the trusts QIP/ efficiency schemes year on year

How we will achieve this?

Goals	How much by when?		
	2020-21	2021-22	2022-23
Better collaborative working with the aim to standardise practices with our health partners across our local system			
To be seen as a hub for shared learning and provider of training across our system	Explore	Baseline	Pilot
To have an agile workforce, empowering our staff, finding the most appropriate and effective way of working	25%	30%	35%
Establish a culture of innovation and service transformation across the Trust	Explore	Implement	
Align and create a local specialist trust partnership within our region	Explore		

Governance

In order to deliver the above programmes of work we have set up the below governance structure and the Transformation Programme Board meet on a monthly basis. These meetings are to report back on performance, to raise any risks or issues to the group along with ensuring a joined up approach. Each month we will focus specifically on one programme to provide more a more detailed and granular update.



Risks to Delivering the Strategy

The most fundamental risk to the successful delivery of this strategy has to be cultural. The Walton Centre must now live its commitment to collaborative leadership, the pursuit of excellence and fulfilling the aspirations of all its employees. There is a risk that the Trust is drawn into short term pressures (financial and others) rather than prioritising service developments, nurturing new partnerships and transforming the services we offer.

On a practical level the key risks are as follows:

- Ensuring that staff are released to work on and support transformation and service improvement programmes of work
- As we work in a complex system within Cheshire & Merseyside when embarking upon collaborative work we will need support to ensure all parties partake in any agree programmes as this will hinder delivery
- Ensuring that the inevitable financial pressures don't distract from the Trust's commitment to transformation
- We need to ensure we keep our transformation work focused and target and avoid knee jerk reactions which may lead to spreading ourselves to thin
- Challenging complacency and the status quo where employees become demotivated
- Local and national political drivers e.g. Brexit, Ministerial changes etc.

The risks will be reviewed and mitigations put in place to ensure that this strategy can be delivered.

"The wings of transformation are born of patience and struggle." – Janet S. Dickens

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD

Date: 5th November 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:	Quality Committee Business Performance Committee
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.	
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	Risk ID003
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	• To consider and note

NHS
The Walton Centre
NHS Foundation Trust

Board KPI Report
October 2020

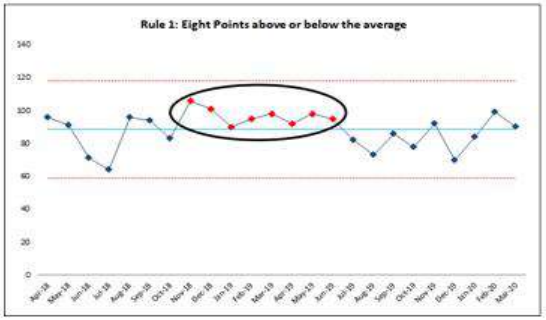
Data for September 2020 unless indicated

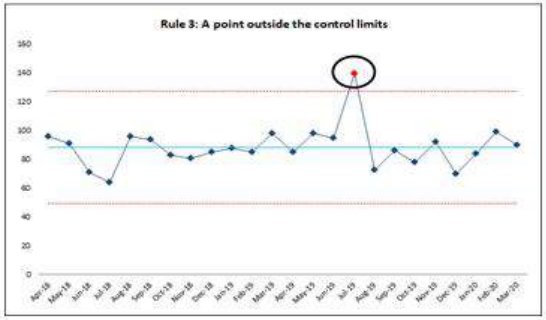
Excellence in Neuroscience

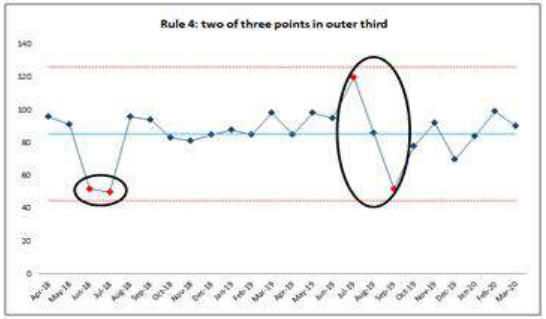
SPC Charts Rules

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).







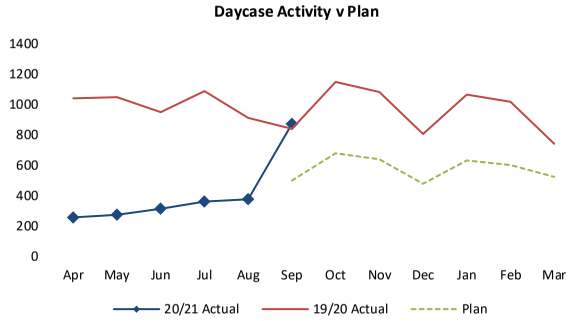
All SPC charts will follow the below Key unless indicated

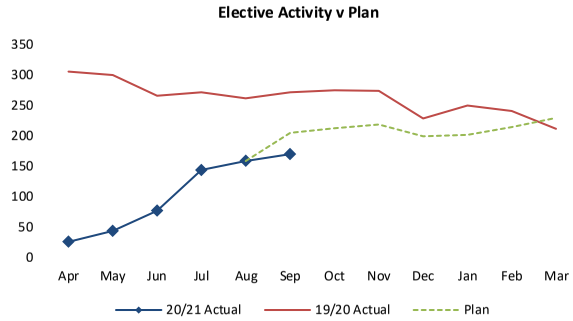
Actual — UCL — Average — LCL — National Average — Target

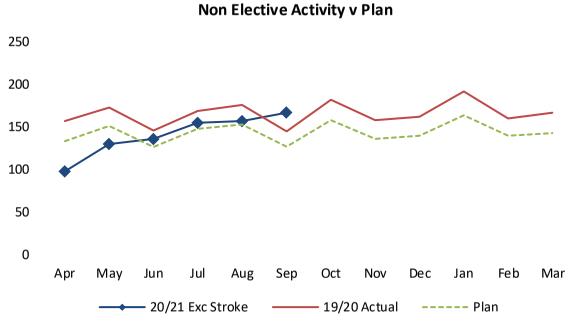
Operational

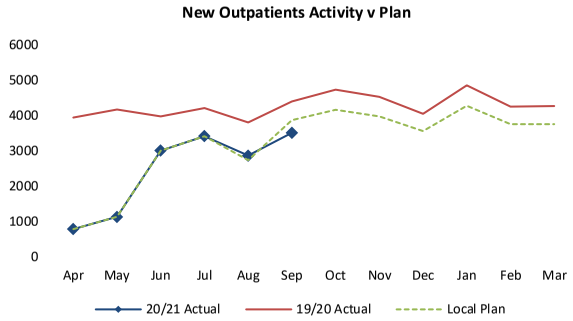
Effective - Activity Recovery Plan

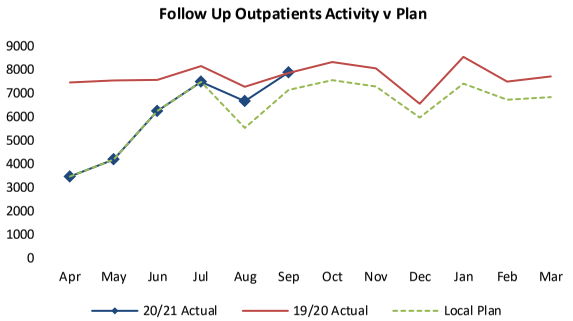
The Walton Centre NHS Foundation Trust











Please note that the activity plans are those that the Trust has submitted as part of the Phase 3 planning submission, at the time of reporting these are still draft and have not been signed off by NHSE/I.

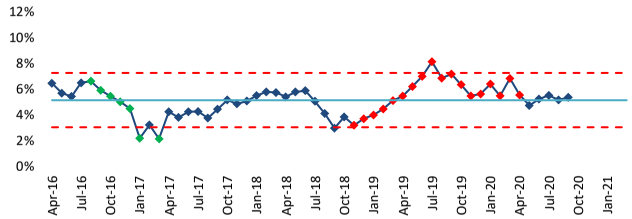
Excellence in Neuroscience

Quality of Care

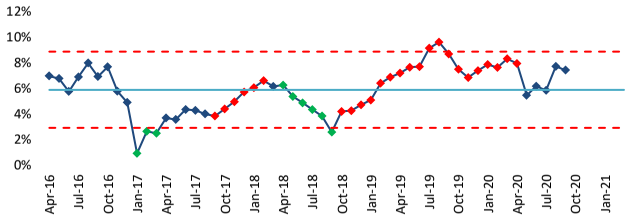
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

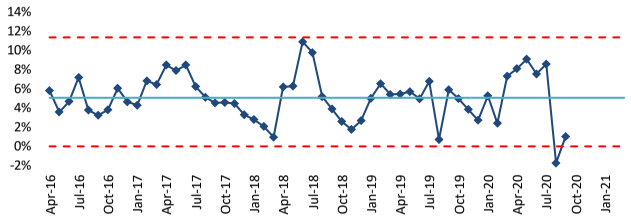
Overall Vacancy Level %



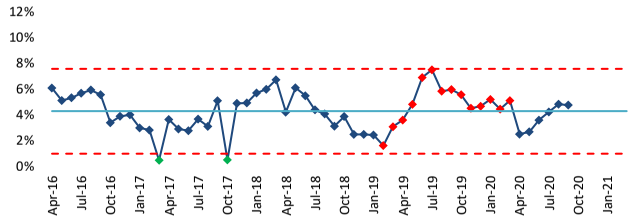
Nursing Vacancy Level %



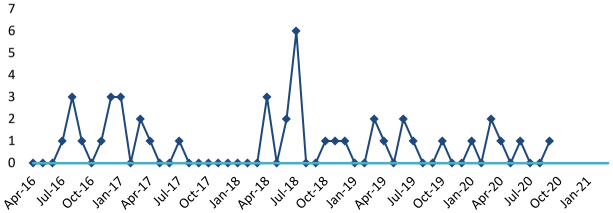
Medical Vacancy Level %



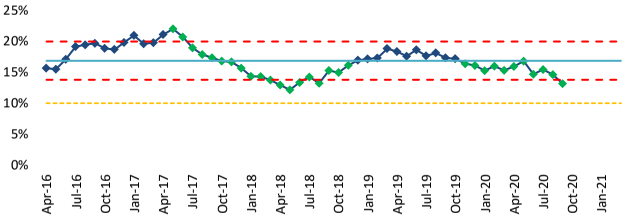
Other Staff Vacancy Level %



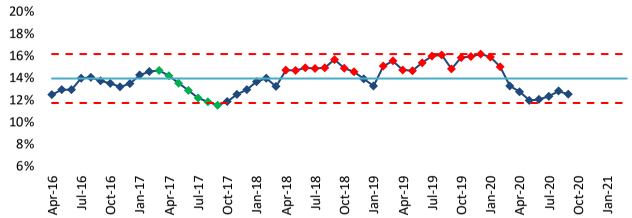
Medical Leavers



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 outside of expected limits.

Nursing Turnover

Nursing turnover has significantly improved over the last 10 months and is within special cause variation. At division level, the target is also outside of the control limit for neurology and neurosurgery.

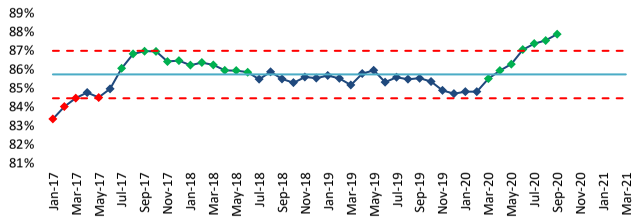
Sickness/Absence

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

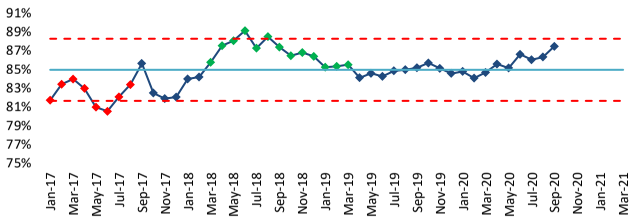
Staff Stability

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.

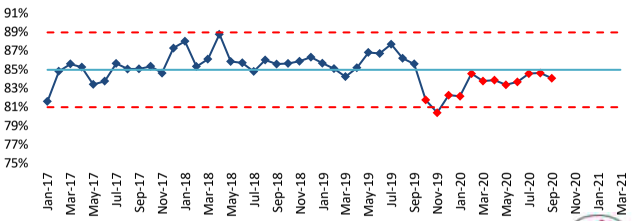
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

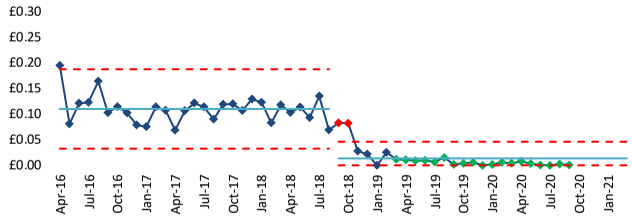


Quality of Care

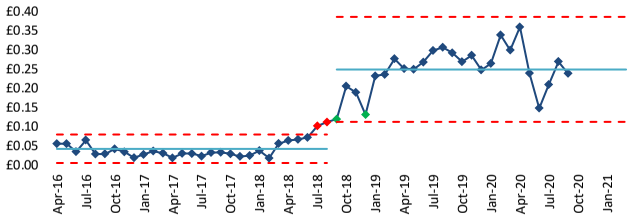
Well Led - Workforce KPIs

NHS
The Walton Centre
NHS Foundation Trust

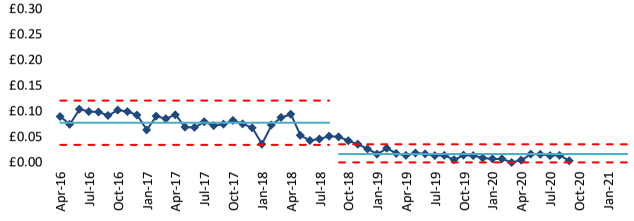
Nursing & HCA Agency Spend (£m)



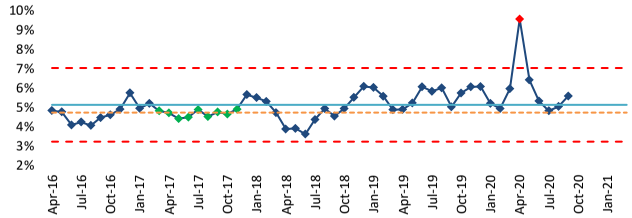
Nursing & HCA Bank Spend (£m)



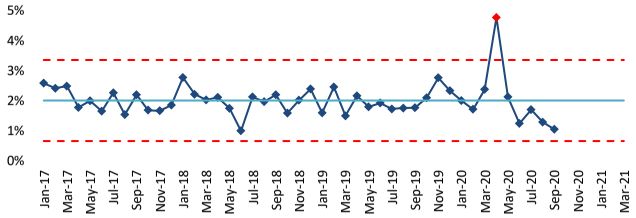
Nursing & HCA Overtime Spend (£m)



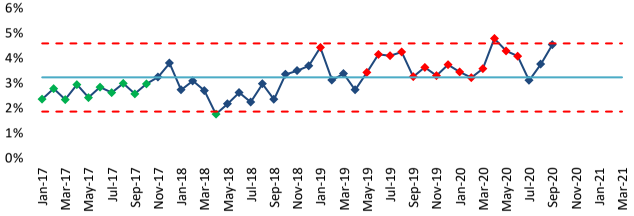
Sickness/Absence (Monthly)



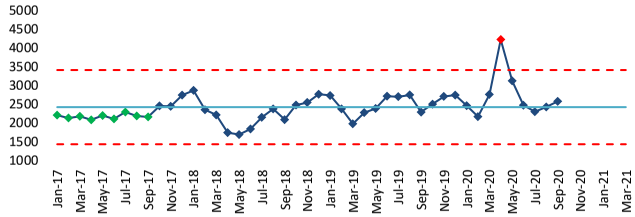
Short Term Sickness/Absence (Monthly)



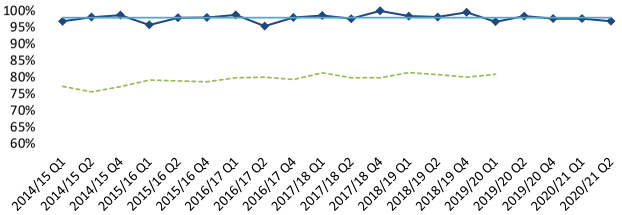
Long Term Sickness/Absence (Monthly)



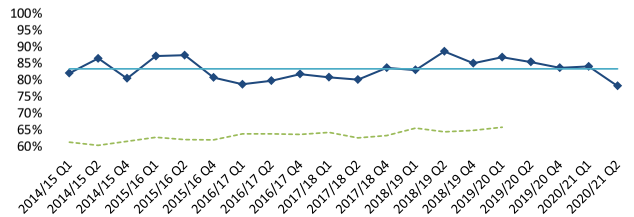
Lost Days due to Sickness/Absense (Monthly)



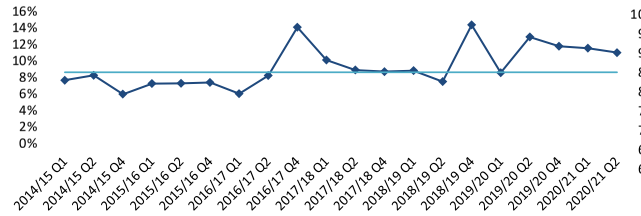
Staff FFT - % Recommend as Place of Care



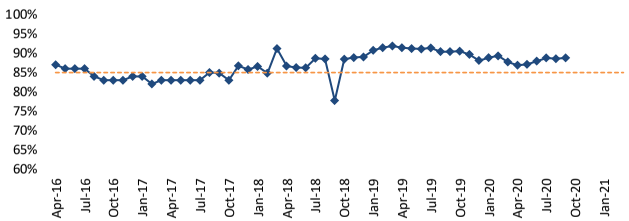
Staff FFT - % Recommend as Place of Work



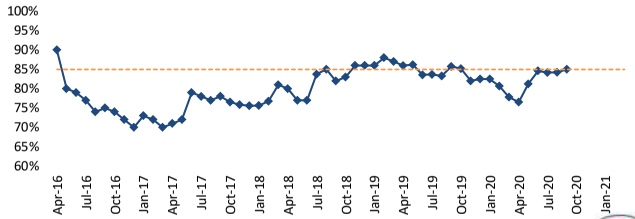
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



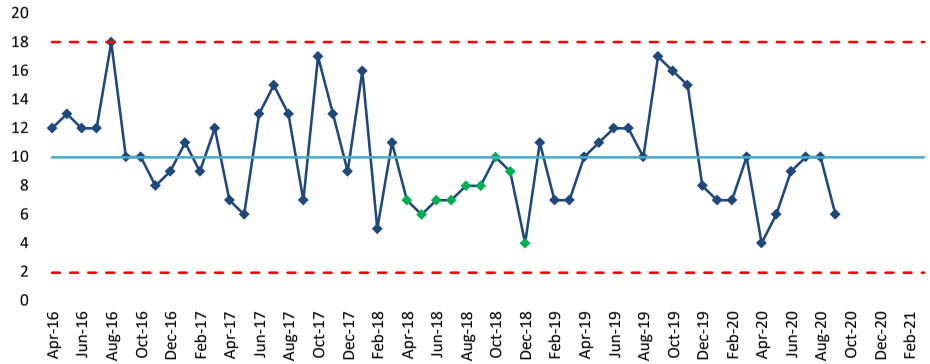
Excellence in Neuroscience

Quality of Care

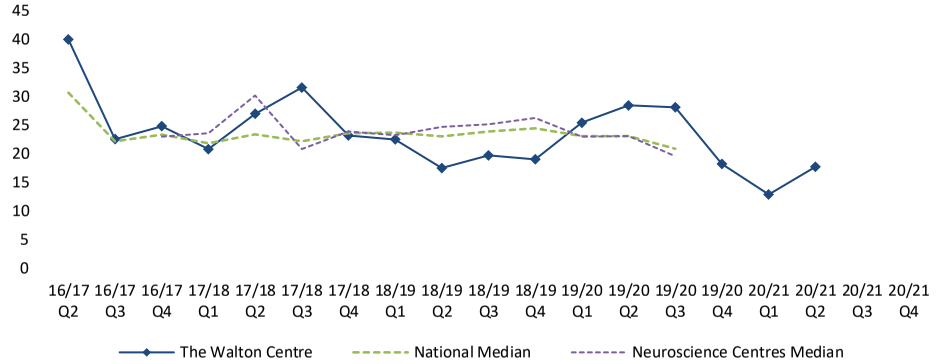
Caring - Complaints

The Walton Centre NHS Foundation Trust

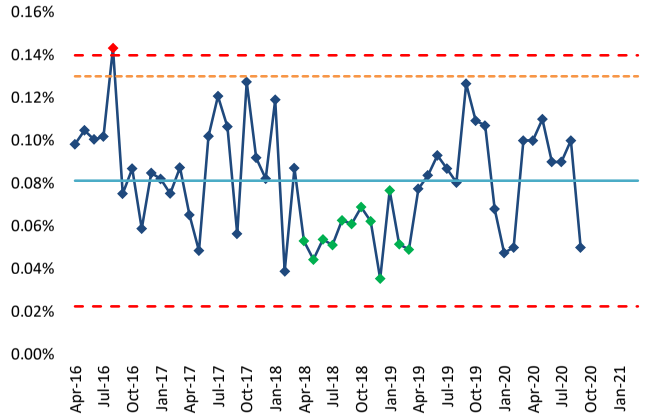
Total Complaints Received in month



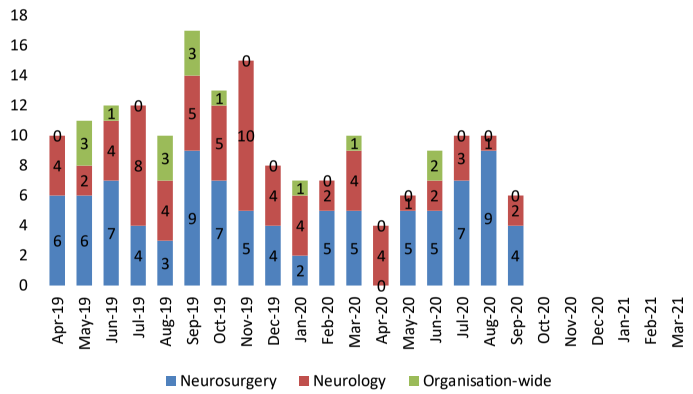
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In September 2020 the Trust received 6 complaints. 2 Neurology and 4 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

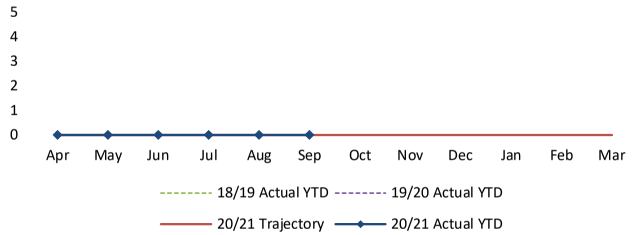
Excellence in Neuroscience

Quality of Care

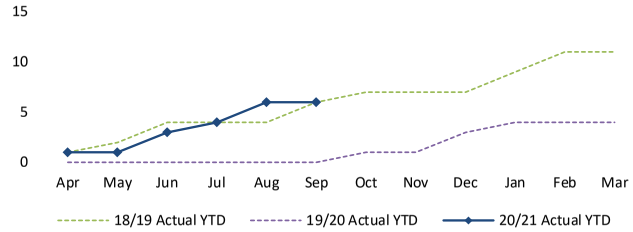
Safe - Infection Control

The Walton Centre NHS Foundation Trust

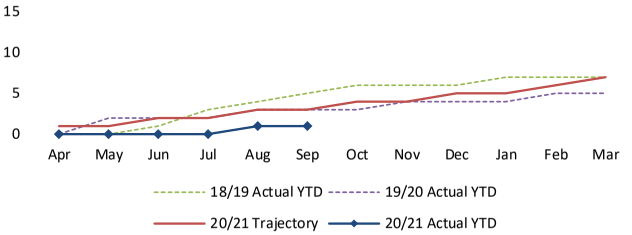
MRSA Bacteraemia



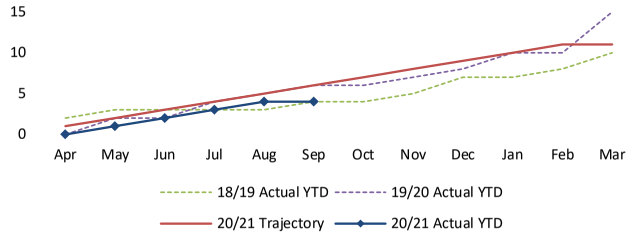
CPE



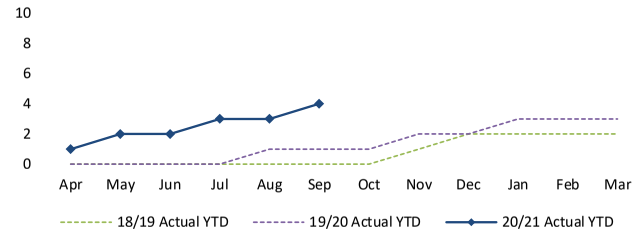
C.Diff



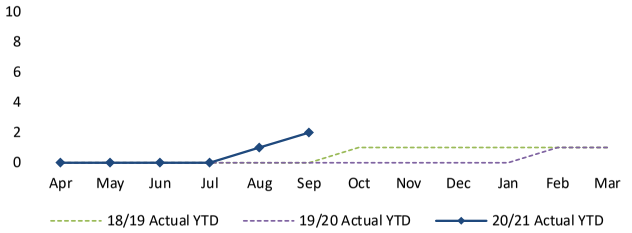
E.Coli



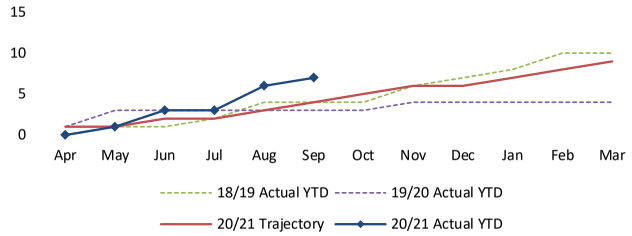
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		1	1				1	**3**
Caton		1					2	**3**
Chavasse				1		1		**2**
CRU					1			**1**
Dott		3		1	1		1	**6**
Horsley		1		1	1	1	3	**7**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**6**	**1**	**4**	**4**	**2**	**7**	**24**

September Breakdown

1x MSSA - Caton
1x PB - Chavasse
1x KB - Dott

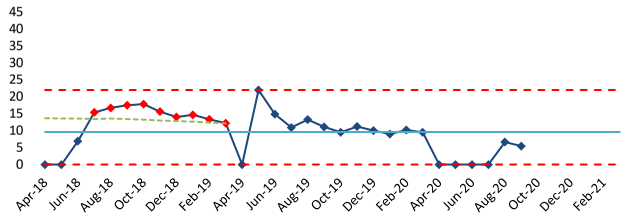
Excellence in Neuroscience

Quality of Care

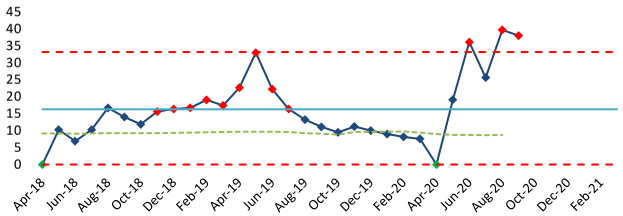
Safe - Infection Control

The Walton Centre
NHS Foundation Trust

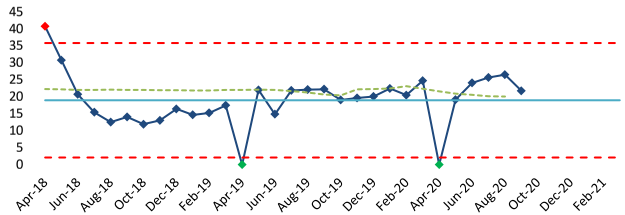
C.Diff Rate per 100,000 Bed Days YTD



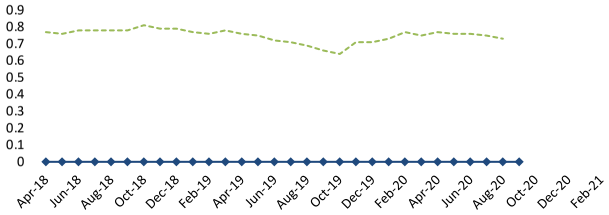
MSSA Rate per 100,000 Bed Days YTD



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 September 20 with the exception of MSSA in which there has been seven recorded instances against a YTD trajectory of four.

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.

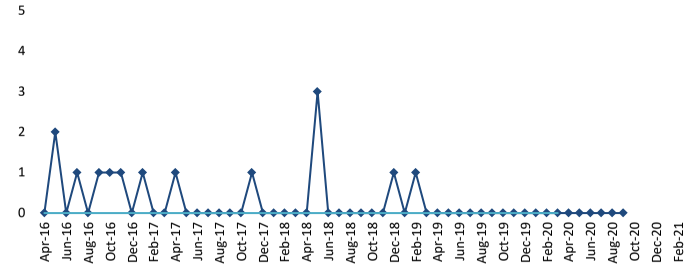
As of March 19 the C.Diff hospital acquired rate is no longer published.

Quality of Care

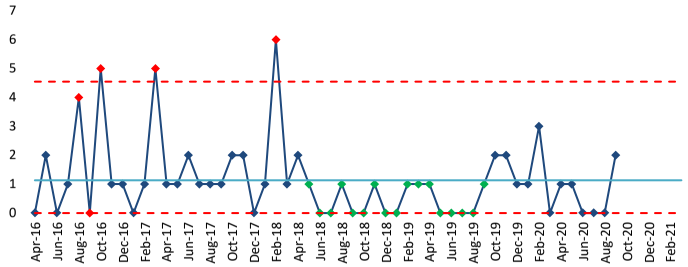
Safe - Harm Free Care

The Walton Centre
NHS Foundation Trust

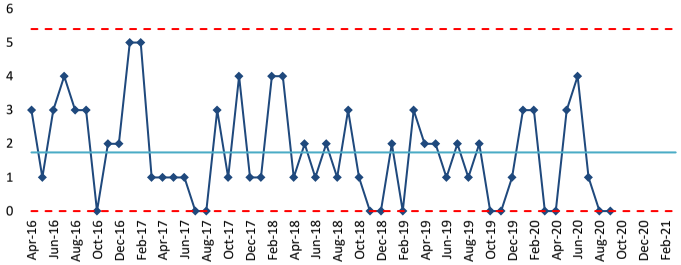
Total Moderate or Above Harm Patient Falls



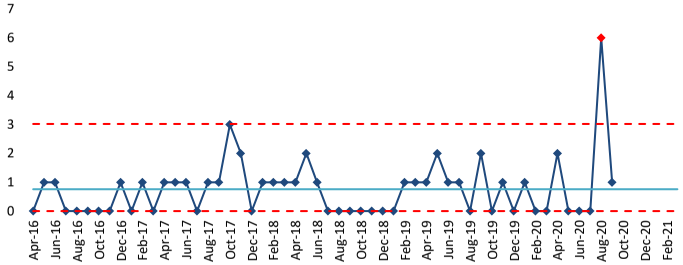
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

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

There were two Hospital Acquired Pressure Ulcers in September 20. One Category Two and one Unstageable.

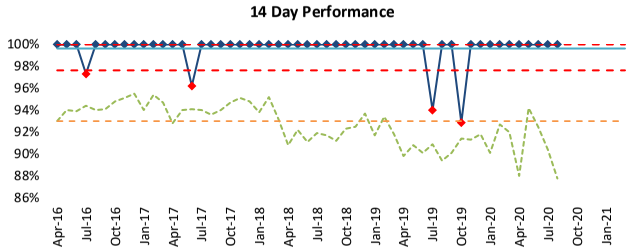
There were no CAUTI incidences in September 20

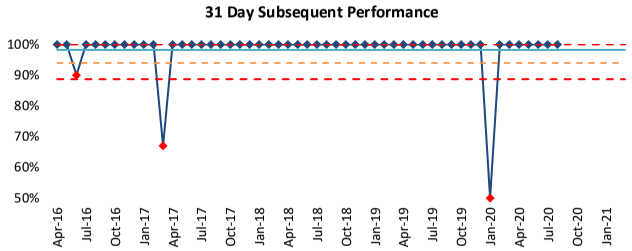
There was one VTE incidence in September 20.

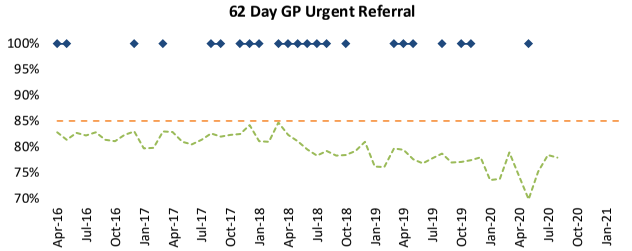
Excellence in Neuroscience

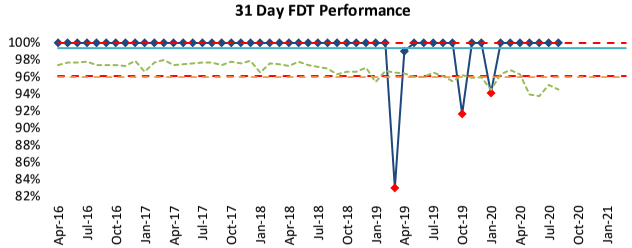
Operational
Responsive - Cancer

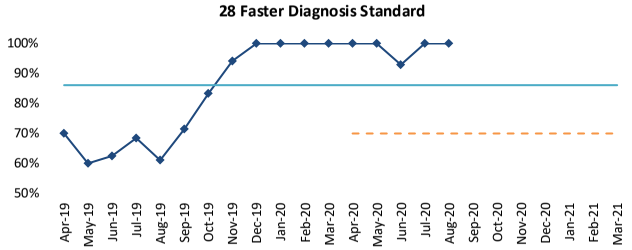
The Walton Centre
NHS Foundation Trust











Narrative

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

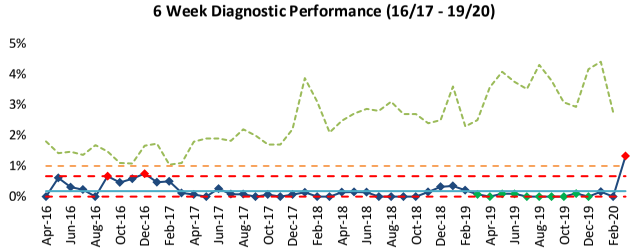
The Trust has continued to see and treat all cancer patients throughout April as these patients were urgent, therefore the impact of covid-19 is minimal.

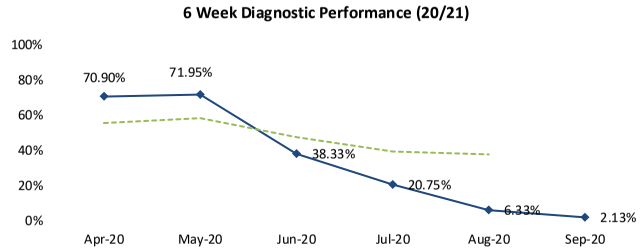
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has consistently met this target since its introduction.

Operational

Responsive - Diagnostics

The Walton Centre
NHS Foundation Trust

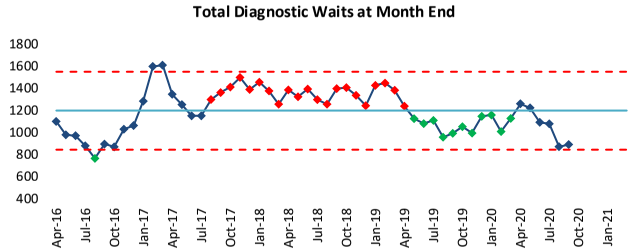




Narrative

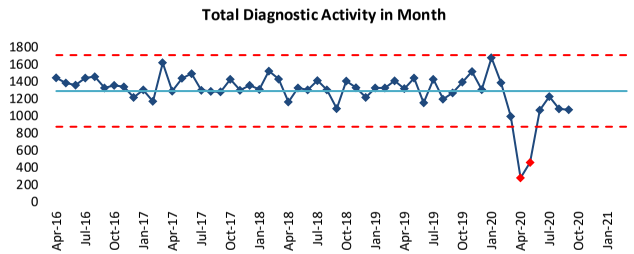
Diagnostic performance in September 20 was 2.13%. This is an improvement from 6.33% in August 20.

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.



There were 19 six week diagnostic breaches in month.

MR - 17
CT - 2



Excellence in Neuroscience

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,681	8,978	297	52,087	51,005	(1,082)
Exclusions	1,786	1,786	0	10,713	10,713	0
Private Patient	20	23	3	120	23	(97)
Other Operating	613	535	(78)	3,680	2,741	(939)
Total Operating Income	**11,100**	**11,322**	**222**	**66,600**	**64,482**	**(2,118)**
Pay	(6,116)	(6,255)	(139)	(36,696)	(35,945)	751
Non-Pay	(2,660)	(2,593)	67	(15,960)	(14,480)	1,480
Exclusions	(1,798)	(1,595)	203	(10,788)	(8,022)	2,766
COVID / Reserves	31	(315)	(346)	186	(2,630)	(2,816)
Total Operating Expenditure	**(10,543)**	**(10,758)**	**(215)**	**(63,258)**	**(61,077)**	**2,181**
EBITDA	**557**	**564**	**7**	**3,342**	**3,405**	**63**
Depreciation	(387)	(402)	(15)	(2,322)	(2,418)	(96)
Profit / Loss On Disp Of Asset	0	0	0	0	2	2
Interest Receivable	14	0	(14)	84	5	(79)
Financing Costs	(53)	(50)	3	(318)	(310)	8
Dividends on PDC	(131)	(131)	0	(786)	(786)	0
I & E Surplus / (Deficit)	**0**	**(19)**	**(19)**	**0**	**(102)**	**(102)**
Capital donations I&E impact	**0**	**19**	**19**	**0**	**102**	**102**
I & E Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**

At month 6, the Trust reported a £760k deficit position before adjusting income to report a breakeven position YTD, in line with NHSI/E guidance. This top up has been required due to increased activity and corresponding increase in costs incurred to deliver this.

The in month position includes £0.2m spend incurred as a result of COVID-19. This has been partially offset by an under-spend in clinical supplies and excluded drugs and devices spend compared to M8-10 in 19/20. This is due to the continued reduction in planned activity (compared to 2019/20).

The underperformance in income is primarily due to Wales and IOM not paying at the levels of income assumed by NHSI/E in their plans for the Trust – this has been raised with NHSI/E (please see the risks section for further explanation).

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Sep-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	39	(10)
Tangible Assets	82,591	81,098	(1,493)
TOTAL NON CURRENT ASSETS	**82,640**	**81,137**	**(1,503)**
Inventories	1,232	1,221	(11)
Receivables	9,287	6,991	(2,296)
Cash at bank and in hand	26,673	41,631	14,958
TOTAL CURRENT ASSETS	**37,192**	**49,843**	**12,651**
Payables	(18,088)	(29,958)	(11,870)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(31,632)**	**(11,870)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,211**	**781**
Provisions	(639)	(628)	11
Finance Lease	(115)	(93)	22
Loans	(25,031)	(24,302)	729
TOTAL ASSETS EMPLOYED	**74,285**	**74,325**	**40**
Public Dividend Capital	27,554	27,696	142
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,085	(102)
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,325**	**40**

STATEMENT OF CASH FLOW - 2019/20	September-20 Actual	Movement Aug-Sep
	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(102)**	**(19)**
Non-Cash Flows In Operating Surplus/(Deficit)	3,510	585
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**3,408**	**566**
Increase/(Decrease) In Working Capital	15,628	2,442
Increase/(Decrease) In Non-Current Provisions	(11)	0
Net Cash Inflow/(Outflow) From Investing Activities	(3,180)	(208)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**15,845**	**2,800**
Net Cash Inflow/(Outflow) From Financing Activities	(887)	(8)
NET INCREASE/(DECREASE) IN CASH	**14,958**	**2,792**
OPENING CASH	**26,673**	**38,839**
CLOSING CASH *	**41,631**	**41,631**

*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 £1.8m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

Any reasonable COVID-19 costs will be reimbursed by NHSI/E if over and above block income levels (for months 1-6)

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	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	49	807
Annual leave provision	287	(287)	52	0	0	0	52
PPE	62	148	259	63	10	94	636
Decontamination	9	8	(2)	6	(3)	9	27
Agile working	21	(19)	1	92	0	3	98
ITU	5	2	(3)	0	2	0	6
Other	37	24	18	23	18	33	153
TOTAL	**520**	**130**	**516**	**302**	**123**	**188**	**1,779**

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 - £409k

In month actual - £201k

In month variance - £208k below plan.

Year to date actual - £921k 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. £0.6m.

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	122	74	636	298	338
Estates	368	31	0	31	184	96	88
IM&T	1,283	107	24	83	642	177	465
Neurology	2,122	44	(3)	47	260	18	242
Neurosurgery	1,702	142	58	84	851	87	764
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,603)	(111)	0	(111)	(737)	0	(737)
TOTAL (excl. COVID-19)	**4,504**	**409**	**201**	**208**	**1,836**	**676**	**1,160**
COVID-19	0	0	0	0	0	239	(239)
TOTAL	**4,504**	**409**	**201**	**208**	**1,836**	**915**	**921**

Capital spend in month is £201k.

It is anticipated that COVID-19 Capital expenditure will be refunded as per the guidance from NHSI/E so will not count against the Trusts capital plan.

There is £122k capital spend on phase 3 heating/pipework scheme. There has been £24k of IMT spend on staffing for projects. There was also additional capital expenditure on neurosurgery equipment (heart start monitors, Rotem for spinal services and a Nitrogen Generator)

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

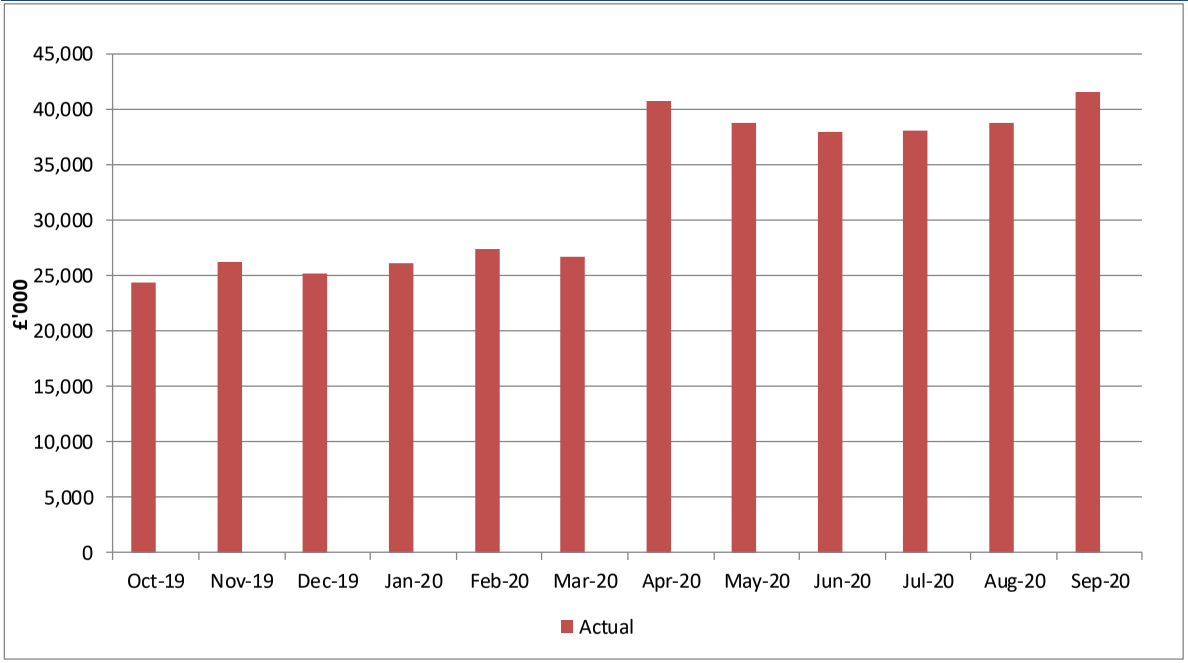
NHS I/E will be reviewing the capital forecast at the half year point.

As of the end of September:

Actual Cash Balance: £41.6m

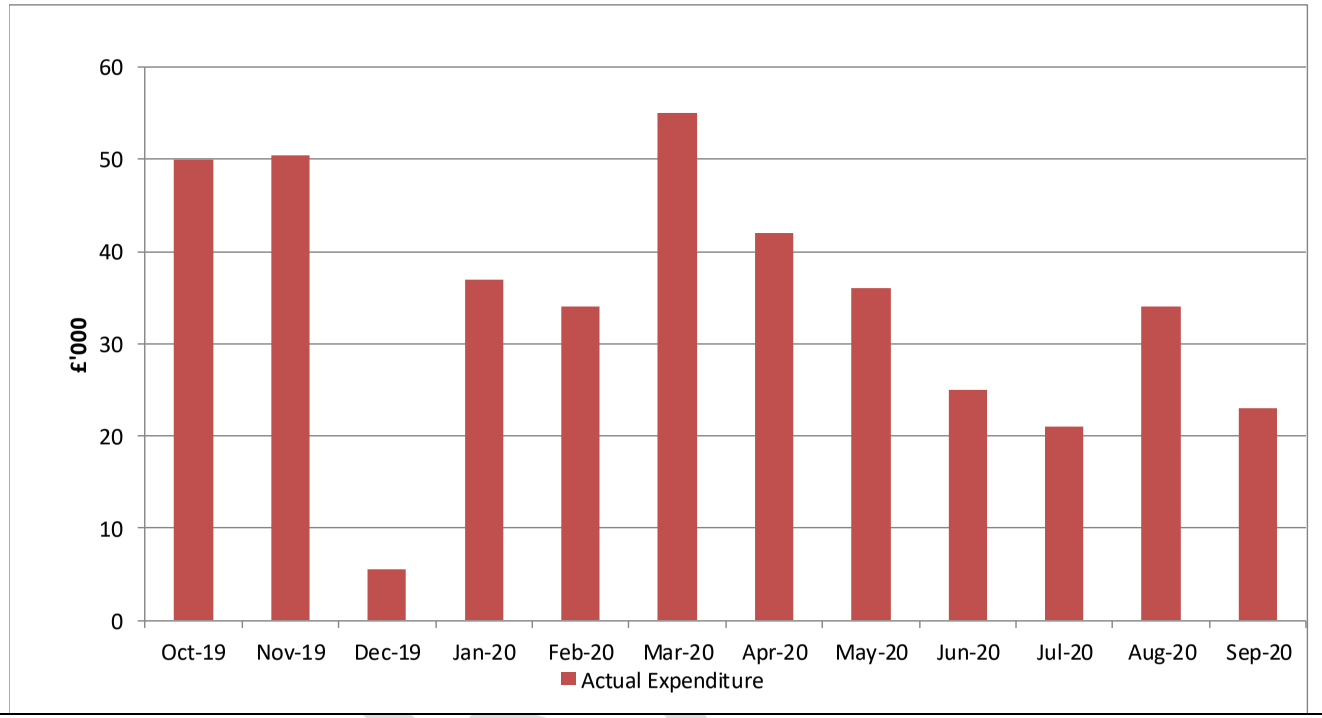
Number of days operating expenses = 123 days

Cashflow against plan (Rolling 12 months)



The Trust cash balance at the end of September was £41.6m. This is an increase of £2.8m from the end of August.

The cash position includes an additional month block payment received in August relating to September for the new financial arrangements to cover the COVID-19 pandemic.

Agency Expenditure: In month Actual: £23k YTD Actual: £181k	**Monthly Agency Expenditure (Rolling 12 months)**  	Agency spend incurred in September was £23k, a reduction of £11k compared to August. There was no additional agency expenditure in month relating to the COVID-19 response. At the end of September, £41k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis for reimbursement).

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 1st 6 months of the year and income being based on block values determined nationally (based on 2019/20 expenditure between November and January 2019). The suspension of PbR will remain in place for the rest of 2020/21, with income remaining at block level based on average income received in M8-10 of 2019/20. 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 is 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 (still being discussed);
- The expectation that trusts will deliver breakeven during the pandemic but it is currently not clear what individual organisational financial targets will be set after September 2020;
- A phase 3 letter was issued by NHSI/E on 31st July laying out national expectations around delivery of activity to recover levels lost during the initial phase of the pandemic. STP's were required to submit draft phase 3 plans by 1st September with final submissions returned on the 21st September. As part of this process the Trust has been completing phase 3 forecasts that have been submitted to the C&M Healthcare Partnership. Allocations have been received and are being reviewed;
- 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;
- 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;
- 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	NHSI/E block payments for planned income is based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. However, Welsh commissioners are currently paying 2019/20 contract levels with no level of inflation. The Trust has now agreed a block payment figure for M1-6 which is at an increased level to the 2019/20 out-turn position (this is still resulting in an underpayment on expected levels of income), which has been assumed within the financial position. It is currently unknown what the approach for Welsh commissioners will be for M7-12. IOM are only paying for activity undertaken rather than a set block payment, the level of income has seen an increase from month 5 and is above the YTD average income and expected in month levels of income, but it is still resulting in an YTD underpayment. Both issues have been raised with NHSI/E and in months 1-6, the shortfall in income is assumed to be covered by NHSI/E (as well as a reduction in spend on excluded drugs and devices). However this could create an additional pressure for the Trust if NHSI/E does not agree to fund this income shortfall for months 7-12. This issue is being raised nationally by the Regional NHSI/E DoF for months 5 and 6 (given that the current financial regime has been extended for this period).
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 due on the 19th October. Further updates will be provided once available. The Trust under-performed against its Elective Incentive Scheme target (mainly in relation to the levels of elective activity) and as such may receive a retrospective financial penalty. This is currently outside the reported financial position and 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 increase 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 beyond September 2020, 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	The Trust had submitted an increased capital plan to the C&M HCP given the investments required in 2020/21. This was not able to be facilitated by the HCP given the forecast over-spend for the providers in the HCP against the overall allocation. This means that there is a risk that the Trust could overspend its allocation (which would impact on other providers in the HCP), unless it reviews its priorities or capital becomes available later in year via any underspend from other HCP providers. It should be noted that an additional £0.5m non-recurrent capital funding was allocated to the Trust for critical infrastructure work which has increased the 20/21 capital plan to £4.5m. However there still remains a forecast over commitment against plan of approx. £0.5m for 20/21. A detailed review of the capital forecast is being undertaken regularly by the DoF and Director of Strategy and Ops to ensure that any potential slippage is being captured and recorded.
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). A phase 3 letter has been issued by NHSI/E around expectations of activity delivery for the remainder of the financial year with the requirement for STP's to submit draft activity plans by 1st September and final plans by 21st September. The Trust has submitted activity recovery plans to the HCP as required as part of this process. Final financial plans to deliver this will be will be submitted to the HCP on the 19th October.

Report to the Trust Board
Date 5th November 2020

The Walton Centre NHS Foundation Trust

Title	**Winter Plan**
Sponsoring Director	Name: Jan Ross Title: Deputy Chief Executive
Author (s)	Name: Jan Ross & Ben Davies
Previously considered by:	N/A
Executive Summary This paper outlines the Trusts winter plan for 20/21 and will be used as the template for future winter plans	
Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	N/A
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• N/A
Action required by the Board	For approval

The Walton Centre
NHS Foundation Trust

WINTER PLAN

CONTENTS

1. Context and introduction

This document sets out the Trusts arrangements in place to allow our hospital to be best prepared to tackle the challenges that winter brings. Whilst winter is not an emergency or considered an unusual event, we at the Walton Centre recognise that this period reflects increases in pressure not only with our Trust but across our whole system. Our ambition is to improve the services for our patients, delivering improved outcomes and better experience of care, whether that be by phone, online or in hospital.

The challenges COVID-19 has placed upon the NHS so far this year are arguably the most demanding and testing we have ever experienced. As winter approaches the 2nd wave of COVID-19 is starting to be felt and as such will make the pressures experienced normally this time of the year even more challenging. From an operational perspective it had meant a total change in how services are provided. We have moved from a totally face to face method of providing outpatients visits to a mix of face to face, telephone and virtual outpatient appointments. Feedback from both patient and clinicians on the whole has been positive.

Research and feedback has also informed us that the restrictions on daily living caused by Covid 19 has had a profound impact on both the physical and mental health of patients who have long term neurological conditions. As such as we continue to develop and review our services consideration is needed in how we address this in the way we provide this type of support to our patients.

Maintaining flow and ensuring patients are being treated and cared for in the correct place and in a timely way requires the involvement and planning of the whole health and social care system. A&E Delivery Boards, which bring together all stakeholders across health and social care to lead and be accountable for patient flow in the system, have been required to create and submit a system-wide Winter plan this year. The Walton Centre is a member of the North Merseyside & Southport A&E Delivery Board, therefore directly feeds into this plan, whilst also less formally ensuring that support is given to our wider geographical footprint. The Walton Centre's Winter Plan for 2019/20 therefore has a focus on our contribution to the North Merseyside plan.

2. Winter planning considerations for the Walton Centre

As with other health providers, the Walton Centre's capacity and demand follows seasonal variations, with the winter period potentially leading to an increase in trauma admissions caused by falls and accidents due to the cold and icy weather conditions. It is however pertinent to acknowledge that as a specialist neuroscience trust the impact of winter on demand is significantly less than our neighbouring acute hospital Trusts.

The more relevant issue for the Walton Centre during the winter period is the consequent impact of the capacity pressures across the wider health and social care system. This is twofold; firstly the impact this has on the flow of patients, both through increased challenges in transferring patients back to their local hospital when they are at high levels of escalation, and longer waits for social care involvement. The capacity pressures in the wider system also require a response and support from the Trust, not only ensuring we transfer neuro patients in a timely way but consider how we can provide support over and above normal levels without compromising our regional service.

3. Reflecting on previous winter - 2019/20

Below is a brief summary of the pressures felt by the trust and the actions we put in place to assist the system to better deal with the increased demand on services across the North Merseyside & Southport A&E Delivery Board. This information has then been discussed and has informed the actions for 2020/21 winter plans.

- Whilst bed occupancy levels increased during the winter period, the Walton Centre was able to manage its elective activity throughout the winter period.
- In support of neighbouring acute Trusts, the Trust provided the following support when OPEL level 3 and 4 were declared:
    - The threshold for admissions of patients with neuroscience conditions was lowered to allow more patients to be transferred into the Walton Centre to help local DGHs bed pressures.
    - Input into all North Merseyside daily calls and support as required.
    - Day-to-day support and response to escalated patients from neighbouring DGHs to expedite reviews or transfers.

Lessons learnt:

- Having better co-ordination of information regarding referrals (pending review and accepted) across rehabilitation and acute beds would be helpful in responding to queries and escalation from neighbouring Trusts in a more timely and informed way. There were many examples where neighbouring Trusts escalated delayed transfers, when the patients had already been reviewed and not accepted or the referral hadn't been received. Whilst mostly impacting on the senior operational team, this did lead to incorrectly seeking information and support from medical colleagues when not required.

- Our escalation responses to OPEL 3 and 4, whilst managed well, were not pre-determined in our winter plan. It is clear not only from this experience but the requirements placed above all health and social care organisations to have robust escalation protocols, that having these pre-planned, communicated and understood internally that this will promote greater alignment across the health system and impact earlier.

4. Influenza Plan

With the onset of winter cold weather increases the risk of flu, not only to our patients but to our staff members as well. As such it is critical that we have robust flu plans, along with a vaccination strategy, to ensure we protect our staff as best as possible against potentially contracting flu. Staff vaccinations are aligned with the national targets and approaches in accordance with our Trusts Influenza plan which is attached in the appendix for reference.

Flu vaccination is one of the most effective interventions we have to reduce pressure on our health and social care system over winter. As such we aim to vaccinate as many of our staff as possible but due to supply and demand pressures we have prioritised front line, patient facing staff to be the first to receive vaccination. We have asked those staff not in this category to utilise the vaccination services being offered by their local GP service so they can get vaccinated in a timely manner.

This year's delivery of the influenza plan is likely to be more challenging because of the impact of COVID-19 on our health and social care services.

5. Capacity and demand

The following forecasting has been undertaken to look at the potential requirements for beds through the forthcoming winter months. Forecasting has been conducted based on last year's length of stay (adjusted to remove Rehab bed days) over the winter months.

G&A		Scenario 1 (19/20 activity)	Scenario 2 (Trust plan* c.85% of 19/20)	Scenario 3 (Trust Elective plan and 115% of Non Elective)	Scenario 4 (Non Electives Only – 100%)
Elective	Nov	35	28	28	-
	Dec	37	32	32	-
	Jan	44	36	36	-
	Feb	56	50	50	-
Non Elective	Nov	70	60	80	70
	Dec	71	61	81	71
	Jan	84	72	97	84
	Feb	87	76	100	87
Total	Nov	104	88	108	70
	Dec	108	93	114	71
	Jan	128	108	132	84
	Feb	143	126	150	87
Available Beds (132)	Nov	28	44	24	62
	Dec	24	39	18	61
	Jan	4	24	0	48
	Feb	-11	6	-18	45

- Trust plan is as per phase 3 recovery plan submitted to the Hospital Cell.

Critical Care Capacity

The Trust critical care unit has the physical bed capacity to increase to 22, however this is dependent upon staff availability and ceasing of elective activity. Use of this capacity will be agreed as part of the Cheshire and Merseyside Critical Care Network escalation plan.

In order to have the ability to provide mutual aid over the winter months we have devised an escalation plan framework based on the demand of the system. This will be utilised to determine what steps we will take to reduce the pressure for external Trusts and create capacity internally.

Threshold Model

System Escalation level	1 Low pressures	2 Moderate pressures	3 Severe pressures	4 Extreme pressures
*WCFT Elective Delivery	None cancelled	>50% cancelled	>50% cancelled	All cancelled, except cancer
Mutual aid offered to the system				
Elective & Cancer	8 Beds Theatre and Day ward Capacity	8 Beds Theatre and Day ward Capacity	8 Beds Theatre and Day ward Capacity	8 Beds Theatre and Day ward Capacity
Inpatient (General & Acute beds)	8 Beds	20 Beds	20 Beds	50 Beds

*Dependent upon the level of mutual aid required the proportion of elective activity delivered at the Trust will vary and may not strictly be reduced as detailed above.

6. Escalation plan

There are three pre-agreed escalation plans in place when the North Merseyside & Southport A&E Delivery Board escalates to OPEL 3 and 4. It should be noted that the first two weeks in January 2021 will be planned in advance to be at these levels.

Action 1

The Trust will, when safe to do so and when quality of care will not be compromised, not pursue the repatriation protocol. This will see patients identified as ready for repatriation remain in a Walton Centre bed whilst the escalation level remains high. Consideration should be given to patients who live further away from the Walton Centre and the impact this will have on visitation and patient and family experience. It needs to be noted however that by doing this it will see a rise in our length of stay for stranded and super stranded patients and this is to be taken into consideration when reviewed this data over the winter period.

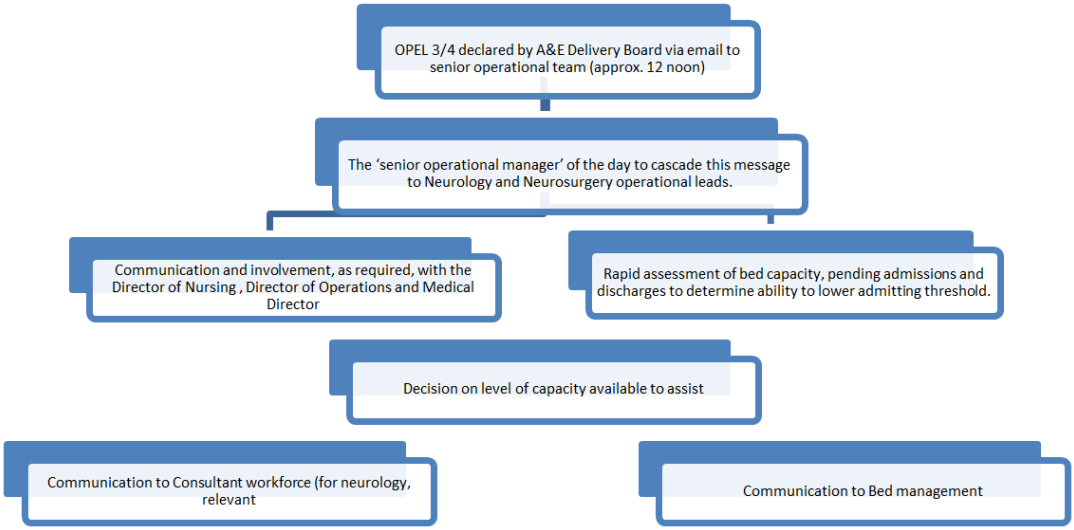
Another factor that may not allow for as much flexibility with this scheme is the relocation of the Spinal Services from Liverpool Hospital Foundation Trust to the Walton centre. With the increase in patients

being seen at the trust it means that demand on our bed base will be higher however this should release bed capacity at the acute setting.

Action 2

When OPEL level 3 or 4 is declared the following escalation protocol will be enacted:

i. Reduced threshold for admission introduced. (Details provided in Appendix 1). This will be actioned, communicated and monitored via the following SOP:



Action 3

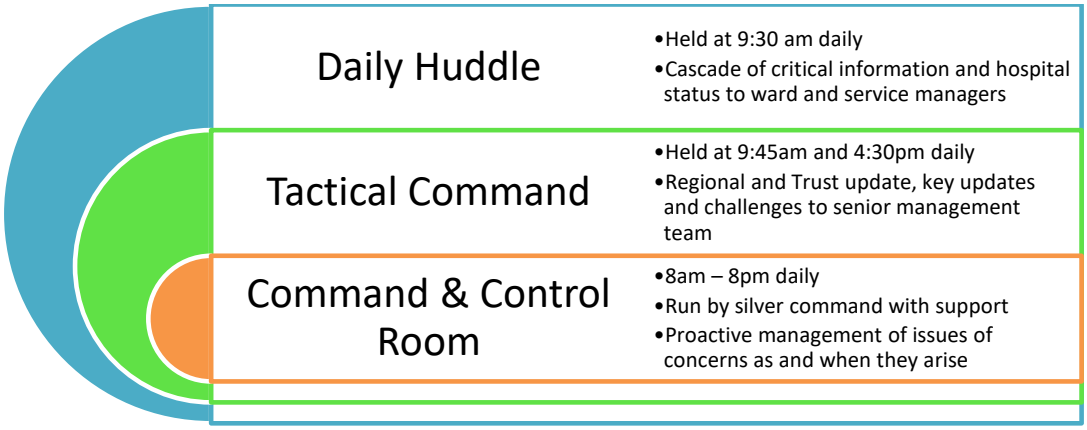
Implementation of the Rehabilitation Escalation Standard Operating Procedure

Full details of this SOP are provided in Appendix 2.

When a patient has been medically accepted for the Cheshire and Merseyside Rehabilitation Network and is medically fit for transfer but no Network bed immediately available, the SOP facilitates the transfer of the patient, subject to bed availability, to an acute bed on the Walton Centre site whilst awaiting a rehabilitation bed to become available.

7. Management approach

In order to manage the concurrent pressures that we will face over winter the Trust will use a command and control structure along with a robust communications plan. By taking this approach it will afford the Trust better grip and control of the challenges we will face and ensure that staff are kept up to date with regular communication channels in place. Below is a high level overview of the daily management and communication strategies that will be in place over the winter months to support our winter plans.



Appendix 1

The Walton Centres reduced threshold for admission in response to bed status and emergency demand across Cheshire & Merseyside

1. The Walton Centre will help whenever we can, as long as it is clinically safe to do so and would not compromise those elements of emergency services that can only be provided here.

2. We would be willing to take some patients **with neurological or neurosurgical problems** if that is their primary problem and they do not have co-morbidity which would make transferring here dangerous.

3. In effect, we would lower our thresholds, and so take patients who would normally not require inpatient transfer here.

4. No clinical criteria will be set out other that in point 2 above.

5. All patients would have to be considered on an individual case-by-case basis.

6. All patients would have to be discussed individually, consultant to consultant (with the on-call consultant).

Appendix 2

Rehabilitation Escalation Standard Operating Procedure

At times of escalation when there is pressure on the acute beds across the Merseyside area and a patient has been medically accepted for the Cheshire and Merseyside Rehabilitation Network and is medically fit for transfer but no Network bed is available the following procedure may be implemented in liaison with the bed management teams of CMRN and WCFT:

- Patient MUST have a planned admission date for a Network bed
- Patient to be transferred to available bed at Walton Centre Foundation Trust
- Patient to be under the care of the Consultant of the week covering the ward patient is admitted to
- Therapy to be provided by acute treating team
- Patient to be informed of reason for transfer and explanation that Specialist Rehabilitation will not start until transfer to Network bed

Appendix 3

Influenza Plan

Executive Summary

Influenza (flu) is a widespread and familiar infection in the UK, especially during the winter months. The illness, caused by the influenza virus, is usually relatively mild and self-limiting. However some groups of people, such as older people, young children and people with certain medical conditions may be prone to severe infection, or even death.

In light of the risk of flu and COVID-19 co-circulating this winter the delivery of a successful flu immunisation programme is essential to protecting vulnerable people and supporting the operational resilience at WCFT. In the event of flu pandemic it is projected that up to 50% of the workforce, may require time off at some stage over the entire period of the pandemic this would massively affect our patients and services at WCFT.

All frontline health care workers should receive a flu vaccination this season. This will ensure they are able to meet their responsibilities to protect all patients and their families as well as themselves. Additionally this will safeguard the overall safe running of services. The flu immunisation programme must be accessible to all and its progress monitored to ensure effective contemporaneous delivery for the duration of the campaign.

In order to deliver the campaign additional support from the divisions and the senior nursing team will be provided for peer vaccinators across all of the clinical areas in the trust. Training has been provided and coordinated by the infection control team working closely with LUHFT.

As required by the Department of Health and Social Care/Public Health England the Trust is required to publish a self-assessment for Trust Board that details our performance against the recommended best practice management checklist (appendix 1).

Background

All frontline healthcare workers with direct patient contact need to be vaccinated for the following reasons:

- Flu contributes to unnecessary morbidity and mortality in vulnerable patients.
- To protect patients and families
- Influenza may increase the risk of acquiring COVID-19 infection.
- Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic).
- Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues.
- Flu-related staff sickness affects service delivery, impacting on patients and on other staff.

In 2019 - 2020, WCFT immunised 80.3% of frontline healthcare workers and met the `flu CQUIN requirement of 80%. However, some organisations achieved over 90% of staff vaccinated. Although there is no CQUIN payment attached to the 2020-2021 seasonal staff `flu campaign the Trust is required to achieve a minimum of 90% of its frontline healthcare workers to be vaccinated.

Duties

Board of Directors

The Board of Directors has overall responsibility for ensuring that all staff are appropriately trained and competent to effectively fulfil their role within the organization and maintain the safety of the organization. The trust has an obligation to comply with statutory and regulatory responsibilities.

Lead Executive Director

The lead executive director of the flu plan is the Director of Nursing and Governance who has strategic responsibility for ensuring that the plan is delivered.

Infection Control Team

The infection control team will operationally manage the flu plan, supported by the divisional team and the senior nursing teams.

Aims and Objectives of delivering the flu plan

- To vaccinate 100% front line health care workers
- To minimise the spread of the virus
- To reduce morbidity and mortality from influenza illness
- To ensure essential and critical services are maintained and expanded as needed
- To communicate timely information to staff and service users
- To protect staff and patients against any adverse effects where possible

Key Issues

Consideration of factors that may impact upon the attainment of uptake:

- Ongoing COVID-19 pandemic.
- WCFT has historically had a good uptake of vaccine from its health care workers. However, there is some staff who perceive the programme to be a coercive approach. This staff group will require further support and guidance
- Staff become resentful if constantly asked if they have had their flu jab in a prolonged campaign and perceive that it is target driven, staff will be supported to understand the importance of having their flu jab
- Some staff that have a genuine reaction to the vaccine in previous years guidance will be given for this staff group.
- Some staff express fears of the safety of the vaccine or that the vaccine does not offer protection.

Delivery Plan

The plan is founded on the view that the Trust has committed leadership and promotion at all levels of the Organisation, we have a dedicated and effective communications plan, ease of access to vaccinations for our workforce and incentives for staff uptake. This will underpin the successful early achievement of herd immunity and maximum uptake by frontline healthcare workers.

PHE have advocated that for the 2020 -2021 campaign 100% of frontline healthcare workers are to be offered the flu vaccination. However our Campaign supports the offer of flu vaccination to all staff regardless of occupation focusing on front line staff in the first phase.

In observing regional best practice, St Helens and Knowsley describe the effective use of 2 peer vaccinators per clinical area coupled with incentives and contemporaneous communications as the reason for their successful uptake of 94% in last year's campaign. The Walton Centre has adapted this practice.

To deliver an effective flu plan the Trust has provided:

- A dedicated member of the infection control team to lead
- Early effective planning following an implementation plan
- A new flexible approach to vaccinator education and training including an electronic competency based assessment/record.
- Revised delivery plan to take into account the ongoing challenges of COVID-19.
- A robust communications plan.
- Regular updates and reports to Board

Key areas to enable delivery of the plan;

- Phased approach to delivery of the programme with frontline healthcare workers targeted in phase one. The vaccinations arrive at the trust in 3 separate batches when the first batch of vaccinations arrive at the trust they will be given to frontline healthcare workers only.
- To ensure that staff are aware of what is expected of them in terms of the benefits of being vaccinated.
- To ensure that staff are given the correct facts about the flu vaccination in order to eliminate rumours/myths, this will be led by the Communication Team.
- Peer vaccinators will be responsible for their own clinical area.
- 'Buy in" and support from the Trust to recognise the multifaceted benefits of vaccination.
- Ensure staff complete the opt out form is they decline the vaccine

The campaign will include different ways to facilitate the access to vaccination to our staff in line with COVID 19 requirements:

- Walk about sessions to all clinical areas in the trust
- Clinics
- Dial a jab
- Drop in sessions
- Placing a vaccination station in Sid Watkins Building
- Vaccinators working nights and weekends to capture this staff group

Timescales for delivery

`Flu vaccinations will be available from the end 28th September 2020 until February 2021 (the campaign may conclude at an earlier date if required).

WCFT purchases `flu vaccine via LUHFT. The Trust has been informed that it will receive a set allocation as the start of the campaign and at subsequent points. Traditionally the majority of vaccinations take place in October/early November; therefore this may impact on vaccine uptake as was the case during the 2019-2020 campaign, when there were widespread issues with vaccine supply.

Conclusion

The trust has an effective flu plan in place to ensure all front line healthcare staff are offered the vaccine and 90% of the staff receive it. The plan will be managed via the infection control committee and the senior nursing team meetings, and updates will be provided to the executive teams.

The self-assessment (appendix 1) demonstrates the delivery of best practice in the effective delivery of the flu campaign to our workforce. It is recognised that achieving a 90% uptake rate amongst staff will be challenging. Despite the desire to achieve >90% of our frontline staff vaccinated, it is likely that the Trust will have a cohort of employees who chose to make an informed decision, and decline the offer of the vaccine. We will continue to capture the reasons as to refusal where possible. This has been presented and received at Trust Board.

	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all front line healthcare workers	Board support at commencement of campaign. Staff declining offer of vaccine asked to complete anonymised proforma to capture reasons for refusal	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	QIV ordered for HCW's and TIV available for HCW's over the age of 65 via Occupational Health	
A3	Board receive an evaluation of the flu programme including data, successes, challenges and lessons learnt	Infection Prevention and Control Committee minutes, quarterly IPC reports	
A4	Agree on a board champion for flu campaign	Director of Nursing & Governance is board champion	
A5	All board members receive flu vaccination and publicise this	Offered to all Board members information circulated by social media, email, Walton weekly	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	All departments invited to Flu Planning Group. Meeting booked for June 2020 and September 2020. Peer vaccinators trained face to face training(September 25th 2020), or e-learning/ online training provided and written instruction approved, staff side representative involved in the opt out process	
A8	Flu team to meet regularly from September 2020	Flu team meeting June 2020, September 2020 and review December 2020. Weekly communications to Trust Flu Fighters A 'wrap up and review' meeting to be held at the closure of the campaign	
B	Communications plan		
B1	Rationale for the flu vaccination	Communication programme	

	programme and facts to be published – sponsored by senior clinical leaders and trade unions	implemented under direction of Director of Nursing & Governance/Infection Prevention & Control	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Accessibility across a 24/7 programme with open access to all employees	
B3	Board and senior managers having their vaccinations to be publicised	Photographs and promotion through Trust media	
B4	Flu vaccination programme and access to vaccination on induction programmes	Provided at induction and details of mobile vaccination and flu clinics provided	
B5	Programme to be publicised on screensavers, posters and social media	Established communications programme e.g. poster, social media, notice boards Trust wide	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly figures submitted to executive team and headline figures promoted widely e.g. safety huddle, Walton Weekly, Trust wide email	
C	Flexible accessibility		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Support from senior leadership for identified peer vaccinators Senior Nursing Team are peer vaccinators Increased number of vaccinators compared to 2019-2020 campaign	
C2	Schedule for easy access drop in clinics agreed	Due to the COVID-19 pandemic there will be programme of vaccinator walkabouts in place of the clinics traditionally offered. This will be subject to ongoing review	
C3	Schedule for 24 hour mobile vaccinations to be agreed	Peer immunisers to provide cover 24 hour 7 day operation	
D	Incentives		
D1	Board to agree on incentives and how	This is now completed	

	to publicise this		
D2	Success to be celebrated weekly	Feature in Walton Weekly and key messages on social media, email	

Report to the Trust Board
Date 5th November 2020

The Walton Centre NHS Foundation Trust

Title	**Nosocomial Infections**
Sponsoring Director	Name: Lindsey Vlasman Title: Acting Director of Nursing & Governance
Author (s)	Name: Lindsey Vlasman Title: Acting Director of Nursing and Governance
Previously considered by:	N/A

Executive Summary

The purpose of the paper is to provide assurance to the trust board that that the executive team are managing nosocomial infections safely. The Walton Centre is working with the national teams to ensure that measures have been put in place to reduce and minimise the transmission of nosocomial infections.

A nosocomial infection is defined as an infection that is acquired in hospital by a patient who was admitted for a reason other than that infection (at least 14 days prior to a positive COVID-19 diagnosis), and in whom the pathogen was not incubating at the time of admission.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with NHSE, CQC, PHE regulations
Action required by the Board	The Board is requested to: • Consider and note the report

The Walton Centre
NHS Foundation Trust

The Management of COVID 19 Nosocomial Infections

Lindsey Vlasman Acting Director of Nursing and Governance

November 2020

Introduction

The purpose of the paper is to provide an overview of how nosocomial infections are being managed at The Walton Centre and the measures that have been put in place to minimise the transmission of these infections.

A nosocomial infection is defined as an infection that is acquired in hospital by a patient who was admitted for a reason other than that infection (at least 14 days prior to a positive COVID-19 diagnosis), and in whom the pathogen was not incubating at the time of admission.

Background

The Walton Centre Infection Prevention and Control (IPC) team has been working closely with the divisions to ensure that IPC compliance is adhered to and nosocomial infections are prevented with no transmission throughout the trust. During the COVID 19 Pandemic NHSE/I have undertaken an exercise to understand where IPC compliance is proving to be the most challenging for NHS organizations:

The key themes

- Robust testing day 1 day 5 and day 14.
- All staff wearing masks including in staff rest rooms and ensuring 2 metre social distancing is maintained.
- Staff socialising together outside of work adhering to national guidance and modelling it for others.
- Patient bed spaces 2 metres apart.
- Attention when doffing PPE without correct removal of masks and disposal increased droplets and risk accumulates in those areas.
- The need for robust cleaning of those areas.
- Managing staffing safely due to the reductions during outbreaks, staff isolating and staff sheilding.

To continue as a COVID secure hospital we need to ensure 100% compliance with all of the above so we can continue to treat elective patients safely for as long as possible.

In addition to this feedback the trust have also received a letter from Bill McCarthy (Executive Regional Director North West) regarding the management of COVID 19 and nosocomial infections in Cheshire and Merseyside) **Appendix 1**

Management of Nosocomial infections at The Walton Centre

- All staff who work at The Walton Centre wear the correct PPE within all areas including back office staff. Signage has been displayed across the trust and inspections for compliance are undertaken by the IPC team.

- A decision has been made for all patients to wear surgical masks, when mobilising out of their bed space ie, when they are attending bath rooms, day rooms, or other departments.

- All bed spaces have been measured by the estates team to ensure that there is a 2 metre socially distanced space between all beds. The total number of beds lost as part of this piece of work is 19 beds.

Dott		Current Layout	2 Metre Distance	Deficit	
	Bay 1	5	5	0	
	Bay 4	6	5	-1	
	Bay 5	6	5	-1	
	Bay 7	6	5	-1	
Cairns					
	Bay 1	5	5	0	
	Bay 4	6	5	-1	
	Bay 5	6	5	-1	
	Bay 7	6	5	-1	
Caton					
	Bay 1	4	3	-1	
	Bay 4	6	4	-2	
	Bay 5	6	4	-2	
	Bay 7	6	5	-1	
Sherrington					
	Bay 1	4	3	-1	
	Bay 4	6	4	-2	
	Bay 5	6	4	-2	
	Bay 7	6	5	-1	
Lipton					
	Bay 4	5	4	-1	
	Bay 5	4	4	0	
				-19	Total

No activity has been lost due to the reduced bed occupancy.

- Risk assessments have also been completed for clinical areas to ensure 2 metre distancing is in place. **Appendix 2**

- Visiting has been suspended and is only agreed in exceptional circumstances with the manager of the area.

- Day rooms have been reviewed within all of the clinical areas to ensure social distancing is in place. Tape and floor posters have also been placed in the areas and furniture has been removed. Further work has been undertaken to make the boardroom into a staff rest room to support with the health and wellbeing of our staff.

- There is a process in place for testing staff and patients on day 1, day 5 and day 14. The quality manager is leading this work with 3 other staff who are currently shielding due to maternity leave. **Process for staff** -they will receive a text message with their results and their line manager will keep a log of day 5 and day 14. **Process for patients**- the IPC administrator emails the clinical area when patients are due to be tested at day 5 and day 14.

- There have been no issues with Covid-19 test turnaround times in conjunction with LCL the trust have reviewed their own internal processes to ensure timely transport from point of test taken to point of transport to LCL.

- Regular communications, and updates via the daily safety huddle and the daily tactical command meeting, about staff socialising out of work and adhering to national guidance.

- The infection prevention and control team have undertaken staff training in all the clinical areas for doffing PPE safely. With a strong focus on Chavasse and Horsley ITU.

- A deep cleaning programme is delivered in the affected areas, the estates team attend the daily huddle and tactical meeting and also the outbreak meetings to support and manage the programme of cleaning safely.

- Staffing has been managed safely with a daily staffing meeting and support from NHSP. The trust has reviewed their current staffing levels and the levels of staffing they could reduce to ensuring all areas are staffed safely. **Appendix 3**

In regards to BAME staff all staff have completed a risk assessment with their line manager and support has been given as required. Staff have been allocated to non COVID areas if required.

Staff Fatigue has been supported with debrief sessions and identifying lessons learnt from the first wave of COVID 19. The boardroom is currently being converted into a staff rest area.

- The safeguarding team have supported any LD patient admissions or clinic appointments ensuring that patients have got the correct support throughout their journey. This patient group are identified via the PAS system when they are attending the trust to ensure that the correct support is in place.

- End of life patients and patients requiring a DNAR, are discussed at the clinical ethical group which is chaired by the Medical Director.

- The wards have been reconfigured using a traffic light system to ensure patients are allocated to the appropriate bed space. **Appendix 4**

Update on Nosocomial Infections at The Walton Centre

- **9/10/2020** A small outbreak within our theatre department was identified were a staff member tested positive for COVID 19. Contact tracing was commenced and confirmed a second positive case. An outbreak meeting was held with the Consultant Microbiologist and a decision was made to undertake asymptomatic screening in theatres were a further 11 positive cases were identified. Staff were tested on day 5 and day 14 also. **Appendix 5**

- **21/10/2020** Confirmed positive COVID 19 patient on one of our Neurosurgery Amber wards. Patient was in a 4 bedded bay area with another 3 patients in the bay. All 3 patients were swabbed in the bay and 1 patient result came back positive the other 2 patients were negative. This was reported as a nosocomial infection to NHSE, PHE and CQC **Appendix 6**

Conclusion & Recommendations

Trust Board are asked to:

- Be assured that the executive team are managing nosocomial infections safely in line with national guidance.
- Working closely with patients and families to ensure that they have the best possible experience.
- Working closely with staff to ensure that their health and wellbeing is maintained.

- Receive further updates / reports when required.

Appendix 1

Ref BM HH 2020-10-20

Accountable Officers and Chairs of
Clinical Commissioning Groups
Chief Executives and Chairs
NHS Trusts of the North West Region

By email

Bill McCarthy
North West Region
5th Floor
3 Piccadilly Place
Manchester
M1 3BN

E: bill.mccarthy@nhs.net

Date: 20 October 2020

Dear Colleagues

At last week's Chief Executive, Accountable Officer and Chair briefings we discussed the impact of COVID across the North West. The North West continues to be the region which is most affected by the high levels of community transmission of COVID. Fourteen out of the fifteen local authority areas with highest COVID prevalence in over 60 year olds are in the region; and it is not therefore surprising that hospital admissions are high and growing and pressure remains intense in all parts of our systems, including primary, community, mental health and social care. Many thanks for the leadership and professionalism you, and our partners in local government, are showing as well as the hard work of your staff, in responding to what is a seriously challenging situation.

In a number of ways we are better placed to deal with the challenge than we were back in the spring and early summer: we understand more about the disease and how it spreads; we have better treatments available; and you have spent time over the summer planning the regional response to a second surge.

But we also face a more complex environment: we must maintain our non COVID services as far as can be done safely - keeping urgent planned work, including cancers, flowing to minimise the risk of harm to those patients, managing the risk associated with waiting for diagnostic and outpatient services, and securing access to primary care, mental health and community support; we must support our staff and their welfare through the continuing pressures they face some 8 months into the emergency; and we are working in a less consensual environment. So I wanted to write to remind you of the approach we have adopted to managing the emergency in the North West, and to identify a number of learnings we take forward from earlier in the year.

The NHS response level remains at Level 3 nationally - regionally led incident management with national support. In practice in the North West region we are now operating at the highest levels of risk. The decision making that we established at the start of the incident, through hospital and out of hospital/community facing cells and with full ICS/STP involvement, remains in place; it needs to be deployed with all the agility and urgency that is implied by the current position.

Each of our systems has established a daily Gold meeting to manage mutual aid and maximise use of capacity. The regional critical care and Infection Prevention and Control cells, along with the incident management meetings have stepped up their frequency; the clinical cell is closely monitoring trends; and the incident management team at region is available 24/7. All organisations and systems will of course have their escalation plans. Where these trigger a proposal to make a significant change to operating policy, for example cancelling a category of activity, this should be brought to the daily gold meeting first to explore all options for mutual aid, and gold should escalate to Region for confirmation. This will enable us all, at pace, to identify support and help wherever possible.

Nosocomial infection rates remain at high levels in the North West. These are causing real risk for patients and staff, and every Board and Governing Body in the North West need to be sighted and satisfied with the detailed plans and compliance measures in place. We do have outstanding practice in a number of organisations across the region and, alongside enhanced regional leadership capacity, each system has identified a lead director who can provide advice and support the immediate spread of best practice. Nothing is more important than keeping our patients and staff safe.

Many of you have been reflecting on the lessons from the spring, and it may be helpful to summarise a few themes:

i. You are aware that in response to concerns about the impact of COVID on Black, Asian and Minority Ethnic staff and communities we have established a Regional Assembly, Chaired by Evelyn Asante-Mensah. Evelyn will shortly circulate an advice note for all Boards and Governing Bodies. In the meantime please ensure that you have acted on and refreshed the risk assessments you have all undertaken to protect all staff at risk; you are engaging fully with Black, Asian and Minority Ethnic staff networks; and you are working with community leaders to support messaging and the uptake of preventative advice and services.

ii. We must continue to support care homes across the North West. Almost 90% now have a NHSmail account to aid communication. Care homes are being supported to implement RESTORE2 to monitor the wellbeing of residents and the use of oximetry to detect silent hypoxia. Improvements in infection control practices and access to Personal Protective Equipment are helping to limit the number of outbreaks. We must work closely with care colleagues to support safe discharge to care homes.

iii. We must keep a close focus on support for people with learning disability and/or autism. It is essential that we continue to contribute to the national Learning Disabilities Mortality Review (LeDeR) on mortality which needs to be completed by the end of December this year. And that we learn from the rapid reviews of the people who sadly lost their lives in the first wave. Findings have been shared with

your Clinical leads through the Mortality Cell, but I just wanted to highlight:

- the need to recognise the early warning signs of deterioration of health and to provide the annual health checks
- All 'Do not attempt cardiopulmonary resuscitation (CPR)' decisions to be around resuscitation and not the limitation of medical treatment, to be specific to the individual, and to include family and carers.
- Improved communication with the person by involving family, carers and Learning Disability nurses.

iv. I am acutely aware of the pressures on staff right across the region and want to work closely with you over the coming months to do all we can to support their wellbeing and resilience. We are looking at an increased health and wellbeing offer to all NHS staff and where possible care staff across the region, including the further development of Mental Health and Wellbeing Hubs, an extended offer as part of the Health and Well Being programme accessed via https://people.nhs.uk/ including a range of Line Manager Support which can be accessed here. We continue to further develop best practice with organisational Health and Wellbeing Leads so that this can be shared organisationally. A very practical way you can help is by the rapid and comprehensive roll out of 'flu vaccination to all frontline health and care staff.

v. At present the Government has advised that formal shielding is not in place, however we do expect that people who are clinically and/or socially vulnerable are supported. Please note that local recruitment for NHS Volunteer Responders is underway in Lancaster, Rochdale, Oldham, Tameside, Cheshire West and Chester, Liverpool and Manchester – please do help publicise this. Further information about NHS Volunteer Responders can be found here: https://nhsvolunteerresponders.org.uk/

vi. Without exception, leaders in the North West have emphasised your commitment to mitigate the health inequalities that have been replicated and exacerbated by Covid. by an expert national advisory group and these have been published for all organisations and systems to implement. The North West Community Risk Reduction Framework should also be prioritised. Further support on health inequalities can be accessed by emailing: england.nwhealthinequalities@nhs.net

I am in addition grateful to you all for your participation in clinical learning as the pandemic has progressed. You will know that Dr David Levy has been chairing the region's clinical cell which regularly reviews data and learning from around the world. The cell is taking stock of learning to date at its meeting this week, and conclusions will be shared with the Medical Directors, Directors of Nursing and other clinical networks.

I realise that you are right in the eye of the COVID storm at present. But you have prepared with great professionalism; you have developed strong collaborative decision making at pace through the hospital and out of hospital/community facing cells; you have developed excellent working partnerships with our colleagues in social care, local government and the wider voluntary and third sector ; and you have fantastic commitment to do everything you can in the interests of patients, communities and staff across the North West. At Region and nationally we shall be alongside you doing all we can to support your success. Thank you again for everything you are doing.

Yours sincerely

Bill McCarthy
Executive Regional Director (North West)

Appendix 2

Matrix for determining Risk Rating

Qualitative Measures of Likelihood (Probability):

Level	Descriptor	Description
1	Rare	May only occur in exceptional circumstances
2	Unlikely	The event could happen at some time
3	Possible	The event might occur at some time
4	Likely	The event is likely to occur in most circumstances
5	Certain	The event is expected to occur in most circumstances

Qualitative Measures of Consequences (harm or loss)

Level	Descriptor	Description
1	Insignificant	No injuries, low financial loss
2	Minor	1st aid treatment, medium financial loss
3	Moderate	Medical treatment required high financial losses, moderate loss of reputation and moderate loss of business interruption. legal action possible-civil.
4	Major	Extensive injuries, loss of business function, major financial loss and reputation. likely criminal prosecution and civil action.
5	Catastrophic	Death, toxic release. Huge financial loss and reputation. Political topic arisen. criminal and civil prosecution imminent.

Likelihood x consequence = Risk Rating e.g. likelihood 2 x consequence 4 = Risk Rating 8

Low Risk 1-5	Moderate Risk 6-12	Significant Risk 15-25

	Consequence							
Likelihood	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**	**Risk Level**	**Timeframe for actions**	
Almost certain	**5**	**10**	**15**	**20**	**25**	**15-25**	**Significant risk**	**Immediate-within 1 month (if risk cannot be reduced, enter on Risk Register)**
Likely	**4**	**8**	**12**	**16**	**20**	**6-12**	**Moderate Risk**	**1-3 months**

Possible	**3**	**6**	**9**	**12**	**15**	**1-5**	**Low Risk**	**3-12 months**
Unlikely	**2**	**4**	**6**	**8**	**10**			
Rare	**1**	**2**	**3**	**4**	**5**			

The Walton Centre NHS Foundation Trust

Health and Safety Risk Assessment Form

Reference No: 04/20	**Division: Corporate**	
Location: Walton Centre NHS Foundation Trust	**Date of Assessment: 22/10/2020**	**Review Date: 31/02/2020**
Name of Assessor: Stephen Holland **Position of Assessor: Estates Manager**		
Risk Assessment: Environmental Risk: **COVID-19 Social Distancing**		

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
Entrances • Are there sufficient surgical masks available • Are there orange bins provided to dispose of clinical	Patients / Staff	Risk of infection	All entrances available	12	• PPE stations have been set up all the entrance to the ward to include surgical masks and hand sanitiser • Stock is replenished • Bins with orange	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
waste/masks/gloves • Is hand sanitiser available • Is the hand sanitiser regularly checked to ensure they are not empty • Is there signage displayed					bags have been provided to dispose of items • Signage is displayed either through posters or pull up boards • Rear entrance to be designated as "staff only" in an attempt to funnel all visitors through monitoring stations	
PPE • Is there sufficient PPE stock available for staff • Are there different sizes available ie gloves • PPE is located in the appropriate places • Are staff adhering to the correct PPE where applicable	Patients / Staff	Risk of infection	Regular PPE availability	16	• Sufficient stock is available and all different sizes • Staff who have allergies have been provided with suitable PPE • Staff are wearing appropriate PPE for specific tasks ie googles • PPE is easily available at entrances to the	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
• Are staff wearing eye protection such as goggles where staff carry out AGP (Aerosol generated procedures) on patients • Have staff attended fit testing • Are staff wearing FFP3 mask if required • Are staff being retrained if the mask has changed • Are staff changing filters on a regular basis if required ie every 28 days					ward and at the front of each bay/ individual rooms • Staff have access to filters from the Pandemic Store or fit testing rooms • FFP3 masks are available and provided • Staff are donning and doffing of equipment appropriate • Staff support each other with donning and doffing if required • Staff are advised to attend Workplace Health and Wellbeing if required for health surveillance checks	

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
Patient Bays • Are beds 2 metres apart • Are windows open for ventilation • Are there clearly identifiable notices on the door if there is an outbreak/infection • Are there clear privacy curtains available in between patient beds • Are normal privacy curtains pulled across to form a temporary barrier where possible.	Patients / Staff	Risk of infection	Existing bed layouts	12	• Corner beds are utilised first where possible • Entrance doors are kept closed if there is an infection outbreak • Privacy curtains are pulled across if possible to form a barrier • Clear curtains have been installed and used • Windows are open when possible depending on the outside weather • Markings have been applied to identify areas for beds to ensure they are not moved too close to each other • Fans have been removed to prevent being used.	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
Beds • Are beds 2m apart edge to edge • Are beds cleaned regularly and display clean stickers when empty • Are patients asked not to visit other patient beds	Staff	Risk of infection	Existing bed layouts	12	• Beds are 2m apart from each other, edge to edge • Beds to be laid out as per circulated drawings • Beds are cleaned daily • Green clean stickers applied when cleaned • Patients are asked not to sit or get close to neighbouring patient beds • Markings on the floor to identify where they should be located	8
Patients • Are patients advised upon arrival or during their staff regarding the need to socially	Patients / Staff	Risk of infection		12	• Patients are advised where applicable regarding social distancing upon arrival • Patients are asked to use hand	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
distance, use hand sanitisers and surgical face masks					sanitiser, surgical face masks if possible • Patients are advised not to share items	
Patient Chairs • Are patient chairs set out correctly to allow social distancing of 2m from neighbouring patients • Are patient chairs cleaned regularly	Staff, Patients	Risk of infection	Chairs at bed sides	12	• Patient chairs are set out to allow for social distancing when patients sit out of bed (either all to left of bed or all to the right of bed) • Domestic staff increased cleaning	8
Nursing Stations • Are wipes available for staff to clean keyboards, telephones and work surfaces after using equipment • Are staff socially distancing at the nursing stations – 2m apart	Staff, Patients	Risk of infection	General housekeeping	12	• Disinfectant wipes are available on the nursing station • Staff are reminded to clean equipment after each use • Housekeeper and Domestic staff regularly clean nursing stations, equipment and furniture	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
					• Staff to remain 2m apart. Staff to wear appropriate face coverings	
Rest Rooms • Are the chairs set out 2m apart • Are windows open for ventilation • Are tables cleaned down after each use • Are masks worn when not eating • Are staff only making their own drinks • Are staff not sharing food, cutlery or crockery • Is the fridge, microwave cleaned down regularly	Staff	Risk of infection	Existing layout and usage	12	• Chairs are set out to allow 2m apart • Tables are cleaned down after each use • Staff only make their own drinks • PPE such as face mask are worn when staff are not eating or drinking • Windows are kept open for through ventilation • Restricted numbers allowed at any one time – as per notice on the door • Additional areas to be provided to all enable easier distancing	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
					• Staff to stagger breaks were appropriate	
Dirty Utility • Are staff socially distancing when in this area • Is the bed pan machine and other items wiped down • Is the door and light switches cleaned down regularly with wipes • Are items disposed of through the correct waste pathways	Staff	Risk of infection	Typical room use	12	• Minimal staff using the dirty utility at any one time • Domestic staff regularly wipe down doors and light switches • Waste is removed on a regular basis either through ward or portering staff	8
Prep Areas • Are staff socially distancing when in this area • Are work surfaces wiped down with	Staff	Risk of infection	Existing layout and operations	12	• Doors are locked when not in use • Minimal staff using the prep area at any one time to maintain social distancing	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
disinfectant wipes after each preparation/use. • Are Pharmacy staff and other visiting staff adhering to correct procedures • Are the Drug keys and other keys wiped clean regularly • Are sharps bins wiped down regular • Are stacker trays cleaned with disinfectant wipes • Are trolleys clean and stickers applied					• Surface areas are wiped down regularly and after each use • Trays, trolleys and stacker trays are cleaned regularly • Doors, drug cupboards and fridges wiped down with disinfectant wipes • Drug keys cleaned regularly after being passed around	
Bathrooms and toilet areas • Are baths, showers and toilets cleaned regularly • Are windows open for ventilation	Staff, Patients	Risk of infection	Typical cleaning regime	12	• Domestic staff regularly clean bathrooms and toilets • Doors, light switches and pull cords cleaned • Windows open for through ventilation	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
					• Increased "touch point" cleaning	
Patient Meal Times • Are patients advised not to share foods • Is disposable cutlery being used • Is suitable PPE worn by staff when handing out food/drinks • Are drink trolleys cleaned regularly	Staff, Patients	Risk of infection	Protected meal times	12	• Trays are cleaned before providing patients with food • Staff wear appropriate PPE when serving meals and drinks • Disposal cutlery is used where applicable • Equipment such as trolleys, flasks etc are cleaned down regularly	8
Staff safety huddles/doctors • Are staff socially distancing when congregating for daily handover meetings • Are staff wearing surgical face masks	Staff	Risk of infection	Face to face meetings	12	• Staff stand where applicable to maintain social distancing during handover meetings • Staff wear surgical face masks at all times	8

Hazard	Persons at Risk	Potential Harm	Existing Control Measures	Risk Rating	Further Action Required (complete action plan)	Residual Risk Rating
Drug trolleys and laptops • Are drug trolleys cleaned down regularly • Are the drawers wiped down • Are the laptops and monitors cleaned with disinfectant wipes • Are the sharps bins cleaned	Staff	Risk of infection	Typical cleaning regime	12	• Drug trolleys are cleaned with disinfectant wipes • Laptops and monitors are cleaned between each use • Sharps bins are wiped after each drug round	8

Appendix 3

Nurse Staffing During COVID-19

1. Situation

In phase 1 of COVID-19 staffing difficulties were exacerbated for all professions including nursing. These were largely mitigated by moving staff from theatres, wards, OPDs and utilising specialist nurses – enabled by the national directive to stop all elective in and out patient activity except the most urgent; There was a drastic reduction in trauma due to less road traffic and the general public not presenting to EDs in the usual way. All this enabled Trusts to utilise staff differently including non-clinical staff to take on supporting roles.

The situation as we enter phase 2 of COVID-19 is significantly more challenging for staffing. None of the above apply - trauma and ED presentation are back to pre COVID-19 limits; there is no national lockdown or directive to stop activity – indeed the reverse is true, there is an expectation we will continue with restoration recognising the impact on patients of the extended waiting lists. Furthermore it is winter and so critical care by the nature of the season is busier, theatre staff who are the only ones close enough in skills to support, are busy with trauma and elective patient cases. Finally with schools back and the difficulties with track and trace means a significant loss of staff - waiting for results for their family dependents or themselves, as well as those actually sick with COVID or other reasons.

It is inevitable therefore that staffing will be extremely challenged and it is anticipated that the usual staffing levels, indeed minimum staffing levels will not be able to always be met. It is anticipated this will be on a scale not seen before i.e. all wards/departments and Trusts are in the same position at the same time for an extended period unlike in a major incident which lasts typically 48/72 hours and in one or two Trusts for example. We will not therefore be able to close areas or divert patients to assist; we are in an unprecedented situation which requires unprecedented actions. We are anticipating this situation therefore it would be remiss not to mitigate the risks associated with reduced staffing by planning ahead.

2. Background

This paper does not replace the research and evidence based safe staffing that is well documented in amongst others the National Quality Board Guidance on Safe Sustainable and Productive Staffing; it is a risk mitigation approach to an unprecedented critical situation in a pandemic. The nurse staffing paper will come to trust board in December 2020.

The NQB paper noted 3 expectations; the right staff, with the right skills, at the right place and time. It is predicted that we will not have the right staff so it's imperative we try and meet the right skills through other means and concentrate on task rather than role. Furthermore as far as possible to supply this to the right place at the time required as often as possible.

There has been national guidance on reduced staffing levels in critical care during COVID-19 pandemic so this paper does not address critical care. Critical care staffing at The Walton Centre will be managed in accordance to these guidelines and a buddying up service will be set up if required working closely with theatres, ACCPs, and SMART team.

3. Assessment & Summary of Actions

While the evidence based safe staffing levels vary between specialities the principles on working with reduced staffing have required greater leadership, oversight and concentrating on tasks not roles. The trust has a daily safety huddle followed by a tactical command group and a daily bed meeting to ensure all areas are staffed safely.

The huddle and bed meeting determines the escalation of staffing actions required and relates this to the daily tactical command meeting. Escalation levels will be revisited each shift and escalated appropriately. When the minimum staffing levels cannot be met and critical levels are being considered, this must be escalated to the Deputy or Director of Nursing and Governance in hours and silver/gold command out of hours.

The senior nursing team have been revising and agreeing their expected, minimum and now critical pandemic staffing levels for each area based on ward layout, speciality and acuity of patients. Out of hours SMART Team will support and manage staffing with the on call teams.

There is a staffing escalation pan for all clinical areas in the form of a Business Continuity Plan, on how staffing would be managed in each area, what levels the area would be happy to reduce down to safely and when specialist nurses, medical staff, and administration staff would be required to support in the clinical areas.

3.a Absolute Red Line Critical Staffing during height of COVID pandemic only

The senior nursing team have decided there should be a minimum of 1 trained nurse with the knowledge required for the wards speciality on a shift, with a minimum of 2 trained staff per ward. Larger wards/units will require a 3rd trained nurse pending on the speciality. To be clear these staffing levels are not productive or sustainable, will mean many nursing activities are not able to be undertaken and only to be applied in the very short term and at critical COVID pandemic times.

4. Recommendations

In summary the paper is to agree the broad principles of critical staffing during the COVID 19 pandemic.

Examples of task cards

Non-specialist Ward Task Card

Volunteers / Administration teams

Roles and Responsibilities:

1. **Dining Companion**
2. **Meals and hydration**
3. **Communication with relatives (daily update)**
4. **Answer ward phone**
5. **Print out the daily comms emails**

Non-specialist Ward Task Card

Registered Nurse from the clinical area

Roles and Responsibilities:

1. **Co-ordinator**
2. **Medication rounds**
3. **Admissions**
4. **Communication with relatives (significant update)**
5. **Risk assessments**
6. **Board Rounds / Ward Rounds**
7. **Documentation**

Non-specialist Ward Task Card

Support Worker

Roles and Responsibilities:

1. Intentional Rounding
2. Washing and dressing
3. Mobilising patients
4. Answer call bells
5. Toileting
6. Observations
7. Dressings
8. Catheters

Non-specialist Ward Task Card

Health Care Professional / AHPs

Roles and Responsibilities:

1. Intentional Rounding
2. Washing and dressing
3. Mobilising patients
4. Answer call bells
5. Toileting
6. Observations
7. Mouth Care
8. Blood glucose checks

Non-specialist Ward Task Card

Medical staff (redeployed to ward team) / Physician Associate / ACCP

Roles and Responsibilities:

1. Phlebotomy
2. Setting up syringe drivers
3. Venflons
4. Documentation

Non-specialist Ward Task Card

Peer Support Worker

Roles and Responsibilities:

- 1. Provide emotional and practical support
- 2. Suggest ideas and inspiration for better wellbeing and lifestyle choices
- 3. Connect you with services and support groups
- 4. Help you to achieve goals related to wellbeing
- 5. Introduce you to a network of people who are on the road to recovery
- 6. Can support over the telephone, email or face to face
- 7. Support service users to plan their own Recovery
- 8. Establish mutual and reciprocal relationships
- 9. Support service users with own wellbeing action plan

Non Clinical Specialist Teams Ward Task Card

(Clergy, Bereavement, E-Roster Complaints)

Roles and Responsibilities:

1. Patient / carer support – Clergy, EOL patients, patients struggling with loneliness supporting facetime/ video calls with families.
2. Patient / carer support – Bereavement Team, EOL patients –relatives
3. Staff support – Clergy, spiritual / stress support.
4. Management support – E-Roster Team, support with completing roster changes/ effective rostering / E-roster KPIs.
5. Management support – Complaints team, support with relative communications
6. Support Emergency Department in escalation, diffusing concerns, supporting nutrition offering snacks and drinks, comfort of patients ensuring dignity maintained / monitoring COVID secure /adherence to PPE / face coverings.
6. Patient Care support – ALL STAFF GROUPS –

All identified actions contained within - Ancillary and Clerical Staff action cards

Example of Ward tasks based on 24 bedded ward

TASK	Number of times per shift	Registered Nurses	Support Worker	AN other professional E.g. AHP	Volunteers	medical staff in ward team / PA's
Admissions	5	x				
Board round / hand over	2	x				
Co-ordinator	1	x				
Medication rounds	3	x				
Intentional rounding	every 2 hours		x	x		
Washing and dressing	24		x	x		
Mobilising	24			x		
Toileting	48		x	x		
Meals and hydration	3				x	
Mouth care	24		x	x		
Dressings	5		x			
documentation	48	x	x	x	?	x
blood glucose	5			x		
catheters	5		x			
dining companions	2				x	
observations	48			x		
Risk assessment	5	x				
Communication with relatives	24 phone calls	Significant conversations			x	
Phone calls	man 1 phone per ward (daytime only)				x	
Phlebotomy and venflons	?					x
Syringe drivers	?					x
No of people		2	3	2	3	1

Appendix 4

CHAVASSE (Area A) **Covid-19 Isolation** **Side Rooms 1-13** **Bay 4**	• Patients who have Temperature >37.8 • and/or new persistent cough and loss of taste or smell • Positive Covid–19 result
CHAVASSE (Area B) **Positive Step down area** **Bays 1,2,3**	• 14 days from positive result AND Immunocompetent
DOTT **All Non Elective admissions** **&** **Elective admissions (if they DO NOT meet the criteria for Caton)**	• All patients should be tested on admission. For patients who test negative, a further single re-test should be conducted on day 5 after admission. • Contact of Covid-19 positive case (Isolate for 14 days) • Asymptomatic • No known contact with a Covid-19 positive case
CAIRNS **All Non Elective admissions** **&** **Elective admissions (if they DO NOT meet the criteria for Caton)**	• All patients should be tested on admission. For patients who test negative, a further • single re-test should be conducted on day 5 after admission • Contact of Covid-19 positive case (Isolate for 14 days) • Asymptomatic • No known contact with a Covid-19 positive case
CATON **All elective surgery including cancer**	• Patients should self-isolate for 14 days prior to any scheduled surgery. If this is not possible Consultant to discuss with patient prior to admission re plan. • & tested in line with WCFT Covid-19 screening protocol • Asymptomatic

Appendix 5

Theatre COVID 19 Outbreak Action log 15/10/2020

Lindsey Vlasman

COMPLETED		AWAITING COMPLETION		NO PROGRESS TO REPORT	

Action	Target/Timescale	Lead		
Index case (1) confirmed positive on 9/10/2020 contact tracing was performed and 12 staff members were tested and sent home, and all results negative. A further staff member developed symptoms on 10/10/2020 and tested positive 15/10/2020. Outbreak meeting to be arranged.	ASAP	Infection Prevention Team		Completed 15/10/2020
A review of break room to be undertaken to ensure social distancing is applied resource are in place.	ASAP	Infection Prevention Team and Theatre Manager		Completed 12/10/2020
All staff to be swabbed within the theatre department and Radiology department, and medical staff who have been in theatres during the outbreak time frame.	2 week period	Infection Control Team Theatre Manager		
Incident logged with PHE, CQC, and NHSE/I	15/10/2020	Infection Control Team Acting Director of Nursing and Governance		Completed 15/10/2020
Template to be completed for CQC with Board statement	16/10/2020	Acting Director of Nursing and Governance		Completed 16/10/2020
All staff in who have been tested will need to be retested on day 5 and day 14, as part of the mass testing programme	31/10/2020	Theatre Manager, Neurosurgery Divisional Manager		
Deep clean of theatre 4 and theatre 5 will to be undertaken	19/10/2020	Estates and Facilities		

		Team		
Further support to be given to theatres with Doning, Doffing and PPE posters to be placed in the department	20/10/2020	Infection Control Team		
Patient to be swabbed who are still an inpatient and attended the Neuro Modulation theatre	19/10/2020	Neurosurgery Divisional Manager		
Additional IPC support to be booked for the weekend	15/10/2020	Acting Director of Nursing and Governance		16/10/2020
Clean and dirty runners to be booked for theatres to ensure IPC measures are in place	16/10/2020	Neurosurgery Divisional Manager		
Daily sitrep report to be commenced for the next 28 days to be sent to NHSE	15/10/2020	Infection Control Team		Completed 15/10/2020
Further outbreak meeting planned 16/10/2020 comms team and ISS to be invited.	16/10/2020	Acting Director of Nursing and Governance		Completed 16/10/2020
Update Trust board of outbreak and actions taken to date	16/10/2020	Deputy Chief Executive		Completed 16/10/2020
A review of elective admissions and welsh patient admissions to be undertaken within Neuro Surgery	20/10/2020	Neurosurgery Divisional Managers		
Dr Dardimissis to send the PHE patient template letter to Clare Chalinor	20/10/2020	PHE Infection Control Team		
Daily outbreak meetings planned for 09:30 this weekend to be chaired by LV	16/10/2020	Acting Director of Nursing and Governance		
Same Day admission lounge to be made into and additional day room for theatre staff	15/10/2020	Theatre Manager		Completed 15/10/2020
Outbreak meetings held over the weekend	17/10/2020	Acting Director of Nursing and Governance		Completed 18/10/2020
Outbreak meeting with microbiologist arranged	18/10/2020	Acting Director of Nursing and Governance		Completed 20/10/2020 no further positive results

Appendix 6

Cairns COVID 19 Outbreak Action log 23/10/2020

Lindsey Vlasman

COMPLETED		AWAITING COMPLETION		NO PROGRESS TO REPORT	

Action	Target/Timescale	Lead		
Outbreak/incident meetings undertaken 21st & 22nd a further meeting planned for today 23rd Updates will also go through Tactical meeting and Trust Safety Huddle	ASAP	Infection control Team		Completed 23.10.20
All staff that has been in close contact with case 1 within 48 hrs of symptoms developing is to be screened. The will also have day 5 & 14 28 staff identified including MDT	23.10.20	Ward manager		
Incident logged with PHE, CQC, and NHSE/I	15/10/2020	Infection Control Acting Director of Nursing and Governance		Completed 23.10.20
Template to be completed for CQC with Board statement	16/10/2020	Acting Director Nursing and Governance		Completed 16/10/2020
Enhanced cleaning from ISS for high touch points in ward areas	22/10/2020	Estates Team ISS		Completed 23.10.20
Further support to be given to ward re: with Doning, Doffing and PPE	30/10/2020	Infection Control Team		
Posters for airborne precautions to be re circulated and visible on wards	21/10/20	Infection Control Team		Completed 21.10.20
Daily sitrep report to be commenced for the next 28 days to be sent to NHSE	23/10/2020	Infection Control Team		Completed 23/10/2020
SBAR to be completed	23/10/20	Infection Control Team		Completed

		Ward Manager		23/10/20
Patients who have attended theatre 6.10.20 – 19.10.20 and remain in the Trust to and screened	22/10/20	Neurosurgical division Infection Control Team		Completed 21/10/20
On line COVID documents to be reviewed to ensure correct versions are available for staff to access	21/10/20	Infection Prevention and Control		Completed 21/10/20

Report to the Trust Board
Date 5th November 2020

The Walton Centre NHS Foundation Trust

Title	**Nurse Revalidation**
Sponsoring Director	Lindsey Vlasman Acting Director of Nursing & Governance
Author (s)	Joe Towell Lead for Nurse Revalidation
Previously considered by:	N/A

Executive Summary

The purpose of the paper us to give an update on nurse revalidation across the trust.

All registered nurses/midwives/nursing associates in the UK are required to maintain their registration with the Nursing & Midwifery Council (NMC) and must fulfil a range of requirements to show they are continuing to be able to practice safely and effectively by way of revalidation every three years.

The Trust uses an e-portfolio system (HeART) provided by external software developer in place since 2016. This system provides a repository for nursing staff to collate/store evidence and manage their registration through an NMC online account.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with NMC
Action required by the Board	• To consider and note

The Walton Centre
NHS Foundation Trust

Nurse Revalidation Update Report – 2019/20

Introduction

All registered nurses/midwives/nursing associates in the UK are required to maintain their registration with the Nursing & Midwifery Council (NMC) and must fulfil a range of requirements to show they are continuing to be able to practice safely and effectively by way of revalidation every three years.

The Trust uses an e-portfolio system (HeART) provided by external software developer in place since 2016. This system provides a repository for nursing staff to collate/store evidence and manage their registration through an NMC online account.

The NMC requirements for revalidation are:

- 450 Practice Hours over 3 years since last registration
- 35 hours of Continuing Professional Development (CPD) since last registration, of which 20 hours must be participatory
- 5 pieces of practice related feedback
- 5 written reflective accounts
- Evidence of a reflective discussion
- Health and Character Declaration
- Professional Indemnity arrangement
- Confirmation by a third party that the registrant has complied with the revalidation requirements

Update 2019/20

During 2019/20 a total number of 100 staff members still currently employed successfully revalidated in accordance with the NMC Guidelines.

No issues with completion were identified during 2019/20 and the Nurse Revalidation Administration Assistant either completed the NMC submission with the nurse or obtained confirmation that the process had been undertaken.

The Trust has maintained a 100% success rate for staff undergoing revalidation during 2019/20 as per below:

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Submitted	25	7	3	4	6	38	2	2	2	5	3	3
Exemption	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of staff members revalidated during 2019/20 – 100												

A small proportion of nurses required support with their revalidation submission during 2019/20. The main reasons for the additional support were due to lack of computer skills, confidence or lack of Continuing Professional Development (CPD) hours. Additional information is always available on both intranet and internet

Nursing Associates

4 Trainee Nursing Associates graduated to Nursing Associates in April 2019 and have been added to the revalidation monitoring database per Revalidation requirements stipulated by NMC. Future NA's will be added as employed.

COVID-19

Due to COVID-19 a 12 week deadline extension was automatically applied to staff due to revalidate in March 2020 along with the option for a further 2nd 12 week extension upon request . Some chose to complete within the original timescale whilst some made use of the extension and completed later.

2020/21

Failure to revalidate leads to serious consequences for the Trust, nurse and their ward/department and we do not anticipate there will be any issues/concerns with any cohort completing the revalidation during 2020/21

COVID 19

Due to COVID-19 a 12 week deadline extension was automatically applied to staff due to revalidate:

- April 2020
- May 2020
- June 2020

A further 12 week extension was available upon request. Some chose to complete within the original timescale whilst some made use of the extension and completed later.

A 12 week deadline extension is optional for staff due to revalidate:

- July 2020 through December 2020

As the Nurse Revalidation Administration Assistant does not have access to NMC extension requests it has been a challenge to ensure accurate knowledge of individual staff deadlines. Ongoing communication with various cohorts has been established to offer support and apprise them of NMC updates as required

The Workforce Information Analyst based within the HR Department has confirmed that as of the time of writing no member of staff has breached their revalidation deadline.

During 2020/21 141 staff members are required to revalidate as per below:

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Submitted	24	3	6	4	9	55	6	0	0	0	0	0
To Be Submitted	0	0	0	0	0	0	0	8	4	14	1	7
Exemption	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of staff members revalidated during 2020/21 – 107 Total Number of staff members still to revalidate during 2020/21 – 34												

Next Steps

The Trust recognises the importance of having a robust and systematic approach to nurse revalidation and will undertake the following:

- Review the level of support required by staff to complete the revalidation process
- Ensure updated guidance and templates are accessible via the intranet site
- Ensure accurate dissemination of changing NMC guidance to staff members

Recommendation

Trust Board is asked to receive and note report

The Walton Centre NHS Foundation Trust

Report to the Trust Board
Date 5th November 2020

The Walton Centre NHS Foundation Trust

Title	**Quarter 2 Governance, Risk & Patient Experience Report**
Sponsoring Director	Name: Lindsey Vlasman Title: Acting Director of Nursing & Governance
Author (s)	Lisa Gurrell- Head of Patient Experience Katie Bailey - Clinical Governance Lead
Previously considered by:	Quality Committee – October

Executive Summary
The purpose of the report is to:

- Provide a Quarterly summary of Governance activity across the Trust for Quarter 2 2020/21, comparing results of data with the previous financial Quarter (Quarter 1 2020/21).

- Provide assurance to the Trust Board that issues are being managed affectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

The report has been compiled using a collaborative approach with key services across the Trust, including Nursing, HR, Quality and Divisional Management to ensure those themes and trends identified are actioned appropriately.

Themes and trends have been identified and agreed via a multidisciplinary approach, with input from the following colleagues: Matrons of Neurology and Neurosurgery, Deputy Director of Workforce, Neurosurgery Operational Services Manager, Neurology Operational Services Manager, Quality Manager and Freedom to Speak Guardian, Neuroscience Laboratories Quality and Governance Manager, Radiology Manager, Radiology Clinical Governance Lead, Estates Manager & Digital Health Records & IG Manager.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with CQC/HSE regulations
Action required by the Board	• To consider and note

NHS
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

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Governance, Risk and Patient Experience

Q2 Report 2020/21

"Governance is a framework to receive, assess and act upon information we know about the services that we provide. Good governance provides assurance about the key issues and themes relating to the safety and experience of patients and staff. Governance is the backbone of the organisation."

1. Introduction

The report represents quarterly activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health and safety.

The report has been compiled using a collaborative approach with key services across the Trust, including Nursing, Human Resources, Information Governance, Quality and Divisional Management to ensure that themes and trends are identified and actioned appropriately. These themes and trends, inform the Governance Assurance Framework process.

1.1. The purpose of this report is to provide:

1. A summary of governance activity across the Trust in Q2 2020/21 compared to Q1 2020/21.
2. Assurance to the Board that issues are being managed effectively.
3. To ensure that robust actions are in place to mitigate risk, reduce harm and ensure that learning is embedded.

The data is accurate from the date that the reports were generated. Should incidents, complaints or claims be withdrawn, those figures will appear in subsequent reports.

2. Executive Summary

2.1. Incident reporting

Serious Incidents (SI):

- 2 serious incidents were reported in Q2 compared with 0 in Q1:
  - unexpected cardiac arrest, 22nd September 2020
  - unstageable pressure ulcer, 13th September 2020

Moderate & above incidents (including Duty of Candour):

- there were 24 moderate incidents in Q2 compared with 16 in Q1
- an increase in pulmonary embolisms noted increasing from 2 in Q1 to 7 in Q2
- all incidents complied with Duty of Candour notification requirements

2.2. Quarterly incident themes

Communication Incidents:

- there were 181 incidents in Q2 compared with 72 in Q1

Infection Control Incidents:

- there were 42 incidents in Q2 compared with 44 in Q1

Safeguarding Incidents and Concerns:

- there were 71 incidents in Q2 compared with 58 in Q1
- 39 incidents reported in Q2 were related to DoLS breaches

Information Governance Incidents:

- there were 37 incidents in Q2 compared with 19 in Q1

RIDDOR:

- there was 1 incident reported in Q2, relating to staff injury, resulting in a 7 day absence from work.

2.3. Governance Assurance Framework (GAF)

One new theme has been identified in Q2, relating to an increase in MSSA Bacteremia's. The IPC team is currently undertaking a deep dive to review the increase in MSSA.

2.4. Risks

The Covid-19 risk register continues to be regularly reviewed by the Executive Team. 3 new risks have been added on the register and further work was carried out to ensure risk descriptions reflected the standard of the Board Assurance Framework (BAF).

2.5. Complaints and Concerns

- there were 26 complaints in Q2 compared with 14 in Q1
- 2 complaints from Q1 were re-opened as further clarity was sought
- there was an increase in numbers received for both divisions in line with increased activity compared to Q1

2.6. Compliments

- 45 compliments recorded in Q2, same number as Q1

2.7. Claims

- there were 9 new claims in Q2 compared with 5 in Q1
- 2 claims were reopened in Q2

2.8. Patient Experience

FFT was still on hold in Q2 due to the Covid-19 pandemic; reporting will re-commence in December 2020.

3. Recommendation

Quality Committee is asked to receive and note this report.

4. Governance Assurance Framework (GAF) Log – Q2 2020/21

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression 9th October 2017	Feedback from incidents continually highlights the issues of violence & aggression (V&A) against staff. This has also been highlighted in the staff survey. Issues of V&A are also identified and discussed at the daily Safety Huddle meeting. This risk is on the BAF. **Lead:** LSMS (Health Safety & Security Group).	During Q2 an increase of V&A incidents is evident. Q2 data shows that 49 out of the 56 physical assaults against staff involved a patient that lacked capacity and 3 patients were responsible for 26 of these incidents.	LSMS Risk Lead/Personal Safety Trainer will: 1. Re-establish V&A MDT working group to meet on MS Teams in Q3. 2. Audit implementation of LAST LAP (Looking After Staff That Look After People) initiative in Q3. 3. Continue to provide post incident support to ward/departmental managers. 4. Body worn cameras for security staff to be rolled out in Q3. 5. Undertake a thematic review and analysis of the previous year to look at the impact of V&A to establish a baseline trajectory. Provide input to inform the Trust specification for a replacement CCTV/Access control system within capital plan.	It is recommended that this remains on the GAF for further monitoring. **Recommendation -** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 286 Appointments Cancellations/Delays 16th January 2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in DNAs, complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Divisional Governance and Risk meetings.	There has been an increase in concerns received in 2020/21, regarding appointment issues. Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments.	1. Service improvement work has been ongoing regarding outpatient appointments. Data regarding concerns and complaints about appointments is feeding into service improvement work. 2. MITEL IT/telephony system now fully installed and in operation. This system advises callers in to PAC of their queue position whilst waiting and keeps the caller updated whilst on hold. 3. Call recording functionality available also. 4. System can identify when there are peak times in the number of callers waiting, this allows department to increase the number of call handlers at certain times throughout the day/week. 5. The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. 6. Clinical validation of all patient appointments was cancelled due to Covid-19 and undertaken in April 2020. 7. Concerns and complaints have reduced recently; however, this will be due to no routine appointments taking place since late March 2020. 8. Recommenced outpatient activity from 1st June 2020 and OPT in letter programme commenced 1st June 2020 for the longest waiting patients reviewed at satellite sites. 9. Trust exploring the opportunity to participate as an adopter of PIFU, patient initiated follows up. 10. Bank staff utilization within PAC however due to self-isolating and sickness within the team, this additional resource has been utilized as back-fill.	It is recommended that this remain on the GAF to monitor improvements in patient and staff experience to ensure that both are sustained. **Recommendation** - Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 300 Rejection of pathology samples by LCL 2nd October 2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. **Lead:** Labs Quality & Governance Manager (Neurosurgery Divisional Governance Meeting).	Rejection data reports now received monthly from LCL. In total, approximately 60 samples a month rejected across the Trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. NOPD and HITU are the highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following an SUI.	1. Monthly rejection data now sent to Matrons, NOPD and HITU Ward Managers. 2. NOPD now preparing samples from late clinics and retaining at the Trust until the following day. 3. NOPD staff have received training on laboratory processes and specimen requirements. 4. Addressograph labels to be used on microbiology samples. 5. When applicable, communications to be given about rejections associated with lack of time on request. 6. IT have prepared a prioritisation document for an order communications system within pathology. This would ensure requests would be completed correctly and reduce number of rejections. This is managed and discussed in Neurosurgery Division.	Incidents to be monitored through Datix. **Recommendation** - Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 301 Fire Safety Compliance 17th January 2018	Following the OPD/NRC fire, and Merseyside Fire Service investigation and inspection of the Trust, the following legislative breaches were identified: 1. Maintenance of fire compartmentation lines. 2. Access to records of maintenance information provided by Liverpool University Hospitals (LUFT) Aintree Estates Department **Lead:** Estates Manager (BPC).	The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. These gaps were as a result of the original building works not being inspected and signed off in as compliant. A subsequent survey by a competent contractor in 2015 post a DH Estates Alert did not identify these breaches either.	1. Registered fire compartmentation contractor has undertaken and completed the works. 2. Fire Safety Advisor provides regular updates on progress to the Fire Enforcement Officer. 3. Outstanding areas are parts of OPD Pharmacy and Jefferson Ward for which Kier have been called back to attend to. Coming to site 19th October 2020 to review.	Continue to monitor until Kier complete remedial works. Ensure software is updated and handed over to the Trust. **Recommendation –** Management of all contractors via application software.

Theme	Context	Analysis	Action	Recommendation
Ref 302 Safeguarding 9th July 2019	Increase in safeguarding incidents reported both internally and externally to the commissioner in 2019/20 as a result of the implementation of new safeguarding section in Datix. It is anticipated that there will be a significant increase in incidents going forward. This is reflected in Quarterly statistics. **Lead:** Safeguarding Matron (Quality Committee)	Following the implementation of enhanced training for staff, there has been a significant increase in the identification of incidents of abuse/neglect. This continued increase in Datix reporting is a positive indicator around staff knowledge and appropriate action in response to safeguarding concerns. There is also an increase in the reporting of DoLS breaches due to untimely Local Authority assessment of the applications. This is in line with the revised Trust policy and processes for Deprivation of Liberty Safeguards (DoLS) applications.	The Datix reports will continue to be monitored with oversight from the Safeguarding Matron and Executive Safeguarding Lead to ensure that appropriate escalation/actions/referrals are addressed.	To continue to monitor to ensure appropriate reporting of safeguarding incidents. Reporting is now split into 2 groups: safeguarding concerns and safeguarding incidents. To await further guidance regarding changes to the DoLS. **Recommendation** - Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 304 – Communication 19th December 2019	Communication issues have been identified via a number of sources, including the staff survey (2019/20), incidents, concerns and complaints. **Lead:** Divisional Governance and Risk meetings.	It was identified from the 2019/20 staff survey results that communication is a Trust-wide issue. Visible increase in incidents evident on review of quarterly statistics, increasing from 72 Q1 to 181 Q2. Furthermore, this subject seems to be a recurrent theme amongst Incident investigations, Root Cause Analysis and Situation, Background, Assessment, Recommendation (SBAR) investigations. Communication also continues to be a theme in complaints and concerns.	1. Introduction of Divisional KPIs to monitor measure and reduce complaints and concerns. 2. Divisions to review current processes for escalation of concerns and complaints. 3. Divisions to identify how learning can be embedded to prevent concerns occurring.	Monitor via incidents, investigations, complaints and concerns. **Recommendation:** Continue to monitor in Q3.

Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	A problem was identified on Lipton Ward, in regards to water safety which led to the testing for legionella bacteria. The samples returned identified a number of positive outlets for legionella pneumophila serogroup 1. Further extended sampling across clinical areas has shown the existence of the same in various areas.	1. Legionella action plan is being monitored and now complete. 2. Additional measures have been undertaken which include the implementation of a thorough flushing regime to all areas and the installation of an additional hot water return shunt pump to try and get the water circulating better. 3. Re-sampling results have shown that, although not eradicated, the readings obtained are showing a downward trend which suggests the measures that have been under taken has had a positive impact. 4. In order to maintain safety and protect the patients further, Point of Use filters (POU) have been fitted to all outlets where it is possible for them to be fitted. 5. Further samples of cold water identified another as positive. Following investigation, there appears to be possible reasons why this may have occurred and these have been rectified. 6. Works associated to eliminating legionella from the water systems are widespread and lengthy; therefore, there will be no "quick-fix" to the problems being experienced. 7. Engineering works have now completed to install a new 54mm hot water return pipe from ground floor to 3rd floor plantroom. This is currently being monitored to see what improvements this has made.	Continue with remedial, re-sampling regime and flushing. Continue to work through Water Safety Action Plan (from Hydrop). Roll out of the Hydrop "compass" software to non-clinical areas throughout the Trust. Rolling programme to strip and clean all outlets prior to re-testing. **Recommendation –** Continue to monitor and work through all actions.

Theme	Context	Analysis	Action	Recommendation
Ref 307 Medication Incidents 14th July 2020	Increase in medication incidents. **Lead:** Safer Medication Group	An increase in medication incidents can be seen on review of quarterly statistics, increasing from 55 Q1 to 75 Q2.	1. Stock discrepancies will continue to be monitored via Safer Medication Group. 2. Pharmacy Risk register reviewed to ensure increase in reoccurring incidents is noted.	Continue to monitor in Q3. **Recommendation –** Continue to monitor.
Ref 308 Catheter Acquired Urinary Tract Infections 14th July 2020	Increase in Catheter Acquired Urinary Tract Infections (CAUTI) identified in Q1. **Lead:** Infection Prevention and Control Committee	As detailed in Q1 report- there had been a significant increase in catheter acquired urinary tract infections (CAUTI) resulting in an associated increase in E Coli Bacteraemia. The presence of a urinary catheter in situ was identified in all cases. This increase reflects the national position; the government have set a goal to reduce healthcare associated gram negative blood stream infections by 50% by 2020/21. A decrease in CAUTIs can be seen on review of Q2 statistics, decreasing from 5 in Q1 to 1 in Q2.	An improvement project has commenced within the acute ward areas and theatres. There are clear goals and measurable targets with an aim to: 1. Avoid unnecessary urinary catheters. 2. All insertions to be undertaken with aseptic technique and managed in line with guidelines. 3. All catheters to be reviewed daily and removed promptly in line with clinical requirements. There are several improvement projects in place in the areas, reviewing procedures/ documentation related to catheter care.	Monitor in Q3. **Recommendation –** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 309 Increase in MSSA Bacteraemia 6th October 2020	Steady Increase in MSSA bacteraemia infections noted on review of quarterly statistics, increasing from 3 Q1 to 4 Q2. **Lead:** Infection Prevention and Control Committee	Analysis of quarterly incident statistics suggests an increase in cases of MSSA bacteraemias.	A working group was established on the 24th August 2020 to examine practice in relation to the prevention of MSSA bacteraemia. This will include observing scrub, decolonisation procedures and environmental audits. MSSA decolonisation will be reviewed in both. Pre-operative clinic for elective surgery patients and ward practice in relation to emergency admissions. There will be a review of practice in relation to practice in relation to Intravenous line management.	Continue to monitor in Q3. **Recommendation** – Continue to Monitor.

5. Incident Management

This section provides a detailed report of the number and type of incidents reported during the Q2. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

TRUST WIDE	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21
Incident					
Total number of Incidents	819	840	741	582	909
Neurosurgery	500	499	439	373	605
Neurology	281	298	269	187	259
Corporate	39	43	33	22	45
StEIS reported SUI's	1	3	1	0	2
Patient Safety Incidents reported to the NRLS	277	249	241	187	272
Accident	110	98	98	58	99
Communication	123	113	97	72	181
Death	13	37	28	37	25
Digital Systems	12	24	23	10	24
Environmental	38	31	19	29	32
Infection Control	21	30	39	44	42
Information Governance	58	49	51	20	37
Investigations, Images & Diagnosis	29	35	21	26	26
Medical Devices, Systems & Equipment	43	42	40	27	42
Medication	68	75	65	55	75
Nutritional and Hydration	9	8	11	14	12
Patient Care	91	83	76	63	104
Safeguarding	70	87	74	58	71
Security	20	13	11	7	14
Treatment and procedure	33	47	25	15	28
Violence and aggression	82	68	62	47	97
RIDDOR	3	3	3	2	1
Percentage reported within 12 hours (as per Policy)	88%	88%	89%	88%	92%
% of level 2&3 incidents acknowledged in 24 hours (as per Policy)	75%	86%	68%	79%	82%
% of level 1 incidents acknowledged in 48 hours (as per Policy)	89%	87%	89%	87%	29%
% of level 0 incidents acknowledged in 48 hours (as per Policy)	87%	89%	92%	93%	96%
Rate of incidents per 100 admissions (excluding Jeff & OPD)	16.35%	16.06%	13.31%	11.3%	15.84%
Number where DOC (Duty of Candour) where patient/relative have been notified?	12	17	19	16	24

5.1. High level incident overview of Q2:

- Trust wide incidents increased from 582 in Q1 to 909 in Q2
- Neurosurgery incidents increased from 373 in Q1 to 605 in Q2
- Neurology incidents increased from 187 in Q1 to 259 in Q2
- Corporate incidents increased from 22 in Q1 to 45 in Q2

5.2. Quarterly incidents by severity:

Incidents by Severity	**Q1 20/21**	**Q2 20/21**
No obvious harm	480	782
Minor harm may require aid/support	81	91
Moderate harm requiring aid/support	16	23
Major permanent harm	0	0
Catastrophic	0	1
To be determined following investigation	5	12
Total	**582**	**909**

5.3. Quarterly themes:

Information Governance (IG):

- there were 37 IG incidents in Q2 compared with 20 IG in Q1
- there were 1 externally reportable incidents to the Information Commissioners Office (ICO) compared with 0 in Q2
- there were 0 breaches of Subject Access or Freedom of Information requests

Communication:

- there were 181 communication incidents in Q2 compared with 72 in Q1

Safeguarding incidents and concerns:

- there were 71 incidents and concerns in Q2 compared with 58 in Q1
- there were 39 incidents in Q2 (related to a breach of DoLS) compared with 33 in Q1

5.4. Key actions to note:

- continue delivering Datix refresher training in Q3 via MS Teams
- undertake a Duty of Candour audit in Q3, this action has been carried over from Q2
- undertake a review of notifications sent from Datix

6. Violence and Aggression (V&A)

TRUST WIDE	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21
Incident					
Inappropriate Behaviour	5	7	9	7	4
Physical abuse/violence - patient on staff	45	40	29	22	56
Physical abuse/violence – Visitor	2	1	1	1	0
Racial abuse/violence - patient on patient	0	0	0	1	0
Racial abuse/violence - patient on staff	3	1	2	2	6
Sexual abuse/violence - patient on staff	1	0	0	2	0
Verbal abuse/Violence - patient on staff	21	18	15	8	28
Verbal abuse/Violence - patient on patient	2	0	0	1	0
Verbal abuse/Violence - other on staff	0	0	0	0	2
Verbal abuse/Violence - staff on staff	0	1	0	0	1
Verbal abuse/violence - Visitor	2	0	6	3	0
Total	81	68	62	47	97

6.1. <u>High level incident overview of Q2 2020/21:</u>

- having seen a continued decline in the number of V&A incidents over the previous 3 quarters, Q2 has witnessed a significant increase
- physical assaults with patient on staff – 3 patients were responsible for 26 of these incidents
- a significant reduction in incidents reported in Q1; largely due to the reduction of the number of inpatient activity due to Covid-19
- NB 'Inappropriate behavior incidents' do not meet the criteria of verbal or physical abuse, but still require reporting. Incidents include circumstances where a patient, relative or indeed a staff member have acted inappropriately or used inappropriate language but did fit within the verbal or physical abuse categories

6.2. <u>Quarterly themes:</u>

- the highest category of incidents continues to be physical assaults with patient on staff at 56 incidents reported, 49 of which relate to patients that did not have capacity
- the location with the highest number of V&A incidents reported was Dott Ward with 26, followed by CRU with 20 and Lipton with 16

6.3. Key actions to note:

- Personal Safety Trainer recruited September 2020 – New training programme has been developed
- LAST LAP initiative has been rolled out in Q2
- Body worn cameras to be rolled out in Q3 for use by security staff
- Ensure V&A incidents are escalated to the daily safety huddle for onward management and monitoring
- Review of current CCTV and access control systems during 2020/21

6.4. Racial Abuse - Incident overview of Q2 2020/21:

- Increase from 2 incidents (patient on staff) in Q1 20/21 to 6 incidents in Q2 2021.

Quarterly Themes:

- 4 Incidents relate to patients assessed as lacking capacity
- 5 of the 6 incidents occurred on CRU
- 1 patient was responsible for 4 incidents

Key actions to note:

- Managers support and offer staff any relevant support following incidents
- All incidents sent to Equality & Diversity lead for assessing and ensuring any further support is offered to staff involved
- LAST LAP initiative (Looking After Staff That Look After People) has been rolled out in Q2. Any issues from staff can be escalated to managers confidentially

7. Complaints & Concerns

The Patient Experience Team (PET) receives a wealth of information surrounding the experience of our patients and their families. The Trust use the positive feedback to share and promote good practice and this information can be found in the table below. This section concentrates on the areas of concern raised by patients and their families. This information helps us to improve services and learn lessons to improve the care and service we provide to our patients. This section analyses the complaints and concerns raised with the Patient Experience Team.

TRUST WIDE	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21
Complaints					
Coroner statement requests	3	1	2	5	1
Police statement requests	9	6	9	12	10
Total Number of Concerns	118	157	152	75	145
Appointment arrangements	66	75	97	43	89
Approach and manner	9	14	18	7	16
Patient Care	10	10	13	8	16
Communication	29	34	45	24	72
Discharge Arrangements	5	8	5	3	4
Total Complaints received	36	37	25	14	26
Approach and Manner	12	11	14	6	10
Treatment	10	10	3	4	8
Appointment Arrangements	12	14	15	4	14
Patient Care	9	4	2	6	8
Communication	10	17	8	11	11
% Acknowledged within 3 working days	100%	100%	100%	100%	100%
% responded to within agreed timescale	100%	100%	100%	100%	100%
Neurosurgery complaints	15	15	12	6	19
Neurology complaints	15	19	12	5	7
Neurosurgery/Neurology complaints	6	2	1	3	0
Corporate	0	1	0	0	0
% signed responses scanned on system	100%	100%	100%	100%	100%
Complaints to Ombudsman	0	2	0	0	0

7.1. Concerns and Complaints:

- 26 complaints in Q2 compared to 14 in Q1
- 2 complaints from Q1 were re-opened as further clarity was sought
- 21 complaints were closed in Q2 and 7 remain under investigation within the negotiated timeframe
- 100% of complaints were acknowledged and responded to within the negotiated timeframe, although 2 required slight extensions which were agreed with the complainant
- The increase in the number of complaints across both Divisions; Neurosurgery 19 in Q2 compared to 6 in Q1, Neurology 7 in Q2 compared to 5 in Q1 is in line with increased activity

Key themes for complaints include:

- Approach & Manner* (10)
- Appointment Arrangements* (14)
- Communication* (11)
- Patient care* (8)
- Treatment* (8)

*to note a complaint may include one or more subject/theme

7.2. Concerns:

- Concerns received increased from 75 in Q1 to 145 in Q2
- Themes still include appointment arrangements (89 from 43) and communication (72 from 24), many concerns relate to increased waiting times as a result of Covid-19 and communication regarding the reintroduction of services
- 54 enquiries were received, themes relating to the referral process and general hospital enquiries

7.3. Compliments

Our compliments remain at the same level with 45 being recorded in both Q1 and Q2, which is understandable due to the impact of Covid-19 in line with reduced activity and reduced visiting arrangements. The compliments received, however, highly commended staff and services during the pandemic.

7.4. Police/Coronial Requests

There was a decrease in the requests 10 in Q2 from 12 in Q1 for police statements/copies of case notes and 1 in Q2 from 5 in Q1 for coroner statements.

7.5. Volunteers:

There was no volunteer activity within Q2 as volunteers have not been re-introduced although the team are in regular communication with them.

7.6. Summary

There was a noticeable decline in complaints and concerns received by PET within Q1 but this has returned to expected levels in Q2.

In Q2, 29 formal complaints were closed, 134 concerns were resolved and 54 enquiries received and responded to. This demonstrates excellent collaborative working between PET and Divisions. All concerns and complaints are reviewed in a weekly meeting with each division which includes divisional directors and leads and members of the Patient Experience Team.

8. Claims / Legal

TRUST WIDE	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21
Claims					
Total new claims received	4	9	6	5	9
Neurosurgery claims	3	4	4	5	6
Neurology claims	1	4	1	0	1
Corporate claims	0	1	1	0	2
Total number of pre-action protocols in quarter	14	10	11	13	7
Number of closed claims in quarter	5	7	10	4	5
Value of closed claims - Public liability	£0	£0	N/A	£0	£0.00
Value of closed claims - Employer liability	£15,736	£0	N/A	£0	£0.00
Value of closed claims - Clinical Negligence	£447,102	£155,194	£485,936.22	£2,715,964.73	£3,203,388.52

All staff involved in claims/coronial reviews or inquests receive full support throughout the process.

8.1. Re-opened claims

(153) Neurosurgery

- Claimant underwent insertion of venticuloperitoneal shunt on 22/07/2016. It was discovered on 24/07/2016 that the claimant had suffered a perforated bowel during surgery which resulted in sepsis and additional surgery.
- The Trust LOR was served in April 2017 admitting all allegations except one. The NHSR closed their file due to no further correspondence from the claimant.

- Negotiations resumed and settlement has recently been achieved in the sum of £59,000 Damages.

(183) Neurosurgery (Pain)

- From October 2013 the claimant was under the care of several Trusts receiving treatment for head, neck and lung cancer. In April 2017 the disease had progressed and the claimant attended CCO but decided against palliative chemotherapy. In August 2017 the claimant's symptoms advanced and was reviewed at Woodlands Pain Services in September 2017. On 03/10/2017, the claimant was admitted to the Trust for nerve block injection and sometime following this developed paraplegia, urinary and bowel incontinence. An MRI showed a large soft tissue lesion from T3 to T8 involving the chest wall and ribs. The claimant was transferred to hospice on 09/10/17 and died on 13/10/17.
- Allegations are that the Trust failed to determine the size/site of the tumour before the procedure on 03/10/17. Had this been identified, the procedure would not have been offered. It is also alleged that, on balance, the procedure should have been stopped once it was identified that there was no T4 spinous process.
- An RCA confirmed that the absence of the T4 spinous process was identified during the procedure and therefore the surgery should have been stopped. Had further imaging been carried out and the tumour identified, the procedure would not have been offered. The consultant does not agree with the findings of the RCA and states he did not identify absence of T4 spinous process since claimant was in an oblique position on the operating table.
- The file was closed due to no response from the claimant following our Trust LOR denying the allegations. In September 2020 further correspondence from the claimant was received requesting disclosure of the Trust's Expert evidence, on a without prejudice basis. Should this be disclosed this will pose a risk regarding breach of duty.
- The claimant requested £17,000 but this request as now reduced to £9,000. NHSR aim to settle this matter up to £5,000. If this matter was to go to Trial, the judge would accept the claimant's case on breach of duty, so to settle at this stage would be cost effective. Claims Manager suggests settling the matter without admitting liability and after further discussion with the consultant in charge of care.

8.2. **Lessons Learned**

The following lessons have been learned from on-going claims. Please note that lessons may have been learned following an RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.

Communication

Lessons learned from RCA – See re-opened claim (153) above.

- There is a need for improved communication within the surgical team/division.
- In retrospect the Consultant has reflected that due to the complexity of the patients' previous abdominal surgery, this patient should have been placed on a planned list rather than an emergency list.

- A number of different Registrars had reviewed the patient during admission pre-operatively and should have made time to review the patient's history. Patient had been consented by one surgeon and operated on by another.
- When planning the shunt the Consultant suggested it should have been inserted into the left upper quadrant of his abdomen and been placed as a left sided ventricular peritoneal shunt which would have potentially avoided the adhesions from the previous abdominal surgery. This would have minimised the risk of bowel perforation.

Treatment

- Claimant admitted for planned endovascular surgery on 14/8/20 which was cancelled due to a medication error. Procedure not rescheduled during that admission due to emergencies. Claimant felt unwell on 18/6/16 unrelated to condition and discharged home on 20/8/20 with plan to follow up at OPD. Then followed several administrative failings resulting in the claimant being lost in the system. Claimant attended an OPD on 16/03/17 where risks of surgery were discussed and underwent an anaesthetic review on 14/06/17 and pre-op on 30/08/17. The consultant requested an OPD review with an up-to-date MRI scan. On 18/01/18 the claimant suffered a SAH and was admitted to the Trust but sadly died on 26/01/18.
- An RCA was conducted and several recommendations were made including a Standard Operating Procedure being published, for the administration of drugs on the wards, and this to be included in the peri-operative drug policy.

Themes

Documentation

- There is an ongoing theme of poor documentation which runs through many of the claims that the Trust received. This is always highlighted in medical mandatory training sessions and junior doctor's induction.
- It has been identified during the investigation of some claims that consent forms show that either the surgery procedure had not been documented correctly or the wrong reason for the surgery has been documented. However, for these cases medical records documentation prior to completion of the consent forms do confirm that the patients were aware of the procedure they were having and the outcome that was hoped to be achieved.

8.3. Coroners Inquests

A 28 year old male with a long standing history of seizures was admitted on 19/02/18 for monitoring of epilepsy with an aim to adjust treatment in order to improve seizure control. The patient's condition deteriorated despite maximal efforts and following admission ITU, he suffered a cardiac arrest on 08/04/18. Despite input from a consultant cardiologist, the patient suffered a further cardiac arrest which was futile and sadly died at 20:03.

Following a formal complaint from the family regarding care, treatment and the cause of death, the family have met with the Trust on two occasions and referred their concerns to the CQC and Coroner.

As part of the complaint an independent review was undertaken by the RCP. Recommendations have been included in an action plan which is under review by the CQC. Directions were received from the Coroner and the Trust attended a first pre inquest review (PIR) on 28/07/20 with legal representation. The family also have legal representation. Direction timeframe has been met. The next PIR is scheduled for 11/11/20 when the Coroner will confirm which staff will be called to give evidence at the Inquest (date yet to be confirmed).

Staff Education and support:

- Training is now provided to to all junior doctors at induction.

9. Safety Section

9.1. Health & Safety - key points to note:

RIDDOR - staff resulting in 7 day absence:

- 1 Incident was reportable to the Health and Safety Executive in Q2

Risk assessments:

- the Deputy Head of Risk continues to provide input into risk assessments to support managers and individuals throughout the Covid-19 response

Fit testing:

- fit testing continues as a priority
- the Governance team is supporting fit testing of clinical staff on day and night shifts
- the Deputy Head of Risk has now been identified as the lead person for fit testing

First aid training:

- First aid training is now complete, with 10 members of non-clinical staff qualified to provide basic first aid.
- First aiders contact details have been provided to Trust reception desks and Security. First aid posters for contacting reception & security have been displayed around non-clinical areas within the Trust.

9.2. Fire Safety - key points to note:

Fire alarms unwanted fire signals (UwFS):

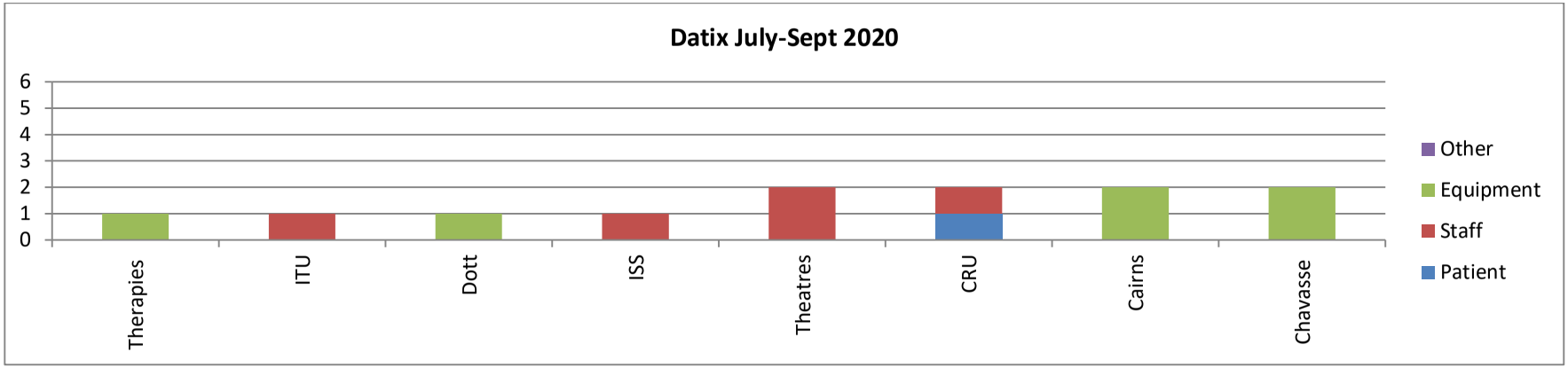
Month	Actual Fire	Call Point	Steam	Toaster	Microwave	Fogging	Nebuliser/ Aerosol	Smell smoke	System fault	FRS Attendance
July 20	0	0	0	0	0	0	1	0	1	1
August 20	0	0	0	0	0	0	2	0	1	0
September 20	0	0	0	2	0	0	1	0	0	1
Total:	**0**	**0**	**0**	**2**	**0**	**0**	**4**	**0**	**2**	**2**

Key Actions:

- The Trust experienced 8 unwanted fire alarms in Q2, which is a reduction of 1 from Q1
- The Trusts, main building, automatic fire alarm is monitored for response purposes by Liverpool University Foundation Trust (LUFT), Aintree switchboard, who receives alarm and activate pagers for local responders. Where required they will summon assistance from Merseyside Fire & Rescue Service (FRS). In Q2 an issue was identified were the physical link (cable) between the Trust and LUFT Aintree had a significant fault, resulting in the breakdown of that link. This left the Trust, albeit temporary, without capability for response to a fire within the Trust main building. Communications were distributed to the Trust advising in the event of a fire alarm to utilise the 2222 Emergency (Fire) telephone number, which would facilitate the response. The Estates Department advised that the issue may take some time to rectify and successful efforts have been made to do so. This issue remains a risk to the Trust and has been added to the Trust wide risk register. Further efforts are being made to enable the Trust to stand alone from LUFT to enable the Trust has an independent system of effective response, which will be managed locally.
- Training remains effective; however attendance for physical sessions has been reduced as a result of Covid-19 social distancing measures, which has resulted in a slight downturn in compliance, currently at 85%. MS Teams sessions are being used to reach those who are working remotely or cannot attend the physical sessions.
- The Trusts fire risk assessment is reviewed as required by date and priority.
- Compartmentation works have ended with the FRS (despite not being able to visit) and are happy with our action.

9.3. Moving and Handling - key points to note:

- Classroom training sessions continues in line with current Trust agreed precautions and onsite training utilizing appropriate PPE.
- Support with complex needs patients with appropriate PPE for the ward and patient status.
- Equipment regulatory inspection/service and maintenance – Lifting Operations and Lifting Equipment Regulations (LOLER) inspections are now complete and all relevant equipment is in date.
- DATIX reports total 12 in this reporting period with no trends or pattern noted.



A total of six assessments were completed in order to support staff in practice in Q2, it is noted that 3 of these are non patient facing staff members.

Key Actions

- Training date arranged on Bed Transfers of Patients for ISS Portering staff.
- Availability of equipment - reminders sent to order replacement equipment in a timely manner and to put equipment on charge as required.
- Support provided in work area with individual staff and patients.

9.4. Emergency Planning - key points to note:

- Due to the impact of Covid-19, the 2019-2020 the Emergency Preparedness, Resilience & Response (EPRR) 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 Trust is compliant with the applicable standards and no actions were required following the self-assessment process. A report will be sent to Novembers BPC, Trust Board and then submitted to Regional EPRR leads following Board approval
- Following a review of the Trusts Senior Managers & Directors on-call system it has been agreed that on-call rota duties will now completed in single day rather than weekly.
- The Senior Manager/Director on call guidance has been updated and re-circulated to on call staff & contact numbers provide to switchboard.

REPORT TO Trust Board
Date 5th November 2020

The Walton Centre NHS Foundation Trust

Title	Morbidity & Mortality Report 2020-2021 Quarter 1 (Q1) & Quarter 2 (Q2)
Sponsoring Director	Name: Dr A Nicolson Title: Medical Director
Author (s)	Name: Patricia Crofton Title: Clinical Quality Lead
Previously considered by:	• Committee (please specify) ____N/A_____
Executive Summary This report is Q1 and Q2 of the quarterly review of Morbidity & Mortality within The Walton Centre. It provides information from case reviews, readmission rates / trends, and surgical site infections and in-hospital deaths. Unless stated, figures relate to both Neurosurgery & Neurology combined. The format of the report has been altered (for consistency with other data presented at Quality Committee) to include the CHKS readmission and mortality report and crude mortality data for 2019-2020, this data was not available for the Q4 report	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do.
Risks associated with this paper	None
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	• Yes – (please specify) ____N/A_____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	Compliance with National guidance on Learning , candour and accountability (A review of the way NHS trusts review and investigate the deaths of patients in England)
Action required by the Board	The Board is requested to: • Discuss and note the position

Quarter 1 (Q1) Morbidity & Mortality Report 2020-2021

Executive Summary

This report is a quarterly review of Morbidity & Mortality within The Walton Centre. It provides information from case reviews, readmission rates / trends, and surgical site infections and in-hospital deaths. Unless stated, figures relate to both Neurosurgery & Neurology combined.
The format of the report has been altered (for consistency with other data presented at Quality Committee) to include the CHKS readmission and mortality report and crude mortality data for 2019-2020, this data was not available for the Q4 report.
Due to the timing of Neurology mortality meetings (quarterly) the neurology case reviews refer to patients whose death occurred in Q4 19/20 and have been presented at Neurology mortality in Q1.
The surgical case reviews refer to patients whose deaths occurred in Q1 20/21.

The report includes a report from the intensive care national audit & research centre (ICNARC).This report presents analyses of data on patients critically ill with confirmed COVID-19 on Horsley Critical Care Unit. The report accounts for all patients with confirmed COVID 19 admitted and include the original admission data (whether in the Walton Centre or in a previous unit), their total organ support (from all units) and the patients final unit outcome.(Appendix)

Q1 20/21 Summary

There were 35 deaths in Q1; all patients were admitted as emergencies, age range from 22 to 95 years. There was no significance identified in relation to day of the week of admission or day of the week of death.

All deaths are subject to an initial mortality review and are then discussed at Divisional Mortality Review Meetings. With the current COVID-19 restrictions, mortality meetings have taken place using MS Teams and although the majority of initial mortality reviews have been completed there are 8 outstanding mortality reviews (28 Completed). There has been a delay in the timing of presentations, going forward the neurology divisional mortality meetings will occur monthly and an invitation will be extended to the stroke physicians at Aintree.

The COVID-19 pandemic has brought very difficult and new challenges in caring for patients and supporting their family and friends at the end of life. A particularly cruel challenge is that, to control the spread of infection patients who were tested positive for Covid-19 must be completely isolated and visiting was suspended throughout the hospital. Often a patient's loved ones were unable to accompany them to hospital, this meant patients were isolated from their families at precisely the time they need them most. Smartphones and tablets were used as alternatives to face to face contact, but of course this cannot replace human contact. Great sensitivity is required with the use of virtual contact with families when a patient is dying, some researchers have cautioned against it, due to the distress this can cause. The use of technologies such as this has been standard practice in critical care; however, this was extended to other acute areas during the lockdown period.

Do not attempt cardiopulmonary resuscitation (DNACPR) discussions present a further challenge across the NHS during the pandemic.
Clinicians faced a sharp and sustained rise in the volume of urgent decisions to take around DNACPR and what was in the best interests of each individual patient under their care. This is not unusual in the Trust as patients have life threatening and life limiting conditions. However, these

difficulties meant greater emphasis was placed on ensuring high-quality timely communication, decision-making and recording in relation to decisions. This was particularly crucial for patients with multiple co-morbidities and those with pre-existing conditions.
This then transferred into an improved bereavement process for relatives, should the patient deteriorate and die. Again, these discussions were made more difficult as clinicians were discussing ceiling of treatment, DNACPR decisions with families who they had never met over the telephone. Of the patients who died in Q1 following discussion with patients (where possible) and families there were 22 DNACPR orders completed. One patient had a unified DNARCPR prior to admission.

Crucially, families unable to visit their loved ones at the end of life needed to know how exceptionally seriously Trust staff took this vital aspect of palliative care. Clinical teams did their utmost to keep in contact with all families and assured relatives that the staff caring for their loved ones would be as gentle, kind and caring as they could ever imagine. Staff were their “proxies”, there at the bedside, striving to convey the love and support they longed to share in person. Staff have expressed they were privileged to care for these patients.

There has been no concerns raised by patient’s families in relation to the difficult communications carried out over the period of lockdown, there is clear evidence documented of families being satisfied with the care and communication provided.
A family has recently expressed a wish to meet with clinical staff following her mother’s death. This was facilitated by the Head of Patient Experience and those staff from Critical Care who cared for the patient at the end of her life. This was an exceptionally emotional experience for both the family members and staff. The family have since provided feedback that felt supported and that they felt assured that the staff caring for their loved-one did their best to convey the love and support they longed to share in person.

The Head of Patient Experience is considering how to provide additional support to those families (at an appropriate time) whose relative has died and they were unable to visit at the end of life.

1 Admission data 1st April – 31st March 2020

The Neurosurgical & Neurological admissions and re-admissions are detailed below. Admissions in Q1 are greatly were reduced as all elective surgery was cancelled due to COVID 19 restrictions.

Q1 2020-21	Apr-20	May-20	Jun-20
Admissions	135	206	260
Re-admissions	6	7	9
%	4.4	3.4	3.5

Table 1: shows admissions and readmissions Q1 2020.

2019-20	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20
Admissions	1331	1290	1242	1198
Re-admissions	74	63	56	52
%	5.6	4.9	4.5	4.3

Table 2: Shows admission and readmission data for 2019-2020

1:1 CHKS data 2019-2020

The table below shows the readmission rate for Walton Centre for the reporting period. 90% of readmissions are recorded within the specialty of neurosurgery.
The trust has a readmission rate of 2.21% and is in the best performing quartile in comparison to the selected peer. Both elective and non-elective readmissions are in the best performing quartile.

Readmissions within 28 days; Age >16	Total Readmitted Spells	Total Spells	Readmission Rate	25th Percentile	Peer Value	75th Percentile
Totals	248	11210	2.21%	7.07%	7.81%	8.99%
1 - Elective	128	9224	1.39%	3.64%	3.97%	4.97%
2 - Non-elective	120	1986	6.04%	11.40%	12.61%	13.54%

Table 3: Readmissions by admission type April 2019 to March 2020

Improvement for non-elective readmissions is noted in the second half of 2019. Elective readmissions have been stable for the whole year. The peer distribution highlights that the Walton Centre has the lowest crude readmissions rate in the peer.

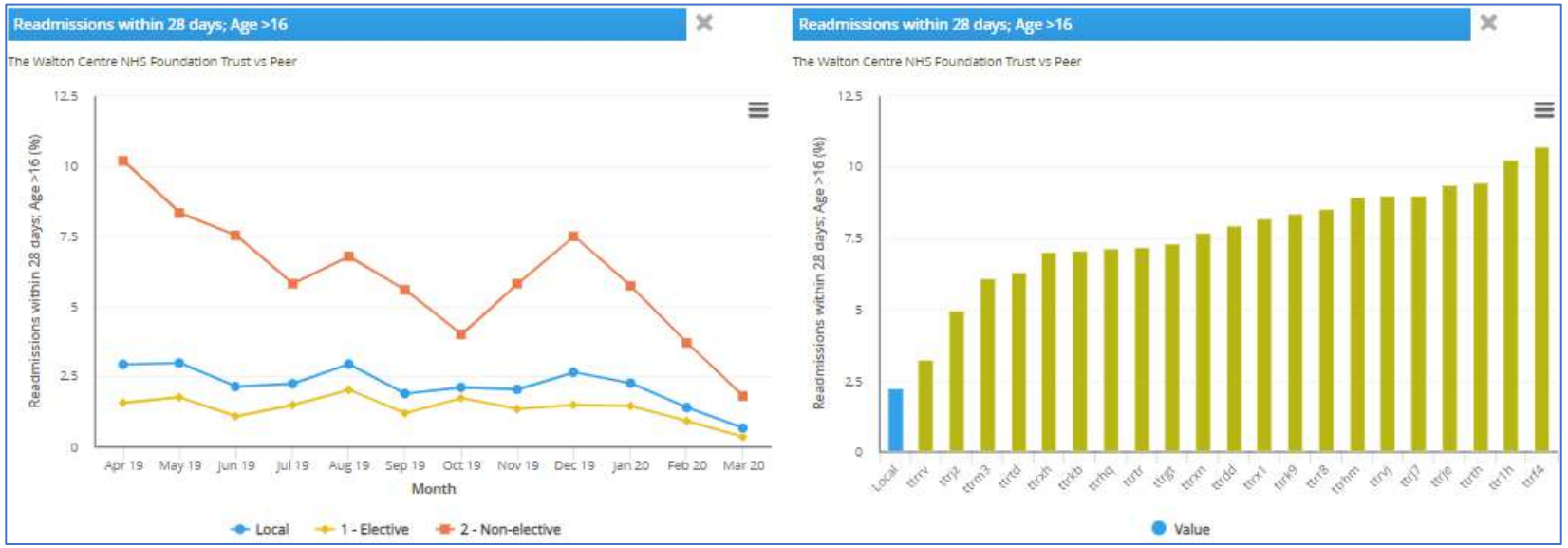


Chart 1: Readmission time series chart and peer distribution April 2019 to March 2020

At a procedure level the numbers of readmissions are low, which skews the readmission rates. In the below table the highest volumes HRGs are shown compared to peer for the period April 2019 to March 2020.

Readmissions within 28 days; Age >16	Total Readmitted Spells	Total Spells	Readmission Rate	25th Percentile	Peer Value	75th Percentile
Totals	248	11210	2.21%	7.07%	7.81%	8.99%
AA52C - Very Major Intracranial Procedures, 19 years and over, with CC Score 4-7	11	103	10.68%	4.17%	8.52%	10.26%
AA54A - Intermediate Intracranial Procedures, 19 years and over, with CC Score 4+	11	74	14.86%	5.26%	6.45%	10.71%
HC64C - Intermediate Extradural Spinal Procedures with CC Score 0-1	10	279	3.58%	2.40%	3.12%	4.34%
AA51C - Complex Intracranial Procedures, 19 years and over, with CC Score 4-7	9	92	9.78%	5%	8.12%	10.53%
HC63B - Major Extradural Spinal Procedures with CC Score 2-3	8	193	4.15%	2.47%	3.72%	5.26%
HC70B - Complex Intradural Spinal Procedures with CC Score 0-1	8	43	18.60%	6.45%	6.23%	10.53%
WH07D - Infections or Other Complications of Procedures, with Single Intervention, with CC Score 0-1	8	22	36.36%	8.11%	14.06%	17.24%

Table 4: Readmissions by HRG April 2019 to March 2020

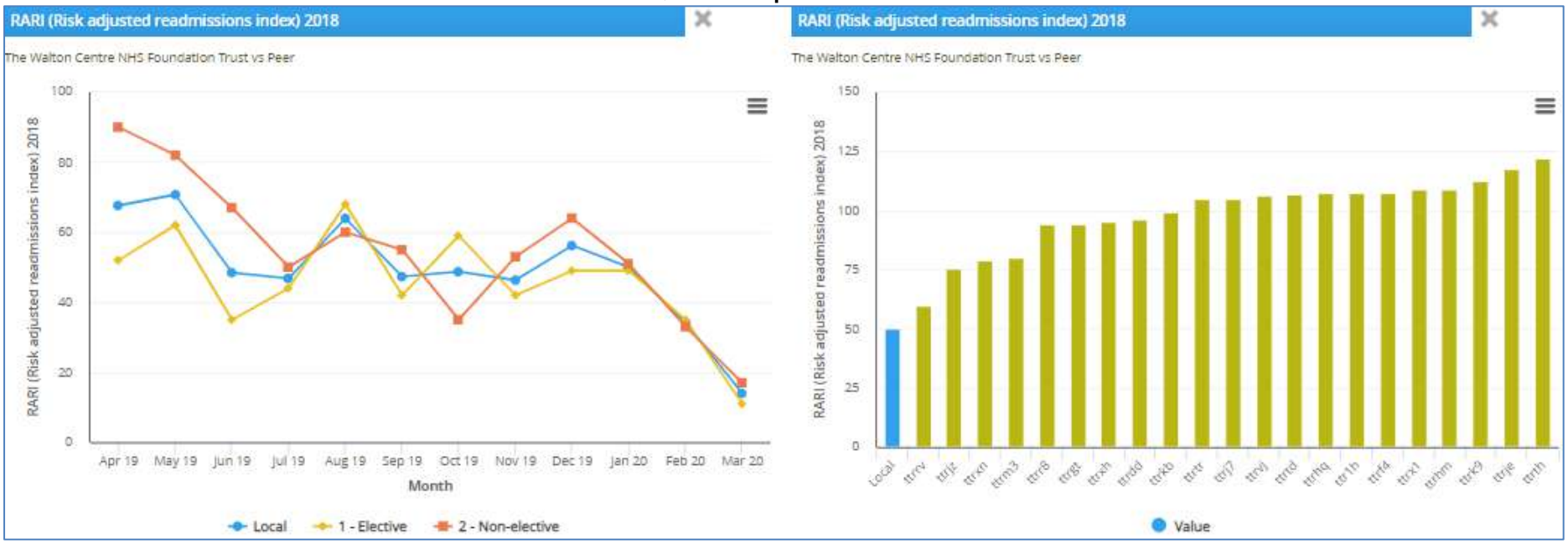
1:2 Risk Adjusted Readmissions Index 2018 (RARI)

The CHKS risk-adjusted readmissions index (RARI) is an index comparing the observed number of emergency hospital readmissions with the number expected, having taken account of case mix. By doing so it provides a fairer comparison of readmissions than simple rates, particularly between providers with different patient characteristics. RARI is expressed as a percentage. An index of 110% suggests 10% more readmissions than expected, whilst 90% suggests 10% fewer than expected.

Admission Type	Observed Readmissions	Expected Readmissions	RARI 18	25th Percentile	Peer Value	75th Percentile
RARI (Risk adjusted readmissions index) 2018	254	506.92	50.11	94.17	101.34	107.66
1 - Elective	131	280.91	46.63	91.17	94.78	113.89
2 - Non-elective	123	226.01	54.42	94.9	103.97	109.63

Table 4: RARI by admission method April 2019 to March 2020

Trust's RARI for the reporting period shows a similar picture to the readmission rate, the peer distribution below highlights that the Walton Centre has the lowest RARI in the peer. Figures below illustrate an improvement for non-elective activity readmissions in the second half of 2019.



2 Surgical Site Infection (SSI) data

The table shows detail regarding nature of operation and degree of clinical urgency. As the number of patients undergoing surgery in the 'immediate' category is low (i.e. the denominator), a single infection in this group may constitute a large percentage, therefore the number of cases is more pertinent in looking for trends.

3: Mortality Q1 2020

In Q1 there were 35 in-patient deaths, 14 patients admitted via neurosurgery, and 21 patients under the care of neurology. This demonstrates an increase in the numbers of deaths in neurology; however, this can be explained as there were 11 deaths related to stroke as the Trust continues to support Liverpool University Hospitals with the delivery of stroke services. There were 18 deaths in critical care, 5 of which were Covid-19 related, 2 of which were transferred from critical care at Liverpool University Hospital (Aintree) as part of the Trust's support to enable critical care capacity.

There were 10 deaths where Covid-19, was either the primary cause of death or was a contributory factor. All patients were admitted as emergencies, age range from 22 to 95 years. There was no significance identified in relation to day of the week of admission or day of the week of death. There were 5 deaths following major trauma, 3 patients went on to be consideration to donate organs. There were no deaths related to thromboembolic complications.

3:1 Quarterly Analysis – Neurosurgery and Neurology

Deaths by Admission Day of Week

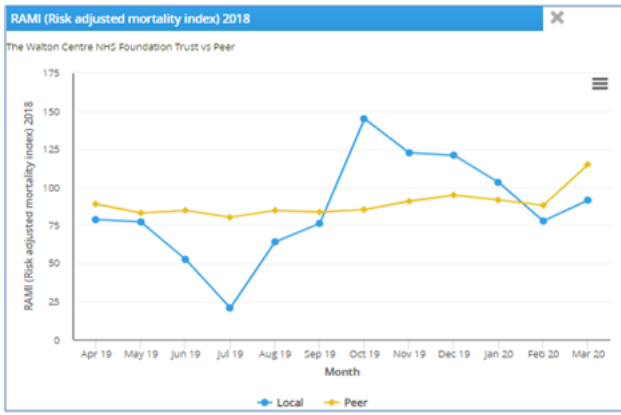
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	5	3	4	2	0	1	17	
Q2 19/20	0	2	3	2	4	2	0	13	
Q3 19/20	7	3	9	7	3	3	5	37	
Q4 19/20	1	2	4	3	6	7	2	25	**92**
Q1 20/21	8	7	2	7	2	3	6	35	

Deaths by Day of Week

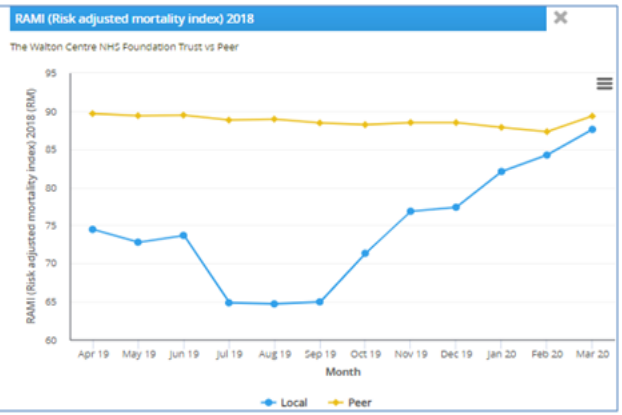
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	6	2	1	3	1	2	17	
Q2 19/20	1	2	1	2	2	3	2	13	
Q3 19/20	2	3	8	1	9	10	4	37	
Q4 19/20	3	2	8	3	1	5	3	25	**92**
Q1 20/21	4	3	6	6	10	4	2	35	

4: CHKS Mortality Data

RAMI18 by month



RAMI18 Rolling 12 month



During March 2020 there were eight deaths and in the RAMI18 model there were 8.73 expected deaths giving a RAMI18 position of 91.60.

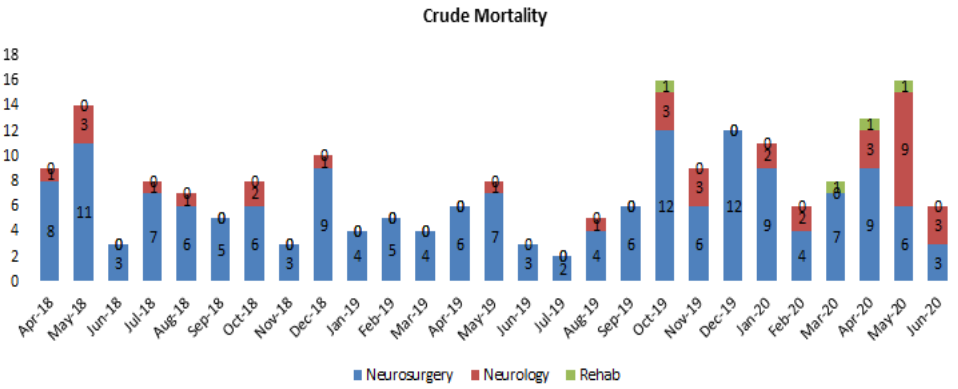
In the period between April 2019 to March 2020 there have been 93 observed deaths with the number of expected deaths from the model of 106.15 resulting in a RAMI18 figure of 87.61. This is 1.7 points below the peer average and places the trust in the interquartile range of the peer. The time series charts below show an increase in RAMI for Walton Centre from October 2019 and places Trust's RAMI above the peer average for four months. The rolling month chart (on right) shows the increase, however highlights that the Walton Centre remains below the peer average.

RAMI18 for HSMR condition groups March 2020

	Observed Deaths	Expected Deaths	RAMI 18 Index	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2018	8	7.41	107.98	77.72	84.8	92.75
109 - Acute cerebrovascular disease	4	4.28	93.44	58.57	78.41	92.47
233 - Intracranial injury	3	2.73	109.72	62.37	94.38	137.29
134 - Other upper respiratory disease	1		20594.35	237.38	180.81	393

RAMI18 for HSMR condition groups April 2019 to March 2020

CCS Group	Observed Deaths	Expected Deaths	RAMI 18 Index	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2018	70	82.71	84.63	80.54	86.82	94.93
109 - Acute cerebrovascular disease	35	42.07	83.20	84.31	91.79	102.26
233 - Intracranial injury	24	23.54	101.94	92.37	109.93	124.14
231 - Other fractures	5	1.66	301.52	85.07	108.32	129.66
42 - Secondary malignancies	3	8.84	33.93	56.25	74.76	83.53
38 - Non-Hodgkin`s lymphoma	2	1.17	170.81	74.71	93.91	102.11
134 - Other upper respiratory disease	1	0.03	3660.24	63.06	101.02	122.57



In March 2020 all of the eight total deaths were in the HSMR conditions

During April 2019 to March 2020 there were 70 observed deaths and 82.71 expected deaths giving a RAMI18 index of 84.63 this is below the peer average and in the interquartile range of the peer. The above table shows the six condition groups with observed deaths during the period compared to the peer.

Two of the condition groups had a RAMI18 index below the peer average and in the best performing quartile of the peer.
Three groups had RAMI18 indices in the worst performing quartile (marked in red). However, these conditions had five or fewer deaths in the 12-month period.

Quarter 2 (Q2) Morbidity & Mortality Report 2020-2021

Executive Summary

This report is a quarterly review of Morbidity & Mortality within The Walton Centre. It provides information from case reviews, readmission rates / trends, surgical site infections and in hospital deaths. Unless stated, figures relate to both Neurosurgery & Neurology combined.
As with Q1 Morbidity and Mortality report, the data from CHKS. Although this is not the full Q2 data it shows how we compare with our peers up to July 20. The Q2 mortality figures are detailed together with the avoidability scores for those cases that have had initial reviews. Again the CHKS data shows comparison with other Trusts.

Initial case note reviews are carried out for all death of inpatients in our care, a consultant uses a list of prompts to screen and then assign an initial avoidability score. All Deaths that are considered “definitely not avoidable” and require no further investigation are then presented at Divisional Mortality meetings. Despite the outcome of a patient death being classed as unavoidable, there can be learning either for clinicians at the Walton Centre or the referring hospital s. Case reviews will be frequently be discussed between divisional teams for learning purposes as there are a number of patients who require neurology and neurosurgery expertise..

During the initial review if concerns are raised the case is referred on for structured judgement review (SJR) as detailed in National Guidance. SJR is a validated methodology and involves trained clinicians reviewing medical records in a critical manner and to comment on phases of care and ultimately assign an avoidability score. If there is a significant concern raised at the time of a patient’s death this will be escalated to the Medical Director and Director of Nursing immediately. A rapid review of the patients care will be carried out. If this review finds any issues with a patient’s care, the patients’ family will be contacted to discuss this further and detail the method of investigation to be carried out. A ‘significant concern’ may be, when a death is sudden, unexpected or accidental, or where there may be a concern raised by the patients’ family that cannot be answered at the time.

COVID-19 restrictions continue to provide challenges in caring for patients and supporting their family and friends at the end of life. There have been 2 patient deaths where patients had developed COVID 19 after presenting with complex conditions and significant co-morbidities.

The Patient Experience Team continue to provide essential support for patients, their families and staff involved in caring for patients at end of life. A common concern raised by patient’s families is in relation to the restrictions with visiting during this difficult time. The Trust guidance is focused on supporting compassionate visiting arrangements for those receiving care at the end of life.

1 Admission data 1st April – 31st March 2020

The Neurosurgical & Neurological admissions and re-admissions are detailed below. Admissions in Q2 have increased due to the easing of COVID 19 restrictions. Understandably elective activity remains lower than 19-20.

1 Admission and readmission for Q2 2020

Q2 2020-21	July 20	Aug 20	Sept-20	Total
Admissions	338	321	328	997
Re-admissions	22	14	17	53
%	6.5	4.4	5.2	5.3

Table 2 Admissions and readmissions Q1 19- Q2 2021

Q	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Q1 20-21
A	1331	1290	1242	1198	601
R	74	63	56	52	22
%	5.6	4.9	4.5	4.3	3.7

CHKS Data Readmissions:

The table below (3) shows the readmission rate for Walton Centre for the reporting period. 86% of readmissions are recorded within the specialty of neurosurgery.
The trust has a readmission rate of 2.01% and is in the best performing quartile in comparison to the selected peer. Both elective and non-elective readmissions are in the best performing quartile.

	Total Readmitted Spells	Total Spells	Aug 19- July 20 Readmission Rate	25th Percentile	Peer Value	75th Percentile
Readmissions within 28 days; Age >16	184	9132	2.01%	7.10%	8.01%	9.05%
1 - Elective	91	7112	1.28%	3.59%	4.02%	4.84%
2 - Non-elective	93	2020	4.60%	11.25%	12.48%	13.07%

Table 3 Readmissions by admission type August 2019 to July 2020

Improvement for non-elective readmissions is noted in the second half of 2019 up to June 2019. An increase in non-elective readmissions is noted in July 2020. Elective readmissions have been stable for the whole year. The peer distribution highlights that the WCFT have the lowest crude readmissions rate in the peer.

Chart 1 Readmission time series chart and peer distribution August 2019 to July 2020

At a procedure level the numbers of readmissions are low, which skews the readmission rates.

Table 4 The highest volume HRGs are shown compared to peer for the period August 2019 to July 2020.

Readmissions within 28 days; Age >16	Total Readmitted Spells	Total Spells	Aug 19- July 20 Readmission Rate	25th Percentile	Peer Value	75th Percentile
A021 - Excision of lesion of tissue of frontal lobe of brain	10	77	12.99%	2.86%	6.28%	8%
U051 - Computed tomography of head	9	71	12.68%	12.78%	14%	14.95%
A559 - Unspecified diagnostic spinal puncture	9	437	2.06%	4.53%	6.23%	7.67%
V337 - Primary microdiscectomy of lumbar intervertebral disc	8	183	4.37%	5.41%	3.65%	11.76%
O033 - Percutaneous transluminal stent assisted coil embolisation of single aneurysm of artery	5	65	7.69%	9.09%	5.46%	16.67%

Table 4: Readmissions by HRG August 2019 to July 2020

Risk Adjusted Readmissions Index 2018 (RARI)

The CHKS risk-adjusted readmissions index (RARI) is an index comparing the observed number of emergency hospital readmissions with the number expected, having taken account of case mix. By doing so it provides a fairer comparison of readmissions than simple rates, particularly between providers with different patient characteristics.

RARI is expressed as a percentage. An index of 110% suggests 10% more readmissions than expected, whilst 90% suggests 10% fewer than expected.

2 Surgical Site Infection (SSI) data-Data collection regarding SSI has changed-September data is unavailable at the time of completion of the report.

Q2	July 20	August 20	September 20
Procedures	195	198	
Infection	2	1	
Infection Rates	1.03%	0.51%	

3: Mortality Q2 2020

There were **23** deaths in Q2; this shows a reduction of 12 (34%) compared to Q1 2020.This reduction can be explained as there had been an increase in patient deaths within the neurology division when the Trust was supporting Liverpool University Hospitals with the delivery of their stroke services.
All patients were emergency admissions, age range from 36 to 95 years. Of the patients who died in Q2, following discussion with patients (where possible) and families there were 21 DNACPR orders completed; one patient had a unified DNARCPR prior to admission. These patients and families we supported by the specialist palliative care and specialist organ donation teams.

There were 14 deaths in critical care, and 8 deaths due to Stroke. 7 Of these 8 patients 7 deaths occurred on Sherrington ward. This increase in patient deaths in one area has been acknowledged by the Senior Nursing team who will liaise with the Trust psychology service to provide additional support to staff.

During Q2 There has been 1 unexpected death in critical care relating to dislodgement of a tracheostomy tube, which following rapid review has been reported to our Commissioners in line with the Trust external reporting policy. A serious incident review has been commissioned by the Medical Director. There have been 22 deaths requiring initial reviews, there are 4 outstanding reviews. All other deaths have been given an avoidability score of 6, (definitely not avoidable). There were several examples of discussion and learning together with issues for feedback to referring hospitals.

These issues related to,

- Documentation on the electronic referral system (ORION).
- An incorrect neurological assessment during a patient referral.

There was 1 death of a patient in Q2 known to have learning difficulties this will be subject to further review using the LeDeR process

During the Q1, one patient death was considered; this was subject to a full SJR including a dedicated cross divisional mortality review. The outcome of the review together with the support offered to the family is detailed in the attached case history. (Appendix 1)

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3:1 Quarterly Analysis – Neurosurgery and Neurology

Deaths by Admission Day of Week- There was no significance identified in relation to day of the week of admission

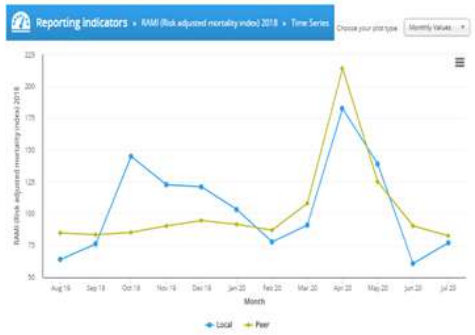
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	5	3	4	2	0	1	17	
Q2 19/20	0	2	3	2	4	2	0	13	
Q3 19/20	7	3	9	7	3	3	5	37	
Q4 19/20	1	2	4	3	6	7	2	25	**92**
Q1 20/21	8	7	2	7	2	3	6	35	
Q2 20/21									

Deaths by Day of Week- There was no significance identified in relation to day of the week of the patients death.

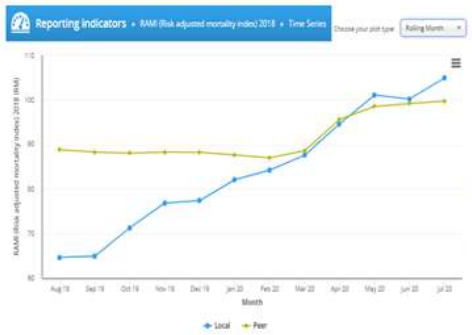
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	6	2	1	3	1	2	17	
Q2 19/20	1	2	1	2	2	3	2	13	
Q3 19/20	2	3	8	1	9	10	4	37	
Q4 19/20	3	2	8	3	1	5	3	25	**92**
Q1 20/21	4	3	6	6	10	4	2	35	
Q2 20/21									

4: CHKS Mortality Data,

RAMI18 by month



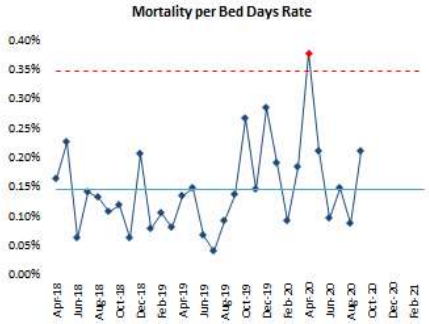
RAMI18 Rolling 12 month



During July 2020 there were eight deaths and in the RAMI18 model there were 10.36 expected deaths giving a RAMI18 position of 77.20 for the month. In July there was a reduced number of monthly deaths as it was seen in June, when compared to April and May 2020 with none of the eight deaths coded with COVID-19.

In the period between August 2019 to July 2020 there have been 117 observed deaths with the number of expected deaths from the model of 111.55 resulting in a RAMI18 figure of 104.89. This is 5.69 points above the peer average and places the trust towards to the upper quartile in the peer distribution. The monthly time series chart below show an increase in RAMI for Walton Centre in April and May 2020 and the Trust's RAMI noted to be above the peer average for five months in the last year. The rolling month chart (on right) shows the increase, in both the trust RAMI and the peer RAMI in the last five months, however the trust has moved from being below the peer to being slightly above the peer rate.

Mortality per Bed Days Rate



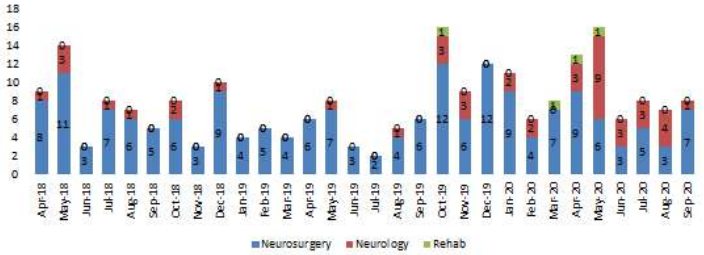
RAMI18 for HSMR condition groups July 2020

Description	Observed Deaths	Expected Deaths	RAMI18 Index	25th Percentile	Peer Value	75th Percentile
July 2020 RAMI (for HSMR conditions)	8	8.07	99.18	67.06	78.54	86.19
109 - Acute cerebrovascular disease	6	6.05	99.24	80.09	95.47	117.46
233 - Intracranial injury	2	1.17	170.63	47.95	86.25	102.96

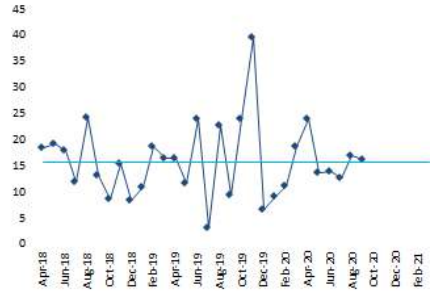
RAMI18 for HSMR condition groups August 2019 to July 2020

Description	Observed Deaths	Expected Deaths	Aug 19- July 20 RAMI18 Index	25th Percentile	Peer Value	75th Percentile
HSMR Conditions	85	89.21	95.28	82.3	89.89	98.66
109 - Acute cerebrovascular disease	45	53.79	83.66	82.49	94.81	103.32
233 - Intracranial injury	28	19.95	140.34	83.1	109.17	126.97
231 - Other fractures	6	1.36	440.02	97.29	111.62	131.76
42 - Secondary malignancies	3	7.03	42.7	48.12	71.84	82.61
38 - Non-Hodgkin's lymphoma	2	1.44	138.73	58.55	85.19	92.26
134 - Other upper respiratory disease	1	0.04	2733.76	60.03	114.66	143.79

Crude Mortality



Mortality Average Length of Stay



During August 2019 to July 2020 there were 85 observed deaths and 89.21 expected deaths giving a RAMI18 index of 95.28 this is above the peer average. The above table shows the six condition groups with observed deaths during the period compared to the peer.

One of the condition groups had a RAMI18 index below the peer average and in the best performing quartile of the peer.
The intracranial injury group is within the worst performing quartile of the peer. The charts below show this was due to a spike in April 2020, when there were four deaths (slightly higher than average), however the expected deaths were 0.79. All of the deaths followed an emergency admission.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
November 2020

Title	**Terms of Reference for Strategic BAME (Black, Asian and Minority Ethnicity) Advisory Committee and Brief Summary of Inaugural Meeting**
Sponsoring Director	Name: Title: Hayley Citrine
Author (s)	Name: Hayley Citrine Title: CEO
Previously considered by:	Executive Team Strategic BAME Advisory Committee

Executive Summary

Following the agreement in Julys Trust Board to support the establishment of the Strategic BAME Advisory Committee that will report into Trust Board quarterly; attached is the terms of reference for the committee agreed by the committee and here for consideration and approval.

The committee has had its first meeting this month, which was well attended, the committee agreed the terms of reference, reviewed the July Trust Board paper and actions, heard from the North West Strategic BAME Advisory Committee and the internal Trusts groups to set the scene. The committee then reviewed both staff and patient BAME data to help review key areas of action and next steps.

Furthermore representatives were agreed from the committee to review all national Board recommendations - establish the most applicable and to prioritise for The Walton Centre. Finally volunteers were agreed from the committee to be part of the tactical COVID command in the Trust; to ensure the interests of both BAME patients and staff groups are embedded as part of our processes.

Now the committee has been established it will report to Trust Board on progress quarterly, this will be at Januarys Trust Board following the next meeting of the committee in December.

Related Trust Ambitions	• Deliver best practice • Lead research, education and innovation • Be recognised as excellent
Risks associated with this paper	• Risk of not having terms of reference would mean lack of clarity on committees function and ability to be held to account
Related Assurance Framework entries	• Several BAF risks are associated with the strategic ambitions and in particular new ways of working during pandemic – the committee provides direction in this year's approach to help mitigate some of those risks further.
Equality Impact Assessment completed	• Yes, disadvantages white and non BAME staff and patients, as focus exclusively on BAME staff and patients due to the inequalities they face e.g. with COVID -19
Any associated legal implications / regulatory requirements?	• Good practice rather than legal implications. It is anticipated new CQC inspections will focus on equality, diversity and inclusion particularly BAME challenges so will be a positive example of evidence
Action required by the Board	• To discuss terms of reference and summary. • To ratify terms of reference, note short update and that further report to Board due January 2021.

Strategic BAME (Black, Asian, Minority Ethnic) Advisory Committee

Terms of Reference

1.0 CONSTITUTION:

1.1 The Walton Centre NHS Foundation Trust's (WCFT) Strategic BAME Advisory Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

1.2 The Strategic BAME Advisory Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Strategic BAME Advisory Committee.

1.3 The Strategic BAME Advisory Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its function.

1.4 The Strategic BAME Advisory Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2.0 PURPOSE:

2.1 The purpose of the Committee is to provide the Board with assurance that;

- The ongoing strategic approach to fairness and equality for BAME staff and communities is robust, timely, addresses inequalities and actively promotes inclusion. This includes the impact of COVID-19 for BAME staff and communities.

3.0 DUTIES AND RESPONSIBILITIES:

3.1 The duties of the Committee can be categorised as follows;

To inform the development and provide assurance against the following strategies, associated policies, action plans and annual reports:

- People Strategy related to BAME
- Equality, Diversity and Inclusion Vision and work related to BAME
- Workforce and patient population strategies, policies or plans related to BAME staff or communities
- The Trust Strategy in relation to BAME

3.2 BAME Equality:

a) To agree the Trust-wide ED&I priorities to establish and maintain equality for BAME staff and patients and oversee the development and implementation of those priorities.
b) Regularly receive updates from the ED&I vision group work and sub group works and the North West Strategic Advisory Committee to enable the committee to understand challenges and opportunities to strengthen equality, address inequality and actively promote antiracism moving towards unconscious inclusion.
c) Review national and regional reports, recommendations and best practice; agree Walton Centres approach and prioritisation of these. Furthermore monitor progress until completion.
d) To analyse own data to prioritise areas of focus and establish quantative and qualitative metrics to be able to measure for improvements in relation to BAME staff

and patient outcomes.

e) To consider supporting approaches, services or actions required to realise ambitions and advise the Trust Board accordingly.

3.3 Policies:

To consider and approve relevant policies, procedures and guidelines in relation to equality, diversity and inclusion related to BAME staff or communities and to escalate to the Trust Board, with an appropriate recommendation, any that may require approval at that level.

4.0 MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following membership:

Members:

Dr Elaine Anderson	Consultant Anaesthetist
Hayley Citrine	Chief Executive (CHAIR)
Mark Foy	Head of Information and Business Intelligence
Jacqui Isaac	Staff side representative
Julie Kane	Quality Manager and Freedom to Speak Up Guardian
Dr Anita Krishnan	Consultant Neurologist, Clinical Director Neurology
Andrew Lynch	Equality and Inclusion Lead
Dr Gashirai Mbizvo	Specialist Registrar
Jane Mullin	Deputy Director of Workforce and Innovation
Dr Farouk Olubajo	Clinical Fellow
Sue Rai	Non-Executive Director
Dr Andrew Rose	Head of Commercial Engagement and Marketing
Mini Saju	SMART Team, ITU
Nasser.Shaikh	EPR Programme Manager
Lindsey Vlasman	Deputy Director of Nursing and Governance

4.2 Members are expected to attend a minimum of 75% of Committee meetings during each financial year.

4.3 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director or Deputy Director Of Workforce and Innovation will chair the committee.

4.4 Other Officers of the Trust shall attend at the request of the Committee if it is considered appropriate due to the nature of the business being discussed.

4.5 An open invitation exists for all members of the Board of Directors to attend the Committee.

4.6 **Quoracy**

The Committee will be deemed quorate provided five members are present including:

- At least one Board Member
- At least two BAME members
- At least one clinical member
- At least one corporate member

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES AND MANAGEMENT GROUPS:

5.1 The Committee will report in writing to the Board of Directors quarterly including a summary of the progress and discussions undertaken and make any recommendations to the Trust Board as required.

5.2 The Committee shall maintain an effective relationship with the North West Strategic BAME Committee and the WCFT's ED&I Group/sub groups ensuring information is shared between groups/committees and the committees work compliments the regional and other approaches.

6.0 PROCEDURAL ISSUES:

6.1 **Frequency of meetings.**
The Committee will normally meet on a bi-monthly basis and as a minimum four times per year.

6.2 Additional meetings may be held on an exceptional basis at the request of or to the Chair of the Committee.

6.3 **Minutes.**
The minutes of meetings shall be formally recorded, checked by the Chair and submitted for agreement at the next meeting.

6.4 **Annual Work Programme**
The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed annually to ensure the Committee is meeting its duties.

6.5 **Administration**
The Committee shall be supported administratively by the Chief Executive's PA, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas

7.0 EQUALITY ACT (2010)

7.1 The Committee will ensure the Trust meets its obligations under the Equality Act 2010 in relation to the remit of the Committee

8.0 REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

Approved by Strategic BAME Advisory Committee September 2020

Approved by Trust Board September/October 2020

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 5th November 2020

Report Title	**Chairs Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Jane Hindle, Corporate Secretary
Purpose of Paper:	
The Audit 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 the Board of the meeting of the Audit Committee held on 20th October 2020	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

The audit committee recommended the proposed amended limits to the Scheme of Reservation and Delegation for Board approval.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Divisional Assurance Presentation

The Committee received a presentation from Neurology Division detailing the governance and assurance structure within the Division. It was noted that the corporate structure was mirrored within the Division to ensure consistency in approach. An update on Divisional Assurance processes would be provided every 6 months regarding changes in any risks.

b) *Audit Committee role in 'Deep Dive' work*

The committee agreed that deep dive work would be owned by Board sub-committees and presented to the Audit Committee if there was a failure in the process. Mechanisms to escalate deep dive work to the Committee would be introduced to these appropriate Board sub-committees.

c) Annual Report – Theatre Consumables Audit

The Committee received the final report of the theatres consumables audit which completed the work set out in the 2019/20 audit plan. Recommendations from the report had been completed and assurances provided that robust controls were in place to mitigate any potential fraud risk.

d) Internal Audit Progress Report Q2

The Committee agreed to requests for amendments to two audit timescales with audits around exit interviews and the review of SMART to be deferred to 2021/22. Assurances were provided that this would still provide sufficient work to provide substantial assurance.

e) Internal Audit Recommendations Report

The Committee received the internal audit recommendations report and it was noted that work would be undertaken within the relevant teams to review each recommendation to clarify if anything had been completed, superseded or was incorrect and had not been communicated to the internal audit team.

f) Losses and Compensations Benchmarking Briefing Note

A briefing note was received detailing the benchmarking process undertaken to compare the Trusts losses and compensations with those of a sample of comparable Trusts and it was noted that there

were significant reporting differences between each Trust and therefore the Trust would use its own historical data as a means of comparison.

g) External Audit Progress Report

The Committee received the external audit progress report and noted the requirement of a new Value for Money audit following a review and update of the code of practice by the National Audit Office. Guidance around this was still being finalised and it was recognised that this would require a fee variation for 2020/21. An overview of the outcome of the Redmond Review was also presented with an overview of key recommendations provided.

h) Executive Response to Challenge Questions

The Committee noted Executive response to challenge questions posed in the external audit progress report and it was recognised that this provided good assurance that the Trust was dealing with the challenges and issues raised. Themes of the challenge questions posed included queries around the Trusts strategy to resume services, the scrutiny of current clinical information, work to address race inequalities, reviewing the strategy for meeting the mental health needs of the local population, the impact of technology on Trust operations and a review of the Trust people plan.

i) Tender Waivers

The committee received a report of tender waivers made in quarter 2 of 2020. There had been 3 occasions where a waiver had been provided. One related to the Trust allocation of a regional purchase of clinical gowns in regards to COVID-19. The second waiver related to Liverpool Health Partnership and the Trust is now looking to put this on a purchase order. The third waiver related to the maintenance contract for the Kinevo microscope and the Trust is now looking to put this on a purchase order.

j) Aged Debt Report

The Committee received the aged debt report and an overview of the largest debts was provided. Assurances were provided that work was ongoing to recover these debts and the finance team met to review aged debts each week.

k) Bad Debt Write-Offs

The committee noted the three proposed bad debt write offs presented totalling 56,874. It was highlighted that each of these related to oversees patients who had since left the country and 75% of the cost of each invoice had been received from South Sefton CCG. Assurance was provided that there would be no impact on the financial performance of the Trust.

l) Committee Cycle of Business 2020-21

The Committee noted the cycle of business for 2020-21.

m) Review of Committee Terms of Reference

It was noted that the incorrect version of the Terms of Reference had been provided for review, this would be updated prior to further submission to the Committee for approval.

n) Quality Account

The Committee received the Quality Account for the year 2019/20 and noted that the priorities for the year had all been achieved. The Quality Account had been signed off by Healthwatch prior to being presented to NHSE/I and the CCG and it was highlighted that joint feedback from NHSE/I and the CCG was awaited. Following receipt of this feedback the Quality Account would be published on the Trust website.

o) Annual Review of Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation

The Committee noted the annual review of Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation noting that the only amendment this year was the thresholds to the OJEU framework.

p) Scheme of Reservation and Delegation Limits Benchmarking and Proposed Limits

The Committee recommended the revised approval limits proposed for Board approval noting that these would only take effect when the current emergency powers ended.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan and there have been no deferred matters during the year. Areas of focus for the coming meeting will be

- Timetable for the preparation of the Financial Statements 2020/21
- External Audit Plan & Fees for 2021-22
- Tender Waivers
- Counter Fraud Progress Report

The Walton Centre NHS Foundation Trust

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REPORT TO TRUST BOARD
5th November 2020

Report Title	**Chair's Assurance Report – Quality Committee 22 October 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 22 October 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Nosocomial Infections and Risk Register with regards to staffing levels across the Trust.
- Service Improvement Presentation & Covid Debriefing sessions for staff.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Medical Director's update
Dr. Nicolson provided an update regarding the current impact of Covid-19. The Executive Team are involved in various regional calls due to the rapid rise in regional covid case, with local trusts needing to cancel elective cases. WCFT are in negotiation neighbouring with regards to mutual support for head and neck cancer and in rehab. Concerns were raised with regards to staffing and the impact of contact tracing on staffing levels.

The GiRFT meeting took place remotely and feedback has been positive.

b) Integrated Performance Report
Ms Vlasman highlighted key points from the report noting that further work regarding the risk assessments is still on-going with the Divisions and Mr. Foy, Head of IT & Business Intelligence. There were two SUIs (unexpected cardiac arrest, unstageable pressure ulcer). It was noted that Divisions are undertaking a deep dive with regards to MSSA and E-Coli following increases in infections. Currently there have been seven MSSA infections with a Trust trajectory of 8 cases for the year. Attention was also drawn to the increases in VTE. This increase is due to Pulmonary Embolism cases in Covid patients.

c) Board Assurance Framework (BAF)
Ms Vlasman explained the three risks on the BAF pertaining to Quality Committee, namely Risk ID001 Coronavirus, Risk ID004 Harm to staff from patients and risk ID005 failure to deliver the benefits of the Quality Strategy. Ms Vlasman advised that the risk score for ID004 will remain at 12 as incidents had increased but could be attributed to three patients and future incidents are to be monitored. The risk score for ID005 will also remain the same. The Trust is endeavouring to deliver the aims of Quality Strategy but larger initiatives may be delayed due to Covid-19.

d) Mortality and Morbidity Report Q2
Dr. Nicolson provided an overview of the report noting that the number of deaths had decreased from April/May which was expected. The report included a detailed review of a particularly difficult case which highlights the challenges of such case to the Quality Committee. Mr. Foy provided an explanation of RAMI data.

e) Equality, Diversity & Inclusion (E,D&I)Update
Mr. Lynch provided an update on the WRES data and noted that that further work is required in this area. Attention was drawn to the formation of the strategic BAME advisory group which will also undertake focussed work on recruitment. Updates were provided with regards to reasonable adjustments, the E, D & I Champions and work in conjunction with schools to promote jobs in the NHS.

f) Infection Prevention & Control Report Q2
Ms. Vlasman gave an overview of the report. It was noted that the Surgical Site Infection data is not correct. This was recorded as an action for the IPC lead nurse to investigate further.

g) Service Transformation – Update during Covid-19
Mr. Davies, Head of Service Transformation delivered a presentation outlining the service transformation initiatives undertaken during the covid -19 pandemic which included the following:-

- IT systems updated to enable Agile Working to be put in place
- Virtual Attend Anywhere appointment system for patients which also included positive feedback from patients.
- Relocation of Stroke services
- Transfer of Head and Neck cancer services.
- Updates on PPE and procurement
- The introduction of relative telephone lines

h) Governance & Risk Management Report Q2
The following points were highlighted from the report:-

- The Risk Register has been reviewed and three new risks added.
- There was an increase in moderate incidents from Q1 to Q2
- There was one RIDDOR incident relating to staff injury
- GAF ref 309 increase in MSSA incidents which are being investigated by Divisions.
- FFT reporting is on hold until January 2021

i) Quality Committee Terms of Reference
The committee agreed to the addition of the Equality, Diversity and Inclusion Group to the Quality Committee Terms of Reference.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan. MECC is to be removed from the work plan as this is not expected to be resumed until April 2021.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
5 November 2020

Report Title	**Chair's Assurance Report – BPC 27 October 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 27 October 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Detailed discussion around the finance framework and planning submission.
-

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Finance Framework and Planning Submission
The Committee were presented with an update on the current situation around the financial framework and noted there had been several changes of late that potentially have a significant impact on foundation trusts. The presentation outlined what this meant for governance and reporting for trusts. It also covered the latest national financial framework together with the key points around financial planning for months 7-12. The final submission to the HCP on 19 October resulted in a forecast of £1.53m deficit which was based on the agreed methodology across the system for allocation of COVID and growth income (although this may be subject to further change). This financial position was also submitted to NHSI/E in a detailed financial submission on 22 October. The presentation would be shared at the forthcoming Trust Board meeting with Non-executive Directors suggesting that a paper be prepared giving an explanation as to why CIPs could not be delivered at the present time. The Committee noted the current situation and acknowledged that it was worrying that a lot of control and governance for trusts had been taken away.

b) Integrated Performance Report
Operations – The Committee were referred to the summary of KPIs which showed cancer performance had remained above target as the Trust had continued to prioritise this activity. Underperforming measures were highlighted but the Committee were asked to note that they were starting to improve. The IPR continued to look at activity rather than performance.

The Committee received an update on the current Covid position in the Trust and across the region.

Finance – The Trust broke even in month 6 as per national guidance but did require a £760k top up (confirmation of this had not been received which could be a potential risk). The Committee were updated on the capital position and it was envisaged would go over and above the capital plan but following the Capital Management Group meeting there did seem to be some options available to bring capital back to plan. Cash remained in a healthy position at £41.6m in the back equating to 123 days of operating costs.

Workforce – The Committee were updated on the current workforce position. Turnover had come down but recruitment remained a challenge. The sickness figures were explained with 5.75% of staff of sick and 3% on special leave, 38 staff were currently self-isolating. It was acknowledged this was a difficult situation to manage on a day to day basis.

c) Transformation Programme Update (Covid Lessons Learnt)
The Committee received a presentation on Covid-19 *the positive impact* which provided updates on the new way of working; service delivery response; HR response; feedback from both staff and patients and getting the balance right going forward. Discussion took place on agile working; home working and how staff were supported to maintain health and wellbeing. The Committee acknowledged an informative piece of work.

d) Follow Up Waiting List Briefing Paper
Following a request by a Non-executive Director at a previous meeting the Committee were updated on the current position. It was noted that following an improvement in the position there had been significant deterioration in March and April 2020 due to the cancellation of routine activity in response to COVID. The paper set out the next steps to address the issue. It was confirmed an update is regularly received by Executive Directors and at the Neurology Performance meeting. Updates would continue to be provided within the IPR and reported by exception to BPC if required.

e) Board Assurance Framework
The Committee received the BAF noting no shift in risks primarily due to Covid. The two emerging financial risks were highlighted relating to Capital Allocation and Financial Plan 2020/21. Target risk scores would be discussed at the forthcoming Executive Team meeting. The Committee agreed that the BAF risks were appropriate and would be discussed in greater at Trust Board on 5 November. It was requested that any further comments be passed to Ms Hindle.

f) Cycle of Business
This was noted and acknowledged that the work load was evenly spread.

g) Neurologic Consignment Agreement for Radiology
The Committee were briefed on the consignment stock supplied by Neurologic for radiology stents, microcatheters and embolization devices. In the past month it had been requested by clinicians that the range of products be increased and this amounted to an increase of £9k to the previously agreed value. Following assurance around any risks the Committee agreed to the uplift and approved the Consignment Agreement to a value of £146,395.

h) E Rostering Update
The Committee received the report detailing the current situation with regards to the development and implementation of a pilot E-rostering system with Skills for Health (S4H) and were updated on the limited level of functionality compared to other comparators on the market. The paper contained various options for consideration with the preferred option being a direct award to Allocate (the current market leaders) via the Framework. It was acknowledged the current system worked well for medics and would remain in place for that function. Discussion took place around funding issues; implementation; compatibility with the present system and time frames. The Committee agreed that a paper would return to the meeting in January 2021 with an update on funding and impletion and it was agreed the cost of the current system that would remain in place be factored in to any business case.

i) Pain Service Options and Key Actions Update
The Committee were presented with a paper setting out the key actions taken in order to mitigate the observed increase in demand for Pain services as a result of a reduction in the service across C&M and Wales during 2019/20. From October 2020 the Trust would no long accept GP referrals and would only provide a Tier III service which was detailed in the paper. The transfer of day case activity to Halton would continue. The Committee noted the actions taken to date.

j) Transformation Strategy

The new 5 year Strategy was presented for consideration and recommendation for approval at Trust Board. The document set out the strategic transformation plan for the coming 5 years covering service redesign and reform to enhance and improve health and wellbeing for patients. Transformation priorities would continue to cover the redesign of outpatient services; theatres and patient flow. In order to deliver these programmes of work the governance structure was outlined together with the risks recognising the most fundamental being cultural. It was agreed that communication would play a key role in addressing the cultural change and Dr Rose would work on this with the Communications Team. The Strategy would be recommended by the Committee to Board for approval.

k) People Strategy

An update of the People Strategy was presented reflecting key issues and actions from the "*We are the NHS People Plan 2020/21, action for all of us*. Objectives had been based on what was contained in the national plan and the Trust's own objectives. The two main themes that had arisen from the national plan were staff health and well-being and flexible working. It was considered that a lot of the objectives would be met by March 2021. The update against the Strategy was noted with further updates to come back to Committee in January and April 2021.

l) Finance and Procurement Strategy

The update against the Strategy covered an overview of the last 12 months covering achievements and challenges and the goals and ambitions for the year ahead. The main focus of the strategy was to support the delivery of the Trust strategy and explanation was provided on what that meant for both Finance and Procurement departments. The Committee were updated on how the teams had adapted to agile and home working with approximately 95% of staff currently working from home. Non Executives noted that it was good to see that Finance was driving the organisation forward and the development of PLICS and SLR reporting would see more emphasis to deliver costs savings and understand cost drivers and benchmark against other trusts. The update against the Strategy was noted by the Committee.

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 THE TRUST BOARD

Thursday 5 November 2020

Title	2019-20 Education and Training HEENW Self-Assessment Report: Executive Summary
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Dr Charlotte Dougan Title: Director of Medical Education Name: Zoe Kershaw Title: Senior Education Manager Name: Liz Doherty Title: Medical Education Development Manager
Previously considered by:	• Committee – Research, Innovation and Medical Education Committee on 04/11/20

Executive Summary

HEE has requested a comprehensive self-assessment from all trusts, covering medical education but also looking at the wider education offering to staff. The format is an overarching report for all learners on accredited training programmes associated with the Trust. This is the second multi-disciplinary self-assessment report on education which has been requested by HEE; the format has been amended based on feedback from trusts following submission of the first report in 2018.

There is a requirement for the return to be approved by Board.

Please note the SAR is submitted via an online portal. The full document is available via virtual board.

Related Trust Ambitions	Delete as appropriate: • Research, education and innovation • Be recognised as excellent in all we do
Risks associated with this paper	Numerous – associated with staff development, competence, motivation, recruitment and retention. There is also a financial risk in ensuring the programme is viable.
Related Assurance Framework entries	BAF risk 006 - If the Trust does not attract, retain and develop sufficient numbers of qualified staff then it may be unable to maintain service standards leading to service disruption and increased costs.
Equality Impact Assessment completed	No – The provision has been impact assessed not the return.
Any associated legal implications / regulatory requirements?	Yes – HEE statutory requirement.
Action required by the Board	The Board is requested to: Approve the return

REPORT TO TRUST BOARD

Thursday 5 November 2020

EDUCATION AND TRAINING SELF-ASSESSMENT REPORT 2019-20: EXECUTIVE SUMMARY

Introduction

The Trust is a Local Education Provider and has an educational contract with Health Education England (HEE) known as the Learning and Development Agreement. HEE introduced a comprehensive self-assessment report (SAR) in 2018 required from all trusts, principally covering medical education but also looking at the wider education offering to staff. The format is an overarching education and training report for all learners on accredited training programmes associated with the Trust. This is the second multi-disciplinary self-assessment report on education which has been requested by HEE; the format has been amended based on feedback from trusts following submission of the first report in 2018.

In 2019/20, the total education contract was worth £2.76 million.

There is a requirement for the return to be approved by Board. The full return is entered on an online system and the background document is available via the Research, Innovation and Medical Education Committee.

2020 Education and Training Self-assessment Report (SAR)

The report is a combination of multi-professional (non-medical healthcare), undergraduate and post graduate medical education. Questions are asked in relation to the HEE priorities for 2020 against the 6 domains of the HEE Quality Framework:

1. Learning Environment and Culture
2. Educational Governance and Leadership
3. Supporting and Empowering Learners
4. Supporting and Empowering Educators
5. Developing and Implementing Assessment and Curricula
6. Developing a sustainable workforce.

There are additional, supplementary self-assessment reports on the following subjects:

- Equality, Diversity and Inclusion
- Incidents and Coroners
- Library Services
- Patient Safety, Human Factors and Simulation
- SAS and Specialist Doctors.

Essentially, the report is the Trust's self-assessment of the extent to which we are successfully meeting the domains of the HEE Quality Framework.

Summary

The Walton Centre is able to demonstrate that it is a learning organisation committed to developing a sustainable workforce, not only for the organisation but the wider health system. Achievements highlighted include CQC Outstanding (2016 and 2019), consistently high standards of learner satisfaction on local and GMC annual surveys and the accreditation of the Neurosciences Masters Module, developed in collaboration with Liverpool John Moores University. In addition to this, the Trust became a Navajo Chartermark Assessor in 2019 which alongside the Building Rapport programme, is evidence of the inherent organisational support available to learners of a diverse background.

The report demonstrates a strong ethos of supporting and developing staff, reflected in the on-going commitment to further study and development for all staff/learners including matching CPD funding support. There is parity of access to medical study leave with equitable budget allocation for SAS staff development and other Trust employed medics. The Trust works in collaboration with numerous partners including Health Education North West (HENW), the University of Liverpool (UoL) and other higher educational institutes (HEIs) such as Bangor University and Edge Hill, local trusts, such as LUHFT as well as other strategic healthcare bodies e.g. Liverpool Health Partners.

The Walton Centre has a strong and growing interest in leading and developing innovative medical practice and has a well-established research programme delivered on site.

<u>Undergraduate Education</u>

The undergraduate medical programme was assessed by the University of Liverpool in 2017 as delivering a high level of specialist training that the students could experience whilst on placement and student experience remains very well evaluated. The formative end of placement assessments were highlighted as an area of good practice and have been adopted across other trusts hosting undergraduate placements in the region. 2019/20 saw a marked reduction in undergraduate medical placements due to programme restructuring by UoL, however, the Trust demonstrated significant agility and innovation in the development of a redesigned undergraduate placement (operational from September 2020). The multidisciplinary aspects of the programme reflect the collaborative ethos of The Walton Centre with input from specialties and professions across the spectrum of Neuroscience.

Areas of Best Practice

This return has identified areas of best practice including:

- Undergraduate Medical Education provision – very high level of student satisfaction continues with formal and informal placement feedback commending the Trust for quality of teaching and pastoral support/clinical supervision provided
- Consistent postgraduate training evaluation via external regulators GMC and HEE NW Postgraduate Schools - excellent or very good in multiple domains across Neurology, Neurosurgery and Anaesthetics
- Trust surgical teaching received Excellence in Neurosurgical Education 2020, as assessed by HEE NW School of Surgery
- Commitment to development of Research, Innovation and Medical Education as a collaborative unit; appointment of Innovation Clinical Lead, only second UK trust to do so
- Neuroscience network and collaboration
- Rehabilitation module – 'Complex Rehabilitation in a Multi-Disciplinary Context' developed with Liverpool John Moores University
- ITU/Theatre Simulation
- Organisational membership of Faculty of Medical Leadership and Management, demonstrable commitment to consultant CPD
- Investors in People (IIP) Gold re-accreditation, formal external recognition and accreditation of commitment to staff health and wellbeing

Areas of Challenge or Risk

The report also identifies gaps or areas which present challenge or risk to the delivery of quality education and training:

<u>Trust Wide</u>

- (Sustainability of) matching CPD funding support for staff following external funding reductions
- The implementation of the apprenticeship agenda and challenge to backfill
- Continuing to maintain a learning culture in the face of increasing organisational demand – higher student numbers across all professions and managing ward capacity/logistics of having them on site alongside increasing service activity (all have been amplified by COVID restrictions)

Multi-professional

- Introduction of new systems and enabling IT access for education facilitators to undertake roles effectively (e.g. accessing ESR)
- Addressing the problem of newly qualified staff relatively little Neuro experience joining the specialist trust, particularly felt in SALT and other
- Addressing skill shortages e.g. in Neurophysiology

Postgraduate

- Challenges enabling quality education CPD to take place
- Consultant engagement in teaching and education – reluctance to take on additional work, limited time for some consultants in job planning with tension between education and service demands
- Medical workforce planning - balancing increased service demands in Neurosurgery against fluctuating higher trainee doctor numbers
- Addressing challenges presented by redesigned postgraduate core training programmes; managing rotational trainee experience in addition to ensuring learning outcomes are attainable.

Undergraduate

- Addressing the problem of resilience within education faculty and consolidated educational leadership
- Hospital and consultant teaching capacity to host increased student numbers and demanding curricula and assessments from UoL.

Simulation and Human Factors

- There is a requirement for further investment in formal training for the Trust's lead who is the Clinical Lead for Education and Development (operating theatres)
- Need to expand the scope of simulation training to include ergonomics and research methods
- Current delivery is ad hoc in nature (15 separate simulations this year) so could be moved into a more formal and structured programme.

Next Steps

The Trust will receive an action or improvement plan from HEE based upon the self-assessment return.

The Walton Centre
NHS Foundation Trust

REPORT TO TRUST BOARD
5TH November 2020

Title	**Annual review of Standing Financial Instructions and Scheme of Reservation and Delegation**
Sponsoring Director	Mike Burns Director of Finance and IT
Author (s)	Zoe Stevenson Financial Accountant
Previously considered by:	Audit Committee – October 2020

Executive Summary

The SFIs and SORD are reviewed annually to ensure they continue to reflect best practice. They were previously reviewed in October 2019 by the Audit Committee and changes were approved by the Board.

Minor changes are required to reflect the change in Financial Accountant, the change in name from NHS Protect to NHS Counter Fraud Authority and a change to the EU threshold tender limits as below.

- £189,330 (excl VAT) Goods/Services Contracts
- £4,733,252 (excl VAT) Works Contracts
- £663,540 (excl VAT) Social & other specific services (Light Touch)

The paper sets out further proposed changes following a benchmarking exercise conducted by the Trust's auditor. The proposed changes were considered and supported by the Audit Committee.

The documents are available in full within Virtual Board.

Action required by the Board	The Board is requested to: • Consider the benchmarking exercise • Approve the proposed changes to the Standing Financial Instructions and Scheme of Reservation and Delegation
Related Trust Ambitions	1. Deliver best practice care and treatments on our specialist field. 2. Provide more services closer to patient's homes, driven by the needs of our communities, extending partnership working. **3. <u>Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff.</u>** 4. Lead research, education and innovation, pioneering new treatments nationally and internationally. 5. Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family centred care. 6. Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing
Risks associated with this paper	

Related Assurance Framework entries	
Equality Impact Assessment completed	
Any associated legal implications / regulatory requirements?	

The Walton Centre
NHS Foundation Trust

Scheme of Reservation and Delegation (SORD) Limits Benchmarking and proposed limits

Introduction

The finance department have been asked to review the current SoRD financial limits within the organisation to ensure that they are still relevant and meet the needs of the organisation or whether they need to be amended to reflect the current NHS environment. The current SoRD financial limits have been in place for a number of years and have not materially changed during this time. As a result of the COVID pandemic the approval limits had started to be reviewed and this culminated in emergency powers being put into place. To note that at the time of writing the emergency powers remain in place. It is felt that a more substantive review needs to be undertaken to see whether any long term changes to SoRD financial limits should take place.

This paper reviews the Trust's SoRD expenditure limits and compares with a sample of comparable Trusts within the North West. The paper will then propose new SoRD expenditure limits based on the benchmarking information.

Overview

The current SoRD financial limits have been in place for a number of years with no material changes during this time. Emergency SORD financial limits were implemented (under clause 5.2 of existing standing orders) in response to the COVID-19 pandemic (approved by Trust Board in April 2020). It was agreed when the emergency powers were authorised that a further paper would be prepared looking at delegated approval limits for 'Business as Usual'. The table below shows the emergency powers that were approved for items of expenditure (pay and non-pay expenditure including software, IT equipment, maintenance contracts, good and services contracts, management consultants):

Value	Standard	Emergency Powers
Up to £15,000	Divisional Directors/ Deputy DON/ Lead Nurses	OR Director of Strategy and Ops/ Director of Nursing
£15,000 to £25,000	Deputy Director of Finance	Director of Finance
£50,000 to £75,000	Director of Finance	Chief Exec or 2 voting Execs
£75,000 to £100,000	Chief Executive	OR 2 voting Execs
£100,000 to £250,000	Business Performance Committee	Emergency Powers - Chief Exec or 2 Executive Directors and Chair acting jointly and after having consulted with at least 2 Non-Executive Directors. The exercise of such powers shall be reported to the next formal meeting of the Board for ratification
£250,000 and above	Board of Directors	Board of Directors or Emergency powers in the event that a meeting of the Board will not take place

Mersey Internal Audit Agency (MIAA) undertook an exercise for the Trust comparing SoRD financial limits to that of 4 comparative Trusts. Comparison of SoRDs identified that no one universal format or approach was applied by the reviewed Trusts and as such a one to one comparison was not always possible.

Typically this was a result of comparator SoRDs not specifying the same level of detail as the Walton Centre SoRD, though in some cases comparator SoRDs did not detail specific monetary values or clarify routes of approval above certain monetary values.

MIAA are not able to make recommendations on possible SoRD financial limits for the Trust on the basis that it could potentially create a conflict of interest moving forward (i.e. if they recommended approval limits and then audit financial controls as part of their remit).

This paper identifies the current SoRD financial limits for the Trust, with comparative information and makes recommendations for the financial limits moving forward.

Benchmarking

The table below shows comparative SoRD financial limits for the benchmark Trusts (undertaken by MIAA). It also shows the proposed financial limits for the Trust (based on the benchmark information):

	WCFT - Current	Trust 1	Trust 2	Trust 3	Trust 4	WCFT – proposed
Income (19/20) *	£132.4m	£185.6m	£170.2m	£117.2m	£324.2m	
Expenditure (19/20) *	£120.9m	£181.3m	£162.3m	£110.5m	£292.6m	
LOSSES AND SPECIAL PAYMENTS						
Fruitless payments	>£5,000 – CEO ≤£5,000 – DoF	>£10,000 – CEO (reported to audit committee) ≤£10,000 – CEO ≤£5,000 – DoF	>£250,000 – Board ≤£250,000 – CEO/ DoF (reported to audit committee) ≤£5,000 – Chief Exec, DoF/ Deputy DoF	>£250,000 – Board ≤£250,000 – CEO/ DoF (reported to audit committee) ≤£5,000 – Chief Exec, DoF	Not specified – covered within other losses	>£10,000 – CEO (reported to audit committee) ≤£10,000 – CEO ≤£5,000 – DoF
Other Losses	>£1,000 – CEO ≤£1,000 – DoF	>£10,000 – Chief Exec (reported to Board) ≤£10,000 – CEO ≤£5,000 – DoF	>£250,000 – Board ≤250,000 – CEO/ DoF (reported to audit committee) ≤£5,000 – CEO/ DoF/ Deputy DoF	>£50,000 – Board ≤£50,000 – CEO/ DoF (reported to Board) ≤£1,000 – Deputy DoF	>£50,000 – Board ≤£50,000 – CEO/ DoF	>£10,000 – Chief Exec (reported to Board) ≤£10,000 – CEO ≤£5,000 – DoF
Damage to buildings, fittings, furniture and equipment	>£10,000 – CEO ≤£10,000 - DoF	Not specified – covered within other losses	>£250,000 – Board ≤£250,000 – CEO/ DoF (reported to audit committee) ≤£5,000 – CEO/ DoF/ Deputy DoF	≤1,000 – CEO/ DoF	Not specified – covered within other losses	>£10,000 – CEO ≤£10,000 - DoF
Ex Gratia payments	>£10,000 – CEO (reported to Board) £5,000 - £10,000 – CEO ≤£5,000 - DoF	>£10,000 – reported to Board £5,000 - £10,000 – CEO ≤£5,000 – DoF	Not specified	>£50,000 – Board ≤£50,000 – CEO/ DoF ≤£2,000 – Legal services manager	>£50,000 – Board ≤£50,000 – CEO ≤£10,000 – DoF/ CoO	>£10,000 – CEO (reported to Board) £5,000 - £10,000 – CEO ≤£5,000 - DoF
Write offs/ Bad Debts	>£1,000 – DoF ≤£1,000 – Deputy DoF	>£1,000 – audit committee ≤£1,000 – Deputy DoF	>£250,000 – Board ≤£250,000 – CEO/ DoF (reported to audit	>£50,000 – Board ≤£50,000 – CEO/ DoF (reported to Board)	Not specified – covered within other losses	>£50,000 – Board ≤£50,000 – CEO/ DoF (reported to Board)

			committee) ≤£5,000 – CEO/ DoF/ Deputy DoF	≤£1,000 – Deputy DoF		≤£1,000 – Deputy DoF
PETTY CASH						
Small incidental items of expenditure	≤£100 – budget holder/ Financial Accountant	>£100 – CEO/ DoF ≤100 – Deputy DoF/ Head of Financial Accounts ≤£50 – budget holder	>£100 – DoF/ Deputy DoF ≤£100 – Petty Cash Imprest Holder	>£50 – Deputy DoF/ Financial Controller ≤£50 – Petty Cash Imprest Holder	≤£25 – Cashiers	≤£100 – budget holder/ Financial Accountant
REQUISITIONING GOODS, SERIVCES AND APPROVING PAYMENTS						
Agency Staff	>£100,000 – Board ≤£100,000 – CEO ≤£10,000 – Exec Directors ≤£5,000 – Divisional General managers/ Senior manager on-call/ Deputy Director of HR/ Medical Staffing Manager	>£100,000 – Board ≤£100,000/ >£100 per hour – CEO ≤£25,000 – Exec Directors ≤£10,000 – Divisional Heads of Ops/ Senior manager on-call/ Deputy Directors	Not specified	>£20,000 p.a. – DoF ≤£20,000 p.a. – Exec Directors/ Divisional Managers	Value not specified – any Director/ Deputy Director of Finance/ Deputy Director of Workforce/ Deputy Director of Business Development	>£100,000 – Board ≤£100,000 – CEO ≤£10,000 – Exec Directors ≤£5,000 – Divisional General managers/ Senior manager on-call/ Deputy Director of HR/ Medical Staffing Manager
Removal expenses	≤£8,000 – Director of Workforce/ DoF	Not specified	Not specified	Not specified	>£5,000 – Director of Workforce/ Deputy Director of Workforce ≤£5,000 – Deputy Director of Finance	≤£8,000 – Director of Workforce/ DoF
All other pay and non-pay expenditure	All figures excl. VAT >£250k – Board £100k - £250k – BPC £75k - £100k – CEO £50k - £75k – DoF £25k - £50k – Other Exec Directors ≤£25k – Deputy DoF ≤£15k – Divisional Directors/ Deputy Director of Nursing ≤£5k – other managers	>£1m – Board ≤£1m – CEO ≤£500k – DoF ≤£250k – Deputy DoF ≤£100k – Exec Directors/ Divisional Heads of Ops ≤£50k – Head of Financial Accounts/ Band 8C managers ≤£25k – Band 8B and 8A managers ≤£10k – Band 7 if relevant to role ≤£2.5k – Band 6 if relevant to role ≤£300 – Band 5 if relevant to role	>£500k – Board ≤£500k – CEO ≤£250k – DoF ≤£100k – Other Exec Directors ≤£50k – Deputy DoF/ Directors ≤£25k – senior managers ≤£5k – budget holders	>£500k – Board ≤500k – 2 Exec Directors (1 of whom must be CEO/ DoF) ≤£250k – Chief Exec/ DoF ≤£181k – other Exec Directors (with advice of Deputy DoF/ Head of Procurement) ≤£40k – Divisional managers/ Heads of Department ≤£5k – budget holders	All figures excl. VAT >£100k – CEO/ DoF/ COO ≤£100k – DoF ≤£50k – any Director/ any Deputy Director/ Heads of Department	All figures excl. VAT >£500k – Board £150k - £500k – BPC £100k - £150k – CEO (EMT) £60k - £100k – DoF £35k - £60k – Other Exec Directors £25k - £35k – Deputy DoF ≤£25k Divisional Directors/ Deputy Director of Nursing & Governance ≤£5k – other managers
NHS Supply Chain	>£25k (excl VAT) – Head of Procurement ≤£25k (excl. VAT) –	Not specified	Not specified	Not specified	Not specified	>£25k (excl VAT) – Head of Procurement ≤£25k (excl. VAT) –

	Deputy Head of Procurement					Deputy Head of Procurement
Zero cost model expenditure	£0 – DoF/ Deputy DoF/ Head of Procurement	Not specified	Not specified	Not specified	Not specified	£0 – DoF/ Deputy DoF/ Head of Procurement
Capital Expenditure	>£250k – Board £100k - £250k – BPC £50k - £100k – EMT ≤50k – capital monitoring group	Replacement assets >£11m – Board (Full Business Case) ≤£11m – Board ≤£500k – EMT ≤£250k – Capital Management Group New assets >£500k – Board (Full Business Case) ≤£500k – EMT (Outline Business Case) ≤£250k – Capital Management Group	Not specified	>£500k – Board ≤£500k – CEO/ DoF ≤£250k – DoF/ DoO ≤25k – DoF/ Project Sponsor	Business Case required All figures excl VAT >£1m – Board of Directors ≤£1m – Management Board & CFC ≤£200k – capital and workforce planning group ≤£50k – Financial review group (unless outside ToR then C&WPG)	>£500k – Board £150k - £500k – BPC £50k - £150k – EMT ≤50k – capital monitoring group
QUOTATIONS AND TENDERS						
Obtain competitive price for goods/ services	≤9,999 – budget managers	Not specified/ no quotes/ tenders required if <£10k	Not specified/ no quotes/ tenders required if <£20k	Not specified/ no quotes/ tenders required if <£5k	≤£9,999 (excl VAT) – budget holders	≤9,999 – budget managers
Quotations: Obtain a minimum of 3 written competitive quotations for goods/ services	£10,000 - £49,999 – Budget Managers	£10,000 to £49,999 – 2 independent officers plus on Board member or senior manager	£20,000 to £49,999 – Head of Procurement	£5,000 to £40,000 – Head of Procurement/ Head of Estates and Facilities	£10,000 to £49,999 – nominated officer/ procurement	£10,000 - £49,999 – Budget Managers To note that regular reviews of cumulative expenditure for individual suppliers (on the same project) will be undertaken to ensure that SoRD limits are adhered to.
Under threshold tenders: undertake a competitive tendering exercise for goods/ services	>£50,000 ≥£181,302 (excl VAT) Goods/ services contracts ≥£4,551,413 (excl VAT) works contracts	>£50,000 – Head of Procurement	>£50,000 ≥£181,302 (excl VAT) Goods/ services contracts ≥£4,551,413 (excl VAT) Works Contracts	>£40,000 – Head of Procurement/ Head of Estates and Facilities	>£50,000 – Nominated Officer/ Procurement	>£50,000 ≥£181,302 (excl VAT) Goods/ services contracts ≥£4,551,413 (excl VAT) works contracts
Over EU threshold tenders: Undertake a competitive tendering exercise for goods/ services	≥£615,278 (excl VAT) social & other specific services (light touch) All cases – Head of Procurement evaluated by a member of the procurement team and at		All cases – 2 officers per the authorised signatory list (one must be a Board member) and Board secretary			≥£615,278 (excl VAT) social & other specific services (light touch) All cases – Head of Procurement evaluated by a member of the procurement team and at

	least 3 stakeholders from the evaluation panel					least 3 stakeholders from the evaluation panel
VIREMENTS						
Virements	Trust must still meet financial targets and total trust budget remains underspent >£50k p.a. – CEO ≤£50k p.a. – DoF ≤£25k p.a. – Budget Holder & Deputy DoF	Trust must still meet financial targets and total trust budget remains underspent >£50k p.a. – CEO ≤£50k p.a. – DoF ≤£25k p.a. – Budget Holder & Deputy DoF	Trust must still meet financial targets and total trust budget remains underspent >£250k p.a. – Board ≤£250k p.a. – CEO ≤£100k p.a. – DoF ≤£50k p.a. – Other Exec Directors (within their own budget centres only) ≤£20k p.a. – Senior Managers (within their own budget centres only)	>£100k p.a. – CEO/ DoF (reported to the Board) ≤£100k p.a. – DoF/ Deputy DoF ≤£50k p.a. – Head of Management Accounts & Budget Holders, Divisonal managers subject to sign off by divisional accountant	Trust must still meet financial targets and total trust budget remains underspent >£100k p.a. – DoF ≤£50k p.a. – Deputy DoF ≤£10k p.a. – Assistant Director of Finance	Trust must still meet financial targets and total trust budget remains underspent >£50k p.a. – CEO ≤£50k p.a. – DoF ≤£25k p.a. – Budget Holder & Deputy DoF
CREDIT NOTES						
Authorisation of credit notes, including internal credit notes	>£25k (excl. VAT) – DoF ≤£25k (excl VAT) – Deputy DoF	Not specified – captured within approval and signing of income contracts and credit notes	Not specified	Not specified	Value not specified – DoF/ Deputy DoF/ Head of Financial Services	>£25k (excl. VAT) – DoF ≤£25k (excl VAT) – Deputy DoF
CONSIGNMENT STOCK						
Responsibility for approving consignment stock agreements	Head of Procurement/ Deputy Head of Procurement to review T&C's prior to financial approval. All figures excl. VAT >£250k – Board £100k - £250k – BPC £75k - £100k – CEO £50k - £75k – DoF £25k - £50k – Other Exec Directors ≤£25k Deputy DoF	Not specified	Not specified	Not specified	Not specified	Head of Procurement/ Deputy Head of Procurement to review T&C's prior to financial approval. All figures excl. VAT All figures excl. VAT >£500k – Board £150k - £500k – BPC £100k - £150k – CEO (EMT) £60k - £100k – DoF £35k - £60k – Other Exec Directors £25k - £35k – Deputy DoF ≤£25k Divisional Directors/ Deputy Director of Nursing & Governance
GIFTS AND HOSPITALITY REGISTER						

Any gifts or hospitality or offers of gifts or hospitality which exceed the £50 threshold must be declared	£50 - DoF	Not specified	£25 Limit	Not specified	>£25 – declaration required	£50 - DoF
LITIGATION CLAIMS						
Payments made on advice of NHS Resolution, insurance company	≤ excess on policy – DoF/ Director of Nursing & Governance – report to audit committee	>£50k – Board ≤£50k - DoF	>£15k – CEO/ DoF ≤£15k – Director of Nursing & Quality/ Medical Director	Not specified	Not specified	≤ excess on policy – DoF/ Director of Nursing & Governance – report to audit committee
Payments made on advice of legal advisor	>excess – DoF/ Director of Nursing & Governance (report to Board)	Not specified – no reference to excess or advice	Not specified	Not specified	≤£1m – CEO/ DoF & Director of CMPE in consultation with NHS Legal Authority	>excess – DoF/ Director of Nursing & Governance (report to Board)
Decision to contest/ initiate other litigation claims	>£10k or contentious case – Board ≤£10k - DoF	Not specified	Not specified	Not specified	Not specified	>£10k or contentious case – Board ≤£10k – DoFScheme

'* based on full year budgeted figures

Recommendations

The board are requested to:

- Recommend approval to change of limits for Board approval